# Couples Experiences of Postnatal Anxiety: A Thematic Analysis approach

by
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Creating alternative stories to help a mother reconnect with her daughter: An individual systemic therapy approach.

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Postnatal anxiety is in the system: a thematic analysis on how couples experience postnatal anxiety.

**Acknowledgements**

As this project is all about families, I want to thank my own first. Thank you, Graeme, for always having my back and supporting me no matter what. Thank you, Matthew, for teaching me to be a mum and always rooting for me no matter what. Thank you, Bruce, for accompanying me to class and teaching me that a smile makes everything better no matter what. Thanks to my mum, dad, sister, and grandfather for helping me keep on track and rooting for me.

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**Declaration of Power**

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**Preface**

My doctoral portfolio comprises three pieces of work. The first is my research project that seeks to explore how couples experienced postnatal anxiety. The second is the combined process report and study, which describes a piece of clinical work I did in the final year of my counselling psychologist training. The third is a paper intended for publication with part of the findings from my research project.

When I think about my journey as a psychologist, I can't help but think about systems; the interrelatedness that allows us as humans to connect with others. I am person that thinks relationally, and I understand people and their stories in their context. So I felt the work that I have done in this portfolio reflects my journey in trying to understand people's stories and how they are so deeply connected to their families and networks.

When I finished my psychology degree in Venezuela, I immediately began working with families, and when I arrived in the UK, I continued my work in CAMHS. This allowed me to understand that mental health difficulties occur in a context that affect the family and that support systems are needed to improve quality of life. In addition, my training in counselling psychology gave me the tools to understand how to connect theory, practice and research while working with my client's unique subjective psychological experience. But most importantly, it allowed me to reflect on my point of view of considering individuals in systems and how this could be of importance for my research and clinical piece.

I had a flavour of systemic therapy before I started my counselling psychology training, but the lectures and supervision awakened a passion for understanding clients at a different level. I see difficulties as arising in, being sustained by and affecting a system. As Boscolo and Bertrando (1996) said, when there is a change in the family system, there is a change in all its members. I can't think about postnatal anxiety without thinking about partners and babies, and I can't think about working with young people without working with their parents.

I like the idea that clients can find alternative stories that allow them to take control of their lives and reconnect with their families (Carr, 2001). And I like the idea that, as therapists, we can help the individual weave healing stories (Vetere, & Dallos, 2008). So I think the idea of systems, creating alternative stories and weaving healing stories connect the three pieces of work I present here.

I hope that the counselling psychology value proposition doesn't sit only to a clinicians' level, but that is taken to develop services and inspire research. I also hope this project leaves the reader curious about the idea that supporting families helps the individual in distress and that an individual in distress means a family in distress.

**Section A: Doctoral Thesis**

**Couples Experiences of Postnatal Anxiety: a Thematic Analysis approach**

My doctoral thesis uses thematic analysis to explore how couples experience postnatal anxiety. In the last years, it has been identified that perinatal services needed to be improved, as their current practice was not offering something of value for mothers (NHS, 2019). It has also been identified that health care professionals need more training around mental health issues in the postnatal period (Delicate, Ayers & McMullen, 2020).

Postnatal anxiety has been poorly researched, and there has been more clinical attention given to postnatal depression even when there is evidence that postpartum anxiety is more common (Fisher, Wynter, & Rowe, 2010, Dennis et al., 2017). In addition, research hasn't focused on how couples experience anxiety. This research argues that when one partner is anxious, the other is anxious and that fathers and mothers both experience difficulties after having a baby, irrespective of the biological component. The hope is that the themes found help professionals to offer better support in practice and services and inspire others to do more research around postnatal anxiety.

**Section B: Combined Case Study and Process Report**

My client work is titled "Creating alternative stories to help a mother reconnect with her daughter: An individual systemic therapy approach". This piece of work explores how parent work is valuable when working with young people in services. It explores how the mother makes sense of her daughter's problems and how, with the help of systemic thinking, she can create an alternative healing story.

The case study I present here also explores how I, as a professional, needed to think about the broader system and the roles I play as a clinician within those systems. Interactions between families and macro systems have been described as problematic; this piece of work shows my efforts to maintain viable relationships with the broad professional community as I intervened with the family (Imber-Black, 1988). It showed the struggle I had when I needed to focus on behaviours that are considered immoral or illegal, maintaining curiosity by exploring alternative views rather than in a social controller role (Cecchin, 1987).

**Section C: Publishable Paper**

My publishable paper is called "Postnatal anxiety is in the system". It aims to showcase the part of my research that explains that when a partner is experiencing anxiety, then the other partner is experiencing anxiety. This is done with the aim of highlighting how healthcare professionals who include partners in postnatal support might be providing something of value for these families.

When I interviewed the families, I stayed with their messages. I stayed with the idea that there was not much information about postnatal anxiety, that fathers were excluded, that they both struggled, that they both took care and bonded with the baby, and that they were hoping that this research would bring more information for healthcare professionals and future parents. So I hope that this paper gets published to disseminate my findings more widely.

The paper has been written according to the specifications of the Journal of Reproductive and Infant Psychology.

## Conclusion

The BPS (2021) describes counselling psychologists as:

> "A relatively new breed of professional applied psychologists concerned with the integration of psychological theory and research with therapeutic practice. The practice of counselling psychology requires a high level of self-awareness and competence in relating the skills and knowledge of personal and interpersonal dynamics to the therapeutic context."

This portfolio aims to demonstrate the integration of systemic theories in research and practice. Throughout this work, the reader will find an emphasis on self-awareness and competence by reflecting on the work and my bias as I carried out the work. The research project hopes to elucidate how couples experience anxiety as a system and describe themes that hope to be of value for professionals supporting them. The clinical work hopes to demonstrate that systemic thinking can help create alternative stories with healing powers in families. And the publishable paper aims to disseminate the idea that couples should be supported together in the postnatal period more widely.

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## Section A: Doctoral Research

Couples Experiences of Postnatal Anxiety: A Thematic Analysis approach

**Abstract**

**Objective**: Investigate heterosexual couples experience of postnatal anxiety.

**Background**: Perinatal mental health has become a matter of public health priority in the United Kingdom. Postnatal anxiety is one of the most common mental health issues parents face after having a baby. However, little is known about how parents experience anxiety after having a baby, and existing research has focused mostly on mothers or postnatal depression.

**Methods**: Nine heterosexual couples were interviewed. The resulting data was analysed using thematic analysis. Themes were developed around the couple's experience of postnatal anxiety.

**Results**: This research has found that couples who experience postnatal anxiety feel that the impact of their difficulties affects the system. This means that both partners struggle with their mental health, that they use self-regulatory efforts as a couple and that they think about the impact of their mental health on their baby and in their bond with their baby. It was found that couples who experienced postnatal anxiety felt that their mental health brings an extra set of difficulties and this leads to a difference between their expectations and their reality that causes them distress. Another finding was that couples modified their behaviour in order to manage their postnatal anxiety. Lastly, the COVID pandemic affected the couples and therefore had an impact on their experience of postnatal anxiety.

**Conclusion**: This work contributed to an important gap in the literature about postnatal anxiety and couples' experience of postnatal anxiety. This study has identified areas for future research to explore and develop.

## Chapter one: Review of literature

### Reflexivity

I would like to begin my research by stating my personal interest and investment in the topic. For years, I have worked in CAMHS services and I have seen first-hand how anxiety affects the lives of parents and children. Having worked with many parents, I have been thinking for a long time about how counselling psychologists might support them better.

I became a second time mother myself during the first year of my counselling psychology doctorate and I remember how anxious I felt after my son was born. It brought to mind an encounter I'd had with a mother in the service where I worked. She had mentioned that she had postnatal anxiety and since then she had felt unable to support her child. She said she had lost confidence and this had affected her parenting. I became interested in postnatal anxiety as I wanted to understand what I was going through. This was a moment where my interest in working with anxious parents and my experience of postnatal anxiety collided. As I have worked in CAMHS for many years, my thinking is always systemic. I think about families as systems and I wondered how parents made sense of someone experiencing postnatal anxiety in the system. I was so invested in the topic that I knew that this was where I wanted focus my research.

I began my research journey wanting to evaluate a group that supports parents experiencing postnatal anxiety. I wanted to evaluate the effectiveness of a programme and how parents saw it, using a mixed-methods approach. I was thinking as a clinician who had developed parenting groups rather than as a researcher. So I needed to reflect on my role in this piece of work. I was initially debating whether to focus on mothers or parents but I have worked with couples before and I am in a long-term relationship; I cannot think about something that affects one partner without affecting the other. It took time for me to realise that I was viewing this project through the lens of a clinician or a parent rather than a researcher. Changing my thinking around my role allowed me to arrive to the conclusion that I wanted to study how couples made sense of their experience of postnatal anxiety. After carrying out a comprehensive literature review, I realised that there was a need for more research studying couples

during the postnatal period. For me, this was a win: not only did I get to research a topic that in interests me as a psychologist but it also interests me at a personal level.

As I worked on my project, I understood that what was needed was qualitative research that focused on the parent's experience of postnatal anxiety. In addition, that, I needed to reflect on my implicit agenda and unconscious biases. I thought that both partners would likely be affected by postnatal anxiety but I was not sure how. I could only speak from my experience and I did not want my bias to disrupt my project. I wanted to think systemically about the topic and I needed to understand if this reflected the couples' experiences. I needed to acknowledge my experience of postnatal anxiety and use it to guide my work without imposing my point of view onto the accounts of the participants. I thought that qualitative research would allow me to use my subjectivity as a research tool. These reflections helped me as I worked on my research and it is my hope that this research will allow the reader to reflect on their own experience of anxiety.

**Introduction**

This chapter will explore the literature around postnatal mental health difficulties in couples. The terms perinatal mental health, postnatal anxiety and postnatal depression will be defined to understand the scope of the literature review. The chapter will explain what we know about postnatal mental health issues, postnatal depression and postnatal anxiety. It will also elucidate the importance of understanding postnatal mental health issues as this impacts children's emotional, social and physical development. Then there will be a review of anxiety and the differentiating features of postnatal anxiety.

Postnatal anxiety will be explored from a systemic point of view. There will be a review on how postnatal anxiety influences parent-infant relationships and how postnatal anxiety impacts couple's functioning. Therefore, there is a review of literature around how partners manage, express and support each other when they experience postnatal anxiety. Finally, there is a review on how postnatal experiences have been studied and how couple's experiences have been studied, this will give an insight into the research around couples experiencing postnatal anxiety.

An important aspect of this chapter is that it aims to identify limitations in the literature past and present and therefore recognize gaps. The chapter concludes by giving a rationale on how couples' experiences of postnatal anxiety can be studied.

Something to consider during this chapter is that most of the literature focussed on postnatal depression rather than postnatal anxiety. Most of the literature is focused on mothers. Most of the literature is quantitative and samples are usually restricted to white, highly educated, heterosexual couples.

**Aims**

The primary aim of this study was to gain an insight into the experience of heterosexual couples that experienced postnatal anxiety, in order to better support them. The second aim was to consider the implications for counselling psychology in both service delivery and in clinical interventions. A third aim was to provide recommendations for future research.

**Definitions**

This section is intended to offer the definitions of some of the key terms, explaining how they are understood within the present study.

Perinatal mental health: Refers to the mental health problems which occur during pregnancy or in the first year following the birth of a baby (although the postpartum time frame has been considered debatable) (O'Hara & Wisner, 2014).

Postnatal anxiety: is the anxiety that occurs following the birth of a baby (O'Hara & Wisner, 2014). O'Hara and Wisner (2014), explained that anxiety disorders in this period include: generalized anxiety, obsessive–compulsive, panic, and social anxiety disorders. They add that the severity and effect of anxiety symptoms (e.g. worry, avoidance, and obsessions) often do not rise to the level of an anxiety disorder diagnosis but they cause at least mild-to-moderate levels of distress and impairment (O'Hara

& Wisner, 2014). There is no official postnatal anxiety definition on The American Psychological Association website to date, although in their policies they advise to screen for mood and anxiety disorders in the postpartum period (APA, 2020).

Postnatal depression: usually abbreviated as PND in literature. PND has been used often to name any mental illness parents have experienced in the postnatal period, including anxiety (Hanley & Hanley, 2009). It has been defined as baby blues (natural hormonal changes after birth that cause distress) becoming incrementally worse with the mother not being able to regain a sense of wellness; symptoms include worries, self-reproach, feelings of failure, lethargy and others (Hanley & Hanley, 2009). APA (2021a) explains that postnatal depression refers to major depressive episodes or minor depressive episode that can affect women within 4 weeks to 6 months postpartum.

Baby blues: are transient depressive symptoms during the first 10 days after giving birth and should be considered different from postnatal depression (APA, 2021b).

Relationship quality: Quality in a relationship can be thought in terms of relationship adjustments such as communicating with each other, understanding and supporting your partner and about dyadic adjustment which means better functioning (Zaider, Heimberg & Iida, 2010). Positive relationship qualities are supportive behaviours; such as showing concern or being dependable; while negative relationship qualities can be considered to revolve around conflicts and discordance; such as partners being critical (Zaider et al., 2010). Therefore, for this research good relationship quality means that partners show positive relationship quality behaviours that help with relationship adjustments and that present dyadic adjustment which mean better functioning (for example: capable of caring for children, sustaining a job and maintaining relationships).

**Background**

Perinatal mental health has become a public health priority in the United Kingdom (Seneviratne, Utterson, & Wilson, 2018). One study have placed a lifetime cost of perinatal depression (PPD) at

£75,728 and perinatal anxiety at £34,811 per woman (Bauer, Knapp, & Parsonage, 2016). There appears to be a high prevalence of perinatal mental health issues: postnatal depression is reported at 12% among mothers without prior history of depression (Shorey, Chee, Ng, Chan, Tam, & Chong, 2018), anxiety has been reported to affect 15% of births/women who have given birth/pregnancies and general anxiety disorder is reported to have occurred in 4.1% (Dennis, Falah-Hassani, & Shiri, 2017) of cases.

The impact of depression and anxiety has been studied primarily on mothers, while father's mental health has received less attention (Dudley, Roy, Kelk, & Bernard, 2001). However, it has been found that between five to 10 percent of fathers' experience perinatal depression while 5-15% experience perinatal anxiety (Cameron, Sedov & Tomfohr-Madsen, 2016; Leach, Poyser, Cooklin & Giallo, 2016). It also has been found that fathers can experience post-traumatic stress symptoms following the birth of their baby (Daniels, Arden-Close & Mayers, 2020).

Research shows that when mothers are experiencing perinatal mental health disorders, their partners have been found vulnerable to mental illness (Darwin, Domoney, Iles, Bristow, Siew & Sethna, 2021). In its 5-year programme, the National Health System has identified the need to develop modern maternity services to provide better access to mental health services for mothers during the perinatal period (NHS, 2017). The NHS has identified that better provision for mothers in the perinatal period will improve maternal mental health and children's mental health and development. But it hasn't identified adequate provision for fathers or couples. Perinatal services only attend to mothers that have given birth to their babies. Couples who adopt or use surrogates are not included for support in this area of the NHS.

Sambrook, Smith, Lawrence, Sadler, & Easter (2019) explain that women tend not to look for help when they experience perinatal mental health issues and they describe the barriers that need to be addressed in order to access mental health services during the perinatal period. First, women have been found to avoid seeking help, and they have reinforced feelings of stigma and guilt; they have

negative attitudes towards diagnosis and treatment. Second, it has been identified that a lack of knowledge around perinatal stress among Health Care Professionals (HCP), women and families often leads to poor recognition of symptoms and an unclear referral process. And perhaps this lack of recognition of symptoms and lack of knowledge contributes to the difficulties in diagnosis in the postnatal period.

Rothera & Oates (2008) found that a lack of knowledge, skills, integrated working and poor access to resources were common issues. Sorsa, Kylma & Bondas (2021) concluded that even when mothers access services, they might choose not to disclose their problems. Mothers felt more able to disclose their problems when GPs were empathetic and non-judgemental and listened during the discussion (Ford, Roomi, Hugh & van Marwijk, 2019).

Schuppan, Roberts & Powrie (2019) described how recently there had been trials for interventions for fathers, but there is not much information about men's help-seeking behaviour. A systematic review found that men interpret depressive symptomatology as a sign of physical health rather than mental health (Seidler, Dawes, Rice, Oliffer & Dhillon, 2016). This research identified that men prefer to discuss their symptoms with their partners, and they identified as "stressed" and "overwhelmed" as these labels were in concordance with their masculine ideals (Seidler et al., 2016). Thematic analysis done research identified that fathers experience difficulties seeking help as there is stigma (Seidler et al., 2016). They did not want to be seen as weak. They perceived themselves as having to provide support and protection and believed that they would endanger their partner if they struggled. They felt health professionals treated them as “spare parts” with no information or support targeted to them. Informal health-seeking behaviours allowed them to compare themselves to other fathers who reassured them but interfered with them seeking formal help as they felt their partners were having a worse time than them (Schuppan et al., 2019).

Non-psychotic mental health disorders have been found to be the most prevalent during the perinatal period, and most of the research has been focused on postnatal depression (Howard, Molyneaux,

Dennis, Rochat, Stein & Milgrom, 2014). Clinical attention has been given to maternal postnatal depression even when evidence for maternal postpartum anxiety is more common (Fisher, Wynter, & Rowe, 2010 and Dennis et al., 2017). Woolhouse, Gartland, Mensah, & Brown (2015) mentioned that most studies focus on the perinatal period (12 months after birth) as more changes are associated with childbirth. They found that the prevalence of depressive symptoms at four years postpartum was 14.5% (Woolhouse et al., 2015).

In fathers, it is even more challenging to assess the impact of postnatal mental health issues. Researchers have found that PND is poorly recognised in men so that prevalence might be under-reported (Stadtlander, 2015). As a result, parental mental health has been under-researched, and PND has taken priority over postnatal anxiety. Researchers have called for attention to understand how couples experience postnatal mental health issues as the available information provides little guidance for professionals (Everingham, Heading, & Connor, 2006).

Something to consider is that when we talked about having a baby most research and services focus on mothers and this doesn't include (1) pregnant individuals who do not identify as women, (2) expectant couples in which one partner is pregnant, (3) expectant parents engaging a surrogate or pursuing adoption, and (4) pregnant people who rely on networks of family and friends for support and caregiving (Clarke, 2019). There is not much information around same-sex couples experiencing perinatal difficulties (Ross, Steele & Sapiro, 2005). And researchers have focused more on studying postnatal depression in sexual minority women than any other area (Flanders, Gibson, Goldberg & Ross, 2016). Although research around the LGBTQ community is important, this research aims to explore heterosexual couples therefore postnatal anxiety will be explored in relation to people that described themselves as mothers and fathers.

For the purpose of this research project, a broad search was done using EBSCOhost, Ovid Online, PsycArticles, PsycINFO and PubMed using the terms: "postnatal anxiety", "perinatal anxiety", "perinatal mental health", "couples experience", "infant development", "self-regulating couples",

“couples management of anxiety”, “bonding and postnatal anxiety”, “couples management of anxiety” from January 2019-September 2021. The information was chosen if the publications were relevant and up to date for psychological knowledge development and were written in English. Contact with the Centre for Maternal and Child Health Research from the School of Health Sciences at City, University of London, was made at the beginning of the project to ensure quality and to understand the research done in the area.

**Parental mental health in the postnatal period and the impact on the family wellbeing**

A large body of evidence states that perinatal mental health and maternal mental health are associated with a negative impact on children's physical and psychological development (Stein, Pearson, Goodman, Rapa, Rahman, McCallum, Howard, Pariante, 2014). Although this investigation is dedicated to the role of anxiety during the postnatal period, it is necessary to include findings on postnatal depression as these two conditions can be comorbid, there have been problems around differential diagnosis between the two conditions and it has been thought that associations attributed to one might include causes associated with the other (Field, 2018; Hanley & Hanley, 2014; Stein et al., 2014). Also, because of the difficulties professionals have reported identifying and understanding mental health difficulties in the postnatal period, it is possible that PND and postnatal anxiety have been at times confused (Rothera & Oates, 2008; Sambrook et al., 2019). Therefore, relevant research for perinatal distress will be discussed.

Stein (et al., 2014) did a systematic review that found that both anxiety and depression in parents affected the following areas for the child: emotional difficulties and social development, behavioural difficulties, attachment, cognitive development, child physical growth and development, feeding, eating habits and attitudes. They also mentioned that the persistence of parental mental health issues impacted children’s outcomes. Mental health issues increase the risk of interparental conflict, which affects children and is detrimental to the parenting quality as their capacity to respond to their environment is compromised (Stein et al., 2014).

Rees, Channon, & Waters (2019) did a systematic review using only postnatal anxiety for their criteria. They found that studies conducted in this area lacked methodological rigour, and they suggested further research is needed to understand postnatal anxiety. In general, they found that studies revealed postpartum anxiety, predicted emotional problems in the child at age 4, and mothers had a high perception of children's emotional problems. For them, the lack of control of prenatal anxiety and comorbidity with depression was a difficulty, so they felt more attention was needed on the role of postnatal anxiety as the only variable. Seymour, Giallo, Cooklin, & Dunning (2015) found that maternal anxiety was associated with low parenting warmth, involvement, efficacy, satisfaction and high parenting hostility. They noted that when comorbidity with depression was present, these parenting behaviours and experiences were more strongly associated. And for fathers, increased psychological distress has been associated with low parenting warmth, lack of consistency and increased hostility (Giallo, Cooklin, Brown, Christensen, Kingston, Liu, Wade & Nicholson, 2015).

It has been found that PND generates an adverse impact on the parent's physical and mental health, interfering with self-care and parenting (O'Hara, 2009). But not much investigation has been dedicated to postnatal anxiety. What is interesting is the notion that parental mental health has an impact on the child as it interferes with the quality of their parenting. This supports the systemic idea that there are patterns in family's lives and experiences, and family members influences the emotional experience of the other (Dallos & Draper, 2015).

**Anxiety and Postnatal anxiety**

Anxiety has been described as the most "troubling and pervasive of emotions". Many people are affected by it in the form of anxiety disorders that, left untreated, can become chronic (Rachman, 2020). The DSM-5 (American Psychiatric Association, 2013) classifies general anxiety disorder as excessive anxiety and worry (apprehensive expectation): the person has trouble controlling worries; can present with restlessness, being easily fatigued, difficulty concentrating, irritability, muscle tension and sleep disturbance; and the anxiety, worry, or physical symptoms cause clinically significant distress or impairment in functioning.

Anxiety has been defined as a feeling of excessive worry and fear with anticipation of future threats, that is characterised by somatic symptoms such as palpitations, sweating and trembling (APA, 2018). General anxiety disorder has been found to follow a chronic course with low rates of remission and moderate rates of relapse and/or recurrence following remission (Keller, 2002). Support around anxiety includes intervening with dysfunctional thinking patterns of rumination, overthinking and repetitive negative thinking (Altan-Atalay, 2018).

Postnatal anxiety, which is not considered a disorder, occurs after childbirth and up to 1 year after the infant's birth (Chhabra, McDermott, & Li, 2020). But there does not seem to be much further investigation around the course of anxiety during this period. During the postpartum period, demands and responsibilities increase. It has been found that what was previously thought of as a time of joy can be detrimental for mental health; researchers have found that some mental health issues can worsen or emerge during the postnatal period as changes of identity bring new challenges to new parents (Fadjukoff, Pulkkinen, Lyyra, & Kokko, 2016; Perun, 2020; Vesga-López et al., 2008).

Researchers have been trying to establish if postnatal anxiety differs from anxiety at any other point in the individual's life. Cunningham, Brown, Brooks and Page (2013) concluded that the postpartum emotional symptoms have the same factor structure observed in non-postpartum populations, which meant that anxiety is similar in different periods in mothers. But researchers have found particular risk factors associated with postnatal anxiety. For mothers the risk factors are: being a young mother, having more education and being employed, caesarean delivery, fear of the birth and of death during delivery, lack of control during labour, low self-confidence for the delivery and the delivery staff, premature delivery, lack of family support, marital/family conflict, social health issues, prenatal depression and anxiety (Field, 2018). For fathers, factors contributing to anxiety included lower education levels, lower income levels, lower co-parenting support, lower social support, work-family conflict, a partner’s anxiety and depression, and being present during a previous birth (Philpott, Savage, FitzGerald & Leahy-Warren, 2019).

Another important distinction to make about postnatal anxiety is the relationship with birth trauma. Birth trauma can be experienced by both mothers and fathers (Daniels et al., 2020). Birth trauma is poorly recognised and insufficiently treated and it can trigger ongoing psychosocial symptoms for women, including anxiety, tokophobia, bonding difficulties, relationship issues and PTSD (Watson, White, Hall, & Hewitt, 2021).

Even when similarities occur both in anxiety and postnatal anxiety, there seems to be some specific elements to the symptomatology of postnatal anxiety. Intrusive thoughts of unwanted infant-related harm have been extensively documented (Collardeau et al., 2019). Researchers have found that mothers and fathers did not differ in the likelihood of reporting harm thoughts and that hostile emotions were stronger amongst postpartum parents, but this did not mean a display of aggressive behaviours (Fairbrother et al., 2019).

Fatigue is expected during the postnatal period, and it is mainly associated with the demands of a baby and sleep deprivation. Sleep deprivation and mood disorders during the postnatal period are significantly connected (Ross, Murray & Steiner, 2005). However, it has been reported that for (well educated) mothers, anxiety is the main contributor to fatigue scores at 6, 12 and 24 weeks postpartum (Taylor & Johnson, 2013).

It also has been reported that women who suffer from generalized anxiety during the postpartum period tend to exhibit avoidant and safety behaviours (Green, Donegan, McCabe, Streiner, Furtado, Noble, Agako & Frey, 2021). And although problematic behaviours are targeted in anxiety interventions, it is only recently that it has been addressed in postnatal anxiety. More specifically, Maguire, Clark & Wootton (2018) explained that most postnatal anxiety interventions focus on cognitive aspects including maladaptive thinking and neglect behavioural interventions such as exposure.

Healthcare professionals such as health visitors, GPs and midwives are the first line of contact for mothers and fathers who experience postnatal anxiety. Researchers have found that midwives tend to believe that all new mothers worry excessively and that anxiety is not as harmful as depression and therefore they don't provide further support (Taylor & Johnson, 2013). Health visitors have reported that they encounter women with postpartum anxiety and they described them as "heavy users" of health visitors or other services which they thought was problematic (Drennan, 2017). But as with other professionals, health visitors reported they needed more information about interventions for postnatal anxiety and training (Drennan, 2017).

Rowe, Calcagni, Galgut, Michelmore and Fisher (2014) consulted with mothers who were experiencing anxiety as they wanted to identify the sources of mothers' worries to develop a psychological intervention. The mothers expressed their concerns were around: their own and their baby's health, infant crying, breastfeeding failure, advice to trust their intuition which promotes perceptions of incompetence in infant care, expectations for autonomous decision-making amidst conflicting information, fear of criticism and inadequacy, interpersonal conflict with relatives and leaving the baby in the care of others (Rowe et al., 2014).

Psychological processes such as guilt, avoidance and adjustment difficulties were experienced across different types of distress during the postpartum period, so these must be considered when thinking about postnatal anxiety (Coates, Ayers, & de Visser, 2014). Loughnan, Wallace, Joubert, Haskelberg, Andrews, & Newby (2018) identified the perinatal period as an area of urgent attention as few studies have evaluated the efficacy of psychological treatments. Anxiety is relatively common in the postnatal period at levels that represent the most severe and distressing, and persistent difficulties (Goodman, Watson, & Stubbs, 2016).

Other process that occur when people are anxious have yet to be studied in people that experience postnatal anxiety. For example, when we talk about negative emotions. Campbell-Sills, Barlow, Brown and Hofmann (2006) found that judging emotions as unacceptable and suppressing emotions was a

common feature in people with anxiety disorders. But there is not much information about this feature and if it occurs during postnatal anxiety. Additionally, Everaert, Bronstein, Castro, Cannon and Joormann (2020) explain how emotional regulation is instrumental to understand anxiety but there has not been much information about the cognitive mechanisms that give rise to maladaptive patterns of emotion regulation. When there is little information with regards to anxiety, there seems to be less information about how process occur in the postnatal period.

Therefore, it is important to understand how couples experience postnatal anxiety to understand anxiety in this period and develop appropriate interventions. As healthcare professionals and researchers have pointed out, there needs to be more information, training and development of interventions for postnatal anxiety to best support parents in the first year of their baby's life.

**Parent-infant interaction and the relationship with postnatal anxiety**

When discussing parent and baby interaction, we need to discuss bonding. Bonding is the process in which attachments are formed between individuals; this early relationship between mother and child is essential in establishing unconditional love from the parent and security and trust from the child (APA, 2020c).

Focus on bonding allows us to think about the feeling between parents and child rather than behavioural responses from the child (Altaweli & Roberts, 2010). For many years the focus on bonding has been in the mother even when similar bonding behaviours have been found in fathers, and it wasn't until 1970-1980 that father-baby bonding was explored (Scism & Cobb, 2017). This perhaps shows the shift in societal changes around babies' care, with fathers and mothers sharing emotional and practical caring responsibilities more evenly (Brooks & Hodkinson, 2020).

Although the concept has been primarily researched as the relationship between mother and baby, and is mainly mediated by breastfeeding, recent findings suggest that this relationship is independent of breastfeeding (Hairston, Handelzalts, Lehman-Inbar, & Kovo, 2019). Bonding can be negatively

affected by postnatal difficulties and it has been associated with poorer neuropsychological, behavioural, emotional, and social development in children (Mascheroni & Ionio, 2019).

Webb & Ayers (2015) conducted a systematic review to identify how parents who presented mental health issues during the postnatal period interpreted emotions in their infants. Their rationale was to try to identify possible reasons for the detrimental effects of perinatal psychological problems on bonding and the mother-infant interaction.

Webb & Ayers (2015) found valid studies which proved that mothers who experienced anxiety or depression had a tendency to identify negative emotional expressions in their infant, and they were probably quicker to identify negative emotions. They found that in relation to anxiety, mothers that identified as anxious were more likely to perceive a sad face as negative than other parents, and they even identified a neutral face as being sad. In comparison, some evidence suggested that both mothers with anxiety and depression were less accurate when recognising happy faces. Webb and Ayers conclude that when mothers are more able to recognise and respond to their baby's negative faces, they are indirectly reinforcing the expression of sadness in their infant, which in turn could bring difficulties in the mother-infant interaction (Webb & Ayers, 2015).

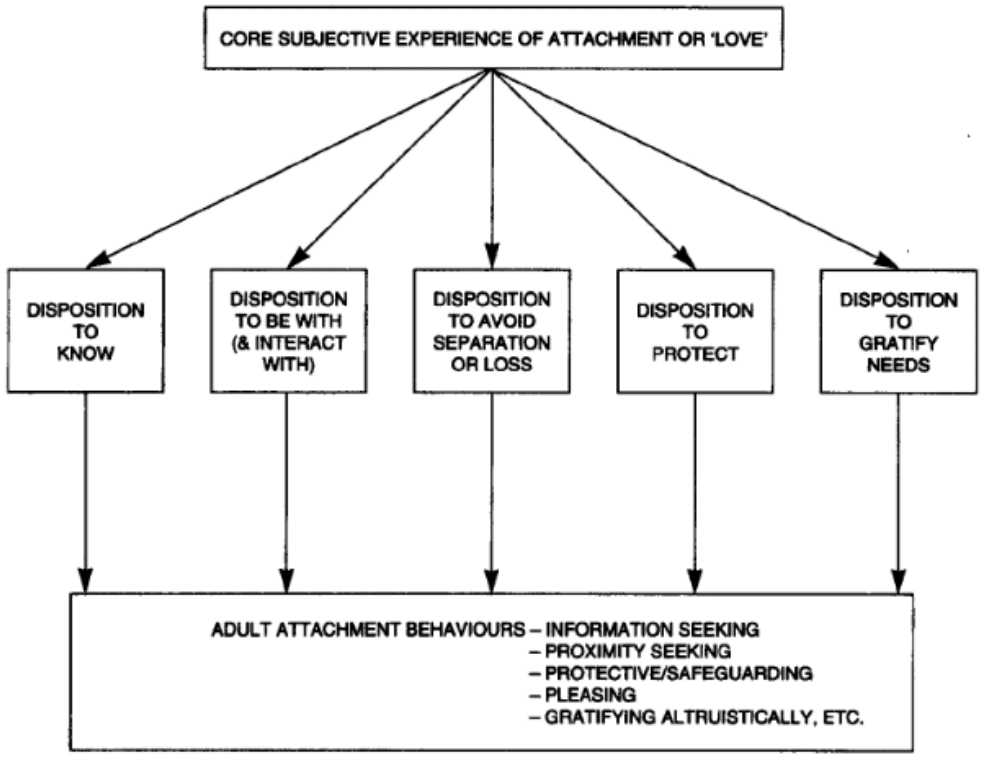
Kujawa, Dougherty, Durbin, Laptook, Torpey, & Klein (2014) studied the possible link between negative parenting and emotion recognition deficits in offspring and how they may be moderated by parental depression. They analysed data from 476 children; the sample was diverse in terms of ethnicity, but mostly from middle-class families, which may point to some of the difficulties around recruiting samples for these types of studies. They were interested in emotional listening to assess if children could identify vocal tone, emotion labelling to match pictures with names of emotions, emotion learning tasks to see if children could use corrective feedback, children internalising and externalising symptoms and parental depression. To measure parenting behaviour, they videotaped the interaction between parent and child. Their results suggested that negative parenting behaviour, which they frame as hostility and intrusiveness, was associated with poorer performance on the emotion recognition

task. Maternal depression only affects child emotion recognition in combination with negative parenting. They also found that parental anger and criticism combined with limiting autonomy development for the child could impair emotional recognition. This is moderated by maternal depression. They found that mothers who have experienced depression have deficits in emotion recognition and flat speech, lower rates of affective facial expressions, and delayed responding.

Disruption in bonding is detrimental for children's outcomes and parents themselves (de Cock et al., 2017). Levels of parenting stress tend to be higher when the bond is disrupted (de Cock et al., 2016). Condon (1993) described how the core of the parental bond is a feeling of love that eventually exposes itself in parental behaviours. Bonding according to Condon is seen as a construct that means that bonding goes beyond the dispositions that parents display towards their children and it represents the core subjective experience of attachment (Condon, 1993).

Figure 1.

Condon’s model of parental attachment (1993).



Condon and Corkindale (1998) found ambivalence in bonding where there might be resentment about the impact of the baby in the parent's lifestyle, and there might be feelings of anger and hostility towards the baby. Thus, it is thought that normal relationships between parents and children can sustain a degree of ambivalence without impacting the bond. And these feelings change and evolve depending on the child's age, and bonding tends to increase for both mothers and fathers (Condon and Corkindale, 1998 and Condon, Corkindale, & Boyce, 2008). They also found that when there is a better partner relationship, there are higher levels of bonding for fathers (Condon, Corkindale, Boyce, & Gamble, 2013).

De Cock and his team (2016) did a study to identify patterns in bonding during pregnancy and postnatal at six months and 24 months with 322 mothers and 247 fathers. They found that feelings of bonding are relatively stable from pregnancy to toddlerhood for parents, but mothers bond faster at the postnatal period than fathers. They also found that parents who show lower bonding tend to show more signs of parenting stress. Bonding seems relatively stable even if there is normal ambivalence. Mothers who showed higher levels of bonding had more adaptive personality characteristics, and they also experienced lower levels of postnatal anxiety and parenting stress. They also experienced more support from their partners, and the partner also reported higher levels of bonding and less parenting stress. The mothers in this group were younger (average age of 29) and had, on average, lower levels of education than the rest of the sample. Still, the sample was mostly highly-educated white couples. Mothers with intermediate levels of bonding presented lower levels of consciousness and agreeableness, which means they showed more anger and hostility, reported more postnatal anxiety and parenting stress, less partner support and perceived their children as more complex. Lower bonding in mothers was correlated with most negative personality characteristics. They were less stable, experienced less partner support and had more postnatal anxiety and parenting stress. Their partners also reported lower bonding and more parenting stress.

For fathers, the patterns appear similar but less pronounced (de Cock et al., 2016). Fathers had higher bonding levels with firstborns. Only mothers showed the partner support differences in terms of the

level of bonding. They suggested that gender differences in these results could be explained by the fact that mothers are usually the primary caregiver and generally more involved in the parenting of their children. Parents with low levels of bonding and other contextual problems have the highest education levels, and the researchers thought this had to do with the demands they were exposed to. But the educational levels in the sample were generally high as it is with postnatal research. Interestingly, they discuss gender differences in the way they share caring responsibilities, but there was no mention about the couples' functioning.

This evidence suggests that anxiety and bonding are linked. When thinking about bonding we think about how parents interpret emotions in their children, the behaviours they engage in to maintain the relationship, their parenting strategies and the emotions they show their infants when they experience deficits (Webb & Ayers, 2015; Condon, 1993; de Cock et al., 2016 and de Cock et al., 2017). But the exploration of this area of research highlights a difficulty with participant recruitment and sampling: most of this research reveals how difficult it appears to be to engage diverse samples, and most research seems to focus on individuals rather than couples as participants.

**A systemic view of postnatal anxiety**

As research has shown, there is an interrelation between parents and their children's outcomes. This view is a systemic view. A systemic view enables one to think about all the members of the family, how they are connected, the way they interact and the patterns they present (Dallos and Draper, 2015).

Systemic models focus on relational patterns and how these affect the individual and the system where they belong (Dallos and Draper, 2015). For example, attachment models point out an association between attachment security in an individual and their cognitions and behaviours as dependents in part of the attachment security of both partners (Mikulincer, Florian, Cowan, & Cowan, 2002). For this model, anxiety happens when intimate relationships are threatened by conflict or crisis that endangers the affective bonds; this interlink in couples makes it impossible to detect any behaviour's "first cause" (Mikulincer et al., 2002). Family systems are viewed as self-regulating. Because the family are

dynamically interconnected, any changes in any aspect of the system can lead to changes in the entire family system (Mikulincer et al., 2002).

Researchers have started to acknowledge that mothers and fathers experience perinatal distress and that partners are able to provide consistent long-term support and detect changes in their partner's wellbeing (Pilkington, Whelan & Milne, 2015). In addition, postnatal anxiety has been thought to have a potential mechanism to explain how personality traits are related to postnatal depression (Roman, Bostan, Diaconu-Gherasim & Constantin, 2019). Due to the association between postnatal depression and postnatal anxiety and the lack of studies around postnatal anxiety in couples, exploring PND research might give us ideas about how couples relate in the postnatal period.

Don and Mickelson (2012) wanted to explain the association between maternal postpartum depression and paternal postpartum depression. They studied 92 couples in the postpartum period by using surveys to gather information on PND, spousal support and relationship satisfaction. They reported that maternal and paternal PND are indirectly linked as there is decreased spousal support and reduced relationship satisfaction. They concluded that during the postnatal period, the couple's relationship becomes more important and more vulnerable as the birth of a child is a significant stressor and their capacity to support each other is reduced (Don & Mickelson, 2012). These findings appear to be across cultures. A similar study with 950 couples in China found that maternal marital satisfaction showed a mediating effect on fathers' PND, and there was a direct effect of maternal PND on paternal PND (Duan et al., 2020).

The transition to parenthood has been associated with an increase in workload and fatigue, which reduces the time for positive social exchanges and intimacy and increases marital conflict and decreases marital quality (Shapiro & Gottman, 2005; Shapiro, Gottman & Carrere, 2000). Moreover, research has found that PND in fathers often appears to follow the onset of depression on their partner (Matthey, Barnett, Ungerer & Waters, 2000).

Castro (2019) found co-occurrence of early postpartum disorder in couples. She described how maternal blues were significantly associated with paternal blues and that maternal highs also significantly predicted paternal highs. She suggests that more studies should focus on couples to understand postpartum disorders. Other researchers agree and suggest that understanding the emotional characteristics of both partners might give a more comprehensive view of postnatal disorders (Collins, 2019).

There are two elements that have been found to influence the way partners interact and experience mental health difficulties. These are affective concordance and couple's self-regulation. This will be explored below.

**Affective concordance**

Affective concordance is when two individuals related by a condition or event tend to experience the same or similar emotional reactions (APA, 2021d). Investigation around this area has found that there is a high degree of parental concordance for psychiatric disorders (Dierker, Merikangas & Szatmari, 1999). Merikangas, Prusoff and Weissman (1988) explained how both partners tended to present similar mental health issues, and in turn, their offspring were more likely to present the same health issues. They also reported that parental concordance for anxiety disorders specifically increased their children's chances to show anxiety and depression. They invited clinicians to understand both diagnostics status in the couples to understand the transmission of affective disorders.

Walker, Liddle, Jordan and Campbell (2017) wanted to explore how affective concordance worked in couples for anxiety and depression. They carried out a one-year cross-sectional study of anxiety and depression in primary care in 13,507 couples by reviewing their medical health records. Nine hundred and twenty-seven people consulted their GP for anxiety, and 538 consulted for depression. They found a three times increase in the probability of anxiety consultation for females if their male partner had also consulted for anxiety and four times in the case of depression. They concluded that their findings support the idea of affective concordance in mental health states in couples and highlight the potential

contextual influences. Goodman and Shippy (2002, p.267) describe marital relationships as “one of interdependence and reciprocity. Accordingly, whatever affects one partner will influence the other”.

Another study wanted to explore anxiety disorders and intimate relationships, and they researched the daily process in couples. Zaider, Heimberg and Iida (2010) studied 33 heterosexual couples where the female had an anxiety diagnosis. Their interest came from the association between anxiety and reported poor marital quality by both partners. They found that there was an association between anxiety and relationship distress, and responses to the daily reports indicated that the wives perceived their partners to cause, aggravate or lessen their anxiety. On high anxiety days, wives reported that their partners alleviated their anxiety. They concluded that because wives often perceived their husbands as appeasing their anxiety, there is a need to consider marital relationships as a critical resource in treating anxiety disorders. They also found that the daily distress reported by husbands was associated with the wife’s anxiety on the day. This finding was explained as wives being unable to provide support when they experienced anxiety.

The authors explained that positive relationship qualities had to do with the supportive behaviours partners showed, such as showing concern or being dependable, while negative relationship qualities had to do with conflicts and discordance, such as partners being critical. What they found interesting was that anxiety appears to have reduced the positive relationship qualities but didn’t increment the negative ones. They concluded that positive displays in couples’ interactions are highly predictive of the stability and the health of the relationship (Driver & Gottman, 2004; Gottman, Coan, Swanson, & Carrere, 1998).

Zaider and collaborators (2010) concluded that their findings supported affective concordance. They reported that if one partner presented anxiety then the other partner would also report anxiety. They concluded that the mood concordance was because of the dyad characteristics rather than mood induction.

One consideration the researchers made was that husbands were frequently rated as alleviating anxiety and in a minority of occasions they were perceived as making anxiety worse. They suggest that this was not surprising as their sample was “largely in the non-distressed range of marital functioning” (p. 170, Zaider et al., 2010). It may be that couples who are functional and present more positive relationship qualities are more likely to engage in this type of research.

**Couples self-regulating**

Self-regulation is the capacity to control one's behaviour through the use of self-monitoring, self-evaluation and self-reinforcement (APA, 2021e), and it has been linked to postnatal anxiety. Holmberg et al. (2020) report that elevated prenatal maternal anxiety was associated with symptoms linked to higher unpredictability in maternal care. However, this association was moderated by maternal self-regulation capacity, as higher anxiety symptoms during the pre-and postnatal period were associated with more unpredictability among the mothers with low self-regulation capacity. Thus, the combination of a higher amount of maternal anxiety symptoms and lower self-regulation capacity seems to constitute a specific risk for unpredictable maternal care.

The transition to parenthood is a difficult period for couples, and researchers have tried to understand how couples’ interactions relate to their anxiety as this interaction has been thought of as a self-regulation effort. Figueiredo (et al., 2018) wanted to study mothers’ and fathers’ positive and negative interactions and anxiety and depression over the transition to parenthood. They studied 129 couples with self-report measures at each trimester of pregnancy, at 3 and 30 months postpartum. They analysed their results by couples and found that couples with high negative interactions (like conflict and discordance) experienced an increase in depression in the postpartum period. For anxiety, they found that positive interactions (like showing concern and support) prevented the father's anxieties in the postpartum period.

These positive interactions are strategies that couples use to self-regulate. Self-regulation in couples is how partners work in the relationship by selecting and changing behaviours to enhance their

relationship (Halford, Lizzio, Wilson, & Occhipinti, 2007; Wilson, Charker, Lizzio, Halford, & Kimlin, 2005). Couples' self-regulation has two components: relationship strategies (behaviours that nurture the relationship) and relationship effort (persistence in applying those efforts). And self-regulation has been linked to relational satisfaction; there is more satisfaction in the couples when partners actively engage in couples' self-regulation (Pepping & Halford, 2012).

Couples' self-regulation tend to come when partners are committed to the relationship and are willing to forgive their partners (Novak, Smith, Larson & Crane, 2018). Partners tend to perceive that their partner makes more effort in the relationship when there is commitment and forgiveness. But relationship self-regulation has not been directly connected to anxiety, while individual self-regulation has some interesting findings.

From a self-regulation stance, anxiety disorders are considered disorders of self and emotion regulation; they can be described when excessive attempts to prevent undesired outcomes prejudice the pursuit of desired outcomes (Rodebaugh & Heimberg, 2008). People with anxiety tend to engage in unnecessary preventative behaviours and avoid behaviours that reduce stress (Rodebaugh & Heimberg, 2008). These behaviours are viewed as not required as they are not ensuring safety and, in the long term, produce more distress. Rodebaugh and Heimberg (2008, p. 145) explain:

> A person who is anxious about aversive affect is motivated to prevent such affect, which often includes the experience of fear, sadness and anger. However, aversive affect is unavoidably triggered, from time to time, by perceptions regarding one's rate of progress toward goal attainment. For example, the person may perceive that her relationship with her husband has become less close than she would like, leading to a degree of sadness as a result of perceiving a meaningful change in position regarding this positive goal. The input, or source for those perceptions (e.g., she and her husband are spending less time together or there is less exchange of expressions of warmth and affection between them), can only be lastingly changed either through changing those perceptions.

And this process where failure to prevent a negative outcome is perceived as interrupting the possibility of achieving a positive result at the desired pace has been described as the process whereby anxiety leads to depression (Rodebaugh & Heimberg, 2008).

It seems that self-regulation in individuals mean directing one's behaviours to reduce distress, while couple's self-regulation efforts direct their behaviours towards their partners and reduce their distress. There is another caveat, quality in a relationship can be in terms of relationship adjustments such as communicating with each other, understanding and supporting your partner and about dyadic adjustment which means better functioning (Zaider et al., 2010). Therefore, functional couples with good quality relationships are the ones that present more adjustment, they support and understand each other and communicate well. This is an important aspect of researching couples as dyads; the quality of their relationship can give us ideas about how they regulate and about the possibility of shared emotional states.

**Support and postnatal anxiety**

In mental health services it is well known that professionals who show care, compassion and empathy towards their patients improve their patients' outcomes (Nightingale, Spiby, Sheen & Slade, 2018). To provide better care, health care professions need to be well supported and cared-for themselves (Nightingale et al., 2018). But what we know is that healthcare professionals supporting postpartum couples lack training and support around identifying mental health concerns (Drennan, 2017; Taylor & Johnson, 2013).

Healthcare professionals are usually the first point of contact for couples experiencing mental health issues. But couples struggle to access support. Delicate, Ayers and McMullen (2020a) wanted to explore the support offered by health professionals to couples who experienced birth trauma. Professionals offered support by listening to parents and then a referral to the birth debriefing service and signposting for self-help. They perceived that more help was requested from women than either

couples-as-units or fathers. They described not having access to the fathers as a barrier to provide support and a possible improvement. They found that referrals to self-help could be due to the lack of available services or the notion that parents need to cope with birth trauma on their own (Delicate et al., 2020b). They also found that professionals had difficulties supporting parents as they didn't spend much time with them and didn't have perinatal mental health training.

But support doesn't have to come solely from health professionals. Family and friends have been considered an effective source of support for people with with postnatal anxiety. Studies have found that when mothers feel more supported by family or partners, they are less likely to experience postnatal anxiety, which was associated with lower levels of depression (Sapkota, Kobayashi, & Takase, 2013).

Harrison, Moulds and Jones (2021) wanted to find out if the support from friends, family and partners moderated the relationship between repetitive negative thinking (RNT) and postnatal wellbeing during COVID-19. Repetitive negative thinking has been linked to postnatal anxiety and postnatal depression. They found that low levels of perceived social support were significantly related to elevated postnatal depression and anxiety symptoms. Conversely, women with low levels of support engage in more RNT. The researchers stress how important relationships are during the perinatal period to moderate RNT and mental health difficulties.

Interestingly, only support from friends – rather than support from family members – was associated with decreasing anxious symptoms in the postnatal period. Harrison et al. (2021) didn't clearly understand why friends' support was a moderator in the relationship between RNT and psychological outcomes, even when women reported partners as most important. They concluded that peer support could be more therapeutic than partner or family support. They felt that women's anxiety could be ameliorated by normalising their experiences through interactions with peers.

Another study wanted to examine if the support from friends and family differs between mothers and fathers (Hughes, Devine, Foley, Ribner, Mesman & Blair, 2020). The levels of support weren't different for the partners, but only fathers' anxious and depressive symptoms were related to family support while the mother's related to friends' support. They offer several possible explanations. One was that mothers appear to attach greater importance to friendships than fathers, leaving mothers more susceptible to loneliness. Another was that gender differences in the nature of friendships had greater buffering effects of friends for mothers than fathers. Third, the results could reflect gender contrast in the parents' willingness to seek help from family members, as mothers usually receive support from family. Fourth, fathers may refrain from seeking help from work friends as they may perceive that doing so may harm their career prospects.

Other studies have found cumulative risk, which means that when women don't have support during their pregnancy, they struggle with postnatal anxiety. And, when they have low support postnatally, it is more likely that their postnatal anxiety increases later (Hetherington, McDonald, Williamson, Patten, & Tough, 2018).

Another study, Harrison, Moore and Lazard (2020), set up focus groups with mothers to explore the stressors and support around postnatal anxiety. They used a realist thematic analysis, and identified five themes. The first, holding unrealistic expectations of birth and motherhood. The mothers described how antenatal classes were subjective and had an agenda, and they felt natural birth was "pushed on them". They explained an absence of realistic information and midwives actively withholding information about interventions, making them feel anxious and out of control. They also felt anxious about breastfeeding as they thought the information presented in antenatal classes, by healthcare professionals, and in social and mainstream media led them to believe it would be easy. They felt let down by the biased information they received. They described the norms and guidelines usually reported in mother-baby websites as anxiety-provoking. These websites aimed to provide support, but instead, they provoked anxiety when the children didn't meet the "unrealistic" expectations, and the advice was "one size fits all". Social media was anxiety-provoking as it was an unrealistic source of

social comparison. And mothers felt social pressure to be the "perfect mum" and do "the right thing". They said they felt judged on their mothering abilities and parenting choices. And they felt guilt when they didn't uphold unrealistic expectations.

Another theme, the importance of peer support, described how motherhood could be isolating and, in turn, cause distress. Having support from family and partners was described as necessary, but friends' support was the most critical source of support. Antenatal classes and breastfeeding cafes were described as the most supportive. Socio-economic differences were noted between the mothers; e.g., mothers living in rural areas tended not to participate in antenatal classes because they were expensive and had fewer options for baby classes. Mothers also reported that baby classes felt isolating as they didn't encourage adult peer interaction. Some mothers reported that large online forums were anxiety-provoking, but smaller groups with specific focus felt supportive. Researchers explained that the effectiveness of the support had to do with the possibility of normalising the mother's experience, feeling they were not alone and someone understood them.

Another theme was uncertainty and poor maternal confidence. Mothers described being unprepared for the change brought about by childbirth, and this was partly due to poor inter-generational integration. As a result, mothers reported a lack of confidence and feeling overwhelmed. They said that online sources of parenting information were anxiety-provoking. They described an overabundance of information with conflicting views that made them feel confused, and they reported experiencing the same feelings in their interactions with healthcare professionals, thinking there was not enough evidence-based information to help them.

Stigma was identifed as another theme. Mothers reported being ashamed of their postnatal anxiety symptoms and hiding them from others. They described being reluctant to disclose their symptoms to professionals as they thought they would be judged a "bad mother", which could result in severe consequences. Thus, stigma acted as an anxiety source and as a barrier to seeking help.

The last theme was a lack of mental-health support and knowledge. Mothers felt there was little support for them postnatally. They consider that they had “slipped through the net” and missed out on support as professionals didn't see they were experiencing difficulties. They felt screening was available for PND but not in-depth enough or tailored to pick up individual challenges or mental health problems. Lack of knowledge about postnatal anxiety was also an anxiety-inducing factor and was a barrier to seeking support. Mothers reported feeling distressed as they were not able to find information about what they experienced. Women were able to identify that they were not experiencing PND, but they couldn't find alternative explanations. Mothers also reported having a sense of relief once they recognised that they had postnatal anxiety, and this was helpful to seek support. However, women also reported not being able to find help about how to cope and manage their postnatal anxiety.

**Postnatal experiences**

Postnatal experiences have been studied using qualitative methods and have focussed on the individuals rather than the couples and mostly on mothers rather than fathers.

The Born and Bred in Yorkshire (BaBY) team wanted to explore father's views and experiences of their own mental health during pregnancy and the first postnatal year (Darwin et al., 2017). They interviewed 19 men at 5 and 10 months postpartum between 25-44 years, most first-time fathers, UK born that lived with their partners. Five of the interviews were conducted as couples as fathers requested the mother's participation. They used thematic analysis, and they found four themes. The first theme, legitimacy of paternal stress and entitlement to health professionals' support, described a "tacit acceptance" of the existence of paternal stress. This came with a questioning of the entitlement of having these feelings. They found that fathers would refer to mental health concerns such as anxiety as “stress”. Most fathers reported more significant stress in the postnatal period as they adjusted to the demands of early parenting and their altered relationship with their partner. They described "role conflict" as losing their former life and activities, and balancing work and home life. They also found that men tend to minimise the emotional components of stress and focus more on the cognitive aspects. They talked about guilt about their feelings and not being able to support their partners. Most

of them attributed stress symptoms to exhaustion, and they saw them as linked to fatigue rather than mental health. Fathers were concerned that focus on their difficulties might take away the support for their partners at a clinical level and a service provision level.

The second theme, protecting the partnership, described how fathers felt that they needed to protect their partner and their partnership during the postpartum period. Fathers reported altered connections with their partners and feeling more distant. Because they had a sense that their role was as a supporter, they focused on their partner's mood and distress rather than their own. For most fathers, the idea of "teamwork" was fundamental to coping with the demands of parenting and "navigating fatherhood". Fathers who reported struggling to understand their partners' perspective and experiences and did not know how to support their partners' mental health drew on practical approaches and problem-solving strategies.

The third theme the BaBY researchers identified was navigating fatherhood. They described how men avoided a conversation about how they managed their mental health and preferred to talk about strategies to manage stress, promote resilience, and successfully navigate fatherhood. They judged their experiences against being a "good father" that provided and protected their family, including actively taking care of the baby and providing practical and emotional support for their partner.

Interestingly, men spoke about how that their usual coping methods didn't work during the postnatal period, and so they had to devise new strategies to manage. The researchers called their attitude self-reliant and stoical as the father sought to "get on with it" and minimised struggles such as depression. Fathers also mentioned that their positive interaction with their babies strengthened their coping strategies. They also described changing their working hours to spend more time as a family.

The fourth theme was diversity in men's support networks. Most fathers reported talking to family or friends, including fathers in their broader social networks. They used these networks to express their

difficulties but mainly in a relaxed manner. Fathers were divided on whether they would want formal peer opportunities. They also said there was a lack of resources tailored to men.

Another qualitative study by Baldwin, Malone, Sandall and Bick (2019) explored first-time fathers' experiences of mental health and wellbeing needs during their transition to fatherhood. Different from most research in this area, this study had a diverse sample, in terms of ethnicity, education, and social-economic status. They recruited 21 fathers, and they analysed their interviews using framework analysis and thematic analysis. As a result, they identified nine categories: 'preparation for fatherhood', 'rollercoaster of feelings', 'new identity, 'challenges and impact', 'changed relationship: we're in a different place', 'coping and support', 'health professionals and services: experience, provision and support', 'barriers to accessing support', and 'men's perceived needs: what fathers want'.

In terms of 'preparation for fatherhood', men described different planning levels, from fathers who didn't prepare, to practical fathers, to overprepared fathers. Fathers who attended antenatal classes said that none focused on the social and mental aspects of preparing for having a baby. Those who felt included by professionals in the classes found them helpful. They also described having an opportunity to meet like-minded parents. However, some men described not being invited to sessions or not having flexibility from work to attend them.

In terms of the 'rollercoaster of feelings', the fathers described mixed feelings. Feelings of excitement with apprehension about being a good father were often expressed. They expressed worries about their partners' and babies' wellbeing. On the other hand, they often described positive emotions about becoming fathers. Fathers described not feeling like a father until the baby was born and feeling that the baby was "not real" during the pregnancy.

The father's 'new identity' came with a sense of accomplishment and personal growth. They described fatherhood as making them feel more confident and secure. They also reported that becoming a father had made them "stronger" and "resilient" as they had to learn to cope with the demands of early

fatherhood by themselves. They described a change of lifestyle, responsibilities and mindset and prioritising their partners' and babies' needs before their own. They also reported spending more time with their family than in social gatherings.

'Challenges and impact' described challenges relating to labour and how stressful they found it. Lack of sleep, skipping meals and balancing work and home triggered tiredness, exhaustion and stress in early fatherhood. Participants described concerns about "missing out" on their baby due to their work demands. The demands of the baby and work left them having no time for themselves. They reported increased worries and pressures as they felt they needed to take care of their partner. They said they wanted to alleviate the burden of household chores and they worried about financial pressures. They were also concerned about the health of their baby and partners. They all reported a negative emotional impact on themselves. They reported feeling "useless" and "demoralised" when they couldn't comfort their baby or give their partners a break. They said that not having an instant bond with the baby was challenging. They reported feeling like a "spare part" when they couldn't stop the baby from crying. They also expressed negative feelings about not being able to support breastfeeding. But they all reported that having a baby was rewarding, fun and enjoyable.

The theme 'changed relationship: we're in a different place', referred to how men perceived their relationship with their partner as more robust after having a baby. However, they described not having time to spend with their partner, arguing more, being less intimate sexually, and their partner being more irritable. They thought these changes had to do with tiredness and the demands of parenthood and understood them as a different phase in their relationship.

The theme 'coping and support' described how the fathers perceived internal and external resources to cope with the challenges of fatherhood. Most of the themes described having to cope alone and not burden their partners with their own worries. Fathers felt that their partners had enough concerns without burdening them with their own. They also thought it was socially unacceptable for men to talk about their difficulties during this period. They described "getting on with it" and figuring it out by "trial

and error". They reported looking for information online about infant care and finding it frustrating because of the amount of information. The men who described feeling comfortable sharing their difficulties with their partners explained working together as a team to manage the demands of parenthood. They managed by sharing daily tasks and taking turns to take care of the baby. The external family was described as the primary source of support, and the men that described friends as supportive had "lighthearted" conversations.

In the theme 'health professionals and services: experience, provision and support', the fathers described positive interactions when professionals included them by asking about their wellbeing. However, many fathers reported feelings of exclusion and accepting this as the norm as their partners had more significant needs and professionals were overworked. They recalled various negative experiences with professionals and a lack of adequate provision for fathers in hospital labour wards even when they had to stay overnight or for long periods. Some were asked to leave after the baby's birth, and they found this difficult. They also reported that if they needed help with their mental health, health professionals would be the last point of call and GPs would be their professionals of choice.

They described a lack of appropriate support and information for new fathers as barriers to seeking support. Some struggled to get help with their mental health, and they didn't know of services available. Some questioned their GP's training to deal with their mental health or felt GPs had too many demands on their time to deal with fathers' mental health concerns. They were concerned that they might be taking somebody else's time by raising their troubles. Fathers were not asked about their mental health by professionals during the perinatal period. They viewed the health professionals as being mainly there for their partners and not for them and considered that professionals didn't care about their views. Culturally for some, complaining about fatherhood or talking about difficulties was not appropriate. Fathers described that perinatal services were mainly for the mothers and they felt uncomfortable sharing their worries in women-dominated groups. And there was a general fear of being perceived negatively by others if they disclosed problems with their mental health.

Lastly, ‘men’s perceived needs: what fathers want’, described the need for better preparation for fatherhood. They wanted to know their role as birthing partners, the emotional and physical demands of parenthood and practical aspects of caring for the baby. They wanted antenatal classes for them or to be included when talking as a couple. They wanted better access to information and services. And even when they accepted that professionals would focus their attention on the mothers, fathers felt they should be asked about their mental health and be offered the same support as their partners. They wanted to know about symptoms and triggers they should be aware of when thinking about their mental health. And they described feeling comfortable asking for support.

A methodological aspect to consider about this study was that this team recruited healthcare professionals from community services to contact fathers who were already engaged. The research was done with the help of the NHS in four London administrative districts, and each site served a diverse socio-economic and cultural population. They were able to spend six months recruiting participants, and they had the support of health visitors who handed out recruitment information during home visits. So perhaps research in this field needs extra resources in terms of time, professionals and money to ensure diversity in their samples.

There have been a variety of investigations around women's experiences. For example, Coates, Ayers and de Visser (2014) produced a qualitative study of 17 women who experienced psychological problems in the postnatal period. They used Interpretative Phenomenological Analysis (IPA), where they developed themes within each interview before identifying similar themes for multiple participants’ across the interviews. They identified four themes. The first, ‘living with an unwelcome beginning, described how mothers started in a way that they hadn't hoped. They described a feeling of "something not being quite right" and not connecting with the baby, which the researchers called distancing and avoiding emotions. They also reported birth-related distress around having difficult birthing experiences or unmet expectations. They talked about feelings of guilt and self-blame from negative birth experiences. Mothers also described the importance of breastfeeding as gaining control of their body and experience after a difficult birth, and they reported anxiety, stress and frustration. Finally,

mothers described feeling unsupported by healthcare professionals with breastfeeding even when they were active in finding practical support.

The second theme ‘relationships within the healthcare system’ describes how the participants have felt mistreated and ignored by healthcare professionals. They reported not feeling cared for, not being listened to, nor asked how they were feeling or treated as equals in decision making. They described not having a point of contact in the healthcare system and "tick-box exercises" around their postnatal care. They described being unable to talk about their distress and not being informed about sources of support. However, when they described positive experiences, they described empathic relationships with healthcare workers.

The third theme described the ‘abrupt and challenging change in their life after having a baby’. They described being vulnerable and dependent for the first time while having to learn to manage a baby. First-time mothers said they had difficulties deciding if their feelings of distress were normal and they reported struggling to differentiate between tiredness, hormonal changes, and feelings of trauma from birth. They described the impact of sleep deprivation and their wish for the baby to sleep longer. Finally, they described feeling overwhelmed once the baby was born and thinking they were the responsible adult with total care for their baby.

The fourth theme ‘meeting new support needs’ described how mothers needed more emotional and practical support. They described their relationship with their partner as being their closest relationship and expressed a desire to disclose everything they were feeling to their partner. They reported understanding the partner's pressure to work and support them and the baby. Even when mothers felt partners were supportive, they described their partners as not being able to understand what they had been through. They also recognised the need to access help outside their relationship and found that peers were the most helpful. They felt that seeking support was difficult and didn't feel like talking when they were particularly distressed. They also felt their problems were not as severe and struggled to get

professional help. They described talking one to one easier than talking in groups, but they found it helpful to share with others in similar situations.

Another study, conducted by Coates, de Visser and Ayers (2015), described how the classification and assessment of postnatal mental health problems might not address the range of emotional distress experienced by mothers, so they wanted to explore symptoms of mental health problems reported by new mothers and their experience of being assessed for them. They interviewed 17 women with babies under a year of age who experienced postnatal mental health problems, and the data was analysed using inductive thematic analysis with a critical realist approach. The researchers accounted for symptoms between the mothers and found: tearful, anxious, stressed, isolated and lonely, angry, overthinking, feeling low, panicky, flashbacks, intrusions and nightmares, frustrations, worries and scared.

They found that mothers didn't identify with depression, but they couldn't find information about other types of distress. The mothers also reported that health professionals focused on depression, and when PND was ruled out, there was no further investigation. They also noted that health professionals would sometimes suggest depression even when it didn't fit the symptoms women described, which was perceived as a way to avoid exploring their complex feelings.

They identified a theme around the need to ‘normalise support seeking’. It was felt that the postnatal difficulties needed to be discussed, and women were keen to promote the message that postnatal emotional problems were common. They also reported not knowing where to get help and fearing stigma. The researchers identified a theme of a need for support irrespective of diagnosis. The women said that their difficulties impacted their daily functioning and relationship with their baby, which means they should receive support. They felt that support was given for postnatal depression, but no clear support pathways were identified for other difficulties.

Another theme was the ‘importance of timing’. Participants reported that immediate support was necessary for acute distress, but some felt that assessment of postnatal depression came too early. Finally, another theme was that a ‘questionnaire is not sufficient’. Some participants said that being asked to fill out a questionnaire clarified their symptoms, but for others, it felt like an over-simplification and they preferred to talk to healthcare professionals.

Another piece of qualitative research was carried out by Boyd and Gannon (2021). They wanted to study how recent mothers experienced unwanted harm thoughts related to their newborns. They analysed the data using thematic analysis grounded in a critical realist epistemology. They identified three main themes.

The first ‘heightened emotions’ explored how the mothers described an overwhelming lack of control over their thoughts. They also explained how emotionally exhausting it was not being able to disconnect from their babies, even when they had childcare. The second theme ‘constructions of motherhood and maternal identity’ talked about the description of replicating and rejecting some aspects of their own mother to arrive at a notion of being a "good mother". They also reported using Google to get information, which was helpful but fuelled their intrusive thoughts. Strong emotions accompanied their ideas, and it seemed that they facilitated self-awareness.

The last theme, ‘costs and benefits of sharing’, relate to mothers’ fears around sharing their thoughts. They described not sharing with professionals and limiting disclosure with partners and friends. They expressed feelings of shame, anxiety and fear of being judged negatively. The researchers concluded that having thoughts of harm didn't mean that the mothers would display harmful behaviours towards their babies.

Investigations such as these may give clarity to clinicians about how to best support parents after having a baby; if common themes emerge around the distress individuals experience after the arrival

of a baby, this may help us provide clinicians and services with clearer information about how to develop helpful and effective interventions (Rowe et al., 2014).

**Couples' experiences**

Currently, there appears to be no research into how couples experience anxiety in the postnatal period. But it is essential to understand how research has approached couples' experiences.

Wilson (2020) wanted to know how British couples experience the male partners' role within family planning. Two interesting ideas came up from this research. First, they used dyadic interviews because it can be difficult for men to participate when the topic seems to be perceived as related to women in the UK. Second, they reported their results by females, males and couples. Writing couples' experiences meant reporting themes where both partners agreed. The limitation of the study was the lack of diversity of the sample. These were economically stable, white British heterosexual couples. The authors recommended exploring these issues across a sample that is more diverse.

Another study wanted to explore first-time expectant couples′ experiences with alcohol consumption (Gouilhers et al., 2019). They interviewed 30 couples together as they wanted to access the interaction between the partners, and it gave opportunities to elucidate shared experiences and meaning, decisions and disagreements. They reported working hard to get a diverse sample, but all couples were highly educated with stable financial resources and planned pregnancies. They used thematic analysis to interrogate the data. They found that the change in alcohol consumption was a relational process that included the partner, and that partners helped handle the struggles associated with reducing their alcohol consumption. The authors made recommendations to clinicians to enhance the involvement of partners even when drinking responsibility lies with women as most partners are there for support.

Another study that explored couples' experiences of receiving uncertain results following prenatal microarray or exome sequencing found a theme that might be relevant for this research. Harding,

Hammond, Chitty, Hill and Lewis (2020) found that couples used support from health professionals, friends, family, the internet and other parents to manage their uncertainty. The couples remained hopeful and stayed positive as a way to manage their difficulties.

Allan, Mounce, Culley, van den Akker and Hudson (2021) used thematic analysis to study couples' experiences transitioning to parenthood after in-vitro fertilisation. They interviewed couples together as this allowed them to understand the couple's negotiation in the transition. They found that men and women experienced anxiety in different ways, but they also described "carefully negotiating the balance between the excitement and anxiety of the pregnancy as a couple" (Allan et al., 2021, p. 439). Couples described being able to identify differences in how they each managed their anxiety. The researchers also found that couples struggled to complain about their mental health difficulties during pregnancy or postnatally because of their infertility. They also found that the couples described negotiating together to adjust to becoming new parents, which the authors consider to be a fluid approach to gender. The couples described the transition to parenthood as sometimes difficult, frustrating, anxiety-provoking and provisional, which they managed with a willingness to learn between them as their parenthood identity settled.

Another study used thematic analysis to understand couples' experiences of parenting a child after an autism diagnosis (Downes, Lichtlé, Lamore, Orêve, & Cappe, 2021). They interviewed the partners together to see how they agreed or disagreed with their experience and how they corroborated or challenged their stories. They found that couples benefited from support from the community as they could share with parents that were having similar experiences. They described learning how to take care of their child best and finding exchanging experiences as a source of support.

**Relevance to counselling psychology**

Counselling psychologists need to act in the best interest of service users at all times (HCPC, 2015) and, as the literature has evidenced, parents have been insufficiently supported after having a baby. Research into the emotional experience of couples after they have had a baby is limited and research

into how they manage postnatal anxiety is even more limited. In order to support parents' mental health in the postnatal period, it is the duty of counselling psychologist to carryout relevant research and use this information to train and educate professionals around mental health difficulties (HCPC, 2015).

Counselling psychologists need to be able to work in partnership with service users, professionals, support staff and carers (HCPC, 2015). This systemic way of working allows us to think about the network of professionals and how to best support families who are experiencing postnatal anxiety. Collaborative efforts need to be made with professionals and couples to ensure families' wellbeing.

Another relevant aspect is that counselling psychologist tend to help develop services and as the NHS moves to improve maternal services (NHS, 2017). The findings of this research can provide recommendations from a mental health point of view that might help develop current policies and provision.

**The COVID context**

This study was carried out during the first UK COVID pandemic lockdown. I collected my data in the summer of 2020, when restrictions to people's activities were in place. For example, it was illegal to leave the house and meet more than one person. This lockdown brought many changes that affected couples that had babies. First, couples that already had babies could not attend any support services, as it was deemed unsafe to meet face to face. Lockdown regulations and NHS guidelines meant that face-to-face support groups ceased, and there was no face-to-face support from health visitors, GPs or baby classes. Second, the pandemic meant that the non-essential workers started working from home. This meant that fathers whose paternity leave would normally last two weeks (before returning to a workplace in the daytime) were at home with their families. Third, people were meant to isolate at home with no household mixing even outdoors. This meant that parents had no in-person support from family or friends. Fourth, COVID was new and, at the time of my data collection, there was no vaccination. People were worried about what COVID was but because this was the start of the pandemic people felt secure at home and the burnout of the pandemic was not even discussed in the

media at the time. Fifth, Covid affected different social groups to differing degrees: people from marginalised communities were affected the most at this time. Despite the furlough scheme, some people lost their jobs, and many struggled financially. The Disparities in the risk and outcomes of COVID-19 published by the NHS website reported that the BAME community was affected disproportionately in terms of infection numbers and deaths, and the support they received. Six, partners were not allowed to be present during hospital births, medical procedures or standard check-ups. Mothers went through pregnancies, labour and postnatal support alone even when there were difficulties.

At the time, the impact of COVID was unknown in terms of the health and social impact that it had on the population. This research discusses how COVID might have affected how couples experienced postnatal anxiety.

**Conclusion**

As discussed, the information about postnatal anxiety is limited. Although some research has pointed to links between partners and their experience of anxiety, there has not been a specific focus on how couples experience postnatal anxiety. The mental health support couple's receive in the postnatal period is based on guidelines that the NHS is trying to improve. It is perhaps the role of counselling psychologist to explore how postnatal anxiety affects couples.The BPS (2021) described counselling psychologists as professionals concerned with integrating psychological theory and research with therapeutic practise and working with individuals' unique subjective psychological experience to alleviate their distress.

This research is necessary on three levels: to improve professional practice, the service providers and the research implications. Most support in the perinatal period has been targeted at mothers without the help or consideration of their partners. WHO (2015) published recommendations regarding maternal and neonatal health, and they highlighted the importance of including fathers during the

perinatal period. Goldman and Burges (2017) recommended the need for interventions for fathers to support their mental health and their families in the UK.

Researchers are working to develop inclusive partner interventions, but current provision is limited, and high attrition rates, and paternal mental health are often not taken into account when new interventions are being proposed (Pilkington et al., 2015). However, interventions that include psychoeducation about postnatal care of the baby, such as breastfeeding and what to expect for fathers, have been found to be helpful by providing information and strategies for problem-solving that increase the parents' knowledge and lower the risk of postnatal anxiety (Tohota et al., 2012).

Information about how couples experience postnatal anxiety could professionals focus on interventions that best support the family. It could also elucidate the dynamics within the relationship and how anxiety management can benefit both partners and their children. It could also inform services of barriers couples have when accessing services and what provision is needed to support postnatal anxiety. There is not much information about the nuances of postnatal anxiety. Having couples relate their experiences of postnatal anxiety might indicate essential features that differ from other types of anxiety. Finally, this aims to be exploratory research with the hope that more investigators benefit from the findings. Specifically, those who are developing interventions need to understand couples' experiences if they are to support the mental health of new parents.

## Chapter 2: Methodology

This chapter will describe the aims and design of the study. It will explain my epistemological and ontological positions and how I went about doing qualitative research using thematic analysis. The chapter contains essential information about the procedural aspects of the investigation, ethical considerations and the phases for elaborating the final themes. I have dedicated a section for reflexivity to describe how the research project was conceptualised, how the interviews informed my project and how my personal and professional life impacted the project.

### Research Aims

The main aim of this research was to gain an insight into the experience of heterosexual couples that experienced postnatal anxiety after having a baby, in order to better support them. As I have described in the literature review, when one member of the system is experiencing anxiety, the other partner will also be affected, and this, in turn, will affect the family (Lin, Chang, Chen, Lee & Chen, 2017; Vismara et al., 2016). I am studying low-to-moderate anxiety where couples have identified themselves as parents who have experienced anxiety in the postnatal period. The Anxiety and Depression Association of America (2021) defines people with mild to moderate anxiety as having full and meaningful lives and the ability to sustain employment, in contrast to people with severe anxiety, who have less functional lives and whose personal relationships are impacted.

The second aim was to consider the implications for counselling psychology in both service delivery and in clinical interventions. The research is done hoping that gaining an insight into couples' experience of anxiety will inform health professionals on how to best support parents during the first year of their baby's life. A third aim was to provide recommendations for future research. In addition, the intention is to disseminate the findings as widely as possible to promote more research around postnatal anxiety and the challenges couples face during this period.

Willig (2013) describes qualitative research aims, as explaining the interest in understanding the experience that people have to certain situations and how people manage the explored situation. This

research aims to identify how couples make sense of and experience their anxiety after having a baby.

**Ontological and Epistemological position**

Qualitative research makes assumptions about possibilities for knowledge. Kock (2015) mentions that ontology is the image we hold of our social reality upon which theory is based. Ontology is an assumption of what you know, while epistemology defines how you get there (Kock, 2015). Epistemology is concerned with the theory of knowledge and explores how we know what we know (Coyle, 2007). Willig (2013) argues that we need to be clear about our research objectives and what we are interested in finding out. For this, we need to adopt an epistemological position. Holding on to this position throughout will ensure that the research is coherent (Coyle, 2007).

Choosing the theoretical framework of a research project defines the research's intent, motivation, and expectations (Kock, 2015). This research project focuses on wellbeing and understanding perspectives (Milton, 2010). Therefore, it aims to learn about the unique experiences and needs of couples with the hope that in the future, more counselling psychologists can provide a tailored and responsive approach to couples experiencing postnatal anxiety (Cooper, 2009).

Ontological positions can be described as "realist" (those who believe that the world is made up of structures that have cause-effect relationships) and "relativist" (those who think that the world is not ruled by laws and values diversity of interpretations) (Willig, 2013). On the other hand, epistemological positions range from "radical relativist", those who believe that we have access to different versions of the experience depending on the resources we use to gather data, to "naïve realist", those who think that the data we collect tells us the truth about reality (Madill, Jordan, & Shirley, 2000; Willig, 2013). Thus, epistemological positions are considered a continuum (Harper, & Thompson, 2012).

My position is that of a critical realist, which offers a middle ground where the world is not reduced to chaos or the universal order, nor does it place value only in the truth of human perspective or remove their views altogether (DeForge & Shaw, 2012). Critical realists view the world as made of events,

experiences and underlying mechanisms that we can only access by how people report their experience (Scambler, 2001). A critical realist stance allows exploring the reality of having a baby with its added challenges and understanding how the couples experience it. We can only access reality by what the participants tell us about it. This approach enables us to examine the possibility of multiple perspectives of the experience.

Critical realism is ontologically realist and epistemologically relativist; there is an external reality, and our knowledge of it depends on the method we use. For Braun and Clark (2006, p.81), when a thematic analysis is used from the critical realist perspective, we "acknowledge the ways individuals make meaning of their experience and in turn, the way broader social context impinges on those meanings, while retaining focus on the material and other limits of 'reality'". This position allows for the analysis of multiple points of view related to a "real" event. Therefore, interviewing couples will allow me to understand the couples' experience of postnatal anxiety and explore the multiple perspectives as individuals and as a couple on how they have made sense of their anxiety after having a baby. The importance of taking this stance is that we know that experience is the product of interpretation. Although it is constructed, it is also real for the person who is having the experience.

**Choosing an analytic method**

Interpretative phenomenological analysis (IPA) was considered for this project, as this method illustrates the quality and texture of the individual experience (Willig, 2013). IPA emphasizes that the research might not have direct access to the participants' reality and that lived experience needs to be understood by having interpretative engagement with the data (Osborn & Smith, 1998). For IPA the analysis is produced by the interpretation of the participant's lived experience, via a process known as the double hermeneutic (Osborn & Smith, 1998). IPA is considered more appropriate with a phenomenological approach to knowledge; it has an idiographic commitment and a clear ontological position (Harper & Thompson, 2012 and Smith & Osborn, 2015). This allows IPA to focus on the characteristics of the individual participants and then to find patterns of meaning across participants. And although the ontological and epistemological position and phenomenological approach of IPA

could help understand the experience of postnatal anxiety, it would not be the best approach to understand a couple's view from a critical realist stance. It was deemed that IPA was not appropriate for this study as interviewing couples might mean that one of the participants does not experience postnatal anxiety and attributes the experience of postnatal anxiety to their partner only. This study might need to include the idea that one of the partners might report the other's lived experience rather than his own and that as a couple they don't have a joined experience.

IPA is a methodology that provides a clear framework on how to conduct research, while thematic analysis is a method that allows flexibility (Braun and Clarke, 2020b). Thematic analysis will allow for the reporting of a joined or an individual view of postnatal anxiety in the couple and the experience of lived experience or the reports of their partner's lived experience. Thematic analysis focuses mainly on the patterning of meaning across participants. This method would best allowed me to identify patterns between the couples.

Grounded theory was also considered. The focus on creating a theory grounded on the data has been helpful for counselling psychology (Fassinge, 2005). But the aim of this research is more exploratory and interested in common themes rather than cause and effect relationships. This research is framed to provide something relevant to the counselling psychology discipline, and common themes are often used as guidelines when professionals plan interventions in the postpartum period (Rowe, Calcagni, Galgut, Michelmore & Fisher, 2014). Therefore, even if the research is exploratory, it would be helpful to the counselling psychology field by incorporating the idea that the couples' experience of postnatal anxiety is relevant to planning perinatal interventions.

Thematic analysis was selected as the most suitable research methodology as it was consistent with the research's main aim and to the field of counselling psychology. This research will use Braun and Clarke's conceptualisation of thematic analysis as they are the most relevant exponents of the method.

**Reflexive Thematic Analysis by Braun and Clarke**

Thematic analysis (TA) has been thought of as a valuable method to explore the experiences and views of a specific group of clients. Braun and Clarke describe TA as a robust and systematic framework for coding qualitative data and identifying patterns across data (Braun & Clarke, 2014). Clarke and Braun (2018) explain that for thematic analysis, the researcher's subjectivity is used as a resource; reflexivity and the situated and contextual nature of meaning is essential for the approach. The reason is that the interpretation made of those patterns is up to the researcher.

TA allows researchers to analyse the data in a sophisticated way and, at the same time, enables them to present findings in a way that is accessible to those who aren't part of academic communities (Braun & Clarke, 2014). This will help with the third aim of providing recommendations for future research as making the result available to academic and non academic communities can bring more wealth to the understanding of postnatal anxiety. In addition, this method allows for identifying patterns across the couples' interviews and for sharing themes that emerge from the data in a helpful way for professionals who support them.

Braun and Clarke (2019) describe themes as patterns of shared meaning underpinned or united by a core concept. They point out that  ar not merely summaries of data. This is important in terms of coding reliability; for them, codes and themes are created organically and depending on the depth of the engagement (Clarke & Braun, 2018). Codes can be theoretically or data-informed. For example, from the literature review, we know mothers who experience anxiety tend to have intrusive thoughts about their baby's health. But there is no information on how couples experience intrusive thoughts, so it is crucial to report the assumed reality evident in the data. Therefore, themes and coding are directed by the content of the data.

The reflexive part in thematic analysis refers to the researcher's subjectivity as an analytic resource and their reflexive engagement with theory, data and interpretation (Braun & Clarke, 2020a). The coding process requires constant questioning of the assumptions that are made when interpreting and

coding the data. Theme creation reflects analytical work; themes are creative and interpretative stories that emerge from the data (Braun & Clarke 2019). The quality of the coding depends on the engagement of the researcher.

As with any model, there are some limitations to Thematic Analysis. Some researchers consider that TA is less robust because it is a method. This refers to TA being a tool for data analysis rather than a framework for research (Willig & Rogers, 2017). Braun & Clarke (2020a) describe how many methodologies in qualitative research have commonalities with TA as they identify patterns in the data. The difference is that TA offers a process for ensuring rigorous and systematic engagement with the data to elaborate a robust analysis independent of any theoretical framework (Willig & Rogers, 2017). For this reason, there is a need to give a detailed and reflexive account of procedures and methods so that the reader can see how the lines of inquiry have led to particular conclusions (Roberts, Dowell, & Nie, 2019). This places theory as a co-requisite of the model rather than a pre-requisite, which Willig and Rogers (2017) consider brings value to TA by being an entry point to qualitative research.

Braun and Clarke (2020b) offer guidance on how the analysis should be conducted to be valid. I followed this process, and I will explain it later in the chapter.

1. Familiarisation with the data: the researcher needs to make sense of the content by reading the material several times.
2. Coding: generating succinct labels that identify essential features of the data that might be relevant to answering the research question. The content of the data directs these labels. It means to code the entire data set and then allocating extracts to codes for later analysis.
3. Generating initial themes: the idea is to identify significant broader patterns of meaning. For this, collecting the data relevant to each theme is vital to review the viability of the possible theme.
4. Reviewing themes: check the themes against the data to determine if they tell a convincing story of the data and answer the research question.
5. Defining and naming themes: A detailed analysis of the themes is necessary to identify the scope, focus and name.

6. Writing up: this involves the analytic narrative, the data extracts, and contextualisation using existing literature.

**Interviewing couples**

This research considers the couples as participants as the interest is in the experience of couples as couples, rather than their experience as individuals. The thought behind interviewing couples together rather than separately is that this enables the research to focus on the relational aspect. For example, when someone in the family is going through something difficult, family members react in different ways. Bjørnholt and Farstad (2014) mentioned that interviewing couples brings interesting knowledge when we think about individuals from a relational self-perspective. During interviews, there is a co-production between the interviewer and the participant, which involves the significant others from the participant's life (Bjørnholt & Farstad, 2014). Therefore, interviewing couples together can bring benefits by showing how they relate to each other.

Bjørnholt and Farstad (2014) described that interviewing couples brings three benefits: it solves ethical problems of anonymity and confidentiality; it illustrates how dynamics can contribute to the content and quality of the data; and the observational aspect of the interaction produces rich data. In addition, it has been thought that when couples are interviewed together, you get a sense of the relationship and how they support each other, while individual interviews allow for self-reflection (Blake, Janssens, Ewing & Barlow, 2021). In recent years, couples interviewed together have gained momentum in relational studies. However, deciding between an individual or joint interviews needs to be based on the needs and time constraints of the project (Blake et al., 2021).

For this project, family wellbeing is essential, so any possible ethical concerns need to be considered. If individual interviews risk the couple's stability by sharing personal confidential information, this is not useful to the project. This project wants to understand how the partners relate, manage and support each other as they experience postnatal anxiety. Hence, a joint narrative of their experience is more relevant for this research. Moreover, a joint interview would give a sense of the quality of the

relationship beyond what they decide to report, which adds richness to the data. Therefore, the most time effective way to gather this data is by conducting joint interviews.

**Research Design and Procedure**

This section describes the sampling, the inclusion/exclusion criteria, the creation of the interview schedule, the recruitment process, participants, data collection, interview procedure, ethical considerations and the data analysis process.

**Sampling**

The sample has been defined by theoretical saturation, where it has been found that a number between 6 and 12 participants will exhaust the themes (Braun and Clark, 2006). The final number was reached when additional data did not generate further insight and within the available timescale of the project. In total, nine couples were interviewed. The interviews ranged from 45 minutes to and 1 hour and 37 minutes.

**Inclusion and exclusion criteria**

Given the constraints of a doctoral research project, inclusion and exclusion criteria were defined to ensure the quality of the data obtained.

Inclusion criteria:

- Recruitment was made of couples where one or both partners identified themselves as suffering from postnatal anxiety. As postnatal anxiety is a relatively unexplored mental health concern, it was established that participants did not need to have a diagnosis of postnatal anxiety. Instead, the requirement was that they felt this was something they struggled with and affected their lives.

- Couples had to have a biological baby between 8 weeks and one year of age to ensure they had enough time to adapt to the changes. In the literature, it has been found that adjusting to having a baby can bring anxiety to mothers. Therefore, having couples who had time to adapt to the initial

abrupt change of having a baby would ensure that their anxiety did not relate to the initial adaptation process. It would also ensure that the mother's feelings were not hormonal due to the "baby blues". Due to the constraints of this research project, it was thought to have a more defined sample will help with time constraints. Therefore, parents with adoptive or surrogate babies were excluded. At a year of age, the limit was to ensure that couples had a recent vivid experience and avoid any forgetfulness about their experience.

- Couples that shared caring responsibilities for their children and were living together. Ensuring that couples lived together meant that they were in an engaged and stable relationship and likely to share caring responsibilities. This would ensure that the couples' experience was reflected.

- The children and parents needed to be healthy at the point of the interview. This meant that they were no concerns around health at the time of the interview. This was to ensure that their experience of postnatal anxiety was captured rather than anxiety relating to other medical problems that were not relevant to the research project.

- The participants needed to be English speaking. I speak Spanish as my first language, and I thought about including both languages. However, in discussion with my supervisor, I realised that analysing data collected in two languages would make the research impossible in the given timeframe. Therefore, to make the study feasible, it was decided to recruit only couples who can speak English.

- Parents who had older children were not excluded if they reported postpartum anxiety arising from the youngest child's birth. This was to ensure that their experience was recent and they could share it without forgetting their experiences. I also thought that having couples with older children would ensure that their postnatal anxiety was not due to adaptation to having a baby.

Exclusion criteria:

- Parents who experienced severe mental health issues and where there were risk concerns were not interviewed. I wanted to be careful about the impact of an interview with someone who was already struggling. I wanted to avoid causing any further distress to somebody already severely impacted by a mental health condition. The risk was thought in terms of adults that could be in acute distress and children that could be subjected to safeguarding concerns. This was done with the idea that struggling families needed to be supported rather than subjected to further distress.

- Participants were also excluded if they had been referred to social services or there were safeguarding concerns or any health concerns. This was to ensure that families were not subjected to further distress and to avoid any possible harm to children or family members. It was also thought that families supported by social services wouldn't benefit from oversharing possibly compromising information.

Participants were asked if they considered there to be any risk or safety issues associated with participating in the interview and were asked twice to confirm that they had read and understood the inclusion and exclusion criteria.

**Semi-structured interview**

A semi-structured interview schedule (Appendix A) was developed to focus on the research question while remaining flexible and open-ended, to facilitate exploration and to include the views of the other member of the couple if one partner felt unable to participate. To make sure both partners had their views heard, probe questions were used to elaborate specific points when required (Willig, 2013). I followed five phases to develop the semi-structured interview guide (Kallio, Pietilä, Johnson & Kangasniemi, 2016). The first was identifying the pre-requisites for using a semi-structured interview; in the literature and methodological review, there was research around couples' experiences and couples' experience of anxiety. The second was retrieving and using previous knowledge; during the elaboration of the literature review, critical aspects were identified. The third was to formulate the

preliminary semi-structured interview guide, based on existing literature on postpartum mental health issues and couples experiencing difficulties and anxiety. Finally, my academic supervisor, an experienced research psychologist, reviewed the interview schedule, and it was approved by the Ethics department (Appendix B). The fourth was the pilot testing of the guide, and the fifth was to present the complete semi-structured interview guide. These last points will be discussed below.

**Pilot interview**

Once the ethics application was approved (Appendix B), there was the need to test whether the semi-structured interview schedule (Appendix A) was relevant and appropriate. For this, I recruited a couple with a 3-year-old child who experienced anxiety during the postpartum period but no longer felt this was a concern. The interview was done using the same format as proposed for the actual interviews. The couple chose to conduct their interview after their child went to bed and it was audio recorded using the university video platform. This setting was considered by the couple as the most useful as they felt that at any other moment during the day they could be interrupted or they wouldn't be able to speak freely.

The interview was used as a guide, and they were asked to reflect on the relevance/ appropriateness of the questions as they answered them. The interview lasted 50 minutes, and they found three items that they felt needed to be reworded or explained further. They also mentioned that although the topic could be distressing, talking in front of their partner allows them to recognise the work and efforts their partners had made. They said the probe questions were helpful as otherwise it might be easy for one partner to take the lead on the interview and the other to step back from answering. The father struggled to respond and the mother took the lead in the discussion. The father mentioned that he was struggling to participate as he felt the mother was the one who experienced anxiety and his role was to support her rather than to feel anxious, even when he described serious concerns about his child's development.

The pilot interview allowed me to examine the interview procedure. Based on my learning, there were

changes made and this affected the way the research interviews were carried out. The changes in procedures and questions based on the pilot interview were as follows:

- Allowing participants to relate their stories but making sure the interview was a reflection of both of their accounts. For this, I used probe questions so both participants could express their views and also reflect on their partner's answers. Examples of probe questions: "what is your view on this matter?" "Do you agree with this?" "Is this joint view?"
- Changes in specific questions that the pilot couple found difficult to understand. They were reworded as follows:
    - "Do you feel your anxiety determines how do you relate with your child?" This question was asked to the couples, and if it needed further explanation, it was reworded as: "Does postnatal anxiety influence the way you bond with your child?"
    - "Do you feel your anxiety influences the time you spend with your child?" This question was asked to the couples, and if it needed further explanation, it was reworded as: "Does postnatal anxiety influence the activities you do with your child?"
    - "What would be useful for professionals to offer?" This was changed to: "What help do professionals offer for postnatal anxiety, and is there anything else you think would be useful?"
- Scheduling the interview time when children were sleeping or when the couples could find childcare. This was done so the couples could have the freedom to speak and focus on the interview and to avoid possibly distressing topics in front of their babies.

**Recruitment process**

The recruitment process was done using social media. The flyer, in Appendix A, was shared with independent healthcare professionals who work privately with parents and children. I contacted independent practitioners to inform them about the project, asked them for help by sharing the flyer on their platform, and shared the inclusion/exclusion criteria to help them direct appropriate prospective participants. Conscious efforts were made to contact BAME practitioners with the hope of obtaining a diverse sample. The professionals who agreed shared the flyer or the research details on their social

media profiles, inviting their followers to participate or share. Most of the professionals who shared the information were White-British. Information about the project was shared using Instagram and Facebook. At the time of recruitment, COVID lockdown procedures were in place. Therefore, social media was the only resource used to advertise. No services were contacted, as it was assumed that organisations were likely to be focusing their efforts on dealing with their COVID response.

The flyer includes a photo of a white heterosexual couple holding a baby. During the creation of the flyer, I was recommended to use a photo as it would make the flyer more attractive to the public. The problem was that all the royalty-free photographs at the time were of white families. I was not able to find royalty and copyright free professional photographs of diverse communities on flyer design platforms. Months later, the Black Life Matters movement brought an interesting change to the inventory of royalty-free stock photographs, with pictures of more diverse communities becoming available. Unfortunately, this change did not come in time for my research project. A more inclusive flyer would have had the potential to attract a more diverse sample, which would have benefited this investigation.

When couples made the first contact, I wrote an email back thanking them for contacting me, asking them how they had found the project, asking the inclusion and exclusion questions and confirming they wanted me to send them the information. The couples who responded that they wanted to participate and fitted the criteria were sent the information sheet (Appendix B), the consent form (Appendix C) and possible interview dates.

A total of 30 couples contacted me, 3 never made further contact, 27 were sent the information and consent sheet, 11 returned the consent forms, 2 never resumed contact to establish the interview date, and 9 couples attended their interview. I was surprised with the amount of people contacting me and not responding but reflecting on it I believe that it may have been related to the COVID pandemic. At around this time, the Maternal, Newborn and Infant Clinical Outcome Review Programme (2020) report was published. It talked about BAME maternal deaths during childbirth, a topic that was then discussed

in social media and in news outlets. In addition, the Birth Better Organization was campaigning for a change in COVID restrictions, to allow partners to be present in hospitals during childbirth. I believe that my research project caught people's attention as perinatal mental health was heavily discussed at the time. However, I advertised during the beginning of the first COVID lockdown in the UK. The impact of the COVID lockdown on parents having to work and assume childcare responsibilities without support became apparent much later. I believe parents contacted me and then the demands of parenting during COVID became obvious and people may not have wanted to engage in further responsibilities. Another possible explanation for the seemingly large drop-out rate among the original respondents could be that one of the partners made the first contact. Perhaps this contact was made without the knowledge of their partners and in discussions between them, they decided not to participate. This could be due to parenting or COVID demands, difficulties in their relationship, fear, and stigma. One thing to note is that those original 30 couples were a more diverse sample than the sample that decided to participate in the study. The COVID pandemic, affected heavily the BAME community, from being more likely to experience worse health conditions, to being more affected by the socio-economical changes COVID brought. This made me wonder whether people from the BAME community had added difficulties that may have prevented them from engaging in an interview at difficult and demanding time.

At the beginning of the interview, all the inclusion and exclusion criteria were stated, and the participants confirmed a second time that they met the requirements. All couples were asked if they had experienced postnatal anxiety, explained as life-altering anxiety attributed to them having a child recently. This was to ensure that this was low-moderate postnatal anxiety rather than everyday anxieties that individuals would experience in their life without life-altering consequences.

**Participants**

A total of 9 couples who had recently had a baby were interviewed; necessary demographic details were asked before beginning the interview and are summarised in table 1. Demographics included ethnicity, employment and education level to assess how diverse the sample was. This was done as

many studies reflect lack of diversity as one of their limitations. As with many other studies, this study had a homogenous sample of white, educated and economically stable couples. All couples were highly functional and there seemed not to be any apparent friction during the interviews.

As conceptualised earlier, all participants reported experiencing anxiety related to the most recently born baby within the last year. The age of the participants ranged between 27 and 40 years old. All participants were employed except for one mother that had recently decided to stay at home. Some participants also spoke about anxiety relating to their previous postpartum experience, during their last pregnancy or at different points in their life, and inevitably described these occasionally during the interview. However, the interview sought to retain focus on the postpartum anxiety around the youngest child. Such data was coded as a way of helping to understand how postpartum anxiety can be connected with previous experiences in life or pregnancy and previous postpartum experiences. It is recognised that the participants' histories and context will influence the interview procedure and bring valuable information to the project. All couples were given pseudonyms to maintain confidentiality.

Table 1. Participants demographics

| Pseudonym | Ethnicity | Employment | Marital status | Education level | Children's age | Age | Health and wellbeing concerns |
|---|---|---|---|---|---|---|---|
| Julie and James | White British | Full time Full time | Married | Higher education | 10 month | 33 & 33 | None |
| Beth and Ben | White British | Stay at home Full time | Married | Undergraduates | 12 moths | 31 & 35 | None |
| Laura and Liam | White British | Employed Self-employed | Married | GSCE GSCE | 2-year-old and 14 weeks | 30 & 36 | None |
| Sally and Steve | White British | Full time Full time | Married | Postgraduate and Graduate | Nine months | 36 & 40 | None |
| Christine and Cameron | White other and White Dutch | Part-time Full time | Married | Masters and Diploma | Three years old and 12 months | 36 & 36 | None |
| Kelly and Kevin | Latina and White British | Part-time Self-employed | Married | Master Master | 10 months | 36 & 40 | None |
| Anna and Andrew | White British | Full time Full time | Married | Undergrad Undergrad | 11 months | 37 & 33 | None |
| Toni and Tyler | White British | Full time Full time | Married | Masters and College | 5 months | 33 & 27 | None |
| Leila and Lucas | White British | Full time Full time | Married | Masters and A levels | 11 weeks | 31 & 34 | None |

**Interview procedure**

The interviews were done using the secure online platform approved by City, University of London, and the audio recording functionality was used. Interviews lasted between 50 min to 130 min. Participants were offered times that work for them, according to childcare. Most couples chose to be interviewed after their children's bedtime. Online interviews allowed the participants to see the researcher, and this created a sense of engagement. Most couples were interrupted by their baby, and some had to attend to their babies or even hold them during the interview. Most couples kept monitors or close proximity to their babies, and when the babies needed them, they were encouraged to attend

to them. At the beginning of the interview, it was explained that we could pause the interview at any moment, and if one member of the couple needed to leave, we could wait for them to carry on. They were also told they could stop the interview at any time if they needed to go. Some couples brought their babies if they needed to feed or if they needed to help them fall back to sleep. This allowed me to observe the interactions between the couple and their baby in a possible anxiety-provoking moment.

All participants seemed engaged and happy to share their experiences. When one of the partners led the conversation, I probed the other partner to hear their views and how they compared to their partners. I wanted to acknowledge the partner that shared their perspective and to include the partner who struggled to participate. But most couples asked each other about their experiences or agreed with each other as they shared their experience. All of the couples seemed to have similar or complementary experiences, and no couples presented major disagreements. All couples seemed loving – many laughed together, touched each other, smiled at each other, and there weren't obvious power struggles. I have experience working with parents, so I am skilled at managing couples, and I looked for guidance from my supervisor to make sure my probing questions were appropriate, and my impressions of nonverbal cues were accurate.

Because the interviews were done with parents who had small children during the COVID pandemic, most parents had no help with childcare. This meant that at times parents had to interrupt the interview to attend to their children. This gave me an opportunity to understand the couples' interactions with their babies and each other. Parents were able to negotiate who would attend to their child and ask about each other's state of mind attending to the baby. It seemed this negotiation allowed them to share the responsibility and show each other support. Some parents brought their children to the interview and they showed me their babies with pride. One parent decided to stand up and rock their baby for the rest of the interview as he thought the baby liked being in constant movement. Other parents played with them, kissed them and cuddled them as we spoke. When babies were around, the couples were more tactile with each other and with their babies, they smiled and seemed happy to be around each other. These interactions allowed me to understand that these couples had loving

relationship, it gave information about the bond with the children, how they regulated each other and gave me the opportunity to understand how they developed joint stories. This enriched my analytic process as, for example, it allowed me to see a disruption in the bond and how they were able to repair it. The father that I described rocking his child because the baby enjoyed it had claimed previously that bonding with his child had been difficult and he did not feel he could provide the comfort a mother could. However, seeing this father rocking his child allowed me to see that he was competent in caring for his child and he seemed loving towards him which made me think it was part of a reparation effort.

Once the interview was done, I thanked the participants for their time and gave them the information in the Debrief Information (Appendix E). The debrief information was also sent by email to the participants.

**Ethical considerations**

The BPS code of ethics and conduct (2018) give guidelines that were followed during this research, and ethical approval was received from City, University of London (Appendix B).

**Risk to participants**

There was the possibility that participants might suffer some distress from revisiting painful experiences and that talking in front of their partners would be difficult. Plans were made to use the Debrief Information (Appendix F) to guide couples to access support if they were experiencing distress. Couples were also advised that they were able to stop the interview if they felt they couldn't continue. However, couples did not report having difficulties sharing their experience and did not show any concerning levels of distress. The couples were open to discussing issues with their partners and reported having previous conversations about their experiences.

It was proposed to exclude participants who experienced severe mental health difficulties or where social services were involved. This was done with the view to avoiding risk or increased distress for participants and their children. Safeguarding guidelines from the university were advised by my

supervisor in case there were any issues, but none of the participants reported social services involvement or safeguarding concerns. City University guidelines include appropriate procedures, referrals and contact information for researchers so the university can manage safeguarding concerns. One partner mentioned that when he was a teenager, he had been depressed and had suicidal ideation but that this was related to a specific family situation, and this was no longer the case. No couples reported any current concerns about their child's health and no safeguarding issues were identified. Some participants were not receiving support, but others had found help from their GP. The couples did not report severe and enduring concerns around anxiety.

**Transparency and Informed consent**

During recruitment, there was clarity about the project aims. From the first contact, there was mention of the inclusion/exclusion criteria, the use of the research and my profile. Once email contact was established, they were sent the information sheet and consent form in advance. They were asked to email acknowledgement they had read the information. At the beginning of the interview, I described the research project and sought confirmation they had read the information and consent. There was a chance to clarify any concerns they had. They were invited to pause if they experienced distress and if they needed to attend to their children. They were informed that they could withdraw before the data was analysed and that confidentiality would be maintained.

**Anonymity**

There is a danger that participants may identify themselves in the descriptive phrases to exemplify themes. This could bring some feelings of distress. To minimise this as far as possible, no identifying details will be used, and details may be altered to protect the participants' identity. In addition, the interviews were transcribed using GDPR-compliant software to protect anonymity. To protect the confidentiality, all recordings were voice only.

**Anonymised data (all electronic forms)**

All data is stored in the researcher's computer and cloud site (One drive), encrypted and password

protected. Data will be retained for a minimum of 10 years.

**Confidentiality of Data**

According to City, University of London, requirements, all personal data (signed consent forms) are digitally stored separately from anonymised and partially anonymised data in an encrypted file.

**Coercion**

A potential ethical concern may be that a couple felt obliged to participate in the study. However, the participant information sheet gave prospective participants full advice on what to expect from the study, and there was no financial incentive to participate. In addition, participants were informed that they could withdraw and pause the interview at any point.

**Safeguarding**

Safeguarding was assessed during the screening process by asking participants if they considered they were at risk or if social services were involved. The university safeguarding guidelines were the reference in case any concerns were identified. This includes appropriate procedures, referrals and contact information for researchers so the university can manage the concerns. During the interviews, no safeguarding concerns were identified.

**The COVID context**

I will like to summarise the practical impact of the COVID lockdown in this research. Methodologically, this research was impacted by the COVID restrictions and the pressures the possible participants were subjected to at the time. This project originally intended to recruit participants using baby groups, support groups and places where mothers usually gather, but because these were all closed social media was the only way to recruit participants. Another difficulty was the lack of BAME participants in this study; one of the reasons for this may be that these communities were disproportionately affected by COVID in terms of health, socially and financially.

During the COVID lockdown, it was advised that people should work from home. Therefore, the

couples I interviewed were together taking care of the baby. This would not have probably be the case without COVID. In the UK, parental leave was 2 weeks at the time, so having fathers at home during the postnatal period is not usually the norm. In addition, COVID restrictions meant that families didn't have families and friends around to support them. Therefore, couples didn't have access to support during this time and that might have affected the way the partners interacted with each other.

**Reflexivity**

This section is intended to outline my reflections on conducting the research as an individual and as a counselling psychologist. During my first pregnancy, I was running a group in CAMHS for parents who had children with harmful behaviours. In that group, there was a mother who shared that the problem with her child had resulted because she suffered from anxiety when the baby was born. She felt unable to respond to the child, and she felt unsure as a mother. She was grateful for the help she was now receiving because she had been asking for it since the child was born, 17 years prior. She mentioned that medical professionals had told her she wasn't ill enough. This statement shook me, and it stayed with me. As I became a mother myself, and lived the reality of what it is to experience anxiety after having a baby, I decided I wanted to know more about the subject.

As we began to think about a research project, my topic was clear: I wanted to help parents who suffered from postnatal anxiety. As a counselling psychologist, I felt that I could provide something of value to these parents and indirectly to their children. As I spoke to supervisors, researchers and parents, I realised that most of the help and responsibility was allocated to mothers. I felt this myself in my journey as a mother, and it made me wonder what happened with partners. I wondered if there was any research around a couple's experiences of anxiety during this period.

I began the recruitment process expecting not to have much response; instead, many people responded to the ad. Some contacted me to tell me that although they didn't fit the criteria, they would be interested in participating. As I spoke to those parents, many of whom were not interviewed, they told me that it was the first time someone had asked what they thought as a couple. Health

professionals were happy to hear about my research, and it was even published on Instagram by a published author that I had seen on the BBC. I felt validated and excited as I thought the project would be helpful to many parents and professionals, and it was valuable from a counselling psychology perspective.

During the interviews, I felt increased pressure; there was a mix of performing as a "good" researcher and the possible bias towards my own experience of postnatal anxiety. I was very mindful of being professional but also being warm. I was also aware to check in regularly with my supervisor during the project and to have safe a space before the interview where I could reflect on my bias and not bring it to the conversation. I kept a log after every interview so I could get a sense of what the couples experience had been like and to reflect on the experience. I had a sense that my experience had similarities with the interviewed couples in terms of the type of thinking and the support my partner and I provided for each other. But COVID was a new aspect that differed from mine, and I thought it could increase their anxiety even more.

Having done a critical review and reading about what anxiety looks like and the impact of anxiety on the bond with the partner and child, I had preconceived ideas on what I might find. For example, I thought the couples would struggle to bond with the child. These ideas were immediately challenged, and I learnt to follow the couples' thinking and to clarify their meanings around anxiety. These challenges made me more open-minded to trust the process and allow them to express themselves freely. I learnt that there are many meanings and valued judgments on the word anxiety and who should be "suffering it", which made me think about how gender roles influence the research. I had prepared a debrief template with information about where to receive help, but most parents had already contacted professionals or had sought support from friends/family. I underestimated the resilience of the parents and was happily proven wrong.

Coding the material is complicated from a couple's perspective. I found myself wondering how to capture the relationship and how this relates to the anxiety. I have found that participants used "I" and

"we", which made me think that codes can be thought about from both individual perspectives and couple's perspectives. At times, the couples seemed to be figuring out or experiencing things together, and at times, they experienced it differently and took on roles that support and complement each other. This is interesting but also difficult.

As a counselling psychologist, I hope that this research brings something of value, but as a parent, I hope that it means that more support becomes available to people that are not "ill enough" to be offered help by the NHS.

**Data Analysis**

Braun and Clarke (2020b) offer guidance on how the analysis should be conducted to be valid. However, they also state the importance of a reflexive stance on each part of the process. Therefore, I will include my reflections on each step.

**Familiarisation with the data**

Terry, Hayfield, Clarke and Braun (2017) state that during this phase, the researcher needs to engage with the data as they read it, which means to be observant, noticing patterns, asking questions and absorbing all the information. For me, it meant reading the interviews twice and writing down my impressions. So, for example, in Kelly and Kevin's interview, I made a note: “Kelly’s cultural differences impact their perception of professionals? Kevin seems to have taken this view as his own.”

It also meant that after reading all the interviews, I made notes about the entire data set. For example: "Postnatal anxiety seems like a missed opportunity, like something was taken away from them?”, “there seems to be an assumption that having babies should be magical” and “are all couples in agreement? I don’t remember any of them disagreeing with each other”.

My notes were mainly questions or tentative statements, which was done on purpose as I wanted to remain curious. Reflexivity was critical as my views impact data collection and data analysis (Shaw,

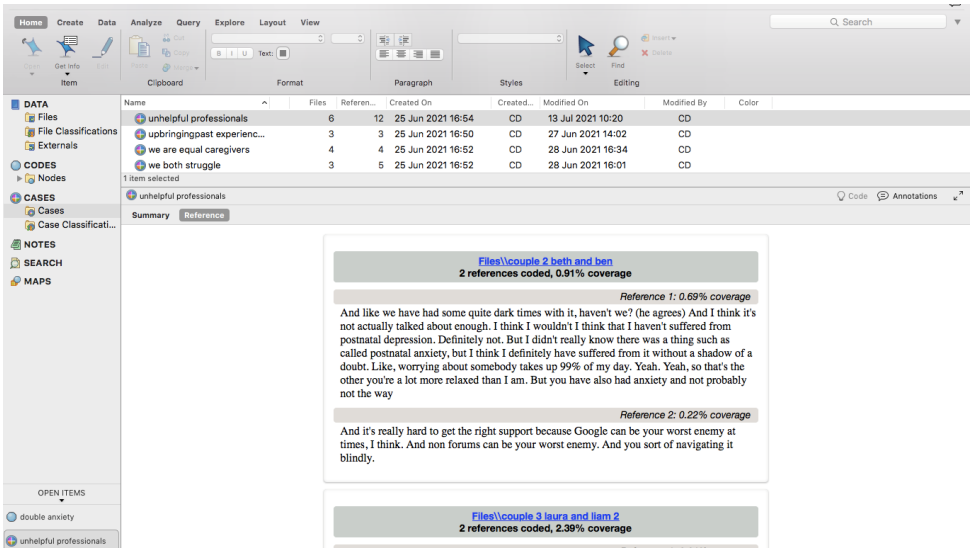
2010). I knew that I was trying to understand my postnatal anxiety academically, so I had a set of ideas that were not reflected in the data. These couples felt connected and managed together, and I thought they would speak of more conflict and disconnection. This was surprising to me as their difficulties in the relationship seemed like adjustments in the face of challenge. I realised that I hoped this was a theme, but I was aware of the steps I needed to take. It would have been easy falling into the trap of making it a theme and keep going, but I wanted to make sure I was doing my research appropriately.

**Coding:**

Coding is a systematic process where the researcher creates meaningful labels attached to specific segments of the data set (Terry et al., 2017). I used phrases that capture the meaning of the data set, and these varied from obvious semantic meaning to more latent or conceptual ideas. Coding is about data reduction and organisation, and I struggled with this. I started coding two interviews by hand, and I found it exhausting, practically challenging, and not very eco-friendly. So I contacted my supervisor, who suggest I should use Nvivo, data analysis software. Using computer programs to code has negative connotations for some researchers (Terry et al., 2017). For me, it was extremely helpful. Nvivo allowed me to code what I wanted, and then it identified all the segments that had been coded under that label and to what interview it corresponded.

Figure 2.

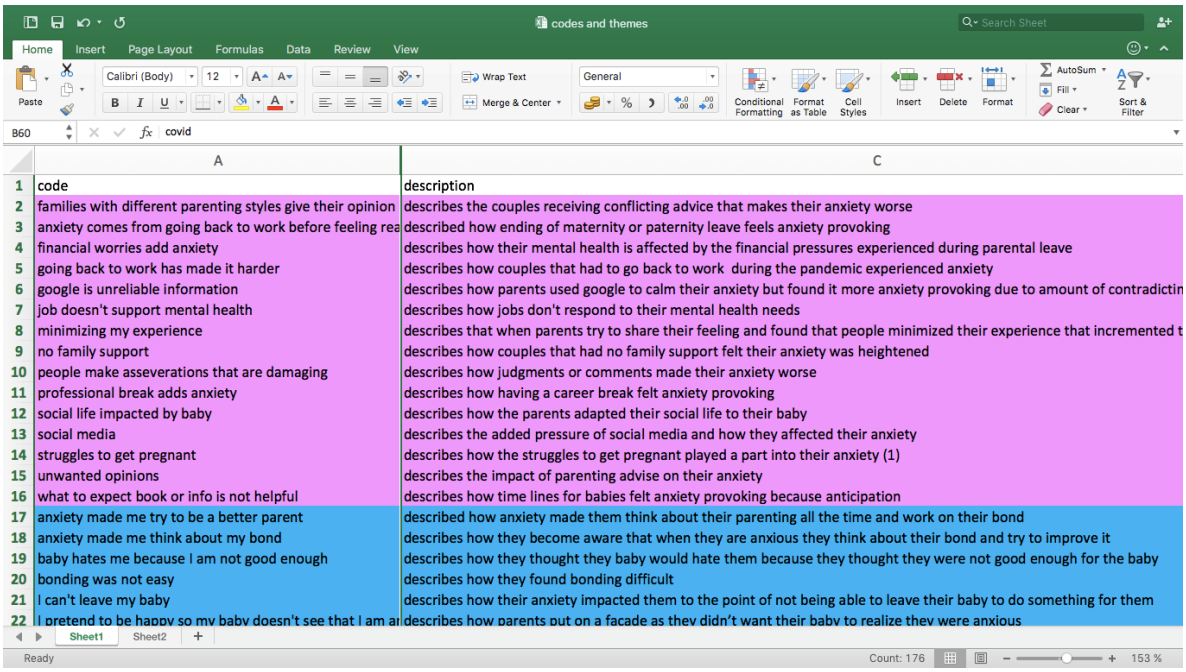
Nvivo coding example



I also did a spreadsheet on Excel that allowed me to collect together the 176 codes I identified and information about what they referred to. This was helpful for the next step. During this process, I had the help of my supervisor to make sure that my procedure was done appropriately and to maintain reflexivity. This was also noted in my reflective journal.

Figure 3.

Excel example of codes and meaning



| | A | C |
|---|---|---|
| 1 | code | description |
| 2 | families with different parenting styles give their opinion | describes the couples receiving conflicting advice that makes their anxiety worse |
| 3 | anxiety comes from going back to work before feeling rea | described how ending of maternity or paternity leave feels anxiety provoking |
| 4 | financial worries add anxiety | describes how their mental health is affected by the financial pressures experienced during parental leave |
| 5 | going back to work has made it harder | describes how couples that had to go back to work during the pandemic experienced anxiety |
| 6 | google is unreliable information | describes how parents used google to calm their anxiety but found it more anxiety provoking due to amount of contradictin |
| 7 | job doesn't support mental health | describes how jobs don't respond to their mental health needs |
| 8 | minimizing my experience | describes that when parents try to share their feeling and found that people minimized their experience that incremented t |
| 9 | no family support | describes how couples that had no family support felt their anxiety was heightened |
| 10 | people make asseverations that are damaging | describes how judgments or comments made their anxiety worse |
| 11 | professional break adds anxiety | describes how having a career break felt anxiety provoking |
| 12 | social life impacted by baby | describes how the parents adapted their social life to their baby |
| 13 | social media | describes the added pressure of social media and how they affected their anxiety |
| 14 | struggles to get pregnant | describes how the struggles to get pregnant played a part into their anxiety (1) |
| 15 | unwanted opinions | describes the impact of parenting advise on their anxiety |
| 16 | what to expect book or info is not helpful | describes how time lines for babies felt anxiety provoking because anticipation |
| 17 | anxiety made me try to be a better parent | described how anxiety made them think about their parenting all the time and work on their bond |
| 18 | anxiety made me think about my bond | describes how they become aware that when they are anxious they think about their bond and try to improve it |
| 19 | baby hates me because I am not good enough | describes how they thought they baby would hate them because they thought they were not good enough for the baby |
| 20 | bonding was not easy | describes how they found bonding difficult |
| 21 | I can't leave my baby | describes how their anxiety impacted them to the point of not being able to leave their baby to do something for them |
| 22 | I pretend to be happy so my baby doesn't see that I am ar | describes how parents put on a facade as they didn't want their baby to realize they were anxious |

## Generating initial themes

This is the first version of the patterning in the data to which the research question acts as a guide to determine what is relevant or not (Terry et al., 2017). During this process, I used sticky notes to organise the codes into groups. Next, I used the Excel spreadsheet to differentiate what codes belong to which themes. For me, this was the easiest part of the process. My previous career in branding taught me how to organise information into clusters under a central organising concept. Once I had the initial themes, I went back to the extracts to make sure they told a relevant and coherent story. Naming the themes was the most challenging aspect of the process, and for this, I met with my supervisor. In this meeting, I explained my themes, what they meant, and what segments best

represented them. This was helpful to find names for my themes, question overlaps in themes, and think if they responded to the question. For example, when discussing the theme of social pressures, I found myself unable to explain it, so I went back to it and realised that "Support" was a better central organising concept.

Figure 4.

First draft of themes with example codes

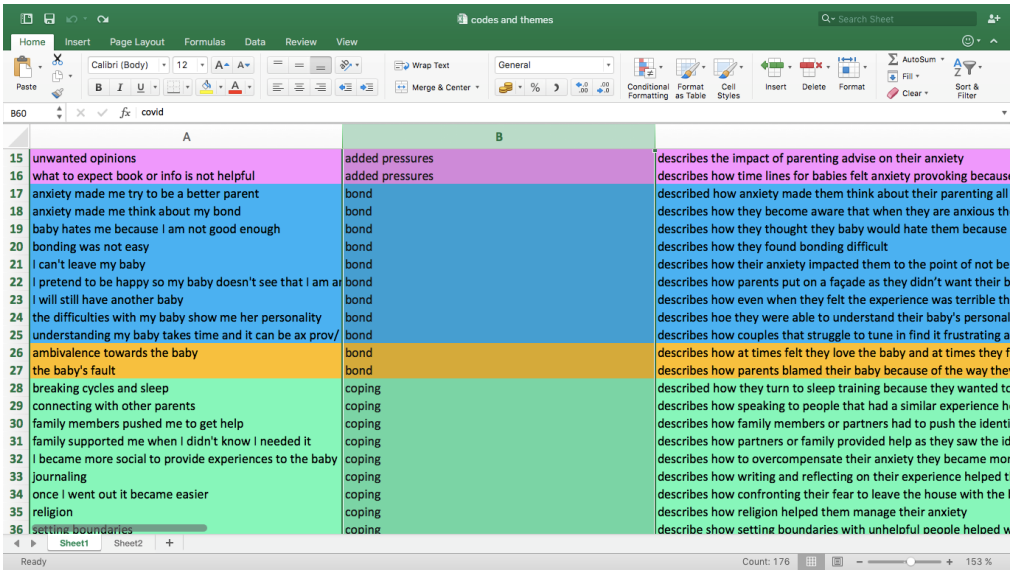
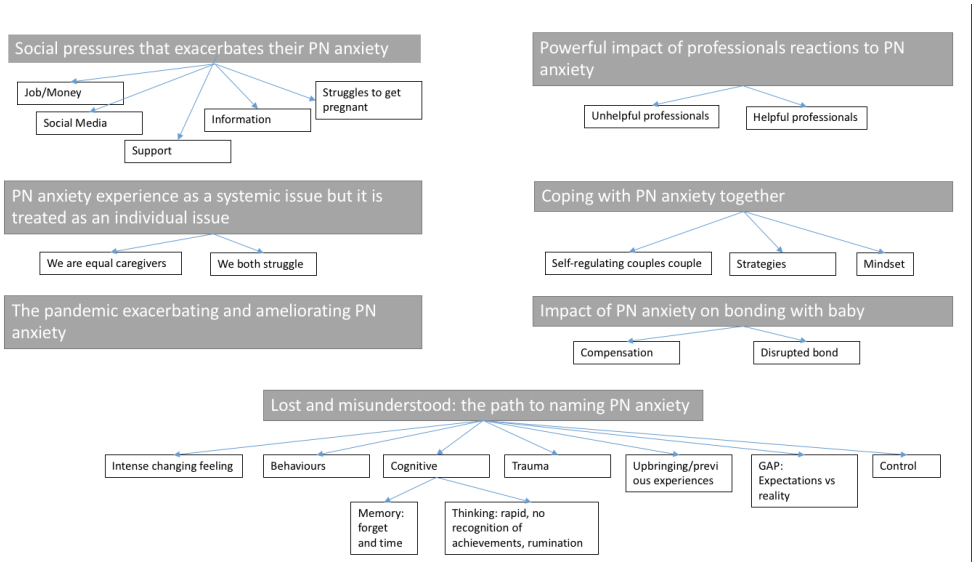



Figure 5.

Initial Themes



**Reviewing themes**

This phase has been called a quality control exercise, as it makes sure themes are representative of the data, work well with the codes and answer the research question (Terry et al., 2017). For this process, I used Nvivo again. I found quotes from all couples that represented each theme where I had difficulties. I understood that the theme needed adjustment or further analytical work. For example, I listed social media as a subtheme, and there were only semi-relevant quotes from 3 couples which made me think that this subtheme was my bias. I came to realise that social media is something that I thought would be relevant, as it was mentioned in the first interview and I gave it more importance than the overall data set had shown me.

**Themes**

According to Braun and Clarke (2006), the criteria for "good" thematic analysis include a thorough consideration of all the data, resulting in themes that are "internally coherent, consistent, and distinctive". The codes with similarities were grouped together in initial themes. Initial themes were reviewed to avoid overlap and determine if they told a convincing story of the data and answered the research question. This process allowed the themes that will be presented to be defined and named.

These themes described my analysis of how participants explained their experience of postnatal anxiety as a couple. This is a “joint story” which might not be the same as their true individual experience. And, although these experiences might not reflect individual experience or the experiences of all couples that suffer from postnatal anxiety in the United Kingdom, it stills offers critical insight for professionals working with couples in the postnatal period (Gobo, 2004).

Once the initial themes were identified, the transcripts were revisited to ensure that the themes were evident and that illustrative quotations could be provided as evidence. This process refined the themes so these could be written up for the results.

**Defining themes and writing up**

Defining the themes moves you to an interpretative position and involves telling a story based on the data and making sense of the patterns and the diversity of meaning (Terry et al., 2017). This part involved writing the analysis, making sure it was clear, cohesive and was of good quality. For this, my supervisor made the final checks to confirm the validity of the work. The 15-Point Checklist of Criteria for Good Thematic Analysis Process (Braun and Clarke, 2006, Appendix G) guided the validity of this work. This piece of work is presented in the next chapter. Finally, the final period of focus and refinement is where the researcher weaves together the data, analysis and literature in response to the research question (Terry et al., 2017). This is the final chapter with the discussion.

**Chapter Three: Analysis and Results**

This chapter intends to present the most salient themes from the nine interviews conducted with couples who experienced postnatal anxiety. This chapter includes the description of each theme and verbatim quotes from the couples to illustrate their views. To clarify the results I have included a figure that will show the themes and a table that describes the meaning of each theme.

Figure 6. Themes

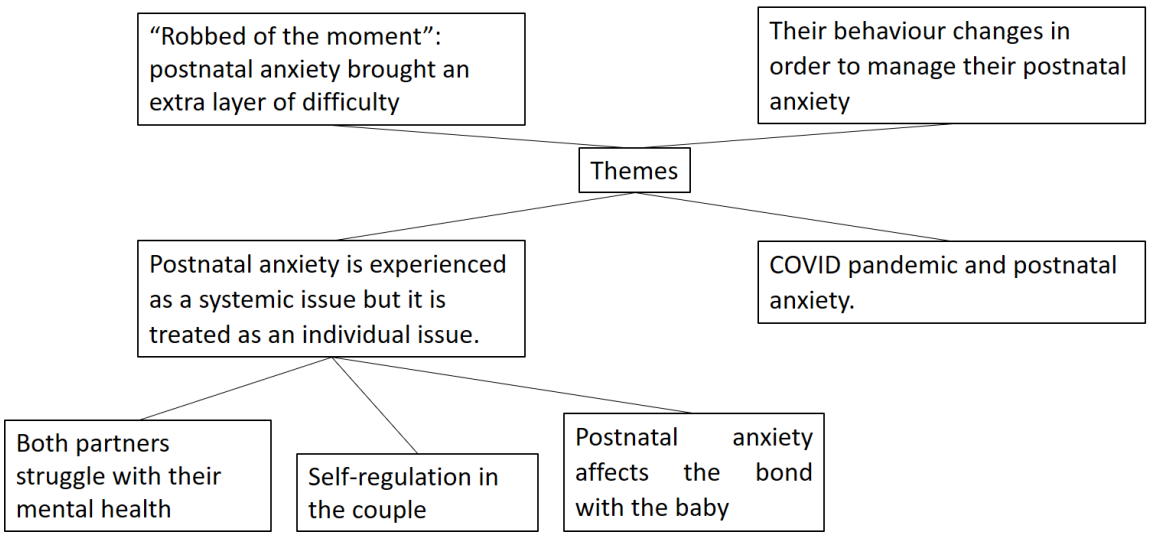


Table. 2 Themes

| Label of themes | Definition |
|---|---|
| "Robbed of the moment": postnatal anxiety brought an extra layer of difficulty | Outlines how the couples expected a positive experience after having a baby, but postnatal anxiety had prevented them from enjoying their experience. |
| Their behaviour changes in order to manage their postnatal anxiety | This theme represents how couples experience that their unusual behaviours were associated with their anxiety and how it seemed that these behaviours were used to manage their anxious thinking. |
| Postnatal anxiety is experienced as a systemic issue but it is treated as an individual issue. | Outlines three subthemes: how couples experience postnatal anxiety in a way where they both struggle with their mental health, how they use self-regulation to manage their postnatal anxiety and how postnatal anxiety affects the bond with the baby. |
| COVID pandemic and postnatal anxiety | Outlines the particular issues that the COVID pandemic brought to these couples and how this impacted their experience of postnatal anxiety. |

**Theme one: "Robbed of the moment" – postnatal anxiety brought an extra layer of difficulty.**

This theme was named after Julie and James explained what postnatal anxiety has taken from what they thought their experience would be.

"We felt robbed of the moment…I had a Disney film expectation. Yeah (partner agrees), you think it's going to be this like, you know, every month, it's going to be giggling and all that sort of stuff is going … like a fairy tale…and it is now frankly, what I would have dreamed of it being like, but for the first six weeks, were not. We were hell on earth." said Julie

Julie spoke, and James was holding her hand and nodding his head, which I understood as them both agreeing with the statement and supporting each other as they talked about a difficult time in their lives. As they spoke, you could sense the disappointment postnatal anxiety had brought. But, perhaps, disappointment is not strong enough, it seemed that postnatal anxiety had taken something from them. It was as if their experience resembles the grief of not being able to experience what they were expecting and the shock that this happened to them. For this couple that had tried to have children for

five years, having a baby appeared to represent the realisation of their dream. Instead, it seemed to bring unexpected difficulties and fears around their new life.

James said, “I was worried that this was going to be the new normal, how something that we wanted for so long can do so much damage to her (referring to Julie)”.

It seemed that for them, there was an idealised idea of what having a baby would be like, and postnatal anxiety had prevented them from feeling what they were expecting to feel. Moreover, it seemed that for couples where the idea of having a baby was idealised, having postnatal anxiety was experienced as extremely difficult. This might be because of the big difference between the idealised expectation and their actual experience, which seemed unexpected to them. Most importantly it seemed that couples were caught in a vicious cycle where postnatal anxiety was perceived as damaging to their experience which came with the grief of losing their idealised postnatal period and which in turn may continue to exacerbate their postnatal anxiety. This vicious cycle, therefore, makes the experience much more complicated.

Other parents had more realistic ideas about having a baby and the challenges that parenting might bring, but this didn’t seem to protect them from the experience of postnatal anxiety. It seemed that postnatal anxiety was not dependent on idealised or realistic expectations but rather an experience that made them worry about their view of what the postnatal experience was meant to be. It appeared that experiencing postnatal anxiety was not lived as a momentary experience but rather as a complete description of their day or even postnatal experience. It seemed that when couples experienced postnatal anxiety, they could not sustain balanced feelings or tolerate ambivalent feelings towards their postnatal experience, parenting or their baby. It was as if postnatal anxiety was an all-encompassing experience that tainted other positive aspects of their experience. Ben and Beth explained that there were children in their extended family, and they were aware that the parenting experience could feel overwhelming and bring some anxiety to their lives. Still, they didn’t expect to suffer from postnatal anxiety and that this experience dictated how they felt about their overall postnatal experience.

Beth explained: “it's definitely harder than I thought it was ever going to be. I think everybody tells you that having a child is the hardest thing you'll ever do… But then it's so rewarding at the same time.” Ben followed up with: “And when they start to really give back it is really rewarding and if you asked me today, everything is great, but yesterday, everything was horrible, I don’t think anything went well yesterday”.

As they spoke during the interview, you could see that Beth and Ben expressed joy and gratitude for having a child and how they could be humorous about their postnatal experience. But at a point during the interview, which took place at night, the baby cried. Immediately both stopped talking, one checked the monitor, and the other went to the baby’s room. Previously, they had spoken about their sleep difficulties, how if they don’t sleep, their anxiety increased, and how much they had hated sleep training. As the baby settled, they could continue with the interview, but their use of humour changed. I understood this as the impact of the anxiety; when the baby cried, I wondered if it made them anxious and if these worries impacted their behaviour. It gave me a flavour of the less positive experience they reported once anxiety was present and how it affected them in their day-to-day life.

Kelly said: “I was so anxious and then Kevin would say something and I just wanted to kill him, everything that he said annoyed me.”

For some couples, that extra layer of difficulty had to do with the negative feelings that postnatal anxiety seemed to bring to their experience. What seems apparent from the way the couples spoke was that postnatal anxiety made them experience feelings of anger, shame, irritability, fear, preoccupation and heightened sensitivity. It seemed that when they described experiencing anxiety, these feelings were immediately associated with their experience. Toni and Tyler had difficulties as Toni had to stay in the hospital for a while after delivering the baby. She described feeling anxious about not being able to be a good mother as she was not present for a time and Tyler expressed worries about not being a good father as he didn’t know what he was doing.

When they described what it was like to have postnatal anxiety, Toni said:

"It's been a rollercoaster, and it's had lots of highs and lots of lows (yes, Tyler agrees) …I didn't realise that if I am anxious, the shame was coming out of every place."

Most parents were able to describe negative experiences and feelings associated with their anxiety as Toni and Kelly did. But even the ones who weren't able to verbalise it would give examples that indicated struggles and difficult emotional experiences. Parents were able to say that focusing on their worries or their complicated feelings took away from enjoying their experience. All couples were able to co-create a story where they described postnatal anxiety worries as ever-present even when they shouldn't have been. Listening to their stories, it seemed like they couldn't shift their thinking and put aside their concerns to enjoy from the interaction between each other and their baby.

Sally said: "All the advice tells you what you shouldn't do. There's nothing to tell you 'what you should do', your best way to take care of your baby effectively. So that was something I was really, really worried about." Steve then developed the idea further: "I think that's a great point that you make, I haven't thought about. But you're right, everything's about 'don't do this', but they'll don't tell you what you should do is… you feel like you have to be hypervigilant all the time, and that affects your mental health, there was no enjoying your time with your baby."

Sally and Steve worried about what to do with the baby, and they gave the impression of being desperate for instructions and wanting to "have a manual" to know what to do with their baby. It gave me the impression that they couldn't just follow their instinct without questioning if what they were doing was correct. But the most relevant aspect of their comments is that they seem to be able to create a joint story of how postnatal anxiety affects their mental health and doesn't allow them to enjoy their experience with their baby.

Feeling robbed of the moment did not only affect first time parents. Second-time parents seemed to have an expectation that they wouldn't suffer from postnatal anxiety with their second child as they had already lived the experience. They seemed to have an expectation that the second time would have been easy.

Laura explained: "It seems not worse this time around, but it seems more intense, is probably the only word I can really think of. I thought I knew what I was doing because I had a baby but my day-to-day life went from being really straightforward and easy to being so difficult. I complicate it quite a lot, not necessarily in a bad way but my thoughts are complicated."

Laura talks about the comparison between her first experience of parenthood and her second; there is a quality change in their experience but there is still anxiety. But what she seems to bring is the disappointment in thinking that she knew what she was doing but that it didn't seem that helpful this time. I wonder if this speaks to the expectation that once you know what to do with a baby, your anxiety would lower but in her case, this didn't happen.

The other second-time parents, Christine and Cameron had a similar experience.

Christine said: "I felt petrified…I think everything was a lot worse… one of my worries was being like a crap mother to the older one, like I couldn't give her as much as we had always given her when she was an only child. Yeah (Cameron agrees). And then what else? I think that, and then also felt guilty. I couldn't give the baby what we gave to my first one, I couldn't go to all the baby classes and give her like 100% attention."

The second-time parents seemed more anxious in the interviews, there was a sense of not being able to manage their anxiety and that their associated feelings were more intense. There seemed to be a change to what made them anxious, a change in the quality of their anxiety. The disappointment seemed bigger than the other couples as they seemed upset their anxiety hadn't lessened with their

second postnatal experience. Perhaps it was the idea that with their second baby they would be able to feel less anxious, and instead postnatal anxiety seemed more difficult and was detrimental to their postnatal experience. In their interviews, it appeared that their interactions were more difficult than those of couples with only one child. I wonder if this had to do with the pressures of having a second child and not being able to get the positive experience they were hoping for.

**Theme two: Couples' behaviour changes in order to manage their postnatal anxiety**

This theme describes how couples experience that their unusual behaviours were associated with their anxiety and how it seemed that these behaviours were used to manage their anxious thinking.

All couples reported that when they experienced anxiety their behaviour changed in a way that they didn't expect or was unhelpful to them.

Anna described:

"I remember when I was walking and trying to get her sleep…trying to like, walking up and down by the sea and her crying and … my anxiety rising, and I could just feel people looking at me… I felt like they were judging me, and it was just terrible. And it's just sort of the pressure builds and the tension builds and, and then you just end up walking up and down so fast and I remember not knowing where I was going, it was just so strange."

This extract highlights the understanding of the process of how postnatal anxiety was experienced by the couples. Like Anna, others seemed to be speaking of feeling anxious and this anxiety impacting the way they acted. For Anna, this aimless fast walking seemed to be associated with the postnatal anxiety she experienced at the time. It suggests that Anna acted in a way that she hadn't planned, that she was not expecting and perhaps that she didn't recognise. What I wonder was the role that the change of behaviour played.

Kelly said: “I worried about him all the time, I stayed awake for hours just looking at him sleep and I didn’t want to sleep, I was afraid something might happen like he couldn’t breathe or something so I wanted to make sure someone was looking after him all the time.”

When Kevin responded, “I went to sleep on his bed,” Kelly asked: “You actually slept on his bed during the night?” They laughed and Kevin answered: “I slept in his bedroom checking that he was breathing properly.”

Their comical interaction gave me an idea that they both realised that they were acting in similar ways as they worried about similar issues. For them, sleeping with the baby allows them to check if the baby is breathing. What became apparent was that their behaviour seemed to allow them to be reassured that their worries would not become real. They seem to be speaking about the possibility of controlling their anxious thinking.

Ben said: "We didn't leave our living room for two weeks. We slept in there,” and Beth followed: “One of us had to sit up with her awake. And then we took it in shifts with a mattress on the floor and the other sitting on the sofa keeping her up straight. And we did that for like maybe like two weeks.” Ben explained, “but when anxiety is there, it was the only thing to do,” (they laughed).

This repeated laugh, similar to Kevin and Kelly, seemed to convey that there was an aspect of surprise that they have acted in this way. I wonder if they were judging their behaviour as unusual. What they described seemed to point out that these behaviours were meant to reduce their anxiety but this didn’t seem to work. I wonder if the behaviours became more extreme as their anxiety increased but also, about the impact of not sleeping properly for two weeks and the impact on their postnatal anxiety.

Julie said: “I made you take her to the GP, the health visitor, to a cranial osteopath, that didn’t work so we went to A&E. I went with a bag (laughs) I thought I was going to be sectioned, I thought I was going

mad and I was not a good mother, I just couldn't stop worrying that there was something wrong with (baby)".

For Julie, who said she struggled with severe anxiety, it seemed that when her worries felt unmanageable the way she coped was to seek reassurance from health professionals. But as with other couples, this behaviour didn't seem to reduce the anxiety and perhaps what Julie describes is an escalation. One professional doesn't help, then on to the next, this doesn't seem to reduce the anxiety and therefore she has "gone mad". This led me to wonder whether the escalation of behaviour has the opposite effect to that which is intended. Instead of reducing anxiety, it seems to be detrimental to their mental health.

Leila said: "I felt mental, like that is the best way to describe it… I'd be thinking to myself and then I would call 111 because (baby) was restless in his sleep, so I would call and they would talk to me like I am crazy but if I didn't I was worried sick."

As with Julie, Leila describes an escalation of behaviour, but what both seem to imply is the irrational aspect of what is happening. They can't stop worrying, they can't stop themselves from acting in a way they seem surprised by and they are aware that this doesn't help their mental health. But they seem to be in a loop that is hard to step out from. It seems that no matter what they do, there is a negative outcome, if they don't act in this way their worries become unmanageable but if they act on their worries, it doesn't help and affects their mental health further. It seems that the couples experience postnatal anxiety and associate irrational behaviours with their anxiety; the function of these behaviours is to manage their anxiety even when they are aware that this actually is detrimental to their mental health.

**Theme three: Postnatal anxiety is experienced as a systemic issue but it is treated as an individual issue.**

This theme represents the idea that partners experience postnatal anxiety as a couple's problem rather than as one partner suffering. On the one hand, both partners experience difficulties with their mental health. On the other, they make active efforts to regulate themselves within the system they belong and they make active efforts to regulate each part of the system. This means that they try to ameliorate the impact of postnatal anxiety on themselves, each other and their baby. This theme has three subthemes: "both partners struggle with their mental health", "self-regulation in the couple", and "compensation in the bond with the baby".

**Subtheme: Both partners struggle with their mental health**

This theme represents how couples experience postnatal anxiety as applicable to both of them where both partners experience worries after having a baby.

Julie looks at James and says: "We have had some quite dark times with it, haven't we?"

James looks at her and nods.

Julie continues: "I think it's not actually talked about enough. I think that I haven't suffered from postnatal depression. But I didn't really know there was a thing such called postnatal anxiety, and I think I definitely have suffered from it, without a shadow of a doubt. Like, worrying about somebody takes up 99% of my day. You're a lot more relaxed than I am. But you have also had anxiety."

James confirms: "I have".

What Julie and James bring is the idea that both of them worry and suffer from postnatal anxiety but also that, although is a shared experience, there is space for individual differences. For them, there is a difference in how they think about their anxiety, one is relaxed and the other isn't but both struggle.

It appears that these couples are able to create a joint story where they identify as a couple that experiences postnatal anxiety rather than an individual. As Leila and Lucas said: “we both need to get a grip” or what I understood as regaining some self-control. And in this joint suffering there is room for the nuances of their individual experience as well.

Ben said: “I think what I've struggled with the most is actually the double whammy of having the overwhelming feelings of wanting to do your best for your daughter but also at the same time for your wife as well. So I think the thing that I struggled with the most is just the double whammy.”

While Beth’s worries were about her baby, Ben is able to recognise that for him there is a difference. Most of the worries reported by the couples were related to the wellbeing of the members of the system. It appears that postnatal anxiety has a strong connection with worries about the health, functioning, or general wellbeing of the systems and their members.

Andrew said: “I think my worry was not lower, but it was more about worrying about her. I felt confident that the baby was ok.” And Anna added: “For me, it was all about (baby), but we were so worried.”

What Andrew seems to imply is that the difference in worries doesn’t minimize the impact they have on them and their wellbeing. And these nuances in their experience don’t interfere with the way they experience postnatal anxiety in the system.

Steve revealed: “We struggled with breastfeeding, we were worried (baby) was losing weight and we were dreading seeing healthcare professionals because we didn’t want to hear the breastfeeding Nazis again.”

What Steve brings up is the capacity for this couple to create a joint story: they both struggle and they both breastfeed. This leads one to wonder whether these couples were able to join stories before the baby arrived, whether this joint story is part of becoming a family system or whether this story is part

of a joint experience of postnatal anxiety. Perhaps it is difficult to answer this without knowing the background story of the couples but what seems apparent is that couples who identify as suffering from postnatal anxiety are able to form joint stories of what they consider a joint experience.

**Subtheme: Self-regulation in the couple**

This subtheme refers to the capacity of how the couples were able to manage their postnatal anxiety. Self-regulation refers to how a partner would find ways to feel better because they are part of the system and because partners supported each other.

Cameron explained: “We could really quickly calibrate, so to speak…we were playing on the same team… basically it’s teamwork…when the mother’s instinct kicks in and I'm trying to help at the same time. But I'm just getting involved, and I'm getting in the way, and it's just making it worse. So for me, it was just retracting…Wait for her to just figure it all out, and then come back in and say ok, where can I help, how can I help? Or even sometimes just let her be and I just let her figure it out. As opposed to me interfering and making her anxious.”

Christine continues: “If I am anxious I just want to sort out things myself, if (baby) is not sleeping I breastfeed…I can do it myself, If you come, it is worse (referring to Cameron), I just need to calm down and I know that you are there if I need you to take (older child).”

This interaction contains several aspects of what self-regulation in a system can include. First, there is an idea that couples are able to “calibrate” or regulate in order to manage their postnatal anxiety. This seems to relate to the idea of finding a balance that ensures that they can function or manage their mental health. Second, this support to reduce the partner’s anxiety might mean either actively engaging or retreating. This seems to relate to the idea that partners use different strategies in order to support each other when they are struggling with their anxiety. Third, partners are able to regulate knowing that they are part of the system even if they don’t make use of it. This seems to relate to the

supportive aspect of being on a system itself rather than making use of it, almost as if the knowledge of being part of the system was reassuring in itself.

Andrew commented: “I know I would have my moments where I go quiet because I'm not quite sure what to do. And I tried to solve things. And that isn't necessarily always the answer. And Anna wasn't necessarily looking for a solution. She was looking for just someone to be there for her, which is what I learned over time."

What Andrew seems to explain is that self-regulation is achieved by learning how his partner needs to be supported when they feel postnatal anxiety. This seemed to allude to a process that the partners go through to understand each other and their experience of postnatal experience. What I understood is that these couples were willing to find ways to understand their partners to learn how to best support them. I wonder if this was an aspect of the quality of the relationship that spoke of the functioning of the system and if this meant that these couples were able to experience postnatal anxiety as a systemic issue because of the type of relationship they had.

Julie clarified: “It is probably the first time that you (James) really had to think about what's going on in my head? How can I care for her? I wasn't really able to vocalise what I needed, which usually I would do. So I think you did have to take on this new role of being very understanding towards me and trying to appreciate what was going on in my head... Which is not a way he would usually think. He doesn't really think like that. He's like, he's a doer. He's not someone that sits and is with his thoughts and thinking …so it definitely, it definitely was a change.”

James followed: “I think I kind of knew what was going on. I mean, luckily, I've been educated by you (Julie)…it was an illness, right? I knew it was nothing that you were forcefully doing. And it was obviously something was going on with you…it was it was frustrating, you know, but I definitely made an effort to internalise that frustration (partner laughs), because I knew this wasn't something that you were choosing to do.”

This interaction between Julie and James allows me to understand that postnatal anxiety impacted Julie, and James, who wanted to support her, needed to understand how to do it. I wonder if what they are explaining is how the system had to adapt and this adaptation in roles and functioning allows them to regulate. And partners might need to adapt the way they think and act in order to support their partners. But I also wonder if what this means is that there is an act of regulation within a partner in order to benefit the system. In James' case, he has to internalise his frustration in order to not aggravate the situation, in order not to affect Julie's mental health and/or to support the functioning of the system.

**Subtheme: Postnatal anxiety affects the bond with the baby**

This theme describes how couples experienced that postnatal anxiety impacted their bond with the baby.

Laura said: "With my anxiety, I think I worry a lot about parenting, how my behaviour will affect them in their later life? … I'm quite aware, almost overwhelmed, at times… I would say I'm a full helicopter parent…I have to tell myself not to just say NO all the time, like, be careful, get down, sit down, because I feel like the fun police sometimes."

What parents seemed to describe is being highly aware that their anxiety and consequent behaviours would impact their children. But moreover, I wonder if the helicopter parenting that Laura mentions is the result of her anxiety. Helicopter parenting is used by parents as a way to describe somebody that pays close interest to their child but also has an overprotective quality as the parents try to shelter children from pain and disappointment. What Laura seems to point out is her awareness that her postnatal anxiety is connected with the way she bonds with her child. Perhaps, postnatal anxiety is what makes her over-worried about their child and therefore be a "helicopter parent". And although Laura makes explicit reference to her behaviour, other parents were able to think about their emotional state as well as their behaviour.

Leila said: “I worry that he will pick up on my bad mood or pick up that I am feeling low. So I am always trying to be happy and bouncing around him and stuff. I am very aware of how our emotions, the way we are, have an impact on people and how it can affect their development. So if you are insecure, I think about attachment styles. If I am not ok I am going to have an insecure child. I am not going to have a child that is not ok with himself, that is not ok with other people…So I feel I have to smile, although I feel anxious.”

What Leila seems to be talking about is the idea of compensation. She gives the impression that one way to secure the bond with her baby and the baby’s emotional state is to try to cover up her own emotional state by pretending to be happy. And while in some cases compensation can be done inadvertently, for these couples it seemed to be a conscious effort. It appears that parents were able to think about and recognise the impact postnatal anxiety might have on their children and that because of this they tried to engage in compensatory efforts to ameliorate the impact of postnatal anxiety and therefore protect their bond.

Tyler said: “I didn’t have a dad, he left. I didn’t know what to do with the baby and Toni was at the hospital. I was worried I was not able to bond because I am not a mum and I can’t breastfeed. But I am the one that knows and does all his routines. I have spent every waking hour with him. And since he was born, I haven’t been away from him for a long period of time. And so for me, I guess, being away from him for an hour or two isn’t a major deal…she gets really anxious, if she’s away from baby for more than an hour and even if he is in the next room to you. She says I want him back. Whereas, I'm ok with it. Because I think that's just because she has been away for so long now and then she feels guilty about that. I'm ok with it but I want to do all his routines, I want to be present as a father.”

What Tyler seems to explain is that postnatal anxiety affects both partners and both engage in compensatory efforts. And, while on the surface both partners make an effort to be present, by either doing all the routines or by not being away for long, it seems that the origin of this behaviour is different.

It appears that Tyler doesn't want to be an absent father and therefore he might be compensating by being the one that knows and does all the routines. While for Toni, not being away from her baby seems to be related to missing out on the time with her baby. What might be important here is that both partners are engaging in similar compensatory strategies but related to different worries, while both of them identify themselves as suffering from postnatal anxiety. So what this brings is the idea that when they experience postnatal anxiety and they become aware this might impact the bond or the baby, they engage in some compensatory effort to ameliorate the impact of their mental health on the bond with their baby. And perhaps to understand how couples experience postnatal anxiety we need to understand the link with the compensatory efforts they do around bonding with their child.

**Theme four: The COVID pandemic and postnatal anxiety**

The COVID pandemic brought significant changes to the United Kingdom. The first COVID lockdown was in place at the time of the interviews. During this time, people had been instructed to work from home, there was good weather, people could go out for a walk for an hour a day and households could not mix. Meanwhile, NHS services were limited, and partners were not allowed to be present during deliveries or examinations; and baby activities and social gatherings were closed. Some parenting groups were beginning to operate online but many baby-related groups struggled to offer a digital alternative. This theme describes the relationship between the COVID pandemic and postnatal anxiety.

One of the practical matters that COVID brought was that couples were not together during deliveries or if the mother and baby had to stay in the hospital.

Toni said: "I had problems with the delivery and a lot of complications and Tyler was sent home. I was there with (baby) and I was so sick…but then (baby) was discharged and I had to stay in the hospital alone. I missed pretty much all of his newborn phase because I was in the hospital and then Tyler didn't know what to do with (baby)".

Tyler continued: "I was at home on my own. Personally, I never had a dad so I didn't know what I was doing. And so I didn't know what to do. And then at the same time I'm having to look after him and I think throughout everything that went on with Toni, I ended up suffering from severe postnatal depression, and then it gradually went on to a lot of depression and anxiety."

The COVID pandemic affected both partners in different ways, the one that was left alone to deal with health difficulties, probably afraid and experiencing difficult feelings around their health and the relationship with their baby. And the one that was home alone, knowing their partner was struggling and restricted by COVID, not being able to support their partner and as it seems in Tyler's case not being able to be supported themselves. What this example lets us see is that the impact of COVID was profound and long-lasting and in the case of Toni and Tyler it seemed that it significantly affected their postnatal anxiety experience.

Leila said: "I thought we would get out the next day, but then he had jaundice…I think it's not the end of the world, but at the time it just felt it was like, it was horrible. I didn't; I just felt like I was on my own. Lucas couldn't come in… it's not like a major complication. It felt like it at the time… I think I blew it all out of proportion…I was worried sick."

As Leila described, being alone intensified their feeling around complications. It appeared that being alone when they struggled intensified their worries. And as Andrew said, "I need to try and provide those assurances, that comfort. But I don't think I could fully because I couldn't be there." It appears that the COVID restrictions had a negative impact on the couples as they experienced anxiety in the postnatal period and had no support from their partners during highly stressful times. For these couples, it seemed that COVID worsened their experience of postnatal anxiety. And these challenges were not only about support during medical procedures but also in other areas, such as work.

Steve said: "I was being put on the spot to do effectively 18-hour days, as well as trying to provide support for Sally. But it was just simple things like that, were getting more and more anxiety driving for

me around and around my job. Because I'd say, you make one mistake and you're gone in my role. So that was a huge amount of pressure to deal with as well."

Steve seems to be saying that COVID added pressure which in turn seemed to increase his postnatal anxiety. This experience of added pressure seems to be described by all the couples. Meanwhile, the pandemic not only added to the parents' pressure, it also prevented people from accessing the usual outlets where they could release the pressure. For second-time parents who knew of the benefits of postnatal groups on their mental health, COVID added an extra difficulty that affected their mental health.

Laura said: "There wasn't really anyone to ask those questions, just kind of silly questions, these little kinds of things that you stress you." To which Liam responded: "Like with the mum friends that you made that first time around."

COVID brought the closure of baby groups, postnatal support, breastfeeding support and children's centres. Laura describes these groups as a source of support where she could ask questions about the things that make her anxious. But what Liam adds makes me think about the bond with people living similar experiences and how that might alleviate the difficult feelings the couples might have experienced. Perhaps, COVID prevented first-time parents from meeting people in similar situations and, because of this, postnatal anxiety may have worsened during the pandemic.

While most couples described the COVID pandemic in terms of added pressure not many were able to discuss the fears of getting ill and how this impacted their postnatal anxiety. But for Kelly who was suffering postnatal anxiety before the lockdown, it was different: "Before, I didn't want to go out, I was worried to take him out and getting something. But with COVID it went like, I didn't want to go out and then almost I couldn't because of the fear."

What Kelly seems be saying is that COVID exacerbated her previous worries and this, in turn, limited her functioning as it affected her going out. This perhaps was not what all couples described at the time, but this was the first lockdown where people thought if they followed the restrictions it would keep them safe. But as the write-up of the dissertation allowed for more time to pass, it became clear that people's worries about becoming ill increased as numbers of COVID deaths increased. Perhaps, the phenomenon Kelly spoke about had to do with the COVID pandemic increasing postnatal anxiety and although it was not for all couples at the time, it is perhaps relevant to consider. As Ben describes in the following quote, the COVID pandemic brought unexpected benefits for some couples which now - after 2 years of COVID – we know is not the most common response to the pandemic or the anxiety it brought to the world.

Ben: "Beth will be with her or around her in some way. Whereas I'm not, I'm separated, and I'm away. And now, I see so much more now. Thanks to COVID for that, you know… I have a bond with (baby)." This theme allows us to think that these couple's postnatal anxiety was made higher due to the negative impact of COVID. This can only be understood with hindsight as at the time there was no awareness of the long-lasting negative effects the COVID pandemic brought to people's mental health.

**Chapter four: Discussion**

In this chapter, the research project's findings will be examined and considered within the context of the research aim. This chapter will review the objectives of the study and findings will be discussed in the context of existing literature. Each theme will be explored based on the available literature. Methodological considerations will be explained to highlight the study strengths and limitations. Clinical implications for healthcare professionals and services providers will be discussed, including recommendations for practice and service delivery. Finally, there will be suggestions for future research, and there will be a discussion of personal reflections around the research project.

The primary aim of this study was to gain an insight into the experience of heterosexual couples who experienced postnatal anxiety, in order to better support them. The second aim was to consider the implications for counselling psychology in both service delivery and clinical interventions. Finally, a third aim was to provide recommendations for future research.

With this study, I hope to bring new knowledge that allows families to receive better care. As I reflect on the topic, I realise that societal expectations place a heavy burden on mothers as they have been traditionally seen to be the main and even sole carers of children. And, for years, gender bias has affected the way parents are viewed, it seems that mothers are have been traditionally seen as nurturing, caring, staying at home and men as providers, emotional cut off, barely involved with their children. And It seems that these views have been reflected in perinatal care, where mothers are the ones that receive care and bear responsibility for the baby, fathers are rarely included. Meanwhile parents who struggle may find themselves in difficult interactions with professionals and leave the encounter feeling that they are not good enough parents. Traditionally, medical and mental health perinatal services have been designed specifically for mothers. I think about this project as challenging these perspectives, where parents can be thought as equals and where struggling parents are in need of support and compassion. Researching the couples' experiences allows us to understand what they need, that both parents can share caring responsibilities, both connect emotionally with their child and both can find difficulties adapting to their new parenting role. When there is a baby, there is a family,

a system and all parts need to be thought about. It is my hope that professionals are able to rethink some of their preconceptions and gender bias when working in perinatal services.

One of the primary considerations of this project is that the analysis is based on what the couples describe as their experience. This is a particular joint way of "storytelling" that couples do together, and this storytelling might sound different if the research had focused on individual experiences.

**Summary of the findings**

This research has found that couples who experience postnatal anxiety feel that the impact of their difficulties affects the family system. This means that both partners struggle with their mental health, that they use self-regulatory efforts as a couple to manage their anxiety and that they think about the impact of their mental health on their baby and in their bond. It was found that couples who experienced postnatal anxiety felt that their mental health brought an extra set of difficulties and this brought a difference between their expectations about life with a new baby and their reality. This discrepancy caused them distress. Another finding was that couples modified their behaviour in order to try to manage their postnatal anxiety. Lastly, the COVID pandemic affected the couples and therefore had an impact on their experience of postnatal anxiety.

A recent research study suggests that couples feel that they do not know enough about perinatal difficulties or know how to get support from professionals (Sambrook et al., 2019). This aligns with the NHS (2017) findings, which identified that clear pathways to mental health support are needed in the postnatal period.

Couples reported intense changing feelings, both positive and negative, that were unpredictable, and they reported that postnatal anxiety made them focus on and perceive only the negative emotions. Everaert and collaborators (2020) talked about the process that occurs when there is anxiety. First, they suggest, there is a negative interpretation bias which means that we tend to appraise ambiguous situations as negative. Second, there is a dampening of positive emotions. This seems consistent with

the couples in the present study, who reported their experience of focusing on negative emotions. Perhaps postnatal anxiety shares similar mechanisms where couples tend to evaluate ambiguous situations as unfavourable and where negative emotions dampen positive situations. As these are explorative results, there is the need for further research on this process in postnatal anxiety. Clinically it might mean that postnatal interventions may need to focus on these negative emotions, especially when results seemed to show that the couples experience a great degree of anger and irritability.

The couples in this study reported an experience of "being robbed of the moment", and perhaps this has to do with a judgment of their emotion or a failed attempt to repress their negative emotions (Campbell-Sills et al., 2006). Couples reported expecting that having a baby would bring only positive feelings, and judging their negative emotions or not repressing them might bring this sense of disappointment. And the overall negative emotional experience impacted them and the quality of their relationship (Don and Mikelson, 2012 and Shapiro & Gottman, 2005).

Couples described their experience as overwhelming, which aligns with research done with mothers individually (Harrison et al., 2020) and fathers individually (Seidler et al., 2016). This has important implications at a clinical level. For example, if we work with one parent individually who experiences overwhelming feelings and postnatal anxiety, we might need to consider including their partner in the intervention.

Interestingly, second-time parents in this study described postnatal anxiety more intensely the second time. Moderate or low-level anxiety is expected as part of the transitional process after having a baby, which has been thought to reduce once adaptation has occurred (Figueiredo et al., 2018). But having second-time parents reporting increased postnatal anxiety brings attention to the importance of addressing postnatal anxiety in first-time parents as a preventative measure for chronic anxiety presentations.

Irritability was a common feature that was described by couples. According to previous research, fathers perceive their partners as irritable (Baldwin et al., 2019). Research also suggests that mothers feel an abrupt and challenging time after having a baby, which sometimes presents with irritability (Coates et al., 2014). In addition, relationship difficulties have also been reported in couples who experience anxiety (Don and Mikelson, 2012). Therefore, irritability seems to be a feature that needs to be considered when assessing and researching postnatal anxiety.

Postnatal anxiety interventions have focused on maladaptive thinking styles rather than behaviour management; only recently, some CBT interventions have started exploring the roles of problematic behaviours (Maguire et al., 2018 and Green et al., 2021). This research found that complex behaviours have a detrimental effect on couples, and the authors identified them as an area where parents needed support. Couples in the present study stated that the function of these behaviours was to control their anxious thinking, but the more anxious they became, the more extreme the behaviours became. Furthermore, these behaviours seemed to increase the parents' fatigue and worries. Interestingly, both partners appeared to engage in these behaviours even when one of the partners didn't report a cognitive anxious thinking style or even when reporting that they didn't understand the function of the behaviour. More importantly, these behaviours were what couples described as "alerts" to their mental health difficulties and was what second parents addressed first as their anxiety returned. Therefore, it might be relevant to think about behaviour management as part of postnatal anxiety interventions.

This research found gender differences in the labelling of postnatal anxiety, which may be consistent with societal expectations around gender differences and mental health. Fathers felt more comfortable labelling their anxious thoughts as worries, as they said they feel responsible for their partners and babies, and acknowledging concern could take focus away from them (Baldwin et al., 2019). However, mothers reported postnatal anxiety irrespectively of their partners reporting postnatal anxiety or mental health difficulties. What was interesting was that, as a couple, they described themselves as experiencing postnatal anxiety.

Father's described "double worries", which are in line with research around father's experiences of anxiety (Baldwin et al., 2019). This could also reflect the societal expectation of being the provider and protector or the family.Meanwhile, sharing these worries around partners and babies seemed to have a powerful positive effect on their partners. This positive effect perhaps has to do with couples' self-regulation of anxiety where fathers engage in behaviours that enhance their relationship (Halford et al., 2007 and Wilson et al., 2005). This could be a coping strategy that helped address the severe impact of postnatal anxiety on their lives.

The couples in this study also discussed what they called traumatic experiences due to COVID restrictions and, in line with the literature, couples found little information and support to manage them (Delicate et al., 2020b). For example, couples who experienced traumatic births started that they were left to manage these traumatic experiences alone without any support or ‘briefing services’ provided by birth professionals (Delicate et al., 2020b). In particular, it seemed that birth trauma acted as a trigger for postnatal anxiety (Watson, 2021). Birth trauma was not only reported by mothers. Fathers also described experiencing birth trauma (even when mothers didn't perceive it as traumatic), which aligns with recent research (Daniels et al., 2020).

COVID restrictions seem to have placed extra distress on birthing partners. Partners were asked to separate when support was needed, which seemed to exacerbate repetitive negative thinking (Harrison, 2021). Meanwhile, previous traumatic experiences, previous anxiety and difficult upbringing impacted the couples and appear linked to their postnatal anxiety. This goes along with research that shows that risk factors such as lack of family support, family conflict, loss of control during birth, and previous history of anxiety or psychiatric history can increase the possibility of experiencing postnatal anxiety (Field, 2018). Most relevant to this research is the finding that when risk factors were present in one of the partners, it didn't necessarily mean that this partner identified with postnatal anxiety. Instead, the other partner felt their partner's risk factor could affect their own mental health, which again suggests the benefits of a systemic approach towards postnatal anxiety.

Another risk element for postnatal anxiety is that mothers seem to hold unrealistic expectations of birth and parenthood (Harrison et al., 2020). This research found that holding unrealistic expectations affected them as a couple as well. The discrepancy between their expectations as parents and the reality of having a baby seemed to be mainly due to the lack of information about the demands of having a baby (further factors were the focus on negative thinking and emotions that postnatal anxiety brought). Moreover, maternal and paternal identity and the cognitive, affective and behavioural changes associated with the transition were reported as anxiety-provoking as previous research has found (Perun, 2020).

One of the key findings of this research is that postnatal anxiety was described as a systemic issue where both partners were affected and presented anxious symptomatology. This view supports the idea that partners are dynamically interconnected (Mikulincer et al., 2002).

Couples described sharing caring responsibilities for their child. This adaptation to new routines and behaviours seemed to be related to a self-regulating capacity more than changes in societal roles. When a partner felt anxious, the other partner was able to detect changes in their partner's wellbeing (Pilkington et al., 2015). Thus they exhibited relationship enhancement behaviours (Halford et al., 2007). This seemed to create a joint story of them being a "team" rather than a "one partner supporting the other" narrative, which appeared to develop the family story. This family narrative, in the view of several participants, allowed for better care of their baby and better support for their partner, which, in turn, helped with their own anxiety. Again, we need to consider the impact of COVID: these couples spent more time together due to the pandemic restrictions, which could have brought a different dynamic in terms of sharing caring responsibilities.

The relationship strategies and relationship effort that comes from self-regulation (Wilson et al., 2005) could be managed through open communication, inferring emotional states, and feeling close to their partner. Remarkably, tasks biologically allocated to mothers, such as breastfeeding, were described as a team effort which perhaps talks about the persistence to apply measures to regulate as a couple.

Other researchers have reported fathers' descriptions of disappointment about their limited role in the baby's care which these fathers also shared (Baldwin et al., 2019).

The notion of both partners "struggling" or experiencing postnatal anxiety seems to support the idea of affective concordance. As with other psychiatric disorders, parents tend to have similar emotional reactions to events, and this had to do with the relational aspect of their relationship (Dierker et al., 1999 and Walker et al., 2017). One factor for future clinical intervention is that children tend to express similar difficulties when there is affective concordance in parents (Dierker et al., 1999 and Walker et al., 2017).

This research highlights the idea that partners tend to lessen the other partner's anxiety. Previous research has found that partners could reduce their partners' anxiety (Zaider et al., 2010). This happens when partners are able to communicate and support each other. Quality in a relationship can be thought of in terms of relationship adjustments such as communicating with each other, understanding and supporting your partner and about dyadic adjustment which means better functioning (Zaider et al., 2010). These couples all seemed to communicate well, were supportive of each other and in general it seemed they presented with positive relationship qualities and overall good functioning (Driver & Gottman, 2004). In addition, research has found that affective concordance and the general experience of postnatal anxiety increment marital conflict and dissatisfaction, supporting the idea that considering the couple is critical to treat anxiety disorders (Zaider et al., 2010).

One interesting aspect was the idea that there was a recognition from the partners to understand that when they were anxious this affected their interaction with their partner and their baby. For example, research has found low parenting warmth, involvement, consistency, satisfaction and high parenting hostility in mothers and fathers that experience postnatal anxiety (Seymour et al., 2015 and Giallo et al., 2015). But in this research, parents recognised that their mental health was impacting their parenting and took proactive efforts to change their behaviours and attitudes towards their children. And although research has found maternal self-regulation as a moderator between anxiety and

maternal care (Holmberg et al., 2020), more understanding is needed around how couples' self-regulation relates to postnatal anxiety.

As discussed previously, part of the systemic view of anxiety relates to the capacity of couples' self-regulation. One aspect worth mentioning is that the relationship dynamic allowed participants to infer each other's emotional states and needs, and partners actively engaged in this new dynamic. Self-regulation has been usually thought of regarding behaviours and goals (Halford et al., 2007). But it seems that other relational mechanisms might influence how couples manage their behaviours which are worth studying.

Moreover, this capacity to understand each other's emotional state and needs allowed partners to explore their own feelings. It seemed that the possibility of shared emotional experiences through affective concordance (Walker et al., 2017) and the potential to engage in behaviours to support each other's mental health (Wilson et al., 2005) allowed each partner to further understand their own mental health difficulties and needs.

Self-regulation has been linked to relational satisfaction; it has been reported that there is more satisfaction in couples when partners actively engage in self-regulation (Pepping & Halford, 2012). Therefore, the quality of the relationship didn't decrease even when irritability and hostility were present in their interaction. Moreover, the quality of the relationship allowed the couples to express gratefulness for each other and gratefulness towards the relationship. One of the considerations of this active engagement is that at certain times this meant giving the partner space and refraining from intervening, at other times it requires different strategies such as a trial and error approach, and sometimes it just required validation and containing. It also meant, at times, using creative avenues to share their experiences, feelings and needs, for example, one participant mentioned that he (she?) and his/her partner kept a blog that allowed them to record their views and choose an appropriate time to discuss this with their partner.

Postnatal anxiety has been linked with a negative impact on a child's emotional development as parental quality decreases when a parent\s capacity to respond to their children is compromised (Stein et al., 2014). Moreover, mothers with postnatal anxiety have reported low parenting warmth and less involvement (Seymour et al., 2015). They have also been found to be prone to identifying negative emotions (Webb & Ayers, 2015). At the same time, fathers who struggle during the postnatal period tend to show more hostility and lower parenting warmth at when their child is older (Giallo et al., 2015). However, these couples reported making active efforts to create a positive bonding experience with their children and create a caring environment for them to grow up. This difference may be explained by the particular sample in this study; these were stable couples where parents had enough financial and cognitive resources to mitigate their worries about practical matters.

Couples described actively thinking about their bonding and how their mental difficulties would impact their children. Interestingly, the experience of postnatal anxiety was described as positive as it made them "better parents", and when combined with therapy, it seemed to bring positive experiences to the couples as it led individuals to give thought to how they might improve their parenting and strengthen their relationship with their children. This seems to align with Condon's bonding theory (1993), where the love parents feel for their children expresses itself in parental behaviours that will increment closeness.

But for some couples, engaging in parental bonding behaviours sometimes seemed to be to the detriment of the parents. Interestingly, one of the couples mentioned “helicopter parenting”, which has been associated with indulgent parenting and the negative wellbeing of both parents and emerging adults (Cui, Darling, Coccia, Fincham & May, 2019). There is a need clinically to evaluate parental behaviours to identify if these are about bonding or safety behaviours related to postnatal anxiety. It may be valuable to explore whether postnatal anxiety leads to certain parenting styles.

Most couples described what Condon (1993) called a disposition to protect, to protect their children from dangers, and protect them from the possibility of being affected by their parents' moods. However,

what they often described is that these behaviours increased their fatigue which has been found to be linked to anxiety (Taylor & Johnson, 2013 and Darwin et al., 2017). And for some parents that were able to access services, therapy had been helpful to balance the care for their children and themselves and explore their anxious behaviours.

All couples reported behaviours explained by Condon's bonding theory (1993), where parents display dispositions to know, be with or interact with the baby, avoid loss or separation, protect, and gratify needs that translate to bonding behaviours. These bonding behaviours for Condon (1993) were about information seeking, proximity seeking, protecting and safeguarding, pleasing, gratifying altruistically and others.

These behaviours seemed to be functional for most couples when they allowed them to reflect on their parenting and anxiety. But for those that recognised a link with dysfunctional and anxious worries, these behaviours caused increased pressure. This can be a difference between bonding and avoidant and safety behaviours, which has been a feature in postnatal anxiety (Green et al., 2021).

Couples mentioned temporary disruption of the bond, which has been described as normal ambivalence in bonding (Condon & Corkindale, 1998). Couples expressed ambivalence and reported increased anxiety when they felt a disruption in the bond. What was interesting was that when one parent experienced negative feelings, the other took on the role to care for the baby. Therefore, the baby was not subjected to negative emotions without reparation or further bonding efforts. And perhaps this had to do with COVID and that both parents were at home and if this is the case, it is important to think what happens when anxious parents don’t have anyone to help them and how this impacts the bond with the baby. But, in general, what couples found was that bonding was affected by anxiety as they felt their postnatal anxiety didn't allow them to “bond straight away” or bond in the way that they wanted.

Couples who encounter negative experiences with health care professionals described increased postnatal anxiety and increased feelings of anger. As with other research, couples described not receiving support around their mental health, healthcare professionals withholding information or giving them biased information (Delicate et al., 2020a and Harrison et al., 2020). What the couples felt was lacking was a tailored approach and more time to understand their needs. Overall, couples described being dissatisfied with their care and they reported that they received little support for their mental health. COVID created added pressure due to the reduction in available services and the separation of couples as they accessed support.

COVID pressures around job security and money increased postnatal anxiety, which aligns with previous research (Perun, 2020). However, this added pressure didn't present any ambivalence or questioning as to whether they were overreacting or not. Instead, they called it "real" and brought more intense feelings, which increased their postnatal anxiety. More importantly, as with the risk factors, difficulties in one partner affected the other. For example, if one partner struggled with work, the other would worry about their finances and workload.

Like previous research, this research found that fathers who had difficulties around work, meaning pressures to balance work and family life, reduction of earnings or lack of job security, presented with anxiety (Philpott et al., 2019). In addition, parents reported increasing their work response and availability due to COVID and that remote working was stressful. But this was not only present with fathers. Mothers also described increased anxiety when their job impacted their mental health and made them question their bonding or think about the change in their identity and how this would affect their work life.

What was thought-provoking was the idea that the COVID pandemic has brought a benefit for couples. COVID allowed parents to spend more time at home supporting their loved ones and taking care of their babies. Fathers specifically talked about not having to miss important moments with their children. But it is worth mentioning that although the couples referred to pressures around work and money,

none of these couples reported hardships or having significant difficulties around their income. Another caveat is the timing of the research, being the first lockdown parents might have not imagine the actual impact the COVID pandemic brought to the population.

Couples also talked about the importance of talking and sharing their difficulties with friends and family members. More specifically, couples reported that they benefited from listening to others in similar situations. As with other research, mothers said that sharing in groups helped with their anxiety as they could normalise their experience (Harrison et al., 2021). Groups where mothers could access other parents in similar circumstances felt even more helpful than previous friendships. But the possibility of sharing with peers was severely impacted due to the COVID pandemic and this had a negative impact on the couples mental health.

COVID limited access to support groups, family members and friends, and all couples reported the impact of the lack of support during this period. Families that felt they had less support reported that their anxiety had increased due to not having people caring for them or helping them. Even second-time parents who had already had the group experience said that the lack of classes and support groups had affected their mental health. They reported wanting a space to ask questions, find reassurance and to talk about their difficulties. This is consistent with previous research that states the importance of peer support for mothers even when they reported their partners are their most important source of support (Harrison et al., 2021)

**Methodological Considerations**

**Strengths**

The strengths of the research rest in the design and method of analysis. Having a pilot interview allowed for the opportunity to review challenges and adapt procedures and questions in the semi-structured interview. In addition, the pilot allowed me to consider the benefit of interviewing the couples' together or individually. In the pilot, the father had difficulties answering some of the quesitons and further probing questions were necessary. This seemed to align with previous research that considered

that dyadic interviewing would ensure that men can engage when they perceive the topics are female/mother related (Wilson, 2020).

Another strength of interviewing couples is that dyadic interviews allowed me to explore the interaction between inidviduals (Gouilhers et al., 2019). Furthermore, interviewing partners at the same time resolves some ethical considerations around anonymity and confidentiality, it illustrates how dynamics can contribute to the content and quality of the data, and the observational aspect of the interaction produces rich data (Bjørnholt & Farstad, 2014). Moreover, a dyadic interview allows the research to get a sense of the relationship and how they support each other (Blake et al., 2021). Additionally, interviewing couples together allows for joint reflection where the researcher can understand how the couples make sense of their negotiation during a challenging time, as it is in the postnatal period (Allan et al., 2021). In this sense, it opens an opportunity to see how couples disagree and agree with their experience and how they corroborate and challenge each other's story (Downes et al., 2021). This allows the creation of a joint storyline that gives information on how they experience postnatal anxiety as a couple.

An understanding of the relationship between the couple informs the analysis. For Braun and Clarke (2019), codes and themes must be informed by the researcher's subjectivity and engagement. Using the quality of the relationship as another finding can validate the analysis. For example, we discussed anger and a certain degree of hostility between the couples in the results. Still, these couples' interactions were loving, and while they described these interactions, there were laughs, touches between partners and faces that indicated remorse which can be thought of as positive relationship qualities (Driver & Gottman, 2004). Braun and Clarke (2006, appendix G) created a checklist to ensure that the thematic analysis process was done appropriately, ensuring that the research was valuable. For this, each data item was given equal attention in the coding process, the coding process was thorough, inclusive and comprehensive, and supervision was sought to discuss the coding process. All relevant extracts for all themes were collected. The themes were checked against each other, and checked against the original data set to confirm that themes were internally coherent, consistent and

distinctive. Supervision was requested to discuss theme development. The data was analysed beyond descriptions. Analysis and data match, and the extracts illustrate the analytic claims. The aim was to settle on an analysis that tells a convincing and well-organised story about the data and topic, and to achieve a good balance between analytical narrative and illustrative extracts. Supervision was sought at each stage of the process to ensure the process was done correctly.

Little is known about postnatal anxiety and how couples experience postnatal mental health difficulties. Using qualitative methodology enabled the analysis of in-depth data about the experiences of couples who faced anxiety with the idea of expanding knowledge in the area.

**Limitations**

The main limitation of this study is the lack of diversity in the participant sample. It was observed during the early stages of this research project was that pre-existing research around postnatal mental health difficulties, postnatal anxiety and couples was based on samples that lack diversity. Efforts were made in this research to ensure a diverse selection, such as requesting BAME practitioners to share the flyer on their social media and ask prospective couples who wanted to participate; nonetheless, this effort was insufficient. Furthermore, COVID restrictions led to me having to use social media instead of social communities, hubs and children centres to recruit participants. The use of social media has several implications. At a socio-economic level, participants need to have the resources to acquire the technology. At a cultural level, they would have to be already interested in mental health as most practitioners used their social media to divulge information about mental health complications. A lack of diversity around mental health professionals on social media platforms was also observed, which can affect recruitment for BAME communities.

Another limitation was the picture included in the flyer. The flyer includes a photo of a white heterosexual couple holding a baby. A more inclusive flyer would have had the potential to attract a more diverse sample in terms of ethnicity, which would have benefited this investigation. Perhaps the image and relative lack of BAME practitioners sharing the flyer could affected diversity of the sample.

Interestingly, the advent of the Black Life Matters movement seems to have, among other things, led to an increase in the number of photographs of non-white families free on online platforms. This resource would allow future practitioners to include more diverse images in their flyers. It is important that future investigations think about how to include images and communications that are more inclusive in order to benefit the recruitment process.

But even researchers that have made efforts in recruiting diverse samples have struggled to engage participants from the BAME community. For example, this was evident in De Cock et al. (2016), which looked at couples and bonding and Wilson (2020), which studied couples' experiences of men's family planning. And even when the research sample is relatively diverse ethnically, still the participants are often highly educated (Kujawa et al., 2014). Only one research mentioned in the literature review described a diverse sample (Baldwin et al., 2019), and they explained how the fathers were already engaged in community services. The research was done with the help of the NHS in four London administrative districts, and each site served a diverse socio-economic and cultural population. They had a recruitment time of 6 months, and health visitors handing in the information during home visits. So perhaps research around this field needs extra resources in terms of time, professional access and money to ensure diversity in their samples.

Another limitation of the research in this sample was the homogeneity of the quality of the couples' relationships. As we have seen, there are positive relationship qualities such as showing care and concern (Driver & Gottman, 2004). And there is relationship adjustments and dyadic adjustments that allow couples to function and communicate better (Zaider et al., 2010). All the couples could be described as functional, with no apparent friction, and they spoke about loving with each other and their children. These couples had psychological resources to manage their difficulties as well as financial resources and external support. This makes this sample relatively homogenous and therefore makes the data less representative of the entire population. These couples are capable of co-creating a narrative, but there might be couples that cannot construct a joint story or families in which anxiety is never named or identified as an issue.

Another consideration is the lack of diversity around gender and sexuality. Because the literature in postnatal anxiety is limited and the research in this area around couples is even sparser, this study aimed to be exploratory. Therefore, limiting the sample to heterosexual couples allowed us to revise the current state of findings for postnatal anxiety for mothers and fathers. As evidence based around couples improves it will be necessary to include research that explores how postnatal anxiety presents in couples with diversity in gender, sexuality and that have adopted or used surrogates to have their children.

And with the sample difficulties, it has been thought that it is essential that a sample is representative of a given criterion and what precisely we are making inferences about (Gobo, 2012). For example, to understand the couples' experience of postnatal anxiety, we need couples who can create joint narratives. Therefore, the quality of the relationship needs to be a positive one. Even when qualitative samples are more representative of the general population, it might be that the findings of particular experiences may still be unique to one participant only and therefore making the generalisation of the experience meaningless (Gobo, 2004).

Another consideration is the impact of the COVID pandemic. In the UK, paternity leave usually ends after two weeks, and maternity leave ends after a year. But the majority of fathers in the sample had the opportunity to spend more time at home (caring for the baby and helping with household activities) as they moved to online working from home. The impact of the pandemic is beyond the scope of this research, but it makes for a particular way to relate as couples spent more time together in unusual and anxiety-provoking times.

This study was exploratory in nature, so therefore findings cannot be generalised to the broader population. However, it is fervently hoped that this study opens the possibility of understanding how couples experience postnatal anxiety and gives information about how professionals can best support them.

## Clinical Implications

### Counselling psychology

Counselling Psychologist need to act in the best interest of service users at all times (HCPC, 2015). When a baby is born, parents need to adapt to a new role. This family embarks on a journey of adaptation that requires all parts (baby, mother and father) to have their needs met. This research has shown the importance of thinking systemically and how all members of the family affect and support each other. As counselling psychologists, thinking systemically about postnatal anxiety allows us to understand how we can best support the family and each individual.

It has been reported that professionals have struggled with their knowledge of perinatal stress (Sambrook et al., 2019). However, it is the role of counselling psychologists to train and educate professionals around mental health issues (HCPC, 2015). Therefore, the more information counselling psychologist have around postnatal anxiety and how couples manage their anxiety after having a baby, the more training we can provide to other professions that support these families.

As counselling psychologists, we need to be able to work in partnerships with service users, other professionals, support staff and carers (HCPC, 2015). And during the postnatal period, collaborative efforts need to be made between doctors, nurses, midwives and health visitors to ensure the family's wellbeing. Therefore, counselling psychologists can inform care plans so that the mental health of the family is supported.

### Wider social context

Participants mentioned how services were stretched, how professionals lack time to support them properly and how they felt more should be done around mental health during the postnatal period. As the NHS moves to create maternal mental health services (NHS, 2017), relevant information regarding postnatal mental health is needed, specifically around postnatal anxiety where evidence is limited.

More researchers are working on postnatal anxiety and possible ways to intervene with couples (Rowe

et al. 2014). More specifically, it has been suggested that interventions that include fathers best support the mental health of couples and their families (Goldman & Burges, 2017). Therefore, including bothe members of the couple during postnatal support will ensure that babies and parents are supported with the hope of providing better outcomes for these families.

It is hoped that this research expands our knowledge of couples who experience postnatal anxiety; and this brings several clinical implications. In therapeutic work, we need to think about psychoeducation around perinatal difficulties and include partners when supporting a family's mental health. It also suggests the usefulness of developing group interventions so couples that experience postnatal anxiety can meet other peers in similar situations. In relation to wider care, we need to think how to include partners in the care of expecting couples. At the moment, there is a societal expectation that mothers are supported and they are solely in charge of the care of their baby. What this research has found is that both partners share caring responsibilities and support each other during the postnatal period; therefore, we need to think about maternity services that are more inclusive of partners. Inclusive services can help couples by allowing them to support each other during important medical procedures and to provide support to partners that are struggling after having a baby. More inclusive services around baby activities and support groups would allow couples to be best supported when experiencing perinatal difficulties by providing information and validation that both partners can experience difficulties after having a baby. Policies need to include new procedures for assessment of perinatal difficulties and support after having a baby. At the moment, after having a baby, there are two check points. The first occurs a few days after the baby is born; at this point, mothers typically discuss their own health and the health of the baby, and there is no inclusion of fathers or explanations around perinatal mental health difficulties. The second check is at 6 weeks, where only the mother is invited and it is more a physical health check rather that an evaluation of mental health difficulties. If the evidence suggested by this research project is confirmed elsewhere, it may prove valuable to include family wellbeing checks as part of standard NHS postnatal support. These wellbeing checks could provide an opportunity where the mental health of the couples can be explored and the impact on the baby is evaluated ensuring that the family can have access to early and appropriate support

around their mental health difficulties.

**General recommendations:**

- Include fathers in the six-week check to assess postnatal mental health and how the couples manage the care of their baby and their own wellbeing.
- Increase awareness around postnatal anxiety, how to identify it and how to make a referral to appropriate mental health services.
- Development of individual and group interventions around postnatal anxiety targeted to couples.
- Developing policies and services further with maternal mental health services dedicated to perinatal mental health, including fathers and partners.
- Provide widespread awareness of postnatal anxiety to increase the public knowledge of postnatal difficulties and what to do if new parents need help.
- For therapists working with couples it is important to consider that couples might affect each other's mood, that they regulate together and that the care of the child needs to be thought about systemically. It is also important to discuss the difference between the parents' expectations and the experience of actually having a baby and to explore what feelings this might bring for them.

**Suggestions for Future Research**

Reflecting on the direction of future research, there are many obstacles to overcome. First, there is still not much information around postnatal anxiety, especially around the "cut off" time of a baby's first year. As we know, anxiety disorders can become chronic if left untreated (Rachman, 2020). Therefore, having more information around the specific symptomatology and the course of postnatal anxiety is needed to understand the importance of intervening during this time.

Moreover, the majority of the investigations around postnatal anxiety have focused on mothers or fathers rather than through the prism of a couple. Perhaps more research about the importance of

assessing postnatal anxiety can be done to provide more information to professionals (Taylor & Johnson, 2013). There have also been mentions of the importance of determining possible treatments for postnatal anxiety (Loughnan et al., 2018). Finally, as anxiety impacts the family during this period, more investigation about couples interventions could be an exciting area of research.

But most importantly, research around BAME communities needs to happen in order to understand how to best support families. As we have seen, diverse sampling has been an issue for this project and others (De Cock et al., 2016 and Wilson, 2020). Whether these are problems with attrition or engagement during the recruitment process, perhaps it is needed to focus only on communities that have been underrepresented in research.

Finally, longitudinal studies might help us understand what happens with postnatal anxiety after the first year of having a baby. Information about the impact on the parents and child can help define the evolution of anxiety, impact on development and mental health and appropriate ways to intervene. In addition, one of the standards in the HCPC (2015) guidelines requires that counselling psychologists understand the nature of mental health difficulties across the the lifespan. Therefore, it is essential to understand the course of postnatal anxiety and identify how it evolves over time.

**Overall Reflections on the Research Process**

Working on this project has been highly satisfactory to me as a clinician and as a parent. Especially when it was well-received during my poster presentation and university conversations, it seems that perinatal mental health has become a matter of extreme relevance thanks to the efforts made by the government and NHS to provide something of value for parents and children.

Learning how to understand people's experiences and how to best account for these joint stories has allowed me to understand how co-creations happen and my role in supporting these collaborative stories. In a way, I have had to work hard in my role as a researcher as my first instinct is always to respond through the eyes of a clinician. However, reporting on the experience of new parents and

managing my views and bias has been an incredible journey where I have been challenged and, at times, validated. I have learnt to listen to the data without the interference of theory.

My focus here on couples comes from my experience working in CAMHS, where if I see a child with anxiety, I work with their parents' anxiety. I thought somehow anxiety affects the whole family, and I wanted to explore how. The parents I have met at during my work in CAMHS and in this research understand that if one of them struggles, the other struggles and that they want tools that will help them support their partners. I was challenged in my views that if parents experience postnatal anxiety, this could damage the bond. As a parent, this challenge to my assumptions brought me joy. But, as a clinician, I wonder if it is valuable for professionals to support parent-child bonding even if anxiety doesn't necessarily impact the bond.

Coming from previous experiences of quantitative methodology, changing to a qualitative one felt uncomfortable. But now I understand that the knowledge generated in this research is of incredible value to me as a researcher and as a clinician. Exploratory analysis of this kind is needed to understand where we should go next. And now that the government and NHS are listening, the researchers' role is to guide them to create better services for parents during the postnatal period.

**Conclusion**

This research has found that postnatal anxiety is still an area worth researching as there are still considerable gaps in knowledge. The general public doesn't seem to understand postnatal anxiety and how to find support around it. Couples who have experienced postnatal anxiety have reported struggling to name what was happening to them. Although several features make postnatal anxiety similar to other instances of anxiety, there are still some significant differences in the presentation.

What has been thought of as an individual issue has been presented by couples as a systemic issue. Couples have reported that they experience anxiety together where partners are both affected by worries and can present with restlessness, being easily fatigued, difficulty concentrating, irritability and

sleep disturbance that creates distress (American Psychiatric Association, 2013). Couples described how professionals thought about anxiety only affecting one partner even when they both struggled. Couples described learning to self-regulate to cope with the demands of postnatal anxiety.

Interestingly, most research has found that anxiety has a detrimental effect on bonding. But these couples described that anxiety made their bond stronger even when there could be temporary disruptions. In addition, professionals were described as having a powerful impact according to their reactions to the couples. Couples reported that helpful professionals had given them tools to manage their anxiety while unhelpful professionals increased their worries. As expected, support is vital while couples experience postnatal anxiety.

It is hoped that this research has given an insight into the experience of heterosexual couples who have experienced postnatal anxiety and that it may help identify better ways to support them. From a counselling psychology perspective, it is hoped that this research provides information that may improve service delivery, clinical interventions and future research.

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Appendix A

**Semi-structured interview**

This interview schedule will serve as a guide: it is to be used flexibly with participants. The aim is to facilitate the free account of their experience and what meaning they make of it.

**Introductions and engagement:**

· Introduce self and study
· Re-iterate consent, confidentiality, and the participants right to withdraw according to the information sheet (use information sheet to refer back to if any questions arise).
· Outline the process of the interview and the approximate length (60-120 min).
· Talk about the changes in the postpartum period and the idea that adapting to the change can be challenging and some people experience difficult feelings around it. Talk about the idea that as a couple one's experience influences the other.
· Check for participant queries.
· Demographics. Participants will be asked to state their ethnicity, employment and marital status, education levels, number of children and health and wellbeing of themselves and their children.
· Encourage both partners to engage in the conversation and reiterate that is important to hear from both of them.

**Interview questions and topics**

Prompts to include both partners in the conversation: Do you agree? Is there anything else that you would like? How was that for you? How do you find it? How is it like for you?

**Anxiety:**

1. Can you tell me how are you both finding this first year?
    a. Probe around worries.
2. How does anxiety get in the way of your life?
3. How is it like for you to experience anxiety at this time?
4. How is that making you feel as a couple?
5. Do you think both of you experience anxiety?
    a. Probe: In what way do you experience it?
    b. Probe: How does it look like?
6. What are the roles you and your spouse have taken on since experiencing anxiety? How has your identity changed and how does your anxiety relate to it?
7. Do you talk to each other about your experience?

**Coping with anxiety:** Some parents feel they can cope with their situation but other parents find difficult coping with it.

8. What is it like for you?
    a. Prompts: What do you feel is helping you cope with anxiety at the moment?
    b. What do you feel you are doing to cope that might not be helping you at the moment?
    c. What would help you to cope better with your situation?

**Impact of anxiety in the couple:**

9. How this experience of anxiety has impacted your relationship?
10. How this experience of anxiety has impacted your parenting?
11. How this experience of anxiety has impacted your social life?

**Impact of anxiety in the infant-parent relationship:**

12. Do you feel your anxiety determines how do you relate with your child?
13. Do you feel your anxiety influences the time you expend with your child?
    a. Probe: around the time of interaction they have.

Prevent you to connect with your child

**Access to information/support:**

14. Where do you access information about the postpartum period?
    a. What sources of support do you rely on? Probe: family, health professionals, books, online resources, social media, friends.

    What would be useful for professionals to offer?

15. Is there anything I haven't asked that you think is relevant? Are there any questions you were expecting that I haven't covered?

**Debrief:**

Thank participant and mention that if they are experiencing anxiety they can get support by contacting their GP, local IAPT, PANDAS or Relate (all the information will be available in the debrief template).

Appendix B: Ethics application

| | |
|---|---|
| Date | 22 Feb 2020 |
| Researcher | Cristina Delgado Torres |
| Project | A Mixed Methods approach to understanding the impact of an Acceptance Commitment Therapy (ACT) protocol on Maternal Postpartum Anxiety. |
| School | School of Arts and Social Sciences |
| Department | Psychology |

## Ethics application

### *Risks*

#### R1) Does the project have funding?

No

#### R2) Does the project involve human participants?

Yes

#### R3) Will the researcher be located outside of the UK during the conduct of the research?

No

#### R4) Will any part of the project be carried out under the auspices of an external organisation, involve collaboration between institutions, or involve data collection at an external organisation?

No

#### R5) Does your project involve access to, or use of, material that could be classified as security sensitive?

No

#### R6) Does the project involve the use of live animals?

No

#### R7) Does the project involve the use of animal tissue?

No

#### R8) Does the project involve accessing obscene materials?

No

#### R9) Does the project involve access to confidential business data (e.g. commercially sensitive data, trade secrets, minutes of internal meetings)?

No

R10) Does the project involve access to personal data (e.g. personnel or student records) not in the public domain?

No

R11) Does the project involve deviation from standard or routine clinical practice, outside of current guidelines?

No

R12) Will the project involve the potential for adverse impact on employment, social or financial standing?

No

R13) Will the project involve the potential for psychological distress, anxiety, humiliation or pain greater than that of normal life for the participant?

No

R15) Will the project involve research into illegal or criminal activity where there is a risk that the researcher will be placed in physical danger or in legal jeopardy?

No

R16) Will the project specifically recruit individuals who may be involved in illegal or criminal activity?

No

R17) Will the project involve engaging individuals who may be involved in terrorism, radicalisation, extremism or violent activity and other activity that falls within the Counter-Terrorism and Security Act (2015)?

No

*Applicant & research team*

T1) Principal Applicant Name

Cristina Delgado Torres

T2) Co-Applicant(s) at City T3)

External Co-Applicant(s)

**T4) Supervisor(s)**

Dr Fran Smith

## T5) Do any of the investigators have direct personal involvement in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest? No

**T6) Will any of the investigators receive any personal benefits or incentives, including payment above normal salary, from undertaking the research or from the results of the research above those normally associated with scholarly activity?**

No

## T7) List anyone else involved in the project.

### Project details

**P1) Project title**

Couples experience of anxiety in the first year of their parenting journey.

## P1.1) Short project title

Couples experience of anxiety in the first year of their parenting journey.

## P2) Provide a lay summary of the background and aims of the research, including the research questions (max 400 words).

Perinatal mental health has become a matter of public health priority in the UK (Seneviratne, Utterson, & Wilson, 2018). There is a high prevalence of perinatal mental health issues and 15% of mother's report experiencing postpartum anxiety (Dennis, Falah-Hassani, & Shiri, 2017). Clinical attention has been given to maternal postnatal depression even though evidence for maternal postpartum anxiety is more common (Fisher, Wynter, & Rowe, 2010; Dennis, et al., 2017; Howard, Molyneaux, Dennis, Rochat, Stein and Milgrom, 2014). A similar pattern occurs with paternal postnatal anxiety, where postnatal depression has been given more attention even though postnatal anxiety has been reported to be more prevalent (Leach, Poyser, Cooklin and Giallo, 2016 and Wynter, Rowe and Fisher, 2013).

There is a large body of evidence which states that maternal mental health is associated with a negative impact on children's physical and psychological development (Stein, Pearson, Goodman, Rapa, Rahman, McCallum, Howard, Pariante, 2014). Maternal mental health can affect the following areas: emotional difficulties and social development, behavioural difficulties, attachment, cognitive development, child physical growth and development, feeding, eating habits and attitudes (Stein, et al., 2014). There is also evidence that maternal anxiety in the postpartum period is associated with low parenting warmth, involvement, efficacy, satisfaction and high parenting hostility (Seymour, Giallo, Cooklin and Dunning, 2015).

There is also evidence of the impact of parental mental health on children. It has been found that paternal postnatal distress is associated with emotional and behavioural difficulties in children under 5 (Giallo, Cooklin, Wade, D'Esposito, & Nicholson, 2014). Moreover, there is evidence that partners influence the mental health of each other. When one partner is experiencing difficulties, the other partner tends to experience difficulties (Giallo, D'Esposito, Cooklin, Mensah, Lucas, Wade, and Nicholson, 2013 & Everingham, Heading, & Connor, 2006).

The transition to parenthood involves physical, psychological and socio-relational adjustments for both females and males (Vismara, Rolle, Agostini, Sechi, Fenaroli, Molgora, Neri, Prino, Odorisio, Trovato, Polizzi, Brustia, Lucarelli, Monti, Saita and Tambelli, 2016). It is a time where there is an increase in vulnerability and psychological distress (Epifanio, Genna, De Luca, Roccella, La Grutta,

2015). There is not much information about how couples experience the postnatal period, but the research available focuses on the individual experience rather than the experience of the couple when adapting to the normal demands of parenting.

The present research project thinks about the couple as the participant in order to understand their experience of postnatal anxiety. Therefore, the research question is how do couples experience of anxiety in the first year of their parenting journey.

## P4) Provide a summary and brief explanation of the research design, method, and data analysis.

Research design:

This project is framed as qualitative research. The idea will be to focus on how the couples' make meaning of their experience of anxiety during the first year of becoming parents and how broader social context affects those meanings to generate new understandings.

Method:

The data will be collected using semi-structured interviews using a secure online platform. The interview will be planned to accommodate the participants so they can have a reflective space. This means planning how we will meet and at a time where they can be interviewed without their child. The couples will be interviewed together. It is planned that the interview will last between 60 to 120 min and that the interview will be recorded. The questions will be informed by the interview schedule.

Recruitment will be via social media and parent-baby classes.

This research will use a purposive sample to recruit a minimum of 6 and a maximum of 12 couples. The number will vary depending on the identification of new themes. The final number of participants will be identified once themes have been exhausted or when the maximum number has been interviewed.

Data analysis: The interview will be analyzed using thematic analysis to identify, analyse and report patterns within the data (Braun & Clarke, 2006).

## P4.1) If relevant, please upload your research protocol.

**P5) What do you consider are the ethical issues associated with conducting this research and how do you propose to address them?**

Risk to participants and potential participants:

There is the possibility that the participants might be unaware of the distress revising their experience might cause and the possibility of finding difficulties talking about it in front of their partner. Participants will be adults of full mental capacity.

To mitigate potential distress, the participants will be carefully selected and given all the pertinent information before the interview. It is proposed to exclude any participants who are experiencing severe mental health difficulties (psychosis or depression), or where there is social services involvement, or whose child is experiencing health-related difficulties and where there are concerns about risk. To select the participants, during the screening phone call they will be asked if they are: (a) currently experiencing severe distress outside of their normal functioning, (b) if they feel they have recurrent thoughts about harming themselves or others, (c) if there are any social services involvement and (d) if there are any concerns around their child's health.

There are two reasons for this, the first is that this project is concerned with understanding the experience of anxiety that comes from the adaptation to parenthood that to some extent every person feels. In terms of clinical levels, this relates to low-moderate anxiety and how people can make sense of their experience when they don't meet the thresholds for ongoing support from services such as GP, Health visitors and/or mental health services. The second is that as per duty of care the researcher would not be able to provide an appropriate response for couples that need support around risk and safeguarding concerns.

Before the interview participants will be given verbal and written information about the study. They will be informed of the possibility of experiencing difficult emotions. They will be offered the chance to ask questions and informed of their right to withdraw their data before it is analysed. They will be told that the research may be published and that direct quotations may be used. They will be required to give their written consent.

This is likely to be a sensitive area of investigation due to the demands of the postnatal period. This has the potential to stir up uncomfortable emotions in the participants. This will be mitigated by allowing participants to stop or pause the interview if it becomes too distressing and by giving them the debrief information where they can find information about how to access further support.

Anonymity:

There is a danger that participants may be able to identify themselves in themes, and descriptive phrases to exemplify these themes, that are written once the study is completed and, in a very few of these instances, may experience some feelings of distress. To minimise this as far as possible, no identifying details will be used, and/or details may be altered to protect the participants' identity.

The researcher will have the services of a professional transcriber following City University Guidelines. To protect confidentiality al recordings will be voice only. To transfer data, we will use encrypted and password protected files. Once the transcriber has given the written transcription they will destroy the recordings. The transcriber will not use the data for any other purposed and will comply with GDPR.

Coercion:

A potential ethical concern may be that a couple feels obligated to participate in the study. However, the participant information sheet will give prospective participants full advice on what to expect from the study, and there will be no financial incentive to participate. If at any point, it is established between participant and researcher that the participant would benefit from alternative psychological interventions, and onward referral will be discussed.

Anonymised data (all electronic forms):

All data will be stored in the researcher's computer and cloud site (One drive), will be encrypted and password protected. Data will be retained for a minimum of 10 years.

Confidentiality of Data:

All personal data (signed consent forms) will be digitally stored and stored separately from anonymised data and partially anonymised data in an encrypted file according to City University of London requirements.

Safeguarding:

As we are talking to couples experiencing difficulties it might be necessary to consider any safeguarding concerns around their children. To mitigate this, safeguarding will be assessed during

the screening process and monitored during the interview. If any worries should arise, the researcher will follow City University of London guidelines. For this, the researcher will fill out the CP-A form and send it to the Designated Safeguarding Lead within 2 hours.

Right to withdrawal:

Participants will be informed that they can withdraw at any point but if the data has been submitted this will be kept confidentially.

## P6) Project start date

The start date will be the date of approval.

## P7) Anticipated project end date

31 Dec 2020

## P8) Where will the research take place?

The UK - The aim is for interviews to be carried out using a secure online platform.

## P10) Is this application or any part of this research project being submitted to another ethics committee, or has it previously been submitted to an ethics committee?

No

## *Human participants: information and participation*

*The options for the following question are one or more of:*
*'Under 18'; 'Adults at risk'; 'Individuals aged 16 and over potentially without the capacity to consent'; 'None of the above'.*

## H1) Will persons from any of the following groups be participating in the project?

None of the above

## H2) How many participants will be recruited?

24

## H3) Explain how the sample size has been determined.

The sample has been defined by theoretical saturation, where it has been found that a number between 6 and 12 participants will exhaust the themes (Braun and Clark, 2006). The final number will vary according to either not finding new themes or reaching the maximum number of participants (12 couples).

## H4) What is the age group of the participants? Lower Upper

18

## H5) Please specify inclusion and exclusion criteria.

Inclusion criteria:

Couples where one or both of the partners identify themselves as suffering from postnatal anxiety.

Couples that have a baby between 8 weeks and one year of age. This is to ensure that parents can have enough time to adapt to the change of roles and have a sense of their new routines and/or normality.

Couples that share caring responsibilities for their children and are currently living together.

Couples that have healthy children.

Couples that have had a biological baby in the past year. This is to take under consideration that a possible source of anxiety might be related to the biological changes to the mother's body.

Exclusion criteria:

Couples where one or both of the partner are experiencing severe mental health issues and there are risk concerns. There is the exclusion of severe mental health issues as the aim of the research is to explore the anxiety that comes from the adaptation to parenthood, therefore it is necessary to exclude any participants that might experience anxiety generated from other sources of concern.

Participants that are not at full mental health capacity.

Participants that have been referred to social services or have safeguarding concerns associated with their capacity as parents or where there are Domestic Violence concerns due to the possible strain the interview might cause on the couple and the impact on the child.

Couples that have children with health difficulties. Due to the possible strain the interview might cause on the couple.

## H6) What are the potential risks and burdens for research participants and how will you minimise them?

This is an area of investigation that might be difficult for participants due to the demands of the postnatal period. Participants might find allocating time for the interview difficult as they need to think about childcare arrangements, feeding and sleeping schedules which can exacerbate their anxiety. For this, it has been thought to offer the possibility of having the interviews using a secure online platform. It is expected that the participants can be interviewed without their baby, appointments will be offered after the baby's bedtime to suit their needs and allow for a reflective space.

Another difficulty will be the potential distress of talking about difficulties which might exacerbate their feelings of anxiety. This could also be the case when discussing difficulties in front of their partner. If any of the individuals show signs of unusual distress during an interview, the researcher will offer the possibility to pause and/or stop the interview. They will be reminded of their right to withdraw and the conditions. At the end of the interview, the participants will be debriefed verbally and in writing and signposted to support services.

## H7) Will you specifically recruit pregnant women, women in labour, or women who have had a recent stillbirth or miscarriage (within the last 12 months)?

No

## H8) Will you directly recruit any staff and/or students at City?

None of the above

## H8.1) If you intend to contact staff/students directly for recruitment purpose, please upload a letter of approval from the respective School(s)/Department(s).

**H9) How are participants to be identified, approached and recruited, and by whom?**

Participants will be recruited using social media using Instagram users and Facebook groups dedicated to providing support for parents in the postnatal period. This includes accounts that provide psychological support, baby classes information, information about parenting and other accounts relevant to couples in the postnatal period.

Approaches may also be made through organizations such as charities that provide activities for parents (Salvation Army, NCT) or practitioners that work with clients in the postnatal period (perinatal psychologist, sleep consultants, hypnobirthing practitioners, lactation consultants).

Anyone who responds will be sent the participant information sheet and a screening telephone call will be arranged.

## H10) Please upload your participant information sheets and consent form, or if they are online (e.g. on Qualtrics) paste the link below.

**H11) If appropriate, please upload a copy of the advertisement, including recruitment emails, flyers or letter.**

**H12) Describe the procedure that will be used when seeking and obtaining consent, including when consent will be obtained.**

Once a possible participant has approached the researcher, the researcher will email the participant the information sheet and a potential date for a screening phone call. The researcher will inform them in the email that the screening session should be done with both partners or that the researcher will call each partner to screen them individually. This will depend on their availability.

A screening phone call will then be arranged to assess their suitability according to the inclusion and exclusion criteria, and to ensure that they understand the information sheet, are willing to participate in the interview and so they can ask any questions about the research. The interview date will be agreed on this screening phone call allowing enough time for the participants to read the information to make an informed decision and arrange childcare.

At the interview, the researcher will confirm that both partners have the information sheet and they understand it, that there are no further questions and that they have the consent form and it is signed (digital signature as it is online interviewing). Each partner will have an individual consent form. The consent form needs to be emailed prior to the interview and the participants and researcher will have a signed copy each. There will be an opportunity to ask questions at any stage of the process.

## H13) Are there any pressures that may make it difficult for participants to refuse to take part in the project?

No

## H14) Is any part of the research being conducted with participants outside the UK?

No

## *Human participants: method*

*The options for the following question are one or more of:*
*'Invasive procedures (for example medical or surgical)'; 'Intrusive procedures (for example psychological or social)'; 'Potentially harmful procedures of any kind'; 'Drugs, placebos, or other substances administered to participants'; 'None of the above'.*

M1) Will any of the following methods be involved in the project:

None of the above

M2) Does the project involve any deceptive research practices?

No

M3) Is there a possibility for over-research of participants?

No

M4) Please upload copies of any questionnaires, topic guides for interviews or focus groups, or equivalent research materials.

**M5) Will participants be provided with the findings or outcomes of the project?**

No

M6) If the research is intended to benefit the participants, third parties or the local community, please give details.

The research aims to provide health care professionals with information about how to best support parents in the transition to parenthood. There is little evidence on how couples experience anxiety and what are the relevant themes that cause worries during the postnatal period. Having more information about postnatal anxiety can inform best practices, training around mental health and perinatal support services delivery.

There might be further benefits for the couples to gain insight around their dynamics, way to support each other and further increase a sense of connection between them. This can come from the reflective space that the interview aims to foster. Talking about their experience in a safe and non- judgmental space might be beneficial in itself.

M7) Are you offering any incentives for participating?

No

M8) Does the research involve clinical trial or clinical intervention testing that does not require Health Research Authority or MHRA approval?

No

M9) Will the project involve the collection of human tissue or other biological samples that does not fall under the Human Tissue Act (2004) that does not require Health Research Authority Research Ethics Service approval?

No

M10) Will the project involve potentially sensitive topics, such as participants' sexual behaviour, their legal or political behaviour, their experience of violence?

No

M11) Will the project involve activities that may lead to 'labelling' either by the researcher (e.g. categorisation) or by the participant (e.g. 'I'm stupid', 'I'm not normal')?

No

*Data*

D1) Indicate which of the following you will be using to collect your data.

Interviews
Audio/digital recording interviewees or events

D2) How will the the privacy of the participants be protected?

De-identified samples or data

D3) Will the research involve use of direct quotes?

Yes

D5) Where/how do you intend to store your data?

Password protected computer files
Storage on encrypted device (e.g. laptop, hard drive, USB

D6) Will personal data collected be shared with other organisations?

No

D7) Will the data be accessed by people other than the named researcher, supervisors or examiners?

Yes

D7.1) Explain by whom and for what purposes.

By a professional transcriber. They will have signed the confidentiality agreement and they will only be provided with voice recordings.

D8) Is the data intended or required (e.g. by funding body) to be published for reuse or to be shared as part of longitudinal research or a different/wider research project now or in the future?

No

D10) How long are you intending to keep the research data generated by the study?

From the information sheet: City will keep identifiable information about you from this study for 10 years after the study has finished.

D11) How long will personal data be stored or accessed after the study has ended?

10 years after is collected as per City Policy.

D12) How are you intending to destroy the personal data after this period?

Electronic data permanently deleted.

*Health & safety*

HS1) Are there any health and safety risks to the researchers over and above that of their normal working life?

No

HS3) Are there hazards associated with undertaking this project where a formal risk assessment would be required?

No

---

## Attached files

TRANSCRIBER CONFIDENTIALITY AGREEMENT .docx

Debrief

Template Jan

2017.docx

CONSENT

FORM.docx

Infor

matio

n

sheet.

docx

Flyer.

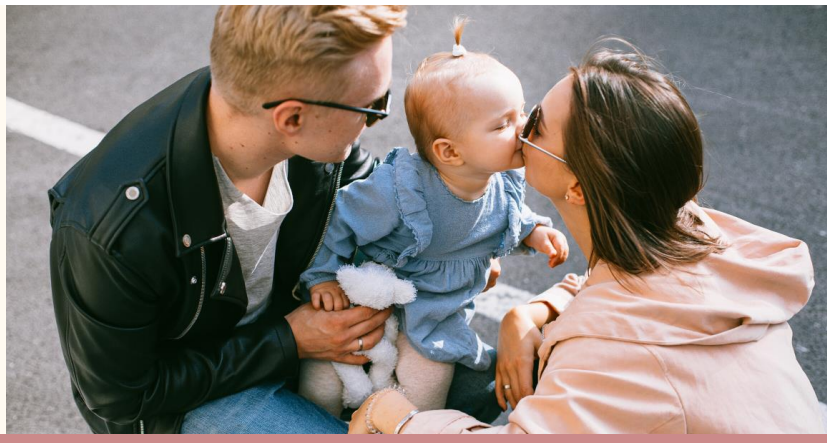
pdf

Semi structured interview.docx

Appendix C: Flyer

CITY
UNIVERSITY OF LONDON
EST 1894

Department of
Counselling Psychology



# COUPLES EXPERIENCE OF ANXIETY IN THE FIRST YEAR OF THEIR PARENTING JOURNEY.

*We are looking for couples to take part in an interview to discuss:*

## ANXIETY AFTER HAVING A BABY

I am approaching couples where one or both partners experience postnatal anxiety. I am approaching couples that have babies between 8 weeks and one year of age. I am seeking to speak to couples that share caring responsibilities for their children and are currently living together.

Couples will be interviewed together by the researcher and you will be asked about your worries and how you manage them, how do they affect you as a couple and as parents. We will be using a secure online platform and arrange a time depending on what is easier for you and fits your childcare arrangements. The interview will last around 60 to 120 min.

For more information about this study, or to volunteer for this study, please contact:

Cristina Delgado Torres

Dr Fran Smith
Research Supervisor

This study has been reviewed by, and received ethics clearance through the City University of London.

If you would like to complain about any aspect of the study, please contact the Secretary to the Senate Research Ethics Committee on 020 7040 3040 or via email: Anna.Ramberg.1@city.ac.uk

City, University of London is the data controller for the personal data collected for this research project. If you have any data protection concerns about this research project, please contact City's Information Compliance Team at dataprotection@city.ac.ukt

Appendix D

**PARTICIPANT INFORMATION SHEET**

**Couples experience of anxiety in the first year of their parenting journey**.

Name of principal researcher: Cristina Delgado

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. You will be given a copy of this information sheet to keep.

### What is the purpose of the study?

I am exploring how couples experience anxiety that arises in the first year of their parenting journey. I want to know about your worries and what it is like for you to experience anxiety at this time. I hope that these results will provide guidance to healthcare professionals working with couples during their transition to becoming parents. I'm a trainee counselling psychologist, conducting this research as part of my professional doctorate in counselling psychology at City University, London.

### Why have I been invited to take part?

I am approaching couples where one or both experience postnatal anxiety or worries around this new journey as a parent. I am approaching couples that have babies between 8 weeks and one year of age. I am seeking to speak to couples that share caring responsibilities for their children and are currently living together. My aim is to recruit up to 12 couples. You are receiving this sheet as you are eligible to participate and I am hoping that you decide to partake in my study.

### Do I have to take part?

Participation in the project is voluntary, and you can choose not to participate. It is up to you to decide whether or not to take part. If you do decide to take part, you will be asked to sign a consent form. If you decide to take part, you are still free to withdraw your interview from the study without giving a reason; the only condition is that it has to be done before I've started analysing the transcript.

### What will happen if I take part?

I will interview you as a couple asking you about your worries during this time and what you do individually and as a couple to manage these worries, how it affects you as a couple and your parenting. We will be using a secure online platform and arrange a time depending on what is easier for you and fits your childcare arrangements. The interview will last around 60 to 120 min. If it easier for you and your partner, we could allocate an

online interview after bedtime to ensure that you have enough privacy and you can both be as free as you can.

This time will be a safe space, where you can discuss freely whatever is on your mind in a non-judgemental space. If you find it difficult to answer any question you don't have to answer and we can move on. You can pause the interview if you need to.

I will be recording the interview so it can be transcribed later using a professional transcriber. Your information will be anonymised and your details will be kept confidential. I am the only person that will know your identity and I will not share it. To protect confidentiality al recordings will be voice only. To transfer data to the transcriber, I will use encrypted and password protected files. Once the transcriber has has given the written transcription they will destroy the recordings. The transcriber will not use the data for any other purposed and will comply with GDPR. Any details, such as names or places, will be deleted or changed before it is written up for possible publication. Computer voice files and transcriptions will be password protected, encrypted and deleted once my research project has been marked and/or published.

In case of an emergency or in case I am worried about you or your baby I will talk to you about it. It might mean that I have to pass on some of your details to my university contact so they can talk to you about what is happening and what might be appropriate agencies to contact. I will always talk to you about this first. I also have a list of possible services that you could contact if you feel you need extra support.

**What are the possible disadvantages and risks of taking part?**

Talking about your worries might elicit some strong emotions but this is not the aim of the study. Perhaps talking with your partner might feel like a new and challenging experience. I am a BACP counsellor and I have experience working with parents; no topic is out of line and my hope is that you feel comfortable sharing your concerns. If you find it difficult we can pause or stop.

**What are the possible benefits of taking part?**

Having a confidential and safe space where you can talk about your worries can help you get a sense of perspective. Sharing your views with your partner can bring you closer together as you share concerns and also ways that you manage them. You can share your needs in a space where you can listen to each other and think about your role as parents and as a couple. Identifying your coping strategies can give you a sense of achievement and fulfilment as you think about strategies that you develop and use in your daily life.

Your experience can help health care professionals develop programs to best support parents in this period. Your contribution can give us information on how parents cope with their difficulties and how they shape their support around them.

**Expenses**

You won't have any expenses. We can meet using a free service on the internet or I will come to you.

**How is the project being funded?**

This project is personally funded.

**Conflicts of interests**

There is no conflict of interest.

**What should I do if I want to take part?**

If you want to participate in the study, please send an email to

**Data privacy statement**

City, University of London is the sponsor and the data controller of this study based in the United Kingdom. This means that we are responsible for looking after your information and using it properly. The legal basis under which your data will be processed is City's public task.

Your right to access, change or move your information are limited, as we need to manage your information in a specific way in order for the research to be reliable and accurate. To safeguard your rights, we will use the minimum personal-identifiable information possible (for further information please see https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/public-task/).

City will use your name and contact details to contact you about the research study as necessary. The only people at City who will have access to your identifiable information will be the Counselling Psychology Department. City will keep identifiable information about you from this study for 10 years after the study has finished.

You can find out more about how City handles data by visiting https://www.city.ac.uk/about/governance/legal. If you are concerned about how we have processed your personal data, you can contact the Information Commissioner's Office (IOC) https://ico.org.uk/.

**What will happen to the results?**

The interview will be used in a thesis for the Professional Doctorate in Counselling Psychology and this includes a publishing section. This might be submitted for publication at a later date in journals relevant to the psychology discipline. All the information will be anonymized to prevent anyone from identifying the couples that have been interviewed. I will use direct quotations in some instances but no one will know these came from you.

**Who has reviewed the study?**

This study has been approved by City, University of London Research Ethics Committee.

**What if there is a problem?**

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through City's complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to the Senate Research Ethics Committee and inform them that the name of the project is [name of project]
You can also write to the Secretary at:

[redacted]
Research Integrity Manager
City, University of London, Northampton Square
London, EC1V 0HB
Email:

**Insurance**

City holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

**Further information and contact details**

Cristina Delgado Torres
Counselling Psychologist Trainee

Fran Smith
Research Supervisor

**Thank you for taking the time to read this information sheet.**

Appendix E

**INFORMED CONSENT**

**Name of principal researcher: Cristina Delgado Torres**

**Title of study: Couples experience of anxiety in the first year of their parenting journey.**

If you are happy to take part in this study, please tick the boxes and provide your signature below.

| | | |
|---|---|---|
| 1 | I confirm that I have read and understood the participant information dated April 2020 for the above study. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily. | |
| 2. | I understand that my participation is voluntary and that I am free to withdraw without giving a reason without being penalised or disadvantaged. | |
| 3. | I understand that I will be able to withdraw my data up until the time it is analysed | |
| 4. | I agree that it's OK for my interview to be recorded. I agree that it's OK for a professional transcriber to transcribe my anonymised interview and for direct quotation(s) from my interview to appear anonymously in the final report | |
| 5. | I agree to City recording and processing this information about me. I understand that this information will be used only for the purpose(s) explained in the participant information and my consent is conditional on City complying with its duties and obligations under the General Data Protection Regulation (GDPR). | |
| 6. | I agree that my data may be kept for up to 10 years but that, after that, the data will be destroyed. I am over 18. | |
| 7. | I agree to take part in the above study. | |

| | | |
|---|---|---|
| _____ | _____ | _____ |
| Name of Participant | Signature | Date |
| _____ | _____ | _____ |
| Name of Participant | Signature | Date |
| _____ | _____ | _____ |
| Name of Researcher | Signature | Date |

When completed, 1 copy for the participant; 1 copy for researcher file.

**Explicit consent for the following should be obtained where applicable:**

- Reuse of data and an explanation of what the data will be used for, as well as reassurance that the data will only be reused in studies which have been given ethics approval.
- The use of direct quotes.
- Sharing data outside the research team (e.g. with collaborators).
- A statement that asks the participant to confirm that they understand that their anonymous data will be made open access, e.g. to underpin journal publication or to meet funding requirements.

Appendix F

**DEBRIEF INFORMATION**

Thank you for taking part in this study. Now that it's finished we'd like to tell you a bit more about it.

I am exploring how couples cope with the anxieties that arise in the first year of their parenting journey. I hope that these results provide guidance to healthcare professionals working with couples during their transition to becoming parents.

If our conversation or the group has made you worry or raised any concerns, please contact me so we can discuss this. If you feel you need further help please contact your GP or local IAPT service. You can also contact the following organisations:

**PANDAS**

The PANDAS Foundation is here to help support and advise any parent who is experiencing a perinatal mental illness. We are also here to inform and guide family members, carers, friends and employers as to how they can support someone who is suffering.

Helpline open from 9am-8pm every day – 0843 2898 401

Email support available – **info@pandasfoundation.org.uk**

**Samaritans**

Provides confidential, non-judgmental emotional support for people experiencing feelings of distress or despair, including those that could lead to suicide.

Tel: 116 123 (this is a free telephone number and will not appear on the phone bill)

Web: **www.samaritans.org**

Email: **jo@samaritans.org**

**Relate**

We're the UK's largest provider of relationship support, and last year we helped over two million people of all ages, backgrounds, sexual orientations and gender identities to strengthen their relationships. If you want to talk to someone about your relationship and get some support, there are different ways that you can contact us to arrange counselling.

If you want to phone us with a general enquiry or book an appointment, please find your nearest Relate and give them a call. https://www.relate.org.uk/relationship-help/talk-someone

I hope you found the study interesting. If you have any other questions, please do not hesitate to contact us at the following:

**Further information and contact details**

Cristina Delgado Torres
Counselling Psychologist Trainee

Fran Smith
Research Supervisor

Appendix G

## 15-Point Checklist of Criteria for Good Thematic Analysis Process (Braun and Clarke, 2006)

| | | |
|---|---|---|
| Transcription | 1. | The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'. |
| Coding | 2. | Each data item has been given equal attention in the coding process. |
| | 3. | Themes have not been generated from a few vivid examples (an anecdotal approach) but, instead, the coding process has been thorough, inclusive and comprehensive. |
| | 4. | All relevant extracts for all each theme have been collated. |
| | 5. | Themes have been checked against each other and back to the original data set. |
| | 6. | Themes are internally coherent, consistent, and distinctive. |
| Analysis | 7. | Data have been analysed rather than just paraphrased or described. |
| | 8. | Analysis and data match each other – the extracts illustrate the analytic claims. |
| | 9. | Analysis tells a convincing and well-organised story about the data and topic. |
| | 10. | A good balance between analytic narrative and illustrative extracts is provided. |
| Overall | 11. | Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly. |
| Written report | 12. | The assumptions about ThA are clearly explicated. |
| | 13. | There is a good fit between what you claim you do, and what you show you have done – ie, described method and reported analysis are consistent. |
| | 14. | The language and concepts used in the report are consistent with the epistemological position of the analysis. |
| | 15. | The researcher is positioned as *active* in the research process; themes do not just 'emerge'. |

(Braun and Clark, 2006, p37)

**Appendix H: Reflective Journal**

Interview 1

I am feeling both excited and exhausted after my first interview. It is exciting the prospect of having done my first interview, but it has been overwhelming to get to this stage. I keep replaying my questions to see to make sure I have done my researcher role appropriately. I am also noticing many things that I can improve, but to a certain degree, I feel even if it was the best interview ever done, I would still find mistakes. I felt that it would have been harder to include both partners in the discussion, but I was proven wrong.

I didn't think they would openly discuss not wanting other babies or not loving their baby. I would have thought this would elicit negative feelings or reactions in me. Instead, I found myself liking them both more. I found that the initial conversation before the recording made us feel at ease, and perhaps this allow them to feel more comfortable in sharing and for me to like them. It also made me think about my own experience of anxiety after having my first baby, I also struggled to love him, "it didn't come naturally", I also had to work hard to fall in love with him. Perhaps this connection made me feel at ease and for them to feel safe to share. Another thing that stuck with me was they felt "robbed", the anxiety had taken something away from their parenting experience when they expected a "fairy tale".

I felt very grateful towards them, how open they were and how they were comfortable to discuss their relationship with me. I reflected about the power of these interviews. Having done the pilot and this interview, I have found that the partners allow themselves to complement each other and show how grateful they are for each other. Both couples said the experience had made them stronger, and it made me think that perhaps also

more communicative for each other. It made me think about my own experience and how I also felt my relationship had become stronger. I wonder if this would be the case with all couples.

Analysis:

Coding the material is complicated from a couple's perspective. I have found myself wondering how to capture the relationship and how does this relates to the anxiety. I have found that participants used "I" and "we", which made me think that codes can be thought about individual perspectives and couple's perspectives. At times, the couples seem to be figuring or experiencing things together, and at times, the experience it differently and take on roles that support and complement each other. This is interesting but also difficult, I am concerned about capturing the richness of the relationship in codes and themes.

I had time to search for other research projects and understand how they capture the richness. Finding the idea that a join reflection captures the couple’s shared meaning gave an understanding on how to interpret the data. It also made me realise that in the interviews, the couples didn't disagree with each other, which for me reinforces the idea that there is a shared experience worth analysing.

I also found it interesting how many coping strategies they used and how fast they change them. It made me think about a sense of desperation and hoping to "get rid" of this feeling or to "make it better". It confirmed the importance of the postnatal period on mental health for everyone in the family at a short and long term.