# Connections lost and sought: An Interpretative Phenomenological Analysis study of women's experiences of perinatal anxiety within the Covid-19 pandemic

Portfolio submitted in fulfilment of DPsych Counselling Psychology, Department of Psychology, City University, London.

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This research process has at times, been isolating; however, I have been truly blessed to have many supportive people walk this long journey with me. I appreciate each of you.

I would not have been able to complete this research study without the eleven women who kindly, generously, and honestly shared their experiences with me. I am so grateful to each of you. Thank you.

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Thank you, Mark, and Ben, you have 'supported' me in multiple ways. I know that it has not been easy, and I am grateful for your consistent support.

To my sisters Marie and Daphne, and my brother-in law, Yelland, for your messages of encouragement, for the telephone calls, for your love and endless supply of uplifting emojis. Thank you.

To my friends, if I still have you, I promise endless coffee and talks that are not cut short.

## Dedication

I have experienced the bittersweet irony of *connections lost and sought.* In the liminal space between my engagement with this research process, and the final production of this work, I sometimes felt that I *lost connection* to my son. Juggling work, study, and family commitments has at times, been a challenge.

Ben, you have shown extraordinary patience, love, and grace towards me over these years while I pursued my studies. Thank you. While I have been studying, you too have navigated your GCSE's, A levels and now you begin your own university journey.
I am so proud of you, and I love you immeasurably.

## Declaration of Powers of Discretion

I hereby declare that the work presented in this portfolio is entirely my own, under the supervision of Dr Julianna Challenor.

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# PREFACE

## Personal Reflections

I sit here, with a bittersweet feeling. This portfolio represents three years of a Counselling Psychology Doctorate, hundreds of clinical hours on placement and many hours at my desk. It is almost at an end. I am a 'second-career' trainee and as I reflect on my years of study, I am conscious of what I have lost and gained in my endeavours. At times, I felt that I had lost precious time with my son, who was a 'young thing' when I embarked on my Masters degree prior to this doctorate. Over the years, I have sat beside many a sports pitch with my books, trying to balance 'being a good mum' with an academic deadline. While I have always strived to be a 'present' mother, I am aware of the times when I have said: "I can't do that right now". These experiences tug at my 'mum guilt' because now, my son is a young man, starting his own university experience. I write this, not with self-pity, but with the candour of sharing my experience of 'loss' in undertaking this adventure. 'Loss' is the thread that runs throughout my portfolio, and it has most certainly not evaded me.

I have gained so much in this endeavour too. Self-pride, for getting this far, at my age! A sense of inner peace, and I have gained a career in an NHS perinatal mental health service; in a team I could only have wished for. I am soon to be a Counselling Psychologist and that makes me proud. I have gained knowledge and insight which I carry forward into my new role. As I reflect on my previous career as a Child and Adolescent Counsellor, and my recent three years on placement, I am aware of how important my clinical knowledge, skills and continued training will be. Yet one thing is sure to me, and that is our universal need for 'someone' who will listen, support, be compassionate, advocate, and understand. I once worked with child who refused to speak. We used the sand tray and the arts each week, and at the end of the session, he used a ball to spell things out to me on a painted alphabet on the wall. Months into our sessions he spelled: SOMEONE.

**Overview of Portfolio**

In the following three sections I shall provide an overview of what the reader can expect to find in this portfolio. Part I: Doctoral Research is a piece of original research which explores women's experiences of perinatal anxiety in the pandemic. Part II: Publishable Journal Article is a research article written for planned submission to a journal on perinatal mental health. Part III: Client Study and Process Report was undertaken as part of my clinical training.

**Part I: Doctoral Research**

I present original qualitative research into the experiences of perinatal anxiety experienced by women in the Covid-19 pandemic. While anxiety is frequently comorbid with postnatal depression, it can be experienced in isolation, affecting approximately 21% of perinatal women (Fairbrother et al., 2019). The conflation of depression with anxiety has potentially shaped our understanding of perinatal anxiety, thereby impacting the provision of care to women with anxiety in the perinatal period. This narrowed understanding reflects a gap in the literature and in our full appreciation of perinatal anxiety. I was curious about how perinatal anxiety is understood in clinical practice and in experience. I wondered whether perinatal anxiety is experienced as a specific state anxiety, with features particular to the context, or whether it could be understood as a trait anxiety, typically experienced by those with a pre-existing history of anxiety. My curiosity stemmed from the literature and from clinical practice, noticing that anxiety in the perinatal timeframe is often overlooked or dismissed as less significant than postnatal depression. Both experiences are significant and my objective in carrying out this research is to contribute understanding to the body of knowledge on this anxiety in the perinatal period, and to inform clinical practice.

I have employed Interpretative Phenomenological Analysis (IPA) as my means of inquiry and analysis. My research design differs slightly from most other IPA cross-case designs, in that I have explored the single phenomenon of perinatal anxiety, within two separate, but homogenous subgroups: those with a history of anxiety, and those without a history of anxiety. While I retained an idiographic focus on each case as the unit of study, I was inspired in my research endeavour by Larkin et al., (2018) to consider a design which could potentially capture the multiple perspectives of these two subgroups: women who experienced perinatal anxiety, with differing histories of anxiety, all contextualised to the Covid-19 pandemic. I sought advice from Professor Smith about comparing two independently homogenous groups; he confirmed that this would acceptable and in keeping with developments in IPA research[1]. Smith (2017) draws attention to the evolving dynamic of IPA design and execution; indeed, he *encourages* adaptation, within the boundaries of its philosophical underpinnings. This design was challenging to manage; I had a large data set, which resulted in four Group Experiential Themes per group. I was mindful to keep a focused adherence to my research question which is: *Exploring the lived experience of perinatal anxiety in first-time mothers in the context of the Covid-19 pandemic*.

The findings in this study suggest that within and across the two groups, participants converged on two themes which exacerbated or induced their anxiety: '*loss of connection to others'* and '*being under-resourced*'. Participants with a history of anxiety responded to the threat of Covid-19 and the consequential loss of connection to supportive others differently from participants without a history of anxiety. 'Loss of connection' is a theme on which all participants converged, albeit the significance diverged between the groups.

[1] Exemplars include Rosthill-Brookes et al., 2011; Smith & Shaw, 2016 and Larkin et.al., 2018.

**Part II: Publishable Journal Article**

I intend to submit my article to The Journal of Prenatal and Perinatal Psychology and Health. The journal publishes research and clinical articles on prenatal and perinatal psychology and health. I read an article by Kate Babetin (2020), published in the journal, on a mother's psychology in the transition to motherhood, which not only resonated with my topic but also introduced me to the journal. I appreciate the structure and more descriptive approach welcomed by this journal, which lends itself to qualitative research.

I distilled my research findings for this article, and I focused on the final cross-group experiential theme in the discussion. Findings reflected that a 'Loss of connection' to others in the pandemic exposed a deficit of coping resources in all participants. The significance of this 'loss of connection' differed between the groups, thereby highlighting a difference in experiences of anxiety between mothers with a pre-existing history of anxiety and those without. While several recent studies have identified that women struggled with isolation (Chivers et al., 2020; Chen, 2021), none probed the significance of women's experiences further. I suggest that a cross-group multiperspectival design, and a phenomenological inquiry, obtained from the use of IPA, has enabled me to achieve this deeper level of understanding into how perinatal anxiety may differ between women with and without a history of anxiety. I present this novel finding in the article, which I hope to be published.

**Part III: Clinical Practice - Client Study and Process Report**

I present a clinical case study and process report which was undertaken as part of my counselling psychology training. Within the client study I have considered key themes that emerged in the context of our work together, which was informed by a relational psychoanalytic framework, incorporating object-relations theory, and a contemporary approach to attachment theory, to make sense of Sophie's (pseudonym) complex trauma, chronic pain, relational processes, and protective dissociative defence. Transference and

countertransferential experiences provided conditions for dynamic shifts in the relationship. I gained tacit insight into intersubjectivity through my countertransference with Sophie. The overarching theme of ‘relationships’ was apparent in Sophie’s narrative; early attachment figures had failed her and traumatised her; despite this, Sophie loved her father and mourned their loss of relationship. The approach enabled me, and in turn Sophie, to appreciate her ‘both-and’ struggle.

These three pieces of work all share a common thread of loss; from loss of contact to others in the pandemic, to loss of relationship with an abusive father, who is still mourned and loved. As I step into my career, I shall retain the appreciation that in life, we all need a ‘someone’.

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# PART I: DOCTORAL RESEARCH STUDY

### Thesis Title

Connections lost and sought: An Interpretative Phenomenological Analysis study of the women's experiences of perinatal anxiety within the Covid-19 pandemic

## Abstract

The perinatal period, which spans from pregnancy to one year after childbirth, is a time in which a significant number of women experience mood and anxiety-related difficulties. Despite anxiety affecting approximately 21% of perinatal women, research has emphasised examining perinatal depression, with a limited focus on anxiety. Perinatal mental health disorders are a public health concern due to deleterious effects on maternal and child outcomes and social and economic impact, if left untreated. This qualitative study explores experiences of perinatal anxiety within the Covid-19 pandemic, in women with a pre-exiting history of anxiety and those without a pre-existing history of anxiety. An Interpretative Phenomenological Analysis approach was employed, incorporating a multiperspectival cross-group design to gain insight into the lived experience of the single phenomenon of perinatal anxiety, across two subgroups. Semi-structured interviews were carried out online during the pandemic, with eleven female participants, all of whom were first-time mothers and had experienced anxiety in the perinatal timeframe. Transcribed interviews were analysed using IPA protocol and updated terminology was incorporated (Smith, Flowers & Larkin, 2022). Four Group Experiential Themes emerged within each group and two Group Experiential Themes emerged from cross-group analysis: 'Loss of connection' and 'Being under-resourced'. Loss of connection to others revealed a deficit of coping resources in each group, which differed in significance between the groups and elucidated differences in perinatal anxiety between women with and without a pre-existing history of anxiety. These findings are discussed in relation to theories of emotion regulation and matrescene. Implications for counselling psychology are considered.

**Key words:** *anxiety, perinatal, perinatal anxiety, motherhood, pregnancy, Interpretative Phenomenological Analysis, IPA, multiperspectival*

# CHAPTER 1: LITERATURE REVIEW

"How we need another soul to cling to."

**Sylvia Plath, The Unabridged Journals of Sylvia Plath**

## Situating this study, and all involved, to the Covid-19 pandemic

Many women experience temporary feelings of anxiety and worry during pregnancy and the transition to motherhood; some women struggle with prolonged anxiety and worries that can blight their daily lives. During the perinatal period, women typically reach out to family, friends, and services, to share experiences, and to seek guidance, information, and validation. The proverb 'It takes a village to raise a child' comes to mind; not only to raise a child, but also, to support the mother in her transition to motherhood.

Towards the close of 2019, the world was engulfed by a coronavirus, known as Covid-19. The unprecedented threat of the virus resulted in a global lockdown in early 2020, in which people were subject to complete or partial isolation. Within the United Kingdom 'village', we were mandated to follow strict measures designed to protect people. If ever we needed a 'soul to cling to', or to 'be the soul to cling to', it was during the pandemic; however, pandemic-enforced measures separated families and friends from each other. These measures impacted the way hospitals and maternity services provided care to women; the provision of maternity support was limited, and women were cut off from their partners' support during hospital appointments and labour (Birthrights.org).

The pandemic created a unique context in which researcher and participants were simultaneously situated, and in which participants were temporally situated to the perinatal period, while experiencing anxiety in various guises.

**Aims and rationale for study**

My objective in this qualitative research study is to explore the lived experience of perinatal anxiety in first-time mothers in the context of the Covid-19 pandemic. In keeping with this objective, I embraced the use of Interpretative Phenomenological Analysis (IPA) as my means of inquiry and analysis. My research design differs slightly from typical IPA cross-case designs, in that I have explored the single phenomenon of perinatal anxiety, within two separate, but homogenous subgroups: those with a history of anxiety, and those without a history of anxiety. While I retained an idiographic focus on each case as the unit of study, I was inspired in my research endeavour by Larkin et al., (2018) to consider a design which could potentially capture the multiple perspectives of these two subgroups: women who experienced perinatal anxiety, with differing histories of anxiety, all contextualised to the Covid-19 pandemic. I suggest that this cross-group design has facilitated the emergence of rich findings, which provide insight into how perinatal anxiety might differ between individuals with, and without, a history of anxiety. Participants shared a temporal perinatal time frame, a shared external threat from the Coronavirus, were similarly mandated to isolate and at times, endured hospital-enforced Covid-19 measures without the support of their partners.

*What is the purpose of understanding this phenomenon?* Anxiety disorders are typically diagnosed according to their nosological classification, however, anxiety symptoms in the perinatal period reveal characteristics that do not comply with diagnostic descriptions as experienced in non-perinatal populations, thereby raising the question whether this a phenomenon distinct to the perinatal period and unique in its nature, or a derivation of a generalised anxiety, similarly experienced in the general population. Previous studies (Highet at al.,2014; Brockington et al., 2006) evidence a mother-infant focus of perinatal anxiety, which differs from more generalised anxiety, even in populations with pre-existing anxiety disorders. Therefore, the importance of understanding perinatal anxiety is to enhance our knowledge of the phenomenon, to enable Counselling Psychologists and others, to effectively identify and support women for whom this is a source of distress.

**Overview of literature review**

In this chapter, I present my review of extant literature pertaining to perinatal anxiety in two parts: the first part highlights two main debates around the topic; this is followed by an overview of recent Covid-19-related literature, which reflects the impact of the pandemic on participants' experiences and reflects the dynamic nature of these experiences, which occurred parallel to the pandemic. This sequential presentation of the literature reflects my temporal engagement with the literature and with the research process; I initially conducted a brief review of extant literature to gauge the discourse around my topic of interest, to consider current thinking and the potential for conducting my proposed study. I then set this aside and conducted my qualitative study, situated around my research question; I analysed the data by means of Interpretative Phenomenological Analysis (IPA). The wonder of qualitative inquiry and indeed, the phenomenological and hermeneutic aspects of IPA, lent themselves to the emergence of themes in my study; consequently, I returned to the literature for further reflection on these rich findings. I present my engagement with the literature here.

**Search Strategy**

Digital databases were searched using PsychInfo, WebofScience, PubMed and Scopus. I screened authors' references for additional articles. Using Boolean language, search terms included 'Perinatal anxiety' AND 'Maternal anxiety' AND 'Postnatal anxiety' AND 'Postpartum anxiety' AND 'Pregnancy anxiety". Articles were largely considered from 2010 to 2022, and I also considered earlier seminal papers. The combined search, with refinements, yielded 149 papers. Abstracts were scanned, resulting in 32 papers retained, which spoke most to the research topic. I returned to the literature post analysis, for new research published on the impact of Covid-19 on perinatal experiences, as this is a dynamic topic which has resulted in a spate of recent publication.

## Introduction to Part 1: Considering two debates in the literature

The perinatal period, which spans from pregnancy to one year after childbirth, is a time in which a significant number of women experience mood and anxiety-related difficulties (Fairbrother et al., 2019). Postnatal depression is typically associated with this period, possibly due to widespread awareness and established understanding. While anxiety is frequently comorbid with depression, it can be experienced in isolation but is less acknowledged; it affects approximately 21% of perinatal women (Fawcett et al., 2019; Fairbrother et al., 2019).

Anxiety, defined in the DSM 5 as '*an emotion characterised by feelings of tension, worried thoughts and physical changes, such as increased blood pressure'* (American Psychiatric Association, 2013) is conceptualised in various ways in the literature, from broad diagnostically sub-threshold symptoms to the five core anxiety disorders[2] (Ayers et al., 2015). Individuals experiencing anxiety are beset by affective, cognitive, and somatic symptoms, with some experiencing transient symptoms (state anxiety), while others experience enduring states of anxiety across situations (trait anxiety), affecting their mood, functioning, relationships, and wellbeing (Bayrampour et al., 2016; Dennis et al., 2017).

Research to date reflects clinical practice, with a disproportionate emphasis on examining perinatal depression, and limited focus on anxiety (Fawcett et al., 2019). Perinatal mental health disorders are a public health concern due to deleterious effects on maternal and child outcomes and social and economic impact, if left untreated (Dennis et al., 2017; Sinesi et al., 2019). In their recent systematic review Dennis and colleagues (2017) found that the prevalence rate for self-reported anxiety symptoms across the three trimesters in pregnancy was 22.9%, while prevalence for disorders based on DSM-5 diagnostic criteria was 15.2% (Dennis et al., 2017; Sinesi et al., 2019). Tracing the history of this topic in the research,

[2] The five core anxiety disorders are panic disorder, generalised anxiety disorder, social anxiety disorder, specific phobia and agoraphobia, as well as obsessive compulsive disorder and post-traumatic stress disorder (Fairbrother, 2019).

extant literature depicts a correlation between anxiety and depression; typically, antenatal anxiety is predictive of postpartum depression (Beck., 1998; Heron et al., 2004). While research has historically been weighted towards investigating postnatal depression, recent evidence suggests that the more specific experience of 'perinatal anxiety' is more prevalent than the typically conflated anxiety-and-depression, potentially constituting a distinct concept, which requires further examination (Huizink et al., 2004; Brunton et al., 2015; Bayrampour et al., 2016; Folliard et al., 2020).

Reviewing research pertaining to perinatal anxiety, I noted two overarching debates in extant literature which are reflected in clinical practice: a) whether perinatal anxiety could be a discrete entity, specific to the perinatal period and uniquely different in its aetiology and clinical presentation from 'typical' generalised anxiety, experienced by the non-perinatal population and b) whether it is a new-onset, transient state, unique to the perinatal period, or an enduring trait, arising from pre-existing anxiety, that 'transitions' into the perinatal period.

The Covid-19 pandemic introduced a new dimension to our shared world, in which researcher and participants were exposed to the same external phenomenon. I suggest that Covid-19 created a unique context of external threat, to which participants, with and without a history of anxiety, responded, and in so doing, brought the debates into sharp focus.

My objective in this study is not to hypothesise on state versus trait anxiety in the perinatal period; my aim is to explore women's lived experiences of anxiety in this period, and to make sense of how perinatal women made meaning of their anxiety experiences.

**Debate 1: Considering whether perinatal anxiety could be understood as a distinct disorder or whether it is located within the spectrum of generalised anxiety.**

Women are twice as likely as men to develop an anxiety disorder in their lifetime (Furtado et al., 2018); in line with this prevalence, many women experience some anxiety and worry during pregnancy about their health, the health of their unborn baby, labour and childbirth, and their ability to cope with motherhood. High levels of anxiety can have detrimental effects on the maternal dyad and long-lasting consequences for the child; in particular, *pregnancy-specific* anxiety is associated with the most deleterious consequences (Huizink et al., 2014).

A commonly held assumption exists that generalised anxiety, commonly experienced in the wider population, and pregnancy-specific anxiety, are correlated; that is, if a woman tends to worry prior to pregnancy, it could be assumed she will do so in pregnancy (Furtado et al., 2018). Generalised anxiety disorder (GAD) is defined by excessive, debilitating, and uncontrollable worry which interferes with one's functioning for a period of at least six months; it is the most typically diagnosed disorder in non-perinatal populations and consequently, is reported to be the most commonly occurring anxiety disorder during the perinatal period (Goldfinger et al., 2019). However, research is evidencing that pregnancy-specific anxiety could be regarded as a distinct phenomenon, with an onset in pregnancy, reflecting an emotional state which is contextually based to this period, with characteristics to worry that differ in content and nature to generalised worries (Huizink et al., 2014; Bayrampour et al., 2016; Blackmore et al., 2016; Goldfinger et al., 2019). The literature suggests that perinatal state-anxiety appears to be unlike generalised trait-anxiety that metamorphosises or transitions across contexts.

Risk factors for perinatal anxiety include psychological, social, and biological concerns; pre-existing mood or anxiety disorders are the most significant psychological predictors of perinatal anxiety (Furtado et al., 2018). Sociodemographic risk factors for new-onset anxiety

include a first-time pregnancy, living with extended family and limited social support (Furtado et al., 2018; Coates et al., 2014). Historic research indicates that a comorbid psychiatric disorder, such as depression, is implicated as a risk factor in developing anxiety in the perinatal period (Furtado et al., 2018). This begs the question whether this view is upheld due to limited understanding of anxiety and depression as separate experiences.

Research exploring anxiety as a distinct experience in the perinatal period is scant; it appears that the conflation of depression with anxiety has shaped our understanding of perinatal anxiety and indeed, that of some healthcare professionals, who potentially underestimate anxiety in this period unless it obviously manifests as a comorbidity with depression. This, I suggest, reflects a significant gap in the literature and in our full appreciation of perinatal anxiety. It is here that I focused my research lens: contextualised to the Covid-19 pandemic, to understand the nature and lived experience of anxiety in the perinatal period, and of equal import, to understand whether women with a history of pre-existing anxiety differ in their experience of perinatal anxiety from those without a history. To explore the phenomenology of this condition women must be invited to share their experiences of living with perinatal anxiety; women's perspectives are largely absent from the discourse around the topic (Folliard et al., 2020).

Research has afforded us insight into the prevalence of anxiety among women in the perinatal period; however, few studies have examined the differentiation between women who develop new-onset anxiety symptoms and those for whom a pre-existing anxiety disorder might be implicated in the development of their anxiety during pregnancy or after childbirth. Clinical emphasis on identifying and treating perinatal 'depression-and-anxiety' is reflected in the research; however, women who experience anxiety in isolation of depression can feel misunderstood and unsupported within the dominant discourse surrounding postnatal depression (Wardrop & Popadiuk, 2013). There is a need to closely examine women's symptoms and experiences of perinatal anxiety, rather than attributing their symptoms to the one-size-fits-all 'perinatal depression' (Goodman et al., 2016).

Anxiety symptoms are typically described according to their nosological classification; however, their presentation in the perinatal period reveals characteristics that do not comply with diagnostic descriptions as experienced in non-perinatal populations. In an Australian qualitative study Highet and colleagues (2014) explored women's experiences of postnatal depression and anxiety; they conducted 28 in-depth interviews with a homogenous group of metropolitan, well-educated women, recruited by convenience sampling, who self-reported postnatal depression and/or anxiety in the last five years. One could question the validity of this timeframe because it could be assumed that recollection could decline after five years. Moreover, their convenience sampling (which can facilitate the generation of qualitative information, but can be open to bias), participants' demographics, and the study's extended timeframe, render the findings ineligible for generalisation. However, qualitative studies rarely intend to elicit generalisable findings, and instead aim for depth of understanding or theoretical development. Participants' anxiety symptoms in this study were found to have characteristics inherent to the perinatal period; they were specifically mother-infant focused, unlike broader worries experienced in the non-perinatal population. Women in this study attributed their worries to discrepancies between expectations of motherhood and actual experiences, loss of control, inadequacy, and insufficient social support. Their excessive worries were 'baby-focused', triggering hypervigilant and overprotective behaviours towards their infants, predisposing the mothers to panic attacks. For these women, symptoms of 'depression', failed to fit with their experiences, which consequently impacted their interpretation of their experiences.

Brockington et al. (2006) used Grounded Theory as a systematic means of data analysis, which befitted their aim of allowing for the discovery and development of theories to emerge from actual phenomena and experiences. Two researchers analysed the data, thus increasing validity. Their study provides insight into symptoms of perinatal anxiety, apparently unique to the period. Brockington et al. (2006) identified that maternal worry is focused on parenthood and infants' health and, as in Highet et al. (2014), despite mothers

experiencing heightened anxiety symptoms, some failed to meet diagnostic criteria for anxiety disorders. While Brockington et al. (2006) employed ‘gold standard’ clinical interviews to measure postpartum anxiety, participants were in receipt of psychiatric care, thereby limiting generalisability of the findings to a wider community.

Lending weight to perinatal anxiety being a unique construct, Coates and colleagues (2014) explored 17 self-selected women’s experiences of undiagnosed ‘emotional difficulties’ in the first year postpartum. Data were analysed according to Interpretative Phenomenological Analysis (IPA), which attempts to make sense of the depth and breadth of participants’ experiences. The sample size (n=17) is large for an IPA study, which could have impacted the quality of analysis. The authors favoured a large sample to reflect the range of emotional difficulties experienced in the postnatal period and they countered the potential impact on depth of quality, with an opportunistic sampling strategy, which allowed the researchers to select participants based on experience. The authors revealed insightful aspects to anxiety and distress in this period: various temporal points in motherhood such as birth and breastfeeding were most notable triggers that led women to feel overwhelmed, guilty, anxious, frustrated and to self-blame.

Thus far I have examined early research which drew attention to worries arising in the perinatal period; these include worries around adjustment to motherhood, ability to cope and mothers’ concerns for their own and their infant’s health. While the symptoms of perinatal anxiety might appear typical of generalised anxiety, such as agitation, excessive worry and hypervigilance, the source of concern appears to be perinatal-specific. More recent research has further developed our understanding of ‘perinatal-specific’ anxiety.

Bayrampour et al. (2016) sought to clarify the concept of pregnancy-related anxiety by means of a concept analysis, which is a methodology used to clarify the relationships and distinguishing characteristics between concepts; for example, anxiety and fear are often

used interchangeably, yet their characteristics differ and being able to define these differentiations can enable us to understand and determine the differences in their inherent and manifested characteristics (Fitzpatrick and McCarthy, 2016). Concept analysis was, therefore, useful in this study, which attempted to clarify the characteristics of pregnancy-related anxiety, to facilitate critical thinking and understanding of the concept; concept analysis is not used to generate new concepts, which was not intended by Bayrampour and colleagues (2016). They identified specific pregnancy-related characteristics to anxiety in the perinatal period: affective responses (e.g., fear), cognitions (e.g., worry) and somatic symptoms (e.g., palpitations). The authors further identified dimensions of pregnancy-related anxiety which focus specifically on mother and unborn baby, and broader worries about support and finances; furthermore, they identified consequences to pregnancy-specific anxiety, such as excessive reassurance-seeking. These concepts, demonstrate the unique characteristics of this anxiety, in this period, and they highlight the potential antecedents and consequences to pregnancy-related anxiety (Anderson et al., 2019).

Early research relied on self-report measures to assess symptoms of anxiety disorders, which had a two-fold consequence: it failed to detect pregnancy-specific anxiety and overlooked subthreshold symptoms (Matthey & Souter, 2019); later research depicts a shift away from examining mothers' symptoms of anxiety, which could mimic symptoms of other anxiety, such as generalised anxiety disorder in a non-perinatal population, towards a closer examination of the content and characteristics of anxiety in this period. Generalized anxiety disorder (GAD) is the most commonly reported disorder in perinatal populations, with prevalence between 4.4% to 10.8% (Goldfinger et al., 2019). However, generalised anxiety is heterogenous, and we know little about the specific focus of worries in the perinatal period. Investigating 'worry content', Goldfinger et al. (2019), in a mixed-methodological study, age-matched a sample of non-perinatal women (n=20) with perinatal women (n=20) diagnosed with GAD, to determine whether perinatal worry has specific components that differentiate it from a non-perinatal population. By controlling for a disorder, the variables of

anxiety experiences were limited. Perinatal women with GAD experienced specific parent-related worries around parenting ability, incompetence, and external judgement; the non-perinatal women with GAD reported worries around broader domains such as work, own health, and everyday matters.

These more recent studies demonstrate distinct characteristics of pregnancy-related anxiety, thereby adding to the accumulating evidence of a perinatal-specific anxiety; notwithstanding this development, Anderson and colleagues (2018) suggest the continued need for further empirical evidence to increase our knowledge. Understanding the course of anxiety in the perinatal period can assist in assessment, prevention, and treatment strategies for women with pre-existing or newly diagnosed disorders, including those with subclinical symptoms (Goldfinger et al., 2019).

Debating perinatal anxiety as a distinct entity, raises questions regarding duration; whether it abates or endures with lasting consequences. Evidence shows that pregnancy-related anxiety, not general anxiety, places women and infants at risk of deleterious outcomes such as increased risk of pre-term births, emergency caesareans and infant developmental issues (Anderson et al., 2018, Ryding et al., 1998). Having considered perinatal anxiety as a distinct entity, with unique characteristics, I consider the second debate in the literature.

**Debate 2: Considering whether perinatal anxiety could be understood as a transient state anxiety, or a manifestation of an enduring trait, grounded in pre-existing anxiety.**

Spielberger's (1972) model of state-trait anxiety defines *state anxiety* as a transitory emotional state that varies in intensity and fluctuates over time, whereas *trait anxiety*, is conceptualised as a relatively stable proneness to threat responses (Spielberger, 1972). In clinical practice, experiences of perinatal *state anxiety* can be overlooked by professionals due to its transient nature, and women's difficulty to identify their symptoms, which they can inconclusively attribute to 'depression'. *Trait anxiety* can be conflated with depression or with a generalised anxiety disorder; however, in perinatal anxiety, as evidenced in pregnancy-related anxiety by Bayrampour and colleagues (2016), the content of worry and anxiety is particular to the perinatal period (Sinesi et al., 2019). These factors raise the question whether perinatal anxiety symptoms have been subsumed within existing disorders such as depression and generalised anxiety. However, existing disorders (depression and GAD) do elucidate the temporal aspect of perinatal anxiety, which can be experienced either as a metamorphosis of a trait anxiety, or as a transient state anxiety. Many first-time pregnant women experience mild to moderate feelings of anxiety across pregnancy (Huizink et al., 2014). While pregnancy-related anxiety is more contextually based than general anxiety, it begs the question whether pregnancy-related anxiety or generalised anxiety subsides soonest; being able to identify this could add weight to the specificity and temporality of anxiety in this context.

Huizink et al. (2014) and Asselman et al. (2020) independently conducted research using data from existing longitudinal studies to examine the relationship between anxiety symptoms across pregnancy. Huizink and colleagues (2014) conducted a study using longitudinal data from three data-waves of a large-scaled sample of 1059 first-pregnancy 'normal-risk' pregnant women, which was part of a Dutch longitudinal study on the transition to parenthood. Huizink et al. (2014) used the self-report Pregnancy Related Anxieties

Questionnaire-Revised (PRAQ-R) to assess pregnancy-specific anxiety and they measured state and trait anxiety with a translation of the State-Trait Anxiety Inventory (STAI), which was found to be reliable and valid. These researchers hypothesised that pregnancy-specific anxiety predicts both state and trait-anxiety levels longitudinally, that is, women would go on to experience temporary states of anxiety and longer bouts of generalised anxiety beyond birth and, conversely, that previous experiences of state and trait-anxiety anxiety would predict pregnancy-specific anxiety in first-pregnancy women. Evidence confirmed that only (pre-existing) trait-anxiety predicted anxiety in pregnancy. Their findings depicted a correlation between pregnancy-specific anxiety and a history of 'trait' anxiety. Further evidence suggested that women with raised levels of pregnancy-specific anxiety may progress to more generalised forms of anxiety over time, beyond the perinatal period (Huizink et al., 2014).

Asselman et al. (2020) also examined the role of pre-existing state-anxiety on perinatal psychopathological symptoms, with similar results to Huizink et al. (2014). In both studies, participants' demographics are similar, both conducted in Europe, and both employed multiple waves of assessment across pregnancy. Asselman et al. (2020) found that women *with* pre-existing state-anxiety experienced higher symptoms over the perinatal period than women *without* pre-existing state-anxiety. While retention rate was high in Asselman et al. (2020) (89.5%), dropout could have occurred amongst women with trait-anxiety, leading to an underestimation of its relationship to symptoms. Both studies support existing literature that suggest a correlation, albeit not a causal relationship, between pre-existing state-anxiety and symptoms of perinatal anxiety. While these studies do suggest a relationship between pre-existing state-anxiety and anxiety in the perinatal period, they raise a question about the determinants of perinatal-specific anxiety: what is it about pregnancy or the perinatal period that might serve as a catalyst to pre-existing anxiety?

Akiki and colleagues (2016) conducted a cross-sectional study, in Canada, using secondary data from the Prenatal Health Project (PHP), a population-based prospective cohort study that recruited pregnant women. The authors constructed a conceptual model, to guide their analyses of existing data for 1992 women included, after exclusions to ensure homogeneity, in their sample. They attempted to identify whether a woman's negative feelings about her pregnancy could affect her mood and predict state-anxiety in pregnancy. Akiki et al. (2016) utilised a version of the State Trait Anxiety Inventory (STAI) to assess broad phenomena such as stress, self-esteem, social support, and mastery, and they added a variable to assess qualitative 'feelings about pregnancy'. Findings reflect that feeling 'unsure' or 'unhappy' about pregnancy resulted in (somewhat predictably) higher levels of anxiety than in women who felt 'happy'. Furthermore, greater stress and low social support were associated with raised state anxiety; similarly, low self-esteem increased anxiety. Conversely, higher mastery predicted lower levels of pregnancy-related anxiety. Pre-existing mood disorders were *not* measured in the original PHP project, which meant that trait-anxiety could not be examined in this study. The use of secondary data, limits control over variables, which, in this study, limited the ability to distinguish between state or trait anxiety and to determine whether 'feelings about pregnancy' could be affected by trait-anxiety.

**Summary**

In my review of extant literature pertaining to the topic of perinatal anxiety, I have outlined two overarching debates that have arisen in the literature. Historic research has largely focused on identifying the prevalence of anxiety symptoms in perinatal women without examining the content, nature and differentiators of these symptoms from other types of anxiety, such as generalised anxiety, experienced in the non-perinatal population and, historic research has seemingly perpetuated the conflation of anxiety-with-depression in this period, which, I suggest, has translated to misunderstanding the unique nature of women's perinatal anxiety experiences. I have further reflected on the significance of this for wider women's health issues, which I hold in mind for now.

## Introduction to Part 2: Literature framed by Covid-19 pandemic

In part two I present an overview of literature framed by Covid-19 pandemic-related themes that arose in this study, which, I suggest, warranted closer inspection post analysis due to the impact of the pandemic on participants' experiences of perinatal anxiety, and due to the dynamic output of research that occurred since the start of this study. This overview does not engage as critically with the literature as I attempted to do in part 1; my aim here is to reflect broadly on recent literature pertaining to the pandemic, and to ponder on findings in my study, while considering those that have already been recorded. In many respects my study's findings echo the findings of recent research; however, as a researcher, I was excited to discover that, at this time, one of my findings does not appear to have been discussed in the literature, providing an opportunity for me to potentially contribute to this growing body of knowledge. I shall discuss this further in the Discussion Chapter.

### *COVID-19: an overview of an unknown threat*

The Covid-19 pandemic resulted in government-mandated lockdowns to manage the risk of virus transmission amongst the population (GOV.UK). As a result of enforced social isolation, many people experienced loss of connection to others and a personal sense of isolation. *Loss of connection* appeared as a broad theme amongst all participants in my study; however, it had differing consequences for participants in the two subgroups: those with a history of anxiety and those without. I shall discuss this finding further in the Discussion Chapter; in summary, the experience of isolation, arising from a loss of connection to others, revealed characteristics that were particular to each group's experiences of perinatal anxiety.

In consideration of my findings, I sought out recently-published literature on Covid-19 (2020 – 2022), pertaining to pregnant women and mothers' experiences of the pandemic. I paid close attention to mental health experiences of the pandemic, for its relevance to this study and to Counselling Psychology.

This recent literature, which largely focused on the impact of Covid-19 on pregnant and postpartum women, typically examined the prevalence of women impacted by the pandemic by quantitative means of inquiry; some researchers conducted qualitative studies to explore the nature and content of participants' anxiety related to the pandemic, contextualised to the perinatal timeframe. My macro inquiry of the literature revealed a broad trend amongst researchers to capitalise on the unique context created by Covid-19-10, uniquely shared by all participants; the pandemic context created an unprecedented opportunity to explore specific responses, to a specific phenomenon, in a particular temporal timeframe. I would argue that this unique context has provided an opportunity to explore the nuances of perinatal anxiety and to gain qualitative insight into the phenomenon.

***Impact of pandemic on prevalence of anxiety***

Green et al. (2022) revealed that since the pandemic, up to 60% of perinatal women experienced worsening mental health symptoms, with an increase in moderate to severe levels of anxiety (Cameron et al., 2020, cited in Green et al., 2022, p. 1145). Pre-pandemic about 21% of perinatal women experienced anxiety (Fawcett et al., 2019; Fairbrother et al., 2019). Pregnant and postpartum women felt vulnerable to the threat of the virus due to fears of potential harm to self and unborn child; vertical transmission could not be ruled out (Chen et al., 2021). Lack of clarity in the information released by government and healthcare sources further exacerbated their fear and anxiety (Chen et al., 2021; Chivers et al., 2020).

***Content of worry in the context of the pandemic***

Green et al. (2022) examined the worry content and impact of Covid-19 in 84 pregnant and postpartum Canadian women who were seeking treatment for an anxiety disorder in the period between April 2020 and October 2020. In addition to completing questionnaire measures and a semi-structured diagnostic interview, participants were invited to verbally describe their most significant worries, both Covid-19 and non-Covid-19 related, and to describe the impact of the pandemic on their lives. The authors assessed their data using a

content analytic approach, from which participants' principal worries emerged; one third of worries were specific to Covid-19, and 40% of these Covid-19 worries were specific to the perinatal context (Green et al., 2022). Of the perinatal-specific worries, in these women with a pre-existing anxiety disorder, a significant proportion of the content related to reduced social support and inability to tolerate uncertainty of the future. Participants' impact statements reflected common perinatal-specific themes of 'Missing out'; they missed out on bonding relationships with baby and being able to share their experiences with others in the perinatal period. The theme of 'Changes to perinatal supports' reflects the issues with which pregnant women struggled; being cut off from family, and support services, and struggles with loved ones being unable to accompany them to medical appointments. Echoing the theme of 'missing out', identified in Green et al. (2022), Vasquez-Vasquez et al. (2021) reported similar responses to the absence of emotional and practical support from birth partners, which had a negative impact on maternal mental health.

In their qualitative thematic analysis of online discourse, Chivers et al. (2020) similarly found that perinatal women experienced a sense of loss and grief from being deprived of social and family support. Women expressed that their perinatal experiences had been overshadowed by pandemic-enforced social distancing measures, which resulted in support being denied to them. Furthermore, a lack of clear and timely information about the virus exacerbated anxiety in this vulnerable group (Chivers et al., 2020). The theme of 'missing out' was highlighted on by Chen et al. (2021) in their American-focused article 'Perinatal anxiety and depression during Covid-19'; the authors note that the reduction in healthcare services and being cut off from birth partners in labour and birth, could have contributed to intensifying perinatal anxiety and depression symptoms in perinatal women.

***Isolation and loss of connection***

Due to the timeframe of the pandemic, there is a limited number of published articles on the impact of Covid-19 on perinatal women; the literature, thus far, indicates that the pandemic has contributed to increased anxiety and perinatal-specific worries, typically in women with pre-existing anxiety. I noted common themes to perinatal anxiety in these studies, which tended to arise from pandemic-enforced measures; consequently, women struggled with the loss of physical and emotional connection, especially when denied access to services, and when deprived of support from their family. Moreover, birth partners were prevented from accompanying women in labour, which exacerbated their anxiety at a time they felt most vulnerable. 'Loss of connection' stands out as a theme in women's experiences within the literature, which is also reflected in my study, and which I consider.

One of the few studies to emerge from the United Kingdom, is Dib et al. (2020), which aimed to provide descriptive data on mothers' mental health, coping and support, during lockdown. The sample of 1329 participants, who lived in the UK with an infant aged less than 12 months, completed an anonymous online survey. The findings of the survey indicate that new mothers, especially those with pre-term infants, and those on a low income (<£20'000-£30'000) experienced symptoms of anxiety, which were compounded by lockdown isolation, decreased access to support networks (which typically provided guidance or validation of their coping skills), and changes to hospital policies which barred women from being accompanied by a supportive person (Dib et al., 2020). Women in these studies felt isolated and robbed of support by their 'loss of connection' to others during the pandemic.

Palus et al. (2022) conducted a cross-sectional survey from March 2020 to June 2020, in Poland, to assess support provided to pregnant women and to analyse the determinants of anxiety among 534 pregnant women during the pandemic. The results obtained by this research indicate the significance that women attribute to support received from loved ones. A correlation was found between childbirth-related anxiety in pregnant women and the

support they received from their loved ones during the pandemic; women supported by loved ones disclosed a reduction in childbirth anxiety, and conversely, anxiety increased in those who did not receive support. Notable too, in this study, is the relationship between the support received from medical staff and levels of anxiety in pregnant women, who have a particular need for support from medical staff at the time of labour and birth, particularly in the context of pandemic-enforced measures in hospitals and limited access to supportive partners (Palus et al., 2022).

In attempt to seek a more phenomenological understanding of the impact of Covid-19 restrictions on pregnant and postpartum women in England, I reviewed a qualitative exploration study by Riley et al. (2021) who conducted an online survey with 2987 pregnant women and follow up semi-structured interviews with 25 participants. Their use of a Thematic Analysis led to findings which identified four main themes, of which one reflected the concept of 'isolation', similarly identified in the studies discussed above. Riley at al. (2021) titled the theme of isolation as "*the isolation, [that] was the hardest";* Covid-19-enforced isolation was identified as a significantly challenging aspect of the pandemic experience for the participants. Prolonged isolation from family and friends led to emotional distress in most participants, although some did report positive benefits such as 'saving money on maternity clothes'. Overall, participants felt that they had missed out on a 'typical' pregnancy due to the pandemic and experienced social isolation and loneliness due to loss of emotional and physical support from family and friends. Social distancing limited contact and increased stress, anxiety, and depression in this cohort. While Riley et al. (2021) have identified that participants struggled most with isolation, I critique their methodological rigour; perhaps a more curious examination of the data might have elucidated the possible significance of *isolation*. I wondered why isolation was hardest and what it meant for these participants.

**Literature Review Summary**

Parts 1 and 2 of this literature review depict a linear evolvement of understanding and awareness of perinatal anxiety in the literature. Considering the themes which emerged in the literature pertaining to perinatal anxiety, contextualised to the pandemic, I have noted two shifts in perinatal anxiety discourse from pre-pandemic literature; hitherto research in perinatal mental health has largely focused on perinatal depression and the comorbidity of anxiety and depression in this period. I suggest that the historical discourse shaped understanding of anxiety symptoms in the perinatal period as synonymous with symptoms of depression; while these two experiences can be comorbid, I argue that many professionals, and the wider public, adopted the historically conflated understanding of perinatal anxiety and possibly overlooked the specific nature of perinatal anxiety symptoms. Recent studies have focused more explicitly on perinatal anxiety, because, I suggest, the pandemic created a unique environment of unprecedented threat in which perinatal women's responses to the threat, particularly anxiety, could be 'examined', distinctly separate from depression, thereby enabling researchers to learn more about the phenomenon.

**Research Objective**

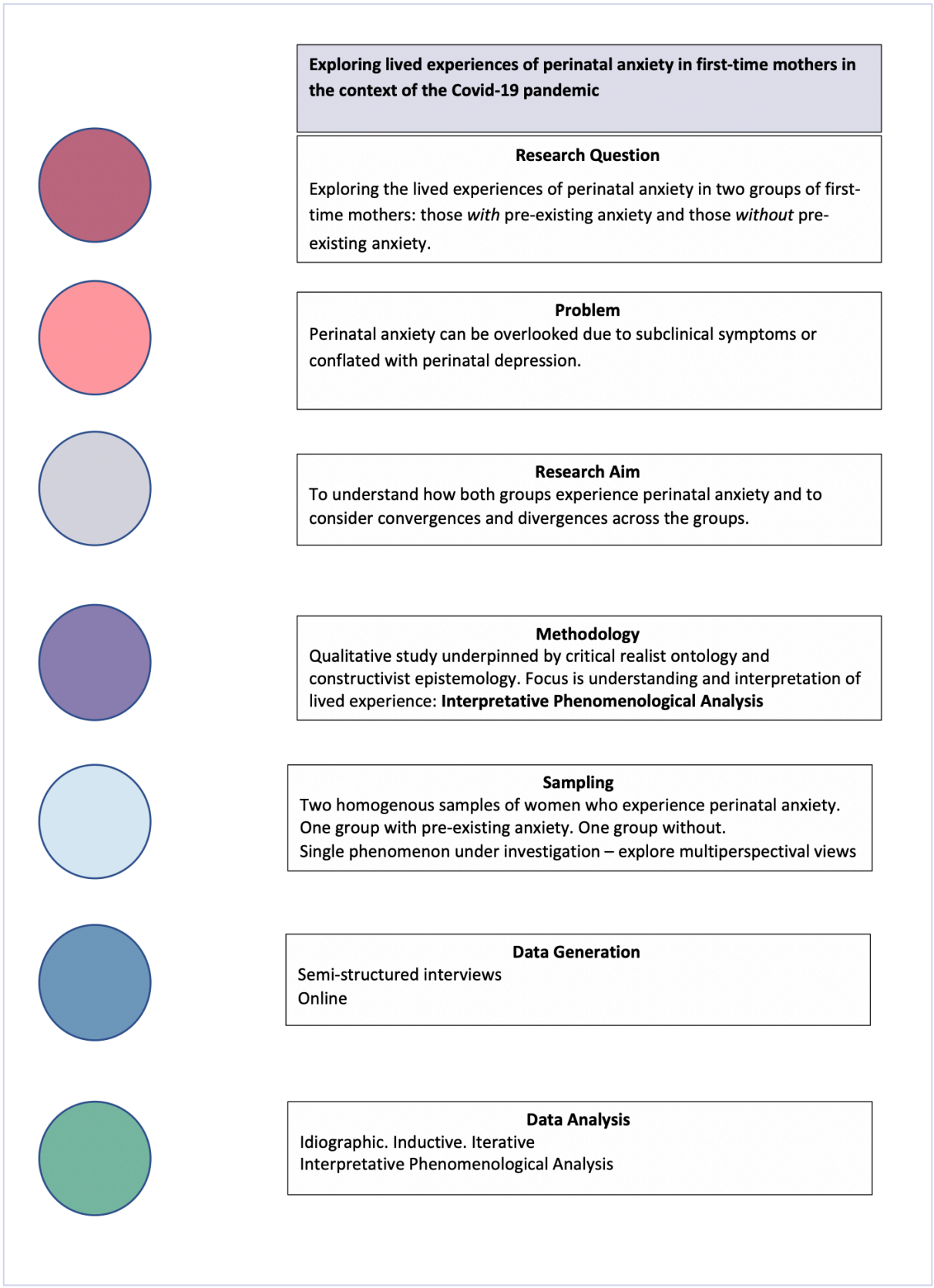
I have considered whether a lack of qualitative inquiry, exploring the phenomenology of perinatal anxiety experiences, told by those who have lived it, has been complicit in limiting our understanding of the phenomenon. My objective in undertaking this qualitative study is to explore the experiences of first-time perinatal women who have experienced anxiety in the perinatal period, within the context of the Covid-19 pandemic. I shall explore the experiences of two groups of women: one with a history of anxiety, and one without a pre-existing history of anxiety. Data will be analysed by means of Interpretative Phenomenological Analysis.

**Research Question**

Exploring the lived experience of perinatal anxiety in first-time mothers in the context of the Covid-19 pandemic.

# CHAPTER 2: METHODOLOGY

## Figure 1. Research overview



### Introduction

This chapter outlines the research methodology for this qualitative Interpretative Phenomenological Analysis (IPA) study, exploring perinatal anxiety in first-time mothers. I begin by outlining the rationale for adopting a qualitative approach before discussing epistemological and theoretical considerations pertaining to the research question and I outline the rationale for my choice of methodology. I provide a map of the research process, substantiating my use of two sample groups to explore a single phenomenon, and the potential for this design to contribute to the ongoing development of IPA research. This is followed by an overview of the data generation and analysis. I pay attention to ethical considerations. Signposted appendices are found at the end of the work.

## Conceptual and Theoretical Framework

### Rationale for qualitative approach

Healthcare has typically relied on evidence-based practice to inform policy and interventions; mental healthcare is governed by this practice and by taxonomic diagnostic criteria, which raises questions about whose versions of 'evidence' are given priority (Rose, 2006). Quantitative research has formed the foundation of evidence-based healthcare; however, quantitative methods are not intended to direct healthcare professionals to the essence of the patient's subjective experience (Biggerstaff & Thompson, 2008, cited in Miller, 2015). While I do not intend to challenge the hierarchy of evidence, I suggest that paying attention to multiple perspectives of phenomena could contribute to the evolution of research within psychology and to its knowledge base (Rose, 2006). In keeping with the search for *meaning and understanding* of experience, a qualitative research paradigm provides an appropriate framework for conducting this study (Willig, 2001).

## Philosophical and Methodological Considerations

Meaningful research requires consideration of ontology, epistemology, and methodology in the appropriate selection of a research design, based on the study's objectives and research question (Cuthbertson et al., 2020). Ontology is concerned with what actually exists – the nature of reality – and this sits alongside epistemology, which concerns how we gain knowledge of what exists and, how we determine its legitimacy (Crotty,1998; Maxwell & MIttapalli, 2011; Slevitch, 2011). The way we perceive reality defines how we obtain knowledge about it, which in turn guides our methodological investigation (Guba & Lincoln, 1994).

### Ontological Stance

One can fall foul of justifying ontological foundations to research without truly considering one's assumptions about reality or how we can make sense of the knowledge we seek. Indeed, after prolonged reflection, I realised that I had done just that in my initial research proposal; I 'returned to the thing itself' to revise my ontological foundation. I expand on this in Epistemological and Ontological Reflexivity below. My ontological stance is that a world exists, 'out there', independent of my or participants' beliefs and knowledge (Willig, 2013); it is neither true nor false (Forsberg, 1992). I suggest that the world encompasses multiple and complex strata of reality and that we make sense of these realities via subjective experiences, interpersonal interactions, and social and dialogic constructions; therefore, many 'truths' exist, rather than a singular 'truth'. It makes sense to me that my ontological stance is realist, not 'direct' (or naïve) realism (Willig, 2019), but that of critical realism, originally attributed to Roy Bhaskar (Bhaskar, 2008). The differential is that unlike 'direct' realism, research data within a critical realist approach is not assumed to directly mirror reality; instead, it is proposed that the researcher needs to interpret it to elucidate understanding of the underlying structures which give rise to the phenomena that we seek to generate knowledge about (Willig, 2013).

**Epistemological Stance**

From an epistemological perspective, my research question is founded on the principle that we subjectively construct our own versions of reality and knowledge and that these versions *matter to us*. Befitting my research question, constructivism, which argues that there is not a singular knowledge 'out there' but instead, *knowledges*, constructed in the mind of the individual, from multiple realities, supports the underlying the aims of this study (Braun & Clarke, 2014; Turnbull, 2002; Ponterotto, 2005). Furthermore, constructivism claims that meanings are constructed through our intersubjective engagement with the world; researchers can gain partial access to meanings by co-construction and hermeneutical interpretation within the researcher-participant dialogue (Crotty, 1998; Ponterrotto, 2005). This stance both supports and underpins a phenomenological methodological approach.

**Ontological and Epistemological influence on methodology**

Critical realism and constructivism mutually appreciate the impact of culture and society on individuals and acknowledge the inherent power of structures within society. Within mental health, such structures take the shape of the National Health System (NHS), NICE[3] guidelines for administering treatments, and diagnostic criteria defined by the Diagnostic and Statistical Manual (DSM-5). These structures exist 'in reality', independent of one's knowledge and experience of them, until individuals encounter them and are subsequently impacted[4]. The problem is that these structures are temporal, powerful, and typically separated from subjective experiences. These structural '*mind-forg'd manacles'* (Crotty, 1998), within our mental health system can overlook the 'truth' of subjective experiences that fall outside of, or do not yet exist, within diagnostic taxonomies. Psychiatric diagnoses are typically utilised in mental healthcare as representations of an ultimately unknowable human condition – there is no objective 'truth' to be found (Pilgrim, 1999).

[3] National Institute for Health and Care Excellence
[4] Example: impact of diagnostic criteria, diagnoses, treatment guidelines, waiting lists, time-limited interventions.

Critical realism enables me to regard the multiple realties that exist within perinatal anxiety – biological, social, psychological - while being able to interpret the subjective experiences of some such realities (Bergin, 2008). Instead of a myopic focus on a diagnosis of ‘anxiety’, ‘therapists might seek idiosyncratic formulations of the antecedent and current conditions, which have shaped the patient’s expression of misery’ (Pilgrim, 1999, p272); so too, I suggest could researchers. I intend to explore subjective realities of perinatal anxiety by means of an Interpretative Phenomenological inquiry.

**Epistemological and Ontological Reflexivity**

In my initial research proposal, I stated that my ontological stance was *relativism.* I had assumed that qualitative research presupposed an ontological commitment to relativism, and therefore, an epistemological commitment to the social construction of reality. I recognised that I was attempting to mirror my ontology with my epistemology – referred to as an 'ontological/ epistemological collapse' (Lincoln & Guba, 2000; Willig, 2016), or what Bhaskar (eg.1978) called the 'epistemic fallacy' (Willig, 2017, p1). I had fallen prey to the 'alternate paradigms' divide (Bhati, 2014).

I reflected on this to re-examine 'what is'; I arrived at the understanding that we exist in a natural and social world, with real objects and structures that have causal powers, which can impact our subjective experiences. This real and knowable world, that exists independently of our consciousness, is *situated* behind our subjective and socially-located knowledge – *and to which I, as a researcher, will have partial access* (Braun & Clarke, 2013). Even though I am asking questions about 'internal' experiences, they are nonetheless context bound and situated 'outside' of my reality; Therefore, I cannot offer 'objective interpretation', but I can aim to acquire a deeper understanding of perinatal anxiety (Slevitch, 2011).

In my clinical work with perinatal women, I began to understand that their experiences could not be construed as 'constructions' of reality, but *subjective perspectives of reality* (Maxwell, 2012). Anxiety, for example, could be driven by 'biochemical, economic, or social structures' (Willig, 1999, cited in Burr, 2015, p112) and therefore, *the way we come to understand their impact upon us*, and to which we only have partial access, is via constructions of those experiences. I recognise subjective experience and personal autonomy, interacting with, and impacted by, external reality. The subjective reality of experiences become meaningful through sense-making, which in qualitative research, occurs collaboratively between the researcher and participant (Crotty, 1998; Braun and Clarke, 2013).

Consequently, I adopt a critical realist ontological stance and a constructivist epistemological stance, matching the employment of IPA.

## Methodology: Interpretative Phenomenological Analysis

I have employed Interpretative phenomenological analysis (IPA) to explore perinatal anxiety in two groups of first-time mothers. IPA is a qualitative approach to research which aims to examine, in detail, personal lived experience (Smith, 2017). It seeks to uncover subjective meaning and provide interpretations, rooted in the participant's lifeworld, which emerge from collaborative engagement between participant and researcher (Finlay, 2011). Frequently used within health psychology, IPA recognises that individual participants might describe the same concern differently, thereby illuminating the convergences and divergences of experiencing the same condition, that is, 'perinatal anxiety' (Smith et al, 2009).

### Theoretical Underpinnings to Interpretative Phenomenological Analysis

IPA is underpinned by three philosophical foundations: phenomenology, hermeneutics and idiography, which inform IPA's methodology (Smith, 2017).

#### *Phenomenology*

Phenomenology is a philosophical approach to the study of experience which does not intend to prove objective universal truths; rather it aims to describe and analyse experience or phenomena in terms of the meaning it assumes for the subject, capturing the essence of an experience, unconstrained by pre-existing knowledge – embodied here in Husserl's phrase, '*to the things themselves'*, (Moran & Mooney, 2003, p3; Smith et al 2009, p12). As a researcher, I have tried to adopt a *phenomenological attitude,* which required a shift from an objective and theoretical focus on 'perinatal anxiety' to reflecting on participants' *perception* of their anxiety, and how each particular participant made sense of her particular experience (Smith et al, 2009). In so doing, I aimed to 'bracket', or suspend, my previous understanding of perinatal anxiety, to prevent distortion and to see it afresh (Finlay, 2011).

*Phenomenological Influence on IPA – Lived Experience*

Husserl's Phenomenology underpins IPA's concern with examining and explicating subjective experience, in terms of the meaning it assumes for the individual, rather than imposing prescribed pre-existing theoretical preconceptions (Smith et al., 2009; Finlay, 2011). IPA's phenomenological foundation enables me to hold a curiosity about the lived experience of anxiety, which encompasses the embodied, socio-culturally and historically situated person; therefore, phenomenology affords me the opportunity to gain insight into participants' lived experiences of perinatal anxiety by exploring both emotional-cognitive and 'felt sense' dimensions of the phenomenon (Finlay, 2011; Eatough & Smith, 2008, p181; Shinebourne, 2011). Dilthey (1985, cited in Van Manen, 1990, p35) suggests that *lived experience* involves our immediate, pre-reflective consciousness of life; phenomenology transforms lived experience into a textual expression of its essence through a process of reflection on its meaning, which is further elucidated through hermeneutic interpretation (Van Manen, 1990).

***Hermeneutics***

Hermeneutics, the theory of interpretation, is the second major theoretical foundation to IPA. Heidegger's concept of *Dasein* articulates our subjective engagement with the world, involving interpretation of phenomenon. The task of interpretation is to give reflective meaning to the essence of the participants' experiences, to unveil meanings possibly unknown to the participant (Shinebourne, 2011; Van Manen, 1990, p 41).

*Hermeneutic Influence on IPA – Interpretation*

Consonant with Heidegger's hermeneutics, IPA subscribes to the idiographic view that phenomenological enquiry is an interpretative process, separating it from a journalistic description of experience. In keeping with a critical realist stance, interpretation in IPA is the means to uncovering, not simply describing, the hidden phenomenon behind the entity's mode of appearing (Shinebourne, 2011). Hermeneutic interpretation is a dynamic cyclical

process, whereby the researcher is required to be reflective throughout, to ask questions not only of the data, but also of her response to the encounter and the data derived therefrom (Smith et al, 2009). This dynamic interpretative interplay between the 'whole' – the researcher's ongoing biography, and the 'part' – the encounter with the participant, represents the *hermeneutic circle (*Smith et al, 2009). Within this encounter, the researcher attempts to ask questions not only of the data, but also of her response to the encounter and the data derived therefrom (Miller, 2015). This iterative process is a core tenet of IPA analysis, where the meaning of a part is illuminated in the context of a larger frame (Smith et al, 2021). Finally, researcher access to the participant's experience is partial, similarly in critical realism; in IPA the aim is to get 'experience close', to provide interpretation that is grounded in the interview data, before seeking substantiation in external theory (Shinebourne, 2011; Conrad, 1987, cited in Smith et al, 2009).

### ***Idiography***

Idiography, the third theoretical underpinning of IPA, is concerned with the *particular* and detailed examination of the single case, to uncover the hidden meaning contained in experience, which contrasts with a nomothetic approach typically used in psychology to make claims at the group or population level (Shinebourne, 2011; Smith et al, 2021).

#### *Idiographic Influence on IPA – The Particular*

An idiographic commitment endorses IPA's rationale for small, purposively selected samples, thus enabling detailed analyses of single cases, to understand the *particular person* and their *particular experience* before considering convergences and divergences across cases (Smith et al., 2009). Idiography does not eschew generalisations and the findings from several participants could highlight shared themes and concerns that may be transferable to a wider population.

**Rationale for choosing IPA**

'IPA is a particularly useful methodology for examining topics that are complex, ambiguous and emotionally laden' (Smith & Osborn, 2015, p1). Perinatal anxiety is an exemplar of such a phenomenon, which participants were invited to reflect on, to seek meanings to experiences, which include embodied, cognitive-affective and existential domains, implicated in lived experiences of anxiety (Finlay, 2011). IPA recognises that participants' subjective, perceptual, and *particular* accounts can illuminate convergences and divergences across a single phenomenon. This is both a strength and a criticism of IPA; small samples sizes and the idiographic aspect do not feasibly facilitate generalisations, however commonalities across cases can provide implicit explanations and useful insights, which can have wider implications; as Caldwell suggests, 'by gaining insight into the individual, insight into the whole can also be achieved' (2008, cited in Pringle, 2011, p21).

Although IPA has been shown to give voice to the *how* of lived experiences, Willig (2013) points to IPA's limitation in explaining *why* phenomena are experienced. IPA's strengths can be found in its three core features: 1. Attending to meaningful subjective experiences, which can further psychological understanding, 2. A commitment to idiography, to the pursuit of the particular, without ignoring divergences across cases, 3. It's interpretative endeavour, which requires the researcher to stay true to the data and to their own role within the process (Eatough and Smith, 2017). Rigorously analysed data, generated by means of semi-structured interviews, with two, small, purposively selected, homogenous samples, could enable me to produce an interpretative analysis of perinatal anxiety, derived from an idiographic commitment to personal experience, within the frame of an IPA study (Smith & Eatough., 2019).

**Researcher reflexivity in IPA**

IPA recognises the duality of the researcher's role: interpretative and co-constructional; a researcher's presuppositions can both hinder and enhance interpretations of another's lived experience (Smith et al., 2009). My role within the research process is apparent from the study design to the generation and interpretation of data. I am called upon to be transparent about my motivations, assumptions, and attitudes, which I imported into the research context – and to reflect on how this impacted each stage (Finlay & Gough, 2003). Reflecting on my pregnancy experience, while I did not struggle with anxiety, as a single woman, I experienced uncertainty and loneliness, which potentially impacts my perspective.

Willig (2013) refers to two types of reflexivity: *personal reflexivity*, which requires me to reflect on how my personal beliefs, values and life experiences may have impacted and shaped the research, including its impact on me, and *epistemological reflexivity*, which requires me to reflect upon my theoretical assumptions and how these have shaped the findings. In practice this has involved articulating my theoretical position, engaging in sustained self-reflection, use of personal diary and will involve incorporating my reflections into the analysis and write up (Finlay & Gough, 2003). It could be argued that reflexivity is now a defining feature of qualitative research that challenges the view of knowledge as objective and independently generated from the researcher and is used to enhance the rigor and ethics of the study (Finlay & Gough, 2003).

**Consideration of other methodologies**

My choice of methodology has been informed by my research question and theoretical foundations. The focus of my inquiry is the 'lived experience' of perinatal anxiety, which is a topic that could lend itself to other methods of inquiry. I explored Grounded Theory (GT) and discursive methods. IPA shares similarities with GT (Willig, 2008) in the analysis of text and identification of themes, however, my decision to use IPA instead of GT was based on IPA's more psychological and interpretative stance than an intention to construct a theory of the

topic, or to consider it at a more macro level of analysis (Eatough & Smith, 2017; Cuthbertson et al., 2020). Reicher (2000, cited in Smith, 2009) distinguishes between IPA and discursive methods; Discourse Analysts examine how participants construct linguistic accounts of their experience, while IPA researchers analyse participants' accounts to understand how participants *make sense* of their experience. While IPA shares a commitment with Narrative Analysis (NA) to language, stories within NA are important in the construction of the self and identity, with the focus on the actual content of the narratives; however, IPA explores the participant's subjective *meaning* to a lived experience, and support my research aims.

## Method: Research Design and Process

### The Case for a Multiperspectival Approach

At the start of this qualitative research study, I outlined my objective, which was to explore the lived experience of perinatal anxiety in first-time mothers in the context of the Covid-19 pandemic. In keeping with this objective, I embraced the use of Interpretative Phenomenological Analysis (IPA) as my means of inquiry and analysis. My research design differs slightly from most other IPA cross-case designs, in that I have explored the single phenomenon of perinatal anxiety, within two separate, but homogenous subgroups: those with a history of anxiety, and those without a history of anxiety. While I retained an idiographic focus on each case as the unit of study, I was inspired in my research endeavour by Larkin et al., (2018) to consider a design which could potentially capture the multiple perspectives of these two subgroups: women who experienced perinatal anxiety, with differing histories of anxiety, all contextualised to the Covid-19 pandemic. I argue that it is only by employing a cross-group design, that I have been able to gain insight into how perinatal anxiety might differ between individuals with, and without, a history of anxiety.

I sought advice from Professor Smith about comparing two independently homogenous groups; he confirmed that this would acceptable and in keeping with developments in IPA research[5]. Smith (2017) draws attention to the evolving dynamic of IPA design and execution; indeed, he *encourages* adaptation, within the boundaries of its philosophical underpinnings. IPA researchers typically rely on a single, relatively homogenous sample who share a particular perspective on a particular experience; however, some IPA researchers are recognising that an experience is not necessarily solely located within the accounts of one group, but in others' experiencing the same phenomenon (Larkin et al, 2018).

**Methodological Ethical Considerations**

I have reflected on broad theoretical ethical considerations and with equal measure, on the ethical principles that guide the process of this research. My overarching ethical aim is to *do no harm*. To this end, ethical considerations have framed the design and implementation of this study, which involved respect for participants' autonomy, privacy and dignity, justification of the research benefits, non-maleficence and an appreciation of power when conducting research with vulnerable people (Groundwater-Smith, 2015; British Psychological Society, 2014). As a trainee Counselling Psychologist, I have adhered to the ethical principles enshrined in our profession's codes of conduct (Thomson & Russo, 2012). I have endeavoured to conduct this research with integrity and in accordance with the ethical guidelines of the British Psychological Society's (BPS) *Code of Human Research Ethics (2014).* I received ethical approval from City University.

[5] Exemplars include Rosthill-Brookes et al., 2011; Smith & Shaw, 2016 and Larkin et.al., 2018.

**Informed consent**

A core tenet of ethical research is the right to make a choice about participation (Groundwater-Smith, 2015). Participants needed to freely consent to the process based on sufficient transparent information (BPS, 2014). I created opportunities for participants to consider participating in the study and to provide consent: I developed a research website which was designed to be anonymously accessed and to provide transparent information for to women to seek further information by emailing me, without commitment, and to continue to a screening call, to assess risk and suitability – by completing a Screening Call Consent Form. Selected participants were required to sign a subsequent Consent to Participate Form. These written and verbal means of communication provided opportunities for informed consent prior to the online interview. Participants were sent a single-use password to access the online interview, permitting researcher and participant to engage in the interview. Prior to starting the interview verbal consent was gained and I reiterated the option to terminate the interview at any stage.

**Interview Distress Protocol**

Ensuring ethical, safe interviews is paramount. Online interviews reduce the ability to provide face-to-face support to distressed participants. The risk of distress was partly mitigated by screening calls. Throughout the interviews I monitored participants' verbal and non-verbal cues for signs of distress or dysregulation. When participants became upset, I paused the interview to determine their mood and to gain permission to continue. I inquired about their immediate opportunities for support from family or partners.

If a participant had become distressed, I would have attempted to provide immediate support and to assess their immediate access to support. If they had experienced heightened distress, I would have suggested that the individual contact to their GP or mental health provider (Pietkiewicz and Smith, 2014). The issue of distress raises a potential dilemma for researcher-practitioners (Thomson & Russo, 2012); while I am a qualified counsellor and I

would try to determine signs of distress and help to regulate a distressed participant, I was nonetheless, a researcher in this context; I was not providing therapy to participants. All participants were furnished with details of support services in the Debrief Sheet (Appendix G) - emailed to participants with Consent Form.

**Figure 2. Distress Protocol Prompt Questions**

1. Can you tell me what you are feeling now?
2. Can you tell me what you are thinking now?
3. Do you feel safe?
4. Is there an adult at home or close by to you now?
5. Are you able to continue or would you prefer to stop?

This protocol has been adapted from: Haigh and Witham, 2015. *Distress Protocol for qualitative data collection.*

**Anonymity and Limitations to Confidentiality**

Participants have the right to respectful handling of their data. I have ensured participants' anonymity; they will not be identifiable in any published work. I made participants aware of the use of anonymised quotes in published material. While I can ensure anonymity, I informed participants of the limitations of confidentiality[6], both prior to participating and prior to interview. If a participant had been at significant risk of harm to self or to others, confidentiality would have been overridden, to ensure that individuals were protected from harm. This was communicated in the Participant Information Sheet, on the website, and verbally, at start of the interview.

[6] 'The duty of confidentiality is not absolute in law and may in exceptional circumstances be overridden by more compelling duties such as the duty to protect individuals from harm.' (BPS Code of Human Research Ethics, 2018, p22).

**Ethical Data Management**

The handling of participant information is governed by 2018 General Data Protection Regulation (GDPR) and Data Protection Act (2018), which safeguards individuals' consent, processing and anonymisation of data (The British Psychological Society 2018).

*Consent Forms*

Consent Forms containing identifiable names will be retained in a separate file, on my password-protected City University storage system until course requirements are fulfilled.

*Email addresses*

Emails of individuals not participating are immediately deleted.

Consenting participants' email addresses will be retained in two groups:

1. Until end of transcription stage, to allow time for participant to withdraw interview data and to send thank you email/ gift voucher.
2. Participants who requested to receive disseminated study, consented to the retention of their email address for this purpose.

*Video and audio recordings*

Video recordings were deleted after transcribing completed. Audio recordings were transferred to City University's encrypted online platform, OneDrive, and in keeping with research data storage, will be stored for 10 years, after which recordings are deleted.

*Transcripts*

Transcripts have been anonymised. Participants were allocated a pseudonym and code. I have not made use of a transcriber. On fulfilment of course requirements, all transcriptions will be destroyed[7].

[7] Source: The British Psychological Society, 2018. Code of Human Research Ethics.

*Data Withdrawal*

I informed participants of their withdrawal rights, and time limits on data withdrawal. This information was made clear in the Consent Form. Participants had the right to withdraw from the study at any point. They had the right to withdraw interview data up to one week from interview date.

*Returning research findings to participants*

Participants have a vested interest in the findings and, in keeping with my ethical obligations, I informed participants of their right to obtain a copy of the published findings. Best practice involved opting in-or-out on the Consent Form (Hintz & Dean, 2020).

**Sampling Considerations**

My research question aims to explore experiences of perinatal anxiety in two groups of first-time mothers: 1. Women *with* a history of anxiety prior to perinatal period and 2. Women *without* a history of anxiety prior to perinatal period.

Professor Smith (personal communication, June 26, 2020) suggested that to ensure homogeneity in each group, I try to age-match participants across the groups, to minimise variables, and ensure to analyse one group before moving to the second group. The unit of study is still the case, and the focus remains an idiographic analysis of meaning. Eatough and Smith suggest: *"One way to strengthen IPA's idiographic commitment is to design more studies which focus on multiple snapshots of experience, and which emphasize patterns of meaning across time."* (Eatough and Smith, 2017, p12).

**Participant recruitment criteria**

Throughout the recruitment process participants were enabled to understand their involvement in the research process, to ensure choice to consent and a willingness to reflect on and share their experiences (Reid et al., 2005).

**Figure 3.** ***Inclusion and Exclusion Criteria***

***Inclusion criteria***

- First-time mothers with a pre-existing history of anxiety.
- First-time mothers without have a pre-existing history of anxiety.
- All women experience perinatal anxiety.
- *Age range for both groups*: 20 to 35 years old, age matched as closely as possible, for homogeneity.
- UK-based, English speaking.

***Exclusion criteria***

- Women who already have children excluded – this increased homogeneity and reduced extraneous variables.
- Pregnant women - To reduce potential for vulnerability and risk, pregnant women were excluded.
- While the perinatal period spans pregnancy to one year after birth; women were only included from birth to one year after birth due to above criteria.

**Recruitment Plan**

I originally planned to recruit pregnant women. Pregnant women with perinatal anxiety could have afforded an insight into current experiences, rather than retrospective reflection, gained from postpartum women. On reflection and discussion with my supervisor, I excluded pregnant women, to reduce the potential for distress.

Women were recruited through perinatal organisations' websites and forums, and via my research website purposefully developed for this study: https://perinatalanxietyandme.com/ The use of social media as a recruitment tool enabled me to reach potential participants via appropriate sites, relevant to this sample (Gelinas, 2017). I approached editors of perinatal support websites, after receiving ethical clearance, to request 'publishing' my study flier on their sites. The flier provided an overview of the study, with an embedded link to my website, which enabled women to seek further information. The multiple points of access to information were purposefully planned to enable potential participants opportunities to freely read about the study before electing to contact me, first via email, and then by an arranged telephone screening call, to which they consented.

## Ethical recruitment considerations

### *Two-stage recruitment process*

To ensure transparency and to provide opportunities for consideration of the study, without pressure to participate, I planned two stages of recruitment.

1. ***Email****:* Study flier appeared on external maternal support websites, with embedded link to my project-specific website. Potential participants (PP) read flier and elected to click on embedded link to my project website, containing Participant Information Sheet. If PP wished to engage further, to seek information or to continue to screening call, she emailed me via project-specific email, linked in website. PP was under no obligation to participate after seeking further information. If she chose not to continue to screening call, her email was deleted. If PP elected to continue to screening call, I emailed her a Consent to Screening Call Form, requiring signature, returned by email, prior to screening call.

2. ***Screening call****:* If the PP's chose to proceed, they were invited to screening call with me, on a dedicated number, until I had 12 eligible participants, who consented to participate. I conducted 58 screening calls and initially recruited 12 eligible participants. Participants who did not meet the research criteria, or I had identified as 'high risk of adverse emotional reactions' (Draucker et al., 2009), were sensitively informed at the end of the call that they had not been selected, with an explanation. I experienced inner tension during this process between 'my inner therapist' who wanted to be able to offer support, and my role as a researcher, who was adhering to the recruitment criteria and ethical boundaries.

3. Selected women, who chose to participate, received a confirmation email with an interview date and second consent form to be interviewed and participate.

***Risk screening***

Alongside screening for eligibility, I assessed the potential risk of adverse emotional reactions in the screening call, to determine whether an individual had current thoughts of self-harm, was experiencing significant anxiety or acute emotional distress.

**Figure 4.** ***Screening for Risk Sample Questions***

- Are you currently experiencing a high level of anxiety or emotional distress?
- Do you currently have thoughts of harming yourself?
- Are you currently having thoughts of harming someone else?
- If you participated in the study and you became distressed, do you have access to a GP, mental health service or responsible person who could support you? (Draucker et al., 2009)

**Cost of Resources**

- Website hosting (2 years = £144)
- Pay-as-you-go SIM card (£10)
- Gift vouchers (£15 each= £165). Participants received an online gift voucher in appreciation of their time.

**Recruited participants**

Initially twelve participants were purposively recruited to create two homogenous groups of first-time mothers. One participant withdrew due to illness.
All experienced perinatal anxiety – in pregnancy and/or within one year of birth.

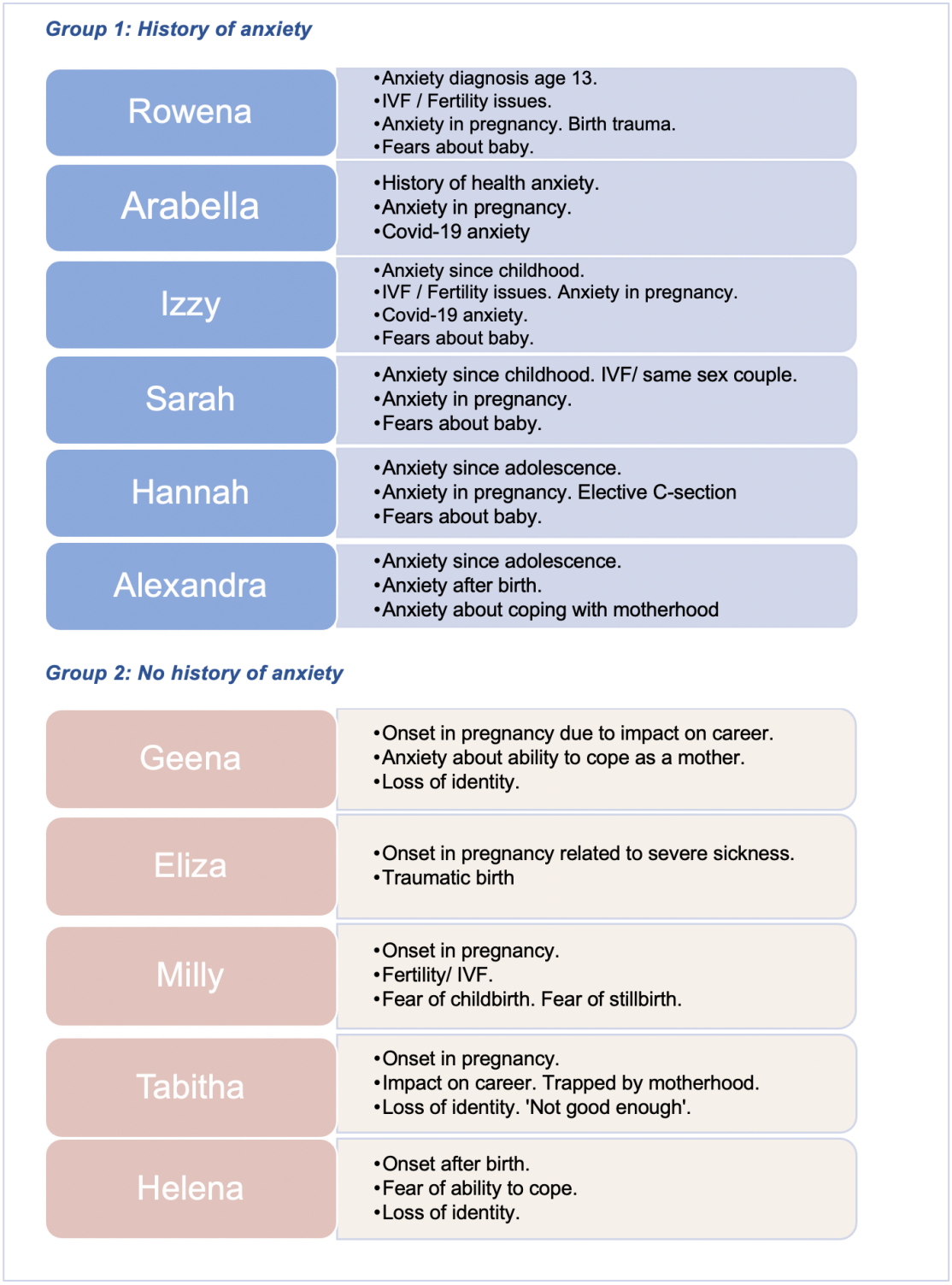
**Reflection on race and ethnicity of sample**

All participants were White Caucasian, from the United Kingdom. These participants were recruited from the group of individuals who responded to the recruitment initiative and who were screened. It would have been preferable to explore experiences reflecting a broader range of ethnicity, culture, and race. This is discussed further in limitations of the study.

**Group 1**: 6 x Participants *with* history of anxiety prior to perinatal period. Participants were not required to have psychiatrically diagnosed disorders; the research focus is on unique experience of anxiety, including sub-threshold anxiety and self-identified anxiety.

**Group 2**: 5x Participants *without* history of anxiety prior to perinatal period.

**Figure 5. Thumbnail Sketch of Participants: Pseudonyms are used throughout the study**



## Data Generation

### Covid-19 Consideration: Online data generation

Covid-19 pandemic has resulted in unprecedented changes to our lives, including conducting research. I have adhered to ethical principles outlined in The British Psychological Society's *Code of Human Research Ethics* (2014, 2018), updated for internet-mediated research and Covid-19 (British Psychological Society, 2020), which regards participants rights to *consent, withdrawal, confidentiality, anonymity, fair treatment,* and *privacy*.

I had conducted my clinical work online during the pandemic and have grown accustomed to the medium; however, as Chiumento et al (2018) highlight, being physically separated from participants raises practical and methodological considerations. I created a 'distress protocol' and reflected on the potential loss of kinesic cues that I might have picked up on in face-to-face interviews. Drawing on my online experience I was mindful of interviewees' contexts, sense of safety and privacy. I wore headphones and invited participants to do the same. I prepared participants for potential disruptions and agreed a protocol for returning to the interview if disconnected. I communicated flexibility and sensitivity towards mother/ baby needs, pausing the interview to enable mother to care for baby.

### Semi-structured Interviews

Smith et al. (2009) reminds us that data collection requires organization, flexibility, and sensitivity. My research aim is *understanding the experience* of perinatal anxiety. IPA enabled me an opportunity to engage with my research question at an idiographic level, by means of semi-structured interviews (Reid, 2005). These 'conversations with a purpose' (Smith et al., 2009, p57) allow for rapport building and for participants to reflect on their experiences, in their own terms, which include embodied, cognitive-affective and existential domains (Finlay, 2011; Murray & Holmes, 2014).

### Interview Protocol

Participants were interviewed online (Zoom). Interviews lasted between 60 to 90 minutes. I interview participants with and without a history of anxiety; therefore, the interview schedule allowed for exploration of a history of anxiety in one group. I video recorded, transcribed, and anonymised the interviews, prior to analysis. The interview schedule (Appendix F) contained open questions, prompts and probes which I used as a guide, rather than dictate the course of the interview, to enable researcher-participant dialogue and to provide a purposeful, but flexible means of exploring topics further (Pietkiewicz and Smith, 2014; Salmons, 2016; Smith, 2017).

## Data Analysis in IPA

IPA utilises an inductive method of analysis which recognises researcher's immersive, reflective, and interpretative role in the analytic process and generation of knowledge (Reid, 2005). Insights gained from the generation and analysis of data emerge via the researcher's emic and etic perspectives and interpretation, thereby reflecting IPA's hermeneutic foundation (Willig, 2013; Pietkiewicz and Smith, 2014). Unlike nomothetic principles, which underlie most empirical work, IPA is idiographic in nature; aiming to gain detailed understanding of first-person experiences, in particular contexts exploring each case, before moving to general statements (Larkin et al., 2006; Pietkiewicz and Smith, 2014).

### Researcher approaches data with two aims

1. To describe and make sense of the participant's world by focusing on subjective experiences, to which access is partial. The objective at the initial stage is to produce a coherent, third-person description, while staying close to the participant's view (Smith et al., 2009).

2. To develop an interpretative analysis, situating the initial description in relation to a wider social, cultural, and theoretical account, while curiously interrogating what *an experience*

*means* for a participant (Smith et al., 2009; Larkin et al., 2006). IPA is characterised by a set of iterative and inductive processes, flexibly applied; researcher moves from the particular, to the shared experiences, and from descriptive to interpretative (Smith et al., 2009). Interpretations are always grounded in the data and subsequently supported by reference to theory within the literature (Smith et al., 2009). The final stage is followed by a written narrative account of the study, where Group Experiential Themes are described and exemplified with participants' accounts, thereby explaining the significant experiential aspects uncovered during the process of analysis and linking identified themes to existing literature (Pietkiewicz and Smith, 2014)

**Changes to IPA Terminology**

Throughout this work I have made use of the updated terminology suggested by Smith, Flowers, and Larkin in the second edition (2022) of their seminal first edition, *Interpretative Phenomenological Analysis* (2009).

**Figure 6. CHANGES TO IPA TERMINOLOGY** (Smith et al, 2022)

| Original | Updated |
|---|---|
| • **Emergent Themes**<br>↓<br>• **Superordinate Themes** | • **Experiential Statements** - clustered to produce:<br>↓<br>• **Personal Experiential Themes** (PETs), to include Sub-themes<br><br>If working towards cross-case themes PETs would be consolidated into:<br>↓<br>• **Group Experiential Themes (GETs)** |

The table on the following page graphically outlines the steps I undertook for the analysis of each single case. I repeated these steps for each case, prior to moving to the next case and before cross case analysis. The steps culminated in consolidation of Group Experiential Themes.

**Figure 7. Process of conducting Analysis in IPA.**

**Adapted from M Larkin, 2021** (https://www.youtube.com/watch?v=_yUCTkvZRxQ)

| Steps I undertook for a single case | Meta-description: aims of each phase | IPA's Technical Description |
|---|---|---|
| Step 1. Re-watched interview video<br>Re-acquainted with the participant and their experience to get to know the data.<br><br>Step 1a. Recorded my **initial reactions** and thoughts onto transcription **by hand.**<br><br>Step 1b. Wrote my reflections, impacts and thoughts into my research diary. | **PHASE 1:**<br>**Working towards Experiential Statements** | **Reflexive reading** |
| Step 2. Conducted detailed **exploratory analysis,** staying close to the account. Made **Exploratory Notes** on transcript. Began to identify where experiences and meaning-making stood out to me. | | **Exploratory Notes**<br><br>Noted use of language, pauses, pronouns, repetitions of words. |
| Step 3. Recorded main claims I am making about the meaning of Robyn's experience – grounded in her account / in the data. Made annotations on the transcript of emerging **Experiential Statements** | | **Experiential Statements** |
| Step 4. I moved to typing notes in columns on transcript and began to organise my work around the **Experiential Statements**. This was an **iterative process**.<br><br>I printed a list of statements and cut them up. Laid them out onto a table, then onto the floor and I stood back to see what 'popped out' to me.<br><br>Began to collate the clipped **statements into themed clusters.** | **PHASE 2:**<br>**Working towards case-level summaries** | Preliminary **clustering of Experiential Statements**<br>Supplementary annotation<br>Reflexive threads |
| Step 5. **Consolidated** my case analysis in a case level summary and table. | | Structured consolidation of analysis<br>Mapping to **Personal Experiential Themes (PETs)**<br>Making sure there was a link back to key data extracts: by direct quotes & page numbers<br>**Sub-themes**<br>linked to key quotes |
| Step 6. Continued analysis for each case.<br><br>Step 7. I moved to **Group Experiential Themes (GETs)** by drawing on **PETs** from clustered material in each group. I worked across Group 1 before moving to Group 2, to develop GETs for each group.<br>Once GET's emerged, I moved to Cross-Group analysis. | **PHASE 3:** Working towards cross-case themes after each individual case has been analysed. | Interpretation took me from the 'whole' to a deeper, detailed interpretation of the 'part' in this hermeneutic process. |

## Outline of Process of IPA Analysis

Photographic trail of evidence in Appendix H

### *Step 1: Starting with the first case: Reading and Re-reading*

### *Step 2: Exploratory Noting*

At this initial stage I noted my reactions and reflections of the data directly onto the transcript, by hand. These exploratory notes included anything that struck me, thoughts I had about experiences and exploratory analyses. I noted semantic content and use of language, pronouns, repetitions, and words that stood out or 'gem' phrases that shone from the script, differentiating these notes into descriptive, linguistic, and conceptual (Smith et al., 2009; Smith et al., 2022). Conducted detailed exploratory analysis, staying close to the account. I made Exploratory Notes on transcript. These form the foundation to the **Experiential Statements**; they tend to have a clear phenomenological focus, remaining close to the participant's explicit meaning, describing things that matter to them.

### *Step 3: Constructing Experiential Statements*

At this stage I had a large data set: the transcript and an additional layer of exploratory notes. I moved toward an analytic shift; I began the process of reducing the volume, while simultaneously maintaining complexity, to articulate the most significant features of the exploratory notes, which are closely tied to the transcript (Smith et al., 2022). I aimed to succinctly capture what I understood about the meaning of an experience to the participant, in particular parts of the text – here we see the double hermeneutic and analytic process in action (Nizza et al., 2021). As researcher, I was actively engaged in deciding which aspects to bring to the fore (Smith et al., 2022). Each experiential statement comprises a conceptual summary of my exploratory notes, while remaining grounded (and referenced) in the data, and points to both the participant's psychological process and the context of that process (Smith and Nizza, 2022). Statements reflect both the participant's original words/ thoughts and the researcher's interpretation (Smith et al., 2022). This is where we can differentiate between a nuanced summary or a rather blunt, depicting the difference between a surface or

deeper level of analysis. Ideally the statements need to reflect the researcher's analytic work, not just a reconfiguration of the data (Smith et al., 2022).

***Step 4: Searching for connections across Experiential Statements***

I deconstructed the long list of Experiential Statements from the transcript in search of connections across the Experiential Statements. I cut them up and randomly laid them out to afford myself a helicopter view. I began to move them around and to arrange statements that resonated and harmonised with one another into clusters with potential interconnections. I repeated this process until I had generated clusters of experiential statements that mapped these interconnections (Smith et al., 2022). These clusters were given titles describing their characteristics, hereby becoming Personal Experiential Themes (Smith et al., 2022).

***Step 5: Naming Personal Experiential Themes (PETS)***

The clusters of Experiential Statements from Step 4 are given titles to describe their characteristics; the clusters, pertaining to each participant, become their **Personal Experiential Themes** (Smith et al., 2022). I continued the individual analysis of each case, one at a time, before working with the collection of Personal Experiential Themes (PETs) to develop Group Experiential Themes (GETs) across the cases. Each PET title reflects an expression of the convergence of the experiential statements (Smith and Nizza, 2022). PETs are so called to depict the type of entity they describe and represent the highest level of organisation when presented in a table (Smith et al., 2022). *Personal:* They pertain to the individual, derived from this particular person, whose case I examine at this particular time. *Experiential:* They relate directly to the participant's experiences or their experience of sense-making. *Themes:* They reflect analytic entities present within the script, a thematic distillation, rather than being specifically tied to the transcript, as statements are (Smith et al., 2022). This depicts a move from the literal level to a more analytic level of description and analysis.

Experiential Statements are identified with a page number from the transcript to evidence the trail of identifying that sub-theme and to ground the theme in the participant's data (Smith et al., 2022). This is the final stage of organisation for a single case, before moving to the next case and on to developing Group Experiential Themes.

***Step 6: Continuing the individual analysis of other cases***

As per above for each case.

***Step 7: From Personal Experiential Themes to Group Experiential Themes across cases***

The intention at this dynamic stage is to look for patterns of similarity and differences across the Personal Experiential Themes (PETs), to generate a set of **Group Experiential Themes** (GETs), to highlight the shared and unique features of the experience across the participants, hereby looking for convergences and divergences across cases (Smith et al., 2022). A table of GETs is produced to show convergence in the participants' experience and to demonstrate the unique way in which individual participants reflect a shared quality (Smith et al., 2022).

***Step 8: Interpretation***

Having completed the group analysis, I moved from the 'whole' to a deeper, more detailed reading of the 'part', thus engaging in the hermeneutic circle when drawn back to the text, interpretatively reading and re-reading it again in the light of the developing analysis (Smith et al., 2022). This deeper level of micro-analysis at the interpretation stage connects the part back to the whole, involving a more sophisticated level of interpretation.

***Step 9: Cross-Group Analysis***

Undertaking a multipersepectival approach required me to carry out a cross-group analysis; this was challenging on several levels, which I shall reflect on here, as I outline the process of analysis. Firstly, I had generated a significant amount of data per group, which I required

not only ‘physical management’ of the data but also, holding the participants, their experiences, and the findings in mind. At the initial stages of analysis, I had felt a closeness to the participants, I had become attached to their stories and in some way, beholden to their themes. Within the personal and group analyses of Steps 5 to 7, I felt able to ‘honour’ the breadth and depth of participants’ personal and group experiences; however, I experienced the cross-group analytic Stage 9 as a cull of the ‘part’, in favour of the ‘whole’. During this stage I, the researcher, experienced my position as more foregrounded while I interrogated the group findings, trying to make sense of their significance to the wider ‘whole’. I had not set out on this study with a hypothesis, or intended to present conclusive findings; however, I felt a sense of responsibility, at this cross-group stage, to uncover the significance of the themes; it felt as though I had reached the zenith of the analytic process at this final stage. My role here was to communicate the *meaning* of the groups’ experiences, to try to answer the question: ‘so what?’

In practice the cross-group analysis began with two sets of data: GETs and sub-themes from Group 1 and from Group 2: I began the process by creating a table of the existing GETs and sub-themes from each group. I then looked across the table for convergences and divergences across the groups; once identified, I tabled these by theme, and I recorded the number of participants experiencing each theme, to gain a sense of convergence. I also located identifying quotes in the transcripts, to ensure that I was staying grounded in the data. Looking across the cross-group table, I noticed that two themes emerged across both groups; however, the significance diverged between the groups. To illustrate this: *Loss of connection* appeared as a theme across both groups and was experienced by all participants across both groups – this was a clear convergence of a cross-group theme. However, ‘loss of connection’ diverged in significance for each group. For Group 1, loss of connection was attributed to a sense of being under-resourced in internal coping resources, whereas Group 2 experienced loss of connection to external sources of support and provision of care. Both groups experienced a sense of *being under-resourced*: Group 1 =

internally and Group 2= externally. At this point it became clear to me, in my interpretation, that loss of connection was a shared phenomenon, albeit with a divergent meaning for each group. Nonetheless, this was a bittersweet outcome, as I had to set some themes aside, to foreground these two overarching themes. I subsequently collapsed the two separate themes of *loss of connection* and *being under-resourced* into one overarching, salient theme: Loss of connection to others reveals a deficit of coping resources. The two themes were interconnected in their significance; one begets the other. To me, this was a clear illustration of the whole and the part in synchrony, which lent weight to my decision to collapse the two themes into one. This was an exciting find and one which not only suggested a possible difference in experiences of perinatal anxiety between those with and without a history of anxiety, but, I suggest, emerged from the cross-group analytic approach. To my mind, this depicts the strength of this approach and the benefit it afforded my study.

**Evaluation of my Research**

Qualitative research aims to produce descriptions and interpretations about phenomena under investigation; therefore, it does not seem fitting to apply quantitative evaluative criteria of validity, reliability, and generalizability to qualitative research; instead, it is more befitting to evaluate qualitative research on its own terms (Smith et al., 2022). Early attempts to define evaluative benchmarks broadly focused on the generic guidelines of 'trustworthiness and rigour': Osborn & Smith (1998) suggested methodology-specific criteria, which included internal coherence and presenting sufficient verbatim evidence to enable the reader to interrogate the interpretation (Smith & Osborn, 2015). Yardley (2000) proposed four characteristics of good qualitative research which offer flexible evaluative criteria: 'sensitivity to context', 'commitment and rigour', transparency and coherence', and 'impact and importance'; while these guiding principles and criteria continue to be drawn upon by qualitative researchers, several new guidelines for the assessment of qualitative research have been produced (Smith et al., 2022).

Broadly, qualitative researchers strive to going beyond 'good enough' analyses, by rigorous commitment to explicit detail and grounding interpretations in data (Pringle, 2011). Rodham et al., (2013) suggest that researchers engage reflexively in the creation of knowledge and monitor impact and biases, to demonstrate trustworthiness. More specifically, Nizza, Farr and Smith (Nizza et al., 2021) have updated and defined quality indicators for achieving excellence in IPA research. In summary, an 'acceptable' IPA paper is required to reflect an orientation to phenomenology and a focus on the experiential; it must reflect IPA's commitment to an interpretative endeavour, moving the analysis beyond the superficial and descriptive, thereby offering new insights into phenomena; moreover, the research should clearly depict an idiographic focus on the individual case, with regard for the particular, rather than the nomothetic (Smith et al.,2022) Nizza et al. (2021) have provided clear guidelines to achieving the above, which I have strived to adhere to, and to demonstrate in my study.

Nizza et al. (2021) identify the four following quality indicators of a good IPA study:

1. *Constructing a compelling, unfolding narrative*: I have aimed to share a progressive story with the reader, to depict a temporal development in my analysis and discussion, built cumulatively through an analytic dialogue between participant's quotes and my interpretations, within and across themes; from themes within single cases, to themes within each of the two groups, to those emerging from cross-group analyses (Nizza et al., 2021).
2. *Developing a vigorous experiential and/or existential account:* IPA foregrounds lived experiences, things that matter to people, and IPA regards the significance that individuals bestow on these experiences and events as paramount. The role of the IPA researcher is to explicitly engage with the significance of what participants report; a good IPA paper will reflect the significance of what things mean, why experiences matter to participants. The Covid-19-10 pandemic created an existential concern for many participants, and I hope to convey the meaning-making around this, in the context of participant experiences. My intention in this study is not to better understand the physiology of perinatal anxiety, but to understand the significance of the experience for participants, at particular times and in particular contexts; conveying this meaning, could help to improve the quality of my study.
3. *Close analytic reading of participant's words:* It behoves an IPA researcher to engage closely and idiographically with the transcripts and to provide a thorough analysis and interpretation of participants' quoted material within the analysis, to give meaning to the data and the experiences described; quotes should not be left hanging without an analytic hook, we are required to uncover, to reveal, the deeper significance of the relationship between the participant and their experience, which we can only achieve by the hermeneutic process of iteratively moving back and forth between the particular quotes and the knowledge contained within the wider transcript (Smith, 2007, cited in Nizza et al., 2021, p376).

4. *Attending to convergence and divergence:* These illustrate the similarities and differences between participants and between groups (in my study), depicting connections between experiences and by highlighting unique aspects to participants' experiences (Smith 2011a, cited in Nizza at al., 2021, p376). I have aimed to strike a balance between depicting how participants share higher order qualities, such as *loss of connection*, without losing insight into unique features of participant's particular experiences, thus aiming further to reflect my hermeneutic engagement between the part and the whole in my analysis (Nizza at al., 2021).

I have aimed to pursue the quality markers in my doctoral research; in the journal article I have written, I reflected on Levitt et al. (2018) criteria for reporting qualitive research. Smith et al. (2021) suggests a few selected criteria from Levitt et al. (2018) that relate directly to IPA, which could be operationalised for journal reporting purposes.

# CHAPTER 3: FINDINGS AND ANALYSIS

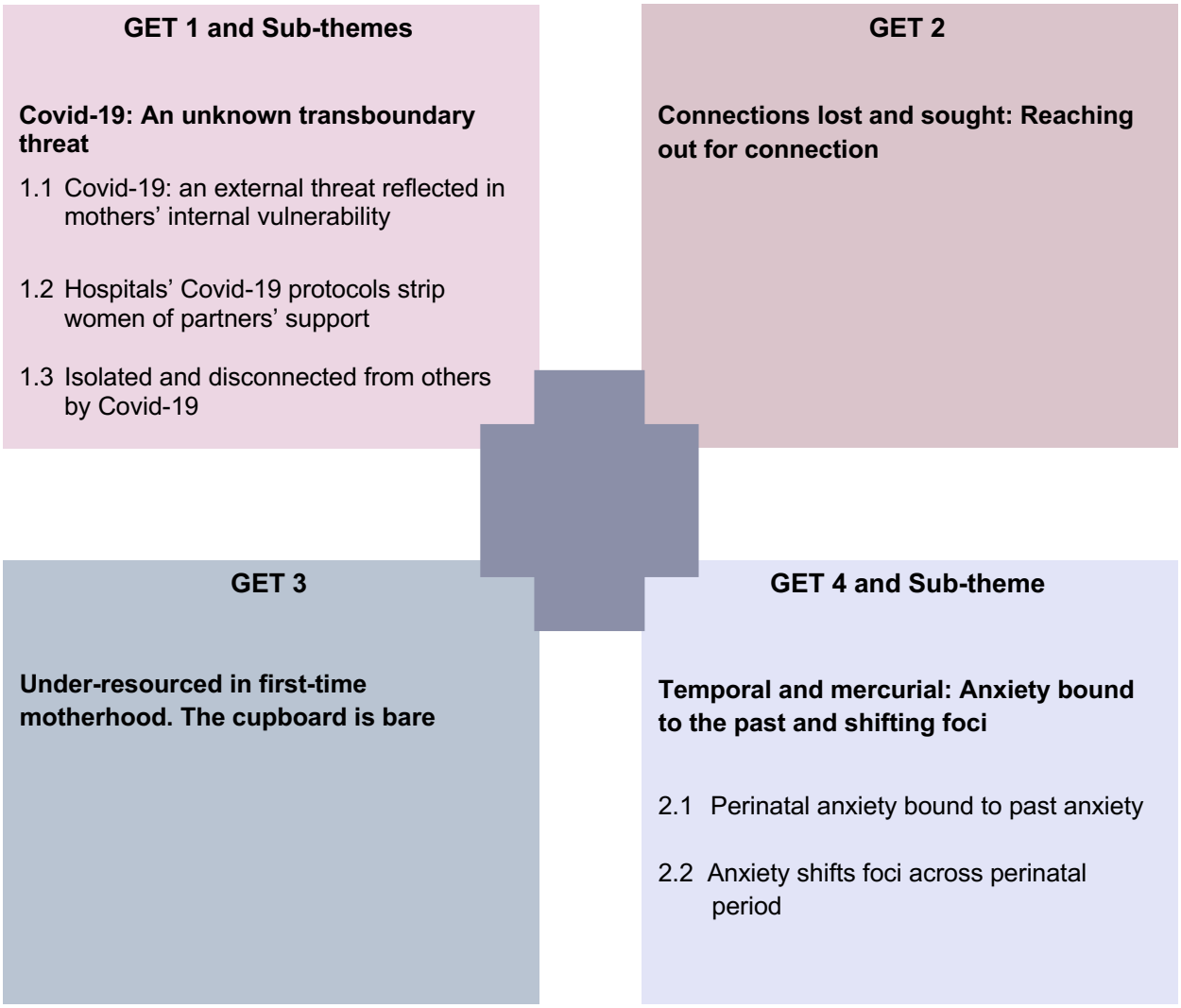
## Introduction to Findings and Analysis

I have analysed participants' experiences of perinatal anxiety in and across two groups by means of Interpretative Phenomenological Analysis (IPA).
**Group 1** participants (n=6) have a pre-existing history of anxiety. **Group 2** participants (n=5) do not identify having a history of anxiety; they identified the onset of their anxiety during pregnancy or since the birth of their child.

My analysis involved an idiographic commitment, first to the experiences of each individual participant, and then to the group account, before considering convergences and divergences across cases and then, across the two groups. There is a duality to being immersed in IPA's iterative and idiographic analytic process; on one hand, repeatedly returning to the transcripts and notes can result in exciting 'gems', perhaps hidden on first inspection; however, the process can initially feel circuitous. Nonetheless, my analysis enabled me to fully immerse myself in the details of participants' experiences, through which I gained a deeper understanding of the lived experience of perinatal anxiety. I have aimed to hold participants' experiences gently in my hands, while giving each one due analytic regard. This two-stage analysis resulted in Group Experiential Themes and Sub-themes for each group, followed by cross-group themes which emerged from the cross-group analysis. I have used the new terminology introduced in Smith, Flowers, and Larkin, (2022). Previous terminology included Superordinate and Subordinate themes; new terminology at group level utilises Group Experiential Themes (GETs) and Sub-themes (STs) respectively.

To protect the identity of participants and other individuals mentioned in interviews, I have allocated pseudonyms, removed locations and any identifying features pertaining to their lives, such as hospital names and participants' professions. Partners have all been labelled as X and baby's' names have been replaced with a generic title of 'baby'. Visual representations of the themes pertaining to each group are presented before each analysis.

**Figure 8. GROUP 1. GROUP EXPERIENTIAL THEMES (GETs)**



## Analysis Group 1: History of anxiety

I have identified four Group Experiential Themes (GETs) in Group 1 that represent the lived experiences of perinatal anxiety and the ways in which participants with a history of anxiety make sense of their perinatal anxiety experience. It is important to contextualise these experiences to the Covid-19 pandemic not only did the pandemic create an overarching context of unknown and, arguably, existential threat to our shared world, but it also became a medium through which the participants were forced to navigate their perinatal experiences, and in so doing, 'Covid-19' emerged within a Group Experiential Theme; what I find particularly interesting about 'Covid-19', is how this external threat reflected Group 1 participants' internal sense of threat and vulnerability, and moreover, how Group 1 and 2 differed in their responses to Covid-19. I shall expand on this feature in the cross-group analysis. I am conscious of writing now, in a 'post-pandemic' context, where the threat of Covid-19 is subsiding; yet, as I present the participants' experiences here, I am acutely aware of the lived and visceral threat that Covid-19 represented.

**Group 1 GETS** are: Covid-19, an unknown transboundary threat; Connections lost and sought: Reaching out for connection; Under resourced in first-time motherhood: The cupboard is bare' and Temporal and mercurial: Anxiety bound to the past and shifting foci. On first gaze, one might not notice the interconnectedness of these themes; however, my close attention to the phenomenological accounts enabled me to understand their interconnectivity. As I stepped back from full immersion in making sense of participants' experiences, I engaged in the *double hermeneutic*, and I asked: 'How have I made sense of their sense-making?' I have gained an understanding of the significance of *connection* to others and of equal import, the *loss* of connection from others. When loss of connection is contextualised to being under resourced, there is little to 'cling to'; for most participants, these experiences seemed to provide the grist for the mill to pre-existing anxiety. Thus, the interconnection amongst the GETs became evident to me through participants' sense-making of their experiences of connection and loss of connection.

## Group Experiential Themes and Sub-themes

### *Group Experiential Theme 1: Covid-19: An unknown transboundary threat*

Towards the close of 2019, the United Kingdom began to hear reports of a new strain of coronavirus emerging from China; the associated disease became known as Covid-19. This posed a threat to the world, unprecedented in our recent history, that resulted in a global lockdown in which people were subject to complete or partial isolation. The existential threat from the virus could be understood as reflected in their internal sense of threat and vulnerability: "*There was that vulnerability and suddenly this big scary thing was happening." (Arabella,175).* Covid-19 'out there' appears to reflect most participants' internal threat and vulnerability, which was compounded by rigid protocols enforced by hospitals, thereby stripping the women of their connection and support and potentially, exacerbating their anxiety. Underlying their anxiety, and linked to other GETs, appears to be an experience of feeling 'alone, unsafe and unable to cope'; expanded upon in sub-themes.

### Sub-theme 1.1: Covid-19 an external threat mirrored in mothers' internal vulnerability

This theme suggests a dual relationship between the experience of Covid-19 as an external threat, which not only transcends geographical boundaries, but also crosses mothers' internal boundary of self-and-baby. The notion of 'duality of threat' reflects the phenomenological mirroring between participants external and internal worlds, as they made sense of their lived experience of being pregnant-in-a-pandemic. It is notable that this theme of 'threat and vulnerability' evolved out of participants' experiences of the pandemic while pregnant; the theme of 'isolation' was more notable postnatally. The threat of Covid-19 was simultaneously perceived externally and as an 'internal' threat to the mother's body, which alerted some participants to their vulnerability and their ability to protect self and baby. Participants started to learn about Covid-19; some keenly tracked its development in the news, scanning for and identifying signs of risk and danger even before friends or colleagues identified the risk as significant:

> *“I read the articles online, I was really worried; people at work would take the mick out on me - ‘it's miles away’.” (Izzy, 179).*

Some participants experienced how ‘other people’ were not as aware of the risk of the virus as they were. Izzy’s colleagues ‘took the mick’, which is short for the Cockney Rhyming Slang expression, ‘Taking the Mickey’, (or taking the piss), which means to mock or tease someone. In other words, people were not taking the perceived threat as seriously as Izzy and some other participants. Sarah asked her doctor about the potential risk of Covid-19, and she replied: “*I wouldn’t worry about it, it's not really going to be a thing.”* Conversely, Sarah and her partner identify the threat of the virus as ‘a thing’, which informed Sarah’s later actions to isolate for the entirety of her pregnancy.

> *“And so, we were like, mmm I think it is. I think it is a thing.” (Sarah, 182)*

I note Sarah’s use of ‘we’; she shares a strong bond with her supportive partner, who also donated the egg which resulted in the baby Sarah was carrying; thus, the ‘we’ transcends their romantic partnership and denotes the collective ‘we’ of parents mutually invested in ensuring Sarah and baby’s health. Sarah’s use of ‘*we were like, mmm’* reflects a joint consideration and subsequent rejection of the doctor’s opinion of the risk posed by Covid-19.

Most participants interpreted the encroaching virus as a direct threat to themselves and to their unborn babies and I suggest, that for some participants, the external threat transcended their internal boundaries, exposing their vulnerability. Pregnant participants experienced vulnerability; their baby’s survival symbiotically depended on their own survival, and the unknown virus threatened that. Rowena and Izzy’s experiences below reflect the duality of this threat; as it moves closer, transcending geographical boundaries, the external threat of Covid-19 begins to raise awareness of their own physical and ‘internal’ vulnerability.

> *"Oh my God, have I got Covid-19, what's going to happen, I'm going to die. I'd get extremes of anxieties that I'm going to die or the baby's going to die... I'm vulnerable, I'm going to die, in a pandemic." (Rowena, 286, 644)*

One can sense the panic in Rowena's speech: '*Oh my God'* simultaneously expresses terror and is imploring, perhaps praying to 'God' that she and baby do not die. When Rowena questions the possibility of her or baby dying, it gives her '*extremes of anxieties'*; the sense of panic, terror and the unknown is thick in this extract. By identifying herself as *vulnerable*, we gain an understanding of how she might correlate this to the fear of dying '*in a pandemic'*. This existential threat seems to render Rowena helpless, but so too does her internal perception of vulnerability. Izzy identifies Covid-19 as an 'external stressor', giving weight to the suggestion of duality of threat, both external and internal:

> *"I felt that my risk was increasing more and more because of being pregnant; those external stressors with Covid-19, because it was everywhere; it felt like constant fear. (Izzy 202).*

The notion of 'internal threat' can be further interpreted from Izzy's extract: '*My risk was increasing… because of being pregnant'* – pregnancy appears to be a factor in *her* increased risk, she uses the word '*because' (*of being pregnant), surrounded by Covid-19 '*everywhere'* – there seems to be no escape from the threat, and furthermore, the use of 'because' alludes to the vulnerability she might feel at being unable to escape the risk 'because' she is pregnant. The image of a 'sitting duck' comes to mind. Continuing the interpretation of internal vulnerability, reflected in the external threat posed by Covid-19, I have considered the pregnant woman's body as a vessel in which her unborn child is internally contained; the sense of 'external' threat runs like an umbilical cord, with the potential to reach the unborn foetus 'internally' contained within the woman's body. To protect herself and her unborn baby from the external threat of Covid-19, Sarah remained at home for months:

> *"During that first lockdown people didn't know what was going on, did they, and so I literally didn't leave the house, I was in the house the whole of lockdown - I'm pregnant, don't come anywhere near me." (Sarah, 210)*

In this above extract, Sarah appears to recognise the lack of clarity around the impact of the virus on pregnant women: "*People didn't know what was going on, did they, and so I".* Sarah therefore makes up her own mind; '*and so I'* reveals a definitive decision to be proactive and remain indoors to protect her baby, which is reinforced further by her emphatic demand that her physical boundaries are not transgressed by others: "*Don't come anywhere near me".* Sarah's experience reflects the interface between physical, personal, and social boundaries which were reconfigured within the pandemic.

**Sub-theme 1.2: Hospitals' Covid-19 protocols strip women of partners' support**

This sub-theme reveals the impact of hospital Covid-19 protocols on participants; for some, this exacerbated their anxiety. The pandemic triggered the creation of physical boundaries and societal protocols, where none had previously existed; pregnant women were instructed to isolate: "*Pregnant women were put on the high-risk list, I didn't leave the house for months." (Hannah, 156*). Hitherto partners who had chosen to share pregnancy and birth experiences were able to attend appointments, scans and the entirety of labour and birth. However, during the pandemic, partners were precluded from attending antenatal hospital appointments and some were forced to wait outside hospitals until their partners were in active labour. Physical boundaries were installed to separate people, ostensibly to keep them safe: "*I walked into the hospital, there was a table, chairs were sectioned out, nurses with face masks, gloves." (Rowena, 71).* Izzy's extract below portrays a change to a once-familiar hospital landscape; it felt '*surreal'* to her, as though she were on a movie set, directed to play a role that separated her from others, '*stay back'*, and somehow alienated her from her own felt experience – '*huge impact on how that pregnancy felt'*.

> *"It just felt surreal, almost like out of a movie, I had never experienced that that level of um, I guess being away from people 'stay back', and 'don't touch this'; I think it had a huge impact on how that pregnancy felt." (Izzy, 207)*

All participants experienced loss of connection and, as a result, isolation due to these newly carved out boundaries; some felt cut off, first physically and then, emotionally, which some described as compounding their anxiety: "*Completely in isolation has made the anxiety intense and unbearable." (Izzy, 422).* These boundaries resulted in couples robbed of shared pregnancy and birth experiences:

> "My husband hadn't heard baby's heartbeat, so, you know, there was those sorts of sad, sad bits to it, really. I really do think it had a huge impact. I was anxious anyway before Covid-19 arrived, but it did compound it I think (Izzy, 217).

Izzy, above, reflected on the impact of Covid-19 protocols on their joint experience; they lost a mutual experience of connection and bonding when prevented from listening to baby's heartbeat, which she repeatedly described as '*sad, sad bits'*. Further reflection reveals Izzy making sense of her pre-existing anxiety and perinatal anxiety, which she described as being compounded by Covid-19, and its consequential protocols which left her devoid of her husband's support and connection in hospital. Sarah's account feels both angry and sad that her partner (and egg donor) missed out on what should have been a joint experience:

> *"I hated it because I was on my own, but also because X was missing out, she'd been to every single appointment, you know like, every, every single appointment since we started this process and I just felt like she was missing out." (Sarah, 191)*

Sarah, above, protectively included her partner in her words 'but also' – so, not only was Sarah impacted, 'but also' her partner, whom she repeatedly (3x) described, through a clenched jaw, as having previously attended '*every single appointment'*; as a same-sex

couple, their *'process'* was filled with numerous challenges to get to the stage where Sarah was pregnant; they faced many hurdles throughout the fertility process, and now X was also '*missing out'.*

Women were stripped of their supportive 'other' at times when some felt most vulnerable and in need of support: "*All that I wanted was completely stripped away from me (Rowena, 460).* Alexandra describes the isolation and separation being alone on the ward after she gave birth: *"I was on the ward for three days by myself, without anyone, anyone you know, that was rough. (6. Alexandra, 154).* Alexandra repeats the word 'anyone' to emphasise that it felt more significant than being by herself on the ward; she was without anyone she knew – Alexandra changes pronoun from 'I' to 'you', perhaps indicating the sense of separation she felt at being alone, without her supportive husband, whom she knows and who knows her, that is, he would possibly have 'known' how to support her and reassure her; without him it was a 'rough' experience.

For most participants, going to, or being alone in hospital heightened their anxiety: "*I was quite anxious being in there on my own, what if something's wrong" (Hannah, 94); "My anxiety started again because I had this fear of doing it all on my own; my trigger was being in hospital on my own." (Rowena, 393, 582).* My analysis began to reveal what I interpret as the hidden aspect to 'being alone'; I note here that I began to sense an emergence of another theme evolving out of 'being alone', which is the fear of 'coping' when alone, or a fear of being 'unable to cope' alone: "*It was because I was going in on my own, how am I going to deal with it?" (Rowena, 190).* I wondered whether this construct around 'coping' might reveal itself later, and if it did, what if I dived deeper into the experience of 'coping alone'; what lay beneath that?

Continuing the theme of being alone in hospital or feeling unsafe in hospital, some participants attributed this to their birth complications *"I had to have an emergency C-section."* (Alexandra, 150). Rowena's extract below depicts a visceral connection between

mind and body in her anxiety experience; it could be suggested that her experience reveals a potential correlation between not feeling safe and birth complications.

> *"My body was going 'it's not safe to give birth, you're not safe, you're not safe, and I think that is why I had so many complications; I think my body just completely shut down. I was highly anxious…. then after that then I haemorrhaged." (Rowena, 158, 437).*

Rowena vividly describes her sense of terror while giving birth, which she attributes to 'not feeling or being safe': her use of '*its' not safe'* prefaces '*you're not safe'*, followed by her sense-making: '*that's why*…' after which she experienced the consequential '*body shut down'*; I curiously wondered why, and Rowena named it: '*I was highly anxious'.* I interpreted that she had experienced her birth environment, and possibly those involved, to be unsafe, evidenced in her use of 'it's not safe', which I posit makes *her* feel unsafe; she repeatedly tells herself this in the use of 'you're not safe' – the words sound out like an alarm, reaching a crescendo of anxiety, before collapsing into '*shut down'*. Rowena responded to threat in the way many people do, her body 'shut down'; her words evidence why she believes she '*had so many complications'.* Izzy's extract below is also rich with vivid experience and sense-making, depicting the impact of not having her husband accompany her to hospital. I curiously wanted to understand more about 'why' partners are important to participants at these times; Izzy's experience enabled me to reflect at a deeper level on the purpose of connection-to-other:

> *"My husband is a big part of my reach-out; I didn't even have him, and I needed him, I needed him and that was a huge contributing factor to why I got in such a state in the hospital, because he wasn't there". (Izzy, 307)*

Izzy describes her husband as a big part of her "*reach out";* from this I understood her husband to play a significant role in her established 'anxiety and emotion regulation

protocol', in which both are engaged, and which serves to calm, reassure, and regulate her. I imagined her feeling anxious, when she physically and metaphorically 'reaches out' to him and finds solace in his support. Her extract reveals how she was stripped of this support, she had nothing to regulate her: not '*even him',* and she really '*needed him'*, which she repeats twice, sounding almost bereft and alone, before she makes sense of '*getting into a state'*, because '*he wasn't there'.* Izzy's experience enabled me to reflect on participants' experiences of being alone, isolated, and scared; I became curious about participants' internal reserves and how being connected to others served participants. Rowena summarised her need for connection as such: "*I feel that we need one other person, so you can rationalise your thoughts." (Rowena, 903).* The 'other person' for Rowena, and some other participants, possibly enables self-regulation, provides reassurance, and supports coping, when anxiety potentially induces feeling 'irrational'.

**Sub-theme 1.3: Isolated and disconnected from others by Covid-19**

Isolation is a theme coursing through all participants' experiences, from being physically isolated in hospital, to enforced isolation because of Covid-19 lockdowns, to isolated in rural locations, and to emotional isolation for some participants who found motherhood a lonely, isolating struggle. Being isolated due to lockdown cut off support for some participants with new babies:

> *"I think it's difficult with the pandemic, like feeling very isolated and not having any social support." (Arabella,337)*
>
> *"I've got six months with this baby, with no support because everything is shut down." (Rowena, 935)*
>
> *"That sort of 'mother and baby' (side), being able to go out and talk to people, that social side wasn't there." (Alexandra, 160; 362)*

Isolation has many guises and these participants struggled with the lack of practical and social support, which could have enabled them in their roles as mothers. I interpreted this as

'external isolation', when cut off from support and interaction with others. Alexandra talks about being isolated due to her rural location: "*We're quite isolated up here, I haven't got family up here, so it's quite a lot to deal with on our own." (Alexandra, 160* and Hannah echoes this with: *"It was very much like kind of us on our own kind of working this out." (Hannah, 259).* Both Alexandra and Hannah express being isolated, however, both mention '*on <u>our</u> own';* notwithstanding their isolation, they depict the presence of another, their partner, who appears together with them and a part of their experience. These experiences of isolation, in this context, with these particular participants feel different from Sarah's experience of enforced isolation, which reflects her loss and regret:

> *"All my friends and family were missing out on us being pregnant (cries); I just missed out on so much and it's like we've worked so hard to like get to this stage, we're actually able to have a child, and it was like taken away." (Sarah, 201)*

Sarah's extract reveals the complexity of her experience, adding nuance to the construct of isolation and disconnection; her extract highlights the consequences she experienced and the depict the layers of her experience of isolation. Sarah and her partner had '*worked hard'* through the challenges of IVF (context), to conceive and carry a baby, which they could not share with others due to her enforced isolation. Moreover, she *(I) 'missed out on so much*' and while she does not expand further, I imagine how she could have faced each heteronormative challenge face-on, only to have the 'results' hidden at home, hence the opportunity was '*taken away'.*

***Group Experiential Theme 2: Connections lost and sought: Reaching out for connection***

This GET presents the theme of 'connections to' others, sought by many participants' when they needed support. When most participants were in the throes of anxiety, they sought connection and comfort in relationships with others. These relationships were able to provide reassurance and regulation, a port in a storm, and a feeling of connection, which facilitated a reduction in participants' anxiety.

Izzy makes sense of the reassurance she receives from her supportive husband; she describes the 'components' of his reassuring support in the extract:

> "*He really knows what I'm like; he has that understanding, just sort of listening to me, he is brilliant to listen to me, he'll listen to me and, and talk me through it, which I do think really really helps because he's not dismissive." (Izzy, 339)*

Reassurance to Izzy means: 'to be known, her needs understood, to be heard, calm communication and to be acknowledged, not dismissed'. These offerings from her husband provide the regulating reassurance she needs – they *"really, really help"* her. Conversely, when Rowena desperately sought and struggled to find help, she felt that her only way out of the isolation and desperation would be to end her life:

> *"I was ringing Samaritans, ringing my midwife, ringing the doctors, in the end I couldn't cope. I just I couldn't see a way out and I thought the only way I would be able to do this is if I took my own life. (Rowena, 253)*

Rowena sought support from various professionals without success; her desperation is reflected in the pace of her words, as she leapt from one call to the next, growing increasingly distressed until she contemplated suicide. Rowena later built a "*good relationship*" with her midwives, whom she found to be *"very open, and I found that really, really helped, they were people." (Rowena, 338).* She identifies their qualities of 'openness'

and ‘realness’, which she found helpful – she could establish a relationship with “*real people”*, unlike Arabella, who cut off her therapist because she felt that she “*wanted a lot from me” (Arabella, 72),* and other professionals: *“that's them cut off”,* possibly because relationships carry the risk of judgement: “*I feel anxious about feeling judged (Arabella,346).* Arabella, below, diverged from other participants, in that she found comfort and solace in cutting off from most people and heading back to her island of birth, her “safe place”:

> “*In the end what was helpful, was I went back to the island that I grew up on, and just cut off from everything else and that helped me, it’s my safe place I just felt at peace.” (Arabella, 75)*

When Sarah received safe and respectful care from her midwives, she surprised herself at her attachment to them, and “*didn't want to leave the midwives”,* which she found “*weird*”. *(Sarah, 605).* Hannah’s extract below presents a divergence in that she found support in an online community who shared her experience and understood anxiety and notably, understood ‘shame’, which possibly felt less exposing to share online: *“An online community of people who shared the same experience has really helped, like if you are feeling shame or feeling worried, I guess someone who understands what those things are.” (Hannah, 452)*.

In the pandemic, most participants lost connection to significant others for at least some time, and this theme reflects how supportive relationships can provide regulating reassurance and comfort.

***Group Experiential Theme 3: Under-resourced in first-time motherhood***

*The cupboard is bare*

A societal narrative exists around an innate 'mother's instinct', which supposedly enables mothers to navigate their way through some of the demands of motherhood. Some mothers, out in the wider world, do experience varying manifestations of this 'guiding instinct' and while most participants in this group did not express feeling devoid of instinct, they sometimes found that 'instinct is not enough'. Motherhood requires more than instinct, it behoves mothers to be resourced in multiple ways, practically, physically, and emotionally. This GET reveals the challenges some first-time-mother participants experienced when trying to cope alone, under-resourced and in a pandemic.

Participants described their experiences of being first-time mothers in a pandemic; most participants doubted themselves and their ability to cope with the challenges they faced. Hannah's extract below illustrates the challenge of 'finding her mother's instinct', which was subsumed by anxiety, and without which she struggled to parent":

> *"I found it really hard to find my instinct as a mum, and to find what was the right thing for my baby, because, you know, of my anxiety, and because of all this information I was getting that was telling me: 'No, you have to do things this way'. (Hannah, 526)*

Hannah struggled to access her innate resources, buried under her anxiety, which caused her to doubt her ability to parent, and to decipher information on 'how' to parent. Hannah's last sentence sounds like an admonishment to herself, as though she is failing at being a parent, letting her baby down, and failing to follow instructions on how to parent – to "*do things this way".* There is an apparent differentiation between her innate understanding of "*what was the right thing for my baby",* that is, her internal resources and knowledge, and those she perceives as external, expert directives: "*No, you have to do things this way".* In

both respects she is struggling "*because, you know, of my anxiety".* This begs the question in my researcher's mind: Is Hannah struggling to access innate and external knowledge because of her existing anxiety, or is her anxiety, in this context, a result of feeling under resourced and therefore, 'incompetent'? Would Hannah feel less anxious if she felt equipped and resourced?

My interpretation is that the pandemic cut off avenues of support that might have resourced Hannah, and other participants, with knowledge, skills, and support. Devoid of these external opportunities due to the pandemic, some participants tried to access their internal coping 'resources' and found their 'cupboards bare'; I suggest that their pre-existing sense of self could be one of 'lacking internal resources to cope', in other words, a cupboard that was already bare. As a result, I interpreted that for these participants, in the context of a pandemic, cut off from support, *and* lacking internal coping resources, their anxiety escalated.

Rowena, below, doubted her ability to cope to the extent that she felt innately flawed, she felt that there was "*something wrong"* with her: "*What's the matter with me', that was my initial thought, 'what is the matter with me, there's something wrong with me'. (Rowena, 751).* Rowena's anxiety was compounded by her self-doubt, that arose from feeling ill-equipped to take care of her baby on her own, which I have interpreted as being 'under resourced':

> "*I was in the house alone, 'oh my God, I'm in the house on me own, something's gonna go wrong, she's gonna stop breathing what, what would I do?'." (Rowena, 602)*

This theme of being 'under-resourced', which, I suggest engenders a sense of being unable to cope, and which exacerbates anxiety, is echoed in Izzy's extract:

> "*I felt that I couldn't do this, I couldn't cope, and that I might miss something really important, and he might be at risk in some way; there were days that I felt like I couldn't do it, that it wasn't going to get better, and that I was failing as a mom." (Izzy, 508)*

I note the escalating pace of panic in both extracts above, "*Oh my God… on me own... go wrong… stop breathing… what would I do?" (Rowena)* and "*I couldn't cope… I might miss something… I couldn't do it… I was failing as a mom" (Izzy).* Both participants experience increasing panic, arising from their inability to cope, exposing their underlying fear, which I suggest, is a fear of not being able to take care of their baby. Feeling under-resourced and unable to cope has a consequence for Alexandra; she became housebound as a result, thereby compounding her isolation and possibly reinforcing her sense of incompetence:

> *"Being so worried that I could not leave the house, wondering how I'd manage; if he gets really upset or is gonna be distressed, how I'd cope away from the house." (Alexandra, 67, 238)*

Pre-pandemic, new mothers would have had opportunities for face-to-face support from friends, family, and services; however, the pandemic cut off these avenues, leaving many parents to struggle alone, in isolation, as Rowena outlines: "*There's no sort of check-ups, so I've got six months now, with this baby with, with no sort of support. (Rowena, 763).* Not only is Rowena referring to the loss of regular health visitor check-ups for baby, but she has also been left without 'being checked on', and like Alexandra, *she* was left without support. Being 'under resourced' as new mothers, led many participants to feel and believe that they were 'unable' to cope or to take care of their baby; a self-belief which appeared to reinforce 'not coping' and which, I suggest, exacerbated their anxiety. Isolation and dis-connection from supportive others, including services, compounded their struggles, and for some mothers, it impacted bonding with their baby:

> *“I was trying to breastfeed, and that wasn't smooth sailing. I instantly felt this kind of like disconnect with him. I was having panic attacks and getting myself into such a state and I think that impacted the bond because I had this genuine belief that ‘I can't take care of you and I can't look after you, the way I need to’.” (Izzy, 454)*

Izzy’s anxiety - ‘*panic attacks’* - around struggling to breastfeed and being unable to ‘*take care of’* and *‘look after’* her baby led to feeling disconnected from her baby, as though the maternal bond was subsumed by her anxiety. It appears that her struggle, which she euphemistically describes as not ‘plain sailing’, could be interpreted as her being under-resourced to breastfeed; she lacked the support to enable her to do so, which in turn, raised her anxiety around being unable to take care of her baby, and which possibly led to a ‘disconnect’ from baby. Izzy identified the foundation to her anxiety: *“I felt that I couldn't do this, I couldn't cope…and he might be at risk.” (Izzy, 139)*. Izzy feared that her inability to cope, which I suggest reflects being under-resourced to cope, would put her baby at risk. Stating that she “*couldn't cope”,* Izzy identified a deficit in her resources. Being under-resourced is a thread that runs through this theme and which I have interpreted as a contributing factor in most participants’ perinatal anxiety experience. Alexandra succinctly supports my interpretation when she identifies her experience as:

> “*I didn't have reserves to fall back on. (Support would have meant) I would have had more resources to fall back on. (Alexandra, 144)*

***Group Experiential Theme 4: Anxiety Temporal and mercurial***

*Anxiety bound to the past and shifting foci*

All participants shared the phenomenon of pre-existing anxiety, prior to their experience of perinatal anxiety. I was curious about how participants made sense of their previous anxiety, in the context of their perinatal anxiety experiences, and I wondered how, if at all, the nature of their perinatal anxiety diverged and converged from previous experience.

This GET illuminated how all participants were somehow bound to their past anxiety; for some, it lay dormant or bubbling under the surface, before appearing in another guise, with a different focus, during the perinatal period; whereas, for others, their perinatal anxiety seemed to transition seamlessly, from previous to perinatal, adopting a similar focus (health), just in a different timeframe; for others, they had lived with anxiety long enough to see it as part of their identity, with an expectation that they would experience anxiety in the perinatal period.

**Sub-theme 4.1: Perinatal anxiety bound to past anxiety**

This sub-theme reflects how some participants are bound to their previous anxiety, either by seeing anxiety as part of their identity, and as a result, might have felt pre-determined to experience anxiety in this context, or, for some, it appeared that their anxiety never went away, but lay under the surface, or appeared 'expectedly' in this timeframe.
Alexandra was "*kind of expecting to have a little bit of anxiety…but it was a lot." (Alexandra, 68),* which seemed to surprise her in its divergence from previous experience; while Arabella recognised that she was "*teetering on the edge" (Arabella, 164), "making me think that it could still be bubbling underneath" (Arabella, 205).*

Izzy, who has "*always had anxiety"* (Izzy, 68) reflects on how she sees herself as an anxious person, primed to respond with anxiety:

> *"Me being me, the next day it turned into worry, there was nothing else to it and then I didn't dare think, 'oh, you might have to have a baby'." (Izzy, 52)*

"Me being me' could be understood as Izzy identifying herself as an anxious person; there is a modicum of acceptance of this notion, which is further validated by her resigned use of '*there was nothing else to it',* as if nothing could be done, or indeed expected of herself; as if

either way, she would have been anxious on discovering she was pregnant. The possible explanation for this could be found in her fear of something going wrong with her pregnancy, hence 'not daring to think about it'; the prospect of loss could be too great to give way to joy and excitement, further evidenced when she later says: "*There was also this kind of looming 'mmm I'm not sure if it's gonna work or not'." (Izzy, 72)*

For Rowena, below, it appears that she identifies herself as part of a group or collective of people who experience anxiety similarly: "*People who suffer with anxiety you cling on, and your anxiety program will cling on to negatives..." (Rowena, 774)*, suggesting that her pre-existing anxiety has pre-programmed her to assess risk: *"…so 'risk' you're clinging on to 'right that's it, now I'm going to die'. (Rowena, 774).* Her use of 'people, you and your' suggest a need for Rowena to distance herself from her anxiety, as though she has been programmed to think and behave in a certain way, as others in this 'group' do. She shifts pronoun when she reveals her terror, which is so great that she fears dying: "*I'm going to die".*

I returned to Rowena's transcript to explore more deeply her feelings around 'having anxiety' because I curiously wondered whether she felt a sense of stigma or shame in this regard. This 'deep dive' elicited a *gem* (Smith, 2011), which I interpreted as Rowena's concern about being seen or identified by others, as suffering with anxiety:

> About her pre-existing anxiety: *"You know I wasn't like 'oh I've got anxiety', I never gave myself* ***that tag****, you know, I get anxious sometimes, you know, so it's not seen as like a mental illness, or anything." (Rowena, 104)*

I wish to draw attention to my use of the word *gem, used above,* which was conceptualised in Smith, Flowers, and Larkin (2009) and further defined by Smith (2011) as a 'relatively rare utterance that is especially resonant and which offers potent analytic leverage' (Smith, 2011, p 6) and insight to a participant's experience, and in turn, to the study. Sometimes, when a participant gives an account of their experience, or later, upon reading a transcript, a researcher can be struck by a comment, or even a word, perhaps an 'utterance' that resonates or causes one to mentally or viscerally 'stop, feel, note' the moment. In Rowena's account above, her use of '*that tag'* struck me; on one hand, it seemed to have an idiographic significance to *her* particular experience, she identified herself as 'anxious-but-not-mentally-unwell'. Rowena did not give herself '*that tag'*, an identifier which could signify a 'mental illness' to others, and which carries risk of stigma. I am not suggesting that I hold the view that Rowena does have a 'mental illness', not at all, I am interpreting her words to illustrate her fear of stigma. On the other hand, the significance of her perception of 'being tagged with a mental illness, as a mother, has implications for women's health; Rowena's fear reflects a wider issue for mothers, who might be concerned about revealing their mental health struggles out of fear of having their children removed if they are considered a 'risk'. Thus, I interpreted that her utterance had both an idiographic significance, and a wider hermeneutic significance, as I circled back to the wider 'whole' from the 'part' of her experience. Smith (2011) refers to this hermeneutic circling as the whole helping the part and the part helping the whole. This is the gem, which adds value to the analysis as a whole (Smith, 2011). This is the excitement of discovery and uncovering meaning within the analytic process. In terms of its analytic value, the *suggestive gem* (Smith, 2011) in this case, referred to the phenomenon of perinatal anxiety, and to the potentially hidden, underlying fear of a mother being identified, or 'tagged' with a mental illness – thereby exposing the fear and risk of being considered an unsafe mother and having one's child removed by services. This was evidenced in more than one participant's experience.

I was curious about the temporality of previous anxiety, now bound to anxiety in the perinatal period; Izzy expressed that: "*Anxiety entrenched the whole of my life, and it's never really gone away, it's a bit like a parasite that it's trying to find the next thing to jump on and latch on to (Izzy, 259, 270),* while Hannah reflects on her past anxiety differing from current anxiety: "*In the past it was much more fear for myself, now I think it was much more of a focus on him, and the fear on what could happen to him. (Hannah, 198);* Sarah's anxiety has built up like layers of sediment over the years: *"I've had anxiety since I was about seven; it has lots of different layers, like a lot of it's to do with my sexuality and things I don't have control of." (Sarah 79).* Arabella's previous anxiety: *"tended to be about health, and again, it seems to be to do with her (baby's) health." (Arabella, 164).*

Alexandra identifies her felt sense of difference between previous '*worries'* and her perinatal anxiety, which feels '*real'* to her: *"Previously I had what felt like worries, but these felt really kind of real.",* which I have interpreted as a possible shift in significance, from general worries to concerns around baby. I purposefully linked these extracts together to reflect a linking thread of temporality, which, for all participants exists between their past and present experiences.

A deeper reflection of temporality begs the question: what does this mean for participants with a history of anxiety? Alexandra identified a phenomenon which appeared in GET 3, and which I have interpreted as follows: pre-existing anxiety could reflect a history of being under resourced, or lacking internal coping resources, which potentially predisposes some women to perinatal anxiety. Alexandra expresses it as: *I got a feeling I would always be anxious; I think because of having felt that before; I wasn't starting from a good base. (Alexandra, 158)*

**Sub-theme 4.2: Anxiety shifts foci across perinatal period**

This sub-theme reflects a shift in analysis, towards the internal and lived experience of perinatal anxiety, moving slightly away from 'external and cognitive' features of the phenomenon. In this sub-theme all participants shared a lived experience of their anxiety shifting focus, from concern to another.

Arabella, Izzy, and Rowena all identify a starting point and a particular focus to their anxiety, after which it shifts focus, dancing between mother and baby. Arabella's anxiety began early, around six weeks pregnant and moved '*like a conveyer belt'*, implying a non-stop pace, moving from one thing, until '*a new anxiety would pop up'.* I suggest that Arabella experienced a lack of control to this conveyer belt experience, unable to get off, as it moved along at a pace, from one concern to another.

> *"It started off when I was maybe like six weeks or so pregnant, it was like a conveyor belt. One particular thing, I would fixate on, and I feel really anxious about and then we'd get to a point where it would be resolved, but then a new anxiety would pop up." (Arabella, 95)*

Similarly, Izzy's anxiety went off like a Catharine Wheel, darting round to different areas and focus of concern; furthermore, I note a sense of exhaustion in Izzy, as she describes being a new mother and experiencing relentless anxiety, "*one thing after another".*

> *"It just instantly went off and moved on to different things, different areas, and worries. As the pregnancy progressed, it became… 'is this normal, is this not, 'is there going to be something wrong with the baby', then reduced movements, and towards the very end of the pregnancy, it then became more about the birth. It's felt like one thing after another since he's been born." (Izzy, 112, 157)*

Izzy's pace of speech is quick and darting: '*it became'; 'then because'; 'and towards';* '*then became',* reflecting her anxiously-shifting attention from one concern to another. Rowena's extracts below couch her hypervigilance to signs in the environment and in her body, which she interprets as cause for concern. She began to take notice of omen-like magpies in her garden, which she interpreted as holding significance for her pregnancy (context); later, she focused her attention on her bodily sensations, interpreting these as indicators of ill-health or impending doom. Rowena became finely attuned to "*any sort of sensation",* as a means of visceral communication, alerting her to potential danger:

> *"I started becoming obsessed with magpies, one for solitude, two for joy. …I started to worry about my health, then baby's health. (Rowena,138, 430). I became obsessed with sort of any sort of sensation: I'm going to die or the baby's going to die." (Rowena, 339)*

Physiological sensations took on a threat-alarm significance for Rowena; she experienced alarming blood pressure results in hospital, which validated her vigilance to her body's signals, which she interpreted as warning signs of danger, thereby exacerbating her anxiety, and eventually, impacting her labour:

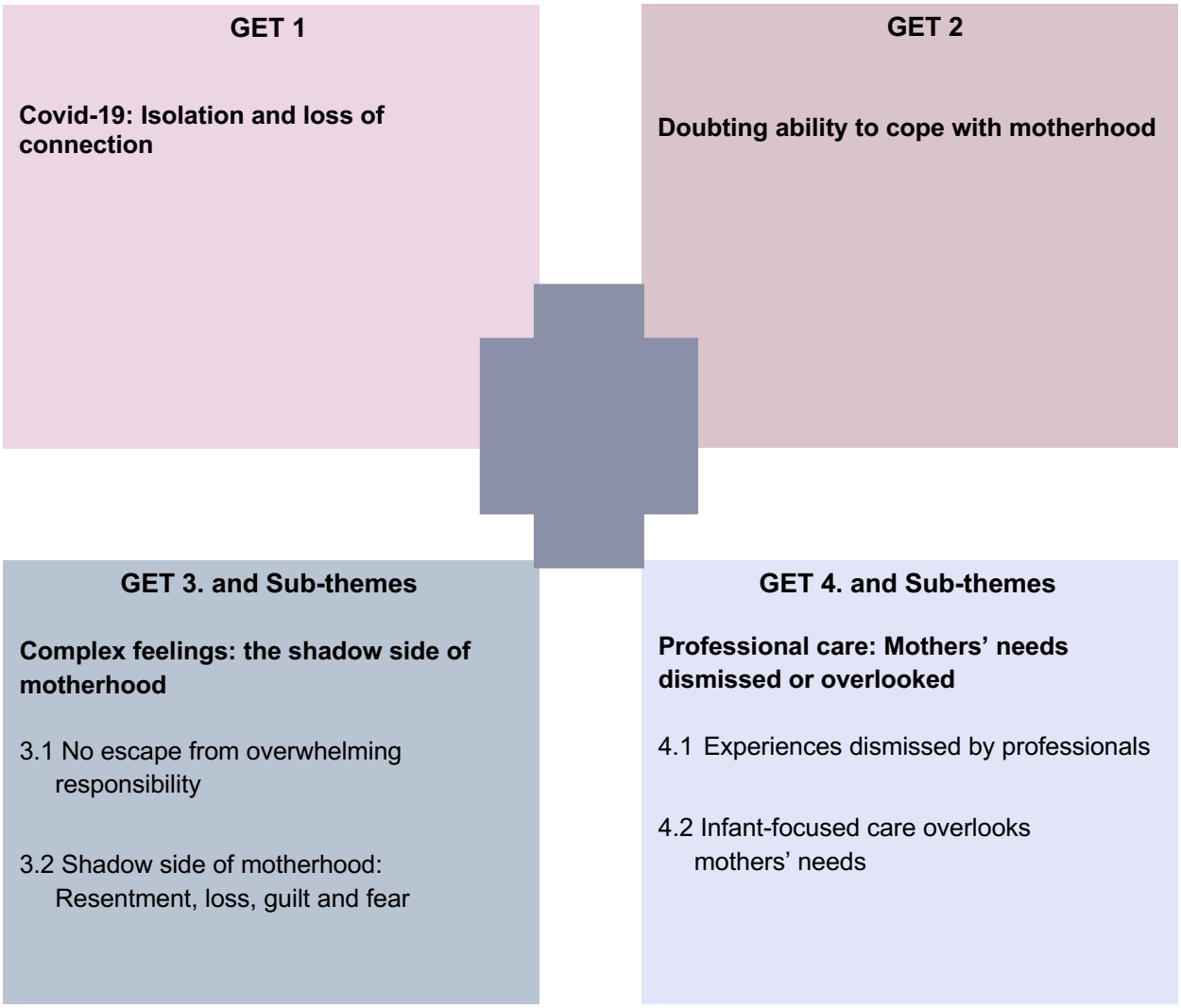
> *"My heart rate was through the roof, my blood pressure diastolic and systolic were both in the hundreds, because I was anxious.* I *was so anxious that my body was going no, you are not ready, it's not safe to give birth; if your body doesn't feel that it's safe it won't go into labour." (Rowena, 133)*

With equal import, Rowena paid acute attention to words, attributing meaning to words that induced threat or vulnerability in her: "*We were both at high risk, I got told 'you're vulnerable', these key words. (Rowena, 161).* I include Rowena's experiences of her physiological sensations and attention to language, to illustrate how this participant focused their attention on different areas, in attempt to gain feedback from their body or environment, in their assessment of threat:

> "*People with anxiety words mean a lot; if you say 'risk', you cling on to that word risk. Words will play on your mind again and again and again; 'vulnerable' is a negative word; 'that's it, I'm vulnerable, I'm going to die', whereas, with 'chance', it sails away." (Rowena, 225).*

Rowena's words convey a desperation, reflected in her 'clinging on' as she scans her environment for signs of danger, in her assessment of risk. Her anxiety and continuous assessment feel relentless and desperate as her words play on her mind "*again and again and again".* Rowena's metaphor about the word chance 'sailing away' created a mental image of her shipwrecked, clinging to word-flotsam.

**Figure 9. GROUP 2. GROUP EXPERIENTIAL THEMES (GETs)**



## Analysis Group 2: No pre-existing history of anxiety

### Group Experiential Themes and Sub-themes

The four GETS identified in Group 2 are: Covid-19: Isolation and loss of connection; Doubting ability to cope with motherhood; Complex feelings: the shadow side of motherhood and Professional care: Mothers' needs dismissed or overlooked.

The pandemic provided the context to Group 2 participants' experiences, as it had for Group 1; however, I noted a difference between the response to Covid-19 amongst Group 2 participants, from Group 1 responses. Group 2 largely responded to pandemic-enforced loss of contact with others as lost opportunities to share their perinatal experiences and to gain knowledge and support from others. Most participants experienced anxiety around being under-resourced, but unlike Group 1, whose participants experienced being under-resourced as a deficit of emotion regulation resources, being under-resourced, for most Group 2 participants, signified a deficit in parental skills, ability, and know-how; the pandemic prevented the external acquisition of these coping resources by cutting off connection to avenues of support. Therefore, I interpreted, that unlike Group 1, who made sense of their anxieties as derived from a depletion of emotion regulation resources, Group 2 made sense of their anxieties arising from a lack of externally acquired skills.

***Group Experiential Theme 1: Covid-19: Isolation and loss of connection***

This group theme evolved from experiences of pandemic-enforced isolation and geographical rural isolation; both these phenomena left some mothers disconnected from their families, friends, and communities. While most participants converged in experiencing isolation 'negatively', a divergence appeared in two participants' experiences, who experienced positive benefits to Covid-19 lockdown.

Some participants felt cut off from their family and friends during Covid-19 lockdown, which exacerbated their anxiety; being disconnected from her community exacerbated Milly's fears around stillbirth:

> *"I think it was exacerbated by lockdown; I couldn't see my friends and family to have that kind of community around me, it was just me at home with my thoughts all the time. (Milly, 122)*

Milly's anxiety had a specific focus, she feared her baby being stillborn (context); I interpreted that cut off from the presence and distraction of her community '*around her', Milly* possibly felt unprotected; their absence created a vacuum, which was filled by frightening (stillbirth) "*thoughts all the time".* Milly experienced the void of both mental and physical isolation. Eliza's anxiety was also compounded by Covid-19 isolation: *"The isolation really compounded it; I was a complete sitting duck for anxiety." (Eliza, 189).* Contextually, Eliza felt unsupported by medical professionals who dismissed her severe 'morning sickness' (hyperemesis gravidarum); I suggest that she might have felt abandoned by them. Being alone at home, suffering with her condition, compounded her sense of 'isolation' and vulnerability, like a "*sitting duck".* Both Milly and Eliza's anxiety filled the void of isolation created by the lack of others' presence or support.

Tabitha struggled being alone in a rural location, which, on the surface, exposes her fear of coping alone with baby: *"Here on my own, in a rural location, and I'm just really concerned*

*what if she chokes, and I'm here on my own." (Tabitha,79)*. Tabitha situates her isolation to her geographical location; she repeats "*here on my own",* and she makes sense of this from a concern that she might not be able to provide emergency care to her baby "*if she chokes";* while I do accept her reasoning at face-value, my analytic curiosity challenges this. I have further interpreted her use of repetition to suggest that she feels 'left here on her own' – perhaps lonely or abandoned, without support. I sense a deeper 'isolation' and loneliness in her extract. One participant's isolation reflected an absence of a bond with her baby:

> *"You are sort of just like left in a room with them and you like…you love em, but it's not what everyone tells you, it's not like the dream is it? (Geena, 191)*

Geena poignantly describes that being "*left in a room with them"* – that is, *left* alone with baby, without support, left *her* feeling isolated and struggling to bond with baby. Each of these participants' experiences reflect an external and internal sense of isolation, and their experiences are connected by a theme of 'being left alone by others' – here isolation feels existential, as though the self is under threat, and unable to survive, when disconnected from others. Geena's experience revealed a maternal bond under threat from a loss of connection; she lost connection to others, 'left alone *in a room'* and to her baby *"but it's not what everyone tells you",* which resulted in: "*I struggled to bond with her" (Geena, 197).*

A divergence occurred in this theme; two participants experienced positive benefits to Covid-19 isolation: "*We have bonded really well; I think that it positively had a lot to do with lockdown and spending quite a lot of time on our own together." (Tabitha,219)* and "*It's (Covid-19) been a bit of a blessing in a way, that he's been there to support me." (Helena, 534).* Linked to, and perhaps underlying, this theme of isolation, is the theme of 'fearing and doubting coping with motherhood', which I present in GET 2.

***Group Experiential Theme 2: Doubting ability to cope with motherhood***

The above theme reflects both external and internal isolation; as though internal isolation emanates from the void created by external isolation; participants' made sense of their experiences of being alone and being 'left' alone by others; in turn, as I considered participant's experiences, I too made sense of their experiences. In this *double hermeneutic* interpretative process, I have tried to understand the convergence of meaning of isolation: the theme that evolved from this is 'doubting one's ability to cope with motherhood'. When left alone with their baby, many mothers appeared to doubt how they would cope or what to do; they lacked 'know-how', which raised their anxiety further.

In this sub-theme I have made sense of how participants might feel overwhelmed and doubt their ability to cope as new mothers, which, I interpret, contributes to anxiety:

> *"Can I cope, I don't know what to do', and then my worrying came in again. I just didn't know what to do." (Geena, 208, 311)*

Geena, above, sounds as if she has come up for air, to catch her breath, before her "*worrying came in again"* and 'drowned' her in anxiety. Her helplessness is emphasised in: "*I just didn't know what to do";* here Geena simultaneously exposes and expresses her sense-making around being unable to cope, she appears to not have the knowledge or skills to cope, which could lend validity to feeling unable to cope. Indeed, feeling under-resourced, unable to cope, compounded her struggle to bond with baby: "*I struggled to bond with her, it took me a long time; it was like 'can I cope', I don't know what to do." (Geena, 191).* Geena links her struggle to bond with the words: "*it was like",* in other words, 'because' she didn't know what to do, she felt unable to cope; she questions her own ability: *'can I cope'* reasoning with*: "I don't know what to do".* Furthermore, I suggest that Helena, below, affirms my interpretation that being under-resourced could be complicit in some participants doubting their ability to cope; being under-resourced can be undermining:

> *“I just didn't know what to do with him’, ‘how am I going to cope with this?’ I still get very worried about my ability to cope. Am I doing the right thing, am I competent? How, how am I going to cope with it? I haven't got the capability to do all of these things. How am I possibly going to cope with this?” (Helena, 260, 383, 556)*

‘Overwhelm’ is the strong feeling I sensed within the above extract; Helena appears to be on a desperate search for her ‘ability to cope’, as though she is opening every drawer and finding no helpful resources inside; the desperation I note is contained in her pace and her self-doubt is contained in her self-directed questions, which include asking ‘how’. The extract ends with an almost resigned desperation: “*How am I possibly going to cope with this?”.* Tabitha experiences similar anxiety, questioning her ability to cope; moreover, her anxiety is exacerbated by her interpretation of external measures (developmental milestones). Tabitha interprets these as a tool which measure her ‘ability to cope, to be a good mother whose baby meets milestones’; the implication being: if baby does not meet milestones, it’s due to her lack of ability and failure as a mother’:

> *“I worry about my ability with baby; thinking ‘oh God, is my baby doing this’, or you know, behind their milestones.” (Tabitha, 389)*

I reflected on how mothers are meant to know what to do. Being cut off from family, friends, community, and services in the pandemic would have limited support in this regard and, I suggest, reflected in this theme, there is a wider question around how we, as a society, resource our mothers to cope.

***Group Experiential Theme 3: Complex feelings: the shadow side of motherhood***

I have used the word 'shadow' in the title of this theme, which stems from my understanding of Jung's 'shadow' (Jung, 1983), representing the darker side to our psyche, a side typically hidden, due to its shame-inducing potential. Motherhood is laden with many societal narratives and expectations, many of which assume joy and 'light', as opposed to the struggles, or 'shadow side' of motherhood. Babies can be utter joy - *and* they cry, keep mothers awake, poop and vomit; they also require physical proximity 24/7; most participants, struggled with these aspects to motherhood and with the potential stigma of naming these struggles out loud, hence the 'shadow side'. In identifying this theme, I am acutely aware of my potential to shame participants reading this work, which is certainly not my intention; I aim to reflect their lived experiences, in all its rawness, with the intention of facilitating understanding.

**Sub-theme 3.1: No escape from overwhelming responsibility**

Some participants felt trapped by a sense of inescapable responsibility, and an expectation to 'get it right': "*A massive responsibility, I wanted to make sure I was doing it all right". (Geena, 246). "Doing it all right"* – I wondered what this meant for Geena and where the notion of 'right' had come from; Tabitha echoed Geena's perception of an external yardstick to being a 'good mother':

> *"Overwhelming anxiety-inducing: I always want to get everything perfect…thinking that I wouldn't be good enough, that I wasn't going to be able to be a good mom. Everybody else's baby is sitting up, it's a comparison thing." (Tabitha, 83, 455, 242)*

Tabitha's extract above reflects both an internal self-measure: "*Thinking that I wouldn't be good enough; be able to..."* and an external comparative measure: "*Everybody else's baby, a comparison thing".* Both Geena and Tabitha express an anxiety-inducing burden of responsibility which carries an expectation of doing motherhood *'right' 'good'* and *'perfect'.*

Helena's extract reflects her sense of inescapable responsibility from which there is no return:

> *"The reality of it hits you; this is forever, you can't just kind of hand them off, and it's not a nine to five job, it's every day, all day. The reality of 'motherhood' became more towards the forefront of my concerns of 'actually this is going to be my all day, every day." (Helena, 70)*

Helena's extract reflects an initial sense of overwhelm at the 'forever' aspect to being a mother; the gravity of which 'hit her', taking her by surprise. I note the pronoun *"you",* as though momentarily dissociating from the shame-inducing notion of wanting to "*hand them off*". The reality of "motherhood" is going to be her *"all day, every day".* I sensed that these experiences might be difficult to express, out of fear of being judged, which I imagine could be shame-inducing, and potentially best 'kept hidden'.

**Sub-theme 3.2: Shadow side of motherhood: Resentment, loss, guilt, and fear**

I present this theme with the preface that these are my interpretations of some participants struggles with aspects of motherhood, which they revealed to me; in no way am I judging participants' experiences. I suggest that my need to state this is twofold, out of regard for participants who shared their experiences, which occurred at a particular time in their life, in a particular context; they might feel differently now, and because I believe that we are never far from social constructs around motherhood, which can foist shame and judgement on mothers, which is not my intention.

I begin this theme with loss - of career and identity: "*My first thoughts were 'work; I can't go to work anymore', I've lost myself. Totally. (Geena, 36, 497).* Geena had worked hard to achieve career goals and her unexpected pregnancy meant an immediate halt to her career due to the nature of her job. Not only did she temporarily 'lose' her job, but she also "*Lost myself. Totally".* Total loss was marked by an end of the previous sentence, and the lone-standing word: 'Totally', depicting her total loss of self, due to losing her career. Conversely,

Tabitha emphasised having ‘given up’ a side of herself, her identity, which she lost in the matrix of motherhood when she gave up her career:

> *“I gave up my career, which was my own choice; I **gave up** that side of me. I worried a lot about my identity changing. I had carved a new identity which I enjoyed. That seems a lifetime ago from where I am now, within an insular community that does not talk about culture, politics, and current affairs.” (Tabitha,146, 623)*

Tabitha’s extract depicts the dichotomies and challenges to becoming a mother who must set aside or leave a career behind. There is a temporal note to her experience, a then and now, and for Tabitha, a potential threat to her identity: ‘Then’ was a *“lifetime ago”,* when she could engage in stimulating conversation, tapped into world affairs and the current zeitgeist, whereas ‘now’ she exists in “*an insular community”* which feels barren of such stimulation. The challenges of motherhood can induce strong feelings, which can be a risk to acknowledge; Eliza, below, feared being considered a risk to her child and ‘sectioned’ if she had disclosed her struggles: “*I think if I had disclosed the truth, I would have been whisked off and put in a mental health place and would have been high risk. (Eliza, 274.)* Geena shared how her resentment built up, inducing anger in her, which transmuted to guilt, which I suggest is a result of the shame she might feel around ‘anger-towards-baby’:

> *“Bubbles over to like frustration and anger, I feel like I resent her sometimes, then I feel bad for that. I feel like I shouldn't feel like that.” (Geena, 397)*

Anger is an emotion that is not socially tolerated from mothers towards their babies, hence its potential to induce shame and guilt, as Geena confirmed: “*I shouldn't feel like that”,* which could be reflecting her awareness of social sanctions to such feelings.

***Group Experiential Theme 4: Professional care: Mothers' needs overlooked***

This group theme reflects participants' help-seeking experiences; most participants experienced being dismissed by professionals whom they felt disregarded or minimised their particular condition or their anxiety; furthermore, some participants experienced perinatal care as 'infant-focused care', which tended to overlook mothers' needs, by prioritising babies' needs.

**Sub-theme 4.1: Experiences dismissed by professionals**

Eliza's experience exemplifies this theme: "*women are dismissed a lot and have to ask for help to get it." (Eliza, 708).* Her overall experience, seeking help for hyperemesis gravidarum (sickness), was one of being dismissed:

> *"I immediately felt dismissed, a bit by my GP, then by the hospital staff. I tried to ask for help, to advocate for myself. Dismissed." (Eliza, 114).*

Eliza is an eloquent, capable woman who was unable to advocate for herself in the context of a system that did not fully understand her specific condition and needs. Similarly, Milly experienced being dismissed by professionals who did not fully appreciate the debilitating nature of perinatal anxiety: "*The midwife was dismissive, the GP said: 'This is quite irrational, how you're feeling'. Everyone knows about postnatal depression, but you know people don't know about perinatal anxiety (Milly, 148.).* Helena, below, also encountered a lack of understanding about perinatal anxiety amongst healthcare professionals; she described being forced to desperation before her anxiety was 'taken seriously':

> *"I tried to get help earlier on, and they brushed it. Nothing got done until I got to the point where I thought about throwing him down the stairs. I was literally at crisis point. That's the point at which it became big enough for anyone to take seriously. (Helena, 574).*

Helena reflects on how professionals "*brushed it*"; they 'brushed it under the carpet', that is, they ignored her and failed to respond to her initial request for help until she became so distressed that her child was at risk, and she was at 'crisis point' – before 'taken seriously'. A divergence in this theme is identified in Milly and Helena's experiences of support: "S*he really validated, why I was scared, and that I wasn't being irrational." (Milly, 109).* Having her experience validated by her counsellor was healing for Milly, who lamented it not happening sooner: "*If that would happen sooner…" (Milly, 136)*. Helena had felt at crisis point, a risk to her child and to herself: "*I genuinely was considering going out and like running in front of a car." (Helena, 574);* In Helena's extract below, she poignantly makes sense of receiving help that alleviated her distress:

> *"Someone to say, 'I'm here, and it's not all on you. Someone being like 'you are safe, you're both safe; sometimes that's all I really need is for someone just to remind me that we're okay." Helena, 477).*

My analysis of this theme is that the gravity of perinatal anxiety does not appear to be fully appreciated within the healthcare system, and that some women struggle to advocate for themselves, in expressing their distress, to secure appropriate support; indeed, for many participants their experiences were dismissed.

**Sub-theme 4.2: Infant-focused care overlooks mothers' needs**

Geena and Eliza have identified a theme of interest; It appears that along the perinatal pathway, some women can experience a phenomenon of being treated as 'the baby's vessel', which can make them feel secondary to the developing baby. I highlight this theme, despite it only appearing in two participant's experiences, because it stood out as a phenomenon that could easily occur, but might easily be overlooked, as Geena experienced:

> "*You get a lot of support for your baby, it's all about baby but no one really checks on the mum, do they?" (Geena, 427).*

Eliza's extract below depicts a sense of feeling abandoned within a system that places more focus on babies than mother; moreover, 'never' being asked how she was doing exemplifies the notion of being overlooked and treated as the 'vessel' within the perinatal pathway. Eliza appears to find it hard to identify that she felt "*insignificant and unimportant",* evidenced in her change of pronoun, from 'I' to 'you', thereby distancing herself 'a little bit' from the possible conflict she might be feeling between recognising the importance of doctors ensuring that her babies are 'fine', and her feeling overlooked. Her reticence to name how she feels secondary is reflected in her use of 'possibility' verbs and diminutive words: "*you may feel maybe a little bit",* as though shyly hiding her feelings, to avoid appearing that she does not prioritise her own babies' welfare – because that would be socially unacceptable.

> *"I was never asked how I was doing. I always got the feeling that I was second priority; 'as long as the babies are fine, that was all okay', and you may feel maybe a little bit insignificant and unimportant." (Eliza, 410, 648).*

Laya' extract reflects her need to be acknowledged and cared for, because she is *also* important; indeed, she is of symbiotically mutual importance, which is affirmed here: "*I think I need to be looked after, and then the babies can kind of as a second very close priority to that." (Eliza, 149).*

Having analysed the Group Experiential Themes from Groups 1 and 2, I now present my cross-group analysis. I have focused on presenting two themes that illustrate similar lived experiences, to reveal the convergences and divergences of meaning-making between participants with a history of anxiety and those without. In doing so I attempt to link my analysis back to my research question; I suggest, the themes discussed below, could provide new insight into perinatal anxiety, as experienced by women with and without a history of anxiety.

**CROSS-GROUP ANALYSIS THEMES: Group 1 and Group 2**

| GROUP 1 | GETs | Meaning: what does this theme mean to this group? | Convergence |
|---|---|---|---|
| **GET 1** | **Covid-19: an unknown transboundary threat** | Covid-19: an external threat reflected mothers' internal vulnerability | OUT |
| **GET2** | **Connections lost and sought: Reaching out for connection** | Hospitals' Covid protocols strip women of partners' support. **Disconnected and isolated from regulating partner**<br><br>Connection provides reassurance and regulation | Converges with Group 2 but meaning differs:<br><br>**Loss of connection to partners** |
| **GET 3** | **The cupboard is bare: Under-resourced in first-time motherhood** | **Under-resourced** and coping alone increases dysregulation and anxiety<br><br>These mothers are **deplete in emotion coping / regulation skills.** | **Deplete in emotion regulation** |
| **GET 4** | **Temporal and mercurial – anxiety bound to the past and shifting foci** | Perinatal anxiety bound to past anxiety: they anticipated being anxious due to past anxiety: 'no reserves'<br>Anxiety shifts foci across trimesters | OUT |

| GROUP 2 | GETs | | |
|---|---|---|---|
| **GET 1** | **Covid-19: Isolation and loss of connection** | Disconnection and isolation from others compound anxiety. Barriers to accessing **support, parenting skills & validation.** Loss of connection to services and support. | Converges with Group 1 but meaning differs:<br><br>**Loss of connection to services & support** |
| **GET2** | **Doubting ability to cope with motherhood** | Being **under-resourced** undermines ability to cope – they **lack the skills to cope**, **not** a lack of regulation / emotion coping skills | Converges with Group 1 but meaning differs<br><br>**Lack of parenting skills** |
| **GET 3** | **Complex feelings: the shadow side of motherhood** | No escape from overwhelming responsibility<br>Loss of identity<br>Shadow side of motherhood:<br>Resentment, loss, guilt, fear, and stigma | **Divergence**<br>Valuable insight |
| **GET 4** | **Professional care: Mothers' needs dismissed or overlooked** | Experiences dismissed by professionals<br><br>Infant-focused care overlooks mothers' needs | OUT |

## Cross-Group Analysis

### Cross-Group Experiential Themes

In this study I have considered perinatal anxiety from more than one vantage point, by exploring experiences of this single phenomenon within, and then across, two small homogenous groups. In so doing, I have attempted to gain a more rounded understanding of perinatal anxiety from two perspectives: participants with a pre-existing history of anxiety, and those without a history of anxiety; both groups shared a lived experience of the single phenomenon and both groups were temporally contextualised to the Covid-19 pandemic.

I first interpreted findings within Group 1 (pre-existing history of anxiety) and then within Group 2 (no history of anxiety). I now present the two cross-group experiential themes which emerged from my cross-group analysis. I subsequently collapsed the two themes into one overarching cross-group theme, which I discuss. Figure 10 above visually illustrates the outcome to my cross-group analysis, summarised in the table. I have tried to depict the convergences of themes across the groups, with one divergent them.

### Overview of cross-group analysis

The pandemic presented an unknown threat to the world of all participants; Covid-19 represented an external threat which, I suggest, mirrored participants' sense of internal threat and vulnerability; however, Group 1 and 2 differed in their responses and meaning-making towards Covid-19. Within and across the two groups, participants converged on two themes which exacerbated or induced their anxiety: '*loss of connection to others'* and '*being under-resourced'*. It is via connection to others that most participants felt safe, reassured, resourced, and regulated, and, conversely, it is by being disconnected from others, I posit, that many participants felt unsafe, under-resourced and dysregulated.

The pandemic foisted isolation and disconnection on all participants, and in so doing, the loss of connection laid bare participants' deficit of resources, thereby compounding, or triggering anxiety around 'coping alone'. The role of mother elicits the need to 'cope, to be prepared, and resourced'. It is a privileged, relentless and at times, challenging role. Typically, participants might have been able rely on their family, friends, or professionals as sources of support. However, the pandemic transcended all boundaries, cutting off support and disconnecting people from one another, and in so doing, created an external threat which, for Group 1 participants, *with a history of anxiety*, exposed a deficit of emotional coping resources, compounded by a loss of connection to others on whom they relied for emotion regulation. My interpretation of this is grounded in participants' previous experiences of anxiety and assessment of themselves as 'deplete in reserves': "*I didn't have reserves to fall back on; I wasn't starting from a good base." (Alexandra, 144, 158).* Such experiences appear to support my interpretation that women with a pre-existing anxiety, could be predisposed to perinatal anxiety, partly because they are deplete in emotion coping 'reserves to fall back on'.

For Group 2 participants *without a history of anxiety*, pandemic-enforced loss of connection to others and to community services, and subsequent isolation, exposed their lack of parenting efficacy and ability to cope with baby. Group 2 participants made sense of their anxiety as arising from a deficit of externally acquired parenting skills and knowledge. Without parental know-how, Group 2 participants doubted their ability to cope. These are the key differentiators between the groups, and which, I suggest, illustrates both convergence and divergence in experience of a) the pandemic and b) perinatal anxiety.

In summary, my analysis revealed a convergence between the groups in the themes of *loss of connection* and *being under-resourced,* albeit the significance of these themes differed between the groups. The differences in significance, I suggest, highlights the distinction between participants with and without a history of anxiety. This leads me to question

whether perinatal anxiety can indeed be considered a specific state anxiety. I would argue that this finding suggests that perinatal anxiety, as experienced by participants *with a history of anxiety* in this study, arose from their perception of threat, being denied the support of their regulating partners, and finding themselves lacking emotional regulation resources. I therefore, wonder whether a pre-existing anxiety predisposes women to anxiety in the perinatal period stemming from a depletion or lack or emotion regulation skills, thereby maintaining their trait anxiety in this perinatal context. Conversely, mothers in this study *without a pre-existing history of anxiety* appeared to experience a state anxiety, with fears and worry content with a specific perinatal focus: childbirth, hyperemesis gravidarum, and more widely, fear of being unable to cope with a baby due to a lack of parenting skills and efficacy.

The findings from these two groups suggest that perinatal anxiety could be understood as both a trait and state anxiety, depending on the mother's pre-existing history of anxiety. This has implications for assessing and supporting women along their pregnancy and postpartum pathway.

**Cross-group analysis reasoning process**

**Group 1 participants** (history of anxiety) perceived Covid-19 as an existential threat which transcended external geographical boundaries and internal boundaries of self-and-baby, thereby inducing a sense of vulnerability. The pandemic created the context in which threat was externally and internally reflected. As a result of Covid-19-enforced isolation and protocols, participants lost connection to others; namely to supportive, regulating partners, but also to friends, families, and support services. The pandemic stripped away emotional and practical support that most Group 1 participants had relied upon, pre-pandemic. I suggest that their typical means of regulation formed part of participants' established anxiety-protocols which enabled them to cope with their pre-existing anxiety. Many participants described partners' significant roles in helping to regulate their anxiety; women

were stripped of partners' support due to hospital enforced Covid-19 protocols, and they experienced further loss of connection to others due to Covid-19-lockdowns. This loss of connection, and isolation, I suggest, exposed participants' vulnerabilities, and further heightened by the responsibility of pregnancy and motherhood, brought into sharp focus their deficit of internal 'emotion-coping' reserves. They looked within and found their 'cupboard' of internal resources scant or bare. I suggest that the confluence of these factors, within this dual context of pandemic and perinatal period, compounded pre-existing anxiety, which in the perinatal context, expectedly took on a 'mother-baby' focus.

**Group 2 participants** were contextualised to the same Covid-19 pandemic and to the same perinatal timeframe as Group1; however, their experiences diverged in their interpretation of threat, in their response to loss of connection to others, and to the meaning they ascribed to fears of coping with motherhood. Covid-19 arose as a theme in Group 2, not as an existential threat that induced debilitating vulnerability, but as a reflection of participants' struggle with loss of connection to others. 'Loss of connection' exposed their physical isolation and the impact of barriers to accessing healthcare services and opportunities to connect with other mothers had on participants' ability to gain knowledge and skills to take care of baby. Participants also lost opportunities to be reassured by others that they were 'good enough mothers'; that is, they did not receive external validation of their parenting. Therefore, unlike Group 1 participants, who experienced a lack of internal coping and emotion-regulation resources, Group 2 experienced being under-resourced in externally acquired resources, competence, parenting skills, and validation. Their fears were largely focused on their perceived lack of ability to take care of their baby, for example: to prevent choking, how to wean, to meet milestones and decipher rashes – knowledge and information that would typically have been acquired from social and interpersonal connections in a pre-pandemic world. Group 2 participants were overwhelmed by their responsibility to ensure the wellbeing of their babies; they were prevented from accessing various types of support due to the pandemic and I interpreted that these factors, combined with self-assessment of being

under-resourced in parental ability and competence, facilitated the development of perinatal anxiety in these participants.

I wish to stress that my interpretation of being ‘under-resourced’ does not reflect a personal flaw. I have gained insight into perinatal anxiety from analysing the experiences of these two participant groups, which I suggest, highlights possible contributors to perinatal anxiety and the potential to resource women in the perinatal period with emotion regulation strategies and practical ‘parent-focused coping’ skills, from a strengths-based perspective. This cross-group analysis could possibly promote understanding of how Counselling Psychologists could enable women to ‘fill their cupboards’.

I discuss the two cross-group themes that emerged from this cross-group analysis in Part 2 of the Discussion Chapter. In this next part of the discussion, I attempt to link the findings back to my research question; my intention in doing so is to foreground findings which, I suggest, could provide new insight into perinatal anxiety, as experienced by women with and without a history of anxiety.

# CHAPTER 4: DISCUSSION

## Contextualising the findings to the research design

My objective in this qualitative research study has been to explore the lived experience of perinatal anxiety in first-time mothers in the context of the Covid-19 pandemic. In keeping with this objective, I embraced the use of Interpretative Phenomenological Analysis (IPA) as my means of inquiry and analysis. My research design differs slightly from typical IPA cross-case designs, in that I have explored the single phenomenon of perinatal anxiety, within two separate, but homogenous groups: those with a history of anxiety, and those without a history of anxiety. While I retained an idiographic focus on each case as the unit of study, I was inspired in my research endeavour by Larkin et al., (2018) to consider a design which could potentially capture the multiple perspectives of these two groups: women who experienced perinatal anxiety, with differing histories of anxiety, all contextualised to the Covid-19 pandemic.

I suggest that this cross-group design has facilitated the emergence of rich findings, which provide insight into how perinatal anxiety might differ between individuals with, and without, a history of anxiety. Moreover, the pandemic created a unique context, akin to a social petri-dish, in which perinatal women were compelled to navigate Government-mandated social measures and hospital-enforced protocols. Participants shared a temporal perinatal time frame, a shared external threat from the virus, were similarly mandated to isolate and at times, endured hospital-enforced Covid-19 measures without familiar support.

I reiterate the study design here, at the start of the Discussion Chapter, in attempt to highlight the significant contribution of the research design to the findings which emerged from this process. Notwithstanding the challenges inherent in this more complex process, I suggest that the cross-group design has borne exciting, and insightful findings, which may not have emerged from a single cross-case design.

**Outline of Discussion Chapter**

My intention in this chapter is to bring you, the reader, on a two-part journey with me, where I discuss the group themes that emerged within Groups 1 and 2, before discussing the themes which emerged from the cross-group analysis. I have carefully reflected on how I present these themes in this discussion.

**In Part One**, I discuss Group Experiential Themes from groups 1 and 2, which I link to extant literature largely pertaining to the pandemic. The discussion begins around each group's experiential themes from a relative position of closeness to participant experiences. My objective is to reveal the convergences and divergences of participants' experiences in each group, with differing histories of anxiety.

**In Part Two** I discuss two themes that emerged from my cross-group analysis, which I link to relevant psychological theory. In this cross-group discussion I take a step back from the experiential themes to ask: 'what is the significance of this theme?'. This process reflects my engagement with the *double hermeneutic,* as I attempt to make sense of participants' sense-making of their perinatal anxiety within a pandemic. The purpose of presenting the work in this way is to make transparent my participation in the sense-making process; as a researcher I am bound up in the process of meaning-making.

I maintained an idiographic commitment when I separately interpreted and analysed the two group's experiences while staying close to participants' accounts and to their sense-making. Thereafter, I engaged in the cross-group analysis, at which point I focused my lens more sharply on the significance of the emergent themes. Following the discussion, I consider implications of this study for Counselling Psychology. I attempt to critically evaluate the strengths and limitations of this study, and I consider possible directions for future research. I end with personal reflections on the research process.

**Summary of Findings**

The Covid-19 pandemic was an unprecedented global phenomenon which required the implementation of social distancing measures to limit the spread of Coronavirus (GOV.UK). Covid-19 represented an external threat, which reflected Group 1 participants' sense of internal vulnerability. Group 1 participants converged in their experience of Covid-19 as both an 'external and internal threat', which mirrored their sense of vulnerability, and which exposed a deficit of emotion coping resources. For Group 2, the pandemic prevented the acquisition of parenting skills or 'coping resources' by cutting off connection to support. Group 2 made sense of their anxiety as arising from a lack of externally acquired skills and knowledge which would have 'resourced' them as mothers. A lack of parental efficacy contributed to Group mothers' self-evaluation as 'incompetent and unable to cope'.

The findings in this study suggest that within and across the two groups, participants converged on two themes which exacerbated or induced their anxiety: '*loss of connection to others'* and '*being under-resourced*'. Participants with a history of anxiety responded to the threat of Covid-19 and the consequential loss of connection to supportive others differently from participants without a history of anxiety. The theme of *loss of connection* signified a deficit in emotion regulation resources in participants with a pre-existing history of anxiety. It is via connection to partners that these participants felt regulated and resourced; being disconnected in the pandemic exposed their lack of emotional regulation skills, which contributed to their perinatal anxiety. Participants without a history of anxiety similarly struggled with *loss of connection,* however, their experiences exposed the impact of being cut off from support and opportunities to develop their parenting skills. As a result of their perceived lack of parenting ability, participants without a history of anxiety felt overwhelmed and anxious. Some mothers disclosed complex feelings of ambivalence towards motherhood. I interpreted that these factors, combined with participants' self-assessment of being under-resourced in ability and competence, facilitated the development of their perinatal anxiety.

## Discussion Part One

### Group 1: Participants with a pre-existing history of anxiety

Group 1 participants had a history of generalised anxiety[8] across their lifespan, prior to their experience of perinatal anxiety. Four Group Experiential Themes (GETs) emerged in Group 1 which reflected how these participants made sense of their lived experiences of perinatal anxiety within the context of a pandemic.

1. Covid-19, an unknown transboundary threat
2. Connections lost and sought: Reaching out for connection
3. The cupboard is bare: Under-resourced in first-time motherhood
4. Temporal and mercurial: Anxiety bound to the past and shifting foci

#### *1. Covid-19, an unknown transboundary threat*

Pregnancy and parenthood signify life-changing transitions which, for some women, can be characterised by a vulnerability to anxiety disorders (Ceulemans et al., 2020; Green et al., 2021). The Covid-19 pandemic created a sense of existential threat, inducing and exposing vulnerabilities in all participants in this study. The threat of Coronavirus transcended geographical and personal boundaries, including the boundary between mother and unborn baby; the threat to life was anxiety-provoking and compounded by unclear information pertaining to the vertical transmission of the virus from mother to unborn infant (Chen et al., 2021; Chivers et al., 2020). This external threat was reflected in Group 1 participants' internal sense of vulnerability: "*There was that vulnerability and suddenly this big scary thing was happening." (Arabella,175).* It is notable that this theme of 'threat and vulnerability' evolved out of participants' experiences of the pandemic while pregnant; a theme of 'isolation' was more notable postnatally. Najam et al. (2022), similarly found that antenatal women displayed statistically higher levels of Covid-19 related anxiety compared to

[8] Generalised anxiety (GAD) can be differentiated from normal anxiety and worry: worry experienced in GAD is excessive, uncontrollable, and interferes with daily functioning for a period of at least 6 months. Goldfinger et al., (2019).

postnatal women, in their cross-sectional descriptive study conducted on 123 perinatal women.

Group 1 participants had all experienced pre-existing trait anxiety prior to the onset of their perinatal anxiety; the theme of 'threat and vulnerability' could suggest that participants' trait anxiety may have predisposed them to experiencing anxiety around the pandemic, thus exposing their vulnerability to a perception of threat. Landsheer and Walburg, (2022) conducted an online questionnaire with three hundred and forty-two French individuals, with a mean age of 34 years old, 290 of whom were women. Although this study was not aimed at perinatal women, the study aimed to examine feelings of fear and vulnerability to Covid-19. Their results highlight the role of trait anxiety in exacerbating anxiety during the pandemic; trait anxiety appeared to increase the perception of participants' vulnerability to Covid-19. Mappa et al. (2020) also conducted a questionnaire (n=178), a method which was most conducive to accessing participants during socially restrictive lockdowns; their objective was to evaluate the psychological impact of Covid-19 on pregnant women in Italy, using the State-Trait Anxiety Inventory (STAI-T), which is a validated test for scoring trait and state anxiety, albeit not perinatal-specific anxiety. Results indicate that an increase in state levels of anxiety were related to pre-existing anxiety in pregnant women in their study.

I suggest that in my study, the external threat of Covid-19 was simultaneously perceived as a threat to the mother's body and to the unborn baby, which alerted some participants to their physical vulnerability, causing them to question their ability to protect self and baby. An unborn baby's survival symbiotically depended on the mother's survival, which was threatened by the unknown virus, hence its ability to transcend boundaries. Moreover, the external narrative surrounding pregnant women as 'vulnerable' to the virus, compounded participants' anxiety and possibly reinforced a self-perception of being unable to cope with the threat of Covid-19 at a time of heightened vulnerability in the antenatal period.

### *2. Connections lost and sought: Reaching out for connection*

In response to the unknown and unprecedented threat posed by the virus, the UK Government mandated social distancing measures to prevent transmission of the virus (GOV.UK; Brown & Wade, 2021). Moreover, pregnant women were identified as 'vulnerable' to Covid-19 and instructed to isolate (GOV.UK). To protect this 'vulnerable' population stringent social distancing measures were enforced by hospitals in response to guidance issued by the Royal College of Obstetricians and Gynaecologists (RCOG), Royal College of Midwives (RCM) and NHS England (Jardine et al., (2020). Despite the recommendations of the World Health Organisation (WHO, 2018) that women should be afforded the emotional and practical support of a chosen birth companion, participants' birth partners in my study were precluded from attending antenatal hospital appointments and prevented from accompanying their partners to hospital until they were in active labour (Nespoli et al., 2021; Birthrights.org), which compounded anxiety in Group 1 participants.

Prior to the pandemic partners who had chosen to share pregnancy and birth experiences were able to attend appointments, scans and the entirety of labour and birth; however, because of restrictive hospital protocols couples in this study expressed being 'robbed' of shared pregnancy and birth experiences, losing a mutual experience of connection and bonding. This finding was borne out in two relatively small qualitative studies; one an Australian two-phased qualitative study, by Vasilevski et al. (2021), which incorporated a national online survey (n=44) and individual semi-structured interviews (n=15) to explore birth partners' experiences during the pandemic conducted; support partners described feeling that they had 'missed out' and had experienced isolation and a negative impact on the bonding experience. The second study of similar sample size used an interpretative phenomenological approach and similarly reported partners' sense of a denied experience at not being present throughout pregnancy and labour experiences (Nespoli et al., 2022).

As a result of social lockdown measures and hospital-enforced protocols, Group 1 participants experienced loss of connection to their partners at times during pregnancy and labour, which caused some participants to feel isolated, alone, and unable to cope. Being alone in hospital until the point of 'active labour' contributed to some participants feeling unsafe, which exacerbated their anxiety. Furthermore, some participants attributed their birth complications and emergency caesareans to feeling unsafe during labour. Both Green et al. (2022) and Vasquez-Vasquez et al. (2021) reported an increase in participants' perinatal anxiety in response to being 'cut off' from emotional and practical support from their birth partners, which had a negative impact on maternal mental health; in particular, women with a pre-existing anxiety disorder disclosed that a significant proportion of their worries related to reduced social support (Green et al., 2022). Chivers et al. (2020) conducted a qualitative thematic analysis of 960 online discussions within an Australian perinatal forum; they similarly found that perinatal women experienced a sense of loss from being deprived of social and family support in the pandemic.

Reflecting on the presence and 'need' of a birth partner, I noted the possible emotion regulation role of partners in this study. Participants made sense of their partner's presence as 'calming, reassuring and advocating for them' during hospital appointments and in labour. Group 1 experiences provide insight into participants' possible reasons to seek connection to partners; the significance could be understood as a need for reassurance and emotion regulation. These interpersonal relationships were relied upon to provide reassurance and regulation, which reduced participants' anxiety in this study. Conversely, the absence of birth partners increased participants' anxiety. One participant described her husband as a big part of her 'reach out'; she attributed his absence in labour to her birth complications. Providing validation to such experiences, the qualitative study conducted by Linden et al. (2022) of 14 Swedish women pregnant in lockdown, and the article by Chen et al. (2021) both identified that being cut off from birth partners in labour contributed to intensifying perinatal anxiety and depression symptoms in perinatal women.

When I closely examined the theme of women reaching out to partners or supportive others for connection, I gained insight into participants' possible need for their partner. I interpreted the significance of seeking connection as 'seeking regulation and reassurance'. I suggest that Group 1 participants required the emotional support and regulation of their partners possibly because they felt under-resourced in emotion coping resources, which could have stemmed from previous experiences of being unable to regulate their pre-existing anxiety. Emotional regulation (ER) is defined as a set of strategies intended to modify the experience and expression of an emotional response in a specific context (Gross & John, 2003, cited in Coo et al. 2022, p4). Few studies exist on how emotion regulation strategies impact perinatal mental health; however, Coo et al., (2022) found that women who were able to regulate their emotions reported fewer symptoms of depression and anxiety during the perinatal period and that the support of regulating interpersonal relationships positively modified emotional dysregulation and perinatal anxiety. I shall expand on emotion regulation in Part Two, when I import emotion regulation theory into my discussion. Participants expressed an internal sense of 'coping deficit', grounded in their inability to regulate their anxiety and in their struggle to access their 'mother's instinct'. I defined these 'coping deficits' as participants feeling innately 'under-resourced', hence their 'need' for the presence of their partners who facilitated their emotion regulation.

Group 1 participants also experienced a loss connection to community services by Covid-19-imposed measures, which impacted their access to social, practical, and community-medical support; consequently, participants struggled to cope without these avenues of support, which increased their anxiety. The impact of being denied access to support and participants' perceived barriers to healthcare in this study was echoed in the findings of a thematic analysis by Karavadra et al., (2020) who also drew attention to Black, Asian and minority ethnic perinatal women's challenges to seeking healthcare services in Covid-19. I am conscious of the limitations of my study, which, despite it reflecting sexual diversity in the sample group, does not reflect race and ethnic diversity. I consider this limitation later.

### *3. The cupboard is bare: Under-resourced in first-time motherhood*

Group 1 participants' experiences of anxiety reflected a trajectory which progressed across trimesters from initially being 'concerned' about coping with a baby, to 'fearing' being unable to cope, to feeling 'flawed' or 'failing' as a mother. I noticed participants' progressive questioning of their capacity to cope, from doubting their practical parenting skills towards a more internalised assessment of 'lacking a maternal instinct'. Some mothers in Group 1 struggled to access their 'mother's instinct', which impacted their ability to cope with their baby, and ultimately resulted in these first-time mothers feeling innately flawed or failing in motherhood. A societal narrative exists around a 'mother's instinct', which supposedly enables mothers to innately navigate their way through motherhood. Some mothers, out in the wider world, do experience varying manifestations of this 'guiding instinct'; however, Group 1 participants found that their instinct was 'not enough'. Consequently, they doubted their capacity to be 'good enough' mothers. Moreover, these mothers feared being stigmatised for disclosing feelings of 'not being good enough mothers' or struggling with motherhood. This deep-seated socially constructed notion of motherhood will be discussed further in the cross-group analysis; however, it is important to reflect on Group 1 participants' internalised views of a 'perfect' mother and how they perceived themselves to be wanting when they were unable to meet these expectations. This experience is similarly identified by participants in Oh et al., (2020) who were equally sensitive to stigma surrounding perinatal anxiety.

Group 1 participants revealed a sense of an 'internal deficit', which they made sense of as stemming from a lack of parental mastery, parenting know-how and insufficient 'maternal instinct'. Feeling inherently under-resourced to cope with motherhood, increased participants' anxiety in this study. This was was similarly identified in a quantitative study by Leahy-Warren et al., (2011) which examined the relationships between social support, maternal parental self-efficacy, and postnatal depression in first-time mothers. In particular, the authors found that mothers' increased perceptions of their parental efficacy, which

reflects the beliefs that parents hold about their capabilities to parent a child, was positively correlated with mothers feeling able to handle the demands of motherhood and a reduction in stress and depression. Clearly, motherhood requires more than instinct; it requires mothers to be resourced in multiple ways, practically, physically, and emotionally (Walker et al., (2019). The pandemic cut off avenues of support which might have resourced participants with explicit knowledge, skills, and support (Sanders & Blaylock, 2021). The absence of these external resources increased participants' isolation and anxiety; some participants tried to access their internal emotion coping 'resources' but found those 'cupboards bare'. I suggest that because of previous dysregulating experiences of trait anxiety, participants possibly experienced a sense of their maternal self as one 'lacking internal resources to cope'. In the context of a pandemic, cut off from support, *and* lacking internal coping resources, Group 1 participants experienced anxiety in the particular perinatal timeframe, with a particular perinatal focus.

Research reflects a lack of comprehensive understanding of potential determinants of perinatal anxiety. Akiki et al. (2016) conducted a large (n=1992) cross-sectional study, using secondary data from a population cohort study in Canada, using the validated Spielberger State-Trait Inventory (STAI) to measure antenatal anxiety. Despite limitations such as their use of secondary data and lacking data on trait anxiety, their findings contribute to an understanding of the determinants of state antenatal anxiety; in particular, low self-esteem, uncertainty about pregnancy, low mastery and lack of social support contributed to participants' antenatal anxiety in Akiki et al. (2016). Being explicitly 'under resourced' and lacking maternal mastery contributed to Group 1 participants' belief that they were inherently unable to cope or to take care of their babies; this implicit self-belief as 'lacking' maternal instinct and know-how appeared to reinforce their lack of mastery and, I suggest, exacerbated their anxiety. Isolation and dis-connection from supportive others, including community services, compounded anxiety, and for some mothers, it also impacted bonding with baby.

### *4. Temporal and mercurial: Anxiety bound to the past and shifting foci*

Group 1 participants shared the phenomenon of pre-existing 'trait' anxiety, prior to their experience of perinatal anxiety. This Group Experiential Theme highlights a temporal bond between pre-existing anxiety and perinatal anxiety. For some participants, perinatal anxiety seemed to transition from previous trait anxiety to perinatal state anxiety, adopting a similar historic focus (typically health-related), albeit in a different timeframe. Participants in Group 1 made sense of their anxiety as a phenomenon that had 'entrenched their whole life', or as an identity with which they had been 'tagged'; they felt the existence of anxiety as a 'looming presence' from the past, from which there was no escape, and which caused them to have to 'cling on' in the present, to survive. Some participants appeared to perceive their pre-existing anxiety as an inextricable part of their identity, with an expectation that they were perhaps pre-determined to experience anxiety in the perinatal period.

Participants expressed how they felt predisposed to experiencing perinatal anxiety due to an implicit deficit of emotional coping resources, which they attributed to their pre-existing anxiety. This temporal aspect begs the question whether perinatal anxiety could be considered a specific state anxiety or as an extension of anxiety experiences in those with pre-existing trait anxiety. In this study, which was framed by the Covid-19 pandemic, it would be challenging to tease apart perinatal anxiety and worry content that is not influenced by the pandemic; therefore, it was necessary to remain beholden to my research question and to remain grounded in the data as made sense of this group's experiences.

Group 1 participants' pre-existing state anxiety appeared to be bound to their experiences of perinatal anxiety; however, the content of their worries and the focus of their anxiety was specifically perinatally focused. Typically research studies in perinatal anxiety have relied on the use of general anxiety scales such as the State-Trait Anxiety Inventory (STAI); despite the STAI being a validated method, it does not assess specific perinatal anxieties and

worries. Huizink et al., (2004) conducted a 58-item questionnaire specifically designed to measure pregnancy related anxiety in 230 eligible first-time pregnant Dutch women, to differentiate pregnancy-related anxiety from generalised anxiety. While this is an early study (2004), the authors used a questionnaire, which is in keeping with the method used in many current studies examining perinatal anxiety within the pandemic, and given it objective, I found this study to be relevant to consider. Findings in Huizink et al. (2004) reflected three aspects of pregnancy-specific anxiety: fear of giving birth, fears over the health of the baby and concerns about one's appearance. The authors concluded that pregnancy anxiety and generalised anxiety could be regarded as different entities (Huizink et al. 2004); however, I cannot draw the same conclusion for these participants in my study with pre-existing anxiety. Despite my study's participants, with pre-existing anxiety, experiencing perinatal-specific content to their worries, their perinatal anxiety appeared to be at least temporally bound to their pre-existing anxiety. More specifically, perinatal anxiety in Group 1 participants manifested as a predisposing vulnerability to anxiety in the perinatal period, and as a deficit in internal resources to regulate anxiety in this period. Participants appeared to transition from pre-existing anxiety to perinatal-focused anxiety, with an anticipation and awareness of their implicit limited emotional coping resources, described by one participant as 'lacking the reserves' to cope.

Furthermore, the mercurial nature of perinatal anxiety was exemplified in the shifting focus of anxiety in Group 1 participants. Their anxiety moved from one concern to another across trimesters and from a mother-focus to infant-focus: from fears around transmission of Coronavirus, to fears of giving birth, to coping with baby and of not being a 'good enough' mother, to fears around transmitting the mother's 'parasitic' anxiety to baby. Together, participants and I made sense of these shifting foci as commensurate with first-time motherhood; however, Group 1 participants converged in their anticipation of fearing the next stage and most notably, they all felt inherently limited in their ability to respond, which I suggest could be attributed to historic experiences of 'not coping' with pre-existing anxiety.

**Group 2: Participants without a pre-existing history of anxiety**

The pandemic created an overarching context of external threat to Group 2 participants' experiences, as it had done for Group 1; however, Group 2 participants diverged from Group 1 in their responses to pandemic-enforced *loss of connection*. Furthermore, while both groups converged in being 'under-resourced', the significance of this experience diverged between the groups; in Group 1 participants' experiences of being under-resourced reflected a deficit of internal coping resources, while being under-resourced, for most Group 2 participants, signified a deficit in explicit parenting coping skills, ability, and practical know-how.

For Group 2, the pandemic prevented the external acquisition of skills or 'coping resources' by cutting off connection to others. Participants made sense of their *loss of connection* from others as lost opportunities to share their joyful pregnancy and birth experiences, and lost opportunities to gain knowledge and support from others. Therefore, unlike Group 1, who made sense of their anxieties as derived from a depletion of internal emotion regulation resources, Group 2 made sense of their anxiety as arising from a lack of externally acquired resources, which contributed to their self-perception as incompetent.

Four Group Experiential Themes (GETs) emerged in Group 2 which reflected how these participants made sense of their lived experiences of perinatal anxiety within the context of a pandemic.

1. Covid-19: Isolation and loss of connection
2. Doubting ability to cope with motherhood
3. Professional care: Mothers' needs dismissed or overlooked
4. Complex feelings: the shadow side of motherhood

### *1. Covid-19: Isolation and loss of connection*

The group experiential theme of *Covid-19 Isolation and loss of connection* reflected both pandemic-enforced isolation and geographical rural isolation; both contexts contributed to mothers feeling disconnected from their families, friends, and communities. While most participants converged in experiencing isolation 'negatively', a divergence appeared in some participants' experiences, who experienced positive benefits to Covid-19 lockdown.

Group 2 participants were impacted by experiences of isolation and loss of connection as new mothers, post childbirth, whereas Group 1 participants largely responded to isolation and loss of connection while pregnant, in relation to an absence of their partners' support. This divergence stood out to me, and I made sense of Group 2 experiences from two perspectives: mothers in this group understood their anxiety to arise from the isolation of being denied access to avenues of support during lockdowns. In turn, these mothers assessed themselves as incompetent and unable to care for their babies, due to a lack of parenting know-how, which contributed to their self-belief of being 'bad mothers', thereby increasing their anxiety. Group 2 struggled with being cut off and isolated from community services and people who might have provided practical support, skills, and validation. These mothers were required to enlist their 'mothering' skills and knowledge to look after their babies while alone and physically isolated, either due to Covid-19 lockdowns or rural locations.

Motherhood behoves mothers to be practically and emotionally 'resourced', to have skills and know-how to take care of babies and indeed, ensure they stay alive. However, these women were isolated and cut off from support services, community nurses, mother-and-baby groups, friends, and families, that is, from opportunities which might have resourced them. In turn, Group 2 mothers doubted their ability to cope, which subsequently impacted their self-esteem, bonding with baby and increased their anxiety. The impact of isolation

emerged as a theme in a qualitative study by Riley et al., (2021), who explored the impact of Covid-19 restrictions on women's pregnancy and postpartum experience in England. The researchers distributed an online survey, completed by 2987 UK women; they subsequently conducted twenty-five semi-structured interviews with women who had completed the survey. Transcripts were analysed by Thematic Analysis and themes were reviewed by a third author to ensure that they were grounded in the data. Of the four themes to have emerged in Riley et al., (2021) 'isolation' was most challenging for their participants, who struggled with loneliness and anxiety from a lack of physical and emotional support from friends and family.

The theme of *Loss of connection* in Group 2 represented a loss of access to 'the communal village' which is typically relied upon to support new mothers, from community midwives, to family, friends, and troupes of aunts and grandparents, who would typically gather around the new mother, offering support and 'advice'. Therefore, I suggest that *loss of connection* for Group 2 participants implied being denied access to acquiring explicit, practical support and skills; it did not appear to signify a loss of connection to a source of emotion regulation as it had for Group 1 participants.

### *2. Doubting ability to cope with motherhood*

Group 2 mothers felt that the loss of connection to their community and to sources of support contributed to their inability to cope with the demands and requirements of motherhood; their experiences reflect overwhelming self-doubt focused on their 'ability to cope': *"How am I going to cope with this?' Am I doing the right thing, am I competent?" (Helena, 383).* Moreover, lacking in competence, confidence and parental self-efficacy, mothers in Group 2 feared being unable to meet external measures imposed on them, for example, ensuring that their children met developmental 'milestones', or measured up to other children's abilities, such as sitting, sleeping, or standing at points in their development.

The outcome to not meeting these real and perceived measures was a self-assessment of not being ‘good enough’ mothers. The transition to motherhood for first-time mothers can induce worry, self-doubt, and anxiety in many women, however in a pre-pandemic context, most mothers who give birth in the UK would typically have access to free National Health Service postnatal care from midwives, health visitors and to a general practitioner (McLeish et al., 2021). However, for these participants, and most other mothers, postnatal care was impinged by restrictive social distancing measures which created barriers to accessing care and support. In a pre-pandemic qualitative study, Wardrop and Popadiuk (2013) explored postnatal anxiety in six first-time mothers whom the researchers engaged in 2-hour interviews. The authors found that the transition to motherhood was experienced as anxiety provoking largely due to the expectations and responsibilities associated with motherhood. These mothers drew a distinction in parental know-how gained from cognitive versus experiential knowledge; reading about parenting was not the same as the embodied knowledge gained from having someone to follow, or indeed, engaging in the role oneself.

Harrison et al. (2020) is a recent qualitative study which identified the stressors experienced by many first-time mothers; in their study, participants identified a source of anxiety arising from guidelines and norms such as developmental milestones, which put pressure on them to measure up to unrealistic expectations, without offering alternative suggestions for circumstances when their babies do not meet the measures. Furthermore, both above studies identified social pressure on women to be the ‘perfect mum’ and to ‘do the right thing’; these studies reflect the experiences of participants in my study in that they shared anxiety around being ‘novice mothers’, lacking agency, feeling pressurised to comply with social comparisons and failing to live up to expectations of what a good mother ‘ought’ to be. Unfortunately, mothers in my study had not been given an opportunity to consider the myths of motherhood, that ‘perfect’ mothers do not exist, which leaves scope for considering how we can enable mothers to transition and to cope with motherhood and, I suggest, scope for challenging social discourse around being ‘perfect’ mothers. Moreover, Wardrop and

Popadiuk (2013) identified ethnic and cultural tensions faced by some women, which can contribute to mothers' pressure to conform to further expectations. While this finding did not arise in my study, it is important for counselling psychologists to consider.

Further studies on the impact of Covid-19 on perinatal mental health reveal that women experienced the pandemic as an overarching threat which overshadowed a major transition in their life and denied them opportunities to share their experience with others (Linden et al., 2022; Sanders & Baylock, 2021). Social support – a person's perception of the availability of others to provide emotional, psychological, and material resources - is a significant factor in increasing a mother's confidence and enabling women transition to motherhood (Cohen and Wills, 1985, cited in McLeish et al., 2021, p452). Barriers to accessing social support reduced Group 2 mothers' opportunities for external positive appraisal, validation, and affirmation – there were few opportunities to be told that they were 'getting it right'. Isolation contributed to these mothers feeling that they were 'getting it wrong', which potentially contributed to their anxiety and reduced a sense of competence.

### *3. Professional care: Mothers' needs dismissed or overlooked*

Group 2 participants' struggles highlighted anxieties around adjusting to motherhood, being unprepared for the demands of being a mother and uncertainty about their competence and ability. These themes were echoed in Harrison et al. (2020) and in Byrnes (2019) who also identified maternal overwhelm in her study on perinatal mood and anxiety disorders among 'at risk' women in the perinatal period. While participants in Byrnes' study differed in their risk profile from my sample, both sets of participants identified unmet needs during the perinatal period: Byrnes (2019) identified that women experienced that the focus of perinatal care was directed towards the foetus/baby, which left participants feeling ignored and their wellbeing overlooked. In my study, Group 2 mothers similarly experienced perinatal care as 'infant-focused care', which tended to overlook mothers' needs, by prioritising babies' needs, leaving some women to feel treated as the baby's 'vessel'.

Disclosing feelings about one's needs being overlooked might be a struggle for some mothers; it can be difficult for mothers to vocalise their unmet needs when the focus of attention is typically infant directed. Moreover, societal scripts and narratives around motherhood are often laden with 'self-sacrifice', 'prioritising' the needs of others and 'foregrounding' children and families' needs. Fear of stigma hangs heavy in the air when mothers contemplate expressing feelings that do not align with being the 'perfect mother'; we are never far from social constructs and idealised images of motherhood which can foist shame and judgement on mothers, which can potentially contribute to anxiety.

### *4. Complex feelings: the shadow side of motherhood*

Some Group 2 participants candidly disclosed their challenges of leaving their careers behind to take up the role of motherhood; during this time of liminality between their past self as 'independent and career oriented' and their current selves as new mothers, participants' experiences reflected themes of loss of identity and loss of self: "*I've lost myself." (Geena, 36)* and *"I gave up that side of me." (Tabitha, 146).* Other experiences of motherhood felt shaming to express, such as feeling trapped by inescapable responsibility, boredom, and the relentless demands of motherhood. These inescapable experiences induced feelings of resentment and anger in some; emotions which are which are not typically socially tolerated from mothers towards their babies, hence the potential to induce shame and guilt as one participant stated, "*I shouldn't feel like that",* reflecting an awareness of social sanctions to such feelings. I identified these experiences in a theme entitled the S*hadow side of motherhood.* This theme felt hidden, it required sensitive uncovering in the interviews, so as not to engender shame and stigma, which I suggest, has further implications for women's fear of disclosure.

Mothers who consider their mental health struggles as a risk to self or to their children often fear their children being removed by social services or themselves sanctioned in some way

by mental health services (I have noted this in clinical practice). This fear potentially prevents women in distress disclosing their struggles or seeking help, as one participant identified: "*I think if I had disclosed the truth, I would have been whisked off and put in a mental health place" (Eliza, 274).*

In my sense-making of participants' experiences, and with Jung (1983) in mind, I identified these complex feelings around motherhood as representing the 'shadow' side to motherhood, a side typically hidden, due to its shame-inducing potential. Jung wrote: "By shadow I mean the negative side of the personality, the sum of all those unpleasant qualities we like to hide" (Jung, 1983, p 87). Motherhood is laden with societal narratives and expectations, many of which assume joy, fulfilment, and contentment, as opposed to the struggles, or 'shadow side' of motherhood. Chapman and Gubi (2022) explored mothers' feelings of 'maternal ambivalence' arising from experiences of motherhood; they similarly identified that mothers experienced a loss of independence, and loss of 'self' when they became mothers, and that they felt shocked by feelings of resentment, boredom, and ambivalence. Unlike my sample of first-time mothers with children no older than 12 months, Chapman and Gubi (2022) recruited mothers with children up to 15 years of age. This sample has a temporal and perspectival advantage over mine in that the authors could explore, longitudinally, how these complex and ambivalent feelings might change over the years. Indeed, their findings reflected that while mothers did experience losses mentioned above, and they experienced unexpected emotions such as resentment and boredom, over time mothers in their study experienced a gradual re-emergence of 'self', with restored balance to their lives as they learned to understand and accept feeling ambivalent without feeling shame and guilt.

In 'The Unspeakables' Staneva, (2020) discusses maternal ambivalence, which she couches within psychological theories; for example, she references Melanie Klein's description of ambivalence as the simultaneous holding of both love and hate towards an

object, akin to the infant's split between 'good breast' and 'bad breast. This begs the question of how a mother verbalises and negotiates ambivalence towards her infant within a culture of 'good mother' constructs. Staneva (2020) identifies that despite advances in feminist-informed research and cultural shifts, the ideology of the 'good mother' is pervasive within social and individual frames of reference, which serves to mute diverse, or as I have identified, shadow, experiences of maternal subjectivity. These experiences remain largely hidden, and further suppress stories of maternal ambivalence and distress. Again, this theme has implications for counselling psychology and how we support women who struggle with complex feelings in motherhood; notably, the need to normalise and de-stigmatise the shadow side to motherhood.

## Discussion Part Two

### Cross-Group Analysis Discussion

I have analysed Group 1 and Group 2 experiences of perinatal anxiety, contextualised to the Covid-19 pandemic. Considering the perspectives of two separate, but homogenous groups, has enabled me to consider the single phenomenon of perinatal anxiety from more than one vantage point. I first interpreted Group Experiential Themes (GETs) within Group 1 (pre-existing history of anxiety) and Group 2 (no history of anxiety) before analysing convergences and divergences across the groups. Two Group Experiential Themes emerged from the cross-group analysis: '*Loss of connection'* and '*Being under-resourced'.*

I collapsed these two themes into one overarching theme. The single theme identifies the significance of loss of connection experienced in each group. Loss of connection exposed a deficit of coping resources in all participants, which differed between the groups. While participants in both groups converged in experiences of 'Loss of connection' and 'Being under-resourced', the two groups diverged in the significance attributed to these experiences, thereby highlighting how perinatal anxiety differed between those with a history

of anxiety and those without a history of anxiety. This finding goes beyond those found in studies which explored perinatal anxiety in the pandemic. While several studies identified that women struggled with pandemic isolation (Chen, 2021; Chivers, 2020) their analyses were limited by not probing the significance of women's experiences further. I suggest that a cross-group multiperspectival design, and a phenomenological inquiry, obtained from the use of IPA, has enabled me to achieve this deeper level of understanding into how perinatal anxiety may differ between women with and without a history of anxiety.

*The meaning I attributed to the themes in Group 1***:** Covid-19 was experienced as an external threat, which revealed participants' pre-existing vulnerability to anxiety. Loss of connection to regulating partners exposed participants' lack of emotion coping resources to regulate anxiety in the perinatal context - that is, they were under-resourced in emotion coping skills. *The meaning I attributed to the themes in Group 2:* Loss of connection to postnatal care and support during the pandemic contributed to isolation and exposed participants' deficit of parental efficacy - that is, they were under-resourced in parenting skills. Consequently, participants assessed themselves as 'not good enough' mothers, which compounded their anxiety and exacerbated their struggles with their transition to motherhood.

In this next part of the discussion, I aim to theorize my findings; I largely draw on psychology theory in which I can potentially ground my work, and which might help to support my findings. I stress that it is not my intention to incorporate 'theories of anxiety'; I have imported theory that bears relevance to participants' experiences of anxiety and stays close to my research question. My objective here is to consider the significance of participants' experiences. I have a vested interest in contributing to my profession, counselling psychology, and a particular regard for furthering understanding of perinatal mental health concerns. Furthermore, I reiterate that my research objective has essentially been to gain insight and understanding of the lived experience of perinatal anxiety. I am curious about

how women make sense of feeling as they do, the significance of their experiences, things that make it better, or worse. The purpose of 'knowing' is to develop our professional understanding and to benefit women who struggle with perinatal anxiety.

**Overview**

In my cross-group analysis I collapsed the two themes: '*Loss of connection'* and '*Being under-resourced'* into one cross-group experiential theme: '*Loss of connection to others reveals deficit of coping resources'.* By doing so I reflect the meaning that I ascribed to the themes; I asked of the data: "what does this mean to each group, and across both groups, what is the convergence? My reasoning is that the collapsed single theme depicts the significance of loss of connection to both groups. I now discuss this in the context of external theories. In consideration of the two themes identified in the cross-group analysis, I have drawn on theories of emotion regulation (Gross and Levenson, 1993) and matrescence (Raphael, 1975). I consider relevant psychological interventions to support perinatal women with anxiety.

***Cross-group theme: Loss of connection to others reveals deficit of coping resources***

Reflecting on participants' experiences of perinatal anxiety, I suggest that women with a history of anxiety were potentially predisposed to a vulnerability of perinatal anxiety. Participants may have entered their perinatal experience under-resourced in emotion regulation strategies. I considered that participants had historically relied on established emotion regulation strategies with their partners; consequently, any deficit of emotion regulation reserves might have been masked by the success of their interpersonal strategies shared with their partners, which had served them well up to this point. However, the confluence of a pandemic and first-time perinatal experience, created an imperfect storm, in which these participants, with a history of anxiety, lost connection to their go-to source of emotion regulation. As one participant identified, her partner was 'a big part of her reach-

out'. I suggest that because of Covid-19-enforced measures, women were stripped of their partners' support and emotion regulation, which exacerbated their anxiety at times of heightened vulnerability, and which subsequently exposed their own deficit of emotion regulation resources.

**Emotion regulation theory**

Reflecting on what it means to regulate emotion we might consider scenarios such as avoiding thinking about painful topics when at work, so that we do not become distressed, or we might cheer up a friend who is feeling low. These examples reflect empathic, prosocial attempts to regulate emotions in self and others. Our ability to regulate our own emotions (intrapersonal regulatory skills), and to enable others to regulate theirs (interpersonal regulatory skills), is built up over a lifespan, initially within the context of early attachment relationships (Bowlby, 1988).

Several theorists have provided definitions of emotion regulation; I shall start with an early definition of the process of regulation by Gross and Levenson (1993, cited in Gross and Munoz, 1995, p153): 'The manipulation in self or others of either emotion antecedents or one or more of the components of an emotional response: behavioural, subjective, or physiological' (Gross & Levenson, 1993). The authors identify two forms of regulation that might occur in regulating one's own or another's anxiety: 'Antecedent-focused emotion regulation' - is regulating something before an emotion, (such as fear) starts, which could affect whether the person has a subsequent emotional response such as panic. 'Response-focused emotion regulation' - is effectively deployed when an emotion has been activated and the individual modulates and regulates their own or another's response. If we contextualise this to the finding in my study, we could consider how a birth partner, who understands the perinatal woman, and can anticipate her responses, might enable her to feel calm, reassured and regulated before she becomes overly anxious; in these situations, birth partners are not intentionally resourcing women, their efforts are intended to alter the

trajectory of negative emotional experiences (Zaki & Williams, 2013). Thus far, early theories (Gross et al., 1993, 1995) of emotion regulation indicate the potential for one person to facilitate the regulation of another's emotions.

Looking more closely at interpersonal regulation, Zaki and Williams (2013) identify this as a core tenet of our psychological lives; we draw on the support from others as a 'resource to dampen stress' (Lazarus and Folkman, 1984, cited in Zaki and Williams, 2013, p803). Zaki and Williams (2013) add that the mere presence of others during difficult times has a beneficial modulating effect on our emotions. Theories on emotion regulation have historically focused on the interpersonal processes involved in *coregulation,* characterised by parent-infant interactions within attachment relationships; however, adult interpersonal regulation is less explored (Zaki and Williams, 2013). More recent theories on emotion regulation provide a more contemporary understanding of the concept; Karademas and Thomadakis (2020) identify emotion regulation as a dynamic and social process of deploying strategies to influence emotions, thoughts, and behaviour, which could include modifying evaluations about something, with the intention of changing the potential emotions that were likely to occur.

So far, the theory of emotion regulation has provided me with a psychological foundation to the processes that could be at work when a perinatal woman feels scared, unsafe, threatened, or concerned, and she lacks the resources or skills to deploy strategies to influence her own emotions. At times like these, I understand that being under-resourced in regulatory strategies could limit a mother's intrapersonal emotion regulation capability – at which point, the trajectory of her emotions, fear, and consequential anxiety, is likely to increase. On the other hand, the presence and interpersonal emotion regulation, provided by her partner, could facilitate the reduction in a woman's perinatal anxiety.

Before I continue to link the theory of interpersonal regulation more specifically with maternal mental health, I would like to pause to note that I am considering this theory in the context of my research finding; my study has highlighted the potential impact of perinatal women being denied access to support from their birth partners during times of heightened vulnerability. I am not intending to disempower women from deploying their own intrapersonal emotion regulation; indeed, I later reflect on the need for counselling psychologists to support women to develop their own emotion regulation strategies, and to resource women who might be under-resourced due to a pre-existing history of anxiety or other contributing factors.

I intended to funnel my theorising from a broad, historical base to a narrower focus on the role of interpersonal regulation in maternal mental health; however, this association has been explored in very few studies (Haga et al., 2012; Marques et al., 2018 and Coo et al., 2022), perhaps demonstrating the need for further inquiry into this topic. Coo et al. (2022) identified that maternal emotion dysregulation contributed to maternal symptoms of anxiety during pregnancy and after childbirth, conversely, women who reported fewer symptoms of anxiety and depression tended to report fewer difficulties with emotion regulation. Coo et al. (2022) indicate that the use of interpersonal emotion regulation strategies by social support persons (or birth partners) modifies the association between maternal lack of emotional control and anxiety, in other words, interpersonal emotion regulation replenishes a perinatal woman's deficit of emotion regulation resources, thereby improving her affect. The authors suggest that the presence of the woman's partner may be especially relevant to maternal wellbeing and conversely, a lack of these close relationships may present a risk for perinatal women experiencing symptoms of depression and anxiety during their transition to motherhood (Coo et al., 2022).

In this part of my discussion, I discussed participants with a history of anxiety; I linked the implications of 'loss of connection' in this group to being under-resourced in regulatory skills. I considered theory on emotion regulation (Gross and Levenson, 1993), thereby highlighting

the pertinence of this finding for counselling psychologists to identify potential opportunities to support women who struggle with perinatal anxiety. The theory of emotion regulation offers a two-fold opportunity for supporting perinatal women; the first opportunity is to consider how we can facilitate the involvement of supportive partners to accompany women throughout the perinatal process, to provide interpersonal emotion regulation when required. The second opportunity is to identify perinatal women who might have a history of anxiety, and potentially lack emotion regulation skills, and to equip these women with strategies to foster their intrapersonal emotion regulation ability. I expand on this below.

My focus of attention in this section has been directed towards the 'deficit' of emotion regulation owing to the prevalence of this phenomenon in this study. Notwithstanding this overriding theme, it is valuable to balance the notion of 'deficit' with a consideration of a theory that promotes emotion regulation in self and others. Non-birthing partners in this study were relied upon to regulate and help organise anxious, fearful, and dysregulated participants, particularly in their birth experience. Paul Gilbert (2014) draws attention to the roots of social motivational and emotional systems conceptualised in his theory of Compassion Focused therapy. These motivational systems include caring for others and responding to threats and to distress in self and others. Caring for others is amongst the most central processes that regulate emotion; our brains are essentially hardwired for social processing, shaped through interpersonal relationships (Gilbert, 2014). Attachment relationships foster caring and nurturing from others (Bowlby, 1969), which includes being alert and sensitive to the needs of others, to their signals of distress and importantly, to take action to alleviate distress (Gilbert, 2014).

However, attachment theory did not espouse caring as its *raison d'etre*, rather, it was the provision of a secure and safe base to proximity seeking (Bowlby, 1969), which the non-birthing partners were called upon to do in this study. Partners in this study attempted to engage in prosocial behaviour, to alleviate their partners' anxiety, yet many were prevented

from doing so by Covid-19 enforced hospital protocols. Prosocial behaviour, such as caring for birth partners, is evidenced to impact physiological processes; research reveals that conditions of caring and safeness induce a sympathetic-parasympathetic balance and increased frontal cortical competencies (Gilbert, 2015) – in essence, enabling a reduction in the threat response and a lowering of anxiety. I do not intend to explore in depth the aspect of social bond formation in emotion regulation, because the emergence of a 'deficit' has been most apparent amongst participants in this study; however, it is noteworthy to highlight the significance of the neuropeptide oxytocin in the psychobiological systems involved in social bond formation and caring (Colonnello et al, 2017). Oxytocin plays a key role in the expression of caregiving and compassion motivation, which modulates the regulation of distress by reducing feelings of separation anxiety; moreover, oxytocin levels during pregnancy and in the early postpartum period are positively associated with maternal care, which can be adversely impacted by perinatal anxiety (Colonnello et al, 2017; Oh et al, 2020). The prosocial approach inherent to the social bond theory considered by Gilbert (2017) highlights that compassionate behaviour implies an ability to attune to others, to notice their signs of distress and to be motivated to alleviate another's distress. Future research could explore the dual role of compassion – that which motivates birth partners to care for and alleviate women's perinatal distress, and indeed, further exploration of the role of self-compassion in enabling women to regulate their own threat responses in the perinatal and birth experience.

**Matrescence Theory**

In participants without a history of anxiety, '*loss of connection'* exposed the impact of being cut off from support services and other opportunities to gain knowledge and parenting skills; 'loss of connection' in this group revealed being explicitly under-resourced in parental efficacy. First-time mothers report higher levels of anxiety (especially pregnancy-related anxiety) than women who have already had a child; becoming a mother is a major life

transition that can create multiple challenges to which a new mother needs to adapt (Huizink, 2022). Mothers in this study, who did not have a history of anxiety experienced increased anxiety in the perinatal period, particularly post childbirth, due to a self-perception of having low parental efficacy. As a result, these first-time mothers feared being unable to take care of their baby, and in turn, identified themselves as 'bad mothers' who were unable to meet babies' needs or social expectations of motherhood. Furthermore, their anxiety was compounded by feelings of ambivalence towards motherhood, which these mothers struggled to articulate out of concerns about being judged and stigmatised. These mothers' experiences need to be seen in a social context, which is not only befitting of participants' experiences, but is also in keeping with my constructivist epistemological stance. I suggest that in their transition to motherhood, these women tended to evaluate themselves against a socially constructed Western view of what a 'good and perfect mother ought to be'; failing to meet such standards of 'perfection', alongside their inability to meet developmental milestones and other socially constructed measurements, these mothers constructed a view of themselves as 'not good enough'. Furthermore, lacking parental skills, know-how and efficacy reinforced their self-perception, which exacerbated their anxiety. Reflecting on participants' self-evaluation of not being 'good enough' mothers, I highlight Winnicott's concept of 'the good enough mother', introduced by Winnicott in 1953, and further elaborated upon in 'Transitional Objects and Transitional Phenomena Playing and Reality' (1971). The 'good enough mother', according to Winnicott (1971) makes 'active adaptation' to her baby's early needs, attempting to respond to its every need, often at the sacrifice of her own. Nonetheless, she is reliable, attuned, and patient *enough* towards baby, and of equal significance, she can tolerate her own failure to be 'perfect' alongside her ambivalence towards baby; in so doing she builds a more robust maternal inner self (Lowy, 2021). Winnicott (1971) postulated that the 'good enough mother' reduces her active adaptation towards the infant over time, according to the baby's increasing ability to deal with, or tolerate, the frustration of the mother's failure to be the ever present 'perfect mother'; indeed, these gradually increasing frustrations enable the infant to experience the mother as

no longer ‘perfect’, but ‘good enough’ at meeting his needs. Consequently, the child learns to adapt to external realities and a sense of the external world. The ‘good enough mother’ ostensibly meets her baby’s needs without the illusion of perfection, yet does so in a ‘good enough’ way, in contrast to ‘bad enough’ mothers who neglect their child’s physical and emotional needs. (Winnicott, 1971; Abramovitch, 2021). While mothers in this study identified that they were meeting their baby’s basic needs, they nevertheless evaluated themselves as ‘not good enough’ by their internal self-measures.

Matrescence is a theory introduced by Raphael (1975) which elucidates the changes that occur in a woman’s transition to motherhood; this rite of passage includes shifts in a woman’s physical being, her social status, emotional life, daily roles and responsibilities, identity, and relationships. Matrescence, akin to ‘adolescence’, as a rite of passage, can be understood to have biological, cultural, social, and psychological implications (Sacks, 2017). It is indeed a bio-psycho-social process. Raphael was the first person to use the word ‘doula’, someone who supports a woman during the process of ‘becoming a mother’, to enable her to accept and acquire her new identity (Kurz et al., 2021). She was suggesting a type of interpersonal support, which pre-pandemic would have been provided by family and maternity professionals; however, participants in this study were cut off from such support in their transition to motherhood. Without support, Kurz et al. (2021) argue that mothers might find themselves diminished, with a deficit of psychosocial wellness, and in turn, feel that they have failed. In this study, participants without a history of anxiety struggled with perinatal anxiety attributed to lack of support and consequential lack of parental efficacy.

Alongside anxiety, participants without a history of anxiety expressed feeling overwhelmed, ambivalent, guilt, boredom, and resentment in their role as new mothers; they shared a loss of identity and a sense of failure. Sacks (2017) identifies that the psychological significance of becoming a mother is often overshadowed by a medical focus on the ‘physical’ aspects in this course; however, more focus is needed on the mother’s psychology in this transition in

service to the mother and being mindful of the impact on her parenting. By enabling mothers to have insight into their emotions, supporting them in this transition with parenting skills and debunking myths around perfect parenting, perhaps women could be enabled to transition to motherhood with reduced anxiety and increased self and parental efficacy.

Normalising maternal ambivalence – the uncomfortable pull and push of wanting a child close, but also craving space and independence – could enable mothers to appreciate that motherhood is no exception to the juggling act that pervades all relationships (Sacks, 2017). Part of our role as counselling psychologists is to enable mothers to tolerate feeling ambivalent. Maternal guilt, shame and 'not being a good enough mother' contributed to these participants' anxiety. Moreover, their struggle to disclose these feelings out of fear of being stigmatised, or worse, having their children removed by social services, highlights the need to normalise such feelings. Motherhood is not a binary experience; accepting the paradox of motherhood is essential (Babetin, 2020). Counselling Psychologists can enable mothers to try to accept the shadow side of motherhood and to tolerate the complex feelings highlighted in this study. Aside from psychological support, it is important to recognise that the pandemic has highlighted the significance of supporting women through their transition, with parenting skills, validation, and community. The pandemic has identified just how important 'the village' is to mothers bearing and raising a child. These layers of support are essential to reducing mothers' anxiety and insecurity (Babetin, 2020).

**Discussion Summary**

The Covid-19 pandemic represented an existential threat, to which Governments universally responded with stringent social-distancing measures, designed to isolate people, with the aim of limiting the transmission of Coronavirus. Perinatal women in this study were significantly impacted by the threat of the virus and by the consequences of mandated measures. Their perinatal anxiety was triggered or compounded by experiences of losing connection to sources of community, support, and emotion regulation. The findings to have

emerged in this study depict a distinction in the experience of perinatal anxiety between participants with and without a history of anxiety. These findings are contextualised to participants' perinatal experiences within the Covid-19 pandemic.

The findings in this study suggest that within and across the two groups, participants converged on two themes which exacerbated or induced their anxiety: '*loss of connection to others'* and '*being under-resourced*'. Participants with a history of anxiety responded to the threat of Covid-19 and the consequential loss of connection to supportive others differently from participants without a history of anxiety. The theme of *loss of connection* signified a loss of connection to regulating partner, which exposed a deficit in emotion regulation resources in participants with a pre-existing history of anxiety. It is via connection to their partners that these participants felt regulated and resourced; being disconnected in the pandemic exposed their lack of emotion regulation skills, which contributed to their perinatal anxiety.

Participants without a history of anxiety similarly struggled with *loss of connection;* however, their experiences exposed the impact of being cut off from support and opportunities to develop their parenting skills. As a result of their perceived lack of parenting ability, participants without a history of anxiety felt overwhelmed and some mothers disclosed complex feelings of ambivalence towards motherhood. I interpreted that these factors, combined with participants' self-assessment of being under-resourced in ability and competence, facilitated the development of their perinatal anxiety.

The differences between the two groups, contextualised to the same threat of Covid-19, has been highlighted by the multiperspectival cross-group design of this study. I suggest that the differences which emerged in the findings between the groups represent a unique finding, deepening our understanding of perinatal anxiety. This has important implications for supporting women with perinatal anxiety.

**Psychological Interventions**

Considering potential interventions to support women in their transition to motherhood and to improve emotion regulation I suggest the use of evidence-based interventions such as mindfulness, mentalization-based treatment (MBT) and Compassion Focused Therapy (CFT). Mindfulness is thought to improve emotion regulation by enabling an individual to fully focus on the present moment, to be more reflective and to slow down automatic thoughts, emotions, and behaviours, which can reduce emotional reactivity (Slade et al. 2020, cited in Penner & Rutherford, 2022, p529). Minding the Baby is an MBT approach that can be initiated in pregnancy and has been evidenced to enable mothers to recognise their own and baby's mental states, which improves emotional insight and behavioural responses (Penner, & Rutherford, 2022).

CFT emphasises the common humanity to suffering, which can enable mothers to become open to their own suffering and struggles; developing self-compassion can buffer the effects of self-criticism (Gilbert, 2017). Self-compassion, as defined by Neff (2003) emphasises self-kindness over self-judgement, which participants succumbed to in this study. Moreover, evidence exists suggesting that self-compassion is linked to mechanisms in emotion regulation in depression and anxiety (Carona et al., 2022). I have co-facilitated a CFT group and mothers reported that speaking to other mothers who shared their self-critical thinking, 'mum-guilt', and 'not being good enough', has been enormously beneficial in normalising complex feelings around motherhood.

**Implications of Findings for Counselling Psychology**

In some respects, it seems at odds to associate the perinatal period with threat, fear, and anxiety; however, for many first-time mothers, and for those who have had children, this time can indeed trigger or compound anxiety. Around 80% of women acknowledge some

measure of fear or anxiety during pregnancy (Melender, 2002) and one in five women experience a significant level of anxiety across the perinatal period (Dennis et al., 2017).

There are multiple reasons, causes and explanations to perinatal anxiety, which cannot be explicated by a single reason or theory. This study has been contextualised to the Covid-19 pandemic; I explored perinatal anxiety in first-time mothers, in a small sample of eleven women, with and without a history of anxiety. I am mindful of complex factors that could have contributed to these participants' experiences. I am conscious of experiences shared by participants that carry deep significance, which I am unable to expand on in this body of work. For example, the experience of hyperemesis gravidarum, a deeply debilitating condition, triggered anxiety in one participant, without a history of anxiety. While the condition alone did not 'cause' her anxiety, when contextualised to the pandemic, with multiple returns to hospital without her partner, and being dismissed by healthcare professionals, her condition contributed to her distress to the point that she considered taking her own life. While I was unable to expand on her experience in this body of work, I wish to note her experience here, so that it does not go unheard and because it has implications for Counselling Psychology which I shall hold in mind for my practice.

I also wish to highlight the experience of one participant, whose anxiety was compounded by her experiences of a typically heteronormative healthcare and maternity system. This participant is in a same-sex relationship; the couple shared the challenges of a fertility experience between them and along the pathway, encountered a heteronormative system, from gender-specific administrative forms to attitudes from healthcare professionals. This too should not go 'unheard' and requires future consideration.

In terms of findings to emerge from this study, I suggest that these have implications for clinical practice in counselling psychology and within maternity services. Prioritising

counselling psychology, the implications are twofold: first, within secondary care, implications include considering how we can enable perinatal women with anxiety to develop emotion regulation strategies, to increase their intrapersonal coping resources, skills, and ability. Moreover, we could consider the wider social and interpersonal sources of support typically used by clients with anxiety, such as online support options. This study has highlighted the significance of others involved as 'emotion regulators' in the lives of some people with anxiety; a source of support, whose significance we should not overlook.

Secondly, perinatal mental health community services and in-patient services are ideally placed to address many issues raised in this study; these services could establish closer links with maternity services in attempt to assess and identify those women at risk of developing perinatal anxiety. Women with a history of anxiety appear to be predisposed to developing anxiety in the perinatal period; their history could be identified at assessment, after which the woman could be assessed further by a psychologist to determine any need for support. Perinatal mental health services typically operate as multidisciplinary teams, which lends itself to multiple opportunities for identifying women at risk of anxiety and supporting those who do present with anxiety. Furthermore, as indicated in this study, some women without a history of anxiety, felt under resourced in parenting skills, which undermined their coping ability and triggered anxiety. This cohort, without a history of anxiety, could be identified at the antenatal stage, perhaps by community midwives, and then referred to perinatal mental health services, to groups such as 'Preparing for Parenting', for example. Many mothers speak about 'slipping through the net' in the literature, and these suggestions above, identify various points in the system where women could be supported.

I would like to reflect on maternity services in this section; women with mental health concerns can fall between two stools, maternity, and mental health services. Mental health needs can sometimes be overlooked or dismissed in the wider medicalised system (Butcher and Willcocks, 2020), and while many midwives strive to offer relationship-based care, the

provision of such care remains limited. Standard midwife appointments in the UK typically last 15 minutes (Butcher and Willcocks, 2020). Women will typically be seen for three hours across their entire pregnancy by a midwife, or multiple midwives, in which they will receive physical care, assessment, screening, and information (Butcher and Willcocks, 2020). While midwives are in a position as gatekeepers to receiving and identifying mental health concerns, the system, overall, does not support this; it is no surprise that responses to mental health symptoms provided by hard-pressed midwives is often received by perinatal women as well-meaning platitudes or dismissals. Stretched healthcare professionals, alongside women's fear of disclosing mental health struggles create a context which limits opportunities to identify and support women with perinatal anxiety. Our healthcare system, and indeed, our society has moved away from 'it takes a village to raise a child' idea; Covid-19 certainly brought home to me, and many others, the importance of communities, families, groups, and partners, in the perinatal pathway, and beyond. If any good has come out of the pandemic, perhaps it is to renew our appreciation for connections to others.

As a result of the findings to have emerged from this study, I have reflected on the implications to my own practice. I shall be starting my career in a perinatal mental health service, after two years placement within this area; I intend to develop a group for antenatal pregnant women, with worries and anxiety, to support women with emotion regulation skills. Our service benefits from a multidisciplinary team on whose expertise I could call for support with this planned project. Furthermore, I have reached out to local community and hospital midwives to start a dialogue about linking our services, to assess and refer antenatal women with anxiety. My objective is to try to identify opportunities to support women before they become too distressed.

**Evaluation of this study: Strengths and Limitations**

My objective in this study, has been to explore the lived experience of perinatal anxiety in first-time mothers in the context of the Covid-19 pandemic. The broader rationale is to

contribute to this growing body of knowledge, to understand the multiple factors implicated in perinatal anxiety, within a context of heightened fear and threat, and to learn from this unique experience, in the hope of understanding how best to support perinatal women, not only in potential future lockdowns, but to understand their need for support throughout their perinatal experience. I suggest that the pandemic created a context of exaggerated threat; however, for many women, with or without anxiety, their underlying need for support still exists, and this study has provided some insight into this phenomenon. I have sensitively reflected on the ethical issues surrounding the recruitment and interviewing of participants in this study; moreover, throughout my engagement with the data, I have tried to maintain a mindful and respectful appreciation of how I convey participants' experiences, either in direct quotes, or once passed through my analytic lens.

Notwithstanding my sensitivity and respect for the recruited participants, this study is limited in its lack of race, ethnic and cultural diversity amongst the participants. Evidence depicts pandemic-related health disparities affecting people of colour (Masters et al., 2021), and unfortunately, my study has not been able to contribute to this body of knowledge.
Whilst engaged in the process of writing, I reflected on my use of language: 'motherhood, women, mothers and maternal'. I used these terms, aware of the absence of gender-neutral terms such 'people who give birth'. This does not reflect a disregard, or a refusal to be inclusive of non-binary or transwomen who become pregnant and give birth. I have elected to use the terms used, to reflect the identities expressed by participants in this study.

Methodologically, the use of IPA has enabled me to maintain a close connection to the data and enabled me to return to participants' experiences time after time, until I felt that I truly 'understood' their experiences and what these meant to them. The process of inquiry was not without its challenges; it was harder than I had anticipated to conduct a study with two sub-groups. Despite the total number of participants being relatively small and manageable, the challenge with two sub-groups arose when I completed Group 1's analysis and moved to Group 2; setting aside or bracketing Group 1's experiences, to fully receive Group 2 was

challenging. I managed this by taking time away from the analytic process and returned to Group 2 a few days later.

I suggest that the cross-group approach which I have used has enabled me to explore perinatal anxiety from two perspectives. The pandemic added a sense of homogeneity to the context of a shared threat, in which both groups experienced a loss of connection to their source of 'resources', from which emerged two divergent experiences, meaning-making and significance to the themes of *loss of connection* and *being under-resourced*. My findings go beyond some studies which explored perinatal anxiety in the pandemic. I suggest that a cross-group multiperspectival design, and a phenomenological inquiry, obtained from the use of IPA, has enabled me to achieve a deeper level of understanding into how perinatal anxiety may differ between women with and without a history of anxiety. I suggest that the design could be considered a strength in that it has facilitated the generation of rich data, across two subsets, from which significant convergent and divergent themes have emerged, which will certainly inform my clinical practice, and which I hope, can benefit our profession more widely. While small, homogenous samples facilitate an idiographic, close immersion in the data, which is in keeping with IPA's principles, a small sample does not lend itself to generalisations. This study did not intend to generate generalisable data, but instead aimed to deepen understanding of the phenomenon of perinatal anxiety, and to facilitate supporting women.

**Future Directions for Research**

This study explored first-time mothers' experiences of perinatal anxiety in a pandemic. This unique context afforded me the benefit if being able to explore a single phenomenon in two groups of women who were exposed to the same global threat of Coronavirus. Moreover, participants shared experiences of social isolation and hospital-enforced safety measures. I suggest that there is merit in conducting a similar qualitative study post-pandemic, to explore perinatal anxiety outside of the pandemic context. I would be curious about exploring

perinatal anxiety in groups of women with and without a history of anxiety, without the threat posed by Covid-19. Furthermore, as identified previously, this study is limited by its lack of ethnic, cultural and race diversity in the sample group; I would suggest a more diverse participant sample in future research.

## Conclusion

Pregnant women and mothers' mental health has consequences for self, child, and others; antenatal anxiety is a significant predictor of postpartum depression and is associated with impaired infant health (Ayers et al.,2015). Adverse outcomes are not only associated with anxiety disorders but also with subthreshold symptoms of anxiety (Bayrampour et al., 2019). Research has evidenced that perinatal women without pre-existing anxiety, who experience sub-clinical symptoms, can be overlooked in clinical practice, while women with pre-existing mood disorders, can have their anxiety symptoms conflated with depression, resulting in skewed clinical focus on depression (Goodman et al., 2016). It is unsurprising therefore, that anxiety symptoms can go unrecognised in clinical practice and in wider maternity and healthcare services (Wardrop & Popadiuk, 2013; Highet et al., 2014; Goodman et al., 2016). This qualitative research study, contextualised to the Covid-19 pandemic, explored the lived experiences of one phenomenon, perinatal anxiety within two separate but homogenous groups: perinatal women without a history of anxiety and perinatal women with a history of anxiety. I suggest that by employing a cross-group design, I have been able to gain a rounded perspective of perinatal anxiety and how it potentially differs between individuals with, and without, a history of anxiety. Covid-19 created a unique environment in which experiences of perinatal anxiety could be explored, in a particular timeframe, in which perinatal women encountered a shared thread. I was curious to explore the significance of perinatal women's experiences of anxiety, how they made sense of their anxiety, what it meant for them and how it impacted them within the pandemic.

The findings in this study depict a difference between the two groups; pandemic enforced measures contributed to pregnant participants, with a history of anxiety, struggling with the loss of connection to their birth partners at times when they felt most vulnerable; furthermore, they struggled to access their 'innate mother's instinct', which impacted their ability to cope with their baby, and ultimately culminated in these first-time mothers feeling innately flawed or failing in motherhood. The theme of an 'internal coping deficit' was interpreted as being 'under-resourced', which revealed a deficit in intrapersonal emotion regulation resources. Further reflection on this theme revealed that these women typically relied on their partners for interpersonal regulation, from whom they were cut off in hospital, due to Covid-19 measures, which exacerbated their anxiety.

Women with a history of anxiety appear to be predisposed to perinatal anxiety, possibly due to a lack of emotion coping strategies. While I did not hypothesise that women with pre-existing trait anxiety would be more predisposed to anxiety in the perinatal period, my findings could support this notion. I suggest that my findings have highlighted a possible significance to these women's experiences of anxiety in the perinatal period; it could be suggested that a history of trait anxiety might predispose women to anxiety in the perinatal period, if they have not acquired emotion regulation skills prior to becoming pregnant. Being under-resourced in emotion regulation skills appeared to contribute to some participants' anxiety in this study. This, I suggest, is a significant finding, deepening my understanding of anxiety in women with a history of anxiety, which has implications for clinical practice. Furthermore, this finding revealed the significance of interpersonal emotion regulation from partners, who appear to provide an informal, but not insignificant, role in regulating their partners' anxiety. This too has implications for enlisting the help of birth partners, and not excluding them from the perinatal experience, if the woman finds their presence beneficial.

Women without a history of anxiety made sense of their loss of connection to others as a loss of access to services, sources and opportunities which could have enabled their

development of parental efficacy. Lacking parenting skills, these women struggled to cope with the demands of motherhood, and they experienced overwhelming self-doubt focused on their 'ability' to cope, which caused them to become anxious and to assess themselves as not 'good enough' mothers. Unlike women with a history of anxiety, who experienced a sense of deficit of emotion coping skills, women without a history of anxiety experienced a deficit of parenting skills and know-how; their anxiety was therefore focused on their lack of 'externally acquired' skills. This provides scope for considering how we enable mothers to cope with the practicalities of motherhood, and, I suggest, scope for challenging the discourse around being 'perfect' mothers.

**Final Reflections**

Anxiety is sometimes mercurial, darting without a focus, other times a desperate vortex without escape and often dismissed, overlooked, or empathised with platitudes. I do have lived experience of that inescapable vortex that is anxiety. In my personal experience of anxiety, albeit not perinatal anxiety, I experienced a lack of understanding from professionals which left me feeling dismissed, judged, or expected to 'pull myself together', until I received support from a caring, supportive therapist. My training and this study have reinforced to me the need to take time to understand our clients' lived experiences. I strive to maintain a phenomenological perspective in my clinical work; this mindset does not stop at research; it has an important place in clinical work. When I reflect on clients' diagnoses, the content of GP letters, files of notes; these sources of information, while useful in many respects, often do not identify the significance of experiences. This research has contributed to shaping my perspective on my clinical work. I am grateful for the learning.

I have held the experiences of mothers in this study in mind as I thought, analysed, and wrote about them. I have been moved by their experiences and humbled by their candour. I can only hope that I have conveyed the significance of their anxiety as they intended. I am

aware of the potential for participants to read this study; I felt a weight of responsibility to ensure that I had captured, understood, regarded, and expressed their fears, feelings, and experiences as they intended them to be heard. I hope that I have done your experiences justice; I am so grateful to each one of you.

This study has afforded me insight into perinatal anxiety which I shall transfer to my clinical work as a counselling psychologist, after qualifying. I intend to disseminate my learning within this community and within maternity services. I am deeply grateful to the women who shared their experiences with me; their experiences will inform help provided to others.

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## PART II: PUBLISHABLE PAPER

**REDACTED**

## PART III: CLINICAL PRACTICE - CLIENT STUDY AND PROCESS REPORT

***A client study of complex trauma: The use of relational psychoanalysis to facilitate integration of self.***

**REDACTED**