Received: 24 July 2023 | Accepted: 21 June 2024

DOI: 10.1111/bjhp.12740

the british psychological society
promoting excellence in psychology

ARTICLE

Women's experiences and views of routine assessment for anxiety in pregnancy and after birth: A qualitative study

Cassandra Yuill[1] | **Andrea Sinesi**[2] | **Rose Meades**[1] | **Louise R. Williams**[1] | **Amy Delicate**[1] | **Helen Cheyne**[2] | **Margaret Maxwell**[2] | **Judy Shakespeare**[3] | **Fiona Alderdice**[4] | **Rachael Leonard**[5] | **Susan Ayers**[1] | **The MAP Study Team**

[1]Centre for Maternal and Child Health Research, School of Health and Psychological Sciences, City, University of London, London, UK

[2]Nursing, Midwifery and Allied Health Professions Research Unit, University of Stirling, Stirling, UK

[3]Retired GP, Oxford, UK

[4]National Perinatal Epidemiology Unit, Nuffield Department of Population Health, University of Oxford, Oxford, UK

[5]National Childbirth Trust, Bristol, UK

Correspondence
Cassandra Yuill, Centre for Maternal and Child Health Research, School of Health Sciences, City, University London, Northampton Square, London EC1V 0HB, UK.
Email: cassandra.yuill.2@city.ac.uk

Abstract

Background: Anxiety in pregnancy and postnatally is highly prevalent but under-recognized. To identify perinatal anxiety, assessment tools must be acceptable to women who are pregnant or postnatal.

Methods: A qualitative study of women's experiences of anxiety and mental health assessment during pregnancy and after birth and views on the acceptability of perinatal anxiety assessment. Semi-structured interviews were conducted with 41 pregnant or postnatal women. Results were analysed using Sekhon et al.'s acceptability framework, as well as inductive coding of new or emergent themes.

Results: Women's perceptions of routine assessment for perinatal anxiety were generally favourable. Most participants thought assessment was needed and that the benefits outweighed potential negative impacts, such as unnecessary referrals to specialist services. Six themes were identified of: (1) *Raising awareness*; (2) *Improving support*; (3) *Surveillance and stigma*; (4) *Gatekeeping*; (5) *Personalized care* and (6) *Trust*. Assessment was seen as a tool for raising awareness about mental health during the perinatal period and a mechanism for normalizing discussions about mental health more generally. However, views on questionnaire assessments themselves were mixed, with some participants feeling they could become an administrative 'tick box' exercise that depersonalizes care and does not provide a space to discuss mental health problems.

Conclusion: Routine assessment of perinatal anxiety was generally viewed as positive and acceptable; however, this was qualified by the extent to which it was informed and personalized as a process. Approaches to assessment should ideally be flexible, tailored across the perinatal period and embedded in continuity of care.

KEYWORDS
acceptability, anxiety, assessment, postnatal, pregnancy, screening

Statement of contribution

What is already known on this subject?

- Perinatal anxiety is experienced by approximately 20% of women, which may be distressing or debilitating for them.
- Research suggests routine mental health assessment during antenatal care is acceptable to women; however, literature also details women's reluctance to disclose mental health problems and potential barriers to accessing support and treatment.
- There is a dearth of evidence on acceptability and experiences of routine assessment for anxiety across the perinatal period.

What does this study add?

- The study provides findings on the acceptability and experiences of routine assessment for anxiety across the entire perinatal period, which can be used to inform delivery of assessment during antenatal and postnatal care.
- Findings show that women's perceptions of routine assessment were generally favourable, seeing it as a tool for raising awareness about mental health and improving support.
- They also provide a more detailed understanding on the relationship between routine assessment, care and support for perinatal anxiety, highlighting how organizational, structural and sociocultural barriers impact acceptability and women's experiences.

INTRODUCTION

Perinatal anxiety can occur during pregnancy and up to 1 year after birth and is experienced by approximately 20% of women (Fawcett et al., 2019). While depression during the perinatal period has been well-researched, anxiety has only recently received significant attention. Perinatal anxiety includes a range of disorders and symptoms, such as generalized anxiety disorder, panic, phobias, social anxiety and obsessive–compulsive disorder (WHO, 2011). Experiences of perinatal anxiety are characterized by intense symptoms of anxiety and fear and evidence shows that even moderate symptoms can be distressing and debilitating for women (Boots Family Trust Alliance, 2013).

Mental health assessment using questionnaires during routine maternity care is recommended in a number of countries, especially for women with pre-existing mental health problems. The UK National Institute for Health and Care Excellence (NICE) guidelines (2014) recommend that women are routinely asked about anxiety using the Generalized Anxiety Disorder 2-item scale (GAD-2)

(Spitzer et al., 2006) by a midwife or other healthcare professional. For women scoring 3 or above, the guidelines recommend further assessment with the Generalized Anxiety Disorder 7-item scale (GAD-7) or referral to their GP or a mental health professional, Yet, research on the diagnostic accuracy of the GAD-2 when used to screen for perinatal anxiety suggests it generates many false positives so may be unhelpful to use in maternity services (Nath et al., 2018). Few studies to date have focused on the extent to which questionnaires, such as GAD-2, are acceptable to women or their experiences of assessment for anxiety.

Research suggests that being asked about mental health during antenatal booking appointments is acceptable to women (Yapp et al., 2019), but this excludes insights about acceptability across the entire perinatal period. Research on women's views of assessment suggests reluctance to disclose mental health difficulties during screening due to fear of stigma and of being seen as a 'bad mother' and feeling uncared for and not listened to by the health system (Button et al., 2017; Coates et al., 2014; Jomeen et al., 2013). There are also potential barriers to women accessing support and treatment, such as insufficient staff time, heavy workloads and lack of or poor training among staff, unclear or complicated referral pathways and lack of funding for services (Button et al., 2017; Ford, Lee, et al., 2017; Ford, Shakespeare, et al., 2017; Webb, et al., 2021).

For the assessment to be successful, it must be acceptable to women throughout the perinatal period as well as psychometrically robust (Brealey et al., 2010; Coates et al., 2015). There is some evidence suggesting anxiety fluctuates throughout the perinatal period (Dennis et al., 2017) and women may have different concerns at different stages of pregnancy and post-birth and may thus interpret questions differently, meaning it is important that assessment measures are acceptable and relevant to women throughout this time. This study explores women's experiences and views of assessment for perinatal anxiety, with the aim of understanding the extent to which they find this acceptable and generating insights for improving perinatal mental health assessment and care at different stages of their perinatal journey.

METHODS

A semi-structured qualitative interview study was conducted between July 2019 and January 2020 with a purposive sample of 41 pregnant and postnatal women. Interviews consisted of two parts. One part was an in-depth interview examining women's experiences of perinatal mental health assessment and acceptability of the assessment measures used, the data and analysis of which is reported here. The other part was a cognitive interview study, the findings of which are reported elsewhere (Meades et al., In press).

Study sample

Women were eligible if they were pregnant or within 6 weeks of giving birth, aged 16 or over and with sufficient English language to take part in an interview. Potential participants were recruited through UK organizations such as the NCT, Maternal Mental Health Change Agents Scotland and the Maternal Mental Health Alliance. Recruitment methods included social media posts (e.g., Twitter and Facebook), information provided during attendance at antenatal groups, baby events and word of mouth. Women who participated were entered into a draw to win one of two £50 vouchers. Women interested in participating were sent a participant information sheet, consent form and eligibility questionnaire to obtain information on demographic characteristics, stage of pregnancy or number of weeks after birth and experiences of depression and anxiety. Given the evidence of comorbidity between perinatal depression and anxiety (Miller et al., 2015), depression and anxiety were both assessed using the clinical questions recommended in the UK, the Whooley questions (Whooley et al., 1997) and GAD-2 (Spitzer et al., 2006). Women completed the eligibility

questionnaire and consent form and returned them to the research team. All women indicating a positive anxiety or depression score on the eligibility questionnaire were encouraged to talk to their midwife or GP and sent details of support organizations.

Participants were purposively sampled according to pregnancy gestation at 12 weeks ($n = 6$), 22 weeks ($n = 6$), 31 weeks ($n = 13$) and 6 weeks postpartum ($n = 16$) in two countries (England and Scotland), which provided a nuanced exploration of the different concerns across the perinatal period and interpretations of questions in order to better inform acceptability of assessment. Women were eligible to take part regardless of whether they scored above and below thresholds on measures recommended by NICE guidelines for assessing anxiety and depression, the GAD-2 and Whooley questions respectively. Forty-six percent of participants scored over the NICE recommended cut-offs for probable depression and/or anxiety. Twenty-nine participants had experienced lifetime mental health problems, while 12 had not; of the 29 participants with a lifetime mental health problem, 23 stated they had received treatment. Most participants were pregnant (61%) and all were from England ($n = 24$) and Scotland ($n = 17$). A majority of the sample were White Caucasian (93%), employed (93%) and educated to degree level or above (85%). Full demographic characteristics are reported elsewhere (Meades et al., In press).

Data collection

Women were contacted to arrange an interview at a convenient time and place for them (e.g., home, health centre, or university). Participants could also choose to have an online video interview if face-to-face was not possible. Interviews were conducted by (AS, LW and RM), three psychology researchers experienced in qualitative interviewing, one of which developed the Stirling Antenatal Anxiety Scale (SAAS), an assessment included in the MAP Study. They lasted up to 95 minutes in total (parts 1 and 2) and explored participants' experiences and views of acceptability of different assessments for perinatal mental health and specifically the Clinical Outcomes in Routine Evaluation (CORE-10) (Barkham et al., 2013), Generalized Anxiety Disorder 7-item (GAD-7), SAAS (Sinesi et al., 2022) and Whooley questions. The topic guide was developed from Sekhon et al.'s theoretical framework of acceptability of health interventions and included seven indicators of acceptability; affective attitude, burden, perceived effectiveness, ethicality, intervention coherence, opportunity costs and self-efficacy (Sekhon et al., 2017) (see Table 1 for definitions). At the start of the interview, participants had an opportunity to ask questions and consent was re-confirmed. Those who disclosed current mental health problems during interviews were offered information on support organizations and self-referral to psychological services. Interviews were digitally recorded, transcribed verbatim and transcripts were anonymized.

TABLE 1 Indicators of acceptability and their definitions adapted from Sekhon et al., 2017.

Indicator	Indicator definition
Affective attitude	How an individual feels about the intervention
Burden	The perceived amount of effort that is required to participate in the intervention
Ethicality	The extent to which the intervention has good fit with an individual's value system. This also includes wider ethical considerations within in health, taking into account social, political and economic dimensions
Intervention coherence	The extent to which the participant understands how the intervention works
Opportunity costs	The extent to which benefits, profits and values must be given up to engage with the intervention
Perceived effectiveness	The extent to which the intervention is perceived as likely to achieve its purpose
Self-efficacy	The participant's confidence that they can perform the behaviour(s) required to participate in the intervention

Data analysis

Data from the qualitative interviews was analysed thematically on NVivo software first using a deductive framework based on Sekhon et al.'s theory of acceptability (Sekhon et al., 2017). Inductive open coding was then conducted to ensure unexpected or emergent themes were captured, following Braun and Clark's iterative process of thematic analysis (Braun & Clarke, 2006). Transcripts were coded line by line with codes from the framework or new descriptive codes. Coding and analysis were conducted primarily by CY, who is a medical anthropologist with experience in thematic analysis and discussed with the research team at regular meetings throughout the analysis phase to ensure reliability. To check interrater reliability, two researchers (AS, RM), who had undertaken the interviews, checked 5% of quotes and interrater reliability was 82%. All disagreements were resolved by discussion.

Ethical approval

Ethical approval was obtained from the City, University of London School of Health Sciences Research Ethics Committee (ETH1819-0689).

RESULTS

Findings are first summarized for Sekhon et al.'s framework of acceptability (Sekhon et al., 2017) and then elaborated on and organized by the following three overarching themes: Raising awareness and improving support; Surveillance and stratifying care; Personalizing care and building trust. These are illustrated with quotes from participants. Nation is noted in participant numbers (i.e., EP = England and SP = Scotland).

Overall acceptability

Table 2 shows the findings summarized according to the indicators in Sekhon et al.'s acceptability framework (Sekhon et al., 2017). The majority of participants reported finding routine perinatal mental health assessment beneficial. Most reported experiencing very few or no assessments during their maternity or postnatal care and would have liked more assessment to be done during this time. They also were not sure what would happen if they scored above a threshold on an assessment and some women were concerned about the implications of assessment, particularly fearing their baby would be taken away.

Raising awareness and improving support

As highlighted in the acceptability findings, most participants found assessment to be beneficial. Questionnaires used for routine assessment were viewed as tools for raising awareness about perinatal mental health and normalizing discussions about it during care.

> Even if you did just do the questionnaire and didn't talk about it, even if it wasn't really expanded, it would make me more self-aware of my mental health, it would become quite normal then for me maybe to become a bit more self-aware.
>
> (SP07)

Participants also reported that assessment for anxiety – and mental health, more generally – was a mechanism for normalizing discussions about it during care. Assessment for perinatal anxiety was also seen as an opportunity to improve and tailor support for women

TABLE 2 Findings according to the framework of acceptability Sekhon et al. (2017).

Indicator of acceptability	Explanation	Example quotes
Affective attitude	Participants reported either a lack of or no assessment during their antenatal and postnatal care Most found assessment to be beneficial and positive and expressed a desire for more assessment, particularly during pregnancy	*I think that was really useful so felt very knowledgeable about it. So if it was going to happen I would happily answer these questionnaires and hold my hands up and say I needed some help.* (EP10) *I think it's really positive. I hope it would pick up things or issues that need, people that need the help and I'm all for it.* (EP13) *I suppose it is important to ask at the start, there's no harm in asking every time, but I think women need to be aware of the circumstances around how they're asking and not make it feel like it is just a tick box.* (SP09)
Burden	No significant burdens reported, though potential barriers were identified Participants had a range of views about the preferred place and method (online vs paper) for completing a questionnaire assessment	*I think screening is a good thing, I think that it needs to be robust enough…I don't think anything would make me drop out on this occasion, because I know that I need the help. If I wasn't as confident and comfortable in saying that, if it takes too long, if it seems too arduous a task, if it involves phone calls, online forms, setting up registration details that you don't have. To me it seems much easier to just be a piece of paper that you can tick.* (EP24) *Me personally I would answer it as many times as I got it, but is that because I feel quite confident in my answers and I feel fine answering them? Do I want to be reminded how depressed I am every time I answer it if I'm on the other side? I think it would depend on where that person is.* (EP18) *After the birth, it has to be at home because the stress to the mother of trying to get the baby out and meet a deadline on time, it's just added unnecessary stress.* (EP13)
Ethicality	Some spoke about the implications of assessment and records about mental health, mostly the fear of social services becoming involved and separating them from their children. They highlighted this as key reason why it is important to inform people about the nature of the questions being asked	*The doctor might think it's a casual tick box exercise and you're sitting there thinking, 'they're going to take this baby away', because that's how they show it on telly.* (EP05) *The reason that I would worry about answering those sorts of things honestly, is because I'd be thinking, 'do people think I'm a danger to my family or to my child? Or is something going to happen now, which means they're worried about safety, from the Social Services point of view?' That shouldn't be a reason not to answer it accurately, because you would hope that if that was a genuine fear or concern, that you would be supported through that rather than removed from your child.* (EP06) *From my own opinion I think it's great it's more knowledge, more information. Some people might find it's quite intrusive if they're quite private and if they want it to just be about their physical health.* (SP03)
Intervention coherence	The majority of participants interviewed did not know what would happen after an assessment, particularly if they scored highly on a questionnaire	*I assume you do these sort of tick boxes and then it gets put into a computer somewhere and then an algorithm spits out high alert, medium, low and then the professional contacts you if you're over a certain threshold, is that right?* (EP21) *I would imagine there would be a referral, won't there? Someone that would then get involved, but I don't know who that would be, or what would happen.* (SP02)
Opportunity costs	Most participants thought the benefits of assessment outweighed the costs	*I think it saves money in the long run, if you invest at the beginning. If someone was having anxiety issues at the beginning, you could put some sort of coping strategies in to begin with, you're less likely to find someone who ends up in a full mother and baby unit, due to lack of coping later on. If people are more open about their mental health and how they're feeling, you're going to save money in the other end of the pressures of Health Visiting, the amount of visits that will be needed to follow up…* (SP07) *I don't find it annoying because I know that it's important for the people that are struggling and I think to have however many people maybe annoyed along the way is a decent enough payoff for catching people who are really, really struggling.* (SP08)

TABLE 2 (Continued)

Indicator of acceptability	Explanation	Example quotes
Perceived effectiveness	Most participants viewed questionnaires as better than a general 'How are you feeling?' question, which was viewed as indicative of superficial support Emphasis was placed on connecting assessment to a further conversation with a healthcare professional and support	*Actually give it the time it really deserves, because I don't think people give it the time it deserves, it's always seen as a tick box exercise, that's kind of just added on…I think it'd make people more honest, because if you feel like you've just gone in and you've mentioned things and nothing's happened, then you just think well there's no point. What's the point next time I mention anything, because nothing's going to happen anyway.* (SP07) *Scales can be quite useful – if someone ticks a certain box, you can then say to them more about that. It opens up conversation. I do struggle with scales used just to input a number on a computer, which I think is how they're often used in mental health services, but I think it can be a useful tool and maybe using them across time as well to see if there's any change.* (SP09)
Self-efficacy	Most felt they could complete the questionnaires but identified potential deterrents from completing questionnaires honestly, especially if it was perceived to be a 'tick box' exercise	*You're just exposing yourself to someone, you've just got to be happy to be vulnerable, which some people are and some people aren't.* (EP13) *[M]aybe the fear of disclosure of some questions probably I would not necessarily answer all of them, but to drop out completely I can't think of a reason why I would do that.* (EP09) *I think [screening] should be for everyone, but only because I think we've not normalized it and until we normalize it, people won't be honest about things.* (SP07)

> I think formal screening gives more structure and more containment to it whereas a conversation could just tick a box 'I asked her how she was', when actually, unless you've a good relationship, you might not find out.
>
> (SP03)

> It would have been good to be asked questions in pregnancy, because I was really anxious during pregnancy and maybe if I'd have been asked some questions or given some kind of questionnaires, it might have flagged to someone that this person is anxious, so therefore when she has the baby, we should check in on her and that anxiety and see how that's going or maybe even provide a little bit more support to her and give her a few phone calls along the way.
>
> (EP04)

Each illustrate benefits of assessment, which participants found outweighed the costs, as demonstrated in the acceptability findings on opportunity costs. Many spoke of the lack of support for mental health antenatally and postnatally, which mirrors participants' affective attitude concerning frequency of assessment. Some highlighted the need for confidence to request access to specific services.

> I basically said, 'I think I need help', she said 'I don't think you do, but I will offer you the services and I will come back', otherwise I think you're just left to drift by yourself unless you're the person that calls up your GP and says 'I need help.'
>
> (EP13)

Others outlined the nuances of perinatal mental health that are important to account for during assessment and support. These were primarily related to physiological changes of pregnancy and realities of caring for infants, as well as what were perceived as 'generalized' experiences linked to pregnancy, birth and parenthood.

> I think that it's even more important if you have had that experience or if you do have something where your baby does need a bit of extra help, mental health then is of a bigger importance…lack of sleep, complete change of lifestyle, probably unexpected things happening to yourself and to your baby can definitely play a big part in it…I think it's a generalised thing that all new parents experiences, anxieties and worries, and it's just knowing where that point is to say this person does need help, this person doesn't.
>
> (SP14)

Surveillance and stratifying care

The acceptability findings show that respondents had a range of views about the preferred place and method for completing a questionnaire for assessment, but most agreed that filling it out privately and in their own time would be optimal. They reported not wanting to complete one while a clinician was watching, feeling this put pressure on them to finish the questionnaire quickly.

> I would rather do it when they weren't there, because otherwise I'd be aware of the time pressure, and I'd be trying to read through it quickly,… whereas if they left it with me, I'd be able to do it at a time that's convenient to me.
>
> (EP04)

> [Y]ou feel a bit more under pressure when there's someone watching you do it. When a health visitor comes to your house, they're sat there and you're like 'oh you're trying to work out if I'm alright'.
>
> (SP01)

There was perceived surveillance regarding assessment, especially if it was done by or in front of a clinician, underscoring the ongoing stigma of mental health already highlighted in the acceptability findings related to ethicality. Some spoke about how this stigma could influence whether a person participates in assessment, hindering engagement and honest responses.

> I think if I was … say if I was worried about my ability to parent, and then I was admitting to someone that I struggled with my worries and struggled with my thoughts then I would possibly hide that.
>
> (EP08)

A handful of respondents discussed how assessment could function as 'gatekeeping' access to further support, raising concerns about how questionnaires might contribute to stratifying perinatal mental health care, allowing only some to access specialist services.

> For me, it's to almost like a qualification to get in to access certain services basically. I feel like if I haven't scored 'high enough' on the questionnaires, I would've not been referred to the perinatal mental health team… If you score low, you're seen by the community midwives; if you score like middling, you're seen by perinatal mental health midwives; if you score high, you're seen by the perinatal mental health team, so it's almost like kind of gatekeeping in a way. It will only let the most eligible people into certain services.
>
> (EP01)

Though no respondents were completely opposed to assessment, there were discussions of its limitations. These usually linked to the need for mental health assessment beyond questionnaires, involving subsequent conversations with clinicians, as stated in the acceptability finding related to perceived effectiveness.

> [T]hey're really good for scoring systems… I think as long as the questionnaires are being used to then have the conversation afterwards with the midwife, with the GP, with the consultant. In isolation, people get annoyed if it's not acknowledged.
>
> (SP17)

> I think it's quite an impersonal way to talk about a very personal issue, and I've personally responded better, I've felt more willing to open up about how I'm feeling through a discussion where I'm talking to somebody face-to-face rather than somebody going through a questionnaire with you.
>
> (EP15)

Personalizing care and building trust

Respondents highlighted the importance of informing people why questions were being asked and what the outcome of assessment would be, as raised in the acceptability findings on ethicality. Most identified the need for assessment to be connected to further care, whether that was a personalized conversation with a clinician or referral to support and mental health services.

> It's that thing of the healthcare professional being the person that's going to decide what happens next. I think that's probably quite scary in terms of the mental health side of things. So I think there's something about having a clear rationale as to why you're being asked to do something, and also then what the potential next steps are and some sense that you have a bit of control in that.
>
> (EP12)

Some respondents pointed out that assessment should be reoccurring throughout the antenatal and postnatal periods – though views on appropriate timing and frequency were varied – to account for mental health changes and provide a comprehensive picture for tailored support and care.

> Maybe you fill it out one day when you've had a really good week and then they're like, 'Oh, you're fine. You don't need to be referred to the parent mental health team, or the perinatal mental health team. You're fine,' and then like, you know, the next week you have a bad week.
>
> (EP01)

> I think it's important to get a good picture of the mum and how she's doing and what's going on. Because then after she has the baby, obviously if she's got depression, anxiety, she's going to be more prone to having postnatal depression, and anxiety, so it's always good to try and get information before.
>
> (SP13)

Others spoke of experiences of maternity care that were not personalized, were lacking compassion and communication and highlighted how time pressures shape – often negatively – their interactions with clinicians and responses to perinatal anxiety assessment.

> Asking 'How are you?', I'm very aware of their time, and it's not the kind of question where you go into detail…it's almost how it's asked. If it's asked sincerely, then you can feel like you can open up, whereas if it's asked in a time-pressured situation and almost as part of a tick box operation, or what feels like a tick box… or I'm asking, but you don't know me, so I'm not really that close for you to open up.
>
> (EP04)

This echoes the acceptability findings on perceived effectiveness and self-efficacy, which describe how impersonal or superficial framings of assessment may act as a deterrent from completing it honestly. Many highlighted the importance of building trust with clinicians for navigating difficult subjects and experiences and of receiving personalized care during and after assessment.

> Talking to somebody you can kind of feel you can build a bit of trust and then talk to them about how you're feeling. Having a questionnaire I think automatically feels like it's administration. You're just filling out a form to put in my file so it's done, do you really care about how I'm feeling?
>
> (EP15)

> I think you do need more formal ways of assessing it, but I think if you have that relationship [with a midwife], when you're chatting about what's been going on they'll pick up if you're worrying more.
>
> (SP03)

DISCUSSION

Women's perceptions of assessment for perinatal anxiety were generally favourable; most perceived increased and improved assessment as needed, with benefits that outweighed the potential costs, such as unnecessary referrals to specialist services. Assessment was seen as a tool for raising awareness about mental health during the perinatal period and a mechanism for normalizing discussions about mental health more broadly. However, views on the questionnaires themselves were mixed, with some participants feeling they could easily become an administrative 'tick box' exercise that depersonalizes care and does not provide a space to discuss mental health problems. Previous research with women in Ireland found that questionnaires were also viewed as a tick box exercise but also a useful mechanism – or 'modality' – for identifying those with perinatal mental health problems and for discussing difficulties (Nagle & Farrelly, 2018). Our findings echo those of Nagle and Farrelly and demonstrate that these are occurring on a wider scale within the population and at different time points during and after pregnancy. For women in this study, the extent to which an assessment was seen as administrative impacted its perceived effectiveness and shaped disclosure.

Crucially, most of the participants in this study did not know what would happen if they scored highly during an assessment for anxiety or if they would be referred to specialist services or support. Research suggests that women often have limited mental health literacy, such as recognizing perinatal mental health problems, which could be a barrier to help-seeking (Daehn et al., 2022). Several participants in this study highlighted how women may not know about perinatal mental health, with an indication that distinguishing general pregnancy- and postpartum-related experiences from perinatal anxiety was not straightforward, but this was viewed less as an obstacle to help-seeking and more as factor shaping engagement with assessment. This highlights the value of not only informing women about the importance of perinatal mental health but also communicating why assessment is being undertaken and what the potential outcomes of it could be.

Assessment experiences and their general acceptability were impacted by structural and organizational aspects surrounding their delivery. There were a variety of views on optimal timing and

location for assessment, which could change between the antenatal and postnatal periods, emphasizing the need for flexibility in perinatal mental health services (Webb, et al., 2021). Prescriptive or inflexible provision is a potential barrier to engagement with questionnaires and should be considered when deciding how to administer assessments in practice. Additional barriers to help-seeking for mental health identified in previous research include accessibility of appointments constrained by time, transportation, childcare, geographical location and unavailable resources and/or healthcare professionals (Daehn et al., 2022), all of which can become more marked postnatally. Staff's perceived lack of time and busy workloads were also discussed as obstacles to seeking help (Nagle & Farrelly, 2018).

Besides structural barriers, women's experiences revealed how sociocultural barriers, such as stigma, shame and fear concerning mental health, continue to steer disclosure and subsequently impact acceptability of assessment. Stigma is a recurring theme in research on perinatal mental health (Nagle & Farrelly, 2018; Webb, et al., 2021) and, for participants, stigma was most commonly connected to how their ability to parent would be judged if they scored highly during assessment. Surveillance, related to stigma, privacy, perceiving being watched and implications of mental health records, suggest that assessment tools are not neutral but instead can carry the modalities – positive and negative – of an institution and intersect with broader sociocultural discourses on maternity and parenthood (Button et al., 2017). Work from anthropologists on antenatal screening for Down's syndrome has shown how assessment 'both enables and constrains' cataloguing and categorizing the social world and trivializing the complexity of conditions (Strathern, 1992; Thomas, 2016).

For perinatal anxiety, this is reflected in what participants called 'gatekeeping' of support and care that is potentially produced by assessment, during which the categorization of anxiety 'severity' cements clinical assumptions about its experience. This categorization, in turn, stratifies women by their assumed experiences of anxiety, which might not reflect their actual experiences and subsequently, governs their access to further support and care. The concept of 'stratified reproduction' describes the ways in which reproduction, maternity and parenting is unevenly distributed among different groups of people, recognizing how some will be supported in their reproductive activities while others are disempowered (Colen, 1995). In the case of perinatal anxiety, those who do not score high enough during routine assessments may not be referred to further support and care. Participants in this study identified several reasons why a woman might not disclose mental health problems during assessment, including stigma, lack of trust and limited awareness or understanding of anxiety symptoms. Importantly, this potential stratification reinforces our argument that assessments for perinatal mental health are not neutral, which shapes acceptability of routine use in terms of ethicality and self-efficacy. Healthcare professionals employing routine assessment for perinatal anxiety in practice should thus be mindful of the possible implications of it and reflexive when it comes the assumptions about experience it may be producing.

The results of the current study are consistent with a recent systematic review recommending perinatal mental health services should be women-centred and operate 'within a structure that facilitates continuity of carer' (Webb, et al., 2021). Our findings are also consistent with other studies, demonstrating how trusting relationships between women and staff facilitate help-seeking and disclosure and that continuity of carer is an important part of establishing this rapport (Nagle & Farrelly, 2018; Oh et al., 2020). Assessment should be informed and personalized, taking place where women feel comfortable, using a method they prefer (e.g. filling a form separately or with a health professional) and connected to clear information about its purpose, further support and referral processes, optimally, sitting in continuity of carer or case-loading teams.

Strengths and limitations

This is one of the few studies to focus on women's experiences of assessment for anxiety, drawing from data across the perinatal period and including participants who were either pregnant or had recently

given birth. Many participants had lived experience of anxiety and depression, which was part of our sampling strategy to ensure these women's voices were included, as they are a priority for being identified and offered treatment. Our findings thus provide a more comprehensive and nuanced picture of women's experiences with assessment and allow for a more detailed overview of acceptability both antenatally and postnatally. However, most women who took part in this study were white, highly educated, employed and spoke English, limiting the generalizability of findings to more diverse populations. This is important, as research suggests women from minority ethnic backgrounds and with lower socioeconomic status are more likely to experience psychological difficulties during the perinatal period but are less likely to access support services and to be asked about their mental health (Harrison et al., 2023; Jankovic et al., 2020). Research is therefore needed on the experiences and views of perinatal anxiety assessment in diverse samples, including minority groups, to fully inform maternity and mental health services. More attention should also be given to the intersections of race, socioeconomic status, language and legal status when considering the needs of women during assessment and subsequent support for perinatal anxiety.

CONCLUSION

For the women in this study, assessment for perinatal anxiety was generally viewed as positive and acceptable; however, this was qualified by the extent to which it was informed and personalized as a process. Women's experiences demonstrated how assessment is not neutral, instead revealing how it is connected to institutional modalities and sociocultural norms and how its efficacy may be affected when perceived as perfunctory. Approaches to assessment should be flexible, tailored across the perinatal period and embedded in continuity of care but must also consider how structural and societal barriers may shift throughout this time and continue to shape women's engagement with perinatal mental health assessment.

AUTHOR CONTRIBUTIONS

Cassandra Yuill: Formal analysis; visualization; writing – original draft; writing – review and editing; data curation. **Andrea Sinesi:** Formal analysis; data curation; investigation; methodology; project administration; writing – review and editing. **Rose Meades:** Investigation; methodology; writing – review and editing; formal analysis; project administration; data curation. **Louise R. Williams:** Data curation; methodology; investigation; project administration; writing – review and editing. **Amy Delicate:** Formal analysis; writing – review and editing. **Helen Cheyne:** Conceptualization; funding acquisition; methodology; project administration; writing – review and editing. **Margaret Maxwell:** Conceptualization; methodology; project administration; writing – review and editing; funding acquisition. **Judy Shakespeare:** Conceptualization; project administration; writing – review and editing. **Fiona Alderdice:** Conceptualization; project administration; writing – review and editing. **Rachael Leonard:** Project administration; writing – review and editing. **Susan Ayers:** Conceptualization; funding acquisition; methodology; project administration; supervision; writing – review and editing.

ACKNOWLEDGEMENTS

This work was part of the Methods of Assessing Perinatal Anxiety (MAP) programme of research. MAP was supported by the National Institute for Health Research (NIHR), Health Services & Delivery Research Programme (NIHR 17/105/16). The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care. We gratefully acknowledge the input and advice of colleagues in the MAP Study Team in conducting this research. The MAP Study Team includes the authors and Catherine Best, Georgia Constantinou, Simon Gilbody, Jennifer Holly, Julie Jomeen, Debra Salmon, Clare Thompson, Nazihah Uddin, J. J. Walker.

DATA AVAILABILITY STATEMENT

Individual, participant-level data are not available but authors can provide sample-level data and information on request after publication. The study protocol is available at https://njl-admin.nihr.ac.uk/document/download/2034506.

ORCID

Cassandra Yuill https://orcid.org/0000-0002-3918-5917

REFERENCES

Barkham, M., Bewick, B., Mullin, T., Gilbody, S., Connell, J., Cahill, J., Mellor-Clark, J., Richards, D., Unsworth, G., & Evans, C. (2013). The CORE-10: A short measure of psychological distress for routine use in the psychological therapies. *Counselling and Psychotherapy Research*, *13*(1), 3–13.

Boots Family Trust Alliance. (2013). *Perinatal mental health: Experiences of women and health professionals*. Boots Family Trust Alliance.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101.

Brealey, S., Sutherland, G., Wiebe, J., & Brown, S. (2010). Screening for postnatal depression–is it acceptable to women and healthcare professionals? A systematic review and meta-synthesis. *Journal of Reproductive and Infant Psychology*, *28*(4), 328–344.

Button, S., Thornton, A., Lee, S., Shakespeare, J., & Ayers, S. (2017). Seeking help for perinatal psychological distress: A meta-synthesis of women's experiences. *British Journal of General Practice*, *67*(663), e692–e699.

Coates, R., Ayers, S., & de Visser, R. (2014). Women's experiences of postnatal distress: A qualitative study. *BMC Pregnancy and Childbirth*, *14*, 359.

Coates, R., de Visser, R., & Ayers, S. (2015). Not identifying with postnatal depression: A qualitative study of women's experiences of distress in the first postnatal year. *Journal of Psychosomatic Obstetrics and Gynaecology*, *36*(3), 114–121.

Colen, S. (1995). "Like a mother to them": Stratified reproduction and west Indian childcare workers in new York. In F. Ginsburg & R. Rapp (Eds.), *Conceiving the new world order: The global politics of reproduction* (pp. 78–102). University of California Press.

Daehn, D., Rudolf, S., Pawils, S., & Renneberg, B. (2022). Perinatal mental health literacy: Knowledge, attitudes, and help-seeking among perinatal women and the public – A systematic review. *BMC Pregnancy and Childbirth*, *22*, 574.

Dennis, C., Falah-Hassani, K., & Shiri, R. (2017). Prevalence of antenatal and postnatal anxiety: Systematic review and meta-analysis. *British Journal of Psychiatry*, *210*(5), 315–323.

Fawcett, E., Fairbrother, N., Cox, M., White, I., & Fawcett, J. (2019). The prevalence of anxiety disorders during pregnancy and the postpartum period: A multivariate Bayesian meta-analysis. *The Journal of Clinical Psychiatry*, *80*(4), 18r12527.

Ford, E., Lee, S., Shakespeare, J., & Ayers, S. (2017). Diagnosis and management of perinatal depression and anxiety in general practice: A meta-synthesis of qualitative studies. *British Journal of General Practice*, *67*(661), e538–e546.

Ford, E., Shakespeare, J., Elias, F., & Ayers, S. (2017). Recognition and management of perinatal depression and anxiety by general practitioners: A systematic review. *Family Practice*, *34*(1), 11–19.

Harrison, S., Pilkington, V., Li, Y., Quigley, M., & Alderdice, F. (2023). Disparities in who is asked about their perinatal mental health: An analysis of cross-sectional data from consecutive national maternity surveys. *BMC Pregnancy and Childbirth*, *23*(1), 263.

Jankovic, J., Parsons, J., Jovanović, N., Berrisford, G., Copello, A., Fazil, Q., & Priebe, S. (2020). Differences in access and utilisation of mental health services in the perinatal period for women from ethnic minorities-a population-based study. *BMC Medicine*, *18*(1), 245.

Jomeen, J., Glover, V., & Jones, C. (2013). Assessing women's perinatal psychological health: Exploring the experience of health visitors. *Journal of Reproductive and Infant Psychology*, *31*, 479–489.

Meades, R., Sinesi, A., Williams, L. R., Delicate, A., Cheyne, H., Maxwell, M., Alderice, F., Jomeen, J., Shakespeare, J., Yuill, C., Ayers, S., & The MAP Study Team. (In press). Evaluation of perinatal anxiety assessment measures: a cognitive interview study. *BMC Pregnancy & Childbirth*.

Miller, E., Hoxha, D., Wisner, K., & Gosset, D. (2015). The impact of perinatal depression on the evolution of anxiety and obsessive-compulsive symptoms. *Archives of Women's Mental Health*, *18*, 457–461.

Nagle, U., & Farrelly, M. (2018). Women's views and experiences of having their mental health needs considered in the perinatal period. *Midwifery*, *66*, 79–87.

Nath, S., Ryan, E. G., Trevillion, K., Bick, D., Demilew, J., Milgrom, J., Pickles, A., & Howard, L. M. (2018). Prevalence and identification of anxiety disorders in pregnancy: The diagnostic accuracy of the two-item Generalised Anxiety Disorder scale (GAD-2). *BMJ Open*, *8*, e023766.

NICE. (2014). *Antenatal and postnatal mental health: Clinical management and service guidance clinical guideline [CG192]*. NICE.

Oh, S., Chew-Graham, C., Silverwood, V., Shaheen, S., Walsh-House, J., Sumathipala, A., & Kingstone, T. (2020). Exploring women's experiences of identifying, negotiating and managing perinatal anxiety: A qualitative study. *BMJ Open*, *10*(12), e040731.

Sekhon, M., Cartwright, M., & Francis, J. (2017). Acceptability of healthcare interventions: An overview of reviews and development of a theoretical framework. *BMC Health Services Research*, *17*(1), 88.

Sinesi, A., Cheyne, H., Maxwell, M., & O'Carroll, R. (2022). The Stirling Antenatal Anxiety Scale (SAAS): Development and initial psychometric validation. *Journal of Affective Disorders Reports*, *8*, 100333.

Spitzer, R., Kroenke, K., Williams, J., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine*, *166*(10), 1092–1097.

Strathern, M. (1992). *Reproducing the future: Anthropology, kinship, and the new reproductive technologies*. Routledge.

Thomas, G. (2016). An elephant in the consultation room?: Configuring down syndrome in British antenatal care. *Medical Anthropology Quarterly*, *30*(2), 238–258.

Webb, R., Uddin, N., Ford, E., Easter, A., Shakespeare, J., Roberts, N., Alderdice, F., Coates, R., Hogg, S., Cheyne, H., Ayers, S., & MATRIx Study Team. (2021). Barriers and facilitators to implementing perinatal mental health care in health and social care settings: A systematic review. *Lancet Psychiatry*, *8*(6), 521–534.

WHO. (2011). *International statistical classification of diseases and related health problems*. World Health Organisation.

Whooley, M., Avins, A., Miranda, J., & Browner, W. (1997). Case-finding instruments for depression: Two questions are as good as many. *Journal of General Internal Medicine*, *12*(7), 439–445.

Yapp, E., Howard, L., Kadicheeni, M., Telesia, L., Milgrom, J., & Trevillion, K. (2019). A qualitative study of women's views on the acceptability of being asked about mental health problems at antenatal booking appointments. *Midwifery*, *74*, 126–133.

How to cite this article: Yuill, C., Sinesi, A., Meades, R., Williams, L. R., Delicate, A., Cheyne, H., Maxwell, M., Shakespeare, J., Alderdice, F., Leonard, R., Ayers, S., & The MAP Study Team. (2024). Women's experiences and views of routine assessment for anxiety in pregnancy and after birth: A qualitative study. *British Journal of Health Psychology*, *00*, 1–14. https://doi.org/10.1111/bjhp.12740