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Women's experiences of anxiety during pregnancy: An interpretative phenomenological analysis

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Abstract

Objective: To qualitatively explore women's experiences of anxiety during pregnancy.

Method: An interpretative phenomenological analysis approach was used to explore women's lived experiences, using semi-structured interviews. Women were recruited through an antenatal clinic in the North West of England and through online forums. Seven women who identified as experiencing anxiety during their pregnancy were recruited. Women were in various trimesters of pregnancy, were not deemed to be high risk pregnancies and had no other psychiatric diagnoses.

Results: Four superordinate themes emerged: 1) Adjustment to pregnancy and motherhood and the experiences of anxiety, 2) Unfamiliarity, uncertainty and uncontrollability of pregnancy influences anxiety, 3) Personal and social expectations and pressures of pregnancy and motherhood and 4) Relying on healthcare systems – the good and bad.

Conclusions: Women described cognitive and emotional aspects of anxiety during pregnancy and how these impacted their wellbeing. Personal and social expectations of pregnancy and motherhood increased anxieties. Healthcare professionals have the potential to reduce anxiety by normalising and validating experiences and offering emotional support. Continuity of care is important for developing trusting relationships so that women feel confident to disclose anxiety. Developing information for women regarding the range of physical and emotional experiences which can occur during pregnancy might be helpful in normalising experiences and reducing uncertainty and anxiety.

Introduction

Pregnancy represents an important time of transformation for women - physically, psychologically and socially. This transition involves a significant change to a woman's identity [1]. Although pregnancy can be a time of joy, it can also be a difficult time for women, potentially leading to anxiety [2]. Although most women will naturally worry about the health of the baby, labour and coping postnatally, some women will experience levels of anxiety which might be excessive, potentially reaching thresholds for clinical levels of generalised anxiety [3]. Generalised anxiety is defined in the Diagnostic Statistical Manual (DSM) 5 (2013) [4] as excessive worry, disproportionate to current events, which the person finds difficult to control, causing distress, and it results in decreases in occupational and social functioning for a minimum of six months [5, 6]. However, the application of diagnostic criteria of Generalised Anxiety Disorder (GAD) to a pregnant population has been criticised [7]

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due to difficulties in distinguishing expected pregnancy-related physical changes and worries from psychosomatic symptoms and excessive worries associated with GAD.

Although prevalence rates vary within the literature, approximately 15% of women will experience clinical levels of generalised anxiety during pregnancy [8, 9]. Antenatal Generalised Anxiety (AGA) has been associated with increased risk of postnatal mental health difficulties [10, 11], disruptions in infant-mother-attachments [12], the release of excess cortisol during pregnancy impacting on the neurodevelopment of the foetus [13] and negative outcomes on the infant's psychological development [14, 15].

Few qualitative studies have explored women's lived experiences of GAD specifically during pregnancy. Of the existing literature, which attempts to investigate anxiety, it is often conceptualised under the umbrella term of antenatal 'distress', encompassing depression, anxiety and stress. Exploring women's experiences of antenatal 'distress', Staneva et al. [16, 17] reported that anxiety and depression arose when women felt their emotional or physical experiences of pregnancy were deviant from social ideals of the 'good mother' or from society's idealised views of pregnancy, which were often unrealistic. Women interpreted emotional distress as indicators that they were inadequate mothers. Similarly, Evans et al. (2017) [18] found that stigma and discrimination of mental health/illness, inconsistency in antenatal healthcare and negative responses from professionals created barriers to women disclosing anxiety and accessing support.

Understanding the experiences specific to AGA is important to improve detection and to develop perinatal psychological treatment as well as offering preventative interventions. Thus, the current study aimed to explore women's experiences of anxiety during pregnancy using an Iterpretative Phenomenological Analysis (IPA) approach.

Method

Design

A qualitative design using IPA was chosen in order to understand people's lived experiences and the meanings they attach to these experiences to make sense of them [19]. Ethical approval was granted by a National Health Service (NHS) Ethics Committee (ref 17/NW/0318) and the Health Research Authority in England, the UK.

Participants and procedure

English-speaking pregnant women, over 18 years of age, and who identified as experiencing anxiety were eligible to take part. Previous miscarriages, In Vitro Fertilisation (IVF) pregnancies, previous traumatic births as perceived by the woman and high-risk pregnancies were exclusion criteria because these experiences might be associated with different anxieties. Women with psychiatric diagnoses other than anxiety or mixed anxiety and depression were also excluded.

Midwives screened patient notes, approached eligible women attending antenatal clinics and sought consent for the researcher to contact them. Online advertisements, using Twitter, Facebook and pregnancy forums, were also used. For this recruitment pathway, women were screened by the researcher. Eligible women willing to participate provided written consent prior to being interviewed.

Interview

A semi-structured interview schedule was developed, informed by current literature and discussions with the university's group of experts by experience of mental health difficulties. The schedule was piloted with two pregnant women and minor revisions to the content and structure were made. The interview covered three broad areas: i) the experience of anxiety during pregnancy, ii) communicating anxiety during pregnancy and iii) seeking women's advice about how to improve healthcare support. Open-ended questions allowed for exploration of arising areas of importance for participants. Women were offered the choice to conduct the interviews either at their home or via Skype. Interviews were audio-recorded and transcribed verbatim by the first author.

Data analysis

Data were analysed using IPA guidelines [20]. Each transcript was read and re-read, while making exploratory notes about meanings, understandings and interpretations of what the participant might have been describing. Interpretations were also made regarding specific language, metaphors and phrases used by participants. The transcript was then re-read and initial notes and data were condensed into emergent themes. These themes were then clustered based on connections and similarities in defining experiences or phenomena. Each cluster was assigned a subordinate theme name which reflected the researcher's interpretations. This process was then repeated for the remaining transcripts. Subordinate themes connected by meaning across all transcripts were clustered together and overarching superordinate themes were assigned, which broadly reflected the shared experiences of participants. Each researcher reflected on and re-examined the process to ensure themes and connections were related to the participants' original data.

After two researchers (BH & DS) analysed the data independently, themes were compared and discussed within the research team to ensure that interpretations were plausible, coherent and grounded in the data. Any disagreements were resolved through discussion of the text and reasoning given by each researcher. All final themes were agreed upon by the research team.

As qualitative researchers bring their own expectations, knowledge, bias and experiences to the research process, it is important for transparency and replicability [19] that the research team outline their backgrounds. The first author was aware that his experiences of being a man, with no personal experience of pregnancy or parenting, might have brought some naivety but also an unbiased perspective. His professional and academic experience of clinical psychology offered perspectives in relation to understanding anxiety and the influence of social dynamics. The research team included a health psychologist (DMS) and a perinatal clinical psychologist (AW), both of whom were women and mothers as well as researchers of pregnancy and parenting. These varied perspectives and experiences within the research team contributed to greater trustworthiness in reducing bias when identifying themes.

Results

Sample characteristics

Eight women consented to participate; however, only seven completed the interviews because one woman gave birth shortly after providing consent. This sample size was consistent with

recommendations for conducting IPA [19] and comparable to other antenatal IPA studies [21, 22]. Participants were aged between 28 and 39. All women were white, employed and lived with either a partner or husband. All pregnancies were planned (see Table 1).

Table 1: Participant Demographics

Participant	Age	Ethnicity	Employment status	Relationship status	Trimester	Previous children	Complications (none deemed high risk by midwives)
P1	35	White	Student	Partnered	3rd	0	Baby in lower average growth percentile
P2	31	White	Employed	Married	2nd	0	Foetus diagnosed with talipes
P3	32	White	Employed	Married	3rd	1	N/A
P4	29	White	Employed	Partnered	1st	0	N/A
P5	28	White	Employed	Married	3rd	0	Vanishing twin syndrome
P6	39	White	Employed	Married	3rd	1	Intrauterine growth restriction
P7	31	White	Employed	Married	2nd	0	Previous ectopic pregnancy and termination

Findings

The analysis yielded 77 emergent themes which were condensed into four superordinate themes that conceptualised the experiences of antenatal anxiety. Superordinate and subordinate themes were depicted diagrammatically to suggest how each theme influenced anxiety as pregnancy progressed (Figure 1).

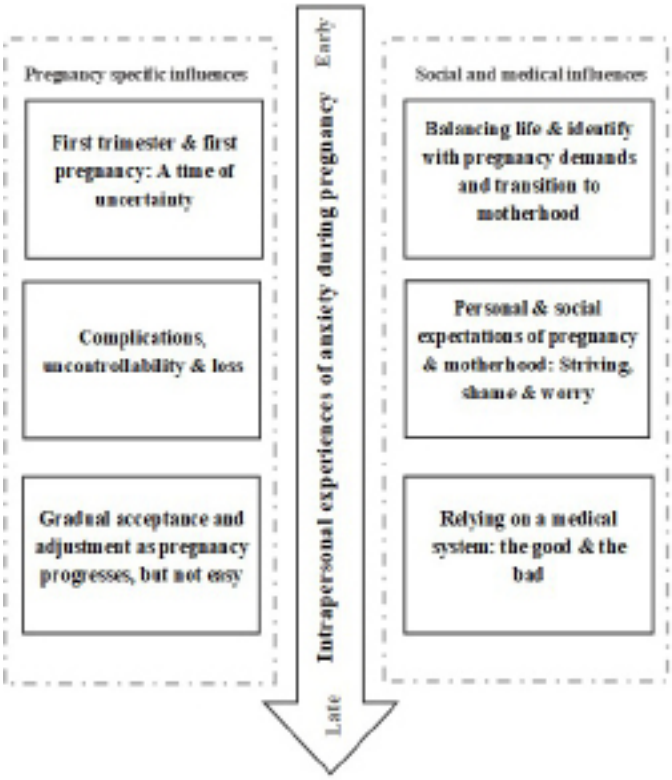

Figure 1: Diagrammatic formulation of women's intrapersonal experiences of anxiety and influencing factors (subthemes and themes) as pregnancy progresses

Superordinate theme 1: Adjustment to pregnancy and motherhood and the experiences of anxiety

Subordinate theme: What it is like to experience generalised anxiety

This theme related to how women described their experiences of anxiety during pregnancy. Their cognitive experiences of anxiety involved 'overthinking' and 'worrying too much' about uncertainties in their lives. Women described anxious thoughts as persistent, uncontrollable, 'not comfortable' and that they could be 'difficult to let go'. Women used words, such as feeling 'upset', 'unsure, 'overwhelmed', 'panicked', 'fear' and 'frantic', to describe their emotional responses. Three women commented on physical changes when anxious, namely tension, poor sleep and a racing heart. Six of the women described how anxiety could impact them and their daily lives, either by them responding by seeking control and reassurance, or when overwhelmed feeling not their 'normal' selves leading to withdrawal and concealing how they felt from others. Not all women reported experiencing anxiety prior to becoming pregnancy, however, those who did explained the cognitive and emotional experiences remained relatively the same, but that the content of their worries, the sources of anxiety, and their responses to anxiety changed during pregnancy.

Subordinate theme: Pregnancy focus of anxiety

All women mentioned the content of their worries and anxieties shifted to focus on pregnancy, motherhood and changes to their lifestyle. Most women spoke of i) concerns of losing the baby (particularly in the first trimester), ii) any abnormalities and their capacity to cope, and iii) fears about complications and labour and iv) feeling responsible for baby's development and any negative outcomes. Similar findings of the content of worries shifting during pregnancy have been reported [18, 23, 24]. The intensity and frequency of these worries seemed to be influenced by trimester and previous pregnancies. Worries also related to being a 'good mother'; for example, ensuring the best environment for their baby whilst in the womb, concerns about breastfeeding successfully, being able to manage stress postnatally and being able to bond. It seemed four of the participants, who might be considered Facilitators in their orientation to motherhood [25], were more preoccupied and anxious about their abilities as good mother and provide the best start for their baby. Raphael-Leff (1983, 2010) described a pregnant woman who looked forward excitedly to giving birth and becoming a mother as having a Facilitator orientation. This kind of woman is thought to treat pregnancy as the culmination of her feminine experience. Throwing herself wholeheartedly into the process, she may start wearing maternity clothes early and she is looking forward to being lead by her baby,. In contrast, women with a Regulator orientation are believed to experience childbirth as a dreaded, exhausting and painful event to be mitigated by medical intervention. To a Regulator pregnancy is an unavoidable means of getting a (unknown) baby. Raphael-Leff

(2010) also defined a third category of maternal orientation: Reciprocators. They reflect the attitudes of expectant mothers (or fathers) who are able to tolerate uncertainty and mixed emotions, in themselves and the baby [27, 33].

In our study women also reported to experience worries which involved body image, impact of pregnancy/motherhood on current relationships and employment, and intrusive thoughts of harm to baby. Intrusive thoughts of this nature can be common in women who experience generalised anxiety or obsessive compulsive disorder and they may also occur in women who may experience psychotic symptoms depending on what they believe the source of the harm to be. In this context these thoughts were triggered by anxiety.

Women spoke of contradictory worry about the presence and/or absence of symptoms and trying to interpret their meaning, but never being fully certain which increased anxiety. The uncertainty intolerance model of GAD [26] seemed a helpful model when understanding these experiences. For women, particularly for whom this was their first experience, pregnancy was a time of uncertainty, which was anxiety-provoking, as they could not truly re-establish a sense of certainty or control until their baby was born.

"…with pregnancy the biggest stressor is knowing that you're not going to get any feedback (assurance) until the kid is born." (P3)

Subordinate theme: Adjusting to pregnancy and motherhood

Adjustment to and assimilation of motherhood into one's identity and life was a source of anxiety for five women. For first-time mothers it seemed difficult to comprehend how life would be once their baby has been born, how they would cope and the impact on their identities. One woman discussed her concerns of becoming 'mumzie' (P4) and whether this would fit with her sense of self:

"And when you think about yourself and your identity and what that is about a lot of that is down to how you live your life and what you do and that feels like that will inevitably change (after birth)." (P4)

This potential dilemma for women might be understood in terms of [25, 27] Raphael-Leff's (1983, 2001) mothering orientation theory. This participant perhaps reflected a Regulator orientation, in that she wished to maintain her 'pre-baby' identity and hoped being a mother would not alter that too much. However, she continued to discuss her anxiety that she would inevitably lose a part of herself in the process of becoming "mumzie":

"So it is kind of thinking you are going to become a bit of the 'mumzie' person, because that is who you are, a mum, but can you maintain who you are by like still making time for friends and the things you enjoy that are separate to your child." (P4)

Again Raphael-Leff's (1983; 2001) theory helps to understand how anxiety and frustration can arise when assimilation of motherhood (and associated expectations) might pose threats to one's sense of self [25, 27]. This same participant discussed social pressures on women having to choose between career and motherhood:

"I feel like I have been on this track since I was at school and so that has been a really long time…. But because I want all of it I don't want to have to choose and, you know, men don't usually or often have to choose." (P6)

In addition to psychodynamic understandings, the sense of choice participants spoke of could be understood from a feminist perspective [28]. Although pregnancy is often a shared experience within partners, women in this study (all of whom were in heterosexual couples) seemed to experience more social losses than their male partners, in terms of interruptions to their career progression, less time with friends and a sense of more responsibility during and after pregnancy to be a devoted parent. These losses could, understandably, lead to dilemmas, anxieties and changes in mood.

Subordinate theme: Coping with anxiety during pregnancy

Four women described how pregnancy could interrupt or prevent the use of their usual effective coping strategies to manage anxiety (e.g., socialising, drinking alcohol and exercising). One participant explained how joint pain and morning sickness due to pregnancy impacted her wellbeing:

"I used to run and that used to help with my anxiety, after I got pregnant I couldn't do that anymore, so it is something I miss that would help." (P1)

When asked what helped to cope with anxiety during pregnancy, all women commented on the importance of social support. Five women reported that social support specifically from women who were or had been pregnant themselves had the potential to be extremely positive and powerful experiences. Women with shared emotional experiences of pregnancy were sources of reassurance and normalisation, which helped the participants feel confident, more tolerant of uncertainty and less anxious.

"I can say these things with them (antenatal group), that I worry I am not taking good enough care of myself and this baby isn't going to get as good a start in life (as her first child) and they laugh and they say 'oh I have thought the same thing'. And rather than being dismissive it is really validating, not to be the only one that feels this way sometimes. And it is reassuring." (P3)

Although women attempted to cope, when anxiety became overwhelming some temporarily disengaged from their pregnancy and attempted to mentally avoid anxieties or potential triggers.

"I guess I just have to push on and forget about this pregnancy and just wait to hold the baby in my arms (tearful), and until then just try not to think about it too much, keep myself occupied and push the worries to the back of my head as much as I can." (P2)

This potential disengagement from pregnancy due to anxiety could lead to ambivalence about being pregnant. High levels of anxiety and ambivalence during pregnancy have been shown quantitatively to be linked to disruptions in prenatal attachment leading to difficulties in the mother-child bonding postnatally [29, 30].

Superordinate theme: Unfamiliarity, uncertainty and uncontrollability of pregnancy influences anxiety

Subordinate theme 2.1: First pregnancy unfamiliar

It was clear from each woman's description of their experiences that the nature of their pregnancy had a significant

impact on anxieties. All seven women spoke of how their first pregnancy increased their anxiety. All women explained this was due to unfamiliarity with what was and was not 'normal' during pregnancy, not only in terms of the physical changes, but also how pregnancy could impact emotions and cognitions. One woman described her change in perspective:

"And since the beginning (before pregnancy) I think I had a different point of view on being pregnant. I thought it would be totally different (disbelieving laugh) and because I didn't know my emotions and worry would be as it has been for me…. (pause) I think because usually pregnant women they don't talk about their feelings, at least my friends, they haven't talked about worrying or worries or things that weren't going well..." (P1)

It seemed women's expectations of how they would feel emotionally during pregnancy might not have matched with the reality and challenges of pregnancy. For the two participants on their second pregnancy, who were more experienced, anxieties were less persistent. The intolerance to uncertainty model [26] can help understand this theme and how the uncertainty of a first pregnancy can lead to anxieties. Given that primiparous women do not have prior experience or information to judge their pregnancy against, this gives rise to uncertainty regarding what is 'normal' or expected, comparisons with other women and attempts to resolve uncertainty (e.g., searching the internet), which for some ultimately led to maintaining anxiety. For second time mothers it seemed their prior experience brought confidence, more certainty and therefore they did not feel as anxious.

"This time around I already have one (child), so the pressure is off a bit. I managed to bring her safety into the world, so I am more open to listening to people who say things like 'oh come on, don't worry'." (P3)

Subordinate theme: First trimester feels uncertain

Six women spoke of their first trimester being the most anxious time. Participants reported this was because of the first twelve weeks of pregnancy representing the highest risk of miscarriage. Due to this increased likelihood, women felt they could not tell friends and family they were expecting, because of fears of potentially losing their baby and having to share their loss. One woman in particular commented on the difficulty with this situation, of women trying to manage the most anxious time themselves without social support. Women reported the first trimester was anxiety provoking because they felt uncertain and unable to establish some sense of control as they waited for their 12-week-dating ultrasound scan. However, as pregnancy progressed, milestones were met, and there were clearer signs that baby was doing well, women reported a gradual acceptance of the uncontrollability and uncertainty of pregnancy, and therefore felt their anxieties decrease. Again, these experiences seem to be in line with the intolerance to uncertainty model [26]. As the first trimester is perceived to be the most uncertain, it is understandable that anxiety is highest, but progression and signs that baby is developing (e.g., ultrasound scans, movement) helps to reduce uncertainty. This decrease in anxiety after the first trimester in pregnancy has also been demonstrated in quantitative studies [31, 32].

"It's (anxiety) gone down definitely, in comparison to the first trimester. I guess it's come with a bit of acceptance of not knowing (laughs) to some degree and at first, there was allot more worry about not being in control at all, whereas now I have started accepting some of that. It does still come back at times, the constant worry of whether the baby is going to be ok, and, yeah (sigh), I go through phases, but it is nothing like it was in the beginning." (P2)

Subordinate theme: Complications, uncontrollability and loss

Six women described a sense of powerlessness, anxiety and loss of hope when faced with pregnancy complications. Four participants experienced complications during their pregnancies (see Table 2). These complications were distressing, not only fearing for the welfare of their babies, but also the loss of hope for providing their baby with the best start in life and plans for pregnancy and labour. Women reported a felt sense of responsibly which led to feelings of sadness, guilt and anxiety. Similar experiences of complications were described by Raphael-Leff (2010) [33] who suggested a loss of a hoped for pregnancy might be particularly distressing for Facilitator orientated mothers, who perhaps on a conscious or unconscious level perceives not being able to provide the best gestation for her baby as a 'failing' of her as a mother [33]. In comparison, one woman who had been diagnosed with a genetic condition which impacted the placenta, but who had given birth before, spoke of a process of accepting and committing to her reality of not having much choice or control in having a 'perfect delivery method', instead putting her faith in medical professionals to help choose the best plan. As this was her second pregnancy she described adjusting her expectations to what she felt were more realistic of her body and the uncontrollability of pregnancy, thus alleviating some guilt and anxiety.

Superordinate theme: Personal and social expectations and pressures of pregnancy and motherhood

Subordinate theme: Personal expectations

Expectations for pregnancy seemed to influence anxiety. A common theme was that women had images and plans for how they hoped their pregnancy and labour would go. However, for four first time mothers these expectations did not match with their reality which led to sadness and concern. One woman explained her sadness and worry at the loss of how she expected her pregnancy to go due to pregnancy scares and complications:

"I guess it had not been that happy story, it has been just stress and worry, and visits to hospital and yeah (sad laughs) maybe for that reason we haven't done it (decorated the nursery). Obviously, I am super excited for the baby, you know, hopefully everything will be ok, but the whole experience and the constant worry if it is going to be ok, it's kind of over shadowed it at times." (P2)

Four women spoke about an image of a 'normal' pregnancy and if their own experiences did not conform when compared to other pregnant women's experiences (or information online) then anxieties increased. Similar findings have been demonstrated in quantitative studies, whereby negative social comparisons to other mothers and low self-confidence in primiparous women were associated with maternal depression [34]. One woman, who later discovered that the position of her placenta decreased her ability to feel her baby's movements, described becoming anxious when she received weekly updates to an app on the phone on what she should expect to feel or when other women would make comparisons:

"A woman I work, she was telling me how her daughter felt movement at sixteen weeks, and I am like 'oh gosh I am twenty five weeks and I haven't felt much' and people are telling me their normal, although they say 'oh it is different for everybody', but it still makes you question what is and isn't right and what should be happening and not. And people keep saying 'oh you look huge' and I am like does that mean I am fat does that mean I am normal. And that makes you think about things too much." (P7)

Subordinate theme: Social expectations

All seven women spoke about the social expectations and pressures regarding pregnancy or motherhood which generated anxiety. One woman spoke passionately about pregnancy being 'heavily moralised' within society, commenting on a sense of judgement and blame for women who might not have the 'ideal' pregnancy conditions (e.g., who are older or overweight) or who might have complications. She explained her frustration at how she felt blamed for things out of her control:

"So, if you have a difficult pregnancy with lots of intervention it's somehow your fault, there was something you didn't do, did you not exercise enough, did you eat properly, did you have folic acid, or did you drink in early pregnancy. And from the health side a lot of the stuff probably makes a marginal difference because there are bigger (uncontrollable) factors." (P6)

Having previously experienced pregnancy and motherhood this participant was aware of social pressures and the emphasis on 'natural' methods, for example, women are expected to breastfeed (even if that is not feasible), as well as being completely devoted to motherhood, perhaps to an extent that a woman's own needs become neglected:

"But if you are on maternity leave there is pressure to be doing really motherly stuff, you are not meant to just be sitting on the couch watching Jeremy Kyle having a year off paid for by your employer and the tax payer , you're meant to be really doing, being quite saintly." (P6)

This often prescriptive social image of the 'good mother' has been critiqued within feminist literature [35], whereby women are expected to embody certain unrealistic ideals of motherhood, which does not recognise the reality of pregnancy/motherhood and the needs of women. Although such experiences might be pervasive for all women adjusting to motherhood, for some this pressure could be very anxiety provoking.

Women spoke about a sense of judgement on them and their ability to be a 'good mother' if their experiences did not fit with social expectations. Women spoke of pressures to constantly feel 'happy' and 'grateful' with being pregnant, with no permission to feel unhappy or ambivalent even though all women reported pregnancy was difficult at times. When asked what people might think if she said she was not feeling grateful one participant said:

"That I won't be a good mother, because like I think most of my friends they always say 'I miss my pregnancy belly' and these kind of things and I'm like 'I cannot wait to get rid of it' because I cannot look at the mirror and feel myself beautiful and it is difficult for me to sleep, especially because my belly is big, and doing small things and also now I have ligament pain so if I walk too much during the day I cannot sleep during the night, because of the pain. So it's not really nice." (P1)

These themes around social expectations of pregnancy and motherhood and resulting feelings of shame and anxiety were also highlighted in Staneva et al.'s (2017) [16] thematic analysis of antenatal distress. Staneva et al. (2017) [16] found that women could feel judged if their physical and emotional experiences of pregnancy did not fit with socially constructed ideals of pregnancy. One participant within the current study described the social pressures to feel and think a certain way during pregnancy, and if a women should speak out about difficult feelings or mental health there was a risk of being judged.

"When people are talking about how they feel and anxiety related stuff people are more likely to make judgements about what they are going to be like as a parent, which is ridiculous. Which they wouldn't do if you were struggling with physical stuff." (P4)

Some women also felt there was no parity between physical and emotional difficulties in social discourse. It was more socially acceptable to discuss physical complaints without fear of judgement. However, if women were to discuss personal or emotional challenges during pregnancy with others there was a risk of being judged or criticised resulting in women avoiding disclosing their feelings.

Superordinate theme: Relying on healthcare systems – the good and bad

Subordinate theme: The impact of healthcare systems on anxiety

All the women's narratives included the impact of the healthcare system on their pregnancy and anxieties. One important theme which all women mentioned was an almost 'double edged sword' experience of medical tests or interventions. Although all women found ultrasound scans reassuring, for most the period of waiting before and between scans was a nervous time. For women whose medical tests indicated potential problems anxiety increased; however, this increased risk to baby prompted access to frequent monitoring and more support which helped somewhat with managing anxiety. It seemed that when problems were indicated and more medical interventions were recommended, women lost hope for a 'natural' pregnancy, but also a sense of control shifting from women feeling in control of their pregnancy to the healthcare system making more of the decisions. Although important, this increased role of medicine during pregnancy and in decision making has been discussed from feminist perspectives as potentially disempowering and therefore anxiety provoking experience if not managed correctly [36]. This shift in control for one woman in particular (who might have a tendency towards a Regulator mothering [33]) was distressing and upsetting:

"In my day-to-day life I am a manager of a team, I own a house, I have got a very happy relationship and a happy family and good friends and it feels like everything is ticking along perfectly…. And yeah I am quite in control. But obviously here there is nothing, I don't know, for a while being told there is nothing you can do, you just have to wait from scan to scan until the baby comes, and just pray for the best." (P2)

Women expressed frustration and dejection with the antenatal healthcare system at times, acknowledging the system was stretched in terms of resources, but because of this women felt powerless to affect change. One woman explained how she would like to have more understanding and control over what

her labour and after-care would involve; however, she felt the system was not able offer enough support and she felt powerless to influence her treatment within a pressured system:

"Yeah but I suppose there is nothing anyone can do. If I could, I know the NHS is stretched and everyone is doing what they can, but if I could I would pay all my savings to make sure I get better care. But I can't even do that." (P2)

Participants were asked about how easy/difficult it was to communicate their anxieties with health care professionals. Four women described their experiences of professionals asking about mental health as a 'tick box exercise' rather than being asked in a curious, personal and sensitive way.

"I mean they ask me about it in general terms (sighs) when I go to an appointment. They have sort of a 'tick box' they do every now and again." (P5)

In their qualitative study, Bayrampour et al (2017) [37] also found depersonalised care and style of questioning was a barrier to women disclosing mental health concerns during pregnancy. Although the National Institute for Health and Care Excellence (NICE) [6] recommends the use of two mental health screening questionnaires (PHQ-2 and GAD-2) consisting of two items each within antenatal clinics in the UK, a qualitative study [38] exploring midwives' and patients' opinions of these questions found them 'blunt' and not entirely helpful, unless the professional was confident and able to facilitate a further conversation about mental health.

In our study, one participant wondered about the relevance of asking questions about her family history of mental health, because it felt probing rather than personal, without an interest in how she was feeling. This uncertainty and fear of stigma regarding mental health/'illness' caused anxiety whether her answers would be used or interpreted in a negative way:

"I think if you knew a bit more about what would happen with that information, or what kind of support they were able to offer. And why the information is relevant. Like if they were asking just about me and how I'm feeling, that's important to ask, but when it is about your family maybe just saying 'we ask these questions for these reasons' because (inferring a reason) I think that would have stopped me worrying and wondering." (P4)

This was also linked to fears that healthcare professionals might themselves have judgements about mental health and what that meant about one's ability as a mother, one mother described that she felt great but worried it would be perceived as depression or another postnatal mental health problem:

"…they had me flagged for having anxiety and depression in the past, and I was a little nervous that I would be seen as high risk, but that I didn't have postnatal depression I had postnatal amazing." (P6)

Similar barriers of perceived judgements have been reported in women accessing perinatal mental health support [39, 40].

Subordinate theme 4.2: Influence of relationship with healthcare professionals on pregnancy and anxiety

Although women described frustration and concerns with the system, women described the people working within those systems as kind and compassionate. Women described how even small interactions with healthcare professionals had the potential to ease difficult times during pregnancy. One woman described going to have a quick routine check at her general practice:

"I was having quite a bad day, and was quite tearful actually when I went in, and she spoke to me for quite a while and actually gave me a hug (laughs) and everything while I was in there. So she was really nice. She could tell there was something wrong. Because when I went in I wasn't crying when I actually went in but she could tell there was something wrong and she got talking to me then. So she was quite nice." (P5)

Five participants spoke about the power of health care professionals to help normalise, reassure, and alleviate anxieties. Given how individual and different one pregnancy can be from another, women explained that midwives often dispelled myths, misconceptions and worries by helping women understand their pregnancies better and normalising both physical and emotional experiences. However, all women commented on the importance of building a relationship with just one midwife in order to establish trust and understanding. Without continuity of care this relationship was difficult to establish, preventing midwives from getting to know the women, creating barriers for women to disclose their anxieties and seek support. Their experiences may need to be viewed in the context of the antenatal care these women receive. In the UK antenatal and immediate postnatal care is mostly midwifery led. Having the same midwife at each appointment allowed conversations about mental health to develop, rather than different midwives asking the same 'tick box' questions. This reported experience by women may be related to the rise of the use of electronic medical records in which a number of entries have to be made. Women also reported having a relationship with a midwife would promote a sense of control and assurance, particularly in times of uncertainty or crisis, as their midwife would be able to offer person-centred care and support women's choice should difficulties occur. Various feminist writers have similarly commented on the power of midwives to empower women during their pregnancy, to support personal choice and to 'de-medicalise' pregnancy [41, 42].

"I am hoping to have a home birth, that is what I have planned for, and the midwifes in my area are really positive about home births and what have you which is really good. They came round a few weeks ago to drop all the things off and they went through all the process about why you might be transferred into hospital and what their process would be at a home birth and all that kind of thing. Which was helpful. So there have been good points in the care I have received in lessening anxiety." (P5)

Clinical Implications

Women were asked in the interview if they had any advice for health care professionals on how they could better support for women during their pregnancy who experience anxiety, we have tabulated this information (see Tables 2 and 3 for an outline of participants' advice).

Table 2: Advice for healthcare professionals from participating women

Asking about mental health	More parity between emotional and physical wellbeing; more time dedicated to discussing emotional wellbeing during antenatal appointments.
	Professionals to be mindful of stigma and barriers to disclosing anxiety; to open conversations in a sensitive and normalising manner, while being transparent about how information regarding mental health will be used.
	Professionals to avoid 'tick-box', closed questions regarding anxiety; development of natural, curious and caring conversations regarding anxiety throughout pregnancy.
Responding effectively	Professionals to give time and listen to what a woman is communicating.
	To respond in an empathic, non-judgemental, validating and normalising manner.
	To collaboratively discuss support with patient; whether emotional support from midwife or further referrals for psychological support.
Relationships	Continuity of care (appointments with the same midwife to build trusting and understanding relationships, and to facilitate disclosure and conversations about anxiety.
	Professionals to become familiar with patients to better offer person-centred care.
	Professional to be confident to discuss mental health. Mental health staff (e.g. psychologists) to offer to support and training to build staff skills if needed.
Practical advice	Additional information regarding upcoming appointments to reduce uncertainty
	Additional appointments or brief 'check ins' during first trimester (anxious time).
	Sharing information regarding all potential outcomes to help women prepare.
	Consider emotional support groups for pregnant women with shared experiences.

Table 3: Participants' advice for pregnant women experiencing anxiety

-	Acknowledging that no 'typical' or 'normal' pregnancy exists, and experiences vary.
-	Recognising the uncontrollability of pregnancy and being compassionate to oneself.
-	The importance of self-care to manage anxiety.
-	Access social support/groups, particularly talking to women with shared experiences.
-	To share emotional experiences with antenatal professionals.
-	To access psychological support if needed.

Our participants advised that healthcare professionals should be aware of persisting stigma of mental health problems and unrealistic social expectations of pregnancy and motherhood. Antenatal professionals need to be confident in discussing anxiety with women in a non-judgemental and empathic way, to normalise and validate experiences, while also aiming to readjust expectations and provide more helpful information regarding the range of emotional and physical experiences which occur during pregnancy. Clinical psychologists can play a role in training and supporting antenatal staff to develop their skills in assessing, responding to and supporting women with anxiety. This psychological support of antenatal staff is in line with UK Department of Health guidance [43], which aim to enhance of perinatal services to better support women and build resilience to improve mother-baby attachments.

In terms of support, women mentioned that talking to other pregnant women with shared experiences of anxiety helped to normalise and validate feelings. Support groups could be offered. In addition, given that expected pregnancies can change due to complications, and this can be difficult to process and adjust to, some elements of acceptance and commitment therapy [44] (Hayes et al, 2006) could be added to such groups to help women cope. The groups could also offer information regarding the physical and emotional experiences of pregnancy to help women understand and feel more in control.

Recent shifts within the NHS in the UK towards midwife-led continuity of care models [45, 46] fit with recommendations from this research. Participants explained that access to the same midwife would help build a trusting relationship to facilitate disclosure of anxiety, to allow conversations regarding mental health to develop and for midwives to fully support and empower women during their pregnancy. This is in keeping with existing literature of the importance of therapeutic relationships when exploring mental health [47, 48].

In respect to screening and identification, the findings from this study (although tentative) indicate that current screening tools in the UK (Whooley questions, GAD-7 and Edinburgh Postnatal Depression Scale) might not be adequate to detect anxiety. AGA is clearly a distinct and separate experience to depression and therefore both the Whooley [49] and EPDS [50] might not be sufficient. Women in this study also focused on the emotional and cognitive experiences of anxiety, rather than the psychosomatic elements which common anxiety instruments tend to test on (i.e. GAD-7). In addition, given the potential for misinterpreting anxiety symptoms as pregnancy symptoms, and challenge of determining expected versus difficulties in transitions to motherhood, different measures should be considered. Perhaps more specific pregnancy-related anxiety questionnaires

would be useful.

Study limitations

Although each participant's experience was unique, more diversity and inclusivity of other demographics may have provided broader narratives and different experiences of antenatal anxiety. The fact that all participants' pregnancies were planned might have influenced women's emotional adjustment, and therefore their narratives regarding pregnancy might not reflect experiences of women with unplanned pregnancies. Although experiences and interactions between anxiety, stigma and pregnancy may be relevant to women from all backgrounds, the specific relationship between participants and the UK health system might make certain findings less transferable to women in other countries, accessing different healthcare systems.

Conclusion

This study explored women's experiences of anxiety during pregnancy. The findings, based on IPA, offer an in-depth understanding of how anxiety is experienced during pregnancy and the various factors which influence anxiety and pregnancy. Women reported more cognitive and emotional experiences of anxiety, rather than psychosomatic. Results also indicated that personal and social expectations of pregnancy and motherhood can increase anxiety. Healthcare professionals play an important role in normalising and validating experiences during pregnancy, while also adjusting expectations to help reduce anxiety.

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