Anxiety during pregnancy: A meta-ethnography of women's experiences of antenatal anxiety and a qualitative exploration of women's experiences of recovery from antenatal anxiety

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Research Portfolio Abstract

Introduction: Antenatal anxiety is common during the perinatal period and, if untreated, can have lasting effects on both maternal and infant outcomes. Despite this, there is little research seeking to understand the lived experiences of women who have had antenatal anxiety. In order to design appropriate perinatal mental health services for women, it is important to gain an understanding of their experiences from their perspective.

Methods: A meta-ethnographic approach was used to systematically search and synthesise qualitative research exploring women's experiences of antenatal anxiety. Five electronic databases (ASSIA and Social Services, PsychInfo, Medline, EMBASE, and CINAHL) were searched. Quality appraisal was carried out using a modified Critical Appraisal Skills Programme checklist. For the empirical project, Interpretative Phenomenological Analysis was used to explore women's lived experiences of recovery from antenatal anxiety. Ten women who self-reported experiencing mild-moderate antenatal anxiety were recruited via social media. Interviews were conducted remotely and transcribed verbatim.

Results: Fourteen qualitative studies were included in the meta-ethnography. The themes across the studies were sufficiently similar to complete a reciprocal translation. Three main themes were identified: 'Characteristics of antenatal anxiety', 'Paradoxical influences on antenatal anxiety', and 'Striving to be a good mother'. For the empirical project, one overarching theme was identified – 'Journey to recovery' – that encapsulated four main themes. The four themes were: 'Someone that "gets it"', 'Safe responsive relationship(s)', 'Locus of control', and 'Knowing what to expect'. Importantly, there was no one aspect that supported recovery, rather it was a combination of factors that worked together over time.

Conclusions: The synthesis raised new insights into the way in which the "good mother" ideal impacts on the influences on antenatal anxiety and the characteristics of antenatal anxiety. It highlighted that there are a number of key mitigators for antenatal anxiety that could be built upon when designing services. The findings from the empirical project highlighted the need for universally accessible information regarding antenatal anxiety. Additionally, it shows the role of relationships and attuned care in allowing women to share the burden of antenatal anxiety. Clinical and research implications are discussed.

Research Portfolio Lay Summary

This thesis explores women’s experiences of anxiety during pregnancy, and their experiences of recovery. Anxiety during pregnancy is common, estimated to effect approximately 1 in 5 women. Research has found that untreated anxiety during pregnancy can impact on the mental health and development of the baby, as well as having a negative impact on the woman and her family. Despite this, little is known about the experiences and views of women who have had antenatal anxiety. Recently, funding has been provided by Scottish and UK governments for development of services to support women who have mental health difficulties during pregnancy and up to one year after their baby is born. In order to design services that work for women and their families, it is important to understand their experiences.

The first part of this thesis reviewed and evaluated the existing research exploring the experiences of women who have had anxiety during pregnancy. It then wove together (synthesised) the findings from each piece of research to create a fuller understanding of women’s experiences. Fourteen studies were identified by the search and three main themes were identified from the synthesis: 1) Anxiety during pregnancy is most commonly related to an increased sense of risk that something will go wrong; coping with the uncertainty of this risk; and specific worry about what childbirth will be like. 2) There are several factors that influence the intensity of the anxiety that women experience. These factors can both increase and decrease women’s anxiety during pregnancy. 3) Pregnancy can be a time of intense scrutiny from others. The pressure to do the “right thing” when it is impossible to define what that really means has a significant impact on women’s experience of anxiety. It can also have an impact on how women try to cope with their anxiety. Based on these themes, several recommendations for healthcare professionals and future research are considered.

The second part of this thesis is a study exploring women’s experiences of recovery from anxiety during pregnancy. Ten women were interviewed about their experiences and the interviews were transcribed and analysed. The interviews conveyed a gradual ‘Journey to Recovery’; where the women described a combination of factors that all worked together to contribute to their recovery from anxiety during pregnancy. The four factors were: 1) Having someone, or a community of people, that “get it” and take the time to understand the women’s experiences of anxiety during pregnancy. This could happen as part of an existing relationship or from a brief conversation with someone new. 2) Access to a supportive, consistent and trusting relationship that allowed the women to feel safe. 3) An opportunity to take back control from their anxiety, and to be allowed to have an active role in decisions about their care. 4) Access to information that allowed them to feel informed and knowledgeable about what was happening during pregnancy, as well as what was likely to happen during childbirth and after their baby was born. These themes highlight a number of ways in which women who experience anxiety during pregnancy could be supported with recovery. Ideas for future research and improvements to healthcare settings are discussed.

Journal Article 1: Systematic Review

Women’s Experiences of Antenatal Anxiety: A systematic review and meta-ethnography

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Abstract

Background: Antenatal anxiety is common during the perinatal period and, if untreated, can have lasting effects on both maternal and infant outcomes. In order to design services that meet the needs of this population, it is important to understand the lived experiences of women who have had antenatal anxiety. Despite this, there is little research seeking to understand the lived experiences of women who have had antenatal anxiety.

Aim: The aim of this meta-ethnography was to synthesise research relating to women's experiences of antenatal anxiety and build a comprehensive understanding of these experiences.

Methods: The seven-step meta-ethnographic approach described by Noblit and Hare (1988) was used to systematically search and synthesise qualitative research exploring women's experiences of antenatal anxiety. Five electronic databases (ASSIA and Social Services, PsychInfo, Medline, EMBASE, and CINAHL) were searched. Quality appraisal was carried out using a modified Critical Appraisal Skills Programme checklist.

Results: Fourteen qualitative studies were included in the final sample. Three main themes were identified: 'Characteristics of antenatal anxiety', 'Paradoxical influences on antenatal anxiety', and 'Striving to be a good mother'.

Conclusion: This synthesis raises new insights into the way in which the "good mother" ideal impacts on the influences on antenatal anxiety and the characteristics of antenatal anxiety. It highlights that there are a number of key mitigators for antenatal anxiety that could be built upon when designing services. The results and limitations are discussed with reference to research and clinical implications.

Keywords: Antenatal anxiety, Meta-ethnography, Perinatal mental health, Women's experiences, Qualitative

Introduction

Perinatal anxiety refers to anxiety that is experienced during pregnancy (antenatally) and/or up to one year postnatally.[1] Recently, there has been an increased recognition of the importance of perinatal mental health as a leading public health issue. The Scottish Government's Mental Health Strategy (2017-2027) included an action around the development of a perinatal mental health Managed Clinical Network in order to improve the recognition and treatment of perinatal mental health difficulties.[2] Additionally, recent publications like the 'Perinatal and Infant Mental Health Delivery Plan' and the 'NES Perinatal Mental Health Curricular Framework' highlight the intentions for assessment and intervention for parents and infants within the perinatal period.[3,4] In their published guidance for the care of women experiencing perinatal mental health difficulties, the National Institute for Health and Care Excellence (NICE) advise that perinatal mental health difficulties should be assessed at every routine appointment.[5] However, this relies on the care provider being appropriately prepared and able to assess perinatal mental health difficulties[6,7] in a normalizing and well-informed manner.[8] It also requires women to feel able to disclose their difficulties, despite perceived stigma around perinatal mental health difficulties being repeatedly found to be a barrier to disclosure.[7,9]

Prevalence of antenatal anxiety symptoms across pregnancy was estimated to be 22.9% in a systematic review of 183 worldwide studies,[10] yet compared to perinatal presentations like postnatal depression and postpartum psychosis it has received comparatively little attention.[11] Self-reported antenatal anxiety levels were found to vary throughout pregnancy with prevalence at 18.2% during the first trimester; 19.1% during the second trimester; and 24.6% during the third trimester.[10] These prevalence rates contrast with qualitative research exploring women's experiences of antenatal anxiety, where women reported the first trimester as the most uncertain and subsequent trimesters as comparatively less anxiety-provoking.[12] The prevalence of specific phobias during pregnancy is estimated to be 8.4%, with tokophobia (fear of childbirth) estimated to occur in 0.032% of women.[13] Previous loss during pregnancy,

pregnancy complications, lack of social support, style of coping, and factors associated with partners have all been found to be risk factors for the development of antenatal anxiety.[14] The authors argued that many of these factors are easily identifiable and have the potential to be modified during antenatal care.[14] However, it has been suggested that healthcare professionals working with women during the antenatal period can feel ill-equipped to manage perinatal mental health difficulties.[15]

Antenatal anxiety has been shown to have a significant relationship with severity of suicidal ideation independent of antenatal depression.[16] Unfortunately, the consequences of this can be catastrophic, with suicide being the highest reported cause of maternal mortality in the UK and Ireland.[17] In addition to this, antenatal anxiety has been found to be significantly related to the development of postpartum depression irrespective of the level of antenatal depression.[18] It could be argued that this relationship is leading to some diagnostic overshadowing, leaving the area of antenatal anxiety to remain little understood. In a recent systematic review and meta-analysis, antenatal anxiety has been linked with a number of negative outcomes for the infant that appear to extend into childhood and adolescence.[19] This includes difficulties with: socio-emotional development, cognitive development, language development, motor development and adaptive behaviour development.[19] A key limitation of this review was the lack of qualitative analysis, meaning that there was little opportunity for exploration of individual experiences. Alongside this, despite 191 studies being included in the review, only 50 were focused on antenatal anxiety.[19] This further highlights the paucity of research around antenatal anxiety.

There has been increasing recognition of the impact of qualitative research for informing service design.[20] Given the developments in services and policy around perinatal mental health difficulties, it would be timely to consider women's lived experiences of perinatal mental health difficulties to inform the next stage of service development. However, there has been comparatively little research qualitatively exploring women's experiences of perinatal mental health difficulties; and therefore, few systematic reviews or syntheses. The overarching themes of ‘Experiences of Motherhood’ and ‘Experiences of Services’ were identified in a meta-synthesis exploring experiences pre-conception to parenting for women with severe mental health difficulties.[21] The authors highlighted themes like ‘Stigma’, ‘Isolation’ and ‘Problems with Service Provision’,[21] themes that were echoed by Staneva et al in their review exploring women’s experiences of psychological distress, depression and anxiety during pregnancy.[22] They found five key themes: ‘Recognising that things aren’t right’; ‘Dealing with stigma’; ‘Negotiating the transformation’; ‘Spiralling down’; and ‘Regaining control’.[22] The authors argue that the way in which the women view their adjustment to motherhood as different or inferior plays a specific role in the women’s distress.[22] However, this synthesis only had 8 studies that met the inclusion criteria, limiting the transferability of their conclusions. The inclusion of studies with a variety of presentations may also dilute the nuances of experience between antenatal distress, depression and anxiety. In addition, only 2 of the included studies were qualitative studies of anxiety, again highlighting the limited research regarding antenatal anxiety. It seems that there has been far more attention paid to postnatal depression,[23-25] and an awareness of lived experiences of postpartum psychosis has been growing;[26-28] meanwhile lived experiences of antenatal anxiety remain fairly unexplored.

Despite the clear impact of antenatal anxiety on postpartum outcomes for mothers and infants, there is little research exploring the lived experiences of women who have had antenatal anxiety. It can be argued that qualitative research allows a deeper understanding of complex subjective experiences and in order to design perinatal mental health services for women and their families it is important to understand the views of those who have experienced it. To date, there has been no systematic review or meta-synthesis of the qualitative literature related to women’s experiences of antenatal anxiety. The current review therefore seeks to address this knowledge gap and synthesise research related to women’s experiences of antenatal anxiety in order to provide a comprehensive understanding of common experiences. It also seeks to appraise the quality of such research in order to ensure the veracity of the conclusions drawn by each study. Meta-ethnography was chosen as the synthesis methodology due to its utility for generating conclusions that go beyond the interpretations of individual studies, as opposed to aggregating findings.[29,30] Given that this is a relatively unexplored area, the generation of novel interpretations allows for a shift forward in the overall understanding of antenatal anxiety. The present review therefore sought to answer the question: What are women's experiences of antenatal anxiety?

Method

This review consulted PRISMA guidelines,[31] as well as following eMERGe reporting guidelines for meta-ethnography.[32] It was registered with the prospective register of systematic reviews, PROSPERO, on 9th November 2021 (Registration number: CRD42021279800).

The seven-step meta-ethnography approach described by Noblit and Hare was used.[29] The phases included: (1) Selecting meta-ethnography and getting started; (2) deciding what is relevant; (3) reading the studies and extracting raw data; (4) determining how the studies are related; (5) translating the studies; (6) synthesising translations; and (7) expressing the synthesis.[29,32]

A common critique of meta-ethnography is that it is not a standardised approach;[33] therefore, the updated and comprehensive guidance by France et al[32] was used to inform data synthesis. Seminal meta-ethnographic studies, for example Malpass et al,[34] Britten et al,[35] and Atkins et al;[36] as well as worked meta-ethnographic examples, for example Sattar et al[37] and France et al[38] were also consulted.

Search strategy and process

Five electronic databases were searched (ASSIA and Social services, PsychInfo, Medline, EMBASE, and CINAHL) on 8th November 2021. Alongside this, manual searches of reference lists from relevant studies were completed on 9th November 2021.[39] Search terms were developed using MeSH terms and keywords. Given the limited research available regarding women's experiences of antenatal anxiety, a broad search strategy was developed. The following search terms were entered into each database: "peri natal" OR "perinatal" OR "antenatal" OR "pre natal" OR "prenatal" OR "in pregnancy" OR "during pregnancy" OR "prepartum" OR "antepartum" AND "maternal" OR "mother*" OR "mum*" OR "wom*" OR "female*" OR "birthing person" OR "birthing people" AND "Anxi*" OR "{Anxiety}" OR "{Anxiety Disorders}" AND "experience*" OR "attitude*" OR "belie*" OR "perception*" OR "understand*" OR "viewpoint*" OR "standpoint*".

Inclusion and Exclusion criteria

This systematic review included studies that fulfilled the following criteria: (1) used a mainly qualitative approach to analysis; (2) reported data related to the experience of antenatal anxiety in women who have been pregnant or are currently pregnant; (3) included women who have been pregnant or are currently pregnant and experienced antenatal anxiety as the primary informants; (4) were published in English; (5) reported on primary data collected via interviews, focus groups, ethnographic data collection, surveys; and (6) were published in peer reviewed journals. In order to be as inclusive as possible, it was decided that studies would be included where there was data available referring explicitly to women's experiences of antenatal anxiety; even if the primary focus was experiences of 'perinatal anxiety'.

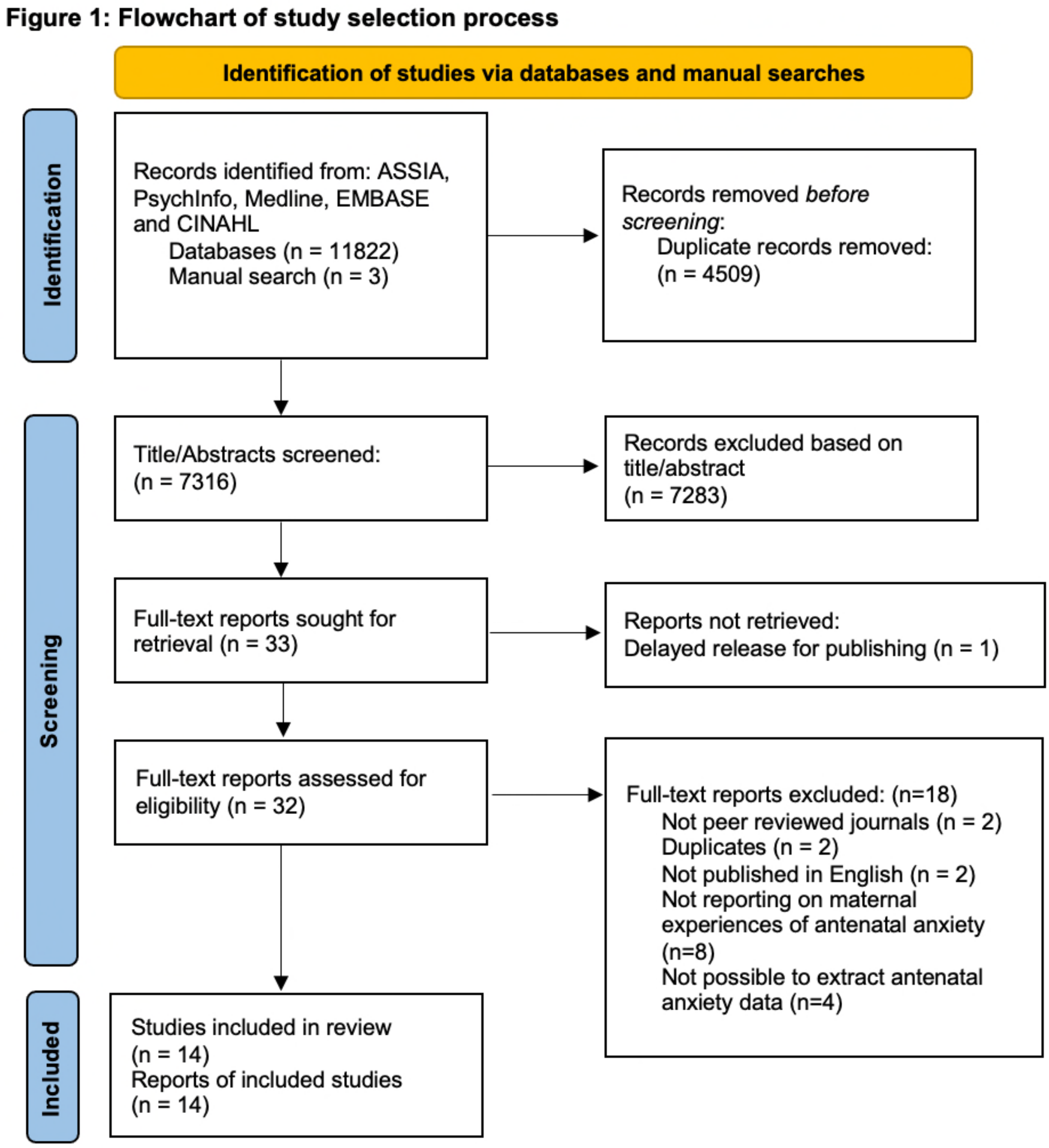
Studies were excluded from the review when: (1) data related to the mothers' experience of antenatal anxiety was not explicitly reported on; (2) the primary focus of the study was on the perspectives of others (e.g., carers or partners); (3) it was not possible to differentiate data based on diagnosis (e.g., antenatal versus postnatal anxiety); (4) studies that used quantitative methodologies; and (5) studies that were not published in peer reviewed journals (e.g., dissertations).

Study Selection Process and Outcome

A diagram detailing the study selection process as recommended by PRISMA guidelines is included in Figure 1.[31] The systematic review management tool 'Covidence' was used throughout the study selection process. Initially, duplicate articles (N=4509) were removed from the studies retrieved. Then, the title and abstract of remaining articles (N=7316) were screened against the inclusion and exclusion criteria by the lead researcher (RB). A second rater (BW) independently assessed approximately 10% of titles and abstracts (N=813) in order to ensure consistency. Raters agreed on 98.9% of the screened papers. Gwet's AC1 coefficient was used to calculate inter-rater reliability as it has been found to produce more stable results compared to Cohen's Kappa.[40,41] Gwet's AC1 coefficient was 0.99, indicating very good agreement between raters.[42] Disagreements between raters (n=9) about the eligibility of studies were collaboratively discussed and resolved by revisiting the inclusion and exclusion criteria.

Next, the full texts of studies that appeared to be eligible were reviewed by the lead researcher (N=32) against the inclusion and exclusion criteria. At this stage one study – Pilkington and Bedford-Dyer – was not included in the review due to a delayed release making the full text unavailable at the time of writing.[43] Eighteen studies were then excluded: two were not peer reviewed journal articles; two were duplicates; two were not published in English; eight studies did not report on women's experiences of antenatal anxiety; and it was not possible to extract data related to antenatal anxiety from four studies. A second rater independently assessed 10% of the full texts (N=3). Disagreements between raters (N=1) were collaboratively discussed and resolved by revisiting the inclusion and exclusion criteria. The remaining studies (N=14) were included in this review and synthesis.

Figure 1: PRISMA Flowchart of Study Selection[31]



Quality Appraisal Process

In considering the most appropriate tool for appraising the quality of the studies included in this review, several key papers and tools were examined including: Critical Appraisal Skills Programme (CASP);[44] Evaluation Tool for Qualitative Studies (ETQS),[45] Standard for Reporting Qualitative Research (SRQR),[46] and Walsh and Downe's checklist.[47] Ultimately, it was decided that a modified CASP was the best fit for the current review and synthesis.[48] Additional questions and prompts for consideration from the checklist developed by Walsh and Downe[47] were added in order to increase the rigour of the quality assessment and appraise additional methodological factors (see Appendix B). In line with CASP, each item was given a rating of ‘Yes’, ‘No’ or ‘Can’t Tell’.[41] An additional item, ‘Somewhat’, was added in order to allow for nuance in appraising papers that have both strengths and weaknesses.[49] Each item included prompts for raters to use to determine whether studies met the criteria, however the prompts were not used as a checklist for meeting criteria.[49] All of the papers were independently reviewed by a second rater. Reviewers agreed on 87% of the codes. Gwet’s AC1 was 0.81, indicating very good agreement between raters.[40,42] Discrepancies were resolved by the lead author referring back to the articles and recoding where necessary in line with the prompts for each criterion.

There is some debate about the assignment of quality appraisal scores in qualitative research.[37,50,51] After reviewing the literature, it was decided that each study in this review would be considered in relation to their strengths and limitations, in particular the impact of limitations on the overall study, instead of assigning overall quality appraisal scores.[52]

Reading and Data Extraction Approach

The lead author began by reading and re-reading each of the papers in full, making initial notes. A data extraction table was developed (see Appendix C) and used to extract relevant contextual data, informed by the Cochrane Collaboration Qualitative Methods Group guidance.[52] Information extracted included: study aim, study setting, sample characteristics/demographics (e.g., age range, diagnosis), number of participants, qualitative methodology (e.g., Grounded Theory, Thematic Analysis), data collection strategy (e.g., interview, focus group), and key themes identified. A separate data extraction table (Appendix D) was also developed for extraction of key concepts, first- and second-order constructs (see Table 1 for working definitions) from each of the studies included in the review.[37] Data extraction was inclusive of all eligible data in order to avoid missing potentially valuable findings.[52]

Table 1: Working Definitions used based on Noblit and Hare,[29] and Malpass et al[34]

Term	**Definition**
First order construct	Women’s views, accounts and interpretations of their own experiences of antenatal anxiety.
Second order construct	Study authors’ views and interpretations of women’s interpretations of their experience of antenatal anxiety.
Third order construct	The views and interpretations of the synthesis authors, developed using first and second order constructs.
Translation	The process of comparing the concepts in one account with concepts in other accounts.[29]

Determining how the studies are related

This phase of Noblit and Hare’s meta-ethnographic approach aims to consider the relationships between the key concepts in the different papers.[29] Meta-ethnographies work to develop ‘third-order constructs’ from the ‘second-order constructs’ developed by the authors of each paper.[35] The interpretations of each author were therefore treated in a similar way to the raw qualitative data included in each study.[34] Determining how the studies are related involves reviewing common and recurring concepts across all of the studies.[37] Noblit and Hare suggest that lists of the metaphors, concepts and themes from each study should be amalgamated and then juxtaposed in order to evaluate their similarities and differences.[29] This allows the authors to determine whether the studies are sufficiently similar to complete a ‘reciprocal translation’ or different enough that a ‘refutational translation’ must be used.[37]

The lead author (RB) of the current review created tables that included both first- and second-order constructs from each of the papers.[34] Similar second-order constructs from each paper were clustered together; with constant reference back to the raw data to ensure they were referring to parallel concepts. Category labels were then created for each cluster of second-order constructs. Contextual information, for example type of antenatal anxiety, was also considered at each stage of the comparison.

Process of translating studies

This phase of the meta-ethnographic approach involves systematic comparison of the meanings of concepts and themes across studies.[32] Given that the concepts across studies were judged to be similar; a reciprocal translation where the studies are “added” together was completed.[29] A common critique of this phase is that the process of translation is not explicitly described by Noblit and Hare;[29] there are therefore several operational processes described by different meta-ethnographic authors.[36,53] It was decided that the process detailed by Sattar et al would be followed as a recent worked example of meta-ethnography.[37] The author RB began by arranging the studies in chronological order. The themes and concepts from the first paper – Eriksson et al[54] – were summarised, holding in mind the context of the study. The themes and concepts from the second paper – Furber et al[55] – were then summarised, commenting on the similarities between paper one and paper two, as well as where the paper diverges or adds new knowledge. This process was repeated for each of the fourteen papers included in the synthesis. A visual map was also developed in order to create a one-page summary of findings and highlight the relationships between findings.[33] This synthesis was then reviewed in totality by author RB for common second-order constructs and patterns across the studies.

Synthesis process

The second-order construct translations (sub-themes) were then compared in order to develop an overarching concept and develop a new interpretation.[32] This phase, similarly to other phases described by Noblit and Hare[29], does not have one clearly defined operationalised process. It was therefore decided that the process described by Atkins et al would be mimicked.[36] In order to do this, the author RB read over the list of sub-themes and their definitions, that had been developed using the second-order constructs (see Table 4). The lead author then drew an overarching model aiming to link it all together. This involved referring back to first-order constructs and the context in order to ensure that the synthesis was clearly grounded in the individual studies.[32] This synthesis was then reviewed by CP and CS, and alternative options for synthesis were considered before reaching the final model.

Results

Study characteristics

A summary of study characteristics can be found in Table 2. The 14 included studies reported the experiences of 273 women who experienced anxiety during pregnancy. This included 138 women with fear of childbirth;[54,56-60] 130 women with antenatal anxiety;[12,55,61-65] and 5 women with Perinatal OCD (POCD).[66] The majority of the studies occurred in the United Kingdom or Australia (n=9); with the remainder in Sweden (n=2), Tanzania (n=1), Pakistan (n=1) and USA (n=1). Two studies highlighted that they had been conducted in Low- and Middle-Income Countries (LMIC),[64,65] as compared to the remaining papers that took place in High Income Countries (HIC). Most studies (n=11) were published within 10 years of the review; with three studies[54-56] published earlier. Women participated antenatally in the majority of studies (n=8); although in five studies participants took part postnatally and in one study[66] there was a mix of women across the perinatal period. Data was gathered via interview in most cases (n=11), with participants in one study[66] interviewed three times each. Focus groups were used in two studies;[61,63] and in another study a free text box was provided as part of a wider quantitative study exploring levels of pregnancy-related anxiety in women who conceived via in-vitro fertilization.[62] The majority of studies (n=11) took place in a community setting (e.g., routine antenatal care), with two studies occurring in both the community and the hospital;[59,63] and one study recruited from an inpatient mother and baby unit.[61]

Table 2: Summary of Study Characteristics

Authors	Number of participants	Presentation	Country	Age	Timing and setting of data collection	Data Collection & Methodology	Study Aim	Key Findings
Eriksson et al. (2006)[54]	20	Fear Of Childbirth	Sweden	24-41	Postnatal; Community	Interview face-to-face; Grounded Theory	To investigate and describe how intense fear related to childbirth is experienced, dealt with and communicated from the perspective of the women themselves.	Key themes: 'manifestations', 'time and fluctuation', and 'judgements according to perceptions of self and others'.
Furber et al., (2009)[55]	24	Antenatal distress (anxiety and/or depression)	UK	23-39	Antenatal; Community	Semi-structured interview face-to-face; Framework Analysis	To explore the experiences of pregnant women who self-reported mild-moderate psychological distress during antenatal care.	Three main themes: 'the causes of psychological distress'; 'the impact of psychological distress'; and 'ways of controlling psychological distress'.

Maier (2010)[56]	27	Fear Of Childbirth	Australia	Not reported	Antenatal; Community	Interview face-to-face; Feminist and poststructural perspectives framed the research.	To provide a qualitative account of a number of women's everyday worries about childbirth.	The central findings were that women worry about their own health and their baby's; normality and the effects of their pregnant and potential birthing behaviours. Also showed that pain is linked with vulnerability and women feel they are not valued for their individual selves.
Greer et al., (2014)[57]	19	Fear Of Childbirth	UK	Not reported	Antenatal; Community	Interview face-to-face; Thematic Content Analysis	To explore 'fear of childbirth' and its impact on birth choices among women and their partners in Northern Ireland.	Three concepts underlying fear of childbirth found: 'riskiness', 'ways of coping' and 'being a good parent'.
Fenwick et al., (2015)[58]	43	Fear Of Childbirth	Australia	Average 29	Antenatal; Community (Recruited from RCT)	Telephone interview; Comparative Analysis	To describe the sources, responses and moderators of childbirth fear in a group of pregnant women assessed as having high levels of childbirth fear.	Women's fears conceptualised into three themes: 'fear stimuli', 'fear responses', and 'fear moderators'.

Rowe & Fisher, (2015)[61]	20	Anxiety	Australia	29-42	Postnatal; Hospital	Focus Groups; Interpretative Phenomenological Analysis	To investigate women's accounts of the sources and explanations of perinatal anxiety to inform clinical and public health responses.	Five themes identified: 'image management', 'single-message health promotion campaigns', 'evidence-based decision making', 'maternal instinct' and 'risk'.
Stevenson et al., (2016)[62]	31	Anxiety	USA	18-37	Antenatal; Community	Unlimited free-text box in online questionnaire; Content Analysis	To capture the experience of pregnancy-specific anxiety in women pregnant via IVF and to identify themes in anxiety specific to pregnancy.	Three main themes: 'anxiety about the health of their babies'; 'perception of maternal health and safety', 'perception of their ability to fulfil the role of mother'.
Evans et al., (2017)[63]	19	Anxiety	UK	Not reported	Postnatal; Mixed: Community and Hospital	Focus Groups; Template Analysis	To explore women's experience of anxiety in pregnancy and views on the use of anxiety instruments in antenatal care.	Three main themes: 'sources of support', administration of anxiety instruments' and 'use of instruments to prompt discussion'.

Rosario et al., (2017)[64]	10	Anxiety	Tanzania	18-34	Antenatal & Postnatal; Community (Recruited from larger quantitative study)	Semi-structured interview face-to-face; Descriptive Phenomenological approach	To explore and understand the experiences and priorities of pregnant women living with fears and worries related to foetal/infant and maternal health, the birthing process and ability to parent the infant (i.e., pregnancy-related anxiety) in Mwanza, Tanzania.	Five themes identified: 'knowledge and understanding', 'partner relationship', 'interactions with healthcare system', 'spirituality', 'experience or fear of HIV/AIDS'.
Hore et al., (2019)[12]	7	Anxiety	UK	28-39	Antenatal; Community	Semi-structured interview face-to-face; Interpretative Phenomenological Analysis	To qualitatively explore women's experiences of anxiety during pregnancy.	Four superordinate themes: 'adjustment to pregnancy and motherhood and the experiences of anxiety', 'unfamiliarity, uncertainty and uncontrollability of pregnancy influences anxiety', 'personal and social expectations and pressures of pregnancy and motherhood', 'relying on healthcare systems - the good and bad'.

Slade et al., (2019)[59]	10	Fear Of Childbirth	UK	25-43	Antenatal; Community/ Liverpool Women's Hospital	Semi-structured interviews phone/face-to-face; Thematic Analysis	To systematically identify the key elements of Fear of Childbirth as reported women themselves.	Seven themes identified: 'Fear of not knowing and not being able to plan for the unpredictable', 'fear of harm or stress to the baby', 'fear of inability to cope with the pain', 'fear of harm to self in labour and postnatally', 'fear of being 'done to'', 'fear of not having a voice in decision making' and 'fear of being abandoned and alone'.
Baylis et al., (2020)[60]	19	Fear Of Childbirth	Sweden	25-38	Postnatal; Community (recruited from RCT)	Semi-structured interviews by phone; Thematic Analysis with stepwise method of categorization.	To describe women's experiences of guided internet-delivered Cognitive Behaviour Therapy for Fear of Birth and to describe the content of their fear.	Women's descriptions of Fear of Birth differed; however, their fear was most often associated with 'fear of losing control', 'fear for the baby's life or health', or 'own life threatening events.'

Rowther et al., (2020)[65]	19	Anxiety	Pakistan	25-40	Antenatal; Community	Semi-structured interview face-to-face; Thematic Analysis	To explore sources, mitigators, and coping strategies for anxiety during pregnancy from the perspective of symptomatic Pakistani women and thereby further our theoretical understanding of the sociocultural experience of prenatal maternal anxiety in South Asia, particularly in relation to women’s autonomy in decision-making and level of social support from an empowerment perspective.	Five sub-themes identified of which two were considered to be connected to agency as a dimension of women's empowerment ('Gaining Voice', 'Skilful decision-making'), two were part of women's enabling resources ('Family support and peer connectedness', healthcare provider connectedness') and one was related to both enabling resources and agency ('Gender norms').
Meehan et al., (2021)[66]	5	Perinatal OCD	UK	27-35	Postnatal; Community	3x online interviews per participant; Psychoanalytically informed approach.	To provide sufficient space for mothers to explore what was meaningful to them in their journey with POCD, with a view to expanding our understanding of the nature of mothers' lived experience.	Three themes identified: 'a difficult road to motherhood', 'protector/ aggressor', and 'mothers' loss'.

Quality of Studies

The outcome of the Quality Appraisal is shown in Table 3. It found that all but one study[56] received a 'Yes' rating for the majority of criteria. The most common weakness (n=8 papers) was not clearly demonstrating researcher reflexivity. Other weaknesses included determining the appropriateness of the analytic approach used;[56,57,62,63] and locating a clear statement of findings within the studies.[54,56,58,63,64] Of note, only one criterion was rated as a 'No' by both reviewers: the context description within Baylis et al.[60] Four studies[12,59,61,66] were scored 'Yes' for all criteria. Particular strengths across all papers included the use of data to support interpretations; consideration of ethical issues; and the relevance and transferability of the papers included.

Outcome of relating the studies

Despite being based in different countries and including women experiencing different aspects of antenatal anxiety (e.g., fear of childbirth; antenatal anxiety; POCD); there were clear common experiences of antenatal anxiety across the papers. After completing this phase, it was clear that the concepts across the papers were sufficiently similar to complete a reciprocal translation. There were no refutational findings identified between the fourteen studies. Eleven categories were developed at this stage from the second-order constructs, which were then revised and merged during later phases. These categories included: 'Good mum/bad mum', 'Judgements and scrutiny', 'Coping with anxiety', 'Impact of healthcare systems', 'Impact of healthcare relationships', 'Impact of family and peers', 'Manifestations of anxiety', 'Past experiences', 'Fear of harm to self', 'Fear of harm to baby' and 'Fear of the unknown'.

Table 3: Summary of Quality Assessments using modified CASP[44] with additional questions from Walsh and Downe[47]

Quality Appraisal Criteria	**Eriksson et al., 2006**	**Furber et al., 2009**	**Maier et al., 2010**	**Greer et al., 2014**	**Fenwick et al., 2015**	**Rowe & Fisher, 2015**	**Stevenson et al., 2016**	**Evans et al., 2017**	**Rosario et al., 2017**	**Hore et al., 2019**	**Slade et al., 2019**	**Baylis et al., 2020**	**Rowther et al., 2020**	**Meehan et al., 2021**
Is there a clear statement of, and rationale for, research question/ aims/ purposes?	Y	Y	Y	S	Y	Y	Y	Y	S	Y	Y	Y	Y	Y
Is the study thoroughly contextualised by existing literature?	Y	Y	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is the method/design apparent, and consistent with research intent?	Y	Y	CT	Y	Y	Y	Y	Y	Y	Y	Y	S	Y	Y
Is the recruitment strategy appropriate to the aims of the research?	Y	Y	S	Y	S	Y	S	Y	Y	Y	Y	Y	Y	Y
Is the data collection strategy apparent and appropriate?	Y	Y	S	Y	Y	Y	S	Y	Y	Y	Y	Y	Y	Y
Is the sample and sampling method appropriate?	Y	Y	Y	Y	S	Y	Y	Y	Y	Y	Y	Y	S	Y
Is the analytic approach appropriate?	Y	Y	CT	S	Y	Y	S	S	Y	Y	Y	Y	Y	Y
Is the context described and taken account of in interpretation?	CT	Y	Y	Y	S	Y	S	Y	Y	Y	Y	N	Y	Y
Has a clear audit trail been given?	Y	Y	S	S	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Was data used to support interpretation?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Was researcher reflexivity demonstrated?	S	S	CT	CT	CT	Y	CT	CT	Y	Y	Y	S	S	Y
Have ethical issues been taken into consideration?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Is there a clear statement of findings?	S	Y	S	Y	S	Y	Y	S	S	Y	Y	Y	Y	Y
Is relevance and transferability evident?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

** Y= Yes; S=Somewhat; CT=Can't Tell; N=No*

Outcome of translation and synthesis process

The synthesis led to the generation of 3 main themes and 10 sub-themes; which were then used to create a line of argument synthesis that helps to understand women's experiences of antenatal anxiety. Once they were identified, a definition was developed for each sub-theme. The themes, sub-themes, definitions and the papers that contributed to the sub-theme development are summarised in Table 4.[34,53] All of the sub-themes were informed by several studies but none of the sub-themes were informed by all studies.

Table 4: Summary table of translated 2nd order constructs, definition of the construct and papers that contributed to their development informed by Malpass et al [34] and Lucas et al[53]

Line of Argument (Themes)	**Translated 2nd order constructs (Sub-themes)**	**Definition (translation) of the 2nd Order construct**	**Papers that contributed to the theme development**
Characteristics of antenatal anxiety: Into the unknown	Perception of increased risk to self or baby	Sense that pregnancy and childbirth is a time of increased risk; both in terms of own health and wellbeing, and in terms of health and wellbeing of unborn baby. Inability to rationalise this concern.	[54-62, 64]
	Managing childbirth	Focus on potential inability of own body to manage the task of childbirth; and/or inability to cope with the pain.	[56-60]
	'Unknown territory'[65]	Uncertainty and lack of control during pregnancy and childbirth contributing to a sense of foreboding and fear. Difficult to know what is normal and what should be a worry.	[12,58-60,64, 65]
Paradoxical influences on antenatal anxiety: Searching for a map of the unknown	Relationships with family and peers	Recognition that relationships with family and peers could mitigate antenatal anxiety experience through understanding, empathy and support leading to empowerment. Lack of positive relationships can also intensify antenatal anxiety experience.	[54,59,63-65]
	Interactions with healthcare professionals	Recognition that interactions with healthcare professionals can both mitigate and intensify experience of antenatal anxiety.	[12,54,63,65]
	Healthcare system	Sense of powerlessness within the healthcare system leading to an increase in antenatal anxiety; concerns about and reality of feeling like a 'piece of meat'. Healthcare system providing opportunity to check wellbeing of baby providing temporary reassurance and reducing anxiety.	[12,56,58,59, 64]

	Past experiences	Considering both positive and negative past experiences intensified or mitigated antenatal anxiety. Similar effect felt when hearing positive or negative experiences of other mothers.	[55,58,66]
	Coping Strategies	Desperation to cope with antenatal anxiety can lead to both positive and negative coping strategies that aim to take back control.	[12,54-58,64,65]
Striving to be a good mother: Trying to navigate the unknown	Expectations and Scrutiny	Motherhood as a time of intense scrutiny (both perceived and actual) and judgement. Carrying the weight of personal and societal expectations of motherhood; how mothers should feel; what they should do.	[12,54,61,63,65,66]
	Doing the “right thing”	Mothers focused on trying to make sure that they are doing the right thing whilst being presented with a myriad of options for what the “right thing” is.	[12,57,61,62,66]

The line-of-argument synthesis has been modelled as a series of circles that help to show the relationships between the themes and sub-themes; aiming to make sense of and understand women’s experiences of antenatal anxiety (see Figure 2). This model was informed by the line-of-synthesis model developed by Lucas et al,[53] which describes the perceptions of young women on their mental health and wellbeing during pregnancy.

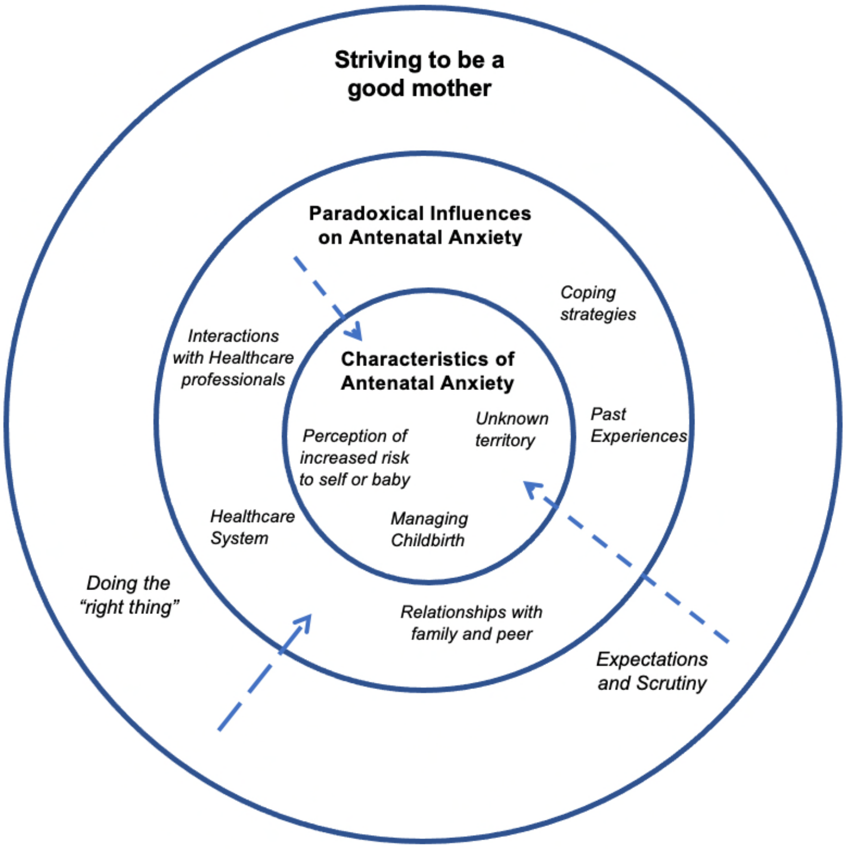
At the centre is the manifestations and characteristics of antenatal anxiety expressed by the women. These were the common features of antenatal anxiety that were described across the studies and included: ‘Unknown territory’,[65] ‘Perception of increased risk’ and ‘Managing childbirth.’ It appeared that underlying each of these characteristics of antenatal anxiety was a fundamental anxiety about stepping into the unknown and the process of tolerating the uncertainty associated with this.

The next circle represents the factors that had an impact on the intensity of the characteristics of antenatal anxiety that the women experienced. These influences included: ‘Interactions with healthcare professionals’; ‘Healthcare system’; ‘Relationships with family and peers’; ‘Past experiences'; and 'Coping strategies'. Critically each of these influences could have both a positive and a negative effect on the intensity of the anxiety the women experienced. It appeared that these influences represented the women searching for something to help them with navigating the unknown territory of pregnancy and childbirth.

The outer circle represents the overall drive of the women to be a "good mother" and the effort involved in achieving this. This theme is underpinned by two sub-themes: 'Expectations and scrutiny'; and 'Doing the "right thing"'. An important aspect of this theme is that there is no one agreed definition for what "good mother" means. This leaves the women in a position where they may end up using external sources to support them to make decisions. However, these external sources are often contradictory and lack individual nuance, leading to a further intensification of antenatal anxiety.

The arrows in the model represent the directionality of the influence between the themes: 'Striving to be a good mother' had an impact on both the 'Paradoxical influences of antenatal anxiety' and the 'Characteristics of antenatal anxiety'. Similarly, the 'Paradoxical influences of antenatal anxiety' had an impact on the 'Characteristics of antenatal anxiety'. For example, the perceived scrutiny from professionals ('Striving to be a good mother') could act as a barrier to disclosure of antenatal anxiety during antenatal appointments ('Influences on anxiety') and therefore hinder the opportunity for professionals to reduce some of the uncertainty associated with pregnancy and childbirth ('Characteristics of antenatal anxiety'). This maintained, or possibly increased, the intensity of antenatal anxiety the women experienced.

Figure 2: Line of argument synthesis



Characteristics of Antenatal Anxiety: Into the Unknown

The theme 'Characteristics of antenatal anxiety' (see central circle, Figure 2) refers to the specific manifestations of antenatal anxiety expressed by the women. The characteristics of anxiety played a central role across most of the studies. This theme has three sub-themes: 'Perception of increased risk'; 'Unknown territory';[65] and 'Managing childbirth'. These sub-themes were all underpinned by the idea that the women were stepping into the unknown and grappling to cope with the uncertainty associated with this.

Perception of Increased Risk

The increased perception of risk to the self[55,58-60,62,64,] or to their unborn child[55,56,58-62,64] was a recurrent concept across the studies. Underlying all accounts was the worry that something bad might happen throughout the perinatal period. This included worries about pregnancy (e.g., losing the baby; becoming unwell; genetic abnormalities);[55,56,58,60-62,64] worries about the risks of childbirth (e.g., safety of interventions for baby and mother);[54-60] and worries about the postpartum period (e.g., postpartum recovery; bonding with baby; relationship with partner).[55,56,62] Perception of increased risk appeared to be enhanced by routine investigations where there was no opportunity for certainty.[61,62] Rowe and Fisher[61] noted that:

> *"Even when the risk is low or the result is normal, some people have difficulty discarding the residual risk that is inherent in a screening test result and continue to regard themselves (or their child) as at risk"* (pg. 63).

This appeared to be particularly the case within the population of this review. One woman stated: *"I was afraid that something would happen to either me or my child, that something would go completely wrong, that I would die"* (R1, primigravid)[60] The lack of certainty that there would be a positive outcome, and inability to provide certainty that this would be the case, appeared to continuously feed into the overall feeling of unknown and unchartered territory that the women experienced.

Unknown Territory

Struggling to tolerate the uncertainty and lack of control inherent to pregnancy and childbirth was a common contributor to the sense of foreboding and fear that the women described.[12,55,56,64,65] For some women, the uncertainty was related to not knowing "*what questions to ask*",[58] and recognising that their "*knowledge and understanding of what a baby might be suffering from is low*" (Berta).[64] For others, it was tolerating the unpredictability and lack of control during labour. This unpredictability seemed to tap into the women's fears of being overwhelmed by the experience and not being able to cope; as well as the sense that in order to be a "good mother" they needed to be able to cope. One woman noted "*I don't know how the birth is going to go or what's going to happen again, you know you're not in control of it, it's just dead scary*" (M21).[59] Another strand of unknown territory was the outcome of the pregnancy, in particular whether the baby would survive*: "… with pregnancy the biggest stressor is knowing that you're not going to get any feedback (assurance) until the kid is born*" (P3).[12] The anxiety related to uncertainty was also amplified in settings where there was a cultural preference for a boy, as a consequence of the unpredictability and inability to control this outcome: "*The worry during pregnancy is mostly thinking about whether it is a son... that is why women get anxious."* (M10).[65] Although there were different themes underlying this uncertainty, the common thread appeared to be the sense that the women were entering – and trying to navigate – unknown territory.

Managing Childbirth

Rumination on the uncertainty around the body's ability to cope with childbirth was a common theme across several of the studies.[56-60] Women expressed specific concerns about bearing the pain of childbirth:[56-60] "*You shouldn't be expected to be in that amount of pain ever"* (M20).[59] They also shared some dubiety about the ability of their body to give birth; for example, one woman shared "*… you see the baby on the scan and you see the head and you think… how could it get out of down there?"* (W6).[57] These underlying themes again seem to speak to the idea that during childbirth the women are stepping into unknown territory which remains utterly outside of their control. This appeared to be the case even for mothers who had had previous pregnancies and labours. Tied in with the worries about managing childbirth, was the sense that there is a right or a wrong way to cope. Some women seemed to experience a pull between the drive to have a vaginal birth because of a belief that "*that's the way babies are supposed to come into this world*" (W6, prim);[57] and the relief of a "*lucky escape from having to endure labour and childbirth*".[58] This prescribed approach to and expectations of childbirth, despite the uncontrollability, placed more pressure on the women and would appear to increase the likelihood of antenatal anxiety.

Paradoxical Influences on Antenatal Anxiety: Searching for a Map

The theme ‘Paradoxical influences on antenatal anxiety’ (see second circle, Figure 2) refers to the factors that had an impact on the intensity of antenatal anxiety described by women across the studies. Importantly, these influences could have both a positive and a negative effect on antenatal anxiety. This theme had five sub-themes: ‘Interactions with Healthcare Professionals’; ‘Healthcare System’; ‘Relationships with Family and Peers’; ‘Past Experiences’; and ‘Coping Strategies’. Underpinning these sub-themes was the sense of the women searching for something that would help them to navigate the unknown territory of pregnancy and labour.

Interactions with Healthcare Professionals

Individual interactions with healthcare professionals that were experienced as both positive and negative was a common theme across many of the studies.[12,54,59,63-65] These experiences had the potential to mitigate or intensify the women’s’ experiences of antenatal anxiety. For women disclosing their worries to healthcare professionals, there were a variety of responses. This included a warm, and interested approach that gave the woman permission to speak about how she felt:

> “*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).[12]

It also included a sense of dismissal or misunderstanding from the healthcare professional: “*I don’t think my midwife understood how scared I was, but if she’d asked or talked about it, I’d* *have told her, but it felt like, no, she wasn't interested in knowing about that*" (1).[54] It could be argued that if women feel that health professionals are interested and understanding, then they feel held in mind and less alone with their experience. This in turn leads to an increase in the sense of safety and a reduction in antenatal anxiety. Conversely, if the healthcare professional is dismissive or appears disinterested then it is possible that the perceived stigma associated with perinatal mental health difficulties is amplified and women are even less likely to disclose any difficulties.

Eriksson et al wondered if the more dismissive responses from healthcare professionals were driven by "*not knowing how to provide appropriate help and support*" (pg. 247).[54] This speaks to the training and supervision available to healthcare professionals providing antenatal care. In particular, the availability of a containing other for those who have a role containing the fears and worries of women.[67] It follows that if healthcare professionals are unsure how to go about providing help and support to women, the women will feel unsafe and unsure; thereby increasing the intensity of their antenatal anxiety. Rosario et al[64] also highlighted the paradoxical influence of healthcare professionals on the women's experience of antenatal anxiety. Whilst one woman noted that "*I feel peace whenever I go to the hospital, since (she) gets advice from them to be well and keep (her) baby well*" (Margaret);[64] another explained: "*She didn't give me clear information or encourage me. I felt like she was adding on my problems."* (Berta).[64] This highlights the individual differences between women and healthcare professionals in terms of information provided and what is viewed as helpful by women.

Healthcare System

The healthcare system was differentiated from individual healthcare professional relationships by Hore et al[12] and it was found that this separation could also be applied within the wider context of this review. The sense of powerlessness the women experienced within the healthcare system appeared to be a significant contributor to antenatal anxiety across most of the studies.[12,51,56,58-61,64] The authors of one study summarised that the women observed the healthcare system to be "*stretched in terms of resources*" (pg.6).[12] In another study, it was noted that this obvious scarcity of resources acted as a barrier to disclosure:

> "*They're (hospital midwives and doctors) always very kind and say, "is there something that you want to talk about?" You feel pressured because, you know, there's like a billion of women waiting, and then you're like, okay maybe it's not that important..."* (Della, primip, birth centre care).[56]

These systemic issues seemed to make it difficult for the women to prioritise their own needs. One woman spoke about trying to bypass public maternity services and recognised that she did not have the option to do this either; intensifying the sense of powerlessness even further:

> "*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).[12]

This highlights the sense of hopelessness and powerlessness that the women felt as a consequence of a healthcare system that seemingly does not allow the flexibility of the right to choose. It also speaks to the lack of containment within the healthcare system if the pressures on the system are spilling into individual care such that women are changing their behaviours and disclosures to attune to it.

Alongside this, Fenwick et al interpreted a sense of the women "*feeling forgotten, alone and invisible*" (pg.243) by the healthcare system.[58] This was echoed by several studies;[12,56,59,61] who also added a sense of "*not feeling known or valued*" (pg. 297),[56] and – strikingly – like a "*piece of meat*" (pg. 8).[59] Paradoxically, other women spoke about a preference for the healthcare system taking control; stating "*you know, you're the expert in the field and um… I'm taking your advice that this is what you'd recommend me to do (…) and that is what I'm going to do"* (Anna).[56] Again, this seems to show the individual differences in terms of how best to manage the sense of uncertainty and unknown: with women either giving themselves over to a bigger system to be managed; or feeling powerless within a system that is managing them.

Many women spoke about the sense of reassurance that they received from antenatal reviews, for example ultrasounds;[12,56] though this was also described as a "*double-edged sword*" (pg. 6)[12] because of the nature of uncertainty whilst waiting for the results. It appears that medical reviews provided the women with the certainty they were searching for during the tests because of the physical proof that their baby was safe and well. However, the time around these tests remained an anxiety-provoking and uncertain time, feeding into the earlier theme around perception of increased risk.

Relationships with Family and Peers

In many of the studies, there was a recognition of the importance of relationships with family and peers and the mitigating effect of understanding, empathy and support on antenatal anxiety.[54,63-65] These relationships appeared to provide women with confidence and access to advice to support them with navigating the unknown territory of pregnancy and childbirth:

> "*He never scolded me, never said anything to me. I feel that nobody gives me as good advice as my husband (. . .) my husband has given me confidence, and he is my best friend*" (M15.[65]

Even women who did not have access to the supportive relationships that they would have hoped for identified relationships as potentially impactful:

> "*You'd get it all out and get some feedback and you know somebody understands you properly, not someone that's medical and seen it, but someone that's actually felt it, you'd get some kind of release and that gives you the strength then to move onto the next stage*" (G1/P4).[63]

It appeared that the distinction between someone that has "seen" antenatal anxiety and someone that has "felt" it was an important factor to support the women to feel fully understood. Rowther et al noted that "*many women described feelings of loneliness or isolation*" (pg 9).[65] It seems that feeling "*properly understood*" allowed women to feel less alone and atypical compared to their peers; reducing the intensity of their anxiety.

There was also a common recognition that a lack of positive relationships and support could also intensify women's experience of antenatal anxiety. In particular, women noted the sense of feeling atypical or unusual for how they were feeling as a result of the responses they received from others: "*... I'd say to people when I was pregnant - I hate it - it's horrible and they'd look at me funny..." (*G1/P12).[63] This appeared to enhance the loneliness and isolation that the women experienced, increasing their antenatal anxiety. Other women reported experiences where they shared their concerns with loved ones and they were dismissed: "*When I told my mother about how scared I was, she just dismissed it completely; she didn't want to listen to what I had to say, not even once*" (19).[54] This again can be juxtaposed with the sense of togetherness and validation that women got from others that understood them.

Past Experiences

Positive and negative past experiences appeared to both intensify and mitigate women's experiences of antenatal anxiety.[55,56,58,66] This effect was mirrored when women heard the experiences of others.[56,58] Women expressed concern about repetitions of previous traumatic experiences, for example miscarriages or traumatic labours. They seemed to fear that they would be unable to cope with another traumatic childbirth experience and described feeling 'terrified', 'really worried' and 'frightened' at the prospect. Some women noted the immediate anxiety they experienced and the build-up to the point where they had previously miscarried: "*At first, [I was] really anxious because I'd lost the other [pregnancy]. So, I was really anxious up to 11 weeks, and for a few weeks after that*" (P7, 19 weeks pregnant).[55] Where others experienced a pull between two opposite emotions and a sense of certainty that the same thing would happen again: "*Obviously, I was delighted but also really, really quite terrified and* *convinced that I was going to miscarry again*." (Rose).[66] Women were described as "*being more realistic this time in relation to expectations of labour and birth*" (pg. 242).[58] Other women appeared to be attempting to accept that childbirth is going to be a difficult experience and there is nothing they can do about it: "*I guess I just resigned to the fact that it's a horrible experience and it will be again*".[58] This seemed to be an attempt from women to try and make the unpredictable predictable, and therefore less overwhelming and anxiety-provoking.

Coping Strategies

Themes and concepts related to women's attempts to cope with their antenatal anxiety was a strong recurrent theme across most of the studies in this review.[12,54-58,64,65] Authors in some of the studies conceptualised the coping strategies described by the women as 'positive', 'healthy', or 'health-conducive' strategies and 'negative', 'or 'other' strategies. Common strategies associated with anxiety were used by many of the women, including evading or avoidance in an attempt "*to protect oneself from the very experience of fear*" (pg. 244).[54] This strategy of avoidance appeared to help in the short term; though in the long-term it likely prevented women from being able to discuss and agree a birth plan or prepare for their labour. Other authors noted a pattern of women searching for information as a coping strategy.[54-56] For some women this seemed to be useful and provide a sense of reassurance:

> "*When I had the bleeding, I can't remember what I looked up. I just typed it into Google and it brought up this message board of other women that have been through the same, which was more helpful"* (P17, 18 weeks pregnant).[55]

Whereas others within the same study found the process of searching for information overwhelming: "*The worst thing . . .. Don't do it, don't do all the books. There is too much information. I panic"* (P2, 18 weeks pregnant).[55] While some authors spoke about women trying to take control in order to manage their antenatal anxiety;[12,57,65] others reflected on the sense of giving over control, either to the healthcare system,[56] or to a higher power through prayer and spirituality.[64,65]

Striving to be a good mother: Trying to navigate the unknown

The theme ‘Striving to be a good mother’ (outer circle, Figure 2) refers to the overall drive of the women to be the perfect mother to their babies. This theme influenced the way in which the women interacted with the influences on antenatal anxiety; as well as the specific characteristics of antenatal anxiety described by the women. ‘Striving’ is used to highlight the effort expended by the women, as well as the lack of clarity around what a “good mother” really means and the unobtainable reality of this standard. This theme is underpinned by two sub-themes: ‘Expectations and scrutiny’; and ‘Doing the “right thing”’.

Expectations and scrutiny

Motherhood as a time of intense scrutiny, both perceived and actual, was a recurrent theme across several of the studies.[12,61,65] Alongside this was the sense of women carrying the weight of personal and societal expectations of motherhood and the way in which mothers should feel and behave.[12,54,63,66] Eriksson et al summarised that the expectations of women “*often ended up in feelings of being different and inferior to other women, (indicating) that socially constructed beliefs about what to feel as a childbearing woman are used as norms against which the women evaluated their own experiences*” (pg. 246).[54] This was echoed by other authors who noted that women avoided sharing how they felt for “*fear of embarrassment, judgement, or being looked down upon*” (pg. 10).[65] Failing to live up to the perceived expectations from society, in particular in terms of how they felt about themselves and their pregnancies, appeared to intensify the sense of isolation and loneliness that these women experienced. Feeling that they were the only one with these experiences also appeared to be inextricably linked with the sense that this must mean that they were a bad mother, adding shame and guilt to the loneliness that the women experienced and intensifying their anxiety:

> “*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).[12]

In addition to the concern around violating societal expectations, the women spoke about the violation of their own expectations of pregnancy and the impact of this on their experience of antenatal anxiety as they navigated the "*reality and challenges of pregnancy*" (pg. 5).[12] One woman noted: "*When I look back, I honestly would call myself delusional (laughs), at...what I thought it was going to be and then what it was*." (Lucy).[66] The unobtainable expectations that women placed on themselves to be happy all the time appeared to intensify their experience of anxiety and their sense of being 'other' or different from other women.

Doing the "right thing"

The determination of mothers to do the "right thing" whilst being presented with a myriad of sometimes conflicting options for what the "right thing" is appeared in several of the studies.[57,61,62,66] This sub-theme was closely tied to the idea of being a "good mother"; with the impression being that a "good mother" knows what the right thing is and is able to implement it. However, often the women did not – and could not – know what the right thing should be with absolute certainty; and this therefore led to doubts about their own abilities:

> "*And they say "trust your intuition" and I don't know, because I have not done this before, and I feel like what is wrong with me that I don't have it, that instinct to know what to do?"* (G1).[61]

Within this sub-theme was also the women's belief in their absolute personal accountability and responsibility towards their babies: "*This is your responsibility now to keep this baby alive...and you have no experience, you have no qualifications*" (Sarah).[66] This personal accountability further fed into the impression that in order for their baby to be safe and well, they must always be doing the "right thing". The pressure associated with this, along with the lack of certainty, appeared to amplify their experience of antenatal anxiety. In particular intensifying their rumination over whether 'something bad' would happen to their baby and the notion that if there were a negative outcome then it would be entirely their fault:

> *"...but I guess if something was wrong with the baby, like permanently wrong, it would be a reflection probably, on me, like did I eat something wrong or did I drink something wrong throughout the pregnancy and all that sort of thing? I guess when you come to the end of something, you always reflect and sort of think, God you know, nine months it's been, have I, did I drink one too many glasses of red or did I have too many cups of coffee or you know all those sorts of things".* (primip, birth centre care).[56]

Given that there is a plethora of often contradictory sources that determine what a "good mother" should be defined as (i.e., the media, healthcare professionals, parenting books), it is understandable that women feel overwhelmed when determining which route they should choose. Managing this under the weight of perceived and actual scrutiny from society and in the face of their own violated expectations is likely to amplify the pressure further, intensifying the experience of antenatal anxiety.

Discussion

Summary of findings

The aim of this meta-ethnography was to synthesise research relating to women's experiences of antenatal anxiety and build a comprehensive understanding of these experiences. Fourteen papers were reviewed which highlighted three main themes: 'Characteristics of antenatal anxiety', 'Paradoxical influences on antenatal anxiety', and 'Striving to be a good mother'.

Central to this understanding were the characteristics of antenatal anxiety described by the women: 'Unknown territory',[65] 'Perception of increased risk', and 'Managing childbirth'. These characteristics shared the common sense of the women stepping into the unknown throughout pregnancy and childbirth, and finding it difficult to tolerate the uncertainty associated with this. This finding has some backing from quantitative research that shows a predictive relationship between intolerance of uncertainty in women with antenatal anxiety and the worsening of anxiety postpartum.[68] Related to this was the women's increased perception of risk to self or their baby during their pregnancy. The women seemed to ruminate on the different possible negative outcomes and find it difficult to break this cycle. A study comparing risk perception of women and healthcare professionals found that pregnant women had the highest risk perception scores.[69] Strikingly, they also found that pregnant women estimated that healthcare professionals agreed with them about the high level of risk, when in reality healthcare professionals risk perception seemed to be lower.[69] This may go some way to explain some of the mismatch between women and healthcare professionals identified in this synthesis.

In the current review, the influences on the intensity of antenatal anxiety were found to have both a mitigating effect and a facilitating effect. In order to reduce antenatal anxiety in women, it can be argued that the mitigating effects of the influences need to be built on, rather than necessarily focusing on reducing the negative aspects of these influences. For example, past negative experiences are, of course, going to have a significant role in anxiety related to the current pregnancy. However, the impact of negative past experiences can be mitigated by sensitive care and support from family, friends and healthcare professionals.[70]

One key factor in this review was the variety of adaptive and maladaptive coping strategies that the women used to try and cope with their antenatal anxiety, for example avoidance. This is consistent with other research exploring coping styles in anxious and non-anxious pregnant women which found that as anxiety levels increased, so did the likelihood that women would use maladaptive coping strategies like denial (or avoidance) and self-blame.[71] Relationships with family and peers provided the women with the opportunity to feel understood by others who had had similar experiences. This theme has been echoed by other qualitative research exploring women's experiences of talking about perinatal mental health difficulties which identified the theme 'finding solace in shared experiences' in the context of navigating the societal norm of what it is to be a "good mother."[72]

Additionally, the healthcare system as both a mitigator and a facilitator of antenatal anxiety was another key sub-theme from this review. The experience of the women feeling unknown, unvalued and as though they had limited choice feeds into the sense of powerlessness that they felt. This was distinct from individual interactions with healthcare professionals. Previous research has shown the importance and value of continuity of midwifery care in services.[73] The meta-synthesis identified the overarching theme of the midwife-woman relationship and argued that this relationship is the way in which personalised care, trust and empowerment can be achieved.[73] Midwifery care has also been argued to be a way in which predictability, control and realistic expectations can be developed via the sharing of individualised knowledge and information.[74] Increasing predictability and control, whilst managing expectations could then reduce the levels of antenatal anxiety.

Impacting on both the characteristics of antenatal anxiety and the influences on antenatal anxiety, was the overall drive of the women to be the perfect mother to their babies. This effort was driven by personal and societal expectations around how mothers should think, feel and behave, and the scrutiny associated with this. The challenge with the perfect mother ideal was that the expectations were unrealistic and were swiftly violated when faced with the reality of pregnancy and childbirth. A similar theme was also identified in a meta-synthesis of studies related to postpartum depression, where the incongruity between expectations and reality was argued to play a role in the development of postpartum depression.[75] Given the relationship between antenatal anxiety and postnatal depression, it seems unsurprising that there are common experiences between the two populations.[18] At times the perceived and actual scrutiny associated with pregnancy acted as a barrier to the women's disclosure of their antenatal anxiety experience. Perceived stigma as a barrier to disclosure is a common finding in the field of perinatal mental health.[7,9] This review adds the perspective that healthcare professionals are perhaps inadvertently feeding into the perceived stigma that women experience by presenting as dismissive or disinterested. It is suggested that these dismissive responses are related to a lack of knowledge around the best way to provide help and support to mothers.[54] It may be that there is a role for clinical psychology in providing ongoing training, support and supervision to healthcare professionals who support women in the antenatal period. This would also provide an opportunity to ‘contain the container’.[67]

Alongside this was the sense that the women held absolute personal responsibility and accountability to do the “right thing” and ensure that their baby is safe and well. This coping response of self-criticism for responsibility in situations has been shown to be significantly more likely in anxious women.[71] Women struggled with navigating a myriad of different advice and information and then determining which is the best “right thing”. The uncertainty associated with this choice had an impact on the experience of antenatal anxiety. A similar theme – ‘trying to figure out if I’m doing things right’ – was found amongst mothers but not fathers in a study exploring the experiences of parents in the first 6 weeks postpartum.[76] The authors argued that methods for building women’s confidence in the postpartum period should be investigated[76] and it is likely that this would also be applicable within the antenatal period. Moore et al explored the experiences of women who used maternal mental health forums.[77] They suggested that online forums may allow women to reconceptualise the concept of a “good mother” and separate stigma from their maternal identity. This separation was as a result of opportunities to speak the unspeakable and see that they are not alone in their experience of perinatal mental health difficulties. Importantly, the forums allowed the women to develop a nuanced understanding that they can be a good mother *and* experience difficulties with their mental health.[77]

Strengths, limitations and reflexivity

This review systematically collated the experiences of women from fourteen studies in order to build an understanding of women's experience of antenatal anxiety. The papers included in this review were scrutinised using a modified CASP in order to increase the rigour of the quality assessment. The quality of each of the papers was also reviewed by an independent rater, further increasing methodological rigour. A further strength of this study is the close adherence to the eMERGe reporting guidelines for meta-ethnography.[32] It has been argued that improving meta-ethnographic reporting can increase confidence in the findings and therefore be used to improve practice, policy and outcomes for service users.[32]

A potential limitation of this review is the heterogeneity of the studies included in terms of setting, antenatal anxiety presentation and qualitative methodology. It may be that this heterogeneity diluted the opportunity to examine women's experience of antenatal anxiety. However, the inclusion criteria was designed to be wide because of the relative paucity of qualitative antenatal anxiety research. Given that several common themes emerged despite this heterogeneity, it is likely that this review does add value to the research base. Similar to this, was the difficulty with 'drawing a line' between antenatal and postnatal anxiety. Some authors argue that experiences of anxiety should be viewed across the perinatal period, in order to understand the longitudinal impact of anxiety throughout the transition from the antenatal to the postnatal period.[78] However, the antenatal and postnatal period have distinct foci and it can also be argued that in order to provide appropriate and directed support at different timepoints across the perinatal period, we must first have an understanding of the similarities and differences.

A second potential limitation of this review is the argument that meta-ethnography should be a team-based approach.[32] Although other researchers were involved at various points throughout the process (e.g., paper inclusion, quality appraisal), ultimately the synthesis was conducted primarily by the lead researcher (RB). The process of meta-ethnography is an inherently interpretative process and the views, beliefs and experiences of the lead researcher may therefore have influenced the synthesis process. However, the themes and sub-themes were also discussed and reviewed by CP and CS, allowing for alternative viewpoints to be considered as part of the synthesis. The lead researcher also kept detailed notes at each stage to try and mitigate the influences of their views, beliefs and experiences.

Conclusions

To the best of the author's knowledge, this is the first meta-ethnography synthesising women's experiences of antenatal anxiety. It raises new insights into the way in which the "good mother" ideal impacts on the influences of antenatal anxiety and the characteristics of antenatal anxiety. In order to address this, it may be helpful to add some nuance to the advice provided to women during the antenatal period, in particular giving information that allows women to make an informed choice about the different potential options at each stage. Importantly, this information should convey to women that there is no 'one right thing', rather there is a process of weighing up the options and determining what is best for them. General information about antenatal anxiety, and what is known about helpful coping strategies could also be provided to women and their families in order to proactively address difficulties and increase general knowledge about antenatal anxiety.

Opportunities for women to feel heard and understood appeared to be a key mitigator for antenatal anxiety. This space could be provided by healthcare professionals, friends, families or peers with similar experiences. It may be that assessing the availability of opportunities to feel heard and understood during routine antenatal care would allow the system to provide targeted support and ensure that these opportunities are made available. Given the effect of healthcare relationships and systems on the maintenance or mitigation of antenatal anxiety; it appears that specific universal training regarding antenatal anxiety for healthcare professionals that work with women during the antenatal period may be beneficial. Alongside this, in order to create a system that ‘contains the container’,[67] it may be helpful to consider further training, supervision and support for healthcare professionals in this setting.

Future research should consider the views of healthcare professionals in relation to the requirement for supervision and support from the healthcare system. It may also be beneficial to examine the lived experience of recovery for women who have experienced antenatal anxiety in order to further explore the mitigating factors for antenatal anxiety. The “good mother” ideal appears to impact on different individuals in different ways, and therefore exploration of the mechanisms of this process may improve the understanding of how and why antenatal anxiety develops. This in turn could give some indication as to how best to support women during the antenatal period.

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Journal Article 2: Original Research Project

‘That little bit of humanity made such a difference’: An interpretative phenomenological analysis of women’s experiences of recovery from antenatal anxiety

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Abstract

Background: Despite antenatal anxiety being consistently linked with negative outcomes for both women and infants, it remains an area that is little understood. In order to guide the development of perinatal mental health services and provide meaningful recommendations, it is important to understand the experiences of those who have recovered. In particular, to understand both the barriers and facilitators to recovery.

Aim: This study aimed to explore women's experiences of recovery from mild-moderate antenatal anxiety using an interpretative phenomenological (IPA) approach.

Methods: IPA was used to explore women's lived experiences of recovery from antenatal anxiety. Ten women who self-reported experiencing mild-moderate antenatal anxiety were recruited via social media. Interviews were conducted remotely and transcribed verbatim.

Results: One overarching theme – 'Journey to recovery' – that encapsulated four main themes was identified. The four themes were: 'Someone that "gets it"', 'Safe responsive relationship(s)', 'Locus of control', and 'Knowing what to expect'. Importantly, there was no one aspect that supported recovery, rather it was a combination of factors that worked together over time.

Conclusion: These findings highlight the need for universally accessible information regarding antenatal anxiety. Additionally, it shows the impact of relationships on the intensity of antenatal anxiety, in particular the power of finding someone that "gets it" who can normalize experiences. Research and clinical implications are discussed, along with the limitations of this study.

Keywords: Antenatal anxiety, Recovery, Perinatal mental health, Women's experiences, Qualitative, Interpretative Phenomenological Analysis

Introduction

Perinatal mental health difficulties are mental health difficulties that are experienced during pregnancy (antenatally) up to one year postnatally. They have been estimated to effect between 10 and 20% of women.[1] With suicide as the leading cause of maternal death in the UK and Ireland,[2] it is clear that the consequences of untreated mental health difficulties during the perinatal period can be severe. In a systematic review investigating anxiety disorders during pregnancy, the prevalence rate for antenatal anxiety was estimated to range from 4.4% to 39%;[3] a striking variance that makes it difficult to be confident about the evidence-base relating to prevalence of anxiety during pregnancy. These estimates are also likely to omit mild-moderate anxiety that does not reach the level necessary for a diagnosis but nevertheless does cause distress in the individuals experiencing it.[4] It has been found that antenatal depression and anxiety can be more common than postnatal mental health difficulties.[5] In a systematic review and meta-analysis, anxiety during pregnancy was found to be a significant predictor of postnatal depression at 1-3 months postpartum and at 10-months postpartum, even when depression during pregnancy was controlled for.[6] Two-thirds of women in a longitudinal study of a community sample of mothers who experienced postnatal anxiety were also found to have experienced antenatal anxiety.[7] Given these relationships, it is possible that antenatal anxiety becomes diagnostically overshadowed by postnatal mental health difficulties, leading the area to be not well understood. If it were better understood, it is possible that services could intervene earlier and prevent the development of postnatal difficulties.

Increasingly, there has been a recognition of the importance and benefits of investing in the development of perinatal mental health services. This is particularly significant given that the combined lifetime costs of perinatal anxiety and depression were estimated to be £6.6 billion.[1] UK Government reports like the 'The Best Start for Life' highlight the importance of the first 1001 days from conception for building the foundations of infants' emotional, cognitive, linguistic and social abilities.[8] Importantly, the report highlights that these abilities develop best within the context of a stable relationship with at least one adult,[8] however this process can be interrupted by perinatal mental health difficulties, like antenatal anxiety.[9] The report also lays out the strategic direction of the UK Government in relation to perinatal and infant mental health. Alongside this, the Scottish Government published policies like the Mental Health Strategy (2017-2027)[10] and the Perinatal and Infant Mental Health Delivery Plan[11] with similar strategic goals for developing perinatal and infant mental health services. The National Institute for Health and Care Excellence (NICE) provided guidance around perinatal mental health care, recommending that at every routine appointment the mental health of mothers should be assessed.[12] However, this relies on the mother feeling safe to disclose concerns about her mental health. It has been consistently found that a lack of continuity of care, as well as perceived stigma can act as barriers to mothers disclosing mental health difficulties.[13,14] When designing services, there has been a growing acknowledgement of the helpfulness and utility of qualitative research for informing the design.[15] Understanding service-users' lived experiences could allow services to proactively address barriers to recovery, as well as building on factors that aid recovery.

It has been found that untreated antenatal anxiety can have long-term adverse effects on both the mother and the infant. This includes socio-emotional problems,[16] including difficult temperament and poor self-regulation;[17] as well as the child's cognitive development.[18] However, antenatal anxiety and perinatal mental health difficulties are complex and multi-faceted, making it difficult to be certain about causal relationships and which relationships can be explained by other confounding variables.[9] The mechanisms explaining these relationships remain not fully understood, further showing the relative paucity of research in the area.

A review of women's experiences of perinatal mental health care identified themes including: a need for collaboration between professionals; stigma as a barrier to disclosure; healthcare professionals unable to meet psychological needs; focus on needs of baby over mothers; need for non-judgemental and compassionate support; need for individualized care-plans; and a need for information.[14] The authors argued that access to a supportive and trusting relationship with a healthcare professional would improve perinatal services for women; allowing collaborative and informed decisions to be made, as well as reducing potential barriers to disclosure of mental health difficulties. However, this review highlighted significant research gaps in terms of gathering views from women on their experience of antenatal mental ill health. None of the included studies focused on experiences of antenatal anxiety and only seven of the thirty-nine studies included were focused antenatally.[14] Similarly, five themes were identified in a meta-synthesis of qualitative studies exploring experiences of antenatal psychological distress, anxiety and depression.[19] These included: realising that things are not right; managing stigma; navigating the transformation; spiralling down; and regaining control.[19] The authors also highlighted a gap in the literature exploring women's views of their experiences, finding only eight suitable studies and only two focused on antenatal anxiety. Furthermore, they noted a lack of research around factors that aided recovery from perinatal mental health difficulties. More recently, a qualitative study exploring experiences of perinatal anxiety found that it was an individualised experience infused with both internal and external forms of stigma.[20] The authors found that establishing a social network that could provide practical, social and emotional support was an important part of managing perinatal anxiety and suggested that healthcare professionals should proactively ask women about their access to social support.[20]

In a study exploring women's experiences of antenatal anxiety, the women highlighted the impact of personal and societal expectations on their anxiety.[21] Women described how unfamiliarity, uncertainty and a lack of control amplified their anxiety, as well as noticing how the adjustment to pregnancy and motherhood played a role in the development of their anxiety.[21] A core critique of this study was that the participants were all interviewed antenatally, whilst they were still experiencing their anxiety and had not yet reached the conclusion of their pregnancy. This potentially interfered with the opportunity to reflect fully on what their experiences of antenatal anxiety had been. In addition, this study excluded women who had a history of pregnancy-related complications (e.g., miscarriage, traumatic birth). Given that it is estimated that one in four pregnancies end in loss either during pregnancy or during childbirth,[22] it would be important not to exclude those with these experiences from qualitative research in this area.

There currently exists a small body of research around recovery from perinatal mental health difficulties. Low parental stress and a child with few behavioural difficulties were both found to be predictors of recovery from perinatal depression.[23] It was also found that antenatal symptom severity, frequency of physical exercise during pregnancy, and living with a partner were significant psychosocial predictors of recovery from antenatal depression.[24] Meanwhile, lowered levels of stress in partners[23] and an absence of previous mental health difficulties[5] were shown to be predictors of recovery from perinatal anxiety. However, these studies tended to define recovery by examining symptom reduction, as opposed to exploring functional improvements. This removed an opportunity to examine the nuance of individual experiences, as well as exploring the quality of life of the women who took part. There is also no examination of the actual lived experience of the mothers involved in either study, meaning it is not known whether the mothers perceived themselves to be recovered or what recovery means to them as individuals.

In a meta-synthesis of qualitative literature exploring mothers' experiences of recovery from postnatal depression and postpartum psychosis, a four-stage recovery process is described: recognising the problem; seeking help; achieving recovery; and maintaining recovery.[25] The role of supportive others – for example, family, the wider social network, or health professionals – have also been shown to play an important role for promoting recovery from postpartum psychosis and postnatal depression.[25,26] These findings are echoed by Hore et al who noted that healthcare professionals have an opportunity to address and reduce antenatal anxiety by normalising and validating women's experiences.[21] Alongside this, it was found that the baby played a key role in women's recovery from postpartum psychosis.[26] The involvement of the baby was experienced by mothers as both a facilitator and a barrier to recovery. Although it is recognised that medication can be a helpful part of the intervention for perinatal mental health difficulties (NICE),[12] it has been found that women experiencing antenatal anxiety are typically unwilling to use medication to manage it as a result of concerns about the impact on themselves or their child.[27] It is therefore important that research builds an understanding of the factors that facilitate recovery from antenatal anxiety from the perspective of those with lived experience, to allow services to develop packages of care that can be used as an alternative to pharmacological interventions.

As has been shown above, there is little research seeking to explore the lived experiences of women who have recovered from antenatal anxiety and what recovery means to them. It may be that this gap is related to the way in which antenatal anxiety is perceived by healthcare services, as well as by the women who are experiencing it. In order to guide the development of perinatal mental health services and provide meaningful recommendations, it is important to understand the experiences of those who have recovered, in particular to understand both the barriers and facilitators to recovery. Similar to other research in the field of perinatal mental health,[21,28] this study aimed to address this gap by exploring women's experiences of recovery from antenatal anxiety using an interpretative phenomenological analysis (IPA) approach. The principal research question was therefore: How do women who have had antenatal anxiety make sense of their experience of recovery?

Method

Design

This study used Interpretative Phenomenological Analysis (IPA) in order to explore how each of the mothers made sense of their experience of recovery from antenatal anxiety.[29] The primary focus of IPA is on exploring how individuals have made sense of their experiences,[30] as well as acknowledging the active role of the researcher in the interpretation.[31] This appeared to fit best with the overall study aim of exploring how women who have had antenatal anxiety made sense of their experience of recovery. The IPA procedure described by Smith et al was used during this study.[30] Data was collected remotely via semi-structured interview.

Ethics

This study received full ethical approval from the Clinical Psychology, University of Edinburgh Ethics Committee (Appendix E). It also received sponsorship from the University of Edinburgh Health in Social Science Research Governance Office (Appendix F).

Recruitment

Recruitment and data collection took place between May and August 2021. The study was advertised through social media (e.g., Twitter and Facebook) and perinatal mental health forums. Mothers who self-reported experiencing mild-moderate anxiety during pregnancy were invited to participate. Mild-moderate anxiety was chosen as the focus in order to try to capture the perspectives of women who may not otherwise have had an opportunity to be heard because they were below the threshold for perinatal mental health services. They were eligible to take part if their pregnancy occurred no more than 2 years ago; they were over 18 and UK-based; and able to provide informed consent. A time limit was given to increase opportunity for detailed recall of experiences; as well as to ensure greater homogeneity of perinatal experiences given the wider societal challenges associated with the COVID-19 pandemic.[32,33] Given the close association between antenatal anxiety and development of postnatal depression or anxiety,[34] previous or current mild-moderate mental health difficulties was not an exclusion criterion. However, women with severe or complex mental health difficulties (e.g., postpartum psychosis), or those experiencing a mental health crisis were excluded due to the remote nature of interviews.

In the first instance, the study advertisement provided access to an electronic Participant Information Sheet (Appendix G) and an opportunity to opt-in to being contacted by the researcher. Participants were then contacted and screened by the researcher to ensure eligibility. This also allowed potential participants to learn more about the study[35] and begin developing a rapport with the researcher in advance of the interview[36]. During the phone call, the researcher provided an overview of the project and verbal information about the process for providing consent, as well as giving a brief description of interview content. Participants then provided written informed consent (Appendix H) before being interviewed. All ten interviews took place remotely via Microsoft Teams video call.

Participants

Fourteen women expressed interest in taking part. One did not provide contact details on the opt-in form. Two did not reply to contact from the researcher after opting in, the reasons for this are unknown. One did not complete the interview due to other commitments. Participants were therefore ten women who self-reported experiencing symptoms of mild-moderate anxiety during pregnancy. A sample size of 6-10 mothers was aimed for, in keeping with IPA recruitment guidance provided by Smith et al.[30] All participants completed a questionnaire (Appendix I), which included questions about demographic information (summarised in Table 1), as well as retrospective questions about their experience of antenatal anxiety (summarised in Table 2). The three questions from the anxiety subscale of the Edinburgh Postnatal Depression Scale (EPDS)[37,38] were also included to retrospectively measure anxiety levels during pregnancy (see Appendix I). This subscale, known as the EPDS-3A, has demonstrated strong evidence for being a psychometrically sound measure of antenatal anxiety.[39]

Data Collection

Data was collected using semi-structured interviews that were conducted via Microsoft Teams video call. Each interview was recorded using Microsoft Teams. Interviews took an average of 59 minutes (range: 46 minutes – 79 minutes). In line with IPA methodology, an interview schedule with prompts was prepared (see Appendix J) and used flexibly to support each mother to speak about the experiences and areas of meaning that were most important to her.[30] Questions like: "What has your experience of recovery been like?", with prompts like "Can you tell me about when you first felt like you were starting to recover?" were used. The interview schedule was reviewed by a layperson, as well as by a perinatal mental health nurse and changes were made in relation to feedback.

Reflexivity

The active role of the researcher in the interpretation process is a key aspect of IPA.[30] Throughout the process, the researcher is working to make sense of how the participant has made sense of their experiences.[30] In order to ensure researcher reflexivity, the lead researcher (RB) kept a reflective log of observations about the process of recruitment, data collection, transcription and analysis (extract included in Appendix K). This included reflections on the influence of the researcher's beliefs on interactions with each participant; as well as considering the impact of the researcher's experiences and characteristics on how data was interpreted and analysed.[40] The researcher also recorded their assumptions of how participants might respond to interview questions, for example the expectation that the baby would play a significant role in the development, maintenance and recovery from antenatal anxiety. The researcher kept detailed field notes following each interview, commenting on details that may not have been captured by the recording in order to further support interpretation.[31]

Analysis

Data Analysis followed the six steps described by Smith et al.[30] The researcher began by reading and re-reading each interview transcript, as well as reviewing the digital recording. Then, the researcher made initial notes on each transcript, making descriptive, linguistic and conceptual comments.[30] Next, the researcher used the initial notes to begin developing emergent themes from each transcript. The researcher repeated this process for all transcripts; before reviewing the transcripts together and identifying the patterns that occurred between transcripts. When identifying patterns, themes were categorised as recurrent where they occurred in at least half of the transcripts.[30,41]

In line with quality guidance,[42] participants were invited to receive a summary of the key themes that emerged from their interviews and provide feedback on how the themes fit with their experiences. This feedback was then integrated into the final report. An anonymised sample of all interview transcripts were also coded by a second researcher (CP) and discussed in supervision.

Results

Participant Characteristics

A summary of the demographic information provided by all participants is included in Table 1. All women had accessed Higher Education and were working full- or part-time. They were all in relationships at the time of interview. Half of the women (n=5) had experienced previous baby loss. Most women (n=8) had been pregnant and given birth during the COVID-19 pandemic; however, all of them had had a part of their perinatal journey during the pandemic.

Table 1: Demographic Information

Participant Number	Age	Baby born	Education level	Employment	Relationship	No. Children	No. Pregnancies
1	25-34	2021	Undergraduate	Full-time	Married/Cohabiting	1	1
2	25-34	2021	Postgraduate	Part-time	Married/Cohabiting	1	2
4	25-34	2021	Undergraduate	Full-time	Married/Cohabiting	1	1
5	35-44	2021	Undergraduate	Part-time	Married/Cohabiting	2	2
6	25-34	2020	Postgraduate	Full-time	Married/Cohabiting	1	3
7	35-44	2021	Postgraduate	Full-time	Married/Cohabiting	1	1
8	35-44	2019	Doctorate	Part-time	Married/Cohabiting	1	3
9	25-34	2019	Undergraduate	Full-time	Married/Cohabiting	1	2
10	35-44	2020	Postgraduate	Part-time	Married/Cohabiting	2	3
13	25-34	2020	Postgraduate	Full-time	Married/Cohabiting	1	1

A summary of information related to their experience of antenatal anxiety provided by participants is included in Table 2. Most women had experienced mental health difficulties in the past (n=7). All mothers (n=10) met the clinical cut-off on the EPDS-3A (scores that are ≥ 5)[43] when completing it retrospectively considering an average week during their pregnancy. Despite this, the majority of participants (n=9) did not receive a formal diagnosis of antenatal anxiety.

Table 2: Antenatal Anxiety information

Participant Number	Trimester first experienced anxiety	Formal Diagnosis?	Mental Health Support during pregnancy?	Medication for anxiety?	EPDS-3A Score
1	4-6 months	No	No	No	6*
2	0-3 months	No	Ongoing personal therapy	Yes	6*
4	0-3 months	No	Private personal therapy	No	7*
5	4-6 months	No	No	No	6*
6	0-3 months	No	No	No	6*
7	0-3 months	No	IAPT, PIMH, Peer Support	Offered but declined	9*
8	0-3 months	No	No	No	7*
9	0-3 months	No	Counselling from specialist bereavement midwife	No	6*
10	0-3 months	No	No	No	7*
13	0-3 months	PND and anxiety	No	No	7*

**Above clinical threshold of EPDS-3A[43]*

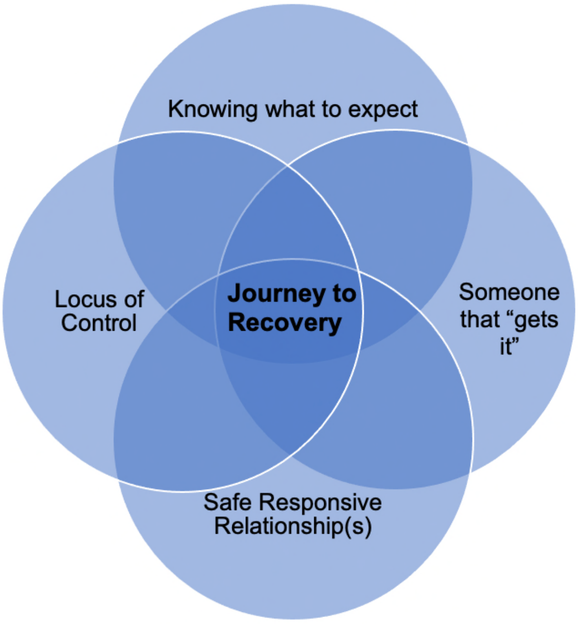
Summary of Themes

There was one overarching theme – 'Journey to recovery' – that encapsulated four superordinate themes. The four main themes were, 'Someone that "gets it"', 'Safe responsive relationship(s)', 'Locus of control' and 'Knowing what to expect'. Each theme had a number of related subordinate themes and these are presented in Table 3, along with a summary of which participants contributed to the development of each sub-theme. A diagrammatic formulation of the themes and their relationships is presented in Figure 1. As can be seen, each of the themes overlaps with one another, meeting in the middle to build towards the women's 'Journey to recovery'. A description and overview of the themes is presented below.

Table 3: Summary table representing themes and subthemes

Themes	**Subordinate Themes**	**Participants that contributed to sub-theme development**
Someone that "gets it"	Feeling listened to and understood	P1, P4, P5, P6, P7, P8, P9, P10, P11, P13
	Shared experiences	P1, P2, P4, P6, P8, P9, P10
	Normalisation – not crazy!	P1, P2, P4, P6, P7
Safe responsive relationship(s)	Containment through attuned care	P1, P2 P4, P5, P6, P7, P8, P9
	Consistent healthcare relationship	P1, P2, P4, P6, P9
	Feeling supported	P1, P2, P4, P7, P8, P9, P10, P13
	Working together	P1, P5, P7, P8, P13
Locus of control	Feeling more in control	P1, P4, P5, P7, P8, P9, P10, P13
	Accepting uncertainty	P1, P4, P5, P6, P13
	Empowered	*P1, P4, P5, P6, P7, P8, P9, P10, P13*
	Self-talk	*P6, P7, P8, P9, P10*
Knowing what to expect	Feeling informed	*P1, P2, P4, P5, P7, P9, P10*
	Individualised healthcare advice	*P1, P2, P6, P7, P10*

Figure 1: Central theme and superordinate themes



Journey to recovery

The theme 'Journey to recovery' captured the women's experiences of recovery from antenatal anxiety and how they made sense of it. The interviews conveyed the women's sense of a gradual build of factors that tipped – or would tip – them into feeling recovered from antenatal anxiety. They highlighted that there was no one aspect that supported recovery; rather it was a constellation of factors that all worked together over time. Importantly, although for many women the safe arrival of their baby acted as the final aspect of recovery, some of the women reported a worsening or shifting of anxiety-related symptoms after their baby was born. These worries often reflected the constant change and shift that is natural within the perinatal period and beyond: "*changes happen so quickly and it just feels like you barely get your footing before there's something new to kind of worry about and plan for*" (P2, line 951-954). Irrespective of the timing of recovery from antenatal anxiety, the women described the same gradual process along the "*recovery road"* (P9, line 598).

Someone that "gets it"

This theme related to the importance of having someone, or a community of people, that "got it" and understood their experiences of antenatal anxiety. The sense that someone "gets it" could happen as part of an existing relationship or just from a brief interaction. This included feeling listened to and understood; finding peers with shared experiences; and having their feelings normalized. The experience of having someone that "*got me*" (P7, line 593) appeared to help the women to feel less alone with their anxiety during pregnancy and "*not crazy*" (P2, line 669); this experience in turn seemed to help them overcome their anxiety.

Feeling listened to and understood

Being listened to and receiving "*gentle understanding"* (P8, line 339) from the system was of significant importance and power for the women receiving care. This was presented in contrast to feeling dismissed and the detrimental impact that this would have had on their anxiety: "*It would have been more difficult if I'd been with someone who was dismissive of it, but he was very understanding*." (P10, line 249-251). The experience of having someone listen without providing advice or trying to change anything appeared to be powerful by itself for many of the women:

> *"She wouldn't say oh have you tried this or have you done that, or you'll like this because of that; she would just listen and… and agree and say yes it's rubbish but it's amazing. Yes nothing fits you, but it's amazing."* (P13, line 682-686).

Healthcare professionals that took time to listen to and understand the women's experiences were often juxtaposed against those that "*just came in and ticked boxes"* (P7, Line 1427-1428). It appeared that this process of someone within the healthcare system taking the time to actively listen to them, helped the women feel less like a number or 'tick-box' exercise, and more like a person. This gentle curiosity, without a time pressure or preconceived idea, then facilitated open sharing and problem-solving with the women. These conversations, sometimes with professionals the women had only met once, often held more power than any other intervention the women received:

> "*Actually, three individual interactions that I had with three different people were probably more valuable than all of the other interactions with people I was under the care of. It was where just… people actually took the time to understand and like ask me… like what are you actually afraid of here? What do you want to know? What do you want? And really just took the time.*" (P7, line 1385-1394)

In contrast communication styles that lead women to feel that they have not been listened to could have an oppressive effect, often worsening the experience of antenatal anxiety: "*And if you're sort of bulldozing over what I'm saying now, what's it going to be like when I'm in labour and I've got no control?"* (P1, line 162-165). The use of the word 'bulldozing' seems to highlight the feeling of being forcibly overpowered by the healthcare system and the fear that this powerlessness will spill into childbirth.

Shared experiences

Hearing or reading about the experiences of peers had a positive impact on most of the women's own experiences of antenatal anxiety. They appeared to take comfort from the solidarity of not being the only one feeling this way: "*It is so helpful because you can talk with other mums who are going through the same thing, so you end up feeling… Ok it's not… it's not you know it's not me; this is just hard to deal with*" (P2, line 822-826). Pregnancy and antenatal anxiety were often viewed as isolating and lonely experiences. However, knowing that they were not alone in their experiences appeared to lessen the isolation and provide some relief. This experience of solidarity occurred despite the restrictions associated with the COVID-19 pandemic often preventing women from meeting in person with peers.

One woman spoke about the burden and loneliness of not being able to speak about her experiences with her existing support network because of how it might make them feel. She noticed that finding someone who had had similar experiences to her with whom she could share, alleviated some of her loneliness:

> *"It is all consuming for you, but then it's so like not shared… so it's like yeah it can be lonely and you just want to be able to talk openly about it, but it makes people uncomfortable. It's not something you talk about… so yeah, I guess it's kind of good to find someone you can as it helps you with not being so lonely, I guess."* (P6, line 231-238).

This sense of antenatal anxiety being "all consuming" was a common thread across many of the accounts. For most of the women, finding someone else that feels the same or similar with whom they could share that burden without worrying about the consequence was invaluable.

Normalisation – not crazy!

Most of the women described 'worrying about the worry' and how this then made them feel more anxious about both their pregnancy and their baby. They then talked about the power of having someone say "*this is normal for a mum to feel this way"* (P4, line 487-488), in particular for supporting them with feeling "*not crazy*" (P2). One woman talked about that message becoming the catalyst for being able to access other strategies: "it *calmed me down enough to then be able to understand my feelings"* (P4, 468-491). This experience appeared to be particularly powerful for one woman who had not had the opportunity to have the conversation whilst she was pregnant. She noticed that having someone say that she wasn't the only one alleviated some of the pressure and judgement that she had been carrying throughout her pregnancy:

> *"And it wasn't until my Health Visitor said that, that I was like Ok it's not me. It's not… this is… this is normal. This is part of becoming a first-time parent. And just feeling like… Ok this isn't because you're a failure, this isn't something you've done wrong.*

> *This is a pretty normal thing you're going through that… that's how it felt… not… not thinking you were crazy anymore." (*P2, line 691-699).

Conversely, another woman continued to believe that she had been 'crazy' during her pregnancy. However, she spoke about the power of her craziness being accepted and worked with, as opposed to dismissed or escalated:

> *"I think having somebody who just accepted my craziness and made… made out like yeah, I was just asking normal questions when probably what I was asking was a little mental at that time…"* (P5, line 1260-1264).

In both examples, it appears that the key factor was that the 'crazy' was accepted for what it was: an understandable response; as opposed to being judged, dismissed or escalated in some way. It seems that this acceptance and validation supported women to feel less 'crazy' and thus less anxious.

Safe responsive relationship(s)

This theme related to the importance of safe responsive relationships for supporting women with their recovery, and indeed the lack of this kind of relationship as a significant barrier. These relationships and interactions provided a containing and attuned space for them to be able to feel safe and secure. For some women the relationship itself was the catalyst for recovery; and for others it was the space within which they were able to 'get through' their pregnancy and childbirth experiences.

Containment through attuned care

Most of the women described experiences of feeling overwhelmed with their emotions and finding that attuned and reassuring care lead to a feeling of containment and safety. This included having the system around them notice their anxiety: "*She definitely picked up that I* *was having a lot of anxiety*" (P2, Line 659-660); and feeling like the system knew how to manage their anxiety: "*She just seemed to know exactly what I needed all the time*" (P4, Line 419-420). Several women spoke about the way in which the system around them appeared to really understand what they needed in the moment to feel better:

> "*She was going by facts because she didn't have anything else to kind of go by. She knows that I am a factual, objective person, so that's what she was helping me to remember."* (P9, Line 485-487).

For these women, this attunement and being held in mind by another person who understood them, lead to a feeling of safety and soothing. The women noted that at times others were able to help them make sense and meaning out of their experiences, for example supporting them to separate their anxiety from the facts:

> *"He would help me kind of reflect on how many times I'd got myself in a state about something someone said, but I haven't really heard them properly. I just heard what my anxiety was hearing."* (P7, Line 402-408)

In the context of the COVID-19 pandemic, many women described the barriers to attuned care that the restrictions (e.g., face coverings, social distancing, attending appointments alone) created.[32,33] They highlighted that often these restrictions lead to an intensification of their feelings of anxiety and overwhelm, and an increased burden of isolation and loneliness. In these instances, the positive impact of attunement, empathy and having someone make sense and meaning from their experiences appeared to be enhanced:

> *"And the midwife just came over and was like, 'Is it ok if I just put my hand on your shoulder?' and that… you know it made such a difference. I know she wasn't supposed to do that, I understood the COVID rules, but I felt horrible just kind of crying by myself on this little chair in the corner without my partner there and that little bit of humanity made such a difference."* (P2, Line 294-305)

The use of the phrase “little bit of humanity*”* seems to highlight the shift from feeling like just a number or name on a page; to feeling like a human going through a difficult time who could be understood by another human.

The women described how this experience of attuned care helped them feel like they could “*breathe again” (*P4, Line 479); as though *“the clouds have lifted a bit”* (P6, Line 504-505); and as though they had “*shared the burden”* (P7, Line 1011) of their anxiety.

Consistent healthcare relationship

Most of the women spoke about the impact of having a consistent relationship with their healthcare team; and the detrimental effects of not having this opportunity for continuity. It is likely that a consistent relationship with the healthcare team could create the foundations for containment through attuned care. However, many women did not have an opportunity to access this continuity which resulted in experiences like speaking to a different midwife at every appointment. The women noticed that: *”It’s hard to be vulnerable like that with somebody straight off the bat”* (P2, Line 265-266) and highlighted the need to weigh up whether the new person was a *“safe enough person to speak with”* (P2, Line 268-269). Not feeling safe to share and open up about how they were feeling then interrupted opportunities for containment through attuned care; normalisation and understanding; and provision of individualised healthcare advice. It is possible that these barriers then inadvertently maintained the experience of antenatal anxiety.

Women recognised the link between a consistent relationship and feeling safe: “*But to have that sense of a relationship… a trusting relationship… uh that enhances that sense of safety”* (P8, Line 816-821). Having a consistent healthcare relationship appeared to allow some of the women to generalise that sense of safety to other members of the healthcare team. One woman described an experience of meeting the hospital midwives when her community midwife was not available:

> *"So I met more midwives there and thought 'these are all lovely people who I'd be quite happy to look after me.' And yeah I think that really helped with putting faces to these kind of nameless midwives that may or may not be looking after me. Even though I didn't meet any of them ever again, knowing that there were people that are friendly that I trusted that were in the hospital kind of helped."* (P5, Line 639-647).

Although not necessarily compulsory to achieve it, consistent healthcare relationships arguably created opportunities for containment through attuned care, feeling supported and working together to overcome antenatal anxiety.

Feeling supported

All of the women described how feeling supported by the network around them both practically and emotionally decreased the intensity of their antenatal anxiety, as well as allowing them to access other strategies for managing antenatal anxiety. They also spoke about the importance of feeling that there was someone available to advocate for them, particularly during childbirth when they felt that they may not be able to advocate for themselves. This theme could be linked with the theme 'locus of control', since feeling supported and as though they had an advocate increased their sense of control over the situation. Women also reflected on the impact of not having support on their own anxiety, as well as the anxiety of their partner:

> "*So, there wasn't kind of the… so no medical support and then there wasn't really the peer support either. So, you know, at the end of the day you're just kind of left to figure it out with your partner about something. Uh. Your anxiety just kind of builds off of each other."* (P2, Line 346-352)

The women described feeling ‘loved’ and as though there were people ‘cheerleading’ or ‘in their corner’, often despite not being able to be physically together. It appeared that this feeling of support from friends, family and professionals made them feel less alone and more prepared for whatever was to come. This support came in the form of book suggestions, advice and recommendations, practical support and advocacy. One woman highlighted that her parents were around a great deal to provide practical support. It appears that this support removed some of the burden, allowing her to be able to access some of the strategies that she knew would help her.

> “*You know just they were always there to sort of help with practical things. You know just to try and make life a bit easier. Which… which does help when you’re you know when you’re sort of stressing and you feel like you’ve got too much to worry about. Too much to think about.”* (P10, Line 301-307).

Finding a network who could provide emotional and practical support appeared to have a positive impact on the women’s antenatal anxiety by allowing them the opportunity and space to implement coping strategies.

Working together

When talking about the turning point where they started to feel like they were beginning to recover, many women began speaking about it as a collective effort. They used ‘we’ and ‘together’ to describe the progress, indicating a movement towards working with others to overcome their anxiety. This was noticeably different from when they were speaking about their experience of anxiety, where they ruminated more on the isolation and loneliness. For one woman this process happened within a single conversation; she described starting the interaction feeling as though she was alone with her concerns, then spoke about the outcome: “*We are going to get this sorted, it is now on its way to being fixed.”* (P1, Line 301-302). For another woman, this process appeared to be more gradual: “*I came to realise that actually we were on the same team.”* (P5, Line 613-614).

For other women, it was the process of working together with their partners to overcome and work through their anxiety that was important. Some spoke about working through the information that they were provided together: “*Neither of us have ever gone through it… so being told the same things together and then talking about it, that was really good.”* (P13, Line 794-797). This opportunity to share the burden of understanding and navigating the flood of information that women are provided with during pregnancy, was another way in which the isolation of antenatal anxiety could be addressed.

This process of working together to get through anxiety even occurred in a situation where both the woman and her partner knew what was happening was not a sustainable strategy. Despite this, the woman appeared to feel completely supported and aligned with her partner against anxiety, working together to manage and overcome it:

> “*My husband was, you know he was supportive and he was saying OK if we need to do this, you know for the next wee while we will do it, we may not have as much money for maternity leave… But we will just do it to get you through.”* (P8, Line 61-66).

Similarly, to other sub-themes within this theme, this sense of working together to overcome anxiety appeared to allow women to share some of the burden of antenatal anxiety that they had been carrying alone up until that point.

Locus of control

This theme refers to the process of women taking back control from their anxiety, as well as taking back control from the healthcare system. The women described feeling ‘powerless’, ‘overwhelmed’, ‘bulldozed’, and ‘out of control’ as a consequence of their anxiety. They also described a sense of having 'no choice' within the healthcare setting about what should happen to them during their pregnancy and labour. This feeling appeared to be amplified further by the ongoing COVID-19 pandemic and the restrictions associated with it.[32,33] A key aspect of recovery for all of the women was the process of returning the locus of control to them as individuals. This included feeling more in control; feeling empowered to voice their needs; changing the way they were speaking to themselves; and, just as importantly, a radical acceptance that it is not possible to control everything.

Feeling more in control

All of the women spoke about feeling in control as a key aspect of recovery from antenatal anxiety. When reflecting back on their experiences, many of the women spoke about the importance of *"finding ways to get control back into it*" (P5, Line 1251). They also spoke about ways that they tried to take back control, for example by planning and organising; and learning as much as they possibly could about what was happening. This process appeared to make pregnancy and childbirth more predictable. This predictability appeared to reduce the sense of overwhelm and fear of being unable to cope, and therefore reduced antenatal anxiety: "*I'm going to try and learn everything I can about this thing to try and control it"* (P4, Line 721-723).

The women also worked to change the way that they interpreted the experience of childbirth from something uncontrollable and silencing, to something that is within their control:

> *"This is… this is a powerful physical experience that you can ride through and that you can have control over and that really helps me because I think… I think my biggest fear was just having absolutely no control and no voice or no agency in the experience and… and this helped me kind of get what I could."* (P8, Line 209-216).

The repeated use of the phrase 'you can' seems to highlight this process of shifting the perspective of childbirth as something that is not overwhelming and unmanageable, and that it can be coped with. This seemed to reduce the fear associated with losing control or being unable to cope and subsequently reduced the intensity of anxiety.

Many women also spoke about the sense of "*feeling in control again"* (P7, Line 1078-1079) as a key indicator that they were recovered or recovering. They reflected that feeling in control was also about "*stability of mood"* (P6, Line 591), and a return to *"being able to live my life"* (P4, Line 882-883) rather than feeling constantly buffeted by anxiety. One woman when reflecting on where she had come on her recovery journey spoke about a sense of *"fragile stability*" (P2, Line 933), acknowledging that there were still many things ahead of her that were unknown and uncontrollable.

Accepting uncertainty

Alongside the importance of taking back control; many women also spoke about the power of allowing themselves to radically accept that it is not possible to control everything. It was a frequent acknowledgement that this is particularly the case for pregnancy, childbirth and the postnatal period. For one woman, this process was about allowing herself some grace that it isn't possible to control everything, but that she would get to it all eventually:

> *"There are elements that I won't think of and things that I can't control and I won't be able to fix everything immediately and I need to give myself a little bit of time to do this, this and this, and you're not going to get done today but it doesn't mean it's not going to get done.*" (P1, Line 1367-1373)

Meanwhile for other women, there appeared to be a dual process of controlling what they could and letting go of the things that they could not. Importantly for these women, the process of letting go was an active effort and decision, as opposed to a passive acceptance.

> *"It was kind of letting go and realizing that I'm not in control and trying again not to worry because knowing the worry can cause harm as well so it was just a real effort…*

> *an active effort to let go and accept that whatever would be would be really."* (P6, Line 394-400).

This effort to actively accept that they cannot control everything could be understood as another way of taking back control and making the unpredictable predictable. This acceptance that they cannot control what happens during childbirth is a realistic expectation and therefore likely to be a helpful position to take to aid with recovery.

Empowered

Most women described a turning point where they felt empowered to speak up and advocate for themselves as a key aspect of their recovery. For some women, the feeling of empowerment came about as a result of advice and support from others, in particular healthcare professionals. This sense of empowerment appeared to be most salient when it came to preparing for their labour. For example, being told that "*if I don't want it to happen, it doesn't have to happen"* (P1, Line 341-342); and "*I can question that and I can get the evidence to make the decision for myself and I don't have to just blindly trust them."* (P5, Line 298-302). These realisations that they were able to be an active participant in decisions appeared to enhance the feeling of empowerment; and this in turn had a powerful effect on their journey towards recovery.

One woman, when reflecting on her experiences of antenatal anxiety, noticed that recovery had helped empower her and made her feel stronger – simply because she had survived and come through it:

> *"You were strong for, you know, being able to…. To get through it and yeah it doesn't like make you weak to have suffered with anxiety. I think like in some ways it makes you sort of feel stronger."* (P10, Line 502-506).

This sense of empowerment is juxtaposed against the sense of powerlessness that some women described in relation to the healthcare system. It appeared that an important part of recovery from antenatal anxiety was the women learning to trust their instincts in relation to what they know will help them. Importantly here, it also appears that the women learned that they were allowed to make their voices heard within a system that perhaps does not always allow an opportunity for this.

Self-talk

Many women spoke about the impact of mantras and changing how they spoke to themselves on their experience of recovery from antenatal anxiety. These mantras were repeated phrases and reassurances that they would say over and again in their heads. The women described how the mantras would calm them down, and quieten the worried thoughts that they were having. Some mantras included phrases that appeared to try and pull the focus away from other experiences and towards the current pregnancy: "*This is a different pregnancy from what I've had before"* (P8, Line 145-146) and "*My body is strong and it conceived this baby."* (P6, Line 134-135). Other women repeated reassurances that they had heard from health professionals in their heads as a mantra: "*I remember going to the scans and sitting there and thinking "Well remember, [Midwife] said it was good and that these things are good and [Midwife] sad that there was nothing to worry about.""* (P9, Line 496-501).

These mantras were presented in contrast to the "all-consuming" experience of antenatal anxiety and the women's experience of ruminating on the potential negative outcomes of their pregnancy. Importantly, the mantras developed by the women tended to focus on the here-and-now facts of their pregnancy, as opposed to focusing on predicting a future they could not guarantee.

Knowing what to expect

This theme relates to the contribution of feeling informed, knowing what to expect and receiving individualised healthcare advice to women's recovery from antenatal anxiety. All women recognised that pregnancy and childbirth is a fundamentally uncontrollable and uncertain thing. Most women then went on to speak about how feeling informed and knowledgeable about what was likely to happen during childbirth, as well as what was happening during their pregnancy, had a notable impact on how anxious they felt.

Feeling informed

Most of the women spoke about the importance of feeling informed as a key aspect of their journey towards recovery. This included feeling informed about pregnancy, childbirth and the postnatal period, and was related to the provision information that increased their knowledge about what was about to happen. The women described reading as much as possible to help inform themselves, this included looking at social media, the NHS website and various books. This information appeared to give them a sense of control, and like they knew what to expect. This in turn reduced their anxiety. "*Yeah, the more information that you have, the more knowledge and understanding that you have… The less what ifs, the better"* (P13, Line 1408-1411). This sentiment was also balanced with an acknowledgement that they can never know exactly what to expect: "*And what it did was it gave me information so that I knew what to expect. Now you can never quite know what to expect, but I felt a little bit more like I knew what to expect."* (P4, Line 733-736). However, feeling informed allowed them to know what was happening during labour, and therefore reduce the fear: "*Once I understood what they were and how they were used… it removed the fear."* (P1, Line 759-761).

Many women also reflected that they hadn't been aware that antenatal anxiety could or should be a concern and did not feel informed about it either. It appeared that their anxiety was worsened simply because they hadn't realised it could be a problem. One woman, when reflecting back on her experiences noted: "*I felt like people didn't really warn me about, you know, this is going to happen and you might feel like this. I felt like I was just kind of left to discover everything myself."* (P9, Line 914-917). Another woman spoke about her perception from the system around her that anxiety during pregnancy is just a part of the process and that there is nothing you can do about it:

> "*I think it's kind of accepted that all women you know, women always feel anxious and worried when they're pregnant, but it's just something you have to kind of put up with a bit"* (P10, Line 147-151).

This speaks to the earlier theme of normalisation as a powerful aspect of the women's recovery. If the women were not aware that antenatal anxiety could be a presenting problem, it is understandable that hearing from a professional that there is a name for how they are feeling would be validating and reassuring. This perception from the system that anxiety during pregnancy is the norm perhaps goes so way to explain the comparative lack of research related specifically to antenatal anxiety.

Individualised healthcare advice

Most of the women highlighted the power of individualised healthcare advice and information for helping them feel more in control of their anxiety. They noted that often the generic advice provided to them (e.g., on the NHS website) was not specific enough, or was 'too perfect' to be applicable to them. Access to more nuanced advice and information which addressed the specific concerns of the women, appeared to be invaluable for reducing anxiety: "*They were so helpful and they were so knowledgeable and I guess they could tell things by being in person that I don't think you could have really read on a page."* (P2, Line 638-642).

The experience of having healthcare professionals explain information in a nuanced way appeared to soothe some women because they were better able to understand and know what to expect: "*Explain things to me and I'm rational. If I don't know then I'm not… not anywhere near!"* (P1, 591-593). The feeling of "knowing" seemed to be tied to the idea of adding some predictability and control into pregnancy and childbirth. Another woman spoke about the importance of being given evidence-based information that made sense to her:

> "*But what made a difference I think for me like someone explaining it to me like facts and evidence, and actually it was the fact that it was evidence and not just hearsay.*" (P7, Line 1848-1851).

The provision of evidence-based information, as opposed to providing generic information or not being able to explain why something has to happen, appeared to be closely related to how trustworthy and knowledgeable the women felt that healthcare professionals were. This in turn affected how safe they felt and therefore had an impact on their experience of recovery. This speaks to the importance of feeling understood and listened to, as well as the women feeling empowered enough to ask the questions that they want answered.

Discussion

This study provides some insight into the lived experiences of recovery for women who have had antenatal anxiety. The interviews conveyed a gradual 'Journey to recovery'; where the women described a constellation of factors that all contributed to their recovery from antenatal anxiety. This included finding 'Someone that "gets it"'; having 'Safe responsive relationship(s)' to support them; taking back the 'Locus of control'; and 'Knowing what to expect' for pregnancy, labour and the postnatal period.

The current study identified the importance of having 'Someone that "gets it"' for promoting recovery from antenatal anxiety. This included the power of shared experiences, a theme that has been echoed by other qualitative research exploring women's experiences of perinatal mental health, where the key theme 'finding solace in sharing experiences' was identified.[44] Despite all the women involved in the study having their perinatal period impacted by COVID-19 and the associated restrictions, it is striking that shared experiences continued to be a key contributor to recovery. This study adds the idea of normalisation from others to support women to feel not 'crazy' as an important factor for recovery. Having their 'crazy' accepted, rather than judged, dismissed or escalated aided the women to feel more in control of how they were feeling. Normalisation has been argued to be a powerful way of reducing stigma related to perinatal mental health difficulties;[44] however, it has also been found to have a belittling effect when used as a way of mislabelling perinatal mental health difficulties as pregnancy symptoms.[45] This indicates that normalisation must be used within specific contexts in order to be useful. Given the findings from this study, it is possible that normalisation within the context of an interaction with 'someone that "gets it"' is the key to its utility. However, further research is needed to understand the mechanisms of normalisation within this population more fully.

'Safe responsive relationships' were also identified as key to women's experiences of recovery from antenatal anxiety. These relationships could be with healthcare professionals, friends, family and partners; the important factor was the presence of someone that made the women feel safe. The themes found in this study are echoed by quantitative research exploring factors influencing women's recovery from antenatal anxiety. For example, it has been found that women that had supportive and collaborative relationships with their midwives experienced a greater reduction in antenatal anxiety compared to women who did not report good relationships with their healthcare system.[46] Similarly, Oh et al found that establishing and engaging support networks – both family and peer support – played a key role for helping women with perinatal anxiety.[20] The importance of trusting relationships with healthcare professionals has been found in several studies;[14,21] it therefore seems unsurprising that this was found to be a key theme in this study too. Perimann et al argued that the midwife-woman relationship acts as the vehicle through which other important aspects of perinatal care can occur.[47]

Taking back the locus of control was the third aspect that played an important role in women's experience of recovery from antenatal anxiety. This included the notion of empowerment as an influential part of recovery. Previous research has highlighted the role of midwives for building confidence that women experience as empowerment.[47] Empowerment has also been linked with women’s sense of control, how informed they feel and the level of trust they feel towards healthcare professionals during childbirth.[48] The present study added the role of empowerment for supporting women to advocate for themselves and feeling empowered to make their needs known to their healthcare team. Another key part of taking back the locus of control was the women striving to accept and tolerate the uncertainty associated with pregnancy and childbirth. There appeared to be a balance between controlling what could be controlled, and acknowledging that pregnancy and childbirth is an inherently uncontrollable process. Qualitative research exploring women’s experiences of antenatal anxiety found that women described a process of gradual acceptance of uncertainty as their pregnancy progressed.[21] This process of gradual acceptance of uncertainty and lack of control seems to be a key psychological process intrinsic to the experience of recovery.

The final aspect that played a role in women’s experiences of recovery from antenatal anxiety was ‘Knowing what to expect’. This included access to information about pregnancy, childbirth and the postnatal period, as well as access to individualised healthcare advice. The relationship between access to information and reduction of perinatal mental health symptoms is supported by quantitative research. For example, it has been found that emotional and informational support play a mediating role between perceived stress and symptoms of antenatal anxiety and depression.[49] Interestingly, antenatal childbirth education has also been shown to lead to increased self-efficacy and self-confidence, as well as an increased perception of control during childbirth.[50] The ability of the midwife to share individualised healthcare advice with women was found to have an important impact on women’s perceptions of predictability and control during childbirth.[51] Additionally, Rowe and Fisher highlighted a reduction in antenatal anxiety when professionals took responsibility for what information was provided to women; as compared to when women were required to seek information themselves.[52]

In contrast to other research exploring women's experiences of recovery from postpartum psychosis,[26] there was no distinct theme related to the role of the baby in recovery from antenatal anxiety. The authors found that the baby has a central role in recovery, however the baby can be experienced as both helpful and unhelpful for the recovery process.[26] In the present study it was found that for some women, the safe birth of their baby was a key aspect of their recovery, however for others the birth of their baby was the catalyst for a new wave of postnatal anxiety. It may be that this represents a fundamental difference between antenatal and postnatal psychological processes in relation to the baby. It would therefore be beneficial to further examine this phenomenon in relation to antenatal anxiety, specifically exploring the role of the baby in the development of and recovery from antenatal anxiety.

Limitations

Although each of the women's experiences were varied, more diversity within the participant sample may have provided a wider range of narratives regarding experiences of recovery from antenatal anxiety. For example, all of the women in this study were in a committed relationship and were able to access support from their partner. It would also be important to understand the experiences of recovery for women who do not have the same access to this support. In addition, all women who took part had attended Higher Education and were high-achieving women in professional job roles. However, although a greater spectrum of diversity may be beneficial, in clinical practice the population of women in this study is likely to be representative of the women who can be hardest hit by antenatal anxiety.

Alongside this, although the study did not explicitly focus on the impact of COVID-19 on antenatal anxiety, it is impossible to ignore the societal context when undertaking qualitative research. Efforts were made to control for the impact of COVID-19 by ensuring that all of the participants had had their perinatal period impacted on by the pandemic and associated restrictions (e.g., lack of face-to-face appointments).[32,33] Participants did have some heterogeneity of experience in terms of the timing of their pregnancy in relation to COVID-19 restrictions and it is therefore striking that, despite this, the main themes regarding experiences of recovery were common to all women.

Conclusion and Clinical Implications

Overall, the findings of this study contribute to the understanding of women's experiences of antenatal anxiety, specifically considering the factors that influenced recovery. Given that many women in this study had not been aware antenatal anxiety was a risk, or indeed something unusual; women would likely benefit from access to universal community-based social support programmes that include information about antenatal anxiety and how best to manage it. This programme could provide access to a group of women with shared experiences ('Someone that "gets it"'); as well as providing an opportunity for empowerment ('Locus of control'); and gaining information ('Knowing what to expect'). There is already a large body of research advocating for the importance and power of continuity of care within maternity services,[53,54] as well as research highlighting why women have a preference for continuity of care.[47] This study adds the notion that it does not always have to be an ongoing relationship that can provide attuned care. In many cases, the presence of someone – anyone – who took the time to actively listen and try to understand could be healing all by itself.

Future research should explore the mechanisms underlying the gradual acceptance of uncertainty in relation to the antenatal period. It may also be beneficial to explore whether the themes identified within this study can be applied postnatally or to other perinatal presentations. This may allow for further examination of the similarities and differences between perinatal presentations and what factors act as barriers or facilitators for recovery. Further to this, research exploring the role of the baby in development and recovery from antenatal anxiety as compared to other presentations, like postpartum psychosis, may be beneficial.

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Appendix A: Journal Submission Guidelines

ELSEVIER

WOMEN AND BIRTH

Journal of the Australian College of Midwives (ACM)

AUTHOR INFORMATION PACK

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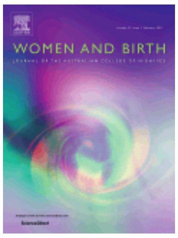

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DESCRIPTION

Women and Birth is the official journal of the Australian College of Midwives (http://www.midwives.org.au/). It is a midwifery journal that publishes on all matters relating to pregnancy, birth, and the first six weeks post-partum. All papers must draw from, and contribute to, the relevant contemporary research, policy and/or theoretical literature. We focus on primary research papers, systematic reviews and research-informed and critiqued discussion papers. While we are based in Australia, our Editorial Board is multi-national and we welcome papers from all over the world. All papers should reflect our global perspective and reach. Articles are double blind peer-reviewed by experts in the field of the submitted work.

Our woman-centred focus is inclusive of the partner, wider family, fetus and newborn, and covers both healthy and complex pregnancies and births. We recognise that individuals have diverse gender identities. Terms such as *pregnant person*, *childbearing people* and *parent* can be used to avoid gendering birth, and those who give birth, as feminine. However, because women are also marginalised and oppressed in most places around the world, we support use of the terms *woman*, *mother* or *maternity*. When we use these words, it is not meant to exclude those who give birth and do not identify as women. The journal seeks papers that take a woman-centred focus on midwifery practice, research, theory, education, management and leadership, maternity service provision, maternal and newborn health, respectful maternity care, breastfeeding, primary health care and relevant aspects of psychology, sociology, human rights and health economics. We welcome papers from all professional disciplines that are relevant to midwifery practice and the scope of the journal.

Our key readers are midwives, maternity care and neonatal nurses, maternity service managers, providers and users, obstetricians, neonatologists, health sociologists and economists, psychologists with an interest in maternal and infant research and policy makers and researchers from all these areas.

The journal is indexed in PubMed, MEDLINE, Thomson Reuters, Scopus and CINAHL.

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BEFORE YOU BEGIN

Before you start we also suggest you look at the style of language and terminology used in the journal. This Editorial provides some information. https://www.womenandbirth.org/article/S1871-5192(20)30088-3/fulltext

More details are provided later in these instructions.

First time authors are strongly advised to co-author with an academic supervisor or experienced colleague who has been successful in writing for publication. Articles submitted for review must be original works, and may not be submitted for review elsewhere whilst under review for the Journal.

If a related article, based on the same work, has been submitted or published elsewhere, it must be acknowledged in the cover letter to the editor, added to the end of the cover letter, and referenced in the manuscript.

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Observational cohort, case control and cross sectional studies - STROBE - Strengthening the Reporting of Observational Studies in Epidemiology STROBE Checklist

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Study of Diagnostic accuracy/assessment scale - STARD - Standards for the Reporting of Diagnostic Accuracy Studies http://www.equator-network.org/reporting-guidelines/stard/

Systematic Review of Controlled Trials - PRISMA - Preferred Reporting Items for Systematic Reviews and Meta-Analyses http://www.equator-network.org/reporting-guidelines/prisma/

Systematic Review of Observational Studies - MOOSE - Meta-analysis of Observational Studies in Epidemiology
http://www.equator-network.org/reporting-guidelines/meta-analysis-of-observational-studies-in-epidemiolog

Reporting the range of methods used to improve healthcare - SQUIRE - Standards for Quality Improvement Reporting Excellence SQUIRE Checklist

Qualitative researchers are encouraged to consult the guideline listed below:

Qualitative research - SRQR - Standards for Reporting Qualitative Research: A Synthesis of Recommendations SRQR Checklist

*Mixed Methods Appraisal Tool (MMAT)*MMAT

Human and animal rights

Ethics in Research – Note that research studies that do not have ethical approval prior to being conducted will not normally be published. We will consider publication, however, if the relevant Institutional Ethics Committee provides you with a letter saying that they do not normally provide ethical approval for studies such as the one you conducted. See Cope Guidelines at: http://publicationethics.org/resources/guidelines

For Human Research please consult the National Health and Medical Research Council’s (NHMRC) research ethics guidelines: https://www.nhmrc.gov.au/research/responsible-conduct-research/summary-national-statement-content

For research involving humans, please address the ethical aspects of the research in the Methods section. State clearly that the subject gave freely informed consent and, if in dependent relationships with members of the research team, issues of perceived coercion must be addressed. To clarify, women and their families, and students are in dependent relationship with researchers and must not be directly approached by the research team to give consent on-the-spot. Participating or not participating in the research must not disadvantage participants in a dependent relationship. Any benefit for participating must not constitute a financial inducement. Participant anonymity must be preserved, unless express written approval to use identifying data is provided. The author must retain written consents, or evidence that such consents have been obtained, must be provided to Elsevier on request.

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The guidelines for the humane treatment of ANIMALS in research are found here: https://www.nhmrc.gov.au/health-ethics/animal-research-ethics

Ethics in Publication

The journal follows the Committee of Publication Ethics (COPE) guidelines and requests authors to familiarise themselves with these guidelines at: http://publicationethics.org/resources/guidelines. A few issues that authors need to pay particular attention to are set out below.

It is ethically questionable to break up or segment data from a single study to create different papers for publication – a practice called 'salami slicing'. If the authors have legitimate reasons for reporting separately on different parts of the same study, or the same data set, they should justify that to the editor at the time of submission. Equally, readers need to be aware that different aspects of the same study are being reported, thus the methods section of the submitted manuscript must clearly explain why the submitted paper is justified.

Use of inclusive language

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Women and Birth requires that authors use woman centred language including referring to births rather than deliveries, to give birth rather than deliver and women rather than patients. Papers that do not adhere to these guidelines will not proceed to peer review.

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In the introduction, create a table using the following headings to summaries (in 100 words or less) the contribution of your paper to the existing literature:
- **Problem or Issue**
- **What is Already Known**
- **What this Paper Adds**

Example of Statement of Significance
Problem
Poor assessment and clinical reasoning are major contributors to adverse birth outcomes.

What is Already Known
Midwifery decision-making during birth is mediated by hierarchies of surveillance and control. Midwives are often unable to implement their preferred decision. The international and national professional decision-making frameworks are not sufficiently detailed to guide midwives' clinical reasoning.

What this Paper Adds
Evidence that half of the midwives interviewed did not use clinical reasoning to make decisions. A new and detailed model of midwifery clinical reasoning which incorporates a role for intuition.

Headings

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- **Conclusion** (summarise key points and make recommendations)

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Appendix B: Quality Appraisal Tool

Developed December 2021

Quality Appraisal Tool

Appraisal options and definitions:

- Yes = The paper meets the criteria.
- Somewhat = The paper has some relevant information where there are both strengths and weaknesses identified.
- Can't Tell = There is insufficient information reported to make a full judgement.
- No = The paper does not meet the criteria.

NB prompts should not be used as a checklist for meeting criteria.

Criteria	Prompts	Appraisal
Is there a clear statement of, and rationale for, research question/aims/purposes?	• Clarity of focus demonstrated • Explicit purpose given, such as descriptive/explanatory intent, theory building, hypothesis testing • Link between research and existing knowledge demonstrated	
Is the study thoroughly contextualised by existing literature?	• Evidence of systematic approach to literature review, location of literature to contextualise the findings, or both	
Is the method/design apparent, and consistent with research intent?	• Rationale given for use of qualitative design • Discussion of epistemological/ontological grounding • Rationale explored for specific qualitative method (e.g. ethnography, grounded theory, phenomenology) • Discussion of why particular method chosen is most appropriate/sensitive/relevant for research question/aims • Setting appropriate	
Is the recruitment strategy appropriate to the aims of the research?	• If the researcher has explained how the participants were selected • If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study • If there are any discussions around recruitment (e.g. why some people chose not to take part)	
Is the data collection strategy apparent and appropriate?	• Were data collection methods appropriate for type of data required and for specific qualitative method? • Were they likely to capture the complexity/diversity of experience and illuminate context in sufficient detail? • Was triangulation of data sources used if appropriate?	
Is the sample and sampling method appropriate?	• Selection criteria detailed, and description of how sampling was undertaken • Justification for sampling strategy given	

	• Thickness of description likely to be achieved from sampling • Any disparity between planned and actual sample explained	
Is the analytic approach appropriate?	• Approach made explicit (e.g. Thematic distillation, constant comparative method, grounded theory) • Was it appropriate for the qualitative method chosen? • Was data managed by software package or by hand and why? • Discussion of how coding systems/conceptual frameworks evolved • How was context of data retained during analysis • Evidence that the subjective meanings of participants were portrayed • Evidence of more than one researcher involved in stages if appropriate to epistemological/theoretical stance • Did research participants have any involvement in analysis (e.g. member checking) • Evidence provided that data reached saturation or discussion/rationale if it did not • Evidence that deviant data was sought, or discussion/ rationale if it was not	
Is the context described and taken account of in interpretation?	• Description of social/physical and interpersonal contexts of data collection • Evidence that researcher spent time ‘dwelling with the data’, interrogating it for competing/alternative explanations of phenomena	
Has a clear audit trail been given?	• Sufficient discussion of research processes such that others can follow ‘decision trail’	
Was data used to support interpretation?	• Extensive use of field notes entries/verbatim interview quotes in discussion of findings • Clear exposition of how interpretation led to conclusions	
Was researcher reflexivity demonstrated?	• Discussion of relationship between researcher and participants during fieldwork • Demonstration of researcher’s influence on stages of research process • Evidence of self-awareness/insight • Documentation of effects of the research on researcher • Evidence of how problems/complications met were dealt with	
Have ethical issues been taken into consideration?	• Ethical committee approval granted	

	• If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained. • Clear commitment to integrity, honesty, transparency, equality and mutual respect in relationships with participants • Evidence of fair dealing with all research participants • Recording of dilemmas met and how resolved in relation to ethical issues • Documentation of how autonomy, informed consent, confidentiality, anonymity, how they handled the effects of the study on the participants during and after the study were managed	
Is there a clear statement of findings?	• If the findings are explicit • If there is adequate discussion of the evidence both for and against the researcher's arguments • If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst) • If the findings are discussed in relation to the original research question	
Is relevance and transferability evident?	• Sufficient evidence for typicality specificity to be assessed • Analysis interwoven with existing theories and other relevant explanatory literature drawn from similar settings and studies • Discussion of how explanatory propositions/emergent theory may fit other contexts • Limitations/weaknesses of study clearly outlined • Clearly resonates with other knowledge and experience • Results/conclusions obviously supported by evidence • Interpretation plausible and 'makes sense' • Provides new insights and increases understanding • Significance for current policy and practice outlined • Assessment of value/empowerment for participants • Outlines further directions for investigation • Comment on whether aims/purposes of research were achieved	

Appendix C: Contextual Data Extraction Template

Data Extraction Template

	Authors	No. Participants	Presentation	Country	Age	Perinatal Timing	Setting	Data Collection	Methodology	Key Findings	Study Aims
1											
2											
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Appendix D: Qualitative Data Extraction Table

January 2022

Qualitative Data Extraction Template
Informed by Sattar et al., (2021)

Study Title:

Author/Year:

Objective:

Themes	**Participant Quotes (First Order Constructs)**	**Primary Author Interpretations (Second Order Constructs)**

Appendix E: Sample of completed Qualitative Data Extraction Table

Study Title: Women's worries about childbirth: making safe choices *Maier (2010)*

Objective: The aim of this research was to provide a qualitative account of a number of women's everyday worries about childbirth. This was facilitated by asking women about their worries and identifying their social and personal contexts.

Themes	Participant Quotes (First Order Constructs)	Primary Author Interpretations (Second Order Constructs)
Worry about wellbeing of baby	*'...we don't want to do anything that's going to harm the baby and that's the truth...' (June, multip, birth centre care).*	Ultimately the women in this study worried every day about the wellbeing of their baby.
Worry about safety of interventions	*'I think I'd feel really awful if I ended up having an epidural because I don't want one, but at the same time I've never done that, been there before, so I do accept that I could even go that way if it was bad enough... (Jenny, multip, private midwifery care).* *'...to be in hospital where they've got the machines, and they've got the doctors and they've got the technology and they've got the drugs... (primip, privare obstetric care).*	Worry about pain included ideas of what is best for the baby. Although this was considered to be no use of drugs in labour, it was dominated by a belief in medical control, which compelled them into a discourse that values intervention and resulted in high rates of drug use in labour. What they understood to be best for their baby contradicted an ideol- ogy where birth is too painful and uncontrollable to manage without intervention.
Worry about uncontrollability of pain	*'...but if anything were to sort of happen, my fear is of being slightly manipulated into a birth that I don't want, that I don't feel is going to be the safest for him, that's fear number one, but then the second fear is of course making a mistake by maybe being a bit too headstrong about that, and something happening to him.... (Bella, primip, birth centre care).* *'...I guess I just assume that you go into hospital and you have the*	Many of the women felt that without access to medical technologies they would be compromising their baby's health, and at the same time expressed worry about the safety of intervention.

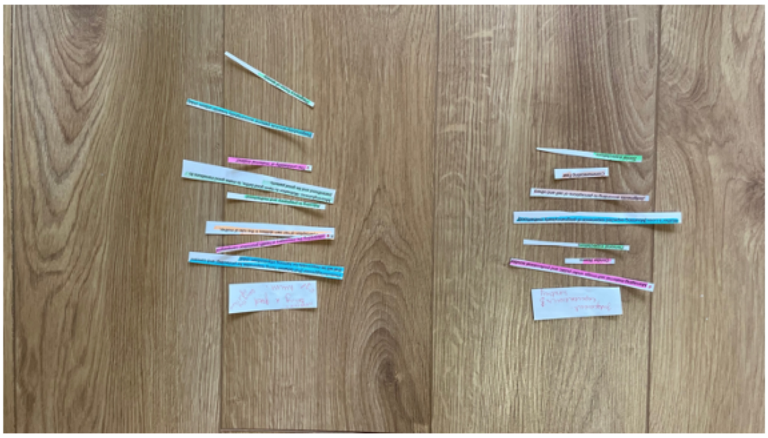
	epidural you know...(multip, birth centre care). *I: 'So how do you imagine labour without an epidural then?'* *Donna: 'Painful, I don't know, everyone says it's really, really painful but I would like to try like with gas mask first, I don't want to go straight to the epidural, I'll try and do what I can I guess.'* *I: 'So do you imagine that you'll need something?' Donna: 'Yeah.'* *I: 'So you don't see?'* *Donna: 'I doubt it, if all my family have had epidurals, all of my cousins, not one of them has had a natural childbirth.'* *'So from her [mother] I've got this unrealistic image, I think it's unrealistic because I think to myself, well she gave birth in an hour and then half an hour, and her mother was the same, and so were her sisters, and I just think I'll be the same because that's what I can deal with, I'll be like that, I'll have the opposite problem* *of getting there in time, and because I want to believe that that would be the case... but my common sense says everyone's different so you might not be anything like that, I'd love to be. So she didn't have any of those issues, so yeah I've only got positive things from her, it's just when I started talking to other people (Gina, primip public medical care).*	
Responsibility/absolute personal accountability towards unborn child	*'...but I guess if something was wrong with the baby, like permanently wrong, it would be a reflection probably, on me, like did I eat something wrong or did I drink something wrong throughout the pregnancy and all that sort of thing? I guess when*	A maternal discourse of absolute personal accountability was shown to be a powerful influence and created significant worries for women regarding their behaviours and their responsibility towards their unborn child.

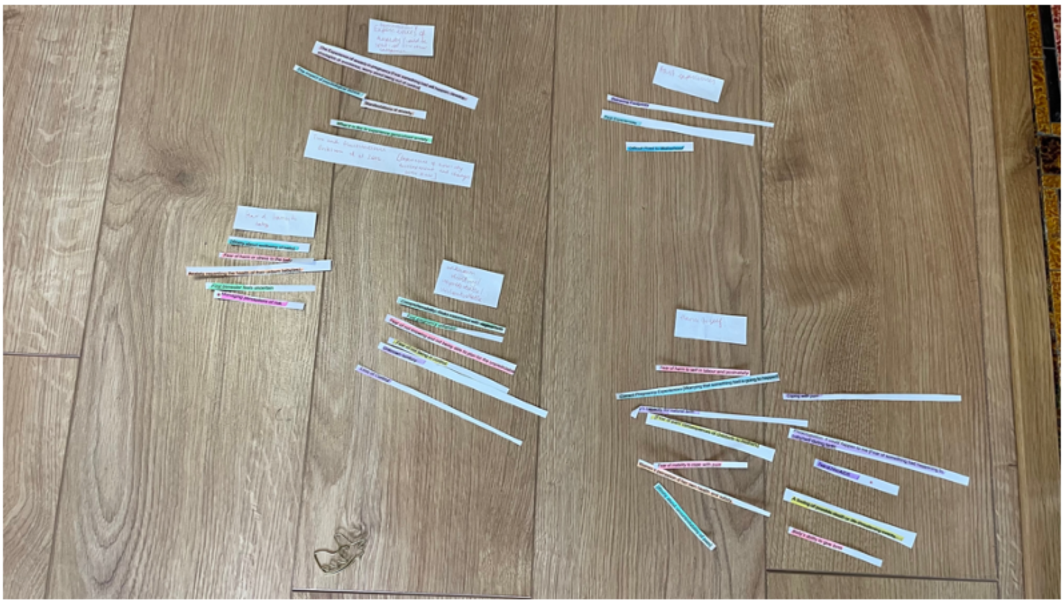
	you come to the end of something, you always reflect and sort of think, God you know, nine months it's been, have I, did I drink one too many glasses of red or did I have too many cups of coffee or you know all those sorts of things'. (primip, birth centre care). *I: 'So when you look at the research question "What are women's worries about childbirth", what does that immediately make you think?' Emma: 'That basically the safety of the baby and you know concerns for the wellbeing, probably I would rate my wellbeing second probably, the last sort of, but basically the concern for the baby's wellbeing (Emma, primip, public medical care).*	They worry throughout their pregnancy that their choic- es, actions and emotions may adversely affect their baby.
Experience of antenatal care impacting impression of childbirth	*They're (hospital midwives and doctors) always very kind and say, "is there something that you want to talk about?" You feel pressured because, you know, there's like a billion of women waiting, and then you're like, okay maybe it's not that important...' (Della, primip, birth centre care).* *No one knows who I am and so you can't really have control...' (Marie, multip, public medical care).* *'I'm like; you fellows' (the obstetricians and midwives) bedmanners are depressing...' (Moni, multip, high risk in-patient public hospital).* *'Yeah, I think a lot of, maybe their dignity... is the way ...you're treated or the way you're spoken to or you... respecting your wishes, I think that has a lot more to do with it...' (Lilly, multip, birth centre care).*	Being vulnerable during the process of labour and birth was expressed in different ways. How women learn percep- tions and expectations about childbirth is intimately tied to the way they experience their antenatal care. How women experience antenatal care appears to shape the expectations they have for care during labour and birth.

Need to follow norms of socio-cultural context and antenatal context	*Anna (multip, private obstetric care): 'I wanted the ultrasound; you know I wanted the other things that were issued ...'* *I: 'So how would you feel then if everything was a choice put back onto you.'* *Anna: 'Oh quite overwhelmed I would imagine yeah there are too many choices not not enough, I mean from my perspective I've, I'd like somebody else to take control and its like I, I've you know you're the expert in that field and you...um I'm taking your advice that this is what you'd recommend me to do at this time in my pregnancy and that what I'm going to go and do and I don't need the extra, your brain is fuzzy enough without to make choices especially about something so important coz if, you know what if you made the wrong decision and its ah with the consequence would be really I wouldn't want to take the responsibility of the choice.'* *'I think a lot of things you don't question ... I found out ... an acquaintance I know, she's had three children and she refused all those tests, everything, she had nothing!... she just said, "no I'm not having it done" ... and I thought, that was wonderfully brave of her, but I think most of us do what's easiest...'*	In contemporary western societies there are very few women who do not willingly access antenatal technology to frame their embodiment of their pregnancy. Susan (multip, public medical care) shows that to be self- determinant means to go against the normal processes that frame antenatal care and to be brave. The women in this study talked about being brave or making choices that were not mainstream with a sense of negativity and lack of validation as individuals within their socio-cultural context and in the antenatal con- text. This significantly influenced their perspectives and expectations for childbirth as a process, experience and conclusion to pregnancy.
Maintaining sense of control	*'I know in the end I said, "I need an epidural", I said to Kevin (husband) "can I have one?", and he said, "you can have whatever you want", and Samantha (friend) said to me ...which I was so glad*	A few of the women actively worked towards main- taining a sense of autonomy through their choices for independent midwifery care or private obstetric care.

	she did ...she said, "you know that's not what you want", she was my support person as well, I said, "I know but can I change my mind?" and she said, "no, you'll be right", and I was ... I mean in the long run I was so glad I didn't, I said, "thanks for saying that"... but I still felt at the time that I was losing control, sort of lost my, I don't know, lost all idea of what I was doing and was concentrating on the pain instead of trying to concentrate on something else.' *'... so for me, I have to kind of make my own decision, and it's usually simple logic to go with what the doctor says, no offence to you to midwives or anything, but they just seem to have that greater power over you because they're the doctor, and that's really the main thing.... I seem to get more information from midwives than from my doctor.... (June, multip, birth centre care).*	
Feeling unknown or unvalued by the system	*'...an imbecile...like I feel a little bit dumb here [hospital] you know, why am I even asking...'*	Most women within this system of care narrated ways that their worries were linked to not feeling known or valued.

Appendix F: Photograph of Meta-ethnography Phase 4: Relating the studies





Appendix G: Signed Ethics Form

Please note: this is also the most up to date protocol for the study.

University of Edinburgh, School of Health in Social Science
Research Ethics, Integrity and Governance

The forms required when seeking ethical approval in the School of Health and Social Sciences have now been merged into this single electronic document. The sections you are required to complete will depend on the nature of your application. Please start to complete the form from the beginning and proceed as guided. On completion the *entire* document should be submitted electronically to your section's ethics administrator using the email addresses detailed on the final page.

Applications submitted without appropriate documentation will be returned.

Please work your way through this form, reading the questions and accompanying information carefully. Sections highlighted in yellow are mandatory, so you must answer all the questions in these sections.

Aside from the mandatory questions you won't always need to answer all of the questions in the form. Section 1 "your project details" includes a set of filter questions that determine the rest of the questions you need to answer. Please read the notes carefully to make sure you answer the right questions. The notes contain hyperlinks so you can jump directly to the relevant section.

Sections highlighted in yellow are **mandatory**. These must be completed for every application.

SECTION 1: Introduction

This is a:
New application for ethical approval – first submission ☐
A resubmission following reviewer comments ☒
A resubmission with requested amendments ☒

Please select your School:

☒ School of Health in Social Science

Please select your subject area

- ☐ CPASS
- ☒ Clinical Psychology
- ☐ Nursing Studies

It is each researcher's responsibility to check whether their project requires Sponsorship, Caldicott Approval, R&D approval, and/or IRAS. https://www.ed.ac.uk/health/research/ethics/sponsorship-and-governance

If the project requires any of these, these need to be secured prior to submitting this application.

Please tick the relevant box before proceeding:

I have checked and this project does not require Sponsorship, Caldicott, R&D and/or IRAS approval ☐

My project requires Sponsorship ☐	Sponsorship letter attached ☒
My project requires Caldicott approval ☐	Caldicott approval letter/e-mail attached ☐
My project requires R&D approval ☐	R&D approval letter/e-mail attached ☐
My project requires IRAS approval ☐	IRAS approval letter/e-mail attached ☐

External Research Ethics Approval

Does your research project require the approval of any other institution and/or ethics committee, nationally or internationally?

Please state the name of the review body and the current status of your application (for example, submitted, approved, deferred, or rejected)? Please include any known submission / approval timelines.

SECTION 2: Your project details

2.1 Project details

Your name: Rebecca Anne Brown

Please enter your project title: Exploring experiences of recovery from antenatal anxiety

Proposed Project Start Date: 1st March 2021

Proposed Project End Date: 1st February 2022

Q1. Are you a member of staff or a student?

☐ Staff member

Supplementary questions for staff members only:

List the names and institutions of any Co-Investigators working with you on the project.

☒ Student

Supplementary questions for students only:

What type of student are you?

Postgraduate Student; Trainee Clinical Psychologist

Please provide your course title or programme name

Doctorate in Clinical Psychology

Who is your supervisor?

Academic Supervisor: Dr Charlene Plunkett Field Supervisor: Dr Caroline Sneddon

Q2. Please indicate any external ethical guidance your project has to adhere to. For example, the British Psychological Society (BPS), the British Academy, the British Association of Sport and Exercise Sciences (BASES)

British Psychological Society (BPS); ethical guidelines for internet-mediated research (IMR) produced by the BPS (2017) will also be considered and adhered to.

2.2 Participants

Q3. Will you be collecting or generating any new data (including autoethnographic writings)?

☒ Yes
☐ No

Q4. Will you be extracting, re-coding or using existing data that contains sensitive information (i.e., identifiable information)?

☐ Yes
☒ No

If the answers to both Q3 and Q4 are ‘no’ you are not required to complete:

Section 4: Potential risks to participants and researchers
Section 5: Participants and data subjects
Section 6: Participant or data subject information and consent

2.3 Security-Sensitive Material

Q5. Does your research project fit into any of the following security-sensitive categories?

☐ Your research project is commissioned by the military.

☐ Your research project is commissioned under an EU security cell.

☐ Your research project involves the acquisition of security clearances.

☐ Your research project concerns groups which may be construed as terrorist or extremist

If you answer ‘yes’ to any of the questions above you must complete Section 8 Security Sensitive Material. You must answer all questions in the section.

2.4 Good Conduct in Collaborative Research

Q6. Will your research project involve collaborative work?

☒ Yes
☐ No

Selecting "Yes" to this question means you must complete Section 10 "Good conduct in collaborative research" later in the form. You must answer all questions in the section.

2.5 Project Funding

Q7. Is funding required for your research project? (To be completed by staff only)

Please indicate how the project will be financially supported.

2.6 Knowledge Exchange and Impact

Q8. Will there be any knowledge exchange and impact activities associated with this project? (To be completed by staff only)

2.7 Consultancy Potential

Q9. Could your research project lead to potential consultancy activities in the future? (To be completed by staff only)

SECTION 3: Description of the research

Q10: Please use the box below to describe your research; including a background summary, rationale, research questions and hypotheses, methodology, procedures. If you have identified ethical considerations that are not addressed in other parts of the form, please outline and discuss them here.

Background Summary and Rationale

Perinatal mental illness (PMI) refers to mental illness that occurs between pregnancy ('antenatal') and one year after the child is born ('postnatal'). It has been estimated that up to one in four women will experience mental illness during the perinatal period (Howard et al., 2018). Consequences of untreated mental health problems during this time can be catastrophic for families, with suicide being one of the leading causes of maternal death in the UK and Ireland (Knight & Tuffnell, 2018). Alongside this, it has been consistently shown that PMI, including antenatal anxiety (O'Connor et al., 2002), can have adverse effects on the emotional, social, behavioural, and cognitive development of the child (Stein et al., 2014). Moreover, Bauer et al. (2015) estimated that the aggregated costs of perinatal anxiety and depression combined was £6.6 billion. They argued that increased resources should be allocated in order to develop interventions that address the impact of PMI on parental and infant outcomes.

Recently, there has been an increased acknowledgement of the importance of perinatal mental health services. The Scottish Government included an action around perinatal mental health in the Mental Health Strategy (2017-2027), as well as recently publishing a Perinatal and Infant Mental Health Delivery plan (Perinatal and Infant Mental Health Programme Board, 2020). The National Institute for Health and Care Excellence (NICE, 2016) issued clinical management and service guidance around antenatal and postnatal mental health, advising that mothers should be asked about their mental health at every routine appointment in order to ensure that any concerns can be addressed quickly. However, this does rely on the mother disclosing any difficulties that she may be having and subsequent access to appropriate care. Perceived stigma from others; stigma around mental health labels; and a lack of continuity of care have all been found to be barriers for mothers disclosing mental health difficulties (Edwards & Timmons, 2005; Megnin-Viggars et al., 2015).

Estimated prevalence rates of anxiety during pregnancy range from 4.4% to 39% (Goodman et al., 2014). This variance in reported prevalence makes it difficult to be confident about the existing evidence-base around antenatal anxiety. Additionally, some anxiety disorders may not reach the level required for a diagnosis, but do still cause mild-moderate distress in those experiencing them (O'Hara et al., 2014) and would not necessarily be accounted for when estimating prevalence rates. Antenatal anxiety has been shown to be a significant predictor of postnatal depression, even when antenatal depression is controlled for (Heron et al., 2004). It is possible that subsequent diagnosis of postnatal depression further masks the impact and prevalence of antenatal anxiety. It has been suggested that anxiety and depression can develop as a result of feelings of frustration, loss and disappointment during the transition into motherhood (Highet et al., 2014). Risk factors for developing perinatal anxiety were grouped into six categories in a systematic review by Leach et al. (2014). They included: demographic and socio-economic (e.g. young maternal age); social and relational (e.g. support system); pregnancy/birth related (e.g. previous perinatal loss); health and lifestyle related (e.g. smoking); psychological (e.g. previous psychiatric history); and infant-related factors (e.g. infant health problems). However, the heterogeneity of the studies included in the systematic review, for example how each study conceptualised perinatal anxiety, limited the authors' ability to synthesise research in the area in a meaningful way. It can be argued that this variance in reported prevalence of antenatal anxiety leads to a gap in the understanding of experiences of anxiety during the antenatal period.

Qualitative methods have increasingly been acknowledged as a helpful tool for informing service design. In their review of qualitative research around experiences of perinatal mental health care, Megnin-Viggars et al. (2015) identified seven themes. They included: need for collaborative care; stigma and fear of consequences; unprepared health professionals; focus on baby; need for non-judgemental and compassionate support; need for information; and the importance of involvement in decision-making. They suggest that perinatal services would be improved if women had access to a supportive and trusting relationship with a mental health informed professional, allowing key decisions to be made collaboratively. However, they also highlight significant research gaps in terms of exploring the experiences of services for women with antenatal mental health difficulties, with only seven of the thirty-nine included studies focused antenatally. Additionally, none of the studies included in the review focused specifically on experiences of antenatal anxiety. A meta-synthesis of qualitative studies around experiences of psychological distress, anxiety and depression during pregnancy identified five themes: recognising things weren't right; dealing with stigma; negotiating the transition; spiralling down; and regaining control (Staneva et al., 2015). The authors echo the idea that there is a gap in the literature in terms of gathering the views of women about their own mental states during pregnancy, with only eight suitable studies able to be included and only two focused on antenatal anxiety specifically. The authors also highlight the lack of research around protective factors, or aspects that aided recovery from PMI.

There exists a small body of research related to recovery from PMI. For example, Shankar et al. (2017) found that low levels of stress in partners predicted recovery from postpartum anxiety; meanwhile low levels of total stress in the parents and a lack of other health concerns in the mother at six years post-birth predicted recovery from postnatal depression. However, this study focused only on post-partum symptom reduction as a predictor of recovery, rather than including functional improvements as an aspect of recovery. Alongside this, Andersson et al. (2010) found that an absence of previous mental illness was one of the biggest predictors of recovery from anxiety and depression during pregnancy. Yet, this research still does not tell us much about the lived experience of mothers who have experienced and recovered from antenatal anxiety or depression. Plunkett et al. (2017) explored the role of the baby in recovery from postpartum psychosis, finding that mother-infant interactions improved self-efficacy and reduced distress in mothers. They also highlighted the importance of wider social networks for promoting recovery from postnatal psychosis. It is not known, however, whether these factors have a role in recovery from antenatal anxiety. Meanwhile, Plunkett et al. (2016) reviewed qualitative literature that explored mothers' experiences of recovery from postnatal depression and postpartum psychosis. They found five themes across a four-stage recovery model: recognition of the problem; seeking help; achieving recovery; and maintaining recovery. They also found a fifth theme – the role of the family – which was woven through each of these stages. It may be that the experiences of recovery from anxiety during the antenatal period follows a similar pattern. However, this study only synthesised the experiences of mothers with postnatal depression and postpartum psychosis and did not focus on the experiences of recovery during pregnancy.

Despite a growing evidence base for intervention in postnatal depression, the evidence base for intervention in other perinatal disorders, including antenatal anxiety, remains scarce (Howard & Stein, 2014). A study by Marchesi et al. (2016) reviewed the interventions available for managing perinatal anxiety and concluded that Cognitive Behavioural Therapy (CBT) should be offered as a first response. Participants in this study tended to be drawn from specialist units rather than community settings, possibly affecting the generalisability of the results; however, given the lack of research in the area of antenatal anxiety it is still important to consider what can be understood from the existing literature. Peer support is a growing area of perinatal mental health research and intervention. Peer support interventions for mothers with antenatal and/or postnatal depression were shown to have a small-moderate effect on improving depressive symptoms in mothers in the short-term (Huang et al., 2020). However, there was a significant degree of heterogeneity between the Randomised-Control Trials (RCT's) included in the study. This included variety in terms of type, frequency and intensity of peer support provided, as well as the type of training that peers received. A meta-synthesis qualitatively exploring women's views on peer support services echoed this critique of peer support research (Reddish, 2018), however they did highlight that mothers valued peer support interventions. Again, perinatal peer support research has tended to focus primarily on postnatal depression and there remains a need to understand the lived experiences of interventions for mothers during the antenatal period.

As has been shown above, it has been consistently found that there is a lack of research exploring antenatal anxiety. This is despite the fact that antenatal anxiety has been shown to be just as potentially damaging as other perinatal mental health difficulties to both the mother and the infant. It may be that antenatal anxiety is diagnostically overshadowed by subsequent diagnoses of postnatal depression, leaving the area to be not fully understood. In addition to this, there is little research seeking to understand how women have experienced recovery and what recovery means for women who have experienced antenatal anxiety. In order to design effective interventions supporting women to recover, it can be argued that we need first to have an understanding of recovery from the perspective of women with lived experience.

Research Question

Primary Question: How do women who have had antenatal anxiety make sense of their experience of recovery?

Secondary Question: How do women make sense of their experiences of antenatal anxiety and their recovery in the context of covid-19?

Methodology

Design

A qualitative design using Interpretative Phenomenological Analysis (IPA) has been chosen in order to explore how participants have perceived and made sense of their experience of recovery from anxiety during pregnancy (Eatough & Smith, 2017). Data will be collected remotely via semi-structured interviews.

Alternative qualitative methodologies, for example Grounded Theory (Glaser & Strauss, 1967), were considered for this study. However, where IPA focuses on exploring how individuals have made sense of their experiences, Grounded Theory aims to develop an explanatory theory of a particular phenomenon across accounts (Smith et al., 2009). It was therefore felt that IPA fit best with the study aim of understanding how women who have experienced anxiety during their pregnancy make sense of their experience of recovery.

Participants

Mothers who self-report that they experienced mild-moderate anxiety during pregnancy will be invited to participate. In line with similar methodologies (Hore et al., 2019), they will be primarily recruited through online advertisements using social media (e.g. Twitter and Facebook), as well as perinatal mental health forums. Participants will be selected purposively in order to generate a sample of mothers for whom the research question is meaningful (Smith & Osborn, 2003). This will also support the development of a relatively homogeneous group, allowing for detailed exploration of similarities and differences between participants' accounts (Smith et al., 2009) of recovery from antenatal anxiety.

Procedure

The study will be advertised on social media (e.g., Twitter and Facebook) and perinatal mental health forums. The advertisement will include the project poster and a link that prospective participants can use to take them to a Qualtrics survey. The survey will include the information included in the 'Participant Information Sheet', and a consent form where participants can consent to being contacted regarding the study and confirm that they fulfill the inclusion criteria for the study. There will then be an opportunity for participants to leave their contact details (email and phone number), as well as the best time to contact them. This information will be downloaded from Qualtrics and saved onto the secure University of Edinburgh OneDrive.

For those that agree to it, the phone conversation will give participants an opportunity to ask questions about the study (Bennett et al., 2007). It will also provide an opportunity for the researcher to begin building a rapport with participants in advance of the interview (McGrath et al., 2019). The researcher will check with participants that they do not have a history of severe or complex mental illness (exclusion criteria). If at this stage the participant highlights that they meet an exclusion criterion, then they will be thanked for their interest and removed from the study. The researcher will share practical information about the interview (e.g., length of interview); speak through the 'Consent form' and 'Participant Information Sheet'; and verbally provide a brief overview of interview content. A provisional interview time will be arranged at a time that suits the participant and the participant will be given the option of video or telephone interview (Coates et al., 2014; Hore et al., 2019). The participant will be given a 48 hour 'thinking time' to consider information discussed.

After 48 hours, the researcher will send an email with clear instructions and the following: a link to the 'Consent Form' stored on Qualtrics to be completed; a link to a questionnaire, also stored on Qualtrics, to be completed prior to interview; Word versions of the 'Consent Form' and 'Participant Information Sheet' for their records; and a confirmation of the interview time. In this email, participants will also be advised that they are free to withdraw from the study at this stage, and requesting that they contact the researcher, if they feel able to, if they do wish to withdraw. Demographic information collected will include the age and occupation of participants, as well as how many previous pregnancies they had prior to the pregnancy being discussed; participants will be advised that all questions are optional. This questionnaire will have three additional questions from the anxiety subscale of the Edinburgh Postnatal Depression Scale (EPDS; Cox et al., 1987; Swalm et al., 2010). This will be to retrospectively measure their anxiety levels during pregnancy. The anxiety subscale, known as EPDS-3A, is made up of item 3 ('I have blamed myself unnecessarily when things went wrong'); item 4 ('I have been anxious or worried for no reason'); and item 5 ('I have felt scared or panicky for no very good reason') from the EPDS (Swalm et al., 2010). In a systematic review of anxiety scales used during pregnancy, the EPDS-3A demonstrated strong evidence for being psychometrically sound for assessing anxiety during pregnancy (Sinesi et al., 2019). Although the EPDS was initially designed to assess postnatal depression, it has been consistently found to measure both anxiety and depression antenatally (Jomeen & Martin, 2005; Swalm et al., 2010). The EPDS-3A was also shown by Matthey et al. (2013) to have convergent validity when compared with other measures of antenatal anxiety, for example the HADS-A (r=0.68).

Interviews will occur remotely, with participants offered the option of completing them via video or audio-only call on Microsoft Teams. Participants will be sent an individual link that will expire after the time and date of the interview. This is in line with other qualitative studies that have collected data remotely (e.g. Hore et al., 2019). Although it has been argued that in-person interviews are denser in terms of information produced (Johnson et al., 2019), it has also been shown that the number of codes produced through video and in-person interviews are comparable (Krouwel et al., 2019). It was found that participants in qualitative interviews about pregnancy and parenting that occurred remotely valued the flexibility that arranging interviews this way afforded, as well as valuing being able to see the researcher's face (Mirick & Wladowske, 2019). Participants reported that the primary challenge of interviews over Skype tended to be technological, however advice around conducting qualitative interviews in this way has been published (Seitz, 2015) and will be considered during this study. This includes sharing written instructions for how to access interviews with participants, as well as providing trouble-shooting options for common difficulties that may arise.

First, the researcher will confirm verbally that consent is still ongoing at the time of interview. Participant address and emergency contact details will be gathered at the start of each interview. These details are being collected in case of emergency or disclosure of neglect or abuse, and will be deleted immediately following the interview. This will be explained to participants at the beginning of the interview and during the initial phone conversation. Rules around confidentiality will be explained to participants at the start of the interview, advising participants that the researcher has a duty of care to contact other professionals should the participant disclose information about neglect, abuse or risk of harm to self.

Participants will then be interviewed using a semi-structured interview schedule that will be developed in advance, with input from individuals with lived experience of PMI. The questions will be open-ended and the interview schedule will be used flexibly to allow the participant to explore the areas of meaning important to them. Prompts will also be prepared for more complex questions to be used where necessary (Smith et al., 2009). At the end of the interview, the participants will be debriefed and there will be a further opportunity for them to ask questions. There will also be an information sheet provided signposting to support, should the participant require it. In line with quality guidance (Tong et al., 2007), participants will be asked if they wish to review a summary of key themes that emerge from the data and provide feedback on how the themes fit with their account. Participants will be given the option of engaging with this on the 'Consent Form'. It will be explained that their contact details will be kept securely for 6-12 months following completion of the study, then destroyed.

Following each interview, the researcher will keep a reflective log of observations about the interview experience (Pietkiewicz & Smith, 2012). This may include observations about the content of the interview, or reflections on the influence of the researcher's own beliefs and judgements on their interactions with the participant. This log will provide some context to the interviews, adding detail that may not be captured in the recordings. It will also ensure researcher reflexivity; allowing the researcher to consider how her own experiences might have an impact on how the data is interpreted or analysed (Peters, 2010).

All interviews will be video or audio recorded using Microsoft Teams; then uploaded to the secure University of Edinburgh OneDrive immediately following interview. Participants will be given the option not to have video recording and if this is the case then audio-only recording will be used. The transcription function of Microsoft Teams will be used during interviews which automatically saves to MS Stream. Transcriptions will be immediately removed from MS Stream following interview and saved onto the University of Edinburgh OneDrive. The researcher will check the transcript against the recording and delete the recording within 1 week of interview. At this point, each participant will be given a pseudonym in order to ensure anonymity.

University of Edinburgh OneDrive is a password protected system that has been deemed to be secure by the University of Edinburgh Information Services. The principles outlined by the General Data Protection Regulation (GDPR) and the Data Protection Act (2018), as well as policy and guidance about data protection and security provided by University of Edinburgh, will be followed. In addition to this, the researcher has completed the MANTRA data management training and will comply with recommendations in these modules.

SECTION 4: Potential risks to participants and researchers

Q11. Is your research project likely or possible to induce any psychological stress or discomfort in the participants or others, indirectly associated with the research?

☒ Yes
☐ No

If "yes" state the types of risk and what measures will be taken to deal with such problems

It is possible that mothers may become distressed during the interview. The below measures will be put in place in order to minimize the likelihood and level of distress:

- Researcher will check participants have a GP and that they know how to contact GP for assistance if necessary.
- Participants will be informed that they are able to stop the interview at any point with no consequence and that they can decide how much information they choose to disclose.
- Participants will be given opportunities to pause the interview and take a break if necessary.
- Participants will be informed in advance about the topics that may be discussed during the interview.
- The interview schedule will be designed to support participants to gradually move towards more sensitive topics (Smith et al., 2009), allowing the researcher to build a rapport with the participant.
- If supervision regarding risk is required, the researcher has access to supervision from both the academic and field supervisor, who are both experienced clinical psychologists. Dates and times of interviews will be shared with supervisors.
- Address and emergency contact details will be gathered at the start of the interview. If the lead researcher is concerned about risk, then they will either contact the emergency contact or if the participant is in immediate danger, then they will contact the emergency services.
- An opportunity for debriefing and signposting to appropriate supports following interviews is built into the project design. An information sheet with details of organisations supporting maternal mental health will be provided to participants.
- The researcher will clearly outline the boundaries of the research role; however, the researcher is also a trainee clinical psychologist working clinically to manage distress and will be able to utilise these skills should participants become distressed during interviews. Additionally, the researcher is experienced with managing distress remotely via telephone and video appointment.

Another possible risk is becoming disconnected during the call/video call as a result of technology failure or as a result of distress. The below measures will be put in place in order to minimize this risk. These measures have been informed by the guidelines published by BPS (2020) around delivering effective therapy remotely:

- During the initial phone call, it will be discussed and agreed what the process will be should the call be disconnected. For example, in the first instance both parties should try to reconnect to the video call, then the lead researcher would contact the participant by phone. This plan will be emailed to the participant after the '48 hour thinking time' along with the confirmation of interview time.
- It will also be discussed what the process will be if the participant hangs up or disconnects due to distress. The following process will be followed:
    - Attempt to reconnect via phone with participant.
    - If disconnection has been in the context of distress and the researcher is concerned about the wellbeing of the participant; then the researcher will contact the emergency contact provided or the emergency services if required. Consent for this will be gained with the initial consent form.
    - The lead researcher will also seek supervision from field/academic supervisor where necessary.
- Clear written instructions for how to access the interview will be shared with participants prior

to the interview, along with the plan of what to do if there is trouble connecting. The general principle will be that the interview will continue by phone as a back-up where connection issues via video prevail.

Q12. Does your research project require any physically-invasive or potentially physically harmful procedures?

☐ Yes
☒ No

If "yes" give details and outline procedures to be put in place to deal with potential problems.

Q13. Does your research project require the use of privacy-invasive technology, such as CCTV, biometrics, facial recognition, vehicle tracking software?

☐ Yes
☒ No

If "yes" - Give details and outline procedures to be put in place to deal with potential problems.

Q14. Does your research project involve the investigation of any illegal behaviour or activities?

☐ Yes
☒ No

If "yes" - Give details of any illegal behavior or activities you may investigate

Q15. Is it possible that your research project will lead to awareness or the disclosure of information about child abuse or neglect?

☒ Yes
☐ No

If "yes" - Indicate the likelihood of disclosure and the procedures to be followed if you become aware that a child has been or may be at risk of harm

It is unlikely that the research project will lead to awareness or the disclosure of information about child abuse or neglect given that participants had mild-moderate presentations of antenatal anxiety. However, if this were to occur, the following steps will be followed:

1. All interview dates and times will be shared with both Academic and Field Supervisors.
2. Participants will be informed prior to the interview about the boundaries of confidentiality and the researcher's duty of care to report disclosure of child abuse or neglect, as well as risk of harm to self. This is also detailed within the 'Participant Information Sheet'.
3. Participants will be asked to provide their address and emergency contact details in case there is a need to contact social work or emergency services. These details will be deleted

immediately following the interview, or immediately following disclosure to the relevant service where appropriate.

4. If the participant discloses current child abuse or neglect, then the researcher will advise that they have a duty of care to share this information. The researcher will advise that the participant can also contact their local social work department directly for support. The researcher will ask the participant if they would like to know the outcome of the conversation with social work.
5. The researcher will then seek supervision from with the field or academic supervisor who are both experienced Clinical Psychologists prior to speaking with social work.
6. The researcher will then follow national Child Protection guidelines (https://www.scotland.police.uk/keep-safe/child-protection/how-to-report-child-abuse-or-neglect/) and contact either the local social work office and inform them or phone 101.

Q16. Is it likely that dissemination of research findings or data could adversely affect participants or others indirectly associated with the research?

☐ Yes
☒ No

If "yes" - Describe the potential risk for participants/data subjects of this use of the data. Outline any steps that will be taken to protect participants.

It is unlikely that dissemination of findings could adversely affect participants or others indirectly associated with the research. In order to minimize this further, participants will be informed that anonymized quotes from their interview will be included in the final report as part of the consent and information sharing process.

Q17. Could participation in this research adversely affect participants and others associated with the research in any other way?

☐ Yes
☒ No

If "yes" - Describe the possible adverse effects and the procedures to be put in place to protect against them.

Q18. Is this research expected to benefit the participants, directly or indirectly?

☒ Yes
☐ No

If "yes" - Give details of how this research is expected to benefit the participants.

Currently, there is little research exploring the lived experiences of mothers who have recovered from antenatal anxiety (Staneva et al., 2015). It is hoped that this study will add to a growing body of research seeking to understand the experiences of recovery in mothers who have had mental health difficulties within the perinatal period.

Perinatal mental health has been made a priority by Scottish Government, with the perinatal and infant mental health programme board delivery plan published recently (Perinatal and Infant Mental Health Programme Board, 2020). Similarly to other research in the field, it is hoped that understanding the experiences of recovery in mothers may help generate further recommendations and ultimately guide the development of perinatal mental health services (Hadfield & Wittkowski, 2017; Megnin-Viggars et al., 2015).

In addition, although this study does not explicitly focus on the impact and experience of maternal anxiety during pregnancy in the context of covid-19, it is possible that the experiences of participants will have been significantly impacted by this wider context. Therefore, it may be that the results from this study are able to inform future research about the impact of covid-19 on antenatal anxiety; as well as providing insights into maternal experiences of recovery from antenatal anxiety during this time. These insights may help with proactive design of Perinatal Mental Health services in future similar situations.

Q19. Will the true purpose of the research be concealed from the participants/data subjects?

☐ Yes
☒ No

If "yes" - Explain what information will be concealed and why.

Q20. Will participants/data subjects be debriefed at the conclusion of the study?

☒ Yes
☐ No

If "no" – Why will participants / data subjects not be debriefed?

Q21. At any stage in this research could researchers' safety be compromised, or could the research induce emotional distress in the researchers?

☒ Yes
☐ No

If "yes" - Give details and outline procedures to be put in place to deal with potential problems.

It is possible that the content of the interview may be distressing to the researcher. However, supervision is arranged regularly with academic and field supervisors who are both experienced clinical psychologists. In addition to this, the researcher is a trainee clinical psychologist who is regularly exposed to distressing information during clinical work; and will be able to employ similar self-care skills to manage any distress.

Please tick to confirm you agree with the following:

I will adhere to School guidance on risk assessment and health and safety and will seek advice on project and travel insurance prior to project commencement.

☒ I agree

☐ I do not agree

☐ Not applicable

SECTION 5: Participants and data subjects. For autoethnographic research also include those who may feature in your writings.

Q22. How many participants or data subjects are expected to be included in your research project?

There is no one sample size that is recommended within IPA (Brocki & Wearden, 2006), with participant numbers varying between studies based on a number of factors, including time constraints and experience of the researcher (Smith & Osborn, 2003). Qualitative studies using IPA to explore other areas of perinatal mental health have had sample sizes ranging from seven women (Hore et al., 2019) to seventeen women (Coates et al., 2014). Smith et al. (2009) advise that the focus in IPA should be on the quality and richness of data collected, as opposed to the quantity of participants that the data is collected from. Brocki and Wearden (2006) note that saturation of themes within IPA is a problematic concept because of the iterative nature of analysis, with new insights emerging each time another data source is added. It has also been argued that each individual experience described within IPA is so unique that data saturation cannot ever be achieved (Hale et al., 2009). Instead, IPA is focused on creating a detailed understanding of each individual's experience, then exploring common themes within the sample. Furthermore, it has been suggested that a sample size of six interviews is adequate to develop sufficiently meaningful themes (Guest et al., 2005). Alongside this, Smith et al. (2009) advise that between four and ten interviews are completed for a professional doctorate in order to allow for adequate time, reflection and discussion (Smith et al., 2009); this is particularly apt given the time constraints inherent in undertaking the Doctorate in Clinical Psychology.

With all this in mind; this study will aim to recruit between six and ten participants in order to be in line with the recommendations of Smith et al. (2009).

Q23. What criteria will be used in deciding on the inclusion and exclusion of participants/data subjects in your research project?

Inclusion

- Mothers who self-identify that they experienced mild-moderate anxiety during pregnancy.
- Pregnancy occurred no more than 2 years previously in order to reduce the chance of errors in recall of experiences (Bennett et al., 2007; Raymond, 2009; Staneva et al., 2015).
- Interview occurs more than 6 weeks following birth of child, in order to allow the mother time to recover from the birth and begin adjusting to motherhood (Raymond, 2009). This is also to give the mother time to process and reflect on her experiences of antenatal anxiety.
- Over 18.
- UK-based.
- Able to provide informed consent.
- Fluent in English

Previous or current mild-moderate mental health difficulties (e.g., anxiety or depression) will *not* be an exclusion criterion, given that antenatal anxiety has such strong links with development of postnatal depression or anxiety (Heron et al., 2004). However, women with severe or complex mental health difficulties such as postpartum psychosis or Bipolar Disorder, or those who are currently experiencing a mental health crisis will be excluded due to lack of face-to-face support.

Q24. Are any of the participants or data subjects likely to be under 16 years of age?

☐ Yes
☒ No

If "yes" - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q25. Are any of the participants or data subjects likely to be children in the care of a Local Authority?

☐ Yes
☒ No

If "yes" - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q26. Are any of the participants or data subjects likely to be known to have additional support needs?

☐ Yes
☒ No

If "yes" - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q27. In the case of participants with additional support needs, will arrangements be made to ensure informed consent?

☒ **Yes**
☐ **No**

If "yes" – What arrangements will be made?

It is possible that this study will have participants with additional support needs. The researcher will speak through the 'Consent Form' and 'Participant Information Sheet' during the initial phone conversation to allow an opportunity to ask questions. There will also be a 48 hour 'thinking time' to allow participants time to consider whether they wish to take part.

During the interview, the researcher will allow extra processing time for the participant after asking questions; repeat questions where necessary; as well as to providing a written prompt.

The researcher has experience working clinically with people with additional support needs and will implement these skills in this setting.

If "no" – Please explain why not

Q28. Are any of the participants or data subjects likely to be physically or mentally ill?

☒ Yes
☐ No

If "yes" - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Since current mild-to-moderate mental illness is not an exclusion criterion this study, and antenatal anxiety has a strong links with development of postnatal depression or anxiety, it is possible that participants may present with mental ill health. Alongside this, participants will be recalling and discussing difficult experiences that may be fairly recent.

The below measures will be put in place to protect and/or inform participants:

- Researcher will check participants have a GP and that they know how to contact GP for assistance if necessary.
- Participants will be informed that they are able to stop the interview at any point with no consequence and that they can decide how much information they choose to disclose.
- Participants will be given opportunities to pause the interview and take a break if necessary.
- Participants will be informed in advance about the topics that may be discussed during the interview.
- The interview schedule will be designed to support participants to gradually move towards more sensitive topics (Smith et al., 2009), allowing the researcher to build a rapport with the participant.
- If supervision regarding risk is required, the researcher has access to supervision from both the academic and field supervisor, who are both experienced clinical psychologists. Dates and times of interviews will be shared with supervisors.
- Address and emergency contact details will be gathered at the start of the interview. If the lead researcher is concerned about risk, then they will either contact the emergency contact or if the participant is in immediate danger, then they will contact the emergency services. Participants will be informed of this in advance of the interview and this information is included in both the 'Participant Information Sheet' and the 'Consent Form.'
- An opportunity for debriefing and signposting to appropriate supports following interviews is built into the project design. An information sheet with details of organisations supporting maternal mental health will be provided to participants.
- The researcher will clearly outline the boundaries of the research role; however, the researcher is also a trainee clinical psychologist working clinically to manage distress and will be able to utilise these skills should participants become distressed during interviews. Additionally, the researcher is experienced with managing distress remotely via telephone and video appointment.

Q29. Are any of the participants or data subjects likely to be vulnerable or likely exposed to harm in other ways?

☐ Yes
☒ No

If "yes" - Explain and describe the nature of the vulnerability and the measures that will be used to protect and/or inform participants/data subjects.

Q30. Are any of the participants or data subjects likely to be unable to communicate in the language in which the research is conducted

☐ Yes
☒ No

If "yes" - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q31. Are any of the participants or data subjects likely to be in a relationship (i.e., professional, student-teacher, other dependent relationship) with the researchers?

☐ Yes
☒ No

If "yes" - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

Q32. Are any of the participants or data subjects likely to have difficulty in reading and/or comprehending any printed material distributed as part of the study?

☐ Yes
☒ No

If "yes" - Explain and describe the measures that will be used to protect and/or inform participants/data subjects.

It is unlikely that this will be a problem, however the researcher will review the 'Participant Information Sheet', 'Consent Form' and 'Debriefing Sheet' with every participant.

Q33. Describe how the sample will be recruited.

The study will be advertised on social media (e.g., Twitter and Facebook) and perinatal mental health forums. The advertisement will include the project poster and a link that prospective participants can click on which takes them to a Qualtrics survey. The survey will include the information included in the 'Participant Information Sheet', and a consent form where participants can consent to being contacted regarding the study and confirm that they fulfill the inclusion criteria for the study. There will then be an opportunity for participants to leave their contact details (email and phone number), as well as the best time to contact them. For those that agree to it, the phone conversation will give participants an opportunity to ask questions about the study (Bennett et al., 2007). It will also provide an opportunity for the researcher to begin building a rapport with participants in advance of the interview (McGrath et al., 2019). The researcher will check that participants do not meet the exclusion criteria for the study (history of complex mental health presentation, for example Bipolar Disorder). If at this stage the participant highlights that they meet an exclusion criterion, then they will be thanked for their interest and removed from the study. The researcher will share practical information about the interview (e.g., length of interview); speak through the 'Consent form' and 'Participant Information Sheet'; and verbally provide a brief overview of interview content. A provisional interview time will be arranged at a time that suits the participant and the participant will be given the option of video or telephone interview (Coates et al., 2014; Hore et al., 2019). The participant will be given a 48 hour 'thinking time' to consider information discussed. After 48 hours, the researcher will send a link to the 'Consent Form' stored on Qualtrics to be completed, and confirm the interview time. This information will then be stored separately from recordings and transcriptions. Participants will also be sent a copy of the questionnaire, also stored on Qualtrics, and asked to complete it prior to the interview.

Q34. Will participants receive any financial or other material benefits as a result of participation?

☐ Yes
☒ No

If "yes" - What benefits will be offered to participants and why?

Section 6: Participant or data subject information and consent

Q35. Will written consent be obtained from all participants or data subjects?

☒ Yes
☐ No

If "yes" – attach participant information sheet and consent form
If "no" – explain why not and how consent is obtained (e.g. orally), and/or if consent cannot or should not be sought for some reason, please provide a clear case and rationale for this

Please find attached 'Participant Information Sheet' and 'Consent Form'. A copy of the consent form will be sent to participants using Qualtrics, a secure online tool for gathering information.

All study materials have been reviewed and amended based on feedback from clinical and field supervisors with experience working with the population. They have also been reviewed by staff who currently work in the setting and amended based on their feedback.

Q36. Have you made arrangements to tell participants what information you will hold about them and for how long?

☒ Yes
☐ No

If "yes" - what arrangements have been made?

This is included in the 'Consent Form' and will be discussed with participants. Demographic Information will be stored separately from consent form information. These will both be stored separately from anonymized interview transcripts.

Q37. Have you made arrangements to tell participants whether you will disclose the information to other organisations?

☒ Yes
☐ No

If "yes" - What arrangements have been made?

This is included in the 'Consent Form' and 'Participation Information Sheet'. Identifiable information will not be disclosed to other organisations, except in cases of risk.

In case of risk, participant name, contact details and address will be shared with the relevant organization depending on what is disclosed. For example, if patient is at immediate risk of harm then 999 will be contacted, and name, address and contact details will be shared.

Participants will be informed of this at the start of interview, in the 'Participant Information Sheet' and

‘Consent Form.’

Q38. Have you made arrangements to tell participants whether you will combine that information with other data?

☐ Yes
☒ No

If “yes” - What arrangements have been made?

Not applicable.

Q39. In the case of children participating in the research, will the consent or assent of parents be obtained?

☐ Yes
☐ No

If “yes” - Explain how this consent or assent will be obtained

If “no” – Please explain why you won’t be obtaining consent

Q40. Will the consent or assent of children participating in the research be obtained?

☐ Yes
☐ No

If “yes” - Explain how this consent or assent will be obtained

If “no” – Please explain why not

Q41. In the case of participants who are not proficient in the language in which the research is conducted, will arrangements be made to ensure informed consent?

☐ Yes
☐ No

If “yes” – What arrangements will be made?

If "no" – Please explain why not

Q42. Does the activity involve using cookies or tracking individual's activity on a website or the Internet in general?

☐ Yes
☒ No

If "yes" – Describe the arrangements, you have put in place to obtain informed consent for the use of these tools?

SECTION 7: Confidentiality and handling of data

Q43. What information about participants/data subjects will you collect and/or use?

The following information will be collected:

- Information included in the 'Consent Form' (e.g., name).
- Contact information in order to share link to Microsoft Teams meeting.
- Demographic information (copy of questionnaire included). This questionnaire will also be on Qualtrics and a link will be shared with participants. Completed questionnaires will be downloaded from Qualtrics and stored on the University of Edinburgh OneDrive. Access to all information will be password-protected.
- Recording of interview will be stored on the University of Edinburgh OneDrive in a separate password-protected folder. It will be deleted within one week of the interview.
- Anonymised interview transcripts will be stored on the University of Edinburgh OneDrive. This system requires user logins to access the computer, followed by user login to access the OneDrive. Passwords will be unique, randomly generated and known only to the researcher. This system has been assessed as secure by Information Support at the University of Edinburgh.
- Contact information (email) if the participant chooses to receive a copy of the themes to comment and provide feedback on; and/or if the participant chooses to receive a copy of the final report. This will be optional and information about these processes are included in the 'Participant Information Sheet', 'Consent Form' and 'Debrief Sheet'. Participants will also be given the option of changing their mind. These details will be stored securely and separately from study data and will be deleted as soon as they are no longer needed.

Q44. Will you collect or use NHS data?

☐ Yes
☒ No

If "yes" – what NHS data will you collect or use?

Q45. What training will staff who have access to the data receive on their responsibilities for its safe handling? Have all staff who have access completed the mandatory data protection training on the self-enrolment page of Learn?

The researcher has undertaken 'MANTRA' training and the Learnpro NHS Data Handling/Information Governance modules. The researcher has access to the University of Edinburgh pages on data protection guidance and is aware of appropriate contacts should anything arise.

Q46. Will the information include special categories of personal data (health data, data relating to race or ethnicity, to political opinions or religious beliefs, trade union membership, criminal convictions, sexual orientations, genetic data and biometric data)

☒ Yes
☐ No

If "yes" – Explain what safeguards e.g. technical or organisational you have in place; including any detailed protocols if this requires special and/or external processing, storage, and analysis.

The demographic questionnaire includes information about previous mental health diagnoses. After downloading from Qualtrics, questionnaires will be anonymized and stored securely on the University of Edinburgh OneDrive which is password-protected. This information will also be stored separately from any other information.

If you answered "no" to this question, please skip Q56 and continue answering the rest of the questions..

Q47. Please indicate how your research is in the public interest:

☒ Your research is proportionate
☐ Your research is subject to a governance framework
☐ Research Ethics Committee (REC) review (does not have to be a European REC)
☐ Peer review from a funder
☐ Confidentiality Advisory Group (CAG) recommendation for support in England and Wales or support by the Public Benefit and Privacy Panel (PBPP) for Health and Social Care in Scotland
☐ Other

Q48. It is essential that you identify, and list all risks to the privacy of research participants. You will then need to consider the likelihood of the risks actually manifesting and the severity of harm if the risks actually manifest.

Risk	**Likelihood of risk manifesting**			**Severity of harm**		
	Remote	**Possible**	**Probable**	**Minimal**	**Significant**	**Severe**
Identifiable due to data linkage	☐	☐ X	☐	☐	☐ X	☐
Identifiable due to low participant numbers	☐	☐X	☐	☐	☐ X	☐
Identifiable due to geographical location	☐ X	☐	☐	☐	☐ X	☐
Identifiable due to transfer of data	☐ X	☐	☐	☐	☐ X	☐
Identifiable due to access of data	☐ X	☐	☐	☐	☐ X	☐
Insert more rows as appropriate	☐	☐	☐	☐	☐	☐

Please use this text box to record any other risks and the likelihood of them occurring, along with the severity of harm.

One primary risk to the study is the risks associated with covid-19 and covid-19 transmission. These risks are potentially very high. Below is outlined the plans for mitigating these risks:

- The project has been designed with restrictions around covid-19 in mind. This includes arranging remote interviews by phone or video and recruiting participants online in order to minimize risk of covid-19 transmission.
- The researcher will continue to review advice provided by University of Edinburgh, NHS Lanarkshire and Scottish Government around restrictions related to covid-19.
- The timeline for the project is generous, allowing for the possibility of delays related to covid-19 if required.

Please identify measures you could take to reduce or eliminate risks identified as possible/significant or probable/severe.

Completed consent forms and demographic questionnaires will be stored separately from recordings and transcripts. This data will be password-protected with randomly generated passwords that only the researcher knows.

Risk of identification due to video or audio recordings will be mitigated using the following steps:

1. Video/audio recordings will be made using Microsoft Teams. Microsoft Teams initially stores recordings on MS Stream, immediately following interviews the researcher will remove it from MS Stream and save to the University of Edinburgh OneDrive.
2. MS Stream also has a transcription function which will be used during interviews. Transcriptions will also be immediately removed from MS Stream following interview and saved onto the

University of Edinburgh OneDrive. The researcher will check the transcript against the recording and delete the recording within 1 week of interview.

In case of low participant numbers, recruitment will be augmented using the Perinatal Mental Health service in NHS Lanarkshire. Participant numbers will be reviewed in October 2021, and this contingency plan will be implemented then if necessary.

Q49. Will information containing personal, identifiable data be transferred to, shared with, supported by, or otherwise available to third parties outside the University?

☐ Yes
☒ No

If "yes" - Please explain why this necessary and how the transfer of the information will be made secure. If the third party is based outside the European Economic Area please obtain guidance from the Data Protection Officer.

Q50. Other than the use by third parties, will the data be used, accessed or stored away from University premises?

☐ Yes
☒ No

If "yes" - Describe the arrangements you have put in place to safeguard the data from accidental or deliberate access, amendment or deletion when it is not on University premises, including when it is in transit, and (where applicable) it is transferred outside the EEA.

Interview recordings will be stored on the University of Edinburgh OneDrive and will be deleted within 1 week of interview. Transcripts will be automatically generated during interview by Microsoft Teams and stored on the University of Edinburgh OneDrive. Automatically generated transcripts will be checked against the recording prior to deletion.

All written data (consent form, demographic information and anonymized transcripts) will be stored on the University of Edinburgh OneDrive which is accessible away from University premises. The researcher will access the data this way from a personal laptop that is password-protected to prevent data from accidental or deliberate access by anyone but the researcher. Both the Qualtrics and University of Edinburgh OneDrive are password protected using randomly generated unique passwords. Raw data will not be saved directly on to a personal laptop.

Q51. Will feedback of findings be given to your research project participants or data subjects?

☒ Yes
☐ No

If "yes" - How and when will this feedback be provided?

Participants will be offered a summary of the key themes as they emerge from the data. They will then be asked to provide feedback about the themes, in order to ensure that their views and experiences are represented truly within the report (Tong et al., 2007). This will not be compulsory and participants will be given the option to take part in this process as part of the initial consent form.

Participants will be invited to contact the lead researcher if they wish to receive a final summary of the findings once the study is complete. In line with guidance around best practice for disseminating information to participants following research completion (Cook et al., 2020), participants will be given the option of receiving a more visual poster-format; a written lay summary; and/or a copy of the final submitted article. A poster summarizing the study will also be circulated on social media once the study is complete (e.g., Twitter and Facebook).

If "no" - Please provide rationale for this.

Q52. How do you intend to use/disseminate the results of your research project?

The study will be written up as part of a portfolio thesis format which includes a systematic review and an empirical research project. It will then be submitted to the Doctorate in Clinical Psychology course at the University of Edinburgh. Alongside this, the project will be submitted to a peer reviewed journal that has published similar studies, for example Clinical Psychology and Psychotherapy. The researcher could also seek to influence the Perinatal Mental Health Care Network in the NHS.

Professionals and representatives with lived experience who have fed into the development of the project will receive a link to the final article; a copy of the poster; and a copy of the written lay summary. The researcher will also request that these three formats be shared on perinatal mental health forums and by the Maternal Mental Health Scotland network. The researcher then intends to spread them more widely using Social Media (e.g., Twitter and Facebook).

Opportunities for presentation of the research, for example CPD events, will be sought within NHS Lanarkshire. They will also be sought outside of the NHS Board, for example relevant conferences like the Maternal Mental Health Conference Scotland.

SECTION 8: Security-sensitive material

The Terrorism Act (2006) outlaws the dissemination of records, statements and other documents that can be interpreted as promoting or endorsing terrorist acts.

Q53. Does your research involve the storage on a computer of any such records, statements or other documents?

☐ Yes
☒ No

If "yes" - Please tick 'Yes' to indicate that you agree to store all documents on that file store

Q54. Might your research involve the electronic transmission (for example, as an email attachment) of such records or statements?

☐ Yes
☒ No

If "yes" - Please tick 'Yes' to indicate that you agree not to transmit electronically to any third party documents stored in the file store

Q55. Will your research involve visits to websites that might be associated with extreme, or terrorist, organisations?

☐ Yes
☒ No

If "yes" - You are advised that such sites may be subject to surveillance by the police. Accessing those sites from University IP addresses might lead to police enquiries. Please acknowledge that you understand this risk by ticking 'Yes'

N/A
☐ Yes
☐ No

By submitting to the ethics process, you accept that your School Research Ethics Officer and the convenor of the University's Compliance Group will have access to a list of titles of documents (but not the contents of documents) in your document store. Please acknowledge that you accept this by ticking 'Yes'

Please confirm that you have contacted your School Research Ethics Officer to discuss security-sensitive material by ticking 'Yes'

N/A
☐ Yes, I have contacted my School's Research Ethics Officer
☐ No, I have not contacted my School's Research Ethics Officer

Section 9: Copyright

Q56. Does your project require use of copyrighted material?

☐ Yes
☒ No

If "yes" please give further details

Section 10: Good conduct in collaborative research

Q57. Does your project involve working collaboratively with other academic partners?

☒ Yes
☐ No

If "yes" - Is there a formal agreement in place regarding a collaborative relationship with the academic partner(s)?

There is a 'Research Agreement' that has been agreed and signed by both the field (NHS-based) and academic (University of Edinburgh) supervisors, as well as the researcher.

If "no" - Please explain why there is no formal agreement in place?

Q58. Does your project involve working collaboratively with other non-academic partners?

☒ Yes
☐ No

If "yes" - Is there a formal agreement in place regarding a collaborative relationship with the non-academic partner(s)?

There is a 'Research Agreement' that has been agreed and signed by both the field (NHS Lanarkshire) and academic (University of Edinburgh) supervisors, as well as the researcher.

If "no" - Please explain why there is no formal agreement in place.

Q59. Does your project involve employing local field assistants (including guides/translators)?

☐ Yes
☒ No

If "yes" - Is there a formal agreement in place regarding the employment of local field assistants (including guides and translators)?

If "no" - Please explain why there is no formal agreement in place

Q60. Will care be taken to ensure that all individuals involved in implementing the research adhere to the ethical and research integrity standards set by the University of Edinburgh?

☒ Yes
☐ No

If "no" - Please explain why care will not be taken

Q61. Have you reached agreement relating to intellectual property?

☒ Yes
☐ No

If "no" - Please explain why you have not reached agreement

Section 11: Good conduct in publication practice

In publication and authorship, as in all other aspects of research, researchers are expected to follow the University's guidance on integrity.

By ticking yes, you confirm that full consideration of the items described in this section will be addressed as applicable

☒ Yes
☐ No

Subsequent to submission of this form, **both the applicant and their supervisor should review any alterations in the proposed methodology of the project.** If the change to methodology results in a change to any answer on the form, then a resubmission to the Ethics subgroup is **required.**

The principal investigator is responsible for ensuring compliance with any additional ethical requirements that might apply, and/or for compliance with any additional requirements for review by external bodies.

ALL forms should be submitted in electronic format. Digital signatures or scanned in originals are acceptable. The applicant should keep a copy of all forms for inclusion in their thesis.

___Rebecca Anne Brown____	______R A Brown________	12/02/2021
Applicant's Name	Applicant's Signature	Date signed

__C Plunkett____________	Dr Charlene Plunkett___	09.12.20
*Supervisor Signature[1]	Supervisor Name	Date

*NOTE to Supervisor: Ethical review will be based only on the information contained in this form. If countersigning this check-list as truly warranting all 'No' answers, you are taking responsibility, on behalf of the HSS and UoE, that the research proposed truly poses no ethical risks.

ISSUES ARISING FROM THE PROPOSAL

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[1] ~~Not required for staff applications~~

Reviewer comments_19.3.21

Overview

Recruitment procedure seems a bit convoluted and it seems that the researcher will have to collect telephone numbers and/or email addresses before consent has been given by participantsWould it not be better that the participants can click on a link within the social media advert that takes them to qualtrics/BOS survey where there will be an information sheet, consent form that they can say whether they wish to be contacted regarding the study? Then in the next screen they can provide their details for contact? They could also fill in the questionnaires online too before the interview date.

As it stands will the researcher be asking the participant the questionnaire questions over the telephone and/or MS teams?

What happens if someone is being interviewed over MS teams but they don't want to be video recorded? It is possible to audio record only – will this be offered?

Q15 The research includes interviews with women with antenatal anxiety, who may also experience postnatal depression and anxiety. For this reason, it is likely that a participant may disclose neglect. It would be good to expand here on which measures will be put in place if this is the case (i.e. how are they going to implement the guidance they are going to consult), and what information are they going to give to the participants about this.

Q23 – how will you ascertain that women have severe mental health difficulties to exclude them from participating? This is also slightly contradictory to what you say in q 28. Suggest more clarity.

Q37 – what identifiable data will you be collecting?

Q43 – you say you will record the interview on a password protected encrypted Dictaphone. Where will this be stored?

Q46 I assume the information will not just be stored on Qualtrics, but will be downloaded and stored securely on the Edinburgh server? This could be clearer here.

Q48 Given that the applicant is going to recruit 6 to 10 participants, the risk related to low participant numbers should be considered possible and some information on how this is dealt with should be added.

In addition the researcher will be collecting audio recordings that are identifiable need to think about how to mitigate risk i.e. will you upload recordings to onedrive secure server straight away so they are not stored on a recording unit? And the audio recording on the unit will be deleted? What is recording the video recordings? Are you thinking about using MS for this? Need to be clear about this and then how you will get these recordings out of the computer software.

Q50 Storing the Dictaphone with sensitive interviews in a locked briefcase until the interview is transcribed seem less secure than storing it in a locked drawer. In theory, a briefcase could be easily removed/stolen. See comment above.

How to access MS meeting:

In the document, it is stated that participants may be contacted via phone if they cannot connect to Teams. It is possible that participants do not connect, because they do not want to take part anymore. It should be acknowledged at the end of the document that this is also ok.

Participant Information sheet:

You state that the interviews will be transcribed after approximately one week. Need to be clear that the person can therefore withdraw up until the interviews are transcribed.

Complaints person should be Matthias as Head of school as long as he is not part of the study.

Linked to point to Q15 in the application form, it's not clear to a naïve reader what the appropriate action refers to in the PIS. Some more information may need to be provided here so that the participant can provide informed consent.

Consent sheet:
Participants cannot withdraw at anytime, as they cannot withdraw after the interview has been transcribed and anonymised. See related comment above under participant info screen.There are no tick boxes, or instructions in the consent sheet to tick a box.
Why do you need the address of the person being interviewed. Principle of minimisation needs to be applied here – this information is not required for your study.
Would have separate consent statement for audio or video consent – some may be happy with audio recording but not video recording.

Also if you are collecting email addresses and will contact participants following the study need to provide more information on exactly when they will be destroyed and/or how they will be stored. These are potentially identifiable data. Suggest that the participants are instead invited to contact the supervisor following the study if they want more information or a summary provided. Then you will not need to keep hold of identifiable information.

Debrief Sheet:
This needs to reiterate the researcher contact detail and the independent person and the complaints contact i.e. head of school.

General point:
There was some discrepancy between the forms relating to inclusion criteria. In the participant information sheet it looked like the research was interested in examining participants' recovery from antenatal anxiety. In the debrief sheet, it looked like the research was interested in exploring the experiences of those recovered from it as well as those who are still recovering from it. In the interview schedule, there were questions related to both full recovery as well as stage of recovery and the inclusion criteria in the ethics form stated women 'experiencing antenatal anxiety' (implying that they are still experiencing it, but also implying that they should not be experiencing it anymore because they had the child). Generally, this needs to be clearer.

Signature: *Role: Ethics & Integrity Lead* *Date 19.3.21*

Position: Lead in Ethics and Integrity/Lecturer in Applied Psychology Position:

Date:

APPLICANT'S RESPONSE (If required)

Thank you for taking the time to review my proposal so thoroughly. Below are my responses to each of the points made above, as well as signposting to the relevant changes within the text. All amendments have been made using the 'track changes' function and highlighted in yellow for ease of review.

Overview

- Recruitment procedure: This was designed with rapport-building in mind and in line with other similar qualitative research. However, the recruitment procedure has been changed to match your suggestions. This includes directing participants to a Qualtrics link that includes the 'Participant Information Sheet' and a consent form where participants consent to being contacted and confirm that they meet inclusion criteria; as well as a space to leave their contact details and the best time to contact them. The changes can be seen on page 9 (Q10) and page 20 (Q33).

- Demographic Questionnaire: As outlined in my original proposal, the plan had been for participants to complete the questionnaire via Qualtrics at the start of the interview so that I could be present if they had any questions or concerns. However, I have now amended this strategy so that the link to the questionnaire will be sent at the same time as the link to the consent form. These changes can be seen on page 9 (Q10).

- Recording: The participants will, of course, be given the option not to be video recorded. They will be given the option of being video and/or audio recorded. I have addressed and clarified this on page 11 (Q10). Additionally, the recording feature on Microsoft Teams will now be used to record interviews instead of a Dictaphone. Recordings on Microsoft Teams are initially automatically saved to MS Stream; however they will immediately be removed and saved to the secure University of Edinburgh OneDrive once the interview is completed. These changes are also described on page 11 (Q10).

- Q15: I have addressed this comment, expanding on the precise steps that would be followed should a participant disclose child neglect or abuse during the interview. These changes can be seen on page 13. The process will be:
  1. All interview dates and times will be shared with both Academic and Field Supervisors.
  2. Participants will be informed prior to the interview about the boundaries of confidentiality and the researcher's duty of care to report disclosure of child abuse or neglect, as well as risk of harm to self. This is also detailed within the 'Participant Information Sheet'.
  3. Participants will be asked to provide their address and emergency contact details in case there is a need to contact social work services. These details will be deleted immediately following the interview, or immediately following disclosure to the relevant service where appropriate.
  4. If the participant discloses current child abuse or neglect, then the researcher will advise that they have a duty of care to share information with social work. The researcher will advise that the participant can also contact their local social work department directly for support. The researcher will ask the participant if they would like to know the outcome of the conversation with social work.
  5. The researcher will then seek supervision from with the field or academic supervisor who are both experienced Clinical Psychologists.
  6. The researcher will then follow national Child Protection guidelines (https://www.scotland.police.uk/keep-safe/child-protection/how-to-report-child-abuse-or-neglect/) and contact either the local social work office and inform them or phone 101.

- Q23: I have addressed this comment and made changes to clarify this point in the text; these changes can be found on page 17. I will ascertain whether women have severe mental health difficulties in the following ways:
    1. The inclusion criteria clearly defines mild-moderate antenatal anxiety;
    2. The poster for the study clearly details that to take part mothers must have experienced 'mild-moderate anxiety during your pregnancy' and 'not currently be experiencing severe mental health difficulties.'
    3. Participants will be asked to confirm that they meet inclusion criteria prior to leaving contact details at initial recruitment stage (see page 9, Q10);
    4. During the initial phone conversation, the researcher will check with prospective participants whether they have a history of, or are currently experiencing, severe or complex mental illness (see page 9, Q10).

- Q37: As detailed in Q43 (page 25) identifiable information such as name, contact details, address and emergency contact details will be collected. These details will only be shared with other organisations should a situation occur where there are concerns about risk to the participant or risk to others. This information is included in the 'Participant Information Sheet' (pages 2 and 3) and 'Consent Form' (page 2, points 10 and 11) to allow participants to provide informed consent. I have clarified the identifiable information that would be disclosed; the arrangements that have been made to tell participants about this; and an example circumstance where information would be shared. These changes can be seen on page 22.

- Q43: Now that I have amended my strategy to use the MS Teams facility for recording interviews, dictaphone storage is no longer an issue. See changes on page 25 and changes to plans for recording described above.

- Q46: Information from Qualtrics will be downloaded and stored securely on the University of Edinburgh OneDrive. See clarification on page 26.

- Q48:
    - In case of low participant numbers, recruitment will be augmented using the Perinatal Mental Health service in NHS Lanarkshire. The researcher's Field Supervisor works in this team. Participant numbers will be reviewed in October 2021, and this contingency plan will be implemented then if necessary. I have added this information which can be seen on page 28. Having said that, several perinatal mental health charities have agreed to share the study advertisement on their Social Media pages and recruitment will be UK-wide given the remote nature of the interviews. Since prevalence of antenatal anxiety is estimated to be between 4.4% and 39% (Goodman et al., 2014), and these figures may not be including those with a mild-moderate presentation (O'Hara et al., 2014); the participant pool is relatively wide already.
    - The MS Teams recording function will be used to record interviews using either the video or the audio-only option, depending on participant preference. Recordings are automatically saved to MS Stream which is part of the University of Edinburgh Office 365 package once interviews/meetings are completed. Following the interview, the researcher will immediately remove recordings from MS Stream and save to University of Edinburgh OneDrive following

the interview, then delete from MS Stream. I have described this process on page 27-28.

- Q50: I have now amended this section holding in mind the new strategy for recording interviews. Interview recordings will be stored on the University of Edinburgh OneDrive and will be deleted within 1 week of interview. Transcripts will be automatically generated during interview by Microsoft Teams and stored on the University of Edinburgh OneDrive. OneDrive is accessible away from University premises. The researcher will access data this way from a personal laptop that is password-protected to prevent data from accidental or deliberate access. OneDrive is also password protected using a randomly-generated unique password. This change can be found on page 28.

How to access MS meeting

As per advice, the following sentence has been added at the end of the sheet in bold: "If you have not connected because you have decided that you no longer wish to take part, that is ok. If you feel able to, please get in touch with Rebecca via email (s2007798@ed.ac.uk) to confirm that this is the case." I have attached the amended copy of 'Interview Access Guidance' to the email (page 2).

Participant Information Sheet

- The 'Participant Information Sheet' has now been amended to detail that participants are able to withdraw up to one week after the interview. This can be found on page 2.
- As part of the sponsorship process, the Research Governance Team have added their contact details to be contacted in case of complaints. I have now added Matthias' name as Head of School as well, see page 4.
- I have now clarified what 'appropriate action' refers to within the Participant Information Sheet by making the following amendments: "We have a duty of care to contact relevant services (for example, Social Work or Emergency Services) if there is a disclosure of child abuse or neglect, as well as disclosures of risk of harm to you. If we are worried about you then we will either contact your emergency contact or if you are in immediate danger, then we will contact the emergency services." These changes can be found on page 3.

Consent form

- Point 3 has been amended to say "I understand that my participation is voluntary and that I can ask to withdraw at any time up to one week following the interview without giving a reason and without my medical care or legal rights being affected." This can be found on page 1.

- The tick boxes and instructions to tick the box have not been included in the 'Word' version of the 'Consent Form' for the following reasons:
    - Once they have verbally agreed to take part, participants will be sent a link to complete the 'Consent Form' via 'Qualtrics'. They will also be emailed Word versions of the 'Consent Form' and 'Participant Information Sheet' for their records (see page 9). The plan to share Word versions of these forms with participants was added as part of the sponsorship review. I am concerned that adding instructions to complete the emailed copy of the consent form would cause confusion for participants.
    - The above process will also be made clear to participants. The original Word version clearly stated: "If you decide to take part in this study, a link to an electronic version of this consent form will be emailed to you to complete. Please keep a copy of this form for your records."

This was also added as part of the sponsorship review. I have amended this to say, "This form is not for completion; please keep a copy for your records. If you decide to take part in this study, a link to an electronic version of this consent form will be emailed to you to complete." (see page 2).

    - Completing consent forms via Qualtrics limits the identifiable information that is required to be shared via email.

- Addresses:
    - As noted on pages 10 and 12 (Q10 and Q11) of the ethics proposal; addresses are being gathered from participants for the following reasons:
        - In case of emergency since participants might be accessing interviews anywhere in the UK – if it is necessary to contact emergency services, the researcher will need to provide an address.
        - In case of disclosure of child neglect or abuse. Should the researcher be required to contact the local social work team, they will need to know which social work team to contact and be able to provide details about the participant.
        - This measure was added as a part of the sponsorship review.
    - These details will be deleted immediately following interviews, so long as there is no requirement to contact Social Work/Emergency services. In circumstances where relevant services do need to be contacted, these details will be kept until they have been passed on to the relevant service and then deleted. This is included in the Consent form (point 11, page 2) with the following statement, "I understand that the lead researcher has a duty of care to share my contact details with the relevant service (e.g., social work or emergency services) should there be a disclosure of child neglect or abuse, or risk of harm to myself. I understand that these contact details will be deleted immediately following the interview, or immediately following disclosure to the relevant service where appropriate."
    - Point 10 on the Consent Form has been adjusted to include the reasons for collecting the address (see point 10, page 2). It now says "I agree to share the address I will be taking part from and provide the name and telephone number of an emergency contact person with the lead researcher in case of concerns about risk to myself or others. I understand that if the researcher is worried about me then they will either contact my emergency contact, or if I am in immediate danger, then they will contact the emergency services."
    - The 'Participant Information Sheet' also outlines the requirement and the reasoning behind it to allow participants to provide informed consent (page 2).
    - The lead researcher will also explain this reasoning verbally to participants during the initial phone call and answer any questions, to ensure that participants are able to provide informed consent. This is outlined on page 10 (Q10).

- I have separated out consent to audio record and consent to video record into two separate statements, as per your suggestion. See page 1, points 6 and 7 of 'Consent Form'.

- Email address collection:
    - It is an important part of the IPA methodology (Tong et al., 2007) to be able to sense-check with participants that the themes that have emerged from the data match with their lived experience. This is why participants are being contacted following the study for their

feedback.

- As described on page 10 of the proposal, in the 'Consent Form' (point 13, page 2), and in the 'Participant Information Sheet' (page 2); participants are being given the *option* to provide these details and engage in this process.
- Participants are being given this option to be actively contacted for feedback because it was felt to be unlikely that participants would contact the researcher even if they want to engage in the process, especially considering that they have a baby or young child at home.
- I have added additional information to the 'Participant Information Sheet' (see page 2), advising that should they choose to engage in this process, their email address will be stored securely and deleted 6-12 months after the study is completed.
- I have amended the 'Consent Form' to clarify when their contact details will be destroyed (see point 13, page 2).
- This process will be explained to participants during the initial phone call, and at the beginning and end of the interview to ensure that they wish to take part and that they understand what will happen with their contact details.
- Separately to this, in order to aid with dissemination of results, participants will be invited to contact the lead researcher if they wish to receive a summary of the key findings from the report. This information has been included on the 'Debrief Sheet' (page 1) and is detailed in the proposal (Q52, page 30)

Debrief Sheet

I have reiterated the researcher contact details, independent person contact details, and the complaints contacts as advised, see page 2 of 'Debrief Sheet'.

General Point Response

Historically, recovery from mental illness was conceived of as a complete absence of symptoms (McGrath et al., 2013) or a return to the same state as before the illness (Jacobson & Curtis, 2000). However, more recently the idea of recovery has been reconceptualized to include the ability to live a meaningful life, despite a possible presence of symptoms, as a result of other psychological or social factors (McGrath et al., 2013). This study is interested in exploring the overall experience of recovery with this reconceptualization of recovery in mind. It aims to understand what recovery means to the individual; and this journey is likely to look different for different people at different stages. For this reason, the interview schedule includes questions designed to capture the full range of recovery experience; from women who are just thinking about recovery, right up to those who would consider themselves to be 'fully recovered' and everything in between. It is intended that the prospective participant pool of women who experienced mild-moderate anxiety during pregnancy but are no longer pregnant will allow for exploration of this range of recovery experience and what it means for each individual.

To increase clarity, I have amended the description in the 'Participant information sheet' (page 1) to match the description of the study in the 'Debrief sheet' (page 1). I have also changed the wording slightly in the inclusion criteria described in this 'Ethics Form' (page 17).

Signature: R A Brown

Date: 13/04/2021

CONCLUSION TO ETHICAL REVIEW (if required)
The applicant’s response to our request for further clarification or amendments has now satisfied the requirements for ethical practice and the application has therefore been approved. *Signature:* *Position:* *Lecturer in Applied Psychology, Ethics & Integrity Lead* Date: 23.4.21

AMENDMENT/S: REQUEST FOR APPROVAL
Signatures: Date:
CONCLUSION TO ETHICAL REVIEW OF AMENDMENT
The applicant's response to our request for further clarification or amendments has now satisfied the requirements for ethical practice and the application has therefore been approved. *Signature:* *Position:* Date:

Acronyms / Terms Used
NHS: National Health Service
SHSS: School of Health in Social Science
IRAS: Integrated Research Applications System
Section: The SHSS is divided into Sections or subject areas, these are; Nursing Studies, Clinical Psychology, C-PASS.
Ethics Administrators

Nursing Studies: nursing@ed.ac.uk

Counselling, Psychotherapy and Applied Social Science: CPASS.ethics@ed.ac.uk

Clinical Psychology: Submitting.Ethics@ed.ac.uk

MA in Health, Science and Society: mahssug@ed.ac.uk

Appendix H: Sponsorship Letter

University of Edinburgh
College of Arts, Humanities and Social Sciences
Research Governance Office
55 George Square
Edinburgh
EH8 9JU

12th February 2021

Rebecca Brown
c/o School of Health in Social Science
University of Edinburgh

Dear Beccy,

Study Title: Exploring maternal experiences of recovery from antenatal anxiety

Sponsor number: CAHSS2101/04

Under the requirements of the UK policy framework for health and social care research, the University of Edinburgh agrees in principle to act as Sponsor for this project. Sponsorship is subject to you obtaining institutional ethics for the project.

As Chief Investigator, you must ensure that the study does not commence until all applicable approvals have been obtained. Following receipt of all relevant approvals, you should ensure that any amendments to the project are notified to the Sponsor.

Yours sincerely

Charlotte Smith

Research Governance Manager

Appendix I: Participant Information Sheet

Participant information sheet

Study Title: Exploring maternal experiences of recovery from antenatal anxiety.

Before you decide whether you would like to take part, it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Contact us if there is anything that is not clear or if you would like more information.

Take time to decide whether or not you wish to take part.

What is the study about?

There is very little research focused specifically on mental health difficulties during pregnancy. This is particularly the case when thinking about the experiences of mothers who have suffered from anxiety during pregnancy ('antenatal anxiety'). This study aims to explore the lived experiences of recovery in mothers who have had antenatal anxiety. It hopes to understand how each of the mothers have made sense of their experiences of recovery from anxiety during pregnancy, as well as exploring the similarities and differences between the mothers' sense-making. The researcher will do this by speaking with mothers who have recovered or are in the process of recovery from antenatal anxiety. Each of the interviews will be recorded and transcribed and then patterns will be explored within the transcripts.

Pregnancy is a significant period of change and adjustment for parents and it is hoped that this study will add to the growing body of research around antenatal mental illness. If research can build an understanding of mothers' experiences of antenatal anxiety, factors that supported or got in the way of recovery, and what recovery means to individuals; then perinatal mental health services can be designed with this in mind.

Why have I been invited to take part?

You have been invited because you:

- Have had your baby no more than 2 years ago and experienced mild-moderate anxiety during your pregnancy.
- Are female and over 18.
- Live in the UK are fluent in spoken English.
- Are able and willing to participate in a 30-90 minute online conversation about your experiences.

Do I have to take part?

No, it is entirely up to you. If you do decide to take part, you will be asked to sign a consent form to show you understand your rights in relation to the research, and that you are happy to participate. If you do decide to take part, you are still free to withdraw up to 1 week following the interview and without giving a reason. If you do withdraw, your data will be destroyed, however this may not be possible after the study has finished. Deciding not to take part or withdrawing from the study will not affect your healthcare or legal rights in any way.

What happens if I am interested in taking part?

A phone call will be arranged with the key researcher, Rebecca, to:

- Answer any questions you might have about the study.
- Speak through the consent form and explain how to provide consent if you decide to take part.
- Arrange a provisional interview time.

There will be a 48 hour ‘thinking time’ to consider the information discussed. Rebecca will email you after 48 hours with a link to the electronic consent form and to confirm the interview time.

What happens if I agree to take part?

If you agree to take part, we will:

- Arrange a time that is convenient to you to speak over video using Microsoft Teams. You will need to be able to do this from a private space. An instruction sheet will be sent to show you how to access the video call. You will also be asked to tell the researcher the address from which you are taking part and provide an emergency contact number in case of emergency. This information will be deleted immediately following the interview, or immediately following disclosure to the relevant service if necessary.
- The researcher will begin by asking questions about your experiences of antenatal anxiety, and will then move on to explore your experiences of recovery from it. The conversation will take between 30-90 minutes.
- With your consent, the interview will be audio and/or video recorded and transcribed (written up) at the same time. The researcher will check the transcript against the recording and delete the recording within 1 week of interview. The researcher will ensure that any information that may identify you is removed.
- The recording and transcript will be stored in a secure place.
- The lead researcher will explore the transcripts for key themes that emerge from the content of the interview.
- If you wish, the researcher can email you with a summary of the key themes, and ask you to give feedback via email on how well they fit with your experience. If you choose to do this, your email address will be stored securely and deleted 6-12 months after the study is completed.

What are the possible benefits of taking part?

We do not anticipate any direct benefits to you of taking part in this study. However, it is hoped that the results of this study can be used to improve perinatal mental health services for those who have similar experiences to you.

What are the possible disadvantages of taking part?

We do not anticipate any significant risks associated with participation. You may find it distressing speaking about your experiences of anxiety during pregnancy. If this happens, the interview can be stopped to give you a break or stopped altogether. You will also be provided with information that gives you an idea of where to go for some support if you wish to.

What will happen with the information collected?

Your data will be processed in accordance with Data Protection Law. All information collected about you will be kept strictly confidential. All recordings will be destroyed once they have been transcribed. No one outside of the research team will have access to any of your information. You will be given a pseudonym during transcription; and all identifiable information will be stored separately from the transcript of your interview in order to minimise risk of identification. All electronic data will be stored on a password-protected computer file. Your consent information will be kept separately from your responses in order to minimise risk.

Transcripts and anonymised information gathered in questionnaires will be stored for a minimum of 5 years and may be used in future ethically approved research. Consent forms will be destroyed 6-12 months after the study is completed.

The information you share is confidential, but this confidentiality has limits. We have a duty of care to contact relevant services (for example, Social Work or Emergency Services) if there is a disclosure of child abuse or neglect, as well as disclosures of risk of harm to you. If we are worried about you then we will either contact your emergency contact or if you are in immediate danger, then we will contact the emergency services. The researcher will discuss this with you before doing anything.

The University of Edinburgh is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. The University of Edinburgh will keep identifiable information about you 6- 12 months after the study has finished.

For general information about how we use your data go to: https://www.ed.ac.uk/records-management/privacy-notice-research.

What will happen to the results of the study?

The study will be written up as a thesis as part of the Doctorate in Clinical Psychology at University of Edinburgh. The final write-up will be submitted for publication in a relevant research journal. Anonymised quotes from interviews will be within the final written report. It is possible that the results of the study will be presented at relevant perinatal mental health conferences. You will not be identified in any reporting of the data gathered. A summary of the findings from the study will be made available to participants who indicate they would like to receive this. This summary will be sent to participants by post / email.

Who has reviewed the study?

The study proposal has been reviewed by University of Edinburgh, School of Health in Social Science Research Ethics Committee.

Who can I contact?

- If you have any further questions about the study, please contact the lead researcher, Rebecca Brown (Trainee Clinical Psychologist) on s2007798@ed.ac.uk
- If you would like to discuss the study with someone independent of the study, please contact Angus MacBeth (Research Director, University of Edinburgh) on
- If you wish to make a complaint about the study, please contact the Research Governance Team (cahss.res.ethics@ed.ac.uk) or Dr Matthias Schwannauer, Head of School of Health and Social Science (M.Schwannauer@ed.ac.uk).

Thank you for taking the time to read this information sheet and for your interest in this study.

Please keep a copy of this sheet for your records.

Appendix J: Participant Consent Form

Participant Consent Form

Study Title: Exploring maternal experiences of recovery from antenatal anxiety
Researcher name: Rebecca Brown (Trainee Clinical Psychologist)
Contact details: s2007798@ed.ac.uk

1) I confirm that I have read and understood the Participant Information Sheet (Version 1, 11/02/2021) for the above study.

2) I have been given the opportunity to consider the information provided, ask questions and have had these questions answered to my satisfaction.

3) I understand that my participation is voluntary and that I can ask to withdraw at any time up to one week following the interview without giving a reason and without my medical care or legal rights being affected.

4) I understand that my anonymised interview transcript and anonymised information gathered in my questionnaire will be stored for a minimum of 5 years and may be used in future ethically approved research.

5) I understand that relevant sections of my data collected during the study may be looked at by individuals from the Sponsor (University of Edinburgh) where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.

6) I agree to my interview being audio recorded.

7) I agree to my interview being video recorded.

8) I understand that my anonymised data will be analysed and interpreted as part of a doctoral thesis, and the final write up will be put forward for publication in a relevant research journal.

9) I understand that anonymised quotes from my interview will be within the final written report.

10) I agree to share the address I will be taking part from and provide the name and telephone number of an emergency contact person with the lead researcher in case of concerns about risk to myself or others. I understand that if the researcher is worried about me then they will either contact my emergency contact, or if I am in immediate danger, then they will contact the emergency services.

11) I understand that the lead researcher has a duty of care to share my contact details with the relevant service (e.g., social work or emergency services) should there be a disclosure of child neglect or abuse, or risk of harm to myself. I understand that these contact details will be deleted immediately following the interview, or immediately following disclosure to the relevant service where appropriate.

12) I agree to take part in the above study.

13) [Optional] I agree to be contacted by the researcher for feedback about key themes that have emerged from the content of my interview. I understand that my contact details will be stored securely and destroyed 6-12 months after the study is completed.

This form is not for completion; please keep a copy for your records.

If you decide to take part in this study, a link to an electronic version of this consent form will be emailed to you to complete.

Appendix K: Demographic and Antenatal Anxiety Questionnaires

Study Title: Exploring maternal experiences of recovery from antenatal anxiety

Please answer the following questions by ticking the most appropriate answer. If there are any questions you would prefer not to answer, please leave them blank.

1) **How old are you?** 18-24; 25-34; 35-44; 45-54; 55+
2) **When was your baby born?** 2018; 2019; 2020; 2021
3) **What is your highest level of education?** Primary school; Standard Grade or equivalent; Highers or equivalent; University undergraduate programme; University postgraduate programme; other…
4) **What is your employment status?** Unemployed, retired, part-time employment, full-time employment, care giver, student, other…
5) **What is your relationship status?** single, married or domestic partnership, widowed, divorced, separated
6) **Which country do you live in?** Scotland, England, Northern Ireland, Wales
7) **How many children do you have?** 1, 2, 3, 4 other
8) **How many times have you been pregnant?** 1, 2, 3, 4, 5 other
9) **How many pregnancies did you have prior to the pregnancy being discussed?** 1, 2, 3, 4, other

The next set of questions relate to your experience of anxiety during pregnancy. If there are any questions you would prefer not to answer, please leave them blank.

10) **When did you first experience anxiety during your pregnancy?** 0-3 months; 3-6 months; 6-9 months
11) **Did you receive a diagnosis during your pregnancy?** Yes (What was it?), No
12) **Did you seek mental health support during your pregnancy?** Yes, (What kind?) No
13) **Did you experience any mental health difficulties before your pregnancy?** Yes, No

14) **Were you given medication for anxiety during your pregnancy?**
Yes, No

The next set of statements relate to your experience of anxiety during pregnancy. Please think back to your pregnancy and answer in relation to an average week:

1) **I have blamed myself when things went wrong.**
    a. Yes, most of the time
    b. Yes, some of the time
    c. Not very often
    d. No, never
2) **I have been anxious or worried for no reason.**
    a. No, not at all
    b. Hardly ever
    c. Yes, sometimes
    d. Yes, very often
3) **I have felt scared or panicked for no very good reason.**
    a. Yes, quite a lot
    b. Yes, sometimes
    c. No, not much
    d. No, not at all

Appendix L: Semi-structured Interview Schedule

Interview Questions

In line with IPA this will be a semi-structured interview. The below topic areas and prompt questions will be used as a guide but it will be used flexibly to allow each participant to explore the areas of meaning that are important to them. Questions may be added or amended based on feedback from interviewees.

TOPIC GUIDE

1) **Experience of antenatal anxiety:** What was your overall experience of anxiety in pregnancy?
    - Prompts:
        - Can you tell me about when you first started to feel anxious?
        - Were there particular things you worried about? Particular physical sensations you noticed? Particular things you did?
        - What did those around you do or say?
        - I'm wondering how COVID was involved/impacted on the experience at all?

2) **Recovery experience:** What has your experience of recovery been like?
    - Prompts:
        - Can you tell me about when you first feel like you were starting to recover? What was that like?
        - What made you think that you were starting to recover?
        - How did recovery happen over time?
        - Was there anything or anyone that helped recovery? (E.g., baby, relationship, staff, friends, partners).
        - Was there anything that got in the way of recovery?
        - I'm wondering how COVID was involved/impacted on the experience at all?
        - I'm wondering how your baby impacted on the experience at all?

3) **Recovery stage:** What does recovery from antenatal anxiety mean for you?
    - Prompts:
        - Where do you think you are in terms of recovery?
        - What do you think others would say in terms of your recovery stage?
        - How would you know that you were recovered?
        - How do you think this definition has changed over time?
        - What do you think helped you towards recovery?

4) **Support:** What was your support network like?
    - Prompts:
        - Who was in the network? E.g., partner, family, professionals, peer support, friends, online information/written information
        - What type of support did they provide?
        - How did your support network react?
        - Did you seek help? And when?

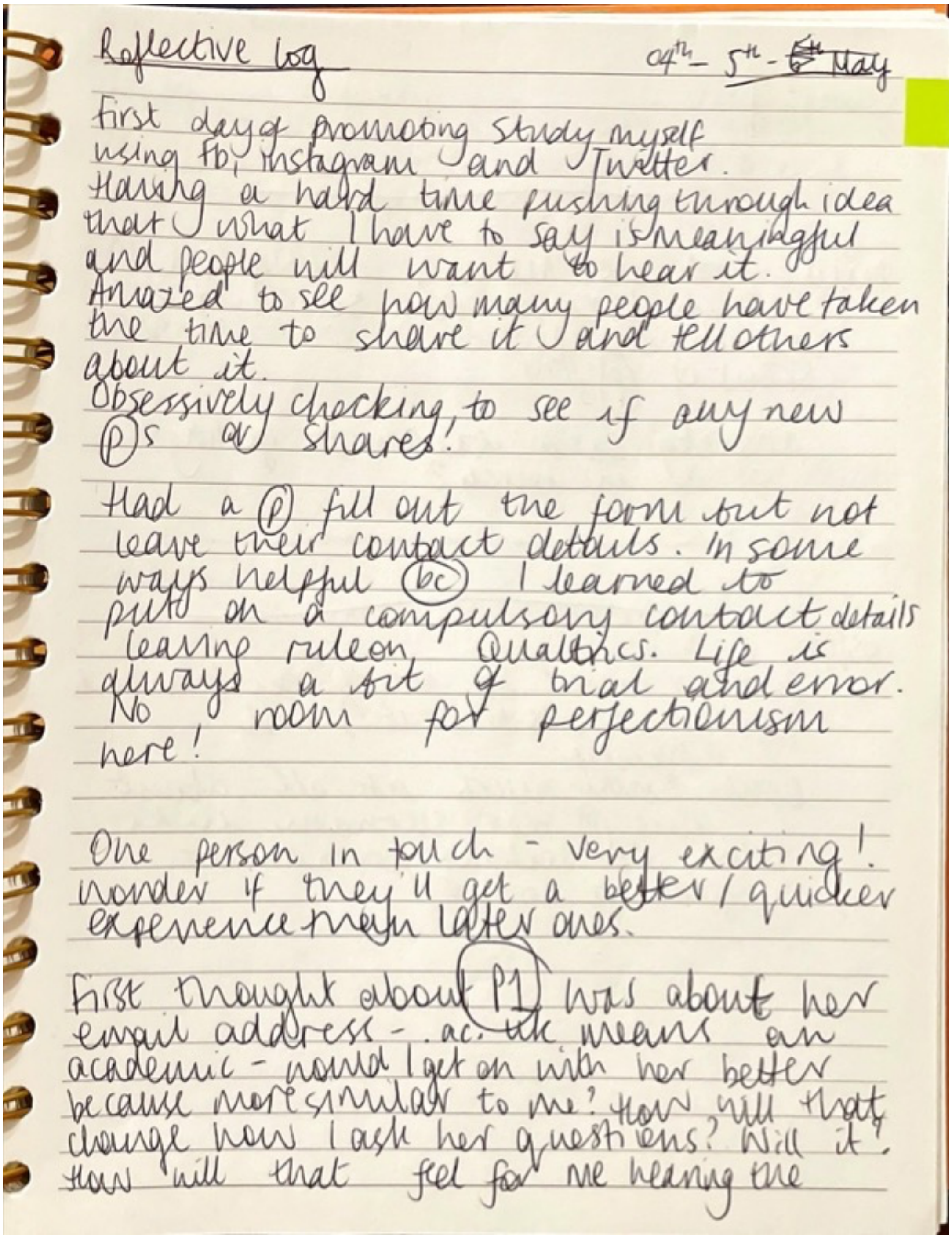
        - What was it like for them?
        - Was there anything they did that helped/didn’t help?

5) **Reflecting back on experience:** Looking back on your experiences, how do you make sense of it all now?
    - Prompts:
        - Is there anything you’d want to say to yourself/others in the same situation?
        - What do you think your loved ones would say to you?
        - How do you make sense of how you recovered?
        - How did it impact on your mood, confidence?
        - Has it changed how you approach life now?

6) Is there anything I haven’t asked you about that you think would be important or helpful to discuss?

7) Do you have any questions for me?

Appendix M: Extract from Reflective Log



Reflective Log 04th – 5th – ~~6th~~ May

First day of promoting study myself using fb, instagram and Twitter. Having a hard time pushing through idea that what I have to say is meaningful and people will want to hear it. Amazed to see how many people have taken the time to share it and tell others about it. Obsessively checking, to see if any new Ⓟs or shares!

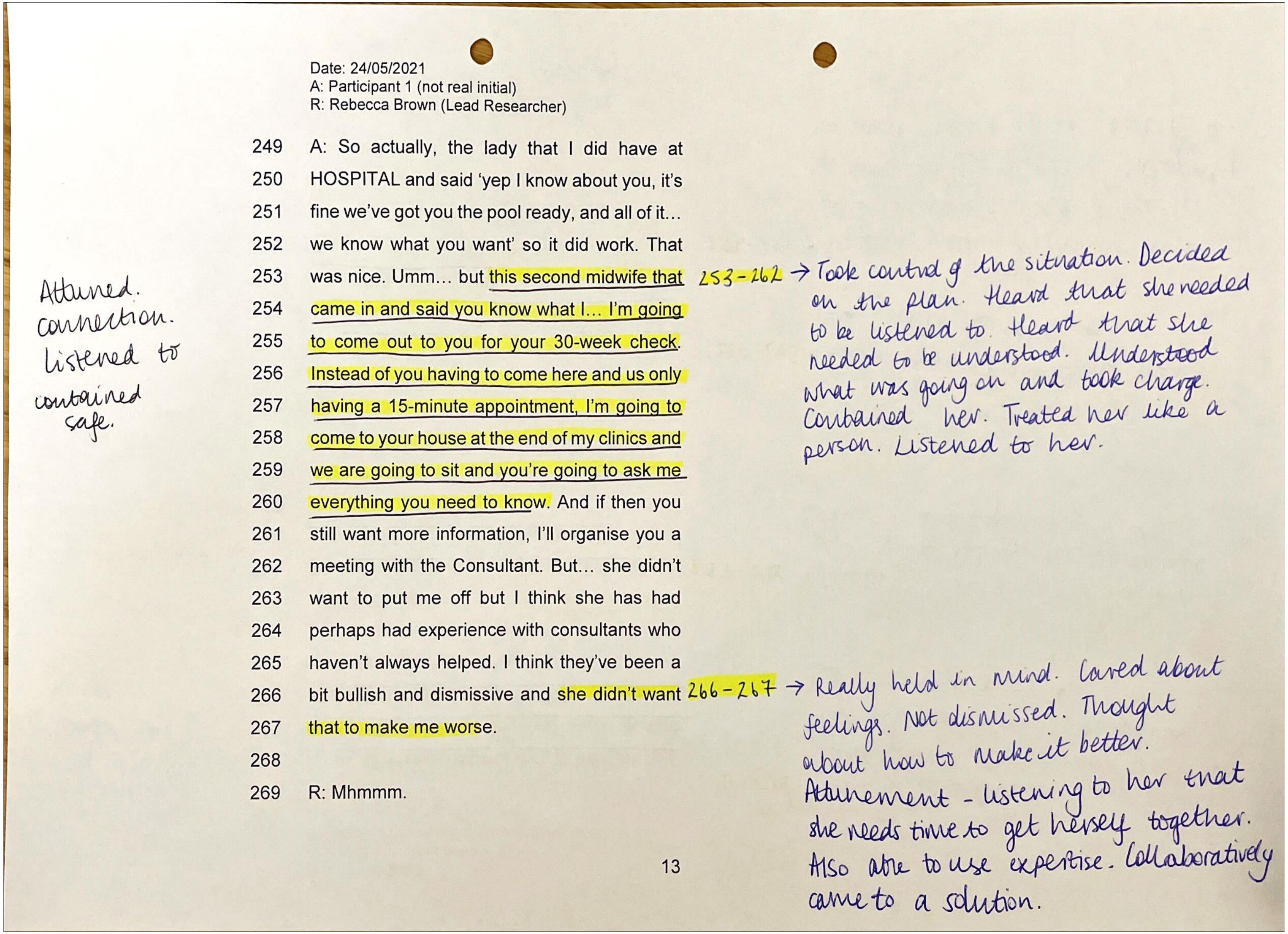
Had a Ⓟ fill out the form but not leave their contact details. In some ways helpful (bc) I learned to put on a compulsory contact details leaving rule on Qualtrics. Life is always a bit of trial and error. No room for perfectionism here!

One person in touch - very exciting! wonder if they'll get a better / quicker experience then later ones.

First thought about (P1) was about her email address - .ac.uk means an academic - would I get on with her better because more similar to me? How will that change how I ask her questions? Will it? How will that feel for me hearing the

*P=Participant; bc=because

Appendix N: Excerpt of anonymised transcript



Date: 24/05/2021
A: Participant 1 (not real initial)
R: Rebecca Brown (Lead Researcher)

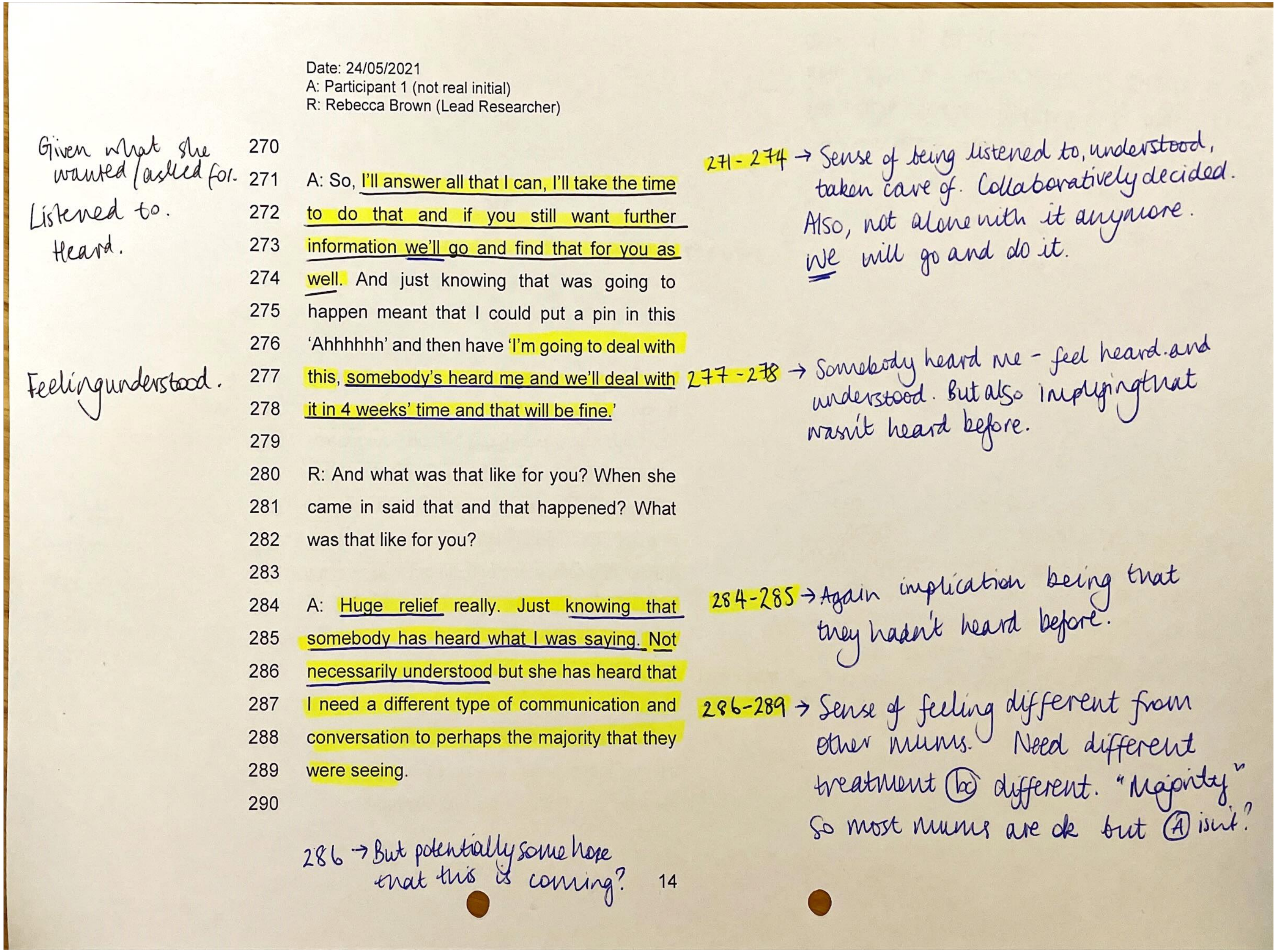
249 A: So actually, the lady that I did have at
250 HOSPITAL and said 'yep I know about you, it's
251 fine we've got you the pool ready, and all of it…
252 we know what you want' so it did work. That
253 was nice. Umm… but this second midwife that
254 came in and said you know what I… I'm going
255 to come out to you for your 30-week check.
256 Instead of you having to come here and us only
257 having a 15-minute appointment, I'm going to
258 come to your house at the end of my clinics and
259 we are going to sit and you're going to ask me
260 everything you need to know. And if then you
261 still want more information, I'll organise you a
262 meeting with the Consultant. But… she didn't
263 want to put me off but I think she has had
264 perhaps had experience with consultants who
265 haven't always helped. I think they've been a
266 bit bullish and dismissive and she didn't want
267 that to make me worse.
268
269 R: Mhmmm.

13

Attuned.
connection.
Listened to
contained
safe.

253-262 → Took control of the situation. Decided on the plan. Heard that she needed to be listened to. Heard that she needed to be understood. Understood what was going on and took charge. Contained her. Treated her like a person. Listened to her.

266-267 → Really held in mind. Cared about feelings. Not dismissed. Thought about how to make it better.
Attunement - listening to her that she needs time to get herself together.
Also able to use expertise. Collaboratively came to a solution.



Date: 24/05/2021
A: Participant 1 (not real initial)
R: Rebecca Brown (Lead Researcher)

Given what she wanted / asked for.
Listened to.
Heard.

270
271 A: So, I'll answer all that I can, I'll take the time
272 to do that and if you still want further
273 information we'll go and find that for you as
274 well. And just knowing that was going to
275 happen meant that I could put a pin in this
276 'Ahhhhhh' and then have 'I'm going to deal with
277 this, somebody's heard me and we'll deal with
278 it in 4 weeks' time and that will be fine.'
279

271-274 → Sense of being listened to, understood, taken care of. Collaboratively decided. Also, not alone with it anymore. we will go and do it.

Feeling understood.

277-278 → Somebody heard me - feel heard and understood. But also implying that wasn't heard before.

280 R: And what was that like for you? When she
281 came in said that and that happened? What
282 was that like for you?
283
284 A: Huge relief really. Just knowing that
285 somebody has heard what I was saying. Not
286 necessarily understood but she has heard that
287 I need a different type of communication and
288 conversation to perhaps the majority that they
289 were seeing.
290

284-285 → Again implication being that they hadn't heard before.

286-289 → Sense of feeling different from other mums. Need different treatment (bc) different. "Majority" So most mums are ok but Ⓐ isn't?

286 → But potentially some hope that this is coming?

14

Appendix O: Photograph of IPA Step 6, identifying themes across transcripts