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Do contemporary social and health discourses arouse peripartum anxiety? A qualitative investigation of women's accounts

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SYNOPSIS

The aim was to investigate women's accounts of the sources and explanations of perinatal anxiety to inform clinical and public health responses. Discussions with groups of women during admission to an early parenting service were audio-recorded, transcribed and analysed using an interpretative phenomenological approach. Twenty women participated (40% had above 'normal' anxiety symptoms; 45% were experiencing moderate or severe stress). The groups reported sources of worry about their babies, themselves and their relationships. These anxiety triggers were interpreted in the context of contemporary social and health discourses about pregnancy, the postpartum period and infant care. Five themes were identified: image management; single-message health promotion campaigns; evidence-based decision making, 'maternal instinct', and risk. Public health campaigns, health professionals and others could ameliorate perinatal anxiety by providing realistic, understandable, numerical information to assist decision making, disrupt inaccurate gender-based stereotypes about mothering behaviours and offer abundant praise for the work of mothering.

Introduction

Pregnancy and motherhood in modern societies create an understandable context for anxiety (Wenzel, 2011). Most women manage the inevitable worries well, but uncontrollable worry that is persistent, excessive and associated with distress and impairment may meet diagnostic criteria for a specific anxiety disorder (American Psychiatric Association, 2013). Perinatal anxiety disorders are common (Ross & McLean, 2006). For example, in an Australian study of a community sample of partnered women who had recently given birth, the 6 month period prevalence of specific or social phobia, panic with or without agoraphobia, or generalised anxiety disorder was 10%, and of adjustment disorder with anxiety was 18% (Fisher et al., 2010).

Perinatal mental disorders can exert adverse effects on cognitive and emotional development, attachment, behaviour and growth in children (Stein et al., 2014). This occurs through complex genetic, other biological and environmental pathways. Some adverse effects can persist into adolescence (Stein et al., 2014). Compared with depression, perinatal anxiety has received far less clinical and research attention (Howard et al., 2014). However, a recent review of the evidence (Stein et al., 2014) reported that elevated maternal anxiety during pregnancy appears to be associated with low birth weight, preterm birth and internalising symptoms in childhood and adolescence. In the postnatal period, elevated maternal anxiety is associated with emotional problems in children, and maternal anxiety either before or after birth is associated with behavioural problems in childhood. In addition to adverse consequences for child development, persistent, disabling anxiety can cause feelings of shame, inadequacy and failure for the mother (Kleiman, 2009).

Women enter a complex world when they become pregnant and give birth, leading to increased demands on

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their psychological resources. Negotiating pregnancy health care, experiencing the birth and recovery, adjusting to the demands of infant care, and for most, managing disengagement from the paid workplace, are emotionally and physically demanding (Rowe & Fisher, 2010). A woman's growing protective emotional attachment to her unborn baby and infant means that, in addition to caring for her own wellbeing, a woman interprets and responds to her experiences during pregnancy and in the postpartum period in light of their potential impact on her child (Condon, 1993; Condon & Corkindale, 1998). In these circumstances, a degree of anxious arousal is both inevitable and adaptive (Wenzel, 2011). Indeed, worry can be important for mobilising resources to manage demanding experiences, as well as for motivating vigilance about safety and wellbeing (Gladstone & Parker, 2003).

However, the bodies and behaviours of women who are pregnant or caring for an infant are highly visible in modern cultures (Nicolson et al., 2010) and acceptable appearance and conduct are reinforced by health systems and the media and are closely monitored by women themselves, their care providers and the public (Collett, 2005). The complexity of modern pregnancy and postpartum care, the plethora of clinical and public health advice, and the accompanying professional and social scrutiny, are potentially anxiety-arousing and exert persistent challenges to healthy psychological adaptation. Wenzel (2011) argues that postnatal anxiety requires specific research and clinical attention.

This study aimed to investigate the sources of worry and anxiety that women identify in the perinatal social and health milieu, the language and contexts they use to describe them, and the meaning that they ascribe to their experiences.

Materials and methods

Approval to conduct the study was granted by The Avenue Hospital Human Research Ethics Committee, responsible for research conducted at the hospital that was the study site (Trial 129, 23rd October 2011).

Setting

The study was conducted at Masada Private Hospital Mother Baby Unit (MPHMBU) (Masada Private Hospital Mother Baby Unit, 2015), located in metropolitan Melbourne in the Australian State of Victoria. This service is one of Australia's internationally-unique non-psychiatrically-designated residential early parenting centres (Fisher et al., 2011a). Approximately 6% of Victorian women who have recently given birth are admitted to an early parenting service annually (Fisher et al., 2011b). Admissions to MPHMBU are by referral from a doctor for treatment for a diagnosable condition including infant sleep or feeding disorders and maternal major depressive episode of postpartum onset, generalised anxiety, adjustment disorder or clinical exhaustion. Mothers and infants up to 12 months of age are admitted together (Fisher et al., 2004). Up to a quarter of women admitted have anxiety symptoms of sufficient severity to meet diagnostic criteria for an anxiety disorder (Rowe et al., 2008). The study took place during admission.

Study design and methods

A cross sectional design was used. Quantitative data were collected about participant characteristics and severity of symptoms of depression, anxiety and stress. The study was designed to investigate a phenomenon that had not been documented in this setting and there were no pre-specified hypotheses. Qualitative methods of collection and thematic analysis of data were therefore appropriate.

Data sources

Brief background survey

Study-specific questions collected demographic details including age, marital status, infant's age, number of older children, cultural background and language, education and health insurance status (an indicator of socioeconomic advantage). The *Depression, Anxiety, and Stress Scale* (*DASS 21*) was used to assess mood and anxiety (Lovibond & Lovibond, 1995). The DASS 21 is a self-report measure of current ("over the past week") depression, anxiety, and stress symptoms, which uses 21 items with response options on a four point Likert scale from 'did not apply to me at all' to 'applied to me very much, or most of the time'. Each of three sub-scales, Depression (D), Anxiety (A), Stress (S) is formed by summing responses to 7 items. Category scores for depression are 'normal' (0–9); 'mild' (10–13); 'moderate' (14–20); 'severe' (21–27); 'extremely severe' (28 and above); for anxiety were 'normal' (0–7); 'mild' (8–9); 'moderate' (10–14) 'severe' (15–19); 'extremely severe' (20 and above) and for stress were 'normal' (0–14); 'mild' (15–18); 'moderate' (19–25); 'severe' (26–33); 'extremely severe' (34 and above) (Psychology Foundation of Australia, 2011). The Depression items assess symptoms of low positive affect, reduced self-esteem and incentive, and a sense of hopelessness; the Anxiety items assess fearfulness and physiological arousal and the Stress items measure tension, irritability and a low threshold to frustration. Higher scores indicate more severe symptoms. The DASS 21 had good internal consistency (Cronbach's alpha D = 0.88, A = 0.82, and S = 0.90) in a large non-clinical sample (Henry & Crawford, 2005). The D and A sub-scales correlated strongly with the Beck Depression Inventory (BDI, r =0.74) and the Beck Anxiety Inventory (BAI, r = 0.81) respectively and the correlation between the DASS D and A sub-scales was 0.54; D and S sub-scales was 0.56, and the A and S sub-scales was 0.65 (Lovibond & Lovibond, 1995).

Small group discussions

Discussion groups took place while infants were in the care of staff. The intention was to identify thoughts, feelings, and behaviours that lead to excessive anxiety. First, participants were invited in an open-ended introduction to brainstorm common sources of worry about pregnancy and motherhood experiences. Second, prompts (such as "could you say more about that?" or "are there other examples?") were used to promote elaboration, clarification of language and concepts and participation of all group members (Liamputtong, 2009). Discussions were facilitated by the authors and audio-recorded with permission. A research assistant observed and took notes.