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Citation for final published version:

Savory, N.A. , Hannigan, B. and Sanders, J. 2022. Women's experience of mild to moderate mental health problems during pregnancy, and barriers to receiving support. *Midwifery* 108 , 103276.  
10.1016/j.midw.2022.103276

Publishers page: <http://dx.doi.org/10.1016/j.midw.2022.103276>

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# **Women's experience of mild to moderate mental health problems during pregnancy, and barriers to receiving support.**

## **Abstract**

### **Objective**

To explore the experiences of women during pregnancy with mild to moderate mental health problems and describe the barriers to receiving support in relation to their mental health.

### **Research design and participants**

This paper reports part of a larger project which recruited women and midwives in one hospital in Wales. Participants completed questionnaires in early pregnancy in an antenatal clinic, and the characteristics of women with and without symptoms of anxiety and depression compared. All women were invited to express interest in a follow up interview in late pregnancy.

Women identified to have depression and anxiety in early pregnancy, but not under the care of perinatal mental health services, were eligible for interview. Interviews were conducted with 20 women using a visual timeline to aid discussion and were thematically analysed.

### **Findings**

In late pregnancy mental health disorders were reported by nine women, of which five were diagnosed during adulthood. EPDS scores found 15 women had symptoms of mild to moderate depression and GAD-7 scores indicating 15 women with mild to moderate anxiety. Three themes were identified: moods and emotions - past, present and future; expectations and control; knowledge and conversations.

### **Key conclusions and implications for practice**

Due to limited access to specialist perinatal mental health services women relied on support networks and self-care to maintain their mental health. More time and better continuity at antenatal appointments along with improved mental health literacy may increase discussions regarding women's mental health during pregnancy. In addition

investment is required to develop strategies and improve access to mental health services for women with mild to moderate mental health problems.

## **Keywords**

Pregnancy; women; experiences; barriers; mental health

## **Introduction**

Around one in five women have mental health problems during pregnancy (Healthwatch, 2019). This is important considering the associations reported between maternal stress, anxiety and depression during pregnancy, for example a more painful labour and higher rate of epidural (Storksen et al., 2015), negative birth experience (Chabbert et al., 2021) and the development of postnatal depression (Howard et al., 2017; Henderson et al., 2018). Mental health problems during the antenatal period are thought by some to impact the developmental process of the fetus (Janssen et al., 2016; Tobon et al., 2016). There have also been suggestions that women with mental health problems in the perinatal period are more likely to use health services, costing both time and money (Grajkowski et al., 2017).

In the UK the National Institute for Health and Care Excellence (NICE) recommends support for women with mild to moderate mental health problems to improve outcomes for mothers and babies (2014) but access to specialist perinatal services in many areas is limited to women with severe illness and even then some have been described as a 'postcode lottery' (Witcombe-Hayes et al., 2018). Psychological therapies have been shown to be most effective for mild to moderate mental health problems as recommended by NICE, but women who choose this face long waiting times (Care Quality Commission, 2017). In addition many women are unaware they have a mental health problem due to poor mental health literacy, for example thinking their lowered mood is normal (Kingston et al., 2015a). Stigma also results in women being reluctant to admit their concerns (Khan 2015; Button et al., 2017) especially at a time which society perceives as a happy event (Raymond, 2009).

Systematic reviews often focus on barriers to accessing postnatal care (Hadfield et al., 2017). In one review, all 24 articles assessed barriers to seeking help to support perinatal mental health in the UK related to postnatal depression (Button et al., 2017). Research has also focused on experiences and barriers for women with severe mental health problems

(Habel et al., 2015; Higgins et al., 2016), ethnic minority groups (Gardner et al., 2014) or those living in areas of social deprivation (Raymond et al., 2014). These found barriers specific to the cohort of women recruited, such as cultural and language barriers, access to childcare, transport issues and for women receiving care outside of the UK, financial aspects of care. Experiences of women in pregnancy with mild to moderate mental health problems in a cross-section pregnant population have received less attention.

Prior research has typically included women who gave birth weeks, months, and sometimes years, earlier (Henderson and Redshaw, 2016; Nagle and Farrelly, 2018; Henderson et al., 2018). Interviewing women during the antenatal period may provide a different view of women's experiences, uncoloured by birth and life with a newborn.

The aim of this study was to explore the experience of pregnant women living with mild to moderate mental health problems not accessing perinatal mental health services and assess barriers to receiving support .

## **Method**

This study was part of the larger 'Mothers Mood Study' project which assessed women's and midwives' experiences of perinatal mental health and service provision one Health Board in Wales. Due to the stigma surrounding mental health (Button et al., 2017), participant-facing information used the words 'moods and emotions' to aid recruitment. Ethical approval for the study was granted by the Welsh Research Ethics Committee (Ref: 17/WA/0319). Recruitment has previously been described in detail (Savory et al., 2021). In brief, phase one consisted of questionnaires completed by women in early pregnancy. These collected data on sociodemographic status, self-reported mental health, and used screening tools to assess support networks and self-efficacy. The Edinburgh Postnatal Depression Scale (EPDS) (Cox et al., 1987) and Generalised Anxiety Disorder-7 (GAD-7) scale (Spitzer et al., 2006) were used to assess symptoms of anxiety and depression.

This paper reviews the second study phase where a subset of 20 women were interviewed to explore their experiences of living with mental health difficulties, and the barriers to receiving support. During the interview a timeline was used to aid discussion and reflection.

Visual methods can be used to instigate and expand discussion, allowing thinking 'outside the box' using participants' own reflexivity (Bagnoli, 2009). Various methods have been incorporated into research studies, the use of photos, paintings, drawings and mind maps

(Prosser and Loxley, 2008) have been used with children as a way to open up conversations (Bagnoli, 2009). A study of didactic pairs of mothers and grandmothers attended interviews about breastfeeding using artefacts to initiate conversations and allowed reflection of their experiences of motherhood and infant feeding (Grant et al., 2018). To our knowledge, the use of novel methods to aid discussion for this group of women has not been used before.

### **Participants and recruitment process**

The first phase of the study took place at a large maternity unit in Wales between November 2017 and January 2018. All women were invited to join the study at their first antenatal appointment if they met the inclusion criteria of aged  $\geq 18$  years, having sufficient spoken and written English and a viable pregnancy of  $\leq 18$  weeks' gestation confirmed by ultrasound scan. Women were excluded if there was a confirmed or suspected serious fetal anomaly. Written consent and contact details were obtained for a follow up interview later in pregnancy and questionnaires completed by 302 women.

Information was sought from the perinatal mental health team regarding referral for women if there were concerns regarding their mental health. Prior to women leaving the clinic their EPDS score was scrutinised to assess safety. This information was included in the PIS. Three women scored high on the EPDS and were spoken to by the recruiting midwife. They stated they had no immediate thoughts of harming themselves. All had a history of mental health problems, none were judged to be at immediate risk of harm, they were being cared for by relevant professionals and had supportive families.

In the second phase, women who consented to interview during initial recruitment in early pregnancy ( $n=211$ ) were assessed against the recommended criteria for mild or more severe symptoms of depression or anxiety as completed in the initial questionnaire, EPDS  $\geq 7$  (Spitzer et al., 2006) and/or GAD-7  $\geq 5$  (McCabe-Beane et al., 2016).

This resulted in 98 (46.4%) women eligible for interview (Figure 1). Further checks of the NHS records around 32 weeks gestation showed the inclusion criteria were not met by 10 women due to: referral to perinatal mental health team (1.8%,  $n=4$ ), fetal medicine (1.8%,  $n=4$ ), miscarriage (0.4%,  $n=1$ ) or not safe to visit alone (0.4%,  $n=1$ ).

Records and contact details were re-checked immediately prior to contacting women (36.9%, n=78). Of these, nine women (4.2%) had not provided sufficient information to enable contact. Three women were not contacted; one (0.4%) had given birth prematurely and two (0.8%) had complications in pregnancy. Initial contact was made with 66 (31%) women via their preferred manner as indicated on the contact form. Initial interest was received from 35 (6.5%) women and appointments made for 25 (11.8%) of these: one (0.4%) gave birth before the arranged interview and four (1.8%) cancelled. The use of a timeline or mind map was offered to women when they agreed to participate in an interview. A pre-prepared timeline was provided with the appointment details to allow time for reflection prior to the interview (Figure 2).

Interviews were conducted with 20 women between May and July 2018. Women chose to be interviewed at either their home (n=11), the hospital (n=7) or university (n=2) and lasted between 20 to 84 minutes. Consent was obtained at the beginning of the interviews, which included permission to audio record the interview. Assurance was also given that all information collected would be kept confidential unless safeguarding concerns for the woman or others were noted. The EPDS and GAD-7 were completed by women immediately prior to the interview to assess current symptoms of depression and anxiety. Women were offered the chance to choose their own pseudonym, but all declined. A laminated copy of the timeline was placed within view of the women during the interview. This was used as a visual prompt and a way of discussing changes in the woman's mental health at different life stages rather than a method of data collection. Semi-structured interviews were based on an interview schedule and all conducted by the same research midwife. Topics of discussion included: changes in mood from infancy and concerns around birth and the early postnatal period; contact with health professionals and conversations around mental health; information identified relating to mental health; support sought or obtained for mental health.

## **Data analysis**

Questionnaire data were analysed using SPSS. Descriptive statistics were produced for background characteristics. A paired sample *t*-test was used to compare EPDS and GAD-7 scores in early pregnancy and at the time of interview.

The first two audio recordings were transcribed by the researcher and the remainder were sent to a University approved transcription service. Audio recordings were transcribed verbatim and any personally identifiable information removed. Transcripts and field notes

were entered into NVivo 11 data management software. An inductive approach to thematic analysis was used to detect, analyse and report on patterns found within the data (Braun and Clarke, 2006). All transcripts were coded by the research midwife. In addition, to increase validity one transcript was coded independently by a member of the research team.

## **Findings**

### **Background characteristics of women interviewed**

Findings from the initial questionnaire at booking for sociodemographic status and mental health history in early pregnancy are shown in Table 1. In brief, 18 women had a partner 11 were multiparous, 17 were white British and 15 educated to degree level or above. Mental health disorders were reported by nine women, of which five were diagnosed during adulthood. EPDS scores found four women had mild and 11 moderate symptoms of depression and GAD-7 scores found 12 women with mild and three moderate symptoms of anxiety. None reported taking medication for their mood condition but two had previously received counselling. At interview one woman was still waiting for counselling and all were between 34 and 40 weeks' gestation.

EPDS question 10 was reviewed; none of the women had indicated they had considered harming themselves. EPDS scores were lower or the same for 14 women and for the GAD-7 10 scored lower or the same compared to measurements completed in early pregnancy. . A paired sample *t*-test was conducted to compare the EPDS and GAD-7 results in early and late pregnancy. Results showed that mean EPDS scores were higher at the beginning of pregnancy (*mean*=9.95) than at interview (*mean*=8.15), with this small sample size (*n*=20) the difference did not reach levels of statistical significance *p*=0.073, whereas GAD-7 scores were similar across time points (*mean*=6.00 V 6.10).

### **Findings from interviews**

Three themes were generated: 1) Moods and emotions - past, present and future; 2) Expectations and control; 3) Knowledge and conversations.

#### **Moods and emotions - past, present and future**

It was evident several women had reviewed the timeline and relayed their life story from childhood to the present day. One reported how the timeline had made her think specifically about her mental health over her lifetime. Several women disclosed conditions

during the interviews including obsessive compulsive disorder (OCD), anxiety, depression and anorexia. Most recalled a happy childhood, with no memories of any mental health problems. A combination of hormonal and major changes in their lives such as moving away from home and going to university were described as triggers for poor mental health. For the majority of women changes to their mental health arose in adolescence or adulthood and mostly prior to the present pregnancy.

*Gwenda: ... sixth form, uni, I wasn't diagnosed with anything but I did have some counselling around self-harm..., mostly in uni. (34yrs, P1)*

Another woman suggested the lifestyle at university may be to blame for some of the problems such as drinking too much and not getting enough sleep and a change had helped stabilise her mood.

Women's reactions on finding out they were pregnant ranged from excited, happy to shock. Anxiety and depression were noted to be at its greatest in early pregnancy often due to fear of miscarriage.

*Becky: ...I spent quite a lot of time feeling a bit anxious... this time last year I ...had a missed miscarriage...after quite a few years of having fertility treatment. (37yrs, G1)*

Financial and practical considerations were of concern for some women as pregnancy progressed. Two women had considered terminating their unplanned pregnancy as they were unsure how they could cope with a new baby. Several stated they had not enjoyed their pregnancy.

*Karen: I have hated it. (35yrs, G1)*

The strong reaction from Karen was due to concern for the safety of her unborn baby. This common worry during pregnancy caused women to focus on the wellbeing of their unborn baby rather than themselves. For Karen the anxiety was so great she requested an elective caesarean section for birth.

For others it was the minor ailments and physical aspects of pregnancy which increased anxiety.



*Tara: ...it's been more painful than I expected which ...impacted my mood, because I've had ...mobility issues... I'm normally a very active person.*  
(32yrs, G1)

Several women related their anxiety to an inability to carry on with everyday tasks; one became tearful as she spoke about feeling like a 'bad partner' because she was unable to carry on with her usual housework. As pregnancy progressed, most women approached the birth armed with information and a plan but when complications arose this led to uncertainty and increase in anxiety.

*Sally... it's the group B strep ...that is worrying me. (29yrs, P2)*

Women diagnosed with a group B streptococcus infection in pregnancy are offered intravenous (IV) antibiotic cover in labour to prevent the condition being passed on to their newborn, which if untreated can lead to severe neonatal infection. Sally and several other women mentioned that even though they were provided with a leaflet, it was information on practical implications which were lacking. In this instance it would have meant Sally could not labour in the familiar environment of the low risk maternity led unit. This had left unanswered questions and little perceived opportunity to discuss concerns with healthcare professionals resulting in anxiety.

When discussing events after birth, the early days with a newborn included practical issues of caring for them which were women's main concern, especially for those giving birth to their first child. It was also the first time where many women turned their attention to their own health.

*Jackie: ...I do get nervous about the baby blues and postnatal and stuff, so I've read quite a lot. (24yrs, G1)*

A few women mentioned the possibility of mental health problems after birth; usually because they had known other family members had problems with conditions such as postnatal depression.

### **Expectations and control**

Many women spent a lot of time comparing themselves to others and trying to be the 'perfect mum' which led to feelings of guilt and frustrations.

*Dawn: I think that was always a worry for me that I didn't want people to assume that I was going to be a bad mother...because of my mental health issues... (20yrs, G1)*

Several women used the word judgement in relation to the views of other people, including health professionals. One woman felt judged for the assisted birth she had on her previous child.

*Laura: I always felt like I'd done it wrong or I'd let myself down ...people going oh I'd never let myself have forceps...I felt awful that I'd put her through that... I think that sort of mummy shame thing... (33yrs, P1)*

The birth had not been straight forward and had led to issues with incontinence after a traumatic forceps delivery. Even so it was the underlying concern for her child rather than her own physical problems which had remained with her and in retrospect wished she had been more open and talked to someone about how she had felt. She had reasoned that anxiety had stemmed partly from trying to be the perfect mum; by doing the right things and comparing herself to others.

One way of overcoming the guilt and frustrations was being organised to feel in control of situations. In order to be in control there was a notable trend of women searching for information throughout pregnancy, with technology being the main source and popular search engines as the preferred starting point.

*Amia: Just [search engine] and see what comes up. (33yrs, P1)*

However a few were critical of the search engines bias or unreliability and depended heavily on official sources, many shared the information with their partner. Others varied their approach depending on the kind of information they were looking for, using baby apps and online forums for pregnancy-related development, minor physical problems and birth-related information.

### **Knowledge and conversations**

When asked about information-seeking around mental health, only three women stated they had looked for or seen information about perinatal mental health. In addition women were unsure of the difference between poor mental health and everyday stresses.

*Pippa: ...bit like this is normal, I'm just making a meal of it and the other part of me felt oh I feel like this isn't normal... (34yrs, G1)*

Efforts have been made in recent years to educate the public about mental health, to enable open discussions and reduce ignorance and stigma around the condition. There was a greater understanding of mental health conditions related to the postnatal period.

*Rhian: ...you mentioned something earlier about or you were asking during the pregnancy but actually in my mind, it's something that happens maybe after. (34yrs, P2)*

This lack of understanding around mental health related also to family, friends, work colleagues and health professionals. Women expressed a fear of sharing with others because of the stigma attached to mental health, resulting in them not discussing their concerns or feeling misunderstood and unsupported.

*Laura: I think there is a stigma...it's certainly made me very wary...I'd probably talk... about things like feeling a little bit low, it wouldn't be something I spoke about really openly.(33yrs, P1)*

Where women felt able to ask for support, this came mainly from friends and family and sometimes work colleagues. A network of support was mentioned by a couple of women, depending on the need. Support came in the form of practical aspects of childcare often from partners and emotional support from female family members and friends.

*Isabel: A problem shared is a problem halved and I've shared it with everyone. (34yrs, P1)*

Even where there was no response to concerns, women felt listened to and able to express their worries which had a therapeutic effect in itself. Support from peers in the same situation were mentioned by nearly everyone whether this was online or at antenatal classes. The strength of peer support was due to women being in a similar position, and women found the sympathy more helpful than if provided by health professionals. Group peer support did not suit everyone, the interactive nature of the sessions for one woman made her feel uncomfortable. Sometimes discussions were not required and women found their own way of supporting their mental health.

*Natalie: Yeah I'm a great believer in self-help... (34yrs, P1)*

Self-help such as singing, exercise, rest or meeting friends was also noted by women as important for mental wellbeing. Only one woman mentioned health professionals as the first person they would turn to if they had concerns about their mental health. Women described discussions around mental health, hampered by antenatal appointments which focused mainly on the physical health of them and their babies. Discussion on the wording of the questions received mixed reactions with a few women stating they were too direct, some stating they were not direct enough, and many not knowing what was being asked.

*Emma: ...how are you feeling question and I've always interpreted it as a physically how are you feeling. (32yrs, P1)*

Questions sounding like a 'tick box' exercise rather than a conversation were mentioned by several women. One woman disliked being asked if she could 'cope'. The wording prevented her from opening up for fear of being judged. Where support was sought from maternity services women found staff approachable, women suggested seeing the same midwife would enhance discussions around mental health.

*Cath: This is the only pregnancy where I feel like I've seen the same midwife enough times to actually, for her to know who I am. (35yrs, P1)*

With only nine appointments for first time mothers and seven for subsequent pregnancies, over a seven month period, it is understandable how sickness, holidays and change of staff can affect continuity. Even when women were concerned about their mental health there did not appear to be services that could be offered to them. One woman with an existing anxiety disorder had been referred via her general practitioner for counselling prior to pregnancy and was still waiting two years later at the time of interview and two weeks prior to the estimated date for birth. One woman with a history of severe OCD who was feeling very anxious and overwhelmed saw her midwife who was unable to refer her to perinatal mental health services.

*Olivia: ...she said 'I've got a lady who is suicidal and she would be someone that I would refer, whereas like, you are someone who is just a bit anxious at the moment'... (29yrs, P1)*

An alternative suggestion made by the midwife was to be signed 'off sick'. Workplaces were the cause of stress for many women but Olivia's preference was to stay at work where she felt 'happy', so taking time off was not a suitable option for her. She resorted to her self-help manuals that she had from previous therapy for her mental health.

## **Discussion**

Interviews with 20 women explored their experiences of living with mental health problems and barriers to receiving support. Previous studies, using both survey and interview designs have focused on the experiences of women with postnatal depression or receiving support from perinatal mental health services (Habel et al., 2015; Higgins et al., 2016). In this study, participants were pregnant women with mild to moderate anxiety and/or depression not receiving specialist support for their mental health. Furthermore interviews were conducted in late pregnancy to capture current experiences, unlike most previous research where information was obtained months or years after birth.

The questionnaires completed in early pregnancy found the majority of women interviewed were white British, married, employed and educated to degree level or above. Self-reported anxiety, depression and stress were the main mental health problems disclosed. The majority of the women discussed major changes in their life as triggers for poor mental health, which arose in adolescence or adulthood and prior to the present pregnancy.

## **Experiences**

Specific to this study was the use of a timeline which added a new dimension to the interviews, having previously been used to map substance misuse (Berends and Savic 2017) or used during pregnancy as an aid to discuss major life events in relation to infant feeding (Grant et al., 2019). The timeline gave a focus to the interview for both woman and researcher and helped trigger women's memories at different time points from childhood in relation to their mental health.

The majority of the discussions focused on women's mental health experiences during pregnancy. Early pregnancy was a time of mixed emotions. Anxiety has been described as a normal emotion, often felt when anticipating an event (Dotson et al., 2017) and anxiety specific to pregnancy as a unique and distinct condition often linked to fear of labour and childbirth (Brunton et al., 2019). A fear of childbirth has been associated with a preference for an elective caesarean section (Storksen et al., 2015) and was requested by two women in this study.

For other women it was the physical changes in pregnancy that aggravated their mental health. As previously found, exercise was described as a way to improve mental health and therefore being unable to continue such activities led to frustrations and decreased mood (Staneva et al., 2017). Additionally feelings of frustration and comparisons with other

women were mentioned, conversely none of the women reported body image issues in pregnancy which have been previously identified (Staneva et al., 2017).

Several issues causing low mood could be related to the inability to control pregnancy, which has been suggested as the biggest concern with pregnancy-related anxiety (Bayrampour et al., 2016). Unexpected pregnancy complications also led to insecurities and a feeling of being out of control. It was not the complication which was the main concern, more the lack of information and opportunity to discuss how these would affect pregnancy and delivery. Being unable to ask questions can result in feeling uninvolved, uninformed or not listened to (Henderson et al., 2018), increasing anxiety. Communication is obviously important for all women but even more so for those with mental health problems as they have been shown to perceive staff interactions as poor and are more anxious about birth (Henderson et al., 2018).

In order to take back control women turned to seeking out information to ensure they understood every aspect of pregnancy. Women with higher education have been found three times more likely to look for information (Sayakhot and Carolan-Olah, 2016), which could explain the numerous accounts of information seeking in this study. Technology played an important role in finding answers in this study and others (Sayakhot and Carolan-Olah, 2016). Despite the concern women had about the health of their baby many women just used a popular search engine and followed the first link regardless of the potential accuracy of the information.

## **Barriers**

Women described several barriers to receiving support for their mental health. Stigma has long been known to reduce openness about mental health, an issue highlighted in the interviews. Women were careful about who they spoke to, even close family were not always aware of the impact of poor mental health, as reported previously (Staneva et al., 2017). In contrast women were keen to join this study and stated it an important topic. It is possible that use of the words 'moods' and 'emotions' in the participant-facing documents led to women feeling comfortable with the topic (Jesse et al., 2008). Most women in the interviews were aware this study related to mental health. Women regard health professionals as generally approachable (Kingston et al., 2015b) and the second most likely person, after their partner, to be informed about mental health concerns (Boots Family Trust Alliance, 2013). Perhaps discussing the subject with a health professional was easier knowing the conversations were confidential as opposed to when speaking

with family, friends and colleagues. Conversely a previous large study reported over a quarter of women hid their symptoms and nearly half were not honest about their mental health problems when talking to health care professionals (Boots Family Trust Alliance, 2013).

In order to seek support women need to be aware of an issue but lack of knowledge around perinatal mental health was evident; several women acknowledged they had not considered mental health problems could occur during pregnancy. In keeping with a large UK survey (Boots Family Trust Alliance, 2013) the majority of women had heard of postnatal depression and some knew about the 'baby blues'. Women were also unsure if they had symptoms of poor mental health or if they were normal changes in mood. This is an issue as lower rates of help seeking have been reported where there is minimal understanding around mental health problems (Smith et al., 2019).

This study asked pregnant women specifically about information they had sought regarding mental health, in contrast to previous studies which have explored general information seeking in pregnancy (Sayakhot and Carolan-Olah, 2016). Limited information was found or sought by women in this study relating to perinatal mental health. This may be because they did not look for information regarding mental health or more likely because they did not recognise the importance of the topic.

In order to ensure women are asked about their mental health, NICE (2014) recommends questions are asked at each routine antenatal and postnatal appointment. These questions were often misinterpreted. Consistent with other reports, women in this study felt questions such as 'How are you feeling?' related to their physical wellbeing (Darwin et al., 2016). In addition women stated they would have been open to discuss their emotional health in pregnancy with health care professionals, as noted previously (Higgins et al., 2016; Evans et al., 2017). Yet time constraints resulted in healthcare professionals focusing on the mother's and baby's physical wellbeing (Darwin et al., 2015; Higgins et al., 2016). The list of tasks carried out and documented in the antenatal records reflect NICE (2019) with a clear schedule of antenatal check-ups, even so appointments have remained the same duration for years, one hour for the first and 10 minutes for subsequent appointments in the local Health Board. Consequently, adding extra assessments to the list over the years has led to tight appointment schedules, reducing the opportunity to discuss mental health (Higgins et al., 2018) which is the latest addition to the list of questions to ask.

Continuity of carer (Higgins et al., 2018) was mentioned by a few women who felt having the same midwife at each appointment would have led them to discuss their mental health as they had built a trusting relationship. In addition it may reduce the need for repeated introductions and an understanding of ongoing concerns, enabling more time to discuss new issues and improve assessment of mood. Continuity in maternity care in the UK is endorsed by NICE, Nursing and Midwifery Council and government policy (Department of Health, 2016; NHS England, 2016; Scottish Government, 2017; National Institute for Health and Care Excellence, 2019; Nursing and Midwifery Council, 2019; Welsh Government, 2019) and strides are being made to implement this service, however there have been reservations from midwives (Taylor et al., 2019) and full implementation in England, the country with the most ambitious plans has been delayed due to service challenges (NHS England and NHS Improvement 2021) Other countries have also recommended continuity schemes such as Canada where a published position statement in 2015 stated continuity of carer as one of its core principles for midwives (Canadian Association of midwives) and Australia recommends continuity schemes but only 10% receive this service (Cummings et al., 2020).

Support for women with mild to moderate perinatal mental health problems is recommended by NICE (2014). Previous studies have shown self-care (Raymond et al., 2014) and a support from friends and family (Berkman et al., 2000) as important for positive mental health. In this study women mentioned their own coping strategies and a network of support from friends, family, work colleagues and peers as important ways to support their mental health and reduce anxiety. Higher levels of social support have been noted to correlated with fewer symptoms of stress and depression in a low income population (Jesse et al., 2014). Peer support in the form of antenatal classes was found to be beneficial in this study, especially the supportive nature of meeting women in the same situation (McLeish and Redshaw 2017).

Women without this protective support network may need to more input from midwives and general practitioners or more specialist perinatal mental health team. Services have been described as a 'postcode lottery'; confusing women and health care professionals (Witcombe-Hayes et al., 2018); in this study by one woman who was initially offered referral to the perinatal mental health team, then later informed by the midwife that on reflection her mental health problem was not severe enough for referral.

## **Limitations**



Acknowledgement is made that a midwife undertaking the interviews could have influenced women and the interpretation of data. Women were aware from the information leaflets that the researcher was a midwife and appeared comfortable in the interviews. Additionally women were mainly white British and highly educated and therefore findings may not be reflective of other cultures or sociodemographic groups. The study also took place at a single site and therefore may not reflect the practice in all settings. Timelines were used as planned but some women did not engage as fully as anticipated yet it succeeded in focusing women's thoughts regarding their mental health at different periods over their lives, which is novel in itself. Changing the process and providing more information prior to use might have made them more accessible. Whether this would have altered results is not known.

### **Recommendations for practice**

NICE (2019) recommends informing women of postnatal blues and postnatal depression but not specifically about antenatal mental health problems. In this study women were unaware of sources of information relating to mental wellbeing. Universal support and the provision of information for women's mental health similar to that of physical health would ensure all women receive support regardless of the presence of a problem. Understanding their own mental health will assist women to detect deviations from normal; however this should not replace discussions with health professionals. Health care professionals can signpost women to official sources of support, such as NHS recommended apps (National Health Service, 2018). Countries such as Australia (<https://www.cope.org.au/expecting-a-baby/mental-health-conditions-pregnancy/>) and America ([https://www.nationalperinatal.org/mental\\_health](https://www.nationalperinatal.org/mental_health)) have dedicated online websites for women and families providing information and advice about perinatal mental health. Signposting women to antenatal groups and self-help strategies could be suggested, especially for women without a support network which was found to be important to women in this study.

Reasons for not asking questions related to mental health included time constraints at appointments. Increasing appointments by five to ten minutes may allow midwives to ask about mental health and women time to ask questions which in itself may allay anxiety for some. Additionally continuity of carer was shown to be important to women. England has several sites which provide continuity of carer and with the number expanding and Wales is developing services. Further roll out of these services will benefit women.

## **Recommendation for future research**

Specialist perinatal mental health services are unable to support women with mild to moderate mental health problems and although psychological therapies are beneficial, long waiting lists exist. Further accessible provision is required. Support networks were particularly beneficial for women and peer support from like-minded individuals. Peer support for women from vulnerable or ethnic minority groups reported positive impact on their mental health (McLeish and Redshaw, 2017). Research to replicate this in a cross-section of pregnant population should assess if these results can be generalised and fill the gap for those without support networks.

## **Conclusion**

This is the first study to use a timeline to aid exploration of pregnant women's experiences of mild to moderate anxiety and/or depression. In this study anxieties were made worse by a lack of control and need for information rather than social and economic issues experienced by women from low socioeconomic backgrounds. Where there is limited access to specialist services women rely on support networks and self-help to maintain their mental health. Women without these support networks may require other avenues to aid their mental wellbeing. More time and better continuity at appointments along with improved mental health literacy may aid discussions regarding women's mental health during pregnancy, which in itself could be beneficial for women's mental wellbeing.

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Table 1. Background characteristics of women interviewed.

Background Characteristics	n=20
	M (SD) R

<b>Age</b>	31.7 (4.9) 20-37
<b>Gestation at interview</b>	36.9 (1.65) 34-40
	<b>n (%)</b>
<b>Do you have a partner?</b>	
Yes	17 (85.0)
Yes, but we don't live together	1 (5.0)
I do not have a partner	2 (10.0)
<b>Parity</b>	
Nulliparous	9 (45.0)
Multiparous	11 (55.0)
<b>National identity</b>	
British	17 (85.0)
Other	3 (15.0)
<b>Ethnic background</b>	
White	17 (85.0)
Other	3 (15.0)
<b>Highest level of education</b>	
Degree or above	15 (75.0)
Below degree	4 (20.0)
Missing	1 (5.0)
<b>Employment situation</b>	
In work	17 (85)
Unemployed and seeking work	1 (5.0)
Out of work not seeking work	2 (10.0)
<b>Main occupation</b>	
Professional/associate professional	11 (55.0)
Other	5 (45.0)
<b>No occupation</b>	<b>4 (20.0)</b>
Student	1 (5.0)
Mother/housewife/care	1 (5.0)
<b>Have you been diagnosed with a mood disorder?</b>	
No	11 (55.0)
Yes	9 (45.0)

**If yes which mood disorder?<sup>a</sup>**

Anxiety	7 (35.0)
Depression	5 (25.0)
Stress	4 (20.0)
Other	3 (15.0)

**Diagnosis**

Adolescence	1 (5.0)
Adulthood	5 (25.0)
Self-diagnosis	2 (10.0)
Unsure	2 (10.0)
N/A	10 (50.0)

**EPDS<sup>b</sup>**

Nil <7	4 (20.0)
Mild 7-12	12 (60.0)
Moderate 13-19	4 (20.0)

**GAD-7<sup>b</sup>**

Nil <5	5 (25.0)
Mild 5-9	12 (60.0)
Moderate 10-14	3 (15.0)

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EPDS - Edinburgh Postnatal Depression Scale, GAD-7 - Generalised Anxiety Disorder-7

N – Number, M – Mean, R- Range, SD – Standard deviation, N/A – Not applicable

<sup>a</sup> women may have more than one diagnosed condition

<sup>b</sup> EPDS and GAD-7 recorded at recruitment

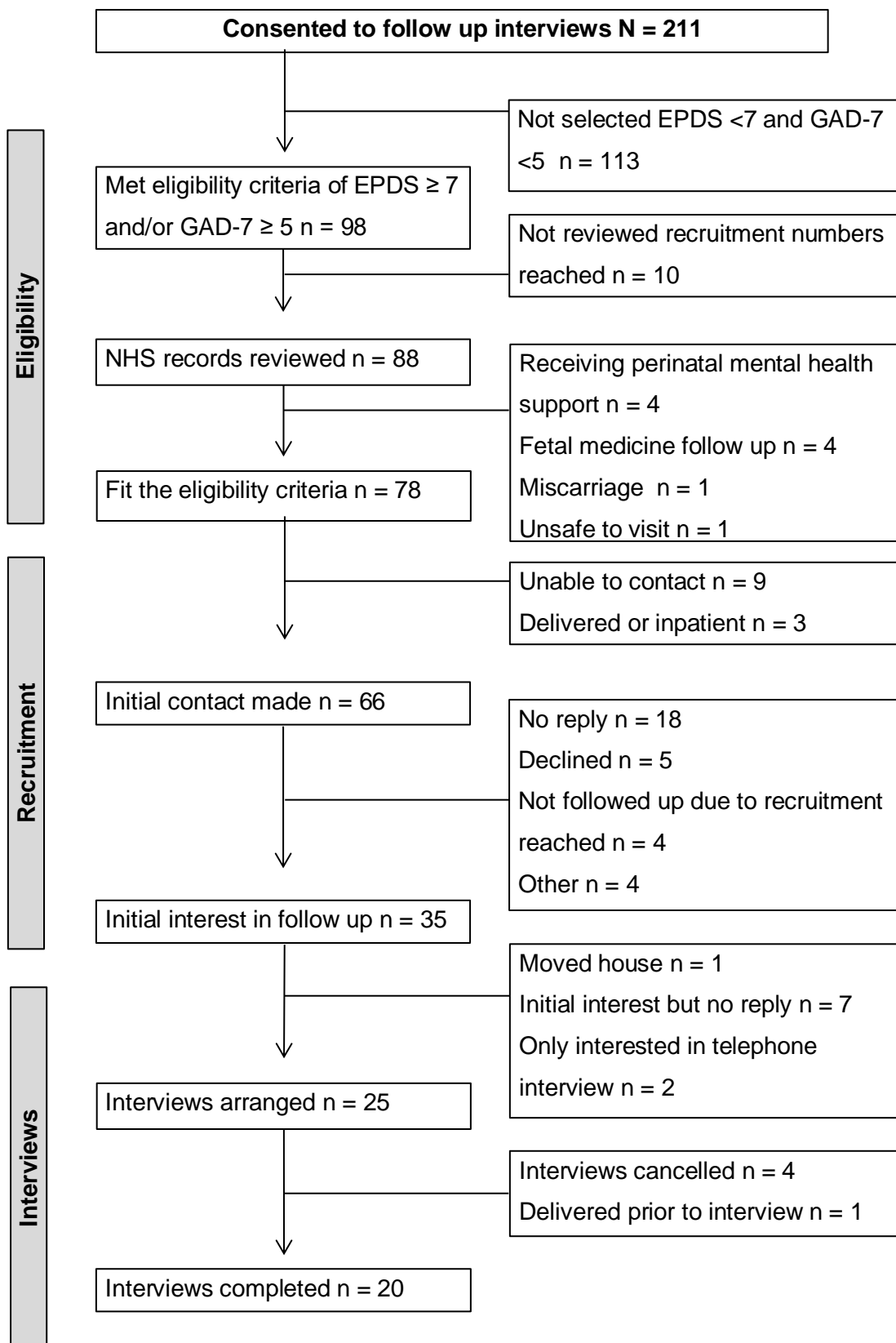
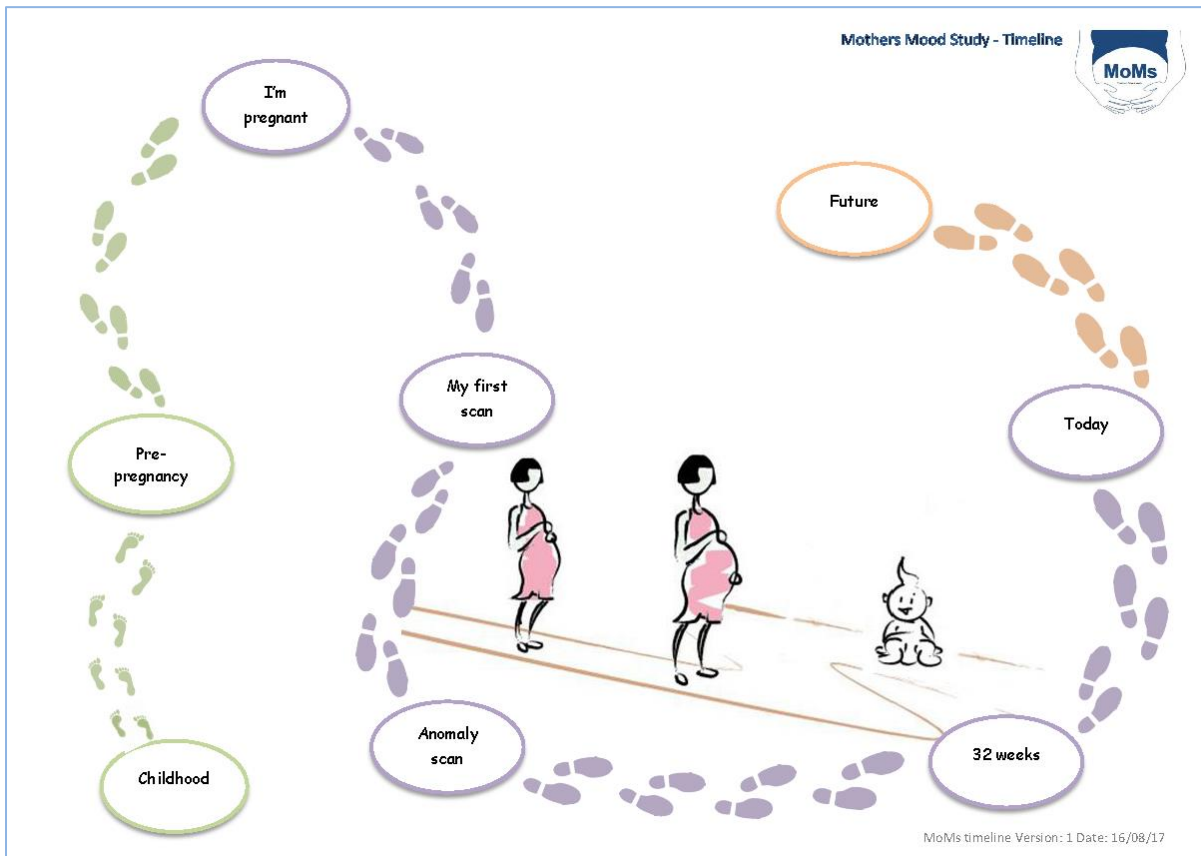


Figure 1. Follow up selection of women for interview with EPDS  $\geq 7$  and/or GAD-7  $\geq 5$ .



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Figure 2. Timeline used in the interviews