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ASSESSMENT OF WOMEN'S EXPERIENCES AND OPINIONS OF ROUTINE ASSESSMENT FOR ANXIETY IN MATERNAL AND POSTNATAL PERIODS

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ABSTRACT

Background: Pregnancy and the postpartum period are two times more common times for perinatal anxiety, which is often disregarded. Tools for assessment that are acceptable and appropriate for expectant and new mothers are needed in order to identify anxiety in this situation. **Methods:** This research used to investigate how women dealt with anxiety and mental health examinations both during and after pregnancy, as well as how they felt about the validity of these tests for perinatal anxiety. 41 women who were either pregnant or in the postnatal stage participated in semi-structured interviews. The acceptability framework developed by Sekhon et al. was used to analyze the data, and inductive coding was added to help find new or emerging themes. **Results:** The majority of women had positive sentiments toward routine perinatal anxiety examinations. The majority of participants acknowledged the necessity of these evaluations and thought that the benefits—such as increased assistance and awareness—outweighed any possible downsides, such as needless expert referrals. Six major themes came to light: (1) raising awareness; (2) fortifying support; (3) striking a balance between stigma and surveillance; (4) controlling service access; (5) offering individualized treatment; and (6) fostering trust. Opinions on the specific usage of questionnaires were divided, despite the fact that assessment was seen as an essential tool for raising mental health awareness during the perinatal period and normalizing mental health talks. A few attendees voiced apprehension that these instruments may diminish the procedure to a purely administrative duty, devoid of the profundity necessary for significant conversations on mental health. **Conclusion:** Women usually perceive routine perinatal anxiety assessments as beneficial and acceptable, provided that the process is educated and customized. These evaluations ought to be flexible, adapted to various perinatal phases, and incorporated into a continuity of care framework.

INTRODUCTION

About 20% of women experience perinatal anxiety, which can appear throughout pregnancy and for up to a year after giving birth (Fawcett et al., 2019). While prenatal depression has been well studied, anxiety during this time has received little to no attention until lately. Generalized anxiety disorder, panic attacks, phobias, social anxiety, and obsessive-compulsive disorder are among the illnesses and symptoms that fall under the umbrella of perinatal anxiety (WHO, 2011). Evidence suggests that even mild symptoms of anxiety can be upsetting and incapacitating for impacted women. These anxiety experiences are frequently characterized by intense feelings of dread and terror (Boots Family Trust Alliance, 2013).

It is advised to include mental health assessment questionnaires in routine maternity care in many countries; this will be of additional importance to women with a history of mental health issues. Routine screening for anxiety using the GAD-2: Generalized Anxiety Disorder 2-item scale should be offered to all women as part of routine antenatal care by their midwife or health professional, according to the 2014 National Institute for Health and Care Excellence guideline in the UK (Spitzer et al., 2006). Women scoring three or more on the GAD-2 should be referred to a mental health professional or their GP for further assessment using the GAD-7. However, the GAD-2 has been reported to reduce its clinical utility in maternity care by creating a high rate of false positives when screening for perinatal anxiety (Nath et al., 2018). However, few studies have examined the acceptability of anxiety tests or experiences of women when considering anxiety tests or the acceptability of instruments such as the GAD-2 itself.

Although this study did not involve investigation of the whole perinatal period, there is evidence from previous research that women in general felt it appropriate to be asked about their mental health during the antenatal sessions (Yapp et al., 2019). According to other studies (Button et al., 2017; Coates et al., 2014; Jomeen et al., 2013), women may also hesitate to report mental health problems when screened because of stigma, fear of being

labeled a "bad mother," or feelings that the health care system is not heard or is not taking care of them. In addition, there are also barriers to access support and treatment, such as underfunded services with poor referral systems, large caseloads, too few or untrained staff, or insufficient staff time. (Button et al., 2017; Ford, Lee, et al., 2017; Ford, Shakespeare, et al., 2017; Webb et al., 2021).

Strong psychometric qualities and acceptance by women over the course of the perinatal period are prerequisites for the effectiveness of perinatal anxiety tests (Brealey et al., 2010; Coates et al., 2015). According to some research, anxiety levels may vary during the perinatal period (Dennis et al., 2017). Additionally, women may perceive assessment items differently depending on the issues they are experiencing at different points in their prenatal and postpartum lives. For this reason, it is essential that the assessment instruments used at this time be appropriate and pertinent to women. In order to improve perinatal mental health assessment and care at different stages of the perinatal journey, this study intends to investigate women's experiences with and opinions regarding perinatal anxiety assessments.

METHODS

A purposive sample of 41 pregnant and postpartum women participated in a semi-structured qualitative interview study. The interviews were conducted in two stages: an in-depth interview, the results of which are presented here, focused on the acceptability of the assessment tools employed and the experiences of the women with prenatal mental health evaluations. The results of a cognitive interview study conducted in the second section have been published elsewhere

Study sample

Women who were 16 years of age or older, pregnant or within six weeks of giving birth, and have adequate English language skills to engage in an interview were eligible to apply. Social media posts (such those on Facebook and Twitter), information shared during prenatal group meetings, baby events, and word-of-mouth were some of the recruitment strategies used. Each mother was given a drawing entry to win one of two gift cards. Interested women were provided with informed consent forms, eligibility questionnaires, and participant information sheets in hopes of gathering demographic data as well as data on stage of pregnancy, number of weeks postpartum, history of depression, and history of anxiety. The Whooley questions (Whooley et al., 1997) and the GAD-2 (Spitzer et al., 2006) were the clinical questions recommended for the assessment of both depression and anxiety, given the evidence of comorbidity between prenatal depression and anxiety (Miller et al., 2015). The women completed the consent form and eligibility questionnaire and returned them to the researcher. Participants who scored positively for anxiety and depression had follow-up contact with the researcher, were informed about support groups, and were advised to contact their midwife or general practitioner.

Participants were purposively sampled at 12 weeks (n = 6), 22 weeks (n = 6), 31 weeks (n = 13), and six weeks postpartum (n = 16) in two countries, England and Scotland. This method allowed for a detailed examination of the various issues that arise during the perinatal period as well as an examination of the ways in which various stages affected the acceptance of assessment instruments. Women who met the GAD-2 and Whooley question scores, respectively, above or below the required criteria for anxiety and depression as indicated by NICE recommendations, were eligible to participate. Of the individuals, 46% scored higher above the NICE-recommended cut-offs for likely anxiety and/or depression. Twelve participants did not have a history of mental health problems, whereas 29 participants did, and 23 of the 29 who did reported having had therapy. Of the participants, the majority (61%) were pregnant, and all (n = 24) were from England and all (17) were from Scotland. The majority of participants (93% were White and Caucasian), 93% were employed, and 85% had completed at least one degree. Complete demographic details can be found elsewhere (Meades et al., In press).

Data collection

To schedule interviews at a time and location that worked for them—such as at home, a health center, or a university—women were called. If an in-person encounter was not possible, participants also had the option of participating in an online video interview. The interviews comprised parts 1 and 2 and lasted up to 95 minutes in total. They were conducted by three psychology researchers with experience in conducting qualitative interviews. In particular, the CORE-10 (Barkham et al., 2013), GAD-7, SAAS (Sinesi et al., 2022), and Whooley questions were used to assess participants' experiences and views on the acceptability of different perinatal mental health assessments in these interviews. An interview guide was developed based on seven indicators that constitute a theoretical framework for the acceptability of health intervention put forward by Sekhon et al. (2017), which were defined: affective attitude, burden, perceived effectiveness, ethicality, intervention coherence, opportunity costs, and self-efficacy. At the beginning of each interview, an opportunity to ask questions was given, and consent was again sought from participants. Participants who reported current mental health issues at the time of interviewing were provided with information about support groups and the opportunities for self-referral to psychological treatment. The interviews were recorded digitally, transcribed verbatim, and anonymised.

Data analysis

NVivo software was used to do a thematic analysis of the qualitative interview data. In accordance with Braun and Clarke's iterative process of thematic analysis (Braun &

Clarke, 2006), the analysis started with a deductive framework based on Sekhon et al.'s theory of acceptability (Sekhon et al., 2017). This was followed by inductive open coding to capture unexpected or emergent themes. Line by line, transcripts were coded using either the framework's preexisting codes or newly created descriptive codes as needed. The study team held regular talks with CY, a medical anthropologist with experience in thematic analysis, throughout the analysis phase to ensure dependability. CY handled the majority of the coding and analysis. After reviewing 5% of the quotes, the two researchers (AS, RM) who conducted the interviews were able to verify the interrater reliability with an 82% interrater reliability. Discussions were used to settle any disputes.

RESULTS SUMMARY

The results are arranged according to the acceptability framework developed by Sekhon et al. (2017) and categorized into three main themes: enhancing support and raising awareness, monitoring and stratifying care, and enhancing care and fostering trust.

Overall acceptability

While most participants thought routine perinatal mental health screenings were helpful, they did point out that these evaluations were frequently sporadic during maternity or postpartum care. Concerns were raised regarding what would happen if they achieved a higher score than others; some ladies were afraid social services would become involved.

Overarching themes

1. **Raising Awareness and Improving support**
   - Assessments were viewed as tools for raising awareness and normalizing discussions about perinatal mental health. Participants highlighted the need for more frequent assessments, especially during pregnancy.
   - Example: "It would have been good to be asked questions in pregnancy, because I was really anxious during pregnancy and maybe if I'd have been asked some questions or given some kind of questionnaires, it might have flagged to someone." (EP04)

2. **Surveillance and Stratifying care**
   - Participants preferred completing assessments privately to avoid pressure. There was concern that assessments might act as ‘gatekeeping’ for access to further support, potentially limiting services to those who scored higher.
   - Example: "For me, it's to almost like a qualification to get in to access certain services basically." (EP01)

3. **Personalizing Care and Building trust**
   - The importance of connecting assessments to further care was emphasized, with a need for clear communication about the purpose of the questions and the outcomes.
   - Example: "I think it's quite an impersonal way to talk about a very personal issue." (EP15)

   Overall, while the routine perinatal mental health assessments were viewed positively, the findings highlight the need for more transparent communication, personalized care, and assurance that assessments would lead to tangible support.

DISCUSSION

Women's perceptions of perinatal anxiety assessments were generally positive, with most recognizing the need for increased and improved assessments. They viewed these assessments as beneficial, primarily as tools for raising awareness about mental health during the perinatal period and for normalizing discussions around it. Opinions about the assessment questionnaires, however, were more mixed. While some felt that the process easily slipped into being merely an administrative task, others thought it depersonalized care and created very little opportunity for meaningful discussion around mental health. This mirrors the conclusions of previous work in Ireland, where women also regarded questionnaires as both a box-ticking exercise and as a useful way to identify perinatal mental health issues (Nagle & Farrelly, 2018). The current study indicates that these attitudes are prevalent and change over the perinatal period. For many participants, the perception of the assessment as administrative only affected its efficacy and impacted their level of information disclosure.

Many of the participants were unclear about the potential implications of obtaining a high score on an anxiety screening, such as whether they would be referred to specialist services. Uncertainty about this reflects more broadly an issue with low mental health literacy among women, including the ability to recognize perinatal mental health problems, which often is what stands in the way of help-seeking. (Daehn et al., 2022). Some participants felt that many women would not understand perinatal mental health or know how to tell more general pregnancy-or postpartum-related experiences apart from perinatal anxiety. Although this was less of a barrier to help-seeking per se, it did impact the way in which women approached and used assessments. This suggests the need not just for educating women about perinatal mental health but also, importantly, for clearly explaining the rationale for assessment and what might follow.

Factors at the structural and organizational levels also impacted on women's experiences and acceptance of the assessments. Indeed, there were different opinions expressed about the best timing and location for assessment, which may change as focus shifts from the antenatal to postnatal period, calling for flexibility within perinatal mental health services (Webb et al., 2021). Rigid or inflexible assessment practices might deter engagement, and other barriers, such as the accessibility of appointments, childcare problems, and staff

workloads, further complicate help-seeking (Daehn et al., 2022; Nagle & Farrelly, 2018).

In addition to structural barriers, sociocultural factors such as stigma, shame, and fear related to mental health significantly influenced disclosure and the acceptability of assessments. Stigma, a recurring theme in perinatal mental health research (Nagle & Farrelly, 2018; Webb et al., 2021), was particularly linked to concerns about how a woman's ability to parent might be judged if she scored highly on an assessment. The notion of surveillance—where assessment tools are not seen as neutral but as extensions of institutional and societal expectations—suggests that assessments can both enable and constrain how mental health is understood and addressed (Button et al., 2017). For example, participants referred to the concept of "gatekeeping," where the categorization of anxiety severity during assessment may reinforce clinical assumptions and potentially limit access to further support and care. This stratification of experiences reflects broader societal issues of "stratified reproduction," where support for reproductive activities is unevenly distributed among different groups (Colen, 1995).

The findings of this study align with recent recommendations that perinatal mental health services should be women-centered and operate within a structure that promotes continuity of care (Webb et al., 2021). Trusting relationships between women and healthcare providers are crucial for facilitating help-seeking and disclosure, and continuity of care plays a key role in establishing this trust (Nagle & Farrelly, 2018; Oh et al., 2020). The assessment should be guided, tailored to women's unique circumstances, and conducted in a setting whereby women feel at ease, clearly informed of the purpose of the assessment, with the repercussions that may follow, within a clear communication strategy, if possible, integrated into a model of continuity of care.

CONCLUSION

Overall, study participants viewed perinatal anxiety assessments as positive and generally acceptable. However, the effectiveness and acceptability of the perinatal anxiety assessment were influenced to a great degree by the extent to which the process was perceived as informed and personalized. The findings suggest that assessments are not neutral processes; they become entwined with institutional practices and broader sociocultural norms, and effectiveness may be compromised if they are seen to be merely perfunctory. Hence, the approaches to assessment must be flexible, tailored to different stages of the perinatal period, and placed within continuity of care. It is also essential to consider how structural and societal barriers may evolve throughout this period and continue to impact women's engagement with perinatal mental health assessments.

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