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ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/rapy20

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To cite this article: Peta N. Maguire, Gavin I. Clark, Suzanne M. Cosh & Bethany M. Wootton (2024) Exploring experiences, barriers and treatment preferences for self-reported perinatal anxiety in Australian women: a qualitative study, Australian Psychologist, 59:1, 46-59, DOI: 10.1080/00050067.2023.2236281

To link to this article: https://doi.org/10.1080/00050067.2023.2236281

Published online: 05 Oct 2023.

AUSTRALIAN PSYCHOLOGIST
2024, VOL. 59, NO. 1, 46–59
https://doi.org/10.1080/00050067.2023.2236281

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ORIGINAL ARTICLE

Exploring experiences, barriers and treatment preferences for self-reported perinatal anxiety in Australian women: a qualitative study

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ABSTRACT

Objective: Perinatal anxiety (PNA) is common, yet few studies have examined the perceived barriers to accessing mental health services and treatment preferences for women in the perinatal period. Further, there is a lack of research specifically exploring Australian women's perspectives on treatment preferences for PNA.

Method: The current study explored the views of 20 women ($M_{age} = 34.65$, $SD = 8.68$) who were experiencing, or who had previously experienced, PNA using semi-structured interviews. The interview questions focused on their experiences of PNA, the perceived barriers and facilitators to accessing treatment, and participants' preferences for treatment.

Results: Verbatim scripts were analysed using inductive thematic analysis and several global themes were identified, including 1) uncertainty concerning changes during pregnancy and postpartum; 2) making sense of pregnancy, motherhood, excessive worries concerning fear of labour, and fear of caring for the baby and anxiety symptoms; 3) treatment preferences; 4) accessibility as facilitators to accessing therapeutic support; and 5) stigma regarding being a "good enough" mother. Each global theme encompassed several organising themes.

Conclusions: The results of the study identified several common experiences of PNA and indicated numerous barriers and expectations in relation to treatment uptake. The findings from this study can be used to inform future service design and delivery for the treatment of PNA.

KEY POINTS

What is already known about this topic:

(1) Perinatal anxiety is often undiagnosed and undertreated.
(2) Treatment uptake for perinatal anxiety is low despite effective treatments being available.
(3) Several barriers to accessing mental health treatment in the general population exist.

What this topic adds:

(1) Women with perinatal anxiety experience several specific barriers to accessing treatment.
(2) Treatment uptake and the delivery of psychological care for perinatal anxiety may be enhanced by reducing barriers, and by increased education regarding available treatment option.
(3) Online treatments may be a more accessible treatment option for those with perinatal anxiety than traditional face-to-face treatment.

ARTICLE HISTORY

Received 18 September 2022
Accepted 5 July 2023

KEYWORDS

Anxiety; perinatal; preferences; treatment barriers; qualitative

Pregnancy characterises an important time of transition physically, psychologically and socially for women. A woman's identity is significantly altered during pregnancy, and whilst this can be a time of joy, it can also be a difficult time which may lead to perinatal anxiety (PNA). Whilst most women will report worries and fears about the health of their baby, complications during birth, changes to their body, changes to their partner relationships, and their ability to care for their baby (Williams & Koleva, 2018), one in six women experience clinically significant anxiety during the perinatal period, defined as the period encompassing pregnancy up to 12-months postpartum (Austin et al., 2017). PNA is characterised by excessive fear and anxiety, as well as related behavioural changes (Austin et al., 2017). PNA has important health consequences and risks for both the mother and infant (Nicol-Harper et al., 2007). Despite the prevalence and impairment associated with PNA for both mother and infant (Grigoriadis et al., 2018; Rees et al., 2019), it is often undiagnosed (Ride et al., 2016) and under-treated (Kendig et al., 2017) in clinical practice.

There is currently limited research exploring women's lived experience of PNA, and the data that does exist is generally limited by examining PNA and depression transdiagnostically, rather than each condition individually (e.g., Highnet et al., 2014). For instance, Hore et al. (2019)

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recruited seven women attending an antenatal clinic in the United Kingdom who self-reported anxiety to qualitatively explore their experiences of PNA. The results of the study indicated that anxiety was generally focussed on pregnancy, uncertainty regarding pregnancy and motherhood. Whilst the abovementioned study highlights women's experiences of PNA in the United Kingdom, further research exploring women's experiences of PNA in diverse samples and other healthcare settings is needed in order to enhance our understanding of women's needs during the perinatal period and women's engagement in treatment.

A recent review by Silverwood et al. (2022) summarised the current literature of PNA, including treatments available. The review found that treatment guidelines currently recommend pharmacological or psychological treatment, including interpersonal therapy and cognitive-behaviour therapy (CBT). Whilst there is established evidence that these therapies are effective in the general population, evidence supporting the effectiveness in the treatment of PNA is emerging (Silverwood et al., 2022). Preliminary evidence supports the use of CBT for the treatment of PNA (Maguire et al., 2018) in individual (Milgrom et al., 2015) and group-based face-to-face delivery (Bittner et al., 2014), as well as low intensity internet-delivery (Forsell et al., 2017; Loughnan et al., 2019). More recently, remotely delivered treatments have gained significant research attention in the general population and have been shown to be efficacious for anxiety and related disorders more generally (Brenes et al., 2015; Carpenter et al., 2018; Hedman et al., 2016; B. Wootton et al., 2018; B. M. Wootton et al., 2019). Such remote treatment options may help to reduce barriers to treatment for individuals with PNA. Despite the availability of a variety of CBT treatment options for women with PNA (e.g., incorporating remote approaches), few studies have explored women's treatment preferences during this period. It is possible that women who are pregnant, or have a small child, may prefer remote delivery options over more traditional face-to-face services.

Research to date has demonstrated that women in the perinatal period generally prefer psychotherapy over pharmacotherapy (Goodman, 2009; Ride et al., 2016). Individual treatment options are also preferred over group-based treatment options (Ride et al., 2016), which is consistent with treatment preferences for individuals with anxiety and related disorders more generally (McCausland et al., 2021; Robertson et al., 2020). However, this preference for individual over group-based treatments may be influenced by previous mental health experiences, as well as baseline anxiety symptoms (Goodman, 2009). While the existing literature provides some evidence to suggest that women experiencing perinatal mental health problems may prefer certain treatment approaches over others, there is limited research exploring treatment preferences for women specifically with PNA when the broad range of CBT treatment options are included. Given the unique challenges faced during the perinatal period, further research examining whether these treatments are acceptable to individuals with PNA is warranted, including in the Australian context.

Despite treatment options being available, there are a number of barriers to accessing psychological support during the perinatal period (Goodman, 2009; Millett et al., 2018; Woolhouse et al., 2009). For instance, qualitative interview-based and quantitative studies conducted from westernised samples [i.e., North American (Goodman, 2009), Irish (Nagle & Farrelly, 2018), Australian (Woolhouse et al., 2009)], the top perceived barriers to obtaining professional help in the perinatal period were stigma/shame and lack of time. The existing literature on the barriers to mental health treatment for PNA has several limitations. Much of the research conducted on perinatal mental health, to date, focuses on perinatal depression rather than PNA. Furthermore, existing research on PNA has primarily employed questionnaires focussing on perceived barriers rather than any in-depth exploration of subjective experiences of PNA. Additionally, research specifically evaluating PNA in the Australian context is scarce. In addition to these limitations, uptake of treatment for PNA remains low (Schmied et al., 2013). Furthermore, much of this research was conducted over a decade ago and treatment barriers and preferences may have changed during this time in response to changes in healthcare systems and service delivery options, thus a contemporary investigation of treatment barriers in an Australian sample is urgently needed.

The aim of the current study was to enhance the existing literature by examining the following research questions using a qualitative approach: 1) what are the experiences of women who have suffered from PNA 2) what do women perceive as the main facilitators and barriers to accessing treatment during the perinatal period; and 3) what are women's preferences for treatment of PNA? The findings may inform mental health policy and guide how to best deliver CBT to women experiencing PNA, especially within Australia where this research is limited.

Method

Design

A qualitative design using thematic analysis was utilised. Qualitative approaches are well suited to exploratory

research such as the current study. An essentialist approach was utilised, where a simple unidirectional relationship was assumed between meaning, experience, and language (Braun & Clarke, 2006). The essentialist approach informed the interview guide and data analysis.

Ethical approval was obtained from the Human Research Ethics Committee at the University of New England (HE18–181). Participants were recruited through advertisements posted on online social media pregnancy related platforms. The study advertisement contained a link which took the participants to the online participant information sheet, requesting participants to read before emailing the researcher to arrange a telephone interview time. No ethical issues arose during the interviews.

Participants

A purposive sample of 20 women who self-reported either they were currently experiencing or had previously experienced PNA were recruited (age range 23-55 years; $M_{age} = 34.65$, $SD = 8.68$). Women were eligible to participate in the study if they: 1) were 18 years of age or over; 2) competent in written and spoken English; and 3) currently or previously suffered from anxiety (self-reported) during the perinatal period. To ensure a variety of views and experiences, women who had and had not accessed past help-seeking were eligible. The demographic characteristics of the sample are outlined in Table 1.

There are several factors which may contribute to determining the required sample size when conducting thematic analysis in qualitative research (Baker & Edwards, 2012). Data saturation, considered to have occurred when the gathering of, and the analysis of, new data does not return additional themes, is considered an adequate criterion for determining sample size. A variety of empirical studies have indicated that 12 participants (Guest et al., 2006) is sufficient for data saturation to have been achieved, that is, when additional data does not provide new information (Mason, 2010). Based on this indicative number, 12 participants were initially recruited. Transcripts of the interviews were reviewed simultaneously as data was collected. Review of the interview transcripts for the 12 participants recruited indicated that new information and perspectives were generated across the final four interviews conducted. Consequently, a further eight participants were recruited and interviewed using the original interview questions, providing a final sample size of 20 participants. Data saturation was judged to have occurred as the responses of the initial 15 participants yielded the same global and organising themes as the responses of the total sample of 20 participants (see "Data Analysis" section for further details).

Table 1. Sample demographics ($N = 20$).

Variables	*N*	%
Pregnant at time of interview	3	15
Previously pregnant	17	85
Nulliparous	1	5
Primiparous	7	35
Multiparous	12	60
Relationship status		
Relationship	18	90
Single	2	10
Ethnicity		
Caucasian	20	100
Highest level of education completed		
Secondary school qualification	3	15
Trade certificate	3	15
University bachelor level qualification	10	50
University postgraduate qualification	4	20
Employment Status		
Employed full time	5	25
Employed part time	8	40
Maternity leave/ home duties	6	30
Unemployed/ unable to work	1	5
Private Health Insurance		
Yes	15	75
No	5	25
Accessed mental health support previously	12	60
Accessed support due to anxiety alone	7	35
Accessed support due to anxiety and depression	5	25
Geographical location		
RA1	9	45
RA2	3	15
RA3	6	30
RA4	1	5
RA5	1	5

Note. Australian Rural, Remote, and Metropolitan Areas (RRMA), where RA1 is a major city, RA2 is an inner regional area, RA3 is an outer regional area, RA4 is a remote area, and RA5 is a very remote area (Australian Institute of Health and Welfare, 2016).

Procedure

Interviews were conducted via telephone by the first author between December 2018 and January 2019. Verbal consent was provided at the commencement of the interview and participants were given the option to withdraw from the telephone interview at any time. Participants were provided emergency contact details on the participant information sheet and were aware of the nature of the interview questions prior to the interview. Interviews lasted between 15 and 45 minutes and were audio recorded then transcribed verbatim by the first author.

A brief demographic questionnaire was administered by the interviewer which included questions relating to demographics (i.e., age, education, mental

health history). Following the demographic questionnaire, participants engaged in a semi-structured interview. Open-ended questions allowed for exploration of participants' experiences and participants areas of importance. The interview questions were developed based on the literature and are outlined in Appendix.

Data analysis

Data were analysed using inductive thematic analysis guidelines (Braun & Clarke, 2006, 2019). Initial codes were identified from the data (PM), and coded transcripts were reviewed by the second author (GC). The authors then met to discuss each code and discuss any discrepancies. Initial codes were then condensed into emergent themes by the first author (PM) based on their conceptual overlap and similarities in discussion with co-authors. Recurring themes were determined based on reflection across the responses of at least two participants. Themes were derived from the entire interview rather than from single questions. Themes were reviewed in consultation with the second author to ensure rigour and validity of the themes and then organised under "organising themes" (i.e., themes that organise the basic themes into clusters of similar themes) and "global themes" (i.e., overarching themes). Following this, through discussion, themes were further refined.

As qualitative researchers bring their own experiences, it is important the research team outline their professional and individual backgrounds to ensure transparency and replicability (Smith et al., 2009). The first author (PM) was aware that having no personal experience of pregnancy or parenting may have brought naivety, however also an unbiased perspective. Her academic and professional experience of clinical psychology in the public health system offered perspectives regarding anxiety, available treatments, and navigating health systems. The research team consisted of three clinical psychologists, two of whom were women (SC; BW), one of whom was a mother (BW), one whom was a father (GC), and two of whom are researchers of anxiety (GC; BW). Regular discussions regarding the transcripts, codes and themes and a thorough review of the results by all authors provided opportunities for the authors to attend to bias.

Results

Themes were identified across participant responses relating to women's experiences of PNA, the main facilitators and barriers to accessing treatment and treatment preferences during the perinatal period. The dominant themes arising from the analysis were categorised within two overarching headings *Common Experiences of PNA and What Treatment Would Ideally Provide* and *Facilitators and Barriers to Accessing Treatment in the Perinatal Period*. Within these, the findings are represented by five global themes which encapsulate several organising themes, as outlined below. The thematic networks can be seen in Figures 1 and 2. These themes are outlined below.

Common experiences of PNA and what treatment would ideally provide

In response to discussions regarding women's experiences of pregnancy and PNA, most participants discussed their uncertainty regarding the changes experienced during pregnancy and postpartum, difficulties transitioning to motherhood, adapting to their new personal identity, and their desire for validation regarding their ability as a mother and partner.

Global theme: uncertainty concerning changes experienced during pregnancy and postpartum

Participants reported that pregnancy and motherhood-related changes affected most areas of women's lives, including *"limiting general functioning"* (P1), feeling *"emotionally unstable. . .hormonal"* (P14), and *"sensitive"* (P2) (Figure 1). Participants discussed how such changes appeared to precipitate the development of their anxiety.

Altered functioning in both mental and physical health. Participants discussed experiencing altered functioning in both their mental and physical health during pregnancy. Participants described their mental health functioning in terms of one's overall ability, the interaction between physical and emotional health, and the ability to cope with day-to-day life. Participant 14 explained mental health as:

> your ability, your emotions and how it comes together to make you function as a person, so your physical health too ….

Changes in physical appearance reinforced the experience of change from a different perspective, and several participants discussed feeling worried about their weight gain and their attractiveness. Participant 12 stated:

> I also felt worried about my weight gain and didn't feel like myself. My identity was compromised … I wasn't sure how to dress my new shape …. I worried about how I would get back into shape … whether or not my partner would find me attractive.

Furthermore, several participants identified that a lack of sleep resulted in them feeling more exhausted, tearful and angry. Participants discussed:

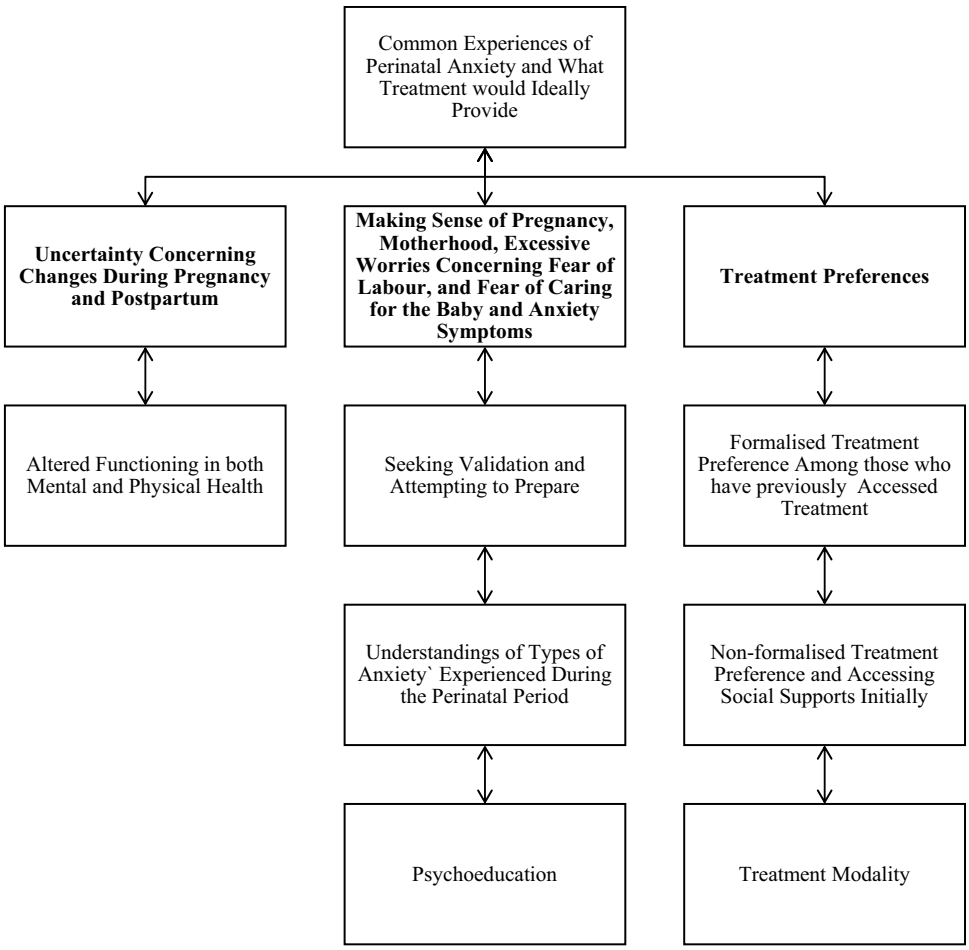

Figure 1. A thematic map of common experiences of PNA and what treatment would ideally provide.

> Experiencing a lot of mistrust in people who were meant to be supporting me [referring to friends and family] (P9); and being
>
> Hesitant to give my baby to others … . because I feared whether others would care for [baby] properly. (P12)

Global theme: making sense of worries and fears across the perinatal period

In response to discussions regarding women's experiences of pregnancy and PNA, the majority of participants discussed their difficulties transitioning to motherhood, adapting to their new personal identity, and their desire for validation regarding their ability as a mother and partner. Further, participants reported experiences of anxiety driven by worry, with worries relating to "*… something would go wrong [with birth or the baby]*" (P13) and worry about being perceived as "*an unfit parent*" (P5).

Seeking validation and attempting to prepare. Half the sample reported feeling underprepared during pregnancy and discussed the perinatal period as an overwhelming time. One participant reported:

> I was trying to seek a lot of help, but I was confused and overwhelmed by the advice I was getting from family and mental health professionals, and I didn't know whose advice to follow. (P9)

Furthermore, participants indicated their anxiety was often experienced due to feeling underprepared for a baby and having insufficient knowledge and information regarding motherhood. Throughout the interviews there was a theme of participants wanting to feel validated so that they "did not feel bad about *[themselves]*" (P11). Participants who had previously accessed formalised treatments discussed feeling "*liberated*" (P7) after finding out that their symptoms are *"really common"* (P7), "*normal*" (P19), and that they can "*fix*" (P19) their symptoms with support.

Several participants discussed how they frequently sought validation from their supports, however a number of participants stated that this often resulted in higher anxiety. One participant highlighted that speaking to supports can be invalidating:

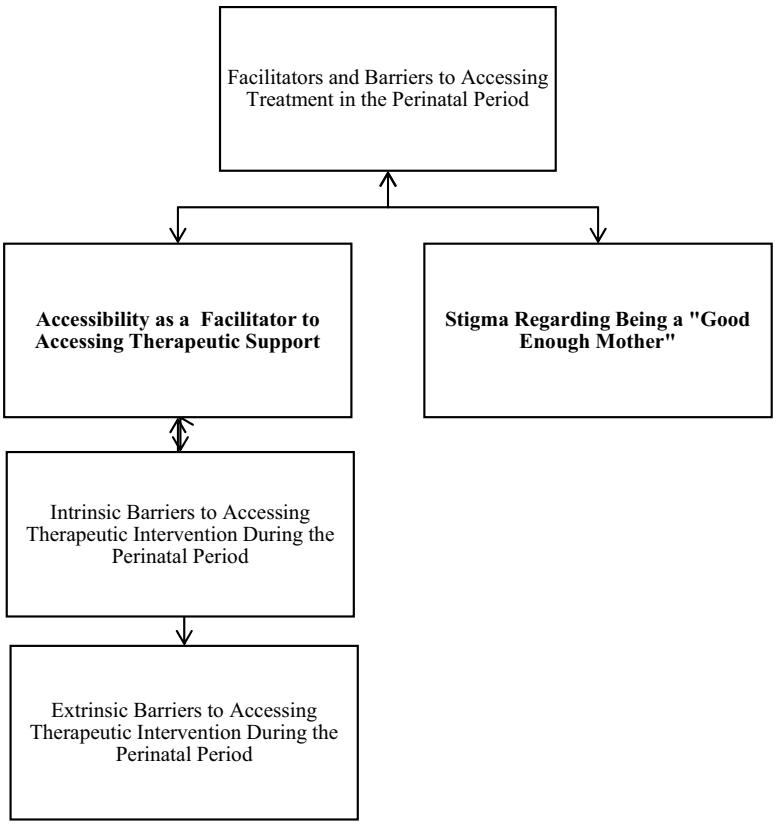

Figure 2. A thematic map of "facilitators and barriers to accessing treatment in the perinatal period".

> My mum and I are really close, and you know had a chat to her about my feelings of anxiety and also my husband, . . . they've never experienced mental health issues so they kind of just put it under the rug and said you'll be right it's only a temporary thing, so it kind of took me awhile to go out on my own and seek help. (P8)

Furthermore, some participants indicated that they would search online when concerned about their baby or their parenting abilities or to search for information. Participant 2 stated:

> When I became pregnant, I was Googling a lot . . . there is a lot of stuff to Google, and you just want to have your baby and have everything go well.

Understanding of types of anxiety. In response to the negative perceptions of their pregnancy and motherhood experiences, participants reported difficulties adjusting to motherhood, and coping post birth. In addition to describing anxiety symptoms generally, the majority of participants described their anxiety symptoms using a diagnostic label. Several participants described difficulties recognising their own anxiety and described feeling that they were "*on edge*" (P9) and feeling as though they "*overthought everything*" (P16).

Several described their primary concerns and worries related to parenting efficacy, including breast feeding, giving their baby adequate nutrition, and the impact of the baby on the family unit. Participant 12 highlighted several worries that perpetuated her anxiety:

> I also worried about whether or not my baby was getting enough milk and about SIDS [Sudden Infant Death Syndrome]. I worried about my baby crying and became very anxious in situations where I thought my baby might cry e.g., in the car, in the shops, during social visits/appointments. . . I avoided driving anywhere or doing anything . . . . I slept with my baby in bed with me rather than in the cot.

Participants who had multiple children discussed the increasing anxiety they experienced with subsequent births. Participant 4 summarised her experience of perinatal anxiety:

> I have suffered from perinatal anxiety. . . . I didn't realise it was actually quite a distressing experience for me until I got pregnant with my fourth child and I was having major anxiety attacks and not coping at all. purely because of the labour.

Participants indicated that information and strategies to manage such worries and fears would be an integral

part of treatment during the perinatal period, as the worries caused great distress for participants.

Psychoeducation. Several participants indicated that an important component of standard perinatal care should include information on support and mental health services available. Participant 8 discussed feeling underprepared and stated:

> I don't think I was very well informed about how to look after myself after having children. We also weren't told, we weren't given brochures during pregnancy about different mental health providers to contact during pregnancy.

Participants discussed wanting information that made them feel *"normal"* (P10). Participant 13, had previously accessed mental health support, and highlighted the importance of having a mental health professional normalise their experience, stating:

> Talking to someone really helped me both times in realizing that … what I was feeling was normal. It was normal to feel overwhelmed after having a baby as your life is changing.

Furthermore, participants highlighted that their expectations of treatment would include:

> Coping strategies … a mental script to go through when you're feeling anxious to manage them … activities to do when you're having thoughts … understanding the causes of the anxiety. (P20)

Responses suggested psychoeducation on practical tools, such as

"*the right way to get my baby to sleep, or feeding my baby, or enjoying time with my baby"* (P9), as well as "*information about medication"* (P17) would also be beneficial in treatment.

Global theme: treatment preferences

In response to discussions regarding women's ideal treatment preferences, three themes were found to capture participants' preferences, namely *formalised treatment preference among those who have previously accessed treatment., non-formalised treatment preferences and accessing social supports initially*, and *treatment modality* (Figure 2).

Formalised treatment preference among those who have previously accessed treatment. The majority of participants indicated a preference of formalised treatments when reflecting on their past or current experience of PNA. A preference for formal treatment was particularly common in participants who had previously accessed a mental health service. Several participants described their General Practitioner as their first point of contact, and these participants indicated they would prefer to access a psychologist that their medical practitioner had recommended. Those participants who had previously accessed treatment discussed wanting "*practical*" (P7) treatment involving "*problem solving"* (P12) and "*cognitive behavioural therapy"* (P11). Furthermore, many participants indicated they would consider accessing a "*psychiatrist*" (P17) or *"medication"* (P15). Participants who indicated they would consider pharmacotherapy recalled their past experiences with mental health during the perinatal period and discussed their preference for preventative practices in relation to medication to reduce the likelihood of relapse. Examples given for preventive measures included a collaboratively created "*[relapse] plan"* (P17) with all of the treating team involved.

Non-formalised treatment preference and accessing social supports initially. Several participants indicated they would initially contact social supports, such as friends and family, or join a mother's group for additional support rather than access professional support or treatment. Participant 9 recalled:

> I joined a mother's group … 1 or 2 of the other mums were experiencing similar things which helped me push through.

The majority of participants that discussed their preference for non-formalised treatments indicated that they would "*contact supports [Lifeline or GP]"* (P5) if the severity of their symptoms increased. Moreover, participants who indicated that they would contact formal supports if their symptoms worsened had histories of accessing supports previously.

Treatment modality. The majority of participants indicated a preference for accessing services "*face-to-face"* (P7) opposed to accessing services over the phone or over the internet due to it feeling more "*personal"* (P7) and *"rapport"* (P4) being better established in face-to-face treatment. Whilst face-to-face was most participants' preference, several participants indicated they would also utilise treatments over internet-videoconferencing. Participant 11 described a preference for treatment delivered over videoconference, stating:

> Preferably Skype because then you can do it while your baby is asleep, at home, especially when they are quite young, because trying to find someone to look after them for you can be quite a big anxiety in mothers lives as well.

Participants from rural or remote geographical locations perceived remotely delivered treatments as more acceptable and highlighted the barriers that this treatment modality would reduce (i.e., distance, time, childcare costs etc.). However, participants also identified that internet connectivity is often poor in such geographical locations.

Participants also indicated their preference of having a *"choice"* (P14) in treatment modality, and several participants indicated they would access several different treatment modalities to suit their needs. Despite treatment modality, participants highlighted the importance of *"rapport"* (P17) and feeling *"a connection"* (P8) with the therapist. Participants who had previously accessed support services discussed their past positive and negative experiences with therapists and rapport building.

Facilitators and barriers to accessing treatment in the perinatal period

Global theme: facilitators to accessing therapeutic support

The responses of the majority of participants highlighted the importance of treatments that are accessible and flexible, such as home visits and after-hours appointments. One participant with past experience explained that supports that offered stability and continuity were supports they would more likely engage in:

> … continuity and stability … having the experience and support of perinatal support previously for the anger I had, they definitely weren't as good as having the continuity care throughout pregnancy and after. (P4)

Moreover, the discussions relating to facilitators and barriers to accessing care highlighted several extrinsic and intrinsic barriers to accessing interventions (Figure 2). Within this theme a range of organising themes related to intrinsic and extrinsic barriers to accessing therapeutic support were identified.

Intrinsic barriers to treatment. An important organising theme was that of intrinsic barriers to accessing intervention during the perinatal period. When queried, barriers to accessing treatment were reported by several participants, with all participants highlighting strong beliefs about being time poor. Participants further highlighted subjective denial and a lack of persona insight and awareness regarding the severity and impact of their symptoms and difficulties, which prevented them from seeking help. One participant described several intrinsic barriers to accessing support, stating that during the perinatal period:

> … time management and identifying that you may need help, you may be in denial and just keep trying to cope, I was so busy with my work and baby that I would forget to look after myself. (P4)

Additionally, participants outlined several other intrinsic barriers, for example one participant reflected on cultural beliefs and lack of knowledge:

> I think cultural beliefs around it and lack of education too, a lot of people haven't heard of perinatal anxiety but have heard of depression. (P20)

Extrinsic barriers to treatment. Participants also discussed several extrinsic barriers to accessing treatment, including lack of treatment availability, long waiting periods, financial difficulties, and phone or internet connectivity issues. One participant explained the financial barriers, wait times and difficulties leaving the house during the perinatal period:

> There's financial reasons … getting in to see a psychiatrist can be [difficult], … there's long waiting periods and seeing a psychiatrist [or] psychologist is expensive, there's the stigma … not knowing what supports are out there, a lack of information about medication during the perinatal period … there's not always awareness that they [supports] exist or they aren't easy to get to and sometimes leaving the house is difficult (P17)

Furthermore, the majority of participants from rural or remote geographical locations (RA3-RA5) identified *"distance"* and *"living remotely"* as the main barrier to accessing treatment. Participants described several of the barriers associated with residing in a rural location:

> Distance … with my husband being away all the time it's hard to get your baby and drive 5 hours just to do something for yourself … and being isolated [is most difficult]. (P3)

Global theme: stigma regarding being a "good enough" mother

Perceived stigma regarding being a good enough mother was a theme identified as a core barrier to accessing treatment (Figure 1). Participants discussed feeling worried about accessing services due to the stigma associated with mental health and help-seeking. One participant explained:

> … it's hard to speak to someone and being afraid to admit it [anxiety] and being told you are doing the wrong thing, or that something is wrong with you when you're already thinking … about if you're raising a baby right …. (P5)

More specifically a barrier to accessing treatment was concerns about professionals and services taking the infant off the mother due to her mental health problems. Participants explained:

> … in general conversation with other friends when they've been struggling, their biggest concern is being labelled a bad parent and having them [Community Services] take their baby … away cause you're not ok, that kind of thing is the main reason. (P7)

While several participants reported concerns about stigma and indicated that treatment should address this, such concerns were particularly reported by those who had previously accessed a mental health service.

Discussion

The aim of the present study was to explore Australian women's experiences of PNA, as well as treatment preferences during the perinatal period. The study further aimed to gain an understanding of the perceived barriers and facilitators specific to accessing treatment during the perinatal period. The findings from the current study highlight that the focus of anxiety during the perinatal period includes the baby (i.e., worries about caring for a baby), relational connections, self-identity (i.e., fear of body image changes, fear of lost or changed identity) and concerns regarding the way other people will perceive them. Further, the findings in this study revealed that most women found adjusting to the mother role during the perinatal period difficult.

While it is common for mothers to experience negative thoughts after childbirth due to social and physical changes (Copeland & Harbaugh, 2019), the current study found several women experienced anxiety in relation to their self-identity and the changes to their physical appearance. Participants in the current study noted difficulties transitioning to motherhood and verbalised increased stress during this period. These feelings are supported by the existing research that affirms that the transition to motherhood elicits changes in emotional wellbeing (Copeland & Harbaugh, 2019; Mercer, 2004). In regard to adapting to motherhood, participants reported difficulty adjusting to being a mother, and highlighted concerns in relation to taking care of their baby. This is consistent with previous research, which has found that despite preparatory efforts during the perinatal period, the process of becoming a mother and adapting to motherhood can be difficult, which results in mothers feeling overwhelmed and underprepared (Choi et al., 2005; Mercer, 2004). Furthermore, women discussed excessive information seeking due to feeling overwhelmed, which in turn resulted in feeling more worried and overwhelmed due to the conflicting information they received regarding motherhood. This finding is consistent with past studies exploring anxiety and information seeking in the general population, where it has been found that increased information seeking in response to change is correlated with increased anxiety (Charpentier et al., 2022). The study adds to the limited literature regarding PNA, especially within the Australian context.

Furthermore, the current study identified several barriers to accessing treatment including accessibility, cost, and stigma. Participants also reported focussing on their baby's needs and avoiding their own distress and anxiety, consistent with previous literature exploring postnatal depression (Coates et al., 2014; Razurel et al., 2013). Furthermore, in line with Oh et al. (2020), the current study found participants reported PNA in relation to being perceived as a "bad mother", which may result in withholding disclosure of PNA to healthcare professionals. The results of the current study are consistent with research examining treatment barriers in women with perinatal/postnatal anxiety and depression (Millett et al., 2018; Oh et al., 2020; Woolhouse et al., 2009), however also offer further insight into the barriers experienced by Australian women, especially those residing in rural and remote areas.

Furthermore, in the current study, the majority of participants resided in major cities or inner regional geographical locations, whilst the minority were from outer regional, remote, or very remote geographical locations. Participants residing in rural or remote geographical locations discussed barriers to accessing treatment during the perinatal period, including distance, isolation, lack of support network, and difficulties due to their partner's working away, suggesting that women residing in rural and remote locations may face more barriers than those residing in metropolitan areas and may not access treatment. This is consistent with the existing literature in the general population which indicates that those residing in rural or remote geographical locations in Australia report more barriers to accessing mental health support, including more structural barriers (i.e., costs, distance) and time restraints (Handley et al., 2014), which may be especially amplified in the perinatal period due to childcare difficulties and related costs, and due to time management difficulties associated with having a new born baby. Further research exploring accessible treatment options and facilitators to accessing treatment is needed.

The findings from this study indicate women would prefer face-to-face treatment due to the perception of face-to-face treatment being more personal and leading to the establishment of rapport. However, it is important to highlight that in the current study participant's preference for online/remote treatments may also be due to lack of familiarity with such treatments. Despite this, the majority of participants indicated they would use remote treatments delivered via internet videoconferencing. These findings are consistent with the growing literature in this field demonstrating that while most participants with anxiety and related disorders would prefer face-to-face treatment, a large proportion would utilise remote treatments (Berle et al., 2015; McCausland et al., 2021; Robertson et al., 2020), and for many remote treatments during the perinatal period may be more convenient due to it minimising the barriers, such as childcare costs, travel distance, associated with face-to-face treatments.

Interestingly, several participants in the current study indicated their interest in pharmacotherapy. This finding is inconsistent with previous research in similar populations (Arch, 2014), which found that women in the perinatal period prefer non-pharmacological treatments. This may be explained by the high number of participants in this study who reported being well supported by a medical team during pregnancy and who have previously accessed mental health support and pharmacotherapy during the perinatal period. Further research in to the acceptability of pharmacotherapy for women in the perinatal period is required.

Clinical implications

The findings from this study highlight several important clinical implications. First, because of the findings highlighting that women are concerned about the meaning and implications of accessing mental health support during the perinatal period, treatments for PNA should use language that is non-stigmatising.

Second, the results emphasise women may feel overwhelmed when provided with a large quantity of information pertaining to pregnancy, motherhood and caring for an infant, however the results also highlight a lack of knowledge and resources in relation to PNA symptomology, comorbidities, prevalence and available treatments in the perinatal period. This raises several practical implications for perinatal treatment providers, including understanding the impact of anxiety on women's capacity to process information provided, whilst considering women's lack of knowledge and awareness of PNA, and lack of knowledge on treatments available. Furthermore, the study found perceived stigma was a barrier to accessing treatment during the perinatal period. Emerging research suggests that despite professionals working in obstetric and women's clinics having a positive attitude towards mental health, their lack of willingness to assess for or discuss mental health is due to a lack of competence and training in mental health (Coates & Foureur, 2019). However, this lack of competence can be addressed with additional training for staff on recognising PNA, which may increase positive conversations regarding PNA with women and reduce perceived stigma. Third, women mentioned they found talking to other women who had experienced or who were experiencing PNA helpful as it normalised and validated their experiences. Despite the findings indicating informal support is helpful, the findings also indicate women's preferences for treatment that is active, and solution focused, that helps them understand their anxiety, and that validates their experiences. Thus, support groups could be offered alongside structured therapy. Additionally, these groups could offer psychoeducation regarding physical and emotional experiences of PNA to assist women in understanding their symptoms. Lastly, treatment during the perinatal period should be accessible for women and provide flexibility in session times and location (i.e., home visits, after hours appointments), which may enhance treatment uptake and adherence.

The findings from this study indicate women are concerned about videoconferencing hindering their ability to build rapport with the therapist. This is consistent with previous research which has shown that rapport is an essential factor underlying successful therapy and client engagement (Simpson & Reid, 2014; Simpson et al., 2005). Despite participants concerns, the existing literature indicates that treatments delivered via videoconference may enhance client engagement and reduce feelings of shame and self-consciousness in the general population (Simpson & Reid, 2014; Simpson et al., 2005). Further, research indicates that clinicians delivering treatments via videoconference also find rapport building a challenge, however that rapport can be established if these difficulties are addressed in session by the clinician and if the clinician displays additional efforts to build therapeutic alliance (Simpson & Reid, 2014). There is also a growing body of research indicating that CBT delivered via internet videoconferencing is effective in the treatment of anxiety and related disorders and results in high rates of treatment satisfaction (Matsumoto et al., 2018). Given the findings from this study indicate women are likely to disengage from treatment if they do not feel a connection with the therapist, remote treatments aimed at women experiencing perinatal mental health issues are likely to benefit from the addition of therapist contact.

The data from this study reflects a breadth of experiences in the perinatal period and show commonalities across women, despite age, geographical location, education, and recency of pregnancy, which might enhance naturalistic generalisability to the broad population of child-bearing women. This study builds on the limited literature investigating women's treatments preferences for PNA and the barriers and facilitators to treatment uptake. Despite providing preliminary data to highlight treatment preferences, as well as barriers and facilitators in this population, several important limitations should be acknowledged.

Strengths and limitations

First, while each participant's experience was unique, more diversity in the sample experience and demographics may have provided broader narratives and may have provided more insights into common experiences of perinatal anxiety, and the perceived barriers and facilitators of engaging in treatment. Second, the inclusion criteria included self-reported anxiety, which was not verified through diagnosis or psychometric measures, thus future research should include self-report severity measures of anxiety and/or a diagnostic interview to confirm an anxiety diagnosis. Research exploring the specific experiences of differing anxiety presentations (i.e., social anxiety, generalised anxiety disorder, obsessive compulsive disorder, birth trauma etc.) may also offer a more comprehensive understanding of women's experiences and their perinatal specific worries and concerns. Third, the entirety of recruitment was conducted online through social media advertisements, thus all participants are likely to have sound online and computer skills, which may have influenced their likelihood in indicating acceptability of online treatments. Fourth, there were a limited number of participants in the perinatal period, and the time between pregnancy and the experience of PNA was not measured. This should be considered in future research, as participants' support systems and the health of the new infant, may have impacted women's treatment preferences and anxiety concerns during this period. Additionally, given the large age range in participants, different services may have been available at different times, and services currently available may not have been a viable option previously. Fifth, participants were not asked about individual factors, relationships and partner supports, or pregnancy experience that might make them more likely to experience PNA. While this was beyond the scope of the current paper, it could be an important avenue for research in the future. Lastly, stated treatment preferences may not translate into actual treatment choices or help-seeking behaviour, thus observational studies may be beneficial in further verifying treatment choices. Despite these limitations, it is anticipated that this research will add to the current knowledge on PNA, barriers to accessing mental health support and treatment preferences in Australia.

Conclusion

The current study explored women's experiences of PNA. The findings offer an in-depth understanding of women's experiences of PNA, as well as women's perceived barriers and facilitators to accessing treatment and women's treatment preferences. The study found that women preferred treatments that are traditionally delivered via face-to-face, however, the results indicate preliminary evidence to suggest that online treatments may be a more accessible treatment option for those with PNA. Whilst online treatments may support improved accessibility for some women during the perinatal period, the results highlighted the issue of connectivity (i.e., internet connection difficulties) for several women, alongside other barriers including cost, and flexibility in session times that were reported for all treatment modalities. Thus, online treatments could be one of many treatment modalities offered to women, and barriers to accessing care need to be addressed in order for treatment to be widely accepted and utilised in this population. Further, the findings highlight the importance of healthcare professionals, such as general practitioners, obstetricians, and community-based support groups, in normalising experiences of PNA and in increasing awareness of treatment options, especially psychological treatments delivered online, to increase formal treatment uptake in this population. Thus, it is recommended that guidelines are further developed to support healthcare providers in understanding PNA and available treatment options.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This research was funded by the primary authors PhD funds, supported by the University of England.

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Data availability statement

The authors confirm that the data supporting the findings of this study are available within the article and its supplementary materials.

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Appendix

(1) What does mental health mean to you?
(2) Could you please describe your understanding of perinatal anxiety?
(3) Have you previously, or are you currently suffering from perinatal anxiety?
(4) What do you think may cause anxiety in the perinatal period? For example are there any worries, fears, or experience that are likely to be particularly anxiety-provoking?
(5) If a you or a friend were suffering from perinatal anxiety what treatment/s would you suggest?
(6) Why would you suggest this treatment?
(7) If you were or a friend were suffering from perinatal anxiety, what type of help would the treatment need to offer?
(8) If you were or a friend were suffering from perinatal anxiety, are there any potential reasons you would not access mental health assistance? If so, what are those reasons?
(9) If you were to access mental health assistance, how would you prefer to access service, for example face-to-face, online, Skype, over the phone, self-help manuals etc., and why?
(10) If you were offered an online treatment program for perinatal anxiety, that you could do by yourself or via Skype, would you be interested? Please explain your answers.
(11) What do you think would make people with perinatal anxiety more or less interested in looking at an online treatment for anxiety so online treatments may be like Skype sessions with professional where you can see them or self-help manuals?