

ANXIETY AND HELP-SEEKING DURING THE PERINATAL PERIOD

**Women's Experience of Perinatal Anxiety and Help-seeking
in the Context of the COVID-19 Pandemic**

by

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A Thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

In partial fulfillment of the requirements of the degree of

DOCTOR OF PHILOSOPHY

Department of Psychology

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Winnipeg

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Abstract

The experience of anxiety in the perinatal period is prevalent with rates rising during the COVID-19 pandemic. While effective psychological treatments are available, help-seeking rates during the perinatal period are low. Despite the recognized importance of supporting the mental health of perinatal women, there is limited literature on the process of help-seeking for perinatal anxiety and the unique aspects of this experience influenced by the context of the COVID-19 pandemic. The aim of the present research was to better understand the experience of perinatal anxiety and to explore the process of psychological help-seeking during the COVID-19 pandemic. Pregnant ($n = 8$) and postpartum ($n = 9$) women were recruited from a hospital-based waitlist for psychological treatment in Manitoba, Canada. Qualitative interviews were conducted and analyzed according to constructivist grounded theory methodology. Participants also completed an online questionnaire, a Mini International Neuropsychiatric Interview (M.I.N.I.), and a mental health graph that assessed perceived mental health. All participants identified having experienced either anxiety and/or depression and sought help for mental health concerns before their current experience of perinatal anxiety. The most commonly experienced anxiety disorder was Generalized Anxiety Disorder, with an average number of three comorbid anxiety and mood disorders. The main themes emergent from the grounded theory analysis included: "Liquid terror" and other experienced symptoms of anxiety; "Here we go again": Recognition and reactions to the re-emergence of anxiety in the perinatal period; Calling in the "Troops": Social support in the context of perinatal anxiety; and "I'm going down all the lists, whom can I call, whom can I get help from?": Help-seeking for perinatal anxiety. These findings suggest that the experience of perinatal anxiety can be both disruptive and disappointing, and that help-seeking can be confusing, and distressing, even when individuals have previously engaged in

help-seeking for mental health concerns. Findings also demonstrated the importance of relationships and social support during the experience of perinatal anxiety and the help-seeking process. Implications for how to better support the mental health of women in the perinatal period are discussed.

Keywords: perinatal anxiety, help-seeking, COVID-19, Constructivist Grounded Theory

Acknowledgements

I would like to thank my co-advisors, Drs. Kristin Reynolds and Patricia Furer for their unwavering support, and guidance. I have learned so much from you both about what it means to be a researcher, clinician, and mentor. I hope to pass it forward one day and look forward to future collaborations. Thank you to my advisory committee, Drs. Gillian Alcolado, Jen Theule, Bev Fehr for your research guidance, and thoughtful feedback. I was so fortunate to have such a supportive team surrounding this work. A special thanks to my research assistants, Ms. Megan Gornik and Ms. Isabelle Hadley for their commitment to this research. I would also like to acknowledge the funding support I received throughout my PhD, which included a Social Sciences and Humanities Research Council of Canada Doctoral Scholarship, Women's Health Research Foundation of Canada Graduate Scholarship and Canadian Psychological Association COVID-19 Student Research Grant.

To my parents, Chris and Gina Petty, for instilling in me a love of learning, and supporting the pursuit of my (many) passions. You have been in the front row for all the ups and downs. I appreciate you both more than I could ever express. To my brother, Sean, thank you for the many treats you dropped off in the writing of this dissertation. You are my favourite big brother. To my cohort (and adopted cohort), especially Brenna Henrikson, Brooke Beatie, Michelle Ward and Jona Frohlich. Your friendships have been the cherry on top of this graduate program. To my husband, Tristan, you are truly my secure base and soft place to land. I could never have crossed the finish line without you and Peeps, thank you. Finally, thank you to the women who shared their stories of perinatal anxiety and help-seeking with me. Your vulnerability, and courage will help in a better understanding of the complex journey of help-

seeking during the perinatal period and will inform future interventions. Connecting with each of you during the height of a worldwide pandemic felt like a hand reaching through the darkness.

Dedication

To my mentor, Dr. John Walker, and to my Oma, Hildegard Pyka.

Table of Contents

Abstract	ii
Acknowledgements	iv
Dedication	vi
Table of Contents	vii
List of Tables	xi
List of Figures	xii
Perinatal Anxiety	1
Impact of Perinatal Anxiety	3
Comorbidity.....	4
Risk Factors for Perinatal Anxiety	4
Risk Factors for Comorbid Perinatal Anxiety and Depression	5
Psychological Treatment of Anxiety	6
Help-Seeking for Perinatal Anxiety	8
Help-Seeking Barriers and Facilitators	9
Theoretical Model of Help-Seeking	12
COVID-19 Pandemic	14
Current Investigation	16
Gaps in the Literature	16
Research Objectives	17
Methodology	18
Research Strategy	18
Social Constructivism	18

Constructivist Grounded Theory	20
Reflexivity Statement	21
Recruitment	22
Participants.....	23
Data Collection, Procedure & Instruments	24
Context of COVID-19 in Manitoba	25
Perinatal and Mental Health Background Questionnaire	25
Meeting 1	29
Meeting 2	30
Qualitative Coding Procedures	32
Ethics	36
Findings	37
Sociodemographic Characteristics	37
Perinatal Characteristics	37
Mental Health Characteristics	41
Current Mental Health	41
Mental Health over the Lifetime	43
Summary of Quantitative and Clinical Perinatal Data	45
Qualitative Findings	48
Theme 1: "Liquid terror" and other experienced symptoms of perinatal anxiety	49
Theme 2: "Here we go again": Recognition and reactions to the re-emergence of anxiety in the perinatal period	60
Theme 3. Calling in the "Troops": Social support in the context of perinatal anxiety ...	64

Theme 4. “I’m going down all the lists, whom can I call, whom can I get help from?”:	
Help-seeking for perinatal anxiety	68
Discussion	79
Psychosocial Characteristics	80
Sociodemographic Characteristics	80
Perinatal Characteristics	81
Characteristics of Perinatal Anxiety	83
Perinatal Anxiety Presentation	83
Comorbidity with Depressive Symptoms	84
Past Experience with Anxiety and/or Depression	85
Mental Health Over the Lifetime	85
Qualitative Themes	86
"Liquid terror" and other experienced symptoms of perinatal anxiety	86
"Here we go again": Recognition and reactions to the re-emergence of anxiety in the perinatal period	89
Calling in the “Troops”: Social support in the context of perinatal anxiety	91
“I’m going down all the lists, whom can I call, whom can I get help from?”: Help-seeking for perinatal anxiety	93
Limitations	96
Recruitment	96
Sample Characteristics	97
Selection Bias	98
Impact of COVID-19	98

Sociopolitical and geographical context	99
Future Directions	100
Expanding research on help-seeking for perinatal anxiety	100
Partner mental health and impact on help-seeking	101
Addressing comorbid conditions	102
Implications	103
Healthcare System	103
Perinatal Mental Health Services	105
Partner, Family, and Friends of Perinatal Women	107
Concluding Remarks	108
References	110
Appendix A: Recruitment Letter to Participants	150
Appendix B: Recruitment Poster	151
Appendix C: Telephone Recruitment Statement	152
Appendix D: Consent Form	154
Appendix E: Perinatal Anxiety Background Questionnaire	160
Appendix F: The Mini International Neuropsychological Interview and Screener (M.I.N.I.) ...	170
Appendix G: Qualitative Interview	171
Appendix H: Mental Health Graph	173
Appendix I: Field Notes	174

List of Tables

Table 1: <i>Sociodemographic Characteristics of Participants</i>	39
Table 2: <i>Perinatal Characteristics of Participants</i>	40
Table 3: <i>Current Mental Health Characteristics of Participants</i>	44
Table 4: <i>COVID-19 Stressor Scale</i>	44
Table 5: <i>Past Mental Health Characteristics of Participants</i>	46

List of Figures

Figure 1: <i>Pescosolido's Network Episode Model-II</i>	14
Figure 2: <i>A visual representation of Grounded Theory</i>	21
Figure 3: <i>Mental Health Graph “Peaks and Valleys”</i>	46
Figure 4: <i>Mental Health Graph “U-shaped”</i>	47
Figure 5: <i>Mental Health Graph “Downward”</i>	47
Figure 6: <i>Help-seeking Model of Perinatal Anxiety</i>	50

Women's Experience of Perinatal Anxiety and Help-seeking in the Context of the COVID-19 Pandemic

A Canadian survey highlights the high rates of perinatal anxiety, with 15-17% of pregnant and postpartum participants endorsing clinically significant symptoms of perinatal anxiety (Fairbrother et al., 2016). During the COVID-19 pandemic, rates were much higher, with some reports of up to 60% of perinatal women experiencing moderate to severe anxiety (Farewell et al., 2020). The perinatal period is significant for both the woman and the developing fetus/infant. Perinatal anxiety may pose serious consequences such as increased maternal stress response (Goodman et al., 2016) and disruptions in the development of a secure attachment between mother and infant (Lilja et al., 2012). Due to the many possible negative impacts of poor mental health during the perinatal period, the World Health Organization has recognized perinatal mental health as a significant public health issue (World Health Organization [WHO], 2008; 2014). Effective psychological treatments have been developed for women experiencing perinatal anxiety (Loughnan et al., 2018). However, rates of seeking professional help for mental health concerns during the perinatal period are low, with only 10-20% seeking help (Dennis & Chung-Lee, 2006; Fonseca et al., 2015; O'Mahen & Flynn, 2008). Why this population is not accessing treatment is not well understood. To address this gap in the literature, the present research explored pregnant and postpartum women's experience of seeking psychological treatment for perinatal anxiety, as well as the experience of perinatal anxiety and associated psychosocial factors, all within the context of the COVID-19 pandemic.

Perinatal Anxiety

The perinatal period spans pregnancy to 12 months following birth (Gaynes et al., 2005). For women in this period, life may be turned upside down by the significant life transition of

pregnancy and parenthood, which is marked by physical, emotional, hormonal, role-identity, relational, and lifestyle changes (Brockington et al., 2006; Kluwer, 2010; Petch & Halford, 2008; Shapiro et al., 2000; Shapiro & Gottman, 2005). Emotional changes that occur during this transition can include increased anxiety.

Anxiety is characterized by feelings of apprehension or fear related to an anticipated threat (American Psychiatric Association [APA], 2013). Anxiety disorders consist of a range of symptoms in the cognitive (e.g., intrusive worries, cognitive distortions), physiological/somatic (e.g., muscle tension, heart racing, dizziness, sweating), and behavioural domains (e.g., hypervigilance, avoidance), which are excessive, difficult to manage, and interfere with daily functioning (APA, 2013). When women experience the onset or exacerbation of anxiety during the perinatal period, this may be termed perinatal anxiety.

A study of over 300 Canadian perinatal women found that 15.8% reported anxiety symptoms during pregnancy and 17.1% postpartum (Fairbrother et al., 2016). Past studies have cited perinatal anxiety rates of 9 to 23% during pregnancy and 11% to 21% during postpartum (Dennis et al., 2017). A modest number of studies have examined how perinatal anxiety presents in terms of specific anxiety disorder sub-types (e.g., Ross & McLean, 2006). A study by Wenzel et al. (2005) used diagnostic interviewing (Structured Clinical Interview for DSM-IV Disorders – Non-Patient Version; First et al., 1997) to assess symptoms of anxiety postpartum. They found that generalized anxiety disorder (GAD) was the most common disorder present in the postpartum period, followed by panic disorder (PD) and social anxiety disorder (SAD). According to a meta-analytic pooling of perinatal anxiety studies reported that GAD was the most prevalent presentation of perinatal anxiety (3.59%), followed by PTSD (1.78%), PD

(1.66%), SAD (1.38%), Agoraphobia (0.68%), and Specific Phobia (0.03%; Goodman et al., 2016).

Perinatal anxiety differs from anxiety experienced in the general (non-perinatal) population due to the presence of symptoms in the context of pregnancy and postpartum experiences, paired with the nature of the worries. Perinatal anxiety has been characterized as being related to specific themes of worry, including fetal well-being, labour and delivery, infant health and safety, maternal performance, and maternal and partner morbidity and mortality (e.g., Blackmore et al., 2016; Misri et al., 2015; Staneva et al., 2015). Little is known about how these themes present across the different anxiety disorders.

Regardless of anxiety disorder type, symptoms of anxiety exist along a continuum with clinical levels of anxiety representing chronic, moderate to severe presentations associated with functional impairment (Goodman et al., 2016; Milgrom & Gemmill, 2015). However, even subthreshold anxiety symptoms in the perinatal period can be detrimental to the mother and developing fetus/infant (Zelkowitz & Papageorgiou, 2005).

Impact of Perinatal Anxiety

Perinatal anxiety can have a negative impact on the developing fetus/infant, the pregnant/postpartum person, and the relationship between mother and infant. For the developing fetus/infant, perinatal anxiety has been linked with intrauterine artery resistance leading to low birthweight (Field et al., 2010; Teixeira et al., 1999), suboptimal changes in fetal heart rate and motor activity (DiPietro, 2010), complications in labour and delivery (Johnson & Slade, 2003), lower Apgar scores, and longer stays in the hospital following birth (Dowse et al., 2020). For the mother, perinatal anxiety is associated with decreased maternal self-confidence (Reck et al., 2012), reduced body acceptance, and increased maternal stress response (Goodman et al., 2016).

Perinatal anxiety may also impair breastfeeding practices (Coo et al., 2020), and has been linked to disruptions in the development of a secure attachment (Lilja et al., 2012), and disturbances in engagement in positive parenting practices (Field et al., 2010). Based on their meta-analysis, Rogers and colleagues (2020) reported that perinatal anxiety is associated with externalizing behaviours, internalizing behaviours, and negative emotionality during childhood, suggesting that perinatal anxiety can have a long-term impact on offspring. Another possible consequence of perinatal anxiety is the development of perinatal depression (e.g., Austin et al., 2007).

Comorbidity

Anxiety and depressive disorders are highly comorbid in the general population (APA, 2013). Epidemiological studies have found comorbidity rates of anxiety and depressive disorders between 40 and 80% (de Graaf et al., 2003; Jacobi et al., 2004; Kessler et al., 1994). A cohort study of 1783 participants found that 81% of individuals with a current anxiety disorder also met the criteria for a lifetime depressive disorder (Lamers et al., 2011). Amongst the perinatal population, 2%-13% meet criteria for comorbid anxiety and depression (Falah-Hassani et al., 2017). In 57% of the cases of comorbid anxiety and depressive disorders, anxiety symptoms preceded the symptoms of depression (Lamers et al., 2011). Comorbidity is an important consideration as comorbid anxiety and depression have been associated with longer duration and severity of symptoms (Lamers et al., 2011), increased disability, impaired functioning (Fichter et al., 2010; Kessler & Frank, 1997), and poorer treatment response compared to individuals with one disorder (Rush et al., 2005).

Risk Factors for Perinatal Anxiety

While there is limited research on predictors of perinatal anxiety, a history of an anxiety disorder prior to pregnancy is associated with an increased risk of development of anxiety during

the perinatal period (Grant et al., 2008; Martini et al., 2015; Matthey et al., 2003). However, women can also experience a first episode of anxiety in the perinatal period despite being psychologically well-adjusted prior to pregnancy (Matthey et al., 2003). Based on a meta-synthesis of qualitative research, Staneva and colleagues (2015) identified themes that may contribute to the development, experience, and maintenance of perinatal anxiety. Some of the themes included the discrepancy between idealized and real experiences of motherhood, feelings of isolation and defeat, feelings of loss of control over emotions, feelings of loss of control over one's physical body, the transition into new roles (including the role of motherhood), and the realization of the mother's role in keeping the infant safe (Staneva et al., 2015).

A systematic review by Furtado and colleagues (2018) on risk factors for perinatal anxiety identified several important factors, including lower educational attainment, living with extended family members, family history of psychiatric disorders, hyperemesis gravidarum, multiparity, and personal history of sleep disorders (Furtado et al., 2018). Other factors that have been identified include a history of mental health problems, food insecurity, experiences of life-threatening events, stress during pregnancy, smoking, pregnancy loss, primiparity, negative childbirth experience, having an infant born prior to 27 weeks gestation, and having an infant admitted to the newborn intensive care unit (NICU; Farr et al., 2014; Giakoumaki et al., 2009; van Heyningen et al., 2017). Additionally, complications during pregnancy or delivery have been associated with increased odds of mental disorders in general (Sommer et al., 2021).

Risk Factors for Comorbid Perinatal Anxiety and Depression

A meta-analytic pooling of estimates from 66 studies of comorbid anxiety and depression during the perinatal period revealed that comorbidity rates vary across pregnancy and postpartum periods (Falah-Hassani et al., 2017). The prevalence rate for comorbid anxiety and depression in

the first trimester of pregnancy was 11.6% and decreased to 9.5% by the third trimester.

Comorbidity rates in the first four weeks following childbirth were 7.6% and increased slightly to 8.2% at 24 weeks postpartum (Falah-Hassani et al., 2017).

Identified risk factors for the development of comorbid anxiety and depression during the perinatal period include young maternal age (25 years old or less), not being married, not having completed high school, experiencing one or more social health issues (e.g., financial difficulty, legal involvement, serious family conflict, homelessness, immigration within the past five years), maternal vulnerable personality (defined by personality traits such as worrier, sensitive, and timid), childcare stress, and perceived life stress (Boyce et al., 2001; Falah-Hassani et al., 2016; Golbasi et al., 2010; Lin and Hung, 2015; Prady et al., 2013; Yelland et al., 2010). Higher breastfeeding self-efficacy, maternal self-esteem, and partner support are protective factors against the development of comorbid perinatal anxiety and depression (Falah-Hassani et al., 2016). Untreated anxiety during pregnancy has been identified as one of the strongest predictors of the development of postpartum depression (Austin et al., 2007; Milgrom et al., 2008).

Psychological Treatment of Anxiety

Fortunately, there are effective treatments for perinatal anxiety. While both pharmacological and psychological treatments are available to women experiencing anxiety in the perinatal period, women have reported a strong preference for psychological treatment (Dennis & Chung-Lee, 2006). Research on the psychological treatment of perinatal anxiety is limited (e.g., Goodman et al., 2016) but growing in recent years. Cognitive behavioural therapy (CBT), whether traditional or third-wave CBT, has been found to be an effective treatment option for perinatal anxiety.

Cognitive behavioural therapy (CBT) has been termed the gold standard psychological treatment for anxiety disorders (Hofmann et al., 2012). CBT focuses on the interrelated nature of affect, behaviours, cognitions, and physical symptoms of anxiety (Misri & Kendrick, 2007). CBT interventions emphasize changing behaviours and challenging cognitive distortions viewed as maintaining the anxiety cycle (Hofmann & Smits, 2008; Stewart & Chambless, 2009). A systematic review published by Loughnan and colleagues (2018) examined five studies evaluating CBT interventions for clinically significant anxiety symptoms in the perinatal population (participants in the included studies had to meet diagnostic criteria based on the Structured Clinical Interview for DSM-IV or meet clinical cut-off scores on a validated self-report measure of anxiety). All of the studies included used either traditional CBT (Green et al., 2015; Lilliecreutz et al., 2010; Misri et al., 2004; Nieminen et al., 2016) or mindfulness-based (third-wave CBT) interventions (Goodman et al., 2014). These interventions were presented either in a group format (Goodman et al., 2014; Green et al., 2015; Lilliecreutz et al., 2010), individual format (Misri et al., 2004), or through online intervention (Nieminen et al., 2016). The reviewed interventions, whether in-person, group or individual modality, Internet-based delivery, or combined with a pharmacological intervention, produced significant effect sizes (Hedges' g of 0.75 – 1.96) and resulted in statistically and clinically significant improvements in anxiety symptoms (Green et al., 2015; Goodman et al., 2014; Lilliecreutz et al., 2010; Misri et al., 2004; Nieminen et al., 2016). For example, Goodman et al. (2014) reported that of 16 participants who completed their mindfulness-based CBT treatment for perinatal anxiety, only one continued to meet diagnostic criteria for an anxiety disorder post-treatment. A subset of the studies also included outcome measures related to participant satisfaction and program adherence, reporting positive results for both.

More recent studies on the psychological treatment of perinatal anxiety have examined the efficacy and acceptability of online and e-health treatment. A mixed methods study by Evans and colleagues (2022), which included a systematic review of qualitative studies and a meta-analysis of quantitative studies, examined the effectiveness of remotely delivered programs and women's views of such programs. They found a beneficial effect in reducing anxiety symptoms (standardized mean difference -0.49 , 95% CI -0.75 to -0.22). Synthesized findings suggested that interventions that included regular contact with the therapists, CBT coping skills such as relaxation, and enough sessions to develop skills without being too time-consuming, were most effective. There was also limited evidence that women valued interventions that were tailored to the unique experiences and contextual factors associated with the perinatal period.

Help-Seeking for Perinatal Anxiety

While effective psychological treatment does exist, rates of seeking psychological services during the perinatal period are low. Approximately 10%-20% of women experiencing anxiety symptoms seek professional mental health treatment during the perinatal period (Dennis & Chung-Lee, 2006; Fonseca et al., 2015; O'Mahen & Flynn, 2008). These rates are much lower than the help-seeking rates for anxiety in the general population (e.g., 25%-80%, with rates varying by disorder type (Andrews et al., 2001; Kessler et al., 2006; Roness et al., 2005).

Consistent with past research in the general population (e.g., Mackenzie et al., 2012), those experiencing perinatal depression seek help at higher rates than those with perinatal anxiety (Woolhouse et al., 2009). Woolhouse et al. (2009) found that those with perinatal anxiety were less likely to seek help for mental health concerns than those experiencing perinatal depression. This study also examined informal help-seeking sources. When seeking help from a romantic partner, family, or friends, help-seeking rates were much higher than from formal

sources and did not significantly differ between those experiencing perinatal anxiety or depression. Past research on help-seeking may provide some ideas about what themes are related to help-seeking processes for women experiencing perinatal anxiety.

Help-Seeking Barriers and Facilitators

There is limited research on perinatal anxiety and even less on help-seeking during the perinatal period. When considering themes related to help-seeking and perinatal anxiety, the present study drew upon the existing literature on help-seeking for anxiety with the general population and those experiencing perinatal depression.

Recognition of symptoms. Recognition of symptoms has been identified as an early step in seeking help for mental health concerns (Jorm, 2000). For women in the perinatal period, this recognition may be challenging as many of the symptoms of perinatal anxiety overlap with typical changes associated with pregnancy and postpartum, including changes in sleep, feeling fatigued, and noticing more worry. Thus, women experiencing perinatal anxiety must be able to recognize their symptoms as above and beyond what should be expected in the perinatal period to determine that their symptoms warrant help-seeking. Research on perinatal depression suggests that symptoms often go unrecognized during the perinatal period (Bauer et al., 2014; Goodman & Tyer-Viola, 2010; Hendrick et al., 2003). Research by Kingston and colleagues (2015) indicated that women in the perinatal period often do not seek help for mental health concerns as they feel unsure about what is normal vs. abnormal during this period.

Mental health literacy. Knowing what constitutes a mental health problem can help individuals identify their symptoms as fitting into this category. Indeed, Kingston and colleagues (2015) found that women with a history of mental health problems were more comfortable identifying whether their symptoms warranted screening during the perinatal period. In the

general population, mental health literacy also has been identified as an essential factor in help-seeking. Mental health literacy is made up of knowledge and beliefs about mental health that help individuals recognize, manage, and prevent mental disorders (Jorm, 2000). Poor mental health literacy is a barrier to help-seeking for psychological distress (Gulliver et al., 2010; Rickwood et al., 2005).

Self-disclosure. Self-disclosure has been identified as a barrier to help-seeking in past research for perinatal depression (Dennis & Chung-Lee, 2006) and in general anxiety populations (Vogel & Wester, 2003). In a retrospective study, women were contacted nine months postpartum and asked what barriers they met when experiencing perinatal anxiety or depression. One of the most frequently cited barriers was feeling too embarrassed to seek help and not having someone to whom they felt comfortable disclosing to (Woolhouse et al., 2009). Contributing factors to difficulties with self-disclosure include stigma and perceived partner social support.

Stigma. Stigma is defined as the negative appraisal of a group due to a perceived negative characteristic of this group (Goffman, 1963). Stigma may be held by the general population, which is termed "external stigma," or may be held by the stigmatized group, leading to feelings of discomfort and shame (Price & Bentley, 2013). For women experiencing perinatal anxiety, stigma may interfere with self-disclosure as women worry not only about being labeled as mentally ill but also being labeled as an unfit or bad mother (Bilszta et al., 2010; Kingston et al., 2015; McCarthy & McMahon, 2008). Stigma has been identified in the research on perinatal depression as a barrier to both disclosure and help-seeking (Byatt et al., 2013; Goodman, 2009).

Partner Support. The relationship with the romantic partner is conceptualized as the most crucial relationship in adulthood (e.g., Beach et al., 1996). It may be especially important

during pregnancy and postpartum periods when there are increased demands on new parents (e.g., Kluwer, 2010). There is evidence that the partner, and perceived partner support, play a role in the help-seeking process during the perinatal period. First, partners have been found to play an important role in helping women recognize symptoms of perinatal distress (Henshaw et al., 2013), which is an important early step in help-seeking (Jorm, 2000).

While women may initially reach out to informal sources of support when experiencing perinatal anxiety, very few continue on to seek formal support (e.g., family physician, mental health care worker; Woolhouse et al., 2009, Fonseca and Canavarro, 2017; Fonseca et al., 2015; Henshaw et al., 2013; O'Mahen & Flynn, 2008). Perceiving that one's partner is supportive of seeking professional help for mental health concerns has been found to increase women's intentions to seek such help (Fonsecca & Canavarro, 2017).

Information on treatment options. Information on treatment options also may play a role in help-seeking for perinatal anxiety. If women feel that the available treatment options would not be helpful, then there would be little reason to seek formal help. These beliefs about treatment efficacy are conceptualized as another aspect of mental health literacy. Knowledge of adequate health care options for the treatment of mental disorders has been identified as a predictor of attending mental health screening during the perinatal period (Kingston et al., 2014).

Access to Publicly Funded Mental Health Services. Psychological interventions such as CBT, are effective in the treatment for anxiety and depression, amongst other mental health concerns (e.g., Hofmann et al., 2012). While effective, such interventions are a substantial investment in resources, time, and finances (Gratzer & Goldbloom, 2016). While the importance of evidence-based mental health interventions has been recognized, there is limited availability

of such interventions in public health care settings in Canada (Kessler et al., 2009; Mental Health Commission of Canada, 2020; Moroz et al., 2020). Even when services are accessed, there are oftentimes excessive wait times (Moroz et al., 2020).

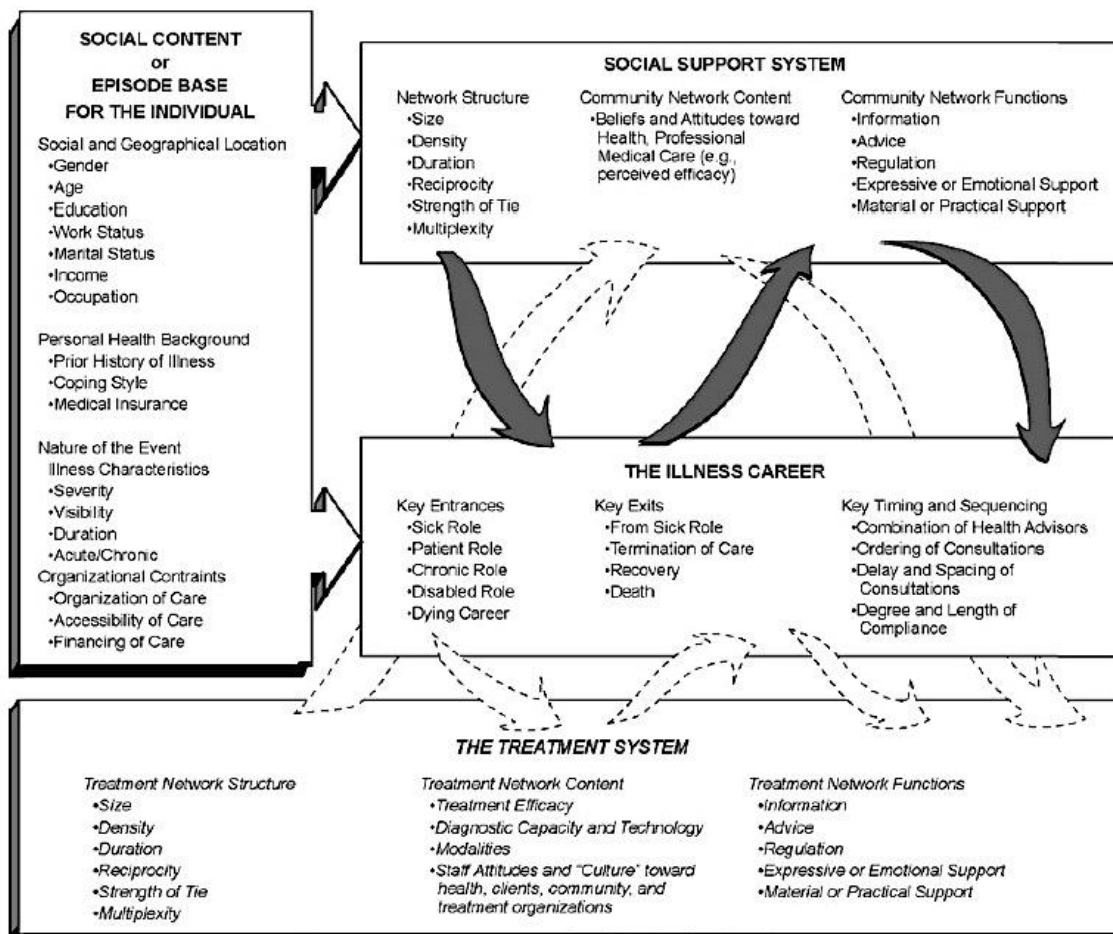
Without treatment, perinatal anxiety can persist in the early periods of parenting and beyond (Giallo et al., 2015; Grant et al., 2008). Given the many negative consequences associated with perinatal anxiety, as previously outlined, this gap between available and effective psychological treatment and low help-seeking rates is an area of concern worthy of investigation for the increased well-being of both mothers experiencing perinatal anxiety and their infants.

Theoretical Model of Help-Seeking

The help-seeking process is defined as "the individual's ability to actively seek help from others (e.g., support, information, advice, treatment) in response to a problem or painful experience" (Fonseca & Canavarro, 2017, p.79). As there has been limited research on the help-seeking process during the experience of perinatal anxiety, a specific theory of help-seeking for this population has yet to be developed. Existing models have also yet to be applied to the perinatal population. Models of help-seeking can be useful in crystallizing the numerous factors, various pathways, potential barriers and facilitators individuals experience when help-seeking and can provide valuable insight into areas worthy of intervention to make this process easier (e.g., Pescosolido et al., 2013).

A model of help-seeking that has been used in research related to help-seeking for mental health concerns is Pescosolido's Network Episode Model-II (Pescosolido & Boyer, 2010; Pescosolido et al., 2013). This model conceptualizes help-seeking as a dynamic intra- and interpersonal process (for an illustration of this model, see Figure 1). The model is composed of four main domains: (a) social content or episode base for the individual, (b) social support

system, (c) the illness career, and (d) the treatment system. The social content or episode base for the individual is made up of sociodemographic factors such as age, marital status, and education, personal health background which includes prior history of illness and coping style, and nature of the event, including the characteristics of the illness and severity. This base is then connected to the social support system, which includes strength of ties, the community's beliefs and attitudes towards healthcare, information and emotional support, and system and illness career which includes delays and spacing of consultation and identification with sick role. The final domain is the treatment system, which mirrors some of the factors included in the social support system, such as strength of ties, and emotional support, though in this context these factors refer to relationships within the formal treatment system, and also include treatment efficacy, and staff attitudes towards health. This model features arrows moving between the domains, highlighting the conceptualization of help-seeking as a dynamic, non-linear model in which the help-seeking individual interacts with multiple systems. While Pescosolido has developed more recent help-seeking models (NEM-III, NEM-III-R; Pescosolido, 2011), the NEM-II has a specific focus on the mental health service system (e.g., Choi et al., 2006) and thus is most applicable for the present study. A particular strength of Pescosolido's NEM-II is that it acknowledges the impact of intra- and inter-personal factors in the help-seeking process and sees treatment as an outcome of the dynamic interaction of these factors (Pescosolido et al., 2013). As there are many indications that the experience of perinatal anxiety is highly impacted by the partner, partner support, and the pregnant and postpartum person is often highly involved in appointments and monitoring with healthcare workers, a model that has a focus on both intra- and inter-personal aspects is highly relevant.

Figure 1*Pescosolido's Network Episode Model-II*

Note. Developed by Pescosolido et al., 2013

COVID-19 Pandemic

The current research was conducted between November 2020 through April 2021, a time marked by the COVID-19 pandemic. COVID-19 is an infectious disease caused by a respiratory virus and transmitted through airborne particles containing the virus (WHO, 2020). The first known case of COVID-19 was identified in Wuhan, China, in December 2019, and by March 11, 2020, the World Health Organization had declared COVID-19 a pandemic. COVID-19 attacks the

respiratory, vascular, renal, and gastrointestinal systems (Astuti, 2020). Symptoms are variable from person to person, though they often include a fever, dry cough, headache, breathing difficulties, fatigue, and loss of taste and smell, with less common symptoms including gastrointestinal, cardiac, and renal symptoms (Ellington et al., 2020). While most people infected with the disease experience mild to moderate symptoms and recover without intervention, some become seriously ill and require medical attention and hospitalization. For those critically affected, COVID-19 can lead to dyspnea, hypoxia, respiratory failure, multiorgan failure, and death (Centers for Disease Control and Prevention [CDC], 2023).

In order to slow down the spread of COVID-19, versions of “lockdown” were implemented by governments worldwide. These lockdowns included social distancing and isolation measures, closure of nonessential businesses, remote learning from home for school, and remote work from home for many employees, with consequences such as job loss and unemployment for many. The abrupt changes to daily life were accompanied by uncertainty and fear around COVID-19 and economic, social, and political stress (Chen et al., 2021).

For perinatal populations, there were unique stressors posed by the COVID-19 pandemic. Firstly, pregnant people were considered a vulnerable population during COVID-19, as they tend to be more susceptible to respiratory infections in general (CDC, 2021; Ellington et al., 2020). There were also many fears about the potential of “vertical transmission” of COVID-19, in which the virus passes from the infected mother to the developing fetus (Kotlyar et al., 2021), as well as adverse pregnancy outcomes, maternal and infant mortality (Rasmussen et al., 2020). There were also changes and loss of many supportive perinatal services, such as in-person classes on preparation for labour and delivery and parenting (Ellington et al., 2020; Horsch et al., 2020). Additional concerns included the ability to have one’s partner or support people in

attendance for maternal appointments, lack of access to caregiver support, and delivering baby in a hospital-setting (Horsch et al., 2020).

The high stress of the COVID-19 pandemic and the many restrictions and secondary losses related to the pandemic had severe consequences for mental health. Increased rates of anxiety, depression, and posttraumatic stress were reported in the general population (e.g., Bao et al., 2020; Talevi et al., 2020) and in perinatal populations (e.g., Saccone et al., 2020; Wu et al., 2020). Farewell et al. (2020) conducted a phone interview and online survey with women in the perinatal period during the COVID-19 pandemic and found that 60% reported moderate to severe anxiety, 12% reported severe depressive symptoms, and 40% reported feeling lonely. They identified the most significant stressors to perinatal women at this time as being uncertainty about perinatal care, risk of self or baby contracting COVID-19, inconsistent information about COVID-19, and reduced social support networks.

As the COVID-19 pandemic had a profound impact on life at the time of data collection, in terms of changes to daily life (e.g., lockdowns, changes to or loss of many perinatal services and supports, job loss), and had severe mental health consequences (e.g., Bao et al., 2019), it is an important contextual factor in the present research. The specific situation in Manitoba during the COVID-19 pandemic can be found in the Methodology section.

Current Investigation

Gaps in the Literature

Perinatal anxiety as a topic unto itself and in the context of help-seeking and the COVID-19 pandemic remains a relatively underdeveloped area of research. As such, there are several gaps in the literature on this widespread and significantly impactful mental health problem.

As noted above, help-seeking rates for psychological treatment of perinatal anxiety are low, both compared to help-seeking for anxiety in the general population (Dennis & Chung-Lee, 2006) and help-seeking for perinatal depression (Woolhouse et al., 2009). While barriers and facilitators for help-seeking have been identified in relation to seeking help for anxiety in the general population, and to a lesser degree, for those seeking help for perinatal depression, little is known about help-seeking for perinatal anxiety and any unique factors associated with help-seeking for this population.

The experience of perinatal anxiety and related psychosocial factors have also not been well explored. While there is some limited research on topics such as perinatal anxiety and presentation across anxiety disorder types (e.g., Goodman et al., 2016) and themes of worry (e.g., Blackmore et al., 2016; Misri et al., 2015; Staneva et al., 2015), there is relatively less information on topics such as comorbidity and psychosocial factors related to perinatal anxiety, such as social support. Additionally, the COVID-19 pandemic, its impact on perinatal anxiety, and the help-seeking process require further research.

Research Objectives

The overarching objective of the present research was to better understand women's experiences with anxiety and help-seeking journeys¹ during the perinatal period in the context of the COVID-19 pandemic. Within this overall objective, I explored the characteristics of perinatal anxiety, including onset, type of anxiety, comorbidities, and the psychosocial characteristics of perinatal anxiety, such as perceived partner support.

¹ Help-seeking in this research refers to psychological help-seeking. While other forms of informal and formal help can benefit perinatal anxiety, for the purposes of this study, and acknowledging the preference for psychological treatment expressed by those in the perinatal period, this is the form of help this research focuses on.

As these topics do not have a very developed base of literature, the present study was largely exploratory, with data driven by the participants' experiences of the given phenomenon rather than guided by preconceived researcher-driven theories and ideas. Qualitative methods were utilized to seek rich data that followed the stories of pregnant and postpartum women who experienced perinatal anxiety during the COVID-19 pandemic and who sought psychological treatment.

Methodology

Research Strategy

As the goals of the research were exploratory, with aims of a rich description of the phenomenon of perinatal anxiety and help-seeking, qualitative methodologies were adopted. Qualitative methodologies are informed by philosophical, ontological, epistemological, and methodological assumptions that inform the data collection and analysis processes (Creswell & Poth, 2017). Thus, identifying a worldview and qualitative methodology aligned with the research objectives were an important step towards understanding the experience of perinatal anxiety and help-seeking in the context of the COVID-19 pandemic. Research was guided by a social constructivist worldview and analyzed using constructivist grounded theory.

Social Constructivism

Constructivism is a worldview that developed out of a response to empiricism. While empiricism views the mind as a passive system that gathers information from which the individual develops knowledge and forms reality, constructivism conceptualizes the mind as an active system in ascribing meaning to the information gathered from the environment. Through this process, the mind creates knowledge and reality (Balbi, 2008; Lincoln et al., 2011; Raskin, 2002). Constructivism thus recognizes that in interacting with the environment, human

beings will understand the world through subjective lenses and, through these lenses, make meaning of the world around them (Lincoln et al., 2011). Social constructivism is a subset of constructivism that posits that the lens through which we make meaning is informed by social processes such as interactions with others and historical and cultural experiences (Creswell, 2014; Creswell & Poth, 2017).

As indicated by past models of help-seeking (e.g., Pescosolido et al., 2013; see Figure 1), the experience of mental health difficulties and the help-seeking process is influenced by intra- and inter-personal factors. Thus, social constructivism, with its acknowledgment of the process of meaning-making through interactions with others and the role of historical and cultural experiences, is a fitting worldview from which to conduct this study.

Regarding research implications, engaging from a social constructivist worldview impacts how questions are asked and the content of questions (Creswell, 2014; Creswell & Poth, 2017). Research questions were developed in an open-ended format, allowing participants to construct meaning of their experience with perinatal anxiety and help-seeking.

While questions remained open, prompts were assessed for the meaning participants ascribed to their experiences or decisions they made and who or what influenced these experiences. Another way the social constructivist worldview impacted this study was how I, as a researcher, engaged in the meaning-making of the data. Rather than engaging in a narrowing-down process, social constructivism encourages uncovering a multitude of meanings (Creswell, 2014; Creswell & Poth, 2017). Adopting a social constructivist lens also influenced the research methodology chosen for the present research. Specifically, a research methodology influenced by social constructivism is Constructivist Grounded Theory.

Constructivist Grounded Theory

In considering qualitative methodology for the present study, Constructivist Grounded Theory (CGT) was selected both for the alignment with social constructivism and because CGT is an appropriate methodology for the research of phenomena that have been relatively unexplored. CGT is also appropriate when there is an aim to construct an explanatory theory of the phenomenon in question (Birks & Mills, 2015; Bryant & Charmaz, 2007; Glaser & Strauss, 1967).

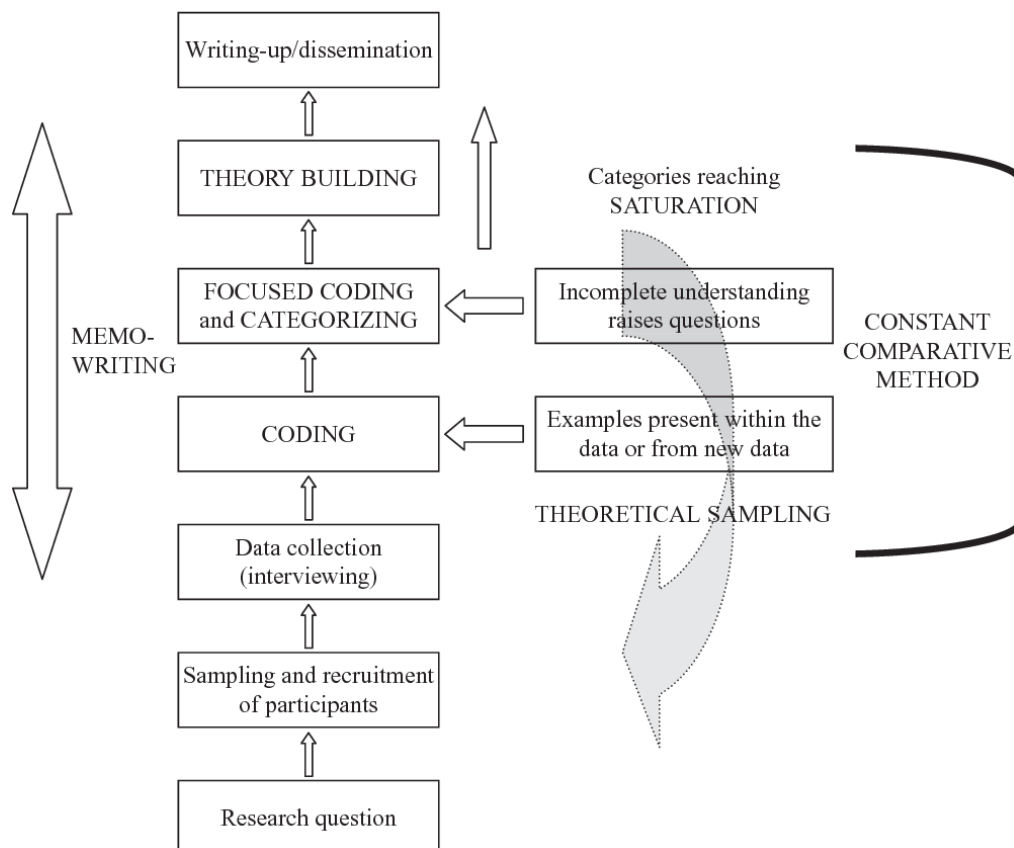
CGT is an iteration of Glaser and Strauss's (1967) Grounded Theory (GT) methodology for qualitative research. Glaser and Strauss advocated for a qualitative method that sought to develop theories supported from the ground up, remaining close to data and participant accounts rather than testing or refining theory through deductive testing. Their outline included: (a) the development of codes and categories which emerge from the data itself rather than from pre-conceived hypotheses, (b) a constant comparison method in which new data are continuously compared against already-coded data, and (c) the simultaneous collection and analysis of data (Charmaz, 2014). GT has been applauded by qualitative researchers for its ability to provide a focus for researchers and a way to expedite progress through the early interaction with and analysis of data (Charmaz, 2014).

CGT is associated with the remodeling of Glaser and Strauss's classic GT into CGT set forth by Charmaz (2000, 2014). Influenced by constructivism, CGT aims to uncover multiple meanings rather than a singular truth or reality (an aim that better aligns with classical GT; Charmaz, 2006). While GT methodologies are often used to build theoretical models in qualitative research, Charmaz identifies a more flexible outcome of this research, including detailed descriptions or conceptual frameworks that create a deep understanding of the

phenomenon (Charmaz, 2014). For a visual representation of the data collection and analysis process, see Figure 2 and the Analysis section of this document.

Figure 2

A visual representation of Grounded Theory



Note. Originally created by Tweed and presented in Tweed & Charmaz (2011, p. 133)

Reflexivity Statement

In CGT, the researcher co-constructs meaning with participants when engaging in the data collection and analysis (Charmaz & Bryant, 2011). As social constructivism acknowledges that individuals' interpretation of meaning is influenced by one's own personal, social, cultural, and historical experiences, research from a social constructivist worldview also must

acknowledge the researcher's interpretational lens. As a researcher, the data gathering, the questions I chose to ask, the probes I followed when interviewing participants, my interpretations of the data, and the framework development were all shaped by my experiences and background (Creswell & Poth, 2017). I acknowledge that I am a white, cis-gender female with a middle-class upbringing. I have had the privilege and access to engage in post-secondary education and, as a result, have a master's degree in clinical psychology and am currently a Ph.D. candidate. While I am not in the perinatal period, or a parent, I had many friends who were pregnant and postpartum during the period of my data collection, and I was able to reflect on their stories as I conducted this research. I also have a desire to experience pregnancy and parenthood, which likely influences my interest in the field of women's health. I am of a similar age bracket to my participants and was also experiencing the impact of the COVID-19 pandemic alongside my participants. My experience in clinical psychology and past work with clients experiencing anxiety and perinatal anxiety have probably positively influenced the interview process through the development of rapport which likely led to richer and deeper disclosure from the research participants. I also acknowledge that I have a personal passion for timely access to mental health treatment and have deep compassion for those experiencing anxiety and other mental health concerns, which influenced the direction of my chosen field of research and informed my interpretive lens.

Recruitment

Participants were recruited from an outpatient anxiety disorders clinic in Winnipeg, Manitoba, the Clinical Health Psychology Anxiety Disorders Clinic at St. Boniface Hospital. Patients at this provincial clinic are referred by family physicians, obstetricians, psychiatrists, midwives, and public health nurses for the psychological treatment of anxiety. Patients on the

waitlist received a letter (Appendix A) and a flyer (Appendix B) in the mail with information about the present research and relevant contact information. Interested participants were screened (Appendix C) before scheduling their first research meeting.

Recruitment continued until data reached theoretical sufficiency, in which new participants' accounts of perinatal anxiety and help-seeking supported themes developed from past interviews, and the thematic framework remained stable. Special attention was also paid to theoretical sampling to ensure that representativeness and richness existed within the sample. For the purposes of the present study, an important consideration was placed on collecting data from both pregnant and postpartum women and those experiencing different anxiety disorders.

Participants²

The eligibility criteria for this study were as follows: (a) being in the perinatal period, which included pregnancy up to 12 months postpartum, (b) age of 18 years or older, (c) fluency in the English language, and (d) experiencing clinically significant anxiety, operationalized as meeting the clinical cut-off on the Perinatal Anxiety Screening Scale (PASS; Somerville et al., 2014) and/or meeting criteria for at least one anxiety disorder diagnosis based on the Mini-International Neuropsychiatric Interview (M.I.N.I. English Version 7.0.2; Sheehan et al., 1998). Perinatal women experiencing psychosis, current substance abuse, or a high risk of suicide were excluded from the study.

A total of 24 patients on the waitlist for psychological services for perinatal anxiety expressed interest in participating in this study. One participant was excluded because she was more than 12 months postpartum at the time of the interview. Six participants completed the

² The participants in this study all identified as women. There is a community of pregnant and postpartum people who identify as transgender, non-binary, two-spirit and genderqueer, and two-spirit, and their voices were not heard as part of this research due to sampling availability.

online questionnaire and M.I.N.I. assessment and were excluded from the research at that point. Four were excluded for not meeting criteria for the clinical cut-off on the PASS and/or for not meeting the criteria for an anxiety disorder, one participant was excluded for high suicidality, and one for substance use disorder. Any data collected from participants who were excluded was not used in data analysis. Seventeen participants met all criteria, and completed all stages of the research, and their data was included in the present research. All included and excluded participants) were provided with mental health resources, including crisis services (see Appendix D). All included and excluded participants also remained on the hospital waitlist for further assessment and potential treatment in the Anxiety Disorders Clinic.

Data Collection, Procedure & Instruments

The primary data used in the present study was the qualitative interview which was developed with a protocol aimed at better understanding the experience of perinatal anxiety and help-seeking in the context of the COVID-19 pandemic. Other data points were used to support this primary objective and the secondary aims. This included an online questionnaire, the M.I.N.I., and the mental health across the lifespan graph. For a complete list of questions administered, including the consent form, online questionnaire, M.I.N.I., mental health across the lifespan graph, and interview protocol, see Appendices D through H.

The online questionnaire was sent to participants via email, and they could print off a copy of the consent form from the online questionnaire. A list of mental health resources was also available for printing or screenshotting on the online questionnaire. The consent form and mental health resources can be found in Appendix D. Meetings were held over video conference to comply with safety standards due to COVID-19 restrictions. The consent form was also reviewed with participants at the outset of their first virtual meeting and they had opportunity to

ask questions about the research. Participants received \$50 in e-gift cards for participation in the study as an honorarium.

Context of COVID-19 in Manitoba

Data were collected from November 2020 through April 2021. At the time of data collection, Manitoba was during the second and third waves of the COVID-19 pandemic. Throughout this time, the government implemented restrictions, including social distancing measures such as “household only” contact or creating a “bubble” by socializing with only one other household. Holiday gatherings over December 2020 were strongly discouraged and limited to “households only.” Schools, daycares, gyms, wellness centers, and businesses also had restrictions ranging from being closed to maximum 50% capacity. Restrictions were also imposed in hospital settings. Visitor access to Manitoba hospitals was suspended on March 19, 2020, requiring patients to attend medical appointments without the support of loved ones and restricting hospital access only to patients. Exceptions included allowing for one visitor in obstetrics for labour and delivery. However, the latter exception was at the discretion of individual facility managers and thus was not available to all patients. All visitors were screened for symptoms of COVID-19 prior to entrance to the hospital and everyone was required to wear masks, including patients during labour (Shared Health MB).

Perinatal and Mental Health Background Questionnaire

Before the first research meeting, I emailed participants a link to the online questionnaire. The questionnaire was adapted from the Perinatal Anxiety Background Questionnaire (Penniston et al., 2021; Appendix E). The first section of the questionnaire assessed participants' sociodemographic characteristics such as age, gender, level of education, ethnicity, occupation, and marital status. This data was used to describe the sample.

The second part of the questionnaire addressed the perinatal characteristics of participants, including current perinatal status (pregnant or postpartum), whether participants were first-time parents, and the number of children in addition to current pregnancy/infant. Participants also were asked about difficulty getting pregnant with current or past pregnancy, complications with current or past pregnancy, complications with current or past delivery, and complications with current or past recovery from pregnancy (postpartum), which, if answered affirmatively also had open-text options asking participants to clarify the complications or difficulties. Participants were asked if they had any experience with past neonatal loss or past termination of pregnancy. They were asked about their perceived physical health throughout pregnancy and postpartum (ratings from *Poor*, *Fair*, *Good*, *Very Good*, and *Excellent*). For those in the postpartum period, participants also answered open-ended questions about the baby's temperament, bond with the baby, and health. This data was used to describe the perinatal characteristics of the sample.

The third section of the online questionnaire contained questions about participants' perceptions of their mental health and physical health over their lifetime (ratings from *Poor*, *Fair*, *Good*, *Very Good*, and *Excellent*). Participants also answered *Yes/No* questions about whether they had experience with anxiety and/or depression and whether they had previously sought help for anxiety and/or depression in the past (not for current episode of anxiety). If participants responded affirmatively to the question about previous help-seeking for anxiety and/or depression, they were then asked if they had engaged in pharmacological, psychological, or other treatment. The online questionnaire also contained a number of self-report mental health measures on perinatal anxiety (Perinatal Anxiety Screening Scale; PASS, Somerville, et al., 2014), perinatal depression (Edinburgh Perinatal/Postnatal Depression Scale; EPDS; Cox,

Holden, & Sagovsky , 1987), COVID-19 stress (Coronavirus Stressor Survey; McLean & Cloitre, unpublished), and a measure assessing perceived support for help-seeking for mental health concerns from a partner or support person (Perceived Partner Support for Seeking Help for Mental Health Concerns; adapted from Fonseca & Canavarro, 2017). This data was used to better understand participants' current mental health, as well as mental health over their lifetime.

Perinatal Anxiety Screening Scale (PASS). The PASS (Somerville et al., 2014) is a 31-item self-report measure that was developed as a screening instrument for symptoms of perinatal anxiety. The items present symptoms of anxiety and participants respond to the frequency of experiencing the symptoms over the previous month using a 4-point Likert scale to respond to statements (0 = *Not at all* to 3 = *Almost always*). While the PASS is not a formal diagnostic tool on its own, it has been suggested that scores of 26 and up indicate a high risk of perinatal anxiety with a sensitivity of 0.3 and a specificity of 0.7 in the detection of an anxiety disorder in the perinatal period (Somerville et al., 2014). The scale has excellent internal reliability in past research (Cronbach's $\alpha = 0.96$; Somerville et al., 2014) and in the present study (Cronbach's $\alpha = 0.93$).

Edinburgh Perinatal/Postnatal Depression Scale (EPDS). The EPDS (Cox et al., 1987) is a 10-item self-report measure that assesses symptoms of depression experienced during the perinatal period. Depressive symptoms are listed, and participants respond to the frequency of experiencing the symptoms over the previous seven days using a 4-point Likert scale to respond to the statements with scale anchors varying to be most appropriate for the question (e.g., 0 = *No, not at all*, or 0 = *Never* to 3 = *Yes, most of the time*, or 3 = *Yes, very often*). As with the PASS, the EPDS is not a formal diagnostic tool. Multiple cut-off scores have been suggested (e.g., scores of 9-11 for possible depression, 12-13 for fairly high possibility of depression, and

14 and higher for probable depression; Cox et al., 1987). In a recent systematic review by Levis et al. (2020) suggested a cut-off score of 11 and above to balance both sensitivity and specificity and a score of 13 and above if prioritizing higher specificity over sensitivity, which is the cut-off score I used in the present study. When comparing the cut-off score of 13, to M.I.N.I. Major Depressive Disorder diagnoses, a 0.69 (0.54-0.81) 95% CI sensitivity rating and 0.91 (0.87 ñ 0.94) 95% CI specificity rating were reported (Levis et al., 2020). The scale has excellent internal reliability in past research (Cronbach's $\alpha = 0.87$; Cox et al., 1987) and in the present study (Cronbach's $\alpha = 0.85$).

Coronavirus Stressor Survey. This measure included assessing experiences and perceived distress related to the COVID-19 pandemic (McLean & Cloitre, 2020, unpublished scale). A number of experiences were listed, such as becoming ill from possible or certain exposure to the coronavirus, increased responsibilities at home due to the coronavirus pandemic, and difficulty getting needed social support due to the coronavirus pandemic. For each listed experience, participants could indicate whether the experience had happened to them, happened to someone close to them, or did not apply to them. There was also a question on how many hours per day participants were exposed to COVID-19 information over radio, television, newspaper, and social media, and a question assessing perceived distress related to COVID-19.

Perceived Partner Support for Seeking Help for Mental Health Concerns. This measure of perceived partner support for seeking help for mental health concerns was developed by Fonseca and Canavarro (2017) for their research on perinatal distress. They developed four questions: (a) *I would be comfortable talking about my emotional difficulties with my partner if I had an emotional problem*; (b) *My partner would support me if I had an emotional problem*; (c) *My partner would encourage me to seek professional help if I had an emotional problem*; and (d)

I would share the decision to seek professional help with my partner if I had an emotional problem. The term “support person” was added after the word "partner" in the statements so that participants who may not have had a partner could still fill out the measure keeping in mind the person they lean on for support (e.g., parent, friend). Participants were asked to respond using a 4-point Likert scale ranging from 1= *Strongly Disagree* to 4 = *Strongly Agree*. Higher scores indicated a higher level of perceived support from their support person to seek help for mental health concerns. This scale has high internal reliability in past research (Cronbach's $\alpha = 0.82$; Fonseca & Canavarro, 2017) and in the present study (Cronbach's $\alpha = 0.86$).

Meeting 1

During the initial meeting, I reviewed the consent form and process of informed consent with the participants. Once informed consent was confirmed, I administered the Mini International Neuropsychiatric Interview to assess symptoms of mental health concerns (M.I.N.I., English Version 7.0.2; Sheehan et al., 1998; Appendix F). The M.I.N.I. interview was audio recorded for reliability testing during data analysis. After completing the M.I.N.I., the participants completed the Mental Health Graph (Appendix G). This graph was used to assess participants' mental health quality over their lifetimes. As the meeting was conducted over video conference, participants could use annotation options in the video conference application to complete the graph. After completing the graph, the date and time for the second meeting were confirmed. The M.I.N.I. was used to better understand participants' experience with perinatal anxiety, including specific diagnoses and comorbid mental health concerns. The Mental Health Across the Lifespan graph was used to assess participants' perceptions of mental health from birth to present.

Mini-International Neuropsychiatric Interview (M.I.N.I. English Version 7.0.2). The M.I.N.I. (Sheehan et al., 1998) is a semi-structured interview to determine DSM-5 diagnoses. The M.I.N.I. assesses 17 of the most common mental health disorders, including anxiety and mood disorders. Participants respond with *Yes* or *No* to questions asked by the administrator, and the administrator circles the corresponding response on the interview form. When needed, the administrator may ask for clarification or examples from the participant. Prior to completing the interviews, I completed a formal training on the administration of the M.I.N.I.. All of the M.I.N.I. interviews were recorded, and a subset (4) of the audio recordings was analyzed by Dr. Patricia Furer (registered clinical psychologist with expertise in perinatal mental health and anxiety disorders). Inter-rater reliability was deemed to be in the "strong" range ($k = 0.835$; McHugh, 2012).

Mental Health across the Lifespan Graph. A graph based on work by Beatie and colleagues (Beatie et al., 2022) was used to explore participants' perceptions of their mental health from childhood to the present day (at the time of the interview). Mental health quality markers of poor, neutral, and excellent were used on a Y-axis with age in increments of 5 years as markers on the X-axis. These graphs were used better to understand the prior mental health of the participants.

Meeting 2

The second meeting focused on the qualitative interview. I met with participants over video conference to engage in the qualitative interview, and interviews took approximately 60 minutes to complete. All interviews were recorded and transcribed verbatim. As the interviews occurred over video conference, participants could choose a location, though they were advised to find a space where they would have privacy. All participants opted to engage in the virtual

interview from their homes for various reasons, including working from home due to COVID-19 social distancing or being on parental leave. Participants were informed that they could tend to their infants during the interview, which resulted in some participants holding or feeding babies for portions of the interview, and some participants taking short breaks to tend to their infant or older children.

Interview questions were created within the context of Grounded Theory methodology for qualitative research. This framework emphasizes that questions be designed to gather rich data without imposing preconceived research ideas into the questions (Charmaz, 2006). Questions were open-ended, allowing participants to describe their help-seeking journeys without leading the investigator.

Questions focused on different aspects of help-seeking, informed by the help-seeking models (Pescosolido's NEMI-II; Pescosolido & Boyer, 2010; Pescosolido et al., 2013; Cauce and colleagues' help-seeking model; Cauce et al., 2002). For example, Liang and colleagues' (2005) process of problem recognition, definition, decision to seek help, and support selection are all areas of exploration. The interview protocol included questions such as "Can you describe for me the anxiety you have experienced?", "Can you tell me about how you came to recognize that you were experiencing 'anxiety'?", "Can you tell me about how you decided to seek help for anxiety?" and "Once you decided to seek help, how did you determine what kind of help to seek?" (Appendix H). According to CGT, the protocol and questions can evolve based on new themes and topics explored in participant responses. Data were transcribed from the audio recordings verbatim by a research assistant, with all potentially identifying information removed before analysis.

Qualitative Coding Procedures

The research team for coding included Dr. Kristin Reynolds (registered clinical psychologist with expertise in perinatal mental health and anxiety disorders), Ms. Megan Gornik, (graduate student in clinical psychology), and myself. In CGT, coding is the link between data collection and the development of an emergent theory or rich description to get a deeper understanding of the data and the larger phenomenon of perinatal anxiety and help-seeking in COVID-19 (Charmaz, 2014). In coding, we (as researchers) aim to understand our participants' experience, viewpoints, context, and actions within their settings (Charmaz, 2014). As described earlier in the research strategy section, in CGT, codes are developed from what researchers interpret in the data rather than preconceived notions (Charmaz, 2014). According to Charmaz (2014), coding is the process through which researchers define what is occurring in the data and begin to grapple with what the data means.

CGT uses constant comparison analysis as a coding process, and this approach involves comparing coded data to previously coded data categories (Charmaz, 2006; Charmaz, 2014; Corbin & Strauss, 2008). Constant comparison analysis allows for the collection and analysis of data to occur concurrently, allowing the initial data to shape the direction of further data collection, termed "theoretical sampling" (Glaser & Strauss, 1967). Data were organized on the NVivo qualitative analysis software (QSR International's NVivo 12 Mac; NVivo, 2018). The coding process involved several steps: initial coding, focused coding, theoretical coding, field notes, and memo writing.

Initial coding. Initial coding occurred in two main steps. The first step in initial coding was line-by-line coding, which allowed us to become immersed in the participants' world by reading through and remaining open to many meanings of the data (Charmaz, 2014). Charmaz

(2014) recommended that coding at this stage be simple and remain close to the data. Line-by-line coding uses action-focused codes, which are used to help reduce tendencies to make conceptual leaps in this early stage of analysis (Charmaz, 2014). Second, longer and more detailed responses were re-coded for an understanding of the participant's experience and the meaning they attributed to this experience. This second part of initial coding also involved coding the initial line-by-line codes for larger analytic stories (Charmaz, 2014). During initial coding, codes tended to expand and collapse as new data was coded and compared to previous codes for similarities and differences. This expansion and collapse continued to repeat, leading to a dynamic rather than a static set of codes.

Focused coding. Following the initial coding, we engaged in focused coding, in which initial codes were reviewed to identify the most frequent and significant themes (Charmaz, 2014). At these steps, decisions had to be made about which initial codes make the most analytic sense to categorize the data. In categorizing data, codes were developed to subsume numerous initial codes as sub-categories (Charmaz, 2014). Categorizing the data condenses the initial coded data, making it easier to work with at the next step of theoretical coding (Charmaz, 2014). Focused coding categories and sub-categories were also tested against more extensive data for fit. In line with constant comparison coding, this meant that there were dynamic shifts back and forth between initial and focused coding (Charmaz, 2014).

Theoretical coding. Finally, theoretical coding was conducted, in which the categories developed during focused coding were analyzed to develop a larger overarching analytical story. This stage was the most sophisticated of the coding steps. It involved conceptualizing the context under which coded themes emerged, contingencies and consequences of the coded actions, and possible covariates of the coded data (Charmaz, 2014). This final coding step involved piecing

back together the data fractured into smaller pieces during the previous coding steps (Charmaz, 2014).

There is some tension at this stage regarding the role of prior knowledge and theories of one's discipline and whether these may play a role at this stage. While GT and CGT emphasize building data from the ground up, staying close to the data rather than using qualitative research to engage in deductive testing, it must also be acknowledged that "there is a difference between an open mind and an empty head" (Dey, 1999, p.251 as quoted in Charmaz, 2006). In recognizing this tension, at this stage in coding, I sought to balance remaining grounded in the data while using the knowledge of the literature on perinatal anxiety and models of help-seeking to aid in moving the analytic story into a theoretical direction.

Field notes and memo writing. Field notes were recorded immediately following the qualitative interviews during the second meeting with participants. Field notes included my observations of participant behaviour, body language, and affect. Field notes helped provide a rich description of the interview context and were used to enrich the interpretation of the participant quotations (see Appendix I for field notes template).

Memo writing occurred as a step between data collection, interpretation, and the writing of this manuscript. My memo writing involved documenting my thought process throughout data collection and analysis. I engaged in the memo writing process following, and sometimes during, qualitative interviews with participants, across different stages of coding, during meetings with my fellow coders (MG and KR), and the development of the theoretical model. Memos included direct quotes from participants, early ideas about emerging themes, initial sketches of theoretical models, areas requiring further development, and discussion from research meetings.

Rigour. While quantitative research has several agreed-upon methods for assessing the quality of the research, this is more difficult in qualitative research (Oliver, 2011). To ensure rigor and trustworthiness in the present research, a number of procedures were followed. Social constructivism acknowledges that individuals ascribe meaning to information through their own set of experiences, which also applies to researchers. All researchers on the team worked to recognize how personal background shapes the interpretation of the data, which is termed “reflexivity” (see Reflexivity Statement).

Another consideration was made to increase the number of researchers involved in coding, keeping in mind that different researchers brought different lenses through which they made meaning of the data. During the coding process, both myself and Ms. Megan Gornik coded transcripts individually and then met in a group with Dr. Kristin Reynolds to review initial codes and develop a coding framework. As new data was compared against previously coded data and the codes and framework evolved, the coding team continued to meet and review the transcripts and framework.

As each researcher brings with them a different lens, there were experiences in the coding process where there were discrepancies between myself and Ms. Megan Gornik, such as decisions about which codes were deemed code-worthy, choices of words, or phrasing for coding labels (Padgett, 2008). While some practices use a statistical measure of ensuring inter-rater reliability (e.g., Cohen’s kappa; Mayring, 2004), these practices are not supported by GT as inter-rater reliability statistics tend to be “elusive” and do not take into account the important process of reaching “consensual validation” with a fellow coder (Padgett, 2008, p.155). Instead, GT promotes the practice of co-coders meeting to discuss coding discrepancies and coming to a consensus through arguments grounded in data (Padgett, 2008). Unanimity is not necessary and

is not the goal in this process; and the coding team was able to resolve any discrepancies that arose. However, if we had needed, other members of the research committee would have been called upon to provide another viewpoint, and to lead to some resolution (Sandelowski & Barroso, 2002).

Another important reason to include multiple researchers in this project was for reflexivity. Reflexivity acknowledges the effect of the researcher at each step of the research process. Including multiple researchers allowed for the discussion of researchers' hidden beliefs and perspectives and how these may impact the interpretation of data. I also wrote in a reflexivity journal where I recorded my own reflections on values and interests throughout the process.

Triangulation assumes that if two or more sources of data, types of data collected, or researchers converge on the same conclusion then the conclusion is more credible (Denzin, 1978). Triangulation was an important concept in this study as analysis often involved examining converging lines of data (e.g., assessing perinatal anxiety with self-report measures of anxiety, and also structured interview of anxiety disorders) and in including multiple researchers in the development of our coding framework and interpretation of the data.

Ethics

Ethical approval was obtained from the University of Manitoba Psychology Sociology Research Ethics Board (Protocol # P2020:007), and from St. Boniface General Hospital Research Review Committee. All ethical guidelines were strictly adhered to.

Findings

Sociodemographic Characteristics

Participants ($n = 17$) responded to sociodemographic questions about age, ethnicity, highest level of education, occupation, and marital status. The findings are presented in Table 1. Participants' mean age was 30.9 years, 47% identified their ethnicity as of European origin and 18% identified as Indigenous. Regarding education, 47% reported that an undergraduate university degree and 12% reported that a high school diploma was their highest level of education. Most pregnant participants identified as working full time (38%) or part time (38%), while most postpartum participants identified as being on maternity leave (78%). Occupations included teachers, social workers, early childhood educators, and administrative assistants. All participants described being in committed relationships (77% reported being married and 23% reported being in common-law relationships).

Perinatal Characteristics

Perinatal characteristics of study participants are presented in Table 2. The sample was split quite evenly between pregnant (47%) and postpartum (53%) participants. For pregnant participants, the majority were in their third trimester (63%), and the rest were in their second trimester (37%). For postpartum participants, the majority were 6-12 months postpartum (44%), followed by 3-6 months postpartum (33%), and 0-3 months postpartum (22%). Over half of the participants were first-time parents (59%), and the remainder had between one and three older children.

Just under a third (29%) of the study participants reported difficulty getting pregnant and identified low egg count, ovulation dysfunction, polycystic ovarian syndrome (PCOS), and multiple miscarriages as related areas of concern. Over half of the participants reported feeling

that they had good health during pregnancy, with 24% reporting their health during pregnancy as *Good*, 24% choosing *Very Good*, and 6% viewing their health during pregnancy as *Excellent*. Over a third viewed their health during pregnancy as *Fair*, and 12% reported feeling that their health during pregnancy was *Poor* (italicized descriptors were the available response options for the question asked). Just under half reported that they had, or were, experiencing complications during their pregnancy with their current infant/developing fetus. In an open-ended follow-up question, participants reported a range of difficulties in pregnancy including gestational diabetes, hypertension, high blood pressure, hyperemesis gravidarum in the first trimester requiring hospitalization, placenta-related problems, and umbilical cord-related problems.

For those in the postpartum period (9 out of 17 participants), 78% reported complications in delivery including emergency caesarean section, having the umbilical cord wrapped around the infant's neck, increased fetal heart rate during delivery, and fourth degree perineal tearing for the mother. Regarding recovery from labour and delivery, 45% reported complications including high blood pressure postpartum, hospital-acquired infection (non-COVID-19 infection), and challenges recovering from labour and delivery (i.e., caesarean section delivery and perineal tearing). Of the participants in the postpartum period, 33% reported that their health since pregnancy was as *Fair*, 33% as *Good*, 22% as *Very Good*, 11% as *Poor*, and no participants described their health since pregnancy as *Excellent* (italicized descriptors were the available response options for the question asked). Babies temperaments were described as being very positive in an open-ended question, with descriptions including "a dream", "happy, smiley, and content, but doesn't like sleeping", "very calm, recently a bit more whiny, but generally calm", "teething and hunger are the only times he is upset, but generally a happy baby". There were no

Table 1*Sociodemographic Characteristics of Participants*

Characteristic		<i>n</i>	%
Ethnicity			
European Origins		8	47.1
North American Aboriginal Origins (First Nations, Inuit, Metis)		3	17.6
Latin, Central, and South American Origins		1	5.9
Asian Origins		1	5.9
African Origins		0	0
Oceania Origins (Australian, New Zealander, Pacific Islands)		0	0
Other		3	17.6
Prefer not to answer		1	5.9
Highest Level of Education			
Primary school or less		1	5.9
High school graduate		2	11.8
Some college/trade school		4	23.5
Graduate college/trade school		0	0
Some university		2	11.8
Graduated undergraduate degree		8	47.1
University graduate degree		0	0
Occupation*			
Full-time		4	23.5
Part-time		3	17.6
Unemployed		7	41.1
Student		1	5.9
Maternity Leave		3	17.6
Health Leave		1	5.9
Marital Status			
Married		13	76.5
Common Law		4	23.5
Single		0	0
Widowed		0	0
Separated		0	0
Divorced		0	0
	<i>Range</i>	<i>M</i>	<i>SD</i>
Age (years)	22-41	30.9	4.5

Note. *n* = 17

*For occupation participants were able to select more than one option

Table 2*Perinatal Characteristics of Participants*

Characteristic	<i>n</i>	%	
Pregnant	8	47.1	
Postpartum	9	52.9	
First-time Parent	10	58.8	
Past Neonatal Loss	4	23.5	
Past Termination of pregnancy	0	0	
Difficulty with getting pregnant			
Current pregnancy/infant	5	29.4	
Past pregnancy/infant**	3**	42.9**	
Complications during pregnancy			
Current pregnancy/infant	8	47.1	
Past pregnancy/infant**	2**	28.6**	
Complications during delivery			
Current infant *	7*	77.8*	
Past pregnancy/infant***	2***	40.0***	
Complications during recovery			
Current pregnancy/infant *	4*	44.4*	
Past pregnancy/infant***	3***	60.0***	
Physical Health Throughout Pregnancy			
Poor	2	11.8	
Fair	6	35.3	
Good	4	23.5	
Very Good	4	23.5	
Excellent	1	5.9	
Physical Health Since Pregnancy *			
Poor	1	11.1	
Fair	3	33.3	
Good	3	33.3	
Very Good	2	22.2	
Excellent	0	0	
	<i>Range</i>	<i>M</i>	<i>SD</i>
Number of children in addition to current pregnancy/infant**	1-2	1.3	0.5
Perceived Social Support	1.3-4	3.3	0.7

Note. *n* = 17

* = These questions were only asked of women in postpartum, *n* = 9

** = This question was only asked of women who were not first-time parents were, *n* = 7

*** = These questions were only asked of women in postpartum AND who were not first-time parents, *n* = 5

health complications reported in relation to babies, and no mention of colic, allergies, or other difficulties.

Mental Health Characteristics

Participants' mental health was assessed using closed-ended questions and self-report measures imbedded in the online questionnaire, as well as with the clinician-administered M.I.N.I., and via the mental health graph. Mental health characteristics are categorized as current mental health, reflecting the experience participants were having with their mental health at the time of the interview, and across the lifetime, reflecting participants' experience with their mental health over the course of their lives.

Current Mental Health

Current mental health in this section refers to participants' mental health at the time of their participation in the study. Mental health at the time of the interview was assessed through measures embedded in the online questionnaire and with the M.I.N.I.. The online questionnaire included the following measures: Perinatal Anxiety Screening Scale (PASS; Somerville et al., 2014), the Edinburgh Perinatal/Postnatal Depression Scale (EPDS; Cox et al., 1987), the Coronavirus Stressor Survey (McLean & Cloitre, 2020 unpublished), and the Perceived Partner Support for Seeking Help for Mental Health Concerns (adapted from Fonseca & Canavarro, 2017). Findings are reported in Tables 3 and 4.

Perinatal Anxiety Screening Scale (PASS). Participants responded to a self-report measure assessing anxiety symptoms experienced in pregnancy and postpartum. All participants reported scores of perinatal anxiety above the suggested clinical cut-off score of 26 (Somerville et al., 2014), with a range of scores from 29 to 85 and a mean score of 54.2 (Range = 29-85; SD = 15.5; see Table 3).

Edinburgh Perinatal/Postnatal Depression Scale (EPDS). Participants completed a self-report measure of depressive symptoms experienced in pregnancy and postpartum. Most participants reported perinatal depression scores above the clinical cut-off of 13 (82% at or above the cut-off; Levis et al., 2020) with a mean score of 15.8 (Range = 7-26, SD = 5.0; see Table 3).

Coronavirus Stressor Survey (CSS)³. Participants reported several experiences related to COVID-19 that either occurred to them or someone close to them. The most commonly reported experiences related to the COVID-19 pandemic included: difficulty getting needed social support (77% of participants), increased responsibilities at home (53%), difficulty getting food, medication or other necessities (35%) and loss of job or lost income (35%). In terms of exposure to COVID-19 information, the majority of participants were exposed to less than an hour a day of information (41%), and a majority reported *some* distress related to the COVID-19 pandemic (47%; options included *very little* distress, *some* distress, and a lot of distress). For complete results, see Table 4.

Perceived Partner Support for Seeking Help for Mental Health Concerns (PPSS). Participants also completed a measure of perceived partner support to seek professional help in the presence of mental health problems. Participants reported generally high social support with a mean score of 3.3 out of a 4-point Likert scale. While there are no formal criteria for cut-offs indicating “high perceived support,” higher numbers reflected higher perceived support with responses based on a 4-point Likert scale ranging from 1 (*Strongly Disagree*) to 4 (*Strongly Agree*). The mean score of 3.3 could be considered high perceived support. Furthermore, the scale authors reported a similar mean score ($M = 3.5$; see Table 3), reflecting that participants in

³ For the list of COVID-19 related events, only statistics that participants stated had occurred directly to themselves are reported here, with the exception of the item regarding a close friend/family member becoming ill from COVID-19

their study perceived “high encouragement” to seek support for mental health concerns (Fonseca & Canavarro, 2017).

M.I.N.I. findings. Participants most commonly met diagnostic criteria for the following anxiety disorders: Generalized Anxiety Disorder (GAD, 12 participants, 71%), Social Anxiety Disorder (SAD, 9 participants, 53%), Panic Disorder (PD, 8 participants, 47%), Agoraphobia (AG, 7 participants, 41%), and Illness Anxiety Disorder (IAD, 2 participants, 12%). Participants also met criteria for other mental health problems such as Obsessive-Compulsive Disorder (OCD, 6 participants, 35%), Posttraumatic Stress Disorder (PTSD, 4 participants, 24%), Major Depressive Disorder (MDD, 4 participants, 24%), and Bipolar 1 Disorder (BP1, 2 participants, 12%). Most participants (15 out of 17) met the criteria for more than one current diagnosis based on the M.I.N.I., with an average of 3 diagnoses (Range = 1-5). There were very even splits within each disorder of pregnant and postpartum participants. For a more comprehensive description of this dispersion, see Table 3.

Mental Health over the Lifetime

Mental health over the lifetime was assessed with items in the Perinatal and Mental Health Background Questionnaire and a mental health graph through which participants described perceived mental health quality over the lifetime.

Perinatal and Mental Health Background Questionnaire Data. In terms of mental health, most participants perceived their mental health over their lifetime as *Poor* (47%). All participants reported experience with anxiety and/or depression, and all participants had sought help for anxiety and/or depression prior to the current perinatal period. All but one participant (94%) had sought psychological treatment, and (82%) reported having sought pharmacological

Table 3*Current Mental Health Characteristics of Participants*

Measure	% _{pr}	% _{pp}	% of total N
M.I.N.I.			
Generalized Anxiety Disorder	41.7	58.3	70.6
Social Anxiety Disorder	44.4	55.6	52.9
Panic Disorder	50	50	47.1
Agoraphobia	71.4	28.6	41.2
Obsessive-compulsive Disorder	33.3	66.7	35.3
Post-Traumatic Stress Disorder	25	75	23.5
Illness Anxiety Disorder	50	50	11.8
Major Depressive Disorder	50	50	23.5
Bipolar 1 Disorder	50	50	11.8
PASS scores above clinical cut-off			100
EPDS scores above clinical cut-off			82.4
	Range	M	SD
PASS	29-85	54.2	15.5
EPDS	7-26	15.8	5.0
PPSS	1.3-4	3.3	0.7
Number of diagnoses (M.I.N.I.)	1-5	3.18	1.3

Note. $n = 17$

%_{pr} = percentage of those who met criteria who were pregnant

%_{pp} = percentage of those who met criteria who were postpartum

Table 4

COVID-19 Stressor Scale

Item	n	%
Became ill from possible or certain exposure to COVID-19	1	5.9
A close friend/family member became ill from possible or certain exposure to COVID-19	3	17.6
Job requires exposure to coronavirus	1	5.9
Lost job or lost income due to the COVID-19 pandemic	6	35.3
Increased responsibilities at home due to the COVID-19 pandemic	9	52.9
Difficulty getting food, medication, or other necessities due to the COVID-19 pandemic	6	35.3
Difficulty getting needed social support due to the COVID-19 pandemic	13	76.5
Exposure to COVID-19 information (radio, TV, Twitter, Facebook, Instagram, Newspaper) over past week		
Less than an hour	7	41.2
Distress related to COVID-19 over the past week		
Some	8	47.1

Note. $n = 17$

treatment for anxiety and/or depression (specific medications were not reported). These results are reported in Table 5.

Mental Health Graph. Another way mental health was assessed was through mental health graphs filled out by participants that assessed perceived mental health quality over the lifetime, which can be seen in Figures 3-5. Three main patterns emerged when analyzing these graphs: “Peaks and Valleys,” “U-shaped”, and “Downward”. In the first and most common pattern, “Peaks and Valleys,” perceived mental health quality was experienced as highs and lows between *excellent*, *neutral*, and *poor* markers of mental health across the lifespan. In this pattern, the first “valley” or dip in mental health quality occurred in childhood to early adolescence, with an increase in both “peaks” and valleys” in an undulating pattern from late adolescence/early adulthood to present day. The second graph pattern was a “U-shape” in which mental health was rated as between excellent and neutral in early childhood, with dips around adolescence and early adulthood, and then some recovery. The third and final pattern evidenced a “Downward” pattern in which mental health quality was continuously decreasing starting in childhood to late adolescence and ending at a low point during the time of the present study.

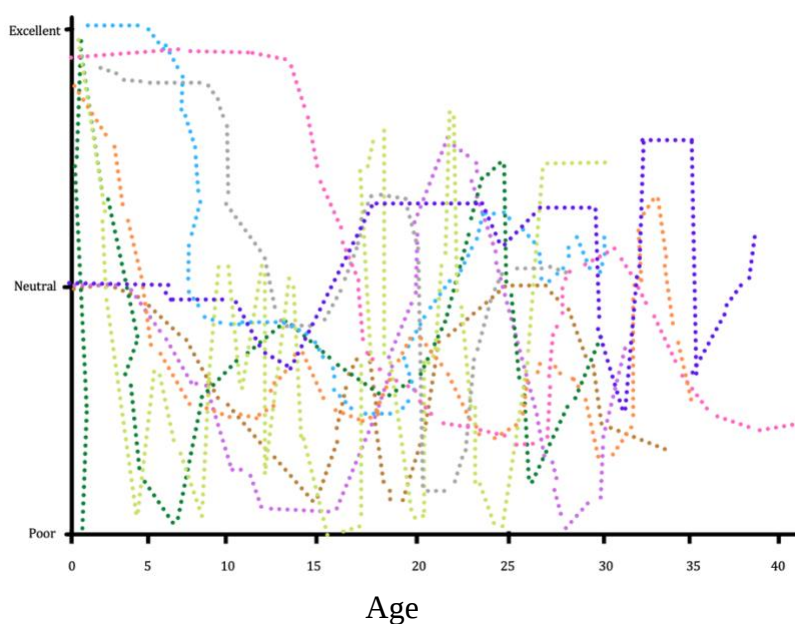
Summary of Quantitative and Clinical Perinatal Data

Participants ($n = 17$, Mage= 30.9) were quite evenly divided between those who were pregnant ($n = 8$) and postpartum ($n = 9$). Just under a third reported difficulties getting pregnant (29.4%) and just under a half reported that they had experienced pregnancy complications (47.1%). For the postpartum participants, a large majority (78%) reported having had complications during delivery, and just under half reported complications in recovery (45%). Over half of the participants were first-time parents (59%). All reported being in committed

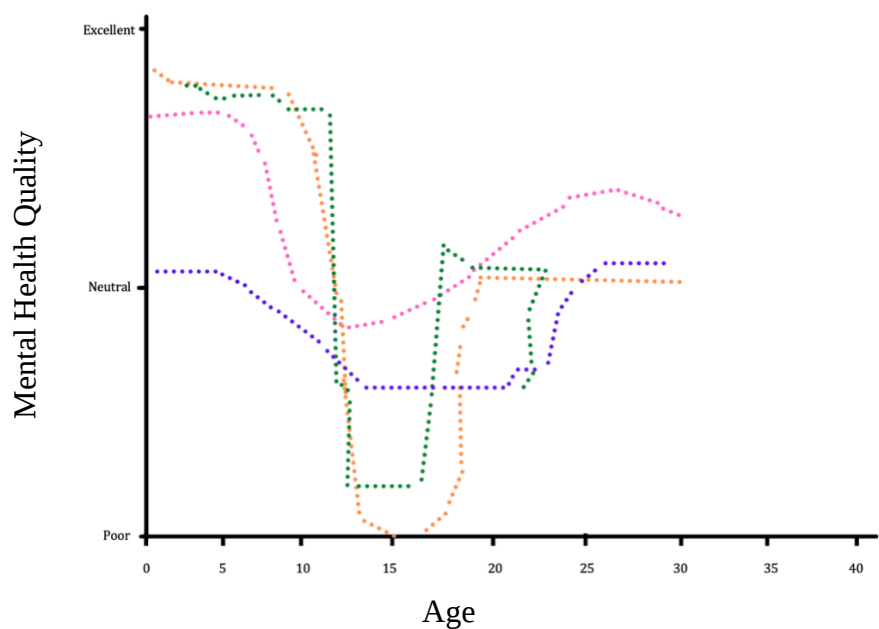
Table 5*Past Mental Health Characteristics of Participants*

Measure	<i>n</i>	%
Past Experience with Anxiety and/or Depression	17	100
Past Help-Seeking for Anxiety and/or Depression	17	100
Past Psychological Treatment	16	94.1
Past Pharmacological treatment	14	82.4
Perceived Mental Health Over Lifetime		
Poor	8	47.1
Fair	6	35.3
Good	2	11.8
Very Good	1	5.9
Excellent	0	0

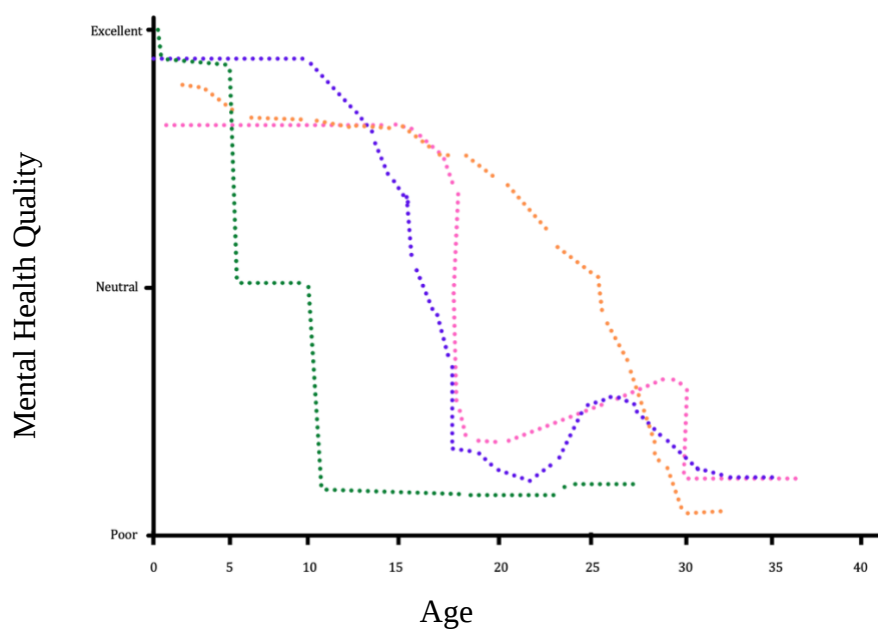
Note. *n* = 17

Figure 3*Mental Health Graph “Peaks and Valleys”*

Note. Different colours represent different participants' data.

Figure 4*Mental Health Graph “U-shaped”*

Note. Different colours represent different participants' data.

Figure 5*Perceived Mental Health Map “Downward”*

Note. Different colours represent different participants' data.

relationships, whether common-law (23.5%) or married (76.5) and reported a high degree of perceived support for seeking mental health concerns ($M_{PPSS} = 3.3$ on a 4-point scale).

In terms of current mental health, participants endorsed many symptoms of anxiety on a self-report measure ($M_{PASS} = 54.2$; 100% at or above clinical cut-off). As noted above, participants met M.I.N.I. criteria for various anxiety disorders: GAD (71%), SAD (53%), PD (47%), AG (41%), and IAD (12%). Participants also endorsed many symptoms of depression on a self-report measure ($M_{EPDS} = 15.8$, 82% at or above the clinical cut-off). As per the M.I.N.I., participants met criteria for MDD (24%), and BP1 (12%). Participants also met criteria for other mental health problems such as OCD (35%), and PTSD (24%). Participants endorsed numerous stressful experiences related to COVID-19 including: difficulty getting needed social support (77% of participants), increased responsibilities at home (53% of participants), difficulty getting food, medication or other necessities (35% of participants), and loss of job or lost income (35% of participants). Just under half of the sample reported mental health over the lifetime as *Poor* (47%), followed by *Fair* (35%), *Good* (12%), *Very Good* (6%), and none endorsed *Excellent*.

All participants reported experience with anxiety and/or depression, and all participants had previously sought help for anxiety and/or depression, with 94% reporting having sought psychological treatment. Three main patterns emerged in the Mental Health Graph which focused on perceived mental health over the lifetime: “Peaks and Valleys,” “U-shaped”, and “Downward”.

Qualitative Findings

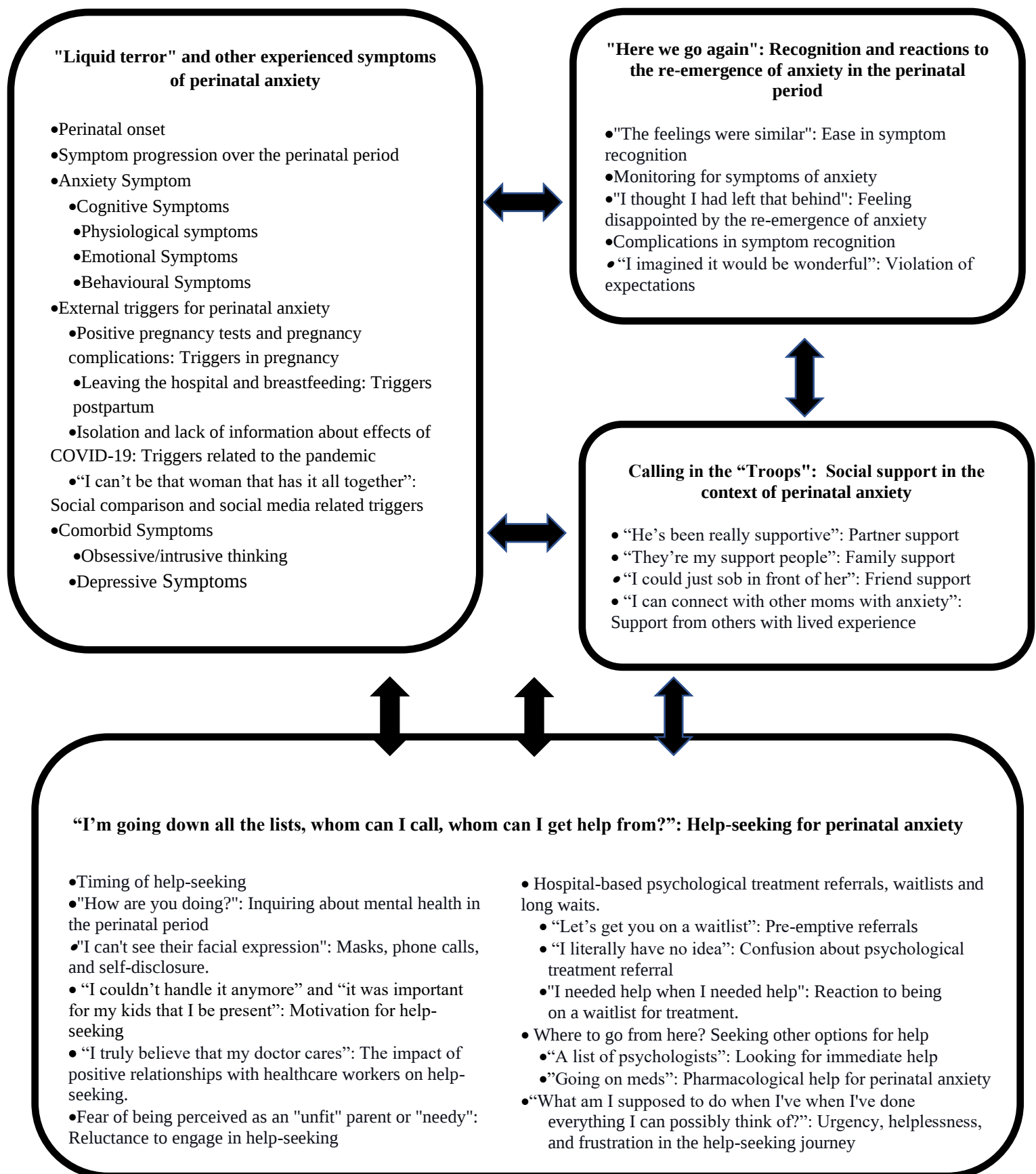
The qualitative analyses generated four major thematic categories representing participants’ experience with perinatal anxiety and help-seeking in the context of the COVID-19 pandemic: (1) “Liquid terror” and other experienced symptoms of anxiety; (2) “Here we go

again": recognition and reactions to the re-emergence of anxiety in the perinatal period; (3) "Calling in the troops": social support in the context of perinatal anxiety; and (4) "I'm going down all the lists, whom can I call, whom can I get help from?": Help-seeking for perinatal anxiety. For a visual illustration of themes, see Figure 6. Participant quotations are attributed to participant identification numbers, and either "PR" to signify that they were pregnant at the time of the interview, or "PP" to signify that they were postpartum at the time of the interview.

Theme 1: "Liquid terror" and other experienced symptoms of anxiety

The first theme related to participants' experience of anxiety. This first theme was important, as participants' experience of anxiety during the perinatal period was the inciting incident that set into motion the help-seeking process. Their experience with perinatal anxiety also strongly influenced how they experienced the perinatal period amid a worldwide pandemic. One participant described her experience as feeling like "liquid terror" injected into her body, painting a very vivid and visceral image of anxiety. This first major theme is broken down into: Perinatal onset, Symptom progression over the perinatal period, Anxiety symptoms, External triggers for perinatal anxiety, and Comorbid conditions.

Perinatal onset. A large majority (15 of 17 participants) of participants experienced an onset of perinatal anxiety during pregnancy. At the time of the interview, eight participants were pregnant and thus experienced an onset of symptoms during pregnancy. Of the nine participants who were postpartum at the interview, seven described an onset during pregnancy, and two described a postpartum onset. For those experiencing an onset during pregnancy, many discussed an onset specifically at the time they found out they were pregnant. These women were a mix of primiparous participants and participants with older children. One participant explained:

Figure 6*Help-seeking Model of Perinatal Anxiety*

From the moment I found out I was pregnant, I was anxious. I probably had eight pregnancy tests, like I did one every two days. And even after I went to the doctor and they confirmed [pregnancy], I still felt anxious. I don't know why. I have no reason to be like that. I have never experienced a pregnancy loss or anything like that, but it's almost like you would think I have. (Participant 112, PR)

The two participants who experienced a postpartum onset noted anxiety symptom onset soon after the birth of their infants. One participant explained that her anxiety symptoms first appeared "three days after my daughter was born" and that this was the same time period in which perinatal symptoms had set in with her first pregnancy (Participant 101, PP).

Symptom progression over the perinatal period. Participants described two main patterns of anxiety symptom progression over the perinatal period. The first pattern described "waves," "spikes," and "spurts" of anxiety that included days and even weeks between heightened anxiety and when they felt some relief from symptoms. One participant described her symptoms as follows: "I feel like my anxiety will come in spurts, almost like I'll be super bad for maybe a week, and then I can have a couple of good days" (Participant 112, PR). These descriptions are reminiscent of the "Peaks and Valleys" pattern many participants described in considering their mental health quality over their lifetime.

The other pattern that emerged was more of a constant, consuming anxiety where symptoms were perceived to be ever-present. One participant described her anxiety as, "It's just debilitating; I mean, I don't really know how else to describe it, just constant, never-ending stress" (Participant 106, PP).

Anxiety symptoms. Participants described the experience of perinatal anxiety as a set of symptoms that were cognitive, physiological, emotional, and behavioural in nature. When

participants described these different facets of anxiety, they often described them in a dynamic way wherein symptoms occurred alongside each other or developed with a cyclical or domino effect in which one symptom triggered another.

Participants' descriptions of their experiences of anxiety were composed of sub-themes following a CBT model, which acknowledges different symptom categories and also acknowledges the dynamic nature of symptom interaction. The sub-sub-themes include: Cognitive symptoms, Physiological symptoms, Emotional symptoms, and Behavioural symptoms. While I aimed to choose quotations that best support the symptom reflected in the sub-theme, many of the quotes reflect multiple symptoms, suggesting the dynamic nature of anxiety.

Cognitive symptoms. Participants' cognitive symptoms seemed to signal the context of their current lives, namely being pregnant or postpartum and worries about the fetus/infant and being in the midst of the COVID-19 pandemic.

There were many worries about the developing fetus or infant's health and safety. One participant explained, "My main concern was always his health and whether he was going to be healthy, whether he was going to make it to full-term, and whether he was going to come out with all ten fingers and ten toes" (Participant 122, PP). She explained that these fears had continued past pregnancy and into postpartum, "From womb to his size right now, I'm always worried about his health, always worried something's going to go wrong" (Participant 122, PP). There were also worries about fitting into new social groups that form with participation in parenting groups, worries about lifestyles changing when becoming a parent, and worries about being a good parent. There were numerous participants who worried about developing postpartum depression and/or psychosis.

Pregnant participants also described worrying about delivering an infant during a pandemic: What this experience would entail with COVID-19 restrictions, whether their partner would be able to be physically present with them in the hospital, and whether it was safe to deliver in the hospital with the high number of COVID-19 infected patients. One participant stated, “I was scared to even be in the hospital, to have to deliver in the hospital, because I was worried that I might become infected being in the hospital” (Participant 120, PP).

There were many worries about contracting COVID-19, the developing fetus/infant and other loved ones contracting and/or dying from COVID-19. One participant explained:

I don't want to get it [COVID-19]. I don't want anyone else to get it. I'm the designated caretaker for my grandmother. I'm always worried about putting her at risk. There's just so much that's unknown about this that puts a lot of stress on me. For the longest time, I didn't know a single person who was affected by this, and now we've heard of people we know who have passed, people who are now getting it, some people who have it and are still feeling the side effects of it, and some people who've made full recoveries. It's just always weighing on you like extra anxiety. (Participant 104, PR)

One participant with two children and an infant also described worries related to the impact of COVID-19 on her children's well-being as they had not been interacting with peers and had not been attending school in-person. At the same time, she described struggling to feel comfortable at the prospect of sending them back to school due to worries about them contracting COVID-19 and struggles with making the "right" decisions for her children (Participant 106, PP).

Other cognitive symptoms of perinatal anxiety included worries about their own anxiety. This included worries about being worried and characterizing cognitive symptoms as an inability

to shut off the brain, feeling that the brain is constantly "rolling" around, and thinking anxious thoughts. One participant explained, "I'm worried about being worried. All the time" (Participant 101, PP).

Physiological symptoms. Participants described many physiological symptoms related to anxiety, including racing heart, hyperventilation, difficulty breathing, shaking, sweating, chest pain, and discomfort. Many described panic attacks that comprised many physiological symptoms occurring concurrently with emotional symptoms. One participant described her panic attacks as:

It started with a racing heart, wanting to jump out of my skin, and a pit of dread in my stomach. I was having a lot of symptoms when I was trying to fall asleep at night after my daughter was born. I would wake up and feel like liquid terror had been injected into my system. I would wake up in a panic, in a fright right out of a sound sleep. (Participant 101, PP)

Most physiological symptoms reported occurred within the context of panic disorder and panic attacks. Some participants experienced severe, chronic panic attacks, "I literally couldn't breathe. My whole body was shaking, vomiting, and chills. And then when all that was over, I would sleep for hours and hours, and then I would wake up the next day, and it would start over again" (Participant 118, PP). While DSM-5 does not include crying as a symptom of panic disorder, many participants reported this in the context of panic attacks. Some symptoms, such as feeling shaky and excessive perspiration, were also reported by participants not experiencing panic attacks.

Emotional symptoms. Participants used many different descriptions for emotional symptoms of anxiety, such as "terror", "dread", "panic", "scared", and feeling "overwhelmed"

and "off". Many participants described these emotional symptoms as being blended with their physiological symptoms during panic attacks, as in the above example from Participant 101 (PP), who described a "pit of dread in my stomach" and "liquid terror had been injected into my system." One participant reported experiencing mood swings, irritability, and being easily angered by "little things."

Behavioural symptoms. Participants described engaging in avoidance, reassurance-seeking, and distraction in response to their experience of perinatal anxiety. Avoidance behaviours included avoiding leaving the house and grocery shopping. As many people were also mindful of social distancing due to COVID-19, I sought clarification from participants about the worry or anxious thought behind the avoidance. In many cases, the avoidance was related both to worries about contracting COVID-19 and worries about experiencing a panic attack when away from home.

Reassurance-seeking behaviours described by participants included online research about fetal health, checking for blood after using the toilet when pregnant, checking the infant repeatedly while the infant was sleeping, and seeking reassurance from medical professionals. One participant who experienced health-related worries about her fetus described purchasing a doppler to check on her fetus's heartbeat to reduce her anxiety (Participant 115, PR). Another participant described worries about reassurance seeking after delivering her infant, "I was constantly trying to determine did I make the right decision in having a C-section, so I would wake my husband up in the middle of the night and be like, 'did we make the right choice?'" (Participant 111, PP). Distraction behaviours were described as a tactic to avoid focusing or trying to escape symptoms of anxiety and included staying busy with household tasks and sleeping more as a way to avoid symptoms of anxiety.

External triggers for perinatal anxiety. While symptoms of anxiety can trigger or intensify cycles of anxiety, participants also identified external triggers for their anxiety. Similar to the cognitive symptoms, external triggers reflected the context in which participants found themselves in – namely being in the perinatal period during the pandemic. This sub-theme was broken down into: Positive pregnancy tests and pregnancy complications: Triggers in pregnancy, Leaving the hospital and breastfeeding: Triggers in postpartum, Isolation and lack of information about effects of COVID-19: Triggers related to the pandemic, and “I can’t be that woman that has it all together”: Social comparison and social media related triggers.

Positive pregnancy tests and pregnancy complications: Triggers in pregnancy. An external trigger for many participants is already identified in the onset section of this theme: finding out that they were pregnant was an anxiety trigger for many. Others indicated that feeling ill during pregnancy, decisions about when to tell others about pregnancy, pregnancy complications, not feeling the fetus kicking during pregnancy, past miscarriages, and emergency C-sections were all triggers for heightened anxiety.

Leaving the hospital and breastfeeding: Triggers postpartum. For postpartum participants, leaving the hospital with infant following labour and delivery triggered anxiety: “It was scary to leave the hospital because I wasn't going to have that team of doctors and nurses that I could just call over whenever I wanted. And it was like, okay, now we're on our own, and it was scary.” (Participant 120, PP)

Another trigger for postpartum patients was breastfeeding, including making decisions about breastfeeding or formula feeding, feeling pressure to breastfeed, and difficulties breastfeeding. One participant recounted her experiences with breastfeeding and how it increased her anxiety:

I got mastitis - It was just bad. I had a lot of anxiety about breastfeeding. I didn't want to. And then, when I would feed, I'd get so anxious and overstimulated. It was crazy. I had to have headphones, and I couldn't hear anything – like so bad. And then she wasn't gaining weight, and I was bleeding [from mastitis]. It was just so horrible. It was a lot of pain and then just anxiety, not even anxiety about the feeding itself but anxiety about having to feed. I couldn't sleep because I'd be so anxious about when the next feed would be. Yeah, so it was a lot- there was a lot of anxiety there for sure. (Participant 110, PP)

Isolation and lack of information about effects of COVID-19: Triggers related to the pandemic. Many participants, both pregnant and postpartum, stated that the lack of knowledge about the effects of COVID-19 on pregnant people, the fetus, or a newborn was a major trigger for anxiety, along with lack of access to needed supports and services, and isolation related to social distancing regulations. One participant explained feeling isolated at home with her children and the impact of this isolation:

It's [referring to COVID-19 social distancing and lockdowns] isolated me. I get more worried about every bump, bruise, and little thing with the kids. It becomes so much more - I get so much more obsessive about everything. Yeah, and it's because I'm not out doing anything, keeping busy, and I have more time for more anxiety-ridden thoughts. (Participant 123, PP)

“I can’t be that woman that has it all together”: Social comparison and social media related triggers. Social media, and comparisons made with social media ideals was an important external trigger for participants. Another aspect of isolation and social distancing described by participants was the lack of in-person contact with one’s social network, and with the community at large. For many, the large majority of social contact was through technology, such as texting,

phone calls, and video-calls. More informal social contact occurred through social media use, and many participants described using social media as a way to compare their own pregnancy and postpartum journeys to those of others. One participant describing her use of social media stated:

If you haven't been around people in real life, those people that you see on social media, you start to imagine them as your friends. It's the closest thing you have to someone who was going through similar things as you are. When they're writing down their thoughts and feelings [and posting on social media], and they're not really aligning with yours, it makes you question how you're dealing with things. (Participant 119, PR)

This social comparison with others was noted as a trigger for anxiety and questioning one's own adequacy as a pregnant or postpartum person. Another participant stated:

I'm wearing my husband's shirt right now during the interview because I didn't have a chance to have a shower yet. But you go on Instagram or social media or TV, these women have their hair curled and they're wearing these outfits, and they're out with baby and baby is in these perfect little outfits. And my baby just barfed all over her onesie, and I have to change it for the third time today, and it's just - you feel very alone, or I guess isolated or kind of ashamed that - what am I doing? What am I doing wrong that I can't, you know, be that woman that has it all together and looks like supermom and is, you know, functioning completely amazingly. (Participant 107, PP)

Women also acknowledged that social media is not an accurate portrayal of reality.

However, this recognition did not seem to reduce the negative impact of these social comparisons on participants. One participant noted, "You go on social media, and everything's

perfect. You know that it's not, but that's what you see, right? And it plays on you for sure" (Participant 107, PP).

Comorbid conditions. While the present study focused on the experience of perinatal anxiety, it is also important to acknowledge the high comorbidity rates of other non-anxiety mental health concerns experienced by participants, including obsessional/intrusive thinking and depressive symptoms.

Obsessional/intrusive thinking. Several participants reported experiencing obsessional or intrusive thinking. Some intrusive thoughts related to the infant included intrusive thoughts and images about accidentally or intentionally dropping the infant while walking down the stairs, shaking the infant, enacting or partner enacting sexual abuse while changing the infant's diaper, or more general harm/safety thoughts related to infant. One participant stated:

I've had some intrusive thoughts. Like one time, I thought my mom had buckled my daughter into the car seat too tightly, and something was wrong with her [referring to infant]. She looked a little pale, and I thought, "oh, good, now I don't have to do this anymore." (Participant 101, PP)

Other intrusive thoughts related to harm coming to self or others, such as driving into oncoming traffic, or driving into pedestrians.

Depressive symptoms. As suggested by the self-reported perinatal depression in Table 5, many participants experienced comorbid depressive symptoms during pregnancy and postpartum. Commonly reported symptoms included excessive sleeping, feelings of worthlessness, low motivation, inappropriate guilt, disconnection, suicidal ideation, sadness, and tearfulness. One participant described feelings of disconnection and tearfulness in this way:

I would sleep for hours and hours, and then I would wake up the next day, and it just started over. I would sit at the supper table and stare at my husband and son. I just couldn't even respond to them when they asked me anything because as soon as I would, I just couldn't stop crying. It was from the minute I woke up to the minute I went to sleep I couldn't stop crying. (Participant 118, PP)

Another participant had experienced a complicated pregnancy in which she was told numerous times that she had likely miscarried. She described shutting down during her pregnancy in reaction to these experiences:

Because it [pregnancy] is just going to be taken away from you again, so honestly, at that point, I just shut down like I just turned off. I was pretty numb for the rest of it. I was probably less anxious after that just because I was turning off; I wasn't letting myself get happy, just letting myself be sad. I was just numb. (Participant 106, PP)

Theme 2: "Here we go again": Recognition and reactions to the re-emergence of anxiety in the perinatal period

The second theme related to participants' recognition and reactions to anxiety re-emerging in pregnancy and/or the postpartum period. One participant described learning that she was pregnant and soon after feeling "here we go again with anxiety" (P115, PR). As all participants endorsed previous experiences with anxiety and/or depression in the Mental Health Background Questionnaire, and some had noted previous experience with perinatal anxiety in prior pregnancies/postpartum periods, participants were familiar with symptoms of anxiety. When asked about how they recognized symptoms, their responses were often brief (as can be seen in the direct quotes) and reflected a clarity in deciphering and conceptualizing symptoms as seen in the sub-theme, "the feelings were similar": ease in symptom recognition. That being said,

a small group of participants noted some difficulty in recognizing anxiety and discerning whether symptoms were related to common symptoms of pregnancy and/or postpartum as reflected in the sub-theme complications in symptom recognition. Some participants with past experience with anxiety in the perinatal period reported being very aware that anxiety could re-emerge once they were in the perinatal period again and monitored for symptoms, as reflected in the sub-theme, monitoring for symptoms of anxiety. In recognizing that anxiety had re-emerged, many participants noted feeling disappointed, as seen in the sub-theme, "I thought I had left that behind": feeling disappointed by the re-emergence of anxiety. One reason participants may have been disappointed by the re-emergence of anxiety during the perinatal period is the violation of expectations reflected by the sub-theme "I imagined it would be wonderful": Violation of expectations.

"The feelings were similar": Ease in symptom recognition. As stated in Table 5, all participants in the present study reported prior mental health concerns with anxiety and/or depression that occurred before the perinatal period. Most participants noted that they easily identified their symptoms during the perinatal period as anxiety due to past lived experiences with anxiety. One participant stated, "Well, I mean, I've experienced anxiety before, so the feelings were similar, and I recognized that they were similar" (Participant 102, PR).

Monitoring for symptoms of anxiety. Participants with older children who had prior experience with anxiety in pregnancy and/or postpartum reported that they were vigilant and monitored themselves for symptoms of anxiety when they re-entered the perinatal period. One participant who had experienced past perinatal anxiety explained that she, her husband, and her parents were all monitoring her for new onset of anxiety this time, "I think we were all hypervigilant about it because of what happened with my first." (Participant 101, PP). Another

participant with past perinatal anxiety explained that as soon as she found out she was pregnant, she worried about anxiety returning and discussed a plan to monitor her anxiety with her doctor.

"I thought I had left that behind": Feeling disappointed by the re-emergence of anxiety. When asked what it felt like when she recognized that her anxiety had returned, one participant responded, "It was scary, it was disappointing and scary... it was still scary because I thought I had left that [anxiety] behind" (Participant 102, PR). Another participant shared a similar sentiment, "I thought I got to this place of realistic wellness and I'm starting to feel like all of that [referring to mental health] is so much more fragile than I realized. And it's like, what do you have to do to get there? [referring to place of mental wellness]" (P114, PR). Another participant stated that upon recognizing that she was experiencing again in postpartum stated, "It feels a little embarrassing in that sense of everybody has a baby; why do I feel like this? Why would this be affecting me like this?" (Participant 118, PP). One participant discussed how the experience of perinatal anxiety had made her and her husband reconsider how soon they would try for another infant, as perinatal anxiety had been so difficult for her. Another participant stated, "Am I always going to be this fucked up person, and then I'm just going to fuck up my kid?" (Participant 114, PR).

There was also disappointment when participants who had previously learned coping strategies to manage anxiety found that their coping strategies were not working during the re-emergence of anxiety in the perinatal period. One participant who had engaged in hospital-based anxiety treatment during a previous experience with perinatal anxiety stated, "I think I have coping skills to handle it, but I don't know, something about postpartum, like my body just can't - my brain can't do it" (Participant 101, PP).

Complications in symptom recognition. While identification of perinatal anxiety was easy for most, some participants attributed symptoms to pregnancy and postpartum factors such as hormonal fluctuations, pregnancy-related nausea, and complicated delivery. Two participants also described difficulty in discerning what was anxiety and what reflected “innate” personality style (e.g., interpreting symptoms as “that’s just me” Participant 115, PR).

“I imagined it would be wonderful”: Violation of expectations. Another theme that emerged was the idea of perinatal anxiety being a violation of expectations about how women are “supposed” to feel at this time of life. “I imagined it would be wonderful and great, and it wasn’t. It was isolating and difficult ... And I don’t know, it was a lot of fear” (Participant 107, PP). Another participant noted:

This is my first and only time being pregnant, so I don’t know any other way. My mom tells me, “Just try enjoying it, enjoy being pregnant,” and stuff. But it’s hard to do that when you’re just nervous and worried all the time. (Participant 112, PR)

This violation of expectations seems to be related to the previous section and the way in which some participants experienced the re-emergence of anxiety symptoms in the perinatal period. While some were monitoring and perhaps expecting symptoms to re-emerge, others felt disappointed in the re-emergence as they had hoped they had “left anxiety behind,” as mentioned by Participant 102 (PR). The violation likely also related to expectations that the perinatal period is a universally happy, “wonderful” experience as often portrayed in the media, rather than as a more nuanced, complex time of life full of a range of emotions. These expectations are also reflected in the sub-theme external triggers, in which participants described the tendency to engage in social comparison with other pregnant and postpartum women.

Theme 3. Calling in the “Troops”: Social support in the context of perinatal anxiety

The third theme related to the ways in which participants engaged with their social networks during the experience of perinatal anxiety, particularly in the context of the COVID-19 pandemic. Interviews were conducted at a point in the pandemic when public health guidelines recommended significant social restrictions and social distancing measures. Calling in the “troops” refers to one participant who explained that when she had recognized that she was experiencing perinatal anxiety, she “called in the troops” referring to her husband and parents to come up with a plan to help her through this period. In this section, “troops” refers to many different groups from which participants received or did not receive needed care, categorized by social relation category: partner support, family support, friend support, and support from others with lived experience.

“He’s been really supportive”: Partner support. The main support person identified by participants was their husband/partner. Support from partners included reassurance that they would help participants “keep an eye out” for worsening symptoms, reminding participants that they had been through anxiety before and they could get through it again, taking time off work to come home and provide support during challenging days, reminding participants about doctors’ appointments and to take medication. One participant described her partner’s support as follows:

He’s been really supportive. He’s encouraged me to reach out. And when I’m taking pills [antidepressants], it’s like, OK, I’m going to take them, I need to get this glass of water, and then I get distracted and don’t end up taking them. He’s good about ‘So, did you take your pills?’ And he’s very supportive of it. He gets a little annoyed about how much I worry about things, but he is really good at it and if I am, I can very easily say to him, I’m having a bad day. He is very, very good about that. I think he is the most positive person

in my life, so I feel good about having anxiety and admitting I have it. (Participant 123, PP)

While many participants described their partners as being able to provide many forms of instrumental support to participants and remaining non-judgmental, some noted that they did not feel deeply understood by their partners:

He's good about it like he's really supportive and not judgmental or anything like that.

Sometimes I feel like he doesn't understand how my brain works, and it's not just the pregnancy part, like outside of it, too, like how fast one little worry can turn into a big worry for me. (Participant 112, PR)

Another participant stated that her husband viewed her as "overly emotional" due to her experience with anxiety, "He has no idea what it is or feels to be anxious or, I mean, to be constantly anxious or to be depressed." (Participant 122, PP).

“They’re my support people”: Family support. Some participants described family members, specifically their parents, as important sources of support. Participants described calling their parents (often specifically their mothers) for support during times of high anxiety. For some, parents and partners worked together with participants to come up with a plan to cope with anxiety and treat mental health concerns. One participant explained, "And the two of us [partner and self] sat down, and we Facetimed with my stepdad and my mom because they, as I said, they're my support people, and we made a plan for me to call my doctor" (Participant 113, PR). Another participant explained that part of the plan that her partner and parents came up with was to move in with her parents, "I called in the troops, so to speak. I called my parents, and I called my husband to come home from work early, and we made a plan at that point to move in with my parents for ten days to try and like head off anxiety at the pass." (Participant 101, PP).

While many participants described feeling supported by family members, others noted a lack of support from parents and in-laws due to a lack of closeness and stigma related to mental health.

“I could just sob in front of her”: Friend support. While we would expect the husband/partner to be a main source of support, especially in light of social restrictions due to COVID-19, participants expressed a clear desire to connect with friends during their experiences with perinatal anxiety. The COVID-19 restrictions made it difficult, however, for participants to seek the needed social support outside of their households. Many participants noted that while they had the support of their partner, they also wanted to see friends and see them in person. One participant stated, "I just wanted to see someone, like a girlfriend, and give them a hug" (Participant 122, PP). Another participant explained that she had a friend who knew she was struggling with her mental health and would come to visit, going against COVID-19 restrictions:

And she came into my house, and I saw her for the first time in I don't know how long, and I just broke down and cried. I felt like after I could just sob in front of her, everything started to get better. She started dropping by, and my other friends started dropping by. Even just seeing someone at my entrance for like ten minutes made such a big difference (Participant 118, PP)

When asked what it meant to her to have social support from her friends, even if it was just a friend in her entranceway for ten minutes, she stated it felt like "I could breathe."

“I can connect with other moms with anxiety”: Support from others with lived experience. While many participants described support needs related to partners, family, and friends, there was also a clear desire to connect with others experiencing perinatal anxiety. While some participants described having friends who were also pregnant or recently postpartum, these

friends generally had not experienced mental health concerns or did not disclose such circumstances, further exacerbating feelings of isolation. One participant explained:

And then you just like compare, you compare yourself and like asking other people that were pregnant and like, 'was it like this for you?' And they're like, 'no.' You're like, 'oh.' I do have one friend who's also pregnant and who's feeling similarly, so that's helpful
(Participant 114, PR)

This tendency to compare was also outlined in a previous section in the sub-theme, Social comparison and feelings of inadequacy. When comparisons are made to idealized portrayals of the perinatal period on social media, or when comparisons are closer to home, such as within a friend group, these comparisons can fit the “compare and despair” pattern. However, when comparing to others and seeing similarities, especially on aspects of self that are vulnerable, as Participant 114 (PR) said, it can be “helpful”.

Finding valuable comparison points with other perinatal women experiencing anxiety was likely more difficult due to the COVID-19 pandemic, social restrictions, and cancellation of many programs such as parent groups. Some participants described looking forward to psychological treatment groups as a way to connect with others with similar experiences. One participant explained, "So I'm going to start these group sessions now. And I'm excited about the fact that there are group sessions because now I feel like I can connect with other moms and other people with anxiety, which is very hard to find in your circle of friends" (Participant 113, PR). Another participant who had already started group therapy at the time of our interview expressed the impact of the peer support side of the group. She explained:

You have friends who're wonderful and great, but there's also a level of - you don't want to be that person who struggled because your friends didn't talk about it. Their birth was

amazing, their pregnancy was beautiful, and you're sitting here going, okay, my birth was awful. I didn't have a connection with my baby right away. So, the group that I'm part of for the therapy group- it's nice to be able to talk to women that you don't know, and you don't have a connection with, and you- its just women being honest and raw, I guess, about their experiences and their feelings. (Participant 107, PP)

Theme 4. “I’m going down all the lists, whom can I call, whom can I get help from?”: Help-seeking for perinatal anxiety.

The fourth and final theme related to participants’ experience of seeking psychological treatment for perinatal anxiety. This was a complex and often frustrating journey for participants, and required perseverance, as demonstrated by one participant’s statement, “I feel like I’m just going down all the lists, who can I call, who can I get help from? I need help with this right now. I need to deal with this right now” (Participant 101, PP). This final theme is broken down into: Timing of help-seeking, "How are you doing?": Inquiring about mental health in the perinatal period, "I can't see their facial expression": Masks, phone calls, and self-disclosure, “I couldn’t handle it anymore” and “It was important for my kids that I be present”: Motivation for help-seeking, “I truly believe that my doctor cares”: The impact of positive relationships with healthcare workers on help-seeking, Fear of being perceived as an "unfit" parent or "needy": Reluctance to engage in help-seeking, “I was really determined”: Attitude towards help-seeking, Hospital-based psychological treatment referrals, waitlists and long waits, and Where to go from here? Seeking other options for help.

Timing of help-seeking. As described earlier, eight participants were pregnant at the interview and thus experienced onset in pregnancy. Nine participants were postpartum at the time of the interview, with seven experiencing an onset during pregnancy and two postpartum

onsets. Thirteen described initiating help-seeking during pregnancy. Four participants, two of whom experienced a postpartum onset and two a pregnancy onset, described initiating help-seeking in the postpartum period.

"How are you doing?": Inquiring about mental health in the perinatal period. A sub-theme that emerged related to help-seeking was when somebody directly asked participants about their mental health and suggested that they seek help for perinatal anxiety. For some participants, this was a friend; for others, it was a therapist; and for others, it was a member of their healthcare team. One participant stated that a friend employed as a social worker visited her postpartum, "She said, 'How are you doing?' and I was like, 'good.' She's like, 'no, seriously, how are you doing?' And I just started crying" (Participant 111, PP). At that point, her friend suggested that she seek help for her mental health. Another participant stated that her public health nurse inquired about her mental health during a postpartum visit, and noted the importance of someone asking about her mental health, "I think sometimes people just ask the right questions, and then I admit I'm struggling because I don't always just outright tell people" (Participant 120, PP).

"I can't see their facial expression": Masks, phone calls, and self-disclosure. As participants were help-seeking during the COVID-19 pandemic, appointments with healthcare providers had either moved to telephone or videoconference appointments or in-person sessions wearing masks. Some participants noted that self-disclosing about perinatal anxiety and asking for help was particularly difficult when they could not see the healthcare provider's face or facial expressions, such as when appointments were over the phone or in person with masks due to COVID-19. One participant noted, "In-person ... It makes me anxious to say things about my

anxiety to somebody when I can't see their facial expression." (Participant 101, PP). Another explained:

I think just putting a face to the person you're talking to... I feel like over the phone, it's hard to humanize the conversation. I find it much easier to see who I'm talking to. Even when you're talking, and even when I'm talking right now when you [referring to PI interviewing] are like nodding, it almost gives like you're listening and understanding. Whereas over the phone, you don't know what they're thinking or how they're reacting to what you're saying. (Participant 106, PP)

Another participant noted that she found video conference sessions with healthcare workers to be more helpful than telephone or in-person masked appointments, as she was able to see the healthcare providers and meet "face to face" without leaving the house and increasing chances of contracting COVID-19 (Participant 101, PP).

“I couldn’t handle it anymore” and “it was important for my kids that I be present”: Motivation for help-seeking. Participants identified two primary motivators for seeking help: symptom severity and the desire to be mentally well for the sake of their children. Participants identified worsening anxiety symptoms such as increased number of panic attacks, feeling unable to stop engaging in reassurance seeking, intrusive thoughts, difficulties with sleep onset resulting in extreme lack of sleep, and suicidal ideation as being symptoms that felt so severe that they needed to seek help. One participant explained:

I ended up having like seven or eight panic attacks back-to-back-to-back-to-back. And I couldn't; I couldn't handle it. It got to the point where I was puking because, for me, like, I get the sweats, and I like faint, and I puke, and it was all day. I was in the bathroom panicking and didn't know what to do. So, I ended up phoning my GP and asking if there

was anything we could do because I just couldn't mentally handle it anymore. (Participant 113, PR)

Other participants stated that intrusive thoughts about harm coming to their infant felt so disturbing and felt so ego-dystonic they recognized they needed to seek help. Participants also discussed worries that their perinatal anxiety would develop into postpartum depression or psychosis and were motivated to seek help to prevent the development of these concerns.

Other participants discussed feeling motivated to seek help so that they could be well for the sake of their children. Some discussed worries that their anxiety would negatively impact their fetus/infant, while others worried that anxiety and mental health concerns would negatively impact the relationship with their infant and older children. When asked why she decided to seek help, one participant responded:

Because I knew I needed it. It was important for my kids that I be present and able. Yeah, honestly, I think it really came down to that with my childhood. My dad had mental health issues, and it destroyed our relationship, and I really didn't want that to happen with my kids. (Participant 106, PP)

“I truly believe that my doctor cares”: The impact of positive relationships with healthcare workers on help-seeking. Participants discussed an overall comfort with disclosing their experience of anxiety and asking for help from their healthcare team (e.g., midwives, family physician, OB). Many described very positive and collaborative relationships in which they felt well cared for, “I’m very lucky that I have her because I’ve heard of other people who have doctors that just rushed them in and out and really don’t care. I truly believe that my doctor cares.” (Participant 104, PR).

Another stated, “My doctor’s amazing. She is the best. I have a pretty good relationship with her, and I just was honest and said, I’m having a lot of anxiety” (Participant 110, PP). Some participants discussed past help-seeking from the same healthcare team that they sought help from during this episode of anxiety and that past help-seeking facilitated current help-seeking:

It was comfortable. I guess I’ve had the same team since my first pregnancy. So, I’m totally comfortable with them. I think if it was a new team or someone I didn’t know, maybe I would have been more uncomfortable. But they already knew that I struggled with anxiety in my first pregnancy. So, it was kind of hard not to admit that I wanted help. (Participant 115, PR)

Another said that when she talked to her family physician about needing help for her anxiety, her doctor responded in a collaborative and responsive manner, “We’ll watch it [anxiety] every point, and we’ll talk about it. We’ll make sure you have the resources that you need” (Participant 123, PP).

“I was really determined”: Agency and attitude towards help-seeking. Participants noted that their agency and attitude was an important aspect in the help-seeking process. One participant acknowledged that help-seeking for perinatal anxiety is difficult, but that her determination helped her continue to pursue help, “I’ve really pushed, it’s required me to push. I can’t say it was easy. I know a lot of people probably would have given up far before I did. I was just really determined” (Participant 106, PP). Others noted that they had to lead conversations about their mental health with their healthcare team by bringing up anxiety. When asked how the conversation about perinatal anxiety came about in her doctor’s appointment, one participant said, “It was led by me. I definitely brought it up and said I’m having some trouble. It wasn’t

difficult for me because I've been there before, so I kind of knew I needed help" (Participant 107, PP).

Fear of being perceived as an "unfit" parent or "needy": Reluctance to engage in help-seeking. Reluctance and hesitation about engaging in help-seeking related to worries about being perceived as "needy" or an "unfit" parent was another sub-theme that emerged. Some participants were hesitant to engage in help-seeking due to fears of being perceived as an "unfit" parent or being separated from their children for treatment. One participant explained that she was worried that if she sought treatment for her intrusive thoughts that she would be seen as "crazy," and child and family services would become involved in assessing her fitness as a parent (Participant 111, PP). Another stated that it was difficult to seek help due to similar fears, "I was worried that they were going to think I wasn't fit to be a mom" (Participant 114, PR). Another participant said that her mother suggested that she may need in-patient care for her postpartum mental health concerns, which made it difficult to seek help, "After that point, it took me a couple of days to even see my doctor because I don't want to do in-patient, I don't want to be away from my kids, I don't want it [treatment] to consume my life to that point." (Participant 101, PP).

Other participants stated that it was difficult to seek help as they worried about being "needy," being a "burden" to others, or felt that they should be able to handle their anxiety on their own. One participant stated that a fear of being needy made it difficult to seek help, "I don't want to be like needy. I hate being needy. I have this fear of being needy." (Participant 114, PR). Another said:

You can feel like a burden. So then, even if you want to say I need help, I would tell myself, like, oh, I don't want to put that stress onto someone else, even a professional.

Maybe the professional has people that are worse off than me and need that professional help more than me. So, I should free up that resource to other people instead of taking it for myself. And so, then you end up like talking yourself down from being able to get the help sometimes that you actually need. (Participant 122, PP)

Hospital-based psychological treatment referrals, waitlists and long waits.

Participants discussed the experience of being referred for hospital-based psychological treatment of perinatal anxiety. When participants discussed this referral process, there were three sub-sub-themes that emerged. The sub-sub-themes were: “Let’s get you on a waitlist”: Pre-emptive referrals, “I literally have no idea”: Confusion about psychological treatment referral, and “I needed help when I needed help”: Reaction to being on a waitlist for treatment.

“Let’s get you on a waitlist”: Pre-emptive referrals. Some participants reported that they had been pre-emptively referred for hospital-based psychological services for perinatal anxiety prior to the onset of perinatal anxiety. One participant explained that she had worked through many mental health concerns with her doctor over the years, which led to her doctor pre-emptively referring her to the perinatal anxiety program:

Because I have a previous history of anxiety, she was like, you know what, like let's be pre-emptive and let's get you on a waitlist for prenatal and postpartum [mental health] care just in case you need it., I'm so glad that we did it then because the wait list is like five months or something like that. And so, I'm so glad that we did it then because I'm still on the waitlist, and now I feel like I need that help. (Participant 113, PR)

Another participant stated that her midwife also placed her on the waitlist for psychological services as a pre-emptive step:

I told them that I had anxiety before pregnancy, they said that I'm more likely to have it during pregnancy, so I think they did the referral then. They said it was like a 'just in case' because I would be more likely to have those issues. (Participant 120, PP)

Others reported that their healthcare team informed them that due to past experience with anxiety or depression that they may be more susceptible to postpartum mental health concerns, and that they would monitor them more closely for the development of symptoms and suggested prior to the onset of symptoms that they seek psychological support.

“I literally have no idea”: *Confusion about psychological treatment referral.* Another theme that emerged was a lack of information, and confusion about what services or program participants have been referred to. When asked about what she knew about the referral her doctor had made, one participant stated, "I literally have no idea," though she knew she had been waiting for "something" for about four months (Participant 111, PP). Another participant explained that her referral source, an OB, didn't know much about the program she was referring her to:

"I wasn't told a lot because she didn't know a lot about the program. She knew she had sent patients there before, and they were very grateful they had gone there. I was told that, like, they helped pre- and post-natal with anxiety and depression." (Participant 113, PR)

Another participant noted that she did not know that she was on a waitlist for psychological services until she received a letter in the mail stating that her referral had been received. At the end of the second and final meeting with participants, a few participants stated that they were happy that they were provided with "treatment" and, upon further questioning,

explained that they had thought that our meetings were the "treatment" they had been on the waitlist for.

"I needed help when I needed help": Reaction to being on a waitlist for treatment. Participants discussed what it felt like to be on a waitlist for no-fee, hospital-based psychological treatment of perinatal anxiety. Participants shared the disappointment of learning there would be a wait for services and the feeling that they could not access help when they needed it. One participant in group treatment at the time of the interview stated, "I wish I would have been able to get in sooner. There was such a long waitlist, and I needed the help when I needed the help" (Participant 107, PP). In terms of wait time between referral and start of treatment, participants noted waiting for multiple months, with some stating between 4-6 months. One participant reported how she felt being on the waitlist, "It's sad. You're kind of like, well, I hope I can wait" (Participant 114, PR). She noted that while she was fortunate enough to have a good social support system, she worried about "exhausting" them if she could not seek professional help in a timely manner. Many participants recognized that there were limited resources available, though that recognition did not ease their distress. One participant stated:

I understand why it is the way it is. I get that there are a lot of people out there struggling with mental health right now, especially right now. And I get that there's probably a shortage of psychologists. But it's, yeah, it's hard to accept when you feel like you really need help. (Participant 119, PR)

Another said:

I understand there are limited resources, but it [the waiting time] is way too long. My daughter was almost five months old before I actually got to talk to somebody [from the

hospital-based anxiety program]. That, to me, is a little scary because if I wasn't as good as I was, that could have been harmful to the baby. (Participant 123, PP)

Other participants worried that they would be on the waitlist for so long that they may no longer need help or would not be eligible for services when they were finally contacted:

There's this weird feeling like, what if I start doing better, and then they call me on the waitlist, am I still sick enough to get help if I've gotten a little bit better? Because I know I'll get sick again. (Participant 114, PR)

Another described hearing that the wait for services would be about six months:

I reached out to my OB and found out that I'm going to be waiting six months. I'm already going to be way past the newborn stage by then. I may as well get taken off the list, but I'll wait just in case. (Participant 112, PR)

Where to go from here? Seeking other options for help. Participants described other ways they sought help, including looking for other psychological services in the sub-sub-theme, “A list of psychologists”: Looking for immediate help, considering pharmacological treatment in the sub-sub-theme, “Going on meds”: Pharmacological help for perinatal anxiety, and the emotional experience of urgently seeking immediate help in the sub-sub-theme, “What am I supposed to do when I've when I've done everything I can possibly think of?”: Urgency, helplessness, and frustration in the help-seeking journey.

“A list of psychologists”: Looking for immediate help. Many participants were looking for more immediate treatment than could be offered by the long waitlists of no-fee hospital-based psychological treatment, and some sought other psychological and therapy options. However, searching for private psychological services proved to be a difficult task, with many noting that the psychologists they contacted were not accepting new clients, finding that there was a waitlist

for private services, uncertainty about how to choose a psychologist who specialized in perinatal mental health, and uncertainty about which health care benefits covered psychologists. One participant stated, "I never really got a list of psychologists. I know your healthcare sometimes covers psychology, sometimes not covered. I never got a list of who would be covered" (Participant 113, PR). Another participant said that she called three psychologists and left voicemails stating that she was struggling but did not receive phone calls back and did not know where to go from there (Participant 111, PP). Others noted that they did not have coverage for private therapy services and that finances had been especially strained during COVID-19. One participant stated:

I don't have benefits right now because I'm not working, so. I am leery about going to see somebody because I don't want to have to pay one hundred and fifty dollars every time because I'm already anxious enough about my finances. (Participant 113, PR)

Some participants reported accessing counseling services such as employee assistance program counseling through their employer or their partner's employer. However, participants noted that employer-funded counseling was often limited to very short-term therapy, and many therapists had waitlists similar to private practice psychologists.

“Going on meds”: Pharmacological help for perinatal anxiety. Some participants discussed using a pharmacological approach to managing their anxiety. For some participants, there was a level of ambivalence around taking medication due to worries about possible side effects for the developing fetus/infant. One participant said “Don't read online. There's just so much scary stuff about antianxiety meds causing autism for the baby” (Participant 104, PR). Many participants also noted the desire to “wait” for psychological treatment rather than starting a pharmacological approach. However, due to lack of availability and long waitlists for services,

as well as increasingly severe symptoms, some started medication. One participant stated, “I tried to seek help through the therapy group first, and then I went on the waitlist. I didn't get on. And then, after she was born, I went on medication.” (Participant 107, PP). Even after starting a pharmacological approach, participants still reported a desire for psychological treatment, “I asked my family doctor to speak to somebody because, like, meds are good, but like, why is this like, why are these things triggering me so much? I want to figure out, like, what do I do?” (Participant 101, PP).

“What am I supposed to do when I've when I've done everything I can possibly think of?”: Urgency, helplessness, and frustration in the help-seeking journey. Participants related the feelings of helplessness and frustration that occurred when they felt that they could not access immediate help for perinatal anxiety. One participant who had already sought crisis services, had received a referral for the hospital-based psychological treatment, and had started a trial of pharmacological treatment stated, “I feel like I'm just doing down all the lists, who can I call, who can I get help from? I need help with this right now. I need to deal with this right now” (Participant 101, PP). Another participant relayed a similar feeling, stating, “What am I supposed to do when I've done everything I can possibly think of? I've asked all the people that could point me in the right direction, and I've done everything they can possibly think of” (Participant 114, PR).

Discussion

In recognizing the importance of mental health in the perinatal period and low help-seeking rates for those experiencing anxiety during this timeframe, the present research was designed to increase our understanding of the experience of perinatal anxiety and the help-seeking journey in the context of the COVID-19 pandemic. Within this overarching objective,

the characteristics of perinatal anxiety, including onset, type of anxiety disorder, comorbidities, and psychosocial factors were explored. Participants were interviewed to collect qualitative data directly from those with lived experience of perinatal anxiety and help-seeking. Quantitative data, such as questions related to perinatal characteristics and self-report measures, were used to support the study's objectives.

Overall, four major themes related to the experience of perinatal anxiety emerged: (a) "Liquid terror" and other experienced symptoms of anxiety; (b) "Here we go again": recognition and reactions to the re-emergence of anxiety in the perinatal period; (c) "Calling in the troops": social support in the context of perinatal anxiety; and (d) "I'm going down all the lists, whom can I call, whom can I get help from?": Help-seeking for perinatal anxiety. These themes are discussed below, following highlighted findings on the psychosocial factors and characteristics of perinatal anxiety reported by the participants.

Psychosocial Characteristics

Sociodemographic Characteristics

It is essential to understand the psychosocial factors described by our sample of perinatal anxiety help-seekers whose voices are present in the results and to acknowledge the voices that were not heard. In terms of ethnicity, the sample was reasonably representative of the diverse ethnic backgrounds of Manitobans (Statistics Canada, 2016), especially when comparing rates of those identifying as European (47.1% compared to 64.5% in the census; Statistics Canada, 2016), and those identifying as Indigenous (17.6% compared to 18% in the census; Statistics Canada, 2016). It is especially important that Indigenous voices were heard in this research in light of the trauma experienced by Indigenous populations in healthcare settings both historically and in contemporary times (e.g., McCallum, 2017).

The research sample had a larger percentage of individuals who identified an undergraduate degree as their highest educational attainment (47.1% compared to 18.2% of the census) and were also more likely to be married (76.5% compared to 57.4% of the census; Statistics Canada, 2016) or in common-law relationships (23.5% compared to 9% of census, Statistics Canada, 2016). When considering the highly educated and coupled nature of the sample, it is important to recognize that lower educational attainment (Furtado et al., 2018) and being single/unpartnered (Low et al., 2016) have been identified as barriers to help-seeking. Yeap and Low (2009) found that lower educational attainment was related to lack of mental health knowledge, which reduced willingness to seek help for mental health concerns. Past research has also identified the partner as a particularly crucial support during the experience of perinatal distress, helping women recognize symptoms (Henshaw et al., 2013) and serving as a facilitator for help-seeking (Fonseca et al., 2015). Thus, we can conceptualize higher educational attainment and the relationship status of the participants in the study as factors that likely facilitated help-seeking.

Perinatal Characteristics

There was an even division of pregnant (47%) and postpartum (53%) participants. All pregnant participants were in the second or third trimester of pregnancy. A few factors may be considered as the possible reasons for the lack of first-trimester participants. People often learn of their pregnancy at four to seven weeks gestation (American Pregnancy Association, 2023). In fact, one in three pregnant people confirm pregnancy with an at-home pregnancy test past six weeks gestation, and one in five past seven weeks (Ralph et al., 2022). The first trimester runs from one through 12 gestational weeks, not allowing much time to recognize anxiety and engage in help-seeking. If the onset of anxiety is considered the “starting point” of the help-seeking

journey, those seeking help after finding out they were pregnant likely did not access a perinatal anxiety treatment waitlist until a later stage of pregnancy, and those with onset following their child's birth likely did not end up on the waitlist until a later stage in the postpartum period. There are likely a number of factors related to delay of seeking and receiving help, with wait times for services only being one of them. More research is needed to determine the various factors related to delay of received treatment.

Many participants reported experiencing neonatal loss, miscarriage, and/or stillbirth (23.5%), as well as difficulties related to conception with their current pregnancy/infant (29.4%) or in past pregnancies (43%), complications in current (47.1%) and past pregnancies (28.6%), complications in delivery with their infant (77.8%) or in past deliveries (40%), and complications in recovery in postpartum (44.4%) or past recoveries in postpartum (60%). It is difficult to compare these rates to the general perinatal populations or other samples experiencing perinatal anxiety because of how these questions were asked (close-ended questions, with additional space for open-ended comments providing further information) and lack of specificity in terms of the type of loss, or condition related to reported difficulties and complications. For example, while many participants reported experiencing neonatal loss, miscarriage, and/or stillbirth, it is not clear as to which specific experiences participants were referring. Statistics related to neonatal and pregnancy loss offer data on specific types of loss (e.g., 1% of pregnancies result in stillbirth, Centers for Disease Control and Prevention, 2022; 10%-25% of pregnancies end in miscarriage, American Pregnancy Association). While comparing rates of complications in pregnancy, delivery, recovery, and loss is not feasible in this research, past research has identified factors such as pregnancy loss as placing women at increased risk for developing perinatal anxiety (Herbert, 2022) and the number of previous

miscarriages/stillbirths significantly predicts symptoms of anxiety in a subsequent pregnancy (Blackmore, 2011).

Characteristics of Perinatal Anxiety

Perinatal Anxiety Presentation

Consistent with past literature (e.g., Goodman et al., 2016), GAD (DSM-5 criteria; APA, 2013) was the participants' most common anxiety disorder presentation. A cornerstone of GAD is the intolerance of uncertainty (e.g., Dugas, et al., 1997). Intolerance of uncertainty has been conceptualized as a “a dispositional characteristic that results from a set of negative beliefs about uncertainty and its implications and involves the tendency to react negatively on an emotional, cognitive, and behavioral level to uncertain situations and events” (Buhr & Dugas, 2009, p. 216). For those with a dispositional intolerance of uncertainty, or who hold negative beliefs around uncertainty, the perinatal period may be especially challenging due to the many uncertainties that accompany this period.

The intolerance of uncertainty is likely a key feature in the concerns common to the perinatal period, including worries about one's own health, fetal/infant health and well-being, giving birth, financial stress, relationship changes, and the availability of needed perinatal services, all of which have been reported in the general perinatal population (e.g., Green et al., 2003; Goldfinger et al., 2020). As chronic worries about various topics are a defining feature of GAD, it is not surprising that this would be the most common diagnosis in the perinatal period. The foci of these worries are further elucidated in the first of the qualitative themes discussed below.

Comorbidity with Depressive Symptoms

Participants experienced a high degree of comorbidity between anxiety and depressive symptoms, with 35% meeting the DSM-5 criteria for a mood disorder (MDD, Bipolar 1 Disorder) and 82% meeting the clinical cut-off on the EPDS, suggesting that most participants experienced depressive symptoms. These rates are consistent with the comorbidity between anxiety disorders and mood disorders found in the general population (e.g., de Graaf et al., 2003; Jacobi et al., 2004; Kessler et al., 1994). While anxiety and depression are highly comorbid in the general population, there may be specific perinatal-related factors that further increase the likelihood of comorbid perinatal anxiety and depression during this period. Dikmen-Yidiz and colleagues (2017) followed a sample of pregnant women to six months postpartum, assessing symptoms of perinatal anxiety and depression at set time points. They reported that perinatal anxiety symptoms peaked in pregnancy, gradually declining to six months postpartum. In contrast, symptoms of perinatal depression peaked at 4-6 weeks postpartum and then declined at six months postpartum (Dikmen-Yildiz et al., 2017).

In considering the context of the perinatal period, these time points hold particular significance. During pregnancy, many experiences contribute to anxiety, such as uncertainty about the viability of the pregnancy, possible complications in pregnancy, and monitoring of the fetus at various milestones. In contrast, the 4-6 weeks postpartum period is marked by early role transition to parenthood, relationship transitions in becoming co-parents, changes in routine, a lack of sleep and fatigue, all of which may be associated with depression. The six-month time point may represent the adjustment to many of the postpartum changes, which may alleviate symptoms of anxiety or depression. However, when examining the perinatal characteristics of

the present study participants, many were 6-12 months postpartum, and continued to meet clinically significant symptoms of anxiety.

Past experience with anxiety and/or depression

All participants identified prior experience with either anxiety and/or depression, and participants discussed the re-emergence of anxiety in the perinatal period in the theme, "Here we go again": Recognition and reactions to the re-emergence of anxiety in the perinatal period. There were no study participants who discussed having a first onset of an anxiety disorder in the perinatal period. All three patterns of the mental health graphs (discussed further below) provided further evidence that participants' current experience of perinatal anxiety was not their first episode of worsening mental health quality (though these graphs are not limited to anxiety experiences). All participants also indicated that they had prior experience in treatment related to anxiety and/or depression.

While a *de novo* onset of anxiety in the perinatal period is not uncommon (Dikmen-Yildiz et al., 2017), rates of first onset versus reoccurrence have not been established. When considering the course of anxiety disorders, it is often characterized as persistent and episodic. Thus, a reoccurrence of anxiety in a period marked by role transitions and hormonal and lifestyle changes is not surprising.

Mental Health Over the Lifetime

The mental health graphs completed by participants are visual representations of participants' perceived mental health quality and suggested that their current experience with perinatal anxiety was not their first episode of mental health symptoms. This is consistent with participants' reports of past experiences with anxiety and/or depression in the self-report questionnaire. Interestingly, the graphs fit the descriptions of the progression of anxiety set forth

in the DSM-5 (APA, 2013). The first pattern, "Peaks and Valleys," with a wave-like pattern fluctuating between higher and lower mental health quality, could also be described as "waxing and waning", a description of the course of anxiety from the DSM-5. The second pattern, "U-shaped," in which mental health quality quickly deteriorated, and then somewhat recovered, could also be described as "episodic", another descriptor of the course of anxiety in the DSM-5. The third, "Downward", with a pattern of worsening mental health over the lifetime, could be described as a long course of "chronic" and "persistent" symptoms unlikely to remit, another DSM-5 description of the course of anxiety. These graphs further supported participants' experience with mental health concerns over their lifetime and that mental health concerns had been present prior to their recent experience with perinatal anxiety.

Qualitative Themes

"Liquid terror" and other experienced symptoms of perinatal anxiety

Anxiety Symptoms and Worry Content. Participants provided vivid depictions of perinatal anxiety in their qualitative interviews, describing cognitive, emotional, physiological, and behavioral symptoms of anxiety (as conceptualized in a CBT model of anxiety, e.g., Beck, 2020; Kaczkurkin & Foa, 2015). While participants' descriptions of physiological, emotional, and behavioural symptoms were similar to anxiety in the general population (APA, 2013; Beesdo-Baum et al., 2012; Helbig-Lang et al., 2010; Rector et al., 2011; Zorowitz et al., 2020), the cognitive symptoms, such as worries about the developing fetus/infant's health and safety, performance as a parent, and developing postpartum depression/psychosis, were very much related to the perinatal period. The other main theme was related to the pandemic, such as worries about themselves/developing fetus/infant/other loved ones contracting COVID-19, and worries related to being perinatal or giving birth during a pandemic. The content of worries

reported by participants was similar to those reported in other research conducted during the pandemic. Green and colleagues (2021), for example, reported that 30% of perinatal participants' principal worries were COVID-19-related and that 40% of those worries were specific to the perinatal context. The content of worries has long been associated with the context and a reflection of a person's circumstances. The content of worries reported by the current participants being related to the perinatal period and COVID-19 aligns with this previous research (e.g., Constans et al., 2002; Diefenbach et al., 2001; Goldfinger et al., 2020).

Social Isolation. Themes in worry content were mirrored in reported triggers of anxiety, namely both perinatal and COVID-19-related triggers. Social isolation, a well-researched topic during the COVID-19 pandemic due to the worldwide shared experience of quarantine and social distancing measures (e.g., Pietrabissa & Simpson, 2020), was highlighted by the participants. Social isolation during the early waves of COVID-19 was associated with increased rates of anxiety and depression, along with loneliness (Hwang et al., 2020; Robb et al., 2020). Even without a worldwide pandemic, the risk of social isolation remains for those in the perinatal period. Taylor and colleagues (2021) conducted semi-structured interviews with 14 participants in the postpartum period. Various themes related to isolation and loneliness were revealed, including feeling that nobody could care for them, that they were "going it" alone, and feeling "dislocated". Researchers noted that feelings of "dislocation" were associated with changes in identity, such as loss of employment, independence, routine, and social lives and relationships. Dislocation also extended to feeling isolated from broader social networks, being confined to the home by the mothering role, and struggling to integrate into social networks for fear they would be perceived as falling short of the ideal "good mother". The researchers noted that while many participants explicitly used terms such as isolation and loneliness to describe their experiences,

other words included "feeling lost, alone, or having nobody." (p. 11, Taylor et al., 2021). These issues were clearly reflected by the perinatal women in the present study.

Social Media and Social Comparison. Falling short of the ideal "good mother" was another trigger reported by participants in the sub-theme, "I can't be that woman that has it all together": Social comparison and social media-related triggers. Social media platforms are breeding grounds for negative social comparison due to the high availability of information about the lives of others (Sabatini & Sarracino, 2015). Social media allows users to portray their lives in idealized ways by posting a highlight reel of exciting, happy moments and leaving out the moments in between, including the messy, mundane, or upsetting moments of life. When being exposed to idealized content, it is common to engage in upward social comparison (e.g., Chou & Edge, 2012). The perinatal period is a time of life in which social comparison over social media may be particularly prevalent as women turn to social media as means of finding relevant comparison targets (e.g., Hopper et al., 2014; Nagl et al., 2021; Thompson & Bardone-Cone, 2022). Social media use increased significantly during the early days of COVID-19 when quarantine and other social distancing measures were in place (e.g., Luo et al., 2021). Due to the low in-person contact with others, social media comparisons may have become especially salient as other in-person comparison targets were unavailable. Consistent with past research on social media and social comparison (Nagl et al., 2021), participants noted feeling inadequate when comparing themselves to the social media portrayals of those in pregnancy and postpartum. While idealized portrayals of the perinatal period on social media can lead to negative outcomes with increased feelings of inadequacy, it is important to recognize the positive potential of social media in light of the aforementioned often-isolating experience of pregnancy and postpartum. Research suggests that women often turn to social media as a resource for asking questions and

seeking advice related to the perinatal period (Dekker et al., 2016; Baker & Yang, 2018). Others use online blogging as a way to make meaning of their symptoms of anxiety in the perinatal period and as a means to connect with others (e.g., Pierce et al., 2022).

"Here we go again": Recognition and reactions to the re-emergence of anxiety in the perinatal period.

Participants generally reported ease in identifying symptoms of perinatal anxiety, related to having had previous experience with anxiety as noted in the sub-theme, "The feelings were similar": Ease in symptom recognition. The role of symptom recognition has been widely identified as an important step in the engagement of help-seeking (Jorm, 2000). The few complications to identifying anxiety in the perinatal period were in discerning between anxiety symptoms and symptoms related to perinatal factors, such as differentiating nausea related to pregnancy or to anxiety. Indeed, many symptoms experienced by those in the perinatal period overlap with symptoms of anxiety, such as loss of appetite, difficulties with sleep, and bodily tension. This can make it more difficult to discern anxiety and depressive symptoms from those expected in the perinatal period, both for the individual experiencing the symptoms and service providers (Matthey & Ross-Hamid, 2011). This is likely much more difficult for those who have not had previous experience with anxiety or those experiencing pregnancy or the postpartum period for the first time.

As none of the participants identified as having a first onset of anxiety during the perinatal period, the re-emergence of symptoms represented relapse or reoccurrence of clinically significant symptoms of anxiety (relapse is the clinically significant re-emergence of symptoms within 12 months of remission, and recurrence is the re-occurrence of a disorder after 12 months of remission; Bockting et al., 2015). The women described feeling disappointed as they had

thought they had achieved remission, especially those who reported previous psychological treatment. The re-emergence of anxiety after remission is very common, with recurrence rates between 39-56% (Bruce et al., 2005; Vervliet et al., 2013) and relapse rates ranging from 13-42% (Lorimer et al., 2021). High relapse rates are common even when remission is achieved through the completion of CBT treatment (Lorimer et al., 2021). One identified predictor of relapse of anxiety symptoms is the occurrence of stressful life events (Heldt et al., 2011). Considering the many changes that occur during the perinatal period, this can clearly be viewed as a time of high stress.

Some participants had the expectation that anxiety could re-emerge in the perinatal period and had monitored for symptoms returning while also having strong negative emotions when anxiety did re-emerge. In considering the nature of anxious thinking, worries tend to be anticipatory and catastrophic in focusing on worst-case scenarios. The CBT model of anxiety posits that anxiety is a dynamic cycle in which one symptom can trigger and escalate further symptoms of anxiety. Worries and catastrophic thoughts about anxiety re-emerging during the perinatal period may represent one such trigger for the worsening of anxiety symptoms. Monitoring for symptoms may represent another, in which constant checking for symptoms (and catastrophic thoughts about the perception of any symptom that could be anxiety) also triggers anxiety. As suggested above, many anxiety symptoms are also commonly experienced in the perinatal period (e.g., nausea, sleep difficulties, bodily tension). Thus, this reaction to anxiety and monitoring for symptoms may contribute to escalating anxiety symptoms.

Anxiety re-emergence in pregnancy and postpartum also represented a violation of expectations for participants. This violation likely relates to societal expectations and "myths" of motherhood and pregnancy. These expectations and endorsement of myths (such as a "a good

mother is also a happy mother") paint an idealized version of motherhood, further enforced by social media (Law et al., 2021; Staneva et al., 2017). Within this blueprint of the perinatal period and motherhood, there is little room left for mental health concerns such as perinatal anxiety, which likely exacerbates feelings that "this shouldn't be happening" and a violation of expectations.

"Calling in the Troops": Social support in the context of perinatal anxiety

Social support in the experience of perinatal anxiety and help-seeking was a significant theme of the qualitative interviews. Social support has been defined as the process through which social relationships promote health and well-being (Leahy-Warren et al., 2018). Social support serves as a buffer during high distress, with perceived availability of support being more important than actual received support, and the two being highly associated only when received support is provided when needed (Cobb, 1976; Melrose, Brown & Wood, 2015). Social support in perinatal anxiety has been identified as a protective factor against the development of perinatal anxiety (Falah-Hassani et al., 2016) and in the help-seeking journey (Fonseca et al., 2015). Additionally, social support in the perinatal period has been associated with reduced bonding failure with infants (Ohara et al., 2017) and parenting self-efficacy (Gao et al., 2014). Insufficient support from partners, friends, and family increases the risk of developing perinatal anxiety and depression (Sufredini et al., 2022).

Participants reported turning to their partners, family, and friends for support during the experience of perinatal anxiety. This aligns with past research suggesting that seeking out informal sources of support during experiences of perinatal distress is common. These informal supports are seen as more accessible, trustworthy, and effective than formal sources of support

(Barrera & Nichols, 2015; Fonseca & Canvarro, 2017). While participants reported receiving support from their partners, family, and friends, unmet needs were also described as noted below.

COVID-19, Stigma, and Peer Support. During the COVID-19 pandemic, accessibility to one's social network was limited due to quarantine and social distancing restrictions. Many participants described not meeting in-person with friends due to COVID-19, and despite having support from partner and family, really needing to connect with friends. Some noted feeling so desperate to connect with friends that they highly valued even having a friend stop by to meet from a distance at the entrance of the house.

Some noted stigma about mental health from family members who perceived them as “overly emotional” rather than recognizing their significant mental health concern. While social support network size and the strength of relationships with the support people have long been established as facilitating help-seeking, recent research by Green and Pescosolido (2023) suggests that those who comprise one's network are an important consideration in its power to propel help-seeking: When an individual contemplating help-seeking from formal sources is surrounded by informal supports with cultural beliefs that do not align with psychological or pharmacological treatment of mental health or who have low trust in the healthcare system, such social support networks may impede help-seeking and attaining needed care.

Another unmet need was access to peers with lived experience of perinatal anxiety. Participants described wanting to connect with other pregnant and postpartum women with lived experiences of perinatal anxiety. In considering the impact of comparing to idealized portrayals of motherhood and pregnancy over social media, connecting with real people experiencing distress may provide more realistic and healthy targets of comparison and may broaden the perception of what makes a “good mother.”

Partner Support. Due to COVID-19 restrictions, partners were likely the most accessible and, thus, influential source of informal support for participants. Findings on the partner's role in the help-seeking process for perinatal anxiety supports past research on the topic. Participants reported enlisting their partner's support in monitoring for the onset and worsening of symptoms of perinatal anxiety, suggesting that their partners helped recognize symptoms of anxiety (Henshaw et al., 2013). Participants also reported high perceived support to seek help for mental health concerns, which has been identified as a facilitator for help-seeking in past research (Gulliver et al., 2010). Finally, participants described collaborating with their partner to create a plan for help-seeking for perinatal anxiety, suggesting that this process is one that a woman makes with her partner rather than on her own (Abrams et al., 2009; Fonseca & Canavarro, 2017; McCarthy & McMahon, 2008). These findings suggest that informal sources of support, especially the partner, can act as a "bridge" from informal help-seeking to formal help-seeking.

“I’m going down all the lists, whom can I call, whom can I get help from?”: Help-seeking for perinatal anxiety

Relationship with healthcare team. While the results identified several possible barriers and facilitators in help-seeking for perinatal anxiety, one of particular importance was the relationship with one’s healthcare team. The team itself varied (e.g., midwives, family physicians, obstetricians), though participants' perceptions of their healthcare providers was generally positive. Just as participants reported feeling supported by informal sources, a high degree of perceived support was reported with their respective healthcare teams. These positive relationships seemed to have reduced barriers to help-seeking. For instance, participants reported feeling comfortable disclosing mental health concerns, likely due to high perceived

responsiveness, understanding, caring, validation, and attentiveness from the health care provider (Reis & Clark, 2013; Reis et al., 2004). Perceived responsiveness increases the ability to self-disclose about vulnerable topics, allowing one to feel safe and not judged or criticized for the disclosure. Thus, women may feel that it is less likely they would be stigmatized with labels such as being an “unfit” parent for disclosure of mental health concerns. It is important to recognize that difficulties with self-disclosure and worries about stigma did arise for some participants. However, positive relationships with the healthcare team may create a strong enough positive effect to overcome these barriers.

Waitlist experience for perinatal women. While waiting for needed services is generally difficult, specific elements of the waitlist experience were particularly stressful for participants. First, they described wanting services as a means of not allowing psychological symptoms to impact their developing fetus/infant, which past research suggests may be a valid concern (e.g., Dowse et al., 2020; Field et al., 2010). As worries about the safety and well-being of the developing fetus/infant were also identified, these additional worries about not receiving treatment for perinatal anxiety may then serve to exacerbate anxiety further. If perinatal women are worried that their anxiety is negatively impacting their developing fetus/infant, this may serve to put a strain on the attachment between the two. Second, participants were cognizant that anxiety was likely, at least in part, related to the stage of pregnancy/postpartum they were in and that if the waitlist caused a long enough delay, they might not receive the services they needed while still in that period (e.g., needing services early postpartum, but only receiving services a few months in).

Help-seeking Model. In comparing The Help-Seeking Model of Perinatal Anxiety (Figure 6) to the NEM-II (Figure 1), there are many shared characteristics. The intra and

interpersonal nature of the NEM-II aligns with the journey described by participants in that the individual factors (e.g., marital status, experience with anxiety and/or depression), social factors (e.g., support from partner), and the healthcare system (e.g., availability of services, referral process), all influence the experience of help-seeking for perinatal anxiety (Pescosolido & Boyer, 2010). The journeys described by participants were also very much non-linear. Participants moved through systems such as informal and formal sources of help as needed, likely moving back to informal sources when help-seeking did not yield immediate access to formal treatment. However, future research is warranted to better understand the timeline of help-seeking and the movement between informal and formal help-seeking systems. The Help-Seeking Model of Perinatal Anxiety also provides some ideas about possible facilitators and barriers to treatment, such as the importance of social supports in monitoring for symptoms, and creating help-seeking plans, confusion about referrals, and the need for timely services that meet perinatal women in the stage of pregnancy/postpartum in which distress is highest. These identified factors may inform future research and the development of interventions to improve the help-seeking journey for perinatal anxiety.

Pescosolido and colleagues (1998) have described three pathways through help-seeking: (a) choice, (b) coercion, and (c) muddling through. Choice pathways were described as the individual making decisions about help-seeking (individual choice) or making decisions with the support of others (supported choice). Coercion pathways were described as individuals engaging in help-seeking with a lack of agency, with decisions made by informal (e.g., friends, family) or formal (e.g., healthcare workers) supports. Muddling through pathways were described as individuals engaging in help-seeking without active resistance or interest in pursuing treatment. More recent research (Beatie et al., 2022) suggested that rather than three distinct pathways,

individual's help-seeking journeys may be characterized by different degrees of these three ways of engaging in help-seeking. In the present study, there were elements of each of the three identified pathways conceptualized by Pescosolido and colleagues (1998). In terms of choice, participants often described individual choices, and choices informed by their partner and family's support in choosing to engage in the help-seeking process. There may have been a "soft" coercion present when participants described going on medication for perinatal anxiety due to long waitlists for psychological services. Muddling through was present in the referral process, when participants described being unaware what the referral entailed, or what they were "waiting" for in terms of treatment.

Limitations

While the present research has many strengths in its exploratory nature with rich data driven by the voices of those with lived experience of perinatal anxiety and help-seeking amid the COVID-19 pandemic, it is also important to acknowledge the limitations of the research. Limitations include the recruitment strategy, sample characteristics, possibility of selection bias, data collection changes due to COVID-19, and the sociopolitical and geographical context within which this research was conducted.

Recruitment

For the present research, participants were recruited from a hospital-based waitlist for psychological services. This is important to acknowledge as this recruitment strategy resulted in a sample of "successful" help-seekers. This only represents the portion of perinatal women experiencing anxiety who engage in help-seeking. Further, this recruitment strategy focused specifically on those on a hospital-based psychological treatment waitlist. It is possible that different information might have been obtained from a sample of women seeking help for

perinatal anxiety in psychological or counseling services outside the hospital setting or who were waiting for psychiatric and pharmacological treatment.

Sample Characteristics

There was diversity in the study sample in terms of ethnicity (that paralleled distribution in Manitoba's census), pregnancy and postpartum stages, and first-time and multiparous parents. Some sample characteristics, however, represented limitations in the research findings. The sample comprised participants who all identified past experience with anxiety and/or depression and past help-seeking for these concerns. Their experience with perinatal anxiety and help-seeking is likely quite different from those with de novo onset of anxiety and no prior help-seeking for mental health concerns. Some plausible differences could be greater ease in recognizing anxiety symptoms, informal and formal sources of support who were aware of past mental health concerns and thus were more aware and potentially monitoring participants for the re-emergence of symptoms, and greater knowledge of pathways to treatment and resources. Participants also all identified as being in relationships, either married or common-law, and had a high education level (compared to Manitoba's census). As mentioned earlier in the discussion, these factors have been related to help-seeking in past research and likely were associated with "successful" help-seeking.

All participants in the present research identified as women. There is a community of pregnant, postpartum people who identify as gender-diverse (e.g., transgender, non-binary, genderqueer, two-spirit). Those who are gender-diverse tend to experience barriers healthcare such as discrimination, and denial of healthcare services when they have disclosed their gender identity (e.g., Baker & Beagan, 2014; Harbin et al., 2012; Searle et al., 2017). When pregnant, or postpartum, gender-diverse individuals may experience heightened distress due to both internal

and external stressors (e.g., inner conflict between one's gender identity and social norms defining the perinatal person as a woman, decisions about disclosing one's gender identity in healthcare settings) (Ellis et al., 2014). Help-seeking for perinatal anxiety as experienced by those who are gender-diverse likely has unique additional barriers that were not represented in the present research and warrants future research.

Selection Bias

Selection bias is another possible limitation of the present research. Those who choose to participate in research have different characteristics than those who do not, such as higher rates of extroversion and approval-seeking (e.g., Kaźmierczak, et al., 2023; McWilliams, 2011; Rosenthal, 1965). There is also evidence that there is an interactional effect of participants' personalities and characteristics (e.g., those with a higher preoccupation with food are more likely to participate in an eating-related study, Haynes & Robinson, 2019; and those who are shorter on time being willing to participate in online versus in-person research, Kraut et al., 1998). It is plausible that the women who self-selected to participate in this study had characteristics such as past experience with anxiety and/or depression and past help-seeking, which made them more interested in participating in the present study and which also influenced the present findings.

Impact of COVID-19

Data was gathered during the early waves of COVID-19. It is possible that some potential participants did not have telephone or internet access which precluded them from study involvement: Contact for recruitment occurred over telephone and email and interviews were held over videoconferencing. Due to quarantine, social distancing measures, closure of schools and daycare, and work from home orders, all participants were in their respective homes during

the meetings. It is possible that in-person qualitative interviews would have yielded some differences in collected data. For instance, seeing a participant wring their hands or jiggle their legs in-person may have cued further prompting in the interview, but such cues were not available over videoconference in which mainly shoulders and face were visible.

Being able to see facial expressions of healthcare workers was deemed to be very important to participants when they described self-disclosure about mental health concerns when engaging in help-seeking. Thus, videoconferencing was likely the best option compared to telephone interviews or masked in-person interviews. Additionally, videoconference interviews reduced some barriers to engaging in the research as participants were able to log into the interview from home, and there was more flexibility in scheduling interviews (e.g., outside of hospital hours). Using videoconferencing also reduced barriers that would be common in non-pandemic times for perinatal women, such finding babysitting options for older children, or travelling to the hospital with an infant who may be fussy or needing a nap.

Sociopolitical and geographical context

The socio-political and geographic context of the study also has implications for how results may be applied in different communities and locations. Manitoba, like all Canadian provinces, has publicly-funded healthcare, which includes access to psychological services in hospitals and some community settings. In other countries, free public healthcare is not available, which likely inhibits psychological help-seeking for those who cannot pay out of pocket or do not have a healthcare plan that includes coverage for psychological treatment. Even within Canada, there are differences in provincial healthcare spending, psychology's place in the healthcare setting, and the number of psychologists available. All of these factors impact the help-seeking journey for perinatal anxiety, and should inform national plans for perinatal mental

health in Canada (CPMHC, 2022). While there were limitations to the present research, the rich data and exploration of the experience of perinatal anxiety and help-seeking in the context of the COVID-19 pandemic offer inspiring directions for future research.

Future Directions

While the present research offers an exploration on the experience of perinatal anxiety and help-seeking, there remains a scarcity of literature on these topics. Future research could: (a) expand on research on help-seeking for perinatal anxiety, (b) consider the role of the mental health of the partner of the perinatal person and its impact on help-seeking, and (c) address the treatment of comorbid perinatal anxiety and depression.

Expanding research on help-seeking for perinatal anxiety

As noted above, it will be important to hear from other subsamples of the perinatal population. A limitation of the present study was the recruitment strategy and sample characteristics, namely the sample being comprised only of "successful" help-seekers who were referred for hospital-based psychological services, all of whom were experiencing a reoccurrence of anxiety/depressive symptoms (no de novo onset of anxiety), had previous experience engaging in help-seeking for mental health concerns, and were coupled with high perceived and received social support. While generalizability was not part of this study's objectives, hearing from other groups who are part of the population of those who experience perinatal anxiety is critical in the understanding of the experience of anxiety and the help-seeking journey. It is likely that including these members of the perinatal population (e.g., those with de novo onset of anxiety, uncoupled) may reveal different factors related to help-seeking. In order to access these missed voices, future research may involve recruiting directly from women's health clinics and

from family physicians and midwives, through community resources such as birthing and postnatal classes, and online.

In furthering the research on help-seeking for perinatal anxiety, quantitative methodology should be considered. Using the results from this study, barriers and facilitators related to help-seeking for perinatal anxiety can be further explored using quantitative analyses and larger samples. In further expanding this line of research, data should be collected from other provinces and territories of Canada to identify specific barriers that may be unique to different areas in the country. Additionally, help-seeking should be expanded to include pharmacological treatment and non-specialized counselling services. It will be important to consider a wider range of types of perinatal distress, such as primary concerns of perinatal depression and PTSD, as well as de novo experiences of perinatal anxiety. These proposed areas of research would be the next critical steps in developing a model of help-seeking for perinatal distress and creating interventions or policy changes as needed to support this population.

Partner mental health and impact on help-seeking

This research underscored the importance of social support in the experience of perinatal anxiety and help-seeking. An important source of social support during the perinatal period is the partner which means that considering their wellness is important also. The mental health of the non-pregnant or postpartum person is also vulnerable during the perinatal period. Research suggests that partners of perinatal women experiencing psychological concerns are at higher risk of developing depression (24-50% increased risk) and anxiety (10-17% increased risk; Dalfen, 2019) than partners of those who are not pregnant or postpartum. Rates of mental health concerns such as anxiety and depression for partners in the perinatal period are 6.4-11.7% (Matthey et al., 2003; Singley & Edwards, 2015). As help-seeking rates of men experiencing

psychological distress are half that of women, it may be expected that their help-seeking rates in the perinatal period would also be low (e.g., Ivancic et al., 2014; Seidler et al., 2016). As partners in the perinatal period perceive their primary role as providing support (Redshaw & Henderson, 2013), seeking help for themselves when the perinatal woman is also experiencing anxiety or depression may be especially difficult. More research is needed to understand the help-seeking process for support partners in the perinatal period and help-seeking processes when both the perinatal person and the partner are experiencing perinatal distress.

Addressing comorbid conditions

In considering the high rates of comorbid symptoms of anxiety and depression, psychological treatment that improves symptoms of both conditions is critical to the mental health of perinatal women. A recent pilot study of a new CBT protocol for perinatal anxiety (Furer et al., 2021) reported that participants not only experienced significant reductions in anxiety from pre- to post-treatment, but also experienced significant reduction of depressive symptoms. This finding suggests that many of the same strategies that improve symptoms of anxiety also may be beneficial for depression but further research is needed.

The treatment of comorbid disorders has also been explored from a transdiagnostic perspective, in which the underlying mechanisms that contribute to many mental health concerns are targeted rather than a focus on any one disorder. The Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders is one example of a protocol that uses this lens in the treatment of emotional disorders, including anxiety and depression (Barlow et al., 2017). A recent case study applied the UP in treating a pregnant person experiencing MDD with anxiety symptoms (Crespo-Delgado et al., 2020). Treatment was adapted for the patient considering the context of the perinatal period (e.g., the discussion of myths of motherhood and

mindfulness exercises focused on the baby's movements). At treatment termination, significant decreases in anxiety and depressive symptoms were reported, with an increase in positive affect. Results were maintained at a 12-month follow-up.

Future research should consider the adaptation and evaluation of a transdiagnostic group intervention for comorbid perinatal anxiety and depression to determine whether perinatal groups would benefit from such an approach. This research could assess whether different presentations of comorbid anxiety and depression in the perinatal period (e.g., patients with primary anxiety with depressive symptoms, patients with clinically significant anxiety and depressive disorders) impact treatment outcomes.

Implications

Healthcare system

The present research has implications for: (a) the screening of mental health concerns in the perinatal period, (b) the importance of a trusting relationship between patient and healthcare worker, (c) supporting patients during the experience of being on a waitlist, (d) the involvement of the support people surrounding perinatal patients, and (e) needed changes to mental health care in the public sector (CPMHC, 2022).

First, regular screening for perinatal mental health is important, as rates of perinatal anxiety are high, and screening has been proposed as a way to close the gap between detection and intervention (Bhat et al., 2021). Perinatal women connect with healthcare providers through routine appointments during pregnancy and postpartum, which provide the opportunity for such screening. Screening can also provide a platform for discussing and normalizing perinatal anxiety, and direct questions about symptoms can increase disclosure about mental health concerns. The use of screening measures (along with follow-up discussion) also may help

healthcare providers determine when to send referrals for treatment of perinatal anxiety, and the inclusion of scores may help with triaging referrals. Both the PASS and the EPDS may be valuable tools in screening for perinatal anxiety and depression in healthcare settings. Additionally, when in-person services are unavailable, videoconferencing meetings are preferable over telephone meetings for facilitating self-disclosure about mental health.

Second, the relationship between the pregnant/postpartum woman and their healthcare provider was shown to be an important facilitator in the help-seeking process. Perceiving one's healthcare worker as responsive, and supportive is critical for patients in self-disclosing about mental health concerns. While screening is an important step in assessing for mental health concerns in the perinatal period, a trusting relationship with a healthcare provider can further facilitate honest and open conversations about mental health.

Third, the present research brings to light the need for support for patients waiting for treatment. Patients would benefit from clearly understanding the services they are being referred for, expected wait times, and where to seek more immediate services while on the waitlist. While resource lists can be helpful, direct referrals to other services would help reduce the burden of help-seeking.

Fourth, healthcare providers should recognize the importance of the support system, especially the partner, in acknowledging and creating plans for help-seeking for experiences of perinatal anxiety. While ensuring patients have good mental health literacy about perinatal anxiety, involving partners in the process would also be beneficial, as they tend to be the support perinatal women first turn to when experiencing distress. Thus, the involvement of informal support persons in screening and discussions about mental health and treatment would be advantageous for perinatal people.

Finally, there is a clear disparity between needed and available psychological services. As the perinatal period is often associated with financial strain and perhaps even loss of health benefits when on parental leave, no-cost services such as those supplied by hospital-based psychological programs, are critical in meeting the needs of perinatal women. Increased funding is needed to support such programs in order to decrease waitlists for services.

Perinatal Mental Health Services

Findings from the present study also have broader implications for perinatal mental health services. While individual CBT interventions for perinatal anxiety are effective, group treatments for perinatal anxiety should also be considered given the high need for services and low availability of resources (Loughnan et al., 2018). Group treatments are considered high volume, low intensity interventions which may be especially important in healthcare settings (Vincent et al., 2021). Group treatment of perinatal anxiety can treat multiple patients simultaneously within a limited number of sessions (e.g., six 90-minute sessions, Furer et al., 2021). As previously stated, group CBT has been shown to effectively reduce symptoms of anxiety (Green et al., 2020; Loughnan et al., 2018; Evans et al., 2022). Group interventions are an attractive form of treatment not only because of their high-volume nature but also due to the element of peer support from others with lived experience, something that participants identified as an unmet need of social support. Additionally, peers in group treatment of perinatal anxiety have been found to help destigmatize the experience of perinatal anxiety (Furer et al., 2021).

Internet-delivered CBT (iCBT) is another low-intensity high-volume intervention approach that can mitigate many of the barriers to treatment access (Loughnan et al., 2019) and thus may be an effective approach for persons with perinatal anxiety. Potential benefits of iCBT include enhanced cost effectiveness, little to no wait time to begin treatment, and increased

accessibility (Gratzer & Khalid-Khan, 2016). Recently, a CBT protocol was adapted from group format to a self-directed online intervention (Overcoming Perinatal Anxiety, Furer & Reynolds, 2015). This intervention could be made readily available to perinatal women dealing with anxiety who have access to an internet connection.

As individuals with anxiety disorders can experience relapse, even after the completion of CBT intervention, relapse prevention strategies are a critical part of psychological treatment of perinatal anxiety. CBT protocols often include modules on relapse prevention planning, generally near the termination of treatment. These can include participants identifying possible triggers for anxiety, signs that anxiety is worsening, and steps to re-engage in strategies to manage symptoms. While relapse prevention planning has good face validity, there has been little research into its efficacy. A recent study by Malins and colleagues (2020) piloted a personalized smart-phone intervention for relapse prevention in which patients who had completed a course of CBT for anxiety were asked what advice they would want to receive if they were struggling with a recurrence of anxiety. They were then prompted by phone message to rate anxiety, and if anxiety was worsening, they would receive the advice they had previously prepared for themselves. At 12-month follow-up, those who engaged in this smartphone intervention had greater well-being than those who were in a control group. An important part of relapse prevention planning as suggested by findings of this study is the normalization of re-emergence of symptoms of anxiety thus reducing feelings of disappointment or shame. Further research looking at relapse prevention strategies for perinatal women will be important. Booster sessions are additional therapy sessions conducted after the termination of intervention sessions, in which previously learned psychological strategies may be reviewed to reinforce progress (e.g., Gearing et al., 2013). Booster sessions have been found to be effective at

preventing relapse of symptom up to 12 months following CBT treatment of anxiety, with patients experiencing lower anxiety sensitivity, less avoidance, and reduced depressive symptoms (Craske et al., 2006). Booster sessions may be an important strategy in addressing the fluctuating patterns of anxiety experienced by perinatal women.

Partner, Family, and Friends of Perinatal Women

Findings highlighted the importance of the informal supports, such as partner, family, and friends in the experience of perinatal anxiety, and in help-seeking. These supports are especially important in monitoring for symptoms of anxiety in the perinatal period and support people may work with perinatal women to plan for help-seeking. As such, it is imperative that these informal sources of support know what symptoms to be on the lookout for, how to support a loved one experiencing perinatal anxiety, and how to facilitate help-seeking.

Participants in the current research identified their partner as being the main source of informal support. Informal supports may look different for those who are uncoupled: a trusted friend, sibling, parent, or other family member may occupy this role for these individuals. Whoever occupies this role for perinatal women should be considered for involvement in healthcare appointments. Having these support people learn about perinatal mental health symptoms may be very valuable. Check-ins with or from this support person may be especially important when they live in different households as it may be more difficult to monitor for symptoms. Thus, direct questioning about mental health symptoms is recommended.

It is clear that social support is a broad concept, and that there are many roles of support to be fulfilled by many groups (e.g., partner, family, friends). Socializing with different groups of informal supports is advised as these different groups may offer various types of support needed

by perinatal women. The COVID-19 pandemic reduced access to at least some of these supports and resulted in increased mental health distress and reduced resources for perinatal women.

Concluding Remarks

This dissertation illustrates the distressing experience of perinatal anxiety and the complex journey of help-seeking in the context of the COVID-19 pandemic. The experience of perinatal anxiety was very much influenced by contextual factors, with triggers and worry content mainly focused on perinatal and pandemic themes. While symptom recognition may have been facilitated by past experience with anxiety and/or depression, coming to terms with the re-emergence of symptoms in pregnancy and postpartum was distressing and violated expectations about this period of life. Social support from the partner was generally perceived as high but other support needs were not consistently met during this period, in part due to the impact of the pandemic. It was noted that the social support that did exist was provided by a number of different relational roles, such as partner, family, friends (and desired peer group). These supports were critical in coping with symptoms and planning for help-seeking. The qualitative research approach highlighted the complex process that is help-seeking for perinatal anxiety. Participants were often motivated to seek help but struggled to find the immediate psychological treatment they needed. Future research will build on these findings with qualitative studies targeting other subsamples of the perinatal population and larger quantitative studies analyzing facilitators and barriers to treatment access. Increasing availability of and access to evidence-based interventions is imperative in responding to the needs of perinatal women and reducing the distress associated with help-seeking during this critical life phase. The present research and its findings illuminate the need for further attention to the experience of

perinatal anxiety and help-seeking, which is necessary for the creation and implementation of strategies to better support the mental health of perinatal women.

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Appendix A: Recruitment Letter to Participants

Hôpital St-Boniface Hospital

ANXIETY DISORDERS PROGRAM
Clinical Health Psychology
M5 McEwen Building
PHONE: (204) 237-2335 FAX: (204) 237-6264

Month X, 20XX

Patient Name

Patient Address

Dear [Patient Name]:

Our clinic is currently conducting a research treatment study on perinatal anxiety. If you have been referred to our clinic for symptoms of perinatal anxiety and are interested in learning more about the study, you may contact the primary investigator, Sarah Petty, at 204-XXX-XXXX. The primary investigator may also contact you directly. You are in no way obligated to learn about the study or participate, and participation will not affect your care or access to other services at this clinic.

Sincerely,

A handwritten signature in black ink, appearing to read 'P. Furer'.

Patricia Furer, Ph.D., C. Psych.
Clinical Psychologist
Anxiety Disorders Program

Appendix B: Recruitment Poster**University
of Manitoba****Hôpital St-Boniface Hospital**

Perinatal Anxiety Research Study

Have you experienced anxiety or uncontrollable worry during your pregnancy or postpartum?

If you answered “yes”, you may be eligible for a 2-session psychological research study.

St. Boniface Hospital Anxiety Disorders Clinic along with the University of Manitoba’s Psychological Services Centre Perinatal Mental Health Clinic are currently conducting a research study on perinatal anxiety and the journey that women experience in help-seeking.

If you are interested in learning more about this study, you may contact the primary investigator Sarah Petty, at (204) XXX-XXXX, or at pettys@myumanitoba.ca.

This research has been approved by the St. Boniface Hospital Research Review Committee and the University of Manitoba Human Research Ethics Board

Appendix C: Telephone Recruitment Statement

Description of recruitment statement: I [Sarah Petty] will introduce myself and briefly go over the details of this study. After I have discussed this study and answered any questions the potential participant may have, I will ask if they are interested in participating in this study. If they are interested in participating, I will schedule a meeting time and location to conduct my interview with them.

Hello, thank you for contacting me about your interest in our research on perinatal anxiety. Can I please confirm your name?

Thank you [patient name],

My name is Sarah Petty; I am a Doctoral student in clinical psychology at the University of Manitoba. I am calling you because your referral to the St. Boniface Anxiety Disorders Clinic indicated that you may be experiencing anxiety and that you are in the perinatal period which spans from pregnancy until 12 months postpartum. We are currently conducting research on perinatal anxiety, is this a good time to tell you a bit about our study?

[If no]

If you are still interested to learn more about it, is there a better time I should call you back?

No: Thank you for your time. Have a nice day.

Yes: Ok, I will give you a call then [time they request to be called back]. Thanks!

[If yes]

This research study is looking at women's experience in seeking treatment for perinatal anxiety.

Participation in this study involves two two-hour meetings that will be held virtually.

Prior to the first meeting I will send you a consent form and online questionnaire to complete about your experiences with pregnancy and birth, your perception of social support, and will assess for symptoms of perinatal anxiety and depression and stress related to the COVID-19 pandemic.

The first meeting will involve a semi-structured interview, and the filling out of a map that will both assess mental health over your lifetime.

The second meeting will consist of an interview about your experience with anxiety and your help-seeking journey.

At the end of the second meeting you will choose two \$25 gift cards to a local coffee shop/grocery store as a thank you for your participation and these gift cards will be mailed to you.

Your participation in this study is completely voluntary. Should you choose to withdraw from the study at any point or feel that you would rather leave some question(s) unanswered, you may do so.

Your interview will be audio-recorded, transcribed, de-identified and then deleted.

Your participation in this research study is in no way linked to the treatment that you are receiving at St. Boniface Hospital. I will not disclose to your doctor whether you decide to participate in this study or not. Whether you decide to participate or not, your treatment will not be affected.

Did you have any questions?

No: Ok.

Yes: [I will answer any questions they have thus far.]

Would you like to participate in this study?

[If no]

Thank you for your time. Have a nice day.

[If yes]

What day/time is best for you?

Date: _____

Time: _____

Thank you for your time. If you need to cancel or reschedule our meeting, please do not hesitate to call me at (204) XXX-XXXX. I look forward to seeing you on [meeting date/time].

What would be the best email address for me to send the online questionnaire?

Email Address: _____

Appendix D: Consent Form

Hôpital St-Boniface Hospital

Informed Consent**Women's Anxiety Symptoms and Help-Seeking During the Perinatal Period****Principal Investigator:**

Sarah Petty. M.A., Ph.D. Candidate, Department of Psychology, University of Manitoba, Ph.
(204) XXX-XXXX/ pettys@myumanitoba.ca

Research Supervisors:

Dr. Kristin Reynolds, Ph.D., C. Psych. Candidate, Assistant Professor,
Department of Psychology, University of Manitoba
Ph. (204) 474-9428/ kristin.reynolds@umanitoba.ca

Dr. Patricia Furer, Ph.D., C. Psych., Associate Professor,
Department of Clinical Health Psychology, University of Manitoba
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Department of Psychology, University of Manitoba
Jen.theule@umanitoba.ca

Dr. Beverley Fehr, Ph.D., Psych, Adjunct Professor
Department of Psychology, University of Winnipeg
b.fehr@uwinnipeg.ca

This consent form, a copy of which you may keep for your records, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. Please take your time to review this consent form and discuss any questions you may have with the researcher. If there is something that you do not understand, please ask the researcher to explain any words or information that you do not clearly understand.

Purpose:

Sarah Petty is conducting this study as part of her Doctoral Thesis, under the supervision of Dr. Kristin Reynolds, Dr. Patricia Furer and her research committee. The purpose of this research is to better understand perinatal anxiety (anxiety experienced during pregnancy or up to 12 months postpartum) and the help-seeking process during experiences of perinatal anxiety. This study will inform researchers, clinicians, and public policy initiatives aimed at enhancing access to care for perinatal anxiety.

Participation:

Your participation in this study is completely voluntary. Should you choose to withdraw from the study at any point or feel that you would rather leave some question(s) unanswered, you may do so. Data collected prior to withdrawal may be used for data analysis.

Participation in this study involves two two-hour meetings. These meetings will take the place of an intake meeting which is a step that all individuals receiving clinical services take. The meetings will occur at St. Boniface Anxiety Disorders Clinic or the Perinatal Mental Health Clinic at the Psychological Services Centre depending on which location your referral was sent. If you are postpartum at the time of the meetings you are welcome to bring your baby with you to our meetings if you wish to do so.

The first meeting will consist of filling out a consent form and a questionnaire about your experiences with pregnancy and birth, your perception of social support, and will assess for symptoms of perinatal anxiety and depression. The consent form and questionnaire can also be accessed online if you would prefer to fill these out prior to our session.

The first meeting will also involve a semi-structured interview, and the filling out of a map that will both assess mental health over your lifetime. For the second session, you will be asked a series of open-ended questions assessing your experience of anxiety during pregnancy and/or postpartum, and your experience of seeking psychological treatment for anxiety. At the end of the second meeting you will choose two \$25 gift cards to a local coffee shop/grocery store as a thank you for your participation and these gift cards will be mailed to you. If you are only able to make the first meeting, you will receive only one \$25 gift card.

Results:

The summary results of this study (not your individual results) should be available by August 2022. If you would like to receive a summary of the results, please provide your contact information below.

Confidentiality:

Only the principal investigator, her supervisors, her research committee, and research assistants will have access to the data. The information that you provide will be de-identified and kept in a secure location on password-protected laptop and paper data will be kept in a locked cabinet at the St. Boniface Hospital.

As the meetings take the place of an intake interview for clinical services, a brief intake letter summing up your presenting concerns will be written up, and a copy of which will be placed in your clinical chart. The service providers that work with you in the future would have access to this clinical chart and the intake letter. Medical records that contain your identity will be treated as confidential in accordance with the Personal Health Information Act of Manitoba. Whether you decide to participate or not participate in this research study, your treatment received at St. Boniface Hospital or Perinatal Mental Health Clinic at the Psychological Services Centre.

Information gathered in this research study may be published or presented in public forums, however your name will not be used or revealed. Data will be presented in aggregate, with the exception of verbatim quotes from the qualitative interview, which will be included to support the aggregate-level data (main themes). No identifying information (e.g., name, age) will be used in the reporting of quotes. We will share findings at conferences, workshops, and in peer-reviewed publications. Despite efforts to keep your personal information confidential, absolute confidentiality cannot be guaranteed.

Limits to confidentiality:

If you disclose information that you are an imminent threat to someone else or to yourself, we are required to break confidentiality to ensure the safety of the person at risk. If you disclose information that a child or other vulnerable person is being abused or neglected, we are required to break confidentiality and report the information to the appropriate authority.

Benefits:

There are many possible benefits to participants of this study. Participants may benefit from being provided with time and space to discuss and express their experiences with mental health with a doctoral candidate in clinical psychology. The meetings will also take place of their intake meeting which would need to be completed prior to treatment at the clinics. There are also possible benefits to the larger community of women experiencing perinatal anxiety and their support networks through a better understanding of perinatal anxiety and the help-seeking journey women go through when experiencing perinatal anxiety. Information learned from this study will be disseminated to fellow researchers and care providers, and may inform interventions to improve access to mental health care services for women in the perinatal period.

Risks:

You will be asked to provide information that you could find difficult or distressing to recall and to talk about. You might also become distressed after participating in this study. If you are distressed, you can stop at any time without consequence. We will also provide you with a list of mental health resources or service providers should you need to talk with someone.

University approval:

This research has been approved by the Psychology/Sociology Research Ethics Board and the St. Boniface Research Review Committee. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Secretariat at (204) 474-7122.

Security:

All questionnaire and interview data will be stored on a password-protected, data encrypted laptop. Any paper materials related to the study will be stored in a locked cabinet at St. Boniface Hospital. University administrators may check the data to see that the research has been ethically done. The University of Manitoba Psychology/Sociology Research Ethics Board and St. Boniface Hospital may review research-related records for quality assurance purposes.

Contact:

If you have any additional questions about this study or your rights as a research participant, please feel free to contact the principal investigator, Sarah Petty, graduate student in Clinical Psychology, University of Manitoba. You may also contact Ms. Petty's supervisors, Dr. Kristin Reynolds and Dr. Patricia Furer. Contact information for these individuals can be found at the top of this form.

Statement of Consent:

I have read this consent form and I understand my role as a participant. I have had the opportunity to discuss this study with Sarah Petty and I have had my questions answered. The risks and benefits have been explained to me. I have not been influenced by any study team member to participate in the study by any statements or implied statements. I understand that I will be given a copy of this consent form after signing it. I understand that my participation in this study is voluntary and that I may choose to withdraw at any time. I freely agree to participate in this research study.

I understand that information regarding my personal identity will be kept confidential, but that confidentiality is not guaranteed. I permit the inspection of my records that relate to this study by The University of Manitoba Research Ethics Board for quality assurance purposes. By signing this consent form, I have not waived any of the legal rights that I have as a participant in a research study.

Participant signature: _____

Participant printed name: _____

Date _____
(day/month/year)

Permission for future contact: I agree to be contacted by Ms. Sarah Petty by telephone, mail, or email for future follow-up in relation to this study, if any of the content from the individual interview is unclear to her.

Yes ____ No ____ Participant Initials ____ Telephone:_____
Email:_____

Would you like to receive a summary of the results of this study?

____No
____Yes, I would like to receive the summary results.

If yes, please provide your contact information below:

Email: _____
Phone number: _____
Mailing Address: _____

Would you like to be contacted for future studies?

____No
____Yes, I would like to be contacted for future studies by Sarah Petty, Dr. Reynolds, or Dr. Furer

If yes, please provide your contact information below:

Email: _____
Phone number: _____
Mailing Address: _____

Mental Health Resources and Service Providers

Websites:

- CANADIAN MENTAL HEALTH ASSOCIATION
Winnipeg Region: **www.cmhawpg.mb.ca**
- ANXIETY DISORDERS ASSOCIATION OF MANITOBA
www.adam.mb.ca
- ANXIETY CANADA
www.anxietycanada.ca
- MOOD DISORDERS ASSOCIATION OF MANITOBA
www.depression.mb.ca

Telephone numbers:

- WINNIPEG REGIONAL HEALTH: MOBILE CRISIS SERVICE

- **(204-940-1781)**
- MENTAL HEALTH EDUCATION AND RESOURCE CENTRE
(204-942-6568) or **(1-855-942-6568)**
- MOOD DISORDERS ASSOCIATION OF MANITOBA'S
POSTPARTUM WARM PHONE LINE
(204-391-5983) available 9 a.m. – 9 p.m./7 days a week)

Service Agencies:

****The service agencies listed below provide no cost or low cost services****

- KLINIC COMMUNITY DROP-IN COUNSELLING SERVICE
Drop-in counselling is available at two locations in Winnipeg. Call for locations and times **(204-784-4067)** or visit www.klinic.mb.ca and go to “counselling services.”
- ANXIETY DISORDERS ASSOCIATION OF MANITOBA
Monday drop-in support groups for anxiety
(204-925-0600)

****For a more extensive list of mental health resources and services please visit:
http://www.cmhawpg.mb.ca/documents/CMHAGuide-Ed16-WEBJune_000.pdf**

Appendix E: Perinatal Anxiety Background Questionnaire**Age:** _____**Highest Level of Education:**

Primary school or less
Some high school
High school graduate
Some college/trade school
Graduated college/trade school
Some university
University undergraduate degree
University graduate degree
Prefer not to answer

Current Occupation Status:

Full-time
Part-time
Maternity leave
Health leave
Unemployed
Prefer not to answer

If currently employed, please list current occupation: _____**Marital status:**

Single
Common law
Married
Widowed
Separated
Divorced
Prefer not to answer

Race/Ethnicity:

North American Aboriginal Origins (First Nations, Metis, Inuit)
European Origins
Caribbean Origins
Latin, Central, and South American Origins
African Origins
Asian Origins
Oceania Origins (Australian, New Zealander, Pacific Islands)
Other _____
Prefer not to answer

Are you pregnant now?

Yes

No

Prefer not to answer

If you answered “yes” to the previous question:**What is your due date?**

If you do not wish to answer this question, please indicate by writing “no”

How has your physical health been throughout your pregnancy?

Poor

Fair

Good

Very good

Excellent

Prefer not to answer

Did you recently give birth (up to 12 months ago)?

Yes

No

Prefer not to answer

If you answered “yes” to the previous question:**What date was your baby born?**

If you do not wish to answer this question, please indicate by writing “no”

How was your physical health throughout your pregnancy?

Poor

Fair

Good

Very good

Excellent

Prefer not to answer

How has your physical health been since giving birth?

Poor

Fair

Good

Very good

Excellent

Prefer not to answer

How would you describe your baby's temperament (baby's overall mood day-to-day)?

If you are pregnant or recently gave birth (up to 12 months ago), is this your first baby?

Yes

No

Prefer not to answer

If you answered "no" to the previous question:

If you are pregnant or recently gave birth (up to 12 months ago) and this is not your first baby, how many children do you have in addition to your baby?

If you do not wish to answer this question, please indicate by writing "no"

Have you ever experienced a neonatal loss (e.g., miscarriage, stillbirth)?

Yes

No

Refuse to answer

Have you ever had a termination?

Yes

No

Refuse to answer

Have you ever had difficulty getting pregnant?

Yes

No

Refuse to answer

If you answered "yes" to the previous question:

Can you please explain the difficulties that you experienced in trying to conceive:

Did you have difficulty getting pregnant with your current pregnancy/infant?

Have you experienced complications during pregnancy, delivery, or recovery (check all that apply)

- ☐ Pregnancy
- ☐ Delivery
- ☐ Recovery

Please explain the complications that you experienced:

How would you describe your baby's health? Any challenges? (if pregnant or postpartum)

How would you describe your bond with your baby? (if pregnant or postpartum)

In general, how has your physical health been throughout your life?

Poor

Fair

Good

Very good

Excellent

Prefer not to answer

In general, how has your mental health been throughout your life?

Poor

Fair

Good

Very good

Excellent

Prefer not to answer

Have you previously experienced a problem with anxiety or depression in your life?

Yes

No

Prefer not to answer

Have you previously sought help for a problem with anxiety or depression in your life?

Yes

No

Prefer not to answer

Perinatal Anxiety Screening Scale
(Somerville et al., 2014)

OVER THE PAST MONTH, how often have you experienced the following? Please tick the response that most closely describes your experience for every question.

	Not at all (0)	Sometimes (1)	Often (2)	Almost Always (3)
1. Worry about the baby/pregnancy				
2. Fear that harm will come to the baby				
3. A sense of dread that something bad is going to happen.				
4. Worry about many things.				
5. Worry about the future.				
6. Feeling overwhelmed				
7. Really strong fears about things, e.g.: needles, blood, birth, pain etc.				
8. Sudden rushes of extreme discomfort.				
9. Repetitive thoughts that are difficult to stop or control				
10. Difficulty sleeping even when I have the chance to sleep				
11. Having to do things in a certain way or order				
12. Wanting things to be perfect				
13. Needing to be in control of things				
14. Difficulty stopping checking or doing things over and over				
15. Feeling jumpy or easily startled				
16. Concerns about repeated thoughts				
17. Being 'on guard' or needing to watch out for things				
18. Upset about repeated memories, dreams, or nightmares				
19. Worry that I will embarrass myself in front of others				
20. Fear that others will judge me negatively				
21. Feeling really uneasy in crowds				
22. Avoiding social activities because I might be nervous				
23. Avoiding things which concern me				
24. Feeling detached like you're watching yourself in a movie				

25. Losing track of time and can't remember what happened				
26. Difficulty adjusting to recent changes				
27. Anxiety getting in the way of being able to do things				
28. Racing thoughts making it hard to concentrate				
29. Fear of losing control				
30. Feeling panicky				
31. Feeling agitated				

Edinburgh Perinatal/Postnatal Depression Scale (EPDS)
(Cox, Holden, & Sagovsky, 1987)

As you are having a baby, we would like to know how you are feeling. Please mark “X” in the box next to the answer which comes closest to how you have felt in the past 7 days—not just how you feel today.

1. I have been able to laugh and see the funny side of things.

As much as I always could (0)
Not quite so much now (1)
Definitely not so much now (2)
Not at all (3)

2. I have looked forward with enjoyment to things.

As much as I ever did (0)
Rather less than I used to (1)
Definitely less than I used to (2)
Hardly at all (3)

3. I have blamed myself unnecessarily when things went wrong.

Yes, most of the time (3)
Yes, some of the time (2)
Not very often (1)
No, never (0)

4. I have been anxious or worried for no good reason.

No not at all (0)
Hardly ever (1)
Yes, sometimes (2)
Yes, very often (3)

5. I have felt scared or panicky for no very good reason.

Yes, quite a lot (3)
Yes, sometimes (2)
No, Not much (1)
No, not at all (0)

6. Things have been getting on top of me.

Yes, most of the time I haven't been able to cope at all (3)
Yes, sometimes I haven't been coping as well as usual (2)
No, most of the time I have coped quite well (1)
No, I have been coping as well as ever (0)

7. I have been so unhappy that I have had difficulty sleeping.

Yes, most of the time (3)
Yes, sometimes (2)
Not very often (1)
No, not at all (0)

8. I have felt sad or miserable.

Yes, most of the time (3)
Yes, quite often (2)
Not very often (1)
No, not at all (0)

9. I have been so unhappy that I have been crying.

Yes, most of the time (3)
Yes, quite often (2)
Only occasionally (1)
No, never (0)

10. The thought of harming myself has occurred to me.

Yes, quite often (3)
Sometimes (2)
Hardly ever (1)
Never (0)

Perceived Partner Support for seeking help for mental concerns
(Fonseca & Canavarro, 2017) adapted for this study

	Strongly Disagree (1)	Disagree (2)	Agree (3)	Strongly Agree (4)
1. I would be comfortable talking about my emotional difficulties with my partner/support person if I had an emotional problem.				
2. My partner/support person would support me if I had an emotional problem.				
3. My partner/support person would encourage me to seek professional help if I had an emotional problem.				
4. I would share the decision to seek professional help with my partner/support person if I had an emotional problem.				

Coronavirus Stressor Survey
(McLean & Cloitre, unpublished)

Below are a number of stressful experiences related to the ongoing coronavirus pandemic (COVID-19). For each experience, check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) it happened to someone close to you; or (c) it doesn't apply to you.

	Happened to me	Happened to someone close to me	Doesn't apply
Become ill from possible or certain exposure to the coronavirus			
Job requires exposure to coronavirus			
Lost job or lost income due to the coronavirus pandemic			
Increased responsibilities at home due to the coronavirus pandemic			
Difficulty getting food, medication or other necessities due to the coronavirus pandemic			
Difficulty getting needed social support due to the coronavirus pandemic			

Over the past week, how many hours a day have you been exposed to coronavirus (COVID-19) information (radio, TV, twitter, Facebook, Instagram, newspapers)

I have not been exposed to any COVID-19 information
 Less than an hour
 One to two hours
 More than two hours

Over the past week, how much distress have you experienced related to the coronavirus (COVID-19)?

None
 Very little
 Some
 A lot

Please describe anything else that concerns you about the impact of coronavirus (COVID-19) on you, your friends, or your family.

Appendix F: The Mini International Neuropsychological Interview and Screener (M.I.N.I.)

M.I.N.I. The Mini International Neuropsychological Interview and Screener
(Sheehan et al., 1998)
(see attached PDFs)

Appendix G: Qualitative Interview

**Ask participants to complete mental health lifespan graph at beginning of interview & use this as a discussion tool during the second half of the interview regarding past experience.*

Preamble:

- Introduce yourself
- Remind participant about the project aims
- Remind participant that the interview will be audio-recorded and let them know when you are turning on the recorder (get consent for this)
- Verify that participant has received and signed the consent form. If you do not have their physical consent form, ask for their verbal consent to proceed with the interview before you get started. Then start the recorder
- Let the participant know that they can refuse to answer any questions that they would like to
- Ask the participant what type of \$25 gift cards they would like to receive (Starbucks, Tim Hortons, Sobeys, Superstore)

General probes to consider throughout:

- Tell me more about that.
- Can you give me an example of that?
- What did/does that mean to you?
- How did/does that impact you?

Topic 1: Experience with Anxiety

1. Can you describe for me the anxiety you have experienced?

Probing questions:

- i. What symptoms have you experienced?
- ii. When did your anxiety symptoms first begin?
- iii. Tell me about what makes anxiety symptoms worse? What does it feel like?
- iv. Have you experienced anxiety in the past, prior to this pregnancy/birth of your child?
- v. How has anxiety impacted your experience of pregnancy/early motherhood?

Topic 2: Problem Recognition and Definition

2. Can you tell me about how you came to recognize that you were experiencing ‘anxiety’?

Probing questions:

- i. Did anything or anyone get in the way or make it more difficult to recognize your symptoms as anxiety?
- ii. Did anything or anyone make it easier to recognize your symptoms as anxiety?

Topic 3: Decision to Seek Help

3. Can you tell me about how you decided to seek help for anxiety?

Probing questions:

- i. Did anything or anyone help you with your decision to seek help for anxiety?
- ii. Did anything or anyone get in the way or make it more difficult to decide to seek help for anxiety?

Topic 4: Support Selection

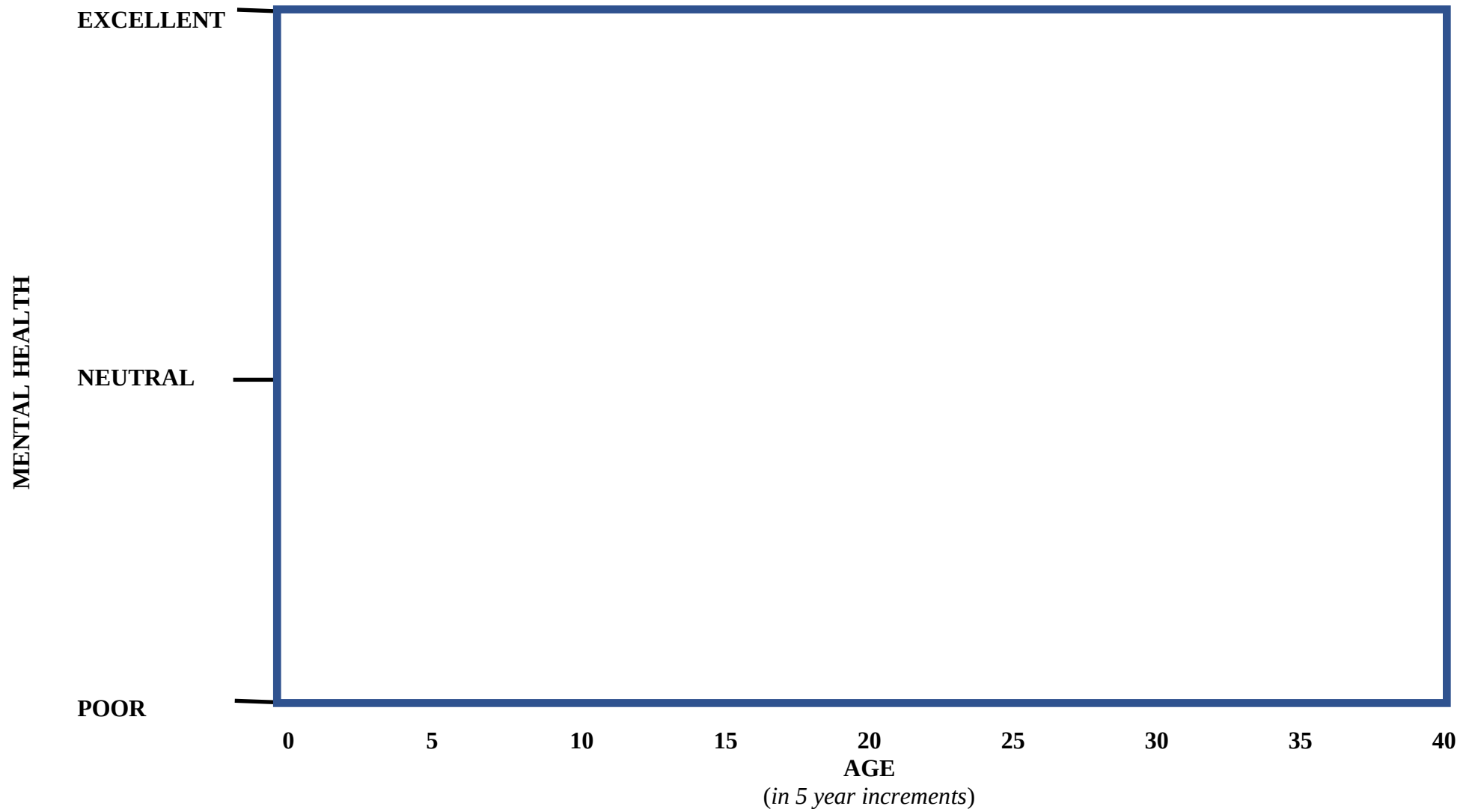
4. Once you had decided to seek help, how did you determine what kind of help to seek?

Probing questions:

- i. What kinds of help did you consider or try?
- ii. How did you end up seeking help here at St. Boniface Hospital/Psychological Services Centre?
- iii. Did anything or anyone help you decide to seek psychological treatment?
- iv. Did anything or anyone get in the way or make it more difficult to seek psychological treatment?

Closing:

- Thank participant for their time
- Remind them that we will send them their gift cards for their preferred source (Starbucks, Tim Hortons, Sobeys, Superstore)

Appendix H: Mental Health Graph

Appendix I: Field Notes

Date:

Location:

Participant #:

Participant Behaviour, Body Language, Affect

Researcher Reflections
