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Anxiety after birth: an existential phenomenological enquiry into mothers' lived experiences

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Anxiety After Birth

An existential phenomenological enquiry into

mothers' lived experiences.

Submitted to the New School of Psychotherapy and Counselling and Middlesex University Psychology Department in partial fulfilment of the requirements for a professional doctorate (DProf) in Psychotherapy and Counselling by Professional Studies

Claire Oakeley

September 2023

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Statement of authorship

This doctoral thesis is authored by Claire Oakeley and has ethical approval from the New School of Psychotherapy and Counselling and the Psychology Department of Middlesex University.

This work is submitted to partially fulfil the requirements of the New School of Psychotherapy and Counselling and Middlesex University for the degree of *Doctor in Psychotherapy and Counselling by Professional Studies*. As the author of this work, I confirm that I am fully responsible for the content and writing and confirm that there are no conflicts of interest.

Abstract

The concept of anxiety after birth has attracted increasing interest from perinatal researchers in recent years, however there are no studies which examine the phenomenon from an existential phenomenological standpoint. The aim of this study therefore was to explore women's lived experiences of maternal anxiety from a new perspective. Eight mothers were interviewed to obtain detailed experiential accounts which were analysed using Van Manen's hermeneutic phenomenological approach. Three emergent themes were identified: 1. Being taken over; 2. Being with uncertainty; 3. Being with others. These themes illustrate the ontological nature of maternal anxiety in it's embodied, ambiguous and interpersonal dimensions. Existential insights into the relational, transitional, and temporal nature of postnatal anxiety are presented. The discussion recognises key implications for therapeutic practice, noting that therapy can play a vital role in assisting mothers to explore their maternal identity, choices, uncertainties and anxious feelings. The study reveals that in addition to the considerable distress that anxiety after birth can bring, it also serves a protective function when understood from an existential context. By listening to the testimonies of mothers we can offer alternatives to a medicalised view of anxiety and shine light on what it is through how it is experienced.

Key terms: *qualitative, phenomenological; hermeneutic; anxiety; motherhood; maternal; postnatal; lived experience; existential; postpartum; embodied; relational; responsibility*

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1. Introduction

'*To grapple with and understand anxiety is, in some sense, to grapple with and understand the human condition*.'

(Stossel, 2014, p. 20)

Research has shown that 17.8% of women experience considerable symptoms of anxiety in the first month after having a baby, settling at approximately 15% in subsequent months (Dennis et al., 2018). Despite these statistics, anxiety after birth is not listed as a condition on the UK NHS website and does not feature in the principal authority on diagnoses: *The Statistical Manual of Mental Disorders*, fifth edition (DSM-V).

While much has been written about postnatal depression, comparatively little research has emerged about experiences of maternal anxiety. There are many possible reasons why the phenomenon of anxiety after birth has been overlooked. First, experiences of maternal anxiety may be difficult to describe or define, which makes researching it a challenge. It is also possible that maternal anxiety is considered to be a normal and expected part of new motherhood, therefore not warranting further exploration. In recent years, some researchers have begun studying the phenomenon. However, this brings its own complexities. Maternal anxiety is sometimes investigated alongside depression, with researchers adopting the collective term, 'postnatal depression and anxiety' (Prenoveau et al., 2017; Holt et al., 2017; Arefadib et al., 2021). Other studies have highlighted the prevalence of comorbidity between the conditions (Fallah-Hassani et al., 2017; Dennis et al., 2018). While these studies importantly feature postnatal anxiety, they do not focus

exclusively on the phenomenon as a distinct entity. Other studies focus on ‘perinatal’ anxiety, a term which covers the entire period from the beginning of pregnancy up to a year after giving birth. While perinatal studies vitally explore the anxious dimensions of becoming and being a mother, the focus is not exclusively on anxiety experienced postnatally. Interestingly, research into perinatal anxiety has revealed that it is an unfamiliar concept amongst health professionals (Folliard et al., 2020) and this is potentially echoed in the community population.

Focused study on postnatal anxiety, however, has seen an increase in research interest over recent years. Studies have explored different dimensions, including risk factors (Dennis et al., 2017; Field, 2018; Janssen et al., 2018; Hijazi et al, 2021; Arnold & Kalibatseva, 2021), consequences (Fallon et al., 2021; Zappas et al., 2021) and possible treatments (Challacombe & Salkovskis, 2011; Green et al., 2015; Marchesi et al., 2016; Langan & Goodbred, 2016). Research into the phenomenon is essential so that it can be identified, understood and treated. However, a clear understanding of the nature of the experience is lacking, and, without this, it may be challenging to establish appropriate treatments. Furthermore, as the concept of ‘postnatal anxiety’ is not featured in diagnostic or public information literature, professionals may not be trained to spot the signs and women might not be aware of the symptoms of postnatal anxiety. Research into women’s lived experiences of maternal anxiety therefore contributes to understanding the nature of the experience from a phenomenological perspective, serving to illuminate the distinctive experience of being anxious after having a baby.

Many research studies have their roots in personal interest and mine is no exception: my professional interests and personal experiences underpin this doctoral study.

Drawing on my own lived experience as a mother and my clinical work as an existential psychotherapist, I have observed that feelings of anxiety after birth can have a significant impact on a mother's quality of life. As a mother myself, I experienced a spectrum of emotions and feelings after the birth of my twins. These ranged from joy and wonder to being on edge, unable to sleep and feeling overwhelmed. My infants were in good health: weights, measures and developmental checks confirmed that all was well, but, while they were thriving, I was not. I consulted my GP, who talked about the baby blues and postnatal depression, but this did not equate to what I was feeling. In the same year that my twins were born, I embarked on another significant life change and commenced the process of training to be a psychotherapist. During my training, I came to realise that my experiences post-birth were predominantly those of anxiety rather than depression. I came to recognise that my post-birth experiences had been misunderstood.

Once qualified, I decided to work therapeutically with parents. In 2012, I set up a small private practice focusing solely on the emotional wellbeing of mothers. Through this clinical experience, I came to realise that anxiety after birth was not unusual. My clients' experiences resonated in varying degrees with my own. To create life meant to fear losing it, and becoming a mother meant becoming entwined with the cycle of life. Women reported feeling worried and anxious in a similar way to myself. While there is no 'one-size-fits-all' category for postnatal feelings, there appeared to be something of a shared experience amongst mothers, largely overlooked by medical professionals. In my work with mothers, it became apparent that they were unaware that postnatal anxiety (PNA) as an entity existed. This strengthened my resolve to investigate these experiences so that they could be better understood.

1.1. Contribution to psychotherapy and postnatal care

Lived experience research can highlight issues of particular interest to therapeutic practitioners (Finlay, 2011) and it is anticipated that the findings of this study will contribute fresh understandings for therapists and psychological professionals working with mothers. These insights may span the personal, physical, social, spiritual and affective dimensions of the phenomenon, helping professionals to better understand mothers' needs within the context of the lifeworld. In understanding the nature of mothers' experiences, practitioners are better placed to work with the contextual and embodied nature of maternal anxiety. As every experience is unique to the individual, a phenomenological understanding importantly puts each mother at the centre of any therapeutic intervention, rather than trying to fit the mother to a pre-set therapeutic framework.

Midwives, health visitors and GPs may gather from this study a contextual perspective on maternal anxiety and knowledge, which can help inform best practice. Understanding women's experiences from an ontological perspective gives a unique viewpoint, which broadens the current field of understanding. New insights might also contribute to the development of support services for mothers. This research seeks to raise awareness of women's experiences so that those caring for them are better placed to spot the signs of PNA and respond with appropriate support. Finally, an in-depth detailed study of what it is like to be anxious after birth is of benefit to mothers themselves. Postnatal distress may feel isolating and stigmatising and research into the nature of the experience can help mothers to understand and make sense of their feelings.

1.2. Study aim and approach

The aim of my study is to explore mothers' experiences of anxiety after birth from an existential phenomenological perspective. The research question is: *How do mothers experience anxiety after birth?* This will be investigated via semi-structured interviews to gain existential phenomenological insights into mothers' lived experiences. With a focus on phenomenological hermeneutics, my existential exploration aims to investigate mothers' subjective experiences in depth. Adopting an open and flexible approach, it is anticipated that meaningful themes will emerge from the data.

Exploring the phenomenon of anxiety after birth from an existential phenomenological perspective offers the potential to broaden existing understandings of maternal anxiety within the field of postnatal care. This study gives a voice to women's individual subjective experiences without preconceptions, judgements or expectations of what that experience might be like. It invites women to describe their experiences as felt in rich detail. Phenomenological research captures both the everydayness and the detailed nuances of being – aspects which may be taken for granted or considered trivial in other research disciplines (Van Manen, 2016). As such, I suggest that the findings of this study offer something new to the postnatal field.

I hope that this study will help mothers, psychological therapists, GPs, midwives and health visitors to better understand what this experience is like, and that the findings will contribute to raising awareness of the nature of this phenomenon. It is important to note that I do not set out to propose a new diagnostic category for anxiety or a revision of any of the current systems of classification. What I do offer is a new way

of thinking about women's experiences of anxiety after birth, accompanied by a detailed consideration of the existential characteristics of this type of anxiety.

As an existential psychotherapist and phenomenological researcher, some key tenets of existential philosophy underpin my work. These include:

- The individualised nature of being and a recognition that experiences will be unique and subjective
- The notion that life has no fixed 'meaning' – it is up to each of us to make sense of our world and discover our own meaning and purpose in life
- We are each responsible for our life choices
- We have a capacity to evolve and grow, meaning that we are not fixed, and we have a range of possibilities open to us
- We exist in a shared world rooted in relatedness, also referred to as 'being-in-the-world-with-others' (Heidegger, 2010)
- There are universal dimensions, sometimes referred to as 'givens', which exist across humanity – these include facticity, freedom, temporality, choice, death and uncertainty

1.3. Summary and structure of thesis

A phenomenological enquiry has a unique potential to unveil deeper understandings of what it is like to be anxious after the birth of a child. I hope that the findings of this lived experience study have the potential to contribute something of value to the field of postnatal care as a whole.

The following chapter evaluates existing literature in the field and presents a narrative review of works, revealing insights into anxiety after birth from an experiential perspective.

Following this, Chapter 3 presents the methodology employed for the study and the rationale for undertaking a hermeneutic phenomenological approach using Van Manen's lived experience method. I detail my use of this approach to analyse the interview data, before giving an overview of the ethical issues pertaining to a human science study of this nature. I follow this with insights into my reflexive process, highlighting areas of key importance.

Chapter 4 thematically presents the findings arising from the data collection, hermeneutic analysis and writing process. I draw on first-person poetic accounts to provide an evocative presentation of the mothers' phenomenological experiences.

Chapter 5 situates the findings within an existential perspective, drawing on the writings of philosophers and theorists to illuminate the meanings of anxiety after birth as felt and experienced. The findings are also considered in relation to research previously conducted in this area. I follow this with a discussion of the strengths and limitations of this study, the implications for therapy and recommendations for future research in this field.

The thesis closes with a conclusion chapter, in which I summarise and reflect on the research findings and their implications for the field of postnatal psychology.

2. Literature review

2.1. Introduction

The aim of this literature review is to present an account of the literature relevant to the experience of anxiety after birth. I begin by describing how the literature search was undertaken and follow with an introductory overview, which examines developments regarding tools for diagnosis, screening and measuring outcomes. I go on to present the key findings of the literature search relating to the experience of anxiety after birth, considering this from the perspectives of Obsessive Compulsive Disorder (OCD), Generalised Anxiety Disorder (GAD) and Panic Disorder (PD). I then outline literature which gives a lived experience perspective on the phenomenon and follow this with an overview of existential perspectives on anxiety and phenomenological research on early motherhood. The review concludes by identifying the gap in the literature in which I position my research and outlining my rationale for conducting this study.

2.2. The literature search

The objective of a literature review is to establish what is already known in relation to the research question under investigation and to identify any gaps in knowledge on the subject. For this task I felt it was appropriate to undertake a narrative review of the available literature to provide a synthesis of already published work. A narrative literature review is a non-systematic and mostly descriptive approach, which felt appropriate for a phenomenological study. Dibley et al. (2020) stress that reviewing

literature for a hermeneutic study is subtly different to other research modalities. Primarily, the literature review process is an opportunity to meaningfully engage with current knowledge and to 'co-create a new understanding' (p. 41). Within this process the researcher engages with the literature to attune to the phenomenon of interest in an open, reflexive way (*ibid*.). Reviewing the literature can be considered as the first stage of the hermeneutic process, where the researcher reviews and interprets what is already known about the phenomenon of interest and considers this in the light of what still remains to be discovered.

Some traditional key principles remained important to ensure a high-quality and rigorous review of the literature. Primarily, I intended to stay close to the kind of evidence I sought in my research question: *How do mothers experience anxiety after birth?* This entailed looking for literature which revealed elements of women's experiences of anxiety, which may manifest themselves via cognitions, feelings, emotional responses, perceptions and bodily feelings. In setting out to identify appropriate texts, I set clear inclusion and exclusion criteria. Search limits were put in place to ensure relevance for inclusion. These included year of publication, full-text, original articles and texts written in English.

For novice phenomenologists, Dibley et al. (2020) recommend using specific frameworks to focus the literature search. I chose to use the SPIDER framework (Cook et al., 2012) to develop and refine my search procedure and to generate potential search terms.

2.2.1. The spider framework

Table 1 – Spider search framework

	Search elements	**Potential search terms**
S	Sample	Mothers, new mothers
PI	Phenomenon of interest	Anxiety after birth, postpartum anxiety (PPA), postnatal anxiety (PNA)
D	Design	Interviews, surveys, questionnaires
E	Evaluation	Experience(s)
R	Research type	Qualitative, mixed methods

Having adopted this framework to generate search terms, I entered my terms into the search engines provided by the Middlesex University Online Library as well as Google Scholar, Academia and ResearchGate. These searches yielded 665 results, which were screened by reading titles and abstracts for suitability. A small percentage of papers (n=41) were of relevance to my study. I stopped searching when it became clear that different search engines were yielding the same results, indicating that a saturation point had been reached. 41 full-text articles were assessed and reviewed in full, of which thirteen were considered relevant. Studies were excluded if: i) they focused on pregnancy; ii) they focused on fathers or children; iii) they focused on postnatal trauma, depression or psychosis; or iv) they focused on incidences, consequences and treatments of PNA and did not mention anything about women's experiences of the phenomenon. The articles selected for

inclusion were carefully assessed for further sources of literature, resulting in a number of additional articles and book titles being identified as relevant. Broader literature relating to existential philosophy, phenomenology and early motherhood was sought to contextualise the concept of anxiety after birth from these perspectives.

2.3. Overview of anxiety after birth

PNA is under-recognised worldwide. However, anxiety symptoms in the first year after birth can be substantial, warranting intervention in approximately 20% of women (Toler et al., 2018). PNA can be difficult to diagnose, and symptoms may be dismissed by healthcare providers as a normal and expected part of new motherhood. While the UK National Institute for Health and Care Excellence (NICE) guidelines recognise that depression and anxiety disorders are common around the time of pregnancy and after birth, PNA is not formally recognised as a distinct diagnosis in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-V). NICE advise on screening and treatment of individually classifiable disorders as listed in the DSM-V, including conditions such as OCD, GAD, PD, Post Traumatic Stress Disorder (PTSD) and phobias, rather than treatment for PNA as a condition in its own right.

The screening tools used for these individual disorders are intended for anxiety across the population as a whole and are not designed to detect postnatal difficulties. Furthermore, in her review of the literature on postpartum anxiety disorders, Ali (2018) notes that few studies examine postpartum anxiety experiences using

standardised diagnostic criteria. She observed that the use of anxiety measurement tools varies across disorders, thus impacting the quality of research findings.

Since anxiety after birth does not have a diagnostic category of its own, postnatal depression has tended to take clinical prominence. Comprehensive research by Matthey et al. (2003) identified that, even when symptoms of anxiety are clearly in evidence, a depression diagnosis takes precedence. The reason for this was unclear but Matthey et al. (2003) concluded that somehow 'depression … trumps anxiety' (*ibid*., p. 144), which potentially leaves serious anxiety symptoms unaddressed. Their study revealed how mothers who met the criteria for postnatal depression experienced panic attacks as more difficult to manage than depressive symptoms. They recommended that, to acquire a more accurate overview of postnatal distress, women should be assessed for both anxiety and depression symptoms after birth. They further suggested that the term 'postnatal mood disorders' (PMD) (*ibid*., p. 139) should be used to reflect that postnatal difficulties are not only depressive in nature. While this term does move away from an exclusive focus on depression, it does not highlight anxiety as a distinct phenomenon.

Later research from Miller et al. (2006) also identified that postnatal depression became the most prominent indicator of postnatal disturbance and noted that anxiety often goes undiagnosed depending on the type of screening used. Their study identified that using the Edinburgh Postnatal Depression Scale (EDPS) along with the Depression Anxiety Stress Scales (DASS 21) was more effective at detecting anxiety than using either scale alone. The study also highlighted that, even when both screening tools are used together, vulnerable women could still have their symptoms overlooked.

Both Miller et al. (2006) and Matthey et al. (2003) draw vital attention to anxiety after birth as an overlooked phenomenon and suggest different means of approaching this dilemma. PNA has gradually become more widely discussed and various organisations in the US have suggested that PPA screening becomes mainstream (Toler et al., 2018). Diagnosis rates may be hindered however, as women with PNA symptoms are less likely to come forward and seek help (Woolhouse et al., 2009). Their study revealed how some women attributed this to feeling embarrassed about being anxious, or not being able to identify someone they would feel comfortable talking to. Several studies have been carried out to investigate different ways to diagnose or screen for PNA. Pierson et al. (2017) have investigated the use of GAD-Q-IV as a diagnostic tool for GAD in postpartum women. Their study revealed the effectiveness of such screening as a first-phase detection method for anxiety in postpartum women. If used routinely, they suggested that this could lead to further investigation, appropriate treatments and prevention of harmful consequences for mothers and their children. Their research focused solely on GAD, however, and did not specifically recognise PNA as a separate phenomenon.

In recent years, diagnostic and screening tools have been trialled to create specific anxiety measuring scales tailored to the perinatal phase. The Perinatal Anxiety Screening Tool (PASS) (Somerville et al., 2014) was created to detect anxiety from pregnancy through to six months after birth. The PASS is more effective at identifying anxiety than the EPDS-A (*ibid*., 2014). However, the tool does not distinguish between differences in anxiety before and after birth, inferring that symptoms are commensurate across this period. Pregnancy and new motherhood are two distinctly different periods in a woman's life, each characterised by different fears and

anxieties (Huizink et al., 2004; Fallon et al., 2016). While the PASS has clear benefits, a more focused tool for each maternity phase has obvious advantages.

Fallon et al. (2016) developed a screening scale, the Postpartum Specific Anxiety Scale (PSAS), to specifically measure PNA. Interviews were conducted with 19 women at two postnatal stages to elicit experiential responses to the open question, '*What are the main anxieties women have at this stage of motherhood?'* (*ibid.,* p. 1081). Analysis of the data was accompanied by an evaluation of existing perinatal surveys and appropriate literature to systematically develop a comprehensive 51-point questionnaire. The PSAS focuses on four anxiety groups: competency and attachment, child welfare, baby care and maternal psychosocial adjustment (*ibid.*). While the PSAS is lengthy to complete, the breadth of anxieties presented enables a detailed representation of women's experiences of PNA and gives credence to the notion that PNA is a multifaceted individualised experience. Testing of the PSAS has suggested that it is a reliable method for screening PPA (Fallon et al., 2016; Duran, 2020). A follow-up study took place to distil the quantity of diagnostic questions into a shorter format (Davies et al., 2021). This resulted in a refined 16-item scale, the PSAS Research Short-Form (PSAS-RSF), for measuring PNA. The shorter form has the advantage of increasing the tool's rapidity of use. In response to the worldwide crisis presented by the COVID-19 pandemic an additional format was developed to meet the anticipated growing mental health crisis. The resultant 12-item scale (PSAS-RSF-C) was conceived to enable ease of use and was translated into five other languages to broaden accessibility (Silverio et al., 2021).

Streiner et al. (2015) write that when individuals complete rating scales there is an expectation that answers will be carefully considered and honestly reported, whereas

it may be that the reality of reporting responses is more complex. Barriers may exist to accurate reporting: recollection of the symptom or experience may be challenging to recall or it may be difficult to quantify the magnitude of the experience. For new mothers, it can be frightening to confess to finding life as a mother difficult for fear of the unknown consequences of such revelations. McIntosh (1993) has revealed that mothers avoided reporting their postnatal negative thoughts to health professionals to guard against being labelled mentally ill or as inadequate mothers. In such cases mothers might minimise their anxiety and not reveal the true extent of their experiences.

The development of screening scales is undoubtedly an important advance in assessing PNA. The psychometric evidence on the PSAS confirms it as a reliable assessor of PPA (Fallon et al., 2016) and its comprehensive development approach underscores the importance and complexity of the phenomenon. Historically, postnatal depression has dominated the maternal psychological sector and the creation of the PSAS and its shorter versions importantly redresses the balance.

2.4. Anxiety disorders from the perspective of the DSM

NICE guidelines (2022) recognise that depression and anxiety disorders are common around the time of pregnancy and after birth. Given that PNA is not formally listed in the DSM-V as a separate condition, I have undertaken a review of literature which reveals something of women's experiences of anxiety as considered within the language of individual disorders as listed in the DSM-V. I have focused specifically on OCD, GAD and PD but have excluded PTSD and phobias, as these manifest as responses to specific triggers.

2.4.1. Obsessive Compulsive Disorder (OCD)

OCD has in the past been classified as an anxiety disorder and listed as such in the DSM-IV, however the diagnostic criteria have altered over time and OCD has since been given a diagnostic category of its own in the DSM-V (Abramowitz & Jacoby, 2014). This change has been contentious, with some scholars advocating for OCD to remain within the diagnostic category of anxiety disorders (Stein et al., 2010). In line with UK NICE guidelines, OCD has been positioned in this review of the literature as part of a spectrum of anxiety disorders which may be experienced after birth. OCD is characterised by intrusive, unwanted and distressing thoughts, which characteristically involve some kind of threat (Chalcombe et al., 2019). Obsessive and unwanted thoughts can be extremely upsetting, and mothers may go to great lengths to neutralise or attempt to get rid of them. It is estimated that a large proportion of the general population experience these kinds of thoughts intermittently (Randomsky et al., 2014), but for some the prevalence and severity of these is a significant cause of anxiety which warrants a diagnosis. OCD is diagnosed in 2% to 4% of women in the perinatal period (Fairbrother et al., 2016) and women are considered to be at high risk of developing OCD during this time. Ali (2018) notes that OCD appears to be particularly prevalent in postpartum women.

In the last 20 years, perinatal OCD has been the focus of numerous studies examining the disorder from various perspectives. However, for the purpose of this literature review, the focus is on research which reveals something of women's experiences of OCD after the birth of the child. Wenzel et al. (2001) were amongst the first to explore the nature of the phenomenon as it presented in a large community sample of 788 women. Members of the selected sample all experienced depression symptoms and were assessed via interview for significant symptoms of

OCD and PD. 84 women reported difficulties with obsessive or compulsive symptoms, and 13 of these women reported concerns relating to their babies. Two key anxieties were highlighted in this study. First, the mothers were worried that their children would pick up germs and subsequently engaged in compulsive cleaning regimes to allay their concerns. Second, mothers revealed frequently checking their infants during the night, harbouring concerns that they would die from Sudden Infant Death Syndrome (SIDS). Participants additionally reported behavioural changes such as pulling out their hair, picking skin and worrying over repetitive dreams. This study revealed the commonplace nature of postnatal OCD and usefully illuminated some of its key features. However, it did have several limitations. First, it was carried out amongst a group of mothers who were experiencing depressive symptoms, rather than anxiety symptoms, and therefore cannot be considered representative beyond this sample. Second, data was assessed via responses to Structured Clinical Interview for DSM-IV (SCID) questions relating to postnatal depression, which did not cover the broader landscape of anxiety disorders, therefore meaning that aspects of the phenomenon were concealed. It is also notable that interviews were conducted by telephone, which may have further limited the breadth of information the participants felt comfortable disclosing.

In a later study, Fairbrother and Woody (2008) focused specifically on mothers' thoughts of harm in relation to their infants. Their aim was to investigate experiences of these thoughts, in addition to their frequency and behavioural manifestations. 100 new mothers were recruited and data was collected via questionnaires and semi-structured interviews. The key findings were that, at four weeks after birth, all the research participants reported thoughts of accidental harm occurring to their infant, while thoughts of intentional harm to the infant were experienced as more distressing

but less prevalent for 49.5% of participants. This study is important as it highlights that thoughts of this kind can be considered a ‘normative aspect of early parenting’ (ibid., p. 228), particularly when coupled with an environment of significant stress and a lack of social support. The researchers additionally suggested that the accurate number of parents experiencing intentional thoughts of harming their babies was likely to be much higher than the study revealed, indicating a need for further research in this area.

Later research by Abramowitz et al. (2010) investigated PPA, depression and obsessive–compulsive symptoms in order to understand the relationship between them. 60 mothers were recruited from a mood disorders clinic and a variety of self-report measures were used to collect data. These included the EPDS, Postnatal Thoughts and Behaviours Checklist (PTBC), Yale-Brown Obsessive Compulsive Scale (Y-BOCS), State–Trait Anxiety Inventory (STAI) and Patient Health Questionnaire (PHQ). The collected data was analysed using statistical analysis software and the results revealed a frequent occurrence of obsessive–compulsive symptoms alongside anxiety and depressive symptoms. Closely echoing Wenzel et al.’s (2001) findings, the researchers noted that the most widespread obsessive thoughts were those relating to SIDS and fears that babies would come to harm from poisoning or germs. All the mothers utilised at least one coping strategy to manage their obsessive thoughts, with the most common being attempts at self-reassurance, frequent checks on the baby and attempts to distract themselves to divert their thoughts elsewhere. The authors acknowledged that their study had several limitations: the participants were all patients at a psychiatric clinic, which may have elevated the measurement scores, and they were assessed by self-report measurement rather than via interview. This potentially has a significant impact on

the data collection and could limit the depth of personal responses. Despite this, the researchers make important recommendations to encourage health professionals to screen mothers routinely for anxiety and OCD alongside postnatal depression, as their research highlighted that these symptoms frequently overlap.

More recently, Boyd and Gannon (2021) explored new mothers' experiences of infant-related harm thoughts (IRHTs). Semi-structured interviews were conducted with eight mothers and data was analysed using thematic analysis. The researchers' findings build on previous work supporting the notion that IRHTs commonly occur amongst a non-clinical population of mothers. The results revealed that both accidental and intentional IHRT were experienced by the participants, with the latter occurring in half of the sample, mirroring Fairbrother and Woody's (2008) findings. The participants turned to self-dialogue to cope with their distressing thoughts and all associated their experiences within cultural notions of bad mothering. Interestingly, some of the mothers related to their intrusive thoughts and saw them as belonging to part of an 'other' self, enabling some distance to be put between themselves and their experiences. Some participants experienced their intrusive thoughts as a form of 'deeper self-knowing' (Boyd & Gannon, 2021, p. 161) as part of an identification with the notion of maternal ambivalence. Approximately half of the participants voiced fears about revealing intentional IHRTs for fear of being judged by others, fearing the possibility of social services removing their children from them. This study was the first to note two sources of intentional harm, observing these phenomena as 'either external or endogenous' (Boyd & Gannon, 2021, p. 160). For the former, participants voiced fears of unknown aggressors 'snatching or violently attacking themselves and/or their children' (*ibid*., p. 161).

The authors acknowledge a couple of limitations: the research participants were drawn from a homogeneous sample with similar socio-economic backgrounds, education level and relationship status. In addition, half of the sample were former or current healthcare workers or were training in the profession. This implies they may have had specialist knowledge of the phenomenon which could have affected the data collected.

These studies collectively reveal the distressing nature of postnatal OCD and how this impacts women's experiences of early motherhood. While the reviewed literature reveals some limitations, the findings illustrate that experiences of this nature are widespread and form a significant part of the phenomenon of anxiety after birth.

2.4.2. Panic Disorder (PD)

In the UK, PD is classified as an anxiety disorder characterised by experiences of panic or fear. While occasional moments of panic are something everyone might experience from time to time, PD features frequent attacks which occur regularly for no particular reason (NHS, 2022). Typical symptoms of PD include a range of experiences such as sweating, palpitations, hyperventilation, dizziness, shaking and a fear of dying. Matsumoto et al. (2019) report that diagnoses of PD are far higher during the perinatal period than in the general population. Other quantitative research has shown that postnatal PD can impact mother/infant bonding, while also highlighting that mothers experience higher levels of anger than women without the disorder (Martini et al., 2020). PD in the general population is associated with an increased risk of suicidal ideation and attempt (APA, 2013) and research reveals that female suicide rates are notably 70 times higher than in the general population within the first year after birth (Appleby et al., 1998).

A review of the literature yielded four qualitative studies, which examine some aspect of women's experiences of PD after birth. Beck (1998) conducted a phenomenological enquiry into six mothers' experiences of PD in the postpartum period. At interview, women were asked to describe their panic experiences in detail and data was transcribed and analysed using Colaizzi's phenomenological approach. Six core themes emerged from Beck's analysis. First, women described their feelings as out of control and noticed that they felt cognitively impaired during their panic attacks. The participants also reported that a combination of feelings of panic and trying to maintain control resulted in physical exhaustion. Mothers additionally reported a strong desire to prevent further attacks from happening and noted that their panic attacks negatively impacted their self-esteem. Interestingly, memory of the attacks continued to have lingering effects long after the panic attack had subsided. This study highlights that PD significantly impacts a mother's quality of life and, while this research focused on a small sample, the detailed method of data collection and analysis yielded important insights for future management, treatment and understanding of the disorder.

In a later study by Wenzel et al. (2001), 11% of a large sample of 788 mothers reported experiencing panic attacks, with the most prevalent symptoms including a racing heart, sweating, shaking and pins and needles. A smaller percentage of women reported related symptoms such as feeling as if they were going to die or choke. After assessment via clinical interview, 12 women met the DSM-IV criteria for a diagnosis of PD, with the researchers noting that postpartum PD bears no symptomatic differences to PD in the general population. While this study largely focused on the prevalence, rather than the experience, of PD, it did focus on physical

symptomology, which, given the large population sample, provided useful insight into the embodied experience of the disorder.

In contrast a small study by Matsumoto et al. (2019) recruited three participants who all met the DSM-IV criteria for a diagnosis of PD. While the focus of this study was to evaluate the therapeutic effectiveness of Cognitive Behavioural Therapy (CBT) for postpartum PD, the assessment surveys used to collect data revealed the nuances of participants' panic experiences. Rather than focusing on symptoms, the research revealed the mothers' internal dialogues in relation to their panic experiences. One participant voiced concerns that her panic attacks would significantly impede her ability to take care of her children and be a good mother, while another worried that a public display of panic would reflect badly on her husband and could negatively impact his career. All participants revealed safety behaviours to mitigate their concerns. These included avoiding exercise, focusing attention elsewhere, always having a family member accompany them when they left the house and checking their symptoms on the internet. These strategies were intended to help mothers cope, but the researchers discovered that these behaviours reinforced the participants' anxieties, perpetuating a cycle of distress. Interestingly the cognitive dimensions of panic appeared to relate to cultural expectations of the role and duties of a mother. However, it is important to note that this study was carried out with a non-Western population and cultural differences were likely to manifest within the data. In addition, the researchers did not set out to explore the phenomenological dimensions of PD and were focused on the therapeutic effectiveness of CBT for the disorder.

More recently, Beck (2021) set out to explore how six women metaphorically expressed their experiences of PD. Interview data was analysed using a 'metaphor identification procedure' (MIF), which revealed that eight metaphors provided an alternative means for women to convey their experiences of the disorder. Mothers most frequently referred to eight metaphors. One metaphor, '*panic disorder is a magnifying glass'*, showed that women felt observed by others during their panic attacks, while '*panic disorder is a hermit*' (*ibid*., p. 371), revealed women's reluctance to leave the safety of their home environment. This imagery echoes Matsumoto et al.'s (2019) findings, revealing the unseen internal experience of living with the disorder. Beck proposes that the use of metaphor helps women to overcome the medicalised language used to describe panic experiences, with encouraging implications for future diagnosis, treatment and outcomes of PD. The descriptive data collected for Beck's study provides rich insights into the internal dimensions of PD, however with one exception, all of the metaphors focused on the impact of the experience, rather than the symptoms.

Compared to other anxiety disorders, there is less research into PD in the postnatal period. Nevertheless, the reviewed studies illuminate the distressing internal experience of PD and the significant impact that safety mitigations have on a mother's quality of life.

2.4.3. Generalised Anxiety Disorder (GAD) and worry

Amongst the general population, the Royal College of Psychiatrists (2022) puts the prevalence of GAD at approximately 4%. Symptomatically, it is characterised by excessive uncontrollable worry and requires a diagnosis from a healthcare professional based on specific criteria outlined in the DSM-V. To qualify for formal

diagnosis, symptoms must have been consistently present for at least six months and have a significant impact on daily functioning. Amongst the postnatal population, the prevalence is similar to that in the population as a whole: a study of 68 women at eight weeks postpartum revealed that 4.4% of participants met the symptomatic criteria for a GAD diagnosis (Wenzel et al., 2003). Notably, however, 32% of this sample displayed significant subsyndromal symptoms including uncontrollable worry. This provides an important indication of the degree to which women are troubled by significant levels of worry in the postpartum period, whether they qualify for a formal diagnosis or not.

A review of the relevant qualitative literature relating to the experiential dimensions of postnatal GAD revealed three studies. In the first, 129 mothers in receipt of specialist psychiatric services were interviewed in depth using the Birmingham interview to explore the social and psychological dimensions of the perinatal period (Brockington et al., 2006). Levels of anxiety were assessed, and mothers were asked to describe what their anxieties felt like. The results revealed that anxiety in the postpartum period was characterised by feelings of panic, fears of cot death, worries about lack of support and concerns for the health and wellbeing of infants. Mothers also feared being criticised by others, with 19% of participants experiencing severe anxiety relating to social services taking their children away. While it is important to keep in mind that this study was conducted with participants who had been referred to psychiatric services and is therefore not generalisable across the general population, the study raises an important point. The researchers argue that PPA presents as a broad range of symptomology, meaning that diagnosing the condition via a formal classification system such as GAD is limiting and problematic.

Other scholars have observed that subsyndromal anxiety, which falls below the threshold for a diagnosis of GAD, has a significant impact on postnatal mothers (Phillips et al., 2007). The researchers named this phenomenon Anxiety Disorder Not Otherwise Specified (ADNOS), noting that mothers in this category are unidentified and therefore undiagnosed. Their research suggests that PNA is highly likely to be widespread, with varying degrees of severity. In a follow-up study, they set out to investigate the differences in symptoms between mothers classified as having ADNOS and those with GAD (Phillips et al., 2009). 167 mothers with infants aged between two and12 months were interviewed and asked to complete a broad range of self-report questionnaires. Statistical analysis software was employed to analyse data. This revealed that 17 women were classified as having what the researchers termed 'maternally focused worry', with the most widespread worries focusing on the health and wellbeing of their infants. Other prevalent worries centred on mothering efficacy, having a crying baby and worries about the practical tasks of infant care. Some participants revealed that their worry had impacted their relationships with their partners. A further 18 participants had symptomology consistent with a GAD diagnosis, and, while their concerns echoed those with maternally focused worry, their anxieties broadened to include financial concerns, relationships with others, household concerns and a range of future-focused 'what ifs'. The researchers concluded that women's experiences in both groups were similar, with the maternally focused worry group focused on topics relating to motherhood and the baby, which did not qualify for formal GAD diagnosis but were still considered clinically significant and warranting support.

These studies collectively contribute to an understanding of the experiential and symptomatic features of PPA disorders. However, in separating these experiences

into distinct disorders, a wholistic overview of the phenomenon is difficult to grasp. In places these studies highlight that symptoms of GAD, PD and OCD overlap, highlighting the challenge of classifying symptoms within a framework of separate disorders. Furthermore, as a diagnosis of GAD requires symptoms to have been present for at least six months, it is likely that many postpartum women do not meet the criteria for diagnosis (Kleiman et al., 2020). The literature further reveals that subsyndromal symptoms and experiences may go undetected within this framework, leaving mothers both burdened and unsupported with their worries. While the language of disorder is in keeping with the medicalised discourse used by the UK mental health profession, it may pose a potential barrier to understanding the phenomenon as lived. Thus, the next section undertakes a review of literature on PNA from a lived experience perspective.

2.5. Lived experience research

A very small proportion of studies have set out to explore mothers' lived experiences after birth, and only one focuses solely on women's experiences of PPA. Using a feminist biographical narrative methodology, Wardrop and Popadiuk (2013) interviewed six first-time mothers to explore postpartum anxiety (PPA) specifically from the perspectives of intensity, meaning and experience. They found that mothers' lack of confidence in their abilities corelated significantly with their anxious feelings. They also identified that women's lack of knowledge about motherhood increased their anxiety of what was required of them and noted that women harboured worries about not living up to the cultural expectations of motherhood. The researchers identified a need to specifically recognise mothers' varying experiences, rather than collectively labelling them as postnatal depression, and highlighted that

women felt that their experiences of anxiety were misunderstood. This research is significant as it highlights the need for change in the conceptualisation of postpartum distress, while also drawing attention to the role of high standards and self-criticism within which the cultural context of motherhood is embedded. Whilst this study is important, the methodological approach and its emphasis on data coding may have limited the scope to reveal the underlying essence and experiential dimensions of PPA. In addition, the authors acknowledge that the homogeneous social status of the participant sample makes it uncertain if the findings are applicable to a wider population.

Whilst Wardrop and Popadiuk's (2013) study is the only one exploring PNA from a lived experience perspective, two further studies shed light on closely related experiences. Coates et al. (2014) undertook a qualitative study of women's lived experiences of postnatal distress using Interpretive Phenomenological Analysis (IPA). 17 mothers who identified as having experienced emotional distress in the first year after birth were interviewed either in person or on the telephone. After analysis, the results highlighted mothers' experiences of anxiety occurring in several domains. The researchers noted that breastfeeding caused significant anxiety, with mothers reporting worries about whether their infants would feed adequately and how long feeding would take. These feelings were found to be particularly prevalent as breastfeeding occurred at regular intervals throughout the day. Mothers also disclosed worries about being overwhelmed and inexperienced at motherhood and collectively lacked confidence in their ability to be capable mothers. Some participants revealed that they felt they ought to know what to do but felt unsteady in their maternal role and unsure of themselves.

Drawing on a detailed analysis of first-person accounts, this study provides valuable insights into women's experiences of postnatal distress. However, anxiety formed only part of a more comprehensive landscape of postnatal suffering. In addition, IPA yields descriptive data which emphasises the cognitive and affective psychological dimensions of the experience, rather than focusing on the phenomenon itself. There is also a debate questioning whether IPA studies are convincingly phenomenological. Van Manen (2017) argues that a study which claims to be phenomenological must undertake the process of epoché and reduction, however this practice was not explicitly evidenced in this study.

Highet et al. (2014) conducted research into women's lived experiences of perinatal depression and anxiety. 28 Australian women were recruited, each self-identifying as having experienced either postnatal depression and/or anxiety within the previous five years. In-depth qualitative interviews were conducted and data was analysed using a Grounded Theory model to ensure that any theory generated originated from lived experience. The key phenomena arising from the data analysis were 'loss' and 'frustration'. These phenomena were linked to three central themes, one of which focused specifically on symptoms of depression and anxiety. The researchers found that women who reported anxious symptoms described them in terms of feeling wound up, agitated and on edge. Anxious mothers additionally reported experiencing extreme worry, focusing primarily on their infants' health and wellbeing. Some women became extremely protective of their infants and others experienced panic attacks. Others disclosed that social settings induced anxious feelings with some mitigating this by avoiding interacting with others. The researchers noted that some symptoms were common to experiences of both depression and anxiety. These included insomnia and difficulties in thinking clearly.

While this study was conducted with a limited homogenous sample, it raises awareness of the symptomatic presentation of perinatal depression and anxiety and the causative features of these. The choice of methodology permitted a large sample size, however the substantial amount of data yielded from a study of this nature can be challenging to manage. Furthermore, the authors of this study do not disclose any aspects of engaging in reflexivity which is necessary to guard against bias in a study of this nature.

A review of the literature so far has revealed that anxiety after birth is considered from the perspective of individually diagnosable disorders, as listed in the DSM-V. As has been noted, these disorders are not listed as specific to the postnatal period itself and research based on these categories is therefore not wholly descriptive of the experience. While research into symptomology aids scholars in understanding PNA, with the exception of one study (Wardrop & Popadiuk, 2013), the lived experience perspective has been neglected – as also observed by Ali (2018).

Wardrop and Popadiuk's study marks an important step towards a cultural understanding of the experience from the context of a feminist narrative. However, an existential ontological understanding of the phenomenon remains absent in the current literature. The next section introduces an existential viewpoint on the concept of anxiety and reviews studies on early motherhood from an existential phenomenological perspective. This is important for context since the current study seeks to explore the phenomenon from this standpoint.

2.6. An existential perspective

2.6.1. Philosophical accounts of anxiety

Within the UK, anxiety is commonly recognised as a disorder which can be treated with medication or talking therapies such as CBT. While the DSM-V and the NHS website offer lists of characteristics, they do not provide comprehensive details of what the experience is like, or indeed what it means to be anxious. Existential literature provides an alternative perspective to the medicalised perspective of anxiety, viewing it as part of existence rather than something to be cured, avoided or removed. While PNA does not feature in existential literature, the concept of anxiety has a rich philosophical history. Existentialists consider anxiety, angst and anguish as a 'given' in life – an unavoidable part of being alive.

In Kierkegaard's seminal work *The Concept of Anxiety* (2014), he makes an important distinction between fear and anxiety. Fear arises from an external threat and is directed towards an object – we are afraid of something. Anxiety has a different quality – it is an internal experience with no specific focus. It is a generalised sense of feeling ill-at-ease with the world. For Kierkegaard (2014), the symptoms of anxiety are interconnected to existential freedom and linked to choice and responsibility. To move forward in life, we must make choices and take responsibility for our actions. However, this process is an uncertain one. Without knowing if we are making the correct choices, we are confronted with what Kierkegaard (2014) refers to as 'the dizziness of freedom' (p. 75). Further, in making one choice, another is lost, and this realisation perpetuates feelings of anxiety and unease. For Kierkegaard there is some benefit to experiencing anxiety, as it forms the vantage point from which humans can progress towards spiritual fulfilment. To interrupt this process with

intervention in the form of medication or cognitive strategies is to interrupt our flow of consciousness.

Heidegger (2010) follows Kierkegaard in considering the focus of anxiety as non-specific and as an inescapable part of our being-in-the-world. For Heidegger, the mood of anxiety is connected with death and nothingness and presents an awakening to the fact that one day each of us will cease to be. This awareness is unsettling and disturbing and Heidegger (2010) posits that we spend time distracting ourselves from this distressing concept in an attempt to keep reality at bay. We absorb ourselves in our social lives, the 'they-self', with gossip and distractions to avoid confronting our finitude. Yet at points of crisis, upheaval and life change, we are jolted out of this way of being, awakened by what Heidegger (2010) terms 'the call of conscience' (p. 314). For Heidegger, if we can heed this call and face our anxiety, we can begin to live an authentic life – one in which we accept responsibility for our lives and acknowledge our being-towards-death. In doing this, Heidegger affirms that we can find true freedom. This means that we are alive to our individual possibilities and options and ready to embrace life authentically with what Heidegger (2010) terms 'resoluteness'.

Thus, from an existential perspective, anxiety is the result of confronting the existential paradox of living and cannot be avoided (Van Deurzen, 1997). Adams (2018) has written that life is informed by the existential 'tension between natality and mortality' (p. 73). He points out that beginnings, endings, births and deaths cannot happen without each other. They are inextricably connected, offering a continual reminder of our temporality. Viewed as such, motherhood brings this confrontation sharply into focus. The process of birth brings us into the middle generation,

heightening our awareness of our transience. In bringing life into the world and facing one's own mortality, mothers come directly into contact with the tension and anxiety inherent in the human condition.

2.6.2. Motherhood

The fields of existential philosophy and existential therapy have largely overlooked female lived experience. However, there are a couple of exceptions. While not a mother herself, De Beauvoir (1997) wrote about motherhood as being imprisoned in the life cycle, where motherhood 'affirms life against time and death' (p. 553). On one hand, a mother gains immortality through her children, yet, on the other hand, she is faced with being one generation closer to her own death. De Beauvoir wrote of a mother's fears of birth as fears for her own loss of physical life in the process of giving birth. Fear of death during delivery is also highlighted in research by Field (2018). While medical improvements in the West have significantly decreased the statistics of mothers dying in childbirth, it is still a reality in other cultures. Research by Edbourg et al. (2015), revealed that many Bangladeshi women are plagued by fears they will die in childbirth. The stark truth for other cultures, as it was for our forebears, is that death and birth go hand in hand.

If a baby has been safely delivered, the reality of motherhood brings further anxieties. The arrival of a new life brings with it weighty responsibility and women may become more focused on their own mortality and fear what might happen to their child if they themselves die (Arnold-Baker & Donaghy, 2005; Edbourg et al., 2015). The philosopher and existential therapist Emmy Van Deurzen (2015) acknowledges that mothers who have given birth have a unique understanding of the mysterious nature of life and 'how close it is to death, the fear of which is always at

the horizon when you have a new-born baby in your arms' (p. 55). Stern and Bruschweiler-Stern (1998) identified that the first task of new motherhood is keeping the baby alive. This responsibility is accompanied by multiple anxieties: will the baby accidentally fall; drown while bathing; be accidentally suffocated? To a new mother, the world can feel like a threatening place where neither mother nor child is safe (Price, 1990). This results in heightened vigilance in mothers, and some are preoccupied with the safety of the baby to the point of obsession, sometimes diagnosed as OCD. Yet these anxieties are connected to survival and Figes (1998) notes that the peril of cot death or unexpected illness is never far from a new mother's mind. Stern and Bruschweiler-Stern (1998) recognised that maternal anxieties lessen with time, but never fully subside.

Stern and Bruschweiler-Stern (1998) also highlight anxieties over feeding the baby and describes these responses as 'forces over which you have little control' (p. 100). They recognised that anxiety around babies' survival and growth are normal and necessary. Such hypervigilance ensures the survival of the species. They write that 'though the psychological strain will be heavy, the fear is actually your ally' (p. 106). Price (1990) similarly suggests that, earlier in our evolution, maternal anxiety was a protective mechanism to ensure the survival of the species in a hostile environment. Today, equally intense anxiety responses are provoked in response to lesser threats. A new mother can anticipate danger and risk everywhere, even in the most unlikely situations. The baby's survival depends on such vigilance (Stadlen, 2015).

Anxiety in motherhood is seemingly never far away. Drawing on De Beauvoir's ideas, Butterfield (2010) writes that, if a woman defines herself solely as a mother, she is in a precarious position of dependency. Changes to her role as mother may jeopardise

not only her identity but her very existence. In her attempts to escape anxiety she ends up in ‘a constant state of worry’ (Butterfield, 2010, p. 72), destined to live a perilous emotional existence.

2.6.3. Contemporary phenomenological research into early motherhood

In the last decade, several contemporary studies have been carried out into early motherhood from a philosophical perspective. These studies offer experiential accounts of what it is like to be a mother from an existential standpoint and offer first-person lived-experience accounts, which help to counterbalance the male perspectives that have taken precedence in philosophical literature (Arnold-Baker, 2020). While, to date, no research has been undertaken into anxiety after birth from this perspective, several of these studies have revealed something of the maternal experience of anxiety. This has been helpful in attuning to the phenomenon, therefore warranting the inclusion of these studies in this literature review.

From a philosophical perspective, our human existence is characterised by our ‘thrownness’ into the world (Heidegger, 2010) – an event which occurs without choice. Stadlen (2015) noted that simultaneously to a baby being born, or thrown into the world, a mother is thrown into new motherhood. Overnight she finds herself in uncharted territory, with her everyday existence dramatically altered. The pregnancy may or may not have been her choice. Whatever the circumstances of conception, new mothers are universally presented with the existential givens of life and need to choose how to respond. Stadlen notes that this choice is accompanied by uncertainty and anxiety. Arnold-Baker (2015) observed that new mothers respond to anxiety and feelings of uncertainty by searching for answers via books, the internet or consulting

others. If considered from an existential Heideggerian perspective, such activities constitute falling in with the ‘they’ and are inauthentic. On the other hand, the search for answers serves to provide a mother with choices. Stadlen (2015) suggested that, rather than turning to experts and books for assistance, a mother’s disorientation in her new life is useful to her. She recognises uncertainty as ‘a good starting point’ for new mothers (p. 45). From this uncertainty, a mother starts to learn. This may, however, feel intolerable to both the new mother and those around her. As a result, this can be a time of uncomfortable emotional turbulence. Such turmoil was identified in research by Barclay et al. (1996), who highlighted that, while ‘mothers undergo a profound reconstruction of self’ (p. 727), they identify feelings of being alone, unsupported, uncertain, frightened and highly anxious.

Arnold-Baker (2020) describes the transition to motherhood as an existential crisis – a time when a new mother recognises that her life has altered immensely. Everyday life feels unfamiliar and the new maternal role is unknown. Arnold-Baker’s (2015) research highlighted the anxiety this transition evoked, observing that new motherhood is a time when mothers are presented with new choices, responsibility and uncertainty. Arnold-Baker (2020) describes how the ‘weight of responsibility leads to a feeling of anguish and worry for mothers’ (p. 30) and highlights that mothers often have their worries dismissed by others. Arnold-Baker attributes maternal worry to mothers seeing the world in a new way, with an awareness of the fragility and uncertainty of life. She writes that becoming a mother impacts all dimensions of existence: the personal, physical, social and spiritual, each dimension bringing its own ontological challenges.

Later research by Garland (2019) explored women's experiences of the transition to motherhood, using the four realms of existence as a framework to analyse and interpret the data. Eight mothers were interviewed about their experiences and the findings revealed that the existential responsibility of motherhood is an ontologically transformational experience across all dimensions of existence. In harmony with Arnold-Baker's (2015) work, Garland's research highlights that mothers recognise the fragility of their infants coupled with their maternal responsibility for their survival. Garland describes this realisation as accompanied by feelings of anxiety, with the possibility of loss awakening a new mother to an existential awareness of mortality. In the personal dimension, she notes that the transition to motherhood requires a woman to take on a new and unknown identity. Yet, in doing so, mothers experience a sense of loss of their former identity and its comparable freedoms (Garland, 2020). The shift into a new mode of being-in-the-world is experienced as a vulnerable time, and the choices and responsibilities accompanying the transition are the catalyst for feelings of anxiety and guilt. Garland's (2020) research highlights that, as profound change is felt across all dimensions of existence, 'there is no place in which a mother feels settled and at home' (p. 72). While this research importantly highlights that new motherhood is felt to be ambiguous, uncertain and overwhelming, it also reveals that motherhood can be a turning point, presenting an opportunity for a mindful way of being and offering new understandings and appreciations of existence.

Shulman (2020) explored mothers' experiences during the first year of looking after a premature infant. Eight mothers from a range of cultural backgrounds were interviewed and data was analysed using IPA. Shulman's findings illuminated the mothers' intense need to keep their babies alive, a process accompanied by an ongoing fear that their babies would die. Fear and anxiety were experienced as

constantly present for new mothers, as they contemplated not only their child's mortality, but also their own. Shulman further referred to bonding with the baby as a tentative process, taking place within the shadow of potential loss. Discharged from hospital NICU, mothers reported feeling different to other mothers, with loneliness and isolation further contributing to their feelings of anxiety. Shulman writes that the process of living with uncertainty brings mothers into contact with both ontic and ontological anxiety. This research highlights that mothering a premature baby and being confronted with mortality so soon after birth causes an 'existential shattering' (Shulman, 2020, p. 131). This study occupies an important place in early motherhood research. However, given that the participants were all mothers of premature babies, the interconnections with anxiety are particular to this distinct group and are therefore not representative of the maternal population as a whole.

In harmony with Shulman's findings, Donaghy's (2020) research into postnatal depression noted that motherhood brings women closer to an awareness of their own mortality and survival, in addition to that of their infants. Her research noted themes of anxiety, in that mothers perceive the world to be dangerous and respond by caring for their children with increased vigilance. Donaghy (2020) links mothers' heightened awareness of mortality with Heidegger's notion of thrownness, where a mother cannot control what the future may bring, writing that this combination of existential givens contributes to feelings of anxiety. She further highlights the prominence of existential freedom and responsibility in new motherhood, noting that mothers must choose how to approach motherhood while also being responsible for the wellbeing of their infants. In giving birth to a child, Donaghy (2020) suggests that a mother's personal projects are temporarily put on hold, giving rise to Tillich's (2008) concept of 'moral anxiety' – a guilt-ridden experience of feeling that one is not

achieving one's full potential in life. She further notes that a mother's sense of self is fragile during the transition to motherhood, bringing into question who she is, accompanied by uncertainty relating to her purpose and direction. Donaghy's work highlights the paradoxes of motherhood: a happy new arrival can be accompanied by tension and feelings of depression and despair. She makes an important contribution to understanding new motherhood from an existential perspective, observing the overlap between depression and anxiety, and offering guidance on how to support mothers therapeutically using an existential phenomenological approach to practice. It is important to note that Donaghy's work focuses on depression, and whilst she touches on themes of anxiety, it isn't the focus of her research.

New mothers' experiences of anxiety are also apparent in Gaffney's (2020) research, which investigated mood and emotions in early motherhood. Eight first-time Irish mothers were recruited and asked to draw or paint an image of themselves which represented their experience of their predominant mood and emotions after birth. At a later stage, semi-structured interviews were conducted in which the participants were invited to talk about their images and experiences in greater detail. Gaffney undertook an interpretive phenomenological approach to data analysis, in addition to a process of image analysis based on Van Deurzen and Adams' (2011) theory of dream analysis. This study revealed two core themes: 'mammy worry' and 'the existential shift of emotions' (Gaffney, 2020, p. 263). The first of these themes revealed rich depictions of how fear, angst and a focus on death come to the fore in early motherhood. Participants revealed how their thoughts centred on imaginary worst-case scenarios and imminent dangers, resulting in mothers taking extra care of their infants to keep threats at bay. Gaffney noted that, while such vigilance came at the price of the mother's existential freedom, it was recognised as a purposeful

choice. Data analysis linked the mothers' worries with their love and care for their infants as well as a recognition of life's finitude. Gaffney's research further raised important points regarding how mothers' emotional experiences are conceptualised in the field of psychology and psychotherapy. She makes recommendations for a creative therapeutic approach to be considered when working with mothers experiencing postnatal mood difficulties. It is important to note some caveats to this research: first, at least one of the participants had a baby in special care, adding additional anxieties to the experience of early motherhood, and Gaffney's research did not set out to intentionally investigate PNA as a phenomenon of its own. However, Gaffney's work makes an important and unique contribution to the existential phenomenological research field, revealing the extent to which worry and fluctuating anxiety permeate the lived experience of new motherhood. She calls for an alternative therapeutic stance to be considered when working with new mothers, so that women are offered an opportunity to consider their experience reflectively without judgement and for therapists to explore new mothers' experiences within an existential framework which recognises the tensions and paradoxes inherent in life.

2.7. Summary

A total of 18 studies were reviewed to identify key themes pertaining to the experience of anxiety after birth. Of these, over half (n=10) were carried out from the perspective of the experience as a disorder (OCD, PD, GAD), which precludes a broader consideration of the experience. A variety of data collection and analysis methods were employed, including measurement scales, questionnaires, statistical analysis, thematic analysis and metaphor identification. Several of these studies were conducted with a large sample size (Wenzel et al., 2001; Fairbrother & Woody,

2008; Phillips et al., 2009; Brockington et al., 2006). Wenzel et al.'s (2001) study recruited the largest sample (n=788) and, while it usefully revealed some key features about the phenomenon, the sample size restricted the opportunity to explore the phenomenon in any meaningful depth. Similarly, Fairbrother and Woody's (2008) study involved 100 participants. While it importantly emphasised the high prevalence of mothers' thoughts of harm in relation to their infants, the large sample size did not allow for a more nuanced understanding of individual subjective experience. Matsumoto et al. (2019) focused on the smallest sample (n=3), which gave rise to detailed insights into PD. However, this study was intended to evaluate the therapeutic effectiveness of CBT rather than the phenomenology of PD, therefore limiting the scope of their findings. Other studies recruited participants from psychiatric clinics (Abramowitz et al., 2010; Brockington et al., 2006), which may have yielded different results to community sampling. Just one study of ten (Beck, 1998) employed a phenomenological method and the detailed findings reveal the individualised nature of women's experience of PD. Beck's study brings rich and meaningful insights pertinent to understanding and supporting women with the condition. However, given that panic is only one dimension of anxiety, other dimensions are unexplored.

Of the remaining eight studies, three took a different approach, investigating the phenomenon outside a disordered perspective. All three undertook a lived experience enquiry, although only one focused specifically on the phenomenon of anxiety after birth (Wardrop & Popadiuk, 2013). While a study of lived experience lends itself to a phenomenological method, the researchers undertook a feminist biographical narrative approach which involved coding their data. This approach has limitations and risks losing the essence of the phenomenon in the analysis process.

Despite this, Wardrop and Popadiuk's research importantly highlighted the cultural expectations of motherhood and their role in the experience of PNA. Of the two other lived experience studies, Coates et al.'s (2014) exploration of postnatal distress undertook a detailed analysis of 17 first-person accounts in which breastfeeding was found to be a significant cause of anxiety. Touching fleetingly on an ontological perspective, mothers additionally disclosed feelings of being overwhelmed. However, these experiences were not explored in greater depth. It is also important to note that this study did not focus exclusively on anxiety, which limits its contribution to the field. Highet et al. (2014) recruited a larger sample (n=28), utilising Grounded Theory to remain close to lived experience. However, this study did not focus solely on anxiety as some of the recruited participants were also experiencing depression.

A small number of existential motherhood studies (n=5) were reviewed because they explored the experience of new motherhood from a philosophical perspective and to some degree touched upon the experience of anxiety. Collectively these qualitative studies (Arnold-Baker, 2015; Garland, 2019; Shulman, 2020; Donaghy, 2020; Gaffney, 2020) contribute to an understanding of early motherhood as a time of existential crisis (Arnold-Baker, 2020). All five studies recruited a small number of participants to allow for rich data collection and meaningful themes to emerge. It is important to note that none of these existential studies set out specifically to explore women's experiences of anxiety after birth, yet they all reveal something of interest regarding the phenomenon under investigation.

2.8. Rationale for this study

The reviewed literature clearly indicates that anxiety after birth in its different guises is comparatively widespread and challenging for many women. In keeping with national guidelines and diagnostic pathways, anxiety after birth is viewed by clinicians and researchers as comprised of separate parts: the obsessions of OCD, the worries of GAD and the physical overwhelm of panic. While the reviewed studies reveal something about the nature of these separate components, they form part of a medically constructed framework and it is not clear what maternal anxiety is as an entity in itself. Furthermore, in considering PNA as a cluster of separate disorders, the ontological nature of the wholistic experience remains concealed. Importantly, there are studies which highlight that mothers' anxiety experiences might not fit within a disorder paradigm: Phillips et al. (2007) draw attention to the significance and impact of subsyndromal anxiety and Coates et al. (2014) describe the importance of exploring women's postnatal experiences from the perspective of distress rather than disorder. A growing body of literature contributes to understanding new motherhood from an existential phenomenological perspective, giving a voice to women's individual subjective experiences of early motherhood.

A detailed analysis of the literature reveals that no studies specifically set out to explore the existential dimensions of anxiety after birth. A phenomenological study examining women's experiences therefore serves to bridge the gap in the current literature. Phenomenology seeks to explore the lived dimensions of the experience itself to reveal what the experience feels like, what it means to be anxious and how women themselves make sense of this experience. Thus, it is anticipated that an existential phenomenological study into women's experiences of maternal anxiety will

contribute new understandings, which will be of value to professionals supporting mothers postnatally.

3. Methodology

The aim of this study was to explore mothers' lived experiences of anxiety after birth from an existential phenomenological perspective. Van Manen's (2016) hermeneutic phenomenological approach was selected to reveal meaningful themes within the context of his four lifeworld existentials. In this chapter, I will summarise the key elements of the philosophical foundations of the phenomenological approach, outline the rationale for selecting hermeneutic phenomenology as my chosen method and provide insight into how I utilised this approach in practice. I will discuss my own reflexive awareness and the relevance of this in relation to the phenomenon under investigation and discuss ethical issues such as risks to participants and confidentiality.

3.1. Rationale for a qualitative research approach

The choice of methodology is fundamental to the project undertaken. The selected methodology determines how the researcher undertakes the study and defines what procedures, tools or approaches are used in the collection and analysis of data. Quantitative research involves measuring phenomena. Large participant samples are required to collect data which can be objectively measured in numbers. In contrast, qualitative research is generally rooted in a subjective and interpretivist perspective. It explores situations or phenomena to provide an in-depth understanding, using small sample sizes to allow time to undertake this. Qualitative research takes on an inductive process, exploring the phenomenon as it is revealed, as opposed to analysing it in the context of pre-specified variables or from a given theoretical

stance. As a result of the small sample size, qualitative findings cannot be generalised to the wider population.

With over ten years' experience as a psychotherapist, I have come to appreciate that human experience cannot easily be quantified. Drawing on this understanding, my research seeks to explore human experience and search for meaning in an inductive, probing and exploratory way. With a focus on lived experience, a qualitative research method is well positioned to provide insight into and understanding of women's experiences of anxiety after birth. My research aim is not to establish a theory, but to reflect upon the meaning of experience – exploring what it is like to be a mother feeling anxious. Phenomenology provides the appropriate vehicle to do this, inviting the researcher 'to slow down, focus and dwell with the phenomenon' (Finlay, 2011, p. 3).

3.2. Phenomenological background and approaches

Edmund Husserl founded the division of philosophy termed phenomenology. He sought to 'return to the things themselves' (Langdridge, 2007, p. 4) to expand his understanding of specific features of human experience and consciousness (Valle et al., 1989). Trained as a mathematician, Husserl applied his ideas to the different sciences. His methods were subsequently taken up by philosophers and later psychologists, and a phenomenological movement was formed.

Phenomenology focuses on each individual's observations of the world they inhabit and the meaning they attach to these observations (Langdridge, 2007). The emphasis is on individual lived experiences, acknowledging the role of the researcher in the process. Husserl believed that one could separate oneself from the

lived experience in order to see things as they are, with fresh eyes (Langdridge, 2007). This requires bracketing, known as a phenomenological reduction, where judgement is suspended for immersion in the analysis of experience. Husserl's transcendental reduction is the point of retreat from the everyday world towards the intersubjective level of the transcendental ego.

Husserl's position has been much debated by existentialists, especially Heidegger (a student of Husserl), who developed phenomenology towards an interpretive approach via language, rather than description. Heidegger's primary concern was the study and meaning of being. He used the phrase 'being-in-the-world' to emphasise the interconnections between human existence and the world, and the term 'Dasein' to refer to the experience of being that is unique to humans. Heidegger's philosophy of phenomenology considers temporality to be a fundamental concept, positioning time as how Dasein understand and interpret the world around them. Interpretation was considered essential for understanding because it helped to reveal what phenomenon might be concealed or hidden. The focus of interpretive phenomenology is to un-conceal the phenomenon – to let it be seen – although the phenomenon can never be fully revealed (Heidegger, 2010). Heidegger's work was developed further by hermeneutic phenomenologists Gadamer and Ricoeur.

3.2.1. Descriptive phenomenology

Descriptive phenomenology focuses on revealing the essence of the phenomenon being investigated. The approach describes rather than explains the experience under investigation. Giorgi (1985) pioneered this method, which is close to Husserl's ideas in its pursuit of essence. Giorgi's method follows the process of epoché and phenomenological reduction, remaining close to the data throughout. The process of

bracketing aids the researcher in focusing on the present experience and the researcher is required to engage in extended reflexivity to ensure their biases and presuppositions are brought into awareness. Giorgi's method is not the only descriptive approach. Colaizzi's (1978) methodology of descriptive phenomenology also requires the researcher to carefully examine their presuppositions about the phenomenon under investigation. Data collection can be acquired via three different means: written practices, dialogue interviews or observations of events. The latter approach is employed in instances when the phenomena under investigation cannot be conveyed. Instead, the process of observation takes a form of perceptual description (Tatano Beck, 2021). Colaizzi (1978) employed a seven-step method of detailed analysis to capture the essence of experience. In his final step Colaizzi discusses the results with his participants and sometimes modifies earlier stages of the analysis accordingly. Giorgi (2006), who argued that this final step skewed the results, criticised this process.

I considered whether a descriptive phenomenological approach could have been suitable for my study. It is particularly useful for under-researched topics and has significant potential for assembling rich personal accounts of experiences. It also has a capacity to unearth compelling and rigorous findings wholly appropriate for a professional therapeutic culture keen to seek research applicable to evidence-based practice (Finlay, 2011). I have, however, had to discount this approach, as I feel it is not realistic to remove my personal lived experience of anxiety after birth entirely from the research process. Further, Heidegger argues that a purely descriptive approach would inevitably involve some degree of interpretation by way of context. Hermeneutic/interpretive methods offer an alternative pathway, with less emphasis on description and greater emphasis on interpretation. Experiences are considered

within the context of other social factors, allowing for richer understandings to develop.

3.2.2. Interpretative phenomenology

Interpretative Phenomenological Analysis (IPA) was considered for this study. Informed by the philosophy of Husserl, Heidegger, Merleau-Ponty and Sartre, this approach pursues idiographic accounts of how individuals perceive lived experiences and make sense of them (Finlay, 2011). Using a systematic approach, IPA involves a detailed analysis of experience and the researcher's position is pivotal in making sense of the participants' experiences within the 'double hermeneutic' (Smith, 2004). IPA allows for the inclusion of some creativity in the data collection process, and, from this perspective, the approach could be useful for my study of a non-mainstream topic. Small sample sizes allow for a rich depth of data collection and a clear set of steps offers clarity in the data analysis process, which draws on a coding system. The clarity of this approach may be appealing to a novice researcher.

Despite its name, IPA has been criticised for being essentially descriptive and not satisfactorily interpretive (Hefferon & Gil-Rodriguez, 2011). Another criticism is that IPA does not place enough emphasis on the role of language (Willig, 2008). With its roots in the discipline of psychology, Van Manen (2017) questions if IPA is, in fact, phenomenology at all. He posits that an approach which seeks to make sense of experience is one which should be termed 'interpretive psychological analysis' (Van Manen, 2017, p. 778), rather than phenomenology. He further argues that Smith's approach is focused on the individual and their own views and understandings of their experiences, rather than being focused on the phenomenon itself (Van Manen, 2017). Despite these criticisms, IPA has become a popular methodology amongst

researchers. Since my own study seeks to explore women's lived experiences of PNA from an existential phenomenological perspective, I have eliminated IPA as a viable option. It does not place importance on the existential dimensions of experience, and in light of the aforementioned criticisms, I do not consider it to be a suitable method to access the eidetic, sentient and meaningful elements of the phenomenon under investigation.

3.3. Epistemology and chosen method

My research aims to focus on mothers' lived experiences of anxiety and will explore existential themes. The researcher's ontological and epistemological positioning will determine their choice of methodology: I am interested in the 'how' (noema) and 'what' (noesis) of the experience of anxiety after birth. With the epistemological focus on experience, a phenomenological research methodology is the most appropriate choice.

My epistemological stance is that of critical realist. My study is undertaken from the premise of ontological realism and epistemological relativism: the world exists independently of what we know or think of it, and we interpret the world we inhabit, reflect upon and speak about (Pilgrim, 2020). I believe that life is mysterious, reality is in flux and we do not know everything there is to know. It is helpful that anxiety after birth does not currently exist as a DSM diagnostic category as diagnosis is in itself an epistemological issue. While the internal reality of anxiety may be unobservable to others, the experience itself is a real inner event.

A critical realist epistemology brings caution to predicting outcomes and does not require the researcher to absent themselves in order to gain 'a birds-eye view of

human experience' (Pilgrim, 2020, p. 28). I openly acknowledge that I have an established relationship with the research topic and have contemplated my own personal perspective and experiences and how these may influence data collection. My research into individuals' subjective experiences of maternal anxiety will be interpreted rather than constructed. Women's experiences will be explored from a relational standpoint, and I will turn to the lifeworld and to lived experience to generate new knowledge (Van Manen, 2016).

From a personal perspective, I am drawn towards creative approaches and have an artistic background, with a bachelor's degree in music. I am profoundly moved by listening to, performing and immersing myself in music. I am attracted to literature and enjoy reading, journaling and writing poetry as means of expressing myself privately in words. I am drawn to beautiful texts, imaginative artworks, contemporary dance and the breadth of human expression as conveyed by a variety of creative means. I am a deep thinker and a senser and am often profoundly moved by what others have to say and have experienced. I tend to listen more than I speak, I often find myself lost in thought and I enjoy pondering new concepts to consider different ways of going about things. I am intrigued by what it is to be human, what it is to experience joy, how it feels to experience suffering and how we navigate life's challenges. This inquisitive nature was the driving force that inspired me to re-train as therapist in 2007 after the birth of my children. As a therapist, I enjoy listening to others, being part of their exploratory journey and sitting by their side as they steer through life's complexities and contradictions. Put simply, I am fascinated by other people and how they experience their world. Thus, my chosen methodology of hermeneutic phenomenology is in keeping with who I am, my epistemological

position, my research aims and my innate curiosity concerning what it means to be human.

3.3.1. Hermeneutic phenomenology

Hermeneutic phenomenology is rooted in the philosophies of Heidegger, Gadamer, Ricoeur and Derrida. The approach is a creative and intuitive one, which eschews rules and stringent procedures in favour of an open and dialectic approach. As such, the researcher is freed from the constraints of a 'right' or 'wrong' way of going about their research (Crowther et al., 2016). In hermeneutic phenomenology the phenomenon under investigation concerns 'an aspect or dimension of human "being" that lies hidden, lost to our understanding because it has gone from "sight"' (Smythe & Spence, 2020, p. 1). Thus, the aim of hermeneutic researchers is to shine light on the fundamental, and sometimes overlooked, aspects of lived experience in ways that prompt further thought (Crowther et al., 2016). In adopting this approach, researchers attune to their data, working in emergent, creative and evolving ways (Crowther et al., 2014). The research participants' accounts provide the researcher with hints of meaning, facilitating understanding and illuminating the significance of the phenomenon under exploration. In order to undertake research from a Heideggerian perspective, the researcher must reveal what it means to be a human being-in-the-world. Heidegger infers that understanding underpins interpretation (Dibley et al., 2020) and the overarching goal of hermeneutic phenomenology is to 'increase understanding of the meaning of human experiences and practices' (Draucker, 1999, p. 361). The researcher retains an open and questioning stance throughout the research process and resists being pulled towards pre-set methods or anticipated meanings (Crowther et al, 2016). The focus of this approach is working

with, rather than working on, the data, and there is an inherent tension between the functional aspects of data collection and presentation and the ontological nature of this methodology.

3.3.2. Van Manen's lifeworlds

My chosen method within hermeneutic phenomenology is Van Manen's (2016) approach to researching lived experience. This hermeneutic phenomenological method considers that interpretation and theorising cannot be separated from the process of writing. This stance requires the researcher to adopt an approach which is 'reflective, insightful, sensitive to language and constantly open to experience' (Van Manen, 2016, p. xi) These qualities align closely with my creative inclinations and the skills I have developed over the years as a psychotherapeutic practitioner. Van Manen realistically accepts that language has limitations when it comes to describing experience but recognises that it contributes much to communicating what is experienceable by our participants on a journey of heuristic discovery.

Language helps to make experiences both intelligible and understandable. Success in this depends partly on the skill of the researcher at conducting phenomenological interviews and partly on the participants' capacity to communicate their inner world via language. There is a need to be wary of both researchers' and participants' tendencies to intellectualise experiences. Van Manen's (2016) approach places value on the non-cognitive dimension to communication – those aspects which are discreet, unspoken and intuitive, very much in harmony with my professional work as a psychotherapist.

Van Manen's (2016) unstructured method allows for creativity, which is both personally appealing and suited to my research aim. He offers guidance rather than

rigid steps to follow and this approach offers greater flexibility than IPA in the interview process (Langdridge, 2007). Questions are designed as prompts to explore the depth and breadth of experience and encourage rich description and meaningful themes to emerge. Van Manen also steers clear of offering a set pathway for analysis, instead encouraging the researcher to creatively engage with the data (Langdridge, 2007). While data is analysed thematically, in a comparable fashion to IPA, it is rooted in the researcher's ability to connect with the text. Van Manen's approach intentionally rejects mechanical coding in favour of distinguishing meaning hermeneutically via 'the texts of life' (Van Manen, 2016, p. 4), in an attempt at co-construction of meaning (Langdridge, 2007). The research takes on a caring attitude in the quest to discover 'that which is most essential to being' (Van Manen, 2016, p. 5).

Given my personal experience of maternal anxiety and my clinical experience to date, one of the key challenges for me as a researcher is the need to be transparent about my biases and assumptions, paying close attention to reflexivity. Each participant's experiences of maternal anxiety will be uniquely personal, just as mine were, and Van Manen's approach not only embraces this but recognises that each experience is not replicable.

Following in the path of Heidegger, Van Manen's (2016) approach offers four lifeworld existentials as additional guides to reflection: lived time (temporality), lived space (spatiality), lived body (corporeality) and lived other (relationality). In line with the aims and objectives of my research, this existential dimension is important: each category is proposed to be essential to the structure of the lifeworld (Van Manen,

2016). These four dimensions will provide the foundation for dwelling in and reflecting upon the existential dimension of anxiety after birth.

As with other phenomenological methodologies, there are limitations. Van Manen (2016) recognises that 'every interpretation can be called into question … every hermeneutic phenomenological conversation is unending' (p. xv). Van Manen (2016) also states that an individual cannot reflect on an experience while they are in it – thus reflection on lived experience is 'always recollective' (p. 10). This is important to consider from the perspective of my research topic. Where is the boundary between a person experiencing PNA and ceasing to experience it? Making such a distinction may be challenging.

Despite some potential limitations, Van Manen's method provides a flexible hermeneutic phenomenological approach from which to explore women's experiences of anxiety after birth from an existential perspective. His approach complements my research aim, my clinical experience and my epistemological position.

3.4. Method

3.4.1. Study design

This qualitative study uses purposeful sampling to collect data from eight mothers via semi-structured interviews. While Van Manen (2016) eschews a set pathway for analysis, he provides guidance on how to approach the lived experience research process. As a novice researcher, I found it useful to consider this guidance as a six-part framework, which I used as a reference guide from which to conduct my

methodological inquiry. Each part of this framework is outlined and considered below.

3.4.1.1. The phenomenon – using personal interest as a starting point

The starting point for qualitative research is to identify the phenomenon of interest. This begins with something which has a personal resonance for the researcher. My own experience of being-in-the-world as a mother piqued my interest in women's experiences of anxiety after birth. When reflecting on one's own experience, Van Manen (2016) suggests that the researcher will be inquisitive into how the phenomenon is also experienced amongst others. It is in this spirit that I was curious to find out the extent to which my experiences of anxiety after birth could be resonant with the experiences of others. Further, an awareness of my own experience of the phenomenon, could be considered a useful starting point for orientating myself to the phenomenon of maternal anxiety in others. There is an intersubjective dimension to the research, in that 'the author recognises both that one's own experiences are the possible experiences of others and also that the experiences of others are the possible experiences of oneself' (Van Manen, 2016, p. 58). In this manner, Van Manen emphasises that parts of the descriptions of experience have a universal nature. Whilst my personal interest and subjective experience of the phenomenon were the starting point of this study, I recognised that it was essential to move forward into the data collection phase with a stance of openness. Gadamar (1975) writes about the importance of being 'aware of one's own bias, so that the text can present itself in all its otherness and thus assert its own truth against one's own fore-meanings.' (p. 268-269). This would require navigating a careful balance throughout the research process and paying close attention to reflexivity.

3.4.1.2. Obtaining experiential accounts from participants

Having decided to pursue a hermeneutic phenomenological approach to this study, the next step was to select an appropriate means to capture experiential accounts from others, congruent with the chosen method. The aim of phenomenological research is to gain access to experiences and reflections of others in relation to the phenomenon of interest. The goal in obtaining these experiential accounts is to 'come to an understanding of the deeper meaning or significance of an aspect of human experience in the context of the whole of human experience' (Van Manen, 2016, p. 62). For my study, I wanted to come to an understanding of the deeper meaning of anxiety after birth through finding out what it is like to be a mother feeling anxious after having a baby. My stance in relation to the phenomenon under investigation was to consider it as a fundamentally human experience. In keeping with Van Manen's approach, I settled on a conversational interview method as a means of gathering personal experiential accounts. I was careful to keep in mind my own experience of anxiety after birth while considering which questions to include for the semi-structured interview process. In line with the phenomenological approach, open questions were used to afford the mothers an opportunity to reflect on and describe their own unique and personal experiences of the phenomenon. This process was designed to be relaxed and unhurried, giving plenty of space for a process of thinking and reflecting out loud.

3.4.1.3. Hermeneutic phenomenological reflection

Van Manen (2016) writes that 'the purpose of phenomenological reflection is to try to grasp the essential meaning of something' (p. 77). He recognises that this task is both straightforward and challenging. How do we grasp the phenomenon under investigation? When I ask the mothers *'what was your experience of anxiety after*

birth like?', how easy or difficult is it for them to answer this question? To gain a comprehension of the phenomenon involves a process of 'reflectively appropriating, of clarifying, and of making explicit the structure of meaning of the lived experience' (Van Manen, 2016, p. 77). To grasp hold of this essence of meaning is a challenge for the researcher. The meaning concealed in the phenomenon is multi-faceted, making communicating it difficult. Van Manen urges the researcher to go about phenomenological reflection texturally. This involves taking the interview audio recording, transcribing it into text and then crafting it into prose. In this form, the researcher can begin the process of reflectively analysing the text for structural and thematic dimensions. This process is essentially unstructured and one which Van Manen (2016) describes as a 'free act of seeing meaning' (p. 79). The structural and thematic element of hermeneutic research assists in providing coherence to the presentation of the findings: essentially, the thematic analysis is foremost a means to get at the notion of the phenomenon under investigation. Throughout the process, the focus is on seeking the meaning inherent in the phenomenon. Thus, while themes convey the experiential forms and structures of the lived experience, they also convey something telling or meaningful within individual personal accounts. A thematic analysis is the means through which the researcher makes sense of the personal accounts, in adopting an open phenomenological attitude to what is concealed within. Van Manen (2016) describes this process as a voyage of 'insightful invention, discovery and disclosure' (p. 88). He therefore also acknowledges that no thematic analysis is complete: it cannot reveal the full meaning and certain aspects will remain hidden and undiscovered.

3.4.1.4. The hermeneutic phenomenological writing process

In hermeneutic phenomenological research, writing is not simply a methodological tool – it is an intrinsic part of the research process itself. The objective of this research method is to create phenomenological text. Part of this process lies in 'literal silence' (Van Manen, 2016, p. 112) – in other words, that which is unsaid. What is left unwritten is considered as important as that which is written. It may be that some aspect of the phenomenon under investigation is experienced as being unspeakable, or beyond words. Polanyi (1969) recognises this as a sense that there is more to tell than we are able to say. Phenomenological writing gives credence to this and honours it. Such experiences beyond words can be inferred in the phenomenological writing, without being explicitly stated. The writing process is therefore deeply reflective and sensitive. Quality of phenomenological writing is prized over quantity. Writing provides the means to attune to the participant's world, to immerse oneself within it and to dwell on it. Writing provides a way of thinking on paper, via the pen or the keyboard – there is scope to draft, reflect and re-draft. It is this process of writing that is essential to hermeneutic phenomenology. Van Manen (2016) considers the writing process as a linguistic endeavour – through writing we make what we have discovered understandable and accessible to others. Van Manen (2016) further elucidates that 'writing gives appearance to body and thought … separates the knower from the known … seeks to make external what somehow is internal' (p. 127). The process of writing illuminates what is concealed in the interview dialogue, and the phenomenon is revealed both in and through the words spoken and written.

3.4.1.5. Maintaining focus on the phenomenon

The aim throughout the research process is to maintain a keen focus on the phenomenon under investigation. This can be a demanding process, requiring investment of time and energy to focus fully on the research question. The goal is to stay actively attuned to the research aim, repeatedly asking oneself, *'what does this reveal to me about the phenomenon under investigation?*' This requires being wary of assumption: guarding against believing we know what the phenomenon is like. It is also essential to be wary of theorising about the phenomenon under investigation. In the case of my research study, I could have been swayed by the participants' usage of diagnostic terminology such as 'postnatal anxiety'. Such a term does not provide a clear picture of what the experience is, or what it is like. In these instances, it is necessary to un-name the phenomenon to study its subjectivity and complexity as it presents itself. In looking phenomenologically, we view the phenomenon as if it is revealed for the first time – with fresh eyes: 'By unnaming things we gain the opportunity to explore their pathic or lived dimensions: our "moods" or ways of being in the world' (Van Manen, 1999, p. 20).

3.4.1.6. Considering parts and whole

Hermeneutic phenomenology involves a continuous circular reflective process between the parts and the whole, which is referred to as the hermeneutic circle. This entails a back-and-forth motion in which the researcher examines their own prior knowledge and experience of the phenomenon, alongside the lived-experience accounts of their participants. As tentative themes begin to emerge, the researcher returns again to the lived experience accounts to re-examine, re-visit and re-consider the themes: a process of stepping back and looking again to see what reveals itself in the personal accounts. It is necessary for the researcher to set out on the research

journey acquainted with their own personal understanding of the phenomenon (Crowther & Thomson, 2020), as this will have a bearing on how the researcher interprets the lifeworld. Heidegger (2010) writes that this 'is not to get out of the circle [of understanding], but to get in it in the right way' (p. 148) – thus it is given that as humans we carry assumptions about the world around us and our experience of it, but it is imperative that these assumptions are acknowledged so that a rigorous interpretation of the phenomenon can be made. To facilitate this, I undertook a thorough reflexive process prior to and during the research process. This is documented later in this chapter.

In summary, this six-phase approach based on Van Manen's (2016) guidance provided a framework in which to undertake an in-depth investigation into the phenomenon of maternal anxiety. It was not intended to be used as a linear progression of steps – rather a free and creative process comprising an alternation between the various phases. This process often required simultaneous engagement with more than one process at a time. Stringent adherence to a rigid and formulaic structure is the anathema of hermeneutic phenomenological research (Crowther & Thomson, 2020) and the process outlined above was time-consuming and intense – weaving in and out and back and forth through the various phases and involving slowing down to allow ample time for interpretations to emerge.

3.5. Researcher reflexivity

As has been referenced, my research interest has its roots in both my personal and professional experiences. To assure the integrity of my findings, it is essential that any biases are acknowledged and made transparent to the reader. Qualitative

researchers are required to ‘negotiate the “swamp” of interminable self-analysis and self-disclosure’ (Finlay, 2002, p. 212) and this process may require a multi-faceted approach. Whilst Van Manen doesn’t explicitly address the subject of reflexivity in his approach, as a practising psychotherapist, reflexiveness is a habitual way of being.

As my research poses the question ‘*How do mothers experience anxiety after birth?*’, it was essential to examine how I had experienced this phenomenon. A Gadamerian approach to this would urge the researcher to question and probe their prior understandings of the topic (Finlay, 2008). To enable this, I presented my research questions to a research colleague prior to commencing my study. I asked her to interview me and this interview was taped and transcribed. My own lived experience of anxiety in early motherhood was likely to be very different to my participants’, but it was crucial to have explored my own position in relation to the phenomenon and to be critically aware of my views, memories and potential biases.

As my research got underway, I maintained a personal reflexive journal. I also used this journal actively throughout the research process. This confessional narrative (Van Maanen, 1988) provided the backdrop for my accountability, detailing any moments in which I could have influenced the interview process and any preconceptions which may impact the findings. I reflected upon the researcher/participant power balance and the questions posed, through to the thematic analysis and subsequent interpretations. This introspective balance had to be carefully negotiated – self-awareness and understanding are vital, while ‘navel-gazing’ (Finlay, 2002) is not. To facilitate this, I frequently asked myself ‘*what is my personal impact on this co-construction of knowledge?*’ While I anticipated that my personal lived experience of anxiety after birth would be distinctly my own, there

were occasional moments of merging and resonance between my experiences and my participants'. These were dutifully documented and reflected upon. I noted that the interview process became almost dance-like as I became aware of becoming drawn into my participants' worlds and then pulling out again to view the data impartially and make the subjective objective (Van Manen, 2016).

Husserl's phenomenology requires previous understandings of the phenomenon to be bracketed (epoché) via the phenomenological reduction, to reveal the phenomenon in its purity and essence. A hermeneutic approach, as developed by Heidegger, Gadamer and Merleau-Ponty, brings the researcher into the process, acknowledging that we cannot completely remove or bracket our fore-understandings of the phenomenon. Merleau-Ponty (2002) famously wrote, 'the most important lesson which the reduction teaches us is the impossibility of a complete reduction' (p. xiv). What is required of the hermeneutic researcher is stance of openness and self-awareness, so that personal bias and presupposition do not colour or influence the data collection. Dahlberg (2006) proposed the term 'bridling' for this activity, rather than bracketing. She urges that personal assumptions regarding the phenomenon must be restrained, encouraging the researcher to 'not understand too quickly, too carelessly or slovenly' (Dahlberg, 2006, p. 16). This process of 'bridling' was ongoing throughout the research journey, from data collection to analysis. The practice of dwelling with and in the data, alongside emergent thoughts and insights, was carried out in a back-and-forth interplay of revisioning, reworking and re-interpreting (Finlay, 2008). I was mindful to proceed cautiously throughout this process, giving time for the phenomenon and its meaning to come forward. My own prior experience of the phenomenon acted as a lens to empathically attune to my participants.

3.6. Participants and recruitment

3.6.1. Sampling

A qualitative research approach requires an appropriate sample of participants who are well positioned to provide data that will answer the research question. For this study it was therefore essential that prospective participants had experienced the phenomenon to obtain relevant data. It was necessary to undertake a purposive sampling approach to select women who were most able to provide insights into the phenomenon. In considering how many participants to recruit, several criteria were taken into consideration:

- The research purpose
- The research methodology and epistemology
- The size of the prospective research population
- The requirements of the organisation within which this research was being conducted.

The aim of this study was to gain in-depth insights into the experience of anxiety after birth. My sample had to be an adequate size to generate enough data, keeping in mind that, as the sole researcher, I would need to be able to manage and analyse the quantity of data obtained. In hermeneutic phenomenology, there is no prescribed sample size, and it is important to keep in mind that this type of research does not aim to demonstrate representativeness. As a hermeneutic phenomenologist I did not set out to report uniformity in experience as evidence of truth (Dibley et al., 2021). It was essential that this research adhered to the guidelines issued by the New School of Psychotherapy and Counselling, which encourages doctoral students to recruit

approximately eight participants for a study of this nature to produce an appropriate quantity of data. With these factors in mind, I set out to recruit eight participants.

3.6.2. Inclusion and exclusion criteria

Inclusion and exclusion criteria are required to assist in generating a sample which is best placed to provide data to answer the research question. With my research methodology's connection to philosophy and lifeworld existentials, due diligence to inclusion criteria rooted in Heidegger's (2010) notions of *being* and *time* was appropriate. My aim was to uncover what it is like *to be* a mother experiencing anxiety *after* the birth of a child.

To be eligible to take part in this study, my inclusion criteria stated that participants would be mothers aged between 25 and 39 whose experience of anxiety after birth occurred more than six months ago, but not more than four years since the birth of their child. The rationale for this sample was that this time frame allowed for some time to have elapsed since birth, and for individuals to have processed their experiences and be able to remember them. Rather than selecting participants according to their age and/or their child's age, it seemed more appropriate to select according to the length of time since their experience of the phenomenon.

My criteria excluded those who were taking medication for anxiety. The rationale for this criterion was that psychotropic medication may affect thoughts, feelings and perceptions and this could potentially distort the recollection of experience. I also excluded pregnant women from taking part in recognition that pregnancy can be a particularly vulnerable time and of my ethical commitment to guard against causing my participants any distress. Single parents were also excluded from participation in recognition that solo parenting may contribute to raised anxiety levels.

As PNA was not formally categorised in the DSM-V at the time of this research, it was unlikely that potential participants would have received a formal diagnosis. Taking this into account, all potential participants were expected to self-identify as having experienced the phenomenon.

3.6.3. Recruitment

The research project was conceived before COVID-19 when my intention was to recruit participants in my local London borough by putting posters and leaflets in community postnatal groups. My recruitment phase coincided precisely with the emergence of COVID-19 in the UK and, as a result of the subsequent closure of groups, I had to rethink my approach. Both the New School of Psychotherapy and Counselling and Middlesex University set out an amended protocol for conducting research interviews at this time. This was to ensure both the safety of participants and compliance with the UK government's COVID-19 restrictions. In line with the new procedures set up by the university ethics committee, I diverted my recruitment strategy to online social media platforms such as Twitter, Instagram and Facebook. I asked research colleagues to post my digital flier on these forums on my behalf and I additionally approached organisations such as Netmums and Mumsnet to request permission to post my research outline. Some of the participants viewed my flier on social media and others came forward after hearing of the project via others who had seen the online posts and had forwarded them the details. One participant was recruited by snowball sampling, where an existing participant forwarded the details to prospective participants among their personal acquaintances. A couple of others expressed an interest after hearing about my study via research colleagues.

After receiving an email or telephone enquiry relating to the study, I arranged a convenient time to speak to each participant on the telephone to undertake a screening process. I read each enquirer the description of anxiety after birth which was provided in my recruitment literature and I also emailed this document to them to read through. A set of screening questions (Appendix A) accompanied this, and I used these to assess each enquirer's suitability for inclusion. Each prospective participant's experience was required to align to the details outlined by the screening questions and to fully meet the inclusion criteria.

Once I had established that each enquirer was a suitable participant, I took time to describe the study in more detail, explaining the research aims and the process involved in taking part. I additionally explained details about the confidentiality of the study and their right to withdraw from the study should they wish to. I also emailed my Participant Information Sheet (Appendix B) and consent form (Appendix C) and offered to answer any questions they had in relation to the study. Once the paperwork had been reviewed, discussed and signed, I booked a date for the interview to take place via Skype. I explained to each participant that my questions would ask them to recall their anxious experiences and might cause emotions to resurface.

3.6.4. Demographics

The eight eligible participants all lived in the UK and Ireland at the time of interview and were spread across geographical regions and ethnicities. I viewed this diversity as a positive outcome of having to shift my recruitment strategy beyond southeast England to nationwide online platforms. All the participants fulfilled the criteria of having a planned pregnancy and not being on any prescribed medication.

Table 2 – Participant information

Participant	Age	Child's age
1	33	17 months
2	31	3 years
3	32	2 years
4	29	2 years
5	32	3 years
6	36	2 years
7	34	3 years
8	35	3 years

3.6.5. Ethical considerations

Ethics approval for this research was sought from the Ethics Committee of the New School of Psychotherapy and Counselling and was granted on 16th June 2020.

As an accredited member of the British Association of Counselling and Psychotherapy (BACP) and a registered member of the UK Council for Psychotherapy (UKCP), I abide by their code of ethics in both my clinical and research activities. In considering ethics, I took as my starting point the following: 'What will this experience be like from the point of view of the research participant?' (McLeod, 2003, p. 169).

It was my ethical responsibility to ensure the wellbeing of my participants: as my participants recalled their experiences of anxiety after birth, this may have triggered distress. I ensured that my participants were presented with enough informative

material to make an informed decision prior to consenting to participate in this study. My participants were offered the right to leave the study at any point up until their data was analysed. I ensured that confidentiality principles were explained at the outset in advance of participants making a commitment to take part in the project. I additionally informed all participants that written and recorded data would be anonymised and identities concealed as far as practically possible; recorded data would be destroyed immediately after transcription; and written data would be stored securely in a locked cabinet in my home. I adhered to GDPR requirements and NSPC/Middlesex University protocols regarding data collection and retention.

All participants were offered an opportunity to pause their interview if they became distressed and I took care to be attentive and sensitive to their feelings throughout the process. Each participant was offered a debrief immediately after the interview. The purpose of the debrief was to check that the participants had not been harmed by taking part in the interview, and to ensure that they understood what would happen next with the interview data. After the debrief had taken place, I emailed a document containing a list of support services. This document provided details of where participants could gain access to therapy if they wanted to continue to discuss their experiences with a qualified therapist in the future.

3.7. Data collection – a research conversation

'To listen is to continually give up all expectation and to give our attention, completely and freshly, to what is before us, not really knowing what we will hear or what that will mean. In the practice of our days, to listen is to lean in, softly, with a willingness to be changed by what we hear'.

(Nepo, 2005, p. 5)

During data collection, my intention was to embark on an in-depth conversational interview approach to encourage the participants to explore their personal experiences of the phenomenon. Van Manen (2016) recognises that participants may struggle to describe their experiences and my semi-structured interview schedule (Appendix D) comprised open questions to assist in eliciting recollections as 'close to the experience as lived' (Van Manen, 2016, p. 67). To help facilitate this process I also noted down a handful of useful phenomenological dialogic prompts, such as *'Can you tell me more about that?'* and *'What was that like?'* and I adopted a stance of open, attentive and active listening. In actively listening to my participants, I could ask them to go back to things they had mentioned earlier, if I had a hunch that this could be a fruitful avenue to explore deeper meaning. In these instances, I would say *'You mentioned X earlier, how did you feel at that time?* or '*What was that like for you?'.* Working in this way is considered appropriate in hermeneutic phenomenology – it is not introducing anything new into the interview, but picking up on something that may have deeper significance in relation to the phenomenon (Dibley et al., 2020). These approaches combined to enable a hermeneutic conversation to take place. The agenda was kept loose and open and the questions were there as guides and prompts if needed, while I also had the freedom to explore unexpected avenues

as they arose. Clarifying questions and reflecting back the participants' own words were also useful approaches to keep the conversation focused and evolving. The aim of the interview was to encourage the participants to speak freely and openly, exploring and expanding on details to reveal a glimpse of the phenomenon under investigation. The nature of this procedure was interpretive: through dialogue with each participant, I embarked on a process of cocreation, enabling a fusion of horizons to arise in the narrative (Dibley et al., 2020). In this process, I recognised that I was as much a part of the interview as the interviewee.

There were some practical considerations regarding data collection and interviews had to be carefully scheduled during periods where participants' children were napping or being looked after by someone else. This was important to ensure that the mothers had a relaxed environment conducive to them being able to take their time to recall their experiences without interruption or hurry. At times, the participants wandered off topic and, on these occasions, I had to carefully consider whether what they were telling me might have relevance in revealing the phenomenon. In these instances, I let them continue with their line of thinking to see what evolved. If the participants drifted off topic, I sensitively guided them back to the interview focus without negating that what they had disclosed to me was of significance to them. On a couple of occasions when I tried to probe into experiences more deeply, asking *'what was that like?',* the participants replied that it was just as they had described, and they had nothing further to add. At these junctures, the participants appeared reluctant to expand on their descriptions and I respected their decisions not to elaborate further. One of my participants asked if she could turn off her webcam and switch to audio if she became visibly upset. I reassured her that this would be fine, and that, if she did feel upset, we could also pause or stop the interview if needed. I

was aware that recalling feelings of anxiety after birth was likely to bring emotions to the surface. Drawing on my own personal experiences of the phenomenon and my training and experience as a psychotherapist, I intended to bring an empathic understanding to the interview and to interact with my participants in an appropriate and sensitive way.

The interviews varied in length, reaching a natural close between an hour and an hour and a half after starting. I offered each participant a debrief to discuss how the interview process had been for them. When this was complete, I emailed the participants a copy of my debrief sheet (Appendix E) with a list of support organisations should they wish to explore any of their experiences in further depth. In my email I thanked my participants for their time and willingness to participate and reinforced that they were welcome to contact me should any questions or concerns arise.

Afterwards I reflected on how it had been to explore my participants' experiences so deeply within a short space of time and then for the interaction to be finished so quickly. I made a note of my personal reflections in my private journal.

3.8. Data analysis

3.8.1. Transcription

The interviews were recorded and transcribed. Wherever possible, I transcribed the interviews in full on the same day they took place. When this was not possible, I transcribed as soon as possible during subsequent days. Transcription was a laborious process, which involved stopping and starting the recording multiple times

and replaying in sections to check for accuracy. I listened carefully to the recordings, copying down every word, noting every pause and including every *'um'* and *'er*'. Pauses and sentences which trailed off unfinished were marked with appropriate punction, such as '…' and laughter and expressions of emotion were noted in square brackets. Each interview was then replayed in full a couple of times further to check for transcription errors and spelling mistakes, and amendments were made.

When conducting human science research, participants' anonymity and confidentiality must be carefully considered. After completion, I rechecked the transcription for any distinguishing features which could potentially reveal my participants' identities. In carefully undertaking this process, the transcripts were free from any personally identifying data and the participants' anonymity was preserved. The participants' names were not included on the transcription file and each participant was assigned a code number and a pseudonym.

The process of transcription facilitated an immersion within each story, and I made notes in the margin of any thoughts or feelings that occurred while I was engrossed in this process. After transcription, I listened again to the interview recording several times to dwell in each individual description of anxiety after birth. I kept in mind the following question, '*How does this participant's description of experience open up a deepened and more reflective understanding of the notion of anxiety after birth?*' I made notes in the margin of my transcript.

3.8.2. Hermeneutic phenomenological analysis and reflection

The interviews were analysed phenomenologically, turning to Van Manen's (2016) approach for guidance. Working with each transcript in turn, I undertook a selective highlighting approach to uncover semblance of meaning. This entailed searching for

phrases which might reveal something about the experience of anxiety after birth. I read each transcript several more times, and, on each reading, I used a different colour highlighter pen to note anything of significance. This process assisted in checking that I had extracted all the phrases which appeared to be particularly illuminating. These phrases were transferred to a separate document in table form: this is illustrated in Appendix F and as an example below in Figure 1. I listened to the transcript a couple more times to note changes in vocal inflection, emphasis, pauses and emotional tone and I made a note of these in the margin of my document.

Figure 1 – Step one – selective highlighting approach

(Statements or phrases from the transcript which reveal something about the experience of anxiety after birth)

I knew that I wasn't sleeping and I was already quite worried during the pregnancy that my mental health would deteriorate and so I was thinking this is the start, this is me developing severe mental health problems after birth.	35–37
I suppose it did highlight the contrast for me of course I should be feeling those things too and I'm struggling to.	185–187

I then repeated the process by highlighting key words or short phrases from those which were previously selected and presented in Appendix F. These key words were transferred in full in a separate document (Appendix G). An example extract is illustrated below in Figure 2. Here, the example in Figure 1 has undergone the second stage of analysis as described above.

Figure 2 – Step 2 – highlighting keywords

I wasn't sleeping	35
Developing mental health problems	37
I should be feeling those things too	186

I then transferred all of these key words and phrases onto separate post-it notes and undertook a process of clustering the key words into tentative themes. Throughout this process I asked myself, '*What is going on here?*' and '*What does this tell me about the phenomenon?*' A lot of time was spent thinking about my participants' stories: thinking facilitated the interpretive process and I spent time dwelling on possibilities and considering potential meanings.

This process was repeated with each transcript so that each interview text underwent a separate individual analysis. Patterns gradually started to emerge and I assigned headings to them. These headings described the collective phenomenon of the cluster of key words. Any key words and phrases which did not fit the cluster were put to one side and reviewed again at a later stage. Returning to step 1, I expanded the key word phrases with my participants' exact verbatim text underneath my tentative headings and reviewed my headings (Appendix H). A brief excerpt to illustrate this for the emergent tentative theme *'Something is wrong with me'* is presented below in Figure 3. This example incorporates the text used above in steps 1 and 2 alongside other text relevant from the previous stages of analysis.

Figure 3 – Step 3 – grouping tentative cluster themes

Something is wrong with me – tentative theme
I knew that I wasn't sleeping and I was already quite worried during the pregnancy that my mental health would deteriorate and so I was thinking this is the start, this is me developing severe mental health problems after birth.
I was so afraid of coping that it made me not cope.
For a long time while I found him really difficult and was really anxious about his development, you know, I found it hard to feel that love towards him. Like my husband and I would be bathing him and my husband would say things like 'oh he's so wonderful, he's beautiful, he's so amazing' and I'd be thinking, 'I don't feel that'.
I suppose it did highlight the contrast for me of course I should be feeling those things too and I'm struggling to.
I'm the one who's not ok and that's what the problem was.
Just that feeling of not being able to cope and not feeling or behaving in a way that was not healthy or appropriate, or how a mother ought to be.

Once I was satisfied that my headings were representative of the selected and highlighted verbatim, I wrote headings onto a fresh set of post-it notes. I then embarked on a similar process to see which of my headings had some connection with the other headings and I placed these into clustered groups. From this process I

was able to assign meta-themes which stood out for me for each group of headings. These meta-themes summarised the subthemes as a whole. The meta-themes and subthemes were then arranged into a table (Appendix I) and further examined in the context of Van Manen's lifeworlds (Appendix J).

3.8.3. Maintaining focus on the phenomenon – crafting stories

Holding the key words, phrases and headings (the 'parts'), in mind, and in keeping with Van Manen's (2016) process of hermeneutic writing, I embarked on a process of crafting stories for each participant (the 'whole'). This intricate process involved moving between the parts and the whole in the hermeneutic circle as I attempted to see what of the phenomenon was emerging. Throughout this procedure, I was engaged in an open and reflective process, constantly questioning and cultivating a curious phenomenological attitude as I engaged with the transcripts. Transcripts can be very lengthy, and my task was to draw the participants' words together into a vivid and meaningful retelling of their story, using their exact words. These stories provided a means of re-presenting the participants experiences and the act of writing continued the process of interpretation. This approach is in keeping with hermeneutic phenomenology where the emphasis is 'not working *on* the data but working *with* data' (Crowther et al., 2016, p. 4). Intrinsic to the writing process is the researcher's understanding of the participant's world, as well as the researcher's understanding of their own stance in relation to the phenomenon and the story being told. In crafting a story out of the transcript, I engaged in a 'fusion of horizons' (Gadamer, 1975, p. 601), as my understandings of the phenomenon became entwined with my participants'.

The process of crafting stories involved several steps – initially I began by editing the transcript to remove unnecessary details such as anecdotes which digressed from the focus on the phenomenon. Using a highlighter, I underlined sentences which described the phenomenon, leaving out any repetitions or superfluous details. From here I joined together the remaining key components into one piece of prose, adding in occasional words where needed to aid the flow of the story and to link one section coherently to another. In some places it was necessary to re-order sentences to improve the flow of the text and I read each drafted story out loud to myself to consider it from a different perspective and to check continuity. Next, I went back to the original transcript to ensure that I hadn't overlooked any important details, and, if this was the case, I ensured these were included in the story at this stage. Having engaged in this interpretive process of story crafting, I put each story to one side for a few days and revisited it some days later with fresh eyes. If reworking was required, I moved between the transcript and the story until I was satisfied that the completed prose provided a rich representation of participants' experiences (see, for example, Appendix K). This was a time-consuming task and one which Crowther et al. (2016) urge the researcher to make space for. I did not rush this task, but carefully considered whether each finished story honoured the participants' experiences and the meaning evoked within these.

I was keenly aware that the completed crafted accounts were just single interpretations of participants' experiences, and the telling of each story came from one perspective in time. There could have been a number of alternative interpretations, and I kept in mind that individual stories would be 'so much deeper and more complex than we who listen can comprehend' (Crowther et al., 2016, p. 2). Crowther et al. (2016) additionally point out that the crafted story belongs neither to

the teller or the listener and should be regarded as a communal cocreation. This sits in harmony with the phenomenological stance that we are always in relation to others in the world, and every story therefore involves a teller and a listener in relation to one another. The story is told to the researcher for them to reveal the phenomenon under investigation.

Having crafted all of the stories, I revisited my thematic headings, checking if they continued to depict the phenomenon as elucidated by the stories. I noted down possible revisions and alterations at this stage, keeping an open mind to further possibilities to be revealed as I continued to dwell with the data. Van Manen (2016) encourages the phenomenological researcher to keep writing, as it is 'in and through the words that the shining through becomes visible' (p. 130). In keeping with this, I continued the writing process and turned to poetry as an additional means of dwelling with the phenomenon.

3.8.4. Further reflection – crafting poems

'Phenomenology is like poetry, in that it speaks partly through silence:

it means more than it explicitly says.'

(Van Manen, 2016, p. 131)

Once again, I revisited the parts and the whole: moving between the transcript, the highlighted sections and the crafted story, I commenced a process of distilling the participants' words further to unveil a deeper level of meaning. Adopting a poetic inquiry approach (Green et al., 2020), the words were drafted onto paper and loosely formed as poems. Leggo (2018) writes that 'poetry is a way of knowing and attending, being and becoming' (p. 73) and this creative act felt entirely appropriate and natural within the hermeneutic phenomenological framework. The drafted poems

were the product of a time-consuming contemplative and interpretative undertaking to arrive at a delicately crafted distilled version of the phenomenon. The process of poetic writing brought the stories alive, and the process of reflecting and rewriting became 'the very activity of doing phenomenology' (Van Manen, 2016, p. 132). The poetic form felt at one with the sensitive nature of the topic – Jean-Luc Nancy (2006) advocates that 'poetry is at ease with the difficult, the absolutely difficult' (p. 4). As I engaged in a process of free writing, eschewing formula and convention, the poems gradually took form. The result was a set of 'found poems' (Green et al., 2020) comprising of the participant's own words which had been carefully distilled into a poetic composition. Throughout this process, I had to decide what to leave in and what to take out, taking care to remain faithful to the mothers' words.

I drafted many poems during this phase of writing: personal poems to encapsulate each individual perspective (Appendix L), poems depicting thematic representations and choral poems drawing together mothers' collective voices as one (Appendix M). Each poem was a re-presentation of the mothers' experiences – crafted faithfully out of their own words with particular attention given to punctuation, line breaks and presentation. The result was a painstakingly considered illustration of the phenomenon, inclusive of its unspoken and unwritten ambiguity.

3.8.5. Dwelling in the data – further interpretations

Writing poems enabled me to look more deeply into the features of the mothers' experiences and I found that the poetic form opened the ontological and lifeworld dimensions conveyed in each account. I read the poems out loud, recording them on my voice recorder and playing them back to myself. This enabled me to submerge deeply into each participant's experience and to hear and experience the words

differently. I returned again to previous steps to consider the emergent themes from a lifeworld perspective. Throughout the interweaving of these contemplative processes, I looked anew for shared themes and common elements, including philosophical existential dimensions not fully identified in the previous analytical steps. Searching for philosophical notions within the stories and poems helped deepen the process of illuminating underlying meanings and reading a wide range of existential literature alongside this task continued the process of duetting with the data. This facilitated what Dibley et al. (2020) refer to as 'creating converging conversations' (p. 127) with the data. This was characterised by the back-and-forth process between carefully studying published existential literature and noting any connections with the newly emergent themes from the current study. This enabled a continuation of my engagement within the hermeneutic circle: reading informed my thinking and rewriting took place with every new interpretation. At times I took this process away from the desk and the confines of my study – dwelling with the mothers' experiences I took my notebook with me while I was out walking, gardening or sitting in the local park. Throughout this process of deep reflection, I continued to question, '*what does this mean?'* and *'what is being conveyed here?'* I was searching for richer meanings at this stage and any newly emergent themes were noted down.

I revisited my themes, looking again and again until I was satisfied that each theme was representative of the participants' lived experiences. Any weaker themes were either incorporated into the main themes or set aside. It became clearer via this process of distillation that the discarded orphan themes were not representative of the essence of the phenomenon. My revised set of three core themes were the result of taking an 'interpretive leap' (Crowther & Thomson, 2020), and strongly

representative of my participants' experiences. My approach to making the interpretative leap is illustrated in the next section.

3.8.6. Wholistic sententious summary and the interpretive leap

In keeping with Van Manen's (2016) wholistic sententious approach, I returned to my finalised themes and attempted to elucidate one phrase which could capture the underlying notion representative for each theme. Rather than undertaking this in prose, I turned once more to writing in poetic form and was drawn to Japanese haiku as a fitting means of wholistic expression. This poetic form lends itself to conveying precise and meaningful observations which are fitting from a phenomenological perspective. Combining key words into a three-phrase 5-7-5 syllable presentation gave rise to a thought-provoking distillation of the mothers' experiences.

Throughout the analytic process, I was mindful of Van Manen's (2016) guidance that 'to write phenomenologically is the untiring effort to author a sensitive grasp of being itself' (p. 132). Via the medium of stories, poems and haikus, I discovered a means to orientate myself to the phenomenon of anxiety after birth from a lifeworld existential perspective.

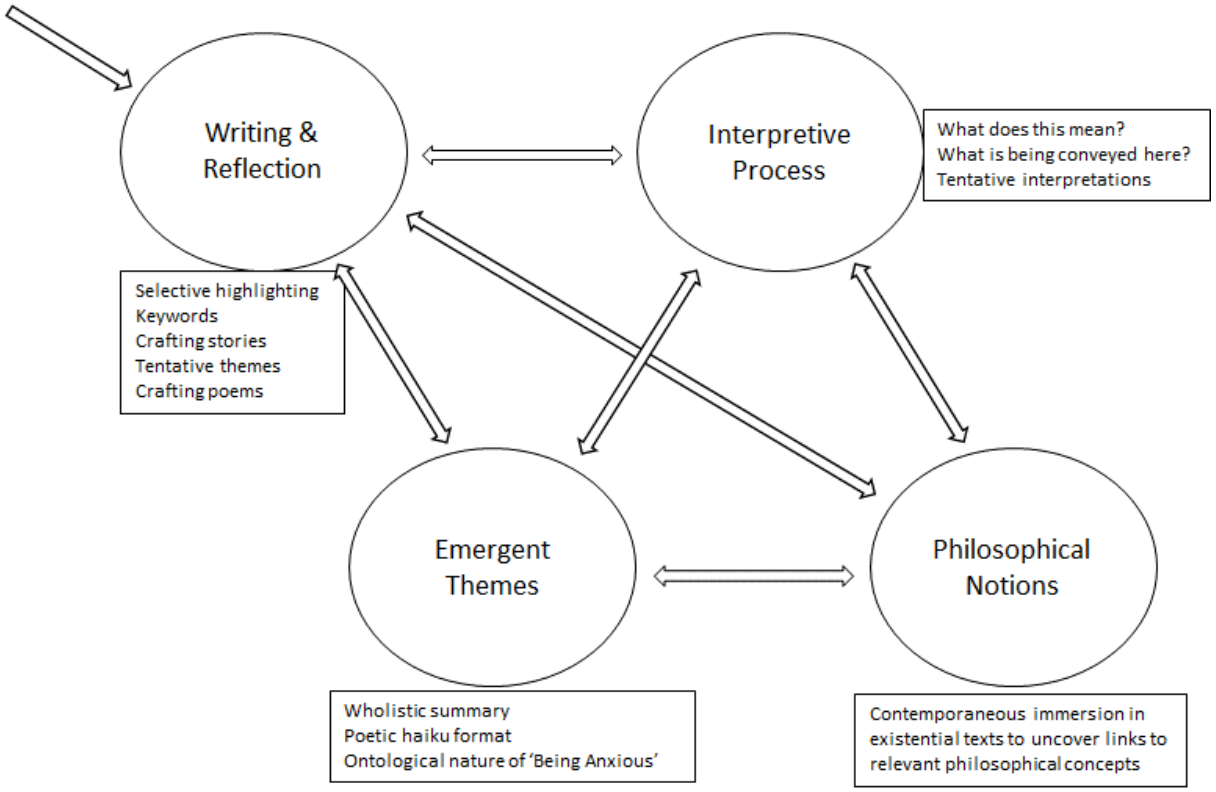
The analysis process was iterative and non-linear. Crowther and Thomson (2020) describe the interpretive leap using phenomenological and philosophical notions as 'crucial in HP work and distinguishes it from other approaches such as descriptive phenomenology and qualitative descriptive studies' (p. 6).

To illustrate the process further, I distilled my analysis into four iterated concepts (writing and reflection, the interpretative process, emerging themes and philosophical

notions and interpretive leap) and represented these in tabular form in Appendix N for the theme of ‘Being with uncertainty’.

Figure 4 shows this distillation and how the process of engaging with the text through story crafting and poetry whilst combining with philosophical reading enabled the interpretive leap.

Figure 4 – Distillation of the reflective process and the interpretive leap



3.9. Summary

This chapter has presented the rationale for the chosen research approach and has carefully documented the method of data collection. In addition, this chapter sets out the process of participant recruitment, data collection and data analysis. Care was taken to ensure this process was undertaken in a professional ethical manner, while

playing close attention to the reflexive process which underpins the research procedure.

The next chapter presents the stories of the eight participants who took part in this study, each revealing their individual experiences of anxiety after birth.

4. Findings

4.1. Introduction

Hermeneutic phenomenological findings place importance on telling the story of the phenomenon through a choice of words that communicate an ontological perspective (Dibley et al., 2020). I begin this chapter by presenting first-person poetic accounts of maternal anxiety for each participant. Richardson (1997) writes that 'poetic representation can touch us where we live, in our bodies' (p. 143). As such, poetry provides a means to vividly illuminate phenomenological experience. Crafted using participants' exact words, the poems honour their individual experiences and bring them alive. Each poem presents the uniqueness of their experiences, told in their own voices, from their own lifeworlds.

Introducing my findings in this way is fitting for phenomenological study of this kind, illustrating a method of hermeneutic engagement which seeks to reveal what it means to experience the phenomenon. Gadamar (1997) cautions that there is an abundance of meanings within lived experience accounts and what emerges from my study is my own interpretation of my participants' experiences and the meaning I ascribe to them.

After presenting the first-person poetic accounts, I will outline the three main themes that emerged from analysing the individual transcripts. These themes are: **Being taken over, Being with uncertainty** and **Being with others**. All the themes and their corresponding subthemes will be discussed individually. Each will be introduced by a haiku poem, capturing the essence of the experience. This will be followed by a

detailed review of the themes, illustrated by verbatim text from the mothers' interviews. A reflection on lifeworld existentials (Van Manen, 2015) will be presented after each theme. Every theme revealed in this study captures the mothers' experiences of anxiety after birth.

4.2. Personal poetic accounts

The following first-person poetic accounts provide a summary of the mothers' phenomenological experiences. They reveal how the phenomenon of anxiety after birth presented itself for each mother. Variations in the written tone, style and punctuation of the poems reflect the uniqueness of each autobiographical account. The mothers' identities have been concealed using pseudonyms for reasons of confidentiality.

4.2.1. Abbie

I can't switch my head off.
Racing thoughts,
hysterical screaming.

He's thriving, but,
I'm not doing enough,
I'm not caring enough.

My chest is tight,
my stomach is churning,
I'm irritable and unpleasant
– I'm breathless.

He won't sleep,
I won't sleep,
I won't cope.

He's different to others,
I can't soothe him,
I can't do it.
Something is wrong.

I read,
I Google,
I check,
I repeat.
Over and over again.

His dad loves him,
but I struggle to.
I should feel the same, but,
I'm not feeling or behaving
how a mother ought to.

Exhausted, low,
and hopeless,
Everything is doomed.

Lonely and isolated,
I struggle to fit in.
What's wrong with me?
Something's wrong with me,
I'm not good enough.

Rage and fury,
shocking and scary,
I feel like my head will explode.

4.2.2. Beth

I can't be by myself
What if something happens?
Restless, panicking
'Please come home!'
My baby cries
I panic
What's wrong?
I can't calm him
I'm not doing this right
It was isolating
Walking the streets at 3am,
no-one else did that.
Obsessed with a schedule
that didn't work,
I wasn't enough
I didn't measure up.

Hopelessness
Exasperated, stressed
Angry.
I hid these feelings.
I tried to be nurturing
I tried to be caring
He always pushed me away.
I felt everything slip away
I felt desperate.

A really bad place
No-one noticed.

I tried to grasp something familiar,
but I had lost myself.
Who was I before I was a mother?
Where have I gone?
I know where and who I want to be,
but can't get there.
How to get being a mother right?

Tingling, heart beating faster
I was ready to fight
The feeling scared me.
I wanted to comfort my baby,
But I couldn't do it.
I had to let go
It hurt deep inside
I'd completely failed
I was fuming and raging.

It looks so easy
It was unmanageable.

4.2.3. Charlotte

How do I do this?
What do I do?
They do it for me, but,
I want to do it.
I want to be a mum.

I worry about the simplest things
How do I put her to bed?
When do I change her nappy?
When do I feed?
How do I feed?
I don't have a clue.

It was day four, and,
I didn't feel like a mum.
They did it all
– it was easier.
.

But I wanted to be the one
to hold her,
to dress her,
to change her.
I wanted to be the mum.

I couldn't breastfeed,
I'm not normal.
I'd hide away,
I'd feed in secret.
She was losing weight
Don't take her away from me.

I'm broken … I'm not working
Why can't I breastfeed?
Why can't I be like everyone else?
My heart is racing

4.2.4. Danielle

My mind is running fast,
like being on a platform
and the train whizzes through.
Obsessive thoughts,
catastrophising,
saying, ‘I can’t do this!’
‘Something is wrong with me’.
A constant swirl
of emotions, thoughts and feelings.
It was exhausting.

I had no support, no-one to ask,
nowhere to go, no direction.
It was isolating.
You suffer in silence.
You’re not normal,
not doing it properly,
No-one talks about how it actually is

That feeling of failure,
of not being good enough,
I must do better,
I must try harder,
I was literally drowning.
Having to present the perfect image
to match up to others,
I lived in two different worlds.

I spent hours cleaning,
If the house was a mess
my mind was chaotic.
Everything had to be
straight,
in order,
tidy
and spotless.
I’d feel calmer then.

How should we fill our days?
What are we going to do?
How do I entertain him?
The days stretched into the abyss
There was no end to them.

I couldn’t catch my breath,
I couldn’t get on top of anything.
Like shifting sands,
every time you got somewhere
it all changed again.
Chasing the shadows,
but the shadows moved.
The fear of things always being the same.

Waiting for time to pass,
waiting for things to change.
It was excruciating.
Counting down time,
counting down milestones,
wishing time away.

I couldn’t bear to be in the same room as him.
Too anxious to pick him up,
not good enough to be around him,
not supposed to be his mother,
I was overwhelmed.
The guilt
for not being a good enough mother,
The anxiety
of never being a good enough mother.

I worried that something was wrong with him,
At the doctor’s I was insistent,
something is wrong with him.
It was anxiety about not knowing what to do
or how to get it right.

I barely slept,
Nervous about something happening to him.
Will he stop breathing?
I would check every night,
I had to be the one to sleep next to him.
I had to be the one to wake him.
I had to be the one to feed him.
I had to check he was ok.

4.2.5. Emma

I was constantly preoccupied
Am I doing the right thing?
Am I doing it the right way?
Am I doing enough?

There were pains in my hands,
They were aching
I was holding the pram so tight
Nervous of her rolling into the road
My whole body was tense

I ate too little, I ate too much
I would grind my teeth
I was on the edge,
a weight pressing on my chest

My husband could compartmentalise,
I couldn't do that.
My husband could do things intuitively,
I couldn't do that.
My friends were doing better than me,
they were relaxed,
I wasn't like that.

On Instagram everything looks great,
I should be doing what they're doing,
Buying what they're buying,
It's a hole you can fall into

A lot of stress
A lot of fights
Just trying to figure things out.
Have you done this properly?
Did you do that correctly?
Things not as carefree as they used to be.

4.2.6. Fiona

Everyone is breastfeeding
And there's me with a breast pump.
Why can't I do what other people can do?
Why can't I be in their club?

They knew what they were doing,
I wanted to be like everyone else
I wanted to be able to soothe my daughter
What if people think I can't do the basics?

I wanted to feel like a good mum,
I'd compare
I'd look at social media
It made me worse

I was cranky and snappy
I had palpitations
Panicky, edgy, hyperventilating
I had trouble sleeping

She was cranky
I couldn't understand
Desperate searching on the internet
What was going on?

What could I do to resolve it?
Why is she crying?
Am I harming you?
Am I giving you enough love?

Am I a good mum?
I need to be a perfect mum
I'm not fulfilling the role of a mum
All the blame on me.

A vicious circle of thoughts.

4.2.7. Gabby

We're not going out today
Something might happen
I could keep him safe at home
I could control the environment

I was overwhelmed
I couldn't look after my children
I couldn't talk to people
Everything felt so big

People are going to judge me
People are going to look at me
Will they talk about me?
Will they think I'm a bad mum?

My head would spin,
I would feel sick
I would ache
I was in pain

I was floating away
Watching my life
Looking in from outside
There, but not there

Intrusive thoughts
I'm a bad mother
I don't deserve him
He should be in care

Social services are going to come
They'll take my baby off me
My house is a mess
I'm a bad mum

A battle in my head
The thoughts consume you,
What's wrong with me?
I'm a piece of crap

I couldn't live a normal life
It was too much
Too anxious and overwhelmed
I felt like I was going to explode

4.2.8. Helen

I don’t know what I’m doing
What do you do with a baby?
Is he going to be okay?
The uncertainty of it all.

I felt anxious about the nights
I used to check on him so many times
Always on edge
Always listening out

I felt anxious going out
Something might happen
I felt overwhelming protection
I wanted to do everything for him

Everyone thought I was a bad mum
That I wasn’t bonding
That I didn’t love him
That I wasn’t doing the best I could

Everyone else seems to manage
Why can’t I?
My worry was my mental state
I felt overwhelmed

If he wasn’t well
If he wasn’t eating
If anything went wrong
It was all my fault

Expectations, of what you should be like
What you’re meant to feel
I just felt awful
I didn’t feel that rush of love

What I was feeling was wrong
I couldn’t tell anyone
They’re going to think
I’m not fit to be a mum

4.3. Theme one: Being taken over

This first superordinate theme explores mothers' experiences of 'being taken over' by the phenomenon of anxiety after birth. The participants reported a feeling of being hijacked by their anxiety to the point where it subsumed their thoughts, feelings, emotions and bodily feelings. This theme comprises two parts: embodied anxiety and thoughts and feelings. While corporeal and cognitive expressions of anxiety are intertwined, it is interesting to reflect on each of these separately as described by the participants.

This theme has close connections to the two other superordinate themes: '*Being with others*' and '*Being with uncertainty*'. This interconnectedness portrays the intricacy of the phenomenon under investigation and, while each theme is given its own section, the interchange between themes will be explored in greater detail in the discussion chapter.

4.3.1. Embodied anxiety

I felt so breathless,
Ready to run and to fight,
My head was spinning.
(Choral haiku)

The mothers described their experiences of anxiety as a bodily state. As the vehicle of their being-in-the-world, the body was viscerally responsive and perceptual to their unfamiliar maternal environment. They reported a rich and vivid array of bodily sensations: almost all expressing a sense that their body was under siege, hijacked and physically taken over by anxiety. The 'choral' haiku (a blend of all participants' words) provides a succinct glimpse into this experience, expressed in the mothers' own words. What was notable from the interviews was the depth and breadth of their

bodily phenomena, uniting to powerfully convey a restless, urgent, trembling, nauseating, weighty, oppressive and destabilising experience. For some, this bewildering bodily state crept up at unexpected moments while the mothers' snatched moments of down-time. Fiona experienced the disquiet of panicky palpitations arising frighteningly out of nowhere:

> *They would just come on – I'd just be watching TV and I'd start getting panicky, edgy, hyperventilating. Sometimes there was no obvious trigger, they would just come.*

There is no stimulus to Fiona's embodied response – she was sitting with her feet up, the television on and her baby asleep. Her unbidden bodily turbulence was an unanticipated and unwelcome phenomenon. It served as an uninvited reminder that the responsibility of motherhood was ever-present, and that rare moments of down-time and rest were tarnished by anxiety. Danielle similarly described her embodied anxiety as a sudden onset of full-body sensations, akin to being on a rollercoaster at a theme park:

> *The anxiety was engulfing – like when you go on those fairground rides, when you go to the top and it drops down. That's what it felt like … the nausea, shaking, rapid heart. I was jittery, clammy, nervous and shaky.*

Describing being at the top of a rollercoaster and about to descend, Danielle's anxiety is conveyed as anticipatory. It arises as full-bodied experience seemingly out of nowhere. As if on a runaway train, she was unable to dictate the velocity of the ride as her engulfing physical reactions spiralled out of control. There was nothing she could do to calm or control them.

> *I would lay down, but I couldn't seem to stop that constant rapid heart, stomach going … it would never switch off. Everything made me jump … like I was walking on a tightrope, I remember the doorbell going off and I would literally jump out of my skin. I was constantly ready to run that's what it felt like. The 'fight or flight' feeling was always there, I was always so on edge.*

In a similar way to Fiona, Danielle describes being physically enveloped by her anticipant bodily anxiety, her words conveying a sense of movement and threat. Everything made her jump – she was primed and ready to react despite no tangible or obvious danger. Everyday innocuous occurrences, such as the doorbell ringing, would trigger a flood of 'fight or flight' reactions. She describes her experience as 'walking on a tightrope' – an illustration of trying to maintain a delicate balance as she attempts to navigate through her day. She found it impossible to switch off as her body prepared to flee from threat, yet the impending danger was unknown. Even when everything was calm and her baby was safely taken care of by someone else, sleep and rest were elusive and unattainable.

Other mothers also reported feeling primed and ready for action. For Beth, this manifested itself as feeling 'ready to fight':

> *I would get tingling in my entire body, in my fingers and my arms. My heart would start beating faster and I was always ready for a fight – to lash out over the smallest matters. My heart would be going at 100 miles per hour, and I would need to scream or hit something. The strong physical response scared me.*

Describing her heart beating at *'100 miles an hour'*, the intense full-body physicality of her pervading anxiety was experienced as overwhelming and frightening. She

spoke about needing to scream and hit things, while keenly aware that she also needed to calm down. She felt physically taken over by a '*really strong urge to go crazy'*, describing it as an experience beyond her control, which left her exhausted and hurting inside. Similarly to Fiona, her embodied reactions were often experienced in response to minor triggers:

> *I would be filled up with so much stress for no reason whatsoever and it would all be over small little things, nothing substantial.*

Like Danielle, Beth recalls having a nervous and edgy disposition, with very little needed to prompt an exhausting full-bodied response.

Abbie expressed her embodied experience as something felt to be very weighty and oppressive:

> *A really tight feeling in my chest, like something heavy is pressing on it and a sinking feeling.*

Her depiction of an embodied heaviness and sinking sensation in her chest painted a vivid picture of her being dragged down by the unbearable burden of her anxiety, an experience which was overwhelming and oppressive. In addition to this unsettling weighty feeling, she describes a critical moment where she has an urge to throw things as a means of gaining a physical release from her unbearable embodied state:

> *It feels like your head is going to explode and you need to throw something to get it out.*

Like Beth, she feels a strong desire to physically expel her intolerable feelings – to be rid of them. She paradoxically experiences feeling both weighed down and anchored by her embodied anxiety, while also mobilised and prepared for action. These contradictory physical forces were experienced as unfamiliar and deeply unsettling.

Emma also describes her embodied experience in terms of an oppressive burden:

> *It is the heightened response I remember, I was just on the edge, pressing weight on the chest, I can't take any more …*

She also became aware of persistent pains in her hands and noticing that the rubber on the pram handle had started to perish and distort, becoming consciously aware of gripping tightly onto the pram handles on her daily walks. She was uncertain whether this could be attributed to fear of the pram rolling way or a manifestation of a pervasive generalised bodily tension, yet she recognised that her anxiety had taken over her body, not just her mind, describing it as '*spilling out*'. Like the other mothers, Emma noticed that, even at rest, she was tense and on edge, with her habit of teeth grinding in her sleep intensifying in the weeks and months after birth. For Emma, embodied anxiety became a round-the-clock companion in its various guises.

Many mothers reported being always alert, with a restless, edgy hyperawareness perceived as ever-present. Gabby vocalised her embodied anxiety as physically painful: '*I'd be hurting inside*'. For her, this was also accompanied by an experience of sensory overload: the lived-space around her was perceived as discordant and unbearable:

> *I was so hyperaware all the time; everything would feel so loud.*

Gabby's experience of sensory overload was accompanied by an overwhelming felt sense that something terrible had happened, without concrete evidence of anything bad having actually taken place. Her daily struggle with her embodied anxiety reached its pinnacle when she experienced dissociative experiences:

> *The only way I feel I can describe it is that you do not feel present in the moment. It feels like, I mean, I'm not a drug user, but I imagine it's what it feels like if you're off your face because everything … it feels very floaty and like you're looking in from the outside. You are not in your physical body – it's like watching things happen in slow motion but you're not actually there, you're not really there. I would get that at times when I was so overwhelmed, or so stressed out that it would just feel that I was leaving my body – it's like watching your life but you're not in it*

Observing herself as there, but not there, she describes an uncanny experience where she is both present and absent. Her body has reached breaking point and her anxiety has become too difficult to bear. She shuts down to the intolerable tsunami of anxious feelings. She describes becoming separate from her body, becoming an outsider looking in. She is temporarily released from occupying her embodied self and this depicts a pivotal moment where she detaches and disconnects from the world around her. In this moment, time temporarily stands still.

4.3.2. Thoughts and feelings

A constant swirling,
I couldn't switch my head off,
Catastrophising.
(Choral haiku)

The lived-body experience of anxiety after birth was accompanied by the mind responding with frequent rumination. All the mothers in this study disclosed being taken over by incessant worry, reporting it as one of the most prominent expressions of their anxiety. The 'mental load' is a phrase used by Emma to describe the oppressive and overwhelming nature of this phenomenon. The mothers' experiences will be explored in detail, accompanied by verbatim vignettes to illuminate their inner worlds in greater depth.

What was revealed in many of the transcripts was that worry was experienced very soon after the moment of birth. Abbie noticed that, in the very first hours of becoming a mother, '*I couldn't switch my head off*' and she elaborated that there were '*lots of thoughts racing around*'. There were moments when she knew that her baby was okay, but her mind was busy and she could not rest:

> *My baby was sleeping, and he was fine, but I was thinking I ought to be waking him up and feeding him.*

For Abbie, an immediate activation of a busy and anxious mind took place. While all was calm, there was a nagging sense that she ought to be doing something. At times, her worries became more heightened, peaking into feelings of panic. Of these instances, she describes a cascade of thoughts:

> *… say he woke up a third or fourth time, I'd start thinking, oh my gosh, this is the start of him not sleeping through the night, I'm not going to get any sleep,*

> *I'm not going to cope … it was really just a selfish thing I think, just constantly panicking that I wouldn't be able to cope and that we had to get him back to sleep, we had to figure it out, otherwise everything would go downhill, I'd start sleeping really badly, I wouldn't be able to cope ...*

Her baby's frequent waking triggered worries that she would be unable to cope and everything '*would go downhill*'. She disclosed that her active mind centred frequently on themes of not being able to manage and these pervasive thoughts would rapidly cascade out of control. At times she described her experience as occupying a dual temporality: future-focused, predicting a negative unfolding of events, while also experienced in the present:

> *I was so scared of not coping that, you know, when something slight went wrong it reinforced that fear and made me feel like I wasn't coping. I was so afraid of not coping that it made me not cope!*

Abbie describes her thought – the fear of not coping - becoming a self-fulfilling prophecy culminating in the experience of actually not coping. Her anxious thoughts and intense feelings and emotions were closely intertwined. While still in hospital, she described becoming hysterical:

> *My husband had gone home and it's very embarrassing to admit but I left him a voicemail in the early hours of the morning, and I remember actually just screaming because I was so hysterical.*

Abbie described her raw emotions as *'all consuming*', reaching beyond the boundaries of the familiar and stretching into something new:

> *It was just a very intense feeling of fury with myself and the situation and actually with my son, even though it wasn't actually his fault at all. And you know, I just wanted to throw things and that's not me at all, that was actually a really different feeling for me.*

She recalled intense moments of tearfulness, fury and rage, which she identified as unfamiliar – not part of her usual self. These feelings were perceived as shocking and frightening. This potent combination of anxious thoughts and raw feelings combined into an omnipresent sense that motherhood was ill-fated:

> *Things are not going to get better; things are very wrong. It's like, even those words wouldn't come into my head, it's a feeling ... that everything is doomed.*

This powerful feeling portrays a mother overcome, overwhelmed and devoid of hope. While this described the very early days and weeks of motherhood, Abbie conveyed that this level of heightened anxiety and emotion persisted intermittently throughout the first year of motherhood, manifesting itself as a tsunami of thoughts and feelings, which ebbed and flowed in waves.

Danielle used a train metaphor to highlight her experience of her runaway thoughts:

> *My mind was running so fast … just like being on a platform and the train doesn't stop there and it just whizzes straight through.*

She described her worries as obsessive in nature, with their harsh criticism always self-directed: '*I can't do this … something is wrong with me.*' She also identified her thoughts as 'catastrophising' in nature, characterised by negative self-appraisals that she was a faulty, inadequate mother. She described a heightened state characterised by a '*constant swirl of emotions, thoughts and feelings*'. Her words

paint a vivid picture of a mother struggling to maintain her equilibrium in the storm that overcomes her. To counter this, she recalls:

> *I felt that I had to be one step ahead … what can I complete next, to keep going?*

Danielle's personal account of her anxious thoughts is vibrant with movement: being swept up in a vortex, trying to pull away to keep going to move forwards in the hope that she could find a more stable place. These opposing forces denote an experience of being pushed and pulled in multiple directions. She reveals that this tension was '*exhausting to live with*' and echoes Abbie's identical words as she recalls that one of her persistent and obsessive thoughts was the worry that she '*wouldn't be able to cope*'.

Fiona also observed her anxious thoughts as judgemental, self-blaming and relentless. She recounted the everyday occurrence of her baby crying descending into a spiral of self-rapprochement:

> *Why is she crying …?*
>
> *Is she in pain …?*
>
> *Then it comes back to me again. I'm not a good mum, I'm not providing for you, am I harming you? Am I physically harming you? Am I giving you enough love? It's all the blame on me.*

The everyday experience of her baby crying escalates from a challenge to be worked out to a significant episode of self-doubt in her mothering abilities. This kind of thinking kickstarted what Fiona described as a '*vicious cycle of thoughts*'. In the

lived-space of motherhood, the nature of this cyclical anxiety maintains Fiona's attention on her new and vulnerable baby. The continual supervision of the infant requires her to be constantly questioning and attentive to every cry and is the driving force behind her hypervigilance.

Charlotte spoke of being bombarded by questions of a practical nature: the 'whats and hows' of motherhood consumed her waking moments as she attempted to fathom the essential tasks relating to caring for her child:

> *When do I feed? How do I feed? Do I give a bottle? How do I put her to bed?*

Such thoughts focus on the mystery that is motherhood. Having transitioned into motherhood, how do I care for this vulnerable being? What exactly do I do? In the early days and weeks this is unknown – it is not obvious, straightforward or simple. This dimension is explored in greater depth in theme two: being with uncertainty.

Helen's thought processes focused on a sharp self-appraisal that she was getting everything wrong, and it was all her fault:

> *I remember thinking I was doing everything wrong; I wasn't doing it right and I wasn't going to be a good mother and I remember really feeling if anything went wrong, or if he wasn't feeling well or if something hadn't gone perfectly, I felt it was my fault. Everything was my fault. If he wasn't eating well, it was my fault. If things weren't going the right way, it was my fault.*

Such thoughts were coupled with a future-orientated preoccupation that she would not get enough sleep at night to be able to function adequately the next day. While Helen was consumed with worries about her baby waking up and disrupting her own sleep, she also found herself listening out for him at night and monitoring him. This

prevented her from getting the sleep that she needed, leaving her in a state of attendant hypervigilance.

Emma's thinking patterns manifested themselves as a constant questioning of whether she was going about the tasks of motherhood in the correct way and if she was '*doing enough*' for her child. She describes her thoughts as heightened, persistent and sometimes obsessive and self-blaming in nature: '*did I miss something?*' The feeling accompanying these thoughts was that there was always something more to be done – that the tasks of motherhood were ongoing and never complete. Obsessive thoughts would be accompanied by a process of checking to ensure that she had done what she thought she had done. The relentlessness of this experience was difficult to manage, and Emma recalls:

> *It would take a lot of work for me to be able to switch off.*

For Emma, one of the most challenging aspects of motherhood was what she referred to as the internalised, invisible 'mental load':

> *It's not seen. It's not tangible. It's not recognised.*

Her burdened and preoccupied mind was experienced as a hidden encumbrance, which had to be shouldered alone each day. She kept her worries concealed from her partner and close family – only adding to the weight of her burden.

Like those of others, Gabby's anxious thoughts were full of self-reproachment. Inside her mind she was beating herself up for her perceived failures as a mother. In addition to this she was preoccupied with imagining a stream of worst-case scenarios. These situations were fictitious and envisioned, yet they were all consuming:

> *I didn't know how to disperse … how to challenge these thoughts … so very quickly in the space of one week I was in full anxiety – I was so afraid of leaving the house. I didn't take my son out on his own until he was 12 months old. I wouldn't drive him in the car – the thoughts were just so consuming of my everyday life.*

With her anxiety spiralling, Gabby took refuge in the lived-space of her home. This was perceived to be a safe space – a place where she could protect and shield her baby from harm. She imagined outside as a place of danger:

> *We were going to die if we went outside.*

Such distressing thoughts devoured her waking moments and significantly impacted her day-to-day life. As they became more extreme in nature, they impacted her ability to eat and sleep and, without nourishment and rest, she observed that her mothering capabilities were challenged with the imminent possibility of breaking down altogether.

On occasions when she was short on sleep, her thoughts would continue their perpetual process of self-sabotage. Using language resonant with some of the other participants, Gabby outlines her distressing experience:

> *It was so exhausting, carrying all this with me. Everything felt so overwhelming and so big – it feels so very big, it's just too much and I'd just feel like I was going to explode.*

A couple of the participants described some of their thoughts as intrusive. These thoughts were characterised as extreme, unwanted, disturbing and distressing. The mothers who revealed these thoughts found them engulfing, taking their experience of anxiety to new and dizzying heights. One mother had an intrusive thought about drowning her baby – a thought that was overwhelmingly abhorrent to her. At other moments she was plagued with distressing thoughts that she might throw her infant daughter out of the window:

> *The thoughts become your worst nightmare through your child, what if someone sexually assaulted my baby? What if my other half did something to my daughter? What if I did? What if I threw her out of the window? And there's no part of your soul or your heart that wants it to happen and that's why it is so distressing because you don't want any of that. It's almost as if your brain knows what you're most afraid of – and will make you think that it's going to happen, that you're going to do it, or someone that you love is going to do it … it's always your worst possible nightmare that will come in your head at that point.*

These thoughts were experienced as repetitive and extremely frightening, leaving the mother more anxious that something was seriously wrong with her. She felt alone with the discomfort of questioning what this might mean about her as a mother.

While thoughts were preoccupying and galloped out of control, they were coupled with strong feelings and emotions. Abbie described an intensity in her emotional

response, something she immediately noted ‘was different’ to any other anxiety she had experienced before. She described her raw emotions as ‘all consuming’, reaching beyond the boundaries of the familiar and stretching into something new:

> *You asked me what it felt like and I’d forgotten this because it was only in the early days but sometimes rage.*
>
> *It was just a very intense feeling of fury with myself and the situation and actually with my son, even though it wasn’t actually his fault at all … it was actually a really different feeling for me.*

Danielle reported being taken over by feelings of aggression and hostility, which were directed towards her partner. Such extreme feelings were uncharacteristic and bewildering:

> *I just couldn’t control my behaviour at the time.*

For Emma, an incident in which her infant daughter was sick in her car seat triggered an immediate and intense reaction:

> *We both flew off the handle, we were so upset … over a car seat!!*

Looking back, Emma was able to recognise that her responses to the world around her were out of kilter with the triggering event. Her reactions portrayed the extent to which she felt continually on edge.

Beth’s intense feelings were not only bubbling at the surface but also deeply held within. She recalled feeling,

> *… complete hopelessness, exasperated, stressed – sometimes actually purely angry because I was like, 'I'm so done with this, I've tried everything, it's not working.*

Almost all of the mothers in this study reported feelings and emotions that brokered new extremes.

4.3.3. Reflection on lifeworld existentials

The mothers' rich accounts of their inner worlds illustrate that their anxious thoughts are recursive. Their thoughts centre on themes of diminished agency (*I'm not able to do this*), harsh self-criticism (*I'm a bad mum; something is wrong with me*), repetitive questioning (*Am I doing enough? How do I do this?*) and catastrophic predictions (*Something bad will happen*). For some, they are intrusive in nature (*what if I harm my child…?*). The mothers experienced their thoughts as unwanted, unbearable, frightening, incessant and haunting. Some expressed a desire to expel them or be rid of them. The stronger this desire, the more the thoughts continued, turning the mother's inner world into a battlefield. At night, their frightful thoughts plagued them, rendering sleep impossible.

Their bodily anxiety comprises a broad spectrum of experiences. On one hand, their corporeal experiences are anticipatory – the threat is unknown and vague and perceived as future focused. However, at some uncertain point in time the threat will arise. At the same time, the threat is also experienced in the present moment, accompanied by a compulsion to flee it, fight it or lash out at it. As a result of this fusion of present and future temporality, mothers reported feeling perpetually switched on: hyperaware, hypervigilant and unable to sleep or rest. These lived-body experiences were unwanted, dizzying, destabilising and exhausting.

With the temporality of anxiety experienced corporeally, as a future danger imported into the present moment, the appearance of embodied anxiety echoes this. The fight or flight response is felt as a pressing urge to respond now, while also involving feelings of being immobilised, weighed down and breathless. The sense of feeling physically restrained by anxiety exists in opposition to being primed and ready to flee. The resultant tension of being caught between extremes is overwhelming. In its most extreme manifestation, the lived-body experience of anxiety manifests itself as a complete corporeal detachment: a dreamlike experience of being present, yet absent.

The broad range of lived-body experiences cannot be tracked lineally, and the overarching commonality is that the bodily experience of anxiety is experienced as engulfing. The lived-body dimension of 'being taken over' is thus paradoxical: while feeling primed and ready to respond to unknown and invisible threats, mothers also feel paralysed and immobilised. It is apparent from their personal accounts that mothers' corporeal experiences of anxiety permeated lived-time, lived-space and lived-body dimensions.

In the temporal dimension, anxious thoughts freeze time – they swirl around in a recurrent closed loop, which feels inescapable. Paradoxically, this circular experience is in tension with the linear dimension of babies' development, where ages and stages progress on a forward trajectory. In parallel to the experience of embodied anxiety, there is an immobilising quality to their anxious thoughts: they paralyse them with fright, and they are accompanied by a swirling vortex of unwanted feelings and emotions.

What stands out from mothers' recollections of runaway thoughts is that positive perceptions of their abilities to manage and be a good mother are absent. At times,

this is rooted in direct experience (*my baby is crying, and I can't calm him*) and at times it is pitched in opposition to direct experience (*the baby is peacefully sleeping but I am not doing enough*). Maternal anxiety manifests itself as an overwhelmingly fretful experience with persistent concerns that something is wrong with the baby. The mothers' anxiety is experienced as a temporal burden – the future intermingles with the present, with predicted tragedy imported into the present moment. The mothers become cut off from reality, presupposing unfounded negative self-judgements. Being unable to calm a crying baby does not make a woman a bad mother, yet this is how it is experienced in the actual moment. The feeling of being a bad or incapable mother is so repugnant that it quickly escalates to more frightening thoughts and feelings, which become overwhelming and intolerable. The mothers' reports of hysteria, screaming, rage, fury and out-of-body experiences portray the lived-space of PNA as saturated with bodily, cognitive and emotional extremes. These extremes deny mothers a stable base from which they can get to know their babies and allow their mothering abilities to grow and unfold over time.

4.4. Theme two: Being with uncertainty

The second superordinate theme explores how the phenomenon of maternal anxiety reveals itself as being with uncertainty. At a new stage in life, all the mothers reported becoming anxious in relation to being in uncertain territory. The mothers embarked on their new role with little or no practical skills or experience and bringing a new life into the world was accompanied by a myriad of unknowns. In caring for their new-borns, they were required to make choices and decisions without any certainty of knowing if they were going in the right direction. The mothers' experiences have been distilled into a choral haiku, capturing the essence of each subordinate theme, in addition to subsequent verbatim vignettes to illustrate the phenomenon in greater detail.

4.4.1. What do you do with a baby?

It's like shifting sands,
That feeling of helplessness
How do I do this?
(Choral haiku)

After birth, the mothers were thrown into a new way of being. From the outset this involved trying to get to grips with the day-to-day practical tasks of motherhood. The primary task was orientated around keeping the baby alive and, from the very beginning, mothers were called upon to ensure the physical survival of their children. Babies are fragile and completely dependent: mothers are inexperienced and unsure about how to look after their infants. In the first few hours after birth, Charlotte disclosed how uncertain she felt:

> *I would worry about how to put her to bed and when do I change her nappy? Do I know when? Do I have to wake up every two hours in the middle of the night? When do I feed? How do I feed? Do I give a bottle?*

Maternal responsibility is awakened by dwelling on the hows and whats of motherhood. The key questions are: '*What does my baby need and how am I going to provide it?*' This awakening of maternal responsibility emerges with considerable intensity. For some, this realisation occurs while they are still in hospital, while for others it is revealed when the mother goes home. Beth disclosed that she felt caught in an in-between transitionary space, charged with responsibility but not yet armed with the necessary knowledge to care for her child:

> *I felt like I had to deal with things, but I didn't know how to – I wasn't equipped, I didn't have the skills.*

Crossing the threshold into motherhood imbues a mother with immediate responsibilities for which she has been unable to prepare. What is known is that the baby needs to be nurtured and cared for, but the accompanying tasks are unfamiliar and need to be learned. Some of the mothers had never even held a baby before and every aspect of care was beset by a multitude of questions:

> *Is he going to be okay? Is this the right thing to do? It was just the uncertainty of it all. What do you do with a baby?*

Some of the mothers did try and prepare for the arrival of their baby by attending preparatory antenatal classes and breastfeeding workshops. Having gathered some preliminary knowledge, they reported feeling anxious if things did not turn out as planned. Many struggled with trying to grasp how to establish breastfeeding:

> *It was very worrisome … what's wrong with my nipples? What's wrong with my boobs? Does she have tongue tie? Is she doing it right? Am I doing it right? I would ask my husband, 'Can you look at this? Is it this hold, or this hold? Or is it this latch?'* – Emma

> *I was so anxious and stressed because breastfeeding didn't really work out for us, which is another layer of anxiety* – Daniella

Getting to grips with feeding was an existential challenge essential for the baby's survival. A fragile new life cannot fend for itself, and the mothers recalled being profoundly impacted when they encountered breastfeeding difficulties. Emma struggled with positioning her child, uncertain whether the difficulty feeding was down to her or her baby. She embarked on a process of elimination, enlisting her husband's support in the analysis of how best to position and hold her baby. Without an experienced breastfeeding counsellor by her side, such questions were impossible to answer, and she was left in the precarious position of not knowing. Charlotte also struggled to breastfeed her baby and was informed by her midwifery team that she had ten days to establish feeding before her milk dried up. With each day that passed, the pressure mounted and her anxiety elevated. She decided that pumping breast milk would keep her milk supply going and bypass the difficulties of positioning and latching:

> *I settled on the idea that I could pump at home and give her that, but then when that wasn't working at home, I was really anxious about how I'm going to carry on? I can't keep giving her 10ml every hour. I can't switch over to SMA because that's that then – no more breastfeeding. So, when I read that you can combine, I thought well that's some sort of comfort – I can do that.*

Recognising that she didn't have adequate support to get breastfeeding established, a combined feeding method offered Charlotte options and hope. Breastfeeding was considered to be a fundamental part of being-a-mother and also representative of good mothering; to achieve anything less was perceived as failure.

> *I had quite a difficult time getting him to latch in terms of the breastfeeding and that added to the whole insufficient motherly feeling that I was having* – Beth

Those who chose to exclusively breastfeed took on sole responsibility for the nourishment of their children. This was coupled with the anxiety of not knowing if their baby was full or whether they were making enough milk. Helen remembered worrying if her baby had fed enough to get through the night and these were elements over which the mothers had little control. With feeding taking place every few hours, uncertainty was never far away. The mothers who struggled to establish breastfeeding felt let down by their maternal bodies and conveyed their disappointment and distress:

> *I was so anxious and stressed because breastfeeding didn't really work out for us* – Danielle

> *I just wanted to be like everyone else – I wanted to be able to breastfeed. I wanted to be able to soothe my daughter* – Fiona

The physical struggle to feed was accompanied by feeling insufficient, guilty and not good enough. Fiona felt that her body had betrayed her and she became alienated from others who seemed to be able to feed effortlessly in comparison. While pumping breast milk provided all the nutritional benefits of breastfeeding, it was experienced as taboo and abnormal. Wary of this, Charlotte took to expressing breast milk in private, out of sight from others:

> *I would secretly take the pump and go to my room and try and express and when they asked, I'd say 'oh I'm just having a nap' or 'I'm just having a shower' but I'm in there pumping secretly…*

Feeding became an obsession loaded with emotion. False starts, challenges and unknowns brought frustration, anxiety and despair.

The continuous self-questioning stretched beyond breastfeeding into the other tasks of motherhood. A crying, unsettled baby demanded attention, but what kind of attention did the baby need? These mysteries were perceived as perplexing and unsolvable:

> *My stress levels were just straight out the door with that feeling of helplessness and inability to control or contain the situation. That feeling of not being enough, not being able to comfort him, I felt like he always needed something, but I just never knew what* – Beth

> *There were many nights when we were pacing the floor for hours, we didn't know why the baby was crying and this went on for six weeks … I'd heat a bottle and feed her and for a few days she'd take a little bit of the bottle and then she'd stop and cry. I had no idea why and I just couldn't figure it out* – Emma

Looking after a new-born was experienced as a puzzle to be solved and caring for a baby became a haphazard process of trial and error. On occasions, mothers would feel that they had made progress only to discover that it was frustratingly short-lived:

> *It's like shifting sands … every time you thought you'd got somewhere, it just all changed again* – Danielle

Learning on the job was rife with unpredictability: what worked one day didn't work the next. The tasks of motherhood required experimenting, modifying and trying again. Each mother and baby were unique, yet there was a universal perception that there was a singular and correct way of going about things. As Beth expressed:

I didn't know what to do to get it right – to get being a mother right.

Beth's wistful expression reveals that maternal anxiety wasn't only in connection with what to do with the baby: it also manifested itself in how to be a mother. This mysterious dimension of motherliness could not be planned, prepared for or predicted: it had to emerge gradually with the passing of time. Yet, in dwelling in the uncertainty of how to be and feel like a mother, time was experienced as open-ended, anxiety-ridden and unbounded:

> *I'd be anxious about how we'd fill our days, what we were going to do, how I'd keep him entertained and the days just stretched out into the abyss, there was no end to them* – Danielle

4.4.2. Seeking certainty

Obsessed with schedule
I needed to understand
how I resolve this
(Choral haiku)

Faced with unknowns, mothers' day-to-day experience was perceived as chaotic and out of control. Days and nights became blurred, time took on a new quality and daily existence felt unpredictable. Mothers were overloaded by choices: *should I respond to my baby's cry, or let him cry it out; do I feed on demand, or impose a structure; should I sleep with my baby or put her in a separate room?* Ambiguity was accompanied by a pursuit of certainty and the mothers turned to expert advice from medical professionals, books and websites. Some mothers tried to impose a routine to bring order to chaos. Helen discovered that following a schedule was initially very helpful – it kept her on the '*straight and narrow*'. However, the schedule also became a source of anxiety with worries about what would happen if things did not go to plan:

Is he going to get to sleep? Are we going to get any sleep? Is he going to wake up?

When things went to plan, Helen's anxiety eased: when they did not, her anxiety escalated. Routine became both a help and a hindrance. Beth's attempts to impose a routine were judged unsuccessful:

He wouldn't stick to the schedule I tried to implement. I couldn't force my baby to stick to the schedule, but I felt that if he could, we would be fine. I was obsessed with the schedule. I would refuse to leave the house and would try and force him into sleeping when it was his nap time, and it just wouldn't work, and he would cry and cry and my stress levels were just straight out the door with that feeling of helplessness and inability to control or contain the situation.

Beth became preoccupied with setting up a routine to the point of obsession. It was hoped that a routine would provide some semblance of order and predictability to counterbalance the uneasy sense of uncertainty. A hope was apparent that if only a routine could be established then everything would miraculously fall into place. Some of the mothers attempted to harmonise their own sleep schedules with those of their babies, sleeping while their infants slept. Yet when this did not work out, the fall-out was dramatic. Danielle described a sense of helplessness when her attempts to do this were thwarted by someone mowing the grass outside the bedroom window:

That felt like my world fell apart because I'd set my heart on that one moment to try and catch myself some sleep. The tiniest things would literally throw me over the edge.

The mothers conveyed a sense of urgency to get things in order, so that life could be predictable, planned and understood. When this did not happen, their anxieties intensified. Conceding that her baby would not stick to a routine, Danielle changed tack and diverted her attention to keeping the house in immaculate order instead:

> *The more anxious I felt, the more over the top I would be to get things perfect or right … especially with the cleaning. I would spend hours cleaning and get really annoyed with my baby when he wouldn't sleep properly because I couldn't clean, and I think that was a way to manage the anxiety. I'd get very irritable if anything was out of place … a smear on the sink … or the slightest mark on his clothes – it was real overkill the OCD stuff. If the house was a mess, it was because my mind was so chaotic. It felt so overwhelming that I couldn't cope, and I think looking back, everything had to be perfectly straight, in order, tidy, spotless and then once that was okay, I'd start to feel calmer and feel like my levels of anxiety would begin to drop.*

In focusing on the lived-space of the home, Danielle has some aspect of her surroundings under control.

Alongside books and websites, medical professionals were also perceived as a source of guidance. When Emma could not fathom why her baby kept crying, she approached her health visitor and a chiropractor for advice. At times, when health professionals were unavailable, she turned to Google for answers. When an unexplained rash on her daughter's hand triggered concern, she scoured the internet for advice. Such actions were understood as driven by maternal accountability – it was deemed essential to get things right to avoid harming her baby:

> *The responsibility of your decision has a positive or negative impact on another human being – and that's something that you can't learn in all the classes …* – Emma

Actions taken in the present had implications for the future and the enormity of this was felt to be overwhelming. Emma's diligence in attending antenatal classes to prepare for birthing and caring for her child did not prepare her for the plethora of unforeseen circumstances:

> *I was putting in the effort, doing the reading, looking at blogs, trying everything and then still failing – you don't realise until you become a parent that it's completely unpredictable. I think it's putting in all the work, expecting an outcome and not getting it and wondering why … what did you do wrong?*

The demands of motherhood were incomprehensible and capricious – each day was subject to randomness and chance. With various avenues explored and no positive outcomes to show for it, Emma concluded that she must be doing something wrong.

Fiona searched the internet, staying up late into the night looking for solutions:

> *She was feeling cranky, and I couldn't understand why. So, I'm desperately searching on the internet looking for an explanation because I just needed to find out exactly what was going on and what could I do to resolve it.*

Fiona was convinced that the remedy to her daughter's crankiness was out there somewhere. Confident that the answer would be available on the internet, she turned her attention away from her baby towards a search engine. Expert literature convinced the mothers that there was a right and wrong way of doing things. If they could only do things the correct way, everything would fall into place. The mothers expressed a need to find out the exact cause of their difficulties so that they could be

resolved swiftly. The uncertainty of not knowing was felt to be intolerable. For some, confirmation of being a good and competent mother could have been achieved by having a baby who slept, fed and settled well. As Beth explained:

> *The main validation I was waiting for was from my son to be a comfortable and happy child, which he wasn't.*

Without this valuable feedback, the mothers feared that their children's health and happiness were at stake. To try and grasp why things were not going to plan, additional efforts were put into sourcing external information, trying new approaches and keeping detailed notes:

> *I wrote down every single bottle, poop, pee and nap for five months straight daily. I didn't miss a moment. I still have that notebook – and that came out of being anxious. Did she sleep? Did she sleep for 55 minutes or 57 minutes? What woke her up? What temperature is the room …? And that's where a lot of the extra worry came in, because I think it all stemmed from me thinking I'd failed* – Emma

Persecutory thoughts came to the fore, with mothers chiding themselves for 'failing' and 'not being good enough'. The ongoing quest for certainty continued in a circular loop of trial, error, partial success/failure and guilt. The mothers craved a certainty that was frustratingly elusive. When advice was followed but attempts were thwarted, the mothers were left in a precarious position. Danielle pinned her hopes on things resolving in time. She counted the days and weeks in hopeful expectations of things falling into place:

> *I used to live from week to week, thinking, 'Right, it's seven weeks now, things will get better … right it's eight weeks now, things will definitely be better this*

week …' I was just waiting for the time to pass and for things to change. It was excruciating … the first three months were just horrific, and I think I used to put little, week 7, week 8 pictures up because it was my way of counting down the time, counting down the milestones but wishing time away …

Without an obvious solution, the hope that time would ease things became one of the few remaining options available.

4.4.3. The 'what ifs' …?

What's wrong with my child?
What if something bad happens?
I can't be alone
(Choral haiku)

Several mothers reported two key preoccupations – 'What if something happens to my baby?' and 'What if something is wrong with my baby?' In harbouring concerns that something might happen to their children, the external world was perceived as unsafe and frightening. There was an anticipatory future-focused temporality to their anxiety in the form of an imminent and unknown danger. Threat is perceived as everything and everywhere. Some mothers were unable to articulate this feeling in any detail – it was more of a generalised felt sense that something might happen.

For Beth, this sense of unease surfaced in the early days and weeks of motherhood. It was experienced as a feeling that she must not be left alone with her baby in case an emergency arose:

I can't be by myself with this child. What if something happens?

Helen was similarly unable to be specific about her concerns, describing a generalised sense of foreboding:

I was just so worried that something might happen to him. I felt an overwhelming protection for him and wanting to do everything for him.

For both mothers, maternal anxiety focused non-specifically on what might happen, what might be hidden out of sight and what might be waiting perilously in the wings. A desire was apparent to obviate danger and protect the infant – either by having a trusted ally close to hand or by mobilising their protective instincts by doing everything for the child themselves. In both instances, preventative action is taken to eradicate threat. The mothers took on a role of omniscient parent, unable to relinquish responsibility to others, while still wanting support.

For Gabby, the sense of external threat was more absolute:

I remember the real fear inside when one day my mum came round and she said, 'shall we go for a walk?' And I can feel it now like even though I'm not in that moment, I can feel that terror because we were going to die if we went outside. I was so afraid of leaving the house. I didn't take my son out on his own until he was 12 months old.

I knew I could keep him safe at home, I knew I could control the environment I was in, but I couldn't control the environment if I was outside the house. I couldn't keep my baby safe in case somebody decides to do something because that's out of my hands. It was better to stop that fear entirely and not go out.

The anxiety that something would happen was so powerful that Gabby kept her baby inside for the first year of his life. Opting to remain cocooned at home, she was convinced that the outside world posed a threat to life and was subject to

randomness and chance. The lived-space of the home became a refuge within which maternal care could be bestowed while avoiding potential future tragedy.

Other mothers reported being frequently preoccupied that something was wrong with their child and were hypervigilant and alert throughout the day and night. Danielle would sit by her son's side each night, carefully monitoring for the slightest hint of anything untoward:

> *I used to think that he'd stop breathing. I would check on him every night and feel his chest. I had to be the one that slept next to him, and I had to be the one to wake up to him and I had to be the one to go and feed him. I had to check that he was ok or else I didn't think he would be ok …*

She repeatedly checked to see if her baby was okay – maternal responsibility clutching her in a state of heightened arousal. She shouldered full responsibility for her son – no-one could take her place as she sat keeping watch. Helen recalled how she would become deeply concerned over minor issues:

> *Every little thing, like if he had too much posset or a gungy eye, I was really worried about it. I used to check on him so many times in the night.*

She conveyed how nothing could be overlooked or missed, and her constant daily vigilance ensured that nothing was. There was always something to check, something to monitor, something to observe: the enormity of maternal responsibility was vast and never-ending.

At times, when anxieties peaked and could no longer be self-contained, some of the mothers actively sought an expert opinion:

I was down the doctors a lot, I was insistent there was something wrong with him. I look back and think it was just another way the anxiety came out; my anxiety as a mum – about not knowing what I was doing, anxiety about me not getting it right, or how I think it should be – Danielle

We went to baby chiropractor, we went to the health visitor, at six weeks old the health visitor came again, and I said, 'look there's something wrong with her – Emma

Convinced there was something wrong, both mothers sought validation and reassurance from health professionals. Their anxiety passed the point where they could keep watch and reassure themselves.

The mothers were faced with choices and possibilities that could have far-reaching implications, not just now, but further down the line. Unable to foresee the outcome of such decisions placed them in an anxious and uncertain position. This engendered a strong protective instinct and a desire to do everything possible to keep their babies safe:

You always have those worries; you have those responsibilities forever – that is one of the biggest things that changes. It's not just like making a project happen in work – it's this person, forever, is your responsibility and if you don't make the right decisions, it will impact them – Emma

4.4.4. Reflection on lifeworld existentials

In experimenting with different ways of being with their baby, the mothers learn how to be mothers in uncertain terrain. While not knowing what to do or how to do it, they are responsible for caring for their babies and this task is imbued with fretfulness and worry. They are required to navigate choices, make decisions and carry out

unfamiliar tasks while keeping their infants safe from unknown dangers. The lived-space of the home is a familiar place of safety and sanctuary while paradoxically representing a locus of isolation and loneliness. The home space is filled with ambiguity – a place where the mothers grapple with the unfamiliar tasks of caring for a new life. A process of trial and error yields both success and failure. In order to tolerate the uncertainty of this process, the lived-space of the home becomes a focus for cleanliness and order in an attempt to quash the messy out-of-control existence of caring for a new-born.

Danger is perceived to be in the present – something is wrong with the baby, and, in the future, something might happen to the baby. Lived-time stretches endlessly ahead, accompanied by speculation about how the days will be filled and when things will become easier. While living in the present, a clearer future is both imagined and craved, fusing temporality. Attempts to impose a routine to bring order are met with mixed results: uncertainty is briefly alleviated only to be followed by distress when the routine does not go to plan.

The lived-body experience of breastfeeding is perceived as unfamiliar, challenging and mysterious, requiring round-the-clock attention. Feeding several times in 24 hours, the days and nights merge and time takes on an ethereal quality. When breastfeeding is not seamlessly established, the mothers perceive their bodies as faulty and failing and alternative ways of feeding are sought in private, away from the public scrutiny of others. The mothers demonstrate a keen awareness that *what I do today will impact my child's future,* infusing day-to-day choices and possibilities with the weight of responsibility. The mother feels that it is she and she alone who must keep watch over her vulnerable infant, while not having the experience or certainty that she is doing anything correctly.

4.5. Theme three: Being with others

The third superordinate theme explores how the phenomenon of maternal anxiety revealed itself in relation to being with others. Three subordinate themes capture more nuanced aspects of this experience: *comparisons to others*, *what others think* and *the impact of anxiety on relationships*. I introduce each subordinate theme with a choral haiku, drawing the mothers' voices together as one and capturing the essence of the theme. I proceed to explore each subordinate theme in more depth using illustrative verbatim vignettes.

4.5.1. Comparison to others

I had to match up
To be like everyone else
That sense of failure
(Choral haiku)

All the mothers experienced heightened anxiety when comparing themselves to their partners, family members and other mums. The transcripts conveyed this as a challenging experience, full of self-directed questions. The mothers perceived that others were more accomplished at calming, soothing and feeding their babies and they felt deficient in comparison. This concern manifests itself initially in the lived-space of the home, where care for their babies was shared with their partners. Abbie, Emma and Beth all assessed their capabilities unfavourably in comparison to their partners:

> *I wanted to prove that I could actually calm him, I could actually comfort him, I could take care of him just as well as my husband could – and then sometimes I couldn't, and that really hurt* – Beth

When Beth is unable to comfort her baby and hands him over to her husband to soothe, she describes a whirlwind of accompanying emotions:

> *I would hate it, absolutely hate it that I couldn't do it – and I'd just be fuming and raging inside.*

Beth becomes filled with indignation at her husband's apparent ease at calming their child. She responds by becoming competitive, wanting to prove to herself that she could also do it, but then having to acquiesce. Stepping down and handing the baby to her husband felt like she had been entirely defeated. Feeling crushed by her experience, she concluded that being a mum was '*completely unmanageable*'.

When Abbie's baby wouldn't settle, she enlisted her husband's support:

> *After feeding my son wouldn't settle easily on me and he seemed more comfortable on his dad. So, I would always let his dad wind him and he would put him down.*

While this eased one difficulty, it created another: in routinely passing the baby over to her husband to soothe, she became convinced that this task was something she was not capable of doing herself. It was not only the practical tasks of caring for her baby which became a point of comparison – she also noted differences in how she felt as a mother in contrast to her husband's paternal feelings:

> *My husband and I would be bathing him, and my husband would say 'he's so wonderful he's so beautiful he's so amazing' and I'd be thinking, 'I don't feel that'. It highlighted the contrast between us; I should be feeling those things too and I'm struggling to.*

Being in the presence of her partner highlighted Abbie's internal struggle with being-a-mother. She felt guilty at not feeling the same towards her baby as her husband did – more so when these feelings were perceived to be beyond reach. Taken over by escalating thoughts, feelings and physical symptoms of anxiety, Abbie sought more hands-on support from her husband. In doing so, she spent less time with her baby and feared this would negatively impact the mother/baby bonding process – this fuelled her anxiety further.

Emma described the tasks of caring for the baby as equally challenging to both her and her husband. However, when things did not go to plan, she noticed that her husband could compartmentalise and move on, whereas she would spend time ruminating on the incident afterwards. She perceived her husband as a more instinctual parent than herself, observing that he would notice things that she did not:

> *My husband picked up on things intuitively and I'm like, 'Fuck! I'm the mum! I should be picking up on those things!'* – Emma

Emma berated herself if she missed things, prompting a barrage of guilt and self-questioning: '*Why didn't I know… why didn't I catch on fast enough?*'. In comparison to her husband, she felt insufficient.

Comparisons to others also extended into mother and baby groups. Rather than being spaces for companionship and support, they became sources of anxiety in themselves. For Danielle, group settings were perceived as '*competitive and overwhelming*', whereas Gabby worried that groups were places where '*people are going to judge me*'. Other mothers avoided them altogether. Fiona did try and engage with groups but feeding her baby in public became a significant cause of anxiety:

> *I went to a mums group and seeing them all breastfeeding upset me, so I'd keep pumping and pumping. It's just not the same when everyone is breastfeeding and there's me with a breast pump. I felt isolated and I thought, why can't I do what other people can do? Why can't I be included in their club? I had to pump, I had to sterilise, I was doing double the work just to feel included. I felt like a breastfeeding fraud. I just wanted to feel like a good mum, I wanted to be normal like everyone else. I kept thinking I'm not a good mum for my daughter.*

Being in the company of others led to distressing comparisons and a feeling of having to work harder to be in the same league and feel included. In the presence of others, Fiona reports feeling isolated, different, fraudulent and not a good mother. Helen conveyed similar sentiments, disclosing how being with others prompted uneasy feelings: *'It was that sense of failure, why can't I deal with it, everyone else seems to manage*'*.* Critical comparisons featured frequently: the key assumption was that everyone else in the room was coping, succeeding and even thriving at mothering. The mothers saw others possessing the very attributes they themselves wished they had. Identifying themselves as the odd one out, their internal dialogue became negative and self-critical – *I am a bad mum, I am a failure*. At a time when mothers could benefit from solidarity and companionship, they experienced the opposite. The experience of being with others challenges their self-perceptions as mothers and comparisons left them feeling inadequate.

Comparison to others also occurred in the virtual realm on social media. Danielle described how Instagram provided a window into other mothers' lives, illustrated by carefully presented photographic imagery:

> *It was the perfect pregnancy shots, the perfect family photos, the perfect breastfeeding photos – but they weren't telling you about breastfeeding at 4am for six hours running straight. No-one tells you about mastitis, or how physically draining it's going to be. You just think it's going to happen and it's going to work out fine and no-one tells you about tongue tie, or latch problems. You suffer in silence; you feel that you're not normal or not doing it properly. No-one is really talking about how it actually is.*

The meticulously choreographed photographs portrayed a polished, joyful and fulfilling image of motherhood, with no hint of the chaotic, challenging and uncertain reality: a veil of secrecy obscured the messiness of motherhood. For Danielle, such images had a powerful effect: she felt that the reality of her own life was not good enough in comparison to others:

> *I was literally drowning underneath – having to present this perfect image because I felt I had to match up to other people.*

The portrayal of other people's perfect lives prompted Danielle to believe that she should do better and try harder, requiring a herculean effort.

Emma also spoke about Instagram being a source of anxiety:

> *You think 'oh my God, how skinny is that girl after she's had her baby' and everything looks great and someone else on Instagram is doing reading with their toddler and I should be doing that … should I buy that toy …? I got sucked up in it.*

In addition to well-presented breastfeeding imagery, social media presented mothers with post-birth body comparisons, as well as selected insights into what others were doing and buying. Fiona echoed this:

> *What doesn't help is looking at social media, looking at my friends – they'd all be doing arts and crafts with their children. I felt that I wasn't fulfilling the role of a mum. I tried to take myself off social media but then there would be a point where I'd go back on, and I'd get so upset because I'm not that type of mum. I remember thinking, I need to be a perfect mum for my daughter – to be the best I could be.*

The perfection portrayed by snapshots of others' lives presented a world where the grass was always greener and became the catalyst for a tyrannical pursuit of perfection. The widely held belief was that to achieve anything less was not to be a good enough mum.

4.5.2. What others think

Others will judge me
They will think I'm a bad mum
I must hide away
(Choral haiku)

Unfavourable comparisons were also accompanied by concerns about what others would think of their mothering abilities. Some of the mothers responded to this by engaging in secretive behaviour in an attempt not to be judged or ostracised from others. Charlotte avoided disclosing she was bottle-feeding to prevent being seen as different to others, and to avoid attracting attention:

> *I carried her screaming her eyes out just so that I could lie, just so that I didn't have to feed her formula in front of them* – Charlotte

When Helen was bottle-feeding in public, she experienced the uncomfortable perception of being criticised by others. While she did not recall any direct comments per se, it was a strong felt sense:

I do recall feeling quite a lot of judgement when we were out and about because he was so little, and I was feeding him with a bottle – Helen

The act of being out and bottle-feeding in public was the catalyst for significant discomfort. Fiona became tearful and recalled fears of how she might be perceived by others:

What if people think I can't do the basics for my daughter? I thought people will think I'm a bad mum.

For Abbie, there was no tangible triggering incident to her anxiety around others - more a pervasive general sense that she was being evaluated by them:

It felt like I wasn't a good enough mum, I didn't have a good enough relationship with him. It felt like everyone saw that and judged me for it.

Gabby dreaded going to groups – her mind would be racing with worries about what others would think of her:

I'd be thinking, 'people are going to judge me, people are going to look at me.'

In response to worries about being judged by others, some of the mothers made concerted efforts to hide their anxiety from others. Beth put on a façade when around others: '*I didn't let it show that I was feeling so helpless*.' Emma and Fiona both concealed their anxiety from those closest to them:

I never talked to my mum about how I was feeling. I never talked to her about my worries, obviously I talked to her about why the baby is crying, what should we do … but all the other stuff I never really talked to her about and I would normally talk to her about everything – Emma

I wouldn't talk about my anxiety to my family – Fiona

The mothers' worries were concealed and internalised, and those in their social sphere were unaware of the extent to which they were struggling. Without conveying this to others, no support could be offered. In some cases, mothers reported withdrawing from social contact altogether as a means of coping – yet this left them without the social support they needed. While being with others triggered anxiety, being without others meant coping alone and the accompanying responsibility fuelled further anxiety. Charlotte acknowledged that, much as she struggled when around others, solitude was not the answer:

I'm not going to be able to win this by myself …

4.5.3. Impact on relationships

Many arguments
Have you done things properly?
I would shout at him
(Choral haiku)

All the mothers in this study had a planned pregnancy and were in a stable relationship with the father of their child. Every participant reported that maternal anxiety impacted their relationship with their partners in numerous ways. For some, this revealed itself as irritation, tension and conflict in the relationship:

Abbie*: I became very irritable with my husband; I'd snap at him for little things.*

Danielle*: I was aggressive and hostile – we were constantly arguing.*

Emma*: There was a lot of stress and fights between me and my husband – trying to figure things out.*

Fiona*: The anxiety made me more cranky, snappier towards my husband. I'd shout at him more often.*

Gabby*: We'd have a lot of arguments with me not being able to get out of my own head.*

Several mothers noticed that when their anxiety became an impediment to day-to-day functioning, they became more dependent on their partners. For Beth, this was particularly apparent in the early weeks of motherhood:

I would be restless if I knew my husband was going to be away for longer than an hour or two. I was really panicking, constantly calling him and saying, 'please come home'.

Beth recalled that while there was nothing wrong with her child at the time, she needed the reassurance of her husband's presence. The knowledge that there was someone close to hand eased the burden of responsibility. Fiona's experience of embodied anxiety was the catalyst for seeking out more time with her husband:

I felt like I was depending on my husband quite a lot because when I was anxious and having palpitations, I felt I needed to talk to someone, and it was always my husband.

The presence of her husband provided a welcome comfort and a listening ear. Gabby's anxiety became so paralysing at times that her partner's presence was a necessity:

He had to do everything for me, he cooked every meal because it was too overwhelming. I was really overwhelmed to the point where I couldn't live a normal life.

While the company of a partner provided support, it could also be a source of friction. When anxieties focused on the safety of their child, some of the mothers noted how their perceptions of danger differed markedly to that of their partners. This frequently led to mothers feeling isolated with their worries. Charlotte recalled feeling concerned about her baby, yet her husband held a different perspective and pointed out that her baby was healthy and happy, and her worries were unfounded. Instances where partners reassured the mothers that their children were in good health and not in danger did little to quell the mothers' anxieties:

> *My husband kept saying 'look at her, she's happy, she loves you' but deep down I kept thinking I should do more* – Fiona

This fretful way of being was not easy to relinquish. For some couples, their differing perspectives resulted in arguments:

> *There were times when I'd be screaming at him saying, 'there's something wrong with our baby' and he'd say, 'there's not, everything's fine' and I'd say 'why aren't you listening to me?' and we'd have a lot of arguments* – Gabby

Abbie described a similar scenario:

> *I was getting really upset and crying and saying to my husband how worried I was about my son and he said, 'look at him, he's fine, he's happy, but you're the one who's imploding!'*

For Abbie, this incident marked a turning point: her husband had observed and voiced what had been latent inside of her. This interaction triggered a frightening realisation:

> *I'm the one who's not okay actually, and that's what the problem was.*

Abbie had been so focused on her child's wellbeing that she had neglected her own.

Some of the mothers recalled how their relationship was impacted by their impulse to control how the tasks of baby care were carried out. Abbie noticed that she developed a tendency to micromanage her husband and would blame him if things did not go to plan. Beth felt that she projected her insecurities into her husband:

> *If I felt like the baby was not being looked after correctly, I'd say, 'give him to me! I can do it!'*

She described the paradox of being possessive about the care for her baby, while at the same time acknowledging that she struggled to look after the baby herself:

> *It impacted our relationship when I wouldn't give him the chance. I had the feeling that no-one else could do it – only I can do it, but at the same time feeling that I couldn't do it!*

Emma also struggled to relinquish responsibility for tasks related to the care of her baby. She describes a scenario where she was unable to prevent herself from checking that her husband had done things correctly and safely:

> *Have you sterilised the bottles properly? Do you have the bottles set up properly? Have you put the lid on right? And he's like 'just stop! Leave me alone – I know how to do a bottle!' And lots of examples of that. Did you heat up the food properly? Is it warm enough? Have you chopped up the toast correctly? That kind of stuff which would obviously piss anyone off – to be challenged and asked all the time – it definitely affected things.*

The responsibility of having to ensure that all the essential tasks of baby care were properly and safely done meant that Emma struggled to hand over to her husband. Being unable to hand over responsibility took a toll on her relationship.

4.5.4. Reflection on lifeworld existentials

The participants' individual accounts reveal that maternal anxiety had a significant impact on mothers' relationships with their partners. They collectively describe an altered way of being with their partners, characterised by irritations, controlling tendencies and quick-to-blame reactions. The lived-space of the relationship has been inextricably altered by the arrival of a baby. The inner and outer world of the relationship has been changed by parenthood, as has each partner within the relationship. There is a tension of opposites as support from partners is both craved and rejected. To share tasks means to share responsibility for the baby, and the mothers were conflicted about doing this. There is a tangible push and pull motion between dependence and independence, responsibility and letting go. Differing perspectives on dangers and risks became a source of relational tension. Learning how to be together as parents became a joint project, which must be navigated both individually and collectively.

Some of the mothers reported difficulty bonding with their infants, experienced in a corporeal way: the mothers struggled to calm and soothe their infants and perceived their partners as more accomplished at this task. The mothers' lack of confidence was perpetuated by their partners' perceived success at looking after their babies. This contrasting experience brought the lived-other relationship with the baby sharply into focus. The bonding between mother and child was not instantaneous: the mothers struggled to feel what their partners appeared to feel so readily. When mothers were together with their infants, they paradoxically felt alone and feared

judgement from others. What they did not realise at the outset, but which later became clear, was that this is a phase – it is temporary. Learning how to be with the baby is a process that unfolds at its own tempo.

Lived-time is observed by the metamorphosis from couple to parents. At the outset, couples are thrown into new parenting together. As time passes, they gain both individual and joint experiences as parents, with hopes and aspirations for family life. This takes place in an ever-changing landscape as the baby grows up.

Having a baby opens a lived-space to occupy with others outside the lived-space of the home, and the mothers found themselves thrown into a new peer group. From the outside, they occupied the same space as the other members of the baby group, all with infants born within a matter of weeks of one another. Yet their internal world jarred with this new space and otherness – and this discomfort was often concealed. The mothers did not know what to say or how to be, and made uncomfortable comparisons with others, concluding that they were deficient in some way. They were also preoccupied with what other mothers would make of them, fearful of being evaluated as inadequate and not good enough. Learning how to relate to this new cohort was anxiety provoking in itself. The mothers were like strangers looking in on a new and unknown world, weighed down with a pressure to fit in. Many gave up trying to fit in, only compounding their sense of social isolation at a time when support from others would have been very valuable.

4.6. Summary of themes

In working with the data there were three emergent themes, each of which were reflected on from the perspective of four lifeworld existentials to illuminate meaning. The first theme, ‘Being taken over’, was evidenced through the participants’ rich

descriptions of being subsumed by their thoughts, emotions and embodied feelings. This was felt wholistically, in both body and mind, with parity between the experiences. From an embodied perspective, mothers experienced a broad range of bodily feelings: being taken over by restlessness and agitation while at the same time feeling weighed down and immobilised. These opposing embodied feelings were experienced as confusing and destabilising. They were also unpredictable in nature, arising unbidden and unexpectedly, even during moments of rest.

The phenomenon of ‘Being taken over’ was further elucidated from the mothers’ descriptions of their thoughts and emotions. All experienced spiralling, racing thoughts relating to self-efficacy and maternal competency, in addition to harbouring worries that their babies would come to harm. Mothers further reported intense feelings and emotions described as ‘all consuming’, highlighting feelings of rage, fury and overwhelm which were frightening and engulfing. Notably, a quarter of the participants reported intrusive thoughts relating to harming their babies, while all the mothers reported feelings and emotions of an intensity beyond anything they had encountered before.

The second theme, ‘Being with uncertainty’, was revealed through the mothers’ accounts of occupying a new role which was shrouded in doubt. The mothers reported a myriad of unknowns encompassing how to look after their babies and how to be a mother. The ensuing process of trial and error led to feelings of confusion, guilt, frustration and despair. Life as a mother was discovered to be unpredictable, with feelings of accomplishment frustratingly out of reach. Faced with many unknowns, mothers sought certainty by consulting books, websites and medical professionals. Routines and schedules were trialled, yet when these failed to work, their anxieties intensified. Mothers berated themselves for being not good enough and reported being subsumed with negative thoughts. The theme of uncertainty was

further evidenced by mothers expressing a concern that something might happen to their infant. This was felt as a generalised sense of foreboding: the world felt unsafe and threatening. While this threat was invisible and unspecific, for many it became a daily preoccupation, characterised by attendant hypervigilance. As such, the theme ‘Being with uncertainty’ has clear interconnections with ‘Being taken over’.

The final theme, ‘Being with others’ was evidenced in three distinct ways. Mothers experienced feelings of anxiety when comparing themselves to others. Being in the presence of others, either in person or via social media platforms, viscerally highlighted the mothers’ own struggles with being-a-mother. Being amongst others challenged their self-perception as mothers and comparisons with others left them feeling inadequate. Mothers additionally experienced anxiety in relation to concerns about what others might think of them. In response to this, many withdrew from social contact altogether as a means of managing their anxiety. Finally, all the mothers reported that maternal anxiety negatively impacted their relationships with their partners. For some this was evidenced by feelings of anxiety bringing irritation, tension and conflict into their relationship. The theme ‘Being with others’ highlights that at a time when mothers needed support they experienced profound feelings of isolation.

5. Discussion

5.1. Introduction

The aim of this study was to explore mothers' lived experiences of anxiety after birth from an existential phenomenological perspective. Van Manen's (2016) hermeneutic phenomenological approach was employed to reveal meaningful themes within the context of his four lifeworld existentials. In this chapter, each of the themes and associated subthemes introduced in chapter four are considered from an existential perspective, informed by the works of philosophers and practitioners such as Husserl, Kierkegaard, Merleau-Ponty, Heidegger, Sartre, Fuchs, Levinas, Buber, van Deurzen and Spinelli. While these scholars have not written specifically on motherhood, their philosophy underpins the ontological dimensions of maternal anxiety as expressed in the mothers' detailed descriptive accounts. Maternal anxiety is revealed as a complex, all-encompassing, uncertain and isolating experience.

5.2. Theme one: Being taken over

'But I can hardly sit still. I keep fidgeting, crossing one leg and then the other. I feel like I could throw off sparks, or break a window – maybe rearrange all the furniture.'

(Carver, 1995, p. 375)

This first superordinate theme revealed mothers' feelings of being taken over by their anxiety to the point where it consumed their thoughts, feelings, emotions and bodily feelings. As detailed in the findings chapter, this theme comprises two parts: embodied anxiety and thoughts and feelings.

5.2.1. Embodied anxiety

The current phenomenological study places particular importance on the lived-body perspective, taking into consideration not only the physical body and subjective experiences, but also the intermediating flow between body and perception (Merleau-Ponty, 2002). This study noted that a diverse array of bodily phenomena were reported among the study participants, illustrating that the body is central to the experience of anxiety after birth. Husserl (1989) wrote that, 'the body is, in the first place, the medium of all perception' (p. 61) and the findings of the present study suggest that the body is a means of evaluating safety and perceived threat in early motherhood. Feelings of being on edge, restlessness and nervousness are bodily phenomena, which prepare a mother to take action. These feelings coalesce into a state of heightened anticipation: a knock at the door caused Danielle to jump out of her skin and Beth's heartbeat accelerated, signalling that she was ready to fight or 'lash out' to protect her infant. These bodily feelings present a perception of the environment as potentially dangerous – they are signals that it might not be safe out there in the world.

McCarthy (2020) writes that pregnancy and birth are momentous corporeal events, and the current study builds on this, revealing that embodied experience remains particularly heightened after birth. The findings suggest that the embodied nature of maternal anxiety is a response to changed surroundings, new responsibilities and a recognition that the lifeworld looks and is different. While several studies on anxiety have noted the prevalence of bodily phenomena (Olatunji et al., 2007, Mallorquí-Bagué et al., 2016), the absence of studies highlighting the embodied nature of *maternal* anxiety is notable. Within the wider phenomenological field, Fischer's (2000) investigation of anxiety among the general population proposes that the prevalence of bodily feelings can be considered a form of body dysfunction. He

noted that corporeal feelings of anxiety manifest themselves as a sense of the body lacking a feeling of solidity. In extremis, individuals can experience that something is 'radically wrong with one's body' (Fischer, 2000, p. 161). The current study into maternal anxiety supports this association, noting that the mothers experienced corporeal disruption: a sense of being overwhelmed and hijacked by bodily feelings. Aho (2020) considers bodily functioning during periods of anxiety to be a temporal disturbance experienced as a feeling of 'speeding up or acceleration' (p. 262). This matches the findings of the current study, where mothers reported the body as in a state of turmoil: the heartbeat quickens and breathing accelerates. Mothers universally reported feelings of restlessness and agitation. Danielle described being on edge and primed to respond: '*Everything made me jump … like I was walking on a tightrope*.' She depicted being delicately balanced yet teetering on the brink of falling, thus highlighting the embodied precariousness of anxiety. These findings denote a breakdown in physiological statis, replaced by intense hypervigilance. The mother becomes estranged from her everyday mode of being-in-the world into something which Fuchs (2003) terms 'desynchronization' – a feeling of displacement. In the throes of temporal disturbance, the once quiescent physiological functioning becomes uncomfortably foregrounded. The current study reveals that, in extremis, bodily displacement was experienced as a sense of complete corporeal detachment – an out-of-body dissociative experience. This resonates with research by Coates et al. (2014), which identified out-of-body feelings as a sense of detachment and disconnection from the infant. Research by Arnold and Pinkston (2014) suggests that while dissociative phenomena provide short-term protection from feelings in the present moment, they act as a barrier to being with the uncertainty of the present. In the current study one possible explanation is that if a dissociative experience provides a temporal release from being in the present, it

facilitates a brief respite from maternal responsibility. While this dissociative example was the exception amongst the participants, the present study demonstrates that embodied feelings were universally experienced as an overwhelming sense of being out of control.

In day-to-day life, the body can be taken for granted and its presence can fade into the background and pass unnoticed as we go about our lives – its inconspicuousness symbolises a life in balance. For phenomenologists, the body is a primary means of understanding phenomena as lived. It denotes our being-in-the-world, as Heidegger (1979) wrote: 'We do not have a body, rather we are bodily' (p. 99). A shifting awareness of body conspicuousness constitutes a means of 'finding oneself in the world' (Ratcliffe, 2008, p. 115), which Heidegger referred to as 'befindlichkeit'. For Heidegger, how we find ourselves in the world is linked to our thrownness – we are required to live in the situations in which we find ourselves. For the mothers in this study, normal physical functioning was experienced as significantly disrupted: participants reported being both ready to run and weighed down. Paradoxically, anxiety both mobilises and inhibits – one is primed to flee but unable to move. This embodied response was a means of communication – an implicit bodily understanding of the uncertainty of motherhood as lived in the moment. The lived-body phenomena also present mothers with a glimpse into the finitude of human existence as experienced in and through the body. Mothers experience an embodied tension between natality and mortality: responsibility for a baby holds at its very core an embodied awakening of being-towards-death (Heidegger, 1996) and the findings of the current study emphasise how bodily perception communicates this. Embodied feelings perceive and process the environment to be a threat, and the life of mother and child to be at risk – as Gabby

articulated, '*we were going to die if we went outside.*' In essence, embodied anxiety is rooted in survival – a first line of defence against threat.

The notion of embodied perception is central to the philosophy of Merleau-Ponty (2002), who wrote that, 'my body is the fabric into which all objects are woven, and it is, at least in relation to the perceived world, the general instrument of my comprehension' (p. 273). Thus, in experiences of anxiety after birth, the body is considered to be part of a whole – a 'mind–body', where body and mind are interrelated and entwined. The body is how a mother experiences anxiety and the means through which she understands and interprets her environment. An embodied consideration of maternal anxiety consequently broadens our understanding beyond that which can be expressed or conveyed by language and thoughts (Todres, 2007, p. 178). The current study therefore presents an alternative perspective on maternal anxiety, differing from the existing literature in the field. An existential consideration of the theme 'being taken over' rejects a Cartesian approach in favour of an empirical one, giving consideration to the meaning of anxiety as experienced and lived.

5.2.2. Thoughts and feelings

The findings demonstrate that the lived-body experience of maternal anxiety was accompanied by racing thoughts spiralling out of control. The mothers' personal accounts of their thoughts and feelings are rich with descriptions of movement, mirroring the physiological depiction of acceleration highlighted in the previous section. The study revealed that the mothers' worries centred on either motherhood or their infants. Worries about motherhood focused on themes of self-efficacy and lack of competence. Mothers universally reported thoughts of self-blame – '*everything is my fault*' – accompanied by widespread ruminations about being a bad

mum or failing at motherhood. These findings resonate with other studies: Law et al. (2021) identified that the second most common thought in early motherhood was '*I am a bad mother*', while others have identified that mothers evaluate themselves in relation to beliefs about good or bad mothering (Choi et al., 2005; Rotkirch & Janhunen, 2010; Kauppi et al., 2012). Further, Philips et al. (2009) highlighted that over half of mothers worried about their performance as mothers, while approximately one fifth harboured significant concerns about the practical issues of day-to-day baby care. This research resonates with the present study in which these worries were experienced universally.

In addition to concerns about lack of competency and 'being a bad mother', the participants in the current study also reported preoccupying thoughts about their babies coming to harm. This was connected to fears of being incompetent, as illustrated in Fiona's account:

> *Why is she crying …? Is she in pain …?*
>
> *Then it comes back to me again. I'm not a good mum, I'm not providing for you, am I harming you? Am I physically harming you? Am I giving you enough love? It's all the blame on me.*

Fiona's chain of thought begins with wondering why her baby was crying, and rapidly escalates to worries about unintentionally harming her baby through her inexperience. A crying infant is a call to respond – a response which is instinctual and cannot be ignored. For Levinas (1979), this is the call of the other: a demand from another that lays claim to us. In the context of this study, the call of the other harnesses maternal responsibility. The very presence of the baby is a primary order to respond. For Levinas (1979), this call to order is not a symmetrical relationship of reciprocity – it is one way: the baby needs something from the mother. In the context

of the current study, I suggest that the call to respond manifests itself more widely than a response to a baby's crying – it manifests itself in being with the baby in its entirety. Even when sleeping, a mother is on the edge of wakefulness – her continual vigilance is ever-present. In accordance with this, the baby is always in mind. Thus, when mothers reported not being able to 'switch off' their thoughts and feelings, this too was a manifestation of the call to respond. For Levinas (1979), the response to the other falls short of the required needs – in these terms, the mother experiences guilt about not being enough. This Levinasian notion was prominent in the findings of the present study – mothers felt themselves to be lacking, not good enough, not motherly enough and not responsive enough. In the eyes of Levinas (1979), the other imposes impossible demands.

In keeping with these ideas, the findings of this study illustrate that mothers strove to be one step ahead, pre-empting difficulties and trying to be prepared for every eventuality. This cognitive agility was paired with bodily restlessness, illustrating the interconnection between body and mind. With the baby's safety considered to be paramount, there was little time to pause and enjoy being a mother – instead, there was a relentless compulsion to be ready to respond to the baby's needs as they arose. The mothers felt personally accountable for every decision and choice, and, in worrying about the baby coming to harm, were aware of the fragility of the life in their hands. Some of the participants worried about harm from external threats and went to great lengths to ensure that their child would not be exposed to danger. Worries for the baby's safety are consistent with other studies in the field: a study by Philips et al. (2014) highlighted that 65% of the research participants reported uncontrollable worry about the safety, health and wellbeing of their infants. Hall and Witkowski (2006) revealed that 62% of mothers experienced thoughts about their baby dying,

while Highet et al. (2014), highlighted that mothers' excessive worries prompted overprotective actions and feelings of panic.

What was notable in the current study was that a quarter of the participants reported experiencing intrusive thoughts relating to purposefully harming their baby. Participants reported having unwanted thoughts of suffocating, throwing and drowning their babies and these thoughts were experienced as abhorrent and distressing. Lawrence et al. (2017) and Collardeau et al. (2019) revealed that over half of parents of infants in the general population experienced this phenomenon, indicating that it is a common experience. For the mothers in the current study, it was felt to be an abnormal, shameful and isolating experience. Research demonstrates that there is no connection between having intrusive thoughts and acting on them (Barr & Beck, 2008; Collardeau et al., 2019), yet the participants in the current study were concerned that their intrusive thoughts were an indication that something was profoundly wrong with them. In addition, they struggled to reveal these experiences to others for fear that their babies would be taken away from them. This places the mother in an intolerable situation of being trapped with her anxious thoughts, frightened about what this means about her as a mother and unable to share them.

Care as worry

Van Manen (2002) wrote that the notion of care in parenthood consists of fretting and worrying about one's children, suggesting that, while a substantial body of literature classifies mothers' worries as disordered, this runs the risk of degrading a 'profoundly human phenomenon' (p. 262). My research concurs with Van Manen's statement that worry is a key factor in maternal attentiveness. Rumination keeps mothers in close contact with their babies, becoming the 'spiritual glue' (Van Manen, 2002, p. 264) that fastens them together. The notion of care as worry is a human

response to being in an uncertain situation and a natural response to vulnerability. If care manifesting itself as worry is perceived as an illness, then it is an incurable one as motherhood, uncertainty and care go hand in hand. The mothers' runaway thoughts and anxious preoccupations were an indicator of their concern – a phenomenon necessary to ensure the survival of the child. Viewed in this way, anxiety after birth is the price mothers pay for loving their children. This viewpoint situates worries about their children as not just understandable, but essential. Van Manen (2002) attests that, the more one cares, the more one worries. Thus, I suggest that motherhood is a double bind – a mother can never be free of worry because 'care is worry' (Van Manen, 2002, p. 270).

Although words were at times not enough to do justice to the felt experience of anxiety, there were hints of meaning in their expression. Emma articulated her anxiety as '*the mental load*': it was felt as heavy, weighty and oppressive. For others, there was an omnipresent felt sense that motherhood was ill-fated, as Abbie expressed: '*everything was doomed.'* These feelings were sensed and difficult to depict in words. In the current study, the wholistic experience of maternal anxiety is revealed to be complex, something to which cognitions cannot adequately do justice. This is expressed by Heidegger (2010) in *Being and Time:* 'The possibilities of disclosure belonging to cognition fall far short of the primordial disclosure of moods' (p. 131). The mood of anxiety discloses more than can be understood or put into words.

The mood of anxiety

Contemporary culture regards moods as transitory inner feelings that are a background feature to our lives. For Heidegger (2010), to be in a certain mood presents us with a way of seeing and experiencing the world differently, affecting our

engagement with it. In contrast, emotions are directed towards something – for example, when we are angry, we are angry about something or towards someone. For Heidegger (2010), moods are distinctly different in that they are objectless. This distinguishes anxiety from fear: we are fearful about something, whereas anxiety is indefinite and unspecified. Heidegger (2010) positions anxiety as a mood – as a subjective response to our being-in-the-world. Echoing mothers' embodied perceptions, moods also indicate 'befindlichkeit' or 'how we find ourselves in the world'. In tandem with embodied feelings, moods are out of our control, coming and going unbidden. The German word for mood is 'stimmung', which translates as 'tuning'. Thus, a mood can be considered as a way of tuning in to, or becoming attuned to, the world around us.

If the mood of anxiety is considered to be indefinite and impossible to flee from (Heidegger, 2010), then it is paradoxical that anxiety primes the body to run in what is known classically as a fight/flight response. This was powerfully illustrated via the mothers' embodied responses, as outlined in the previous section. Whalen (2015) noted that, because we are unable to flee from anxiety, 'it is oppressive' (p. 30) and the mothers in this study illustrated that they were overcome by the unease this presented. Heidegger (2010) wrote that, 'Thrownness into death reveals itself to it more primordially and penetratingly in the attunement of anxiety' (p. 241). This is one of his central concepts. Being-towards-death reveals the nothingness which confronts us with our existence – the possibility of us ceasing to be. For a mother, this is a double confrontation – a mother confronts not only the finitude of her own existence but also that of the baby for whom she is responsible. For mothers, the mood of anxiety discloses the meaning and significance that being a mother carries. Once a baby is born, it is 'a being-towards-death', vulnerable and dependent on its mother for survival. After birth, the mood of anxiety is a response to the reality of this

profound responsibility. The mother is part of a world that feels different – part of an unknown maternal landscape in which it is her task to keep the baby alive (Stern & Bruschweiler-Stern, 1998). This involves learning the everyday tasks of baby care, which are accompanied by a pervasive felt sense that something might happen as she goes about this task. A mother is taken over by the mood of anxiety experienced as a primordial sense of non-specific danger or threat. Threat is perceived but is unknown and invisible, manifesting itself as a feeling that arises out of nowhere. As Fiona expressed, the mood of anxiety '*would just come on – I'd be watching TV and I'd start getting panicky*'. This expression illustrates that anxiety is not directed specifically towards a person, event or thing – it is objectless. In this sense, it cannot be grasped at, fixed or got rid of – it is a mother's attunement to being in an uncertain world. In becoming a mother, a woman undergoes a transformative process of being before herself (Heidegger, 2010), attuned to the mood of anxiety accompanying the juxtaposition of natality and mortality.

5.2.3. Summary

While the theme 'Being taken over' is presented in two parts, both are interconnected as part of the same experience. To separate mind from body would imply a Cartesian dissection of this experience, whereas a phenomenological perspective views being anxious in its wholistic sense. Care as worry is experienced in body and mind – the call of the other is an embodied response to keeping the baby in mind and the 'mood of anxiety' is a mind–body state of being-in-the-world as a mother. The theme 'Being taken over' therefore makes an important distinction: the mothers' embodied experiences of being taken over by anxiety are not only as challenging as their psychological counterparts, but they are also intimately intertwined. This has important implications for future understanding and management of the phenomenon, which will be addressed in the next chapter.

5.3. Theme two: Being with uncertainty

'I feel myself so unknowing, so doubtful about many things.'

(Gaskell, 1923, p. 20)

This study set out to explore women's experiences of anxiety after birth and the findings suggest that uncertainty is a prominent feature of maternal anxiety. Though it is a hundred years since Elizabeth Gaskell's (1923) diaries were published, her sentiments echo the universal experiences of the participants in the present study.

5.3.1. What do you do with a baby?

This study demonstrates that one of the key features of the mothers' experiences of anxiety was not knowing what to do. Crossing the threshold into motherhood meant being thrown into uncertain territory, manifesting itself in doubts and hesitancies. The mothers were aware of the rudiments and duties of baby care, but they collectively expressed that these tasks and skills did not come naturally to them. When motherhood arrived, they did not know how to do it.

The current study revealed that being in a position of not knowing how to look after a baby situated the mothers within an existentially insecure space: their previously familiar life was in the past, and their future as a mother was in the process of unfolding. In transitioning from one state to the next, they occupied what was conveyed as an 'in-betweenness-of-being' – a foreign and unfamiliar landscape. The interconnectedness between maternal transition, uncertainty and not knowing has been identified in previous literature. Barclay et al. (1997) revealed that uncertainty is a common hallmark in the transition to motherhood. This resonates with research by Arnold-Baker and Donaghy (2005), who wrote that 'procreation means facing the inescapable evidence of thrownness, the impossibility of controlling one's environment or what the future may bring' (p. 35). This correlates with the present

study, where mothers described feeling out of control in response to the uncertainty of their situations. As Beth recalled: '*My stress levels were just straight out the door with that feeling of helplessness and inability to control or contain the situation.*' This finding is further supported by others (Nelson, 2003; Darvil et al., 2008). The current study confirms a clear interconnection between not knowing, uncertainty and maternal anxiety.

For the mothers in the present study, being unsure of what the future would bring was experienced as profoundly destabilising. They were displaced from a life which was previously predictable and familiar into one which was unpredictable, unfamiliar and unknown. Heidegger (2010) termed this state of ontological insecurity as 'Unheimlich' (translated as 'uncanny' and a sense of 'not-being-at-home'). As mothers grappled with working out how to look after a new-born, they occupied a temporal space between one world and another. With their previous everydayness dissolved, they were confronted with their existential givens: to embark on life with a new-born meant to confront uncertainty head on. From a Heideggerian perspective the phenomenon of 'not-being-at-home' has the potential to be an enlightening experience, yet for a mother this uncanniness-of-being occurs while confronted with maternal responsibility. It is within the immediacy of '*how do I look after a baby*' where a mother is first confronted with uncanniness: she has become a mother and she holds a baby in her arms who requires food, comfort and sleep. These needs are communicated by her baby crying and the mother is required to respond – but the question is how? In the early phase of motherhood this is all unknown.

Freedom, choice and responsibility

For the mothers in this study, caring for a new baby required making decisions without prior knowledge or experience to draw on. The mothers had to embark upon

an uncertain process of learning by trial and error without the certainty that they were doing things right. This process involved making choices, and the freedom to choose induced anxiety. Kierkegaard (2014) referred to this phenomenon as angst, which he described as the ‘dizziness of freedom’. This represents a pivotal moment, a time of recognising the importance and significance of decisions and choices. Being newly responsible for a vulnerable baby requires a multitude of decisions: to move forward, every mother has to embrace freedom, choice and responsibility. With no obvious clarity about doing things the right way, the tasks must be learned on-the-go, putting mothers in a precarious position.

An important finding in this study was that many mothers expressed their anxiety in relation to not knowing how to feed their babies. They were universally aware of the dominant cultural narrative that ‘breast is best’, which manifested itself as an intense desire to get breastfeeding successfully established. While many undertook introductory breastfeeding workshops when pregnant, the theoretical approach to feeding contrasted sharply with the reality. Many struggled to breastfeed and grappling with different holds and positions increased their feelings of anxiety. Aware that feeding was fundamentally essential for the baby’s survival, the difficulties presented the mothers with an existential crisis: the need to get it right became an urgency. If a baby was losing weight, the prospect of them being admitted to hospital or even being taken away from the mother was real and terrifying. In such moments of crisis, difficult choices had to be made. Continuing to exclusively breastfeed meant taking on the sole responsibility for the baby’s survival. For some this was accompanied by a sense of being up against time, having to get breastfeeding established before the window of opportunity closed. Some of the mothers weighed up alternative options: abandon breastfeeding altogether, attempt to pump

breastmilk, switch to formula or try a mixed-feeding approach. These options had to be contemplated from a place of not knowing.

Such challenging choices in the face of uncertainty correlated with the findings of research carried out by Simmons (2020), who identified the existential tensions inherent in maternal decision-making. Simmons observed that making decisions increased mothers' feelings of apprehension and responsibility while decreasing mothers' sense of certainty and control over outcomes. In the current study, this was exacerbated further: if mothers decided to seek an alternative to breastfeeding, they commonly experienced profound feelings of guilt and shame. This had a weighty impact on the mothers' emotional wellbeing: they berated themselves for failing and expressed feelings of inadequacy and deficiency. These findings correlate with McCarthy's (2020) observation that breastfeeding experiences can define self-perceptions of good mothering. For the mothers in the current study, failing at the tasks of motherhood was perceived as failing at motherhood itself, and this presented a profound ontological crisis.

From an existential perspective, there is always an element of uncertainty and some degree of regret in making choices (Sartre, 2003). Every choice made confronts us with what might have been – in making a choice, an alternative option has been lost. For the mothers in this study, making choices without prior experience brought risk. They were keenly aware that the new life in front of them was fragile and the stakes were high. From a Kierkegaardian perspective, there are no correct decisions: 'There are two possible situations – one can either do this or do that. My honest opinion and my friendly advice is this: do it or do not do it – you will regret both' (Kierkegaard, 1987, p. 169). However, when it came to breastfeeding, the mothers held a universal perception that there was no choice – breastfeeding was perceived to be an obligation and the only correct option. A Sartrean perspective would attest that, in

discounting alternative possibilities, the mothers had in fact made a choice, and to deny that other choices exist would be to act in bad faith. Thoughts around breastfeeding were additionally intertwined with the temporal dimension of motherhood: time was passing, milestones would come and go and the clock could not turn back. Breastfeeding offered only a limited amount of time to get it right and this heightened urgency manifested itself as feelings of anxiety.

Given the ambiguity of learning how to be a mother, the mothers in this study searched for some sign that they were getting mothering right. While it takes time for a baby to begin to interact with others by smiling and making eye contact, some of the mothers conveyed that having a contented happy baby would have been a definite sign of getting things right. This affirmation proved frustratingly elusive, leaving the mothers feeling insecure and questioning their competency. This finding ties in with evidence from previous studies (Lundgren & Berg, 2007; Wilkins, 2006), which revealed that mothers wanted to be affirmed as competent mothers and were keen to receive encouragement that they were doing things correctly. The current findings are additionally in accord with those of Persson et al. (2011), who found the absence of affirmation and encouragement from others left mothers feeling insecure and uncertain.

Lost in the transition to motherhood and not knowing what to do with a new baby left the mothers in this study dwelling on their inadequacies rather than their accomplishments. They were universally quick to criticise themselves, something which Beth described as an '*insufficient motherly feeling*'. The tendency for mothers to dwell on their perceived inadequacies was a phenomenon recognised by Stadlen (2011). She noted that as it takes time to get to know a baby, mothers may often fail to notice that they are making progress. She also observed that reflection on the early phase of motherhood generally happens when it has passed. The present

study supports these notions, revealing that maternal knowledge must be acquired gradually with experience. In essence, motherhood must be lived in a forward direction and understood backwards (Kierkegaard, 1987). The findings reveal that it is a mother's responsibility to keep going through the mire of uncertainty to reach a point of understanding. Being-in-the-world as a mother means dealing with motherhood as it presents itself day by day. Without the certainty of knowing if a point of understanding will ever be reached, it is intensely anxiety inducing.

Whilst the phenomenon of not knowing was experienced as destabilising and anxiety provoking, from an existential perspective it is a position which holds potential value. In being with uncertainty and experiencing the dizziness of freedom, a mother has an opportunity to find her own unique way of mothering. New possibilities and existential freedom become attainable in the presence of anxiety – it is anxiety that indicates that we are engaged in something new and open to possibilities. Hollis (2001) writes that denying this opportunity risks the despair of depression, while Stadlen (2011) attests that starting motherhood from a position of humility ultimately leads to learning and adventure. From the perspective of the current study, both standpoints hold value. Whilst occupying a position of not knowing was deeply uncomfortable for the mothers, it served to facilitate a profound developmental shift. I posit that grappling with the unknown and being with anxiety is an essential and beneficial process in discovering how to be a mother. This goes against the cultural narrative that anxiety is a disorder and must be controlled, diminished or conquered. Counter to this, I assert that maternal anxiety must be acknowledged, listened to and welcomed. Maternal anxiety carries a message: it has the potential to reveal what is important and precious to each mother. It enables a mother to situate herself within the maternal landscape and work out what is right for her and her baby – as such it is a fundamental part of embarking on the process of discovering who she is as a

mother. This will involve making some difficult decisions and mistakes along the way, but ultimately these will add to the mother's understanding of herself as a mother.

5.3.2. Seeking certainty

As outlined previously, existential freedom and choice bring responsibility, and, with a new life to care for, the mothers in this study universally experienced a sense of urgency in getting it right. In response to the unknowns and potential risks, they felt compelled to seek certainty (Dewey, 1929). Books, websites and experts were consulted to throw light on the unknowns of how to look after a baby. Prior studies have noted the importance of this phenomenon: Arnold-Baker (2015) observed that mothers turned to books to control and alleviate their anxiety, while Apple (2006) suggested that part of the task of motherhood is to gather, analyse and evaluate expert advice. The findings of the current study are consistent with these, perhaps suggesting that turning outwards to seek guidance and advice is part of the cultural rite of passage into motherhood. Over time, an entire industry proffering advice has emerged out of a societal intolerance of uncertainty. At the time of writing (2022), a vast array of approaches to mothering are now documented both online and on bookshelves. A Google search for books on the topic of '*caring for a baby*' yielded over 2,000 results with themes ranging from sleep and feeding approaches to emergency first aid. In addition to print literature there are numerous podcasts and websites tendering advice and guidance to steer mothers through the mystery of motherhood. The current study revealed that mothers actively sought sources of information to make informed choices and decisions to alleviate their anxiety. These findings correlate with research by Cucchiara and Steinbugler (2021), which revealed that new mothers were resolutely dedicated to obtaining and implementing expert knowledge. Their study confirmed that mothers wanted to be informed about what to do and how to do it, so that their mothering choices were grounded in

expertise. These findings tally with the findings of the current study, where mothers devoted a lot of time to researching and compiling strategies to set up feeding and sleep schedules. However, it was also discovered that consulting external sources on these matters did not diminish the mothers' anxieties but elevated them: with so much advice to choose from, mothers became anxious about making the right decisions. In the current study it was discovered that expert sources provided differing and sometimes opposing advice. While one book might advocate feeding by routine, another might promote feeding on demand – mothers must try and fathom which approach is best. Feeling overwhelmed by choice plunged the mothers back into a place of uncertainty. This phenomenon was recognised by Cucchiara and Steinbugler (2021), who termed it the 'expertise paradox'. On one hand professional literature equips a mother with knowledge, but, on the other, it brings feelings of anxiety and failure if things do not work out as expected. The mothers in the current study craved simple and straightforward answers but were thwarted when their attempts to implement the recommended advice were unsuccessful.

From an existential perspective, a reliance on books and experts for guidance can be viewed as a means of renouncing existential freedom. Having a baby offers an opportunity to embrace the uniqueness and novelty of motherhood and creatively make it one's own. There is an ontological freedom to choose how to be a mother and to carve one's own individual path – one which is rich with possibilities. Yet as the findings of this study have highlighted, this freedom is anxiety provoking. Existential anxiety is experienced when we are confronted with our freedom and the awareness that we are responsible for our future (Sartre, 2003). When a woman becomes a mother, she recognises that responsibility is not just for her self, but also for her baby. Freedom, choice and responsibility awaken mothers to an authentic mode of existence, bringing the basic tenets of existence into focus. This study

contextualises the quest for certainty as a proactive attempt to quash existential anxiety – to seek out the familiar and tried and tested approaches, rather than dwell with ambiguity. This finding agrees with the findings of other studies: Arnold-Baker (2020) noted that, faced with uncertainty, mothers must ultimately confront a future that is unpredictable and uncontrollable.

In addition to fleeing from freedom, the current study revealed the mothers' thrownness into a contemporary mothering culture, which demanded proficiency and expertise. The mothers were universally certain that there was a correct and proper way of mothering. Scholars have observed that, over the past 50 years, mothering has changed and evolved to become a more intensive task (Nelson, 2010; Hays, 1996), accompanied by a sense that there is always more one could be doing. In the current study this was in evidence and eloquently voiced by Abbie, who explained that she often felt that, '*I wasn't doing enough, I wasn't caring enough.*' Hays (1996) revealed that mothers' internalised self-critical voices drove them to consult experts to discover what else they ought to be doing. Hays (1996) termed this phenomenon 'intensive mothering', an ideological process which was 'child-centred, expert-guided, emotionally absorbing, labor intensive and financially expensive' (Hays, 1996, p. 8). She suggested that this approach has become widely culturally recognised as the 'proper way' to raise a child. Later research by Faircloth (2014) supported this suggestion, indicating that society had become focused on an 'infant determinism paradigm' (p. 49). Parallels are drawn between experiences in infancy and lifelong consequences, giving rise to an ever-increased importance of chosen parenting approaches in the early years. The findings of the current study demonstrate that mothers were cognisant of this. As Emma stated, '*the responsibility of your decisions has a positive or negative impact on another human being.*' It can thus be suggested that this weight of responsibility, coupled with high aspirations for

a child's future, results in 'correct parenting' becoming an urgent preoccupation. These results confirm the association between culturally idealised mothering standards and self-critical assessment of mothering efficacy. Thus, when expert guidance did not bring about the expected results, the mothers in the current study reached exasperation. As Emma voiced, '*I was putting in all the effort doing the reading, looking at blogs, trying everything and then failing … and wondering why … what did I do wrong?*' The mothers universally spoke of deep feelings of failure and inadequacy at not 'getting it right'. They worked hard to try and understand what they were meant to do and, when things still did not go to plan, they blamed themselves. This finding complements Blum's (2007) research, which identified a phenomenon she termed the 'mother-valor/mother-blame binary' (p. 202). She suggested that Western culture held mothers accountable for child outcomes and consequently responsible for the outcomes of society as a whole. Blume observed that the task of being a good mother required ongoing selfless dedication to child rearing, with mothers required to constantly scrutinise their parenting approach out of fear of being blamed and judged. The current study supports the evidence from Blume's observations: societal pressure coerces mothers into being a certain way, following cultural expectations and leaning on expert advice so as not to fail at good mothering. This dynamic is further complicated by encountering expert advice portraying differing and often opposing opinions. Faircloth (2014) discovered that, when mothers felt compelled to choose one mothering approach over another, they ran the risk of becoming socially tribalised.

Who am I?

One unanticipated finding of this study was that, while mothers grappled to work out how to care for a baby, they simultaneously turned their focus inwards towards themselves, seeking to answer the question, '*What kind of mother am I?*' In reflecting

on their choices and responsibilities, many mothers evaluated themselves as deficient and were burdened with feelings of guilt. As Abbie expressed, '*There was a feeling of … not feeling or behaving in a way that was healthy, or appropriate, or how a mother ought to be …*' Being immersed in the uncertainty of motherhood and finding that books and experts did not provide certainty, a mother's identity as a mother was itself uncertain. This finding was also reported by Donaghy (2020), whose research into postnatal depression revealed an indisputable association between identity perception and emotional wellbeing. She suggested that a clear sense of self is linked to safety, security, meaning and purpose in life. Donaghy (2020) expands to identify the transition to new motherhood as an experience which impacts every part of a woman's existence – manifesting itself as a deconstruction of the self. This correlates strongly with the findings of the current study, where seeking certainty in how 'to do' the tasks of motherhood is also an attempt to work out how 'to be' a mother. In the current study, this transitional experience was characterised by guilt and anxiety related to not knowing.

Existentially, the notion of a mother as a fixed entity is an impossibility: human development is in a constant state of flow – a process of changing and continually becoming. Motherhood epitomises this – it is a temporal dimension: an ever-evolving process. As the child grows and changes so does the mother. It is therefore never possible to grasp or define being-a-mother in its completeness. As Daniella perceptively articulated, being-a-mother takes place on '*shifting sands*' – just as you think you have achieved a position of homeostasis and know what to do and how to be, everything alters, predictability is shattered, and one returns again to a place of unknowing.

In the face of uncertainty and without much-needed affirmation of doing mothering right, I suggest that the mothers in this study were plunged into a crisis of being. In

their self-appraised failure, they succumbed to existential guilt (Tillich, 2008), ultimately questioning, *what have I made of myself as a mother?* To fulfil their destiny as mothers, they felt obliged to 'conquer' mothering – to be skilled at it, to enjoy it and to thrive on it. In the absence of this idealised achievement, they experienced feelings of dejection and desperation. This both echoes and complements Donaghy's (2020) research and reveals the pressure mothers are under to fulfil their potential. Donaghy identified this phenomenon as 'crisis-making', which in relation to the current research suggests an overlap in the phenomenology of postnatal anxiety and postnatal depression. This shared existential experience could be an important area for future research in the field.

5.3.3. The 'what ifs' …?

The mothers in this study reported being preoccupied with thoughts that harm would come to their baby. For some, their anxiety manifested itself as a generalised sense of foreboding, while others harboured specific worries: their baby would stop breathing while sleeping, the outside world was unsafe or the baby was seriously ill. The mothers responded to these worries in various ways, such as checking the baby, keeping the baby at home and making repeated visits to GPs and other health professionals to seek reassurance. While to a new mother these experiences are novel, phenomena such as these are not unusual and have been noted by other researchers in the field.

Fairbrother and Woody (2008) revealed that thoughts of harm befalling the baby were universal amongst participants. They identified that mothers worried about a variety of scenarios including accidents, abduction, harm by another person, animal attacks and serious illness. Abramowitz et al. (2003) set out that, in response to concerns about accidental harm coming to the infant, mothers engaged in a variety

of mitigating strategies. These included repeated checking, seeking social support and avoidance of specific activities. The current study resonates with these findings – mothers responded by exhibiting an attendant hypervigilance: checking, scanning and monitoring for signs of anything untoward. Even when everything was going well and the baby was thriving, the mothers struggled to switch off their heightened state. These feelings persisted when relatives or friends came to visit, with some of the mothers reluctant to allow visitors to pick up or touch their baby. This phenomenon was also observed by Stern and Bruschweiler-Stern (1998), who suggested that it was a natural protective instinct – a process of evaluating who is safe to touch the baby and who poses a potential threat.

Mainstream literature considers women's postnatal experiences as diagnosable disorders (Matthey et al., 2003; Reck et al., 2008), with Phillips et al. (2009) proposing the distinction of a specific 'maternally focused worry disorder' (p. 415) distinguishable from existing anxiety disorders. The current research takes a different perspective: viewed within an existential context, a mother's intensified concern for her infant's survival is not disordered, but an essential part of motherhood. The behavioural characteristics of checking, attendant hypervigilance, scanning for danger and being unwilling to let anyone else hold, touch or feed the baby are part of keeping the baby safe to ward off threat. This view is supported by Stern and Bruschweiler-Stern (1998), who wrote that the 'task of motherhood is to keep your baby alive' (p. 93) and added that being vigilant to dangers creates a safety net around the baby. The current study posits that becoming a mother rouses an awareness of being part of the cycle of life, which includes death. The infant is vulnerable and depends solely on its caregivers to sustain its life. Through the process of giving birth a mother becomes awakened to this fact – she possesses an embodied awareness of the tension between natality and mortality (Adams, 2018).

The mothers in this study convey an experience of being at the very heart of this tension, a means of being-in-the-world, which was unequivocally necessary to sustain life. Thus, the transition to motherhood marks a shift from an inauthentic forgetfulness-of-being towards glimpses of an authentic mode of being-towards-death (Heidegger, 2010). The uncertainty of new motherhood and the fragility of the new-born puts mothers in direct contact with the givens of existence. Death is the ultimate and most challenging aspect of our existence – it constitutes a 'primordial source of anxiety' (Yalom, 1980, p. 29). In being aware of the finitude of existence, Kierkegaard (2014) posited that we experience awe and dread, which he describes as the battle between being and non-being. While this may come to the fore during times of serious illness (Breitbard, 2017), it also surfaces after the birth of a child, when threats, danger and death are potent. Pre-motherhood, momentary angst or death anxiety is managed by distraction – absorbing ourselves in idle talk or the preoccupations of the 'the They' (Heidegger, 2010). However, a mother must take care of her child in the shadow of existential threat and undertake the essential protective tasks which ensure the survival of her child. This places maternal anxiety in a different light. Rather than positioning the phenomenon as disordered, it can be considered fundamental – an essential component of being human.

These findings complement contemporary research undertaken by others: Prinds et al. (2013) and Garland (2020) have highlighted that after birth a mother becomes existentially awakened to the givens of life and to her personal responsibility. Garland (2020) writes that a mother's hypervigilance and desire to be the only one to take care of the infant place her in an essential present-day mode of being where she attends and responds to her baby's needs in the here and now. Arnold-Baker's (2020) notes that the vulnerability of the new-born infant highlights 'the mother's existential responsibility both to herself and to her baby' (p. 22). For the most part,

the mothers in the current study did not talk of worries regarding their own mortality, but they did express sombre concerns over the perceived fragility of their mental health, and these findings are noteworthy in themselves.

In summary, the current study demonstrates that feelings of uncertainty were universal amongst the participants, with mothers needing to make important choices without the certainty that they were the right ones. For this, the mothers turned to external sources of information for guidance yet found the array of contradictory information baffling and anxiety inducing. Learning how to be a mother required a trial-and-error approach and mothers were dejected when things did not work out as hoped, experiencing feelings of failure and negative self-perceptions. Many were preoccupied by harm befalling their infant, illustrating that they were in direct contact with an awareness of the fragility of the life in their hands. Faced with uncertainty and a lack of affirmation that they were succeeding at motherhood, the mothers were plunged into an existential crisis, questioning, *who am I as a mother?*

Considered from an existential perspective, these phenomena illustrate the mother's awakening to an authentic mode of being-in-the-world. The fragility of existence and the vitality of survival underpin her thoughts, feelings and actions. While being with uncertainty was experienced as unsettling and unwelcome, it is a fundamentally important part of the maternal transitionary process rather than something to be rid of. Furthermore, it is through this phase of uncertainty and trial and error that a mother gradually learns how to be a mother and to make motherhood her own.

5.4. Theme three: Being with others

'There's no need for red-hot pokers. Hell is – other people!'

(Sartre, 1989, p. 47)

It is clear from the work with the participants in this study that anxiety after birth was experienced in relation to others. Three subordinate themes presented: *comparisons to others*, *what others think* and *the impact of anxiety on relationships*. Each of these will be discussed in turn in relation to the existing literature in the field and considered from an existential philosophical perspective.

5.4.1. Comparisons to others

Maternal anxiety clearly manifested itself in relation to comparisons with others. Initially, this phenomenon occurred in the lived space of the home, where the mothers learned how to take care of their babies with their partners, but comparisons also extended into the wider world via mother and baby groups, and into the virtual world via social media.

Immersed in the uncertainty of caring for a baby, mothers look to others to work out what to do and how to do it. Yet being in the presence of others, in real or virtual fashion, results in unfavourable comparisons. While learning how to be a mum, a mother is also getting to grips with a new identity and it is important to mothers to feel a sense of belonging to motherhood to affirm that what they are doing is right. Without this affirmation, the mothers in the current study experienced a dissonance in their sense of self. Over time, a mother must make motherhood her own and work out who she is as a mother, yet this act of self-creation is accompanied by loneliness and isolation. Yalom (1980) wrote that to be like everyone else and to conform with others saves us from the isolation of selfhood, yet mothers must be with the solitude

of maternal uncertainty to work out who they are. To try and conform and blend in with other mothers meant to be inauthentic and was difficult to enact. As a result of trying to match up and be like everyone else, mothers experienced a tension in their self–other identity, resulting in feelings of anxiety.

Comparison to partner

The most immediate comparison after birth is to the behaviours, attitudes and approach of the partner. Caring for their babies at home with their partners led to unfavourable self-comparisons focused on mothering competency. Feeling less accomplished than their partners, mothers experienced feelings of incompetence and resentment. They felt that the tasks of baby care were primarily their responsibility and implicit in this was the notion that to fail at these tasks was to fail at being-a-mother. For some this became a struggle to prove to themselves that they could do it, escalating into a competitive interaction with their partners. This idea features in Stadlen's (2011) work, where she observed how one parent competitively attempts to turn the family into two teams. This was the case with Beth, whose observation of her husband's apparent ease at caring for their baby led to her determined efforts to prove that she was equally capable. On occasions when things did not work out, the resultant despair and feelings of anxiety were difficult to bear.

Comparisons with partners additionally extended beyond the tasks of care into comparisons of how one ought to feel as a parent. Abbie's experience highlighted that establishing a parent–infant bond evolves at a different pace between couples. The discrepancy between her own feelings and her husband's feelings towards their baby led to internalised anguish. Tietz et al. (2014) revealed that mothers diagnosed with postpartum anxiety experienced reduced bonding with their infants. From the findings of the current study, it is difficult to ascertain whether maternal anxiety

impacted bonding or whether difficulty bonding resulted in anxious feelings. For Abbie, it was the observance of her husband's ease of bonding with their baby which highlighted her own uncertain feelings. She voiced that she 'should' be feeling the same as her husband, yet those feelings felt frustratingly beyond reach. Miller et al's. (2006) research highlighted that mothers' experiences of anxiety about bonding were linked to perceptions of good and bad mothering. This was also the case in the current study, where the mothers voiced an expectation that they should have been able to instinctually meet their baby's needs.

Comparisons in groups

Comparisons also extended beyond the lived space of the home into mother and baby groups. Here the mothers observed the apparent ease with which others interacted with their infants, leaving them with anxious feelings that they were doing things incorrectly. Being with others highlighted difference: for Fiona, this manifested itself as being the only member of a group not breastfeeding. Even though she was bottle-feeding breastmilk, she felt like a fraud in comparison to others. There was a desire amongst the mothers to prove that they *could* be like others, as to be otherwise was perceived to have failed at motherhood, and to be different to other mothers was to feel socially excluded. Stern and Bruschweiler-Stern (1998) wrote that mothers have a deep need for psychological support from others, to exchange information and observe how others go about being a mother, emphasising that these interactions satisfy various needs including needing assurance, learning how to do things and affirming belonging to a new social sphere. This view contrasts with the findings of the current study, which suggests that, rather than being spaces for companionship and support, mother and baby groups became a source of anxiety in themselves. The mothers came away from the groups feeling isolated, unhappily noting that other mothers were thriving while they were failing. It is surprising to note

that this finding about groups has not been discussed within other research and it is noteworthy that, within the general literature on anxiety, research on social comparisons is sparse.

Existentialism recognises that we are relational beings (Heidegger, 2010; Sartre, 2003) and this social existence prompts us to think about ourselves in comparison to others. In accordance with this study, Arnold-Baker (2020) observed that mothers do not feel like mothers because the image they have of others contrasts markedly with how they feel. The current study revealed how mothers observe others as confident, accomplished and competent, carrying a sedimented worldview that this is how a mother should be. When their own experiences fail to match up to this, they experience a crisis of being. What they do not know at the time is that they need a period of adjustment to work out who they are and how to be a mother. This inevitably means discovering differences as well as similarities to others. Such nuances in being-a-mother are invisible within the mothering group.

Comparisons on social media

Portrayals of mothering perfection on social media fuelled the mothers' anxieties and took comparisons to others from their immediate lived spaces into the wider virtual world**.** Mothers felt under pressure to match up to others but were unsure how to achieve this. In recent years social media has become a typical means of narrating individual parenting experiences online (Cino & Formenti, 2021), a phenomenon which has been termed 'sharenting' (Blum-Ross & Livingstone, 2017). Social media brings digital representations of family life into the public arena, transcending the limitations of space and time (Cino & Formenti, 2021). This practice has facilitated a culture of surveillance, as observed by Monahan (2011), where mothers turn their attention outwards to monitor what others are doing and critique and calibrate their

own behaviour accordingly. Large-scale sharenting has contributed to a social construction of early motherhood, one in which mothers compare themselves to a carefully curated ideal. The present study demonstrates how mothers consistently found themselves falling short of virtual portrayals of motherhood. Research shows that being exposed to upward comparisons results in negative outcomes (Vogel et al., 2014), negative self-evaluations and decreased feelings of wellbeing (Kross et al., 2013). For the mothers in the current study, comparisons via social media were a significant contributor to anxiety.

In turning to social media, the mothers could anonymously observe from a distance how 'they' (Heidegger, 2010) went about motherhood: how they looked, what they did and what they purchased. These images imbued mothers with a version of motherhood that was perfect, happy and contented. Many reported being temporarily swept up by this captivating portrayal of idealised mothering, aspiring to be the same. Immersing themselves in this virtual world presented the mothers with the possibility of renouncing their existential freedom to choose how to be a mother in favour of copying others. This only temporarily alleviated their anxiety, as they soon discovered that the rose-tinted portrayals of virtual mothering were unattainable and were plunged into feelings of despair and isolation. Paradoxically, maternal anxiety manifests itself as an estrangement from others – in comparing and noting the differences, a mother feels detached from those around her.

Not only was wanting to be like other mothers an attempt to fall in with others, it was also a means of bringing certainty to the uncertainty of what to do and how to be. To try and emulate others was to adhere to a pre-set expected way of doing things, to avoid thinking for oneself and to adopt others' values and approaches (Cooper, 2010). Heidegger (2010) referred to this as 'falling-in' with others – an inauthentic mode of being in which we adopt the trends of those around us, becoming

tranquilised that this is the way to be. In doing this, a mother becomes part of a socially acceptable homogeneous mothering group but neglects to discover what it means to be a mother for herself.

Spinelli (2015) noted that existential anxiety is the 'lived experience of relational uncertainty' (p. 29) and being with others brought into focus the mothers' sense of incompleteness. Mothers craved something solid and certain to hold on to as a means of discovering how to be a mother. However, in existential thought, our existence is not fixed or static, but is continually in a process of development - a '*being*-always-becoming' (Spinelli, 2015, p. 61). For a mother, this developmental process is profoundly anxiety provoking as she craves the stability of the secure mothering identity which she perceives others to have.

The mothers' desire to be part of the 'mother club' was pitched against also wanting to hide away. They spoke of wanting to conceal their anxious feelings, prompting them to want to retreat from others and in some cases to avoid groups and social contact altogether. Thus, for the mothers in this study, anxiety closes down the social dimension, revealed by a push-and-pull dynamic between yearning to belong and needing to retreat. Van Deurzen and Arnold-Baker (2005) posit that to go along with the 'they' and do as they do reduces anxiety, yet the mothers in this study experienced an increase in anxious feelings when their attempts to do this failed.

In motherhood, choosing one's own unique path enables the opportunity to reflect on possibilities and options that are right for each mother and to undertake mothering in accordance with personal values. Yet what is seen from the current study is that there is a period when a mother can neither deny her freedom and conform to the perceived norms of motherhood nor grasp her freedom and choose her own individualised path. Instead, she withdraws from others, occupying a void-of-being, a

lost place, where she is uncertain, anxious and frozen by not knowing what to do or how to be. This is a profoundly destabilising place, where a mother feels different and at odds with those around her, questioning her very being. This confronts a mother with a crisis – *if I don't feel, think and act as they do, then who am I?*

5.4.2. What others think

It is human nature to want to make a good impression on those around us (Rui & Stefanone, 2013) and the findings of the current study illustrate that motherhood is no exception. The previous section highlighted that social media often presents an idealised portrayal of life as a mother and, as mothers occupy a new and uncertain identity, they care deeply what others think of them. In doing so, they seek to be part of the group – fitting in, doing as others do and being as others are. This phenomenon makes sense, as ineffective self-representation has been linked to rejection and disapproval from others (Tokunaga, 2011). To be concerned about what others think is to hope for affirmation as a mother in an attempt to confirm maternal identity.

This was the focus of research by Watson and Friend (1969), who termed the phenomenon, 'fear of negative evaluation' (FNE). They developed an evaluation scale with which they observed that individuals who scored highly were anxious and nervous in social situations, endeavouring to gain approval from others. Subsequent research by Gilbert (2009) and Tangney et al. (2007) established links between FNE and feelings of guilt and shame. The current research reveals that a fear of negative evaluation of mothering competency was universal amongst the participants. These findings build on those of Rotkirch and Janhunen (2010) and Seagram and Daniluk (2002), who both identified FNE as a cause of guilt and shame in mothers, while research by Guendouzi (2006) highlighted women's fears of being perceived by

others as deficient or ‘bad’ mothers. Liss et al. (2013) revealed a link between mothers’ fear of others’ disapproval and symptoms of depression, a link which was also observed by Kim et al. (2011). What is notable is that, within the maternal field, FNE has not previously been linked with experiences of maternal anxiety.

In the current study, all the mothers reported worries relating to what others would think of them as mothers, highlighting that being-a-mother means to be subject to the opinions and judgements of others. For some, awareness of the scrutiny of others arose when needing to feed their baby in public, while others experienced a generalised sense of being judged, as if waiting to be found out as a fraudulent or inadequate mother. The mothers could not know how others perceived them – they could only make an interpretation. Yet, in being in the presence of the other, they experienced what Sartre (2003) referred to as a disruption or disintegration of their world. When a mother is with other mothers at baby groups she views herself as if through their eyes. Anticipated or perceived judgement led them to try and avoid what Sartre (2003) termed ‘the look’ of the other.

Notably, this made mothers feel accountable to others and compelled to justify their being-in-the-world-as-a-mother. One way to do this was to conform, to be like others and to look and act as they do. This closely aligns with the subordinate theme of *comparison to others*: in order to be like them I must do what they do and if I do not, I am different and something is wrong with me as a mother. This is illustrated by Fiona’s experience:

> *I went to a mums group and seeing them all breastfeeding upset me, so I’d keep pumping and pumping. It’s just not the same when everyone is breastfeeding and there’s me with a breast pump. I felt isolated and I thought, why can’t I do what other people can do? Why can’t I be included in their*

club? I had to pump, I had to sterilise, I was doing double the work just to feel included.

Fiona felt that she had to justify herself through her feeding method to be included. Pumping breastmilk in the privacy of her home felt completely different to feeding her daughter breastmilk in the presence of other mothers. The Sartrean (2003) 'look' of others transformed her world into an alien space – it was *their* space rather than *her* space. Thus, a mother's existential freedom is curtailed by those around her – the world of mothering is no longer her own, a concept that Sartre refers to as alienation: to be alienated is to be separated from the freedom to be the mother one wants to be and to be thereby separated from others. This experience had an alienating effect on Fiona's freedom and she voiced a sense of isolation. Being in the presence of others causes something to change forever and mothers became preoccupied with thoughts such as, '*what would others think if they saw me doing this …?*' Robbed of her freedom, Fiona could no longer feel satisfied about pumping breastmilk: an awareness of others destabilised her sense of self.

From a Sartrean perspective, a mother is an object for others, meaning that she can be interpreted via the eyes of the others and objectified by them, with no control over what others think of her. The presence of others is enough to drain her perception of her status as a mother. The mother's shift from subject to object is both uncontrollable and disrupting. In the present study, none of the mothers did anything to provoke criticism – they were simply grappling with how to be a mother – but a sense of feeling others' eyes upon them became a catalyst for discomfort and self-doubt.

Mothers reacted to this phenomenon by withdrawing and trying to manage in isolation to avoid the feelings of shame and inadequacy which emerged in the

presence of other mothers. As a consequence, the mothers did not seek support and were alone with their anxiety. Thus, being in the presence of other mothers paradoxically leads to isolation.

Cultural considerations

All the participants in this study were UK residents, however a range of cultural heritages were represented. One mother reported how part of her anxiety about bottle feeding was situated in relation to cultural expectations, revealing how it was culturally frowned upon. She was acutely aware of the dominant narrative in her cultural heritage that 'breast is best' and responded by bottle feeding in secret away from the gaze of others. Interestingly, other participants reported similar feelings indicative that this experience was felt cross-culturally. This illustrates that women have sociocultural pre-understandings regarding how to be a mother and what is expected of them. When they struggle to meet societal expectations, the findings show that anxiety is experienced in relation to being judged by others.

5.4.3. Impact on relationship

The current study shows that becoming parents constitutes a new way of being together in the world and is a challenging period for couples – a finding which has also been reported by others (Kuersten-Hogan & McHale, 2021; Stadlen, 2015). Studies have illustrated that relationship fulfilment can decrease during pregnancy and the postnatal period (Don & Mickelson, 2014; Mitnick et al., 2021) and other research demonstrates that mothers experience a rise in relationship difficulties after birth and an increase in negative perceptions of their partners (Mitnick et al., 2021). These findings are echoed in the current study with mothers reporting that their relationships were negatively impacted in several ways. Research by Darling et al. (2022) proposed that relational tension and a lack of partner support predisposes

women to develop mood and anxiety disorders in the perinatal period, yet the findings of the current study suggest that a more complex intersubjective phenomenon is at work.

From an experiential perspective, the mothers revealed that their anxiety manifested itself as being snappy, irritable and argumentative with their partners. While these feelings originated out of concern for the safety of their baby, many reported that their partners did not share these concerns. Mothers' worries were frequently met with incredulity by their partners. They felt unheard when they voiced their anxieties that something was wrong with their child or that something might happen to them. To be met with a response of '*the baby is fine!*' was to be not listened to. Worse still was to be told that it was the mother herself who was the problem. These findings resonate with Stadlen (2015), who notes how easy it is for 'a mother both to hurt, and be hurt by, her partner' (p. 218). Lanman (2003) observes that new parents frequently hold polarised views, which highlight the differences between partners, while other scholars have noted that, for mothers, support from partners in the postnatal period is essential to relationship satisfaction (Mauthner, 1998; Fuggle et al., 2002). In the current study, what was evident was that the mothers' experiences of not being understood created a dynamic of relational dissonance, where neither party grasped the other's point of view. In not feeling understood the mothers questioned their own sense of self, fuelling further anxiety. When maternal anxiety was not met with paternal openness and understanding, mothers reported feeling alone and isolated with their concerns.

Maternal anxiety also manifested itself interpersonally in behavioural ways, with some mothers monopolising the tasks of baby care to ensure that they were done properly. Others reported a tendency to hover over their partners when they were looking after their children. This notion features in the work of Stadlen (2015), who

observed that new mothers assume that the correct way to look after a baby is their way. The mothers also acted as if the safety of their baby was primarily their responsibility yet shouldering this alone was anxiety inducing. At other times, mothers felt dependent and reliant on partners for support. The dynamic of both craving and rejecting support was confusing for both partners. When mothers dominated the tasks of care, their partners were pushed out and denied the opportunity to learn. To hand over the tasks meant to relinquish full responsibility, which caused the mothers' feelings of anxiety to heighten. In wanting assistance, but being unable to renounce responsibility, a mother is caught in a double bind: in both instances her anxiety is perpetuated. In addition, both partners feel criticised by the other: the mother implies that the partner is not capable, while the partner considers the mother to be overprotective. This relational interplay leads to isolation and alienation from one another, creating distance rather than fostering closeness. This is echoed in Stadlen's (2011) work, in which she observed how mutual irritation renders each parent unable to understand the logic of the other's actions.

Sartre (1989) recognised that we tend to criticise one another for our own inadequacies. In the present study, mothers critiqued their partners' capability while having doubts about their own. At a time when reciprocity, cooperation and empathy would have united both parents in the joint project of baby care, both partners interact in a way which impedes close and honest communication. Jaspers (1941) recognised an innate human tendency to be averse to listening and engaging with one another openly. For him, true connection arises from a meeting of our real selves in which we are able to be receptive to one another's beliefs and needs within a genuine relational encounter. In this way, both partners have a means to communicate with honesty and be met with openness. However, to bring our real selves to a relationship we must first know ourselves and second make each other

the focus of attention. As new parents, both partners are in a phase of transition and in a process of discovering a new identity. While they grapple with transitioning into parenthood, the relational encounter centres around how ‘to do’ parenting, rather than how ‘to be’ parents, and in this mode of being partners engage with one another as objects rather than subjects. For Buber (2013), this type of relating was described as an I/It encounter, and, in this mode, partners are distanced from one another as they survey and contemplate the practical tasks of parenting.

In addition to learning how to be a parent, they must also learn to relate to one another as parents. This involves being in tune with one another, collaborating, supporting and listening to each other, and allowing one another to emerge into a relationship as parents. Buber (2013) has referred to this type of encounter as I/Thou – a relationship characterised by reciprocity and care for the other. The current research reveals how anxiety is an impediment to I/Thou relating – with the baby as the primary focus the mother monopolises the tasks of care, thus controlling the relational dynamic. When her partner does not understand or share her anxiety, a relational divide ensues, and partners become adversaries rather than allies. Consequently, parents experience moments of mismeeting (Buber, 2013) characterised by a lack of empathy and connection.

As revealed in the theme of ‘being taken over’, a mother’s embodied being is continually primed to respond to the infant, a way of being-in-the-world which affords little respite and is experienced as engulfing. In contrast, she notes how her partner displays a more relaxed demeanour – yet his apparent ease of being may even pose a potential threat: if he does not display the same level of hypervigilance when caring for the baby, will it be safe in his care? It is this disquieting thought that keeps the mother hovering in the background when the partner looks after the baby. She is unable to relinquish responsibility, he feels micromanaged and not trusted, and the

accompanying feelings of irritation further hinder closeness. The mother's way of being highlights the impossibility of relinquishing responsibility for the baby. Through the bodily experience of giving birth, she is confronted with an awareness of the givens of existence, her child's fragility and mortality and her maternal responsibility for keeping her child alive (Prinds et al., 2014). In accordance with Garland's (2020) findings, the deep-rooted responsibility that mothers carry is experienced as so profound that no-one else can take her place. The constancy of responsibility, care and vigilance is an intensely draining experience, which other scholars have also noted (Arnold-Baker, 2015; Garland, 2020). No matter how much care, support and love a partner may demonstrate towards the baby, the Levinasian (1979) notion of the call of the other overrides everything, keeping the mother inextricably bound to her baby's safety, above everyone and everything else. The resultant relational tension leaves little space for partners to affirm their roles within a relationship, something which Buber (2013) considered to be an innate human need. While a couple might occupy the same lived space, they inhabit very different worlds.

5.5. Validity

Validity and rigour within the field of qualitative research falls under the scrutiny of trustworthiness, credibility, dependability, confirmability and transferability (Dibley et al, 2020). Vagle (2018) suggests an additional consideration, proposing that validity in phenomenological research is primarily evidenced by the researchers ongoing engagement with the phenomenon and the lived experience accounts of the participants. In this study, the ongoing engagement with the phenomenon and the transcripts was achieved through the process of writing and reflection. It was through crafting stories out of the participants' own words and then distilling this further into poems that I was able to remain orientated to the phenomenon in a sustained way.

Van Manen (2016) emphasises that the writing process is the research and I found it to be a deeply reflective and fully immersive one. All the while the process of writing and reflection was taking place, I repeatedly contemplated the question ‘what does this reveal about the phenomenon?’ As documented in Chapter 3, crafting the poems enabled me to look deeply at the mothers’ experiences and to be open to the ontological dimensions conveyed through each mother’s words.

5.5.1. Trustworthiness

A researcher demonstrates the trustworthiness of their study by being open and clear about the study design and methods. The research design is clearly outlined in Chapter 3 which details the steps undertaken for the process of phenomenological analysis, accompanied by detailed examples in the Appendices. Trustworthiness in this study is further enhanced by engaging in a reflexive process throughout the duration of the work. This was achieved by carefully exploring my own experience of the phenomenon before I set out to recruit my participants. In undergoing an interview with a research colleague, my biases and assumptions about the phenomenon were identified and discussed. As detailed in chapter 3, to maintain a reflexive position throughout the research process, I kept a journal of my thoughts and reflections, noting moments when I might have been influencing the enquiry, drifting off course, or feeling stuck.

5.5.2. Credibility & dependability

These aspects have been considered together, since ‘the same strategies that determine credibility in qualitative studies also determine dependability’ (De Chesnay, 2014, p. 16). Credibility and dependability in qualitative research relate to the integrity of the research procedure and the necessity of establishing whether the methods outlined would lead to the findings presented (Dibley et al., 2020).

Establishing credibility and dependability in hermeneutic phenomenology can be challenging, since the method does not come with a definitive set of steps or instructions and every hermeneutic phenomenological study will be approached differently. As such there is no absolute measure of rigour since it is impossible to repeat the same piece of work (Crowther & Thomson, 2018). This is due to the interpretive nature of analysis requiring a 'fusion of horizons' (Gadamer, 1975, p. 601) which will be unique to those involved in the study. Credibility and dependability have been evidenced via the inclusion of participant quotes in Chapter 3 which demonstrate the integrity of the interpretations. Crowther & Thomson (2018) further emphasise that it can be extremely difficult to fully articulate the later interpretive stages of the analysis in great detail, since much of it is iterative. My personal experience of the later interpretive process supports this notion, however care has been taken in Chapter 3 and the Appendices to convey how the analytical process unfolded.

5.5.3. Confirmability

Confirmability in qualitative research is evidenced via the ability to evidence that the findings arose out of the collected data and were not generated from my own assumptions or understandings of the phenomenon. Appendices F-L chart this process with the participant Abbie: evidencing the phenomenon was rooted in the participant's own words as I moved from the transcript through the key phrases of analysis. Furthermore, the themes presented in the findings chapter are clearly illustrated with verbatim text taken from a range of participants. At various stages of the analysis, my interpretations and the emergent themes were discussed with my academic supervisors to facilitate confirmability of the study findings.

5.5.4. Transferability

Transferability denotes the ‘probability that the study findings have meaning to others in similar situations’ (Spezilae et al, 2011, p. 49). This can be enhanced by providing transparency across the processes underpinning the research, such as data collection and analysis (Dibley et al., 2020), as well as situating the findings within the wider literature. These procedures have been evidenced in Chapter 3 and in the Appendices. Positioning the findings within the wider literature has been evidenced in this chapter.

5.6. Strengths and limitations

The current study was conceived prior to the COVID19 pandemic and UK nationwide lockdown restrictions coincided with the data collection phase. This meant that participant interviews had to take place via video call rather than in person. This brought the benefit of being able to extend my participant recruitment geographically, rather than recruiting solely in the Southeast of England as originally intended, which is likely to have broadened the diversity of the sample. It also made participation more accessible to mothers of young children, eliminating the need to travel and incur expenses and importantly eliminated the risk presented by COVID19 at the time. All the participants reported being comfortable using a video platform and this may in part have been due to video calling becoming an everyday means of keeping in contact with the outside world during the COVID19 lockdowns.

There were some key points to consider when conducting an interview via video platform: a private, quiet space was required and the mothers had to arrange time and space in their home environment when they could speak without being overheard or interrupted. Some studies have reported that establishing rapport and

forming relationships via video platforms can be a challenge for the qualitative researcher (Deakin & Wakefield, 2014; Mirick & Wladkowski, 2019; Khan & MacEachen, 2022). Another potential limitation was that a full embodied sense of the participant was absent, meaning it was challenging to observe body language, hand gestures and non-verbal communication: this is something which has been noted by other researchers (Hesse-Biber & Griffin, 2013).

To counter these limitations, I brought my experience as a phenomenological therapist to the interview process. At the time of interview, I was working several hours a week via video platform with my therapy clients and was experienced and comfortable at working in this way. In addition, I am accustomed to working phenomenologically in my therapeutic practice: this involves staying close to what the client tells me; bracketing my assumptions; being aware of my biases and attuning very carefully to what is being said. As a therapist I am at ease in working with the unknown, in having to respond sensitively to emotion laden accounts and being careful not to lead the client in any particular direction. The semi-structured research interview therefore played to my strengths: I was able to be-with my participants in their distress in a holding and containing way. Importantly, I was comfortable with silence and rather than leaping in with a follow up interview question, I gave the participants space to be with the silence, recognising that in these moments participants were processing their thoughts and feelings in response to my questions and prompts. That said, I didn't treat the encounter as a therapeutic one, the goal was to collect a rich and detailed account of experience, rather than provide a therapeutic intervention. Despite this it was interesting to note that all the participants reported some benefits to taking part in the research interview. They gave a range of feedback disclosing the benefits of participation such as: being listened to and acknowledged; being able to express feelings and emotions which

had not previously been disclosed; being able to make sense of their experience; and being able to contribute to new understandings in the field of postnatal psychology.

Hermeneutic phenomenology produces an interpretation of the phenomenon under investigation; one which comprises a co-constitution of the content and process of both the researcher and the participants. Gadamer (1975) refers to this as ‘a fusion of horizons’ (p. 601), a notion which puts forward the idea that an understanding of the phenomenon is reached by an ‘ability to see the thinking of the Other in the context of one’s own understanding’ (Dibley et al., p. 25). From this perspective, being the sole researcher on this study brings both benefits and limitations. Being a mother who had myself experienced anxiety after birth meant that I had been in close proximity to the phenomenon under investigation. As documented in Chapter 3, this was carefully addressed by attending to reflexivity throughout the research process; I was keenly aware of any possible assumptions and biases. For the phenomenological researcher, the interpretation of the participants’ experiences and Gadameran (1975) fusion of horizons constitutes the hermeneutic process. Those from positivist research disciplines, however, may perceive this as a limitation.

Since reaching an understanding of the participants’ experiences is rooted within context, a phenomenological study of this nature is not considered to be generalisable across the wider population (Crotty, 2005). Van Manen (2016b) is careful to caution that the findings derived from hermeneutic phenomenological analysis do ‘not yield absolute truths, or objective observations’ (p. 7) and this was not the aim of this research. As outlined in Chapter 3, Van Manen (2016) acknowledges that the researcher’s interpretations can be questioned: had another researcher undertaken the same piece of research with the same participants, they might have reached different understandings. This is because each researcher will

bring their own pre-understandings to their interpretations (Crowther & Thomson, 2020). Yet what this study does offer is a privileged inside view of the nature and experience of anxiety after birth as felt and lived. This research also provides a vital platform for women to voice their experiences or anxiety, contributing to raising awareness of the phenomenon.

My research could be criticised for its small sample size, however this is characteristic of a hermeneutic phenomenological study. The sample of eight mothers afforded the opportunity to explore their experiences in significant depth and to analyse each transcript in detail to reveal rich insights about the phenomenon. It could also be argued that seeking representative themes across the eight transcripts was a reductive process: limiting the breadth of detail presented. As such, it may have been beneficial to reduce the sample size, to retain the richness of detail as presented in each personal account.

The overall findings of this study offer a glimpse into the nature of the phenomenon, but they are not the end point. Van Manen (2016) cautions that 'every hermeneutic phenomenological conversation is unending' (p. xv) and as a consequence these findings are not presented as fixed, definitive or conclusive. They are positioned as providing a rich depth of understanding of the phenomenon as represented by the eight mothers who generously shared their experiences with me.

5.7. Implications for clinical practice

The proposed shift towards understanding women's experiences of anxiety phenomenologically is also applicable to working with mothers in therapeutic practice. In recognising the embodied, relational and uncertain dimensions of maternal anxiety, clinicians will be well-placed to provide a supportive, reflective and

empathic response to mothers. In adopting a different attitude towards anxiety, women's experiences can be contextualised, validated and understood. A deeper level of understanding of the experiential and existential dimensions of PNA are relevant to all practitioners involved in postnatal care, both medically and psychologically. The relevance of this research therefore encompasses counsellors, psychologists, health visitors, midwives, GPs and psychiatrists.

For therapists and psychologists, the findings illuminate the depth and breadth of mothers' subjective experiences highlighting the importance of listening, clarifying and acknowledging, rather than attempting to minimise, eradicate, or treat individual experiences as illness or disorder. Existential therapy lends itself well to the themes which have been presented in this study, since at its core it seeks to explore what it means to be human. With importance placed on the subjective experience of each individual, there will be no fixed way of working with the phenomenon, however, an existential phenomenological approach to therapy would seek to explore a mother's own lived experience perspective in depth and in context.

As Adams (2013) writes, 'anxiety is a teacher' (p. 105) and from this perspective therapists can work with mothers to harness their anxiety to consider life's meaning, and to connect with what is important and valued. Therapy offers a space to explore a mother's freedom, choice and responsibility and give her time to arrive at her own decisions, in harmony with her own values. Therapy also provides an opportunity for a mother to explore the challenges inherent within a women's role as a mother and to explore her new identity and what this means to her.

A significant finding of this study was the relational dimension of PNA. In addition to individual therapy there would be value in therapeutic group work for mothers, where they can share their worries and gain support and validation from one another.

Group work offers the potential to transform the experience of being with others from being a source of anxiety, to being a source of support. Groups also offer the potential to alleviate the feelings of isolation and loneliness that often accompany motherhood and could provide a valuable space for companionship and shared experiences.

5.8. Recommendations for future research

This research has highlighted the lived-experience dimension of anxiety after birth as being a relatively new and underexplored area. Whilst the current study is an important step towards exploring mothers' experiences, there is scope for further research into this phenomenon. Future work could focus on one of the presented themes in greater depth, to explore its deeper meaning and significance. There is also potential to conduct a similar study across different demographics, for example how anxiety after birth is experienced for older mothers, mothers of multiples, or single mothers.

Whilst the current research proposed three core themes relating to anxiety after birth, there are other dimensions which fell outside of the scope of this study which could additionally be explored to establish a broader picture of the phenomenon. These could include the father's experiences of anxiety; how anxiety after birth is experienced within the couple relationship; how anxiety after birth is experienced for women whose pregnancy was unplanned. What is important is that research into the phenomenon continues, so that our understanding of the experience can progress, and appropriate support can be offered to those who need it.

5.9. Personal significance of this research

I drafted my research proposal in 2017 with few expectations regarding its potential impact on the wider realms of my professional or personal life. I knew that phenomenology was a research method and therapeutic approach, but at the outset of this study I was naïve to the extent to which they were intimately interconnected. Both require the practitioner and researcher to draw on 'critical, reflexive intuitive interpretation, inferential thinking, bodily awareness; and a capacity for warmth, openness and empathy' (Finlay, 2011, p. 7). Whilst the goal of research was different to therapy, I began to observe how my research activities enhanced my therapeutic abilities. Practicing and researching phenomenologically led to what I would describe as a *'professional immersion'*: becoming more attuned to participants and clients, attentive to the fine details of experience and more aware of myself in relation to the Other. This has deepened over time and in 2020 I began teaching existential phenomenology to Masters students training to be psychotherapists. This brought another dimension to my engagement with phenomenology and the hermeneutic circle: absorbed in an ongoing loop of practice, teaching, writing and questioning unveiled new understandings in all professional spheres.

Outside of my professional environment, adopting a phenomenological attitude has manifested as a more reflective stance towards self and others. I am mindful to engage in a way that is as unbiased as possible, and to keep in mind that everything and everyone we encounter has a context in relation to others and the world around them. Phenomenology has honed my pathic, intuitive abilities; qualities which hold value beyond academia and the therapy room, into my own interpersonal relationships. The study and practice of phenomenology has enabled a deeper, richer engagement with being: in essence, it has been life enhancing.

6. Conclusion

'It is precisely the most subjective ideas which, being closest to nature and to the living being, deserve to be called the truest.'

(Jung, 2001, p. 118)

This study posed the question *How do mothers experience anxiety after birth?* It explored this through a detailed hermeneutic phenomenological analysis of eight women's lived experiences. Three core themes emerged: *Being taken over*; *Being with uncertainty* and *Being with others.* These themes revealed that anxiety after birth is experienced as a complex, isolating and fully immersive experience. The experiences underpinning these themes permeate all four of the lifeworld existentials (Van Manen, 2016).

Bringing the existential components to the fore has enabled a positioning of maternal anxiety as a comprehensible human response to profound life change and its accompanying responsibility – one which is arguably difficult or impossible to prepare for. The findings of this study reveal an existential shift in how a woman finds herself in the world as a mother, with anxiety experienced via the mind–body, lived space and relational dimensions. Furthermore, this study reveals that the existential changes in motherhood comprise a temporal experience and period of questioning and uncertainty. These findings have been discussed within the context of existential phenomenological literature and are resonant with contemporary research into existential perspectives on new and early motherhood.

This study has exposed that mothers find their experiences of anxiety to be challenging and difficult to manage, yet importantly highlights that these experiences are understandable in context. Maternal anxiety is a part of being-a-mother:

transitioning to a new and unfamiliar identity, building competency, maintaining vigilance and being responsible. Women are anxious because they *care* about their fragile infants: an essential factor for ensuring infant survival. This study therefore puts forward a significant paradigm shift: rather than being considered as a disorder – something to be diminished, cured or eradicated – PNA can be understood as serving an essential existential function.

While common themes were identified across the study participants, it is important to acknowledge elements of aetiological diversity amongst women's experiences. Furthermore, it is essential to note that anxiety is experienced at varying intensity for different individuals. Lived experience of the phenomenon reveals that it is subjective, which makes defining or categorising it very challenging. This may be a contributing factor to the absence of clear public messaging about what anxiety after birth is. This study additionally highlights the importance of considering anxiety after birth as distinct from a more generalised perspective of everyday anxiety, as it specifically involves a mother in relation to her infant and the world and people around her.

Lived experience research of this nature generates a different kind of knowledge: in-depth personal accounts provide a rich source of experiential knowledge. Lived experience research therefore has the capacity to transform traditional understandings of experiences, offering alternative dimensions, which may complement, contrast or diverge from textbook accounts of the phenomenon (Rabeharisoa, 2017). In adopting a hermeneutic phenomenological approach for this research study, it has been possible to reveal the granular, nuanced, embodied nature of mothers' experiences exposed in everyday detail. These subjective experiences of maternal anxiety are ontologically representative of what postnatal anxiety *is*. Exploring anxiety after birth from this methodological standpoint has

generated a fresh perspective of the experience, underpinned by its existential structures. This differs from a traditional medical symptom-focused model and brings meaning to the personal, social and embodied context of the phenomenon.

As featured in the discussion chapter, this study highlights some key insights for psychotherapeutic practice and emphasises the value of adopting a phenomenological stance in therapy. As this was a small-scale study, aspects of the phenomenon inevitably fall outside its scope, and recommendations have been made for further research in this area. It is hoped that the insights gained from this study can complement more empirical findings from other studies to help facilitate a broader understanding of the experience.

As stated in the introduction, it was never my intention to reveal *why* women experience anxiety after birth or to propose a theory about the phenomenon: my intention was to offer new ways of thinking about and understanding women's experiences as they are felt and lived and to present these in the context of existential philosophy. In the words of the Roman poet Virgil, '*Trust one who has gone through it*.'

At the outset, I suggested that women's experiences needed to be explored and understood ontologically in order to attune to the everydayness of the experience and reveal what it means to be anxious after the birth of a child. This study has fulfilled this aim and it is hoped that the themes raised will bring the phenomenology of maternal anxiety into active dialogue with empirical researchers, therapists and perinatal professionals, as well as with mothers themselves.

To experience
maternal anxiety
is to be human.
(Concluding haiku)

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8. Appendices

Appendix A: Screening questions

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Participant screening information

Anxiety after birth - a description

Anxiety is a natural response to feeling unsafe or threatened, however not all anxiety is about things that are obvious and visible. We can worry about the future or that something bad may happen to our baby or ourselves – or just feel overwhelmed at times and on 'high alert'.

A reasonable amount of fear and worry is normal and expected after having a baby. If you experience quite a lot of anxiety, it can become a challenge to your daily life.

You may experience anxiety after birth in any of the following ways:

- **In your body.** This may include *any* of the following experiences – increased heart rate; tummy pain; digestive disruption; tightness in the chest and/or throat; changes to breathing; changes to appetite; difficulty falling asleep; difficulty staying asleep; teeth grinding at night and muscle tension.
- **In your mind.** This may include *any* of the following experiences – racing thoughts; fears about the future; imagining the worst; ruminating (turning worries over and over in your mind); worrying, obsessing about things, intrusive and unpleasant thoughts; feeling irritable and being forgetful.
- **In your behaviour.** This may include *any* of the following experiences – trying to control situations; seeking reassurance from others; repeatedly checking things; being on the lookout for danger; and avoidance of certain situations, places, or people.

(Adapted from Anxiety Canada (2020) – 'Recognizing Post-partum Anxiety')

Participant Screening Questions

- Do you remember experiencing any of the above on a regular basis in the year after birth?
- Did these experiences become a significant feature of your day-to-day life?
- Did these experiences impact your enjoyment of daily life?
- Did these experiences impair your ability to lead a normal life?

Thank you for taking the time to read this information. Please consider your answers to the above questions. If you think that these descriptions relate to you then you may be suitable to participate in this study.

Further information will be provided if you are happy to participate.

Warm regards

Claire Oakeley – Researcher
Email: CO654@live.mdx.ac.uk
Address: Via NSPC, 61-63 Fortune Green Road, London, NW6 1DR
Telephone: 07934 132192

Academic Supervisor: Dr Claire Arnold-Baker,
Address: NSPC, 61-63 Fortune Green Road, London, NW6 1DR
Telephone: 020 7435 8067

- **Reference**

Anxiety Canada. (2019). Recognizing Post-Partum Anxiety.
https://anxietycanada.com/articles/recognizing-post-partum-anxiety/

Appendix B: Participant information sheet

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Participant Information Sheet

Research Title: ANXIETY AFTER BIRTH – AN EXISTENTIAL PHENOMENOLOGICAL ENQUIRY INTO MOTHERS' LIVED EXPERIENCES

Conducted by: Claire Oakeley **Email:** CO654@live.mdx.ac.uk

as a requirement for a Doctorate in Existential Psychotherapy and Counselling by Professional Studies from NSPC and Middlesex University

Date: April 2020

You are invited to participate in a research study. Before deciding to take part, it is important that you understand why this research is being conducted and what it will involve. Please read the following information carefully and discuss with others if you wish. If there is anything which is unclear or if you would like further information, please do get in touch. Please take your time to carefully consider whether you would like to take part in this research study.

What is the purpose of the research?

This study is being carried out as part of a Doctorate in Existential Psychotherapy and Counselling by Professional Studies from NSPC and Middlesex University.

The aim of this study is to explore women's experiences of anxiety in the postnatal period. It is hoped that this study will assist mothers, therapists and medical professionals in understanding what this experience is like.

What will happen to me if I take part?

After you have expressed an interest in taking part, I will call you to check that you meet the inclusion criteria for this study. Participation involves taking part in a single interview which will last between 60 and 90 minutes. This will take place at a time and location which is convenient to you - this may be in your own home, in a local therapy room or by Skype. The interview will be carried out during the daytime and during your child's nap time if they have one. You will need to arrange for your baby or child to be looked after for the duration of the interview. This could be with a partner, family relative or close friend. During the interview you will be asked to speak freely about your experiences of anxiety after birth. If there is a large geographical distance between our locations, the interview will take place via Skype. The interview will be recorded onto a digital voice recorder and will be transcribed either by me, or by a professional transcriber. After the interview you will be offered the opportunity for a debrief.

What will you do with the information that I provide?

The digital recording of our interview will be transcribed by me or by a professional transcriber after which it will be destroyed. In the transcription all identifying features will be removed and you will be given a pseudonym. Your anonymised transcript will be analysed by me and the findings written up as part of a doctorate thesis. The results may also be published in peer-reviewed academic journals. I will ensure that your personal details are changed so that you are not identifiable. If you would like to

withdraw from the study, you can do so up until your data has been transcribed and analysed. You can request that your data is destroyed. Your anonymised data will be stored on an encrypted memory stick which only the researcher will have access to. Paper copies of your interview will be stored in a locked cabinet in the researcher's own home.

Your consent form and personal data will be kept securely for 10 years and will be treated confidentially. This data will be held separately from interview transcripts. All anonymised written interview data will be stored securely and destroyed after a period of 10 years. You have the right to access any personal data collected during the research process and this can be obtained in writing via the contact details below.

What are the possible disadvantages of taking part?

Due to the sensitive nature of the research topic, it is possible that talking about your personal experiences may be upsetting. Should you wish to explore any issues that have arisen for you as a result of participating in this research, please contact your GP and/or refer to the list of support organisations and charities listed on the accompanying sheet.

What are the possible benefits of taking part?

In taking part in this study you will be sharing your experiences with a sensitive and understanding person. You will be contributing to an under researched area of literature about women's experiences of anxiety after birth.

Consent

You will be required to sign a consent form in order to take part in this research. I will take the time to go through this with you before the interview to make sure you have understood the information provided

Am I eligible to take part?

In order to be eligible to take part in this study, you must be between the ages of 25-39, be in a stable relationship and have had a planned pregnancy. Your experience of postnatal anxiety may or may not have been diagnosed by a medical professional but must have occurred more than 6 months ago, but not more than 4 years post-birth. You are not eligible to take part if you are currently taking medication for anxiety or depression or are currently pregnant.

Who is organising and funding the research?

This research is not externally funded and is being undertaken as part of a doctoral degree programme at NSPC/Middlesex University. All proposals for research using human participants are viewed by an Ethics Committee before they can proceed. The NSPC research ethics sub-committee have approved this study.

Your time and involvement in this research study is greatly appreciated. Thank you for taking the time to read this information sheet. If you have any further questions before signing the consent form, I can be contacted via the contact details below.

Kind regards

Claire Oakeley - Researcher

Email: *CO654@live.mdx.ac.uk* ***Address:*** *Via NSPC, 61-63 Fortune Green Road, London, NW6 1DR Telephone:* 07934 132192

Academic Supervisor:

Dr Claire Arnold-Baker, NSPC, NSPC, 61-63 Fortune Green Road, London, NW6 1DR Telephone: 020 7435 8067

Appendix C: Consent form

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Written Informed Consent

Title of study: Anxiety after birth – an existential phenomenological enquiry into mothers' lived experiences.

Academic year: 2019/20

Researcher's name: Claire Oakeley **Email:** CO654@live.mdx.ac.uk **Telephone:** 07934 132192

Supervisor's name: Claire Arnold Baker **Email:** claire@nspc.org.uk **Telephone:** 020 7435 8067

- I have understood the details of the research as explained to me by the researcher and I confirm that I have consented to act as a participant.
- I have been given contact details for the researcher to keep in the participant information sheet.
- I confirm that the risks and benefits of taking part in this research have been explained to my satisfaction.
- I understand that my participation is entirely voluntary. I further understand that the data collected during the research will not be identifiable as far as is practically possible, and I have the right to withdraw from the project at any time and request that my data is destroyed, up until it has been transcribed and anonymized, without obligation to explain my reasons for doing so. After this time the data will be processed, and it will not be possible to withdraw.
- I further understand that the data I provide may be used for analysis and subsequent publication in academic journals and I provide my consent that this may occur.
- I understand that my data will be stored securely in a password protected document on an encrypted memory stick which will be kept in a locked cabinet in the researcher's own home. I further understand that paper copies of my interview will be stored in a locked cabinet in the researcher's own home. All data will be stored for ten years and then destroyed. I confirm that I have given my consent for my data to be stored in this way.

_____ _____

Print name Sign Name

date: _____

To the participant: Data may be inspected by the Chair of the Psychology Ethics panel and the Chair of the School of Science and Technology Ethics committee of Middlesex University, if required by institutional audits about the correctness of procedures. Although this would happen in strict confidentiality, please tick here if you do not wish your data to be included in audits: _____

Appendix D: Interview schedule

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Interview Schedule

Title of study: Anxiety after birth– an existential phenomenological enquiry into mothers' lived experiences.

Researcher's name: Claire Oakeley **Email:** CO654@live.mdx.ac.uk **Telephone:** 07934 132192

Supervisor's name: Claire Arnold Baker **Email:** claire@nspc.org.uk **Telephone:** 020 7435 8067

An example of my intended interview questions and prompts is provided below.

- I wonder if you can tell me about your experience of anxiety after birth and in the postnatal period?
- What do you recall about feeling anxious after birth and in the postnatal period?
- What was your anxiety like?
- What does your anxiety mean to you?
- How did the experience of anxiety after birth affect you?
- What changes did you associate with the experience?
- What feelings were connected to your experience?
- What thoughts stood out for you?
- What body sensations were you aware of at that time?
- How did your experience of anxiety after birth and in the postnatal period affect those close to you?
- Is there anything else connected with your experience what you would like to share with me?
- Tell me more about that
- What did that feel like?
- Can you give me an example?

Appendix E: Debrief sheet

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DEBRIEFING SHEET

Researcher's name: Claire Oakeley **Email:** CO654@live.mdx.ac.uk **Telephone:** 07934 132192

Supervisor's name: Claire Arnold Baker **Email:** claire@nspc.org.uk **Telephone:** 020 7435 8067

RESEARCH TITLE: Anxiety after birth – an existential phenomenological enquiry into mothers' lived experiences.

Thank you for taking the time to participate in this research project and for making a valuable contribution to our knowledge about women's experiences of anxiety after birth.

This research was designed to explore the phenomenon of anxiety after birth. This research, and your contribution to it, is important as it seeks to expand on the literature that currently exists on this experience. This research will also inform Health Care Professionals, by providing examples of what it is like to experience anxiety after birth.

The digital recording of our interview will now be transcribed by the researcher, or a professional transcriber, after which it will be destroyed. In the transcription all identifying features will be removed and you will be given a pseudonym. Your anonymised transcript will be analysed and the findings written up as part of a doctorate thesis. The results may also be published in peer-reviewed journals. If you would like to withdraw from the study, you can do so at any point up until your data has been transcribed and anonymised. After this time your data will be processed, and it will not be possible to withdraw. Your anonymised data will be stored on an encrypted memory stick which only the researcher will have access to. Paper copies will be stored in a locked cabinet in the researcher's own home. All data will be destroyed after a period of 10 years.

Having taken part in this research you will be given the opportunity to have a full debrief after the interview where you will be invited to talk about your experience of being interviewed. Should you wish to explore any issues that have arisen for you as a result of participating in this research, please contact your GP and/or refer to the list of support organisations and charities listed below.

I hope you have understood the overall aim and purpose of this study and enjoyed your participation in it. Should you have any concerns or queries regarding the research, please feel free to contact me (Tel: 0207 435 8067 Email: CO654@live.mdx.ac.uk).

Further Resources Information Sheet

Anxiety UK (National charity supporting people with anxiety)

Infoline: 03444 775 774

Text Service: 07537 416905

Email: support@anxietyuk.org.uk

Web: https://www.anxietyuk.org.uk/get-help/

PANDAS (Pre and postnatal depression advice and support - including anxiety)

Helpline**:** 0808 196 1776

Email support info@pandasfoundation.org.uk

Web: http://www.pandasfoundation.org.uk/

Association for Postnatal Illness (UK charity providing support)

Telephone: 0207 386 0868

Web: https://apni.org/

UKCP Psychotherapy Register

A list of qualified registered psychotherapists

Web: http://members.psychotherapy.org.uk/find-a-therapist/

Appendix F: Analysis 1 – Selective highlighting approach – Abbie

Statements or phrases which appear to reveal something about the experience of anxiety after birth.

Verbatim text from the transcript of the recording	**Line number**
The anxiety I felt the night he was born was different	8
I couldn't sleep and the issue wasn't that my son was waking up a lot and everything, he wasn't, he was actually a good sleeper from the start but I couldn't switch my head off.	16-17
Just lots of thought racing around. We were in the hospital at the time, still, and I just became absolutely hysterical	19-20
It was extreme anxiety a lot a lot of anxious thoughts	22
I remember actually just screaming because I was so hysterical	24
My baby was sleeping and he was fine but I was thinking I ought to be waking him up and feeding him	29-30
There was this tension because I really wanted to sleep. And there was this feeling that I was selfish for wanting to sleep and not wanting to wake him up and feed him, and thoughts that I was a bad mum already	32-34
I knew that I wasn't sleeping and er, I was already quite worried during the pregnancy that my mental health would deteriorate and so I was thinking this is the start, this is me developing severe mental health problems after birth	35-37
Even though he wasn't crying, he was putting on weight so there was no concerns about his weight or anything but just this feeling that I ought to be feeding him more, I wasn't doing enough, I wasn't caring enough.	41-43
Well the fear I'd had really throughout my pregnancy and even before of not being a good enough mum and not loving my son enough and not being able to cope	46-47

Verbatim text from the transcript of the recording	Line number
A lot of worries a lot of physical feelings of anxiety, and it wouldn't be every day, or all the time, but it would be fairly often	62-63
A really tight feeing in my chest, like something heavy is pressing on it and a sort of sinking feeling in my chest, and then also in my stomach	67-68
Like butterflies in your tummy, like a kind of churning feeling	72
Slightly breathless almost, but not breathing fast	75
One of the worst impacts was that it made me very irritable with my husband. I'd snap at him for little things, be a bit controlling I think, try and micromanage him a little bit around the areas I was anxious about	81-83
Even though my son slept really well, any time he woke up in the night, I sort of panicked about it a bit. And I could be a bit mean to my husband and say 'Oh it's because you were noisy going to the bathroom' and that kind of thing which was really unfair.	85-87
I'd say 'oh it's because you didn't do this, or you did that' - just really being quite unpleasant	89
It bought a lot more tension into our relationship because my husband was actually just really fantastic and a lot more supportive than my friends' husbands and did a whole lot but I was not grateful, just irritable and it was very hard for him	91-93
I'm not going to get any sleep, I'm not going to cope, so it was just a really selfish thing I think, just constantly panicking that I wouldn't be able to cope and that we had to get him back to sleep, we had to figure it out, otherwise everything would go downhill, I'd start sleeping really badly, I wouldn't be able to cope	99-103
I was so afraid of not coping that it made me not cope	105
I started to notice he seemed different from other babies, in my mind anyway, it would happen quite often when were out, he'd be in the pram, or at a swimming lesson, or a music class, he'd just start shouting, not crying, just shouting and I couldn't soothe him	110-112
I couldn't soothe him. I would get very anxious about that	115-116

Verbatim text from the transcript of the recording	Line number
It felt like, I wasn't a good enough mum, I didn't have a good enough relationship with him. It felt like everyone saw that and judged me for it. It made me feel quite a lot of negative thoughts about my son, that something was wrong with him.	118-120
My recurrent fear has been that he's on the autistic spectrum and that's something that I'm still worried about now but for different reasons. But it's quite interesting how I became a bit fixated on that	124-126
I would spend a lot of time googling things he was doing or not doing, googling experiences of other parents whose children turned out to be autistic, you know finding parallels between their experiences and my son. Looking up all the red flags to watch out for	132-134
I'd keep checking until something would happen that would reassure me and then I'd stop worrying about it. The next week something else would worry me and I'd start googling again	138-140
It was just very hard, very all consuming, very anxiety provoking. Just worrying a lot and being tearful about it quite a lot	145-146
I do wonder if it affected my relationship with my son. Firstly, because I think I let my husband do quite a lot because I was so anxious about some things like for example my son wouldn't settle easily on me after feeding. He'd sort of squirm quite a lot, he seemed more comfortable on his dad.	155-157
I do wonder if that created a bit more distance between me and my son and also this perception in me that I couldn't do it, I couldn't soothe him.	160-162
Worrying about my son's possible autism made it harder for me to appreciate his positive qualities and that might have affected our bond as well	173-176
I really just didn't enjoy my son for a long time.	178
For a long time while I found him really difficult and was really anxious about his development, you know, I found it hard to feel that love towards him, like my husband and I would be bathing him and my husband would say things like 'oh he's so wonderful, he's so beautiful, he's so amazing' and I'd be thinking, ' I don't feel that'	180-183

Verbatim text from the transcript of the recording	Line number
I suppose it did highlight the contrast for me of course I should be feeling those things too and I'm struggling to.	185-186
It's just a feeling of not coping things not being right	205
Something during the mealtime, something just tipped me over the edge and I, you know, I was getting really upset and crying and saying to my husband how worried I was about my son and he said 'look at him, he's fine, he's happy, but you're the one whose imploding' and that really stood out for me	215-218
I'm the one who's not ok and that's what the problem was	221
Just that feeling of not being able to cope and not feeling or behaving in a way that was not healthy, or appropriate, or how a mother ought to be…	223-224
Whenever I read other people's accounts of postnatal anxiety and it seems to be more focused around worries that something bad will happen to the baby, you know, but I feel like my anxiety is more selfishly themed, you know, that I can't cope	232-234
It feels quite self-involved and not maternal and not what a mother should be worried about	236-237
It does become more normal and you think, well, that's just me, that's just how I am	254
The days when it's not ok, it's really not ok – so I was not coping but I think it makes it harder to know if you've really got an anxiety disorder per se, the fact that it's not every day, it's not constant	262-264
It would be things that I've been worrying about under the surface that have been building up over a few days – just suddenly get too much and everything feels too much	267-268

Verbatim text from the transcript of the recording	Line number
Well quite exhausting and feeling quite low and hopeless	274
Things are not going to get better; things are very wrong. It's like even these words wouldn't come into my head it's a feeling that --everything is doomed	277-278
I did have quite a lot of social anxiety around fitting in with the new mum friends I made	285-286
They all found it a lot easier to talk to each other than I found it. I would not know what to say sometimes, well actually I was spending such a lot of the time when I was with them in trying to keep my child calm, you know.	291-293
I couldn't really concentrate on the conversation or contribute very much, just thinking they didn't like me as much as they liked each other and just thinking they didn't want to spend time with me and that sort of thing	293-295
It was horrible because I just had lots of thoughts, like what's wrong with me, or somethings wrong with me… you know, I'm not good enough, lots of those kind of very negative thoughts about myself	297-299
You asked me what it felt like and I'd forgotten this because it was really only in the early days, but sometimes, rage	318-319
It was just a very intense feeling of fury with myself, and the situation and actually with my son, even though it wasn't his fault at all. And you know, I just wanted to throw things and that's not me at all, that was actually a really different feeling for me	323-325
It was quite shocking, very scary	327
It was really terrifying	329
It feels like your head is going to explode and you need to throw things to get it out	332

Appendix G: Analysis 2 – Keywords – Abbie

Phrase or keyword	Line Number
The anxiety was different	8
I couldn't sleep	16
I couldn't switch my head off	17
Lots of thoughts racing	19
Absolutely hysterical	20
It was extreme anxiety	22
A lot a lot of anxious thoughts	22
Just screaming	24
So hysterical	24
I ought to be waking him	29/30
My baby was fine	29
I ought to be feeding him	30
Tension, I wanted sleep	32
I was feeling selfish	32/33
I was a bad mum already	33/34
I wasn't sleeping	35
Developing mental health problems	37
I wasn't doing enough	42
I wasn't caring enough	43
Not being a good enough mum	46
Not loving my son enough	47
Not being able to cope	47
I was so scared of not coping	49
A lot of worries	62
A lot of physical anxiety	63
A really tight feeling in my chest	67
Something heavy is pressing	67
Like butterflies in your tummy	72
A churning feeling	72
My breathing changing	74
Slightly breathless	75
Very irritable with my husband	81
Mean to my husband	86
Be a bit controlling	82
Quite unpleasant	89
Tension into our relationship	91
I was not grateful	93
Just irritable	93
Afraid of not coping	105
He seemed different from other babies	110
I couldn't soothe him	112
I would get very anxious about that (soothing)	116
I wasn't a good enough mum	118
I didn't have a good enough relationship with him	118

Phrase or keyword	Line Number
Judged me for it	119
Negative thoughts about my son	120
Something was wrong with him	120
Recurrent fear	124
I became a bit fixated	126
Googling experiences of other parents	132
Finding parallels between their experiences and my son	134
I'd keep checking	138
That would reassure me	140
All consuming	145
Worrying a lot	145
Being tearful about it quite a lot	146
I wonder if it affected my relationship with my son	155
More comfortable on his dad	157
I couldn't do it	161
I couldn't soothe him	162
I do wonder if that created a bit more distance between me and my son	160/1
Worrying (about my son's possible autism) made it harder for me to appreciate his positive qualities	173
That might have affected our bond as well	176
I didn't enjoy my son for a long time	178
I found him really difficult	180
Anxious about his development	180
Hard to feel that love towards him	181
I don't feel that	183
I should be feeling those things too	183
It's just a feeling of not coping	205
Things not being right	205
Tipped me over the edge	215
I'm not the one who's ok	221
That feeling of not being able to cope	223
Not feeling or behaving in a way that was healthy or appropriate	224
Not how a mother ought to be	224
My anxiety is selfishly themed	232
I can't cope	234
It feels quite selfish	236
Self-involved not maternal	236
Not what a mother should be worried about	237
That's just me, that's just how I am	254
It's not constant	262
Building up	267
Everything feels too much	268
Exhausting, low, hopeless	274
Things are not going to get better	277
Things are very wrong	278
Everything is doomed	278
A lot of social anxiety	285

Phrase or keyword	Line Number
Fitting in (with new mums)	285
Not knowing what to say	291
Trying to keep my child calm	292
Couldn’t really concentrate	293
They didn’t like me	294
What’s wrong with me?	297
Something’s wrong with me	297/8
I’m not good enough	298
Very negative thoughts about myself	298/9
Sometimes rage	318
Intense feeling of fury	323
Wanted to throw things	323
That’s not me at all	324
A really different feeling	325
Shocking, scary	327
Terrifying	329
It feels like your head is going to explode	332
Need to throw things to get it out	332

Appendix H: Analysis 3 – Grouping clusters/tentative themes – Abbie

Not fitting in with the others

I did have quite a lot of social anxiety around fitting in with the new mum friends I made

They all found it a lot easier to talk to watch other than I found it. I would not know what to say sometimes, well actually I was spending such a lot of the time when I was with them in trying to keep my child calm.

I couldn't really concentrate on the conversation or contribute very much, just thinking they didn't like me as much as they liked watch other and just thinking they didn't want to spend time with me and that sort of thing.

Intensity of emotion

The anxiety I felt the night he was born was different

We were in the hospital at the time still and I just became absolutely hysterical

It was just extreme anxiety and a lot a lot of racing thoughts…my husband had gone home and its very embarrassing to admit but I left him a voicemail in the early hours of the morning and I remember actually just screaming because I was so hysterical

It was just very hard, very all consuming, very anxiety provoking. Just worrying a lot ad being tearful about it quite a lot.

Quite exhausting and feeling low and hopeless

You asked me what it felt like and I'd forgotten this because it was only in the early days but sometimes rage.

It was just a very intense feeling of fury with myself and the situation and actually with my son, even though it wasn't actually his fault at all. And you know, I just wanted to throw things and that's not me at all, that was actually a really different feeling for me.

Quite shocking, very scary and if you've come from a background where you have seen a lot of rage in your parents, which I have, and said, you know, 'that will never be me' but then to feel it that was really terrifying

It feels like your head is going to explode and you need to throw something to get it out.

Everything is doomed

Things are not going to get better; things are very wrong. It's like, even those words wouldn't come into my head, it's a feeling... that everything is doomed.

Well, it would be things that I've sort of being worrying about under the surface that have been building up over a few days um… just suddenly gets too much and everything feels too much.

I can't switch my head off

I couldn't sleep and the issues wasn't that my son was waking up a lot and everything he wasn't, he was actually quite a good sleeper from the start but I just couldn't switch my head off.

There was this tension because I really wanted to sleep and there was this feeling that I was selfish for wanting to sleep and not wanting to wake him up and feed him and thoughts that I was a bad mum already.

Just lots of thoughts racing around.

I was worried about… my baby was sleeping and he was fine but I was thinking I ought to be waking him up and feeling him.

A lot of worries…

Even though my son slept really well, any time he woke up in the night I sort of panicked a bit.

…say he work up a third or fourth time, I'd start thinking, oh my gosh, this is the start of him not sleeping through the night, I'm not going to get any sleep, I'm not going to cope…it was really just a selfish thing I think, just constantly panicking that I wouldn't be able to cope and that we had to get him back to sleep we had to figure it out, otherwise everything would go downhill, I'd start sleeping really badly, I wouldn't be able to cope.

Something is wrong with him

I started to notice he seemed different from other babies, in my mind anyway, it would happen quite often when we were out, he'd be in the pram or at a swimming lesson, or a music class, he'd just start shouting, not crying and I couldn't soothe him.

It made me feel quite a lot of negative thoughts about my son, that something was wrong with him.

My current fear has been that he's on the autistic spectrum and that's something that I'm still worried about now but for different reasons but it's quite interesting how I became fixated on that.

I would spend quite a lot of time googling things he was doing or not doing, googling experiences of other parents whose children turned out to be autistic, you know

finding parallels between their experiences and my son. Looking up all the red flags to watch out for.

I'd keep checking until something would happen that would reassure me and then I'd stop worrying about it. The next week something else would worry me and I'd start googling again.

Something is wrong with me

I knew that I wasn't sleeping and, I was already quite worried during the pregnancy that my mental health would deteriorate and so I was thinking this is the start, this is me developing severe mental health problems after birth.

I was so afraid of coping that it made me not cope.

For a long time while I found him really difficult and was really anxious about his development, you know, I found it hard to feel that love towards him. Like my husband and I would be bathing him and my husband would say things like 'oh he's so wonderful, he's beautiful, he's so amazing' and I'd be thinking, 'I don't feel that'.

I suppose it did highlight the contrast for me of course I should be feeling those things too and I'm struggling to.

I'm the one who's not ok and that's what the problem was.

Just that feeling of not being able to cope and not feeling or behaving in a way that was not healthy or appropriate, or how a mother ought to be

It physically took over me

A lot of physical feelings of anxiety

A really tight feeling in my chest, like something heavy is pressing on it and a sort of sinking feeling in my chest and then also in my stomach.

It's like butterflies in your tummy, like a kind of churning feeling.

My breathing changing. I don't know how to explain it really. Slightly breathless almost but not breathing fast. I don't know how to describe it.

Feeling sick

All the tearfulness and things like that

Quite exhausting

It feels like your head is going to explode and you need to throw something to get it out.

I doubted my capabilities

I couldn't do it, I couldn't soothe him

I couldn't soothe him. Nothing I did seemed to help

He seemed more comfortable on his dad

I found it hard to feel that love towards him

Anxiety affected our bond

He'd just be shouting, it would be very loud, I couldn't soothe him, I would get very anxious about that.

It made me feel a lot of negative thoughts about my son, that something was wrong with him.

I do wonder if it affected my relationship with my son. Firstly because I think I let my husband do quite a lot because I was so anxious about something like for example he wouldn't settle easily on me after feeding. He'd sort of squirm quite a lot and he seemed more comfortable on his dad so I would always let his dad sort of wind him and he'd fall asleep on him and my husband would put him down. I do wonder if me giving him to my husband all the time, to do that very soothing ritual… you know I still breast fed him all the time, I did that part, I do wonder if that created a bit more distance between me and my son. And also this perception in me that I couldn't do it. I couldn't soothe him. And of course all this worrying about autism and all this looking for behaviours and what was wrong and all this thinking that other people found him annoying, it's a very negative way to think about your son and I wonder if spending so much time and mental energy thinking about those negative things made me feel more globally negative about him as a person and not be able to see or enjoy his positive qualities.

I really just didn't enjoy my son for a long time

I think for a long time while I found him really difficult and was really anxious about his development you know I found it hard to feel that love towards him and my husband and I would be bathing him and my husband would say things like 'oh he's so wonderful he's so beautiful he's so amazing and I'd be thinking, 'I don't feel that'.

It affected my relationship

One of the worst impacts was that it made me very irritable with my husband. I'd snap at him for little things, be a bit controlling I think, try and micromanage him a little bit around the areas I was anxious about.

Even though my son slept really well, any time he woke up in the night, I sort of panicked about it a bit and I could be a bit mean to my husband and say, ‘Oh it’s because you were noisy going to the bathroom’ and that kind of thing which was really unfair.

I’d say, ‘oh it’s because you didn’t do this, or you did that’ just really being unpleasant.

It bought a lot more tension into our relationship because my husband was actually just really fantastic and a lot more supportive than my friends’ husbands and did a whole lot but I was not grateful, just irritable and it was very hard for him.

I am not enough

I was a bad mum already

Even though he wasn’t crying, he was putting on weight so there were no concerns about his weight or anything but just this feeling that I ought to be feeding him more, I wasn’t doing enough, I wasn’t caring enough.

The fear I’d had really throughout my pregnancy and even before, of not being a good enough mum and not loving my son enough and not being able to cope.

I suppose it did highlight the contrast for me of course I should be feeling those things too.

It felt like I wasn’t a good enough mum, I didn’t have a good enough relationship with him.

It was horrible because I just had lots of thoughts, like what’s wrong with me, or somethings wrong with me…you know, I’m not good enough, lots of those kind of very negative thoughts about myself

Well, it feels quite selfish really. It feels quite self-involved, um, and not maternal and not what a mother should be worried about.

Just this feeling of not being able to cope and not feeling or behaving in a way that was healthy, or appropriate or how a mother ought to be.

Appendix I: Analysis 4 – Themes & subthemes – Abbie

Meta-theme	Sub-theme
Being taken over	Extreme emotion
	Embodied experience
	I can't switch my head off
	Everything is doomed
Difficulty Relating	Marital tension
	Difficulty bonding
	Not fitting in
Not good enough	I am not enough
	I can't do this
Something is wrong	Something is wrong with him
	Something is wrong with me

Appendix J: Analysis 5 – Van Manen's lifeworlds – Abbie

	SUB-THEME	VERBATIM EXAMPLE	LIFEWORLD
Being taken over	Extreme emotion	I was so hysterical; intense feeling of fury; sometimes rage	Lived body
(Loss of autonomy)	Embodied experience	Tight feeling in my chest; something heavy is pressing; butterflies; a churning feeling; slightly breathless; head is going to explode; need to throw something	Lived body
	I can't switch my head off	I ought to be waking him up and feeling him; I'm not going to get any sleep; I'm not going to cope; I'd start sleeping badly; I wouldn't be able to cope; I was so scared of not coping	Lived time Lived other
	Everything is doomed	Everything feels too much; things are not going to get better; things are very wrong; it's a feeling…. That everything is doomed.	Lived body
Difficulty relating	Marital tension	Irritable with my husband; a bit controlling; really unfair; not grateful, just irritable	Lived other Lived space Lived time
(Guilt)	Difficulty bonding	I didn't have a good enough relationship with my son; a lot of negative thoughts about my son; my son wouldn't settle easily on me after feeding; he seemed more comfortable on his dad; distance between me and my son; I really just didn't enjoy my son for a long time; I found it hard to feel that love towards him; I don't feel that; I'm struggling to	Lived other Lived time Lived body
	Not fitting in	They found it easier; I would not know what to say; I couldn't concentrate; they didn't like me; they didn't want to spend time with me	Lived space Lived time Lived body Lived other

	SUB-THEME	VERBATIM EXAMPLE	LIFEWORLD
Not good enough	I am not enough	I ought to be waling him up and feeling him; I really need sleep; I was feeling selfish; not wanting to wake him; I was a bad mum already	Lived time Lived other
(Guilt)	Doubting capabilities	I couldn't do it; I couldn't soothe him; Nothing I did seemed to help; He seemed more comfortable on his dad; I found it hard to feel that love towards him;	Lived other Lived body
Something is wrong	Something is wrong with him	He seemed different from other babies; he'd just start shouting; something was wrong with him	Lived time Lived body
(Uncertainty)	Something is wrong with me	This is me developing severe mental health problems; you're the one whose imploding; I'm the one who's not ok	Lived body

Appendix K: The crafted story – Abbie

I remember feeling really anxious the night after my son was born in hospital. I've been very anxious before, but the anxiety I felt the night he was born was different. I couldn't sleep and the issues wasn't that my son was waking up a lot - he wasn't, but I just couldn't switch my head off. There were lots of thoughts racing around and I just became absolutely hysterical. My husband had gone home, and I left him a voicemail in the early hours of the morning and I remember screaming because I was so hysterical.

My baby was sleeping, and he was fine but I was thinking I ought to be waking him up and feeding him and at the same time there was this tension because I really needed to sleep. I was feeling selfish for wanting to sleep and not wanting to wake him up and feed him - I was a bad mum already. Even though he wasn't crying, he was putting on weight so there were no concerns, but I just had this feeling that I ought to be feeding him more, I wasn't doing enough, I wasn't caring enough.

I was so scared of not coping that when something went slightly wrong it reinforced that fear and made me feel like I wasn't coping. There were a lot of worries and a lot of physical feelings of anxiety. I would experience a tight feeling in my chest, like something heavy is pressing on it and then a sort of sinking feeling. In my stomach I would feel butterflies and a kind of churning feeling. I noticed my breathing changing and I became slightly breathless

I became very irritable with my husband, I'd snap at him for little things, be a bit controlling and try to micromanage him. When my son woke up in the night, I panicked, and I would blame my husband and say 'Oh it's because you were noisy going to the bathroom'. I could be really being quite unpleasant to him. It bought tension into our relationship. He was actually really fantastic and supportive, but I was just not grateful, just irritable and it was very hard for him.

If my son kept waking, I worried that this was the start of him not sleeping through the night. I worried that I'm not going to get any sleep, I'm not going to cope, it was just a really selfish thing. I was constantly panicking that I wouldn't be able to cope, and everything would go downhill. I was so afraid of not coping that that made me not cope!

From about one month old, I started to notice that he seemed different from other babies, we'd be out, and he'd just start shouting, not crying, just shouting loudly. I couldn't soothe him. Nothing I did seemed to help, and I would get very anxious about that. I thought that something was wrong with him. I would spend quite a lot of time googling things he was doing or not doing, googling experiences of other parents, finding parallels between their experiences and my son. Looking up all the red flags to watch out for. I'd keep checking until something would happen that would reassure me and then I'd stop worrying about it. The next week something else would worry me and I'd start googling again.

It felt like I wasn't a good enough mum, I didn't have a good enough relationship with him. It felt like everyone saw that and judged me for it. I let my husband do quite a lot because I was so anxious about things. After feeding my son wouldn't settle easily on me and he seemed more comfortable on his dad. So, I would always let his dad wind him and he would put him down. I wonder if me giving him to my husband all the time, to do that very soothing ritual… created a bit more distance between me and my son. I also had this perception that I couldn't do it. I couldn't soothe him.

I just didn't enjoy my son for a long time. I found him really difficult, and I found it hard to feel that love towards him. My husband and I would be bathing him, and my husband would say 'he's so wonderful he's so beautiful he's so amazing' and I'd be thinking, 'I don't feel that'. It highlighted the contrast between us; I should be feeling those things too and I'm struggling to.

I was getting really upset and crying and saying to my husband how worried I was about my son, and he said, 'look at him, he's fine, he's happy, but you're the one whose imploding' and that kind of stood out for me. I'm spending all this time worrying about my son and that he's not ok but I'm the one who's not ok actually and that's what the problem was.

There was a feeling of not being able to cope, not feeling or behaving in a way that was healthy, or appropriate, or how a mother ought to be… It feels quite selfish really. It feels self-involved, not maternal, and not what a mother should be worried about.

Things that I'd been worrying about under the surface that had built up over a few days would just suddenly get too much - everything felt too much. It was exhausting,

and I felt low and hopeless. Things were not going to get better; things were very wrong. It was a feeling that everything was doomed.

I struggled to fit in with my new mum friends; that feeling that they all found it a lot easier to talk to each other than I found it. I would not know what to say sometimes well actually I was spending such a lot of time when I was with them in trying to keep my child calm, you know I couldn't really concentrate on the conversation or contribute much. I felt that they didn't like me as much as they liked each other, and I thought that they didn't want to spend time with me.

In the early days I would sometimes feel rage - a very intense feeling of fury with myself, the situation and my son. I just wanted to throw things and that's not me at all, that was a very different feeling for me. It was shocking and very scary - it was terrifying. It feels like your head is going to explode and you need to throw something to get it out.

Appendix L: The crafted found poem – Abbie

I can't switch my head off.
Racing thoughts,
hysterical screaming.

He's thriving, but,
I'm not doing enough,
I'm not caring enough.

My chest is tight,
my stomach is churning,
I'm irritable and unpleasant
- I'm breathless.

He won't sleep,
I won't sleep,
I won't cope.

He's different to others,
I can't soothe him,
I can't do it.
Something is wrong.

I read,
I Google,
I check,
I repeat.
Over and over again.

His dad loves him,
but I struggle to.
I should feel the same, but,
I'm not feeling or behaving
how a mother ought to.

Exhausted, low,
and hopeless,
Everything is doomed.

Lonely & isolated,
I struggle to fit in.
What's wrong with me?
Something's wrong with me,
I'm not good enough.

Rage and fury,
shocking and scary,
I feel like my head will explode.

Appendix M: Choral poem – All participants

“Being taken over”

I felt sick,
nauseous,
like being on one of those fairground rides,
Tummy churning,
Jittery, clammy, nervous and shaky,
Ready to run,
Ready to lash out,
Ready for a fight.

My body tingled with pins and needles,
I’d feel breathless.
Unable to eat
unable to sleep
Always on edge.

Dry mouth,
Heart pumping,
Palpitations,
A heavy weight in my chest,
Pressing down.

I’d be fuming,
I’d be raging inside,
I needed to hit something,
I needed to scream,
for no reason.

Restless & panicky
Panicky and edgy,
I was talking on a tight rope,
My head was spinning.
It was engulfing.

Hyperventilating,
hyperaware,
A feeling that something awful might happen,
It would never switch off,
Everything made me jump
Everything felt loud,
So draining,
exhausting.

I’d ache inside,
I’d be hurting,
Heartbroken.
A sinking feeling
Like something terrible had just happened.

Watching my life,
but not being in it.
I’d be there, but not really there,
every day the same.
My head was going to explode,
I couldn’t take anymore.

Appendix N: Example process – Theme 2: Being with uncertainty

Writing & reflection Selective highlighting, keywords, crafting stories, tentative themes, crafting poems	**Interpretive process** What does this mean? What is being conveyed here? Tentative interpretations	**Further interpretations - emergent themes** Wholistic summary, poetic haiku format to grasp the ontological nature of '*being anxious*'	**Philosophical notions and interpretive leap** Contemporaneous immersion in existential texts to uncover links to relevant philosophical concepts
How do I do this? How do I know what to do? When do I feed? When do I change nappies? Am I doing anything right? Nothing I do helps to soothe my baby. He needs something from me, but I don't know what that is. He's crying but I don't know what to do. I don't know how to get this right.	➢ Anxiety manifests as not-knowing ➢ What does my baby need? ➢ How will I know? ➢ If I don't know, how can I provide what he needs? ➢ Feelings of insufficiency ➢ To not know means to not be good enough ➢ Ambiguity	**WHAT DO YOU DO WITH A BABY?** *It's like shifting sands,* *That feeling of helplessness* *How do I do this?* (Choral haiku)	➢ Ontological crisis ➢ An 'in-betweenness-of-being' ➢ Existentially insecure ➢ Kierkegaard's 'angst' & 'dizziness of freedom' ➢ Sartre's 'choices and options' ➢ Heidegger's 'unheimlich' - not feeling at home
He won't stick to the schedule I try and impose. It became an obsession, I tried to force him into it. I was scouring the internet looking for answers, I read the blogs, I tried to follow the theories, I wrote everything down, but I couldn't control and contain the situation. I cleaned until the house was spotless.	➢ Anxiety manifests as seeking answers to the unknowns ➢ Everything was carefully documented in order to find patterns which would provide answers ➢ Things that could be controlled became an obsession: so that at least something felt manageable	**SEEKING CERTAINTY** *Obsessed with schedule* *I needed to understand* *how I resolve this* (Choral haiku)	➢ Dewey – compelled to seek certainty when faced with unknowns ➢ The expertise paradox – too much choice leads to further uncertainty ➢ Renouncing existential freedom by seeking concrete answers ➢ Sartre - confronted with freedom ➢ Existential anxiety ➢ Hays - Intensive mothering to meet cultural pressures & get it right
I was afraid to leave the house, it was too dangerous outside. I kept him close to me at night, I would keep checking on his breathing, I thought he might stop breathing. What if my child gets ill? What if the health visitor takes my child away from me? What if something happens?	➢ Anxiety manifests as a protective instinct ➢ Checking for something untoward ➢ Scanning for danger ➢ Hypervigilance ➢ Future-focused threats experienced in the present ➢ Maternal responsibility weighs heavily	**WHAT IF…?** *What's wrong with my child?* *What if something bad happens?* *I can't be alone* *(Choral haiku)*	➢ Infant vulnerability – connection between natality and mortality ➢ Heidegger's notion of being-towards-death ➢ Kierkegaard's notion of awe and dread – being and non-being. ➢ Sartre – responsibility