Which pregnant women worry that something might be wrong with the baby?

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Abstract
Little is known about the normal range and pattern of pregnant women’s worry about something being wrong with the baby, nor how this relates to other factors. We report longitudinal data from 1057 pregnant women who completed postal questionnaires at 16, 22 and 35 weeks of pregnancy. Worry that there might be something wrong with the baby was found to be one of the most prevalent worries at 16 weeks although not as widespread a source of extreme worry as ‘miscarriage’ or ‘giving birth’. Worry dropped in mid-pregnancy but rose again at 35 weeks. Multivariate statistical techniques were used to discover which variables were independently related to worry about the baby. The most important factors were perceived likelihood that there might be something wrong with the baby and trait anxiety, although negative mood, previous pregnancy outcomes and initial reactions to the current pregnancy were all found to have significant, independent effects.
Which pregnant women worry that something might be wrong with the baby?

Introduction

Screening and diagnostic tests for fetal abnormality are now in widespread routine use and a number of studies have examined women's anxiety levels in relation to the results of the screening tests which they have undergone (1,2). Most babies do not have abnormalities, and these tests can, potentially, reassure parents that this is so. However, it has been argued (3) that the reassurance is needed only because the tests created doubts in the first place. This raises questions about the extent to which, in the absence of specific considerations about testing, pregnant women do worry about the possibility of something being wrong with the baby. Although it is reported to be a universal concern (4), the existing literature on women's experiences of testing sheds little light since most studies focus on a particular screening technique, or on a particular subgroup of women, usually "high risk", or women given true or false positive results. Many studies are retrospective and have used a generalised measure of anxiety such as the Spielberger state anxiety score (5), with the assumption that any anxiety is about fetal abnormality (1, 2).

There are, however, many other things that a pregnant woman might worry about: again a number of studies have addressed the issue of generalised anxiety and its implications in the aetiology of maternal and fetal complications (6,7). Other studies have addressed the general concerns of pregnant women (8-10). Worry about the health of the baby has been identified as a major concern ( eg ref. 10) but with relatively small samples it is not possible to explore the factors which might influence such a worry. For example, personality characteristics and past history might be expected to account for some of the variation in women's feelings. In short, little is
known either about the range of variation nor about why particular women may be worried and others not.

In this paper, we will examine the extent to which women are worried about the possibility of something being wrong with the baby relative to other worries they may have, and determine whether there are demographic, experiential, attitudinal and personality characteristics associated with this worry. The data were derived from the Cambridge Prenatal Screening Study (11-15), a large, prospective study of pregnant women which not only examined the knowledge, attitudes, and experiences of pregnant women booked for antenatal care at hospitals with different screening policies but also monitored their worries throughout pregnancy and after delivery.

Methodology

The Cambridge Prenatal Screening Study:
The purpose of the study was to chart the knowledge, attitudes, anxieties and experiences of pregnant women from before their first hospital appointment through to the post-natal period, with a particular focus on screening for fetal abnormality. A series of four postal questionnaires, designed for the study, allowed us to look at women's experiences in the context of other things happening in their lives. Questionnaires were sent at or before 16 weeks (time 1), at 22 weeks (time 2), 35 weeks (time 3) and at 6 weeks postnatally (time 4). This paper presents data from the first three questionnaires.

Recruitment of sample:
Pregnant women were recruited to the study between January and March 1990 in
nine District hospitals, all within 60 miles of Cambridge (UK). District Hospitals are non-teaching hospitals, and are where the majority of pregnant women in the UK deliver their babies. Women were recruited via a letter and questionnaire forwarded to them with notification of their first hospital appointment, which was generally at around 12-14 weeks. 3550 questionnaires were sent out of which 1876 (53%) were returned. All women booking for antenatal care in the study hospitals during the target period were eligible for the study; there were no exclusions. Recruitment continued until each hospital had distributed all the questionnaires allocated. Valid responses were obtained from 1824 women (51%) while 52 were from women who had miscarried prior to receipt. Not all questions were answered by all women. In particular, 140 women completed an alternative version of the questionnaire which contained no questions specifically about screening and fetal abnormality. 

Measures:

Worries: Worries were measured using the Cambridge Worry Scale (CWS) (11,15,17). This lists issues of possible concern to pregnant women, covering pregnancy, health, relationships and socio-economic items. Women score each from 0 (not a worry) to 5 (extremely worrying). The items vary slightly at different gestations. Sixteen items were listed in the first questionnaire. Only one item will be considered in detail in this paper: >the possibility of something being wrong with the

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1The purpose of these was to create a control group whereby we could check whether the questionnaires were raising awareness or creating anxiety about fetal abnormality. There was no evidence that worry about fetal abnormality differed between those receiving the two questionnaires: F(1,1799)=.50 ns.

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baby' and this will be referred to as *baby worry*.

**Independent variables:**

A large number of variables were considered which were all derived from responses in the first questionnaire: initial reactions to the pregnancy; thinking of the baby as a person; physical well-being; negative mood; reproductive history; trait anxiety; perceived likelihood of the baby having a problem; age; religious influence; level of education; paid employment; and whether or not the woman had a partner. These are described below together with sample characteristics.

**Analysis:** Data were analysed using the Statistical Package for the Social Sciences using analysis of variance (ANOVA). One-way ANOVAs were carried out for each independent variable at each time point, followed by Scheffé contrast tests to establish which pairs of groups differed significantly from each other. Repeated measures analysis of variance was used to investigate different patterns over time for different subgroups. Finally, all variables were entered into a factorial analysis of variance, which indicates which variables contribute an independent significant effect on baby worry when the others are taken into account.

**Sample characteristics and details of independent variables**

Although 1824 women were recruited to the study, the data reported here are restricted to women who: completed all three antenatal questionnaires; were less than 16 weeks pregnant at recruitment; and were never told that any screening test had revealed (possible) problems with the baby (N=1072). Mean age, along with baby worry and trait anxiety scores (both measured at the first questionnaire) did not differ for this selected group when compared with the whole sample. For example,
comparing those who had only completed one (n = 284) or two (n =143) or three questionnaires (n = 1397) F(2,1798) = 0.80, ns for baby worry.

**Initial reaction to pregnancy:** The first question women were asked was "How did you feel about finding that you were pregnant?" The five response options (overjoyed; pleased; mixed feelings; not very happy and very unhappy) were collapsed to three categories: positive (N=791, 74%), mixed (N=246, 23%) and negative (N=35, 3%).

**Thinking of the baby as a person** Do you think of your baby as being a person yet? Response options were 'yes' (N=747, 70%), 'no' (176, 17%), 'don't know' (N=93, 9%) and 'haven't thought about it' (N=53, 5%). These last two responses were combined for the analysis.

**Physical wellbeing:** Women were asked "How have you been feeling so far during your pregnancy?" Response options were "Sick and tired some of the time" (N=517, 48%), "Sick and tired all of the time" (N=428, 40%), "Same as usual" (N=56, 5%), "Very well" and "Blooming" (these two were combined for the analysis: N=70, 7%). Responses given refer to physical feelings at the first questionnaire early in pregnancy. This question was asked again in later questionnaire and analyses for times 2 and 3 use the answers given at those times.

**Negative mood:** Women were presented with a list of 21 adjectives and asked to circle all of the words that described how they felt at that moment. The negative mood score was the number of negative adjectives chosen: zero (N=357, 34%), 1-3 (654,61%), >3 (N=54, 5%). The number of negative adjectives appears to be useful
measure of generalised negative mood; we have found it to correlate highly with standardised measures of depression and anxiety ($r = 0.50$ with the Edinburgh Postnatal Depression Scale and 0.55 with the state scale of the STAI see ref 16). As with physical wellbeing, this question was asked again in later questionnaires and analyses for times 2 and 3 use the answers given at those times.

Reproductive history ("herstory"). Women were classified into the following groups:

- **GpN**: No previous pregnancies ($N=404$, 38%)
- **GpS**: Previous pregnancies all Successful ie they resulted in the live birth of a healthy baby ($N=390$, 37%)
- **GpU**: Previous pregnancies all Unsuccessful ie did not result in the live birth of a healthy baby ($N=80$, 8%)
- **GpS/U**: Mixed pregnancy experiences ie at least one Successful pregnancy and one Unsuccessful ($N=186$, 18%)

'Unsuccessful' pregnancies were those that resulted in miscarriage, stillbirth, the birth of an ill or handicapped child or a termination for medical reasons. These events are all grouped together for this paper, although we have considered them separately elsewhere (15). Terminations of pregnancy for non-medical reasons have been distinguished from 'unsuccessful' pregnancies in that the cessation of the pregnancy is presumed to be the desired outcome, they will have occurred early in pregnancy and the woman will not have undergone any screening tests. In general, they appear to have virtually no impact on the outcome measures used in this study (15) and they have therefore been disregarded for these classifications.

**Trait anxiety:** The Spielberger State Trait Anxiety Inventory (5) has two parts: 'trait', which measures anxiety as a personality characteristic and 'state' which measures
the anxiety of the moment. On the basis of the 'trait' scores, women were grouped in quartiles based on the scores of the original sample of 1824 as 'very low' (N=262, 25%); 'low' (N=280, 27%); 'high' (N=251, 24%); and 'very high' (N=242, 23%). The mean score was 38.4 (sd 8.1). (State anxiety scores will not be reported in this paper).

Likelihood of a problem: Women were asked "Have you any reason to think that your baby might be more likely than any other to have some sort of a problem?" The sample was grouped according to the three response options 'yes' (N=142, 14%); 'no' (N=760, 77%) and 'don't know' (N=92, 9%). (This question was not asked in the 'alternative' questionnaire. Percentages are based on the 994 women who answered the question).

Age was classified as < 21 years (N=97, 9%); 21-34 years (N=984, 83%); and >34 years (N=81, 8%). The mean age was 26.9 years (sd 4.8).

Religious influence "Does your religion or religious upbringing influence the sorts of decisions that you make about your life?" Response options were: not at all (N=638, 60%), a little (N=226, 21%), quite a lot (N=89, 8%), completely (N=22, 2%), and not applicable (N=90, 9%).

Level of education This was classified as minimum (ie the women left education at the earliest possible age which was usually 16 years), (N=599, 56%); some further (up to the age of 18 years) (N=331, 31%); and higher (above the age of 18 years) (N=142, 13%).
Paid employment Six hundred and sixty three women (62%) were in paid employment at time 1, and 403 (38%) were not.

Married or living as married. One thousand and thirteen women (95%) were married or living as married, 59 (6%) were not.

The socio-demographic characteristics of this particular study group described above define a population broadly representative of the childbearing population of the areas served by the study hospitals. This part of the UK is largely rural or with light industry. While all localities have areas of social disadvantage, there were no inner-city hospitals. Only one had a large ethnic minority group and we were not successful in recruiting from that sector in spite of trying to use link workers. Use of the term 'married or living as married' was left to the women themselves; the apparently high rate of babies conceived within stable relationships may reflect different interpretations of the term. Lower rates of teenage pregnancy occur in the UK compared with the USA (18).

Results

Baby worry in the context of other worries: Every one of the worries listed was given the full range of scores from 0 to 5. For baby worry, 10% scored zero at time 1; this was a lower percentage than scored zero for any other worry (Figure 1). More women scored 4 or 5 for 'miscarriage' and 'giving birth', but the mean score for baby worry was higher than for any of the other worries (mean 2.55, sd 1.54). Sixteen percent scored the maximum of 5 for baby worry and a further 12% scored 4.
Baby worry over time

Baby worry dropped at time 2 and rose again at time 3, although not to the initial levels (Table 1). Repeated measures ANOVA showed these differences were significant (F (2,1035) = 85.5 p<0.0001).

Baby Worry x independent variables

The only independent variables that were not significantly related to baby worry at any time point were being married (or living as married) and influence of religion. Thinking of the baby as a person was not significant at times 1 or 2, but at time 3 those who had answered 'no' had higher baby worry than those answering 'yes' (p<0.05). Although all one-way ANOVAs were significant, the independent variables were highly inter-related. When all of these variables were taken into account, the factorial analysis of variance carried out for each time point showed that education, age, being in paid employment and physical well-being, were not significant. The variables which did show independent effects, in order of significance at time 1, were: likelihood of a problem, trait anxiety, negative mood, herstory and initial reaction to pregnancy. F values and significance levels at each time point are shown in Table 2. The total multiple R^2 was 0.21 at time 1 and 0.13 at times 2 and 3.

As Table 2 shows, perceived likelihood of a problem was the most significant.
predictor of worry at time 1, but was less important at times 2 and 3. The F ratios for all five variables were lower at time 2 than at time 1, but trait anxiety became relatively more important again at time 3. Initial reaction to the pregnancy was the least significant predictor, but, unlike the other variables, it maintained the same level of association at each time point.

**Baby worry x likelihood of problem**

Figure 2 shows the pattern of baby worry for the three groups answering 'yes', 'no', and 'don't know' to this question. Figure 2a shows the basic mean scores for each group; figure 2b shows adjusted means which take into account the contributions of the other significant variables. Baby worry was significantly higher throughout pregnancy for those women who answered 'yes' or 'don't know' than for those who answered 'no'. At time 2, those who answered 'don't know' had significantly higher scores than those who answered 'yes'. However, note how the mean score for the 'don't know' group becomes lower at each time point once other variables are taken into account. This is a reflection of the higher levels of trait anxiety of the women who answered 'don't know'. Repeated measures analysis showed significant differences in the pattern of change over time (F = 11.47 p<0.0001), with the 'yes' group showing a steeper drop from time 1 to time 2 and a steeper rise from time 2 to time 3 than the other groups.

Figure 2 (Baby worry x likelihood of problem) about here

**Baby worry x trait anxiety**

Women with higher trait scores had higher baby worry scores (Figure 3). As before, Figure a shows basic means, and figure b means adjusted for the contribution of the

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other variables. The two middle groups do not differ significantly from each other, and, by time 3, the group with the lowest trait scores is closer to these two groups than at previous time points. However, the group with the highest trait scores remains significantly more worried throughout. The groups did not differ significantly in their pattern over time. The effect taking other significant variables into account (Figure 3b), is to slightly reduce the differences between the groups, but the basic pattern remains the same.

Figure 3 (Baby worry X Trait Anxiety Group) about here

Baby worry x negative mood The relationship at times 1 and 2 was linear: the more negative adjectives scored, the higher the worry about the baby (Figure 4). At time 3 the most negative group had lower scores than would have been expected from the previous time points and were not significantly different from the middle group. When the other variables were taken into account, the scores of the most negative group are reduced (Figure 4b), reflecting the fact that this group has a greater contribution from the other variables such as trait anxiety.

Figure 4 (Baby worry x negative mood) about here

Baby worry x herstory
The consistent pattern was that women with only successful pregnancies were the least worried and those with only unsuccessful pregnancies prior to this study were consistently the most worried (figure 5). Women with mixed pregnancy experiences were slightly less worried than those who had never been pregnant before. Women with only unsuccessful pregnancies were the group whose mean score changed
most after adjusting for other variables. This is a reflection of their significantly higher trait anxiety scores. The groups did not differ significantly in their pattern over time.

Figure 5 (Baby worry X Herstory) about here

Baby worry x initial reaction to pregnancy

The unadjusted means show women with mixed feelings about the pregnancy as consistently the most worried about the possibility of something being wrong with the baby (Figure 6). However, adjustment for the other significant variables has the effect of substantially decreasing the means for both the negative and the mixed groups (Figure 6b). This reflects that fact that non-positive reactions to the pregnancy are highly related to other significant factors such as previous pregnancy experiences. The result of this is to make the positive and mixed groups more similar; the significant effect in the factorial analysis can be seen to be primarily because the negative group have the lowest mean scores. Although the negative group do not show the characteristic rise in scores between time 2 and time 3, there was no significant difference in the way the groups changed over time.

Figure 6 (Baby worry x initial reaction to pregnancy) about here
Discussion

We have shown that worry that there might be something wrong with the baby is indeed a very prevalent worry for pregnant women. Most women rate their worry in the mid-range, but for some women it is a very major worry. In most cases, worry drops by mid-pregnancy and rises again at the end. This corresponds to the characteristic U-shaped curve for mood during pregnancy first described by Lubin and colleagues (19).

Because our study was very large, we were able to examine the relationship between baby worry and a range of independent variables to try and explain why some women are more worried than others, and why not all women follow the same pattern over time. A range of experiential, attitudinal, personality, and mood factors were found to be related to baby worry. Perhaps not surprisingly, women with previous pregnancies which had not resulted in the birth of a healthy baby had the highest baby worry scores. This was especially so if they had not also had a successful pregnancy. However, in terms of reproductive history, the group who were statistically most different from the rest were the women who had had only successful pregnancies; these women were significantly less worried than the other groups. So, it is not just that previous unsuccessful pregnancies increase baby worry, but having experience of at least one successful pregnancy also decreases baby worry.

Trait anxiety score was also a strong predictor of the extent of women's baby worry. The sample was divided into four roughly equal sized groups according to whether their scores were in the top 25%, the next 25% etc. Groups with lower trait anxiety scores did not necessarily have significantly lower baby worry scores, but the top
quartile group were consistently more worried throughout pregnancy. So, this indicates that high trait anxiety is a sufficient but not a necessary condition for baby worry: in other words, if a woman is of a highly anxious disposition then she will probably worry about something being wrong with her baby, but she might still worry for other reasons even if she is not an anxious type.

Initial reaction to the pregnancy was also predictive of baby worry: in the basic analysis, women with *mixed* feelings were the most worried. The most frequently cited reasons for mixed feelings were: previous pregnancy experiences, unplanned pregnancy or social and housing difficulties. Thus, accounting for other significant variables, particularly previous pregnancy experience and trait anxiety reduces the mean score of this group. However, the multivariate analysis also had the effect of lowering the mean score of the group who were most negative about their pregnancy, who already had low scores. This is because this group had higher trait anxiety scores, which therefore masked their relative lack of worry about the baby.

One of the strongest predictors of baby worry was the answer given in early pregnancy to the question "Have you any reason to think that your baby might be more likely than any other to have some sort of a problem?". As might be expected, women answering 'yes' to this question were significantly more worried about the baby than women answering 'no'. The pattern of worry of the women answering 'yes' differed from those answering 'no', dropping more in mid-pregnancy, and rising more steeply again at the end. This was characteristic of women having amniocentesis (11), which many of these women will have done. The particular interest of this variable is in the women answering 'don't know'. These women were just as worried as those answering 'yes', and, indeed, had significantly higher scores at time 2. What
leads a woman to answer 'don't know' to this question? It may reflect general nervousness and a desire not to 'tempt fate' by answering 'no'; they did have significantly higher trait anxiety scores than other women, but they are still significantly more worried than the 'no' group when this was accounted for. It may, alternatively, reflect general ignorance; this group did contain a disproportionate number of women with the minimum level of education ($\chi^2 = 20.6$ df $p<.001$). It may of course also be that in some cases 'don't know' is the right answer, for example, if a woman does not know whether some previous event or current lifestyle puts her baby at risk. Depending on the reason for answering 'don't know', there are some obvious strategies that might be adopted for turning some of these 'don't know's into 'no's, and thus reducing their worries about the baby. We are currently undertaking further analysis of women who answered 'don't know' to this and a number of other questions in the study, since there is a suggestion that they might be a vulnerable group (work in progress).

The remaining variable that made a significant independent contribution to baby worry was negative mood. At time 3, there was no longer a difference in baby worry between women circling 1-3 negative words and women circling more than three; the significant difference was between these two groups and women circling no negative adjectives. This may well be a reflection of the fact that there was a general rise in the number of negative words circled between time 2 and time 3, thus, it was the women who circled none who were exceptional. At times 1 and 2, the relationship is a straightforward linear one: the more negative a woman feels, the higher the worry score. This is true even once other variables have been accounted for, in other words the relationship with baby worry is not just because women who choose more negative adjectives have higher trait anxiety. Furthermore, we have just seen that

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negative feelings about the pregnancy were associated with lower worry. Thus, the direction of the relationship between baby worry and negative mood is not necessarily what one would have predicted: we might have hypothesised that negative mood would be associated with apathy and worrying less about the baby. That this is not so may help shed a small amount of light on a question raised in an earlier study (20) where it was found that women with low emotional wellbeing postnatally were more negative about their babies. The question was whether these women were more negative about their babies because of their low mood or whether their low mood was a result of having a less likeable baby. The present finding would argue against the first interpretation if we take baby worry to be an indicator of positive concern about the baby.

Demographic variables, notably age and education, initially showed a significant relationship with baby worry, but then were found not to be significant once other factors were taken into account. This is an interesting finding. It is not often that we can expect a direct relationship between demographic variables and outcomes; more usually they are proxies for something else (21). In this particular case, however, a more direct link might have been postulated, for example, older women might be expected to be more worried about something being wrong with the baby because they are indeed at somewhat higher risk, and recent developments in diagnostic testing have emphasised this. However, despite a very strong statistical relationship from a simple analysis of variance in this study and similar findings elsewhere (10,22) which appeared to support that hypothesis, the factorial analysis was able to show that the effect was mediated through other variables. Age was, in fact, significantly related to every one of the other significant independent variables: older women were much more likely to have mixed feelings on finding that they were
pregnant; were much more likely to have been pregnant before and thus more likely to have had at least one unsuccessful pregnancy; and were least likely to circle no negative adjectives. They were also most likely to say 'yes', they thought it that their baby was more likely than others to have a problem, while the youngest group, who also had the highest trait anxiety scores, were more likely to say 'don't know'. Such a situation - highly inter-related independent variables - is very common, and it is only through the use of multivariate statistical techniques that we are able to disentangle all the separate effects.

The results presented here indicate that for the pregnant women in this sample, some degree of worry about whether or not the baby will be alright is normal: only 10% indicated that they were not at all worried. We have shown elsewhere (11) that baby worry is, in general, unrelated to the tests that a woman undergoes, except when results are abnormal, and that it is unrelated to knowledge about prenatal tests (14). We have shown here that the extent of this worry is largely determined by aspects of the woman=s life that she brings with her to the pregnancy: previous experiences and current attitudes are important. We cannot say how women in different cultural or socio-economic situations may feel. These women are pregnant in a health-care system that allows them free access to ante-natal, perinatal and post-partum care. Ultrasound scanning was offered to all women and there was a widespread belief that antenatal care was reassuring, (unpublished data). For most of the women here the pattern of worry was consistently U-shaped except for those women who answered no to the question "Have you any reason to think that your baby might be more likely than any other to have some sort of a problem?" If raised anxiety does have implications for fetal health (7) then we would suggest that the main message for practitioners to be derived from these data must therefore be with
regard to this question. If, for example, every woman’s caregiver were to ask it of her at the beginning of pregnancy and to follow up on her answer if it is ‘yes’ or ‘don't know’, then it would probably be possible to reassure many woman who would otherwise continue to worry throughout pregnancy.

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References


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Table 1: Baby worry at each time point

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<thead>
<tr>
<th></th>
<th>time 1</th>
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<th>time 3</th>
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<tr>
<td></td>
<td>mean</td>
<td>sd</td>
<td>mean</td>
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<td>baby worry</td>
<td>2.56</td>
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Table 2: Results of factorial analyses of variance for the independently significant variables at each time point

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<th>Time 1 F (df)</th>
<th>Time 2 F (df)</th>
<th>Time 3 F (df)</th>
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<td>10.56*** (2, 929)</td>
<td>10.09*** (2, 921)</td>
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<td>trait anxiety</td>
<td>25.29*** (3, 931)</td>
<td>16.11*** (3, 929)</td>
<td>20.51*** (3, 921)</td>
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<td>negative mood</td>
<td>19.21**** (2, 931)</td>
<td>14.48**** (2, 929)</td>
<td>14.50**** (2, 921)</td>
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<td>herstory</td>
<td>13.94*** (3, 931)</td>
<td>8.93*** (3, 929)</td>
<td>3.86* (3, 921)</td>
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<td>reaction to pregnancy</td>
<td>7.42** (2, 931)</td>
<td>7.21** (2, 929)</td>
<td>7.53** (2, 921)</td>
</tr>
</tbody>
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*p<0.01, **p<0.001, ***p<0.0001