

## **Pregnancy and Childbirth: Postpartum Anxiety (PPA) and Support for New Mothers**

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*Perinatal mood and anxiety disorders (PMADs) are a significant mental health concern worldwide. In Canada, researchers, maternal mental health advocates, and practitioners are working to increase understanding of mental health in the perinatal period. This article focuses on the necessity to expand and build upon current understanding of PMADs, particularly postpartum anxiety disorders (PPA). The traditional construct of postpartum depression (PPD) is inadequate to understand, assess, diagnose, and treat the wide range of postpartum mood disorders. Anxiety disorders may be underdiagnosed among new mothers. Specific risk factors are explored for this population and support interventions are provided for PPA. Additionally, this article explores ways to improve understanding of PMADs from a sociocultural perspective and to improve protective factors that may enhance a new mother's mental health. Addressing the gaps and needs in postpartum mental health will positively affect mothers, fathers, their families, and our communities.*

### **Pregnancy and Childbirth: Postpartum Anxiety (PPA) and Support for New Mothers**

Perinatal mental health is vitally important and has significant impact on the pregnancy, postpartum, transition to mothering, and parent-child attachment (Fairbrother et al., “Depression”; Marchesi et al; Mollard). Researchers demonstrate that postpartum anxiety (PPA) disorders receive considerably less attention than postpartum depression (PPD), despite how common anxiety disorders are among pregnant and postpartum women (Fairbrother et al., “Depression”; Farr et al.; Pilkington et al., “A Review”). Postpartum depression screening has long been the standard for new mother's postnatal adjustments—potentially neglecting the factors of anxiety and stress during this crucial transition time (Miller et al.). In fact, Stephen Matthey and

colleagues underscore that although many new mothers may not meet the criteria for PPD, they do meet the criteria for PPA. Monique Seymour et al. advance anxiety as “one of the most frequently reported mental health difficulties experienced by parents following childbirth” (“Maternal Anxiety” 314). As such, PPA is a public health concern and a needed area of emphasis for maternal advocates.

The rise of perinatal mood and anxiety disorders (PMADs), specifically PPA, is a significant area of concern for women’s mental health. Indeed, 17.1 percent of postpartum women have experienced an anxiety disorder compared to 4.8 percent of women suffering from PPD (Fairbrother et al., “Perinatal”). Likewise, researchers have observed anxiety disorders in 16 percent of their community sample, as opposed to 13 percent prevalence of postpartum depression (Highet et al.). A mother’s distress significantly impacts her mental health and can also have implications for parenting behaviours and infant development (Grant et al.; Mollard). The emphasis in this article is to provide insight into experiences of distress, loss, and frustration in the perinatal period that can be risk factors for PPA. Additionally, we discuss the significance of intimate partner support as both risk and protective factors against PPA to further understand the supports needed in the perinatal period in a woman’s life.

### The Perfect Mother

Society has represented motherhood as an exciting, pleasurable experience that brings immense joy (Choi et al.). Distressed and discontented new mothers experience feelings that contradict society’s beliefs and messages that she should be happy and fulfilled after becoming a mother (Ruybal and Siegel). Sociocultural ideals of the perfect mother commonly frame the new mother’s perception of her personal inadequacies, which may contribute to feelings of loss, frustration, and anxiety (Highet et al.). Internalizing the ideals of what a good mother should look and feel like, combined with fears of judgment, can lead to intense feelings of guilt and shame in new mothers (Wong). These feelings significantly increase a woman’s risk of experiencing PMADs (Dunford and Granger). Andrea O’Reilly and others write prolifically about the impossible standards of perfection in patriarchal “good mothering”. In *Of Woman Born* (1976), Adrienne Rich describes a summer retreat from male and cultural exigencies. Rich writes about the freedom she experienced being away from sociocultural pressures: “we fell into what I felt to be a delicious and sinful rhythm... . This is what living with children could be—without school hours, fixed routines, naps, and the conflict of being both mother and wife with no room for being simply, myself” (156).

Rich describes re-entering regular city life and languishing in the institution of motherhood: “my own mistrust of myself as a ‘good mother’ returned, along

with my resentment for the archetype” (157). Rich also aptly articulates the intensity of changes and ferocity in the experience of becoming and being a new mother:

Nothing to be sure, had prepared me for the intensity of the relationship already existing between me and a creature I had carried in my body and now held in my arms and fed from my breasts. Throughout pregnancy and nursing, women are urged to relax, to mime the serenity of madonnas. No one mentions the psychic crisis of bearing a first child, the excitation of long-buried feelings about one’s own mother, the sense of confused power and powerlessness, of being taken over on the other hand and of touching new and physical and psychic potentialities on the other, a heightened sensibility which can be exhilarating, bewildering, and exhausting. (14)

Betty Friedan (1963) similarly highlights how societal values and definitions of what it means to be a woman can lead to depression and other psychological issues. Indeed, a mother’s attitude and beliefs about perfect mothering is a predictive factor for PMADs (Sockol et al.). Motherhood experiences are often overshadowed by sociocultural myths that good mothers are happy mothers and that mothers should seek goodness and happiness at all costs (Held and Rutherford). Many women feel unprepared for motherhood and have unrealistic expectations based on these cultural myths (Mollard). As a result, mothers feel inadequate when they compare themselves to these myths, and they work harder to compensate for anything less than perfect by being “supereverything” (Choi et al., 167). Additionally, new mothers may struggle to cope with the changes and perceived loss of control in their lives (Bilszta et al.). Motherhood has been described as a period of loss and frustration (Highet et al.). The perinatal period brings with it a new reality that may be vastly different from what they envisioned, and difficulty adjusting to the loss of their old life may heighten distress. The transition to motherhood often means unexpected and unwelcome changes for many women. Changes occur in new mothers’ bodies, activities, workload, and social roles, which can lead to dissatisfaction with the actual experience of being a mother and to increased disappointment and frustration (Highet et al.). Discrepancies between expectations and experience often lead to feelings of shame, making a woman feel like a bad mother (Dunford and Granger). Even admitting to feeling anxious or depressed can make a new mother feel like a failure, which reinforces her feelings of shame and guilt (Dunford and Granger).

In addition to potential feelings of loss and frustration, a psychological shift occurs for new mothers when the child becomes the primary focus. This shift leads to new concerns and demands for which the mother feels unprepared (Haga et al.). Mothering skills and tasks, such as breastfeeding, may not feel

like they come naturally—again contrary to society’s images of females as natural mothers with innate abilities to care for their child (Choi et al.; Ruybal and Siegel). Poignantly addressed, P. Choi and colleagues have emphasized that the “realization of motherhood” (172) and the “reality of motherhood” (173) are fraught with psychological stress, conflict, and distress. Many mothers believe they are failing if they struggle with baby management and the adjustment to this new role (Bilszta et al.). These internalized expectations and judgments about mothering efficacy are linked to depressive symptoms (Dunford and Granger). This cognitive dissonance—the discrepancy between personal expectations and actual lived experience of motherhood—puts mothers at greater risk for developing PMADs (Haga et al.).

### **This Is My New Identity?**

Changes to a woman’s identity and roles significantly affect perceptions of self and can contribute to increased distress in motherhood. Women experience abrupt and significant changes to their lives with little preparation (Highet et al.). Western culture places high value and expectations for success on the mother role. Internalized expectations for control and mastery of the motherhood role lead to stressful challenges and unpredictability, which can increase a woman’s struggle to cope with her new identity (Haga et al.) and heighten anxiety in her life. A woman’s ability to incorporate the concept of motherhood into her self-identify is shown to act as a predictor of her postpartum mental health. If she cannot reconcile her new role and the expectations she perceives, then she is likely to experience distress (Seymour-Smith et al.).

### **New Mother’s Identity and Loss**

Periods of change, particularly life transitions such as motherhood, create stress because there is a loss of identity (Seymour-Smith et al.). As a new mother, a woman finds herself facing increased demands, responsibilities, fatigue, and environmental stressors (Seymour et al.). A woman often gives up her job, hobbies, and social engagements to become a mother, losing many parts of her daily life (Seymour-Smith et al.). The baby now dictates a mother’s schedule, often resulting in a loss of self and a loss of time for things she enjoyed, which were part of her identity. Motherhood-related changes fuel feelings of loss and frustration and engender “the context in which mental health symptoms [are] developed” (Highet et al.182). Adding fuel to the fire, increased anxiety perpetuates self-doubt, loss of self, and diminished confidence as a new mother (Seymour et al.). Furthermore, anxiety lowers parental warmth, satisfaction, and self-efficacy, and increases parenting hostility.

## Is This Normal?

Lack of general societal awareness about anxiety in the perinatal period increases a mother's experience of distress. Nichole Fairbrother and colleagues ("Perinatal") argue that PPA disorders receive very little attention in comparison to postpartum depression research and services. In fact, they hail their study as the first of its kind, which studies a representative sample of the prevalence and incidence of PPA. Similarly, other researchers have highlighted how new parents have insufficient awareness and understanding about perinatal anxiety, thus contributing to their vulnerability (Pilkington et al., "Enhancing").

Low societal awareness about anxiety disorders directly impacts women's mental health awareness and ability to access appropriate resources: "The lack of general awareness about anxiety disorders in the perinatal period when compared with depression supports the notion that perinatal anxiety is insufficiently recognized. This is likely to be not only delaying early recognition of symptoms, but also causing confusion amongst those with perinatal anxiety" (Highet et al. 183). Many women were unaware of the symptoms of anxiety disorders, and the available resources they accessed were insufficient in differentiating between symptoms of depression and symptoms of anxiety (Highet et al.). The women found themselves trying to fit their anxiety symptoms into a depression checklist that did not yield relevant or helpful information. Thus, unable to find information that fit their personal experience, they were filled with further confusion, angst, and frustration.

## Stigma

Another consequence of the lack of societal awareness about PMADs is the stigma attached to mental health disorders. Fear of mental health problems and reluctance to accept the mental-health label can create an insurmountable obstacle for new mothers (Bilszta et al.). Society creates stereotypes for individuals suffering from mental illness—often labelling them as weak or attention seeking and blaming them for the disorder (Ruybal and Siegel). In a time when physical, mental, and emotional limitations make accessing help difficult enough, the additional hurdle of stigma and negative perceptions can be too much to contend with (Bilszta et al.). Changing perceptions that the woman is not at fault increases an individual's willingness to provide support and sympathy (Ruybal and Siegel) and increases mothers' help-seeking behaviors. Attribution-based campaigns creating awareness and reducing blame will serve to increase the social supports available to new mothers.

## Support: What Do Mothers Need?

A significant gap exists in understanding the type of support a new mother may need. There are often deficiencies in the support new mothers receive, which exacerbate and increase the risk for PMADs.

### *Significance of Intimate Partner Support*

Although we eschew the significance of intimate partner support, we recognize even more the increased challenge and potentially higher risk for PMADs that single mothers/parents may experience; we also acknowledge that many single parents fare very well and are not immediately disadvantaged because of their partner status. Researchers outline the importance of social support and emphasize how partner support, both practical and emotional, is foundational to the mother's wellbeing (Bina; Haga et al.; Pilkington et al., "A Review"). The addition of a baby affects the intimate partner relationship, including interpersonal dynamics and the balance of power. Mothers may find it overwhelming to care for their own needs, their baby's needs, and their partner's needs (Bilszta et al.). Additionally, insufficient partner support increases the demands placed on new mothers, creating feelings of frustration and disenchantment (Highet et al.). Kim Boland-Prom and Nancy MacMullen (2012) emphasize the centrality of the partner relationship as both supportive and stressful. Sherry Farr and colleagues attribute low social support and high stress as impacting a woman's self-confidence, thereby increasing her distress. Rena Bina argues that the "type of social support as well as its degree of significance ... vary according to women's cultural backgrounds" (579). Indeed, cultural differences in support needs and resources and a multiplicity of factors affect a mother's mental health and wellness.

Researchers focusing on prevention of PMADs indicate partner support as an instrumental protective factor (Pilkington et al., "A Review"; Pilkington et al., "Enhancing"). New parents are more vulnerable to mood disorders because of their new roles and responsibilities and the physical, emotional, and mental demands of these changes (Pilkington et al., "A Review"; Seymour et al.). Additionally, there is inadequate information and preparation for the challenges and adjustments they may face in this transition (Pilkington et al., "Enhancing"). Targeting partner support to reduce the risk for postpartum mood disorders is ideal for many reasons: it is not gender specific, it can be long term, and it provides ongoing exposure so that changes can be noted (Pilkington et al., "A Review"). Adjusting to motherhood can be facilitated by providing adequate social support to new mothers and building their belief in their abilities (Leahy-Warren et al.).

### *Feeling Alone: Mothers Need Community*

Psychosocial factors are among the biggest risk factors for postpartum women. A woman's social identity is just as important to her sense of self as her intimate and interpersonal relationships are (Seymour-Smith et al.). Many women lack community connections, which makes it difficult for them to normalize their experiences or to differentiate between normal and concerning psychological adjustments (Bilszta et al.; Seymour et al.). A sense of "us" provides belonging and connection in addition to providing meaning, coping, and resilience (Seymour-Smith et al.). Women suffering from depression or anxiety are more prone to isolate themselves and to withdraw from social situations further limiting their interactions with the outside world (Hight et al.). Having insufficient programs for new mothers means they do not have the opportunity to make connections with other mothers and to gain support, leaving them feeling disconnected and alone (Hight et al.).

Silje Haga and colleagues conducted a study to determine why some new mothers have a greater sense of wellbeing than others. One of the helpful influences promoting wellbeing was participation in an informal postpartum group, where women could normalize their experiences, network, and gain social support. P. Choi and colleagues reveal that women value and desire support from other mothers, and Haga and colleagues contend that involvement in a new mother's group offers a place to gather information, normalize, and gain a sense of control. The authors also recommend group counselling as a viable option, as it provides both professional help and fulfills a new mother's need for support from other mothers. Rena Bina's extensive 2008 study further underscores the importance of community support and its instrumental role in a mother's wellbeing. Involvement in a religious community or in another community structure was found to reduce a mother's risk for psychological distress, including depression (Seymour-Smith). Other researchers emphasize the necessity of community for creating important relationships and reciprocal learning from a variety of perspectives (Mollard).

### **Assessing Postpartum Anxiety**

Screening and assessing perinatal anxiety are a challenge, given that both definitions and assessment measures for perinatal anxiety are inconsistent, inadequate, or underutilized (Grant et al.). Indeed, "screening instruments which have been validated for use in perinatal populations do not exist" (Fairbrother et al., "Perinatal" 50). Current diagnostic criteria used to assess postpartum mood disorders are the same as they are for nonreproductive periods, despite the suggestion that perinatal anxiety can have symptoms specific to motherhood. There is a need for assessment tools and criteria sensitive to the unique context and challenges of motherhood. Women are at

higher risk for developing anxiety symptoms in the first postnatal year, which highlights the necessity of screenings for the postnatal period (Seymour et al.). Increased use of screening tools—including specific postpartum/perinatal anxiety scales and items specific to new motherhood—would significantly influence the accurate diagnosis of postpartum mood disorders; the use of depression scales, namely the Edinburgh Postnatal Depression Scale (EPDS), is more widely used.

Anxiety is a significant condition for many new mothers, yet the depression modules for postpartum screenings are primarily used. These screenings assess depression and lump anxiety symptoms under the depression category rather than looking at them separately (Matthey et al.; Miller et al.; Chavis). Women are 60 percent more likely to be diagnosed with anxiety disorders in their lifetime than men (National Institute of Mental Health), and the postpartum period poses a time of increased risk. Yet the education, awareness, and interventions continue to focus heavily on postpartum depression, and give far less attention to anxiety (Chavis). In a recent study of eighty-six first-time mothers, Llena Chavis found that 68 percent of these mothers experienced moderate to severe anxiety. The study shows anxiety to be almost as prevalent as depression in first-time mothers. High scores of anxiety are typically associated with high scores on the EPDS (Cox et al.), and anxiety often presents as depressive symptomology (Pereira et al.). New mothers may be identified as depressed, yet it is the symptoms of anxiety causing them the most distress, and these are not being properly addressed.

The co-morbidity of anxiety and depression negatively impacts prognosis and increases treatment time for women suffering from anxiety disorders (Matthey et al.; Miller et al.; Pereira et al.). Depression left untreated poses considerable risk to mother and baby because of self-harm or harm to baby; therefore, it is the focus in postnatal checks (Chivas). Practitioners may be focused on a single diagnosis, and miss symptoms of other mood disorders, which may not present in postnatal depression screenings (Matthey et al.). Distinguishing between anxiety and depression is crucial so that treatments can be specific to the symptoms (Miller et al.). A woman may not screen for depression at her initial postpartum check, yet she may still be suffering from symptoms of anxiety. Not all anxious parents are depressed (Matthey et al.), but unaddressed anxiety leaves women vulnerable to depression (Matthey et al.; Miller et al.). In our haste to rule out depression, healthcare providers may miss symptoms of anxiety and distress, increasing the risk a new mother may become severely depressed.

The major life changes and transitions of motherhood place women at an increased risk of many mental health concerns, yet postpartum depression takes precedence in public health policies and assessment tools (Pereira et al.). The EDPS has been the standard for assessing postpartum depression for



decades, with only limited items specific to anxiety (Fairbrother et al; “Depression”; Miller et al.), but prenatal and postnatal anxiety are often missed during screening with EPDS (Farr et al.). Over a decade ago, Renée Miller and colleagues proposed broader screening tools and classifications to encompass depression, anxiety, and stress. In their study, they find that 29 percent of women had at least one classification of depression, anxiety, or stress. Initial use of only the EPDS had missed identifying 6 percent of the women in their study who were experiencing other symptoms of distress. Other research supports earlier findings that anxiety symptoms were grouped under depression modules, placing patients at risk of misdiagnosis and mistreatment, thereby exacerbating distress (Matthey et al.). The rates of affective disorders for women can nearly double when anxiety is included in the screening (Matthey et al.). In Carlo Marchesi and colleague’s systematic review of perinatal anxiety disorders, all eighteen studies use the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5, American Psychiatric Association, 2013) to diagnose anxiety disorders, which may not be used by all doctors screening postpartum women. Boland-Prom and MacMullen argue that limited time frame and mood states are problematic in the current medical models of postpartum depression. They advocate for models that support a broad variety of moods in addition to biopsychosocial and person-in-environment perspectives. Miller and colleagues propose broader screens of postnatal distress to include depression, anxiety, and stress for screenings in new mothers. They argue that depression as the standard for postnatal maladjustment neglects the anxiety and stress symptoms that many women with distress experience. Their recommendation was to use the Depression, Anxiety, and Stress Scale (DASS-21; Lovibond and Lovibond) because it more accurately measures broader affect states in postpartum women. Priscilla Pereira and colleagues support the need for lengthier postpartum care and for more extensive mood screenings. They argue that a gap in studies between the postpartum period and maternal adjustment increases the risk for new mothers. Despite the awareness that postpartum mood disorders have a significant effect on mothers and their children, there is very little known about the actual transition process of affected women to motherhood.

### Identification of Postpartum Anxiety

The spectrum and scope of postpartum health models require a change. For decades, the biomedical approaches to postpartum mental health have influenced the discourses, assessments, and interventions of professionals. These approaches do not take into consideration the complexity of systemic influences and psychosocial factors during the postpartum period (Pereira et al.). Those working with new mothers would benefit from advocating for

models placing motherhood within broader social and environmental contexts (Boland-Prom and MacMullen). These models are more representative when they include existing social group networks and group memberships that can identify strengths and supports for alleviating anxiety (Seymour-Smith et al.). Understanding the mother within a system is necessary to both identifying and reducing anxiety (Chavis). Mental health advocates are called on to expand the standard postpartum screening tools to include broader criteria for postnatal distress. Researchers have found postpartum anxiety disorders to be more prevalent than depression, highlighting the need for both clinical and scientific attention (Fairbrother et al., “Depression”; Fairbrother et al., 2016; Seymour et al. “Perinatal”).

Additionally, there is a need for perinatal research and literature that includes broader populations of women. Existing research data are primarily based on the experiences of married women (Clout and Brown; Martini et al.; Schmied, et al.). There is a dearth of postpartum research examining predictors of PMADs for single mothers (Clout and Brown). Cindy-Lee Dennis and colleagues echo this limitation and note that single mothers are underrepresented in their study of postpartum anxiety. Yet another gap in postpartum research exists for sexual minority women (lesbian, bisexual, or queer). There is little information on risk factors and protective factors for sexual minority mothers, and the differences in social variables for a queer mother could significantly contribute to the prevalence and determinants of perinatal mental health (Alang and Fomotar; Flanders et al.).

### Psycho-Education

Education and information can be provided by healthcare practitioners to prepare and equip at-risk, expectant mothers and their supports. Psycho-education can set the stage for realistic expectations and explores the normal responses a mother could have throughout the transition to motherhood (Chavis; Seymour et al.). Mental health workers can identify at-risk expectant mothers by examining a mother’s system, supports, and construction of self. Does she see herself as competent and confident? Is she willing to accept that the process may not be as she envisioned it? If not, providing skills and information on the wide range of infant behaviour as well as postpartum mood disorders can empower new mothers and build on their strengths (Chavis).

Psycho-education would work best if implemented throughout both antenatal and postnatal periods. Antenatal education should include postnatal emotional changes and information on seeking help. Establishing a relationship with healthcare providers and mental health professionals that continues throughout both periods can also increase the likelihood of early recognition

and intervention (Bilszta et al.). Continuing care also allows health practitioners to identify existing social group networks and group memberships by assessing a mother's group identification as low or high, which can predict the likelihood of mental health concerns. Interventions focused on existing networks have proven to be a protective factor for new mothers (Seymour-Smith et al.).

### **Alternative Motherhood Discourses**

Advocates for mothers can help create alternative motherhood discourses that challenge the idealized perfect mother or good mother (Choi et al.). Cultural and societal myths perpetuating unrealistic standards for mothers need to be critiqued. Cultural constructions of motherhood can create false expectations that set a woman up to fail. Further dialogue around the maternal role can expose the faulty concept of motherhood as instant bliss, fulfillment, and satisfaction (Mollard). Advancing discourse normalizing a broad spectrum of moods and feelings in the postpartum period and the prevalence of PMADs can better prepare mothers and families. This discourse lets women know they are not alone in experiencing a less-than-perfect transition; anxiety is normal and to be expected (Chavis).

Being aware of the difficulties and the range of emotions around pregnancy can help new mothers cope (Pilkington et al., "Enhancing"). Silje Haga and colleagues offer the concept of "good enough parenting" to ease the pressure on new mothers. We need to challenge the discourse of mastery. Likewise, we need to support expectant mothers to know that a range of emotions and challenges are common. Recognizing that parenthood is stressful, we can encourage mothers to embrace a mindset of acceptance and flexibility (Pilkington et al., "Enhancing"). The transition to motherhood can be facilitated by strengthening a mother's belief in her abilities (Leahy-Warren et al.).

### **Helping the Partner**

Motherhood has a steep learning curve and does not always come easily or naturally. We can use a mother's social supports and can strengthen the parenting couple's relationship as protective measures against anxiety (Leahy-Warren et al.; Seymour-Smith et al.). Researchers have demonstrated new parents prefer to receive support from one another, and several factors have been identified as enhancing the partner relationship. For example, positive communication, emotional closeness and support, practical support, and minimizing conflict enhance the relationship a new mother has with her partner and can help alleviate both depression and anxiety (Pilkington et al., "Enhancing"). Likewise, helping to recognize guilt and shame that may be

experienced by new mothers can assist in early recognition of postpartum mental health concerns.

Low social support and satisfaction with the spouse or partner have been associated with higher risk for PMADs (Martini et al.; Schmied, et al.). Although lesbian, bisexual, or queer mothers are reported to experience better partner support because of their deliberate and planned nature of parenthood and the, potentially, more equitable distribution of parenting duties (Ross), we suggest these protective factors to PMADs may be overshadowed by external social factors. Indeed, queer mothers are likely to experience increased feelings of isolation and barriers to effective social support because of homophobia, heterosexism, social stigma, and strained relationships with family of origin (Alang and Fomotar, 2015; Ross). In her discussion of queer mothering, Margaret Gibson indicates that “bisexual identities have been erased across parenting research” (355). She also says that fatherhood movements have admonished LGBTQ parenting as much as they denigrate single mothers with low socio-economic status, which further adds to the isolation and stigma likely to be experienced by queer or single mothers.

## Conclusion

The postpartum period is when a woman is at greatest risk for mental health concerns (Seymour-Smith et al.). Thus, it is crucial that awareness and understanding of postnatal mental health become a priority for counsellors. New mothers may require extra support from healthcare providers and society in general to ease them into their new role and to help them reconcile their new identity. New mothers face incredible pressure to succeed, yet many lack the necessary structures and supports to help facilitate their transition into motherhood (Haga et al.). Society’s stereotypes and attributions reinforce the perfect mother ideal creating feelings of shame and guilt, which also act as barriers for help seeking (Ruybal and Siegal). There is a need for improved education and awareness for women, their partners and loved ones, and healthcare providers (Fairbrother et al, “Perinatal”). Women and their support providers need to be aware of the risk factors, protective factors, and warning signs for anxiety disorders as well as postpartum depression. It is our duty to advocate for early identification and intervention.

Discussing and assessing anxiety prior to the postpartum period are also recommended, as antenatal anxiety is associated with increased risk of postpartum anxiety. Awareness and exploration of anxiety in a mother’s adjustment to pregnancy and eventual motherhood could lead to early identification and interventions for women at risk (Grant et al.). Addressing the gaps and needs in postpartum mental health will positively affect mothers, fathers, their families, and our communities.

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