



Women's Experiences with Postpartum Anxiety: Expectations, Relationships, and Sociocultural Influences

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Evidence about anxiety in the postpartum is sparse and contradictory. Our research expands this knowledge by using a qualitative methodology, the Feminist Biographical Method, to explore first time mothers' experiences of postpartum anxiety. Data collection included 1.5 to 2.0 hour interviews with six women about their experiences of anxiety in their transition to motherhood. We transcribed the interviews and used an iterative hermeneutic coding process to develop themes and subthemes over the course of four coding cycles. The findings include five major themes: (a) experiences of anxiety, (b) expectations of a new mother, (c) issues of support, (d) societal scripts of motherhood, and (e) the transition. One conclusion that we draw is the need for healthcare professionals to provide improved support and validation to new mothers facing postpartum anxiety, by expanding the definition of postpartum distress, especially anxiety, and by better understanding women's anxiety through culturally-embedded contextual and relational lenses.

Keywords: Anxiety, Biographical, Feminist, Hermeneutics, Interpretive Methods, Mothers, Postpartum, Women's Health

Pregnancy and the transition to motherhood greatly impact women's health, well-being, and social roles (Huizink, Mulder, Robles de Medina, Visser, & Buitelaar, 2004). A substantial body of research focusing on postpartum depression and related distress exists (Bandelow, Sojka, Broocks, Hajak, Bleich, & Ruther, 2006; Beck, 2002; Engqvist, Ahlin, Ferszt, & Nilsson, 2011; Milgrom & Beatrice, 2003; O'Hara & Swain, 1996), but despite the preponderance of information about postpartum depression, there seems to still be some controversy over how it should be classified, as well as its potential relationship to disorders such as anxiety. In the Diagnostic and Statistical Manual, Fourth Edition, Text Revision (DSM-IV-TR; American Psychiatric Association, 2000), postpartum depression is not classified as a separate disorder, but is rather a postpartum onset specifier of Major Depressive Disorder (e.g., occurs within 4 weeks of delivery). However, Hendrick and colleagues (Hendrick, Altshuler, Strouse, & Grosser, 2000) suggest that postpartum depression might have different features than typical depression.

Other researchers have questioned if what is currently termed postpartum depression might actually represent "a constellation of symptoms in which depressive behaviour is simply the most easily recognized" (Marrs, Durette, Ferraro, & Cross, 2009, p. 102). Brockington (2004) has implied that the term postpartum depression is an umbrella term that encompasses several disorders. Finally, some researchers have found that anxiety symptoms, especially generalized anxiety about motherhood and self-criticism, account for much of what they call "postpartum psychiatric distress" (Marrs et al., 2009). Given the murkiness of the situation, there is a need to consider anxiety disorders in the postpartum as a group of disorders separate from depression; unfortunately, knowledge about anxiety during the postpartum is limited and contradictory. Additionally obscuring the issue is that postpartum anxiety is usually examined in the context of women already reporting depressive symptoms (Wenzel, Haugen, Jackson, & Robinson, 2003).

While dealing with anxiety at any time is difficult, managing increased anxiety levels at the same time as managing a new baby could increase this difficulty. Furthermore, these new mothers might find it distressing to be feeling anxious at a time which is generally considered – and expected – to be a time of great joy. Maternal anxiety has also been found to affect a new mother's concept of herself as "mother." Hart and McMahon (2006) found that higher symptoms of postpartum anxiety were associated with more negative attitudes toward motherhood and the self as mother. Furthermore, these effects were found to be greater with maternal anxiety than with maternal depression. More research, especially qualitative studies, is needed to better understand this phenomenon so that health care professionals can provide targeted and effective support. Our research, therefore, expands the limited knowledge base through an in-depth exploration of women's experiences of anxiety during the postpartum.

Literature Review

Anxiety in the Postpartum Period

One of the major problems in better understanding anxiety during the postpartum is the lack of knowledge, few studies, and little discussion about this issue. In contrast to the abundant research, as well as ample social and media discussions focused on postpartum depression (PPD), there is little consistent information about the prevalence and presentation of anxiety in the postpartum period (Ross & McLean, 2006). This is problematic given that postpartum anxiety might be more common than is generally recognized, and that women who struggle with anxiety might not receive adequate acknowledgement, support, or treatment. Some authors have reported prevalence rates of Generalized Anxiety Disorder to be as high as 8.2% (Wenzel, Haugen, Jackson & Brendle, 2005), and have found worsening of panic symptoms in the postpartum period (Bandelow et al., 2006). In a study of pre-discharge anxiety in 422 new mothers, Britton (2005) found 24.9% of mothers have moderate anxiety and 1% of mothers have severe anxiety. With the little information that does exist, as seen in these studies, there is some strong evidence to suggest that postpartum anxiety is relatively common and problematic for many women.

Unfortunately, with a paucity of studies examining postpartum anxiety, contradictions arise in the literature due to variability in research methods, tools, and perspectives. For example, some researchers have found no difference in prevalence rates of anxiety between childbearing women (women who had borne a child in the last 10 years) and non-childbearing women (women who had never borne a child; van Bussel, Spitz, & Demyttenaere, 2006). This finding contradicts other research on anxiety in the postpartum, and raises doubts as to whether there is an actual or only a perceived increase in symptoms. Additionally, this result raises serious questions regarding methodological soundness in this and other studies, for example: How can the results be so different between studies? What differences are there in the populations assessed, the instruments used, and the analyses made?

A second complicating problem is the issue of comorbidity between anxiety (e.g., restlessness, racing heart, ruminating, sense of dread, worry, panic attack, fears and phobias, irritability, sleep disturbance) and depression (e.g., sadness, diminished pleasure in activities, fatigue or loss of energy, feelings of worthlessness or excessive guilt, diminished concentration, indecisiveness, changes in appetite/weight, insomnia or sleeping too much). Given that many of symptoms are similar in both depression and anxiety, a thorough assessment is necessary in order to develop a clear differential diagnosis (e.g., identifying how the symptoms cluster together and determining whether it is only anxiety, only depression, or both anxiety and depression at the same time). Yelland and colleagues (Yelland, Sutherland, & Brown, 2010), who found that 12.7% of their sample of 4,366

women in Australia scored above the normal range on a self-report anxiety scale at six months postpartum, also reported that 8.1% of their sample evidenced comorbid anxiety and depression. Austin and others (2010) found high levels of comorbidity as well. Of the participants who were identified as having a major depressive disorder, 33% also suffered from an anxiety disorder. In these studies, it is unclear as to whether a thorough differential diagnosis could be established through the questions posed in the instruments, without the addition of an in-depth assessment interview. Regardless, the findings point to possible high levels of comorbidity between anxiety and depression, which highlights the importance of recognition and treatment of both issues when present, rather than a predominant focus on depression.

A third major problem in assessing for anxiety disorders during the postpartum is the lack of consistent protocols regarding anxiety screening and the lack of relevant tools that are sensitive enough to assess for various forms of anxiety. Although anxiety screening instruments exist, there are no anxiety-specific screening instruments *routinely* used during the postpartum period (Rowe, Fisher, & Loh, 2008). Rowe and colleagues (2008) state that this is problematic because it could lead to co-morbidities being under-recognized and a lack of appropriate care provided to those women who are suffering. These authors also note that participants were likely suffering from severe fatigue, and that using the term “postpartum depression” obscured the complexity of postpartum psychological distress. Thus, accurate assessment of anxiety during the postpartum, whether in practice or research, continues to be highly problematic, and women’s distress related to anxiety continues to be inadequately addressed and treated.

Some researchers, however, are making efforts to examine screening instruments for their usefulness and accuracy in assessing anxiety and depression during the postpartum. Despite the fact that a self-report measure for the screening of postnatal *depression* is widely used in many countries (Matthey, Henshaw, Elliott, & Barnett, 2006) – the Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden, & Sagovsky, 1987) – EPDS scores alone do not yield a complete picture of postpartum psychiatric distress. In particular, Matthey and colleagues (2006) suggest that although the validated cut-off score for indicating probable major depression on the EPDS is 13, there is variability in the cut-off scores used in practice and the instrument is not sensitive enough to anxiety disorders.

Another example is a study by Rowe and colleagues (2008), in which they compared EPDS scores with the results of clinical interviews (i.e., engaging women in discussions about their symptoms). They found that more than 50% of the women in their sample were mislabeled as “probably suffering from a major depression” according to their EPDS scores, when in fact they were suffering from disabling anxiety, an adjustment disorder, or a minor depression according to their in-depth clinical interviews. Matthey (2008) asserts that although there are anxiety-specific questions on the EPDS, when only a total score was used on the scale, 11 of 18 women with anxiety disorders did not screen positive. These women would not have been identified as having mood difficulties through the use of the EPDS total score alone. Finally, Matthey and colleagues (2003) assert that when anxiety is included in our conceptualization of poor psychological adjustment, prevalence rates increase significantly (Matthey, Barnett, Howie, & Kavanagh, 2003).

Transition to Parenthood, Stress and Anxiety

The transition to motherhood can be very stressful, because in addition to labor and delivery, many new mothers face unfamiliar expectations and demands (Britton, 2008). Goldstein, Diener, and Mangelsdorf (1996) found that the transition to motherhood is associated with increasing levels of stress over time. Women in their study reported

experiencing significantly more stress each month in the first three months postpartum than during the first six months of pregnancy. Given this increase in stress, it follows that anxiety might also increase because it has been well established that psychosocial stressors can play a significant etiological role in the development of anxiety for those who have a vulnerability (Wenzel et al., 2003). Furthermore, learning to manage the new external responsibilities associated with motherhood might additionally contribute to the development of anxiety, given that the presence of demands that seem uncontrollable has been linked to anxiety (Wenzel et al., 2003). The transition to parenthood does not appear to be a short-lived phenomenon for women, and instead, seems to be a gradual and complex process that lasts far beyond the actual birth (Woollett & Parr, 1997).

The course of anxiety symptoms might also be different for first-time mothers than for those with older children. Dipietro and colleagues (Dipietro, Costigan, & Sipsma, 2008) found that although the anxiety of the multiparous women in their sample decreased from pregnancy through the first 24 postpartum months, the first-time mothers showed the opposite trajectory, suggesting a strong sociocultural and contextual, rather than biological, link to anxiety.

Adding to this is the highly individualistic orientation in Western cultures where nuclear families are expected to raise their children with little family assistance and without the safety of a close community network. This lack of social support in the culture might lead to maternal anxiety, which then affects a new mother's concept of herself as "mother." Hart and McMahon (2006), for example, found that higher symptoms of antenatal anxiety were associated with more negative attitudes toward motherhood and the self as mother, and these effects were found to be greater with maternal anxiety than with maternal depression.

Overall, the existing evidence about new mothers suggests that postpartum anxiety is problematic for many, and that this anxiety might be obscured by the dominant discourse of postpartum depression in North American culture and health care, and the accompanying body of research that supports this influential perspective. In considering what we already know about postpartum anxiety – high prevalence and incidence rates and lack of consistency in screening measures – it is clear that additional research is needed to learn more about this issue and how it impacts women. It is also clear from our literature review that more qualitative research is required in order to better understand the complexity of the phenomenon, and its relation to postpartum depression, and typical or healthy functioning. In this article, therefore, we present the findings from our qualitative exploration into the experience of new mothers who struggle with postpartum anxiety as a way of broadening the dialogue.

Researchers' Experiences

Andrea Wardrop: I spent two years working as a research assistant in a clinic for pregnant and postpartum women with various mental illnesses. The methodology for the research I conducted on postpartum depression and treatment of psychiatric disorders was quantitative, and the forms I asked the women to fill out offered little opportunity for them to share their personal stories. I became frustrated with my work since most of the women seemed eager to talk to me about their experiences during this transitional time, and I was unable to include this information in the studies. I realized that there was a narrowness to the information I was collecting that did not reflect the women's depth of experience. I also came to believe that the participants were frustrated and dissatisfied with acting as research participants because they recognized the inadequacy of the answers they could provide, and knew that their experiences as a whole were not being addressed.

We often hear of postpartum depression in both academia and the media, and, personally, I was involved in several research projects that focussed on postpartum

depression. Knowing that it would be the focus of my work as a research assistant, I had steeled myself to deal with depressed new mothers. However, when I began my work, I was struck by how many women seemed to be impacted by anxiety instead. Even though our interactions were generally short and relatively cursory, many women spoke about their worries and fears, their parenting skills, their relationships with their partners, and their babies' health and development. With many of my discussions centering on worry, apprehension and apparent perfectionist tendencies, I began to wonder about the levels of anxiety some of these women felt, and why they bore the classification of having "postpartum depression."

Another area of curiosity for me was how the women developed their concepts of motherhood. For instance, what information had they received about the practicalities of this transition? What did this new status of "mother" mean to them and how might this affect their conception of themselves? Was some of their apprehension and worry rooted in messages they had received about what motherhood was like or should be like? What role might popular media such as television, movies, magazines, books, and newscasts play in this messaging? Though I learned a great deal through my work, since I was not able to converse with the women in any depth, their experiences remained largely a mystery to me. Wanting to come to a greater understanding of these experiences, I decided to embark on this project during my graduate training, with Natalee Popadiuk (second author) as my research supervisor.

Natalee Popadiuk: When Andrea first described her work with clients and the quantitative research she had been involved in at the clinic, I was intrigued and fully supportive of her proposed qualitative study of anxiety in the postpartum. Although it seems incomprehensible to me now, postpartum anxiety was not something that I had heard much about at that time. Like many others, my experiences and discussions with friends, family, clients, and colleagues had predominately focused on postpartum depression and the utter exhaustion associated of having a (new) baby in the house. Movies, television shows, magazine articles, and other forms of popular culture that had infiltrated my life over the years only portrayed stories of postpartum depression – news reports about depressed new mothers who had killed their babies, Marie Osmond's debilitating postpartum depression and suicidality, Brooke Shields and the knock-down fight with Tom Cruise about the use of antidepressants and postpartum depression. Thus, when Andrea shared with me what she had seen with women at the clinic, I became aware that this was not only an important psychological and medical issue, but also a social issue regarding the social construction of women's postpartum experiences and the silencing of anxiety experiences through the dominant discourse of postpartum depression.

In working with Andrea about the methodology that she might select to best address her research question, I suggested the feminist biographical method, a form of narrative inquiry that could provide space for her to contextualize participants' stories within a sociocultural framework. With this structure, she could focus on how anxiety was embedded in women's lives, before, during, and after the birth, as well as explore pertinent details about family dynamics, meaning of the experiences, and expectations of childbirth and becoming a new parent in our society. The addition of a feminist lens would also support Andrea to deepen the analysis by specifically allowing her to examine the diversity issues of gender, social class, and ethnicity to better understand how each participant's social location helped to create, maintain, or inhibit certain aspects of their anxiety within their individual experiences. For example, this lens might help us better understand what anxiety looked like, as well as how it felt and played out in a woman's life who could be seen as privileged in our society (i.e., highly educated, professional status, high economic earnings, dual-income parents) compared to another woman who might not have as much access to resources.

Overall, I saw the need for a methodology that would foreground aspects of participants' experiences that might otherwise remain unnoticed, unnamed, and unimportant in other methodologies, in which context and social location were not considered. The issue of postpartum anxiety appeared to require research with a social justice agenda that could make sense of women's confusion about their own experiences, of healthcare professionals' lack of knowledge and understanding of postpartum anxiety, and of society's overriding dominant discourse focused on postpartum depression.

Methods

Given that there is little knowledge focused on the lived experiences of women with postpartum anxiety, we decided that an in-depth qualitative study was necessary. We chose the feminist biographical methodology, a form of narrative research, to address depth, context, and meaning; women's experiences and voices; and a sociopolitical analysis (Denzin, 1989; Merrill & West, 2009; Popadiuk, 2004). First, we approached participants using a holistic lens through which to view their anxiety – as new mothers within a particular time, place, and culture. Specifically, we asked questions to elicit participants' experience of the phenomenon as a way of better understanding their intentions, motives, desires, thoughts and emotions within the context of their lives (Schwandt, 2000).

In essence, we became the biographers of a part of someone else's life story through the questions we asked, the quotations we chose, and the written documents that we created. Descriptions that biographical researchers present in their work are interpretations because what researchers know is filtered through language and the meanings they attach to participant narratives, since we cannot have direct access to their inner lives (Kyllönen, 2004). A social constructionist perspective might best explain how biographical researchers are co-constructing knowledge with participants about how they co-construct themselves, their experiences, and the world in which they live through interactions and exchanges with others in their communities and society (Gergen, 1985).

Second, by exploring women's experiences, we joined other feminist researchers with the intention of generating new kinds of knowledge based on women's experiences by using a methodology that calls for connection, meaning-making, and relationship (Broch-Due, 1992; Miller & Stiver, 1997). Finally, this methodology emphasizes the sociopolitical and historical aspects of lived experience. As feminist clinicians and researchers (Popadiuk, in press), we were excited about the opportunity to utilize a critical theory lens to delve into women's stories in light of the broader sociocultural discourses of new motherhood and anxiety in society.

Recruitment and Sampling

We received ethical approval for this study from a local university Research Ethics Board, as well as a hospital Ethical Review Committee. We used a purposive sampling approach in our recruitment methods (Patton, 1990). We had hoped to specifically recruit women from a specialized mental health program focused on postpartum anxiety where women had already been identified by the medical profession as suffering from postpartum anxiety. However, only one patient from this program contacted us, and in the end, no one from this program participated in our study. Thus, we used two additional recruitment strategies to locate participants who could speak about their experiences of postpartum anxiety, regardless of an official diagnosis: (a) an e-mail distribution of the study advertisement to graduate student listserves at local universities, and (b) talking about the research with new mothers known to us, such as friends, family, and colleagues. Ten women

emailed to express interest in participating in the study, but in the end, only six women participated.

Participants

Six women met the following inclusion criteria: (a) a mother of an eldest or only child three years or younger, (b) self-identified as “highly anxious,” and (c) anxiety was the primary mental health concern during first six months postpartum. We chose a time limit of three years in an attempt to strike a balance between completeness and clarity of participants’ recollections and societal context of their experiences of the transition to motherhood, with a desire to include as many women as possible who wanted to take part in the research. Each participant completed a telephone screen (e.g., Did you experience anxiety and worry that you would characterize as excessive? Did these symptoms cause significant distress or impairment in social, occupational or other important areas of functioning?) To their knowledge, none of the participants received a formal diagnosis of an anxiety disorder in the postpartum period. All of the participants were Canadian with four of the six women self-identifying as White with European ancestry, one as Taiwanese, and another as Japanese. All had lived in Canada for much of their adult lives. At the time of interview, participants’ ages ranged from 28 to 42 years, five were partnered in heterosexual relationships, and one was single. They were mothers of children aged 5.5 months to 3 years. All participants had a Bachelor’s level education or higher and worked in professional roles or were pursuing further education.

Data Collection

After providing informed consent, participants engaged in a single narrative interview that consisted of several prompt questions of approximately 1.5 to 2 hours in length. The interviews were conducted in mutually convenient places, including the university and participants’ homes. At the beginning of each interview, I (Wardrop) took notes about participants’ demographic information, and all interviews were audio-recorded. Each interview consisted of an exploration of the participants’ personal experiences with anxiety and the transition to parenthood and was guided by questions such as “what are your ideas about motherhood and how did you come to know this?” and “what link might there be between your experience of anxiety and your experience of mothering?” Prompt questions were used where appropriate to direct the interviews. However, the interviewer allowed the participants to inform the research process with regards to what information they thought was most important in describing their experiences (Wertz, 2005).

Immediately following each interview, I (Wardrop) took notes about the experience in the interview to increase my personal awareness of self in this interpretive endeavor, and transcribed the entire audio recording. Campbell and Wasco (2000) assert that the emotionality of researching participants’ lives, and also the affective experiences of the researcher listening to emotionally-laden material, should be acknowledged through the research process. Though much of social science focuses on thought rather than feeling, feminist scholars have argued that feelings shape research and form a natural part of inquiry. Thus, these authors assert that feminist research processes connect knowledge and emotion. Due to its lack of formal and rigid structure, a narrative interview increases emotional labor demands and the complexity of power relations in the interview process. Although this increased emotional labor and complexity in power relations make the work of the interviews more taxing for those involved, inclusion of these elements in the research process, in this case in the form of personal memos, provides opportunities for greater richness and depth of understanding.

In total, we collected approximately 11 hours of interview data and 117 pages of single-spaced transcription. Interviewing six participants in-depth allowed for significant narrative data to be collected, and yet, provided a small enough sample size for an in-depth analysis of each participant's narrative. Smith (as cited in Moules, 2002) supports this perspective by stating that hermeneutic inquiry is validated, not by the numbers of participants, but by the completeness of the examination of the topic and the depth to which the interpretation extends our understanding.

Data Analysis

Hermeneutics refers to the interpretation of texts, including written texts, narratives and other textual forms. Heidegger, a pioneer in hermeneutic theory, asserted that understanding is a circular process (Packer & Addison, 1989). As we embark on studying a given phenomenon, we do so with a certain preliminary understanding of it, formed out of our presumptions, our expectations, and our cultural backgrounds. When we then gather information about our particular phenomenon of study through inquiry, the knowledge we gain is structured in terms of those preliminary understandings. This interpretive process is referred to as the "hermeneutic circle," because it is an iterative, rather than linear process. Packer and Addison (1989) state that in the hermeneutic circle, the two end points of the line are joined, with knowledge informing perspective and perspective informing knowledge. The information acquired through conducting an inquiry is thereby accommodated into the researcher's perspective, and this creates a back-and-forth process. Specifically, new knowledge becomes part of the researcher's perspective as the process unfolds and then the researcher with a new perspective sees things in a slightly different way. This new understanding is not meant to form a static base of knowledge, but rather to become a practical base for interpretation that is dynamic and changing (Packer & Addison, 1989).

Packer and Addison (1989) describe three phases of hermeneutic inquiry. The first is what these authors call "entering the circle," which they describe as finding a perspective from which to proceed with interpretation. Since this projection of one's own perspective is seen as inevitable in interpretive frameworks, the point of entry into this circle is usually deliberate and should stem from engagement with and concern for those who are participating in the research, rather than an attempt at objectivity. The second phase described is the conducting of the inquiry, which involves the circular process of assimilation and accommodation of knowledge and understanding. The third phase of hermeneutic inquiry described is the evaluation of the resulting account with an eye to increased understanding of the phenomenon in question.

By linking participants' personal accounts with a shared popular culture, we explored the connection between the personal and the universal, and how these reflect one another. Packer and Addison advocate for this type of interpretive, hermeneutic inquiry, stating that it focuses on human activity situated in context and the offspring of such activity: institutions, histories, accounts, records, texts, stories, lives. It makes no sense to imagine any of these existing in the absence of beings like ourselves, who wish to study them and, conversely, it would make no sense to think that we could exist, as psychologists and inquirers, apart from or independent of a whole range of practices, institutions, and accounts. People both constitute and are constituted by their social world; we contribute to sustaining it as what it is (or changing it); it made us what we have become. We are not, and cannot become, the neutral and dispassionate observers that both empiricism and rationalism would have us be (pp. 19-20). This relationship and interdependence between individuals and the institutions of society reflects the metaphorical hermeneutic circle described above.

Engaging in a process Saldaña (2009) calls “pre-coding,” we read each transcript several times with an eye to identifying patterns in the participants’ stories, and flagging portions of narrative that answered the research questions. We coded participants’ narratives in the margins of the printed hard-copy documents, made decisions about the thematic content of discrete quotations, used a cut-and-sort method of working with the quotations, and then placed participant quotes into initial thematic classifications. Saldaña (2009) asserts that coding is cyclical, and that each cycle of coding “further manages, filters, highlights, and focuses the salient features of the qualitative data record for generating categories, themes, and concepts, grasping meaning and/or building theory” (p. 8). We engaged in four cycles of coding, refining the thematic codifications each time (Merrill & West, 2009; Popadiuk, 2004). This iterative hermeneutic process allowed us to develop a comprehensive set of themes from the interview data. During this coding process, we discussed the issues with which we were struggling with each other, as well as with colleagues, and documented our decision-making processes through memos. The final cycle of coding yielded 331 codes. Twelve of the codes contained biographical information; we classified the remaining 319 codes into the five major themes and their associated sub-themes (see Table 1).

Table 1. Overview of Themes and Subthemes

Themes	Subthemes
Experiences of Anxiety	n/a
Expectations of a New Mother	Preparation Cognitive versus experiential knowledge Appearance Birth, joy, and bonding Comparisons
Issues of Support	Health professionals Husband Family and friends Feeling alone
Societal Scripts of Motherhood	Media representations of motherhood Myths of motherhood Pressure to conform to societal expectations Gender scripts Social class norms Ethnicity and culture of origin
The Transition	Overwhelm What helped? Self-care Further along in the transition

Trustworthiness and Credibility

Developing trustworthiness and credibility is an important aspect of conducting qualitative health research (e.g., Farmer, Robinson, Elliott, & Eyles, 2006; Moules, 2002). First, we engaged in debriefing by consulting with each other, as well as with peers and colleagues, about the interpretations we were making of the data. Moules (2002) suggests that the use of this credibility technique is not to provide “an expert evaluation of ‘truth,’ but an opportunity to open the interpretations from the narrowness of one’s vision, prejudices, and focus” (pp. 32-33). Second, we engaged in several cycles of coding, separating the text into

different lengths of code to balance the need to include enough text to allow for contextualization without sacrificing specificity. One of our goals was to ensure that each coded piece of transcript focused on one primary issue. Third, we kept an audit trail of all coding decisions, coding schemes and memos.

Finally, after the fourth round of coding and categorization, primarily conducted by the first author, the second author reviewed a 10% random selection of the codes from each category, a total of 32 codes, to see if these codes could be placed into the existing categories. We came to agreement without discussion on the thematic categorization of 25 of those 32 of the codes. For five of the 32 codes, there were two possible themes within which the code might fit, and we came to agreement on placement once we discussed the primary focus of the quotations. A final code required a more lengthy discussion, which prompted a slight revision to one of the thematic descriptions. This revision resulted in refinement and increased specificity in the description of one theme, but did not change the categorization of any other codes.

Results

Experiences of Anxiety

Several participants thought that having an infant with a medical issue (such as low birth weight or colic) or “high needs” contributed to their experiences of anxiety. One mother commented, “[I] worry about her being some kind of psychotic baby, having some health issues, worrying about why she’s crying so much. And then worry about whether or not I’m going to be able to tolerate it, for how long.” Here we see that having an infant with high needs not only resulted in more work for this participant, but also in more worry and psychological distress. Several participants mentioned their own physical health issues as contributing to their anxiety. One mother focused on this connection, “I’m not getting any sleep, and I’m not eating very well, and I’m not resting enough. And I’m not healing very well, there are wounds.” Sleep deprivation, and being ill or in pain were often triggers for instances of heightened anxiety for participants.

Additionally, participants described their specific constellation of symptoms associated with their anxiety. Physical symptoms mentioned included panic attacks, breathing difficulties, headaches, over-arousal, being tired, appetite changes, heart racing, adrenaline and feelings of the body shutting down. Emotional symptoms included upset, overreaction, anger, rage, frustration, overwhelm, being “stressed out” and crying. Participants also cited cognitive anxiety symptoms such as rigidity, worry, dissociation, and over-concern about their babies. These detailed descriptions of anxiety provide evidence to suggest that anxiety might be a major issue for some new mothers. Although some of these symptoms, such as appetite changes, fatigue and emotional upset are features of depression, participants clearly linked these with anxiety:

I felt like this must be postpartum depression, right, because that’s the only sort of term I could come up with that was something – “postpartum something.” Which is what intrigued me about your study because when I read it I was like, “right, postpartum anxiety.” So much more fit with how I felt at the time. Because I wasn’t depressed, I mean I cried a lot but it was frustration tears, not sad, poor me tears. They felt very different to me.

Expectations of a New Mother

Expectations about becoming a new mother provided the back-drop for increased feelings of anxiety. These expectations included a focus on self (what participants thought they should do), other (both what participants expected of others and what others expected of the participants), and social norms (what participants believed about societal pressures).

Preparation. Several participants expressed that they had not engaged in many of the tasks they perceived as preparatory tasks for the transition to parenthood, such as reading books, researching parenting issues, or setting definable expectations. Karen said “I actually didn’t read much on parenting. I was interested in his development, rather than parenting because I guess, having no expectations, I didn’t really have a plan.” Three other participants also expressed that they did less research and preparation than they imagined other expectant mothers might do.

Cognitive versus experiential knowledge. Many participants expressed that it was difficult to accurately set expectations about the transition to motherhood before experiencing it first-hand. Participants drew distinctions between knowledge that comes from books and observations of other mothers versus an embodied knowledge that comes from engaging in the act of mothering. One participant explained: “you can try to be prepared, you read books, you can talk to other moms and be informed, but on the other hand, you really can’t be prepared.” Participants found that the actual role and work of motherhood were profoundly different than expected, and that this led to increased anxiety, as demonstrated by one participant’s words: “my lack of experience, and, um, what do you call it like shock of misunderstanding, or that aspect of mothering probably exacerbated the anxiety in that way.” Another noted: “if I have something to model, something positive to model, to learn, then I think it probably wouldn’t be so difficult. And I’d probably have a better ability to cope, and then I would be less anxious.”

Appearance. Many participants expected there would be little change to their appearance when becoming a new mother, or that they would return to “normal” quickly after birth. One woman stated that before she had her son, she thought moms should look “more put together,” and that they should be “dressed by noon.” She explained that “[I] didn’t expect it [my look] to change. I didn’t expect it to be any different than before, and that was very, very wrong.” All of the participants who commented on their expectations about how new mothers should look found that those expectations were not borne out.

Birth, joy and bonding. Several participants expressed that there was a significant mismatch between their expectations of joy and bonding and their actual experiences, and that this caused them distress. As one participant explained, “you have this screaming, wiggly, slimy little thing that you can’t even – there’s no connection between you. I had no connection, it was just my responsibility.” Many participants expressed that they also expected to feel bonded with their infants right away, but found that it took several months to feel a bond growing. One mother explained “that bond was the result of hard work. When my daughter came out, I loved her but I hadn’t yet fallen in love with her, and that falling in love is a process. And it continues to be nurtured.” Some participants mentioned that the lack of an immediate bond with their children exacerbated their feelings of anxiety: “bonding can take a long time, and having talked to quite a few people now – that causes a lot of anxiety among people.”

Comparisons. Participants spoke of other mothers, including their own mothers, sisters, friends and acquaintances whom they thought managed the tasks and responsibilities of mothering better than they did themselves. A mother of two children stated “the voice of your mother in your head, like what they did and what their experience was. I think [it] is a big thing.” She said that her mother and other mothers she had seen could manage, so she did

not understand why she could not: “the other mothers that I know managed to make dinner every night. Why can’t I?” These negative comparisons of themselves to other mothers fueled their anxiety:

And so all of those expectations, when they’re not being lived out, which was my experience, then that directly affects the anxiety level. So not only am I a brand new mom not knowing what I’m doing with this other stuff going on, the chaos of it all, I’m also not hitting the markers I should be hitting, in my head. And so, what I wanted to say earlier is like the anxiety feeds off itself almost. So I’m anxious and so I’m thinking, I’m not like Mrs. Cleaver, now I’m even more anxious, like, oh crap, I’m even more anxious? So now I’m really not. You know what I mean? And my sister isn’t [anxious] and my mom wasn’t, oh crap, now I’m really anxious! And so it’s almost cyclical or feeds off itself, and it rollercoasters. So yeah, absolutely those influences I believe are woven into the anxiety, perhaps fuel it.

Several participants expected themselves to perform better in their role as new mother than they thought they actually did. For instance, one woman stated: “I definitely thought [new mothers] should be confident and competent. I didn’t realize all the learning . . . that stuff wasn’t easy. So, you fail like constantly in the first year, you’re just doing everything wrong.” Another participant echoed this statement, saying:

That’s a huge thing, I think, about anxiety and perfectionism is I guess a lot of anxious people are trying to please everyone all the time. So you have this little tiny person who’s complaining at you non-stop, very, very loudly. You just feel like a total failure, and you’re obviously doing something wrong.

As with comparisons of themselves to other mothers, these participants thought that they were failing or falling short when they measured themselves against their own high expectations.

Issues of Support

Although our participants were professional, capable women who believed that they had a good support network of professionals, family, and friends, they often experienced invalidation of their anxiety-related experiences and found the type of emotional and practical support they needed lacking. This resulted in many participants feeling lonely and isolated.

Health professionals. Several participants expressed that they did not get the amount and/or type of support they thought they needed from the healthcare system. They asserted that their doctors did not ask the right questions to determine that they were struggling, and most women thought that their concerns were not addressed appropriately when they did come to light. One woman explained that when she went to see her doctor because her emotions were very different from anything she had experienced before, she reported that “he kind of heard my stories and said ‘well you’re not depressed, so you’ll figure it out. It’ll sort itself out in a couple of days, or a couple of weeks, or however long it’s going to take.’” Similarly, another stated:

that still annoys me too – that my family doctor had no idea and didn’t ask . . . and when I said my baby was crying all the time, she said it was colic. And she kind of jokingly said “don’t throw the baby out the window,” and I just thought that was kind of dumb. Like, I mean, I understand why she said that,

but it wasn't really like "oh, how are you?" It was like a fait accompli that it was going to be really hard and like I can handle it with one off-hand joke. Like, okay, it's all fine. I'm not going to throw the baby out the window.

This type of dismissive reaction from both men and women health professionals resulted in participants feeling frustrated and angry that their concerns were not being heard or valued, and it had the impact of eroding their confidence in trusting their own experiences.

Husband. Several participants thought that they did not receive appropriate support from their husbands. One woman said:

I also really thought that my husband would play a more active role . . . so I had this feeling that I was responsible, but I had this other idea that my husband was still going to be there for me, and I think that was a real major let down.

Another expressed that this perceived lack of support was tied with her anxiety: "What's the link between motherhood and anxiety? Well, I'm not getting a lot of support at that time, at least I don't feel like I'm getting the support at the time." Although most of the participants expressed that they believed their husbands were trying to be supportive, in most cases, they did not actually feel supported. In particular, several women expressed that they had expected a more equitable division of labor in caring for their infants than they experienced, and this made them frustrated and angry. Some noted that they did not feel that they could relinquish the control necessary for others to support them. One participant stated: "And my husband was stressed out by my stress, and I wouldn't let him help. So, I really had no idea that that would happen."

Family and friends. Three of the six participants expressed that the amount and/or type of support that they received from family and friends was inadequate and/or inappropriate. One woman, referring to the difficulties she experienced in the postpartum, said: "I even had [very close friends] give me a buck-up buckaroo kind of talk . . . or not actually believing you have postpartum. Unless some kind of psychiatrist has diagnosed that, they're not going to believe you." Rather than feeling supported by those in their social networks, it seems that these participants felt more criticized or dismissed. Another participant expressed that she felt burdened rather than supported by the many family members that were present during the early postpartum period. She stated that this was because "they're not really support people. They give you a whole bunch of opinions and ideas and advice. That's not what I need at that time. I believe that's not what most moms need at the time." Conversely, some participants identified that they had wanted their families and friends to be more involved. For instance, one participant stated, "I am a single mom, and my mom was my support person, and she wasn't being very supportive. So I did not have any support really at all."

Feeling alone. Many of the participants expressed that they had experienced feelings of general loneliness and isolation during the initial postpartum period. When asked about the link between the experience of anxiety and motherhood, some participants listed their feelings of isolation as a major factor: "I think that was another main component of the anxiety that at the time, there was like no one, like that I would normally turn to for help. There was no one available." Another participant said "there were all these people there, but I felt really alone in what I was struggling with, and although I shared it with people, I got the feeling that they didn't really grasp what was happening." These quotes suggest that it was not only physical or social isolation that the participants experienced, but that they felt psychologically alone in dealing with the struggles in the transition to mothering.

Societal Scripts of Motherhood

Participants described how their personal experiences were embedded in the larger context of North American (Canadian) society, especially around media and cultural norms. They also described how their own intersection of their diverse social locations (e.g., gender, social class, ethnicity) impacted their struggle with postpartum anxiety.

Media representations of motherhood. All of the women interviewed identified that they thought that images of new mothers were absent, and/or that they felt unable to relate to the images of new mothers presented in the media. One said “I can’t think of seeing that many portrayals of the beginning of motherhood in the media – just an absence of information. So you just assume that you have a baby but you’re still yourself, your pre-baby self.” Other participants spoke about the prevalence of negative representations of mothers they saw in the news media, such as stories about infanticide or filicide. Several participants also identified that popular media, such as television shows and advertisements portray new motherhood as being easier and less time consuming than it is in reality. Another explained how these representations are insidious and interact with expectations of the self, leading to increased anxiety:

So there’s lifelong expectations and there’s *Leave it to Beaver* and there’s my mother and all those things sort of build up and while I don’t consciously think “Oh, I have to be like Mrs. Cleaver today and iron my dress,” [but] it’s still in there somewhere, that’s what influence is. I mean you’re kind of bombarded by it. And so all of those expectations, when they’re not being lived out, which were my experience, then that directly affects the anxiety level.

Myths of motherhood. Several participants expressed the idea that there is a taboo about discussing the difficult issues of the transition to motherhood, and that the “ugly stuff” is not talked about in our society. One spoke about the stigma attached to admitting that you are struggling, saying that motherhood is: “almost like the secret society, you know what I mean? And because our society says you’re supposed to be perfect and motherhood is natural, there’s no way we’re gonna put ourselves out there and say ‘uh, I’m not normal.’” Participants discussed how this idealized display led to feelings of anger and frustration about being led to think their experiences of motherhood would be more pleasant than they actually were. Another stated:

We do forget, though. I remember my mom saying to me “well I can’t remember, I can’t remember the first year.” And I was like “what the hell?” ... but, you know, if I wasn’t in this situation to talk about it and even talking about it a year and a half later when I’m doing sort of ok, a lot of stuff has already gone through the cracks, it’s already gone into the oblivion. Yeah, there’s a weird thing that happens where you forget and maybe that’s part of why we don’t talk about it so much.

Here, she suggested that mothers end up contributing to this motherhood myth themselves because they forget what the early postpartum period was like once they are coping better.

Pressure to conform to societal expectations. All six of the participants spoke about the pressure they felt to do things the “right” way, according to society’s standards. Several participants described feeling judged on their mothering skills and attributes. For instance, when one participant’s baby began to lose weight, she worried that she would be blamed and feared the consequences. She said, “the nurse that came to our house made us really nervous.

Yeah, she made me feel that she was going to take my baby away if her weight didn't increase." This participant expressed that she was concerned not only about how she would be perceived as a mother, but also how her son would be perceived, saying "I guess I want other people to see me as a good mother and my child as a good boy." Another spoke about the pressure placed on new mothers to breastfeed exclusively. She stated "I think there's a real sense of women these days at least, at least more educated women that you're a bad mother if you don't breastfeed exclusively, and that your child's going to be harmed. And it's not true." Although she thought that having her husband sometimes bottle-feed their son would have alleviated some of the problems she experienced, she felt pressured to do what was seen as best for her baby without consideration of her own well-being. Another participant also felt pressured to breastfeed, and experienced criticism when she had difficulties breastfeeding. She stated that "it would have been nice to know that breastmilk sometimes doesn't come in, and that that's not a natural thing either and not to put so much freakin' pressure on...there was huge guilting around that." However, the women also felt that societal norms dictate that breastfeeding should not be done in public spheres. One said: "that's something that you don't see a lot of is women nursing their children. You magically nurse your child every 2 to 3 hours, but no one ever sees it happen. It just happens somewhere."

Gender scripts. All of the participants expressed that they thought that there is a gender imbalance in the tasks and responsibilities of parenthood. A participant described the societal expectation that mothers act as the primary caregivers for their children, and the unequal division of labor she thought there was between her and her husband:

As a mother, and as a female, there's an expectation that if you're there, you're in charge and you'll take care. And it's with my husband, but it's also with everyone else. Like if we go out, I'm the default carer for our son, and it always was that way . . . and I was really surprised because I had, like, I'm the breadwinner in our family, I'm used to a much more equitable division. And when our son came along, it was like there was no equity, there was no even attempt at equity.

Another pointed out that fathers are not expected to have the same parenting skills and knowledge that mothers are expected to have, indicating that it is not only the division of tasks that is at issue, but an overall responsibility. Yet another participant expressed that it was in the first few weeks postpartum when she was breastfeeding a lot that she really started to feel gender inequalities in parenthood:

I just felt this big huge weight on me. For the first time I felt it was unfair that I was the woman and I'm the mom so I have to stay with the baby and feed him every two hours. I just felt this "life is so unfair and there's nothing I can do about it."

One participant asserted that the educational materials that are readily available to fathers have a different tone from those that are intended for mothers: "The ones for dads . . . actually talk more about psychological issues than the women's ones do. . . . Whereas the books mothers read are like technical parenting baby-care books." She also addressed the issue of gender in parenting with regards to what we learn from previous generations:

Your role models – a lot of men in our generation, their fathers weren't as active and involved. So I don't think they have high expectations of themselves. I think if anything, if they're doing a lot of domestic stuff, they

feel proud because they're doing so much more than their fathers in that way. Whereas for women- for our current generation- our mothers' generation really did everything. They worked and they did everything at home for the most part.

Social class norms. Participants described aspects of mothering that they perceived as being more or less challenging depending on the social status of the new mother. Several participants mentioned that more affluent mothers would have increased access to various resources. For instance, they would have the means to hire help, to procure quality childcare, to make a "comfortable nest," to buy better equipment, and to make use of community resources. A few participants also mentioned that being of a higher social class increases your options by allowing you to live in better neighbourhoods or to take time off from work. The participants also identified challenges that might be associated with being of higher social standing. One stated that women of higher social class might have a harder time asking for help, while another asserted that there might be more "teamwork" in less affluent families. Similarly, one participant explained that financial resources cannot replace social resources.

Ethnicity and culture of origin. Participants described their perceptions of how race and culture of origin impact the experience of transitioning into motherhood. One spoke about special issues of cultural tensions and access to resources faced by immigrant mothers, and that she felt she has to "negotiate between Canadian cultural values and [East Asian] cultural values. Language is one item that parents have to, that I have to decide. Not knowing what resources are available, not having a support group, dealing with cultural differences. Yeah, social network." She also noted that immigrant women often have a lower socioeconomic status than non-immigrant women, and might therefore have less access to resources. The four participants of Western European ancestry spoke of the individualistic nature of North American society and how this contributes to feeling a lack of being supported through the transition. One woman stated:

I think that another big factor is that families are spread out and it's a very individualistic society where we don't see a lot of childbirth, or new babies, where it's not a part of our culture. It's just not normal, like it's common, but it's not a normal thing for us. Which is so weird that it's not. We have to create these artificial groups of women to have a sense of commonality, whereas it should be the most natural thing in the world. But it's not.

The Transition

The process of adjustment between participants' sense of self and identity before and after childbirth is one that takes considerable time, effort, and change. Participants, in retrospect, were able to identify the temporal nature of the transition and how the experiences of mothering and anxiety slowly began to shift.

Overwhelm. All of the participants expressed feeling overwhelmed in the early postpartum. This centered on the tasks and the time associated with mothering, as well as the significant burden of responsibility. One woman described what it was like to go for a walk: "You would get so far from your house and then your baby would lose it on you. And you'd breastfeed it, but as soon as you put it back in the stroller it would be screaming. It would have a meltdown, and you would have to go from wherever the hell you were – you could not get home that fast."

She also described feeling a sense of "overwhelming responsibility," which another participant's narrative supported:

even if you go on vacation, you're always responsible. . . . I guess it's tied into anxiety in that if you're someone who doesn't worry, like if you just take things day by day, you don't really think ahead. But because I see everything in the future all the time and I'm aware of like all the permutations and computations of what could happen, like all the time, at least so I think, I have that responsibility of anything that could ever happen on my shoulders all the time.

What helped. Several participants expressed that what was most helpful to them was engaging with a community of other mothers. One woman said:

That was the best thing that ever happened to me . . . that worked well for me because I was in a group setting. I found other people that were also not experiencing the joys of mothering and they were watching out for me. I suddenly felt like I was being looked after, watched out for too.

Another shared that she did not take part in any mothers' groups, but that talking to some other women with children who shared her experiences of feeling overwhelmed in the early postpartum period normalized her experience. She also found that keeping herself busy with her own education helped her manage the transition, because it gave her a break from the overwhelm she experienced in caring for her baby.

Self care. Several of the participants interviewed expressed that they had not known how to take care of themselves and engage in self-care during the early postpartum period. One woman stated: "I couldn't recognize that for me, taking care of myself meant sleep." The participants expressed the importance of mothers navigating the transition to motherhood by learning to care for themselves, and several of the participants stressed the need to believe that they were deserving of self-care. One participant stated: "Self care is huge. You have to know how to do it, first, and you have to feel ok about getting it. You have to feel like you have the right; you deserve it." There is a sense that self-care needs to be negotiated around the more highly prioritized needs of the baby, and that many new mothers do not really know how to best take care of themselves within this new context. This lack of ability to allow for time and rest for themselves increased these new mothers' feelings of anxiety:

I was the one that got up every three hours and I was the one that took care of her and I was the one that still did the laundry and cleaned the house and made supper for my husband. So I felt like all those things still had to happen. So I was really kind of partly responsible for my own anxiety, right.

Further along in the transition. All of the participants expressed that managing the role of mother became less distressing and overwhelming with time. One woman said "I do feel a lot more comfortable with him right now, but at least at the beginning, there were times when I felt like I just couldn't understand what he wanted." Another participant described motherhood as "the most unnatural joyous journey" and stressed the importance for her in becoming more comfortable with uncertainty:

And so I think if anything I've become comfortable with not knowing. And that's probably been the biggest leap for me, where I thought I would intuitively know everything and you know, be a good mother and that would just happen, somehow (*laughs*). How did I think that would happen?

Several of the participants spoke about the rewards of motherhood that they are now experiencing. One woman stated that “now it’s so great, like it’s the best thing. Like, I’m so filled with gratitude that I have her now.”

Discussion

The purpose of this research was to create new knowledge about women’s experiences of anxiety in the postpartum through in-depth interviews. This study contributes to a richer understanding of women’s experiences of postpartum anxiety, and adds to the small, but growing body of literature on this issue.

Three major findings emerged from the data. First, our findings point to the need to specifically recognize and name the varying experiences of postpartum distress, rather than using the umbrella term of postpartum depression. Several mothers in our study expressed that they were interested in participating because we had used the term anxiety in study advertisements. They spoke strongly of feeling misunderstood and alienated amidst the dominant discourse that implies that postpartum depression is a single, distinct issue, and perhaps, the only issue that really counts. Women who did not show symptoms of, or resonate with, descriptions of depression, often felt marginalized by friends, families, and professionals. For instance, several of our participants mentioned that they had been assessed for postpartum depression, but did not meet the cut-off score on the EPDS for depression and were, therefore, not identified as needing help. This is in line with the research of Miller and colleagues (Miller, Pallant, & Negri, 2006), who suggested that 10% of the women in their total sample were distressed, but would have been overlooked if they had relied solely on depression as a marker for distress in the postpartum.

Our second major finding relates to issues of high expectations. The participants’ sense of competence, or perceived lack thereof during the postpartum, appeared to have contributed to their sense of anxiety, overwhelm, and loneliness. Participants in our study often made comments associated with high expectations, including “I did think I had to be perfect,” and “perfectionism . . . the idea that you can do a baby perfectly . . . like, if your baby’s crying, you’re doing something wrong,” and “the needing to be perfect and the needing to do it right and the needing to be solely responsible.” Further support of this connection between high expectations and postpartum anxiety is found in a study of perfectionism in highly educated, employed pregnant women (Macedo et al., 2009). These researchers found that some perfectionistic beliefs, such as unattainably high standards, the inability to take pleasure in one’s performance, and uncertainty about one’s capabilities might be associated with distress in pregnancy. From participant responses about the media, we can see that idealized images of motherhood and the labor associated with it abound in society and are internalized to the degree that striving to achieve this unattainable level of perfection will almost certainly result in a sense of frustration, disappointment, and anxiety for many women.

Our third major finding relates to the connection between women’s health, and the cultural context of childbirth and parenting within the context of urban professional women. There is a disconnection in Western society from many important health and developmental issues such as birth, breastfeeding, illness, aging, and dying. Full-time professional women living in large cosmopolitan centers might be highly capable in most realms of their lives, but might be virtually separated from childbirth and childrearing of others in the community. Kitzinger (1978) asserts that no matter the personal skills and attributes of a new mother, the occupational and emotional tasks of motherhood are very taxing and challenging. Furthermore, she states that mothering does not provide women with the opportunity to anticipate, study, and master a specific skill set, and that this dynamic quality of mothering

can lead to insecurities in new mothers. Four participants in our study spoke of the individualistic nature of North American culture and how this worldview contributes to a lack of being supported through the transition to motherhood and leads to further anxiety. Many women in this society, therefore, are left to learn about childbearing and parenting through books and formal teaching, instead of as a deeply embedded part of the culture. The lack of knowledge, or more precisely, the presence of a particular type of knowledge, serves to increase women's anxiety of not knowing what to do and not living up to the cultural ideal.

Implications for Practice

Many implications arise from the results of this study for healthcare professionals, including counselors, doctors, and nurses who work with new mothers. Our findings highlight the need for changes in our language and conceptualization of postpartum distress, as well as in our screening procedures and treatment of women. It is evident from our research that the dominant discourse surrounding postpartum depression is problematic and appears to exacerbate feelings of anxiety. Health care providers need to recognize a broader spectrum of issues, and to ensure not to trivialize the difficulties new mothers might face, even if they do not meet clinically-significant cut-off scores or fit into particular diagnostic categories.

Professionals working with new mothers also need to be aware of the larger sociocultural climate in which new mothers are embedded (e.g., Houvouras, 2006), rather than locating postpartum distress as an individual disorder. Addressing issues of competency, anxiety, high expectations, and guilt may be very important in normalizing experiences and engaging women in meaningful discussions that break down barriers and connect them to others. Healthcare workers need to have the knowledge about and ability to work with these commonly internalized ideals by using feminist strategies such as consciousness-raising, validating, and normalizing to debunk unrealistic images that many women hold as unwelcome role models.

Additionally, increased cross-referrals by primary care physicians for their patients to seek out individual and group counseling would be beneficial. Referrals to outside support need to be made carefully, and in collaboration with the women, so that their individual needs, diversity issues, and comfort levels are taken into account. Knowing the specific community resources and target population is important in making appropriate referrals. In connection with addressing the transition issues, primary care physicians and nurses could help in assisting women to take steps toward regular self care by focusing on how to engage in meaningful self care activities and avoid the associated guilt.

Our participants' descriptions of loneliness and isolation point to the need for healthcare professionals to consider the importance of relational connections in women's lives. Feminist relational theories, such as Relational-Cultural Theory (RCT) discuss the importance of diversity issues (e.g., gender, social class, and ethnicity) and meaningful relational connections for psychological health, adjustment, and identity development (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991; Popadiuk, 2008a, 2008b). RCT also postulates that disconnection from others limits psychological growth, and often leads to depression and anxiety. Our findings provide evidence for the usefulness of a relational-cultural lens to more effectively assess the level and quality of perceived support within a cultural context, and the resulting psychological health or distress. Although participants in our research had family and friends in their lives, none of the women felt that they were getting the kind of support they needed. Several participants in this research indicated that being part of a community of new mothers was very helpful for them in managing the transition to motherhood, a finding that points to the importance of validating and mutually empathic relationships. Therefore, any measures that can be taken to strengthen meaningful community and relational supports

among new mothers, such as postpartum support groups or peer-run groups, should be encouraged.

Unique Findings in this Study

This study contributes to our understanding of postpartum anxiety as distinct from postpartum depression, and addresses how self-criticism and high expectations, often developed from larger societal expectations, contribute significantly to postpartum distress. It also illuminates the relationship between postpartum anxiety and the cultural context within which new mothers are undergoing this major life change, indicating a need for more feminist, social constructionist, and narrative methodologies (Young & Popadiuk, 2012).

Limitations

The women in this study are well educated, financially secure, and have given birth to healthy children. Their intersectionality of social statuses affords them possibilities (Arthur & Popadiuk, 2010; Popadiuk, 2008) that are often not available to many new mothers, as echoed by some participants. The applicability of these findings to other groups of women is unknown, although threads of resonance between this research and other studies (e.g., Bondas & Eriksson, 2001; Landy, Sword, & Valaitis, 2008; McBride-Henry, 2010) suggest that many gendered societal expectations of mothers and mothering might cut across social class and ethnic identity categories. Another limitation of this study is that each woman was interviewed only once. A second interview or a series of interviews over time might have provided the participants and interviewer with opportunity for further reflections, which might increase the richness of understanding.

Future Research

This inquiry informs future research by highlighting the need for better screening procedures, prevalence rates, and treatments if a broader range of terms is used to describe the difficulties women experience in the postpartum. Additionally, this study informs future research by highlighting the importance of relationality. Using Relational-Cultural Theory (RCT; Jordan, Kaplan, Miller, Stiver, & Surrey, 1991) as a framework, for example, to investigate women's relational supports for transitioning to motherhood might be especially informative. Finally, this study provides a basis upon which future research could explore the intersectionality of women's social identities, such as social class, ethnicity, sexual orientation to better understand how these aspects impact women's perception of self, the experiences of motherhood, important relationships, and support groups and programs.

Conclusion

In this article, we have addressed issues in the identification and recognition of postpartum anxiety, the role of high standards and self-criticism in postpartum experiences, and the cultural context in which the transition to motherhood is embedded. Women navigating the transition to motherhood contend with a number of changes and new roles, and our societal scripts and cultural attitudes toward mothering play a large role in how this transition unfolds.

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