

PRACTICE BRIEFS



Perinatal and Postpartum Anxiety

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ABSTRACT: Perinatal and postpartum anxiety (PPA) affects an estimated 15–20% of pregnant and postpartum individuals, yet it remains underreported, poorly screened, and absent as a standalone diagnosis in the *DSM-5-TR*. This Practice Brief examines the diagnostic presentation, etiology, and assessment strategies for PPA, alongside evidence-based treatment approaches. Professional counselors are uniquely positioned to identify PPA, provide culturally responsive care, and advocate for systemic change to improve outcomes for this vulnerable population.

Introduction

Pregnancy and childbirth are widely regarded as joyful milestones. Yet for many, this expected happiness is interrupted by debilitating anxiety. An estimated 15–20% of perinatal and postpartum individuals meet clinical criteria for anxiety or an anxiety-related disorder (Ayers et al., 2025; Fawcett et al., 2019; Womersley & Alderson, 2024), and the true prevalence is likely higher as PPA is underreported and poorly assessed. The perinatal period generally spans from pregnancy to the first year after childbirth (Womersley & Alderson, 2024). The postpartum period is sometimes defined narrowly as the weeks immediately following delivery; however, in mental health literature, it is often defined as extending into the first year after childbirth (Feldman et al., 2025). Counselors can play a meaningful role in identifying and supporting those affected by PPA. This Practice Brief introduces PPA, including its diagnostic presentation, evidence-based screening tools, and key treatment considerations, to increase professional counselor awareness and advocacy.

Description of the Topic

Symptoms and Diagnosis

Perinatal and postpartum anxiety is not a single disorder but rather a broad category that includes several anxiety-related conditions, such as generalized anxiety disorder (GAD), panic disorder, specific phobias, obsessive-compulsive disorder (OCD), and social anxiety disorder (Feldman et al., 2025). Symptoms of PPA largely mirror the symptoms of anxiety and anxiety-related disorders. What most distinctly sets PPA apart is the content and context of the excessive worry or intrusive thoughts that characterize it.

A consistent and defining theme of PPA is preoccupation with the health and well-being of the newborn. Those with PPA commonly report worrying about cleanliness and germ contamination in the baby's environment (Drake et al., 2024). Concerns about sudden infant death syndrome (SIDS) and other conditions affecting infants and young children are also frequently reported (Abramowitz et al., 2025; Drake et al., 2024; Starcevic et al., 2020). While brief intrusive thoughts are common and considered normal during the postpartum period (Collardeau et al., 2019), some individuals experience prolonged and distressing intrusive thoughts about accidentally or intentionally harming the baby, or about harm coming

to the baby from outside sources. Beyond infant-focused concerns, anxiety may also center on the parents themselves. Feelings of self-doubt about one's ability to parent competently, as well as sensitivity to how one's parenting is perceived by others, are commonly reported sources of distress (Goldfinger et al., 2020).

Consistent with general OCD symptoms, individuals with OCD-related PPA may engage in compulsive behaviors to seek relief from intrusive thoughts. However, the focus of these compulsions often centers on the infant, such as repeatedly checking on the baby during sleep, engaging in excessive cleaning, or seeking reassurance about the infant's health from pediatricians or medical resources. For those experiencing doubt about their efficacy as a parent or intrusive thoughts of harming the child, avoidance of being alone with the infant may serve as a compulsive strategy to manage anxiety (Abramowitz et al., 2025; Drake et al., 2024).

Providing a specific diagnosis for PPA presents a challenge for clinicians, as it is not a standalone diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; *DSM-5-TR*; American Psychiatric Association [APA], 2022; Zappas et al., 2021). Although the peripartum onset specifier—defined as occurring during pregnancy or within four weeks of delivery—can be applied to mood disorders, anxiety and OCD-related disorders lack an equivalent perinatal specifier (Gill et al., 2024). This leaves counselors relying on broader diagnoses such as GAD or adjustment disorder with anxious mood, without the nuanced treatment implications that a perinatal specifier might provide. PPA is highly comorbid with mood disorders during the perinatal and postpartum periods (Feldman et al., 2025). Distinguishing between disorders is complicated by overlapping symptoms such as sleep disturbance, fatigue, and impaired concentration (Clinkscales et al., 2023).

Etiology and Risks

The causes of PPA are multifaceted, arising from biological, psychological, and behavioral factors that uniquely affect individuals before and after childbirth. From a biological standpoint, the hormonal fluctuations that occur during pregnancy and after delivery play a central role in triggering anxiety symptoms (Feldman et al., 2025). The rapid withdrawal of estrogen and progesterone, elevated throughout pregnancy, can significantly disrupt neurotransmitter systems which are closely tied to mood stability (Schweizer & Graham, 2025). Compounding this, the natural biological instincts that emerge to protect a newborn, although evolutionarily adaptive, can manifest as persistent hypervigilance and a state of heightened arousal, leaving new parents in a near-constant state of alert even without genuine threat (Zappas et al., 2021). Sleep deprivation from the nighttime demands of childcare further triggers and amplifies these biological and psychological vulnerabilities (Cox, 2025; Ladyman et al., 2022; Zappas et al., 2021).

Research consistently identifies a personal history of anxiety or mood disorders as one of the strongest predictors of PPA, as the hormonal and emotional upheaval of childbirth can reactivate or significantly worsen symptoms that may have previously been managed or even dormant (Feldman et al., 2025). Individuals with a history of trauma, obsessive-compulsive tendencies, or panic disorder are particularly vulnerable, as the demands and uncertainties of new parenthood can serve as powerful triggers for these pre-existing conditions (Doncarli et al., 2024; Feldman et al., 2025; Jones et al., 2025). Additional risk factors for developing PPA include holding negative perceptions of the quality of care provided by medical staff or the broader healthcare system during pregnancy and childbirth (Feldman et al., 2025; Sun et al., 2023). A traumatic birth experience or unplanned caesarean section may also contribute to developing PPA symptoms (Clinkscales et al., 2023). Poor newborn health outcomes, such as preterm birth or admission to the Neonatal Intensive Care Unit (NICU), can further elevate this risk. Socio-demographically, younger maternal age has also been identified as a contributing factor (Feldman et al., 2025; Jones et al., 2025; Swift et al., 2020), potentially reflecting more limited financial and social support, higher rates of unplanned pregnancy, and fewer established coping skills (Swift et al., 2020).

Assessment Strategies

Despite the estimated high prevalence of PPA, individuals are not routinely screened for anxiety disorders during pregnancy or following childbirth (Sharma, 2022). Ideally, screening would occur through a clinical diagnostic interview, but its time-intensive nature makes self-report screening instruments a practical alternative (Zappas et al., 2021). Although several professional organizations have emphasized the importance of screening for perinatal mental health concerns, implementation remains inconsistent. Most notably, the American College of Obstetricians and Gynecologists (ACOG; 2023) recommends routine screening for mental health conditions throughout the perinatal period. The ACOG guideline specifically identifies the Generalized Anxiety Disorder-7 (GAD-7) and the Edinburgh Postnatal Depression Scale (EPDS) as appropriate screening tools for anxiety symptoms. As these brief screening tools are more frequently administered by obstetric and pediatric providers during routine visits (ACOG, 2023), counselors should develop referral relationships with providers so that individuals with elevated scores receive further evaluation and counseling. Additionally, anxiety in the perinatal period is not limited to birthing parents. Partners, including fathers, can also experience it and benefit from inclusion in screening (Leach et al., 2016).

A number of screening instruments have been evaluated for use to assess anxiety during the perinatal period. Although originally developed to identify postpartum depression, the EPDS contains three anxiety-related items that have been examined as a distinct anxiety subscale (Feldman et al., 2025; Zappas et al., 2021). The GAD-7 and its abbreviated version, the GAD-2, are widely used in primary care settings and have demonstrated strong psychometric properties among perinatal populations, although recommended cutoff scores may vary across studies and populations (Ayers et al., 2024; Feldman et al., 2025).

Some anxiety-related conditions remain poorly captured by general screening measures. For example, postpartum OCD may not be detected through broad anxiety screening instruments. In these cases, the Obsessive-Compulsive Inventory (OCI), available in both four-item (Abramovitch et al., 2021a) and 12-item versions (Abramovitch et al., 2021b), may be used. The Perinatal Anxiety Screening Scale (PASS), the first instrument developed specifically to assess perinatal anxiety, evaluates domains such as acute anxiety, excessive worry, perfectionism, and social anxiety (Somerville et al., 2014). Importantly, it also addresses concerns unique to the perinatal period, including fears related to fetal and infant well-being, childbirth, and parenting.

Treatment Approaches

Medication

The course of treatment for PPA depends on the severity of symptoms, with pharmacotherapy reserved for more severe presentations (Zappas et al., 2021). When indicated, selective-serotonin reuptake inhibitors (SSRIs), specifically sertraline, are considered first line treatment, as they effectively treat both anxiety and depression (Zappas et al., 2021). Furthermore, with the benefits outweighing the risks, SSRIs are also generally considered safe for use during pregnancy and while breastfeeding (Womersley & Alderson, 2024; Zappas et al., 2021).

Cognitive Behavior Therapy

Along with medication, psychological interventions have also been found to be effective in treating PPA. Cognitive behavior therapy (CBT), delivered either individually or in group counseling settings, has been found to reduce anxiety symptoms in those struggling with PPA (Feldman et al., 2025). Donegan et al. (2022) further explored how CBT produces these improvements, finding that group CBT reduced not only anxiety and depressive symptoms, but also maladaptive beliefs about uncertainty and parenting perfectionism. For postpartum women specifically, reducing these unhelpful beliefs appeared to be a key part of why their anxiety improved, though this was not the case for women who were still pregnant.

Dialectical Behavior Therapy

Dialectical behavior therapy (DBT) focuses on using distress tolerance skills to help individuals manage intrusive thoughts (Grunberg et al., 2022). DBT also focuses on balancing acceptance strategies with change-oriented behaviors using mindfulness techniques to help keep new parents grounded. Emotional regulation skills teach perinatal and postpartum individuals to process a normal spectrum of negative emotions, such as grief and shame. DBT's interpersonal effectiveness skills, such as the DEAR MAN communication framework, can also be used to help new parents assertively express their needs, resolve co-parenting conflicts, and secure vital social support (Grunberg et al., 2022).

Group Counseling

Group counseling provides a structured environment where individuals can dismantle stigma and cultural expectations, while voicing intense feelings surrounding parenthood (Grunberg et al., 2022). Group counseling also provides a learning environment in which parents can observe peer modeling and share practical problem-solving strategies to improve overall parental functioning (Grunberg et al., 2022). Empirical evidence shows that group therapy programs lead to a significant drop in maternal anxiety scores from pre- to post-intervention after eight weeks, with therapeutic benefits remaining stable for at least four weeks post-treatment (Appleton et al., 2025). In addition to group counseling, counselors should also connect clients to accessible community supports such as breastfeeding groups, and community parent groups. These non-clinical groups offer easily accessible, low-barrier, and cost-effective spaces for social connection, and normalization of postpartum distress (Appleton et al., 2025; Zivin & Courant, 2024).

Other Preventative Approaches

Prenatal psychoeducation has been shown to be a vital preventive tool in decreasing perinatal mood and anxiety disorders (PMADs). A study of 70 first-time mothers found that prenatal education significantly lowers maternal anxiety levels at both six weeks and six months postpartum compared to standard care alone (Kamalifard et al., 2025). Examples of psychoeducation material include expectations of infant development and care, postpartum healing, and coping skills for stress and sleep deprivation. In addition to psychoeducation, peer support networks have been shown to significantly reduce anxiety. Peer-led approaches increase maternal self-esteem and decrease risk of developing PMADs (Appleton et al., 2025; Kamalifard et al., 2025). By blending psychoeducation with peer support, counselors can help individuals cope with emotional distress before it escalates into PPA.

Cultural and Ethical Considerations

Cultural Considerations

When addressing PPA, counselors should be intentional in examining cultural and systemic factors that shape a parent's reality. Perinatal anxiety varies significantly by socioeconomic and cultural factors. Low-income Latina women often experience a spike in positive anxiety screenings during the first trimester (13.6%), whereas low-income Black women maintain a prolonged vulnerability to anxiety across both the perinatal and postpartum stages (Wenzel et al., 2021). Black, Hispanic, and low-income individuals navigate severe health-care inequalities, resulting in lower rates of treatment initiation, clinical engagement, and long-term care retention (Zivin & Courant, 2024). These disparities are driven by structural failures, including implicit bias and obstetric mistreatment within hospitals, which strip marginalized individuals of their autonomy and can trigger anxiety (Zivin & Courant, 2024).

Class and income levels play a significant role in the presentation of PPA and access to treatment. To prevent financial barriers, counselors should utilize referral networks. This includes connecting clients with sliding scale community mental health clinics, integrated behavioral health, and providers embedded within federally qualified health centers, free community-based peer support groups, and telehealth (Joiner et al., 2022; Zivin & Courant, 2024).

Ethical Considerations

Counselors must practice with cultural humility, maintain strong diagnostic awareness, and protect both the parent and infant throughout treatment. One major ethical consideration is helping parents accurately understand treatment risks. Many postpartum individuals overestimate the risks of psychiatric medications, especially SSRIs, while underestimating the long-term developmental and attachment-related effects of untreated peripartum and postpartum mental health conditions (de Wet et al., 2023; Wenzel et al., 2021). Counselors are ethically responsible for providing balanced psychoeducation, clarifying the risks and benefits of treatment options. Postpartum individuals are vulnerable to shame and judgment, which can lead to minimization of symptoms and delay in seeking treatment out of fear of being perceived as “unfit” or facing child protective services. Counselors must create a nonjudgmental environment that explicitly distinguishes between unwanted, intrusive thoughts of harm which are common in PPA and active delusional intent or psychosis (de Wet et al., 2023; Wenzel et al., 2021). Distinguishing between non-delusional intrusive distress and true risk is vital to balancing client confidentiality with mandatory child safety responsibilities, ensuring providers do not inappropriately report or penalize parents seeking help (de Wet et al., 2023).

Advocacy

Guided by the ACA Advocacy Competencies, counselors must advocate for change across multiple levels of care (Toporek & Daniels, 2018). At the individual level, counselors can help parents develop self-advocacy skills, especially when their concerns have been dismissed in medical settings (Fitzgerald et al., 2024). At the community and institutional systems levels, counselors should address the drop off and low engagement disparities among minority and low-income populations by advocating for culturally appropriate outreach groups, diverse provider recruitment, and integrated care models that combine mental health screening directly into pediatric and obstetric settings (Joiner et al., 2022; Zivin & Courant, 2024). Counselors must support broader policy changes, including expanded insurance coverage, trauma-informed training, and preventative perinatal mental health services.

Conclusion

Perinatal and postpartum anxiety is a prevalent yet frequently overlooked condition that demands greater attention from the counseling profession. As this brief has outlined, PPA manifests across a spectrum of anxiety-related disorders, is shaped by complex factors, and disproportionately affects marginalized populations who face significant barriers to care. By sharpening diagnostic awareness, utilizing validated screening tools, implementing evidence-based interventions, and advocating at both the individual and systems levels, professional counselors can play a transformative role in reducing the burden of PPA and supporting the health and well-being of parents and their children.

Resources

- [Perinatal Mental Health: Educational Resources for Providers, Patients, and Families](#), American College of Obstetricians and Gynecologists
- [Resources for Providers](#), Massachusetts General Hospital Center for Women’s Mental Health
- [Resources for Providers](#), Policy Center for Maternal Mental Health
- [Training](#), Postpartum Support International

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