

Seeing Red: A Grounded Theory Study of Women's Anger after Childbirth

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Qualitative Health Research
2022, Vol. 32(12) 1780–1794
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DOI: 10.1177/10497323221120173

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Abstract

Persistent intense anger is indicative of postpartum distress, yet maternal anger has been little explored after childbirth. Using grounded theory, we explained how and why mothers develop intense anger after childbirth and the actions they take to manage their anger. Twenty mothers of healthy singleton infants described their experiences of anger during the first two postpartum years. Mothers indicated they became angry when they had violated expectations, compromised needs, and felt on edge (e.g., exhausted, stressed, and resentful), particularly around infants' sleep. Mothers described suppressing and/or expressing anger with outcomes such as conflict and recruiting support. Receiving support from partners, family, and others helped mothers manage their anger, with more positive outcomes. Women should be screened for intense anger, maternal-infant sleep problems, and adequacy of social supports after childbirth. Maternal anger can be reduced by changing expectations and helping mothers meet their needs through social and structural supports.

Keywords

sleep, mothers, postpartum care, mental health and illness, self-care

Background

Clinicians, families, and researchers are increasingly aware that the time after childbirth can be marked by distress (Howard & Khalifeh, 2020). Postpartum emotional distress has been described by mothers as feeling “numb,” “mechanical,” and “really bad about feeling low” (Beck, 2002; Mauthner, 1999). Hagen (1999) and others have indicated emotional turmoil may serve the function of prompting and assisting mothers to signal the need for support and resources from individuals close to them. Feeling sad and anxious are common ways for people, especially women, to express their distress to others (Simon & Lively, 2010). However, another way that people can express distress is through persistent and intense anger.

In accounts of postpartum depression, women have reported feeling uncharacteristic anger and rage (Beck & Indman, 2005). Empirical accounts of postpartum emotional distress may have contributed to neglecting anger because they have labeled anger as “frustration” and “irrational irritability” (Beck, 2022; Highet et al., 2014). Wood et al. (1997) interviewed 11 mothers, and identified “fierce” anger as not only directed towards children

but also towards partners, women themselves, family members, and health care providers. The women's anger could last for months and occur in parallel with disturbing impulses of self-injury and harming the infant (Wood et al., 1997).

Anger is often treated as a subtheme of postnatal depression (PND) (Holopainen & Hakulinen, 2019; Johansson et al., 2020; Kathree et al., 2014). For example, in a meta-ethnographic synthesis of PND in women migrating from low-income to higher income countries, anger was prominently represented as “I am worried,

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alone, and angry—this is not me” amongst four main themes including making sense of feelings, dealing with feelings, and actively changing how women felt about their situation (Schmied et al., 2011). However, Ou et al. (2022) found that, of a sample of women in the postpartum period who experienced intense anger, half experienced probable depression while half did not, suggesting that anger is a distinct mood problem that can be independent of depressive symptoms. Regression analysis indicated that income, number of children, depressive symptoms, maternal sleep quality, and maternal anger about infant sleep were significant predictors of intense maternal anger (Ou et al., 2022). Empirical sources provide limited exploration of mothers’ characterization of anger. We remain unclear about how mothers develop and express anger and its outcomes. The purpose of this study was to explain how and why mothers develop persistent and intense anger, the steps they take to manage their anger, and outcomes associated with intense anger and its management during the postnatal period.

Theoretical Framework

The study employed a relational autonomy theoretical framework. Because persons are understood as socially, politically, and economically situated beings in relational autonomy theory, it is necessary to examine factors that influence autonomy. Relational autonomy theory is relevant to women’s postnatal experience because the birth of an infant is a fundamentally relational event with a mother and child in situated social contexts (e.g., gendered roles within the family). Women’s accounts of postpartum depression and anger involve issues related to autonomy because mothers have identified losses to personal autonomy (e.g., from inability to work) contributing to their distress (Klein et al., 1998; Tronick et al., 1997; Wells et al., 1999). Relational autonomy theory assumes that a person’s ability to have and exercise autonomy is supported by others within a social context (Hirani & Olson, 2016; Mackenzie & Stoljar, 2000). Becoming a mother involves learning to manage both maternal and infant needs, a process that is made easier with relational (e.g., partner, kin) and structural supports (e.g., family friendly policies, community programs) (Goering, 2017).

Methods

A grounded theory study uses data generated from participants to develop an interpretive theory about the phenomenon under investigation through the use of focused codes and theoretical categories to create a theory that may be helpful to understanding the phenomenon (Charmaz, 2006). This constructivist grounded theory study guided by Charmaz (2006) received ethical

approval from the university behavioral research ethics board. This grounded theory study was an independent qualitative component of a mixed methods investigation of postpartum maternal anger. Eligibility criteria included basic fluency in English, being over 17 years of age, and having a healthy infant (not born premature or having health problems requiring extensive medical management). Women who indicated they were willing to participate in an interview about mood after childbirth were recruited from a cross-sectional online survey about maternal and infant sleep and maternal mood based on their anger and depression scores. Purposive sampling of a subset of women who had anger levels near or above the 90th percentile on the State Anger Scale, indicating intense anger, (Spielberger, 1999) and varying levels of depressive symptoms followed. Email invitations were extended to 32 women who were willing to be contacted based on their anger scores; 11 did not reply to the email invitation and 21 agreed to the interview. One of the 21 individuals who had initially consented to be interviewed canceled the interview because of time constraints related to a new job. Two interviews were excluded from the analysis because, during the interviews, it was revealed that the participants’ infants had significant health problems requiring ongoing medical monitoring and intervention.

Audio-recorded semi-structured interviews were carried out by telephone with mothers from across Canada. The mothers provided written consent between May 2019 and March 2020. Interviews were transcribed by a professional transcription company and checked for accuracy against the audio-recordings. The first author commenced data analysis using MAXQDA software after the first interview was transcribed. Analysis started with initial line-by-line coding. With each subsequent interview, the first author, in consultation with the second author, undertook constant comparisons of line-by-line codes within and between interviews to generate focused codes. Charmaz and Thornberg (2021) asserted that grounded theory methods enable researchers to move beyond description through constructing concepts that explicate what is occurring in the data. As theoretical categories are developed, the researcher uses theoretical sampling, and refines interview questions for subsequent interviews (Table 1). The core category, “Seeing Red,” was related to the majority of codes and accounted for the most data (Charmaz & Thornberg, 2021). Figure 1 reflects the findings generated by the process. Throughout each step, both reflexive and methodological memos were produced to record the process of analysis and analytical reflections.

Ethical Considerations

In preparation for interviewing women about potentially sensitive subjects related to postpartum

Table 1. Interview Guide and Question Refinements and Additions over Time.

Original questions	Question refinements and additions over time
Can you tell me about the birth of your baby and what that was like for you?	Addition: Have you felt angry at yourself since your baby's birth? For what reasons did you feel angry at yourself? How did you express this anger at yourself?
Can you describe a typical day and your feelings and moods throughout the day?	Refinement: Can you tell me what the most challenging part of having an infant has been for you? How does that affect how you feel on a daily basis?
Could you describe an atypical day when you might have been feeling overwhelmed or upset?	
Were there any points in time you might have felt frustrated or even angry?	Addition: Can you tell me why you were angry? Were you expecting something different?
Can you tell me about how you came to feel angry? What were the circumstances?	Addition: Did you feel like you had unmet needs at that time/those times? Can you tell me more about what those unmet needs were for you? How did having unmet needs affect your mood?
When you were angry, was it toward anyone or any people in particular? Can you tell me more about that?	
How did you handle your anger?	Addition: How would you describe the outcomes of expressing your anger? How would you describe the outcomes of not expressing your anger? Addition: Would any kind of support have helped you during the time you were angry? What kind of supports (from who/what type) would have benefited you? Addition: What prompted you to want to do the interview?
If you expressed your anger, who did you express it to?	
Were you feeling any other emotions at the time you were angry or after you were angry?	
Did you feel like you kept your anger in or did you let your anger out? What happened when you [kept your anger in/let your anger out]	
What other ways did you use to manage your anger at that time? Were they effective?	
Tell me about your thoughts and feelings following your anger.	
Do you do anything different to manage your anger now?	
What works for you?	
What does not work for you?	
What would you tell another mom who was having similar experiences?	
Were your feelings of anger different from any anger that you might have experienced before? If they were different, how were they different?	
Have your feelings of anger brought any positive/negative changes in your life?	
Is there anything else you think I should have asked about anger and distress that I have not covered?	

emotional distress, the first author volunteered at a local non-profit peer support organization that assists mothers and families coping with perinatal depression and anxiety. Because intrusive thoughts, suicidal ideation, and thoughts about self-harm have been found in association with intense anger and depressive symptoms, the first author engaged in a suicide prevention workshop to prepare to provide support for women who expressed thoughts about self-harm during telephone interviews. The first author developed a list of Canadian postpartum mental health resources and instructions about seeking help applicable to all interview participants. Participants received a \$25 CAD

Amazon gift-certificate as an honorarium for participation.

Rigor

Charmaz (2006) argued that the degree of theoretical sensitivity in a grounded theory study is the primary indicator of rigor; this can be evaluated through an examination of a grounded theory's credibility, originality, and resonance. In this study, as indicated by Charmaz and Thornberg (2021), credibility is fostered by having sufficient amounts of relevant data, developing a thorough analysis, and engaging in reflexivity. The study interviews

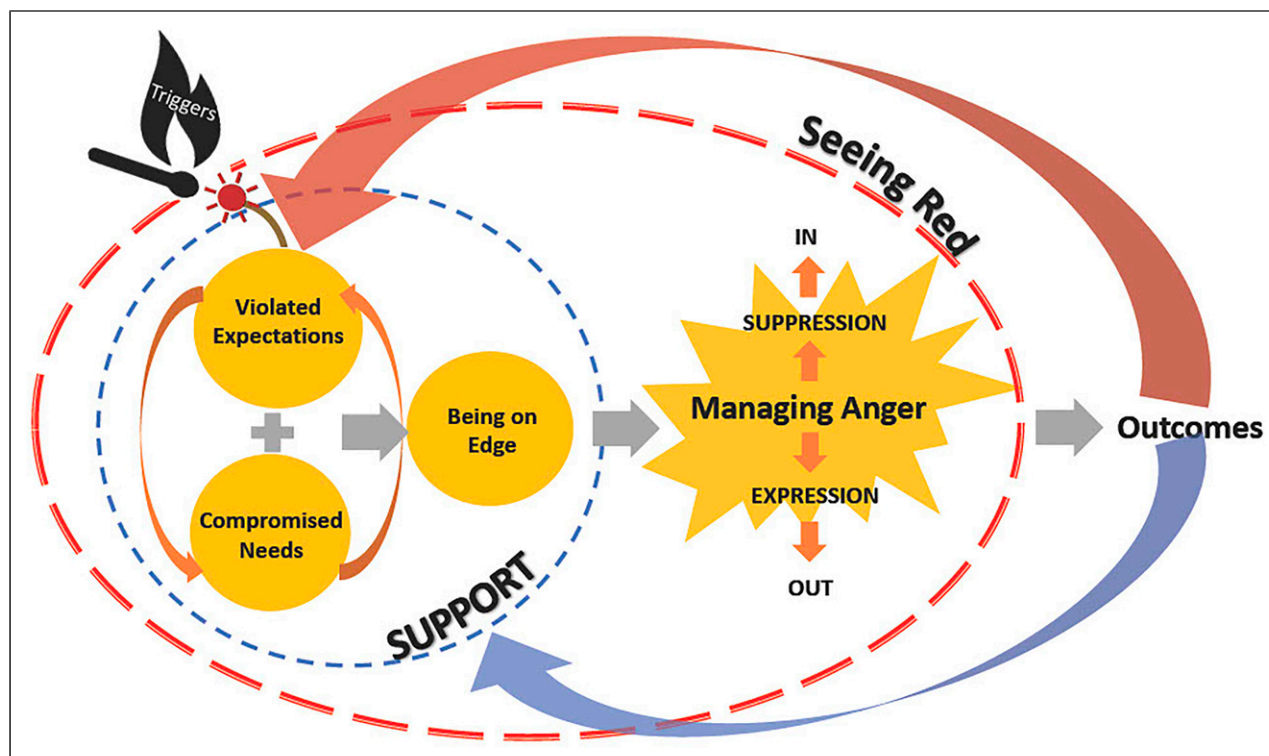


Figure 1. Seeing red: The process of becoming angry and managing anger.

Table 2. Study Sample Characteristics (n = 18).

Characteristic	Mean/N, (Range/%)
Age (years)	32.3 (25–37)
Infant age at time of interview (months)	14.3 (7–23)
Infant sex (male)	66.7%
Education	
Postgraduate degree	4 (22.2%)
University degree	11 (61.1%)
University courses	2 (11.1%)
High school	1 (5.6%)
Household income	
>CAD\$110,000	7 (38.8%)
CAD\$90,000–CAD\$110,000	5 (27.8%)
CAD\$60,000–CAD\$89,999	3 (16.7%)
CAD\$30,000–CAD\$59,999	3 (16.7%)
Number of children at home	1.7 (1–4)
Anger ^a	32.8 (25–49)
Depressive symptoms ^b	11.7 (4–20)

^aState Anger Score of 27 constitutes 90th percentile in anger (high anger).
^bEdinburgh Postnatal Depression Scale Cut-off for possible depression is >12.

enabled explication of the context, process of anger development, and effects of participants’ anger. The extensive memoing undertaken by the first author and in-depth discussions about the relationships between theoretical

categories with the co-authors also enhanced the study’s credibility. The grounded theory is also original because, to our knowledge, a theory about the development of maternal anger in the postpartum period has not been published. Finally, member-checking with a subsample of five participants revealed that participants found the theory resonated with their experiences. Participants indicated that the theory was useful because it clarified their understanding of their anger.

Results

Participant Characteristics

Telephone interviews with twenty women from across Canada were conducted between April 2019 and March 2020. Interviews varied from 50 min to 2 hours in length. Two interviews were excluded post-hoc because, during the interviews, participants indicated their infants required special medical management of health problems (exclusion criterion). The average age of participants was 32 years (See Table 2), while infants’ average age was 14 months. There were two BIPOC (Black, Indigenous, and People of Colour) participants (Indigenous and South Asian descent); the remaining participants were of European descent. All participants were partnered in different-sex relationships. The mothers’ household income varied from \$45,000 CAD

to greater than \$110,000 CAD per year. Half of the participants were first-time mothers.

Except for one mother, all of the mothers had anger scores greater than or equal to the 90th percentile ranging from 25 to 49 on the State Anger Scale, indicating that they had experiences with intense anger. The mothers recruited had differing levels of depressive symptoms. Participants' EPDS scores ranged from 4 to 20, with half of the women ($n = 9$) having scores above the cut-off for possible depression.

The Process of Seeing Red

Intense and persistent anger was described by the women as physical sensations, such as feeling "hot" and "heavy" in different parts of the body like the head or chest, or a full-bodied experience in which "blood is boiling," "shaking," and "burning," and having the feeling of built-up emotion that needed to be released. Participants indicated their anger could overtake reason, felt difficult to control and varied in intensity from intense frustration to rage and fury. *Alicia* (mother of one) recalled that:

There were many times when I would be so mad and yelling at my husband, like, this isn't me, what is wrong with me, this isn't who I am, and just so angry. And raging, definitely raging, because there was just so much anger built-up. And it's funny that we have this Incredible Hulk poster, and it says, *The Monster Unleashed*, and I literally remember seeing that a couple of times and seeing myself as this monster being unleashed, because there's so much rage inside of me, that I needed an outlet.

Several participants indicated that the depth and intensity of their anger after childbirth was greater than the anger they had experienced before having a baby.

The basic process of seeing red (becoming angry and managing anger) encompasses the three stages of (1) triggers illuminating violated expectations and compromised needs, (2) managing anger by suppressing or expressing anger, and (3) experiencing the outcomes of anger. In the postpartum period, the first stage (trigger stage) of seeing red occurred when a situation that highlighted a violation of participants' expectations occurred. Triggers were situations or behaviors from another person that were regarded as insults, rejections, or unfairness. Triggers could also constitute mothers' own behaviors and their inability to accomplish an expected goal; these occurrences compromised mothers' needs. Triggers created opportunities for anger to erupt because they served as a breaking point for the

women when they felt they could no longer tolerate their situations. Triggers exposed violated expectations which comprised a mismatch between what a woman expected to happen in a situation and what actually happened. Violated expectations resulted in compromised needs, including physical, emotional, self-esteem, and self-actualization (ability to pursue non-parenting personal activities) needs. Having violated expectations and compromised needs contributed to women feeling on edge (Figure 1). For example, a common trigger for seeing red was mothers having to manage infants who could not go back to sleep by themselves after nighttime wakes. Those situations illuminated violated expectations about maternal competence and shared parenting responsibilities when partners did not assist at night. Participants' needs to get adequate sleep were compromised and they felt on edge because of exhaustion.

In the second stage (management stage) of seeing red, anger was expressed or suppressed and could be reduced. Anger was expressed towards the self and/or to others. Mothers suppressed their anger towards others when they did not want to display anger; this was usually in an effort to protect children from their anger or because women feared damaging relationships with partners. Other times, women expressed anger to others as a bid for support. In the outcomes stage, the women experienced after-effects that were associated with their attempts to manage their anger. Expressing anger often accompanied tension and conflict with others but could also recruit support. When the women chose to suppress their anger at other adults, it was difficult to resolve their anger because they could not address the underlying cause of their anger with the person they held responsible. Expression of anger as a bid for help and support from other adults could be associated with temporary tension and conflict but also result in improved situations. Mothers linked recruiting support to reducing their violated expectations, compromised needs, and feelings of being on edge.

Triggers Illuminating Violated Expectations and Compromised Needs

The first stage of seeing red was activated by triggers, which were events that highlighted unacceptable situations that served to reveal participants' violated expectations and compromised needs. The violations and compromises contributed to the women feeling on edge. Triggers for anger could include partners' unsupportive remarks or actions. For example, *Ava* (mother of two)

was struggling to settle her infant back to sleep after a night wake when her partner asked in an exasperated tone why the baby was still crying. For *Ava*, that comment indicated her partner's lack of empathy for her struggle with soothing the baby and implied that she lacked competence as a parent. Other examples of triggers included defiance from older children, not being heard by others, and participants' inability to meet their own expectations for how they should parent. Such events compromised participants' views of standards of behavior for others (e.g., partners, family members) and themselves.

Violated Expectations

Triggers exposed violations of participants' expectations. Participants indicated that they had expectations for being able to meet their physical and emotional needs, to be competent as parents, and to receive support from others. Commonly, participants expressed expectations for their partners to engage in parenting as a shared undertaking. When partners did not measure up, participants' expectations were violated and their abilities to meet their needs (such as having enough time for rest and self-care) were compromised. After giving birth to her second child, *Shannon* (mother of two) expected her partner to step up his parenting efforts. However, because her partner was experiencing mental health problems, *Shannon* had to single-handedly manage all the childcare and household work. She explained her expectations of her partner:

I had read an off-hand comment about how second kids are often harder for dads because like they really have to step up. When the first baby comes, dads just take care of mom. But when baby number two comes, that's when dads really have to be parenting. And I found that my husband didn't adjust well. I got tired of accommodating him and I have since told him one of things I find infuriating about that situation is, I was the person who was supposed to be taken care of and I was taking care of literally everyone else. Like, I was taking care of his parents and their feelings and him and his feelings and the 2-year old and the 2-year old's feelings, and the new baby, and nobody was taking care of me. (*Shannon*)

The participant's expectations for support and help from her partner were violated, which left her with compromised needs to receive care from others as well as for time for herself to engage in non-parenting activities.

A common area of violated expectations that contributed to mothers' intense anger was interruptions to their own and their infants' sleep. Infants' constant wakes at night and difficulty settling back to sleep added to mothers' fragmented sleep and exhaustion. They served as a trigger for

participants' violated expectations and compromised needs, which increased anger for several participants. *Alicia* (mother of one) described how sleepless nights triggered her anger:

I definitely had a lot of anger around sleep. I attribute it back to the inability to control his sleep. And then getting frustrated with, why the hell won't you sleep, and what's wrong with you, what's wrong with me, because I haven't been able to fix it for him, I haven't been able to make him more comfortable or figure out what's causing the problem.

Participants' expectations of effectively managing their time with their infants and having time for themselves were also violated. *Megan* (mother of one) described how her inability to get enough sleep undermined her expectations of being a competent mother and having time for herself. *Megan* explained,

It felt like I wasn't able to enjoy any of my time as a new mother. I put a lot of pressure on myself to think I could continue to travel and work and do all these things as a new mother...It definitely affected my confidence in myself as a mother, and this ideal I had in my mind to just be always present and loving and gentle sort of state.

Dawn (mother of one) articulated the disconnect between "knowing" the demands of having a baby prior to the baby's arrival and what it was actually like. The discrepancy violated her expectations about being a competent parent because she attributed the difference to her inability to "handle" what was happening. Having violated expectations was part of the fuel for participants' intense anger because they increased the risks for compromised needs, which were associated with feelings of being on edge (stress, exhaustion, anxiety, resentment, and despair).

The role of support for mitigating violated expectations. Participants described how having consistent support reduced the violation of their expectations. *Margaret* (mother of two) provided a clear example of how support enhanced her ability to keep anger at bay. When meeting the demands of care for her baby, she had struggled with not losing her temper with her older child, who was going through a prolonged phase of having tantrums. Family support allowed her the rest she needed which enhanced her capacity to parent the way she wanted—in a calm and understanding manner. *Margaret* explained:

Yesterday she [older child] had been away for the weekend with her grandparents and she came home and I was trying to make dinner, and they're both in a stage where they're both

jealous for my attention and fighting over my attention now. Because we had been without her all weekend, when she was having a tantrum last night, on the ground screaming and thrashing and I was trying to make dinner, I had a lot more patience for her and a lot more understanding that she'd been without us and this was her reaction, than I would have if I'd had a whole weekend of her having tantrums. I didn't have those big rage feelings at all – it was very annoying, but I had more understanding.

Conversely, the women who described losing community or family support (e.g., after moving to a new place), linked their recurring anger to their expectations not being met. *Kelly* (mother of two) described her family as intensely supportive, which helped her meet her expectations for parenting competence during the challenging early days of mothering her first baby. However, her mother was less available to help her with her second baby because of family circumstances. That absence of support increased episodes of anger at herself and her partner. Having family support helped women to meet their needs for sleep and rest. When support was not available, mothers' abilities to meet their own needs were frequently compromised.

Compromised Needs

Violated expectations were associated with participants' compromised needs, which enhanced feelings of being on edge (e.g., feeling exhausted or being in despair); all of those conditions provided fuel for women's intense anger. The participants described compromised needs for adequate sleep and nutrition, feeling connected to and cared for by others, feeling confident as a mother, and self-actualization through time for meaningful non-parenting activities. A few participants explained that, because they did not have the time or energy to eat properly, they were less able to cope with the stresses of parenting. Mothers indicated that their need for adequate sleep was their most consistently compromised physical need that increased feelings of being on edge and intense anger. Many participants indicated they experienced multiple infant night wakes, which interrupted their sleep. *Ava* (mother of two) related:

There would be times where I would be in tears. Maybe feeling sorry for myself. Like, why do I have to be up taking care of this baby, having to breastfeed the baby? Just wanting my needs met, and they're not being met, like night after night. I'm not getting sleep...During the day then I wouldn't cry, normally. That's when I would get angry and want to yell. But at night then it would be no, I'm angry and I'm going to cry.

Mothers had expected to become competent at parenting; their distress about sleep was associated with compromised needs for feeling confident as a mother.

Participants often described compromised needs for connection, love, and care from others. Some mothers spoke of wanting to be "mothered" by their partners and mothers after childbirth. Unfortunately, participants' mothers were not always available, and partners sometimes lacked the skill or inclination to show the care that the women desired. Some women had mothers who provided practical help, such as bringing food and child minding, but lacked the ability to provide the emotional connection and care the women wanted. Participants also spoke of missing emotional intimacy with their partners, exacerbated by lack of quality time together.

Finally, participants indicated challenges to meeting their needs for self-actualization. They often regarded returning to work and engaging in non-parenting activities as contributing to meeting their needs for self-actualization. *Maya* (mother of one) indicated that her baby had just begun attending daycare at the time of her interview and described a sense of revitalization from performing a work role wherein she felt competent and confident. Engaging in work provided normalcy after the baby's birth; *Alicia* related:

People think I'm crazy because I took a teaching job, despite the lack of sleep. It was probably the best thing for me; I felt I found me again, post-baby. I got to teach without him – I spent a full day away from him, and it was really good. It was really good to have that time apart, and the sense that I was contributing to society again and doing what I love. And that was probably, although it doesn't really sound like, self-care. Working was a really great blessing.

Similar experiences described by other participants spoke to the women's needs to engage in activities beyond their motherhood role and how easily that need was compromised, given the consuming nature of infant care.

The role of support for mitigating compromised needs. Many participants indicated that support from partners, demonstrated through partners' active care of infants, was critical for the them to meet their needs for rest. Participants who had infants with serious sleep problems explained that their sleep deficits were reduced by partners who would take the "morning shift" with the baby before they went to work. Partners' engagement in childcare allowed those women to get some uninterrupted sleep before starting their day. *Colleen's* (mother of two) partner took turns sleeping with the baby so that she could have some nights when she could sleep undisturbed. Some partners and family members provided breaks so that participants could meet their compromised needs for self-

care. For example, *Meadow's* (mother of one) mother would spend time with the baby once a week so that she could shower or go for a massage. *Margaret's* (mother of two) parents and in-laws regularly babysat the children, allowing her to have time for herself and time to spend with her partner thus nurturing emotional connection. Even in situations in which participants had been triggered to anger, they could benefit from the experience if the person(s) who angered them realized that the participants needed their support and offered it. Support helped mothers meet compromised needs through buffering their feelings of anger. *Serenity* (mother of one) who described having a terrifying intrusive dream after serious sleep deprivation and awaking screaming saw her partner increase his efforts with infant care. Some participants emphasized the helpfulness of partners reading their cues (sensing that women were on edge) and intervening to help with the baby.

Being on Edge

Participants indicated that their violated expectations and compromised needs were associated with distressing emotions—the most prominent were stress, anxiety, exhaustion, despair, and resentment. Participants' descriptions of their daily lives emphasized their stress. For example, *Elisabeth* (mother of four) described her challenges with trying to meet all her children's needs:

In the morning it would be super chaotic trying to get everybody ready, lunches ready, and making sure they have all their things to get out the door on time. The baby is suddenly crying because she's hungry and just woke up and needs to be fed or she had a diaper blowout and so you're trying to deal with cleaning up and getting the kids ready and then getting myself ready and out the door all at the same time. Sometimes that would be just throwing the baby in the car seat and trying to get out the door and she's screaming and it's challenging trying to manage all the different age groups at the time and then having a child who doesn't want to get dressed or something like that. There's always multiple things going on because everybody has all these needs and I'm only one person trying to field all these different needs.

In addition to feeling stressed, many participants described anxiety as a component of being on edge. Participants' concerns about failing to provide the best care for their infants exacerbated their violated expectations of themselves as competent mothers and compromised their need for confidence, resulting in worry, anxious thoughts, and fear. *Serenity* (mother of one) related the experience of waking up and panicking about the baby being smothered under the sheets, only

to find the baby asleep in the crib at the foot of the bed. *Shannon* (mother of two) described how her anxious thoughts put a very negative wash on her day, making her more likely to react in anger to triggering events. Some mothers identified their anxiety as most pronounced at night time (e.g., expecting to be woken by their infants during the night), which interfered with their ability to fall asleep, which contributed to feelings of exhaustion during the day.

Despair was another component of being on edge. Participants explained that despair included grief, disappointment, and feeling trapped. It made participants feel raw and less able to regulate their emotions, which enhanced anger for some mothers. For example, *Kelly* (mother of two) expressed her despair about not being able to take pleasure or feel happy during a Christmas gathering with her family despite expecting that she would enjoy being with her family.

Resentment was another major element of being on edge. Many participants described feelings of resentment towards their partners for the freedoms that they enjoyed. *Kelly* (mother of two) linked her feelings of resentment toward her partner to him not understanding her needs for time alone when he was at home:

I get to shower twice a week. My husband has a shower every single day. I do not get to have a shower ever peacefully. He's supposed to have the kids so I can shower without being interrupted and it's not two minutes before both my children are sitting on the bathroom floor screaming at me or throwing things in the tub and he's out sitting on the couch on his phone... Or if I lock the bathroom door they literally stand at the bathroom door and pound on the bathroom door while I'm trying to take a shower. It's very frustrating. Like, why don't I get to have a shower in peace?

Participants indicated that experiencing stress, despair, anxiety, or resentment, and, sometimes a combination of these emotions, increased their anger. For example, *Alicia* (mother of one) described knowing that she was sleep deprived and exhausted when she would lash out at her partner unfairly for small things like leaving his clothes on the floor. *Nicole* (mother of two) explained that she would lie in bed at night anxious about being able to fall asleep and then grow angry at herself for not being able to sleep.

The role of support for mitigating feelings of being on edge. Feelings of being on edge could be reduced by support from others. Some participants recollected health care providers who recognized their challenges and connected them to resources, such as therapy, and provided regular check-ins. Their efforts helped the women

reduce violated expectations, meet their compromised needs, and ameliorate feelings of being on edge. Conversely, feelings of being on edge could be exacerbated when support was lacking or inappropriate. For example, *Alicia's* (mother of one) family doctor refused to address her baby's discomfort at nighttime and pressured her to sleep train as a solution to his nighttime crying, increasing her stress. *Serenity* (mother of one) indicated that, when her baby was not gaining weight adequately, she confided her emotional struggles to her family doctor but was brushed off, leaving her to cry in the car. Lack of appropriate support exacerbated the women's anger because their expectations for support and care were violated. When participants became angry, they attempted to manage their intense anger.

Managing Anger

The third stage of seeing red involved managing anger through the expression or suppression of intense anger. Mothers indicated that the way they managed their anger depended on how they directed their anger. Participants could direct anger outwards towards the person(s) they held responsible for triggering their anger. They could also direct anger inwards at themselves. They could also express anger in both directions. Frequently, participants directed their anger outwardly towards partners and children (e.g., misbehaving older children or infants who would not sleep). Anger directed at self was expressed through participants being hard on themselves for their perceived failures. When women were angry at themselves, their feelings of being on edge were intensified and longer lasting. Participants who were able to forgive themselves for being angry or who saw anger as a purposeful tool experienced less intense anger. Participants who described being unable to come to terms with their anger at themselves would ruminate on their anger, relive their anger, and increase their perceptions of inadequacy. In the worst situations, a few mothers talked about having thoughts about self-harm and even suicide when they were very angry at themselves. Those mothers were supported by the first author who provided a list of resources relevant to their area of residence and instructions on how they could seek assistance.

Angry participants, who directed anger outwardly, yelled, screamed, or swore. They described stomping, slamming doors; and on a few occasions, breaking or throwing things. Some women punched or screamed into pillows by themselves. Several women indicated that expressing their intense anger helped them alleviate the lack of control that they felt over their circumstances. Many participants spoke of crying in anger. They snapped at the person to whom their anger was directed. Participants could engage in heated arguments

with partners and sometimes children. Mothers sent children to time out for misbehavior that made them angry. They would also engage in angry cleaning around the house.

Conversely, some participants chose to suppress their anger because they were reluctant to demonstrate it to others. When participants directed anger inwardly, they described clenching their fists and gritting their teeth. *Elisabeth* (mother of four) talked about "stewing" about situations that angered her. When *Dawn* (mother of one) was asked about how she expressed her frustration or anger, she replied:

I internalize things. That's the kind of person I am. There has been a couple of times when I've sent a couple of text messages to my husband that are shorter than I intend because I'm frustrated but, no, typically I don't express it. I don't want it to come out to other people and it's important to me not to let it come out to my baby, so I work really hard to make sure that's not happening because that's important to my parenting philosophy.

That mother attributed her anger suppression to her personality and fears about jeopardizing her relationship with her partner because she had seen the consequences of expressed anger and conflict on other relationships. Several other participants also suppressed their anger and resentment towards their partners because they feared compromising their relationships. *Serenity* (mother of one) described suppressing the anger she had towards her partner while he was entertaining friends in the living room and drinking, with her trapped in the bedroom with the baby, despite wanting to express anger. She linked suppressing her anger to fear of upsetting others:

It's anger at first and then I would get sad. I don't want to show that I'm mad... I think I'm too scared to make other people upset and so I don't. Like my fear of making people upset is more than me wanting to tell people. I feel like I don't really know how to control my anger or how to get rid of it or lower it down. I don't lash out at anybody but in my head it's like very overwhelming, sometimes when I get mad.

When participants managed their anger by suppressing it, they further compromised their needs and exacerbated their feelings of being on edge by choosing not to alert others to their distress. When *Dawn* (mother of one) was asked if there were negative outcomes from internalizing her anger, she replied:

There could be support available or help if I needed it and it's not being made available because I'm not letting people know what I need. I try to make it seem like everything's fine

and I don't need anything. I'm sure if I could let people know more that I need something, it might be made available to me.

Participants emphasized their extensive efforts to avoid expressing anger to their children. *Margaret* (mother of two) talked about walking away temporarily even if moments later the children would follow her. Participants often distracted themselves if they could not physically remove themselves. *Dawn* (mother of one) managed her mounting frustrations with her baby when he was having an unsettled day by taking him out for walks in the stroller to get a break. A few mothers engaged in deep breathing to reduce their anger. When they could not get away from the children, participants described turning on a show or movie for their children and listening to music or podcasts using earphones to reduce their anger. *Kelly* (mother of two) shared her strategy:

I try to really calm myself especially when it comes to my kids. I try really hard not to have an immediate reaction because usually they have something that they need. So, if they're really on top of me I try to take like really deep breaths and I try to stop what I'm doing and I get down on their level and try to understand what they need.

Other participants managed their anger by purposefully reframing the situation, taking on their children's perspectives about situations, or using humor. Finally, some participants simply accepted their feelings of anger and told themselves "this too shall pass."

The role of support for managing anger. Support was crucial for helping mothers reduce their anger. When partners could sense that mothers were distressed, they took over the care of the baby or children to provide mothers space to calm down. *Colleen* (mother of two) engaged in venting to a friend and meeting her physical needs to come down from her anger. She shared:

I got myself an A&W burger with a friend and we ended up having a coffee party, and it was just really pleasant and it went from like I almost cried and I actually did lose my temper at somebody that morning, to like, okay, I can now handle the rest of the day.

Supportive people helped reduce participants' feelings of being on edge and enabled them to meet their compromised needs, thereby reducing their anger. Even without immediate family support, the mothers indicated that it was possible to get a mental break and emotional support from other parents/friends through attending community programs that facilitated parent-child gatherings. A few mothers also sought counseling as a

sustainable way of managing their anger at themselves and resentment towards their partners.

Outcomes of Anger

The final stage of seeing red for participants was experiencing the outcomes of their ways of managing their anger. Participants' expression or suppression of their anger affected their expectations, needs, feelings of being on edge, and ability to recruit support. Expressing anger towards others could be associated with short-term negative outcomes.

Mothers reported that their children were surprised at, upset by, or frightened by their anger. This made mothers feel sad because they realized that their expression of anger violated their expectations of parenting competence and compromised their need to feel confident as a parent. Participants described experiencing guilt and shame after expressing their anger to their children. *Shannon* (mother of two) shared her disappointment with herself after being angry:

I had like a little rage cry while they were both in the tub... and was getting more frustrated because they were crying, and like overwhelmed. And I kept trying to take deep breaths and get a handle on this and I just couldn't. And that feeling of being out of control at that point was very aggravating...I am a grown up. I am not acting like a grown up, but I am a grown up. Why is this happening to me?

Participants reported feeling inadequate when their anger violated their expectations of the competent mother they wanted to be (e.g., calm, patient, gentle).

Anger expressed at partners could also be associated with immediate negative results. For example, participants talked about how their expression of anger could trigger their partner's anger, resulting in conflicts that became heated. *Sara* (mother of one) recalled:

We've had a couple actually like really just knockdown, drag them out fights just screaming at each other and yeah, being very unkind, slamming doors, throwing things. Rage would be a good way to refer to it for sure and I feel like mine just ends up escalating his.

On the other hand, participants indicated that their expression of anger could act as a catalyst for change. Mothers who purposefully expressed their anger regarded their anger displays as ways of signaling their need for support. In the short term, mothers' anger could help partners and others to become aware of their compromised needs and to offer help and support. Partners who responded positively to participants' bids for support created opportunities for mothers to

reduce their anger. In some instances, anger was a communication tool that mothers used as a last resort. *Frances* (mother of two) recalled saying to her partner: “It’s unfortunate that the only way that I can actually get you to hear me and, you know, respond, is to lose my cool in a very serious way, but unfortunately that is what you respond to.” A longer-term benefit of expressing anger to partners was participants moving beyond their anger to put conscious effort into mending and strengthening their relationships. For example, *Colleen* (mother of two) articulated that her anger experiences actually served to push her and her partner to cultivate “compassion and graciousness” towards one another as a strategy to allow them to reframe their anger.

Expressing anger also helped the women reaffirm their expectations, prioritize their needs, and look after themselves, which could prevent and mitigate their feelings of being on edge contributing to anger. Participants channeled their anger to solicit help from others and create boundaries. *Kelly* (mother of two) related:

I’m way more demanding about what I need to be happy. I’m not trying to be bossy or be mean. But if I’m going to the gym, it would be let’s clean the kitchen before you go... And then I would never end up going. And now I’m like no. I’ve decided I’m doing this. My alarm’s gone off. I’m going right now. Don’t care. You figure it out. So just being more demanding about what I need to feel good as a human.

Shannon (mother of two) shared that she splurged on a YMCA membership for the childminding so that she could have some time to herself. *Sara* (mother of one) explained that she could channel her anger to articulate and stand up for her needs with her partner. Participants invited partners to step up to the plate and many times they did. For example, *Colleen’s* (mother of two) partner started taking turns with providing night time care for their baby after he was weaned. Other partners would take the morning shift with the baby so that mothers could make up some of their sleep deficit.

When participants were unable to recruit support after they expressed their anger or because they suppressed their anger and did not make their needs known, some reduced their expectations and made attempts to accept that their needs would be compromised. Women described consciously choosing to let go of expectations they thought were not useful. For some women, that approach did not work because they could not accept that support was not forthcoming. Realizing that their bids for support were ignored fanned their anger. For example, *Liz* (mother of two) had regular conflicts with her parents and partner about trying to meet her sleep needs by sleep training her baby despite efforts to use her anger to recruit

their support. Women also spoke about being kinder to themselves and celebrating wins, such as keeping their children alive and fed.

Discussion

To our knowledge, this is the first interpretive theory explaining the development and management of maternal anger after childbearing. The process of “seeing red” during the postpartum period includes the stages of (1) triggers illuminating violated expectations, compromised needs, and being on edge, (2) managing anger, and (3) experiencing anger outcomes. Triggers served to reveal inequitable or undesirable situations, which highlighted women’s violated expectations and compromised needs, and feelings of being on edge, in the absence of support. Feeling on edge entailed perceptions of stress, anxiety, exhaustion, despair, and/or resentment, emotions which enhanced anger. Participants indicated that receiving desired social support was consistently associated with the prevention and reduction of intense anger. Lack of, or inappropriate support, fanned the flames of women’s anger. In the management stage of seeing red, mothers suppressed or expressed their anger and engaged in strategies to reduce anger. They varied in their ability and willingness to express anger. Many times, mothers indicated that they were also angry at themselves for their own shortcomings as a parent. [Del Vecchio et al.’s \(2017\)](#) work supports the study findings because they reported that lower self-perceived parenting competence was associated with greater parenting anger. The outcomes of anger indicated effects of participants’ anger expression or suppression. Support from others following expression of anger reduced and/or resolved participants’ anger. This finding supports the anger recalibration theory wherein anger expressed at others is used as a tool to achieve better treatment from others; anger captures the attention of the other party and facilitates communication through rapid information exchange ([Sell, 2011](#); [Sell et al., 2017](#)). Because participants’ expression or suppression of anger affected their expectations, needs, feelings of being on edge, and ability to recruit support, those who suppressed their anger and did not make their expectations and needs known to others continued to experience violated expectations and compromised needs. They remained on edge and prone to intense anger. With regards to emotion expression and suppression, a meta-analysis of 43 studies demonstrated that emotional suppression of positive and negative emotions (including anger) was associated with worse social and interpersonal outcomes ([Chervonsky & Hunt, 2017](#)). Young women in romantic relationships who were able to express their anger directly also endorsed sharing responsibility for their anger and being in more egalitarian relationships as compared to young women

who did not express their anger to their partners (Jaramillo-Sierra et al., 2017). In a sample of 325 mothers with young children, Korean investigators found that anger suppression was associated with lower life satisfaction for mothers compared with mothers who made proactive efforts to address anger (Chung & Kim, 2017). Taken together, these findings suggest that the ability to express anger constructively is important for interpersonal wellbeing.

This interpretive theory presents central components of intense anger in the postpartum period in the relationships between violations of expectations, compromised needs, and feelings of being on edge. Discrepancies between women's preconceived notions of how life would be after having a baby and what followed created violated expectations, which took many forms. Staneva and Wittkowski (2013) identified primiparous mothers' difficulties with reconciling romanticized notions of motherhood and infant care, even when recognizing their notions as unrealistic. Our study extended their findings by demonstrating that multiparous mothers were not immune from such expectations. Although violated expectations have been linked with maternal depressive symptoms (Harwood et al., 2007; Lazarus & Rossouw, 2015; Rizzo & Watsford, 2020), our study linked violated expectations to women's anger. That finding fits with an integrative review identifying anger as a mismatch between reality and expectations after childbirth (Ou & Hall, 2018). Although participants expected parenting to be shared with their partners, the mothers indicated that parenting was mostly their responsibility. Notwithstanding modern expectations for equity and fairness in the division of parenting labor (Douglas & Michaels, 2004; Dow, 2016; Henderson et al., 2010), our findings suggest that parenting remains a highly gendered role. The participants' struggles speak to the need to encourage partners to engage in more childcare.

Violated expectations about having personal time (including for sleep), emotional connection, support, and self-actualization exacerbated compromised needs and feeling on edge. Failure to meet maternal needs for support resulted in anger. Participants either altered their expectations or risked continuing anger. We contend that women's affective responses (e.g., anger or sadness) to compromised needs are a bid for others to offer support to meet their needs. Edward Hagen (1999), an anthropologist who examined postpartum depression as a support and resource deficit model, argued that postpartum depression is a functional and evolutionary adaptation that assists mothers to gain resources and social support to meet their needs. His hypothesis fits with a relational autonomy perspective because child rearing involves considerable time, energy, and resources from mothers who require supportive relational and

structural contexts. Hagen (1999) indicated that, when significant others witness mothers' depressed mood and reduced infant engagement, they increase their provision of support. Mothers' displays of anger in this study served the purpose of calling attention to their distress over violated expectations and compromised needs. Anger can help women assert themselves, in the context of their relationships, to preserve personal and relational autonomy. Averill (1983) identified anger expressed in close relationships as increasing respect from the anger recipient for the person expressing anger. A display of anger could serve as an important component of women's ability to negotiate more help and support from their partners and others; however, in our study, this strategy was not always successful for negotiating support depending on how it was received by the other party.

Participants in this study reported being on edge with an array of feelings that preceded anger (e.g., stress, resentment, despair). This finding is supported by more general studies that have linked anger with stress (Martin & Dahlen, 2005), hopelessness and sadness (DiGiuseppe & Tafate, 2007; Ellsworth & Tong, 2006), anxiety (Hawkins & Cougler, 2011; Minkel et al., 2012), exhaustion (Minkel et al., 2012), and resentment (Miceli & Castelfranchi, 2019). Prikhidko and Swank (2019) indicated that maternal stress reduces mothers' ability to engage in emotion regulation strategies and can lead to maternal anger. The grounded theory, "Seeing Red," not only extends understanding of the effects of anger in the postpartum period but also fits with findings from other studies of women in the postnatal period. Koukopoulos et al. (2020) argued for the recognition of mixed negative affective states in the postpartum period, inclusive of anger, anxiety, depression, and emotional lability. Kettunen et al. (2014) found that postpartum depression was a non-homogenous disorder because women could experience concurrent anxiety, hostility, and somatic symptoms. Williamson et al. (2015) found that irritability (defined as increased anger and ill-temper) had strong and significant factor loadings with depression in the postpartum period. The findings of this study and others suggest that postpartum anger is frequently accompanied by other mood disturbances.

Clinical Implications

Our study findings suggest that intense anger is a relevant mood disturbance in the postpartum period and that maternal and infant sleep challenges significantly contribute to women's anger after childbirth. More than half of participants related their intense anger and distress to infants' sleep problems and their own sleep problems. These findings underline the importance of assessing

women for the presence of intense anger and sleep problems in the first postpartum year and the need to provide evidence-based strategies to improve mental health and parent-infant sleep. All participants spoke about how inadequate or inappropriate social and structural supports contributed to their anger and distress. Those findings emphasize the need to systemically examine the deficiencies and gaps in the current postpartum support provided by health care structures, clinicians, and community organizations across Canada. A relational view of autonomy suggests that availability of social (e.g., partners, family, friends) and structural supports (e.g., clinicians, parental leave policies that promote partner involvement), and community programs (e.g., parenting support groups to enhance parenting efficacy) are necessary to meet infants' and mothers' needs. Capacity building through policy changes that can increase family members', clinicians', and community supports are necessary for managing maternal sleep and mental health problems in the context of childbearing and childrearing.

Strengths & Limitations

Rigor demonstrated through the processes of interviewing, analyzing, and theoretical sampling is a strength of this study. The use of telephone interviews facilitated participation of women from across Canada. Our study also has limitations. The sample was predominantly white, well-educated, and of higher socioeconomic status with limited representation from BIPOC women and no representation from women who were not partnered. Representation of BIPOC voices is critical to promoting inclusion, recognizing that non-perspectives are often marginalized (Watson-Singleton et al., 2021). The findings are not transferable to mothers in general. Finally, causal claims cannot be made with this interpretive theory.

Conclusion

For the women who experienced anger in the first two postpartum years, persistent and intense anger occurred as a multifaceted phenomenon and process. The daily struggles of parenting, without adequate support, triggered women's violated expectations, compromised needs, and feelings of being on edge. Women's ability to reduce and/or resolve their anger was affected by the way that they managed their anger and the presence or absence of appropriate social and structural supports. Outcomes of women's expression of anger could include more hostile and negative relationships with partners and kin or enhanced support that reduced violated expectations, compromised needs, feelings of being on edge, and ultimately anger. It is important to assess maternal anger and

sleep and infant sleep problems after childbirth and to identify ways to support mothers to meet their needs for autonomy, sleep, and emotional connection to reduce their anger.

Acknowledgements

We are grateful to the participants who shared their experiences of anger and emotional distress with us.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This study was funded by a UBC School of Nursing Sheena Davidson Internal Research Grant and a UBC 4-Year Fellowship.

Data Availability

Data can be made available from the corresponding author upon request for non-commercial purposes.

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References

- Averill, J. R. (1983). Studies on anger and aggression: Implications for theories of emotion. *American Psychologist*, 38(11), 1145–1160. <https://doi.org/10.1037/0003-066x.38.11.1145>
- Beck, C. T. (2002). Postpartum depression: A metasynthesis. *Qualitative Health Research*, 12(4), 453–472. <https://doi.org/10.1177/104973202129120016>
- Beck, C. T. (2022). Teetering on the edge: A third grounded theory modification of postpartum depression. *Advances in Nursing Science*, 10-1097. <https://doi.org/10.1097/ans.0000000000000432>
- Beck, C. T., & Indman, P. (2005). The many faces of postpartum depression. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 34(5), 569–576. <https://doi.org/10.1177/0884217505279995>
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. sage.
- Charmaz, K., & Thornberg, R. (2021). The pursuit of quality in grounded theory. *Qualitative Research in Psychology*, 18(3), 305–327. <https://doi.org/10.1080/14780887.2020.1780357>
- Chervonsky, E., & Hunt, C. (2017). Suppression and expression of emotion in social and interpersonal outcomes: A meta-

- analysis. *Emotion*, 17(4), 669–683. <https://doi.org/10.1037/emo0000270>
- Chung, K.-S., & Kim, M. (2017). Anger factors impacting on life satisfaction of mothers with young children in Korea: Does mother's age matter? *Personality and Individual Differences*, 104, 190–194. <https://doi.org/10.1016/j.paid.2016.08.010>
- Del Vecchio, T., Jablonka, O., DiGiuseppe, R., Notti, J., & David, O. (2017). Psychometric evaluation of the parent anger scale. *Journal of Child and Family Studies*, 26(11), 3013–3025. <https://doi.org/10.1007/s10826-017-0824-3>
- DiGiuseppe, R., & Tafrate, R. C. (2007). *Understanding anger disorders*. Oxford University Press.
- Douglas, S. J., & Michaels, M. W. (2004). *The mommy myth: The idealization of motherhood and how it has undermined women*. New York: Free Press.
- Dow, D. M. (2016). Integrated motherhood: Beyond hegemonic ideologies of motherhood. *Journal of Marriage and Family*, 78(1), 180–196.
- Ellsworth, P. C., & Tong, E. M. (2006). What does it mean to be angry at yourself? Categories, appraisals, and the problem of language. *Emotion*, 6(4), 572–586. <https://doi.org/10.1037/1528-3542.6.4.572>
- Goering, S. (2017). Mothers and others: Relational autonomy in parenting. In *The oxford handbook of reproductive ethics*. Oxford University Press.
- Hagen, E. H. (1999). The functions of postpartum depression. *Evolution and Human Behavior*, 20(5), 325–359. [https://doi.org/10.1016/S1090-5138\(99\)00016-1](https://doi.org/10.1016/S1090-5138(99)00016-1)
- Harwood, K., McLean, N., & Durkin, K. (2007). First-time mothers' expectations of parenthood: What happens when optimistic expectations are not matched by later experiences? *Developmental Psychology*, 43(1), 1–12. <https://doi.org/10.1037/0012-1649.43.1.1>
- Hawkins, K. A., & Cougle, J. R. (2011). Anger problems across the anxiety disorders: Findings from a population-based study. *Depression and Anxiety*, 28(2), 145–152. <https://doi.org/10.1002/da.20764>
- Henderson, J. M. T., France, K. G., Owens, J. L., & Blampied, N. M. (2010). Sleeping through the night: The consolidation of self-regulated sleep across the first year of life. *Pediatrics*, 126(5), e1081–e1087. DOI:10.1542/peds.2010-0976
- Hight, N., Stevenson, A. L., Purtell, C., & Coe, S. (2014). Qualitative insights into women's personal experiences of perinatal depression and anxiety. *Women and Birth*, 27(3), 179–184. <https://doi.org/10.1016/j.wombi.2014.05.003>
- Hirani, & Olson, J. (2016). Concept Analysis of Maternal Autonomy in the Context of Breastfeeding. *Journal of Nursing Scholarship*, 48(3), 276–284. <https://doi.org/10.1111/jnu.12211>
- Holopainen, A., & Hakulinen, T. (2019). New parents' experiences of postpartum depression: A systematic review of qualitative evidence. *JBI Evidence Synthesis*, 17(9), 1731–1769. <https://doi.org/10.11124/jbisrir-2012-266>
- Howard, L. M., & Khalifeh, H. (2020). Perinatal mental health: A review of progress and challenges. *World Psychiatry*, 19(3), 313–327. <https://doi.org/10.1002/wps.20769>
- Jaramillo-Sierra, A. L., Allen, K. R., & Kaestle, C. E. (2017). Young women's anger in romantic relationships: Gendered rules and power. *Journal of Family Issues*, 38(13), 1825–1851. <https://doi.org/10.1177/0192513x15592029>
- Johansson, M., Benderix, Y., & Svensson, I. (2020). Mothers' and fathers' lived experiences of postpartum depression and parental stress after childbirth: A qualitative study. *International Journal of Qualitative Studies on Health and Well-Being*, 15(1), 1722564. <https://doi.org/10.1080/17482631.2020.1722564>
- Kathree, T., Selohilwe, O. M., Bhana, A., & Petersen, I. (2014). Perceptions of postnatal depression and health care needs in a South African sample: The “mental” in maternal health care. *BMC Women's Health*, 14(1), 1–11. <https://doi.org/10.1186/s12905-014-0140-7>
- Kettunen, P., Koistinen, E., & Hintikka, J. (2014). Is postpartum depression a homogenous disorder: Time of onset, severity, symptoms and hopelessness in relation to the course of depression. *BMC Pregnancy and Childbirth*, 14(1), 402. DOI:10.1186/PREACCEPT-1301881224127235
- Klein, M. H., Hyde, J. S., Essex, M. J., & Clark, R. (1998). Maternity leave, role quality, work involvement, and mental health one year after delivery. *Psychology of Women Quarterly*, 22(2), 239–266. <https://doi.org/10.1111/j.1471-6402.1998.tb00153.x>
- Koukopoulos, A. E., Angeletti, G., Sani, G., Janiri, D., Manfredi, G., Kotzalidis, G. D., & De Chiara, L. (2020). Perinatal Mixed Affective State: Wherefore Art Thou? *Psychiatric Clinics*, 43(1), 113–126.
- Lazarus, K., & Rossouw, P. J. (2015). Mother's expectations of parenthood: The impact of prenatal expectations on self-esteem, depression, anxiety, and stress post birth. *International Journal of Neuropsychotherapy*, 3(2), 102–123. <https://doi.org/10.12744/ijnpt.2015.0102-0123>
- Mackenzie, C., & Stoljar, N. (2000). *Relational autonomy: Feminist perspectives on autonomy, agency, and the social self*. New York: Oxford University Press.
- Martin, R. C., & Dahlen, E. R. (2005). Cognitive emotion regulation in the prediction of depression, anxiety, stress, and anger. *Personality and Individual Differences*, 39(7), 1249–1260. <https://doi.org/10.1016/j.paid.2005.06.004>
- Mauthner, N. S. (1999). Feeling low and feeling really bad about feeling low”: Women's experiences of motherhood and postpartum depression. *Canadian Psychology/Psychologie Canadienne*, 40(2), 143–161. <https://doi.org/10.1037/h0086833>
- Miceli, M., & Castelfranchi, C. (2019). Anger and its cousins. *Emotion Review*, 11(1), 13–26. <https://doi.org/10.1177/1754073917714870>
- Minkel, J. D., Banks, S., Htaik, O., Moreta, M. C., Jones, C. W., McGlinchey, E. L., Simpson, N. S., & Dinges, D. F. (2012). Sleep deprivation and stressors: Evidence for elevated negative affect in response to mild stressors when sleep

- deprived. *Emotion*, 12(5), 1015–1020. <https://doi.org/10.1037/a0026871>
- Ou, C. H., & Hall, W. A. (2018). Anger in the context of postnatal depression: An integrative review. *Birth*, 45(4), 336–346. <https://doi.org/10.1111/birt.12356>
- Ou, C. H., Hall, W. A., Rodney, P., & Stremler, R. (2022). Correlates of Canadian mothers' anger during the postpartum period: A cross-sectional survey. *BMC Pregnancy and Childbirth*, 22(1), 1–12. <https://doi.org/10.1186/s12884-022-04479-4>
- Prikhidko, A., & Swank, J. M. (2019). Examining parent anger and emotion regulation in the context of intensive parenting. *The Family Journal*, 27(4), 366–372. <https://doi.org/10.1177/1066480719855371>
- Rizzo, I., & Watsford, C. (2020). The relationship between disconfirmed expectations of motherhood, depression, and mother–infant attachment in the postnatal period. *Australian Psychologist*, 55(6), 686–699. <https://doi.org/10.1111/ap.12472>
- Schmied, V., Beake, S., Sheehan, A., McCourt, C., & Dykes, F. (2011). Women's perceptions and experiences of breastfeeding support: A metasynthesis. *Birth: Issues in Perinatal Care*, 38(1), 49–60. APA PsycInfo <https://doi.org/10.1111/j.1523-536X.2010.00446.x>
- Sell, A., Sznycer, D., Al-Shawaf, L., Lim, J., Krauss, A., Feldman, A., Rascanu, R., Sugiyama, L., Cosmides, L., & Tooby, J. (2017). The grammar of anger: Mapping the computational architecture of a recalibrational emotion. *Cognition*, 168, 110–128. <https://doi.org/10.1016/j.cognition.2017.06.002>
- Sell, A. N. (2011). The recalibrational theory and violent anger. *Aggression and Violent Behavior*, 16(5), 381–389. <https://doi.org/10.1016/j.avb.2011.04.013>
- Simon, R. W., & Lively, K. (2010). Sex, anger and depression. *Social Forces*, 88(4), 1543–1568. <https://doi.org/10.1353/sof.2010.0031>
- Spielberger, C. (1999). *Manual for the state-trait anger expression inventory–2*. Psychological Assessment Resources.
- Staneva, A., & Wittkowski, A. (2013). Exploring beliefs and expectations about motherhood in Bulgarian mothers: A qualitative study. *Midwifery*, 29(3), 260–267. <https://doi.org/10.1016/j.midw.2012.01.008>
- Tronick, E. Z., Beeghly, M., Weinberg, M. K., & Olson, K. L. (1997). Postpartum exuberance: Not all women in a highly positive emotional state in the postpartum period are denying depression and distress. *Infant Mental Health Journal*, 18(4), 406–423.
- Watson-Singleton, N. N., Lewis, J. A., & Dworkin, E. R. (2021). *Toward a socially just diversity science: Using intersectional mixed methods research to center multiply marginalized Black, Indigenous, and People of Color (BIPOC)*. Cultural Diversity and Ethnic Minority Psychology.
- Wells, J. D., Hobfoll, S. E., & Lavin, J. (1999). When it rains, it pours: The greater impact of resource loss compared to gain on psychological distress. *Personality and Social Psychology Bulletin*, 25(9), 1172–1182. <https://doi.org/10.1177/01461672992512010>
- Williamson, J. A., O'Hara, M. W., Stuart, S., Hart, K. J., & Watson, D. (2015). Assessment of postpartum depressive symptoms: The importance of somatic symptoms and irritability. *Assessment*, 22(3), 309–318. DOI:10.1177/1073191114544357
- Wood, A. F., Thomas, S. P., Droppleman, P. G., & Meighan, M. M. (1997). The downward spiral of postpartum depression. *MCN: The American Journal of Maternal/Child Nursing*, 22(6), 308–316. <https://doi.org/10.1097/00005721-199711000-00007>