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Perinatal Mood and Anxiety Disorder in Times of COVID

A testimonio of abandonment and misrecognition in Silicon Valley

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ABSTRACT | Between 15-20% of pregnant and birthing people in the United States experience symptoms of Perinatal Mood and Anxiety Disorders (PMAD). This percentage is higher for individuals who are low income, racially minoritized, and/or marginalized. Social systems of care and support have been shown to reduce symptoms of PMAD and help optimize the health of pregnant and postpartum people. For many people, COVID-19 further exacerbated the negative impacts of PMAD, largely because of disruptions of social support networks and health care resources. This article uses testimonio and autoethnography to discuss the stress, abandonment, and feeling of loss associated with the disruption of access to postpartum mental health care and support. While such feelings of loss and abandonment may feel personal, this article argues that it is critical to recognize the structural dimensions of perinatal mental health and postpartum care. The author concludes that *misrecognition* of the structural dimensions of PMAD contributes to structural violence.

Keywords: pregnancy; postpartum; mood and anxiety disorder; social support; structural violence; misrecognition.

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Many close and intimate relationships ended during the pandemic. For some, the pandemic was not the cause for the breakup. Instead, it created the conditions that finally brought to light major problems in a relationship that had either been ignored or tolerated for too long. But for me, the pandemic *was* the reason my relationship abruptly ended. And like many relationships these days, mine ended over a text. Or at least that was our last conversation: an ambiguous, 'I'll call you, you call me.' It was an ending that had no resolution. I was left asking: Is it over? Is that it? Are we done? It was all so unclear at the end.

I was dumped by my therapist. That is what I *felt* happened. But maybe I should say, 'let go' or 'forgotten'. Would that make it seem less sad, less embarrassing? I don't know.

From the beginning, our relationship and meetings had to be flexible. My therapist worked with first responders and was often called on as an expert witness in court. We would only schedule our sessions a few weeks in advance and I had to be open to rescheduling in case she had to attend to an emergency or court proceeding. I was fine with the situation but what that meant in practice was that sometimes we would schedule sessions through texts. There was so much going on at the end of our relationship and I can't remember if she told me she would text me with a new date and time or if I was supposed to text her when I was ready. It's all a blur. But either way I didn't reach out and neither did she. I guess I just expected her to text at some point but she didn't. But to be fair, neither did I. In the end, as we sheltered in place, I was left to work through my postpartum depression and anxiety on my own during the onset of the COVID-19 pandemic.[1]

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This article follows a *testimonio* format, method, and analysis (Behar 1993; Caballero et al. 2019; Latina Feminist Group 2001; Maier and Dulfano 2004; Stephen 2013; Rosales 2000). I have chosen to use testimonio to articulate – and reflexively examine – the layered meanings and intersecting politics that shape perinatal mental health in the United States. There is a political component to testimonios; they are more than the act of storytelling, sharing oral histories, or anecdotal accounts. Testimonios are not only an oral telling of a person's experience and understanding of an event (bearing witness) but they are also performative and have the capacity to be used as political tools that document everyday experiences and strategies of survival. Testimonios demonstrate how lived experiences and everyday life are intertwined with larger political, economic, and social processes (Latina Feminist Group 2001). Although testimonio methods and analyses are rooted in Latin American and Latinx traditions, other feminist and anti-racist scholars have discussed the importance of using autoethnography as a tool to highlight how structural patterns are experienced in people's daily lives, including often overlooked mundane and routine moments (Harrison 1991 Yates-Doerr 2020a; Delisle 2021). The testimonio presented in this article – *my* testimonio about navigating the challenges seeking postpartum mental health care and support – helps illuminate larger systems of inequity, neglect, and isolation that can permeate the lives of pregnant and postpartum people in the United States.

Therapy is a contractual relationship that is bound by an ethics of care and responsibility (APA 2017). An important part of the therapeutic relationship and treatment process is how therapy comes to an end. It requires thoughtful consideration, planning, and clear dialogue (Norcross et al. 2017). The ending of therapy is professionally referred to as 'termination.' There are many reasons why therapeutic relationships and treatment end. Regardless of whether they are mutual or unilateral, it is commonly advised that the therapist clearly communicate with their patient the ending of care and responsibility. According to the ethics codes of the American Counseling Association and the American Mental Health Association, therapists and counselors should not abandon a client (Vasquez et al. 2008). The are clear distinctions between termination and abandonment: 'abandonment occurs when there is an absence of a clinically and ethically appropriate process for ending the professional service'; and 'termination is the process of taking clinically and ethically appropriate steps to establish a closing disposition on the current professional relationship' (Davis and Younggren 2009: 575). Even if a patient drops out of therapy, several codes of ethics and professional norms (Rappleyea et al. 2009; Vasquez et al. 2008; Norcross et al. 2017) dictate that the provider 'make a reasonable effort to contact missing clients and offer pretermination counseling along with any useful referrals' (Davis and Younggren 2009: 574). In some cases a single phone call can suffice, but it is also recommended that the provider further attempt to contact a client in writing before an official termination is completed (Vasquez et al. 2008).

None of this happened with my therapist. Everything just ended. I felt a deep sense of loss and a feeling of abandonment. Such feelings can be common among some patients who experience an unexpected or unplanned termination of therapeutic treatment that ended without their consent (Vasquez et al. 2008). But looking back, it was complicated. At the time, I didn't know about the ethics of ending therapy. Nor did I think critically about how the COVID-19 pandemic impacted mental health practices and care. How there was, for example, no playbook or established procedure to help guide therapists as they provided—and sometimes had to terminate—care during a global pandemic. What I *did* know was that an important relationship and resource I depended on was suddenly gone. Because I felt our relationship ended so abruptly, I wrestled with those feelings of abandonment. That is why I was so hurt and initially felt resentful that the conditions of the pandemic seemed to have absolved my therapist of any commitment and responsibility to me and my mental health. It felt personal. I mean, it *was* personal but it was also more than that. At the time, however, I couldn't see much beyond the personal. My attention was centered on having lost the only tool I thought I had to help me manage my mental health. I could not see the larger picture. I could not make the connections between my lived experiences and larger structural patterns that created barriers to care, health inequities, and structural violence. Instead, at first, I misplaced my frustration and disappointment around the inaccessibility of mental health services for postpartum people squarely on my therapist. It is this *misrecognition* that I want to think through in this article.

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Years before, after the birth of my first child, I experienced severe postpartum depression and anxiety. I had no idea what to do or even how to recognize my condition because perinatal mental health and postpartum care were never mentioned to me by anyone or discussed in the books I read to prepare me throughout my pregnancy and delivery. Everything focused on what happened before and during childbirth. And everything after giving birth focused on the baby and no longer on me. I was completely unprepared.

In my case, my postpartum depression and anxiety was the result of an undiagnosed condition with my thyroid. I only had one visit with a health care provider during my whole postpartum period. It was a quick visit at six weeks and the physician barely talked to me. My vitals were checked, I was given a pelvic exam and then encouraged to move on. I might not have ever known that I had any issues if I had not gone for a well-visit a year and a half after giving birth where I was diagnosed with postpartum thyroiditis. After I had given birth, my thyroid began to overproduce the hormone thyroxine. I experienced sudden and extreme weight loss, increased heart rate, hair loss, anxiety, nervousness, and depression. I knew I wasn't feeling well but I didn't know what was *wrong*. It was a painful and exhausting time in which almost every waking moment of my day was filled with a panic that somehow I was going to make a mistake that was going to cause my baby to get hurt, sick, or die. I had these daily irrational fears of not being able to protect my baby from essentially everything; most often they were non-existent issues.

At the end of every day, I collapsed in exhaustion, but with some slight feeling of relief that my infant son was still breathing and living. I had managed to keep him alive another day. But that feeling was short lived; those irrational fears and anxieties always crept up and hit me hard as the morning sun filled my room. My husband was very patient and supportive, but I know it must have been frustrating and emotionally draining for him at times. A month after my initial diagnosis, my thyroid began to stabilize, and eventually returned to a normal level. I finally was able to start feeling better. A little more like myself. But I suffered deeply without any professional help during that time. What made it worse was that I was removed from most of my social support since I was conducting my dissertation fieldwork far from home during my late pregnancy and the majority of my first year postpartum. I also just didn't understand what was going on. I had no explanation for how I was feeling, let alone any tools to help me manage my mental health. I lacked the knowledge and language to express what I was going through and vocalize that I needed help.

But this time was going to be different.

From my previous experience, I realized that securing mental health resources in the United States required more time, phone calls, and fighting through the dead ends and inefficiencies of the bureaucracy that is our public health care system. This time around, I tried to get ahead of things. I worked hard to seek out the care I needed to help support me through my second pregnancy and postpartum.

During my first pregnancy and postpartum I was an underemployed graduate student. I was able to secure health insurance in the United States only because I was pregnant and low-income and therefore was eligible for California's equivalent of Medicare, the federally funded health insurance program. In Mexico, I relied on the insurance program contracted out by Fulbright which worked through a reimbursement system that was time consuming and difficult to use. Both insurances were basic and focused primarily on my biological health. Getting a referral to see a mental health specialist was more than a challenge; it seemed impossible.

But this time I had a good job with comprehensive health benefits that included mental health care. I worked ahead of time with my OB/GYN to monitor my thyroid while pregnant. Equally important, I secured mental health support by getting a referral for a therapist. Although I had 'good' insurance, it was still filled with bureaucratic obstacles to care. I could not go straight to a therapist and seek care. I needed a referral from my primary care physician. That referral was everything. I was lucky because I had access to good quality health care subsidized by my employer, but my ability to obtain good health and well-being was still contingent on me knowing how to navigate and work through insurance bureaucracies. But I also needed a doctor who would take the time to listen and validate my concerns. This is often what it takes to help make bureaucracies work – a real person who is willing to help make things happen. After my first prenatal visit, my doctor immediately gave me a referral. Eventually, after weeks of calling a long list of therapists, I finally found someone who would accept me. And the best part was that she was down the street from my house and I liked her.

We started our sessions, and essentially our relationship, during the middle of my pregnancy. I thought starting early would give me a little extra time to prepare and identify a set of tools I would use once the baby was born. But I soon realized that I needed those 'early' therapy sessions to help me get through the depression I was experiencing *while* pregnant. Up until that point, I had only heard and used the term postpartum depression. Because of my earlier postpartum experience I had not thought much about mental health issues during pregnancy or that experiences extended beyond depression and anxiety. That is when I learned about the more encompassing term Perinatal Mood and Anxiety Disorders.

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Perinatal Mood and Anxiety Disorders (PMAD) is a more comprehensive term that covers a spectrum of mental health conditions that can occur during pregnancy up to the first year after giving birth. These include Major Depression, generalized anxiety, Post-Traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD), and Postpartum Psychosis. Postpartum Mood and Anxiety Disorders are a critical global public health issue that impact the health and well-being of birthing individuals and their infants; with repercussions that further extend to families and communities (Byrnes 2018; WHO 2008). According to the National Institute of Child Health and Human Development, depression and anxiety are two of the most common complications individuals experience while pregnant and after giving birth (2019). The two can also happen at the same time. According to recent estimates, about 15-20% of pregnant and birthing people experience symptoms of PMAD (Johnson Rolfes and Paulsen 2021). However, the numbers are significantly higher for low income, racially minoritized, and marginalized populations (Kendall-Tackett 2017). Furthermore, many individuals who experience PMAD go undiagnosed. Up to 85% of people who experience perinatal depression do not receive care or treatment in regard to their mental health (Morain et al. 2023). There is no universal set treatment for PMAD; instead, the focus tends to be on prioritizing *individualized* care. Psychotherapy (talk therapy) is one of the most common methods of treatment. However, in some cases medications are also used. PMAD is one mental health condition among many that do not receive adequate attention or funding.

Globally, mental health services have been persistently underfunded; where countries spend less than two percent of their health budgets on mental health (WHO 2018). This continues to be the case although, according to the Lancet Commission on Global Mental Health and Sustainable Development, 'the global burden of disease attributed to mental disorders has risen in all countries in the context of major demographic, environmental, and sociopolitical transitions' (Patel et al. 2018). Resources are limited and difficult to access primarily because there is a general lack of support and political will for scaling up mental health care systems across the globe, and particularly in low- and middle-income countries (Lancet Global Mental Health Group 2007). In the United States, there continues to be a lack of qualified mental health providers, and this is particularly challenging for rural and underserved communities (Kverno and Kozeniewski 2016; Mehrotra et al. 2017; Patel et al. 2020). This shortage has been exacerbated because of the pandemic (Auerbach and Miller 2020). When COVID-19 hit, it seemed to take all these issues and magnify them.

The COVID-19 pandemic has significantly impacted the mental health of individuals across the globe (Duden et al. 2022; Torales et al. 2020), this includes pregnant and postpartum people (Hessami et al. 2020; Preis et al. 2020; Mollard et al. 2021; Barbosa-Leiker et al. 2021; Wu et al. 2020). To lower the transmission of COVID-19 and to keep populations safe, at the beginning of the pandemic many governments across the world implemented public health preventative measures that relied on enforced social isolation, often given names such as 'stay at home,' 'lock down,' and 'social distance.' Until vaccinations became available, these measures, along with masking, significantly helped in keeping most people safe and lowering transmission rates. However, these isolation measures did not protect the population equally. It is important to note that work from home options were primarily afforded to high- and middle-income workers. For those deemed essential workers, who were primarily lower income and racially minoritized, work from home options were not an option. In fact, many lower income and racially minoritized workers, who primarily worked in occupations deemed essential (e.g. in agriculture, health care, food processing and service, factory and warehouse work, retail and grocery service, and transportation) were required to continue laboring in their jobs but now in unsafe working conditions that not only impacted their physical health but also the health of their family members at home (Hawkins 2020; Obinna 2021; Rogers et al. 2020).

Although it has been documented that in times of public health crises populations experience an increase in the burden of physiological suffering and a decrease in overall mental health, global responses to the pandemic prioritized a medical response and neglected integrating approaches that also included mental health resources and services (Duden et al. 2022). National policies, implemented at the beginning of the pandemic, that required people to stay home were effective in lowering the transition rates of COVID among the general population, but they also had unintended consequences that impacted the socio-emotional wellbeing of individuals. Furthermore, due to these isolation mandates, stress levels increased for perinatal people, especially women of color, as the early months of the pandemic resulted in uncertainty and job loss, the closure of daycares and school, and increased responsibilities for the care of children and households (Mollard et al. 2021). For many people, perinatal mental health was negatively impacted by pandemic-related public health policies that separated them from accessing social support networks and postpartum health resources (Rice and Williams 2021) along with economic and nutritional needs such as secured employment, sick leave, and access to food and housing (Barbosa-Leiker et al. 2021). These are the kinds of systemic and structural factors that shape how conditions such as PMAD play out in individual lives.

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It's not that I was unfamiliar with the structural dimensions of global health care going into my pregnancies. My primary research centers on maternal health and reproduction. My long-term work focuses on documenting changing childbirth practices and access to health resources among Maya women in rural Quintana Roo, Mexico. My work examines the historical and structural factors that shape and disrupt women's access to health care (Dixon et al. 2019; Miranda 2015). In a sense, because of my research and field experiences, you might think I should have been more prepared for my own postpartum recovery. But things are different when it's you going through it. And even in my own research, I focused on pregnancy and childbirth – not on what happened after. For me, it was hard to recognize at first that I had PMAD. It was not until after I had my own children and experienced perinatal depression and anxiety that I shifted my research to focus on postpartum care and perinatal mental health. This was intentional; I turned my experience into a research project in part because I was shocked at how little I knew about it. Looking back, turning this into research was also a way to cope and *do something* about my experience.

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My second pregnancy was tiring and long. I felt nauseous almost every single day. There were times when I did throw up, but mostly it felt like I was perpetually rocking side to side on a boat. But this wasn't the tranquil image of a small boat floating on the gentle seas. My boat was rough. Day after day of not feeling well eventually took a toll on my mental health. I was depressed along with physically feeling horrible. During that time, I was an adjunct professor and teaching a full course load while also interviewing for more stable positions. Maybe because of my precarity, or some deep internalized need to continue working with a smile, I chose to tell very few people how difficult my pregnancy was. In some ways, I also felt like it wouldn't matter. It would not change my situation. And I feared I would be labeled a complainer, especially as a contingent Latina faculty member. This was pre-COVID times in the United States, when laborers were stigmatized for taking too much time off and presenteeism (going to work when sick or unwell) was commonly practiced by academic employees (Kinman and Wray 2018).[2] I went to work sick and my students came to class sick. This was the culture and expectation of the times. I remember this one time teaching during the first trimester while having a really bad cold and a terrible cough that was hard to suppress. I went to class with my iced pregnancy nausea tea and a handful of cough drops ready to get through the day. I would lecture and periodically take a break and hunch down behind the podium and hold myself in a ball while I coughed enough to allow me to get back up and continue lecturing. At the time this seemed like the most reasonable thing to do. I was a good worker, right?

I got through the pregnancy and eventually I gave birth to a beautiful healthy baby. The first few months after having a baby are hard. Especially the first weeks dealing with the physiological changes that come along postpartum. The heavy bleeding, the cramping, the sore breast and nipples, the changing hormones, the overstretched or torn perineum, the painful hemorrhoids, the aching muscles from pushing for hours in a certain position or just from the body carrying so much weight for months. And for some, there is also the healing from major abdominal surgery. In the United States, C-sections account for about 30% of all births (Martin et al. 2021). And of course, there is also sleep deprivation; I had severe sleep deprivation.

Many women in the United States have noted that their childbirth journey was marked by intense focus during the prenatal period and if/when postpartum care was delivered it was often infrequent and late (Tully et al. 2017). In fact, the American College of Obstetrics and Gynecologists (ACOG) states that 40% of women do not attend a postpartum visit with a health care provider (ACOG 2018). Furthermore, ACOG highlights that these numbers are higher for racially minoritized individuals and those with limited resources. When addressing postpartum care, the majority of attention is focused around the first 12 weeks after giving birth. One of the main reasons behind this early focus is that ‘more than one half of all pregnancy related maternal deaths occur after the birth of the infant’ and a substantial number of those deaths take place during the early postpartum period (Kassebaum et al. 2014). There are many physiological and psycho-social factors that impact the physical and mental health of individuals the first three months after giving birth. However, it is important to also discuss some of the long-term postpartum complications that can impact the quality of life of individuals. For example, for some people PMAD does not end after the first three months postpartum and PMAD can be experienced long after the first year postpartum.

Five months after my baby was born, I was still dealing with postpartum depression and anxiety. Having access to an affordable and qualified mental health care provider was helping me get through my days. I returned to therapy sessions a few weeks after giving birth. I would come in with my infant son. He usually slept and so I brought him strapped in his portable car seat carrier. I sat on the fluffy, but not too comfortable, tan couch and my therapist and I proceeded to talk for the next 45 minutes. I left our sessions feeling a little lighter. Things seemed to be going okay. I still needed help and some days were better than others, but I felt supported and that meant a lot. With my therapist's help I felt like I could get through this and I would emerge on the other side feeling more secure and whole. This form of support was particularly meaningful because I did not live near my extended family and therefore I had very limited social support.

One day in late February 2020, I took my infant son with me to pick up my six-year-old from school. I brought the stroller and the baby sat and watched as my older son played with a couple of his friends after school on the play structure. I was talking with another parent and then I heard a cry. My six year old son was on the ground crying and bleeding. I didn't know what to do. Should I run over and leave the baby alone in the stroller or take a minute and push the stroller over or wait for my son to come to me? I panicked and I froze. I was so fortunate my friend was there to help me. She stayed with the baby while I picked up my son and assessed the situation. He had slipped on the structure and busted open his chin; there was blood everywhere and flesh bulging out of the open cut. He needed stitches. I was able to calm him and myself down and get us all into the car. As I drove home I called my husband, who had just finished teaching, and told him to meet us at the house so he could take our oldest son to the hospital. I stayed home with the baby and waited. During that time I texted my therapist and canceled our afternoon session. I told her what had happened and she was very understanding. I was not charged a cancellation fee. The last thing she said was for me to text her when I was ready for another session, or I think she said that she would text me with available times to meet. Two weeks later, a 'shelter in place' order was declared in the Bay Area because of COVID-19. And I never heard from my therapist again.

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Since my relationship with my therapist ended without closure, I was left imagining what it might have been like if we stayed together – especially during the scary, unknown, and isolating time of the pandemic. I wondered how it would have even been possible to continue with therapy now that I was sharing every moment of the day with my family in our very small duplex. Shelter in place mandates resulted in the home no longer being a private place. Everything was now happening within the walls of our homes via screens and phones. My husband and I were teaching full time online, my oldest son transitioned to virtual elementary school, and the baby was right there growing and learning in the middle of all this. Our small space functioned not only as our home, but also converted to a university classroom, office workspace, elementary school, and a day care. During all these changes, what impacted us the most was that the little childcare support (public school and daycare) we did have vanished overnight.

Due to the forced isolation, our parents and other extended family were unable to visit and provide even a few moments of relief especially during times of high stress and exhaustion. We were essentially alone and everything felt impossible. I was overwhelmed.

As a result of us all sheltering at home, certain things just didn't seem like they could work, such as therapy. How and where was I supposed to find a space where I could talk to my therapist? Was I supposed to go for walks out in public during my therapy session or call from my car in the driveway? Although I had worked so hard to secure access to professional mental health care and relied so heavily on it, the conditions of the pandemic made me feel that therapy was an unimaginable thing to continue. And so maybe that is why I did not reach out to my therapist. So, maybe it was actually my fault for not staying in touch. But I also felt my relationship with my therapist was important enough that she would have reached out. Knowing my triggers and anxieties, she would have realized that I still needed help and it was her responsibility as my therapist to see if I was okay. Right?

I was hurt that she never called, even if it was to say goodbye because to me our relationship mattered. Our last interaction came a year later in the mail as a formal letter letting me know that she was no longer accepting my insurance and I was therefore no longer her patient. It was such a bureaucratic and cold end. For me it was very personal.

But looking back, I was having a hard time seeing the structural beyond the personal. When COVID-19 hit, it starkly revealed the deep structural problems that plague mental health care and postpartum care, especially for vulnerable populations, in the United States. But the pandemic also revealed how many mental health providers were being exploited, overworked, and essentially abandoned by the public health care system and society. During that time, I did not, or could not, see the situation from the perspective of my therapist. I could not see how *she* might also have been struggling from the pandemic. In fact, research has shown how the mental wellbeing of health care workers and providers across the globe was negatively affected by the COVID-19 pandemic and how that eventually impacted the quality of services they provided to their patients (Bojdani et al. 2020; Nvé Díaz San Francisco 2022; Salgado de Snyder et al. 2021; Weibelzahl et al. 2021). I could not see all those other factors – even though I was dealing with them – that had worked in concert to disrupt and sever our relationship.

I was just dealing with so much. I struggled because of the isolation, the uncertainty, the responsibility or having to manage it all including keeping my family safe, and ultimately the realization that I had very little support to get through it. Among all the physical, emotional, and social experiences of COVID, the lack of childcare and the pressure to stay productive at work proved to be too much. Not only was this stress and hardship experienced by many parents (Cheng et al. 2021; Lange et al. 2022; Vescovi et al. 2021), it was also explicitly documented by academics, particularly women with small children (Crook 2020; Yates-Doerr 2020b). As laborers in the neoliberal university our value was intricately tied to our productivity as scholars and teachers. According to Huppatz et al. (2019), those with care responsibilities, specifically women with small children, have been systematically disadvantaged within the neoliberal market demands and audit culture of the university. The pandemic just made this worse.

I was spread too thin. Some days I felt I had nothing left to give. Daily life was hard sometimes. I did cry and experienced a deep sense of hopelessness, frustration, resentment, and exhaustion. I really needed my therapist. She was a personification of the kind of social care that I felt I needed – the kind of care that has been largely forgotten in our health care system. I was sad she was no longer in my life. To cope with this sense of loss and abandonment I eventually started telling people[3] about what had happened and searching for other forms of social support. This act of telling helped.

I was desperate for shared human connections and a year after the start of the pandemic I began to look for them everywhere I could. It felt good to not only share what I was going through but also to hear I was not alone. In non-pandemic times, I would have had access to professional forms of mental health support such as a therapist, group therapy, or participated in postpartum support groups (especially now that I knew such things existed).

During the pandemic these professional resources disappeared, or they felt inaccessible or just impossible. But the pandemic and the lockdowns also cut people off from informal networks of care and support such as family and friends. Such losses are critical and devastating. As Nelson (2021) states, human evolution has prioritized cooperative behavior and communal care as a tool of survival. Furthermore, she argues ‘it has been an evolutionary mandate to rely on other individuals, kin and non-kin alike, to help in raising children’ (Nelson 2021: 295). I really wanted to be physically close to my family and friends. I could have used some help with caring for my children, support with daily necessities like preparing meals, grocery shopping, and maintaining my household chores. But more than anything I longed for a hug from my mom and my tias/aunties. I wanted to be able to sit with my friends and laugh or be comforted by their physical presence. I missed the emotional support and love they all provided for me and my children. So when this too was no longer accessible, I was left to figure out new forms of obtaining social support that could help me work through my postpartum depression and anxiety.

Social support, whether formal or informal, has been shown to reduce symptoms of PMAD (e.g. Feinberg et al. 2022). But the pandemic and the lockdowns disrupted much of that support. People were left having to find social support in other ways. For many, that is when technologies of communication (telephone, social media, internet) took on a more important role in their social support and mental health (Bermejo-Sanchez et al. 2020; Duden et al. 2022; Jullien and Jeffery 2022). As I worked through my postpartum depression and anxiety during the lockdown, I sought support from my kin and social networks as much as I could. Although I would have preferred to be physically close to my family and friends, I eventually ended up relying on the phone to stay close to my support networks. In order to have some sense of privacy, I arranged childcare duties with my husband where every once in a while, he would watch our oldest at home while he prepped to teach online and I would put the baby in the stroller and go for a long walk while the baby took his afternoon nap. That was the only time during the first year and a half of the pandemic that I was ever semi-free from childcare responsibilities and had a few moments of privacy and time for myself. Because of that freedom, I was able to reach out to my family and friends.

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I have gone back through this experience multiple times and wondered what I should have done differently. At the beginning, should I have focused my efforts on seeking care and support from my kin and social relationships rather than depending solely on professional mental health care from my therapist? Should I have been more persistent? Should I have known better? Should I have looked for other options? Because how could I not have been able to fix things? How could I have not been capable to take care of myself and find viable solutions to address my health. But no, this can't be. Surely, it can't all be my fault.

Just as I had essentially misplaced blame on myself for not doing enough, I did the same with my therapist – one of the few actual human faces that had been able to help me through such a difficult time. She did help me, and I am grateful for everything she did. When I lost that connection, I felt betrayed and I focused on that feeling more than the memories of how supported I felt under her care. My own fear, anxiety, and depression clouded my ability for perspective and empathy. Again, the personal often overtakes the structural in how we see things – it makes it hard to realize or see the structural violence and loss we're up against.

As I have discussed throughout this article, I struggled with finding available resources and solutions to address my mental health. Having been born and raised in the United States, I know I was heavily socialized to view mental health as an individualistic endeavor that required me to actively work to secure care. This belief, or ideology, has been deeply ingrained despite my training, research, and work in anthropology about the structural inequities in global health care systems. It is hard to see those structural and historical factors when it's you who must fill out the form or wait endlessly on the phone just to get some basic level of care or support. But the truth is, in the end, mental health is beyond individual motivation, proactive behavior, and work. It needs to be built into social and institutional systems of care. The responsibility cannot and should not be placed solely on the individual. I know this. And I knew this. But I still lost sight of it all.

According to the Constitution of the World Health Organization, 'health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO 2006). Postpartum health encompasses much more than the physical well-being of an individual. Social relations and support have proven to help prevent and minimize depression and anxiety during pregnancy and postpartum (Negron et al. 2013). Before the pandemic there already existed many barriers when seeking access to mental health professionals, especially for pregnant and postpartum people (Byrnes 2019). This again was compounded by the COVID pandemic which also laid bare inequalities within our health care system. According to Nelson, the pandemic, and the lockdown in particular, 'has had the effect of revealing societal fractures that were mostly ignored by those with the structural and institutional power to create better lives for everyday people' (2021: 295). When confronted with a lack of access to professional mental health providers, many individuals have sought support from their partner, family, and friends. In my case, I too relied heavily on my husband, friends, and family to help fill in the hole left by the absence of professional therapy.

But there is more to the picture here than the issue of individual choice and the importance of social, familial, and kin networks. As Fraser (2017) puts it, this is not just a matter of a 'crisis of care,' but rather a much deeper crisis of social reproduction. The COVID pandemic has demonstrated how the underfunding and disregard of mental health services ultimately results in a higher burden of disease. The lessons from COVID reveal that it is imperative we find ways to increase support for pregnant and postpartum people both structurally and socially. The high percentage of people (one in five) experiencing Perinatal Mood and Anxiety Disorders stresses the real human cost and unneeded suffering people experience when mental health is ignored or denied. We must do better.

I began this article by talking about my relationship with my therapist, and that is where I want to end. I was angry with her. I blamed her. This was something that I felt and expressed and experienced. My experiences and feelings were real and valid, but they were also laden with misrecognition (Bourdieu 1977). That misrecognition, which effectively pits individuals within a damaged system against one another, is a fundamental part of the problem here. I was blaming the structural and systemic on the personal. This is easier to see after the fact, with some analytical distance. As I think through the whole situation now, I remember her talking about the kind of work she was doing. She was on the front lines of a system that produces endless trauma. Her job was to work with and through the collective traumas of first responders and so many others. I was one of many. But she was just one person who was supposed to field all the pain, emotion, and damage of a deeply flawed mental health care system. Rather than address those issues, our system atomizes and individualizes them and pins our hopes on treatments like therapy – which are powerful and healing but ultimately unable to alleviate deeper structural violence and loss. I felt, at the time, that I had been abandoned by my therapist. In reality, I had been abandoned, like so many others, by our broader social system. It is that abandonment that must be addressed, not as a problem of individualized, itemized care, but rather a collective problem that can only be rectified through political mobilization that brings about material and structural change. This kind of work can begin, I think, through processes of recognition, such as testimonio and autoethnography, that help us document, assess, and shine light on the impacts of trauma and structural violence. We truly need to tell to live (Latina Feminist Group 2001).

Furthermore, we can continue with a purposeful and intentional recognition of the value and power of the social and kin relations that help keep us afloat during such difficult times. I realize now that the abandonment I felt was due to a sense of loss of something, someone that mattered to me. I blamed my therapist, and I blamed myself. But this is how structural violence pulls us apart and pits us against one another. To push back, we need to highlight and bring about change to the structural processes that isolate people and communities, including health care providers.

I would like to end by thanking my therapist for the care she provided me the few months we were together. I hope this article can help us heal and focus our work to addressing the larger structural factors that continue to reproduce violence and pain.

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Notes

1. This article was originally written in the fall of 2021. A year and a half since the start of the COVID-19 pandemic. It was also the year many universities and schools across the country returned to in person instruction.

2. Maybe one positive outcome that can come from the pandemic is a new cultural shift in work culture and policy; one that encourages employers to value work-life balance and the overall health of their employees and for laborers to feel comfortable and able to stay home while they are sick or unwell. The pandemic has shown the public health and societal necessity for paid sick leave alongside the push to normalize the practice. However, my optimism is starting to quickly fade as I have returned to the university and feel the pressure around me and others to stay productive, available, and present. The demands of the neoliberal university seem to continue even after a global pandemic.

3. I started to think that my difficulty accessing and maintaining a relationship with a mental health care provider was unacceptable. The structural barriers to care made it almost impossible to attain care. I was angry, frustrated, and sad. Mainly because I felt that going to therapy was helpful and I wanted it back. I wanted to feel comforted in sharing my disappointment and frustrations. But I also wanted to talk more with others about my postpartum depression and anxiety because I felt it was hidden, yet common. The stigma of PMAD, and mental health in general, continues through everyday silences.

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