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First-time mothers' perceptions of social support: Recommendations for best practice

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Abstract

Research indicates social support is imperative for postpartum well-being. The types of social support and access to preferred supports are less understood. This article considers first-time mothers' perceptions of the effectiveness of social supports and perceived barriers to accessing support and provides recommendations for best practice. A search of the literature for terms related to postpartum social support was conducted. Major themes were identified and synthesised. A critique and analysis of the literature is presented with recommendations for best practice. Much of the research around postnatal support fails to distinguish the specific type of support, meaning creating support solutions for the postpartum period may not be effectively targeted. Recommendations for individualised support are made.

Keywords

mothers, postpartum depression, postpartum distress, social support

Introduction

Some groups of first-time mothers are at known risk for potential mental illness or psychological distress in the postpartum period. Thus, research concerning best practice options for support is vital to ensuring positive outcomes for women after they have had a baby. Previous research has shown that social support is instrumental in promoting well-being in the postnatal period (Razurel et al., 2012), with this literature considering issues such as levels of social support and impact on distress, types of support and access to those supports for women after childbirth. Similarly, low social support can equate with a lower quality of life (Webster et al., 2011). While much of the research is focussed on the benefits of social support, some literature outlines issues with the utilisation of the social support available to women, as well as issues accessing those supports (Leahy-Warren et al., 2018; Prevatt and Desmarais, 2018) – a particularly salient issue for particular groups, including women with migrant, refugee or asylum seeking backgrounds (Benza and Liamputtong, 2014; Tobin et al., 2014). This overview draws together the existing literature concerning social support for women in the postpartum period. There are two key areas which are addressed: (1) the perceptions first-time mothers have of social supports, and (2) the barriers women face in accessing social support. The overarching questions are as follows: what are first-time mothers' perceptions of social support, and what barriers do they face in accessing support?

Distress, depression and anxiety

Research suggests between 7 and 80 per cent of women experience some form of postpartum distress from the more common 'blues' to depression (Slomian et al., 2017; Ussher,

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2004), although it may not be labelled as such outside of biomedical settings (Goldbort, 2006). This distress is not specific to particular groups of women, with Chavis (2016) reporting in their research with women up to 24 months postpartum that postpartum distress may be experienced 'regardless of income, education, race, perceived social support, or the sense of competence' (p. 474). Increased distress is typically found earlier in the postpartum period and dissipates as the woman becomes more familiar with her new role (Leahy-Warren et al., 2011).

Postpartum distress (PPDS) is any psychological problem which impairs daily functioning, encompassing a range of experiences such as anxiety and stress, but not including the 'baby blues', which presents in the days immediately following childbirth and is likely attributed to hormonal and birth-related factors (Coates et al., 2014; Miller et al., 2006; Ussher, 2004). More commonly, researchers have focussed on postpartum depression (PPD) which begins from between 2 weeks and 4 months postpartum and is experienced as more severe depressive symptoms similar to classic depressive symptoms (Austin et al., 2017). Austin et al. (2017) stipulate that Perinatal Depression and Anxiety (PNDA) includes depressive and anxiety disorders such as mild to severe depression, generalised anxiety disorder, obsessive compulsive disorder, panic disorder, social phobias and posttraumatic stress disorder, which occur during the perinatal period, the more severe of which can affect approximately 20 per cent of women. While the perinatal period is considered from conception to the first year postpartum, one in seven women in Australia report persistent depressive symptoms up to 7 years postpartum (Austin et al., 2017).

Data sourced from the Australian Bureau of Statistics found women contribute more to family and home life when they return to employment postpartum than men (Craig et al., 2012). Mothers who work in paid employment and have children have been shown to surrender time for themselves in order to provide quality time for the child and maintain working commitments, particularly mothers who attempt to balance paid work with motherhood and who may face feelings of guilt and judgement (both their own and others) at leaving children with non-parental care (Craig et al., 2012; Evans et al., 2012). These factors have been found to contribute to postpartum distress and may account for some of the extended period aforementioned.

Women with migrant, refugee or asylum seeking backgrounds undergo a 'double transition' as they face motherhood with geographical and emotional displacement from what is familiar (Migliorini et al., 2016: 139; Tobin et al., 2014). Many have also experienced significant levels of trauma, and motherhood may exacerbate feelings of powerlessness or lead to re-traumatisation. For example, Studies by Tobin et al. (2014) and Benza and Liamputtong (2014) highlight the specific challenges women with asylum seeking and migrant backgrounds face which exacerbate issues in the perinatal period. These include low local cultural knowledge, little to no connections, language barriers, isolation, social and racial oppression, fear, distrust, birthing in a mainstream medicalised system which may be very different to that in their countries of origin, and personal disempowerment. Language and communication barriers alone have a direct impact on the health and well-being of women in minority groups, while the lack of culturally relevant rituals which are known to maintain and bolster well-being during the perinatal period may also negatively influence the health of mothers. The needs of this cohort are complex, multifaceted and deserving of significant attention in terms of perinatal care (Migliorini et al., 2016; Tobin et al., 2014: 837).

For many women, the myriad of fears relating to childbirth are universal and can add to perinatal distress. These include but are not limited to concerns about the pain of delivery, fear of complications, interventions and emergency caesarean section, and overall safety during and after delivery of mother and infant, and motherhood, in general (Rania, 2019). These factors, together with the fact that a medicalised birth may be incongruent with the idealised birth of some women, can lead to birth trauma. Birth trauma – an experience where women may feel powerless, dehumanised and disrespected – can severely impact postnatal well-being (Beck, 2018; Rania, 2019). The emotions and beliefs surrounding childbirth and trauma can be powerful for not only the mother but also for health care professionals as they bear witness to and are involved in the process of childbirth and the myriad experiences which accompany it. This too can in turn impact the mother's experience (Leinweber et al., 2017; Morano et al., 2018).

Social support

Early works by Sherbourne and Stewart (1991), Bloom (1990) and Uchino et al. (1999) define social support as support which is considered functional, and which leads the receiver of the support to feel cared for, valued and with a sense of belonging to a larger network. Taylor (2011) states that the mere perception of support improves health and well-being by reducing stress levels. Social support may be provided by partners, family, peers, colleagues and others from within the community (Sherbourne and Stewart, 1991). Social support has been categorised into two main areas: structural support and functional support. Structural support refers to the existence and quantity of support through formal and informal social relationships (Leahy-Warren et al., 2012), whereas functional support is the specific type of perceived support (Taylor, 2011). Sherbourne and Stewart (1991) report a model of five functional elements; (1) *emotional support* through understanding and the encouragement to express feelings, warmth, nurturance and reassurance; (2) *informational*

support through providing advice and guidance, helping another to understand, sourcing resources and/or coping strategies, information, advice and management strategies; (3) *instrumental support* through material, monetary and behavioural aid, tangible assistance, services, specific aid or goods; (4) *appraisal or comparison support* refers to encouragement and advice by those who have been in similar situations and (5) *social companionship* by spending leisure time with others (Ni and Lin, 2011). Leahy-Warren et al. (2012) limit functional support to four key proponents: *emotional, informational, appraisal* and *instrumental*. Regardless of how social support is categorised, the effectiveness of social support depends on the perceived need and effectiveness and also on the relationship between the giver and receiver of the support (Leahy-Warren et al., 2012; Ni and Lin, 2011). Slomian et al. (2017) discuss social support in terms of needs: the need for information, psychological support, a sharing of experiences and the need for practical support. Many aspects of support are indicative of having someone the person feels close to, particularly in terms of emotional and informational support where sources could be either professional or personal.

The main role of social support is protecting the physical, mental and emotional well-being of those exposed to stress. More specifically, social support has been found to buffer against stressors, reducing psychological distress, depression and anxiety in turn impacting physical health (Thoits, 2011).

It has been argued that in order for social support to be effective, the support needs to be personalised, and needs must match the support provided (Leahy-Warren et al., 2018; Taylor, 2011). Women are likely to need and seek support from a variety of sources, including from other women (Ni and Lin, 2011) and in times of stress, women are more likely than men to give, access and benefit from social support (Taylor, 2011). Social support by way of rituals is vital to well-being. For migrant women, social support can enhance health and well-being for all mothers, including those in minority groups (Migliorini, et al., 2016). In Dennis and Chung-Lee's (2006: 327) review, which included cross-cultural data of women up to 1 year postpartum, they reported

> specifically, women wanted: (a) to be given permission to talk in-depth about their feelings, including ambivalent and difficult feelings; (b) to talk with a nonjudgmental person who would spend time listening to them, take them seriously, and understand and accept them for who they are; and (c) recognition that there was a problem and reassurance that other mothers experience similar feelings and that they would get better.

There is a risk of psychological distress and possible isolation for those who fear stigmatisation, are unable to effectively communicate the type of support they need, are unable to access culturally familiar and relevant social supports or have limited social networks.

Need for informal support

Many studies have found that women report 'less than adequate social support' (Darvill et al., 2010; Lee et al., 2017; Negron et al., 2013; Prevatt and Desmarais, 2018: 127; Rowe et al., 2013; Slomian et al., 2017) and often experience insufficient supports emotionally and psychologically in the postpartum period (Darvill et al., 2010; Leahy-Warren et al., 2011; Prevatt and Desmarais, 2018). Negron et al. (2013) and Slomian et al. (2017) found this lack of, or dissatisfaction with, social support increased the risk of postpartum distress. A qualitative systematic review of the literature by Dennis and Chung-Lee (2006) conducted across 11 countries found women were three times as likely to suggest speaking to a lay person who may understand what they are going through over seeking professional help. They found that a key theme in terms of preferences for social support was simply having the opportunity to talk to someone who would empathise. However, the mothers demonstrated a preference for support from other women with children, which they felt came from experience and a place of genuine understanding. This kind of reassuring support was most effective, as it provided the women with a sense of confidence (Dennis and Chung-Lee, 2006). Similarly, a Canadian multisite descriptive qualitative study by Letourneau et al. (2007) reported that women expressed the need for interaction and talking with someone who could offer them one-on-one time and emotional support.

The supportive role family, friends and peer counsellors play in enhancing the well-being of mothers postpartum has been considered in a number of qualitative and quantitative studies (Barkin et al., 2014; Darvill et al., 2010; Leahy-Warren et al. 2012; Letourneau et al., 2007; Negron et al., 2013; Ni and Lin, 2011; Prevatt and Desmarais, 2018; Razurel and Kaiser, 2015; Reid and Taylor, 2015). Participants in these studies varied, including mothers prenatally, 6 weeks postpartum, up to 1 and 2 years postpartum. Mothers of first-time mothers in particular have been identified as a main source of emotional, practical, appraisal and informational support (Leahy-Warren et al., 2012). Qualitative research in the United States by Chavis (2016) and research on South American women in Italy by Migliorini et al. (2016) found the support offered by mothers was more desired and efficacious than that provided by their partners. In some cases, depression was found to be related to low partner support. Despite this, partners and mothers were shown to be key support people, and for some migrant women, the change in culture which allowed for increased father support and involvement was found to be highly valued (Benza and Liamputtong, 2014).

While social support from friends and family has been identified as highly valued and contributing to improve postpartum outcomes (Ni and Lin, 2011; Taylor, 2011), there is conflicting research regarding the effectiveness and accessibility of friends and family as support. Research suggests family, friends and partners are the most important factor in addressing the needs of mothers (Reid and Taylor, 2015). Yet, despite many women reporting family and friends as key in providing them with emotional support, Dennis and Chung-Lee (2006) found many women felt family and friends were unable to be supportive due to a lack of understanding about PPD. Letourneau et al. (2007) similarly found that while the support of close friends and family was essential, it was not always sufficient, with women reporting feeling burdensome and sometimes judged for their distress. Other mothers may also be important sources of support (Negron et al., 2013); however, Letourneau et al. (2007) report the potential for competitiveness. Nevertheless, other mothers may be particularly important sources of support for first-time mothers who experience frustration with their partner or other family members (Hong Law et al., 2018; Negron et al., 2013).

Importantly, not all women have access to or draw upon social networks for support. For example, Barkin et al. (2014) and Darvill et al. (2010) found women experience difficulties seeking help if family were not living close by, and women may not be sure where to find support in such instances (Dennis and Chung-Lee, 2006; Letourneau et al., 2007). In these instances, one potential source of support may be community mothers' groups and playgroups, which have been shown to provide support and connections for many women, including first-time mothers (Strange et al., 2014). Dennis and Chung-Lee (2006) found for some mothers these groups provide companionship and a sense of normality, and yet for some they can be the source of greater isolation through feeling a sense of competition with other mothers in the group and the pressure to attain or portray the idealisation of motherhood or pressure to conform to expectations about particular styles of parenting (Dennis, 2010; Dennis and Chung-Lee, 2006). For women with migrant, refugee or asylum seeking backgrounds, accessing culturally familiar community supports may be challenging. Transport, language, unfamiliarity with the neighbourhood and available services are all barriers to connecting with social support (Benza and Liamputtong, 2014; Tobin et al., 2014).

Inadequate professional care

There are various challenges for health professionals providing emotional support to mothers. Screening for depression may be insufficient (Corrigan et al., 2015; Prevatt and Desmarais, 2018), and women from various countries, including Iceland and the United Kingdom, have reported that medical health centres were 'inappropriate' to deal with emotional needs of women postpartum and lack of culturally responsive care (Dennis and Chung-Lee, 2006: 324; Tobin et al., 2014). Razurel et al.'s (2011) study involving high socioeconomic, low-risk first-time mothers in Western Europe also found women to be stressed when dealing with health care professionals for postpartum emotional support. Some research has found issues with trust and disclosure, such as participants choosing not to disclose symptoms of postpartum mood disorder to their primary health care provider (Prevatt and Desmarais, 2018) and being fearful of having concerns minimised and dismissed (Letourneau et al., 2007). Issues such as Female Genital Mutilation are also relevant to some women, who may find their experiences difficult to discuss in a foreign setting (Benza and Liamputtong, 2014). A US study by Prevatt and Desmarais (2018) found while some women were least likely to report concerns to their midwives, they were most likely to disclose to their obstetrician/gynaecologist or paediatrician as more time was spent with them giving more opportunity to establish a relationship. This finding may not reflect the direct role of the health care professional, but rather the increased time spent with these health care providers and which may differ in circumstances where the midwife or nurse is the primary caregiver. Darvill et al.'s (2010) qualitative study in the United Kingdom, of women 6 to 15 weeks postpartum, found that if bonds with health professionals had been formed prior to the birth, it was useful postpartum for a continuation of the support role.

A need for more informational support to be provided by professionals has been identified in previous research (Manuel et al., 2012; Shaw et al., 2006; Slomian et al., 2017), with a corresponding lack of overall professional postpartum care, a lack of continuity of care, a lack of culturally responsive care, and thus low preparedness for the postpartum period (Benza and Liamputtong, 2014; Darvill et al., 2010; Leahy-Warren et al., 2011; Rowe et al., 2013; Tobin et al., 2014). Antenatal classes have been found to provide a good foundation for informational support and knowledge leading up to and including the birth, but in some studies have been found as inadequate for postpartum information and support (Corrigan et al., 2015; Darvill et al., 2010; Razurel et al., 2011). One explanation for this offered by Razurel et al. (2011) is that women may be more focussed on the birth and that the postpartum period is too far removed to be of immediate concern.

Hong Law et al. (2018) and Rowe et al. (2013) discuss a lack of available resources to handle postpartum care in terms of education for new mothers and their networks, and how they perceived familial support. Research by Razurel and Kaiser (2015) found information, advice, support and appraisal provided by professionals postpartum showed a decrease in anxiety in women in France. They recommended it is important for health care professionals to provide other types of support, emotional and appraisal,

given their exposure to women postpartum. Letourneau et al. (2007: 447) found 'most mothers' prefer to have face-to-face support in their homes, as some women reported leaving their homes with a small child to gain support could be an onerous task.

Barriers to accessing social support

Research shows that various barriers to accessing social support exist for many first-time mothers, making it extremely difficult to seek social support (Prevatt and Desmarais, 2018). Barriers identified across this literature can be considered under two main areas: *Self* and *Societal* (Hong Law et al., 2018; Negron et al., 2013).

In terms of self, the literature indicates that feelings of guilt, shame and embarrassment often prevent women from sharing how they feel in the postpartum period (Letourneau et al., 2007). Some researchers have argued that denial of levels of distress may lead some women to be hesitant to admit they are not coping or disclose how they feel (Dennis and Chung-Lee, 2006; Letourneau et al., 2007; Liss et al., 2013; Negron et al., 2013). Feelings of worthlessness, a lack of motivation or energy and issues of pride and independence also all became barriers for some women (Letourneau et al., 2007; Negron et al., 2013; Prevatt and Desmarais, 2018). The systematic review by Dennis and Chung-Lee (2006) aimed to identify help-seeking barriers and treatment preferences for PPD. The review included 40 articles and found women experienced inadequate emotional and practical support as they felt unable to share feelings comfortably with family or health care professionals. The review found some women's biggest hurdle was openly sharing their feelings, which was reinforced by health professionals, partners and family through a lack of acknowledgement and effective practical and emotional support. Women reported fearing that their baby might be removed, being hospitalised or being placed on medication that would potentially have lasting side effects (Dennis and Chung-Lee, 2006; Letourneau et al., 2007). It is not to say PND would be curtailed or prevented if effective support were readily available. Rather, that an open environment for sharing the experiences of that distress may facilitate feelings of connectedness and well-being – a feeling that one is supported, which as Leahy-Warren et al. (2018) describes is often more important than the support itself.

Societal expectations of motherhood can exacerbate feelings of inadequacy and shame, which may inhibit support seeking and raise fears of not being seen to be a good or capable mother (Hong Law et al., 2018; Negron et al., 2013). Research suggests there is a reluctance to admitting feelings of depression or distress and pressure to cope with what is seen as a mother's role, particularly among cultures where mental illness carries a heavy stigma and stoicism is employed. PPD may be negated by health care professionals, partners, families and the mother herself, delegating failure and weakness to those who admit the need for support (Benza and Liamputtong, 2014; Dennis and Chung-Lee, 2006; Prevatt and Desmarais, 2018). Societal barriers may contribute to silencing some women who need to feel as though they can share information about their feelings and experiences in a safe environment where they can talk openly: some women may feel stifled and unable to 'unsilence their voices' in a public setting (Jones et al., 2014: 496). As noted, societal barriers may be exemplified by some mothers' groups which are designed to provide peer support yet have been found to intensify the need to portray the image of the ideal mother, which may impede sharing (Dennis and Chung-Lee, 2006; Letourneau et al., 2007). Research by Slomian et al. (2017) supports this, finding that first time mothers lacked 'reliable and realistic information' about the realities of the postpartum period (Slomian et al., 2017: 11). Hong Law et al. (2018) describe how social media can exacerbate idealisation of motherhood and how others are perceived, which has direct implications for mothers who may be feeling pressure to reach the standards of ideal motherhood. In their study which comprised 32 semi-structured interviews with first-time mothers in Australia, 6 to 8 months postpartum, mothers described feeling guilt and pressure to be better mothers than they felt they were (Hong Law et al., 2018). Addressing societal norms may aid in normalising the postpartum period and the distress that may occur within in, as would increasing culturally responsive care. These issues of adhering to societal norms, pressures to be a good mother, and feelings of inadequacies may be especially salient for women who are experiencing the additional pressures of living in a new culture (Tobin et al., 2014).

Critique of the literature on social support for postpartum women

Across different studies, it is difficult to determine what kind of support is being discussed. There are many references to the importance of social support; however, specifically which types of support are lacking or sought is not always clear (Ni and Lin, 2011; Reid and Taylor, 2015). Furthermore, much of the research suggests increasing supports by family, peers and professionals yet fails to suggest in which ways this might happen and in which ways it would be most useful. Leahy-Warren et al. (2018) describe the need for individualised support; however, how this might be achieved is unclear. While there is research which explicitly details the preferences of new mothers' suggestions which would negate the need for women to have to ask for support, such as pre-planned interventions or apps, they do not address how women would access or opt into them (Hong Law et al., 2018). Conversely, research by Prevatt and Desmarais (2018) was very specific in how to address both increased supports and barriers to help

seeking by making practical suggestions. These included the development of a post-birth plan and changing specific parental leave policy time frames and public awareness campaigns to address issues which relate to the need for support and stigmas around PPD.

While research in this area draws upon various and diverse research methodologies, which could be viewed as a strength, there are limitations within the specific studies. Much of the qualitative research uses small, homogeneous samples which are predominantly White, higher socioeconomic, educated and English speaking (Letourneau et al., 2007; Rowe et al., 2013). Quantitative research tends to include participants who are married, fluent in English, educated and of higher socioeconomic status (Leahy-Warren et al., 2012). Much of the research includes only healthy, full-term, uncomplicated births; support needs and perceptions for women who experience distressing birth or have interventions due to early- or late-term babies are typically not included as participants. Moreover, women who birth at home, presumably with support, are often not considered, despite the needs this subset may have in terms of social support, especially as their choice to homebirth may impact their visibility to health care professionals and follow-up services on offer to those who go through hospital programmes. Some of the research measured the effects of social support at 6 and 12 weeks postpartum (see, for example, Darvill et al., 2008; Leahy-Warren et al., 2012; Letourneau et al., 2007). The first 3 months after birth may not be representative of the supports a mother may receive; the baby becomes less dependent, the initial excitement of the birth, and visitors lessens and leave time has dwindled. Measuring support satisfaction and support needs well into the first year would be valuable. Many of the studies report support perceptions after minimal interactions – a once or twice administered self-report questionnaire or a once-off interview. This is despite research suggesting the need for an established, ongoing, trusted relationship in order for women to share their experiences. Support offered in the research included interventions and technology. It would be of value to consider interventions which were offered as standard opt-out options or were tailored to respond in real time. Further research into the types of devices and technologies women would enjoy using is warranted, given the current trend towards social media and applications and taking into account the possible stigma and shame that may prevent women from engaging otherwise.

By addressing many of the barriers and facilitators of support, it could be argued that although social support may aid in the alleviation of postpartum distress, it appears to be a marked experience of many women, despite the conditions of support on hand. Thus, Ussher's (2004) argument that postpartum distress is a normal function of motherhood is noteworthy.

Recommendations in the literature

Individualised home care

Recommendations for increasing social support include improving existing support such as empathetic listening by health professionals, increased home-based services, individualised care and providing community resources with local, consistent support (Dennis and Chung-Lee, 2006; Letourneau et al., 2007; Slomian et al., 2017). Individualised social support provided at the 'right time and of the right type' was highly recommended for mothers postpartum (Barkin and Wisner, 2013; Chavis, 2016; Hong Law et al., 2018; Leahy-Warren et al., 2012, 2018: 220; Ni and Lin, 2011). Across many of the studies, face-to-face care provided in the home through informal care was desired (Barnes et al., 2009; Letourneau et al., 2007; Manuel et al., 2012). Programmes with home visits coupled with phone calls were also desired (Letourneau et al., 2007). Studies by Letourneau et al. (2011) and Biggs et al. (2015) found phone calls to be an effective way to mediate shame and stigma, while providing flexibility and privacy. In a study by Biggs et al. (2015), the majority of women would have liked visits to their home in addition to phone support. A systematic review by Shaw et al. (2006) and a meta-analysis by Nievar et al. (2010) found overall, women were more satisfied with the support interventions which included home visiting programmes, that they were effective for mental health and they improved maternal behaviour. Letourneau et al. (2011) recommend future in-depth qualitative research to assess the effectiveness of both in-home and telephone support. Interventions aimed at self-care, empowerment and quality time where the mother is nurtured through individualised care such as trusted one-on-one emotional support and sensitivity around judgements and 'ideal' mothering would also be of value (Barkin and Wisner, 2013; Hong Law et al., 2018; Leahy-Warren et al., 2012). Prevatt and Desmarais's (2018) recommendation for post-birth education and support plans would fit within the need for individualised care.

Peer to peer

Peer support is the provision of emotional, appraisal and informational assistance to address a health-related issue of a stressed focal person. A peer is defined as 'someone who possesses experiential knowledge of a specific stressor or condition and similar characteristics as the potential recipient' (Dennis, 2010: 561). Arguably, emotional support may be best provided by those who have faced similar problems (Taylor, 2011). Peer, mentor or group support has been extensively shown to be effective in this way (Biggs et al., 2015; Cust, 2016; Dennis, 2010). By drawing on the skills acquired by others, coping barriers may be overcome (Taylor, 2011). Although partners and family have been

found to be relied upon most, peers provide an element of appraisal, security and self-confidence for new mothers (Darvill et al., 2010; Letourneau et al., 2007).

Findings suggest women seek role models to which they could emulate, in order to feel more confident; trusted relationships are sought (Ni and Lin, 2011; Rowe et al., 2013). Women want to share, to be heard and understood by someone they feel has been through the same situation and can offer experienced encouragement and support (Corrigan et al., 2015; Darvill et al., 2010; Leahy-Warren et al., 2012; Negron et al., 2013; Ni and Lin, 2011). Several studies supported this idea; women felt encouraged, supported and reassured by informal talking therapies, sharing similar experiences with other women and being able to air doubts, feel recognised, accepted and normal (Dennis and Chung-Lee, 2006; Hong Law et al., 2018; Ni and Lin, 2011; Rowe et al., 2013). Women explained wanting 'a mom, but not your mom' (Hong Law et al., 2018; Letourneau et al., 2007: 445). Rather than treatments from a professional, women in some studies have reported preferring talking therapies with someone 'non-judgemental' (Dennis and Chung-Lee, 2006: 323). A desire for a 'reference person' or a buddy to always have with them as a support and as someone to look out for signs of distress was expressed, as was the desire to share with both same-aged and older mothers as a way of finding company and perspective around what to expect (Hong Law et al., 2018; Slomian et al., 2017). These accounts strengthen the argument that a buffer aids in the experience of postpartum distress.

Education

Cultural awareness, public education, early intervention and an open dialogue around the postpartum period and its stressors have been flagged by a number of authors (Dennis and Chung-Lee, 2006; Goldbort, 2006; Hong Law et al., 2018; Letourneau et al., 2007; Manuel et al., 2012; Negron et al., 2013; Tobin et al., 2014), to promote disclosure of distress and increasing help seeking (Prevatt and Desmarais, 2018). Creating new avenues for support through the use of technologies such as Skype and applications for smart devices has been suggested by Hong Law et al. (2018). Increased screening of mental health and education in the form of postpartum classes held by professionals has also been suggested (Corrigan et al., 2015; Darvill et al., 2010; Letourneau et al., 2007; Prevatt and Desmarais, 2018; Slomian et al., 2017). These could incorporate topics such as expectations versus reality and mastering day-to-day tasks (Hong Law et al., 2018). Moreover, education targeting support networks, particularly men and partners could increase awareness of symptoms and risk factors (Castle et al., 2008; Hong Law et al., 2018; Rowe et al., 2013). Training for health care professionals in cultural awareness and responsive care and the intricacies around the needs of women with migrant, refugee or asylum seeking backgrounds is recommended, as well as increasing access to translators and community services (Benza and Liamputtong, 2014; Tobin et al., 2014). Campaigns including targeted verbal and printed information aimed to boost greater public awareness would address the stigma which affects many women's experience of speaking out when they are in need of support (Letourneau et al., 2007). Support groups and community health prevention initiatives, particularly interventions including other mothers, may benefit women and are frequently recommended (Dennis and Chung-Lee, 2006; Hong Law et al., 2018; Letourneau et al., 2007; Manuel et al., 2012; Razurel et al., 2011; Shaw et al., 2006; Webster et al., 2011). Finally, educating health care professionals on the importance of increased emotional support and providing a space to share and give voice to the experiences and fears around the perinatal period may help mothers to process any disappointments and incongruences between what was expected and what happened during birth (Benza and Liamputtong, 2014; Rania, 2019).

Prevention

Negron et al. (2013), Reid and Taylor (2015) and Ni and Lin (2011) recommend bolstering family and peer supports and planning for the postpartum period prior to giving birth as ways to circumvent the need to actively seek support postpartum. Addressing family leave benefits which addresses the standard guidelines and which operationalise social support as the norm is recommended (Leahy-Warren et al., 2012; Manuel et al., 2012). Interventions which incorporate planning and pre-arranged support which negate the need for women to have to ask and which encourage prevention and information from reliable and credible sources are needed (Hong Law et al., 2018; Negron et al., 2013). Providing a wider assessment of overall health in the postpartum period would be of benefit (Corrigan et al., 2015) as would continuity of professional care (Rowe et al., 2013). Shaw et al. (2006) recommend more qualitative and non-randomised controlled trials to further understand support postpartum.

Conclusion

Although it is well established that appropriately provided social support can buffer the effects of postpartum stress as well as provide practical and emotional assistance, overall, research internationally suggests that the levels and quality of social support available are largely inadequate (Letourneau et al., 2007; Negron et al., 2013; Rowe et al., 2013). Facilitators to social support such as increased home visits, interventions designed to increase educational programmes, culturally appropriate health care and communication with informal and formal support persons to normalise postpartum distress were evident in many studies with varying degrees of success in reducing postpartum isolation and

distress (Hong Law et al., 2018; Nievar et al., 2010). Despite the success of the various strategies to facilitate social support, the need for increased informal supports, individualised care, improved professional care, reassuring and compassionate health care approaches and the normalising of postpartum distress exist (Darvill et al., 2010; Hong Law et al., 2018; Leahy-Warren et al., 2018; Letourneau et al., 2007; Tobin et al., 2014). It could be inferred that in line with the research which suggests a certain degree of postpartum distress is to be expected and a normal part of transitioning to motherhood, that social support serves not to remove or prevent all stressors necessarily, but rather acts as a sounding board and buffer (Leahy-Warren et al., 2018; Ussher, 2004). Confounding these needs are the personal and societal barriers to help seeking which are presented in a number of papers across a number of cultures (Benza and Liamputtong, 2014; Letourneau et al., 2007; Migliorini et al., 2016; Prevatt and Desmarais, 2018; Tobin et al., 2014). The experience of receiving support is highly individual; the avenues through which social support may come are personal, societal and professional. This is further individualised through personal preferences and cultural norms for *which* type of support, *when* and *how* it is needed (Leahy-Warren et al., 2018). This highlights a one-size-fits-all style approach may not be effective (Chavis, 2016; Hong Law et al., 2018; Leahy-Warren et al., 2018; Ni and Lin, 2011; Small et al., 1994). If the facilitators and barriers are considered overall, despite the effectiveness of some programmes in increasing maternal satisfaction and maternal behaviours, the need for support remains not so much as a means to end suffering, but as an avenue in which the suffering can be verbalised and heard.

The evidence is inconsistent around the satisfaction of social support provided by friends, family, community and health care professionals with some research claiming each to be very effective and some claiming it insufficient and inappropriate (Corrigan et al., 2015; Dennis and Chung-Lee, 2006; Prevatt and Desmarais, 2018; Rowe et al., 2013). Much of the research indicates social support is an individualised need and the asking, the providing and the receiving of it would be more effective if it were designed and delivered according to those individual needs (Hong Law et al., 2018; Leahy-Warren et al., 2018). This may be the ideal outcome however potentially cumbersome. Thus, it might be argued women need help to recognise their own support needs and possess the skills and confidence to facilitate the receiving of this support postpartum. In contrast, health care professionals, family, friends and the community may need to increase their own awareness, repertoire and availability around identifying and providing postpartum support (Barkin and Wisner, 2013; Hong Law et al., 2018; Leahy-Warren et al., 2012; Negron et al., 2013; Razurel et al., 2011; Reid and Taylor, 2015). The increasing normalising of postpartum stress and the reduction of stigma around postpartum issues may aid in more open conversation, expectations and practises. When considering mothers in paid employment and the extended period of time postpartum stress can be experienced, there appears a need to consider the types of support which may be of particular importance to this group of women who are combining the roles of mother and paid worker. Particularly in terms of societal barriers to support seeking, the workplace is an area which may be of importance as women may be expected (by themselves and employers) to fulfil roles in the same way they were before having children not taking into account the potential need for flexibility and individualised amendments to roles and schedules.

In summary

Much of the research around postnatal support fails to distinguish the specific type of support which is provided or lacking (Reid and Taylor, 2015); however, it is evident from the literature there exists a need for increased and better facilitated functional supports overall. Some women are not feeling adequately supported and face a range of barriers to seeking support. Emotional and appraisal supports are particularly required to facilitate open discussion and for the opportunity for those experiences to be validated and heard empathetically. When family, friends and significant others are not available – and sometimes even when they are – some women seek the individualised, informal support of peers who can provide a semblance of familiarisation and understanding to what they may be experiencing, so they may begin to feel 'normal' amid the new paradigm of motherhood (Marshall and Thompson, 2014; Ussher, 2004).

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