

Mothering Our Mental Health: How Postpartum Mental Health
Impacts Children's Mental Health in Adulthood

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A thesis

submitted in partial fulfillment of the
requirements for the degree of

Master of Public Health

University of Washington

2026

Committee:

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Program Authorized to Offer Degree:

Department of Health Systems and Population Health

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Abstract

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The current study, driven by Attachment Theory, examines the previously untested relationship between postpartum maternal mental health and the mental health of children in young adulthood. To test this relationship, the study uses data from four waves of the Future of Families and Child Wellbeing Study (previously known as the Fragile Families and Child Wellbeing Study). Findings from multiple logistic regression models reveal that postpartum feelings of anxiety were associated with the child reporting feelings of anxiety as an adult; while meeting depression criteria postpartum was associated with the child meeting the same criteria in young adulthood. Additionally, mental illness measured by diagnostic criteria yielded different results than mental illness measured by reporting feelings of the foundational symptom. Further, non-Hispanic Black participants were significantly less likely to report feelings of depression and anxiety across all measures and controls; and socioeconomic status measured by relation to the poverty line was not a significant indicator. The most significant finding of this study was the effect of postpartum maternal mental health on the mental health of their children in young adulthood, a relationship which varied depending on the measurement used. This highlights the

need for mental health research and data collection to not limit operationalizations to diagnostic criteria to represent experiences with mental illness. This study contributes to scholarship by extending research of the mother-child mental health relationship into adulthood rather than limiting to childhood and adolescence and expands typical methodology by measuring anxiety and depression using both diagnostic criteria and reporting of the most traditional symptom. Now that this study has established a relationship between postpartum maternal mental health and the mental health of children as young adults, multiple avenues for further research can be pursued.

INTRODUCTION

Mental illness and distress following the birth of a child has always existed, yet it has not been considered a serious occurrence until recently, previously being dismissed as mere “baby blues”. As we come to better understand postpartum mental health, we still tend to focus on one mental illness over others – postpartum depression. Postpartum depression can manifest in persistent feelings of sadness, lack of energy and enjoyment, difficulty taking care of yourself and your baby, and more (National Health Services 2022). Though postpartum depression is more commonly discussed, postpartum anxiety is experienced at higher rates. Postpartum anxiety occurs when persistent worrying impacts one’s daily life and functioning, marked by symptoms such as feeling a loss of control and rapid heartbeat, often accompanied by a panic attack (Duszynski-Goodman 2023). About 1 in 7 women¹ experience postpartum depression, 1 in 5 women experience postpartum anxiety, and 2 in 3 people diagnosed with postpartum depression also show symptoms of postpartum anxiety (Cleveland Clinic 2022; Liu, Erdei, and Mittal 2021; Radoš, Tadinac, and Herman 2018).

¹ Reflecting already existing literature, this paper will use *women* and *females* interchangeably, referring to individuals with female genitalia, however, as an author, I recognize that this is not reflective of the difference between sex and gender – a biological feature versus a socially constructed idea. The data used in this paper does not differentiate between sex and gender among their participants, meaning any differentiation between sex and gender on my part would be an inaccurate portrayal of the research and its focus.

These disorders, however, do not solely affect mothers, impacting the wellbeing of their children in multiple dimensions. The relationship between maternal mental health² and child mental health has been established across various time points; however, experts have not extended the research to examine the impact of maternal mental health, specifically in the postpartum period, on child mental health in young adulthood. The current study utilized Attachment Theory as the foundation of its theoretical framework, identifying postpartum maternal mental health as a possible disruptor to healthy mother-child bonding and attachment formation. The current body of literature has not expanded its scope to consider the impacts of

² Though the term “maternal mental health” implies a connotation of mental health related to motherhood, the actual definition and parameters of the term, as well as related labels such as “maternal depression” and “maternal anxiety,” differ according to various organizations and disciplines. According to the United States of America’s Health Resources & Services Administration, “maternal mental health” means “a pregnant or postpartum person’s overall emotional, social, and mental well-being” (Maternal & Child Health Bureau 2024). Multiple published studies treat “maternal depression” and “maternal anxiety” as depression and anxiety experienced by mothers during whatever sample of time they are measuring, not limited to antenatal or postpartum restraints (Coles and Cage 2022; Pires et al. 2019; Engelhard, Hishinuma, and Rehuher 2022; Goodman et al. 2011; Goelman et al. 2014). For the purposes of this paper, “maternal mental health” will refer to the mental health of women, considered mothers due to being examined in relation to their children, at any point after becoming pregnant, unless otherwise specified.

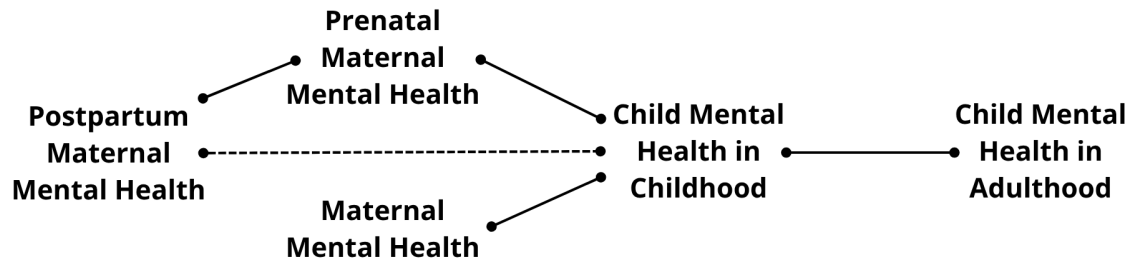
mother-child mental health on young adult wellbeing. This paper prioritizes an exploratory lens, seeking to establish the existence of this relationship through the following question: How does mothers' postpartum mental health affect the mental wellbeing of their children in young adulthood?

LITERATURE REVIEW

Status of Perinatal Mental Health Research

Perinatal mental health, referring to the mental health of an individual during pregnancy and up to one year postpartum, is extremely underfunded and under researched (O'Hara and Wisner 2020). For mental health research on a global scale, about 3.7 billion US dollars are spent annually, equal to less than 50 cents per person of the worldwide population (Woelbert et al. 2020). In the United States, about \$4.6 billion was directed to psychological research in 2022, an increase from previous years but still only 4.9% of the year's total federal research budget (Stamm, Page, and Assefa 2025). Women's health is also significantly underfunded and overlooked, with 5% of 2020's global research and development funding allocated to research on women's health, 80% of which was directed to women's cancers and the remaining 20% (1% of the entire budget) was to be used for all other women-specific health conditions ("Funding research on women's health" 2024). Taken together, our understanding of women's mental health is severely lacking compared to our understanding of men's mental health, as health research has historically prioritized the inclusion of male test subjects (Maddern and Walker 2025). Subsequently, we have more questions than answers about how mental health is impacted by components of female biology, such as sex-specific hormones, or female-specific experiences, including pregnancy and birth.

Developmental Pathway Map of the Current Literature



The dotted line represents an area of literature that is less explored.

Figure 1. Developmental Pathway Map of the Current Literature

Despite lacking resources, experts have strongly established three key relationships between: 1) maternal mental health and child mental health in childhood, 2) prenatal maternal mental health and child mental health in childhood, and 3) child mental health in both childhood and adulthood. The relationship between postpartum maternal mental health and child mental health in childhood has also been explored, though to a lesser degree. In reviewing the literature, it was helpful to map out the existence and progression of established relationships, a version of which is presented in Figure 1 as a developmental pathway map.

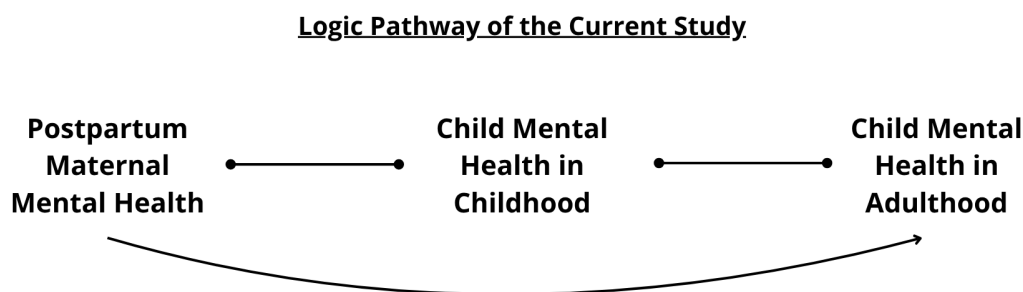


Figure 2. Logic Pathway of the Current Study

Missing from the literature was any exploration of postpartum maternal mental health and mental health of their children in adulthood. However, the previously established relationships and components of Attachment Theory suggest such a relationship should exist. In Figure 2, the logic pathway for this study includes three components: postpartum maternal mental health, child mental health in childhood, and child mental health in young adulthood. In line with the current literature (as depicted in Figure 1), the study's logic pathway presents a primary connection of postpartum maternal mental health to child mental health in childhood to child mental health in young adulthood. Given its absence from the literature, this study focuses on the direct pathway from postpartum maternal mental health to child mental health in adulthood. A review of existing, relevant literature on the relationships depicted in Figures 1 and 2 follows.

Perinatal Mental Health

Prenatal anxiety and postpartum anxiety are separate diagnoses, just as prenatal depression and postpartum depression are, although the conditions can be related. Among a sample of pregnant women in Brasil in the early 2000s, women with prenatal depression were 2.4 times more likely to present with postpartum depression than mothers who did not report

experiencing depressive symptoms during pregnancy (Faisal-Cury and Menezes 2012).

Similarly, prenatal depression was identified as a significant predictor of postpartum depression among mothers in Australia (Leigh and Milgrom 2008).

Just as depressive disorders and anxiety disorders are often co-occurrent among the general population, perinatal depression and perinatal anxiety are frequently related, even acting as predictors of each other. Both prenatal anxiety and prenatal depression have been found to increase the risk of postpartum depression, with one study specifically identifying prenatal generalized anxiety disorder independently predicting postpartum depression compared to prenatal generalized social phobia, the presence of both anxiety disorders, and the absence of anxiety disorders (Robertson et al. 2004; Lee et al. 2007; Coelho et al. 2011). Interestingly, a study found that women with prenatal anxiety were 2.6 times more likely to have postpartum depression even when controlling for prenatal depression, showing that the relationship between prenatal anxiety and postpartum depression is not simply due to the cooccurrence of prenatal anxiety and prenatal depression (Austin, Tully, and Parker 2007). Though the majority of studies examining perinatal mental health and child outcomes focus on prenatal mental health, the established relationship between prenatal and postpartum mental health allows us to examine the mentioned studies within the context of postpartum mental health and child outcomes.

Maternal Mental Health and Child Mental Health

When examining the relationship between maternal mental health and outcomes in children, researchers often look either at prenatal mental health or maternal mental health concurrent with said child outcomes. Prenatal mental health is seemingly prioritized over postpartum mental health due to the physical impact on a child when in utero, as stress often

manifests in sleeping difficulties, increased heart rate, headaches, poor appetite, and/or fast or shallow breathing, all of which can interrupt the proper growth of the fetus (Sissons 2023). Stress can also lead to high blood pressure, which can turn into chronic hypertension that may then trigger preeclampsia and possibly lead to death for both mother and child due to eclampsia and related complications (Yu et al. 2013). In addition to presenting physical threats to both mother and child, prenatal stress, and relatedly prenatal anxiety and prenatal depression, can pose psychological and cognitive threats to children which do not manifest for years. Prenatal anxiety is associated with poor child behavior and psychopathology, such as behavior/emotional problems, Attention-Deficit/Hyperactivity Disorder symptoms, externalizing problems, and self-reported anxiety, a relationship that is observed in multiple age groups (3.9 years, 6.75 years, and seven years) (Brand and Brennan 2009).

The association between postpartum depression and depression in children is moderated by maternal educational attainment, but this is not a moderator for the relationship with prenatal depression; suggesting that while prenatal depression can be indicative of postpartum depression and thus, may both be related to child mental health, the extent of that effect may vary by timing (Stein et al. 2014). When treated for a moderating effect of maternal childhood abuse, child mental health problems were high regardless of prenatal depression if their mother experienced abuse as a child. Conversely, for the children of non-abused mothers, prenatal depression significantly predicted behavioral and emotional problems (Chen et al. 2023).

The postpartum period is critical for mother-child bonding, yet mothers experiencing mental illness outside of that postpartum period can still impact the mental health of their child, whether occurring directly after the one-year postpartum range or many years later. Maternal depression is significantly related to poor child mental health, across multiple subcategories of

mental health such as internalizing, externalizing, and general psychopathology (Goodman et al. 2011). The effect of maternal depression on child mental health is moderated by the quality of childcare, such that children in low-quality childcare who are exposed to maternal depression and anger exhibit more behavioral problems and worse prosocial functioning (Goelman et al. 2014). Opposingly, children in high-quality childcare did not display poor mental health in relation to poor maternal mental health (Goelman et al. 2014). Examining older children, specifically adolescents ages 14 to 19, maternal anxiety which was measured at the same time as child mental health was associated with higher levels of adolescent depression (Coles and Cage 2022). Further, maternal depression was associated with higher levels of adolescent anxiety (Coles and Cage 2022). Conducting evaluations in the postpartum period, when the child was 2-3 years old, and again at 4-5 years old, researchers have found that the longer a child is exposed to maternal depression, the greater the likelihood the child will experience mental health problems (Pires et al. 2020). Effective treatment of maternal depression is associated with a decrease in child mental health symptoms (Engelhard et al. 2022). Thus, if a child does exhibit mental health symptoms, effective treatment should extend to the mother as well, as maternal depression hinders adequate child mental health treatment (Engelhard et al. 2022). Exposure to maternal mental illness and distress throughout childhood and adolescence puts children at risk of experiencing mental disorders themselves, which do not simply disappear once they reach adulthood.

THEORETICAL FRAMEWORK

As shown in the review, a relationship between mothers' mental health and the mental health of their children has been established, the direction, strength, and presence of the

relationship vary according to the time of exposure, stage of child development, and disorders being considered. The sole consistent aspect of the field at present is the actors of the relationship themselves, mother and child. Attachment Theory and its implications provide a life-course lens to examine the two-decade-long development of this relationship.

While bond formation can occur during pregnancy, the relationship, in its full effect, begins at birth. The first year following childbirth is critical for attachment formation between mother and child, foundational to the child's mental, social, and cognitive development (Cassidy, Jones, and Shaver 2013; Alhusen, Hayat, and Gross 2013; McNamara, Townsend, and Herbert 2019). Interruptions to healthy, secure attachment formation, including decreased bonding due to postpartum depression and postpartum anxiety, can negatively impact the child's future relationships, even beyond their mother. (McNamara et al. 2019; Cassidy et al. 2013). The relationships complicated by insecure attachment can be familial, platonic, professional, and/or romantic, potentially leading to negative outcomes in various aspects of life. Difficulty forming and maintaining healthy relationships, particularly in adulthood, can lead to "failure" in dating, financial insecurity, and lack of establishment within a community (Sagone et al. 2023; Scrima et al. 2015; Jedynak 2024).

Complications such as these, as well as the insecure attachment itself, can lead to feelings of loneliness, low self-worth, and suicidality (Akdoğan 2017; Cogan et al. 2025). Attachment theory has also explained the link between anxiety and depression as comorbidities, which often appear together during the perinatal period (Rajkumar 2022; Radoš et al. 2018). However, consensus has not established a causal relationship between postpartum maternal mental illness and insecure attachment of the child.

As earlier reviewed, the literature has established a relationship between the mental health of mothers and the mental health of their children at various points of childhood and adolescence, yet foregone consideration of the children's mental health into adulthood. Other research exploring Attachment Theory utilized attachment styles as the predictor or outcome in adult health studies (Pietromonaco and Beck 2019; Ahrens, Ciechanowski, and Katon 2012; Karveli et al. 2023), failing to consider attachment development instead as the mechanism behind a relationship including adult health. The current study bridges these gaps by examining whether postpartum maternal mental health influences children's mental health in adulthood, given the pathway Attachment Theory provides to understand postpartum maternal mental health and its impact on attachment development.



Figure 3. Conceptual Model

Drawing on Figure 2, the conceptual model (Figure 3), illustrates the causal mechanisms of the relationship between postpartum maternal mental health and child mental health in young adulthood. I suggest this relationship operates through three components of Attachment Theory: bonding, attachment style, and mother-child relationship. If postpartum maternal mental health interrupts health mother-child bonding, fractured bonding will promote development of an insecure attachment style, which will have negative effects on the mother-child relationship, as well as the child's other relationships, which will negatively affect the child's mental health as a young adult. Additionally, I suggest the social determinants of health and structural determinants of health, as shown in Figure 3, function as moderators. Unique from typical conceptual models, there is an absence of arrows or other signifiers assigning covariates to specific timepoints or places of occurrence. This is an intentional choice, as the relationship covers more than 20 years of time and all covariates may interact with the relationship multiple times and in various directionalities. Though Figure 3 depicts a causal model, data limitations restrict the ability to establish causation, and all conclusions will be regarding correlation and association.

This conceptual model provides structure for this exploratory study, in which I question: How does mothers' postpartum mental health affect the mental wellbeing of their children in young adulthood? To establish this potential relationship, I test the following hypotheses:

H1: I hypothesize that postpartum maternal mental health will be positively associated with child mental health in adulthood, such that a mother experiencing a specific mental illness during the postpartum period will increase her child's chance of experiencing the same mental illness at approximately 22-years-old.

H2: Diagnostic criteria for conditions such as anxiety and depression include feelings of these conditions. However, the criteria also include more heavily stigmatized topics such as

suicidality. As a result, I expect mental illness as measured by all diagnostic criteria and mental illness as measured by limiting to the most traditional symptom will yield different results.

H3: Due to additional cultural stigma and the use of non-culturally informed data collection, I anticipate that non-Hispanic Black participants will be significantly less likely to report anxiety and depression.

H4: Lastly, I theorize that socioeconomic status, as measured by relation to the poverty line, will act as a significant control variable.

I use data from the Future of Families and Child Wellbeing Study (FFCWS, previously known as the Fragile Families and Child Wellbeing Study) (McLanahan et al. 2026) and logistic regression to consider this research question and hypotheses.

DATA AND MEASURES

Data

The FFCWS is a longitudinal, stratified sample of 4898 children born in large United States cities (population over 200,000) between 1998 and 2000 (McLanahan et al. 2026). Births to unmarried women were oversampled by a ratio of 3 to 1, resulting in an over-sampling of Black, Hispanic, and low-income families. Seven waves of the study are currently released. This study analyzes data from the first (collected from 1998 to 2000; at birth), second (1999-2001; at age 1³), fifth (2007-10; at age 9), and seventh (2020-24; at age 22) waves, as they are the only waves with data applicable to postpartum maternal mental health, child mental health in adulthood, and the covariates included in the study. These data were collected via interviews

³ These are the target ages for data collection and are approximate for each participant.

with mothers shortly after birth, follow-up interviews conducted with the mothers when the children were approximately one year old, and follow-up interviews conducted with the children when approximately 9 and 22-years-old, respectively. It is important to note that two of the waves used here are over twenty years old, which limits their contemporary application and generalization, particularly when examining a continually developing field such as mental health.

Table 1: Descriptive Statistics (N = 1450)

	Mean/Prop. (SD)	n
Meets Constructed Anxiety Criteria	0.14 (.34)	1450
Meets Constructed Depression Criteria (Conservative)	0.29 (.46)	1450
Meets Constructed Depression Criteria (Liberal)	0.36 (.48)	1450
Felt anxious/tense/worried for at least a month in the past year	0.26 (.44)	1450
Felt depressed/sad/blue for at least two weeks in a row in the past year	0.41 (.49)	1450
Race/Ethnicity		1450
White, non-Hispanic	.19	
Black, non-Hispanic	.49	
Hispanic/Latino	.25	
Other, non-Hispanic	.03	
Multi-racial, non-Hispanic	.03	
Percentage of Poverty Line		1450
0-99%	.38	
100-199%	.24	
200%+	.38	
Educational Attainment		1450
Less than High School Diploma	.11	
High School Diploma or Equivalent	.39	
Some College or Technical/Trade School	.41	
College Degree or Graduate School	.09	
Worked for Pay in the Past Week	.63	1450
Received Social Welfare Aid in the Past Year	.43	1450

Sample

Due to the longitudinal design of the data, the analytic sample was restricted to mother-child pairings (identified under the same family ID) who had valid answers to all measures

included in the analysis (n=1,450). Considering the sensitive nature of the study topic, the overrepresentation of marginalized individuals, and the fairly small sample size, this listwise deletion approach was more appropriate than using imputed data.

Measures

Dependent Variables.

Though other mental health conditions are included in FFCWS interviews, anxiety and depression are explored to the most depth. Multiple dependent variables are used to operationalize these two concepts and are all drawn from wave 7. To capture anxiety, I first use FFCWS's constructed variable measuring if respondents met *anxious criteria* in the last 12 months. The FFCWS used questions and diagnostic criteria from the Composite International Diagnostic Interview - Short Form (CIDI-SF). Scoring for this constructed variable followed CIDI-SF's requirements, which align survey items with DSM diagnostic criteria. An additional measure of anxiety was included in my models representing experiencing *feelings of anxiety* due to issues with other constructs, such as: lack of cultural sensitivity and being trauma-informed and infrequent revisions to ensure contemporary accuracy. This measure was drawn from children's self-reports of having a month or longer period in the past year where they felt tense or anxious.

The dependent variables used to capture depression follow a similar pattern, representing *criteria* and *feelings of depression*. For FFCWS's constructed variables measuring if respondents met depression criteria, two operationalizations were included representing two levels of symptom manifestation in the previous 12 months: conservative and liberal. Once again, the questions and diagnostic criteria for depression came from the CIDI-SF. The conservative scale

represents people whose depressive symptoms were present “most of the day,” while the liberal scale counts individuals who report depressive symptoms present for “at least half the day”. As with anxiety, children’s self-reports of feeling depressed, sad, or blue for at least two weeks in a row at any time in the past year was included in the analysis.

For the variables of feeling anxiety and depression, responses were recorded as “1” representing “Yes” and “2” representing “No”. The depression variable included as additional recorded response option of “3”, indicating “No, on antidepressants”. I recoded the data into individual binary variables for both, wherein those who report feeling anxious/tense or depressed/sad/blue are coded as “1”, and those who report no such experiences are coded as “0.” Those who reported taking antidepressants when asked about feelings of depression were coded as “1”, as their prescription demonstrates a previous, if not current, experience with depression.

Independent Variable.

The independent variables are identical to the dependent variables, yet capturing mothers’ mental health rather than children’s. Just as I had two outcome variables measuring anxiety and three measuring depression in children, I measure anxiety and depression through two and three variables about mothers, respectively. For the variable reporting *mothers’ feelings of depression*, mothers on antidepressants were grouped with those who reported feeling depressed/sad/blue, as mirrored from the children’s variable. Maternal mental health questions were included in the second wave of data collection, asking mothers about their experiences over the past approximate 12 months since birth. While this encompasses the full postpartum period, it does create the possibility of recall bias among mothers, especially if they only experienced postpartum mental illness soon after birth.

Control Variables.

A variety of control variables are included in the models. Analysis of anxiety and depression use the same control variables across all models. First, I include the child's race/ethnicity, percentage of the poverty line, and educational attainment, all captured in wave 7. The *race/ethnicity* variable represents the children's racial and ethnic identities as they report them in the seventh wave, not considering identities, whether matching or different, they reported during wave five. This demographic was coded as a categorical variable with five categories: white, non-Hispanic; Black, non-Hispanic; Hispanic/Latino; other only, non-Hispanic; and multiracial, non-Hispanic. This mimics the categories constructed by FFCWS rather than the races asked about in the interviews: white; Black or African American; Asian or Pacific Islander; Native American or Alaskan Native; and other, with Hispanic being a separate question. *Household socioeconomic status* (SES) is collected as a categorical variable with five categories representing the ratio of the child's total household income to the official poverty threshold: less than 50%, 50-100%, 100-199%, 200-299%, and 300%+. For instance, a participant's response recorded as 100-199% has an income which ranged from meeting at or exceeding to 99% over the poverty line. These categories were collapsed into three response levels to ensure sufficient variability levels to perform analysis: 0-99%, 100-199%, and 200%+. *Educational attainment* is a categorical variable with the following five categories: less than high school diploma, high school diploma or equivalent, some college or technical/trade school, and college degree or graduate school, and other, however "other" did not have any responses and was dropped.

The second models include the previous three controls as well as the child's sex and experience of parental abuse. *Sex* is a bivariate variable coded "1" for female and "0" for male

and collected in wave 1; the sample does not include any participants who self-identify as intersex. *Parental abuse* is captured using children's reports of abusive behaviors during the fifth wave, at age 9. Though the sixth wave collected information on abusive parental behavior, the questions asked about abuse at the hands of one parental figure (i.e. mother, father, or primary caregiver), while the fifth wave survey included separate questions about abusive behavior from three parental figures: mother, father, and social dad. This variable includes physical abuse, such as being spanked or hit, and verbal abuse, such as being shouted, yelled, screamed, or cursed at. It is important to note that the interview questions did not use the verbiage of "abuse", and thus it is unknown if the study participants would personally categorize their experiences as abuse or not.

The third and final models include the previous five controls in addition to the child's employment status and recent use of social welfare services, both of which were collected during the seventh wave. *Employment status* is a binary variable where those who have worked for pay in the past week are coded as "1" and those who have not worked for pay in the past week are coded as "2", I recoded this to a bivariate variable in which "1" is yes and "0" is no. The final covariate captured any use of *social welfare services* in the past year by the child or anyone in their household; this was originally coded in 5 separate binary variables where 1=yes and 2=no. Welfare services, in the context of this constructed binary variable, includes five public aid programming categories: Temporary Assistance for Needy Families (TANF) or general assistance, unemployment insurance or worker's compensation, Supplemental Nutritional Assistance Program (SNAP) or Electronic Benefits Transfer (EBT), Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI), and cash aid. Participants were coded as having received social welfare aid if they reported receiving any of the programs

previously listed (e.g., someone would be coded as “1” if they reported receiving SNAP but no other aid).

METHOD

The purpose of this analysis was to examine the impact of a mother’s postpartum mental health on the likelihood of their child experiencing similar mental health problems at approximately 22 years old and how this fluctuates in light of a limited number of sociodemographic characteristics. As the study is examining health risks of children given the health status of their mother, odds ratios are most appropriate to understand this relationship, thus logistic regression was chosen as the analytic method. Due to data limitations, only associations can be examined, not causal effects.

RESULTS

Descriptive Findings

Nearly half of the children self-identified as non-Hispanic Black (49%), followed by Hispanic/Latino (25%), and non-Hispanic white (19%), with non-Hispanic other and non-Hispanic multiracial each making up 3% of the sample, as reflected in Table 1. The sample is fairly vast in its representation of SES, 38% of the children report an income 0-99% of the poverty line, 24% have an income between 100 and 199% of the poverty line, and the final 38% report their income as at or above 200% of the poverty line. Education appears to be highly prioritized among the sample population, as 39% of the respondents attained a high school diploma or equivalent and 41% report completing some college or technical/trade school. With wave seven surveys representing respondents at approximately age 22, it is likely that these

statistics do not fully depict respondents' commitment to education as it does not differentiate between currently being in college and having taken some college classes before withdrawing. The majority of the sample worked for pay in the past week (63%) and 43% reported that they or someone in their household received social welfare aid in the past year. 14% of respondents met the constructed anxiety criteria, however, 26% reported feeling anxious, tense, and/or worried for at least a month in the past year. 29% of the sample met the conservative constructed depression criteria, while 36% met the liberal variation of the criteria. Symptom wise, 41% of respondents reported that they felt depressed, sad, and/or blue for at least two weeks in a row in the past year.

Anxiety

The first regression results, predicting meeting the constructed anxiety criteria (Table 2) stand apart from the other regression predictions, finding considerably less significant associated factors across all model levels. Biological/genetic demographic features (i.e. race/ethnicity and sex) held almost all significant associations. The sole remaining significant covariate was SES as measured by use of welfare aids. However, SES operationalized using relation to the poverty line and employment status held no significant bearing on the risk association. Respondents' risk of meeting criteria is not found to be correlated with their mother meeting the same criteria during the postpartum period.

Race/ethnicity was associated with a significant decrease in risk of meeting criteria – but only for non-Hispanic Black respondents. In Model 1, non-Hispanic Black respondents were correlated with being 55% less likely to meet the anxiety criteria than non-Hispanic white respondents ($p < 0.001$). That correlation, however, changed value in Model 2, respondents now 57% less likely to meet criteria ($p < 0.001$). The associated risk decreased even more in Model 3

Table 2: Logistic Regression Predicting Meeting Anxiety Criteria

	Model 1 OR (CI)	Model 2 OR (CI)	Model 3 OR (CI)
Mother Met Anxiety Criteria One Year Postpartum	1.05 (0.43 - 2.55)	1.11 (0.45 - 2.70)	1.10 (0.45 - 2.69)
Race/Ethnicity (vs. White, non-Hispanic)			
Black, non-Hispanic	0.45*** (0.30 - 0.67)	0.43*** (0.29 - 0.65)	0.37*** (0.24 - 0.56)
Hispanic/Latino	0.79 (0.52 - 1.20)	0.77 (0.51 - 1.18)	0.72 (0.47 - 1.10)
Other, non-Hispanic	0.51 (0.19 - 1.37)	0.56 (0.21 - 1.52)	0.52 (0.19 - 1.41)
Multi-racial, non-Hispanic	1.29 (0.63 - 2.66)	1.40 (0.68 - 2.92)	1.28 (0.61 - 2.68)
Percentage of Poverty Line (vs. 0-99%)			
100-199%	1.03 (0.68 - 1.55)	1.08 (0.72 - 1.64)	1.11 (0.73 - 1.69)
200%+	0.90 (0.61 - 1.31)	0.97 (0.66 - 1.42)	1.03 (0.69 - 1.53)
Educational Attainment (vs. Less than High School Diploma)			
High School Diploma or Equivalent	0.94 (0.53 - 1.67)	0.90 (0.51 - 1.61)	0.97 (0.54 - 1.73)
Some College or Technical/Trade School	1.60 (0.91 - 2.81)	1.42 (0.80 - 2.53)	1.56 (0.87 - 2.78)
College Degree or Graduate School	0.75 (0.34 - 1.65)	0.62 (0.28 - 1.37)	0.71 (0.32 - 1.59)
Female		1.84*** (1.34 - 2.54)	1.74*** (1.26 - 2.40)
Reported Parental Abuse at Age 9		1.54 (0.35 - 6.73)	1.72 (0.39 - 7.61)
Worked for Pay in the Past Week			1.03 (0.74 - 1.43)
Received Social Welfare Aid in the Past Year			1.95*** (1.40 - 2.70)
Observations	1,450	1,450	1,450

Notes: n=1450. Results are presented via odds ratios and confidence intervals. Data is not imputed. *** p<0.001, ** p<0.01, * p<0.05, + p<0.1

with all the covariates included, non-Hispanic Black children then 63% less likely to meet the criteria compared to non-Hispanic white children (p<0.001). Sex held a predominantly

significant association, in Model 2, daughters were 84% more likely to meet anxiety criteria than sons ($p < 0.001$). The strength of the correlation only minorly changed with the addition of SES covariates in Model 3, as the likelihood of women meeting criteria over men dropped to 74%, yet this still held a highly significant association ($p < 0.001$). In the final model, receiving social welfare aid was significantly associated with meeting anxiety criteria, chances being 95% higher than those who did not report receiving aid ($p < 0.001$).

Feelings of Anxiety

Anxiety as measured by reporting feeling anxious, tense, and/or worried for at least a month in the past year yielded considerably different results (Table 3). Though maternal feelings of anxiety, much like mothers meeting anxiety criteria, was insignificant in Model 1, that facet of postpartum mental health was marginally significant in Models 2 and 3. Race/ethnicity continued to only be consistently significant for non-Hispanic Black respondents, however, non-Hispanic multiracial respondents held a marginally significant relationship with feelings of anxiety in one of the models. Some college or technical/trade school was associated with an increased risk of feelings of anxiety, as was holding a college degree or being in graduate school, however the latter's significance was marginal. Sex was once again a significant predictor of feelings of anxiety. Social welfare aid was also correlated with a significant increase in risk.

In Model 2, having a mother who reported feelings of anxiety postpartum was associated with a 34% increased risk of reporting feelings of anxiety yourself ($p < 0.1$). This correlation decreased slightly in M3 to 33% ($p < 0.1$). The correlation strength between feelings of anxiety and a race/ethnicity of non-Hispanic Black changed slightly with each addition of covariates. Non-Hispanic Black participants were 40% less likely to report feelings of anxiety compared to

Table 3: Logistic Regression Predicting Reports of Feelings of Anxiety

	Model 1	Model 2	Model 3
	OR (CI)	OR (CI)	OR (CI)
Mother Reported Anxiety Symptoms for at least a Month Postpartum	1.31 (0.95 - 1.82)	1.34+ (0.96 - 1.85)	1.33+ (0.96 - 1.85)
Race/Ethnicity (vs. White, non-Hispanic)			
Black, non-Hispanic	0.60** (0.43 - 0.83)	0.59** (0.43 - 0.82)	0.51*** (0.36 - 0.71)
Hispanic/Latino	0.95 (0.67 - 1.35)	0.94 (0.66 - 1.33)	0.88 (0.62 - 1.25)
Other, non-Hispanic	0.87 (0.44 - 1.75)	0.95 (0.47 - 1.91)	0.91 (0.45 - 1.83)
Multi-racial, non-Hispanic	1.61 (0.86 - 3.00)	1.71+ (0.91 - 3.21)	1.60 (0.85 - 3.02)
Percentage of Poverty Line (vs. 0-99%)			
100-199%	1.04 (0.75 - 1.44)	1.08 (0.78 - 1.50)	1.09 (0.78 - 1.52)
200%+	1.03 (0.76 - 1.38)	1.09 (0.81 - 1.47)	1.11 (0.82 - 1.51)
Educational Attainment (vs. Less than High School Diploma)			
High School Diploma or Equivalent	1.20 (0.76 - 1.89)	1.17 (0.74 - 1.85)	1.23 (0.77 - 1.96)
Some College or Technical/Trade School	1.77* (1.12 - 2.80)	1.64* (1.03 - 2.60)	1.76* (1.10 - 2.82)
College Degree or Graduate School	1.76+ (1.00 - 3.10)	1.53 (0.86 - 2.71)	1.70+ (0.95 - 3.05)
Female		1.55*** (1.21 - 1.98)	1.48** (1.15 - 1.90)
Reported Parental Abuse at Age 9		0.93 (0.36 - 2.42)	1.01 (0.39 - 2.65)
Worked for Pay in the Past Week			1.16 (0.89 - 1.51)
Received Social Welfare Aid in the Past Year			1.76*** (1.36 - 2.27)
Observations	1,450	1,450	1,450

Notes: n=1450. Results are presented via odds ratios and confidence intervals. Data is not imputed. *** p<0.001,

** p<0.01, * p<0.05, + p<0.1

non-Hispanic white participants in Model 1 (p<0.01). In Model 2, non-Hispanic Black

respondents were 41% less likely than non-Hispanic white respondents in reporting feelings of

anxiety ($p < 0.01$). The consideration of extended SES factors in Model 3 affected the strengths of both the correlation and the significance, as non-Hispanic Black children were 49% less likely to report feelings of anxiety than non-Hispanic children ($p < 0.001$). A non-Hispanic multiracial identity was correlated with a 71% stronger likelihood of reporting feelings of anxiety than a non-Hispanic white identity, however this relationship was only significant, and marginally significant at that, in Model 2 ($p < 0.1$). Some college or technical/trade school was associated with increased chances of reporting feelings of anxiety, being 77%, 64%, and 76% more likely to report feelings of anxiety than those with less than a high school diploma in Models 1, 2, and 3, respectively ($p < 0.05$; $p < 0.05$; $p < 0.05$). The correlation between holding a college degree or being in graduate school and reporting feelings of anxiety was marginally significant; in Model 1, participants with the highest educational achievement were 76% more likely to report feelings of anxiety compared to those with less than a high school diploma ($p < 0.1$), whereas the former participants were 70% more likely to report feelings of anxiety compared to the latter participants in Model 3 ($p < 0.1$). Daughters were significantly associated with an increased likelihood of reporting feelings of anxiety, with women being 55% more likely than men in Model 2 ($p < 0.001$) and 48% more likely in Model 3 ($p < 0.01$). Finally, receiving social welfare aid in the past year was associated with a 76% increase in reporting feelings of anxiety ($p < 0.001$).

Depression

For depression, the criteria level is the same for mother and child. In other words, all models predicting meeting conservative depression criteria are considering mothers meeting

Table 4: Logistic Regression Predicting Meeting Conservative Depression Criteria

	Model 1	Model 2	Model 3
	OR (CI)	OR (CI)	OR (CI)
Mother Met Conservative Depression Criteria One Year Postpartum	1.28	1.34	1.35+
	(0.91 - 1.81)	(0.94 - 1.91)	(0.95 - 1.92)
Race/Ethnicity (vs. White, non-Hispanic)			
Black, non-Hispanic	0.52***	0.50***	0.47***
	(0.38 - 0.71)	(0.37 - 0.69)	(0.34 - 0.64)
Hispanic/Latino	0.88	0.86	0.83
	(0.63 - 1.22)	(0.61 - 1.20)	(0.59 - 1.16)
Other, non-Hispanic	0.66	0.74	0.73
	(0.33 - 1.32)	(0.37 - 1.48)	(0.36 - 1.46)
Multi-racial, non-Hispanic	0.76	0.83	0.81
	(0.40 - 1.45)	(0.43 - 1.60)	(0.42 - 1.56)
Percentage of Poverty Line (vs. 0-99%)			
100-199%	0.93	0.97	0.96
	(0.68 - 1.27)	(0.71 - 1.34)	(0.70 - 1.32)
200%+	1.06	1.16	1.14
	(0.80 - 1.41)	(0.87 - 1.55)	(0.85 - 1.53)
Educational Attainment (vs. Less than High School Diploma)			
High School Diploma or Equivalent	1.73*	1.68*	1.70*
	(1.10 - 2.73)	(1.06 - 2.66)	(1.07 - 2.70)
Some College or Technical/Trade School	2.13**	1.87**	1.92**
	(1.35 - 3.37)	(1.17 - 2.98)	(1.20 - 3.07)
College Degree or Graduate School	2.08*	1.66+	1.73+
	(1.19 - 3.65)	(0.94 - 2.95)	(0.97 - 3.08)
Female		2.01***	1.97***
		(1.58 - 2.56)	(1.55 - 2.51)
Reported Parental Abuse at Age 9		2.92+	3.07+
		(0.85 - 10.1)	(0.88 - 10.7)
Worked for Pay in the Past Week			1.22
			(0.95 - 1.58)
Received Social Welfare Aid in the Past Year			1.31*
			(1.02 - 1.68)
Observations	1,450	1,450	1,450

Notes: n=1450. Results are presented via odds ratios and confidence intervals. Data is not imputed. *** p<0.001, ** p<0.01, * p<0.05, + p<0.1

conservative criteria one year postpartum while all models predicting meeting liberal depression criteria are considering mothers meeting liberal criteria one year postpartum.

Conservative Criteria.

Examining associated risk of meeting conservative depression criteria (Table 4), children with mothers who met the same criteria are more likely to meet the criteria themselves, however the significance of this correlation is marginal. Similar to the risk of meeting the anxiety criteria, non-Hispanic Black respondents are the only respondents with a risk significantly different than that of non-Hispanic white respondents. All educational attainment levels were associated with a higher likelihood of meeting criteria compared to less than a high school diploma, though the strengths of correlation and significance varied substantially. The association between sex and meeting criteria was again strongly significant, and the strength of the association was higher than or equivalent to any other mental health measure's association with sex. Conservative depression criteria is the only measure that had a significant association with parental abuse; the association was considerably strong, though the significance was marginal. Social welfare aid was again associated with an increased likelihood of meeting the criteria, though the strength of the association was weaker than the association in all model levels of both anxiety measures' predictions.

The association between mothers meeting conservative depression criteria and children meeting conservative depression criteria was insignificant until Model 3, in which having a mother who met criteria was associated with a 35% increase in risk, though the significance of this association was marginal ($p < 0.1$). Non-Hispanic Black participants were strongly associated with being 48% less likely to meet the criteria in Model 1 ($p < 0.001$), 50% less likely in Model 2 ($p < 0.001$), and 53% less likely in Model 3 ($p < 0.001$). In Model 1, respondents with a high school diploma or equivalent were associated with a 73% higher likelihood to meet criteria than respondents with less than a high school diploma ($p < 0.05$). Including sex and parental abuse as

covariates, the strength of the correlation dropped to 68% ($p < 0.05$), however the correlation strength then increased to 70% when considering additional SES factors ($p < 0.05$). Among educational attainment, the association between completing some college or technical/trade school and meeting criteria had the strongest significance; in Model 1, children with some college or technical/trade school were 113% more likely to meet criteria compared to those with less than a high school diploma ($p < 0.01$). In the following model, college or technical/trade school was associated with an 87% increase in likelihood ($p < 0.01$), and the association rose back to a 92% increase in the final model ($p < 0.01$). Reaching a college degree or graduate school was associated with a 108% increase in likelihood of meeting the criteria in the first model ($p < 0.05$). The significance of this association was marginal in Models 2 and 3, however, with increased likelihoods of 66% and 73%, respectively ($p < 0.1$; $p < 0.1$). Reporting paternal abuse was associated with being nearly 3 times more likely to meet criteria, compared to those who did not report abuse ($p < 0.1$). Adding the final SES variables, the association increased, respondents who reported abuse were more than 3 times more likely to meet criteria ($p < 0.1$). Respondents who were social welfare aid recipients were 31% more likely to meet criteria ($p < 0.05$).

Liberal Criteria.

The relationship between mothers meeting liberal depression criteria and children meeting the same criteria is the only relationship of the current study that is significantly correlated across all three models. Race/ethnicity was statistically significant only for those who are non-Hispanic Black, who were considerably less likely to meet the criteria compared to non-Hispanic whites. Educational attainment was a significant predictor across all levels of

Table 5: Logistic Regression Predicting Meeting Liberal Depression Criteria

	Model 1 OR (CI)	Model 2 OR (CI)	Model 3 OR (CI)
Mother Met Liberal Depression Criteria One Year Postpartum	1.32+ (0.98 - 1.78)	1.40* (1.03 - 1.89)	1.40* (1.03 - 1.90)
Race/Ethnicity (vs. White, non-Hispanic)			
Black, non-Hispanic	0.57*** (0.42 - 0.76)	0.54*** (0.40 - 0.73)	0.51*** (0.37 - 0.69)
Hispanic/Latino	0.91 (0.66 - 1.25)	0.89 (0.64 - 1.23)	0.86 (0.62 - 1.20)
Other, non-Hispanic	0.75 (0.39 - 1.42)	0.83 (0.43 - 1.60)	0.82 (0.42 - 1.57)
Multi-racial, non-Hispanic	0.77 (0.42 - 1.45)	0.84 (0.45 - 1.59)	0.82 (0.44 - 1.56)
Percentage of Poverty Line (vs. 0-99%)			
100-199%	0.89 (0.66 - 1.19)	0.93 (0.69 - 1.26)	0.93 (0.69 - 1.25)
200%+	0.94 (0.72 - 1.23)	1.03 (0.79 - 1.36)	1.02 (0.77 - 1.35)
Educational Attainment (vs. Less than High School Diploma)			
High School Diploma or Equivalent	1.50* (1.00 - 2.25)	1.45+ (0.96 - 2.19)	1.47+ (0.97 - 2.22)
Some College or Technical/Trade School	1.91** (1.27 - 2.87)	1.68* (1.10 - 2.55)	1.72* (1.13 - 2.63)
College Degree or Graduate School	1.81* (1.08 - 3.04)	1.45 (0.86 - 2.46)	1.51 (0.89 - 2.57)
Female		1.99*** (1.59 - 2.50)	1.96*** (1.56 - 2.46)
Reported Parental Abuse at Age 9		2.13 (0.77 - 5.89)	2.22 (0.80 - 6.16)
Worked for Pay in the Past Week			1.16 (0.91 - 1.48)
Received Social Welfare Aid in the Past Year			1.28* (1.01 - 1.62)
Observations	1,450	1,450	1,450

Notes: n=1450. Results are presented via odds ratios and confidence intervals. Data is not imputed. *** p<0.001, ** p<0.01, * p<0.05, + p<0.1

education, with some college or technical/trade school having the highest associated risk of meeting the criteria. The association between sex and meeting liberal depression criteria was

strongly significant, with women being almost 2 times more likely than men to meet said criteria. Participants who reported receiving social welfare aid in the past year were also significantly more likely to meet the criteria than those who reported receiving no aid.

In Model 1, children whose mother met liberal depression criteria postpartum were 32% more likely to meet the criteria than children whose mother did not meet the criteria, though the association was marginally significant ($p < 0.1$). The two following models, however, both predicted that children were 40% more likely to meet the criteria if their mother met the same criteria, the significance of the association strengthening as well ($p < 0.05$; $p < 0.05$). A racial/ethnic identity of non-Hispanic Black was associated with a decreased likelihood of meeting the criteria, compared to a non-Hispanic white identity; however, the gap widened as the former were 43%, 46%, and 49% less likely to meet the criteria in Models 1, 2, and 3, respectively ($p < 0.001$; $p < 0.001$; $p < 0.001$). Participants with a high school diploma or equivalent were associated with being 50% more likely than participants with less than a high school diploma to meet criteria in the first model ($p < 0.05$). The strength of the correlation weakened to 45% more likely in Model 2, then slightly strengthened again in Model 3 with a 47% higher risk, though the significance of these associations were both marginal ($p < 0.1$; $p < 0.1$). In the first model, children who completed some college or technical/trade school were correlated with a 91% increase in likelihood of meeting criteria compared to children who completed less than a high school diploma ($p < 0.01$). Some college or technical/trade school was associated with a 68% higher chance in Model 2 ($p < 0.05$) and a 72% increase from the likelihood of less than a high school diploma in Model 2 ($p < 0.05$). Attaining a college degree or attending graduate school was significantly associated with being 81% more likely than less than a high school diploma in meeting criteria, however this relationship was only significant in Model 1 ($p < 0.05$). Daughters

were 99% more likely to meet criteria than sons in Model 1 ($p < 0.001$), the association strength only decreasing slightly in Model 3 to 96% more likely ($p < 0.001$). Participants who were recipients of social welfare aid were associated with a 28% higher risk of meeting criteria compared to non-recipients ($p < 0.05$).

Feelings of Depression

Depression operationalized as feeling depressed, sad, or blue for at least two weeks in a row at any time in the past year generated starkly different predictions, maternal postpartum depression symptoms having no significant association with children's likelihood of reporting the same symptoms. Non-Hispanic Black participants were strongly correlated with a smaller risk of reporting feeling of depression compared to non-Hispanic white participants. Non-Hispanic other respondents were the only racial/ethnic group to be correlated with a decreased risk of reporting feelings of depression, though the correlation's significance was much weaker than that of non-Hispanic Black respondents. Participants with an income at least 200% over the poverty line are correlated with a decreased likelihood of reporting feelings of depression compared to those whose income is 0-99% of the poverty line; this is the only measure across all models with a significant difference in associated risk according to SES, however its significance is marginal. The only level of educational attainment that is consistently associated with a higher likelihood of reporting feelings of depression than those with less than a high school diploma is some college or technical/trade school, though a college degree or graduate school is correlated with an increased likelihood of reporting feelings of depression, though the relationship is only significant in Model 1. Daughters were again almost 2 times more likely to report feelings of

Table 6: Logistic Regression Predicting Reports of Feelings of Depression

	Model 1	Model 2	Model 3
	OR (CI)	OR (CI)	OR (CI)
Mother Reported Depression Symptoms for at least a Month Postpartum	1.04 (0.80 - 1.36)	1.08 (0.83 - 1.42)	1.08 (0.83 - 1.41)
Race/Ethnicity (vs. White, non-Hispanic)			
Black, non-Hispanic	0.59*** (0.44 - 0.79)	0.57*** (0.42 - 0.76)	0.54*** (0.40 - 0.72)
Hispanic/Latino	0.98 (0.71 - 1.35)	0.96 (0.70 - 1.33)	0.94 (0.68 - 1.30)
Other, non-Hispanic	0.51* (0.26 - 0.99)	0.57+ (0.29 - 1.11)	0.55+ (0.28 - 1.08)
Multi-racial, non-Hispanic	1.02 (0.55 - 1.87)	1.12 (0.60 - 2.07)	1.07 (0.58 - 1.99)
Percentage of Poverty Line (vs. 0-99%)			
100-199%	0.86 (0.64 - 1.14)	0.91 (0.68 - 1.21)	0.92 (0.69 - 1.23)
200%+	0.80+ (0.62 - 1.04)	0.87 (0.67 - 1.14)	0.90 (0.68 - 1.18)
Educational Attainment (vs. Less than High School Diploma)			
High School Diploma or Equivalent	1.32 (0.90 - 1.93)	1.27 (0.86 - 1.87)	1.31 (0.89 - 1.94)
Some College or Technical/Trade School	1.73** (1.17 - 2.54)	1.53* (1.03 - 2.27)	1.59* (1.06 - 2.36)
College Degree or Graduate School	1.75* (1.06 - 2.87)	1.41 (0.85 - 2.34)	1.48 (0.89 - 2.47)
Female		1.96*** (1.57 - 2.44)	1.92*** (1.54 - 2.39)
Reported Parental Abuse at Age 9		1.10 (0.46 - 2.62)	1.14 (0.48 - 2.72)
Worked for Pay in the Past Week			0.97 (0.77 - 1.23)
Received Social Welfare Aid in the Past Year			1.26* (1.01 - 1.59)
Observations	1,450	1,450	1,450

Notes: n=1450. Results are presented via odds ratios and confidence intervals. Data is not imputed. *** p<0.001, ** p<0.01, * p<0.05, + p<0.1

depression than sons. Receiving social welfare aid also significantly increased one's correlated likelihood of reporting feelings of depression.

In Model 1, non-Hispanic Black participants were associated with a 41% lower chance of reporting feelings of depression compared to non-Hispanic white participants ($p < 0.001$). The gap widened slightly with each additional model, non-Hispanic Black participants correlated with a 43% and 46% lower chance in Models 2 and 3, respectively ($p < 0.001$; $p < 0.001$). The only other racial/ethnic group to have a significantly different associated risk than non-Hispanic white is non-Hispanic Other, who were 49%, 43%, and 45% less likely to report feelings of depression ($p < 0.05$; $p < 0.1$; $p < 0.1$). Respondents with an income 200% or above the poverty line are correlated with a 20% decreased risk of reporting feelings of depression compared to respondents with an income 0-99% of the poverty line in Model 1, however the relationship is no longer significant in the following models ($p < 0.1$). In Model 1, some college or technical/trade school was associated with a 73% higher chance of reporting feelings of depression compared to those with less than a high school diploma ($p < 0.01$). The association dropped considerably in the second model, some college or technical/trade school now 53% more likely to report feelings of depression ($p < 0.05$). The third model yielded a slight increase in association, with children with some college or technical/trade school now 59% more likely to report feelings of depression ($p < 0.05$). In Model 1, attaining a college degree or graduate school was significantly associated with a 75% increased chance of reporting feelings of depression compared to less than a high school diploma ($p < 0.05$). Women were associated with being 96% more likely to report feelings of depression than men in Model 2, the correlation decreasing slightly to 92% in Model 3 ($p < 0.001$; $p < 0.001$). Participants who received social welfare aid in the past year were correlated with a 26% higher likelihood of reporting feelings of depression ($p < 0.05$).

Table 7: Logistic Regression Predicting Mediating Power of Employment Status on Reporting Anxiety Symptoms

	Model 1 OR (CI)
Mother Reported Anxiety Symptoms for at least a Month Postpartum	1.93* (1.14 - 3.24)
Race/Ethnicity (vs. White, non-Hispanic)	
Black, non-Hispanic	0.51*** (0.37 - 0.72)
Hispanic/Latino	0.87 (0.61 - 1.24)
Other, non-Hispanic	0.92 (0.46 - 1.86)
Multi-racial, non-Hispanic	1.61 (0.85 - 3.04)
Percentage of Poverty Line (vs. 0-99%)	
100-199%	1.23 (0.77 - 1.95)
200%+	1.76* (1.10 - 2.81)
Educational Attainment (vs. Less than High School Diploma)	
High School Diploma or Equivalent	1.71+ (0.96 - 3.07)
Some College or Technical/Trade School	1.11 (0.79 - 1.55)
College Degree or Graduate School	1.13 (0.83 - 1.53)
Female	1.48** (1.15 - 1.90)
Reported Parental Abuse at Age 9	1.04 (0.40 - 2.75)
Worked for Pay in the Past Week	1.28+ (0.96 - 1.71)
Received Social Welfare Aid in the Past Year	1.73*** (1.34 - 2.25)
Mother Anxiety Symptoms x Worked for Pay	0.55+ (0.28 - 1.07)
Observations	1,450

Notes: n=1450. Results are presented via odds ratios and confidence intervals. Data is not imputed. ***
p<0.001, ** p<0.01, * p<0.05, + p<0.1

Interactions

Across all measures and models, employment status was insignificant while receiving

social welfare aid was strongly significant, raising the concern that one or both were acting as mediators rather than covariates. The third model for all measures was rerun two times each, one testing for an interaction between the independent variable and employment status and the other testing for an interaction between the independent variable and receiving social welfare aid. Social welfare aid yielded no significant interaction effects, while employment status produced only one significant interaction, with mothers reporting anxiety symptoms, as seen in Table 7. This relationship was only marginally significant however, which, when considered along with being the only significant interaction, led to the conclusion that neither employment status nor receiving social welfare aid mediated the relationship between postpartum maternal health mental health and the mental health of children in adulthood.

DISCUSSION & CONCLUSIONS

Hypothesis 1

H1: Postpartum maternal mental health will be positively associated with child mental health in adulthood, such that a mother experiencing a specific mental illness during the postpartum period will increase her child's chance of experiencing the same mental illness at approximately 22-years-old.

Considering the central relationship of the study, postpartum maternal mental health had varying effects on the mental health of children in young adulthood. For anxiety, children were 33-34% more likely to report feelings of anxiety when their mother reported the same at one year postpartum, though this relationship was only marginally significant. For depression, however, children were 32-40% more likely to meet criteria when their mother met the same criteria, a relationship whose strength and significance varied depending on criteria definition and included controls. Both disorders supported the existence of a relationship between postpartum maternal

mental health and children's mental health in young adulthood, supporting H1. The results suggest that the impact of genetics and inherited risk cannot be ignored; however, the results cannot be explained by genetics alone, as that would likely have a greater effect on the strength of the relationship. Rather, I suspect genetics play a *part* in the relationship between postpartum maternal mental health and child mental health in young adulthood, along with various factors not measurable in these models such as attachment styles, lifelong accessibility to health care, family social capital, and learned responses to distress and trauma. Additionally, the independent variable represents the mothers' mental health in the entire postpartum period, meaning the yielded relationship results may be impacted by the length of postpartum illness, and thus the length of time that mother-child bonding was interrupted, but this possible effect is unknown with the existing data.

Hypothesis 2

H2: Diagnostic criteria for conditions such as anxiety and depression include feelings of these conditions. However, the criteria also include more heavily stigmatized topics such as suicidality. As a result, I expect mental illness as measured by all diagnostic criteria and mental illness as measured by limiting to the most traditional symptom will yield different results.

Turning to variation in measure types, the results demonstrated that mental illness measured by diagnostic criteria yielded different results than mental illness measured by reporting feelings of the foundational symptom. For anxiety, child's reporting feelings of anxiety was significantly associated with reported feelings of anxiety by mothers, while meeting criteria was not significant. Contrastingly, meeting depression criteria, both conservative and liberal, was significantly related to mothers meeting the same criteria, yet reporting feelings of depression was insignificant. Since the measure types' significance varies by disorder, diagnostic criteria

and feelings of foundational symptoms yield different results, supporting H2. Thus, no conclusion can be made at this time for future mental health data collection and analysis as to if one measure type is more sensitive. What is clear, however, is that the traditional diagnostic criteria measure is not sufficient enough alone to accurately portray experiences with mental illness. The validity of a criteria-only measure is likely weakened further when participants come from marginalized communities with additional stigma, cultural connotations, and fractured trust in medical professionals and researchers.

H3: Black-White Differences in Child Mental Health

H3: Due to additional cultural stigma and the use of non-culturally informed data collection, I anticipate that non-Hispanic Black participants will be significantly less likely to report anxiety and depression.

Based on current results concerning race/ethnicity as a predictor of children's mental health in young adulthood, the findings initially seem surprising given known ethnoracial differences related to mental health. I find that non-Hispanic Black children are significantly less likely to report anxiety and depression across all measures (as compared to non-Hispanic white children). While it may be tempting to conclude that non-Hispanic Black children are experiencing fewer mental health issues, this would be flawed given what is known about ethnoracial differences in strain and attitudes toward mental health. Due to systemic prejudice and oppression, Black people experience more strain from experiences with explicit racism, the cognitive toll of remaining hyper-aware, and abundant exposure to the victimization of people in their communities. As a result, Black people are more likely to experience distress and grief, leading to higher rates of physical and mental health complications (Talbert 2022; Erving et al. 2025; Wilson et al. 2023). This is exacerbated for Black women, Black queer people, and Black

individuals who hold several marginalized identities (Erving et al. 2025; Thorpe et al. 2024; Lee et al. 2023). This suggests results should show *higher* reports of poor mental health from the analytic sample. Instead, the current finding demonstrates the suppressive effect attitudes, beliefs, and mental health stigma can pose to Black individuals considering their own mental health and care options. People of color, particularly Black people, are more likely to hold attitudes and beliefs about mental health that fuel and internalize stigma and limit treatment seeking, which holds across various age groups (Conner et al. 2010; DeFreitas et al. 2018; Clement et al. 2015; Fields-Oriogun et al. 2024).

In measuring rates of complicated experiences like sexual assault and mental illness with self-reports, underreporting frequently occurs due to stigma, fear, and shame, leading to research often using data that does not properly represent the problem. Issues with self-reporting in general are discussed in the Limitations subsection, but it has further impact on racial and ethnic minorities. The maternal reports of anxiety and depression were collected during the second FFCWS wave, the interviews for which took place between 1999 and 2001. Stigma about mental illness is still quite rampant in society today, though it has significantly improved since the turn of the century. It is only in recent years that we as a society began to understand that postpartum sadness is often not simply “baby blues” but an actual problem that requires treatment. However, discussions expanding understanding of postpartum mental illness, and increasing empathy for those who experience it, were primarily directed towards white mothers and middle-class families, excluding mothers of color and low-income families. Thus, the time in which this data was collected had increased stigma around mental health compared to today, likely leading to an underreporting for women across race/ethnicity (Schomerus et al. 2022; Pescosolido et al. 2021). However, the increased mental illness stigma for racial/ethnic minorities possibly exacerbated

the rate of underreporting among mothers of color in the study (Krill Williston, Martinez, and Abdullah 2019). This stigma, though improved by the seventh wave of data collection, likely impacted the self-reporting of children as well; leading to meaningful misrepresentative data for both independent and dependent variables.

Hypothesis 4

H4: It is expected that socioeconomic status, as measured by relation to the poverty line, will act as a significant control variable.

Current results do not offer support to H4; SES measured by relation to the poverty line was not a significant predictor, nor was SES measured by employment status. However, SES measured by social welfare aid was positively associated with anxiety and depression across all dependent variable operationalizations, whereby receiving social welfare aid increased the likelihood of experiencing mental illness. A pairwise correlation test was conducted, ensuring that none of the variables were capturing the same information and misrepresenting factors in the relationships. The test confirmed the three SES measures were independent from each other, so why did three facets of SES – income, employment, and governmental aid – yield such remarkably different results? I theorize this largely stems from the operationalization of employment status. Most of the variables included in the current study asked participants to speak to the past year, yet when capturing work for pay, only the previous week was considered. While this temporal slope is understandable as employment status can be very fluid, particularly for young adults, reporting employment status from only the past week is not indicative of an individual's overall SES.

In addition, relation to poverty line and social welfare aid variables were both representative of the participant's household, rather than limited to the participant themselves. The respondent's financial stability, or lack thereof, may not be accurately represented when considering their entire household, given respondents are approximately 22 years old and thus may still be living at home at data collection. The same could be said for receiving social welfare aid, someone in your household receiving social welfare aid does not mean you benefit from it. Additionally, relation to the poverty line was constructed from the household income as reported by the participant, which could be based on income at the time of the interview or recalled from an earlier time, such as the most recent tax season. If any big life events occurred, such as birth of a child, loss of a job, or moving, since this context for income reporting, the calculated relation to the poverty line input may no longer be accurate or relevant. While it is meaningful that receiving social welfare aid held significant relationships across all outcome measures, the restrictions of the various SES variables limit the ability to draw any conclusions on the suitability of some SES indicators over others.

Sex Disparities

Beyond the hypotheses, the analysis yielded intriguing results concerning a key factor – sex. Women were strongly more associated with mental illness than men across all measures. This result could be showcasing a difference in how maternal bonding operates and is interrupted for mother-daughter and mother-son pairings. However, it would be inappropriate to come to such conclusions without considering the effects of structural misogyny. Similar to Black individuals' exacerbated strain due to systemic racism, women experience more stress from overt sexism and gender-based violence all while typically maintaining historical gendered division of

labor (Kelley and Gilbert, 2023; Ogbuanya and Ogbuefi 2025; Laz-Figueroa et al. 2025). There is also a culture, especially in Western society, of boys being taught “not to cry”. A five-year-old girl may be consoled when she cries in reaction to scraping her knee, but a five-year-old boy could have the same injury and is told to “suck it up” or “be a man”. The boy will internalize those messages, forming an association between expressing emotions and being put down or seen as inferior (Arnold 2022). These taught expectations and formed associations are then carried on through life, even when met with targeted deconstruction. All considered, the current study’s sex disparities may be in part due to differences in mother-daughter and mother-son bonding, but it would be inappropriate to conclude as such due to already existing sex disparities in mental health.

Limitations

The study’s most significant limitations stem from the use of self-report data. Reliability of self-report data should always be carefully questioned and assessed, especially for a topic as personal and stigmatized as mental health. The quality of this self-report data can be affected by two potential biases: social desirability bias and recall bias. Social desirability bias, in this context, is fueled by shame and other experiences of distress, which may limit participants’ willingness to share. The risk of social desirability bias is furthered by FFCWS researchers administering the survey, where administrators pose questions as written on the survey and respondents must verbally answer, rather than participants divulging sensitive information completing the survey themselves, with the benefit of privacy. Self-report data further limits the study due to recall bias, as participants could be challenged to accurately remember their mental health experiences in their entirety from the past 12 months, as opposed to collecting those

measures from medical records or a journaling strategy, for example. This potential problem is worsened for mothers recalling mental health during the postpartum period, as it is a time consisting of hormonal fluctuations, lack of sleep, physical fatigue, and forgetfulness; or “baby brain” and “pregnancy brain”, as it is often called (Lacritz 2016). Thus; these potential biases restrict interpretation of results to reports of depression and anxiety, rather than actual occurrences of depression and anxiety.

Additionally, a significant number of participants were lost to attrition. The sample’s racial/ethnic makeup was reasonably aligned with the racial/ethnic makeup of mothers in wave 1, suggesting that there are no meaningful racial/ethnic differences in who was lost to attrition versus not. Yet, the other social and structural determinant measures for sampled children, such as those from the conceptual model, cannot be compared to that of mothers in wave 1, thus any further conclusion on attrition patterns cannot be reached. For instance, educational attainment within the sample suggests a strong prioritization of education among the participants, however, it is also plausible that those lost to attrition may have more turbulent lives, possibly due to lower educational attainment and resulting implications. Lastly, with approximately 21 years in between the collection of the independent and dependent variables, many societal changes occurred concerning mental health knowledge and understanding, stigma, diagnostic processes, and accessibility and affordability of care, which the study cannot measure or assess. This history bias could substantially alter whether feelings of depression and anxiety, and/or willingness to share such feelings, meant the same to mothers and their children.

CONTRIBUTIONS & FUTURE DIRECTIONS

With the mother-child mental health field's current focus on children's mental health in childhood and adolescence, the current study provides a significant contribution by establishing the previously theoretical relationship between postpartum maternal mental health and the mental health of children in young adulthood. In doing so, this study also highlights the need to expand the scope of the field to include child's mental wellbeing in adulthood. In exploring this relationship, the study could not consider all relevant factors at present, such as children's experiences with the child welfare and criminal legal systems, which future research should address. Additionally, evaluation of mothers' sociodemographic characteristics could provide great insight into this relationship, but these elements fell outside the scope of this project. For example, future work might analyze variation in this now established relationship based on if mother-child pairings shared a racial/ethnic identity. These potential avenues of exploration will expand our understanding of how the relationship is affected by various social, structural, cultural, and population differences. While this evaluation cannot test for causality, it sets a foundation for future studies with appropriate data to be able to take that step. Finally, conversations should be had within the discipline discussing the sufficiency of diagnostic criteria measures alone to represent mental health as a concept, or if expanded measures such as those used in this study should be more widely adopted. Growing our understanding of mother-child mental health using the findings here and future areas of study could carry implications for perinatal mental illness interventions, mental health treatment in young adulthood, and stigma surrounding mental illness.

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