Georgia State University
ScholarWorks @ Georgia State University

Sociology Theses | Department of Sociology

7-15-2009

Postpartum Depression and Self-Help Books: Medicalizing Misery and Motherhood

Kirstin Michelle McMillen

Follow this and additional works at: http://scholarworks.gsu.edu/sociology_theses

Recommended Citation
McMillen, Kirstin Michelle, "Postpartum Depression and Self-Help Books: Medicalizing Misery and Motherhood." Thesis, Georgia State University, 2009.
http://scholarworks.gsu.edu/sociology_theses/25

This Thesis is brought to you for free and open access by the Department of Sociology at ScholarWorks @ Georgia State University. It has been accepted for inclusion in Sociology Theses by an authorized administrator of ScholarWorks @ Georgia State University. For more information, please contact scholarworks@gsu.edu.

POSTPARTUM DEPRESSION AND SELF-HELP BOOKS:

MEDICALIZING MISERY AND MOTHERHOOD

by

KIRSTIN M. MCMILLEN

Under the Direction of Dr. Wendy Simonds

ABSTRACT

Motherhood is an ideal that is ostensibly valued and rewarded in American culture. It is no wonder, then, that a disease which threatens a woman's ability to adequately fulfill her motherly duties receives a great deal of attention. My study aims to explore how ideas about postpartum depression (PPD) are presented in popular media through an examination of the messages and advice in PPD self-help books. Findings reveal that self-help authors make two significant assumptions: motherhood is a woman's job that should bring happiness, and when mothers are not happy medical intervention in necessary. Through their gendered assumptions about parents' roles and their insistence on a biological explanation for PPD, self-help authors prevent a healthy dialogue that examines patriarchal structures in the institutions of family and medicine. By focusing solely on the biological factors at play when women have babies, self-help authors alienate fathers, adoptive mothers, and foster parents who experience depression without biological origins. Only when PPD is discussed within the context of our social realities can we truly understand parenthood and depression.

INDEX WORDS: Postpartum Depression, Motherhood, Self-help, Medicalization, Support

POSTPARTUM DEPRESSION AND SELF-HELP BOOKS:

MEDICALIZING MISERY AND MOTHERHOOD

by

KIRSTIN M. MCMILLEN

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of

Master of Arts

in the College of Arts and Sciences

Georgia State University

2009

Copyright by
Kirstin Michelle McMillen
2009

POSTPARTUM DEPRESSION AND SELF-HELP BOOKS:

MEDICALIZING MISERY AND MOTHERHOOD

by

KIRSTIN M. MCMILLEN

Committee Chair: Wendy Simonds

Committee: Elisabeth O. Burgess
Dawn M. Baunach

Electronic Version Approved:

Office of Graduate Studies
College of Arts and Sciences
Georgia State University
August 200

TABLE OF CONTENTS

LIST OF TABLES		v
CHAPTER		
1	INTRODUCTION	1
2	LITERATURE REVIEW	2
3	METHODS	15
4	SUPPORTING MOTHERS	19
5	MEDICALIZING MOTHERS	40
6	CONCLUSION	61
REFERENCES		64
APPENDIX	List of Books Included in Content Analysis	68

LIST OF TABLES

Table 5.1: Causes Given for PPD 44

CHAPTER 1: INTRODUCTION

Motherhood is an ideal that is ostensibly valued and rewarded in American culture. It is no wonder, then, that a disease which threatens a woman's ability to adequately fulfill her motherly duties has received a great deal of attention in recent years. Indeed, Logsdon, Wisner, & Pinto-Foltz (2005) note that "effective mothering is a public health concern, and health care providers must understand conditions such as postpartum depression (PPD) that adversely affect a women's ability to mother her infant" (652). Beck, Records, and Rice (2006) call PPD a "dangerous" and "devastating mood disorder" (735). Findings vary on the actual incidence of PPD, but studies generally conclude that 11-15% of mothers suffer from PPD (O'Hara & Swain, 1996), and judging by the increased awareness of this disease in recent years, the number of people who identify with the "symptoms" of PPD might increase as well.

CHAPTER 2: LITERATURE REVIEW

Much of the research on PPD focuses on the predictors of PPD and the effectiveness of various treatments for PPD. What is missing from this body of knowledge is a sociological perspective that questions the construction and management of this disease. Little has been done to question the medicalization of a condition that is common to most women after giving birth to a child, especially when this syndrome is barely discernable from the "baby blues" that 80% of mothers experience (Kleiman and Raskin, 1994). In fact, if one were to accept the definition of PPD found in the DSM-IV[1], it would appear that the only possible "normal" reaction to having a child is euphoria. Inherent in labeling an unhappy mother as pathological is the patriarchal ideal that women should be nurturing, compassionate mothers while men are the successful breadwinners.

Rather than viewing birth as a natural process that women experienced long before the advent of obstetrics, childbirth and the period following childbirth has increasingly become a medicalized event. Brockington, Macdonald and Wainscott (2006) note that from the perspective of psychological medicine, childrearing "is the most complex event in human experience" (253). Further, the authors note that pregnant women and women who have recently given birth are "prey not only to the gamut of general psychiatric disorders, but also those

[1] An episode that begins within 4 weeks of birth. Symptoms include depressed mood, often accompanied or overshadowed by severe anxiety, markedly diminished interest or pleasure in activities, appetite disturbance, usually loss of appetite with weight loss, sleep disturbance, most often insomnia and fragmented sleep, even when the baby sleeps, physical agitation (most commonly), or retardation, fatigue, decreased energy, feelings of worthlessness or excessive or inappropriate guilt, decreased concentration or ability to make decisions, recurrent thoughts of death or suicidal ideation. The criteria include symptoms reflective of the pervasive mood disturbance and physiological dysregulation (sleep, appetite, and cognitive disturbances) of depression. Symptoms must be present for most of the day nearly every day for a minimum of 2 weeks. A decline from the woman's previous level of functioning and significant impairment must occur.

specific to the reproductive process" (253). Such a perspective pathologizes childbirth and the experience of motherhood.

In addressing the "perils" of PPD, it is important to ask why the unhappiness of mothers has struck such a nerve, particularly among Americans. On one hand, the suffering of anyone, physical or mental, should be addressed. Women, in particular, have been marginalized not just in society in general, but especially within the institution of medicine. Women's psychological and physical needs have long been compromised by a system of care that accepts that male bodily experience as normal and the experience of women as pathological and mysterious (Simonds, Rothman and Norman, 2007; Martin, 2001; Taylor, 1996). Feminists have fought ardently to have the experiences of women acknowledged and addressed within the medical model of care (Taylor, 1996), and progress in this area should not be taken lightly.

On the other hand, one must question whether we are defending the rights of women to healthy minds and bodies or if PPD receives attention because something more sacred is at stake. There is so much bound up within the ideals of motherhood that the collective sensitivity to depression after motherhood cannot be taken lightly. Adrienne Rich (1986) sees motherhood as the most important of all the feminine ideals that are ascribed to women when she acknowledges that women are seen as "beneficent, sacred, pure, asexual, nourishing, and the physical potential for motherhood…is her single destiny and justification in life" (34). To be sure, while women are twice as likely as men to be diagnosed with depression in general (Taylor, 1996), this depression has not captured the same amount or type of attention that depression after motherhood has garnered. It is imperative, then, to examine this phenomenon and our collective reaction to it. Quite simply, depression after motherhood is important because motherhood itself is important. Further, not only has the positioning of women and also mothers have changed

over time, so have the expectations of how mothers should mother. Sharon Hays (1996) calls the form of mothering that currently dominates American culture "intensive mothering." Within this model of mothering the mother sees herself as central figure in child's life, she allows the needs of her child to supersede her own needs and desires, and mothering is seen as something completely separate and different from paid labor (Hays, 1996). This standard for childrearing arose out of a cultural view that sees children as innocent, special creatures that need constant attention and nurturing in order to successfully develop into well-adjusted, healthy, happy adults (1996). In the middle ages, children were not children; they were just young adults. "The ideology of child rearing flowed directly from the values, beliefs, and hierarchical organization of society as a whole" (Hays, 1996: 24).

In the 1800s there was a shift in beliefs about how women's work as mothers was to be done. Children were seen as precious and needing to be gently cultivated by their moral mothers. Indeed, rhetoric of the time told women that "the good mother must not only lavish affection on the child; she must also be constantly vigilant in maintaining her own virtue and using the proper methods to instill like virtue in her child" (Hays, 1996: 32). Motherhood became a job, and an exhausting one at that. When parents view children as angelic creatures who need special nurturing in order to develop properly, society then requires a special form of parenting that accommodates the needs of these innocent children.

Simultaneously, mothering had come to be seen as something that women could not naturally do; rather scientific experts were needed to guide women through the difficult and important challenge of raising children (Hays, 1996). These "experts" typically came in the form of doctors, such as the popular Drs. Holt, Hall and Watson (Hays, 1996). Just as doctors asserted themselves as the experts of pregnancy, literally wiping midwives out of the birthing process in

the United States in the process (Simonds, Rothman, and Norman, 2007), doctors took on the task of telling women not just how they should bring a child into the world, but also how they should raise these children. Throughout the 19th and early 20th century childrearing techniques were seen as important because they resulted in the upbringing of future citizens. Therefore these techniques were seen as beneficial to society as a whole. By the 1930s, the underlying messages in childrearing advice supported the idea that "the natural development of the child and the fulfillment of children's desires are ends in themselves and should be the fundamental basis of childrearing practices" (Hays, 1996: 45). This perspective on child-rearing is still the standard today. These expert-guided methods of childrearing are now "more emotionally absorbing, labor intensive, and financially expensive than ever before" (Hays, 1996: 46).

Depression, then, becomes problematic because it interferes with a mother's ability to properly raise her child(ren). Any interference with the proper raising of children is taken seriously. In her analysis of the self-help movement associated with PPD, Verta Taylor (1996) found that awareness of PPD gained momentum when cases of infanticide received public attention. While the medical community considered depression in general to be a health concern, it was not until babies began dying at the hands of mothers with a severe form of PPD (now known as Postpartum Psychosis) that PPD in general received attention, not just from the medical community but from a larger community of moral advocates (Taylor, 1996). Indeed, Logsdon, Wisner, & Pinto-Foltz (2006) note that "effective mothering is a public health concern, and health care providers must understand conditions such as postpartum depression (PPD) that adversely affect a woman's ability to mother her infant" (652).

The expectations for mothers to live up this standard of intensive care are further intensified by the bonding/attachment rhetoric of the 1960s and 1970s (Bobel, 2002; Taylor,

1996; Eyer, 1992). Based on findings that women who spent more time with their infants immediately following birth displayed better mothering skills and raised children who developed better than those of women who did not "bond" with their infants, the mother-infant bonding movement placed women under even more pressure to mother "correctly." Women were encouraged to birth in hospitals where they could be monitored during this sensitive "bonding" period. Within this ideology, mothers are expected to be "the prime architects of their children's lives and are blamed for whatever problems befall them, not only in childhood but throughout their adult lives" (Eyer, 1992: 2). This notion permeates childbirth and childrearing still today, and serves to maintain the importance of mothers being happy so that they can effectively "bond" with their young infants. Eyer (1992) argues that this movement had less to do with well-researched findings than with the desire of obstetric professionals to necessitate their expert intervention in this movement, thereby securing clientele who needed obstetric doctors to cure their pathologies: "because bonding was a construction of medicine, it would ultimately serve to protect the interests of that institution" (Eyer, 1992: 2). This medically upheld notion that women should be happy in the period of time following childbirth further benefits the medical model of care. Sad, anxious, lonely mothers are encouraged to talk to their doctors about their struggles with PPD. These doctors benefit from the fees they charge to see these patients, and when PPD sufferers take prescription anti-depressant medicine, they are lining the pockets of doctors and drug manufacturers alike.

Obstetricians and medical practitioners are not the only ones positioned to benefit from maintaining the ideal of a happy mother. Various authors contend that keeping women happy with childrearing means keeping capitalism alive and well (Coontz, 1992; Eyer, 1992; Rich, 1986; Wearing, 1984). Rather than viewing motherliness as an intrinsic quality among women,

"the sentimentalization of family life and female nurturing was historically and functionally linked to the emergence of competitive individualism" (Coontz, 1992: 44). Indeed, Betsey Wearing (1984) makes a similar claim when she states that "the class nature of the relations of production in advanced industrial capitalist societies…is an important source of women's oppression and provides a material basis for the generation of ideologies which legitimate women's responsibility for domestic labour and in particular for the reproduction of labour power" (15).

Mothers, then, are essential not only to the continuation of the ideals associated with the private sphere, but their participation in this system ensures the well-being of so many other components of competitive individualism. At a very basic level, women produce and raise future capitalists. Further, happy mothers participate in a culture of consumption in which they throw baby showers and shop for a multitude of essentials for every stage of a child's development. Keeping mothers happy with motherhood also ensures their limited participation in the workforce, leaving men to compete with only each other for positions. When so many have so much to lose from women's unhappiness with motherhood, it is important to examine the ways the experience of motherhood serves the interest of men (Rich, 1986).

At the very least, we must question why this syndrome is so important by assessing who benefits from the way PPD is currently being handled. Understanding why and how this disease matters helps guide our examination of why women feel unhappy with motherhood in the first place. Martinez, Johnston-Robelo, Ulsh and Chrisler (2000) outline three models used to explain PPD. The first, and most prevalent, is the medical model, which attributes the symptoms of PPD to biological factors, such as fluctuating hormones after childbirth, despite the fact that such a causal relationship has not been established (Llewellyn, Stowe, & Nemeroff, 1997; Nicolson,

1998). The typical treatment for PPD within this model is antidepressant medications, even though their effectiveness in treating PPD is still unknown (Gjerdingen, 2003). According to Martinez et al (2000), one important feature of the medical model approach to PPD is a preoccupation with the impact maternal depression has on a woman's family, especially the mother's partner and the infant. Husbands or partners have been found to be at risk of developing depression as a result of the mother experiencing postpartum depression (Areias, Kumar & Figuieredo: 1996). According to the medical model, infants are at risk when their mothers are depressed. Clay and Seehusen (2004) claim that most of the studies on PPD and its impact on mothering have found differences between children of depressed mothers and children of non-depressed mothers.

This concern for the welfare of the infant stems from the way children are viewed before they are even born. In their examination of obstetric care in the United States, Simonds, Rothman and Norman (2007) discuss the tendency of medical practitioners to place higher importance on the fetus than on the mother, even to the point where the mother's body is considered a risk to her unborn child. By strapping on fetal monitors and viewing ultrasounds on fetuses, medical practitioners prepare to intervene at a moment's notice to rescue the fetus from her high-risk mother (Simonds, et al 2007).

Emily Martin explains this interventionist attitude when she remarks that "the metaphor of the body as a machine continues to dominate medical practice in the twentieth century and both underlies and accounts for our willingness to apply technology to birth and to intervene in the process" (2001: 54). The importance of how childbirth is experienced has become lost in the medical model's preoccupation with the end product (Martin, 2001). In fact, within the medical model the experience of childbirth is not just ignored; it can be altogether traumatic. Kitzinger

(2006) writes that women are often misdiagnosed with postnatal depression when they are actually suffering from Posttraumatic Stress Disorder (PTSD), which is “a normal reaction to insensitive care when a woman has no choices and no means of escape” (3). Many of the components of maternity care within the medical model are detrimental to women: using the male body as the norm: “what could be seen of men’s bodies was assumed as the pattern for what could not be seen of women’s” (Martin, 2001: 30), the use of interventions such as forceps and cesarean birth (Simonds et al, 2007; Martin, 2001; Kitzinger, 2006, Rich, 1986), and fragmented care that distances women not only from other means of support, but also from their own bodies (Rich, 1986; Martin, 2001).

An alternative to looking at biological causes of PPD is to look at external factors that can cause stress during the postpartum period (Martinez et al, 2000). Proponents of this perspective agree that there are many factors that contribute to PPD (McIntosh, 1993; Buultjens & Liamputtong, 2007). Many studies have found that external factors such as the presence of support networks and realistic expectations about motherhood affect the experience of motherhood greatly. For example, Buultjens and Liamputtong (2007) found that “gender divisions of labor in the home and gender-based expectations about roles, responsibilities and power relations can be identified as possible causes of postnatal depression” (85). Because it is women who do the mothering (Doucet, 2006), and not men, women are held primarily responsible for all that raising a child entails. This task is made ever more difficult by nuclear family-style child-rearing, at least for the middle class (Martin, 2001). Many women, particularly those who previously worked outside of the home, are not prepared for the intense loneliness and powerlessness associated with being homebound after the birth of a child. This isolation is directly related to the privatization of home life after the industrial Revolution

(Coontz, 1992; Rich, 1986). Rather than relying on extended families and kin networks, Americans withdraw into their private, nuclear homes to raise children. This burden, which typically falls on the shoulders of women, can be quite depressing and may result in many of the symptoms associated with PPD.

Many women are not prepared for parenting under these conditions, or any conditions for that matter. Much of the depression that arises after childbirth may be due to the dissonance between the reality of motherhood and the fairy tale version that women are told. Adrienne Rich (1986) beautifully captures the bewildering nature of motherhood:

> No one mentions the psychic crisis of bearing a first child, the excitement of long-buried feelings about one's own mother, the sense of confused power and powerlessness, of being taken over on the one hand and of touching new physical and psychic potentialities on the other, a heightened sensibility which can be exhilarating, bewildering, and exhausting (36).

For many, pregnancy itself comes as an unexpected surprise. The relationship between unplanned pregnancy and postpartum depression is not explored in postpartum depression literature. However, stress during pregnancy has been found to be a risk factor for PPD (Josefsson et al, 2002; O'Hara and Swain, 1996; McCoy et al., 2006), and unplanned pregnancies can be stressful situations. Among those who do choose to become pregnant, the reasons for doing so are as varied as the pregnant women themselves. Barbara Katz Rothman notes that "since there are a lot of things people want when they want to 'have' a child, there are lots of ways of marketing parenthood" (2004: 27). It is through this marketing of parenthood –

baby showers, depictions of idyllic parenthood in the movies and television, the buzz surrounding celebrity pregnancies, commercials featuring the latest baby gear, family vacation destinations – that expectations become tied up in the popular images of parenthood. Not surprisingly, the reality of parenthood looks nothing like the images marketed to us on a daily basis.

One expectation – or rather, assumption – our society has is that a birthing woman will have some kind of partner support, but this is not always the case. Dennis and Ross (2006) found that women's conflict with their partners and lack of partner support are associated with PPD. The impact of the support a woman does or does not receive is not confined to her home life. The way a mother is cared for immediately following the birth also influences how a mother feels. After a woman gives birth, insufficient support by postnatal nurses is another factor contributing to the women's postnatal depression (Buultjens and Liamputtong, 2007). "Nurses have a special responsibility to help mothers learn to look after their newborn baby" (Buultjens and Liamputtong, 2007: 86). In the view of the authors (2007), nurses can play a role in diminishing the experience of PPD by assisting mothers with some of the new tasks of motherhood while they are still in the hospital, such as breastfeeding or general childcare.

Researchers have also been curious about the influence of sociodemographic factors and lifestyle choices on PPD. In their survey of 158 women, Hall & Wittkowski (2006) found that there were no significant relationships between PPD and social support, age, number of children, and marital status. They remark that these findings serve as a reminder that "negative thoughts may be experienced by many new mothers, irrespective of demographic characteristics" (327). In contrast, in their review of studies looking at the relationship between sociodemographic factors and PPD, Ross, Campbell and Blackmore (2006) concluded that participants in previous

PPD studies are “predominantly women who are aged 25 to 35 years, white, of middle or high socioeconomic status, and in a marital or equivalent relationship” (708). As such, more diversified samples of PPD sufferers are needed in order to better understand the relationship between socioeconomic status and PPD.

McCoy et al (2006) investigated the possible correlations between several factors and PPD. These factors include the mother’s age, whether or not she is breastfeeding her baby, tobacco use, her marital status, the type of delivery, and history of depression. The results of their study indicate that formula feeding instead of breastfeeding, smoking cigarettes, and a history of depression were associated with higher scores on the Edinburgh Postnatal Depression Scale.

As PPD becomes a focal point for the postnatal care of women, research conducted by midwives, feminist scholars, and activists has begun to challenge the traditional notions of how PPD is identified and treated (Hall and Wittowski, 2006). Generally speaking, these authors contend that feeling depressed and overwhelmed are common to childbirth and should not be treated as medical events. Further, by examining PPD through a feminist lens, we are able to address the components of our social structure that contribute to the pressure to find motherhood a blissful, happy time.

Examining PPD depression from a feminist perspective one is able to look critically at the way in which obstetric healthcare is structured. Taken as a whole, obstetric care in the United States is concerned with efficient, profitable, litigation-free birth. Feminists argue that this approach, unsurprisingly, does not serve the bests interests of women, particularly when women want peaceful, natural births that are not measured against a ticking clock. Some feminists (Kitzinger, 2006; Simonds et al, 2007) go so far as to say that most obstetric births in

the United States are traumatizing, simply because of the way that medical birth is structured Kitzinger (1996) is critical of the way that the PPD label is slapped on any woman who is unhappy after birth. She laments: “distress after birth is often discussed as a disease that strikes women” (2006: 3). Kitzinger argues that when the focus is placed on the mother’s performance during childbirth “the failure of the maternity services to give humane care can be ignored” (3).

Feminism also provides the opportunity to question the childrearing techniques suggested by “experts” such as pediatricians and authors of child-rearing advice books. In her investigation of mothering techniques used by women and perpetuated through advice books, Sharon Hays (1996) argues that society expects women to adhere to an exhausting form of mothering that places children at the center of the universe.

The study of PPD may be no better situated than within the context of the self-help movement (Taylor, 1996). As infanticide resulting from mothers’ PPD gained media attention in the 1980’s, a self-help movement emerged in response to the harsh treatment of mothers who committed these murders. Members of this movement worked to remove the “bad mother” label that many depressed women were given by creating a forum where women could talk openly about the difficulties of motherhood and shed the myth of blissful motherhood. The self-help movement had a precarious relationship with the medical community: on one hand, the self-help movement was started by compassionate medical practitioners who recognized the ways in which the medical model was failing women who showed signs of distress and anxiety after childbirth. The goal was to create a movement where women were given the affirmation and compassion they were not getting within the medical model. Taylor (1996) remarks that this self-help movement relied heavily on “the emphasis on self-transformation, emotional expressiveness, collectivism, separatism, caring and community advocated by feminist

organizations in the late 1960s and 1970s (112). On the other hand, however, while the PPD self-help movement sought to create a distinct, separate sphere where the plight of depressed mothers could be addressed, the movement worked to legitimize the experience of PPD through the medical model's classification of PPD as a bona fide disease.

Examining self-help books on PPD reveals how the self-help movement has changed over time. Martinez et al (2000) conducted a content analysis of magazine articles pertaining to PPD published between 1980 and 1998. In examining media sources, which are "major sources of information about health and illness for most people" (Martinez et al., 2000: 40), the authors found that messages of PPD in the media are dominated by the medical perspective, suggesting that "the postpartum period, like menstruation, menopause, and childbirth, is another example of the medicalization of women's experience" (2000: 49). Further, the authors found that many of the PPD articles contained heteronormative, middle class assumptions about the experience of childbirth and childrearing in America (Martinez et al., 2000).

My study examines self-help books on PPD in order to understand how this syndrome is addressed by a movement that seeks to distance itself from the medical community while simultaneously seeking the legitimization of PPD through medical channels. I take a feminist approach; I question the ability of a historically patriarchal institution – medicine – to effectively address the needs and experiences of women. When it comes to childbirth, obstetric care has fallen short of providing woman-centered care that is personable, patient, and compassionate (Simonds et al, 2007; Martin, 2001).

CHAPTER 3: METHODS

Examining self-help books on PPD allows me to explore how this syndrome is explained to women by voices of the self-help movement. These voices take many forms: doctors, nurses, psychologists, celebrities, and "regular" moms have written books aimed at helping the many women who experience depression after childbirth. Content analysis allows me to answer the fundamental questions of research – who, what, why and how (much)? Books (or passages within the book) are my unit of analysis because I am making "descriptive and explanatory statements" (Babbie, 2001: 306) about passages within the PPD self-help books.

The criteria for selecting books for this study are straightforward. In order to select books for my study, I browsed book descriptions on www.amazon.com. I used the following search terms in varying combinations to ensure a complete search for relevant books: postpartum depression, postnatal depression, self-help, depression, baby blues, support, childbirth. In order to qualify as a self-help book on postpartum depression, all books selected had to meet the following criteria: 1) All books included in this study had to be primarily about the experience of depression after childbirth. In other words, books that are about pregnancy or depression in general and make brief references to PPD in some form will not be included in the analysis. 2) All books selected had to have the explicit purpose of providing help or support to moms with PPD. For example, a book that is written for clinicians to be able to understand the signs, symptoms and treatments for PPD would not be appropriate for this study due to its intended audience and purpose. The Appendix lists the books that were used in this analysis. Because the number of books that meet the criteria for this study is so small, sampling was not

used. Rather, the entire (known) collection of self-help books on PPD published prior to 2007 were included in this study.

Notably, authorship of the books included in this study is entirely female. For the purposes of analysis, I grouped authors into four main categories: celebrity moms (N=2), authors who were doctors or psychiatrists (N=7), “regular” moms who wrote about their own experiences with PPD (N=12), and one author was categorized as a researcher. While two authors are labeled as “Celebrity Moms” it is important to note that they both experienced PPD themselves.

In terms of applying a framework to this study, I applied a feminist approach to conceptualization by allowing the case to define the concept (Becker, 1998). In other words, while I could conjecture what concepts I would uncover in examining the self-help books, it was important to consider the ways in which PPD and the issues surrounding it can be addressed in different ways, depending on the author and her approach to the topic. As such, my intention was to allow the PPD self-help books to shape the concepts explored in this study.

However, bearing this approach in mind, I looked for certain themes to appear in PPD self-help books based on my research prior to the study. For example, I looked for manifestations of the medicalization of PPD, such as the recommendation that the mother define her experience as a medical condition or illness, rather than a result of social factors, and seek psychological/medical treatment for it. This very notion assumes that PPD only affects women who give birth, rather than women who adopt children or act as foster parents. Therefore I looked at how these self-help books address the experiences of all mothers, even those who do not experience the “hormonal” effects of childbirth.

Because PPD is also a reflection of our cultural beliefs about motherhood and the status of children, I also examined whether self-help books on this subject promote a patriarchal perspective on motherhood and childrearing. For example, Chris Bobel (2002) discusses the ideal that because mothering is embodied in women, all issues related to mothering are only of concern to women. Therefore, I focused on the extent to which PPD is portrayed as solely a women's issue, rather than one which involves the direct participation and concern of both women and men. I also examined whether or not self-help books promote the notion that women should address their depression for the sake of their children and partners, furthering the stereotype that the physical and emotional needs of women should be subjugated to the needs of men and children.

In terms of race, class, and gender issues, I focused on whether self-help books on PPD reflect the voids that exist in contemporary research on this topic. For example, one of the issues that receives attention with regard to PPD is the loneliness inherent in being homebound with a child, for middle class mothers, at least (Martin, 2001). Hays (1996) also addresses middle class mothers by exploring the cultural contradictions of motherhood that working (professional) women face. Postpartum depression is experienced differently among women of different socioeconomic statuses, yet research continually focuses on the plight of middle class women. Therefore I looked for this theme to appear in self-help books as well in order to determine whether these sources of aid to women reflect a narrow, primarily middle class experience of this syndrome. This narrow focus may manifest in the inclusion of solutions to dealing with PPD that are accessible solely to middle and upper class women, such as frequent (expensive) visits to a physiotherapist, anti-depressant regimen which are assumed to be covered by a robust

healthcare plan, and use of other costly support networks such as housecleaning services and babysitters.

Similarly, I focused on whether PPD self-help books reflect a perspective that is devoid of sensitivity to social and cultural traditions outside of the experience of white, heterosexual women. I wanted to address the question of whether authors of PPD self-help books make extremely heteronormative assumptions about women who raise babies. For example, I explored whether or not self-help book authors address issues same-sex couples may face when depression occurs after childbirth. I wanted to know whether PPD self-help book authors address how issues of race complicate the experience of parenting. Do they make the assumption that mothers and readers of self-help books have lives completely unaffected by race?

This research adds to a body of knowledge that aims to improve the health of women through a better understanding of PPD. By exploring one of the primary avenues women have for addressing and understanding PPD – self-help books – I assess the strengths and weaknesses of the self-help movement. I hope that my analysis will generate feminist ideas for how aid might be given to depressed mothers. As a sister, daughter, niece, cousin, and friend, my role is to provide a level of awareness and understanding of PPD that benefits not just the women I love, but an entire community of women who deserve to know the implications of their healthcare. Such an understanding would allow women's healthcare providers to provide postpartum care that is relevant, effective, and empowering.

CHAPTER 4: SUPPORTING MOTHERS

One of the emergent sociological themes in postpartum depression self-help books is the assumption of gender role norms. This theme is clearly present throughout self-help books when authors discuss the notion of support. This very notion carries with it the assumption that women are primarily responsible for childrearing, and partners are there to serve as "backup". When self-help authors discuss how mothers can be supported, they are also describing the roles that mothers and fathers "should" have. These gender roles can be examined from varying perspectives when support is examined in two different ways: when support is discussed at a micro-level, such as from family, friends, and at a macro-level, such as community and societal support. Examining the way self-help authors discuss these two levels of support reveal the varying and interconnected ways that expectations about motherhood are perpetuated.

Self-help literature makes abundantly clear the importance of various forms of support for postpartum mothers. For many authors, the degree to which a mother is supported during the postpartum period can determine whether or not she is susceptible to postpartum depression.

> The idea of a support network is key: Studies indicate that women with multiple sources of support adjust to the postpartum period more easily than women with a single source or none at all. (Kleiman and Raskin, 1994: 153)

Further, if women experience PPD, support networks make all the difference when it comes to recovery.

> Mobilizing personal, emotional support systems is an important adjunct to either medical treatment or psychotherapy, or both. (Huysman, 1998:98)

> Good quality social support is overwhelmingly the most important factor involved in either preventing PND or alleviating symptoms

> and reducing the risk of severe and prolonged depression. (Nicolson, 2001: 141)
>
> Strong, faithful, understanding husbands were crucial to mothers recovering from PPD. (Poulin, 2006: 105)

However, a mother's general need for support is complicated by the fact that we live in a culture of individualism, nuclear families, and limited kinship systems of support. Self-help authors address the ways that our systems of support have diminished compared to other cultures and to times in the past. As a result women have no buffer between them and the misinformation that comes to them from society. Mothers lack a community of supportive women to turn to when they have childrearing questions. For example, family is seen as being more scattered and smaller than for mothers in the past:

> The contemporary family changed dramatically over the course of the second half of the 20th century and one important factor has been the breakdown of the extended family…This means that social support around the time of having a baby can be a problem, particularly when large distances are involved (Nicolson, 2001: 109).
>
> First, in today's smaller families, women usually have little experience caring for the babies of others or being around women who are having babies…Second, extended families usually live too far away to help at home during the crucial first two weeks after delivery (Sebastian, 2006: 7).
>
> In today's society, extended families are rarely available, and thus a ready-made network including the woman's mother, aunts, sisters, and in-laws is not there to help her cope with her experience (Kleiman and Raskin, 1994: 3).

The nuclear family model adopted by most Americans also leaves many mothers feeling alone and isolated. Linda Sebastian (2006) notes that "many working women who give birth feel alone because both their peer and social groups remain at work or their families are unavailable.

Having a baby separates a woman from her support system and keeps her isolated at home (8). Without an extended kin network to call upon, self-help authors portray partners, mostly referred to as fathers, as the primary source for support for postpartum mothers and "the person who can alleviate the most stress in your life" (Venis and McCloskey, 2007: 138). Self-help literature makes abundantly clear the fact that women should be first and foremost supported by the fathers of their babies.

> The importance of support from your husband or partner cannot be overemphasized…most women regard their husbands as their main source of emotional and physical support (Rosenberg, Greening and Wendell, 2003: 144).
>
> Of course, your greatest source of aid and encouragement will probably be your husband (Kleiman and Raskin, 1994: 159).
>
> Your partner is the person you are closest to, and therefore he is your most important source of support. In fact, studies show that if your partner is supportive…you will be less likely to develop postpartum depression (Venis and McCloskey, 2007: 138).
>
> Research continually suggests that the contributions of the father to the family, if he is present, are critical to the health of the family (Roan, 1997:57).

Yet sometimes women find themselves alone or simply with unsupportive partners who are not participating in childcare as the mothers had hoped. In her interviews with mothers who had postnatal depression (PND), Paula Nicolson (2001) found that "very few of the fathers…met their partners' expectations in relation to emotional support and childcare" (148). Sharon L. Roan (1997) notes that "many women are upset with the response of their partners to parenthood and their increasing needs, feeling their husbands are not supportive, empathetic, or helpful enough" (57). The disappointment that women feel when their partners do not participate in childcare as they had envisioned represents serious inequities in the way that childrearing

responsibilities are managed. Indeed, many mothers find themselves dealing with partners who not only hold mothers primarily responsible for childrearing, but also expect mothers to (continue to) fulfill a myriad of other "wifely" duties:

> These women had husbands who – far from being supportive – wanted their wives to continue keeping the house clean, having food on the table, and having sex (Poulin, 2006: 105).
>
> My husband and I argued quite a bit. He was hesitant to take an active part in caring for our daughter, but criticized everything I did. He was also critical of my inability to keep the house clean since I wasn't working (Poulin, 2006: 108).
>
> My husband has never been supportive. When I would tell him how exhausted I was, he thought I was being a baby. My husband always made sure he was happy. But he just wanted me to clean, work, clean, work…My husband never helped with the crying babies or sleepless nights…He wanted me to take care of the baby in the day, and sleep with him at night (Poulin, 2006: 112).

Self-help authors also give advice which assumes women take on the gendered roles that the husbands above desired of their wives.

> Leave the beds unmade. Close the bedroom door if you don't want any unexpected visitors to see (Kleiman and Raskin, 1994: 63).
>
> Simplify your housework. Do the same chores less often or do fewer chores until you feel better. For example, it's okay to change your sheets every other week for awhile if you usually do it every week" (Kleiman and Raskin, 1994: 64).
>
> Simplify dinner. Replace a salad with sliced cucumbers. Replace a casserole with broiled chicken that you simply rub with oil and sprinkle with garlic. Replace homemade dishes with frozen entrees, spaghetti with sauce from a jar, or macaroni and cheese (Kleiman and Raskin, 1994: 64).

Not only does this type of advice reinforce the notion that women should be solely responsible for the unpaid labor in the home, but it asserts that one of the very conditions causing women's

depression in the first place – feeling overburdened with little support – is justified because it is her duty to do the housework. Also implied in this type of advice is the idea is that the mother's break is only temporary. Once the worst is over she is expected to return to her full workload:

> Now that you're feeling better, it's time to get reacquainted with the day-to-day tasks of your daily life. You don't have to suddenly start doing 100 percent…Set a reasonable schedule for yourself" (Bennett, 2007: 310).

One aspect of a mother's "workload" is her sexual obligation to her husband. Despite the fact that "loss of the libido is one of the recognized losses that can occur in depression" (Dalton, 1980: 78), self-help authors make it clear that a woman is expected to nurture the sexual part of the relationship. Whenever sexual advice is given, it carries the assumption that mothers are having sex with men, mothers only have sex with one man, and that sex defines the relationship with this one man. Bennett (2007) notes that sex is "a way to allow your partner to express *his* love to you (my emphasis), and vice versa…your primary relationship is the only relationship you have where you *can* be sexual (author's emphasis) – it sets your relationship with your partner apart from all other relationships" (274). Advice directed at mothers in lesbian relationships, or at women who have sexual relationships with someone other than the father of the baby, is non-existent. Rather, advice seems to focus on the "problem" of decreased libido during depression and how to address that:

> "It's important that you not wait too long to get your sexual self back. Only you know what 'too long' means, but don't necessarily wait until you feel completely comfortable, either emotionally or physically" (Bennett, 2007: 274

> "You need to nurture your connection with your partner, especially now when you need his support the most…Spending time alone with your partner does not necessarily mean that you have to have sex. You can be intimate without sex, using hand-holding, massage, or taking quiet walks together" (Venis and McCloskey, 2007: 130).

That the issue of men wanting sex from their libido-less wives is included in these readings represents essentialist notions about gender. By making statements about men and women such as the one below, authors like Dalton (1980) perpetuate notions about sexuality that do not reflect the reality for all women.

> One of the problems that childbirth can produce in the mother is a loss of sexual pleasure and desire…while her partner still keenly desires sexual activity (77).

Where self-help authors give advice on intimacy directed at the (male) partner who wishes to resume sexual activity with the depressed mother, they encourage men to be sensitive to the needs of the healing woman in order to get what he needs. In the example below, the male sex partner is encouraged to be loving and attentive to his partner's needs, but it is very clear that it is *his* need for intercourse that must be delicately tended to. Further, the example below shows how penetration sex is the ultimate goal:

> In all cases where the loss of libido has occurred after childbirth, it is necessary for the partner to start again with the whole wooing process. The woman needs to feel she is loved all day long, not only before intercourse. She wants to be kissed and cuddled and spoilt. If she resents any approach, or runs away from intimacy, then no attempt should be made to complete the sex act. She needs more arousal, more love-play, and only when she is relaxed and stimulated should insertion occur (Dalton, 1980: 84)

It is also clear that women, too, have internalized this ticking alarm clock that holds them accountable to a timeline of sexuality that meets their partner's needs. When addressing the loss of libido that comes with PPD, self-help authors describe women's deep guilt and shame over their inability to fulfill their sexual duties as wife.

> Because of sleep deprivation and the demands of a new infant, mothers frequently find themselves so exhausted that sexual

> relations are the last things on their minds. This may create guilt and stress between partners, adding to the strain of the postpartum period (Osmond, Wilkie, and Moore, 2001: 236).
>
> For many women the greatest possible insult is for her partner to refer to her as 'frigid' or 'ice cold' (Dalton, 1980: 77).

Underlying these messages about sex and shame is the fact that mothers are essentially told that they must barter sex for support – if they do not nurture their intimate relationship under highly stressful conditions, mothers risk losing the love and support of their first line of defense. It does not matter that they most likely do not desire sex; they must work to restore their sexual lives to pre-baby condition. Self-help authors seem to empathize with this quandary, but do little to challenge it.

Self-help authors also do little to challenge notions of femininity. In addition to emphasizing the importance of sexual healing in overall recovery from PPD, self-help authors also focus on how feminine behavior lends itself to recovery from depression.

> If you used makeup before the baby, get back in the habit…When you go out (or stay in), take a shower, fix your hair (or at least comb it) and dress well (that means get out of those big, baggy sweatpants). You count!" (Bennett, 2007: 214).
>
> Put on a little makeup, even if you won't see anyone else all day. You deserve to look pretty, just for yourself. If you really don't have the energy, just apply mascara (thirty seconds). If you can spare thirty more seconds, add lipstick or lipgloss. You give yourself a subliminal message every time you pass a mirror when you do this: 'My appearance matters'" (Kleiman and Raskin, 1994: 86).
>
> Take a bath in scented oil, or wear perfume. Don't wait for a special occasion – do it for yourself. A wonderful fragrance sends the subconscious message that you are special and attractive" (Kleiman and Raskin, 1994: 64)

Or, in the case of the "mommy" character in an illustrated story of postpartum depression for children, women can get some "retail therapy," as long as daddy allows it:

> Mommy thinks maybe she needs to get out of the house so she takes the baby shopping. Buying clothes takes her mind off her problems, but once she gets home she realizes she spent too much money. Now she has another problem; explaining the bill to Daddy! (Dupuis, 2005: 40).

When women find themselves participating in a parenting dynamic that does not look like what they had envisioned, they often express anger and resentment over the situation. Some self-help authors encourage this expression. By acknowledging the angry feelings a mother may have, these self-help authors normalize a negative response to motherhood and the imbalance of responsibility for childrearing that exists between the parents.

> Far from feeling guilty and a burden to their partners, many of them expressed fury at the man for not being prepared to change while they themselves do the work and make the compromises (Nicolson, 2001: 144).

> Many women are resentful of their partners because they feel that the baby has changed their lives drastically but that their partners' lives haven't changed at all (Venis and McCloskey, 2007: 132).

> I felt like my life changed so drastically and my husband's was the same. At least he could leave, be with grown-ups, take a break, get paid, feel productive, have fun, sit down during meals, go to the bathroom *alone*, get dressed, knows *his* job comfortably well, and was not alone like I was. I was really pissed (Jessie L. cited in Venis and McCloskey, 2007 37).

> I never felt I would hurt my baby, but I wanted to hurt my husband for being so unaffected. He just went on with his normal life, without interruption, and it made me furious. My life was in pieces (Talya cited in Poulin, 2006: 109)

Yet, even though self-help authors acknowledge the importance of venting, they ultimately pathologize these feelings of anger and resentment towards male partners as symptoms of PPD. Rather than addressing issues of gender role inequality, these authors take an

approach that is couched in medicalized views of women and what feelings they are "allowed" to experience.

> If you are experiencing anger and resentment at your husband…and these feelings are brand new it is likely that this anger is a symptom of PPD (Kleiman and Raskin, 1994: 50)

It seems perfectly reasonable that a woman, even if she had never experienced rage towards her husband before, would feel rage over her circumstances. Paula Nicolson (2001) stands alone when she puts the anger and resentment that many women feel towards their partners in context by challenging the notions of gender and motherhood. She questions the notion that women want to and should be mothers:

> Is it 'natural' for a mother to *desire* to take full responsibility for spending most of *her* time with her child? What then can we say about the frustration, boredom and feelings of personal inadequacy that are bound to emerge when an intelligent, lively adult focuses almost exclusively on others' needs. This is a major self-sacrifice that is likely to result in a severe depression if the woman seriously believes this *is* her destiny (Nicolson, 2001: 116).

Sharon Roan (1997) also notes that "much heartache, stress, and arguing could be avoided if husbands could overcome the notion that they are less responsible in family life issues" (150).

Other self-help authors do little to acknowledge the rage and disappointment a mother might feel when her partner is unsupportive. Instead, they should learn how to better ask for help from their husbands, who, as men "simply do not know how to be supportive" (Roan, 1997:182). Yet while this approach may provide women with some guidance on how to communicate with their partner, it does little to challenge the sexist notions that leave many women to bear the burden of childrearing alone. This is problematic as it normalizes and legitimizes the way things are. Because PPD is seen as a disease that resides within the woman's body, it stands to reason that for these authors, to challenge sexist norms will do little to prevent

or treat PPD. Rather, it is the responsibility of the "diseased" woman to learn how to reconcile her needs for help with the normative roles she and her partner assume.

> Make your needs known – to yourself, your spouse, and others. Bottling up feelings of frustration will only make the days ahead harder. Tell your husband 'Everything seems so chaotic right now. It would give me some peace of mind if you could keep the house straightened up (Roan, 1997: 47).
>
> Who would want to step up and do a task if it's going to be judged as wrong or inadequate? After awhile, anyone would stop trying. If you truly want to feel like you have a full partner and less like it's all on you, you need to change your mindset and behavior (Bennett, 2007:235).
>
> Couples should talk about what the father can do to help. He should be made to feel as important as he is. He needs goals and clear ideas of your expectations (Roan, 1997: 58).
>
> Ask your partner to give the baby one or two of his night-time feedings…Ask your partner to help with the dishes when they start to pile up (Venis and McCloskey, 2007: 121).
>
> One of the most frustrating aspects of PPD is articulating how you feel. Finding words for the confused and intense web of emotions affecting you can be challenging, and that's putting it mildly. So, to keep the lines of communication open, whenever you do have a clue as to what it is that you want or need (or feel), make sure you tell your partner as quickly and as clearly as possible (Bennett, 2007: 264).

In this last example, the woman's wild emotions keep her from getting the help she needs. Among the many responsibilities that she has to juggle as mother, she also needs to clearly articulate what needs to be done and delegate effectively in order to be supported by her partner. Further, this condescending approach assumes that men are clueless when it comes to parenting and housework and need to be told what to do in order to be helpful, and that women are too emotional to articulate clear thoughts. Self-help authors reinforce gender-based power

dynamics by portraying women and men this way when the help that women *really* need is to end the cycle of gender stereotypes.

While self-help authors emphasize the woman's partner as playing a primary role in a postpartum mother's success at adapting to motherhood, they also address other types of micro-level support as well. Other immediate family members, extended family members, friends, neighbors, churches, and support groups, to name a few, are also an essential for the mother's good health and well-being.

> Because the transition to motherhood can be such a traumatic and demanding, you need the help of others before, during, and after delivering your baby. In other words, you can't do it alone. If you feel like you're doing it alone, then that in itself is related to an increased risk for postpartum depression (Rosenberg et al., 2003:37).
>
> Social support is a powerful factor affecting the severity of stress during the postpartum period. Earlier we told you that social scientists don't really know what causes PPD. That's true, but one thing is well established about PPD: Social support is a critical factor in the origin, course, and outcome of PPD (Kleiman and Raskin, 1994: 151).
>
> Studies indicate that women with multiple sources of support adjust to the postpartum period more easily than women with a single source or none at all (Kleiman and Raskin, 1994: 153).

This important social support can come in the form of help with chores and childcare, or it can come in the form of emotional support:

> The most important role support people play is that of encouraging the new mother to express her feelings and of listening to her in a supportive way and nonjudgmental manner. Accept the new mother's feelings. Remind her that if she can express and accept feelings, that is a step toward healing (Roan, 1997:161).
>
> The strength to find my way back to normal wasn't just in the medications I took or the therapy I underwent…It was also the friends who brought cards and meals and cleaned my house,

> women who took care of my children and offered many words of encouragement (Zahn, 2006: 178).

Self-help authors acknowledge not just the importance and absence of extended support systems, but of support systems of women, in particular. It seems that because women are seen as primarily responsible for mothering, only a community of other women could understand and support a mother through the postpartum period. In this sense, it seems as though self-help authors walk a fine line between encouraging women to seek support from the places it is available – oftentimes a male partner – and simultaneously setting mothers' expectations for the fact that mothering *is* a woman's job, and other women – not men – should help you with it.

Without kinship systems of women that are readily available to mothers, one form of support authors recommend is support groups. Marie Osmond (2001) explains that support groups work: "for young mothers to be in contact with other women provides a comfort zone where they can safely share their concerns as well as their joys (30). Most self-help authors view them as a godsend to moms who can benefit greatly just from knowing and talking to other moms who struggle with motherhood.

> Just finding out that you're not alone in what you've been thinking and feeling has tremendous value for women with postpartum depression…Groups can be supportive, and often the women in them are able to come up with many positive ways to help each other (Rosenberg et al., 2003: 122).

> These groups can provide enormous support and hope for the woman who feels isolated by her depression and needs support and validation from other women. It can be a huge boost to your morale to see other mothers who have felt as badly as you feel right now come out of the black hole of recovery (Kleiman and Raskin, 1994: 146).

On the other hand, three self-help authors are wary of the effectiveness of these support groups. For some self-help authors, these support groups represent a "danger zone" for women who might be negatively impacted by seeing extremely depressed mothers.

> I'd looked forward to an uplifting meeting, but this is a bummer. These women are a wreck. I feel sorry for them and want to help them…but I am in no position to play social worker. And it's not good for me to be in a room filled with so much pain. I'm purging myself of pain. I can't afford to wade through it so soon (Resnick, 2000: 165).
>
> Support groups are not for everyone. Initially, a very ill mother may not be able to attend a support group. Likewise, mothers with very mild postpartum depression for baby blues may feel that the group she is attending has more serious concerns. Some women are simply not helped by talking to other women (Roan, 1997: 171).

This perspective is problematic, especially when we consider the fact that society perpetuates a myth that motherhood is always happy. The fact that some self-help authors assert that it would be negative for mothers to see other depressed mothers reinforces the notion that the myth of happy motherhood should be protected. In fact, while one self-help author (Huysman, 1998) recommends that expectant mothers should attend a postpartum depression support group in order to understand the experience of depressed and be prepared for the possibility of becoming depressed, the authors (Rosenberg et al., 2003) of another self-help book advise against a pregnant woman attending such a meeting. They justify this perspective by saying: "If you are pregnant, you have a unique set of problems and should not be exposed to problems you don't have. You might begin to worry more and feel like you are never going to get better" (123).

Self-help authors note that one complication is that women have a hard time asking for any kind of support. Self-help literature devotes attention to gendered notions about how gender roles and norms discourage women from asking for help. For example, a gendered notion

among self-help authors is that women often do not ask for help because they feel as though they should put others first and care for themselves last.

> Women frequently find it much easier to give social support than to receive it…Some women are so used to giving to others that they no longer even know how to get in touch with their own needs, let alone ask for help (Kleiman and Raskin, 1994: 152).
>
> The maternal instinct can be so all consuming that we in essence allow other parts of ourselves to fall asleep under its influence: our intellect, our social needs, our passions, and even our health. Once deadened for any length of time, these parts of our lives can be forgotten (Osmond, 2001: 191).
>
> After all, women are caretakers by nature. We know how to fix things. I didn't need help…I was the one who gave help (Osmond, 2001: 15).

Self-help authors note that many women are afraid to for help because they are ashamed and guilty for how they feel and afraid people will think they are bad mothers. They feel as though they are (and society expects them to be) solely responsible for the welfare of their children, without help from anyone.

> Looking back, I know I could have made a phone call to any number of friends or family members who would have dropped what they were doing and brought over groceries, but I couldn't let myself ask for help. In my mind, it really didn't feel like an option (Osmond, 2001: 99).
>
> New mothers therefore are in a difficult position – they have to be superwomen – both self-reliant and an effective 24-hour, 7-days-a-week carer. Cotemporary society has failed to take issue with this paradox. Many women, because of this, feel guilty, inadequate and bad mothers, a vision of themselves compounded by a 'secret' guilt surrounding ambivalence towards both their role as mother and their children (Nicolson, 2001: 109).
>
> Almost every night as I drove, I would fall apart emotionally, deluged with guilt about the mother I wasn't capable of being anymore (Osmond, 2001: 165).

> Many women suffer in silence, condemning themselves over their own bizarre thoughts or behavior. They have felt alone, frightened, misunderstood, and reviled for their feelings. They are ashamed (Huysman, 1998: 23).

> I lay down in the bed and tried to sleep, but my thoughts were agonizingly harsh. 'Why would I be given my life if I couldn't handle it? What kind of mother am I? How could I be so selfish? Here I had seven beautiful children, a thirteen-year marriage, and a long-lasting career, so many things that other people would love to have. My mother raised nine kids and coped with life on the road. She didn't fall apart. Why am I such a failure?' (Osmond, 2001: 137).

> For most women, as their symptoms worsen, they often try to hide their problems and avoid contact with others. Unaware that other women share her problem, they feel alone. They believe they are 'bad' mothers to be having the feelings that accompany postpartum depression (Sebastian, 2006: 14).

> I know my feelings of inadequacy and embarrassment at not being able to cope caused me to downplay my true condition to my doctor, my neighbors, my co-workers, my extended family, and eventually even to myself (Osmond, 2001:186).

Self-help authors view shame as integral to PPD and describe shedding these feelings of shame as a big step in the recovery processes. Shedding these feelings of shame can come through interacting with other mothers who have experienced postpartum depression or just coming to a realization that it is *okay* to feel depressed. In either case, however, authors make central the notion that women need validation for the way they feel.

> I was holding in my hands e-mails representing the lives of women across the United States. They were thanking me for talking about my experience with PPD. Each of the stories was different, but they all made reference in some way to one thing we shared: shame. Shame that had caused them to remain silent about their problem. Many of them said that it helped them so much just to know they weren't the only ones who were suffering…After reading many letters, I realized that the very first step to healing was to somehow dispel the shame women feel for being depressed (Osmond, 2001: 183).

> You need to be able to talk with people you trust and who care about you and what you're going through. Not only is it a relief to share your feelings and frustrations with others, but it can also help you to see that you are not alone in your struggles (Venis and McCloskey, 2007: 70).
>
> I cried tears of relief as I discovered other women who had survived PPD to the degree that I had it…The only thing that kept me sane was knowing that others had PPD and had made it through (Poulin, 2006: 3).
>
> PPD wasn't your fault in any way, shape, or form, and you have no reason to feel guilty, ashamed, imperfect, or bad in any way (Bennett, 2007: 26).
>
> I found this postpartum depression message board on one of the Postpartum Depression sites…I found my home. This was my family that I had been looking for. These women were suffering the same shame and guilt but all at different levels, the pain was still the same though (MacDonald, 2002: 26).
>
> Though my doctors had been helpful medically, it wasn't until I began reading other women's accounts in the material Sherie gave me that it became painfully clear. I could have been reading my own journal. Like me, these other women cried an inordinate amount and felt as if they had no connection to their infants. They felt guilty and mournful, and their minds were flooded with negative images of themselves dying or their babies being killed…I was shocked that these stories related to me and that these women all sounded like sane, competent people (Shields, 2005: 141).

For many of these women, validation comes from the interactions they have with a community of women experiencing the same thing. In this way, women are turning away from medical channels in order to seek a sense of solace that comes from speaking with women who share their plight. Turning away from established medical channels and instead seeking support from other "regular moms" is a key feature of the PPD self-help movement and of self-help literature in general (Simonds, 1992).

Some self-help authors also broaden their discussion of support to a societal level. At a macro-level, self-help authors say support is crucial but lacking. The most common way that self-help authors say women are not supported at a societal level is through the persistently unrealistic portrayal of motherhood. In some cases, society perpetuates postpartum depression by idealizing motherhood and portraying it as a time in a woman's life that should be easy, natural, and worry-free.

> We all expected this to be the happiest time in our life. The buildup of to the expected period of bliss after a baby arrives seems universal. All the images we've seen in the media while growing up – scenes of mothers holding their calm babies so serene and fulfilled, scenes of a clean home with dinner on the table as Mommy and baby wait for Daddy to come home from work – feed our expectations (Poulin, 2006: 89).
>
> It's like you're not supposed to shatter the frilly, gooey, fuzzy images of new motherhood with the reality of sleep deprivation, exhaustion, and frustration (Poulin, 2006: 93).
>
> If you believe what you see in television commercials and magazine advertisements, every mother has a perfectly flawless infant with a twinkle in his eyes and a smile of contentment on his face. His mother wakes happily to feed him. She is always rested and her makeup is in place. She places the baby to her breast and they both gaze meaningfully into each other's eyes. They bond instantly. By now you've discovered the reality behind the Gerber Baby myth – the incessant crying, the endless dirty diapers, the sleepless nights. Society reinforces the myth of the perfect baby in the arms of the perfect mother, with all her maternal instincts intact…Our culture and media play a powerful role in shaping our expectations. Ands these expectations, in turn, create enormous pressures on mothers to strive for perfection (Kleiman and Raskin, 1994: 198).
>
> Close to seven hundred thousand new moms *do* develop postpartum depression every year…A large part of the blame for this must be placed on our society's attitude toward motherhood. Our culture has been very reluctant to talk about the reality of having a baby and the enormous physical, emotional, and relationship changes that it brings. In fact, society seems intent on

> perpetuating antiquated, unrealistic expectations of new mothers that should have disappeared years ago (Venis and McCloskey, 2007:1).
>
> These mythical attributes of motherhood were created by society in ages past to promote and facilitate the birth of more children who could contribute to the family economy. They remain tightly woven into the fabric of modern society. And yet the idea that mothering comes naturally and is carried out without little sweat or strain is a real disservice to women (Roan, 1997: 50).

In these examples, we see how myths about how mothers and parents behave sabotage the well-being of mothers. Instead of acknowledging the incredible responsibility that comes with caring for babies and young children, society not only romanticizes motherhood, but also disregards the difficulties of it. The prevailing cultural notion is that motherhood, and indeed a maternal instinct, should come easily and naturally to women. Self-help authors describe the ways that mothers are expected to bear the entire burden of child-rearing, and they should also look good and feel physically and emotionally healthy while doing it.

> Society seems to celebrate those who have their children one day and then return to work the next. In other cultures, women are allowed to rest and nurture their newborns before returning to their other work. With the help of many others, they are allowed to recover and then resume their lives. In our society we are supposed to quit completely or act as if nothing has changed (Shields, 2005: 168).
>
> Many new moms (even those without PPD) are taught by the multibillion dollar cosmetic industry that they should have their changed bodies…A myth that is particularly hurtful at this time is the ridiculous one that expects new moms to snap back to their pre-pregnancy bodies after only sex weeks. This idea is ludicrous (Bennett, 2007: 195).
>
> Whether we call ourselves martyrs or superwomen, some of us come to believe that we must give entirely of ourselves when we become mothers. We seem to feel that our families cannot survive unless we shoulder most of the burden. The superwoman myth is harmful because it thrusts the success of the family on you instead

> of defining motherhood as a role that should be Embedded within a network of social and public support (Roan, 1997: 73).

Other authors address the ways that society makes motherhood difficult for women by highlighting policies and practices that devalue women. Short hospital stays, for example, demonstrate the lack of caring our society provides to women once they deliver their babies. Marie Osmond (2001) notes how the period of physical and emotional changes that take place after birthing a child are all but ignored "in our North American culture, where women are expected to return home from the hospital to a normal routine twenty-four to forty-eight hours after the birth of the baby" (236).

> Our society minimizes the impact of having a baby, especially a first baby. Recently, 'drive-through deliveries' have gained widespread attention in the media and even in the U.S. Congress…This trend reflects the attitude that having a baby is 'no big deal' and that a woman should quickly return home to carry on with her life. But, in fact, the physiological and psychological changes that you experience at delivery are unparalleled in your entire life (Sebastian, 2006: 13).

> The doctors said that I had recovered enough physically and that the baby and I were free of complications. Medically, this may have been true, but I instinctively knew that I was not ready to leave. I wanted to stay in the hospital to rest and have someone take care of me and the baby (Osmond, 2001: 84).

> Pregnancy and childbirth are not illnesses, but I think our current system of discharging a new mother from the hospital so soon after giving birth is full of hazard. It may save money overall, but I have to question what the cost is to a woman's well-being and the welfare of the infant. They are sending home an exhausted, hormonally-confused, physically stressed woman with a tiny, fragile being who needs twenty-four hour care (Osmond, 2001:86).

While self-help authors may critique the level of care that women receive when they have their babies, they do not suggest that women should go elsewhere to have them. Instead, they suggest that what women need is simply more time in these hospitals. Self-help authors do not

question typical birthing dynamics or explore other options available, such as a midwife-attended homebirth. By omitting such a critique, self-help authors are proposing increased medicalization of women and childbirth.

Policies regarding maternity leave and daycare provisions are also scrutinized by self-help authors:

> In past decades, there seemed to be more emotional support for new mothers. Society approved and applauded its new members. Assistance and advice to new mothers was always available. Children were highly valued. Western cultures still contend that a new life is to be cherished and celebrated, but in reality, there are few support structures that take children into consideration. The lack of daycare alternatives for working mothers is one example. Moreover, new mothers may be penalized in the workplace (Roan, 1997: 66).

While Roan (1997) may be idealizing the days of old, she does make clear the problems associated with society's stance on mothers and children: "mothers today are revered less because children are revered less. Children today are viewed by society with perhaps the lowest regard ever seen in modern times" (75). Roan describes how motherhood's place in society is directly linked to PPD:

> Some depression can result from a new mother's attempt to live up to what is expected of her in today's society. New mothers don't become depressed because of their babies. Their unhappiness stems from living in a world in which, they soon realize, they will receive little help or support. How society treats new mothers is very important to their well-being (62).

Gender inequality, represented on both an interpersonal and societal level, clearly plays a role in the misery of motherhood. With the occasional help from their partners and in isolation from other families and mothers, women are expected to provide most of the parent-work for children. The inherently stressful nature of this arrangement, however, does not receive as much

attention as the mysterious hormonal inner workings of a woman's body. Self-help authors do not call for criticism of gender norms; instead they blame the victim and focus on the "disease" inside women's bodies. Such an approach absolves all of us from the messy and complicated task of unraveling the negative consequences of antiquated gender norms.

CHAPTER 5: MEDICALIZING MOTHERS

With so many self-help authors discussing the myriad ways that mothers without support systems fall prey to PPD, it would appear as though the lack of proper support for mothers in the United States is the primary cause of PPD. However, self-help authors endorse medicalized explanations and treatments for PPD. Indeed, echoing the findings of Martinez et al's (2006) examination of PPD articles in magazines, self-help books on PPD are dominated by a medical model perspective. Of the self-help books examined in this study, only two of the twenty-two books attributed the experience of PPD to something other than biology or hormones. The medicalization of PPD can be seen in several different ways throughout the self-help books: in the way self help authors define the illness and its causes, through the reference to risk factors that could lead to becoming depressed, through a preoccupation with the impact that PPD has on the mother's family, especially her children, and through the recommended treatment of this illness, which is typically anti-depressants. Combined, these factors contribute to an overall view of this illness that is grounded firmly in the medical model.

Much research has been done to explore how and why human experiences, particularly those of women, come to be understood through medical channels. Peter Conrad (2000) defines medicalization as the process whereby a problem is defined "in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using medical intervention to 'treat' it. Medicalization occurs when a medical frame or definition has been applied in an attempt to understand or manage a problem" (322). In doing so, "medical practice becomes a vehicle for eliminating or controlling problematic experiences for the purpose of securing adherence to social norms" (Riessman, 2003: 48). In other words, members of

society are still held accountable for observing and adhering to the norms of society, but when they fail their label is one of sickness rather than deviance. Further, Riessman (1983) notes how "medicalization has resulted in the construction of medical meanings of normal functions in women – experiences the typical woman goes through, such as menstruation, reproduction, childbirth, and menopause" (14). In this sense, women fall more heavily under the watchful eye of the medical model and more of their experiences are deemed pathological by the medical community.

Irving K. Zola (1972) expanded on this idea and illuminated the fact that the medical model seeks to expand its power and authority by monitoring and controlling an increasing number of human behaviors and conditions. Problems that may have otherwise been attributed to social causes are instead viewed as medical conditions. This is certainly the case with PPD. Commonly found throughout self-help books on PPD is the notion that PPD is and should only be defined as a medical illness. Dana Rosenfeld and Christopher A. Faircloth (2006) note how the institution of medicine has asserted its authority and control "by redefining social problems as medical ones and claiming that their own expertise was the most appropriate one to cure them" (2). Indeed, the excerpts below illustrate how self-help authors construct PPD as a medical condition that will only be resolved through medical treatment.

> Accept the reality of PPD as an illness and recovery will be easier (Bennett, 2007: xiv).
>
> You must seek treatment from a health-care practitioner, and therapy and medication are usually necessary to help you recover from it (Venis and McCloskey, 2007: 11).
>
> Some professionals might treat these complaints and symptoms strictly as psychological problems. No one may be aware that these inappropriate thoughts, feelings and behaviors are symptoms of a medical problem (Huysman, 1998: 38).

In fact, some self-help authors indicate that if left untreated, PPD will get worse rather than go away on its on. Many authors describe dire consequences for women who do not receive the "proper" treatment for their depression. However, in order to benefit from this treatment, one must first accept that she has a real illness, much like the alcoholic must admit she has a drinking problem in order to recover.

> Because PPD will continually get worse if not treated, it's important for you to quickly seek treatment. But remember, to fully receive treatment, you have to first accept the fact that you have PPD (Bennett, 2007: 185).
>
> The birth event triggers a long-term and serious illness, a psychopathology, which is definable, treatable, and controllable – but only once it is recognized as such (Huysman, 1998: 39).
>
> The changed personality and lifestyle may persist for twenty or more years, with the condition gradually changing into premenstrual syndrome (Dalton, 1980: 3).

Women who do not seek medical treatment for their depression are seen as irresponsible and taking risks with their health. Indeed, one self-help author claims that women who do not receive treatment (in this case, anti-depressants) for depression will become permanently brain damaged:

> You, like a great many other women with postpartum depression, will not improve without treatment…even if you are one of the few women who does make it through the experience without help, you will have permanently altered pathways in your brain and be even more susceptible to stressors and hormonal events in the future (Rosenberg, Greening, & Windell, 2003: 84).

Self-help authors rarely break from their adherence to a medicalized view of PPD. Paula Nicolson (2001), however, explains how and why the medical model is the most popular avenue of care for depression:

> Experts have different explanations about the causes and effects of depression. The most frequently rehearsed perspective on depression is the emphasis upon depression as an illness. Such a model is popular because it removes the stigma that sometimes accompanies psychological problems by showing that depression is not the fault of the individual who is suffering. They have something physically wrong with them. They are not to blame as they have an illness that can be 'cured' (12).

Other passages reveal how self-help authors acknowledge some limitations of viewing PPD as a medical issue. Doing so removes any focus from the "real" reasons women might be depressed, and the medical model's approach strikes one author as damage control, rather than looking at the source of the problem.

> There are sensible reasons for women's postnatal distress and labeling it 'illness' does not help (Nicolson, 2001: 37).

> As though by imposing their 'scientific' language on someone, they could make sense of and contain all of the fever and fret…They offered me not explanations, either for my 'illness' or for my treatment. Psychiatric practice seemed more like an exercise in damage control than an effort to find a cure (Shaw, 1998: 152).

Self-help authors also adhere to a medicalized view of PPD through their assertions that PPD is a hormonal or biochemical issue. While no biological cause for PPD has been identified (this is why PPD is a syndrome and not a disease), most self-help authors maintain that fluctuating hormones and/or faulty brain chemistry cause PPD. Table 1.2 illustrates the frequencies for causes of PPD mentioned.

Table 5.1 Causes Given for PPD

Cause of PPD	#
Biology – hormones	10
Don't know but Probably Hormones	4
Unique for each woman who experiences it.	2
Multifaceted	2
Not Mentioned	2
Negative thinking and lack of support	1
Mostly biology but some other factors	1

> Although researchers believe that shifting hormone levels and changes in the hypothalamus and pituitary glands are involved, they still have much to discover regarding exactly what's happening and to whom (Bennett, 2007: 14)

> Though many of the studies have insufficient data to establish a diagnosis of depression, most clinicians agree that there is sufficient implication regarding physiological and biochemical events in postpartum psychiatric disorders, primarily involving the endocrine system (Huysman, 1998: 35).

> Although there doesn't seem to be a consensus as to what causes postpartum depression, many believe that they rapid change in hormones at delivery may be significant enough to cause a mood shift (Shields, 2005: 138).

> Postpartum depression is completely hormonal/physical and can happen to anyone regardless of her personality (Poulin, 2006: 8).

In fact, what many authors assert is that the fluctuating hormones sets PPD apart as a special kind of depression, one that only new mothers can suffer.

> Perinatal mood disorders are caused primarily by hormonal changes which then affect the neurotransmitters…These perinatal mood disorders behave quite differently from other mood disorders because hormones are going up and down (Bennett and Indman, 2003: 29).

> These hormones cause postpartum depression (PPD) to feel very different from other depressions. When people suffer from depression at other times – not after pregnancy – they're constantly down in the dumps. PPD doesn't feel like that. You're probably up and down and all around, like a roller coaster (Bennett, 2007: 223).

> It is also different from all of the other mood disorders (like bipolar depression) in that it is the only one that is a combination of the irregularities of both hormones and other neurotransmitters (Rosenberg et al., 2003: 5).

The passages above illuminate the way that postpartum depression is not only a biomedical issue, but also a *unique* biomedical issue. What makes PPD so unique is its proximity to the birth of a child, as well as its relationship to a woman's hormones. However, despite self-help authors' claims that PPD is a unique disorder, most do not suggest unique treatments. In fact, most recommend a course of treatment very commonly used for "normal" types of depression. One of the most prominent and striking ways that self-help authors adopt a medicalized approach to guiding women through PPD depression is through their endorsement of anti-depressant medications to treat PPD.

> Although there's a stigma about taking medication, I encourage moms to be open-minded. The drugs are temporary until the body/mind can work itself out (Poulin, 2006: 5).

> Medical treatment is necessary because your brain chemistry needs to be addressed. Depression of any kind is best treated by a combination of medication and psychotherapy…sometimes without medication, you won't be able to make use of the other treatments (Rosenberg et al., 2003: 93-94).

> Medication can stabilize these symptoms enough to allow you to invest the psychological energy that therapy requires. We strongly recommend that in severe cases of PPD, medication contributes to a quicker, fuller, longer-lasting recovery (Kleiman and Raskin, 1994: 98).

Further, despite a lack of conclusive evidence regarding the safety of long-term anti-depressant use, both for the mother and her breastfeeding baby (Osmond, 2001; Kleiman, 2005), self-help authors make a variety of claims about the usefulness and safety of medications. For one, many authors dispute the "myth" that anti-depressants are addictive:

> Some people fear becoming addicted to psychiatric medication. However because these medications help restore your brain chemistry to its normal state, you would not become addicted (Sebastian, 2006: 85).
>
> Moms also worry that if they start taking a medication then they'll always need it. This isn't true (Bennett, 2007: 126).

They minimize the severity of side-effects of anti-depressants:

> Side effects from psychiatric medications often resolve within days or weeks as your system adjusts, and once the depression is gone, these side effects often seem like a small price to pay (Kleiman and Raskin, 1994: 108).

They also contend that it is better for the mother to breastfeed on drugs than it is for her to be depressed.

> The risks of being depressed and not being adequately treated are generally far greater than the risks of taking medication while being effectively treated and breast-feeding (Rosenberg et al., 2003: xxii).
>
> Most medications we prescribe do not appear to have long-term effects for your baby, and any adverse effects are usually reversible when you stop taking the medication or when you stop breast-feeding (Rosenberg, 2003: 111).
>
> The growing consensus is that the benefits of breastfeeding seem to far outweigh any risk of harm to a baby when their moms take medication (Bennett, 2007: 131).

Yet some authors feel that there simply is not enough evidence to conclude that breastfeeding while on anti-depressants is safe.

> It's important to note that even with the most current literature to support the use of certain medications during these periods and more physicians being comfortable treating pregnant and nursing women with antidepressant medications, it remains a matter of ambiguity (Kleiman, 2005: 91).

This discrepancy between authors who advise women to breastfeed while on drugs and those who feel that anti-depressants while breastfeeding are not safe touches on a component of PPD, which is pressure on mothers to breastfeed. Some self-help authors perpetuate the notion that "good" mothers should breastfeed:

> If you stop breastfeeding while you are taking medication, then your baby and you will both lose out (Rosenberg, 2003: 110).

However, many self-help authors clearly debunk the myth that women have to breastfeed to be good moms. In fact, many self-help authors point to this pressure as a component of postpartum depression.

> Whatever your decision about breastfeeding, keep in mind that breastfeeding is not a test of how competent a mother is, how feminine she is, or how much she loves her baby (Kleiman and Raskin, 1994: 127).

> I attribute a great deal of my PPD to my breast-feeding failure. I felt sad, cheated and bitter that I didn't experience the wonderful nursing relationship that the books I read talked about (Poulin, 2006: 48).

Despite any controversy over the safety of anti-depressants, many of the women who had PPD themselves attribute their recovery entirely to taking anti-depressant medications:

> "I am the proud owner of perspective, what I consider Zoloft's greatest gift to me" (Resnick, 2000: 161).

> "My husband and family provided great support, but the medication was the savior here. I had no way of lifting myself out of the tar pit without it" (Poulin, 2006: 56).

In fact, some self-help authors contend that medications are the only effective, proven treatment for PPD and for making sure that the suffering mother become "as productive as she was before the onset of the illness" (Huysman, 1998: 92):

> I contend that no psychotherapy or behavior modification in the world will stop a real postpartum depression. They can only delay it, perhaps only to repeat at a future date…mood disorders, including postpartum depression…can be effectively treated today with modern medicine (Huysman, 1998: 85-86).

In this passage, it appears as though Huysman (1998) views therapy and behavior modification as measures that only keep the illness at bay, whereas medicine actually cures the illness (as long as you take it forever!). In fact, Huysman goes on to say, without any evidence, that it is safe to take anti-depressants indefinitely:

> There is no reason to think that with recovery or even marked improvements the medications should be discontinued. In fact, it would be foolhardy, since improvement is an obvious result of the medications" (1998: 96).

However, not all self-help authors feel this way about medication. Indeed, Marie Osmond (2001) sees medication, rather than therapy, as a temporary fix:

> The idea of taking a pill to make depression go away is very appealing, but it sidesteps the cause and only treats the symptoms, like a bandage that only hides an infection. Unless we can acknowledge the feelings we are covering up, it will only be a matter of time before the depression returns in another form (198).

Other authors identify reasons why they are uncomfortable taking or even recommending medications as a treatment for PPD. Their reasons range from lack of evidence that supports the effectiveness of anti-depressants, to undesirable side-effects of medication, to a belief that PPD is not something that can be remedied with drugs.

> A mom with PPD doesn't always need medication in order to recover, though – sometimes all she needs is support, education and psychotherapy (Bennett, 2007: 126).

> There must also be an awareness that the FDA has approved these drugs only for short-term use. However, they tend to be prescribed

> for months and even years at a time. As yet, we do not know the long-term effects of these medications, and what the patient's cellular and neurotransmitter response is after long-term use (Osmond, 2001: 280).
>
> I've never considered resuming the pills. They would simply have delayed the dilemma. They enabled me to survive an impossible crisis and helped me compose myself sufficiently to begin life again. But they had no answers for me and they hadn't erased the questions (Shaw, 1998: 83).
>
> Drugs without self-understanding are not helpful in the long term, although for some women they may seem to be the only answer at the time (Nicolson, 2001:14).

Viewing postpartum depression as a hormonal problem that anti-depressants can remedy becomes complicated when the perspective of a few self-help authors – those who consider adoptive mothers and even fathers as candidates for postpartum depression – is considered. These authors contend that women and men who have not given birth can also experience PPD. This claim obviously puts into jeopardy the notion that PPD is purely a biochemical issue, as other factors would have to cause PPD if people who do not give birth can suffer from it. As a result, it is clear that the self-help authors who do broach the subject of adoptive mothers and dads with PPD do so carefully, without completely dismantling the blame-free "protection" that a purely medicalized view provides. In this way, the self-help movement acknowledges those who are marginalized by the medical model – men and women who do not have a biochemical "reason" to be depressed – without compromising the "progress" science has made with women who have already been diagnosed with "real" PPD. For example, Marie Osmond (2001) delicately acknowledges that:

> Adoptive mothers, due to the stress and sudden changes in their lives and schedules, can also suffer almost every symptom of postpartum depression (42).

For Osmond, the challenges and changes that come with rearing a child are enough to cause most of the symptoms of PPD, but not PPD itself. Similarly, when acknowledging the fact that PPD "can happen to anyone – even dads and women who didn't give birth" (35), Shoshana Bennett (2007) favors a medical cause for this phenomenon when she explains:

> Many moms who adopt have a history of infertility, and because of this infertility, some have taken a variety of medications to help them conceive…This inability to carry and birth a baby isn't only difficult on these women emotionally, but also physically and hormonally (40).

While adoptive mothers do not have the fluctuating hormones that mothers who just gave birth have, they may have experienced hormonal fluctuations in the past due to infertility drugs. Bennett (2007) highlights these fluctuations and in doing so maintains the medicalized label of PPD.

Fathers are also occasionally seen as at risk for PPD. Bennett (2007) mentions the fact that at least 10% of fathers get PPD. However, the PPD that fathers get is different than the PPD that mothers get:

> Their symptoms are different from the fluctuating hormones moods and emotions that moms with PPD exhibit. Fathers seem to have more tension and short-temperedness as the main symptoms of their PPD. Other feelings are confusion, anger, frustration, and helplessness (39).

Other self-help authors echo this notion:

> There are…great differences between maternal and paternal PND. The mother's is generally of hormonal origin…The male type of PND is more often brought about by the change in circumstances within his life, and the deprivation of sleep which invariably follows the arrival of a baby into the family unit (Dalton, 1980: 198).

> My husband did urge me to see a doctor, but was himself emotionally 'unavailable.' Perhaps he was experiencing his own PPD (minus the hormone imbalance), which, by the way, is *not uncommon* for new fathers (Huysman, 1998: 185).

Only one author connects the capacity for non-birth mothers to have PPD with the notion that there are other possible causes for PPD:

> For a long time, experts believed it was a strictly biological response to giving birth – a reaction to the craziness of our hormones returning from pregnancy to pre-pregnancy levels. But now we know that adoptive mothers, grandmothers, and even fathers can all experience PPD and that many birth mothers, who also have hormonal changes, do not develop the condition. These factors have led many researchers to believe that the causes of postpartum depression are psychological and sociological as well as biological (Venis and McCloskey, 2007: 10).

While only a few authors challenge the medicalized notions of PPD by examining depression among adoptive mothers and fathers, some self-help authors challenge medicalized notions by mentioning alternative therapies. However, most of the attention devoted to discussing alternative therapies is aimed at convincing readers of the dangers and ineffectiveness of alternative therapies. Many self-help authors are so steeped in the medical model that they spend pages and chapters discrediting alternative therapies that one can access without going through medical channels.

> You'll have those who, again, don't think the problem is biochemical, or they advocate naïve New Age or self-help medical beliefs…You can align yourself with the universe and buck up all you want, but you simply can't positive think your way through PPD or any other kind of serious depression. If you have a mood disorder of some kind, you need to recognize that in all likelihood it has biochemical roots, and that your recovery will come much, much faster if you address it on multiple levels, including the biochemical level (Bennett, 2007: 16).

> Herbs can be wonderful but they can also be dangerous…They are powerful medicines, often produced with little or no regulation or safety monitoring (Bennett & Indman, 2003: 97).

Rosenberg at al. (2003) look at several different types of alternative therapies, such as acupuncture, homeopathy, and herbal remedies. For all of these therapies, they conclude that none should be used in the treatment of postpartum depression. The following passage about herbal remedies is representative of their overall view of anything that does not come from a pharmacist:

> Part of the intrigue of taking an herb is *not* going to a doctor, but essentially prescribing for yourself. This just isn't safe. Herbs and medications both need to be prescribed by qualified physicians (Rosenberg at al., 2003: 138).

Perspectives like these embody the medicalized perspective, which sees the doctor as the only "real" authority qualified to help to women suffering PPD, and the medical office as the only place where women can receive "valid" treatments for their depression. There is no real reason provided for *why* these physicians should be granted sole authority over the health and well-being of depressed women; we are only told that they have this authority. Such perspectives discourage the kind of questioning and curiosity about how this problem of depression among mothers could be addressed. Instead, women are encouraged to avoid investigating alternative therapies in favor of seeking treatment from the long-established medical complex.

Another way that self-help authors adhere to a medicalized perspective is through their reference to risk factors. As discussed in the literature review section of this paper, no cause has been identified for PPD. Therefore, in place of causes, risk factors are identified as *potential* causes for PPD. The range of risk factors mentioned among self-help authors is as varied as

those identified by research studies on postpartum depression. For the sake of brevity, not all risk-factors mentioned in the self-help books analyzed will be mentioned here; rather, I will merely emphasize the fact that some risk factors appear more frequently than others, and some risk factors appear to be *contradictory*. For instance, depression during pregnancy is seen as one of the strongest risk factors for PPD. However, euphoria during pregnancy, specifically the last trimester, is also seen as a risk factor. Similarly, a woman is at risk for postpartum illness if she is too young, or if she is too old. Self-help author Sharon Roan (1997) notes that "there are a bewildering range of factors that might increase the risk of experiencing a postpartum illness. But even women who have not had a postpartum illness can identify with several of these descriptors, some of which contradict each other" (7).

Despite all of the risk factors that help to predict who will suffer from PPD, some self-help authors insist that PPD strikes suddenly, without warning. Such a perspective lends itself to the disease-like nature of PPD by portraying PPD as an unforeseen, uncontrollable event that strikes unsuspecting women. When depression is viewed this way, it is no wonder that drugs (dispensed by doctors) are seen as the only way out of such a quagmire.

> She never knows when her brain chemistry will shift and her moods will drop (Bennett and Indman, 2003, 69).
>
> PPD can happen to anyone (think roulette wheel) (Bennett, 2007: 33).
>
> It strikes without warning, bringing guilt, misery, and helplessness…It attacks, at random, royalty, nobility, and famous personalities as well as the typist, the factory worker, and the shop assistant (Dalton, 1980: 4).
>
> The more I read other women's stories the more I realize that it does not matter my background; this disease will take hold of any woman. I am not unique, nor do I think that there is an explanation why some of us get Postpartum Depression and some of us do not (MacDonald, 2002: 34).

> PPD can strike without warning – in women with no history of depression or women who have had it before (Kleiman, 2000:17).
>
> Part of the problem is that depression is not something that you anticipate. It just sneaks up on you – sometimes with shocking abruptness" (Rosenberg at al., 2003: xix).
>
> PPD frequently strikes without warning – in women without any past emotional problems, without any history of depression, and without any complications in pregnancy" (Kleiman and Raskin, 1994: 2).

Despite all of the risk factors the medical community is working to identify, self-help authors report that PPD still strikes without warning. There is apparently no factor that can predict, or no amount of education that can deter, PPD from happening to women.

A final way that self-help authors adhere to a medicalized perspective of PPD is through their focus on how depression affects the rest of the family, particularly the infant. Previous research has shown that medical practitioners tend to be preoccupied with the well-being of the baby, and in doing so tend to overstate the negative effects of maternal depression on babies. For instance, some self- help authors explain that PPD is detrimental to infants because depression interferes with the crucial bonding time between mother and infant. Although previous research has shown that this supposed special bonding time is nothing more than science fiction (Eyes, 1992), self-help authors still assert that compromising this sacred time is detrimental for babies.

> The mother-infant connection is vital to the mental and physical health of the baby. Anything that interferes with the critical process of bonding will have a detrimental effect. Depression only makes the new mother less able to respond to the needs of the infant Sebastian, 2006: 54).
>
> Staying depressed and anxious can have long-term effects on your bond with your baby (Venis and McCloskey, 2007: 101).

> Immediate help to decrease some of the negative effects that can result from untreated depression – specifically the negative impact on the mother, on mother-baby bonding, and on the family – is essential (Zhan, 2006: 232).

Self-help authors caution that more than just the "critical bonding period" is compromised when a mother is depressed; the overall health of the infant is in danger. This possibility is mentioned by self-help authors as one of the primary reasons to get help for depression: do it for your child.

> We are greatly concerned about the serious and long-lasting dangers for both your bond with your baby and your baby's development if you choose to remain depressed and anxious rather than taking medication (Rosenberg at al., 2003: 111).
>
> One of the most important reasons for not putting off treatment is because your baby and your children will suffer if you are depressed. But it's not just your children who will be affected by your depression. So will your family and friends (Rosenberg, Greening, & Windell, 2003: 68).
>
> Indeed, one of the hardest things about being a mother is learning that to take good care of your children you must take very good care of yourself (Roan, 1997: 166).

In the passage above, not only does Roan (1997) highlight the fact that the reason for women to take care of themselves is because they are needed to care for others, mothers are also seen as habitually unable to care for themselves. This paradox – that mothers are expected to provide care to their families but are also conflicted about caring for themselves – represents one of the many ways that mothers are failed by a medical system that does not take into account the myriad of ways that mothers do not practice self-love because they are too busy fulfilling society's expectations to love others. If it is true that one of the *hardest* things about motherhood is learning to love oneself, do we not have responsibility to understand why mothers feel this way?

According to self-help authors, infants are not the only family members who can be negatively affected by a mother's depression; fathers and older siblings are also seen as victims when the mother is depressed.

> And the rest of the family is affected as well. Husbands, parents, and children will ultimately suffer, and in some instances whole families may be torn apart (Shields, 2005: 139).

Fathers, in particular, are seen as victims to the ravages of their partner's depression:

> Given how debilitating PPD can be, it's crucial that you recognize the effects that your condition has not only on you, but on your partner as well (Bennett, 2007: 258).
>
> Men don't have it easy in this scenario, for sure. Just ask any husband of a woman with PPD, it's like walking on eggshells (Kleiman, 2005: 114).

In fact, depression is labeled as a culprit for divorce when women do not take "responsibility" for their illness by seeking medical treatment.

> Postpartum depression…can be recognized as a cause of conflict, separation and divorce (Huysman, 1998: 106).
>
> Postnatal irritability also affects the partner, for too often he is at the wrong end of the mother's bad temper. He finds that she has changed from the elated, vivacious person she was during pregnancy into the ever-moaning bitch of today. Can you blame him if he stops for a quick pick-me-up on his journey home before he faces another irrational flow of verbal abuse or physical danger?...Postnatal irritability is a frequent cause of the collapse of marriage or relationship. She has changed beyond all recognition and he no longer loves this new personality (Dalton, 1980, 74).

It is not only women who are seen as "home wreckers" when they are depressed. Fathers, whom we have learned can also suffer from a form of PPD, are also seen as threatening to their children when they are depressed. Shoshana Bennett (2007) notes that:

> When fathers suffer from PPD, their baby boys are especially affected. These boys have been found to have twice as many behavioral problems in their first few years as other children without depressed fathers. So, if you think your partner may be depressed, be sure to encourage him to find help as soon as possible – if not for his own sake, for the sake of his kids (39).

Not all self-help authors view depression as a surefire way to destroy developing children. Indeed, some self-help authors make the point that the negative effects of depression on children and on her partners are overemphasized and dramatized.

> Women who suffer from postpartum blues or mild or short-lived postpartum depression need not fear that they have caused their children great or lasting harm. Children are resilient and survive our misfortunes and mistakes (Roan, 1997: 186).
>
> And if they have been affected, please know that children are remarkably resilient (Bennett, 2007: 91).
>
> Suggesting that a woman's distress places a burden on her partner does not really help us understand the problem or reach a solution (Nicolson, 2001: 137).
>
> Your baby cannot read your mind! Your thoughts or feelings will not damage your baby or the relationship with your baby. What babies can sense is temperature, hunger, wetness and physical contact. Your baby will feel close to you regardless of depressed or anxious thoughts running through your head (Bennett and Indman, 2003: 55).

By providing these perspectives, self-help authors who downplay the effects of depression on babies and families also serve to debunk many of the myths surrounding bonding and the notion that mothers are solely responsible for the outcome of their babies. Many other factors influence the health and well-being of children and families, and these self-help authors open the door to discussing these factors by removing complete focus on how the mother alone influences her family.

Despite the few self-help authors who adopt an alternative view to the medicalized approach to PPD, most self-help authors reflect a medicalized view in the advice that they give to mothers. Postpartum depression seems to be a unique illness in the way that it has been historically ignored and carries a great deal of shame for the women who experience it. The gains that researchers, activists, and self-help authors have made in raising awareness of the depression are helping women to feel comfortable talking about their experiences. What is unfortunate, however, is that women have limited access to information, support, and treatment for PPD because the medical model of care has monopolized the care and treatment of PPD, and the medical model of care is not without weaknesses.

For example, it is important to recognize the unwarranted, political power physicians have to define and treat illnesses. "The political dimension inherent in medicalization is underscored when we note that structurally dependent populations – children, old people, racial minorities, and women – are subject disproportionately to medical labeling" (Riessman, 2003: 49). Those who are politically the weakest - most notably women, in this case – find their experiences pathologized and placed under the control of doctors.

Recipients of medical care are often distanced from knowledge of their own bodies through the language that doctors use to communicate with one another and with patients. Medicalized conditions such as PPD become shrouded in secrecy through the use of highly technical language (Conrad and Schneider, 1980). Through the use of their own proprietary language, doctors ensure that they appear as specialized experts, but in doing so they alienate patients from their own bodies and prevent people from viewing illness through any lens other than a medicalized one.

When this happens, external and social causes of illness and suffering become obscured by the technical medical labels that doctors put on our human experiences. The consequence of this reality is highlighted when Stark and Flitcraft (1982) explain:

> Medicine attracts public resources out of proportion to its capacity for health enhancement, because it often categorizes problems fundamentally social in origin as biological or personal deficits, and in doing so smothers the impulse for social change which would offer the only serious resolution (29-32).

Further, not only does the medical model prevent us from examining social problems and how they manifest in the physical body, but in the case of PPD, the medical model also alienates a significant number of people who experience the symptoms of PPD. It is imperative that we adopt other means of examining the issue of PPD other than through medical channels. Doing so would help the myriad people who rear children – fathers, adoptive mothers, extended family members – by acknowledging the difficulties they, too, face in raising children. These difficulties need not only arise out of misfired synapses in the brain or hormonal fluctuations; many parents experience depression for external, social reasons. Adopting an alternative to the medicalized viewpoint would allow us to examine and truly address what makes raising children so difficult.

It is important to note that it is not simply doctors and pharmaceutical companies that are solely responsible for medicalizing human conditions. To cast the medicalization of PPD as solely the responsibility of medical professionals is ignoring the agency of consumers "outside the political economy of medicine" (Hart, 2006: 160). In fact, non-medical actors may do more medicalizing than medical actors (Hart, 2006). While there has not been research done on the agency of women with PPD and how and why they seek drugs from doctors, the parent-driven

desire for Ritalin that Hart (2006) describes can be used as a model to understand why and how women go to their doctors seeking drugs.

When the medical model is critically examined, it becomes clear that what is needed is a truly reliable system of support, information, and care that puts women – not their infants or their families – first and helps to empower women to challenge notions of mothering and mother work in a safe environment. We have reached a point that has been long-awaited for many activists: our society now acknowledges PPD and the fact that not all women enjoy motherhood. Now is the time to progress beyond the antiquated care that is provided from a patriarchal institution that relies solely on pill-popping to “restore” women to their “normal” states.

CHAPTER 6: CONCLUSION

An analysis of self-help books on PPD provides a valuable look at the circumstances surrounding motherhood and how we interpret and address these circumstances. Despite their proximity to a feminist, self-help movement, self-help authors contribute to a distorted picture of motherhood by accepting and promoting gendered and medicalized ideas about mothering. Considering the quest for legitimization through medical channels, it is not surprising that self-help authors would rely biological causes for PPD, rather than examining societal reasons for maternal misery. What is surprising, however, is that fact that despite the varying types of authors who write self-help books on PPD, there is little variance in their advice. Only a few authors – Osmond (2001), Roan (1997), and Nicolson (1998) - openly question the role of external forces in maternal depression and question the practice of medicating mothers for depression. The general consensus over the fact that PPD is a biological illness that requires medical treatment illustrates the pervasiveness of medicalized views of motherhood.

While examining self-help books helps to illuminate the ways that depression after childbirth is discussed, it is also important to acknowledge the weakness inherent to this study. In general, the method of content analysis raises concerns about reliability and validity (Babbie, 2001). Further, because my analysis is limited to recorded communication, I cannot ask self-help authors what they meant when they said certain things; I must interpret passages myself, a task which carries with it the subjectivities of my perspective. Moreover, understanding the advice of self-help authors only provides half the picture needed to explore PPD and self-help books. Absent from this study is an understanding of how readers of self-help books interpret

the content of the books. Simply because a self-help author asserts that PPD is a medical issue does not mean that the reader agrees with this statement and acts accordingly.

Despite its weaknesses, this study serves as an important reminder of how gender role norms and medicalization continue to play a significant role in the lives of women. The PPD self-help community could do more to help women by rethinking these gendered, medicalized ideas about motherhood. For example, self-help authors are slowly debunking the myths that motherhood always looks and feels blissful. By discussing such realities, self-help authors are helping to free mothers from the pressures of perfect motherhood. Self-help authors should continue to address and question other ways that social constructions of motherhood and childhood contribute to depression. By exploring social components of PPD, self-help authors help women to see that depression does not have to be solely a medical issue; depression has its roots in social conditions as well.

Starting in the 1980s, PPD activists laid the groundwork for a way of talking about PPD and allowing women to express their negative feelings about motherwork. This movement has become, however, another process of medicalizing women and self-help authors have done little to question this. In order to truly help parents who are struggling with depression, self-help authors must begin talking about PPD in a way that accounts for the experiences of all women in all walks of life. They must address PPD in a way that accounts for the realities of the social world in which we live. They must think about varying family structures and child-rearing arrangements. Most importantly, they must address these challenges by placing the welfare of women, and not the medical establishment, at the core of their work. With their accessibility and aim to help their audiences, self-help authors are in a special position to affect change in the movements in which they participate. Self-help authors can and should lead the way in thinking

critically about how we can care for women better than we ever have before, even (and especially) if that means finding an alternative to placing the care of women and mothers in the corridors of medical institutions.

REFERENCES

Areias, M.E., Kumar, R. Barros, H., Figuieredo, E. 1996. "Correlates of Postnatal Depression in Mothers and Fathers." *The British Journal of Psychiatry* 169(1): 36-41.

Babbie, Earl. 2001. *The Practice of Social Research*. 9th ed. Wadsworth: Belmont, CA.

Beck, Cheryl Tatano, Kathie Records, and Michael Rice. 2006. "Further Development of the Postpartum Depression Predictors Inventory-Revised." *Journal of General Neonatal Nursing* 35(6): 735-745.

Becker, Howard. 1998. *Tricks of the Trade: How to Think About Your Research While You're Doing It*. The University of Chicago Press, New York.

Bennett, Shoshana S. 2007. *Postpartum Depression for Dummies*. Wiley Publishing: Hoboken, NJ.

Bennett, Shoshana S. and Pec Indman. 2003. *Beyond the Blues: a Guide to Understanding and Treating Prenatal and Postpartum Depression*. Moodswings Press: San Jose, CA.

Bobel, Chris. 2002. *The Paradox of Natural Mothering*. Temple University Press: Philadelphia.

Brockington, L.F., E. Macdonald, and G. Wainscott. 2006. "Anxiety, Obsessions, and Morbid Preoccupations in Pregnancy and the Puerperium." *Archives of Women's Mental Health* 9: 253-263.

Buultjens, Melissa, and Pranee Liamputtong. 2007. "When Giving Life Starts to Take the Life Out of You: Women's Experiences of Depression After Childbirth." *Midwifery* 23: 77-91.

Clay, Emily C. and Dean A. Seehusen. 2004. "A Review of Postpartum Depression for the Primary Care Physician." *Southern Medical Journal* 97(2): 157-161.

Coontz, Stephanie. 1992. *The Way We Never Were*. Basic Books, New York.

Dalton, Katherine with Wendy M. Holton. 1980. *Depression After Childbirth: How to Recognize, Treat, and Prevent Postnatal Depression*. Oxford University Press: New York.

Dennis, Cindy-Lee and Lori Ross. 2006. "Women's Perceptions of Partner Support and Conflict in the Development of Postpartum Depressive Symptoms." *Journal of Advanced Nursing* 56(6): 588-599.

Doucet, Andrea. 2006. *Do Men Mother?* University of Toronto Press: New York.

Dupuis, Tara. 2005. *The Moody Blues: One Family's Journey through Postpartum Depression*. Regal Printing Limited: Hong Kong.

Eyer, Diane. 1992. *Mother-Infant Bonding: A Scientific Fiction*. Yale University Press: New Haven.

Gjerdingen, Dwenda. 2003. "The Effectiveness of Various Postpartum Depression Treatments and the Impact of Antidepressant Drugs on Nursing Infants." *Journal of the American Board of Family Medicine* 16(5): 372-382.

Hall, Pauline L. and Anja Wittkowski. 2006. "An Exploration of Negative Thoughts as a Normal Phenomenon After Childbirth." *Journal of Midwifery & Women's Health* 51(5): 321-330.

Harcarik, Carol S. 2006. *Mommies Cry Too: A Painful & Triumphant Story of Postpartum Depression*. Hartington Press: Lake Mills, WI.

Hart, Nicky with Noah Grand and Kevi Riley. 2006. In *Medicalized Masculinities*. Eds Dana Rosenfeld and Christopher A. Faircloth. Pgs 132-164. Temple University Press: Philadelphia.

Huysman, Arlene. 1998. *The Postpartum Effect: Deadly Depression in Mothers*. Seven Stories Press: New York.

Hays, Sharon. 1996. *The Cultural Contradictions of Motherhood*. Yale University Press: New Haven.

Josefsson, Ann, Lisbeth Angelsioo ,Goran Berg, Carl-Magnus Ekstrom, Christina Gunnervik, Conny Nordin, and Gunilla Sydsjo. 2002. "Obstetric, Somatic, and Demographic Risk Factors for Postpartum Depressive Symptoms." *Obstetrics and Gynecology* 99(2): 223-228.

Kitzinger, Sheila. 2006. *Birth Crisis*. Routledge: New York.

Kleiman, Karen. 2000. *The Postpartum Husband: Practical Solutions for Living with Postpartum Depression*. Self-published.

Kleiman, Karen. 2005. *What am I Thinking? Having a Baby after Postpartum Depression*. Self-published.

Kleiman, Karen and Valerie Raskin. 1994. *This Isn't What I Expected: Overcoming Postpartum Depression*. Bantam Books: New York.

Kushner Resnick, Susan. 2000. *Sleepless Days: One Woman's Journey through Postpartum Depression*. St. Martin's Griffin: New York.

Llewellyn, A. M., Stowe, Z. N., & Nemeroff, C. B. (1997). Depression during pregnancy and the puerperium. *Journal of Clinical Psychiatry*: 58, 26-32.

Logston, Cynthia M., Katherine L. Wisner, and Melissa D. Pinto-Foltz. 2006. "The Impact of Postpartum Depression on Mothering." *Journal of General Neonatal Nursing* 35(5): 652-658.

MacDonald, Sheila. 2002. *Out of the Darkness: Postpartum Depression is Not Something We Can Fight Alone*. PublishAmerica: Baltimore.

Martin, Emily. 2001. *The Woman in the Body: A Cultural Analysis of Reproduction*. Beacon Press: Boston.

Martinez, Renee, Ingrid Johnston-Robledo, Heather M. Ulsh, and C. Chrisler. 2000. "Singing 'The Baby Blues': A Content Analysis of Popular Press Articles About Postpartum Affective Disturbances." *Women & Health* 31(2/3): 37-56.

McCoy, Sarah J. Breese, Martin Beal, Stacia B. Miller Shipman, Mark E. Payton, and Gary H. Watson. 2006. "Risk Factors for Postpartum Depression: A Retrospective Investigation at 4-Weeks Postnatal and a Review of the Literature." *Journal of the American Osteopathic Association* 106(4): 193-198.

McIntosh, J. 1993. "Postpartum Depression: Women's Help Seeking Behavior and Perceptions of Cause." *Journal of Advanced Nursing* 18: 178-184.

Nicolson, Paula. 1998. *Postnatal Depression: Psychology, Science, and the Transition to Motherhood*. London: Routledge.

Nicolson, Paula. 2001. *Postnatal Depression: Facing the Paradox of Loss, Happiness, and Motherhood*. Wiley Publishing: New York.

O'Hara, M.H., & A.M. Swain. 1996. "Rates and Risks of Postpartum Depression- A Meta-Analysis." *International Review of Psychiatry* 8: 37-54.

Osmond, Marie with Marcia Wilkie and Dr. Judith Moore. 2001. *Behind the Smile: My Journey out of Postpartum Depression*. Warner Books: New York.

Poulin, Sandra. 2006. *The Mother-to-Mother Postpartum Depression Support Book*. Berkley Books: New York.

Rich, Adrienne Cecile. 1986. *Of Woman Born: Motherhood as an Experience and an Institution*. W.W. Norton & Company: New York.

Roan, Sharon L. 1997. *Postpartum Depression: Every Woman's Guide to Diagnosis, Treatment and Prevention*. Adams Media Corporation: Holbrook, MA.

Rosenberg, Ronald, Deborah Greening and James Windell. 2003. *Conquering Postpartum Depression: A Proven Plan for Recovery*. Perseus Publishing: Cambridge, MA.

Ross, Lori E., Vashti LS Campbell, Cindy-Lee Dennis, and Emma Robertson Blackmore. 2006. "Demographic Characteristics of Participants in Studies of Risk Factors, Prevention, and Treatment of Postpartum Depression." *Canadian Journal of Psychiatry* 51(11): 704-710.

Rothman, Barbara Katz. "Motherhood Under Capitalism" in *Consuming Motherhood*. 2004. Eds Janelle S. Taylor, Linda L. Layne, and Danielle F. Wozniak. New Jersey: Rutgers University Press.

Sebastian, Linda. 2006. *Overcoming Postpartum Depression and Anxiety*. Addicus Books, Inc.: Omaha, NE.

Shaw, Fiona. 1998. *Composing Myself: A Journey through Postpartum Depression*. Steerforth Press" South Royalton, Vermont.

Shields, Brooke. 2005. *Down Came the Rain: My Journey through Postpartum Depression* Hyperion: New York.

Simonds, Wendy. 1992. *Women and Self-Help Culture: Reading Between the Lines*. Rutgers University Press: New Brunsswick, New Jersey.

Simonds, Wendy, Barbara Katz Rothman, and Bari Meltzer Norman. 2007. *Laboring On: Birth and Transition in the United States*. Routledge: New York.

Taylor, Verta. 1996. *Rock-a-by Baby: Feminism, Self-Help and Postpartum Depression*. Routledge: New York.

Venis, Joyce A. and Suzanne McCloskey. 2007. *Postpartum Depression Demystified: As Essential Guide for Understanding and Overcoming the Most Common Complication After Childbirth*. Marlowe & Company: New York.

Wearing, Betsey. 1984. *The Ideology of Motherhood*. George Allen and Unwin: Australia.

Wilson, Katie. 2007. *Out of the Abyss and into the Light: A Spiritual Journey Through Postpartum Depression*. PublishAmerica: Baltimore.

Zahn, Tina with Wanda Dyson. 2006. *Why I Jumped: My True Story of Postpartum Depression, Dramatic Rescue & Return to Hope*. Revell: Grand Rapids, MI.

APPENDIX

List of Books Included in Content Analysis

Bennett, Shoshana S. 2007. *Postpartum Depression for Dummies*. Wiley Publishing: Hoboken, NJ.

Bennett, Shoshana S. and Pec Indman. 2003. *Beyond the Blues: a Guide to Understanding and Treating Prenatal and Postpartum Depression*. Moodswings Press: San Jose, CA.

Dalton, Katherine with Wendy M. Holton. 1980. *Depression After Childbirth: How to Recognize, Treat, and Prevent Postnatal Depression*. Oxford University Press: New York.

Dupuis, Tara. 2005. *The Moody Blues: One Family's Journey through Postpartum Depression.* Regal Printing Limited: Hong Kong.

Huysman, Arlene. 1998. *The Postpartum Effect: Deadly Depression in Mothers*. Seven Stories Press: New York.

Kleiman, Karen. 2000. *The Postpartum Husband: Practical Solutions for Living with Postpartum Depression*. Self-published.

Kleiman, Karen. 2005. *What am I Thinking? Having a Baby after Postpartum Depression*. Self-published.

Kleiman, Karen and Valerie Raskin. 1994. *This Isn't What I Expected: Overcoming Postpartum Depression.* Bantam Books: New York.

Kushner Resnick, Susan. 2000. *Sleepless Days: One Woman's Journey through Postpartum Depression*. St. Martin's Griffin: New York.

MacDonald, Sheila. 2002. *Out of the Darkness: Postpartum Depression is Not Something We Can Fight Alone*. PublishAmerica: Baltimore.

Nicolson, Paula. 2001. *Postnatal Depression: Facing the Paradox of Loss, Happiness, and Motherhood*. Wiley Publishing: New York.

Osmond, Marie with Marcia Wilkie and Dr. Judith Moore. 2001. *Behind the Smile: My Journey out of Postpartum Depression*. Warner Books: New York.

Poulin, Sandra. 2006. *The Mother-to-Mother Postpartum Depression Support Book*. Berkley Books: New York.

Roan, Sharon L. 1997. *Postpartum Depression: Every Woman's Guide to Diagnosis, Treatment and Prevention*. Adams Media Corporation: Holbrook, MA.

Rosenberg, Ronald, Deborah Greening and James Windell. 2003. *Conquering Postpartum Depression: A Proven Plan for Recovery*. Perseus Publishing: Cambridge, MA.

Sebastian, Linda. 2006. *Overcoming Postpartum Depression and Anxiety*. Addicus Books, Inc.: Omaha, NE.

Shaw, Fiona. 1998. *Composing Myself: A Journey through Postpartum Depression.* Steerforth Press: South Royalton, Vermont.

Shields, Brooke. 2005. *Down Came the Rain: My Journey through Postpartum Depression* Hyperion: New York.

Venis, Joyce A. and Suzanne McCloskey. 2007. *Postpartum Depression Demystified: As Essential Guide for Understanding and Overcoming the Most Common Complication After Childbirth*. Marlowe & Company: New York.

Wilson, Katie. 2007. *Out of the Abyss and into the Light: A Spiritual Journey Through Postpartum Depression*. PublishAmerica: Baltimore.

Zahn, Tina with Wanda Dyson. 2006. *Why I Jumped: My True Story of Postpartum Depression, Dramatic Rescue & Return to Hope*. Revell: Grand Rapids, MI.