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Mothering and the Functional Self: A Hermeneutic Exploration of Texts on Perinatal Mood and Anxiety Disorders

Kathleen M. Pape
Antioch University - Seattle

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Mothering and the Functional Self: A Hermeneutic Exploration of Texts
on Perinatal Mood and Anxiety Disorders

A Dissertation

Presented to the Faculty of
Antioch University Seattle
Seattle, WA

In Partial Fulfillment
of the Requirements of the Degree
Doctor of Psychology

By

Kathleen M. Pape

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Mothering and the Functional Self: A Hermeneutic Exploration of Texts
on Perinatal Mood and Anxiety Disorders

This dissertation, by Kathleen M. Pape, has
been approved by the Committee Members signed below
who recommend that it be accepted by the faculty of the
Antioch University Seattle at Seattle, WA in partial fulfillment
of requirements for the degree of

DOCTOR OF PSYCHOLOGY

Dissertation Committee:

Philip Cushman, Ph.D.
Chairperson

Melissa J. Kennedy, Ph.D.

Leslie Butterfield, Ph.D.

Date

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Abstract

Mothering and the Functional Self: A Hermeneutic Exploration of Texts on Perinatal

Mood and Anxiety Disorders

Kathleen M. Pape

Antioch University Seattle

Seattle, WA

Mothering is a rich and complex experience involving challenging tasks, a developing relationship with one's child, and socially defined roles. How mothering is viewed varies depending on the cultural norms and historical era under consideration. This study is a textual interpretation of three books written about perinatal mental health, especially how those texts describe the challenges and struggles of birthing and mothering. I develop understandings about how clinicians respond to those issues and in the process understand themselves, their practices, and their sociocultural roles. Finally, I consider the shape of the current social terrain that brings to light the experiences of birthing women and the clinicians who treat them. Drawing on philosophical hermeneutics I interpret three books concerned with perinatal mental health (Stone & Menken, 2008; Bennett & Indman, 2010; Shields, 2005). Considering the themes that emerged, I describe how the beliefs of this era regarding birthing and mothering and corresponding therapeutic practices are reflected in these texts. Five main themes are identified. First, is that maternal suffering is overlooked and perinatal mood and anxiety disorders are undertreated. Second, suffering is reduced to a medicalized disorder located within the mother and her biochemistry. This created disorder in the mother and prevented her from enacting her role as mother and necessitated an individualist response. Third, the mother

is viewed as an object whose wellbeing is important primarily because it serves others in her family. Fourth, perinatal mood and anxiety disorders are seen as being universal. Finally, the clinician is viewed as a professional expert tasked with bringing order to the mother's biochemical disorder. I discuss how particular ways of being for clinicians and mothers are highlighted within these texts, and the implications of such for therapeutic practices. The beliefs expressed in these texts reflect and reinforce a predominant way of being in contemporary culture, which I describe as the functional self—a self that is valued for actively and efficiently performing social roles that reinforce current arrangements of gender and the political status quo. The electronic version of this dissertation is at OhioLink ETD Center, www.ohiolink.edu/etd

Dedication

My deepest gratitude to: the members of my committee, in particular Dr. Philip Cushman, for your patience, guidance, and endurance throughout this process. My parents, Darlyne and Don Pape; your daily actions taught me the importance of study and the joy of nurturing a strong intellectual curiosity. My in-laws, Frank, Gwyn, and Matthew Korahais; your steady support allowed me the time and space to produce this work. My siblings, Amy, Ben, Jim, Mike, and Joseph; you taught me how to be tough, smart, and kind. My communities; your constant encouragement kept me working on the goal. Alex and Nate; you not only kept our household strong and functioning as I had less to contribute, you also made this whole process far more fun than it probably deserved to be. Thank you.

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Introduction

In November and December of 2013 a series of articles in two prominent British newspapers—*The Telegraph* (Booker, 2013; Freeman, 2013) and *The Guardian* (Henderson, 2013)—caused concern and alarm for clinicians and lay people associated with women’s perinatal health. The articles told the story of a pregnant woman, Alessandra Pacchieri, who due to complications from an untreated bipolar disorder, lost custody of her infant.

An Italian citizen, Ms. Pacchierri was temporarily in England during the summer of 2012 to complete her job training as an airline hostess for Ryanair. One evening, either because she was running out of money to cover her expenses (Henderson, 2013, para. 2), or because she could not find her other children’s passports (Booker, 2013, para. 1), she experienced what was described as “something of a panic attack” (Booker, 2013, para. 1). She called the police, and they arrived while she was on the phone with her mother in Italy. The mother informed the police that her daughter had a “bipolar condition” (Booker, 2013, para. 1) and had not been taking her medications due to concerns about the possible negative effects on her fetus.

The police told Ms. Pacchieri that they were taking her to a hospital to “make sure the baby was okay” (Booker, 2013, para. 2). Ms. Pacchieri reported later that she was startled when she realized that they had taken her to a psychiatric hospital. She asked to return to her hotel room, but was instead restrained and sectioned under the Mental Health Act which is similar to involuntary treatment laws in the United States. Approximately five weeks later, Ms. Pacchiere was forcibly sedated and restrained.

Several hours later, she awoke in a different hospital having had a caesarean section performed on her, and her baby placed with British social services.

After several legal attempts to obtain contact with her baby, Ms. Pacchieri was escorted back to Italy without her baby. When she returned to Italy, she began taking her medication again, and initiated legal processes to regain custody of her daughter, who was still in Britain. When she returned in February, 2013, the judge who heard her case ruled that though she seemed more stable now that she was taking her medication, he “could not risk a failure to maintain her medication in the future” (Booker, 2013, para. 5). The judge refused to grant her custody, and ordered that the daughter be adopted within the UK.

Though this case has been called “unprecedented” (Freeman, 2013, para. 5), it highlights concerns about how mental health struggles in mothering can be perceived. In particular, it reflects how those perceptions, when acted on by clinicians and institutions within particular sociocultural contexts, effect women who mother and their children.

Historians, such as Apple and Golden (1997), Lerner (1971), and Zinn (2003) have argued that motherhood is a socially constructed role that women enter into with the birth or adoption of a child. An understanding of the experience of motherhood and the practices of mothering occur within a particular historical context and are dependent upon the shared sociocultural understandings of what it means to be a mother. Within the discipline of motherhood studies, writers have made a distinction between the socially constructed role of motherhood and the lived experience of mothering (O’Reilly, 2010; Rich, 1976/1986; Wong, 2012). In this discipline *Motherhood* refers to the institution of motherhood as defined and described by a patriarchal culture. *Mothering* refers to the

lived experience of the social and inter-subjective practices of nurturing and caring for dependent children, and may include practices that resist or reinforce the institution of motherhood (O'Reilly, 2010, p. 2).

Cultural artifacts reflect understandings of dominant ways of being for humans in a particular time. Books about perinatal mood and anxiety disorders, as cultural artifacts, can reflect understandings about what it means to be a mother who struggles. By describing aspects of the lived experience of mothering, as well as clinicians' responses to these experiences, these texts also reflect how motherhood is defined and described in this time. By exploring and interpreting how the challenges and struggles of birthing and mothering are described, within the field of perinatal mental health, I hope to understand more about the shape of the current social terrain that brings to light the experiences of birthing women and the clinicians who treat them.

Background of the Problem

Naming and defining maternal experience. For the past four decades, naming and defining the struggles that mothers may have during the perinatal time has been fraught with conflation, generalization, redefining, and renaming of disorders (Godderis, 2009, p. 2; Karraa, 2013). For the emotional difficulties that new mothers might express, the term that has been most commonly recognized is Postpartum Depression (PPD). However, perinatal health clinicians and mothers' advocates have emphasized that women struggle with several mood and emotional challenges, not only depression, and not only after they give birth (Bennett & Indman, 2010; B. Meyer, personal communication, September 16, 2011). Therefore, an additional term has been used in recent years, Perinatal Mood and Anxiety Disorders (PMADs).

It has been argued that the term “perinatal” does not accurately represent the mother’s experience, since “natal” is more strongly connected to the baby’s birth than the mother’s pregnancy and early mothering (P. Cushman, personal communication, November 15, 2014). However, I have chosen to use that term in this study about mothering because it is currently the most commonly used term to denote struggles in mothering. It is also a specific term used within a particular cultural context and historical time (E. Goetzen, personal communication, November 15, 2014). In this study I am exploring the way struggles in mothering are described within texts from this historical era, therefore, it seems the most fitting term for the purposes of this study.

Perinatal Mood and Anxiety Disorders are defined as “a mood disorder (for instance, depression) or anxiety disorder (for example, panic) beginning during pregnancy or during the first year postpartum” (Bennett & Indman, 2010, p. 146). In the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, the specifier, “with peripartum onset” may be applied to major depressive and/or manic episodes, as well as “postpartum onset” during brief psychotic episodes (American Psychiatric Association, 2013).

PMADs are often attributed to hormonal changes that affect brain chemistry during or following pregnancy (Bennett & Indman, 2010) as well as psychosocial factors such as family history, stressors, lack of social or familial support, and sexual abuse (Misri & Joe, 2008). Though prevalence rates for PMADs vary, recent studies estimated that of pregnant women and mothers in the first year postpartum approximately 13–19% experience symptoms of major or minor depression (C. T. Beck, 2001; Gavin et al., 2005; O’Hara & Swain, 1996).

PMADs denote the umbrella term encompassing six principal disorders that may occur around pregnancy, birth, and up to one year after birth. They include depression, obsessive-compulsive disorder, panic disorder, psychosis, post-traumatic stress disorder (PTSD) as well as Bipolar I and II (Bennett & Indman, 2010). For the purposes of this study, I use the term Perinatal Mood and Anxiety Disorders (PMADs) to describe the general descriptions and understandings of the maternal struggles discussed in the books on perinatal mental health. However, when an author refers specifically to one disorder, I use that term (e.g., Shields' postpartum depression, PPD).

Mothering and motherhood from an interpretive perspective. In contrast to the positivist method of empirical research in the natural sciences and epistemology in philosophy, as well as reflecting social and political changes of the later twentieth century, several intellectual movements developed around ideas of interpretation, truth, and understandings. This included movements such as poststructuralism, deconstruction, constructionism, postmodernism, social constructionism, and hermeneutics. Described as the “interpretive turn” in philosophical methods, these practices emphasized interpretive activities and are influenced by practices in disciplines such as literary criticism, feminist theory, jurisprudence, cultural anthropology, and historiography (Bohman, Hiley, & Shusterman, 1991, p. 1). Previously, interpretation was seen as necessary only in trying to understand historical texts or different cultures. However, scholars in the philosophy of language began to point out that there are interpretive problems that must be addressed even when trying to understand speakers and writers within one's own culture and time (Bohman et al., 1991, p. 3).

Language is a social practice that helps to define the cultural context.

Philosophers such as Martin Heidegger (1962) and Hans-Georg Gadamer (1960/1991) noted that humans, as self-reflecting beings, cannot remove themselves from their cultural context. Heidegger's term for what is seen, acknowledged, and shared in a particular sociocultural era is *Lichtung* which, literally translated from German, means "a clearing in the forest" (Dreyfus, 1991, p. 163). In any particular time and culture, what is recognized and considered important is only what can be seen in the clearing, in the contemporary understandings of that time and place. The practice of hermeneutics uses language to explore what is seen in a particular cultural clearing and therefore what is considered important.

Hermeneutics in particular considers everyday practices as representative of what it means to be human in a particular time and place. Stigliano (1989) noted,

What hermeneutics studies is understanding, as it is constituted in practices by and for an interpreting community for whom the practices have significance and as practices are expressed in and by institutions, shared stories, narrative and myths which comprise an identifiable tradition. (p. 50)

Ruddick (1989/1995) claimed that the experience of mothering did not involve a gendered role as much as it was made up of essential practices. She defined practices as "collective human activities distinguished by the aims that identify them and by the consequent demands made on practitioners committed to those aims" (p. 14). She further described these maternal practices as three tasks, or demands: preservation, growth, and social acceptance (p. 17). Ruddick was attempting to differentiate between the practices of mothering, which can be done by anyone in a caring role, and the identity of mother which is usually ascribed to women and is therefore subject to gender norms.

Some writers drawing on the interpretive turn—a shift in philosophical thought that included postmodern and hermeneutic methods that focuses on interpretations and meanings of actions, ideas, and words—used the idea of the clearing to consider the way mothering actions were interpreted. Specifically noted were the difficulties mothers experience in developing their multiple maternal identities, and the demands on mothers to think in rigid, either/or ways about their mothering selves such as good or bad, present or absent, working or stay-at-home (Caplan, 2012; Sheehy, 2011; Wong, 2012).

Clinical research conducted on mothers' experiences of moving into the role of mother and the practices of mothering, as well as texts written to guide clinicians who treat mothers through this developmental time, express shared understandings of terms and ideas about mothering and motherhood. The questions asked, the populations researchers ask these questions of, the answers heard and considered important enough to report, as well as the way the findings are reported, all occur within the society's shared understandings of motherhood. This includes what it means to be a good mother, engaged in the practices of mothering, and what it means to be a clinician helping mothers who appear to be struggling. These shared understandings of the experience of becoming a mother constitute a knowledge base that influences the way researchers investigate the phenomenon, the way clinicians treat difficulties that arise, and the way mothers understand their struggles.

Items produced and used in a culture—its research, books, films, objects, designs, laws, and tools for everyday living—are the cultural artifacts of that era. They illustrate the beliefs about what is good in that particular time and place, and as such they reflect how the self is understood or conceptualized in that era (Cushman, 1995, p. 19). Within

this study I consider contemporary literature on perinatal mood and anxiety disorders (PMADs) to be cultural artifacts. As cultural artifacts, these texts reflect the era and also reinforce and influence the social world and framework, thereby reinforcing the dominant cultural narratives of their era (Cushman, 1995, p. 19). The way in which mothering is conceived and represented in cultural artifacts, such as books on perinatal mood disorders, will reflect and influence the structures of gender, wealth, and power in a historical era. Additionally, these ideas about mothering will both influence and be influenced by the social, political, and cultural forces of the particular historical era, and in particular by ideas about the institution of motherhood, and the everyday practices of mothering.

In this study—a textual exploration and interpretation of three books on perinatal mental health—I seek to uncover how the challenges and struggles of birthing and mothering are described. I also hope to develop understandings about how clinicians respond to those issues and in the process portray themselves, their practices, and their sociocultural role. In general, I hope to understand more about the shape of the current social terrain that brings to light the experiences of birthing women and the clinicians who treat them.

Motherhood as historically situated. Historians have argued that since women are members of society, their roles in it will vary depending on the requirements of the larger society (Lerner, 1971; Zinn, 2003). Several authors have described how the dominant cultural narratives of motherhood, and the daily practices of mothering, have changed depending on the power and status of women and the economic, political, and social needs of a given era (e.g., Coontz, 2000; Demo, Allen, & Fine, 2000; Lerner,

1971; Zinn, 2003). Just as history has traditionally focused primarily on the experiences of powerful, white, European and American men, so too, the history of motherhood has tended to consider mothers a homogenous group, rather than diverse people whose mothering decisions occurred within differing contexts and circumstances (Apple & Golden, 1997; Collins, 2007; D. Richardson, 1993).

As opposed to the idea of biological determinism, where mothering is an instinctive, universal role for all biological females, Apple and Golden (1997) argued that motherhood is a culturally defined idea. It is formed and reformed by the members of a society, the social, political, and economic forces, and the structures and traditions that define that society and those individuals. Further, scholars argue that though mothers cannot remove themselves from these traditions and ideas, they are not passive recipients of these ideals either (Apple & Golden, 1997; O'Reilly, 2010; Wong, 2012). As Apple and Golden (1997) noted, "whether mothers reject prevailing social beliefs or embrace them fully, they are, through their daily practices, continually redefining the meaning of motherhood" (p. 3).

Context

Several authors have described and critiqued the cultural landscape in which contemporary women mother (e.g., Godderis, 2009; Maushart, 2000; Mauthner, 1995; O'Reilly, 2010; Slaughter, 2012; Vandenbeld–Giles, 2014; Warner, 2005; Wong, 2012). In this section I highlight five aspects of the cultural terrain that seem particularly pertinent to the experience of becoming a mother in this time. These aspects include the contemporary societal expectations of mothers and their practices, global economic insecurity, political and social instability, motherhood and neoliberalism, and recent

trends in the field of psychology toward a more diagnostic, biologically-based etiology of human suffering.

Contemporary societal expectations of mothers. One of the predominant themes among contemporary writers on mothering is that mothers are stretched and overwhelmed by the multiple demands of mothering (Hays, 1996; Maushart, 2003; Slaughter, 2012; Warner, 2005; Wood & Newton, 2006). The demands described include balancing workplace requirements with childcare responsibilities (Slaughter, 2012; Wood & Newton, 2006), navigating society's expectations of mothers (Hays, 1996; Maushart, 2003), and raising children in a political environment that for the past thirty years has significantly eroded policies that traditionally supported children and families (Warner, 2005). Warner (2005) noted that as governmental and social programs for families have diminished and workplace demands have increased, women, who already report a disproportionate responsibility for childcare, have felt the pressure most acutely (p. 250). O'Reilly (2010) clarified that women and mothers are impacted by policies of all sorts—medical, governmental, and workplace—because these policies have the potential to free women and mothers or to oppress them (p. 10).

Ideals articulated by second wave feminists in the 1960s and 1970s espoused partnership and marital values of reciprocity and shared responsibilities. These values have influenced contemporary parenting relationships so that most mothers in recent decades have expected that their partners would help shoulder the domestic duties. This expectation has continued to grow as women continued to advance vocationally and financially (Brewis, 2011, p. 147). This is particularly true now as studies have shown that there are more women in the workforce making more money than in previous

decades (United States Department of Commerce, 2011). Despite the influence of second wave feminism, and even though women are working more and making more money, they are not reporting equitable distribution of daily tasks with their male partners. Contrary to the ubiquity of the term “work-life balance,” contemporary time-use studies indicated that women continued to do more childcare and housekeeping than did their male counterparts (Gjerdingen & Center, 2004, p. 103). As Brewis (2011) stated, “women especially continue to struggle to manage the demands of work, personal relationships of all kinds, motherhood, and other life activities” (p. 148). Benjamin (1988), in describing gender inequality in all facets of life, noted that this imbalance “undermines the intimacy and solidarity which are the theoretical goal of modern marriage” (p. 207).

Even as daily demands on women continue to grow, so too do the societal expectations of what constitutes good mothering. Scholars in maternal studies have described the oppressive nature of dominant ideologies of motherhood which demand that the mother identify primarily, if not exclusively, as a mother and organize all of her time and resources around that role (Caplan, 2012; Hays, 1996; O’Reilly, 2010; Wong, 2012). Caplan (2012) described “the Perfect Mother Myths and the Bad Mother Myths, which in combination create the societally pervasive framework that leads to the blaming of mothers for so much and to the negative labeling of potentially everything any mother might do” (p. 79). Similarly, Hays (1996) wrote about “intensive mothering” (p. 9) as the societal demand for continual and endless nurturing of children by mothers, the reliance on experts rather than the mother’s experience, and a demand that mothers be fully

fulfilled by this depletion. Hays noted that these demands created an energetic, logistical, and financial hole that mothers were tasked to fill.

Drawing on the philosophy of Foucault's observational gaze, Wong (2012) asserted that these contemporary, damaging narratives about mothering have created a maternal "panoptican" (p. 4). She clarified that within this situation "discourses of mothering are ostensibly invisible and overlooked; and many women struggle and personalize issues to themselves, remain silent, and internalize madness rather than locating the madness in the institutions and expectations of mothers within our society" (p. 5). Wong, and several feminist writers on maternal issues, recognized that larger societal challenges have been internalized by mothers and contribute to their distress. In this arrangement, the external stressors are often unseen or unacknowledged and it is the mother who appears unreasonable, unstable, or incompetent.

Observers of maternal writings have noticed that mothers often expressed an overwhelming ambivalence about their role of mother. Brown (2010), in her analysis of contemporary motherhood memoirs, interpreted this ambivalence to be a result of social conditions and excessive expectations that are found in contemporary ideologies of motherhood. These social conditions included difficulties such as social isolation, lack of preparation for the challenges of motherhood, the loss of individual identity and the delay in the development of a maternal identity, and the conflicts between work and childcare. She noted that "after decades of increasing gender equality and opportunities for women, these mothers find themselves facing maybe even more oppressing norms of what constitutes 'good mothering' than their predecessors" (p. 137).

Ambivalence was defined by Brown (2010) as “the coexistence of conflicting and opposing thoughts or feelings” (p. 122). She clarified that, with mothers, ambivalence is “usually described as a coexistence of love and hatred” (p. 122). She noted that though the mothers expressed ambivalence about their role, they expressed joy and excitement about their children and engagement in their developing relationships with their children. Mothering their children did not create ambivalence, but rather trying to mother their children according to external demands and norms of what a good mother is and does did create ambivalence in these mothers (p. 136). Brown referenced Freud in describing how unexpressed conflicted feelings are turned in on the mother and may manifest as depression, anxiety, or general guilt and torment (p. 122). Because maternal ambivalence is so rarely presented in other forms of maternal literature, for example in parenting advice books, it becomes viewed as what Brown described as “deviant and problematic” (p. 124).

Global economic insecurity. Social scientists and economists have documented how economic insecurity, which also contributes to workplace pressure, has increased for a majority of the workforce in the past few decades (Harvey, 2005; Sennett, 2006). Some writers noted that women seem to feel this pressure in relation to motherhood more than do men in relation to fatherhood (Bullock, 2003; Slaughter, 2012; Vandebeld-Giles, 2014). Globally, it is mothers who make up the largest majority of people living in poverty (Vandebeld-Giles, 2014). Even in more privileged environments, this concern is felt by women most acutely (Slaughter, 2012). As Gloria Steinem (2014) observed, “I’ve yet to be on a [college] campus where most women weren’t worrying about some

aspect of combining marriage, children, and a career. I've yet to find one where many men were worrying about the same thing" (p. 1).

In an attempt to defend against economic insecurity, women are feeling pushed to increase efforts in their work and careers. However, women often cite career demands as being in conflict with motherhood, and feel little external support for their work or their mothering. For example, the United States is one of only five countries worldwide that do not guarantee access to some type of paid maternity leave for women (DeLauro, 2013). Some researchers believe that this lack of support partly explains the steadily growing number of women since the baby boom following World War II who are delaying having children or deciding to not have children (Brewis, 2011, p. 148; Wood & Newton, 2006, pp. 338–340). Koropecykj-Cox and Pendell (2007) asserted that women's decisions to delay having children, or to not have them at all, might be a way of what they called "navigating an uncertain competitive economy" or to avoid what has been termed the "motherhood penalty" where women lose opportunities for advancement, earn less money over the span of their work life, or are subtly denied access to more demanding and rewarding jobs because they are, or have the intention to become, mothers (p. 900).

Researchers on maternal wellbeing posited that women delay or avoid having children because they recognize the impact becoming a mother might have on their education, their financial security, their careers and jobs, and their responsibilities to other family members, as well as the lack of support in being able to meet those challenges (Koropecykj-Cox & Pendell, 2007; Wood & Newton, 2006). These concerns are well founded as research has indicated that when women do become mothers, all of

these roles, positions, and opportunities are impacted, often for the worse (American Psychological Association, 2014).

These writers and researchers have noted a conflict inherent in contemporary mothering. A mother is expected to be fulfilled by being a mother, while risking negative economic and diminished career prospects, which may impact her ability to care for her children and for herself. In an era where income inequality has become so marked, it seems natural that the impact on how women feel about their mothering and about the future for their children would be noticeable and might present itself as feelings of anxiety, worry, overwhelm, and perhaps despair and depression.

Political and social instability. Observers of contemporary political movements have noted that women's choices about becoming mothers, and how they become mothers, have been under political attack. Access to contraceptive care and abortion are significantly threatened. At the same time, a woman's ability to effectively care for herself and her family is challenged. Recently the US House of Representatives voted down the Pregnant Workers Fairness Act, which prohibited discrimination against pregnant women in the workplace. As political observers have noted, many women are experiencing a bind—they can neither prevent their pregnancies from coming to full term, nor are they protected in any sort of economic way should they elect, or feel forced, to bring a pregnancy to term (Clawson, 2014).

Possibly reflecting trends of the past few decades regarding women's political power and consequent wellbeing in the United States, a recent study of worldwide maternal mortality rates (MMR) noted that the rate of maternal deaths has more than doubled in the United States since 1987. In 1987 in the United States there were 7.1

maternal deaths per 100,000 live births. In 2013 there were 18.5 deaths per 100,000 live births (Morello, 2014).

Strikingly absent from two of the three texts in this study was any sort of reflection on American women's attitudes towards bringing new life into the world following the terrorist attacks of September 11, 2001, in New York City, Washington, DC, and Pennsylvania. The one exception was Shields' reflections on her experience of these events. These attacks were unprecedented and significantly affected the views of safety and wellbeing for most people living in North America (Galea et al., 2002, p. 982). One study showed that of mothers surveyed, 68% of them experienced significant distress after the events of September 11th, including "concern about other family members or friends, concern over economic/financial impact of the attacks, and social and environmental concerns" (Kennedy, Chalesworth, & Chen, 2004, p. 335). In addition, mothers reported notably more distress and symptoms of anxiety and depression than did others in the larger community (Kennedy et al., 2004, p. 336).

Villalobos (2010) noted that, similar to all terrorist events, though the disaster of September 11th directly and physically affected a very small percentage of the American population, it caused general emotional responses that included chronic fears of unexpected harm for a significantly large percentage of Americans, and even for those in other countries. She also described what she termed "insecurity osmosis" (p. 59) where one develops fears in response to another's misfortune. She noted that with the advent of information technologies, we are no longer limited to the misfortunes of our immediate friends and neighbors, but instead witness those tragedies and misfortunes daily as they arrive on our technology devices. She clarified "what is new is the magnitude of the fear,

the subjective component of insecurity that objective statistics may fail to capture” (p. 59).

In speaking about mothers in particular, Villalobos (2010) noted that “the twenty-first-century environment leaves many women mothering in fear” (p. 61). She then described mothering practices that, taken out of context, might appear to be negligent (e.g., allowing children to explore outside of their neighborhood while unaccompanied by an adult) but that within the context of an unstable and threatening environment appeared to make sense (e.g., the children learn survival strategies). These practices were conscious, sophisticated practices the purpose of which was to prepare children to live in a threatening world. Her research highlighted the importance of placing observable parenting and, in the case of this study, mothering behaviors within a larger historical context in order to understand the practices and the women who choose them.

The sociologist and ethnographic researcher Carolyn Ellis (2002) was in an airplane flying to Dulles airport at the time of the September 11th attacks. As she later noted in her recollections of that event:

I had to make sense of this experience in order to reconstruct a personal life and social world in which I could live, a life and world that held the possibility of a meaningful future in spite of shattered illusions of comfort and safety. No matter where you were or what you were doing that day, I suspect this is a task you faced as well. (p. 377)

Though reflections on the event and effects of 9/11 were absent from *Perinatal and Postpartum Mood Disorders* as well as *Beyond the Blues*, an interesting remark was made at the September, 2011 Postpartum Support International (PSI) National Conference. The conference was held two days after the tenth anniversary of the 9/11 terrorist attacks. The week leading up to the anniversary, and consequently up to the PSI

conference, was full of media references to the event, memorials, and writing about the effect of that event on US culture, politics, and social attitudes. It struck me that the only place that week that I did not come across some reference to the 9/11 events was at the PSI conference itself. There was absolutely no mention of it. However, at one point during the conference, one of the main speakers noted that they were using the term “Perinatal Mood and Anxiety Disorders” now, rather than “Perinatal Depression,” because “we have been seeing a lot more anxiety in the past few years than depression.” (B. Meyer, personal communication, September 16, 2011).

Motherhood and neoliberalism. Several writers have explored the psychological impact and manifestations of contemporary political theory and societal arrangements generally referred to as neoliberalism (Binkley, 2011; Layton, 2009; Peltz, 2005; Schwartz, 2005; Vandenbeld-Giles, 2014). Neoliberalism, as described by Harvey (2005), is “a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong property rights, free markets, and free trade” (p. 2). He further noted that within a society embedded in neoliberal ideals all human actions and encounters are considered within the domain of the market. Layton (2009) described a neoliberal subjectivity which repudiates and demeans such human conditions as vulnerability and dependence, and in particular fears eventual uselessness in the market that is the larger society.

Each of the three texts in this study was written at a time when the ideals of neoliberalism were increasingly influential in the social structure. As Harvey (2005) noted, these ideals have “become incorporated into the common-sense way many of us

interpret, live in, and understand the world” (p. 3). Mothering is a social practice and as such will be influenced by the way we live and understand our world.

Layton (2009) described a case in which a new mother was conflicted and uncertain of her role caring for a vulnerable other. This mother also noticed her discomfort with her increasing dependence upon those around her in order to fulfill all of her work and maternal responsibilities. In particular, the mother was uncertain of how to maintain status and perform a predominantly female task (e.g., mothering and caring for another) when attributes associated with female were demeaned and rejected:

She . . . equates ‘girly’ with something weak and loathsome. . . . [T]his patient isn’t so sure she likes what for her, since pregnancy, are new feelings of dependence on her husband. For she, like many other professional middle-class women in their 20s and 30s . . . has fashioned and has long lived an identity that largely repudiates dependency. . . . [T]he disidentification [with dependency] is nurtured by the psychic demands of the space in which contemporary patriarchy and capitalism meet. Traditionally the two have come together to split and gender relationship female and autonomy male. (p. 111)

In connecting this to contemporary social influences, Layton (2009) noted that “neoliberal subjectivity is now available both to males and females of a certain class, but it is a form of subjectivity that promotes manic activity, devalues caretaking, and denies both dependence and interdependence” (p. 111). Maternal studies scholars have noted that mothering, as a practice that involves caretaking and dependence—on the mother as well as the mother on others—is a practice that holds little value in the neoliberal economic market of contemporary human interaction (Vandenbeld–Giles, 2014).

In describing the personal and social results of neoliberalism, psychoanalysts have commented on how the privileging of individual advancement has reflected a social climate that ignores communal, relational, and familial responsibilities and values. The psychological outcomes of such a climate were noted by these writers (Layton, 2009;

Peltz, 2005; Schwartz, 2005). Layton (2009) described the splitting that occurs in response to this devaluing. Peltz (2005) described a “proliferation of manic defenses” (p. 347) in response to a loss of reliability for the provision of basic needs. Schwartz (2005) noted reactions that are a “deeply ingrained defense against psychotic anxieties about the continuity of humanity itself” (p. 404). All of these difficulties, reactions, and outcomes present during a time when humans are valued for their individuality, agency, and autonomy, and almost exclusively responsible for the results of their circumstances. Mothers must also navigate this political and social climate. As Vandenberg–Giles (2014) noted “Mothers must be neoliberal self-optimizing economic agents in the ‘public’ realm *and* maternalist self-sacrificing mothers in the ‘private’ realm” (p. 4).

The historian, Stephanie Coontz (1992), who researches historical shifts in family structures and norms, noted that “self-reliance is one of the most cherished American values,” including families who “stand on their own two feet” (p. 69). However, self-reliant, self-contained families have not been the norm for much of American history, and in fact communal and local public aid to families has more often been the rule rather than the exception. “Americans have been dependent on collective institutions beyond the family, including government, from the beginning” (Coontz, 1992, p. 70). In her analyses, she noted that the belief that most families follow a specific, ideal family type (e.g., male breadwinner, two-parent families, self-reliant) is a myth, and does little to build the support systems that families need, and that have been systematically ignored or dismantled for the past four decades (Coontz, 1997).

Recent trends in psychology. There is an absence of sociological and political critique in books about perinatal mental health. This absence is not so surprising when

the trends in psychological research for the past three decades are considered. On July 17, 1990, then-president George H.W. Bush declared the decade commencing January 1, 1990, as “The Decade of the Brain” (Bush, 1990). Federal funds were committed to the National Institutes of Health and the National Institute of Mental Health for further research into brain-based diseases. In the years following, mental illness was primarily conceptualized within a disease and bio-medical model. Function, or outward, observable behavior, became the main marker of mental health or illness. In addition, the cause of illness was located in the individual person, most often in the workings of their brain (Hedges & Burchfield, 2005).

The American Psychological Association declared the decade of the 20-aughts, as “The Decade of Behavior” (Azar, 2000). This both reflected and reinforced a rarifying of empirical, scientific, positivistic practices. Random controlled trials, looking at outward behaviors and observable symptomatology, led to the development of empirically supported treatments. These empirically supported treatments then became the dominant form of practice within the field of psychology (Slife, Yanchar, & Reber, 2005).

Several writers within psychology and psychoanalysis have described and critiqued the privileging of positivistic, empirical research over the lived experience of the individual, as well as how the complexity of lived experience manifests in relationships (Cushman, 2013; Hoffman, 2009; Layton, 2009; Stern, 2013). These, and other writers, are particularly concerned with the dominance of diagnosing disorders within the individual and ignoring social contexts and political concerns that are strongly influential on the client, the therapist, and the therapeutic relationship, as well as the profession as a whole (Cushman, 2013; Fowers, 2005; Greene, 2010; Hoffman, 2009;

Layton, 2009; F. C. Richardson, 2005; Stern, 2013). The emphasis in contemporary psychology on individualism, while encouraging virtues such as personal awareness and emancipation, also reinforces ways of being that are isolating and precarious. In critiquing individualism F. C. Richardson (2005) noted that it “risks emotional isolation and debilitating alienation by significantly downplaying lasting social ties, a sense of tradition, or wider purposes beyond individual self-realization” (p. 27).

The lack of understanding of the social and the relational within psychology further contributes to an emphasis on instrumentalism which F. C. Richardson (2005) defined as the tendency to “collapse the cultural and moral dimensions of life into merely technical and instrumental considerations” (p. 33). The valuing of instrumentalism in psychology contributes to an emphasis on technique and outcome and a blindness to exploitation and manipulation (Cushman & Gilford, 1999; Fowers, 2005; F. C. Richardson, 2005). Additionally, instrumentalism deems psychotherapy as a technique to fix patients who are judged to be disordered, but diminishes practitioners’ abilities to evaluate the moral good of psychological work: beyond the idea of appearing to fix an immediate problem in an individual’s functioning (F. C. Richardson, 2005).

The confluence of neoliberalism with the recent focus on the biological and neurological source of human suffering has formed what Pitts-Taylor (2010) described as a “contemporary biopolitical economy. . . . With an emphasis on individual responsibility and market fundamentalism” (p. 639). She noted that “Market-based health care policies construct populations of individuals who are encouraged to ensure their own health and promote their own personal wellness and success in the face of economic insecurity and

globalization” (p. 639). The two ideologies together bring the focus deeper into the individual and further from the context in which the individual must exist.

Summary

Becoming a mother, bringing a new life into an unpredictable and unstable world, demands that one construct an understanding of a life and world where the future is possible, since one’s child will inhabit it. For a mother, this challenge may present itself with feelings of anxiety, worry, uncertainty, fear, sadness, and/or despair. All of which match the symptoms of perinatal mood and anxiety disorders. It is essential, then, that symptoms of PMADs are considered within a larger social and political context.

The ideas expressed in the three books—*Perinatal and Postpartum Mood Disorders*, *Beyond the Blues*, and *Down Came the Rain*—came to light within this social, economic, political, and professional era. In this study I describe how the authors of the three texts reflected and resisted these beliefs and norms. Exploring and considering the themes which emerged in my interpretation of the texts, as described in the following Results chapter of this dissertation, will further illuminate the ways in which these cultural artifacts, the texts, resist and reinforce the cultural terrain.

Literature Review

Mothering and motherhood as subjects worthy of study have steadily increased in importance since the mid-twentieth century. Recently, O'Reilly (2007) noted that, "most academic disciplines, from anthropology to women's studies, were engaged in some form of motherhood research . . . motherhood has developed from an emergent to an established field of scholarly inquiry" (p. 1). In the past three decades the struggles that mothers experience have also become a significant concern in academic and clinical literature. Research into perinatal mental health has increased tremendously. A recent search in PsychINFO of the term "Perinatal Mental Health" retrieved 259 results published from 1980 to 1999. Using the same term, but searching for publications from 2000–2014 retrieved 1,445 results. Searches for the term "Postpartum Depression" retrieved 808 results for the time period 1980–1999, as opposed to 2,412 published results for the time period 2000–2014. In addition, a new field of study, Maternal Theory, which draws from diverse academic specialties, has contributed to the dialogue around mothering, motherhood and maternal struggles (O'Reilly, 2007; Wong, 2012). How these maternal experiences are described and understood is quite different between the broad field of maternal studies and the more specific clinical research into maternal mental health. Notably, clinical research into maternal struggles rarely acknowledges the cultural context in which contemporary women mother.

Medical Research on Perinatal Psychiatric Illness

Psychiatric illnesses following childbirth became a major, international focus of study after a conference at the University of Manchester in 1980 (Glangeaud, 2014). This conference resulted in the formation of the Marcé Society, named for the nineteenth-

century physician Louis Victor Marcé, who studied postpartum psychiatric illness. Research into perinatal mental health resulted from calls for additional study and information into the health related quality of life factors that impact mothers in the postpartum period (Hamilton, 1982; Rogan, Shmied, Barclay, Everitt, & Wyllie, 1997).

Most of these studies used a bio-medical model approach—meaning that they attributed observed symptoms to an underlying biochemical process in the woman that is exacerbated by the physical and hormonal effects of pregnancy and childbirth. These researchers applied a psychological diagnosis to maternal struggles, formally naming it as a depression or mood disorder (Benedek, 1952; Dalton, 1980; Sichel & Driscoll, 1999).

Marcé had pointed to the “sympathie morbide” (Hamilton, 1982, p. 16) as the basis for a hormonally-caused disorder in new mothers. His term was interpreted by later researchers to indicate the endocrine system, a biological system as yet unnamed in Marcé’s era (Hamilton, 1982, p. 16). Though originally concerned with postpartum psychosis, the Marcé Society eventually took up the investigation of postpartum depression, albeit with continuing difficulties in establishing a clear terminology (Hamilton, 1982).

Building on Marcé’s theory of a hormonally-caused disorder, Benedek (1952), a psychoanalyst, conducted a study in conjunction with a physiologist to determine if women’s hormonal shifts correlated with “psychodynamic manifestations of the sexual drive” (p. 9). Benedek and her physiologist colleague followed fifteen female patients through 10 ovulation cycles each. Benedek met with four of the women for daily psychoanalytic sessions. The other eleven were receiving daily psychoanalytic sessions with other psychoanalysts in Chicago. The physiologist collected vaginal smears and had

the women record daily basal thermometer readings, to chart the ovulation cycle, which were then evaluated by a lab. At the end of ten months, Benedek reviewed the daily notes of the psychoanalytic sessions with the prediction that they would reflect the hormonal changes of the patients. Matching her notes to the lab results of the vaginal-smear and basal body-temperature charts she asserted that:

1. There is a correlation between each hormonal variation of the sexual cycle and the psychodynamic manifestations of the sexual drive.
2. Parallel to and correlated with the hormonal cycle, there is an emotional cycle. Both together constitute the sexual cycle in women.

(p. 9)

Benedek (1952) argued that “the difference between the female of other mammals and the human female is not an actual independence of sexual physiology but a more complex, more delicate, interaction between physiological regulation and human personality” (p. 410). She noted that the healthy or unhealthy adaptation of a woman to her adult roles, including mothering, had to do with how well she managed her reactions to hormones and physiology. However, Benedek did grasp the cultural and psychic contradictions inherent in mothering in her time:

It seems that to be a good mother is a highly complex task in our society. It requires that the woman have a personality which permits her to be passive, to be loved and cared for, so that she may give in to her physiological needs with pleasure, without protest, and thus enjoy pregnancy and motherhood. At the same time she must have an active ego, sufficiently strong to overcome the dangers of passivity and of the tendency to narcissistic withdrawal inherent in her procreative function. (p. 412)

Katarina Dalton (1980/2001) a British endocrinologist, furthered the concept of hormonal imbalance as the etiology of a woman’s experience of emotional distress after

birth. In her study, 500 new mothers completed questionnaires at each of their antenatal visits and at six days, six weeks, and six months postpartum. The information obtained included general demographic criteria such as age, occupation and general health, as well as an assessment of the mother's emotional state. At the end of the survey period, it was determined that 7% of the respondents had confirmed symptoms for what Dalton termed post-natal depression (PND) that required medical intervention but not hospitalization. Because the 7% of women who confirmed symptoms of PND were also the women who, as Dalton described "blossom and exude vitality in pregnancy" (p. 5), she concluded that post-natal depression was not the result of a personality deficit. Rather, she argued that it is a "hormonal illness which is preventable" with medical intervention (p. 5).

Current conceptualizations of PMADs often implicate the mother's unstable brain chemistry due to hormonal imbalances. Sichel and Driscoll's (1999) "earthquake model" is often cited, where the mother's brain chemistry holds "fault lines" that "erupt" when under too much pressure from a "stressful life and/or hormonal events" (p. 99). Kendell (1985) represented two of the dominant cultural views of PMADs when he stated that childbirth "for some women is the most important event in their lives," and that childbirth "is a time of major physiological upheaval, involving massive endocrine and circulatory changes with widespread secondary effects in other systems" (p. 3). Wisner, Chambers, and Sit (2006) noted that "the neurobiology of women with postpartum mood instability appears differentially sensitive to the destabilizing effects of hormonal withdrawal at birth" (p. 2616).

Two of the most highly cited scholarly articles referenced in most studies on PMADs included Michael W. O'Hara and Annette M. Swain's (1996) *Rates and Risk of*

Postpartum Depression—A Meta-analysis, and Cheryl T. Beck's (2001) *Predictors of Postpartum Depression: An Update*.

O'Hara and Swain (1996) used estimates from 59 studies on postpartum depression involving a total of 12,810 subjects. In the results of their meta-analysis they established a prevalence rate for PPD in the general population of 13%. The meta-analysis failed to indicate that there is an increase in non-psychotic depression following childbirth, as opposed to other times in a woman's life. However, they noted that since depression in the postpartum period affects the children, spouse and family members of the woman, it should be treated promptly (pp. 46–47). The authors, in an attempt to convey the results of their findings on risk factors, combined risks with several small effect sizes into the following composite to describe a woman at risk for PPD:

She is most likely to occupy a lower social stratum but women representing middle and upper social strata will also be abundantly represented. She is very likely to have experienced life stressors during pregnancy and may have had a more difficult than normal pregnancy or delivery. She will be experiencing marital difficulties and experience her partner as providing little in the way of social support. Compounding the life stress she is experiencing and her poor marital relationship will be her perception that others in her social network are not particularly supportive of her. Finally, her history will show evidence of psychopathology, in most cases major depression or dysthymia, and she will show evidence of being at least mildly depressed and anxious, and excessively worried.
(p. 47)

C. T. Beck (2001) analyzed 84 studies of postpartum depression conducted in the 1990s to determine the effect sizes of risk factors for developing PPD. Though her study found thirteen significant risk factors, ten of the factors had moderate effect sizes and three had small effect sizes. Those risk factors with moderate effect sizes included: depression before delivery in the prenatal time period, as well as at any time in the woman's life, problems with self-esteem, childcare stress, a lack of social support or not

the kind of support the mother needs, disruptive or unsatisfying marital relationship, infant temperament, experiencing maternity blues, marital and socioeconomic status, and having an unplanned pregnancy (p. 275). C. T. Beck cited O'Hara and Swain's (1996) prevalence rate for PPD of 13%.

Other meta-analyses have established moderate to small effects for predictors of or risk factors for PPD that include: the new mother feeling overwhelmed by childcare and other responsibilities, feeling emotionally fragmented, feeling inadequate or expressing a negative self-evaluation or low self-esteem (C. T. Beck, 2001; Homewood, Tweed, Cree, & Crossley, 2009), a sense of "maternal failure" (Abrams & Curran, 2011), child care stress, and life stressors (C. T. Beck, 2001; Brockington, 2004), Hispanic or Mexican-American women who are highly acculturated into the United States (C. T. Beck, 2006), lack of social support, low marital satisfaction (C. T. Beck, 2001), and financial strain (Abrams & Curran, 2007).

Perinatal Mental Health in the Everyday Vernacular

Beginning in the 1990's information and publications about postpartum depression moved beyond the medical and scholarly realm into books for a general audience. This was in keeping with the intention of grassroots organizations such as Depression After Delivery (D.A.D.) and Postpartum Support International (PSI) to "increase awareness among public and professional communities about the emotional changes that women experience during pregnancy and postpartum" (PSI, 2014, para. 1).

In addition to increased attention from academia, outreach by grassroots organizations brought the issue of perinatal mental health into the everyday vernacular. The term "postpartum depression" had become so ubiquitous that often new mothers

simply stated “I have postpartum,” with the depression designation implied, even though postpartum is, strictly speaking, a time period after the delivery of a baby (B. Myer, personal communication, September, 2011).

Literature on postpartum mood disorders for the general audience comes from two different, yet at times related, viewpoints. Though books on PPD were initially written by health care and mental health professionals (Kleiman & Raskin, 1994; Sichel & Driscoll, 1999), in subsequent years celebrities published memoir accounts of their experiences with PMADs, (Osmond, Wilkie, & Moore, 2001; Shields, 2005) signaling a certain societal acceptance of PMADs and its treatment, or at least an attempt to destigmatize the disorder and to encourage mothers to access treatment.

Sociocultural Research

Several researchers challenged the biochemical etiology of mothers’ struggles following childbirth and instead pointed to sociocultural phenomena that unnecessarily burden new mothers with unreasonable expectations derived from a dominant cultural narrative of the all-giving, all-sacrificing mother (Caplan, 2012; Horwitz, 2011; Johnson, Burrows, & Williamson, 2004; Knaak, 2009; Landy, Sword, & Valaitis, 2009; Lee, 1997; Mauthner, 1995; Mercer, 2004; Miller, 2005; Moloney, Hunt, Joe-Laidler, & Mackenzie, 2011; Nicolson, 1998; Oakley, 1979; Rogan et al., 1997; Wong, 2012). Other researchers identified a transition process that occurs with becoming a mother and the challenges inherent in that process, (Moloney et al., 2011; Rogan et al., 1997).

Simone de Beauvoir (1952) wrote about the ambiguous nature of pregnancy and mothering and the ambivalence women may feel about it. She pointed to the feelings of melancholy and disappointment that arose with birth and separation as well as the ways a

child might enrich a woman's life, if circumstances were favorable enough for her. De Beauvoir gave voice to the burden new mothers may feel as they realized the extent of tasks and limits of freedom that a child entailed, as well as the sense of liberation (from her own mother) and security (from her husband) that a woman may achieve in the role of mother. De Beauvoir also identified the one-sided nature of the relationship between mother and child, and what she described as "the morose disappointment in subjects who hope that an outward event can renovate and justify their lives" (p. 536). She also asserted that "no maternal 'instinct' exists: the word hardly applies, in any case, to the human species" (p. 537). De Beauvoir argued that there were no universals of mothering. She argued that what determined a woman's response to mothering was her "total situation" (p. 537). Further, de Beauvoir described the complexities that arose in mothering when the status of women in the culture was oppressed, demeaned, or secondary.

The mother's experience of motherhood was further explored and articulated by feminist writers in the sixties, seventies and eighties (Chesler, 1972/2005; Friedan, 1963/2001; hooks, 1984; Oakley, 1979; Rich, 1976/1986). Contrary to the cultural belief of the all-giving, surrendering, maternal love, these writers described the complex and sometimes conflicted nature of motherhood, and in doing so, began to make the mother a subject in her own experience. This was a challenge to the cultural expectation that the mother deny her own subjectivity in favor of her child (Benjamin, 1988; Bordo, 1993/2003).

Chodorow (1978) brought a sociological critique to psychoanalytic views of family and mothering. She argued that no understanding of mothering or the role of

mother can be undertaken unless issues of gender and sexual inequality are also considered (p. 3). Wilchins (2004) described the ways gendered roles are cultural. She stated that “although reproduction is a fact, what we make of it is heavily shaped by culture” (p. 136).

Sociocultural research and perinatal mental health. In the past ten years, there has been an increased understanding of the variations and complexities of motherhood, the challenges that mothers may experience, and how these challenges may be viewed as psychiatric disorders (Abrams & Curran, 2007, 2009; Davies et al., 2007; Graham, Lobel, & DeLuca, 2002; Likierman, 2003; Wong & Bell, 2012). Using open-ended interviews, structured interviews, and surveys researchers have asked women about the ways in which they have managed the developmental process of becoming mothers and the meanings this developmental process and their new roles hold for them (Currie, 2009; Lupton & Schmied, 2002; Miller, 2007; Moloney et al., 2011; Murphy, 2007; Rogan et al., 1997). These studies contributed to the expression and development of a vocabulary for the motherhood experience, and to a broader understanding of struggles in the mothering experience.

Several researchers have produced studies that used grounded theory to explore the ways women described their experiences of becoming mothers, including their struggles and challenges (Abrams & Curran, 2011; Barclay, Everitt, Rogan, Schmied, & Wyllie, 1997; Currie, 2009; Knaak, 2009; Mauthner, 1995; Nicolson, 1998; Rogan et al., 1997). These studies contributed new perceptions about maternal experience. They challenged the pathologizing of mother’s struggles and instead explored the role of motherhood in Western societies. This included discussions of how sociocultural

representations and expectations of women and mothers defined and delineated the experience of motherhood. Abrams and Curran (2007) confirmed that socioeconomic status and financial strain were contributors to postpartum depression (PPD). They also noted in their review of the literature that “despite the lack of definitive evidence, a biological explanation for the origins of PPD is currently the dominant explanation for PPD among U.S. treatment providers and in the popular press” (p. 291).

Sociocultural perceptions of struggles in mothering included an understanding of the magnitude of change, loss, and isolation that new mothers experienced in the course of becoming mothers (Barclay et al., 1997; Nicolson, 1998), and that women who described suffering from these struggles and significant losses do not see themselves as depressed, nor were they diagnosed as such (Rogan et al., 1997). Complex descriptions of mothers’ experience of suffering as both a failure, and themselves as good and loving mothers who sacrifice for their children were described (Abrams & Curran, 2011). Other apparent contradictions were described such as the attempt to live up to cultural perceptions of good mothering as a burden and as a means of dealing with postpartum struggles (Currie, 2009). Finally, the influence of the mother’s environment on her struggles to develop her mothering practices was highlighted (Nicolson, 1998).

Mauthner (1995) conducted semi-structured interviews with 40 mothers of young children in England of which 18 identified as having postnatal depression and named it as such. Mauthner focused her article on her interviews with those 18 women. In her research, Mauthner attempted to “ground the theory in the women’s own voices” (p. 314). Among the many concerns raised by the mothers, she noted that their isolation seemed instrumental to their development of a mood disorder, and her research indicated

that “depression is related to a person’s loss of voice and authentic connection with another” (p. 318). Mauthner also noted that “they described how they viewed themselves and others in moral and oppositional ways in terms of better or worse, ‘good’ or ‘bad,’ ‘right’ or ‘wrong,’ rather than in ways which could embrace difference and diversity” (p. 319), but noted that the mothers, themselves did not “construct motherhood in idealized and moral terms” (p. 319). Mauthner attributed that construction to ideas within the contemporary sociocultural era, and acknowledged that these constructions were “informed by dominant representations of motherhood within Western societies” (p. 319).

Nicolson (1998) used semi-structured interviews with 24 women in the London, England area. She interviewed them over four time periods: when they were pregnant, and at 1 month, 3 months, and 6 months postpartum. She found that these mothers reported symptoms similar to PMADs, or in her terminology post-natal depression (PND). These symptoms included fatigue, unhappiness, loss, and inability to cope with demands of childcare, homecare, and self-care. However, there were clear causes for these symptoms in their social circumstances. Nicolson noted that the symptoms of PND were “associated with the shared problems surrounding the conditions of motherhood and thus expectations about the character of *women’s* lives” (p. 109).

Knaak (2009) interviewed 33 mothers from a large Canadian city (a total of 45 postpartum experiences since the women had 1–4 children, therefore some of the women were recalling events from the past three months whereas others were recalling events from as much as five years prior—making for a large variation) who reported ranges of feelings from “mostly and mainly happy to clinically depressed” (p. 80). She found that

mothers who struggled or experienced postpartum emotional difficulties reported that their lives were lacking in six resources: “prioritizing self-care; having manageable situational stress; having enough help; feeling understood; feeling ready for the baby; and having realistic/pragmatic, core beliefs and expectations” (p. 80). Knaak (2009) noted that the mother’s expressions of what they “should do reveals how broader discourses about ‘good mothering’ function as an organizing structure for how women seek out and mobilize various protective resources” (p. 80).

Wong, a psychologist, and Bell, a counselor, in their review and reconceptualization of PPD noted that a psychiatric diagnosis, such as postpartum depression, is a label that “fails to capture or take into account a mother’s familial, relational, and sociocultural experiences” (2012, p. 141). They further clarified that there were ways in which a diagnosis such as PPD might facilitate a woman in receiving much needed care and support as well as avoid judgment from others regarding her struggles as a mother. However, they also acknowledged that the same recognition and diagnosis could be disempowering and create more oppression for mothers who are already struggling. They pointed out the importance of validating a mother’s experience while considering the many relational and social factors that contributed to her struggles. They further emphasized the importance of understanding the multiple factors involved in struggles with mothering so as to increase an awareness of how mothers suffer and to what extent they suffer, as well as to contribute to measures for prevention of depression and other mood disorders, and to establish effective means of treatment should prevention not succeed.

Alternative understandings of struggles in mothering. Several studies described the challenges new mothers faced and the ways in which they met those challenges and obtained a sense of competence in their role as a mother, and a new definition of self. Mercer (2004) reviewed studies around Maternal Role Attainment (MRA) and synthesized studies that evolved from that theory and current studies of the transition to motherhood. Her synthesis led to support for a new term “Becoming a Mother” which she described as an ongoing transition which involves “a commitment to and involvement in defining her new self” (p. 226).

Other studies noted that these understandings of self as mother were drawn from the dominant cultural narratives and traditions in which these mothers were embedded. Miller (2005, 2007) studied 17 women in the UK over the year that they transitioned to motherhood. She interviewed them on 3 separate occasions (7–8 months pregnant, 6–8 weeks postnatal, and 8–9 months postnatal). She noted that “becoming a mother is potentially disruptive to a sense of self” (p. 25). In attempting to describe their experiences and sense of self, Miller (2005, 2007) found that the mothers’ narratives were drawn from cultural and social knowledge. In addition, dominant discourses of social, medical, and moral knowledge and beliefs were prominent when mothers felt unable to express their experiences either out of confusion or uncertainty. Expert narratives were woven into the women’s narratives by the women.

The mother, as an active, engaged, thinking subject, was described by Benjamin (1988) and Ruddick (1989/1995). They continued, in line with the feminists of the decades prior, to explore the complex interaction and relationship involved in the

experience of becoming a mother, and the ways in which those interactions acted upon the mother as well as the child.

Hays (1996) noted the social construction of a time-intensive, child-centered, energy-consuming ideology of parenting which she called “intensive mothering” (p. 4). According to Hays, this ideology placed mothers in conflict with other accepted ideals of adulthood, such as career success and financial gain. M. Beck (1997) described the difficulties and hardships of women attempting to fulfill contradictory and paradoxical expectations of them as female, wives and mothers—a situation that often led to what she termed a “breaking point” (p. 5).

Several writers in the field of maternal studies have highlighted the importance of political and social environments in supporting or diminishing maternal power and agency. They closely considered the ways in which these structures mutually influence the personal, social, and political practices of mothering (Caplan, 2012; O’Reilly, 2010; Wong, 2012). They considered maternal agency to be crucial in resisting patriarchal ideas of motherhood that are oppressive to women and mothers and that may contribute to their struggles and suffering.

O’Reilly (2010) in describing the importance of maternal agency and empowerment conceded that scholars are divided and unclear about how maternal agency is achieved and enacted (p. 14). What they are in agreement about, however, is that contemporary motherhood and the ways a maternally devaluing, patriarchal society demands that it be practiced, are essentially disempowering and oppressive to mothers (p. 17).

Similarly, Wong (2012) discussed ways in which the medical and psychological treatment of mothers who are suffering can be both an act of resistance against patriarchy and a form of oppression of women. As a psychologist she acknowledged that clinicians are also subject to sociocultural norms and expectations. She described “the confines of the mother’s panopticon . . . regardless of who we are, what we do (even feminist maternal scholars) cannot exist outside the fortress of constraint and self-surveillance” (p. 11).

Hermeneutic Explorations of Perinatal Experience

Research which used hermeneutic explorations of women’s experiences during pregnancy and postpartum have highlighted the importance of the individual mother’s experience and context and have provided conceptualized and historical understandings of the experience of mothering and of struggles in mothering (Barr, 2008; Fleming, Vandermause, & Shaw, 2014; Fouquier, 2011; Humphries & McDonald, 2012). Further, these studies have offered clinicians who may encounter mothers who are struggling more complex and nuanced understandings of the experience of pregnancy, birthing, and mothering.

Studies which used hermeneutic interpretation have contributed to an understanding of postpartum depression as being a condition in which the mother felt “stuck in a liminal state” (Barr, 2008, p. 362) and struggling to transition to a new identity and role as mother. Barr noted that when postpartum depression is conceptualized in this way, what may be helpful for the mother is the mentoring and guidance of another more experienced mother who also understands the difficulties of postpartum depression.

The results of hermeneutic studies of mother's experiences were described as interpretive, though not necessarily generalizable to larger populations. Rather, as Fleming et al. (2014) explained in their study of the influence of electronic information on the quality of provider-patient communication, the results should "resonate with practitioners and childbearing women throughout the world in ways that influence our understanding, which can impact clinical practice and the experience of birthing" (p. 245).

In her study of three generations of African American mothers, Fouquier (2011) noted that a hermeneutic interpretation "provides a more complete and less distorted vision of mothering than those that have been defined by the dominant culture" (p. 147). In acknowledging the Afrocentric and feminist theory view of her interpretation of the language used by her participants, Fouquier identified the importance of culture and tradition to African American mothers and addressed taken-for-granted issues of power, politics, and privilege in traditional research on the mothering experience (p. 147).

Humphries and McDonald (2012), two Canadian mental health nurses and researchers, conducted a hermeneutic exploration of mothers who were not breastfeeding their infants due to mental health challenges. The actions of these mothers were contrary to the evidence-based practice of breast feeding which is largely adhered to in Canada. Humphries and McDonald pointed out the risk of rigid responses to women's experiences by health care practitioners that can result from following what they described as "acontextualized, broadly-based best practice guidelines" (p. 377). Their study highlighted the importance of understanding the way a mother as a whole lives out her situation and the context in which she must mother.

Conclusions

In their discussion of perinatal mood disorders, Stone and Menken (2008) reported that “our nation is finally awakening to acknowledge the full spectrum of maternal experience” and “we are simply illuminating long existent facts” (p. xxvii). However, it seems important to wonder about the lens through which motherhood is viewed by researchers and clinicians, the perspective or point of view of the observers, and what is believed to encompass the “full spectrum of maternal experience” (p. xxvii).

Empirical psychological, medical, and nursing studies of postpartum depression and perinatal mood and anxiety disorders have described theoretical perspectives of PMADs (C. T. Beck, 2002a, 2002b; Brockington, 2004); established prevalence rates (Gavin et al., 2005; O’Hara & Swain, 1996); pointed to potential risk factors for developing PMADs (Abrams & Curran, 2007; C. T. Beck, 2001, 2006, 2008b, 2008c; Knaak, 2009; Wisner et al., 2006); and assessed the risks and benefits of treating mothers with symptoms of a mood disorder (Misri & Kendrick, 2007; Stocky & Lynch, 2000). Other than risk factors which may include psychosocial risk factors for a psychological disorder, empirical studies of PMADs have not taken into account the sociocultural terrain in which these disorders have come to light.

Empirical, scientific studies claim objectivity. However, particularly in the case of motherhood, investigators and clinicians fail to account for the reality that all investigators were at one time mothered, and therefore have a history which informs their opinions and values about that experience, whether they were mothers themselves or not. Stigliano (1989) noted that a cultural terrain has a profound effect on the interpretations

that define social institutions (p. 50). As such, researchers are already in the experience they attempt to study objectively, yet present their explorations as universal truths.

Concerns have been raised about the use of the PMADs diagnoses (Brockinton, 2004; Hamilton, 1982; Nicolson, 1998), and the political and social context in which these diagnoses have arisen (Godderis, 2009; Nicolson, 1998). However, most authors and activists within the field of perinatal mental health seem to be primarily concerned with getting new mothers screened for postpartum disorders, de-stigmatizing the disorder, establishing an etiology, and developing and validating treatment regimens (PSI conference, personal communication, September, 2011). All of which are important. However, these tasks are being accomplished without reflection on how these practices may resist or reinforce an oppressive status quo.

Scholars of maternal theory have pointed out the ways in which the current social terrain largely influences how the experiences of mothering and motherhood are understood (Caplan, 2012; Nicolson, 1998; O'Reilly, 2010; Wong, 2012). These investigators have considered the mother's experience, and the ways her experience may contribute to struggles in mothering—including the difficulties of adhering to a dominant narrative of motherhood within a patriarchal culture (Caplan, 2012; Horwitz, 2011; Lee, 1997; Mauthner, 1995; Mercer, 2004; Miller, 2005; Moloney et al., 2011; Nicolson, 1998; Oakley, 1979; Rogan et al., 1997; Wong, 2012). They have also criticized the ways in which power structures and scientism have constructed motherhood. Nicolson (1998) noted:

The role of “mother” . . . has been socially constructed within patriarchy through a complex set of power relations which ensure that women become mothers and practice motherhood in narrowly defined ways. This is achieved in part through the mechanism of “science” which bolsters existing power relations. (p. 9)

Statement of the Problem

Books written by researchers and clinicians about perinatal mood and anxiety disorders (PMADs) and the empirical studies that these authors draw from arise within a culture that values evidence-based, scientific research. The belief that this type of research conveys objective, universal truths about human experience, regardless of social or historical context, has been called “scientism” (Cushman, 2012, p. 1; F. C. Richardson et al., 1999, p. 10). Scientism, an uncritical acceptance and application of empirical research, when applied to clinical practices risks reinforcing a rigid clinical response that limits or distorts understandings of human experience and alters the way clinicians respond to human suffering (Cushman, 2012; Gadamer, 1996; F. C. Richardson et al., 1999). In research and practice with mothers who are suffering, rigid and distorted responses by clinicians may include failures to understand the mother’s experience as a reasonable response to her life and circumstances (Humphries & McDonald, 2012).

Roth (2011) stated that “a science that does not critically interrogate its theoretical concepts literally does not know what it is doing” (p. 106). A healing profession, like psychology, that attempts to support mothers, but does not reflect upon its practices, runs the risk of reproducing destructive dynamics that contribute to the pain and struggles these mothers experience. There is a need to explore how mothers’ experiences are expressed in the literature, how clinicians understand their practices of treatment and healing, and how both reflect and/or resist the shared stories and traditions of motherhood.

Building on the hermeneutic research into maternal experience and the work of maternal theory scholars mentioned above, in this study I explore the ways struggles in

mothering are described in texts on PMADs. These texts express clinician's responses and understandings of themselves, their practices, and their sociocultural roles. With these explorations, I consider the current social terrain that brings to light the experiences of mothers and of clinicians. This study addresses the taken-for-granted assumptions and beliefs that result from an unexamined and unexplored evidence-based or scientific approach to care. In an unexamined body of research, there is a risk of approaching mothers with presuppositions and rigid expectations of their experience. Of primary concern are the unacknowledged ways in which values and beliefs are transferred from the clinician to the mother that serve to reinforce a potentially oppressive status quo.

Though research has explored more diverse descriptions and experiences of mothering, and though the maternal theory researchers have described the cultural environment in which women mother, this study will further ask the question "What is the current social terrain that brings to light these experiences of mothers and clinicians, and how do the ways that mothers' and clinicians' experiences are described reinforce or resist this cultural terrain?" By drawing attention to the taken-for-granted beliefs expressed in the texts, I hope to contribute new perspectives of this experience and offer clinicians and mothers another interpretation of maternal struggles.

Description of the Study

Specifically, in this study I examine three books focused on PMADs. One was written specifically for healthcare practitioners: Susan Dowd Stone and Alexis E. Menken's (2008). *Perinatal and Postpartum Mood Disorders: Perspective and Treatment Guide for the Health Care Practitioner*. One was written for clinicians as well as for a general audience: Shoshanna Bennett and Pec Indman's (2010) *Beyond the*

Blues: Understanding and Treating Prenatal and Postpartum Depression & Anxiety.

The third was written primarily for a general audience: Brooke Shields' (2005) memoir, *Down Came the Rain: My Journey Through Postpartum Depression*. In the methodology chapter, under the subheading "Description of the Texts," is a more detailed discussion of each book, as well as the rationale for choosing each.

I conduct a textual interpretation of the understandings of mothering communicated in these writings. Using Heidegger's idea of beingness, I ask of the texts, "What is it like to be a being living in a world that would produce these texts?" I look for the ways birthing and early mothering are described and understood, and in particular the ways struggles in early mothering are described and understood. I develop understandings about how clinicians respond to those issues and in the process understand themselves, their practices, and their sociocultural role. In general, I hope to understand more about the shape of the current social terrain that brings to light the experiences of birthing women and the clinicians who treat them.

Importance of the Study

The purpose of this study is to recognize assumptions and presuppositions in the professional literature about mothering, motherhood, perinatal and postpartum mood disorders, and women's developmental experiences. The study should benefit new mothers in their process of becoming mothers, by bringing to light the assumptions held by mothers and clinicians about mothering practices and motherhood. Also examined is the tendency to establish universal beliefs about mothering and motherhood that may not be applicable to each mother's individual experience.

This study would benefit healthcare practitioners such as nurses, OB/GYNs, and midwives, as well as psychologists and psychotherapists who work with new mothers. Explorations of clinical understandings, and explicating unacknowledged beliefs, will contribute information, and promote reflection by clinicians when making individual treatment decisions for the mothers they encounter. The results of this study should challenge preconceived notions of what is good or bad, healthy or unhealthy mothering, as well as expand the understandings of the complex relationship of mother and child. As Benner (1994) noted:

The ethical issues of our understanding of a good life and what we consider to be an equal opportunity for the freedom to pursue health and happiness are central to whether our human science practices allow us to reveal, critique, and preserve a range of diversity in a pluralistic society. If our human science is monolithically patterned on the physical sciences, it will allow only decontextualized, elemental, rational, atomistic agents or overly determined, radically unfree objects to be revealed. Aspects of being human related to being constituted by membership, participation, relationship, and human concerns will be covered over by the methods of the physical sciences. In the study of health and illness, we run the risk of medicalizing more and more spheres of human existence if our science allows us to study only disease, cellular processes, biochemistry, and treatments. (pp. xv–xvi)

In addition, as public debate about mandatory screenings for postpartum mood disorders continues in the political realm (Belluck, 2014), this study could invite policy makers to reflect on the current ways in which motherhood, and struggles in mothering, are viewed.

Definitions

For the purposes of this study:

Becoming a mother will mean the experience of giving birth to or adopting a child for the first time with the intention to raise the child to adulthood within one's household.

Hermeneutics refers to an interpretive practice using exploration and reflection (Stigliano, 1989, p. 47) and *ontological hermeneutics* is the form of interpretation that considers what it means to be human in a particular historical time. It seeks to “clarify the *being* of the entities that interpret and understand, namely, ourselves,” (F. C. Richardson et al., 1999, p. 200). It considers what it means to be human in this time and place.

Postpartum depression (PPD) is defined by the American Psychological Association as “a serious mental health problem characterized by a prolonged period of emotional disturbance, occurring at a time of major life change and increased responsibilities in the care of a newborn infant. PPD can have significant consequences for both the new mother and family.” (American Psychological Association, 2007, para. 1).

Perinatal mood and anxiety disorders (PMADs) refers to mood and anxiety symptoms that a woman may experience during pregnancy and up to one year postpartum. These may include symptoms of anxiety, depression, and psychosis (University of North Carolina School of Medicine, 2014).

Motherhood refers to the institution of motherhood as defined and described by a patriarchal culture (O’Reilly, 2010, p. 2).

Mothering refers to the lived experience of the social and inter-subjective practices of nurturing and caring for dependent children, and may include practices that resist or reinforce the institution of motherhood (O’Reilly, 2010, p. 2).

Theoretical Framework

Philosophical hermeneutics. The theoretical framework for this study is the philosophical hermeneutics of Martin Heidegger (1962) and Hans-Georg Gadamer (1960/1991) as discussed by Cushman (1995), Lawn (2006), F. C. Richardson et al. (1999), Stigliano (1989) and Warnke (1987), and as utilized in the practice of interpretive phenomenology as described by Benner (1994). Hermeneutics, arising from the practice of interpreting religious texts, is at its most basic a practice of understanding. Gadamer (1960/1991) noted that “understanding always includes interpretation” (p. 399). Any attempts to analyze, critique, or make sense of a practice, text, or person will always include an interpretation that is influenced by the traditions and values of a place and time—a particular historical era.

Mothering is a set of practices enacted within a certain tradition, time, and place. How mothering is identified, conducted, and evaluated will be determined by the particular values and collective understandings of the good in the place and time in which mothering occurs—the shared understandings about motherhood. Because mothering practices are embedded in a sociocultural tradition, understandings about these practices will contain several presumptions and prejudices that are often taken for granted, or unnoticed. Philosophical hermeneutics can aid the interpreter in bringing to light the presumptions and assumptions about daily practices and in understanding the terrain in which certain beliefs and actions arise. A central question of this study—“How are struggles in early mothering described and how do clinicians understand their practices and roles?”—calls for a hermeneutic framework which takes as its starting point the socio-historical context in which everyday practices and experiences occur.

Heidegger's (1962) notion of "being-in-the-world" (p. 78), which is the basis for ontological hermeneutics, emphasized that beings can never be detached from the social world in which they exist. Heidegger proposed that there is no understanding of humans or human experience outside of the world that constitutes them. Benner (1994) noted: "We have understanding because we are always already in the familiarity of our cultures and societies. . . . Understanding makes it possible to uncover things in our world, that is, it discloses the world" (p. 70).

As opposed to the Cartesian tradition and the epistemological emphasis that holds that there are universal truths that can be discovered and known, ontological hermeneutics asks what it means to be a person in the world at a particular time, and how persons understand the world they inhabit. Unlike the Enlightenment and Romantic Eras ideals in the natural sciences, that believed reason and objectivity were split from subjective experience and feeling, Gadamer (1960/1991) proposed that there is no objective, removed point from which one can view a human experience unfettered by tradition, prejudices, and attitudes. "Understanding is never a subjective relation to a given 'object' but to the history of its effect; in other words, understanding belongs to the being of that which is understood" (Gadamer, 1960/1991, p. xxxi).

Though humans are constituted by their culture, they are not trapped in it, or solely determined by it. Rather, they embody their culture and its understandings, and they act on their culture and form new understandings. Heidegger's (1962) concept of Being holds that we are not stagnant entities, but are rather always becoming, always happening. And with this fluidity within a structure, new interpretations and understandings may arise or become known through the process of interpretation, or in

Gadamer's (1960/1991) understanding, through dialogue. "Our nature or being as humans is not just something we *find* (as in deterministic theories) nor is it something we just *make* (as in existential and constructionist views) instead, it is *what we make of what we find*" (F. C. Richardson et al., 1999, p. 212).

Central to Heidegger's (1962) philosophy and Gadamer's (1960/1991) emphasis on understanding is the concept of the cultural clearing. The cultural clearing is a description of the space of understanding and recognition in a culture. In the clearing certain ideas can come to light while certain others are outside of the horizon, beyond our view. Benner (1994), describing Heidegger's concept of local and general clearings, noted:

A person or a group may have an individual clearing but that clearing is an interpretation or understanding that is possible only because of our shared background understanding [a result of being] dialogical beings engaged in our world through a shared, community understanding. (p. 70)

In research, as well as in health care and all knowledge disciplines and practices, the horizon is created by what we pay attention to, and what we ignore, (Benner, 1994, p. 70; Cushman, 1995, p. 302). The intention of this study is to bring to light that which has been noticed, paid attention to, and named in the experience of mothers who are struggling and that which has been ignored. These acts of attention and ignoring have not been conscious or conspiratorial events, but rather have arisen out of a particular sociohistorical era where multiple dynamics brought to light some experiences but not others. Everything cannot be included in the clearing. Some things always lie beyond the horizon (Cushman, 1995).

The way that humans interpret their understanding constitutes their being.

Heidegger (1962) described the uniquely human existence, which he termed “Dasein,” as constituted by understanding:

Understanding constitutes rather the Being of the “there” in such a way that, on the basis of such understanding, a Dasein can, in existing, develop the different possibilities of sight, of looking around, . . . and of just looking. In all explanation one uncovers understandingly that which one cannot understand; and all explanation is thus rooted in Dasein’s primary understanding. (p. 385)

Interpretations, such as the way we describe struggles with mothering and motherhood experiences, are not outside of us, observed and chosen by us, but rather arise from and are formed by cultural traditions, the historical time, social practices, and what is believed to be significant. The way these experiences are described, including troubling and distressing experiences, is informed by what Leonard (1993) described as “all those hidden skills and practices and linguistic meanings which are so all-pervasive as to be unnoticed and yet which make the world intelligible for us, create possibilities, and the conditions for our actions” (p. 56).

Gadamer argued that our understanding of a text or other forms of communication or presentation can occur only from our own perspective, or within our own situation, and as it concerns us (Warnke, 1987, p. 68). Gadamer held that the meaning of a text is shared or created and understood together by the author and the readers. (Warnke, 1987, p. 69). Beliefs and ideas do not stand alone, solid and unchanged, until disproved. Rather our understandings are constantly forming as our beingness encounters the text. Rather than trying to claim objectivity, Gadamer argued that “prejudice and tradition are essential to understanding” (Warnke, 1987, p. 75).

Humans are already beings in the world, part of a moral and historical tradition. Our interpretations of texts arise within a shared understanding of the context and historical situation in which these texts have meaning. Attempts to understand the lived experience of mothers, and the struggles they endure, will result in an interpretation that can only have significance or make sense within the particular sociohistorical era from which it arose, with its particular moral values, understandings of the good, and traditions. As Gadamer (1960/1991) stated, “to interpret means precisely to bring one’s own preconceptions into play” (p. 397). The authors, as well as the readers, of books on PMADs are embedded in their experiences and meanings. This will shape the way they understand their experiences and the words they use to describe those experiences. So, too, will the particular historical time and moral values that are present shape our understandings of the texts.

Stigliano (1989) described hermeneutics as “founded on the premise that language is constitutive of human life . . . speech . . . creates the clearing in which we encounter objects, events and persons by expressing ontological distinctions” (p. 47). The dissemination of research and writings on clinical practices are also aspects of the clearing in which ideas are encountered and descriptions constitute our world. “Hermeneutics, then, articulates the understanding people embody as selves, as members of a community, and of their world as embodied in a tissue of linguistic practices” (Stigliano, 1989, p. 49).

Literature defining and directing mothering practices has had a significant influence on the way mothering and motherhood are viewed (Nathanson & Tuley, 2008).

The authors of books about mothering practices express beliefs and values about what mothers do and how they behave.

Such literature is based on the assumption that mothers need to be both corrected and directed, and that, when left to their own devices, mothers will get it wrong. Mothers are perceived as needing guidance, and this guidance, historically, has been shaped at least in part by a political and ideological agenda that would confine women to traditional roles within the family and society. (Nathanson & Tuley, 2008, p. 1)

Books about perinatal mood and anxiety disorders arose within this same sociocultural landscape. The goal of this study is to illuminate the meanings and presumptions embedded in these texts written by experts. This would allow new understandings of the way mothers experience themselves, their situations, and their daily practices. The hope is to expand the horizon to facilitate freedoms within those daily practices.

How well a woman meets the socialization requirement of motherhood and performs mothering practices will be dependent largely on the interpretation the community makes of the woman and the mothering role. Similarly, how well the woman herself feels she has become a mother will depend greatly on the definitions and understandings of mothering and motherhood within the particular historical time that constitutes her. In addition, the descriptions of mothers' experiences, how these experiences are understood and interpreted, will illuminate what it means to be human in that particular time.

A hermeneutic exploration of the way PMADs have been conceptualized in the literature for clinicians and mothers, and then acted upon in the clinical setting, can highlight preconceived notions of women, mothers, and clinicians' roles. In addition it may identify a cultural and historical perspective present in the research and bring into

the foreground beliefs and attitudes that are taken for granted and that flatten varied and textured experiences of motherhood. Without critical reflection to help guide discussions of treatment and care, clinicians and researchers risk taking for granted historical particularities and assuming them to be universal truths rather than culturally and historically bound practices.

Methods

Purpose

The purpose of this study is to explore the understandings that professionals within the field of perinatal mental health have about birthing and mothering and how they enact those understandings in their practices as expressed in texts on perinatal mood and anxiety disorders. I explore the ways challenges in early mothering are described in three books about perinatal mood and anxiety disorders (PMADs). I consider clinicians' responses to mothers who struggle, and their understandings of themselves, their practices, and their sociocultural roles. Ultimately, I hope to understand more about the current social terrain that brings to light these experiences of mothering and of the clinicians who work with mothers.

Research Approach

Interpretive phenomenology. In this study, I use an approach that developed out of Heidegger's (1962) ontological hermeneutics and Gadamer's (1960/1991) philosophical hermeneutics. Referred to by Benner (1994) as "interpretive phenomenology" (p. xvii), this approach considers the practices, experiences and language, as expressed in written work, to reflect beliefs and values about beings in a particular historical era. Benner noted that:

Interpretive phenomenology cannot be reduced to a set of procedures and techniques, but it nevertheless has a stringent set of disciplines in a scholarly tradition associated with giving the best possible account of the text presented. The interpretation must be auditable and plausible, must offer increased understanding, and must articulate the practices, meanings, concerns, and practical knowledge of the world it interprets. Good interpretation is guided by an ethic of understanding and responsiveness. (p. xvii)

In using interpretive phenomenology, I hope to develop understandings and to make explicit the practices, concerns, and beliefs of those in the field of perinatal mental health. An interpretive phenomenology should bring to light the taken-for-granted beliefs, meanings, and concerns of practitioners within a particular social world (Benner, 1994, p. xviii).

This research approach is appropriate for this study because it allows me to interpret the beliefs and understandings about perinatal mental health as reflected in the practices, experiences and writings of those who encounter the challenges and struggles of mothers and mothering. This includes professionals in the health care and perinatal mental health professions as well as one woman who wrote about her experiences and struggles in early motherhood. I look at the everyday lived experience of these writers and mothers as they described their journeys, practices, and beliefs about the struggles of mothering. As Benner (1994) stated “Interpretive phenomenology . . . is concerned with life world, human concerns, habits, skills, practices, experiential learning, and notions of the good that fuel health care practices, help seeking, and receiving” (p. xx). Stigliano (1989) noted that “social practice, constitutive of a social world, is made self-reflective by hermeneutics” (p. 51). The books about PMADs—their etiology, risk factors, effects, and treatments—are part of a social practice, constituting a social world. In this hermeneutic interpretive study, I make this practice self-reflective.

Brenner (1994) described principles related to interpretive phenomenology, noting that “One must not read into the text what is not there . . . The extremes of idealizing and villainizing are to be avoided” (p. xvii). She also noted that the design of the study will include following lines of inquiry; entering into dialogue with what is

noticed in the text; and using interpretive analysis to delineate themes, exemplars, and paradigm cases (p. xvii). This form of research requires attention, flexibility, and openness, as well as discipline and focus from the researcher:

The dialogue with the participants and situation must make claims on the researcher's understanding and shape the dialogue . . . The interpretive researcher is constrained by the demands of the text—carefully listening, hearing the voices and concerns inherent in the text, giving the fullest possible account . . . The interpretive account should illuminate the world of the participants, articulating taken-for-granted meanings, practices, habits, skills, and concerns.” (Benner, 1994, pp. xvii–xviii)

Further, the validity of an interpretation is obtained when there is a resonance and mutual understanding from others in the field, particularly of understandings and knowing that have been sensed or felt but not fully articulated (Benner, 1994, p. xviii). “The goal of interpretive phenomenology is to uncover commonalities and differences, not private idiosyncratic events or understandings” (p. 104).

Writers on philosophical hermeneutics hold that information, beliefs, and practices are grounded in a social and historical context (Gadamer, 1960/1991; Heidegger, 1962; Taylor, 1991). As such, these practices convey values about what is good and right (Cushman, 1995; F. C. Richardson, 2005). Those who develop and disperse information, perform professional practices, and hold beliefs about those practices are also grounded in a social and historical context. Their practices and writings will therefore reflect values about what they believe is good and right. Further, there is no way to escape the social context in order to obtain objectivity. Rather, researchers will move back and forth from the specific to the general, from the part to the whole, from their perspective to the other's perspective, and back again in what is referred to as the “hermeneutic circle” (Cushman, 1995, p. 22; F. C. Richardson et al.,

1999, p. 205). This analysis, while moving towards the text, back to experience and reflection, and back to the text again should make more obvious that which is included and excluded in the beliefs and practices that are described and therefore the values that the writers and researchers hold and enact. The need for this sort of analysis within perinatal mental health is supported by F. C. Richardson's (2005) observation that "modern psychology and psychotherapy *both* creatively address emotional problems in living *and* inadvertently perpetuate ideals and practices of our way of life that may actually contribute to those very problems" (p. 21).

This study, a hermeneutic interpretation, looks at the everyday lived experience as expressed in practices and activities described in texts on struggles in mothering. The texts I engage with and interpret come from three books written about PMADs. In the texts practices are described that are so everyday that their meanings are taken for granted and often remain unnoticed. This interpretation attempts to make explicit the beliefs and meanings, and therefore the moral values that are implied in these texts. Mothering and working with struggling mothers are historically situated, contextual practices that reinforce or resist cultural narratives about what it means to be a mother, and what it means to be a clinician. Therefore these can be seen as moral practices steeped in what is believed to be good practice. Given this understanding, I am interested in the following.

Research questions. The following questions guide my exploration of the texts:

1. How are the challenges and struggles of birthing and mothering described within these books? What behaviors or presentations are considered problematic and/or in need of treatment, and what behaviors or presentations

are *not* considered problematic? In what ways do experiences seem to become symptoms?

2. How do clinicians respond to the struggles exhibited in new mothers, and in the process understand themselves, their practices, and their sociocultural role? What questions do clinicians ask of mothers, and how do those questions, and what they hear of the responses, determine how professionals define and describe the experience of becoming a mother?
3. What is the historical and social context in which these books arose? What do these books tell us about this historical era and the social terrain that brings to light these experiences?
4. In what ways are clinicians helped to better understand the mother's experience by the words and diagnostic terms that are used, and in what ways might the words and diagnostic terms cloud the clinicians' understandings of a mother's experience? In what ways are mothers helped to understand their experiences by the words and diagnostic terms that are used, and in what ways might these same words and diagnoses confuse or cloud mothers' understandings of their experience?
5. Do the beliefs and descriptions of mothers' challenges and struggles presented in these books move women to alter, shape, and manage their behaviors? If so, how does this altering present itself in the clinical setting?
6. What are some of the taken-for-granted beliefs about the experience of motherhood and the experience of becoming a mother that are represented in the books? What are some of the myths about mothering and motherhood that

are challenged, and what are the myths that are reinforced in the books? What assumptions are made about “normal,” “good,” and “healthy” mothering?

7. In what ways do our current understandings of PMADs exercise power, and whose interests are served by the way the challenges and struggles of mothers are conceptualized? Are those individuals, institutions, and groups whose interests are served by the way the challenges of mothers are conceptualized aware that they benefit from these conceptualizations and interpretations? How do the words and definitions that are unquestioned undercut the validity of experiences of oppression and abuse?

These questions draw out the ways in which the text describes struggles in birthing and mothering and the clinical responses to those struggles.

Description of the texts. The books used in this study come from three distinct, yet mutually influential, categories. The first book, Stone and Menken’s (2008) *Perinatal and Postpartum Mood Disorders: Perspective and Treatment Guide for the Health Care Practitioner*, was written by scholars, practitioners, and leaders in the field of perinatal mental health, and was meant to be used by clinicians who are treating women diagnosed with, or at risk for developing a perinatal mood disorder. The second book, Bennett and Indman’s (2010) *Beyond the Blues: Understanding and Treating Prenatal and Postpartum Depression & Anxiety*, took this clinical information and put it into a form intending it to be understood by clinicians as well as readers who are not trained clinicians. The third book was a memoir written by a well-known celebrity, Brooke Shields’ (2005) *Down Came the Rain: My Journey Through Postpartum Depression*. These books described the dominant beliefs that health care practitioners

and mothers hold about PPD and PMADs. By doing so, they also contributed to the language used to discuss struggles in mothering within the clinical field as well as in popular language. The research from which they drew described predictors or risk-factors for PMADs, conceptualizations of mental and emotional disorders in pregnancy and mothering, as well as treatments considered to be effective. They therefore served to shape the way the experience of mothering can be viewed.

The stated goal of each of the books in this study was to assist women, family members, and health care providers in recognizing when a woman is suffering severely and in intervening effectively—to diagnose and treat. The development of organizations such as Postpartum Support International was prompted by a lack of response to new mothers in crisis and in need of help, therefore many of the publications in the field have an activist bent to them, and a pressure to “bring the topic into the light” (Bennett & Indman, 2010, p. 17). This study intends to explore what has been brought into the light, and what may have been left in the dark.

Each book was chosen as a representation of collective understandings of struggles and challenges in the perinatal experience. Though they cannot represent every experience, they were considered, by clinicians and leaders in perinatal mental health, to be important in understanding the experience of mothers (P. Indman, personal communication, November 15, 2011; H. Koss-Noble, personal communication, November 9, 2011). Stone and Menken’s book is listed on the PSI website, and contains chapters from several leading writers, researchers and activists in perinatal mental health, (e.g., Brockington, Misri, C. T. Beck, and Honikman). Stone is a licensed clinical social worker and a past president of PSI. She is a contributor to the New Jersey Governor's

Task Force Educational Webinar on postpartum depression. Menken is a clinical psychologist specializing in maternal mental health and is the co-founder of The Pregnancy and Postpartum Resource Center at Columbia Presbyterian Medical Center. At the time of this study, she is a current board member of PSI as well as the New Jersey Coordinator.

Shoshanna Bennett is a psychologist who was one of the founders of Postpartum Assistance for Mothers. She was a past president of Postpartum Support International, as well as past president of the California State organization, Postpartum Health Alliance. She has presented on national programs as an expert in Postpartum Depression and Perinatal Mood and Anxiety Disorders. She experienced two episodes of postpartum illness after the birth of her children, and she described some of those experiences in Chapter One of their book. Pec Indman is the Chair of Education and Training for Postpartum Support International. Their text is a recommended resource for several national and regional organizations including: the US Navy, Spectrum Health in Michigan, Durham Regional Health Department of Canada, New York State Department of Health, Broward Healthy Start Coalition of Florida, Clarian Health in Indiana, the International Childbirth Education Association, and the United States Department of Health and Human Services.

Shields' memoir is ranked #3 on Amazon bestsellers in PPD, and was on the New York Times Bestseller list in 2005 (the year it was published) for five weeks. Her memoir is referenced in Chapter Four of the Stone & Menken book where Shields was credited with giving "this illness the validity, legitimacy, and the attention it needed" (Misri & Joe, 2008, p. 65). Shields' book is often mentioned, and often sold, at PSI

conferences. Clinicians have reported that they keep extra copies in their office to loan out to clients who are struggling after the birth of their babies (S. Misri, personal communication, PSI Conference, June 25, 2005; B.G. Meyer, personal communication, PSI Conference, September 14, 2011).

Shields' book was an important addition to this study specifically because her story provided context and meaning. The events she recalled and described were situated in her everyday experiences. Smithbattle (1994) argued that

Narratives . . . recover what formal theories necessarily overlook, how we are inherently social and historical beings. By revealing the context within which narrators act, stories demonstrate that meanings are lived out on the background of shared understandings that develop within a sociocultural tradition. (p. 145)

Brown (2010) in her analysis of maternal narratives described maternal memoirs as “publicly accessible sources that provide an excellent window into expanding public discourse on motherhood” (p. 121). Brown also noted that since maternal memoirs arise from popular culture, they will define the socially acceptable ways of being a mother and of mothering practices, including aspects of the mothering experience that may be challenging for members of a culture to acknowledge or understand (p. 121). Shields' memoir of her experience and diagnosis of postpartum depression seemed to serve these dual roles. It expanded the public discourse on motherhood and maternal mental illness and defined socially acceptable ways of treating maternal mental illness.

Interpretive analysis. In interpretive analysis written text is engaged with and explored to illuminate the beliefs and meanings contained within the everyday practices that the text describe. Benner (1994) noted that “the aim of interpretive phenomenology is to use indirect discourse to uncover naturally occurring concerns and meanings” (p. 112). In this study I followed Benner's strategy for organizing an interpretive analysis

which included an analysis of themes present in the text, highlighting “exemplars,” and denoting “paradigm cases” (p. 112).

An analysis of themes, what Benner (1994) termed “thematic analysis” (p. 115), looks at meaningful patterns, repeated practices, and concerns expressed within the text. I looked for repeated themes as expressed by the authors. Thematic analysis involves drawing out recurrent themes from all three books, first individually and then together. The presentation and discussion of these themes serve as the results and articulated understandings of this study.

Exemplars, according to Benner (1994), “demonstrate intents and concerns within contexts and situations” and “convey aspects of a paradigm case or a thematic analysis” (p. 117). Exemplars have also been described as “particular patterns of action that included a rich description of the situation and responses within a given text” (Chesla, 1994, p. 173). Exemplars in this study are quotes from the texts that best represent the concerns and patterns that form the themes of this analysis.

Paradigm cases are described as “strong instances of concerns or ways of being in the world, doing a practice, or taking up a project” (Benner, 1994, p. 113). A paradigm case will allow certain ways of being, understandings and meanings to be seen and known, while necessarily excluding other understandings, meanings, and ways of being. It will represent many of the themes expressed in all three of the texts which I explored.

Reading and rereading the texts allowed certain themes, concerns, patterns of meaning and common situations to arise. Noting these themes, I then developed an outline which addressed the patterns and themes emerging from the texts as well as the research questions that grounded this study. The text of each book was then explored in

detail and portions of the text that represented strong examples of themes or patterns were added to the outline. Comparisons between the books occurred throughout the study.

As similar patterns of concerns arose, these were considered as exemplars. Finally, a paradigm case, which represented multiple themes found in the texts, was identified. It is discussed at the end of the Results chapter. In this study I did not seek to restate what is known about perinatal mood and anxiety disorders, but rather to explore why and how we know certain things about this experience, and do not consider or wonder about other aspects of this experience. I consider the ontological understanding—what constitutes the knowing we have (Benner, 1994, p. 102).

The Study Design

The findings of my exploration are organized in a way so that the uniqueness of each book, as well as their similarities, was described. I began by considering the texts within the context of late twentieth century, early twenty-first century Western culture. This placed the texts in relief against the background of cultural, political and social events of the past two decades. Each text was then described in the following way:

1. An overview of the text, including its general tone;
2. A description of the themes presented in the text;
3. Exemplars from each theme that represented the beliefs and conceptualizations of the authors around early mothering and motherhood;
4. A summary of the overall conceptualization of struggles in mothering and clinicians' responses to these mothers as presented within the text.

After considering each book individually, I then looked at the three books together. I looked for where and how themes were shared or contradicted. As per

Benner's (1994) description, I was looking for the similarities and differences between the books.

Evaluation of the interpretive analysis. My interpretation is considered valid if mothers and clinicians recognize some of their practices and meanings within this interpretation, and understand them in a new or deeper way—understandings and taken-for-granted beliefs are revealed and recognized (Stigliano, 1989, p. 62). In Leonard's (1993) description, the interpretation is valid if it “resolves the breakdown and open(s) up new possibilities for engaging the problem. . . . Competing accounts do not negate each other. Rather, they set up a conversation” (pp. 67–68). My hope for this study is that it adds to the conversation about mothers, their struggles, and clinicians' responses to these women.

Forestructure. Scholars in the human sciences who use hermeneutic or interpretive phenomenology have criticized the ahistorical claims of neutrality and objectivity within scientism (Benner, 1994; F. C. Richardson et al., 1999). They point out that both the interpreter and the interpreted exist within a history of tradition, beliefs, values, and taken-for-granted practices that have been informed by multiple sources of knowledge and understanding (Fowers, 2005; F. C. Richardson, 2005). By contrast, hermeneutics and interpretive phenomenology hold that both the researcher and the reader approach the literature from a particular set of experiences. To deny these traditions and experiences is not neutrality or objectivity, but is rather a denial of the perspectives and prejudices that are present in all research in the human sciences. That dismissal and denial of perspective within the scientific methodology is what Gadamer (1960/1991) referred to as “the tyranny of hidden prejudices that makes us deaf to what

speaks to us in tradition” (p. 270). Gadamer described an alternative to scientism’s claims of neutrality:

[A] hermeneutically trained consciousness must be, from the start, sensitive to the text’s alterity. But this kind of sensitivity involves neither “neutrality” with respect to content nor the extinction of one’s self, but the foregrounding and appropriation of one’s own fore-meanings and prejudices. The important thing is to be aware of one’s own bias, so that the text can present itself in all its otherness and thus assert its own truth against one’s own fore-meanings. (p. 269)

Therefore, an important step in this study has been for me, as the interpreter, to establish my own prejudices and fore-meanings, what Benner (1994), drawing on Heidegger’s philosophy, referred to as “forestructure” (p. 71). Forestructure is the preunderstanding with which we approach an interpretive project or task. The forestructure includes the “fore-having,” “fore-sight” and “fore-conception” (Plager, 1994, p. 72).

Fore-having. The fore-having acknowledges that each researcher comes to the tasks of interpretation with their own histories and experiences. These previous events helped to form beliefs and understandings about the world, and specifically about that which is engaged with in interpretation (Plager, 1994, p. 72).

In this study, my fore-having includes my own experiences in becoming a mother and my experiences as a psychotherapist and clinician, including my work with new mothers in distress. My fore-having also includes my experiences in the grassroots community of Postpartum Support International (PSI) and the scholarly/activist community of Motherhood Institute for Research and Community Involvement (MIRCI). In this research I considered and reflected on my own experiences so that I could situate myself and my prejudices within the analysis. This included reviewing my journal entries from my son’s first two years as well looking at the books (Leach, 1997, and

Sears & Sears, 2003) and the ideas that I used to educate myself and make sense of my daily experience of early mothering.

Fore-sight. Fore-sight acknowledges that we enter into any interpretation from a point of view that has been influenced by our background. In this study the fore-sight is the point of view from which I enter into the exploration of these texts—my interpretive lens. Leonard (1994) noted that “this conceptual orientation to the phenomena functions as a vehicle for gaining access to the phenomena and is open to revision as the analysis proceeds and new meanings and understandings are revealed by the study” (p. 57).

My point of view in regards to this study comes from not only being a mother, but also being a clinician within a professional culture with certain values and ethics. My understanding of what is right and good as a clinician establishes part of my point of view as I enter this study. Two factors are most salient to this position. The first is that I have been trained in areas of psychology that do not conform to the current emphasis on scienticism and the scientific basis of psychology. Rather, I have been trained to consider intersecting lines of context and culture within which my clients and I exist.

Additionally, I am trained to be more comfortable with ambiguity than with clearly delineated methods of human healing. As such, I consider the mothers with whom I have worked, who are suffering, to be reflecting certain aspects of the social terrain in which we must live. I seek to maintain stability within my professional community which often compels me to establish practices that are generally accepted but of which I am suspicious. As such, I seek to work in a competent, helpful fashion, but do not believe that the most empirically supported and researched method is necessarily the

right one for all clients in all situations. This places me in some tension with my professional community.

During this study, I was aware of a constant tension. As a clinician for whom these mainstream ideas of PMADs have been helpful in working with mothers who were suffering, and a scholar familiar with the literature critiquing psychological practice, I was in conflict. I have appreciated the clinical and social advocacy work that has been done in order to alleviate the suffering of mothers. Yet there were important aspects of the mother's experience and the clinician's practices that needed to be acknowledged and questioned. Becoming further educated about critiques of therapeutic culture brings many of my own therapeutic practices into question. Yet, I am still faced with the suffering of my clients and therefore feel compelled to respond in some competent or useful way. This is a state in which many clinicians who are aware of critiques in therapeutic culture must find themselves as well (Cushman, 2015).

Fore-conception. The fore-conception describes how we approach interpretation with some expectation of what we already believe we know or understand about the phenomena and some anticipation of what we might find. This includes what I consider worth questioning and what I think a plausible answer might be. Leonard (1994) noted that "there is always a preliminary sense of what counts as a question and what would count as an answer" (p. 57).

Drawing from my own perinatal experiences, there are ways in which I will approach the authors' descriptions of perinatal struggles. Crucial to my fore-conception are memories of two habits or practices that I recall from the first months of my son's life. Both of these habits reflected a sense in me that my life and world had become

unalterably changed by my giving birth and becoming a mother. During the first few weeks after my son was born, whenever I was out in public I would find myself looking at strangers—adults crossing the street, people in grocery stores—and wondering “Are they a parent?” I was profoundly curious to discover who in my community had made this transition, how they had done it, and what did they know that I was only beginning to understand. I felt myself slipped into a new category of adult, of person, and wanted to know who else was there with me, how they enacted this role, and what they thought about it.

The second memory also reflects this sense of profound disruption and transition. Often while reading a book to my young son, I would find myself scanning the drawings and pictures, especially if the story was about a family, looking for clues as to how they had constructed their life. I was considering everything from the way Richard Scary’s bears managed their day-to-day lives, to how Arthur’s family of aardvarks arranged and decorated their homes. Ironically, there was no lack of parenting information books or Pottery Barn catalogs around to tell me precisely how I should manage my day-to-day life as a parent and how I should decorate my home. But I believe my intense curiosity had more to do with my attempts to understand not what to do but rather how to live, how to construct a life beyond the doing and the buying. My world had changed, I was no longer living as I was prior to becoming a parent. Yet much of how I had known myself was still present, still in the world. As Heidegger (1962) described it “That *world* is no longer. But what was formerly *within-the-world* with respect to that world is still present-at-hand” (p. 432). My fore-conception of this study is a sense of how transformative the experience is of becoming a mother—how confusing, destabilizing,

and at times frightening that transition might be—and also how much of the mother, as she has known herself to be, is also present and yearning to understand and make this transition.

Data Collection

I began this study by reading each book individually to get a general sense of its authors' tone and perspectives, and the book's general task (e.g., to inform, to reassure, to describe). I read the books again and noted the general themes within each book as well as those themes shared among the books. The third time through the books I used a photocopied version of the books. I did this so that I could physically cutout examples of the themes and group them together, by theme, into large manila envelopes. This allowed me to evaluate the predominance of certain themes and whether some of the initial themes were subthemes of other more strongly represented themes.

I then went back through these representations of the themes and re-read the sections of the books from which they came. I began to look for differences and similarities within a theme. For example, I noticed how understandings show up for the clinician in the professional relationship, and how understandings are expressed by the mother about expectations and norms. I considered differences within similar practices in order to develop a more complex understanding of how clinicians describe mothering, and how they understand their roles and practices.

In using philosophical hermeneutics in this study I explored and interpreted the meanings conveyed in the texts as being constitutive of the world and historical time in which they are relevant or for which they hold meaning. The texts pointed to the practices and therefore social roles that were embodied by mothers and clinicians, and the

practices and roles that mothers and clinicians were expected to adopt and master.

Finally, what the texts expressed about the self in the late twentieth and early twenty-first century was reflected on and described.

Results

Perinatal and Postpartum Mood Disorders: Perspectives and Treatment Guide for the Health Care Practitioner (2008)

Description. Stone and Menken's (2008) *Perinatal and Postpartum Mood Disorders: Perspectives and Treatment Guide for the Health Care Practitioner* contains contributions by respected researchers and clinicians in the field of perinatal health. It is divided into four parts, with eighteen chapters, for a total of 353 pages of writing and references. At the end of the book is a resource list of websites and organizations offering information and support about women's health and mental health. The book contains 18 chapters written by a total of 24 authors, including the two editors, Stone and Menken, who each contribute their own chapters.

The authors' credentials, from a scholarly perspective, are impressive. Their biographies indicate that they are sufficiently qualified to speak as experts on the issue of perinatal and postpartum mood disorders. All have multiple publications on the subject and several years working in the field of maternal medicine and mental health. Some are leaders of national organizations concerned with maternal mental health. Of the 24 authors, six are medical doctors, three are from the nursing profession (2 ARNPs, 1 DNSc), eight have PhDs, two have MS degrees, and two co-authors have bachelor's degrees. There is one attorney (JD) and one author with no advanced degree specified; she is the Executive Director of the What to Expect Foundation, an international health education organization.

The editors noted that "while ambitious in reach, the authors who contributed time and thought to this project are well recognized leaders, thinkers, clinicians, and advocates within this practice specialty" (Stone & Menken, 2008, p. xxvii). The

foreword to *Perinatal and Postpartum Mood Disorders* was written by Ian Brockington, PhD, FRCPsych, the founder and inaugural president of the Marcé Society, as well as the first chairman of the World Psychiatric Association's section on Women's Mental Health. His writings have been regularly cited as seminal works by researchers in the field of perinatal mental health (Braverman, 2008; Honikman, 2008; Menken, 2008).

Perinatal and Postpartum Mood Disorders is organized into four sections. The first section, "Part I: The Importance of Maternal Mental Health," begins with three chapters on the effects of maternal mental health on others (children, infants, and older siblings). The fourth chapter is an introduction and overview of perinatal mood disorders.

The second section, "Part II: Perspectives on Risk Factors, Screening, and Diagnosis," addresses some of the most prominent theories about the risk factors, causes, and etiology of Perinatal Mood and Anxiety Disorders (PMADs). It also includes a chapter on complementary and alternative treatments for postpartum depression.

The third section is entitled "Part III: Professional Perspectives" (though the entire book is written by professionals of one sort or another, in the field of women's health). Specifically, this section includes views from an obstetrician, a pediatrician, a nurse, and an attorney who specializes in the legal defense of women accused of infanticide.

The final and largest section of the book is "Part IV: Treatment Options for Perinatal Mood Disorders." This section encompasses more than 120 of the 353 pages. It includes chapters on the risk-benefit analysis of using medication, the effectiveness of Dialectical Behavioral Therapy, a study that uses Interpersonal Psychotherapy to treat

antepartum depression, and a case study that uses psychodynamic approaches to treat postpartum depression. The penultimate chapter outlines a program to increase maternal empowerment through health literacy. The final chapter describes the importance of structured social support for the prevention and treatment of PMADs.

Part III and Part IV best represent clinicians' responses to mothers. In these sections, clinicians reflect their understandings of themselves and their sociocultural role. In describing their theories and justifications for treatment, as well as the interventions for which they advocate, clinicians show how they view women and mothers and how they view themselves as clinicians and healers working with mothers who are struggling.

General tone. *Perinatal and Postpartum Mood Disorders* is intended primarily for clinicians to guide their assessments and interventions with mothers. As Brockington (2008) stated in the Foreword:

The purpose is education, targeted at health care professionals of all kinds, and students in all those professions . . . This volume will summarize what is now known and serve as a primer for clinical reference. It will broadcast an optimistic message. Ignorance and pessimism are no longer justified. (p. xxi)

One of the significant challenges in interpreting *Perinatal and Postpartum Mood Disorders* is the variety of authors. Each contributor presents a specific viewpoint, which reflects their profession, perspective, and experience. It is beyond the scope of this study to explore in depth the writings of each author. What I describe is what Benner (1994) referred to as a "family resemblance" or shared ideas and values that the authors expressed, including ways in which they support one another's views and ideas, and ways in which they challenge or contradict one another's views.

The tone of the writers in *Perinatal and Postpartum Mood Disorders* is authoritarian. Overall, the authors do not encourage dialogue or exploration of issues

related to perinatal mental health. The authors convey a sense of urgency and advocate for a form of acculturation, professionalization, and proceduralism in perinatal mental health. This urgency ostensibly arises from an intention to inform clinicians, but also implies an expectation that clinicians conform to certain understandings, treatments, and conceptualizations. In this sense, the hermeneutic notion that in the human sciences description is prescription is supported. By establishing the source of knowledge about PMADs within their descriptions, the authors move all subsequent discussions toward their interpretations and understandings of this experience. Surprisingly, there is no discussion, argument, or explicit expression of differing theoretical views among the authors.

Thematic analysis. While there are noticeable differences in professional view, writing voice, and sources of information among the authors, certain repeated patterns of meaning, knowledge, and beliefs are present. These patterns reflect the way the authors conceptualize the struggles of early mothering, and how they expect clinicians to respond to mothers who are struggling.

Using Benner's (1994) definition of "thematic analysis" as the identification of "meaningful patterns, stances or concerns" (p. 115), I explored the text in *Perinatal and Postpartum Mood Disorders* looking for patterns, shared beliefs, and common views expressed about the experience of perinatal mood and anxiety disorders. These commonalities were identified as themes.

The themes relate to two of the main concerns of this study: how the challenges of early mothering are described within the text and understood by health care professionals;

and the implicit understandings of the clinicians about their responses to these challenges, their practices, and their sociocultural role. The themes are:

- Perinatal mood disorders overlooked and undertreated;
- Suffering reduced to a medicalized disorder;
- Struggles located within the mother;
- The mother as object;
- Perinatal mood and anxiety disorders as universal;
- The clinician as a concerned expert, advocate, and guide;
- The clinician as a scientific detective and diagnostician; and
- The clinician as a rational expert bringing order to the disordered.

I include exemplars within each theme as a way to illuminate the ideas and concerns, as well as the complexity, of each theme. The exemplars' purpose was to show how the authors conveyed a way of being a mother who was struggling, and a clinician concerned with mothers.

Perinatal mood disorders overlooked and undertreated. In the reading and exploration of the *Perinatal and Postpartum Mood Disorders* text, themes arose that reflected the way the authors viewed and described struggles in early mothering. That mothers struggled was never challenged, in fact it was emphasized. All 24 authors (100%) showed indications that they believed perinatal mood disorders had been overlooked and undertreated. These struggles were described as symptoms, and were viewed as residing within the mother either physiologically, psychologically, behaviorally, or due to her social circumstances. There was an emphasis on addressing these struggles in the mother because of the impact her struggles have on those around

her, most notably her baby. Finally, these struggles, and the way they have been named and conceptualized were considered universal—to be found in all cultures regardless of cultural norms and beliefs about disease and disorder. Cultural differences were highlighted only to provide the clinician with a means to intervene effectively, using the same conceptualization and treatment, with a mother who may not share a similar understanding of the world and her place in it.

Mothers suffer tremendously. All three books in this study challenged the common belief that mothering was an immediately blissful, fully satisfying, uncomplicated experience, which the mother adjusts to without disruption. The field of perinatal mental health has arisen in response to the profoundly negative, at times fatal, impact that this particular belief—what all the authors characterized as a false belief—has had on women and those around them (C. T. Beck, 2008a, p. 213; Godderis, 2009; Klempner, 2008; Parnham, 2008, p. 232).

Postpartum Support International (PSI) was founded in 1987 expressly “to increase awareness among public and professional communities about the emotional changes that women experience during pregnancy and postpartum” (PSI, 2010–2014). The editors of *Perinatal and Postpartum Mood Disorders* called the struggles that mothers have “the long-ignored public health crisis of perinatal mood disorders” (Stone & Menken, 2008, p. xxvii). As Klempner (2008) noted:

When Andrea Yates drowned her five children in the bathtub on June 20, 2001, postpartum depression (PPD) etched itself permanently on the national consciousness. Perhaps nothing highlights the need for diagnosis and assessment more vividly than the tragedy of filicide. (p. 87)

All 24 authors (100%) in *Perinatal and Postpartum Mood Disorders* recognized that mothering is difficult and that mothers suffer tremendously as they adjust to

pregnancy, give birth to their children, and become mothers. The ways in which the authors described these struggles and responded to them reflected their beliefs about these struggles including the cause of the struggles and how to manage them. One pair of authors in *Perinatal and Postpartum Mood Disorders* cautioned: “The notion that impending motherhood is guaranteed to be a wonderful experience often prevents women from reporting accurate symptomatology to their caregivers” (Misri & Joe, 2008, p. 70).

In describing the importance of nurses’ responses to and care for mothers, C. T. Beck (2008a) noted:

By dispelling destructive myths of motherhood, nurses can give women permission to express any negative feelings they are having since the birth of their infants Women can experience a series of losses due to childbirth: loss of energy, relationships, roles, lifestyle, and self. (p. 213)

Mothering includes complicated realities. All 24 of the authors (100%) in *Perinatal and Postpartum Mood Disorders* described the complicated realities in which women become pregnant, give birth, and mother their children. Spadola (2008) noted that “Realistically complex portrayals of pregnant women in the media are uncommon, but images of the happy pregnant consumer abound” (p. 176). It was acknowledged that pregnancies are not always planned or expected. “Approximately half of all pregnancies in the United States are unintended. Women may experience feelings of guilt or resentment about this ‘accident’ even if the pregnancy is subsequently desired” (Spadola, 2008, p. 171).

Also mentioned were the challenges when a mother encounters the perinatal health care system. “A low-income woman entering the prenatal center system may feel overwhelmed from the moment she places the first call for an appointment” (Bernstein & Weiss, 2008, p. 322). It was further noted that challenges continue after the mother

gives birth. “The prenatal care model in which women are seen frequently as birth approaches, but not for a month to 6 weeks after delivery, may contribute to a sense of isolation in women experiencing depression and anxiety during the immediate postpartum period” (Spadola, 2008, p. 177).

There are many social cues about what women and men should expect during pregnancy. . . women and men are offloaded with information about what to expect when they are expecting. For those women and men who have had an extended period of time to anticipate pregnancy because of infertility treatment, these expectations can grow to be even greater. The desire and wish for the pregnancy and parenting experience may be built on a significant emotional as well as financial investment. (Braverman, 2008, pp. 156–157)

Suffering reduced to a medicalized disorder. The struggles that mothers presented were described by each of the authors (100%) in *Perinatal and Postpartum Mood Disorders* as symptoms, leading to the identification of diagnoses and disorders originating or contained within the mother and oftentimes requiring professional intervention. A gradation of struggles from less severe (e.g., baby blues/postpartum blues) to very severe (e.g., postpartum psychosis with suicidal ideation) were described.

The “Baby Blues” level of suffering. A certain level of struggle in mothering, that was time limited, was normalized by seven out of the 24 authors (29%). This level of struggle and emotional response was called either the “Baby Blues” (Klempner, 2008, p. 92; Lofrumento, 2008, p. 188) or “postpartum blues” (Birndorf & Sacks, 2008, p. 243; Misri & Joe, 2008, p. 67; Spadola, 2008, p. 172). The baby blues/postpartum blues were described as common, expected, and not to require immediate intervention. Klempner (2008) explained that “anywhere from one-half to three-quarters of all new mothers are bound to have a bad day” (p. 92). The symptoms of the baby/postpartum blues were described as: “feeling labile, anxious . . . mild mood changes, and short-fused or sensitive

reactions to so-called constructive criticism. . . . fatigue, inability to sleep, and lack of appetite” (Klempner, 2008, p. 92).

Misri and Joe (2008) described postpartum blues as:

[A] transient condition with symptoms such as mild mood swings, irritability, anxiety, and insomnia being limited to two weeks postpartum. . . . These symptoms, which typically peak within two days postdelivery, affect approximately 50% of women and will resolve with minimal or no treatment. (p. 67)

Caution regarding the time limits of these symptoms, as well as concern that they indicated more serious problems, was stated:

Reassurance, a little extra sleep, or support with the baby or other children and household chores can reduce these transient feelings. Professionals who educate women on the normalcy of certain feelings can relieve anxiety. However, some symptoms may be severe. When they last more than 2 weeks, it places the woman at risk for a more serious form of postpartum mental distress. (Klempner, 2008, p. 92)

From “Baby Blues” to increasing levels of mood disorder. This same caution was echoed by Misri and Joe (2008). “Persistence beyond two weeks is not typical of postpartum blues, nor is suicidal ideation. Symptoms of the blues require close monitoring in women with a prior history of major depression as these may be early indicators of relapse” (p. 67). Spadola (2008) warned that “1 in 5 women with mild postpartum mood instability will progress to symptoms of postpartum depression” (p. 172).

It is the timing rather than the symptoms themselves that distinguish the occurrences of perinatal depressive disorders Clinically, an onset of depression within the first year of delivery is considered postpartum. The reason for this arbitrary definition is that, frequently, symptoms are triggered by onset of menstruation or the process of weaning. The timeline for these events for every woman is highly individual, but frequently tends to fall within 12 months of childbirth. (Misri & Joe, 2008, p. 70)

Postpartum depression was described as presenting at any time during or after the pregnancy up to one year postpartum and to have similar symptoms as the baby/postpartum blues:

(1) feeling sad, irritable, or angry; (2) insomnia; (3) disinterest in activities of daily living; (4) disinterest in the baby or existing children; (5) feeling guilty, hopeless, helpless, and/or worthless; (6) labile moods with or without bouts of uncontrollable and unexplainable crying; (7) anhedonia or lack of pleasure in baby and/or family; (8) constant fatigue and exhaustion; (9) changes in appetite; (10) lack of concentration, difficulty focusing or thinking clearly; (11) excessive and irrational worry; (12) feelings of being a bad or inadequate mother; and (13) changes in sexual desire or significantly lower libido extending beyond the initial 6-week check-up. (Klempner, 2008, p. 3)

Postpartum psychosis was described as “the most serious form of postpartum mental illness” (Klempner, 2008, p. 93) and as having several of the same symptoms as postpartum depression, except more extreme. “Extreme insomnia or inability to sleep even when given the opportunity, rapid mood swings, confusion, and disorientation” (Klempner, 2008, p. 93).

Five out of 24 authors (21%) noted that the adjustment to a new baby in the house will cause many of the same reactions in mothers, and in men/fathers/partners, that are similar to psychiatric symptoms. Lofrumento (2008) acknowledged that distinguishing between a mother who was overwhelmed, up at night with her baby, fatigued, and exhausted, and one who had a perinatal mood disorder was extremely difficult:

The challenge for the pediatrician is being able to distinguish between the normal new mother, who after weeks of sleeplessness, fatigue, and adjustment to being a parent, appears overwhelmed and exhausted, and the mother who is having true symptoms of PPMD [postpartum mood disorder]. (p. 189)

Stressors understood as risk factors for disorder. Stressors in adjustments to parenting were understood as risk factors for developing a disorder. Twenty of 24 authors (83%) in *Perinatal and Postpartum Mood Disorders* emphasized the risk for

lower-level, expected distress in new mothering to advance to a mood disorder in need of intervention. The delineation of normal versus pathological primarily had to do with the amount of time, postpartum, the mother was struggling. External situations or stressors were mentioned not as understandable reasons that the mother may struggle for longer than two weeks postpartum. Rather, any external stressors were viewed as risk factors that increased a woman's chance of developing a diagnosable mood disorder. In her section entitled "Prevalence and Risk Factors" Klempler (2008) noted that risk factors for a perinatal mood disorder, rather than understandable emotional responses to grief and loss, included:

[M]edical problems in mother or infant; chronic pain; inflammation; lack of sleep; history of sleep, eating, or substance disorders; breast infections or other lactation issues; abrupt weaning and other baby feeding difficulties. . . . [M]arital or family conflict, feeling isolated, role transition or loss of personal freedom, number and ages of other children, child care conflict, the absence of a partner or family support system, moving, and leaving a valued place of employment. . . . [I]nfertility, fetal demise, elective termination, or the loss of a newborn. . . . [A]nd compromised neonates beginning their lives in the neonatal intensive care unit has exploded, subjecting these mothers to intense, and, often, ongoing stress. (pp. 91–92)

Struggles located within the mother. All of the authors (100%) in *Perinatal and Postpartum Mood Disorders* described the struggles in mothering as located within the mother. This included the failures of the mother's maternal instinct, hormonal dysregulation, a history of mental illness or a predisposition to mental illness, an inability to cope with stress, and general female biology. Brockington (2008) described these struggles as "a disturbance of the instinctive bond between mother and child—a perversion of the maternal instinct" (p. 20). He attributed this maternal instinct to all women who become mothers.

The mother's biological abnormalities. The mother's biological and chemical vulnerabilities were implicated in her struggles. Jolley and Spach (2008) in their chapter on stress system dysregulation and perinatal mood disorders described several ways in which a woman's physiological state made her vulnerable to perinatal mood disorders:

Most clinicians who work with women with perinatal mood disorders . . . feel strongly that there is a biological basis for perinatal mood disorders, a premise based on dramatic changes in a woman's mood during pregnancy and postpartum Because of the dramatic hormonal increases (particularly estrogen and progesterone) during pregnancy and rapid postpartum drops affecting HPA axis regulation, pregnant women may be at increased risk for HPA dysregulation resulting in mood disorders. (p. 133)

Because research suggests that women with PPD have diminished capacity to physiologically cope with stress regardless of the source, every effort should be made to help the woman structure her daily routines and cognitions such that they are stress-reducing. On a practical level, this may mean the entire family rallies behind the mother to help her get adequate sleep, exercise, rest, and nutrition, variables known to promote stress reduction. (p. 148)

In describing risk factors for perinatal mood disorders, Kelmpner (2008) pointed to "the complex biochemical and endocrine changes that accompany the antepartum and postpartum stages" which "have a cataclysmic, if not always, catastrophic impact on a woman's mental and physical health; and thus on her capacity to carry, deliver, lactate, and bond with an infant" (p. 91).

It is important to note that the emphasis on the mother's biological and physiological vulnerabilities was advanced by all of the authors (100%) in *Perinatal and Postpartum Mood Disorders* in an attempt to relieve the mother of blame for having a mood disorder, not to increase the guilt she may already feel. Even so, repeated descriptions of risk, such as the following, made the mother the central cause of her distress:

Motherhood provokes major changes in a woman's body, marriage, identity, career, and interpersonal relationships. It is generally accepted that this cascade of biopsychosocial upheaval contributes greatly to PPD. But it cannot be overlooked that PPD is rooted not just in the present cascade of events, but also in a woman's history. (Menken, 2008, p. 313)

Psychosocial risk factors as located in the mother. Even psychosocial risk factors which contribute to a mother's struggles were seen as located within the mother, rather than located within the social and relational realm or outside of her control. Jolley and Spach (2008) introduced their chapter on stress system dysregulation and perinatal mood disorders by noting that previous research on the etiology of perinatal mood disorders focused on psychosocial risk factors, as opposed to physiological risk factors. This included factors such as life stress, marital discord, personal or familial history of depression, or a lack of social support. Different risk factors in the mother's social environment were described by ten of the 24 authors (42%) in *Perinatal and Postpartum Mood Disorders*. These risk factors included poor health literacy (Bernstein & Weiss, 2008), marital problems and social forces (Birndorf & Sacks, 2008), social cues in relation to infertility treatments (Braverman, 2008), a lack of social support and lower socioeconomic status (Klempner, 2008; Misri & Joe, 2008), psychosocial history (Menken, 2008), and loss of independence (Spinelli, 2008). There was an implied understanding that these factors were largely out of the mother's control, but the mother was still primarily responsible to solve them in a way that was socially condoned:

Just as a person with inadequate health literacy may not perceive the need to manage chronic conditions or practice preventive health behaviors, those with inadequate mental health literacy may not understand the nature of a psychological illness, let alone possible treatments. Without mental health literacy, a patient would not know or expect that there is an entire discipline of caring mental health professionals that can help them. (Bernstein & Weiss, 2008, p. 327)

“Pregnancy has been described as a period of emotional crisis (Benedek, 1952). In fact, it is addressed more appropriately as a developmental period in which the mother-to-be transitions from independence to motherhood” (Spinelli, 2008, p. 292).

There are a number of psychosocial risk factors that contribute to perinatal depression, including the lack of a partner, social, or family support. Physical, mental, as well as sexual abuse issues, play a significant role in contributing to the onset of perinatal depression. . . . Unplanned pregnancy is also a vital factor that needs to be considered. This is particularly significant in women who go ahead with the pregnancy despite the lack of partner or social support. . . . Stressful life events, chronic stressors, and socioeconomic status also contribute to the risk of perinatal depression. . . . A previous pregnancy loss, miscarriage, stillbirth, or abortion is another risk factor for a major depression in the postpartum (Misri & Joe, 2008, pp. 68–69).

Birndorf and Sacks (2008) acknowledged the role of social forces and beliefs in contributing to the struggles that mothers experience, and the lack of effective response by others to struggling mothers. “Social forces may be at play, including the prevailing myth that pregnancy is protective against psychiatric illness, and is somehow a naturally ‘happy’ time in life” (pp. 238–239). However, a majority of their discussion of risk factors focused on the individual mother:

While no woman is immune from psychiatric symptoms in the setting of pregnancy, certain risk factors have been identified to help predict problems in pregnancy, and thus may help target screening . . . One group of these risk factors is those intrinsic to a woman’s biology and psychology, including genetics, personal and family history of mental illness, and character traits. Other risk factors more indirectly affect a woman’s environment in the setting of pregnancy, including behaviors such as unhealthy patterns of sleep, exercise, nutrition, and relaxation. Additionally, poor psychosocial supports, marital or family discord, low socioeconomic status, or recent stressful life events have also been identified. Feelings about the pregnancy itself, such as an unplanned or unwanted pregnancy, may also serve as a source of stress, thereby contributing to risk. (p. 239)

Two of the 24 authors (8%) in *Perinatal and Postpartum Mood Disorders* recognized the social forces which present impossible standards to which mothers are subjected, and tried to lessen these demands. However, even when pointing out the

unachievable standard, they would often reinforce other impossible standards. Menken (2008), in her chapter on psychodynamic therapy for postpartum depression, presented an example of that contradiction when she wrote:

A major goal of psychodynamic psychotherapy is to help each mother discover her own authentic voice, and to become the “good enough” mother that she can be. In her book, *No Greater Love*, Mother Teresa (1989) captured the importance of accepting one’s own capacity to love with the following words, “Do not think that love, in order to be genuine, has to be extraordinary. What we need is to love without getting tired.” (p. 319)

Menken was making a case for the mother to feel good enough about her mothering, but in the process she described two superhuman extremes of mothering—the example of Mother Teresa, and inexhaustible love. Even Kelpner’s (2008) normalizing of the baby blues “Anywhere from one-half to three-quarters of all new mothers are bound to have a bad day” (p. 92) implied that one-quarter of new mothers never have a bad day—an impossible standard for any human whether currently parenting or not.

By contrast, one of the authors (4%) in *Perinatal and Postpartum Mood Disorders* presented one exception to the belief that the cause of the mood disorder would always reside within the woman and was primarily a result of her personal history, biology, or coping and not due to circumstances outside of her control. C. T. Beck (2008a), writing from the perspective of a labor and delivery nurse, called on nurses to obtain careful histories of mothers’ experiences when they are admitted to labor and delivery and then to use this information to provide a safe environment for the mother.

During admission to labor and delivery, it is important for nurses to take a careful history regarding any specific fears women may have about giving birth, such as fear of an epidural. Once identified, nurses can take special care regarding these fears. (p. 214)

C. T. Beck (2008a) also noted that traumatic birth experiences may cause symptoms of posttraumatic stress disorder in the mother. She further recognized the role that those outside of the mother have in preventing this and tasked nurses with noticing mothers at risk for trauma and intervening on their behalf.

The best intervention to prevent PTSD secondary to childbirth is to prevent birth trauma in the first place. Nurses' knowledge of risk factors for PTSD due to traumatic births is important so that they can be alert to these high-risk women. (p. 214)

The mother as object. Part I of *Perinatal and Postpartum Mood Disorders* was entitled "The Importance of Maternal Mental Health." Three of its four chapters (75%) focused on the effects of maternal mental health on others. This included chapters on the effects of maternal perinatal stress, anxiety, and depression on the neurodevelopment of the child (Glover, Bergman, & O'Connor, 2008, pp. 3–16), mother and child attachment and bonding disorders (Brockington, 2008, pp. 17–40), and the effects of postpartum depression on the other siblings in the family as well as the infant (Chase-Brand, 2008, pp. 41–64). Chase-Brand (2008) called the family members of women with PPD "collateral victims of maternal depression" (p. 60).

These chapters, as well as individual remarks by authors throughout the text, were meant to emphasize the importance of perinatal mental health, and to justify the attention towards mothers' struggles and resources for treatment and the necessity of responding to these struggles. However, the emphasis on others in the mother's world reflected the belief that the mother's suffering was considered significant primarily because of the impact it had on others. The essential importance of a mother feeling well was so that she could function more effectively for others in the family. Birndorf and Sacks (2008) called perinatal mood and anxiety disorders a "familial disease." "When a mother has a

chronic mental illness, she is not the only one who suffers; the partner, infant, other children, and entire family are affected by this familial disease” (Birndorf & Sacks, 2008, p. 243). In the foreword, Brockington (2008) argued:

In most families, the mother is the main source of comfort, care, and counsel: all members benefit from her devotion, enthusiasm, and resourcefulness, and all—especially the children—suffer from her discouragement. Every effort we make to improve mothers’ well-being and morale is a contribution to family life, and the health of the next generation. (p. xix)

In their Introduction to *Perinatal and Postpartum Mood Disorders*, the editors wrote:

The enormous impact of compromised maternal mental health on child development, social stability, and family health has offered indisputable evidence These authors present compelling evidence for the importance of assessing and treating maternal anxiety and stress during pregnancy to prevent neurodevelopmental sequelae in the fetus. (Stone & Menken, 2008, p. xxviii)

A more exclusive focus on the mother arose in the fourth chapter in Part I. In this chapter, Misri and Joe (2008) provided an introduction to perinatal mood disorders, including prevalence rates, risk factors, diagnosis and screening. The final section of this chapter was entitled “Consequences” (pp. 75–78). In this section, Misri and Joe reviewed research concerning outcomes of untreated maternal depression and anxiety on the mother and on the fetus or child. They cited studies that indicated that a mother’s emotional state during pregnancy had effects on the fetus and later on into that child’s early years. Though they acknowledged that “the exact mechanisms of maternal stress on fetal development remains unclear,” Misri and Joe asserted that “these studies demonstrate the far reaching effects of prenatal exposure to mood and anxiety disorders on toddlers and preschoolers” (pp. 76–77). This assertion conveyed a sense of the mother’s mood as a toxin to which the fetus can be exposed. They concluded this section with the acknowledgement that many of these studies did not control for circumstances

outside of the mother, such as substance abuse or mental illness in the mother's partner. The sources of maternal suffering were presented as residing within the mother—her moods, her failure to obtain treatment—with long-term effects on her child.

Perinatal mood and anxiety disorders as universal. Four out of 24 authors (17%) in *Perinatal and Postpartum Mood Disorders* described studies on perinatal mental health that included mothers from non-culturally dominant ethnic and non-middle class groups (C. T. Beck, 2008a; Bernstein & Weiss, 2008; Honikman, 2008; Spinelli, 2008). However, the ways in which multiple socioeconomic factors influenced a particular individual mother and her mothering were absent from the descriptions of these mothers' experiences.

Spinelli (2008) described the subjects in her study as:

[F]ifty pregnant depressed women . . . of a predominantly fragile group of recent immigrants from the Dominican Republic. Homes were often transient and chaotic, with unpredictable and unstable support systems. For some, circumstances were even more tragic. Partners were involved in drug sales and street crime, and many were incarcerated. (p. 302)

In her chapter, Spinelli did not reflect on how these circumstances might influence how these mothers viewed their situation, including their pregnancies or new motherhood. Nor did she consider the larger social, historical, cultural, or political dynamics that might have led these women to be in the United States as immigrants. Instead, the circumstances were seen only as an impediment to treatment. "Many women were lost to treatment and follow-up because of disconnected telephone numbers. . . . Our attrition rate suggests the need for more diligence in follow-up with mothers in less permanent populations" (p. 302).

Honikman (2008) in her chapter on the role of social support cited research about, but failed to consider other explanations for, African-American women's reports of postpartum depression.

Using data obtained from 26,877 women with newborns in the state of Iowa, race/ethnicity was found to be a risk factor for depressed mood in late pregnancy and the early postpartum period. Lower levels of social support emerged as a possible explanation for why African Americans reported more depression. (p. 343)

C. T. Beck (2008a) acknowledged that providers must become educated about the experiences that mothers in other cultures have. However, she recommended this because she considered PMADs to be a universal medical disorder.

Postpartum depression is no longer considered confined to Western/industrialized countries. It is a universal phenomenon In order to provide culturally competitive [sic] care, nurses need to become aware of the different ways women from specific cultures experience postpartum depression and what type of symptoms they may present with. (p. 212)

C. T. Beck (2008a) allotted one paragraph each, in her chapter, to Korean mothers and to Muslim mothers that included the following:

In Confucian society, a sign of wellbred upbringing and a high level of education is a person's ability to repress their emotions. Expressing one's emotions in somatic symptoms is a more acceptable way of expressing distressing feelings. Korean mothers will often share symptoms, such as headaches, chills, numbness, and dizziness, with their nurses when they are trying to express their emotional problems.

Muslim women experiencing postpartum depression have a different problem to contend with. According to Islamic medicine, illness occurs when an individual has moved away from the will of Allah Because of this cultural belief, Muslim mothers suffering from postpartum depression may be hesitant to admit they have a mental health problem. Nurses need to be respectful that Muslim women may wish to include prayer and meditation to help them connect with Allah. (p. 212)

The view of PMADs as universal discounted the complexity of women and mothers who are constituted by and must enact their mothering practices within the

cultural and political environments in which they live. This would apply to mothers in all cultures, not only in those cultures that are seen as other, or non-dominant.

In addition, the idea of PMADs as universal denies the heterogeneity of the mothering experience. Lofrumento (2008), writing from the perspective of a pediatrician, recommended a simple, universal screening method that could be used on all mothers to recognize a disorder that is subtle, diverse, and arising during a time of change and transition:

Pediatricians, who provide the care for newborn infants, encounter mothers in the postpartum period more frequently than any other health care provider These factors give pediatricians a unique opportunity to recognize postpartum mood disorders and provide both information and referrals when needed. However, this cannot occur unless pediatricians educate themselves and their office staff to recognize the often subtle presentation of this disorder, establish a universal screening method for all new mothers, and create an action plan for follow-up that is easily implemented. (pp. 183–184)

Klempner (2008) provided a list of either/or characteristics that also flattened the complexity and diversity of the mother's development:

Clinically, I find it useful to ask for a baseline self-description of how each woman formerly perceived herself as compared to “who she's become” at this point in time. Ascertaining whether she views her core self as resilient or rigid, optimistic or pessimistic, introverted or extraverted, passive or active are all key indicators as to how she may problem-solve and resolve this current difficulty. (p. 97)

Overall, in the *Perinatal and Postpartum Mood Disorders* chapters, no consideration was given to the cultural or socio-political environment in which the mother mothers. In addition, mothering responses and behaviors which may make sense within a particular context were not considered or explored.

The clinician as a concerned expert, advocate, and guide. *Perinatal and Postpartum Mood Disorders* was written by clinicians and professionals who work with

new mothers, in order to offer information and guidance to other clinicians and professionals. Therefore, the beliefs and views expressed in it can be interpreted to reflect the ways in which clinicians understand themselves, their practices, and their roles. In *Perinatal and Postpartum Mood Disorders*, clinicians were viewed as concerned experts and advocates for struggling mothers, who have been ignored by a medical and mental health system that was described as difficult to navigate and often unresponsive to mothers' distress. Clinicians were expected to recognize or detect signs and symptoms of perinatal mood and anxiety disorders in a mother, and to respond quickly and competently, lest they fail the mother in her time of need. Clinicians' responses were expected to be informed and effective, and to include medical or psychological interventions. The purpose of the intervention was to bring order to a disordered presentation in the mother.

All of the authors (100%) in *Perinatal and Postpartum Mood Disorders* demanded that clinicians be concerned with mothers who were struggling, that they validate the mother's distress, and that they educate the mother about her symptoms. Most importantly, these authors felt that clinicians should intervene quickly and effectively. This included recommendations that health care professionals listen to and seriously consider the concerns mothers have, and respond in a respectful, yet directive, way. The clinician's response was seen as a form of caring for the mother and expressing concern for her wellbeing.

C. T. Beck (2008a), writing from the perspective of a nurse, described the seven behaviors that women who were struggling with a mood disorder identified as caring in the nurses they encountered:

1. Having sufficient knowledge about postpartum depression to make a quick, correct diagnosis is viewed as an essential aspect of caring.
2. Using astute observation and intuition leads to an awareness that something might be wrong with the mother.
3. Nurses provide hope that the mothers' living nightmares will end.
4. A nurse's readily sharing valuable time was perceived as caring.
5. Caring involved the nurse making an extra effort to provide continuity of care for the mother.
6. Understanding what the mother was experiencing provided much needed comfort. (p. 205)

C. T. Beck's list is a good example of the hermeneutic idea that in the social sciences description is also prescription, and vice versa. In this case recommendations of good clinical work also served as expectations, and expectations of good clinical work can be interpreted as an aspect of the definition of a good clinician (P. Cushman, personal communication, May 29, 2014).

Clinicians were seen by all of the authors (100%) in *Perinatal and Postpartum Mood Disorders* as advocates for mothers. This included not only advocating for the recognition of PMADs as a "public health crisis" (Stone & Menken, 2008, p. xxvii) and the necessity of providing treatment, but also advocacy in navigating the structural barriers and challenges to receiving treatment.

Women face multiple barriers to obtaining treatment for mood disorders, including inadequate insurance coverage or financial support, lack of providers, and difficulty securing childcare or social support needed to comply with visits. (Spadola, 2008, p. 176)

The prenatal care model in which women are seen frequently as birth approaches, but not for a month to 6 weeks after delivery, may contribute to a sense of isolation in women experiencing depression and anxiety during the immediate postpartum period. (Spadola, 2008, p. 177)

Women are hesitant to accept the diagnosis of psychiatric illness in the perinatal period due to fright, trepidation, denial, and humiliation that goes along with mental illness. This leads to delays in the recognition and treatment of the illness, thereby endangering the mother and the developing baby. . . . Minimizing the associated morbidity and mortality is vital in ensuring stability and providing a secure environment. The barriers faced by women and caregivers are numerous: to help overcome this obstacle, clinicians must engage in a consensual practice of involving the woman and a significant other in the management of this multifaceted illness and make every attempt to facilitate timely intervention. (Misri & Joe, 2008, pp. 65–66)

The help-seeking barriers for women suffering with postpartum depression have important implications for nurses working with new mothers. . . . How can nurses facilitate help-seeking behaviors of mothers experiencing postpartum depression? Nurses are in the forefront of care and can either promote or hinder women seeking treatment. (C. T. Beck, 2008a, p. 212)

It was noted that time limits compromised the practitioners' interactions with the new mother who might not feel safe in disclosing her struggles.

Having a comfortable relationship with a nurse in a physician's office, hospital social worker, or group support facilitator enables a woman to ideally unlock the fear, shame, or guilt she may feel of becoming a bad or even crazy mother. Giving her time to unravel her story and reveal her thoughts or feelings is not always easy given the time constraints of most busy physicians, hospital staff, or private practice clinicians. However, offering a woman safety and space to share concerns enables detection and avenues of treatment that are vital to short-circuit a harmful and/or protracted depressive episode. (Klempner, 2008, p. 96)

Although pediatricians have a unique opportunity to identify mothers suffering from or at-risk for PPMD, several obstacles exist in the pediatric practice. . . . [T]he first obstacle for pediatricians to overcome is education in all aspects of postpartum mood disorders, including signs and symptoms as well as the risk factors in a mother's history. The second obstacle is a shortage of time for visits. . . . Doctors who are in a hurry may not truly listen to the mother's needs, or they may feel too swamped to deal with mental health issues. Some pediatricians, already pressured for time, may be afraid to "open up a can of worms." There is not a great deal of room and flexibility in most doctors' schedules to allow an involved emotional discussion with a mother who may open up about her feelings, even for crisis management. (Lofrumento, 2008, pp. 192–193)

However, even with these structural barriers and limitations, medical and mental health providers were described in these chapters as being highly influential in a

woman's wellbeing during pregnancy and in the postpartum period. Part of the role of the clinician was to recognize their influence and authority, and to use this to facilitate mothers' responses to and acceptance of care and treatment:

Every pregnant woman should maximize her environment for good mental health and overall wellness. Professional counsel is important because patients are often more motivated to take care of themselves and fetus after hearing advice from practitioners. (Birndorf & Sacks, 2008, p. 247)

Essentially, your goal here is to help the patient articulate her personal values. Even though she has already asked you to make the decision for her [regarding medication use] it is your job to help her make this decision for herself. (Birndorf & Sacks, 2008, p. 255)

Well-intended family members and sometimes even the obstetrician and/or pediatrician will tell a new mother that she just needs to get some rest. It is useful for a therapist to show the patient that he or she understands that she is not simply struggling with sleep deprivation. The therapist can explain to the patient that what she is experiencing is treatable and she will get better. The therapist should ask the patient if she could put her trust in the therapist's knowledge that she will improve, even if she herself doesn't feel that way. (Menken, 2008, p. 314)

Parnham (2008) writing from the perspective of a defense attorney who represents women who have harmed or killed their children, encouraged clinicians to be aware of and responsive to signs and symptoms of disease:

It is imperative that clinicians who treat a new mother and her baby (be they ob-gyns, maternity ward nurses, or pediatricians) be aware of the reality of postpartum illnesses and the legal consequences of such should any act put the mother in the spotlight of the criminal justice system. To meticulously document the acts and interactions between mothers and children and to gently probe the mental wellness of the mother will be of enormous benefit in the unfortunate future should something dreadful occur. (p. 220)

The clinician as a scientific detective and diagnostician. How the clinician recognizes when a mother is suffering was an issue of concern throughout *Perinatal and Postpartum Mood Disorders*. Specifically, the importance of clinicians recognizing disease and disorder, when mothers try so hard not to show it, was emphasized.

If a woman sometimes hides behind a veil of shame believing she *should* be thrilled with her baby and be happy despite feeling otherwise, our mission as professionals is to detect and treat this disorder as thoroughly and efficiently as possible. (Klempner, 2008, p. 89)

The dynamic that the obstetrician has with a patient has the potential to be more intimate and profound than other doctor-patient relationships. Obstetricians are in a unique position to recognize pregnant and postpartum patients suffering from mood disorders and should be prepared with referral strategies to mental health professionals. (Spadola, 2008, p. 179)

“How are *you* feeling?” This simple question to the mother is vital at the first postnatal visit. Usually at 2 to 4 weeks after the birth of a baby, mothers are tired and even a bit overwhelmed by their new responsibilities. Most mothers will welcome the empathetic concern about how they are doing at a time when all the focus is on the new baby. They may also, however, be afraid to open up completely, even if they have a preexisting relationship with their pediatrician More important even than asking the question is listening carefully to the answer and observing the mother’s face. If the answer is a quick “I’m doing fine” but the facial expression says otherwise, ask more detailed questions such as “How are you sleeping?” “Who is helping you with the baby?” “Are you worried about anything in particular about the baby?” Listening to the mother, observing her affect and her interaction with the baby are opportunities for identifying mothers who may be struggling with very uncomfortable feelings. Asking the questions can be the easy part. The challenge for pediatricians is to be prepared if these questions of concern bring an emotional answer. (Lofrumento, 2008, p. 189)

One solution to the mother’s lack of disclosure was for clinical practitioners to use universal screening of all new mothers. Nine out of the 24 authors (38%) supported using formal screening measures (e.g., Edinburgh Postnatal Depression Scale, Beck Depression Inventory, Antenatal Psychosocial Health Assessment, Postpartum Depression Checklist). Screening was often presented as a way to meet mothers’ needs within an environment where healthcare professionals are limited in time for, and attention to, mothers who are suffering. Why the mothers may not be forthcoming with their struggles was only minimally addressed by five of the 24 authors (21%). These authors identified guilt, shame, fear, denial, and lack of knowledge of perinatal mood disorders as the reasons women did not disclose.

Regardless of their symptoms, it is not uncommon for mothers to try to hide their depression, anxiety, or intrusive thoughts of harming the baby or themselves for fear of having the baby taken away. Because mothers with PPMD [postpartum mood disorder] may minimize or hide their symptoms, pediatricians need to look carefully for clues. (Lofrumento, 2008, p. 186)

Multiple studies have now shown the value of maternal screening. In one study, 50% of women with clinically significant symptoms of depression remained undetected by clinicians. . . . [T]o screen mothers of newborns has been shown to significantly improve the identification of mothers with PPMD. (Lofrumento, 2008, p. 191)

Logistically, time and staff are in short supply in many hospitals and clinical settings. This is regrettable because nothing can replace the importance of the face-to-face interview using relevant psychometric antenatal and postnatal mental status screening tools. Ideally, these tools, released with informed consent, would move across disciplines and medical settings along with the postnatal mother's treatment, increasing the probability of rapid diagnosis and quick intervention. . . . The problem with the standard, postdelivery 6-week check-up in the gynecologist's office is that PPD may not have fully emerged. In addition, a woman in denial or feeling shame or guilt may not take advantage of the check-up to share her thoughts or feelings. (Klempner, 2008, p. 102)

The clinician as a rational expert bringing order to the disordered. Once the mother's distress is recognized, either by asking or by using screening instruments, the clinician was to respond with alacrity and competence. The clinician's effective response was viewed as necessary to lessen the suffering of the mother, but it was also noted that it was essential to protect the baby and other children in the mother's care. Most importantly, clinicians were to take the mother's distress seriously, or risk failing in their professional duties.

When mothers finally get the courage to open up and admit to clinicians how they have been feeling since delivery, often women feel like they are patronized and their symptoms are minimized. Women are often told to just hang in there because what they are experiencing is the maternity blues and will go away on its own. These health professionals fail mothers in their initial call for help. (C. T. Beck, 2008a, p. 210)

The importance of recognizing, assessing, and treating perinatal mood disorders cannot be too strongly emphasized. This volume will summarize what is now

known and serve as a primer for clinical reference. It will broadcast an optimistic message. Ignorance and pessimism are no longer justified. We are in a much stronger position to understand what is wrong with these troubled mothers and to intervene effectively. A great deal can now be done to restore mothers to full mental health. (Brockington, 2008, p. xxi)

Though the importance of listening to and understanding the mother's feelings and opinions about the form of treatment and care that she received was mentioned, the clinician was considered the holder of scientific (seen as accurate and reliable) information, and therefore the one most capable of making a rational decision about care.

After taking a thorough history, it is important to ask the patient herself about her feelings regarding medication. . . . Clarifying what is scientifically known and unknown may help reduce the risk of bias impacting the patient's initial impressions. Oftentimes, patients need to express fears or concerns they have about how others (friends, family, partners) would judge them as an inadequate mother if they were to decide to stay on medications through pregnancy. (Birndorf & Sacks, 2008, pp. 245–246)

Experiencing a bout of the blues, my patient, Arlene said, "Having this baby was a mistake. If I can't think straight anymore, how can I raise a child?" I quipped that Dr. Zachary Stowe (personal communication) often comments that, "part of the new mom's brain was delivered with their placenta." She chuckled and stated, "Wow, that's good to know." A few days later, after much needed rest, her sunny personality emerged. (Klempner, 2008, p. 88)

Troubled mothers in need of scientific cures. Thirteen of the 24 authors (54%) in *Perinatal and Postpartum Mood Disorders* mentioned the importance of the mother sharing her experience, and the clinician listening to her concerns and supporting her in her treatment decisions. However, none of the 24 authors (0%) questioned the importance of the mother receiving treatment or the authority of the clinician. Due to the ways in which women, in particular pregnant women, have been excluded from research studies, these same authors acknowledged that the empirical support for treatment protocols was minimal.

The *Physicians' Desk Reference (PDR)*, a compilation of FDA-approved drugs, is currently one of the primary resources [for determining medication protocols for perinatal mood disorders]. However, this database is highly imperfect for our purposes because . . . women, and specifically pregnant women, have not been included in the majority of clinical control trials. . . . Studies are further complicated by the fact that pregnant women have distinct physiology. Therefore, general knowledge about psychiatric drugs cannot necessarily be applied to pregnant women. . . . No psychiatric drug has yet been approved by the FDA as being safe for use during pregnancy or lactation. (Birndorf & Sacks, 2008, pp. 248–249)

Since specific guidelines for effective, safe treatment of antepartum depression do not exist, interpersonal psychotherapy should be a first-line treatment in the hierarchy of treatment guidelines for depressed pregnant women. (Spinelli, 2008, p. 304)

Though the lack of research data on pharmacological treatment for women, and in particular pregnant women, was mentioned, psychotropic medications were still advocated for by five of the 24 authors (21%) as a necessary treatment for mothers who were struggling (Birndorf & Sacks, 2008; Misri & Joe, 2008; Spadola, 2008). Clinicians were expected to obtain information and make decisions about treatment based not only on the US Food and Drug Administration's (FDA) labeling, but also from research findings for particular drugs and from consultation with more experienced clinicians. Further they were to use their knowledge to assess levels of risk and advise treatment that created the least harm to the mother and to the fetus or baby.

We recommend that health practitioners view the FDA pregnancy categories as both helpful but maybe misleading, and thus should not solely guide treatment. Practitioners should not rely only on the letter category of risk, but additionally should consider the research findings for each drug. (Birndorf & Sacks, 2008, pp. 248–249)

In light of current scientific knowledge that untreated mental illness itself can be harmful to a fetus, a new question must now be posed [to clinicians]: How to manage psychiatric disease by causing the *least* harm to the mother and fetus alike? Current clinical knowledge puts mental health practitioners between a rock and a hard place. (Birndorf & Sacks, 2008, p. 238)

Kendall-Tackett (2008), in her chapter on complementary and alternative treatments for postpartum depression, identified reasons why women may pursue alternative treatments instead of more conventional treatments and interventions. “One reason patients prefer alternative medicine is that they can control their own health care. Instead of having to wait for a doctor’s appointment, they can address their depression right away” (p. 108). Kendall-Tackett’s reason for providing this information could be interpreted to be so that the clinician might be more informed of the mother’s private, independent actions: “If you understand why women might prefer to use these modalities, you can talk more comfortably with them. And they are more likely to be forthcoming about using them” (p. 108).

Overall, all of the authors (100%) in *Perinatal and Postpartum Mood Disorders* conveyed the belief that the suffering and challenges that mothers experience, once beyond the two week window of postpartum blues, were disordered. The goal of intervention and treatment was thought to bring order. Mothers were considered “troubled” and in need of expert, professional help that will “restore” them to health (Brockington, 2008, p. xxi). It was assumed that with the proper treatment the mothers would get better, that their symptoms would improve or be alleviated. Additionally, it was assumed that this improvement would result from professional, clinical interventions based upon the latest research—not from changes in circumstances or the mother’s own development and understanding of herself and her role.

By helping women target the full spectrum of presenting conditions in the perinatal period and encouraging their early engagement in treatments powerfully responsive to all identified conditions, clinicians could increase positive outcomes, maternal empowerment, and optimal health for society’s most critical dyad. (Stone, 2008, pp. 283–284)

The text as the clinician's interpretation of the mother's experience. Perinatal and Postpartum Mood Disorders was written by clinicians and represented the clinician's role in caring for mothers who are struggling. The text was not a direct or immediate account of the mother's potentially more complex experience. It only presented the clinician's view of the mother's learning of mothering practices and transitioning to a new role and new way of understanding herself in the world. As such, it was an interpretation by clinicians of the mother's experience. As an interpretation, it was subject to the historical and social understandings and prejudices of its authors. Therefore the interpretations will always be incomplete and open to dialogue and revision. The interpretations will also reflect the moral beliefs of good and right of the historical era in which the authors live (Sugarman & Martin, 2005, p. 261).

This does not mean that the information in *Perinatal and Postpartum Mood Disorders* is therefore without value. Those aspects of the text that resonate with our understandings and offer new knowledge that makes sense can bring new perspectives to the experience of maternal struggles and clinicians' responses to mothers. The danger is that it will also reinforce moral values of good and right, which could be oppressive to women and mothers by dictating moral values that tell the woman if who she is and what she is doing is right or wrong.

Considering the consequences for the entire family, it is imperative to understand risk factors and improve diagnosis and assessment of those at risk for postpartum mood disorders. Rapid response enabling prevention and treatment benefits families in the short run and society in the long run. As so many new mothers say when they feel better: "I have me back again"—that is the goal of diagnosis and screening. (Klempner, 2008, p. 103)

In contrast to the belief of the clinician as the expert, one of the 24 authors (4%) described the significance of mothers receiving support from their peers. Honikman

(2008), in the final chapter of the book on the role of social support, noted the importance of non-clinical, peer support and information that provided significant help to mothers who were struggling. Honikman quoted Richard Marshall, MD, an early researcher of the experience of parents with a newborn in a neonatal intensive care unit (NICU). She presented his observation that “a certain kind of concern and mutual support is available only from those peers in whom issues of authority and power are not important considerations” (p. 344). She further identified important characteristics of self-help groups, as opposed to professional or clinical intervention:

First, they represent a dynamic process of mutual help in which knowledge is pooled, experiences are shared, hopes are reinforced, and efforts are joined. Second, they are composed of peers sharing a common problem or stressful life situation, providing the message that the participant is not alone. Third, groups are voluntary, charging no or minimal fee for help. Last, the locus of control is the group, rather than professionals. (p. 344)

In advocating for peer support, Honikman acknowledged the different experience that one receives from one’s peers—those who directly share a similar experience and who have knowledge as well as understanding.

Summary. The contributors to *Perinatal and Postpartum Mood Disorders* described their views of mothers who struggle, and the implicit understandings of the clinician about those struggles. These difficulties were described in medical, diagnostic terms as perinatal mood and anxiety disorders—a mental health disorder—the etiology of which lay in the mother’s physiology, stressors, or coping abilities. In addition, perinatal mood and anxiety disorders were considered to be a universal phenomenon.

It was stressed that these disorders deserved acknowledgement and competent, immediate response from clinicians. The mother’s suffering was recognized as significant and care for her was justified, in large part, because of the impact her disorder

might have on those around her, for example her children and family. The contributors emphasized the importance of the healthcare provider's role as an advocate and guide for the mother, as well as a detective and diagnostician. Finally, emphasis was placed on the healthcare practitioner as a rational, scientific expert who must intervene quickly and effectively in order to not "fail" the mother (C. T. Beck, 2008a, p. 210). In particular, the concern that severe disorders might manifest in maternal suicide or infanticide compelled clinicians to recognize and treat the mother's symptoms immediately and thoroughly.

The presentation of the clinician as expert diagnostician and treatment provider overshadowed any sort of complex presentation of the mother's role, her view, or her voice. Though vignettes were offered, it was always from the clinician's point of view. This was a text about the clinician's role, more so than about the mother's experience. The clinicians' role was to use their scientific knowledge and diagnostic skills to cure the mother of her disordered behavior and thinking so that she may be an effective mother. As such, it presented a one-sided therapeutic relationship, where the clinician is the expert who intervenes and the mother is the passive, sometimes desperate, recipient of care. That these clinicians care, and believed that others should care about mothers who are suffering, was obvious. But it was taken for granted that the clinician would be the identified expert in this experience—the holder of answers and information—much more so than the mother. It was also taken for granted that distress and struggle, beyond a specific time period of about two to three weeks, was considered disordered in the mother, regardless of her particular situation.

The final chapter of the book described the role of social support in the prevention and treatment of perinatal mood disorders. It also included an overall description that conveyed the way women with perinatal mood disorders were viewed throughout *Perinatal and Postpartum Mood Disorders*. In particular, it made the clinician and the perinatal support movement the holder of knowledge and cure, and the mother the one who must be cared for and informed.

The premise of the phrase (*sic*) *mothering the mother* is the keystone of the message conveyed to perinatal families through a method of conversational, nonjudgmental emotional support. This approach believes that: (1) every mother needs a mother; (2) if a mother is not well, then her family is not well; and (3) mothers deserve care and are worthy of being the focus of society's attention. As previously stated, there is a universal message expressed throughout the perinatal social support movement. It has three simple components: (1) you are not alone; (2) you are not to blame; and (3) you will be well, your experience is real, and there is help available. (Honikman, 2008, p. 348)

Though all of the contributors (100%) in *Perinatal and Postpartum Mood Disorders* wrote in an authoritative tone, they also expressed the many confusions, complications, and inconsistencies that were present when working with another human during a time of transition for the patient, or mother. I suspect they reflected the dynamic that may occur when a professional, tasked with treating and curing an experience that is not well-understood, encounters a person in a transition when she is growing and adapting to a new role and a world-changing experience. These authors displayed how the seemingly ordered world of medical treatment presents with authority about a complex and necessarily disordered human experience of life change, new roles, loss, and growth.

Beyond the Blues: Understanding and Treating Prenatal and Postpartum Depression and Anxiety (2010)

Description. Bennett and Indman's *Beyond the Blues: Understanding and Treating Prenatal and Postpartum Depression and Anxiety* is a concise and relatively short book about perinatal mood disorders. The 157-page book, published in 2010 and updated in 2011 by Moodswings Press, includes 18 pages of resources, an index, an appendix of medical terms and healthcare professionals, and a matrix of treatment protocols. Written for women, their partners and families, and the healthcare practitioners who work with them, it is a recommended resource for the United States Department of Health and Human Services, U.S. Navy, Durham Regional Health Department of Canada, New York State Department of Health, and the International Childbirth Education Association.

The eight chapters cover topics such as the symptoms and presentations of perinatal psychiatric illness, the types of support helpful for a mother suffering from these conditions, and the supports expected from partners, families, and healthcare professionals. The foreword, written by the current president of the Marcé Society, Katherine L. Wisner, MD, MS, noted that the book “fills the void between sufferers of postpartum disorders (women, men, and families) and healthcare professionals” (Wisner, 2010, p. 15).

The need for a book like *Beyond the Blues* is reinforced in the Preface and Introduction. In the Preface, it is claimed that almost one-quarter (23%) of women suffer from a mood disorder during or immediately after pregnancy. Therefore there is a strong need for healthcare professionals to be adequately trained to recognize, diagnose, and treat these disorders (Bennett & Indman, 2010, p. 16). The goal of *Beyond the Blues*, as

stated in the Preface, is “to summarize the most current research and information into a practical, easy-to-use format . . . to provide the most essential and up-to-date diagnostic and treatment information as concisely as possible” (p. 16). This goal is accomplished by the brevity of the text, as well as by its structure, which is marked by short sections, bullet point lists, and repeated directives.

In the introduction, Barbara Dehn, RN, MS, NP a practicing nurse, noted that with information and “a range of effective solutions,” the difficulties of postpartum depression could be alleviated. “*Beyond the Blues, Understanding and Treating Prenatal and Postpartum Depression & Anxiety* is a resource that has helped countless health care providers, women, and their families to recognize the signs of postpartum depression and help those who are struggling” (Dehn, 2010, p. 17). She then explained how important the book was in her everyday work:

This book has assisted me in helping new parents when they’re struggling. This is clearly the best postpartum guide I’ve ever used in my practice. I’m so convinced of its value, I keep copies in my office to give away to those in need. (Dehn, 2010, p. 18)

Dehn’s report that she gives away copies of this book, the list of institutions for which it is a recommended resource, and the chapters dedicated to those persons in direct contact with mothers point to how influential are the ideas and beliefs contained within *Beyond the Blues*.

The co-authors of the book, Shoshana Bennett, PhD and Pec Indman, EdD, have been involved in the field of perinatal mental health for more than 20 years. In the section “About the Authors” (p. xi) it is noted that Bennett is a licensed clinical psychologist with a PhD, two master’s degrees, and three teaching credentials. She founded Postpartum Assistance for Mothers in 1987, which later evolved into Postpartum

Support International. Also noted is that Indman is a licensed marriage and family therapist with a doctorate in counseling, a master's degree in health psychology, and a previous career as a physician assistant in family practice at Johns Hopkins University.

Both authors are well credentialed and speak nationally and internationally on issues of perinatal mental health. Even so, in the text they explicitly stated that their work is inspired by their personal experiences of postpartum depression (Bennett) and working with and advocating for women and their healthcare needs (Indman). They stated that they are “devoted” (Bennett, p. 25) and passionate (Indman, p. 27) about this work. I have met and spoken with Pec Indman twice in recent years. Both times she struck me as warm, caring, informed, and deeply committed to helping mothers get the support and resources they need.

General tone. In keeping with Bennett and Indman's (2010) intention to summarize and be concise, the book reads like a 157-page health and wellness pamphlet that one might discover in their physician's office. The clear and useful information is presented primarily in bullet-point lists, with boldface type, rather than in narrative content. For example, the chapters written for those other than the mother (i.e. partners, family members, healthcare practitioners) each contain a list of “What to Say, What Not to Say” (pp. 70, 77, 83). These included what Bennett and Indman identified as helpful statements such as “I'm here for you” (p. 70) and unhelpful statements like “Just buck up and tough it out” (p. 78). Perhaps due to the purpose of the book, which is to communicate necessary diagnostic and treatment information quickly and clearly, there are no theoretical discussions about the etiology or meaning of perinatal mood and anxiety disorders.

Exceptions to the bullet point format are found in the beginning section where Bennett and Indman tell their personal stories of how they learned about and became passionate about perinatal mental health. In particular, Bennett's story regarding her experiences following her two births gives an intimate and complex description of the difficulties, struggles, and trauma that she endured. Her first person account of a traumatic birth informs the rest of the information in the book, but has a distinctly different tone. Her story gives her struggles a context and conveys a particular meaning about her as an individual.

The difference between the general, decontextualized information about perinatal mood and anxiety disorders, and the real, complex experiences of becoming a mother is noticeable in *Beyond the Blues* and reflects an aspect of most books on perinatal mental health. In context, Bennett and Indman demonstrated, women's reactions make sense. There is a reason that a mother may be unable to stop crying after a particularly terrifying birth experience, or may feel numb, deeply saddened, and grief-filled. Out of context, those reactions could be interpreted as symptoms that might indicate disorder.

Thematic analysis. Like the other two books in this study, Bennett and Indman (2010) display repeated patterns of belief, meaning and knowledge. These patterns reflect the way the authors conceptualize struggles of birthing and mothering, and how they understand the roles of those around the mother, including clinicians.

Using Benner's (1994) definition of "thematic analysis" as the identification of "meaningful patterns, stances or concerns" (p. 115) I explored the text in the Bennett and Indman book looking for patterns, beliefs, and views—what are identified as themes—expressed about the experience of perinatal mood and anxiety disorders.

The themes I describe relate to two of the main concerns of this study: how the challenges of early mothering are described within the text and understood by health care professionals, and the implicit understandings of the clinicians about their responses to these challenges, their practices, and their sociocultural role. The themes of *Beyond the Blues* are

- maternal distress as real, common, and expected;
- perinatal mood disorders overlooked and undertreated;
- suffering reduced to a medicalized disorder;
- the mother as object;
- the clinician as a caring and concerned professional;
- the clinician as a scientific diagnostician; and
- the clinician as a rational expert bringing order to the disordered.

I include exemplars within each theme as a way to illuminate the ideas and concerns, as well as the complexity, of each theme. The exemplars' purpose was to show how the authors conveyed a way of being a mother who was struggling, and a clinician concerned with mothers.

Maternal distress as real, common, and expected. Bennett and Indman (2010) emphasized the reality of perinatal distress and struggle for women. The struggles were viewed as common and expected, up to a certain point, but beyond that point the distress and struggle were conceptualized as a biologically-based disease. They acknowledged that the distress and struggle occurs within families and communities. They emphasized the ways in which those around the mother suffer in addition to the mother. Finally, they

advanced the belief that when a mother is well, she will willingly fulfill her familial and community obligations naturally—that this is a sign of mental wellness and recovery.

Bennett and Indman (2010) challenged beliefs about generally accepted patterns and common expectations of parenthood, such as that early mothering was a stress-free, always happy, always fulfilling time. “Most often we are told the glowing side of parenthood; you will feel instantly bonded and fall madly in love. This may happen, but often it’s a process of getting to know this demanding stranger” (p. 65). They described many of the losses that beset a home, or marriage, when a new baby arrives, including losses of freedom, sexuality, and intimacy. Some of the beliefs that they confronted involved unrealistic expectations of a mother to care for others and a home. They stated, “Even a non-depressed postpartum woman cannot realistically be expected to cook dinner, clean house, and care for the baby” (p. 68).

Bennett and Indman (2010) addressed issues of transition, grief, and loss in the chapter written primarily for partners. The validation and discussion of the emotions that followed those changes were directed at the partners, not the mothers:

There are losses associated with becoming a parent, and it’s important to acknowledge and grieve them. It is normal for your relationship with your partner to change. . . . It’s easy to feel rejected. Remind yourself, it’s not a personal rejection. (Bennett & Indman, 2010, p. 66)

They also acknowledged “normal and healthy” questions in the chapter written for partners, such as “Will I be a good parent?” (p. 66).

By contrast, the chapter written for mothers was entitled “Women with Perinatal Disorders” and primarily addressed symptoms and diagnostic information. In this chapter, having a mood disorder was what was validated and discussed. Descriptions of

emotional pain were viewed as risk factors or symptoms of a perinatal mood or anxiety disorder:

Women who suffer postpartum emotional difficulty experience their emotional pain in many different ways. Here are some of the common feelings they express:

No one has ever felt as bad as I do.

I'm all alone. No one understands. . . .

I've made a terrible mistake. . . .

I wasn't cut out to be a mom.

Please know that each woman may experience these feelings at varying levels You might also recognize some of your symptoms listed in Chapter 2. (Bennett & Indman, 2010, p. 49)

They stated at the beginning of the section on “The Psychiatric Issues of Pregnancy” that “contrary to popular mythology, pregnancy is not always a happy, glowing experience” (p. 31). However, they then limited the list of unhappy, dull experiences to psychiatric issues that may present during pregnancy, as opposed to the other logistical, emotional, and social issues that may arise. “Pregnant women can and do experience depression, bipolar disorder, anxiety and panic, post-traumatic stress disorder, obsessive-compulsive disorder, and even psychosis” (p. 31).

Perinatal mood disorders overlooked and undertreated. As a way of increasing awareness of maternal distress, Bennett and Indman (2010) each shared their personal stories that had inspired them to work in perinatal mental health. Indman reflected upon the ways in which women’s needs, and in particular pregnant women’s needs, had been excluded or ignored by the medical community and the research that informed it. After discovering a pamphlet on perinatal mood disorders in a physician’s office and learning about these disorder for the first time, she recalled “in all my years of training, I had learned nothing about perinatal mood disorders. I thought back to some of the women I had probably misdiagnosed. Why aren’t health practitioners taught about PPD?” (p. 26).

Bennett recalled her struggles during and following the births of her two children. At the end of her first pregnancy she endured a very difficult labor that ended when she underwent a Caesarian-section. She wrote:

I suddenly became aware that I was hovering over myself, watching myself in pain. Although at the time I had no words to label that bizarre sensation, I now know it to be called an out-of-body experience. Still not dilating, I was finally given a C-section. My illusion of being in control was shattered. I had been a professional dancer, and my body had always done what I had wanted it to. The visual image I repeatedly had during this ghastly time was of a beautiful, perfect, clear glass ball violently exploding into millions of pieces. That was the self I felt I was losing. Hopelessness and helplessness replaced my previous feelings of control and independence. I was left with a post-traumatic stress disorder that haunted me for years.

I soon learned a skill that I would practice for a very long time—acting. I bought into the myths that I was supposed to feel instant joy and fulfillment in my role as a mother, as well as an immediate emotional attachment to my baby. As my daughter, Elana, was placed in my arms, I managed to say all my lines correctly. “Hi, honey, I’m so happy you’re finally here,” I said, wanting to feel it (as I did later on). Inside, I was numb. (Bennett & Indman, 2010, p. 20)

Though this recollection is deeply moving, the authors spent little space in the rest of the book discussing what this kind of event might mean for mothers. They acknowledged the problems and difficulties, and then moved quickly into problem-solving and treatment plans. This emphasis was reflected in their instructions for a mother looking for a psychotherapist: “Research has shown the most effective types of therapy for your condition are cognitive-behavioral and interpersonal. You are experiencing a life crisis; long-term intensive psychoanalysis is not appropriate” (Bennett & Indman, 2010, p. 51).

Suffering reduced to a medicalized disorder. In the Introduction to *Beyond the Blues*, Dehn (2010) pointed out the misconception that early mothering was without difficulties. She noted that during this time the mother was recovering from her birth experience and that the mother’s body was undergoing “a tremendous hormonal upheaval that rivals any roller coaster ride” (p. 17). The mother was further described as

“stumbling around the house in a fog” (p. 17) from sleep deprivation and also “confronting the loss of her previous life and any sense of control over her time” (p. 17).

She admitted:

As health care providers, we do our best to help parents prepare for the birth, yet often gloss over the reality that bringing home a newborn with his own temperament and round-the-clock feeding will undoubtedly lead to a major life adjustment. (p. 17)

However, Dehn (2010) did not connect this major life adjustment to growth and a reorganizing of values, but rather to the feelings of being overwhelmed that resulted in a diagnosis of postpartum depression. She asked, “Can this be overwhelming and lead to postpartum depression? The answer is yes, and yet it’s not hopeless” (p. 17).

Bennett and Indman (2010) understood that it mattered that women have some way to make sense of their experiences and to ascribe meaning to them. Bennett noted the importance in being able to name one’s distress. She described her response, after struggling severely after two pregnancies, when she watched a television documentary about postpartum depression. She recalled that “the tremendous sensation of relief that someone had, at long last, described the turbulent agony I had been living felt like a weight being lifted from my whole body” (p. 24).

Similar to the authors in *Perinatal and Postpartum Mood Disorders*, discussed in Klemner (2008, p. 92), Misri and Joe (2008, p. 67), Spadola (2008, p. 172), and Birndorf and Sacks (2008, p. 243), Bennett and Indman (2010) attempted to clarify the perinatal mood and anxiety disorder diagnoses. They noted:

There are six principal perinatal mood and anxiety disorders which are

- depression
- obsessive-compulsive disorder (OCD)

- panic disorder
- psychosis
- post-traumatic stress disorder (PTSD), and
- bipolar disorder I or II. (p. 30)

They described common symptoms of pregnancy and how those differ from symptoms of depression—the normal from the not normal:

Pregnancy	Depression
Mood up and down, teary	Mood mostly down, gloomy, hopeless
Self-esteem unchanged	Low self-esteem, guilt
Can fall asleep, physical problems may waken (bladder, heartburn), can fall back to sleep.	May have trouble falling asleep, May have early morning wakening and difficulty falling back to sleep. (p. 31)

They described the *Baby Blues*, which have many of the same symptoms as perinatal depression or anxiety, but noted that the *Baby Blues* “should be gone by three weeks postpartum” and are “not considered a disorder since the majority of mothers experience it” (p. 34). The authors advanced a biomedical model for the etiology of perinatal mood and anxiety disorders, and encouraged women to seek out treating professionals to cure it. They noted that perinatal mood and anxiety disorders “are triggered mainly by hormonal changes, which then affect brain chemicals called neurotransmitters” (Bennett & Indman, 2010, p. 29).

Preference was given to the views and information about perinatal mood and anxiety disorders that resulted from empirical studies and the practices of the medical community, generally referred to as “science” (Bennett & Indman, 2010, p. 101). The

information obtained from empirical research studies was passed on via this book for the benefit of the mother, by “well-informed professionals” (Bennett & Indman, 2010, p. 15).

The most noticeable reflection of the concept of suffering as a biological disorder, located in the mother, and not a complex, human experience of grief or despair at one’s situation, was the preference given to the diagnoses over the person or experience. It was noticeable in the book’s subtitle, “Understanding and Treating Prenatal and Postpartum Depression & Anxiety.” It did not say “treating *women experiencing* Prenatal and Postpartum Depression & Anxiety.” This could be interpreted to mean that the focus of concern for this text was on understanding the disorder, more so than on understanding the mother or the unique individual who is in distress. Rather, it was implied that understanding the disorder leads to understanding the mother in distress.

Though they mentioned the impact of life stressors on the women who were struggling, these stressors were seen not as causes for distress and disorder, or a legitimate source of suffering in women. Rather, the stressors were something to be managed well as part of the woman’s recovery from a biochemical disorder within her body and brain. They accepted the theory that hormonal changes which affected brain chemicals were the cause of perinatal struggles and disorders. That belief, however, was challenged by Bennett’s description of her traumatic birth experience that left her numb and shattered, and was either a cause of, or contributed to, her later suffering.

These mood and anxiety disorders are triggered mainly by hormonal changes, which then affect brain chemicals called neurotransmitters. Life stressors, such as moving, illness, poor partner support, financial problems, and social isolation, are certainly also important and will negatively affect the woman’s mental state. Strong emotional, social, and physical support will help her recovery. (Bennett & Indman, 2010, p. 29)

Bennett and Indman's (2010) presentation of the etiology of perinatal mood and anxiety disorders and its treatment created a contradiction. They stated that when women are experiencing postpartum emotional difficulties, and present in a clinician's office, the women will often say, "This can't be happening to me! I take care of everyone else in a crisis" (p. 49). They respond by telling these women "our brain doesn't care what we do for a living! No one is immune" (p. 49). This was understood to mean that Bennett and Indman were telling these women that they did not cause their suffering. Rather the cause was their brain, which was malfunctioning. These mothers must have realized that their brains were still part of their bodies and beings.

The concept of an independent, personified brain that didn't care and that wasn't functioning properly was a brain that had betrayed the person, in this case the mother. By distancing the brain from the mother, Bennett and Indman created a false split within the suffering mother—there is who she is and knows herself to be, and then there is her brain which is creating something different. This split would have significant implications for the mother since, according to Bennett and Indman (2010), the goal of treatment was for the mother to return "100% back to herself" (p. 117). How can a suffering mother accomplish this if a crucial part of her being has mutinied? In addition, their focus on the malfunctioning brain or hormonal changes obscured other significant and valid reasons that a mother may be suffering—grief, loss of her previous life, overwhelming burden with too-little support, or trauma.

The mother as object. Bennett and Indman (2010) viewed perinatal mental health as something that occurs within a woman's brain chemistry, but that affects all of those around her. This was apparent in the way they attributed PMADs to internal

hormonal changes that affect the mother's brain chemistry (p. 29) and the way they dedicated 35 of their 157 pages (22%) to information to meet the needs of those in relationship to the mother (e.g., children, partners, friends).

They began their section "Consequences of Untreated Mood Disorders" by describing its effects on the struggling mother's children, not the effects of a mood disorder on the woman experiencing it. They emphasized that everyone around the mother was affected by her struggles, especially the infant and other children. They underlined this belief by quoting the Department of Health Service's 2002 Mental Health Policy Panel: "maternal depression was placed at the top of the list entitled 'Most significant mental health issues impeding children's readiness for school'" (Bennett & Indman, 2010, p. 46). They articulated the child's perspective of the mother's suffering this way:

Children usually notice if Mom is, or has been, crying. They will notice if Mom yells or gets angry over little things. Perhaps they will notice that Mom stays in bed more, does not have the energy to take them to the park, or does not seem to laugh much lately. Maybe they see her staring blankly into space, not paying much attention to them. Children can tell this is not the Mom they used to know, and they need honest, clear explanations about what is occurring. (Bennett & Indman, 2010, p. 73)

To be fair, Bennett and Indman (2010) did recognize the importance of those around the mother as also supports for the mother. Specific chapters were dedicated to partners/spouses, children, and family members, as well as professionals whom the mother may encounter during her pregnancy and postpartum. Bennett and Indman specifically addressed those who may be with the mother on a daily basis, and who may most directly observe the mother's struggles as well as be affected by them. In addition, they provided guidance in how these family members and close friends might support the

mother in her recovery and transition. In doing so, they recognized that a mother's distress occurs not only within the mother, but also within a context of others.

Even so, Bennett and Indman (2010) did not address current socio-historical factors, as described in the context section of this study. The way they presented their information indicated that they believed that the mother mothers within a familial and community context, but not within a historical or political context. In addition, the purpose of supporting the mother was to enable her to return to her role of caring for others.

Repeatedly, Bennett and Indman (2010) made a point of stating that many of those who were around the mother can, and should, help the mother when she is struggling. This included a bullet point list in the chapter "Siblings, Family, and Friends" entitled "What You Can Do to Help" (79). This point was also notable in the "What to Say, What Not to Say" sections for people who were around the mother, "Say: We will get through this. . . . Do Not Say: Think about everything you have to feel happy about" (pp. 70–71). In addition, they encouraged mothers to "find and surround yourself with non-judgmental, caring support" (Bennett & Indman, 2010, p. 53).

They described the role of social support in providing an environment that validates the mothering experience, connects her to other mothers, and may provide information about resources as well as practical support (Bennett & Indman, 2010, p. 106). They also pointed out the importance of supporting the mother in the ways that she needed. For example, they highlighted the risk of putting a struggling mother into a group with non-struggling mothers and how that may cause further isolation for the mother who is struggling. "A depressed mother is already feeling different and

inadequate compared to other new mothers. Attending a ‘normal’ new-mothers’ group may intensify her alienation” (Bennett & Indman, 2010, p. 83).

However, maternal expressions of extreme emotions were seen not as accurate representations of the mother’s experience, but rather as indications of disorder that required care and treatment to make her better quickly. The chapter written for partners concluded with a quote from Bennett’s husband recalling his experience following the birth of their first child:

You’ve just come home from a long day at work, hoping to find a happy home—and what you find makes you want to get back into the car and leave. Your wife is in tears, the baby is crying. The house is a mess, and forget about dinner. By now you know better than to ask how her day was. Her response is always the same. “I hate this ‘mother’ stuff. I don’t want to be anyone’s mother. I want my old life back. I want to be happy again.” You shrug, go to hold the baby, and wonder why your wife is feeling this way, why she’s not as happy as you are about the baby, and when she will snap out of it. (Bennett & Indman, 2010, p. 2)

It is noteworthy that, though the mother in this scenario (Bennett) explained exactly what was happening to her—she hated the role of mother and grieved for her former life—the partner’s response was to wonder why she was feeling this way and when she would “snap out of it.” The feelings and meanings for mothers were presented, and then dismissed as not being relevant to the situation. Bennett’s expressions of loss and profound disappointment were either ignored or simply not considered credible. In any event, in this story, they were not heard. The central subject in this scenario is not the mother who is suffering, but rather the baby, “*the one in the midst of this mess*” (Bennett & Indman, 2010, p. 72).

Though Bennett and Indman assured mothers that “Your thoughts or feelings will not damage your baby or the relationship with your baby” (p. 60) three pages later Bennett and Indman stated “Remember that the best gift you can give your baby is a

happy, healthy mom” (p. 63). That the mother was a good mother, or inherently enjoyed being a mother was taken for granted in Bennett and Indman (2010). Nowhere was Bennett’s statement to her husband “I hate this ‘mother’ stuff” validated as a reasonable response for a mother. The mother can be overwhelmed, but an expression of dislike or resentment or rejection of her mothering role was suspected as being an indicator of emotional disorder.

Overall, Bennett and Indman reflected the belief that crucial to the mother’s struggles was her inability, while depressed or anxious, to be an effective member of the family—to care for her infant and other children, and to be a good partner to her spouse. They presented a view of the mother as an object whose role was to meet the needs of others.

It was never acknowledged, in Bennett’s personal descriptions of her struggles, or her husband’s descriptions of her struggles, that she was there with her children, and not indifferent to their plight. Her children were apparently cared for well-enough that they survived, even as she suffered. In fact, it was quite possible that Bennett, the mother, was the one most suffering in these scenarios, and most in need of others for her, not her for others.

The clinician as a caring and concerned professional. As indicated earlier in this study, *Beyond the Blues* was used as a resource by clinicians in several institutions. Knowing and understanding the information conveyed by Bennett and Indman was considered a hallmark of competent, concerned care by practitioners. According to Bennett and Indman, part of this competency involved professionals being able to recognize and detect a mood disorder in a mother. They recommended several screening

tools to be used in the service of uncovering what the mother may be hesitant to show or express. Once a disorder was detected, their recommendations for treatment were formulated and direct. They instructed professionals to supply educational materials to the mother, encouragement for self-care, as well as treatment in the form of psychotherapy and medication.

Bennett and Indman (2010) dedicated an entire chapter to health practitioners who might encounter a pregnant woman or mother. This included not only psychologists, physicians, and nurses, but also doulas, lactation consultants, childbirth educators and new parent group leaders. They began the chapter by proclaiming “All providers who touch the lives of pregnant and postpartum women need this information. The fact that you are reading this book clearly indicates that you are a caring and concerned professional” (p. 81). A couple of pages later, in discussing new parent support groups, they advanced the same belief: “If you know that the leader of the group is sensitive (such as those reading this book) and discusses mood problems, this mom will be fine in such a group” (Bennett & Indman, 2010, p. 83). Similar to the authors in *Perinatal and Postpartum Mood Disorders*, they suggested that all members of an office staff read their book and be familiar with “signs, symptoms, and treatment” (p. 81).

However, Bennett and Indman believed that clinicians should have professional limits to their expressions of care and concern, and should view the mother’s struggles as similar to a biological disorder. “It is important not to underreact or overreact to these women’s symptoms. Just treat them as matter-of-factly as you would any other common perinatal experience, for example gestational diabetes” (Bennett & Indman, 2010, p. 81).

Bennett and Indman (2010) repeatedly instructed health practitioners to give the mother a list of the resources contained in the back of their book. The resources were extensive, taking seventeen pages, and included perinatal health organizations and books, as well as research articles. All of the organizations, books, and articles listed concerned perinatal mental illness (with the exception of Doula's of North America, which is broadly concerned with pregnancy, birth, and maternal care regardless of mental health issues). There were no books or articles about motherhood or perinatal distress that considered the situation from a different viewpoint. Several of the authors from *Perinatal and Postpartum Mood Disorders* (2008) as well as the book itself were listed in the Resources section (pp. 125–142)

The clinician as a scientific diagnostician. Bennett and Indman (2010) understood that women want to appear as good mothers, even when they were concerned that they were not being good mothers. In the chapter written for health practitioners, they described how women may be moved to alter, shape, or manage their behaviors in order to appear like a good mother.

Shame, guilt, or fear of judgment may cause the woman to hide her feelings. She may present more “socially acceptable” complaints such as fatigue, headache, marital problems, or a fussy baby. Just because a woman is smiling or well groomed, don’t assume she is not suffering silently. Postpartum depression is a hidden illness. Although there are risk factors to help predict postpartum depression, there is no particular “type” of person who becomes afflicted. (Bennett & Indman, 2010, pp. 81–82)

Bennett and Indman (2010) reassured health practitioners that, even though the mother may feel accused of being a bad mother when the practitioner asks about her struggles, all that is needed is the practitioner’s “matter-of-fact tone” (p. 82) for the mother to not feel shame, and to openly accept the information the practitioner has to

offer. “But once she hears your matter-of-fact tone, and understands no shame should be attached to postpartum illness, she will be able to accept the information. In the long run, you will be saving time and providing quality care” (p. 82).

Just in case the clinician’s matter-of-fact tone did not reassure the mother enough to disclose her struggles, Bennett and Indman (2010) also recommended using screening surveys with mothers. “We recommend whenever possible using standardized screening surveys specifically designed for perinatal use” (p. 84).

We recommend you [pediatricians and neonatologists; OB/GYNs, midwives, and other women’s healthcare providers; postpartum doulas and visiting nurses] use a standardized postpartum screening tool such as EPDS [Edinburgh Postnatal Depression Screening] or the PDSS [Postpartum Depression Screening Scale]. Women should be assessed throughout the first year. (p. 94)

Bennett and Indman (2010) also provided prenatal, pregnancy, and postpartum risk assessments that included signs and symptoms for a clinician to watch for that may indicate disorder “missed appointments . . . Excessive worry . . . Looking unusually tired” (p. 85) and questions that “at the bare minimum” (p. 85) should be asked of all mothers.

These questions included:

Have you ever had episodes of being down or sad, extreme worry, panic attacks, repetitive thoughts or behaviors that are troublesome, bipolar or extreme mood swings, loss of touch with reality, or an eating disorder? . . . Are you taking any medications (prescription or nonprescription) or herbs on a regular basis? (p. 86)

Affirmative answers to these questions, which may indicate disorder or mental illness, were highlighted by Bennett and Indman (2010). However, affirmative answers to these questions which in context might be reasonable for that type of response were not included. The primary purpose for the clinician’s inquiry into a mother’s wellbeing was not to get a more complete and complex picture of the mother, who she was, and what she was experiencing. Rather, the clinician inquired specifically to assess for disorder

and to recommend treatment. Similar to the brevity and directness of their book, Bennett and Indman did not spend a great deal of time discussing how best to listen for and interpret the mother's unique experience.

The clinician as a rational expert bringing order to the disordered. Overall, Bennett and Indman (2010) described the mother's struggles as a disordered version of the mother—not being herself. The purpose of their book, for mothers who were struggling, for their family members, and for the healthcare practitioners who encounter them, was to bring order to the disordered mother.

All new mothers need a wellness plan, because all moms need nurturing. This is not a luxury—it is a necessity! If a woman is at high risk, she should meet with a knowledgeable psychotherapist before pregnancy to create a prenatal and postpartum wellness plan. This plan may include follow-up appointments with other professionals such as a psychiatrist or nutritionist, sleep arrangements (to ensure blocks of uninterrupted sleep), food and eating (who will shop and cook), and getting breaks away from the baby during the week. If an illness occurs, a wellness plan will be in place that will support and speed recovery. (p. 104)

Often, the support that Bennett and Indman (2010) advocated for mothers took the form of directives for the mother to follow. For example, regarding seeking psychotherapeutic care, Bennett and Indman wrote “Do not assume . . . Be a good consumer. Shop around until you feel satisfied that you are in capable hands” (p. 50). They even provided the mother with mantras to repeat. If they were contrary to the woman's experience, Bennett and Indman stressed that “it is important to say them frequently, as if you really mean them . . . *I will recover! I am not alone! This is not my fault! I am a good mom! It is essential for me to take care of myself! I am doing the best I can.* (pp. 51–52).

These directives indicated that Bennett and Indman (2010) recognized the vulnerable place that mothers were in, and the importance of clarity when one feels lost,

confused, and alone. Bennett and Indman were even directive towards family and friends of the mother in telling them not to be directive or demanding of the mother. They instructed “while it is positive to encourage her to share her thoughts, it is unhelpful to demand it. Let her know you are willing to listen without judging her. Trust that she will open up when she is ready and feels what she has to say will be treated seriously and respectfully” (p. 76).

The Treatment chapter contained charts of treatment protocols for “Pre-Pregnancy,” “Pregnancy,” and “Postpartum” with specific plans of treatment dependent upon the woman’s history and the extent of her past mental illness diagnoses. Each phase of intervention had a primary form of treatment, “Treatment 1” and a back-up form of treatment, “Treatment 2” (pp. 120–123). Clinicians were instructed that “treatments should be followed in sequence, with Treatment 1 tried first, followed by Treatment 2 if necessary” (p. 119). The major difference between the first-line treatment, “Treatment 1” and secondary treatment was more medication, or more intensive interventions such as Electroconvulsive Treatment (ECT).

The chapter written for health practitioners contained separate sections for the different health practitioner specialties (e.g., psychotherapists, primary care providers, pediatricians). Each section presented that specialist as one who directs and organizes the mother’s care. For example, the section written for primary care providers outlined several ways in which the provider directs or monitors the mother’s wellbeing based upon the provider’s understandings of her:

As a primary care provider, you may have a longstanding relationship with your patient. You have a good sense of her mental and physical health history. This puts you in an advantageous position to evaluate her pre-pregnancy risk, and provide appropriate direction. Your office may provide a safe haven should a

pregnancy or postpartum mood problem arise. Please have information from the Resources chapter available, as well as referrals to local professionals trained in perinatal mood and anxiety disorders. (p. 93)

The section written for psychotherapists, psychologists, and social workers was similar:

As a mental health care provider you may have had a relationship with the woman or couple before a pregnancy. You are a critical element in creating and being a part of her preconception planning and perinatal safety net. It is essential that you are familiar with risk factors and the most current information on how to reduce risk factors. Be familiar with the research regarding relapse and current medication recommendations for perinatal women. You can help her monitor symptoms and work with her health care providers. Have the information in the Resources chapter available for her and her providers. (pp. 92–93)

The end of each section contained the same injunction, “Have the information in the Resources chapter available for her and her providers” (pp. 93–100). They were referring to the Resources chapter of *Beyond the Blues*. These sections written for health practitioners indicated two strong beliefs of Bennett and Indman. The first is that professionals were considered knowledgeable experts regarding the mother’s experience, as well as what the mother needed in the way of care. Secondly, they presumed that the struggles that mothers had would be resolved by the resources in their Resources chapter. In other words, they believed that the mothers were struggling because of a mood disorder and not because of other real or relevant factors in their lives and worlds, such as poverty, injustice, or bodily threat.

As a birth doula, you are in a unique position to screen prenatally for risk and to watch for early warning signs of emotional problems. If, for instance, when administering the Pre-pregnancy and Pregnancy Risk Assessment, you discover the woman has suffered a previous traumatic delivery or childhood sexual abuse, she may experience flashbacks during the upcoming birth. Have referrals to local professionals trained in perinatal mood disorders and information in the resources chapter available Use the Pre-pregnancy and Pregnancy Risk Assessment on *all* women who employ your services. If you continue to see these women postpartum, use the Postpartum Risk Assessment. Keep in mind that this information can be gathered quite informally, simply through chatting. (pp. 95–96)

You [postpartum doulas and visiting nurses] have the opportunity to observe the home and social environments of the mother, which can give crucial information about her well-being and that of the family unit If her house is unusually neat and clean, you will want to find out who is doing the housework. If she is, for example, obsessively cleaning or awake in the middle of the night vacuuming, this is not normal. Have referrals to local professionals trained in perinatal mood disorders and information in the Resources chapter available. (p. 96)

Summary. The most comprehensive summary of Bennett and Indman's (2010) overall conceptualization of perinatal mood and anxiety disorders might be found in the script they suggested for a mother who is struggling to explain herself to her older child:

You may have noticed I have been crying and getting mad a lot lately. Some of the chemicals in my body are not working right, and it has been affecting how I feel and how I act. I want you to know I love you very much, and I love the baby, too. I also want you to know that this is not your or anybody else's fault. I am taking good care of myself and getting help so I can get better as fast as I can. I am probably going to have good times and bad times, but I will get better and better until I'm completely well. I am looking forward to taking you to the park again. I love you very much. (p. 75)

In this exemplar, several of the themes from *Beyond the Blues* were clearly presented. The mother has been in distress. The distress was caused by the chemicals in her body, indicative of a biological etiology of disorder. That the distress was contained within the mother was further verified as the mother assured her child that no one else is at fault or contributing to these disordered behaviors and emotions. The mother has been recognized by those who can cure her as having a perinatal mood and/or anxiety disorder. She is following the directives given to her for taking care of herself as well as receiving professional help. She will improve and get better. And when she is better, she will display this by taking care of others, such as the child, whom it was assumed she loved and liked to be with at the park. The assumption was made that the mother did want to be with her children, that she liked her children, that she held no resentments or conflicted

feelings towards her children—even when the birth of that child may have created tremendous trauma for the mother.

In *Beyond the Blues* what can be seen in the clearing is that mothers suffer. What is excluded, not seen, in the clearing are all the complex, negative, conflicted feelings mothers may have towards their offspring—the source of their trauma, the source of their loss of freedom. Bennett and Indman (2010) mentioned some of the losses, the 24/7 demands, the hardships and drudgery of mothering. But the one place where the mother's genuine feelings about them were expressed—Bennett's statement "I hate this 'mother' stuff. I don't want to be anyone's mother. I want my old life back" (p. 72)—was interpreted as an indication of disorder, not as a genuine, valid way of feeling about one's life. The assumption was that the cured mother would love all this mother stuff—that she would always want to go to the park with her child, not that the healthy mother might at times be bored to tears at the park with her two year old.

Bennett and Indman (2010) expressed the belief that clinicians who read their book, and therefore were either informed of or fully accepted their directives, were caring and concerned professionals. Similar to the information conveyed in *Perinatal and Postpartum Mood Disorders* (Stone & Menken, 2008), Bennett and Indman's descriptions of health practitioner interventions was a good example of the hermeneutic idea that in the human sciences description is also prescription, and vice versa. In this case recommendations of good clinical work also served as expectations, and expectations of good clinical work can be interpreted as definitions of a good clinician (P. Cushman, personal communication, May 29, 2014). According to Bennett and Indman, a good clinician watches for disorder, uses their intimate connection to the

mother to observe and diagnose her, and interprets her suffering according to those concepts as expressed in screening instruments and the *Beyond the Blues* Resources chapter.

Several assumptions were expressed by Bennett and Indman that conveyed implicit understandings about clinicians. The first was that clinicians, as knowledgeable, caring, and concerned professionals could cure the mother's suffering. This confidence in cure was based on the beliefs that the mother's suffering indicated a biological disorder, and that clinicians knew enough, if informed by their book, to bring order to that disorder. Clinicians served the role of scientific diagnostician and rational scientist who brings order to disorder when encountering mothers who were suffering.

Down Came the Rain: My Journey Through Postpartum Depression (2005)

Description. *Down Came the Rain: My Journey Through Postpartum Depression* is the model and actress Brooke Shields' 226-page memoir in which she described her experience of pregnancy and postpartum depression (PPD). The nine chapters in the book cover approximately three years in Shields' life, and provide descriptions of, and her reflections about, her struggles becoming a mother. The book includes an afterword which lists resources offering information and assistance to new mothers who may be suffering after the birth of their child, as well as information for those who support these mothers. It also lists three phone hotlines including 911 and a suicide hotline.

In the first part of the memoir Shields (2005) detailed the difficulties she had in conceiving a baby, as well as her subsequent traumatic birth experience. Even after she had agreed to try in vitro fertilization (IVF)—a physically and emotionally taxing

process—she experienced several miscarriages. It took several rounds of IVF before she conceived and carried her pregnancy to term. Complications during a long and protracted delivery necessitated an emergency caesarian-section, and then a second emergency surgery to repair severe and life-threatening damage which had occurred to Shields during the delivery. Shields also noted the challenges she and her husband faced in caring for her daughter, Rowan, who was born with multiple, temporary impairments.

One of the most moving aspects of Shields' book was the fact that it described the struggles, vulnerabilities, and disappointments of an otherwise notable and powerful public figure. It reflected Shields' elevated status as a celebrity and her everyday status as a vulnerable human being. I suspect the popularity of her book had as much to do with its recognizable descriptions of the struggles and hardships that a mother might encounter in birthing her baby and becoming a mother as it had to do with her notability.

In her book, Shields (2005) conveyed a similar theoretical conceptualization of PPD as that of the authors of *Perinatal and Postpartum Mood Disorders* and *Beyond the Blues*—that there was a biological cause for her suffering, involving disrupted brain functioning. Shields supported and advocated for similar treatment protocols—therapy and medication—as were described in the other two books. In addition, she asserted that social activism around PPD involved increasing awareness of the disorder and diagnosis, screening, and making treatment more accessible for the mother. However, her reflections—which included her struggles, her developing relationship with her daughter, and her fears and confusion about her identity as a mother and her practices of mothering—provided a more textured understanding of the experience of mothering and

of being diagnosed with a perinatal mood disorder that was not present in *Perinatal and Postpartum Mood Disorders* or *Beyond the Blues*.

General tone. *Down Came the Rain* is written in a first-person narrative, which feels personal and conversational. As the reader, the story prompted in me a sense of connection with Shields, even though it is probably safe to assume that our lives are quite dissimilar. Given its sales and popularity, it would seem that many mothers have felt similar to Shields and identify with her story.

The technical and medical information Shields (2005) conveyed in the book is clear, but also minimal. As opposed to the clinical, authoritative tone of the authors in *Perinatal and Postpartum Mood Disorders*, or the health and wellness pamphlet style of *Beyond the Blues*, to read Shields' memoir feels like having a long, intimate conversation with a close, informed friend who has already been through what the reader might be experiencing. As the reader, I could imagine myself sharing with her my story of motherhood, as we pushed our jogger strollers along. That immediacy seems to normalize Shields' experience and to dispel the stigma that can accompany a diagnosis of mental illness. Similarly, unlike the other two books, it provides a description of the ongoing development and day-to-day challenges of a new mother. These descriptions included the nuanced and sometimes contradictory everyday practices and beliefs of a new mother.

Thematic analysis. Similar to the other two books in this study, Shields (2005) displays repeated patterns of belief, meaning, and knowledge. These patterns reflect the way Shields conceptualizes struggles of birthing and mothering; how she understands the

roles of those around her; and her assumptions about what is normal, good, and healthy mothering.

Using Benner's (1994) definition of "thematic analysis" as the identification of "meaningful patterns, stances or concerns" (p. 115) I explored the Shields text looking for patterns, beliefs, and views expressed about the experience of perinatal mental health—the identified themes.

The themes I describe relate to two of the main concerns of this study: how the challenges of early mothering are described within the text and understood by mothers; and the implicit understandings of the clinicians about their responses to these challenges, their practices, and their sociocultural role. The themes of *Down Came the Rain* are

- struggles in birthing and mothering overlooked or ignored,
- the mother as object,
- the importance of the mother's self-reflection,
- the individualist explanation as default position,
- the importance of context,
- the influence of medical knowledge on the mother's understanding, and
- the helpfulness and limitations of medicalization.

Struggles in birthing and mothering overlooked or ignored. For me, the most notable aspect of Shields' (2005) story was all that she went through in order to become a mother, as well as the clearly conveyed sense of loss and disorientation she experienced as she navigated the process of coming to know herself as a mother. She lists many of the stressful events in her life prior to and immediately after her daughter was born:

In the past five years, I had been divorced, gotten remarried, suffered a miscarriage, and gone through numerous rounds of fertility treatments. Someone

who had been like a brother to me had killed himself, my father had died three weeks before my daughter was born, we had moved into a new apartment, and Rowan was born after a long and traumatic labor and delivery. To top it off, we had no baby nurse, we were inexperienced parents, my daughter had to wear a harness, my husband had to return to work in a different city two weeks after the birth, and I was inflated like a Macy's Thanksgiving Day Parade balloon [from the medications following surgery]. (p. 140)

The title of Shields' (2005) book, *Down Came the Rain*, was taken from a line in the Itsy Bitsy Spider nursery rhyme. Six of the nine chapter titles (67%) referenced children's books or nursery rhymes (e.g., "The Little Engine that Could," "See Mommy Run," "Are you my Mother?" "Had a Great Fall," "And Then There Were Three," "Out Came the Sun"). Immediately prior to Chapter 1 is a story that reflected Shields' experience of pregnancy and motherhood:

Once upon a time, there was a little girl who dreamed of being a mommy. She wanted, more than anything, to have a child and knew her dream would come true one day. She would sit for hours thinking up names to call her baby.

Eventually this little girl grew up. Though she'd met and married her Prince Charming, she was having trouble conceiving. She began to realize that her dream wasn't going to come true without a great deal of medical help.

So she went on a long journey through the world of fertility treatments. When none of them worked, she got frustrated and depressed. She felt like a failure.

And then one day, finally, she became pregnant. She was thrilled beyond belief. She had a wonderful pregnancy and a perfect baby girl. At long last, her dream of being a mommy had come true. But instead of being relieved and happy, all she could do was cry. (Shields, 2005, p. 1)

As a reader, I cannot know for certain why Shields wrote an introduction to her memoir in this fairy tale style. I can posit two guesses. One is that Shields' book was published when her daughter was two years old. For many mothers, fairy tales are a large part of what they are reading in those early years. Her writing may have reflected what she was reading. In addition, she may have been aware that her daughter might read her memoir someday, and may have wanted to place the events in a way that her daughter

would not feel guilt or shame. What can be interpreted, however, is that the manner of this fairy tale confronts the mythical happily-ever-after of fairy tale stories, including those beliefs held about mothering and motherhood. In addition, it makes medical help a crucial aspect for one to obtain her dream. While the story articulated the disruption of beliefs and expectations around motherhood, it also reflected Shields' understandings of her experience, and her confusion when the initial attainment of her dream did not immediately complete her happiness.

Shields (2005) described her struggles, as well as her reflections and confusions about her suffering. "I'd thought we would be undeniably bonded from the moment I laid eyes on her. What was wrong with me?" (p. 71). She reflected on her difficulties both expressing and making understood to others her thoughts and feelings about her suffering: "I felt like a failure, and had tremendous guilt about not feeling close to my baby, but there was no way to explain the situation to anybody" (p. 74). When she did share her confusions and concerns with others, it was often met with dismissal, minimization, or insistent instruction about what she was experiencing and what she should do about it: "How could *you* be depressed, you have it all and are so lucky to have a baby" (p. 144). "I would sometimes get mini-lectures from my mom about how lucky I was to have been blessed with this incredible child and how I was going to be fine" (p. 75). Shields reported that her OB/GYN acknowledged that "there's pressure for women to suppress their feelings, swallow their emotions, and get on with mothering" (p. 137). The OB/GYN diagnosed Shields with "a more acute form of postpartum depression. . . . It's a real affliction, she said, and because for some reason people are hesitant to talk about it, it isn't diagnosed nearly enough" (p. 136).

The mother is expected to perform through the struggles. Shields (2005)

described incidences where, even though she was scared, suffering, or grieving a miscarriage, she felt that she could not show or express those feelings:

The stage manager can tell that something is wrong as I wipe tears from my face, but he has no choice other than to cue the Muppet rock band to file onto the stage and then point at me for my entrance. As they say, the show must go on. (p. 5)

As I came out of my hospital room on the gurney, I saw the scared look in everyone's eyes. I sensed the disappointment and concern in their expressions and wanted to put them at ease. Used to being the one in control and onstage, I felt compelled to be calm and courteous to the waiting well-wishers. . . . So even though my mind was racing . . . I was trying to comfort everyone else. . . . I heard a voice say "Here she comes," as if I were Miss America. I smiled at the absurdity of the comparison. (p. 37)

Shields (2005) represented the expectations of mothers that they sacrifice their own feelings and reactions for the sake of the show—that is for the sake of upholding the image of the ideal mother. Near the end of the book, after she has described and reflected on her journey and suffering, Shields instructed women who identified with her story: "DO NOT WASTE TIME! Get help right away" (p. 223). She also recommended, as she learned from her own experience, "Don't be ashamed and don't disregard what you are feeling" (p. 223).

The importance of understanding and guidance. By contrast, one person who was described as not only offering tangible help, but also hearing and understanding Shields' confusion and suffering, was a baby nurse she hired named Gemma. "[W]hen I told her how I felt disconnected to my daughter, she stopped immediately, tilted her head slightly, and looked right into my eyes" (p. 106). Gemma provided constant support to Shields as she was finding her way as a new mother. She reassured Shields, guided her, and facilitated her growth and transition without taking over the process.

Gemma also acknowledged the difficulties Shields (2005) had experienced during the delivery. “Gemma kept reminding me that having a baby was traumatic, that a C-section was a big deal, and that I needed to be easier on myself” (p. 107). Shields recalled that “Gemma never tried to replace me, but she encouraged the baby and me to become more bonded . . . She didn’t belittle my feelings, and she didn’t act alarmed by my gloomy disclosures” (pp. 106–107).

Shields (2005) was supported and encouraged by Gemma in her developing skills as a mother: “She had a subtle way of instructing and encouraging. She was never overbearing and managed to help me feel like I was in control and handling it all well” (p. 106). “Under Gemma’s calming and nonintrusive tutelage, I had gotten used to doing things a certain way” (p. 121)—indicating that she was learning how to mother her unique child and to become the mother she was in relation to this child.

The mother as object. Difficulties articulating the complex relationship between a mother and her baby were present in all three texts in this study. The solution that was reinforced was for the mother, who was suffering, to get better so that she could care for her child and other family members. As a memoir, Shields (2005) was the subject of her story. Even so, there were several moments in the text where either expectations of her as a mother, or where an emphasis on her diagnosis rather than her experience, made her the object of the story.

Shields’ (2005) story was full of contemporary motherhood beliefs that expected the mother to sacrifice herself and her life for her child. These beliefs included ideas such as that good mothers are sacrificial, and perfect; that they always instinctually know what to do; that they will always expend enormous amounts of energy, time, and resources

towards their always vulnerable and always deserving child; and finally, that a mother is willing do all of this because having a baby, to which she is endlessly devoted, is what defines and completes her as a woman—that the mother’s only need or desire is to fulfill the baby’s needs and desires.

The belief that only a bad mother doesn’t find complete and constant joy in sacrificing her life for her child contributed to Shields’ guilt and confusion. She stated “I had always felt that a baby was the one major thing missing from my life, that a child would complete the picture and bring everything into focus” (Shields, 2005, p. 69). Regarding her dissatisfaction and sadness with mothering, she stated “I hadn’t even told my doctor what I was feeling. It was just too shameful” (Shields, 2005, p. 78).

Following the C-section and emergency surgery, Shields was exhausted and in a great deal of pain. Even so, she was both expected to, and felt that she must, meet all of her daughter’s needs. Immediately after returning to her postpartum room she was encouraged to breastfeed her daughter. While struggling to do so she felt “like I was somehow not performing up to speed as a woman” (p. 51). This insecurity continued into many new aspects of her mothering. “I was failing at things that, according to popular belief, were supposed to be the most natural in a woman’s life. . . . I started strongly believing that I couldn’t be a mother” (pp. 66–67).

Right after the birth Shields and her husband had to contend with keeping a sunlamp paddle on her baby (to treat her jaundice) and changing her in and out of a leg and body harness with each diaper change (due to the baby’s malformed hip sockets). Shields (2005) was immediately overwhelmed:

Over the five days that I was in the hospital with Rowan, I was in a bizarre state of mind, experiencing feelings that ranged from embarrassment to stoicism to melancholy to shock, practically at once. I didn't feel at all joyful. (p. 55)

Shields (2005) recalled: "We were anything but peaceful, and because we were alone, we were overwhelmed" (p. 62). She noticed her own struggle to keep up with her newborn's demands: "I really needed to rest, but we seemed to be in an unrelenting routine of sporadic sleep, baby care, and lots of tears" (p. 67). The disconnection between her expectations and her reality seemed to exacerbate her feelings of inadequacy. "My present reality was the antithesis of everything I had expected, and I was desperate for the connection and pure joy I thought I would have experienced in motherhood" (p. 80).

The importance of the mother's self-reflection. Like many new mothers, Shields (2005) eventually realized that learning a new role and understanding a new relationship, like mothering, takes time, experience, and self-reflection. She also eventually realized that the deeply satisfying aspects of mothering may not happen right away. Shields described how myths about mothering had distorted her own process and experience of becoming a mother. She stated "though I didn't realize it, I was guarding as sacred an idealized version of mother and child" (p. 95).

Shields (2005) reflected on a scene from a movie in which she had played a 15 year old mother who gives birth on a deserted island. Shields recalled that in the movie her character births the baby unattended and "the infant intuitively finds his way to my breast and starts to suck while I look on, smiling" (p. 95). This image of effortless motherhood is not exclusive to the actress who was in that role, but reflected a belief—a false belief—about motherhood. Shields' story is itself a challenge to these false beliefs

about motherhood. Mothers do suffer. Yet there were still limits around the expression of suffering and maternal experience in her story—mothers suffer, but it is a biological disorder, not a moral, political, or relational problem for which understanding is lacking.

Placing two events from the Shields' book next to one another exemplifies the importance of self-reflection. Shields (2005) described events where her physical vulnerability brought her closer to herself and her understandings of her experience. Her first attempt at in vitro fertilization (IVF) ended in a miscarriage:

The moment I got into the house, I started writhing in pain. There was a slow stabbing sensation that came in waves that I imagine were contractions. What followed were the most excruciating six hours I have ever experienced. . . I was in the process of losing a child, and all I could do was wait it out. . . . I stayed in my bed alone, and knew there wasn't anything anyone could do to make it better. (p. 21)

Afterwards, Shields had time and space to reflect on this loss:

The storm had passed and I had weathered it. I didn't feel any self-pity but instead as if I had gone through a terrible rite of passage. I had never endured such a lonely and painful experience; it had aged and matured me. (p. 22)

However, the same opportunity to reflect, that she had had after her first miscarriage, was not available to her later, after the even more difficult traumas of birthing her baby by emergency C-section and her emergency surgery. She recalled that “though I had left the drama of the operating room, I had entered a different kind of mayhem by coming back to my room. Here the real circus began” (p. 48). The necessity of caring for a baby, and the surrounding expectation that she be overjoyed with her baby, interfered with her opportunity to reflect on her losses and to make sense of her experience. She did not have the time or the solitude to be self-reflective, as she had after her miscarriage.

Right after major, emergency surgery, she reported that she felt responsible to manage a room full of relatives, friends, and staff (many of whom, Shields realized, were not necessary to her care, and were only in her room to catch a glimpse of a celebrity's baby). "The flow of traffic was almost unreal. . . . I didn't have the energy to ask people to leave and felt like I would have time to digest it all and relax later" (Shields, 2005, p. 49). After the birth, with her baby sharing her postpartum room, she recalled "I thought the pain would keep me awake at night, but it was impossible to tell because I was up every hour and a half, feeding the little machine I called my daughter" (Shields, 2005, p. 54).

Without time to transition and reflect in the hospital, Shields (2005) described the confusion she felt when she returned home:

As I walked barefoot into our apartment, carrying my newborn, I felt disoriented. When I had left this space five days ago, I was a totally different person. Now, passing through the same doors, I had become a mother, and the world, as I related to it, had entirely changed. (p. 61)

Shields made reference to several impulses she had to escape her situation: "I even thought I'd welcome being kidnapped" (p. 68); "Rather than wanting to care for her, I wanted to forget her and run away" (p. 70); "I considered walking out the front door and never coming back. I could just calmly leave and enjoy my freedom for a while before being discovered wandering upstate . . . I spent time fantasizing about disappearing forever" (p. 90). In part, this reflected Shields' need for solitude to contemplate her experiences and reflect upon her new understandings of herself as a human in the world, with a new little human for whom she was responsible. Unlike the description after her miscarriage, where she could see and integrate the change that had happened to her, after the birth of her baby she was overwhelmed and expected to function. These references to

escape also pointed to her growing awareness of how trapped she was and how her life had irrevocably changed.

Shields (2005) articulated an important observation about her situation. She stated that “depression is a very self-absorbing affliction, and when you are in it, it is so overwhelming that it’s hard to think of anybody else” (p. 201). That is one of the purposes of feeling depressed. It focuses one back on one’s self when that kind of intense, exclusionary focus is needed in order to find one’s way. Near the end of the book, Shields reflected on the necessity of her condition slowing her and almost forcing her to attend to her experience and changes:

Living through those long months after giving birth has given me a deeper appreciation of my daughter than I might have had if the experience had been easier. In addition, because the depression leveled me, I was forced to analyze myself more deeply than I would have ever done by choice. (p. 216)

The slowing of action, analyzing, and appreciating were necessary for Shields to catch up to herself, her experiences, and her new life. It allowed her to come to know who she was as a mother, as someone new, altered, and changed.

Shields (2005) described her growing appreciation of the challenges she had faced, as opposed to the ideals she and others had harbored. She questioned many of the myths of mothering and measured them against the realities of her life.

When I claimed I wanted to be someone’s mother, I didn’t factor in the devastating fatigue, the loss of personal freedom, and the overwhelming fear that are part of being a parent, not to mention the heartache. Chris and I were *responsible* for this new human being we had created. (p. 152)

I am still amazed by how strong societal expectations are . . . 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 either quit completely or act as if nothing has changed. (p. 168)

I continued to talk to my friends who were also parents, and when I recognized how common so many of my concerns were, I felt relieved. . . . Nobody knows what they're doing when they first have kids, and I wasn't going to fail, because it wasn't a test. As long as I tried, I would pass. There was more than one acceptable way to raise children. (p. 204)

The individualist explanation as default position. *Down Came the Rain* is a personal telling of one's story to a larger audience. Of Shields' (2005) purposes in telling her story, two were interpreted by me to be her trying to understand her personal experience, and her wanting to validate other mothers' struggles and to encourage them to get help. Her book served a social need by bringing a previously ignored and poorly understood maternal experience into the public dialogue (Misri & Joe, 2008, p. 65). Even so, the book provided this service within an individualist story of self-realization—what Taylor (1991) called “radical reflexivity” (p. 304)—where Shields' focus was primarily on her own subjective experience. This included a conceptualization of her difficulties as residing within her and the demand that she must overcome her struggles herself:

As I witnessed life continuing all around me, the survival instinct surged through my body, and I thought, Oh my god, I don't want to die. I am not ready to die. I want to live! I felt angry that the people around me were all up and very well. I heard a voice in my head that said, “They can't help you. *You* have to stay alive.” (Shields, 2005, p. 47)

There was a continual tension in Shields' (2005) story between the explanation of her struggles as residing in her physically—specifically her hormones and brain chemistry—and the explanation of her struggles as residing in her knowledge and beliefs. Rarely was it recognized that her struggles were also within her relationships and societal expectations of the mothering role.

Shortly after her baby was born, Shields and her husband decided to relocate from their home in New York City to their home in Los Angeles. Shields recalled her concern

about leaving her baby nurse, Gemma. As she, her husband, and the baby drove away in the cab to the airport, Shields recalled:

I stared out the window and honestly wasn't sure I could do it without Gemma. I explained my fear openly and with a great deal of emotion. . . . Chris looked at me with a slightly worried expression and asked if I had gone off my medicine. (p. 114)

What Shields (2005) continually described in her story was a disorientation—a not knowing who she was, what her values were, or where she fit in—once she became a mother. Taylor (1991) pointed out having answers for these ethical questions is necessary for a coherent sense of self (p. 305). Without an understanding of where one is coming from, or a certainty of where one stands on important issues, it is difficult to react to life circumstances in a way that feels right and good and resonant with one's integrity (Taylor, 1991, pp. 305–306). In other words, it's hard to know what to do and how to fix what is not right:

As I held my five-day-old baby girl in my arms, I looked around the apartment and thought, “Where am I?” It was like being in the Twilight Zone At first I thought what I was feeling was just exhaustion, but with it came an overriding sense of panic that I had never felt before. . . . I started to experience a sick sensation in my stomach; it was as if a vise were tightening around my chest. Instead of the nervous anxiety that often accompanies panic, a feeling of devastation overcame me. I hardly moved. (Shields, 2005, pp. 61–65)

Shields (2005) described the loss of significant aspects of her life, and the grief that, now that she was a mother, those parts of her life were gone forever. She also attributes that loss to her own beliefs:

There was a freedom in performing, and I felt I would never be able to experience it again. I became aware that, as a mother, your priorities get switched, and I felt surprisingly resentful. In my mind, being a mother meant not being able to be onstage. It was an irrational thought, but according to my current state of mind, having a baby commanded an all-or-nothing approach; I didn't believe in the possibility of balance. I wasn't sure I was ready for such an ultimatum. I didn't realize that I was the one who had made it. (p. 93)

In ascribing full responsibility for her career-versus-child ultimatum, Shields (2005) failed to recognize that cultural messages were also influential in establishing that belief. She wondered about this ultimatum: “was I supposed to be defined solely as a mother now that I had a baby?” (p. 99). She also noticed how she was being treated by others, including former professional colleagues. “I started feeling like I no longer mattered. In their eyes, I was no longer an actress; I was now just a mom” (p. 130). This had a profound effect on her. “My senses of identity and self had been markedly unsettled” (p. 131).

Shields (2005) noted that when she began asking other mothers if they had experienced what she had, for the most part she received responses that seemed to criticize her and question her experience. She reported “I wanted to find the community of people who said, “Oh yeah, I felt the same way. Mine was bad, too, but don’t worry, many mothers feel that way. It really will pass” (p. 144). Finding a community of mothers who had shared a similar experience would have provided support for Shields, and would have assisted her in finding her values and orienting her experience in mothering and motherhood. Without some mutual understanding, or when the only understanding of her struggle that is available is an internal conceptualization, a mother is left to conclude that she must be wrong, deficient, or not normal. It creates a suspicion within the mother about her experience and leaves her alone to find her way through it—thereby necessitating an individualist resolution. That is, the mother looks to herself to solve her difficulties.

I interpreted Shields’ resolution to her disorientation as being founded in an individualist belief—the solution residing in her:

Although being a mother is not the only thing I am, it further defines me. I realize I can be a mother and have a career. I think I feared losing myself when I had a child, and the postpartum only made it worse. . . . I may have doubted it before, but I now know that I do deserve to be a mother. Even though I am far from perfect, I am doing my best. (p. 219)

The importance of context. Of the many authors in the three books in this study, Shields (2005) was the only one who mentioned larger political and social events that occurred around her experience of becoming a mother. For example, she described her reactions to the terrorist attacks on September 11, 2001. She was living in New York City while performing in the Broadway production of *Cabaret*. Two days after the attacks she was again performing:

Mayor Rudolph Guiliani wanted Broadway to reopen on Thursday, September 13. *Cabaret* was one of the first shows back on, and it was a sad, sad show. We did the performance for an audience of sixty-eight people as opposed to the thousand who normally filled the seats. After the show was finished, it was quiet. There wasn't even any applause. The audience got to their feet and mouthed the words "Thank you." (p. 12)

The loneliness of this scene reflected a larger lostness within the American culture. It also described a larger version of the societal pressure to keep performing through the suffering. After this show, Shields and some of the other cast members went to Ground Zero together:

After walking through the devastating wreckage together, we started talking about the importance of family and of being surrounded by those you love. I missed my husband terribly and was very scared. All I wanted was to be with him and to start our own family. (Shields, 2005, p. 12)

Shields (2005) described the immediate emotional impact on her of the 9/11 attacks, but did not reflect upon it, specifically, once she had become a mother. Later in the book, she described her work with a psychotherapist. Regarding her therapy, Shields noted that "exploring the issues surrounding motherhood was revelatory and cathartic. . .

. I had time to think, ask questions, and allow my psyche to mull over whatever issues came up” (p. 150). Several questions arose for her in the therapeutic space. Shields asked herself “What kind of mom will I be? Will it be different for me because I’m older? . . . How will I raise a well-adjusted, happy, healthy, and well-behaved little girl?” (p. 151). Shields noted that “one of the issues this therapist helped me examine initially was what it meant to bring a child into the world” (p. 151).

The influence of medical knowledge on the mother’s understanding.

Unlike the other two texts in this study—*Perinatal and Postpartum Mood Disorders* and *Beyond the Blues*—in *Down Came the Rain* the clinicians’ responses to a mother’s struggle were perceived and then repeated by the mother, Shields. This was a text about the mother’s experience and how she viewed the clinicians with whom she worked. Though the clinician’s perspective is present in the text, it primarily presents Shields’ perspective of her situation, which included her understandings of the clinician’s knowledge and role.

Shields (2005) described the effects of being diagnosed with a postpartum mood disorder. In particular, she described conversations with others about her care and treatment that did not lead to understanding, but rather to coercion and directives.

On a flight to L.A., Shields (2005) and her husband met another couple, with whom they were acquainted. As Shields and her husband began to describe her experience postpartum, the wife of the couple disclosed her own previous diagnosis of postpartum depression. She suggested to Shields that she may also be experiencing the same disorder and should get treatment immediately. At the end of the six-hour flight, Shields made an off-handed comment to the other couple about involuntary mental health

treatment for all four of them. She reflected “I meant no disrespect but felt like I was in some kind of intervention and was being forced to admit I had a disease” (p. 117).

During a conversation with her prescribing physician, during which she expressed her desire to discontinue the medication, she reported:

When I finished my little speech, he laughed and said, “Trust me, it’s working” . . . I told him I didn’t want to need it, and he repeated that it wasn’t addictive and that I wouldn’t have to be on it for long. “Let’s be patient,” he said. . . . I wanted to prove to myself that I could get better without help. (p. 113)

Shields (2005) reported that later she did discontinue her medication without informing anyone. She explained “I didn’t even tell Chris, because I knew he would object, and deep down, I did not want to be told to stay on it” (p. 128). Off of her medication and struggling to adjust, a friend extracted a promise from Shields—“she made me swear” (p. 134)—that she would call her physician and report that she had discontinued her medication. Shields reported feeling “like a little kid taking orders” (p. 134).

Shields (2005) described disconcerting feelings about her second baby nurse and so began to spend more time with her infant. Because of this, Shields noticed her growing competency and skills as a mother, and her growing understanding of her daughter:

I wouldn’t leave my baby with the nurse and instead began taking her with me everywhere. . . . [T]he end result was that I surprised myself with my competency. . . . I got used to putting her in the BabyBjorn or the stroller with one hand. It felt like a triumph to be able to navigate the car seat and all of the other things one needs when one has a child. The fact that I was mastering the logistics all by myself made me feel more confident. (p. 121)

As Shields (2005) pointed out her developing confidence in herself as a mother had a significant effect on her beliefs and moods. Though Shields wondered if the

medication contributed to her increased confidence as well as the change in her mood, she also acknowledged that the mood shift and her increasing confidence in her mothering practices coincided:

I was learning to bond with my daughter from the outside in, and although it was a slow process, I felt less hopeless. I don't know if it had anything to do with the fact that, as I'd promised my doctor, I'd been diligently taking that little pink pill, but I was no longer crying morning 'til night. (p. 123)

The helpfulness and limitations of medicalization. There was an important contradiction about her struggles that was expressed by Shields (2005). Though so much of her journey involved encounters and relationships with others, it seemed that Shields, and those around her, located her distress and disorder within her and her brain biochemistry. At times Shields accepted that medicalized and individualized interpretation by concluding that her struggles were a biological disorder located within her: "Now I understand that my severe unhappiness stemmed from a medical condition" (p. 220). "Once it has been properly diagnosed, medicine and therapy can provide much of the desired relief" (p. 139). But, notably, the relief of which she spoke was only relief within her, not relief from structures around her, or necessarily improvement in her relationships. Her conclusion is confusing because in her story, it was the mutual and trusting relationships with others, as well as the space to process her own experiences, thoughts, and feelings and come to know who she was as a mother, within a specific context, that were crucial in learning to navigate her journey successfully:

Nothing could prepare me for the rigors of motherhood. Rowan came without a call sheet or stage directions. Every day I joked about meeting her for the first time, because I felt as if I still didn't really know her. (Shields, 2005, p. 123)

Part of maternal development that Shields (2005) described involved the creativity and curiosity to discover who the unique being one's child is and is becoming, as well as who

the woman is becoming as a mother. The danger of an over-reliance on technical proficiency that a decontextualized, scientific, medical approach supports is that it constricts the space for the mother to develop unique understandings about herself, her child, and their developing relationship.

In the course of her story, Shields (2005) described reading articles and pamphlets about postpartum depression. She felt a sense of recognition when she read about other women describing their feelings and experiences. “I was shocked that these stories related to me and that these women all sounded like sane, competent people” (p. 142). Regarding the stories that others shared with her about their experiences with postpartum depression, she noted that “the most effective aid seemed to come in the form of a pill. That made me feel better about taking the medicine” (p. 146). She also reported that she recognized that she “would have to do more than just swallow a pill . . . I now needed to address healing emotionally” (p. 147), which was the impetus to begin working with a psychotherapist. It appeared that she distinguished between the brain-chemistry, physical mode of healing, in the form of psychotropic medication, and the self-reflective, emotional mode of healing, in the form of psychotherapy. It was possible that the first form of healing may have increased her technical skill in managing her struggles, but the later was what allowed her to develop her understandings of her relationships, her values, and her place as a mother. However, both methods focused on her which encouraged an individualist understanding of her difficulties.

In my attempts to demonstrate how much better I was, I would add facts about how one’s hormones play a role in the illness and quote such statistics as “One out of ten women suffer from postpartum depression” to show that it was much more common than one might think. I needed to prove to everyone that I really wasn’t a bad mother and that I could be trusted. The truth was that I needed to trust myself first, and I wasn’t fully at that point yet. (p. 202)

Though Shields' (2005) book was published three years earlier than Stone and Menken (2008), and five years earlier than Bennett and Indman (2010), Shields used the same diagnostic terms and descriptions as the other two books. She mentioned that she obtained her information from some pamphlets that had been given to her by a friend, an article in *Parents* magazine that had been written by the acquaintance she sat with on her flight from New York City to Los Angeles, and from the National Mental Health Association (pp. 139–140). She distinguished the baby blues “quite common among new moms” from postpartum depression which “lasts longer than two weeks, or starts more than two weeks after giving birth” (p. 142). Neither descriptor took into account the varied experiences and reactions involved when a woman gives birth. Shields noted:

I began trying so hard to make it obvious that I was a good and attentive mother that it was becoming tiring. I had such guilt about having experienced a dark time with my daughter that I wanted to make up for it. It was as if I had committed some crime and needed to preface everything with “Look everybody, look at how rehabilitated I am. I am even better than before.” (pp. 201–202)

Shields (2005) recalled a comment by an acquaintance whose wife had been diagnosed with PPD and supported the use of medication: “Nothin’ wrong with better living through medicine” (p. 136). Though the medical labeling of her struggles, and the fact that it had a treatment protocol, were significant for Shields, it also carried consequences. Medicalizing her suffering engendered doubt about her feelings and reactions, and served to limit and constrict acceptable responses to mothering and motherhood. Though Shields did not elaborate explicitly in her book, she did occasionally acknowledge that there were some things wrong with better living through medicine:

Having a baby is difficult enough; even under ideal circumstances, it is an incredible adjustment. Once you have been given a diagnosis of postpartum depression, it is hard to know whether what you're feeling is "normal." Every time I worried about something regarding Rowan's care or behavior, I wondered whether my thinking was colored by the depression I'd been fighting. Was I okay, or was this the start of another depressive episode? (p. 203)

That Shields rarely described feeling well-supported in developing a sense of herself as a good mother, and a trust in herself and her relationship to her child, was not taken onto account in her assessment. What was important in her recovery was her ability to be self-reflective, think contextually, and develop a relational interpretation of her experience—a lived sense of herself as a mother to her child within her family and community.

There are benefits and problems inherent in using a medical, diagnostic term to categorize struggles. These terms hold meanings for the mother and for those around her that go beyond a diagnosis and treatment. They define whether a mother is good and trustworthy with her baby. How differently might Shields have considered her feelings and experiences if they had been conceptualized the way her baby nurse, Gemma, described them, in ways that contextualized her distress and did not reduce it to an individualist interpretation.

Summary. Shields (2005) provided a first-person perspective of perinatal mood and anxiety disorders. Though in the book she made explicit the losses and struggles that she experienced in the process of becoming a mother, she also described her difficulties in expressing her suffering to others. This difficulty in expression was exacerbated by her own and other's beliefs about mothering and motherhood which included the expectation that she keep up a performance of normality when she felt anything but normal and stable.

Shields (2005) described and reflected on expectations of mothering and motherhood to which she had been exposed both explicitly and implicitly. She described her questioning and development of her values about what constituted a good mother and what practices were right for her and her baby. This included coming to understand herself in relationship to her baby and to others around her. This also included Shields examining what it meant to bring a child into the world that she inhabited; specifically, a world that had been disrupted by the events of her personal life and larger sociopolitical events like the September 11th attacks on New York City. She also described how these expectations, taken out of the context of her birthing experience and her relationship with her daughter, impeded her recovery.

The development of a satisfying relationship with her daughter, facilitated by useful and nurturing support from others, alleviated much of Shields' suffering. Those relationships and her confidence in enacting mothering practices led to a richer sense of understanding about her mothering and the identification of herself as a mother. Shields (2005) attributed much of her relief to her medical treatment, which included medication and psychotherapy.

Shields (2005) accepted a medical interpretation of her suffering. She noted the helpfulness, as well as the limitations, of having a medical diagnosis to define her experience. Her reflections provided an illuminating view into the effects of defining struggles in mothering as a medical problem, including her attempts, once diagnosed with a mental health disorder, to reassure others that she was a good and capable mother.

Some of the benefits that Shields (2005) expressed about defining her struggles as a medical problem included: a clear response and protocol for treatment, the belief that

she would get better, and freedom from self-blame (because what had happened to her was a medical problem that she did not cause, rather than a defect of character). Some of the limitations expressed about defining her struggles as a medical problem included: a separation from her context (by removing the focus from the events around the birth of her daughter and her later adjustment and instead focusing on her biological and hormonal effects on her brain), locating the suffering within the individual mother, and an obscuring of understanding in favor of technical knowledge. These limitations necessitated an individualist response, where Shields had to rely on herself for resolution. This may have been the impetus to write a memoir of her experience—a form of radical reflexivity that served to situate her within an ethical space so that she might come to know who she is and who she has become as a mother.

Summary: Analysis of the Three Texts Together

Having explored each book individually and the themes they presented, I then considered the three books together. I looked for where and how themes were the same or similar, and how they were different. As per Benner's (1994) description of thematic analysis in interpretation, I was looking for the similarities and differences between the books. It was within the shared themes, as well as the differences between books, that the real life practices of mothers and clinicians can be seen.

There were five shared or similar themes that emerged from the exploration of the three texts:

1. Maternal suffering is overlooked, and perinatal mood and anxiety disorders are undertreated.

2. Suffering is reduced to a medicalized disorder located within the mother necessitating an individualist response.
3. The mother is an object whose wellbeing serves others.
4. Perinatal mood and anxiety disorders are universal.
5. The clinician is a rational, concerned expert who brings order to the disordered.

Maternal suffering is overlooked, and perinatal mood and anxiety disorders are undertreated. All three texts (Stone & Menken, 2008; Bennett & Indman, 2010; Shields, 2005) explicitly stated that there was a need to increase awareness of the struggles that mothers experienced. The purpose of each book was to contribute to an increased awareness of these struggles, as well as to guide clinicians and mothers in treating her mood disorder. All of the authors expressed the belief that perinatal mood and anxiety disorders had been overlooked, undertreated, or not talked about enough. The editors of *Perinatal and Postpartum Mood Disorders* described “the long-ignored public health crisis of perinatal mood disorders” (Stone & Menken, 2008, p. xxvii). Bennett and Indman (2010) in *Beyond the Blues* wondered why, when the estimated rate of postpartum depression is 20% and the rate of gestational diabetes is between 1–3%, women are not regularly screened for postpartum depression but they are for gestational diabetes (p. 16). *Down Came the Rain* was praised by Misri and Joe (2008) in *Perinatal and Postpartum Mood Disorders* as a book that “gave this illness [postpartum depression] the validity, legitimacy and the attention it has needed since it was first described by Marcé in 1817” (p. 65).

All three books included a Resources section with listings of organizations, websites, and publications that addressed perinatal mood and anxiety disorders. The reader was encouraged to use them, and if the reader was a clinician who encounters pregnant women or new mothers, she was encouraged to have those resources available to distribute to mothers.

Suffering is reduced to a medicalized disorder located within the mother necessitating an individualist response. In all three books, a biomedical etiology of perinatal mood and anxiety disorders was advanced, and the mother's suffering was addressed as a medical disorder in need of professional treatment. Medication and psychotherapy were the primary treatments advocated for by 25 of the 27 authors in this study (93%). There were some exceptions to that including Kendall-Tackett's (2008) descriptions of complementary and alternative treatments in *Perinatal and Postpartum Mood Disorders* (pp. 107–132) and Honikman's (2008) description of the importance of social support in the prevention and treatment of perinatal mood disorders, in *Perinatal and Postpartum Mood Disorders* (pp. 339–355). Also, Shields (2005) described the benefits to her mood and sense of wellbeing when she was able to begin exercising again following her C-section and the surgery on her ruptured uterus (p. 163) as well as when she felt supported by her baby nurse who gently assured and guided her in the process of becoming a mother and caring for her infant (p. 114). Even so, Shields strongly advocated for medication treatment, as well as acknowledging the benefits of psychotherapy (p. 161).

All of the authors asserted that they were challenging the commonly held belief that mothering was always a happy, blissful time in a mother's life. The challenge to that

belief, however, was not that circumstances or social expectations of mothers were unjust, or the potential cause of their suffering. Rather, the authors' concern was that the false belief that mothering is always a happy time prevented women from disclosing their struggles to clinicians, and therefore interfered with clinicians recognizing and diagnosing disorder: "The notion that impending motherhood is guaranteed to be a wonderful experience often prevents women from reporting accurate symptomatology to their caregivers" (Misri & Joe, 2008, p. 70).

In *Beyond the Blues*, Bennett and Indman (2010) addressed the feelings of loss and grief, as well as the challenges of life transitions, that may come with parenting. However, they covered this in the chapter written for the partners of mothers. The chapter written specifically for mothers, "Women with Perinatal Disorders," primarily addressed symptoms and diagnostic information for a perinatal mood or anxiety disorder. The assumption seemed to be that all members of the family might suffer, but it was the mother who should be most closely watched for symptoms of a disorder.

At the same time, all three books described situations and circumstances that were challenging for mothers. These situations were usually referred to as psychosocial risk factors (Bernstein & Weiss, 2008; Birndorf & Sacks, 2008; Braverman, 2008; Jolley & Spach, 2008, p. 134; Klempler, 2008, pp. 91–92; Menken, 2008; Misri & Joe, 2008). Bennett and Indman (2010) never explicitly used the term psychosocial risk factors, but did list social and interpersonal circumstances in their lists of risk factors for PMADs—such as social isolation or poor support (p. 37). These situations and circumstances were never seen as the primary cause of the mothers' diagnosable disorders but rather as something that could be managed better, or would have less impact, once the mother's

disorder was diagnosed and treated. As such, the mother's mood disorder was considered to be located within the mother herself, not within circumstances or relationships. It was the mother's hormonal vulnerability, her brain chemistry, and her lack of prevention measures which caused her to become disordered.

In *Down Came the Rain*, the dismissal of social and relational factors in favor of a disease and disorder explanation for the mother's suffering was particularly striking. For much of Shields' (2005) story, she described the loss, stressors, and traumas that surrounded her experience of becoming a mother (p. 140). However, Shields concluded that her suffering was due to a "medical condition" (p. 220). Order was established by medicalizing the mother's suffering—that is, by providing a medical diagnosis for her suffering (postpartum depression) and treating it with medication. Shields was both relieved by this diagnosis, it allowed her to name her suffering, and also noticed how it obscured an understanding of her experience: "Was I okay, or was this the start of another depressive episode?" (p. 203).

The belief that the mother's suffering was a medical disorder in need of professional treatment highlighted certain aspects of the mother's experience, notably her physical symptoms and her difficulties functioning. It also presented a means to address the mother's suffering in a medical, pharmacological, or psychotherapeutic way. In other words, it provided a means to treat and cure the mother, but not necessarily to understand her or her situation. In addition, there were no calls for social or structural changes beyond having mothers screened for disease and improving their access to medical treatment.

The emphasis on diagnosing and treating a disorder precluded a full exploration of the mother's experience. This was expressed in *Beyond the Blues* by the directive that mothers who were struggling should look for manualized, therapist-directed practitioners, and to not pursue a form of therapy that may facilitate expressions of deep wounding, injustice, or intolerable conditions:

Research has shown the most effective types of therapy for your condition are cognitive-behavioral and interpersonal. You are experiencing a life crisis; long-term intensive psychoanalysis is not appropriate. . . . Be a good consumer. Shop around until you feel satisfied that you are in capable hands. (Bennett & Indman, 2010, p. 51)

In *Perinatal and Postpartum Mood Disorders*, an example of the emphasis on disease and disorder, rather than the mother's experience, could be found in the chapter that described an interpersonal psychotherapy approach for antepartum depression (Spinelli, 2008, pp. 289–304). The author, Spinelli, noted that interpersonal psychotherapy (IPT) used as its basis for treatment conceptualization the belief that depression is a biological illness, and that IPT was “a problem-focused psychotherapy” (p. 291). Spinelli clarified that in spite of its name “Interpersonal Psychotherapy (IPT),” this form of therapy “does not presume an interpersonal etiology of depression, but highlights the possibility that depression occurs in an interpersonal context” (p. 293). Spinelli acknowledged the many changes and challenges that a new mother may experience, including loss of independence, grief, loss of identity, and fears of illness or death in her or her baby. However, within IPT, practitioners viewed these challenges as “problem areas for treatment” located within the mother, and something that the mother must learn to manage (p. 295).

Though Spinelli (2008) argued that the etiology for disorder lies within the mother, and not within her relationships, the mother's views of her situation were not mentioned in any of the treatment protocols that Spinelli described. In this form of treatment it was the therapist who diagnosed the mother, decided who was suitable for treatment and who was interpersonally significant to the mother, identified the problem areas to be worked on in treatment, and explained to the mother what the mother's role was, as the patient in treatment. In the middle phase of treatment, the mother, as the patient, is "encouraged to give up her sick role" (p. 295)—implying that the mother's distress was a chosen role of sickness and disease, not a genuine expression of her experience. The end of treatment was described as including "movement towards the woman's independent competence" (p. 295), which is contradictory to such a directed, unilateral, and authoritarian form of therapy.

Two excellent examples of the preference given to medical disorder over human experience are the full titles of two of the books: Stone and Menken's (2008) *Perinatal and Postpartum Mood Disorders: Perspectives and Treatment Guide for the Health Care Practitioner* and Bennett and Indman's (2010) *Beyond the Blues: Understanding and Treating Prenatal and Postpartum Depression & Anxiety*. Notable to me about these titles is that the mother is never mentioned as a subject. The disorders, and the health care practitioners who treat these disorders, are mentioned as the foci of the books. The emphasis is placed on the disorders and the professionals who treat them, not on the unique and complex women who present with struggles, losses, disorientation, and challenges.

The mother is an object whose well-being serves others. In all three books the mother was seen as the crucial member of the newly expanded family. Her wellbeing affected those around her. In *Perinatal and Postpartum Mood Disorders* the first three chapters of Part I (75%) focused on the effects of maternal mental health on those around the mother, particularly her children. The authors regularly made the point that if the mother was experiencing a mood disorder, at any time during the perinatal period, her infant would be negatively affected, potentially for several years. It was believed that the mother's vital role in the family was limited to her influence on her children. Therefore, she should be treated, if she is suffering, in order for her to better fulfill that role and have a more positive influence (Stone & Menken, 2008, pp. 60, 243; Bennett & Indman, 2010, pp. 46, 63, 73–79; Shields, 2005, pp. 188–189).

The emphasis on others in the mother's world reflected the belief that the mother's suffering was considered significant primarily because of the impact it had on others. Bennett and Indman (2010) began their section entitled "Consequences of Untreated Mood Disorders" by describing its effects on the struggling mother's children, not the effects of a mood disorder on the woman diagnosed with it. An understanding of the mother-child relationship as a duality, of only containing the mother and the child, not other important figures and influences, contributed to an either/or idea of mothering—either the mother is fully present and the child is taken care of, or the mother is struggling and the child is neglected. That both may struggle together and be taken care of, or that both may be being neglected was not considered.

Shields (2005) articulated her struggles to develop a mutually satisfying relationship with her daughter. This included her growing confidence in her mothering

practices, her awareness of implicit beliefs about what a mother should do and be that were not reasonable or necessary, as well as the opportunity to reflect on her experiences and changes in becoming a mother. She also described how a lack of understanding from those around her necessitated an individualist response to her suffering: “They can’t help you. *You* have to stay alive” (p. 47).

The necessity of an individualist response, during a time when a mother is trying to form a new relationship with her baby, would most likely bring about some sort of split. The complexities and difficulties of maintaining two diametrically opposed ways of being in the world would be overwhelming both to the mother and to her relationship with her child. However, within all three books, the emphasis was not on resolving this split for the mother’s or the relationship’s sake, but rather for the sake of the mother fulfilling her role in the family.

Differences in focus on the mother. Though the authors in all three books advanced the belief that the mother’s primary responsibility for getting better was to fulfill her role of caring for others, it was important to note the difference in the cover images of each book. The cover of *Perinatal and Postpartum Mood Disorders* and the cover of *Beyond the Blues* both show an image of a mother holding a baby. The image on the cover of *Perinatal and Postpartum Mood Disorders* is a photograph of a mother looking down at her baby, who is looking out at the camera. The *Beyond the Blues* cover is a drawing of a mother figure holding a baby. The mother figure is looking out to the side and the baby figure appears nestled in her arm facing her.

The cover of *Down Came the Rain*, by contrast, shows only a close-up profile photograph of Shields. There is a photo of her with her daughter on the inside sleeve

next to the author's bio. This may have been intentional on Shields' part as a way to protect her daughter. She mentioned several times in her memoir that she was conscious of not exposing her daughter to the publicity that she, Shields, endured because of her work as a model and performer. However, Shields' story primarily expressed her personal experience of postpartum depression and described an individualist resolution to her struggles. The subtitle of the book is "My Journey through Postpartum Depression." As such, *Down Came the Rain*, much more so than *Perinatal and Postpartum Mood Disorders* or *Beyond the Blues*, reflected the unique experience of a mother's struggle, challenge, and suffering as an event that specifically affects the mother, rather than something to be treated for the benefit of others.

Perinatal mood and anxiety disorders are universal. Perinatal mood and anxiety disorders were considered to be universal, found everywhere, regardless of the fact that PMADs are Western conceptualizations of illness and disorder (Stone & Menken, 2008, p. 212; Bennett and Indman, 2010, pp. 67, 82; Shields, 2005, p. 220). When studies were described, for whom the subjects were non-white, non-middle class, or non-Western mothers, no background information was referenced about the social, cultural, or historical nature of these mother's experiences. This implied a white, middle class, Western norm against which all mothers were perceived.

There was encouragement for clinicians to become aware of cultural differences in treatment, but only so that clinicians could more effectively utilize Western conceptualizations and treatments of disease on those from diverse backgrounds. The benefits and risks of clinicians treating a non-Western mother for a Western-named mental illness and a Western conceptualization of treatment were never questioned.

Even when discussing mothers from culturally dominant backgrounds, there was no mention of the contexts in which these mothers were developing and forming their mothering practices. This conveyed a generality and timelessness to the experience of perinatal mood and anxiety disorders, rather than an understanding of how certain contexts call for certain responses from mothers.

Shields (2005) mentioned her experiences following the events of September 11, 2001, in New York City. Her descriptions reflected a larger lostness within American culture, and also reinforced the societal pressure to keep performing through the suffering. She did not explicitly reflect on this event or its meanings later after her daughter was born, except to remark that one of the things she reflected on in psychotherapy was “what it meant to bring a child into the world” (p. 26).

A focus on context may have been more likely since Shields’ book is a memoir. However, the absence of context from the other two books conveyed a sense of timelessness and universality to the information around perinatal mood and anxiety disorders that from a hermeneutic perspective could not be warranted.

The clinician is a rational, concerned expert who brings order to the disordered. Each of the three books included authors who were authorities of one type or another, and whose writings presented a sense of professional expertise. *Perinatal and Postpartum Mood Disorders* included authors who were experts in their professional fields, mostly clinicians, but also social service advocates and one attorney. *Beyond the Blues* shared this similarity. The authors, Bennett and Indman, in addition to being clinicians, were also seen as authorities in the field of grassroots perinatal mental health advocacy, and as national speakers on the subject of perinatal mental health.

In a more nuanced way, Shields (2005) also held a position of expertise. Though not a clinician or an expert in perinatal mental health (prior to the publication of her book), she was recognizable to many as a performer and celebrity. As such, she commanded a certain respect and platform to tell her story. If we use as the definition of expert one who is worth listening to and whose voice has been heard, then Shields would fit that definition. As such, she was ascribed power to define what is good and right in our daily practices. This is the case even though celebrities' lives are often quite distinct from the majority of people in this country.

All of the authors presented themselves as advocates for women's perinatal mental health. Their concern for women was noticeable in their writing and practices. They advocated for mothers to get their needs met—including medical, emotional, and physical needs. Mostly, they wanted women to be able to access professional help when they were suffering. In addition, they advocated for the importance of clinicians listening to a mother, and trying to respect her decisions about treatment, as long as the mother was accepting of the diagnosis given to her and complying with the doctor's directives (Stone & Menken, 2008, pp. 108, 203, 245; Bennett & Indman, 2010, pp. 50–51, 76; Shields, 2005, pp. 106–107).

The ways in which mothers who were struggling could be failed by family, clinicians, social systems, and medical and legal institutions were described in each of the books. In *Perinatal and Postpartum Mood Disorders* and *Beyond the Blues*, clinicians were tasked with serving these mothers. This was most often described as the clinicians, caring and concerned professionals, serving as advocates and guides for the mothers. In addition, clinicians were described as rational, scientific experts who detected and

diagnosed mental and emotional disorders and knew the appropriate treatment for the mother. The professionals' knowledge of PMAD's symptoms, risk factors, and presentation, as well as its treatment, was viewed as more important than their understanding of the mother's experience.

In Shields' (2005) story, the clinicians were described as the calm, knowing guides for her journey. They were the ones who named her struggle and advocated for her treatment in the form of medication. It appeared, however, that Shields decided to enter therapy on her own. In addition, her understanding of her journey arose as much from her own reflections on her experiences as from what others told her about what she was experiencing. However, her language and descriptions of PMADs follows the same etiology and conceptualizations as those presented in *Perinatal and Postpartum Mood Disorders* and *Beyond the Blues*.

Clinicians were encouraged and expected to notice a mother's presentation, and quickly and accurately diagnose her with a mood disorder, if applicable, and facilitate her treatment. Universal screening tools were relied on to inform clinicians of what mothers may not be able or willing to share with a clinician. Why the mother may not be disclosing about her experience was only occasionally addressed by the authors. Guilt, shame, denial, and lack of knowledge were identified as reasons that a mother would be hesitant to disclose their struggles (Klempner, 2008, p. 102; Lofrumento, 2008, p. 189). Far more emphasis was placed on the expert obtaining enough information to see that a mother was suffering and diagnose her with a PMAD.

Bennett and Indman (2010) expressed a belief that the clinician was influential enough on the mother that the clinicians "matter-of-fact tone" (p. 82) regarding a

mother's struggles and possible PMAD diagnosis would be enough to reassure a mother and to open her to receiving a diagnosis of a PMAD as an objective and non-judgmental assessment. They also supported the use of formalized and universal screening tools.

The authors all conveyed the belief that they were screening, detecting, and diagnosing mothers out of concern and a wish to help. The main emphasis in all of the books was to diagnose women who were suffering and to get them help quickly. Understanding the mother's complex, and maybe contradictory, experience was not emphasized. In Bennett and Indman (2010), by encouraging women to seek cognitive-behavioral or interpersonal therapy for what was termed a crisis, and to avoid a form of psychotherapy such as intensive psychoanalysis (p. 51), developing an understanding of the complex and contradictory experience the mother may be having, was actively discouraged.

All three texts presented as a belief and a value that mothers who were suffering were emotionally disordered, and in need of treatment to restore order in themselves and their lives. The clinician was viewed as the expert who brings order to the disordered mother. The disordered mother was a mother who did not feel like herself, and it was believed by all of the authors that the administration of a cure and the establishment of order would result in the mother feeling familiar to herself again.

The call for order took the form of certain phrases addressed to the struggling mother in *Beyond the Blues*: "it is important to say them frequently, as if you really mean them . . . *I will recover!* . . . *I am a good mom!*" (Bennett & Indman, 2010, pp. 51–52). The authors conveyed a sense of urgency in addressing the mother's struggles. They consistently instructed health care practitioners to be prepared and to act decisively.

“Have the information in the Resources chapter available for her and her providers” (pp. 93–100).

There was an undercurrent of concern and trepidation about mothering struggles in each of the texts. This was expressed by the sometimes alarmist language used (e.g., Shields’ all-caps “DO NOT WASTE TIME,” p. 223) as well as by the conflation between the more common experience of postpartum depression and the very rare event of infanticide in *Perinatal and Postpartum Mood Disorders* (Chase-Brand, 2008, p. 45). This encouraged a need for rational order, as the underlying fear was the unnecessary loss of life for a baby and possibly the mother. It also indicated two strong beliefs: that professionals were the knowledgeable experts, the holders of scientific (seen as accurate and reliable) information; and that the interventions indicated in the texts would resolve the mother’s suffering, regardless of her situation or context. The professional treatments would restore the mother to health.

Differences in perspectives. One of the differences between the three texts involved the authors’ varying perspectives. The authors in *Perinatal and Postpartum Mood Disorders*—clinicians who have encountered mothers who are suffering—represented the perspective of the professional healer and medical treatment provider. They saw what mothers presented to them, but did not necessarily experience what the mothers were experiencing (or did not say so explicitly).

This was partially the case with *Beyond the Blues*. Though Bennett described her experience as a new mother and the struggles and problems with moods and unhappiness that she encountered, she and Indman wrote the book from the perspectives of clinicians who treated mothers who were struggling. Even so, it was noticeable in *Beyond the*

Blues that the information seemed to come closer to the mother's day-to-day experience. The descriptions had more specificity and directness to them.

Finally, *Down Came the Rain* was written from the perspective of a suffering mother, and provided a more immediate and personal description of her struggles. Her story included descriptions of the confusion, questioning, and eventual development of an understanding of her experience. *Down Came the Rain* contained many more specific, contextual descriptions of Shields' life as a new mother. She provided the perspective on the clinicians who diagnosed and treated her. Which may be why the only time the reader encounters a description of the mother resisting or actively defying treatment recommendations was in *Down Came the Rain*.

Another significant difference between the books had to do with the difference between a narrative that builds in understanding of a story or event (Shields, 2005) and the collection of data and information that the other two texts presented. In *Perinatal and Postpartum Mood Disorders* and in *Beyond the Blues* it was difficult to form an internal image of the mother, or mothers, to whom they alluded in their descriptions or vignettes. The presentations of their case-study mothers were one-dimensional—they had a mood disorder. The focus on symptoms, rather than persons, meant that the clinicians were treating a disorder, a pathology, not a complex, multidimensional human person. It objectified the mother, reducing her to a binary status of “well” or “ill” with the transient status of “recovery” or “in treatment” as the only other dimension.

By contrast, in *Down Came the Rain* several subtle, yet crucial, descriptions of everyday events, and what Shields (2005) observed and felt about them, gave a more complex image of what Shields experienced and understood as a new mother. Shields

noted the invasive feeling of being ascribed a diagnosis for her experience when she reported feeling “like I was in some kind of intervention and being forced to admit I had a disease” (p. 117). The assessment by another person that she was experiencing postpartum depression came after Shields had spent 116 pages of the 226 page book describing the events and her experience before, during and after her daughter’s birth. The person who posited that she may have postpartum depression was another mother who had been diagnosed with the disorder previously, and had spent maybe four or five hours on a plane with Shields, primarily describing her own experience after the birth of her son. It reflected a belief about medical diagnoses—that a person’s complex and unique experience can be quickly and accurately explained if it matches a particular list of symptoms. An understanding of the person’s unique context or situation was considered insignificant. Even so, Shields understood her suffering as being caused by a medical disorder, which was the belief expressed in *Postpartum Mood Disorders* and *Beyond the Blues*.

Down Came the Rain as a paradigm case. In considering all three texts, I realized that *Down Came the Rain* is a paradigm case of how birthing and mothering are described, as well as clinicians’ responses to mothers who struggle. Benner (1994) defined paradigm cases as “strong instances of concerns or ways of being in the world, doing a practice, or taking up a project” (p. 113). As a personal account, Shields (2005) reflected many of the beliefs articulated in the other two books in this study, *Perinatal and Postpartum Mood Disorders* and *Beyond the Blues*. However, rather than describing beliefs about mothers and their struggles, and clinicians’ responses and implicit

understandings, *Down Came the Rain* also described ways in which those beliefs were lived out by Shields and by the clinicians with whom she worked.

The publication itself of a book like *Down Came the Rain* illustrated a solution to one of the main issues expressed in all three books—mothers' suffering is overlooked, and perinatal mood and anxiety disorders are undertreated. *Down Came the Rain* was mentioned in *Perinatal and Postpartum Mood Disorders* as a book “that brought this disorder [postpartum depression] out into the open without stigma, shame, and embarrassment” and that “gave this illness the validity, legitimacy and the attention it has needed since it was first described by Marcé in 1817” (Misri & Joe, 2008, p. 65).

Shields (2005) described her struggles becoming a mother, birthing her child, and adjusting to her role as a mother. She was eventually diagnosed with a perinatal mood disorder (Postpartum Depression) and began a plan of treatment that included medication and psychotherapy. Though there were differences between Shields' book and the other two, as described above, overall her story strongly reflected the values and beliefs articulated in *Perinatal and Postpartum Mood Disorders* and *Beyond the Blues*. These values included the belief that perinatal mood disorders are a medical disorder located within the mother; that it is caused by a new mother's fluctuating hormones; medication helps; the clinicians and health care professionals are experts in identifying, diagnosing and deciding treatment for this disorder; and that the child suffers because of the mother's disorder.

Though at first Shields (2005) resisted the efforts of others to diagnose and treat her, in the end these acquaintances and clinicians were seen as the scientific, rational experts who knew what Shields was experiencing even when Shields herself was

confused or uncertain, or when her experience was as yet unformed. The disordered mother in *Perinatal and Postpartum Mood Disorders* and *Beyond the Blues* was considered cured when she had a restoration of her appreciation for her child and her role as a mother. Though the most effective cure, as Shields articulated “seemed to come in the form of a pill” (p. 146) she also noticed that she felt more connected with her daughter, and more confident as a mother as her depressive symptoms abated. Which intervention or change caused her improvement was unclear to Shields and to the reader.

Shields’ status as a celebrity reinforced the belief that PMADs were a universal disorder—even a beautiful celebrity can suffer from this disorder. Her public status also implicitly supported an extension of the clinical gaze—the sense that all mothers are in the public eye all the time. No one seemed to notice the profound socioeconomic and lifestyle differences between one such as Shields and most other mothers. Shields (2005) made an observation about her celebrity status that may be reflective of mothers within a judgmental environment. She stated:

This is one of the most unnerving aspects of being in the public eye [being hounded by the press when trying to leave the hospital after her daughter’s birth]. No matter how resentful I feel about this perpetual intrusion, I always need to remain calm and in charge. People ask me if I ever get used to the loss of privacy. Even though I have had to deal with it since I was a baby myself, the answer is *no*. My strategy has been to try and find ways to be congenial but not completely vulnerable. (p. 57)

In some ways Shields (2005) seemed to subvert the extension of the clinical gaze by stating out front, in writing, that she was not always in control, that she struggled, that she was a less-than, good-enough mother after her daughter’s birth. But the story was also her journey through, and eventual victory over, the disorder of postpartum depression. It reinforced the optimistic messages in the other texts. That is that if a

struggling mother accepts the medical diagnosis of the scientific, rational expert, and follows the assigned treatment protocol, everything will work out fine.

Discussion

This study is a textual interpretation of three books written about perinatal mood and anxiety disorders (PMADs). The authors of the three books approached the subject of PMADs from the perspectives of psychology, nursing, healthcare, social advocacy, and personal experience. Using a hermeneutic methodology I explored how the challenges and struggles of birthing and mothering were described within these three books. In-depth examination of the texts individually and together indicated repeated, similar descriptions about mothering, and about clinicians' responses to mothers who struggle. These descriptions were organized into themes and supported by exemplars from the texts.

There were five shared themes that emerged from the exploration of the three texts: maternal suffering is overlooked, and perinatal mood and anxiety disorders are undertreated; suffering is reduced to a medicalized disease located within the mother necessitating an individualist response; the mother is an object whose wellbeing serves others; perinatal mood and anxiety disorders are universal; the clinician is a rational, concerned expert who brings order to the disordered.

The themes bring to light taken-for-granted beliefs and convey meanings about struggles in mothering and clinicians' responses and understandings of themselves, their practices, and their sociocultural roles. I interpret the meanings conveyed in the texts as being constitutive of the world and historical time in which they are relevant. The texts point to the practices and social roles that mothers and clinicians are expected to adopt and enact. The practices and social roles reflect understandings of the good in the era in which they emerge. I describe how the current social terrain brings to light these

experiences and ascribes value to what could be called a new way of being, a functional self.

Research Questions Reviewed

Considering the themes that emerged in the three texts, I now return to the research questions in this study to discuss the overall conceptualization of struggles in mothering. The research questions (RQ) that guided my study were:

1. How are the challenges and struggles of birthing and mothering described within these books? (RQ 1)
2. How do clinicians respond to the struggles exhibited in new mothers, and in the process understand themselves, their practices, and their sociocultural role? (RQ 2)
3. What is the historical and social context in which these books arose? What do these books tell us about this historical era and the social terrain that brings to light these experiences? (RQ 3)
4. In what ways are clinicians helped to better understand the mother's experience by the words and diagnostic terms that are used, and in what ways might the words and diagnostic terms cloud the clinicians' understandings of a mother's experience? In what ways are mothers helped to understand their experiences by the words and diagnostic terms that are used, and in what ways might these same words and diagnoses confuse or cloud mothers' understandings of their experience? (RQ 4)

5. Do the beliefs and descriptions of mothers' challenges and struggles presented in these books move women to alter, shape, and manage their behaviors? If so, how does this altering present itself in the clinical setting? (RQ 5)
6. What are some of the taken-for-granted beliefs about the experience of motherhood and the experience of becoming a mother that are represented in the books? What are some of the myths about mothering and motherhood that are challenged, and what are the myths that are reinforced in the books? (RQ 6)
7. In what ways do our current understandings of PMADs exercise power, and whose interests are served by the way the challenges and struggles of mothering are conceptualized? (RQ 7)

Challenges in Mothering Viewed as a Medical Disorder—(RQ 1)

Mothering as a challenging and difficult developmental task was confirmed by the ideas and beliefs expressed in the books. Further, some of these challenges were considered to be indicative of medical disorder located within the biochemistry of the mother. It was believed that this was far more common for mothers than was previously thought. Symptoms that meet the criteria for being a medical disorder in the mother were described as the mother not enjoying motherhood, not functioning well as a mother, or grieving one's former life. Any of these behaviors or feelings that lasted longer than two weeks after birth were considered problematic. At that stage knowledgeable recognition, diagnosis, and clinical intervention were necessary in order for the woman to recover.

Challenges in birthing and mothering were most often seen as disorders located within the mother. The disorders were caused by the mother's unregulated hormones, her

lack of resilience to psychosocial stressors, or her inability to manage adequately her vulnerabilities. The most common manifestations of these disorders were defined as a mother not enjoying her role as a mother, or expressing misery and confusion about her role. The belief was expressed that these disorders were overlooked, ignored, and undertreated. For the sake of mothers, their families, and most importantly their children, early recognition and access to treatment of the mother was thought to be vitally important.

The Clinicians' Role—(RQ 2)

In the texts, clinicians were tasked with not ignoring, overlooking, or minimizing the struggles and suffering that mothers' endure, and to diagnose these struggles as a perinatal mood or anxiety disorder so that the mother can receive effective treatment. Clinicians were to respond to these challenges in mothers by looking for and detecting disorder and treating it promptly and completely. The purpose of intervention and treatment was to restore mothers to their former functional selves and to facilitate their transition into and acceptance of their role as mother. Clinicians were seen as concerned advocates, detectives, diagnosticians, and rational experts who brought order to disorder, thereby relieving suffering. They know they have fulfilled their role when a mother reports that she feels like herself again.

The benefits of medicalizing suffering—(RQ 4). It cannot be overlooked that the ways in which these authors conceptualized maternal suffering has allowed women to receive help. They also emphasized the medical nature of the suffering. The medical terms conveyed in a powerful way that a mother experiences a great deal of suffering and the medical perspective granted her suffering legitimacy. By receiving a medical

diagnosis, mothers also received help for a situation that has been overlooked and responded to inadequately. Viewed as a medical disorder that can be cured, resources can be found and advocated for, credence is given to her suffering, and clinicians are thought to be able to create protocols in order to assure a successful response in the mother.

Preference given to knowledge over understanding—(RQ 4). It is important to consider the difference between what was described in the texts as knowledge and curing, and what mothers may be seeking, which is understanding (Barr, 2008; Humphries & McDonald, 2012; Wong & Bell, 2012). Becoming a mother involves a dramatic reinterpretation and evaluation of one's values, beliefs, and meanings in life. It is difficult, if not impossible, for one who enters into this role to remain unchanged by it. F. C. Richardson (2005) noted that “if we think of psychotherapy as a kind of applied science, it is not going to be of much help to individuals who are faced with moral or existential questions concerning their lives and choices” (p. 19).

Women who become mothers, like all humans, are complex beings who live with contradiction. Gadamer (1996) noted that, “the human being is not only a natural object. Rather, each of us is, in a mysterious way, unknown both to ourselves and to others” (p. 164). Becoming a mother is a significant, life-changing shift of all aspects of a woman's world. It involves questions and reconsiderations of her values, her time, her resources as well as existential concerns about life and death. Essentially, a mother must become philosophically minded and engaged with issues of human existence and meaning. This is an enormous task:

If philosophy is an attempt to understand the incomprehensible, an attempt to take up the major human questions to which the religions, the world of myth, poetry,

art and culture all offer responses, then it must encompass the mystery of the beginning and the end, of being and nothing, of birth and death, and, above all, of good and evil. These are enigmatic questions which do not appear to have any answer that would constitute “knowledge.” (Gadamer, 1996, p. 167)

All three texts reduced the complex experiences and values inherent in mothering one’s children, including the struggles one experiences in developing a moral and useful way of being a mother, into either disorder or wellness. This privileges functionality and action over contemplation and reflection. It also advances moral beliefs about what it means to be a good mother (i.e., functional, easily transitioning into the role), and what it means to be a bad mother (i.e., one who puts her children at risk by not functioning and not enjoying her role). Particularly deceptive was how the authors claimed that having a PMAD does not make one a bad mother, while still advancing the distinctions between functioning and not functioning, equating not functioning with pathology.

Mothers Altering, Shaping, and Managing Behaviors—(RQ 5)

Women are moved to alter and manage their presentation to the clinician because of the way in which their suffering and therefore the way in which good and bad mothering are conveyed by the diagnostic terms used.

The texts in this study acknowledged that mothers do not readily share their difficulties with clinicians. Guilt and shame were mentioned as possible reasons for such reticence, but the conceptualization of PMADs as disorders within the mother, and the values that medicalized view conveyed, were never questioned by the authors. Wong’s (2012) description of the “mother’s panopticon” (p. 8) described how the clinical values of what constitutes a good or bad mother can be extended into the mother’s daily experience and judgments of her own mothering. In the texts there was no recognition given to the idea that the mothers may be responding or presenting in a certain way

because their situations, or the demands on them, were unreasonable and impossible to obtain. Mothers only received support if they accepted the description of their struggles as a diagnosable disorder and adhered to a specific and unilateral treatment regime.

Shields (2005) noted that she had never gotten used to the loss of privacy that her life had required, even though she had had to manage it since she was young. She stated “My strategy has been to try and find ways to be congenial but not completely vulnerable” (p. 57). This tension, between congeniality and minimal vulnerability, is an excellent description of a way of managing the “mother’s panopticon” (Wong, 2012, p. 8) within which mothers are constantly feeling under surveillance and judged. In addition, the beliefs Shields expressed about mothering and motherhood—that the success of a pregnancy rests only with the mother, that she will adjust effortlessly to mothering, that a traumatic birth should not impede mothering tasks—can only be believed if the mother is seen as invulnerable.

Taken-for-Granted Beliefs About Mothering and Motherhood—(RQ 6)

An unhappy mother is an ill mother. The taken-for-granted beliefs about the experience of motherhood and the experience of becoming a mother that are represented in the texts included the belief that mothers naturally enjoy all of the practices of mothering, and that not liking the practices of mothering was the same as not liking one’s child. Similarly, to not be fulfilled by mothering, or to grieve her former independent life, meant that the mother was not, or would not become, a good mother, or may have a mood disorder. It was assumed that all mothers have access to the resources needed to feel fulfilled and competent as mothers, even if they lacked access to PMAD treatment. There was no discussion of financial, societal, or racial issues that impeded a mother’s

ability to provide for her child. Finally, I interpreted the descriptions in the texts to mean that there is little grey area between a mother who is happy mothering and one with a mood disorder.

The mother's biology, not her circumstances, causes her disorder. The assumption was that mothers struggle and suffer because of biological or hormonal imbalances. The social and interpersonal was not as influential in the mother's development as was the physical and biological. However, as Sugarman and Martin (2005) pointed out:

[I]t is a mistake to equate human actions and experiences with those neurophysiological, chemical, and biological phenomena they require. Psychological development would be impossible without the embeddedness of biological individuals in sociocultural contexts and practices. To think otherwise is like attempting to explain the behavior of baseball players without reference to the rules, regulations, and conventions of the game. (p. 260)

Similar to Sugarman and Martin's (2005) baseball analogy, the prevailing biological view of PMADs attempts to explain mothers' emotions and behaviors without exploring and critiquing the sometimes oppressive, confusing, and isolating norms of contemporary motherhood expectations.

The focus on mental or emotional disorder precludes an articulation of what is considered normative experience, possibly as insidious, archaic notions of motherhood become the unexamined acceptable ideals of mothering and motherhood. In this case, researchers and clinicians risk pathologizing the everyday social, practical, personal, and relational struggles that mothers experience as they move into their new role.

Chrisler and Johnston-Robledo's (2002) feminist critique of the concept of PPD as a strictly hormonal illness, as well as the medicalization of women's struggles, included the insights that the diagnosis of PPD is:

Defined vaguely, which encourages . . . overuse; represents women's behavior as erratic and potentially dangerous to self and others, have been absorbed into Western (perhaps especially North American) culture as stereotypic caricatures of women; and serve as a form of social control that tells women that some of their emotions are inappropriate, thus silencing them from speaking out about the oppressive conditions of their lives. (p. 174)

Conceptualizations of PMADS as the Exercise of Power—(RQ 7)

By conceptualizing PMADs as a biomedical disorder located within the woman that can be treated by medical, pharmacological, and psychological treatments, clinicians and prescribers benefit. They become the source of expertise and cure on whom the mother, because she is disordered, must rely. This conceptualization also diminishes the mother's power to describe and define her experience. The often heard remark at PSI conferences "Most women don't know what they have until we diagnose them" (B. Meyer, personal communication, September 16, 2011) lacks the understanding of how naming and defining experience allows psychological and medical clinicians to exert power. Literally and figuratively description is prescription in the field of perinatal mental health. Clinicians describe, detect, and diagnose mothers' experiences, thereby limiting the discourse about maternal experience and defining aspects of good or acceptable motherhood.

The authors of these three texts do not see their practices as exercising power, or if they do, the power is seen as being in service to the women for whom they care. They believe that the conceptualization of PMADs as disorders that are located in the mother benefits mothers who are struggling by directing care and resources for them. They see this way of understanding struggles in mothering as benefitting first and foremost the mothers who are suffering. By enacting these models of disorder and treatment they see themselves as not failing mothers.

In many ways the work of clinicians in the perinatal mental health field, as well as grassroots organizations such as Postpartum Support International, are benefitting mothers. They have been instrumental in addressing suffering that has long gone unnoticed and ignored. However, to not realize how the conceptualization that they advance also benefits their interests as professionals undercuts the emancipation they seek for mothers. Professionals and clinicians become the arbiters of what is acceptable in mothering. The mothers themselves, who may have hesitations or questions about what they are expected to do, or how they are expected to feel about their life and role, have less of a voice in the experts' discourse on mothering.

Social, political, and economic structures that are based on the power given to paternalism and misogyny also benefit from a conceptualization of struggles in mothering as being a result of biochemical vulnerabilities located within the mother. This conceptualization deems as suspect women who reject aspects of the mothering role that they find unnecessarily burdensome or in contradiction to their developing values and understandings of themselves and their children. By designating women's resistance and questioning of social norms as disease and disorder, women are denied permission, space, and time to challenge those structures and norms that impede the nurturing of their children or that may be a threat to the survival of themselves and their children. By demanding that mothers constantly do for others, opportunities for self-reflection and contemplation of their transition is blocked. Without those opportunities it becomes difficult for mothers to develop understandings of themselves, their children, and their situations that are a good fit with their social environment and their developing

understandings of their changed role within that environment. This would allow them to see themselves as connected, relational, potent, and powerful.

Individualism—(RQ 1, RQ 3)

This is a particularly difficult era for mothers. No longer as well connected to extended families or to traditions in parenting and childrearing as in eras past, contemporary mothers, on their own, must continually think, decide, and act to care for themselves and their children (Ruddick, 1989/1995). However, as F. C. Richardson (2005) noted, “our distinctive modern emphasis on personal inwardness and inward depths . . . tends to leave us deeply disconnected from one another and the social world” (p. 27).

The dilemmas of the isolated, individual mother and child. The texts in this study reflected an isolated individualism, where the disorder was located in the mother, leading to a reliance on the individual to resolve her internal problem. The resolution would often necessitate the guidance of experts to correct the disordered individual and return her to functioning adequately in her unquestioned role.

But the ideology of self-contained individualism brings still more complications. An emphasis on individualism places the mother in conflict with her role of protecting, nurturing, and guiding her child, a role that will call for mutuality, and at times, for her to sacrifice her desires to the needs of her child. The mother must also be connected to her children and to a common understanding of values and moral goods.

F. C. Richardson (2005) referred to a social and relational disconnection as a:

subject-object ontology. . . . This approach makes people the responsible center of their own moral universe. But it also risks emotional isolation and debilitating alienation by significantly downplaying lasting social ties, a sense of tradition, or wider purposes beyond individual self-realization. (p. 27)

For the mother and child relationship, this pervasive individualism or subject-object ontology, leaves little room or opening for the give and take relationship between the mother and her child. It becomes either the mother for the child, or the child providing for the mother—what Benjamin (2004) described as “doer and done to” (p. 5) relationships. F. C. Richardson (2005) warned “ontological individualism’s view of things runs a high risk of deteriorating into an amoral clash of will against will, power against power” (p. 29). Parents and childcare providers understand that this clash of wills is as possible with a child as it is between fully grown adults. At its most extreme, we see how this might result in infanticide or maternal despair and suicide. The value placed on individualism requires that a mother both increasingly move towards autonomy (Kirschner, 2005, p. 272) while also encouraging the independence and autonomy of her child. This leaves little room for what Benjamin (1995) described as the pleasure that arises from the mutual recognition between mother and child, the eliciting of a response that allows both to be subjects (p. 46).

The slow eroding of women’s rights in recent decades—the loss of professional and economic protection while pregnant, the loss of access to determine when and how to become pregnant, and the loss of real, significant support and safety nets for families—is obscured by the ideology that looks solely to the individual woman or mother to function in her roles, heal herself, and find her way to a mothering relationship with her child that is satisfying for her, and satisfying and promoting of her child.

The greatest risk that individualism poses within the field of perinatal mental health is that a mother’s suffering becomes only a problem for her and her clinician to solve, not a problem that needs to be considered socially and politically. As Nicholson

(1998) noted, the resources with which most women have to mother will make them ill. Excessive or exclusive focus on the individual mother blocks the discussion of social and political changes that could lessen the burden on mothers.

The mother's relationship to and responsibilities for her infant are complicated concepts that may have been difficult to navigate in such a short, directive, and concise book like *Beyond the Blues* or in such a technical book as *Perinatal and Postpartum Mood Disorders*. A mother becomes a mother by taking on the responsibility to care and nurture another more vulnerable being. As Sara Ruddick (1989/1995) noted, "The concept of 'mother' depends on that of 'child,' a creature considered to be of value and in need of protection" (p. 22). However, the cultural variations in which that responsibility has been enacted are numerous and largely dependent on the norms and values of the mother's and child's historical time and social environment (Apple & Golden, 1997; Coontz, 2000; hooks, 1984/2007; Ruddick, 1989/1995).

Benjamin (2004) noted that relationships, such as a mother-child relationship, are often believed to result in an either/or duality, in which the mother either gives in completely to the child's demands, or resists them to the child's detriment. Benjamin noted the importance of a shared way of being that she called the "usable third" (p. 13). The mother, or other primary caregiver, "must create that space by being able to hold in tension her subjectivity/desire/awareness and the needs of the child" (p. 13). The authors in the three texts, by privileging the mother's role in caring for others as a sign of health, flattened the interaction into an exchange of the mother for others, rather than a tension that the mother learns to manage.

In discussing mothers' expressions of not being good enough, Benjamin (2011) connected that belief to "a profound sense that in our unsafe society children can never be protected or given enough to make them safe" (p. 28). Given that protecting one's child is an essential task of mothering, in an unsafe world, and in particular in an unsafe world where traumas and fears are readily shared and experienced thanks to electronic and social media, a mother may be significantly challenged in ever feeling as though she has or could accomplish that task. She will forever feel on the verge of failure. Benjamin challenged the belief that women should believe that they can always protect their children in an unsafe world: "The question is not why women as mothers can't get a grip but why they think they should have one, and such an omnipotent and perfect one as that?" (Benjamin, 2011, p. 28).

The clinician's role as enacting individualism. The ideal of the all-powerful mother, who predicts, secures, and protects was reflected in the ways clinicians understood their roles towards mothers. The clinician as advocate, guide, expert, detective, diagnostician and one who brings order, is reflective of the mythology around mothers and mothering, and is equally fraught with impossibility and failure. But the cost of that failure in maternal suicide or infanticide is horrific for most humans to contemplate. The fear of clinicians that they will fail mothers who are struggling compels a directed, almost rigid, response.

The mother-child relationship as a social role. Fowers (2005) described virtue ethics as originating in "the essentially social nature of humans who are born into and live within ongoing communities" (p. 44). His reference to Aristotle's idea of "flourishing" (p. 43) sounds like what Shields described as she grew in her mothering

relationship with her daughter, and what I interpret the authors in *Perinatal and Postpartum Mood Disorders* and *Beyond the Blues*, mean when they describe women feeling like themselves again and fulfilled by their mothering roles.

We find [Fowers explained] what is good neither in an ethereal, otherworldly experience nor in pleasures taken as a reward for and respite from ordinary tasks. Flourishing is thoroughly intertwined with our everyday lives, with our work and our leisure, our personal relationships and our public involvements. Virtue ethics focuses on *how* we participate in ordinary affairs, and those activities form an interrelated whole. We find what is good by exercising our full capacities in meaningful activity toward worthwhile aims and in the pleasure we take in that exercise and its ends. Thus, human excellence emerges in the exemplary exercise of natural human capacities. (Fowers, 2005, p. 43)

Motherhood is clearly an institution that seems to be both constantly forming, and held by, tradition and beliefs. How mothering is understood will depend on what can be viewed within the cultural clearing. New mothers report that it is helpful to observe other mothers in the practice of raising their children, both to increase their own understanding of their new maternal role, and to normalize their feelings of incompetence and confusion as they adjust to this role (Barclay et al., 1997; Nelson, 2003). What these new mothers grasp is that there are implicit and explicit social understandings about mothering. To fully understand themselves as mothers, they must not only consult experts but also observe those in their community who currently manifest competency in this role. Specifically, they need to see how other, more experienced mothers enact their daily practices in meaningful ways, for the worthwhile benefit of nurturing and protecting their offspring. In so doing, the mother is also exercising her full capacity as a whole being, not simply serving the needs of her child.

The Functional Self—(RQ 3, RQ 7)

Considering the three texts together, ways of being for the clinician and the mother are highlighted. The clinician in the three texts comes to light as an informed, caring and rational technician; the holder of expert knowledge; and an advocate who knows, better than the mother, what the mother needs in order to be more ordered rather than disordered. In the three texts the mother comes to light as the passive recipient of medical intervention and remedy. She is an impersonal, confused, chaotic, physiologically fragile threat to the wellbeing and functioning of her child and family. Her problems are biologically-based and simplistic enough that if the medical disorder is screened for, diagnosed, and treated, then she will get better. She is presented as, immediately or eventually, willingly accepting any help, advice, or guidance that the clinician offers to her, and appreciating it as the way back to herself. The mother's threat to her child is emphasized while other, larger threats to communal and social wellbeing are ignored. A correction of her thinking, beliefs, or physiology (via medication) will return her to herself—the cheery, functioning, willing nurturer of others. The others become her life, and she feels like herself again.

Within these texts, the self of this era comes to light as, above all, what might be called a functional self. This is reflected both in the demands that the mother seamlessly transition into her role of mothering without disruption, confusion, or hesitation, and in the way that clinicians understand their role, which is to respond to mothers knowledgeably, effectively and actively lest they fail in their response to mothers. The functional self is recognized by its activity. The self of this era does not exhibit functioning in contemplation or by wondering about and questioning that which she is

called to do. Rather, she functions by performing her roles, by doing. The functional self does not respond with confusion, or by accepting that humans are not fully knowable. Further, fully understanding the person is not necessary so long as failures in functioning can be fixed. What those failures or gaps in doing may indicate or mean, what purpose they may serve to the person or the clinician, are not considered important. To not act with alacrity is considered a failure.

The functional self that is reflected in the three texts shares characteristics with Cushman and Gilford's (1999) description of the "multiple self" which can shift seamlessly and effortlessly from one personal subjectivity to another (p. 22), for example from single individual to pregnant to mothering. In the case of the clinician it is reflected by the rapidity of detection, diagnosis, and treatment without much regard for the complexity of the mother and her situation: "Grappling with the fundamental questions, such as who one is and what is meaningful, seems increasingly replaced with a can-do, don't think too hard ahistorical, superficial, keep-moving mentality" (Cushman & Gilford, 1999, p. 28).

In this understanding of the self, periods of depression, of not functioning, can be seen as a form of resistance to that which demands, if not thoughtless actions, action that doesn't require close consideration. This valuing of functionality, of doing and fulfilling one's role, reinforces powerful discourses of demanding and intensive mothering practices (Caplan, 2012; Hays, 1996; O'Reilly, 2010; Wong, 2012). In this environment, the mother is subject to demands that she always provide for, always be content in her role, and always give to her child.

Given the expectations of mothers in an era where the performing, functional self is valued, resistance to that moral value could come to light as depression, worry about the result of one's actions, or despair at ever doing enough and therefore being enough. This same resistance could create conflict for mothers who exist in an era that values their functionality and yet are not convinced that what they are doing is right, matters, or is in keeping with the values they are exploring and discovering as mothers. Most notably, an exclusive focus on functionality puts a mother in direct conflict with her child, who is anything but a promoter of functional behavior. Whatever a mother achieved or did before she became a mother will be significantly challenged after the child is born by an as yet unsocialized, dependent, unscheduled, and unpredictable infant.

Though both Bennett and Indman (2010) and Shields (2005) described traumatic, unexpected birth experiences, there was little reflection on what that might mean for a new mother, especially what it might mean for a new mother in an era that values functionality, to experience such a messy and non-functional delivery that required outside medical intervention. The mothers in these cases failed as individualists and failed in their functioning by not birthing their children themselves. These two failures would have violated the values of the era, the moral good that demands that one find the solution to maintain functioning within themselves. The resolution of this failure is found by locating the failure within the mother, yet separate from her conscious choice, by attributing her reaction to her hormones or brain chemistry. The mother then is offered an opportunity to resolve the failure of individualism and functioning by fixing herself through medication and psychotherapy so that she can again function in her role as mother.

Summary

Though the field of Maternal Theory has given a platform for expressions of the divergent contexts and experiences of motherhood (O'Reilly, 2007), few North American authors in psychology have explored the varied cultural and historical contexts from which struggling mothers, and the clinicians who encounter them, draw their language, meanings, and definitions. The lack of historical context in psychological research can create gaps in psychological understanding which can insidiously reinforce misunderstanding, oppression, and pain. Nicolson (1998) offered this critique:

Psychology as an academic discipline ignores women's lives and fails to take gender seriously as a focus for analyzing human behavior beyond a crude variable to identify sex differences. Even so, psychology has much to say about women, what they should be like and particularly where they fail. (p. 109)

Though writing more than a decade and a half ago, Nicolson's observation of psychology's tendency to ignore women's lives except to prescribe behavior and assign failure and blame is a warning to be heeded in the field of perinatal mental health. It is crucial that the women who seek help for struggles and challenges about birthing and mothering are listened to and understood, particularly when their presentations challenge our beliefs and understandings. We help our clients when we realize the limits of our expertise, especially when we realize that our expertise is granted to us by the norms and values of our historical time. Clinicians must also critically explore how accepted, taken-for-granted beliefs about their roles and their practices may reflect historical norms rather than putative universal, objective facts. Without critical examination, psychologists risk recreating the same dynamics and structures that oppress and depress the mothers they are attempting to help.

As grassroots organizations and PMADs researchers work diligently to reach out to mothers who are suffering and provide them with treatment, it is possible that hidden assumptions and taken-for-granted beliefs about mothering and motherhood might conceal injustice and the oppression of mothers behind sanitized, medicalized treatment. Rather than confronting political and social norms that serve to oppress mothers, a medicalized conceptualization of perinatal mood and anxiety disorders looks no further than the mother—her hormones, her fragile physiology, her inability to manage stressors—as the cause of her suffering. This places the burden of resolution on the individual women themselves and excuses the larger society from its moral and political responsibilities to women and children. This happens not in spite of, but rather because clinicians are acting upon what they believe is morally good and right—to screen, detect, diagnose and treat.

Limitations of the Study

Limits of time prevented me from interpreting every, or even most, books that have been written about PMADs. Instead, I have selected books that were reflective of the mainstream and most broadly held views of PMADs—their etiology, treatment, and meaning. That meant, however, that other views of the experience of maternal struggles and the responses of clinicians have been excluded. Though this interpretation may represent the view of the dominant cultural narrative, it also risks reinforcing that view by privileging these writings over others. In addition, it excludes voices in the mothering literature that challenge dominant beliefs and indicate other ways of approaching the experience of mothering struggles.

Similar to criticisms of the feminist writings of the 1960s and 70s, much of the PPD and PMAD literature uses as its standard subject the white, heterosexual, middle-class female—demographics that also describe me. Given the impossibility of disengaging from one's own historical and social context, this study is also embedded in my context. My hope and intention is to make explicit what is assumed or taken-for-granted in these texts so that windows of questioning and insight may be opened. This could lead to considerations of what other women in other circumstances experience.

The dualistic approach to understanding is so prevalent in this historical time, that it was present even in a study which sought to interpret and explore understandings, rather than to enforce either/or ideals of knowledge. As a researcher embedded in this historical time, it took all of my concentration and focus to remain open. That was not always possible. In the end, I hope my efforts shed light on the taken-for-granted ways of viewing struggles in mothering and in doing so challenge the culturally dominant narrative of mothering and motherhood.

Implications for Future Research

Given the challenges and limitations of expressing beliefs and ideas in writing, it would be helpful to engage clinicians in interviews or dialogues which may allow them to express their questioning, uncertainty, and growing awareness of the complexity of PMADs that may be missed in their writing. In addition, it would be useful to explore books on maternal experience written by non-clinicians to see how beliefs about struggles and challenges in mothering are reflected in those texts. Similarly, asking mothers how they navigate challenges in mothering using social or communal, as opposed to medical or clinical, solutions could further our understandings of the maternal experience.

Conclusion

In this study I explored three texts on perinatal mood and anxiety disorders—*Perinatal and Postpartum Mood Disorders: Perspectives and Treatment Guide for the Health Care Practitioner*, *Beyond the Blues: Understanding and Treating Prenatal and Postpartum Depression & Anxiety*, and *Down Came the Rain: My Journey Through Postpartum Depression*. I looked for themes and patterns in the descriptions of birthing and mothering and in clinicians' responses to struggles in mothering. I considered what the clinicians' responses indicated about their understandings of their patients, themselves, their practices, and their sociocultural roles. Finally, I looked for what these themes expressed about the current social terrain that brings these experiences to light. I described a prominent way of being in our era as a functional self that is recognized by actively fulfilling roles and is expected to easily and happily transition from one way of knowing and experiencing to another.

My interpretation will be considered valid if mothers and clinicians recognize some of their practices and meanings within this interpretation, and understand them in a new or deeper way—as taken-for-granted historical beliefs rather than the one, universal truth about mothers (see Stigliano, 1989, p. 62). Though the field of perinatal mental health has contributed significantly to maternal wellbeing, it is also a practice that must be explored and critiqued if it is to keep from reinforcing oppressive mothering norms. My hope for this study is that it adds to the conversation about mothers, their struggles, and clinicians' responses to these women.

To become a mother, to take on the task, and discovery, and joy of nurturing another complex human being into adulthood will necessarily ask for a dramatic and

complex adjustment of the mother, and new understandings of herself as well. How a mother moves from who she knew herself to be before, to who she must become involves complex transitions and unknowns. This is treacherous territory, taken on in a precarious historical time with an unpredictable future for the mother, her child and her grandchildren. It is no wonder that a value of functionality would come to light at this time as a necessary attribute for good mothering. So much is at stake. Yet the way through the difficulties of this time may lie in broader and more contextual understandings and knowing of relationship and a shared good. These principles could guide our nurturance of the next generation, while enriching the lives of the women who mother.

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