Commentary

A feminist science commentary: a socially cognizant analysis of postpartum depression in the Western world

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Abstract

In Western and Eurocentric literature, postpartum depression (PPD) has been explored through medical and psychosocial lenses highlighting the inextricable social nature of the illness experience. Using a feminist theory analysis lens, this paper urges for critical consideration of the social requirements and cultural expectations that the mother and newborn exist within. This analysis explores the medicalization of childbirth, the conception of flawless motherhood, and the perceived deviance from feminine gender scripts as prudent risk factors to consider in the development of PPD. The medicalization of childbirth is characterized with rigidity, loss of maternal agency, and an external locus of control compounded by system strain. Widespread, Western constructs of maternal perfection and excellence create a dissonance for new mothers between idealistic motherhood and experienced reality, generating low maternal esteem and isolation. Finally, depression experienced amidst motherhood has been considered deviant from the classic, Western feminine gender script, generating maternal shame and guilt. The feminist analysis of PPD lends itself towards a socially cognizant analysis that acknowledges social priorities and expectations that leave new mothers suffering in isolation.

The feminist science school of thought

Western society reveres sciences to a culturally pure standard – yet, science remains a human endeavour and humans are inherently biased.[1-5] The concept of "westernized" used in this exploration hereafter refers to a white, Eurocentric way of thought involving binarized and androcentric outlooks.[1-5] Indeed, westernized science is not morally excellent and elite as its human innovators are not impervious to error, cultural stereotypes, and political agendas.[2-5] It becomes easy to participate as a consumer of scientific knowledge that perpetuates androcentric and cis-normative stereotypes.[1-5] As such, science knowledge can become a locus of gender inequality by continuing to ask questions, analyze patterns, and develop conclusions rooted in Eurocentrism, androcentrism, and binarism.[2-5] To explain, scientific priorities are aligned with what society deems as important and worthy of investigation…there was a time when the female body was not considered relevant.[2-5] If there is a perception that female bodies are objects, complex, messy, inferior, or problematic, this rhetoric seeps into science knowledge pursuits, which only perpetuates their disregard in literature.[5,6] Thus, feminine gender scripts and expectations are undeniably at the core of how we choose to respond to the feminine body.[1-5,7] When responding to the feminine body through science and medicine, feminist theory urges the consideration of structural, cultural, and sociological conditions that contribute to feminine distress.[4,6] By no means am I arguing for a gynocentric science, but rather a socially cognizant science.[1-6] By including social constructs, expectations, and behaviours in the analysis of disease, it will propel a richer and fundamentally better understanding of humanity.[1-6]

Western culture, feminist theory, and postpartum depression

A social and cultural rhetoric is imperative in the analysis of postpartum depression (PPD).[8] Westernized medical models have established PPD as a depression with onset occurring within 1 year of childbirth.[9-11] New parents can experience anhedonia, changes in appetite, sleep disruptions, fatigue, diminished self-esteem, suicidality, and indecisiveness.[9-11] Having a parent afflicted with PPD can affect familial stability, maternal health, paternal health, the child's developmental milestones, and the child's mental health later in life.[9-11] This demonstrates the gravity of the disorder.

The etiology of maternal PPD remains ambiguous; recent science has propelled exploration into biological phenomena and hormonal imbalances that explain the PPD context.[9,12,13] This innovation has generated several causational biological hypotheses, and given the nuance and complexity, they will not be reviewed in this paper.[9,12,13] While biological contributions are imperative in causal analysis, a solely biological focus medicalizes the approach to PPD, emphasizing it as a treatable phenomenon.[13,14] Indeed, it fundamentally focuses on a mother's inner biological workings and rhythms.[13,14] By no means does this commentary aim to minimize these aforementioned contributing factors. As the psychosocial literature has endeavoured, a complementary social rhetoric to the biological reductionism is necessary. The examination of PPD requires an analysis of the world

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the mother and newborn child exist within, along with its social requirements and cultural practises – of which the feminist school of thought lends itself nicely.[15] Why? Science, disorders, and medicine occur within a society, and therefore, they are not culturally neutral… there is no isolated biological vacuum.[15]

I want to sincerely acknowledge the progress the medical and allied health community has made in approaches to PPD, such that current clinical support considers social determinants and cultural factors in the causal and healing pathways.[13-15] This represents a shift from the historic paternalistic and reductionist approaches.[13-15] Yet, more work must be done to advocate for a science that prioritizes cultural and social constructs that contribute to physical manifestations of distress. This is especially important because finding this perspective in healthcare can be influenced by context, accessibility, and social location. Thus, this commentary contributes to the psychosocial analysis of PPD that complements and transcends the speculated biological and medical models.[16,17] Using a feminist school of thought analytical approach, this commentary exists to enrich the social rhetoric around PPD urging the scientific and clinical community to prioritize cultural facets that complicate PPD development and progression.[8,15-17]

Depression after childbirth is lonely, inescapable, crippling, and unwanted.[16,17] Depression in the postpartum period is terrifyingly confusing and uncontrollable.[16,17] Depression postnatally is self-deprecating and threatening to feminine identity. It is a time of overwhelming guilt and real doubt.[16,17] It is a true moment of vulnerability amidst society projecting their perceptions of the consuming joys of motherhood.[16,17] As Buutljens and Liamputtong asserted, PPD is when, "giving life starts to take the life out of you".[17] Indeed, each individual suffering from PPD has their own array of circumstances that change their adaptations to postnatal life. Thus, this analysis has no intention of generalizing the PPD experience.

The necessity for a socially cognizant analysis of PPD emerged from a realization that the fundamental physiology of pregnancy has no geographical borders.[9,18] It is a shared similar experience that globally and generationally unites pregnant persons.[9,18] Yet, the conceptualization, social relevance, and cultural dialogue around motherhood varies significantly between regions.[9,18,19] In fact, transcultural analysis suggests the ethnokinship sphere, mainly consisting of Asian countries, have relatively lower rates of PPD, in comparison to the technocentric West.[9,18,19] Scholars have attributed this to ethnokinship rituals and traditions that emphasize maternal postpartum rest and health, along with strong involvement from feminine figures (grandmothers, aunts, community elders, etc.) during maternal recuperation and child care.[9,18-20] Other scholars have suggested that in the technocentric West, pursuit of postpartum practises that prolong maternal rest are often interpreted as weakness and passivity during motherhood.[9,18-20] Indeed, this nuance suggests that cultural and sociological conditions must become relevant in the PPD analysis. Using a feminist analytical approach, this analysis aims to explore and synthesize relevant Western structural and social conditions contributing to PPD. This exploration posits the medicalization of childbirth, the conception of flawless motherhood, and the view that depression during motherhood is deviant from the Eurocentric feminine gender script, all must be prudently considered in the PPD risk factor analysis.

Medicalization of childbirth

Firstly, the medicalization of childbirth and motherhood in Western culture is an essential component of the proposed socialized PPD analysis.[12] Childbirth represents an incredibly raw, intimate, and human moment demonstrative of powerful agency.[12,21] Further, childbirth is a defining transition point into the postpartum period and marks the beginnings of the motherhood reality.[12,21] In the Western sphere, the medicalization of the birthing process is empirically supported with the augmented use of ultrasounds, fetal heart monitors, and amniocentesis tests, along with an increase in the number of births occurring within hospital settings executed by obstetrical professionals.[21] Indeed, such machinery and technology ensures the safety of mother and newborn. Resultantly, childbirth and motherhood become conceptualized as medically precarious, requiring constant professional guidance, intervention, and scrutiny.[22,23] Institutionalization of childbirth makes the beginnings of motherhood highly technical, rigid, and procedural only exacerbating the intimidating and foreign nature of motherhood.[22,23]

The emphasis around the mother being a patient within a hospital, only enforces an external locus of control during the birthing process, establishing a tone for motherhood thereafter.[22-24] Importantly, literature notes that an internal locus of control, as measured by the Rotter Internal and External Scale, is of paramount importance to maternal satisfaction during childbirth, and feelings of preparedness moving forward.[24,25] Furthermore, intimacy and privacy are sacrificed in medical institutions, with both maternal and fetal inner bodily workings being projected on screens, evaluated, and discussed by professionals.[26] In this dialogue, there can be an adversarial relationship between maternal and fetal health that defines the mother as a mere "passive vessel" during pregnancy.[21,27] Dialogue around successful pregnancies reduces to statistics and probabilities that heavily emphasize child health, such as childhood mortality rate, with less regard for maternal well-being.[27,28] Such a rhetoric dehumanizes the initial beginnings of motherhood, and the focus on chances or likelihoods, effectively removes the mother's agency around her pregnancy outcomes.[27,28] Finally, loss of maternal autonomy can be reinforced by the mother-care provider interaction.[27] Care providers are revered to have privilege knowledge which bestows them with medical authority to control, instruct, advise, prescribe, and even, restrict.[21,22,27] Although care providers act with pure intentions of improving health outcomes, there is an inherent power differential that must be acknowledged that erodes the mother's internal locus of control.[21,27] Importantly, there remains a stigma that entraps mothers regardless of their birthing plan. There is judgement when alternative childbirth plans are pursued, alongside a perceived deviance from "natural" when a birthing plan that relies on medicine and institutions is pursued.[14] Such uncertainty and pervasive judgment only augment the insecurity and loss of control mothers endure when attempting to autonomously decide their birth plan.

Minimization of maternal agency continues into the immediate postnatal period defined as the fragile 24 hours spent in the hospital following parturition.[29] Physical and cognitive exhaustion strain the mother as she shifts from her idealized image of an infant to the tangible, overwhelming interactions with her baby that has just arrived.[29] Medical literature posits that 5 to 7 days in the hospital with continuous family visitation allows for an effective, safe, and comfortable transition into motherhood.[29] It allows new mothers to rest, receive proper education around parenting, and establish

feeding patterns with guidance from professionals.[29] Realities of the initial postnatal period include mothers immediately breastfeeding to establish infant feeding patterns despite their exhaustion.[29] Mothers can also be isolated from family and friends in hospital wards, and in some medically necessary cases, the baby can be placed in an infirmary away from the mother.[29] As a result of system strain, discharge is usually restricted to within 24 to 48 hours barring complications, and is increased to 4 days with invasive surgical interventions.[29] Notably, literature indicates that only 47% of new mothers reported feeling prepared for immersive infant care by six weeks postpartum, demonstrating systems are strained in prioritizing maternal preparedness.[29,30] Indeed, it is worth acknowledging that new mothers, as a result of their social location, intersectionality, mistrust of the health system, and harmful systemic inequities, may regard a prolonged hospital stay as a source of distress. For some, a rushed and disruptive immediate postnatal period can diminish their perceived control and self-confidence.[27,29-31] Without safety and comfort in the first exposures to motherhood's realities, maternal vulnerability increases which effectively halts the mother's rest and emotional recuperation that are vital to her health.[27, 29-31]

Societal expectations: flawless motherhood and maternal excellence

Secondly, as mothers transfer from the immediate postnatal period into the postpartum period, they are bombarded with societal expectations about motherhood.[31-35] Western culture continues to sensationalize and romanticize motherhood as a moment of total joy, fulfillment, and happiness.[31-35]An illustrative example is the seemingly innocent question of, "how do you like being a mother?" to which there are a socially expected set of answers that include, "it is the best moment of my life," or "everything is perfect now."[31-35] Yet, little attention is given to motherhood's taxing realities including the unfamiliarity of caregiving, the change in lifestyle, sleep deprivation, and minimal time for self-care.[31-35] Disconfirmed expectations of parenthood generate challenges with adjustment, a dissonance or sense of betrayal between what is and what should be, and a context for mental health symptom development.[31] This discrepancy between idealism and reality is only augmented with the expectation for maternal excellence - to be a good mother.[31-35] Reflecting on current practices, acceptable parenting is institutionally enforced in Western culture.[31-35] Should competency and confidence in parenting be questioned, agencies are prepared to intervene.[31-35] Indeed, this provision for childhood protection is utterly necessary; yet, for a mother suffering from postpartum depression, these agencies only augment their fear, uncertainty, and drive towards embodying the façade of a perfect mother.[31-35] Thus, this idea of acceptable and safe parenting becomes hyperbolized to flawless, tiring, and immersive mothering.[31-35] Defined by qualitative research, maternal excellence involves quantity of time spent one-on-one with the child, amount of time taken off work, and ability to breastfeed.[33,35] Hays ideology suggests the Western rhetoric around good mothering involves an occupying "child-centered, expert-guided, emotionally demanding, labor intensive and financially straining" role.[36] In other words, the child is above-all-else.[36] McMullen and Stoppard added to postnatal expectations stating that pregnant persons are to be "a good woman, mother, and wife."[37] Even though mothers acknowledge these expectations are unrealistic, they still consider them a benchmark of maternal excellence.[37] Choi and colleagues in 2005 determined that mothers who perceived themselves to not meet the "perfect" criteria, only endured and worked harder at the unattainable standard, rather than being transparent about their difficulties.[38] Resultantly, several participants reported isolation, withdrawal, burnout, and a loss of self.[38] This poignantly demonstrates how pervasive and invasive societal expectations can be on human behaviour.[37,38] Evidently, when these expectations are internalized, maternal self-efficacy decreases with a corresponding increase in maternal guilt.[31-35,39] Importantly, research shows that high maternal self-efficacy is protective against the development and progression of postnatal depression.[39] With low maternal self-efficacy, mothers begin to question their worthiness and fitness.[31-35,39] The discrepancies between maternal expectations and their perceived inadequacy initially manifests as self-doubt, escalates into shame and self-inflicted frustration, and can end with avoidance of maternal feelings altogether.[31-35,39]

Postnatal body image and body expectations are also implicit in Western maternal excellence standards.[31] There is a pervasive notion in postpartum infant care that a mother's body *still belongs to the baby*, despite her pregnancy being over.[31,40,41] In a qualitative study, mothers viewed their body existing to serve the babies needs no matter the sacrifice and their physical exhaustion.[41] For example, mothers often described their breasts as "food for a baby," and one mother even conveyed she felt like a "milk cow".[41,42] Implicit in these statements is a loss of maternal confidence, autonomy, and bodily integrity.[41,42] Breastfeeding is inextricably woven into the social construction of good mothering; the importance of breast feeding is supported by the medical community, and several postpartum organizations through slogans such as "breast is best".[31,32,40,41] Mothers who choose not to or experienced challenges with breast feeding express sentiments of *failure*, as if they are not able to perform natural maternal functions.[31,40-42] Mothers internalize this challenge as a personal shortcoming, viewing themselves as a faulty body machine leading to disempowerment and loss of maternal identity.[31,40-42] This is utterly compounded with maternal guilt as they are not able to sustain and provide for their child in the way that they are "supposed to".[31,40-42] Often, these mothers despite their challenges and in some cases physical pain, continue to breastfeed because they feel compelled to conform to social values.[31,40-42] Literature has suggested that PPD may reduce breastfeeding rates, while not breastfeeding may increase PPD risk.[42] Finally, evidence also suggests that breastfeeding practices can restore maternal control, and reduce PPD symptomatology.[42] The relationship between breastfeeding and postpartum depression is evidently complex, and serves to confirm that body expectations, which are socially influenced, are imperative in the PPD analysis.[42]

In Western society's construction of maternal excellence, the media perpetuates pressure for postpartum individuals to return to their pre-pregnancy figure amidst the pressures of immersive infant caregiving.[31-33,41] Weight gain and stretch marks are common in the postpartum period.[31-33,41] There is this perception that, "when you don't have the baby in utero, and you still have extra weight, you don't have an excuse anymore".[41] Often the postpartum body ideals perpetuated by the media are unattainable, or only attainable with self-deprecating and exhausting practises.[41-43] If such self-discipline practises are pursued, they only serve to alienate mothers from their "true self".[41-43] Erasing the physiological stresses of pregnancy is easier said than done, and the pressure of social acceptance can be overwhelming.[41-43] Comparisons to the media and to other

pregnancy experiences are inevitable and it only forces individuals to become aware of their perceived flaws.[41-43] Qualitative research suggests that new mothers constantly worry over the permanency of these postpartum changes, as they perceived postpartum bodies to be less sexually desirable.[44] Unfortunately, this promotes self-critical and self-policing behaviours that result in mother's feeling inferior to a falsified social standard.[31,41-44] Delving deeper, maternal and postpartum bodies are physiologically different, and new mothers often share their frustration over their lost control that cause them to "leak, drip, squirt, expand, contract, sag, dilate and expel".[41,42,45] There is an abrupt change for mothers from pregnancy to postpartum that they are reconciling with, from eating for two to being pushed to become fit and slim.[41-43] Confusion and loss of identity is a true struggle; mothers feel their bodies become unrecognizable, uncontrollable, "floppy, loose and even, gross".[31,41] At their very core, they feel different and less feminine in the skin they are in.[41]

Motherhood, the feminine gender script, and stigmatization

Finally, depression during motherhood is often viewed as deviance from the feminine gender script.[32,46,47] As a social construct, gender scripts put forth expectations regarding ways of appropriately existing and interacting with the world.[7,40,48] Indeed, science and medicine are not culturally immune to the biases implicit within these scripts.[7,46,48] Western scholarly literature has noted extremely strong views around PPD.[31,46,47] Gruen in 1990 established that depression is considered culturally acceptable with financial instability, death, or partner related conflict, yet when depression's causal factors are associated with the arrival of a child, it is not culturally accepted.[31,49] Why? Motherhood is recognized as the pinnacle of the "female experience," and has been a central component of defining femininity.[46,50] Thus, feminine gender scripts suggest motherhood is a period of affirmation for one's self-identity, self-esteem, and self-fulfillment.[31,46,49,50] Woven into the feminine gender script is the expectation that feminine individuals are quiet, reserved, enduring, and caregiving figures.[31,46,49,50] Thus, PPD symptoms including anger, rage, irritability, and apathy around caregiving are deemed as inappropriate.[36,49,51,52] The unpredictability of their depression and emotions are in direct contrast to the poise and stability mentioned in feminine gender scripts.[31,46,49,50] As a result, self-labelling tendencies occur, and mothers are filled with shame and guilt about not experiencing motherhood and femininity *correctly*.[31,46,49,50] Because parenthood, coitus, and pregnancy are deemed as natural within human behaviour, childlessness or unhappiness upon the arrival of a child are wrongfully deemed as deviant.[31,46,49,50] Implicit in the feminine gender script is maternal instincts; this implies maternal satisfaction is programmed into femininity and thus, responding to a child should be intuitive and straight-forward.[46] Thus, when PPD prevents the desire to care or parent, mothers feel as though they are violating the natural way of things.[46] This only increases their feelings of deficiency, dysfunctionality, and self-blame – that something is "fundamentally wrong" with them.[46] Perhaps, this analysis culminates in the evidence put forth by Hall and Wittkowksi who determined that majority of their study participants felt their PPD was *unjustified*.[31,51] The idea that PPD is seen as unwarranted and unreasonable by those actually experiencing it only serves to show that their expectations of femininity and maternity, which are socially informed, exclude the PPD symptomatology.[31,51]

The deviant label and conflict with gendered expectations, results in a pervasive stigma around PPD.[52] Importantly, stigma is a relational concept, informed by social roles and opinions.[52] This stigma reinforces judgment from others about poor parenting, fear of not meeting parental expectations, risk of custody challenges, and even potential for child protective agency involvement.[31,52] Undoubtedly, society interacts differently with those that have a mental illness. Indeed, the intersectionality of maternity and mental health stigma truly worsens the mother's label of being unwell, abnormal, and even a threat.[31,51,52] Stigma is unparalleled in how PPD is created and sustained as it decreases maternal self-efficacy and increases maternal guilt; most importantly, at its core, PPD stigma creates a multifaceted maternal fear.[31,51,20] These mothers face inescapable fear and uncertainty about the unfamiliar emotions they are feeling.[8,31] Even further, they endure through fear about the challenges and losses that could ensue should their depression become revealed.[8,31] Thus, the present and the future are daunting, and resultantly, the mother is utterly trapped. Perhaps, fear explains why those who suffer from postnatal depression often avoid health seeking behaviours for fear of judgement and repercussions.[31,52] In fact, mothers do everything possible to distance themselves from the "PPD pathology", and often refer to their depression as feeling down or feeling low because of the weight of the label.[31,52] The most upsetting reality is that the guilt, inadequacy, insecurity, and fear are endured in silence and isolation as a result.[11,31]

A consolidation

The above exploration aims to illustrate that the PPD experience is informed by the way in which mothers interact with their world, and the social realities they resultantly face.[8] Western society's maternal expectations which demand perfectionism are untouchable and rigid resulting in self-deprecating outlooks during exhaustive attempts to conform within a society that is unwelcoming to sadness during motherhood.[8] Practises that cause a mother to question their maternal worthiness begin immediately with the birthing process, and are further augmented by societal standards and stigmatization that add overwhelming fear, guilt, and shame to a mother's perceived inadequacy.[8,31] A mother experiencing PPD is actively struggling with herself, her biology, her psychology, her new role, and her society with all of its falsehoods and fantasies.[8,31,32] Postnatal depression is complex and simultaneously includes challenges with personal identity, body image, self-confidence, sexuality, femininity, and autonomy to name a few.[8,31,32] A PPD analysis restricted to hormones or biological fluctuations neglects the very fact that our social priorities dictate how we respond to the feminine body.[7,8] Our response to the feminine body and PPD must realize that the Western structural climate creates blame, unrealistic social standards, and rigid gender scripts that are unattainable.[7,8,48] Along with many feminist scholars, this paper urges that these Western structural conditions make it quite easy for mothers to feel a sense of failure during motherhood, and our society only reacts with condemnation and blame when mothers express their depressive symptoms – this is a perpetual cycle and a harsh reality that leaves mothers suffering alone.[8,31] Thus, it is vital that our response to the feminine body through the health sciences encourages social cognizance.[8]

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