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3 WE HAVE NEVER BEEN NORMAL: POSTMODERN POSTPARTUM EXPERIENCES AND THEIR DISCONTENTS

> "Irresolvable stress can lead to depression."
>
> "Knowing that you are doing a good job is important for coping with stress."
>
> "Unfortunately, such recognition is not often expressed."
>
> "Their decisions can endanger human lives."

While these quotations come from a story covering an *Environmental Health* study of pilots and workplace health (Schmidt 2016), they could easily be attributed to the working world of the new mom. Preparations begin *at least* sixty to ninety minutes before the day's first departure, perhaps with some small talk but most definitely with the hashing out of—or intense negotiations through—what the day will hold for "the crew." Then there's the assessment of the physical environment and mental work of documenting things that need to be addressed. (There's some nonessential disorder, but the day must go on.) There's probably some ruminating on what went wrong yesterday, but, simultaneously, the challenges of present weather conditions must be accounted for in how they might affect the day's plans. Then there's the additional (over)preparing for obstacles that might be met along the way.[1] And that's just "preparing for takeoff": "The goal is to get everyone and everything lined up to attain that all-important on-time departure" (McFly 2016). But there are no on-time departures in the precarious work of parenting tiny human life. The cargo is far more complex—and ultimately unpredictable.

The *Deutsche Welle* story relates that around 12.6 percent of pilots in the study evidenced signs of depression. According to the Cleveland Clinic

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(2018), 50–75 percent of new moms experience "baby blues" and up to 15 percent experience a "more severe and longer-lasting depression." Fifteen to 75 percent is a significant leap and invites scrutiny of the classification systems defining depression.

The Cleveland Clinic (2018) defines "postpartum blues" or "baby blues" as a condition that begins one to four days after delivery, comprising "frequent, prolonged bouts of crying for no apparent reason, sadness, and anxiety." Treatment is described as follows: "All you'll need is reassurance and help with the baby and household chores."

"Postpartum depression" (PPD), on the other hand, is "far more serious." "There will be 'highs' and 'lows,' frequent crying, irritability, and fatigue, as well as feelings of guilt, anxiety, and inability to care for your baby or yourself." PPD can begin days or even up to a year or more after delivery. Recommended treatment includes psychotherapy or antidepressants (Cleveland Clinic 2018).

There's also "postpartum psychosis" (notably depicted in the film *Tully* [IMDb 2018]). Postpartum psychosis is defined as a severe form of PPD. Onset and duration of symptoms mirrors that of PPD, though they may also include "severe agitation, confusion, feelings of hopelessness and shame, insomnia, paranoia, delusions or hallucinations, hyperactivity, rapid speech or mania." Hospitalization and treatment with medication are recommended (Cleveland Clinic 2018).

In addition to those postpartum disorders already mentioned, a small number of new mothers may experience postpartum obsessive-compulsive disorder, postpartum post-traumatic stress disorder, or postpartum/peripartum bipolar disorder, well described by the Anxiety and Depression Association of America (2018).

It is particularly noteworthy that the early symptoms of the more concerning postpartum disorder—PPD—are, in reality, nearly indistinguishable from the "baby blues" that the majority of new moms experience in the first few weeks after delivery. The binary we seek to complicate in this chapter is just that: "simple" baby blues versus "serious" PPD, or, in other words, the binary construction of the classifications of a "normal" postpartum state versus a "nonnormal" mental and emotional aberration. This binary constructs

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an unforgiving theoretical line that new moms are warned not to cross. Yet, we argue that in real-world maternal experience, the chaotic feeling of postpartum sadness is a *normal* outcome of labor and delivery: because *nothing* is "normal" in the postpartum period—it is a period of constant mental, emotional, and physical change. As detailed in our pregnancy-risk chapter (chapter 1, "It Was Never about the Coffee"), it is this very dynamic of the constantly changing body that both makes it impossible to map onto black-and-white binaristic systems and represents risk and uncertainty because of this "in-betweenness" that *is* pregnancy. Thus, the overly simplified diagnostic systems of psychiatric medicine will necessarily fall short of capturing the ever-changing state of the postpartum mind-body as it works to reestablish its own baseline "nonpregnant" state. Yet, there is a real need to help women who are in subjective distress or moments of crisis. Where, then, is the happy medium in a classificatory system that can helpfully direct women to the appropriate resources yet can still allow for the *natural* and *normal* fluidity of the postpartum woman?

We encourage normalizing that continuum of postpartum feelings and behaviors because, indeed, postpartum maternal decision-making can cost human lives. The diagnostic binary of "normal" baby blues sadness versus "abnormal" PPD reinforces mental health stigma. New moms want to be labeled "normal"—not "mentally ill"—and will sub/consciously approach postpartum discussion and diagnostic medical visits with the aim of circumventing such labels at the cost of receiving help that could improve her and her baby's quality of life. Because PPD includes symptoms such as "inability to care for your baby or yourself" as well as a "hopelessness" that could lead to suicide or infanticide, it's well worth analyzing the network of nodes affecting the discourse surrounding these diagnostic practices, including how such diagnostic tests themselves feed into this problematic postpartum binary.

IS IT MORE THAN BABY BLUES?

The Cleveland Clinic (2018), as is common with other health-care organizations in neoliberal societies, inherently puts the onus on the suffering new mother to recognize potential mental health issues in herself. At the six-week

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postpartum visit common to US birthing contexts, her doctor may ask the following two questions:

1. Over the past two weeks, have you felt down, depressed, or hopeless?
2. Over the past two weeks, have you felt little interest or pleasure in doing things?

If the exhausted new mother can muster the courage to say yes (when relevant), the doctor may administer a more in-depth depression screening tool; however, the idea that asking for help would be an admittance of failure with dire consequences was a mythos that pervaded my own first pregnancy.

A friend in my doctoral program communicated the following to me over a collegial dinner: "Be careful what you admit to your doctor about the baby blues. You don't want your baby taken away." We are both highly educated and ascribe to a holistic understanding of well-being. Yet, as a mother and a mother-to-be, living in a society that blacklists mental illness, we internalized the fear of unwelcomed intervention in the most vulnerable of times: the delivery of and first days of caring for fragile new offspring. The level of vulnerability inherent in admitting the need for mental support shortly after the trauma of expelling a new life from one's loins—admitting you are struggling to care for a child you created and carried for nine months prior, that your mind is failing when your body succeeded—cannot be understated. The physician-administered screening tool, then, is a disruptively unparalleled request for exposure from someone the mother has entrusted with the care of her most intimate bodily experiences. Furthermore, the overwhelmed new mom must ask herself: do I trust the *ethos* [2] of the diagnostic tools my health-care provider will use to assign my place on the "ab/normal" postpartum continuum?

Postpartum Screening Test as Actant

The rhetoric of many PPD diagnostic tools provides a compelling case for the patient to lie given the perception (via societal stigma) that consequent outcomes are set in stone. In other words, it doesn't take a PhD to understand which answers will label you as problematically mentally disturbed and incapable of caring for yourself or your child versus being a trooper through the trials of new motherhood. We must also necessarily recognize the inherent

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privilege of being PhD holders in this situation. Being a professor comes with a certain level of cultural clout; underserved demographics, however, remain infinitely more vulnerable in the face of Child Protective Services and, therefore, to the perceived or real consequences that may come with being labeled dangerously depressed. Enter the plethora of self-diagnostic tools available online—an anonymous way to self-check one's supposed psychological aptitude at "normal" motherhood.

Consider the Postpartum Depression Test from Psycom (Remedy Health Media 2018):

> I feel like a failure as a mother and guilty for not being happy around my baby.
>
> True
> False
>
> The thought of harming myself has occurred to me.
>
> True
> False
>
> I feel anxious and panicky for no good reason.
>
> True
> False

Psycom is clear to offer the caveat that "only a licensed mental health professional or doctor can give a formal diagnosis of postpartum depression," but also that "you should only answer true if you have been experiencing the symptom nearly every day for at least 2 weeks." Is the takeaway, then, that if "the thought of harming myself has occurred to me" every other day instead of every day, it's just "normal" baby blues? The answer choices, which must be registered according to a true/false binary, mirror the larger ab/normal postpartum sadness binary. There is little to no nuance here to guide and encourage the potentially suffering new mother into deeper discussion with her health-care provider.

The virtues of collective intelligence notwithstanding, the internet is notorious for proffering poorly constructed advice for the sake of expediency; there must be fewer rhetorical frameworks guiding us toward unhelpful

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answers in the formal diagnostic tools used by our health-care providers, right? That brings our discussion to the Edinburgh Postnatal Depression Scale (EPDS) (Psychology Tools, n.d.), considered the gold standard in diagnosing PPD (D. Levine 2017).

The EPDS was designed for pregnant women and new moms to identify their risk for perinatal depression. It is also used to identify general depression in the larger population, and it's easy to see why. The EPDS provides a bit more nuance in its Likert scale (e.g., "No, not at all," "Hardly ever," "Yes, sometimes," "Yes, very often"), but it has been criticized, among other reasons, for its lack of specificity to the postpartum period. One question, for example, asks the quiz taker to assess how much "things have been getting on top of me." We can think of dear mom friends who would likely respond, "I haven't been able to cope at all"—with laundry, since 4 and 6 were born. Though we offer this example somewhat in jest, other issues plague the test. Quiz takers are asked to determine how often in the past seven days they have "felt sad or miserable," with no recourse for communicating or assigning weight to other factors that might be contributing to said sadness or miserableness. Another question provokes the quiz taker to rate how often they have "blamed [themselves] unnecessarily when things went wrong." There's a lack of clarity in the terms "blamed," "unnecessarily," and "wrong" here (a standard problem with self-report inventories in general). What defines the assignment of "blame" in this case? More importantly, how does the quiz taker know whether the assignment was "necessary" or, at some level, "unnecessary"? Isn't the ability to recognize responsibility in "wrong"-doing a sign of health and maturity?

Applying rigorous rhetorical analysis to such screening techniques may confound our understanding of the results they're meant to reveal: a sense of subjective emotion, the patient's perception of their current situation. Yet, researchers have suggested, time and again, that the scale needs to be "shorter, easier to use and more specific to identifying PPD" (Cohen quoted in D. Levine 2017)—harking back to the more productive rhetoric of *standardized* or *hospital* birth plans. Dr. Lee S. Cohen[3] is a key player in initiatives led by health-care practitioners to improve the diagnosis of

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postpartum disorders; Cohen suggests that "there has been rapid growth in the development of a variety of web-driven screening tools for many mental health issues, but 'to date there has been little attention to the use of technology to better diagnose and treat PPD'" (quoted in D. Levine 2017). Essentially, Cohen is advocating for the benefit of technological actants in targeting more productive diagnosis of postpartum disorders.

We present our analysis of the EPDS and other widely circulated PPD screening tools to extend this conversation and to suggest, like Cohen and Dr. Donna Stewart,[4] that such tools are actants. That is, we suggest, from our unique perspective, that such tools can play an active part in dismantling the postpartum binary of ab/normal sadness. A well-designed web screening or app has the potential to influence the new mom to trustingly, and truthfully, explore her complex postpartum feelings and to seek help when needed if the technology itself takes part in critically framing a nuanced picture of the postpartum experience of sadness. Both Cohen and Stewart, however, point out that there's little utility in developing additional diagnostic tools if *treatment* cannot also be elevated in similar ways. Stewart asks, "Why screen if you don't have the services? . . . That's where the gap is" (quoted in D. Levin 2017). According to Cohen, however, using big data to enhance the *ethos* (the credibility and authority and, thereby, effectiveness) of screening tools is the first step, which can be followed by technological actants that come in the form of "treatment delivery tools—if you score a certain number, you have a link to a treatment tool—[coupling] specific screening with effective delivery of treatment, for getting women well and doing it in a timely way" (quoted in D. Levine 2017). Both practitioners push for constructing a more complete picture of the ethical nodes in postpartum decision-making.

In other words, the creation of such screening and treatment tools may become important nodes in the networked *ethos* of contemporary maternity advice, but they contribute little to positive, actualized results if the women who need them do not have access to them. Enter the node of note for this particular book: social media mothering groups and the circulated discourse (or lack thereof) surrounding PPD.

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KAIROTIC IMPLICATIONS: PPD AS SOCIAL MEDIA DISCOURSE

Though one might expect that PPD is as stigmatized in social media mothering groups as it is in geographically bound discourse communities, it is a surprisingly common subject in both general and specialized mothering groups alike. What's most significant here, however, is not the amount of discourse dedicated to postpartum disorders but the rhetorical notions of *kairos* (a favorable moment for decision or action) and hedging (a rhetorical strategy used to make statements less definitive or forceful) that nearly universally affect new media mothering group discussion of postpartum disorders. Both rhetorical moves contribute to more deeply entrenching the binary of "normal" versus "abnormal" postpartum sadness.

Consider a post from a specialized feeding group in which the original poster (OP) delivered a PPD "rant." The OP details how her child's doctor discovered results from a test conducted months earlier indicating the OP was at risk for PPD. More testing (i.e., paperwork) is now necessary to confirm that diagnosis—a diagnosis that had been made months earlier but not shared with the OP. Worse yet, when the OP follows up with *her* doctor, the staff person she speaks with concludes her situation isn't an emergency. The staff person recommends the OP connect with her doctor later and abruptly ends her conversation with the OP.

While the OP evidences no hedging in announcing the acuteness of her symptoms, she does demonstrate rage at the delayed course of treatment: *kairos* is clearly at play. While some commenters may continue the discussion by noting their surprise (delight) at pediatrician involvement in the fight against PPD, most will cry "unacceptable!" at a physician's laxity in not *immediately* informing a patient of a high score on a PPD screening (given that early intervention is critical for the health and well-being of mother and child); the physician has thwarted the OP's opportunity to act on "a favorable moment for decision or action." Ultimately, commenters' cries constitute multiplied collective vocalizations for "self-advocacy!"

In this representative vignette, one commenter explicitly points out that obstetricians, primary care providers, and pediatricians are not experts

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on mental health—it's not their job—so new mothers need to take mental health care into their own hands. Indeed, many commenters advise skipping the typical ob-gyn or primary care provider routes and going straight to a therapist, "not tak[ing] NO for an answer," and being "super pushy" when it comes to mental health needs. We note particularly the neoliberal tones to these responses: your Optimal Mental Health (as a facet of Optimal Motherhood) is *your* responsibility alone, and responsible citizens should perfectly maintain this "resource." Thus, while the collective empathy among commenters might bring relief to the OP by reassuring her righteous indignation, there is much to consider given the concerns already raised in this chapter: Do new moms have the expertise to diagnose their own postpartum disorder symptoms and the confidence (let alone energy) to "push" for their own mental health needs while tending to the lives of their newly formed little ones?

Another *kairos*-relevant trend in social media mothering group discourse about postpartum disorders concerns the tendency of new moms to reach out only *after* they have been suffering for a significant period of time. Such OPs in generalized and specialized social media mothering groups begin their threads in line with what follows: "I've been feeling this way for a long time and . . . ," "I started noticing symptoms of deep worry and sadness months ago . . . ," "I've finally been diagnosed but . . ." ("but" being a classic marker of hedging). These admissions are often met with condolences from well-meaning empathetic commenters who project personas situated somewhere between cheerleader and chastising parent. Commenters are often quick to say, "Good on ya for getting help!" but also, implicitly or explicitly, "Why did you wait so long?" unintentionally reinforcing the opposite side of the binary. These unintentional reprimands come in the form of comments using the imperative, "You need to get another doctor"; comments that reference the OP's supposed misunderstanding of the situational urgency, encouraging she take action "ASAP"; and comments that invoke repetition and exclamatory punctuation, such as "Call back!! Call back!!" When such vulnerability is met with reprimand, it's reasonable to conclude that many OPs will be hesitant about posting postpartum issues in the future; the expectation has been set that she is damned if she does and damned if she doesn't. If she doesn't seek help, she faces the physical,

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mental, and emotional challenges that consume those with PPD alone—or with the reproof of her online village. If she does seek help, she faces the internally or externally imposed stigma attached to the label of a depressed and otherwise unfit mother.

Social media mothering group commenters are surprisingly quick to share, in detail, what particular psychotherapeutic or medicinal interventions worked for them in their own battles against postpartum disorders—but only in comments (rarely, if ever, as original posts), suggesting that discourse about mental health disorders and treatment is reserved for threads that will not show up in the mainstream feed of social media mothering groups. This discourse choice embodies rhetorical hedging on a larger scale by relegating a particular subject of contemporary maternal decision-making discourse—postpartum disorder treatment—to a particular (and particularly limited) space: comments only. This choice might appear to be at odds with the chorus of women crying for heightened awareness and self-advocacy when it comes to postpartum disorders. However, rather than suggesting that women suffering from postpartum disorders be responsible for outing themselves and proclaiming their disorders more prominently in their social media worlds, perhaps what we're suggesting here is creating an alternate but equally prominent place for such discussion, as in the mentoring programs being initiated and actively advertised by some specialized feeding groups (see chapter 4, "Breast/Fed Is Best: Whose Algorithm Is Feeding My Baby?"). Consciously creating such a conspicuous space for this work supports the normalizing of the differential continuum of postpartum feelings and behaviors.

Moms' Best Friends: Guilt and Shame

As mentioned, the postpartum disorder discourse of social media mothering groups—often uncomfortable and conceivably controversial—may be unintentionally reinforcing the larger nodes of guilt and shame that feed postpartum disorders. Original posts inquiring about members' experiences with postpartum disorders are often hedged with language such as "Is this allowed?" "Please don't judge me!" and "I hope I'm not alone." Such introductory phrasing (negatively) colors the reading of what comes next in the given post. Posts commonly include those inquiring whether there are other

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online mothering group members suffering from depression and/or anxiety. Just as commonly, these posts are hedged with language wondering whether such inquiry is "allowed" and whether other mothers feel like they are "doing this thing wrong." Such posts communicate guilt via the perception of having committed an offense, which is inherent to the question of what topics might be off limits for discussion in a social media mothering group. Shame is also evidenced in such posts—feelings of humiliation or distress at having done something "wrong" or foolish and the expression of disquieting desire for other moms to own up to feeling like less than Optimal Mothers or to a general feeling of failure at mothering.

Where do such guilt and shame come from? We have already explored the deceptively complex *ethos* of health-care providers' frameworks for responding to issues of PPD as well as general trends in mothering group social media discourse that mirror a real-world reluctance to discuss postpartum disorders in concert with larger social stigmas surrounding mental health care. We must also acknowledge memes and other technological actants that circulate alongside or through postings of members of social media mothering groups (in groups that function as formative villages in contemporary mothers' parenting decisions). Consider the following text circulated on a birth doula / sleep consultant page in late 2019:

> If you cried this week because the exhaustion was so physical your limbs felt like lead.
> If you felt stretched, pulled between the needs of different children, and guilty that you simply didn't have enough energy.
> If you're struggling with depression or anxiety and wondering when you'll start feeling yourself again.
> If you're just holding on, juggling work and life and your relationship and lurching between coffee and wine.
> Remember this: to your children, you are the world.
> You are the world.
> (COPE 2019)

Though the text is seemingly positive in its implicit refrain of "you matter," the underlying message is, "you should put up with the exhaustion, the never-ending guilt, the harrows of depression and anxiety, because, well,

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baby." Baby is privileged over mom by this technological actant, which purposefully or not so purposefully feeds the narrative that suffering through PPD or anxiety is the expected course of martyrdom for the new mom. Martyr is the *expected* persona a postpartum mother must perform. Silently suffering through life-depleting sadness, a sadness that causes you to question your identity and self-worth, is presented as a satisfactorily *normal* requirement of new momhood. What we need to recognize is that performing the persona of martyr is not merely physically damaging but also mentally and emotionally damaging for the postpartum mother; this *pathos*-laden, emotionally gut-wrenching, viral post exemplifies this damage, pinning the suffering new mother, inescapably, into current binary discourse (valiant martyr vs. failed depressive) surrounding postpartum sadness.

Another example of a technological actant—one that doesn't tiptoe around its insistence that guilt (the kind of guilt that fuels postpartum disorders) is both useful and part and parcel of new motherhood—is a viral post from June 2019, circulated by Taylor Kulik (figure 3.1).

> Too often in our culture, providing information is perceived as "mom-shaming." Now, I'm not saying that mom-shaming doesn't happen, because it does! But sharing info is not shaming. The content I share, harmful impacts of sleep training and punitive discipline, tends to trigger people, and I GET IT. I've been hesitant at times to share what I really want to here out of fear of offending people.
>
> I want to talk about why you might feel triggered. Maybe you feel guilty. I know I do. I mess up daily—I yell, I lose my patience, whatever it may be. And I feel guilty. But is this a bad thing? Are we so afraid of the discomfort of guilt that we are willing to deny information that could be helpful to our children? I am on a Brené Brown kick lately, & I want to share how she explains the difference between shame & guilt:
>
> "Shame is a focus on self; guilt is a focus on behavior. Shame is, 'I am bad.' Guilt is, 'I did something bad.'" She goes on to explain that "shame is highly, highly correlated with addiction, depression, violence, aggression, bullying, suicide, eating disorders.
>
> "Here's what you even need to know more: Guilt is inversely correlated with those things. The ability to hold something we've done, or failed to do,

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USE GUILT
TO FUEL
GROWTH.

@taylorkulik

Figure 3.1
A viral Facebook post from June 2019, circulated by @taylorkulik.
Source: Kulik (2019).

> up against who we want to be is incredibly adaptive. It's uncomfortable, but it's adaptive."
>
> So, no, I don't think that feeling guilty is bad. I've realized that it can be a helpful, productive part of the adaptive process. If you are feeling triggered by information someone is sharing, ask yourself "why?" If you are feeling guilty, accept that feeling, & do something. Whether it's learning more, hearing someone else's perspective, or making an effort to do better next time, act on it & make positive changes! What if we could all have difficult, vulnerable conversations? What if we could admit our mistakes & work to improve them? I think we might create positive changes in the world for not only us, but future generations.
>
> And at the end of the day remember that you are enough. You are a good parent.

There's a lot to unpack here. The post, in fact, ends with a point we agree with: "What if we could all have difficult, vulnerable conversations? . . . I think we might create positive changes in the world for not only us, but future generations." Where we might beg to differ is in the simple statement that "sharing info is not shaming" and that one can necessarily, with ease, compartmentalize shame as a selfish act of self-focus or that one can just as easily categorize guilt as a productive feature of flexible behavior. *How* one goes about sharing information, especially in social media mothering groups, absolutely can and does result in mom-shaming—a shame that is not purely

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self-fueled but influenced by a network of actors and actants expressed in infinitely complex ways.

The language of "triggering" and "offending people" deserves careful unpacking too, but, more importantly, we need to consider how "guilt" is synonymized with "being triggered" and how that problematically neutralizes or otherwise misrepresents a primary criterion in diagnosing a clinically serious mental illness: PPD. Notwithstanding the problematic ways that "trigger" has been co-opted from PTSD diagnostic criteria (and postpartum PTSD is an increasingly recognized condition) into vernacular language, the term is also invoked here to intentionally instigate feelings of maternal inferiority (with the idea that this feeling of inferiority could, hopefully, motivate ambitions toward Optimal Motherhood). Indeed, the viral post seems to announce that there will be guilt in new motherhood, and the only responsible course of action is to accept that that guilt will be painful but necessary for growth into an Optimal Mother—that if we just think about our behavioral choices as new mothers hard enough and long enough, we will avoid the pitfalls of PPD and, importantly, that guilt might, in fact, be indicative of real ineptitudes. The culture of Optimal Motherhood oozes from this passage.

In fact, the inherent message of "dwelling in discomfort" only further evidences the kairotic problem discussed earlier in this chapter: across social media spaces, women are suffering far too long in silence because of a perceived notion that the guilt, shame, and sadness they are battling are, at best, nothing more than a little baby blues, and, at worst (as indicated by Kulik's viral post), indicative of true failings. Discourse like this, which claims that the experience of shame and guilt is a "normal" part of the postpartum experience but that sadness beyond a quick bout of the baby blues is not, erases opportunities for productive postpartum recovery, meaningful discussion, and a collective movement past the norms of Optimal Motherhood. It is only when mothers (and the society that reinforces the norms of Optimal Motherhood) undermine this binary and internalize the idea that feelings of postpartum dysphoria are not so "different" after all that women may become more willing to talk about their postpartum feelings and walk the path toward understanding what all parents want to

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believe (and, arguably, need to believe to persist): "you are enough. You are a good parent."

CONNECTING ONLINE AND OFFLINE NODES

Observing social media mothering group discourse afforded productive insight into the slices of postpartum life members were willing to share among (presumably) trusted group members. Institutional review board and ethical internet research guidelines, however, left us little leeway for most powerfully representing the raw and unfettered perspectives of new and veteran mom participants, the type of data that would confirm the problematically binary-bound representation of postpartum sadness that we observed in said social media mothering groups; therefore, as explained in the book's introduction, we interviewed a convenience sample of mothers and health-care practitioners regarding their thoughts on PPD.

The Moms

"Did you discuss postpartum depression and other like disorders with your doctor or anyone else?"

Interviewed moms commonly felt the need to state that they did *not* have PPD when answering whether they discussed the issue with doctors:

> "Yes, they brought it up while I was pregnant and then after at any and all follow-up things. They would ask the screening questions, but I never had that with either boy."

> "We had some education at our hospital prior [to] giving birth. I had someone from [the] hospital to check in with me after I was done. A lot of people asked me 'how are you,' so that was helpful. I felt SO hormonal and had too many tears, but I never got depressed."

> "Yes, they asked me at my ob-gyn. I didn't have it, but they asked me about it. I didn't have time to be depressed with twins. I didn't have time to think about my own feelings, honestly."

The third mom's response is of particular interest given that she rhetorically situates PPD as a nonissue in tension with lack of time and a privileging

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of her children's wants and needs over her own as a mother. She admits to dishonest, or at least nonexistent, engagement with her own feelings because she perceived her children to be more significant stakeholders in this particular decision at this particular time. Her narrative speaks to an important conclusion of this book: enveloping (or being enveloped in) the rhetoric of Optimal Motherhood problematically erases the mother in the mother-child parenting relationship and, thereby, precludes productive maternal decision-making. Such a rhetorical move should be considered in the construction and delivery of PPD diagnostic actants like the previously discussed diagnostic questions in clinic room conversation and the EPDS.

Even when interviewed moms (reluctantly) admitted being diagnosed or suffering with PPD, the agency for open discussion was placed on the health-care practitioner rather than being initiated by the mom (an opposing pattern to previous "self-advocacy" social media findings): "Yes, with [my third child], I had postpartum depression, and I had to be medicated. I wasn't intending on talking to my doctor, and he brought it up, and he said I needed medication, and so I finally gave in." The inclusion of "I finally gave in" is of particular rhetorical significance. The interviewee implicitly indicates she was fighting an ongoing battle against being diagnosed with—or at least against taking medication for—PPD. She did not want to be labeled in the binary of aberrant sadness or otherwise be complicit in this intervention, one that signaled she needed assistance to function as a stable care provider, something she had presumably already been succeeding at twice over.

The *ethos*, or credibility and authority, that other parties hold in postpartum mental health-care decisions was blatantly presented in the interviewed moms' answers: "I did not [discuss postpartum depression . . . with my doctor or anyone else]. And I did experience some postpartum depression, but I grew up in a house that wasn't progressive around these issues, so we didn't talk about it—otherwise my mom would be mad. The doctor asked, but I brushed it off because my mom was in the room." In this instance, a young mother's dependence on (or perhaps fear of) her own mother as an authority in her decision-making process inhibited her ability to openly and honestly discuss her postpartum mental health-care concerns with her medical practitioner. The doctor was not able to effectively intervene in the patient's suffering with PPD given the patient's mother's physical presence and invisible

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emotional *ethos*. There is an interesting tie to social media mothering group shaming and silencing here.

Receiving a poor, shaming, hurtful, or otherwise negative reaction to a post soliciting parenting advice—or even *fear of* receiving a poor reaction, having silently observed discourse in the watchdog community—can disempower new and vulnerable moms (particularly young ones) from bringing such important decision-making discourse to their medical practitioners. Rather than working together to come to an ethically informed and community-supported best-practice decision, nodes in the network of contemporary maternity advice have severed literal lifelines. What if the mother had been more concerned for her daughter's mental well-being? What if the doctor had asked the mother to leave the room? What if the patient were able to muster the courage to have the discussion despite the odds stacked against her? *What if the agency lies in the network as a whole rather than in one person or entity? Our interviewee well articulates what is at stake in this proposed agential shift:* "I did not [discuss postpartum depression . . . with my doctor or anyone else] and mostly because it did not come up. I had a couple of friends with it. I don't think I knew anyone who was clinically depressed who needed assistance. I personally did not experience it. It's terrible, and it taints your whole experience." The last sentence of this quote—"It's terrible, and it taints your whole experience"—realistically captures the exigency of this book as a whole. We must work to recognize how difficult contemporary maternal decision-making is and how social media mothering groups designed to be supportive villages too often become platforms for polemics that misrepresent complex decision-making realities in the form of black-and-white binaries. Then, and only then, can we begin to envision ways to reframe these communities. These communities could empower mothers to take advantage of the human and technological actants converging in social media, as well as assemble an instrumentally significant *ethos* of happy and healthy parental decision-making that cares for the mom as much as or more than those around her. But there's still stigma, as evidenced in the following moms' answers.

"Do you feel there is a stigma around this conversation?"

As supported by our observation of discourse in contemporary social media mothering groups, interviewed moms seemed to agree that issues of PPD are being talked about, but probably not enough yet. In response to the question

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"Do you feel there is a stigma around this conversation? Why or why not?" the interviewed moms answered as follows:

> "I don't feel like there is so much, but I didn't experience PPD, but I've seen so many people share openly about it, and I think that's something that's common now. I know it's something that's hard to admit and come to terms with and it becomes less of a stigma."

> "I feel like there's less of a stigma around it. I haven't personally encountered someone experiencing [an] intense form of it. I feel like there was more stress and anxiety about 'will I have it?' beforehand. My doctors all built me up to believe I was going to get it, so it kind of took away from the 'this could be joyous' attitude. Instead, I was expecting something worse."

What is intriguingly common to these two responses is the implicit passing of responsibility to those suffering from PPD to do the work of lessening the stigma. The first respondent clarifies that she "didn't experience PPD" but that it's "hard to admit and come to terms with and it becomes less of a stigma," thereby structurally juxtaposing the circulation of first-person narratives of suffering with the lessening of the stigma. The second respondent juxtaposes "less stigma" with personal encounters of intense PPD, implying that it is the intensity of suffering that determines whether the stigma is lessened or strengthened. An additionally revealing comment in the second respondent's answer is the assertion that her doctor prepared her for the worst and made her believe that she would suffer from depression in her postpartum period. This was a particularly disabling discussion, according to the respondent, because she was hoping to indulge in the "joy" of the perinatal period; instead, her medical practitioner, presumably one of the figures with the most influence in her perinatal decision-making, caused her to feel the opposite of joy in expecting "the worst": inevitable PPD.

The intensity of language used by social media mothering group members as well as interview participants is duly worth noting:

> "Yes. I do. I feel like a lot of women feel like they have postpartum[5] and they're not a good mom and people don't want [to] talk about it. And taking medication feels like you're failing and that's really hard."

> "Yes. I do." Full stop. "Not a good mom." "You're failing."

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"Absolutely, and I think part of it is the normal stigma of talking about mental illness. So many people have this attitude of, 'why would you be depressed; you just had the best thing in the world: a baby . . . you couldn't possibly have depression,' and people brush it off as being tired."

"Absolutely." "Normal stigma." "You couldn't possibly have depression."

"YES. People pretend it's not happening, especially on social media. People just post happy things on social media."

"YES." "People *pretend it's not happening, especially on social media*" (emphasis added). While we might argue with this respondent that people on social media *are* talking about postpartum depression, another interviewee brings up a productive (if implicit) distinction between "understanding" and "feeling":

"Yeah, I do. I feel there's a stigma. I think that women are becoming more and more understanding, but in society there's a stigma."

While women may be becoming more knowledgeable about and generally more aware of PPD (its symptoms and causes), how it is *perceived* (and how it is *talked about*) is another story.

"Are there related topics you wished were being discussed that are not being discussed by moms and/or doctors?"

The fact that topics related to PPD were not being discussed was evident in social media mothering group discussions of PPD as well as in interviewees' responses to the question "Are there related topics you wished were being discussed that are not being discussed by moms and/or doctors?"

"My peds office is great with talking about everything. My OB was good, too. She didn't tiptoe around anything. I like that. My sister is the opposite, so I hope that doctors are good with not tiptoeing around sensitive topics."

"I wish postpartum was more aggressively discussed."

"In general, I wish that people were more comfortable asking their pediatrician or ob-gyn questions. I think people feel like they have to figure it out themselves (I was that way). 'What are ways that I can manage this?' I also think they should ask the new mom serious questions in private without their mom/husband being there."

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There is direct reference to the American bootstrapping *ethos* in the respondents' answers to this question as well as a clear delineation of PPD as a "sensitive" subject that deserves "aggressive" attention on the part of medical practitioners. "Tiptoeing" is a particularly apt description given the attention we want to put on not only *what* is discussed in social media mothering groups but *how* it is discussed. Silence can be particularly damaging for various reasons but talking *around* sensitive subjects may be equally if not more damaging.

The Nurses

We wanted to include the voices of real-world medical practitioners, both doctors and nurses, in this project, particularly in regard to the discussion and practices surrounding diagnosing and treating PPD (their satisfaction levels with current engagement and recommendations for future areas of research). Not unexpectedly—given the complicated legal context of contemporary medical practice liability—we were unable to find doctors willing to comment; however, a convenience sample of nurses wished to make their voices heard.

"Do you feel there is a stigma around this [postpartum disorders] conversation or practice?"

When asked to comment on the non/existent stigma surrounding postpartum disorder discussion and diagnosis, nurses seemed to agree that although the stigma was lessening, it was still an important factor in women neglecting postpartum mental health care:

> "Yes—there is in general. I think that people think of it as a weakness. People always say 'just be happy.'"
>
> "It's lessening, but yes, there is definitely a stigma. People feel shame surrounding the subject so they don't want to talk about it. They feel bad because they should."

Nurses offered language concerning "weakness" and "shame," complementing findings from face-to-face interactions and observations of online moms concerning how postpartum disorders are contextualized in everyday conversation. One nurse went on to contextualize "stigma" specifically as a matter of needed ongoing education:

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> Oh yeah, for sure. With any type of mental illness, there's so much stigma and shame. Moms might not be educated about their hormones, but there is a scientific reason for you to feel this way. There's a lot of guilt. "I have a new baby, why do I feel this way?" and they get buried in this guilty feeling.
>
> I had someone in the ER who came in with postpartum, and she was saying, "I can't even look at my daughter" and thought, "What's wrong with me? Why do I feel this way? I'm fine, I don't need help." People don't want to seek out help, but they need to utilize resources.

Considering that the nurses in our study (and other medical practitioners) advocate for ongoing education regarding postpartum disorders, we felt it would be pertinent to ask the following question: "How do you discuss and/or diagnose depression and other like disorders with your pregnant and postpartum patients?"

"How do you discuss and/or diagnose depression and other like disorders with your pregnant and postpartum patients?"

One nurse echoed the kairotic concerns discussed earlier in this chapter: "It has a lot to do with how they're attaching or bonding with the baby, which I think is a late cue, but it's the most measurable. It's a huge indicator." Criticism of the "measurable" nature of this variable aside, we call attention to the nurse's mention that ineffectual bonding is a "late cue," which accords with our observations of the *untimely* nature of current postpartum discourse.

Another nurse noted the shame inherent in answering the typical postpartum "quiz": "From my time, there are a lot of pre- and postnatal screenings; however, there is a lot of shame in answering those questions. Nurse practitioners and doctors sometimes need to push past these screenings to get the answer, and the shame can make that really hard." The nurse further implicated patients' partners in ongoing postpartum disorder work: "Also, sometimes the partner is a co-parent that also encourages a discussion of depression."

Though these short answers provide compelling evidence that complements interpretations of findings discussed earlier in this chapter, one nurse's lengthier personal narrative proved equally if not more valuable:

> Oh my gosh this is such a great question. I have struggled with my own general depression since I was in college. And we need to talk about it more, and

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> it needs to be less of a stigma all around. It's a HUGE part of my discharge teaching. I always talk about discharge teaching, but I talk about it before they walk out the door. We will get the history of the patient beforehand (depression, anxiety: we flag when moms have had depression in the past) so we know beforehand if it's something we need to look out [for]. I try to bring it in matter of factly so that it doesn't feel so heavy.
>
> It's SO common.
>
> I always ask, "Have you ever had medication, counseling, suicidal thoughts?" and I talk about it with the dad present. Or if I need to ask in a gentle way, I say "Have you ever heard of postpartum blues?"
>
> It's REALLY common, even if there's no history, and I don't think that's known. There's a dramatic change of hormones from moms after they give birth. The placenta was FULL of hormones that grow the baby, and the hormones drop after, and you'll cry a lot for a week or two.
>
> There are SO many times where I bring up "post baby blues," and moms get tears in their eyes. For about every 10 I bring it up, 6–7 moms nod their heads and agree.
>
> I also think it's difficult because a lot of times, during the 9 months [of pregnancy], everyone checks in on the mom, but when the baby arrives they forget to check in with her and just focus on the baby.
>
> It's always smart to have a good tribe with you that can help and encourage you.
>
> We ALWAYS screen new moms. It can happen up to a year postpartum.

The nurse's conflation of baby blues with PPD and her insistence on the commonality of PPD are particularly revealing. While other health-care professionals might balk at the idea of conflating the definitions of these clinical conditions, the rhetorical move here is to emphasize that these new mothers are not struggling alone ("It's SO common. . . . It's REALLY common"), that they are experiencing symptoms that can be explained in a medically sound and accessible fashion ("The placenta was FULL of hormones that grow the baby, and the hormones drop after, and you'll cry a lot for a week or two"), and that there is a shift in the focus of discourse after the baby arrives ("but when the baby arrives, they forget to check in with her and just focus on the baby") that significantly affects the mother's mental health. Even the nurse's awareness of tone in the delivery of this information ("I try to bring

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it in matter of factly so that it doesn't feel so heavy. . . . Or if I need to ask in a gentle way, I say 'Have you ever heard of postpartum blues?'"[6]) offers so much to the discussion of how *ethos* can and should be built around the circulation of parenting advice for contemporary mothers.

"Are there related topics you wished were being discussed that are not being discussed by moms and/or doctors?"

While there is so much to learn from *how* such advice is rendered and circulated, we felt compelled to ask the nurses, too, whether "there [are] related topics you wished were being discussed that are not being discussed by moms and/or doctors"; in other words, we wanted to know about what was not being talked about in addition to what was being talked about. The nurses we interviewed generally did *not* reiterate the need to talk about postpartum disorders or otherwise highlight postpartum disorders as a completely neglected topic of discourse among health-care professionals and their patients, as had the new moms we interviewed for this study; rather, they had some specific suggestions:

> "Maybe postpartum sex? Also depression should continue to be a topic of conversation to normalize it."

> "There is literally 0 percent chance that vaccinating your child will give them autism. Vaccinate your kids."

> "Yeah, I wish domestic abuse. They ask it once and they should ask it multiple times because no one is actually [supposed] to answer that with one question. They need to make the person feel safe and have the partner leave the room."

> "Social media. It can create a negative image."

Of particular interest to this book is the final suggestion, that social media needs to be a more prevalent topic of discussion in all postpartum discourse.

CONCLUSION: BLURRING THE LINES

The discourse that circulates via social media mothering groups can be variously heartening and troubling. Baby Forum's "What It Feels Like to Have Baby Blues, PPD, No PPD" infographic (figure 3.2), for example, does

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WHAT IT FEELS LIKE TO HAVE

BABY BLUES	PPD	NO PPD
Sleep Deprivation makes you emotional	**Sleep Deprivation** makes you angry	**Sleep Deprivation** makes you tired
Bonding with Baby doesn't happen immediately	**Bonding with Baby** doesn't happen at all	**Bonding with Baby** happens shortly after birth
The Changes in Your Life make you feel overwhelmed	**The Changes in Your Life** make you feel worthless	**The Changes in Your Life** make you feel excited
You Cry Tears of sadness	**You Cry Tears** of frustration	**You Cry Tears** of joy
Your Mind is foggy and unclear	**Your Mind is** full of bad thoughts	**Your Mind is** forgetful and distracted
Your Worry about un-important things	**Your Worry** if you are fit to be a mother	**Your Worry** if baby is pooping enough
After a Few Weeks you start to feel better	**After a Few Weeks** you start to feel worse	**After a Few Weeks** you get into a good routine

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Figure 3.2

Source: Vanessa Rapisarda quoted in kmswear22, June 13, 2018, at 6:10 a.m., comment on emccaskey (2018).

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damage in rigidly insisting that "bonding with baby doesn't happen at all" under PPD; such false statements enhance the guilt and shame that confirm a new mother's desire not to be labeled with aberrant sadness, and stymie complementary help-seeking behaviors.

The infographic is hyper-determined, stylistically (in its iteration of vertical columns of vastly contrasting colors). It doubles down on its insistence that baby blues, PPD, and absence of depression are discrete categories, though the reality is that these feelings and behaviors all exist on a continuum of normal postpartum experience that can certainly at times become debilitating or need treatment. It also reinscribes the dangerous binary that a new mother's body and brain (self-worth) are tied exclusively to the baby. Rather than technological actants and human actors that further establish existing binaries in postpartum disorder discourse, we need to ensure new mothers making mental health maternity decisions know that an experience that seems to blur existing mental health diagnostic lines is normal and that there is no trophy for waiting out the symptoms of PPD—in the same way that there are no "winners" in the gamifying of infant feeding decisions, discussed in chapter 4, "Breast/Fed Is Best: Whose Algorithm Is Feeding My Baby?"

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Assembling the Networked Ethos of Contemporary Maternity Advice

By: Jessica Clements, Kari Nixon

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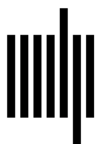

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