The Social Construction of Postpartum Depression

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Abstract

Postpartum depression (PPD) is a serious mental health condition that affects 5%–60% of women in the days and months after giving birth (Kwee & McBride, 2016; Öksüz, 2021; Shi et al., 2018). PPD not only affects the mother but has health and well-being influences on the infant and other family members (Praetorius et al., 2020; Shi et al., 2018). PPD is experienced worldwide and disproportionately impacts women who do not meet dominant narrative expectations of pregnancy and motherhood (Jackson-Best, 2016; Maji, 2018; Staneva et al., 2017). This literature explores the impact of dominant narratives on women experiencing PPD and how these narratives are shaped by the medical model and neoliberal expectations (Cosgrove & Vaswani, 2020; Kwee & McBride, 2016). Intersectional and assemblage theory are used to explore the impact of these policies on women's experiences and identities (Chadwick, 2017; Crenshaw, 1991). Additionally, recommendations for practice which incorporate an intersectional and trauma informed care lens are considered (Jackson-Best, 2016; Polmanteer et al., 2019; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Lastly, this literature review supports further exploration of intersectional factors of mothers and social institutions and how this can inform care practices for mothers experiencing PPD (Jackson-Best, 2016; Polmanteer et al., 2019).

The Social Construction of Postpartum Depression

Postpartum depression (PPD) is a serious mental health condition that affects women in the days and months after giving birth. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychological Association [APA], 2013) defines PPD as a major depressive disorder starting during the peripartum stage or up to 1 year after giving birth. PPD shares many of the same characteristics as other types of depression and includes symptoms such as diminished interest or pleasure in activities, depressed mood (e.g., feelings such as sadness or hopelessness), fatigue or loss of energy, decreased concentration, and possibly suicidal thoughts or ideation (APA, 2013). Women may experience exhaustion, appetite changes, somatic symptoms, social isolation, and diminished self-worth (Praetorius et al., 2020). Maternal depression also impacts the mental, physical, and interpersonal well-being of the woman's child and partner (de Camps Meschino et al., 2016).

In Canada, the rates of PPD are 23% for the general population and 30% for mothers under 25 years old (Statistics Canada, 2019). Worldwide PPD rates range from 5% to 60% (Kwee & McBride, 2016; Shi et al., 2018). PPD is the most common mental health concern experienced by new mothers, and PPD leading to maternal suicide is the number one cause of death in the first year after giving birth (Doe et al., 2017; Maxwell et al., 2019). The definition of mother varies among cultures, and as such, so does the expression and experience of PPD (Scharp & Thomas, 2017; Thomason et al., 2015). These statistics indicate a significant and universal prevalence of PPD, affecting mothers as individuals, as well as their infants and families (de Camps Meschino et al., 2016; Johansson et al., 2020; Praetorius et al., 2020).

Many environmental factors impact a woman's risk for PPD. Poverty, lack of secure employment resulting from pregnancy and birth, lack of support, minority status, immigration

status, and young age are contextual risk factors for PPD (Ghaedrahmati et al., 2017; Maxwell et al., 2019; Statistics Canada, 2019). Furthermore, pregnancy and new motherhood are a period of increased risk for domestic violence (Ghaedrahmati et al., 2017). It is significant to note that many of the contextual factors that affect PPD disproportionately impact young mothers, partially explaining the higher incidence of PPD in this demographic (Ghaedrahmati et al., 2017; Jackson-Best, 2016; Maxwell et al., 2019).

As PPD can impact many systems and individuals, there has been much exploration of PPD through the regulatory lens, such as requiring PPD screening, and the medical lens, with antidepressant prescription as first-line treatment (Staneva et al., 2017). Conceptualizing PPD through regulatory and medical models brings attention and awareness to the condition and its far-reaching implications (Limandri, 2019; Milgrom et al., 2015). However, the medical and regulatory models and neoliberal political worldviews disavow the mother's agency and autonomy (Cosgrove & Vaswani, 2020). Social constructs and expectations of the "good mother" are fertile ground for stigmatization and disempowerment when women experience PPD (Staneva et al., 2017). Faced with social oppression at a time of identity transition, women may silence their emotions and inner experience (Maji, 2018; Staneva et al., 2017).

This research review proposes to explore how the social factors of neoliberalism and the medical model contribute to the construction of the good mother stereotype, influencing women's experiences of PPD, identity, and self-silencing. The significance of this research is to contribute to the literature regarding the social construction of motherhood and PPD. The literature review is guided by the research question, *how does the experience of PPD influence mothers' perceptions of identity and experience with self-silencing?*

Self-Positioning Statement

It is necessary to situate oneself in the literature review process to provide transparency and understanding to the reader (Patnaik, 2013). As a researcher, I hope to gather information from a broad perspective and synthesize it into a coherent thread that will further understanding of the experience of PPD and the social contexts that influence self-silencing. Exploring and defining my personal and professional position reflexively throughout the research process will increase the validity and reliability of the review (Creswell & Poth, 2018; Neumann & Neumann, 2015). Not only is reflexivity critical to the research process and situating the researcher within the research, but it is also a self-awareness and growth process for the researcher (Patnaik, 2013).

Personal Position

I am a cisgender, White, middle-aged female in a long-term heterosexual marriage, and I am the mother of two teenage children. I was fortunate to have healthy, uncomplicated, and desired pregnancies and births for both of my children. I have not experienced PPD. I thoroughly enjoyed staying home with my children for many years, and I recognize the privilege within which I live that allowed me this opportunity. Socioeconomically, I live in a middle-class setting through my husband's income. However, as a stay-at-home parent for many years, I have not accrued stable nor substantial financial earnings. This juxtaposition of privilege and dependence perplexed me. For me, the social narrative that a stay-at-home mom is doing the "most important job in the world" contrasted with a lack of recognition from the government and society for this labour; only to be labelled a dependent on income taxes highlighted the disparity created by dominant narratives and patriarchal influence.

It is interesting how my husband and I decided who would stay home with our children. While we recognized it was a stereotypical and traditional choice, it was what we had both

experienced as children and thus valued a mother in that position. Being cognizant of this "choice" allowed us flexibility in defining our roles as mother and father and finding agency and autonomy within our traditional family structure. However, through this research, I recognize how I had internalized aspects of the good mother narrative. It is interesting to consider the influences in that choice and what was actually my choice.

It is essential to be aware of bias regarding my own values, expectations, and internalized norms of motherhood. As someone who wanted to have children, and has education and experience working with and parenting children, I have an initial inclination and bias toward perceiving mothers as wanting the role. Furthermore, I believe in a woman's reproductive rights, which may indicate a bias toward expecting pregnancy as wanted. Additionally, this belief in reproductive rights aligns with neoliberal expectations of agency and self-determination. To be aware of my bias requires acknowledgement and awareness of biased moments, and reflexivity to assess the potential influence on the literature review.

As my children are mostly grown, I can reflect on the growth, changes, and challenges for myself as a mother and woman. I have come to recognize the vulnerability of women, particularly mothers, as they negotiate their position within the patriarchy, medical model, and neoliberal forces that oppress. As an act of social justice, I hope this literature review contributes to the voices of mothers.

Professional Position

A narrative review requires the researcher to further understand the topic by synthesizing themes and key issues from various sources related to the research question (Efron & Ravid, 2019). For this narrative literature review, I planned to identify issues that play a role in the social construction of PPD from a Western perspective. I approached this research from a

postmodern, social constructionist worldview.

Postmodernism is a view that does not accept an absolute truth but instead suggests that the realism we perceive in the world is a social construct, developed to keep those with power and those without power in their relative positions (Freedman & Combs, 1996). Social constructionism implies that we form our identity through language and meaning making from the "culturally available and appropriate stories…historically constructed and negotiated in [society] and within the context of social structures and institutions" (White, 1993, p. 37, as cited in Redekop, 1995). Our personal narratives are a collection of the social relations and intersection we experience in our lives (Combs & Freedman, 2012).

I am moved by Michel Foucault's stance of "language as an instrument of power," and that one's ability to participate in the discourses that shape society is indicative of one's power in society (Freedman & Combs, 1996, p. 37). This phrase eloquently summarizes the critical awareness I had of being both lauded and unrecognized by society for being a mother, and it can be applied to the themes of intensive mothering and societal expectations from the literature review. This concept of power can be applied to knowledge: those with power have knowledge, and knowledge is power (Freedman & Combs, 1996).

To situate myself in the research process, I used a bubble map to consider a range of factors that construct and motivate my personal and professional selves. The map allowed me to separate and delineate my roles and organize my research approach and reflection. Further strategies to increase my awareness and depth of knowledge were to consult with a psychology professional within the field of birth trauma and with a peer who studies and employs intersectionality theory in her work with immigrants.

Review of the Literature

A literature review as a stand-alone research method can identify gaps or inconsistencies in the literature, identify future research, and provide new perspectives (Turner, 2018). A literature review aims to progress the knowledge in the topic area by generating a trustworthy interpretation of current and past research (Efron & Ravid, 2019). This literature review initially aims to synthesize the impacts of the social factors of the medical model, neoliberalism, and mental health perspectives of PDD. Secondly, this literature review aims to show how these social factors impact and influence the social and individual stigma faced by women who experience PPD.

The search engines EBSCO, PsycINFO, and PubMed were used to search the keywords *postpartum depression, stigma, identity, social construction*, and *self-silence*. Literature on male experiences of PPD was excluded from the review (see Eddy et al., 2019; Johansson et al., 2020; Sipsma et al., 2016; Tokumitsu et al., 2020). The intent was not to dismiss the challenges faced by fathers during this transition period but rather to examine the gendered experience women encounter. The review considered studies from 2015–2021, with the exception of seminal works in reference to theories, models, or definitions. The prevalence of maternal suicidality while experiencing PPD is severe (Praetorius et al., 2020; Shi et al., 2018). However, literature pertaining to maternal suicide was excluded from this review to focus on women's experiences with stigma and self-silencing. Studies were from various countries—Canada, the United States of America, Mexico, China, Japan, Sweden, Australia, and India. In part, these studies note the cultural and ethnic uniqueness of motherhood and PPD and, thus, reveal consistency and similarity of broad social constructs associated with motherhood and PPD, which is the focus of this review. My interpretation of the unique and similar constructs situates this review within the

intersections and context of my own experience.

This review is organized into the following sections. First, the history and implication of institutional and political social factors are reviewed (i.e., the medical model and neoliberalism). Next, the consequences of these social factors on women's perceptions of intensive mothering, stigma, and self-silencing are considered. Finally, future directions for review and gaps in existing research are considered.

Social Factors and PPD

PPD and the Medical Model

The medical model assumes a stance that physiological factors cause mental health disorders and disease (Huda, 2019). This view suggests that a mental health disorder's aetiology is a possible deficiency or maladaptation of genetics, neurotransmitters, or neuroanatomy as the source of the individual's symptoms and distress (Limandri, 2019). Ethically, peri- and postnatal biological research is limited, and as such, there is a paucity of research into specific neurophysical variations in PPD (Limandri, 2019). The prominent theory of depression hypothesizes that an imbalance of neurotransmitters (i.e., serotonin, norepinephrine, and dopamine) causes depression symptoms (Limandri, 2019). Medications prescribed increase or influence the uptake of neurotransmitters to reduce symptoms.

Sertraline is the most frequent selective serotonin reuptake inhibitor (SSRI) prescribed for PPD (Cuomo et al., 2018; Pinheiro et al., 2015). It has a short metabolite half-life, reduced transmission, and less impact on breast milk and breast milk production compared to other SSRIs (Cuomo et al., 2018; Pinheiro et al., 2015). Numerous studies have indicated the safety of consuming SSRIs for PPD for mother and infant (Cuomo et al., 2018; Pinheiro et al., 2015). However, studies on the efficacy of sertraline and SSRIs indicate monotherapy use of

antidepressants is not an adequate standard of treatment (Milgrom et al., 2015; O'Hara et al., 2019).

The medical model advocates for early screening and aggressive treatment with antidepressant medication to prevent the negative impacts of PPD (Cosgrove & Vaswani, 2020; Limandri, 2019). Medical discourse suggests disease lies within the individual and views problems, such as PPD, as a collection of symptoms (Worrall, 2018). However, only considering symptom reduction excludes the mother's experience (Cosgrove & Vaswani, 2020). Mothers may express uncertainty and ambivalence towards using antidepressant medication to treat PPD due to concerns about their own and their baby's health (Limandri, 2019; Milgrom et al., 2015).

Within the medical model, a woman and infant's health care needs are prioritized over their social and psychological needs (Cosgrove & Karter, 2018; Kwee & McBride, 2016). Even though there is widespread knowledge of emotional and mental health concerns for postpartum women, there continues to be a focus on their medical and pathological health (Kwee & McBride, 2016). Thus, the medical model poses a barrier to accessing psychosocial care (Cosgrove & Karter, 2018; Kwee & McBride, 2016). These barriers contribute to the stigma and shame that women experience (Kwee & McBride, 2016). Women's voices and knowledge can be dismissed within the medical model as pregnancy and birth are pathologized and considered as symptoms and procedures (Chadwick, 2017; Kwee & McBride, 2016). This medicalization of pregnancy and delivery may place the doctor in control while silencing and disempowering the woman (Chadwick, 2017; Cosgrove & Vaswani, 2020; Woollard, 2018). The medical model views PPD as an individual fault or deficiency rather than as situated in the broader environment (Worrall, 2018).

PPD and Neoliberalism

Neoliberalism is the worldview that considers individuals as self-concerned agents, not members connected to the larger community (Cosgrove & Karter, 2018; Douglas et al., 2021). This view suggests that people's needs are "best met through the marketplace rather than through engagement in political life" where the government has an obligation to well-being, gender equity, and human rights (Cosgrove & Karter, 2018, p. 670; Cosgrove & Vaswani, 2020). The commodification of wellness and privatization of social services creates a market whereby health is measured in terms of economics, and it is the individual's responsibility to provide for their own wellness and health (Cosgrove & Karter, 2018; Sakellariou & Rotarou, 2017).

Depression is an example of the commodification of mental health (Cosgrove & Karter, 2018). Rates of depression are reported in terms of productivity loss, sick days' costs, and expenditures of pharmaceutical and other health care measures to treat depression (Cosgrove & Karter, 2018). The dominant narrative of economic loss places the burden on the individual to be treated for depression and then return to work to contribute to the economy (Cosgrove & Karter, 2018). However, the environment and context of factors influencing a person's experience with depression are not considered or are disconnected and made disparate from depression (Cosgrove & Karter, 2018; Douglas et al., 2021). People are seen as having experienced trauma, illness, or disease and in need of treatment, rather than social justice being seen as the remedy (Maxwell et al., 2019; Worrall, 2018).

The neoliberal view condemns people to be at-risk, pre-diseased, or diseased by screening for depression with an agenda to ensure "efficiency over engagement, [and] productivity over citizenship" (Cosgrove & Karter, 2018, p. 674). These policies are criticized for ignoring potential iatrogenic harms from screening (Cosgrove & Karter, 2018; Cosgrove &

Vaswani, 2020; Worrall, 2018). The neoliberal worldview that the individual is responsible for their health may further stigmatize mothers by labelling them as diseased and responsible for their PPD experience (Douglas et al., 2021). A focus on efficiency without regard for intersecting factors "pathologizes and depoliticizes women's experiences of pregnancy and maternal stress" (Cosgrove & Vaswani, 2020, p. 50).

The neoliberal perspective on wellness influences the medical model. This influence occurs in Western countries like the United States and Canada. Some states have mandatory PPD screening and prevention policies that disregard the iatrogenic risks of screening and the unproven effectiveness of antidepressant medication (Cosgrove & Vaswani, 2020; Limandri, 2019). In Canada, PPD screening is not recommended, however, routine screening is used in Alberta (Premji et al., 2019). Public health nurses use the Edinburgh Postpartum Depression scale during baby wellness check-ups and will refer high-risk women to their doctor for follow-up care, which is most often pharmaceuticals (Alberta Health Services, 2019; Premji et al., 2019).

The restructuring of healthcare policies to reflect neoliberal policies and ideals has resulted in many inequalities in healthcare (Baru & Mohan, 2018; Sakellariou & Rotarou, 2017). Market principles, including consumerism, privatization, and deregulation, exemplify neoliberal ideals of individual responsibility (Baru & Mohan, 2018; Sakellariou & Rotarou, 2017). However, based on reviews of neoliberal policies and healthcare, marginalized people are found to have less access to healthcare and welfare services and may experience further stigmatization for not attaining the neoliberal ideals of individual responsibility (Baru & Mohan, 2018; Sakellariou & Rotarou, 2017). The medical and regulatory models can leave women pathologizing their birth experience and feeling disempowered (Kwee & McBride, 2016).

Stereotypes and PPD

Neoliberal medical model practices provide a framework that shapes and influences the way people interact with these institutions. The expectations, access, and barriers within these frameworks are foundational to the evolution of stereotypes practiced in societies. Following is a review of social and intensive mothering stereotypes experienced by women.

Social Stereotypes

There are many commonalities among cultural and historical constructions of women's sexual and reproductive embodiment, such as abject femininity, becoming a woman with menarche, and not talking about women's sexuality (Ussher et al., 2017). Patriarchal and heterosexist cultural and religious power dictates secrecy and silence surrounding women's sexuality (Maji, 2018; Ussher et al., 2017). Traditional stereotypes uphold the discourse whereby unmarried women should not think about sex (Ussher et al., 2017). The dominant narratives by White, middle/upper-class women who dictate the good woman stereotype include engaging in self-policing to contain and control sexual desire (Kerrick & Henry, 2017; Meeussen & Van Laar, 2018). Self-policing is integral to female gender roles displaying nurturance and calmness for others while silencing the self to conform to societal standards (Maji & Dixit, 2019). These narratives may continue into pregnancy and mothering.

Cultural expectations of how mothers should behave and feel leads to the construction of dominant motherhood narratives (Maji, 2018; Maxwell et al., 2019; Ussher et al., 2017). Womanhood narratives often consider motherhood as a defining moment. In addition to the good mother narratives, this feeds into intensive mothering norms (Meeussen & Van Laar, 2018). The good mother narrative suggests that women are self-sacrificing in their goal to care for their children (Maji & Dixit, 2019). Intensive mothering norms propose that mothers are innately

skilled to be mothers and should be the primary person responsible for the children (Meeussen et al., 2016; Staneva & Wigginton, 2018). These norms set the standard in which to achieve affirmation of one's social identity and sense of self. Dominant narratives such as the "ideal pregnancy," "love at first sight," and the "good mother" can provide guidance surrounding normative experiences (Kerrick & Henry, 2017). Conversely, these narratives can be constraining by representing an unattainable standard to which a woman may perceive and judge their experience (Kerrick & Henry, 2017).

A woman does not need to subscribe to the social standards and norms of motherhood to feel the impact of dominant narratives. Research has indicated that all women experience motherhood narrative pressures, which may negatively impact their psychological well-being (Henderson et al., 2016; Meeussen & Van Laar, 2018). The hegemonic and pervasive discourse of motherhood creates an environment wherein women, regardless of whether they subscribe to mothering norms or not, experience guilt, shame, increased stress and anxiety, and decreased self-efficacy (Henderson et al., 2016). These results indicate that the omnipresent societal motherhood narratives are an "inescapable cultural mandate" where the choice to accept or reject societal norms is elusive (Henderson et al., 2016, p. 513).

An example of the pervasiveness of cultural mandates is the worldwide public health message that breastfeeding is best. When the World Health Organization, hospitals, doctors, and community are the voice of the message, the pressure is immense. There is much evidence for the health benefits of breastfeeding for the infant and the mother. However, these messages present a monolithic, gendered, and socially normed view of the woman (Balint et al., 2018; Woollard, 2018). These messages are directed at women during a time of vulnerability—managing a significant life transition along with interacting with new institutions, policies, and

relationships (Balint et al., 2018). The public health campaign reinforces gender stereotypes of motherhood and women as the only natural caretakers (Maji & Dixit, 2019; Meeussen & Van Laar, 2018). This example draws awareness to the manipulation women experience as their rights and autonomy are constructed and policed by the patriarchy (Balint et al., 2018; Cosgrove & Vaswani, 2020).

Intensive Mothering

Intensive mothering is an ideology that has developed in the wake of neoliberalism. Women balance the cultural and gendered narratives to provide domestic security with the neoliberal expectations to be productive members of society. As a result, mothering norms have evolved into time and resource intensive expectations (Myers, 2017). Each individual uniquely perceives intensive mothering. Still, general themes are that the woman knows what is best for the child, naturally knows how to parent, and willingly sacrifices herself to put the needs of children, and others, ahead of hers (Staneva et al., 2017). Intensive mothering also impacts her partner, as the mother assumes maternal gatekeeping behaviours to affirm their identity and accomplishment of societal expectations (Meeussen & Van Laar, 2018; Staneva et al., 2017). Maternal gatekeeping behaviours include restricting or setting the standard for their partner's involvement in childcare and household management, or doing the tasks themselves (Meeussen & Van Laar, 2018). Pressure to be the perfect mother can lead to exhaustion and burnout (Meeussen & Van Laar, 2018).

Work and family lives are connected, and intensive mothering ideologies can play roles as women and families negotiate family and work life. Due to the gendered nature of parenting, women experience the gendered pressure more so than fathers (Henderson et al., 2016). Some women may decease career ambitions to meet intensive mothering demands, thereby confirming

feminine and mothering stereotypes (Meeussen & Van Laar, 2018). It becomes an iterative process whereby an attempt to affirm one's identity as a mother requires adherence to social norms, which thereby reinforce gendered stereotypes and results in a constricted and silenced view and experience of women (Balint et al., 2018; Henderson et al., 2016; Meeussen & Van Laar, 2018).

In response to intensive mothering expectations, women may respond with prevention or promotion foci to manage their beliefs and personal expectations (Schoppe-Sullivan et al., 2017). A promotion focus is attending to potential success and positive outcomes, an alignment of values with societal norms (Meeussen & Van Laar, 2018; Schoppe-Sullivan et al., 2017). With a prevention focus, women use hyper-vigilance to prevent adverse outcomes and threats to identity or status (Meeussen & Van Laar, 2018; Schoppe-Sullivan et al., 2017).

While good mother narratives exist independent of race, socioeconomic status, or sexual orientation, intensive mothering is prominent with White women of middle or higher socioeconomic status (Schoppe-Sullivan et al., 2017). The inherent status involved with intensive mothering may further constrict who is part of the "in-group," while continuing to define what is socially acceptable for mothers. This practice continues to devalue and discriminate the motherhood experience of "out-group" women, negating women's autonomy and further silencing their experiences (Jackson-Best, 2016; Maxwell et al., 2019; Staneva et al., 2017; Ussher et al., 2017).

Individual Factors and PPD

Neoliberal ideology and medical model practices establish the foundational framework for the development of social standards (Chadwick, 2017; Cosgrove & Karter, 2018). These standards evolve into "in and out group" experiences that promote standards and norms to which

mothering and mental health are evaluated by (Jackson-Best, 2016; Maxwell et al., 2019; Scharp & Thomas, 2017). The individual who does not “fit” into these norms may experience barriers and oppression, such as immigration and socioeconomic status, and reduced mental health, resulting in stigmatization (Daoud et al., 2019; Ghaedrahmati et al., 2017; Jackson-Best, 2016; Maxwell et al., 2019).

Immigrant Experience

Immigrant women experience higher rates of PPD (Statistics Canada, 2019; Topa et al., 2017) and access health care services less routinely and less frequently than nonimmigrant women (Ussher et al., 2017). There are many social determinants of health that are impacted by the immigrant experience, such as language barriers, transportation, lack of access to health care services, and lack of awareness of health care support (Ussher et al., 2017). Women may also not seek care due to cultural mothering norms (e.g., other family members receive care first) and the role of women in their culture or religion of origin (Shi et al., 2018). As well, women with low status or unfamiliarity with the health care and community services systems are more likely to deny their strength and “assume passivity in the face of dominant ideology" by conforming to avoid social stigmatization (Topa et al., 2017, p. 117).

Immigrant women may face discrimination and disempowerment in their interactions with medical or community services (Topa et al., 2017). Practitioners may, knowingly or not, use racial or ethnic microaggression in their management of the woman's health care and PPD symptoms without recognizing the intersecting context (Arthur, 2018). Immigrant women experience constant observation and comparison with Western ideals and standards (Barkensjö et al., 2018; Topa et al., 2017). Immigrant women may self-silence against dominant forms of power to deal with oppression (Topa et al., 2017).

PPD and Stigma

During pregnancy and postpartum, many women contend with many changes to their body, social relationships, and emotions, along with interaction with new institutions, such as obstetrics and childcare (Priddis, 2015; Staneva et al., 2017). These personal and interpersonal changes result in changes in exposure to discrimination due to stereotypes related to sexuality and motherhood (Rosenthal et al., 2015). Women may experience discrimination for not conforming to the ideal mother stereotype (Staneva et al., 2017).

Examples of women who are frequently socially devalued as mothers are women of colour, single or young mothers, members of LGBTQ2+, women with disabilities, and women of low socioeconomic status (Öksüz, 2021; Rosenthal et al., 2015; Sheeran et al., 2018; Sipsma et al., 2016; Trettin et al., 2006). Discrimination is positively associated with anxiety and depression symptoms and is negatively associated with self-esteem (Rosenthal et al., 2015; Sipsma et al., 2016). Discrimination and stigma are associated with isolation, loneliness, and not seeking care. These factors affect a woman's experience and recovery from PPD (Hansson et al., 2017).

PPD is associated with mental health illness, which continues to endure stigma (Manago et al., 2019). In many settings, seeking help for mental health issues requires seeing "specialists," which reinforces the stigma that there is a "problem" with the mother (Maxwell et al., 2019). Many women will not seek help and feel the need to "wear a mask" and hide their distress to avoid the stigma associated with seeking help (Maxwell et al., 2019). PPD symptoms at subclinical levels are often experienced but concealed because of associations with mental illness and women's internalized mental health stigma (Kwee & McBride, 2016; Mickelson et al., 2017).

Stigma about PPD or struggles with motherhood may come from family, friends, or community members. There are many stories of joy and happiness postpartum, but few stories about feelings of distress and depression (Mickelson et al., 2017). If a woman does not meet cultural and or religious expectations (e.g., gender or disability of baby), she may experience lower social standing in her family (Shi et al., 2018). Furthermore, cultural and familial interpersonal relationships may dictate whether a woman may have an opportunity to express negative feelings (Driver & Shafeek Amin, 2019; Shi et al., 2018). For example, in China, the norm of living with extended family after childbirth may lead to numerous complex, and perhaps conflictive, relationships where mothers have little opportunity to express their needs (Shi et al., 2018). This practice is associated with higher rates of PPD for women in China (Shi et al., 2018).

When a woman's experience with motherhood and gender roles aligns with motherhood's cultural and socio-political institution, this may affirm their identity and internalization of the good mother narrative (Hansson et al., 2017; Staneva et al., 2017). Self-stigma or internalization of stigma suggests that an individual endorses or finds the stereotypes relevant (Hansson et al., 2017). However, this creates a situation where women stigmatize each other or themselves. Compliance or acceptance of culturally defined "mother" reinforces and emboldens this constrained, sociopolitical view of motherhood (Kerrick & Henry, 2017). This positive feedback loop continuously increases the risk of a mother not disclosing their struggles with PPD as isolation, stigmatization, and inability to attain good mother standards hang in the balance (Hansson et al., 2017; Kerrick & Henry, 2017).

PPD and Self-Silencing

Parenting efficacy mediates internalized stigma and impacts intrapersonal constructs such as self-efficacy (Mickelson et al., 2017). Internalized stigma is defined as the negative feelings

(e.g., shame, deviance, or embarrassment) that a woman experiences about their PPD symptoms (Mickelson et al., 2017). Experience stigma is a woman's perception of being stigmatized by others due to her PPD symptoms (Hansson et al., 2017; Mickelson & Williams, 2008). If women perceive others are treating them differently because of their PPD symptoms, they may be less likely to reach out for direct support (e.g., ask for help) and instead use indirect support seeking behaviours (e.g., sighing without explanation, ambiguous vocalizations) in an attempt to preserve self-esteem and avoid disclosure (Mickelson et al., 2017). Direct and indirect support seeking mediates experienced stigma and influences interpersonal constructs such as social support (Mickelson et al., 2017).

Developmentally, for many women, identity is built through the gradual development of a sense of "agency through communication" (Miller in Maji & Dixit, 2019, p. 4). Women's relational self has three core features: interest and attention to others to have an emotional connection, the expectation of mutual empathetic process, and expectation of relationship (Jack, 1991). The self-silencing theory is based on attachment theory (Bowlby, 1982) and self-relational theory (Surrey, 1985), suggesting that women silence thoughts, feelings, and actions as a strategy to maintain relationships (Tariq et al., 2020).

However, self-silencing is rooted in internalized social and gender norms and gender-based hierarchy (Maji & Dixit, 2019). To conform to societal norms, women portray an external "false" self (self-sacrificing, nurturing others before self) and silence their inner self, one's thoughts, feelings, and ideas. Self-silencing is a motive for avoiding conflict, disapproval, and loss of love rather than obtaining happiness and satisfaction in relationships (Jack, 1991; Surrey, 1985). For example, mothers who experience a lack of affection or require time to develop affection for their infant often experience intense feelings of guilt and shame as their experience

does not conform to societal norms (Rosenthal et al., 2015). This silencing for the sake of conformity and relationship poses a dialect of empowerment and disempowerment. Women's motives for self-silencing may be based on positively and negatively internalized cultural, spiritual, and familial narratives (Heshmati et al., 2021; Surrey, 1985).

Summary

PPD is a mental health concern that impacts the lives of mothers, their infants, and other family members, and is a public health concern (Praetorius et al., 2020). There are many personal risk factors of PPD, such as previous experience with depression, depression during pregnancy, substance use, or childhood trauma (Praetorius et al., 2020). In addition, personality traits, such as control and self-efficacy, have been shown to impact a woman's experience of PPD (Brenning et al., 2019). There are also environmental risk factors of PPD including poverty, lack of secure employment resulting from pregnancy and birth, lack of support, minority and immigration status, and young age (Ghaedrahmati et al., 2017; Maxwell et al., 2019; Statistics Canada, 2019).

Many women who experience PPD may experience distress such as isolation, loneliness, and a lack of support due to stigma (Maxwell et al., 2019). Many factors shape the development of stigma. The medical model contributes to stigma by focusing on physical symptoms and medicalizing pregnancy and birth, and pathologizing the birthing woman (Cosgrove & Vaswani, 2020). Neoliberal policies contribute to the worldview that individuals are responsible for their ability to contribute to the market (Cosgrove & Karter, 2018; Cosgrove & Vaswani, 2020). Healthcare is evaluated through the lens of economic loss rather than a social condition (Cosgrove & Karter, 2018). This political drive to be productive provides a foundation for intensive mothering (Hansson et al., 2017). The cultural acceptance of intensive mothering

creates a constraining view of the mother (Myers, 2017; Staneva et al., 2017).

Cultural stereotypes of the good mother narrowly define a mother as selflessly dedicated to her children and the natural caregiver (Staneva et al., 2017). This stereotype is pervasive such that women who are not mothers or who do not subscribe to the good mother ideal experience stigma (Myers, 2017). Due to their age, gender of partner, socioeconomic status, immigration or minority status, or mental health status, marginalized women may experience discrimination and stigmatization for not attaining the good mother ideal (Hansson et al., 2017; Staneva et al., 2017).

There is a multitude of factors that contribute to the social construct of motherhood. A woman who is experiencing PPD may encounter discrimination and oppression from a single element or multiple sources and may experience stigmatization as a result (Maxwell et al., 2019; Mickelson et al., 2017; Rosenthal et al., 2015). A woman's reaction may be to self-silence to avoid stigma (Hansson et al., 2017). Self-silencing speaks to the vulnerability in women's gendered experience and the narrow social constructs of "mother" (Hansson et al., 2017).

Implications for Counselling Psychology

The literature review informs about environmental, political, social, and medical factors that influence a woman's experience with PPD. Overall, there is a worldwide prevalence of PPD between 5%–60% (Kwee & McBride, 2016; Öksüz, 2021, Shi et al., 2018). Numerous studies have illuminated how intersecting factors of race, ethnicity, and immigration influence a women's chance of experiencing PPD and the experience itself (Kwee & McBride, 2016; Maxwell et al., 2019). The awareness of these intersecting factors has important implications for counselling.

Institutional and neoliberal policies and practices provide the frameworks which

formulate the interactions between a woman's interpersonal relationships, intrapersonal relationships, and social factors (Grzanka & Miles, 2016). Intersectional theory, developed by Kimberlé Crenshaw, provides a method to analyze how various social and political factors combine and illustrates points of oppression and privilege (Crenshaw, 1991; Mirza, 2013). Once the analysis is complete, intersectionality theory focuses on the development of social justice and action practices (Buchanan et al., 2020; Crenshaw, 1991; Warner et al., 2020). Intersectionality theory in psychology is criticized for limiting itself to identifying intersecting factors and negating the call to social action (Buchanan et al., 2020; Crenshaw, 1991; Goff & Kahn, 2013; Grzanka & Miles, 2016). Additionally, it is suggested that intersectionality views oppression and privilege from a personal rather than an institutional vantage point (Stevens et al., 2018; Warner et al., 2020). Therefore, to present a comprehensive view of the social construction of PPD, intersectional theory is explored through its extensions of decolonial intersectional theory and embodied intersectional theory and further through assemblage theory. Furthermore, discussing the implications for counselling psychology begins the process of conceptualizing ethical and competent care for the individual or population being studied. Cultural humility and ethical implications of moral rights and social justice are considered.

Intersectional Theory

Intersectionality is a theory of identity that explains how gender, race, ethnicity, socioeconomic status, and immigration interact to create one's experience and sense of self (Crenshaw, 1991; Mirza, 2013). Beyond categorizing the segments of vulnerability and oppression, with intersectional theory, one can view the interactive relationships between these social factors and how they play a role in the mental health of mothers experiencing PPD (Stevens et al., 2018). Moreover, the social factors that contribute to the vulnerability of mothers

experiencing PPD are not considered additive to the mother's PPD experience but as intricately intertwined, signifying the social construction of PPD and the related complex mental health treatment needs (Stevens et al., 2018).

Intersectionality refers to the concept that "structures of inequality are mutually constitutive" (Warner et al., 2020, p. 262), meaning the oppressed and the powerful assume their socially constructed role. For women experiencing PPD, this may include internalizing the narratives of the good mother and ideal pregnancy and the resulting self-stigma (Staneva et al., 2017). Women may silence their experience with PPD to protect themselves from external stigma (Praetorius et al., 2020). This external stigma may be displayed in a subversive manner through the very institutions set out to help women experiencing PPD. For example, the medical model defers to a "sickness" framework with pathologization and diagnosis of the individual and will often require mothers to seek support from specialists, which may be experienced as further "othering" (Grzanka & Miles, 2016; Warner et al., 2020).

Does intersectionality as identity theory reflect grounding in neoliberalism? The neoliberalism unit of trade is the agency, liberated self, disconnected from the social context (Warner et al., 2020). From a neoliberal construct, this may look like representation, inclusion, and recognition for one's difference but without equality or institutional representation (Crenshaw, 1991; Goff & Kahn, 2013; Grzanka & Miles, 2016). For the woman experiencing PPD, this may look like representation and recognition of their situation, but with interventions that place the responsibility for change and well-being onto the mother (Grzanka & Miles, 2016). The intersectional lens presents a tension-filled dialectic between affirming identity and succumbing to neoliberal ideals (Grzanka & Miles, 2016).

Intersectionality provides a framework for analyzing the complexities of individuals'

lives (Grzanka & Miles, 2016; Warner et al., 2020). Intersectionality also includes a call to action and social justice to change the "relationships among systems of domination" (Crenshaw, 1991; Grzanka & Miles, 2016, p. 383). However, the latter is often forgotten in mental health practice (Chadwick, 2017; Grzanka & Miles, 2016). The result is a focus on identities and not the structure of power imbalance. Reducing intersectionality to identity identification may reflect psychology's focus on the individual and the simplicity of social categorization, reflecting a modernist epistemology (Goff & Kahn, 2013). A woman's multiple identities create an "either/or" situation, whereby identities are compared, excluded, or multiplied, further stigmatizing the woman (Grzanka & Miles, 2016).

Furthermore, the methodology of psychological study has been critiqued for perpetuating an "either/or" situation with identity (Goff & Kahn, 2013). Overall, psychological research methodology favours generalizability of causality and results, thereby preferring the 2x2 factorial design (Goff & Kahn, 2013). This preference reduces research to study the influence of two independent variables against one dependent variable (Creswell & Poth, 2018). The result is a study that focuses on a single axis of intersectionality, creating parsimonious data to which otherwise may be a complex situation when all intersections are considered (Goff & Kahn, 2013). In a sense, the parsimony and generalizability of the research data, along with the individual focus of many psychological theories, reinforces neoliberal practices by essentializing the identity of the individual woman who experiences PPD (Goff & Kahn, 2013).

To address the critique of intersectionality theory conceptualization in psychology are calls to move beyond labelling identities and to employ all tenets of intersectional theory. The tenets of intersectional theory, as described by Settles et al. (2020), include:

1. Structures of inequality are mutually constitutive, such that sexism, racism, classism,

hetero-sexism, and other "isms" co-create and substantiate each other;

2. These interrelated power structures inform subjective experiences of social identities, such that a person's social group membership (e.g., race) cannot be understood without also understanding the other social groups to which they belong (e.g., gender and class); and
3. Theory and praxis should be combined to consider social justice actions and goals (p. 798).

Intersectional theory has the potential to advance psychology's integration of institutional, political, and social contextual factors. Intersectional theory and its extensions provide a critical and transformative method for conceptualizing the social construction of PPD (Settles et al., 2020).

Embodied Intersectionality

Embodied intersectionality conceptualizes power and disempowerment through the intersection of external situatedness (intersection of social factors) and the embodiment and lived experience of the individual (Mirza, 2013; Ussher et al., 2017). The embodied lens of intersectionality considers the phenomenological experience of an individual's identities. This lens addresses the "either/or" situation by examining multiple identities, which are a part of the embodied experience.

The social norms of intensive mothering and the good mother intersect with a woman's embodied experience when experiencing PPD (Staneva & Wigginton, 2018). Women who experience PPD make sense of their embodied experience by situating it within the social context. The mothers balance precarious social norms and an essentialist image of the good mother with their distress (Staneva et al., 2017). The imperative to remain happy, calm, and

knowing is in opposition to the experience of distress when experiencing PPD and creates a dialect of identities (Maxwell et al., 2019; Staneva et al., 2017).

To frame their experience with distress within dominant discourse, women who experience PPD find limited vocabulary, people, and place, to express their distress (Lara et al., 2016; Staneva & Wigginton, 2018). Moreover, women may perceive stigmatization if sharing their PPD experience. Mothers will often minimize and distance from their depressed self by externalizing the distress as experienced by others, by using metaphor or codes, or by denying and silencing themselves (Maji, 2018; Staneva & Wigginton, 2018). Embodied intersectionality provides a lens to conceptualize the lived and felt experience of the individual woman and her experience with PPD.

Decolonial Intersectional Theory

Intersectionality theory and psychology are criticized for having a Western focus, perpetuating Eurocentric/North American and colonialist views (Patil, 2013; Warner et al., 2020). The common psychological pursuit of self-expression, growth, and emotional satisfaction are goals of individual theories of psychology and has roots in a neoliberal view of individualism disconnected from social context (Cosgrove & Karter, 2018; Warner et al., 2020). Decolonial intersectional theory aims to break intersectional theory out of its Western hegemonic confines, to consider how colonial agendas, mentality, and power structures privilege and oppress the intersections of people and populations from a cross region or transnational perspective (Macleod et al., 2020; Warner et al., 2020). A transnational perspective recognizes that "women's experiences are not the same everywhere because of intersectionalities and context, but they share commonalities as related to patriarchy being a transnationally dominant system" (Canetto, 2019, p. 146).

PPD is a worldwide phenomenon, with rates ranging from 5%–60%, with increased prevalence in immigrant populations (Kwee & McBride, 2016; Öksüz, 2021; Shi et al., 2018). In Canada, PPD rates range from 12.2%–24.1% for the immigrant populations, 11.1%–21.2% for Indigenous populations, and 5.6%–12.9% for Canadian born, non-Indigenous populations (Daoud et al., 2019). Decolonial intersectional theory provides a lens through which to conceptualize both the similarities and differences of the transnational experience of PPD. One conceptualization of the social construction of PPD is through the lens of self-silencing theory.

Silencing the self theory suggests that women silence their experience to maintain connection to relationships and community, and that the ability to voice one's needs and wants is necessary for well-being (Jack, 1991). By silencing their PPD experience, women can live the good mother narrative, which prevents stigmatization by community and self. This theory holds a Western dominant cultural view whereby interpersonal silence is oppressive and gendered, creating a loss of self-identity (Lara et al., 2016; Maji, 2018; Maji & Dixit, 2019). However, within majority world settings (a quantitative reference to the majority of the world that does not live by Western, Eurocentric individualistic standards), identity is created through an "interdependent cultural construction of self," and silence may be used as a method to promote well-being (Warner et al., 2020, p. 270). This brief example highlights how theory is culturally and temporally bound, and in this case, is rooted in colonial ideology (Canetto, 2019; Macleod et al., 2020). Decolonial intersectional theory aims not to replace colonial based psychology but to expand and pluralize knowledge, power, and being (Macleod et al., 2020).

Assemblage Theory

Gilles Deleuze and Félix Guattari developed assemblage theory, situated in a postmodern philosophy, in 1987 (Bogic, 2017). Assemblage is a translation from the original French word,

agencement, which philosophically includes two definitions: “both the subject who is acting and the act of arranging, on the one hand, and the resultant arrangement itself” and “agencement includes both human and non-human elements” (Bogic, 2017, p. 140). The debate whether assemblage theory is an extension or replacement for intersectional theory is beyond the scope of this paper (for further discussion see Bogic, 2017; Puar, 2011; Warner et al., 2020). However, assemblage theory addresses the critique of intersectional theory as conceptualizing identities as static, enduring, and “discrete and distinct” from one another by viewing identities as inseparable (Bogic, 2017, p. 143). Assemblage theory considers identity as an experience that is socially, historically, and geographically constructed (Puar, 2011).

An assemblage is a pattern of "affective, discursive, embodied and material relations" that result from the event (Warner et al., 2020, p. 266). Furthermore, assemblage theory focuses on the act of becoming that results from the relational interactions with structures of power (Warner et al., 2020). When using an assemblage lens, the perspective is from what structural influences produce these narratives and experiences (Conway et al., 2018; Warner et al., 2020).

Clients and mental health practitioners consider their intersecting identities related to power and their interactions, which result in generating unique realities (Chadwick, 2017; Conway et al., 2018). Intersectional theory is criticized for viewing power as solely oppressive (Chadwick, 2017; Puar, 2011). In assemblage theory, power is viewed as a creation of relating autonomous parts that assemble to become something new (Conway et al., 2018). Power is thus considered as temporal and spatially situated, itself a process of becoming. This fluid view of being addresses the ambiguous agency of intersectional subjects through a relational process of becoming (Chadwick, 2017).

Assemblage theory’s view of agency is relational and an “emergent process of becoming”

rather than a state of being, as conceived in neoliberal views of agency as self-determination (Chadwick, 2017, p. 494; Cosgrove & Karter, 2018). Agency in assemblage theory refers to a "decentred view of agency (following Foucault) in which power is seen as a force which produces agency, subjectivity and resistance" (Chadwick, 2017, p. 494). An example within this framework considers power in the medical model and the prescription of antidepressants for PPD. A doctor may subjectively assume power over the mother by prescribing antidepressants based on a PPD screening while concurrently experiencing a lack of agency as health care policy dictates the action the doctor must follow. The mother may display resistance by refusing the medication or taking the medication to protect herself from the stigmatization associated with not conforming to the "good patient" and "good mother" narratives—both actions of the patient display a process of relational and embodied agency (Chadwick, 2017).

Discussing PPD using intersectional theory and its extensions reveals the complex and layered social, political, interpersonal, and intrapersonal factors that constitute the social construction of PPD. This contrasts with the positivism within dominant institutions, including psychology, and political aims of parsimony (Settles et al., 2020). This view reflects a goal to generalize findings across all members of a group without consideration of context. Additionally, the dominant psychological practice focuses on the individual, thereby situating the responsibility of the PPD experience on the mother (Settles et al., 2020). The psychosocial restrictions that women experiencing PPD encounter obscure knowledge of the postpartum experience without these factors (Chrisler & Johnston-Robledo, 2018). Using intersectional lenses provides an opportunity to appreciate and explore a complete analysis of the factors involved with a woman's PPD experience.

The social constructionism of intersectional theory creates space to "acknowledge the

diversity and complexity" in each woman's unique experience, embodiment, and empowerment, and examines the role of power (Chrisler & Johnston-Robledo, 2018, p. 71). The analyses of intersections and power, and the interactions between, can inform counselling research and practice. By using this critical awareness, praxis can demonstrate social justice, a tenet of intersectional theory (Settles et al., 2020). In this sense, theory is embedded in practice and practice is embedded in theory and requires reflective awareness of the practitioner to maintain informed, competent, and ethical practice.

Recommendations for Practice

Political and systemic institutions influence the social construction of PPD. The medical model situates the problem in the woman with a focus on pharmaceutical treatment and prevention (Cosgrove & Vaswani, 2020). Neoliberal politics situate health care within the marketplace, implying that a loss of productivity due to (mental) illness is a problem for the autonomous individual who has the agency to choose to be productive (Cosgrove & Karter, 2018). These ideas contribute to social norms and narratives of the good mother and intensive mothering. The mothering social norms are so prevalent that all women, regardless of motherhood status, are compared to this standard (Deeb-Sossa & Kane, 2017). Internalization of these messages can be helpful and problematic. Women whose experience and identity align with the good mother narratives may find connection and affirmation of their role (Mickelson et al., 2017). Women whose experience does not fit into the dominant narrative may experience stigmatization by others or by self (Maji & Dixit, 2019).

An intersectional theoretical perspective provides a lens to consider the interaction between systemic, political, and psychosocial factors that influence the experience with PPD and shape a woman's identity (Jackson-Best, 2016). This suggests the therapist, researcher, activist,

and client are not separate or unequal, and all play a role in social justice (Buchanan et al., 2020). The following recommendations for practice are focused primarily on the counselling session and the role of the therapist.

Addressing Barriers

Rates of PPD are higher in marginalized populations (Ghaedrahmati et al., 2017; Maxwell et al., 2019; Statistics Canada, 2019). An intersectional approach considers the complexity of intersecting factors and how they "interweave" to create a unique phenomenon for each woman experiencing PPD (Stevens et al., 2018, p. 628). Logistical barriers (e.g., transportation, childcare, and fee coverage) and coordination with other health care providers and services are essential items to consider when providing intersectional care (Hailemariam et al., 2020; Stevens et al., 2018). Assessing for and removing barriers to treatment is an example of social justice, a tenet of intersectional theory (Hailemariam et al., 2020).

Furthermore, implementing strategies to overcome these barriers can support treatment engagement (Etherington et al., 2020; Stevens et al., 2018). Examples to consider are flexible appointment times (e.g., offering a window of time to attend, rather than a specific hour), child minding services, and telepsychology services. By assessing barriers to treatment, one can consider how these barriers intersect and lead to decision making by the therapist, clinic, and client (Etherington et al., 2020).

Stigma regarding mental health and maternal mental health is a significant barrier to treatment (Haynes, 2017; Kwee & McBride, 2016). Health care practitioners can perpetuate PPD stigma by referring those with severe needs to specialists and not recognizing or normalizing the distress in women who are minimally or suboptimally distressed, resulting in gaps within their healthcare (Kwee & McBride, 2016). Psychoeducation, advocacy, and normalizing mental health

care and care for PPD in ways that speak to the population's concerns are vital.

Trauma Informed Care

When recognizing the oppressing intersections in the lives of women experiencing PPD, it is imperative to consider the role of trauma. While beyond the scope of this paper, the perinatal period is a time of increased risk of trauma. Rates of interpersonal violence against the mother increase during this period, and there is potential for traumatic births, many of which are not validated by the medical system or social norms (Chadwick, 2017; Hailemariam et al., 2020; Kothari et al., 2016; Polmanteer et al., 2019). Furthermore, sequelae of adverse childhood experiences of the mother can impact maternal mental health (Sperlich et al., 2017). Trauma informed care recommends that care is provided to all individuals through a trauma informed lens to not marginalize, stigmatize, or re-victimize any individual (Polmanteer et al., 2019).

The foundational framework for trauma informed care (TIC) created by the Substance Abuse and Mental Health Services Administration (SAMHSA) recommends six principles: (1) safety; (2) trustworthiness and transparency; (3) peer support; (4) collaboration and mutuality; (5) empowerment, voice, and choice; and (6) cultural, historical, and gender issues (SAMHSA, 2014, p. 10). There is a paucity of research on TIC in PPD care. However, Polmanteer et al. (2019) provide a conceptual framework. The TIC principles created by SAMHSA provide the framework, and action steps that incorporate the unique needs of women experiencing PPD are connected to each principle. For example, emotional, psychological, and physical safety are considered for mothers and infants, including recommendations such as convenient spaces which are secure for infants and children, respect for mothers, information about confidentiality, and use of safety plans (Polmanteer et al., 2019). For principle three, trustworthiness and transparency action items consist of community connection through education, awareness, and

engagement (Polmanteer et al., 2019; SAMHSA, 2014). Collaboration and mutuality, principle four, continues connection and respect for mothers by valuing their experiences and voices into service planning, intervention, and evaluation (Polmanteer et al., 2019; SAMHSA, 2014). Empowerment, voice, and choice, principle five, are demonstrated through actions such as providing mothers with control, choice, and decision-making opportunities with services, understanding their rights, and the risks and benefits of treatment (Polmanteer et al., 2019; SAMHSA, 2014). Furthermore, action items that include awareness and treatment for traumas related to oppression, vulnerability, and diversity support principle six regarding cultural, historical, and gender issues (Polmanteer et al., 2019; SAMHSA, 2014).

Trauma informed practices are integrated into all levels of service, including but not limited to the physical space, organizational structure, and health care interventions (Polmanteer et al., 2019; Sperlich et al., 2017). Steps such as training in TIC practices and the development of TIC policies can develop a foundation for TIC PPD care. Overall, this strengths-based approach is grounded in and is responsive to an understanding of the impact of trauma on women's experiences with PPD (Polmanteer et al., 2019).

Interventions Focused on Identity and Role

Intersectional theory is a theory of identity (Crenshaw, 1991). Interventions focused on clarifying one's self-concept and one's perception of their intersecting social roles can invite the client to explore who they are as a person, mother, mother experiencing PPD, and other social roles such as daughter, partner, friend, or in their career. Additionally, it is essential to explore how the client perceives that their intersecting factors influence or enhance their experience with PPD (Etherington et al., 2020). Additionally, psychosocial interventions reduce isolation and provide an avenue to develop connections with a new group (Anokye et al., 2018).

The synergy between an individual's intersecting factors and how they relate to social, systemic, and political systems can be explored through the client's social roles (Etherington et al., 2020). Psychoeducation can provide information about the new role as a mother and how that influences their individual sense of self. Developing a life plan and integrating it with one's maternal realities is an opportunity for action (Staneva et al., 2017). Furthermore, exploring how unmet expectations are posited on a woman, regulating their bodies, may allow women to externalize the distress they are experiencing (Jackson-Best, 2016; Staneva et al., 2017).

Narrative therapy is founded on social constructionism, and such techniques such as externalizing and documentation may be useful for treatment of PPD (Combs & Freedman, 2012; Jackson-Best, 2016). Revisiting or reconfiguring meaning making of life experiences can develop empowered identity within the social context (Combs & Freedman, 2012). Situating the experience with PPD and the resulting behaviours within a larger context can help to externalize the PPD experience and decentralize the power (Chadwick, 2017; Mirza, 2013).

Self-Efficacy

Learning parenting and childcare skills are interventions that improve a woman's efficacy as a mother (Berma et al., 2018; Henderson et al., 2016). Research indicates that parenting classes and peer groups and PPD peer groups are influential for developing efficacy in a mother's new social role (Berma et al., 2018; de Camps Meschino et al., 2016). From an intersectional lens, it is necessary to consider skill building and self-efficacy that does not reaffirm intensive mothering norms (Deeb-Sossa & Kane, 2017). Furthermore, it may be advantageous to invite clients to explore what skills they have learned from parenting and peer groups and from their different identity groups (Berma et al., 2018; de Camps Meschino et al., 2016; Deeb-Sossa & Kane, 2017). For example, using what a mother learned about infant sleeping habits in a

parenting class and what they have experienced culturally to provide a framework for themselves.

Self-efficacy can be identified through the narrative therapy intervention of unique outcomes. Discovery of unique outcomes can illuminate times or situations where the mother has a different experience than what is expected (Guilfoyle, 2015). For example, a woman choosing to talk about her experience with PPD is an act of resistance against the dominant norms of motherhood bliss.

Cultural Humility

Cultural humility in practice can begin with the use of non-pathologizing and stigmatizing language (Haynes, 2017). The term PPD, even though it is commonly used in the literature, can be pathologizing and center the experience in the woman. Haynes (2017) suggests the term *perinatal psychological distress* to describe the distress experienced by new mothers and as a way to explore what psychological or social factors are contributing to their experience. Methods for engagement with the community may vary depending on intersecting factors such as immigration, culture, or ethnicity. For example, referral to services via community advertising may be appropriate for some, where others may prefer personal references (Baker et al., 2016). Considering the location of services, language of services, and timing of services around significant cultural or ethnic events are additional methods to reduce barriers to access to treatment (Baker et al., 2016; Driver & Shafeek Amin, 2019).

It is imperative to incorporate communication of the client's cultural and ethnic values related to family, personal autonomy, mental health, and motherhood (Garfield & Watson-Singleton, 2021; Heshmati et al., 2021). These intersections shape a woman's experience with PPD and identity formation and are necessary to provide ethical intersectional theory-based care

(Baker et al., 2016). To be inclusive, these cultural recommendations for practice are broad measures. However, as a therapist, it is necessary to assess all intersecting factors equally and be aware of bias or assumptions based on the client's demographic information (Arthur, 2018; Baker et al., 2016).

Social Justice

Intersectional theory has been criticized or devalued by incomplete use of the theory as often the last tenet of social justice goals is missed (Crenshaw, 1991; Settles et al., 2020; Stevens et al., 2018). Intersectional theory and its extensions can provide research to guide changes in care and practice models, and thus social justice. Researchers who explore positive outcomes from intersectional theory recommend perinatal health practices that support the social contextual factors for patients (Stevens et al., 2018).

In their 2018 study of marginalized perinatal women, Stevens et al. utilized an intersectional-feminist perspective to exam the effectiveness of the perinatal mental health care model. Intersectional principles guided the model to address the vulnerability of the perinatal women in need of mental health care. To begin, the team addressed mental health stigma and mistrust of mental health professionals. Support was developed to attend to childcare needs (e.g., child minding services, flexible appointment times), transportation, and financial barriers. Furthermore, a trauma informed care treatment approach was applied to all levels of care and interaction in the clinic. The results indicated increased retention, engagement, and treatment outcomes, and engagement that continued into the postpartum period. These results suggest that an intersectional approach to program development may reduce mental health disparity among marginalized perinatal women.

Next Steps for Research

The complexity of the social construction of PPD in Canada and worldwide would benefit from further attention. The prevalence of PPD globally necessitates exploring similarities and differences in experience, support, and treatment (Warner et al., 2020).

Transnational feminism (TF) further develops decolonial intersectionality by considering a heterogeneous view of women, rather than a homogeneous feminine identity worldwide (Heshmati et al., 2021). Feminism is criticized for characterizing women as a homogenous "sisterhood" defined by the cultural values of the global North. The global North refers to countries such as Canada, United States, Western Europe, and developed Asian countries, and is characterized by feminist issues of gender inequality and "issues of women's bodies" (Deb, 2016; Heshmati et al., 2021, p. 48). The global South refers to countries within Africa, Latin America, and developing Asian countries, and is characterized by the feminist issues of oppression and violence (Heshmati et al., 2021). This one-dimensional view oppresses the women of the global South, thereby espousing a "demeaning paternalism similar to the patriarchal system so many global Northern feminists claim to oppose" (Heshmati et al., 2021, p. 48). When conceptualizing the social construction of PPD worldwide, a TF approach considers the "meaningful global differences" of women's experiences through consideration of history, geography, and institutions (Deb, 2016; Heshmati et al., 2021, p. 49). Future research could include transnational analyses of PPD experiences to highlight commonalities and differences of women's experiences, but also to identify colonial and patriarchal history and influence on the PPD experience (Deb, 2016; Jackson-Best, 2016).

Our colonial past defined nations' borders and sex, gender, and race, which is a practice that continues today (Heshmati et al., 2021; Settles et al., 2020). For example, situating research

location is often from a colonial perspective, with an expectation that research published outside of the global North situates its location within the finding (Patil, 2013; Settles et al., 2020). This same level of expectation is often not required when the location is within the Western, Eurocentric North and demonstrates a continuing prioritization of Western, Eurocentric ideals, with other perspectives viewed as less than (Settles et al., 2020). To decentralize the power of the global North, future research could offer the same expectation regardless of location and situate the research, reflecting upon the social and political context that frames the research (Canetto, 2019; Settles et al., 2020). From a Canadian psychology practice standpoint, conducting research in this manner upholds ethical Principle IV, Responsibility to Society, of the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association [CPA], 2017). Situating research within its sociopolitical context is beneficial and just as it reflects an awareness and response to human need, value, and respect (CPA, 2017).

This search of the literature resulted in only one study of maternal health using assemblage theory, revealing an area in great need for further exploration. An assemblage analysis of PPD in Calgary has the potential to bring to light the influences, power, and oppression that are managed by all involved in a woman's experience of PPD. As PPD has implications not only for the mother but also for the infant and other family members, evaluating the assemblage of the PPD experience may help to de-pathologize the situation for the mother and identify other sources of support or need for change required for the mother and the family (Chadwick, 2017; Staneva et al., 2017). Furthermore, understanding the interactions and relationships between policy, regulation, doctors, nurses, and the women experiencing PPD can indicate where change is required in public health policy and accessibility.

This literature review presented the social construction of PPD from a global North

perspective. The dominant narratives of intensive mothering are situated in a Western worldview. This review reflects how this worldview can be stigmatizing for those outside of this definition of motherhood. Nevertheless, an opposite orientation of the dominant mothering narratives of the global South and how they differ, support, or oppress a woman's experience with PPD was not considered. Furthermore, examination of how these narratives promote or protest neopolitical and medical model constructs of the global South could be researched. Future work is needed to disentangle these complexities. Decolonial intersectional and transnational feminism, or assemblage methodologies would be beneficial for this research. PPD research from the perspective of the global South would provide practitioners with greater understanding of the heterogeneity of women's experiences transnationally. This promotes the social justice tenet of intersectionality, as well as cultural humility and ethical practice (Anokye et al., 2018; College of Alberta Psychologists [CAP], 2019; Crenshaw, 1991). Furthermore, there can be implications for practice with regards to increasing awareness of the history, knowledge, and differences experienced by immigrant mothers and how to provide culturally appropriate and beneficial services and psychoeducation to empower immigrant women (Daoud et al., 2019; Ussher et al., 2017).

Future research considering other marginalized identities intersecting with PPD can broaden the perspective of women who experience PPD. The options for research here are vast. The following examples are not indicative of priority for research but highlight areas noted in the literature as lacking: sexual minority populations, adoptive parents, age, disability, immigrant status and socioeconomic status, and cultural and ethnic populations, among others (Chrisler & Johnston-Robledo, 2018; Douglas et al., 2021; Öksüz, 2021; Shi et al., 2018; Trettin et al., 2006). Further research of intersectional model delivery can evaluate mental health disparity from

various extensions of intersectional theory (Jackson-Best, 2016; Warner et al., 2020). The implications may result in awareness of inequalities or inequities in institutions. Gathering of this research would have an additive effect, enriching the conceptualization of the social construction of PPD.

There is much awareness about the stigma woman experience, whether it is about mental health in general or specifically about PPD (Mickelson et al., 2017). Future research could examine how reducing stigma influences a woman's experience with PPD. This research could explore representations of PPD within the medical model, and within neoliberal policies, and how these representations align with or contradict women's experiences, and how this influences treatment (Cosgrove & Karter, 2018; Cosgrove & Vaswani, 2020; Ussher et al., 2017). In addition, interaction between the medical model and neoliberal representations and stakeholders, such as the mothers, family members, and care providers, could be beneficial (Chadwick, 2017; Cosgrove & Karter, 2018). Moreover, examining how these interactions impact choice, decision making, and self-care by the mothers and other stakeholders could be beneficial (Chadwick, 2017; Staneva et al., 2017).

Future work devoted to the development and study of practitioner practices in regard to PPD stigma is called for (Mickelson et al., 2017). There is much research on mothers' perceptions of stigma, however, understanding other stakeholders' perceptions, such as fathers, doctors, and communities, may deepen the analysis (Kornaros et al., 2020). Furthermore, recommendations of interventions to increase parenting self-efficacy, support seeking, and identity transition are needed (Kornaros et al., 2020; Mickelson et al., 2017).

The possibility of many oppressive intersects for woman experiencing PPD warrants further exploration of trauma informed care (TIC) practices for the treatment of PPD. The

literature review presented in this paper found only one model of TIC for PPD by Polmanteer et al. (2019). Repeated implementation and evaluation of this model will inform about its effectiveness and generalizability. TIC is a model that promotes specific practices in all levels of an organization (SAMHSA, 2014). As such, it would be important to consider the location and development of a TIC model. Would a TIC-PPD program fit best into an organization that already practices TIC? Are there models of TIC being used in local medical settings that could be expanded to incorporate PPD care or is the best course of action to develop a program? Future research could investigate the implementation of TIC-PPD programs. Additionally, research about the challenges and benefits of changing practices to a TIC model within a "live" setting could be developed. Moreover, the interaction between TIC and the medical model framework and neoliberal expectations of mental health and economy could be examined.

Future work on discrimination experienced by mothers might extend a TIC model and analysis. For many women, pregnancy and motherhood are a time of increased discrimination associated with narratives of sexuality, motherhood, and the "devaluation of motherhood" (Rosenthal et al., 2015, p. 689) for woman who do not meet the standard (e.g., women of colour, immigrants, young age, etc.; Barkensjö et al., 2018). Further evaluation of discrimination stress on a woman's experience of PPD would add more evidence to the social construction of PPD, as well as identify areas for intervention. Future research could evaluate experiences with discrimination with diverse groups of women and diverse geographies and consider interventions to address discrimination.

Research points to the effectiveness of psychosocial interventions for decreasing PPD symptoms (Anokye et al., 2018; Kwee & McBride, 2016). However, there is also research pointing to the lack of implementation or support with the medical model for holistic

programming that incorporates mothers' psychosocial needs (Anokye et al., 2018; Barkensjö et al., 2018; Kwee & McBride, 2016; Staneva et al., 2017). Barriers vary from lack of funding, lack of qualified personnel, and lack of awareness by policy makers, to name a few (Kwee & McBride, 2016). Working with an intersectional approach and its extensions provides opportunities to address the needs and barriers to wellness of mothers who are experiencing PPD and to identify areas for institutional and policy change.

Reflexive Self-Statement

As I began this project, my goal was to bring more awareness to the complexity of women's experiences with PPD and situate the experience within a social context. My interest in this topic developed from a personal and professional stance. My experience as a mother and the associated challenges and changes to my identity made this a significant developmental period in my life, as it is for many mothers. Professionally, I am interested in attachment theory and how the neurobiological development of children is influenced and shaped by their caregivers (Haynes, 2017). I was motivated by the idea that if mothers are healthy and supported, their children can also be healthy and supported.

Researching PPD throughout my master's program has broadened my perspective immensely. However, it was the process of this literature review that led to many "ah-ha" moments! I recognized and found the words to describe the nuances of my experience as a mother and a woman. It has been a liberating experience for me, for my political views, personal experiences, and understanding of dominant narratives in society. During the writing process, I had the opportunity to receive feedback from a feminist practicing psychologist. Her statement that this paper represents a separate narrative struck a chord and revealed how internalized the dominant narrative is for me. I wrote the literature review from a lens of trying to bend and fit

this feminist narrative into the dominant patriarchal narrative. The preceding sections are written from a perspective of embracing the feminist, gendered, intersectional narrative as having its own space and voice, without the need to misshape. This consultation challenged my existing knowledge and guided me towards a more integrative perspective and theoretical structure (Enosh & Ben-Ari, 2016).

In my internship practice, I have used this burgeoning knowledge on intersectional theories with many clients. I appreciate that these theories provide a framework to maintain a curious therapeutic stance, honour the client as the expert in their life, and explore the political, institutional, and social factors that influence their experience. Furthermore, understanding intersectionality as more than a static list of factors belonging to the client has allowed me to view intersectionality as an evolving interaction between power as dominance, power as resistance, privilege, and oppression. To understand a client's distress as socially constructed is nonpathologizing and reveals the strength and resilience of the client.

Given my identification with silencing, pregnancy, and motherhood, it is imperative that I am aware of potential confluence and projection. Neumann and Neumann (2015) define confluence as overidentification with the subject or participants of research. Projection is defined as perceiving what is said through expectations that I have attached to the topic and participants (Neumann & Neumann, 2015).

Before beginning the research process, I used a bubble map to explore the many roles I have and to identify the privilege and oppression I experience with each. This map provided a method to determine which narratives I have internalized and what bias I hold. After writing this paper, I completed a second bubble map through an intersectional lens to assess the psychosocial, political, and systemic factors that influence my identity. This bubble map clarifies

and consolidates the various disparate and muddled concepts I held previously and now consider through an intersectional lens, considering the influence of dominate narratives and preferred narratives. Excitingly, I find myself more grounded in who I am as a woman.

Through the literature review process, I recognized the social construction of my identity. This process has empowered me to embrace the narratives that are a fit for me and to have the vocabulary and knowledge to evaluate and situate medical practices, neoliberal policies, and dominant narratives. I found this reflexive practice informative and empowering as an academic and individual with one role informing the other, leading to an embodiment of these roles (Adamson & Johansson, 2016). Professionally, understanding, having awareness of, and acknowledging the intersecting factors in my life will allow me to be aware of how I am becoming and to discuss the role of power within the therapeutic relationship with the client.

Conclusion

PPD is a serious mental health condition that impacts 10%–15% of women after childbirth in Western countries and ranges between 5%–60% in non-Western countries (Kwee & McBride, 2016; Shi et al., 2018). PPD affects the mother's well-being and the health and development of the infant and the family (Praetorius et al., 2020; Shi et al., 2018). As PPD can impact many systems and individuals, there has been much exploration on PPD through the regulatory lens, such as PPD screening, and the medical lens, with prescription of antidepressants as first-line treatment (Staneva et al., 2017). Conceptualizing PPD through regulatory and medical models brings attention and awareness to PPD and its far-reaching implications. Research suggests the medical and regulatory models disavow the mother's agency and autonomy (Cosgrove & Vaswani, 2020). Social constructs and expectations of the ideal pregnancy and good mother are fertile ground for stigmatization and disempowerment when

women experience PPD (Staneva et al., 2017). Faced with social oppression at a time of identity transition, women may silence their emotions and inner experience (Maji, 2018; Staneva et al., 2017).

This research explored the construction of the good mother narratives through patriarchal institutions such as the medical model and neoliberalism. The medical model places the PPD experience with the mother (Cosgrove & Karter, 2018; Cosgrove & Vaswani, 2020). There are program developments in some locations that address intersecting psychosocial factors; however, the medical model remains grounded in a Eurocentric, patriarchal epistemology. Furthermore, neoliberal policies commodify mental health in terms of loss of productivity and the expense of sick days. The neoliberal political worldview considers individuals as self-determining and having the agency to choose the course of outcomes in their lives (Douglas et al., 2021). This worldview continues to stigmatize mothers by placing the responsibility on mothers for experiencing PPD and labelling the experience as a mental illness (Douglas et al., 2021).

Arising from neoliberal productivity expectations are the intensive mothering norms that are a part of the good mother narrative. The good mother narrative suggests that women are inherently caregivers and skilled mothers and develop worth through self-sacrifice for their children (Kerrick & Henry, 2017; Meeussen & Van Laar, 2018). By balancing expectations of neoliberal productivity and gendered narratives, mothering norms have developed time, resource, and labour-intensive expectations (Myers, 2017). The good mother narratives exist regardless of race, socioeconomic status, or sexual orientation; however, intensive mothering standards are most prominent with White, upper and middle-class women (Schoppe-Sullivan et al., 2017). The intensive mothering standards are a source of stigmatization for marginalized women (Deeb-Sossa & Kane, 2017).

These institutional, political, and social factors contribute to the social construction of PPD. Moreover, women's individual intersecting factors influence the power or oppression a woman experiences from these social constructs. Women marginalized by socioeconomic status, race, ethnicity, and immigration status experience higher rates of PPD and interact with health care providers less frequently (Jackson-Best, 2016; Ussher et al., 2017).

One method through which individuals may develop their identity is their social relationships (Jack, 1991; Maji & Dixit, 2019). When a woman's experience with motherhood aligns with social, cultural, and political norms, this may affirm their identity and internalize good mother behaviours (Hansson et al., 2017; Staneva et al., 2017). However, women whose motherhood experience does not meet internalized and social expectations may experience self-stigma.

When conceptualizing the social construction of PPD, it is helpful to consider the relationships between intersecting identities of women experiencing PPD and socio-political factors. Intersectionality theory provides a method for analysis, assessment, and treatment (Crenshaw, 1991). Research indicates the positive impact intersectional theory has on the development and provision of PPD services (Settles et al., 2020; Stevens et al., 2018).

Examining intersectional theory and its extensions provides the opportunity to conceptualize the social construction of PPD from various lenses, thus adding richness and complexity to the examination of power, decentralized power, oppression, and privilege. Assessing the interrelated power structures identifies the subjective individual experiences of women experiencing PPD. Considerations for practice are the formation of identity(ies), including awareness of opportunities for resistance and empowerment, and self-efficacy through skill building with parenting and other areas identified by the client as a necessary component to

their success. Finally, social justice can be practiced by providing trauma informed care, cultural humility, and reducing barriers to access to treatment.

References

Adamson, M., & Johansson, M. (2016). Compositions of professionalism in counselling work: An embodied and embedded intersectionality framework. *Human Relations, 69*(12), 2201–2223. https://doi.org/10.1177/0018726716639118

Alberta Health Services. (n.d.). *Postpartum depression: Healthy children and families.* Retrieved August 8, 2021, from https://www.albertahealthservices.ca/info/Page16138.aspx

American Psychiatric Association [APA]. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Anokye, R., Acheampong, E., Budu-Ainooson, A., Obeng, E. I., & Akwasi, A. G. (2018). Prevalence of postpartum depression and interventions utilized for its management. *Annals of General Psychiatry, 17*(1), 18–18. https://doi.org/10.1186/s12991-018-0188-0

Arthur, N. (Ed.). (2018). *Counselling in cultural contexts: Identities and social justice.* Springer.

Baker, A. E. Z., Procter, N. G., & Ferguson, M. S. (2016). Engaging with culturally and linguistically diverse communities to reduce the impact of depression and anxiety: A narrative review. *Health & Social Care in the Community, 24*(4), 386–398. http://doi.org.proxy.cityu.edu/10.1111/hsc.12241

Balint, P., Lina, E., & Tiziana, T. (2018). State power and breastfeeding promotion: A critique. *Contemporary Political Theory, 17*(3), 306–330. http://doi.org/10.1057/s41296-017-0158-3

Barkensjö, M., Greenbrook, J. T. V., Rosenlundh, J., Ascher, H., & Elden, H. (2018). The need for trust and safety inducing encounters: A qualitative exploration of women's experiences of seeking perinatal care when living as undocumented migrants in Sweden.

BMC Pregnancy and Childbirth, 18(1), 217–217. https://doi.org/10.1186/s12884-018-1851-9

Baru, R. V., & Mohan, M. (2018). Globalisation and neoliberalism as structural drivers of health inequities. *Health Research Policy and Systems, 16*(Suppl 1). http://doi.org/10.1186/s12961-018-0365-2

Bogic, A. (2017). Theory in perpetual motion and translation: Assemblage and intersectionality in feminist studies. *Atlantis: Critical Studies in Gender, Culture & Social Justice, 38*(1), 138–149. https://journals.msvu.ca/index.php/atlantis/article/view/4774

Bowlby, J. (1982). Attachment and loss: Retrospect and prospect. *American Journal of Orthopsychiatry, 52*, 664–678. https://doi.org/10.1111/j.1939-0025.1982.tb01456.x

Brenning, K., Soenens, B., Mabbe, E., & Vansteenkiste, M. (2019). Ups and downs in the joy of motherhood: Maternal well-being as a function of psychological needs, personality, and infant temperament. *Journal of Happiness Studies, 20*(1), 229–250. https://doi.org/10.1007/s10902-017-9936-0

Buchanan, N. T., Rios, D., & Case, K. A. (2020). Intersectional cultural humility: Aligning critical inquiry with critical praxis in psychology. *Women & Therapy, 43*(3-4), 235–243. https://doi.org/10.1080/02703149.2020.1729469

Canadian Psychological Association [CPA]. (2017). *Canadian code of ethics for psychologists*. https://cpa.ca/docs/File/Ethics/CPA_Code_2017_4thEd.pdf

Canetto, S. S. (2019). Teaching about women and gender from a transnational and intersectional feminist perspective. *International Perspectives in Psychology: Research, Practice, Consultation, 8*(3), 144–160. http://doi.org/10.1037/ipp0000111

Chadwick, R. (2017). Ambiguous subjects: Obstetric violence, assemblage and south African

birth narratives. *Feminism & Psychology, 27*(4), 489–509. https://doi.org/10.1177/0959353517692607

Chrisler, J. C., & Johnston-Robledo, I. (2018). The sexual body. In J. C. Chrisler & I. Johnston-Robledo (Eds.), *Woman's embodied self: Feminist perspectives on identity and image* (pp. 65–88). American Psychological Association. http://doi.org/10.1037/0000047-004

College of Alberta Psychologists [CAP]. (2019). *Standards of practice.* https://www.cap.ab.ca/Portals/0/pdfs/CAP-StandardsOfPractice.pdf?ver=2019-07-03-130054-187

Combs, G., & Freedman, J. (2012). Narrative, poststructuralism, and social justice: Current practices in narrative therapy. *The Counseling Psychologist*, *40*(7), 1033–1060. https://doi.org/10.1177/0011000012460662

Conway, J. M., Osterweil, M., & Thorburn, E. (2018). Theorizing power, difference and the politics of social change: Problems and possibilities in assemblage thinking (Introductory essay). *Studies in Social Justice, 12*(1), 1–18. http://doi.org/10.26522/ssj.v12i1.1745

Cosgrove, L., & Karter, J. M. (2018). The poison in the cure: Neoliberalism and contemporary movements in mental health. *Theory & Psychology, 28*(5), 669–683. https://doi.org/10.1177/0959354318796307

Cosgrove, L., & Vaswani, A. (2020). Fetal rights, the policing of pregnancy, and meanings of the maternal in an age of neoliberalism. *Journal of Theoretical and Philosophical Psychology, 40*(1), 43–53. https://doi.org/10.1037/teo0000139

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241. https://doi.org/10.2307/1229039

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). Sage.

Cuomo, A., Maina, G., Neal, S. M., De Montis, G., Rosso, G., Scheggi, S., Beccarini Crescenzi, B., Bolognesi, S., Goracci, A., Coluccia, A., Ferretti, F., & Fagiolini, A. (2018). Using sertraline in postpartum and breastfeeding: Balancing risks and benefits. *Expert Opinion on Drug Safety*, *17*(7), 719–725. https://doi.org/10.1080/14740338.2018.1491546

Daoud, N., O'Brien, K., O'Campo, P., Harney, S., Harney, E., Bebee, K., Bourgeois, C., & Smylie, J. (2019). Postpartum depression prevalence and risk factors among Indigenous, non-Indigenous and immigrant women in Canada. *Canadian Journal of Public Health, 110*(4), 440–452. http://doi.org/10.17269/s41997-019-00182-8

Deb, B. (2016). Cutting across imperial feminisms toward transnational feminist solidarities. *Meridians, 13*(2), 164–188. https://doi.org/10.2979/meridians.13.2.09

de Camps Meschino, D., Philipp, D., Israel, A., & Vigod, S. (2016). Maternal-infant mental health: Postpartum group intervention. *Archives of Women's Mental Health, 19*(2), 243–251. http://doi.org/10.1007/s00737-015-0551-y

Deeb-Sossa, N., & Kane, H. (2017). Pregnancy without women: Lessons from childbirth classes. *Sexuality Research & Social Policy, 14*(4), 380–392. http://doi.org/10.1007/s13178-016-0265-6

Doe, S., LoBue, S., Hamaoui, A., Rezai, S., Henderson, C. E., & Mercado, R. (2017). Prevalence and predictors of positive screening for postpartum depression in minority parturients in the South Bronx. *Archives of Women's Mental Health, 20*(2), 291–295. https://doi.org/10.1007/s00737-016-0695-4

Douglas, P., Runswick-Cole, K., Ryan, S., & Fogg, P. (2021). Mad mothering: Learning from

the intersections of madness, mothering, and disability. *Journal of Literary & Cultural Disability Studies 15*(1), 39–56. http://doi.org/10.3828/jlcds.2021.3

Driver, N., & Shafeek Amin, N. (2019). Acculturation, social support, and maternal parenting stress among US Hispanic mothers. *Journal of Child and Family Studies, 28*(5), 1359–1367. https://doi.org/10.1007/s10826-019-01351-6

Eddy, B., Poll, V., Whiting, J., & Clevesy, M. (2019). Forgotten fathers: Postpartum depression in men. *Journal of Family Issues, 40*(8), 1001–1017. https://doi.org/10.1177/0192513X19833111

Efron, S. E., & Ravid, R. (2019). *Writing the literature review: A practical guide*. The Guilford Press.

Enosh, G., & Ben-Ari, A. (2016). Reflexivity: The creation of liminal spaces—Researchers, participants, and research encounters. *Qualitative Health Research, 26*(4), 578–584. https://doi.org/10.1177/1049732315587878

Etherington, N., Isabel, B. R., Giangregorio, L., Graham, I. D., Hoens, A. M., Kasperavicius, D., Kelly, C., Moore, J. E., Ponzano, M., Presseau, J., Sibley, K. M., & Straus, S. (2020). Applying an intersectionality lens to the theoretical domains framework: A tool for thinking about how intersecting social identities and structures of power influence behaviour. *BMC Medical Research Methodology*, *20*, 1–13. http://doi.org/10.1186/s12874-020-01056-1

Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities.* W.W. Norton & Company.

Garfield, L., & Watson-Singleton, N. N. (2021). Culturally responsive mindfulness interventions for perinatal African-American women: A call for action. *Western Journal of Nursing*

Research, 43(3), 219–226. https://doi.org/10.1177/0193945920950336

Ghaedrahmati, M., Kazemi, A., Kheirabadi, G., Ebrahimi, A., & Bahrami, M. (2017). Postpartum depression risk factors: A narrative review. *Journal of Education and Health Promotion, 6*(60). https://doi.org/10.4103/jehp.jehp_9_16

Goff, P. A., & Kahn, K. B. (2013). How psychological science impedes intersectional thinking. *Du Bois Review, 10*(2), 365–384. http://doi.org/10.1017/S1742058X13000313

Grzanka, P. R., & Miles, J. R. (2016). The problem with the phrase "intersecting identities": LGBT affirmative therapy, intersectionality, and neoliberalism. *Sexuality Research & Social Policy, 13*(4), 371–389. http://doi.org/10.1007/s13178-016-0240-2

Guilfoyle, M. (2015). Listening in narrative therapy: Double listening and empathic positioning. *South African Journal of Psychology*, *45*(1), 36–49. https://doi.org/10.1177/0081246314556711

Hansson, L., Lexén, A., & Holmén, J. (2017). The effectiveness of narrative enhancement and cognitive therapy: A randomized controlled study of a self-stigma intervention. *Social Psychiatry and Psychiatric Epidemiology, 52*(11), 1415–1423. https://doi.org/10.1007/s00127-017-1385-x

Haynes, E. (2017). Listening to the voices of women suffering perinatal psychological distress. *Transactional Analysis Journal, 47*(2), 126–137. https://doi.org/10.1177/0362153717691977

Henderson, A., Harmon, S., & Newman, H. (2016). The price mothers pay, even when they are not buying it: Mental health consequences of idealized motherhood. *Sex Roles, 74*(11), 512–526. https://doi.org/10.1007/s11199-015-0534-5

Heshmati, S., Ali, S. R., & Pitre, S. (2021). Transnational feminism and the policing of Muslim

women's bodies: Implications for therapy. *Women & Therapy, 44*(1-2), 47–62. https://doi.org/10.1080/02703149.2020.1775012

Huda, A. S. (2019). *The medical model in mental health: An explanation and evaluation*. Oxford University Press. https://oxfordmedicine.com/view/10.1093/med/9780198807254.001.0001/med-9780198807254

Jack, D. C. (1991). *Silencing the self: Women and depression*. Harvard University Press.

Jackson-Best, F. (2016). A narrative review of maternal depression research focusing on women of Caribbean descent in the Diaspora and Caribbean women in the region. *Journal of International Women's Studies, 17*(3), 32–44. https://vc.bridgew.edu/jiws/vol17/iss3/4

Johansson, M., Benderix, Y., & Svensson, I. (2020). Mothers' and fathers' lived experiences of postpartum depression and parental stress after childbirth: A qualitative study. *International Journal of Qualitative Studies on Health and Well-Being, 15*(1). https://doi.org/10.1080/17482631.2020.1722564

Kerrick, M. R., & Henry, R. L. (2017). "Totally in love": Evidence of a master narrative for how new mothers should feel about their babies. *Sex Roles, 76*(1-2), 1–16. http://doi.org/10.1007/s11199-016-0666-2

Kornaros, K., Zwedberg, S., Nissen, E., & Salomonsson, B. (2020). A hermeneutic study of integrating psychotherapist competence in postnatal child health care: Parents' perspectives. *Infant Mental Health Journal, 41*(1), 108–125. https://doi.org/10.1002/imhj.21828

Kwee, J. L., & McBride, H. L. (2016). Working together for women's empowerment: Strategies for interdisciplinary collaboration in perinatal care. *Journal of Health*

Psychology, 21(11), 2742–2752. https://doi.org/10.1177/1359105315586211

Lara, M. A., Navarrete, L., & Nieto, L. (2016). Prenatal predictors of postpartum depression and postpartum depressive symptoms in Mexican mothers: A longitudinal study. *Archives of Women's Mental Health, 19*(5), 825–834. http://doi.org/10.1007/s00737-016-0623-7

Limandri, B. J. (2019). Postpartum depression: When the stakes are the highest. *Journal of Psychosocial Nursing & Mental Health Services, 57*(11), 9–14. http://doi.org/10.3928/02793695-20191016-03

Macleod, C. I., Bhatia, S., & Liu, W. (2020). Feminisms and decolonising psychology: Possibilities and challenges. *Feminism & Psychology, 30*(3), 287–305. https://doi.org/10.1177/0959353520932810

Maji, S. (2018). Society and 'good woman': A critical review of gender difference in depression. *International Journal of Social Psychiatry, 64*(4), 396–405. https://doi.org/10.1177/0020764018765023

Maji, S., & Dixit, S. (2019). Self-silencing and women's health: A review. *International Journal of Social Psychiatry, 65*(1), 3–13. https://doi.org/10.1177/0020764018814271

Manago, B., Pescosolido, B. A., & Olafsdottir, S. (2019). Icelandic inclusion, German hesitation and American fear: A cross-cultural comparison of mental-health stigma and the media. *Scandinavian Journal of Public Health, 47*(2), 90–98. https://doi.org/10.1177/1403494817750337

Maxwell, D., Robinson, S. R., & Rogers, K. (2019). "I keep it to myself": A qualitative meta-interpretive synthesis of experiences of postpartum depression among marginalised women. *Health & Social Care in the Community, 27*(3), e23–e36. https://doi.org/10.1111/hsc.12645

Meeussen, L., & Van Laar, C. (2018). Feeling pressure to be a perfect mother relates to parental burnout and career ambitions. *Frontiers in Psychology*, *9*, 2113. https://doi.org/10.3389/fpsyg.2018.02113

Meeussen, L., Veldman, J., & Van Laar, C. (2016). Combining gender, work, and family identities: The cross-over and spill-over of gender norms into young adults' work and family aspirations. *Frontiers in Psychology, 7*, 1781–1781. https://doi.org/10.3389/fpsyg.2016.01781

Mickelson, K. D., Biehle, S. N., Chong, A., & Gordon, A. (2017). Perceived stigma of postpartum depression symptoms in low-risk first-time parents: Gender differences in a dual-pathway model." *Sex Roles, 76*, 306–318. http://doi.org/10.1007/s11199-016-0603-4

Mickelson, K. D., & Williams, S. L. (2008). Perceived stigma of poverty and psychological distress: Examination of interpersonal and intrapersonal mediators. *Journal of Social and Clinical Psychology, 27*, 903–930. https://doi.org/10.1521/jscp.2008.27.9.903

Milgrom, J., Gemmill, A. W., Ericksen, J., Burrows, G., Buist, A., & Reece, J. (2015). Treatment of postnatal depression with cognitive behavioural therapy, sertraline and combination therapy: A randomised controlled trial. *Australian & New Zealand Journal of Psychiatry, 49*(3), 236–245. https://doi.org/10.1177/0004867414565474

Mirza, H. (2013). 'A second skin': Embodied intersectionality, transnationalism and narratives of identity and belonging among Muslim women in Britain. *Women's Studies International Forum, 36*. https://doi.org/10.1016/j.wsif.2012.10.012

Myers, K. (2017). "If I'm going to do it, I'm going to do it right": Intensive mothering ideologies among childless women who elect egg freezing. *Gender & Society, 31*(6), 777–803. https://doi.org/10.1177/0891243217732329

Neumann, C. B., & Neumann, I. B. (2015). Uses of the self: Two ways of thinking about scholarly situatedness and method. *Millennium, 43*(3), 798–819. https://doi.org/10.1177/0305829815576818

O'Hara, M. W., Pearlstein, T., Stuart, S., Long, J. D., Mills, J. A., & Zlotnick, C. (2019). A placebo-controlled treatment trial of sertraline and interpersonal psychotherapy for postpartum depression. *Journal of Affective Disorders, 245*, 524–532. https://doi.org/10.1016/j.jad.2018.10.361

Öksüz, E. E. (2021). Postpartum depression among women with disabilities: A multicultural counseling perspective. *Journal of Multicultural Counseling and Development, 49*(1), 45–59. https://doi.org/10.1002/jmcd.12205

Patil, V. (2013). From patriarchy to intersectionality: A transnational feminist assessment of how far we've really come. *Signs: Journal of Women in Culture and Society, 38*(4), 847–867. https://doi.org/10.1086/669560

Patnaik, E. (2013). Reflexivity: Situating the researcher in qualitative research. *Humanities and Social Science Studies, 2*(2), 98–106.

Pinheiro, E., Bogen, D. L., Hoxha, D., Ciolino, J. D., & Wisner, K. L. (2015). Sertraline and breastfeeding: Review and meta-analysis. *Archives of Women's Mental Health, 18*(2), 139–146. http://doi.org/10.1007/s00737-015-0499-y

Polmanteer, R. S. R., Keefe, R. H., & Brownstein-Evans, C. (2019). Trauma-informed care with women diagnosed with postpartum depression: A conceptual framework. *Social Work in Health Care, 58*(2), 220–235. http://doi.org/10.1080/00981389.2018.1535464

Praetorius, R., Maxwell, D., & Alam, K. (2020). Wearing a happy mask: Mother's expressions of suicidality with postpartum depression. *Social Work in Mental Health, 18*(4), 429–459.

https://doi.org/10.1080/15332985.2020.1769003

Premji, S., McDonald, S. W., Zaychkowsky, C., & Zwicker, J. D. (2019). Supporting healthy pregnancies: Examining variations in nutrition, weight management and substance abuse advice provision by prenatal care providers in Alberta, Canada. A study using the all our families cohort. *PloS One, 14*(1), e0210290-e0210290. https://doi.org/10.1371/journal.pone.0210290

Priddis, H. S. (2015). Autoethnography and severe perineal trauma - An unexpected journey from disembodiment to embodiment. *BMC Women's Health, 15.* https://doi.org/10.1186/s12905-015-0249-3

Puar, J. K. (2011). "I would rather be a cyborg than a goddess:" Becoming-intersectional in assemblage theory. *philoSOPHIA: A Journal of Continental Feminism, 2*, 49–66.

Redekop, F. (1995). The "problem" of Michael White and Michel Foucault. *Journal of Marital and Family Therapy, 21*(3), 309. https://doi.org/10.1111/j.1752-0606.1995.tb00164.x

Rosenthal, L., Earnshaw, V. A., Lewis, T. T., Reid, A. E., Lewis, J. B., Stasko, E. C., Tobin, J. N., & Ickovics, J. I. (2015). Changes in experiences with discrimination across pregnancy and postpartum: Age differences and consequences for mental health. *American Journal of Public Health 105*(4), 686–93. https://doi.org/10.2105/AJPH.2014.301906

Sakellariou, D., & Rotarou, E. S. (2017). The effects of neoliberal policies on access to healthcare for people with disabilities. *International Journal for Equity in Health, 16*. http://doi.org/10.1186/s12939-017-0699-3

Scharp, K. M., & Thomas, L. J. (2017). "What would a loving mom do today?": Exploring the meaning of motherhood in stories of prenatal and postpartum depression. *Journal of Family Communication, 17*(4), 401–414.

https://doi.org/10.1080/15267431.2017.1355803

Schoppe-Sullivan, S. J., Yavorsky, J. E., Bartholomew, M. K., Sullivan, J. M., Lee, M. A., Dush, C. M. K., & Glassman, M. (2017). Doing gender online: New mothers' psychological characteristics, Facebook use, and depressive symptoms. *Sex Roles, 76*(5), 276–289. https://doi.org/10.1007/s11199-016-0640-z

Settles, I. H., Warner, L. R., Buchanan, N. T., & Jones, M. K. (2020). Understanding psychology's resistance to intersectionality theory using a framework of epistemic exclusion and invisibility. *The Journal of Social Issues, 76*(4), 796–813. http://doi.org/10.1111/josi.12403

Sheeran, N., Jones, L., Rowe, J., & McDonald, H. (2018). Adolescent mothers' experiences over time. *Family Relations, 67*(3), 428–443. https://doi.org/10.1111/fare.12312

Shi, P., Ren, H., Hong, L., & Dai, Q. (2018) Maternal depression and suicide at immediate prenatal and early postpartum periods and psychosocial risk factors. *Psychiatry Research, 261*, 298–306. https://doi.org/10.1016/j.psychres.2017.12.085

Sipsma, H. L., Callands, T., Desrosiers, A., Magriples, U., Jones, K., Albritton, T., & Kershaw, T. (2016). Exploring trajectories and predictors of depressive symptoms among young couples during their transition to parenthood. *Maternal and Child Health Journal, 20*(11), 2372–2381. http://doi.org/10.1007/s10995-016-2064-3

Staneva, A. A., Bogossian, F., Morawska, A., & Wittkowski, A. (2017). "I just feel like I am broken. I am the worst pregnant woman ever": A qualitative exploration of the "at odds" experience of women's antenatal distress. *Health Care for Women International, 38*(6), 658–686. https://doi.org/10.1080/07399332.2017.1297448

Staneva, A. A., & Wigginton, B. (2018). The happiness imperative: Exploring how women

narrate depression and anxiety during pregnancy. *Feminism & Psychology, 28*(2), 173–193. https://doi.org/10.1177/0959353517735673

Statistics Canada. (2019). Maternal mental health in Canada, 2018/2019. https://www150.statcan.gc.ca/n1/en/daily-quotidien/190624/dq190624b-eng.pdf?st=pCx_PQ_thttps://www150.statcan.gc.ca/n1/en/daily-quotidien/190624/dq190624b-eng.pdf?st=pCx_PQ_t

Stevens, N. R., Heath, N. M., Lillis, T. A., McMinn, K., Tirone, V., & Mervat Sha'ini. (2018). Examining the effectiveness of a coordinated perinatal mental health care model using an intersectional feminist perspective. *Journal of Behavioral Medicine, 41*(5), 627–640.

Substance Abuse and Mental Health Services Administration [SAMHSA]. (2014). SAMHSA's concept of trauma and guidance for a trauma-informed approach. *HHS Publication No. (SMA*) 14-4884. https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

Surrey, J. L. (1985*). The "self-in-relation": A theory of women's development*. Wellesley College, Stone Center for Developmental Services and Studies. https://www.wcwonline.org/pdf/previews/preview_13sc.pdf

Tandon, S. D., Leis, J. A., Ward, E. A., Snyder, H., Mendelson, T., Perry, D. F., Carter, M., Hamil, J., & Le, H. (2018). Adaptation of an evidence-based postpartum depression intervention: Feasibility and acceptability of mothers and babies 1-on-1. *BMC Pregnancy and Childbirth, 18.* http://doi.org/10.1186/s12884-018-1726-0

Tariq, A., & Yousaf, A. (2020). Self-criticism, self-silencing and depressive symptoms in adolescents. *Journal of Behavioural Sciences, 30*(1), 60. http://pu.edu.pk/images/journal/doap/PDF-FILES/4_V30-1-2020.pdf

Thomason, E., Flynn, H., Himle, J., & Volling, B. (2015). Are women's parenting-specific beliefs associated with depressive symptoms in the perinatal period? Development of the rigidity of maternal beliefs scale. *Depression and Anxiety, 32*(2), 141–148. https://doi.org/10.1002/da.22280

Tokumitsu, K., Sugawara, N., Maruo, K., Suzuki, T., Yasui-Furukori, N., & Shimoda, K. (2020). Prevalence of perinatal depression among Japanese men: A meta-analysis. *Annals of General Psychiatry, 19*, 1–11. http://doi.org/10.1186/s12991-020-00316-0

Topa, J. B., Nogueira, C. O., & Neves, S. A. (2017). Maternal health services: An equal or framed territory? *International Journal of Human Rights in Healthcare, 10*(2), 110–122. https://doi.org/10.1108/IJHRH-11-2015-0039

Trettin, S., Moses-Kolko, E., & Wisner, K. L. (2006). Lesbian perinatal depression and the heterosexism that affects knowledge about this minority population. *Archives of Women's Mental Health, 9*(2), 67–73. http://doi.org/10.1007/s00737-005-0106-8

Turan, J. M., Elafros, M. A., Logie, C. H., Banik, S., Turan, B., Crockett, K. B., Pescosolido, B., & Murray, S. M. (2019). Challenges and opportunities in examining and addressing intersectional stigma and health. *BMC Medicine, 17.* http://doi.org/10.1186/s12916-018-1246-9

Turner, J. (2018). Literature review. *Performance Improvement Quarterly, 31*(2), 113–117. https://doi.org/10.1002/piq.21275

Ussher, J. M., Perz, J., Metusela, C., Hawkey, A. J., Morrow, M., Narchal, R., & Estoesta, J. (2017). Negotiating discourses of shame, secrecy, and silence: Migrant and refugee women's experiences of sexual embodiment. *Archives of Sexual Behavior, 46*(7), 1901–1921. https://doi.org/10.1007/s10508-016-0898-9

Warner, L., Kurtiş, T., & Adya, A. (2020). Navigating criticisms of intersectional approaches: Reclaiming intersectionality for global social justice and well-being. *Women & Therapy, 43*(3-4), 262–277. http://doi.org/10.1080/02703149.2020.1729477

Woollard, F. (2018). Should we talk about the 'benefits' of breastfeeding? The significance of the default in representations of infant feeding. *Journal of Medical Ethics, 44*(11), 756. http://doi.org/10.1136/medethics-2018-104789

Worrall, A. (2018). Bringing our gaze to perinatal depression. *International Journal of Narrative Therapy and Community Work, (2)*, 1–11. https://search.informit.org/doi/10.3316/informit.700257083861135