

# Seeking Social Support: How Women with Postpartum Depression Navigate Cultural Stigmas that Influence How They Disclose Their Struggles

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## ABSTRACT

This research explored how women with postpartum depression (PPD) seek social support while navigating cultural and interpersonal discourses. The aim of this research was to identify what motivates women to disclose their struggles with postpartum depression and discover the ways in which they receive (or do not receive) social support. Relational dialects theory and social support theory were used as a guide to interpret the cultural and interpersonal discourses that impact disclosure and support. Social media and cultural expectations placed upon women contribute to beliefs that they will have a natural motherly instinct, that parenting will be easy, and that they will have an instant love for their child. Qualitative analysis took place through semi-structured interviews with women who have experienced PPD in the last five years. When women with PPD had expectations that did not meet their reality, this motivated them to disclose their struggles to close others so that they were not seen as “crazy.” Most instances of disclosure yielded an outpouring of support, but the idea of what helpful support looks like is unique to each individual. It was also revealed that healthcare providers must do better at recognizing and supporting women with PPD.

## INTRODUCTION

Postpartum depression (PPD) is an illness affecting women post-birth that is not often talked about or recognized. According to Gavin et al. (2005) and O’Hara and Swain (1996), “between 13% and 19% of women will experience the onset of a depressive episode in the 6 months post-delivery” (as cited in Stana & Miller, 2019, p. 297). Although PPD is common, many suffering women do not seek help on their own (Freed et al., 2012). As a result, many cases of PPD are left untreated because they are unwilling to disclose their illness and get help. According to Pearlstein et al. (2009), there is a “well-established relationship between untreated maternal depression and impaired child development” (p. 358). Therefore, recognizing signs of PPD and getting support in the early stages is essential to the health and safety of mothers and their children (Freed et al., 2012).

Without women disclosing their struggle with PPD, it is difficult for them to receive proper care and support. Significant challenges present themselves when women with PPD feel as if they cannot disclose their struggles. Previous research has identified multiple barriers that prevent women with PPD from disclosing their illness. Most notably, culture can influence “how individuals experience or express their symptoms, as well as how they make sense of their illness” (Freed et al., 2012, p. 3). Unfortunately, the stigma in society regarding PPD is strong (Anderson, 2013; Pearlstein et al., 2009; Scharp & Thomas, 2017), which often deters women from disclosing their illness. Social support for women with PPD is unattainable when they feel as if they are unable to disclose their struggles. Therefore, the purpose of this study is to discover how women with PPD navigate cultural stigmas that impact their choice to disclose – or not disclose – their struggles with those closest to them. The remainder of this paper will discuss how social support is enacted through communication, using relational dialectics theory (RDT) as a lens to depict how societal stigmatizations play a role in disclosure and social support.

Although communication research regarding PPD is lacking, an abundance of psychology research is devoted to PPD. While psychological research of this topic is important, communication research related to PPD and the relationship between disclosure and social support is needed. The stigma surrounding PPD often deters women from disclosing their illness. Thus, they are unable to receive the social support and treatment they need. The literature review will define postpartum depression and explain how it relates to disclosure and social support. When women with PPD disclose their struggles and seek support, they often turn to their spouse, friends/family, a healthcare provider, or other struggling mother’s. Additionally, Relational Dialectics Theory will be used to analyze the cultural and interpersonal discourses that are present in the disclosure process for women with PPD.

## REVIEW OF LITERATURE

### *Postpartum Depression (PPD)*

Postpartum depression is a condition that many women struggle with after giving birth to a child. According to Mayo Clinic (2021), symptoms of postpartum depression include severe mood swings, withdrawal from family and friends, inability to sleep, loss of energy, severe anxiety, and thoughts of harming oneself or one's child. The American Psychological Association states that one in seven new mothers in the United States experience PPD (as cited in Tang et al., 2021). While this illness is not uncommon, the stigma around this topic prevents women from disclosing their struggles and getting the treatment they need. Studies have shown that "PPD is underrecognized and undertreated," which is linked to low rates of screening, diagnosis, and treatment (Pearlstein et al., 2009, p. 357).

The fact that PPD is underrecognized and often left untreated can lead to serious implications for the mother and the child. In fact, PPD has been associated with a "higher incidence of excessive infant crying or colic, sleep problems, and temperamental difficulties," thus, intensifying the mother's own symptoms (Pearlstein et al., 2009, p. 358). The absence of treatment for women suffering with PPD stems from a lack of social support. Women with PPD are often scared to disclose their illness due to the stigma and societal/cultural implications associated with PPD. Anderson (2013) explains that "many women will suffer with their symptoms in silence, as they fear societal stigmatization and lack a social support network with which to share their feelings" (p. 710). It is clear that societal stigmatization, often caused by the idealized expectation of motherhood, deters women from disclosing their struggle with PPD.

The stigma that women with PPD face is perpetuated by the idealized expectations of motherhood. In the United States, mothers are expected to "express unconditional love for their children, sacrifice anything for their children's well-being, and ultimately provide resources to promote the child's physical, psychological, and social development" (Scharp & Thomas, 2017, p. 403). It is assumed that being a good mother is implicitly linked to being a woman (Everingham et al., 2006). Everingham (1994) found that motherhood is thought to come as a natural instinct for women in Western societies (as cited in Everingham et al., 2006). Consequently, women are pressured to fulfill their gender roles (Stana & Miller, 2019). As a result, when women find themselves "struggling with life" in the postpartum period, they are "overwhelmed with strong feelings of failure, guilt, disappointment, worries, loneliness, uncertainty, bereavement, and unfulfilled expectations" (Edhborg et al., 2005, p. 263). Additionally, the experience of becoming a mother is supposed to be joyful. So many women feel ashamed or guilty about their feelings and are less likely to seek treatment or get help with PPD (Anderson, 2013; Pearlstein et al., 2009).

**Social Support.** When enduring a health crisis such as PPD, it is important to have a social support system. Social support is defined as communication within close relationships that provides a safe space to disclose the struggles of everyday life (Goldsmith & Albrecht, 2011). This support allows the struggling individual to feel loved, cared for, and valued (Goldsmith & Albrecht, 2011). In situations where health is an issue, support can be given and received in many ways. Enacted support is organized into four categories – informational support (advice and problem-solving), emotional support (sympathy and caring), tangible support (helping with tasks) and appraisal support (helping evaluate a situation) (Goldsmith & Albrecht, 2011). While most efforts to enact support are helpful, Goldsmith (2004) explains that "some pieces of advice may be substantively wiser than others, some emotional support attempts may be heartfelt, whereas other attempts are superficial and obligatory" (p. 19). It is difficult to determine what kind of support is most effective for women with PPD, but scholars do know what sources women turn to when seeking support. The outlets for support include spouses, friends and family, health providers, and other struggling mothers. The following section will discuss the barriers that prevent women from disclosing their struggles and seeking support, given that PPD is highly stigmatized.

### *Disclosure and Support*

Social support has been shown to significantly help women struggling with PPD (Edhborg et al., 2005; Stana & Miller, 2019; Tang et al., 2021). In a study that looked at women with PPD and their coping strategies, research found that talking to someone was the most common way for mothers to cope with depressive symptoms (Tang et al., 2021). Edhborg et al. (2005) explained that mothers with PPD feel lonely and tired, longing for someone to talk to and help them through their struggles. However, most forms of social support can only be effective when the woman with PPD discloses her struggles. There are numerous outlets in which a woman with PPD may feel comfortable disclosing her feelings in order to receive the much-needed social support. However, previous research has found that there are barriers that exist when deciding to disclose symptoms of PPD. The following sections will outline the sources of social support for women with PPD and the barriers to disclosure in these outlets.

**Disclosure to a Spouse.** Women with PPD may find support from their spouse, or the individual with whom they are raising their child. A study looking at couples that experienced postpartum depression found that “being understood was the most important form of support desired by mothers from their partners” (Everingham et al., 2006, p. 1748). However, women with PPD are usually afraid of disclosing their struggles to their partners out of fear that they would not understand, or that they themselves would be considered inadequate mothers (Everingham et al., 2006).

Additional communication research explains why disclosure of PPD to a spouse is important. In a study looking at PPD narratives, women explained that their marriage was strained after the birth of their child due to a lack of time for one another and their mutual interests (Edhborg et al., 2005). The demands of a child caused them to “not talk or touch each other as much as earlier” (Edhborg et al., 2005, p. 264). The lack of physical connection between partners can cause challenges within their relationship. According to Cutrona (2012), “intimacy grows when individuals disclose aspects of themselves, and these self-disclosures are met with understanding, validation, and caring” (pp. 393-394). Therefore, when women disclose their struggles with PPD to their spouse, it meets the woman’s need to feel understood and facilitates their relationship.

**Disclosure to Friends/Family.** Disclosing PPD to family or friends is a difficult decision for women to make. Although these individuals can function as a support system for women struggling with PPD, they are often concerned about judgement. A study about PPD and help-seeking barriers found that women resisted telling friends or family because they were fearful that “discussion about their emotions would give their family a ‘bad name’ and risk their being seen as responsible for problems within the family” (Dennis & Chung-Lee, 2006, p. 325). Another barrier that deters women with PPD from disclosing to their friends or family is the concern that they will not understand. Given that these individuals have not experienced PPD, “family members are often unable to provide assistance or promote help seeking due to a lack of understanding about postpartum depression” (Dennis & Chung-Lee, 2006, p. 325). Overall, the fear of judgement, in addition to a poor understanding of PPD, can prevent women from disclosing their illness to friends and family.

**Disclosure to a Healthcare Provider.** Health care providers can help women with PPD, but women must feel comfortable disclosing that information to them. Dennis and Chung-Lee (2006) found that “health professionals play a salient role in either promoting help-seeking behaviors or hindering the obtainment of treatment” (p. 326). However, women with PPD must trust their provider before disclosing their illness. One nurse that works in labor and delivery explained that “if they don’t trust you, they might not share as honestly with you. If they feel they cannot trust you to listen then they are not going to tell you things” (Dalton et al., 2021, p. 622). Research shows that women with PPD are afraid to disclose their struggles, so healthcare providers must do a better job at facilitating conversations with their patients and enacting treatment plans if their patients show signs of PPD (Freed et al., 2012). Therefore, it is critical that health care providers come across as trustworthy, display sympathy, and listen so that their patients feel heard. When this occurs, women with PPD are much more likely to disclose their illness to their health care provider, which is “crucial for proper care of the patient and baby” (Dalton et al., 2021, p. 622).

**Disclosure to Other Struggling Mothers.** Research has found that women with PPD feel most comfortable disclosing their illness to other women experiencing PPD in online PPD support groups (Anderson, 2013). Given that “few experiences in a woman’s life as life-altering as giving birth, it is often thought to be a binding commonality” (Johnson et al., 2020, p. 649). Stana and Miller (2019) note that women are driven to online support groups because of social barriers and the stigma that exists surrounding PPD. Even if these support groups take place primarily online, mothers can unite and support one another. According to Anderson (2013), they are able to “normalize and validate women’s actions as mothers and PPD symptoms and provide a safe place for disclosure” (p. 718).

A study performed by Johnson et al. (2020) termed the word, “‘motherland’ – a place where mothers go to be together and struggle through parenthood” (p. 651). The research describes how women benefit from birth storytelling, or in other words, sharing and listening to a birth story to build motherwisdom (Johnson et al., 2020). One woman in the study explained that she felt supported when she heard that other mothers had similar stories (Johnson et al., 2020). They also add that sharing stories allows struggling mothers to recognize that their feelings and experiences are a normal part of the journey through motherhood (Johnson et al., 2020). Disclosures related to storytelling were shown to be beneficial for mothers struggling with PPD. The study found that birth storytelling was empowering for women and provided them with “emotional, esteem, and informational support, while building a support network that functioned to build camaraderie (Johnson et al., 2020, p. 663). Overall, women with PPD are

able to disclose their illness to other struggling women, free of judgement, and receive support from other individuals that can understand and validate their experiences.

**Considerations for Disclosure.** It is important to note that disclosure for women with PPD is complicated due to the perceived stigmas and the daunting process of disclosure itself. In addition to the sensitive nature of this topic, mothers experience “crushing stigmas” and “report feeling guilty that they cannot meet idealized expectations of motherhood” (Scharp & Thomas, 2017, p. 401). Consequently, the decision for women to disclose their struggle with PPD is difficult. Furthermore, if women decide to disclose their illness, the process of disclosure itself is challenging. Greene (2009) explains that “once disclosers decide to disclose, they then consider how to enact the disclosure, including the timing, location, and channel” (as cited in Venetis et al., 2018, p. 654). Thus, disclosure of PPD can be a long, time-consuming process, likely preventing women from disclosing their illness to other individuals. Despite these difficulties, research has shown numerous benefits associated with disclosure of PPD. One study concluded that social support results in an increased life expectancy, speedier recoveries from illness, and improved mental health (Stana & Miller, 2019). Therefore, it is extremely important to understand the relational and cultural complexities that push or prevent women with PPD to disclose their struggles and thus, receive social support. Relational dialectics theory can be used as a lens to understand the relational and cultural complexities that impact disclosure.

### *Relational Dialectics Theory*

Relational dialectics theory (RDT) is a theory that explains interpersonal communication contradictions and the larger social and cultural impacts at play. Given that PPD is a topic that is socially and culturally stigmatized, this theory is important for understanding communication related to PPD. Initially, RDT focused on how the “interplay of opposing forces” affects interpersonal communication (Baxter & Norwood, 2016, p. 1). This theory has developed over time, initially focusing on a single contradiction or single relationship type (Baxter & Norwood, 2016). Baxter and Montgomery (1996) identified three dialectical tensions present in interpersonal relationships, including autonomy-connection, openness-closedness, and predictability-novelty. In an interpersonal relationship, for example, one may desire to maintain privacy, while also wanting to open up to their partner. These desires contradict one another, leading to a push and pull relationship that causes tension. RDT has now evolved into what Baxter and Norwood (2016) describe as an understanding of how social and cultural influences “anchor the pull between independence and interdependence” and construct relational meaning (p. 2).

**The Utterance Chain.** Baxter’s original work was based on a Russian theorist, Mikhail Bakhtin, who developed the concept of the utterance chain (Littlejohn & Foss, 2009). The utterance chain is defined as a form of communication that links prior utterances and future expectations (Baxter, 2010). The utterance chain is classified into distal and proximal utterances (Baxter & Montgomery, 1996). According to Scharp and Thomas (2017), “distal links of the utterance chain refer to shared cultural responses and anticipations whereas proximal links refer to the responses and anticipations idiosyncratic to a particular speaker” (p. 404). These two types of utterances are further categorized into already-spoken and not-yet-spoken links (Baxter & Montgomery, 1996). The already-spoken links relate to previous interactions that impact current communication, while not-yet-spoken links are anticipated communication responses (Baxter, 2010). For example, if a man were to say, “I love you” to their partner, they would be making this claim based on past interactions with their partner that demonstrate a love for one another (already-spoken links). They also may expect their partner to say, “I love you” in return (not-yet-spoken links) because of previous instances where their partner says, “I love you” back (already-spoken links).

**RDT and Disclosure of Postpartum Depression.** Baxter’s most recent adaptation to RDT emphasizes the importance of cultural expectations in interpersonal communication, which can be useful in explaining disclosures associated with PPD, given that the illness is highly stigmatized in society. Freed et al. (2012), found that “stigmatizing attitudes have a direct impact on help-seeking behaviors” because they are less likely to disclose to others out of “shame about their symptoms or fear judgment from others” (p. 3). For women with PPD, the cultural expectations of motherhood, in addition to stigmatizing attitudes, hinders them from disclosing to others and seeking social support.

It is important to note that Baxter and Montgomery’s initial findings are also relevant to PPD disclosures. They explained that relational partners “experience something like intra-role conflict to the extent that they perceive incompatible expectations associated with their ‘role’ as a member of a personal relationship” (Baxter & Montgomery, 1996, p. 7). In any relationship, disclosure is a “role” that is shared by both members, which helps build and grow the relationship. However, contradictions within social life are normal and unavoidable (Baxter &

Montgomery, 1996). Even though disclosures are needed within interpersonal relationships, there are times when people want to maintain privacy. This is defined by Baxter and Montgomery (1996) as openness and closedness. In terms of PPD, openness-closedness could help explain why some mothers remain closed off, but also desire to share their struggles with those around them. Women with PPD are pushed to disclose their illness in order to fill their “role” in interpersonal relationships, but also pulled to maintain privacy and avoid judgement from society.

**Distal Already-Spoken Links and PPD.** According to Baxter (2010), the “distal already-spoken link in the utterance chain refers to the utterances circulating in the culture at large” (p. 50). This explains how prevalent ideas within society influence the communication process. In terms of PPD, this could explain how cultural perceptions play such a dominant role in the disclosure process. Scharp and Thomas (2017) explain that the “dominant ideology of motherhood serves as a heuristic through which motherhood can be understood and by which a ‘good mother’ is judged” (p. 403). If a woman with PPD is concerned about being judged due to cultural expectations, it could prevent disclosure and thus, a chance for social support. Therefore, distal, already-spoken links could be related to the disclosure process and explain how mothers with PPD are influenced by cultural perceptions.

**Proximal Already-Spoken Links and PPD.** Proximal already-spoken links occur when a “relationship’s past meaning bumps up against the meaning of the relationship in the present” (Baxter, 2010, p. 51). This presumes that past interactions will impact future communication. Everingham et al. (2006) states that “difficulties in communication have been associated with fathers’ perceived lack of support for mothers suffering postnatal depression” (p. 1745). According to RDT and the utterance chain, this likely means that previous interactions demonstrated a lack of support. In the disclosure process, women with PPD may be hesitant to disclose their struggles when they assume others will not understand (Everingham et al., 2006). Whether it be with a spouse, friend, family, or doctor, previous interactions will influence their decision to ask for (or not ask for) support.

**Distal/Proximal Not-Yet Spoken Links and PPD.** Distal and proximal not-yet spoken links can have a substantial impact during the disclosure process of PPD. According to Baxter (2010), “both proximal not-yet-spoken and distal not-yet-spoken examine the role of anticipated response and evaluation by others” (p. 52). For women with PPD, not-yet spoken links have a massive influence on their decision to disclose their illness. As mentioned previously, women with PPD have expectations about how others will respond when or if they disclose their struggle with PPD. For example, mothers with PPD often believe that disclosing their illness to outsiders will be received with negativity, giving their family “a bad name” (Dennis & Chung-Lee, 2006). Furthermore, mothers struggling with PPD are hesitant to disclose this information to their healthcare provider, worried that their doctor will see their illness as a barrier to being an effective mother and could possibly refer them to Child Protective Services (Freed et al., 2012). These examples demonstrate that women with PPD have anticipations for how others react when they disclose their illness. Therefore, not-yet spoken links and the notion that they will be perceived negatively by others impacts whether or not women with PPD feel comfortable asking for social support.

### *Research Questions*

Prior research has looked at PPD and the barriers that prevent women from disclosing their illness. Cultural expectations and social stigmas have been shown to greatly inhibit women from disclosing to others and seeking help (Anderson, 2013; Pearlstein et al., 2009; Scharp & Thomas, 2017). While this research explains why women are hesitant to disclose their struggles with PPD, there is no current research that looks at what *motivates* women to disclose their struggles. Therefore, the lack of understanding as to why women with PPD choose to disclose this information to close others led to the following question:

*RQ1: How do cultural and interpersonal discourses influence how women choose to disclose their postpartum depression with close others?*

Cultural stigmas within society have proved to make it challenging for women with PPD to disclose their struggles and get support. A study looking at stigmatized mental health issues found that receiving social support reduced the negative effects of the stigmas they felt from society (Chronister et al., 2013). Therefore, it is imperative that women suffering from PPD find the social support they need to confront the stigmas surrounding this topic. The only way women can overcome these stigmas and seek support is through interpersonal communication in their social networks. The following research question will address how women navigate these cultural and interpersonal discourses while seeking social support.

*RQ2: How do cultural and interpersonal discourses influence how women with PPD receive (or do not receive) social support?*

## **METHODS**

Qualitative methods of research were selected to study PPD, disclosure, and social support. The qualitative paradigm was the best approach for this topic because PPD is a unique disorder that everyone may experience differently. As a result, an individual's experience with PPD may vary widely. Taylor and Francis (2013) state that "words and language are fundamental tools for creating and validating knowledge in qualitative research," in turn giving meaning to human experiences (p. 3). Therefore, conducting interviews allowed participants to explain the complexities of their experience with PPD.

### *Participants*

A total of eight females who have personally experienced PPD within the last 5 years participated in this study. The participants selected were between the ages of 26-40, with the average being 33. Of the eight individuals, six were married and two had a partner but were not married. These individuals were recruited through the researcher's personal network. Half of the participants were recruited through the researcher's initial Facebook post requesting participants. The other half of the participants were contacted to participate after publicly posting about their struggles with PPD on Instagram.

### *Interviews*

Interviews were conducted in a semi-structured format, which ensured that all participants were asked the same questions. This format allowed for reliable and replicable data, while allowing the researcher to ask follow-up questions as necessary for more detail. Semi-structured interviews support "reciprocity between the interviewer and participant...and allows space for participants' individual verbal expressions" (Kallio et al., 2016, p. 2955). This style of interviewing guaranteed that the data represented the most detailed and informative perspectives.

The list of interview questions was composed of 20 questions and included the opportunity to ask clarifying questions when needed. In summary, the participants were asked about their experience with PPD, who they disclosed their struggles to and why, and how that disclosure impacted their relationships. Please see the Appendix for a list of questions that each participant was asked.

### *Procedure*

Upon IRB approval, the researcher recruited participants and scheduled interviews. Interviews took place via Zoom, given that participants were geographically dispersed throughout the United States (Wisconsin, Nevada, and Texas). Interviews lasted between 30 and 70 minutes and were audio-recorded with consent from the participants. Upon completion of each interview, the interviews were transcribed. All potentially identifying information was modified or removed to ensure that participant information remains confidential. After transcription was complete, the transcripts were analyzed, from which distinct themes were identified.

### *Data Analysis*

A thematic approach was used to analyze the data collected during the interviews. In this specific study, thematic analysis allowed the researcher to unite the unique experiences of the participants. Upon completion of all interviews, the transcripts were coded in accordance with the two research questions. The codes from each research question were then gathered into distinct themes. Braun and Clarke (2006) explain that a thematic analysis allows the participants' stories to be heard, while allowing the researcher to investigate the broader social contexts within which the experiences occur. Therefore, this form of data analysis aids in the understanding of how disclosure of PPD and whether or not a woman receives social support is impacted by cultural and interpersonal discourses.

## **RESULTS**

Although every response was unique, common themes emerged after looking through the data. The five themes that resulted from RQ1 explain who women chose to disclose to and their motivations for doing so include: Safe Spaces, I Need You, I'm Not Myself, I'm Not a Psycho, and Can Good Things Come from Bad Situations? The five themes that were found in RQ2 address how women felt supported, as well as how they could have been supported better: Take Me Seriously, Talk Me Through It, Give Me a Break, and Do Better. These themes are explained below.

*RQ1: How do cultural and interpersonal discourses influence how women choose to disclose their PPD to close others?*

The purpose of RQ1 was to identify who women chose to disclose their struggles with and their motivations for doing so. The impact of cultural and interpersonal discourses will be addressed in the discussion section. Five themes emerged and are discussed below. Every participant had a unique story that played into the development of each theme.

**Safe Spaces.** This theme represents the people with whom the women with PPD felt comfortable disclosing their struggles. When participants were asked who they confided in while struggling with PPD, they all indicated that they chose people they felt safe with and trusted. The people that participants disclosed their struggles to included their spouse/partner, their mother or sister, their doctor, and/or a close friend. Participants were also asked to identify why they specifically chose to confide in each individual. One participant, Maggie, stated that she disclosed her struggles to her husband and her sister because she spent most of her time with them and those were the people in her life with whom she was genuinely the closest. Another participant, Mary, added to this and explained that the people she disclosed to were in it with her and saw her in her daily life. She said they were all safe places for her and that made it a lot easier to confide in them.

Whether or not it was the first person they opened up to, every participant confided in their spouse/partner in some way. Maggie explained that she went directly to her husband because “he is very supportive and he’s always been a safe place and very easy to talk to.” Madeline stated that her husband is her best friend, so she did not want to talk to anybody but him. Some women chose to talk to their spouse because they have also been through anxiety and depression. As a result, their partners were able to understand what they were going through. Mary, whose husband has had depression in the past, said she has no idea how women do it if they have a spouse who has never been depressed. She stated that her husband “remembers what it felt like to be in the fetal position on a bed and not wanting to move.” Because of this, she said her husband was on her team and even more gracious, uplifting and affirming. Madeline also said that her husband could relate to the feeling of what she was going through. Her and her husband had talked extensively about her anxiety prior to having children. This way, her husband could better understand her and the things that triggered her anxiety. This made her feel comfortable disclosing her struggles to her husband.

Multiple women indicated that they disclosed their struggles to their mom. Madeline said she talked to her mom because she felt like her mom could relate, “seeing as though she went through it too” and could understand the difficulties of the postpartum period. Melissa explained that the first person she confided in was her mom. She called her mom saying, “I want my mom, I need my mom.” Melissa said her mom is amazing and always knows best, stating that she has often been the cure to her problems in the past.

A few women chose to talk to their doctors before confiding in anyone else. Maria, who has had anxiety and depression prior to PPD, recognized that something was off and called her doctor to make an appointment right away. She knew that she needed to go back on medication and believed her doctor could help. One participant, Mackenzie, said she kept her struggles a secret from everyone until she talked to her doctor. Once her doctor acknowledged and validated her feelings, she started to accept that she needed help and could not get through this period of her life alone. After that conversation, she was put on medication and started talking to her husband and mother about her struggles.

**I Need You.** This theme represents that women with PPD recognized that they needed help during this time, so they were motivated to disclose their struggles. In response to a question regarding why she felt motivated to disclose her struggles, Maria stated, “I felt like I wasn’t going to make it out of that if I didn’t have them. You know, I knew I needed them in a way that I have never felt before.” Another participant, Mary – who describes herself as a very faith-based person – also shared a compelling story. She explained she was motivated to disclose her struggles because she “so badly wanted out of them and I knew that I could not get out of it on my own.” Mary’s husband told her a story about God sending lifeboats to people in need to “get them to shore.” Mary stated that she felt foggy during this time and needed something to allow her to see things more clearly. Mary explained, “I knew I could get to shore through the vehicle of wisdom and prayer and accountability from people that I love. And then through medicine, ultimately as well.” All of these reasons contributed to Mary’s decision to disclose her struggles.

Although the individuals that the participants disclosed to did not always know how to help, the act of disclosing in itself was helpful. One participant, Miranda, explained that disclosing her struggles did not take away her anxiety and depression. However, she claimed, “when you start talking about something out loud, it kind of loses its power.” The act of sharing her feelings out loud made her feel as if she was not dealing with her problems alone.

**I'm Not Myself.** This theme represents the motivation to disclose their struggles because the women felt they needed to give people an explanation. All of the participants mentioned that they did not feel like themselves – they were crying all the time, quick to anger, and/or anxious about everything. Mya said that her partner picked up on the changes, so she needed him to know “why I didn’t seem myself.” Another participant, Melissa, explained that she was not eating, drinking, or sleeping during the postpartum period. She said her husband looked at her and stated, “that’s not you, something’s wrong.” Madeline described that she hated how she felt during that period of her life. She said, “I knew it wasn’t me. I knew I wasn’t the best mom that I could be to my boys. I knew I wasn’t being the best wife. I’m not a mopey, sad person. So I was like, this just can’t – and isn’t – going to be who I am.”

For Miranda, she tried to hide how she felt for a long time before opening up to others. She explained, “man, I tried to hold it in for a very long time. Not for anyone else, but for me.” She would try and convince herself that she would feel better soon. This did not work for long and Miranda stated, “there came a point where I couldn’t hold in the emotion and the intensity that I was feeling.” When her emotions would show, people would ask her if she was okay. It was in these moments that she felt compelled to be “very honest and blunt” about what was going on in her head.

**I'm Not a Psycho.** This theme represents the motivation to disclose their struggles because the women did not want to be seen as crazy. Five out of the eight participants mentioned the word “crazy” or “psycho” at some point during their interview. Maggie explained that she confided in her husband because she did not want him to think that she was crazy. She said, “I didn’t want to become this horrible, ugly person. I just needed him to understand and then be able to better support me.” Maria explained that she wanted a couple of people in her life that she could be honest about her feelings with. She said there was clearly something wrong with her and she could not always hide it. She stated, “I felt like I was literally going crazy.” Mackenzie explained that she felt like she was “a crazy human being.” She said she first confided in her doctor because she needed them to tell her that it was going to be okay and that she was not crazy. One participant, Melissa, admitted that she initially was hesitant to disclose her struggles because she was afraid of being seen as crazy. When she faced that fear and decided to confide in someone, she said it was comforting to just be honest and not have to put on a fake face.

**Can Good Things Come from Bad Situations?** This theme represents that many women felt like their struggles with PPD ultimately strengthened their relationship with their spouse/partner. Every participant indicated that their spouse/partner stepped up while they were struggling with PPD and they grew in appreciation for one another. PPD can take a huge hit on your relationship with your partner, Miranda explained. She said, “imagine someone every day is coming to you crying with all this anxiety and fear constantly. It was very hard for him to have to hold me up.” There was a lot of tension in their relationship because of this. Although this challenged their relationship, Miranda indicated that her husband “pulled up so hard” and put his feelings aside in order to fully support her. Another participant, Madeline, said her husband would try to help but she would push him away. At first, this took a toll on their marriage. Once she started accepting his help, she said, “he did amazing supporting me. Without him, I don’t know what I would have done.” Ultimately, Madeline explained that her and her husband grew much closer and she had a whole new respect for him.

One participant, Mackenzie, explained that her and her husband “just went through the motions as parents” prior to her experience with PPD. Through everything, she said, “I realized I need to take time for myself and me and my husband need to take time for each other.” Mackenzie described it as a beautiful experience that created a really special bond with her husband. Mya explained that her and her partner were much more in tune with one another after her experience with PPD. Her partner was able to see when she was getting overwhelmed and was able to help out so much more because of that. Another participant, Mary, recalls feeling so broken and helpless, “like a bag of bricks that my husband had to carry around.” However, she remembers her husband being so proud of her and responding “as if I was the queen of the world.” She described that her relationship with her husband improved and grew in intimacy as a result. Overall, when women reflected on their experiences, they felt as if their relationship with their spouse/partner had flourished, despite possible challenges at the onset of PPD.

*RQ2: How do cultural and interpersonal discourses influence how women with PPD receive (or do not receive) social support?*

The purpose of RQ2 was to determine the ways in which women with PPD receive (or do not receive) social support. The impact of cultural and interpersonal discourses will be addressed in the discussion section. Four themes emerged and are discussed below. Every participant had a unique story that played into the development of each theme.



**Take Me Seriously.** This theme represents that individuals who women disclosed to (or the women themselves) were unsure of how serious the issue was. Participants expressed that it was helpful to have people acknowledge their feelings. However, a few women were hesitant to tell others about their struggles because they “didn’t want to call it something it wasn’t,” according to Mary. Another participant, Maria, explained that she did not know what it was she was feeling. The only thing she knew was that she was not okay. She said, “I didn’t want to over exaggerate before I kind of had a clear idea myself. I also didn’t want to alarm the people around me.” Maria added that she did open up to her husband later on, but he “wasn’t sure how serious to take it.”

One participant, Miranda, explained that she felt supported when “somebody looked at me and acknowledged that it *is* as serious as it feels to me. And didn’t try to make it less serious.” She said people need to acknowledge their feelings at face value, without judgement or pity. Miranda stated that when her husband would look at her and say, “I hear you,” she slowly started feeling safer. She explained that people around a new mom must take things as seriously as the woman says they are. Otherwise, the new mom can feel really alone. Overall, this theme showed that it is imperative that individuals who women confide in acknowledge their feelings and take them seriously.

**Talk Me Through It.** This theme represents the feelings of support the women felt when there was someone to talk them through their experiences with PPD. Some women went to online support groups or talked to other struggling mothers, while other women needed their doctor or therapist to talk them through their feelings. Mya explained that she needed an outlet for her feelings, so she went online and read about other women’s experiences to gain some understanding. Another participant, Maria, found an online support group where she could connect with other struggling mothers. The group, called The Mom’s Mental Health Initiative, also connected women to healthcare providers that specialized in postpartum mood disorders. When she reached out to the group, she said someone emailed her right away and said they were sorry she was feeling the way she did and that they understood her struggles. From there, she was connected to a doctor that specialized in postpartum mood disorders and was added to a text group where she could talk with other struggling mothers. Maria explained that she has no idea how she would have navigated PPD without them and that having other women to talk to was very beneficial.

Miranda explained that she began to feel better when she started going on walks with her husband and talking through her feelings. In addition to that, she had a friend that talked her through her struggles. Her friend explained that she was “in the thick of it.” Her friend was very upfront and direct about the difficulties of the postpartum period, comparing it to Navy SEAL training. In Miranda’s worst moments, she said that talking to her made her hopeful that things were going to get better. Another participant, Mary, talked to a friend that was “deeply in the same season” as her. She said that was one of the most helpful things that happened to her during that period of her life. They would communicate via an app called Marco Polo, both talking about their anxiety and depression and how they were trying to get through it. In general, these women felt supported when there was someone they could talk to or connect with who could relate to what they were feeling.

**Give Me a Break.** This theme represents the messages of support felt by the women when they were given a break from the demands of motherhood. Some of the participants indicated that they needed help around the house, while others needed help caring for the baby. Mary explained that her husband really stepped up and did not expect her to do the normal things that she would do around the home. She also said they changed their schedule and stopped making plans because she did not have the capacity to do the things she normally would. Miranda also stated that when someone comes to visit the baby, maybe bring them some food, do some laundry for them, and clean the kitchen. She said, “those are the things that new moms definitely need.” Another participant, Melissa, explained that she used to love cooking, cleaning, shopping, and doing the laundry. After having the baby, her husband recognized that she could not do those things anymore. When he started doing more of the household chores, she claimed she felt very supported through that.

Melissa also explained that it was helpful when her husband would take the baby so she could try to sleep. Her husband would say, “I have the baby. He’s safe. Go get some sleep.” That alone gave Melissa some time to herself and allowed her to recuperate. Mya stated that she felt the most supported when her husband would help out with the kids. She said she needed to be able to step away from time to time. When her husband would take the kids, she felt like she could have the break she needed. One participant, Mackenzie, even had a doctor “prescribe” that she left the house alone at least twice a week. She described that her husband would come home from work and take the kids, while she would get in the car and drive around the block. She said, “I would come back and it was like a breath of fresh air.”

**Do Better.** This theme represents that it was rare for women to feel supported by their healthcare providers. Each woman had a unique experience with their healthcare provider, but it was clear that many of the experiences were negative. Melissa explained that she wished there was a specific support group for women with postpartum anxiety and depression. She described how she was on hold for hours trying to get an appointment with her OB, only to be referred to the on-call therapist. She said the on-call therapist was trying to help, but they did not have the tools to assist with postpartum mood disorders. Melissa explained how frustrating it was to sit there being miserable and not having any way to change it. Maria also voiced that there needs to be more healthcare providers that are experts in postpartum disorders. The primary care doctor that she initially saw regarding her struggles with PPD only prescribed her 5 milligrams of an anti-anxiety medication. After finding a doctor that specialized in postpartum through the Mom's Mental Health Initiative, she was bumped up to 20 milligrams of the medication. The new doctor explained that the 5 milligrams was not doing anything to help her. After Maria was prescribed a higher dose, she started to feel better. She said this goes to show that doctors need to refer out if postpartum is not their expertise. However, she commented that there's "no niche" for postpartum and can understand why it would be difficult for providers to refer out. This explains why there is a need for healthcare providers that specialize in postpartum.

A few participants also indicated that there needs to be a better screening protocol for postpartum women. Miranda explained that doctors have no idea how to help new moms once the baby is born. She said the mom is all of a sudden forgotten about and none of the doctors ask, "hey, how are you?" Miranda explained how doctors just hand you a piece of paper and as long as you do not fill out the worst answers, you hear nothing more. Maria also commented on how easy it is to "get swept under the rug." Mya, who is a healthcare provider herself, explained that the survey they give new moms at a check-up is called the PHQ9. It is a general tool that is used to screen for depressive symptoms. She explained how this tool is designed for generalized depression and is not specific to postpartum depression. She also added that healthcare providers fail to screen for anxiety-related postpartum disorders.

When Madeline was asked if she wanted to share any final thoughts, she responded by saying, "I just hope, you know, that people start to realize that PPD is common and that it's nothing to be ashamed of. You're not weak because of it." She went on to explain that doctors need to talk about that more. She said, "they mention it in passing, but they don't continue the conversation." Mary, who was one of the only participants that had a positive experience with her doctor, explained how beneficial it was to have her doctor talk to her about PPD. Her OB told her that she did not need to fear, but "your goal is to survive, not thrive. If you thrive, great, but survival is the goal. Hearing that over and over again made me not feel like a failure when I felt like I could barely survive." Mary explained that her OB was the only person that gave her a realistic expectation for what postpartum would look like, which was very comforting. However, most women do not receive this kind of support from their healthcare provider. In general, the themes for RQ2 revealed the ways in which women felt supported, while highlighting that healthcare providers must do better to advocate for women with PPD and give them a voice.

## DISCUSSION

The purpose of this study was to examine the cultural and interpersonal discourses that impact disclosure and social support for women with PPD. This section brings understanding to the participants and their stories and the ways in which cultural and interpersonal discourses have affected them. As stated in the previous section, the themes found in RQ1 and RQ2 revealed the motivations and impacts of disclosure, as well as the ways women received (or did not receive) social support. The following section will address these themes in further detail, including the cultural and interpersonal discourses that were interwoven within the participants' responses. This section will also discuss how these findings relate to previous research, in addition to the social support theory and relational dialectics theory.

*RQ1: How do cultural and interpersonal discourses influence how women choose to disclose their PPD to close others?*

The five overarching themes for RQ1 were: Safe Spaces, I Need You, I'm Not Myself, I'm Not a Psycho, and Can Good Things Come from Bad Situations?. These themes revealed who women chose to disclose to and their motivations for doing so. The results also indicated that there were positive outcomes from disclosure in many situations.

Women who were suffering from PPD tended to confide in individuals such as their spouse/partner, their mother or sister, their doctor, and/or a close friend. Prior research (Anderson, 2013; Dalton et al., 2021; Dennis & Chung-Lee, 2006; Everingham et al., Johnson et al., 2020) confirmed that these people would be sources of support for women with PPD. In all cases, the people that women chose to disclose to were people they trusted and felt safe with. Often, women would turn to people that have supported them in the past, which supports a component of RDT.

Proximal already-spoken links impact a decision to disclose information based upon past interactions with a certain individual (Baxter, 2010). Thus, women were highly motivated to confide in certain people because of their past interactions. For example, one woman explained how her mother was someone she trusted and went to with her problems in the past. As a result, her mother was the first person with whom she wanted to confide. Another interesting aspect of RDT that relates to disclosure was the fact that women felt more comfortable confiding in people that have experienced depression in the past. In situations when women have had previous conversations with someone else about their struggles with depression, they were more likely to confide in them given that they could understand their experience. Again, this is an example of a proximal already-spoken link (Baxter, 2010), given that a past interaction impacted their decision to disclose.

Many women indicated that they did not feel like themselves during the postpartum period. They would describe feelings of rage and uncontrollable thoughts, fears, and emotions. This made women motivated to disclose their feelings in an attempt to explain to those around them why they were acting a certain way. However, their feelings during this time also played into the belief that they were not being a good mom. As defined by Baxter (2010), a distal already-spoken link refers to cultural messages circulating in society. Society says that a good mother cannot feel rage or have uncontrollable thoughts (distal already-spoken link). Therefore, this distal already-spoken link hindered participants from admitting their true feelings because there was a sense of guilt and fear. Multiple women explained how they would never hurt their baby, but they can understand why someone would. One woman described how her feelings became so overwhelming that she needed a way out. She explained how she would never take her child out of this world, but for a long time she contemplated taking herself out. Society's idea of what a mother should and should not be contributed to the idea that their feelings were unacceptable and not "normal."

Another motivation for women to disclose their struggles came from the need to explain to others that they were not crazy or psycho. When women were asked if they were fearful or hesitant to disclose their struggles, only one of the 8 participants confirmed that they were. However, the fact that the word "crazy" and "psycho" came up again and again in the interviews indicated that larger cultural and interpersonal discourses were at play. The idea that people with mental health issues are crazy or psycho shows that there are stigmas regarding mental illness. Given that this message is circulating within society, it represents a distal already-spoken link. As a result, women felt hesitant to disclose their struggles because of cultural messages and a fear that they would be labeled crazy or psycho. Further, women felt motivated to disclose their struggles because they needed to explain their behavior to those around them. As Baxter (2010) explains, proximal not-yet-spoken links refer to the anticipated response from someone after a disclosure. As many participants indicated, they were anticipating that they would be labeled crazy or psycho by others if they did not explain what was going on (proximal not-yet-spoken). Thus, they were motivated to disclose their struggles to avoid these negative labels. This played a large role in what women felt was acceptable or unacceptable to disclose to others.

While women chose to confide in a variety of people, it was clear that the impact of disclosing their struggles to a spouse or partner was beneficial. Many women indicated that their struggle with PPD initially caused tension in the relationship with their spouse. For example, one woman described how she wanted help from her husband, but when he would offer it, she would push him away. This relates to Baxter and Montgomery's initial research, which found that interpersonal relationships need a blend of both autonomy and connection (1996). There are moments when one desires to feel loved and supported, but also times when one needs to feel independent and self-sufficient. This finding supports RDT and the idea that opposing desires can cause interpersonal tension. However, despite these initial hardships in the women's relationship with their spouse/partner, every participant commented that their relationship ultimately grew stronger. These findings support Cutrona (2012), which found that relational intimacy would grow as a result of disclosure.

*RQ2: How do cultural and interpersonal discourses influence how women with PPD receive (or do not receive) social support?*

The four overarching themes for RQ1 were: Take Me Seriously, Talk Me Through It, Give Me a Break, and Do Better. These themes revealed the ways in which women did or did not feel supported. The results indicated the types of support that were beneficial, while also highlighting that there is a disconnect between women with PPD and their healthcare providers.

Societal expectations were an interesting aspect that played into disclosure and social support. Almost all of the participants indicated that social media was the place where they learned what motherhood should look like. The participants revealed that social media presented unrealistic expectations that they felt they needed to attain. One participant noted that "no one talks about the shitty stuff" on social media. Everything that is presented about motherhood is positive – an instant bond with the baby, breastfeeding will be easy and beautiful, and that

motherhood will be fun and joyful (distal already-spoken). When these women began to struggle during the postpartum period, many of them felt guilty for not living up to societal expectations. As described by Stana & Miller (2019), these women felt pressured to fill their gendered role within society. One woman explained how she asked herself: how dare I be upset? She claimed that motherhood is supposed to be a beautiful thing and felt guilty that she hated being at home with her kids during maternity leave. These expectations of what motherhood is supposed to look like made it difficult for them to cope with their feelings and ask for support.

Many of the women explained how they were not sure if they should label their experiences as PPD. They expressed that they were not able to admit it was PPD until after their symptoms had improved. Multiple participants attributed their feelings to other situations in their life that were scary and anxiety-inducing. For example, many of the participants that were interviewed had their child during the COVID-19 pandemic. Isolation during this time caused depressive symptoms and the fear of their newborn contracting COVID-19 contributed to their anxiety. Additionally, some women described that their children had health scares. Whether their child spent time in the NICU or had troubles later on in their infancy, this added to the depression and anxiety that they were feeling. While all of these situations can certainly exacerbate symptoms of PPD, the fact that multiple women tried to attribute their feelings to outside factors indicates that there is a stigma surrounding PPD.

Every participant explained how having help with the child and chores around the house was a way they felt supported. When they had help with these tasks, they were given a much-needed break from the demands of being a mother. As Goldsmith and Albrecht (2011) explain, these acts of support are tangible. While it is good to know how to support a mother with PPD, the idea that women are primarily responsible for childcare and household chores is perpetuated by societal norms. As explained by Scharp and Thomas (2017), women are expected to bear the burden of motherhood, often while sacrificing their own well-being. It is interesting to note how these distal already-spoken messages that are circulating in society impact how women receive support. Most often, women with PPD benefit from tangible acts of support so that the responsibility of being a parent does not solely fall upon them.

The findings in this research support the fact that PPD is underrecognized and undertreated, which was initially established by Pearlstein et al. (2009). All but one participant explained how they had a poor experience with their healthcare provider. Women commented on the fact that the screening tools were targeted at individuals with general depression, not postpartum depression specifically. Mya, who explained that postpartum women receive the PHQ9 survey, said that there should be better screening tools given by healthcare providers. An example of a more inclusive screening tool would be the Edinburg Postnatal Depression Scale (EDPS). This tool screens for both depression and anxiety and is specific to postpartum women. In addition to a better screening tool, it is important that the healthcare provider properly acknowledges the responses. Multiple women felt that their concerns were “swept under the rug” unless they were to indicate they were suicidal. It is vital that doctors address each concern with empathy and understanding.

The reason it is so important that healthcare providers take these issues seriously is because they come from a place of power. In society, we seek out and respect the opinion of a doctor. As a result, the comments or actions of one doctor can have a huge impact on a woman with PPD, whether it is positive or negative. For example, a few participants indicated that they were told by multiple healthcare professionals that they needed to breastfeed for the health of their child. Since they were told by doctors that they should breastfeed, they strived to attain that goal. However, complications with breastfeeding and the mental toll that it takes prevented many women from being able to breastfeed. Consequently, they felt like they were a failure as a mother. This insecurity in their ability as a mother stemmed from the fact that a doctor told them they should breastfeed. A few mothers advocated that doctors should adopt the term, “fed is best,” rather than “breast is best.” A mother should be reassured that their efforts to feed their child are appropriate, no matter how it is achieved.

The authority that a doctor has also plays a role in the support of women with PPD. One participant explained how her doctor gave her a “prescription” to leave the house alone at least twice a week. Given that she had an order from her doctor to do this, she was more willing to accept that advice. Additionally, her husband saw it as something she needed to do for her health, so he stepped up and watched the kids while she would leave the house. Another participant explained how her parents' whole view changed when she told them that her doctor recommended medication for her PPD. She described that their reaction would have been a lot different if she simply said, “I think I need to be on medication.” Finally, many participants expressed how doctors need to give women with PPD better access to support services. They also explained how there should be doctors, therapists, and support groups that are specifically devoted to treating women with postpartum mood disorders. Although many women recognized that these services are not available, they said that doctors and other healthcare providers need to advocate for change. Again, healthcare providers have power and authority. With their support, it is possible that care and treatment specific to women with PPD could be achieved.

## LIMITATIONS AND FUTURE RESEARCH

One area of limitation for this research was the number and demographics of the participants. The researcher hoped to recruit more participants for the study, but time constraints and the difficulty of finding people willing to talk about such a sensitive topic prevented this. Additionally, a more diverse demographic from which to draw participants from would have been beneficial. External factors such as race, socioeconomic status, occupation, marital status, and access to healthcare all impact the experience a woman may have and lead to additional findings.

The research revealed why women were motivated to disclose their struggles with PPD and the ways in which they felt (or did not feel) supported. Future research could focus on the impact of PPD on the woman's immediate family, as many women acknowledged that their family was affected by their struggles. Additionally, the participants expressed that their healthcare providers did not do enough to recognize and treat PPD. As a result, future research could look at how healthcare providers can better facilitate conversations surrounding PPD. A critical study regarding the implications of rhetoric, narrative and women/gender would also be helpful in understanding this topic further.

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## APPENDIX

### *Interview Protocol*

1. When did you first find out you were pregnant?
2. How did you feel during your pregnancy?
3. What were the expectations you held for that pregnancy?
4. What were the expectations you held for the post-birth experience?
5. Where do you think you learned those expectations?
6. Explain how well-equipped you felt to be a mother.
7. Looking back, when did you first start feeling symptoms of PPD?
8. What were some of the first signs you noticed that indicated you were suffering from PPD?
  - i. How did that make you feel?
9. When you first acknowledged you were suffering from PPD, who were the individuals that you wanted to confide in?
  - i. Why did you choose those individuals?
10. What, if any, hesitations did you have prior to disclosing your struggles with PPD? If you did, what were they?
11. What, if any, outside factors made you fearful of judgment when disclosing your struggles with PPD?
12. What was the main reason you decided to disclose your struggles with PPD?
13. Why, if at all, did you feel like it was important to disclose your struggles with PPD to others that are close to you?
  - i. How did they react?
14. If it was challenging to disclose that information, can you elaborate on why that was so difficult?
15. How would you describe the relationship between you and \_\_\_ after you disclosed your struggle with PPD?
16. Did you find that disclosure to others was beneficial? If so, why? If not, why?
17. Did you feel like others were supportive after you disclosed your struggles with PPD? Why or why not?
18. Were there people in your life that you didn't feel comfortable disclosing too?
  - i. If yes, what were some of the reasons for this reluctance?
19. Is there anything else you would like to add to this discussion?

20. Is there anyone else you can think of that may be interested in participating in this study?