Constructions of Motherhood and Fatherhood in Newspaper Articles on Maternal and Paternal Postpartum Depression

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Abstract

Postpartum depression (PPD) is a medicalized condition that exists on a continuum of postpartum mood disorders. PPD is reported to be experienced by 10-15% of mothers and 10% of fathers during pregnancy or after the birth of a baby. PPD, as experienced by either parent, is considered a serious condition because of its potential short- and long-term negative impacts on the developing child.

In this thesis I explore how motherhood and fatherhood are constructed in the context of articles on maternal and paternal PPD in Canadian and American newspapers. Specifically, I focus on how references to the opposite partner were used to position each parent, and how each parent was positioned with respect to the new baby.

In the articles on maternal PPD, husbands were either inconsequential to the story, positioned as being absent, or constructed as supporting the mother through instrumental and action-oriented behaviours. In addition, mothers were constructed as lonely and isolated because of self-imposed limitations (e.g., feeling ashamed for not being happy).

In the articles on paternal PPD, the mother-father relationship was based on differences and competition. Fathers were constructed as isolated, lonely and misunderstood, most often through mother-blaming, such as by positioning the mother as responsible for the father's well-being (e.g., causing his PPD), and by labelling PPD "a woman's domain." Fathers' loneliness was presented as being due to imposed limitations of others (e.g., others did not properly prepare fathers for fatherhood).

Mothering was constructed as being instinctually skilled, tolerant, and self-sacrificing, with the inherent capability to manage multiple roles and changes. The mother-baby relationship was constructed as naturally joyful, all-important and –consuming. Fathers were not expected to be as skilled or instinctively prepared and tolerant, to engage in chores/childcare, or to be explicitly overjoyed with the baby. Mothers were blamed for their distress in the role, while others were blamed for fathers' distresses.

Gendered stereotypes in the parenting role were perpetuated in these newspaper articles. Parenthood was not constructed as a collaboration, but rather motherhood and fatherhood stood in isolation from each other, with motherhood positioned as the primary role. These constructions continue to maintain fathers in the background of parenthood as an "other," and to position mothers as responsible for the well-being of her partner, child(ren) and herself.

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Dedication

To the future.

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List of Abbreviations

CDA	Critical Discourse Analysis
MPPD	Maternal postpartum depression
PPD	Postpartum depression
PPPD	Paternal postpartum depression
PPP	Postpartum psychosis

1. Introduction

Fatherhood and motherhood are powerful ideologies that are intimately woven into all cultures[1]. In addition, ideologies, expectations, and assumptions are often evident (either overtly or covertly) when talking about illnesses, diseases, or abnormalities. Postpartum depression (PPD) is such a malady, sometimes called a "disorder of motherhood" (Roan, 2010) or "a thief that steals motherhood" (Beck, 2008, p. 121). However, fathers are also said to experience PPD. Therefore, assumptions and expectations about motherhood and fatherhood can be ascertained by analyzing presentations of PPD in various public spheres (e.g., literature, media, and the Internet).

PPD is conceptualized as occurring on a continuum of postpartum mood disorders, ranging from the least severe form of the baby/maternal "blues" (henceforth referred to as the blues) to the most severe form, called postpartum psychosis (PPP). The extremes for the prevalence of a diagnosis of maternal PPD (MPPD) in North America are 4% to 20% (e.g., CMHA, 2012; Suda, Sega-Nishida, Newton, & Duman, 2008; Whiffen, 1992), and up to 50% for paternal PPD (PPPD; Ballard & Davies, 1996; Bradley & Slade, 2011; Goodman, 2004; Melrose, 2010; In case, 2010). The most common statistic reported for MPPD is approximately 10-15% (e.g., American Psychological Association, 2007; Bina, 2008; CPA, 2009; Posmontier & Horowitz, 2004; Rychnovksy & Beck, 2006) and 10% for PPPD (e.g., Paulson & Bazemore, 2010). The following is a compiled list of symptoms from a number of sources (e.g., APA, 2000; Knudson-Martin & Silverstein, 2009; Letourneau et al., 2010; Nicolson, 1990; Roehrich, 2008; Suda et al., 2008; Whiffen, 1992) that fathers and mothers may experience after childbirth: mood swings, guilt, shame, suicidal ideation, energy loss, loss of interest, agitation, motor retardation, anxiety, irritability, and/or insomnia.

Up to 80% of mothers who have recently given birth will experience the blues within a week postpartum, which is defined as a tearful, emotional disturbance and instability that subsides within hours (e.g., Clay & Seehusen, 2004; Heron, Craddock & Jones, 2005; Riecher-Rossler & Fallahpour, 2003; Sharma, 2005) or 10-14 days postpartum (APA, 2000; CMHA, 2012.; Chalmers & Kimak, 2009; Riecher-Rossler & Fallahpour, 2003). Intervention for the blues is often restricted to no treatment (Sharma, 2005), or additional education and/or time

[1] For the purposes of this thesis, when speaking about Canadian and American culture, I am referring to a culture that promotes maternal competence and happiness, and is individualizing when it comes to disease, symptoms and treatment.

(Riecher-Rossler & Fallahpour, 2003). The blues is assumed to be an adjustment period to the sudden change in hormones after giving birth (Godderis, 2010; Riecher-Rossler & Fallahpour, 2003; Whiffen, 1992). However, although the blues is very common and is considered an adjustment to normal biological changes, its association with other, more serious forms of mental illness (e.g., PPD and PPP) results in it being constructed as abnormal functioning (Godderis, 2010).

PPP follows severe depression and is defined by delusions and sometimes hallucinations that usually revolve around the baby (Clay & Seehusen, 2004). PPP occurs in approximately 0.002%-0.2% of mothers within the first year postpartum (Clay & Seehusen, 2004; Heron et al., 2005; Riecher-Rossler & Fallahpour, 2003), and is associated with a risk of suicide and infanticide (Riecher-Rossler & Fallahpour, 2003). The rate of infanticide due to PPP has been estimated at 4% (Clay & Seehusen, 2004). This extreme and rare end of the postpartum mood disorders spectrum is believed to be caused by manic episodes experienced by women who have bipolar disorder (either diagnosed or not; Clay & Seehusen, 2004; Heron, et al., 2005; Sharma, 2005). Treatment for PPP often includes hospitalization and mood stabilizers (Clay & Seehusen, 2004; Heron et al., 2005; Sharma, 2005). I will not focus on either PPP or the blues because (1) the blues are very common and usually remit spontaneously, and (2) PPP is very rare and sometimes has extreme consequences, and often requires intense treatment.

PPD is considered a serious condition (agreed to by 90% of American physicians, Seehusen, Baldwin, Runkle, & Clark, 2005; Riecher-Fossler & Fallahpour, 2003), primarily because of the negative and long-lasting impacts that can occur in the family, but especially for the developing child(ren). The negative impacts on a developing child, such as social and emotional adjustment difficulties (Melrose, 2010; Ramchandani, Stein, O'Connor, Heron, Murray, & Evans, 2008), are worse when both parents are diagnosed as having PPD (Hanington, Ramchandani, & Stein, 2009; Letourneau, Duffet-Leger, Dennis, Stewart & Tryphonopoulos, 2011; Melrose, 2010). Ballard and Davies (1996) suggested that children may develop impaired self-concepts, be more self-critical, and have difficulty with peer relations when both parents experience PPD. When PPD is experienced by both partners, the parents are twice as likely to perceive health problems in their baby and children (Melrose, 2010). As well, parents experiencing PPD are less likely to read to their child(ren), which can impact expressive language development (Paulson, Keefe, & Leiferman, 2009). However, if one parent is not

suffering from PPD, that parent may be able to compensate for the impacts that the PPD of the other parent might have on a child (Melrose, 2010), although this finding is not consistently supported (Goodman, 2004, 2008). PPPD "seems specifically related to behavioral and peer relationship difficulties, whereas MPPD appears to be associated with a broader spectrum of child disturbance" (Ramchandani et al., 2008, p. 369). Boys seem to be particularly affected by both PPPD (Hanington et al., 2009; Melrose, 2010; Ramchandani, Stein, Evans, O'Connor & ALSPAC, 2005) and MPPD (Ramchandani et al., 2005).

An impaired mother-child bond is presumed to be the cause for developmental delays and difficulties that result from MPPD (Held & Rutherford, 2012; Riecher-Rossler & Fallahpour, 2003). So-called deficient mother-baby interactions may impede normal cognitive, language, emotional and/or behavioural development in these children (Beck, 1995; Bishop, & Skuse, 1995; Canuso, 2008; Clay & Seehusen, 2004; CPA, 2009; Riecher-Rossler & Fallahpour, 2003; Stein, Malmberg, Sylva, Barnes, Leach, & the FCCC team, 2008). MPPD has also been shown to have a negative impact on child development between 3-5 years of age, but the effects are more broad than those attributed to PPPD (e.g., across all domains of emotional and behavioural functioning, such as depression, anxiety, and conduct problems; Ramchandani et al., 2005). Behavioural problems are also present in the pre-teen years (Agnafors, Sydsjo, Dekeyser, & Svedin, 2013); however, this effect does not seem to be caused by MPPD, but rather by prolonged and recurring maternal depression after the postpartum period (Agnafors et al., 2013).

A major controversy in the treatment literature for MPPD is whether antidepressants are safe for mothers to take. Many mothers fear their infant will be affected by the drugs through breastfeeding (Boath, Bradley, & Henshaw, 2004; Bonari, Koren, Einarson, Jasper, Taddio, & Einarson, 2005). This position does not seem to be entirely unwarranted. Di Scalea and Wisner (2009) argued that caution must be taken because empirical long-term studies on the question of whether antidepressant medications leak into breast milk are lacking. In addition, they stated that the amount of antidepressants found in breast milk, and the effects of these antidepressants on babies, vary by the type of antidepressant (Gentile, 2005). However, Gentile (2005) suggested that this area has not been adequately studied and so it is unknown at what concentration medications would start to affect a young brain. Of concern, too, is whether the infant will experience withdrawal if s/he is exposed to antidepressants in the breast milk (Gentile). Gentile indicated that withdrawal has been shown to occur in children whose mothers

were taking antidepressants (e.g., tricyclics) while pregnant, but this relation has not been researched with respect to breast milk exposure. As of 2004, The Food and Drug Administration (FDA) had not approved any psychotropic or antidepressant medications for use during pregnancy or breastfeeding (Clay & Seehusen, 2004). Nevertheless, Clay and Seehusen (2004), Di Scalea and Wisner, and Gentile suggested that physicians and mothers need to weigh the potential costs of exposing a child to untreated MPPD. If the physician and mother deem that a pharmacological treatment is preferable, then the mother could stop breastfeeding; but doing so has been associated with PPD (e.g., Ugarizza, 2002), albeit inconsistently (Dennis, 2004b). As well, it is important to remember that pharmacological treatments are not the only ones available to mothers and their families.

When a father has PPD, independent of whether the mother has PPD, infants are twice as likely to cry excessively at 2 months (Melrose, 2010), twice as likely to have behavioural and emotional concerns at 3-5 years old (Melrose, 2010; Ramchandani et al., 2005), and more likely to be diagnosed with Oppositional Defiant Disorder or Conduct Disorder at 7 years of age (Melrose, 2010; Ramchandani et al., 2005; Ramchandani et al., 2008). These negative effects are worse if a father experienced depression both in the prenatal and postpartum periods, although there are no apparent ill-effects if a father was depressed only during his partner's pregnancy (Ramchandani et al., 2008). According to Ramchandani et al. (2008) "It may be that effects previously attributed solely to maternal [postpartum] depression are, in fact, partly accounted for by paternal effects or factors related to both partners" (p. 396).

Some researchers have concluded that professionals should screen both parents, such as with self-report scales like the Gotland Male Depression Scale (GMDS; Madsen, 2009), and the Edinburgh Postpartum Depression Scale (EPDS; Bielawska-Batorowicz & Kossakowska-Petrycka, 2006; Lai, Tang, Lee, Yip & Chung, 2010; Madsen, 2009; Zelkowitz & Milet, 1997), especially if the mother is experiencing PPD (In Case, 2010; Thomas, 2010). Other suggestions for intervention and/or prevention include having professionals teach both parents about PPD and where to look for resources (Garfield & Isacco, 2009; Thomas, 2010), and to focus on the family unit (Ramchandani et al., 2008; Zelkowitz & Milet, 1997). Researchers also suggest that organizations should have groups that can accommodate the fathers' and mothers' schedules so that both can be included (e.g., in prenatal classes; Chin, Hall & Daiches, 2011), and more men should be hired as service providers (Chin et al., 2011).

For fathers specifically, Chin et al. (2011) suggested that more prenatal discussion with professionals needs to occur to prepare fathers for the changes (both positive and negative) that will occur after the birth of a baby, such as changes in the romantic relationship, the lack of time that will come from having a baby (e.g., for himself, or time with the partner; Bradley, MacKenzie & Boath, 2004), and that "life as you know it will cease to exist" (Bradley et al., 2004, p. 46). According to the participants of Letourneau et al.'s (2010) study, male partners reported "anger, frustration and even rage, often in response to their lack of preparation for the possibility of PPD in their lives" (p. 44). Fathers tended to minimize symptoms of MPPD as being a result of becoming a new mother, and often did not realize that anything was wrong until the partner returned to her "old self," thinking that the sensationalized infanticide cases in the media were representative of PPD (Letourneau et al.). In a study on fathers' retrospective descriptions of their partner's PPD, 31% remembered her being "happy and joyful" (Garfield & Isacco, 2009, p. 295).

For ease of discussion, maternal and paternal PPD will be reviewed separately, with a focus on stereotypes, expectations and roles.

1.1 Maternal Postpartum Depression (MPPD)

The onset of MPPD is defined as within 2 to 4 weeks of giving birth, according to standard diagnostic criteria in the DSM-IV-TR (APA, 2000), although the Canadian Psychological Association (CPA, 2009) and the American Psychological Association (2007) PPD fact sheets state that it can begin during pregnancy. Zelkowitz and Milet's (1997) sample of women with PPD illustrated that 74% had an onset in the postpartum period, but 14% had an onset during pregnancy (40% according to Whiffen, 2004), and 12% were experiencing depression before becoming pregnant. Generally, the duration is from six months to a year, although some say it can last longer (Whiffen, 1992). Depressive symptoms are almost twice as prevalent during the postpartum period compared to other times in a woman's life (Whiffen, 1992); however this relation could, at least in part, be an artefact of age since, in Western societies, the median age for a primaparous mother is 26 years, and the average age of onset for a woman's first depressive episode is age 28 (Whiffen, 2004).

Not all researchers accept the general criteria, however, as stated above. For example, Ugarizza (2002) attempted to define PPD from women's perspectives, and compared what they had to say to what the DSM-IV-TR (APA, 2000) lists as criteria for major depression. The

DSM-IV-TR criteria for PPD are that a major depressive episode occurs within 4 weeks of having given birth, and that the symptoms of PPD persist for at least 2 weeks and decrease in frequency and severity over time. For the mothers who participated in Ugarizza's study, in contrast to the DSM-IV-TR, their symptoms did not progress in a linear downward trend, their sleep was not disordered but deprived, their guilt was specific to harming their babies (which seems to be unique to PPD), they did not want to die, and they did not lose interest in previously pleasurable activities, but yearned for these activities and felt that engaging in them would have been helpful. When taken out of the context of a manual, there is inconsistency and debate in the so-called fundamental criteria for diagnosing PPD.

1.1.1 Causal theories. The MPPD-related academic literature on the causes of PPD revolves around three main schools of thought: biological, sociological/stress and coping, and feminist models (Abrams & Curran, 2007; Barnes, 2006; Martinez, Johnston-Robledo, Ulsh, & Chrisler, 2000). Each of these varies in terms of individualization (e.g., conceptualizations based on individual flaws) and contextualization (e.g., the degree to which broader influences are considered, Dubriwny, 2010). The biological view posits that PPD is caused by sudden changes in immediate, chemical factors that occur within a few days of having given birth (Martinez et al., 2000; Nicolson, 1990; Sudo et al., 2008; Whiffen, 1992). As well, the biological view is implicit in the findings that women have an increased risk of developing PPD if they have a psychiatric history, if psychiatric illness runs in the family, if they were depressed while pregnant, and if they have had more than one child (Escriba-Aguir, & Artazcoz, 2011; Nicolson, 1990; Whiffen, 1992). The treatment of choice for this model is pharmacological (Barnes, 2006). The sociological/stress and coping model posits that PPD can be caused by social stressors in the mother's life, such as marital tension, care of a newborn, infant temperament (Whiffen, 1992), low levels of support (Smith & Howard, 2008; Whiffen, 1992), the shock of the sudden role-change, socioeconomic status (Bishop & Skuse, 1995; Canuso, 2008; Stein et al., 2008), and a feeling of disconnection from social relationships (Mauthner, 2003). The feminist model challenges the concept that the feelings mothers experience after having a child, which become part of the diagnosis of PPD, are abnormal. This model highlights cultural and societal pressures (e.g., to look as good as celebrities do after giving birth, Daniel, 2006) in addition to the experience of a loss of autonomy (Daniel, 2006) and other perceived losses (Nicolson, 2003), and the pressure to be happy because of the new baby (Daniel, 2006; Nicolson, 1990;

Symon, 1999). "PPD" occurs as women navigate the conflicts between what they are experiencing and the personal, societal and cultural expectations that they feel obligated to meet (Barnes, 2006; Biehle & Mickelson, 2010).

1.1.1.1 Biological perspective. There is a very large literature on this model of MPPD. When people think about biological changes and PPD, the common belief is that the depression is caused by sudden changes in the concentrations of ovarian hormones (estrogen and progesterone) following childbirth (Martinez et al., 2000; Nicolson, 1990; Sudo et al., 2008; Whiffen, 1992). During pregnancy, estradiol (a type of estrogen) and progesterone levels can rise significantly. Then, after 3 days postpartum, these hormones drop to normal levels (Zonana & Gorman, 2005). Results, however, seem to be unsupportive of the notion that these quick hormonal changes impact PPD (as reviewed by Zonana & Gorman, 2005). In fact, research has been moving away from a focus on these two hormones, and instead is considering either how these hormones affect other biological processes in the body (e.g., stress-hormone levels, Suda et al., 2008), or other processes and/or chemicals all together (e.g., allopregnanlone, Zonana & Gorman; cortical-releasing-hormone, Rich-Edwards et al., 2008; and oxytocin, Consiglio, 2006).

Biological interventions are the treatments that result from a biological model of MPPD. Dennis (2004a) made the following conclusions in her review of biological interventions: nortriptyline (a tricyclic antidepressant) is no better than a placebo at preventing PPD and relapse; more research is needed on estrogen and progesterone therapy (although research suggests that long-acting synthetic progesterone increases depressive symptoms); thyroxine (a thyroid hormone) does not impact PPD (in women who are positive for thyroid dysfunction); and omega-3 fatty acid supplements do not influence depressive symptom expression, but oral calcium supplements do have some support in significantly reducing the prevalence of PPD at 12 weeks postpartum. On the basis of her review, Dennis did not recommend any biological intervention over another.

The literature on the biological model of MPPD is far larger than the literature that covers the other two models, which illustrates its prevalence and status in research and public discourses. At this point, and based on the research reviewed so far, no specific biological and/or chemical factors strongly predict the development of MPPD (e.g., Rich-Edwards et al., 2008; Zonana & Gorman, 2005). The findings that fatigue and perceived level of stress (Corwin,

Brownstead, Barton, Heckard, & Morin, 2005) are the best predictors of MPPD supports the idea that biology is not the only factor involved, despite the dominance of biological discourses.

The biological model is inherently individualized and decontextualized (i.e., it focuses on symptoms experienced by an individual that are presumed to be caused by one's physiology). The context of a woman's life is typically lacking in a biological conceptualization. As Dubriwny (2010) stated, "Once postpartum distress is taken out of its social context of motherhood, it becomes the medical problem of *individual* women" (p. 292). This way of conceptualizing MPPD can minimize a mother's distress, put more pressure on her to not be distressed, encourage her to think that there is something wrong with her as a person, and put almost all of the responsibility to deal with the distress (including to be the one to know when and where to seek treatment) on her. Arribas-Ayllon and Walkerdine (2008) suggested that the medicalization of behaviour is a social "strategy of control" (p. 95). As suggested by Held and Rutherford (2012), "When the most important job in the world becomes one of the most distressing, perhaps we need to look seriously, not only at mother, but at the job itself" (p. 119).

1.1.1.2 Sociological/stress and coping perspective. A driving force behind this perspective is that women who have been diagnosed with depression, including PPD, focus more on the social factors in their lives when they are asked to talk about their experiences (see Stoppard & McMullen, 2003). In Ugarizza's (2002) study, none of the participants believed that biology was the sole culprit of their distress, although a few did attribute some degree of responsibility to hormonal factors. More often, these women felt that a lack of preparedness for motherhood (Choi, Henshaw, Baker, & Tree, 2005; Homewood, Tweed, Cree, & Crossley, 2009; Zelkowitz & Milet, 1997), lack of support (also in Zelkowitz & Milet, 1997), fatigue and difficulties in breastfeeding (also in Haga, Lynne, Slinning, & Kraft, 2012) and delivery were the major contributors to their PPD. Other possible contributing factors could be high levels of stress (including work and financial; Zelkowitz & Milet, 1997), low self-esteem and loneliness, as well as feelings of incompetence, loss of self, an inability to cope (Letourneau et al., 2010), and isolation (Knudson-Martin & Silverstein, 2009).

The explanatory model developed from the interviews conducted in Ugarriza's (2002) study was that PPD is caused by social changes (e.g., role-changes), difficulties giving birth (e.g., unplanned caesarean section), "failure" to breastfeed in a society that values and promotes breastfeeding, hormones (to a small degree), or a combination of any of these factors. Aside

from unhappiness, marital discord became a major problem after the onset of PPD. According to these women, the discord stemmed from the feeling that their husbands did not understand, that their husbands did not or were not able to help with childcare, or that their husband's life continued on as normal whereas the mother's had changed significantly. These women felt that being educated about PPD, as well as obtaining help to care for the baby and having opportunities to get out of the mother role and do something they enjoyed, would have been helpful. Mothers who had had their first child believed that they would be better able to cope with a second child because of their initial experiences. In contrast, some of the mothers who had more than one child were surprised and disheartened when PPD was not lessened after subsequent births. This finding is consistent with the results of Zelkowitz and Milet's (1997) study, in which 48% of the women who were experiencing PPD had delivered their first child, 40% their second child, and 12% their third.

Becoming pregnant and birthing a child create a number of changes in a woman's and the family's life, and it is these changes that the sociological/stress and coping viewpoint proposes as the most important factors in the development of PPD. The accumulation and/or perception of stressors in the postpartum period create a burden that is difficult for a new mother to cope with (e.g., Whiffen, 2004). Postpartum social supports (e.g., friends, family, financial) have been heralded as some of the most important preventative and ameliorating factors for PPD (Bina, 2008; Haga et al., 2012; Negron, Martin, Almog, Balbierz, & Howell, 2013; Posmontier & Horowitz, 2004), especially instrumental (e.g., being helped with practical tasks, such as housework, Garfield & Isacco, 2005; Negron et al., 2013) and emotional supports (Knudson-Martin & Silverstein, 2009). Much of this research comes from cross-cultural studies, where lower incidences of PPD are attributed, at least in part, to supportive postpartum cultural rituals (Bina, 2008; Posmontier & Horowitz, 2004).

Posmontier and Horowitz (2004) reviewed the difference in birthing and postpartum rituals between technocentric (i.e., where "technology is valued over social support networks," p. 35) and ethnokinship (i.e., where "social support rituals by family networks are the primary focus of the immediate and later postpartum periods," p. 35) cultures. Many "rituals" of technocentric cultures are not very supportive of new mothers and families. For example, while many places of employment do offer maternal and/or paternal leave, not all offer paid leaves. In a 2006 census in Canada, the percentage of women who received paid maternal leaves ranged by

province and territory from approximately 36% (Nunavut) to 83% (Prince Edward Island; Dzakpasu & Pelletier, 2009). A benefit of parental leaves is that they do provide the opportunity for both parents to take on the chores related to having a new baby; however, the financial burden might, nevertheless, work against this support.

In contrast, in many ethnokinship cultures (e.g., China, Japan and Korea) there is a mandatory recovery period for new mothers, about a month or two long (e.g., Posmontier & Horowitz, 2004). Often, during this period, there is a lot of support from immediate and extended (female) family members. Also during this period, the mother is socially secluded from non-family members to encourage recovery and to decrease stress. The benefits of such a recovery period can be seen even within a technocentric culture, as evidenced by a reduced rate of PPD amongst an Amish group in Tennessee (Posmontier & Horowitz, 2004). This group allows for a period of rest for a new mother, and the mothers can draw on many social supports. One way that mothers are supported is by being supplied with foods that are believed to be healing. Just as the new infant is taken care of, so is the mother. Bina's (2008) review of cross-cultural factors and MPPD identified this recuperation period as an alleviating factor for PPD, as long as the mother received support from family members she liked and wanted support from (e.g., her own parents rather than her mother-in-law). Closely related to social supports is the finding that increased religiosity is associated with decreased PPD (Bina; St. Pierre, 2007), presumably due to increased community cohesiveness and social support for new mothers within religious communities (Bina).

With respect to nonbiological interventions for PPD, Dennis (2004b) stated the following: interpersonal therapy is initially effective at preventing PPD, but these effects disappear at 24 weeks postpartum; results for the effectiveness of cognitive-behavioural therapy are mixed; psychological debriefing (e.g., where a midwife or other health-care professional talks to the mother about what will happen after the baby is born) either increases depressive symptoms or does not have any impact on the prevention of PPD; antenatal and postnatal classes also appear to have no significant, generalized impact on the development of PPD, although Dennis cited some research that suggested an antenatal/postnatal group may be helpful for primiparous, but not multiparous women; research suggested that intrapartum support (e.g., hiring a doula) is helpful in the first few months postpartum, but not in the long-term, although these results were also mixed; and supportive interactions (e.g., home nursing care for the child)

appeared to prevent PPD at a 6-week postpartum assessment, but these positive impacts were not maintained at 16- and 24-week follow-ups. Dennis reviewed other interventions (e.g., midwifery teams and educational strategies) and found the results to be mixed or ineffective. Interventions that showed positive results were flexible postpartum care, where postpartum care is tailored to the individual mother's needs and wants, and relaxation with guided imagery; however, Dennis stated that more research on these strategies is needed before she would recommend them for clinical practice.

Support, therapy and education are commonly emphasized modes of treatment. With respect to therapy, interpersonal and cognitive-behavioural therapies are the most cited treatments for MPPD (e.g., Clay & Seehusen, 2004; CPA, 2009; Dennis, 2004b). Support groups are also said to be helpful (e.g., Riecher-Rossler & Fallahpour, 2003; Ugarriza, 2002), although there is little empirical evidence to support this claim (CPA, 2009). Yet, in Grube's (2005) study, women who had partners who were rated as "supportive" spent less time in the hospital and recovered more quickly from their illnesses. Support is only helpful, however, if it is is appropriate to a mother's needs and wants (Knudson-Martin & Silverstein, 2009; Posmontier & Horowitz, 2004). For some women, receiving help and support (e.g., with childcare) is viewed as an implicit message of her failure as a mother (Knudson-Martin & Silverstein, 2009), and others believe that they should not have to ask for help from others (Negron et al., 2013). Women's individual expectations and needs are very important considerations when treating women with PPD (Haga et al., 2012). For the women in Ugarriza's (2002) study, although they felt that group support would have helped ameliorate their depressive symptoms, many also felt that it would have been unrealistic to participate in such groups because their schedules were overburdened as it was.

Barnes (2006) and Whiffen (2004) suggested using an attachment theory framework when therapists are working with women who experience depressive symptoms in their postpartum periods, or childbearing depression (CBD, as Whiffen preferred to call it. Attachment theory, originally developed by John Bowlby and further developed by Mary Ainsworth, categorizes a baby's relationship style with important persons (usually its mother) based on how secure and safe the mother has made the baby feel over time and in a variety of threatening situations (e.g., being with strangers or being sick, Weiten & McCann, 2007). There are traditionally three attachment styles: secure, where a child feels safe and comforted when

with its primary caregiver; anxious, where a child is nervous when with a caregiver and is not easily calmed by him/her; and avoidant, where the child seems ambivalent to the presence or absence of the caregiver (Weiten & McCann, 2007). These early attachment styles are said to influence a child's future relationships as she/he ages, especially in close and/or romantic relationships (Wiffen). Whiffen stated that "pregnancy makes a woman especially vulnerable to relationship distress because the baby is a tangible manifestation of her commitment to her partner, and she will be sensitive to any indication that this commitment is not shared" (p. 157). Similarly, Barnes described MPPD as "a reaction to unmet needs" (p. 28). Attachment needs (e.g., to be reassured and loved) are particularly prominent during transitions, such as bringing a baby into the family. Support for the theory that PPD is caused by unmet needs in the romantic dyad comes from studies that have shown a relationship between PPD and attachment insecurity, and between PPD and marital dissatisfaction (reviewed by Barnes). Further studies have shown that women with insecure styles in the romantic relationship displayed more difficulty recovering from negative emotions (Behringer, Reiner, & Spangler, 2011). Whiffen emphasized that what has gone wrong in the postpartum period is not something with the mother, but something with the family system (namely the romantic pair of mother and partner). By teasing out what she wants and needs from her partner, whether she is or is not getting that, and how she reacts when she does or does not get what she wants or needs, the mother can come to understand how both she and her partner have contributed to the distress they have been experiencing during the transition of becoming a family rather than an exclusive dyad (Whiffen). This framework also lends itself to and encourages couples' therapy.

The sociological/stress and coping model focuses on a mother's ability (or, more accurately, the lack thereof) to cope with the myriad changes and stresses that occur after a child is born and brought home (e.g., birthing difficulties, financial stress, marital discord, fatigue, and unpreparedness). Personal flaws are also emphasized, such has experiencing low self-esteem and a "failure" to breastfeed, and it is these feelings and beliefs that are targeted with individual therapy. A generic lack of support and loneliness are also cited as prominent contributors to MPPD, which is the impetus for the supportive treatments (primarily groups of other mothers experiencing PPD). The sociological/stress and coping perspective is contextualized, especially in comparison to the biological perspective, but it is still individualized. It might target

treatments to individual needs (e.g., support and relationship needs), but it also maintains focus and blame on the individual.

1.1.1.3 Feminist perspective. When researching MPPD, feminist researchers often produce themes similar to those researchers who follow a stress and coping model, except that instead of pathologizing women's concerns about feeling overwhelmed, out of control, or having difficulty adjusting to her new role, feminist theorists understand these reactions as a normal, acceptable part of giving birth. Nicholson (1990) interviewed 24 women four times – once while pregnant, and at 1, 3, and 6 months postpartum. The interviews were intended to gather data on postnatal experiences, including depression. Nicholson (1990, 1999) found the themes of physical adjustment (e.g., giving birth and failure to breastfeed), initial insecurities (e.g., "lack of confidence in dealing with new tasks, the shock of role change, fear about not loving the baby," p. 693), inability to cope with contradictory health advice, support networks (e.g., support and advice not necessarily preventing PPD, but sometimes causing more stress) and loss of former identity (e.g., body image, sexuality, personal space and time, professional identity) to be prominent in these women's interviews. Nicholson (1990, 1999) emphasized that these concerns are normal reactions to the life-changing experience of motherhood. She did not agree that PPD is a "common but 'abnormal'" (1990, p. 690) response to myriad stressors that a new mother experiences. Instead, she understood PPD as "dependent on the respondent's *interpretation* and their cognitive and emotional reactions, rather than on an *accumulation* of stressors" (1990, pp. 692). How one interprets events is intimately influenced by the historical and current cultural context within which one lives (Burr, 1995; Fairclough, 1995/2010; Willig, 2001). Rather than PPD being medicalized and constructed as something is *wrong* with a mother, Nicolson (1990, 1999) argued that it should be viewed as a normal reaction to grieving the loss of the stability and familiarity of a mother's "old life," and indicative of the transition and growth into a new one. Women's experiences need to be validated, not just normalized (Knudson-Martin & Silverstein, 2009).

To illustrate, in technocentric cultures, new mothers are required to return to more-or-less normal routines soon after the addition of a new baby, and many mothers do not have the opportunity for familial support (e.g., because of finances and/or geographic location, Posmontier & Horowitz, 2004). In 2006 in Canada, an average of 11.6% of women returned to work at 6 months postpartum (Dzakpasu & Pelletier, 2009). The necessity to suddenly balance

the old way of life with a new one is likely to cause some upheaval and stress.

A significant concern for feminist theorists is the societal expectations with respect to new motherhood (e.g., Barnes, 2006; Knudson-Martin & Silverstein, 2009; Nicolson, 1990; Whiffen, 2004). According to the feminist perspective of MPPD, a mother's distress in the postpartum period comes from a conflict between her expectations of what it takes to be a good mother (which are influenced by her society and culture, Burr 1995; Fairclough, 1995/2010; Willig, 2001) and the reality of her situation (Abrams & Curran, 2007; Barnes, 2006; Beck, 2002; Biehle & Mickelson, 2012; Choi et al., 2005; Whiffen, 2004). For example, researchers have shown that, during pregnancy, mothers have expectations about how much a husband should contribute to postpartum responsibilities, and that these mothers express more distress and depressive symptoms when these expectations are not met (Biehle & Mickelson, 2012). This example of depressive symptoms developing from unmet expectations relating to the partner illustrates that there is more to PPD than a mother being unable to cope with the demands of parenting, and that expectations about being a good mother also entail expectations about the partner's role. In addition, many women experience a paradox, whereby they want to care for their child or be happy to have the child, yet, at the same time, are sad, distressed, and grieving for so many losses (Knudson-Martin & Silverstein, 2009; Nicolson, 1999).

"Bad mother" is one of the worst labels a woman can be given (e.g., Knudson-Martin & Silverstein, 2009; Posmontier & Horowitz, 2004). There are many ways in which a mother can be considered "bad." For example, many mothers fear being stigmatized if they admit that they are not overjoyed by their new life with their new baby (e.g., Barnes, 2006; Beck, 2002; Clay & Seehusen, 2004; Nahas & Amasheh, 1999; Riecher-Rossler & Fallahpour, 2003), because being unhappy is not consistent with the high social expectations of motherhood (Held & Rutherford, 2012; Knudson-Martin & Silverstein, 2009). The "Yummy Mummy" phenomenon is credited with being a major contributor to this stereotype (Daniel, 2006). Picture a new mother who looks beautiful, is in great physical shape, and is supremely happy about her new baby – this is a "Yummy Mummy". This image of motherhood has been perpetuated and encouraged by media coverage of celebrities who have recently given birth (Daniel, 2006). Yet the idea of being a "bad" mother if one is not happy after the birth of a child is not just a North American concept. Bina (2008) and Posmontier and Horowitz (2004) stated that a standard belief for Jordanian women is that if they are sad or complain after they give birth, then they are bad mothers because

they are not fulfilling their role as wife and mother. The belief that something is wrong with a mother if she is not happy to be a mother is implicit in the Hmong practice of having a Shaman put a mother's soul back into her body. The Hmong believe that the escape of the soul is the reason why a mother would be unhappy with caring for her child (Bina, 2008). These types of stigmas, stereotypes and myths create an environment where mothers are uncomfortable asking for help, and feel even guiltier about being depressed. In this way, striving for the golden apple of happiness can create a sense of loneliness (Mauss et al., 2011).

There are also a number of myths that add to the mounting expectations that are difficult for mothers to meet (Barnes, 2006). These expectations ultimately revolve around what it is to be a "good mother" (Knudson-Martin & Silverstein, 2009), a "perfect mother" (see review by Beck, 2002), and a "superwoman" (Held & Rutherford, 2012). For example, the "myth of maternal instinct" is based on the expectation that mothers survive and care for their child on pure instinct, without external knowledge or help (Barnes, 2006; Beck, 2002). This myth is consistent with the ideological belief that mothers should be able to care for child, family, husband, self and work easily and without complaint (Knudson-Martin & Silverstein, 2009). The "myth of maternal bonding" sets the societal norm high by expecting mothers to bond deeply and immediately with their baby (Barnes, 2006). The "myth of the supermom" is the ultimate "good mother" image, where a mother is "limitlessly available and loving, self-sacrificing and consistently able to manage the overwhelming demands of an infant without ever asking for help" (Barnes, 2006, p. 30; Held & Rutherford, 2012). According to Madsen's (2009) participants a good mother is someone who is caring, engaged, lively, happy, trusting, consoling, present, and secure. A good mother also gives time to the child, shows love for the child, is physically close to the child, is responsive to the child, and shows intimacy towards the child. As Held and Rutherford (2012) stated, "To be an ordinary devoted mother, a woman not only had to sacrifice herself to her children, but also be *happy* about it" (p. 111, emphases in-text). Beck (2002) and Knudsen-Martin and Silverstein (2009) suggested that the myth of the supermom is responsible for why women wait before they seek help (if they do at all) – they do not want to admit that they need help because they should be able to handle everything themselves. Being unhappy, despite wanting to be happy, indicates a personal failure and weakness that mothers do not want to admit to (Knudson-Martin & Silverstein, 2009).

After the birth of a child, attention is focused almost solely on the care of the baby, which

may influence expectations and perceptions of the mother's role and transition (Posmontier & Horowitz, 2004). As well, the myths of motherhood set high expectations not only for what the relationship between the mother and the child should be, but also for the level of involvement of her partner (which is often low because the mother should be able to handle almost everything on her own, Barnes, 2006). In addition, these myths affect not only the perspective of the mother, but also those of her partner (Barnes, 2006). For example, the partner might believe that the mother is the caregiver, and the father is the breadwinner. Partner expectations are also important in how societal expectations can have an impact on the mother and family because partners will behave according to their expectations, which might perpetuate or ameliorate the pressure a mother experiences to meet societal expectations.

The feminist perspective acknowledges many changes in a mother's life (e.g., experiencing role changes and a lack of confidence in the new role, managing contradictory advice, and accepting the loss of an old identity) and believing that feeling sad, uncertain and unsettled is normal and expected. Mothers should be allowed to grieve for all of the things they have lost so that room can be made for the new life. Primarily, MPPD emerges out of a conflict of ideological motherhood, which is built on societal expectations and assumptions, and the real-life experiences of motherhood. In many cultures and societies, there is a dichotomy of the good and bad mother. Therefore, if a woman is not a good mother (and the goal is to be a supermom), then she is a bad mother. The easiest way to be deemed, and to believe oneself to be, a bad mother is to not be indiscriminately happy about it. The feminist perspective is predominantly societally contextualized, thereby conceptualizing a mother's distress as the result of broader social and cultural expectations. Most often, the distress is believed to be caused by experiences that are inconsistent with what mothers were led to believe motherhood would be like.

To summarize the theoretically-based empirical literature, the emphasis of the biological view is on predisposing biological factors (e.g., past personal and/or familial history of depression; e.g., Whiffen, 1992), rather than quick changes in bodily chemicals following childbirth (e.g., Zonana & Gorman, 2005). There is a large literature on the sociological/stress and coping view, which often comes from personal accounts of women (e.g., review by Bina, 2008). There is also a lot of support for the feminist view about how deep-seated societal and cultural expectations add to (or create) a mother's distress in the postpartum period.

The conflict between the biological, the sociological and feminist perspectives is focussed on the directionality of the stressors, and the degree of individualization and contextualization. Research supports that having a psychiatric and/or familial history of mental illness may make a woman more vulnerable to developing PPD; on the other hand, physiological factors such as lack of sleep and hormonal changes could be viewed as consequences of having to cope with multiple life stressors. The biological and sociological theories both individualize the problems to be within the mother's biology or character, although the sociological perspective is more contextualized. The feminist perspective socially contextualizes a mother's distress, shifting blame from the individual to the deeply imbued ideologies of the larger societal system within which a woman lives.

1.2 Paternal Postpartum Depression (PPPD)

In the past ten years, research has emerged showing that men also experience PPD (e.g., Clay & Seehusen, 2004; Paulson & Bazemore, 2010; Whiffen, 2004). In 2010, Paulson and Bazemore's (2010) meta-analysis made headlines (literally) when they reported that 10% of fathers develop prenatal or postpartum depression. Paulson and Bazemore searched for published research that related to PPD in men, but excluded studies that relied on the men's partners already having been diagnosed with PPD. The incidence of PPPD was highest between 3-6 months postpartum. Rates of PPPD were also highest amongst US samples, compared to international samples, and when self-report was used compared to structured interviews. Within Paulson and Bazemore's sample of research articles, women had a higher rate of PPD (23.8%) than men. The authors also found a moderate correlation between PPD of partners, but they were very clear in stating that caution was needed when interpreting this relationship, and that an overall disruption in the co-parenting relationship could be responsible for this correlation (Paulson, 2010). Their analysis does not give any indication of directionality between the PPD of either parent.

Most other studies have researched the presence of PPD in men whose partners had previously been diagnosed with PPD (e.g., Roberts, Bushnell, Collings & Purdie, 2006; Zelkowitz & Milet, 1997). In these studies 20-50% of husbands developed PPD, or some other psychiatric illness, within the first year postpartum (Ballard & Davies, 1996; Bradley & Slade, 2011; Goodman, 2004; Melrose, 2010; In case, 2010). This rate is much higher than the 1.2%-25.5% of men in a community sample who were diagnosed with PPPD (Goodman, 2004;

Melrose, 2010). Goodman (2004) specified that these rates of depression, in husbands versus in a community sample, were relevant for mild to moderate depression, not major depression.

Many researchers have found a positive correlation between a mother and a father experiencing PPD (e.g., Escriba-Aguir, & Artazcoz, 2011; Giallo et al., 2012; Goodman, 2004; Kerstis, Engstrom, Edlund, & Aarts, 2013; Pinheiro et al., 2006; although Nishimura, & Ohashi, 2010, did not find a correlation in a Japanese sample, nor did Mao, Zhu, & Su, 2011, in a Chinese sample), and most have suggested, or stated, that PPPD begins after the onset of MPPD (e.g., Ballard & Davies, 1996; Goodman, 2004; Letourneau et al., 2010; Ramchandani et al., 2008; Roberts et al., 2006). For example, the American Psychological Association (2007) states that fathers can become depressed in the postpartum period if "the mother is depressed or if the father is not satisfied with the marital relationship or with life after the birth of the child" (p. 3). According to Goodman (2004), 19.6% of couples had depressive symptoms 1 month after the birth of a baby, 4.7% had symptoms after 2 months, and 40% of men with PPD also had a partner with PPD (Ballard & Davies, 1996). Thomas (2010) suggested a "contagion" theory for why men experience PPD, implying that men "catch" PPD from their wives. Bielawska-Batorowicz and Kossakowska-Petrycka (2006) and Goodman (2008) implied a lack of support on the wives' parts as being the cause of PPPD:

> For first time fathers all tasks related to childbirth are unfamiliar and might become difficult. In such circumstances a father looks for support from the most obvious source of support – his partner. However, when this primary source of support is depressed and she needs a lot of additional help herself, the amount of support received by men might not be satisfactory (Bielawska-Batorowicz & Kossakowska-Petrycka, 2006, p. 23).

The "father-infant relationship may suffer" (Goodman, 2008, p. 627) due to such a reduction in support.

Roberts et al. (2006) noted that a father's ability to support the partner and family, which is known to be a factor in MPPD (Garfield & Isacco, 2009; Roberts et al.), is also compromised when he has PPD. Zelkowitz and Milet (1997) were among the few authors who suggested a non-contagion explanation for PPD in both parents: "where stress is high and social resources may be lacking, both parents may have difficulty coping with the demands of a new family member" (p. 433).

Goodman (2004) reported that 42% of fathers met criteria for a psychiatric diagnosis if their wife was hospitalized for PPD, compared to 4% of fathers whose wives had not been hospitalized for PPD. In addition, fathers reported more symptoms if the mothers experienced

PPD, compared to fathers living with mothers without PPD (Roberts et al., 2006). Goodman suggested that PPPD occurred due to a break-down of the romantic relationship due to MPPD ("when a woman is experiencing postpartum depression, her partner cannot rely on her for support and his psychological adjustment may be impaired," p. 32), which could be related to what Ballard and Davies (1996) suggested as a trigger for PPPD: "a conflict between the traditional father role of providing economic support for the family and emotional support for the mother" (p. 67). As well, if a mother experiences PPD, fathers are expected and required to "take over house-keeping and childcare responsibilities that their wives could not manage" (Thomas, 2010, p. 621).

PPPD may manifest a little differently than MPPD. For example, crying and sad mood may not be endorsed by, or apparent in, men who are eventually diagnosed with PPD (Melrose, 2010). Instead, Melrose (2010) described "masculine presentations of depression" (p. 201), such as being stressed out, being burnt out, and fearing seeming pathetic to others. Behaviours such as social withdrawal or isolation (Madsen, 2009; Melrose), indecisiveness, cynicism, irritable mood, avoidance, extra-marital affairs (Melrose), anger (possibly due to feeling helpless at not being able to "fix" the mother's PPD; Madsen, 2009; Thomas, 2010), fear of harming himself or the baby, self-criticism (Madsen, 2009) and violence are more commonly indicative of PPPD (Melrose), as are insomnia and a loss of libido (Ballard & Davies, 1996). Also, alcohol and drug use is associated with PPPD (Pinheiro et al., 2006), although these behaviours are not sufficient proof of PPPD (Madsen, 2009; Melrose). Roberts et al. (2006), however, did not find that alcohol use increased when men experienced PPD. Melrose also cautioned that some symptoms may not be a result of PPD. For example, "a new father's irritable mood may be attributed more to infant crying or feeling excluded from the mother-baby bond" (p. 202), and "spending extensive time at work away from the family may be perceived as a need to maintain the traditional male role of provider and breadwinner rather than as an avoidance behaviour" (p. 202).

Many of the hypothesized causes for PPPD are similar to those for MPPD (e.g., CPA 2009). For example, men experience hormone changes in the postpartum period (Melrose, 2010). Melrose (2010) reported that testosterone decreases up to 33% during the first 3 weeks postpartum, estrogen increases a week before birth, cortisol and vasopressin levels drop, and prolactin usually increases. With respect to prolactin, if it decreases rather than increases, men

seem to be more susceptible to negative mood states. Many of the hormonal changes are theorized to be beneficial to parenting because they decrease aggression (Melrose). There is no mention as to how long effects from these changes might last, which leaves room for the suggestion that hormonal changes are related to mood changes early in the postpartum period but cannot account for the long-lasting mood disturbances that continue for months after the baby is born. Bielawska-Batorowicz and Kossakowska-Petrycka (2006), however, argued that PPPD is more related to situational factors (e.g., external stressors) rather than to biological predisposition.

Qualitative studies are consistent with much of the quantitative research, although Chin et al. (2011) suggested that a mother's pregnancy and labour was more stressful for fathers than the postpartum period. For example, Chin et al. reviewed six qualitative studies that used interviews with men who had experienced, or were experiencing, PPD and noted three themes: emotional reactions to transitions, definition of the father role, and redefinition of the marital relationship. Emotional reactions varied across the stages of childbearing. For example, fathers reported feeling like an outsider during pregnancy, helpless during labour, and a variety of emotions in the postpartum period, such as amazement, love, and confusion. They also felt overwhelmed, and struggled to balance the desire to stay home with the family, the responsibility of having to go to work, and the necessity of doing other activities. The father role was still primarily defined as the "provider," but fathers were also nervous about knowing what to do and deciding whether to be like their own parents or not, feeling that they had not received a lot of practical information on how to care for a child, and feeling as if talking to other parents would have been helpful. In the marital relationship, the fathers found that they had to be more mature (e.g., expressing less child-like behaviours, tag-teaming with their partner, and taking no risks); they felt more calm, stronger, and united with their partner, but also felt uninformed about the changes that would occur in the relationship (e.g., lack of sex).

Other risk factors include having a history of depression (Goodman, 2005; Ramchandani et al., 2008), having a partner with PPD (before and/or after birth; Bielawska-Batorowicz & Kossakowska-Petrycka, 2006; Dallos & Nokes, 2011; Goodman, 2005; Letourneau et al., 2010; Ramchandani et al., 2008), being in a stressful or unsupportive relationship (Ballard & Davies, 1996; Bielawska-Batorowicz & Kossakowska-Petrycka, 2006; Dallos & Nokes, 2011; Goodman, 2005), being a step-father, being the partner of a single mother, having a history of poor social

functioning, having a working-class occupation (Goodman, 2005), being unemployed (Ballard & Davies, 1996; Dallos & Nokes, 2011), or having concerns about finances in general (Bielawska-Batorowicz & Kossakowska-Petrycka, 2006; Zelkowitz & Milet, 1997). Bradley and Slade (2011) also noted other risk factors that might play a role in the likelihood of a man developing PPD, including the parenting style of his parents, his personality, his experience of the birth, his perception of the baby, and the perception (his and his partner's) of his ability to parent (Ballard & Davies, 1996). In addition, men over 30 might be less likely to become depressed (Ballard & Davies, 1996).

Like mothers, fathers feel the pressure of societal expectations and gender roles. For example, Solantaus and Salo (2005) stated that "fathers' roles have been defined as providing social and economic security to the family and emotional support for the mother during the infant period" (p. 2158) and, with respect to the relationship with the child, being "playmates" (p. 2158). Women were described as the "gatekeepers to the nursery and fathers need acceptance and support from them to become actors in infant care" (p. 2159) because it is assumed that men lack the "maternal instinct" (Madsen, 2009; Solantaus & Salo, p. 2159). Fathers, thus, often feel barred from being allowed to be active in the parenting process (e.g., Dallos & Nokes, 2011; Madsen, 2009), and consequently have many negative feelings when needing to care for the child, such as ambivalence and experiencing the child as demanding, fretful and difficult to comfort (Madsen, 2009). Bradley, MacKenzie and Boath (2004) found that fathers tended to describe the support and help they gave, rather than what they received. This emphasis was interpreted as evidence of the gendered role of parenting.

Fathers have also been reported to experience distress due to their own expectations. In Bielawska-Batorowicz and Kossakowska-Petrycka's (2006) study, fathers who had experienced PPD tended to experience inconsistency between what they expected fatherhood to be and how they perceived fatherhood to be going. Non-depressed fathers did not report experiencing this inconsistency, or not to the same degree. For example, if mothers played with the child more than the father expected she would, he experienced less relationship satisfaction with his wife, and experienced more distress and/or depressive symptoms (Biehle & Mickelson, 2012). Fathers experiencing PPD were also more likely to perceive their relationships, supports and financial states more negatively (Bielawska-Batorowicz & Kossakowska-Petrycka, 2006).

The role of fathers is changing, however. This change is dubbed by some as a "contemporary" role (Dallos & Nokes, 2011, p.155) or "new fatherhood" (Madsen, 2009, p. 16). For example, fathers participate in antenatal classes (Chin et al., 2011; Madsen, 2009; 90% according to Garfield & Isacco, 2009); offer support and help during pregnancy (Chin et al., 2011; Madsen, 2009), labour and delivery (Chin et al., 2011; Madsen, 2009); share in child-care (Chin et al., 2011; Madsen, 2009), housework, and the finances (Chin et al., 2011); and are otherwise involved in parenting (Dallos & Nokes, 2011). Part of the changing role of fathers is due to the trend for women to maintain positions in the workforce after the birth of a child (Madsen, 2009), and a man is "expected to provide her a lot of help, cope well and support his family" (Bielawska-Batorowicz & Kossakowska-Petrycka, 2006, p. 27).

Madsen (2009) was one of the few studies that focussed on definitions of a "good father." In his study, interviewed parents (women and men) described a good father to be attentive, intimate, sympathetic and loving, present, interested, and ensuring that the child feels loved and understood. Finances were mentioned only by one father. These definitions were not dependent on the parenting style of their own father; in fact, it was generally the opposite (i.e., fathers strove to not parent like their own fathers).

Despite PPPD now being recognized, there are still a number of barriers to treatment and help. For example, fathers generally do not know where to look for PPD resources (Letourneau et al., 2010). Even if they are aware of resources, they can feel unwelcome at PPD support groups because these groups are likely to be comprised mostly of women (Melrose, 2010), or they feel that the groups are patronizing toward fathers (e.g., they are told by the group facilitator that they now have to learn how to iron; Bradley, MacKenzie & Boath, 2004). Fathers have also felt that people do not care about how they are coping because others (including professionals) ask about the mother and the baby, but not the fathers (Letourneau et al., 2010; Thomas, 2010). Fathers have also expressed that it is difficult to reach out to others for help or support (Letourneau et al., 2010; Madsen, 2009) because they feel like they need to be independent and "strong," and do not want to be a burden (Letourneau et al., 2010). Men have also reported that they are too overwhelmed and tired to seek help, claiming a "lack of time and energy" (Letourneau et al., 2010, p. 45) due to "caring for other children, … work commitments and transportation challenges" (Letourneau et al., 2010, p. 45).

1.3 PPD: Blame and Responsibility

A sense of blame and responsibility can create a lot of stress and pressure for a person, especially if there is a belief that these responsibilities stem not only from one's own, but also from others', expectations. Who is to blame and who should take responsibility for PPD, including its development, the negative effects it can have, and its treatment? In Roehrich's (2008) interviews with husbands of women with PPD, some expressed that they had developed depressive-like symptoms because they had to commit to a full-time job and take up the responsibility for all of the chores and child-care that the wife could no longer do because she was depressed. Roehrich and others (e.g., Thomas, 2010) seemed to imply, or explicitly state, that the mother is the cause of the man's PPD. As well, in Roehrich's study, there was an undertone of resentment, wherein if the father could have a full-time job, take care of the baby and do the housework while experiencing depressive symptoms, then the mother should be able to help out, too, despite her depression.

Similarly, a number of studies have researched the negative effects of PPD on the development of the newborn. To recap, results have suggested that the child's language (Canuso, 2008; Stein et al., 2008) and cognitive development (Bishop, & Skuse, 1995), as well as behavioural and emotional development (Clay & Seehusen, 2004; CPA, 2009), could be impaired or delayed when either, or both, parents experience PPD. The majority of these articles focused on impairments that could develop from MPPD; the role that partner and/or family support could play in reducing the depressive symptoms of the mother, or in helping the child, was rarely mentioned. As well, the idea that babies could bond with partners and not just the mother was a rare concept in the MPPD academic literature (except in Riecher-Rossler & Fallahpour, 2003), especially within the biological and sociological models. Non-maternal bonding was a topic in the PPPD literature, however. The primary concern, therefore, was the healthy emotional, social and psychological development of the child(ren), which was a responsibility imparted to both parents, but only when the articles about mothers and fathers were considered together. However, given the emphasis on how MPPD can cause long-term harm to a child, and the positioning of mothers as the primary caregiver through an absence of discussions about partner-related support in the academic articles on MPPD, the implicit responsibility of childcare and child-harm was placed with mothers.

In public discourses, as analyzed in the academic literature, there is a view that if a mother is depressed after having a baby then there is something wrong with her (e.g., Daniel, 2006; Held & Rutherford, 2012; Nicholson, 1990). Specifically, there is something wrong with her maternal instinct (e.g., Dubriwny, 2010). These myths of motherhood put responsibility on the mother to not feel depressed after giving birth, and to have an instinctive intimate bond with her child. These pressures may serve to worsen a mother's depressive symptoms in general, if not contribute to their onset. This good mother-bad mother dichotomy (Held & Rutherford, 2012), which is seen as based on individual characteristics and behaviours (rather than a mother's life-context, McMullen & Stoppard, 2006), places a mother in a no-win situation: either she is viewed as a bad mother if she is depressed (e.g., because she is not happy about being a mother and cannot take care of her baby or self), or the PPD is perpetuated by feeling obligated to hide it behind a portrayal of "supermom, superwife, supereverything" (Choi et al., 2005, p. 167).

Some blame for the development and delayed treatment of PPD has been placed on physicians by acknowledging that they can fail to ask appropriate questions that could encourage women to admit their symptoms, or that could help the physicians identify and diagnose PPD (Dennis, 2004b). As well, sometimes when a mother does express her emotional concerns to her physician, the doctor sloughs it off, saying that her feelings are normal and they will desist soon (Abrams & Curran, 2007; Clay & Seehusen, 2004; Riecher-Rossler & Fallahpour, 2003). Fathers tend to minimize sad symptoms in the same way, and also to believe that MPPD is reserved for when a mother kills her child and/or herself (Letourneau et al., 2010). Jellinek (2007) strongly suggested that the responsibility for detecting PPD before it has harmful effects lies with the paediatrician, particularly since s/he is often the only doctor a mother will see in the first six months after childbirth, and is often the person who diagnoses a mother with PPD (Clay & Seehusen, 2004). According to Seehusen et al. (2005) study, 46% to 70.2% of family physicians (well-child visits and postpartum gynaecological exams, respectively) self-reported that they attempt to screen for PPD in new mothers. Paediatricians, however, do not have an accurate awareness of, or training in, postpartum mood disorders (Wiley, Burke, Gill, & Law, 2004), despite overwhelmingly agreeing to its validity as a diagnosis and its severity. It appears that if paediatricians were to become an active part in the identification of PPD in the early postpartum period, much more training and awareness would be required.

Jellinek (2007) suggested that paediatricians need to set the stage for psychosocial discussions by having brochures and other reading materials in paediatric waiting rooms, as well as by discussing these topics in the first visit. In doing so, the awkwardness and/or fear of a screening procedure after a few visits would be buffered by framing this procedure in the context of an already established emphasis on family functioning. Wisner, Scholle and Stein (2008) also put responsibility for prevention and treatment on the medical system by saying that doctors should find a way to collaborate with mental and general health services. If such collaboration were to happen, then the mother could be monitored, educated and/or treated during pregnancy, as well as in the postpartum period. These same strategies could be applied to early intervention in and prevention of PPPD.

For fathers, academic discourses on PPPD are mostly framed in sociological/coping and stress (e.g., finances) and feminist terms (e.g., being a "bread winner" and having to take on more responsibilities at home and with childcare because his partner is experiencing PPD). In the MPPD literature, fathers/husbands are not often referenced, whereas mothers are in much of the literature about PPPD, especially in the context of contributing to PPPD (e.g., by not being available to support fathers, and by giving fathers more work by being depressed and/or going back to work earlier than has occurred in previous decades). Fathers are given less access to direct child care, partly because there is a myth that fathers lack a maternal (parental) instinct (Dallos & Nokes, 2011; Madsen, 2009; Solantaus & Salo, 2005). Without the dominance of a biological conceptualization, discourses about fatherhood are less individualized and more contextualized, which allows understanding and interventions to be based on conceptualizations other than that of the flawed individual.

"In a culture that both idealizes and devalues motherhood" (Clark, 2008, p. 449), mothers are blamed and held responsible for all aspects of PPD, while fathers seem to be generally absent or ignored. A movement toward putting responsibility on physicians has begun, thereby removing from mothers some responsibility for screening and seeking treatment for PPD. However, in the literature, excuses were given for why asking the medical community to consistently screen for PPD is unfeasible (e.g., 51% of paediatricians said they would not have time to screen in their practices, Wiley et al., 2004), and so responsibility is shifted back to mothers. As well, academic research is still heavily focused on MPPD, or a wife's role in PPPD,

and therefore "mothers continue to be placed at the centre of the family and are accountable for the mental and physical well-being of their children and partners" (Godderis, 2010, p. 463).

1.4 Media

One can view the media as constantly interacting with societal assumptions and stereotypes. "Media texts are sensitive barometers of cultural change" (Fairclough, 1995/2010, p. 60), which influence, and are influenced by, society in a dynamic way (Ball-Rokeach & DeFleur, 1976). The media are a powerful tool that can shape widespread events, shape the discourses that people use, and shape how people position themselves in relation to particular power inequalities and hierarchies (Fairclough, 1995/2010). It is also important to remember that the media maintain social stability by "reinforcing existing social values" (Vivian & Maurin, 2000, p. 325), yet can also help to encourage social change by asking the audiences to reassess these values (Fairclough, 1995/2010; Vivian & Maurin, 2000). In order for the public to engage with the stories in the media, the content needs to mesh, to some extent, with societal values (Vivian & Maurin, 2000). This meshing is partly completed by the fact that the mass media are infiltrating, more and more, the private sphere of living (Fairclough, 1995/2010). For example, the mass media are, by nature, public, yet they are most commonly consumed in a private environment (e.g., the home). As well, media texts bring private life (e.g., grieving) into the public sphere. The presentation of media texts has turned to conversationalization (e.g., speaking and addressing the audience with colloquial and casual language) and consumerization (e.g., constructing the audience as consumers and passive spectators that lack action). According to Fairclough, some have argued that conversationalization is a shift to a more equal stance between the media, the audience, and the powerful others who influence the media. However, because power is inherently unequal in the mass media (i.e., the audience has little influence on what is said, and is generally unable to give feedback), and is typically accessed and controlled by those who have economic, political or cultural power, he wondered:

> Do conversationalized discourse practices manifest a real shift in power relations in favour of ordinary people, or are they to be seen as merely a strategy on the part of those with power to more effectively recruit people as audiences and manipulate them socially and politically? (p.13).

I would agree that conversationalization is a powerful tool to draw audiences into the control and influence of more powerful others, and that audiences can be made complacent by the illusion of community and common morality. However, with the recent development of social media, the

potential for an audience to comment on, and even to direct, what is covered by media has broadened considerably.

In the spirit of encouraging social change, on September 26, 2009, the Mental Health Commission of Canada launched an 8-week campaign in the Globe and Mail called "Breaking Through" (M. Pietrus, personal communication, November 9, 2009). This campaign was an effort to bring mental health awareness to the general public, including awareness about PPD. It is because of this campaign that I have chosen to analyze newspaper articles, as they are meant to convey information and stories to a heterogeneous and wide-spread population.

The analysis of how PPD is conveyed in the media appears to be lacking in the literature. To my knowledge, there are no studies of how PPD, specifically, is taken up in newspaper articles. Studies of newspaper articles seem to focus on court cases related to infanticide by mothers, where the mother is sometimes diagnosed with a postpartum mood disorder (Barnett, 2006; Cavaglion, 2008); or about depression in general (Bengs, Johansson, Danielsson, Lehti, & Hammarstrom, 2008). Cavaglion (2008) analyzed 19 newspapers from popular Israeli newspapers between 1992 and 2001, focusing on six infanticide-by-mother cases in that period. He found racial and cultural inequalities in how mothers were represented. For example, Jewish mothers (who were in a traditional mother role) were absolved by focusing on their psychopathology. Arab, young and unwed mothers, however, were represented more often as criminals. Barnett (2006) analyzed 250 American newspaper articles, based on ten infanticide cases for a 12-year period "since the 1990's" (p. 414). She found that journalists focused on the individual, characterizing mothers "in oppositional terms, as either superior nurturers driven to insanity because they cared so much, or inferior caretakers who shirked their maternal duties because they cared so little" (p. 411). This observation led her to conclude that simplistic myths of motherhood (e.g., "the all-knowing, all-loving, and all-powerful mother," p. 411) were perpetuated to the exclusion of the complexities actually involved in motivating the behaviours that lead to infanticide (e.g., economic stresses, postpartum distress, and alcohol/drug abuse).

Bengs et al. (2008) analyzed 26 articles from three newspapers that focused on personal experiences of depression in men and women. These researchers discovered gendered representations and explanations of depression. For example, journalists simplified and overlooked a variety of explanations for men with depression, emphasizing work rather than relationships or feelings. For women, journalists emphasized a variety of explanations (internal

and external), and were more focused on relationship-, feelings-, and biomedically-oriented explanations of depression. When described through narratives, women were reported as describing their experiences of depression as "an insidious destruction of the façade" (p. 970), with many presentations of emotions. Men's reported experiences, on the other hand, described depression as "a sudden dramatic crack in the façade" (p. 969) that involved physical repercussions. Men also felt that they needed to keep an emotional distance when recovering and did not want to seem "feminine" or "weak". Despite portraying men as not wanting to appear feminine or weak, some presentations of men (e.g., by journalists) were as "vulnerable and confused" and "passive" (p. 970), which served to challenge masculine norms. Similarly, some women were presented as "capable of managing their depression by being reflexive, communicative and active" (p. 970), which served to challenge the feminine norm that women are helpless and passive.

Two studies have focused on how PPD is taken up in magazines, specifically (Martinez et al, 2000; Schanie et al., 2008). Martinez and colleagues noticed the same gap in the literature that I have (i.e., that analyses of PPD in the mass media are missing), and argued that it was important to illuminate what information about PPD is being conveyed through magazines, including how consistent the information is and what causal theories are most commonly discussed (e.g., the medical/biological, the sociological/stress and coping, or the feminist models). These authors analyzed 11 articles about PPD from 11 magazines, and eight about the baby or maternity blues from five magazines published between 1980 and 1998. The magazines varied in topic and target audience (e.g., from *Science* to *Glamour* to *Time*). The authors used content analysis to evaluate the frequency and content of five major areas: definitions, causes, symptoms, treatment, and assumptions. For both the PPD- and baby blues-featured articles, they reported many inconsistencies relating to these topic areas. For example, in the PPD-featured pieces, they found that PPD was most often defined by a list of symptoms, but no symptom was reported 100% of the time. As well, the medical, sociological and feminist theories were mentioned often, and usually in combination, although the medical model (and therefore encouragement of antidepressants) predominated. And, overall, mothers were assumed to be heterosexual, married, and of middle-class.

Schanie et al. (2008) replicated Martinez et al.'s (2000) study using magazine articles published between 1998 and 2000. Schanie et al. were interested in determining if the

presentations of PPD had changed after the coverage of the Andrea Yates[2] case that began in 2001, and celebrity controversies (e.g., Tom Cruise versus Brooke Shields in 2005[3]). These researchers found similar results as Martinez et al. (i.e., many inconsistensies), but also noted that the "normal" experience of motherhood was not discussed and that scare tactics were used to emphasize the horror of a postpartum mood condition, such as by blurring the line between PPD and PPP.

Held and Rutherford (2012) studied advice books and magazine articles about the baby blues or PPD that were published between 1952 and the early 2000's. They concluded that there has been a mostly consistent message that motherhood and bad feelings do not mix, and the presence of this inconsistency indicates a personal flaw. The writers of the articles and books persistently avoided situating "motherhood itself as the cause of serious emotional distress" (p. 107). Treatment for the situation was based on changing each mother so that she could enjoy motherhood, and it was expected that mothers would not allow themselves to be distressed for long, especially because of long-lasting impacts for the child(ren) (which would expose a "deficient mother," p. 114). In fact, in the 1990's, the expectation to be happy and get help immediately (because of impacts to the child) grew to encompass the beginning of pregnancy, not just the postpartum period (also Weir, 2006, as discussed in Godderis, 2011). Prescription medications became more prominent in helping mothers adjust to motherhood as biomedical explanations of the blues and PPD overshadowed psychodynamic ones. For a brief period in the 70's, the media began to recognize that getting married and being a mother to the exclusion of a woman's own life (and having to give up everything she used to enjoy) is not satisfactory, distress which was further exacerbated by the obvious inequalities of home- and childcare. However, in the 1980's, constructions of motherhood returned to individual faults. Therefore, in over 50 years of media coverage, the dominant solution to, and problem of, PPD was to be found in individual mothers rather than in the construction of motherhood itself.

Although not concerned with PPD or depression, Stibbe (2004) studied constructions of masculinity in *Men's Health* magazine. Constructions of men's health and masculinity were presented in counter-healthful ways, such as emphasizing "muscle size, alcohol tolerance,

[2] Andrea Yates pleaded guilty to drowning her five children. She had been diagnosed with PPP, although it was sometimes called PPD in the media.

[3] Brooke Shields had publically admitted to experiencing PPD after the birth of her child, and to taking antidepressants to help with the distress. During an interview on *Access Hollywood*, Tom Cruise publically condemned Shields (both personally and professionally) for using antidepressants, saying she should have used vitamins instead.

sports…and violence" (p. 45), having great and loud sex without condoms, eating red meat, and not participating in the domestic activity of cooking unless it was barbequing red meat or using a can opener. Predominately, the constructions of masculinity served to perpetuate the hegemony of power and privilege over women (and animals), rather than to promote good health.

While analyzing two best-selling Australian magazines targeted to women, Moran and Lee (2011) also found that masculinity was privileged. For example, women were discouraged from practicing safe sex because it inferred a lack of trust or commitment to the (presumably male, long-term) partner. Safe sex practices were also discouraged through an exclusion of discussions about safe sex. As well, sex was constructed as something that women give to men, and sex is necessary to maintain this romantic relationship. Not only does the relationship seem to depend on "great sex" (p. 159), but it is the woman's responsibility to understand what a man needs and wants, and to adjust her behaviours and appearances such that she can give him the best satisfaction possible.

Lastly, Dubriwny (2010) studied 28 television news stories about PPD between 2000 and 2007. Similar to Held and Rutherford (2012), Dubriwny concluded that postpartum disorders have become medicalized, individualized conditions; the news stories imply that they temporarily interfere with "a woman's natural ability to mother" (Dubriwny, p. 286), thereby reinforcing the "good" or "essential mother" construction. This framing is made possible by taking postpartum illnesses out of their societal contexts. As well, good and "diverted good" (Dubriwny, p. 293) mothers were constructed as white, middle to upper class women with a pristine home and a whole family (mother/wife, husband and child[ren]). Recovery, therefore, was defined as being able to fulfill the patriarchal hegemonic role of mothering, which does not include negative or ambivalent feelings.

1.5 Present Study

As is evident, gaps exist in the literature with respect to how PPD is taken up in mass social communications, such as newspapers. The academic literature reviewing maternal and paternal PPD identifies clearly gendered representations of parenthood (e.g., who is given responsibility and blame). MPPD is highly individualized and somewhat contextualized, while PPPD is more contextualized and comparatively less individualized. In this thesis, I analyze how parenthood (mothering/motherhood and fathering/fatherhood) is constructed through discussions of PPD in newspaper articles, using Critical Discourse Analysis. I am particularly interested in

which gendered parenting roles are perpetuated and which are resisted. As well, I am interested in what these constructions of parenting and parenthood convey about parents' relationships with each other and a new baby.

Being aware of what is and is not being conveyed about parenthood through PPD in newspapers could help to illustrate the assumptions and resistances that are present and absent in societal discourses. Critical awareness of these presuppositions and constructions could help to reinforce discourses that challenge damaging or unconstructive ideologies.

2. Methodology and Methods

2.1 Data Collection

My data consisted of Canadian and American newspaper articles dating from January 2008 (the year this project began) to June 2012 (the month that data collection was completed to meet the deadline for the thesis defence). Using ProQuest, I searched for articles that included such terms as postpartum depression, postnatal depression, and baby blues. Use of these terms generated articles that also used parts of these terms, such as depression. As data collection continued I discovered that there were also articles focused on PPPD (i.e., male partners experiencing PPD, not their reactions to a female partner experiencing PPD). To ensure a more complete set of articles, then, I redid my searches, using the same terms as above, but combining them with "mom/mother/women/woman" and "dad/father/man/men." This strategy yielded a total of 227 articles that mentioned PPD in some context (57 were articles on PPPD, and 172 were articles on MPPD).

I excluded articles that were not about PPD, parenting or pregnancy. For example, there was one article reporting the narrative of an athlete who could no longer play due to an injury, and he compared the effects of not being able to play to having PPD. Other articles that were excluded included stories of court cases (i.e., articles that reported on the legal proceedings surrounding an event of infanticide). These articles varied significantly in style from other articles, especially with respect to sensationalism and a focus on entertainment, and could merit an analysis themselves. Sometimes, there were duplicates of articles. In these situations, the longest article was kept because the duplicates were word-for-word segments of the larger article. I felt it was beyond the scope of this research to analyze how choices to shorten a story changed its function and focus. In the end, I generated data from 76 articles on MPPD, and 21 articles on PPPD. Only one article was repeated between the two sets of articles. These articles spanned 51 newspapers in Canada and the United States (see Appendix A for details).

The articles on MPPD dated from February 2008 to June 2012, with 2 in 2008, 20 in 2009, 21 in 2010, 17 in 2011, and 16 in the first half of 2012. Three articles related to depression during pregnancy, 13 related to the "science" of PPD (e.g., hormones, predictions and research), two related to parenting in general, 14 related to treatment programs for PPD (some of which were more about the program than about PPD itself), and the rest (44) related to PPD directly

(e.g., an overview of symptoms, causes, and treatments, narratives, and suicides or infanticides supposedly caused by PPD).

The articles on PPPD dated from October 2008 to May 2011, with 1 in 2008, 3 in 2009, 15 in 2010, 2 in 2011, and none in the first half of 2012. Fourteen articles related to PPPD (e.g., an overview of PPD, a few narratives), two related to parenting in general, and four related to research other than the meta-analysis completed by Paulson and Bazemore (2010). In May 2010, Paulson and Bazemore published a meta-analysis on PPPD, and the relationship with MPPD. This publication spurred an influx of articles about PPPD, as noted by the increased frequency of articles in 2010. Twelve of the articles in 2010 were published between May 18 and June 22, all of them relating, in some way, to Paulson and Bazemore's article. After June 22, the frequency of articles relating to PPPD dropped off.

In all but one of the articles on both MPPD and PPPD couples were portrayed as heterosexual, the majority of which were noted to be married.

After obtaining the articles from ProQuest, I attempted to find the articles via the Google search engine. There were some articles that I was unable to find a direct URL for, in which case I used the ProQuest link. If a person attempts to use the ProQuest link and it cannot be accessed, the article can be found via ProQuest by typing in the name of the article in the .

2.2 Methodology

Burr (1995) argued that we develop in a historically- and culturally-relative world, which we learn as our language use develops. This position suggests, then, that because we learn to use language in a cultural context, which itself is situated in a historical context, we are more likely to use certain discourses over others (Sims-Schouten, Riley & Willig, 2007). For example, North American English-speakers sometimes use the idiom, "it's raining cats and dogs," whereas non-North American French-speakers would not use this idiom because an equivalent saying does not exist in their language. Consequently, our understanding of "reality" is impacted and arranged by the language we have learned to use (Sims-Schouten et al., 2007). Our understanding of reality and truth is constructed through our everyday interactions (which themselves are geographically, temporally and participant dependent). However, these discourses are limited or encouraged by our cultural and historical realities (Fairclough, 1995/2010; Willig, 2001) which create the "discursive economy" (Willig, 2004) upon which we draw. "Discursive economy" refers to the culturally enforced discourses (e.g., lingos, idioms, and

assumptions) that influence how people position themselves and each other (Willig, 2004). Furthermore, the discursive economy that has been made available to us is constrained by societal and cultural dictates that reinforce powers (e.g., politics), hierarchies (e.g., manager over cashier), and inequalities (e.g., doctors vs. patients; Fairclough, 1995/2010), which illustrate the social and cultural ideologies that influence these discourses. Fairclough (1995/2010) defined ideology as "propositions that generally figure as implicit assumptions in texts, which contribute to producing or reproducing unequal relationships of power, relations of domination" (p.14). That is not to say that language users are stuck in the discourses that are available to them in everyday conversation, but rather that choosing alternatives to the socially accepted and presupposed language sets may create a resistance to the ideologies and powers that influence our societal language; which can, in turn, create changes to the overall societal discourse (i.e., use of the discursive economy).

I used the methodology of critical discourse analysis (CDA) to analyze the newspaper articles that formed my data set. CDA is similar to the analytic method of discourse analysis (e.g., CDA also analyses discourse-as-text, Blommaert & Bulcaen, 2000) except that it focuses on analyzing discourses in the context of how discourses maintain, legitimate or resist power hierarchies, dominances and inequalities (Blommaert & Bulcaen, 2000; Fairclough, 1995/2010; Van Dijk, 1999; Wood & Kroger, 2000). Researchers who use CDA are also interested in the ideologies that support these dominating discourses (Blommaert & Bulcaen, 2000; Fairclough, 1995/2010). Unlike discourse analysis, CDA approaches the data with some a priori assumptions, such as "the knowledge that being black, being a woman, being young or being the boss will most likely be evident from the way people write and talk" (Van Dijk, 1999, p. 460). CDA does not assume that people are equal and use equivalent discourses (unlike conversation analysis, for example; Wilkinson & Kitzinger, 2008).

CDA allowed me to determine how speakers employ discursive resources to perform social actions, and to identify which discourses are used with what potential consequences (e.g., who is and is not foregrounded in media texts; Fairclough, 1995/2010). CDA also goes beyond the text to postulate how the greater context of one's culture, society, and cultural history constrains or provides opportunities for one's discourses and constructed categories. In sum, given that I want to determine the possible functions of these texts in social discourse, CDA is very much suited to my analyses.

According to Fairclough (1995/2010), "…media texts are sensitive barometers of cultural changes…" (p. 60) and can be used to analyze shifts in power, ideologies and (in)equalities over time (or, what appear to be shifts in discourses and cultural values but in fact might perpetuate pre-established powers). As such, due to the nature of a text being temporally and spatially discontinuous (e.g., from when and where it is written, to when it is published, to when and where it is consumed), he sees mass communication as a *chain of events*. Rather than a set of disparate texts that report on the same event or series of events, events are *recontextualized* as they move down the chain. As well, one chain of communication events may intersect with another chain to recontextualize other events. For example, the chain of events relating to MPPD might influence the conceptualization of the events relating to PPPD, and vice versa (e.g., if both parents are said to experience PPD, perhaps PPD is reconceptualised less as a "woman's illness," Bascaramurty, 2010, L1, or perhaps the causes are seen as having more of a sociological basis rather than a biochemical one). What this means is that reporting events is not an objective process. Communicative events are presented differently depending upon the goals, values and priorities of the institutions and situations within which they exist, and presentations shift over time (e.g., the focus may shift from the accusations of one politician to the negative reactions of other people to the accusations). As such, analyzing mass media productions is not a simple, decontextualized task.

Fairclough (1995/2010) developed a CDA framework for media texts (verbal, visual and written). Fairclough suggested that media analysis is not just an analysis of the *text* (i.e., what is said), but, simultaneously, of contexts within texts (e.g., linguistic usage, how things are said), the "discourse practices" of the texts (e.g., the ways in which media texts are produced, received and distributed), and the "sociocultural practices" that influence texts (e.g., the economic and political institutions within which the media operates). As well, there are other aspects within each text (representations, identities and relations) which should be considered simultaneously, partly because they could have ideological roots. Representations refer to events, situations, people and relationships as presented in text, such as through foregrounding (e.g., those actors that are prominently featured, either directly or indirectly), backgrounding (e.g., those that are ignored or minimized compared to those who have been foregrounded), and presuppositions (e.g., assumptions which "help to reproduce relations of domination through assuming a consensus that doesn't exist," p. 109). Identities refer to how those people who are involved in

the broadcasted material (e.g., interviewees) are constructed (e.g., as an expert). Relations refer to the constructed relationships amongst various participants (e.g., reporter-audience, reporter-expert, reporter-interviewee) in the media text (e.g., as equals, as informer).

Another aspect of media analysis that Fairclough (1995/2010) strongly emphasized was that of intertextuality. Intertextuality refers to an interpretive analysis of the consistency or heterogeneity of genres, format/structure, and voices (e.g., direct or indirect quotations) within a given text. It also refers to how other texts that are part of the chain of events are embedded, transformed or disregarded. For example, two groups may be mentioned relatively equally in frequency, but framing, language choice, and (assumed) associations with other texts (e.g., drug trafficking or terrorism) may, in fact, position one group as the antagonist and one as the protagonist, despite appearances of being treated equally.

2.3 Methods

For this analysis, given the large amount of data, I focused on representational issues, such as backgrounding, foregrounding, absences, inclusions, and presuppositions; and some intertextuality issues, such as framing and ordering effects (e.g., is there a pattern where one person is more often mentioned first or second?). For example, I observed how the relationship between partners, and the relationship between each parent and the baby, was represented in the context of relevant textual references. By textual references, I mean the following: for the articles about MPPD, extracts that included any of the key words of father(s), dad(s), daddy/daddies, husband(s), partner, family/families, spouse(s), parent(s), marriage(s)/married, relationship(s), parent(s), and they/them and he/him (if the context implied "parent(s)" or "partner") were collected. Similarly, extracts from the articles about PPPD that contained any of the key words of mother(s), mom(s), mommy/mommies, mum(s), wife/wives, partner, family/families, spouse(s), parent(s), marriage(s)/married, relationship(s), parent(s), and they/them and she/her (if the context implied "parent(s)" or "partner") were collected.

I used the same process for the baby-references in both the articles about paternal and maternal PPD. Extracts were collected if they included any of the following key words of baby/babies, son, daughter, child(ren), offspring, the name of a child, pregnancy, birth, postpartum, born, trimester, terms of endearment (e.g., "little one"), it/he/she (if the context implied that "it," "he," or "she" referred to a baby or child), and new/expectant (mother or father or parent).

3. Analysis of Partner References: Articles on Maternal Postpartum Depression

In the academic literature on MPPD, partners are often mentioned in the context of how they can be impacted by MPPD (directly, Batorowicz & Kossakowska-Petrycka, 2006; and indirectly through use of the term "family"), and of how they can be a significant source of support for mothers (Negron, et al., 2013). In the literature on PPPD, mothers are often presented as being to blame for the onset of PPPD (e.g., Thomas, 2010), partly because fathers have lost a significant social support if the mother is unavailable to them due to PPD (e.g., Batorowicz & Kossakowska-Petrycka, 2006). In the next two chapters I analyze how parenthood is constructed in the context of newspaper articles on paternal and maternal PPD.

Of note, in the articles on MPPD, men were referred to as husbands almost twice as often as they were referred to as fathers or dads (22.86% versus 10.85%, respectively), which served to privilege the spousal relationship over the parental one.

3.1 Support

In the articles on MPPD, when partners were mentioned, typically they were portrayed as either inconsequential or as absent, or as having an instrumental- or action-oriented relationship with the mother.

3.1.1 Absent husbands. In these articles, there was a noticeable lack of references to partners, which, with the exception of one article, always referred to husbands. Out of 75 articles on MPPD, there were a total of 175 references to partners; 13 of these articles did not mention partners at all. The relative lack of partner-references was put into clearer relief when the number of references to women in the articles on PPPD was determined. In the 21 articles on PPPD, there were 134 female partner-references. Therefore, the average number of partner-references across all of the articles of PPPD (M = 6.38) far surpassed the average number of partner-references across all articles of MPPD (M = 2.33). When husbands were referenced, they were presented as being absent:

> "He was going from working to building the house" (van den Hemel, 2012).

> While her husband was working long hours at his job in Burnaby, Turner was left with the task of handling her depression by herself while raising a young family (van den Hemel, 2012).

> When my husband returned to work I assured him we would be fine. Early in the morning I would settle into the sofa, a spot my husband would often find me nine hours later (MacIntyre, 2011).

> If dad has to go back to work right away and mom is left by herself, that can lead to tough times if people aren't picking up on the cues (Berenyi, 2009).

Placing husbands at work constructed their role as an economic one. By being at work, husbands were necessarily absent during times of need for both mothers and babies: "We continued to cry together until my husband arrived home hours later" (MacIntyre, 2011) and "Turner was left with the task of handling her depression by herself while raising a young family" (van den Hemel, 2012). Husbands were also presented as being away for a long time, such as "nine hours later." These extracts conveyed the absence of the husband, even though he was referenced. In addition, by constructing husbands as being absent, mothers were presented as being lonely and on their own in coping with motherhood.

3.1.2 Inconsequential husbands. If a husband was not constructed as being absent, he was likely constructed as being an inconsequential player in the mother's story:

> … and with my hair pulled back in a style that my husband fondly called the 'Nancy Kerrigan' (MacIntyre, 2011).

> The 27-year-old woman was found dead on Oct. 5 by her common-law husband Harnet Mahal (Berenyi, 2009).

> She had burst into tears as her husband drove past her favorite pizza joint (Anstett, 2011).

> My husband came to lunch two hours after I had taken the medication [in the hospital]. I was a different person (Pearce, 2009).

These statements portray partners in a passive capacity, where they were inconsequential to the story and could be replaced by almost anyone. For example, a friend, co-worker or doctor could have found the mother in the apartment after she had committed suicide, could have visited the mother in the hospital, or could have been driving past the pizza place. In this last example (the third extract above), although anyone could have driven the mother past her favourite pizza restaurant, she might not have "burst into tears" with just anyone. On the other hand, it was the pizza place, not the husband, which was given responsibility for the tears. When a husband was reported as making a contribution, it was by giving his wife a "fond" pet-name, "Nancy Kerrigan." Although husbands were mentioned, they were not important or consequential to the mothers' stories.

The following extracts could be read as exceptions to what was stated before, but are instead consistent upon closer inspection:

> And then I'd show everyone, especially my husband and eight-month-old son, what a kick-ass player I was (Withey, 2011b).

> I daydreamt about dying in an accident or simply leaving so my husband could find a new wife to love and care for Will (MacIntyre, 2011).

In these examples, the partner was portrayed as being important to the mother; however, again, the partner had little to no consequence to, or importance in, the mother's story. In the first extract, the husband was passively present, and was a vague motivation to the mother. In the second extract, it was the baby who was the motivation for the mother to leave or die, and the husband was a vehicle through which the hope for a better life for the baby could be achieved.

3.1.3 Instrumental and take-charge husbands. There are three types of support in romantic relationships: instrumental (providing practical help, such as with chores and childcare), emotional (such as talking to the mother about her feelings and comforting her) and stability (e.g., "just being there," Garfield & Isacco, 2009, p. 295). Partners were not constructed as having an emotional relationship with the mother, but instead were discussed in the context of an instrumental- and/or action-oriented relationship:

> "When you are in that state, you are not functioning, and finally my husband had to step in and say 'Something has to happen'" (Roth, 2010).

> …When I could no longer remember simple details, my husband staged an intervention with our midwife, who convinced me to take Gravol (MacIntyre, 2011).

> She couldn't recognize her own illness, but her husband intervened and brought her to the hospital, the start of a 14-month recovery from postpartum depression (Stewart, 2010).

Here, the husband was portrayed as someone who took charge (e.g. "step in" and "staged") to help the mother when she could not help herself ("She couldn't recognize her own illness"). However, he was belatedly involved - on the outside, observing - until the situation reached a point where he was compelled to "intervene" in the situation (e.g., "you are not functioning" and "I could no longer remember simple details"). He was constructed as absent until a considerable amount of time had passed ("finally"), and the severity of the situation had reached a climax ("14-month recovery"). Again, the mothers' lives were cast as a lonely space that the mother traversed alone for a long time before someone offered to help.

The spousal relationship was also cast as instrumentally-based. For example, a presumed role of the husband is that he is involved in conceiving and in the decision to have a baby ("Now she and her husband…are talking about having another child," Ochs, 2012). It is possible to

argue that an emotional and supportive connection can be assumed in this type of statement (e.g., that a man would only talk about having a baby if he had strong feelings for a woman), but this assumption is not necessarily the case. For example, some people have children out of duty rather than wanting to have a child with a specific partner. Because the reader was left to assume that an emotionally supportive relationship existed between partners, while instrumental and action-oriented help was expressly discussed (e.g., the husband fulfilling his economic role), instrumental and action-oriented relationships were privileged over emotional ones.

In contrast, the following extracts do convey an emotional response and relationship that does not rely on instrumental support:

> I've never asked him why he cried that night, but I suspect it was a mixture of sadness and relief. He confided in me months later he would leave for work each day scared that one of us wouldn't be there when he returned. He knew the woman he married would never hurt her child or herself, but stress and exhaustion had turned me into a different person (MacIntyre, 2011).

> "Because my partner and I are lesbians, we had gone through extra steps to get this baby. This was a very planned child and my partner was very supportive" (Winston, 2012a).

Both a sense of collaboration ("my partner was very supportive") and consequentiality ("He … [was] scared that one of us wouldn't be there when he returned") were presented, in combination with descriptions of excitement, anticipation and sadness (e.g., "She and her husband had planned the pregnancy and very much wanted to have a baby," Winston, 2012b). These collaborative constructions, however, were considerably outnumbered by the greater number of emotionally irrelevant constructions of the spousal relationship (11 versus 38; e.g., absent, inconsequential, instrumental support, and action-oriented support).

Although both extracts convey an emotional relationship, it is interesting to note a possible gendered presentation of partner support in these two extracts. The first one referred to a male partner who was worried about his wife's and child's safety, but who was cast as perhaps helpless to intervene. The second extract referred to a female partner who was presented as being supportive, without hesitation or worry. However, as there was only one article featuring a homosexual couple, there is not enough evidence to confirm this possible pattern.

3.2 Responsibility and Blame

Responsibility and blame can be inferred without actually stating that someone is responsible or to blame for a situation. By positioning someone or something as responsible, underlying assumptions and expectations are illustrated. In the case of a negative situation or

consequence, blame is inherent in responsibility. In the articles on MPPD, mothers were positioned as responsible for the spousal relationship/marriage, the negative impacts of PPD, and parenting.

3.2.1 "Relationship". Husbands were implied in the terms "marriage," "marital relationship/problems/strife," "relationship" and "support." However, these terms were frequently qualified:

> The condition wreaked havoc on her mental health and her marriage (Withey, 2011a).
>
> Depression…strained her marriage (Picard, 2009).
>
> One of the best predictors of who will suffer PPD is whether a woman's relationship is strained before the birth (Picard, 2009).

"Marriage" and "relationship" were not always qualified, but when they were, they were qualified as being possessed by the mother (e.g., "her marriage" or "a woman's relationship"). Although a marriage or relationship does technically mean an interaction and collaboration of two or more people, qualifying it as the mother's positions the mother as being responsible for the relationship. Inherently, therefore, the problems in the relationship are due to a lack of responsibility on her part. Only once did an extract qualify the relationship as "their."

3.2.2 Effect on others. PPD is considered to be a serious issue because it is said to have negative consequences for the developing baby or infant and other children in the house. It is also very distressing for mothers because they often feel no bond with their baby and either want to, or feel that they should have a bond. Discussing the impacts of PPD was very common in these articles. These impacts were usually in the context of the child, the mother, the partner and/or the family.

> …Research has shown that postpartum depression can lead to paternal depression, create significant marital tension, interfere with maternal-infant bonding and affect child development (Abells, 2009).
>
> Postpartum depression is of considerable concern because of the negative impact this illness has on the mother and on her family (Abells, 2009).
>
> "…if you have the disease, get into treatment, because it can have a big impact on your family" (Beck, 2011).

In the discourses that spoke to the effect that PPD has on others, there was recurrent evidence of the use of "her family" or "your family" (speaking to the mother). In these newspaper articles, the partner was rarely mentioned, independently, as having an impact on

child development, whereas the mother was often referred to in this way. There was also a "contagion discourse" whereby a mother was implied as being the cause of PPPD ("Research has shown that postpartum depression can lead to paternal depression," and "24-50% of men studied suffered from their partner's depression," McLaug, 2011) either because it was believed that she was depressed first, and/or because PPD was often constructed as being owned by mothers. In this case, there was a trend of PPD being framed as a woman's illness by gendering "paternal depression," rather than qualifying "maternal depression." This trend illustrated the assumption that PPD is assumed to be firmly associated with mothers. Through defining the family, child and PPD as "hers" the mother was given the responsibility, and hence blame, for the negative effects that PPD had on anyone connected with her. This positioning also cast husbands as susceptible and vulnerable.

3.2.3 Parent = mother. There were times when collaborative or "gender-neutral" terms, such as "parents," were used. Upon closer inspection of the format and broader context of the articles, however, these gender-neutral terms were not as neutral as they appeared to be.

The term "parent" is supposed to be a neutral term, and may also elicit discourses of two people working together, possibly as a team. "Parent" was used throughout these articles in different contexts, such as presenting responsibility for the care of the baby (e.g., "That way, once a child is born, the parents will have somewhere to turn for practical advice or to get help with child care," Buffalo News, 2011), placing blame for causing harm to the baby if either parent has PPD (e.g., "Children with a depressed parent are themselves more likely to manifest symptoms of depression," Klass, 2012), or when attempting to seem unbiased and objective (e.g., "Depression damages the interactions between parents and children"). However, in the broader contexts of the articles, and across all articles, there were subtleties that framed "parent" to mean "mother," as in the following extract:

> Title: *Parents' mental health is critical to children's care*
>
> Like many other primary care doctors, I sometimes sense the shadow of depression hovering at the edges of the exam room. I am haunted by one mother with severe postnatal depression. Years ago, I took proper care of the baby, but I missed the mother's distress, as did everyone else.
>
> Nowadays it's increasingly clear that pediatricians, obstetricians, gynecologists and internists must be more alert. Research into postnatal depression in particular has

> underscored the importance of checking up on parents' mental health in the first months of a baby's life.
>
> …
>
> Depression may become part of a vicious cycle in these families: An overwhelmed and depressed parent is less able to follow a complex medical regimen, and a child ends up in the emergency room or the hospital, creating more pressure and more stress for the family.
>
> "There is a high burden of maternal depression, anxiety," among mothers bringing children to an emergency room. … "It influences their own perception of how well they can deal with their kids' problems."
>
> It's also become clear that there may be genetic propensities to depression. Its appearance in parent and child may in part reflect inherited vulnerabilities.
>
> And all of that reaffirms how critical it is for primary care doctors to ask the right questions and offer diagnosis without stigma.
>
> "Moms appreciate being asked. … It may be the only time they've been asked about their depression."
>
> I often find myself urging mothers to pay more attention to their own medical problems and mental health. Pediatric colleagues tell stories of depressed parents who break down and cry during a child's visit, but then say they're too busy taking care of the family to get help for themselves.
>
> I don't love the "do it for your child's sake" argument, I worry it suggests that the parent isn't important in her own right. But to be honest, I make that argument anyway, because it works.
>
> "They are open to doing something about their own issues because it could help their kid, and that's a very strong hook for mothers" …
>
> So if parents are open to being asked, and if we know that identifying depression has important benefits for our patients and their parents, why aren't we better at asking? … (Klass, 2012).

The title contains the term "parents" which was prominent throughout the article. This use of "parent" situated the article on fathers and mothers. However, the article began with a story about a mother. And, although "parents" was used often, only "mother" was ever specified throughout the article. The terms "husband," "wife," "either parent" or "both parents" were never used, which kept mothers as the focused subject of PPD. For example, the statement "'There is a high burden of maternal depression, anxiety' among mothers bringing children to an

emergency room" could have been "'There is a high burden of parental depression, anxiety' among parents bringing children to an emergency room." Also, sometimes "parent" and "mother/mom" appeared to be used interchangeably, as in "I worry it suggests that the parent isn't important in her own right." So, although there was an appearance of inclusion of both fathers and mothers, fathers were not actually named in this discussion of PPD.

The framing devices that were used above were common throughout the articles that used the term "parent." Many titles had "mom" or "mother" in them, which immediately focused the reader on mothers. As well, the topics before and/or after mentions of "parents" were primarily about mothers, which either primed the reader to interpret "parent" as "mother" or immediately shifted the focus from parents to mother. In addition, rarely was the father specified in articles that reliably used the term "parent." In other words, when "parent" was used mothers were the only parent that was talked about specifically, such as stating statistics related to mothers or narrating a story from a mother's perspective.

In instances where the term "parents" was not used but both parents were mentioned, the woman was always mentioned first and then the father (e.g., "She and her husband, Jim, had yearned to adopt and add to their family," Barton, 2009; "Still, some women and men have trouble distinguishing sadness or grief from depression," Berggeotz, 2010; and "PPD is a form of clinical depression that can affect women, and sometimes men, after childbirth," Roth, 2010), with one exception ("In men or women who are not breast-feeding, drug choice depends on symptoms, personal preference and side effects," Buffalo News, 2011). This ordering of mother first served to put the mother in the forefront of the reader's mind, which then primed the reader to think about women first when reading the article. Therefore, women were associated first with PPD and whatever other aspects were being talked about. As well, this consistent ordering effect served to minimize the partner's position and role in parenting, by subtly placing him in the background, when compared to the focus and positioning the mother received.

3.3 Loneliness and Isolation

As previously demonstrated, mothers' loneliness was constructed as a consequence of having absent, emotionally unavailable husbands who helped them only after considerable time had passed and distress had been experienced. Additionally, mothers were constructed as lonely and isolated out of a fear of not wanting to be seen as irrational, and not wanting people to know

that they could not handle being a parent, that they were not happy about it. Mothers were also presented as feeling that no one would understand their distress:

> She did everything she could to keep the problem from her partner, friends and family (Winston, 2012a).
>
> When they do reach out for help, their concerns are often sloughed off by friends, family and health professionals (Picard, 2009).
>
> "Many mothers are afraid to confide in loved ones, and this may leave them feeling isolated" (University of Wisconsin-Madison School of Medicine and Public Health, 2009).
>
> Morrow found it difficult to tell family and friends she was depressed because she thought no one would understand (Anstett, 2011).

Loneliness and isolation went hand-in-hand with not speaking to people out of a belief ("no one would understand") or an experience ("sloughed off") that their struggles would be minimized and not accepted. These narratives constructed others (partner, family, and friends) as absent, unavailable, or lacking understanding. In addition, with the exception of the first extract, partners were assumed to be encompassed by the vague terms of "family" and "loved ones". This absence of explicit terms, such as "fathers" or "husbands," further constructed partners as removed from a mother's life. Importantly, mothers were positioned as lonely and isolated due to self-imposed limitations (e.g., their own beliefs), except in extract 2 ("often sloughed off").

3.4 Summary

A discourse of responsibility was created for mothers, while husbands (rather than fathers) were put into the background, sometimes so far that they were completely absent, were seen as replaceable (e.g., by co-workers, doctors or friends), or were part of vaguely referenced others (e.g., family, loved ones). Partners were framed as husbands who were constructed as being absent and inconsequential to a mother's story, unless husbands were involved in some sort of instrumental support or intervening action. Therefore, although "partners," "husbands," or "fathers" were mentioned in these articles, only a superficial or non-existent spousal relationship was created. Similarly, mothers were cast as alone in the journey of motherhood. Contributing to the absence and backgrounding of husbands was that "parents" was consistently framed to mean "mother." This privileging of the parent-equals-mother construction not only

served to minimize the fathering role, but also to place all responsibility and blame for PPD, and care of the child, family and husband, squarely on mothers.

4. Analysis of Partner References: Articles on Paternal Postpartum Depression

There were many fewer newspaper articles relating to PPD in men than in women. Nevertheless, these articles contained several extracts relating to the spousal ("wife," "wives," or "partner") and parental relationship ("mother," "mom," "mommy"; 23.13% and 37.32% of the partner reference extracts, respectively), with the parental relationship being slightly more emphasized. In fact, there were many more references to women across all of these articles (M = 6.38) than there were references to men across all of the articles on MPPD (M = 2.33), despite there being 3.6 times as many articles on MPPD. Therefore, not only was greater importance given to the parental/spousal relationship in the articles on PPPD than in the articles on MPPD, but women had a significantly more substantial presence in the articles on PPPD than men did in the articles on MPPD.

In these articles, the spousal relationship was constructed as a competition, primarily through a focus on blame and differences.

4.1 Women as Comparators

Throughout the articles on PPPD, PPD was attributed to women, such as through calling PPD "the domain of women" (Kirkey, 2010), "a condition long thought to affect only mothers" (Rabin, 2010), "a disorder of motherhood" (Roan, 2010), or a "woman's illness," (Bascaramurty, 2010). Emphasis was also brought back to the mother through comparing fathers' experiences to those of mothers, and implying that PPD is a woman's condition without actually stating it; for example, "A new bundle of joy might bring the blues to more than mama" (George, 2010) and "Postpartum depression isn't just for mom" (Chufo, 2010). Positioning women as that to which men were compared solidified PPD as a woman's illness, which foregrounded mothers in the discussion of PPPD. Similarly, articles presented PPD as mother-centred by specifying when PPD was not referring to women (e.g., "Most of us have heard of new moms experiencing the "baby blues," or actual postpartum depression, but few acknowledge that paternal postpartum depression is just as real," Brott, 2010). Therefore, rather than bringing a focus to the issue of PPPD, or equalizing the construction of PPD, fathers continued to be backgrounded, and mothers foregrounded.

4.1.1 MPPD as a barrier to PPPD treatment. With many, if not all, mental health distresses, barriers to treatment are a significant topic of debate and intervention. In the articles on PPPD, barriers to treatment and awareness were discussed in the context of women, such as in

terms of women's increasing awareness and acknowledgement of MPPD and willingness to seek treatment.

> Over the past few years, postpartum depression has been talked about openly and as a result more women are comfortable seeking care when the baby blues become the more crippling illness of depression. Men, on the other hand, have remained in the shadows of the mental health world in this regard until recently (O'Shea, 2010).
>
> Both women and their doctors have become more aware of the risks of postpartum depression, as well as the benefits of early diagnosis and treatment. There has been much less research on how men cope with the stress of fatherhood, even though the mental health of both parents is crucial to the well-being of their children (Szabo, 2010).
>
> Most of us have heard of new moms experiencing the "baby blues," or actual postpartum depression, but few acknowledge that paternal postpartum depression is just as real (Brott, 2010).
>
> "A big barrier to treatment is that postpartum depression is still widely seen as a woman's illness" (Bascaramurty, 2010)

Authors argued that fathers' paternal struggles have been "in the shadows," "underemphasized" (Healy, 2009), less researched, and ignored (e.g., "It's not viewed by health professionals and the public as a problem in fathers," Roan, 2010). Fathers were in this position because of a dominant assumption (e.g., "viewed," "few acknowledge") that PPD is a "woman's illness," and that mothers and children take priority during the postpartum period ("While obstetricians and pediatricians assess moms for signs of PPD, few physicians inquire about fathers," Bothum, 2010). "But" and "on the other hand" were used to emphasize the differences between the mother and father, most often in an attempt to illustrate that fathers are in a worse position than mothers (e.g., they are given less consideration in social, professional and private spheres). "Isn't just" (e.g., "isn't just for mom," Chufo, 2010), "just" (e.g., "paternal postpartum depression is just as real"), and "even though" (e.g., "even though the mental health of both parents is crucial to the well-being of their children") were forceful ways to appropriate the title of PPD from the domain of mothers. These sorts of statements served to make the inequality of PPD explicit through comparisons with the current state of research, treatment and acknowledgment of MPPD. However, these comparisons did not serve to combine paternal and maternal PPD as disorders that should be considered together, but rather could be read as minimizing the importance that has historically been attributed to MPPD.

4.1.2 Gendered symptoms. Because PPPD is not as common in the public discourse as is MPPD, problems were created with respect to awareness, understanding, and getting help and treatment. A call for awareness was prominent:

> Better understanding of men's depression during the postpartum period is critical because it often manifests differently than women's... In general, depressed men are more likely to exhibit hostility and aggression, whereas women who are depressed tend to become sad (Wang, 2010).

> Symptoms of postpartum depression in men can be different from those seen in women. While many women with postpartum depression complain of exhaustion, men often exhibit aggression and violence, and adopt impulsive behaviour such as gambling, taking on extra-marital affairs and abusing drugs and alcohol (Bascaramurty, 2010).

Here, a lack of acknowledgement and understanding of fathers' distresses was presented as being caused by a lack of awareness of the gendered symptoms of PPD. Mothers were portrayed as being sad and tired, whereas fathers were cast as expressing externalizing behaviours, primarily anger, aggression, or violence. Although these extracts can serve to bring awareness to part of the reason why PPPD is under-recognized, they do so by minimizing mothers' symptoms. For example, fathers' symptoms were privileged by the specificity and long lists of symptoms, which were then compared to "women tend to become sad," "complain of exhaustion" and "get tearful." Tiredness and tears are not perceived to be as serious as aggression, violence, and behaviours such as gambling or having an affair. The term "tend to" was used only when speaking about mothers' symptoms, whereas fathers' symptoms were not hedged in this manner. Male symptoms were hedged by "often" and "most likely" which constructed a more immediate situation than that for mothers.

Taken together, a competitive discourse was created through the ways in which language was used in these types of extracts. A call for awareness about PPPD was prominent throughout these articles, but this call was mostly bolstered by sidelining the importance of MPPD, while at the same time consistently resurrecting the discourse that PPD is a woman's illness. MPPD was minimized by foregrounding the immediacy and severity of PPPD (e.g., aggression and violence versus sadness) and by stating that fathers' distresses have been underemphasized, ignored and overshadowed. Because mothers were described as owning PPD, it became mothers' faults that fathers' loneliness and distress had been ignored.

4.2 Vulnerable Fathers

4.2.1 Risky PPD. In the academic literature there have been suggestions (Roehrich, 2008) of, or direct statements (e.g., Thomas, 2010) about, a contagion theory that explains why men develop PPD – they "catch" it from their spouse. Although a contagion discourse was not explicitly evident in the articles on PPPD, there was a subtle directionality in a risk discourse.

Taken in isolation, some of these extracts presented this influence as directionless (e.g., "Depression in one spouse should be seen as a red flag, alerting doctors that the other parent is at high risk," Szabo, 2010, and "Among the other conclusions: depressive symptoms in either parent could trigger more severe illness in the other," George, 2010), although some clearly did state a direction (e.g., "In the meta-analysis, men had a higher risk of depression if their partner also had depression," Roan, 2010, and "The whole burden is on him and it makes sense to me that a man whose wife has PPD is more vulnerable to depression himself," George, 2010). However, the way in which the articles that contained these extracts were framed primed the reader to read these statements (especially those that were vague) as being directional from the mother to the partner. For example:

> One of the most significant findings is that men whose partners have experienced PPD are at heightened risk to develop it themselves, says lead author James Paulson… "When one partner becomes depressed, that causes stress and strain on the relationship," he explains. It can affect how intimate they are with each other, how they handle household tasks, and trigger arguments (Bascaramurty, 2010).

In this extract, the author paraphrased a supposed expert's statement, but made the statement directional. Therefore, when a seemingly directionally-neutral statement was presented next, presumably from the mouth of the expert, as indicated by the quotation marks, the reader was primed to read "one partner" (from "When one partner becomes depressed") as referring to a mother. In the context of the other mother-blaming strategies that had been used (e.g., that PPD is owned by women), readers were further primed to interpret this parental link as indicating that PPD is an illness that is passed from the mother to the father. The statements where the direction of risk was clearly going from father to mother were rare (e.g., "Much less is known about how "daddy depression" might influence the mother's mental health or outcomes for children," George, 2010), and got lost amidst the clearer message that MPPD puts fathers at risk.

4.2.2 Loneliness, isolation and being unsupported. Being lonely and feeling isolated are major contributors to PPPD (e.g., Bielawska-Batorowicz & Kossakowska-Petrycka, 2006), and fathers were often positioned as such:

> Men typically turn to their wives for support, but women who are wrung out by the demands of their babies may have little left to give their husbands (Szabo, 2010).
>
> The contemporary father may be more vulnerable to this malady than previous generations of fathers because of the increasing number of women in the workplace and the corresponding expectations that he should have more responsibilities at home (Roan, 2010).
>
> Sometimes they feel crazy for worrying about the baby, dismissed by moms and grandmas when they do speak up, and feel further alienated (O'Shea, 2010).
>
> But men face unique pressures, Courtenay says. Although fathers today are more involved in rearing children than ever, they often lack the broad social networks enjoyed by mothers, who are more likely to find consolation by sharing stories and strategies with friends (Szabo, 2010).
>
> Fathers are less likely than women to seek access to mental-health services and are more prone to caregiver burden or strain, but 24-50% of men studied suffered from their partner's depression (McLaug, 2011).

These extracts presented the ways in which fathers felt lonely and isolated, both before and after the PPD had set in. In short, fathers felt dismissed ("by moms and grandmas"), misunderstood, and unable to talk about their distresses. Primarily, fathers were in these lonely situations because of their wives: wives were presented as being too tired to emotionally support their husbands (first extract); women were working more in contemporary times (second extract); women supposedly had social networks that acted as a buffer for them to stave off emotional crises (fourth extract); and men were told by experts that women were supposed to be given all of the attention during the postpartum period ("The answer I got from the counsellor was, 'Now is not the time for you. Now is the time to take care of your wife'," Bascaramurty, 2010). As well, societal expectations contributed to fathers feeling lonely and ignored. For example, it was stated that fathers were expected to have more responsibilities at home (second and fourth extracts). However, fathers being expected to do more at home was also framed as a consequence of more women maintaining jobs after childbirth, and fathers being dismissed was constructed as due to mothers being more important in the postpartum period. Therefore, even though societal expectations were implied, mothers were blamed for these large-scale pressures. Fathers were presented as helplessly lonely and isolated because they were a victim of socially-imposed limitations that stemmed from a focus on mothers, their supports, and their careers.

Contributing to the risk discourses was the implication that women (wives and grandmothers, for example) can exacerbate, and perhaps even cause, PPPD.

It is worth noting that throughout the articles on PPPD, terms such as "marriage" and "relationship" were qualified by "a" or "the" rather than by one partner or the other, unlike in the articles on MPPD. Despite the preponderance of mother-blaming throughout the articles on PPPD, neither parent was given strict responsibility for the relationship itself. They were both either equally responsible or not responsible for the relationship. However, the relationship or marriage was not qualified as "theirs," either; therefore, neither partner had responsibility for the relationship.

4.3 Summary

In the end a divide was created. These articles on PPPD created a competition-like challenge to appropriate the term PPD from mothers. The urgency of this challenge was bolstered by repeatedly constructing PPD as a "woman's illness" or a "woman's domain," and by using mother-blaming strategies (e.g., risk discourses, mothers being responsible for fathers' loneliness and vulnerability). This attempted appropriation and the use of these discursive devices served to reinforce the gendered construction of PPD. Rather than attempting to construct PPD as a challenge that both parents experience, these authors constructed an "it's worse for fathers" discourse (e.g., because their struggles tend to be overlooked), thereby breaking apart the parental/spousal relationship, and strongly encouraging the reader to choose the paternal or maternal side, but not both. PPD became a competition rather than a social issue that needs attention.

Gendered presentations and stereotypes were also perpetuated throughout these articles. For example, symptom descriptions (e.g., where fathers are aggressive and violent and mothers are sad) coincide with pre-established gendered behavioural stereotypes where men are "active, aggressive and extroverted" (Johannsson, Bengs, Danielsson, Lehti, & Hammarstrom, 2009, p. 641) and women are "passive, sensitive and introverted" (Johannsson et al., 2009, p.641). As well, because the parental/spousal relationship was not constructed as a collaborative venture, much of the focus of these articles involved blaming mothers while casting fathers as victims. Nonetheless, motherhood was maintained as the primary parental role, and fathers were, yet again, primarily backgrounded.

5. Analysis of Baby References

Unsurprisingly, because PPD is, by its classic definition, depression that occurs after the birth of a baby, babies were referenced proportionately as often in the articles about PPPD and MPPD. The articles on MPPD contained 680 baby-references (an average of 9.07 baby-references across all articles on MPPD), and the articles on PPPD contained 194 baby-references (an average of 9.23 baby-references across all articles on PPPD). In both types of articles there were common constructions, albeit with subtle differences. Descriptions of babies as burdens, of the relationship between a parent and baby as bittersweet, and the potential of harm coming to the baby were presented in both types of articles. There were also additional discourses presented in the articles on MPPD that were either mostly, or completely, absent from the articles on PPPD, such as strictly positive references to the baby, references to the necessity of self-care, and constructions of "good" and "bad" parents.

5.1 Role Expectations

5.1.1 Burdens. Note that, although many of the presented burdens and stresses were similar for mothers and fathers, there were some differences between the two types of articles. For example, some of the extracts from the articles on PPPD presented the role of unpreparedness and/or not having appropriate parenting-models as contributing to PPPD:

> "We are expecting dads to be more involved in parenting than we ever have before … Most dads are welcoming of that, but they don't have any models about what a dad is supposed to do. That creates uncertainty, and that uncertainty can lead to anxiety and depression" (Roan, 2010).

> "One of the problems for men is that often, they don't have as much direct child care experience [as women], and when put into that situation, they don't know how to deal with it…There's panic, frustration, a whole range of emotions and feelings. Sometimes they get angry and lose control" (Lisi, 2008).

PPPD was framed as resulting from being unprepared, which was the fault of others (e.g., "they don't have any models about what a dad is supposed to be"). Mothers, on the other hand, were presumably well prepared for parenting (e.g., "they don't have as much direct child care experience [as women]").

In addition, mothers were constructed as burdened by chores they were doing (e.g., "[she] found herself overwhelmed by the challenges of looking after two children … meeting their needs and managing the home," McPhee, 2012), whereas fathers were constructed as burdened by having to do the chores in the first place (e.g., "He was saddled with taking care of his wife,

his son, and working," Bascaramurty, 2010). Here, "saddled" emphasized that partaking in these multiple activities was not part of his role. In addition to being burdened by chores, the articles on PPPD made more references to the burdens of the baby itself (9% of the baby-references from the articles on PPPD versus approximately 3% of the baby-references from the articles on MPPD), such as "Two-year old Jaden was begging his exhausted dad, Jason, for attention" (Bascaramurty, 2010), "a colicky baby is chaos defined for a new dad" (McPhee, 2008), and "at times [new fathers] are overwhelmed by the constancy of caring for an infant" (O'Shea, 2010).

Stereotyped behaviours and roles were constructed through these differences, such as that men are less experienced at parenting than mothers are (and that is because of a lack of preparedness and/or a lack of appropriate modelling for "hands on" parenting), that fathers are not expected to be involved in chores and childcare, and that the children themselves have a more negative impact on fathers than they do on mothers. Therefore, mothers were constructed as more skilled, prepared, and tolerant, and were expected to manage multiple roles, whereas the fathers were presented as lacking clear definitions and expectations surrounding the father-baby relationship.

5.1.2 Bittersweet relationships. Delving further into the roles of mothers and fathers, the relationship with the baby was discussed in various ways. In both types of articles, the parent-baby relationship was constructed as bittersweet, meaning both wonderful and distressing: "Am I feeling bummed out about the news? Why, yes, rather! I've got a great little baby! He's handsome, smiley, healthy, possibly clever. How could there be feelings of despair?" (Withey, 2011b) and "It is truly the hardest job you'll ever love. It magically changes everything" (Bothum, 2010). There were, nevertheless, subtle differences in how this bittersweet relationship was constructed for fathers and mothers.

In the articles on MPPD, the construction of the mother-baby relationship as bittersweet relied on the emotional disparities that mothers reported or were reported as experiencing, such as "You have this beautiful new baby and you feel like you should be full of joy, not stress" (Withey, 2011a), and "Bringing a life into the world is supposed to be one of the happiest moments in a woman's life, but as many as 80 percent of new moms experience some form of the baby blues, including PPD" (Ricks, 2009). These mothers were presented as being distressed by these disparate emotions, not wanting to feel unhappy, and as confused by these feelings.

In the articles on PPPD, the primary feeling presented was that of frustration (e.g., "The 33-year-old father stressed that he loves his little boy, and has never spanked him, but has felt the frustration that might lead others to do so," The Associated Press, 2011), but not sadness or despair. The constructed problem for fathers was that their lives had changed as a result of the baby (e.g., "It magically changes everything," Bothum, 2010), and these changes were unexpected because these fathers were, again, unprepared for parenthood (e.g., "They might relish becoming parents, but they can also be unprepared for the infant in their lives," Roan, 2010). As well, the frustration that fathers experienced was attributed to not being able to share their parenting stories with others (e.g., "there aren't always a lot of opportunities for dads to share how they're feeling" Bothum, 2010).

The responsibility of the problem, therefore, lay with different people, depending on the type of article. Mothers were constructed as being responsible for their own divergent emotions, as evidenced by the use of "you" (e.g., "You have this beautiful new baby and you feel like you should be full of joy, not stress," Withey, 2011a) and "I" (e.g., "I've got a great little baby!" Withey, 2011b). In addition, unacceptable emotions (e.g., feeling unhappy) were constructed as the primary problem in the mother-baby bond, whereas it was frustration and changes for the fathers. Fathers were also constructed as being more passive in how their lives changed in that other people were implicated as needing to take a more active role in preparing men to be fathers (e.g., "…but they don't have any models about what a dad is supposed to do," Roan, 2010). In sum, other people were blamed for the breakdown of the father-baby bond, whereas mothers were blamed for the breakdown of the mother-baby bond.

5.2 Mother-Baby Bond

5.2.1 Mothering as a positive experience. In the articles on MPPD, some discourses were presented that were entirely absent in the articles on PPPD, such as strictly positive references to the baby.

The mother-baby bond was a common topic whose importance was legitimized in the discussion of PPD and mothers. Usually, this bond was discussed in the context of a mother having no bond with a baby, which was presented as being bad and requiring intervention (e.g., "psychiatrists advise them to call their doctors before the scheduled six-week check-up," Robin, 2012). Most often, the PPD was claimed to interfere with the relationship, which was also a huge loss for the child (e.g., "If mom, who the child has previously bonded with, is now

depressed, the child may experience this new distance as a type of loss" [Spears, 2012]). Sometimes, however, PPD was described as interfering with the mother's ability to bond with the baby (e.g., "Depression interfered with her ability to bond with her son" [Picard, 2009]), which suggested an instinctual proclivity to bond with a baby. Of note, the mother-child bond was discussed almost to the exclusion of other relationships, such as with a partner, family or work. Through this exclusion, the baby was constructed as the most important aspect of a mother's life that needed to be considered when talking about PPD. Everything else was secondary, at best.

In the articles on MPPD, there were many references to how joyful, blissful, and wonderful a new baby could be, such as "I had delivered her beautiful baby girl a few months earlier" (Abells, 2009); "I have this five-year-old who knows how to tell jokes. That is so worth it" (Pearce, 2009); "I am proud of the mother I have become and the loving, amazing toddler I helped create" (Withey, 2011a); and "I had an angel baby" (Winston, 2012b). These descriptions of the baby and the mother's elated reaction to it constructed their relationship as something positive, beautiful, blissful and emotional.

5.2.2 Caring. A discourse of caring for the child and parent was also present. This topic was primarily discussed in the articles on MPPD, however. Parental care and/or baby care was presented in only three of the articles on PPPD, and was not a consistent construction of the father-baby relationship.

The construct that stood out in these articles was that mothers are presented as being motivated to look after themselves only for the sake of the baby, as illustrated by the following extracts:

> "I think we really need to help women understand that the best way to take care of their baby is to take care of themselves" (Anstett, 2011).

> The good news…is that women tend to respond very well to a combination of medication and counselling and are highly motivated to get better for the sake of their children (Jarry-Shore, 2009).

> I don't love the "do it for your child's sake" argument; I worry it suggests that the parent isn't important in her own right. But to be honest, I make that argument anyway, because it works (Klass, 2012).

> …Pediatric colleagues tell stories of depressed parents who break down and cry during a child's visit, but then say they're too busy taking care of the family to get help for themselves (Klass, 2012).

Other people were presented as seeing a mother's health as important for its own sake, as well as the baby's (e.g., "I worry it suggests that the parent isn't important in her own right"), while mothers were presented as holding a strong belief that they should only care for the baby (e.g., "…and highly motivated to get better for the sake of their children"). This belief was presented as not being in mothers' favour, but rather as to their own detriment (e.g., "…they're too busy taking care of the family to get help for themselves"). Nevertheless, a baby's health was privileged over that of mothers.

Because these references to caring were found almost exclusively in the articles on MPPD, the mother-baby relationship was further constructed in a stereotyped way. First, these references, and their exclusion from the articles on PPPD, constructed the mother as the primary care-giver. Second, mothers were presented as self-sacrificing because the baby always came first. Even seeking out and finding the time to treat PPD was a self-sacrificing act, because it was done for the child, not for the mother.

5.2.3 Extremes of mothering. In the articles on PPPD, the "good father" or "bad father" was not explicitly discussed. Although it might be assumed that statements about the negative effects of spanking and yelling at a baby might imply what is understood as the "good" or "bad" father, there was no explicit naming of this discourse. In the articles on MPPD, however, there were discourses that explicitly related to the "good mother" and "bad mother." Rather than the good/bad mother being inferred from statements presented (as for the fathers), the good/bad mother was explicitly pointed out in the statements about motherhood. The "bad mother" was constructed in three ways: (1) not being able to care for a baby; (2) not being happy about being a mother; and (3) being responsible if the child is taken away.

There were a number of reasons presented as to why mothers feel "bad," such as that they do not feel bonded with the child (e.g., "They may feel emotionally detached from their babies," McLaug, 2011), they feel resentful towards the child (e.g., "Saying I am feeling resentment toward my children is a really hard thing to come out and say," Hill, 2012), they are not happy about being a mother (e.g., "I had a real dislike of motherhood and of my child," Winston, 2012a), and they feel unable and inadequate to care for the child (e.g., "I felt like I couldn't take care of my children," Berggeotz, 2010). These sentiments accumulated in a fear of being judged

(e.g., "I worried every eye would be watching us, judging me for poor parenting," MacIntyre, 2011), and of the baby being taken away (e.g., "You don't even want to admit having them [horrific thoughts] because you think they will take the baby away," Picard, 2009). Adding to the presentation of fear, mothers were said to be afraid that a baby would be taken away by an anonymous "they" (e.g., "…you think they will take the baby away," Picard, 2009) or ambiguous others (e.g., "There's also a fear that disclosing depression will mean that the woman is judged unfit as a parent and will lose her child," Bounds, 2010). This fear of "others" was implicated as creating pressure for mothers not to express their fears and distresses. Overall, a mother having a child taken away from her was the ultimate sign that the mother was, in fact, a bad one.

By far, the most prevalent "bad mother" construction was that of not being happy about motherhood, and not feeling elated to be with the child. For example, "Women who become depressed after childbirth not only battle their feelings, but have the added guilt of feeling that they're failing as mothers" (McLaug, 2011), and "I didn't feel the glow of sunlight with my baby, being blissed-out as I was sitting and rocking her…I felt like I was supposed to love [her] more. I felt I was a bad mother because I wasn't doing it right," (Hunter, 2010). Equating guilt and shame with not being ever-joyful with the baby illustrated a powerful societal ideology that mothers should not be unhappy.

The problems that mothers experienced were positioned both on individual women and on women experiencing PPD as a group. For example, there was a lot of use of "she" (e.g., "She was just an anxious "terrible mother" because she couldn't get her newborn to nap," Zdeb, 2011), "I" (e.g., "I didn't want to get help … I felt like I couldn't take care of my children," Berggeotz, 2010), "their baby" (e.g., Zdeb, 2011), "her baby" (e.g., Jarry-Shore, 2009), and "such women" (Robin, 2012). As well, statements such as "Such women aren't able to take care of themselves or their babies" (Robin, 2012), and "They may feel emotionally detached from their babies and react negatively to a fussy, sick or crying child" (McLaug, 2011) placed fault with mothers by referring to challenges as things that mothers could not do, rather than abilities that were being interfered with by PPD. On the surface, these extracts seemed to suggest that mothers do not need to feel guilty or ashamed for not being elated when looking after a newborn; however, there were subtle implications that these mothers were, in fact, failing on a personal level.

If a "bad mother" is a mother who does not want to be around a child, who feels inadequate to care for a child, and whose child will be taken away from its home, then what is a "good mother"? In mothers' reports, a good mother was presented as being equated with a "perfect" mother (e.g., Laucius, 2011), a "super mom" (McPhee, 2012), and even "Queen of Mothers" (Withey, 2011a). Many mothers were constructed or constructed themselves as striving for this ideal, or at least trying to appear as if this ideal was being achieved (e.g., "I'd hide my bad score, practise in secret until I got it perfect," Withey, 2011b). However, this construction of the perfect mother was consistently resisted, not just via explicit denunciation. Some comments were sarcastic and/or biting, such as in describing the extreme expectations that go into being a "perfect mother": "To exclusively breastfeed at all hours with a euphoric grin on our faces. To vigilantly check toys and soaps for potentially hazardous ingredients. To keep that child happy and safe no matter the cost to us," Withey, 2011a). More implicitly, there was evidence of the notion that a woman can still be a good mother despite experiencing PPD: "Getting help for this does not mean you're a bad mother … It means you're a good mother" (Mulford, 2010) and "Experiencing the syndrome does not mean anything is wrong with a woman's ability to be a mother," (Home New Tribune, 2011), which further helped to resist the stereotypical "good mother" ideology. However, although the Mulford quote resisted the "good mother" construct by reversing the expectations of the dichotomy, it nevertheless perpetuated a dichotomy of mothering as either "bad" or "good," which allows little room for variations of mothering.

One consequence of the good/bad mother constructions was the pressure to be perfect (e.g., Withey, 2011a) and self-sacrificing (Klass, 2012). These pressures, however, were also somewhat resisted in articles on MPPD (e.g., Withey, 2011a). Also, a highly emphasized aspect of being a mother was the pressure to feel happy (e.g., Picard, 2009), but commenting on this pressure helped to expose the myth that motherhood is a "purely positive time in a woman's life" (McPhee, 2012). Several statements explicitly stated the problems associated with these motherhood constructions:

> "The main reason why women don't seek professional help for their depression is they don't want to admit that they're not happy about the joyful event of motherhood like everyone expects them to be" (Picard, 2009).

> …[a] new mothers' brain is rebalancing hormones and that, combined with the stresses of moving into a new female role, can cause the blues…women are ashamed because they are expected to be so happy at the birth of their child" (Hunter, 2010).
>
> "There's a real stigma around having a hard time basically and this myth out there that it's exclusively a positive time in a woman's life…It can be really wonderful and great but it can also be really difficult too at times and stressful. We as a society don't usually want to talk about that" (McPhee, 2012).
>
> They don't always feel like they can talk about some of the things that are difficult or some of the things that maybe they're not enjoying because they fear that risk of being judged or, heaven forbid, called a bad mother (McPhee, 2012).

When these assumptions were presented, the societal expectations of the ever-joyful mother were nevertheless resisted. The resistance occurred by virtue of the authors mentioning these expectations in the context of the guilt and shame they created for mothers. Many of the resistive discourses veered into feminist-based explanations (e.g., that motherhood is not entirely joyful, but is stressful and there are many changes that occur); however, authors mentioned these expectations but went no further with them: changes were not suggested, and other expectations were not discussed, such as what is considered a "normal" range of emotions to experience after a baby comes home. Therefore, the foundation for change was present but not actively pursued.

5.3 Father-Baby Bond

Despite there being the same average number of baby-references across both sets of articles (approximately 9 references per article), there was less variability in the ways babies were referenced in the articles on PPPD compared to the articles on MPPD. In both types of articles, references of harm coming to the baby (e.g., "The state of a father's mental health also appears to affect his offspring's prospects of developing mental illness – especially that of his son," Healy, 2009) and of a bittersweet relationship with a new baby (e.g., "Although thrilled with baby Josephine and the responsibilities that go along with being her dad, he found himself in a spiraling habit of neglecting his own health needs while trying to balance the demands at home and work," Bothum, 2010; and as discussed above) were prevalent constructions. Additionally, use of the baby as a descriptor or specifier (e.g., "His next research endeavor involves exploring what's happening in a new baby's family when both parents are depressed," George, 2010) and as an indicator of time (e.g., "The men are at highest risk for depression three to six months after the birth of a child," Rabin, 2010) were also common in the articles on maternal and paternal PPD. However, the articles on PPPD lacked recurring themes of a purely

positive relationship with the baby, as well as of caring for the baby (obligatory or otherwise). Exclusion of these aspects of the father-baby relationship, while including bittersweet references and emphasizing the problems that a baby causes for a father (discussed above), constructed the father-baby bond as lacking in positive emotions and blissful connectivity. The lack of primarily positive references also failed to construct the expectation that fathers should be ever-joyful of a new baby. This is especially illuminated when compared to the relationship that was constructed between mothers and babies (i.e., a strongly emotional, happy and all-consuming relationship, or at least the expectation thereof).

In addition, because there was less variability in how babies were referenced in the articles on PPPD compared to those on MPPD, the references in which the babies were inconsequential (e.g., where the baby was a descriptor/specifier or used to indicate the passage of time) dominated. These inconsequential references, where the baby was used to add detail to a situation (e.g., the "1 year olds," The Associated Press, 2011), or was referred to indirectly (e.g., "birth" or "pregnancy"), objectified the baby's purpose and position in a parent's life. In the absence of the construction of a strong emotional and happy relationship with the baby in the PPPD articles, the objectified baby became an important part of the father-baby construction. Therefore, the father-baby relationship was constructed as lacking an emotional connection, being rife with problems, and involving objectification of the baby.

5.4 Summary

Despite their presence, the resistances to the "good mother" construction were overshadowed by the number of other discourses that perpetuated the motherhood ideal, emphasized what a "bad mother" was, and put blame and responsibility on mothers. A mother's role was largely defined as being an instinctually skilled, tolerant, self-sacrificing primary caregiver who was expected to be prepared for motherhood and to be able to manage multiple roles (e.g., caring for children, doing chores). Mothering was presented as being all-important and all-consuming in both an emotional and instrumental way, and she was expected to be elated about this relationship, even if there were some bittersweet moments. If there was a breakdown of this relationship, it was primarily due to personal failures on the mother's part. Some resistance to the mothers-are-to-blame paradigm was evident, but this resistance was a whisper compared to the more well-defined role of motherhood.

In contrast, fathering was constructed as lacking expectations to be as skilled or prepared as a mother, to engage in chores and/or child care, or to be as instinctively tolerant of a baby. A father's relationship with a baby was bittersweet, objectified, and in distress due to the number of unexpected changes that occurred after the baby was born. When fathers were presented as having difficulty with the fathering role, and as having a primarily bittersweet relationship with the baby (rather than the bittersweet and positive presentations associated with mothers), they were not positioned as blameworthy. Instead, because fathers did not have the same well-defined parental role as mothers, fathers' attempts at performing outside of the stereotyped role were acknowledged, but failures were blamed on other people (e.g., for not properly preparing fathers, and for not giving fathers appropriate role-models for involved parenting). Possibly because of the fault lying with others, fathers were not framed as being afraid of any consequences of PPD.

Overall, mothers were clearly given dominance in the parental-child relationship and parental role definitions. In comparison to the defined stereotyped roles of mothers, fathers were seemingly absent from the baby relationship. Again, fathers were backgrounded in the act of parenting and parenthood. As well, fathers were given far fewer responsibilities for the baby and for the development of a bond with the baby compared to mothers, which further situated the role of bonding with, and caring for the baby, on mothers.

6. Conclusion

In the newspaper articles on paternal and maternal PPD gendered representations of parenthood and the spousal relationship were constructed through a variety of devices, such as the absence of male-partner references, inconsequential references, mother-blaming, comparison of mothers and fathers, and competition between them. Despite a call for fathers to be allowed to be more involved in parenting and to be supported in doing so (consistent with the changing role of fatherhood that has been noted in the academic literature; e.g., Chin et al., 2011; Madsen, 2009), they were nevertheless maintained in the background, while mothers were given the majority of the responsibility of caring for a family.

Parenthood was not constructed as a collaboration or partnership, but rather motherhood and fatherhood seemed to stand in isolation from each other, in an "either/or" construction, and motherhood was positioned as the primary role. This maternal role was foregrounded through focus and volume (i.e., there were many more articles on MPPD than there were on PPPD), through constantly using mothers as the standard to which fathers were compared, and via constructing mothers as responsible for parenthood and the spousal relationship. These constructions continued to maintain fathers in the background of parenting, and continued to position mothers as responsible for the well-being of their partners, child(ren) and selves.

Throughout these newspaper articles, parents were assumed to be married and heterosexual (with the exception of one article on MPPD that featured a lesbian couple), which speaks to, and perpetuates, the prominent societal expectation that a family has a mother and a father (e.g., Dubriwny, 2010; Martinez et al., 2000), and that marriage is "unambiguously superior to being single" (Godderis, 2010, p. 459). In the articles on MPPD, the spousal relationship was privileged, and the husband was constructed as having very little to do with the care of the family, or much of a role at all. For example, although in the academic literature instrumental (e.g., helping with practical tasks, such as chores, Garfield & Isacco, 2005; Negron et al., 2013) and emotional support (Knudson-Martin & Silverstein, 2009) are purported to be the most important supports for mothers in the postpartum period, in the newspaper articles, support from a woman's partner was instrumental (not with everyday tasks of child- and house-care, but economic and reproductive) or action-oriented (but only after a seemingly long time of inaction and distance).

In the articles on PPPD, both the spousal and parental relationship was emphasized, but both were constructed as being based on differences and competition rather than similarities and collaboration. Part of the competition discourse involved an attempt to take the term "PPD" away from women (while at the same time continuously reinstating PPD as a "woman's illness" and "domain"); and part of the differences discourse came from observations and "facts" that symptoms differ between maternal and paternal PPD, as is supported by research (e.g., Madsen, 2009; Melrose, 2010). These differences and comparisons formed the basis of the PPPD-is-caused-by-wives/mothers construction.

In addition, not only were partners generally absent in the articles on MPPD, they were also relatively absent from the media, in general. Compared to the number of articles that were specific to women, combined with the discovery that no articles on PPPD were found from May 2011 to June 2012 (and very few before May 2010), it appears that once the "novelty" of PPPD wore off, the status quo returned, and parenthood and PPD again became a "woman's domain." Husbands and fathers were relegated to the background yet again; this time in a more direct way. Future studies focused on the period following June 2012 are needed to determine subsequent patterns of reporting on PPPD in Canadian and American newspapers.

It is interesting to note that, despite a call for more attention to, acknowledgement of and acceptance for PPPD, there is no obvious evidence that this concept has become part of popular discourse. Because parenting ideologies are so culturally ingrained, they require more than a month's worth of resistance to engender change. In addition, widespread resistance would be required to alter such engrained presuppositions and ideologies, which suggests that, although the media can be a site for discursive change, they cannot be the sole instigator of it.

Both fatherhood and motherhood, in the context of the nuclear family, were constructed as lonely spaces. This loneliness was gendered in that mothers were presented as being lonely due to self-inflicted reasons (e.g., believing that they would be judged as a bad mother) in addition to having a physically and emotionally absent husband; fathers were presented as being lonely due to limitations imposed by others (e.g., not being properly prepared for parenthood), and primarily by their wives (e.g., by her working outside the home and having needs that overshadowed his). Wives have also been blamed in this way in the academic literature, where husbands are said to be expected to take on more responsibilities in the household and with childcare (Bielawska-Batoriwicz & Kossakowska-Petrycka, 2006; Roehrich, 2008) due to

women maintaining jobs in the postpartum period (Madsen, 2009). In both the newspaper and research articles, there were times when the changing role and expectations of fatherhood (e.g., from playmate [Solantaus & Salo, 2005] and breadwinner/provider [Barnes, 2006; Chin et al., 2011] to being a hands-on parent) were presented as being welcomed and wanted by fathers; and yet there were also times when these changes were presented as being forced upon them. An in-depth look at notions of want versus imposition of the parenting role could further illuminate subtleties in gendered ideologies, blames, role implications and expectations.

Gendered representations also extended to practices that constitute fathering and mothering. Fathering was not constructed as intuitive (because fathers are assumed to lack the "mother instinct," Madsen, 2009; Solantaus & Salo, 2005), but instead as something that was stressful and frustrating, which could have been avoided if others had properly prepared him for the changes that would take place after a baby joined the family. This imperative to prepare fathers is consistent with Chin et al.'s (2012) suggestion as to how to prevent and/ameliorate PPPD. In the newspaper articles, it was presented as understandable, then, that a father's relationship with his baby was simultaneously negative and positive because he was managing many unexpected transitions and changes. As Bradley et al. (2004) advised fathers, "Life as you know it will cease to exist" (p. 46). What made a father's experience worse was if his wife was not available to support him, which has also been stated as a significant contributing factor to PPPD by researchers such as Goodman (2004, 2008) and Bielawska-Batorowicz and Kossakowska-Petrycka (2006). If a mother was experiencing PPD, authors of the newspaper articles took up a risk discourse, whereby a father was said to have developed PPD because his wife was unable to support him due to her struggle with PPD. Perhaps, as Letourneau et al. (2010) suggested, fathers were unprepared "for the possibility of PPD in their lives" (p. 44), which caused their own PPD. This risk discourse was also evident in the academic literature as a contagion discourse (e.g., Thomas, 2010).

In contrast, in the newspaper articles, mothering was perpetuated as an innate, intuitive process (e.g., Barnes, 2006; Beck 2002) whereby a mother was supposed to be happy and overjoyed with her child and with caring for him or her (Held & Rutherford, 2012; Knudson-Martin & Silverstein, 2009). The mother-child relationship, like the father-child relationship, did have bittersweet moments, but the mother-child relationship was additionally presented as purely positive. Not feeling elation was a cause of great distress for mothers in that it positioned them

as a bad mother, because mothers are not supposed to be unhappy (Held & Rutherford, 2012; Knudson-Martin & Silversteing, 2009). Although the academic literature states that PPD in either or both parents can have long-lasting, negative outcomes for a child, only mothers, in the newspaper articles, were constructed as being concerned with the broader impacts of PPD. This difference could stem, at least in part, from the expectation that the mother-baby relationship should be positive, immediate, instinctive and deep (Barnes, 2006). When producers of mass media communicate these expectations, they both emphasize (e.g., Beck, 1995; Canuso, 2008; DiScalea & Wisner, 2009; Gentile, 2005; Riecher-Rossler & Fallahpour, 2003) and reiterate (e.g., that which is present in other media forms, Held & Rutherford, 2012) that an impaired mother-baby bond is the cause of developmental, emotional, behavioural, cognitive and language delays (e.g., Bishop & Skuse, 1995; Canuso, 2008; Clay & Seehusen, 2004).

The good/bad mother dichotomy (Barnett, 2006; Held & Rutherford, 2012) was clearly present in the newspaper articles on MPPD. There were a number of resistances to the myth of the supermom (Barnes, 2006; Held & Rutherford, 2012), such as through hyperbole and minimizing the pressures of this dichotomy by stating that a mother can still be a "good" mother despite experiencing PPD. What was interesting was that while the "good mother" construction was resisted, the "bad mother" construction was not. This difference might lie in the assumptions made about each construction. For example, the good mother construction was presented as unrealistic when it came to the societal and personal expectations that a mother should be able to do everything without complaint (Knudson-Martin & Silverstein, 2009) and be blissful and happy about it (Held & Rutherford, 2012). Statements were made about how detrimental and stigmatizing these expectations are (e.g., Barnes, 2006; Clay & Seehusen, 2004; Riecher-Rossler & Fallhpour, 2003). However, more prevalent was the fear, guilt and shame associated with not being ever-joyful, with the necessity to be self-sacrificing (even in the context of receiving treatment for oneself because it is being done for the good of the child), and with the necessity to hide one's distress for fear of the child being taken away. Narratives and "expert" opinions on these "bad" aspects of mothering were not necessarily resisted, but rather were taken for granted as bad. In the end, the message was that the good mother was an unrealistic pedestal to strive for, but being a bad mother should be avoided at all costs.

Discourses relating to mothers were more individualized (Dubriwny, 2010) compared to those relating to fathers. For example, the bad mother construction was based on a variety of

individual behaviours that a mother was not doing, such as being happy, and being able/wanting to care for the child. There was no explicit bad father construction. Individualization of problems puts blame for, and responsibility to prevent and fix, those problems on the person who is experiencing them, in this case, mothers. On the other hand, the onus for prevention and treatment for fathers was put onto others, including wives.

In the academic literature there is a debate as to whether PPD should, in fact, be considered an illness distinct from Major Depression. The International Classification of Diseases guide (ICD-10, The World Health Organization [WHO], 1993), the DSM-IV-TR (APA, 2000), and the DSM-V (APA, 2013) include onset specifiers for mood disorders in the postpartum/peripartum period, but PPD is not classified as a disorder in its own right. The DSM-V, however, does state that women (it does not mention men) who experience PPD are, in addition, likely to experience severe anxiety. Similarly, Whiffen (1992) suggested that PPD differs only from Major Depression with respect to severity, with PPD being milder, although there does appear to be a prevalence increase for women who are pregnant or who have given birth. This increased prevalence, however, could be more indicative of the stresses and triggers that are present when having a baby, rather than indicative of a unique disorder (Whiffen, 1992). As well, Riecher-Rossler and Fallahpour (2003) stated that this increased prevalence is only present in the first few weeks after giving birth. After this time, the prevalence is the same for other women who are considered at high risk for developing depression (e.g., women with a personal or family history of depression). Whiffen (2004) maintained that PPD is not distinguishable from depression experienced by women at other times in their lives. She also suggested that trying to categorize PPD as a distinct diagnosis is a double-edged sword because (1) if PPD is not considered a unique disorder wherein women are susceptible, then researchers might not receive funding and women might not receive the treatment they need; and (2) if it is unique, it "fosters the perception…that PPD is hormonal and self-correcting" (Whiffen, 2004, pp. 154), which also minimizes women's feelings and a focus on treatment for new mothers. Riecher-Rossler and Fallahpour (2003) argued that whether or not PPD should have its own categorization, screening tools and treatments, is irrelevant. Despite the uniqueness debate, depression during pregnancy and following childbirth confronts families, physicians, social workers, and other health-care professionals with special needs for care that are not necessarily present with non-postpartum depression.

These newspaper articles seemed to take Riecher-Rossler and Fallahpour's (2003) position, that PPD warrants special, critical attention because of the harm that can befall developing children. However, the writers of these articles did not discuss the debate as to whether PPD is, in fact, different from or the same as Major Depression. The ways in which PPD was constructed in these newspaper articles was that it is a distinct illness and special kind of depression that demands significant and immediate attention. This construction of specialness maintains PPD, and all of the other constructions and ideologies that are related to it, as isolated and separate from other distresses. In addition, the focus on harm to the baby not only serves to maintain PPD as a unique and special disorder; it might also limit parenthood discourses in the context of PPD because the expectation to care for a vulnerable child is so strong that other aspects, which could contribute to depression in pregnancy or in the immediate period following childbirth, such as death of a family member, loss of employment, are not primary considerations (Whiffen, 1992). This limitation likely contributes to the challenges of resisting and changing these parenting and parenthood ideologies.

Although equality in many aspects of life is an ideal in North American society, it is clear that, in the parental discourses around PPD in newspaper articles, inequality in the constructions of both motherhood and fatherhood, and the gendered expectations of these roles, was very much present. PPD for either parent was constructed as a grave concern (e.g., Hanington, et al, 2009; Letourneau, et al., 2011), yet Canadian and American cultures have not created a discourse about shared parenthood in this context; rather motherhood and fatherhood (or, arguably, husbandhood) were separated from each other. Motherhood held all of the parental cards, and fathers/husbands were relegated to the background, as "other".

Presentations in the media both correspond to and influence public ideologies and assumptions. The media can perpetuate, resist or change public constructions of various events and people. Clearly, societal assumptions, expectations and ideologies are, at least in part, responsible for parent distress and PPD (e.g., Nicolson, 1990, 1999, 2003; Solantaus & Salo, 2005). Only by being aware of these discourses can change be implemented. Having an understanding of how representations (or lack thereof) frame groups of people - such as how biological and sociological frameworks individualize the issues of PPD and place blame, whereas feminist frameworks allow for broader, social understanding that is not based on individual faults - will allow a base from which social change can occur. The media could be a

part of this process, but might not be the space within which to start change. The media have many pressures with which to contend (e.g., to manage the tension of being informative and entertaining, Fairclough, 1995/2010), and it is much easier to maintain hegemonic practices than to change them (Dubriwny, 2010). However, the media are a good mass communicator, and as changes occur, the media can disseminate and promote them. On a smaller scale, the present results might be able to inform health practices, as well as future anti-stigma campaigns and PPD educational programs, by making people more aware of what discourses they encounter so that less destructive ideas are perpetuated.

6.1 Context of Sample

The results of these analyses were clearly influenced by the sample of newspaper articles that was used. For example, the large difference in the number of articles on MPPD as compared to PPPD could mean that there was not as much chance for variability of discourse with respect to PPPD, especially for resistive discourses. As well, this sample was purely situated in American and Canadian newspapers, where it might be assumed, without evidence to the contrary, that the lay-people presented in the articles were stereotypically "North American" (e.g., white, middle-class, heterosexual nuclear families). This assumption is based on research conducted by Dubriwny (2010) who noted the prominence of this assumption in TV news broadcasts about PPD. All but one of the relationships in the newspaper articles analyzed for the present study referred to a heterosexual marriage. In addition, if a person was not within the stereotype of the white, heterosexual nuclear family, authors seemed to explicitly draw attention to what might be perceived as different (e.g., "Because my partner and I are lesbians…" Winston, 2012a; and "Kahlon, a Sikh who was born in India and moved to Calgary in 1999…" Berenyi, 2009). In addition, how news stories circulate likely limited the variability of newspaper articles in these analyses because articles are easily available for other authors and newspapers to use across countries (e.g., a story can be duplicated with minor edits). Although the nature of the data chosen for the present study inevitably influenced the analysis, this study nevertheless presents a snapshot of the state of gendered presentations of parenthood (motherhood and fatherhood) in mainstream Canadian and American newspaper articles on PPD that were published during a particular time in the early 21st century.

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Appendix A

Alphabetical lists of newspapers by country

Canada	United States
Belleville EMC	Baltimore Sun, The
Burnaby Now	Buffalo News
Calgary Herald	Charlotte Post
Daily Gleaner	Chicago Defender
Edmonton Journal	Chicago Tribune
Globe and Mail	Courier Post
Leader Post	Courier, The
National Post	Daily Camera, The
Ottawa Citizen, The	Dayton Daily News
Province, The	Detroit Free Press
Review, The	Detroit News
Saskatoon Sun	Florida Times Union
Spectator, The	Homes News Tribune
Star Phoenix	Houston Chronicle
Telegraph Journal	Indianapolis Star
Gazette, The	Journal and Courier
Times - Colonist	LA times
Toronto Star	Ledger, The
Vancouver Sun, The	Montgomery Advisor
Whitehorse Star	News Journal, The
Winnipeg Free Press	Newsday
	North Shore News
	Northumberland Area Health Unit
	Poughkeepsie Journal, The
	Record, The
	Sentinel
	South Florida Sun - Sentinel
	USA Today