“Being a mom = having all the feels”: social support in a postpartum depression online support group

Alexandru Stana\textsuperscript{a} and Alanna R. Miller\textsuperscript{b}

\textsuperscript{a}Winona State University, Winona, Minnesota, USA; \textsuperscript{b}Department of Communication, Languages, and Cultures, Fayetteville State University, Fayetteville, North Carolina, USA

ABSTRACT

Postpartum depression represents one of the most common complications associated with childbirth, with current estimates placing its prevalence between 13% and 19% among recent mothers. Literature suggests severe implications for both mothers and children, and identifies stressful life events, poor marital relationships, lower socioeconomic status, and lack of social support as major predictors of a PPD diagnosis. This study sought to investigate types of social support sought and received by women with PPD. In contrast with previous research, informational support was found to be the most frequently used type of support, followed by emotional support and network/community support. Selective coding revealed two overarching themes in the PPD support group: social construction of motherhood, and social barriers to treatment. The study makes policy recommendations, including suggestions to facilitate women’s access to health care and support both in offline and online settings.

Introduction

Postpartum depression (PPD) is identified in psychiatric literature as a series of depressive episodes that occur following childbirth (O’Hara & McCabe, 2013). The most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) classifies PPD as a form of unspecified depressive disorder with peripartum onset (American Psychiatric Association, 2013). The most current conceptualization of PPD indicates that the “peripartum onset” specifier includes “mood symptoms occurring during pregnancy or in the 4 weeks following delivery” (American Psychiatric Association, 2013, p. 186). With the 4-week specifier, the American Psychiatric Association estimates that between 3% and 6% of women who give birth will experience the onset of a major depressive episode (2013). However, it is estimated that between 13% and 19% of women will experience the onset of a depressive episode in the 6 months post-delivery (Gavin et al., 2005; O’Hara & Swain, 1996), a figure supported by current CDC data, which suggest that one in nine women will experience PPD symptoms (Ko, Rockhill, Tong, Morrow, & Farr, 2017).

The medical, personal, and economic implications of PPD for mothers, their partners, and children, are considerable. Any major depressive episode has the potential to significantly disrupt a person’s ability to function adequately; what sets PPD apart, however, is that women with PPD bear the tremendous responsibility of carrying for one or more infants, which implies consequences not only for mothers but also for children (O’Hara & McCabe, 2013). Recent research shows that a PPD diagnosis might affect mothers’ willingness and ability to breastfeed (Gagliardi, Petrozzi, & Rusconi, 2012), although other studies have found little support for this correlation (Dennis &
McQueen, 2009). Furthermore, extant literature indicates that women with PPD may be less likely to participate in immunization programs and to attend wellness child health visits, and are more likely to use corporal punishment, provide inappropriate foods, and display lack of knowledge of sensitive parenting (Hazen, Connelly, Kelleher, Barth, & Landsverk, 2006; Taylor, Guterman, Lee, & Rathouz, 2009; Zajicek-Farber, 2009). Past studies have also showed that depressed mothers are more likely to be unemployed compared to mothers without PPD and less likely to be employed full time (Ertel, Rich-Edwards, & Koenen, 2011) – although the direction of influence between depression and unemployment remains unclear.

Risk factors associated with PPD have been investigated by a broad body of literature. Such research (e.g., Beck, 2001; Robertson, Grace, Wallington, & Stewart, 2004; Wang, Wu, Anderson, & Florence, 2011) includes factors that have a moderate or strong association with PPD, such as history of depression, episodes of depression and anxiety during pregnancy, low self-esteem, stressful life events, poor marital relationships, lower socioeconomic status, young maternal age, and, particularly important in the context of this study, lack of social support.

Some preliminary research (e.g., Evans, Donelle, & Hume-Loveland, 2012) investigated the occurrence of social support in online support groups for women with PPD. The current study builds on and expands extant research, with an emphasis on the role-played by online social support at the complex intersection between social construction of motherhood and postpartum depression.

The culture of motherhood and PPD

Although many causal factors have been considered for PPD (Evans et al., 2012; Lee, 2003; Mauthner, 1999), some scholars indicate PPD is at least partially exacerbated by how motherhood and gender are socially constructed (Mauthner, 1999; Taylor, 1996; Taylor & Van Willigen, 1996). Taylor (1996) notes that although PPD shares symptoms with generalized depressive disorder, it is inseparable from the pressure women feel to fulfill gender roles: “The depressive thoughts associated with postpartum illness articulate women’s ambivalence toward motherhood and how they feel unable to fulfill an idealized but demanding and restricting role” (p. 28). Thus, any discussion of PPD and social support should examine these social constructions of gender.

In the social construction of gender, motherhood is treated as a natural and desired role for women (Austin & Carpenter, 2008; Chodorow, 1978; Hays, 1996; Miller, 2007; Rich, 1986; Taylor, 1996). Feminist scholars have refuted these traditional gender constructions for decades (Chodorow, 1978; Hays, 1996; Oakley, 1976; Rich, 1986). For example, Chodorow found little historical or biological evidence of a “maternal instinct”: “the evidence from animals, plus observations of human parenting, allow us to conclude that the hormonal basis of nurturance in parturient females is limited.” (p. 29). Despite the efforts at exposing the myth of natural motherhood, these ideas persist. Not only does motherhood continue to be naturalized and valorized in our culture (Hays, 1996; Warner, 2005), but “as an institution, [it] remains oppressive to women today – competitive, artificial, isolated, and individualistic” (Fox, 2014, p. 87).

Furthermore, there has been significant popular discussion of the pressures, not just to become a mother, but to become the perfect mother (Arendell, 2000; Hays, 1996). Judith Warner’s (2005) New York Times bestseller, Perfect Madness, describes the “mommy mystique,” which establishes impossible standards, while at the same time blinds women to the struggle through an emphasis on the “choices” women now have: “we are consumed with doing for our children in mind and soul and body – and the result is we are so depleted that we have little of ourselves left for ourselves. And whatever anger we might otherwise feel – at society, at our husbands, at the experts that led us to this pass – is directed, also, just at ourselves” (p. 33). And so, while women receive the message from society that they must have children to fulfill their role as a woman, they also are pressured to give their whole selves to the task.

The increased pressure of perfect motherhood and intensive mothering influences women’s experience of PPD as well as their likelihood and method of seeking treatment (Dennis, 2009; Taylor, 1996). Some scholars indicate that women may be driven to psychological distress through these impossible
standards (Mauthner, 1999; Schur, 1984). Schur (1984) notes in his analysis of gender norms and deviance that mothers are simultaneously told all they need to mother is their natural instincts and that they are wrong and need male experts: “Thus an endless circle of uncertainty, confusion, and insecurity was set in place. Childrearing norms were confusing and often contradictory, and on top of that they tended to change rapidly from year to year” (p. 92). One of the reasons women may resist seeking treatment is the perception they failed to fulfill their “natural” gender role as a mother (Anderson, 2013; Dennis, 2009; Evans et al., 2012). The stigma of PPD may drive women to seek help online, where they enjoy a degree of anonymity (Evans et al., 2012).

**Social support in online support groups**

The study of social support originated with epidemiological data suggesting that the presence of a social network was related to positive health outcomes and well-being, including both physical and mental health (for a review, see Cohen, Gottlieb, & Underwood, 2001; Pierce, Lakey, Sarason, Sarason, & Joseph, 1997). Even a cursory review of the massive body of literature available highlights that there is no single conceptualization of social support. The present study takes the perspective according to which social support is essentially a sequence of communication acts with the principal function of managing health-related uncertainty, “providing a sense of reassurance, validation, and acceptance, the sharing of needed resources and assistance, and connecting or integrating structurally within a web of ties in a supportive network” (Albrecht & Goldsmith, 2003, p. 265).

Previous studies underline the health benefits associated with receiving various types of social support. An extensive body of research (e.g., Cunningham & Barbee, 2000; Goldsmith, 2004; Uchino, Cacioppo, & Kiecolt-Glaser, 1996) indicates that the presence of social support is correlated with longer life expectancy, quicker recovery from illness, better coping with stress in individuals diagnosed with chronic disease, and better mental health. Social support can occur in different types of settings and can take on various forms. Prior investigations (e.g., Braithwaite, Waldron, & Finn, 1999; Eichorn, 2008; Evans et al., 2012; McCormack & Coulson, 2009; Peterson, 2009) have found that social support in online settings often takes the form of communication behaviors designed to offer informational, emotional, network, esteem, and other miscellaneous types of support.

The presence or absence of social support as coping strategy may play a central role in the health outcomes and well-being of vulnerable or sensitive populations (Albrecht & Goldsmith, 2003; Rossetto, 2015). Extant literature suggests that online support is more likely to be sought by individuals belonging to vulnerable populations or diagnosed with culturally- and socially stigmatized disorders (Eichorn, 2008). It was indicated in previous research that “those in greatest need of social support may be the least likely to get it” (Silver, Wortman, & Crofton, 1990, p. 398). The anonymity of online support groups may thus be particularly appealing to individuals diagnosed with stigmatized disorders, including PPD. As Gottlieb (1988) noted, membership in a support group can be seen as an informal mode of therapy where participants who share similar life challenges can openly express their anxieties, fears, or concerns in a context less structured that traditional therapeutic settings but more socially and culturally consistent with the members’ life situations. An alternative view of the relationship between social support and health outcomes was proposed by Kaplan, Patterson, Kerner, and Grant (1997). Specifically that study found that it may not be lack of social support that leads to declining health but, conversely, declining health may cause reductions in social support network size. This might explain why mothers with PPD symptoms may resort to online support groups to compensate for declining social support in real life.

The massive psychiatric and psychological literature investigating postpartum depression, on the one hand, and the growing body of research on online social support networks, on the other hand, are yet to be connected in the context of social support for mothers with PPD. Following the discussion of social support in online groups and the paucity of systematic inquiry of support groups for women with PPD, two research questions were posed to guide this investigation:
RQ1: What are the types of social support offered and sought in the online support group for mothers with PPD symptomatology?

RQ2: What are the major themes present in the online support group for mothers with PPD?

**Methods**

**Data collection**

To answer the research questions, a thematic analysis of an online support group for women with PPD was undertaken. We first conducted a comprehensive online search of support groups for mothers diagnosed with PPD. The search yielded a relatively large number of such groups. We eventually selected an online community that is the product of collaboration between a nonprofit organization that works to raise awareness and provide resources to women with a spectrum of maternal mental disorders, and an online platform that hosts a variety of online peer support groups. Both organizations will remain unnamed to protect the participants’ privacy. This specific support group was selected because it was very active in terms of number of posts and participants, and it was closely monitored by both organizations mentioned above. In addition, the administrators of the online support group platforms are medical professionals.

The online group analyzed was closed (i.e., creating a profile is required to gain access to the forum) and moderated. Similar to previous investigations (Evans et al., 2012; Keski-Rahkonen & Tozzi, 2005; Stana, Flynn, & Almeida, 2017), written permission to utilize forum data was requested and obtained from the online platform’s administrators. The present study was then approved with exempt status by the Human Rights in Research Committee (HRRC) at a Southeastern university in the United States.

Using instructions provided by the authors, the forum’s administrators selected the most popular threads during the previous 30 days. A thread’s popularity was determined using two criteria: total number of posts and total number of views. The decision to include in the thread selection criteria members who read messages but do not post (sometimes identified as “lurkers”) was based on previous research that suggest even non-active members benefit from participation in online support groups (Van Uden-Kraan, Drossaert, Taal, Seydel, & Van Der Laar, 2008). In order to further protect participants’ privacy, the online group’s administrators thoroughly de-identified the data before submitting it to the authors of this study; specifically, names and/or pseudonyms were replaced with randomly generated numbers. Specific geographical locations were also removed from the data.

**Forum members**

A total of 64 participants posted in the 17 threads analyzed here. All participants were women. The exact geographical locations were removed to protect posters’ privacy, but larger geographical locations, such as states and countries, were discernable in the data set. English-speaking participants posted from various countries including the United States, Canada, Ireland, New Zealand, and France.

**Data analysis**

Approximately 15% of the data were used for training purposes and for establishing acceptable intercoder reliability indices. The remainder of the data – seventeen threads – yielded 248 separate posts. Data were analyzed in three distinct stages of coding: open, axial, and selective. During the first stage, both authors reduced raw data to independent idea units. During this stage, the 248 posts in the data set were broken down into 1272 units which convey a single, independent idea.
The second stage of data analysis – axial coding – required independent idea units to be assigned to categories and subcategories derived from analogous themes (Lindlof & Taylor, 2002). By employing this research strategy, the present study had two broad objectives: to reexamine existing literature regarding the occurrence of social support in online support groups, and to investigate whether new broad themes, perhaps specific to the PPD support group, would emerge in the analysis (Smith & Krugman, 2010).

Before the second axial coding commenced, intercoder reliability procedures were undertaken. Both authors first completed several training sessions. During these sessions, a subsample of the data was jointly coded, using as guidance social support category definitions provided by Braithwaite et al. (1999) and similar social support literature. Then, each author coded individually approximately 5% of the data. At first, acceptable intercoder reliability indices were not obtained for all categories. Specifically, relatively low indices were obtained for the following categories: provide emotional expression (Krippendorff’s $\alpha = .65$), community building (Krippendorff’s $\alpha = .60$), and validation (Krippendorff’s $\alpha = .57$). After additional training sessions, during which further social support literature was reviewed and more sample data were coded, satisfactory intercoder reliability indices were obtained for all categories. The Krippendorff’s $\alpha$ values for the 19 subcategories in the analysis ranged between .81 (e.g., provide information; empathy) and 1.0 (e.g., request personal disclosure; display gratitude)

The last stage of data analysis was selective coding, during which broad themes were identified for discussion. This stage corresponds to the third and last stage of thematic analysis, dimensionalization (Lindlof & Taylor, 2002).

**Results**

The present study used a modified version of a code book validated by Braithwaite et al. (1999). Modifications to the original code book were warranted by a series of factors, primarily the minimal presence or even complete absence of certain social support categories in the data set analyzed for this study. Drawing on prior theoretical social support work (e.g., Cobb, 1979; Cutrona & Suhr, 1992; Schaefcr, Coyne, & Lazarus, 1981), Braithwaite and colleagues’ code book included five supercategories: informational support, tangible assistance, esteem support, network support, and emotional support. Each supercategory included in turn a number of subcategories. For the present study, informational support and tangible assistance were collapsed because cases of tangible assistance occurred very infrequently in our dataset. It is feasible that the dearth of support in the form of tangible assistance in our data set is not accidental, but rather determined by the specific medium investigated here (online). In the early formulations of social support typologies, tangible support was defined as concrete assistance offered to someone who has experienced loss of resources, such as financial assistance, clothing, food, transportation, or housing (Cohen et al., 2001; Cutrona & Russell, 1990). It thus seems a reasonable assumption that tangible support is more likely to occur in traditional, face-to-face support groups compared to online groups; however, this proposition needs to make the object of future research.

Supported by similar previous research (e.g., McCormack & Coulson, 2009; Peterson, 2009), a fifth supercategory, titled unique support communication and comprising categories such as prayer/religious expression, poetry, and humor, was added to the code book. In addition to previous empirical support for the decision to add the fifth supercategory, the inclusion of a supercategory of communication behaviors that do not seem immediately supportive was warranted by theoretical underpinnings of social support communication. Specifically, Cohen et al. (2001) noted that “others can influence cognitions, emotions, behaviors, and biological responses in manners beneficial to health and well-being through interactions that are not explicitly intended to exchange help or support” (pp. 129–130). Table 1 provides a list of categories identified in the analysis, along with frequencies and percentages.
As seen in Table 1, informational support was the most frequently encountered type of social support (n = 731; 57.5%), followed by emotional support (n = 281; 22.1%), network/community support (n = 174; 13.7%), unique support communication (n = 55; 4.3%) and esteem support (n = 31; 2.4%). Data were entered into SPSS 22 and a one sample chi-square test was conducted to compare observed and expected frequency. The chi-square test indicated that the differences between frequencies of the five social support supercategories could not occur by chance ($\chi^2$ = 1273.53, df = 4, $p$ < .0001), likely reflecting the need of group members for specific, rather than generic, forms of support. In response to RQ1, the following section discusses the super- and subcategories of social support identified in the analysis.

**Informational support**

Posts placed in this supercategory offered support through the alleviation of uncertainty regarding postpartum depression and its outcomes and provision of practical guidance to forum members. Informational support was offered in the form of the following subcategories: a) request personal disclosure (n = 41); b) provide personal disclosure (n = 470); c) request information (n = 12); d) provide information (n = 160); and e) provide advice (n = 48). In a typical informational support interaction, a new member of the support group would start a thread disclosing personal information pertaining to how the postpartum disorder had been affecting her health, interpersonal, social, or professional interactions. In response, other members of the forum would reciprocate self-disclosure, but could also provide objective information regarding the disorder, and practical advice regarding treatment or management of the mental disturbance.

Although not prominently featured in our dataset, advice has been identified by extant research as a critical form of social support during times of heightened stress and uncertainty (Peterson, 2009). Advice commonly took the form of guidance offered by forum members, as in the following examples: “Make more therapy appointments, revisit your medications with your doctor, get a haircut, brush your teeth…do just one small thing”, or “[…] you sound like you need in-person, or at least telephone contact RIGHT NOW!”

**Emotional support**

The second most frequently type of support found, emotional support included the following subcategories: a) encouragement (n = 80); b) provide emotional expression (n = 132); c) empathy (n = 43); d) sympathy (n = 11); and e) physical affection (n = 15). The most prominent subcategory of emotional support was provide emotional expression, represented by statements as “I’m glad you’re here”, “So much love to you”, or “This whole thing is a nightmare”. Another form of emotional support was provided relatively prominently in the form of encouragement, which would frequently occur in short interjections, such as “you can do it, mama” or “There IS light at the end of the tunnel!”

Other forms of emotional support, such as empathy or sympathy, were much less present in the data set. It is noteworthy the presence of emotional support offered in the form of physical affection. This category, illustrated by examples like “Hugs to you fellow mamma!” is only rarely mentioned in previous literature, with the notable exception of Braithwaite et al. (1999).
**Network/community support**
The third most frequently encountered form of social support, this supercategory aimed at creating and maintaining a sense of community and occurred in the form of the following subcategories: a) normative introductions and welcoming messages (n = 47); b) community building (n = 38); c) forum maintenance (n = 5); and d) display gratitude (n = 84). A supercategory titled “network” was present in Braithwaite et al. (1999) original code book; however, this supercategory was limited to messages aiming to expand participants’ social network by facilitating connections between them with others who shared similar interests or situations. In the present study, the “network/community support” supercategory was expanded to include welcoming messages posted to define the forum as a supportive and safe space for newcomers. In keeping with Braithwaite et al. (1999) code book, only messages meant to create structural connections between participants, and between participants and the online group, were included in this supercategory. Messages posted to offer emotional support were coded in a different category.

The most frequently types of support in this supercategory came in the form of normative introductions/welcomes (e.g., “Hello to all of you”; “Hi everyone”), community building (e.g., “I wish everyone on here could get together in one big room”; “You are SO not alone”), and display gratitude (e.g., “Thank you all so much. I really appreciate you reaching out to me”).

**Esteem support**
Similar to extant research (Braithwaite et al., 1999; Gray, 2013), messages aiming to boost participants’ sense of worth and esteem were relatively low in frequency. This supercategory was represented by compliments (n = 18) (e.g., “I echo the others here in how brave you are for finding the resources that fit into your life during this time”), validating messages (n = 6) (e.g., “You are already a good mom, because you are doing your best to get well and you care to get well”), and relief of blame (n = 7) (e.g., “[…] and remember it is NOT your fault. You have a medical condition and it is the job of your health-care providers to get you well”).

**Unique support communication**
The fifth social support supercategory made up 4.3% of all messages included in the analysis and consisted of three subcategories: a) prayer/religious expression (n = 10) (e.g., “There but for the grace of God go I”); b) poetry/quotations (n = 20) (e.g., “OCD is a weed. Rip up the roots!”); c) humor (n = 25) (e.g., “[…] and it was even said in English but with a French accent…grrrr. It was so much more than babee blewz”). As noted by previous research, humor is a constant presence in online support groups and arguably an important form of performing social support (Oliffe, Ogrodniczuk, Bottorff, Hislop, & Halpin, 2009; Peterson, 2009; Seymour-Smith, 2013). In the group investigated here, humor frequently took the form of sarcasm or self-deprecation, as in the following examples: “we spent Valentines [sic] Day talking about what stresses us out in our relationship these days…so much fun”, or “That was one of the only things that kept me sane in the early days – or half sane anyway lol”. In other instances, humor would be employed in a more overtly supportive and encouraging manner: “Here’s to all of us for having the courage to go out and do things:))”

**Social support themes**
At the conclusion of the second stage of data coding (axial), the two researchers identified by consensus two evident patterns or themes in the data, perhaps caused by the unique characteristics of PPD as a mental disorder and the population afflicted with it. As discussed in the literature review, PPD is interconnected with the social construction of gender. The data here both reinforced this interconnection and revealed some new considerations health professionals should consider when treating this population of patients.
Theme 1: social construction of motherhood

The first pattern that emerged in the analysis was the reinforcement that gender constructions are part of the problem. Women would often comment on how “this was not how we were told motherhood would be” or “motherhood should be different.” It was evident on the forum that many women struggle with their gender roles, contributing to their suffering:

I think as we grow up were [sic] are taught we are suppose [sic] feel a certain way about being a mom. … I often feel like there is very little time for me. I feel like a servant, or maid.

Several women expressed the rejection of the “natural” and “inevitable” role of motherhood:

[...] it’s very hard when everyone just keeps brushing it off and saying it’s because of my severe depression why I feel this way when inside I feel it’s the fact I had a child and it was not for me that is causing me to be depressed in general.

But beyond rejecting the naturalness and positive narrative of motherhood, these women often pointed to our current culture of motherhood, intensive parenting, as part of the problem:

I want to be perfect for them and I hate feeling like I’m not measuring up in any way. But the standard I’m setting is way too high and I’m sure I’m not alone in that. We care so much so we want to be everything but we can’t be and we have to have compassion for ourselves and know that anxiety and stress comes with the territory of being a mom (along with the joy, love, pride, fulfillment, etc.)

Several women also pointed to media one source of this narrative:

our society has Hollywood-ized everything about motherhood and it is so unhealthy for real moms to try to live up to the standards set by the media. [...] social media can be a wonderful source of support and feeling connected..but ‘the perfect life’ posts can increase one shame, guilt, discontent, feelings of inadequacy..etc.

Many women on the forum indicated they were aware of and suffering from this social construction of gender.

All this is consistent with previous literature (Dennis, 2009; Mauthner, 1999; Taylor, 1996), but should be of note to both feminist scholars and health-care practitioners. For feminist scholars, PPD can be seen as one of the tangible examples of the severe dangers of the social construction of gender. For health practitioners, it is important not just to treat the individual patient, but understand some of the macro-social factors that contribute to the illness and may affect treatment. In this instance, some of these women are driven online for treatment because of the stigma of challenging the dominant gender narrative of motherhood:

If you think about other things in life, like a really awful place of work or something, you can say “I hate my job” and people understand because of its hard parts. If you say “I hate being a mother” people take it to mean you are selfish or hateful. That isn’t true. […] and it IS a shame that we have to sit ’alone’ in the dark on a message board in order to feel understood.

Theme 2: social barriers to treatment

Another strong pattern in the data was salient sharing of barriers to treatment. Many of these barriers were directly related to larger social problems of gender inequality and the social construction of gender. As noted, the stigma and silence about PPD provide one notable barrier for treatment:

Part of the problem in dealing with PPD is that nobody really talks about it. When I started spiraling into depression I felt like I was going crazy, like someone had taken over my brain. I didn’t know what was happening to me.

I’m glad to see a recent trend toward screening for PPD during pregnancy, but it will take a long time for that to become routine in all OB/midwifery practices. And the fact that as moms, we have to worry about child welfare being alerted about us just because we reached out for help.. it’s SO NOT OKAY! We need to reach moms sooner and do a better job of supporting them; not scare them away from getting help.

In one interchange, several women note that the silence adds to the PPD struggle:
I went to all kinds of prep classes and followed all the visits with my doc. No one mentioned anything about mood disorders.

Yes, I agree. I felt cheated and pushed down. They made this a whole worse for me. The stigma of PPD presents a significant barrier to treatment, and in these cases worsened the women’s suffering. Along with the stigma for seeking treatment, women also struggled economically with getting help. Women’s disadvantaged economic position often made them more vulnerable to not seeking treatment.

Spent all day trying to find a psychologist or counselor. I briefly got to speak with a psychologist with great reviews but of course my insurance may not cover her.

I just went through a similar thing last Thursday night and Friday morning trying to find a therapist. It’s so hard to keep putting your lately out there, over the phone, to strangers and telling them a little of your story to see if they fit with you and make you feel comfortable (or as comfortable as you can feel).

For women, who are likely to make less money than men, or be dependent on their husbands economically, financial hardship can be another barrier to treatment.

Finally, there is a growing body of literature about the historical and contemporary unequal treatment of women by doctors. These studies show a lesser quality of care in areas of pain management (Hoffman & Tarzian, 2001), HIV (Carter et al., 2014), heart disease (Kent, Patel, & Varela, 2012; Westerman & Wenger, 2016), behavioral health, osteoarthritis, and critical care (Alspach, 2012). Women in this study noted similar dismissal by doctors and/or mistrust of doctors:

I have chronic depression, which I told my ob-gyn – but he seemed completely at a loss when it came to follow-up care. When I called his nurse (such a sweet lady) she took it more seriously – I asked if you can have PSTD from a hard labor and he actually laughed at me.

Studies have found women’s experiences are more likely to be dismissed than men’s by healthcare practitioners (Hoffman & Tarzian, 2001). Personal experience, as well as historical mistrust, can both prevent women from seeking treatment or trusting the treatment they receive.

I saw a psychiatrist & she said I could have PPD or clinical depression but wasn’t particularly interested in me.

While many women on the forum spoke positively about the treatment that they had received, there was a significant number of women who suffered from the social barriers noted above. The social barrier to treatment may drive these women to seek treatment online. Understanding these barriers is also important in any future health policy decisions.

Discussion

This study revealed both enduring patterns in online social support and unique considerations for this population. Consistent with previous literature (e.g., Braithwaite et al., 1999; Flynn & Stana, 2012; Stana et al., 2017), much of the communication on the forum is informational support. This finding may indicate a fundamental truth of communicating online: it is primarily an information tool and without a large amount of informational support, other forms of social support cannot
occur there. Remarkably, this finding is not congruous with the only other known investigation of an online support group for women with PPD, which found emotional support to be the most salient category (42%), followed by informational support (37.5%) (Evans et al., 2012). This inconsistency, which could result from differences between the groups investigated by the two studies, highlights the importance of more focused research on this important subject. Our findings, however, are consistent with the theoretical foundations of social support communication, in particular, Cutrona and Russell’s Optimal Matching Theory (1990). Cutrona and Russell’s model predicted that, for stressors with elements of controllability, which included transition to parenthood, support focusing on problem-solving strategies (particularly informational support taking the form of advice, input on norms, or feedback on personal decisions) would be more salient compared to uncontrollable events – such as bereavement, loss of relationships, or unemployment – which require increased emotional support. However, not all aspects of motherhood, particularly in the larger context of the social construction of motherhood, are controllable. This might explain the still prominent presence of emotional support in Evans et al. (2012), as well as the present study.

It was noted both in our data and by experts elsewhere that seeking and receiving information about postpartum depression is an important tool in treatment. Dennis and Chung-Lee (2006) found that one of the major barriers to seeking treatment was an acceptance of myths and lack of knowledge about postpartum depression. Indeed, education and informational support have been shown to be a beneficial first step in group therapy treatments of PPD (Ugarizza, 2004). Women suffering from PPD also rank informational support at the top of their wants and needs (Letourneau et al., 2007; Ugarizza, 2004). Informational support is evidently an important part of treatment and encouragement to seek treatment and is key to treatment because of the common misunderstandings and myths about, not just PPD, but motherhood in general.

Perhaps contrary to expectations of a female-only forum, particularly gendered communication was not evident, a finding contrary to work elsewhere (Stana et al., 2017). In a PTSD forum, dominated by military men, researchers posited that a lack of emotional support may be attributed to masculinity norms (Stana et al., 2017). While emotional support was higher in this study than that particular study, the presence of emotional support on the support group investigated here was comparable to other studies of more mixed gender forums (Braithwaite et al., 1999). This finding is notable because it refutes the gender construction of women as more emotional, or needing to give and receive more emotional support. Indeed, the postpartum depression social support movement was founded on the idea that women are uniquely suited to treat one another because of their nurturing nature (Taylor, 1996): “Embedded in women’s self-help communities is a logic that reflects the traditional pattern of gender differentiation found in American families. It is women who generally have primary responsibility for caring for families, neighbors, and friends” (p. 123). The deep irony of postpartum social support is that while it acknowledges the ways the social construction of gender contributes to the disorder, it perpetuates the social construction of gender in its underlying logic of women’s unique ability to care for others. The data from this forum, with more than half of all communication acts categorized as informational support, refutes the social construction that emotional support is what women need or want most.

As should be clear from this study and others, the social construction of gender is a major contributor to the suffering of PPD. It was such a strong underlying factor that it is worth asking whether PPD would exist or exist with such a large presence if we did not have a culture that makes motherhood and intensive mothering normative. Indeed, previous researchers have called PPD a culture-bound condition (Stein & Kruckman, 1983, as cited in Amankwaa, 2003). Some may counter that PPD must exist separately from gender because fathers can also suffer from PPD – but the biggest risk factor/predictor for paternal PPD is maternal PPD (Don & Mickelson, 2012; Musser, Ahmed, Foli, & Coddington, 2013). To the best of our knowledge, currently available literature has not analyzed data that could establish causal relations between gender constructions and PPD. It should be the focus of feminist scholars more directly whether PPD is literally caused by gender constructions. If so, feminist praxis has valuable public health implications as well as political implications.
All these findings lead to some practical implications from this study. The clearest implications lie in guidance for eliminating the social barriers for treatment. As noted from this study and others, the social stigma of PPD may prevent women from receiving proper care (Anderson, 2013; Dennis, 2009; Evans et al., 2012). Letourneau et al. (2007) found the shame and pressure towards intensive mothering to be the number one barrier to treatment. Dennis and Chung-Lee (2006) concluded that informational support is the key to countering this stigma. One possible reason for informational support being such a large part of this data is the need to dispel and refute these common misunderstandings and myths that stand in the way of offline treatment.

The economic barriers discussed by the women on the forum are also a significant problem for seeking treatment. Ugarizza (2004) also noted this in her study of offline groups. Attendance at such groups created significant hardships in terms of finding childcare and scheduling attendance with other responsibilities. The economic barrier to treatment is compounded by the fact that low socio-economic status is one of the risk factors for developing PPD (Wang et al., 2011). But, to be clear, this economic barrier is also a social barrier as long as women are systemically economically disadvantaged through pay inequality and workplace policies that are not family-friendly, such as paid family leave policies and flex-time. Working for these policy changes would have wide-reaching consequences, including enabling these women to more easily seek treatment.

Finally, health-care practitioners should be aware of the historical and cultural distrust some women may feel toward medical professionals in order to aid the health provider–patient interaction. Much of the pushback to medicine we see in feminist discourse from the natural and home birth movement and anti-vaccine movement may be attributed to this distrust (Yochim & Silva, 2013). Many women in this study noted this barrier. Because, as previous literature suggests, women/mothers often perceive health-care professionals as lacking understanding of their complex medical conditions, Dennis and Chung-Lee (2006) also recommended health-care practitioners demonstrate a “willingness to share their time in an unhurried atmosphere and to be aware of nonverbal behavior” (p. 328). If practitioners do not approach this interaction with cultural sensitivity, these women might be driven away from treatment.

One of the reasons these women were driven to online social support comes from precisely the social barriers noted above. Stigma, economic difficulties, and mistrust of medical personnel are all alleviated through the online forum. The forum we studied was anonymous, which helped lessen the social stigma for treatment. Economic barriers were easily overcome by there being no cost for participation in the forum. Other common economic complications, such as travel expense and childcare are also not required in online forums. The forum also is available 24 h a day and seven days a week, leading to no scheduling difficulties. And finally, the women are also helping one another, and thus there is no health-care practitioner to mistrust. The women know that the other women responding can relate to and understand their suffering. Viewed from this perspective, online social support is superior in reaching and serving a stigmatized, marginalized population. However, few experts would argue that online social support is sufficient to treat PPD. Although how perfectly online social support addresses these common problems does raise important questions about how to use online social support as a method to eliminate these social barriers to treatment: Is there a way to use the capacities and benefits of online social support to encourage offline support and seeking further treatment? Can health-care practitioners use these capabilities and benefits more widely to reach those who won’t or can’t seek treatment? These would be relevant questions to explore in the future.

Limitations and future research

This study is one small part of this growing literature, and, as such, there are some limitations and future questions, which should be noted. The most obvious limitation of this study is that it investigated only one support group, with specific characteristics – a closed and closely monitored
community – and thus these findings cannot be extrapolated to the entire spectrum of online PPD support groups. Furthermore, the monitoring of the support group by medical professionals could also significantly change social support dynamics in this group compared to unmonitored forums. Also, the present study examines the nature of this online social support group, but it cannot, with the present methodology employed here, examine the quality of care or value the women may derive from participation. Future research in the area should pair this method with clinical assessments or qualitative interviewing to get a fuller picture of the benefit of online social support.

Disclosure statement

No potential conflict of interest was reported by the authors.

References


Peterson, J. L. (2009). “You have to be positive.” Social support processes of an online support group for men living with HIV. *Communication Studies, 60*, 526–541. doi:10.1080/10510970903260368


