

Pregnancy Reclaimed

Art Therapy as Intervention for Depression and Anxiety

Depression and related mental health disorders are common during pregnancy and the postpartum. Despite cautions against the use of psychotropic medication during pregnancy, many physicians continue to use medication as a frontline treatment. A number of theories have been put forth in an attempt to explain mental health struggles during pregnancy, yet there is inconclusive evidence that hormones or other physiological changes during pregnancy precipitate this occurrence. Instead, it is theorized that sociocultural factors are at the root of female struggle during pregnancy and into the postpartum. Women find themselves in a culture that sexualizes, commodifies, and medicalizes pregnancy then capriciously and callously evaluates and criticizes the postpregnancy recovery. For these reasons, art therapy is perfectly positioned to support the depression and anxiety symptoms experienced by women during pregnancy. If women during pregnancy are allowed opportunities to use the expressive arts for wellness, it is anticipated that this means of coping will carry over to the period of the postpartum and beyond.

As a licensed psychologist, I have been in practice for over twenty years with two other female practitioners. We pride ourselves on intentionally creating a female-centred therapeutic environment. Yet it was not until I became professionally affiliated with a nurse midwife who referred patients to me that I came to recognize the manifold ways in which misogyny infiltrated the sacred space of pregnancy and motherhood. My clients entered treatment with symptoms of depression and anxiety. As a clinician, I immersed myself in the literature and found that these women were not isolated cases, but, in fact, were illustrative of the larger population of pregnant women suffering from mental health issues.

From a Western cultural viewpoint, a wanted pregnancy with the potential for future progeny is considered a wonderful occurrence, thought to be met with a powerful, positive emotion. It is presumed that the expectant mother and surrounding community will celebrate this most sacred process. Pregnancy is widely regarded as a miracle of sorts. Medically, socially, and spiritually, this process is viewed with wonderment; it is from a single cell that a new life is ultimately created. The myth of pregnancy, largely an idealized view, positions the expectant mother as emotionally happy and well. The belief is that she will experience a greater sense of joyfulness and elation at the prospect of creating new life. It is further presumed that pregnancy and impending motherhood will give her life greater purpose and significance (Solomon).

This idealized perception is then challenged when contrasted with a growing body of research that finds a considerable number of women experience emotional difficulties during and after pregnancy (Bonari et al. 727). A significant number of women experience depression and/or anxiety symptoms during pregnancy and in the twelve months postpartum. It has been found that these symptoms can initially develop during this period of time or worsen in terms of intensity. It is presumed and medically theorized that hormonal changes contribute to the increased risk of depression and anxiety (727). However, precipitating conditions are multifactorial and, thus, require a more nuanced approach addressing relevant social and cultural factors. This is true for the period of pregnancy as well as the postpartum. Stephanie Knaak in her article "Having a Tough Time" discusses the emotional struggles women face during the postpartum period: "Equally as important, socio-cultural and feminist research has shown how cultural factors, such as idealistic 'motherhood mystique' discourses, motherhood's devalued status, and a lack of positive social structuring of the postpartum period all contribute to the proliferation of emotional difficulties after childbirth" (81).

In response to the needs of our clients, my colleagues and I sought to create an affirming female space, antithetical to imposing medical offices; nevertheless, we failed to recognize how even in this feminist environment, our clients were bombarded with narratives and visual imagery of idealized and sexualized pregnancies. A cursory look at the magazines stacked on our waiting room tables showed story after story providing tips on how to keep fit during pregnancy and on how to quickly return to a prepregnant figure; most notably, they contained full page spreads featuring pregnant supermodels and actresses showing off their small "baby bumps." Not only were my clients subjected to these damaging cultural standards and ideals before they entered our practice, but we unwittingly reinforced and normalized these faulty expectations.

This article explores the current struggles that women experience during pregnancy and childbirth. With increased medical surveillance and attendant

intervention, the medical community has stripped pregnancy and childbirth out of the hands of women. The emotional repercussions have been widespread. No longer connected to a knowledgeable and informed female system, women find themselves at the mercy of a medical system whose priority is to evaluate, caution, and intercede in a natural process. With this medicalization, there has been the loss of respect for women's intuitive awareness and the resultant emotional and spiritual changes that this experience engenders.

The Sexualization of Pregnancy

Imogen Tyler in "Pregnant Beauty" argues that the 1991 *Vanity Fair* photograph of Demi Moore, naked and in late-stage pregnancy, "marked the breaking of the powerful cultural taboo around the representation of pregnancy" (23). Provocative, this image, shot by famed photographer Annie Leibovitz, quickly became a media sensation. From this initial experience, the "bump" has ushered in a new wave of sexualized imagery of the pregnant form. On one hand, feminists celebrated that the pregnant body was no longer hidden from public view or draped in modest clothing to hide this physical transformation. Tyler maintains that the maternal is no longer "confined to traditionally domestic or child-oriented spaces, such as private homes, hospitals, parks and playgrounds" (21). However, revealing the pregnant body in such an erotic fashion simultaneously ushered in a glamorized pregnancy aesthetic outside a woman's control and regulated by the media. The intimate experience of pregnancy is now subject to the male gaze; the woman is evaluated and scrutinized based on meeting unachievable cultural ideals, much as nonpregnant girls and women are forced to measure their beauty based on media representations. "Until the 1990s," Tyler remarks, "pregnancy provided even the most famous women with some respite from the scrutiny and documentation of their bodies, clothing and personal lives" (27).

One year later Demi Moore again graced the cover of *Vanity Fair*, donning only body paint. Appearing in an "outfit" complete with a vest and tie, this visual iconography indicates a kind of sexualized yet stereotypically masculinized identity. It appears that pregnancy did not affect her physically or emotionally; this glamorized photograph shows a quick and seamless return to a prepregnancy form. A close reading of the cover reveals that pregnancy had no visible effects on the actress; there are no stretch marks, no breast changes and, notably, no baby. Instead, as the title of the article reveals, this is "Demi Moore's Birthday Suit," a clear play on her nudity, her "wearing" of a suit, and her rebirth as a strong, independent woman. If change occurred to her because of pregnancy, we are not privy to it. Reading these covers intertextually, it is reasonable to conclude that the earlier image celebrated her sexualized pregnant form, not

her newfound identity as mother. In a patriarchal society that still traffics in denying mothers their complex identities, Moore cannot publicly declare her motherhood and still be desirable. It is not sufficient to live well—to eat nutritiously and be active—it is now expected for women, both during and after pregnancy, to conform to standards of media-defined attractiveness.

It would be remiss to ignore the cultural climate, including media culture, that permeates the lived experience of our clients. Understanding the images and cultural messages provide a necessary context to read the worry, sadness, and dissatisfaction that is powerfully felt and expressed in session. Nonetheless, a thorough consideration of the literature on mental health during pregnancy is required to fully appreciate the scope and depth of these mental health challenges.

Pregnancy and Mental Health Challenges

A review of the literature suggests that pregnancy is not a protective factor for the development of depression and anxiety symptoms. In fact, during pregnancy, a significant number of women—some studies indicate up to 25 percent—may meet criteria for mental health disorders (Bonari 727; Swanson et al. 553). Of those, significantly fewer are identified and treated (Vesga-Lopez et al. 805). For some who are afflicted, this symptom profile is a continuation of previous episodes of depression and/or anxiety (Dimidjian et al.135; Hendrick 3). In these cases, pregnancy may increase the risk of a reoccurrence or exacerbate a mental health episode. For some women, pregnancy and the postpartum period usher in depression or anxiety symptoms for the first time (Hendrick et al. 135). Mental health issues affecting this population are of significant concern due to the potential adverse effects that may result (Bonari et al. 727). Studies indicate that depressed women, presumably because of their suffering, are more likely to engage in unhealthy behaviours, which place themselves and the developing fetus and/or newborn at greater risk for harm. It has been found that there is an increased potential for alcohol and drug use, a lack of prenatal and infant medical care, impairment in the attachment bond, and self-harming behaviours (NIHCM 5).

Although greater societal awareness of postpartum depression exists, studies suggest that depression and anxiety are more likely to occur during pregnancy (Figueiredo and Conde 247). It is important to consider that disorders of depression and anxiety are strongly correlated. Some research suggest that the comorbidity of the disorders is as high as 60 percent, which means if diagnosed with a major depressive disorder, the client is more likely to be struggling with an anxiety disorder and conversely as well (Kaufman and Charney, 69). Some experts posit that the symptoms of each specific disorder are, in fact, capturing only select pieces of a larger, multifaceted condition (McGlinchey and

Zimmerman 473). It is, therefore, not surprising for clinicians to see clients, including pregnant women, who are diagnosed and receiving treatment for both psychiatric disorders.

A concern when working with pregnant women is that mental health problems may be unheeded by medical professionals given that select symptoms of depression and/or anxiety resemble the experience of a normal pregnancy (Cohen et al. 275). For example, an anxiety disorder may be difficult to determine because a certain amount of worry is normal in everyday life, especially when pregnant. Additionally, during pregnancy, mood fluctuations and weepiness may occur, fear is commonly experienced, sleep and eating patterns may change, and mental foginess is often reported. Given the dramatic physical changes that occur, women often report body image issues. If these symptoms persist, intensify, and co-occur with feelings of guilt and worthlessness, a loss of interest in activities, and a withdrawal from social engagement, it may signal that a more significant mental health diagnosis is present (Cohen et al. 275).

Identified Risk Factors

Several potential causes for the development of mental health problems during pregnancy and the postpartum have been postulated. One theory that has gained much interest is the role hormones play in the manifestation of psychiatric symptoms (Bonari et al. 727; Brummelte and Galea 767; Hendrick et. al. 93). This idea is commonsensical and consistent with a medical conceptualization of the female struggle. It is theorized that hormones, which cause the abrupt and dramatic physiological changes during the period of pregnancy, fuel an emotional vulnerability to mental health symptoms (Hendrick et. al. 93). The hormones that have been studied include progesterone, estrogen, prolactin, cortisol, thyroid, oxytocin, and vasopressin. However, after considerable research, there is a lack of consensus regarding the significance these hormonal changes play in influencing psychiatric symptomatology during pregnancy and the postpartum. Victoria Hendrick et al. state that “it may be that despite good theory and rigorous testing, a medical explanation for this occurrence does not exist” (98).

Other risk factors focus squarely on psychological, social, and cultural variables that influence the pregnant woman’s quality of life. Exposure to excessive stress, living alone, inadequate social support, partner conflict, financial hardship, and a history of trauma place the pregnant and postpartum woman at increased risk for the development of mental health challenges (NIHCM 5). Taken alone, or in combination, these risk factors can exact a significant toll on the wellbeing of the pregnant woman or new mother.¹

Conventional Treatment

The medical community's attempt to ameliorate these emotional challenges often includes the prescribing of psychotropic medication (Dalke et al. 385). This can be a complicated proposition when medicating a pregnant or nursing mother. Determining a safe and effective medication for this population has been the subject of considerable debate (Cohen et al. 277). Controlled studies have been limited because of the potential risks for the mother and developing fetus (Dalke et al. 386). Given the traumatic history of medication use with pregnant women, many are reluctant or unwilling to take even those medications deemed to be safe. Those women who eventually relent may suffer fear and worry about the possible negative and unknown side effects, which complicate their treatment and, potentially, render the intervention counterproductive. It is worthy to note that many experts in the field believe the risks of newer, select psychotropic medications are low and potentially less deleterious to the mother and developing fetus than leaving the depressed woman untreated (Bonari, et al.726).

Given the potential risks, recent guidelines by the American Psychiatric Association and the American Congress of Obstetricians and Gynecologists, encourage pregnant women with depressive symptoms to opt for psychotherapeutic treatment instead of psychotropic intervention. Nonetheless, despite these concerns, the use of antidepressant medications continues to be offered as a frontline treatment (Dalke et al. 385). In select and presumably severe cases, the use of psychotropic medication may indeed be necessary and appropriate (Cooper et al. 544). However, despite these institutional warnings, everyday practitioners continue to see psychotropic medication as an acceptable treatment for pregnant and postpartum women. This begs the question that if the struggles of women are not primarily physiological, but created by sociocultural factors, is medication the most appropriate treatment? One could argue that the medical community is treating the symptom but failing to address the true problem. Experts in the field must carefully consider those interventions that effectively address the underlying cause. It could be reasoned that interventions aimed at ameliorating these sociocultural concerns in a woman's life may be costly, time consuming, and beyond the scope of traditional medicine. Nonetheless, a depressed woman may need just that type of social and community-based support to heal her emotional wounds.

The vast research on wellbeing identifies family and community as necessary for optimal health and wellness (Lee and Szinovacz 660). Therefore, it stands to reason that the pregnant woman, too, benefits from this connectivity. Historically, families lived in close physical proximity. Hence, there was a ready system of physical and emotional support for the young to rely on during life

transitions. A demographic trend is for adults seeking education and employment to move from their home communities, resulting in the “nuclearization of families” in which a separation from extended family and close friends occurs (Sathyanarayana and India 296). For women, however, pregnancy and motherhood are important rites of passage. Thus, women at this stage of life benefit from the connection to close allies who are more knowledgeable and experienced. Historically, women provided support to women throughout the process of pregnancy and early motherhood (Cahill 339). Grandmothers, mothers, aunts, and knowledgeable women within the community were the vestiges of wisdom who supplied essential care to the neophyte. This continuous support and attention allayed the young woman’s worries while simultaneously honoring the sacred process of pregnancy and motherhood. This ongoing dialogue among females demystified a process that can, at times, be bewildering. Given the significant body changes and emotional upheaval that often accompany pregnancy, this mentorship provided an essential framework for making the experience an organic part of the life cycle. Pregnancy and birthing were regarded as healthy and predictable events in the lives of women.

A natural offshoot of this type of support included doulas and midwives, who, with greater experience and training, were integral players in community support and were available to pregnant women. Although outside of the family circle, these helpers allowed for a seamless entrance into the pregnant woman’s life space. Given the profound changes experienced during pregnancy, the expectant mother’s questions, worries, and uncertainties would be promptly and meaningfully addressed by knowledgeable helpers (Staneva et al. 570).

Midwives, Feminist Birthing Practices, and the Aftermath

One could argue that the breakdown of female community during pregnancy is not a recent phenomenon, but, in fact, can be traced back to the removal of midwives and other women from birthing chambers (Tamulis 368). Women, for centuries, have worked as midwives: these figures are mentioned in the Bible, and in records throughout Ancient Greece, Rome, and West Africa. As Valerie Lee in *Granny Midwives* explains: “Historical midwives include Socrates’ mother. Although many of the women from antiquity, including nuns and ladies of the manor, performed their duties as acts of charity, British history records a tradition of women who delivered babies for pay” (25). Throughout this time, men were barred from delivery rooms. Until the seventeenth century in the United States, “childbirth was firmly located within the domestic arena, an exclusively female domain” (Cahill 337). In fact, there were laws enacted in some American colonies that outlawed a male presence in birth chambers, and in “1522, German physician Wertt, who had camouflaged himself as a

woman so he could study childhood in the lying-in chamber, was burned to death for such a transgression” (Lee 174). Throughout the seventeenth and eighteenth century, men worked to discredit and displace midwives from the sphere of birthing and argued that they did not possess the requisite medical knowledge or intelligence to care for pregnant women (Mitchinson 163). Initially, male involvement in birthing was relegated to the most problematic deliveries with typically devastating outcomes for the newborn and/or mother (Johanson et al. 892). In the nineteenth century, through the use of effective lobbying, physicians positioned themselves as “men of science,” capable of creating superior care with safer and healthier delivery, which undermined the power and influence of midwives (Mitchinson 163).

This male takeover of birthing culture extended well beyond the delivery room. Historically, midwives not only served the pregnant woman’s physical needs but cared for other children in the home, cooked meals, mended clothes, and generally tended to the family’s wellbeing. They created a healthy environment in which to welcome a new child. Beginning in the late eighteenth century, American society moved from a reverence for midwives and midwifery practice to a reliance on a medical model of delivery largely because of the aggressive campaigning of the American Medical Association in the United States and the establishment of all-male medical schools. It was during the late nineteenth century that male doctors fought against midwives (Brodsky 49). This is in contrast to Europe where there was less contention, and the professions negotiated boundaries serving to more effectively co-exist (49). It is with the introduction of physician control that the condition of pregnancy became a “term of pathology,” warranting obstetric involvement, and that midwives began taking a more diminished role (Tamulis 365).

In order to enact an ideological shift in female health care, male physicians discredited the midwives: they were charged with being in concert with the devil or, because they possessed no formal obstetrical training, hazardous to the health of the mother and baby.² This led to more upper-class women rejecting midwifery and subjecting themselves to male physicians and a new philosophy of birthing practices (Tamulis 369). As male obstetricians took over birthing rooms, surgical procedures and instruments became the norm (Mitchinson 163). No longer was childbirth a female-centred experience with multigenerational women participating (Hutchinson 112). It was now routine for the pregnant women to be alone with a male physician and attendant, who was, more likely than not, also male. Women’s labouring bodies became literally open for the male gaze. Women were discouraged from actively participating in their own labour and began delivering babies on their backs, often with the use of forceps—an instrument that was, for some time, kept a secret from the labouring mothers (Brodsky 50; Tamulis 367).

Peter Chamberlen, the British surgeon who in the seventeenth century invented forceps, “blindfolded his women patients so that they would not see his obtrusive and intrusive box” (Lee 28). Forceps are contested sites: “connections between forceps and phallus are not to be ignored. Both are hidden tools used to penetrate women’s bodies” (Lee 28). Forceps are an apt metaphor for the treatment of pregnant women, not only during labour and delivery but also throughout their pregnancy. Pregnant women are subjected to patriarchal, violence and their bodies are open for public consumption without true informed consent. Our culture’s promotion of an eroticized pregnancy aesthetic and the medicalization of pregnancy are merely other iterations of the forceps; they are outside women’s control, intrusive, violent, and, in many cases, we, as women, are blind to our own violation.

Medicalization of Pregnancy

With the medicalization of pregnancy, or what some critics label “modern engineering obstetrics” (Cahill 338) comes a pathologizing of a normal and healthy biological event. Indeed, as Peter Conrad in “Medicalization and Social Control” explains, “medicalization describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders” (225). It follows, then, that pregnancy is regarded as “risky” and requires testing, rigidly scheduled obstetric appointments, and constant monitoring. Questions and concerns in between appointments are triaged and funnelled into a que. Women are left waiting for reassurance by medical experts that they and their unborn are healthy. The medicalized modern birth culture is one founded on obstetric intervention, which can elicit a cycle of medical treatments, or as Heather Cahill in “Male Appropriation and Medicalization of Childbirth” remarks: “It seems the problems occurring as a result of one intervention usually require other interventions for their treatment” (339). This process has potential mental health ramifications for the expectant mother. In fact, “the routine use of ‘high tech’ interventions such as epidural anesthesia, forceps and caesarean section are closely associated with the incidence of post-natal mood disturbance” (339).

The current mindset around pregnancy is that the condition carries with it significant risks, which legitimize the need for an ever-growing body of prenatal tests (Schaffer). Women may not fully understand the rationale for recommended testing or how to interpret the results (Kukla and Wayne). The perceived threat of potential calamity is omnipresent in this medicalized system, as the obstetrician practises defensive medicine to mitigate the liability of a negative outcome (Johanson 893). With this mindset, pregnant women are subjected to an ever-increasing number of unnecessary tests and interventions

(893). It is the doctor's prominence and authority in this space that bespeaks the inherent peril of this endeavour and the voices of women have essentially been silenced.

Prenatal Diagnosis and Screening

Unfortunately, this prenatal experience has become significantly more confusing with the advent of prenatal genetic testing deemed by its critics to be unreliable and misleading. Although not purported to be mandatory, the American Congress of Obstetricians and Gynecologists now offers all pregnant women, regardless of age, health, and familial risk factors, prenatal genetic screening (McGowan; Soriano). Ushered in by the human genome project over a decade ago, unregulated prenatal screening tests have become mainstream. Insurance companies are now increasingly allotting remittance for this screening, even with low-risk women. The manufacturers' claim that this new, less invasive type of genetic testing—requiring only a simple blood draw to administer—is far superior to traditional methods (McGowan). The pharmaceutical companies advertise their testing products and promise women, simple “clear answers” with catch phrases offering women “peace of mind” with their use (Schaffer). Given the shortcomings and limitations of this process, it has added more stress and uncertainty to an already medicalized pregnancy.

Prenatal testing rests on the assumption that with greater knowledge of the health of the fetus, pregnant women's lives will be meaningfully enhanced. It is presumed that with this so-called essential information, women will be better able to make informed choices about pregnancy outcome. However, the deficiencies associated with this and other testing is not clearly put forth by the manufacturers, which leads to erroneous assumptions that the test results are essentially accurate (McGowan). The error rates of these tests are often not well explained or understood by pregnant women. Of greater concern, the attending physicians may, too, have insufficient understanding of the limitations of these screening instruments generally, and the meaning for their patients, specifically (McGowan; James). One physician, Mark Leach, in “Your MaterniT21 Test is Never Positive,” simply states, “NIPS [non-invasive prenatal] tests remain just screening tests. They are never truly positive or truly negative.” He further explicates the dubious nature of these outcomes: “NIPS tests are screening tests. They are a recalculation of the probability that your child may—emphasis on MAY—have Down syndrome (or one of the other conditions they test for). Every one of these tests has false positives and false negatives.” Leach's comments are particularly important given the fact that one screening company, Panorama, states that the test is “99% Accurate, Simple & Trusted” (Daley).

Errors linked to these screening instruments have been at the centre of high profile exposés. Both false positives and false negatives have been reported in the media. Based upon test results, some patients were assured that the fetus they were carrying was without chromosomal abnormality but found at birth that a disability did indeed exist (James; McGowan). By contrast, others were erroneously informed that they were carrying a fetus with a genetic syndrome. Accounts from those women adversely affected describe the emotional anguish they experienced as they attempted to understand the disabling condition for their offspring. Some of these women opted to terminate their pregnancies based upon this screening data, later to find that the tests results were wrong (McGowan). The New England Center for Investigative Reporting found that “likely hundreds of women are aborting fetuses based on this new generation of testing. One company reported a 6.2% abortion rate based on screening results alone—and without further testing, there is no way to know how many of those may have been due to a false positive” (James). The testing companies continue to state that their products are superior and place the responsibility for accurately deciphering the test results squarely on the physicians, but in many cases, the physicians lack adequate information about the test to provide good counsel to their patients (Daley). Although it is outside the scope of this article to discuss the benefits or lack thereof of any specific prenatal genetic screening, these tests do reveal that the culture of pregnancy is hypermedicalized, which can engender in expectant mothers’ feelings of confusion, pain, and sorrow, which can lead to anxiety and depression.

Art Therapy: An Innovative Approach to Treatment

A conceptual framework that appreciates the cultural reality existing for pregnant women should be at the forefront when creating an effective treatment approach. Although nearly absent in the literature, sociocultural factors are fundamental to the pain and struggle faced by women during the antenatal and postnatal periods. Mental health providers should refrain from joining with other systems to pathologize women, but instead critically reflect on the issues faced by women during these most important life events. Women find themselves in a culture that sexualizes, commodifies, and medicalizes pregnancy, and then capriciously and callously evaluates and criticizes the postpregnancy recovery. Through it all, American culture “both underestimates and undervalues vital psychosocial changes occurring within the woman as she undergoes this important transition in her social statuses, i.e. from woman to mother” (Cahill 339).

I draw upon the work of Shaun McNiff when I propose that the arts have the potential to heal through creativity (5). Though largely unrecognized,

expressive therapies have been used in the mental health, rehabilitation, and medical arenas for centuries. The expressive arts may involve art, music, dance/movement, drama, play, and creative writing. Within the context of psychotherapy and counselling, the expressive arts then serve a therapeutic function by supporting clients to reconcile emotional conflicts, increase self-awareness, solve problems and increase self-esteem (American Art Therapy Association). It is predicated on the belief that all people have the capacity and the need to express themselves creatively (Malchiodi, "The Art and Science" 1).

Despite the view of art therapy as a "new age" treatment, "uses of the imagination in healing are as old as the most ancient shamanic cultures" (Long 315). Seminal psychotherapeutic theorists have long highlighted the importance of artistic endeavours in the therapy process. In the 1900s, Sigmund Freud, the father of psychoanalysis, recognized the usefulness of artistic expression for those "patients" unable or unwilling to process material verbally. He used the visual arts as a tool to facilitate emotional release and potential catharsis (Rosenzweig 237). Similarly, Carl Jung has observed that drawing personal mandalas, a graphic symbol depicting the universe in Hindu or Buddhist practice, had a positive and calming influence and engendered psychic integration with his patients (Henderson et al. 148). Additionally, Jung saw the benefits of emotional expression through the visual arts generally, and he encouraged his patients to engage in this practice (Hoffmann 199). More recently, psychologists have studied the role of art making in treating conditions as far ranging as post-traumatic stress disorder and traumatic brain injury (Malchiodi, "Handbook of Art Therapy" 2). According to the American Art Therapy Association, employing art in mental health settings (such as psychiatric hospitals, schools, residential treatment, and crisis centres) allows clients to "reduce anxiety and increase self-esteem," while "improv[ing] or restor[ing] a client's functioning and his or her sense of personal well-being."

Psychotherapeutic treatment may be informed by a number of different theoretical orientations, though unique in its philosophy and treatment, each has the potential to facilitate healing (Spooner 163). Moreover, art therapy may be used as an adjunct to a therapeutic approach or a stand-alone treatment (Malchiodi, "Expressive" 7). Many therapies—for example, psychodynamic, CBT and interpersonal—may incorporate expressive modalities into treatment to achieve positive outcomes (7). In this context, expressive therapies are conducted within the context of psychotherapy and counselling by professionals from a variety of backgrounds (Bucciarelli 153). Given its powerful healing potential, many providers not specifically trained as art therapists, naturally call upon expressive therapies in their work. By contrast, art therapists are mental health professionals who additionally have substantial art preparation and may possess a license or certification in this discipline (American Art Therapy

Association). The visual arts, given their accessibility, universal appeal, and low cost, command a primary position in the field of art therapy. When surveyed, art therapists most often report an eclectic counselling approach that draws upon pieces of different theories; the expression of art, however, is the primary treatment modality (Vick 10).

Art making as therapeutic treatment should be explored for pregnant women because, first and foremost, they are in the process of creating. Outside the discourses and institutions that circumscribe and appropriate this experience, women's bodies are engaged in producing new life. In this intensely imaginative time, women can externalize and materialize their physical, psychological, and emotional selves. According to Randy M. Vick in *Handbook of Art Therapy*, "art making is an innate human tendency, so much so it has been argued that, like speech and tool making, this activity could be used to define our species" (6). The definition of innate is "inborn," meaning that which has existed from birth. Read from this context, art returns us to this natural state. Pregnancy and childbirth, which have been transmogrified into a sterile, male-centric realm, have, in many ways, been taken out of women's hands. Thus, it is art making that allows for a realignment of body and self, a restoration of mental and spiritual health (Stuckey and Nobel 254). By literalizing creativity through art, women reclaim agency and wrest control of their reproductive and productive selves.

For these reasons, art therapy is perfectly positioned to support the depression and anxiety symptoms experienced by women during pregnancy and the postpartum period. If during pregnancy, women are allowed opportunities to use the expressive arts for wellness, it is anticipated that this means of coping would be carried over to the period of postpartum and beyond. Aleksandra Staneva et al. in their meta-synthesis of qualitative research describe a number of emotional themes specific to these populations, including inertia, self-silencing, denial, fear, and loss of control (571). Art making is powerful for it permits physical action and experimentation that is material and tangibly felt (Avrahami 6). Through this engagement, there is an increased capacity to contemplate feeling states, make sense of life experiences, and create a potential course of action with the goal being personal growth, self-acceptance, and emotional healing.

The Case of Celeste

The powerful healing potential from this mode of therapy was made real to me in my work with a thirty-one-year-old client, whom I will call Celeste. When referred to therapy by her OB-GYN, Celeste was sixteen weeks into her second pregnancy. Celeste presented as an attractive, well-groomed woman, who was polite and well spoken. She appeared upset and nervous throughout our initial sessions alluding to her fear of increased depression. She described

a difficult postpartum depression after the birth of her first child, Katie, now age three. Celeste had been in a committed relationship with Luke for seven years total, and had been married to him for the last four years. She described this marriage in positive terms and stated that she and Luke had a strong bond and enjoyed a happy and comfortable life together. Her daughter Katie was described as a happy and responsive child, who was physically healthy and was meeting her developmental milestones on time.

Celeste comes from an affluent and well-connected family system. Her parents own a successful business, and Celeste is a beneficiary of this resource. Celeste described enjoying many friendships, including those with extended family members. Celeste, being the only daughter in her family of origin, is well cared for by her parents and brothers, who have taken over the business. She is not obligated to maintain a rigid work schedule, and can work at the business when she desires.

After the birth of her first child, Celeste became depressed within two months. Celeste described much guilt and anguish over her emotional state. From her adolescence, Celeste reported wanting to have a child but after suffering from depression, she questioned if she was indeed “mother material.” She was placed on a routinely prescribed antidepressant medication by her OB-GYN, which significantly helped her through her difficulties. In an effort to avoid exposing her baby Katie to the drug, she abruptly stopped breastfeeding, which she described as difficult for both her and the baby. Celeste did not seek mental health support, counselling, or therapy, at that time but instead spent more time with her mother and began an intensive workout schedule. Celeste reported that within a three-month period, she felt much better and was seen by her family as back to herself. She stated that an added benefit of this routine was that she had returned to her prepregnancy weight and physical appearance.

Now that she was pregnant again, she was fearful and sad. When realizing she was pregnant, she abruptly stopped her antidepressant so as not to expose the neonate. The OB-GYN provided research showing the increased potential for depression to reoccur during this pregnancy and into the postpartum. The doctor suggested she consider staying on the medication, since it had few risks, but left the decision to her. After discussion with her husband and family, Celeste decided that she would not stay on the medication and resigned herself to suffering through her pregnancy and returning to the medication immediately after the birth of her child. The doctor, Luke, and her family encouraged her to submit to therapy throughout her pregnancy to ensure her basic wellbeing and safety. Celeste stated in frank terms that therapy was most likely a waste of her time, but since she had committed to this plan, she would attend therapy until her delivery.

Celeste attended therapy faithfully, but her lack of engagement in this process was obvious. After several weeks of rather stagnant discussion, I introduced art materials in an effort to foster increased interest. Immediately, Celeste seized on the water colours, which served to spark an odyssey of emotional exploration and greater self-understanding. At first, Celeste was more involved in the process of experimentation with the paint, without much verbal output. Given her increased enthusiasm, I permitted this period of self-directed exploration.

After several sessions, however, a dialogue developed wherein Celeste expressed her previous idealized beliefs about marriage and motherhood. At this point, she painted images of sunshine, flowers, swings, and baby blankets, which for her exemplified the romanticizing of life as a wife and mother. Through art making, however, she discovered the truth of her experience-- how she actually felt in her life and marriage. Her paintings became rather sketchy and dark with themes of physical ugliness and emotional sadness. Ultimately, Celeste recognized this discrepancy and could discuss her relationship struggles at the time of her first pregnancy and into the postpartum. Her husband, who had always been interested in her physically and was a willing sexual partner, became indifferent and even rejecting. Initially she attributed his lack of sexual interest during pregnancy to his worry about her and the baby's physical safety. But even after the birth of their daughter, he rebuked her sexual advances. Celeste stated he appeared to find her round and full figure unappealing. As she discussed these experiences, she became more verbal and engaged. Soon, thereafter, Celeste experienced reduced depressive symptoms, was more energetic, assertive, and freely discussed her emotional needs. Ultimately, she shared these insights with her husband, and they accepted a referral to a marital therapist.

Celeste stayed in individual therapy throughout the course of her pregnancy and for a year after delivery. During her pregnancy, she got involved in pregnancy fitness classes at the community centre, and enrolled in a painting course at the community college. She no longer met diagnosis for depression and successfully delivered a healthy, full-term baby boy. Celeste did not return to medication after the birth of her son and was able to breastfeed for a period of nine months.

It is interesting to draw upon various psychological theories to explain the emotional struggle and eventual healing that occurred in this case; a number of theories could be effectively applied. However, I practice largely from an Adlerian perspective informed by feminist theory, which easily permits the integration of expressive modalities (Graham and Pehrsson 11; Otting and Prosek 79). From this theoretical orientation, Celeste's experience must be contemplated from a sociocultural perspective. Given the messages that girls, adolescents, and women in the dominant culture receive, Celeste's worthiness was believed to be partly based upon achieving an idealized state of marriage,

family, and motherhood. Celeste was then confronted with the discrepancy between this idealized image and the deficiencies she lived with in her partnership. The failure to secure a safe and satisfying marital relationship at the time of pregnancy and during the postpartum left Celeste feeling alone and undesirable, which was later found to be at the centre of her emotional conflict. Ultimately, the pain was turned inward and a depressive episode resulted. I contend that it was an art therapy intervention—the use of a nonthreatening visual medium—and not the course of psychotropic medication that facilitated Celeste’s healing.

Celeste is but one of many examples illustrating the power of expressive therapies to support emotional healing. Pregnant and postpartum women, given sociocultural variables, are at risk for the development of depression and anxiety that pose a true hazard for the mother and child. Despite these cultural and medical exigencies, it is the clinicians’ responsibility to attend to and care for their clients. Mental health professionals need to get past the false assumptions that are offered as cause and treatment, and instead prioritize the pregnant woman’s emotional and spiritual needs. Art therapy as a clinical intervention offers a particularly resonant treatment for pregnant women. It is a noninvasive and holistic form of therapy that, by its very nature, valorizes the pregnant woman’s creative processes while supporting her healing and wellness.

Endnotes

¹In the United States, women of colour are more likely to be living in poverty. According to 2015 census data, 23.1 percent of African American women and 20.9 percent of Hispanic women live in poverty (Tucker and Lowell 1). Due to the history of racial and cultural maltreatment and overdiagnosis, there may be less confidence in mental and medical health care systems (Derek et al. 881).

²This accusation is ironic because the fact is there is “compelling evidence that indicates the involvement of men in childbirth around the turn of this [Eighteenth] century brought new hazards to mothers and babies rather than greater safety; the increased transmission of fever and injuries associated with careless use of technology, especially the forceps are but two” (Cahill 338).

Works Cited

American Art Therapy Association. “About Art Therapy.” American Art Therapy Association, Mar. 2017, arttherapy.org/about-art-therapy/. Accessed 9 Oct. 2017.

American Psychological Association. “APA Center for Psychology and Health.”

- American Psychological Association, 2014, www.apa.org/health/. Accessed 9 Oct. 2017.
- Avrahami, Dalia. "Visual Art Therapy's Unique Contribution in the Treatment of Post-Traumatic Stress Disorders." *Journal of Trauma & Dissociation*, vol. 6, no. 4, 2005, pp. 5-38.
- Bonari, L., Pinto, et al. "Perinatal Risks of Untreated Depression During Pregnancy." *The Canadian Journal of Psychiatry*, vol. 49, no. 11, 2004, pp. 726-35.
- Brodsky, P. L. "Where Have All the Midwives Gone?" *The Journal of Perinatal Education*, vol. 17, no. 4, 2008, pp. 48-51.
- Brummelte, S., and L.A. Galea. "Depression during Pregnancy and Postpartum: Contribution of Stress and Ovarian Hormones." *Progress in Neuro-Psychopharmacology & Biological Psychiatry*, vol. 34, no. 5, 2010, pp. 766-76.
- Bucciarelli, Amy. "Art Therapy: A Transdisciplinary Approach." *Journal of the American Art Therapy Association*, vol. 33, no. 3, 2016, pp. 151-155.
- Cahill, Heather A. "Male Appropriation and Medicalization of Childbirth: An Historical Analysis." *Journal of Advanced Nursing*, vol. 33, no. 3, 2001, pp. 334-42.
- Cohen, L.S., et al. "Treatment of Mood Disorders During Pregnancy and Postpartum." *Psychiatric Clinics of North America*, vol. 33, no. 2, 2010, pp. 273-93.
- Conrad, Peter. "Medicalization and Social Control." *Annual Review of Sociology* vol. 18, 1992, pp. 209-32.
- Cooper, W.O., et al. "Increasing Use of Antidepressants in Pregnancy." *American Journal of Obstetrics and Gynecology*, vol. 196, no. 6, 2007, pp. 544-e1-5.
- Dalke, K.B. et al. "Depression and Anxiety during Pregnancy: Evaluating the Literature in Support of Clinical Risk-Benefit Decision-Making." *Current Psychiatry Reports*, vol. 18, no. 59, 2016, pp. 8-12.
- Daley, Beth. "Oversold Prenatal Tests Spur Some to Choose Abortions." *Boston Globe*. 14 Dec. 2014, www.bostonglobe.com/metro/2014/12/14/oversold-and-unregulated-flawed-prenatal-tests-leading-abortions-healthy-fetuses/aKFAOCP5N0Kr8S1HirL7EN/story.html. Accessed 9 Oct. 2017.
- Dimidjian, S., et al. "Staying Well During Pregnancy and the Postpartum: A Pilot Randomized Trial of Mindfulness-Based Cognitive Therapy for the Prevention of Depression Relapse/Recurrence." *Journal of Consulting and Clinical Psychology*, vol. 84, no. 2, 2016, pp. 134-45.
- Figueiredo, B., and A. Conde. "Anxiety and Depression in Women and Men from Early Pregnancy to 3-Months Postpartum." *Archives of Women's Mental Health*, vol. 14, no. 3, 2011, pp. 247-55.
- Graham, M.A., and D.E. Pehrsson. "Adlerian Theory." *Integrating the Expressive Arts into Counseling Practice*, edited by Suzanne Degges-White and Nance Davis, Springer Publishing Co., 2011, pp. 7-28.
- Henderson, P., et al. "Empirical Study on the Healing Nature of Mandalas."

- Psychology of Aesthetics, Creativity, and the Arts*, vol. 1, no. 3, 2007, pp. 148-54.
- Hendrick, V. "General Considerations in Treating Psychiatric Disorders during Pregnancy and Following Delivery." *Psychiatric Disorders in Pregnancy and the Postpartum: Principles and Treatment*, edited by Victoria Hendrick, Humana Press, 2006, pp. 2-11.
- Hendrick, V. et al. "Hormonal Changes in the Postpartum and Implications for Postpartum Depression." *Psychosomatics*, vol. 39, no. 2, 1998, pp. 93-101.
- Hoffman, B. "The Role of Expressive Therapies in Therapeutic Interactions: Art Therapy—Explanation of the Concept." *Trakia Journal of Sciences*, no. 3, 2016, pp. 197-202.
- Hutchinson, F. "Maternity Care and Every Child Matters." *Making Sense of Every Child Matters.* *Multi-professional Practice Guidance*, edited by Richard Barker, Policy Press, 2009, pp. 11-127.
- James, Susan D. "Prenatal Test Have High Failure Rate, Triggering Abortions." *NBC News*. 14 Dec. 2014, www.nbcnews.com/health/womens-health/prenatal-tests-have-high-failure-rate-triggering-abortions-n267301. Accessed 9 Oct. 2017.
- Johanson, R., et al. "Has the Medicalization of Childbirth Gone Too Far?" *BMJ*, vol. 324, no. 7342, 2002, pp. 892-95.
- Kaufman, J., and D. Charney. "Comorbidity of Mood and Anxiety Disorders." *Depression and Anxiety*, vol. 12, no. 1, 2000, pp. 69-76.
- Knaak, S. "Having a Tough Time: Towards an Understanding of the Psycho-Social Causes of Postpartum Emotional Distress." *Journal of the Association for Research on Mothering*, vol. 11, no.1, 2009, pp. 80-94.
- Kukla, R., and K. Wayne. "Pregnancy, Birth, and Medicine." *The Stanford Encyclopedia of Philosophy*, edited by Edward N. Zalta, 17 Feb. 2011, plato.stanford.edu/entries/ethics-pregnancy/. Accessed 9 Oct. 2017.
- Leach, Mark. "Your MaterniT21 Test Is NEVER Positive." *Down Syndrome Prenatal Testing*, May 2014, www.downsyndromeprenataltesting.com/your-maternit21-test-is-never-positive/. Accessed 9 Oct. 2017.
- Lee, H.J., and Maximilian E. Szinovacz. "Positive, Negative, and Ambivalent Interactions with Family and Friends: Associations with Well-Being." *Journal of Marriage and Family Therapy.* *Journal of Marriage and Family*, vol. 78, no. 3, 2016, pp. 660-79.
- Lee, Valerie. *Granny Midwives and Black Women Writers: Double-Dutched Readings*. Routledge, 1996.
- Long, J.K. "Medical Art Therapy: Using Imagery and Visual Expression in Healing." *Clinical Handbook of Health Psychology: A Practical Guide to Effective Interventions*, edited by P.M. Camic and S.J. Knight, Hogrefe & Huber, 2004, pp. 316-41.
- Malchiodi, Cathy. "The Art and Science of Art Therapy": Introduction."

- Handbook of Art Therapy*, edited by Cathy Malchiodi, Guilford Press, 2012, pp. 1-15.
- Malchiodi, Cathy. "Expressive Therapies History, Theory, and Practice." *Expressive Therapies* Ed. Cathy Malchiodi, Guilford Press, 2005, pp. 10-24.
- McGlinchey, J.B., and M. Zimmerman, "Examining a Dimensional Representation of Depression and Anxiety Disorders' Comorbidity in Psychiatric Outpatients with Item Response Modeling." *Journal of Abnormal Psychology*, vol. 116, no. 3, 2007, pp. 464-74.
- McGowan, Kat. "Pregnant Pause—Prenatal Testing is About to Make Being Pregnant a Lot More Stressful." *Quartz*, 25 Mar. 2016, qz.com/646436/prenatal-testing-is-about-to-make-being-pregnant-a-lot-more-stressful/. Accessed 9 Oct. 2017.
- McNiff, Shaun. *Art Heals: How Creativity Heals the Soul.*: Shambhala Publication, Inc., 2004.
- Mitchinson, Wendy. *The Nature of Their Bodies*. University of Toronto Press, 1994.
- National Institute for Health Care Management (NIHCM). "Identifying and Treating Maternal Depression: Strategies & Considerations for Health Plans." *NIHCM Foundation*, June 2010, pp. 1-26, www.nihcm.org/pdf/FINAL_MaternalDepression6-7.pdf. Accessed 9 Oct. 2017.
- Otting, T.L., and E. A. Prosek. "Integrating Feminist Therapy and Expressive Arts with Adolescent Clients." *Journal of Creativity in Mental Health*, vol. 11, no. 1, 2016, pp. 78-89.
- Rosenzweig, Rosie. "MotherArt and Maternal Health." *Journal of the Association for Research on Mothering*, vol. 11, no. 1, 2009, pp. 224-238.
- Sathyanarayana, R., and V. India. "Work, Family or Personal Life: Why Not All Three?" *Indian Journal of Psychiatry*, vol. 52, no. 4, 2010, pp. 295-97.
- Schaffer, Amanda. "Too Much Information." *Technology Review*, 17 Dec. 2013, www.technologyreview.com/s/522661/too-much-information. Accessed 9 Oct. 2017.
- Solomon, Andrew. "The Secret Sadness of Pregnancy with Depression." *The New York Times Magazine*, 28 May 2015, www.nytimes.com/2015/05/31/magazine/the-secret-sadness-of-pregnancy-with-depression.html. Accessed 9 Oct. 2017.
- Solomon, Andrew. "The Secret Sadness of Pregnancy with Depression." *The New York Times*, 31 May 2015, nyti.ms/1SDOd5V.
- Soriano, Jen. "To Test or Not To Test? What Parent-to-Be Need to Know about Genetic Testing." *ParentMap*, 2 Apr. 2015, www.parentmap.com/article/geneticstesting. Accessed 9 Oct. 2017.
- Spooner, Heather. "Embracing a Full Spectrum Definition of Art Therapy." *Journal of the American Art Therapy Association*, vol. 33, no. 3, 2016, pp. 163-66.
- Staneva, A.A., et al. "The Experience of Psychological Distress, Depression,

- and Anxiety during Pregnancy: A Meta-Synthesis of Qualitative Research.” *Midwifery*, vol. 31, 2015, pp. 563-73.
- Stuckey, H.L., and J. Nobel, “The Connection between Art, Healing, and Public Health: A Review of Current Literature.” *American Journal of Public Health*, vol. 100, no. 2, 2010, 254-63.
- Swanson, L.M. et al. “Relationship Among Depression, Anxiety, and Insomnia Symptoms in Perinatal Women Seeking Mental Health Treatment.” *Journal of Women’s Health*, vol. 20, no. 4, 2011, 553-58.
- Tamulis, S.C. “Midwifery, and Ministers: The Puritan Origins of American Obstetrics.” *Literature and Medicine*, vol. 32, no. 2, 2014, 366-87.
- Tucker, Jasmine, and Catlin Lowell. “National Snapshot: Poverty Among Women & Families, 2015.” *National Women’s Law Center*, Sept. 2016, www.nwlc.org/resource/modest-recovery-largely-leaves-women-behind. Accessed 9 Oct. 2017.
- Tyler, Imogen. “Pregnant Beauty: Maternal Femininities Under Neoliberalism.” *New Femininities: Postfeminism, Neoliberalism and Subjectivity*, edited by R. Gill and C. Scharff, Palgrave, 2011, pp. 21-36.
- Vesga-Lopez, O., et al. “Psychiatric Disorders in Pregnant and Postpartum Women in the United States.” *Archive of General Psychiatry*, vol. 65, no. 7, 2011, pp. 805-14.
- Vick, Randy, M. “A Brief History of Art Therapy.” *Handbook of Art Therapy*, edited by Cathy A. Malchiodi, Guilford Press, 2012, pp. 5-16.