

Journey to Parenthood:
How New Fathers and Mothers Make Sense of Perinatal Emotional Distress

By

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Abstract

This dissertation study drew on in-depth interviews with a class diverse sample of 30 mothers and 17 fathers who experienced emotional distress as a new parent. The definitional boundaries of perinatal mental health conditions, such as postpartum depression, are debated and these diagnoses have been criticized for individualizing social problems. Nonetheless, the postpartum depression diagnosis is being extended to fathers and additional conditions are coming to be recognized as perinatal mental health disorders (e.g., anxiety, PTSD). In light of the contested nature of these conditions, I drew on social constructionist theories on health and illness to examine how lay parents made sense of and acted on their perinatal mental health symptoms. I found that distressed new parents provided nuanced, complex accounts of perinatal mental health and largely did not individualize their troubles. Further, parents exercised a great deal of agency in addressing their mental health conditions, whether in seeking professional help or implementing non-medical solutions. Their illness narratives were shaped, but not determined, by medicalized discourse.

I also drew on feminist theories to explore the social and cultural factors that contributed to their perinatal mental health symptoms, in light of changing gender roles. I found that mothers and fathers largely spoke to the same stressors and concerns as they adjusted to parenthood, including the overwhelming demands of caring for an infant, the difficult-family work balance, and changes to the marital relationship. This speaks to the convergence of gender roles in modern families, as well as growing super-parent pressures. However, nuanced gender differences were also found. Mothers were disappointed by the high expectations of motherhood, whereas fathers were frustrated by the ambiguous nature of modern fatherhood. There was a tendency to fall back on traditional gender roles when parents felt overwhelmed or in the face of structural barriers. Class-based differences were starker than gender differences, with low-income parents citing everyday hardships and problematic relationships over idealized expectations of parenthood. This difference is best understood within the larger contexts of low-income and middle class lives, in which the former may not have expected as much control over parenthood and further that parenthood was relatively more rewarding than their other social roles. The difficulty balancing the demands placed on new mothers and fathers calls for improved family supports and policies.

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*To Mom, with Love
(it wasn't just the fish oil and breastmilk that made me smart)*

In Memory of Dad, my life was blessed by your involved presence and constant love.

Table of Contents

Abstract.....	iii
Acknowledgements.....	iv
I. Introduction.....	1
Brief History and Overview of Perinatal Mental Health Conditions	3
PMADs as Contested and Potentially Medicalized Diagnoses	5
The Social Construction of Health and Illness.....	9
Medicalization.....	10
Lay Knowledge and Illness Behavior	13
Feminist Theories on Families.....	16
Gendered Caregiving.....	16
Family Policy and the Public-Private Divide.....	19
Dissertation Overview.....	20
II: Literature Review on PMADs	22
The Occurrence of PPD and other PMADS	23
The Biomedical Model	23
The Psycho-Social Model	26
The Feminist Model	29
The Constructionist Model.....	31
Addressing Perinatal Mental Health	35
The Adverse Consequences of Perinatal Mental Health Symptoms	35
Help Seeking Behavior	36
Treatment Approaches	38
Research Gaps and My Study.....	39
III. Research Methods and Sample.....	42
Analytical Approach: Qualitative Research and Grounded Theory	42
Recruitment Procedures and Participation Criteria.....	44
Final Sample	45
Table 1. Participant Characteristics	50
Data Collection and Analysis.....	53
IV. What Is This? Naming One's Condition	57
Diagnostic Overview	59

Table 2. Diagnostic Overview.....	60
Postpartum Depression Awareness.....	62
Awareness of Maternal Depression.....	63
Awareness of Paternal Depression	65
Blurry Diagnostic Boundaries in Everyday Life	73
Severity and Length of Symptoms	73
Multiple Life Stressors.....	75
Distinguishing across Conditions	78
Hesitancy among Fathers.....	82
New Mental Health Identities.....	84
Conclusion.....	87
V. Why Is This Happening? Explaining the Occurrence of Perinatal Distress	90
Overview of Parent’s Lay Explanations.....	91
Table 3: Overview of Parents Lay Explanations for Perinatal Distress	94
The Pregnancy.....	95
Becoming Pregnant.....	95
Planning for Parenthood.....	100
The Birth and Early Parenting Experiences.....	104
Childbirth.....	104
Hormones.....	106
Breastfeeding	111
Bonding with Baby	114
Parenthood	115
Deflated Expectations and Relentless Demands	116
The High Expectations of Motherhood.....	119
The New Ambiguities of Fatherhood	122
The Dark Shadow of Dysfunctional Family Backgrounds.....	127
Making Ends Meet	130
The Family-Work Balance	138
No ideal timing.....	139
Family Friendly Employers, or the Lack Thereof.....	142
The Push and Pull of Work.....	145

Transitions in Marriages and Relationships	148
Sustaining Relationships on Limited Time and Energy	148
The Struggle of Living Egalitarian Ideologies	150
Dysfunctional Relationships.....	156
Medicalization as Individualizing?	158
Conclusion.....	161
VI: How to Fix It?Managing Perinatal Distress	163
Becoming a Patient	163
Table 4: Help Seeking Patterns	164
Experiences with Professional Mental Health Treatment	173
Breastfeeding and Mental Health.....	180
Attitudes towards Medication	183
Disclosure and Social Support.....	188
Self-Help.....	195
Life changes.....	196
Relationships – Fix them or Leave Them	197
Difficult Career Choices.....	199
Time and Adjustment.....	202
Unresolved Distress	204
Parents’ Recommendations.....	206
Conclusion and Discussion	210
VII. Conclusion	212
Sociological Significance	212
Research Limitation and Future Directions	216
Social, Cultural, and Policy Implications	219
Practice Implications.....	220
Reflections as a Researcher	222
References.....	226
Appendix A. Recruitment Letter	247
Appendix B. Semi-Structured Interview Guide	248
Appendix C: Analytical Tables.....	253

I. Introduction

A baby will make love stronger, days shorter, nights longer, bankroll smaller, a home happier, clothes shabbier, the past forgotten, and the future worth living for. –*Unknown*

The period surrounding childbirth is contradictorily characterized as both a joyous and stressful time. Childbirth is a momentous and widely celebrated event, marking a desirable life change for many. Yet, this transition is associated with a loss of leisure time (Claxton and Perry-Jenkins 2008), a return to more traditional gender roles (Fox 2001; Johnson and Huston 1998; Sanchez and Thompson 1997), declines in marital relationship quality (Cox et al. 1999; Crohan 1996; Lawrence et al. 2008), and family-work balance stress (Hays 1996, Miller and Sollie 1980, Walzer 1998). In sum, the transition to parenthood is major life change accompanied by many new stressors.

Today, it is widely recognized that pregnancy and childbirth puts women at risk for Postpartum Depression (PPD). In fact, PPD is widely regarded as the most common complication of childbirth (e.g. Robertson et al 2003; Letourneau et al. 2012), impacting up to 20% of childbearing women (Gavin et al 2005). Recent research has highlighted that fathers are also at risk for depression during this time period (e.g. Escriba-Aguir and Artazcoz 2009; Paulson and Bazemore 2010; Goodman 2004), as portrayed in recent headlines that “New dads can get postpartum depression, too” (CNN, Oct. 13, 2008). In addition to depression, expectant and new parents may be at risk for other mental health conditions, such as anxiety, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), bi-polar flare-ups, and postpartum psychosis, collectively referred to as perinatal¹ mood and anxiety disorders (PMADs).

While recognition of these conditions provides important support for new parents, these diagnoses are contested and surrounded by mixed messages. That is, it is not clear if there are distinct perinatal mental health conditions according to etiological biomedical criteria, these conditions are inconsistently recognized by mental health professionals, and they are often described in many different

¹ Perinatal refers to “about childbirth,” including pregnancy, childbirth, and the period shortly after childbirth.

ways across both professional and popular discourse. Further, these diagnoses have been criticized for medicalizing and individualizing troubles that are often rooted in the structural and cultural organization of parenting. Becoming a parent is a major life change, and parenthood itself is a very important responsibility. Although there is confusion over exactly what postpartum depression and other PMADs are, the biomedical model has been the major cultural narrative for understanding perinatal mental health. Yet there is little knowledge of how lay people make sense of their symptoms. This is especially relevant as these diagnoses are being expanded to additional conditions and extended to fathers. At the same time that definitions of perinatal mental health are in flux, families and gender roles are also rapidly changing. Many young adults today desire shared gender roles; however, gender inequality still persists. There is very limited family policy support for this major responsibility, and gender inequality places different pressures on mothers and fathers.

My dissertation study is based on in-depth qualitative interviews of a class-diverse sample of 47 mothers and fathers who experienced perinatal mental health symptoms as a new parent. Drawing on feminist theories and the social construction of health and illness, I explored the lived experience of perinatal mental health distress to ask:

1. How do parents make sense of and act on their own perinatal mental health symptoms? That is, how do parents label their condition and account for the occurrence of these symptoms? Why do some parents seek professional help while others do not?
2. How are perinatal mental health symptoms shaped by the social organization of parenting, including traditional and changing gender norms, class background, and family policy?
3. Are distressed parents able to get the help and support they need? How do these diagnoses help facilitate support, or the lack thereof?

This introductory chapter details the diagnostic background of these conditions and the sociological theories that guided my research questions and analysis. First, I provide a broad overview of perinatal mental health and demonstrate how these diagnoses are contested. In light of the contested

nature of these conditions, my dissertation study draws on social constructionist theories on health and illness to explore how distressed parents made sense of and acted on their perinatal mental health symptoms, including research on medicalization, lay beliefs, and illness behavior. Understanding that PMADs are not strictly or even primarily biological in nature, I also draw on feminist theories to investigate the social and cultural circumstances that shape perinatal mental health distress, including gendered caregiving and the impact of family policy.

Brief History and Overview of Perinatal Mental Health Conditions

Postpartum depression (PPD) first appeared in the DSM with the fourth edition, published in 1994, as a subtype of major depression disorder. Prior to this, the DSM-II (1968) recognized “psychosis with childbirth” as a distinct condition, but this was dropped in the 1980 DSM-III, stating that “there is no compelling evidence that postpartum psychosis is a distinct entity” (quoted in Valley Women’s Health Access Program 2004: 1). Inclusion of PPD in the DSM resulted from grassroots mental health activism in the 1980s, led by mothers who experienced depression and anxiety following childbirth and were frustrated by the lack of support and treatment options (Taylor 1996). Yet, the categorization and defining details of PPD remain a source of debate and contention.

As a subtype of depression, the DSM-IV specified that the onset of major depression symptoms must occur within the first 4 weeks following childbirth to be diagnosed as PPD. Many advocates, researchers, and practitioners feel this is a prohibitively narrow timeframe, and instead implement an onset window of up to one year (Gavin et al. 2005; O’Hara and McCabe 2013). It was widely anticipated that the DSM-V would extend this onset period to 6 months post-childbirth, along with adding a prenatal onset period, as recommended by the DSM advisory committee on PPD (Jones 2010, O’Hara and McCabe 2013). However, when the DSM-V was released (2013), it maintained the original 4 week onset period, but added a prenatal onset which can occur any time during pregnancy. In its current classification, PPD is officially known as “major depression disorder with peripartum onset,” which “can

be applied to the current or... most recent episode of major depression if onset of mood symptoms occurs during pregnancy or in the 4 weeks following delivery” (APA 2013). As will be further detailed below, there is no clear etiological evidence that PPD is distinct from depression, hence this classification as a subtype of major depression. This is a maternal diagnosis only, which does not include fathers.

In popular media, PPD is often distinguished from the baby blues and postpartum psychosis. The baby blues refers to normal distress experienced by a majority of parents after the birth of a new child. The baby blues is not a clinical mental health condition, as the symptoms are not severe or prolonged. Postpartum psychosis is a rare but serious condition experienced by only 0.1-0.5% of postpartum mothers, characterized by delusions and hallucinations which may lead to suicidal or infanticidal behavior. Although popular literature often places these three “conditions” on a continuum, in which PPD is in the middle in regards to severity of symptoms, the scientific literature views psychosis as a distinct condition rather than simply a very severe case of depression (e.g. O’Hara and McCabe 2013; Sharma and Burt 2011). Prevalence estimates vary widely due to key methodological differences, including the time frame utilized, how depression is measured, and populations included. A widely cited meta-study from 1996 provided a prevalence rate of 13% (O’Hara and Swain 1996), whereas a more recent meta-study found a 19% prevalence rate (Gavin et al 2005). A recent meta-study of postpartum depression in fathers established a prevalence rate of about 10%, which is twice the rate of depression than men in general (Paulson and Bazemore 2010).

Professional discourse on perinatal mental health is in the midst of a shift, with increased attention being given to a variety of mental health disorders that can occur during the prenatal and postpartum period beyond PPD. This includes the extension of this diagnosis to fathers, often qualified as *paternal* postpartum depression (e.g. Kim and Swain 2007; Melrose 2010). There is also an increased focus on the fact that depression can occur during pregnancy, thus the turn from the term “postpartum”

towards “perinatal” or “peripartum.” Further, new and expecting parents may be at risk for other kinds of mental health conditions, including anxiety, obsessive-compulsive disorder, post-traumatic stress syndrome (PTSD), and bi-polar disorder.² There is difficulty in establishing clear prevalence rates for these other PMADs. However, some studies suggest that anxiety-related conditions, combined, may be more prevalent than depression among both mothers and fathers (Matthey et al 2003; Wenzel et al 2005). The top screening tool, the Edinburgh Postnatal Depression Scale (EPDS), is specific to depression (Matthey et al 2003), and there are no standard screening tools for the other PMADs.

This expansion is prompted by concerns that health practitioners have focused too narrowly on PPD, which may result in inappropriate diagnosis and treatment. Indeed, a recent study by Abramowitz and colleagues (2010) found that many women treated for postpartum depression had symptoms more consistent with obsessive compulsive disorders, suggesting that PPD has become a catch-all diagnosis. Depression and anxiety may also be conflated, as many women with PPD display predominately anxiety-like symptoms (Matthey et al 2003; Wenzel et al 2005). There is also concern that perinatal bi-polar symptoms are confused for PPD, which can have devastating consequences as bi-polar disorder can be worsened by antidepressants (Sharma and Burt 2011). Thus, in advising on how PPD should be categorized in the DSM V, Dr. Jones advised the APA in 2010 (p. 2-3):

There are however, a number of problems with their continued prominence, particularly the use of PPD to refer to the whole range of psychological distress following childbirth, from the mild and transient “baby blues” through to episodes of severe and potentially devastating affective psychosis. This has lead [sic.] to the confidential enquiries in the UK to recommend that the terms PND/PPD not be employed, as they are too wide to have any useful meaning.

PMADs as Contested and Potentially Medicalized Diagnoses

Despite advocates pushing for broader recognition of a variety of PMADs, they were ultimately inconsistently included in the recently published DSM-V. There is no recognized peripartum onset for anxiety disorders or post-traumatic stress disorder. Psychosis is included as a possibility under the

² Bi-polar disorder is not generally framed as a condition that occurs anew with pregnancy or delivery, but rather, at risk for becoming worse during this time.

peripartum qualifiers for depression, bi-polar I and II, and brief psychotic disorder, using the same pregnancy and 4 weeks postpartum time frame applied to PPD. Aside from the psychosis designation, bi-polar disorder now also includes a “peripartum onset” specifier for new depressive and manic episodes. Although there is not a peripartum specifier for “Obsessive Compulsive and Related Disorders,” the DSM V notes that, “Onset or exacerbation of OCD, as well as symptoms that can interfere with the mother-infant relationship (e.g., aggressive obsessions leading to avoidance of the infant), have been reported in the peripartum period.” None of these peripartum onset specifiers include fathers. Further, by referring to “pregnancy” and “delivery” in these specifiers, it seems that these diagnoses are intended for biological mothers only. Although the DSM is often considered the “bible” or “gold standard” for diagnosing mental health conditions, many experts in perinatal mental health apply a broader understanding of the condition.

The inconsistency in definitions across advocates, experts, and the DSM results from the unclear etiology of these conditions. This is true even for PPD, despite its widespread acceptance as a legitimate diagnosis. PPD is a “contested illness,” in that it is a generally accepted condition but there is difficulty in establishing its biomedical boundaries, according to Phil Brown’s definition (1995). A growing body of solid research on PPD has examined the etiology and epidemiology of PPD, indicating that PPD is truly just depression. Contrary to popular perception, this is not primarily a hormonal disorder. There are many psycho-social risk factors, but these are consistent with depression in general, as will be reviewed in more detail in the following chapter. Nonetheless, the confusion surrounding the etiological pathways of PPD can be seen in leading health consumer websites. For example, WebMD (2015) states that “Postpartum depression seems to be triggered by the sudden hormone changes that happen after childbirth, miscarriage, or stillbirth.” Medline Plus (2015), a National Institutes of Health resource, more clearly states that “the cause is not known,” but then stresses the possibility of hormonal and physical changes associated with childbirth while completely neglecting to mention any well-evidenced psycho-

social risk factors, aside from prior history of depression. In contrast, PMAD advocacy websites, such as Postpartum Support International or Postpartum Progress, offer more nuanced explanations by highlighting a combination of biological, psychological, and social risk factors. In addition to complex causal pathways, it is also not clear if mothers and fathers are actually at a greater risk of depression during the postpartum period, and, in fact, if parents in general have a higher risk of depression than non-parents (Evenson and Simon 2005; Rosenthal et al 2012; Wisner et al 1994). Although there is now a solid body of research on PPD, there are still many difficulties and controversies in interpreting etiological evidence in order to categorize PPD as a mental health condition (Jones 2010).

Experts debate whether PPD should even be considered a subtype of depression in absence of a specific etiology. The widespread acceptance of PPD as a diagnosis is often justified on the grounds that while PPD is essentially just depression, this diagnostic term helps increase awareness about the risk of depression during the postpartum period, encourages help-seeking and treatment, and effective treatment should take into account the unique life circumstances related to parenting stress (e.g., Jones 2010, Reicher-Rossler and Fallahpour 2003). Maternal and paternal depression during the perinatal period can have lifelong impacts on child development (reviewed in the next chapter), another primary justification for the PPD diagnosis. To be clear, however, the adverse impacts of parental depression are not limited to biological parents or only to the perinatal timeframe (Rosenquist 2013). Indeed, a recent study demonstrates higher rates of depression among mothers of 4 year olds than of infants (Woolhouse, Gartland, Mensah, and Brown 2015); yet, there is no diagnostic concept of “preschool parent depression,” or, as one may ponder, “raising teenagers depression.” In sum, the current categorization of PPD is a compromise that reflects political and social concerns, rather than biomedical etiological criteria.

Additional PMAD conditions are also inconsistently included in the DSM-V, as noted above, and researchers are only just beginning to understand the etiological pathways of these other possible

conditions. Further, awareness among lay individuals appears low. For instance, the diagnostic bias towards maternal PPD is apparent in leading health consumer websites, such as Pub Med Health, Mayo Clinic, and WebMD, all of which describe PPD as a condition occurring only in mothers. They often give attention to the “continuum” of the baby blues, PPD, and postpartum psychosis, but other PMADS are rarely discussed outside of leading advocacy websites such as Postpartum Support International or Postpartum Progress. Recently, a New York Times feature called attention to the diversity of perinatal mental health conditions in a piece aptly titled, ““Postpartum depression isn’t always postpartum. It isn’t even always depression.” (Belluck 2014). Yet, even the advocacy websites give only minimal attention to perinatal mental health among fathers and the NYTimes piece did not include paternal mental health at all. Rather than focusing on both mothers and fathers in popular PMAD resources, paternal perinatal mental health is addressed far less often and typically in only a few resources devoted exclusively to paternal perinatal mental health, such as postpartummen.com.

Although both expert and lay awareness is low, these additional PMAD diagnostic terms are currently in circulation. Therefore, these conditions could be classified as “potentially medicalized conditions,” according to Brown’s typology of conditions (1995). This refers to conditions in which the biomedical definition is not applied or there is conflict in making a definition and also that the condition is not generally accepted or is questionable. Yet, the process of medicalizing these conditions has begun, with these labels being applied to some parents and somewhat represented in the DSM-V. Thus, in some ways, these conditions are more like “contested conditions,” in that biomedical boundaries are far from clear but there is some acceptance of these conditions. However, compared to PPD, these other PMADs are far less known and there is even more confusion in establishing their etiological boundaries. Thus, I refer to these other PMADs, including paternal PPD, as emergent diagnoses; in that, medicalization has already begun, but they are not yet widely accepted. They are contested and not yet

accepted on the same level as PPD. In sum, experts debate the definition and categorization of PMADs and conflicting accounts are also apparent in popular medical discourse.

The Social Construction of Health and Illness

Social constructionists argue that human knowledge and behavior is created through an ongoing process of human interaction and interpretations, including medical knowledge and practice (e.g., Foucault 1973; Friedson 1970; Nicolson and McLaughlin 1987). The social constructionist model is in marked contrast to the biomedical model of medicine, which, as critiqued by Mishler (1981), assumes that “the definition of disease as deviation from normal biological functioning” (3), in which the social construction of normality is not questioned. The biomedical model is also built on “the doctrine of specific etiology” (1981: 6), or the belief that diseases must have a specific cause but tends to neglect many social factors that also contribute to health and illness. This model also contains the assumption of generic diseases, or the belief that each disease has specific characteristics that are universally found across populations, which then overlooks the wide range of historical and cultural variations in disease. Finally, the biomedical model assumes that medicine, being scientific, is neutral; thus neglecting social, cultural and political influences on the practice of medicine. Social constructionists, in contrast, focus on just those social, cultural, and political influences that shape the definition and experience of illness, as well as the practice of medicine.

Drawing on social constructionist approaches, the “sociology of diagnosis” highlights the social milieu of a medical diagnosis. This includes the social construction of a diagnostic category as well as the application of a specific diagnosis and treatment to particular persons in their social locations. Sociology of diagnosis, as a named theoretical paradigm, is relatively new, but it claims a host of newer and older studies as falling into its framework, including studies on medicalization, lay beliefs, and illness behavior. As explained by Jutel (2009: 279):

[T]he sociology of diagnosis does not have a clear identity or literature, hanging more on the coat tails of medicalization, disease theory, or history disease. It’s not that diagnosis has been

excluded from medical sociology, it's simply that it has been well buried in these and other areas of focus, and whilst pivotal, it hasn't been clearly isolated from these interests.

Diagnosis is at the center of these studies, due to the power of disease categories:

Disease categories connect aggregate statistical data and practice. As we have seen, they link and conflate diagnosis, prognosis, and treatment; they are ghosts in the health system's software. But perhaps ghosts are an imprecise metaphor, for systems of disease classification are very real and quite intractable technologies, linguistic tools that allow the machines and institutions of government and health care to function. Disease entities are social realities, actors in complex and multidimensional negotiations that configure and reconfigure the lives of real men and women. (Rosenberg 2007: 27).

The sociology of diagnosis examines the social consequences of having (or not having) a diagnosis (Brown 1995; Jutel 2009). A diagnosis can organize previously unconnected troubles and legitimate one's complaints, but a conflicted diagnosis is less likely to bring such relief (Jutel 2009). A diagnosis also impacts "illness behavior," defined as "the ways in which given symptoms may be differentially perceived, evaluated, and acted (or not acted) upon by different kinds of persons" (Mechanic and Volkart 1960; see also Goffman 1968). Further, diagnosis and illness behavior are shaped by social factors, such as gender, ethnicity, class, education, and religion (Mechanic and Volkart 1960; Zola 1973). A social constructionist approach is particularly appropriate for examining contested PMADs, with sociology of diagnosis helping to integrate medicalization theories with research on lay knowledge and illness behavior.

Medicalization

Medicalization is the process by which life troubles come to be known as medical disorders. Medicalization is characteristic of a bureaucratic society, with increasing reliance on the role of the expert (Zola 1972). Medicalization can be a more humane way of dealing with problems as well as reduce some of the individual moral blame for deviance; however, it also becomes a new form of social control (Conrad 2007, Conrad and Schneider 1980, Zola 1972, 1975). Zola (1972) argued that people are increasingly held responsible for their physical and mental health, and as such, medicalization

individualizes social problems. Biomedicalization, a subtype of medicalization, emphasizes the biomedical or physiological characteristics of a condition, and therefore further individualizes these problems by rooting them in problematic bodies (Clarke and Shim 2011). In focusing on medical problems and solutions, other causes and solutions are overlooked, especially those at the larger structural level (Conrad and Schneider 1980). PMADs are constructed as a psychological illness. Parenthood is stressful, and some parents experience more stress than others. The immediate period before and after the birth of a new child can be particularly trying, but at what point have parents experienced a clinical disorder?

Whereas men tend to have their deviant functions medicalized, women's ordinary functions have been medicalized (Reissman 1983), including childbirth, menstruation, and menopause (e.g. Ehrenreich and English 1973, Riska 2003; Reissman 1983). Reissman (1998) argued that women are disproportionately subject to medicalization because biological sex differences fit well with the biomedical orientation, women visit doctors more often, and women's overall structural subordination make them more vulnerable to medical social control. While these concerns remain relevant in the 21st century, a newer trend is to also medicalize uniquely male experiences, such as balding and impotency (Conrad 2007, Rosenfeld and Faircloth 2006). Masculinity studies illustrated how men are also disadvantaged by gendered social structures; however, the institution of medicine has been neglected in much of this work (Rosenfeld and Faircloth 2006). Nonetheless, it's widely acknowledged that masculinity leads to risky behavior, suppressing emotions, and denying pain, inducing a reluctance to seek medical treatment. In addition to this focus on "deviant" behavior, we now see men's normal aging conditions coming under the medical purview (i.e., andropause, balding, and erectile dysfunction) (Conrad 2007) although the medicalization of men's emotions remains a relatively neglected area (Rosenfeld and Faircloth 2006). The extension of PPD to men, as well as the growing focus on "new" PMADS, is clearly an expansion of medicalization. Further, the often-found focus on hormonal causation

for PPD illustrates biomedicalization, and even paternal PPD has been theoretically linked to men's changing testosterone levels.

PPD as a diagnosis has been investigated by medicalization theorists, as will be reviewed in the next chapter. Yet, this theoretical approach is best suited for examining the process and consequences of medicalization, often by examining competing claims and textual discourse. As such, these theories have limited capacity for exploring the impact of medicalization on everyday life, including how lay people draw on competing claims to interpret and act on their troubles. To be certain, these scholars have examined some everyday consequences of medicalization, such as the benefit of medical labels for shared understanding, being able to talk about one's problems, and receiving support. But, it is less clear the extent to which people individualize their problems and ignore other possible explanations and solutions as a result of medicalizing these troubles. Medicalization theories highlight the medical arena as in institution of social control, but have been criticized for "portraying the individual patient and the lay public more generally as essentially passive and uncritical in the face of modern medicine's expanding jurisdiction" (Gabe 2004: 62; see also Williams and Calnan 1996). To be certain, medicalization scholars recognize the growing power of consumers as a driver of medicalization in the 21st century (e.g. Conrad 2007). I did not examine the medicalization of PMADs as a social movement or analyzed expert claims-making in detail; rather, I focused on lay illness narratives and knowledge of a medicalized condition. Therefore, my study contributes to the need for medicalization theorists "to go beyond the accumulation of different cases of medicalization to try and develop a more integrated theory of the process of medicalization, its causes and consequences, and to related these to recent changes in medical organization and knowledge and the growing challenge to medical authority" (Gabe 2004: 62-3).

Lay Knowledge and Illness Behavior

To better understand sense-making in everyday life, I turned to theories and research on lay knowledge. Lay knowledge can be defined as “the ideas and perspectives employed by actors to interpret their experiences of health and illness in everyday life” (Williams 2004:135). Individual beliefs on health and illness are representative of our society and culture, including medical ideas (Herzlich 1973). Davison and colleagues (1991) coined the term “lay epidemiology” to describe how individuals account for illness, in the face of illness, by drawing on a combination of personal, familial, social, and professional sources of knowledge.

Lay beliefs, in turn, influence illness behavior. Rogers and colleagues (1999) identified a “symptom iceberg,” in which roughly a third of individuals with symptoms do nothing, a third self-treat, and the remaining third consult a medical professional, thus pointing to the diversity of individual responses to illness as well as significant resistance to medical jurisdiction. The health belief model proposes that compliance with medical recommendations is shaped by perceived susceptibility to a health problem, the belief that the problem is a serious risk, the belief that compliance will reduce this risk, and perceptions that there are no major barriers to compliance (Becker 1974, 1993; Rosenstock 1966). Further, help-seeking and illness behaviors are shaped by social variables (i.e., class, gender, race, education, religion), cultural understandings of illness, disease specific understandings of a condition (i.e., commonality and outlook), and individual experiences with symptoms (i.e., severity and perceived threat) (Herzlich 1973, Mechanic 1978, Mechanic and Volkart 1960, Zola 1973). The relationship between lay beliefs and illness behavior is very complex, as noted by Pill and colleagues (2001: 212):

Within any modern urbanised society ... there will also be a large number of therapeutic options potentially available to people. These will range from self-treatment, folk-remedies, advice from family and friends, and increasingly the Internet, over-the-counter pharmaceutical preparations, unofficial and alternative healers, and healers from other non-Western traditions. People make choices about what to do, and who to consult, on the basis of such factors as perceived availability, whether payment has to be made, and the explanatory models (EMs) that they hold, *i.e.* the particular set of beliefs marshalled in order to deal with the current episode of illness.

Such EMs are typically rather idiosyncratic and changeable, heavily influenced by both personality and cultural factors, and need to be understood by examining the circumstances in which they are employed. The concept of EM has proved a useful tool for looking at the process by which lay people organise and manage episodes of impaired well-being.

This line of research highlights the interplay of social structure and personal agency (Brown 1995; Brown, Lyson, and Jenkins 2011). Whereas medical professionals emphasize the scientific evidence-based characteristics of a diagnosis, lay patients tend to stress the experiential or behavioral aspects of their condition (Popay et al 1998; Prior, Evans, and Prout 2011). Lay patients may draw on their experiential knowledge to reshape, expand, or overturn entrenched or expert beliefs (Brown, Lyson, and Jenkins 2011). Lay persons also draw on expert discourse and scientific findings, but often in a creative and strategic way, bolstering the legitimacy of their own experience (Copelton and Valle 2009; Fuller 2011; Markens et al. 2009).

Kim and Ahn (2002: 34) found that lay beliefs about mental illness are often “elaborate, consensual, and moderately accurate with respect to academic theories.” Yet, as illustrated by France and colleagues, lay mental health beliefs are shaped profoundly by culture (2007: 414; see also Angermeyer and Dietrich 2006, Marsella and Kaplan 2002):

[C]ultural narratives of mental illness do not necessarily reflect an objective reality or universal understanding. Different historical and cultural traditions frame depressive experiences within different contexts, thereby promoting and/or limiting particular symptoms and shaping different understandings and meanings of depression and its appropriate treatment. Such narratives are probably best conceptualized as social constructions that must be understood within the cultural context that socializes, interprets, and responds to them.

The relatively small body of research on lay mental health knowledge finds that most people prefer psychosocial explanations, including poor childhoods and life stressors, over biological causation (Angermeyer and Dietrich 2006), but acceptance of genetic etiology is growing (Jorm et al. 2005). Further, lay persons hold more positive attitudes about therapy and counseling than towards psychiatric medications; however, Americans have more accepting attitudes on medication compared to their international peers (Angermeyer and Dietrich 2006). The United States is unique in allowing direct-to-

consumer advertising. Advertisements for depression medications promote the view that depression is caused by a brain chemical imbalance, out of proportion with the actual evidence on multi-causation. Therefore, Americans may be more likely to subscribe to biomedical beliefs, but more research is needed (France et al. 2007). Although psychosocial explanations are generally preferred, biological causes are given more consideration for schizophrenia or severe mental health conditions (Angermeyer and Dietrich 2006, Martinez 2010). Exposure to the mental health system increases support for biological causation as providers share professional information on mental health (Martinez 2010), although patient perceptions still do not perfectly mirror their provider's explanations (Kuyken et al 1992).

Quantitative research in this area tends to examine the mismatch between lay perspectives and expert opinion as a problem that must be remedied in order to reduce stigma and increase the use of professional mental health services. However, qualitative research on lay beliefs indicates that many people's fears about seeking treatment are often reasoned, well-grounded, and are not necessarily irrational (Pill et al. 2001). For instance, the belief that professionals do not have time to discuss patient problems or they cannot really fix the underlying life circumstances accurately characterizes many situations (Pill et al. 2001).

In contrast to the medicalization theorists' fears that behavioral and mental health diagnoses reify the biological, it appears that the lay public attitudes remain rooted, in many ways, in psychosocial explanations. Yet, it is worth asking whether this is also the case for PMADs, where the hormonal discourse is so strong. Indeed, the existing body of research on lay etiology of depression focuses on biochemical imbalances in the brain (i.e., serotonin levels) or genetic explanations as representing biological causation. Therefore, the supposed role of hormones and the physical process of childbirth for PMADs add a new dimension to research on lay etiology. France and colleagues suggest that the

chemical imbalance explanation of depression is a cultural narrative in the United States (2007), and I suggest that the hormonal causation explanation for PPD is also a cultural narrative.

Feminist Theories on Families

Feminist theories draw on many other sociological theories, but orient gender as a central concept for explaining society, including family structures and dynamics. Gender is reproduced through everyday interactions in which individuals are held accountable to normative conceptions of masculinity and femininity (West and Zimmerman 1987). Feminist theories also call our attention to the links and interconnections across different dimensions of inequality, primarily, race, class, and gender (Acker 2006, Collins 2000, hooks 1984). These intersections are more than the additive effects of being disadvantaged on multiple fronts, as unique dimensions of inequality emerge when race, class, and gender interact. These dimensions can be revealed by investigating everyday lived experiences, and shed important insights on how to improve our society to achieve improved equality and democracy (Collins 2000, Smith 1990). In examining perinatal mental health distress, the gender division of caregiving labor and family policy are especially relevant, and are also shaped by race and class. I draw on feminist theories to highlight alternative explanations for perinatal mental health distress, in recognition of the fact that health and illness are not strictly biomedical in nature.

Gendered Caregiving

The family is a gendered institution, with different roles and expectations for mothers and fathers. The transition into parenthood often leads to a more traditional gender division of labor (Fox 2001; Sanchez and Thompson 1997). In the traditional gendered division of labor in nuclear family units, fathers work in the public sphere as breadwinners while mothers are located in the private sphere where they keep house and rear children. This division of labor is built on the ideology that women are naturally suited for mothering and are more caring and nurturing by their very nature (Cancian and Oliker 2000). However, this model has not been historically dominant and also does not describe many

contemporary families (Coontz 2000, Hays 1996). Diverse modern families now include working mothers, single parents, blended families, dual earner families, and gay families, in addition to gender traditional families.

Mother's nurturing responsibilities persist, and have even grown stronger, even as they are increasingly employed outside of the home. They still have more responsibility for children; for example, mothers spend about twice as much time caring for children under six compared to fathers (Sandberg and Hoffeth 2001; US Dept of Labor 2005). Intensive mothering refers to contemporary dominant ideologies in which good mothering is constructed as selfless, child-centered, emotionally painstaking, and time intensive (Douglas and Michaels 2004, Hays 1996, O'Reilly 2004). Good mothering is to be responsive to science on child development and health (Apple 2006, Beatty et al 2006, Litt 2000), often through textual discourses on proper childrearing (Smith 2005). Class and race shape the cultural expectations, meanings, and practice of motherhood (Arendell 2000; Hays 1996; Hill 2012; Hill and Sprague 1999; McMahon 1995). Mothers of all class backgrounds accept the ideology of intensive motherhood to a certain extent, but middle and upper class women engage in the most labor intensive practices (Hays 1996; Lareau 2003), such as "attachment parenting" and breastfeeding (Blum 1999; Bobel 2002). Meanwhile, many of the parenting ideals and practices of working class or poor women are viewed as inferior (Hays 1996; Lareau 2003).

Mothering is often valorized as the most important job in the world, with severe consequences for all of society if not done right. Yet, this labor is also devalued by making it invisible, assuming it is easy due to maternal instinct, dismissing it as not the "real" work of the formal economy, or failing to provide sufficient social supports for mothering (England & Folbre 1999, Glenn 2000, Hays 1996). Expert discourse on good parenting is often contradictory (Hays 1996). Prior research has linked gender inequality and the high expectations of motherhood to postpartum depression and anxiety, as will be further detailed in the following chapter.

Fatherhood is also rapidly changing, but without a clear emergence of a unitary father role (Gerson 1993). As men's wages have fallen and work becomes less secure (Autor, Katz, and Kearney 2006; Kalleberg 2009), anxieties connected to the breadwinning role may be becoming more pronounced. Indeed, in a study of new parents, Walzer (1998) found that fathers were more likely than mothers to worry about financial responsibilities. Although men are generally advantaged by traditional gender roles, dominant power is complex and fragile, resulting in vulnerabilities even among those who appear advantaged (Connell 1987).

Further, the traditional breadwinner-homemaker model is in decline. Modern fathers are following very different paths, in which some escape families responsibilities altogether while others have become more intimately involved in family life. Although involved fathering is growing, support from societal institutions has lagged behind (Gerson 1993). Those aspiring to be involved fathers today often do not have role models in their own fathers, and are not necessarily finding adequate socialization into a hands-on fathering role elsewhere (Bradley, Mackenzie, and Boath 2004; Deave and Johnson 2008). Further, fathers' nurturing roles are not always well respected or acknowledged; for example, involved fathers have reported employers who are resistant to extending family friendly workplace practices to men or being ridiculed for being the stay-at-home parent (Fried 1998; Gerson 1993). Finally, caregiving fathers experience many of the problems and anxieties long associated with motherhood, such as feeling overwhelmed by childcare responsibilities, worries about their child(ren)'s wellbeing, and difficulties balancing work and home (Gerson 1993).

At the same time that gender egalitarian attitudes are spreading, the economy has become more precarious, leading to additional ambiguity for men's family goals. While young men often profess gender equalitarian values and desires, economic uncertainty questions the feasibility of this goal. In response, Gerson found that some men eschew family life altogether and others fall back on more traditional gender roles (2003, 2010). In the latter case, men feel they need to work harder to ensure

their competitiveness in the new economy, and hope to have a domestic wife taking care of things at home but this is at odds with young women's desires (Gerson 2010).

Family Policy and the Public-Private Divide.

Family social policies have lagged behind changing gender roles, new diverse family forms, and contemporary economic policies (Coontz 2000). Social and family policies can either intensify or help ameliorate inequality (Esping-Anderson 1990, Fraser 1994, Hacker 2002, Glenn 2002, Massey 2007). Compared to other industrial nations, the United States has meager social safety nets and offers few universal family supports (Hacker 2002). Of particular relevance to this dissertation, we are the only industrial nation without universal paid family leave, sick time, or health insurance.³ We also have higher rates of poverty and historically high rates of class inequality (Esping-Anderson 1990, Gilbert 2008, Piketty and Saez 2008). This state of meager policy supports has a real life impact on the stressors experienced by new parents, as well as their access to the resources needed to address these stressors.

Fraser argues that the welfare state is in crisis, because it is out of sync with modern diverse family forms and contemporary economic realities, and in result, does not provide sufficient supports for women and children (1994). The family wage reflects labor and economic policies that assume a nuclear, heterosexual family with male breadwinners and female homemakers. Corresponding social insurance policies also assume and reinforce the ideological family. Meager family supports assume that mothers are always available for carework, while husbands and fathers will meet the families' economic needs. Means-tested relief for the poor stigmatizes families who do not fit into the idealized family image, including low-income families, racial minorities, and single parent families. Further, family policy is rooted in a false dichotomy of public and private (Glenn 2000). Family is viewed as the private sphere, and therefore the responsibility for raising children largely falls on individuals. Yet, families serve the

³ The Affordable Care Act (ACA) is arguably a universal coverage due to the individual insurance mandate. ACA government subsidies have also made insurance more affordable. However, these aspects of the ACA did not start until January 2014 and were not available to families during my data collection timeframe.

public good, for example, by reproducing future workers and sustaining current workers in the modern division of labor, a responsibility that primarily falls on women (Folbre 1994). Further, while the family gets little support from the public, it is still regulated and constrained by public forces, including the economy, employer demands, and dominant cultural ideologies about parenting practices.

In sum, families are gendered in many ways and yet gender roles are rapidly changing. As traditional family norms are breaking down, with mothers increasingly working and fathers becoming more intimately involved in home life, traditional ideologies still persist. Further, gender roles and expectations are shaped by class background, including access to resources needed to meet parenting responsibilities. The false-divide between the public and private has resulted in meager policy protections for individual families, who must instead navigate new gender ideals and a precarious economy with limited support. Perinatal mental health distress cannot be removed from this gender, class, and policy context.

Dissertation Overview

To answer my research questions, I explored lay accounts and everyday experiences of perinatal emotional distress through in-depth interviews with 47 mothers and fathers. The following chapter summarizes the current body of literature on PMADs, including the specific research gaps that my study helps address. The third chapter details my study methodology and the characteristics of my sample of 30 mothers and 17 fathers. Parent's illness narratives are divided into three analytical chapters. In *Chapter IV: What is it? Naming One's Condition*, I provide an overview of the "conditions" experienced by my sample participants, and detail difficulties in organizing symptoms and causes into a clear diagnosis or non-medical label. In *Chapter V: Why is this Happening? Explaining the Occurrence of PMADs*, I show that most parents combine biological, psychological, and social accounts of distress. Social explanations were dominant in explaining their occurrence of PMAD symptoms, but the persistence of biomedical explanations demonstrates the power of medicalized discourse. In *Chapter V:*

How to Make it Better? Managing PMAD Symptoms, I examined the strategies parents employed to address their mental health symptoms, including professional mental health treatment, social support, self-help, and life changes. My concluding chapter draws out the theoretical significance of my main findings, including research limitations and future research needs; delineates practice, societal, and policy implications; and reflects on my positionality and experiences as a researcher.

Briefly, I found that medicalization of parental distress shapes these parents narratives in important ways, but does not blind them to the social stressors in their lives and they also act with agency and exercise control in overcoming their mental health distress. Further, while gender does shape new parents expectations and behaviors, mothers and fathers alike were overwhelmed by high cultural expectations of parenthood and the paucity of supports and resources for their new caregiving responsibilities. Whereas middle class mothers were often let down by the high expectations of motherhood, low-income mothers did not expect as much control over motherhood and instead primarily cited struggles related to poverty. Finally, while several parents benefited from professional help, the promise of these diagnoses for expanding access to quality perinatal mental health care is far from realized.

II: Literature Review on PMADs

Once neglected, maternal PPD is now a widely known and well-researched condition. This research is multi-disciplinary, but sociological research is underrepresented. There is less research on PPD in fathers and the other PMAD conditions, although this is rapidly growing. In this chapter, I review literature that explores the occurrence of PMADs and briefly touch on the consequences of PMADs and treatment approaches. Research that has explored the occurrence of PMADs can be divided into four models. The biomedical and psycho-social models assume that PMADs are real in investigating what causes them. These lines of research are important for understanding the diverse factors that lead to these conditions, and also their contested etiology. That is, even while the biomedical and psycho-social models treat PMADs as real conditions in exploring what causes them, they also provide evidence that perinatal mental health conditions are largely not distinct conditions. The feminist model has highlighted the role of gender inequality and unrealistic pressures of motherhood in exploring the everyday lived experience of PPD. The constructionist model is concerned with the emergence and construction of PPD as a mental health condition. The feminist and constructionist models are more critical about whether PPD is real, but have not yet explored other PMADs including the extension to fathers. The research on the consequences of PPD and treatment options is important for understanding why many scholars call for PMAD diagnoses in the absence of a specific etiology, although this line of research also generally assumes that these conditions are real. My dissertation project was informed by all these threads of literature, but situated itself in the feminist and social constructionist traditions.

The Occurrence of PPD and other PMADS

The Biomedical Model

The biomedical model⁴ seeks to delineate physiological factors, such as hormones, that may cause PMADs, primarily PPD, psychosis, and bi-polar episodes. In coining the term “postpartum depression,” Yalom and colleagues proposed that PPD was similar to premenstrual syndrome (PMS) and resulted from the hormonal changes that occur with childbirth. These hormonal shifts include rapid decreases in estrogen, progesterone, cortisol, and beta chorionic gonadotropin. However, all delivering women experience these hormonal shifts, whereas only a minority of women experience PPD. Initially, researchers examined whether women with PPD were experiencing abnormal hormonal shifts. With the exception of women with certain thyroid conditions, this has not been the case (Flores and Hendrick 2002; O’Hara and McCabe 2013; Riecher-Rössler and Hofecker Fallahpour 2003; Wisner et al. 2002). Another challenge to this theory is that many women experience PPD after their hormones have returned to normal, and further, adoptive mothers also experience PPD (Romito 1990, Lee 1997).

Researchers are now focusing on why some women may be more sensitive to normal hormonal changes. Initial evidence to support the sensitivity theory includes that a history of premenstrual dysphoric disorder is a risk factor of PPD (Flores and Hendrick 2002), as premenstrual dysphoric disorder is also marked moodiness in response to normal hormonal shifts. Further, in an experimental study, Bloch and colleagues (2000) simulated the hormonal changes of pregnancy and childbirth in a small group of women, and found that about half of the women with a prior history of PPD reported marked mood symptoms, whereas none of the women without a prior PPD history reported significant moodiness. However, this could also indicate expectancy effects (Rosenquist 2013). This was a ground

⁴ As it applies specifically to the etiology of PMADS, this is somewhat more narrow than the term “biomedical model” as illustrated by Mishler (1981). Mishler discussed an overarching approach to understanding disease and the practice of medicine, whereas here I am more narrowly referring to research on the biomedical, or physiological, risk factors, although this certainly fits into the broader biomedical model as envisioned by Mishler. The psycho-social model also fits into the biomedical model, in seeking to identify a specific etiology; however, it also challenges this model, somewhat, by pointing to social risk factors.

breaking study for the hormonal sensitivity theory, but was a very small sample and did not delineate the mechanisms by which some women are more sensitive to hormones. It's also possible that hormonal changes could make new mothers more vulnerable to depression in combination with other risk factors (Reicher-Rössler and Hofecker Fallahpour 2003), thus, possibly acting more as an adverse coping mechanism rather than a causal factor. Although new research on hormonal sensitivity means that the role of hormones should not be dismissed, it does not mean that hormones should be taken as the dominant or most common explanation for PPD in mothers. Likewise, changing hormones as an adverse coping factor does not mean that hormones are a necessary ingredient for PMADs.

Interestingly, hormonal causation for paternal PPD has often been suggested, extrapolating from the fact that men can experience a significant drop in testosterone levels during their partner's pregnancy and early period of fatherhood (Kim and Swain 2007; see also www.postpartummen.com). However, this has not been directly researched for fathers and is inconsistent with the research that has not clearly established hormonal causation for women. As with women, we should question why only some men experience PPD if many are experiencing a drop in testosterone. Further, preliminary evidence suggests that fathers have a later average onset of PPD (Goodman 2004; Paulson and Bazemore 2010), thus, presumably past the period of any drastic hormonal changes. In light of the struggle to clearly establish a role for hormonal etiology among women, this extrapolation to men is suspect.

However, a hormonal causation for postpartum psychosis and bi-polar are more strongly evidenced. Regarding psychosis, delusions and hallucinations are generally linked to brain chemistry, and few would argue that social or cultural factors would better explain symptoms of this nature. Some cases of postpartum psychosis have been linked to a personal or family history of schizophrenia (Reicher-Rössler and Rohde 2005; Yonkers et al. 2012). In other cases, postpartum psychosis appears to be a manifestation of bi-polar disorder, as previous self or family history of bi-polar is a major risk factor

(Burt and Stein 2008; Yonkers et al. 2012). Further, childbirth has been more clearly found to impact bipolar disorder, with 1 in 4 bipolar women suffering a severe reoccurrence during the immediate postpartum period. This represents a significant increase in risk, with symptoms most often occurring within the first couple weeks following childbirth – during the period of rapid hormonal changes (Jones and Cantwell 2010; Reicher-Rossler and Rohde 2005; Sharma and Burt 2011). Compared to depression, bi-polar and schizophrenia also have stronger evidence for a genetic basis (reviewed in Rosenquist 2013). Altogether, this research suggests a stronger link between bipolar disorder and postpartum psychosis to the physiological processes of childbirth and biomedical brain processes, compared to PPD; however, these conditions are not as common as postpartum depression or anxiety. In sum, hormonal etiology is the exception and not the rule.

Sleep deprivation is another factor that impacts depression through biomedical processes (Dørheim et al 2009; Posmontier 2008). Poor sleep quality has been linked to baby blues, PPD, and psychosis (Dørheim et al 2009; Posmontier 2008; Ross, Murray, and Steiner 2005). Sleep quality impacts the balance of major neurotransmitter, chemical, and hormonal brain systems; therefore, impacting depression and psychosis through biomedical pathways (Ross, Murray, and Steiner 2005). Further, sleep loss may be a key factor predicting psychosis among mothers with bi-polar, but more research is needed (Ross, Murray, and Steiner 2005). Yet, this relationship can run both ways as having a mental health condition can also make sleep difficult. Further, PPD cannot be reduced to chronic sleep deprivation (Dørheim et al 2009). Finally, it's important to keep in mind that while the adverse impact of sleep deprivation operates through physiological processes, access to sleep is often shaped by cultural and structural factors. In the case of infant-induced sleep loss, this includes the organization of families into isolated nuclear units and the gendered division of labor.

The Psycho-Social Model

The psycho-social model uses quantitative social science techniques to identify psychological and social risk factors for PMADs, thus expanding the focus beyond biomedical factors but still assuming that these are real conditions. This line of research is often framed as being about PPD, but actually often conflates depression and anxiety by using screeners, such as the Kessler psychological distress scale (K6) or Edinburgh postnatal depression screen, that pick up on both depression and anxiety symptoms. Although there is far more research on mothers, much of the early research on PPD in fathers is rooted in this model. Overall, there is stronger evidence for psycho-social risk factors, compared to hormones.

A previous mental health history is among the strongest risk factors for perinatal depression and anxiety in both mothers and fathers (Burt and Stein 2008; Riecher-Rössler and Hofecker Fallahpour 2003; Escriba-Agui and Artazcoz 2010; Nishimura and Ohashi 2010; O'Hara and Swain 1996;; Matthey et al 2003; Wenzel et al 2005). Cognitive-behavior theories examine psychological and personality characteristics that may make some women more prone to PPD, such as negative attributional style, neuroticism, learned helplessness, and low self-esteem (Lee 1997, O'Hara 1982, O'Hara and Swain 1996, O'Hara and McCabe 2013), although this line of research has died down and not been extended to fathers.

In addition to these psychological risk factors, many sociological risk factors have been established. Social support, which includes both practical assistance and emotional support, is a moderate to strong protective factor against PPD for mothers (O'Hara 1986; O'Hara et al. 1983; O'Hara and Swain 1996), across different ethnic and socioeconomic groups (Horowitz et al. 2005; Logsdon and Usui 2001). The relationship between PPD and social support runs in both directions, as depressed women may distance themselves from potential support persons (Beck 1993; O'Hara 1986). Thus far,

research on social support for paternal PPD has been mixed, but leaning towards social support as an important factor (Escriba-Agui and Artazcoz 2010; Goodman 2004; Kim and Swain 2007).

Marital status is not related to PPD among mothers (Horowitz et al. 2005; O'Hara and Swain 1996), although being a divorced, separated, or non-residential father puts men at greater risk (Bronte-Tinkew et al 2007), which is also true of depression in fathers in general (Evenson and Simon 2005). Low marital satisfaction increases the risk of depression for both mothers and fathers (Escriba-Agui and Artazcoz 2010, Giallo et al. 2012; O'Hara 1986; O'Hara et al. 1983; O'Hara and Swain 1996, Romito 1990). There is a moderate to strong correlation of depression between marital partners (Escriba-Agui and Artazcoz 2010; Goodman 2004; Paulson and Bazemore 2010), as well as anxiety (Matthey et al 2003), although the direction of influence has not been studied (Paulson and Bazemore 2010).

Stressful life events, such as family illness or death, job changes, and housing insecurity, also increase the risk of PPD (Horowitz et al 2005, O'Hara and Swain 1996), with one study indicating that negative life events may be a stronger risk factor for fathers than mothers (Escriba-Aguir and Artazcoz 2010). The birth of a child, itself, can be a stressful life event that imposes a new burden of responsibility while disrupting prior lifestyles (O'Hara et al. 1983; Riecher-Rössler and Hofecker Fallahpour 2003), especially for first-time parents (Harkness 1987, Romito 1990) or those with unwanted pregnancies (Abrams and Curran 2009). These findings are consistent with the larger body of stress-process theory, which links stress to poor mental health (e.g., Aneshensal 1992, Pearlin et. al. 1981, Thoits 1995)

While mothers with low-education, who are younger, or are of a minority racial/ethnic group are at greater overall risk for PPD (Howell et al. 2005, Segre et al. 2007), this is accounted for by socioeconomic status (SES) (Rich-Edwards et al. 2006, Wang et al. 2011). The relationship between maternal PPD and SES is modest but consistently found (O'Hara and McCabe 2013), including in early investigations of paternal PPD (Giallo et al. 2013). In addition to SES, financial problems increase the risk of PPD (Hope, Power, and Rogers 1999; Horowitz et al. 2005; Romito et al. 1999; Seguin et. al. 1999;

Stein et al. 1989). Interestingly, employment status (i.e., full time employment, part time employment, unemployed) is not a risk factor for mothers (Horowitz et al. 2005; O'Hara and Swain 1996, Romito 1990), but unemployment or underemployment is a risk factor for fathers (Nishimura and Ohashi 2010, Giallo et al. 2012, Giallo et al. 2013). Although the psycho-social risk factors are largely the same, this difference in employment status is an important finding that speaks to gender roles in the family and men's breadwinning pressures. Few studies have examined employment beyond employment status, however, two Australian studies found that poor workplace conditions, such as high stress or few family friendly policies, increases the risk of both maternal and paternal PPD (Cooklin et al. 2011; Giallo et al. 2012).⁵

Researchers have also examined the social circumstances surrounding pregnancy and childbirth, in light of the PPD diagnosis being connected to childbirth. Complicated pregnancies and deliveries, as well as unplanned interventions, increase the risk for PPD (Blom et al 2010). Breastfeeding is often hypothesized as lowering the risk of PPD as it tames hormonal withdrawal (biomedical model) and also promotes parent-infant bonding (psycho-social model). However, this research is equivocal and breastfeeding does not clearly demonstrate a mental health benefit. Depressed mothers are less likely to breastfeed, but cause and effect is not clear (Dennis and McQueen 2009). One well-designed study suggests that maternal mood influences breastfeeding more so than the reverse (Dennis and McQueen 2007). Infant health and temperament can influence PPD (Blom et al 2010; Dudley, Roy, Kelkm and Bernard 2001; Vik et al 2009). However, causality may run both ways, as a depressed parent may not be as attentive to infant needs or interpret her child's behavior as being more temperamental (Melrose 2010). The number and parity (i.e., birth order) of children has largely not been found to be a risk factor among mothers (Horowitz et al. 2005; O'Hara and Swain 1996).

⁵ These studies were conducted with data gathered before Australia implemented universal paid parental leave in 2011. Unfortunately, this line of research is missing in the U.S., where work and family protections are even more scarce.

The strength of this model is that rather than individualizing depression, it roots these problems in life contexts. Yet, while these lines of research help us move beyond the biomedical model and its focus on physiological causation, in accepting PPD as a medical diagnosis, the psychosocial model still affirms the medical model of emotional distress related to child bearing (Romito 1990). In this regards, the psycho-social model falls within the sociology *in* medicine tradition. Sociology *in* medicine refers to medical sociology research that operates within the main parameters and concerns of medicine. In this model, sociology serves medicine, and thus is subordinate to the medical model (Straus 1957; White 2002; Zimmerman 2000). However, the psycho-social line of research also demonstrates that the risk factors are the same as those found for depression and anxiety in general; that is, they are not unique to parents or to the perinatal period.

The Feminist Model

Feminist scholars point to gender inequalities in the family and broader society as the primary reason why the postpartum period leads to emotional distress, drawing on qualitative studies examining the everyday lived experience of postpartum depression. These studies are largely based on recruiting women with a PPD diagnosis, although keep in mind that this diagnosis has been found to conflate depression and anxiety and, indeed, participants in these studies have spoken to symptoms of both.

Women as mothers are primarily responsible for caring for babies, although this labor is undervalued and not sufficiently supported (Crittendon 2001; Folbre 2001). Childbirth begins the sudden and dramatic transition into motherhood, which women may not be prepared for due to idealistic images of mothering. Myths surrounding motherhood set very high expectations. Motherhood is thought to bring total self-fulfillment and happiness (Edhborg 2005; Lee 1997; Nicolson 1990) and mothers are expected to perform their duties perfectly (Berggren-Clive 1998, Wood et al 1997). The reality of motherhood often contrasts with these images, leading to conflict, stress, and depression (Edhborg 2005; Mauthner 1999). In turn, mothers experience additional guilt and depression when they

experience PPD symptoms as “good mothers” should not have negative thoughts (Edhborg 2005; Mauthner, 1999).

Caring for a newborn is difficult, and mothers are often left to manage these responsibilities on their own, in the context of isolated, private nuclear families and traditional gender roles (Fox and Worts 1999). Mothers are often frustrated by the inequitable division of household and child rearing labor (Abrams and Curran 2009; Lee 1997). Further, many parents have little direct experience caring for infants and children due to the nature of isolated nuclear families (Lee 1997; Leung et al. 2005). Mothers also report a loss of their previous selves as they struggle to adjust to the new maternal role (Amankwaa 2005; Beck 1993; Beck 2002; Edhborg et al. 2005; Nicolson 1990; Oakley 1980). Motherhood is not what they expected it to be and they find themselves longing for their former independent, autonomous, and, perhaps, professional selves. Further, it is difficult to balance motherhood with careers (Horowitz and Damato 1999; Lee 1997; Taylor 1995).

To the extent that the “supermom” ideal is a feature of the white upper and middle class, more research is needed to document whether lower class and nonwhite mothers find failed expectations of motherhood to be central to their PPD experience (Taylor 1995). Indeed, Abrams and Curran (2009) found that PPD among low income African American and Latina women cannot be explained primarily by deflated expectations of motherhood or loss of self. Rather, these mothers were depressed by the daily life struggles (2009a: 359):

Mothers did not interpret this experience of “feeling overwhelmed” as an internal psychological state that was divorced or alienated from its larger context. Rather, these feeling of being overwhelmed were deeply grounded in the daily context of the strains of financial hardships, reliance on public benefits, a marginal relationship to the labor market, lack of social and childcare support, the demands of parenting multiple children and ill children, dangerous inner city environments, and often tenuous or completely nonexistent relationships with the children’s fathers....[T]he low-income women in our sample may not have shared the experience of an autonomous self as described by middle-class women in other studies.

Feminist scholars are critical of the PPD diagnosis for medicalizing troubles that are better understood as rooted in gender and social inequality. However, these studies have also revealed that

this diagnosis has helped women discuss their troubles and get help and support. As a limitation, these studies have only focused on mothers, been biased towards middle class mothers, and have largely recruited women with an actual diagnosis.

The Constructionist Model

The constructionist model problematizes the definition of PPD as a mental health condition, drawing on the limited evidence for hormonal etiology as well as the literature questioning whether new moms are at an actual increased risk for depression. Constructionists examine the process by which PPD came to be recognized as a mental health disorder, critically investigate claims made about PPD, and highlights alternative approaches for understanding perinatal emotional distress, including cross-comparative research. This model dovetails with the feminist model, which as addressed above, also examines the medicalization of PPD. The constructionist model, however, is not examining the occurrence of PMADs in individual parents so much as the occurrence of PMADs as a medicalized condition in society.

Indeed, most of the research in this vein is rooted in medicalization theories. Verta Taylor (1996) examined the emergence of this condition through women's health movement activities, in one of the earliest sociological investigations of PPD. Taylor found that in contrast to the dominant model of medicalization, in which doctors, pharmaceutical companies, or other experts lead the medicalization of a condition; the medicalization of PPD began as a grass roots movement led by mothers who struggled with depression after childbirth. Thus, women were active agents in medicalizing PPD rather than passive victims (Taylor 1996). The emergence of the paternal PPD diagnosis, which is not yet complete in regards to official recognition in the DSM, has not been systematically investigated. However, based on my observations, it is clear that this is following the more traditional top-down approach in which these diagnoses are being initiated by experts (e.g. researchers who are establishing this risk and practitioners who treat the condition), rather than as a consumer social movement among fathers.

Taylor and other feminist scholars have noted the contradictions of medicalizing emotional distress that occurs during the postpartum period (e.g., Nicolson 1999, Mauthner 1999), as also noted above. Whiffen argues that “the term ‘postpartum depression’ is misleading because it implies that the depression is related causally to having a baby,” (2004: 153) thus implying a biological etiology. In addressing the fact that mothers, in general, are at an increased risk of depression, Romito (1990: 10) asks:

[A] high percentage of mothers in general are distressed and unhappy; their suffering sometimes approaches what professionals define as a “psychiatric illness”. Is there any theoretical or practical reason then, for trying to identify (or better, to construct) different categories of suffering, labeling what happens in the first year after birth as “post-partum depression” and what happens later as “mental distress in mothers of preschool children”? Indeed [studies of mothers of preschool children] create grave doubts about the validity of postpartum depression as a concept, independently of how it is defined.

McMillen (2009) argues that the reason why PPD depression gets so much attention, compared to the high rates of depression among women in general, is because motherhood is such an important cultural role and society is very concerned about the consequences of “bad” motherhood. The medicalization of postpartum emotional problems has also been criticized for extending medical social control over mothering emotions and narrowly constructing the appropriate emotional responses (Regus 2007). However, this diagnosis also challenges dominant ideals of motherhood as joyful, self-fulfilling, and natural, as noted by Mauthner (1999: 152, see also Dubriwny 2010, Taylor 1996):

The label “postpartum depression” was a source of relief and reassurance to these women because it suggested that they were not “going mad.” Rather, they were experiencing a medically recognized “problem,” shared by other mothers, and for which they were neither responsible nor to blame.

Yet, mothers who are struggling are framed as having a medical condition, which may lead to the assumption that “healthy” mothers, then, are performing their idealized roles with little distress (Dubriwny 2010).

The social control and individualized aspects are accomplished through public education campaigns, screening, and popular discourse (McMillen 2009; Regus 2007). Sociologists have examined the construction of PPD depression in popular literature, finding it to be highly bio-medicalized. In a content analysis of popular magazines articles on PPD in the U.S. from 1980-1998, Martinez and colleagues (2001) found that while these articles were very inconsistent and contradictory, hormones were the most commonly cited explanation of PPD, oftentimes to the exclusion of other explanations. A follow up study on popular press articles published between 1998 and 2006 found a clear increase in articles about PPD (Schanie et al 2008).⁶ Biomedical causes of PPD still prevailed, although the gap between medical and social explanations had narrowed. Yet if only a single factor was mentioned, it was typically hormones. Overall, the range of information published was still contradictory and oftentimes inaccurate, but a few exceptional articles provided accurate and useful information. Both studies also found that the magazines privileged medical treatment of PPD (Martinez et al. 2001; Schanie et al. 2008). Content analysis of television news media and self-help books also primarily emphasize PPD as a biological problem (Dubriwny 2010, McMillen 2009). In sum, the popular media overemphasizes biomedical factors in comparison to actual evidence.

Unfortunately, web based media has not been systematically investigated from a constructionist perspective, despite the dominance of the internet for health and self-help information. Seventy-two percent of internet users, or 59% of all U.S. adults, sought health information online in 2012. Approximately 1/3 of U.S. adults use online searches to try to figure out what medical condition they or a family member/friend may have, with women and young adults more likely to engage in “online diagnosing” (PEW 2013). In the absence of systematic research on internet discourse on PMADs, as an aside to the literature review, I note that in consulting web-sources often throughout the course of my

⁶ The attention given to celebrity Brook Shield’s experiences with PPD, which included a public debate with Tom Cruise, may be responsible for the increased media attention, as well as the Andrea Yates case, in which a postpartum psychotic woman murdered her 5 children (Schanie et al. 2008; see also Dubriwny 2010).

research, internet discourse appears a lot more nuanced than previous content analysis of print resources suggest. Health information websites such as WebMD or Medline tend to offer simplistic, biomedical accounts, which is consistent with prior research, but advocacy offer more complex, multi-dimensional accounts of perinatal mental health. Further, the advocacy discourse tends to be responsive to new research, and, in fact, is a major outlet for disseminating new findings to lay audiences. In addition to a case study on the social construction of PMADs in internet discourse, there is also a need to better understand how new media, in general, expands the social control of medicalization but can also operate as a form of resistance.

Returning to the existing body of literature on the social construction of PMADs, anthropological research has pointed to perinatal emotional distress as being widely acknowledged across cultures, but with important cultural differences in how this problem is understood and treated (e.g. Oates et al. 2004). One cross-cultural qualitative study demonstrated that western and non-western cultures alike recognized the role of physical discomforts of pregnancy and childbirth, child rearing demands, low social support, problematic family dynamics, and sleep loss. However, only Western cultures adopted a medical view of this distress, citing biomedical causes as well as a need for psychotherapy or medical treatment. However, even among the Western nations, only respondents in the United States mentioned antidepressants as a treatment option. All cultures felt family support was vital, but western cultures also stressed the role of professional treatment (Oates et al. 2004). Unfortunately, there are insufficient measures for comparing rates of “postpartum depression” across cultures (Asten et al. 2004; Oates et al. 2004), which could be very informative for better understanding how cultural and structural forces shape the incidence of depression.

While additional etiological research is needed, many pathways and risks for PPD are now clear and it is generally accepted that there are multiple factors that contribute to depression and anxiety. However, additional PMAD conditions require far more research. While the designation of PPD as a

medical condition is widely accepted in many circles, there are concerns about medicalization and individualizing these troubles, especially in light of the scant evidence for hormonal etiology. The feminist and social constructionist models fall within the sociology *of* medicine tradition, meaning that it challenges, rather than accepts, the core assumptions of the medical professions (Straus 1957; Zimmerman 2000).

Addressing Perinatal Mental Health

It is not clear that PPD has a distinct etiology, although more research is needed on the other PMADs. However, many experts argue that these diagnoses are still called for because they can encourage help-seeking and promote effective treatment. Untreated parental mental health can have adverse consequences for children, and therefore it is believed that the PPD diagnosis and awareness of this condition helps encourage parents to seek help early. Further, it is thought that effective treatment needs to take their parental circumstances into account. For this reason, a brief review of the adverse consequences of PPD, help-seeking behavior, and treatment of this condition is warranted.

The Adverse Consequences of Perinatal Mental Health Symptoms

PPD is associated with adverse consequences for children and families. In sum, depressed parents may be less attentive or engage in questionable parenting practices, which can have lifelong impacts on child development. Depressed mothers interact less with their babies (eg., less talking, smiling, holding), engage in fewer safety practices (eg., well child visits, immunizations, home safety, car seat usage), and may be more punitive (eg., spanking, yelling) (Beck 2002; Field 2010; Letourneau et al. 2012; Logson, Wisner, and Pinto-Foltz 2006). In result, children of PPD parents are at increased risk for lifelong health, social, and cognitive delays (Logson, Wisner, and Pinto-Foltz 2006, Milgrom and McCloud 1996; Sluckin 1990). In more extreme cases, infants may be harmed or killed (Field 2010). More research is needed on depressed fathers, although one study examining fathers of one-year olds found that paternal depression increased the likelihood of them spanking their children and they were less likely to

read to their children (Davis, Davis, Freed, and Clark 2011; see also Bronte-Tinkew et al. 2007). Paternal PPD at eight weeks postpartum has been found to increase behavioral and social risks among their children later in life (reviewed in Fletcher, Matthey, and Marley 2006 and Musser et al 2012). More research is needed on other PMADs, but it is reasonable to assume that unmanaged perinatal mental health symptoms, of any sort, would have adverse consequences for children during this formative time of child development. Effective treatment and attentive parenting by the other partner (i.e., father) can help protect against these adverse consequences (Fletcher, Matthey, and Marley 2006; Melrose 2010). In light of a high correlation of depression across partners and increased awareness of paternal PPD, there is rising concern about the impact of depression on children when both parents are depressed (Fletcher, Matthey, and Marley 2006; Goodman 2004). Yet, the adverse consequences of poor parental mental health are not limited to birth parents or only to the perinatal period (Rosenquist 2013).

Marital dissatisfaction can be both a cause and consequence of PPD (Milgrom and McCloud 1996), and there is a high correlation of PPD across partners (Fletcher, Matthey, and Marley 2006, Escriba-Aguir and Artazcoz 2009; Goodman 2004; Paulson and Bazemore 2010). In general, the transition to parenthood increases marital distress (Cox et al. 1999; Lawrence et al 2008), and depression increases marital conflict and divorce risks (Burke 2003). Depressed people may distance themselves from important relationships, be more aggressive and temperamental in interpersonal interactions, or less engaged in co-parenting (Beck 1993, Burke 2003, Bronte-Tinkew et al. 2007; Letourneau et al. 2012)). The non-depressed partner often takes on additional parenting, household, and economic responsibilities. They may also be worried about the safety of their spouse and child when they are at work (Meighan et al. 1999; Siverns 2012).

Help Seeking Behavior

For the most part, help-seeking behavior for PPD has not been systematically studied (Dennis and Chung-Lee 2006), although it often emerges in the qualitative literature. Stigma is often found to be

a major barrier preventing help-seeking, which includes both the stigma of being viewed as a failed mother and/or the stigma associated with mental illness (Abrams, Dornig, and Curran 2009; Amankwaa 2003; Berggren-Clive 1998; Dennis and Chung-Lee 2006; Edhborg et al. 2005; McIntosh 1993). Amankwaa (2003) found that middle-class African Americans were reluctant to seek treatment it would counter their “strong black woman” self-image. Similarly, low-income women in another study initially dismissed PPD as something that “good mothers” cannot have (Abrams, Dornig, and Curran 2009). These attitudinal barriers can inhibit both informal and formal help-seeking. A study of low-income PPD women found that they were very hesitant to seek professional help due to negative past experiences with mental health services and resistance to pharmaceutical treatment (Abrams, Dornig, and Curran 2009). There appears to be a strong preference for informal help from family and friends (Abrams, Dornig, and Curran 2009; Amankwaa 2003; Dennis and Chung-Lee 2006).

No research, to my knowledge, has specifically examined help-seeking behavior for perinatal distress among fathers; however, men are generally less likely to utilize physical or mental health services (reviewed in Lorber 1997). The norms of masculinity encourage men to be strong and stoic, thus leading to many men ignoring or self-managing their symptoms (Lorber 1997; Oliffe and Phillips 2008). In developed nations, about half as many men as women are diagnosed with depression, with the gap partially explained by men’s reluctance to express and treat symptoms of depression (Oliffe and Phillips 2008).

The discourse surrounding perinatal mental health often stresses the large portion of mothers who do not seek help. These low help-seeking rates are seen as a problem that must be fixed, such as by highlighting barriers to treatment. However, less is known about men and women’s active decisions to seek or not seek professional help.

Treatment Approaches

Although various specialized treatment options for PMADs now exist, rigorous evaluation of treatment options is lacking and has focused primarily on maternal treatment to the exclusion of fathers. Medication is just as effective for general depression as for PPD, in which mixed results are generally found (Field 2010; France, Lysaker, and Robinson 2007). There is little evidence that medication, in general, is a superior treatment approach compared to therapy and other approaches (O'Hara and McCabe 2013; Rosenquist 2013). In treating maternal PPD, pregnancy and breastfeeding safety are a special consideration and need more research (Field 2008, 2010; Flores and Hendricks 2002; Fitelson et al. 2011; O'Hara and McCabe 2013; Rosenquist 2013). There are also concerns that misdiagnoses can lead to inappropriate medications; especially in the case of confusing bi-polar for PPD (Sharma and Burt 2011; Yonkers et al. 2012). The main advantage of medication is that it can be managed by primary care physician and is more widely available than psychotherapy services, rather than efficacy itself (O'Hara and McCabe 2013). Perhaps as a result of ease and availability, antidepressants appear to be the first line of treatment (Rosenquist 2013). Certainly, the profit-motive of pharmaceutical companies and direct-to-consumer advertised also contributes to this.

Yet, women generally prefer psychotherapy over medication (Dennis and Chung-Lee 2006; Fitelson et al 2011). A wide range of interventions and therapies (e.g., general counseling, interpersonal psychotherapy, cognitive behavioral therapy, psychodynamic therapy, group therapy) can be useful in treating PPD, but there is little evidence for a preventative impact (Dennis and Creedy 2007; Fitelson et al 2011; O'Hara and McCabe 2012). Therapy that is sensitive to the unique needs of pregnant and postpartum mothers is often recommended, but more evaluative research is needed. For example, perinatal sensitive therapy could address parenting anxieties, mother-infant bonding, role transitions, and interpersonal conflict (Clark et al. 2003; O'Hara and McCabe 2013). In recognition of family-level factors that can lead to or be affected by PPD, a family systems approach to therapy is increasingly

recommended (Letourneau et al 2012). Overall, however, the precise components of effective interventions are not yet known and more evaluative research is needed (Dennis and Creedy 2007; Fitelson et al 2011; O'Hara and McCabe 2013). Preferred and effective treatment for depressed or anxious fathers has not yet been thoroughly examined, although a few practitioners are beginning to specialize in this area (e.g., Dr. Will Courtenay). While more research is needed on professional mental health treatments, even less research has examined self-help or alternative mental health strategies, such as peer-support or nutritional supplements. Although we do not really know if common alternative approaches help, they also pose little risk (Fitelson 2011).

Although PMAD diagnoses are often justified on the basis that this helps promote perinatal sensitive treatment, there is surprisingly little research on effectiveness of such treatments. The fact that medication seems to be the most common treatment, even though mothers prefer therapy, confirms medicalization theorists fears about dependency on easy, individualized solutions and that these diagnoses serve the interests of drug companies. Although evaluative research on therapeutic approaches is lacking, it is plausible that perinatal sensitive or family systems therapy are helpful to many mothers. Yet, we know little about the extent to which such services are promoted and available for parents seeking perinatal mental health support.

Research Gaps and My Study

While research on PPD has been broad and multidisciplinary, sociological contributions are underrepresented and not well integrated with feminist literature on families. We have seen that perinatal mental health conditions are contested, in that it is not clear if these are distinct diagnoses. The biomedical and psycho-social models have revealed many interacting risk factors, but have not demonstrated that most PMADs are necessarily unique compared to their root condition (that is, postpartum depression is just depression). However, these diagnoses may be useful for encouraging help-seeking and promoting more effective treatment, which is important in light of the adverse impact

of poor parental mental health on children. Nonetheless, medicalization theorists are especially critical of these diagnoses, as a form of social control that individualizes women's troubles. However, these studies largely focus on expert and professional discourse, rather than lay experiences and perspectives. Feminist theories are also critical of this medicalization, but in examining the lived experience of PDD, they note many advantages for helping mothers get help and support. Yet, a shortcoming of these studies is the inclusion of only study participants who are either professionally or self-diagnosed with PPD, resulting in research that is biased towards the perspective of mothers who accept PPD as a legitimate diagnosis. Therefore, we know little about how diagnostic understandings of these conditions impact the experiences of those with mental health distress but with no actual diagnosis. These studies are also biased towards middle-class, white women. Neither medicalization nor feminist theorists have examined the extension of these diagnoses to fathers, which may be especially interesting in light of changing gender roles and also speaks to the growing influence of the institution of medicine. In general, there is limited research on the other PMADs, although these other conditions ultimately point to the expansion of medicalization, for better and worse.

My sociological study applied and built on feminist theories of gendered carework and sociology of diagnosis, united by a social constructionist approach. In light of the diversity of possible perinatal mental health conditions as well as the contested etiology and definition of conditions, PMADs are surrounded by many mixed messages. My study focused on how new parents who experience mental health symptoms made sense of their experiences and acted on their symptoms. This included an exploration of how these diagnoses shaped their understandings of their troubles, as well as alternative cognitive schemas they offered. Likewise, I also examined lay reactions to perinatal emotional troubles, which ranged from medical help-seeking to making life changes. My study also sought to expand the feminist model by further examining the social factors and cultural expectations that shape perinatal mental health among a class-diverse sample of mothers and fathers. The feminist approach helps to

counter the overemphasis on biomedical and individual-level risk factors, which is especially important as perinatal mental health diagnoses are being extended to new populations and conditions. My study was rooted in the more critical, sociology of medicine tradition, which does not take these diagnoses for granted; however, my investigation of parents' direct experiences with perinatal emotional distress and help-seeking also affirmed the value of mental health diagnosis as well as unmet treatment needs, and therefore, also contributes to the sociology *in* medicine.

III. Research Methods and Sample

My analysis was based on an in-depth qualitative interview study of 47 new parents who experienced perinatal mental health symptoms. In this chapter, I describe my analytical approach, recruitment strategies, final sample characteristics, interview data collection, and data analysis techniques. My study was conducted under the guidance and approval of the University of Kansas Human Subjects Committee of Lawrence (HCSL #19231), in full compliance with the standards of ethical research.

Analytical Approach: Qualitative Research and Grounded Theory

Qualitative research methods provide rich and nuanced data that can reveal new insights not well captured by standardized survey design. Qualitative researchers reveal patterns of social interaction and social life, rather than statistical generalizability (Warren and Karner 2010). I was interested in how parents describe their lived experience with marked emotional distress during the transition to parenthood, and this analysis was facilitated by symbolic interactionist and grounded theory approaches. The in-depth interview method moves beyond treating participants as simply informants, to also consider them as valuable experts on the social phenomena in question. The interview method I employed was designed to solicit illness narratives; my interview guide is further detailed below in data collection (see also Appendices A and B). Illness narratives are “the story-telling and accounting practices that occur in the face of illness,” generally across multiple levels, from the individual characteristics to external factors that impact a person and their illness (Bury 2006:82; see also Bury 2001 and Reissman 1993). For the patient, illness narratives help them deal with their new reality. For the researcher, these narratives prioritize patient viewpoints and also reveal important cultural patterns.

Grounded theory is a qualitative approach that stresses an ongoing relationship between collecting and analyzing data, and flexibility throughout the research process (Charmaz 2002, Glaser and Strauss 1967; Strauss and Corbin 1990). The original formation of grounded theory eschewed explicit theoretical frameworks and research questions, arguing that theory development should be grounded in the data rather than testing existing theories (Glaser and Strauss 1967). The original conception of grounded theory, although inductive, was still largely based on a positivist, objective understanding of theory, in which data and findings are thought to reveal universal, generalizable truths (Charmaz 2006). The ability to enter research with no preconceived theories has since been widely questioned (e.g. Atkinson, Coffey, and Delmont 2003, Charmaz 2006), and grounded theory is also sometimes criticized for paying insufficient attention to social context and macro forces (e.g. Burawoy 1998). In contrast, a constructionist approach to theory and grounded theory methods stress that analysis cannot be separated from the larger context (Charmaz 2006). Further, feminist scholars have illustrated research is always impacted by the knowledge and positionality of researchers (Sprague 2005). I entered this project as a young, white mother, from a working class background but ascending to the middle class, which undeniably influences my interpretation of the data. My academic approach builds on the social construction of health and illness and feminist theories, and is also situated in the multi-disciplinary body of research on perinatal mental health, rather than eschewing existing data and findings.

Although my study is not wholly inductive in nature, grounded theory analytical techniques are useful, especially the newer approaches that focus on interpreting socially constructed realities (Charmaz 2006), which in my study includes parenting ideologies, gender ideologies and practices, illness narratives, and lay health knowledge. In particular, the iterative and dynamic analytical techniques of grounded theory are useful in promoting an honest fit between preconceived theory and the data collected, including the possibility of revising or discarding these theories as indicated by

emerging themes. In this sense, I aimed to refine or reconstruct theory more so than build new theory from the ground up.

Recruitment Procedures and Participation Criteria

I used convenience sampling techniques to identify the unique group of parents I was seeking. Research participants were recruited on the basis of experiencing symptoms of PMADs, rather than having a diagnosis. In my recruitment materials, I sought participants who “went through an emotionally difficult time after your first child was born. For example, you had strong feelings of sadness, fear, anxiety, anger, or frustration.” These symptoms had to occur within the first year post childbirth, and last for at least two weeks, which is consistent with the literature and professional treatment of PMADs. This approach was essential for exploring a wide variety of lay beliefs and illness behavior; as noted in the previous chapter, previous qualitative research has focused only on parents with a diagnosis which may be biasing findings towards those who accept the legitimacy of PMAD conditions. To better explore variation on how parents understood, accounted for, and reacted to their symptoms, it was important to recruit both those who did and did not have an official diagnosis.

I introduced additional “controls” to my study participation criteria, to help narrow the focus on my specific research interests. I recruited first-time parents to better explore cultural expectations of parenthood. Parents also had to be in a cohabitating or married heterosexual relationship, due to my research questions on gendered caregiving. Thus, both mothers and fathers had to be present in order to truly investigate how changing gender roles are negotiated in everyday life during the transition to parenthood. Further, single parenting and homosexual parenting introduce many additional stressors that were beyond the scope of my study and therefore such parents were not recruited for my study.

Participants were recruited primarily from a medium-sized college town and large metropolitan area in the Midwest through flyers, letters, and snowball sampling. Recruitment letters were distributed through childcare centers, family agencies, and doctor’s offices; a copy of my recruitment letter is

included in Appendix A.⁷ Participants were offered \$25.00 for their time, funded by a small research grant from the Midwest Sociological Society (MSS). The letters distributed through childcare centers were the most effective recruitment strategy. Only one doctor's office agreed to distribute letters, which resulted in a single recruitment. I found that doctors' offices were difficult to access, as most simply ignored my request and follow-up calls. To expand my outreach to fathers, I also posted a small recruitment blurb in the newsletter of local non-profit that promotes fatherhood as well as a forum post of the website "Postpartum Men." Both of these strategies produced some results. Snowball sampling and word-of-mouth was also a very effective recruitment strategy. A few early participants were key in referring other parents, and my own personal contacts also helped spread the word about my study. Many fathers were recruited through their wives, suggesting that women were important in encouraging fathers' participation. Further, my study gained some local press in 2012, which led to some additional participation.

Final Sample

My final sample of 47 parents included 30 mothers and 17 fathers. The mothers included one from the upper-class, 14 from the middle class, and 15 who were low-income. The fathers included 14 from the middle-class and 3 who were low-income. See Table 1, at the end of this section, for a complete overview of participant characteristics. All participants were assigned a pseudonym, and shared last initial was assigned to help link couple participants together.

I defined low-income as either parent or their child qualifying for any type of means-tested government assistance. This ranged from Stacey, who was homeless with no source of income, to the Bs who had three jobs between them, but their children still qualified for Medicaid due to low wages. Middle class was an even more broadly defined category, as being everyone who did not qualify for government aid but not clearly wealthy. This ranged from the Cs and Scott, whose families just barely

⁷ To my knowledge, no one was actually recruited through the flyers, which were posted in public spaces, and therefore a copy of this is not included.

did not qualify for any assistance, to a couple families with annual incomes over \$100,000. One mother, Sachi, may have met my definition for low-income, but it was unclear as her family never actually applied for aid. In light of her ambiguous income, I deferred to the fact that she and her spouse both had college degrees in assigning her into the middle-class group. There was one mother, Elizabeth, who belonged to the upper-class. For analytical purposes, I grouped her with the middle class parents because I cannot draw conclusions about how perinatal mental health may differ for the upper class based on a single respondent, and Elizabeth herself came from a middle-class background. Importantly, I compared her illness narrative closely to those of the middle-class mothers, and found that their stories were largely the same. Elizabeth did not have to worry about finances and was able to hire household help, but the culture of motherhood she subscribed to and her non-financial stressors as a new parent were consistent with those found in the truly middle-class sample.

The educational backgrounds of these parents are consistent with larger socioeconomic patterns. Most of the low-income parents had a high school level of education, although a few had a college degree and others were working on one. All but three of the middle class parents had a completed college degree, and several had advanced graduate or professional degrees. Most of these professional degrees were held by the mothers. Several middle class mothers were more educated than their partners, including those who participated as individuals.

My participants were mostly white, but with two African American mothers, two Asian mothers, who were also immigrants, one Hispanic mother, one biracial mother (white/African-American), and one African American father. Two of the fathers were European immigrants living in the United States, and one father resided in the United Kingdom. The Bs were in an interracial relationship, and participated as a couple. Five other participants, who participated as individuals, were in interracial relationships.

The age of my participants at the time of childbirth ranged from 16 to 47 years.⁸ The fathers were only two years older than the mothers, on average. Low-income mothers were an average age of about 24 years compared to 30 years for the middle class mothers, which is consistent with larger SES trends. However, the low-income fathers were older than their middle class counterparts, which is likely an anomaly of my very small sample of low-income men.

Almost all of the middle class participants were married, with the exception of two fathers. Cohabitation was more common than marriage among low-income participants; although interestingly, a few respondents still referred to their partners as their wife or husband, noting that they consider themselves married. Seven relationships, all among low-income parents (6 mothers, 1 father), ended between the time of childbirth and our interview, but a few moved towards engagement or marriage.

The mental health symptoms/conditions of my participants are presented in the next chapter, as this was part of my analysis on lay beliefs and the social construction of health and illness. A wide range of mental health symptoms and conditions were represented, but mostly depression. About one quarter of the participants did not seek any type of mental health treatment, but their symptoms were generally characteristic of how PMAD conditions are described. Their mental health symptoms occurred during pregnancy or within the first year following childbirth. Again, for the purpose of my study, how parents understood, accounted for, and reacted to their symptoms was more important than a precise diagnosis, and, in fact, the analysis of lay beliefs and illness behavior was expanded by a broad definition of perinatal distress.

A few participants were exceptions to my participation criteria. Erica was not cohabitating with her son's biological father; but rather, his stepfather. However, Erica and her fiancée began dating and cohabitating before her baby was born. The biological father abandoned her immediately upon pregnancy, and her fiancée is the only father her son has known and he has been there from day one.

⁸ Nicole participated in my study as an adult, but was a teen when she first became a parent. HSCL criteria required that participants were adults at time of interview participation.

Bethany gave birth to a previous child who was put up for adoption. She does have two “stepchildren” who live with her and partner on a shared custody arrangement; however, she did not help raise them when they were infants or toddlers. Thus, for all intents and purposes, her current baby was her firstborn. Stacey also had a previous child, who died in an accident at a young age. I probably would have excluded Stacey from my study, but she did not disclose that she had a previous child until later in our interview. At that point, I found that her illness narrative still held value for my study. Scott also has two “stepchildren” from his fiancée. Scott and his fiancée began cohabitating during their pregnancy, so he became a “stepfather” and biological father around the same time. He did not raise his stepchildren as babies or toddlers, but received more guidance than the typical first-time father due to his fiancée’s experience. Finally, Nicole was a teenager when she experienced depression with her first baby, and while she resided with her boyfriend and his mother some of this time, they were not truly in a serious long term relationship. She experienced depression again with the pregnancy of third child, in the context of an on-again-off-again, cohabitating, long term relationship. We discussed her experiences during both of these periods in her life rather than focusing only on her initial transition to parenthood. I still found aspects of her story to be relevant to my research questions. Finally, I had wanted all of my participants to be from the United States due to our unique social policy context, but I allowed Giles to participate from the UK as I needed more father participants. Aside from the different family policy context, the rest of his story was still relevant to my research questions.

I do not feel that the low-income fathers are representative of low-income men in general. In addition to the fact that this was a very small group, some of these men were also outliers in regards to age and education. My sample also had limited ethnic diversity. Therefore, my analysis was limited in its ability to examine patterns of race, in general, and SES patterns, among fathers. However, I was successful in recruiting some hard to reach populations.

Prior feminist studies on PPD have been biased towards middle class mothers, but researchers generally noted an attempt to secure a more economically diverse sample. A few key strategies were critical to my success in recruiting this population. I allowed for cohabitation instead of strictly requiring marriage. Although cohabitation is growing across all sectors of American society, it is more common among low-income and working class families (Fields 2004). However, these families still represent a two-parent household which was more important for my research questions than the legal status of their relationship. I did not require a diagnosis, which as explained above was essential for my research questions on lay beliefs and illness behavior. I was also concerned that requiring a diagnosis could result in class biases, when low-income individuals are less able to afford mental health treatment. I also made sure to recruit in childcare centers and family service agencies that accepted state funded payment sources. One Head Start center was useful in pointing out that my original recruitment letter was above the literacy level for their clientele. I revised my letter accordingly, and felt that the new letter was more effective in recruiting parents in general. I have been a low-income mother myself, and it's possible that this also helped me be more sensitive to recruiting and interviewing low-income mothers.

Recruiting fathers was more challenging than recruiting mothers. I feel my recruitment letter was written to be equally attractive to mothers and fathers, but still limited by the fact that men are generally less prone to discuss emotions. It is possible that my gender as a female limited some male participation. Additionally, mothers generally have more involvement with childcare and family services, my most successful recruitment spaces. As noted above, mothers were important gatekeepers to fathers' participation; and in result, over half of my fathers participated as a couple. The postpartum men website was essential to recruiting my last three fathers, which also expanded my study beyond the local area. It is interesting that the leading website on postpartum depression and anxiety in fathers only yielded three results, further pointing to a gender pattern regarding the willingness to participate in

an interview study on perinatal mental health, compared to the relative ease of recruiting mothers for my study. Nonetheless, I still managed to recruit a satisfactory sample of 17 fathers. In addition to simply being diligent in identifying new recruitment spaces, I feel that not requiring a diagnosis was also helpful in recruiting men.

Table 1. Participant Characteristics

Name*	Characteristics at Time of Childbirth						~Age of child at interview	Notes
	Age	Marital Status	Race	Class	Edu.	Employment		
<i>Couple Participants (n=20)</i>								
Randall A.	mid 40s	Cohabit	W	Low	BA	FT entry level human service	2.5 years	Loses job within first year, remains unemployed
Laurie A.	mid 30s		W		MA in progress	FT entry level/ student		
James B.	mid 20s	Married	B	Low	Tech. degree in progress	FT+PT entry level service work/ student	3.5 yrs.	
LeAnna B.	mid 20s		W		Tech. degree	FT service work		
Cory C.	low 30s	Married	W	Lower middle	BA in progress	FT human services/ student	6 yrs.	
Alyssa C.	low 20s		W		HS	Homemaker		
Kevin D.	late 20s	Married	W	Middle	MA in progress	FT in IT/ student	8 mos.	Laid off, followed by homemaker than PT position within 1 st yr
Lydia D.	late 20s		W		MA	FT education		
Rich E.	mid 30s	Married	W	Middle	BA	FT retail managerial	1.5 yrs	
Kara E.	late 30s		W		PhD in progress	PT Higher Ed & Research/ student		
Matt F.	mid 30s	Married	W	Middle	Some college	FT in IT	1.5 yrs.	
Jenna F.	low 30s		W		PhD in progress	PT Higher Ed & Research/ student		

Name*	Characteristics at Time of Childbirth						~Age of child at interview	Notes
	Age	Marital Status	Race	Class	Edu.	Employment		
Brandon G.	low 30s	Married	W	Middle	BA in progress	PT education/student	1 yr.	
Susan G.	low 30s		W		MA	FT higher ed admin		
Jeff H.	late 20s	Married	W	Upper Middle	MBA	FT Industry	2.5 yrs	
Sabrina H.	late 20s		W		BA	FT Human Services		
Ben I.	low 30s	Married	W	Middle	MA	FT Higher Ed. Admin	6 yrs.	
Jill I.	late 20s		W		MA	PT Research		
Anthony J.	mid 20s	Married	W	Middle	MA	FT Finance	2 yrs.	
Julie J.	mid 20s		W		BA	FT Education		Loses job as a result of extended medical leave
<i>Individual Father Participants (n=7)</i>								
Jack	low 40s	Cohabit	W	Middle, then low	BA	FT construction ^	3 yrs.	^Lost job, then occasional self-employed work
Scott	late 20s	Cohabit	W	Low Middle	BA in progress	3 PT positions	2 yrs.	In an interracial relationship
Thomas	low 30s	Married	W	Upper Middle	BA	Homemaker	2+ yrs.	Returns to education field within 1 st yr
Dylan	low 30s	Married	W	Middle	MA	FT professional	6 yrs.	
Sean	mid 30s	Married	W	Upper Middle	BA	FT in IT	2+ yrs.	
Alex	low 40s	Cohabit	W	Middle	BA	FT	1 yr.	In an interracial relationship
Giles	late 30s	Married	W	Upper Middle	M.S.	FT human services	2 yrs.	Resigns from job around a yr.
<i>Individual Mother Participants (n=20)</i>								
Stacey	low 30s	Cohabit	W	Low	GED, some college	Un-employed; volunteers	3 mos.	Left partner almost immediately, becoming homeless
Erica	low 20s	Cohabit	W	Low	Some college	PT service	3 yrs	Job changes and unemployment during 1 st yr.
Desiree	low 20s	Cohabit	W	Low	<H.S.	PT entry level health	3 yrs	In an interracial relationship. Laid off and becomes homemaker in 1 st yr.
Andrea	mid 20s	Married	W	Low	AA	FT service	3 yrs.	Later divorces

Name*	Characteristics at Time of Childbirth						~Age of child at interview	Notes
	Age	Marital Status	Race	Class	Edu.	Employment		
Kristi	low 20s	Cohabit	W	Low	BA in progress	FT service/ Student	2.5 years	Leaves partner within 1 st yr.
Bethany	low 20s	Cohabit	W	Low	GED	Homemaker	4 mos.	Seeking employment
Isabella	mid 20s	Cohabit	Hisp.	Low	Some college	Homemaker	3.5 yrs	
Caitlyn	low 20s	Cohabit	W	Low	BA in progress	Homemaker /student	1 yr.	
Kassie	mid 20s	Married	W	Low	BA in progress	PT entry level	2.5 yrs	Leaves partner
Madison	adult teen	Cohabit	W	Low	H.S.	Homemaker	2 yrs.	Leaves partner within first year, then entering work and college
Robin	25	Married	W	Low	H.S.	Homemaker	3 yrs	Later divorces
Nicole	1 st : teen 3 rd : mid 20s	Cohabit	W/B	Low	GED	Unemployed, followed shortly by mix of PT/FT service work	1 st : 8 yrs; 3 rd : 1 yr.	In interracial relationships
Samantha	mid 20s	Married ?	W	Low	BA in progress	Homemaker /student	2 yrs.	Returns to work later
Sachi	low 30s	Married	Asian	Lower Middle	BA	Homemaker	3.5 yrs	In an interracial relationship
Natalie	late 20s	Married	W	Middle	BA in progress	Homemaker /Student	2 yrs	Employed after graduating, within 1 st yr.
Miki	low 40s	Married	Asian	Middle	PhD	FT Research	2 yrs.	
Shelley	low 30s	Married	B	Middle	MA in progress	Homemaker /Student	2 yrs.	
Emma	mid 30s	Married	W	Upper Middle	PhD	FT Research	5 yrs.	Resigns position within 1 st yr.
Linda	late 20s	Married	W	Upper Middle	MA	FT Higher Ed Admin	6 yrs.	Resigns position later
Elizabeth	late 20s	Married	W	Upper	MA	FT Education	2.5 yrs	Resigns position within 1 st yr.

**All names are pseudonyms. Shared last initials are used link couples to each other in the following chapters.*

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Data Collection and Analysis

I interviewed all mothers and fathers using the same semi-structured interview guide, although my interview guide evolved slightly over time; the final version of my interview guide is included in Appendix B. I asked about illness experience, family background, expectations of parenthood, marital/partner relationships, division of labor, employment, parenting stressors, help-seeking behavior, and lay definitions of PPD. The interview guide was carefully constructed to allow participants to share their own accounts of their emotional distress, before I asked more specific risk factors as informed by the literature. For instance, early in the interview, I asked participants open-ended questions on what they were experiencing and why they felt this way. After fully exploring these responses, I asked more specific questions about risk factors based on the literature. In discussing their mental health “condition,” I used the same labels that individuals applied to their own situation, whether it was a clinical condition, such as PPD, or was just referred to as stress. When no clear label had been applied by the respondent, I simply referred to their “emotions” or “distress.” I turned specifically to PPD at the end of the interview, to explore lay understanding of this condition and whether respondents felt this diagnosis applied to them. I probed thoroughly into their responses, and also summarized and repeated back their statements to ensure I held an accurate understanding, which was indeed helpful in allowing parents to clarify what they had shared. I also administered a demographic face sheet to collect information on age, employment, income, education, and race of the respondent and their partner.

I interviewed parents at a location and time that was convenient for them, which was typically their home while their child was at childcare or taking a nap. Some parents preferred meeting at my office or in a quiet public space like a library or coffee shop. All but one participant were interviewed in private.⁹ One mother, Bethany, was only comfortable being interviewed with her partner, who was not a participant himself, and I accommodated this request. I had some concerns that she might hold back

⁹ That is, private from personal relations as some did chose public locations where bystanders may have overheard portions of the interview.

some information, but her partner actually encouraged her to share more. When couples participated, they were interviewed apart from each other with confidentiality extending to their partner. Four interviews with fathers were conducted by phone due to geographical distance. The interviews lasted just under 2 hours on average, ranging from 1 hour and 15 minutes to 3 hours. The only clear group differences in length of interview is that the interviews with low-income men were significantly shorter; however, with only 3 fathers in this category, it is difficult to say if this was a class-based pattern. Interestingly, the four interviews with the fathers by phone lasted substantially longer, suggesting that the anonymity of a phone interview may have facilitated more disclosure. The length of the interviews, in general, allowed me to explore a range of biomedical, individual, family, and social factors in-depth. Although I was initially concerned that a lengthy interview touching on many private topics may be burdensome, no one indicated fatigue nor declined to answer any questions. In fact, many participants commented they appreciated being able to share their story in a complete and holistic manner, and were motivated to share private details in hopes of helping future parents in their situation.

Interviews took place from summer of 2011 through early spring of 2013. Parents were interviewed from about three months after childbirth to up to eight years later, with most interviews clustering around one-to-three years post childbirth; this is represented in Table 1 in the column labeled “age of child at interview.” Originally, my research design stipulated that their first born had to be 3 years old or less, but I found this to be overly restrictive especially as parents with older children asked to participate. My initial concern was that participants would forget key details if too much time had lapsed, but I found that parents memories remained strong even after several years, likely because having your first child is such a monumental life event.

The interviews were audio-recorded and transcribed. Interview transcripts were analyzed using open-coding procedures assisted by Atlas.ti qualitative software; coding details are further detailed below. I employed a transcriptionist, who was instructed to transcribe the interviews verbatim. I was

able to review my transcripts relatively soon after each interview. My analysis in the following chapters provides quotes throughout to support my findings. These quotes were edited for clarity, largely by removing fillers (e.g., 'uh' 'uhm' 'you know' 'like'), stammering and repeated words, or unintentional errors in speech, as I felt readability was more important than capturing all of the nuances of speech and I was not conducting a conversation analysis. These edits were minor, in scope and quantity, and I was careful not to change the meaning of quotes.

Qualitative research is inductive and interpretive in nature, and therefore generalizability, reliability, and validity are typically treated together under concerns about quality, rigor and trustworthiness (Golafshani 2003). This is supported through the iterative research design of grounded theory, in which data collection and analysis inform each other in an ongoing process. I made slight revisions to my interview guide based on emerging results. I also presented preliminary research results to academic audiences, human service professionals, and popular media fairly early in the research process, which created a valuable feedback loop for additional data collection and analysis. Although I used qualitative analytic software to assist with coding and organization, I still reviewed complete transcripts so as to not lose sight of the full context of people's stories.

With over 90 hours of interview audio, touching on so many different factors, I often felt like I was drowning in data. My biggest challenge was making sense of all this data, and in light of the large and ever growing body of research around perinatal mental health. My transcripts were coded for subtopics, for organizational purposes, and for emergent themes, for analytic purposes. Even with software-assisted coding, the amount of data and codes I had was overwhelming. I kept a running list of interesting points and patterns, as my approach to analytic memos. I also sorted key details of each illness narrative into tables to help identify patterns; some of these tables are shared in the appendix as they also provide the reader with a comprehensive overview of key aspects of each participant's illness narratives. After my chapter structure began to emerge, I conducted a second layer of coding based on

which chapters and sub-sections quotes may fit into. My findings were further refined as I prepared conference presentations, spoke with colleagues, engaged with perinatal mental health advocates, and drafted my dissertation. Analyzing data and writing up the results are often intertwined in qualitative research, which was certainly true of my research style.

IV. What Is This? *Naming One's Condition*

“Maybe when our moms were being new moms it’s what you call new motherhood, that’s just what it was. You didn’t have names like postpartum depression and it was just expected. And the moms who got it, you had to hide it, because that’s what was expected of you.... Just help these other moms know that it’s a fairly normal thing to go through. Like 20% of new moms experience some sort of postpartum mood disorder.” –Lydia D.

“I think society understands that mothers can be depressed, but I don’t think there’s a general understanding that fathers can.” –Thomas

The postpartum depression (PPD) diagnosis did not always exist, as recognized by parents in this opening quote. Lydia D., a white, middle-class mother, recognized the benefit that the PPD diagnosis had for herself and mothers like her; whereas Thomas, a white, middle-class father, came to learn about paternal PPD but points to the need for more widespread awareness about depression in fathers. In this chapter, I explore the labels that parents applied to their condition. How do they come to define themselves as having, or not having, a PMAD? I found that many parents accepted and benefited from a mental health label, while others were more inclined to view their situation as simply having difficulty in adjusting to parenthood. Although the latter group reported mental health symptoms that were atypical for them, they questioned whether they truly had depression, anxiety, or any other clinical mental health condition. As such, their troubles have not been constructed as illness, although accounting for distress still occurred. Fathers were the most hesitant to adopt a mental health label, which likely reflects norms of masculinity as well as limited awareness of paternal mental health. Most parents applied diagnostic labels to their conditions – primarily postpartum depression but a variety of other mental health diagnostic labels were present, including anxiety, PTSD, bipolar disorder, and psychosis. The application of labels was shaped by awareness of PMAD conditions, the nature of symptoms, prior mental health histories, and professional diagnostic feedback loops, as well as gender and class.

The first step in constructing illness is the simple recognition that something is wrong. After noticing that something is out of order, then begins the process of creating order. In the case of perinatal mental health, this includes naming one's condition, explaining why it happened, and working to get better. This chapter focuses on what parents called their condition, as shaped by awareness of the different mental health conditions. In the following chapters, I examine parents' accounts of why their distress occurred and the responses they took to ease their symptoms. Although I bracket these dimensions into separate chapters, in reality, these processes of constructing illness overlap and interconnect, rather than simply proceed sequentially. As observed by Lorber (1997), "The perception that something is wrong and the guesses as to the cause are always experienced in a social context.... In every society, the symptoms, pains, and weaknesses called illness are shaped by cultural and moral values, experienced through interaction with members of one's immediate social circle and visits to health care professionals and influenced by beliefs about health and illness" (1997:1). Once troubles are recognized, parents soon begin making sense of them through labeling. Is it just the normal stress of having a baby? Maybe this is postpartum depression? Of course, explanations of what caused the distress shape how it will be labeled. Is it related to becoming a parent, or other life stressors? The actions parents take to relieve their distress also shape its label. Some distressed parents responded by seeking medical help, where professionals take over naming. The doctor or therapist may accept, reject, or reshape the person's account of their distress. Yet, even among those who chose not to seek professional help, self-diagnosis is rooted in general understandings of perinatal mental health, and often involves consulting health websites and books, where advice on managing distress is given. Actions taken to relieve mental health symptoms then feedback into labeling through whether or not the action taken was effective – for example, if the medication worked, the diagnosis was correct, but if not, other diagnoses and treatments must be considered. In sum, PMADs were constructed through interactive processes of labeling, accounting for why, and responding to mental health symptoms; and

this sequencing varies across illness narratives. This dissertation organizes these three aspects into separate chapters for organizational neatness, but they always overlap and interact.

In this chapter, I overview the labels and diagnoses applied to the emotional distress experienced during the perinatal period by the parents in my study, including both professional and self-diagnosis. Depression was the most common label applied, but other conditions were present and several participants questioned if they had a clinical condition at all. Many mothers applied the PPD label to their condition, which was shaped by widespread awareness of maternal PPD. There was less awareness of paternal PPD, which may explain the hesitancy of fathers to apply a clinical label to their condition. As diagnostic boundaries can be difficult to define and apply in everyday life, I then look at various factors that shaped how a condition was labeled, which includes the nature of one's symptoms, previous mental health histories, and larger life contexts. Finally, I examine how a mental health diagnosis during the perinatal period sometimes led to new lifelong understandings of one's mental health.

Diagnostic Overview

Table 2 provides a basic overview of the diagnoses represented in my study, demonstrating diagnostic type by the number of parents by gender and class, as well as the overall frequency of professional or self-diagnosis for each condition. Table A3, in the appendix, provides a more detailed overview of the mental health labels by each parent. Understanding that labels shift over time, this diagnostic overview represents the *final* label offered by parent as the *most plausible* name of their condition, at the time of our interview.¹⁰ Initial premonitions may become the final label –it really was just stress or it truly was postpartum depression, for example. Other labels shift over time, such as when “just stress” does not go away after several weeks or months, and the individual then comes to understand their condition as depression or anxiety. These conditions ranged from the non-clinical baby

¹⁰ Interviews took place from about 3 months to 8 years following childbirth, with a cluster around 1-3 years. See Table 1 in the previous chapter.

blues to postpartum psychosis. Diagnoses are not mutually exclusive, with a few parents experiencing more than one mental health condition during the perinatal period. Again, most labels reflect a prolonged feedback loop across the stages of constructing illness, but I present them now so that the reader can understand the overall diversity of perinatal mental health conditions experienced by the parents in my study.

Table 2. Diagnostic Overview

		Baby blues/ Just stress	Baby blues or possible depression	Depression, perinatal onset or preexisting worsens	Anxiety, perinatal onset or preexisting worsens	PTSD, perinatal onset	Bi-polar, Preexisting worsens	Postpartum Psychosis
Gender and Class	mid. class mothers (n=15)	0	1	12	1	0	0	1
	L.I. mothers (n=15)	0	2	12	4	2	1	0
	mid. class fathers (n=14)	1	4	7	2	0	0	0
	L.I. fathers (n=3)	0	3	0	1	0	1	0
Type of Diagnosis	Self dx	1	10	13*	1	0	0	0
	Prof. dx	0	0	18	7	2	2	1
Subtotal**		1	10	31	8	2	2	1

Notes:

*One mother received an adjustment disorder diagnosis, but does not agree with this diagnosis and instead self-diagnosed with PPD.

**Diagnostic labels were not mutually exclusive and therefore, add up to more than the total sample size of 47. For example, some parents reported depression and anxiety. However, others noted they had depression with anxiety-dominant symptoms, which I characterized as only depression since this was the label they applied.

We can see most participants identified with a depression diagnosis, at 31 of 47 parents. Additionally, many parents reported symptoms of depression, but were ultimately uncertain whether their condition was clinical in nature. At the least, these ten parents could be said to have the “baby

blues,” the most common mental health “condition” during the postpartum period. The baby blues have not been clearly defined, but is not considered a clinical mental health condition (Burt and Stein 2008). These 10 parents did not seek a diagnosis, although a small number received limited counseling. It is likely that *some* of these parents would have received a diagnosis, if treatment were sought. However, there’s no way of determining which parents would have been diagnosed and what specific diagnosis would be most appropriate. It is interesting to note that fathers were most likely to be in this uncertain category, in addition to a father who was certain that he did not have a mental health condition (i.e., just stress). Further, when pressed, most fathers in the uncertain category were inclined to think that “just stress” was more plausible, whereas mothers tilted more towards the possibility of depression. Turning to those who more confidently reported they had depression, middle class and low-income mothers were about equally likely to cite depression. However, the middle mothers were more likely to explicitly identify as having prenatal or postpartum depression; whereas several low-income mothers spoke to depression, more generally. As stated by Erica, a young, low-income, black mother, “I mean, depression is depression, no matter what other name you put in front of it.” Although other parents did care about this distinction, but were uncertain about the definition of postpartum depression, as will be detailed further below. The high self-diagnosis rate for depression is interesting, which likely speaks to the high awareness of PPD, as will be further detailed in the next section, and therefore, greater currency of this diagnostic term.

Eight parents had an anxiety diagnosis, but it is worth noting that many of the mothers and fathers who labeled their condition as prenatal/postpartum depression spoke of anxiety-dominant symptoms. Most everyone referred to anxiety in general, rather than qualifying it as a perinatal condition. That is, hardly anyone labeled their anxiety as *prenatal* or *postpartum* anxiety, whether self or professionally diagnosed. The one exception is Sabrina, who offered “prenatal anxiety” as the probable diagnosis for her severe symptoms during pregnancy. Although the qualifiers “postpartum” and

“prenatal” were seldom attached to these anxiety diagnoses, they all stressed life circumstances and emotions connected to the transition to parenthood. Finally, a few parents experienced PTSD, bi-polar flare-ups, and postpartum psychosis. There are no clear gender differences regarding anxiety and the other conditions, but likely due to the overall small numbers of these conditions. Nonetheless, this helps demonstrate the diversity of PMADs.

As this diagnostic overview includes both professional and self-diagnosis, they may not be “correct” diagnosis in the clinical sense. Indeed, it is likely that at least some cases would be labeled differently if treated by an expert in perinatal mental health. The inability to pinpoint a precise mental health diagnosis would be a weakness if I were attempting to offer an objective view of PMAD etiology. However, there are many strengths to this approach when employing a social constructionist framework. I am less concerned with proving the accuracy of a label, and more interested in lay perceptions of mental health. I am also interested in how diagnoses are shaped by and shape life experiences. Furthermore, this approach does not assume there necessarily is a correct clinical diagnosis. Even professional health providers struggle to apply correct diagnoses, as discussed in the introductory chapter and will be seen below; and there is also no clear etiology for these disorders. I accept these diagnoses as real in the sense that these parents experience patterned symptoms of distress, which were shaped by complex interacting biological, psychological, and sociological factors. Whether a “real” medical disorder or not, the implications of defining and treating troubles as a mental health condition are real and is what holds my sociological interest. As famously stated by W.I. and Dorothy Thomas, “If men define situations as real, they are real in their consequences.”

Postpartum Depression Awareness

Diagnosis, of course, depends on awareness. This is true for both professional and self-diagnosis. Individuals must recognize and link their “symptoms” to an existing diagnosis to apply such labels. Their knowledge of different diagnostic categories facilitates consulting with a medical professional or self-

help resources, which further shapes their understanding of these conditions. The crux of the movement to include postpartum depression in the DSM, even while etiological evidence remains equivocal, was the potential benefit for increasing awareness of and effective treatment for perinatal mental health.

As a reminder, PPD in women has been officially recognized since 1994 with the DSM IV and prenatal depression was recently added with the DSM V, although paternal PPD is not yet an official diagnostic category. Popular print discourse and newscasts on postpartum depression have previously been found to focus primarily on PPD as an individualized, hormonal disorder, despite evidence to the contrary; however, internet discourse on these conditions may be more complex and nuanced to the psycho-social risk factors, as reviewed in Chapter II. Distressed parents today are likely drawing on a variety of discursive messages when seeking to understand their perinatal mental health, and therefore, the labels they may apply to their condition. I turn specifically to what the mothers and fathers in my study knew about both paternal and maternal PPD.

Awareness of Maternal Depression

Every parent in my study, mothers and fathers alike, had heard of postpartum depression in women. Most mothers thought about whether they had this diagnosis, sometimes prompted by suggestions from friends and family, prior to our interview. This diagnostic term is now common enough that most parents could not pinpoint where they first heard about it, and instead referred to a more general awareness and hearing about it from multiple sources, as shared by fathers and mother across different class backgrounds:

I think I might have heard it in a psych class ages ago. And it seems like I've heard it in passing during medical commercials ... I'll see books about it and see it referred to occasionally. It's kind of just in our society. *—a father*

I've heard of it, yeah, I mean I just seen things on TV, like people in the news after they killed their kid, you hear about it.... I know that I got some information on it in a packet from somewhere. *—a mother*

Some more specifically recalled learning about PPD from pregnancy/birthing books and classes and their birthing professional, as shared by Miki, a middle-class Asian mother:

So you get emotional and depressed and it could last from couple weeks or couple months to a year or it could be very long... I learned a lot about it while I was reading it (pregnancy books).

Many parents noted that awareness of this condition has not always been present, but is growing. In sum, maternal PPD is commonplace in contemporary pregnancy/childbirth and mental health discourse.

Some mothers and their partners paid special attention to these messages, recognizing that they were at increased risk. They generally pointed to previous mental health histories or certain personality characteristics which they felt made them more vulnerable. Mothers, then, brought up these risks with their doctors, while some fathers spoke of paying close attention to their partner's moods. For example, Robin, a low-income white mother, shared:

I heard it when I was looking through all these books that talked about it a lot. And it said if you do have a history of depression talk to your doctor. So when I was going in the first couple appointments I said now I have had depression so postpartum depression might be an issue. She said, 'We'll definitely keep an eye on that.'

In contrast, other mothers felt that PPD was something that would not really happen to them.

Oftentimes, these feelings of immunity were linked to having strong mental health, looking forward to motherhood, or generally having good life circumstances, as represented by Julie J., a white, middle class mother who also had work-based expertise in mental health:

You know all that stuff (about PPD), but I didn't think it applied. I felt – what's the word – immune from those bad things that happen. I expected it to be exactly the way I planned and thought and dreamed of...(but) it can happen to anyone. That's the thing. It doesn't have to be because you're in a bad marriage or because you're not with the father or because you have financial problems or because you're young or old or anything. I mean, it can happen to anyone.

However, when they did experience symptoms, they generally were not in denial. It was more of a surprise that it happened, rather than a serious barrier to recognizing their mental health needs. They

may regret not recognizing it sooner, but still knew of this condition and where to find additional information.

Once a mental health need was recognized, parents found additional information readily available in pregnancy/parenting books as well as online, where they learned more about the specific symptoms of PPD and more about other perinatal mental health conditions. In addition to awareness of symptoms and treatment options, PPD websites provided a community of support for depressed or anxious mothers and sometimes helped connect women to local resources. Chapter VI will detail help seeking and symptom management, but suffice to say, awareness was essential. Some parents reported misperceptions they initially held about PPD. For example, some saw PPD as a rather severe condition with high risk for suicide or infanticide, as indicated by Brandon G.:

Most of what I heard about it initially came from high profile news cases, the Susan Smith, Andrea Yates ... that kind of stuff. So I knew that it could be extreme, but at the same time initially I just dismissed those people as crazy.

In sum, awareness of maternal PPD was widespread, and further there was ample information available to help correct misperceptions. This widespread awareness helps to explain why PPD was the most commonly accepted diagnostic label, and further, why many mothers were comfortable self-diagnosing this condition.

Awareness of Paternal Depression

In contrast to the widespread awareness of maternal PPD, very few parents, mothers and fathers alike, knew that fathers could have postpartum depression, as stated by Jack, "I thought it only happened to females." Yet, with paternal PPD not being an official DSM diagnosis, this lack of awareness is more complex than simple ignorance. Is there anything to be aware of? Paternal PPD is still in the process of being medicalized. However, while not an official diagnosis, there is discourse surrounding this condition and some fathers are now being treated for it. Yet, there is generally less awareness of this condition among both experts and they lay public, compared to maternal PPD. Paternal PPD is

largely treated as a side note in the most popular resources on PPD, if at all, and I have only identified a couple websites that explore paternal PPD in great detail (www.postpartummen.com and www.drchristinahibbert.com).

More fathers heard of paternal postpartum depression than I expected, with seven being familiar with this diagnosis prior to participation in my study, all of whom were middle-class fathers. These were largely the same fathers who confidently applied a perinatal depression diagnosis to their own condition.¹¹ Although this group of fathers became aware of this condition and adopted this term to describe their own condition, they recognized and experienced the general lack of awareness surrounding paternal PPD, as indicated by Shaun when discussing the “discovery” of paternal PPD as a distressed new father:

Fantastic in that I think what I found great was that somebody would admit that fathers can have depression full stop, or that someone will admit that a man can have depression as a result of becoming a father full stop. Or even that somebody was actually talking about men and male depression in the concept of fatherhood at all, because I just, I don't really see any resources out there or any kind of commentary out there that says anything.

Likewise, when discussing my dissertation research informally with friends and colleagues, I've found that everyone has heard of PPD in mothers, but very few have heard of paternal PPD. These fathers spoke of more-or-less stumbling across information on paternal PPD, as demonstrated by Alex, an older, white middle-class father:

But I don't remember where I heard it. I think that maybe either my wife or somebody, maybe my shrink, I really don't know who mentioned it to me. I didn't know that the paternal postpartum, I didn't know if that actually existed or anything like that. Somewhere I read it or I saw it or I heard it, or whatever...I do not recall. See, I knew I had the depression... I knew that I was going through something and whatever it was called didn't concern me. Then somebody somewhere said, well you have postpartum, but who it was, I don't know.

Some fathers found this information when looking into men's mental health, more generally. There is a high correlation of perinatal depression across partners, so some fathers learned about paternal PPD

¹¹ Three of these seven fathers were recruited through the Postpartum Men forum, thus my sampling technique shaped this result.

when seeking more information on their wife's condition. Generally, however, PPD informational resources targeted fathers in their support roles as partners of depressed mothers, rather than their own mental health risks and needs, as noted by Kevin D., an educated, middle-class father:

It was more like, here's what you can do as a partner of someone with post-partum depression, sort of thing. Rather than saying, and also there's, you're at risk for a male's version of postpartum depression... Even on sort of the national website for post-partum depression it's very women centered... Not that that's a bad thing, but it's interesting to me that even on the major resource there's not really much mention of, that men can go through depression as well.

A few of the parents who came to learn about paternal PPD discussed first being very skeptical of this condition. For instance, Giles learned about this condition through his work in social welfare, but dismissed it as just an excuse for lazy fathers. One educated middle-class wife spoke of her initial reaction to her husband sharing that he thought he also had PPD:

Shortly after I started to feel better he (husband) said, I think I have this too. And to me, I thought to myself, 'Well you're just being a copycat. Like you just want medicine, you want to feel better, you just want the attention now.' So I didn't like validate it at all. I was awful about it. But in my head I didn't rationalize it or validate it, but out loud I did... I have had the empathy, I guess, the skill to say good things and not snarky comments.... And I'm like, 'How could you be going through this because you're not even at home with him. I'm the one taking care of him all day. You don't have hormones that are going wacko'.... Even if it was just a show, an outwardly supportive of his concerns and then thinking that he was just being a copycat.... Now I'm on board and supportive.

Despite this skepticism, these parents later accepted this diagnosis based on their own experiences, and especially, after feeling that treatment for paternal PPD helped. In another example of skepticism, Shaun generally accepts that he had paternal PPD, noting that he experienced nearly every symptom highlighted on the postpartum men website, yet, still occasionally expressed doubt about whether this diagnosis could really be applied to men.

Most parents were not familiar with paternal PPD, prior to our interview, as noted by one mother, "I've never really heard of a guy having that." Yet, when informed towards the end of the interview that that some researchers and practitioners are looking into paternal PPD, most participants accepted this possibility, and further, were very supportive of this development. Scott, a lower-middle

class white male who's partner already had children, shared:

If there's something specific to say, "Hey, this is what's going on," it'll probably make it easier for them, and definitely need as much support. I don't know, maybe this is an assumption, but I'd say fathers probably don't get nearly as much attention when they get down and depressed when women do because of the understanding that PPD is something that is real, if they get a lot of attention, I mean, I know specifically going to our follow up meeting with the doctor and they asked (my fiancé) about it several times, nobody asked me how I was feeling, you know what I mean? So, I think it'd have to help.

Yet, the possibility of paternal PPD was typically framed as a condition that parents expected would be qualitatively different than maternal PPD -- primarily, in that men did not experience childbirth or radical hormonal shifts, as shared by Emma, a highly educated middle class mother:

I would think it would be possible, I don't know if biochemically if that's possible. But I think emotionally they can get depressed.... Well, it's a big life change and you get a little bit of sleep. I think fathers can put pressures on themselves that would lead to a depressed state.... I think that you're talking about a different set of circumstances. I think with mothers there's a real biochemical process that can go on in the body. Whereas with fathers, it's a life change.

As such, paternal PPD was often hypothesized as less severe than what would be expected in women. In contrast, a few parents did perceive a role for hormones, based on previous knowledge that men's hormone levels also change during the perinatal time period, as demonstrated by Jill I:

I think that men can get depression after the birth of a child... I want to say I read something though about how men's hormones can actually change when their children are born. And it's, I'm not really sure, I think the testosterone goes down, something about the reaction to that and that's biological, it's normal, whatever. So I don't know how that interplays with it, but yeah, I mean, I definitely do (think fathers can have PPD). I think it's different, fundamentally.

Rather than PPD in fathers challenging the hormonal discourse surrounding PPD, it may strengthen it through these qualifications that PPD in men is fundamentally different. Framed this way, it's not that men and women are going through the same thing. Women are perceived as experiencing a biochemically based depression, in addition to life stressors, whereas men's depression is "only" about life circumstances. This frames women's depression as different, and perhaps, worse.

In linking paternal PPD more strongly to life changes, compared to maternal PPD, the condition was often attached to father's changing roles. Parents widely noted that fathers today are more hands-

on in raising their children, but while still experiencing financial pressures, as shared by both Giles, an older, white father, and James B., a younger, black father, respectively:

It's good that it's being put like that (paternal PND), but the problem is that it's perceived that the mum does all the hard work, so why would there be an impact on the dad? And I have to say, that society has changed significantly.... But it's changed from those stereotypes and perhaps men have always been like this, but because they've been just workers.

Because if women can get it, it's not necessarily the pregnancy that makes women go postpartum, it's just all the responsibilities and all the new things that you gotta bear. They're going to add weight on your conscience. And of course a man would probably be able to get it.

Some qualified that they would expect to see this condition more among involved fathers. A few mothers were in more gender traditional relationships, and this was where more skepticism was found, as demonstrated by Sachi, an Asian stay-at-home, lower-middle class mother:

I don't know, because most fathers are working and they don't stay home all day. So maybe mothers will have more.... I don't believe that (fathers get PPD), but maybe some people, maybe some sensitive fathers, but I don't think that happened to my husband... And I think that's very rare too.

Interestingly, the belief that PPD is hormonal and men do not go through hormonal changes was not enough, in itself, to cast widespread doubt on the diagnosis. Rather, parents pointed to fatherhood as a major responsibility and life change, especially with changing gender roles, but also noting that not all fathers experience such stressors and therefore the diagnosis may be limited.

Despite lack of awareness, most parents felt that the paternal PPD diagnosis was a positive development that could help fathers. Many noted that this may help overcome difficulties that men, in particular, have in admitting mental health difficulties and obtaining support, as shared by Alex and Sabrina H., both middle class parents, respectively:

I'm glad that it has been diagnosed or identified or whatever and hopefully it'll save some families....I think most importantly it's good that there has been some recognition of the existence of paternal postpartum depression and hopefully it'll save a family or two here and there. I know men are still macho and they don't really want to go for help and stuff like that. I'm not. I'm all about sharing and asking questions and sharing my view, or whatever, and listening to people.

I can definitely see how it could happen and if it does, it should definitely be dealt with and they should be able to go and talk to someone just the same as the mother can.... That's not something you would really think of a man having. Like men in general you think don't have emotions, they're just cold hard rocks. If they actually say they're going through something like that, I think that would be worth noting or listening to.

As such, the diagnosis can help create awareness that men also have emotional needs, help depressed fathers know they are not alone, and create a community of support.

Despite overall support for this emergent diagnosis, some questioned whether paternal PPD is the best name for this condition. Some found that likening the condition to postpartum or postnatal¹² depression was useful, as it oriented depression and anxiety to the circumstances surrounding having a baby. For example, the British father, Giles, shared:

And they referred me on to some chap at the hospital who deals with the postnatal depression, PND. And he was looking at it and said, oh you've got the equivalent of that.... To have it likened to PND, yeah, in terms of the sudden change and maybe it was too difficult for me to cope with emotionally.

While calling attention to the unique factors surrounding depression during the perinatal time period can be useful, for others, the term postpartum is too strongly linked to mothers or hormones, as demonstrated by Kevin D., an educated, middle class father:

In that guy's introduction to his blog, his little five-line bio is father, stay at home dad, survivor of paternal postnatal depression. And when I read that I thought, huh, that's an interesting name for it. Because when you read postpartum depression that sort of means you've delivered a baby. So postpartum depression doesn't really "exist" in dads because we didn't deliver a baby or anything, there's no part of us that's not there anymore, sort of thing. And so I didn't know there was a name for it. I thought it would just be depression, just the all-encompassing big D, sort of thing.

Neither postnatal or postpartum are well-known or obvious terms for fathers seeking more information about their mental health, as addressed by an educated father with web design expertise:

Yeah, it's a tricky term as well, because if you're – this'll sound like a silly reason – but if you're ever trying to look to find support and you don't know what to search for, the last thing you'd probably search for is postpartum as a term. That's just the web side of me coming in, but just

¹² Postpartum and postnatal mean the same thing, and simply reflect regional differences in terminology. Postpartum is more commonly used in the United States, whereas postnatal is more commonly used in the European countries.

purely trying to find resources, I think I can't remember how I stumbled upon it as a resource. But it was by a circuitous route that I ended up there rather than... So in terms of simply men's depression and father's depression there's really not a lot... There's stuff, but mostly what you find is just a posting on someone's blog or bad forums that have nothing on them, rather than any kind of concerted, organized effort to talk about this stuff. And also mostly just someone's opinion, not actually anybody saying there is something here that is worth talking about.

A few parents, primarily highly educated middle-class participants, expressed concerns about extending this diagnosis to men. Without necessarily naming it as such, they were concerned about medicalization. In particular, they thought the condition might be over-diagnosed, led to an overreliance on medication, or had a sense of permanence, as demonstrated by middle class fathers, Thomas and Jeff H., respectively.

I sort of have a love/hate relationship with diagnoses. I mean, I've worked in a school a long time, so I guess where I'm heading with this is I've seen a lot of things get over-diagnosed. And of course I have that fear about when there's a label for something, people want to feel like they have it. So I've seen overmedicated kids in schools, kids who didn't need it. So that's the one side. The other side of the coin is, of course it really helped me. And so when it's legit, I think it's a good thing to have that label.

I don't know. I could see where it could be beneficial, but I could also see where it might make things worse I mean, I don't know, I just think a diagnosis just gives it more of a permanent feel, I guess. I don't know. Or a much more severe feel to it.

Others were concerned that it could become a trendy diagnosis or create a new market for pharmaceutical companies. Some mothers also cautioned that it would be important that the pendulum does not swing the other way, in which a new focus on fathers would distract from addressing mother's needs, as shared by Elizabeth, an upper-class, white mother:

I think that's, anytime they can admit or acknowledge what people are feeling, I think that's good. I think the more that can be known about it the better. I hope they still, like the focus doesn't turn too much towards men where it's not on women since it's such a, just in some areas I think people don't want to talk about it or acknowledge it I don't know, I think sometimes the medical community, they're quick to help men and figure out men's issues and sometimes, sometimes women's issues get pushed to the side, so you don't want it to tilt, I guess, too far that direction. But just acknowledging that this happens after you have a child to anybody and that people need help I think is a good thing.

These parents still ultimately felt that it could be useful to recognize and treat paternal PPD, and further that effective treatment would be beneficial to the larger family. However, one low-income mother who gets very little parenting support from her spouse, Isabella, was rather skeptical about this diagnosis, and was concerned it would provide another excuse for men to do little, if any, parenting:

I don't know because then that would be their excuse to not help. They'd be like, oh ok, well -- Yeah, I guess, I mean that's something. I guess it could be a possibility.

The uneven awareness of paternal PPD helps explain why fewer fathers identified with the depression label, even though they described symptoms of depression and widely admitted they were not themselves. However, this may change if the medicalization of this condition takes hold. Whereas the medicalization of PPD in women began at the grassroots level, with depressed mothers and a few key medical professionals advocating for the inclusion of PPD in the DSM, the medicalization of PPD in fathers appears to follow the more traditional top-down approach to medicalization. There does not appear to be any organized movement of male patients pushing for this diagnostic designation, although certainly some individual male patients work to spread awareness. By and large, attention to paternal PPD is driven by scientific research and key medical professionals who are raising awareness. Although professionals have been the main claims-makers, patient buy-in is critical for the success of a medicalization campaign (Conrad and Schneider 1980). Judging from the participants in my study, patient buy-in is probable. Parents felt that the depression and anxiety in new fathers is real, and that diagnosis can improve supports for fathers. However, this qualitative study is not generalizable to the larger population and additional research is needed. Trend studies suggest that while education and awareness about mental health has improved over time and there is greater acceptance of professional mental health help-seeking, stigma towards those with serious mental health conditions has not improved significantly (Schomerus et. al. 2012). Paternal postpartum depression is not cast as a severe and persistent mental health condition; nonetheless, it may have a stronger feeling of severity among men.

Blurry Diagnostic Boundaries in Everyday Life

PPD awareness certainly helped many parents, and especially mothers, name their condition as depression. However, naming one's condition was not always easy and labels were often fluid. Just as perinatal mental health diagnoses are contested in the medical literature, parents experiencing perinatal mental health symptoms often had difficulty identifying the best name for their condition. Again, the diagnostic overview and Table 2, above, indicates the most plausible label based on retrospective accounts, thus obscuring real life difficulties in naming one's condition. In some instances, the first label applied to emotional distress remained the one and only label. Yet, in other cases, the process of applying the "correct" label took weeks, months, and even years, taking into account feedback loops regarding why the person experienced distress and what worked to resolve it. Hard labels were not always applied, as demonstrated above, some parents continued to question whether what they experienced was simply heightened distress or a clinical condition.

Severity and Length of Symptoms

Parents were often very rational in naming their condition by matching their symptoms to what they read and heard about PPD and other PMADs, taking into account severity, timing, and length of symptoms. Yet, questions still emerge when symptoms were more ambiguous. Generally, everyone noted that they felt different and were definitely not themselves. For example, Anthony J. is a white, middle class father who feels he probably just very stressed while his wife had severe depression, but his wife feels that it also led to depression in him:

I don't know, Julie and I have talked about... Julie kind of felt it was more of a depression. I always described it as more of a burn out. Kind of like what I was telling you before, I struggled more when I was here (at home). I'd do fine if I was at work, somewhere where I could focus well and get through work. I didn't have troubles getting out of bed in the morning or some of those typical things you think of with depression. It definitely could have been some extent of it possibly at one point.

Everyone in my study shared that their mental health distress was unusually high, but the question then

remained whether these abnormal feelings were severe or lengthy enough to qualify as a clinical condition. In comparing his perinatal distress to prior experiences with depression, for example, Cory C., a lower-middle class father combining work and school, stated:

I was definitely having some trouble completing tasks and staying focused and things like that [but] when I was depressed, before, I would literally get to a point where I was not really functioning. I would be not showering, not doing laundry, not going out of the house, not showing up for work... so my level of functioning was still pretty high, so I don't feel like I had [clinical depression].

Cory notes some impact of his emotional distress on his functioning, but not to the same extent as prior depression.

As reviewed in the introductory chapter, the DSM specifies that symptoms must occur within the first four weeks following childbirth, whereas practitioners often extend this in practice to six or twelve months. Clearly, even professionals do not agree on the timing of postpartum depression. Prenatal depression can occur anytime in pregnancy, but is given less attention than postpartum depression and only just recently acknowledged in the new DSM. Distressed parents have a sense that PPD occurs around childbirth, but mixed messages surrounding this timeframe make this call difficult to make, as shared by Erica, a young, black mother:

When I was reading about it (PPD) in the books and stuff, I was like, that's not going to happen to me. But, and they were saying, it'll be right after you had the baby...But after I had my baby I was happy.... I was still thinking, oh the sky's the limit, I could still do this, I could get this done, I could get this done. But it's when I started stepping my foot out and trying to better myself and being knocked down, and knocked down, and knocked down, where it started depressing me.... That's why I assumed I didn't have post-partum depression because it wasn't right after. But I mean depression is depression, no matter what other name you put in front of it.

Using similar rationale, Elizabeth, an upper-class mother, paid attention to the length of her symptoms, and went to her doctor and received her diagnosis after not feeling better after a few weeks. Indeed, the so-called continuum of baby-blues, postpartum depression, and postpartum psychosis is often presented in a way that encourages parents to seek help if symptoms last for more than two weeks. At the point of seeking professional help, then, most parents received an official diagnosis. Although, as

will be further discussed in Chapter V, some parents had their concerns dismissed and did not receive a professional diagnosis, including Miki and Alyssa C. However, they continued experiencing symptoms and therefore, in retrospect, felt comfortable applying the postpartum depression and prenatal depression labels, respectively, to their condition. This is a very rational approach to labeling their condition by paying close attention to the nature and severity of one's symptoms, in consultation with a professional or textual discourse.

Multiple Life Stressors

Parents also evaluated their symptoms within their larger life context. Many of these parents were dealing with additional major stressors in their life, beyond the transition to parenthood. Among parents who did not apply a definitive label to their condition, these multiple life stressors were often cited as the reason for their ambiguity. For example, Scott was trying to finish up his college degree while balancing multiple jobs and dealing with a stressful move. Further, their son was very temperamental and after a prolonged period of not knowing what was going on, he was diagnosed with a rare medical condition associated with pain. He also experienced the loss of a family member. When asked if he may have experienced postpartum depression, Scott replied:

I had something going on there, but also, there was a lot going on, I think anybody would probably have a tough time going through that....I think it would make more sense to say that if none of those stressors were going on and I had the same reaction, I think that would be more of a pinpoint. But I think I reacted in a way that a lot of people would.

Scott never experienced mental health strain like this before and admits that his symptoms were severe; yet, he is hesitant to apply a medical diagnosis in light of the multiple life stressors he was experiencing. Among the others, Randall A. experienced many poverty and relationship stressors, Corey C. was adjusting to an unplanned pregnancy and rushed marriage, Anthony J. was dealing with his wife's severe PPD which included multiple hospitalizations, Jack's drug addicted partner abandoned the family, and Shelley had her baby prematurely while her husband was residing in another state for career reasons. Madison linked her anxiety, which she also was not sure if was clinically severe, primarily to domestic

abuse rather than the birth of her child, in and of itself. Isabella noted that in addition to a major life change, her spouse did not help out much and perhaps rather than depression, “I was just mad at my husband.” Others also experienced the loss of beloved family members, friends, and pets during the perinatal period.

Further, some parents accepted that parenting and life, in general, is often difficult, but this does not necessarily mean one has a clinical condition. For example, Jack is an older, low-income white father who has a bi-polar diagnosis, but preferred to refer to his perinatal distress as just being “gnarliness”:

I don't know what applies to anything or what other stuff going, I mean, my life's just my life. The right labels for it, I don't think I had any disease, I don't think there's anything wrong, I don't anything right... Unless I'm freaking out, running away from my kid or not dealing with her, you know.

However, while Jack suggests that his symptoms were not severe and therefore not clinical, he did share apparent signs of impaired functioning, such as struggling at work and sometimes staying in bed all day. Sabrina, a middle class white mother, shared similar skepticism about clinical mental health conditions. She concluded that she likely had prenatal anxiety during her pregnancy, as she would lay on the couch all day worried about motherhood and her co-workers also noted she struggled with pregnancy, but did not feel she was clinically depressed or anxious postpartum, because although she was emotional and stressed, she ultimately coped well with her life stressors. Samantha, a low-income mother with a middle class background, provides another example. Early in her interview, she shares:

I did see a therapist. I think he was about four months old. I still got therapy because I didn't know if it was postpartum or what. I just didn't feel like I could manage my life and my moods anymore and I wasn't interested in medicating.... I swear, like I do have moodiness, but I think there's so many contributing factors that as an adult I don't think that's a mental disorder, I think it's just a circumstantial thing.

At this point, she is skeptical about applying a medical diagnosis to her situation, and also rejects her therapists “adjustment disorder” diagnosis. However, later in the interview, Samantha expressed:

I think I did (have PPD). I think those first couple weeks. And I think there's a lot of factors, I don't know if you can really say it's caused by this or caused by that or what mine was caused by... I mean those first two weeks I just remember that feeling of sadness was so horrible and I mean I've never experienced anything like it and again, I never have. And I never had experienced anything like that before.

Samantha goes back and forth, sometimes contradicting herself. This ambiguity demonstrates the difficulty of applying a hard label to one's mental health symptoms, even when they are severe, due to the presence of multiple extenuating factors combined with a hesitancy to medicalize life stressors.

Interestingly, however, many other parents also experienced multiple life stressors, but did not hesitate to adopt a clinical diagnosis. For instance, Erica experienced extreme poverty and multiple moves, but knew she was depressed. Struggles with poverty were widespread among many depressed and anxious parents, and some were also in dysfunctional relationships. Some parents adopted clinical mental health diagnoses while others did not, although they all cited new or growing stressors during the perinatal period. Sociologists and psychologists have long documented the link between lower SES and greater mental health risks (e.g. Adler et al. 1994, Robert and House 2000, Weitz 2001). Further, stress process theory has demonstrated how prolonged exposure to stress adversely impacts both mental and physical health through physiological bodily reactions, thus linking sociological forces to biomedical processes (Aneshensal 1992, Pearlin et. al. 1981, Thoits 1995). In my research sample, many low-income parents experienced numerous life stressors but were also less likely to apply a firm diagnosis to their condition. In part, this is likely connected to having less access to affordable health care thus preventing professional consultation. However, this class-based pattern may also be linked to the fact that much of the PPD discourse often focuses on hormones, whereas these parents primarily cited multiple life stressors including struggles with poverty.

These life stressors will be further detailed in the next chapter, but we can see how experiencing multiple life stressors sheds doubt on a perinatal mental health diagnosis. Yet, postpartum depression is officially classified as a subtype of major depressive disorder, in which life stressors are a recognized risk

factor. It is the timing, rather than causal etiology, that defines PMADs. Nonetheless, some parents linked this condition specifically to having a child, including hormones, rather than these larger risk factors for depression rooted in poverty and other life struggles.

Distinguishing across Conditions

For other parents, it was clear that a clinical mental health condition existed, but the difficulty was in determining which condition, precisely. In particular, it can be difficult to distinguish a flare-up of a pre-existing condition with the onset of a new perinatal mental health condition, as shared by Brandon G., a middle class father with a long history of severe and persistent depression:

The stress of that new period, I definitely noticed that it. Well, ok so, let's put it this way. On the new medicine I was doing really well and even as well as I was doing, with all that stress I experienced a dip in my mood that I had to go up on my medicine some. So yeah, I guess you could say that it did impact my depression... But I already had a diagnosis. It did worsen it.

Brandon spoke of his depression getting worse, but did not think of it as a different condition. Robin, a low-income white mother, also noted her previous history of severe recurrent depression which she thought she had under control, but then she began feeling depressed again:

I've heard most of it (PPD) can usually last up to six months, so I didn't think so at the time. I thought I was just really depressed, it was my actual depression coming back... but looking back on it now I think what I had probably could have been postpartum depression because it was a lot deeper and a lot more severe.

In contrast to Brandon, Robin feels her most recent experience was more significantly different, and therefore, was PPD as a different condition than her prior depression. This is likely shaped by the heightened awareness that surrounds maternal PPD, as noted above. Popular discourse typically frames PPD as its own condition, rather than as a subtype of depression. Further, the etiological literature identifies previous mental health history as a top risk factor for PPD. The DSM points to depression as being perinatal when the most recent *episode* occurs during pregnancy or shortly after childbirth, thus suggesting a distinct onset from previous episodes of depression. Therefore, depression that continues into pregnancy or postpartum is presumably just depression. But, should it be understood as perinatal in

nature if it becomes markedly worse or takes on new characteristics during this time period? There does not seem to be any clear answer to this question, and we can see that in everyday life, distressed parents struggle with this distinction. Further, quantitative research has not consistently distinguished between a new onset of new symptoms, re-emergence of previous symptoms, or symptom carry-over in establishing PPD rates and risk factors, because most studies measure depression in a snapshot of time (Reicher-Rossler and Rohde 2005).

Other parents struggled with exactly what is meant by postpartum depression, assuming that it must be linked to childbirth or maternal feelings. For instance, Andrea rejected the possibility of PPD while accepting that she was definitely depressed, in stating, “I wanted to be with [baby] and most of my blues were related to [my husband] and I.” Again, the DSM classification of PPD distinguishes this condition as a subtype of depression based on onset timing, rather than distinct causes or symptoms. That is, it does not explicitly link PPD to childbirth or feelings towards pregnancy or the baby. In this sense, the distinction between PPD and depression is, perhaps, inconsequential. Yet, several parents believed that there was an important fundamental difference between these diagnoses, and felt this distinction was important, as shared by Desiree and Caitlyn, both young, low-income mothers, respectively:

It’s hard to tell after that point whether it was actually postpartum depression or just my normal depression.... they say mothers that have postpartum depression have a hard time bonding with their children. I don’t feel like I really had that hard time once they came home, especially, I guess.

I just figured I was depressed, I didn’t think it was (postpartum) I don’t know... Because she really has no factor at all in me being depressed...I mean, I guess the roles that I’m expected to have, like the cleaning and taking care of her all the time, that contributes to it, but it’s not necessarily being a mom, it’s just that I don’t have help.

In considering PPD, these mothers all thought about their emotions in context of motherhood.

Interestingly, it was often the low-income mothers who debated this meaning of PPD. Although they

accepted they were depressed, they distanced themselves from the notion of being a bad mother or not enjoying motherhood, perhaps as a reaction to the stigma against young and poor mothers.

Finally, in recognition of various PMADs, other parents struggled in identifying whether they are experiencing perinatal depression, anxiety, psychosis, or some other condition, as shared by Susan G., a middle class mother who was ultimately diagnosed with and treated for PPD:

In those early web searches, I questioned early on if I actually had some sort of postpartum psychosis, like, because the thoughts were just so weird and recurring and just to get so focused on something weird like that. I can't clothe my child. But I never had any hallucinations, I never had any voices that were telling me to do anything. So it was pretty much ruled out that it wasn't psychosis...Then there's also post-partum OCD, which [others] have struggled with where, the house has to be clean and that kind of stuff. So that has a level of anxiety to it but I don't think (I had this). I was trying to self-diagnose in those early days. I don't know that my family practice doctor, she must have, if she prescribed Zoloft I'm sure did say that, she officially diagnosed me as postpartum depression, but I don't think I officially got that moniker probably until that first hospitalization.

The severity of Susan's case, leading to multiple hospitalizations, made this distinction difficult. The distinction between anxiety and depression was another difficult call to make, especially as anxiety is a symptom of depression, as observed by Alex, an older middle-class father who adopted the paternal PPD label:

It went as far as depression, yes. It was anxiety for sure...Well, I don't know how to tell the two apart... It was anxiety driven depression, if you will.

Other parents with a professional or self-diagnosis of PPD discussed symptoms of anxiety more so than sadness, and it's possible that their condition may have been more accurately diagnosed as anxiety. The DSM does not explicitly recognize perinatal anxiety, yet, a recent study by Abramowitz and colleagues found that many women diagnosed with PPD displayed symptoms more consistent with anxiety and OCD disorders (2010).

Diagnoses may shift overtime while the underlying symptoms remain the same, as illustrated by Julie J. who experienced severe depression with multiple hospitalizations and various treatment approaches:

First it was prenatal and then postpartum and then just general clinical because it's never (gone away)... At one time I did have a doctor think it might be bipolar, but the medication didn't reveal that.

This example demonstrates that even mental health professionals struggle with making accurate diagnoses. It is worth questioning the utility of shifting labels when the underlying condition remains the same. Yet, Julie's condition only improved after she was connected with an expert in perinatal mental health who provided in-depth therapy that helped to increase her parenting-efficacy, thus demonstrating that a PPD diagnosis sometimes leads to more appropriate treatment. Julie's struggle with finding the right treatment will be further detailed in Chapter VI.

Among those who sought treatment, which was over half the sample, parents generally agreed with their professional diagnosis but a few did not. For example, Emma's OB concluded she did not have PPD but she was later diagnosed with postpartum psychosis by a different team of doctors. In retrospect, Emma and her later medical team believe that her psychosis was preceded by depression and she now disagrees with the original assessment that she was "fine." This demonstrates that medical options vary, even in severe cases. In another example of questionable professional diagnosis, Samantha was diagnosed with adjustment disorder after seeking treatment for what her and her family thought was PPD. However, Samantha is skeptical of the adjustment disorder diagnosis and instead leans towards a PPD self-diagnosis:

I thought it was (postpartum depression), but the more I started seeing a therapist they didn't think that it really was. I mean, I was definitely in the postpartum period, but I had so many other factors, so many other things that were going on that attributed to anxiety and frustrations that I don't... It might have been heightened because of all the new parenting things, but I don't know.... Who doesn't have an adjustment disorder?

These accounts, along with Julie's story of shifting diagnosis, reiterate that mental health professionals also experience difficulty in applying the right diagnosis, and further, point to role of doctor-patient relationships, which will be detailed in Chapter VI.

Again, the etiological literature points to PPD having the same symptoms and risk factors as general depression; hence it's classification as a subtype of depression. Rather, it's the unique impact that depression can have on child development as well as the need for perinatal and family sensitive treatment that justifies PPD as a unique subtype of depression. However, we can see that in the popular perception, many parents assume that PPD is a distinct diagnosis with unique causes and symptoms. This includes beliefs that PPD should be more severe than general depression, feels different than previous episodes of depression, or is directly connected to childbirth or maternal feelings.

Hesitancy among Fathers

Eight of the eleven parents who did not apply a definitive label to their condition were fathers. Further, among these eight parents, the five fathers leaned towards "just stress" as being more plausible, whereas the three mothers leaned more towards the possibility of clinical depression. This pattern requires additional research using more generalizable, quantitative methods. However, there are theoretical reasons to believe that this gender pattern is more than a sampling fluke.

Many of these fathers were experiencing additional stressors, as demonstrated above. Yet, so were many mothers including those who adopted the PPD label with more certainty. For instance, Kristi was in a manipulative relationship and struggled with poverty, while Bethany recently lost her home. The three mothers who leaned towards PPD as a plausible explanation also experienced multiple life stressors. Thus, while presence of additional stressors is an important consideration, this does not really explain the gender difference.

A key difference may be the lack of awareness currently surrounding paternal PPD; as illustrated above, only seven middle-class fathers had prior awareness of paternal PPD. All but one of these fathers applied this diagnosis to themselves. However, Sean still expressed some doubts as he was not entirely convinced that this diagnosis was appropriate for men:

What I think is quite hard to believe, again, is that I feel like the definition I've had in my head is one that's caused, it's a female thing that's caused by a hormonal imbalance or a chemical imbalance that occurs as opposed to depression due to having a child around in your life.

Even after visiting the postpartum men website, designed to educate men about the possibility of paternal PPD, and closely matching his symptoms to those listed on the website, Shaun still struggled to overcome his previous understanding of PPD, largely due to the predominant belief that PPD is primarily a hormonal disorder.

The remaining fathers had never heard of paternal PPD and did not apply this label to themselves, as demonstrated above. Yet, many entertained this possibility once informed of paternal PPD, in acknowledgement that their mental health was different than usual. Most ultimately remained uncertain, although Randall was very partial to the suggestion:

Wow. You know, I could....Yeah, that's interesting you say that because it makes a lot of sense.... I wouldn't really know how to diagnose postpartum in men, but I could have had it.... Because I was acting out of character... I didn't know I could be so mean at times.... It's just this feeling that, oh, click, that makes sense. It's, I don't know, it's not like a logical thinking, it's just a feeling of, click, when a piece falls into place, it explains.

These fathers ultimately know little about the paternal PPD diagnosis, and the information I provided certainly was not enough to make an informed judgment.

Thus, on one hand, the hesitancy to provide a strong name to their condition may reflect the lack of awareness around paternal PPD. Diagnosis provides a shared understanding of symptoms, but only assuming that people are actually aware of the diagnosis and have received accurate, consistent information about the condition. This benefit is not yet fully realized for paternal PPD. It's understandable that most fathers would not readily adopt this diagnostic term without knowing more about the condition; however, many of these fathers were also uncertain that they experienced a clinical mental health condition of any type. Thus, we must also consider that men are generally less likely to recognize and seek help for a whole host of mental health conditions, including depression in general. This is rooted in masculinity, as mental health needs challenge the ideal of the strong,

autonomous, and independent male, as well as cultural assumptions that men are inherently less emotional than women (Oliffe and Phillips 2008). Indeed, one participant, Jeff, a middle-class white father, felt that the paternal PPD diagnosis may backfire for these reasons:

It (paternal PPD) might make the father think, 'Oh god what's wrong with me, why am I getting post-partum depression,' because he's probably going to catch hell from anybody he tells... And the thought can go across his wife's mind, 'Oh I married this guy, I thought he was going to be a wonderful father and here he is with post-partum depression, and I'm the one who had the kid.'

In sum, the fact that men were less likely to apply a hard mental health diagnostic label to their condition likely reflects both the lack of awareness surrounding paternal PPD as well as gendered mental health attitudes. My study is biased towards fathers more sensitive to mental health as they were willing to participate in a research study that was clearly about emotional health. Many parents noted the therapeutic benefit of the interview, and fathers in particular noted that they had not previously been able to fully share their stories and express their feelings in a judgment-free environment. Thus, even though the study was biased towards emotionally sensitive men, several did not seek professional help and a few also reported not having any informal mental health supports, as will be detailed in Chapter VI. The movement towards medicalizing PPD in men is an interesting development to be watched closely. Stereotypes that men have stable and strong emotional health may prevent this diagnosis from taking hold; however, the parents in this study were largely receptive to this emergent diagnosis. Further, as gender roles change, the rules of masculinity are also softening.

New Mental Health Identities

For many parents, the perinatal period was their first entry into the mental health system, and prompted new understandings about their past and future mental health for some. There are many reasons why parents may seek mental health treatment or adopt a new mental health identity for the first time during the perinatal period. To begin with, PPD awareness campaigns draw increased attention to mental health symptoms during this time. This may result in new parents being more in-

tuned to their mental health, and some medical providers now routinely screen for PPD during obstetric or pediatric check-ups. These awareness campaigns often stress the adverse impact that untreated PPD can have on parenting and child development. Therefore, in addition to increased awareness, there may be increased motivation to seek help during this time. Indeed, as will be further discussed in Chapter VI, this was often the case. Finally, the stressors surrounding the transition to parenthood may bring forth these mental health symptoms for the first time, or worsen previously low-lying symptoms; Chapter IV discusses these life stressors in great detail. Combined, these factors indicate that the perinatal period provides a unique moment for successful entry into the mental health care system.

Then, after a mental health diagnosis has been officially applied, parents sometimes have new, retrospective understandings of their previous health as well as more proactive approaches towards future mental health. This demonstrates an opposite pattern than those parents, described above, who already had pre-existing mental health conditions and then pondered whether their perinatal distress was something different or more of the same. Rather, some parents' new diagnoses during the perinatal period led to new understandings about their previous mental health. Further, whereas many parents remained unequivocal about their mental health status, these parents adopted a clear identity as someone with mental health struggles.

For example, Linda previously considered herself the one with strong mental health, while other relatives had major depression. Linda, a middle-class, professional mother, went over two years with her PPD symptoms before seeking help, and was somewhat surprised to receive a PPD diagnosis although she accepted the diagnosis as valid. She now feels that she may have had prior episodes of depression, which she did not recognize at the time similar to how she did not initially recognize her PPD, and definitely has experienced depression since:

I had never in my life remember feeling like I had depression. Now since I've had [baby], and when I was diagnosed with depression with the counselor, ever since that time I have gone through ups and downs of having depression.

Lydia D. also recognized a mental health history, only in retrospect, in response to my question about previous mental health history, “Now that I’m, now that I’ve gone through this and looking back, yes, I do think so.” Interestingly, Lydia’s awareness came from her PPD experience rather than her prior education and work experience in mental health.

Other parents did not necessarily see themselves as always having strong mental health, but still experienced clinical mental health identities for the first time. For instance, Stacey noted, “I’ve always needed something, because when I grew up I noticed I was slightly different.” Stacey is an older, low-income mother who had a longstanding ADHD diagnosis with medication, and prior therapy related to dysfunctional family circumstances but without a mental health diagnosis. However, while she was still in the hospital, post-delivery, she had her first panic attack. She left the hospital with medication and a follow up appointment for mental health services. Her eventual diagnosis was PTSD, which was traced back to childhood trauma. Her panic attack and extreme anxieties in the postpartum period were connected to fears of losing her baby. Thus, Stacey likely had the underlying symptoms of PTSD for some time and the cause was not childbirth itself, but there was no clear recognition or diagnosis until new parenting anxieties made her symptoms difficult to ignore.

Dylan provides a similar case, in which he noted lifelong depressive and anxious feelings, occasionally treated with therapy. But, when he was expecting a child, his anxiety became more severe:

In retrospect I’ve learned that I am an anxious person ... but it was all kind of subtle anxieties that I, you know, had picked my finger nails, even twirling my hair, when I had long hair, I would always fiddle with my hair, so I think that I always had these like anxious undertones that are a part of my personality.... And then, you know, I think that it just like hit me over the head, I think that I couldn’t suppress it anymore and the anxiety came out, and it came out in these panic attacks (during wife’s pregnancy). And I never had a panic attack before.... I only recognized it because I immediately went to seek counseling. Because I couldn’t function at work, and luckily I had a boss who was like, “Oh yeah, I had panic attacks too,” I think she might’ve been the first that kind of labeled it, for me.... I think there were underlying things there, and it was definitely related to the pregnancy.

During the perinatal period, Dylan was obsessed with death – that his baby might die, his wife might die, or he would die. These fears were more debilitating than his prior anxieties, manifesting themselves in

panic attacks which he had never experienced before. Several years after this event, Dylan still identifies as someone with an anxiety disorder that requires ongoing treatment.

Rather than being cured, these parents continue to manage their mental health. Julie J.

concluded:

And I wouldn't change anything because it's made me who I am, but it was so painful and it is what it is and it sucked. But I am who I am now because of it, so yeah. It's really scary and I'm terrified that it (depression) would happen again, which is why I say I'm in recovery and not cured, because I have been better and then I've gotten worse.

Most parents in my study were not yet far removed from their PMAD experience and the perinatal time period, and therefore, this theme requires additional longitudinal study. Yet, it appears that the perinatal period can provide a critical moment for reshaping mental health attitudes and help seeking behavior. From a critical sociological perspective, however, there is concern that individuals may remain on medication longer than circumstances require, and thus, medicalize life troubles. This is a fair concern for those whose distress is rooted primarily in adjustment to the life change of parenthood. After these troubles subside, a person could become dependent on medication. From a sociology-in-medicine perspective, however, this is a positive development that could result in improved and more proactive mental health management over their remaining life course. This is particularly important for those who will experience ongoing mental health symptoms severe enough to other interfere with their ability to function and quality of life.

Conclusion

PPD and other PMAD diagnosis are arbitrary, in that there are etiological debates over their definitions and classification, and the evidence is often not represented accurately in popular mental health discourse. In everyday life, applying these labels to one's own condition is also difficult. Does this matter? Yes and no. A vague recognition that something was wrong was often enough to work towards getting better. Further, this demonstrates active agency and hesitancy towards medicalizing life troubles. It was when symptoms were debilitating and difficult to manage that naming their condition

became important. Most distressed parents consulted a professional when symptoms persisted, which generally led to clearer diagnosis – but not always. It was particularly frustrating when parents undergoing treatment still experienced diagnostic uncertainty. In such cases, professionals and parents alike were searching for a fit between symptoms, effective treatment, and diagnosis. It's also worth asking whether some parents, men in particular, dismissed concerning symptoms as being just stress, in which unmanaged stress could potentially lead to adverse personal and family consequences.

From a sociology-in-medicine perspective, the PPD diagnosis can be applauded for increasing awareness of mental health needs during the perinatal period, and paternal PPD and additional PMAD diagnosis hold promising potential for doing the same. Yet, inaccurate understandings and inconsistent awareness mean that this potential is not fully realized. For example, despite widespread general awareness of maternal PPD, we saw that some mothers held restrictively narrow views that it must be linked to childbirth or feelings about motherhood. Although paternal PPD was far less known, my study respondents were open to this possibility. The recognition of perinatal mental health needs led to new lifelong mental health identities among some, which will presumably lead better management of mental health over their remaining life course. Many parents identified with a prenatal or postpartum depression diagnosis. While depression is among the most common mental health conditions, we also need to consider that postpartum depression is serving as a catch-all diagnosis as prompted by an overall narrow focus on PPD to the exclusion of other possible conditions.

From a sociology-of-medicine perspective, however, these diagnoses provide another example of life troubles becoming increasingly medicalized. As these conditions expand, the concern is that most new parents could potentially be viewed as having a mental health problem, but often in response to the typical stressors that surround parenthood. These illness narratives, however, illustrate that many parents were hesitant to adopt a mental health label, even while noting they were definitely not themselves. Parents paid attention to the nature, severity, and length of their symptoms; took previous

mental health histories into account; and also factored in the role of multiple life stressors. In this way, they rationally assessed their situation based on experiential understandings and within their life context. It is not yet clear if the distinction between maternal and paternal PPD will reify or challenge supposed hormonal etiology. Mental health identities will continue to evolve in response to the expansion of perinatal mental health conditions, and the extent to which parents embrace new PMAD labels will be shaped by how these conditions are ultimately defined and the awareness campaigns that surround them.

In continuing to explore patterns of acceptance and resistance to medical explanations of perinatal distress, the next chapter examines the accounts parents provided to explain why they were experiencing perinatal mental health symptoms.

V. Why Is This Happening? Explaining the Occurrence of Perinatal Distress

The depression was like this perfect storm and it had to do with hormones and the support from my husband and then the kind of feeling like, not even knowing what the hell I was doing and if I could do this. --*Susan G.*

Just overload -- like it was the number of stressful events adding up to, it was a really rough year. And I think it would have been a really rough year even if we hadn't had the baby. You know what I mean? Like it wouldn't have been lollipops and sunshine. We would still have had to deal with the stress of moving, the stress of being married, the stress of being newlyweds, the stress of job switches and full time school, full time work. --*Cory C.*

In the face of mental health symptoms, parents cannot avoid asking themselves, "Why?" Why do they feel the way they do? What is leading to all of these negative emotions? Postpartum depression, as a diagnosis, has been criticized by sociologists for medicalizing and individualizing problems are better understood to be social and cultural in nature. The turn to PMADs, with its broader focus, expands this medicalization of parenting stress – additional emotional responses (e.g. anxiety) and additional populations (e.g. fathers) are coming under the medical purview. While many parents were uncertain about the best label to apply to their condition, as reviewed in the previous chapter, they were clearer in discussing the factors that shaped their PMAD symptoms. I found that the parents in my study offered complex, multi-dimensional accounts of their distress, as can be seen in the opening quotes by Susan and Cory. Interestingly, parents were more likely to focus on explanations rooted in life circumstances over individual-level factors.

Parents' own accounts highlight how perinatal mental health distress was shaped by the social organization of parenting, including traditional and changing gender norms, class background, and work-family policy. Mothers and fathers largely cited the same stressors, pointing to the convergence of gender roles. However, nuanced gender differences reveal entrenched traditional gender roles, which parents sometimes fell back on when overwhelmed or in the face of structural barriers. Class based

differences were more stark than gender differences, with daily lived struggles of poverty more prominent than the cultural expectations of parenthood.

Overview of Parent's Lay Explanations

Health and illness are socially constructed in the everyday lived experience. This chapter largely addresses parents' "lay epidemiology" (Davis et al. 1991) to describe how parents accounted for their perinatal mental health distress, by drawing on a combination of personal, familial, social, and professional sources of knowledge. Prior research on illness beliefs and lay epidemiology have illustrated both correspondence and tension between expert knowledge and lay knowledge, in which lay patients draw on expert knowledge but also reshape it according to their lived experience and social positions. I applied my sociological eye to these accounts to draw out gender and class patterns in parents lived experience and lay accounts of perinatal mental health, which are best understood within the full context of the transition to parenthood. However, it is useful to first understand the range of the specific factors parents felt contributed to their perinatal mental health distress.

Parents offered a diverse array of biological, psychological, and social accounts. Again, lay explanatory accounts are shaped by the discourse surrounding any given condition. Popular discourse on perinatal mental health has been found to focus primarily on individualized, hormonal causation, despite evidence to the contrary, and focuses primarily on mothers, as reviewed in the Chapter II. However, advocacy websites offer more nuanced, complex accounts of perinatal mental health. Nearly every parent in my study reported consulting the internet for information, which oftentimes was their only source of detailed information on perinatal mental health. In sum, distressed parents today may be drawing on a variety of discursive messages when seeking to understand their perinatal mental health.

My interview guide was carefully constructed so that parents could first offer their own accounts of distress, as reviewed in Chapter III. Only after exploring the explanations originally offered, did I ask about specific risk factors drawing on a checklist informed by the literature and emergent

themes. Since most parents cited numerous factors, I asked parents to identify the one or few factors that *most* contributed their perinatal distress. Table 3, below, provides an overview of common explanations by gender and class. Table A5, in the Appendix, provides a more detailed account of all explanations offered, by each parent.

In result, sleep deprivation, social isolation, inadequate social support, insufficient me-time, non-dysfunctional marital distress, and a stressful family-work balance emerged as the most frequently cited contributors to perinatal mental health distress, which was true across mothers and fathers of different class backgrounds. When combining financial stress with struggles with poverty, this also emerged as a commonly cited factor. Among mothers only, hormones and breastfeeding struggles emerged as a widely cited factor. A dysfunctional marital relationship was an important factor, impacting nearly half of the low-income parents. Infant characteristics (e.g., infant temperament or health) and caring for an infant as generally overwhelming were also commonly cited. Several parents also discussed the overall life change, although this was a somewhat fuzzy category as many of the other factors also touch on changes associated with the transition to parenthood. This demarcates parents who spoke more directly about the overall life change or having many things going on at once. Overall, however, we can see that perinatal mental health distress is largely about the transition to parenthood, and all of its associated changes, according to these parents. Woven throughout these transitions to parenthood, many middle class parents also discussed a loss of identity, although I had a difficult time quantifying this. Also buried within many of these factors, are the cultural expectations of parenthood and trying to live up to these ideologies. Despite the predominance of social factors, individual level factors such as mental health history, hormones, and personality type are still apparent. Only 4 parents cited personality type, but as a word of caution, this is the one factor listed that I did not systematically ask each parents about in my interview guide, therefore, this may be an underrepresentation of the perceived role of personality in lay narratives.

Of particular note, thirteen parents cited a mental health history with seven finding this to be a primary factor. An additional eleven parents had a mental health history, although not framed as directly contributing to their perinatal mental health symptoms. A mental health history is the strongest risk factor for PMADs, as reviewed in Chapter II, and consistent with my sample in which more than half the parents had at least one prior mental health episode. A small portion of these parents had a continuous history of mental health problems, in which mental health symptoms were ongoing and existed immediately prior to pregnancy. Desiree shared, “I don’t think I really remember not being depressed.” These parents linked their perinatal mental health symptoms to their existing condition, but also noting that it got worse due to circumstances surrounding pregnancy and postpartum, as shared by Kassie, “Pretty much as far as I can remember I’ve been a depressed person. But when I got pregnant it was crazy. I was really depressed. Not just maintaining.” Some of these parents also received new diagnoses during this period, such as Kassie who was newly diagnosed with anxiety. More often, parents with a mental health history had only one or a few prior episodes. These prior episodes were often in relation to other stressful life events, notably, their teenage years, a family loss, or a rough break-up. Thus, the perinatal onset of mental health symptoms was more clearly distinct and not always anticipated. And rather than being simply an individual proclivity towards mental health conditions, prior histories were almost always connected to other life difficulties.

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Table 3: Overview of Parents Lay Explanations for Perinatal Distress

	Middle Class Mothers (n=15)	Low Income Mothers (n=15)	Middle Class Fathers (n=14)	Low Income Fathers (n=3)	Total* (primary)	Notes
Sleep Deprivation	12	11	10	1	34 (9)	Only middle class parents cited this as a primary contributor
Social Isolation/ Cabin Fever	15	10	9	0	34 (7)	
Inadequate Social Support	5	9	6	0	20 (4)	Only mothers cited this as a primary contributor
Insufficient me-time/leisure time	7	7	11	1	25 (2)	
Marital stress, (non-dysfunctional)	11	9	7	2	29 (10)	
Dysfunctional relationships	0	7	1	1	9 (5)	
Family, work, school balance	6	8	11	2	27 (5)	
Job stress (not family balance)	1	0	5	2	8 (4)	Only fathers focused on this as a primary factor
Financial stress (non-impoverishing)	5	n/a	4	n/a	9 (2)	I defined these two categories to be mutually exclusive. Only fathers focused on non-impoverishing financial stress as a primary factor.
Poverty Struggles (meeting basic needs)	n/a	14	n/a	3	17 (7)	
Overall Life Change	7	1	6	0	14 (12)	Many other factors point to this, these parents pointed out this factor more explicitly
Dysfunctional Family background	1	2	1	0	4 (1)	8 additional parents grew up in dys. Families, but not explicitly identified as a causal factor
Mental Health History	4	6	1	2	13 (7)	Several other parents had a MH history, but did not explicitly identify as a causal factor
Partner's Mental Health Condition	1	0	4	2	7 (2)	
Personality Type	2	0	2	0	4 (2)	
Infant characteristics	9	2	5	1	16 (8)	
Bonding with baby	5	2	2	0	9 (1)	A few parents also noted difficulty bonding as an effect
Baby care as overwhelming	4	7	3	0	14 (5)	Many other factors point to this, these parents pointed this out more more explicitly
Unplanned Pregnancy	0	4	2	0	6 (3)	Many other low income had unplanned pregnancy, but not a major stressor overall
Pregnancy/birth complications	6	3	n/a	n/a	9 (3)	Only middle class mothers identified this as a primary factor
Hormones	13	10	0	1	24 (6)	
Breastfeeding struggles	10	7	n/a	n/a	17 (7)	Not investigated systematically in fathers, although some noted stress in trying to support wives bfeeding

*The first number is total frequency and number in parenthesis represents those stating this as one of the most important factors

A few class and gender patterns among are apparent among the explanatory factors offered. These patterns are discussed throughout this chapter, as I examine these factors further within the larger context of parents' stories. I start with their pregnancy and proceed through the adjustment to parenthood, including the new family-work balance and the impact of becoming a parent on relationships. These stories often deviate from explanatory factors, but provide important context for understanding mental health distress among new mothers and fathers, as well as gender and class differences in how explanatory factors stood out to new parents. Further, the cause and effect of perinatal mental health distress often interacted, as these stressors unfolded in the everyday lived experience.

The Pregnancy

Becoming Pregnant

Parenthood has been increasingly delayed in western societies. The average maternal age of childbearing has grown from about 21 years in 1970 to 25 in 2010, and the number of women having their first child at age 35 or later has grown substantially (HSRA 2012). Delayed parenthood reflects the growing cultural belief that individuals should first discover themselves, be in a stable relationship, and be economically secure before taking on the responsibility of a child. Marriage and job security are also occurring at later ages in contemporary society. The prospect of parenthood began very differently across the families in my study. The vast majority of low-income participants experienced unplanned pregnancies, whereas those from the middle class carefully planned the timing of parenthood. The Bs, an interracial couple, were the only low-income parents reporting that they planned their pregnancy; both of whom noted that this was unusual compared to their friends. In contrast, the vast majority of the middle class parents planned their pregnancy. This pattern among my small, qualitative sample is consistent with broader trends in the U.S., in which low income individuals are more likely to have and

bear children outside of wedlock and at a younger age (Kearney and Levine 2012; Kennedy and Bumpass 2008).

In planning their pregnancies, the middle class parents waited until they felt secure in their education, careers, and relationships, as shared by Sabrina H.:

I don't think we were ill-prepared by any means. Like I said, I had my old checklist. I wanted to finish school and I wanted to have a good job and I wanted to be out of [hometown].

These pregnancies, then, were meant with great excitement, as shared by Shelley, a black-middle class mother:

I was overjoyed. I don't think that word will ever be able to describe the joy I felt just to know that I was able to bring forth life and give my husband something that we both wanted, so - very, very, very happy moment.

However, a few parents with anxiety predominant symptoms noted that pregnancy marked the beginning of their symptoms. Although happy, they were also fearful of this major life change, knowing that life would never be the same. Dylan, an educated middle class father, who experienced his first panic attack during his wife's pregnancy, discussed the anxiety resulting from his discussions with other fathers, "There's this ambiguous like, 'What happens?' 'Well everything changes' 'But how?' Well, no one really tells you exactly how, and so, there's a lot of uncertainty." Ben I. echoed, "I mean, I wanted kids, I definitely wanted kids...(but) I knew this would change everything. And so there's always the fear of the unknown." Dylan was also very fearful that he, his wife, or baby could die. Sabrina was crippled by anxiety that life would never be the same, and further, that she would not be a good mom.

Unplanned pregnancies, primarily experienced by the low-income parents, were typically greeted with feelings of fear, uncertainty, and regret. These parents often questioned if they were ready for the major life change and responsibility of parenthood, as shared by Erica, a young, black mother who reported that she was "devasted" upon discovering her pregnancy:

It was just so much going on and I wanted to be something. I had so many dreams and I just thought, can I do this? We were young, we were still trying to be selfish, you know where you're a kid you're like, I want these shoes, I want these pants, I want this shirt, I want this. And

we really had to learn to be parents, seriously. Like we weren't ready for that. We weren't ready. I mean, I was 21, but I was not ready to have a child.

Young adulthood has become a new life-course stage characterized by self-discovery and minimal responsibility, and clearly, many of these young parents also subscribed to this new cultural ideal. Some also noted the shame or stigma of an unplanned pregnancy outside of wedlock, as shared by Samantha, an educated, low-income, white mother:

We're from a real small town, so I kind of felt like... I just never wanted to be one of those girls who had a baby outside of a marriage. I felt like, what does that look like for our family to have both of our daughters have children out of wedlock?

Although no one treated Samantha poorly, but she internalized this stigma. Out-of-wedlock births now represent about 40% of all births (CDC 2013) and this stigma has declined (Cherlin 2008), but it has not disappeared. The Cs chose to marry rather than have their son out-of-wedlock and several others became engaged.

For the most part, these parents wanted kids eventually, but this was not good timing, as represented by Kassie, a married, white, low-income mother:

I was happy, because I always wanted a baby, but I didn't know if I was ready. And then I would be ready and her dad would be happy one minute, and then, I don't want this the next minute...And I was just, I was really happy and then I'd be like, god, why can't I just not be pregnant right now.

A few others had more serious doubts about whether they were in the right relationship for having kids together. They tended to be in young relationships in which parenting together had not been discussed.

In the case of the As, and older, educated, low-income couple, it was already becoming clear that they were incompatible as a couple:

That was kind of an odd time in our life. I had been separated from Randall for about a month. We were still cohabitating, but we were not a couple anymore just because of relationship problems. And we had kind of planned to start breaking further apart... And then I found out I was pregnant. And I was having a lot of emotional problems at the time.

Finally, some wondered if they were suited for parenthood, at all, as demonstrated by Kristi and Jack, respectively:

I was scared because I never wanted to have a kid. I always had my nieces around, I'd rather spoil them because I can give them back. I was getting nervous about the same thing. Oh here I got one... I didn't know how I was going to handle it. I didn't know. Because when I had my nieces and stuff, when they were kids, just crying would get to me. I'm afraid of the things - not having sleep again. Hear everybody's horror stories. That didn't help at all.

Friends would have kids and I'd be like... that's neat, I got a dog, everything how [it is] is perfect, my dog is. I could do a dog, but not kids.

Despite initial fears, these parents generally came to look forward to motherhood or fatherhood. Most mothers made a conscious decision to keep their baby after considering their options, including two women who resisted their partners' pressure to have an abortion. Erica, the mother quoted above who was initially devastated by her unplanned pregnancy, discussed her conscious decision to keep her baby despite the biological father's objections:

And he was being a straight jerk about it, like telling me he would give me money for abortion and things like that. And although I was thinking about it, I didn't want the abortion to be because someone offered me the money. I want it to be my decision. I said, 'You know what, I'm not having this baby for you, I'm going to have the baby for me.'

Although they knew life would be difficult with a baby, most of these mothers very rationally considered their options. Early childbearing can lead to economic disadvantage for women (Loughran and Zissimopoulos 2008), but Kearney and Levine propose that early childbearing may be more attractive to low-income women as they have relatively less hope for economic advancement to begin with (2012). These mothers did fear that having a baby was going to make their educational and career goals more difficult, but at the same time, often came to see parenthood as a new beginning. For most, then, this was not a major contributor to their perinatal mental health.

However, two low-income mothers were constrained in their family planning choices and continued to regret their pregnancies. One young mother could not afford an abortion and instead abused her body hoping to miscarry:

It was pretty sad. I was suicidal. I was calling adoption agencies, abortions, clinics. I was really trying to get rid of it. Sometime or another I was punching myself trying to get it to come out.

This mother also abused drugs and alcohol during her pregnancy. An older mother ignored prenatal care, hoping to miscarry and also in self-denial of the pregnancy. She would not consider an abortion due to personal beliefs but continued to regret her pregnancy, "It was an unexpected pregnancy and for most of the pregnancy it was unwanted pregnancy. I'm not sure when my mind changed on that." These mothers experienced a loss of control and emotional distress throughout their pregnancies.

Two of the fathers who did not plan their pregnancy also felt they had little control over the choice to become a parent. These were both older, middle-class fathers who never planned to have children, and thought that their partners were in agreement and practicing a birth control method. One father reported discussing options with his partner upon discovering the pregnancy. However, he was indecisive and went along with his partner's desire to keep the child. He later regretted this decision but it was too late to reconsider their options:

I remember thinking many, many times, even not so long ago, even just a few days ago I even think, 'Why didn't I just say no?' because I had said no so many times before. I was so clear that there's not going to be a baby in my life. And this wasn't something I decided just a few months before. I'd known it for a long time. I never wanted to have kids.... [I felt] unimportant because - useless because of the regret of not speaking up and standing by my will, 'No, no, I cannot do this kid. I'm sorry.' And unimportant because she was going around making all these various plans and decisions and everything, and I was just plain old depressed, feeling like shit and ready to jump off a roof of a building and just whatever.

In contrast, the other father stated it was never open for discussion with his wife. Both fathers acknowledged that this was ultimately a woman's choice, but felt constrained nonetheless. They both also felt a strong sense obligation to their unexpected fatherhood role, and therefore were fully committed to raising their child. Nonetheless, the unplanned pregnancy, especially when they intended to be child-free, was the primary contributor to their paternal PPD. This was a particularly sensitive issue, shared in the strictest of confidence because they know it is socially unacceptable to not want your children.

Planning for Parenthood

Once pregnancy was accepted and a baby expected, parents began preparing for this reality, materially and mentally. Western societies have long been characterized as having isolated, nuclear family structures. In result, many parents have not even held an infant before they have their own child and are now almost solely responsible for this new baby's survival and healthy development. Low-income parents focused on securing the practical items needed for their child, such as diapers, car seats, clothes, and baby furniture. Middle-class mothers studied intensively for childbirth and parenting by reading a lot and attending classes. Fathers, in general, spoke more often of financial preparedness and getting the house ready. Preparations for parenting was not directly cited as an explanatory factor, but this context is important for understanding what parents expected of parenthood.

I asked all parents about pregnancy/childbirth/parenting education as well as direct experience with infants and children. To summarize, the middle class mothers read a lot more and attended more classes, but there were no notable gender or class differences in direct experience with children and babies. Most new parents had at least some experience with children, and few had experience with babies. This pattern was mostly shaped by their extended family background, in which those who were older siblings or had young nieces and nephews had hands-on experience with children. To the extent that babysitting provided experience, mothers were more likely to have this background, although babysitting experience was not widespread and a couple fathers also spoke of babysitting experience.

Just as they studied in college or trained for their careers, middle-class mothers approached motherhood with a similar penchant for studying and becoming as prepared as possible for parenthood, as demonstrated by Lydia D. and Susan G. respectively:

I had also read tons and tons and tons of books, which was like one of my crazy mom things. Like obsessively reading all of the books I could because I wanted to be as prepared and be the best parent, be the best person in labor.

The birthing class, breastfeeding class, newborn safety and CPR and baby care, so we did them all. And I did the prenatal exercise, we did that for 6 weeks through the hospital. We read a lot. I

think we did the normal amount of preparation... [I read] the *Mayo Clinic Guide to Health and Pregnancy*, it's a big, thick one. I read the *Girlfriends' Guide to Pregnancy*.

These middle class mothers also read extensively about child-rearing, oftentimes identifying a parenting philosophy that they planned to implement, such as attachment parenting, love and logic, or referring to one parenting expert they preferred over others. Dr. Sears was particularly popular among many middle class mothers. The science of motherhood implies that experts know the best caregiving practices which will maximize their children's wellbeing, but therefore also serve the larger social good by raising well-balanced, productive citizens (Litt 2000; Smuts 2006). What good mother would not want the best for their child and to ensure that their child becomes a valuable member of society? Yet, expert advice changes often and is contradictory (Hays 1996). Interestingly, some of these mothers referred to their preparation as a "normal," as seen in Susan's quote. However, there clearly was no "normal" when considering the class and gender variation across these parents.

To be certain, most low-income women also read in preparation for childbirth and baby, but many only read one book, most commonly *What to Expect When You're Expecting* which is primarily a pregnancy guide. Further, less than half of low-income women attended a pregnancy and childbirth, breastfeeding, or parenting class during pregnancy, although many were constrained by cost, scheduling, or transportation. Although low-income mothers rarely read in advance about parenting, they still sought parenting advice on an as-needed basis, typically online, after their children were born. Many also took advantage of parenting education opportunities available through Early Head Start, community health providers, or homeless or women's shelters. Thus, while the low-income mothers did not educate themselves as extensively as the middle class mothers in advance of their baby's arrival, they were hardly unprepared and did not hesitate to get information when they need it.

Although low-income mothers did not seem any more or less likely to have hands on experience with children, they appeared more confident in relying on experience and instincts as a source of expertise, as shared by Bethany and James B., respectively:

I just pretty much learned as I went along.... And I tried to help raise my little sisters growing up, they weren't baby babies, but I helped raise them.... I didn't take any classes, I didn't read anything, I just went with the flow and let it happen.

They had the classes, I didn't take any of the classes. I assumed I'd be a good parent because I had two good parents and that's basically where I was going to take my parenting from. I actually had a talk with my father about that before my son came and he even reinforced my own thoughts to say, 'Well I think you're going to be a good father.'

There were a few exceptions in which low-income women also studied a lot for parenthood, as represented by Samantha:

I pretty much read the *What to Expect When Expecting* book cover to cover. I kept up with the little *My Baby's Progress* week by week. I was really, really like, I just felt like I had no idea. I don't think I've ever studied for something more in my life. I think I was just really obsessed with getting as much information as I could. I bought him the father books and he didn't read them. I was upset about that.... I was really worried, I think I like because I didn't even feel comfortable handling babies at that point. I'm not even sure I ever changed a diaper before [baby], so.... I felt like I didn't know what to do and I wanted to know what to do and how do you know until you actually have the baby so. So that's why I consumed myself with reading everything I could possibly read.

Interestingly, the low-income mothers who read more extensively had middle class family backgrounds or were college educated, including Samantha, thus the general class pattern still holds when considering mother's SES background more broadly.

Rather than extensive learning, when asked about preparation activities, low-income mothers mostly spoke to securing basic material needs and baby supplies, often wishing they entered parenthood in more economically secure circumstances. For example, Kassie spoke of making sure she had enough diapers for the baby she was expecting:

I actually had stocked up on diapers and stuff, like everything I needed for her... I mean, I had, I'm not kidding, I took a picture of it at one point, I wish I had it for you. My entire closet jam packed full of diapers and wipes and baby stuff all the way to the top. It was crazy. My friends all laughed at me about it. It lasted all the way up until probably a year.

Of course, middle-class mothers also secured these items, but they rarely discussed these activities thus indicating a taken-for-grantedness of basic material security..

Fathers too, often spoke to financial preparedness and material security, but more so in regards to long term security than the baby's immediate needs. Some fathers worked towards promotion and advancement at work, as represented by Rick E., a middle-class father in his 30s:

I think that us knowing we were going to try to have a baby, that sort of thing, kind of forced me to take some steps to make myself more promotable and make my wishes known a little more and maybe strive a little harder to make myself stand out so that I was able to take the next step in my career.

Jack spoke of giving up self-employed contracted work to become an employee because, "This is what having a kid is, you have to know every week (you'd have a paycheck)." Several fathers mentioned building more of a savings, as shared by Kevin D.:

Before we had [baby] we went through Dave Ramsey's Financial Peace University and we had, and in that program you, he has this list of baby steps that you go through for finances. And his advice, when you're going to be a parent, is build up a savings account as big as you can. And so we did that and we ended up with a pretty good emergency fund.

Whereas middle class mothers often cited Dr. Sears or another child rearing expert, middle class fathers often cited Dave Ramsey, a financial guru. Dads also focused a lot on more on practical house stuff, from setting up the baby's room or baby-proofing to securing a good house for the family. For example, in preparing for fatherhood, Scott shared:

The process of having to find a new house for us and something that would fit us all, so it was just a lot of more logistical type changes, just kind of preparing in that way.... For me it was mostly just getting everybody in one house. That was really my concern initially and what I was trying to do.

Fathers largely rejected the male breadwinner role as an ideal when asked what makes a good father, however, these preparations for baby reflect engrained gender roles.

In regards to preparing for their hands-on parenting roles, fathers often attended pregnancy and parenting classes with mothers. They appreciated some of the hands on experience this provided, as noted by one middle-class father, "I was really needing classes, like change a diaper ... because I had no experience." However, fathers tended not to read and study up as much as the mothers. For example, Rich E. shared about reading books, "No, but I was supposed to. My wife read plenty of them. No, I did

not read any books.” Father’s often noted that mothers would tell them what they needed to know, as demonstrated Matt F., a middle class, white father:

I’ll ask my friends, they already have a lot of children. Or usually I get advice from Jenna’s reading magazines, books, Internet. She’s pretty good about that... we get the *Parents* magazine over the website, she’ll send me articles. I’ll read those.

Fathers also treated these resources more like reference guides, similar to low-income mothers, which they did not read thoroughly but would look up information in books or online when actually needed. A few fathers did read more, but always less than their spouses – such as Kevin D. who read 2 or 3 books, but Lydia D. read “seven or ten.” These particular fathers often sought resources directed specifically towards fathers and written by fathers, but often noting that there were not many such options.

The Birth and Early Parenting Experiences

Childbirth

Most parents were satisfied with their childbirth experience, and delighted in sharing their birthing stories. There was, of course, some trepidation during childbirth that something could go wrong with the baby or the mom; but this anxiety was short lived and most births went well. However, there were a few important exceptions in which birth complications directly shaped poor mental health. The Hs son was born with a serious birthing injury which was not immediately recognized. It was initially a very difficult emotional time when they were not certain if their son even had something wrong and then when his diagnosis called into question whether he would survive. This emotional roller coaster got much better when he recovered and come home, but there were still long term stress anxieties about his long-term development. Shelley is a middle-class, black mother who had a high-risk pregnancy and premature delivery. She was then concerned about her son’s wellbeing, and further, the early delivery came at a bad time for her education and her spouse’s career. Sachi also was primarily distressed by a premature birth. These birthing complications were not the only stressor for these parents, but were cited as important contributing factors and, further, something over which they had little control.

A few mothers had caesarian sections, which sometimes posed post-birth health complications. These mothers lamented their struggles with baby care while their bodies were still healing, and especially after fathers went back to work and were no longer available for help. One mother ended up going back to the hospital for several days as a result of a post-surgery infection, and felt this interfered with her ability to immediately bond with her daughter. Beyond these pains and struggles, having to have a caesarian or other birthing interventions was sometimes viewed as being a failed mother. In contemporary motherhood, high expectations of motherhood extend to visions of the perfect childbirth. As a direct result of feminist action in health care, women today are more empowered during childbirth than previous decades. While childbirth is still medicalized in many respects, women are more educated about childbirth options. Women are encouraged to develop a birth plan to better ensure their birthing wishes are respected. Overall, this is a positive development. However, a few mothers in my study experienced birth complications, and they did not always prepare for Plan B. There is perhaps a false confidence that education and birthing plans will guarantee a good birth. They then felt like failed mothers from the first day when they did not have an ideal birth, as shared by Natalie:

I was really disappointed. I felt like I had all these plans. I was going to not have any drugs. You know, the whole thing that everybody says. And then they tell me, well, you probably need a C-section because you're not making any progress.... I just remember crying to [husband], 'I was like this is not what I want, this is not, nothing has gone the way that I had planned.'

The inability to have a natural childbirth sometimes called into question their womanhood, as Samantha stated about her emergency caesarian:

To be like, ok, I'm a woman, my big difference in life between man and woman is I'm supposed to be able to birth and nurse children. Men can't do that, that's my purpose of being a woman. I didn't birth him and I wasn't nursing him, so it was just extremely upsetting to me.

Further, these mothers sometimes blamed themselves, for birthing decisions they may have made differently.

Hormones

Childbirth is the event marking the drastic hormonal shifts experienced by all mothers. Again, hormonal causation has been a leading explanation for PPD; however, this theory is not strongly evidenced. The current body of evidence points to hormonal causation for PMADs as the exception rather than the rule. Yet, much of the popular discourse stresses hormonal causation well beyond the hormonal exceptions found by research. With this in mind, I expected most mothers to bring up the role of hormones early, independently, and prominently in their illness narratives. However, hormonal explanations of distress were very complex and somewhat contradictory. Only seven mothers offered a hormonal explanation for their distress, independently without a prompt, and only six mothers' pinpointed hormones as a *leading* contributing factor to their condition. Further, no one viewed hormones as a sole cause. Susan G. for example, had a severe case of PPD and felt that hormones played a prominent factor, but also spoke to other important factors shaping her depression:

It was just kind of a perfect storm, I think. I've read a lot about - obviously I've done a lot of research and stuff now about post-partum depression in particular. It seems like this particular type of person, this type A personality is prone to it. And just being so hard on myself and not letting things kind of go with the flow. So yeah, I think it was primarily just a combination of personality characteristics, the situation with [my husband], and the hormones.

Although only a minority of mothers focused in-depth on the role of hormones, nearly every mother agreed that hormones contributed to their emotional distress when asked. Indeed, as reviewed above, hormones emerged as one of the more common explanations of perinatal mental health symptoms. In explaining why they thought hormones were a factor, most women referred to simply feeling different or being moody. In light of this moodiness, some mothers also noted there was not otherwise a good reason why they were so moody, as represented by Elizabeth:

Definitely I would say hormones because it was, that's a big part of it I think because you can't control it. It's so overwhelming that just feelings you have and you're just confused with why?

To be certain, these women still discussed other factors at length, and here are largely referring to their rapid mood swings and crying episodes. Another common reason for accepting hormonal causation is that medication proved effective.

Although these explanations seem rational, there is reason to be skeptical. First, mental health disorders and sleep deprivation also lead to mood swings. Second, psychiatric medications do not provide hormonal therapy. Finally, in light of the etiological evidence, it's unlikely that *most all* of the women in my sample actually experienced hormonally induced PMAD symptoms. This, therefore, speaks to the power of the hormonal discourse that surrounds PMADs in popular discourse. Indeed, Bethany's response directly speaks to the common knowledge that hormone changes are drastic after childbirth:

Of course, I can't tell, I don't have a hormonal reader that tells me how bad my hormones are, but yes, I think they are. Because right after you give birth your hormones are going 90 to nothing, so. And I was really, really, really irritable after giving birth.

And, even more to the point, when I asked Nicole why she felt hormones were a factor, she replied with a laugh, "Because that's what they keep telling me." Nicole used "they," ambiguously – it's not clear if she's referring to her doctor or family, or perhaps, the generalized "they" of society. Nonetheless, she clearly absorbed the message that postpartum women are emotional and depressed because of their hormones, along with many other mothers.

However, in understanding that hormonal causation is the exception and not the rule, this does mean that some mothers may have been the exception. Previously, sociologists have been overall critical of attributing PPD to hormones, but new evidence requires us to rethink this. The mothers who stressed hormonal or biochemical causation included the mother with psychosis, a depressed mother with a thyroid condition, and a couple depressed mothers who spoke of menstrual cycle moodiness, all of which are risk factors for hormonal causation or the sensitivity thesis. Yet, those who identified hormones as a primary factor were also all middle class, so there also appears to be a cultural difference. In light of their stronger educational preparation for parenthood, they were likely exposed

more to the biomedical discourse on PPD. Further, recall that some mothers felt that hormones made sense when there was not another clear reason for their moodiness. Middle class mothers by and large did have good lives, with stable relationships, promising careers, and financial security. As further detailed below, most low-income women experienced serious life stressors which may more clearly explain episodes of crying or anger.

Although acceptance of hormonal causation was dominant among mothers, there was some resistance to this explanation. For example, a middle-class mother, Natalie noted:

No, I don't think so, I think, especially with that nurse telling me that they (hormones) were. I was bound and determined I would not to make them a factor.

Likewise, Andrea, a low-income married mother, shared:

I'm sure they (hormones) were, but I think more of it was thinking that I was very hormonal and trying to fix everything (in my marriage) myself and not make any noise. But all the while I had all this building up, I mean, you could tell by my body language that I was pretty mad. I was pretty under-loved and frustrated.... [Looking back], I was pretty reasonable pregnant woman and mother.

For both Natalie and Andrea, the suggestion that they were hormonal distracted from what they felt were their true stressors. For Natalie, breastfeeding was an immediate and major postpartum stressor, which she felt the delivery nurse was not adequately addressing. Andrea initially believed hormones played a role, but in retrospect feels she was making excuses for herself, in denial of the impact of her poor marital relationship. Isabella was ultimately uncertain about the role of hormones, expressing doubt along similar lines when asked why she felt hormones were a factor:

Because I was mad, but then I was trying not to be mad because they said not to get upset or anything when you're breastfeeding, so. But yeah, like I told you I was mad at my husband, not helping enough.

While Isabella first considers her anger as being hormonal, those feelings were then attributed to her husband not helping out. Ultimately, it is the lack of support from her husband that Isabella stressed as a primary cause of her possible depression. Julie J. was the other mother who questioned hormonal causation, saying, "I assume so, but I really don't know," and going on to explain that her severe

depression continued well after childbirth and when her hormones returned to normal, thus actively challenging the common assumption. While these mothers provide an important critique of presumed hormonal causation, they were in the minority.

Fathers further complicate the picture, as there was little prior awareness of paternal PPD among my study participants, as explained in the previous chapter. Therefore, fathers were less likely to be exposed to discourse surrounding paternal postpartum depression, including the extrapolation of hormonal causation in men. Fathers never independently suggested that their emotions were hormonal in nature. Further, when probed, it was clear that few considered this explanation before, and most rejected this idea. A few fathers at least entertained the notion, rather than rejecting it outright, often referring to prior knowledge that fathers experience hormonal changes surrounding childbirth. For example, Jeff H., a middle-class white father, responded:

Uh, (hormones) that were making me emotional? Hmm, kind of, I mean, there's a few times where I like - I remember we had a couple of friends over, married couple over and it was me and my buddy out back or whatever. And I don't know, I was just like, we'd had a couple drinks or whatever and it's just like, 'Oh you're the only one I can relate to.' I mean, it was just like a weird girl moment. Looking back on it, yeah....The only thing I've ever heard of before that was I know I read an article where they said a guy's testosterone goes down either nearing pregnancy or after the birth or something, so that they're less assertive or aggressive or something... So, I mean, I don't know. I saw little changes in myself where I could, I think where that was probably occurring.

In addition to this awareness of shifting hormones in expectant/new fathers, Jeff referred to his moodiness as being "like a weird girl moment." This also speaks to the fact that men are not generally seen as moody or hormonal creatures. Although my study is novel in including fathers, the lack of awareness of paternal postpartum depression combined with sex differences in hormones (real and perceived) complicates the comparison of hormonal explanation across men and women. As awareness of PPD grows, it will be interesting to watch whether this development challenges or reinforces hormonal theories and discourse.

Finally, parents' general lay definitions of PPD pointed to another contradiction. Although parents never focused solely on hormones in their own illness narratives, hormones appeared more prominently in their generic definitions of postpartum depression. To be certain, most parents provided definitions which focused on the symptoms of PPD rather than causation. However, when causation was mentioned, hormones were nearly always brought up and, often times, to the exclusion of other potential factors, as indicated by the following quotes:

It's essentially just depression caused by hormone imbalances after pregnancy. --*Scott*

Depression mothers feel after they've had a baby... The hormonal changes are causing it. –
Desiree

Women's hormones were also a common reason for why parents either doubted paternal PPD or stressed it would be different, as reviewed in the previous chapter. Yet, some parents also cited life changes and new responsibilities as also contributing to maternal PPD. For example, take LeAnna B.'s definition:

I think that your body is changing through the pregnancy and you have to deal with that change. And then when the baby comes out, then your body's trying to get back and then dealing with all of that and the hormones and lack of sleep and then still trying to be a wife and then a mother and take time for yourself, it's very overwhelming and dramatic.

LeAnna received an official PPD diagnosis, and, generally, parents with an official diagnosis for themselves or their partners offered more nuanced definitions of PPD, perhaps reflecting increased exposure to diagnostic discourse, either directly from a medical professional or in reading up on their condition.

In sum, mothers frequently accepted a role for hormonal causation, but ultimately offered complex accounts of their perinatal mental health systems beyond simply hormones. It appears that the dominant biomedical discourse surrounding childbirth and perinatal mental health influences their illness narratives, but did not blind them to alternative explanations.

Breastfeeding

The vast majority of the mothers in my sample intended to breastfeed, and several did so with little difficulty. Breastfeeding is often promoted as a protective factor against PMADs, because it is thought to tame post-childbirth hormonal changes and promote mother-infant bonding (e.g. Kendall-Tackett 2010), although empirical research findings have actually been mixed (Dennis and McQueen 2009). My study demonstrates that when breastfeeding did not go well, it may be a risk factor for PMADs. Over half of the mothers in my study cited difficulties with breastfeeding, with most feeling this directly contributed to their perinatal mental health conditions. In fact, several mothers identified breastfeeding troubles as one of the most important contributors to their perinatal mental health symptoms. This emergent theme was not initially suggested by the literature, and I added a breastfeeding question after the first few mothers I interviewed all spoke, at length, about their struggles with nursing. More recently, a large quantitative study found that breastfeeding contributes to PPD when mothers are unable to breastfeed as planned (Borra, Iacovou, and Sevilla 2015). My research is consistent with this new finding, and helps to illustrate the reasons why it can be so upsetting when breastfeeding does not go as anticipated.

To begin with, many mothers were surprised by their breastfeeding difficulties, believing that as a natural function it was going to be easy, as shared by Emma:

I felt like a failure. It was really hard. Because I'm used to being able to do what I want to do. I haven't, I never really had any setbacks with anything. And so to, something (breastfeeding) that was supposed to be so natural to be so difficult, it definitely felt like a failure on my part.

Emma also noted that her breastfeeding class did not prepare her for this, as the instructor stressed how natural and easy breastfeeding was and did not provide any indication that it can be difficult. In reality, there are many challenges that can make breastfeeding difficult. Many mothers experienced an insufficient milk supply, some pointing to a family history of similar problems. Others struggled with

getting their infant to properly latch. Others spoke of breastfeeding as being very painful, even though they were instructed that proper breastfeeding should not hurt.

A few of these mothers may have been helped by better lactation support. Low income mothers, in particular, could have benefited having affordable access to a breast pump. However, most mothers had access to lactation support. They worked closely with lactation specialists and implemented many strategies for promoting lactation or proper infant latching. These techniques were often very rigorous and therefore distressing, as shared by Jill I., an educated middle class mother, “Even when I wasn’t nursing him, I was thinking about nursing him and I was dreading nursing him and I was recovering from having nursed him.” Samantha, an educated low-income mother, notes it was not only tiring, but felt “robotic”:

When I came home from the hospital, I was having a really hard time nursing him. I had to wear a nipple shield and nursing him, it was so hard because I’d have to like wake him up in the middle of the night and so I’d only sleep for an hour or two at a time and I’d be so anxious it felt robotic, it didn’t feel natural. And it’s supposed to be the most natural thing there is and it was odd.... it just didn’t feel like it was right, it didn’t feel like it was happening the way it should happen. I remember just going into the shower and just weeping.

Getting breastfeeding to work is a lot of work, on top of their other demands as new parent and while sleep deprived. Further, this was another area where they questioned their competency as mothers, including whether their baby was getting enough essential nutrition. They also received contradictory messages on whether and how they should keep trying to breastfeeding, as demonstrated by Miki, an Asian immigrant:

She (mom) didn’t breastfeed me when I was a baby, so she didn’t know at all what to do with the breastfeeding situation. So she just kind of like, ‘Why don’t you just give him formula? He’s so hungry, crying all the time.’ So she would give me that kind of comment all the time and she sounds like I’m not feeding him on purpose. But at the same time lactation consultant and doctors are saying don’t give formula, because that’s not going to help my breastfeeding supply. So I had like both sides.

These efforts did not always produce desired results, and mothers who were ultimately unable to sustain breastfeeding experienced mixed emotions. On one hand, they felt instant mental health

relief as they were no longer obsessed about nursing and facing the rigorous demands of trying to get it to work. They felt more assured that their child was getting enough milk, and also gained important time for themselves and other infant-bonding activities. Yet, on the other hand, they also experienced guilt and shame in not being able to provide their child “the best,” as shared by Natalie:

I know this is better for her, but I’m going crazy. I’m not enjoying my child like I feel like I should be. I was kind of starting at this point to resent her for not feeding the way that she should.... And I was bound and determined to try, but I think society has gone so much the other way that you feel just terrible if you can’t breastfeed.

Middle class mothers internalized this breast feeding guilt more so than low-income mothers. Although low-income mothers acknowledged the benefits of breastfeeding, they generally did not beat themselves up as much when they were unable to breastfeed, as demonstrated by Bethany:

It wasn’t a huge deal. I mean it was, but it wasn’t. I wanted her to be on the breast because of the nutrition and the, all of that good stuff, but, it just didn’t happen. ... I wasn’t going to get that special bonding time with her, but... I play with her and we get our bonding time together.

However, you can see that Bethany felt somewhat contested and other low-income women also felt this way. For the most part, low-income mothers did not focus on failed expectation of motherhood, although when they did, inability to breastfeed was often the exception.

Wolf (2011) has compared the actual science on breast feeding to public health messages, finding that the benefits of breastfeeding are overstated and distorted in public health campaigns, taking on moralistic undertones. Wolf is critical of these campaigns for putting undue pressure on women to breastfeed, as it can be burdensome and is a responsibility that falls solely on women. My research findings also demonstrate how these messages can negatively impact mental health when breastfeeding does not go well, including internalized guilt for not giving their children what is perceived as the absolute best. While breastfeeding may have benefits, it is not without challenges. Yet, breastfeeding has moved beyond a well-grounded evidence-based public health issue to become a moralistic cultural ideal. The pressure to breastfeed clearly has negative mental health consequences for

mothers who experience nursing difficulties, as discussed by several women in my study and also supported other recent research (Borra et al. 2015).

Bonding with Baby

The birth of a child is a momentous event, and while most parents reported an instant bond, as shared by Isabella, “I loved him the first second I saw him,” some did not. This is a romanticized belief that new parents should feel an instant bond of overwhelming love for their child. For example, Scott shared:

I expected this huge overwhelming sense of fatherhood right when he popped out, that didn't necessarily happen, it took me, really, probably close to five or six months before I really, that feeling, that parenting feeling, the bond with your child, actually happened.... I didn't expect that, that was the big thing for me, I didn't anticipate that, I thought it'd happen right away, and it kind of took me back a little and made me a little nervous, at first, like why didn't this happen right away? ... You know, it wasn't like you see in the movies, where they hand you your baby, that didn't (happen) with us.

The sentiment that this expectation comes from popular images of childbirth, such as movies, was echoed by Robin, a low-income mother:

You hear about the magic stories of as soon as you look into the baby's eyes there's music. I didn't actually bond with her until she was about six months old.

Many of these parents found that their strong bond developed several months later, largely tied to their baby becoming more interactive and engaging. It makes sense that many parents need more time to engage with their babies before strong bonds develop, but this counters beliefs about natural parenting instincts. When parents did not instantly bond with their children, as expected, they often felt guilty, as shared by Jill I., a middle-class, white mom, who did not “truly” bond with her son until he was about 6 months old:

I felt pretty guilty about that. I think I got over it though when I heard other parents say that the same thing happened to them.... and I knew that Ben didn't feel bonded with him either until later and I think that was a source of anxiety for me that neither one of us felt terribly bonded to him.

You can see that Jill was initially very worried about this, but was comforted when she learned this was

not actually so abnormal. A couple of mothers with severe PPD initially regretted having their child, and wanted to put them up for adoption because they felt so disconnected from them, which was a more lasting source of shame and stigma, as shared by Susan, “I think, even now, that’s probably the piece that brings up the most kind of shame for me, is that memory of not wanting her.” A few additional parents took perceived poor bonding as a sign that they were not well-suited for parenthood or doing something wrong, thus leading to feelings of failure.

This concern was most common among middle class mothers, but impacted some fathers and low-income mothers as well. Perhaps mothers expect a natural bond, whereas fathers recognize a need to work at it more. And generally, middle class mothers held higher expectations of motherhood, as we also saw with breastfeeding and will see in more detail below.

Parenthood

The expectations and lived reality of parenthood are shaped by our social structure and the cultural ideals that surround families. Early in my interview, I asked parents what made a good mother *or* father, as aligned with their own gender. Interestingly, mothers and fathers gave similar descriptions, largely describing good parents as being loving, caring, attentive, and selfless. Then, I asked about the other gender (i.e., asked a mother about what makes a good father), most simply responded with “the same.” If they elaborated, it was often to explicitly reject traditional male-breadwinner and female-caretaker gender roles rather than to highlight differences. Occasionally, low-income parents indicated that mothers may be more emotionally nurturing to their children, whereas the father’s role is to be more of a mentor, teacher, or role model. However, this occasionally cited difference was rooted more in a concern for absent fathers than acceptance of a male patriarchal role. In theory, these mothers and fathers valued contemporary gender roles and they often spoke to their desire to co-parent. Many of their stressors were in fact more similar than different, as mothers and fathers work together to raise babies within demanding social environments. However, we will also see that subtle differences in how

parents prepared, responded to, and experienced the transition to parenthood reflect entrenched gender roles. Further, important class differences in planning, preparing, and adjusting to parenthood emerged.

Deflated Expectations and Relentless Demands

Parenting often turned out more difficult than anticipated, for both mothers and fathers. Of course, they knew that parenting was not going to be easy and that everyone says that it's a big life change. Nonetheless, actual experience revealed that parenting was even more challenging than they imagined, as indicated by Brent G.:

I knew that it would involve a large lifestyle change and a big time commitment to [our daughter]. I knew that we would plan things and work around her schedule. I think it's lived up to those expectations. But that's now. At the very beginning everything was a shock, just how much work it required.... It was definitely very scary stressful experience. And it's a huge life change for a lot of people. And like I said, the normal taking classes doesn't really prepare you for the nitty gritty, just how much of a life change it can be.

Parallel to the expectation for an instant bond, many parents anticipated a feeling of completeness when they entered parenthood. Cory C. shared:

Well, I thought that, going into it I really thought Alyssa was going to be a great mom and I was going to be a great dad, we were going to have this cool little family unit... I really felt like we were going to have picnics in the park and sunshine and balloons and happiness, that kind of - yeah.

But instead of the perfect family unit, Cory and Alyssa C. fought a lot and generally had a difficult time adjusting to their new life. In their case, pregnancy came earlier than expected. For most middle-class parents, however, having children was the final planned step for their ideal image of young adulthood for those in the middle class – career, marriage, *and* children. Their careful planning and strong desire for a child, then, also led them to expect pure happiness, as indicated by Linda:

I just thought that...I would be happy all the time. ...I assumed I was going to have more balance with my life, that I was going to be content in all areas.... I think because I wanted to get pregnant, it took so long to get pregnant. I think it was something I wanted so much, and so when you think it's something you want versus not wanting, I think I just assumed that since I wanted it so bad that why would I be frustrated or disappointed when I had my child?

Bonding and emotional connections were not always experienced as expected, and neither was the daily lived experience of parenting. Above all, most parents lamented that when you are caring for an infant, there is little-to-no time for anything else, as expressed by both fathers and mothers, Jeff H. and Natalie, respectively:

I know I'm going to have to change diapers. I know there'll be times at 3 o'clock in the morning that I'm going to have to feed him. But all the other, the things you can't see like ok, I'm going to go fix myself a can of Spaghettios – upp, I need to go change of diaper, upp he just vomited on himself so now we got to give him a bath, and pretty soon your Spaghettios are 2 hours away. It was those things that were a big, came out of left field or wherever, blind sighted me. ... I mean, you just got to let everything you planned on accomplishing that day kind of go to the wayside.

I felt like we were prepared with the things that really mattered. Obviously you don't drop them, you don't shake them when you're mad, those types of things. But I felt like I wasn't really prepared for the amount of time that she wanted to spend with me. Like I guess I kind of thought I could put a sleeping baby in bed and they would sleep. Oh I was so wrong... I couldn't even wash the bottles or the pump equipment without having her with me. I had to wear her in order to get anything done..... I mean, everybody tells you that, but I don't think you really get it until you [experience it].

It was not the individual tasks of caring for a child that were difficult, but rather the relentless, around-the-nature character of this work. This is very different from other life roles and responsibilities, which are usually more predictable, on a schedule, and with more clear indications of productivity.

Additionally, caring for infants result in sleep loss, which was the top cited contributing factor to perinatal emotional distress across mothers and fathers of different class backgrounds. In devoting themselves to shared parenting labor, fathers also sacrificed sleep. Sleep loss impacts mental health through physiological processes in the brain, and further, makes it difficult to cope effectively with other life stressors. Again, while parents knew infant care is demanding and sleep would be lost, they did not understand the toll it would impose until they actually experienced it.

Further, the demands of infant care left parents with little time and mental energy for themselves, from meeting their most basic needs, such as healthy meals and hygiene, to being able to enjoy more leisurely pursuits. Ben I. speaks of this difficulty:

I did not truly understand the weight of how keeping this human being alive would feed on me.

The first couple weeks just breathing and eating and such became, oh my god, it's hard to do. Thus, the demands of infant care not only add new stressors to one's life, but also interfere with self-care activities that traditionally help people cope during stressful times.

Parents also experienced mental health strain when they had a difficult time understanding their child's needs. A crying child can grate anyone's nerves, but even more concerning for one's mental health, is feeling like an incompetent parent who is failing their child when unable to soothe a screaming child. Infants have their own personalities and are often not predictable. Many parents observed that their child was different than expected based on what they read or heard about babies, as represented by Caitlyn:

Because I've never been with a baby 24/7. She's quite different than what I thought, but not really in a bad way. She just, she's more of a handful than I thought she was going to be. I think it's just uniquely her personality that... She has these attitudes and sometimes you just don't know what to do with her.... Each baby's different. It's very stressful. That's frustrating when they've been crying for hours and hours and hours and you start crying too.

These feelings of inadequacy reflect our isolated nuclear family structures, in which most parents today have little-to-no experience with babies until they have their own baby who they are suddenly responsible for keeping alive pretty much on their own, as observed by Elizabeth:

And maybe looking back, probably since I didn't have any experience with babies or children that may have made it more overwhelming. There's so much to learn. You learn fast but you're still, it's all this new information.

In placing the responsibility for raising the next generation on individual mothers and fathers, new parents also feel judgment and guilt when they have fallen short of meeting this important responsibility, as lamented by Desiree:

Everybody thinks they know the right way, so everybody's trying to tell you to do something that they think is right. Nobody really respects other people's decisions on how to raise their own kids. There's always been a lot of pressure on mothers on how their kids turn out.

Indeed, mothers felt this judgment more, as will be further highlighted below. Further, parents often felt that other parents adjusted easier and more quickly to these challenges, as shared by Natalie:

Everybody's understanding but then I just felt like it took me longer to get into the groove of things that it seemed like these super parents are able to handle immediately and I just, that was kind of frustrating for me.

Thus, in comparison, they feel even more incompetent in their new parenting role. However, they are comparing themselves to how they think other new parents adjust and cope, and not necessarily the reality of other parents' struggles.

For the most part, mothers and fathers spoke of the same stressors in discussing their difficult transitions to parenthood. As outlined above, caring for an infant is not easy and involves round-the-clock care. It can be a very isolating and thankless endeavor. Parents are trying to juggle infant care with other responsibilities, namely work, which leaves little time for self and relationships. And throughout all of this, parents are sleep deprived. Although moms and dads largely described similar stressors in adjusting to parenthood, there are some important gendered nuances. As I will turn to next, mothers felt the pressure to meet really high expectations for motherhood whereas fathers are frustrated by the more ambiguous expectations of fatherhood.

The High Expectations of Motherhood

For mothers, deflated expectations often resulted from the idealistically high expectations of motherhood. Parenthood is thought to lead to happiness and self-fulfillment, as illustrated above and in prior research on PPD. This was especially true for women, who sometimes referred to a supposed natural instinct for motherhood, as shared by Susan G.:

I think I probably just like anybody expected it to be difficult, but to be able to pick it up fairly easily. I've always been someone who's been able to muddle my way through anything. I'm a fairly, I consider myself a fairly intelligent, competent person. So I think I thought it would just all be pretty natural, all come pretty easily.... I think what I was so shocked by and what just hit me really hard wasn't that I wasn't competent at the giving a bath or changing the diapers or whatever. But that I wasn't competent at that feeling of maternal affection and protection.

Susan's quote also demonstrated expectations of control and competency. Further, there is a lot of pressure on mothers to perform their duties perfectly, and with little help from others. This theme was

more dominant among middle-class mothers, who often held a clear image of what pregnancy, childbirth, and mothering was going to be like.

When actual experience deviated from these images of a perfect mother, they then questioned whether they were good moms, as shared by Lydia D.:

What set me over the edge was having those expectations that I was setting upon myself. Because the breastfeeding – formula would have been just fine. It wouldn't have killed anybody. But I felt like only good moms breastfeed. Bad moms use formula.... Expectations around parenting and what I should be doing with sleep and what I should be doing during the day. I shouldn't want to just sit around and watch TV, I should want to interact with my child, I should want to hold him all day. I should want to, you know, whatever. And so those expectations were the hardest, I think, and what really set me over the edge.

They also felt a loss of identity of their previous selves, characterized by independence, autonomy, and success, in contrast to their experience as mothers where they felt incompetent and a loss of control.

Successful mothering is not standardized or measureable in the same way that many of their previous roles and responsibilities were, such as productively at work, as shared by Linda:

I think that I self-guessed myself a lot in terms of taking care of (my son) I felt like I knew what was expected in terms of feeding the baby and how to change the diaper and stuff. But I think when you, for example, when you're breastfeeding – and I breastfed with all my kids – but when you're first breastfeeding you're like, you can't tell how much the baby's getting, so you're guessing, well did I feed him enough or did I not. Should I feed him longer? So I think you're always guessing yourself whether you did something correctly or not. For me that was how it was, I was always like that. Well, did I do that long enough, did I, if he's crying in his bed, should I let him cry a little longer? Some of those things.

The intensive preparation for motherhood that many of these women engaged in shaped their feelings of incompetency and loss of control. Parenting books and other expert advice implies that there are proven solutions to every pregnancy, childbirth, or childrearing issue, thus resulting in frustration when this advice did not work. Further, these manuals contributed to the high expectations of motherhood in suggesting that certain parenting practices must be followed for the health and wellbeing of their child. Yet, mothers often found parenting advice to be contradictory in regards to “best” practices, consistent with Hays' review of parenting literature (1996), which then left them at a

loss for what they should actually do. Overtime, these mothers learned to let go of expert advice and to instead trust their “instincts” or learning through experience, as represented by Jill I.:

I think part of what stressed me out a lot from the start was that I looked at too many things across the spectrum... And I don't think I realized that there were such diametrically opposed opinions about everything and they're all evidence based apparently. And so as a researcher, I can't find the one that has the most evidence to support it because both sides claim all this evidence and they have all these studies to support and whatever. So I got really overwhelmed by all the differing, I was sort of buried in it, so to speak.... I think that there's no way to understand what it means to be a parent until you just do it. And so I think that is probably very stressful for me.

Perinatal mental health distress related to the high expectations of motherhood is consistent with previous feminist literature on PPD, and also reflects how motherhood has become more intensive and demanding over recent decades (Hays 1996). This prior research has become somewhat dated, but my study confirms that there is still this pressure, which, if anything, has grown. For mothers today, this also includes idealized expectations and pressures around natural childbirth and breastfeeding, as addressed above. Middle class mothers spoke in more depth about these expectations, but low-income mothers were not completely immune to feelings of being a failed mother.

These high-expectations combined with intensive preparation for motherhood also provide insight into the uneven medicalization of officially recognized perinatal mental health conditions. Recall that depression is included in the DSM-V with a peripartum onset, despite unclear evidence of an increased risk, whereas anxiety disorders have a more clear peripartum risk, but no specified peripartum onset classification in this manual (see Chapter I). Mothers are expected to be happy, and therefore, unhappy mothers are clearly a problem and thus subject to medicalization. However, it is not as clear that anxious mothers are deviant. Rather, the high expectations of motherhood and pinning the responsibility on protecting and raising well-rounded children on individual mothers encourages anxiety. Therefore, anxious mothers could easily be seen as very attentive, diligent mothers rather than deviant moms who must be fixed. Of course, many anxious mothers felt debilitated by their symptoms and are

encouraged to seek help by postpartum advocates, but they are often treated under the moniker of depression rather than anxiety.

The New Ambiguities of Fatherhood

Fathers also struggled to live up to the expectations and roles of modern fatherhood. However, whereas mothers often cited the pressure to be a perfect mother and expressed doubts that they were a “good mom,” fathers rarely identified as being a “bad” dad. Rather than aiming to be perfect, their frustrations and disappointments largely spoke to the ambiguities of modern fatherhood.

Fathers knew that gender roles have changed and recognized they should be more involved than previous generations. They do not simply accept this new belief -- they embraced and helped move these new ideals forward, as demonstrated by Ben I.:

I couldn't see doing it (fatherhood) any other way, so it's hard to comprehend working 60, 70 hour weeks. I don't think it's an accident. I [put] myself on my career path where that was never going to be an issue, to not want to be at every doctor's appointment and every soccer practice and everything... I want him (son) to know my first thought is to be there. That's just the way I work, so it's really hard to see the other side (traditional fathers), although it's the majority when you look out there.

In large part, this was because these fathers genuinely desired closer relationships with their children than they had with their own father, as shared by Rick E.:

Yeah, my dad wasn't really involved in the parenting all that much at all. He worked a lot. And he came home and he worked at home... I don't know if it was because he didn't want to be involved or he wasn't comfortable, or he just did what he could I guess to help, but mom was the parent, basically.

Rick goes on to say he does not plan to approach fatherhood the same “probably because his relationship with all of his kids is still weird to this day.” They also want close, long-lasting relationships with their spouses, as conveyed by Alex:

I don't believe in that world of the old... traditional way where the guy's really tough, doesn't have any issues, just does his thing and act like a man. Don't talk to your woman about this or that, let women decide. I'm not with it. So having a friend in your partner, having somebody that has your back if you ever need them to, that's huge.

Egalitarian marital relationships were not common among their families of orientation, but often led to awareness their own moms were overburdened or dissatisfied in their relationships. The common desire among my study participants to strive for egalitarian families in hopes of having a better family than what many grew up in is consistent with what Gerson found about what today's young adults desire for their families (2010).

Yet, in practice, it was often difficult to know exactly what involved fatherhood and shared parenting roles meant or how it should be practiced, as eloquently explained by Scott, a lower-middle class cohabitating father:

Figuring out how to be a dad, nowadays, you know, most of our fathers and their fathers, their job was to have a job, you know, that's what you did... but society changes, obviously your gender roles get muddy... we understand that's not so cut and dry anymore, it leads a lot of ambiguity to fatherhood nowadays.... I mean, it's a daily struggle, just trying to figure out the right way to do things, the wrong way, you know, recognizing the wrong way of doing things, and trying to get better each day and recognizing the things that are working, things that aren't working, and trying to do more of the things that are working.

Many fathers noted that it takes conscious effort to not fall back on traditional gender roles, or just let mom do it all because she's the one on maternity leave or responsible for breastfeeding, as described by Kevin D.:

I like to play a lot with [my baby]. And I think one of the challenges for me at the beginning was, ok, well I have this one week old who can't hold his head up, like what do I do? At the beginning it was very much, "Ok well what do I do with this baby?".... And so I think one of the things that challenges dads is like right at the beginning, what do I do with this baby, because it's very tempting to just let mom be in charge because the baby, every two hours wants to eat, and then there's naps that have to happen and then there's this developing a routine and there's so many things that mom can provide during that time that I think is challenging for fathers to know how to step in and know to say things like, 'Well what can I do for you right now, what can I do for the baby?'

Some dads questioned if they were really needed. To be certain, they believe that dads are important and contribute to the healthy development of a child. But they also felt that they were replaceable, not as good at it as moms, or the least important member of the family. This seemed especially true when fathering newborns - who do not play, are difficult to soothe, and received most of their care from

breastfeeding mothers on maternity leave. For Shaun, this was the main reason he felt depressed, as he described it:

For me it tied into ... not really knowing what my role was in the whole thing, not really knowing where I was going.... there was nothing I wouldn't try and do. But ultimately, especially towards the beginning, that baby doesn't need a father, it feels like the baby doesn't need the father... So I was just this kind of useless third wheel... You've already been through a nine-month process in which you've sat on a chair because you're pretty much a pointless part of this process.... I think the feeling of having no role, of being completely replaceable.... if you failed at your job you could be out the door.

Further, fathers often had little guidance and practical support for involved fatherhood. A few had positive role models in their own fathers, but most had absent or relatively disengaged fathers.

Their own fathers provided a counter example rather than an active role model, as noted by Cory C.:

I think it's one of those things where I'm actively trying to be a better dad than I felt like my dad was. And I think that it is difficult... I have no role model. I mean the closest I have to what I feel is a good role model is a friend of mine's dad that I was friends with in high school, you know what I mean, Bill Cosby or something.

Cory was not the only father to cite Hollywood dads as a more realistic role model than their own fathers. While there is a lot of praise for involved fatherhood, fathers sometimes felt ignored by doctors and educators. Shaun discussed what he called the "daddy chair":

I found it a little bit odd because everywhere that I went in the process I would essentially have a chair that was mine to sit on, and wherever you went you would be sort of put on a chair somewhere, because you're the father, so you just get put on the chair over there. And then unless you insert yourself in the conversation, then you would be very much ignored and the conversation would be with mom.... And once, I think most people were quite receptive once they realized that I wasn't just going to sit there and be quiet and that I did want to get involved and find out things... But certainly the assumption was always that I wasn't going to want to know anything, and I found literature and a lot of the stuff that was out there pretty poor.

Shaun touches on another observation made by many fathers, which is the paucity of good parenting literature addressed primarily to fathers. In light of these paltry supports, fathers largely turned to their wives to learn how to be a parent, although moms had mixed feelings about this, as will be seen below in the section on relationships. Nonetheless, dads were trying.

In addition to insufficient models and supports for learning how to father, men noted a lack of socializing opportunities for them. This was especially noted among fathers who took on primary caregiver roles and wanted more adult interaction, as shared by Giles after he became a stay-at-home dad:

But now you have a trendy element where the moms quite happily do lunch and if a man is the carer involved, that means he's excluded from the lunch. So even if you step up to the plate, you're disadvantaged, particularly if you're the carer.

Social and emotional support is an important resource for coping with life changes and stressors, and Dads often felt they just needed to talk to other fathers in similar situations to help get through these rough times. They desired another man's perspective, but it was difficult to connect with similarly situated fathers.

While interpreting and adapting to involved fatherhood, intense breadwinning pressures remained. Rick shared:

For me I think [the biggest stressor has] been probably the financial burden just because being the sole income with a little one and the wife in school and house payments and credit card debt and student loans and all this stuff Anxiety over how we're going to pay the bills and how many more bills are going to be coming in? How many college loans will we have to pay back? We're paying off my wife's education from the savings of our child's own education and things like that.

This is a very real, practical concern as there were bills to be paid. However, it is also a gendered pressure in which fathers focused in more depth on breadwinning pressures. Although actively seeking work, Randall has not had much luck, which led to many insecurities, "I feel inadequacy by not being employed... but the way my mind work I'd still think, oh I'm almost the perfect dad, but not quite."

The entrenched power of this traditional ideal was especially apparent when it emerged in the narratives of fathers who explicitly rejected the primarily breadwinner role. For example, Thomas and his wife agreed that he would be a stay-at-home father as she had a prestigious, well-paid career. Thomas was good with this nontraditional arrangement in theory, but found that being a 24/7 parent

was very anxiety provoking and difficult for him to handle. The couple then enrolled their daughter in a daycare to help relieve Thomas's anxiety, which was helpful. But then, Thomas noted:

And that was a whole new wave of guilt because then I felt like a bum. I'm a stay at home dad, but my kid's at daycare. So basically I'm an unemployed bum... And then I just realized, I gotta get a job.

In referring to himself as an "unemployed bum," Thomas's guilt lines up with traditional male breadwinner expectations more so than his incapacity to be a stay-at-home father. Likewise, Kevin D. tried a stint at stay-at-home fatherhood, but asked himself, "Am I really contributing to the family if I'm not going to work?" Kevin's quote is further striking as he was one of the fathers most explicitly committed to egalitarian gender roles throughout his interview.

Compared to other responsibilities of contemporary fatherhood, breadwinning was a more clear and straightforward role. But how to balance and prioritize was not as clear and a constant struggle for moms and dads alike, as will be further detailed below. Several dads found themselves having to sacrifice family time for work. These work-family exchanges resulted in disappointment and frustration when fathers found they were not as involved as they originally envisioned. For example, Brandon G. noted how his relationship with his daughter changed during a short period when he faced increased responsibility at work and school:

I was very stressed and ... the thing that I noticed mostly was how [my daughter] would react.... It was hard to know that there was a time when she would have not have minded either of us, to go from that to a point where she was upset when I would try to hold her and she would prefer her mom. Not that I blame her, but it still was crushing.

In the end, however, very few fathers reported feeling like failed fathers. The ambiguity of fatherhood and rapidly changing roles may, in fact, have enhanced feelings of being a good dad, especially when they compare themselves to other fathers. Jeff H., a middle-class, white father, shared,

One of the *Parenthood* magazine that we got this week said that the average father spends 6 ½ hours a week with their kids and I thought that was appalling. I know I spend at least double that, if not triple. I mean, I think a good father is just a matter of being there and interacting with your children, not just sitting on the couch with the TV on or whatever in the same room

with them. It has to be more than that. Just a lot more interaction and, I guess, guiding them where you can.

James B., a low-income black father, echoed:

I've got plenty of friends who are there, and they're helping raise their kid with their wife or mother of their child, but they're not doing anything. They're letting the women do everything. They'll do things, like they're not even around hardly.... They're not giving their kid the time and attention that they need. Basically they're just there to say they were there. So they can say, 'Oh, I didn't run out on my kid,' but at the same time they're not devoting the necessary essentials to their kid

Whereas many mothers obsessed over whether they were implementing the best childrearing practices to perfection, including guilt over their child's lifelong wellbeing, fathers took comfort in the more straightforward fact that they were actively involved in their children's lives. In fact, they were great dads compared to the absent fathers, workaholics, and slackers they see amongst them. And rather than feeling like they were being negatively judged, fathers instead spoke of the compliments they received when others noticed their involvement as fathers.

Yet, even while few fathers internalized feelings of being a bad dad, the ambiguities of fatherhood were still challenging and frustrating. Today's new fathers are muddling through fatherhood with little direction and limited support. To the extent that active parenting is still largely assumed to be the mother's responsibility, it is easy to overlook the multiple stressors that new dads today are facing. In turn, this limits the support available for paternal mental health, as will be discussed in the next chapter.

The Dark Shadow of Dysfunctional Family Backgrounds

A fair portion of parents discussed having dysfunctional childhoods, which shaped both their previous mental health history and perinatal distress. This was an emergent theme, which revealed itself in response to my early question about family background. I initially included this question to learn more about gender roles in participants' families of orientation, towards better understanding how these backgrounds shaped their own gender practices and ideals. In asking this question, however, many

participants instead focused on how dysfunctional childhood experiences shaped their family visions. Therefore, I adapted my interview guide to ensure that I probed into both familial gender roles and adverse childhood experiences.

The role of abusive or otherwise dysfunctional childhoods has not been well highlighted in previous literature as a risk factor for PMADs. Yet, child abuse is a well-known risk factor for mental health problems in general (e.g. Kessler et al. 2010). Some participants had parents with alcohol or drug problems, which often lead to neglect. While some parents felt abandoned by absent fathers, others bemoaned authoritarian patriarchs who were controlling and had harsh tempers. A few participants went through several step-parents, representing general instability and additional family dissolutions. Some parents witnessed domestic abuse, and others were physically abused themselves. A couple mothers experienced sexual abuse. Two mothers spent time in the state foster care system. These families were not always dysfunctional across the board. Several had one supportive parent and one who was abusive. Some participants noted many strong aspects of their family, characterized by love and support, but with occasional but marked dysfunction. Thus, the impact of the dysfunctional family background also had an uneven impact on their mental health and struggles as new parents. Nonetheless, these parents' narratives reveal two processes by which dysfunctional childhoods shaped their perinatal mental health -- limited social support during this transition and insecurities of self as a parent.

These parents defined their ideal family as being nearly opposite of their own upbringing, and were very motivated to create a safe, stable, and supportive family for their children. Desiree shared:

I think it feels really important to me to not have my kids live the same kind of life that I did... I want them to always be able to have both of their parents, even if someday me and [partner] weren't together, I want them to be able to look to both of their parents for guidance in anything and to always be there, to not take my frustrations out on them. To make sure they stay at home where they belong and never get taken into the state custody.

Yet, these parents were striving for something better without having a strong positive model of a healthy family. Parents worried that the cycle of dysfunction could be repeated or doubted their ability to parent without good modeling, as demonstrated by Julie J:

On some level, I was already panicking and worrying about how could I be a parent when I wasn't parented myself very well? So my fear and trepidation about how can I do this. I don't think at first I could really verbalize that and even recognize that in myself.

Julie identified this link between her childhood and her own parenting insecurities as a primarily contributor to her prenatal and postpartum depression, in retrospect. Unfortunately for Julie, this root cause was not identified and addressed until nearly three years after her severe depression began, as will be further detailed in the next chapter. This poor treatment experience further indicates a lack of awareness about the potential link between dysfunctional childhoods and perinatal mental health symptoms, although this theme was very apparent in my sample of parents.

These parents became particularly distressed when they saw possible signs that a family cycle of dysfunction was going to repeat itself. For example, LeAnna was abandoned by her biological father and abused by a stepfather. As a result, LeAnna has trouble trusting men, and as a younger adult thought she would never get married and have children. James helped LeAnna feel different about men – that some men can be trusted and have strong father potential. However, when LeAnna felt she did not get good support from James, she feared she made a great error in trusting James and having a child with him. James did not mean to be unsupportive, but was overwhelmed with the transition to parenthood while working two jobs. In the end, LeAnna and James worked things out and provided better support to each other. Nonetheless, this was a major fear and source of anxiety that contributed to LeAnna's PPD, which, in many ways, reflected fears rooted in her childhood more so than James' actual intentions and actions. Likewise, Cory C's marital problems lead to similar anxieties:

There was just a lot of stuff like I was really scared that if our relationship didn't work, like I wouldn't be able to be the kind of dad that I wanted to be -- and I still have like this overarching fear that my kids will end up being like I did.

“Like I did” refers to his years of anger issues, alcoholism, and mental health history resulting from his dysfunctional childhood. In another example, Kassie was in a very dysfunctional relationship with her husband, who was addicted to drugs:

It just brought back, especially with her father not being there, memories of my dad not being there and how jacked up my family was and how I could prevent her from experiencing all that.... Yeah, it seems like [a cycle] because my dad was addicted to drugs and so is my husband.... So it's just heavy weight, and again, not wanting to repeat the past with family thing.

Additionally, these parents continued to have strained relationships with their parents or siblings, thus limiting the availability of social support as a new parent. Insufficient social support, in general, is a strong risk factor for PMADs, and further, access to social support is beneficial for coping and recovery. Perhaps more than anything, distressed parents wanted help with their baby, so they could catch up on sleep, have couple time, or concentrate on work. But, as Cory C. noted, even though his relationship with his father has improved, “He’s really not somebody I’m ever going to leave my kids with.” Desiree and her mother also mended their relationship, and she gets a lot of help from her mom today. However, she speaks of other relatives who have repeated a cycle of poor parenting. She no longer trusts them to help with her children after one relative spanked her one-year old for normal toddler behavior. Yet, they give her a hard time for being “too easy” on her kids because she will not “smack ‘em,” thus casting her as a bad mom. In addition to practical support, these parents bemoaned not being able to turn to parents and other relations for emotional support, to simply talk through their problems or receive good parenting advice. Kassie shared, “I don’t have anyone really close to me... and it makes it hard for me to recognize good relationships.” For these parents, a history of mental health issues started early but reemerged during their life transition into parenthood with new fears and concerns.

Making Ends Meet

It was not parenting or parenting expectations that low-income parents found most distressing, but rather daily life hardships associated with poverty. To be certain, most all parents cited financial

stressors in light of increased expenses and underpaid parental leave. However, middle class parents were still able to count on a decent quality of life. But from housing to transportation, healthcare, and sometimes even food, low-income parents struggled on a daily basis to make ends meet. A large body of research has consistently demonstrated the link between low SES and increased risk for mental health problems, in large part due to exposure to more stressors and with less access to effective resources for coping (e.g., Aneshensal 1992, Pearlin et. al. 1981, Thoits 1995).

For many, these struggles existed prior to childbirth, but when poverty interfered with their ability to secure needed resources for their children, life stress became more profound, as shared by Desiree:

I've always had depression, but once the (twin) girls were born that definitely started becoming worse. Some of it was because of the situation, the fact that we didn't have our own place to live, depending on my mom for a roof over our head. Worrying about how we're going to provide for them, because I was only working part time, so didn't really make a lot of money. I didn't know how we were going to be able to get our own place.

Desiree's story epitomized many of the struggles experienced by low income mothers struggling with mental health conditions. Desiree had a difficult childhood, and she became unexpectedly pregnant at a young age. She cohabited with the father of their children, and their relationship has struggled. Desiree was laid off her part-time job when her twins were still infants, and her worsening social anxiety prevented her from securing a new job. She was treated for depression and anxiety during her pregnancy, but it has remained untreated since she was dropped from Medicaid after the twins were born. Although each parent's story was unique, many other low income mothers and fathers struggled with similar problems.

Housing insecurity was common – two mothers experienced homelessness, nine resided with extended family or friends for at least a portion of the postpartum year, and nearly all experienced multiple residential moves over short time periods. Stacey become homeless as a result of leaving her abusive partner; regarding her anxiety, she shared, "My financial situation would be the most important

because I'm homeless and do not have a vehicle and don't know what's going to happen tomorrow or the next day." More than half of these parents lived with extended family, which led to additional interpersonal conflict and little control over their living environment. The housing that they are able to afford was sometimes infested with pests, had appliances or plumbing that did not work, and questionable landlords. Only a few mothers spoke of food insecurity, but with great concern for how it impacted their child's health and wellbeing, as shared by Madison:

I think that's part of the reason why I measured so small because I was malnourished and it was mostly junk food, not nutritious food.... she was breastfed but I needed to have the nutritious food.

Food and shelter are essential life needs, and our culture valorizes the ability of individual family units meeting these needs on their own. Thus, low-income parents are often demonized when unable to fully provide for their children's basic needs.

In light of being unemployed or underemployed, these parents must depend on government aid for themselves and their children to survive. The welfare system was difficult to navigate and full of strict rules. From being disrespected by welfare workers to having a Medicaid application denied because of a paperwork error, parents were constrained by the welfare system. In tears, Erica shared:

I remember two weeks straight being so hungry, so hungry...The stuff we had, rice and potatoes in a can and corn, we couldn't eat it because I needed to feed [baby] that. You know? Nobody should have to live like that.... And you know, you get case workers that are assholes, ok... I remember that lady I had (who asked) why we did have (food) stamps, I told her, "You don't need to talk to me crazy. You can talk to me with respect," ... And she just pretty much blew me off after that and every time I would call her she said, well, "I have (to wait) 45 days, "... It's not fair. Not when you're eating canned food, not even getting the right nutrition that you need, not even eating meats or anything. One person could have changed that. All it would have took was one person's attitude to flip around for me and my family to eat, and we couldn't.

Even mothers with a college education reported how difficult it was to understand all of the rules and complex paperwork. Some mothers reported inconsistent regulations and rules. For example, one mother said her child was cut off of Medicaid because she could not provide a birth certificate to establish paternity. However, this is a policy rule that should apply only to TANF and not to other forms

of aid. There were many other instances in which parents reported conflicting information across different case managers or agencies. Some parents were allowed to reinstate services after correcting a paperwork error, whereas others were instructed that they had to wait a year before they could even apply again. It's not clear if mothers are actually being given inaccurate information or if they are misinterpreting guidelines in light of the complex rules that vary from program to program. The welfare system may be even more difficult for fathers to navigate, who are less likely to access welfare benefits and often treated as invisible in welfare services (Katz, LaPlaca, and Hunter 2007). This was definitely true for Jack, who did not even know that government assistance for childcare was available until after he already lost his job. A child welfare worker came looking for his child's mother, who had already abandoned them, but instead was able to help connect Jack with help, "So she was of assistance, but I wasn't looking for it, I didn't know what to do but sit there."

In addition to difficulties with the welfare bureaucracy, parents felt the stigma of being dependent on government aid, as noted by Samantha, "Using WIC checks is horrible, like they really need a different system for it because it's very, very embarrassing and humiliating." Samantha may have been more sensitive to this stigma because she had a middle class background. Her unintended pregnancy led to becoming low-income, as she left a job to move across the country to join her baby's father. Although her fiancé was employed, their income was tight and Samantha temporarily benefited from Medicaid and WIC. She also felt guilty for using aid while living in a nice suburb. These parents were not taking advantage of government aid and preferred secure employment, but still felt the stigma of needing aid. However, as highlighted in the section on work, there is a paucity of decent-paying family friendly jobs and many barriers to securing and maintaining steady employment with young children. Erica shared:

It's hard as a family, especially when me and my fiancé we have one car.... So most of our relationship has been, oh she's working, he's not, oh he's working, she's not, because we've always had one car. And the schedules will always conflict somewhere. So it's like we can never get above. If me and my fiancé could each have a car, I know with our motivation and how hard,

how driven we are, we can both find jobs. We have been together 4 years, we have never had a job both of us together at the same time. If we had that, if we had that, we wouldn't struggle. We're great with what we spend our money on, how we spend our money, things we need.

A few parents were accused of fraud, such as for being unable to provide a birth certificate or paper work errors. Kassie had a fraud case opened because she accepted a temporary job, totaling only four days of seasonal employment, but did not immediately report it because she thought she had to have her paystub first. Rather than working with her to correct this error, her caseworker cut off her assistance and would not return her calls. The strict control of the welfare bureaucracy extended to educational and career decisions, as observed by Laurie A.:

And then when you're a person like me that really genuinely needs some help – not much, but some help – to get through the college stuff, they don't want to do that. They just want to get people back into a McDonald's job and I think it's backwards.

TANF and child care assistance is only available to those working or in job training, but a traditional four-year college degree does not count as job training. These parents were then discouraged by being stuck in a dead-end job with no support available for improving their employment prospects for a better future for their family. Further, for every step forward they lose a benefit, thus leaving them in the same overall position, as noted by Kassie:

[They should] not make it so hard to be self-sufficient, I guess. Because like I said with the whole [childcare assistance] thing, they make it so you can maintain, but if you do a little bit more to be more independent, they take something away that brings you back down again. It's very restrictive and it's hard. I don't know, I say that a lot, I don't know.

Although government aid was very difficult and stigmatizing to access, low-income parents questioned how they would have survived without it. Yet, even with assistance, many parents still could not afford many basics, as the quotes above highlighting housing and food insecurity demonstrate.

Further, most parents could not access affordable healthcare to take care of their own physical and mental health needs. My research participants largely came from a region with exceptionally restrictive income guidelines for Medicaid coverage for able-bodied adults. They became parents before Medicaid expansion was implemented, which has still not been adopted in this region. Adult men rarely

qualify for Medicaid, and pregnancy-based Medicaid for women is cut off after their 6-8 week postpartum appointment. This is problematic, because the postpartum appointment is often when a PMAD is diagnosed and treatment begins. As a result, many low-income mothers either did not accept treatment or ended treatment early, as will be further detailed in the next chapter. Sometimes, post-childbirth physical health complications were not fully covered such caesarian section infections. Some of these parents also had chronic health conditions that were going ignored, as represented by Bethany:

I had an endometriosis surgery and it ended up coming back... And then I found out that they cut my insurance, so I can't go get help... the help that I need because the government doesn't want to cover mothers. But if the mothers get sick, they can't take care of the babies. So it's all one big vicious circle.

Likewise, Stacey has a chronic auto-immune disorder associated with pain. It can be controlled with medications and regular checkups, but she has a difficult time affording these, and shares:

If I run out of my prescriptions, if I don't have my medicine, I'm not able to function. If I'm unable to function that means I'm not able to be productive and that means I'm not able to be a good mother, Christian, I mean, everything because I become a miserable person.

These parents did not always know what, exactly, was going on with their health, and therefore, were also at a loss for what self-care strategies they should be implementing. Caitlyn for example began experienced chest pains, but is not certain if they are due to her depression and anxiety or the fact that she was at risk for cardiovascular disease. These parents worry a great deal about what will happen to their children if they are suddenly incapacitated by their untreated conditions. A couple parents were also unable to maintain employment when struggling with these untreated health conditions.

Low-income parents often experience one stressor after another, and a general life of instability which takes a constant toll on their mental health, as noted by Laurie A when discussing the most important stressor impacting her mental health condition:

It would be instability in general. I think if I would have been able to have a life that was just not so many changes every time I turned around something new, you know, Randall's losing his job, now I'm losing my job, now grandma's having a heart attack and all these things.

Poverty makes every other stressor more difficult, especially couple relationships. And when impoverished, parents had fewer resources for coping with these stressors and their resultant mental health symptoms. As Erica concludes:

I hope people really listen because I have so much motivation. I pushed myself, and I pushed myself, and I pushed myself and mentally I'm strong because of who raised me and how I was raised.... There's supposed to be things around that help you, but really it's not helping you. It's making it worse.... I feel like once you're in this situation of – and there's no better word to put it than poverty – it's like you're 6 feet underground and you have to use stakes and knives or nails to climb your way out because nobody seriously wants to help you.

In examining low-income women's experiences with PPD, Abrams and Curren (2009) found that daily hardships were a better explanation for distress among low-income mothers, compared to the idealized expectations and loss-of-self found in previous qualitative studies based largely on middle class mothers. My findings echo Abrams and Curren's study, with the added benefit of being able to directly compare the stories of middle-class and low-income women. To be certain, there were also low-income mothers who questioned whether they were good mothers, but daily hardships were more salient in their narratives. My study only included three low-income fathers, but daily hardships were central to their stories too. In their discussion on why low-income mothers did not report a loss-of-self, Abrams and Curren hypothesized: "The low-income women in our sample may not have shared the experience of an autonomous self as described by middle-class women in other studies, given their circumscribed material circumstances and limited opportunities for independence even before the birth of their infants" (2009: 359). In examining the larger life contexts of the mothers in my study, I was able to support this hypothesis.

Middle class mothers often felt constrained by motherhood, bemoaned a loss-of-control and previous identities, and were disappointed by the expectations of motherhood. They tended to have successful careers and marriages, and appeared to continue to expect control in carefully planning their pregnancies and studying intensively for motherhood. Yet, this may have ultimately been a false sense of control. Parenthood is fundamentally different than many prior life experiences and you cannot study

for motherhood or fatherhood in the same way you might for school or a new job skill. Parenthood is far less predictable than other roles and responsibilities and much of it is learned through practice.

In contrast, low-income women generally did not report feeling constrained by motherhood itself, so much as the ongoing constraints they experienced in their everyday lives. Their struggles with poverty, housing insecurity, bad jobs, and poor relationships become even more stressful as they impacted their ability to provide for their children. Most came from economically disadvantaged backgrounds characterized by instability. Further, they also knew their timing was not ideal and therefore there would be many challenges to parenthood. They did not study intensively for motherhood, but they also did not cite this as a problem. Working class and poor women had more stifling work environments, as will be further detailed below, and were under the strict control of welfare bureaucracy and regulations. Their housing choices were also limited. They were not accustomed to great control and success in their lives, and therefore were not in a position to expect idealistic motherhood or a lot of control. It could also be that compared to everyday life hardships of being low-income, motherhood was relatively more rewarding. That is, they may feel they have more agency and success as parents compared to their other social roles as “unskilled” workers and “dependent” citizens. This is consistent with Edin and Kefala’s study (2005) on non-marital childbearing among low-income women, in which mothering was relatively rewarding compared to their ongoing, daily hardships.

As a closing example, recall Emma’s quote above, in which she noted, “I felt like a failure. It was really hard. Because I’m used to being able to do what I want to do. I never really had any setbacks with anything.” She was speaking about her breastfeeding difficulties, but this also demonstrated how she internalized feelings of failure in light of a life history of success. This contrasts sharply with Kassie’s observation, in a quote shared above, “I don’t know, I say that a lot, I don’t know.” This was in regards

to not being sure how to become more self-sufficient, but also acknowledging the number of unknowns that characterized her narrative

The Family-Work Balance

Work place stressors were a commonly cited factor shaping perinatal mental health, impacting nearly three-fourths of the parents in my study. Whereas employment status has largely not been found to be a risk factor for mothers (reviewed in Romito 1990), early research suggests that it is for paternal depression as reviewed in Chapter II (Giallo et al 2013, Nishimura and Ohashi 2010, Rosenthal et al 2012). However, quantitative measures of employment status (i.e., employed, unemployed, underemployed, full time, part time, job quality, etc.) are limited in their ability to capture how work life contributes to perinatal distress across various employment types. The new parents in my study spoke of there simply not being enough time in the day to do everything, especially when combining employment with caring for a new baby.

The majority of young adults today, both male and female, view the ideal family as consisting of dual earners and shared caregiving (Gerson 2010, Pedulla and Thebaud 2015), and most new parents in my study also embraced this ideal. Although this was a commonly shared goal, it hardly meant that balancing a career with family was easy. Even as the presence of dual earner households continues to grow, both mothers and fathers are spending more, not less, time actively caring for their children compared to previous generations (Sayer, Bianchi, and Robinson 2004). Parents often felt they were performing inadequately in both their parenting and worker roles. Family-work conflict is a well-known stressor for working parents in general. For example, 40% of fulltime working parents in the United States cite balancing work and family as the *biggest* challenge they face as parents (Rankin 2002), and over half of all men and women report family-work conflict (Jacobs and Gerson 2004). Thus, this stressor is hardly unique to new parents. However, the postpartum period is when parents first confront the fact that balancing work and family is harder than anticipated. We are surrounded by images of super

parents who succeed at both work and family, perhaps obscuring how difficult this balance truly is, as indicated by Emma:

So I really gave my career 100% and then when [my son] was born, I was really torn. But I tried to do my best at both and I felt like [my son] wasn't getting the best that he should because I didn't like him in daycare. But I really had a passion for what I had done and enjoyed my work and was highly successful at it. [I earned my PhD] and I had a post-doc, I mean, I did everything that you could do.... *I had every belief that I would be able to continue with my career and having a baby would just add to my life.*

The image of the parent who perfectly balances work and motherhood is sometimes referred to as being a "super mom." Middle-class mothers felt the pressure to be a super mom most intensely, as noted by Jenna F, "We're still expected to be June Cleaver, just with a job." Increasingly, fathers are also experiencing super parent pressures as they engage in more caregiving while maintaining breadwinning responsibilities. While "super-dad" pressures may not be internalized to the same extent as super mom pressures, this stressor cannot be ignored especially as gender roles change. In fact, a higher proportion of fathers cited the family-work balance or other employment stressors compared to mothers, likely indicating being in less family-friendly jobs as well as the ambiguity of new father roles.

No ideal timing

In addition to the impact of changing gender roles, the family work crunch is shaped by the changing economy. The demands of the contemporary labor market make it difficult to time parenting right. Maternal age has not been found to be a risk factor for postpartum depression or anxiety (O'Hara and Swain 1996). More research is needed on fathers, although a recent Australian study indicates that younger fathers are at greater risk for PPD (Giallo et al. 2013). My qualitative study suggests that there is no ideal time to enter parenthood, whether relatively younger or older, as a working parent.

As reviewed above, the low-income parents generally had unplanned pregnancies and entered parenthood at a younger age. This was far from ideal and often perceived as interfering with their educational and career goals, as shared by Madison, a young low-income mother, "It was still scary (throughout pregnancy) because I was so young and it kind of ruined school. It was going to make

everything harder.” Despite this setback, most of these parents still worked towards getting a college education. While it was challenging to stay focused on their educational and career goals with a young child, their child also provided high motivation to succeed, as shared by Kassie:

I want to be able to provide more for her and, like opportunities and stuff like that, I never had. I was never pushed to do anything other than go to school, just get through high school. My mom went to a little, had some college, didn't even get her associate's degree... I want to push it... She's my concentration.

These parents recognized the value of a college degree for securing a good job in today's economy, although early childbearing makes continuing their education more difficult and then the stressful work-family crunch also includes school responsibilities.

Although middle class parents planned childbearing more carefully, generally after earning a college education and securing a good job, the timing of family with careers was still difficult. Most middle class parents were still fairly new to their career and some were finishing up graduate degrees. This reflects the extended education and multiple job transitions commonplace in the contemporary economy. In contrast to previous generations who could count on lifelong careers with no or little college education, often with the same employer, today's middle class spends more years in formal education and may go through several job positions before settling into a career, if ever (Kalleberg 2009).

Thus, while many middle class families felt they had a good job, they were often still relatively new to their position. In result, they had not yet accumulated much leave time, as shared by Ben I.:

For me (being a good father), it's giving the time. I couldn't comprehend not doing as much as I can. The irony is the first few months I was new to this job and so I felt like I probably couldn't get away, just taking time off as much as I should have.... I didn't think to ask that (for unpaid leave) at the time.

As relatively new employees, they were also still proving themselves in their careers. Mothers worried about whether their employer would see them as committed to their occupation when having to take maternity leave so early on the job. Mothers and fathers, alike, felt intense pressure to give their

employers 100%, if not more, to prove themselves as competent and devoted in their field. In result, they may shorten their parental leaves and were hesitant to limit work time, which just increased the work-family stressors that contributed to their perinatal mental health. Linda, a professional, middle class mother who felt that overall life balance was a leading contributor to her PPD, explained:

I had to compete to get that job with other people in my office. And so I think I felt like I had to really prove myself, that I was really good at it. And I was implementing, I was trying to implement a lot of change, so I think that was why.

In addition to proving themselves to their employers or coworkers, some parents noted that as younger employees, they were still learning and sharpening their job skills. Andrea was a low-income, married mother who felt very contested in her commitment to a new career and her baby:

I didn't want to lose the skill that I'd just learned – but I did not want to leave [baby]. I was really sad about that, even though it was just a few hours at night.

Although middle class parents entered parenthood with a more secure education base than most of the low-income parents, many were working on graduate educations. This reflects the professionalization of the middle class and growing need for advanced education for good careers. Thus, like many of the younger low-income parents just starting their college education, several middle class parents were also balancing parenting, employee, and student roles, as detailed by Kevin D.

Right when he was born I was working full time and going to grad school full time, so I was coming home and doing homework. And I was very fearful like, I'm never going to see [my son] because I'm going to come home and I'm going to have to do homework and so what, right at the beginning when he was kind of developing his sleep schedule there was a lot of times where I would do homework with him in a sling just so that I could get a little bit of that bonding time with him.

Kevin found ways to multi-task, although the balance was still very draining. In sum, the timing of career development and young families is at serious odds with each other, and limited options for balancing work and family.

Family Friendly Employers, or the Lack Thereof

The difficulties in balancing work and family illustrate the impact of work and family policies, which have not kept pace with labor market changes in the United States. As just demonstrated, many new parents have insufficient leave time as younger employees, although even many seasoned employees felt this strain as there are no leave-time guarantees in the United States aside from the unpaid leave provided by FMLA. The United States is well-known for its meager social policies. We are the only industrial nation without guaranteed paid sick leave, paid vacation, or paid parental leave. We also have relatively long work hours, and the lack of universal health insurance ties many parents to full-time work.

In a social welfare system where most employee benefits are voluntary, such benefits generally accrue to those with better jobs to begin with. In addition to poverty wages, low income parents rarely benefited from paid paternity leave or sick leave in any form, as bemoaned by Erica, a young black mother in the service economy, when I asked if she can take sick time:

Heck no, I ain't never had a job like that, ok! Like they all say, 'Oh that's fine, oh that's fine,' but when you're in the room while they're firing you, they're bringing up the days that they said were fine, but they obviously weren't fine because ... you're bringing it up now, like you're firing me.

Not only did Erica and many other low-income parents not have paid sick leave, they risked losing their jobs for taking time off to care for children. FMLA job protections generally does not cover short absences due to acute illness and certainly does not cover absences related to unreliable childcare. In this example, Erica was fired from a job that she returned to only four weeks after having her baby. Despite her commitment to her employer, she was disposable. She also felt that putting her child in daycare so soon contributed to his reoccurring illnesses. Likewise, Laurie A. spoke of the pressure to work with a sick baby:

[My boss] was just pretty much a jerk.... Then Christmas came and the retail business and we were busy and I always felt very pressured like I couldn't take care of [my baby] if she or I got sick. So there were a lot of days when I would have bring her into my office in a little palette

that I made and she would just sleep there when she was sick because I didn't feel that I could take time off, that I would not have a job if I did.

In contrast, the middle class parents in my study had more access to paid leave and generally better work environments. However, the amount and type of family-friendly benefits still varied widely. Most faced at least a portion of leave that was unpaid, thus increasing the pressure to return to work quickly. Among my sample of mothers, Sabrina took the shortest maternity leave, explaining:

I only had 3 weeks. We don't get like maternity leave or anything like that. You just use whatever vacation/sick time you have. I mean, there's FMLA too, but I didn't want to do that at a reduced rate. I thought I'd just go back to work. Like I said, I only had 3 weeks off.

Sabrina's son was still suffering from a severe birthing injury when she returned to work. Laurie A. also planned to return to work quickly, however due to an emergency caesarian, had no choice but to take the full 6 weeks. Although she appreciated the "extra" time off, it was financially difficult to be without her income for even longer.

Fathers felt especially disadvantaged in taking extended time off after their child's birth, typically not having any access to paid paternity leave and also due to employer expectations that they should return to work quickly. By law, fathers have a right to FMLA leave, but some were unaware of this benefit while others received contradictory information about FMLA for fathers from their employers. For example, Jeff H. discussed the confusion he experienced when trying to use FMLA to cover paternity leave, in which he was told something along the lines of that he had to take either 2 days or 2 weeks off, and there were no other options. Although Jeff cannot recall the specifics of what he was told, the advice he was given by human resources for his major corporate employer is suspect. FMLA provides *up to* 12 weeks of unpaid leave, and there should not be restrictions on shorter time period or either-or formulas. Most fathers only took a week or two of paternity leave, sometimes due to FMLA confusion or employer pressures but most often due to financial need. Most would have preferred lengthier leaves, as shared by Matt F.:

I didn't get the maternity leave as much...So it was taking on all these more responsibilities, but not having the time to adjust and spend and bond with the little one.... Maternity leave is great because you spend time, but you're also, especially the first time parents it'd be nice to have that time, just life change, to deal with it... I couldn't, because also I'm still having to work and so I was having the stress of having to deal with projects and things that are needing to be done... It's more demands but still having to do the same and it's just overwhelming.

These fathers noted that paternity leave would have given them more time to adjust to fatherhood, learn more about baby care, bond with their children, and also support their wives. A couple mothers noted that their perinatal mental health symptoms began or worsened after fathers returned to work, as this left them without a vital source of support, as indicated by Jill I.:

And then it peaked, like the initial peak of it was the day that my husband went back to work. He had just started his job so he didn't have any time built up. And in addition to not having time built up he sort of jumped in midstream to some stuff that was going on with work and they really couldn't, they couldn't even give him unpaid time at that time....And so for him I think it was, look I just started this job, I can't start right now already asking to take care of my crazy wife. So I would say that the day he went back to work was, my mom came over that day and I just, I remember spending most of the day just freaking out and crying.

Short leaves also impacted mothers directly, with a few who returned to work before the minimum recommended six week maternity leave as we saw in the examples of Erica and Sabrina, above. Six weeks tends to be the *minimum* recommended leave, as the most appropriate leave length, ranging from six weeks to upwards of a year, is widely debated (e.g. Blau and Kahn 2013; Miller 2014). Yet these few mothers returned to work at only three, four, or five weeks post-childbirth. For the most part, they did not feel ready to resume work as they were still adjusting to their new parenting roles, were sleep deprived, and also worried about the health and safety of their newborn in childcare.

In addition to family leave policies, workplace scheduling and workloads played an important role. Fathers, and a few mothers, felt employer or coworker pressures to return to work as soon as possible. For middle class parents, this reflected the demanding nature of their work in which their expertise could not be easily replaced while they were away, as represented by Emma:

Well, I had to (go back to work after 6 weeks). I didn't feel like I had much of a choice.... I would have liked to have stayed home more... You know, nobody ever talked to me about that (FMLA). I know it was difficult for my job for me to be away.

Low-income parents also felt the pressure to return to work quickly, driven more by working in low-wage industries which were constantly plagued by high turnover and staff shortages than having valuable expertise. James B., a father with two jobs, shared:

In fact, my old supervisor, who's not there anymore, he said, 'Are you sure you need the whole week off?', because he knows how bad it was going to get. But I told him I need at least that week. But I didn't try to take longer than that.

James insisted on a week's leave, because "I wanted to get to know my son right from the start and get a feel for being a father," but in the end, his mental health was seriously strained by not having enough time for himself while balancing fatherhood with two different jobs.

Low-income workers typically suffered from family unfriendly hours in addition to a paucity of family-friendly benefits. This combination of bad hours and no benefits extended to some parents on the edge of the middle class, like Scott who combined up to three job positions with no benefits, as each position was part-time or self-employed. Among the middle class parents, job friendly hours and benefits did not always come together. For example, when asked if his employer was family friendly, Rick E. responded:

It's a very progressive company as far as benefits and that sort of thing. They have same sex health benefits and have lots of leaves of absences and things like that. So from that perspective they're very family oriented. The type of position I'm in obviously can lead to certain stresses on the family (e.g., demanding hours). But that's I think unavoidable in the position I'm in and that's the company as a whole

New parents desired and sought family-friendly positions in hopes of maximizing their ability to both care and provide, but these jobs were simply not widely available. The paucity of family friendly work policies made the transition to parenthood more difficult than often necessarily, and sometimes lead to difficult sacrifices in either the work or family sphere.

The Push and Pull of Work

In light of the difficulties combining work and family, one might think that work was nothing but a source of stress. Yet, most parents also valued their work lives. Employment was both stressful and

enjoyable, sometimes simultaneously. Working was very stressful, but so was not working. The push and pull of work was shaped by the relative rewards of a particular position and the availability of quality childcare. Some parents found their work duties enjoyable and most appreciated the change of pace and focus offered by work. Several parents noted that they felt more competent and productive at work, as noted shared by Linda, a middle-class mother:

Like I was pretty confident that I was good at my job and I would get pretty much instant feedback in terms of, if I was meeting with a [client] I kind of could feel how the appointment was going. When I'd meet with my supervisors I'd get that instant feedback. So I think there was a difference with that, between being a mom. I mean, the baby cries or maybe the baby doesn't, but you're just like, there's this real like, well am I doing a good job? There's not that feedback.

The rewards of work often contrasted sharply with feelings of loss-of-control and incompetence at home. This sentiment was expressed across mothers and fathers, but primarily among those from the middle class. For the most part, these parents held professional positions that were characterized by autonomy and meaningful skilled work, as echoed by Susan G, "My job is very much a part of me and very fulfilling.... going back to work and being reminded that I could do something again was definitely therapeutic." Further, work simply got people out of their homes and therefore helped relieve social isolation. This function of work was appreciated by low-income and middle class parents, alike, as noted by Sabrina H. and Laurie A., respectively:

I was happy to go back to work. I'm not a stay at home type of person. Even in those 2 weeks I was kind of chomping at the bit to go back. I don't think I could be a stay at home mom, unless there were lots of activities I could do outside the house.

I like to be a working mom. I don't think I'm cut out to be a stay at home mom. I'd like to be able to work less than I work. But I think I need that outside interaction as a person.

Work was much more contradictory for low-income parents. About half of the low-income mothers were unemployed at time of childbirth, and a few more experienced unemployment within the first year of childbirth. Most of these mothers would like a job, like Bethany:

It (employment) would pull me out of, well, I feel guilty, because for one I would bring financial thing for my family (and) it wouldn't give me time to think about it (mothering insecurities)....

I'm looking for it now... (but) I just don't want one of those McDonalds job that I hate going to work and I just do it because I have to.

Transportation problems, childcare problems, and difficulty finding family-friendly jobs often made securing a job difficult. Those who were employed tended to be in dead-end, routine jobs that were not particularly rewarding, as Kassie described her work as a CNA:

It's just depressing and hard (work), you don't ever get noticed for the things you do well... And you do one thing wrong and you're like hounded, you almost get fired over it. It's a big mess. Or even if something's not your fault, it is your fault because they're short (staffed) or something.

Although Kassie's employer was difficult, she found other rewards in working with people and as a provider to her family. Generally, however, low-income work was not intrinsically rewarding in the way that many middle-class careers were.

Kassie ultimately had to quit her job when she could not find affordable childcare to cover her weekend hours. Childcare, in general, is another factor shaping the push and pull of work. Many low-income parents struggled with finding affordable childcare that covered the hours they needed, and ended up losing jobs as a result. At least two mothers pulled their children from unsafe childcare situations. Additionally, some mothers experienced guilt about sending their child to a daycare, reflecting the traditional belief that mothers are the best caregiver. For example, Miki discussed how she felt both happy and guilty to be back at work:

Which made me feel guilty because it's like, I'm choosing work over [my baby]. Many mothers stay with the baby much longer and I feel happy to be at work and I feel like I'm not really thinking about him as much as I should have. But I was happy (at work)... They're (daycare) feeding him and that kind of thing, which I felt like mothers should do, not some stranger.

Fathers also participated in selecting childcare arrangements and often worked their jobs around the availability of childcare; however, they did not feel guilty about the use of daycare.

The push and pull of work is individualized in many ways, in regards to personal preferences for employment and the characteristics of different job positions which shaped these varied responses to work. These seemingly individual preferences, however, are ultimately tied to the cultural expectations

surrounding work and family, as well as the structure of contemporary labor markets and social policies. Demanding and inflexible work environments were too common, and reflect outmoded assumptions that reproductive labor is being covered by someone else, traditionally females. Men are more likely to be in family-unfriendly work positions, on average, but many women were also in such positions, especially those from the poor and working classes. Clearly, many employers no longer assume a female caretaker but reproductive labor is still largely externalized as a private responsibility and formal childcare is not adequately meeting this need. Super parent images make this balance look easier than it really is while the paucity of strong work-family protections exacerbates, rather than ameliorates, these difficulties.

Transitions in Marriages and Relationships

It is no secret that having a baby changes relationships. Nearly every parent in my study discussed relationship difficulties, emerging as a leading contributor to perinatal mental health symptoms. It was difficult to sustain relationships on limited time and energy, and further, ideals for equalitarian relationships are difficult to implement in practice. These were the types of difficulties straining most of the relationships. A few parents were in dysfunctional relationships, characterized by complete lack of support, manipulation, domestic abuse, or substance abuse.

Sustaining Relationships on Limited Time and Energy

The most common story was that new parents were snippy with each other when tired, as shared Bethany, a low-income cohabitating mother:

I was trying to be a super-parent. And he was too, when we were trying to both push ourselves to the point where we couldn't go on without sleep or we couldn't go on without having that time away from her and the house and everything. And it would end up causing problems between us. We were arguing and fighting and irritable. It was really hard.

Further, there is little time for each other and date nights are nearly impossible. Couples may not have the same understanding of how much together time they need. Often, one partner was more hesitant to leave the baby behind, as Miki complained:

So it's not like we couldn't find anybody to take care of him or anything like that, but we just chose to do that. I think my husband's more - he worries a lot. So he can't trust like babysitters... I know many (college) students who do babysitting and they actually have some knowledge about child care or language development, so you can trust them. He's like, no, no I'm not. So he kind of refused to do that. And sometimes that kind of frustrates me because I want to have our own time.

Tight finances or no one to watch the baby also made it hard to get out of the house as a couple.

Generally, the loss of couple time was mourned. Ben I. shared that it was a feeling of having lost his best friend.

In addition to time with each other, parents wanted time for themselves, as shared by James B. who was balancing two jobs:

Emotional distress, with me the way I felt, it was about my free time... And there was times arguments would stem from that because I'm frustrated, I felt like I'm not getting any of my time in. And I had to come home to a crying baby at night. Oh, that was basically it for me. That was, my days off were few and far between. And even when I had a day off from one place it didn't mean I had a day off from the other place. So I typically rarely had a whole day off.

This led to marital dissatisfaction when couples did not agree on what the fair balance between domestic responsibilities and me-time was, or if it seemed that one partner was getting more leisure time than the other. Typically, mothers thought fathers held on to their previous routines more, including leisure time, while they were unable to do so. Yet, it was fathers who most bemoaned the loss of leisure time, suggesting that mothers were perhaps more prepared for this reality, but then upset when their spouses did not seem to be making the same level of sacrifice.

Whatever the source of frustration, limited time and energy made it difficult to implement effective communication to address these issues, as shared by Matt F., a married, middle-class father:

We didn't have enough time to fully vent and argue and fight and make up. All we had enough time was to yell at each other and go to bed. And wake up in the middle of the night and [do] feedings.

These arguments were often over the division of labor, which brings in gendered roles and expectations in contemporary families.

The Struggle of Living Egalitarian Ideologies

The commitment to equalitarian families among my study participants is very encouraging and consistent with recent research pointing to the common desire for equalitarian relationships among young adults today (Gerson 2011; Pedulla and Thebaud 2015). However, more couples value shared parenting as an ideal than what is observed in actual parenting practices; and less than ideal practices are often associated in an increase in parental stress (Huston and Holmes 2004; Milkie et al 2002). Gender egalitarianism and shared parenting can be a difficult ideal to achieve, perhaps especially among the first generation to embrace these ideals so widely and with few models and social policy supports. Parents in my study spoke of their trials and tribulations in achieving, or failing to achieve, this ideal. As with other parenting expectations, falling short of ideals led to depression, anxiety, and other perinatal mental health systems. Further, perceived unfairness in the division of domestic labor was a major source of marital tension.

To be certain, several parents were satisfied with their division of labor, feeling that it was equitable and therefore a valuable resource for getting through this difficult time. Many others, however, were disappointed by how shared parenting and domestic responsibilities unfolded during the transition to parenthood. As would be expected, it was overwhelmingly mothers who complained that their partners fell short of egalitarian ideals. Samantha shared:

I mean that (unequal labor sharing) really caused a lot of strain on our relationship at that point in time. I felt resentful that he wasn't valuing the work I was doing at home and for the family like I felt like he should. And that just because he was bringing home a checkbook that kept us in the house there was so much more that went into it and I just felt like our family was going to fall apart.

Although disappointed and frustrated, many of these moms still noted that their spouses do a lot, perhaps more than the average dad, as indicated by Jenna F.:

I thought [father] would be a little bit more participatory, I think. But I think he's actually done great. I think compared to traditional male stereotypes that he has put in maybe 80% more effort than what society expects him to do, so on one hand I can't beat him up too much, but then on the other hand it's very frustrating.... There was definitely tension and fighting and

changing of roles. I honestly thought about leaving for the first year. There were times that I knew he wanted to leave. There's no question in my mind that he wanted to leave. And there were times that I really wanted him to.

Depending on family circumstances, mothers did not necessarily expect to divide the labor 50/50. At the least, however, they wanted their domestic labor recognized as difficult, equally important as paid work, and they also wanted some relief from this around-the-clock responsibility, as Caitlyn, a young, low-income, cohabitating mother shared:

I even explained this to [my boyfriend], because he's like, 'I'm working all the time and I'm tired, I need to go take a nap.' I'm, 'My job is never ending.' Being a stay at home mom is a full time 24/7 job. I don't even sleep during the night like he does.

These mothers voiced their concerns and worked to negotiate a more fair arrangement. Jenna F., above notes the arguments her husband and her would get into about this. Elizabeth shared:

That (shared parenting) was sometimes a point of contention, I think that made things a little worse because [my husband] would still want to get things done or be on the computer or do laundry when I felt at least at that time he needed to be doing something with the baby or holding him or paying attention.... I think I did (push for more involvement), because I was really frustrated sometimes. In the beginning it's like, this is not only my child. You know, especially when they're a tiny baby and you're feeling so, all you're doing is taking care of the baby, like somebody else has to do this too.... I think he just needs reminding every once in a while.

Typically, the gender balance of labor was renegotiated to be more fair, sometimes more easily than other times. Some mothers, however, continued to receive little-to-no help from their partners, as bemoaned by Isabella, a low-income, Hispanic mother:

Just me, doing everything... I get really upset just talking about it.... he comes home and he's tired. So I have to deal with them the whole day pretty much... you know, I do want to take a little break sometimes. I wish he could help a little bit more.... There's times that he would (help), but I'd be like asking him 15 times, then he'd be like ok, so. Yeah, I had to pretty much almost beg him to get up and get the baby.

Like other mothers in this position, they had to beg for very small amounts of help. Renegotiating shared responsibilities was stressful, but it was even more frustrating and depressing when these efforts were not successful.

Those who received little-to-no help were all low-income mothers, who all participated in my study without their partners. Many of these mothers appeared to have mismatched expectations with their partners about gender and parenting roles. Couples with shared non-traditional gender ideals often noted how their relationships were founded on these ideals, as something they talked about and practiced before having children. In contrast, many of the low-income mothers with unsupportive spouses experienced unintended pregnancies. Most had not really discussed or yet planned for a long-term relationship with their boyfriends, and, in fact, may not have in fact otherwise ended up in a long-term relationship with these men. Further, other research suggests that among the working-class, women are more likely to adopt contemporary gender ideals compared to men, and that the precarious state of male employment may lead some to reassert patriarchal authority in the home instead (Hill and Zimmerman 1995, Rubin 1994). To be clear, however, there were some low-income parents who shared similar visions for modern gender roles. They are working towards this, but may be falling short of expectations just as with the middle class parents.

From their perspective, fathers were overwhelmed by their new responsibilities and not purposely trying to avoid female-typed domestic work. Again, my sample only included fathers who were very hands-on, even if the gender division of caregiving labor was not exactly equal. Even the few fathers in my study who never wanted kids were still actively involved in their children's lives and shared this labor with their partners. There were no men with blatantly patriarchal views in my study, although this may describe some of the completely unsupportive spouses described by some of the low-income mothers. Indeed, they sometimes suspected that it was a "man thing."

Turning to partners working towards gender egalitarian roles, parents pointed to many reasons why this was difficult to implement in practice. The first and foremost difficulty was the tension between employment and home responsibilities. As addressed above, moms and dads alike struggled to balance work and family. In the contest between these spheres, many felt that moms will always put

family first and dads will always put work first. Couples disagreed on whether dads really did need to put their jobs first, as Giles reports:

She didn't like the fact that my work clearly came first. And she viewed it as me avoiding it, whereas in fact it was just the nature of the beast.

"The beast" is Giles' demanding job with constant overtime. Moms wondered if work was an excuse to avoid responsibilities at home, but then the dads noted that their income really was needed for family survival and their jobs often inflexible. This was the primary source of marital tension and depression for the Fs, with Matt explaining his perspective:

From my perspective it was a survival.... I always provide, and she's like, 'No you need to spend this time (with daughter), you can't work.' It always felt like an attack of 'you need to cut back here or there' and I'm like, 'I can't.' Kind of felt back against a brick wall because I'm getting her saying I want you to do this and this and I'm like, I've got this job this is what we survive on and I can't do it.

Matt also goes on to explain that his employer does not have flexible hours and his sick leave is very limited. He acknowledged that more of this burden fell on Jenna, but because she had a more flexible schedule. But while Jenna's schedule may have been more flexible, her project deadlines and work responsibilities still suffered and her career had higher earning potential in the long run. They both made valid points, illustrating how difficult it is to negotiate equalitarian parenting roles within a social structure lacking strong work-family policies and protections.

Gender imbalances sometimes resulted from beliefs that one parent, typically the mother, was more comfortable with or better at parenting than the other. In Thomas's case, his feelings of incompetency were wrapped up in his perinatal anxiety:

My challenge is I actually still get a little nervous about doing the right thing with her. When my wife is home, I'm perfectly fine with her, I'm perfectly content and happy.... And if [my wife] says, 'You can play with her or do the dishes,' I will almost always say, 'Let me just do the dishes.' Because I think I realize she likes being with her more. I mean, that would be the option she chose anyway. But I need to tell myself, don't do that every time. Sometimes you need to choose the 'be with her' option.

Thomas clearly did not reject women's work, especially as he took on the housework, but he is still working on reaching his expectations of himself as an involved father. Other dads noted that even when they tried, moms were usually better at soothing their baby, as shared by one middle-class father:

I would like to say it's equal, but I know that's not the truth. I think the goal for us was to try to make it as fair and equal as possible. But she does do most of it simply because she's around more. And a lot of times even if I go in there in the middle of the night and try to tend to [baby] because she's woken up and she's upset, a lot of times she'll just ask for mom and won't have it any other way. So even though I give an attempt, I have to basically hand her off anyways.... In an ideal situation I think it would be more fair and even.

From the mothers' perspectives, however, they also had a hard time figuring it out. For example, the wife of the father just quoted, expressed:

I was under the illusion that we would be able to be 50/50. If you were the one with the boobs, it starts off not being an equitable relationship to begin with. And then whoever stays home (during maternity leave) is the one that learns all the little ins and outs and so like it kind of became a relationship where I knew what she needed and I could tell him. And I kept trying, like, 'No, just try things. That's the only way I know what it is she needs, I just try it.'

Thus, while this couple agreed that their daughter prefers mom, the wife questioned whether it had to be that way. But fathers were sometimes getting mixed signals, in which moms want more help, but then moms also hovered, doubted their spouses competency, or were less than patient in helping them learn their duties. Dads were then further aggravated as they tried to figure out their roles and responsibilities.

It is true, however, that babies are often more bonded with mothers due to breastfeeding and their longer maternity leaves. Many others noted that the division of labor begins unequal with the typical maternity leave arrangement. This advantaged mothers in providing them with more time for bonding with their baby and figuring them out. However, they also often took on additional household duties during this period and it can be difficult to break this pattern. When moms went back to work and/or school, things were harder on everyone and dads sometimes needed to step up and do a lot

more. Aside from maternity leaves, there are other times when work demands shift, and parents need to actively recognize and work towards sharing domestic responsibilities, as noticed by Brandon G.:

And I think it's not because it needs to be that way, but it's because we've set up this pattern from when I was doing [my internship] and more work and had stuff to do in the evening. So I don't think it's very balanced right now.... I definitely need to help more, taking care of the daily tasks, whether it's washing dishes or doing diaper laundry.

Modern gender ideals were still negotiated within the more traditional female-homemaker/male-breadwinner partnerships. These parents were not just blindly following traditional roles; rather, they chose an arrangement that seemed best for their family and economic circumstances. They were often still working towards gender equity by sharing decision making and helping each other. Those in traditional arrangements struggled to define equity within a traditional model, as noted by Alyssa C.:

But at the time that [baby] was born all we saw was, everyone was like, we have to divide time equally, we both have to work, that kind of stuff. So it seemed kind of like, what's wrong with us, why are we not doing what everyone else is doing? So it was kind of frustrating that it seemed like all I was doing was taking care of the baby and all he was doing was going to work and school. But probably about six months in we kind of had gotten to figure it out to where, ok, well this is just us. We're not like the other people and that's ok.

Alyssa and Cory C. both spoke of the difficulties of embracing gender equalitarian ideals, but while practicing a traditional division of labor. This is not to say that they regret this choice, but that this too takes work and can lead to many frustrations, disappointments, and martial arguments. Mothers like Caitlyn, Isabella, and Robin never felt that the hard work of being a stay-at-home parent was acknowledged and supported, and therefore continued to be distressed by their more traditional arrangement.

These points of contention were not always about whether each partner is doing their fair share of labor, but also about how to raise a child. When traditional gender roles are rejected, parents also reject simplistic notions of what father knows best (e.g., finances) and what mother knows best (e.g.,

baby care). Rather, they had to come to agreement on key parenting strategies and approaches. This then was another potential point of disagreement, as shared by Cory C.:

Usually like how to handle finances, how to do things with the baby. So lots of times I would want to take the baby from [Alyssa] to try something different and that would result in some real gnashing of teeth and snarling ... So there was this back and forth when we were both angry and upset and we both wanted to take the baby away from the other person, right. Not good stuff.

The most common disagreements were over finances, where the baby should sleep, and how long the baby should be allowed to cry. Again, parents were trying to reconcile these differences on limited time and energy.

It was not the gender equalitarian vision, itself, which parents found distressing, but working towards this goal with insufficient cultural and social supports. They are part of the first generation of parents to embrace new gender roles so widely, and therefore are proceeding with little guidance and often through a process of trial and error. Further, work and family social policies have not kept pace with this changing reality, and in result, this tension manifests itself within marital relationships.

Dysfunctional Relationships

A handful of parents struggled in dysfunctional relationships. In contrast to the more typical relationship stressors, in which relationships were strained but couples still worked to support and respect each other, the dysfunctional relationships had far more serious problems to work through with fewer strengths, including domestic abuse, drug and alcohol abuse, or extra-marital affairs.

Jack and Cassie had partners with serious drug addiction problems. Jack shared, "The major source of distress is that she is a junky, prostitute, bad mother." In result, both Jack and Cassie became the single parent by default as they could not rely on their partners for any help. Jack additionally had to deal with the potential adverse impacts of drug use during pregnancy on his child. He was unable to get effective treatment for his girlfriend, but made sure she was at every prenatal appointment and then dealt with his daughter being born with a morphine addiction. Jack was very anxious about his daughter's

health and development. Cassie's husband spent their rent money on drugs, and she had to be extra vigilant to make sure he did not return baby items to the store for drug money. Randall has struggled with alcoholism, which was stressful for his family when a DUI eventually led to job loss. In contrast to the other cases, however, Randall did not abuse or neglect his family as a result of this alcoholism and actively sought help. So while the relationship itself was not severely dysfunctional, the resultant instability still had a negative tool on both parents mental health.

A few mothers experienced domestic abuse. Robin and Stacey were in controlling, manipulative relationships, and Madison's relationship was physically violent. Madison initially thought having a child may make their relationship better, but instead it became more controlling and abusive:

I think he, looking back on it, I think he thought that if we had a baby it was like tie me to him. And he always held that against me, if I ever left.... He would just say like, I can't believe you, why would you want to take her away from her dad. We need to be a family and stuff like that.... He threatened to use the court system and stuff and fight for her.

These mothers were all financially dependent on their spouses. Robin shared that her spouse would not let her get a job because he would not take care of the baby, and went on:

I despised him half way through. Not even a year into the relationship I didn't want to be with him anymore. I just didn't have enough strength or anything to stand up for myself. I was a doormat.

These mothers all eventually left their partners, which was an instant improvement to their mental health, as will be further detailed in the next chapter. However, these breakups were very difficult and led to new stressors, primarily, poverty due to their prior financial dependency, child custody battles, or the guilt of raising a child without a father figure. Kassie's estranged husband threatened to kill them after she left, and Madison continued to experience anxiety about whether her daughter's father will find them.

It is obvious that dysfunctional relationships are bad for one's mental health. During the perinatal period, such relationships have additional implications. These parents typically cannot rely on their addicted or abusive spouse for help, and therefore become a single parent by default. In addition

to their new child-rearing responsibilities, they are taking care of their partners' problems. Some are fearful of their spouses and most worry about how these problems are going to impact their children's wellbeing. Finally, they have fallen so far short of the perfect family image that they cannot help but feel like failures, not just for finding themselves in this situation but also for bringing a child into a dysfunctional situation.

Medicalization as Individualizing?

PPD is a medical diagnosis, and other negative emotions are coming under the purview of new perinatal mental health diagnoses. Medicalization is critiqued for individualizing problems that are better understood as social in nature. The PPD discourse does not entirely reduce this condition to one caused by individual factors, such as hormones and personality, but the biomedical emphasis outweighs actual evidence and therefore PPD has come under additional fire as a medicalized diagnosis, as previously reviewed. However, research has primarily focused on expert claims-making rather than how distressed parents, themselves, understand their conditions. My study demonstrates that social and cultural explanations were widely recognized and expanded on by the parents in my study. However, this is a nuanced conclusion to draw, because as we saw in the previous chapter, not all parents identified as having a PPD diagnosis. Yet, we can narrow our focus to the parents who had an actual PPD diagnosis or applied this self-diagnosis with confidence, and see that they too pointed to many life stressors.

These multi-dimensional, nuanced accounts indicate that medicalized discourse does not blind people to the difficulties they are facing in their lived experience. This finding is consistent with the literature on lay etiology, in which lay individuals tend to adopt psycho-social explanations for mental illness over biomedical explanations (Angermeyer and Dietrich 2006). Yet, PPD introduces yet another complication as this diagnosis is more uniquely linked to a supposed hormonal causation. Hormonal explanations may provide a simple, easy-to-believe explanation for emotional troubles, a core concern

of medicalization theorists. Only a minority of these mothers pinpointed hormones as a primary explanation, and these women all still focused on length on other factors. Previous mental health histories were common, pointing to another individualizing factor; yet, most parents also linked prior poor mental health to life circumstances and stressful events.

Although participants did not primarily offer individualized explanations for their distress, they tended to focus on social and cultural factors that were in their immediate social milieu. That is, they pointed largely to micro and mid-level factors and less often to macro, structural conditions. This included their social relationships, immediate family (past and present), and work stressors. Of course, this is where everyday life occurs and therefore may be expected to be more readily apparent and visible. These micro and mid-level factors are also consistent with the popular and professional discourse on the psycho-social risk factors for PMADs.

But, do parents have a structural consciousness? Do they have a sense that these problems are shared with others? Or, that there are political, structural forces contributing to the troubles of their everyday milieu? That is, do they have a sociological imagination (Mills 1959)? Some parents did, but for the most part, the sociological imagination was limited. As my interviews progressed and I began to hear the same stories, as part of my interview technique, I would share that I have heard this from other parents or that the literature also touches on this. This tactic was meant to reassure parents and express empathy, but I then noticed that times parents responded along the lines of “really?” “I was wondering,” or, “that’s what I hear now, but I didn’t realize that then.” Also recall that most mothers did not focus primarily on the role of hormones in their own stories, but then there was a tendency to more broadly define PPD in simplistic hormonal terms. Perhaps, these parents feel that their stories were an exception, because they had so many things going on in their own lives at once, but that most other people are experiencing hormones or other individual level factors. But, actually, most parents spoke of multiple life stressors and the quantitative literature also confirms that the strongest risk factors are

psychosocial in nature. To clarify, parents have heard about the more common new-parent stressors. But as we saw, they often did not realize how hard it would be until they actually experienced parenthood.

There also appeared to be a belief in individual exceptionalism. Yes, they heard parenting is hard and they will not get much sleep and so on, but they have always been good at overcoming challenges, they planned for their baby, they have always had strong mental health, they have a good partner, and so on, were the reasons offered for why many parents did not expect to have such a difficult time. This was especially true among middle class parents, whom have a history of success and come to expect control, as discussed above. Individual exceptionalism may lead to feelings of immunity against common stressors, and further, medicalized discourse may prevent full awareness of shared life struggles during the transition to parenthood.

Turning to macro structural or cultural explanations, the most widely acknowledged factor was the societal pressure to be a super mom. Mothers were very aware that this was part of our overarching culture and that it's a dangerous ideology for their mental health. Similarly, many fathers noted the relative lack of real supports for fatherhood. Mothers and fathers alike brought up the poor economy, which had a direct impact on some families who experienced job loss and lead to a general sense of financial insecurity and anxieties among many. The very educated mothers sometimes mentioned family friendly work policies that they knew of in other nations, most often, extended paid maternity leave. At the other end of the spectrum, the poorest of the mothers were sometimes very critical about the lack of real job opportunities and our nation's seemingly backwards funding priorities. Their attempts to access government aid brought to light the contradiction of being stigmatized as a poor person but not being provided with enough resources to escape poverty despite their best efforts. In sum, some parents were very explicit about structural factors rooted in social policy, although these explanations were not widely offered. Does this reflect the individualizing tendencies of mental health diagnoses or

the larger individualistic culture of American society? It's difficult to say, and further, medicalization itself is a reflection of our individualized culture.

Conclusion

Parents offered many explanations for their perinatal mental health symptoms, rooted in their lived embodied experiences with perinatal distress and situated within their larger life context. My interpretation of these illness narratives necessarily simplifies the complexities of each unique case and obscures many individual circumstances, but serves to highlight how perinatal mental health is actually a lot more complex than typically represented in the popular discourse. The often neglected social sphere is very important, well beyond the psycho-social risk factors that are typically quantified.

I expected to observe stark gender differences in the everyday lived experience of perinatal mental health conditions, but rather, found that mothers and fathers largely shared the same stories. As gender roles converge, mothers and fathers found themselves struggling with many of the same stressors. Moms have long pointed out that raising children is hard, as is combining work and family. Today's fathers are finding that the same is true for them as they increasingly take on caregiving tasks. Mothers and fathers alike are tired, mourn the loss of previous lifestyles, feel overwhelmed in trying to be good parents, and struggle with the work-family balance. These stressors often cumulate in marital tension, to the dismay of both partners.

Yet, there were nuanced gender differences. These differences largely point to the anomie of rapidly changing gender roles, and falling back on more traditional gender roles when parents were overwhelmed or in the face of structural barriers. Many moms felt like failures when they are less than perfect at balancing these many responsibilities, pointing to the fact that mothers still internalize the primary caregiver role. As family gender roles for men change, fathers rarely felt like failures although they still had a very hard time figuring it all out. Fathers spoke in more detail about breadwinner pressures and while this is a real concern, it was also the most clear and straightforward parental role

available to them. Many of these frustrations manifested in marital tension. Many parents did not fight with each other because one or the other held onto traditional gender ideals, but rather, because each partner felt overwhelmed by their new responsibilities. Demanding and inflexible workplaces contributed to the difficult family-work balance, which often manifested itself in marital tension. The paucity of family-work policies exacerbates these difficulties and often makes egalitarian gender roles difficult to implement.

In contrast to the more subtle gender differences, the class based differences in perinatal mental health experiences were very apparent and stark. SES status may overall be a modest risk factor for acquiring perinatal depression, but being low-income fundamentally shaped the everyday lived experience of this distress in many ways. Whereas middle class mothers focused on failed expectations of motherhood, poor women cited everyday struggles with poverty. Further, they were more likely to be in unsupportive or dysfunctional relationships. With these larger life contexts in mind, low-income mothers may not have expected as much control and perfection in motherhood, and further, find motherhood more rewarding compared to their other social roles.

Parents explanatory narratives somewhat challenge medicalization theory as we see them offering very nuanced, multi-dimensional, and complex accounts of their emotional distress, including a heavy focus on social and cultural factors. Yet, they also confirmed many individualistic explanations and tended to focus primarily on their immediate social milieu. Mothers did not accept hormonal causation as a simplistic explanation for their troubled emotions, nonetheless, most accepted a role for hormones. Of course, when sociologists critique the individualizing aspects of medicalization, we are also pointing to how these problems are addressed. Medicalization is theorized to promote individual cures over social solutions. The next chapter will draw our attention to how parents resolve their perinatal mental health symptoms and their thoughts, more broadly, on how to address the problem of poor perinatal mental health.

VI: How to Fix It? Managing Perinatal Distress

“I think I’m in recovery meaning that I don’t think you’re cured because it could definitely happen again. And I do have down days where it’s reminiscent of what I used to feel like, and I recognize that. But that’s very rare. I’m working, taking care of the house, functioning as a parent. I want to just feel normal again, I don’t feel so heavy and clouded.” –*Julie J.*

Upon recognizing something is wrong, distressed parents began the process of getting better – for themselves and for their babies. This chapter addresses the approaches parents took to restore good mental health. The majority of parents sought professional mental health services, both mothers and fathers and across class backgrounds. While most benefited from professional services, other parents pointed to deficiencies in the availability or quality of care, especially for low-income parents. Mental health was often glossed over when addressing breastfeeding difficulties. Distressed parents were not quick to treat their ills with a pill, as many preferred therapy and self-help and medication was only accepted with caution. All parents also practiced self-care strategies and several worked on making difficult changes in careers and relationships; thus demonstrating that parents did not rely on professional treatment alone. However, self-sacrificing super parent images, the belief that rearing children is an individual responsibility or the stigma of being viewed as a bad parent sometimes prevented parents from seeking more support or taking better care of their needs. Further, a few parents were not able to find good solutions to their ills, for example when they could not afford mental health care or their problems did not have clear solutions within their personal control. Parents’ advice and recommendations largely centered on improved awareness and support, rather than structural preventative approaches.

Becoming a Patient

Judith Lorber (1997: 9) observed, “Symptoms do not make a woman or man a patient – seeking professional help does.” In my study, twenty-six parents sought new professional help for mental health

symptoms during the perinatal period, although a few parents did not receive the help they sought. Eight continued or increased existing or recently-received mental health services. These mental health services ranged from a one-time consultation to medication to therapy to hospitalization. Thirteen parents did not seek any kind of professional mental health consultation or treatment. In this section, I explore why parents did, or did not, seek professional help. This decision was not a simple yes-no divide, as some parents initially opted against seeking help only to later seek services. Table 4, below, breaks down help sought or services received by gender and class. Table A6, in the appendix, provides an overview of the decisions to seek help or not by each parent. Zola observed that people do not always seek help when they are most sick, but rather, when they struggle to accommodate their symptoms (1973).

Table 4: Help Seeking Patterns

	Middle class Mothers (n=15)	Low Income Mothers (n=15)	Middle Class Fathers (n=14)	Low Income Fathers (n=3)	Row subtotals*
Received Therapy	5	8	6	2	20
Received Medications[^]	8	6	5	1	20
Hospital or ER treatment	2	1	0	0	3
Attended support group	4	1	0	0	5
Any professional help, unduplicated	8 (53%)	12 (73%)	9 (64%)	2 (67%)	31
Wanted/sought help, but not received	3 [#]	3 [#]	1	0	7[#]
Neither sought or received help	5	3	4	1	13
*The first four rows (type of treatment) are <i>not</i> mutually exclusive; [#] This includes 3 low-income mothers who received a little help, but not the level desired due to affordability; and one middle class mother who did not initially get the help see sought but then received professional help much later. Thus, total of last three rows adds up to 51 because these 4 mothers were double counted.					

Every parent eventually recognized that they were not quite themselves. Scott shared, “When good things started happening and it made me sad, I think that’s when I really realized that something

was off.” Generally, this resulted from self-awareness although sometimes close family-members or friends helped them see that they were not themselves. Friends and family were also often helpful in encouraging their loved ones to seek professional help, as demonstrated by LeAnna B, who received medication from her OB for PPD:

I didn’t realize I had postpartum depression. One of my co-workers came by to visit me and it was after a whole morning and late evening crying so hard that I couldn’t even get my eyes open because they were so swollen and she forced me to go to the doctor. I had no clue, I thought this was normal.

In this regards, friends and family have sanctioned that the parent needs more help to cope with their symptoms (Zola 1978).

After recognizing that something was wrong, parents had a strong motivation to get better for the sake of their baby. This was the case for both seeking professional help or in managing one’s mental health without formal mental health services, as represented by Kristi, who received medication from her OB, and Isabella, who focused on self-care strategies:

I said I didn’t want to get to the point where you shake your kid. I didn’t want to let it get to that point when she cried. That’s about the time she was getting colicky. And that’s where I was like, yeah, I can’t do this.... I didn’t want to end up like the people on TV who drowned their kid, I didn’t want to end up like that. I wanted help before that ever happened.

That’s why I try to push myself not to feel like that and not to be depressed, because I don’t want my kids to see me depressed. I don’t want that.

These parents, along with numerous others, stressed that they needed to get better so that they could perform their parenting duties and not let their distress carry over to their baby’s wellbeing.

Even though parents generally recognized that something was off, they were not always certain that their symptoms were clinically severe, as shared in Chapter IV. Middle class mothers were the most likely to link their abnormal feelings to what they had heard and learned about postpartum depression, and, generally, awareness of postpartum depression was a strong motivator to seeking help. This is consistent with prior research on illness behavior, in which familiarity of symptoms prompts help-seeking (Mechanic and Volkert 1960). PPD awareness is now widespread, with advocates highlighting

the symptoms that should prompt mothers to seek help. Further, these campaigns stress that all mothers are susceptible and the consequences of untreated PPD can be serious, also important factors for compliance according to the health belief model (Rosenstock 1966; Becker 1974).

Mothers with PPD diagnoses very often combined therapy and medication, with a few also attending support groups. Fathers tended to wait longer to seek help and received less extensive services, perhaps due to the lack of awareness about paternal mental health. Four of the eleven fathers who eventually sought help did so after learning about PPD, often through internet searches. Three of the fathers went to only one or two counseling sessions, and did not have this service tied to an actual diagnosis. This helps to explain while although the fathers in my study were less inclined to label their condition as clinical, they had similar professional help-seeking rates compared to mothers. Generally, fathers received less extensive mental health services compared to the mothers, in that they sought services for a shorter period and were less likely to combine different types of professional services.

However, Nicole's first pregnancy when she was a minor points to a counter example regarding the susceptibility of pregnant and postpartum mothers. Her dad had her treated for depression because he thought she was behaving abnormally, and she took medication for a very short treatment. However, when they found out she was pregnant; he discontinued her treatment because their family saw depression during pregnancy as normal. Nicole reported that she was definitely depressed, but as a minor, had little control over her mental healthcare options. A few mothers felt they just needed to ride out the hormonal moodiness of pregnancy and childbirth. Thus, while PPD increases awareness of mental health during pregnancy and childbirth, there is also a counter belief that moodiness during this time is normal.

Even if parents felt that they likely had a mental health condition, they still gauged the severity of their symptoms before seeking professional help, as noted by Natalie:

You know, of course if I needed it, I would have gotten the help that I needed because that's what you have to do for your child. But I just never felt like it was past the point that a good talk with [my husband] couldn't handle, I guess.

In contrast to Natalie, Kassie shared:

I have no one around me, I have no support... I had no free support, so I might as well have a paid support. At some point I was actually paying for it (therapy) myself.

Many parents found that self-help, informal social support, making life changes, or giving themselves time to adjust was sufficient for restoring their mental health, as will be further detailed below. As Natalie and Kassie's quotes demonstrate, the availability and quality of informal support impacted whether parents felt therapy would be useful. Additionally, many parents did not feel medication was called for until at least trying some of these other strategies. Their ability to manage their symptoms on their "own" (albeit with social support) was the most commonly cited reason for not seeking help. Of particular interest were the parents who were fairly confident they had a mental health condition but did not seek any professional mental health treatment. To be clear, they consciously chose not to seek help rather than being held back by inaccessibility to mental health services. Although a small group, they demonstrate that some people adopt medical labels while rejecting medical treatment. These labels helped them acknowledge that something was wrong, but they focused on addressing the concerns and life circumstances that were leading to their depression or anxiety.

However, if these other strategies did not work or symptoms worsened or persisted for too long, parents were generally willing to seek help, as demonstrated by Elizabeth:

I came home and I was fine for a week or so. But then you just start getting more crying and sad and you can't articulate why for any reason But it was a little while before I realized it, and then once I did, I called. But at first I thought this is just kind of, because you hear everyone kind of feels a little sad or bad for a little while, so I thought I'd wait it out, but it didn't go away.

In PPD awareness campaigns, the distinction between the baby blues and PPD help parents delineate the severity and temporality of normal vs. abnormal distress following childbirth, at least among mothers. Fathers tended to seek treatment later, such as Randall who reported first trying to be stoic.

Other commonly cited factors for not seeking professional help were time and financial pressures, especially when parents already felt overburdened by their new responsibilities, as shared by Matt F. and Shelley, respectively:

It (therapy) probably could have been (helpful). By the time I really probably needed it was more just financial and time was so bad so that I didn't feel I had either of those to give to get that emotional therapy or support.

I did think about it (seeking professional help) but it just, not knowing the area and not sure if that's what I needed to do, I just kind of brushed it off.... because I was moving, you know what I mean. As I was starting to deal with some of those issues, I was leaving one doctor, coming to another one and it was mainly, my focus was trying to make sure he (son) had the doctors that he needed to continue with his, you know with his success.... I thought about it (PPD), I just never mentioned it.

These parents often shared that they were putting their baby's needs first while neglecting their own needs. However, at the point they felt their symptoms were severe enough to potentially impact their child, they drew this connection and paid more attention to their own needs. As noted above, concern for their child's wellbeing was a strong motivation for getting better. This was also generally true of the financial pressures, in that parents would prioritize paying for mental health services if they felt they were truly needed. This is consistent with previous literature finding that symptoms that interfere with daily activities prompt a visit to the doctor (Herzlich 1973; Mechanic 1978; Zola 1973), and in this case, parenting is the most pressing responsibility which must be met.

Unfortunately, cost was still a major barrier for many low-income mothers, as exemplified by Desiree:

I just felt like I needed some help to try to regulate my emotions. I was having trouble with it.... I think the problem probably was the therapist that I had, we just weren't clicking right... which was another part of the reason why I didn't go anymore is because after the twins were born and after I was out of the hospital 6 weeks postpartum my insurance ended because I was getting it through [Medicaid]. So I didn't have the money to continue going... I probably would have asked for a different therapist if I would have been able to get it without having to worry about the cost.... I thought about maybe trying another medication... [but] I wouldn't have been able to pay for it, so I didn't want to start on it and then have to stop it because it can become worse if you suddenly stop the medicine.

Desiree was still suffering from depression and severe anxiety at the time of our interview, more than three years after the birth of her twins. Some low-income parents felt they could not afford treatment at all, and others ended treatment early because they knew their pregnancy based Medicaid coverage would be cut off after their postpartum check-up. Kristi shared, “When they finally prescribed me Zoloft I stopped taking it, I wasn’t supposed to, but I stopped taking it like a month or 2 later because I couldn’t afford it.” Even with sliding scale clinics, many parents could not afford their portion and clinics would not see them if they had past-due balances.

The decision to seek professional help, or not, sometimes reflected prior experiences with professional mental health services. Those who had a positive history with mental health services were quick to seek help again, as shared by Dylan, who was treated for anxiety:

I think that I’m a person that’s kind of predisposed to seeing counselors. I’ve used psychotherapy in the past, mainly depression. I think I learned through this process that depression and anxiety are co-related, so, I was predisposed to depression and anxiety before, but depression was most obvious so I had seen counselors to help with, I don’t know, the breakup of a girlfriend in college, is like one episode I remember.

Not only did these parents see how mental health treatment helped them before, they also had experience with navigating the mental health system and were often able to return to an established provider. A few parents were receiving ongoing mental health for long-standing mental health diagnosis, and therefore, received proactive care for the anticipated changes brought by childbirth and becoming a parent. Laurie A., who had bi-polar, explained:

I knew that during the pregnancy I hadn’t been on the right amount of the medication, they’d only given me the basic bare minimum and they told me to sign up, so I signed up for a postpartum depression group before I was even depressed. And I told them I don’t know why I’m here, I just think I should be here because I could get depressed.... I think I had a lot more support than a lot of women do when they first have their baby because everybody knew I was bipolar, my whole care team and my family. So I got a lot of support when I first came out, was given anti-depressants right away so that I wouldn’t become postpartum and all that.

Low-income mothers were most likely to fall into this category of receiving ongoing mental health services. These parents were already patients, and treatment was expanded to include childbirth as a

new risk to be managed. Further, prior mental health experiences shaped their familiarity with mental health symptoms.

Conversely, those who had negative past experiences with the mental health system were very hesitant to re-enter this system, which was especially the case for people who had bad previous experiences with medication. For example, in discussing her awareness of PPD, Natalie shared:

I never thought not me. I just, all I could think was, 'Why wouldn't these people get help?' And then when I felt it (PPD) for myself, I just kept thinking about that time in high school when I was getting help and they kept putting me on medication, and I really hate medication.... So any thought that I had about seeking help was kind of cut off at the knees because I thought that that's the route they might go.

Natalie was confident that she was depressed, but not willing to seek professional help. Parents with no mental health history were also hesitant to seek help, in part because their strong mental health history implied that should be fine and able to cope. Emma shared:

No, I'd never had any mental illness, never had any worries or never really... I think that's one of the reasons (I went so long without help), because I was a very sane, driven person. And...very career oriented.

These parents felt like they should not need professional help when they have never needed it before.

A few parents were not generally predisposed to utilizing professional mental health services, as demonstrated by Jeff H.:

I don't think it was that severe, but I don't think I'd feel very comfortable talking to a doctor or a therapist anyhow.... I think it would take some big event to convince me that I needed to be on some sort of medication of that sort... I rarely, very rarely take medication.... it's not like I have a distrust of the medical establishment or anything like that, it's not like that at all. It's just that, I don't know, to me just try to work it out your own way or whatever.

Fathers were about equally likely to seek help, but those who did not were more likely to express skepticism about mental health services compared to mothers who also chose not to seek treatment. Father often noted that formal help was "not their style," thus tapping into traditional beliefs about stoic masculinity.

James and LeAnna B. provide an interesting example of the difficulties that arise when both partners do not share the same understanding of mental health and mental health services. LeAnna was not sure if she had PPD, but she also had her feelings dismissed when shared them with James. At this point, James doubted that PPD was real and felt that LeAnna should be strong and overcome her negative feelings. James is also very anti-medication. LeAnna did not discuss her emotions anymore with James, and was further angered and depressed by his response which indicated a lack of support. She then continued to doubt whether anything was really wrong and this also made her uncomfortable in bringing it up with her doctor:

And then when I went to go speak to my doctor, she said, 'Well why didn't you come to me and say something?' Because I didn't think that's what it was. I didn't know. I didn't know this was something wrong. You know, my husband goes to every doctor's appointment too and I didn't feel, I don't know, comfortable talking with my doctor about how I felt. I felt comfortable talking to the doctor about the baby with him, but not me.

As noted above, it was a friend who convinced LeAnna to go back to her OB to discuss her condition. James came to accept PPD as a real thing after seeing LeAnna continue to struggle and also how treatment helped her, and now regrets not supporting her more fully from the beginning. At the time, however, his anti-medicalization attitude made getting help more difficult for LeAnna.

Availability of appropriate mental health services was also relevant. A number of parents noted that it was difficult to find professionals with expertise in perinatal mental health, but most settled for generalists or kept searching. However, one father, Shaun, cited this as the primary reason for not getting professional help:

So I'm not scared of the idea of counseling, I actually really welcome it... I just wanted to be able to sit in a room with somebody and talk. So I was very for the idea of counseling, but the few times I tried to actually find somewhere, I found navigating the types of counseling and the jargon used and the lack of any resources that seemed to be specifically talking about men that weren't talking about gay counseling, I basically found it really hard to find anything combined that with the lack of time.... I found very few resources But also when you do find male counseling a lot of the times you find that it's sort of gay counseling or kind of sexual relationship counseling, which wasn't what I was looking for.

Shaun was specifically looking for counseling around fatherhood insecurities, but it was not available as far as he could tell, even though he resided in a metropolitan area. Considering how difficult it was for parents to find experts in maternal perinatal mental health, it seems all the more difficult for paternal perinatal mental health. A few mothers attended a support group, which I considered a professional service because the group was headed by a medical professional and expert in perinatal mental health, but fathers did not feel these support groups were really for them.

Finally, a few parents, but not most, were hesitant to seek help because of stigma or embarrassment. In particular, mothers worried that seeking help would be taken as a sign that they were bad parents, as demonstrated by Robin and Samantha, both low-income mothers, respectively.

So I felt like if I did get that depressed I had to deal with it on my own because I was guilty and ashamed, I guess, to tell anybody else because I didn't want to lose [my baby].

I know that my husband talked with my sister and then my mom called, they're like, 'Do you need to go to the doctor?' It just upset me more because I was embarrassed... It just felt like somebody stopping in and saying, if you need to go get help, then I'm not being a good mom... like, well how dare they?... I didn't want my husband to be concerned, like to leave me alone with the baby because I had absolutely no anger or frustration towards the baby or anything like that... I wasn't like mad that I had had a baby or anything. Just know that kind of stigma with postpartum depression I didn't want him to think that I'm going to harm him or not take care of him good enough or neglect him.

Both of these mothers did, however, eventually seek help. Samantha sought therapy after feeling like she was not really getting any better and also because she was not getting sufficient support from her husband. Robin's depression became much more severe and she contemplated suicide. She then switched from fearing that she would lose her baby, to the possibility that her baby would be motherless if she did not get help:

It was me and [baby] alone in the house and I said, 'I can't do this, I can't do this,' and I grabbed a bottle of pills and then she woke up and I went into the room and she just smiled at me and her eyes sparkled and I was like, 'I can't do this. I'm here for her if nothing else.' And so I couldn't come out of the depression even though, like I was holding her and I was being a mom, but I couldn't shake it and so I said, 'I need help because I'm not going to leave her alone.'

In sum, there were many reasons why some parents chose not to seek help. For the most part, they made rational judgments about when help was truly needed. Distressed parents' illness behavior is

consistent with the larger body of research on illness behavior, regarding how people interpret and act on their symptoms. They considered the severity of their symptoms, potential consequences, and gauged the effectiveness and availability of informal coping resources available for coping. PPD awareness campaigns shaped their understanding of their susceptibility as well as the consequences of unmanaged perinatal mental health. Overall, most parents in this study were willing to seek help when they needed it. However, help-seeking was not always driven by individual attitudes, as a paucity of providers and financial constraint prohibited help-seeking among a few parents otherwise inclined to use professional services. This may be especially true of perinatal mental health conditions as relatively new conditions calling for specialized approaches, and particularly for paternal perinatal mental health.

Experiences with Professional Mental Health Treatment

Once the decision to seek help was made, was help received? Indeed, when it comes to perinatal mental health, seeking professional help was not necessarily sufficient for becoming a patient. The professional who they consulted also had to legitimize their symptoms as an actual mental health condition. And even if a person's condition was legitimized with a mental health diagnosis, they did not necessarily get the type of help they wanted or needed. Most parents were satisfied with their treatment, primarily because they felt their doctors were responsive and the solutions they provided seemingly worked. A few parents, however, were not satisfied with the care they received.

Two mothers, Miki and Emma, had their concerns dismissed by their doctors telling them that they were normal. Miki shared, "She said if I don't, if I feel like I need to kill myself, that's when I need to get professional help or medication, but otherwise this is normal." Miki did not challenge her doctor, although she questioned this advice as it was not consistent with what she read about PPD. Miki felt she was struggling with depression even though she was not suicidal. Another mother, Alyssa C., did not have her concerns completely dismissed when she brought up her possible prenatal depression with her OB, but felt her condition did not get the attention it deserved:

She (OB) was like, well, that's normal and went to her medicine cabinet and was like, 'Here's a free sample of this drug and if it works I'll write you a prescription.' And I kind of was like, 'I'm not comfortable doing that, I'm pregnant.' I know obviously you wouldn't give it to me if it wasn't safe for pregnancy, but how do we know what's really safe and not safe? You know, I just would have rather tried something like therapy or something before that. I didn't want to go straight to medication, so when she went straight to medication along with kind of dismissing it in just a sense of, 'well that happens.' Rather than, what's going on, why do you feel like this is the problem?

This response turned Alyssa off from talking to her OB about any such troubles again, although she still felt she was depressed during her pregnancy. These stories suggest a more traditional activity-passivity doctor-patient relationship, in which the doctor was in charge (Szasz and Hollander 1956). Alyssa's case also points to the conflict between her doctor's biomedical view of the condition, and her more relational view (Friedson 1970). These parents did not come to a shared consensus with their provider, although they still adopted their own views of the situation. A few other parents also indicated that their provider only offered medication and did not discuss other options, although they were more satisfied with this response, sometimes nothing that medication was what they expected when they brought this up with a general practitioner or OB. If they wanted therapy, they reported, then they would have consulted a mental health provider more specifically.

Emma's case is particularly interesting, because after her doctor dismissed her symptoms at her postpartum check-up, she then went three years before being diagnosed with postpartum psychosis. Emma's husband suggested to her that something may be wrong. She did not agree with his assessment, but agreed to bring up postpartum depression at her 6-week postpartum obstetric check-up, "And I asked, the doctor was like, 'Well you feel fine, don't you?' I was like, 'Sure, I feel fine.' And that was it." This was not simply a matter of conceding to doctor authority; however, as Emma genuinely thought she was fine. But things were not actually fine and, rather, her symptoms became progressively worse over the next few years, to the detriment of Emma and her family. First, Emma gave up a prestigious career, as she also got a bad review at work but thought she was just overwhelmed by too much responsibility. Emma's psychosis manifested itself in paranoia that someone was abusing her

son or trying to kidnap him. To address this concern, the family moved often, spent a lot of money on security, and took their son to several doctors to treat his supposed abuse. There were no real indications of any real threats to her son's safety, but Emma was convinced and provided very elaborate rationalizations for her suspicions. Her son's medical team eventually turned their attention to Emma, suggesting that she may be experiencing psychosis. By this time, Emma had a second child, still an infant. Emma's husband and the medical team were able to convince her to at least try medication:

The psychosis had gone so far it even seemed unrealistic to me. Like people, always before when someone would try to get me to explain what was going on, I would have an explanation for it. But at the end it was just like I was living in another world. Nothing made sense to me.... And basically the doctor said, 'All right, try going on this medicine and if what you're seeing and experiencing doesn't stop, then maybe there is a real cause for concern. And we'll do what we need to do to help you.' So that was the line that they took with me.

Emma had to be convinced that taking the medication was more important than continuing to breastfeed her second child. Her husband was also adamant that he wanted her to try medication and after consulting additional professionals, Emma agreed to try it, thus illustrating the guidance – cooperation model. The medication worked rather quickly and in retrospect she was able to see that she suffered from paranoid delusions caused by her psychosis. "Looking back you can see some of the signals. But we just kind of glossed over them and kept on going." Emma feels strongly that her OB missed a valuable opportunity to address her mental health before it spiraled so far out of control, and now wants doctors to know, "If someone thinks enough about it to bring it up, it's a real concern and it needs to be treated that way."

Only a few fathers opted for mental health treatment specifically for PPD, but they were especially concerned that their concerns would be dismissed due to lack of awareness. However, their primary care physicians took their concerns very seriously, as shared by Kevin D.:

He (PCP) was aware of it, which I was thankful for because some of the reading that I did ... one article said especially male doctors are going to be more like apt to not prescribe an anti-depressant, just like get over it, kind of thing, just man-up sort of thing.... He was very much, he was more on the ball than I thought he would be... I told him, I think during the appointment I said something about I think I might be going through a male version of post-partum depression.

And he says, 'Yeah, I've seen lots of cases of this. And I know that men go through this sort of thing.' So it was sort of my awareness of what it was called and what to really name it, that that's how it came up.

Thomas' doctor was also very attentive and Giles' physician referred him to someone with expertise in perinatal mental health. This shared consensus between these fathers and their doctors was built on the fathers studying up on paternal postpartum depression. Kevin's account, in particular, demonstrated how he pulled from paternal PPD advocacy discourse to frame his condition with his doctor and that he was prepared to defend his claims. Recall, however, that Shaun never found someone with expertise in paternal mental health. Although the fathers who sought help were generally satisfied with their care, these men still stressed that better awareness of paternal PPD is needed, as stressed by Thomas:

I guess I've heard of post-partum depression in a male, but you just didn't know much about it. So I sort of felt like I was this bad dad or something like that. I guess getting more information out there can help... at least knowing that you're not completely insane or wrong.... and I guess just like letting dads know what their options are. Like, Lexipro has been successful or therapy has been successful or whatever.

Many parents received good treatment, which was responsive to their individual preferences, needs and circumstances. As with seeking help in the first place, the severity of one's symptoms and perceived cause of their distress shaped their treatment preferences. Effective, individualized treatment is built on a close, collaborative relationship between provider and patient, characteristic of the mutual participation model. Laurie A. shared:

I'm really willing to help myself, so when I work with a therapist and we're on the same team and we really work together, it's not just like oh you need to fix me. I really try and help and I've been told that it's helpful for them because they suggest things that I need to do and I actually do them.... I had all these tools to help me, I knew I was going to be ok.

Several parents combined different treatment approaches, which in Laurie's case helped proactively manage her preexisting condition, bi-polar disorder, which is known to get worse with pregnancy and childbirth. Dylan discussed the multi-faceted approach he took to get his new anxiety diagnosis under control:

[Medication is] what finally did it, and you know, to some extent.... In retrospect, I did need a drug. I tried lots of tools and I feel like I was proactive when I was trying to deal with it. I remember we took a CPR class, a baby CPR class because I was so freaked out that he was going to choke to death. I think we went in and tried to alleviate by doing practical things, but they just weren't good enough... I think it helped a little, but I don't think, you know, I mean I still went to therapy after I started medication I think that, so it wasn't like I took medication and everything's wonderful.

In contrast to mothers who had their condition dismissed by their OBs, Lydia D. used a nurse-midwife who recognized that Lydia was likely depressed during her postpartum check-up and went to great lengths to follow up with Lydia and encourage her to accept medical treatment. Her mid-wife listened to Lydia's problems, provided a prescription, and also connected her with a support group.

Effective treatment sometimes proceeded through trial and error, which was frustrating and prolonged getting better. Susan G. and Julie J. both experienced severe PPD, with suicidal thoughts, and voluntarily admitted themselves to psychiatric hospital units more than once. Although hospitalization would seem to be the most intensive level of treatment available, the fact that both of these mothers required multiple rounds of hospitalization demonstrated that there were no magic or easy solutions. In Susan's experience, the inpatient mental health units had a "treat and street" philosophy:

One of the frustrations for me and definitely for my mom was, I was hospitalized three times over the course of the summer... And when I was at [the same hospital for the first two admissions] I never saw a psychiatrist.... At [hospital] there was no really group therapy or like individual therapy, like talk therapy. It was none of that... I think the work they have to do is definitely difficult and I think the real attitude is treat and street. They kind of give you the medication that they need to think to get you stable.

Hospitals largely stabilized their condition in order to prevent suicide and other dire consequences, but generally did not provide these mothers with effective long term solutions for improving their mental health. Susan's first couple of hospitalizations did not go well, although she did find some utility in meeting with the social worker to learn about community resources. The third time, Susan went to a different hospital where a psychiatrist did a complete medication review. She soon got better with the medication change, in combination with strong family support and possibly her hormones returning to

normal. Susan concluded, “For me it was the two months of pure hell and then in a matter of days it just kind of changed.”

In contrast to Susan’s relatively quick recovery, Julie’s severe depression began during pregnancy continued for nearly three years with “seven or eight” rounds of hospitalization. Regarding Julie’s treatment experience, her spouse, Anthony, bemoaned:

Now I think of it there were definitely times when I and Julie’s mom we were kind of like, ‘Do we take her to the hospital, do we not?’ It got to the point where she got admitted so many times and came back and still wasn’t better you started doubting whether that’s really doing any good, getting her admitted, if it’s not really doing anything different. But then you kind of want to walk that fine line of if she’s in harm’s way, going to do something to herself, she needs to be under watch.

In retrospect, Julie feels that the hospitals provided very limited help beyond emergency stabilization. Throughout this period, her diagnosis changed from prenatal to postpartum to just depression, and they even considered bi-polar, as reviewed in Chapter IV. They also tried many different medications, in addition to psychosocial approaches such as cognitive therapy and journaling, but nothing really worked long-term. Julie shared:

I mean it was helpful to talk to someone, we really were just dealing with some of the surface issues and really didn’t get to address the underlying, emotional issues. But she did help connect me to people like [my psychiatrist] who had experience with the perinatal medication and through her I got connected to another therapist who did eye movement desensitization and EMDR therapy. And with her is where I really got to the deep underlying emotional thoughts and feelings about my childhood and issues, resolving those things.... I was on pretty much every medication that you could try and nothing really ever worked or fixed me. It might have pulled me out of the gutter a little bit, but it didn’t fix things.

Julie’s treatment experience provides a valuable insight. It was ultimately in-depth therapy that addressed Julie’s underlying fears about her capacity to mother and led to her improvement, rather than the biomedical approaches focused on medication, and the effective treatment was delivered by a team with perinatal mental health expertise who applied a family systems approach. As noted in the previous chapter, several parents spoke to the connection between their own dysfunctional childhood and their own worries as a parent, although this has not been stressed in the larger body of research on

PPD. In retrospect, Julie felt this was her underlying issue all along. It appears that Julie's final team of providers, with perinatal mental health expertise, were more in-tune to this connection than were the hospital-based providers. In the end, Julie benefited from professional mental health treatment, although it was a long and frustrating road.

Some parents benefited from professional help outside of the medical system, primarily, support from early childhood educators and similar professionals. For example, Brandon and Susan G. were connected with Healthy Families, a program that provides diverse supports for "at-risk" families, broadly defined. The Gs received home visitors who focused on parenting skills for healthy child development, with the idea that this could help address Susan's concerns that she was incompetent and did not know what she was doing as a mother. Susan felt that she was already in recovery by the time she received this support, but she and Brandon still found these services useful. A few families received support from Tiny-K, a service that targets families with children who have physical or developmental delays. This included Desiree's family. Desiree could not afford mental health services, as addressed above, but valued the support she received from Tiny K:

I really like our Tiny K worker. She does really good with our kids. She never really acts critical of our parenting. She actually really encourages us and tells us how good we do and stuff like that. She gives advice on things, but she doesn't try to tell us what we need to do. She just says, this is something you might try to help out this situation. And it's usually me asking her for the advice too.

This service was especially valuable for Desiree because she grew up in a dysfunctional family and had family members who criticized her parenting style, as mentioned in the previous chapter. Tiny-K helped her dismiss bad parenting advice and to feel better about her own skills as a parent. Although Tiny-K does not provide mental health treatment, these home visits also reduced this family's isolation in the face of Desiree's severe social anxiety. Effective therapists also focused on the parent-child relationship and helping parents identify strategies for feeling more competent as a parent, as demonstrated by Linda:

[My therapist] talked to me a lot about how I was feeling and I remember really talking about my anxiety of that hour, hour and a half, that I'd be home with [baby], what to do? And she talked about menu-planning.... It just seemed so silly to think I didn't even know what to do with my child for an hour and a half before my husband comes home to help me.... And one of the things she had me do is she had me write down all the things that, brainstorm things that we could do together. Read a book, take a walk, play with blocks. I mean, just simple things like that, which were, it seems so silly thinking about it.

Julie J.'s final team also met with Anthony to provide more of a family systems approach, which he found useful for his own mental health as well. Although these parenting suggestions and affirmations may seem obvious, as Linda noted in retrospect, depression and anxiety made it difficult to be rational when solving even seemingly small problems. Therefore, these professionals played a very important role in helping distressed parents manage their fears and concerns, and therefore, also in improving their mental health as they regained feelings of control and competency. Further, these examples illustrate that effectively treating perinatal mental health is not limited to medical authorities or strategies that focus only on the "patient" as an individual.

Breastfeeding and Mental Health

In light of the number of mothers who were depressed or anxious due to breastfeeding difficulties, how do medical professionals balance treating breastfeeding difficulties with mental health? According to the mothers in my study, the answer is not very well. The professional discourse and literature focuses primarily on providing mental health treatment that allows for ongoing breastfeeding, including calls for safe medication options (e.g. Fitelson et al 2011). This is important, but unfortunately, there is not a lot of attention being given to the reverse scenario, that is, addressing breastfeeding difficulties while also acknowledging and supporting mothers' mental health needs. This skewed balance is apparent in professional discourse, and mothers also spoke of having their mental health glossed over as they were working with professionals on their breastfeeding difficulties, as demonstrated by Susan G. and Jill I, respectively:

I think probably erroneously so in that very first appointment, I focused so much with her (doctor) on my disappointment at the breastfeeding going so poorly and obviously she focused

on the problem at hand and maybe overlooked the fact that depression wise I was also kind of struggling.

I also was very, like at first, no pacifiers, no bottles, I was really hardcore. I wanted it to work.... And I went through the whole entire laundry list of things and even the lactation consultants who tend to be like I'm going to get you to breastfeed no matter what – at least that's I think they were, the goal is breastfeeding, it's not help for the mother.... Most of the time you can still make it, figure out a way to get through it. I could not get through it.

Not only may healthcare professionals be ignoring mental health troubles when addressing breastfeeding difficulties, the pressure they exert to continue breastfeeding may exasperate these struggles, as shared by Natalie:

I feel like my doctor helped with adding that stress because talking about making sure you have breastfeeding classes and make sure you're going to breastfeed and when you get home don't do anything but breastfeed that baby. It was just constant and then all of these other moms that I'm friends with that have breastfed and are huge advocates for it. And all the studies that say that it's better. You have this baby and want to do everything right, I mean, every mom wants that for their kid.

In some ways, low-income women may have felt more pressure to breastfeed by healthcare professionals. Even a mother who chose to pump and bottle-feed her daughter, rather than directly nurse due to past sexual abuse, but was continually pressured to actually nurse by her doctors. Others felt intimidated or manhandled by lactation specialists; for example, LeAnna shared:

I think it (breastfeeding difficulty) was maybe I was so tense and so stressed and then also the lactation nurse in the hospital, she was very intimidating and basically it made me feel like I was stupid for not comprehending how and what to do and I was afraid to ask.

Perhaps middle-class mothers are believed to have more intrinsic motivation to nurse and therefore do not need to be pressured as intensely by professionals. There are concerted efforts to focus breastfeeding campaigns on low-income women who are seen at more “risk” of using formula (USDA 2004, Wolf 2011). Yet, this pressure is also consistent with the larger pattern of low-income patients being more controlled and given less choice in healthcare systems, that is, the activity-passivity model (Friedson 1970). LeAnna's experience demonstrated the patronizing side to breastfeeding education. “Breast is best” is now part of the ideology of good motherhood, and therefore, lower rates of breastfeeding among low-income mothers is a deviancy that must be corrected.

Of additional concern, the only lactation medication available in the U.S., Reglan, has a side effect of depression and anxiety. A couple mothers in my study were prescribed this medication without their doctor discussing its mental health risks. This included Miki, who had her concerns about depression dismissed, as addressed above. It is concerning that not only did her doctor dismiss her depression symptoms, the doctor also seemingly did not recognize that she prescribed a medication that may have made Miki's condition worse. Miki learned of this danger through her own research, and felt significantly better after discontinuing this medication on her own. The other mother, Susan, also only learned of this risk through her own research.

As discussed in the prior chapter, the social pressure to breastfeed as well as the rigors of getting it to work was very distressing. Several mothers, including Susan, Jill and Natalie, quoted above, discontinued breastfeeding. The informed decision to quit breastfeeding demonstrated these mothers' agency and provided mental health relief, but they then felt the guilt and judgment for not giving their child "the best," as reviewed in the prior chapter. Middle class mothers often consulted with their child's pediatrician before making this decision, who assured them that their mental health was an acceptable reason to use formula and that their children would still be healthy. Thus, medical authority was important for legitimizing this decision but is also an interesting contrast to the public health pressure to nurse in the first place. In light of the patronizing medical pressure experienced by the low-income mothers, as just described above, it's worth asking whether low-income women would be granted the same permission to quit as easily. Low-income mothers did not report actively discussing this decision and their options with medical authorities; rather, they withdrew from consulting medical professionals in the face of patronizing care. Middle class mothers are more generally seen as more responsible parents and health care consumers, and therefore may be seen as better trusted to make breastfeeding or formula decisions and thus granted doctor's permission more readily. More research is needed to explore class differences in medical authority and breastfeeding pressures more specifically. While many

mothers felt better after no longer breastfeeding, other mothers felt better when breastfeeding finally did start working. As such, breastfeeding support was beneficial. However, a single-minded focus on breastfeeding at all expenses was not helpful for mother's mental health.

Attitudes towards Medication

The help-seeking experiences shared above have already touched on mixed experiences with medication. For example, some parents did not seek help because they did not want medication, some parents did not do well on medication, where as other parents benefited immensely from psychiatric medications. Medicalization theorists are concerned that diagnoses leads to an unnecessary reliance on medication as a quick solution to life problems, and also find that pharmaceutical companies have a strong profit motive in promoting new diagnoses (e.g., Conrad 2007). These concerns are well-founded, but my study reveals that lay patients do not blindly accept medication as a simple solution to their ills. In fact, the parents in my study were very skeptical and cautious about the role of psychiatric medication.

The most common concern about psychiatric medications was that these individuals might become addicted or dependent on them. This was a very experiential concern, rooted in either their own past experiences with medication or seeing family members with addiction problems. In not wanting medication for his depression, Scott shared:

I seen my mom go through that process and, I don't know, I just didn't want to be on medication to be honest with you, I just would rather find a way to deal with myself and you know and find a way to really pinpoint the problem, not necessarily medicate it... I know how that stuff is, once you get on that stuff it creates other problems and then you're stuck on that medication, and then maybe that medication isn't necessarily the right medication and then they switch to another medication. I guess I've seen my mother go through this process for years, and I just don't want to get caught in that loop.

Similarly, Stacey accepted medication in the hospital to address her panic attacks, but was very quick to wean herself from the medication:

I just don't want to become dependent (on medicine), it's my family history.... There's various research, all kinds of statistics that say addiction is hereditary and I do not want to.... I weaned myself off of them and now I'm leaning on therapy.

Another mother discussed her own history of abusing medication:

I absolutely did not want to medicate at all.... I actually abused the medicine tremendously. I would look up disorders and medications that are used to treat it and get prescribed it. I was pretty horrible as a teenager.... I don't, not that I would be afraid I would do that again, but I just don't feel like I ever really needed them probably in the first place because I used them incorrectly anyways.... I don't think the medicine did anything but probably, I mean I was still depressed, I was very depressed as a teenager and the medicine was just recreational to me.

In addition to concerns about dependency, some parents noted that they did not like how they felt when they were on such medication before— that they were not themselves or it made them foggy.

Regarding her past experiences with mental health treatment, Robin stated:

After I'd been on the medication and I hated what I turned into, because I was basically a zombie on the medication and I hated how I felt and I knew I could push through it, things just had to change.

These direct negative experiences with medication provided strong resistance to medication even in the face of doctors who were quick to write prescriptions and direct-to-consumer pharmaceutical marketing.

Some parents had concerns that aligned very closely to medicalization critiques. This includes that medications in general are over-prescribed, and further, an awareness of the link between diagnosis and medication. Recall from Chapter IV that Thomas is concerned about over-diagnosis and over-medication, due to seeing the ADHD diagnosis being over- applied in the school system. Likewise, Sabrina H. works in the human services field and has drawn similar conclusions about diagnosis and over-medication:

I have a hard time figuring out what's depression and what's just generally just feeling, you know, down and out.... I kinda think that sometimes antidepressants and the psych drugs are overprescribed sometimes. I mean, some people genuinely do need them, but I've seen some clients come through, they just drug them to death. They're basically a zombie sitting there slobbering in the chair. Ok, this is overkill. They're not that bad off. So I have, I think I have hesitations just in general about that.

Others noted that medication may make you feel better, but will not really address the underlying problem, as stressed by Ben I.:

Potentially there's an answer, it doesn't mean you medicate everything.... It's (medication) not a copout, but it's also not a, it doesn't solve everything. It could mask what you're feeling right now, but there's an underlying source, kind of thing.

Nonetheless, most of these parents felt that medication can be useful if it's really needed, but should be taken with caution and generally not until other approaches have been tried, as we saw above in Alyssa C.'s quote about her unsatisfactory consultation with her OB. The decision to accept medication was sometimes a very difficult one to make, for all the reasons highlighted above and also a belief that parents were weak if they were unable to get better on their own, as demonstrated by Jill I.:

I think at the time I still suffered from the misconception – I'll say that because I feel completely different about it now – that it was a sign of weakness to need to be medically treated. I think I still, and here's the thing, I had been through my undergrad in psychology and very focused on, I kind of poked in adolescent psychology a little bit but also very interested in community based mental health. And so looking back I'm like, why, and I've learned enough about all medications and, you know, took my drugs and brain and behavior courses and everything ... but still harbored this feeling that there was something wrong with me, that I was unable, incapable of overcoming it myself.

Likewise, Dylan really struggled with his decision to take anxiety medication, which was made only after also trying in-depth therapy and numerous self-help strategies:

I remember him (mental health provider) saying, 'You know, look, anxiety is like high blood pressure, there are people who can control it using exercise and kind of more social means, psychotherapy, type things but then there's those who need medication to control it.' He made it move from being something's wrong with me, like I'm crazy, you know, that type of thing, 'Look your body is not producing enough chemicals to regulate this.' And then also, you know, [worried that it is] kind of a crutch. I just remember, this is after, you know, Prozac and all that stuff was so popular in the late 90s and so it was like, I just feel like they were throwing a pill at everything, and I didn't want to be a part of that. And that I was somehow weak, it would be a crutch, I would be, there's something wrong with me, I'd be a weaker person if I took medication.

Although they were hesitant to begin medication, it did help and in retrospect Dylan, Jill I., and other parents found that medication was critical to their recovery. In accepting medication, some parents stressed that medication was a short term tactic, which helped them break the cycle of negative

thoughts and in turn helped them focus on taking care of themselves or making lifestyle changes. For example, LeAnna B. advises:

I don't like taking medication on a ritual basis.... You don't have to be on them the rest of your life, just maybe to help you get over what you're going through and that issue.... Get on medication even if you don't like it, do it for a little bit. It really does help, I think. It helped me at least.

Thus, even the decision to take medication was treated with caution.

Some parents found that they will continue needing medication to help manage their mood, a conclusion typically drawn after attempting to discontinue their medication only to find themselves getting depressed or anxious again. These parents then also adopted new mental health identities, feeling that they probably have a more persistent mental health condition rather than just a prenatal or postpartum condition, as reviewed in Chapter IV. Recall the story of Dylan, who received his first official diagnosis of GAD and took medication only after exhausting other strategies. Dylan tried to quit his medication, but high anxiety returned and he learned he needs to tweak his dosage in response to other stressful life events – not just becoming a father. In thinking about his overall mental health history, Dylan ponders, “I don't know if I changed because of it (becoming a father) or it kind of brought everything to light.” These parents spoke of ongoing mental health management, rather than true recovery. For instance, Jill I. had a significant mental health history with periods of severe depression. Yet, she had this under control and well-managed several years before entering parenthood. Jill thought she was completely recovered, and, in fact, was irritated by her mother's suggestions that she should be on guard for PPD. She was hesitant to seek treatment and begin medication, although it ultimately helped. Jill shared that she has since experienced additional periods of depression:

So I went off of it (medication) and did ok for a few months. And then ... everything came crashing back and I was like, “Oh, it's not only postpartum.’ You know what I mean? I think I realized at that point that there was more to it. That yes, what I had suffered from was definitely postpartum depression, but that the reason I suffered from it was not just hormonal and just postpartum, it was [also a biological tendency towards depression]. So anyway, I had a really, really, really dark time again when he was two. Then I did go to a psychiatrist and I've been seeing that same person.

These parents remain on medication, but still demonstrate active agency and control by experimenting with their regimen and continuing to engage in self-help techniques.

In sum, parents who sought professional help had mixed experiences. Many benefited from professional help, but some had their concerns dismissed or received inappropriate treatment. Although medication is widely available, parents were generally cautious about taking it. It is striking the extent to which these parents were active agents in their mental health care, although this is consistent with the erosion of hierarchal medical authority and the rise of consumerist models of healthcare (Bury 1997). Patients have more access to medical information, including alternative viewpoints, with the internet and self-help groups. This includes perinatal mental health advocacy discourse, which helped prepare parents for an active role in the mental health management. However, patient agency was not always exercised in direct negotiations with healthcare providers, but seen in how distressed parents acted behind the scenes. Their self-education on perinatal mental health helped inform their decision to seek care or not, and also in how they framed this issue with their doctor. Many received the care they expected, but those who were not satisfied chose not to comply with their doctor's orders, sought a different provider, or looked more into self-help strategies. In contrast to non-compliance as a problem that must be corrected (e.g. Parsons 1951), these parents acted with agency and held nuanced understanding of their needs in the context of their larger life relationships (e.g., Conrad 1985; Stimson 1974).

Further, professional mental health treatment was never viewed as the only path towards getting better by the parents in my study. I now turn to the non-medical approaches, including social support, self-help, and life changes that also helped parents get better, either in combination with professional treatment or in lieu thereof.

Disclosure and Social Support

Distressed parents widely spoke to the value of social support, which included both emotional support and practical help with the baby. They were generally grateful for and satisfied with the support they received from their friends and family. For example, Stephanie attributed beginning to feel better to her support network:

Just knowing that I have people around that'll help me, that I can call my stepmom or my best friend. That [friend] will help us with [baby] whenever she can. Just stuff like that. And that I can go to [my husband] anytime I need and just talk.

Likewise, Andrea shared:

I was able to talk to people about what was going on and they were supportive... and that helped too because some of the women had gone through similar situations. And just them supporting me and praying with me and offering to help with baby, and just loving me.

To secure help and support, distressed parents first needed to share their troubles with others. Mental health conditions are usually invisible, although close friends and relations may notice the person is not themselves. Yet, as an invisible condition, distressed parents typically had the option to pass, cover, or disclose their emotional troubles, and thus, exercised a great deal of control over the potential stigma of perinatal mental health conditions. Distressed parents widely engaged in selective disclosure, in which they identified people thought to be helpful and understanding based on prior patterns of support, as shared by Shelley:

I only confide in people that I know that actually can help build me and that have the faith that I have, honestly. I choose not to share things with people that they don't understand how I believe and so they'll try to twist me to think something different or negatively and that's not who I am. We have to be an equal understanding, where I am, what I expect, so. That could be family members, friends, whoever. I just won't come to you if I know that you don't have anything positive or you're not going to be steering me in the right direction.

Spouses were the most commonly cited source of useful support. However, it was sometimes difficult to provide support to each other when both partners were struggling. In this instance, husbands sometimes covered their symptoms as to not further distress wives who were viewed as having an even more difficult time.

Partners did not always have the same understanding of mental health and support needs, as was seen above in the example about the Bs. LeAnna shared:

No communication, support and understanding on how I felt and what I needed. I was just a mom. I didn't feel I was important to anybody else, I had my baby that was the first thing, and nobody cared about how I was doing mentally and physically... It (talking to husband) backfired and it became this big drama, argue and fight and it would turn around and make me feel like I was wrong for feeling this way.

However, her eventual PPD diagnosis helped leverage more support and understanding from James.

Partners generally stepped up to the plate when their spouse was receiving mental health treatment, going above and beyond to provide extra help and support. A few mothers, however, did not benefit from such support. Recall that Miki's OB told her that she was normal, although she felt she had PPD.

Miki was disappointed in her doctor's response:

I felt like I was overreacting because doctor is saying it's normal, but I wanted, I think I was expecting her to say more like, 'Oh you need help.' And if she listed some, any things that need to be done like taking medication or maybe husband needs to be more involved or something like that I could tell my husband, 'Oh doctor says this and this, so you have to do this.' But since she said it's actually normal my husband didn't have to do anything else because it doctor approved my condition.

Miki was not satisfied with the emotional or practical support she received from her husband, and felt that the PPD label would help her leverage more support. Indeed, medical authorities legitimize illness.

The sick role mandates that the patient works towards getting better, with proper care and support (Parsons 1951). In this case, it potentially provides relief from the expectation that mothers should do most, if not all, caregiving labor. However, Kristi received a PPD diagnosis, but her boyfriend did not provide more help with their daughter but rather accused her of misusing the diagnosis to seek attention.

Perinatal mental health advocacy websites focus in great detail on how spouses can support their loved ones and help with their recovery. Many mothers benefitted from increased social support in light of widespread awareness and mutual understanding about maternal PPD. However, awareness of

paternal PPD lags behind maternal PPD, and therefore, so was correspondent social support. For example, Kevin D. shares his experience with disclosing his condition to his mother:

When I told my mom about what I was going through, she said, 'Well it sounds to me like you're a new parent and you're going through that stress.' And I think it's more than that. I think it's much more than just being a parent and being responsible for new things. It's a lot more complex than that.

Interestingly, Kevin's wife Lydia was also skeptical of the diagnosis although she was outwardly supportive. Overtime, she came to see the utility of expanding the PPD diagnosis to men:

Now I'm on board and more supportive, I guess. Because his mom was like, 'Well, we just call that being a new dad. We don't call that post-partum blah, blah, blah.' Hearing all about it I do respect [father] a lot more for having the guts to go and get it taken care of.

Distressed parents also widely noted that other parents were an important source of emotional support, as they best understood what they were going through. But to be certain, they avoided parents who seemed to be perfect, as noted by Jill I.:

My mother-in-law was not useful... She also compared me to Ben's sister a lot, who had four kids. And would be like, [sister-in-law] just felt like she never had any of that stuff going on, she never had any kind of depression and da, da, da... then I also remember with the breastfeeding... I had been through so much with it, that when I decided that it was the healthiest possible decision for myself and my child for me to stop doing this...she just kind of dismissed it as that I didn't like it, so I quit.

Men generally felt it was more difficult to connect with other fathers and to discuss such feelings among each other; whereas mothers felt the super-mom façade and competitiveness sometimes limited their opportunities for social support.

Another barrier to asking for help was the belief that parents should be able to handle this on their own and that their children were solely their responsibility. For example, when I asked Jeff H. if he could ask anyone to watch the baby when he was feeling stressed out, he replied:

To tell you the truth I don't think the thought crossed my mind. I think I was just kinda under the impression that ok, I, we chose to have [baby], this is just what we got to do. I mean, even if we're stressed out or whatever. I don't know if I thought it was going to be a reflection on us...I don't know if it was just I was afraid of judgments or what it was. But I never, I guess I didn't like really feel comfortable with asking for help.

Likewise, Shelley discussed learning to ask for help:

Most times I think as new mothers we want to feel like we can do it and we don't really need the help of others because I don't know, for some reason it must make us feel incompetent. I don't know why, but I've seen a lot of people, well they just want to do it themselves. They don't want to ask for help. If you need someone to come over while you take an hour nap or a two hour nap, just open your mouth and ask. I think that's pretty hard.

Parents felt that sharing their struggles with others or asking for help would be admitting failure. This attitude reflects our individualistic culture, as well as the nature of isolated nuclear family units in which the responsibility for raising infants largely falls on individual parents. Again, the super parent pressure is relevant, as noted by Kara E.:

I think the pressure to be a professional working woman and to be the perfect mother or all in, the, to be a primary care giver, because it's not [easy]. You have a village... and it took me awhile to be ok with that... I have other people in my village that are helping me raise my child and that's ok.

There was a general sense that the stigma associated with mental health is not what it used to be, but still present. A common misperception is that mothers with PMADs are highly prone to infanticidal or suicidal behavior. While this is true in rare instances, the media blows this out of proportion by focusing on the most tragic but sensational cases – Andrea Yates and Miriam Carey, for example. Further, popular news stories often do not distinguish between PPD and psychosis. Thus, many women felt the need to stress that their depression was not that severe, or in cases where depression was that severe, to downplay or cover such symptoms. For instance, recall that Susan experienced multiple hospitalizations. She never thought of harming her baby, but she wanted to give her daughter up for adoption and experienced suicidal thoughts. While Susan is now largely open about her experience with PPD and even shares her story publicly, she initially would not disclose that she was hospitalized or wanted to give her baby up for adoption:

I think I just posted something (on facebook) like, ' I'm going to be honest with my Facebook world that post-partum depression is the scariest thing I've ever had to deal with.' And it was amazing the kind of support that I got. Not just from close friends but from work friends and acquaintances. Like I said I didn't go all the way and tell very many people about how bad it was, and that actually was a challenge, I think. It's a challenge to tell people you're struggling, but

then not to be able to tell them how much you're struggling.... But then to not then say to someone, 'Oh well what can I do or tell me more about what you're going through and how I can help,' to not be able to say to them, 'Well I want to give my daughter up for adoption.' I couldn't, you don't say that to someone, because no matter how supportive they are, they're going to think you're crazy. So in a way I think the social support was helpful, but also a double-edged sword.

As already addressed above, others felt that if they disclosed that they had, or possibly had, PPD then others would assume the worst and worry about the safety of their baby. This stigma revolved less around the presence of a mental health condition and more about the stigma of being a failed mother. We can see that Susan embraced the PPD label, but long covered her most severe symptoms that could call into doubt her capacity for motherhood.

Similarly, the stigma of being a bad mother extended to disclosure of breastfeeding struggles. Jill I. was a particularly interesting case, as she was a strong breastfeeding advocate due to her professional background in public health. Jill felt she could not turn to her closest friends and colleagues for support with her PPD as her inability to nurse was so central to her struggles. Her decision to quit was largely beneficial to her mental health, but her friends subscribed to the "breastfeed at all costs" mindset. These mothers were careful to justify why they could not breastfeed, as explained by Kara E.:

[We] must give our children breast milk at all costs and, no, I don't think so. If it costs us our mental health, no. And I knew this all rationally, but I still just felt horrible and guilty and believed at the time, I would let other people know, like when I was making formula it's like, 'My breasts don't work.' Make sure people knew because I didn't want to be viewed as a bad parent, I guess.

Kara explains to others that she uses formula due to her physical incapacity to nurse although her mental health was also key to the decision to stop pumping. The ideology of motherhood also points to the all self-sacrificing mother, thus a mother's own mental health could be a suspect reason for not nursing. These mothers instead disclose their physical problems with breastfeeding while also stressing their diligence in trying to make it work. To be certain, trying to make it work was also exhausting and therefore drained their mental health, but to admit this may imply that they did not try hard enough and did not sacrifice enough for their child.

Fathers felt a similar stigma regarding the implications of a mental health condition for meeting their social responsibilities as a partner and father. Take for example, the opposite reactions received by Thomas and Shaun, respectively, when they brought up their emotions with their wives:

I remember one conversation we had late at night after a particularly stressful day and I sort of opened up and I said, 'I hate the fact that I'm about to say this, but I don't like her (baby). I just don't like her.' And I think I said at the time, 'I know it's going to stop, I know it's not forever, but I do not like her.' And she (wife) was very nice about it. She could have flipped out there and really gotten upset herself, but she was good about it.

She's (wife) gone from being somebody who I can tell anything to and I can admit to weakness and therefore work through it to a certain extent, to being somebody that I am almost scared to tell some of my weaknesses to. When I went through the six months after the baby was born, I would regularly be crying in the kitchen, in the bathroom, I would cry on the train to work, I would cry in the office, I'd cry everywhere. I'd cry when she'd gone to sleep, but I wouldn't let her see because the most important thing was she didn't see me falling to pieces. And it's still true today.... She was talking to me and she said that she thought that I needed to kind of get out and do more and be more kind of jolly and what's up with me? ... And I sort of tried to explain to her how upset I'd been and she basically just said, 'You gotta pull yourself together and get over it.'

It can be difficult to reveal that one is actually struggling with parenthood and may even regret having a child to the person they chose to start a family with. Whereas Thomas's spouse was understanding and encouraged him to seek professional help, Shaun lost an important confidant in his wife. Other fathers chose to not bring their feelings up with their spouse at all because they felt they would not understand, and that their reactions would only make the problem worse. Again, it was not depression or anxiety, per say, that was most stigmatizing, but the possibility of being viewed as a failed husband or father. Of course, a mental health condition itself also compromises the masculine identity, and we can see that although Shaun was clearly depressed, when he attempted to discuss it with his partner, he was essentially told to man-up. This aligns with the general stigma of needing help in a society that valorizes independence and self-sufficient families, which, as noted above, was a reason some parents did not ask for more practical support.

Postpartum psychosis, experienced by Emma, is another story altogether. This diagnosis is not well understood, even among professionals. Popular discourse often associates psychosis with suicide

and infanticide. This is a real concern, and awareness campaigns want mothers to get help before these tragic outcomes occur. Nonetheless, the desire to harm self or others is not always present, and is a very stigmatizing symptom. Recall that Emma was not suicidal or infanticidal, but rather, experienced paranoia that led to hyper-vigilance about her son's safety. The manifestations of delusions and hallucinations experienced by mothers with postpartum psychosis vary widely, although delusional behavior in general is not well understood and the stigma is perhaps akin to that associated with schizophrenia. Emma shared:

I don't talk about it. I found out very early on... I'd get a pretty dramatic reaction.... It's pretty rare for me to bring it up, because it's very hard for people to relate with what I went through.

Clearly, feelings of not wanting your child, having to be hospitalized in a psychiatric unit, or experiencing delusions are experiences that are not well understood by many.

I have highlighted many barriers to seeking and receiving social support, although most parents ultimately found and benefited from social support. Since recovery, many parents have more widely shared their stories in hopes of helping others get the support they need and also to help break down the stigma surrounding these conditions, as shared by Linda:

I decided I needed to share with other people about my depression and I told friends because I thought, you know what, people have a lot of issues in their lives... and it's so important for us to share and to realize and try to help with the stigma of this, that it's ok and that's part of life. And I remember thinking that when my kids get older, I'm going to tell them about me having depression after they were born.

A few parents have spoken publically about their experiences, such as at local schools and universities, at early childhood education conferences, or had their stories featured in the local newspaper. Further, several parents shared that they participated in my study in hopes of spreading awareness and improving support for perinatal mental health.

Self-Help

Several parents noted that you have to take care of yourself, which includes self-care activities like good hygiene, diet, and exercise, as well as getting me-time and still doing the things one enjoys.

These activities helped restore identity and provided a sense of normalcy, as observed by Shaun:

So I had week away from my baby and my wife. And that week was... enough for me to find a bit of a sense of myself again. And it was just silly things. I did a bunch of cooking. I did a bit of mucking about, I did some writing.... It gave me a sense that somewhere under all the rubbish there is a fraction of myself still existed. And so that kind of, to believe that I hadn't been completely erased was enough for me to kind of think, ok, there's a bit of me in there

Me-time and hobbies also provided a much-needed break from the demands of infant care, as shared by

Jeff H.:

I'll just go outside and run and put on the headphones and blare some music. I mean, that's just been a really good, I guess, coping mechanism for me or whatever. It's just a way or shedding yourself of all responsibilities and anxieties and just get outside your own head for a little bit.

For LeAnna, exercise gave her both a sense of control and a break from family responsibilities:

I started going to a gym and exercising and that really did help. And then I quit exercising and then I started going back into a depression again.... The losing weight and then the knowing that I did something productive to keep myself healthy and afterwards of the feel that I succeeded in something and I did it and I was proud of myself... [a sense of] control, and also a little bit of free time. I didn't have no screaming baby, no husband, I had my time.

While self-help techniques may seem obvious for coping with mental health stressors in general, for PMADS, the need to care for oneself was not always so apparent. Emma shared, "That was difficult because I was used to putting myself last and that became even more of a [problem]." As demonstrated in the previous chapter, parenthood is seen as all self-sacrificing, especially motherhood. Therefore, it's difficult to recognize the need to care for oneself, as noted by Shelley, "You kind of let self go away. You don't really pay attention, focus on yourself, kind of lose yourself to focus on everything else, everybody else."

The connection between PMADs and child wellbeing helps draw attention to the need for parents to take care of their own needs. Generally, parents reported that they had to take care of themselves for their baby, but one mom, Jill I., identified a problem with this widespread belief:

I hope they are taking it (PPD) really seriously. Because the health of a mother and the health of a father are the most important things to the health of a kid. Not that it's all about the kids, but you know, that's funny because I think that's the major motivator. You treat women with postpartum depression because it's better for their kids so that they're healthy, but isn't it also better for them as people because they're human beings too?

As noted by Jill I., the wellbeing of the baby should not be the only reason to take care of oneself. While perinatal mental health diagnoses are important in helping parents recognize their own needs and allowing them to make time for themselves, these diagnoses also draw a boundary between parents experiencing mental health symptoms and “normal” parents who are seemingly performing the self-sacrificing, super-parent role with little problem. These diagnoses then have a contradictory aspect, in which they call attention to the need for some, but not all, parents to care for themselves, therefore suggesting that this is a unique need for mentally ill parents only. However, in providing recommendations to other parents, these parents widely stressed the need make time for yourself from the beginning.

Life changes

Parents identified a number of life circumstances that contributed to their perinatal mental health symptoms, as reviewed in the previous chapter. Their awareness of social factors in turn pointed to changes they needed to make in their life towards improved mental health and satisfaction with life. Not all life stressors were in their control, but marital relationships was an area where distressed couples could exercise agency and work on improvement. And to the extent possible, they also worked on addressing stressors related to the family-work balance.

Relationships – Fix them or Leave Them

During the transition to parenthood, several parents questioned whether their marriages/partnerships would last, however, most of them worked out their issues. Alex shared:

I can put it like this, up until recently I did (worry about divorce). And after a couple of conversations I no longer do.... And then all of a sudden there's this horrible, horrible weight off your, like my heart literally hurt for a while and that was taken off.

Again, their children provided a very strong motivation to work on relationships, as demonstrated by Shaun:

I think it (marriage) will [last]... There's a lot of good stuff in there...There's no way that I would break up with my wife now that we have kids. I don't want to even think about going there.

Generally, fathers feared becoming a non-residential parent; whereas mothers were hesitant to become a single parent and also desired a father-figure in the home.

Co-parenting with limited time and energy was difficult, as shared in the previous chapter. In many cases, relationships simply needed time so that parents could eventually catch up on sleep and exercise patience with each other. Renegotiating gender roles and expectations took more active effort, and as touched on in the previous chapter, was a stressful process unfolding through marital disagreements, fights, and strained communication. In the end, however, parents usually found common ground and came to share the work more equitably or to better understand and appreciate each other's roles and responsibilities in light of larger work and family contexts. Jeff H. shared:

Somewhat of a realization I had to come to as a father and husband, think guys too often think about, well my mother's house was never this dirty when we were growing up and whatnot. And I guess having too high of an expectation or whatever, where mothers in the past they might not have had to work... Yeah. I had to learn to let certain things go. I mean, if the house is just a total wreck, you just gotta let it go. Both people are doing the best they can or whatever to stay on top of everything, so... I mean, it's, some days it gets aggravating or whatever because just as a man you kind of feel emasculated a little bit that you're having to vacuum and do all these domestic chores or whatever. But, I mean, it's just one of those things you gotta take a step back and say, look at the bigger picture.

These renegotiations were often based on a shared committed to gender equity and co-parenting, as stressed by Kevin D.:

We were sharing [housework] before, it's been a value for us since day one of being married is... we didn't want to have the traditional roles of husband and wife and I think it's been something that's kept us very happy and satisfied with each other....the other big challenge for dads is, we carry on this life before baby that, we get into that routine and if we're creatures of habit like I thrive on routines... and so coming home for me after [my son] was born it was kind of like coming home every other day ... But eventually Lydia was just like, 'Kevin, just check in with me when you get home.' ... So it was nice for her to do that in a non-confrontational way.

Lydia was very upset that Kevin was not helping enough at first, but their shared values and open communication helped resolve this issue. It was generally mothers who kept advocating for more involvement by dads, and fathers who had to work on doing more around the house or with their baby. Interestingly, in contrast to the few mothers who used, or attempted to use, the PPD diagnosis to leverage more support, these mothers were more direct in advocating for more help on the basis of egalitarian values and the health of their relationship. Although it benefited their mental health as well, it was not negotiated in these terms. As such, these negotiations set the tone for what was expected of co-parenting and marriage in general, rather than as a temporary measure to address an acute illness.

Although most couples worked out their problems, others did not. A few mothers left unsupportive or dysfunctional relationships, but only after their attempts to get more support from their partners failed. Gerson found that many young women today report a preference for being single over accepting a traditional relationship (2010). Likewise, mothers in my study were unwilling to remain in traditional, dysfunctional, or otherwise dissatisfactory relationships. Financial dependence and the desire for a two-parent family made this choice very difficult, as demonstrated by Kassie and Robin, respectively:

He was just dragging me down. But I felt like it's my duty as her mom to try and make it work with her dad. I wouldn't do it to the point where it would be hazardous to her or anything like that. But you know I at least owed it to both of us to try.

I had to think about [my daughter] and what was best for her. And all along I thought that it was better for her to be together with him (her father), but that's really not what was healthy.

The decision to become a single-parent was not taken lightly, and rather reflected careful consideration of what was really best for their baby and themselves. Although a very difficult decision to

make, once made, mothers reported instant improvement to their mental health, as demonstrated by

Kristi:

I didn't start to feel better until me and him split. I finally felt like a weight was lifted off. I think that mostly had to do with it.... Oh I was happier. I loved it because I was like I could be who I wanted to be and I didn't care.

Their focus on the importance of a healthy relationship for their child is consistent with Edin and Kefalas' (2005) research on poor single mothers, in which they put motherhood before marriage. These mothers rationally weighed the benefits of a two-parent family against the drawbacks of their dysfunctional relationships.

In addition to the mothers quoted above, Stacey, Andrea, Madison, and Nicole also left their dysfunctional relationships. Jack's relationship also ended, when his child's drug addicted mother abandoned them, rather than a conscious decision on his part. In contrast to the couples that made it, those that ended were not built on a strong foundation or shared gender ideals to begin with. They could not fix their relationships, so they instead left bad relationships for the benefit of their mental health and their children's futures.

Difficult Career Choices

The family-work balance was very stressful, although active solutions in the work sphere were often difficult to implement. Recall the contradictory impact of work on perinatal distress, in which working outside the home was also very rewarding. Thus, even though some parents found that combining work and family was just too overwhelming, pulling back from work was a difficult decision. A few parents, however, ultimately made this decision in an effort to gain more balance in their lives, as indicated by Elizabeth:

And I was a pretty good teacher and I wanted to be there and do things and be there, the extra things. But then I couldn't because I was taking care of [sick baby], which is obviously more important, but I just felt like I wasn't doing either job as well as I could... And on the one hand I knew that it (quitting) was the right thing because I knew I needed to be with [my son]. But it just was also - I just didn't want to do my job not as well.

Like many other parents, Elizabeth felt that she was not performing well as either an employee or parent. Emma, Linda, and Giles also resigned from their positions. Linda and Elizabeth felt they made the right decision for their mental health, but they then also experienced guilt and identity loss because their careers previously meant so much to them, as shared by Linda: and Elizabeth, respectively:

I remember being in the laundry room and thinking, 'What have I done? I have quit my job, oh my gosh.' Like, kind of my identity. And it was.

Elizabeth also misses her career and bemoans not applying her professional degree, and noted that she needs to "figure it out sometime."

Emma also experienced some mental health relief, but ultimately still had serious mental health problems that were not diagnosed for another three years, as illustrated above. Giles was the only father to leave his career in an effort to improve his mental health; in particular, in hopes of bonding better with his daughter. His long hours were certainly draining him, and his wife and others suggested that he was avoiding family life by working so hard. However, Giles did not really feel any mental health relief by quitting his job. Although he does not regret leaving this particular stressful job behind, it did not help his depression. He is now considering re-entering the workforce, but looking for a job with normal hours. While medicalization is criticized for promoting simple, individualized solutions over more difficult changes, these cases call into question whether better mental health management may help avoid drastic life decisions that are later regretted.

Low-income women also quit their jobs when unable to establish job-family compatibility, but they then experienced the stress and stigma of becoming even more impoverished. Whereas middle class parents felt they were underperforming at both work and family, low-income parents did not stress feelings of incompetency but rather concerns about how poor work environments interfered with their ability to parent or that parenting demands made it impossible to keep inflexible jobs. For these women, quitting work was a temporary measure, rather than a permanent lifestyle change, as they continued to seek more family-friendly employment.

For many other parents, low-income and middle-class, leaving a stressful job was not a realistic option. For example, Samantha spoke of her unfulfilled desires to be a stay-at-home mom:

I would like nothing more than to be a stay at home mom. I would love to just keep a nice home and raise a happy family. I feel like that's, it's not easy, it's stressful, but I feel like if I'm home and can be there for my husband 100% that it would be easier. Like I'm working now for the first time in, and I absolutely hate coming home exhausted at the end of the day and trying to take care of him and his needs and the home and all the, the second shift.... I mean, I want to raise my children. I hate having my child now in daycare more than anything. I just want to be home with him.

Samantha would have benefited from more help from her spouse, but mothers in more equitable relationships also sometimes desired this option. Others would simply like more flexibility to explore other career options. For example, Alex had been planning a change of careers, involving some financial risk. This was no longer possible after expecting a son:

And one other thing that's probably really important in this that right before we got pregnant I was planning to quit my job and go off on my own or look for another job in [a craftsman] industry. And then when you got pregnant, there really wasn't much of a discussion about my quitting my job.... And I resented that a lot. I resented the fact that I tried so many times to leave this place and focus on something I really wanted to do and now I couldn't do it because now I've got this kid and this kid is kind of a ball-and-chain.

Financial need tied many parents to their jobs. However, to the extent possible, parents minimized work responsibilities and tried to not let work spill over into home life, as shared by Shaun:

I kind of let [work] go a little bit.... I try and do it as well as I possibly can and I try and take, there are other people that rely on me and I try to make sure I do everything that I need to do. I'm not someone who naturally slacks off. So I do feel quite guilty about it and I know that there will be periods in the future where I can't do that.... The work one is a very big stressor.... Because I know they're only going to be young for a certain amount of time and it's, it won't be money that I miss on the deathbed.

We can see Shaun was also contested in regards to his work commitments. On one hand, he was confident that family is more important than work, but on the other hand, he was also worried that he is not completely meeting his responsibilities as an employee.

In contrast, there were those who thought they would be a stay-at-home parent, but discovered that working was actually the better option for their mental health. For example, Julie shared:

My whole life I had wanted to be a stay at home mom. And that was the plan, for me to stay at home with her and not work outside the home at all.... Because I felt like being a mom and raising children is the most important thing in the world. And it's not that I don't think that now, I just know there's more to it. It's not so black and white.... Not working was more stressful than working, because working is where I could get away. I wanted more work. Because being at home with her and more of an at-home mom was more stressful than working.

Unfortunately for Julie, she lost her job in the face of extended absences resulting from her severe and not-well managed PPD. Losing her job delivered another blow to her mental health, which she described as her low point. However, after she started to get better she found a new job which also helps her maintain her recovering mental health. The desire to return to work for their mental health was not unique to mothers. As we saw in the previous chapter, Kevin D. and Thomas also decided to go back to work after initially trying stay-at-home fatherhood. For example, Kevin was overwhelmed by full-time work and school, but when he was laid off and had the opportunity to stay-at-home, still felt breadwinner pressure. He then found a part-time job, which he noted led to a major improvement to his mental health, "as a much more manageable load to bear."

Parents adjusted their work responsibilities to the extent possible, although structural barriers such as workplace policies and expectations, the availability of alternative jobs, and economic need constrained their agency in this area. Many parents simply had to adjust to new time pressures and their expectations of the family-work balance.

Time and Adjustment

Many parents noted that it simply took time to adjust to the realities of parenthood. Interestingly, the suggestion of "just give it time" is commonly seen as an insensitive response to mental health struggles, but for those who were not experiencing severe symptoms time really was sufficient. Further, even those who benefited from professional mental health treatment still often noted natural improvements that occurred with time.

The saying goes that time heals all things, and for perinatal mental health, the number one thing that time healed was sleep. Parents commonly tied the timing of their improved mental health to the

same time that their babies began sleeping better. Another key healing factor of time is that as babies get older, they gradually become easier to care for and also more interactive. During the earliest weeks, parenting feels like a thankless task, with no real feedback or reward from the baby. As they begin to smile and play, parenting became more rewarding and parent-child bonds grew, as shared by Alex:

It's much, much better and for several reasons. One of them is that you just kind of fall in love with the kid. There's nothing you can do, they're so damn cute. And they start doing silly little things and they like you and they look up to you somehow. They think you're cool. And then they're just cute, they're funny.... that's one of the reasons I feel better, just because I started liking the kid. I really didn't like him at first at all.

More interactive children also gave parents very important feedback that they were, in fact, good parents. Elizabeth also shared how her son's first smile was a key moment towards feeling better, "He started smiling then, like actual smiling... and I remember that day, that being so exciting that he was actually doing something."

Also with time, parents simply become practiced and therefore more confident that they knew what they were doing, as noted by Natalie: "I think just time. Like the more time I got used to taking care of her myself without [my husband] there, it got a lot better." Samantha added, "Just feeling more confident having the baby... just getting kind of into the swing of it." With time, expectations of parenthood changed, typically towards letting go of idealized expectations as informed by their lived experience. Parents came to accept that they are not perfect, but their babies are still happy and thriving, and therefore, they are still good parents. Linda shared, "To say that I'm not a supermom and it's ok not to be, I'm still a good mom. And I think I came to realize that I am a good mom." Likewise, parents simply adjust to the new demands on their time and their multiple responsibilities no longer seem so overwhelming – they have survived so far and things keep getting a little better day by day. Further, parents slowly gained time for themselves and begin restoring their previous identity.

Unresolved Distress

Most parents felt better, or well on their way, at the time of our interview, but a few were still struggling. This included a few mothers who were not able to access the mental health care they desperately needed. For example, Desiree knew she needed treatment, but simply cannot afford it on their single family income. Her anxiety is particularly bad, and prevents her from leaving her house which in turn isolates her children and limits her ability to draw on community resources. She would like to attend parenting classes, but is crippled by the thought of being in a room full of strangers. She would also like to get a job to help her family out financially, but again, this is not possible with her severe anxiety. Desiree is caught in a vicious cycle in which she does not have enough money to treat her mental health, but her untreated mental health conditions prevent her from earning money. Caitlyn provides another example, and she was uncertain if her mood problems were strictly a mental health condition or also impacted by her untreated polycystic ovarian syndrome; she cannot afford treatment for either. Likewise, several parents also had physical health problems they could not afford to treat, and sometimes interfered with their ability to parent. At this time, 22 states have still not accepted Medicaid Expansion through the Affordable Care Act (Kaiser Family Foundation 2015), leaving our poorest citizens without any affordable health care options under the new law meant to provide universal coverage.

A sociological understanding of perinatal mental health makes it clear that professional mental health treatment is not always sufficient, in and of itself, for resolving distress. Although parents actively tackled their life problems, some problems were simply beyond their control – primarily, poverty. As shared by Laurie:

The way that I feel and have felt all along is that my bipolar's like this constant, right now, it should be right in the middle because I have the proper tools that should take care of it. I have the behavioral techniques that I do, I have medication that's effective, I have a psychologist...I can keep it here if I do the things that need to be done. But there's all these other things coming at me from other directions -- that make me not be as successful as I need to be with the bipolar.

These other things include unreliable employment, multiple residential moves, and general income insecurity. Erica felt that while she came out of depression with the support of her family and church, the life circumstances leading to her depression were just as difficult as ever:

I find myself thinking about the past sometimes now, but I gotta shake it off. I mean I'm not going to stop thinking about a lot of stuff until I'm out of this hole, until I'm up out of here, until I have a degree or I have a career. I don't even like saying a job anymore. I need a career. I need some stability.... It's hard. The main thing is it's hard when you can't get your kids what they need, let alone what they want. That's the hardest part.

America has high poverty rates compared to our peer nations. Our individualistic values lead to blaming the victim, although sociologists have long pointed out the structural roots of poverty including neoliberal economic policies. These parents have a strong work ethic and their children provide a strong motivation to succeed, but face limited opportunity and insufficient resources for escaping poverty.

Some relationship problems also remained, primarily cases in which spouses were not providing satisfactory support, but the relationship was not dysfunctional enough to risk new problems posed by a break-up. For example, Isabella and Samantha still want more support and help from their husbands, but they also have their good times as a couple plus their spouses are involved fathers, even if in a more traditional sense. These two mothers feel their relationships will ultimately make it, although two other mothers had more serious doubts about the long term status of their relationships. Although still dissatisfied with their relationships, the decision to become a single parent or take their child away from a residential father remained a difficult one to make.

Finally, one older middle class father was still severely depressed at the time of our interview, because he still did not want to be a father. He did not intend to be a father, but felt the social responsibility to be present and was actively involved for the sake of his child, although it has been literally just an act. He concluded:

Where you're looking at something and you can't actually understand why you don't get any benefit. And that something is a child. And even in my work previously I used to get a benefit, an emotional benefit. And I don't get that. I used to get it, but I assume in a way that was on my

terms. So am I being pathetic and just shake myself out of it, and I've tried that many a times. Limited moments of joy.... All I can describe it as is that switch that supposedly is there, isn't.

Therapy, medication, job changes, nor time have led to him to feeling better or actually enjoying fatherhood. He refers to the switch that is not there, presumably a fatherhood instinct. Our society valorizes having children. Choosing to be child-free has become more accepted, but still carries stigma. But to already have a child and want to be child-free would not be widely accepted. Thus, this father was also cut off from emotional support, which while this would not change the fact that he is a father, it may be helpful to have someone acknowledge the legitimacy of his feelings and just being able to talk about it.

These parents' stories demonstrate that there is not always a "cure" for perinatal mental health problems, but that accessible, affordable health care, addressing poverty, and expanding family planning options could go a long way.

Parents' Recommendations

In light of their experiences with perinatal mental health symptoms, what do these parents recommend for dealing with this problem? Participants were asked for their thoughts on both preventing their type of perinatal mental health condition, as well as what would help those already experiencing a similar condition. Some parents doubted whether these perinatal mental health conditions could be prevented, as noted by one mother, "I don't think there is anything to help prevent what they're experiencing in the first place. I think what we could do is help treat it when it does come up, because there are treatments," or another who shared, "Hmmm, in my case it would have been hard to prevent it completely because of the chemistry side of things."

Parents who entertained the possibility of prevention largely focused on being prepared for the transition to parenthood. However, this message was primarily to be prepared to be unprepared, in that you do not really know parenthood until you actually experience it and that it could turn out very different than expected – as shared by Kristi: :

As much information they know to prepare themselves, that might help... (but) you can be over-prepared. I've known a lot of people, you can be over-prepared for something, and when it happens you don't know what to do. Because I think I had a friend like that, that she read everything you're supposed to read, and did everything you're supposed to do, and when that baby happened - Phew. And it was nothing like the book said.... It's like as soon as that baby's born, you have no idea how, I mean, if you're not a parent, yeah, there's no way, just ride what's going to happen.

As such, parenting books and stringent parenting philosophies were not the recommended path to becoming more prepared for parenthood. These parents suggested that prospective parents not hold a specific image of what parenthood will be like, and when it comes to learning parenting strategies, be prepared with some resources and ideas rather than embracing specific parenting approaches. Susan G. shared advice she recently gave to an expecting friend:

[My friend] was talking about her experience with her doctor and how she would bring her iPad with questions and her doctor seems to be giving her jabs about how over prepared she is and that kind of thing. She had shared some stuff on Sunday night about her family background. So I, it's funny I had actually emailed her today to just say, 'Just be prepared to not have the control that you think you're going to want, or that you're preparing yourself to have.'

Many parents thought that talking to other parents about their trials and tribulations may help, but not with those who are alarmist or have strong advice on what parents should or should not do.

Some parents felt that marital relationships could be better prepared for the arrival of a baby.

Caitlyn wondered if this could have prevented many her stressors:

I think communication is the number one thing because [my boyfriend] and I never really talked about a schedule or sharing responsibilities. It just, they just assume it should be because I'm a stay-at-home mom.... So I think just before a baby comes just talking about who's going to do what and I think assigning certain roles, and just communication.

Some parents suggested marital counseling before having a child -- similar to the idea of pre-marital counseling, but pre-baby counseling, to help open up these lines of communication and establish shared expectations about shared responsibilities.

Some parents said to do your own thing while you still have a chance, while others said to go ahead and begin giving up your leisurely time now. They also stressed the importance of new parents taking care of themselves and prioritizing at least a little time for themselves, from the beginning rather

than waiting until they become distraught. A few parents also suggested finding key social supports ahead of time, in regards to both those who will help with the baby and those who can provide emotional support, because you may not have time to identify such supports later or feel bad asking for help when already distressed.

Only a few parents pointed to larger social changes by way of prevention. Jenna F. spoke of the need to get rid of the competitive, super parent culture:

Oh, and letting mothers off the hook a little bit, instead of having this idealized 1950s interpretation of motherhood. Which, you know, we talk about how we've kind of let women off the hook for that, but if you actually look at the cultural frames that we have for that, we still have it. We're still expected to be June Cleaver, just with a job.

A few other highly educated mothers echoed this sentiment. A few low-income mothers pointed to the need for real resources for meeting the material needs of a new baby, as well as opportunities for families to escape poverty, as suggested by Bethany:

Well, like they used to say, it was a village that helped take care of a child, now it's just all on you. Nobody wants to help anymore. You have to go through all these hoops and jump through all these different things just to get a pack of diapers for your child. Society thinks you should be able to do it all on your own, but society doesn't provide the things that you can do. They're taking jobs from us that help us provide for our children and then they get mad at us because we can't get the jobs. So I think that's one of the biggest problems is not being able to get the help that we need to provide.

In regards to their recommendations for parents already experiencing mental health distress, awareness was the most widely offered solution, in order to help parents seek help as well as improve the quality of help received, whether from medical professionals or informal social supports. Although everyone has heard of PPD, parents felt a more realistic understanding of this condition was needed rather than a focus on the extreme. And while better awareness of PPD risk factors may be helpful, parents also stressed that people should know it can happen to anyone. Brandon G. noted, "It was something I didn't expect to happen to Susan. In hindsight it might have been obvious." Julie suggested:

Maybe the prevalence, knowing that maybe it happens to more people than you and it can happen to anyone. That's the thing. It doesn't have to be because you're in a bad marriage or

because you're not with the father or because you have financial problems or because you're young or old or anything. I mean, it can happen to anyone

Improved awareness of the lessor known conditions, such as paternal postpartum depression or postpartum psychosis was also stressed. Kevin D. noted:

It's hard to find post-partum depression resources that are aimed at dads. Because typically it is more just moms that do that, that go through that. But I can't imagine some of the more unspoken things about parenthood, you wonder how many men have gone through things like this, but they've just not acknowledged it or they've not known that it's possible for them to go through some sort of post-baby delivery depression. I think it's because you don't hear about it a lot and because there's that sort of stereotype of well dads don't go through depression, they just are having a weak moment and they need to man up sort of thing. I think that dads would do well to learn that there are other dads out there that have gone through this.

Likewise, participants feel that awareness of paternal mental health can help men talk about their struggles, especially in a society that often denies men's emotional needs.

Several parents stressed the importance of willingness to seek mental health and that you need to be your own advocate until you secure the help you need. There were many concerns that mental health care was not accessible enough and that better treatment options for perinatal mental health were desperately needed. Many mothers advocated for regular screening for PPD by OBs, as some did not initially recognize their symptoms or had their concerns dismissed by their doctors with no real investigation. The value of informal support was also stressed, along with the concern that people keep their problems to themselves or are hesitant to really talk about any struggles with parenthood. Andrea advised, "You have every right to feel all these emotions. It's not bad if you feel them.... Reach out, as hard as it is." Parents would like to see more opportunities for new parents to support each other. This was especially noted for fathers, as men do not have as many close emotional supports and, further, few people are asking dads how they are doing. Finally, new parents stressed the need to be willing to make changes in your life, and again, drawing on your supports can also help in this regards. Again, more structural solutions were missing when asked how to address existing distress, although a few mothers stressed the need for health care coverage.

Conclusion and Discussion

Parents implemented a wide variety of solutions to improve their mental health, including addressing the underlying conditions that strained their mental health. They exercised a great deal of agency in choosing to seek professional mental health care or not, and also in identifying and implementing other solutions. Although medicalization is a form of social control, these parents exercised control based on rational, experiential assessments of their situation. They were flexibly attentive and responsive to what they were feeling, and also gauged the options available to them within their larger life contexts. Their responses ranged from not seeking any mental health treatment, at all, to accepting new mental health identities which will lead to a future of mental health care.

While it is tempting to conclude that the parents who took medication were simply drugging their problems away, this would not be a fair conclusion as no one relied on medication, alone, to fix their problems. They accepted medication with caution, and also implemented self-help techniques or made difficult life choices, and sometimes medication helped provide the clarity of mind needed to focus on these other solutions. Parents were not interested in medicating their emotions, per se, but only when their emotions became debilitating and interfered with their ability to function.

Although these “illness” narratives demonstrated resistance to medication in many ways, they did not escape the power of medicalization altogether. In particular, we can also see the individualizing power of medicalization when parents shared their recommendations more broadly. The skepticism surrounding prevention among some parents illustrates a very medical view of these conditions, as something that just happens to bodies and minds, rather than something that could potentially be prevented through social reforms. Further, the popularity of improved awareness is a solution that aligns well with the medical view of perinatal distress. Awareness campaigns assume that these perinatal mental health conditions are real, and primarily focus on medical solutions, improving illness behavior, and self-help rather than larger social critiques and reforms.

Nonetheless, we can see that improved awareness is still needed, even if it is not a cure all. Although the presence of these conditions as a distinct diagnosis is debated, the promise of the postpartum depression diagnosis is that it can help parents seek and receive the help they need, as well as provide treatment that is sensitive to the unique concerns and needs of new parents. The narratives of the parents in my story indicate that this promise is not fully realized. Even when looking only at PPD, the most well-known condition, several mothers did not get the professional help or informal support they needed. Thus, improved awareness is not needed just to improve illness behavior among parents. Indeed, we saw that distressed parents made well-reasoned decisions about the management of their condition and, further, often acquired greater expertise on perinatal mental health from self-education than what they found from the providers they consulted. Rather than patient behavior, problems more often lied in the availability and quality of care. This included structural barriers, such as affordability of care, but also providers who did not have the knowledge and capacity to provide perinatal sensitive care. Yet, awareness campaigns typically target consumer behavior rather than provider education.

Inadequate care was also rooted in narrow bio-medical understanding of the condition, in which medication was offered as the easy solution but this was not always appropriate. Further, parents often received mental health care that focused on them as individual patients rather than a family-systems approach, and the role for non-medical professionals was limited but useful. Finally, the focus on severe cases of PPD contributed to inappropriate care, as some doctors dismissed less-severe cases and mothers themselves felt the stigma associated with extreme cases. Enhanced awareness of the diversity of perinatal mental health conditions, including both the range of severity and condition types, is needed to fully realize the benefits of mental health diagnosis. Further, an improved focus on primacy of psycho-social risk factors over biomedical risk factors would improve the availability of holistic care and support, while also better calling our attention to social changes that could help prevent and reduce mental health problems during the transition to parenthood.

VII. Conclusion

My dissertation study drew on interviews with a class-diverse sample of 47 new mothers and fathers with perinatal mental health symptoms to examine lay understanding of these conditions and highlight the role of social factors. Perinatal mental health conditions, especially PPD, may not be distinct conditions after controlling for common mental health risk factors; however, in the everyday lived experience, these parents' stories demonstrate that the birth of a child is a circumstance that often brings together these risk factors. Parenthood, itself, is a major life change and often accompanied with marital changes, financial stress, and sleep deprivation. Caring for an infant is difficult and a major new responsibility, on top of existing roles and responsibilities, primarily employment. Further, it is a very important and valorized role, surrounded by high yet contradictory and shifting cultural expectations. Thus, in everyday lived life, mental health distress during the transition to parenthood is very real. In the face of these stressors and resultant emotional troubles, parents held diverse and nuanced views of their condition and how to best handle it.

I begin by reviewing the sociological significance of my study to medical sociology and feminist scholarship. In this section, I also draw out the limitations of my study and future research needs. I then turn to the implications of my research for practice, policy, and social reform. Finally, feminist scholars stress reflexivity in research, in which researchers consider how their position impacts their research and vice versa. Therefore, I conclude with my reflections as a researcher, demonstrating how my research and own self co-evolved.

Sociological Significance

My qualitative interview study on perinatal mental health was unique in including both mothers and fathers, securing a class diverse sample, and recruiting on the basis of symptoms rather than diagnosis. I found that gender differences in experiences with perinatal mental health distress were far

more subtle than I expected. However, this was not entirely surprising in light of converging gender roles. Most of the parents in my study were combining caregiving and paid employment, as is typical in many modern families, and therefore, mothers and fathers largely reported the same stressors around caring for new babies, relationship adjustments, and the family work balance, all the while sleep deprived. These parents were also widely committed to shared, egalitarian gender roles, but experienced frustration and marital tension when trying to implement these ideals in practice. They are the first generation to adopt non-traditional gender roles so widely, and are doing so with sparse policy supports. There was a tendency to fall back on traditional gender roles when parents felt overwhelmed or in the face of structural barriers, with fathers emphasizing breadwinning and mothers prioritizing caregiving.

Further, mothers and fathers experienced different caregiving pressures. Mothers face very high expectations, and therefore felt disappointment and guilt when they failed to reach these unrealistically high expectations. The ideology of motherhood has come to include breastfeeding expectations, which led to frustration and disappointment when breastfeeding was difficult. Mothers often heard that “breast is best,” but difficulties of breastfeeding were not well acknowledged and moms often felt pressure to breastfeed at all costs. The deflated high expectations of motherhood were especially true of middle class women, who often questioned if they were good moms.

Fathers are increasingly involved as caregivers, and while our society often applauds this development, the father caregiver role is still not clear nor adequately supported by society. Fathers spoke of insufficient role models and limited social support. From employers to medical professionals, their roles as involved fathers were not fully recognized. Further, fathers’ breadwinning pressures remained, and were perhaps even heightened by the insecure economy. However, the ambiguity of fatherhood had a contradictory effect on mental health. On one hand, they were definitely stressed and frustrated in trying to figure this all out, especially when it led to marital tension. They often proceeded

through a process of trial and error, while also taking cues from their spouses. On the other hand, however, fathers rarely questioned if they were good dads, and rather, felt that they were better than many absent or disengaged fathers that surround them. Thus, the multiple fatherhood roles available and unclear standards were also advantageous in protecting a sense of strong self-worth.

The class differences were much more stark and apparent, although my study was limited in examining class differences among fathers due to small sample size. Low-income parents struggled on a daily basis to make ends meet and provide for their children. They languished in dead end jobs that typically did not offer family friendly scheduling or benefits. Low-income women were not immune to feelings of being a failed mother, yet, the ideology of motherhood was less salient to their narratives than were daily life hardships. Poor mothers may have been less inclined to obsess about ideal motherhood when they were hustling to meet their children's basic needs. However, this pattern also reflects different expectations of control and success. Whereas middle class women were accustomed to success through careful planning in their education, careers, and marriages, low-income women were more accustomed to instability and being controlled by employers and welfare agencies. Thus, in comparison to previous life experiences, the unpredictable nature of parenthood or failure to achieve certain parenting practices was very unsettling for middle class mothers. In contrast, low-income woman did not appear to hold overly idealized images of motherhood in the first place, and mothering was relatively rewarding compared to their other roles and responsibilities.

Turning to the significance of my study for medical sociology and the social construction of health, my innovative sampling based on symptoms rather than diagnosis provided many interesting insights. Medicalization theorists are concerned that everyday life problems are being medicalized, and thus addressed as individual problems under the control of medical authority. However, these parents' stories demonstrate that many parents with mental health symptoms, which were consistent with clinical criteria, are actually very cautious in adopting medical labels. They questioned if they are

experiencing normal stress or something more severe, and took into account many factors within their larger life context. By and large, parents did not attribute their troubles to biomedical or individual factors, and rather, spoke of the difficulties of caring for infants, deflated parental expectations, relationship troubles, the difficult family-work balance, and struggles of poverty. Yet, most mothers felt that hormones played a role which speaks to the power of biomedical discourse on perinatal mental health, but only to a certain extent because they did not offer hormones as a simple solution as they also spoke to many life struggles. Yet, parents tended to focus on micro and meso level factors, and perhaps did not fully appreciate the extent to which other parents experienced the same struggles or the larger structural context leading to these troubles. In this sense, the sociological imagination was lacking, which reflects the individualizing nature of medical diagnosis as well as our individualized culture.

Many parents eventually embraced a mental health label, which helped them seek help and support, as other feminist researchers on perinatal mental health have noted. Interestingly, however, some parents accepted a mental health label while rejecting formal treatment, thus, naming a condition was also helpful for implementing self-help strategies or recognizing the need for life changes. Those who turned to professional help were active agents in managing their care, as informed by their own self-education about perinatal mental health. Parents often spoke to preferring therapy or trying self-help strategies before taking medication, which was generally only accepted with great caution. Parents engaged in selective disclosure, and were particularly careful to cover aspects of their condition that could cast them as a bad parent. Indeed, being seen as a bad parent was potentially more stigmatizing than having a mental health condition. Although all parents exercised non-medical strategies, such as informal social support, self-help, and implementing life changes, again, a structural consciousness regarding the potential prevention of perinatal mental health conditions was largely lacking. Interestingly, many parents shared the same concerns as medicalization theorists, but these concerns

were not rooted in academic theories, but rather, experiential understandings based on their own experiences or those of people they knew.

Research Limitation and Future Directions

My study revealed an interesting pattern in which some parents adopted new lifelong mental health identities after their perinatal mental health experience. I did not explore identity in great depth, but additional research should look at identity, disclosure, and stigma over time. Is the perinatal period a critical moment for reshaping mental health identities, as suggested by the few parents who indicated new lifelong understandings of their mental health? Further, a couple mothers indicated that they plan to tell their children about their PPD when they are older. It would be interesting to learn more about how parents reframe their narrative when disclosing a perinatal mental health condition to their own child.

Prior sociological research has been critical that biology or hormones have anything to do with postpartum depression. However, recent research suggests that hormones may play a role in some cases, as reviewed in Chapter II. Further, prolonged depression and anxiety does impact biomedical processes in the brain. Increasingly, both natural scientists and social scientists are investigating the interplay between nature and nurture, although sociologists are perhaps behind on this trend. Certainly, investigating biomedical processes takes us out of our comfort zone, in regards to both theory and methods. However, our viewpoints as sociologists will be essential for ensuring that social processes remain central to such analysis and not simply relegated to an after effect of biomedical or psychiatric processes. My study demonstrated the extent to which biomedical, hormonal explanations seeped into lay narratives, but was not designed to investigate the interplay of hormones and psycho-social risk factors from an etiological perspective. Nonetheless, PPD and other perinatal mental health conditions could provide an excellent case study for exploring nature and society interactions more thoroughly in future research. Certainly, however, hormonal causation has been exaggerated in the discourse

surrounding PPD, and it would also be interesting to track whether the expansion of the PPD diagnosis to fathers will strengthen or weaken presumed hormonal causation.

The hesitancy to turn to professional medical help as well as the active agency exercised by patients is consistent with prior research on lay epidemiology and illness behavior. More research is needed to better integrate medicalization theories, which tend to stress social control, with research on illness behavior with its emphasis on individual agency. My dissertation study helps contribute to this need, but this is a very complex theoretical problem that requires far more research. Perinatal mental health is a good case study for exploring this contradiction, but future studies of medicalized conditions would benefit from more systematically studying the interactions between expert opinion, popular discourse and claimsmaking, doctor-patient interactions, and illness behavior.

My study was biased towards fathers with gender egalitarian attitudes. Some of the low-income mothers who were included in my study as single participants spoke of partners who appeared to be more gender traditional, but such fathers did not participate in my study. My study was biased towards fathers who were sensitive to their emotional health, which also runs counter to the masculine stereotype. This is likely a direct result of my sampling, in which stoic men or those who were not comfortable discussing emotions would not be inclined to participate in an in-depth interview about emotional distress. Finally, I have noted the lack of class diversity among my sample of fathers, with only three low-income fathers who were not necessarily very representative. These sampling biases are a major limitation of my study, and impact my findings on both the gender and class based differences in perinatal mental health distress experiences as well as lay understandings on perinatal mental health. More research is needed on all facets of father's perinatal mental health, and future qualitative research should include masculine stereotyped men as well as more socioeconomic diversity. This may best be accomplished by a study design that looks more broadly at the transition to fatherhood, without requiring mental health symptoms or a diagnoses but still investigating mental health in data collection.

On a similar note, my study lacked sufficient racial and ethnic diversity for looking specifically at these patterns, and therefore, future research should explore the impact of race and ethnicity on everyday lived experiences with perinatal mental health struggles.

On a final note about my research findings and methodology, I often had a difficult time identifying clear sociological patterns. With 47 interviews averaging around two hours each, I was drowning in data. However, this was not simply due to the sheer volume of data, but also due to the unique and diverse nature of these narratives. Although recruiting on symptoms rather than diagnosis was a strength in my research design for exploring lay understandings of mental health and illness behavior, this introduced a lot of variation into my study in regards to the nature and severity of mental health symptoms. Gender or class differences may have been more apparent if the study was limited to participants with more homogenous mental health characteristics.

Yet, these diverse narratives are also characteristic of our postmodern society in which individuals increasingly have different life experiences and hold diverse viewpoints. This postmodern diversity was true of my sample of parents as well. For example, while most parents worked and were stressed by the family-work balance, their individual work environments and employer expectations varied widely. While these parents widely rejected traditional gender roles, their ideas and understandings of gender equity varied. Marital relationships were shaped by gender, class, and work, but also intimately impacted by each partner's personality, communication styles, and expectations brought over from their families of orientation. The discourse that surrounds perinatal mental health diagnosis is also diverse and contradictory. Certainly, larger social forces shaped parents illness narratives in many important ways, but they never determined them, and further, these patterns were best understood with the context of each parent's unique life context. Nonetheless, cross cultural research could help highlight how broad cultural gender patterns, poverty rates, and social and economic policies impact the occurrence and distribution of perinatal mental health conditions.

Social, Cultural, and Policy Implications

Often referred to as the most common complication of childbirth, most perinatal mental health conditions are more accurately understood as a complication of life or parenting. Although biomedical risk factors may have a role in some cases, the etiological evidence primarily points to psycho-social risk factors. My study further illuminated how parenting pressures and a paucity of social policy supports shaped perinatal mental health. With this in mind, implications for the culture of parenting include:

- Provide strong supports for nuclear families. Parenting is a difficult task, and parents have little prior experience with children and receive little support for raising their children in isolated nuclear families. Further, in our individualistic society, parents are hesitant to ask for help because they see raising children as their sole responsibility or fear that asking for help is a sign of failure. The need for support challenges the ideology of super parents, or the idea that individual parents can do it all perfectly and by themselves.
- Balance the needs of new parents with those of their infants. Parents have their own needs, and the belief that their children's needs always come first can lead to mental health strain when parents neglect themselves and their other relationships. Parents generally took better care of themselves after recognizing the potential for adverse consequences on their child due to their own mental health; however, a more balanced view of parental and infant needs from the beginning may help prevent perinatal distress.
- Recognize that fathers are increasingly involved in caregiving and also have emotional needs. They need practical and emotional support for their caregiving responsibilities, as opposed to the common assumptions that women are the primary caregivers and men are uninterested or incompetent in caregiving. Also ask Dads how they are doing.
- Temper parenting advice. Parents should be prepared to be unprepared, and take expert advice with a grain of salt. Advice is more useful when offered as a tool kit of things to try, as opposed to being sold as the best or only way to do something for the child's wellbeing. Recognize that there are many different ways to be a good parent, and trust that parents generally make good decisions for their unique situations.
- Support egalitarian families. Many young adults today desire shared gender roles and egalitarian relationships, for their own personal growth, mutually supportive relationships, and close bonds with their children. However, this is difficult to implement in practice. As a starting point for better supporting these desires, medical professionals, parenting experts, early childhood providers, and employers should treat both mothers and fathers as caregivers. Further, new family policies are needed to help parents better balance work and family, as further detailed below.

Policy implications include:

- Expand accessible and affordable healthcare. The Affordable Care Act (ACA) has the potential to remedy this problem, and ensure that new parents get the physical and mental health care they need. However, the Supreme Court ruling that Medicaid Expansion is a state option has excluded many poor citizens from the benefits of the ACA.
- Implement paid parental and sick leave policies. Mothers and fathers need ample time to adjust to parenthood and meet the demands of infant care. Unpaid leave forces parents back into work before they are ready, and the paucity of guaranteed paid parental and sick leave is out of sync with the reality of dual earner and single parent families. In light of the fact that many mothers and fathers who enjoyed returning to work and the reprieve it provided from parenting, it will be difficult to identify the best approach to paid parental leave. Flexible policies can help accommodate parental preferences, but can also fall prey to employer pressures and societal expectations, for example, a belief that fathers do not actually need paternity leave and therefore should not take it if optional. Graduated parental leave, in which parents ease back into work with reduced hours and responsibilities could help relieve family-work pressures while also providing the benefit of working outside the home.
- Expand safe, affordable childcare options. Quality childcare enables employment and also expands the village needed to help raise children. The paucity of affordable, quality care was a major stressor for low-income women, and also constrained their ability to work. This includes a need for childcare during non-standard hours, to meet the needs of parents working in the service economy.
- Eliminate poverty. Clearly, poverty increases the risk of mental health disorders, including perinatal mental health conditions. The poor are often blamed for their plight and viewed as being lazy, but most poor adults are working. This was also true of the low-income parents in my study, and those who were not working were in school or seeking work. Poverty is a structural problem, which calls for new economic policies, such as living wage regulations and progressive taxation.

Such social reforms are far reaching and often political. Although difficult to realize, such social change has the potential to reduce or prevent the occurrence of perinatal mental health conditions in the first place.

Practice Implications

These distressed parents participated in my study in hopes of helping other parents in similar situations and their illness narratives pointed to many ways in which perinatal health supports and treatment can be improved. Practice implications include:

- Expand awareness of the diversity of perinatal mental health conditions. Although it is worth questioning whether PMADs are truly distinct conditions, from a practice perspective, it does

not make sense to focus on only depression in prenatal/postpartum mothers to the exclusion of other conditions or fathers. Awareness should promote realistic understandings of these conditions, and not just extreme cases which can increase stigma and prevent help-seeking. The lay public needs improved awareness so that distressed parents seek help when they need it and also to improve informal social support by friends and family. Professionals also need better education so they do not dismiss their patients concerns.

- Improve accurate identification of perinatal mental health conditions. Screening can help identify perinatal depression and anxiety, but new approaches are needed to help identify other conditions. Postpartum psychosis may be especially difficult to identify, due to the lack of self-awareness. The postpartum check-up is not adequate for identifying perinatal distress that occurs during pregnancy or later-on in the postpartum period, nor among fathers. Therefore, family practitioners, pediatricians, child care providers, and other family service providers should help screen for perinatal mental health concerns or provide additional information to their clients.
- Enhance the availability of medical professionals with perinatal mental health expertise. This includes ensuring that medical professionals in physical health, such as OBs, family physicians, and pediatricians have sufficient knowledge of perinatal mental health to make appropriate referrals. In turn, more mental health professionals with perinatal mental health expertise are needed to meet this demand. In the absence of a clearly distinct etiology, the need for perinatal sensitive treatment justifies PMAD diagnosis however the shortage providers with sufficient expertise is apparent.
- Expand the community of experts who can help address perinatal mental health. Perinatal distress is often the result of feeling incompetent as a parent. Thus, early childhood educators and other family service providers can play an important role in providing realistic expectations of parenting and child development, and help reassure parents about their skills. This challenges the commonly accepted belief that a medical diagnosis is necessarily addressed by medical authorities.
- Promote treatment options. Some parents preferred therapy while others preferred medication, and yet others preferred to manage their symptoms outside of the formal mental health care system. Distressed parents may be discouraged from seeking further help if treatment options are not explained and offered. Many parents preferred self-help techniques and effectively managed their condition on their own, but self-help strategies should be promoted in a way that does not imply that parents should “just get over it.”
- Provide holistic mental health treatment, in which the providers takes the time to understand the individual’s unique concerns and life circumstances – past, present, and future. Medication and traditional therapeutic approaches may not address the unique fears and concerns of expectant and new parents. Family background and social locations shape parents’ expectations and concerns about their own family. Marital relationships and parent-infant bonding are also important. Therefore, a holistic approach may include a family systems approach. The ability to provide holistic care requires that more attention is given to psycho-social risk factors instead of the narrow focus on hormonal causation.

- Be more attentive to mental health when addressing breastfeeding difficulties, as breastfeeding regimens can be very physically and emotionally exhausting, and mothers question their competency and worth. Support breastfeeding but do not promote breastfeeding at all costs; rather, help mothers balance the decision to breastfeed with their own needs.
- Recognize that perinatal mental health conditions may not actually be limited to the perinatal period. In some cases, it is the unique circumstances surrounding pregnancy and childbirth that temporarily bring forth mental health risk factors. In other cases, these circumstances or heightened awareness of PPD make preexisting mental health symptoms more apparent. This, then, can provide a unique opportunity for reshaping mental health attitudes and behaviors throughout a person's remaining life course.

Although the PPD diagnosis is contested, it is unlikely to disappear and rather expansion of perinatal mental health conditions is more likely. The promise of these diagnoses is that they will improve help-seeking and effective treatment, and the recommendations outlined above can help realize this promise.

Reflections as a Researcher

Through the course of this project, I evolved as a scholar, reflected on my own parenting identity and experiences, and gained insights into my own mental health identity. As a researcher, I saw my focus shift from being primarily in the sociology *of* medicine tradition, in being very critical of the PPD diagnosis, towards appreciating the value of this diagnosis and therefore towards sociology *in* medicine. I attempted to combine these approaches, which was often difficult and somewhat precarious. However, it was impossible to deny the benefit of mental health diagnosis and treatment for many of my participants, as well as their need for improved services and supports. Yet, the individualizing tendencies of medicalization are still concerning, especially the prospect that nearly every parent could be seen as having a mental illness as these conditions expand. As a scholar, I also found myself moving in an interdisciplinary direction, in part because prior research on perinatal mental health is interdisciplinary, but also because I have landed in interdisciplinary, applied research in my own career path. It is easier to be a critic as an armchair theorist, it seems, than when one is actively involved in

trying to implement social and policy change. Further, I felt a strong obligation to respect my participants' wishes that their stories potentially benefit other distressed parents.

One of my early research participants, a mother, introduced me to a Postpartum Support International advocate who leads the local support group, who herself is a nurse and postpartum OCD survivor. Together with a few others, we founded a perinatal mental health task force intended to improve awareness and treatment for perinatal mental health. From a traditional, positivist approach, my participation in this task force, especially alongside one of my research participants, would violate norms of researcher detachment and unbiased research. However, feminists have countered that there is no such thing as unbiased research, and further, that activism and personal experiences can provide valuable insights into the social phenomena in question. Feminist scholars add that it is better to acknowledge and reflect on our position and biases as researchers than to ignore them. It has been interesting to find myself becoming an advocate for perinatal mental health when I was originally very skeptical that such conditions were real. I have an important role on the taskforce in stressing the social and cultural side of perinatal mental health, highlighting the research and actual evidence base, and advocating for policy change; but in no way consider my expertise as more valuable than the postpartum survivors or providers who have supported countless mothers and fathers over the years.

Our efforts are a labor of love in light of our numerous other obligations, and therefore our ambitions are often greater than the time and resources available. Nonetheless, we have highlighted the diversity of perinatal mental health in local media, provided education to early childhood professionals, worked to improve better identification and referrals with local doctors, and advocated for Medicaid expansion. Some of these efforts have been more successful than others. Our letters to the state legislature have fallen on deaf ears, and doctors have been very inconsistent in improving their practices to better serve parents with perinatal mental health concerns. For example, one disappointing discovery was that some doctors would prefer not to identify potential perinatal mental health conditions than to

have the responsibility and potential liability for ensuring that effective treatment is received. On the other hand, early childhood professionals have demonstrated eagerness to expand their knowledge and skills around perinatal mental health. My research combined with the expertise of my advocate partners point to many areas of potential improvement, but this experience has also demonstrated the difficulty of implementing even small changes that largely work within the existing system.

I also gained valuable insights as a parent researcher. Although I am confident I never experienced a perinatal mental health condition, I can still identify with the stressors and pressures of parenthood. My identity as a parent was beneficial in recruiting other parents and their willingness to disclose their struggles. During their interviews, parents often stated that only other parents can really understand the difficulty of being a parent. Certainly, my experience as a parent helped build rapport with my participants and gave me important insights into their stories. However, I also found it interesting how their stories led to me reflecting on my own parenting. For example, mothers would describe in great detail their intensive mothering and yet how they still felt guilty or that they were not good mothers. I would think to myself about how I never did half of what these parents do, but maybe I should be doing more and maybe I have not spent enough time with my kids and no wonder they are having such-and-such problems. I reminded myself that this is the problem with motherhood culture and therefore was able to distance myself from these anxieties, but these feelings still served to demonstrate how easy it is to fall into the trap of motherhood comparisons and guilt.

I also gained insight into my own mental health and more appreciation of the value of mental health diagnosis. I was happy as a new parent and can now see all the advantages I had – a healthy, wanted pregnancy; prior experience with infants; a healthy, egalitarian relationship; strong social supports; and basic financial security. But, this project helped me become more aware to the mental health toll that similar stressors have taken on me at other times. For example, the anxiety I experienced as the first person in my family to go to college and again when I was the first to leave my home state

and resettle hundreds of miles away. Or more recently, the mental health strain of trying to meet my life goal of earning my PhD, while life kept throwing me curve balls like I never experienced before, first with my spouse's lay-off, becoming the primary breadwinner while still working on my dissertation, my children's health and educational problems, and, already feeling depressed and like a failure for taking so long to complete my degree, the unexpected loss of my father.

I joke that I have Dissertation Depression and Anxiety, which while in jest, others are beginning to take note of the mental health toll of graduate school and academia, in large part driven by heavy workloads in a high-pressure, competitive environment (e.g. Fogg 2009). Even while I know that that my problems cannot be solved with a pill and are rooted in life circumstances, awareness of depression still helps me take better care of myself and reach out to key supports. So, while I was beyond happy when both of my daughters were born, these recent experiences helped me relate more to the mental health struggles of my participants and also contributed to my revised perspectives on the medicalization of emotional distress. To be certain, I do not think the pressures of graduate school are equivalent to the high expectations that surround parenthood, and especially the stigmatizing risk of being viewed as a bad parent, but the parallels still provided valuable introspection as a researcher and person.

Perinatal mental health is a fruitful topic for exploring gender, families, and health and illness. My study was the first of its kind to directly compare the lived experience of perinatal mental health across middle-class mothers, low-income mothers, and fathers. Their stories highlight that perinatal mental health distress is far more complex than often understood, and fundamentally shaped by social and cultural factors. My study was also unique in recruiting on symptoms rather than diagnosis, and thus revealed diverse understandings of emotional health and active responses to managing these troubles. These will be interesting trends to continue to monitor as the medicalization of perinatal mental health conditions expand.

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Appendix A. Recruitment Letter

Dear Parent,

My name is Carrie Wendel-Hummell. I live in Lawrence, KS with my husband, Mike, and our two daughters, Jazlyn (12 yrs) and Jula (5 yrs). I moved here from Waterloo, Iowa about 8 years ago to attend the University of Kansas as a graduate student.

I am writing you because I am looking for parents to participate in my dissertation research project. I would like to interview people who went through an emotionally difficult time when they had their first child. We know that becoming a parent can be very stressful, but researchers do not know a lot about how this stress is different for mothers and fathers. In my study, I want to better understand these differences. In order to qualify for my study, you should meet *all* of the criteria listed below:

- You went through an emotionally difficult time after your first child was born. For example, you had strong feelings of sadness, fear, anxiety, anger, or frustration.
- You were married to or living with the child's other biological parent when your first child was born. It is OK if you separated later on. (I will only interview you and will not contact the other parent. If the other parent contacts me for an interview and meets all these criteria, I might interview him or her separately.)
- Today, your first born child is 5 years old or younger.
- Today, you are 18 years old or older.
- You are either the biological mother or father.

If you meet the above criteria, I would like to hear your story. I will spend about 90 minutes interviewing you about what it was like to become a parent. I will ask you about the things that you found difficult and stressful. I will meet you a time and place that works well for you, this spring or summer. Your interview will be confidential, which means that I will not use your real name or your child's real name in my study. I also will not tell anybody that you participated in my study. I will pay you \$25.00 in cash for your time.

If you would like to participate in this study you can contact me at 785-XXX-XXXX or by email at cwendel@ku.edu. This is my personal cell phone, so if you need to leave a message/text it will remain private. If you have any questions about this research project you can contact me or my faculty supervisor, Dr. Shirley Hill, at 785-864-XXXX or hill@ku.edu. If you have any questions about research participant rights, you can contact Stephanie Dyson-Elms at (785) 864-XXXX, (785) 864-XXXX, or stephanieDE@ku.edu.

If you qualify for my study and would like to tell me your story, I look forward to hearing from you!

Sincerely,

Carrie Wendel-Hummell
785-XXX-XXXX (cell)
cwendel@ku.edu

(signed and printed on department letterhead)

Appendix B. Semi-Structured Interview Guide

[Fluff] Thanks for agreeing to talk with me. As you know, this study is about the experiences of parents who experienced emotional distress following the birth of their infant. I'd like to starting by asking a little about the child --

Probe throughout

Part A: Illness Narrative

1. a. Can you tell me a little about your child – boy or girl? What is their name? When was (child's name) born? Biological or adopted? How old is he/she now?

b. What was [child] like as a baby? (Contented? Colicky?)
2. a. How did you feel when you knew you were going to have/adopt [this child?]

b. Can you tell me about your pregnancy and birth experience? (normal or complications?)
3. Did you and your partner have any kind of preparation for becoming a parent? (e.g., Parenting classes, Previous experiences with children? Read books?)
4. Looking back, do you think you and your partner were adequately prepared? (*if no*: What could have been improved?)
5. Has motherhood/fatherhood turned out like you expected? How so? (or) Why/Why not?.
6. What do you think makes someone a good mother? (Define a good mother)
7. What do you think makes someone a good father? (Define a good father)
8. What was your family like growing up? (Do they reflect these images? Gender traditional or non-traditional? How does your background family shape what you want your family to be like (different/same)?)
9. Turning to the emotional distress you experienced – when did that begin? How old was (child's name)?

10. Can you describe how you felt during that time, to the best of your recollection?
 - a. *Listen for, prompt as necessary:* length of symptoms, specific emotions
 - b. Have you ever felt like this before? (If yes, probe for mental health history)
 - c. During [your/your wife's] pregnancy, did you ever consider that having a baby might make you feel like this? (-or- How did you think you were going to feel after the baby was born?)
11. Why do you think you felt like this? (What lead to your emotional distress?)
12. Was your employment status impacted by becoming a parent? How so? (such as quitting, changing hours, etc.)
 - a. *If employed at time of childbirth:* How do you combine work and family life? Were/are you satisfied with this arrangement?
 - b. Is your employer family friendly? (Flexible hours? Sick leave/pay?)
 - c. *If took parental leave (see demographic questionnaire for amount of time)* Do you feel you got a long enough parental leave? How did you feel about returning to work (i.e. relieved or regretful)?
 - d. *If not employed:* Do you want to be employed? (If yes, what kind of job do you need in order to balance work with family (hours, location, etc.))
13. Can you tell me briefly how you and your partner share: Taking care of baby? Housework? Paid employment? Was this different than before? Were you satisfied with this arrangement?
14. Do you feel financially secure? (Tell me more? –or- In what way?)
 - a. *If low income:* Do you receive any assistance from the state (TANF, food, healthcare, WIC, housing). Have you had any trouble getting the help you need?
 - b. If you had a financial emergency, for example an expensive car repair, would you be able to: Draw on savings? Finance it on credit? Borrow from friends or family?

15. How did becoming a parent impact your marital/partner relationship?
- Social/emotional support; arguments/fights
 - Couple time
 - Romantic intimacy/Sex life
 - If there were troubles:* Did you ever think that your relationship might not last?
16. What kind of help and support did you get from others in caring for (child's name)? (For example, if you're feeling stressed and need couple time or me time, do you have someone who would babysit?) Are you satisfied with this help?
17. I'm going to go through a list of factors that can sometimes cause stress. For each one, will you tell me if you think it also contributed to your [depression/anxiety/emotional distress/etc. – *use their language throughout*]? (*probe for yes answers – How so?*) (*skip any that already emerged in previous responses*)
- Being isolated from other adults
 - Loss of leisure time
 - Daily work of taking care of (child's name)
 - Mothers only, if applicable:* troubles with breastfeeding
 - Worrying about (child's name) health and safety
 - Bonding with (child's name) (*probe:* did you ever feel left out of the [mother/father] and child relationship?)
 - Daycare/nannies (finding good care, feeling comfortable that child was well cared for while you're at work)
 - Other stressful life events (i.e. – moving, job change, death/ill family members)
 - Troubles with other family relations
 - Hormones
 - Loss of sleep

Required Probe: Of all the factors that you've mentioned (*list*), which of these do you think were the most important?

18. What negative effects has your [depression/anxiety/emotional distress] had on you or your family? (i.e., parenting suffered, bad lifestyle choices)

Part B: Help-Seeking

19. How could you tell that you were [depressed/anxious/distressed]? (self awareness or someone else brought it to your attention)
20. Did you talk to anyone, at the time, about how you were feeling?
 - a. Who did you tell? What was their response? (Were they helpful?)
 - b. Is there anybody you would not want to talk about this to? (Or purposely hide them?) (Why?)
21. Did you seek any kind of help? (Did you ask anyone for help?)
 - a. What kind of help? (*Listen for, probe:* Professional? Family? Informal?) How did that go? Did you receive the help you sought/needed?
 - b. How did you know you needed this help?
 - c. (*if not already brought up*) Did you ever consider medication? Therapy?
22. Where did you get advice about caring for your baby?
 - a. *Listen for, probe as necessary:* Magazines, books, doctors, family, friends, parenting classes, websites (*get specific titles or websites if possible*)
23. When did you start to feel better?
 - a. Why do you think you started to feel better?
24. What do you think would help to prevent other new mothers/fathers from experiencing [depression/anxiety/distress] in the first place?
25. What do you think should be done to help other new mothers/fathers who are already experiencing [depression/anxiety/distress]?

Part C: Postpartum Depression (PPD) Cultural Attitudes

If PPD has emerged from the parent during interviews:

26. You mentioned postpartum depression earlier in the interview. Where did you learn about postpartum depression?
 - a. *Listen for, probe if necessary:* friends, family, websites, magazines, books, medical professionals (*If they mention websites or literature, see if they remember the exact source; providing a list of popular sources if necessary to help job memory.*)

27. What do you know about postpartum depression? (What would you say are the basic characteristics of postpartum depression? (or) What are the most important things about postpartum depression that new mothers/fathers should know about it?)

28. *If parent already indicated that she/he had or may have had PPD:* How do you know that what you experienced was postpartum depression? (Why do you think you had postpartum depression?) *(If mother/father has mentioned PPD, but has not suggested that she/he had PPD, skip to question 28c below).*

If PPD has NOT been brought up by parent in interview

29. Have you ever heard of postpartum depression?

30. *If no, and not previously brought up:* Do you think you may have had any other mental health condition, such as depression or anxiety? *(do explain PPD out of courtesy, and note any reactions of thoughts about the diagnosis)*

If yes

- a. Where have you heard about PPD?
- b. What do you know about it?
- c. Looking back, do you think you may have had PPD? Why or why not?

If the possibility of fathers having PPD has not emerged.

31. Do you think fathers can get PPD? Why or why not?

32. Some researchers and doctors are saying that men can get PPD. Do you think it would be helpful to treat fathers for PPD, if they are showing symptoms? *(Adapt this question for those how have heard of PPD)*

To conclude

33. Thinking generally, not just about your own experience, what do you think are the biggest challenges that new mothers/fathers face in today's society?

34. Those are all of the specific questions I have:

- a. Is there anything else you would like to add about your experiences?
- b. Do you have any questions about my research?

Thank respondent for their time. Ask if they'd be willing to accept a follow-up call or meet again if I think of any other questions.

Appendix C: Analytical Tables

Table A4. Overview of MH Diagnoses or Other Labels, to compliment Ch. 4

Participant	Diagnosis/Label		Mental Health History	Comments
	Professional Diagnosis	Self-Diagnosis		
Couple Participants – Low-income				
Randall A.	Increased management of pre-existing anxiety	Accepts anxiety diagnosis, but also believes depression was present, possibly paternal PPD	Anxiety and Panic disorder since childhood. Recovering alcoholic.	Also received an ADHD diagnosis during this period related to employment troubles
Laurie A.	No new diagnosis, but proactive treatment for PPD due to pre-existing bi-polar	Bi-polar and anxiety flares up during postpartum “more difficult to manage”	Bi-Polar disorder; Anxiety	
James B.	None sought	Possibly depression, and definitely out-of-the-ordinary	None	
LeAnna B.	Postpartum depression	←Same; also had PPD with second child.	Depression as a teen	
Couple Participants – Middle Class				
Cory C.	None sought	Heightened distress, probably not depression but not sure	Depression as adult; recovered alcoholic	Postpartum distress did not feel as bad as previous episodes of clinical depression.
Alyssa C.	Prenatal depression, possibly (see comment)	Prenatal depression; postpartum: Increased stress (i.e. baby blues); later experienced PPD with third child.	Depression during puberty	Did not receive an official diagnosis, but OB offered depression medication
Kevin D.	Paternal Postpartum Depression	← Same (he asked Dr. about this)	None	
Lydia D.	Postpartum Depression	←Same	In retrospect, believes she has history of depression, but no prior official diagnoses	
Rich E.	None sought	Heightened stress and anxiety, not clinical (i.e. baby blues)	None	Although doesn't believe clinical, more stress/frustration than ever before experienced
Kara E.	Prenatal and Postpartum Depression	←Same	Chronic depression, on medication (feels that PPD was different)	Adjusted medication dosage during pregnancy and breastfeeding.

Participant	Diagnosis/Label		Mental Health History	Comments
	Professional Diagnosis	Self-Diagnosis		
Matt F.	None sought	Heightened distress, possibly depression	None	
Jenna F.	None sought	Postpartum depression	None	
Brandon G.	No new diagnosis, but increased medication in response to increased stress	←Same	Chronic depression, but significantly improved management early in wife's pregnancy	
Susan G.	Postpartum Depression	←Same; As a severe case, psychosis was considered but rejected by self.	None	A severe case of PPD resulting in multiple hospitalizations.
Jeff H.	None sought	Heightened distress, possibly mild depression	None	
Sabrina H.	None sought	Prenatal: Prenatal anxiety probable -- not sure but definitely "abnormal." Postnatal: Heightened distress (i.e., baby blues)	None	
Ben I.	None sought	Paternal postpartum depression with anxiety	None, but anxious personality and has a family history of anxiety	
Jill I.	Postpartum depression	←Same	Periods of depression	
Anthony J.	No new diagnosis.	"Burn out," possibly mild depression; different than pre-existing anxiety.	Anxiety (well managed throughout this period)	Wife believes he was depressed
Julie J.	Prenatal Depression, Postpartum Depression, General Depression. Bi-polar considered, but rejected after treatment failed.	←Same	Therapy as child, but doesn't think a diagnosis; depression in college. In retrospect, maybe other depression episodes.	Severe case of depression, resulting in multiple hospitalizations

Participant	Diagnosis/Label		Mental Health History	Comments
	Professional Diagnosis	Self-Diagnosis		
Individual Father Participants – Low Income				
Jack	Increased treatment of preexisting bi-polar	“Gnarlyness,” mostly stress but possibly depression; throughout pregnancy and postpartum period	Bi-polar; ADHD	Downplays MH condition, yet apparent signs of impaired functioning
Individual Father Participants – Middle Class				
Scott	None sought.	Doesn't know, possibly depression and “definitely something”	None	
Thomas	Paternal PPD	←Same	None	
Dylan	General Anxiety Disorder	←Same	Periods of depression; anxious personality, and in retrospect, maybe history of clinical anxiety.	
Shaun	None sought	Depression, paternal PPD seems likely	Short episodes of feeling depressed, perhaps not clinical and never prolonged	
Alex	Unknown if new diagnosis applied, but continued therapy with existing provider who treated previous depression and was overseeing ongoing recovery	Paternal PPD	Depression a few years before pregnancy, but was in recovery when pregnancy occurred	Alex links pre-existing depression and paternal depression to different factors, and views them as distinct.
Gregor	Depression, with therapist likening condition to postnatal depression	Paternal PPD	None	
Individual Mother Participants – Low Income				
Stacey	PTSD related anxiety	Accepts PTSD, but thinks PPD is also plausible	In retrospect, PTSD thought to go back to childhood, but not diagnosed until postpartum period.	Also has a long-standing ADHD diagnosis.
Erica	None sought.	Depression, possibly PPD	None.	

Participant	Diagnosis/Label		Mental Health History	Comments
	Professional Diagnosis	Self-Diagnosis		
Desiree	Preexisting depression and anxiety worsens during prenatal period. No treatment sought postpartum.	Agrees with professional diagnosis, also wonders about PPD	Chronic depression and anxiety	
Andrea	None sought.	Depression, but not PPD	Depressed moods, but maybe not clinical (never diagnosed)	
Kristi	PPD	←Same	Periods of depression, from teen years on	
Bethany	No new diagnosis, continual treatment for existing diagnosis	In addition to existing conditions, thinks she also had postpartum depression with symptoms beginning during late pregnancy	Depression and PTSD	
Isabella	None sought.	PPD plausible, but not sure; described condition as “almost” depressed”	A single previous episode of depression	
Caitlyn	Prenatal: PTSD Postnatal: no diagnosis sought due to no insurance	Prenatal: accepts professional diagnosis Postpartum period: Depression, but maybe not PPD	Mental health treatment as an adolescent related to dysfunctional childhood, unsure if received diagnosis at this time but symptoms were of depression	Also has Polycystic Ovarian Syndrome, which is associated with increased risk for depression or anxiety
Kassie	Anxiety	Accepts anxiety diagnosis, but also thinks she had PPD	Depression, continuous and ongoing	Also received an ADHD diagnosis during the perinatal period.
Madison	Limited therapy received but no diagnosis.	Anxiety; Not depressed, but “very sad”	None	
Robin	No new diagnosis sought --ER stabilization for suicidal ideation only.	PPD, in addition to existing diagnoses	Chronic depression, including suicide attempts; borderline personality disorder	Felt depression was under control before pregnancy

Participant	Diagnosis/Label		Mental Health History	Comments
	Professional Diagnosis	Self-Diagnosis		
Nicole	Pregnancy 1: Depression* Pregnancy 3: No formal treatment sought, although ER staff worried she was suicidal when she went in for possible pregnancy complication **	Pregnancy 1 & 3: Prenatal and postpartum depression Pregnancy 2: Very emotional and moody during pregnancy, possibly depressed, but emotionally well after birth.	None, aside from pregnancies	*Depression diagnosis made early in pregnancy, but before pregnancy was known. After discovering pregnancy, they questioned whether she was really depressed or just emotional due to pregnancy. ** Nicole refused MH treatment at this time, but agrees she was suicidal.
Samantha	Adjustment Disorder	Maybe PPD but not sure; skeptical of Adjustment Disorder Diagnosis	Depression, anxiety and Bi-Polar during teen years. According to Samantha, bipolar likely a misdiagnosis due to her abusing the system to get desired medications.	Contradicts herself regarding whether she has PPD, thus indicating ultimate uncertainty
Individual Mother Participants – Middle Class				
Sachi	None sought.	PPD	None, but experienced similar feelings during an earlier life transition	
Natalie	None sought.	PPD	Depression as a teen	
Miki	Diagnosis sought, but none provided as doctor dismissed.	PPD, in retrospect.	None	
Shelley	None provided	Thinks may have had PPD, or it was at least trying to set in. Uncertain.	A few episodes of depression, but not at time of pregnancy	Did not discuss with doctor until after one year postpartum
Emma	Postpartum psychosis, possibly preceded by PPD	In retrospect, began with PPD and it turned into postpartum psychosis, but did not recognize it at the time	None	During immediate postpartum period, OB dismissed symptoms. Psychosis diagnosis made 3 years later.

Participant	Diagnosis/Label		Mental Health History	Comments
	<i>Professional Diagnosis</i>	<i>Self-Diagnosis</i>		
Linda	PPD	← Same	None, but in retrospect recognizes possible depression episodes. Family history of depression.	Did not seek treatment and diagnosis until over 2 years post-birth
Elizabeth	PPD	← Same	None	

Table A5. Overview of Factors that contributed to mental health symptoms, to compliment Ch. 5

Participant	PMAD Condition Basic overview	Primary Contributing Factors	Additional contributing factors	Comments
<i>Couple Participants – Low-income</i>				
Randall A.	Pre-existing anxiety; felt depressed, possibly paternal PPD.	<ul style="list-style-type: none"> • Mental health history, including alcohol abuse • Job change followed by job loss • Poverty/Financial stress • Relationship troubles 	<ul style="list-style-type: none"> • Laurie’s bi-polar condition • Maybe hormones and aging • Overall life situation – not parenting 	<ul style="list-style-type: none"> • Several factors are causes and consequences which spiral off each other • Dysfunctional family background
Laurie A.	Pre-existing bi-polar, which flares up. Pre-existing anxiety.	<ul style="list-style-type: none"> • General instability including poverty hardships and insecure employment • Mental health history, including medication changes 	<ul style="list-style-type: none"> • Relationship stress; including partners alcohol abuse, incompatibility, and parenting differences • Family, work, school balance 	
James B.	Felt very abnormal; possibly paternal PPD	<ul style="list-style-type: none"> • Loss of me-time • Family work balance (2 jobs) • Sexual intimacy 	<ul style="list-style-type: none"> • LeAnna’s PPD • Relationship stress • Financial stress (borderline poverty) • Sleep deprivation 	
LeAnna B.	PPD	<ul style="list-style-type: none"> • Marital distress, primarily, insufficient emotional support from James. • Body changes and insecurities • Temperamental baby, and feeling like she did not understand his needs 	<ul style="list-style-type: none"> • Social isolation • Insufficient social support • Financial stress (borderline poverty) • Family-work, somewhat • Breastfeeding difficulties • Housing difficulties (beyond financial) • Family babysitter stress • Sleep deprivation 	<ul style="list-style-type: none"> • Dysfunctional family background, contribute to marital fears • Mental health history as a teen
<i>Couple Participants – Middle Class</i>				
Cory C.	Baby blues, possibly depression	<ul style="list-style-type: none"> • Being a newlywed and new parent all at once (overall life change) • Marital stress • Sleep deprivation 	<ul style="list-style-type: none"> • Difficult family-work balance • Bad housing situation, including neighbor stress • Loss of leisure time • Temperamental baby • Insufficient social support • Dysfunctional family background 	History of mental health episodes

Participant	PMAD Condition Basic overview	Primary Contributing Factors	Additional contributing factors	Comments
Alyssa C.	Prenatal depression; postpartum baby blues	<ul style="list-style-type: none"> • Pre: hormones • Pre and Post: <ul style="list-style-type: none"> - learning to be a wife and mom at same time - marital stress 	<ul style="list-style-type: none"> • Post: Sleep deprivation • Post: Breastfeeding difficulties • Post: baby temperament and acid reflux • Post: Social isolation/ lack of social support 	<ul style="list-style-type: none"> • Social isolation was a dominant theme, although not identified by Alyssa as a primary factor • Mental health history during puberty
Kevin D.	Paternal PPD	<ul style="list-style-type: none"> • Overall lifestyle adjustment • Lay-off, shaped by cultural breadwinning pressure • Worried about being a good dad 	<ul style="list-style-type: none"> • Work, school, family balance • Overwhelmed during Lydia's PPD, taking its toll a little later on. • Loss of leisure time • Sleep deprivation 	
Lydia D.	PPD	<ul style="list-style-type: none"> • Unrealistic expectations as a mother; high expectations and feeling incompetent/ unproductive • Breastfeeding difficulties 	<ul style="list-style-type: none"> • Hormones • Marital stress (cause and effect) • Social isolation • Some sleep deprivation • Some financial worries • Extended family stressors 	
Rick E.	Baby blues, probably not a clinical mental health condition	<ul style="list-style-type: none"> • Financial Stress as sole breadwinner • Uncertain future -- financial, career, and residential 	<ul style="list-style-type: none"> • Difficult work-family balance • Sleep deprivation • Loss of leisure time • Kara's PPD and breast-feeding struggles. 	Family/work balance was a reoccurring theme, but not identified as a primary factor by Rick.
Kara E.	Prenatal and Postpartum Depression	<ul style="list-style-type: none"> • Breast feeding difficulties, including worries about baby's nutrition • Sleep deprivation, exacerbated by breastfeeding difficulties • Mental Health history, frequent episodes 	<ul style="list-style-type: none"> • Difficult pregnancy and delivery • Social isolation • Hormones • Feeling incompetent as a mother, related to high expectations • Financial stress • Loss of leisure time • Limited support and help with baby from others • Extended family stressors • Marital distress (cause and effect) 	

Participant	PMAD Condition Basic overview	Primary Contributing Factors	Additional contributing factors	Comments
Matt F.	Baby blues, possibly depression	<ul style="list-style-type: none"> • Sleep Deprivation • New time pressures, including overall life change and family/work balance • Negative job reorganization, which also increases financial pressure 	<ul style="list-style-type: none"> • Marital stress • Buying a home • Social isolation • Limited family support due to distance 	Marital stress was prevalent throughout narrative, although not identified by Matt as a primary factor
Jenna F.	PPD	<ul style="list-style-type: none"> • Hormones • Sleep deprivation • Overall life change • Marital stress, due to mismatched parental expectations 	<ul style="list-style-type: none"> • Family, work, school balance • Social isolation • Loss of leisure time • High demands of herself as a mother, including constant attentiveness • Childcare stress • Buying a house • Family losses 	
Brandon G.	Pre-existing depression, perinatal period called for additional treatment.	<ul style="list-style-type: none"> • Susan's severe PPD; including difficulty providing effective support and treatment, and being the primarily caretaker during this time • Sleep Deprivation 	<ul style="list-style-type: none"> • Baby health scare (short term) • Trying to support Susan's breastfeeding troubles • Difficult family, school, work balance • Loss of leisure time • Childcare stress (short term) 	Ongoing mental health history
Susan G.	PPD, including hospitalizations	<ul style="list-style-type: none"> • Hormones • Personality type and feeling loss of control and identity loss • Breastfeeding difficulties • Anxieties about partners' dependability due to his mental health history 	<ul style="list-style-type: none"> • Bonding with baby (cause and effect) • Baby health scare (short term) • Family background of severe mental health problems & codependency 	Also experienced marital stress, childcare stress, and financial stress, but did not feel these contributed to her primary diagnosis of PPD
Jeff H.	Heightened distress (i.e., baby blues), possibly mild depression	<ul style="list-style-type: none"> • Son's serious birthing injury, initially • Loss of control, predictability, freedom, etc. associated with overall life change • Marital changes/stress (cause and effect) 	<ul style="list-style-type: none"> • Job security fears during economic downturn • Social isolation, somewhat • Loss of leisure time • Extended family stress 	

Participant	PMAD Condition Basic overview	Primary Contributing Factors	Additional contributing factors	Comments
Sabrina H.	Probably prenatal anxiety; postpartum: baby blues	<ul style="list-style-type: none"> • Prenatal: General anxiety about life change and unknowns • Pre: doubted her capacity for mothering • Postpartum: son's serious birthing injury, with potential for long term consequences 	<ul style="list-style-type: none"> • Pre: Social isolation (cause and effect) • Pre: Fear of loss of freedom/leisure time • Pre and post: Sleep deprivation due to insomnia, cannot take meds • Post: Family-work balance, somewhat • Post: Hormones, briefly 	
Ben I.	Paternal PPD/ anxiety	<ul style="list-style-type: none"> • General anxiety about life change, including things that could go wrong and loss of control • Sleep Deprivation 	<ul style="list-style-type: none"> • Changes to marital relationship • Baby's temperament and health • Social isolation • Family-work balance, somewhat • Loss of leisure time and time to take care of self (cause and effect) 	<ul style="list-style-type: none"> • Also notes anxious personality type • Resurgence of symptoms later on due to family losses
Jill I.	PPD	<ul style="list-style-type: none"> • Hormonal • Mental health history, as a biochemical predisposition • Breastfeeding difficulties • Major life transitions -- baby, job and residence • Sleep deprivation 	<ul style="list-style-type: none"> • Loss of leisure time and freedom • Delayed bonding with son • Baby's temperament and health • Spouse's mental health • Social isolation, somewhat (cause and effect) 	Had been in recovery from prior mental health for several years
Anthony J.	Baby-blues, possibly mild depression.	<ul style="list-style-type: none"> • Julie's PPD; including difficulty finding effective treatment and increased responsibility during her prolonged mental illness 	<ul style="list-style-type: none"> • Difficult family-work balance; demanding job is difficult when Julie is ill. • Loss of leisure time • Marital stress, loss of closeness 	Mental health history of anxiety, but did not worsen during this time

Participant	PMAD Condition Basic overview	Primary Contributing Factors	Additional contributing factors	Comments
Julie J.	Prenatal Depression; Postpartum Depression; General Depression; hospitalizations throughout	<ul style="list-style-type: none"> • Pre and post: Feelings of being in inadequate mother, connected to dysfunctional childhood 	<ul style="list-style-type: none"> • Prenatal: Body changes and pregnancy complications, including no control over diet • Social isolation (cause and effect) • Motherhood not as expected and infant care as overwhelming • Difficulty bonding to baby (cause and effect) • Prenatal and postpartum issues leads to guilt about baby's health/development • Inability to function at work leads to feelings of guilt and failure • Mental health history (therapy but no previous diagnosis) 	<ul style="list-style-type: none"> • Maybe hormones, but uncertain. • Experienced marital stress, but more as a consequence of severe PPD
<i>Individual Father Participants – Low Income</i>				
Jack	Preexisting bi-polar with flare-ups. Baby Blues.	<ul style="list-style-type: none"> • Drug addicted and absent baby-mother • Worried about impact of mother's drug use on fetus/infant; baby was born with opiate addiction • Being a single father, by default of absent mother • Mental health history 	<ul style="list-style-type: none"> • Unsteady finances and employment, as result of being single father, not having steady childcare, and his illness • Difficult work-family balance; see above. • His own health problems and demanding treatment regimen • Extended family stress 	
<i>Individual Father Participants – Middle Class</i>				
Scott	Probably depression	<ul style="list-style-type: none"> • Infant's temperament and eventual medical diagnosis • Difficult family-school-work balance; balancing 2-3 jobs at once 	<ul style="list-style-type: none"> • Not feeling an instant bond with son • Financial insecurity • Social isolation • Loss of leisure time • Baby care as overwhelming • Sleep deprivation • Stressful housing and move • Family loss 	<ul style="list-style-type: none"> • Delayed bonding with his son dominant throughout narrative, but not identified as a primary factor by Scott. • Maybe hormones, uncertain

Participant	PMAD Condition Basic overview	Primary Contributing Factors	Additional contributing factors	Comments
Thomas	Paternal PPD	<ul style="list-style-type: none"> • Not well suited for being a stay-at-home father—feels incompetent, overwhelmed, and isolated. • Sleep deprivation 	<ul style="list-style-type: none"> • Personality type-- anxious and temperamental • Limited social support • Loss of leisure time • Later, guilt over emotions and sending baby to daycare while unemployed (effect that cycles back into emotions) • Marital stress and declines in intimacy (cause and effect) 	
Dylan	General Anxiety Disorder (prenatal and postpartum)	<ul style="list-style-type: none"> • Personality predisposition to anxiety • Fear of vague life changes and something going wrong; worsened by not having physical connection to pregnancy and baby 	<ul style="list-style-type: none"> • Many life changes at once (marriage, new job, baby) • Loss of leisure time • Sleep deprivation • Difficult work-school-family balance 	Prior mental health episodes
Shaun	Depression, probably paternal PPD	<ul style="list-style-type: none"> • Feeling unneeded/least important member of family • Loss of previous self 	<ul style="list-style-type: none"> • Social isolation • Inadequate social and emotional support • Sleep deprivation • Marital troubles, including being target of wife's strong temper • Family-work balance; no time for anything else • Finding his role as a father 	History of occasional mild depression
Alex	Paternal PPD	<ul style="list-style-type: none"> • Unplanned pregnancy; never intended to be a father; regrets and resentment • Marital stress, primarily related to pregnancy resentment 	<ul style="list-style-type: none"> • Loss of independence and autonomy • Pregnancy adversely impacts career goals and stuck in a disliked job; resentment • Overwhelming nature of parenting an infant • Social and emotional support somewhat lacking • Financial stress 	<ul style="list-style-type: none"> • In recovery from circumstantial major depression; medication withdrawal during pregnancy was difficult • After depression, guilt over resentment and delayed bond

Participant	PMAD Condition Basic overview	Primary Contributing Factors	Additional contributing factors	Comments
Giles	Paternal PPD	<ul style="list-style-type: none"> • Unplanned pregnancy; never intended to be a father. • Loss of identity (as a childless adult) 	<ul style="list-style-type: none"> • Inadequate social support and help for baby • Extended family stress • Family work balance; demanding occupation • Social isolation; loss of previous friendship circles 	Loss of marital closeness as a consequence but not a cause
<i>Individual Mother Participants – Low Income</i>				
Stacey	PTSD driven anxiety	<ul style="list-style-type: none"> • Poverty hardships, including homelessness (resulting from leaving partner) 	<ul style="list-style-type: none"> • Prenatal: Unplanned and unwanted pregnancy • Prenatal: Dysfunctional, relationship, partner is controlling and unfaithful (break up shortly after baby born) • Prenatal: Social isolation • Caesarian complications • Previous life loss leads to heightened anxiety about losing baby • No insurance and with chronic health condition • Hormones, aging related • Sleep deprivation 	<ul style="list-style-type: none"> • Dysfunctional childhood • Mental health history (therapy, but no known previous diagnosis)
Erica	Depression, possibly PPD	<ul style="list-style-type: none"> • Poverty hardships, including employment, housing and transportation insecurity; general lack of stability; trying to become income secure and getting knocked back down. 	<ul style="list-style-type: none"> • Struggles with welfare system • Racial discrimination • Limited support due to no family in area • Childcare stress • Relationship stress, due to poverty and being new to both relationship and parenthood • Hormones, briefly 	

Participant	PMAD Condition Basic overview	Primary Contributing Factors	Additional contributing factors	Comments
Desiree	Preexisting depression and anxiety worsens. Possible PPD.	<ul style="list-style-type: none"> Poverty hardships, including housing insecurity Mental health history, severe and persistent 	<ul style="list-style-type: none"> Unplanned pregnancy Expecting and caring for twins, including premature delivery Social isolation (cause and consequence) Lack of dependable support and help Marital stress, related to adjusting to parenthood while young 	<ul style="list-style-type: none"> Mental health continues to worsen because no resources for treatment Dysfunctional childhood Uncertain about hormones, due to MH history Later on, distraught by child's autism diagnosis
Andrea	Depression, but not PPD	<ul style="list-style-type: none"> A failing marriage, including spouses affair, and stress of her trying to save marriage Partner not interested in baby 	<ul style="list-style-type: none"> Inadequate social support, initially Social isolation Sleep deprivation After break-up, consequential stress of being a single parent and feelings of failure Legal worries related to spouse's behavior 	<ul style="list-style-type: none"> Thought hormones at the time, but in retrospect, this was an excuse Some mothering insecurities, but felt those were normal and not related to depression
Kristi	PPD with anxiety	<ul style="list-style-type: none"> Being a new mother as overwhelming, including baby's difficult temperament Dysfunctional marital relationship, including no help from baby's father 	<ul style="list-style-type: none"> Poverty hardships Breastfeeding pressures Sleep deprivation Social isolation Loss of me-time Hormones Pregnancy anxieties (probably not clinical): unplanned pregnancy and previous miscarriage 	<ul style="list-style-type: none"> Prior depression episodes, but not anxiety Family losses, later, lead to a resurgence of depression symptoms Family-work as stressful, but also a good distraction

Participant	PMAD Condition Basic overview	Primary Contributing Factors	Additional contributing factors	Comments
Bethany	Pre-existing depression and PTSD worsen. Possible PPD.	<ul style="list-style-type: none"> • Anxieties about if she was a good mom • Fear of losing daughter, rooted in previous life losses 	<ul style="list-style-type: none"> • Infant care as overwhelming, trying to be super parent and feeling the loss of child-free lifestyle • Poverty hardships, including job and housing insecurity • Sleep deprivation • Mental health history, severe and persistent • Initially, limited outside support and help with baby • Marital stress and loss of couple time • Hormones • Breastfeeding difficulties, somewhat 	<ul style="list-style-type: none"> • Poverty and loss of child-free lifestyle dominant themes, although not identified by Bethany as primary factors. • Dysfunctional childhood
Isabella	Possibly mild PPD.	<ul style="list-style-type: none"> • Husband doesn't help with out with baby much, which compounds all the other difficulties 	<ul style="list-style-type: none"> • Caesarian complications and difficult recovery • Worries about mothering skills, feels she doesn't understand baby's needs • Breastfeeding difficulties • No me-time or breaks from mothering • Financial stress/poverty • Sleep deprivation • Maybe hormones 	Single prior episode of depression
Caitlyn	PTSD and depression.	<ul style="list-style-type: none"> • Overwhelmed my motherhood, especially with partner not helping much with baby or around house and also meeting her student responsibilities (depression) • Stressful living situation with mother-in-law (depression) • Social isolation (depression) • Car accident during pregnancy (PTSD) 	<ul style="list-style-type: none"> • Serious birth and recovery complications-- painful and separated from baby • Financial stress/poverty and dependency • Struggles with welfare system • Breastfeeding difficulties • Limited support with family far away • Relationship stress; young couple and little emotional support • Lack of me-time • Dysfunctional and abusive childhood (including foster care) • Polycystic ovarian syndrome, including hormones 	Mental health history as a teen, connected to dysfunctional childhood

Participant	PMAD Condition Basic overview	Primary Contributing Factors	Additional contributing factors	Comments
Kassie	Anxiety (new diagnosis) and probably PPD	<ul style="list-style-type: none"> • Insufficient social support (practical help and emotional) • Financial stress/poverty, including housing insecurity 	<ul style="list-style-type: none"> • Dysfunctional relationship, including partner's drug addiction, emotional abuse, and no support/help • Mental health history related to dysfunctional childhood (depression); also concerned about a possible cycle of dysfunction. • Sleep deprivation • Difficult family, work, school balance, worsened by undependable childcare • Social isolation • Loss of me-time • Unable to sustain breastfeeding over time • Hormones 	Dysfunctional marriage and mental health history were dominant themes, although not identified by Kassie as primary causes.
Madison	Very sad and anxious; maybe PPD	<ul style="list-style-type: none"> • Domestic violence, also leading to worries about baby's safety • Socially isolated and no support (as a result of domestic violence) 	<ul style="list-style-type: none"> • Unplanned pregnancy and being young • Infant care as overwhelming, because partner won't help • Financial stress/poverty, including housing and food insecurity • Loss of leisure time • Hormones • Sleep deprivation • Guilt that child doesn't have a father figure (later, after break-up) 	
Robin	Severe and persistent depression, worsened during pregnancy and postpartum.	<ul style="list-style-type: none"> • Dysfunctional marriage • Feeling like a bad mother/mothering insecurities (Cause and effect) • Social isolation • Insufficient social support 	<ul style="list-style-type: none"> • Mental health history, ongoing/continuous • Financial stress/poverty and dependency • Lack of me-time • No help from spouse, who didn't want baby • Guilt over not instantly bonding to baby • Family/school balance, and later, family/work/school • Breastfeeding pressure, somewhat • Hormones • Sleep deprivation 	Dysfunctional childhood

Participant	PMAD Condition Basic overview	Primary Contributing Factors	Additional contributing factors	Comments
Nicole	Prenatal and postpartum depression (PPD); mild with firstborn and severe with 3 rd child	1 st : Teen pregnancy struggles, including dysfunctional relationships with parents and baby's father 3 rd : Unwanted pregnancy, throughout; within an insecure relationship	Both: <ul style="list-style-type: none"> • Financial insecurity/ poverty • Sleep deprivation • Hormones 3 rd : <ul style="list-style-type: none"> • Troubles with the law 	Dysfunctional childhood
Samantha	Adjustment Disorder; possibly PPD	<ul style="list-style-type: none"> • Birth/caesarian complications and initial breastfeeding difficulties • Worrying about if she's a good mom • Overall life changes (unplanned pregnancy, begin cohabitating followed by marriage, quitting job and moving to another state) 	<ul style="list-style-type: none"> • Loss of identity • Relationship stress, including not enough help from partner • Sleep deprivation (cause and effect) • Social isolation and cabin fever • Financial stress/poverty, also feeds into relationship stress • Difficult family, school, work balance • Extended family stress • Body changes and insecurities • Hormones 	Mental health history as a teen (may have been misdiagnosed due to seeking diagnosis for medication)
<i>Individual Mother Participants – Middle Class</i>				
Sachi	PPD	<ul style="list-style-type: none"> • Premature birth, medical mistake, and related worries about health and development; overwhelming need to protect baby. • Social isolation/lonely (living abroad) • Adjusting to motherhood and worries about if doing it right 	<ul style="list-style-type: none"> • Loss of emotional closeness with spouse while she is in Japan • Loss of leisure time, somewhat • Hormones • Cultural differences/stress (international/biracial family) 	Went to Japan for late pregnancy/ early postpartum period (difficult to choose between spousal or parental support)

Participant	PMAD Condition Basic overview	Primary Contributing Factors	Additional contributing factors	Comments
Natalie	PPD	<ul style="list-style-type: none"> Breastfeeding difficulties Sleep deprivation 	<ul style="list-style-type: none"> Birth complications, not as planned Infant care as overwhelming, not quite as expected and felt other moms adjust better Family-work balance, and having to take a job due to financial stress when wanted to be a SAHM (later reemergence of distress after main PPD) Daycare stress, related to above 	<ul style="list-style-type: none"> Rejects hormones as a postpartum factor Prior mental health history as a teen
Miki	PPD	<ul style="list-style-type: none"> Breastfeeding difficulties, including lactation prescription Insufficient practical and emotional support from spouse, mostly due to his heavy work/student demands 	<ul style="list-style-type: none"> Temperamental baby; bad sleeper Hormones Sleep deprivation Social isolation, during maternity leave Loss of me-time and couple-time Guilt about whether she was a good mom Insufficient support; all family abroad and cultural differences in childrearing styles 	
Shelley	Possibly mild PPD	<ul style="list-style-type: none"> Premature delivery 	<ul style="list-style-type: none"> Limited social support due to recent long-distance move and family far away Spouses demanding career, not available for long periods of time Social isolation resulting from frequent moving and no longer working Identity and lifestyle change as a homemaker and in a new town Infant care as overwhelming and unfamiliar Hormones Sleep deprivation 	<ul style="list-style-type: none"> Many life changes over a short timeframe and spouses demanding career were dominant throughout her narrative, although not identified as primary factors by Shelley Prior depression episode(s) Dysfunctional childhood

Participant	PMAD Condition Basic overview	Primary Contributing Factors	Additional contributing factors	Comments
Emma	Postpartum psychosis, possibly preceded by PPD	<ul style="list-style-type: none"> • Biochemical changes • Work-family balance (cause and effect) • Long distance moves, also leading to social isolation 	<ul style="list-style-type: none"> • Personality type -- need to succeed • Breastfeeding difficulties, initially • Sleep deprivation (cause and effect) • Financial stress 	
Linda	PPD	<ul style="list-style-type: none"> • Insecurities as mother and wife -- high super mom expectations and feeling incompetent • Lack of family/work/self-balance 	<ul style="list-style-type: none"> • Loss of previous identity • Breastfeeding guilt for quitting "too early" • Marital stress and resentment (cause and effect) • Sleep deprivation • Social isolation • Hormones 	
Elizabeth	PPD with anxiety characteristics	<ul style="list-style-type: none"> • Overall life change • Hormones • Social isolation/cabin fever 	<ul style="list-style-type: none"> • Infant care as overwhelming, compounded by colic and lack of experience • Spouse had insufficient paternity leave, which could've helped with baby care and feeling isolated/confined • Sleep deprivation • Concerns about initial bonding with baby • Loss of leisure time • Marital stress, wanting more from father, initially. • Family work balance, later • Strained relationship with mother, possibly 	Also noted feelings of loss of control, but more as a symptom than cause

Table A6. Professional Help Seeking Decisions, to compliment Ch. 6

Participant	PMAD Condition Basic overview	Professional Help Sought?	Why or Why not?	Comments
<i>Couple Participants – Low-income</i>				
Randall A.	Pre-existing anxiety; felt depressed, possibly paternal PPD.	Yes, went to a therapist he had seen before. Increased anxiety medication and began treating ADHD.	Recognized need and built on prior help-seeking behavior, but felt like stoicism prevented him from getting help sooner	
Laurie A.	Pre-existing bi-polar, which flares up. Pre-existing anxiety.	Continues ongoing services, which includes “proactive” treatment for bipolar during pregnancy and childbirth, and perinatal mental health support group.	Has always maintained treatment for her bi-polar condition. Consulted mental health provider immediately upon discovering unplanned pregnancy.	
James B.	Felt very abnormal; possibly paternal PPD	No	Believes strongly in self-help and very anti-medication.	
LeAnna B.	PPD	Yes, discussed with OB and received medication	Uncertain at first and James dismissive; didn’t bring up at postpartum because husband was with her. Crying a lot, and a friend later encouraged her to go back to doctor to discuss it.	James and Leanna have different views on mental health and medication.
<i>Couple Participants – Middle Class</i>				
Cory C.	Baby blues, possibly depression	Talked with a counselor at school, a few times. No formal therapy w/diagnosis. Sometime later (after 1 st year), received depression medication from PCP.	Couple sessions with counselor and informal support enough, initially. Would’ve liked marital therapy but Alyssa not really on board. Open to professional help when needed due to MH history.	
Alyssa C.	Prenatal depression; postpartum baby blues	Brought up with OB during pregnancy once, didn’t seek further help.	Knew she was depressed, but not happy with OB’s medication response so implemented self-help. In retrospect, marital therapy would’ve been good but not happy with how it was brought up by Cory.	Very cautious attitude about medication – should be last resort.

Participant	PMAD Condition Basic overview	Professional Help Sought?	Why or Why not?	Comments
Kevin D.	Paternal PPD	Yes, brought up with PCP and received medication	Learned about paternal PPD online, which made sense and he talked about it with Lydia who also encouraged him to ask doctor. Was worried his doctor wouldn't take him seriously, but he did.	Lydia shared that she was skeptical of paternal PPD, but didn't want to dismiss Kevin and now sees it was real.
Lydia D.	PPD	Yes, in denial at first, discussed with midwife but didn't accept treatment or medication immediately but did shortly later; also attended support groups.	Felt she should mention it, but really not sure if depression. Midwife followed up to track her symptoms and kept encouraging her to try medication.	
Rick E.	Baby blues, probably not a clinical mental health condition	No	Not needed because symptoms not severe and also not his style. Talked to wife some, but didn't want to stress her too much when she had her own PPD.	
Kara E.	Prenatal and Postpartum Depression	Continues services with standing provider, increases medication. Attends support group.	With history, knew it was depression. But with baby, sought help more quickly than tended to previous episodes.	
Matt F.	Baby blues, possibly depression	No	Not opposed, therapy probably would have helped, but money and time already tight.	
Jenna F.	PPD	No	Not so bad that she couldn't get through it on own and also no time; willing to seek therapy when needed if more severe	
Brandon G.	Pre-existing depression	Continues MH services, but requests med check earlier to increase meds during the stressful perinatal time	Standing relationship with provider and recognizing need for higher dose.	
Susan G.	PPD, including hospitalizations	Yes, brought up with OB and sought emergency hospital services a few times. Also attended support group.	Severe symptoms, medication from doctor not helping quickly enough and felt suicidal.	Took several rounds to get treatment right.
Jeff H.	Heightened distress (i.e., baby blues), possibly mild depression	No	Not severe enough to need, and even if, not inclined to use formal MH services. Prefers self-help and informal support.	

Participant	PMAD Condition Basic overview	Professional Help Sought?	Why or Why not?	Comments
Sabrina H.	Probably prenatal anxiety; postpartum: baby blues	Discussed anxieties with OB once who opened the door for more support, but choose not to seek further professional help.	Didn't accept how bad her anxiety symptoms were at time, but in retrospect says definitely abnormal.	Somewhat skeptical about psychiatric meds because thinks too many people are over-prescribed.
Ben I.	Paternal postpartum depression/ anxiety	No	Wife recommended it, but felt he was able to handle on own. OK with therapy or medication, but only after trying to work things out with self-help and change.	
Jill I.	PPD	Yes, therapy and medication, limited support group participation	Encouraged by mom and knew needed help. Was resistant at first, especially to medication.	
Anthony J.	Baby-blues, possibly mild depression.	Yes, later on – meet with wife's last therapist a few times	Recommended by wife and her therapist and he agreed it could be helpful.	
Julie J.	Prenatal Depression and Postpartum Depression, followed by just Depression	Yes, several rounds of inpatient hospitalization, different medications, and different providers – beginning with pregnancy until around 2 years postpartum.	Recognized her severe symptoms, including suicidal thoughts.	Nothing really worked well until she connected with a both a psychiatrist and therapist with perinatal MH expertise
<i>Individual Father Participant – Low Income</i>				
Jack	Preexisting bi-polar with flare-ups. Baby Blues.	Continues existing MH treatment and medication	Has always maintained MH treatment, as supported by a family member	
<i>Individual Father participant – Middle Class</i>				
Scott	Probably depression	Yes, a few therapy sessions but doesn't continue	Knew something wrong when couldn't find joy in anything, but didn't find therapy too useful as he's already introspective and did not want medication	Anti-medication, due to a parent's dependence and thinks it causes more problems than it solves.
Thomas	Paternal PPD	Yes, consulted PCP and received medication. Didn't do therapy because had in past and didn't find it useful.	Knew something wrong, learned about PPD though wife and reading around, wife encouraged going to PCP	
Dylan	General Anxiety Disorder (beginning during wife's pregnancy)	Yes, first therapy followed by medication later	Predisposed to seek help, due to previous intermittent MH needs. Exhausted self-help strategies before trying medication.	Cautious about medicine due to medicalization concerns.

Participant	PMAD Condition Basic overview	Professional Help Sought?	Why or Why Not?	Comments
Shaun	Depression, probably paternal PPD	No, but did want counseling	Thought it would be useful to talk to someone, but couldn't find anyone specializing in men's issues, besides gay men's or sexual relationship issues. Also, time pressures and inadequate search terms made it difficult to explore therapy options more thoroughly.	
Alex	Paternal PPD	Continued therapy and medication monitoring with current provider; also began marital counseling	Began therapy previously to deal with previous life stressors and depression; was cutting down on psych meds when paternal PPD occurred but discontinued completely during pregnancy due to concerns about dependency; marital counseling due to risk of divorce.	
Giles	Paternal PPD	Yes, PCP who prescribed medication and a couple therapy sessions with a PPD expert. Discontinued both after a short period.	Realized he was in a severe depression, especially when he began driving recklessly. Treatment didn't help much.	
<i>Individual Mother Participants – Low Income</i>				
Stacey	PTSD driven anxiety	Yes, MH provided immediately in hospital and follow-up with short-term medication and behavioral therapy	Had panic attack in hospital and nurses knew something off, hospital also arranged the follow up care. Accepts medication for short term only. Difficult to afford, but prioritized therapy.	Cautious about medication due to abuse in family.
Erica	Depression, possibly PPD	No	Not sure if met criteria and no insurance. Also felt she could get through it with her own tools and consulted faith based supports. But says if there was a pill that would make her feel better she would take it, but her problems bigger than that.	
Desiree	Preexisting depression and anxiety worsens. Possible PPD.	Yes, during pregnancy but discontinued	Knew she needed help based on history of depression, but didn't click with therapist and didn't seek another because she knew she would lose insurance soon. Would like MH treatment again but can't afford.	

Participant	PMAD Condition Basic overview	Professional Help Sought?	Why or Why not?	Comments
Andrea	Depression, but not PPD	Tried some relationship counseling, and more recently, individual therapy.	Felt it was circumstantial and needed to focus on saving marriage, although partner didn't participate in counseling well. More recent is to help cope with change, including break up.	
Kristi	PPD with anxiety characteristics	Yes, consults OB and gets medication but ends early	Knew it was needed, had depression before and heard of PPD, also encouraged by mom. But discontinues medication early because she knew insurance was ending	
Bethany	Pre-existing depression and PTSD worsen. Maybe PPD.	Yes, continues ongoing behavioral therapy where she focuses on new perinatal stressors	Prioritizes mental health treatment based on her history; would like more therapy but cannot afford, and will not take medication	Anti-medication due to seeing addiction in family members
Isabella	Possibly mild PPD.	No	Didn't think that bad, and busy taking care of baby, but open to professional help if it gets really bad.	
Caitlyn	PTSD and depression.	Yes, limited therapy during pregnancy for PTSD. None postpartum.	Her anxiety following a severe car accident during pregnancy was debilitating, but therapy not that useful. Would like to seek help again, but cannot afford without insurance.	
Kassie	Anxiety (new diagnosis) and maybe PPD.	Yes, returned to a previous provider, received new diagnoses and medications	At first too busy to get help, but then noticed she was not functioning well but needed to as a parent	
Madison	Very sad and anxious; maybe PPD	Not until later, and then related to domestic violence.	Feels she could've used help a lot earlier, but fearful of partner. Therapy is helping, but does think maybe she needs medication due to domestic violence related anxiety	Troubles primarily related to domestic violence, rather than parenthood itself.
Robin	Severe and persistent depression, worsened during pregnancy and postpartum.	Yes, emergency stabilization in ER only	Hesitant to seek mental health help due to prior bad experiences with medication and therapy; however, wanted it when her symptoms were severe but no insurance and couldn't afford it. Sought emergency stabilization when she was suicidal because she wanted to live for her baby.	Spouse did not want her to get treatment because of the cost; he was upset when she went to the ER.

Participant	PMAD Condition Basic overview	Professional Help Sought?	Why or Why not?	Comments
Nicole	Prenatal and postpartum depression (PPD); mild with firstborn and severe with 3 rd child	First pregnancy: Yes, depression medication shortly before learning was pregnant but then immediately stopped. Third pregnancy: No, however police were called when she went to ER for health concerns, but they could not force treatment on her.	1st. She was a minor and her dad thought she was depressed and put her on medication 3rd. Wanted an abortion, not MH treatment; felt problems rooted in poor life choices and relationship troubles and not something treatment could address.	1. MH treatment stopped after pregnancy discovered, because family thought her emotions were normal for pregnancy
Samantha	Adjustment Disorder; possibly PPD	Not at first, but seeks therapy later	At first, stigma and didn't think severe enough to need treatment, but as symptoms continue sees it impacting functioning. Thinks marital therapy would have been better, but spouse doesn't think it's needed.	Anti-medication due to prior medication abuse
<i>Individual Mother Participants – Middle Class</i>				
Sachi	PPD	No	MH treatment stigmatized in Japan, but also believes should try to get through it yourself first the best you can. Feels therapy can have value if really needed.	
Natalie	PPD	No	Not so severe she couldn't get through it with husband's support, didn't want diagnosis on health record and didn't want medication	Anti-medication due to bad experiences with psych meds as a teen
Miki	PPD	Yes, told OB but provider said it was normal	Felt her symptoms sounded like PPD and husband also suggested, but did not seek second opinion.	Felt a mixture of reassurance and disappointment by Dr's response.
Shelley	Possibly mild PPD	Not during perinatal period, but brings up when son a toddler when still feeling down.	Very busy focusing on premature baby's need and uncertain if really needed. Draws on self-help and faith-based supports. Doesn't want medication but would've liked a diagnosis.	Not inclined to use medication unless needed – didn't want to be "chemically suppressed."
Emma	Postpartum psychosis, possibly preceded by PPD	Yes, asked OB but it was dismissed. Received diagnosis about 3 years later with second pregnancy when seeking treatment for her son.	Spouse asked her to ask about PPD at her postpartum check-up. Later, was seeking help for her baby based on her delusions and child's medical team eventually turned their focus to her.	Was uncertain of psychosis diagnosis at first, but agreed to try out the medication as a test.

Participant	PMAD Condition Basic overview	Professional Help Sought?	Why or Why not?	Comments
Linda	PPD	Yes, but not until more than 2 years later during second pregnancy; receives therapy and medication.	At first, thought she could manage and so busy, thought just stress and not depression; but never got better and husband noted she didn't seem happy and encouraged help seeking.	
Elizabeth	PPD	Yes, consulted OB early and received medication.	Self-awareness that symptoms were impacting functioning and consistent with PPD.	