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# Postpartum Depression: Standardizing Motherhood?

by

Pamela J. Regus

Under the Direction of Wendy S. Simonds

## ABSTRACT

An expansion of the medicalization of Postpartum Depression (PPD) is evident in increased screening for maternal depression that begins in pregnancy and continues in the postpartum period, and in the growing number of medical professionals alerted to watch for signs of maternal distress. Although a definitive etiology of PPD remains elusive, the scientific and medical fields – highly imbued with authority to create knowledge in Western society – promote essentialist views of motherhood that espouse “natural” attributes such as maternal instincts and tendencies to nurture. Mothers who struggle with these standards of motherhood are then defined as being ill and become patients under the care of the medical profession until they can perform adequately in their motherhood roles, or they face social condemnation and legal repercussions for being “bad” mothers. Because characteristics of the “normal” postpartum period are said to be similar to symptoms of general depression, how do some women come to identify their postpartum experiences as depression while others do not? Does the choice of traditional obstetrics or an alternative, such as midwifery, make a difference in the incidence of postpartum depression? And what changes in the social support network occur in a woman’s life as a result of a diag-

nosis of PPD? Using Foucault's theory of docility, critical constructionism, and postmodern feminism as the theoretical focus, and in-depth interviews as the research method, I compare the postpartum experiences of mothers who have been diagnosed with postpartum depression with mothers who have not been diagnosed. The sample includes mothers who gave birth with the assistance of obstetrics and mothers who gave birth with the assistance of certified nurse-midwives. In order to examine the differences in approaches to and treatment of postpartum depression, I also interview a sample of obstetricians and certified nurse-midwives. Findings show that medical professionals use gender-normative assessments, such as physical appearance, language, and nurturing tendencies to determine whether the mother is performing as expected; if not, she is defined as ill and treated with antidepressant medication. Although the majority of mothers in the sample experienced feelings of depression in the postpartum period, many resisted diagnosis and medication. Mothers found the greatest support in their peers, rather than those closest to them, citing the ability to talk candidly about the struggles they face in their motherhood roles as the way to avert or heal from PPD. This finding highlights the enforcement of normative motherhood within the social institutions of the family and medicine; thus, cultural change from ideological representations of motherhood may come about through peer relationships.

**INDEX WORDS:** Postpartum depression, Motherhood, Medicalization, Expansion of medical control, Maternal behavior, Childbearing years, Normative motherhood, Mandatory motherhood

Postpartum Depression: Standardizing Motherhood?

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Pamela J. Regus

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

in the College of Arts and Sciences

Georgia State University

2012

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2012

Postpartum Depression: Standardizing Motherhood?

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## CHAPTER 1

### INTRODUCTION

At her six-week checkup after giving birth, an obstetrician told the young mother that she must not have postpartum depression (PPD) because she “looked good,” noting that she was dressed nicely, her hair was fixed, and she wore makeup. The observation, based on gender normative physical appearances, raises concern about medical diagnoses and treatments of PPD, which symptoms are said to resemble a “normal” postpartum period – sleeplessness, weight loss, fatigue, exhaustion, change in appetite – and which treatments typically include antidepressants or psychiatric counseling, or a combination of both (Puckering 2005; National Institute of Mental Health 2002; The National Women’s Health Information Center 2002). The emergence of PPD as a treatable disease expands medical control during the childbearing years beyond the physical to include psychological and emotional aspects. The *Diagnostic and Statistical Manual (DSM-IV)*, published by the American Psychiatric Association, provides diagnostic guidelines for mental disorders. It defines PPD as clinical depression occurring within six months after childbirth, a serious and disabling condition that significantly impacts the mother’s general and mental health and could lead to tragic outcomes, including suicide. The movement of PPD into the medical model is visible as the condition is defined as problematic but treatable, with suspected but indefinite causes, symptoms, and treatments to alleviate suffering.

The expansion of medical control over psychological and emotional aspects of childbirth can be seen in recent legislation regarding PPD. In 2006, New Jersey passed a law which requires mandatory screening of all new mothers for PPD. The wife of the governor of New Jersey, Mary Jo Cody, experienced PPD after the birth of her children, and the legislation was a result of the governor’s political influence to help other mothers who may be suffering from the malady. However, the program was not

as effective as perhaps intended. For example, some mothers wound up in police custody or were forced to go to an emergency room after confiding difficulties they were experiencing, or found that the hotline set up to assist them was staffed with personnel with little or no training. Some were forced to take antidepressants or antipsychotic drugs to keep from losing custody of their baby (The “Mothers Act” 2009).

A similar federal bill, the Melanie Blocker Stokes MOTHERS Act (Moms’ Opportunity to Access Health, Education, Research, and Support for Postpartum Depression), passed in 2010 as part of President Obama’s health insurance reform bill (Stone, 2010). Proponents of the MOTHERS Act recommend screening for depression at the first pre-natal checkup, and they assert that the risk of harm that treatment with antidepressants may cause to the developing fetus should be weighed against the risks that maternal depression poses. They insist that the bill does not mandate screening nor subsidize the use of antidepressants but rather supports education, research, and access to treatment (Stone 2010). Critics of the bill contend that it will have serious consequences such as those that happened in New Jersey after the 2006 state law was passed.

Prescribing medication during pregnancy is particularly alarming as, historically, the use of some medications during pregnancy has produced devastating results. In the 1950s and 1960s, diethylstilbestrol (DES), a synthetic hormone, was prescribed to women who were at risk for miscarriage; it was later linked to vaginal cancer in the daughters of women who took it during pregnancy (Healy 2004). Similarly, in the late 1950s and early 1960s, thalidomide was promoted as a safe sleeping aid, and was subsequently found to cause severe birth defects when taken during pregnancy (Healy 2004). As a result of the thalidomide tragedies, the Food and Drug Administration (FDA) tightened its drug approval process to focus on constructs of “safety,” “effectiveness,” and “approval” (Davis 1984). But the FDA often fails to identify serious side effects until after a drug has been approved and on the market. In the 1990s, the drug Cytotec was used for inducing labor, which caused a severe complication – amniotic fluid embolism

(AFE) – and almost certain death for women who had previously undergone caesarean-section deliveries and then attempted to have a vaginal birth (Wagner 2006). And since the introduction of Prozac and other SSRIs in the late 1980s, questions have arisen about their harmful side effects, most notably the propensity to induce suicidal thoughts in patients with depression, especially children and adolescents (Healy 2004). The long-term effects of antidepressants – on the developing fetus, on the breastfeeding infant, or on the mother – are unknown.

While obstetrics focuses on risks associated with pregnancy and childbirth, a growing number of women choose midwifery because of its holistic approach to childbearing. Instead of defining pregnancy and childbirth as diseases with symptoms and risks, midwifery views pregnancy and childbirth as normal life events. According to the Midwives Alliance of North America (MANA), the Midwives Model of Care includes:

- Monitoring the physical, psychological and social well-being of the mother throughout the childbearing cycle;
- Providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support;
- Minimizing technological interventions; and
- Identifying and referring women who require obstetrical attention. (Midwives Alliance of North America 2001)

In contrast to obstetrical management of birth, midwifery's goal is to offer assistance, education, support, and nurturance with as few interventions as possible. Support extends not only to the mother but to the entire family, and continues beyond the birth into the postpartum period. Certified nurse-midwifery combines both midwifery and medical knowledge in a medical setting, usually in a hospital and under the direction of medical personnel. Given its focus on the normalcy of pregnancy and childbirth, what is the certified nurse-midwife's (CNM) view of postpartum depression? And is there a difference in the postpartum experiences of mothers who choose a CNM over obstetrics for their care during pregnancy, childbirth, and the postpartum period?

### **Purpose of the Study**

In this study, I use in-depth interviews to compare the narratives of women who have received a medical diagnosis of PPD with those of women who have not been diagnosed. I include women who chose traditional obstetrics for their pregnancy care and delivery as well as women who used a CNM in order to examine differences in outcomes and incidences of postpartum depression. I also interview a small sample of obstetricians and CNMs in order to compare their perspectives on the “disease,” as well as their approach to treatment. The purpose of this study is to examine how mothers come to define the postpartum period in terms of illness, whether their postpartum experiences vary by the medical care they receive, and what changes, if any, the diagnosis and treatment of PPD bring to the lives of mothers who suffer with PPD. I use Foucault, critical constructionism, and postmodern feminism as the theoretical foundation of this study, and I use grounded theory methods in my analysis of the narratives.

### **Importance of the Study**

This study is important for several reasons. First, the movement toward medication as the preferred treatment for PPD is counterintuitive to the practice of using caution in the foods, drinks, and medications ingested during pregnancy and lactation. The use of antidepressants is too new to know the long-term effects of these medicines on the developing fetus or breastfeeding infant, or on the mother. Second, medicalization, a process which “organizes a broad and ever growing range of behaviors and aspects of everyday life into categories of health and illness” (Haritty & Tiefer 2003: 43), can be a means of social control, promoted by medical experts and/or pharmaceutical companies with the ulterior motive to benefit professionally or economically from including PPD in the field of medicine (Haritty & Tiefer 2003; Conrad & Schneider 1992). And third, the medicalization of women’s issues, visible in such life events as childbirth, PMS, menopause, and increasingly postpartum depression, among others, tends to pathologize women; it “reframes women’s experiences of their own lives and bodies” (Haritty & Tiefer 2003: 44).

For example, Murphy-Lawless (1998), in *Reading Birth and Death: A History of Obstetric Thinking*, chronicles the medicalization of childbirth, illustrating the power that scientific knowledge has in shaping women's experiential knowledge of the birth process. Presenting women's bodies as faulty, medical experts promoted their science as a means of lowering the risk of death for mother and baby (though it did not). This gave greater control to obstetric practices and greater authority to male-midwives and, later, obstetricians. These practices "produced a complete scheme of labor management in 1920" (Murphy-Lawless 1998:172) which is still practiced today, including that the hospital remains the preferred place of birth, that obstetricians use forceps or vacuum devices to remove the infant from the mother's body when necessary or convenient, and that the typical birth position of the woman is horizontal and immobile – designed for doctors' convenience even though it slows labor and makes pushing more difficult (Simonds 2002). In addition, episiotomies are routinely performed, drugs are used to induce labor or to ease the pain of labor, and the caesarean-section rate is at an all-time high: 34 percent of all births (National Institutes of Health, 2010). According to a report by The World Health Organization, c-section rates above 15 percent indicate overuse of the procedure, performed most often in high-income areas, and offers no health benefit to mothers and babies (Gibbons, Belizán, Lauer, Betrán, Merialdi and Althabe, 2010).



## CHAPTER 2

### LITERATURE REVIEW

Murphy-Lawless (1998) chronicles the movement of childbirth into the medical realm, in which medical intervention and obstetrical practices came to be accepted as the norm. The male-dominated field of obstetrics offered empirical, scientific knowledge of the childbirth process which gradually replaced women's experiential knowledge. Midwives were discredited by the new obstetricians as dirty, ignorant, and unprofessional. The risk of complications and/or death of the child or mother became the impetus for surrendering agency over to medical experts in the birthing process (Murphy-Lawless 1998). Further, Murphy-Lawless asserts that the firm entrenchment of scientific "evidence" and the authority of the medical profession make it difficult to reclaim agency in the birthing process. She finds that the struggle between the patriarchal male as hero and the (presumed) physically and intellectually incapable woman is clearly visible in the childbirth arena, which delineates the concept of knowledge as power, dominance by the knowing individuals (obstetricians), and subjugation of women in childbirth.

Similarly, others echo the view that obstetrics empowers the mostly male-dominated field of experts while it discounts women's knowledge, intuition, experience, and role in the birth process. In spite of the rhetoric of choices available to women and a focus on "natural childbirth," obstetrics still dominates the childbirth arena (Simonds, Rothman, and Norman 2007; Simonds, 2002; Goer 1999). Natural childbirth practices such as Lamaze train women to be compliant patients rather than allow the birth process to unfold naturally. Medical interventions routinely used in these births include episiotomies to prevent tears to the perineum during childbirth, fetal monitors to screen for fetal stress during delivery, and drugs such as Pitocin or procedures such as amniotomy (manual rupture of the amniotic sac) to speed up labor if labor does not progress according to a standardized timeline. As Goer (1999) states:

The typical obstetrician is trained to view pregnant and laboring women as a series of potential problems, despite the fact that pregnancy and childbirth are normal physiological processes that are no more likely to go seriously wrong than, say, digestion. (Goer 1999: 3).

Goer, Murphy-Lawless, Simonds et al, and others reject the obstetrical belief that women's bodies are weak and need the obstetrician's medical intervention to rescue the baby from the mother's body. They suggest that while both obstetricians and midwives are experts on pregnancy and childbirth, obstetricians tend to be surgical specialists while midwives are experts on normal births.

Some research shows a resistance to medicalization of childbirth with the resurgence in the practice of midwifery (Simonds et al. 2007; Goer 1999). In contrast to the pathological focus of obstetrics on the risks associated with childbirth, midwifery takes a holistic, woman-centered approach. Rather than a medical event with the obstetrician as the manager of the birth process, midwifery views pregnancy and childbirth as normal life events and the midwife as educator, facilitator, and nurturer.

Midwives facilitate the physical aspects of birth with minimal technological interventions, placing the mother as the central focus. Whereas obstetricians enter the birth scene in fleeting moments, the midwife stays with the laboring woman to offer continual assistance and encouragement throughout labor, regardless of the length of time it takes to give birth. If labor slows or stops, they recognize it as a natural function and let the woman rest. Beyond the physical, they monitor the emotional and social well-being of the mother during labor and childbirth, and offer support continuing in the postpartum period and throughout her childbearing years.

Direct-entry midwives offer the purest form of midwifery, assisting mothers through knowledge obtained experientially through apprenticeship or through midwifery education programs such as that offered by the Seattle Midwifery School (Simonds et al). They offer assistance in home births or in birth centers. On the other hand, certified nurse-midwives (CNMs) are trained and certified in the two professions of nursing and midwifery, and bridge the two disciplines by typically offering midwifery within a medical setting. The American College of Nurse-Midwives (ACNM) describes its mission:

To promote the health and well-being of women and newborns within their families and communities through the development and support of the profession of midwifery as practiced by certified nurse-midwives and certified midwives. Midwives believe every individual has the right to safe, satisfying health care with respect for human dignity and cultural variations. (American College of Nurse Midwives).

Although medically trained, the goal of certified nurse-midwives is to advocate for the woman so that she has the kind of birth that she desires, which could mean resisting medical interventions by offering alternatives to supposed complications in labor, or to requesting pain management such as epidural if the woman requests it (Simonds et al. 2007; Wagner 2006). And as CNMs are often employed by obstetrical practices to work in conjunction with obstetricians in either hospital settings or birth clinics, the time they are able to spend with a laboring woman may be limited if there are a number of women in labor at the same time. In addition, in a hospital setting, a hierarchy of power exists that places the CNM below the obstetrician; thus the CNM must carefully advocate for the woman without alienating the obstetrician, as the obstetrician has the ultimate say in the birth process.

A body of literature suggests that social controls placed on women during pregnancy result in their objectification and continues in motherhood. Through the discourse of endangerment, the period of pregnancy is structured as part of the extended timeline of childhood, removing the focus from the woman and placing it on the developing fetus (Brooks Gardner 1994; Rothman 1982). Medical texts that increasingly redefine pregnancy so that the fetus is conceptualized as an infant establish fertilization as the beginning point of life (Isaacson 1996). This practice extends the timeline of childhood into the womb and establishes a temporal boundary (Zerubavel, 1991) with profound political implications: it bestows rights on the “fetus-infant” while it erodes the reproductive rights of the pregnant woman (Isaacson, 1996: 472). The rhetoric of endangerment places sole responsibility on the woman to gain expert knowledge and to act responsibly so that a healthy infant results from the pregnancy (Brooks Gardner 1994:72; Rothman 1982). Socialization, through both medical experts and popular sources, obligates the pregnant woman to regard the fetus’s health as more important than her own and to cen-

ter every action, thought, and ingestion on giving the fetus every possible chance for optimum development.

In the United States, a woman's behavior during pregnancy becomes subject to many measures of control that emphasize the indirect consequences of her actions, thoughts, and feelings on the malleable fetus. These control efforts require the pregnant woman – and the pregnant woman alone – to self-impose restraints, with the alleged future good of the child to be born at stake. (Brooks Gardner 1994:71)

Indeed, legislation proposed in Georgia by State Rep. Bobby Franklin, HB-1, would criminalize miscarriages, making it a felony if women could not prove that human involvement was not a factor in the miscarriage (Dykes, 2011). Thus, the woman's life becomes secondary to the good of the child. This self-sacrifice extends to even risking their own lives if doctors recommend it, as in the case of fetal surgery (Casper 1998).

Some literature suggests that the greater number of women than men diagnosed with depression is a result of the medicalization of women's emotionality. Stoppard (2000) asserts that women, more than men, are socialized to use coping strategies such as forbearance and negotiation, which are often characterized in the psychiatric field as passive, problem-avoidant, emotion-focused, and viewed as deficits. The androcentric focus of psychiatric norms places women at greater risk for "atypical depressions" that include anxiety/depression syndrome rather than the DSM-IV specified symptoms of Major Depressive Disorder which typify male depressive symptoms (Stoppard 2000).

Similarly, Shields (2002), in a study of stereotypical gender differences in emotionality, posits that women's emotional expressions are often connected with weakness, making women more vulnerable to the dominance of medical experts. Bilirakis (2004) suggests that hormonal factors contribute to the increased rate of depression among women, which is approximately twice the rate of depression among men. Stoppard and McMullen (2003) and Mauthner (2002) implicate social reasons for the increased rate of depression among women, arguing that women's depression is caused by cultural prescriptions about the "good mother" which prevent women from expressing any negative feelings about

mothering. Others support this ideological argument, suggesting that discourse surrounding motherhood bolsters cultural expectations of the Happy Birth, the belief that having a baby should be a happy time in a woman's life (Kaur 2004; Smith 2004; Meltz 2003).

Mothers themselves, anxious to live a Gerber commercial, may feel ashamed or guilty about having any negative thoughts. . . . Antidotes for postpartum depression begin with an awareness of symptoms: excessive worry about caring for the baby; teariness; anxiety or panic; inability to sleep when the baby sleeps; difficulty doing regular tasks; inability to take pleasure in the baby. (Meltz 2003).

Depression, then, is said to result because the reality of motherhood often contrasts sharply with idealized constructions of motherhood (Mauthner 2002).

Sensationalized cases of “normal mothers” killing their children, such as that of Andrea Yates who, in 2001, drowned her five children in a bathtub, contribute to the fear that untreated PPD can lead to postpartum psychosis (Kaur 2004) and have a tragic end. PPD prevention programs are then established to train health care workers to identify women with PPD and get them into treatment (Smith 2004). Hubert (2002) suggests the result is that more women willingly collude in their own gender-biased diagnoses.

### **Defining Postpartum Depression**

The emotional instabilities that often accompany pregnancy, labor, delivery, and recovery are not a new phenomenon. Hippocrates described emotional difficulties of the postpartum period thousands of years ago, and mid-19<sup>th</sup> century studies highlighted psychotic episodes but did not label PPD a separate illness (Kruckman and Smith 2000). Nor is PPD a condition unique to Western cultures (Dennis 2004); research shows PPD is reported to exist in a wide array of countries – among them Brazil, Cambodia, Canada, China, Czechoslovakia, France, Germany, India, Korea, Malta, Mexico, Sweden, Taiwan, and Turkey.

In the United States today, the medical community does not label PPD a distinct disease but views it as an affective disorder with characteristics similar to general depression occurring in the postpartum period, generally up to six weeks following delivery (Kruckman and Smith 2000). Although the Diagnostic and Statistical Manual of Mental Disorders (DSM) II listed PPD as a separate illness during the 1960's, it eliminated the category in 1980, stating that there was not enough evidence to consider it a distinct disorder (Kruckman and Smith 2000).

Weitz (2004) suggests that the DSM is problematic in that it often politicizes diseases. She claims that although the DSM provides standardized diagnostic criteria for mental illnesses, clinicians are often biased when applying them to female and/or minority patients. A panel of experts decides what is considered a disease, yet their decisions often reflect historically-situated norms and values. For example, the DSM listed homosexuality as a disease in the DSM until 1973, reflecting cultural values of that period (Ford and Widiger 1989). At the same time that homosexuality was removed as a disease in the DSM, a new pathology was introduced: gender identity disorder. Similarly, the DSM considers premenstrual dysphoric disorder (PMDD) and its less severe form, premenstrual syndrome (PMS), as psychiatric disorders that affect between 3-8 percent of women. These "disorders" occur cyclically, approximately one week prior to the menstrual cycle, and pathologize the hormonal process differentially for women than for men (Callaghan, Chacon, Coles, Botts, and Laraway 2009). Some results of this method of disease classification are that more African Americans than whites are diagnosed as paranoid schizophrenics with violent tendencies, and more women than men are diagnosed as having illnesses such as depression and histrionic personality disorder (Weitz 2004).

*Williams Obstetrics* (Cunningham, Leveno, Hauth, Gilstrap, and Wenstrom 2001), the influential textbook for medical students studying obstetrics, states that postpartum depression is similar to other depressions that develop at any time, but qualifies as "postpartum" if onset occurs within 3 to 6 months after childbirth. Prevalence is said to be from 8 to 15 percent of postpartum women, with certain

groups more at risk: adolescents and women who have a history of a depressive illness. The authors remark that up to 70 percent of women with a previous episode of postpartum depression will have a subsequent episode. Criteria for diagnosis must include either depressed mood or loss of interest or pleasure every day, along with any four of the following symptoms that last for a 2-week period: weight gain or loss, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive or inappropriate guilt, diminished ability to think or concentrate, recurrent thoughts of death, suicidal ideation or suicide attempt. Effective treatment most often requires pharmacological intervention in conjunction with a psychiatrist to monitor for thoughts of suicide or infanticide. The text suggests that improvement occurs naturally over the 6 months after delivery, but in some cases symptoms may last for years and have a negative effect on the quality of the relationship between mother and child. Although the authors assert that “pregnancy often evokes overwhelming joy” and that mood disorders during pregnancy tend to be milder, they ironically also find that stress during both pregnancy and the postpartum period can provoke mental illness (p. 1419). Thus, they recommend screening for mental illness during the first prenatal exam, including history of prior psychoactive disorders or use of psychoactive medications. In addition, they say that screening is necessary in cases of sexual abuse, substance abuse, or violence as these conditions increase risk of depression in pregnant or postpartum women.

Supportive treatment alone is not sufficient for major PPD. Pharmacological intervention is *needed* in most instances, and affected women should be *managed* in conjunction with a psychiatrist. (Cunningham et al: 396, emphasis added).

The medical emphasis on managing women’s bodies is evident throughout *Williams Obstetrics*.

Websites provide information about the malady as well as resources for parents seeking assistance in dealing with depression after giving birth. *The National Women’s Health Information Center* (2002) describes PPD as “a range of physical and emotional changes that many mothers can have after having a baby.” It separates PPD into three distinct categories: the “baby blues,” which occur soon after

childbirth and continue for one to two weeks; postpartum depression, which starts anywhere from soon after to even a few months after childbirth and continues for as long as one year; and postpartum psychosis, an extreme form of PPD which usually begins within three months after childbirth. According to current medical wisdom, the baby blues affect an estimated 50-80 percent of all new mothers, postpartum depression affects between 3-20 percent, and postpartum psychosis affects approximately .1 percent (or 1 per 1000 births) (Kruckman and Smith 2000).

Organizations such as Postpartum Support International (PSI) and Postpartum Education for Parents (PEP) are headed by medical doctors, psychiatrists, Ph.D.s, and other experts. They encourage professional medical help for the mother as well as support from family, friends, and support groups. They express the belief that the disorder is caused by a combination of physical and social factors, specifically hormone changes which affect brain chemistry and social stresses such as poor partner support and social isolation. Consequently, emotional, social, and physical support are the recommended remedies. The PEP website states:

Our society does not currently accept brain disease as it accepts physical illness. There is a stigma about depressive disorders. The illness is difficult to explain. Those closest to a depressed mother need to understand that while psychological and environmental stress may play a role, depression is basically a physical and chemical disorder. Give support, encouragement and hope. Your assistance during this time of crisis is invaluable. (Logan 1989).

Thus, the PEP website iterates a common bid for legitimacy, presenting PPD as a real disorder with physical and social causes, and not “just in her head.”

PSI offers an anthropological approach to its analysis of PPD, comparing various cultural practices of the postpartum period. It finds that, in the United States, the postpartum period is informally structured as compared to non-Western, rural cultures in which extended families provide support during the postpartum period. For instance, in the U.S. the postpartum period lacks social structuring of postpartum events and social recognition of the role transition to motherhood. It also fails to assist new mothers with care of child and encouragement for care of self, and lacks cultural rituals which enhance



and support motherhood and permit cultural emotions such as fear linked to childbirth (Kruckman and Smith, 2000). PSI characterizes the postpartum period in the United States as emotionally draining, stressful and fatiguing; the baby blues and mid-levels of depression are said to result from modern birthing practices, the lack of clear role definition, and the lack of social support for the new mother (Kruckman and Smith 2000). (However, as mentioned earlier, PPD is not unique to Western culture, but is found in many non-Western countries as well.)

Self-help books also provide information on the topic of depression in the postpartum. A perusal of the pregnancy and childbirth section of a large national bookstore chain illustrates the selection of books available that include, among others, *Your Pregnancy Week by Week* (Curtis and Schuler 2008), *What to Expect When You're Expecting* (Murkoff and Mazel 2008), and *Great Expectations: Your All-in-One Resource for Pregnancy and Childbirth* (Jones and Jones 2004). All three books provide descriptions of the causes, symptoms, and treatments of PPD similar to those found in *Williams Obstetrics*, and the books are credentialed with a doctor as author, consultant, or creator of the forward section of the book. Curtis and Schuler suggest that PPD is part of the "postpartum distress syndrome" (PPDS) that also includes baby blues and postpartum psychosis (p. 545). The authors state: "Experts consider some degree of postpartum distress to be normal...Every postpartum reaction, whether mild or severe, is usually temporary and treatable" (p. 545-546). They suggest that women who are high risk may start antidepressants during pregnancy or right after delivery. Murkoff and Mazel suggest a concerted effort to inform both the public and professionals about PPD:

Public education campaigns are underway to spread the word about PPD...Hospitals are, or will be, required to send new mothers home with educational materials about PPD, so that they (and their spouses) will be more likely to spot the symptoms early and seek treatment. Practitioners are becoming better educated, too...in recognizing risk factors, screening routinely for the illness postpartum, and to treat it quickly, safely, and successfully. (Murkoff and Mazel 2008:459).

With such a strident education campaign, rates of diagnosed cases for PPD are sure to rise, and treatment is sure to follow.

The self-help books further suggest that if mothers are feeling great after delivery, fathers are at a dramatically increased risk of falling into a postpartum slump, suggesting that fathers can also suffer postpartum depression. Jones and Jones address male postpartum depression, stating that fathers must recover from the shock of childbirth and may feel overwhelmed with new responsibilities of caring for the expanded family. While antidepressants are recommended for mothers with PPD, for fathers the prescribed remedy is rest and time to process the birth, encouragement from the wife to relate to the baby in his own way and to show him how to handle the baby, and to explore new ways to express affection when the new mother is uninterested in sex. Although the books allude to the fact that the condition is temporary, they suggest immediate intervention if the mother suffers PPD, endorsing medication in conjunction with counseling for the depressed mother.

### **Symptoms and Treatment for PPD**

According to Kruckman and Smith (2000), symptoms fall into physical, emotional, and behavioral categories and vary by severity of PPD. Symptoms of the baby blues are mild and last a few days to a few weeks, whereas postpartum depression is marked by longer periods of depression. Physical symptoms range from lack of sleep, no energy, and appetite changes to headaches, chest pains, heart palpitations, and hyperventilating. Emotional symptoms run the gamut from anxiety and excessive worry, confusion, sadness, and feeling overwhelmed or inadequate as a parent to hopelessness, thoughts of suicide, bizarre hallucinations and incoherence. Behavioral symptoms range from crying, oversensitivity, and irritability to panic attacks, hostility, and paranoia. Postpartum psychosis is the most severe, with symptoms that may include extreme confusion, loss of memory, inability to function, and possible harm to infant or self (Kruckman and Smith 2000).

Treatment options vary widely and include psychiatric intervention, psychotherapy, cognitive-behavioral therapy, antidepressants, antenatal classes, relaxation techniques, educational strategies, social support during the postpartum period, and more (Kruckman and Smith 2000). However, the efficacy of these approaches is difficult to determine due to research design flaws, specifically small sample size and exclusive sampling, that fail to determine the outcomes of such interventions (Dennis 2004). Estimates of the prevalence of PPD vary due to unstandardized reporting practices as well as to the vagueness in defining PPD.

### **PPD and Legislation**

Legislation plays into the issue in several distinct ways. First, postpartum depression is used as an insanity defense in some cases in which mothers harm or kill their children. Attorneys for Andrea Yates, the mother who drowned her five children in a bathtub in 2001, successfully employed this defense, saving her from the death penalty and sending her to prison for life (Colb 2003). The jury had to decide between two possibilities in determining her fate: either Yates was a good mother who experienced temporary insanity, or Yates was an evil monster who murdered her children (Colb 2003). Colb asserts that the insanity defense could not spare her a life sentence because to accept her actions as a lapse from sanity would shatter a benevolent view of motherhood, allowing the possibility that other mothers could commit similar atrocities. Therefore, the jury convicted her out of the need to hold her accountable and to keep other mothers from similar actions (Colb 2003). Her conviction was overturned in 2005 and she was sent to a minimum security mental hospital, where ten years later she awaits a hearing in which a judge or jury will decide whether she will be allowed to leave and continue outpatient treatment in a community-based facility (Gardner 2011).

It is rarely disclosed that multiple factors converged that resulted in the tragic deaths in this case. Yates was treated for schizophrenia and depression after the birth of her first child, and re-

diagnosed after the birth of her fourth child. She, her husband, and four small children lived in a cramped bus converted into a living space, but shortly before the birth of their fifth child moved into a more spacious home. In addition, she was influenced by religious fanaticism that led her to believe she was a bad mother and that her children would be spared an eternity in hell if she murdered them. And her physician warned her husband and her after the birth of their fourth child that an additional pregnancy could result in renewed mental problems; yet the responsibility of caring for five young children after the birth of the fifth child fell solely on her. In retrospect, Yates' husband said the family knew of her illness but thought she was doing well. They never suspected that she would kill her children (Couric and Morales 2005). Her family sued the psychiatrist responsible for Yates' care, claiming that he

improperly medicated her with strong psychotropic drugs that are known to cause mania, anxiety, impaired judgment, agitation and aggressive reaction. "We feel that our family would still be whole today if it were not for Dr. Saeed's terrible misconduct." (Parker 2002).

Although he was removed as an administrator from the treatment facility as a result of the criminal negligence charges, he continues to practice psychiatry there (Parker 2002).

As mentioned earlier, legislation also enters into the PPD issue with a law passed in New Jersey in 2006 that mandates depression screening for all new mothers and an education project to teach women and their families about the condition. It recommends screening at the beginning and midway through pregnancy and at two, four, and six months postpartum. Similar laws have been passed in California, Illinois, Minnesota, Texas, and Washington, and are pending in Iowa and New York. These laws include provisions for increasing awareness of PPD, for educating new mothers of the malady, and/or for informing them of resources for counseling available to them (Postpartum Support International 2010). Administrators for the New Jersey screening program found that removing the word "depression" from the screening instrument and slipping the depression questionnaire in with all of the other papers that must be completed by the patient results in almost 100 percent compliance with the screening mandate (Johnson 2006). In response to critics who allege that the bill is intended to increase pre-

scription medications, N.J. Governor Richard Cody, whose wife experienced PPD, insists that the bill does not cover, encourage, or subsidize medication but is designed to increase education, awareness, research, and diagnosis of the condition. However, some of the 3,000 women who called the New Jersey 24-hour postpartum depression hotline within the first three years of its inception charge that the hotline was staffed with persons unknowledgeable or unsympathetic to mothers with PPD and failed to offer advice that was helpful or to refer them to reliable resources (Young 2008). Similarly, the MOTHERS Act (Moms' Opportunity to Access Health, Education, Research, and Support for Postpartum Depression Act), requires screening for postpartum depression on a national level. Also called the Melanie Blocker-Stokes Postpartum Depression Research and Care Act (H.R. 20), it was enacted in 2010 as part of the current administration's health care reform bill (Stone 2010). The bill's author, self-professed women's health advocate Rep. Bobby L. Rush, D-IL, states: "It's time for us to recognize postpartum depression for what it is – a mental health condition that requires medical treatment, not jail time" (Harris 2005). Rush states that the overturn of Yates' murder conviction in 2005 leads to a better understanding of postpartum depression by the public as well as law enforcement officials, and that the bill would help erase the stigma associated with PPD by recognizing it as a true illness (Harris 2005).

A transcript of a training program for medical professionals held in New Jersey in 2011 tells of a lack of resources for mothers with PPD. In her address to the assembly, Katherine Stone commends New Jersey for its advocacy but bemoans the failure of other states to adopt similar policies, as she remarks that in the entire country there are only two "special treatment" inpatient facilities for mothers with PPD:

Women are rarely screened. I know that's not the case, thank you, here in New Jersey. You guys have a plan in place and you're really getting things done in that regard. But outside of this state, it's just not happening in the same way. It's not institutionalized and part of a routine of what people do...And I love this quote from Dr. Wizner in Pittsburgh who said, this is a disease that lives between specialties – OB/GYN, psychiatry, pediatrics – patients are running around in circles. (Stone 2011)

New Jersey leads the nation in the push for medicalization of PPD, mainly because the governor's wife, Mary Jo Cody, suffered PPD after the birth of her children. Stone goes on to say that 85 percent of women who have a mental illness after the birth of a child are not treated, which can lead to self-medication with harmful behaviors such as smoking, drinking, or taking drugs. She says that the risk to the baby if the mother is not treated for depression is likely prematurity, low birth weight, and/or low Apgar scores. The risk to the mother is that it would affect attachment and bonding with the baby and likely lead to the discontinuation of breastfeeding. A question that remains is whether PPD would have such an active campaign in New Jersey, and consequently nationally, if it was not the wife of a politician that experienced difficulties in motherhood.

### **Impact of PPD on Family**

Perhaps the most compelling argument used to garner support for its medicalization is that PPD affects the family – the infant, the spouse, and older siblings. Some studies claim that children with depressed mothers may exhibit long-term deficits that affect the child beyond infancy to school age, such as inhibited speech development and a weak mother-child relationship, due to the mother's failure to interact with the infant (Puckering 2005; Toneguzzi 2004; Meltz 2003). A Scottish study which provided adult mental health services for new mothers found that deficits relating to the weakened mother-child bond persist beyond when the mother's depression ends (Puckering 2005). In Barbados, researchers found that maternal depression, along with reduced infant lengths and weights at 7 weeks, 3 months, and 6 months postpartum, were predictive of lower scores on the Common Entrance Examination (CEE) for entry into high school, at ages 11 to 12 years (Galler, Ramsey, Harrison, Taylor, Cumberbatch, and Forde 2004). A contrasting study found that cognitive problems in the 4-year old children of depressed mothers showed no lingering effects from PPD at the 7-year level, although the children were affected by such conditions as low SES (Kurstjens and Wolke 2001), which typically is not treated.

Some literature on PPD finds that fathers can also experience PPD resulting from additional stresses such as the mother's depression, having an unsupportive relationship, or being unemployed (Ballard and Davies 1996). Kleiman (2006) finds that 62 percent of fathers suffer from the baby blues some time during the first four months following birth, and 10 percent suffer from PPD. The Early Childhood Longitudinal Study, involving 5,089 two-parent families, also asserts that approximately 10 percent of new fathers suffer from PPD, causing decreased interaction between father and infant with implications for future development of the child (Paulson, Dauber, and Lieferman, 2006). The deterioration of intimacy due to lack of communication about the stresses of a new baby is said to cause postpartum depression in fathers, and 25 percent of all couples end their marriages within five years of having a child (Parks 2005). Some symptoms of PPD in fathers include dramatic weight gain or loss, difficulty sleeping, sadness, loss of interest in normal activities or hobbies, and difficulty making decisions, due to the shift to parenthood (Smyth 2003). The finding that fathers can experience PPD should rule out biological factors such as hormones as the cause of PPD and place more emphasis on social or structural factors (Kleiman 2006). A brief look at sociological literature finds no resistance to the concept that fathers can also have PPD.

Currently, depression rating scales used for diagnosing PPD include: 1) the Hamilton Rating Scale for Depression, 2) the Beck Depression Inventory (BDI) (see Appendix C), and the Edinburgh Postnatal Depression Scale (EPDS) (see Appendix D), among others. The depression surveys are administered by a health professional or may be completed by the patient, and higher scores indicate higher levels of depression.

### **Feminism and PPD**

Feminists illuminate the primacy of the maternal role in patriarchal society that, despite advances in opportunities for participation in the public sphere, enforces women's responsibility as care-

givers of children (Douglas & Michaels, 2004; Taylor, 1996; Rich, 1986). Media promote the idea that women can “have it all” – the job, the family, independence, beauty, wealth, health. The lack of structural supports such as universal health care, a national high-quality day care system, or workplace conditions that accommodate the raising of children keep women anchored in the private sphere even if they work outside of the home. The changing roles of women result in questions surrounding “appropriate” behavior around such contemporary issues as working mothers, lesbian motherhood, single motherhood, abortion and birth control rights, and the choice of self-identity outside of motherhood.

Not all feminists view medicalization of women’s issues only as a negative form of social control. Ehrenreich (2009) suggests that the feminist health movement successfully nudged breast cancer from the shadows of patriarchal medicine and led to research into its causes and better treatment methods for women who develop the disease. Treatment prior to feminist activism included radical mastectomies that removed chest muscles and lymph nodes along with the breast that often left women disabled, and the practice of anesthetizing women for biopsy and performing a mastectomy at the same time if cancer was found. This latter practice meant that women went into surgery not knowing if they had cancer and came out without a breast if they did. Feminist influence on the medicalization of breast cancer brought awareness to the full disease, created solidarity among women who then began to question their doctors, spawned support groups and other resources for women with breast cancer, and brought about major changes in treatment protocols. But Ehrenreich finds that feminist influence has only marginally changed the focus of breast cancer research, despite today’s ubiquitous pink breast cancer awareness campaign. She asserts that research has shown that only 30 percent of women diagnosed with breast cancer have a known risk factor such as delayed childbearing or late onset of menopause, that faulty genes account for only 10 percent of breast cancers, and that lifestyle choices such as a fatty diet have been negated as likely causes. Ehrenreich, who herself was diagnosed and treated for breast cancer, suggests that the current focus on pink ribbons for the cure distracts from the culpability



of environmental pollutants such as AstraZeneca, which once manufactured pesticides, which are suspected carcinogens, but now manufactures Tamoxifen, a drug used in the treatment of breast cancer.

Further, she suggests that mammography and treatment protocols have limited efficacy:

These interventions do not constitute a “cure” or anything close, which is why the death rate from breast cancer had changed very little from the 1930s, when mastectomy was the only treatment available, and 2000, when I received my diagnosis. Chemotherapy, which became a routine part of breast cancer treatment in the eighties, does not confer anywhere near as decisive an advantage as patients are often led to believe. It’s most helpful for younger, premenopausal women, who can gain a 7 to 11 percentage point increase in ten-year survival rates, but most breast cancer victims are older, postmenopausal women like myself, for whom chemotherapy adds only a 2 or 3 percentage point difference, according to America’s best known cancer surgeon, Susan Love. (Ehrenreich 2009:19)

Thus she says that feminist activists press for corporate responsibility in cleaning up the environment rather than participating in the “breast-cancer cult” of fundraising events such as the Avon Breast Cancer Crusade or the Susan G. Komen Race for the Cure. Of the more than 500 grants totaling almost \$270 million that Komen endowed in 18 countries in 2010, only 24 percent went toward research, and 20 percent went to administration and fundraising costs. (Susan G. Komen Race for the Cure, 2010, retrieved from [http://ww5.komen.org/uploadedFiles/SGKFTC\\_FY10Annual Report.pdf](http://ww5.komen.org/uploadedFiles/SGKFTC_FY10Annual Report.pdf)). Although feminist activism has brought about positive change for women with breast cancer, the ability of medicine to impose its authority over women’s bodies remains.

On the issue of postpartum depression, some feminists find that medicalization proffers the chance for structural change, including renegotiation of traditional gender roles (Taylor, 1996). Taylor suggests that medicalization offers advantages that include lenient judicial response to depressed mothers who injure themselves or their babies, insurance coverage for treatment, training for health professionals to recognize and treat, and research funding. She finds that support groups for mothers with depression, which sprang from the women’s self-help movement in the late 1980’s, represent collective action for women to resist traditional ideologies of motherhood and to build solidarity with other women. Taylor stresses the role that media play in furthering discourse blaming mothers for all of the

ills of society and in echoing current political conservatism that calls for a return to traditional family values:

When women express their negative feelings, they experience themselves as different from traditional – and ideal – mothers. Solidarity with other women and the group consciousness that grows out of participation in self-help makes it possible, however, for women to use cherished ideals about motherhood for their own purposes “...to replace the myth of maternal bliss with a more inclusive view of motherhood” that is “more realistic and accurate” and places more emphasis on “the challenges and difficulties that are part of the territory.” (Taylor 1996:142).

From this stance, medicalization provides a socially acceptable platform for women to express the difficulties of mothering without facing social condemnation, to bring about change in the idealized version of motherhood.

### **Complicity of Drug Companies**

Drug companies are business enterprises, seeking constant expansion of their markets through innovation in product and marketing (Diller 2005; Thomas 2004; Engler 2003). Their profitability relies on tweaking existing medications to form “new drugs”; on expanding disease categories (for example, generalized depression to include childhood depression and postpartum depression); and on marketing their products to medical professionals and to the public (Angell 2004). Spending on research and development of new drugs increased from \$3.2 billion in 1983 to \$43 billion in 2007 (Editorial, 2008). Additionally, drug companies benefit from monopoly rights that include patent protection and tax breaks for research and development expenses.

The amount that drug companies spent on direct-to-consumer advertisement more than tripled between 1996 and 2000, amounting to about \$2.5 billion in 2000 (Lee 2009); in 2006 it increased to approximately \$4 billion annually (Rowe 2006), and in 2011 it increased to \$5 billion on TV ads alone (Spatz 2011). Drug ads can be seen on public transportation buses and trains, on television, in print media such as journals, magazines, and newspapers. Dr. Lisa Schwartz remarks on the results of drug advertising:

“We’re increasingly turning normal people into patients. The ordinary experiences of life become a diagnosis, which makes healthy people feel like they’re sick” (cited in Rowe 2006). Individuals pressure doctors to prescribe the advertised drugs, to the extent that the typical American had 12 prescriptions a year by 2004, up from seven prescriptions a year in 1994 (Rowe 2006).

Perhaps the worst part is that prescription drug ads have immersed us all in a pervasive drug culture that seems to have no boundaries. We are being reduced to helpless “consumers” who have no capacity to deal with challenges other than by taking a pill. (Rowe 2006: 9).

Advertising drugs fits the American consumer lifestyle, bringing medical problems to the personal level and offering medication as a “quick but ultimately patient-centered fix” (Tone and Watkins 2007: 7).

Some research suggests that, because drug companies contract with academic institutions and receive government sponsorship of research projects, scientific research is biased. This practice places the health of consumers in jeopardy (Angell 2004; Krinsky 2003). In 2008, three professors at Harvard Medical School and two at Emory University were accused of failing to disclose large amounts of money they received from the drug companies for which they were conducting research. The two researchers at Emory received more than \$1 million between them from the drug companies between 2000 and 2008 (Pereira 2008; Armstrong 2009). Dr. Charles Nemeroff, one of the Emory professors, admitted that several of the large drug companies including Smith-Kline Beecham, Janssen Pharmaceuticals, Astra-Zeneca, Bristol-Myers, and Wyeth-Ayerst Pharmaceuticals, had contributed to the university in substantial ways because of their connections with him (Harris 2008).

In his book, *Let Them Eat Prozac: The Unhealthy Relationship between the Pharmaceutical Industry and Depression* (2004), psychiatrist David Healy explains the history of drug use in psychiatry in the U.S. He maintains that depression replaced nervousness, the psychiatric illness prevalent during the first eight decades of the twentieth century. Tranquilizers were the preferred treatment for “nerves” and were available over-the-counter or through prescriptions, making them widely available to large numbers of individuals regardless of their socioeconomic status. Although the use of tranquilizers began

to wane in the 1970's, it primed the population for accepting psychotropic drugs to treat emotional symptoms. Healy states that depression was rarely heard of prior to the development of Prozac; in order to market antidepressants the pharmaceutical companies had to also market depression as a treatable illness (Healy 2004). SSRIs replaced tranquilizers as the preferred treatment for the new disease, depression.

Diller (2005) questions the practices of American psychiatrists in what he calls a "drug culture," noting the dramatic shift toward medicating disorders such as depression and hyperactivity which began in the early 1990's. He finds that 9 out of 10 children under the care of American psychiatrists are on one or more psychiatric drugs, whereas European physicians and psychiatrists rely more heavily on other treatments (Diller 2005: 28). Although his study focuses on children's health, he finds that drug companies influence medical professionals by funding national physicians' conferences, by offering free samples of high-priced medications, by wooing physicians with free dinners and consultant fees. In addition, drug companies hire expert witnesses to affirm the efficacy and safety of their drugs, and they withhold findings which indicate ineffective, negative, or harmful effects. Although drug companies are required to file negative reports with the U.S. Food and Drug Administration (FDA), they are not required to publish or make public harmful outcomes. Diller maintains that the profit-driven drug companies are most loyal to protecting the interests of their stockholders, even to the point of endangering their customers.

Similarly, Thomas (2004) exposes fraudulent marketing practices which drug companies use to gain profits, including suppressing research that contains negative data about their products. In addition, she finds that drug companies promote drugs for off-label use – that is, they encourage physicians to prescribe drugs approved for a specific disease for many other ailments. For example, she cites a study that found the makers of the drug Neurontin, approved for the treatment of epilepsy, paid doctors to prescribe it for manic depression, restless-leg syndrome, and other ailments. The drug company

hired ghostwriters to create articles promoting off-label uses of Neurontin and then paid honorariums of \$1000 to doctors who lent their names as authors to the articles. The company was sued when a patient diagnosed with bipolar disorder attempted suicide while taking Neurontin. Thomas asserts that the influence of drug companies is enormous: the proportion of doctors to drug representatives is two to one, and there is one drug company lobbyist for every member of Congress (Thomas 2004).

Davis (1984) also highlights two concerns with the FDA, conflict of interest in the drug approval process and failure to release negative reports about the safety of drugs, in his account of the drug approval process for DMSO in the 1960s. He traces the evolution of the FDA's bureaucratic power, illustrating the importance of historical, political, and media influences on the FDA's drug approval process. In 1906, the U.S. passed the Food and Drug Act for the purpose of ensuring the safety of foods and drugs. When abuses continued, amendments to the act were passed in the late 1950s to protect against improper drug labeling and advertising. In 1962, as a result of public outrage to birth defects caused by the drug thalidomide, the FDA added that a drug must not only be proven to be safe but also effective in order to be approved. On the heels of the thalidomide tragedy, the makers of a new drug, DMSO, an industrial solvent whose medicinal value was discovered by accident and reported in the media as a "wonder drug," applied for approval. The FDA found that the drug had the potential to cause harm, specifically toxicity to the eyes in animals during the testing process, and it halted all tests of the drug on humans. Because of public interest stirred by the media and the promising healing properties that it supposedly offered to persons suffering from conditions like arthritis, bursitis, and sprains, some scientists and lay persons alike pushed for approval. Politicians, including one whose wife had scleroderma, a condition that causes painful thickening of the skin, tried but failed to legislate Congressional approval for the drug to treat scleroderma, arthritis, and other conditions. A second wave of media interest in DMSO in the early 1980s created further divisions between the FDA and proponents of the drug, with some alleging that the FDA's ban on the drug was a conspiracy with drug companies to increase profits.

A black market for the drug sprang up, and individuals could obtain DMSO from those sources or industrial grade DMSO from places such as hobby shops, garden stores, health food stores, and others. As long as the suppliers did not label DMSO as a drug, the FDA had no authority over the commercial solvent. Although the drug was finally approved in the U.S. for use in interstitial cystitis, the FDA's medical agent and the researcher for the drug company involved in the DMSO application process were accused of improper conduct and conflict of interest for bribery and failing to release negative reports of the drug.

The general public believes that drugs are federally regulated and therefore safe for consumers once they are approved by the FDA. However, a committee report by the Institute of Medicine, an affiliate of the National Academy of Sciences which advises Congress on public health issues, finds that the FDA has limited funds and authority to regulate licensed drugs once they are approved for consumer use (Nesmith 2006). Such limitations weaken the FDA's ability to protect and advance the public's health, and fail to hold drug companies accountable for the safety of their products. The report criticizes the use of fees paid by pharmaceutical companies to fund the FDA's drug-approval process – authorized by the 1992 Prescription Drug User Fee Act – as a conflict of interest for the FDA which tilts the regulatory balance away from monitoring the safety of drugs once they are approved. Further, the failure of the FDA to release negative reports about the safety of drugs raises concerns about “the extent to which the pharmaceutical industry has permeated the agency and how it may be influencing the agency's policies, practices and regulatory actions” (Koski 2004: 24).

Finally, Schetky (2008) finds an expansion in the pharmaceutical industry that has increased its influence among legislators and physicians but which has created a conflict of interest regarding drug safety and regulation. She maintains that the pharmaceutical industry is the largest lobby in Washington, DC, making substantial financial contributions to Congressional campaigns that in return result in extension of drug patents, tax breaks for the drug industry, and pro-industry legislation such as the pas-

sage of the Medicare prescription benefits. The Medicare prescription legislation, led by the congressman who later took over the lead of the main drug company lobbying group, was passed without allowing the government to negotiate the prices (Whitehouse 2008). Drug companies wield influence over physicians as they underwrite continuing medical education programs and conventions amounting to \$12 billion per year, which averages from \$11,000 to \$13,000 on marketing and promotions per physician annually.

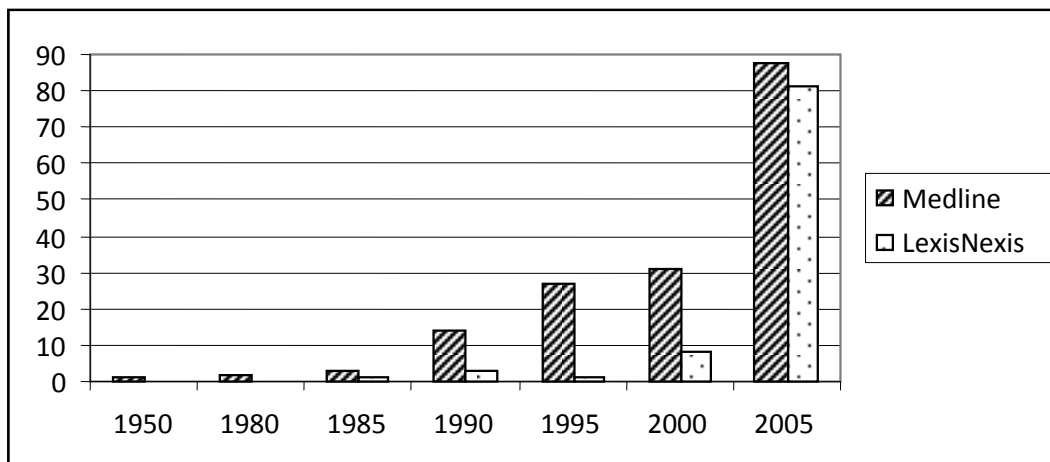
The number of drug representatives, called “Pharma Barbies and Pharma Kens” by critics because they are often hired based more on good looks rather than medical knowledge, doubled to 90,000 between 1996 and 2001 (Elliott 2006). In addition, in violation of patient and physician privacy, drug reps use physicians’ prescribing records, obtained by researchers from pharmacies and sold to the drug companies, to efficiently target physicians most likely to prescribe their medications. With incentive bonuses of \$30,000 to \$50,000, drug reps are often rewarded for aggressively promoting their product, which often includes such unethical behavior as “distorting research data, minimizing side effects, or promoting questionable drugs or the off-label use of products, in addition to offering lavish gifts, trips, or expensive tickets to sporting events” (Schetky 2008: 116). Although some physicians insist that their prescription practices are not influenced by such gifts from the drug companies, Schetky asserts that numerous studies show that even small gifts to physicians lead to an impulse to reciprocate. “PRs [pharmaceutical reps] try to influence physicians and pretend that they are giving impartial information while the physicians pretend that they are not being influenced and that they are not customers” (Schetky 2008: 116). Coupled with direct-to-consumer ads for prescription drugs, the work of the drug reps increases the sales of prescription drugs and the profits of the pharmaceutical industry, at the expense of patients who may be harmed by dangerous, or at best ineffective, drug prescription.

## PPD in Medical Literature

In 2007, I examined how the medical profession defines and frames PPD through a content analysis of articles contained in Medline, an on-line source for medical knowledge contained in the database of the U.S. National Library of Medicine (NLM), and with articles contained in the general news portion of LexisNexis (Regus 2007). Because the articles in Medline are generally written by medical professionals – doctors, nurses, psychiatrists, medical researchers, PhD’s, and others – they are an important source for understanding the medical perspective on PPD. Alternately, the articles in LexisNexis allow for an understanding of “lay” representations of PPD in the press. The sample of 109 articles was carefully chosen from both databases in 5-year increments, revealing changing definitions and frames over time.

The articles showed the emergence of the medicalization of PPD, evident in several areas: in the number of articles that increase from one published in 1950, to 87 published in 2005 (see Table 1); in the expanded list of medical professionals alerted to watch for signs of depression in their patients –

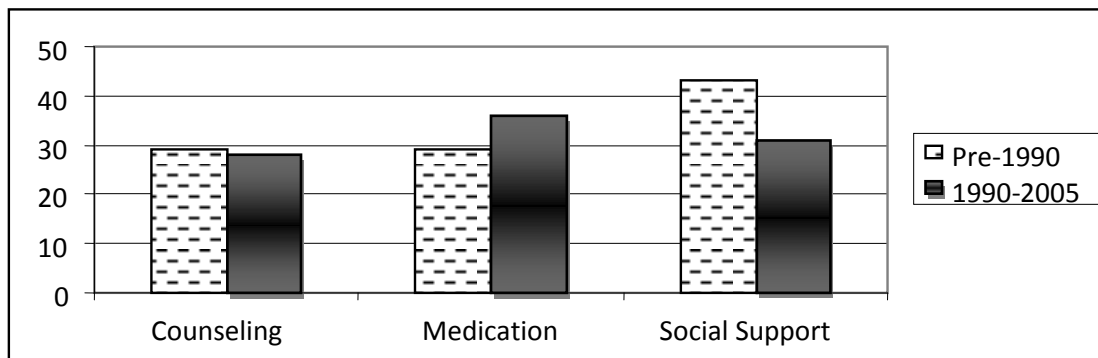
**Table 1: Frequency of articles on PPD in the Medline and LexisNexis Databases**





from OBs to pediatricians, nurses, primary care physicians, and social workers; and in the extended timeline of onset that includes not only a longer postpartum period but also pregnancy. Movement into the medical model is further evident in the suggested causes, the growing list of symptoms, and the screening instruments and methods used for detecting PPD. Medical professionals are encouraged to look for signs of depression in the patient's words, facial expressions, grooming, body language, and interaction with the infant. Thus, medical professionals determine what behaviors and appearances are normal for mothers, monitor mothers' conformity to those behaviors and appearances, and diagnose and treat those who fail to conform. Through the medicalization of PPD, the standards of motherhood are more firmly set, women's emotions are pathologized, and medical professionals intervene to lower the risk of harm to the infant. The result is that medical professionals gain greater control over women's bodies and emotions during the childbearing years, and women's voice and agency are further eroded. Just as the field of obstetrics devises timelines for the progression of pregnancy, the development of the fetus, and the progress of labor, all of which disempower women in the process of childbirth (Simonds 2002), medical professionals also establish timelines for the postpartum period, the onset of depression, and the duration of the illness that affect the probability that women will be diagnosed.

The sample articles show a narrative which changes over time, from presuming the disease is caused by single factors, such as hormones or lack of family support, to a combination of multiple biological and social factors that are said to predispose women to PPD. And although definitive causes remain unknown, social support as the preferred treatment prior to 1990 changes to medication in 1990 and beyond (see Table 2). The intensified interest in PPD that begins in the sample articles in 1990 predates the sensationalized case of Andrea Yates, a mother presumably with PPD who drowned her five children in a bathtub in 2001. And ironically, the increased emphasis on PPD corresponds to the introduction of Prozac to the U.S. market in 1987. Since the advent of Prozac, the rates of clinical depression have skyrocketed.

**Table 2: Recommended Treatment Pre-1990 and 1990-2005**

When a mother is fully functioning in her motherhood role, the infant develops optimally, the spousal relationship thrives, and the whole family is healthy and happy, nurtured by the mother. When a mother is not fully functioning, infants become dependent and fussy, the marital relationship suffers, and the family experiences chaos and stress. Thus the articles promote gendered ideals that place responsibility for the health and well-being of the whole family on the mother, with the expectation that she will maintain the home, the children, the spousal relationship, and her physical attractiveness. The consequence of not diagnosing and treating PPD is harm to the child, distress to the family, and finally harm to the mother herself. The scientific representations of PPD make it possible to treat the individual mother who struggles in her motherhood role rather than changing the cultural ideologies of motherhood that contrast sharply with reality. Mothers who do not meet the standards of motherhood simply become patients under the care of medical professionals. The growing list of symptoms, the expanded timeline for onset, and the many medical professionals charged with watching for signs of distress in the mother make it more likely that more women will be diagnosed with PPD.

In sum, existing literature emphasizes the social control placed on women from pregnancy throughout motherhood, which objectifies women and makes it possible for the medical profession to continue dominance over women's bodies -- and minds. Essentialist views of women create normative motherhood, and aberrations from those standards lead to treatment with drugs to bring the mother up

to par. Drug companies promote remedies to the disease, furthering their profits and further eroding women's agency in childrearing practices. What is missing from the literature is how women come to define their postpartum experiences either in terms of illness or as part of the normal adaptation to motherhood, and whether they receive additional support as a result of a diagnosis of PPD. With this study, I hope to add this missing part to the existing body of literature on PPD. While books have been written on the effect of PPD from the feminist perspective (Taylor 1996) or from an autobiographical stance (Shields 2005), I believe my approach offers new insights. Many studies accept the pathological view of the postpartum period and attempt to uncover causes and effects of the illness on the infant and the family. I believe that my study, which contrasts and compares the narratives of mothers with varying birth experiences who have been diagnosed with PPD with those from mothers who have not been diagnosed, offers new insight into the lived experiences of the postpartum period and reveals the effects of medicalization of PPD on women's lives. Specifically, I uncover the process by which some mothers come to define their experiences of motherhood in terms of illness, and I investigate whether and how diagnosis and treatment changes the support network for mothers. While I acknowledge that medication may be very helpful in some cases of PPD, the general trend seems to be to prescribe medication during pregnancy or the postpartum period as a quick fix for mothers struggling with the motherhood role in spite of little knowledge on the long-term effect of medication on the developing fetus, on the breastfed infant, and on the mother. Perhaps the findings from this study will add to the scant current research that questions the practice of solving social problems through medication.

## CHAPTER 3

### THEORETICAL BACKGROUND AND METHODOLOGY

#### Theoretical Background

The theories of Foucault, critical constructionism, and postmodern feminism are applicable to the study of the medicalization of postpartum depression. Foucault asserts that social control in modern society moved from direct physical control to more subtle degrees of moral control intended to keep individuals compliant, manageable, and submissive. Foucault's concept of bio-power suggests control over the population that is maintained not by external power but by the individual's internalization of knowledge and discourse created by institutions, such as medicine, the government, and others. The individual then identifies with and conforms to the normalization that such knowledge produces. Thus power is not from above but rather throughout the body of the population. For Foucault, "truth" is constructed through discourse in the activities of everyday life; individuals create and subscribe to regimes of truth, discursive formations that carry an assumption of authority with the power to deem knowledge as true or false. Individuals discipline and manage their bodies in order to perform according to these beliefs, becoming "docile bodies" (Foucault 1980). First conceptualized in institutional settings such as prisons, schools, the military, and factories, domains of docility are contemporarily evident not only in these settings that manage the prisoner, the student, the soldier, and the worker but in the everyday actions of all individuals who observe and are observed constantly by those around them.

Docility is particularly evident in the context of "healthism" in which individuals are compelled to take responsibility for their health by engaging in risk-free and health-promoting behaviors and undergoing periodic medical checks for the purpose of disease prevention and early detection. For pregnant women and mothers of young children, the responsibility extends beyond their individual bodies to

include the health of their infants. In this respect, docility results from varied forms of formal and informal surveillance (e.g., medical screening for depression, enforcing the cultural parameters of a “good” mother) and achieves willing compliance with norms and standards established by the medical profession.

The transformation to docility is achieved through disciplinary technologies that create the knowing, the knowable, and the self-knowing individual. First, hierarchical observation categorizes, distributes, and creates a definition of what is normal or not normal, and the transformation of individuals to knowing individuals requires awareness of these categorizations. Second, normalizing judgment allows understanding of self through biology, economics, and linguistics. Normalization is evident in national standards for educational programs, medical practices, and industrial processes and products. And third, examination occurs as the individual turns self into subject, undergoing a process of self-understanding mediated by an external authority figure such as doctor, psychoanalyst, or priest (Foucault 1975). In contemporary societies, discourse becomes an effective means of social control, instrumental in managing conformity through its normative operations. The process of separating the normal from the abnormal allows treatment rather than punishment for the abnormal but also serves as an enforcement of conformity for the normal (Rabinow 1984).

The second theoretical position that is applicable to the PPD issue is critical constructionism, a synthesis of conflict theory and social constructionism that focuses on how the meanings of social problems are constructed. Critical constructionism maintains that elite interests determine which phenomena are problematic; provide explanations for the causes of the phenomena; and persuade the public that the phenomena are problematic and, therefore, require action (Heiner 2002:9). Influenced by corporate sponsorship and driven by profits, the media serve as vehicles for influencing public opinion. By reporting on social problems caused by the less powerful but deflecting reports which implicate wrongdoing by their corporate sponsors, the media participate in shaping public response to social problems.

Critical constructionism recognizes an imbalance of power between the elite and those with the least amount of power in society. From this theoretical perspective, those in power exert their influence to maintain the status quo, allowing their continued dominance. This perspective is useful in examining the influence of the medical profession and the pharmaceutical industry on the construction of postpartum depression as a disease, both of which have much to gain in medicalizing the condition.

Postmodern feminism, which seeks not only to include women in research but to deconstruct hierarchically informed knowledge and power (Hesse-Biber, Nagy and Yaiser, 2004), is also relevant to my topic. Postmodern feminism is concerned with giving women the same rights as men, but recognizes that race, class, ethnicity, gender, and sexuality intersect to create multiple consciousness and to affect social structure.

Postmodern feminists often use texts (in varied forms), the products of dominant culture and signs of postmodernity, in conjunction with the view of the oppressed, as the starting point of cultural interrogation...not in order to reconstruct another view of the social world (an exercise in power and colonization) but rather to unravel the social processes and relations that have constructed the social world in hierarchical ways. (Hesse-Biber et al, 2004:19).

The intent of postmodern feminism is to create resistance to the status quo and interrupt power-knowledge relations. This perspective recognizes that essentialist and determinist views of the body established the male image as the ideal and the female image as the “other” and facilitated the expanding and on-going classification of the female body as pathological.

Medical and scientific discourse has confirmed the pathology of female biology and legitimated women's subjugation, prescribing in the past what activities women should engage in, what clothes they should wear to preserve appropriate 'womanliness', their moral obligation to preserve their energy for child birth and so on. (King 2004:31).

Postmodern feminism recognizes that gender constructions and identity are rooted in the procreative process of the female body to a much greater extent than that of the male body as a result of medical and scientific discourse.

## Sampling

For this study, I first interviewed a small sample (five each) of obstetricians (OBs) and certified nurse-midwives (CNMs) in order to compare their definitions of and experiences with postpartum depression. Two of the OBs had private practices, and one was part of a large group of OBs, all of whom were white men who practiced out of for-profit hospitals. One OB was a black woman who practiced at Central County Hospital in Atlanta, a public hospital which serves a mostly minority and poor population. The fifth OB, a black man, practiced at a non-profit clinic for Latinas in the northwestern part of the metro area. The CNMs were all white women, two of them practiced in large obstetrical groups, one was in a midwifery group that worked independently of obstetricians but with a specialist on call, and two worked at Central County.

I then interviewed a sample of 35 women whose youngest child was between 12 and 24 months old. Sixteen of the mothers received a medical diagnosis of PPD, and 19 are mothers who have not been diagnosed. The sample is also divided by mothers who chose the traditional obstetric care for pregnancy and delivery, as well as those who chose to use certified nurse-midwives (see Table 3 below).

**Table 3: Sample of Mothers by Diagnosis and by Birth Assistant**

	Diagnosed		Not Diagnosed
OB	9		9
CNM	7		10

I included – but did not specifically recruit – unmarried mothers in the sample, whether diagnosed with PPD or not, for the purpose of investigating the support system and the coping mechanisms they use when the support of a spouse or partner is lacking. In addition, I included demographic information such as age, household income, and race/ethnicity.

When I began this study, I interviewed the medical professionals first because I hoped they would be a source of recruiting mothers for the study from their practices. I left flyers with them and requested that they place them in their waiting rooms or give them to mothers who fit the study parameters and who they felt were likely to participate. They all agreed graciously; however, only one mother came to participate as a result. She had seen the flyer posted in the office of her CNM, a group that works independently from obstetricians in the midtown area. At the same time, I contacted the director of a Montessori school on the south side of town, a friend of mine, who invited me to present my research and hand out my flyers at a parent meeting one evening. From that presentation, I had one mother volunteer to be interviewed, and we arranged for me to come to her home one morning at a later date to interview her. Stymied by the low response rate and trying not to despair, I contacted the Southeastern University Child Development Center, where children of faculty, full-time students, and some employees of the State of Georgia send their children for daycare. I was given permission to distribute my flyer to the parents in that facility, and finally I got several responses, which seemed like a bonanza after such a slow start. All five of the respondents from that group were faculty members of Southeastern University. When those interviews played out, I sought permission and left flyers at various daycare centers throughout the metro area, some funded by the Georgia lottery and others corporate franchises. I got a few more respondents from that effort. I also posted flyers at a local gym and at a coffee shop, but received no responses from those sites.

I also searched online for support groups for mothers with PPD, and found the Postpartum Support International website that lists PPD support groups available in each city. The site listed three groups for the entire metro Atlanta area, out of which only one was an active group. Although one seemed to be in the process of being set up or dismantled, it was not active and gave no indication of whether it would be in the future. Another was initially set up as a group in the south Metro area, but the director said that because they rarely had members attend, they resorted to seeing patients individ-



ually on an as-needed basis. The group that was active was set up as a Meet-up.com group, which meets casually rather than under the supervision of medical professionals. Its founder and leader is a mother who experienced depression after the birth of her child, and the group members whom I interviewed spoke highly of her. Meet-up.com groups are formed based on mutual interests, such as hiking, board games, wine tasting, and in this case, postpartum depression. The mothers whom I interviewed who were part of this group found great comfort in being able to talk about the difficulties they were facing in a group of others facing similar issues, without judgment or fear of being labeled a bad parent. Some said they had tried other groups for moms and only felt worse when the talk was all about how wonderful motherhood is and what a blessing they've been given.

Participants who came to the study from these sources shared several characteristics: all of them had at least an undergraduate college degree, and quite a few had graduate degrees; only one was of a minority; and 20 out of 23 had family incomes of over \$100,000.00 annually. To help balance the sample, I set out to find mothers with lower incomes and less education as well as African American, Hispanic, or Asian mothers. I contacted the OB whom I interviewed at Central County Hospital, and she said that I would have to go through the hospital's review board to obtain permission to interview their obstetric patients, a process similar to obtaining the approval of the university's Internal Review Board (IRB). She suggested that, once I had that permission, I could set up food or snacks in the waiting area and hopefully interview mothers while they waited for their appointments. However, this process seemed to have a few drawbacks, including the tedious process of obtaining permission from the review board, the likelihood that the efforts would produce little results because the interview itself takes about an hour, and the waiting room would not offer the privacy conducive to having mothers talk candidly about their experiences. Thus, I decided to try other means to recruit minority and low-income mothers. Friends gave me the names of two African American midwives who practice in the metro area, as well as a midwife who practices in a hospital that serves low-income families on the south side of

town. One of these midwives suggested that I contact various chapters of Mocha Moms, a social group that is open to women of color of all economic backgrounds. From that effort, I was able to interview two African American mothers with family incomes below \$30,000.

Finally, I sent emails with my flyer attached to the local affiliates of the National Alliance on Mental Illness (NAMI). The director of a residential treatment center for women with substance abuse (SA) issues called me and said that she received the flyer from one of the NAMI chapters. She said that the facility has between five and ten clients with dual diagnoses who would fit the parameters of my study. She circulated my flyer along with a sign-up sheet among the residents. Although we had scheduled three days for me to be on site to interview a total of seven mothers who volunteered for the study, one of the supervisors advised her that we would have to obtain permission from the facility's CEO. The CEO had one question about the study: "Why would they want women who are actively in SA treatment to participate in and complete such a survey?" My response was: "My study focuses on mothers with diagnoses of postpartum depression. In the study, I compare the experiences of mothers who have been diagnosed with those of mothers who haven't been diagnosed. I'm looking at whether the amount of social support a mother has keeps her from experiencing depression after childbirth, and whether that support increases as a result of a diagnosis. Truthfully, I am not too familiar with issues of substance abuse, except that I've heard it referred to as 'self-medication.' If so, the stressors that mothers experience or the chemical makeup that would lead to SA could also likely lead to postpartum depression. My questions refer strictly to mothering experiences regardless of other factors, such as unemployment, poverty, single parenthood, and SA, that may be present. And because postpartum depression occurs at all income levels and in all races/ethnicities, I am trying to get as inclusive a sample as possible. Most of the participants who have responded to my study so far have been white women with family incomes of over \$100,000, which skews my sample and leaves out the experiences of lower-

income and minority mothers.” I was given permission and completed six interviews with mothers from that facility.

The six mothers from the treatment facility had family incomes of less than \$20,000, five of them had less than a high school diploma, and five were unmarried, although three were in committed relationships. Five were White and one was Black. Some of them told of stressful situations such as having been in abusive relationships or of problems that stemmed from being raised by someone other than their biological mothers. Three experienced the traumatic sudden death of their partner by suicide, drug overdose, or auto accident. Although all six mothers from this facility had been diagnosed with PPD, they went off their medications within a short time after starting them, some because they felt they needed to work through their emotions, one because she did not want to depend on a drug to make her happy, but others because they could not afford the prescription. All of them ended up self-medicating, which led to their voluntary or involuntary participation in the rehabilitation program and removal of their children to foster care.

I chose the timeframe of 12 to 24 months post delivery because onset of PPD is said to occur within the first six months to one year postpartum; thus my interview with the mothers would avoid the power of suggestion that could lead to a diagnosis of depression. And if a mother was undergoing treatment for PPD, she would hopefully be on her way to recovery, if not fully recovered, by 12-24 months. Further, memories of pregnancy and delivery and the months following childbirth would still be fresh.

### **Data Collection**

I used in-depth interviews in order to examine the language that mothers use to describe their experiences with motherhood, the birth process, the changes that occur in their relationships as a result of motherhood and/or PPD, and their knowledge and experiences of PPD. The interviews provided in-

sights into the nuances in the lives of mothers, both with PPD diagnosis and without, and according to the birth options they chose (traditional obstetrical care or certified nurse-midwifery). The interviews were scheduled at a time and place convenient and comfortable to the mothers. Thus some were conducted in the mothers' homes, some at coffee shops or restaurants, and some in their offices at their places of employment.

My interview instrument for the mothers contained open-ended questions that allowed exploration of respondents' experiences with motherhood and/or PPD as well as demographic characteristics such as age, race/ethnicity, family income, and marital status (see Appendix A). I tape recorded and transcribed the interviews verbatim, and I used grounded theory methods to identify indicators, grouping like indicators into variables and concepts. The most salient concept, the importance of talking to someone about the difficulties of mothering, became the core category, the key to the story. I conducted a pre-test of the interview instrument, interviewing a white, middle-class mother with a 24-month old child who used an obstetrical practice for pregnancy care. Although the interview flowed easily and seemed like a conversation between peers, one question concerning how the respondent's mothering style differs from that of her own mother seemed particularly difficult for her to answer. However, I kept the question in because I felt that it would be revealing of how the women were treated by their own mothers.

For interviewing obstetricians and certified nurse-midwives, my interview instrument contained questions regarding their view of what postpartum depression is, what causes it, and how often they encounter patients with it in their practices (see Appendix B). I asked what signs of the illness they look for, whether they rely on the woman's self-report, and what their course of action is when postpartum depression seems evident. I also asked how long their patients typically have symptoms, and what they believe would happen if a patient with postpartum depression was not diagnosed and treated.

## Coding

I began coding the interviews by combining broad themes, which I identified by the questions on my interview instrument. For example, I assembled all responses to the question, “What do you find difficult about being a mother?” into one group, and all responses to the question, “Has being a mother affected your relationship with your spouse, and if so, how?” into another. I continued this process for each question on the interview instrument. Then I looked at each group of responses to find the similarities and differences within each. I identified concepts, such as fatigue, no time for self, having to discipline, monotony, isolation, not knowing what the baby wants or needs, and so on for the difficulties mothers faced. For the question regarding the relationship with the spouse, I identified concepts, such as yes, we used to be quite the adventurous team; yes, we don’t have much time for each other; no, I’m grateful we’re on the same page, and so on. I grouped the concepts according to similarities, creating categories, or variables such as physical difficulties of mothering, or limited time to spend with husband/partner. Dissimilar concepts were set aside for possible new concepts. When new indicators failed to add new dimensions to a concept, the concept was considered theoretically saturated, or grounded. Constant comparison also resulted in fracturing and reconstituting the data, regrouping concepts which fit with other developing concepts (LaRossa 2005). The process continued until concepts reached an adequate level of abstraction, which LaRossa suggests occurs when the label grouping similar concepts contains neither too many nor too few indicators. For example, in the pre-test conducted with one interviewee, the respondent’s answers indicated that her mother was a source of support and yet also a source of feelings of guilt or inadequacy. She spoke of difficulty in trying to breastfeed her infant, and she indicated that the difficulty may have occurred because the medical staff took the infant away after delivery without giving her a chance to breastfeed her. She also said that someone (she did not remember who) suggested that the difficulty may have occurred because the infant may have been given a bottle of sugar water while in the hospital nursery. Although she used a breast pump to extract

milk for her infant every 2-4 hours for a few months, she did not continue long enough to suit her mother. As a result of her mother's reaction to substituting infant formula for breast milk, the respondent expressed feelings of guilt and inadequacy. On the other hand, when faced with difficulties such as a sick child, her mother was the first source of advice that she sought, and a Dr. Spock baby book (given to her by her mother) was the second. From this respondent's account, several possible categories emerged, such as: guilt for perceived failure to mother adequately; difficulty with expected maternal behaviors such as breastfeeding; interference from the medical staff and others; and sources of advice. Responses from all interviews were examined for possible similar concepts, as well as others as they arose.

Axial coding allowed concepts to be systematically linked and the relationship between variables explored. Coding in this phase involved placement of variables into categories that answered the questions *who, what, when, where, why, and how, and with what consequences*. This phase helped to answer these questions about how mothers dealt with the difficulties they faced as well as who they turned to for help, when they felt help was needed, and the consequences for seeking that help. As each category was analyzed, it was evaluated for its relationship to other categories. From the connections made between categories, a core variable, the importance of talking candidly with someone about the difficulties of mothering, was chosen. This variable became the main theme of the research, the centerpiece for the overall story (Glaser 1978; Strauss 1987; LaRossa 2005). Conceptually, the core category is an abstraction of the salient issues found in the data. The core category is chosen based on the following requirements (Glaser 1978; Strauss 1987): It must be central, all other major categories can be related to it; it must appear frequently in the data; the explanation that emerges must be logical and consistent, no forcing of data. In addition, others must be able to follow the analyst's path of logic and agree that the explanation is a plausible one. The name/phrase used to describe the central categories should be sufficiently abstract that it can be used to do research in other areas, leading to a more gen-

eral theory. As the concept is refined analytically through integration with other concepts, the theory will grow in depth and explanatory power. The concept is able to explain variation as well as the main point made by the data. In other words, the explanation still holds when conditions vary (Strauss 1987). Mothers in this study revealed a theme throughout the interviews: feeling relief when they were able to talk candidly with someone about the difficulties they faced with their mothering experiences. This finding applied to several concepts, including in friendships, in paid work, and in the spousal relationship, but differed in each context. Axial coding focused analysis on one variable at a time, looking for conditions, interactions among actors, strategies and tactics, and consequences (Strauss 1987).

Selective coding involved systematic coding of the core category. In this phase, coding was limited to codes that related to the core category. In other words, the core guided further theoretical sampling and data collection, looking again for conditions, interaction among actors, strategies and tactics, and consequences. The core, the importance of talking candidly with someone about the difficulties of mothering, differed within each category. For instance, mothers reported that while work provided many benefits, they were not able to talk about the difficulties they faced with mothering or with balancing work responsibilities with their parental responsibilities at work, unless it was with a co-worker or co-workers who also had small children. To do so would be considered proof of ineffective work habits or lacking qualifications for the job. This created a divide between mothers and their male or childless female colleagues who were thought to be unsympathetic to the mother's situation. As a result, respondents reported feeling resentful for policies that they felt favored males in the workplace, or they accepted that productivity would temporarily be less than the optimum. This last phase of coding revealed the contexts in which mothers could or could not talk candidly about their mothering difficulties, how they determined to whom they could reveal their difficulties, and the consequences thereof.

### **Limitations of the Study**

The small sample sizes of medical professionals and of mothers means that findings from this study cannot be generalized to the respective larger populations. Further, most of the mothers who participated in this study shared several characteristics: the majority of them were white working mothers with college degrees and family incomes of over \$100,000. Therefore, their experiences may not be valid for minority women or mothers with less education and lower family incomes. However, the knowledge gained from the mothers' narratives, both those with a PPD diagnosis and those without, reveal the similarities in their mothering experiences. Their narratives enlighten us to the daily lived experiences of mothers and the sense of inadequacy that many feel as a result of idealized versions of motherhood. In addition, this study aids our understanding of how some mothers come to identify as having PPD, whether diagnosis changes or increases their support network, and the effectiveness of the prescribed treatment protocol. The findings could shape future research on women's experiential knowledge of PPD, and could have policy implications such as providing alternatives to the practice of prescribing antidepressants, such as increased social support during the postpartum period.



## CHAPTER 4

### PPD PERSPECTIVES FROM THE LOCAL MEDICAL COMMUNITY

While medical research shows an intensified interest in postpartum depression, what influence does that research have on medical professionals in the metro Atlanta area? To understand how the local medical community approaches the issue of postpartum depression, it is crucial to know how they define it, what symptoms they look for, and how they treat it. It is reasonable to believe that their understanding of the malady would affect whether they view the postpartum period as potentially pathologic, which would affect how they view their patients and what they look for when examining them. Thus, I interviewed a small sample (5 each) of obstetricians and certified nurse-midwives in the metro Atlanta area. I included three obstetricians who practice out of for-profit hospitals and were at varying stages of their professional life. Of these three, one is close to retirement and had quit practicing obstetrics but kept up the gynecological services for his patients, whereas the other two had practiced for more than 10 years and were actively practicing both obstetrics and gynecology. All three were white men. The fourth obstetrician, an African-American woman, practices at Central County Hospital, an urban public hospital where patients are primarily low-income and the majority are African-American (King, Humphrey, Wang, Kourbatova, Ray, Blumberg, 2006). The fifth obstetrician, an African-American man, practices at a non-profit clinic in a suburb in the northwestern part of the city that serves a Latina patient population. (Note: The names of respondents and places where they practice have been changed to protect their identities).

The certified nurse-midwives (CNMs) whom I interviewed for this study were all white women, though they worked with different patient populations. Two worked in conjunction with OB/GYN prac-

tices that worked out of the for-profit hospitals in the area, one worked in a midwifery group independent of obstetricians but with a medical doctor on call as required for nurse-midwives to work in a hospital setting, and two worked in Central County's obstetrics department. Of the two CNMs at Central County, one was involved in the actual obstetric care of patients, while the other was involved in the family planning program; both served the maternal population that I wanted to study. Basically, my goal in interviewing both OBs and CNMs was to explore whether the choice of a CNM was more preventative to PPD than choosing an OB for pregnancy and delivery, considering that CNMs typically spend more time with their patients than OBs and often have fewer interventions in the birth process. Would their advocacy for the laboring woman and more holistic view of pregnancy carry over into the postpartum period, assuring mothers that their "symptoms" – both physical and emotional – are a typical part of post-delivery adjustment? And again, it was important to see if, and how, their practices differed according to the patient population they served.

Four of the OBs and four of the CNMs met me in their offices during their office hours, and one CNM met me at a coffee shop on her day off. To interview the fifth OB, I visited the clinic for Latinas twice before I finally found the doctor in, at which time I waited over two hours for him to finish his patient exams so that he could complete the interview. He greeted me with a large stack of files in his arms and continued to read through them for a few minutes before finally giving me his full attention for the interview. The interviews were brief, each taking approximately 10-15 minutes, except for the CNM who met me at a coffee shop (her interview lasted close to an hour,) and the OB who practices at Central County Hospital (her interview lasted about 45 minutes).

### **Setting the Stage: The Physical Environment**

Since the interviews were mostly conducted in the medical professionals' offices, it was interesting to note differences in their waiting rooms. The waiting rooms of the OBs and CNMs who practice

out of for-profit hospitals were furnished with comfortable and color-coordinated furniture, carpeting, and accessories, with a variety of reading materials ranging from fashion and home décor magazines to health and parenting magazines. Patients waiting to see these doctors and CNMs were all women of varying ages, some pregnant and some not. There were no men or children present in these waiting rooms.

In contrast, the offices of the OB and two CNMs at Central County Hospital were very stark, with gray walls, folding chairs, and worn furniture. Located within the hospital itself, the offices were functional but very austere. I was told that Central County's obstetrical patients go to satellite clinics throughout in-town neighborhoods for their prenatal and postnatal care, and come to the hospital only for labor and delivery. Thus, Central County's OB/GYN patients were not in the immediate area where the interviews took place.

The clinic that serves the Latina population was entirely different. A small waiting room with folding chairs lined up in rows faced a television set that was hung high on a wall and was tuned to a Spanish-speaking network. The room was filled with expectant or new mothers and their spouses or partners and their infants and children. There was little reading material, except for a few pamphlets printed in Spanish. When the mothers were called back for their examination, their spouse or partner and children would accompany them, or occasionally an older child would watch over an infant in the waiting room while the mother and her partner/spouse went back for her examination. At first, one might assume that Latina mothers have more family support than the mothers in the private practices, but there may be more practical reasons for the whole family attending the mother's examination. For example, the family may have only one licensed driver, or one car, or need the children there to interpret in case there is a language gap between the doctor and the parents. It is unclear whether gynecologic care of non-pregnant or older women is offered here, since the women in the waiting room were all pregnant or new mothers.

The procedure for the prenatal and postpartum visits for patients of the OBs and CNMs who practice out of for-profit hospitals is individual care, usually a one-on-one physical exam and brief consultation with the medical professional. However, it differs for those who attend the obstetric clinics at Central County Hospital and again for those who attend the clinic for Latinas. At Central County, patients, along with their partner/spouse or other support person, attend a program called CenteringPregnancy that includes their individual pre-partum check-ups as well as a group session with an informative and open-discussion format along with other couples at similar stages in their pregnancies. The purpose of this format is to address not only the physical aspects of pregnancy but also the psychosocial needs of the mother and her family (Massey, Rising, and Ickovics, 2006). Mothers are encouraged to ask the questions they have pertaining to issues of pregnancy during the group session rather than in the physical exam. Proponents of CenteringPregnancy suggest that this type of program creates stronger communities by fostering networks among the mothers-to-be as well as providing educational programs from a much wider array of medical professionals than individual care can provide, which enhances the well-being of the mother and her family and the community at large (Massey et al, 2006). Dr. Reddy, the OB whom I interviewed at Central County, explains the benefits of the CenteringPregnancy program:

What it offers is group support, right, so the visits are two hours long, and they're basically a discussion, two facilitators, and basically the women get to talk about whatever. Now it's not free conversation, because there're specific educational objectives for these sessions, but they [mothers] do typically become bonded, often they have reunions after they deliver, and some of them form an ongoing social network. So the question would be, does that coping or learning how to cope help women who are at risk for postpartum depression or who have depressive symptomatology? I don't know that we know the answer to that. (Dr. Reddy)

So rather than individual care, Central County's obstetric patients receive care in a group setting, and the benefit is peer bonding as well as providing educational sessions for both the mothers and their spouses/partners. And as stated above, the Latina clinic postpartum visit includes the mother along

with other members of the family. A pediatric clinic for infants and young children is situated in the same small building, just on the other side of the mothers' clinic.

### **Defining PPD**

Although I expected to find differences in the way OBs and CNMs approached the topic of PPD, their definitions and the suspected causes of PPD were similar. Most defined the disorder as pathology, an atypical condition that occurs in some patients after giving birth. I had expected the CNMs to offer a more-holistic view of the postpartum period, allowing that women adjust to the physical and emotional effects of childbirth at varying rates. Just as the CNM focus on childbirth allows for variances in the progression of labor and advocacy for the mother in the birth process, I anticipated the same perspective would carry over into the postpartum period. But perhaps because the CNMs not only work in conjunction with OBs but are trained in both obstetrics and midwifery, the obstetrical training takes a more prominent lead than midwifery in their view of the postpartum period. In addition, the CNMs whom I interviewed worked in hospital settings, which require adherence to strict medical practices, which may be a logical explanation for their medicalized view of the postpartum period.

Three of the OBs defined PPD as clinical depression that occurs in the postpartum period, although one of them indicated that it could begin toward the end of pregnancy. The other two OBs, however, offered a slightly different opinion of what PPD is: Dr. Parks defined it as "an abnormal response to a delivery and acceptance of motherhood, and Dr. Hardy defined it as "...a depressed effect, and they [mothers] lose that joy of life when ordinarily they would be happy having the baby but when they come in, they're sad, they're not sleeping, they're not eating, little things bother them, those types of symptoms to me signal PPD" (Dr. Hardy). Although these latter two OBs explicitly promoted that motherhood should be a natural state for mothers and a joy-filled time, the others implicitly promoted the same with the symptoms that they look for in patients: crying, sadness, feeling overwhelmed, anxiety,

anhedonia or dysthymia (both are medical terms designating the loss of joy in one's life). Other symptoms mentioned throughout the interviews included sleeplessness, fatigue, loss of appetite, loss of libido, all which could be expected as a result of giving birth or of having a newborn infant with unrelenting needs and irregular sleeping patterns.

The CNMs offered very similar definitions and symptoms, such as “an exaggerated pathology from the hormonal changes in pregnancy, where patients are so depressed that they lose their sense of reality, of what their situation is, what's going on around them” (Mary B., CNM). The CNMs also added that the mother may not engage in self-care (for example, not wanting to get dressed, groom oneself, or eat appropriately) or care of the baby, or she may have thoughts of hurting herself or the baby. The Medline articles generally indicated that losing sense of reality or acting on thoughts of hurting herself or the baby are often symptomatic of the more extreme and rarer condition of postpartum psychosis.

Indeed there seemed to be some blurring of the lines between “normal” postpartum conditions, PPD, and postpartum psychosis. Some of the mothers whom I interviewed felt that medical professionals lack an understanding of what mothers go through in the postpartum period. For instance, many said they found it difficult to find time to do the usual self-care activities, such as taking a shower (Debbie, diagnosed; Carly, not diagnosed) or eating at regularly scheduled times (Carly, not diagnosed; Tamarra, not diagnosed). Rather than a symptom of depression, they indicated that it was more a practical issue; the demands placed on them to care for the infant, often alone and without any assistance, resulted in changes in their normal routines. Some felt that the main questions asked by the medical professionals pertained to whether they felt they would hurt themselves or the child. However, mothers felt that while they may occasionally have had those thoughts fleetingly in moments of despair, they would never act on them; rather, they had so many other issues that the professionals failed to recognize. For instance, mothers struggled with the relentless responsibilities and physical fatigue that often comes with having a child, but those issues were rarely addressed in their visits with their OBs or CNMs.

### When and How Often PPD Occurs

The onset, according to these medical professionals, varies from immediately after giving birth to several months post delivery, and a couple suggested that depression could begin in pregnancy. Dr. Stephens, in one of the for-profit hospital groups, said:

People that have it, the great majority of people that have it are going to already have it by the time they come in, and we really don't make a conscious effort to talk to them about it until they come in for their 6-week visit. I think it's usually a part of what we screen for at 6 weeks. I have a little speech that I give about the 4 things that we talk about at your postpartum visit, but that's a long time after delivery. (Dr. Stephens)

Although this OB believed that onset usually occurs before the 6 week postpartum checkup, he also indicated that it can start during pregnancy or have onset several months after giving birth. The local medical professionals' responses to the time of onset supported the extended timeline for onset, including during pregnancy and throughout the first year, as found in the Medline articles.

When asked how often they see it in their practice, answers ranged from 1 or 2 percent (Dr. Parks, the older OB who no longer practices obstetrics) to "very few" (Dr. Reddy, the OB at Central County Hospital who rarely sees patients postpartum) to 15-25 percent in the private practices. Dr. Parks, the older OB, may have quit seeing obstetrical patients before the increased interest in PPD, and the low rate at Central County may be due to a low percentage of mothers who return for their postpartum checkups. Dr. Taylor at the clinic for Latinas says he sees it frequently, but as his patient population faces unique obstacles to treatment (discussed later), there is not much he can do. Dr. Stephens believed that PPD is recognized only in half of the patients who have it, and others – OBs and CNMs – echoed that sentiment:

I think we don't diagnose it enough. I think if you're not sensitive to it, you never see it because if you don't ask people about it they're never going to tell you. If you're sensitive to it and you're asking people about it, particularly if you're lucky enough for them to have brought another family member with them to their visit, you pick up on a lot. (Sarah G., CNM)

Sarah G. indicated not only a reluctance of mothers to talk to medical professionals about mothering difficulties, but she alluded to the expectation that other family members will identify symptoms of depression in the mother and report them to the medical professional. She also believed that many cases of PPD go unrecognized, partly because of the reluctance of mothers to reveal any difficulties to medical professionals, but also because of a failure of medical professionals to be aware of the potential for PPD in their patients. She expressed the need for medical professionals to be more alert in their surveillance, looking for signs in the mothers themselves but also taking cues from other family members when present. Medical professionals' responses indicated the need for knowledge about the disorder so that mothers who are struggling with PPD can receive the help they need. Note that the gaze upon mothers extended to family members as well as the medical professionals, requiring vigilant observation from both. This supports Foucault's concept of social control at the capillary level; the gaze upon mothers creates conformity to normative motherhood, enforced through the institutions of medicine and the family. The idea that "they're never going to tell you" unless you ask about it implies adherence to the good mother ideal, that breaching this ideal by revealing struggles with motherhood is stigmatizing and something that most mothers are unwilling to do. Women may be particularly hesitant to discuss such problems with a doctor, perhaps because they may feel shame for struggling with their role, or feel they would be pressured to take medication, or may even be at risk of losing their children.

### **Causes and Symptoms of PPD**

All of the medical professionals indicated that a biological component, particularly the dramatic drop in hormones post-delivery, is likely to play a role in PPD, but most said that other factors contribute to it as well. Stressors such as problems in the home life, a family or personal history of depression, or low thyroid functioning are also suspect. Katy T., a CNM, indicated that having less support is a major factor, and that "some people are kind of prone to having an experience of depression in their life at



various points that are stressful for them.” And a CNM from an obstetrical group indicated that the expectations about being a mother often do not match reality, and can contribute to PPD:

I think there’s a component of unmet fantasy. A lot of women today, because of the media and because they’re removed from their families, are removed from the reality of other people having babies...[they think] people are supposed to give birth and look like they never had a baby. They’re supposed to have their makeup done, and the babies are supposed to be perfect and they’re supposed to be perfect and their marriage is supposed to be perfect, and that’s really not the reality because having a baby is incredibly stressful. People aren’t really prepared for that. (Sarah G., CNM)

The media, then, were said to play a role in promoting idealized versions of motherhood which becomes a part of the expected culture of motherhood and, without exposure to the realities of what motherhood really entails, becomes a shock to mothers when they struggle with the reality of their new roles. This dissonance between idealized versions of motherhood and reality is a possible cause of PPD. But medical professionals also implicated several larger social issues as possible factors that contribute to PPD. The first was the belief that people are “removed from their families,” which suggests a lack of familial closeness that could be interpreted as physical distance because families move away from extended family and thus lack the support that physical proximity to other family members could provide, or as emotional distance from family members that lessens the amount of support available. The second was the suggestion that media serve as a substitute for family closeness, which allows Hollywood versions of motherhood to become the expectation, and those versions contrast sharply with the reality of motherhood. And the third implied that the marriage or partner relationship undergoes a period of adjustment, for a time feeling less than perfect, because of the stress that having a child brings. And finally, the stereotypical view of what a normal postpartum period should be was evident in the medical professionals’ narratives, which creates ever-tighter boundaries around normative motherhood. If these structural issues are factors in the increasing prevalence rates of PPD, it seems that treating mothers with antidepressants would prove ineffective, as the individual mother may receive temporary relief but the structural issues would remain unchanged.

Dr. Hardy, an OB in an independent practice in a northern suburb, stated:

What I see as a clinician is such a decrease in the hormone levels and an increase in responsibilities for the new mom, and these kind of come together to cause a feeling of hopelessness and they feel like too much is on them where really they *should be* experiencing the joy of having the baby. (Dr. Hardy, emphasis added).

The expectation that motherhood is a joyful time was again explicitly pronounced here, furthering the idealized version of motherhood. Dr. Hardy implicated not only biological causes for PPD, but also the disproportionate responsibilities placed on mothers for the care of the child. Normative motherhood was evident in his suggestion that mothers alone take on the increase in responsibilities, and they should be feeling joy during the postpartum period, but the gendered nature of division of childcare responsibilities makes it overwhelming. A normal postpartum period, then, was presumed to be that it is mothers who will be the primary caretakers of the infant, and that they will enjoy the additional responsibilities that come with having a child and will handle them with ease. Deviations from the norm, assessed according to specified symptoms, were considered illness. And again, the essentialized view that women are naturally adept at mothering was displayed in this quote.

Further indications of combined biological and social causes for PPD became evident in the interviews. Dr. Stephens suggested that certain people have “an underlying susceptibility,” whether chemical or genetic, while others become depressed because of situational factors such as family stress or economics. As Mary B., a CNM at Central County, stated, “I think some people just get it, bad luck.”

Dr. Hardy also referred to economics as well as relationship issues as possible causes for PPD:

I think it [PPD] is across the board, it's just that people who have more economic means, you know, more well off, have more support, you know, and then just getting gas for the car is not a big problem. They can get gas for the car. But if you can't even get gas for the car, you know, then it makes it worse. (Dr. Hardy)

Dr. Hardy implicated a person's socioeconomic status as a possible cause for PPD: if a mother struggles economically, then she is more likely to experience PPD. Support in this instance seemed to imply material resources rather than emotional support. It may be that having economic support allows persons

more access to resources, but it says nothing of the emotional support that may or may not be available to mothers. Dr. Stephens echoed the suggestion that the current economic conditions add to the stress that can lead to PPD, which may account for an increase in the number of cases of PPD:

Certainly in our economy in the last few years, a lot of people that, unfortunately economics is a big deal, and certainly economic hardship has been much more common in the last two years, which therefore makes that certainly a trigger for it [PPD]. And so I would say it probably has increased if for nothing more than that. (Dr. Stephens)

Thus, persons who suffer economic stress were believed to be more likely to experience PPD. Again, if structural issues such as the economy cause stress that may lead to PPD, it seems illogical to treat mothers with antidepressants; the economy will not change with such treatment. In fact, some of the mothers with low family incomes who participated in this study received diagnoses of PPD and were prescribed medication, but none of them continued the medication protocol, some simply because the cost of the medication added more economic stress to their already dire situation.

So while hormones were a suspected cause, most of the medical professionals acknowledged social contexts as possible triggers for PPD. These included financial stress, lack of partner support, realities that differ from their expectations of motherhood, and the overwhelming and unrelenting responsibilities that come with mothering. They also included the idealization of motherhood espoused through media representations and Hollywood actors, which support sexist gender expectations that women look the part – be in good shape and wear makeup. Biological and social factors, then, are said to provide the opportunity for PPD to occur.

As mentioned before, the medical professionals listed symptoms typical of those found in the Medline articles: crying, sadness, feeling overwhelmed, anxiety, anhedonia or dysthymia (the loss of joy in one's life). Other symptoms mentioned throughout the interviews included sleeplessness, fatigue, loss of appetite, loss of libido, and others. One of the CNMs described these as "classic symptoms," which indicated a general acceptance of clinical depressive symptoms applied to the postpartum period. Medical professionals' "sign work," defining certain emotions or behaviors as signs of depression, then

firmly established the standards of normative motherhood. The signs can be grouped according to emotions such as crying, sadness, feeling overwhelmed, anxiety, and loss of joy, or to conditions such as sleeplessness, fatigue, lack of appetite, and low libido, or to behaviors such as not grooming oneself, or not taking care of the infant. Through the medical gaze, clinicians used these signs to assess mothers as either normal or ill, and the subsequent course of action depended on the clinician's perception of the mother's mental health: a clean bill of health or treatment for PPD. Thus, women's emotions were pathologized, and the essentialist view that mothers have instinctual tendencies to nurture represented the normal postpartum period. Mothers who struggle with their mothering responsibilities represented deviations from the norm. What clinicians' sign work did not account for is the lack of sleep, the mindless activities, the relentless responsibilities that mothers face, often alone, and the contextual social factors that make caring for a newborn difficult. Instead, it set standards for behaviors by which all mothers are judged.

Because one of my research questions was how do mothers come to identify their postpartum experiences as depression, I asked the medical professionals whom I interviewed whether the patient self-reports symptoms or if other family members recognize certain behaviors as symptoms and ask for help. This question came about after reading Brooke Shields' autobiographical account of her experience with postpartum depression, in which she described her husband's persistent concern that she was not bonding with her baby. Because he seemed to mirror the inadequacies that she felt as a mother, she sought medical treatment and was prescribed antidepressants, which she felt helped her recover. I questioned whether this type of role enforcement, by husband/partner or other family member or person close to the woman, could lead mothers to identify their postpartum experiences as depression. Dr. Stephens responded:

Anytime we have patients that we think have major depression, we talk to their family members. I personally have called, numerous times, husbands or significant others and said, look, this is -- whether she says it or not -- this is a problem, and be aware of it. And *however you can help us with it*, if it's just telling us things are better or worse, or you know, just be-

ing aware of it. But I think we're obligated to involve family. A lot of times it comes from the husband or the mother calling us and saying, hey, so and such is coming in today and she's not right, or not doing well, and that kind of thing. I bet a third of the time we have people that have major depression come, we're alerted from the significant other and not the patient. You know the classic term. "Something's wrong, she's not my wife, she's not behaving normally," whether it's -- again, I think there's the two groups, the group that withdraws and the group that acts out, you know, yells and screams and complains and cries, you know, that kind of thing. It's a hard thing. (Dr. Stephens, emphasis added).

The local medical professionals whom I interviewed indicated that sometimes the patient herself phoned in and expressed her distress, or sometimes a family member phoned in with concerns about a change in the mother's behavior. Otherwise, medical professionals saw it as their responsibility to recognize signs of depression during the postpartum visit. Again, the psychiatric gaze upon mothers extended beyond the medical profession to other family members, and imposed expectations of standardized behavior on mothers. The paternal gaze of medical professionals increased surveillance of mothers, in collusion with other family members such as the husband or the mother's own mother. The term "help us with it" implied a hierarchy that puts the doctor in charge and the family members as enforcers, all looking for signs of abnormality in the mother. One of the findings from my interviews with mothers was that many chose not to talk with their husband/partner or mother about the difficulties they were facing with their mothering responsibilities, possibly because of the type of role enforcement – by medical professionals and family alike – that was obvious in the quote above. Instead, they chose to talk with peers – other mothers with children close in age to their own – or people not in their close circle, such as store clerks or beauticians. (More on this follows in Chapter 5). Standardized behavior was also indicated in what one CNM looked for in new mothers:

So at about 4-6 weeks when daddy looks like, you know, somebody's been beating him the whole 4 weeks, then you know there's a problem. When you see a situation where the mother is not the primary person taking care of the baby, because sometimes you'll see the daddy changing the diapers and the daddy feeding the baby, that's not what you'd expect to see at that point. Or if the mother looks very disheveled, she's not clean, she's not very well cared for, or if you see a physical symptom like she's not taking care of, either she had stitches and they didn't heal properly, or she had a wound and it didn't heal properly. The other thing to look for is that we know before we see them, we have a little synopsis of what their delivery was like. If you have somebody with a long, complicated, maybe a disappointing labor, like you had a

mother who really had an idea in her mind about how she wanted things to go, and not only did it not go that way it went really badly, maybe her breastfeeding failed after a lot of trying or she had a delivery that wasn't at all what she expected, maybe she had an emergency or the baby had problems and was hospitalized, those are red flags that you need to be looking for depression. (Sarah G., CNM).

Thus the mother's role was reinforced as the nurturer of the entire family, the primary caretaker of the infant but also held to standards for her physical presentation as well as that of her husband. The quote above emphasized the importance placed on physical appearances as a sign of mental health, much the same as the OB mentioned earlier in the introduction who had assumed that the young mother was not depressed because she was well dressed, her hair was groomed, and she wore makeup. Gender roles were explicitly promoted, and departure from such standardized behavior was considered pathologic, thus shared parenting responsibilities were considered a sign of illness. Indeed, medical professionals reify gender roles as they examine patients not only for physical health but also for signs of depression. What is astonishing in the above quote is that breaching gender roles, such as sharing parenting responsibilities – the father feeding the infant or changing diapers—is considered mental illness, as PPD is defined as a mental illness by the DSM-IV and the medical professionals whom I interviewed. Besides physical appearances and behaviors that counter normative motherhood, medical professionals and the Medline articles also implicated perceived failures of women's bodies, such as a long or complicated delivery or difficulty breastfeeding, as contributing factors to PPD. Much as obstetrics established a timeline for the progression of labor and delivery, which timeline determines whether a birth will be deemed "complicated" or normal, a timeline also fits the medical understanding of PPD, determining whether adjustment to motherhood is normal or pathological. Thus, by defining the "symptoms" of PPD, a standardized model of motherhood promoted by local medical professionals emerged that included bodies that perform perfectly in childbirth and breastfeeding, adherence to traditional gender-normative parenting roles, behaviors and emotions that display natural tendencies to nurture, and physical appearances that are gendered and socially acceptable.

Dr. Hardy suggested that the difficulty of identifying some cases of PPD comes from the mother's own reluctance to divulge difficulties she may be experiencing:

So it [PPD] is a big problem. It often goes undiagnosed because people are not on the lookout for it... Part of it is they [mothers] think they're supposed to say, "Okay, I'm doing fine" and they're not expected to say, "Okay, well gosh, you know, this is a lot, I don't feel good, I'm up all night, you know the baby's crying, my boyfriend is off drinking beer all night, and he doesn't help, he doesn't do laundry, he doesn't go to the grocery store, he doesn't change the baby, those kinds of things. (Dr. Hardy)

His quote explicitly highlighted the expectation that mothers bear full responsibility for the care of the child while fathers' participation is arbitrary, and that ideological representations of motherhood keep mothers from being able to voice their dissatisfaction with the status quo. Therefore, he believed medical professionals should be vigilant in their assessment of the mother's state of mental health. Because his statement seemed to suggest that a certain segment of the population is more likely to experience PPD, I asked him whether he thought PPD affects mostly single mothers or mothers with low incomes or little social support. He said he believes it happens in all categories, but that these characteristics create stress that makes PPD more likely to occur. It reinforced his earlier assertion that persons of lower socioeconomic status are more likely to experience PPD. And, his statement iterated the ideology of the good mother, indicating that mothers are expected to be able to handle motherhood with all its warts and are hesitant to reveal any difficulties they are experiencing because of the high expectations placed on them. But again, rather than "fixing" the behaviors of the boyfriend in the situation above, it is the mother who received a diagnosis of PPD and treatment that included medication.

The symptoms of PPD that local medical professionals outlined strongly supported the essentialist view that women are naturally adept at motherhood. They suggested that nurturing and competency in childcare are instinctual components of being female, and that transition to motherhood should be a time of joy. And, they perceived departures from this ideal as signs of illness that could be fixed through treatment. Structural or situational factors that were believed to contribute to PPD were not

addressed, nor were the behaviors of others who impacted the lives of mothers; it was the woman who was deemed to be ill.

## Screening

Just as the Medline articles indicated that physicians should ask questions in conversational style to assess mothers' mental state in pregnancy and the postpartum, the OBs and CNMs whom I interviewed supported this practice. Although screening was high on each of the local medical professional's postpartum protocol, they did not use a formal screening tool; rather, they talked with the patients about their physical recovery from childbirth and their adaptation to motherhood. During this "conversation," they looked for signs of distress, such as crying, or if the patient indicated feeling overwhelmed or anxious. Dr. Stephens, who practices out of Parkridge Hospital, indicated that he does not actually screen patients in the hospital, but believed that is part of the nursing protocol. Instead, he talked with each patient during their postpartum checkup usually four to six weeks after childbirth, and covered difficulties they might be facing. This, too, was in keeping with the medical literature that delineated the nurses' role as taking an emotional assessment of the mother after childbirth, before she was discharged from the hospital. The Medline articles indicated that other medical professionals who have contact with the mother after her discharge from the hospital, such as the pediatrician and the primary care physician, are also responsible for recognizing symptoms and treating them. Thus, the local medical professionals whom I interviewed used informal screening to detect PPD in their patients, and screening through conversational technique seemed to be the status quo regardless of race or class. Dr. Taylor described his method for assessing his Latina patients' mental state postpartum:

I don't actually screen patients for depression, but I do silently note whether they are upset or whether they have complaints that may indicate more than just physical distress. I just had a mother who came in 10 days after giving birth complaining that the incision [episiotomy] was painful, and as it can be expected to still be painful that soon after delivery, I spent some time asking her questions about what's going on at home. I look for signs of abuse, like bruises or



marks, or if the husband seems intimidating, because we're required to report any suspected cases of abuse. (Dr. Taylor)

Interestingly, Dr. Taylor suggested that complaints of physical distress a certain length of time after childbirth then become suspect to emotional or psychological distress. In much the same way that OBs use time-carved periods to determine the progression of pregnancy and labor, so too is the postpartum period built around timing, such as pain from an episiotomy 10 days after childbirth. One must wonder whether psychological distress or abuse would be suspected if a mother complains of pain on the 11<sup>th</sup> day after childbirth.

Doctors informally screened patients for signs of depression, but then faced the challenge of deciding what to do if a patient is found to be depressed. Dr. Reddy, at Central County, although a proponent of screening, expressed shortcomings in the pressure to screen for PPD:

That's the problem with the recommendations to do the screening: People don't like to screen for things for which they don't have a response, right? And so the natural feeling – and OB/GYN doesn't do much to actually train you to deal with this, right? We probably do more now than we did before, so you end up with people going 'I'm supposed to screen but I don't know what to do.' And I think part of the message that goes with the screening is you should have referrals, you don't have to deal with it but just be able to say who to go to. That's what's really sad because we really have few resources. If you go throughout the state, there is nothing. But then, in Georgia, mental health resources, as a whole, are poor. So you get people who deal with mental health, but then don't want to deal with pregnant women because they're nervous about that, and then you have people who deal with pregnancy and they don't want to deal with the mental health issue, and there are few resources. Here you have Zachary Stowe [psychiatrist and director of the Women's Mental Health Program at Emory], and he's the go-to guy, that's the name everybody thinks of, okay, if I have to refer somebody, that's who I should refer them to, and so he's the resource that anybody at Parkridge will probably come up with. And it's amazing to me that, out of any contacts, he's the one name, nobody knows anybody else. (Dr. Reddy)

As this statement indicated, a lack of resources to which the OBs and CNMs can refer their patients with PPD created a dilemma for them if a mother was found to be depressed. But this statement carries a much larger supposition, as it implied that the campaign to screen, diagnose and treat PPD does not come from the physicians themselves, but from another source. Dr. Reddy indicated that the training in medical school does not train specifically for screening, leaving OBs on their own to determine the best

way to screen for PPD. And confounding that dilemma was what to do if a mother was found to be depressed, which also made it difficult for OBs to refer their patients to qualified resources. She suggested that mental health professionals are uneasy treating pregnant and breastfeeding mothers who experience PPD. Possible explanations for this could be the risks involved in using medication during pregnancy or while breastfeeding, or because of the temporary nature of PPD, which would make the relationship with a PPD patient a short-lived one. Further, she suggested that OBs are uneasy treating patients who are experiencing PPD. Her assertions lead me to question: if it is true that OBs are not comfortable treating their patients who experience PPD, and the mental health field is not eager to treat pregnant and breastfeeding women, who or what is at the forefront of the medicalization of PPD?

### **Treatment**

Just as the care that mothers receive in pregnancy and the postpartum differed by race and class, so did treatment. An important question this study asks is whether the way medical professionals view postpartum depression translates into treatment strategies for their patients. The CNMs and the OBs at Central County and the Latina clinic did not treat their patients who experienced PPD but referred them to other resources (more on this follows). All of the OBs and CNMs who worked out of the for-profit hospitals indicated that they prescribed medication, specifically antidepressants, and even more specifically, most often Zoloft, for mothers who showed signs of distress. One CNM remarked that she had also worked as a family nurse practitioner before, in which position she had “psych patients that weren’t even pregnant or maternity patients at all, so I’m very comfortable treating depression and anxiety” (Katy T., CNM). Most believed that medication is the fastest way to alleviate symptoms of depression, and they felt that mothers with a newborn infant may not have the time to attend counseling sessions or support group meetings. Ironically, Dr. Hardy stated: “But really the combination of counseling

and pharmacology, some medicine, would give a good response usually.” Dr. Stephens expressed a similar concern, that

mothers with a “brand new seven pound baby that I have to be with 24 hours a day,” sometimes, people that might benefit from counseling – or whatever word you want to use – feel like they don’t have time or the means to do that, and then they automatically will say, “Okay, I’ll just try medicine” kind of thing. (Dr. Stephens)

Even though these professionals recognized the benefit of counseling and/or support, they prescribed medication as a fast remedy for mothers with PPD. Medication then allowed the mother to receive treatment without interfering with the responsibilities of mothering; she would not have to interrupt her schedule of feedings, naps, and diaper changes in order to receive help for her psychological distress.

All of the medical professionals who administered medication as treatment spoke of a trial-and-error method of prescribing. Most said they provide patients with samples as they leave the office and a prescription to be filled later. They described starting patients at a low dose and then gradually upping it after about a week and upping it again if necessary. Marsha F, a CNM, said she tells the mothers that it takes three to four weeks to feel “any kind of difference” and that the medication can be changed if needed. Another CNM said that treatment depends on what the symptoms are: “I tell people that the medicine that we use for depression is a lot like perfume. What is perfect for one person may be horrible for you. So we don’t really know until we try” (Sarah G., CNM.). So while one medication at a certain dose may work for some, others may need a higher dose or a different medication entirely to see results.

Dr. Hardy, an OB who now works as a single practitioner but who at one time had CNMs and a Physician Assistant on staff, suggested that the medication often has a placebo effect:

Well, I mean, the patient, a lot of times they say, “well it [medication] hasn’t worked for me,” or they’re getting immune to it, or something like that, but that’s probably not really the case. It probably is working, but we may have to adjust the dose. But if they think that it’s not working, that’s part of the problem; then if you give it to them they’re going to think it’s not working, so you have to switch to something else, even though it may be very similar in biochemical action.

But if they can switch to something else and they think that one is working, so that gives us a one up. (Dr. Hardy)

Note the term “one up,” which implied success in convincing the mother that the doctor knows best. Discounting the patient’s experiential narrative, Dr. Hardy seemed to view prescribing medication as a mind game in the process of alleviating symptoms of PPD. Between trial-and-error prescriptions and effectiveness that relied on the mother’s belief that the prescribed medication will work, treatment seemed to be less than precise. He believed that medication is the fastest and most convenient treatment for PPD. He acknowledged the limitation of medicating patients, but because some of the older medications are economically affordable, even if they are not as effective as the newer ones, they are readily available to patients with PPD. He heavily promoted the idea that the mind, specifically positive thinking that the medication will work, is more important than the medication itself in treating PPD.

Almost every medical professional interviewed indicated that a problem arises if a mother is found to be depressed. Frustrated with a lack of resources, the private OBs and the CNMs who practice out of for-profit hospitals did prescribe medication for mothers with symptoms of PPD. Once a patient is on medication, the amount of monitoring for progress differed. Two of the CNMs saw the patient back in two weeks to assess whether the medication was working, while one saw them back in three months. The two CNMs and the OB at Central County and the OB who assists Latina patients referred their patients to other mental health resources rather than attempting treatment (more on this follows). Of the three OBs who work out of for-profit hospitals, only one saw patients back in two to three weeks, then once a month for six months, then once every six months tapering to once a year (although he said he tries to get them off medication after six months to a year, with some requiring more extensive therapy). The other two had a less vigilant approach to monitoring their patients’ progress, one seeing them back in three to four months, and the other instructing his patients to call if not better in a couple of weeks.

One of the most prescribed drugs by the local medical professionals is Zoloft, which is a newer SSRI that has been promoted as safe during pregnancy and breastfeeding. However, an advertisement on television for attorneys that take on medical claims recruits clients whose children were born with defects as a result of taking Zoloft during pregnancy, which signals that there have been actual cases of defects related to the drug. Further research into the effects of Zoloft shows that the FDA now requires a warning in Zoloft's packaging literature for prescribing the drug to pregnant and breastfeeding women. The FDA site on Zoloft reveals the following side effects of the drug on the fetus or breastfed infant:

Reported clinical findings have included respiratory distress, cyanosis, apnea, seizures, temperature instability, feeding difficulty, vomiting, hypoglycemia, hypotonia, hypertonia, hyperreflexia, tremor, jitteriness, irritability, and constant crying. These features are consistent with either a direct toxic effect of SSRIs and SNRIs or, possibly, a drug discontinuation syndrome. It should be noted that, in some cases, the clinical picture is consistent with serotonin syndrome...When treating a pregnant woman with ZOLOFT during the third trimester, the physician should carefully consider the potential risks and benefits of treatment. (U.S. Food and Drug Administration.)

A separate warning includes that infants exposed to Zoloft in the last trimester have an increased risk for persistent pulmonary hypertension of the newborn (PPHN), a condition in which the blood bypasses the lungs and deprives the body of oxygen. These sometimes-serious side effects can require extended hospitalization, respiratory support, and tube feeding. The warnings, though dire, include short-term effects of the drug, but long-term effects are still unknown. The Medline literature on PPD suggested that depressed mothers perceived their children as difficult, less adaptable to change, dependent and sober with negative emotionality (Whiffen 1990). Although the Medline articles attributed these negative traits to the mother's depression, one must question whether exposure to Zoloft (or other antidepressants) during gestation or breastfeeding are the actual cause of the child's distressing temperament. It harkens back to the age-old question: which comes first, the chicken or the egg.

Dr. Stephens indicated awareness of critics who say the medical profession has a tendency to over-prescribe medication:

I think, for better or worse, our profession does, I don't want to say we throw medicine at people, but we are very willing to talk about it, prescribe medications. I mean they do work but I think we as care providers probably do that more often than trying to seek out help groups or things like that that people can benefit from. I have a couple of counselors and a couple of doctors that I can call, but not, I think there's a level in there that we miss, you know what I mean, that unfortunately and probably is more up to patients to seek out than we give them information on. (Dr. Stephens)

From this perspective, then, the role of the medical professional was not to offer alternatives but to prescribe medication; the mother's responsibility was to find support on her own. Even though he recognized the benefits of alternatives to medication, Dr. Stephens suggested that doctors prescribe medication because they have few resources to which they can refer their patients who have symptoms of depression. Again, it seemed that it is not the OBs who are pushing for the medicalization of PPD; they were frustrated that there is no one to whom they can refer their patients, thus they were left to treat psychological and emotional disorders even though they are not specifically trained to do so. (More on the lack of resources in Atlanta follows.) Dr. Reddy at Central County also recognized the benefits of therapy in lieu of drugs for depression:

I work with psychologists, and one of the things we've talked about is no one is seeming to offer a psychotherapy intervention in pregnancy. It's just not there. People haven't used it in research, and we're thinking, why is that? Why isn't the response that maybe therapy would improve the outcome for both the mom and the baby? And you know, maternal bonding is critical and really affected by mental health disorders, so even if it doesn't have any effect on the birth and maternal complications, you have to think down the line, how is this going to affect bonding and then parenting going forward? And those are issues that we should try to deal with during the pregnancy, because they can only be worse and the woman is at higher risk for a postpartum reaction undealt with. And I see what happens is that the women opt out of the medication and then they get nothing, which isn't helpful. (Dr. Reddy)

Dr. Reddy offered a more holistic approach to treatment – psychotherapy during pregnancy – that she felt would benefit both mother and infant, but indicated that resources for such alternative treatment are lacking. She suggested that counseling during pregnancy could avert episodes of depression in the postpartum period as it would give the mother skills to help her cope with the difficulties she could face in the postpartum. And she acknowledged the hesitancy of mothers to take or stay on medication, as they “opt out” of it, and then are left to deal with whatever symptoms they have on their own. Other

local medical professionals acknowledged that although alternative treatments such as therapy, counseling, or support groups, may benefit mothers who experience PPD, they felt they have few options other than to prescribe medication for them, whether for lack of resources or because of a mother's limited time and ability to attending counseling or support group sessions.

So while screening via conversational style was part of the postpartum protocol, the dilemma arose when a patient was found to be depressed. Although the for-profit practitioners prescribed medication, it seemed they did so because of a lack of alternatives, and then it was done in a hit-or-miss fashion. For minority mothers who were exhibiting symptoms, the treatment differed.

### **Outsourcing Patient Mental Health Care for Minority Mothers**

As described above, the OBs and CNMs who work out of the for-profit hospitals rarely referred their patients to resources such as support groups or psychiatrists or counselors, but they did prescribe antidepressants for mothers who were experiencing postpartum depression. However, the physicians and CNMs who work with minority mothers relayed obstacles in treatment options for their patients. According to Dr. Reddy, the obstetrician at Central County, and Patricia S., a CNM at Central County, a very low percentage – between 20- 30 percent— of Central County mothers attend their postpartum visits; most return only if and when they need birth control or are pregnant again. Thus it is difficult to assess the mental state of mothers in this population, and unless they seek help or are found to be depressed during their pre-partum or postpartum visits, these mothers are left to deal with difficulties of motherhood without medical intervention. If mothers were found to be struggling with depression, either during pregnancy or following childbirth, they were sent to Central County's Obstetrical Psychiatrist (Psych OB), or a visit with a psychiatric social worker or a psychologist, all located in the Central County Hospital building. The OBs and CNMs at Central County, although not in the practice themselves of prescribing antidepressants, said they do reassure mothers who are reluctant to take the prescribed medi-

cation that the medications are safe and beneficial and should be taken as directed. Dr. Reddy's perspective was that mothers in this population are expected to be strong, are not used to analyzing themselves, and do not want to take medication. Thus she asserted that treatment for this group, whether it is counseling or medication, often is difficult and ineffective:

I think particularly lower socioeconomic group women have a concept of powerlessness that invades their lives. They don't self-assess, they don't learn to self-assess. For African-American women, there is the myth of the supermom, basically women take on the burden for taking care of everybody, and they're supposed to be strong, right? And so they're not supposed to admit that they need help or show weakness. All of that goes into a difficulty in engaging women in therapy or selecting it as an option, and they don't feel like they can control themselves. So they don't believe that the result will be that I can make a difference in who I am or what I am or how I feel, so it's another barrier to getting them engaged. I don't know how you get over those barriers, but I do think as we sit and offer women an intervention, often medicine is the one because trying to do the therapy route is really compromised, and it takes a lot of work to get somebody who basically is going to go "yes" and "no," or not go into any details, to talk about their issues. (Dr. Reddy)

Thus the characteristics of the particular patient population with whom Dr. Reddy works keeps them from the psychological gaze, and makes treatment ineffective or nonexistent. Nevertheless, she was a proponent for screening every mother for PPD, and said that screening tools such as The Edinburgh Postnatal Depression Scale, even with its vague questions, are just a starting point in recognizing high-risk cases. If the score on the EPDS or other screening tool is high, she felt it indicates the need for further investigation or questioning, even though she believed that barriers to effective treatment for PPD exist for this group.

The Latina population also faced obstacles to effective treatment in postpartum mental health issues. According to Dr. Taylor, the Latina patient population has unique problems that keep the mothers from seeking help. Some of the mothers are undocumented immigrants, and most have no insurance and little money for treatment. Dr. Taylor said the only option he has, if he finds that they are depressed, is to send them to the Georgia Department of Public Health, which is itself an ordeal that requires the mothers to arrive early and hope to be seen. Since the patient load there fills quickly, the number of patients that can be seen in a day is capped early.



But truthfully, I hate it when a mother starts crying, because then you have to spend 30 more minutes trying to find out what's going on, and there's not a lot of resources for them. A lot of our patients are undocumented immigrants with no insurance and not a lot of money, so the only thing we can do is refer them to the health department, which is difficult because the health department limits the number of cases they will take in a day, so if you're not there first thing in the morning, then you're out of luck. But it's hard with a new baby to go and wait there to see someone. (Dr. Taylor)

Thus Dr. Taylor indicated that he does not prescribe medication for depression but then must follow through, talking with the patient to find out more about the home situation. His main focus in that instance is looking for possible signs of abuse. If abuse is found to be the cause of the mother's distress, it is mandatory that he report it to authorities.

### **Limited Resources**

As discussed earlier, low-income patients at Central County and Latina mothers who showed signs of depression were referred to someone other than the OBs or CNMs who assisted with labor and delivery. However, the OBs and CNMs in the private sector attempted to alleviate symptoms when mothers showed signs of depression. They discussed treatment options with patients but believed the fastest, most effective, and readily-available means was prescribing medication. Dr. Stephens, who practices out of Parkridge Hospital, conversed with each patient during their postpartum checkup, and covered difficulties they might be facing. He said that the dilemma comes when a mother is depressed, as medication is often the only alternative he can offer because there are few resources in the Metro Atlanta area to which he can refer mothers:

A hard part for us is, I think – not just Atlanta – in our community it has been difficult over the years to find psychologists or psychiatrists who have experienced it [PPD] very much or care very much about PPD. I think the great majority of the people, and it all probably has to do with economics, but it seems to me that a lot of the people who go into that area in our community are: (a) interested in children; or (b) interested in people that they have, or will have, as patients for a long time. (Dr. Stephens)

Dr. Stephens expressed frustration with not having anyone to whom he can refer his patients, and he implicated economics for the lack of resources for mothers with PPD. He suggested that resources that

are available are limited to certain groups with certain characteristics, or by practicality issues such as geographical proximity to the patient. And of course the availability of resources relies on the economic feasibility for those providing the resources; after all, medicine is also a business enterprise that requires financial means for its continuation.

Regarding the suggestion of limited resources, I found it difficult to believe that a city as large and diverse as Atlanta would have few resources for mothers with PPD. To explore how difficult it would be for mothers to find support in their motherhood roles, I searched online with the search terms “PPD support groups Atlanta” and, although many sites came up, some were on-line blogs written by various authors on the subject, while others referred searchers to resources such as Postpartum Support International (PSI), Jenny’s Light, or Postpartum Progress. PSI listed contact information for support groups in each state, or to resources such as psychiatrists or psychologists who are “experts” in PPD. It listed three PPD support groups for the state of Georgia – one in Atlanta and one in Stockbridge, a southern suburb of Atlanta; the third was very general and did not give a location. Of the three listings, only one was an active group, and it was set up as a meetup.com group, which bills itself as an active peer support group led by a mother who experienced PPD. The group that supposedly meets in Stockbridge was set up as a function of a medical center, but when I called, I was told they no longer meet as a group because they have such few attendees, but do meet one-on-one with mothers who call for assistance. Similarly, a site called “Jenny’s Light” listed three groups for the entire state of Georgia -- two groups in Atlanta and one in Athens. I did not investigate the Athens group since it is not considered part of the Metro Atlanta area; the second group was the Stockbridge medical facility that does not meet as a group but sees mothers one-on-one when they call for assistance; and the one active group was the same meetup.com group mentioned earlier. And Postpartum Progress listed support groups throughout each of the United States and Canada. For Georgia, it listed four groups – one in Athens, two in Atlanta, and one in Stockbridge. Again, the one in Stockbridge no longer meets as a group, the

Athens group is not part of Metro Atlanta, and of the two in Atlanta, only one was active – the same meet-up.com group.

Although the search results showed that a support group for mothers with PPD met at DeKalb Medical Center on Thursdays, when I called the number listed on the site, I was told there is no group for mothers with PPD, but that there was a group addressing parenting issues for postpartum parents. One of the sites listed medical “experts” who deal with postpartum depression and the services and contact information available for them. One of its listings -- for a psychiatrist knowledgeable in the treatment of PPD -- listed a support group as one of its services, but again, when I called for more information, I was told that there is not an active group. They gave me the number for the meet-up.com group, the one group that is active in the metro area. I contacted the state coordinator for a program under Mental Health America of Georgia, called Project Healthy Moms, to ask for information on support groups for PPD in the metro area, and she referred me, again, to the one active group – the meetup.com group. The site called Postpartum Healing listed nine resources that included physicians and therapists, all of whom have experience and knowledge of the needs of clients with PPD. I sent an email and flyer describing my research to each one, mainly for the purpose of recruiting clients who fit the study parameters. Four of them responded that they were willing to post my flyer in their office so that their clients could contact me if they wanted to participate in the study, one of the emails was returned as undeliverable, and I received no reply from the remaining four. The final site I explored was the National Alliance on Mental Illness (NAMI), which has local chapters throughout the state of Georgia. I sent emails with flyers, with the intent of recruiting more mothers for my study, to branches in Atlanta, DeKalb County, Northside Atlanta, Clayton County, Cobb County, South Cobb, and Fayette County. From this endeavor, I received an email from the director of a residential treatment facility in Cobb County for mothers with substance abuse issues. She said that several of the clients fit the param-

eters of my study. Six women with multiple diagnoses, including PPD, volunteered to be interviewed from that facility.

Thus, with limited support groups available – one to be precise -- for mothers with depression in the entire Metro Atlanta area, and only a handful of “experts” knowledgeable in treating PPD, medication was the treatment option available. Some of the mothers who were diagnosed with PPD reinforced the statement that resources are limited for mothers with PPD. One mother told of approaching her doctor for help; he gave her the contact information for a PPD support group in the area. However, when she called the number, she found that the group no longer existed. She was very disappointed; it took so much courage for her to approach the doctor for help in the first place that she did not go back for more assistance from him. Mothers also told of being given samples of antidepressants at their doctors’ offices, as well as prescriptions to be filled later, even though they did not want to take medication. One told of tossing the medication in a drawer when she got home, and another told of holding onto the medication, “just in case” she needed it. While samples are usually complimentary, delivered to doctors’ offices by drug representatives, and meant to get patients started on a drug right away until a prescription can be filled, there are potential problems when physicians who are not used to treating mental issues with psychotropic drugs give them to their patients. These include the failure to know whether the drug interacts dangerously with other drugs the patient may be taking, that expiration dates may go unnoticed, that directions on the appropriate way to take the medication may not be explained clearly, and that patients would not be informed to stop taking the medication in case of a recall (Chimonas and Kassirer 2009). And, because the samples are delivered by drug representatives and thus readily available, they may not be the most effective or cost-efficient means of treatment, only the most convenient for the physicians to hand to their patients.

Because many on-line support sites came up in my search, I asked Dr. Reddy, at Central County, if she thought they were helpful for mothers. She said that for the current generation of mothers, the internet is a great source of information:

I do think that kind of what you'd call social capital, you know, or cohesiveness that is missing mostly in people's lives, is also being found in these mom internet sites. I think people are trying to achieve that same sort of intimacy and friendships through going to these sites, they are very popular and *lots* of women use them. And I think as younger people evolve, it's their status, this is what they know, this is how they socially connect, it will be as good, because it fills that same need for us who are more interpersonally related, we're like, nah, it's not just as good. There are advantages to being more truthful, you can say things about what's happening in an anonymous environment, it doesn't come back to you, right? So I do think in some ways it could encourage women to be more honest or to divulge more about what's happening to them. So I think there may in fact be an evolving standard where this may be just as good, it's probably something we'd want to investigate or figure out, but they do *something* because they are so popular. I mean they clearly are filling some kind of need that women feel. And I think it's different for this younger generation. Have you ever seen two kids texting each other back and forth even though they're in the same place? Well, obviously it's working just the same for them or else they would be talking to each other. And in some instances it works better. So I do think, you know, from our perspective, oh it's not as good – no, it actually *is* just as good or better. (Dr. Reddy)

The internet sites, then, could be a source of comfort for mothers who struggle, allowing them to divulge the difficulties they're facing without repercussion or stigma, and with the ease of going online at home at their convenience. Although not face-to-face encounters, they could have instantaneous rapport with other mothers with similar issues, and the anonymity of such rapport can remove some of the risk of being judged a bad mother for struggling with mothering issues. Of course, the one thing required to utilize such support is access to a computer, which again may leave some unable to access that resource. Most of the sites require those who wish to participate to register with the site, which may offer some degree of security when visiting those sites.

### **Consequences of Not Treating PPD**

When asked what happens if a mother is depressed but not diagnosed and treated, responses from the OBs and the CNMs ranged from possible suicide or infanticide, to affecting the relationship

with their spouse, partner, infant and other children in the family. Dr. Stephens indicated that “really bad visible things that happen with respect to injury or that kind of thing” is a possibility, but he went on to say: “probably a lot of that is unmeasurable, you know, whether that’s the ability to take care of a child or the ability to have a meaningful family relationship” (Dr. Stephens). And Dr. Taylor also said it could have bad consequences if the depression is severe, with somebody getting hurt. Dr. Reddy from Central County cited a few extreme cases, where suicide or infanticide was the outcome, such as “...the woman who drove into the Hudson River with her kids, or probably Susan Smith is another example” (Dr. Reddy). These were both well-publicized sensational cases, not any that she personally experienced. Some of the CNMs stated that it could lead to psychosis, or could go away on its own, or could put the mother into a constant state of depression. Thus, local medical professionals believed the impact of untreated PPD could affect the infant’s physical well-being, mental health, and psychological development over the lifetime, as well as the mother’s mental health and a lack of a sense of success in her motherhood role. Physical harm to the child was the most urgent consequence, and neglect and the psychological consequences that stem from neglect were said to possibly cause permanent damage when mothers who are depressed are not treated. Dr. Reddy at Central County remarked:

So that’s why I think we have to increase our sense of treatment and intervention is that it may really have lifelong consequences, they’re not terrible, like nobody’s going to die, but it does really change the course of relationship, and probably a childhood, raises the possibility of abuse and violence for the child going forward, and I think all of those are real consequences. (Dr. Reddy)

Just as the Medline articles placed most of the responsibility for the health and well-being of the child on the mother, the local medical professionals whom I interviewed also stressed the importance of the mother in the physical and psychological development of the child. Physical harm to the child or to the mother herself is one potential consequence of PPD, but psychological harm that carries over into the life of the child was also cited as a less visible consequence. And the consequences mentioned rest fully with the mother, with no mention of the father’s involvement or impact on the child’s well-being.

In sum, medical professionals in the metro Atlanta area gave very similar interpretations of the definitions, causes, frequency, and symptoms of PPD as contained in the Medline articles. They viewed the postpartum period as potentially pathologic, with the disorder affecting between .1 percent and 20 percent of their patients, but they believed that they miss up to 50 percent of mothers with PPD either because they are not vigilant enough or because mothers do not reveal their struggles to them. Most believed this is because mothers think they are expected to say that everything is fine, and so they do not divulge the challenges they are facing. The OBs and CNMs screened informally for PPD in conversational style rather than using a depression screening instrument to assess the physical and mental state of their patients, as they looked for signs of distress during the postpartum exam at 4-6 weeks post-childbirth. They implicated both biologic (such as hormones or thyroid malfunctions) and social (such as financial stress, relationship issues, or lack of a supportive partner) conditions as possible causes of PPD. Symptoms ranged from crying, irritability, feeling overwhelmed, or anxiety to failing to take care of baby or self, losing touch with reality, or feeling suicidal. Further, interviews with local OBs and CNMs revealed that there is not much difference in the way the two disciplines approach the issue of PPD, most likely because both are trained in the medical profession and must adhere to policies of the medical establishments where they practice. Their responses reflected the discourse surrounding PPD in the Medline articles, which are written by medical professionals – MDs, OBs, nurses, psychiatrists, PhDs, and others who conduct research on PPD.

However, treatment modalities varied by patients' class and race or ethnicity. The Medline articles showed a movement away from social support to medication as the preferred treatment for mothers who experience PPD. The OBs and CNMs who practice out of the for-profit hospitals prescribed medication for their patients with PPD, even as they recognized the benefits of other treatment protocols such as counseling or support groups. However, the local OBs expressed frustration with a lack of resources to which they could refer their depressed patients; the CNMs did not mention alternatives to

medication. Because of the lack of resources in the Metro Atlanta area, medication – even with its trial-and-error method of prescribing – was the most convenient, if not the only, way they treated symptoms of the malady. With one active support group and only a handful of practitioners knowledgeable about PPD in the entire Metro Atlanta area, the medical professionals felt that medication is often their only option. Whether for economic reasons or discomfort in dealing with women who suffer mental distress in pregnancy or the postpartum period, there is a lack of resources to which the OBs and CNMs can refer their depressed patients, which results in their venture into prescribing psychotropic drugs for mental conditions. While one of the OBs expressed reluctance to prescribe antidepressants for his patients – even though he did prescribe them when necessary, none of the CNMs expressed any hesitancy.

Once a patient was prescribed medication, the frequency with which the local medical professionals monitored their patients' progress varied from two or three weeks, to three or four months, to telling the mothers to call if they are not feeling better in a few weeks. Given that it takes three weeks or more for the medication to take effect, the time span for getting relief would be extended even more if the dosage or the drug needed to be changed. It seems treatment is an imprecise method, but so is the follow-up.

The OBs and CNMs at Central County and the Latina clinic do not treat mothers who experience PPD but refer them to other sources. Depressed mothers who go to Central County for prenatal care and childbirth have access to psychiatrists, social workers, or counselors within the Central County healthcare system, but the problem that hinders their treatment is that only 20-30 percent of them return for their postpartum visit. They are not available, then, for physical or mental assessment, and therefore face difficulties with motherhood without medical intervention. The CenteringPregnancy program provided for them during their pregnancies is geared toward education about issues of pregnancy and parenting, which is said to build healthier families and stronger communities by providing a social network among couples in the same stages of their pregnancies. The bond between these cou-



ples is believed to remain after the births of their children, providing a source of stable peer support. The medical professionals whom I interviewed at Central County suggested that the CenteringPregnancy program attempts to circumvent the special characteristics of this population that keep them from seeking medical help for depression, namely that they are expected to be strong, to take care of everyone, and are not self-analytical. Thus counseling would prove ineffective, and many are hesitant to take medication when prescribed.

However, a larger problem that exists and should not be ignored is that if mothers in this group are found to be struggling in their motherhood role, they often face dire consequences that are difficult to overcome. Black and Latino children living in poverty are most likely to be forcibly removed from their families and placed into “more stable” homes, most often with white families (Roberts 2002). Racial inequities that exist in structural institutions such as the child welfare system reify the concept that impoverished families are typically unfit and in need for closer supervision. Once a child is removed from the home, the process of regaining that child proves almost impossible as obstacles, such as financial means for legal representation, or quality jobs that lift the family out of poverty, are difficult to obtain. The CenteringPregnancy program at Central County, although well-intentioned, is similar to the child welfare system in that it could be “reinforcing disparaging stereotypes about Black family unfitness and need for white supervision” (Roberts, p. ix).

Dr. Taylor, the OB who serves the Latina population, also expressed frustration with a lack of resources for his depressed patients, many of whom are illegal immigrants and/or lacking health insurance or the financial means to pay for extensive medical care. Although he said he frequently sees signs of depression – mainly crying – in his patients, the only resource available to him was the Georgia Department of Public Health, which has programs for maternal and child health. Although these services are available for Latina mothers who experience PPD, there is a huge caseload that requires the mothers to arrive early with the hope of being seen. His main concern, then, was to rule out abuse, which he is re-

quired to report if it is suspected. But it seemed that his biggest regret is that if a mother cries, it created a time crunch to his already packed schedule. It is unknown how mothers who experience PPD are handled through the Public Health Department.

Just as the Medline articles placed most of the responsibility for the health and well-being of the child on the mother, the local medical professionals whom I interviewed also stressed the importance of the mother in the physical and psychological development of the child. If left untreated, they suggested life-long consequences ranging from physical harm to psychological impairment that may even lead to violence later in life. Although their concern is most likely philanthropic in nature – wanting to provide relief for mothers who struggle with lack of energy, negative emotions, and feelings of anxiety or being overwhelmed – the medical professionals unwittingly enforced standardized behaviors expected of mothers. Language, such as “should be a happy time,” reinforced the essentialist notion that mothers are naturally adept at nurturing, and deviations from that are pathological. Mothers who struggle with responsibility in their motherhood roles can be brought up to par through medication. The medical gaze that starts with the medical practitioner extends to other family members who are asked to monitor the mother’s progress in adapting to her new role. Thus a hierarchy exists with doctor as the authority, family members as support team watching the mother for signs of pathology, and the mother as subject.

Medicalization of PPD places psychological distress of the postpartum period into the medical model, with medical diagnoses, specified symptoms, and treatment modalities administered by medical personnel. Grobstein and Cyckowski (2006) offer a critique of the practice of placing psychological and emotional issues into the medical model. They maintain that the purpose of medicine is to alleviate suffering, and the medical model offers the chance for recovery for those who experience psychological distress. They assert that in the medical model, doctors are active agents who diagnose and treat mental disorders, while patients are passive recipients of treatment; patients change in the process of interaction with doctors, but doctors and the wider culture remain unchanged. However, they find several

weaknesses in the medical model. First, it presumes an ideal from which some are said to deviate, and thus fails to account for variations between individuals. Second, it assesses mental health from outward appearances, failing to account for a person's inner subjective experiences. And third, a quick fix may not be the most optimal; rather, effective treatment should bring about both personal and cultural change. Applying their critique of using the medical model to address psychological and emotional matters to the issue of PPD, it is apparent that PPD is considered a deviation from normative motherhood. It is diagnosed through outward signs (symptoms) such as physical appearances, negative emotions, and behaviors that differ from idealized versions of motherhood and traditional gender roles. Those outward signs are defined and assessed by medical professionals, who then offer treatment for mothers who exhibit said symptoms. The medical model fails to account for contextual situations and variations in the physical and psychological lives of mothers, instead standardizing emotions, behaviors, and appearances that constitute a "normal" postpartum period. Medication, although a convenient and sometimes quick fix, may result in remediation of depressive symptoms but does little to change cultural proscriptions of motherhood or structural issues such as the economy that are said to be likely causes of PPD. Medication does little to change role enforcement that keeps mothers compliant to the societal expectations placed upon mothers, nor does it improve an individual's personal coping mechanisms; thus, depression is likely to recur in those patients when similar contexts arise. This could explain why a bout of depression is often believed to be the best predictor of future episodes of depression.

In his studies on depression, Sheff (2009) asserts that, in addition to biological and psychological causes of depression, one must consider depression from the individual's perspective. He suggests that shame is a basis for depression, experienced sometimes so quickly as to be unrecognized, but threatens the social bond with others, which leads to more shame. The threatened lack of community creates a feeling of alienation that leads to depression. Thus a cycle forms that is difficult to break: shame-alienation-shame. He believes that the best form of treatment for depression is to strengthen the pa-

tient's social bonds, either by improving the ties with those in the individual's current situation or by having the patient recall a time when they felt they were a valuable member of a group. He finds that automatically labeling conditions mental illness creates humiliation, embarrassment, and a self-fulfilling prophecy that makes recovery more difficult, and that normalizing would be a better remedy, in many cases, that would avoid social rejection. Finding just one person who respects the patient and stands by them can be the catharsis that breaks the cycle of depression. He rejects the blanket use of antidepressants as the best therapy and asserts that pharmaceutical companies present misleading positive results for antidepressants by following up at only four to six weeks after starting on the protocol, but that antidepressants lose their effectiveness soon after that period. Similarly, Healy (2004) finds that psychiatry treats emotions as enemies and pathologizes not only negative emotions, like crying, but others, like laughing, as well. He says that antidepressants blunt emotions and inhibit grief, and he questions whether the absence of emotional expression could be an even greater problem. In my study, three of the mothers who received diagnoses of PPD were grieving the death of their husband/partner. Others were in a sense also grieving – the loss of independence because of a job loss, the loss of friends because of an upcoming move, the loss of freedom to do things spontaneously, and others. The medical professionals who diagnosed them with PPD may or may not have known the circumstances surrounding their distress, but prescribed medication to help them get through their difficult period. Less than half of the mothers who received prescriptions stayed on the medication as directed, some because they felt they needed to work through their emotions and others because of the cost of the drugs. If we apply Sheff's theory of shame as a causative factor for depression, then the source of shame could come from a number of contexts the mothers described: feeling inadequate in the motherhood role, not liking motherhood as much as they should, feeling overwhelmed and/or exhausted, failing at breastfeeding, uncertainty about whether they are "doing" motherhood correctly, and so on.

Although local medical professionals treat their patients who experience distress in the postpartum period with medication, there are many disadvantages to that practice. The short-term effects of antidepressants on the fetus and breastfeeding infant can be serious, and long-term effects are unknown. Medication will not change the hormonal, structural, or social factors that are believed to cause PPD. And medication will not improve a mother's coping skills, making it more likely that she will experience episodes of depression in the future. And finally, medication, specifically the labeling that a diagnosis brings, can be a self-fulfilling prophecy that keeps the mother in a cycle of shame-alienation-shame, making depression a recurring experience. Medical professionals, by delineating the symptoms of depression, espouse idealistic standards of motherhood that are gender-specific and essentialist in nature, and through the medical gaze, diagnose and treat mothers who fail to maintain those standards.

## CHAPTER 5

### THE LIVED EXPERIENCE OF MOTHERHOOD

In this study, my research goals are to explore how some mothers come to define their postpartum experiences in terms of illness, and whether the social support they receive in the postpartum period increases as a result of a diagnosis of PPD. In the last chapter, I examined the perceptions that local medical professionals have for their patients during the postpartum period, whether their perceptions support the medical literature on PPD, and whether their perceptions lead to diagnoses of PPD. In this chapter, I examine mothers' perceptions of their motherhood roles, of their experience with labor and delivery, and of the changes they undergo in their social lives as a result of becoming mothers. I show how their perceptions influence whether they view their postpartum periods in terms of normalness or pathology. Through interviews with mothers who have received a diagnosis and those who have not, I compare the commonalities and the differences of their postpartum experiences and how they relate to PPD. Note: Although the narratives come from interviews with real mothers, the names are not real; they have been changed to protect the identities of the participants in this study.

#### **Childbirth and Medical Assistance**

One of the suggested causes of PPD is a traumatic birth experience or, at the least, one that differs from what the mother had wanted or expected. Ironically, almost all the mothers in this study felt that the OBs and CNMs who assisted them in childbirth were very professional and worked in their best interest, even if they had interventions or ended up with a c-section. In fact, two of the mothers said their labors were very long, and they wished that the OB or CNM would have offered a c-section as an

alternative. They felt they began their motherhood exhausted and sore after going through a long labor, and that a c-section would have circumvented those problems. Mothers in the sample expressed satisfaction with – even admiration for – the medical professionals who assisted them in labor and delivery regardless of whether their birth attendant was an OB or a CNM. And although some regretted having interventions, such as drug- induced labor or amniotomy (rupture of the membrane that contains the amniotic fluid surrounding the fetus) to artificially start labor, they felt that the medical assistants did what was best for them.

Only one mother expressed the experience as being part of a “system in which you are treated like a number rather than a person” (Danita, not diagnosed). She felt that she knew intuitively what she needed to bring her child into the world. Instead, she was given drugs for inducing labor and other drugs for softening the uterus, which she felt caused the baby’s heart to stop several times during labor. She finally insisted that the medical team stop all drugs, which they did, and the baby was born soon thereafter. Although she had had an ultrasound that showed no complications just before the onset of labor, the umbilical cord was wrapped around the baby’s neck, causing distress that she insisted was a result of the interventions. Asserting that she knew what was best for her body, she was able to finally deliver her baby on her own terms.

The respondents in this study, then, did not support research that points to the birth experience as a possible cause of PPD. Regardless of whether the birth went as expected, whether they had interventions, an easy or a difficult labor or a c-section, and regardless of whether the birth attendant was an OB or a CNM, mothers in this study expressed satisfaction with their birth experience.

### **Feelings of Depression**

Interestingly, most of the mothers in the sample (32 out of 35), whether or not they were diagnosed with PPD, said that they felt depressed at some point after the birth of their child. Some of them

cited situational factors such as moving, job loss, the death of their partner, or conflict with relatives that caused them to feel depressed, while others thought that hormonal changes after childbirth contributed to their experience of depression. Difficulty or failure to breastfeed, a colicky or clingy baby, or slow healing from a c-section or resultant infection also contributed to experiences of depression.

For mothers who received a diagnosis, the most cited symptoms were crying, anxiety, and extreme fatigue. They expressed their experience with PPD in terms such as “I knew I wasn’t myself” (Kelly, diagnosed); “I felt like I was the babysitter, not the mother, and that I could give him back” (Lisa, diagnosed); “I didn’t have the skills to deal with that [responsibilities of motherhood]” (Angela, diagnosed); “I’m a real tidy, cooking housewife, but I just didn’t want to do nothing” (Leslie, diagnosed), and “Knowing that mothers should have that bond with their child, I didn’t feel that; I felt like it had to be forced” (Joni, diagnosed). One mother said she could not control her crying because she was grieving the death of the baby’s father at the same time; she initially resisted medical intervention but was diagnosed with PPD when admitted into a substance abuse treatment facility. The mothers who received diagnoses attributed their experiences with PPD to such triggers as exhaustion, a tendency to be a perfectionist, an abusive relationship, or a husband who pressured the mother to breastfeed for a longer time than she wanted. Other suggested causes were not eating well; not leaving the house for a week at a time; feeling alone even when in a room full of people; and feeling like they were trapped in an unhappy marriage that would be even more difficult to leave because of the baby. Some felt relief after being diagnosed, such as Nicole: “She [nurse] treated me like I’m not the craziest person in the world, that it wasn’t such a weird thing.” Others felt better knowing there was a name for it and someone who could acknowledge it and help them through it (Monica, Terri, and Michelle, all diagnosed).

Mothers who were not diagnosed shared some of the same characteristics as those who were diagnosed: crying, feeling lonely, a lack of control, isolation, and feeling inadequate in their mothering abilities:



I cried a lot, I think everybody does. I think it's hard not to with the amount of hormones going through my body. I did cry a lot. I think I cried every day, for a long time, about something. But then, like the Kleenex commercial on television would make me cry. But I didn't feel out of control or anything or that I might hurt myself or anything. (Emily, not diagnosed)

I mean, never diagnosed or anything. I think there were definitely times when I felt complete lack of control. I mean there were definitely times when I would be reduced to tears. I don't know how much of that is hormonal, but there were just times where I would definitely lose it. And up until recently, most of the time I would think, if I only cried once this week, it was a pretty good week. (Carly, not diagnosed)

They indicated biological factors, such as hormones, or social factors, such as less time spent with friends, as the possible causes of their distress. They were able to cope with the emotions or difficulties, perhaps with the belief that they only had some of the symptoms of depression but not the more serious desire to hurt oneself or the baby, or that the symptoms were temporary or normal conditions of the postpartum period. They rejected their symptoms as signs of illness, and instead put their feelings in context with what they considered a normal adjustment to motherhood because they believed that others also experienced similar difficulties. But their narratives acknowledge that their "symptoms" are abnormal, deviating from their non-postpartum state. They recognized crying, feeling sad or inadequate, and lack of control as symptoms of difficulty but not necessarily of illness. This may be because of the blurring of the lines between depression and the more serious postpartum psychosis, in which the danger lies in the potential for suicide or infanticide. Some said that medical professionals who questioned them about their emotions in the postpartum period focused on whether they had thoughts of hurting themselves or the child, which did not match most of the difficulties they were experiencing. The mothers in this study defined their "symptoms" as distressing, though less serious than thoughts of suicide or infanticide. As one mother explained:

I felt like some amount of depression was okay, to keep me in the bed and close to my baby, so I didn't really like make a big deal out of it, and I felt like I would just come out of it. I didn't feel like I needed to get medication or anything like that, and I talked about it to friends, I did, and I realized that I wasn't the only one who wanted to pull my hair out. It helped, because you feel alone, isolated, but then when you talk to friends and realize that, well I'm physically here by myself but other people have been in the same boat, I'm going to live, I'll live through this. I actually found it [depression] to be quite normal. (Alissa, not diagnosed)

Knowing that other mothers experienced similar difficulties made it easier for Alissa to accept her struggles as a normal, even good, part of the postpartum experience, as it let her prioritize being with her baby. By talking with friends who were mothers themselves, she found that her problems were not unique but something that others go through in their adjustment to motherhood. This eased her mind and resulted in her view of the struggles as a normal part of motherhood. But the depth of her feelings was intense: “wanted to pull my hair out” signifies great frustration with the responsibilities she faced. But she viewed the struggles as a temporary condition that she believed she would “just come out of;” thus she resisted medical definitions of her struggles and believed that she, too, would make it through the difficult times.

Indeed, one of the common themes in the mothers’ narratives was the relief mothers received from knowing that others had experienced similar difficulties in the postpartum period. Sometimes that came from talking with other mothers who were candid about the difficulties they faced, and sometimes it came from their own experience. Maddie, who was not diagnosed, said that when she became pregnant with her second child, she had a more realistic view of what it would be like, knowing from experience that the first three months after the birth of her first child were very difficult. She, as well as several other mothers in the study, indicated that knowing what to expect helped to prepare for impending childbirth and the postpartum period. But Maddie’s knowledge came through experience rather than through word of mouth or through medical sources. She entered her second pregnancy with the expectation that the three months after having her second child would be difficult, which actually made it easier for her to adapt to the family’s newest addition. In contrast, her first postpartum period was difficult because she had not anticipated how hard it would be and so was not prepared for the challenges she faced. Similarly, Amanda said she wished she had known more about the realities of motherhood before birth so that she could have been more prepared:

I wish friends with kids had not only told me to keep my mind open if I sense anything related to postpartum, but I wish, and my mother talked about this, I wish mothers were really honest

with new mothers about what it's like. I have a cousin who had a child a couple of years before I had a child, and I remember talking to her about a month after her son was born, and she said, it is not puppy dogs and ice cream, which is really a couched way, it was the first time anyone had ever been that honest with me. And that took me aback because I'm the kind of person that, I like to prepare myself. If it's the worst, I just want to know, I need that preparation. So if I had had friends who said, 'those first couple of months are going to be rough, you're going to cry a lot, it's normal,' then maybe when it happened to me it would have been, everybody told me, okay, I'm not so odd. I think it's that feeling of "it's just me" that's hard. (Amanda, not diagnosed)

The idea of being prepared highlights the dissonance between what women think motherhood will be like and the realities. And as Amanda suggested, the shock of facing those difficulties makes mothers feel like they are the only ones experiencing such challenges. She acknowledged that if she had known that the postpartum period would be difficult, it could have made the transition easier for her. Again, her statement supports the assertion that ideological representations of motherhood contrast sharply with the lived experiences of motherhood. She expressed a desire for a mentorship of sorts, for a friend or relative with experiential knowledge to have shared the challenges with her so that she could have been prepared to meet them if and when she faced the same challenges. It seems the ideologies of motherhood impact mothers in a harmful way, making it difficult to express negative emotions surrounding motherhood, unless others have been through the same trial by fire. Other mothers also said they wished they had known beforehand how difficult the transition to motherhood would be:

Nobody prepared me for how hard the newborn phase would be, and I wish somebody had told me that because I thought it was just me. And probably, when my youngest was about 6 weeks old, my mother told me that the first 6 weeks, for her oldest, the first month was the worst month of her life. And I wish so badly that she had told me that before and that I would have known what to expect, and now I tell everybody that it's just awful, you just have to get through it and survive it because you're just awake all the time. (Terri, diagnosed)

I just want to tell each of them, and I do try to tell everybody – not to tell horror stories or anything – but I say, look, you're going to think it's the worst 6 weeks of your life, and that's normal, and all you have to do is get through it. I wish, I think I had this vision like a Johnson & Johnson commercial, that I was going to gaze lovingly at my newborn, you know, and that was what it was going to be like. No one really prepared me, and I took the labor and delivery class, I took a breastfeeding class, I didn't know, I had no expectation, nobody told me. (Emily, not diagnosed)

These mothers related a silence that mothers keep around their personal struggles with motherhood, which perpetuated the feeling that everyone else was able to adapt easily and therefore something must be wrong with them. Although they felt that knowing how difficult the adjustment to motherhood would be would have made their adaptation during the postpartum period easier, very few of the mothers heard about the difficulties before going through them themselves. Even taking labor and delivery and breastfeeding classes, such as Emily mentioned, did not prepare her for how difficult and demanding the postpartum period can be. The impact that media has in perpetuating the idealized view of motherhood is visible in her statement that she thought having a baby would be like a Johnson & Johnson commercial. The quotes illustrate the hesitancy of mothers to be candid about their frustrations with mothering, which highlights the stigma that surrounds expressions of negative mothering experiences. In turn, not revealing those difficulties reinforces the ideological representations of motherhood that at times contrast so sharply with women's postpartum realities. Mothers often perceived those differences in terms of personal inadequacy, which led to guilt and shame. Kelly, who received a PPD diagnosis, referred to the difficulties of motherhood as a well-kept secret:

The "speed mommies" – "Isn't this wonderful, oh they're [kids] great!" I don't reach out to friend them probably as much as I should, but no, the mothers [in her mother's group] are like, "Good Lord, this is crazy, why did I do this?" That's the conversation we need to have. We actually, there's a book club component to our mother's group too, and it's the first one I had gone to, and the lady who was hosting had just had her second [baby], her kids are a month further apart than my two, and she said, "You know, when I first, at my baby shower for my first child, everyone sort of crowds around and Oh, you're going to be marvelous, isn't it wonderful. And my sister and my best friend from college and my best friend from elementary school all stood there and smiled, and one of my guy friends from college is there with his wife and their new son and said, Honey, boy have you gone and done it. I thought he was rude, but two weeks after my daughter was born I called him and said thank you because everyone else lied to me. I called my sister and I called my girlfriends and I said, why didn't you tell me how hard this was? And they said, well it's not the kind of thing you want to say to a first time mom." And no, it's not, you don't want to look at a pregnant lady and say "Honey this is the worst thing you've ever done, you just don't know what you've done to yourself," because you're in it, right, but I kind of think that people need to talk a little bit more about how hard it can be. (Kelly, diagnosed)

Kelly suggested that mothers fall into one of two groups: those who believe in the ideological representations of motherhood and who at least act like they live up to the standards of that ideology (the

“speed mommies”), and those who candidly admit that the expectations placed on mothers create an impossible standard to achieve. She found it difficult to be with those who fit into the first group, because doing so highlighted the inadequacies that she felt in her own mothering abilities. Her comment about the practice of not telling first time mothers of the challenges of motherhood echoes the assertion that it is a well-kept secret that only is discovered through experience, or rarely by word of mouth. There seems to be an unspoken covenant that mothers only talk about their mothering challenges with other mothers, perhaps more because of the shared experiences rather than a conspiracy to keep first-time and childless women in the dark. Initiation into motherhood, then, seems to require that new mothers enter without knowledge of the difficulties that lie ahead. Although the mothers in this study felt that knowing in advance what to expect would have helped with the transition into their new role, the silence on the part of their mothers, sisters, friends, and medical professionals highlights the stigma attached to expressing such negative thoughts about mothering. Perhaps the fear is that if women knew ahead of pregnancy how difficult the challenges of motherhood would be, they might choose to remain childless.

But expressing negative feelings about motherhood can bring admonishment from others, and so the silence remains. One mother told of the rebuke she received while dealing with her mothering frustrations in a less-than hostile way:

There were times when I thought, if you could just admit how hard it was. I remember one time when I was bouncing her and I was like, [in a baby-talk voice] “you’re freaking driving me crazy and I don’t know what I’m going to do,” and you know I was doing it in baby talk, and I was letting my feelings out, and bouncing her, and then of course she starts laughing because she likes the bouncing. I brought her into see my boss, and I said, “We tell her [in baby-talk voice] she’s the best baby on earth, but if she doesn’t learn to sleep through the night we might trade her,” and she said “Oh my God, you can’t say that, you’ll mark her for life.” Every now and then I felt like, doing it as a joke, being able to admit that it was hard and that she was driving me crazy, and doing it in a sing-songy way and bouncing her or whatever, sometimes just admitting you felt that helps. Some people say you aren’t allowed to have those feelings or you can’t possibly say that, or you’re a bad mother. I just felt it was a safety valve. You know, it’s like you have milk streaming, you have poop here, and I haven’t taken a shower in 72 hours, but I’m supposed to be the model Madonna, no. (Carly, not diagnosed)

Carly expressed the difficulty mothers have in admitting how hard mothering can be. Allowing herself to express the frustrations she felt as a mother helped her feel better about the relentless responsibilities, sleepless nights, and lack of time for herself, but to do so she had to do it in a joking or playful way. She felt that was the only acceptable way for her self-expression. And she made sure to say that the baby liked it, thus no harm was done to the baby by saying those things, which revealed the responsibility placed on mothers to raise happy and healthy children. The response from her boss, that she should not say those things because they could have long-term implications for the child, revealed the expectation that mothers safeguard every aspect of the child's life, to the point of self-monitoring every thought, action, and emotion for the good of the child. It supports Brooks Gardner's (1994) earlier finding that mothers in the U.S. are expected to center their lives around the child and to do everything possible to foster the child's optimal development. The reaction of Carly's boss highlights the stigma attached to revealing negative feelings of mothering, even if in a playful tone, and illustrates how role enforcement occurs even in casual settings. This finding echoes the good mother ideology that permeates our culture, and is an example of Foucault's social control occurring at the capillary level rather than from above. Mothers are expected to love every aspect of mothering and to selflessly do all that they can to promote the well-being of their child(ren). And resistance to the ideal is greeted with reprimands! One mother said that it is unfortunate that mothers do not get progress reports for their mothering practices as one would get in the paid working environment, thus they never know if what they are doing is good for the child in the long run. In a sense, however, mothers do get performance reviews in the form of rebukes or reprimands for what others perceive as deviations from idealized motherhood.

### **Changes in the Social Landscape**

Respondents in this study revealed that women go through many changes in their social networks once they become mothers. Indeed, entering motherhood resulted in major changes in their

friendships as well as in their participation, at least temporarily, in the paid workforce. It brought less drastic changes in their relationships with their husbands or partners, or with other family members, other than giving them a shared goal of raising the child. Although only sixteen of the 35 respondents were actually diagnosed with postpartum depression, all but three of the total respondents acknowledged feeling depressed during their postpartum period. They related that the changes in their lives as a result of becoming a mother often brought about feelings of isolation and of being overwhelmed with unrelenting responsibilities. To illustrate the changes that occur in women's lives as they become mothers, and the impact those changes have on whether a mother experiences PPD, I examine how mothers view fathers' participation in childcare. Further, I analyze the changes that occur in women's friendships once they become mothers. And, I look at the role that participation in the paid work force plays on whether a mother experiences PPD.

### **Fathers' Participation in Childcare**

Immediately following the birth of their child, some mothers were surrounded by husbands, parents, and/or in-laws, all doting over the new addition; however, most of the mothers were left with sole responsibility for the child once the husband returned to work and the parents or in-laws went home after the first few days to three weeks postpartum. This was regardless of whether they had had a vaginal birth or a c-section. For mothers, participation in childcare was mandatory; for fathers, participation seemed to be arbitrary. For example, some of the women in the sample said that their husbands/partners were willing to participate in taking care of the child when asked, but they did not take the initiative. Mothers spoke of having to lay everything out so that fathers could bathe or feed the child, or do the laundry or grocery shopping.

I mean, he's great, but it's still me saying, can you throw a load in the washer, can you unload the dishwasher, not just him deciding, like looking and seeing "oh this needs to be done or that needs to be done." It's always me designating it out, and he'll never say, I don't have time for it,

I mean he's happy to help. I just think that men, either the way that they're wired or the way they're brought up, they just don't think of that stuff. (Amanda, not diagnosed)

It seemed that fathers' participation in the daily tasks of childcare was optional, while mothers' participation was assumed, or taken for granted. Thus mothers often felt as though the responsibility of childcare lies fully with them, and the relief they received from the father's participation was minimized. For instance, Kim (not diagnosed) asked for her husband to occasionally pick up the child from daycare so that she could attend an exercise class on her way home from work without putting the child through the trauma of separating from her yet again. Her husband felt that it was not worth the expense of him driving to pick up the child from daycare. Kim was frustrated that, although both worked outside of the home, she was locked into a daily routine that kept her from activities that would benefit her while her husband was free to choose what he would do and when he would be responsible for the child. Other mothers had similar accounts:

I have to ask my husband for mom's night out, I have to ask him for any Saturday that I want to, say, like go to the outlet mall. You know I have to plan that well in advance. It can't be dropped on him the last minute, and he can go do whatever he wants at the drop of a hat and I'm expected to deal with it, and that rubs me the wrong way. Just because I had the baby doesn't mean that you're not as responsible. (Abby, diagnosed)

I was a full-time college student, and her father was just starting a career in trucking where he had to be gone for a month or a month-and-a-half at a time. So I felt abandoned, it felt like a lot so I got real sad about that. It started making me so resentful with him being gone, because I felt like he left me with all this responsibility, even though he's doing it to provide for our family. I felt like he thought that was enough and I had to do everything else, just because he's the one providing. (Angela, diagnosed)

Most of the time I feel like a single parent because my husband isn't around very much when I need him to be. I'm alone with my kids most of the time during the day and sometimes late into the night as well as the weekend. (Michelle, diagnosed)

Mothers attempted to negotiate responsibilities with their husbands or partners to alleviate the burden of having full responsibility for the child, but often these attempts fell short. Thus mothers were often resentful for the freedom that their husbands or partners had, whether or not the mother also worked outside of the home. Research has shown that both mothering and fathering practices are structured by



males' greater access to economic resources within a patriarchal society (Gerson 1993; LaRossa 1988). The mothers in this study provided narratives that indicated adherence to traditional gender roles wherein the father's role is situated more as provider and the mother's role as nurturer. This finding was evident regardless of the education or income level of the respondents in this study. Because child-care responsibilities were divided according to these traditional gender roles, mothers often expressed their experiences in terms such as abandonment, resentment, and anger, and feeling like they are a single parent raising a child.

Thus the addition of a child into the family required an adjustment from being a couple to having a child or children totally dependent on them. According to the mothers in this study, fathers had flexibility to determine the amount of participation in childcare and to pursue a career or other interests, while mothers had more restrictions on their activities because of the responsibilities for childcare. Some research has shown that fathers are more involved in their children's lives than in past generations (Bianchi, Robinson and Milkie 2006; James 2009; LaRossa 2011). However, Bianchi et al (2006) found that fathers increased their participation in childcare from two hours per week in 1965 to seven hours per week in 2000. Other research shows that the increases can best be understood by the very low threshold of fathers' participation in childcare in the first place; the bulk of child care remains the mother's domain (Douglas and Michaels 2004; Hochschild 1989; Taylor 1996). For instance, James (2009) states:

Nowadays, the notion of a 'good' father increasingly includes an element of care-giving and just as we have witnessed progress in relation to the social construction of motherhood, the ideology of fatherhood has also evolved so as to include an element of nurturing....An increasing number of fathers are identifying more with parenting and home-making per se and men have increased their involvement in domestic chores, albeit from a very low base. (James 2009:274)

According to the good father ideology, fathers contribute more than in past generations to childcare and household chores, and are more emotionally connected with their children. But although fathers report being active with their children, Lareau (2000), through interviews and extensive observations of a sam-

ple of families, found that they exaggerated their involvement and knew little of the details of their children's activities. Instead, they played a more symbolic role in the family: they set the tone for the household and taught children physical prowess and life skills. And as LaRossa and LaRossa (1981) found earlier, Lareau also found that fathers are often specialists in play and laughter with their children. The interviews with the mothers in this sample support that finding, as mothers indicated that fathers are not always actively involved in the day-to-day care of their children but are willing to participate when asked and if convenient. Because this sample size is small, it cannot be determined to represent the participation of fathers in the greater population, thus further research with a larger and more diverse sample would provide a better understanding of the role that fathers play in taking care of the child(ren) and the home.

On the other hand, some mothers expressed that the transition to parenthood created a stronger bond with their spouse or partner:

He has been a really good father, and I think that's part of it, because it can change the relationship if there are things you didn't know about the person. So mostly I'm grateful that we're on the same page, we usually agree about things or we can discuss things that we disagree on. (Susan, diagnosed)

We're very united in terms of what to do with him, we agree, we enjoy, there's no issue there, if anything I think it brought us closer. (Debbie, diagnosed)

Adaptation to parenthood was made easier because of the shared interest in the well-being of the child. This was particularly true if the couple had similar parenting styles or views of what each parent's role is in caring for the child. And the father's participation eased the feeling that mothers were in it alone. The mothers expressed that stress was part of the transition from couple to parents, but that the benefits were worth it in the long run. Although fathers were often willing to participate when asked, their participation in childcare was arbitrary while the mother's participation was mandatory. Mothers felt that the burden remained with them to see that every aspect of childcare was taken care of. The transition from couple to parents resulted in negotiating which responsibilities could be shared, but often re-

quired the mother to set the stage so that the father could participate in activities such as bathing or feeding the child. This was true even if both parents worked outside of the home. However, many of the mothers indicated that the shared responsibility of the child created a greater bond with their husband or partner, and strengthened the marital relationship. This was true whether or not mothers were diagnosed with depression.

Although the cultural proscription is for increased father participation in childcare, the amount of that participation is comparatively low compared to mothers' participation. Taylor (1996) asserts that the women's PPD self-help movement advocates for husbands to increase their participation in housework, childcare, and in providing emotional support for their wives who are depressed, to counter the notion that only women are capable of providing such care. However, mothers in this sample who were depressed received no extra support with their mothering responsibilities as a result of a diagnosis. Only one mother, who strategically resisted diagnosis, received additional care from her partner when she confided in him the feelings of depression that she was experiencing. Thus the movement away from social support to medication as a remedy for PPD maintains the cultural status quo for parenting, negating the need for structural change as it locates and treats the problem of PPD within the individual mother rather than the gendered nature of family life. It weakens the chance for remediating the tremendously disproportionate assignment of childcare and housework to mothers.

### **Motherhood and Friendships**

While adaptation to parenting can positively or negatively affect the relationship between the mother and the father, the biggest change in the social networks for the mothers in the sample was with their friends. Pre-pregnancy friendships were based on shared interests and flexible schedules that allowed them to spend time together in mutually satisfying pursuits. But many of those relationships fell away once respondents became mothers.

It changed a lot of my relationships with friends. A lot of my friends weren't even married, let alone planning to have children, so both my husband and I compared it to if I had been diagnosed with cancer, like no one quite knew how to handle me when I was pregnant. They were like overly-cautious, didn't really want me there because they thought like I was going to break, or whatever. But my lifestyle and all my friends' at the time lifestyles are very different right now, whereas they used to be very similar. (Cheryl, not diagnosed)

I had, I think about this sometimes, most of my closest friends, when I was pregnant, were single and childless, that if I look at pictures of my baby shower, I rarely talk to any of those people anymore. And it's too bad because these are the friends I had all the common interests and all the things that are really me, and now most of my friends are women with kids my daughter's age. Not necessarily people who I share the common interests with. (Amanda, not diagnosed)

The dynamics of friendships changed once women in this sample became mothers. Demanding schedules often meant less time to spend with friends doing things they used to do together before pregnancy. As Amanda indicated in the quote above, the interests she used to share with her friends were part of her identity. Now her friendships are based solely on being a mother. She remarked that her single friends may be jealous of her new status, which seemed to imply an imaginary boundary that single friends are hesitant to cross: the world of motherhood and their singleness simply do not mesh. And Cheryl compared the transition to motherhood to cancer, a condition that made her single friends avoid her because they somehow viewed her as fragile. Her experience reiterated that motherhood involved the transition into a very different world than that of her single friends, which meant not only less time spent with them but hinted at a difference in the types of activities in which mothers are expected to participate. Not only did the types of friendships and activities change, but the amount of time available to spend with them became limited:

And you know, we have friends that live in our neighborhood, that's part of the reason we chose that neighborhood to move there because we like them, they're awesome people. But they're always so busy and they have a full family available, so they have sisters and brothers and grandparents, so they have this sort of network of people around them, whereas for us it's just the three of us. We're the satellite section of the family, and that's hard. (Emily, not diagnosed)

It's not as easy to go out to dinner with them, especially on weekdays, and my schedule now is around my son's schedule, so I have met other people who have children of the same age, but I'm not able to maintain the relationships I had with people who don't have kids. (Erin, not diagnosed)

The mothers quoted above did not receive diagnoses of PPD, but they felt the time spent together with friends was limited not only because of the baby's schedule but those of their friends and extended family as well. While the loss of friends that came with motherhood was upsetting to many respondents, it was something that they recognized as part of life transitions that also wrought changes in their friendships – moving from one locale to another, marrying, having children, completing a graduate degree. Mothers spoke of these shifts in friendship as a sense of loss. They expressed limitations in their independence and expression of individuality as their activities then became child-centered.

It is hard to see some friends, but my friends in Atlanta that I grew up with are all on their second or third child, so that means that they're not as available. And I think, in retrospect, towards the middle of winter I had some resentment toward that because I sort of think the moms who had been through this a few times should have reached out more. (Nicole, diagnosed)

As Nicole indicated above, some relied on their friends as mentors in their new roles and therefore felt resentful when that support was not there. As the demands of motherhood required women to build their days around naps and feedings, which interfered with the more flexible schedules of their childless friends, even those friends with children were limited in their expendable time because of their own mothering responsibilities. When mothers did get together, often arranged as “play dates” for their children, their visits were usually child-centered, spent chasing after their children rather than having uninterrupted conversations or activities. In this respect, friendship anchored the mothers' identities in their roles as mothers because the responsibilities that come with mothering were always first and foremost. Motherhood limited their ability to venture into shared interests with friends, unless those interests were child-centered, and mothers in the sample regretted the loss of friends when they became mothers.

But not all mothers found the shift in friendships fully detrimental. Some felt they had more friends now than ever before – other mothers with children close in age to their own. For some, regardless of whether diagnosed, the newfound friendships were satisfying:

I have so many friends now that I did not have. I would say that I had one friend before I had kids, and this has just opened up a whole new world. I have two really close mom's club friends that, we go on vacations together, or go out to eat dinner all the time. Our kids play, and all that, and then I have I would say, 10 to 15, 20 other friends that I can talk to about, you know, everything and anything, whatever. And when we see each other, we talk. It's totally different than my life before. (Abby, diagnosed)

If nothing more, it's kind of, having a child kind of seals the deal with friends who have already had children. So it made it a little more comfortable. (Alissa, not diagnosed)

Regardless of whether or not mothers were diagnosed with PPD, the glue that held new friendships together seemed to be having children close to the same age as one's own. Some of the new friendships developed out of memberships in mothers' groups like "Mothers' Morning Out" or "Moms of Preschoolers (MOPS)," or mothers with kids in the same daycare center. Some mothers' groups offered chances for women to meet while their children were being entertained separately, and some provided guest speakers or discussions that mothers found helpful for resolving their own parenting dilemmas. Groups like "Mothers' Morning Out" allowed mothers to enroll their children in a program that meets two or three times a week for a few hours, giving mothers a chance to be child-free for a short period of time on a regular basis, and a chance for children to socialize with other children. These groups provided a network for mothers in the sample to meet other mothers with children the same ages as their own. For instance, Nicole, who was diagnosed with PPD, was very enthusiastic about a group called "Stroller Strides," which meets at local parks or malls. There, mothers exercise together with babies in strollers for an hour five mornings a week, under the direction of a trainer. Not only are the mothers able to get in their fitness workout, but afterwards the babies play together on blankets on the grass while the mothers chat. Through participation in this group, mothers build a network of friends, get back into shape after pregnancy, and begin to socialize the babies on making friends.

In sum, mothers in the sample found the greatest change in their social network to be with friends. Rather than friendships based on mutual interests, mothers became friends with other mothers with children close in age to their own. Some were saddened by the loss of single or childless friends,

while others felt that motherhood gave them a chance to make new friends. Friendships based on motherhood offered the advantage of peer support for solving parenting issues, even more so than the support they received from husbands or partners or family members. Indeed, mothers indicated that friendships trumped support from husbands or respondents' own mothers, offering an arena where motherhood could be shared with peers without strict reinforcement of gendered expectations.

Whether because husbands and respondents' mothers might judge or encourage adherence to the idealized version of motherhood, respondents, whether diagnosed or not, found refuge in friendships with peers to be the most valuable asset in obtaining support in their motherhood roles. Mothers built social networks through these friendships, often gleaned through membership in mothers' groups like Mothers' Morning Out, Moms of Preschoolers, neighborhood groups, or a depression support group.

### **Motherhood and Paid Work**

It's balance, you know, everyone says we're a society that's in awe of children and families, and not to get political, but all the darn Republicans who are like "family values," you should see them with kids, it's like yeah, only if I actually stay home with them full time, and nobody explains how you actually feed them. (Carly, not diagnosed)

Many of the mothers in the sample (23 of the 35, and one who was looking for a job) returned to paid employment sometime after the birth of their child. But the decision of whether or not to return to work was not a simple matter. The standard of living today often requires that both parents engage in the paid workforce. Mothers in the sample showed that whichever choice the mother made – to return to paid employment or to be a stay-at-home mother – created ambivalence and required adaptation, either to tighter finances or to navigating the responsibilities of both paid employment and raising children. No matter what choice she made, it often brought judgment from others who thought she had made the wrong decision. For instance, Amanda described the difficulty of returning to work after having a child:

It never stops; it's exhausting. I feel like there's a lot of guilt involved, maybe being a working mother. When I was home with my daughter, I felt guilty because I didn't enjoy doing that 24/7, and now that I'm working I feel guilty because how could I leave a two year old at a facility for eight hours a day? I know people do it and she's fine, and she's happy, and she runs in to class every morning without looking back, but just never knowing if you're really doing the right thing. (Amanda, not diagnosed)

The transition back into the workforce can involve accepting that full-time motherhood is not the enjoyable venture that our culture proposes. In the narrative above, Amanda revealed hesitancy to return to work because of the cultural script that impels mothers to place the well-being of the child first, and the uncertainty that entrusting her child to someone else for the duration of the workday would be good for the child. Guilt resulted from not knowing whether what she was doing was best for the child. LaRossa (2011) distinguished between the culture of fatherhood, which suggests more participation in childcare, and conduct, which shows minimal increases in fathers' participation in childcare; likewise, there seems to be a contradiction between the culture of motherhood that places full responsibility for the care of the child(ren) on mothers and the practice of mothers returning to paid work. In the spring of 2010, over 21 million mothers were in the paid workforce (U.S. Census 2011). Nationally, almost 64 percent of mothers with children under age 6 returned to paid employment; 56 percent of mothers with infants under one year of age were in the paid labor market in 2010 (U.S. Census 2011). As James (2009:272) refers to this as "the new motherhood," mothers in this study related the tension that the dissonance between the cultural expectation and practice creates:

I remember driving home thinking, should I go home and be a mother and just that, should I be home with her all the time, or should I do this [work], and what does that mean? And it took me a while when I finally realized that the person who sort of created or brought her into the world was this person that, you know, I had done all this schooling to get a PhD, five years in graduate school between a masters and a PhD. We moved across the country to do that, twice, and now I have this job, and I realized that I want [my daughter] to be able to go to school and say, yeah, my mom is a professor, and to be able to have that as part of her identity, to have the things that I do, because it was just hard to wrap my head around whether or not I should give this up, this job, or spend more time at home with her. And then I finally reconciled it, it took a few months. It was hard. (Emily, not diagnosed)



In the quote above, Emily was able to settle her unease about her decision to return to paid work by recognizing that not only she benefits from the additional identity that her career provides, but the child would benefit in the long run too. She felt that having a successful career provides a good role model for her daughter. While some conservative politicians push for a return to strong family values that includes gender-normative roles, i.e., the mother's place is in the home, this mother eventually resisted that pressure in favor of one that allowed her to participate in both endeavors. The findings from this study support Hays' (1996) earlier findings that mothers who work in paid employment straddle two very different ideologies:

the historically constructed image of warm, nurturing mothers on the one side and cold, competitive career women on the other, between the call for a revival of 'family values' and the call for greater workplace efficiency, and between the impersonal pursuit of self-interested gain in the context of a competitive market system and the empathic pursuit of nurturing personal relations in the context of mutual obligations and commitments. (Hays 1996:16)

These competing ideologies created a tension that made it difficult for mothers to feel successful in either paid employment or family life. The return to work, although difficult for a time until the mother and child were used to the routine, created guilt around leaving the child in the care of someone else for the purpose of pursuing a career. Men are not expected to think in this same way, but are expected to return to work soon after the birth of a child. Although this study does not investigate whether fathers preferred to return to paid work after the birth of their child rather than stay at home, the mothers in this sample indicated that fathers did return to work within days or a week after the child's birth.

As can be expected, the mother's return to paid work presented both benefits and difficulties for the mothers in the sample. Indeed, work seemed to offer a buffer from PPD: only five of the 23 mothers who returned to the paid workforce were diagnosed with PPD, while 10 mothers who stayed at home were diagnosed with PPD. Only two stay-at-home mothers in the sample were free from a diagnosis of PPD, whereas 18 of the mothers who returned to work were free from diagnoses of PPD. Thus, mothers who chose to stay at home were not immune to the negative effects of their choice. While the

high standard of living today often depends on two incomes, mothers who stayed at home revealed that they faced tighter financial conditions as they forfeited their incomes, and they felt pressure to do more of the tedious chores of keeping house. Even if the mother decided to be a stay-at-home mother, it seemed that uncertainty was part of the equation:

I have some girlfriends that don't work, and first I have to say I think it's all relative. I think whether you work five days, four days, one day, or no days, I think we all have the same struggles, and my group of moms in the neighborhood, we all understand that. And even our husbands are a great example because my cousin, whose daughter was born the day before [my son], doesn't work, [another friend] works three days a week, and we all have the same issues, so I do understand that. But, a lot of times I'll hear them say, well what if your child doesn't develop the same, and I'll say I think he will, you know. And I actually I think with his personality and seeing how he's done with school, which we call it school, I think he's so well adjusted that if I were ever to decide not to work, I couldn't take him out entirely, you know. And I can talk with them about how torn I was in the beginning, and how I tried to be more accepting of it, but when I did, they would always say, "well just don't work." And I'd say, "well it's not entirely up to me," and also I don't want to just not work at all, and I really love my job. (Kim, not diagnosed)

In the quote above, Kim suggested that mothers face the same challenges whether they are stay-at-home mothers or in paid employment. She explicitly stated that the decision to work outside of the home, or not, depends not only on the family's financial state but also on what the family considers best for the child. As can be seen from her quote, it is not always immediately evident that the choice made will be what is best for the child in the long run, which created ambivalence about the choices made and judgments from others about the decision to work outside of the home. Her referral to daycare as "school" seemed an attempt to nullify the criticism her friends had for placing her child in daycare. And her final statement, which indicated that she loves her involvement in the paid workforce, placed her needs last. The decision to work outside of the home, or not, makes it a guessing game as to whether one is "doing" motherhood correctly. Indeed, there seems to be a great deal of performance anxiety in women, both those who stay-at-home and those who participate in paid employment.

Others found that time at home with the child, whether temporarily or permanently breaking from the paid workforce, created opportunities for bonding, a benefit they enjoyed that perhaps their

spouse/partner did not have because of their work schedules. Kelly, who stayed home with her child, expressed appreciation for the time to focus on projects that would not be possible if she were working:

I have them [kids] all to myself, pretty much most of the day, all days, and then my, I get to cook. Well, when you're working, it's hard to prioritize getting home and getting a healthy meal, I can spend a lot more time making sure I'm buying the kind of things I want to be feeding them, preparing things at home that I think are good for them and that they would enjoy, so I really do enjoy that part. I'm about to make that transition [back to work], but everything's going to fall apart in just a little bit and that's okay, I expect that. I feel like I'm constantly juggling, like trying to keep the house clean when I don't really feel like cleaning. We're not in a place to hire a maid right now because I'm not working. So I think that the hardest part, just the strain on your finances and now that I'm at home I feel the pressure, you know, emptying the dishwasher, and not letting dishes pile up in the sink, that sort of thing. (Kelly, diagnosed)

After staying home for a while after the birth of her child, Kelly alluded to the time crunch that she expects once she returns to paid employment, and a less-than perfect performance of the duties she now fulfills as a stay-at-home mother once she is back in the paid workforce. Stay-at-home mothers in the sample explained that they are expected to be efficient but find it difficult to be productive while caring for their children. They felt that housework was tedious and must be prioritized so that the needs of the child(ren) come first. Some stay-at-home mothers indicated that their husbands did not understand why things like laundry or dishes did not always get done, while others said that their husbands did not say anything about what is left undone, nevertheless they feared that their perceived inadequacy bothered them. Not working outside of the home, then, not only placed a financial strain on the family's income, but it also placed pressure on the mother to be more productive in the home, to complete household chores that they would prefer to be hired out but could not justify because of the reduced income. Mothers were concerned that their husbands thought they were not doing their part in taking care of the children and the home, and they described the work women do as mothers and housewives as unfulfilling and tedious.

While it is more acceptable to certain populations – political conservatives, for example - for mothers to choose to stay at home, mothers also can face criticism for that choice. This is especially true of single and/or low income mothers who are often forced to work outside of the home due to reforms

in welfare policies that require recipients to be employed within a time period of receiving benefits.

Alissa, an unmarried black mother, told of her experience in postponing her return to work:

Well I found that we live in a culture that seems to lack the social support for mothering, so I was really shocked by that. I think that my decision to be a full-time like stay-at-home mom, first of all, was very instinctual for me, like who else is going to take care of her besides me. I thought that decision would be a lot more supported, that I wouldn't have to constantly defend myself. So I think that's been the most difficult part, having to constantly explain why I didn't clock into work today. My family, friends, random strangers that I may have a conversation with, you know, "where are you working, are you working," as if this [motherhood] isn't enough. I'm just starting to work, like I didn't want to do any type of work for the first year of her life, and then I wanted to do something maybe part-time, once she turned a year, and that didn't work because I was still very actively nursing her, and before I had her I worked as a midwife assistant, so going back to birthing just wasn't a good fit for also having a small child. I took her to a birth, and she was a year old, and then I left her with my mom once, and that just didn't work. You never know how long you're going to be there, my breasts filled up, and I didn't really like being away from her for long periods of time. So then I said, let's wait until she's 18 months, and then I'll go back. So now I'm just getting into doing a little bit of work, but if it appears to not work at this age, then we'll push it to 2. But we'll see. (Alissa, not diagnosed)

Alissa had moved back in with her own mother, as she faced the pressure of providing financial security for her child while making the decision to stay at home until she feels comfortable leaving the child.

Although her decision felt "instinctual" for her, it was not always in alignment with what others had expected of her: she was the first in her family to stay home with a child, and to breastfeed, which brought up continual questions about her mothering practices. She indicated that her relationship with the baby's father fared better once she moved into her mother's home, which allowed them to enjoy each other's company without the pressures of the full-time responsibilities of co-parenting the child. The father remained active in Alissa's life, but not involved in the day-to-day task of parenting. However, the criticism Alissa faced for staying home does not generally apply to married mothers with employed spouses and adequate incomes to support the family.

Another mother, Debbie, felt criticized for keeping her child in daycare while she looked for a job which would fit with her parenting responsibilities, such as one that does not require travel:

A lot of times I worry and stress over it, but it's something, things that I make up in my mind, you know? It's the biggest thing I worry about, right now I'm not working. I had an interview last week and I'm looking for a job that, because there are jobs I can do without travel, and I

have [my son] in daycare, you know, it's just things I make up in my mind. I wonder if people think, "she's not working, her kid's still in daycare," you know it's just things I make up in my mind. So I never felt judged by anybody. And if I felt like somebody was negative, I felt like it wasn't those closest to me, like my family. If I feel like somebody is judging me, you know, "you keep him at your mother-in-law's a lot," I think it's in my mind, you know, I think these people are probably thinking that, I have no proof. Time passes on, and people don't know about it, it's just lack of knowledge. If I put myself in their situation, I'd think why would someone who's sitting at home put their kid in daycare? Like right now, I'm looking for a job, taking my time, I'm not pulling [son] out [of daycare] and disrupting his routine. But I don't want people to think I'm like a little princess. (Debbie, diagnosed)

While she felt that it was only a matter of time before she found a suitable job and that she did not want to interrupt the child's routine only to return him to daycare once she was employed, she was concerned that others were not in support of her decision and judged her negatively for it. She acknowledged that she would probably think the same thing of another mother who kept her child in daycare while they are not actively employed. Her reference to not wanting people to think she is a "little princess" highlights the expectation that mothers be selfless and sacrificing, always putting the needs of the child first. To do otherwise suggests a woman who is pampered and spoiled, something that contrasts sharply with normative motherhood. But her concern is not overly worrisome because it is the generalized other that may not approve; her family and those closest to her accepted her decision.

Mothers who returned to careers or paid employment expressed several benefits for choosing to do so. One of the more common themes was that having a child made them put boundaries between their work and home life, creating more balance between the two. Erin spent long hours in the lab before she had her child, she now works "more like a nine-to-five, and that gives me more time for other things" (Erin, not diagnosed). For this mother, because she has a flexible work environment, she found it beneficial when she was stressed to spend an hour or two away from the office while her son was in daycare. The work day, then, with her son in daycare, provided a break from both career and mothering responsibilities when needed, which alleviated tension that likely would not be relieved if she were a stay-at-home mother or had less-flexible working conditions. Another mother, Kim, reduced her paid work hours from 80 hours a week to 40:

So I am so much better at setting boundaries, and it's not just because I'm doing it for somebody else. It's because I know the limitations for me, too, because I look at things now as resources, and if I give overly to work, it's got to take away from somewhere else. I don't want to take away from my family, because 40 hours a week is tough. I mean I didn't do that [80 hours] every week, but I never did under 50 or 55 before that. It is a great thing, but I think that part of it is the struggle of being a working mom that I know I have to do 40 hours right now, and so that's what I do, I do the minimum. (Kim, not diagnosed)

Establishing parameters around her work schedule allowed this mother to make the most of both her career and parental responsibilities. She allowed herself to "do the minimum" for a while so that she could be both a productive worker and a responsible mother. Other mothers desired some temporary easing of expectations in their careers but faced repercussions from co-workers who resisted any remediation, which created an us (mothers with young children) versus them (males and childless female colleagues) atmosphere in the paid labor market:

Some people [co-workers] have older children, and I'm the only one in my area. And it's like, people will, like I have one colleague who, "well I don't want to hear you using your kid as an excuse," and I'm like, oh someone else uses their commute as an excuse and that's an excuse but a kid isn't? And it's like, you know, it's not an excuse, it's just that for five years can I not be assigned to things at night? You know, I've done six night classes, other people have done none, I'm just asking, while she's in daycare, could I be done by six o'clock? And I think the other thing is there are a lot of women in the academy, and it's not just the men, it's often the women [who are most critical.] I have a friend and her pushback is that they are older women who thought they couldn't have kids and a career, and so they're almost like, well why, I couldn't do it all, I wasn't allowed, why should you be able to do it all, and they resent, probably because they wanted kids and chose not to have them. And that sucks because then you have the men who don't understand, and the women who are not compassionate.... (Carly, not diagnosed)

Carly expressed almost animosity that she felt from co-workers whose expectations were not conducive to balancing both paid work and motherhood. She alluded to a generation of older female co-workers who felt they had to choose between career and motherhood, and who resent any deference given to mothers in the workplace who have young children. Mothers in the sample were often unable to negotiate their job requirements for fear of being viewed as inadequate or incapable of fulfilling the requirements for the position. Alliance with a friend who was also a mother with young children helped Carly to stay in the workplace, giving her support to continue the "battle" for recognition, or at least understanding, as she strove for balance between her paid position and her role as mother.

Other mothers expressed that having paid work made parenting more enjoyable and gave them a break from the mundane tasks that mothering required and allowed them to focus on the positive rewards of motherhood:

I came back to the office and felt like me again, not having to nurse or do diapers and stuff like that, and being able to be a mom when I come back home, that was what keeps me, really, I think, effective as a good mother because I have the other side. I am a mother with them but only in these settings, right, I don't have to worry about diapers and nursing and feeding and sleeping habits. I enjoy teaching them and I know, because we always laugh, here everyone is finishing the day and doing other things, for me I'm going to my second job, being a mother, and because it's a very defined time that I have, weekends and after work, then I think I enjoy it much better. It doesn't stretch all day, all night, every day, every night for years. (Maddie, not diagnosed)

For Maddie, having both career and children allowed her to enjoy both, with clear boundaries between the two and a break from some of what she considered less-enjoyable aspects of mothering – diapers, nursing, feeding and sleeping habits. Conceptualizing mothering as work, as her “second job,” removed it from the realm of obligation and made it desirable. She was able to delegate some of the less-enjoyable aspects of mothering and not feel like she was shirking her mothering obligations. Other mothers who participated in paid employment echoed the sentiment:

I actually feel that by the time we get home after the end of the day and eat and take bath time and go to the park, it's right there, it's pretty much time for him to go to bed, and he's a pretty good sleeper. So, nothing ever feels too stressful because by the time we do all the things we have to do, I kind of get a natural break to my day. (Cheryl, not diagnosed)

I just love to see her at the end of the day, I like to hold her and just observe her, and take care of her, feel like she has a sturdy person as a mother, you know I've got to a place in life where it's relatively easy to take care of her, to afford daycare and the things she needs and still have a career that I love. So I guess the thing I love most is just having her around. (Gina, not diagnosed)

These mothers found balance between career and family responsibilities, with workplace flexibility that allowed them to adjust their schedules to better fit their needs. The transition from work to home life was something that gave them a well-rounded day, not totally absorbed in their career but also not fully immersed in tedious parenting responsibilities. The paid employment gave them an identity besides

that of mother, which they describe as being “sturdy,” “fulfilled,” and having a “natural break” to the day.

However, the issue of working moms created a tension around whether it is appropriate or best for the child to be in daycare or in the care of someone other than the mother while the mother pursues a career in the paid workforce. Mothers in this sample who returned to work justified placing their child in daycare by saying that their children were happy in daycare, and that daycare provided many different kinds of stimulation that mothers alone could not provide. For example,

I feel like she’s really someplace good. And like I said, I know people in other daycare say it’s just changing and feeding them, but she’s doing music every day, she’s doing art every day, I feel like it’s more pre-school than daycare. So I think that makes it a lot easier, not with the paycheck, you know, writing that check every month is tough. (Carly, not diagnosed)

Other mothers told of their child running off to daycare, not looking back, which gave them a sense of relief that the child was happy in that environment. The very word “daycare” has negative connotations, thus referring to daycare as “more pre-school” offers a more socially acceptable justification for placing one’s child in such an environment. For many mothers working for pay, having relief from some of the tedious chores associated with mothering allowed them to enjoy both career and parenting, in healthy doses of each. And having the child in an environment that provided more than what the mother could provide on her own made it easier to adapt to the responsibilities of both work and home environments and eased the apprehension that they could be doing harm to their child by not being a full-time primary caretaker.

But not all mothers who return to paid work are so lucky to have a work environment that is flexible to make the return to work easy. Several of the mothers who returned to paid employment in the university system spoke of a male-oriented work environment that lacked support ranging from a lack of a clear maternity leave policy to schedules that conflicted with their parental responsibilities.

My husband was shocked by this [lack of clear maternity leave policy], you would think that, you know, people at universities tend to be more liberal and more open, and yet some of the atti-



tudes are like, I'm currently one of only two out of 30 faculty in my department with young children, and the other is a man, which I'm sorry, is different. You know it is. (Carly, not diagnosed)

While this mother spoke of a maternity leave policy that was unclear and often unfavorable to mothers, it seems to take on additional credibility because her husband also recognizes the injustice inherent in its absence. While the repressive policy was visible to her, it seemed to be invisible to her husband until she pointed it out to him. She spoke of the differences between what is expected of mothers in the workplace and what is expected of fathers or mothers with older children in the workplace. Another mother, a professor, told of teaching classes when her baby was just weeks old because the chair of her department failed to inform her that she had the option to take time off under the Family Medical Leave Act (FMLA). She said that caused her to feel unsupported by her colleagues and to resent the university:

That made me feel very tense and that's why I was trying to prove that I was still committed, because I felt like he wasn't, he's reported to have made a comment to somebody about women having babies really screws up his scheduling duties, whatever. How inconvenient. Of course, he's a father. (Gina, not diagnosed)

In these accounts, mothers felt that the workplace favors men, who are less likely to have to fit childcare responsibilities into their working hours and who often rely on their wives to take on those tasks. Some complained of having certain work activities, such as meetings scheduled late in the afternoon, teaching evening classes, or attending departmental functions scheduled in the evenings, or picking up faculty recruits from the airport for their campus visits, that interfered with picking up their child from daycare on time or interrupted the dinner and bedtime ritual for their child.

Especially as an academic, and a mother, you know, the people I have been mentored by have been men, and mostly white men with wives who stay home. I'm like, yeah, they have 100 page vitas, to get to that point I'm going to have to work for 10 years longer than all of them put together. But sometimes I'd like to have a wife to stay home and take care of me. I think sometimes I feel like I get the short end, because I do have to be the one that's always up in the morning, and my daughter is very much a mama's girl, so I can get her to do things that other people can't. (Emily, not diagnosed)

The extra work to which this mother alluded just to reach the point that her childless female colleagues or male colleagues – whether parents or not -- had attained seemed to be an uphill climb. And again the

tension between mothers and their male or childless female coworkers became visible. At home, this mother was the parent responsible for getting the child up and ready in the mornings and during the night if the child's sleep was interrupted, which took a physical toll on her. She revealed the difficulty of trying to achieve a balance taking care of her family yet being productive at work. Being a mother in a paid position interfered with opportunities for advancement that others without childcare responsibilities had. But by keeping their parenting challenges hidden at work, mothers likely perpetuate the inflexibility that makes the workplace seem favorable to men, upholding the status quo and making change unnecessary. According to these mothers, the male-oriented workplace has not adapted to the needs of mothers (or parents, for that matter), so that they can accomplish both paid work and parenting duties. Long-held practices rather than intentional discrimination are believed to be the reason policies have not bent to accommodate parents with childcare responsibilities. This is visible in the lack of information on maternity leave, which is mandated by the FMLA rather than the university itself and inconsistently applied throughout the university. Indeed, another professor at the same university found that she was able to integrate back into the work routine gradually, and her department was supportive when she had to take leave to take care of a sick child. The lack of a clear policy in this one institution reflects the wider culture where some workplaces are flexible and allow flex-time or similar policies so that mothers – or parents – can adequately care for their children and complete their work commitments, while others are not so accommodating or supportive. The lack of support for mothers in the workplace added pressure for mothers to be productive and created a stigma for those who struggle with balancing both sets of responsibilities. From the interviews with the mothers in paid positions, it seemed that mothers were hesitant to express their needs in the workplace for fear of being labeled incompetent. Yet the demands for the mother to be the primary source for meeting the needs of the child placed her precariously in her place of employment.

When I was back to work for 3-1/2 months when I was pregnant with her, the expectation was that if my son missed daycare, that I was going to stay home from my job as opposed to my

husband. We've had to talk about that, with me going back to work, he's going to have to start making dinner during the week a couple of times, and he says, oh yeah, oh yeah, fine. But you know there's going to be a little more take out in our lives, and until he sees that in the budget, I think it'll be fine and then he's going to go, whoa, why are we spending all this money on take-out? Well, you didn't cook any Thursday night this month, so we got takeout. (Kelly, diagnosed)

Again, the gendered division of labor in both the workplace and the family make it difficult for mothers to accomplish success in both realms. The assumption that it is mothers who will leave their job to take care of the child discounts the contributions that mothers make in the workplace. Yet the often-competing demands placed upon them required that they find some way to balance the two worlds. Mothers who returned to paid employment after having a child attempted to alleviate the demands placed upon them, perhaps by allowing themselves to be less productive at work for a period of time, justifying it as a temporary lapse in their full potential. They were more likely to set boundaries between work and home responsibilities so that they could feel somewhat successful in both dimensions, even at the expense of delaying advancement in their careers.

The experiences of the mothers in this sample who returned to paid work support the findings from a study that examined the effect of paid employment on mothers. Leupp (2011) finds that mothers who enter the paid workforce have lower depression rates than those who stay at home, but only if they have realistic expectations that balancing work and parenting responsibilities will be difficult and they are willing to let some things slide and get more help from their husbands with childcare and household responsibilities. On the other hand, "supermoms," mothers who expect that balancing paid work and parenting will be easy, have higher rates of depression than those with more realistic expectations. "Guilt over not being able to manage the work-family balance and frustration over division of household labor could also play roles in the increase of depression symptoms in the supermom group" (Leupp, 2011). The mothers in my study who returned to the paid workforce, regardless of whether or not they received a diagnosis of PPD, acknowledged that either their work productivity or some of the household chores would have to slide, at least temporarily.

The benefits some mothers received from returning to work made the stress of balancing responsibilities worthwhile. Besides the financial gain from paid employment, a few mothers in the sample expressed satisfaction in having an identity other than that of “just mother.” For example,

It’s important to maintain the mother’s life the way she wants it to be, and obviously it’s not an easy thing, but I’ve decided that, as sort of a feminist, I am a feminist but sort of a feminist idea that I was not just a mother but I was Dr Morgan and I was a friend and a daughter and a sister and a colleague, I was not going to be just a mother as my identity. And I remember before the baby came, I was pretty focused on that, and I was pretty freaked out over the idea of giving all that up and sort of losing my identity and becoming just, a friend of mine told me that people would greet her as “well hello, new mommy” and she said, and I find, too, that kind of thing. And I was nervous about that part and about the medication and then visits to the therapist, I started seeing a real therapist, in hour-long sessions, a few weeks ago who she recommended, and that’s helped me deal with negative emotions. So that I didn’t really focus on being a certain kind of mother, I’m just trying to be myself and take care of her the way that feels natural. (Gina, not diagnosed)

For this respondent, mother was but one facet of her identification, as she tried to fulfill her mothering role in a way that made sense for her, recognizing that it is contrary to society’s expectations of the motherhood role. Depressed before pregnancy, she took medication during her pregnancy as she felt that the mother’s health is just as important as that of the child. Yet her allusion to “negative emotions” indicated that she, too, thought of women’s emotionality in terms of pathology and made it seem unnatural. Through the support of a therapist she was able to shape her motherhood role as she saw fit. She resisted the societal expectation that motherhood would take priority over all other facets of her life, and she consciously sought help with doing so. Although not diagnosed specifically with postpartum depression, she was taking medication and getting counseling for depression.

Work for some mothers provided a support that may have been lacking in their personal lives. One mother stated that currently her friends are her co-workers who have children, which allowed her to round out her social network through work. Although she did not have time to be around others because of the demands of work and family life, she found satisfaction through the friendships that developed at the workplace. Again, balance was the key to successfully managing both career and motherhood, according to the mothers in this sample who returned to work. Although time in the paid work-

place kept this mother from bonding with other non-working mothers, she found that co-workers with young children were a good substitute. Another mother also recounted that a co-worker who also had a young child gave her invaluable advice that she has adopted as her own mantra: "This too shall pass." She said it helped her to put difficult times, such as teething or the obstinate "no" period that her child was going through, in perspective, realizing that they're normal phases that will not last long. It helped her to deal with the stresses she encountered in motherhood as temporary events rather than a constant challenge, and it allowed her to enjoy the lighter moments of raising a child:

I don't have to look at him and go "I can't live with this" because he'll be over it before I even realize that it's bothering me. For the most part, I'll think, oh man, you've been doing a lot of that recently, then the next day it'll be fine. (Cheryl, not diagnosed)

As discussed earlier, the best source of support comes from peers, mothers with children around the same age as theirs. If some co-workers are mothers with young children, the work environment supplements the social network of friends, offering support that may be lacking otherwise.

In summary, the paid work environment offers mothers benefits that include an alternate identity to that of "mother," the ability to work at something they find satisfying, and an appreciation for their parenting opportunity that might otherwise engulf them if not for the distraction of employment outside of the home. Mothers who work with other mothers with young children find an extended support network among their peer co-workers that might be lacking without that paid work environment. The findings from this study support research that shows that the key to successfully navigating both paid work and parenting responsibilities is finding balance between the two, allowing that expectations of perfection in either sphere will have to be relaxed. Mothers highlighted the stigma attached to talking about the difficulties of mothering in a male-oriented workplace. In fact, the only workplace environment in which they could talk candidly about their struggles was one in which their co-workers were also mothers with young children. Otherwise, they felt they would be criticized for not being as productive as expected, and that others would perceive such talk as an excuse for not living up to those expect-

tations. Although the inability to express their needs as mothers in the paid workforce created a stress between their dual roles, they felt that the benefits of working outside of the home outweighed the negatives. Gendered expectations for mothers are evident in both the paid work environment and the home, making it a challenge to balance responsibilities inherent in both.

As LaRossa (2011) proposed, the culture of fatherhood suggests more involvement of fathers in childcare, but parenting practices of respondents in this study adhere to traditional gender roles for both mothers and fathers, regardless of whether mothers participate in the paid labor market. This was true whether mothers' family incomes were over \$100,000 or \$0-20,000, and whether mothers were white or minority. For mothers, the culture of motherhood espouses "intensive parenting" (Hays 1996), an ideology that holds mothers responsible for childrearing that is child-centered, expert-guided, emotionally absorbing, labor-intensive, and financially expensive. Narratives of the mothers in this study support the cultural ideation of motherhood, but their practice of motherhood has changed: the majority of mothers in this sample are in the paid labor market. While fathers had the choice to be involved in childcare, mothers did not, thus mandatory motherhood presented challenges in the divide between paid work and family life. The ideologies that surround motherhood keep women compliant to the role of motherhood, even when working full-time outside of the home; that compliance ironically creates strategies which uphold the ideologies. For one, the reference to daycare as "preschool" supports Hays' finding that mothers feel "...they should spend a good deal of time looking for appropriate paid caregivers, trying to make up for the lack of quantity time by focusing their energy on providing quality time, and remaining attentive to the central tenets of the ideology of intensive child rearing" (Hays 1995:322). Thus "preschool" rather than "daycare" is a more acceptable form of childcare, justifying the mother's delegating childcare to someone other than her during the workday. For another, mothers' accounts of the time spent after work with their child(ren) suggest that they emphasize quality over quantity. Their accounts illustrate the influence that ideology has on them to uphold the cultural expectations of moth-

erhood, and the ambivalence those ideologies created over their choices, whether or not they worked outside of the home.

### **Mothers' Advice to Mothers**

One question that I asked mothers in the interviews was "Do you have any advice for other mothers who may be experiencing PPD?" Whether diagnosed or not, respondents most often mentioned the need to be able to talk with someone about the difficulties they were experiencing. While some told of getting relief from symptoms of depression by being able to talk with someone about their struggles, some felt they avoided diagnosis simply by talking with someone, and still others were diagnosed but felt that they could have circumvented depression if they had talked with someone about their struggles with motherhood. Overwhelmingly, mothers in this sample recommended that other mothers who may be experiencing difficulties in their motherhood role talk with someone to help them cope. They conveyed that not talking of their struggles led to feelings of despair and isolation, as though they were the only ones experiencing such troubles.

However, respondents revealed that, because of the stigma involved and the rejection they might feel as a result of disclosing such difficulties, they were very selective with whom they revealed their discomfort with their mothering role. The 16 mothers who received a diagnosis had approached their OBs or CNMs for assistance with difficulties they were facing in their motherhood roles, and all 16 were told they were experiencing PPD. One of the mothers experienced the more extreme form of PPD, postpartum psychosis, and was sent from the hospital to a psychiatric hospital for a short period of time. Her mother and her partner took care of the baby for about a month, until they felt she was well enough to care for him on her own. For the others, although the typical medical response to these cases of PPD was to prescribe medication, only seven followed the practitioners' recommendations to take the medication as directed. Some simply chose not to:

I was against taking meds, I call them 'crazy meds,' and I was like, I'm not crazy. (Liz, diagnosed)

They put me on Lexapro, and I stayed on it not even a week, and it was helping, but I was getting to where I didn't want to be on a drug to feel good. (Angela, diagnosed)

I didn't want those feelings, I just wanted to be normal. Take medicine to mask those feelings? And that's how I felt, it would mask those feelings. (Joni, diagnosed)

I don't think the care I got from my OBGYN was very good. He just said 'oh you're sad, yes, you're depressed, you shouldn't be feeling this way anymore, lets write you a prescription' and wrote the prescription and went along his merry way. I definitely feel like he could've offered to refer me to a counselor or psychologist to help me maybe work through some of the things I was feeling rather than just writing a prescription and expecting that to make everything better. (Michelle, diagnosed)

While these mothers did not want to depend on medication for relief, that was the remedy offered to them. Two others went off medication because they could not afford the prescriptions. The mothers in the quotes above resorted to self-medicating to alleviate their symptoms, were arrested for their involvement in illegal activities (either selling drugs or multiple DUIs), and are now undergoing treatment for substance abuse (SA) as a condition of avoiding jail time and getting their children back from foster care. As part of the treatment in the SA facility and diagnoses of PPD, they are taking antidepressants. However, it is questionable whether they would keep up their medication regimen if not required by the SA treatment program, and if the stakes were not so high. They have to prove compliance with the treatment protocol and show progress in overcoming their addictions before they can get their children back. Their initial resistance to taking antidepressants reveals a desire to work through emotional difficulties rather than to numb them with medication.

Three other mothers were given samples and a prescription to be filled when they told their medical practitioners about their struggles, but they also chose not to take the medicine:

I actually went to the doctor and asked for medication, but I never took it because I felt better as soon as I went to see him, which was weird." (Susan, diagnosed)

They gave me samples of it and a prescription, and I went home and threw it in the cabinet. Because number one, she said, you're not going to be able to breastfeed your son. Boom, that was



it. And I also like to be in my own mind and don't want to be altered, even though I think that hormones alter my mind. I really believe that. (Abby, diagnosed)

Susan, the mother in the first quote above, was surprised at how much better she felt after simply telling her doctor of her symptoms. She was able to get the relief she needed without using medication, even though she had asked her doctor for it. Abby, the mother in the second quote, chose not to take the prescribed medication because she did not want to give up breastfeeding. Note that she preferred to "be in my own mind" rather than altering her condition with drugs, even if that condition was distressful. She attributes the difficulties she felt to hormones. Another mother, Erin, who was depressed before becoming pregnant, felt that she avoided postpartum depression altogether by seeking counseling for that episode of depression instead of taking medication. She felt that although it took longer to get relief through counseling rather than through drugs, the counseling gave her social skills that helped her to better communicate her needs to her spouse and to see that her needs were valid rather than selfish when she became a mother. And several mothers, some who were diagnosed and others who were not, told of getting almost immediate relief from attending a PPD support group where they felt they could express themselves without fear of judgment and rejection, and where other mothers were experiencing very similar issues. Knowing that other mothers had similar negative experiences of mothering eased the guilt or shame they had for their dislike of certain aspects of motherhood or the inadequacies they felt they brought to their motherhood roles.

Medication, then, was not the ideal remedy for the mothers in this sample. Of the 16 mothers who received a diagnosis of PPD, only seven of them followed through with the prescribed medication, for varying reasons. Overwhelmingly, mothers in the sample found relief simply by knowing that others were experiencing similar situations within their mothering roles, and being able to talk candidly about their difficulties diffused the distress over what they felt were their individual shortcomings. Until they talked with others and found they shared similar struggles, the idealized version of motherhood made it

difficult for them to accept their own perceived inadequacies; only through talking candidly about their struggles did they find that they were not alone.

Mothers revealed that context matters in the realm of speaking about their difficulties with motherhood. They indicated that the most relief came from talking with other mothers who were willing to be candid about the difficulties they were facing in their new roles. Conversely, talking with mothers who only spoke of the wonders of motherhood made some feel even worse, as if they were the only ones struggling with their new-found responsibilities. Yet the prevailing image of motherhood is that women step into this role easily and that instincts guide them in their care of the infant. All of the mothers in the sample liked certain aspects of motherhood – watching their children learn, feeling so much love for them, feeling a stronger bond with their spouse or partner because of the child – but many felt inadequate or overwhelmed with their responsibilities as mothers. Regardless of their levels of income or education, and whether diagnosed or not, mothers indicated that knowing that other mothers were going through similar trials helped them to cope with their own struggles. Mothers who were diagnosed recommended that other mothers who may be experiencing PPD seek someone to talk with whom they felt would not judge them. Most often that was with peers with similar issues, such as in a PPD support group or other mothers' groups, but also included peripheral persons they did not know, such as the check-out clerk in the grocery store or the nail technician at the nail salon. As one mother who was diagnosed recommended:

Find somebody that you trust to talk to. Whether it be a perfect stranger, if you meet somebody and you feel like you connect to them, talk to them, don't shut down like I did because it will drive you nuts. You know, go pamper yourself, go to the barber shop, or somewhere, go get your nails done, because you're getting pampered and you're able to talk to a perfect stranger who doesn't know you. It takes a load off. (Ashley, diagnosed)

As Ashley indicated in the quote above, trust is a key component in choosing whom to talk with. Respondents felt that confidants they did not know personally were less likely to judge them, and if they did, the consequences would not be so detrimental because they were part of the generalized other,

not in their close circle of family or friends. Ashley, in the quote above, highlighted the “load” that mothers feel they carry alone, and the damage that not talking about their struggles causes. Others had similar accounts:

Not telling anyone is the worst feeling in the world. I tell people everything, not to be the Debbie Downer, but just knowing and not being caught off-guard. You know you want the child, and I think society does put those expectations, like it’s supposed to be this instant mother/baby bond, you know. You get six weeks and your body is supposed to snap back, you’re going on no sleep, it’s just this unrealistic expectation that makes women feel like what’s wrong with me, everybody else is doing it. So I think it’s just good advice: if it happens, it’s normal. There’s nothing wrong with you, it does get better. I think talking with people, finding a supportive group, helps. It takes some time, it took me awhile, maybe because I was a little ashamed, but I find that the more I talk about it, it helps. (Debbie, diagnosed)

Debbie’s narrative revealed the effect that idealized motherhood had on her. Because the culture of motherhood creates an expectation that mothers should bond instantly with their child and should have their bodies back in shape within the six-week period after giving birth, she felt shame when those things did not happen. Her reference to being the “Debbie Downer” highlights the stigma attached to talking about the difficulties of mothering; talking about those difficulties is not something mothers are expected to do, but are expected to be happy and to love being mothers. And although she indicated that talking about the difficulties was not easy at first, it got easier the more she did it. She indicated a desire to normalize difficult experiences rather than pathologizing them, which she found happened by talking with other mothers about those difficulties. But because other mothers refrain from talking about those difficulties, it made her feel like something was wrong with her. Amanda’s narrative was very similar:

I didn’t purposely avoid seeking medical treatment, but I just felt that more than anything, I needed to be able to connect with other mothers who felt similar to how I did. I desperately needed other moms to talk to who were in the same situation I was and were struggling with the same things. After attending [the PPD support group] and learning about the professional support that was out there, I became more interested in possibly finding a medical/psychological professional who could help me. But what I craved more than anything was the opportunity to talk with other moms experiencing the same thing. (Amanda, not diagnosed)

Peer support proved to be most helpful in remediating the distress mothers felt in the postpartum period. The ability to talk with others with similar experiences let them know that they were not bad mothers, but that others were struggling with the same issues. The mothers expressed shame and desperation at what they thought were shortcomings in their abilities to mother, until they found out that others shared the same difficulties.

While peer support was crucial in putting their mothering experiences in perspective, some of the respondents indicated that they did not disclose their negative experiences with their husbands/partners or with their mothers. Some of the reasons for not disclosing were that neither their husbands/partners nor their mothers were very nurturing, or that they would worry too much. Some felt that if they told their mothers about being depressed, they would blame themselves for the depression or would feel badly for them.

I talked to my sister about it, she was helpful. My mom is very religious, so her thing was like, well just pray, which that didn't help. Prayer can help, but you have to do more than that. So I avoided talking with her. (Veronica, not diagnosed)

I do not think I felt comfortable telling my mother, I think I was embarrassed, I don't think I told my mother. (Amanda, not diagnosed)

I didn't tell my mom for a long time. I found that it was easier to talk to strangers about it than people that I'm closest to, so I didn't tell my mom for a long time. And I didn't even tell my sister about it for a long time, because she had a really easy pregnancy. She has one child, and anytime I mentioned anything, I don't know, I just felt like she didn't get it. (Nicole, diagnosed)

Stigma was apparent as the fear of rejection or causing others pain kept mothers from talking openly about their difficulties with motherhood. It is possible that respondents viewed husbands/partners and their own mothers as upholders of the ideals of motherhood, and thus felt shame or embarrassment to reveal their struggles to them. Doing so would likely have been perceived as failing to live up to the commitments that society expects from mothers. And, if one did reveal the difficulties they were having in their motherhood role, what would be expected from those closest to them? Kim, who was not diag-

nosed, expressed disappointment at the lack of response from her husband and her mother when she told them about her struggles:

But I think the one time I considered actually seeing someone about depression was when I had come to the realization that I wasn't getting the emotional support that I needed from my mom and my husband, who were the two people that I should have, and instead they were kind of needing more from me. Instead of giving me any kind of support, I felt like they were taking from me too. (Kim, not diagnosed)

In the quote above, Kim highlighted the burden that mothers often feel they carry in regard to caring not only for the infant but for the entire family. When she turned to her husband and her mother for help and received none, it made her feelings of depression worse. It seemed that not only the fear of rejection made it more difficult for mothers to talk with those closest to them but also the fear that nothing would come from such a revelation, which would also be devastating. Only one mother received additional help after telling her partner, the baby's father, about the emotional difficulties she was experiencing. Her partner then created a space where she could be alone when needed, and he took full care of the child when she needed a break. While not officially diagnosed with PPD, she described her postpartum experience in terms of distress:

The baby's dad, at first, didn't believe that anything was wrong with me, but I had to tell him that I just didn't feel right, that he wasn't in danger and the baby wasn't in danger, but I felt like no one would miss me if I were gone. But he finally looked online at postpartum depression, and he's really stepped up to help me. I saw him every day that I was pregnant, and we worked on our relationship. He's moved back in, and he made a separate bedroom for me – we live in a loft, and he made a bedroom for me, he has a bedroom, and the baby sleeps in her bassinette in the living room. Some days he will take care of her entirely, change diapers and feed her, so that I don't have to do anything. And he helps clean, too. (Veronica, not diagnosed)

Veronica was given a questionnaire before her discharge from the hospital to fill out and return a few weeks after the birth of her child, but she chose not to do so:

I purposely avoided it because with the answers I had to give, they were going to diagnose me with it, and I just felt like I can handle it on my own. So even though my doctor knew something was off, she took my word for it, but I just didn't want to be treated like something was wrong with me. But she knew something was wrong. I didn't want to be on medication, because I know my body would react to it and all the side effects, and I didn't want to have to take other drugs to counter the side effects of the antidepressant. (Veronica)

So while identifying her emotional state in the postpartum period as distress, and her partner found a term for it – postpartum depression – online, Veronica strategized in order to avoid diagnosis. She felt that diagnosis would bring pressure to take medication, which was something she wanted to avoid because she feared that the side effects of medication would wreak havoc in her body. She said that several situational factors contributed to her struggles: she had lost her job and was dependent (for the first time since she was 16 years of age and on her own) on the baby’s father for support; he had lost his job and was struggling to make his own at-home business work; she had to give up her dream of moving to New York to become a writer; and she and the baby’s father were not married and were undecided whether they would stay together. He moved out of the couple’s residence shortly before she found out she was pregnant; thus she felt that his return to the relationship was solely out of obligation. They worked on their relationship, and the father stepped up to provide relief from some of the daily parenting responsibilities. Thus she felt that medication, with its potential side effects, would not solve the issues that contributed to her depression. She sought understanding and support from her partner, and luckily he responded in a positive way. Although Veronica received the help she needed from her partner when she confided that she was distressed, none of the other mothers who told of feeling distressed received any additional help, not from their spouses or partners, nor from their own mothers or extended families, nor from medical professionals unless they were diagnosed with PPD, in which case the only support offered was medication.

Situational factors also played a role in other mothers’ experiences of depression. Mothers gave accounts of a variety of factors that contributed to feelings of depression: a move, a job loss, the sudden death of the baby’s father, an unplanned pregnancy, an infection, difficulty breastfeeding, a colicky baby, incarceration of the baby’s father, fatigue, and others. Although the situational factors varied widely, certain elements were visible throughout. The overwhelming responsibility that mothers felt they shouldered alone, in addition to fatigue that comes from lack of sleep or pain that lingers after

childbirth, made the challenges of mothering even more difficult. Mothers expressed a feeling of abandonment by their spouses or partners, whether due to work, death, emotional estrangement, jail, or simply his moving into another room. The additional stressors, when added to their mothering responsibilities, made some seek professional support to cope with their struggles, while others dealt with mothering issues alone. As mentioned earlier, only one mother received additional assistance with childcare once she confided to her partner the depressive symptoms she was experiencing.

Why is it so difficult for mothers to talk about the difficulties they experienced in the postpartum period? And how do mothers choose in whom they can trust to reveal those difficulties? Emerson (1970) suggests that individuals define reality through social interaction, anticipate events and reactions of the other, and behave according to what is expected in a particular social situation. They most often seek to avoid confrontation, even if they perceive a violation of social norms, and by doing so, they maintain social order. She maintains that in an interaction, parties take one of two stances, “nothing unusual is happening” or “something unusual is happening.”

The process of accepting a “nothing unusual” or “something unusual” stance involves interpretation, negotiation; direct assertions and counterassertions, implications and counterimplications; frameworks for interpreting the other’s subsequent moves and techniques for discounting the other’s moves. If one takes the “something unusual is happening” stance, they see that an individual has committed an act of a particular nature, recognize that acts of that nature are prohibited, and charge that the individual has committed a prohibited act. The individual who accuses the offender “may be challenged in terms of the kind of act that took place, the actor’s responsibility for it, the existence of the rule, or the applicability of the rule” (p. 272). The challenger, therefore, must carefully interpret the action as deviant by proving intent or defining the meaning of the action as deviant, and successfully convince third parties that a violation has occurred. If one takes the “nothing is unusual” stance, then action is not required, even though the individual may have to adjust their view of the particular norm

they feel was violated. Thus it is more common for individuals to take the “nothing unusual is happening” stance. In close relationships, such as those of spouses or mother/daughters, there is much to be gained from social interaction, such as respect and a valued position within the family, but there is equally as much to be lost. If mothers are struggling with motherhood, before they talk with anyone about it they must first consider the possible reactions of the other. In close relationships, there is more of a social contract in which each person’s role is assumed, even if not always verbalized. From the mothers’ interviews, it was clear that mothers are expected to be the primary care providers for the child(ren), even if they work outside of the home. Several instances of role enforcement by family members were visible, such as advice (wanted or unwanted) offered by the mothers’ own mothers, or the criticism mothers felt from husbands (whether explicitly stated by husbands or not) when household tasks were left undone, or the criticism for not breastfeeding for as long a period as the husband/partner or the mother’s mother felt was appropriate – and in one case for breastfeeding longer than family members thought appropriate. If mothers feel shame for not living up to this social contract, enforced not only by family but also through idealized versions of motherhood, through media and medical professionals, they may seek confidants who are less committed to enforcing that contract.

Revealing such difficulties to those closest to the mother could likely invoke a “something unusual is happening” response that may lead to rejection, humiliation, or mandatory treatment. Those closest to the mother would be more likely to hold the mother to high standards of motherhood. Persons who are less emotionally invested in the relationship would be more likely to take a “nothing unusual is happening” stance, and a confrontation would then be avoided. For example, if mothers tell other mothers who are experiencing the same issues, the likelihood of a negative reaction is less because the negative reaction could then invoke a negative counter-reaction. Telling persons in the outer periphery, such as store clerks or nail technicians, would lessen the likelihood of a negative reaction even more. And, if a negative reaction did occur in these peripheral relationships, the possible consequences



– rejection, embarrassment, mandatory treatment – would not be as great as would be with those closest to them. One could simply walk away from that relationship. One mother told of losing friends because she shared with them her mothering struggles, which was distressing, but losing the relationship with one’s husband/partner or mother would take a greater toll. In the same logic, revealing difficulties to medical professionals, even though they are in the periphery and not close in relation to the mother, would bring about a “something unusual is happening” stance that would have consequences that could include pressure to take medication or having one’s children removed from them. Thus mothers avoided talking with medical professionals about their struggles with motherhood.

As one mother said in the interviews, it took just one mother in her mothers’ group to stand up and admit that things with motherhood were not so rosy, but then other mothers felt that they could open up about the difficulties they were facing, too. In a sense, the first mother was testing the waters to see what kind of reaction she would get, taking a risk of confrontation or rejection. The mothers in that group responded with a “nothing unusual is happening” stance, accepting the first mother’s revelations with empathy and understanding. Thus the mothers in the group were able to follow suit and get relief without having to jeopardize the bonds of those closest to them, or risk being labeled bad mothers, because they were among others who were also “breaking the norm” by deviating from normative motherhood. Losing friends, or being shamed by them, would be distressing but not as devastating as losing one’s relationship with or being shamed by one’s spouse/partner or mother. Because of the huge emotional investment in the close social relationship, the risk of rejection is often too great to take.

The ability to talk with others about difficult mothering issues holds the promise for structural change. The more mothers talked candidly about their struggles, the more other mothers were freed to also share their personal struggles. One mother had said “This is the conversation we need to be having,” rather than promoting normative motherhood through silence or endorsement of the essentialist view of women as nurturers. Only when the realities of motherhood become the normalized view will

mothers be free of the high standards that are impossible to achieve. Then perhaps the culture will become more tolerant of the variations in mothering styles and the variances in the rate of adaptation to the responsibilities of motherhood. Mothers will then feel supported in their roles rather than alone, judged, silenced, or stigmatized.

### **Normalizing Motherhood**

My findings thus far support other research on the changes that occur in women's lives as a result of entering motherhood. First, mothers in this study bore the bulk of responsibility for childcare and for work in the home, even as research has shown that fathers' participation in that realm has increased over the years (Bianchi et al 2006). This produced feelings described as resentment, anger, and abandonment. Second, the majority of mothers with young children returned to paid work, and described a tension between the two worlds of work and motherhood (James 2009; Douglas and Michaels 2004; Lareau 2000; Taylor 1996; Hochschild 1989). And as Leupp found earlier, the mothers indicated more balance in both worlds if they relaxed the expectations of perfection in either. Third, mothers indicated that their friendships changed once they became mothers (Mauthner 2002), as they are now centered around their motherhood role instead of mutual interests. They described the change in friendships in terms of loss but also found support in their interactions with other mothers. And finally, mothers found the greatest relief through the ability to talk candidly with other mothers (Mauthner). By doing so, they found that they are not alone in their struggles with their motherhood roles.

However, there is a slight, but important, difference between those findings and the results from this study. Mauthner (2002) suggested that mothers with PPD in her study did not seek help for depression after the birth of their child, often until they reached a breaking point, either because of the stigma attached to failing to cope with motherhood or because of a lack of knowledge about PPD. Some of the mothers in her study did not identify their experiences with PPD until a medical professional in-

formed them that what they were experiencing was PPD. In this study, while stigma may have played a part in mothers choosing not to seek medical intervention, I think there is something else that may explain their decisions. First, because mothers in this study placed such a high value on talking candidly with others about their struggles, I do not think that stigma is totally to blame for the lack of labeling their experiences as PPD, or they would not have divulged those experiences to anyone. That they were able to talk with others about their experiences made them aware that they were not bad mothers, nor were they the only ones experiencing distress during their postpartum period, which gave them relief from that distress. Thus, they were able to put their experience in context of normality rather than pathology. The ability to contextualize their situation, to see their particular circumstance as a normal reaction to the social and physical events they were experiencing, kept them from seeking medical help. Second, most of the mothers in my study had knowledge of PPD: some had read about PPD in books about pregnancy, a few knew of friends or acquaintances who actually experienced PPD, and a few heard of PPD through their OB or CNM. Thus I do not believe the reason they did not seek medical help was because they did not know what it was. They indicated that medical professionals missed what they were going through by focusing their questions on whether or not a mother feels that she may hurt the child or herself. The mothers in this study had knowledge of PPD but chose to view their distress as normal for whatever contextual social or physical situations they were going through. They chose to keep their distress out of the medical realm and to cope with their struggles without medical intervention. Even most of those who received a diagnosis did not feel that medication was the best remedy for their particular situation, and they either did not take the medication when prescribed or discontinued it shortly after starting it.

The majority of the mothers in this sample experienced what could be defined as symptoms of depression in their postpartum period; however, few self-identified their experiences as PPD, and even fewer followed the prescribed course of treatment when they received a diagnosis of PPD. Physicians

treat physical ailments with remedies such as medication, after all that is their expertise. And currently they treat emotional or psychological stress the same way as they treat physical ailments – with medication. But mothers in this sample mostly rejected the use of medication for whatever factors they believed contributed to their distress. For them, medication might numb one's feelings, but it would not solve the sting of the death of a partner, nor the strain of unemployment or low incomes, nor the tension of a contentious relationship, nor the stress of coping with a colicky baby. The mothers seemed to have a more practical approach to addressing their distress, instead turning to peers and others in their general environment for understanding and empathy, and finding relief by doing so. It seemed they found a dissonance between treating their mothering issues the same way one would treat a physical ailment, not because of a lack of knowledge or the stigma attached to mental illness, but perhaps because they did not see their situation as illness, much less mental illness.

This sample is small and fairly homogenous, thus further exploration is needed to see if this finding holds true across different populations of mothers. If the finding proves true on a wider scale, the movement to pathologize what most mothers encounter in the postpartum period further standardizes motherhood rather than recognizing the social and physical contexts in which it occurs. Mauthner says that criticisms of feminist views on PPD fail to acknowledge the differential experiences of women in the postpartum period; rather, my study suggests that medicalizing PPD standardizes motherhood and fails to acknowledge differential experiences of women in the postpartum period. Contextual issues varied widely and were rarely taken into consideration before treatment was prescribed. The standard treatment was medication, even though medical professionals acknowledged that alternatives such as support groups and counseling would also be beneficial in a great number of cases. Thus mothers who sought medical attention for distress in the postpartum period felt that the real issues they faced were not addressed and would not be assisted through medication alone.

The findings of this study support Sheff's assertions that having just one person who validates what a person feels, and who normalizes those feelings rather than labels them as pathologic, can break the cycle of depression and open the door for an empathic relationship that brings about healing and normalcy.

## CHAPTER 6

### CONCLUSION

Local medical professionals viewed the postpartum period as potentially pathological, and they looked for signs of distress in their patients. Just as the Medline articles revealed that medical professionals promoted essentialist views of womanhood in their definitions and symptoms of PPD, the interviews with local OBs and CNMs support that finding. By delineating the symptoms of the illness, they promoted what mothers *should* be feeling and *should* be experiencing after childbirth, expanding their expertise beyond the physical to include psychological aspects of childbirth. And as the Medline articles showed a movement away from social support to medication as the preferred treatment, the local medical professionals most often treated mothers who appeared to be depressed with antidepressants. However, treatment differed by race and ethnicity: mothers who sought postnatal care at the clinic for Latinas or at Central County, a public hospital that treats mostly minority and low-income patients, were not treated for PPD by the OBs or CNMs but referred to other sources for assistance. Patients from the private practices who experienced PPD received samples of drugs and prescriptions to be filled later. And just as the Medline articles suggested that medical professionals should assess patients' mental health through conversational style, local clinicians used informal screening methods, such as conversation, rather than the standardized depression screening tools to assess their patients' mental health during their postpartum checkup. Only one OB in the private practices (Dr. Stephens) expressed frustration at the lack of resources to which he could refer his patients who struggle with motherhood, and one OB, Dr. Parks, offered counseling as well as medication; the other OBs and CNMs in the private practices had no hesitancy to prescribe medication. Dr. Reddy at Central County Hospital suggested that psychother-

apy during pregnancy could be an effective alternative to medication and could possibly avert PPD and provide coping skills that would lead to better parenting down the road. However, she acknowledged that such an alternative is neither practiced nor available. Although I had expected that CNMs would possibly allow greater tolerance for the variation in the adaptation to motherhood in the postpartum period because of their advocacy for the woman in the birth process and their more holistic approach to labor and childbirth, there was no discernible difference between the way the OBs and the CNMs approached the issue of PPD. Both disciplines regarded the postpartum period as at risk for emotional disorders and both prescribed medication as treatment. Both espoused normative views of motherhood that set standards for all mothers regardless of situational factors that may contribute to a mother's distress.

Mothers' narratives of their experiences of motherhood showed that the social fabric changed drastically when women became mothers. The biggest change occurred as friendships shifted from being based on mutual interests to friendships that revolved around motherhood. They described the loss of friends as a result of becoming a mother as distressful, but the newfound friendships with other mothers were a source of support when and if mothers were candid about the difficulties they were having in their roles as mothers. The new friendships often formed as a result of membership in mothers' groups such as Mother's Morning Out, Moms of Preschoolers, or various neighborhood mothers' groups. The one support group available for mothers with depression in the Atlanta area offered tremendous relief for mothers who found it helpful to be able to talk candidly with other mothers who also were experiencing difficulties with their roles as mothers.

Not only did the nature of friendships change after becoming a mother, but so did the work practices of mothers who participate in the paid workforce after childbirth. Mothers who returned to the paid workforce (25 out of 35 mothers in this sample returned to work after having a baby) often found the workplace to be male-oriented and not conducive to balancing work and parenting responsi-

bilities. Although work provided benefits of extra income, an identity other than mother, and a break from the tedious aspects of childcare, women in this study felt they could not talk of their parenting struggles in the workplace for fear of being labeled incompetent. The only exception to this silence was if a co-worker or co-workers were also mothers with young children. Some coped with the tension this created by allowing themselves to be less productive in either the workplace or the home for a period of time, recognizing that life would get easier once the child had less rigid bedtime and feeding demands and more consistent sleeping schedules. Mothers, whether they returned to paid work or stayed at home, felt that they bore the bulk of responsibility for childcare, whereas their husbands' or partners' participation in childcare was arbitrary. Although fathers were willing to participate when asked, mothers expressed frustration that they had to be asked in the first place and that mothers had to set the stage so that fathers could accomplish the tasks. This meant that motherhood resulted in mandatory participation in childcare, which left the responsibility squarely on the mothers' shoulders and minimized the relief they hoped to receive from the fathers' participation.

Almost all of the mothers in this sample told of experiencing symptoms of depression during the postpartum period. However, only 16 of them received diagnoses. They expressed their symptoms in terms of feeling lonely, isolated, inadequate, exhausted, overwhelmed, anxious, and others. Although many described their experiences as distressing, those without a diagnosis did not view them as illness but rather a temporary condition that would resolve on its own or the less serious symptoms of PPD than suicidal or homicidal ideation. Thus most did not seek medical intervention but found relief in the ability to talk with others about those difficulties, which helped them to see that they were not the only ones who struggled with their motherhood roles. Those who had received a diagnosis were prescribed medication, but less than half followed the recommended protocol for various reasons. Some felt that they could have avoided PPD had they talked with someone about their struggles, and others felt their recovery from PPD was because of talking with someone. Diagnosed or not, mothers revealed the cau-



tion they used in choosing to whom they would reveal those difficulties, most often choosing peers or persons in the periphery instead of those closest to them such as husbands/partners or their own mothers. Two factors went into considering in whom to confide: trust – that the confidante would not reject or humiliate them, and candor– that opened the door for shared expressions of those difficulties. If the reaction of the peer or peripheral confidant was negative, it would not be at such a great cost as would a negative reaction from a husband/partner or one’s own mother. Thus medication was not the ideal remedy for the mothers in this sample, but the ability to talk with others about their mothering experiences proved most valuable.

### **Applied Implications**

Examination of the social aspects of postpartum depression reveals the expansion of social control over women’s bodies through medical diagnoses of psychological and emotional disorders. In this study about the social aspects of postpartum depression and the effect that a diagnosis of PPD has on women’s lives, I question whether defining PPD as an illness, and particularly prescribing medication as treatment, improves women’s lives. Although medication may be necessary in some cases and can provide a “quick fix” for women suffering from severe depression in the postpartum period, the practice of medicating social problems locates the problem within the individual and thus removes the potential for social change. As my research shows, mothers who received a diagnosis rarely received additional help with care of the infant or child. Even if mothers worked outside of the home, the bulk of the responsibility for the care of the child fell on them. Indeed, most mothers in my study, whether diagnosed or not, experienced what are considered symptoms of depression during the postpartum period. They revealed social or structural contexts for their depressive symptoms, which would not change as a result of medication. Thus, they often resisted diagnosis and medication and found greatest support in the ability to talk candidly about the difficulties they faced in their motherhood roles. But because ideology of the

“good mother” is ubiquitous and it perpetuates the belief that mothering is instinctual, mothers hesitated to speak of the difficulties they faced, often believing that everyone else was handling their responsibilities well and so their struggles were a result of personal weaknesses.

Ideological representations of motherhood remain the commonly accepted view, enforced by medical professionals and lay persons alike, which often stuns mothers when they are in the midst of realities that differ greatly from the cultural script. The mothers in this study revealed the harm that those romanticized views of motherhood have on their lives, not the least being the stigma attached to expressing negative emotions surrounding motherhood. They suggested that the greatest relief comes from being able to talk candidly about the issues they faced, but because motherhood is at once considered sacred (thus certain activities are deemed inappropriate for mothers) and undervalued (taken for granted), they attempted to conform to the impossible standards placed upon them.

According to Taylor’s (1996) model of PPD, women’s self-help movements renegotiate motherhood through the discussion of postpartum illness in the popular advice literature, which tends to redefine gender relations. Support groups give women the opportunity to build networks with others with similar experiences, to build their confidence and self-esteem, and to provide advice for dealing with medical, legal, and other professionals. Thus, she finds that support groups promote social and personal change. The mothers in this study supported the contention that peer support is what is most beneficial for mothers who are struggling with their motherhood roles. However, with only one support group for mothers with depression in the entire metro Atlanta area, medication was the only treatment available for those who sought medical intervention. Because less than half of those who were diagnosed took the prescribed medication for the recommended amount of time, medication was not the best treatment for this group. This finding illustrates the social contract that women have to fulfill their motherhood roles in an adequate way, enforced through social institutions such as the family and medicine.

The practice of medicating social and structural issues that contribute to depression proved not to be the best remedy overall for the mothers in this study. Yet the lack of resources to which medical professionals can refer their patients with depressive symptoms and the availability of samples and prescriptions resulted in a quick-fix mindset that treats PPD in a hit-or-miss fashion. As one OB remarked, medication often works because of its placebo effect: if the mother believes it will work, then it is more likely to be effective in remediating their distress. However, the practice of prescribing medication removes the impetus for social change and instead finds its remedy in treating the individual mother. The increased use of medication, evident in the Medline articles and in the local medical professionals' practices, represents a change in direction of treatment since Taylor's book was published in 1996, even as mothers in this study suggested that the greatest relief came from peer acknowledgment of the negative aspects of mothering.

The diagnosis of PPD infers disease from behavior, specifically failure to conform to gendered expectations. Both the Medline articles and the narratives of the local OBs and CNMs whom I interviewed pointed to symptoms of PPD that contrasted with idealized versions of motherhood, namely crying, feeling overwhelmed, having no joy, failing to groom oneself, and others. However, mothers in the sample suggested that such symptoms stemmed from having tedious and mundane chores to do and unrelenting responsibility for care of the child, such that practical matters like bathing have to wait because the demands of caring for the child take priority. The cultural script requires mothers to be primary caretakers of children, and role enforcement occurs through gendered physical and behavioral assessments.

Applying the medical model to PPD keeps social issues of gender inequality at the individual level, negating any need for cultural change. The finding that many of the mothers in this sample resisted diagnosis and refused medication indicates their belief that PPD is a problem in living rather than a disease. The difficulties they experienced were because of additional social stressors, such as the death of

a partner, a move, or the loss of a job that evoked feelings that needed to be worked out rather than medicated. The potential for over-prescribing medication exists, along with the potential for harmful side-effects that can cause harm to infants and mothers alike. Long-term effects of antidepressants have yet to be determined, but the FDA requires new warnings for use in pregnancy and breastfeeding for some of the most often-used antidepressants, including Zoloft. The question remains as to who benefits from diagnoses of depression – the mother, the infant, medical professionals, or outside interests such as drug companies.

### **Theoretical Implications**

My findings offer theoretical extensions (Snow 2004) of postmodern feminism, critical constructionism, and Foucault's concept of docile bodies. Critical constructionists and postmodern feminists would recognize the subjective nature of PPD diagnoses as aberrations from normative motherhood. Medical professionals promoted essentialist views of women as nurturers, and mothers who struggled with the relentless responsibilities of mandatory motherhood were brought up to par with medication. On the other hand, fathers' participation in childcare was negotiable, applied whenever and however they so chose. Further, a hierarchy existed with the medical professional as the expert and other family members recruited to watch for signs of depression in the mother. Despite the findings from this study that show that 32 of the 35 women in this sample experienced some feelings of depression during the postpartum period, such feelings are considered aberrant and treated with medication if the feelings are disclosed to a medical professional. Local medical professionals promoted ideological representations of motherhood, and prescribed medication as the remedy for failing to meet those standards. For mothers, guilt, shame, depression, and a sense of failure resulted when reality differed from the romanticized version of motherhood. The cultural expectation that women will become mothers despite societal attitudes that devalue motherhood created a sense of disillusionment which new mothers often

described as feeling angry, entrapped, isolated, and hostile. The mothers' narratives implicated the dissonance between such high expectations and reality, which created a sense of inadequacy or failure for mothers. The influence of the medical profession on women's maternal identities supports feminist and constructionist recognitions of imbalances of power.

Although emotional difficulties of the postpartum period have been noted since the time of Hippocrates, the 2007 analysis of Medline articles showed an expansion in the campaign to define, diagnose, and treat PPD beginning in 1990 (Regus 2007). And interviews with local medical professionals showed adherence to similar screening, diagnosing, and treatment protocols. From a critical constructionist approach, one must ask why a phenomenon that has been around for a long time is suddenly found to be a social problem, and why others are excluded from such a label (Heiner 2002). Heiner suggests that for an issue to be labeled a social problem, it must be regarded as such by a significant number of people or by a number of significant people. Thus power lies in the ability to convince others that the phenomenon is problematic and needs remediation. Best (1990) finds that in order to understand how and why a condition becomes labeled a social problem, one must examine what the claim is and who is making it. Similarly, Conrad (2007) reasserts from his earlier work that "the greatest social control power comes from having the authority to define certain behaviors, persons, and things" (Conrad and Schneider, 1992:8, cited in Conrad 2007). While medical authority is difficult to refute, Conrad finds a movement away from the medical profession, as arbiters of social control, to corporate interests such as the managed care and pharmaceutical industries. Pharmaceutical representatives inform doctors of the benefits that their products provide, and they provide product samples for doctors to give to their patients. Doctors then become the gatekeepers who administer pharmaceutical products to mothers who exhibit signs of depression. Thus power shifts from medical professionals to pharmaceutical companies and managed care corporations who determine the best course of action for said conditions.

Pharmaceutical companies have much to gain in expanding their “definitional categories” of established disorders rather than establishing new ones (Conrad 2007: 69; Best 1990). For example, Conrad points out that GlaxoSmithKline introduced the antidepressant, Paxil (paroxetine hydrochloride) to the market as an effective remedy for generalized anxiety disorder (GAD) and social anxiety disorder (SAD). The successful ad campaign promoted SAD as a common mental health problem; as a result, personal traits such as shyness and worrying became medical issues that could be “cured” through treatment. PPD is an example of this definitional expansion, as it is defined as generalized depression with onset during the first six months after giving birth. Even though characteristics of a “normal” postpartum period are similar to the symptoms of generalized depression (weight loss, change in eating and/or sleeping patterns, fatigue, exhaustion), and the majority of mothers in this sample experienced symptoms of depression, definitions of PPD as a treatable illness made women of childbearing age a readily-available market of patients/consumers.

Conrad defines medicalization as “a process by which non-medical problems become defined and treated as medical problems in terms of illness and disorder” (2007: 146). SAD, GAD, and PPD are examples of human conditions that have been medicalized; PPD has become recognized as a medical problem with symptoms, suspected causes, and treatments that include antidepressants. And to reiterate, the increased attention that PPD garnered in the Medline articles from 1990 onward corresponds to the introduction of the antidepressant Prozac to the U.S. market in 1987 (Regus 2007). With the confluence of academic research and pharmaceutical companies, the constructionist approach points to pharmaceutical companies as the new harbingers of the medicalization of PPD and doctors as gatekeepers who prescribe medication to alleviate its symptoms. My interviews with the local medical professionals who treat PPD showed that the only option they have is to prescribe antidepressants, in a trial-and-error fashion, for their patients who show signs of distress.

Through the constructionist lens, then, it is clear that, although medical professionals are enforcers of normative motherhood, they do not seem to be at the forefront of the medicalization of PPD. Because medical professionals are not trained in screening for PPD or in prescribing psychotropic medications, and because they have few if any alternatives available to treat PPD, it seems that the push to diagnose and treat comes from elsewhere, most likely the pharmaceutical industry.

This study extends Foucault's theoretical concept of "biopower," which suggests that discourse is a form of power emanating from interaction with social institutions and serves as a means of social control. According to Foucault, it is in consensual relationships that reality, domains of objects, and rituals of truth are produced, illustrating his concept of power (specifically biopower). Accordingly, power is not simply imposed upon individuals but is enforced through society's institutions – medicine, the family, religion, the state. Through these institutions, individuals define themselves; normative expectations tell us how to behave and what actions to take. In this study, experts present as truth a normative ideal of motherhood that sets the standards of motherhood. The ideology of the "good mother," supported in the Medline articles and in the narratives of local medical professionals, tells us what motherhood *should* be and what mothers *should* experience. Heavily influenced by the ideological representations of motherhood, women's mothering experiences are framed through the eyes of the medical profession, setting standards for mothering that shape maternal identities. Thus, medical knowledge has the power to determine the expectations of motherhood by which all women are judged. Women define themselves according to these normative expectations, and they either personally seek medical treatment for their perceived inadequacies, or they are encouraged by family or medical professionals to undergo treatment for those inadequacies, or they seek relief through candid relationships with peers. Deviations from normative motherhood are mediated through the medical professional, bringing the struggling mother back up to the established standards of motherhood. Alternately, some mothers resist medical categorization and instead find solace in relationships with other mothers who experience

similar difficulties with their mothering roles. Through candid interaction with peers they are able to view their struggles with motherhood as normal adaptation rather than illness.

Surveillance – by medical authorities, family, and state policies – is yet another example of Foucault’s disciplinary power. Medical professionals look for signs of deviation from the ideal, and they recruit others, such as family members, to also watch for such signs. As Foucault asserts, normalization occurs within the body of people and optimizes the well-being of each individual; it is used for the good of the state and to protect the lives of its people. This is visible in the issue of PPD, as the medical profession upholds normative motherhood and furthers gendered essentialist views. State and federal policies that promote awareness of PPD and screening of new mothers increase surveillance of mothers, and thus increase enforcement of the standards of normative motherhood. Medicalization, then, operates as social control at the “capillary level” (Foucault 1980: 39), from all social relationships rather than from above or below. Individuals shape their actions and attitudes of motherhood through the discourse of PPD, exemplifying Foucault’s concept of docile bodies: ideological representations and medical categorization compel women to conform to societal expectations of motherhood. The individual disciplines and manages their body in order to perform according to these truths. Thus the individual is not a passive recipient but a producer of power, and agency is exerted through choosing these regimes of truth as well as in acts of transgression. Docility works individually, not en masse, as the individual constantly exercises power over oneself for optimum functioning. Although the form of coercion changes from external control to self-control, cohesiveness is maintained in modern capitalism through the shared activities of everyday life, through discourse which shapes ideas and opinions, through socialization of individuals, and through the production of knowing subjects. If deficient, the depressed woman, through the use of medication, becomes a good mother. Because “experts” deem treatment to be in the best interest for the health and protection of the infant and family, some mothers willingly conform to treatment protocols, while others seek relief through peer relationships.



### Policy Implications

Support for mothers (and fathers) could come from policies that require insurance to cover the costs of providing trained mentors for new parents. Because mothers in this sample found it difficult to talk with medical professionals or their own mothers, husbands, or sisters about the difficulties they faced in their motherhood roles, or because they preferred to attend support groups or mothers' groups with peer leadership rather than professional sponsors, a program that offers regularly-scheduled home visits with a paid mentor for a specified amount of time in the postpartum period could provide the support needed to adapt to the parenting role. Including fathers in the visits would give both parents the skills they need to proficiently participate in childcare and relieve some of the mothers' responsibilities. During the first few months postpartum, whether for a few hours a week or bi-weekly, home visits would give the parents a chance to bond with someone with whom they could confide their difficulties and learn skills needed to take care of the baby. It would give them a chance to have regularly-scheduled breaks from caring for the baby alone so that they could take a shower, take a nap, catch up with chores, or whatever they choose to do. Brooke Shields described the benefits she received from having a paid "baby nurse" come into her home to help her adapt to being a mother:

It was good to be taught by somebody with whom I felt uninhibited. I was more receptive around Gemma and did not feel judged at all if I didn't know how to do something. In addition, it felt good to be able to talk to someone with whom I didn't have a history. Gemma was tireless, loving, and had a great sense of humor. She didn't belittle my feelings, and she didn't act alarmed by my more gloomy disclosures...Gemma kept reminding me that having a baby was traumatic, that a C-section was a big deal, and that I needed to be easier on myself. (Shields 2005: 107)

The key to having a successful mentorship is the ability to boost the parents' confidence in their parenting abilities without judgment. As mothers in the sample indicated, when someone close – like their own mothers, husbands, or sisters – offered parenting suggestions, it felt like judgment or unwanted advice. And talking with a medical professional about their struggles often brought unwanted conse-

quences, such as feeling pressured to take medication or risking having their children taken away. Having a paid mentor would remove some of the judgment and risk and allow the parents to adapt to parenthood and all its demands. It could help avert the feelings of inadequacy, loneliness, and judgment that mothers in this sample expressed as depression, and give fathers the skills and confidence to be more engaged in the care of their child(ren).

A second policy that would benefit mothers is one that would provide counseling for pregnant women that prepares them for the emotional and psychological challenges they may face after the birth of their child. Because so many of the mothers in the sample expressed surprise at the difficulty they faced in the postpartum period, one-on-one or small-group counseling could counter idealistic views of motherhood and prepare mothers for the reality of caring for an infant. Not only would it provide coping skills for mothers when they do struggle with motherhood, it would open the door for them to be able to express the difficulties they do experience without feeling that they alone are lacking what it takes to be a good mother. If more women are comfortable talking about the challenges they face with their mothering, it would not be such a well-kept secret that catches unsuspecting mothers by surprise. This could bring about cultural change that promotes a more normalized view of motherhood and lessens the impact of idealized motherhood on women. And it could provide coping skills that may help prevent future episodes of depression. As one mother in the study revealed, counseling during her pregnancy helped her to be able to voice her needs and communicate more effectively with her spouse, thus avoiding PPD after the birth of her child.

A third policy recommendation would be for more research into alternative therapies for depression and how they could best be implemented for mothers with PPD. Some holistic sites list alternative treatments for depression, such as including into the diet more Omega-3 fats provided by foods like salmon, sardines, and almonds. Some promote exercise and/or exposure to sunlight or full-spectrum light when sunlight is diminished. If medication depends on a placebo effect, as one OB had

suggested, then perhaps the suggestion that these alternatives would work would prove just as effective, but without the potential side-effects that antidepressants have.

### **Future Research**

This research revealed several surprising findings, namely that mothers who received a diagnosis of PPD resisted taking medication; that mothers who were diagnosed received no extra social support in caring for the child; and that mothers found the most value in being able to talk candidly about their mothering challenges with their peers rather than those closest to them. Going forward, I would like to conduct this study on a broader scale, to see if the findings hold true for a larger population. The mothers in this study exhibited traditional gender roles, with mothers bearing the bulk of the childcare responsibilities whether or not they work outside of the home, and fathers participating when convenient for them. But would this finding repeat itself in a wider population? It would be interesting to know if that pattern is consistent across a larger and more diverse sample of mothers. The interview instrument used in this study was effective in getting mothers to share their experiences, and thus I would use the same in a future study.

A second future research study would be to examine the perspective of minority and low-income mothers on PPD. Because this sample is very small and consists mostly of white middle-class mothers, it would be interesting to interview African American, Hispanic, Asian, and low-income mothers to see if their postpartum experiences differ from the current sample. As the medical professionals who treat minority and low-income mothers indicated, there is a difference not only in the way they view their patient populations but also in the treatment available for them. I would utilize the same interview instrument used for this study, as it was effective in having mothers open up about their experiences with motherhood. Thus my research would parallel this current study, examining whether the

amount of social support minority or low-income mothers have keeps them from being diagnosed with PPD and whether that support increases as a result of a diagnosis.

A third study would be to interview fathers about their participation in childcare. Because this current study focuses on mothers' narratives, and because those narratives show that mothers' participation in childcare is mandatory while fathers' participation in childcare is negotiable, getting fathers' side of the story would be helpful in knowing how fathers perceive their role in taking care of the child. The interview instrument for this study would need some alteration, specifically asking about the birth and childcare experiences from the father's perspective rather than the mother's. And because it is traditionally mothers who stay at home with the infant for a period of time and the father who returns to work soon after the birth, it would be interesting to know whether fathers are reluctant to return to work outside of the home or if work is a welcome diversion from the responsibilities of childcare. Do fathers feel the same tension between work and home responsibilities that mothers in this study felt after the birth of a child?

And finally, because there is scant research indicating that fathers can experience postpartum depression, it would be interesting to conduct a study that examines fathers' experiences of childbirth and the postpartum period. The interview instrument used in this current study would need to be modified; more specifically, questions related to the birth of the child would need to be reworded to account for the father's role and perspective of the birth. Some of the questions I would hope to answer are: Do fathers identify their experiences of the postpartum period as symptoms of depression? If so, do they seek medical help for depression after the birth of a child? Do they get relief by talking with others about the challenges they face in their roles as fathers, and if so, with whom do they talk? How did they perceive their role in the birth process? And what is their perception of the medical professionals who helped deliver the child? These are questions that would give a more complete picture of childbirth and the postpartum period from the fathers' point of view by including narratives of fathers' experiences.

To conclude, mothers in this study felt that the greatest relief comes from being able to talk with someone about the difficulties that come with motherhood. When medical professionals, experienced mothers, or society in general are silent about the negative experiences of mothering, idealized versions of motherhood become the expected norm and create a dissonance for mothers whose reality differs from the romanticized view. The stigma of talking about the negative experiences highlights the expectation that motherhood comes naturally, and mothers who have difficulty with it feel that their experience is the result of personal weakness or shortcomings. Mothers who struggle then experience shame and guilt for not living up to the norm. When they are able to talk candidly about those struggles and find that others also experience difficulties, they realize that they are not alone and are not bad mothers. Indeed, the silence surrounding these difficulties can be described as a well-kept secret that perpetuates standardized motherhood. Whether mothers were diagnosed with depression or not, they most often recommended that other mothers find someone whom they could trust to talk about their difficulties with mothering. Some avoided diagnosis by being able to talk with others candidly; some felt relief immediately just by expressing their difficulties to someone; and others felt they could have avoided PPD if they had spoken to someone about the struggles they were having in their roles as mothers. Indeed, the term “diagnosis” itself carries a connotation of pathologizing typical – yet socially unacceptable – responses to motherhood. The culture of motherhood keeps mothers locked into rigid performances of their roles; they receive criticism for almost any decision they make, while fathers receive praise for any amount of childrearing activities in which they choose to participate. Cultural practices have a long way to go to reach true egalitarian parenting.

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## APPENDICES

### Appendix A

#### Interview Instrument for Mothers

Have you ever been diagnosed with postpartum depression?

What medical professional assisted you during pregnancy and childbirth?

How did you feel when you found out you were pregnant?

What was your pregnancy(ies) like?

Tell me about the birth of your youngest child. (Where? Who was your birth attendant? Interventions? Did it go as you expected?)

How do you feel you were treated by the medical professional(s) who helped you give birth?

Would you have changed the ways things went, if you could? How?

#### **About Motherhood...**

Has becoming a mother changed your life? If so, how?

What are the things you most enjoy about being a mother?

What are the things you find most difficult about being a mother?

How do you cope with the difficulties? Do you receive help from anyone with the difficulties? If so, from whom?

Did you feel supported in your role as a mother? If yes, by whom?

Did you receive help from anyone with care of your infant or other children? If yes, from whom? What did they do to help? Were others (spouse, family members) present or close by much when you were a new mother?

Did you breastfeed your baby? If yes, how long? How would you describe that experience?

Has the reality of being a mother been different from what you expected? If yes, how so?

How has becoming a mother affected your relationship with your spouse? With your other family members? With friends? Has there been any conflict in your relationships with significant others since the birth of the baby?

Do you ever feel judged by others for how well you “do” motherhood? If yes, by whom?

As a mother yourself, do you choose to do things differently than your mother did? If so, what, and how are they different?

Did you ever feel depressed when you were a new mother? What was that like for you?

Have you ever been diagnosed with depression? With PPD?

Did you learn about postpartum depression during your pregnancy? If yes, what was the source of your information?

Have any of your family members ever been diagnosed with depression? If yes, who? How would you describe their depression?

How old were you when they were depressed?

What kind of treatment, if any, did they receive? Was it effective?

How long did their depression last?

Have any of your friends ever been diagnosed with depression? If yes, what is their age, their gender, their race/ethnicity? How would you describe their depression? How did their depression affect your relationship with them?

### **Demographics**

1. What year were you born?

2. What is your race/ethnicity?

3. What is your marital status?

Never married?

Married? How long? Do you and your spouse/partner live together?

Divorced?

Widowed?

4. Are you currently working?

On maternity leave?

Unemployed?

Stay at home mom?

5. What is your occupation?

6. What is the highest level of education you've completed?

Less than high school diploma

High school diploma

Some college / 2 year college degree



Four year college degree  
Graduate degree or higher

7. What is your family's income level?

\$0 – 20,000

\$21,000 – 40,000

\$41,000 - 60,000

\$61,000 - 80,000

\$81,000 - 100,000

Over \$100,000

8. How many children do you have? What are their ages/genders?

	Age	Gender
Child 1		
Child 2		
Child 3		

(Interview ends here for mothers without a diagnosis of PPD)

.....  
**About the experience with PPD...**

Tell me about your experience with PPD:

How did you know you had PPD? (e.g., friends, family, commercial, self-help, ob-gyn, pediatrician, primary care physician, other?)

How long has it been since you found out you had PPD?

How would you describe your symptoms? (e.g., sleep too much/too little, fatigue, suicidal thoughts, thoughts of harming child, etc.)

How did you feel about the diagnosis?

Whom did you tell about your PPD? (e.g., doctor, counselor, social worker, support group, family member(s), friend(s), other?)

What were their reactions?

Did you receive additional help from anyone with care of your infant or other children after being diagnosed? If yes, from whom? What did they do to help?

How do you feel you were treated by the medical professional who diagnosed you?

Do you feel that the diagnosis has changed your relationship with your partner/spouse in any way? If yes, in what ways has the relationship changed?

Do you feel that the diagnosis has impacted your relationship with and/or feelings about the baby/ies?

Do you feel that the diagnosis has changed your relationship with other family members in any way? If yes, with whom and in what ways has the relationship changed?

Had you ever been depressed before you were diagnosed with PPD? How would you describe this depression? (When did it occur? How long did it last? What kind of treatment, if any, did you receive? Do you feel the method of treatment was effective?)

What kind of treatment, if any, are you receiving now for PPD (or other depression)?

Do you feel that the treatment has helped you?

If yes, in what ways has the treatment helped? How long after treatment did it take before you felt any improvement in your symptoms?

If no, what do you think would help?

Would you have any recommendations or advice for other women experiencing PPD? (In regard to treatment options? to seeking medical care? to maintaining relationship with their partners? to maintaining relationships with other family members or friends?)

Is there anything you want to add before we stop, or any questions you think I should have asked?

**Appendix B****Interview Instrument for Medical Professionals**

1. Can you tell me what postpartum depression is? What causes it? What are the symptoms?  
How frequently do you see it in your practice?
  
2. Do you look for postpartum depression in your patients? If so, what do you look for?  
Do patients tell you they have postpartum depression?
  
3. What, if anything, do you usually recommend as treatment? Once a patient is diagnosed,  
how often do you see them to monitor their progress? How long does recovery take? What  
would happen if a new mother who is depressed is not treated for PPD?

## Appendix C

## Beck Depression Inventory (BDI)

Choose one statement from among the group of four statements in each question that best describes how you have been feeling during the past few days. Circle the number beside your choice.

1	<p>0 I do not feel sad.</p> <p>1 I feel sad.</p> <p>2 I am sad all the time and I can't snap out of it.</p> <p>3 I am so sad or unhappy that I can't stand it.</p>	8	<p>0 I don't feel I am any worse than anybody else.</p> <p>1 I am critical of myself for my weaknesses or mistakes.</p> <p>2 I blame myself all the time for my faults.</p> <p>3 I blame myself for everything bad that happens.</p>
2	<p>0 I am not particularly discouraged about the future.</p> <p>1 I feel discouraged about the future.</p> <p>2 I feel I have nothing to look forward to.</p> <p>3 I feel that the future is hopeless and that things cannot improve.</p>	9	<p>0 I don't have any thoughts of killing myself.</p> <p>1 I have thoughts of killing myself, but I would not carry them out.</p> <p>2 I would like to kill myself.</p> <p>3 I would kill myself if I had the chance.</p>
3	<p>0 I do not feel like a failure.</p> <p>1 I feel I have failed more than the average person.</p> <p>2 As I look back on my life, all I can see is a lot of failure.</p> <p>3 I feel I am a complete failure as a person.</p>	10	<p>0 I don't cry any more than usual.</p> <p>1 I cry more now than I used to.</p> <p>2 I cry all the time now.</p> <p>3 I used to be able to cry, but now I can't cry even though I want to.</p>
4	<p>0 I get as much satisfaction out of things as I used to.</p> <p>1 I don't enjoy things the way I used to.</p> <p>2 I don't get any real satisfaction out of anything anymore.</p> <p>3 I am dissatisfied or bored with everything.</p>	11	<p>0 I am no more irritated by things than I ever am.</p> <p>1 I am slightly more irritated now than usual.</p> <p>2 I am quite annoyed or irritated a good deal of the time.</p> <p>3 I feel irritated all the time now.</p>
5	<p>0 I don't feel particularly guilty.</p> <p>1 I feel guilty a good part of the time.</p> <p>2 I feel quite guilty most of the time.</p> <p>3 I feel guilty all of the time.</p>	12	<p>0 I have not lost interest in other people.</p> <p>1 I am less interested in other people than I used to be.</p> <p>2 I have lost most of my interest in other people.</p>

			3 I have lost all of my interest in other people.
6	0 I don't feel I am being punished. 1 I feel I may be punished. 2 I expect to be punished. 3 I feel I am being punished.	13	0 I make decisions about as well as I ever could. 1 I put off making decisions more than I used to. 2 I have greater difficulty in making decisions than before. 3 I can't make decisions at all anymore.
7	0 I don't feel disappointed in myself. 1 I am disappointed in myself. 2 I am disgusted with myself. 3 I hate myself.	14	0 I don't feel that I look any worse than I used to. 1 I am worried that I am looking old or unattractive. 2 I feel that there are permanent changes in my appearance that make me look unattractive. 3 I believe that I look ugly.

15	0 I can work about as well as before. 1 It takes an extra effort to get started at doing something. 2 I have to push myself very hard to do anything. 3 I can't do any work at all.	19	0 I haven't lost much weight, if any, lately. 1 I have lost more than five pounds. 2 I have lost more than ten pounds. 3 I have lost more than fifteen pounds. (Score 0 if you have been purposely trying to lose weight.)
16	0 I can sleep as well as usual. 1 I don't sleep as well as I used to. 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep. 3 I wake up several hours earlier than I used to and cannot get back to sleep.	20	0 I am no more worried about my health than usual. 1 I am worried about physical problems such as aches and pains, or upset stomach, or constipation. 2 I am very worried about physical problems, and it's hard to think of much else. 3 I am so worried about my physical problems that I cannot think about anything else.
17	0 I don't get more tired than usual. 1 I get tired more easily than I used to. 2 I get tired from doing almost anything. 3 I am too tired to do anything.	21	0 I have not noticed any recent change in my interest in sex. 1 I am less interested in sex than I used to be. 2 I am much less interested in sex now.

			3 I have lost interested in sex completely.
18	0 My appetite is no worse than usual.		
	1 My appetite is not as good as it used to be.		
	2 My appetite is much worse now.		
	3 I have no appetite at all anymore.		

#### SCORING

1 – 10: These ups and downs are considered normal.

11 – 16: Mild mood disturbance

17 – 20: Borderline clinical depression

21 – 30: Moderate depression

31 – 40: Severe depression

Over 40: **Extreme depression**

## Appendix D

### Edinburgh Postnatal Depression Scale (EPDS)

Taken from the British Journal of Psychiatry June, 1987, Vol. 150 by J.L. Cox, J.M. Holden, R. Sagovsky ( In [www.childbirthsolutions.com](http://www.childbirthsolutions.com) )

The Edinburgh Postnatal Depression Scale has been developed to assist primary care health professionals to detect mothers suffering from postnatal depression; a distressing disorder more prolonged than the "blues" (which occur in the first week after delivery) but less severe than puerperal psychosis. Previous studies have shown that postnatal depression affects at least 10percent of women and that many depressed mothers remain untreated. These mothers may cope with their baby and with household tasks, but their enjoyment of life is seriously affected and it is possible that there are long-term effects on the family.

The EPDS was developed at health centers in Livingston and Edinburgh. It consists of ten short statements. The mother underlines which of the four possible responses is closest to how she has been feeling during the past week. Most mothers complete the scale without difficulty in less than 5 minutes.

The validation study showed that mothers who scored above threshold 92.3percent were likely to be suffering from a depressive illness of varying severity. Nevertheless the EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week and in doubtful cases it may be usefully repeated after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorder.

Instructions for users:

1. The mother is asked to underline the response which comes closest to how she has been feeling in the previous 7 days.
2. All ten items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.
5. The EPDS may be used at 6-8 weeks to screen postnatal women. The child health clinic, postnatal check-up or a home visit may provide suitable opportunities for its completion.

.....

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Baby's Age: \_\_\_\_\_

As you have recently had a baby, we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

1. I have been able to laugh and see the funny side of things.

As much as I always could  
Not quite so much now  
Definitely not so much now  
Not at all

2. I have looked forward with enjoyment to things.

As much as I ever did  
Rather less than I used to  
Definitely less than I used to  
Hardly at all

3. \* I have blamed myself unnecessarily when things went wrong.

Yes, most of the time  
Yes, some of the time  
Not very often  
No, never

4. I have been anxious or worried for no good reason.

No, not at all  
Hardly ever  
Yes, sometimes  
Yes, very often

5. \* I have felt scared or panicky for not very good reason.

Yes, quite a lot  
Yes, sometimes  
No, not much  
No, not at all

6. \* Things have been getting on top of me.

Yes, most of the time I haven't been able to cope at all  
Yes, sometimes I haven't been coping as well as usual  
No, most of the time I have coped quite well  
No, I have been coping as well as ever

7. \* I have been so unhappy that I have had difficulty sleeping.

Yes, most of the time  
Yes, sometimes  
Not very often  
No, not at all



8. \* I have felt sad or miserable.

Yes, most of the time

Yes, quite often

Not very often

No, not at all

9. \* I have been so unhappy that I have been crying.

Yes, most of the time

Yes, quite often

Only occasionally

No, never

10. \* The thought of harming myself has occurred to me.

Yes, quite often

Sometimes

Hardly ever

Never

Response categories are scored 0, 1, 2, and 3 according to increased severity of the symptoms. Items marked with an asterisk are reverse scored (i.e. 3, 2, 1, and 0). The total score is calculated by adding together the scores for each of the ten items.