Postpartum depression and the medicalization of motherhood:
A comparison of lay and professional views

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The Ohio State University, 1990
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POSTPARTUM DEPRESSION AND THE MEDICALIZATION OF MOTHERHOOD: A COMPARISON OF LAY AND PROFESSIONAL VIEWS

DISSERTATION

Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy in the Graduate School of the Ohio State University

By

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*****

The Ohio State University

1990

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"Illness expands by means of two hypotheses. The first is that every form of social deviation can be considered an illness. Thus, if criminal behavior can be considered an illness, then criminals are not to be condemned or punished but to be understood (as a doctor understands), treated, cured. The second is that every illness can be considered psychologically... Psychological theories of illness are a powerful means of placing the blame on the ill. These two hypotheses are complementary. As the first seems to relieve guilt, the second reinstates it." (Susan Sontag, Illness As Metaphor, 1979)

Sociologists concerned with the expansion of illness labels in modern society use the concept of medicalization to describe the process through which deviant behaviors are increasingly defined in medical terms and absorbed into the health care system for treatment. Studies of medicalized phenomena have encompassed such disparate social problems as hyperactivity in children, alcoholism, menopause, battering, and homosexuality (Conrad, 1976; Schneider, 1978; Bell, 1987; Warshaw, 1989; Bayer, 1981). Research on the medicalization of social problems often questions the appropriateness of the institution of medicine expanding its social control functions in this manner and the effect of
such deviance designations on those newly defined as "ill."

Freidson (1970), an early champion of inquiry into these topics, previously criticized the disciplinary sub-fields of the sociology of deviance and medical sociology for paying inadequate attention to the development of designations of deviance (and illness-as-deviance) and for failing to study actors' meanings for their experiences. His application of a sociology of knowledge approach in medical sociology thus sidesteps the medical question of what causes disease, and focuses instead on sociological topics such as illness as a social state, the illness-labeling process, and the social and individual effects of medicalization.

A. THE PROBLEM OF POSTPARTUM EMOTIONAL DISORDERS

Some researchers writing about the phenomenon of postpartum depression (PPD),\(^1\) commonly understood to refer to emotional distress on the part of a mother following the birth of a child, argue that these experiences are best understood and treated in a medical context (Hamilton, 1962; Dalton, 1980). Others disagree with such an application of the medical model,\(^2\) and locate the origin of postpartum emotional distress in various social psychological and social structural variables (Oakley, 1979; Nicholson, 1985). The debate over the etiology and appropriate response to postpartum difficulties is not restricted to an arrid professional context; increasingly lay activists are writing
about these experiences, taking positions on the issues and forming self-help and advocacy organizations.3

Thus postpartum depression presents an interesting problem when viewed from a sociology of knowledge perspective. Both lay and professional constructions of the problem are in flux, and various models compete for ascendancy as the paradigm through which PPD will be interpreted. The goal of this dissertation is to apply the sociology of knowledge framework suggested by Freidson to the phenomenon of postpartum depression. Lines of inquiry include descriptive analysis of the typifications and processes used by mothers and medical professionals in constructing explanations for PPD, assessment of the extent and effects of the medicalization of these problems, and consideration of the influence of gender and motherhood norms on the beliefs and behavior of both groups in relation to their understanding of emotionally problematic postpartum experiences.

The theoretical grounding for this dissertation rests in the phenomenological and feminist social science perspectives. As a type of sociology of knowledge perspective, phenomenology is particularly useful as a means of "reality reconstruction"; increasing the understanding of social behavior by revealing the inside perspectives of social actors (Schwartz and Jacobs, 1979). Given that postpartum depression is by definition a female experience
and is therefore a gender-bound phenomenon, and given the concern of feminist health writers with the expansion of medical intervention ever more deeply into women's lives, a feminist social science perspective is appropriate for considering the political and ideological dimensions of medical social control for women in this area.

Although the literature on depression following childbirth has grown markedly in recent years, none of the empirical work to date uses these perspectives. It is hoped that this study will contribute to research findings on postpartum emotional difficulties as well as the sociological literature in the following areas: the influence of gender on the medicalization process, deviance attribution processes, and health and illness behavior. Additional goals are to assess and possibly extend theoretical models that have been generated to account for medicalization and the social control of deviance in women.

**Literature on Postpartum Emotional Disorders:** While it may be said that a true body of literature on postpartum disorders has begun to form only recently, observations of the occurrence of distinctive psychological disturbances associated with childbirth date back as far as a descriptive account of a single case by Hippocrates in the fourth century B.C. What is regarded as the most significant early empirical work was Marce's *Traite de la Folie des Femmes Enceintes*, published in 1858. Marce's study of 310 cases of
mental illness associated with childbearing led him to postulate a connection between organic changes in the pelvic organs and the appearance of psychological symptoms (Hamilton, 1962).

Nineteenth and early twentieth century writing on postpartum depression primarily focused on psychotic reactions, and opinion was divided between those postulating physiologic versus psychogenic causes for these disorders. The study of these problems did not proceed systematically, however, and advancements in theory and treatment were hampered by neglect of the subject and ideological biases that colored early research efforts. Attention to the topic of postpartum disorders waned until the resurgence of interest in the impact of childbearing on women accompanying the publication of Helene Deutsch’s *The Psychology of Women* in 1945 (Atkinson and Rickel, 1984). Deutsch’s psychoanalytic approach stimulated interest in the topic of postnatal adjustment and factors influencing its outcome. Up to the 1960’s, however, most research was based on clinical populations and involved case studies of individual patients or patients from single practices.

Since the 1960’s a general resurgence of interest in depression has coincided with a slight increase in research on postpartum depression (Atkinson and Rickel, 1984). Medical researchers have focused on the changes in hormonal levels accompanying pregnancy and birth, although few of the
studies arguing for a biochemical etiology have involved careful measurement of actual hormone levels. Some medical research, based on psychoanalytic theory, focuses on personality variables. Occasionally medical studies even take note of the social stress associated with childbirth and early motherhood. But it was not until the 1970's that social scientists took much of an interest in studying postpartum disorders.

Within the social sciences the corpus of research on PPD has been conducted within psychological and social-psychological frameworks and published in psychology journals. The impact of a variety of psychological variables on postpartum emotional adjustment has been explored, including psychoanalytic factors, personality and attitudinal variables, cognitive-behavioral variables, life event variables and social support variables (for a comprehensive overview of the psychological tradition in the study of postpartum emotional disorders see Hopkins, Marcus and Campbell, 1984).

More recently, the use of life event variables in conjunction with social support variables has dominated psychological discussions of these disorders. Studies framed around these issues conceptualize pregnancy, birth and new motherhood as stressful life events. Social support is proposed as a mechanism for moderating stressful life events which, if absent, may predispose women to depression during
the stress-filled postpartum period (Cutrona and Troutman, 1986; Cutrona, 1984; O'Hara, Rehm and Campbell, 1983; Wandersman and Wandersman, 1980).

The topic of psychological distress following pregnancy has rarely been addressed directly in the sociological literature. Where it has been explicitly discussed, the approach taken parallels the recent trend in the psychological literature toward examining life events, stress and social support (Stemp, Turner and Noh, 1986; Norbeck and Tilden, 1983). The more general topic of changes in the family following the birth of a child dates back to the 1950's in the form of studies on the transition to parenthood. These studies utilized a systems conceptualization of the family, examining the effect of the addition of a new member on the family unit. The birth of a child is described as a crisis event necessitating a major reorganization of the family social system (Hobbs and Cole, 1976; Russell, 1974; Hobbs, 1968; LeMasters, 1957).

Research into postpartum emotional disturbances from a social science perspective has produced a plethora of conflicting results, undoubtedly due to discrepancies in the assumptions guiding the research and inconsistencies in the design and implementation of the measures used. Recently, several scholars have critically reviewed these studies, citing deficiencies including the following: the overall paucity of research findings; the absence of conceptual and
theoretical models to guide the research; problems in the conceptualization of the various postpartum reaction types; inconsistent instrumentation; the lack of integrated measures and models of causality; and the dearth of qualitative and experiential research results (Nicholson, 1985; Nixon, 1985; Atkinson and Rickel, 1984; Hopkins, Marcus and Campbell, 1984).

Hopkins has pointed out that even the most basic assumption guiding the research—that postpartum emotional upset represents an abnormal response to the birth of a child—may be questionable in light of our lack of knowledge of what "normal" postpartum adjustment is (1984:511). The sexism inherent in many of the assumptions made about PPD in research has also been remarked upon by feminist scholars:

"It is the combination of the assumption that motherhood has a prescribed pattern from which variation represent illnesses, and the assumption that childbirth is a crisis point for hormonal fluctuations, that underlies the conceptual problems in the literature. These problems typify a male-oriented perspective on women—as objects without human variation (Nicholson, 1985)."

In summary, examination of social science research into postpartum depression reveals an overreliance on psychological and social-psychological perspectives. This research tradition is marred by a number of conceptual and methodological problems and has not produced conclusive findings. Two of the unquestioned assumptions of this
research tradition are particularly limiting when viewed from a sociological perspective. The first is a tendency in the research to focus almost exclusively on the question of cause at the expense of insight which might be gained through the use of a more interpretive framework. Such a framework would permit examination of mothers' interpretations of their emotional difficulties and the manner in which labeling functions to shape and control postpartum experiences. The second is an emphasis on postpartum conditions as individual problems with isolated antecedents. An awareness that the social structure can influence what appear to be personal and private events (as expressed in Mills' concept of the sociological imagination, or the feminist aphorism "the personal is political") is absent from discussions of these disorders.

The absence of a genuinely sociological perspective is perplexing given growing bodies of work examining distinctively social factors in the etiology of depression (Brown and Harris, 1978), the labeling and social construction of mental disorders (Freidson, 1970; Scheff, 1984), and the social control of the emotional states of women (Schur, 1983). Although feminist researchers have raised the issue of an androcentric bias in the assumptions underlying research on postpartum conditions, these insights have not been translated into much empirical work.
Relationship of the Present Study to the Literature:
The present study seeks to overcome the deficiencies in the social science tradition of research on postpartum disorders by applying a sociology of knowledge perspective and a feminist perspective to examine the labeling and social control of this type of emotional deviance in mothers. Two competing frameworks for postpartum disorders will be analyzed: the interpretations of medical professionals, recognized as authorities on medical and psychiatric conditions, and the interpretations of women who actually experience troubling postpartum emotions.

B. DEVIANCE, MEDICINE AND SOCIAL CONTROL: THE PHENOMENON OF MEDICALIZATION

Illness Roles and Meanings: Interactionist and phenomenological perspectives in sociology have stressed the social construction of meaning for human experience as the basis for social action. The idea that the meaning of behavior is a construct implies recognition that meanings may vary from one social actor to the next, from one context to another, and from one historical period and culture to another. What is of importance from such a viewpoint is how meaning is created, or how labels for certain kinds of experiences are created and the consequences of their application (Berger and Luckman, 1966).
The labeling, or societal reaction theory of deviance is one such perspective. In this formulation deviance refers to any behavior regarded as violating significant social norms. The behavior or situation itself is of less concern than imputations made about it; in other words, the problematic qualities attached to the behavior are conferred rather than inherent (Archer, 1985:773).

The means by which society secures adherence to social norms is referred to as the system of social control. The most powerful variety of social control comes from having the authority to define what is deviant and what is not—to have the legitimate authority to label the behavior of others. The extension of these concerns into medical sociology has produced recognition of illness as a socially constructed experience, one which moreover is likely to be regarded as a form of deviant behavior. A concern with medicalization implies a concern with the meanings of illness, its construction as a deviant experience, and the operation of the health care system as an agent of social control.

In medical sociology three concepts are often used to delineate the physical from the social aspects of ill health. Disease refers to pathological abnormalities distinguished by signs and symptoms, while illness refers to the subjective experience of those abnormalities. Thus, "to be ill is not simply to be in a biologically altered state,
but also to be in a socially altered state which is seen as both deviant and (normally) undesirable" (Field, 1976:335). Sickness refers to the social organization of the experience of illness into role behavior in such a way so as to manage the disruption caused by its effects.

Talcott Parsons was the first to highlight the deviancy and social control aspects of illness in his conceptualization of the sick role (1951). In this ideal type construct, it is asserted that two privileges are extended and two requirements must be met by the individual who is ill. The privileges are that the individual is not held responsible for the condition and is temporarily exempt from normal role obligations. These privileges are only maintained as long as the individual fulfills the requirements of defining the illness as undesirable and cooperates with a competent care giver in order to get well.

As the first commentator on the institutionalization of the experience of illness, Parsons played an important role in the development of deviancy models of mental illness and in our understanding of the social construction of disease categories (Turner, 1987). It has become de rigueur for commentators to note the deficiencies of Parsons' concept, citing the conditionality of the privileges extended and its underapplicability to chronic and highly stigmatized conditions among other limitations (Mechanic, 1978; Friedson, 1970; Turner, 1987). Yet it remains that Parsons
defined the parameters of our understanding of illness as a form of deviance and the imposition of social control through the structuring and labeling of illness behavior.

**Origins of Medicalization:** Increasingly, forms of deviant behavior have been given medical labels and interpretations and located in the medical system for treatment and control. Conrad and Schneider (1980) speak of medicalization as the reigning paradigm of deviance designations of the current era, following upon earlier eras when sin and then badness/criminality were used to account for rule-breaking behavior. In their view, such a change in deviance designations has consequences well beyond merely justifying the emergence of a new agent of social control, including altering the legal status of deviance, shifting the attribution of responsibility away from the individual, and changing the meaning attached to the behavior itself.

There is less agreement about the source, extent and effects of medicalization. Some attribute the movement toward medical social control to increasing bureaucratization (Zola, 1986). Others look to its resonance with emergent social values and the growth in third party payments (Conrad and Schneider, 1980). Still others hold professional and capitalist imperialism responsible (Illich, 1976; Navarro, 1976). One line of thought highlights the knowledge base of medicine itself as the locus of power and control. Conrad and Kern (1986) describe the importance of
the success of the germ theory of disease in the 19th century in establishing the legitimacy of the medical profession and in the expansion of its jurisdiction. Turner (1987) argues that medical discourse, defined as the relationship between knowledge and power in medicine, operates as a system of benign regulation which is used to manage socially deviant individuals. Starr speaks of the cultural authority of the medical profession as extending beyond its grounding in science: "Its authority spills over its clinical boundaries into arenas of moral and political action for which medical judgment is only partially relevant and often completely unequipped" (1982:5).

It is precisely the political and moral overtones of medical practice and ideology which have most concerned feminists. Concern over the sexual politics of health care and the role of medical ideology in preserving male dominance have been the focus of feminist critics of the profession of medicine. Such a perspective has been directed at medical ideology about women, the history of women's health care practices, and the attitudes and training of medical practitioners, among other topics (Ruzek, 1979; Ehrenreich and English, 1972, 1973; Scully, 1980). The views expressed by Barbara and John Ehrenreich are typical of those writing from a feminist perspective on the operation of medical social control for women:
"...the doctor-patient relationship is an ideal one for the transmission of almost any kind of message that doctors may feel inclined to convey. Given the intimacy and authoritarianism built into the relationship, and the prestige and presumed expertise of the doctor, the patient is likely to take such messages much more seriously than he or she would from other people. Certainly in the case of women's medical care there seems to be consistent bias toward sexism" (1978: 64,65).

More recently feminist commentators on women and medicalization have argued for a less passive view of how medicalization has affected women. Catherine Riessman says that although women have been the main targets in the expansion of medicine, women themselves participated in the medicalization process, and gained as well as lost as a result of the medicalization of their life problems (1983).

Other aspects of the received wisdom on the inexorable nature of medicalization have also been called into question. Fox (1986) argues that medicalization and demedicalization are concurrent social processes. In her view the patients' rights movement and the home health care movement are reactions to overmedicalization. Strong (1979) questioned the motives of those decrying medical imperialism, observing that sociological critics also have professional interests to serve and may be guilty of their own brand of professional imperialism. He further argues that structural limits to professional imperialism exist within the medical profession, among them the absence of financial incentives, the lack of successful medical
treatments for many psychological conditions, the diminished influence of doctors over patients due to the highly structured and truncated nature of medical consultations, competition from other care providers (such as social workers), the freedom of choice of patients to seek treatment and to follow medical advice, and the growth of the medical model itself from a deterministic reduction of all health problems to organic causes into a multi-dimensional conceptualization of the causes of ill health. Finally, Strong observes along with Riessman that the medical model may have liberating features for the individual, providing a source of individual defense and refuge.

Those researching and writing on the topic of medical social control agree in three general areas: first, that medicalization is currently a major paradigm for deviance designations; second, that medicalization supplies meaning to experiences labeled as medical problems and alters behavior by shaping it through the application of social control; and three, that the process of medicalization can be affected by powerful moral and political considerations. Disagreements over the effects and the extent of medicalization suggest that these factors must be assessed on a case by case basis. It is my intention in the dissertation to examine these issues as they pertain to the phenomenon of postpartum emotional disorders.
C. SOCIAL CONSTRUCTIONS OF HEALTH AND DISEASE: LAY AND PROFESSIONAL CONCEPTIONS

Laypersons and medical practitioners approach the issues of health and illness differently because of variations in their stock knowledge and in the structuring of their respective roles. The differential manner in which categories of individuals construct interpretations for a single event was described by Schutz as a problem in the social distribution of knowledge. Schutz used the ideal types of "expert," "man in the street," and "well informed citizen" to illustrate how the source and extent of one's knowledge of a subject and its perceived relevance determines the legitimacy of one's opinion (1971:134). The views of recognized experts (such as doctors) and informed social actors (such as health activists) are viewed as authoritative and prestigious and are given more credence than other forms of socially derived knowledge.

Hayes-Bautista (1978) furthered elaborated Schutz's ideal types to explain the interaction between patients and practitioners. His argument is that differences exist between the perceptions of illness held by patients and practitioners, that there are social and cultural reasons for the differences, and that the differences exert some influence upon the relationship between the two and on the practice of therapy itself.
For the patient, the stock of knowledge about the problem or disorder is likely to be informal, to have been acquired randomly, to tend toward increasing comprehensiveness, to contain contradictory elements, and to be understood in terms of partial clarity—focusing on how rather than why things work. As an example, one of the respondents from the study explained her postpartum difficulties in the following way:

"I don't know that it is any one thing. I think that it can be caused by a combination of things, of not having support and maybe a physical problem like a hormonal imbalance or PMS type thing, or maybe that you're anxiety-ridden because you don't know how to take care of a baby."

For the practitioner, the stock of knowledge about the problem is likely to be formal, to be acquired through an exclusion of highly specialized and structured sources (medical education), to tend toward increasing exclusiveness, to contain few contradictions, and to be characterized by a striving for clarity—focusing on the location of the problem in a symbolic universe of meaning. The following statement from a well-known medical source on PPD exemplifies the characteristics of the practitioner's stock of knowledge:

"Childbearing is accompanied and facilitated by endocrine changes of considerable magnitude. Data which have been assembled...suggest that puerperal mental illness is related to physiological changes that involve the endocrine system. Postpartum diminution of
thyroid secretion has been implicated in syndromes which originate or persist late in the puerperium, but there are indications that this is but one of a complex of relevant hormonal phenomena" (Hamilton, 1962:112).

Based on his study of urban Chicano patients and their interactions with medical practitioners, Hayes-Bautista developed a framework that suggests that all such interactions involve a dynamic process of negotiation between competing stocks of knowledge. The management of discrepancies in stock knowledge is a significant component of patient-practitioner interactions. In a medical interaction each presents an assessment of the problem which is derived from their stock of knowledge. The negotiation between the assessments may produce one of five types of interactions: confirmatory (where the patient’s assessment is confirmed by the doctor); vacuum-filling (where the patient knows little and adopts the practitioner’s assessment wholesale); additive (where some new element of the practitioner’s knowledge is added to that of the patient); exclusionary (where there is a conflict between the two and one yields to the other’s view—usually the patient yields); and subtractive (where there is conflict and the patient rejects the view of the practitioner). Such negotiations determine the future course of the professional relationship between the patient and practitioner.

Lay Constructions of Illness. The subjective component of the experience of illness creates a wide range of
possible responses to the signs and symptoms associated with a given condition. For example, it is possible for an individual to manifest such signs and symptoms and not define the condition as illness (and consequently to avoid the sick role). It is equally possible for an individual to believe that he or she is ill and to attempt to assume the sick role in the absence of empirical verification of a recognizable condition (Idler, 1979). Illness may therefore be experienced either in the context of the health care system or outside of it, and lay knowledge, beliefs and practices may exist alongside medical knowledge or in place of it. As Idler states, "The experience of illness does not need to be objectively verified (by medical personnel) or even externally acted upon for illness to constitute social data" (1979:725).

For the layperson to initiate contact with a medical practitioner there must first be a consciousness of symptoms or feelings which deviate from everyday standards of normality (Freidson, 1970). In an early study of the process through which individuals determine whether a state of impaired health constitutes illness, Apple (1960) found that interference with usual activities and recent onset were significantly associated with a presumption of illness. Those presuming illness were most likely to seek medical care. Other powerful influences on decisions made about whether or not medical care is appropriate are the presumed
seriousness of the condition, cultural factors (Zborowski, 1952), social class, and previous experiences with medical consultations (Fitzpatrick, 1984).

Some have used the phrase "illness iceberg" to refer to the fact that only a small amount of illness behavior is presented to medical practitioners, even in the presence of troubling signs and symptoms (Last, 1963; Scambler and Scambler, 1984). Lay health care provided in the context of the community provides the largest proportion of care in illness, and may involve the following components: individual self-care; family care; care from an extended social network; and mutual aid in the context of self-help groups (Dean, 1986).

For a determination of whether illness behavior is likely to be presented in a medical consultation, Freidson stresses the role of what he calls the lay referral system in organizing the help seeking process:

"First, lay social structure organizes the initiation of contact between sick person and therapist. . . . Second, both lay and professional social structure organize the social state of being sick: whether or not one is "really" ill and can or must adopt a sick role; whether or not one may assume a new special social identity; whether or not one must assume the status of an object to be worked on by others; and whether or not one can ever again assume a normal identity and status in the everyday world (1970:323)."

Freidson asserts that rates of health care utilization can be predicted by the degree of cultural variation of the lay
referral structure from professionally approved notions of illness and treatment. The greater the variation, the lower the utilization, especially when the lay referral structure itself is cohesive and extended. Freidson also argues that illnesses which are regarded as illegitimate, carrying stigma and "spoiling" the identity of the individual are the least likely to result in a medical consultation (cf. his discussion of stigmatization surrounding the use of mental health services, p. 297-299).

**Professional Constructions of Illness.** The clinical role of the physician is "to assign a medical label to symptoms that laymen have already singled out as undesirable" (Freidson, 1970:253). It is the practitioner's role as the legitimate labeler of medical and psychiatric conditions that provides official certification for the explanation of the patient's failure to comply with social expectations (Turner, 1987:40). Starr observes a growth in the dependence of people seeking benefits requiring certification as the various certifying and gatekeeping functions of doctors has grown (1982:20).

It is the gatekeeping function of medical practice that establishes the physician as a moral entrepreneur: one who eradicates or contains undesirable behavior by labeling and treating it (Freidson, 1970). Moral entrepreneurs are predisposed to identifying variations from the norm of wellness as constituting deviance (i.e. illness) rather than
behavior that merely falls within "broad boundaries of the normal" (1970:255). The primary medical entrepreneurs are not everyday practitioners; those most likely to act in this way are spokespersons for the medical profession itself, individuals who crusade in health matters as an avocation, and those associated with lay interest groups. The entrepreneurial component of medical practice is exacerbated by the medical decision rule: the tendency of physicians to impute disease rather than risk overlooking it. Overdiagnosis is most likely to occur in situations where the physician can benefit, where the patient is suffering distress with ambiguous signs and symptoms, and where conventional treatments are not absolutely contradicted by the observed signs and symptoms. Underdiagnosis is most likely in situations where doctors do not stand to gain and in the case of stigmatized illnesses (1970:254-259).

Since patients often present problems to physicians which are not purely biophysical in nature, and since the prescribed treatment for any condition may contain suggestions for changes in behavior, the moral dimension of medical practice is further extended into medical discourse. "In their encounters with patients, doctors may interpret personal problems and encourage individual behaviors in directions that are consistent with the society's dominant ideologic patterns" (Waitzkin, 1989:224). According to Waitzkin, doctors are trained to direct the attention of
patients toward objective symptoms, signs and treatment and away from their personal difficulties, thereby depoliticizing inquiry into the causes of problems and ultimately reifying problematic social relations.

The Gulf Between Lay and Professional Concepts. The picture painted by writers such as Freidson (1970) depicts an unbridgeable gulf between the social constructions of professionals and laypersons concerning illness: "Given the viewpoints of two worlds, lay and professional, in interaction, they can never be wholly synonymous. And they are always, if only latently, in conflict" (321). Others, like Fitzpatrick (1984), disagree with this assessment, citing the persistence of folk models of health and illness among physicians, as well as a pragmatic attempt on their part to bridge the modes of thought between the two systems. Fitzpatrick also contests the popular view of patients as ignorant and naive: "The point argued here is that the idea of unbridgeable gulfs, whether in terms of knowledge versus ignorance or a more cultural theory of separate worlds of experience, may be misleading or damaging" (25). Turner (1987) argues that the application of a phenomenological perspective, due to its reconstruction of the inside perspective of participants, is best equipped to account for the differences between lay and professional groups, and the reconciliation of conflicts into cooptation or successful opposition.
D. DEVIANCE AND THE MOTHER ROLE

Following the observation by Becker (1963) and Scheff (1984) that attributions of deviance result from the responses of others to one's residual rule-breaking, it follows that the rules must be widely known for deviance to be imputed. Feminists were among the first to apply a critical perspective to the social role of mother. The essence of the feminist perspective on motherhood is to critique institutionalized and mythical features of the mother role while at the same time reclaiming the reality of women's mothering experiences. Analyses typically involve the debunking of a wide range of romanticized and confining myths about how mothers should act and what they should feel. Feminists have described motherhood as a highly prescribed social role with powerful and narrow norms governing its performance; despite the elevation of motherhood to an idealized role concept, there is little social support for acting out the role and less support still for admissions by mothers of difficulties and disappointments in their mothering experiences.

Motherhood: Myths and Realities. The emergence of motherhood as a glorified, mythologized concept has been traced to the Victorian era (Dally, 1982; Hoffnung, 1989). The influence of patriarchal ideology over the social construction of the mother role may be seen in widespread
assumptions of the naturalness and universality of motherhood along with the seeming inability of researchers to trace the etiology of emotional problems following childbirth to anything other than biological factors or the psychological makeup of individual women. Laws and Schwartz observed that medical accounts of PPD typically overlook the fact that in giving birth a woman becomes a mother, assuming a role with culturally derived meanings that can be expected to influence feelings and experiences (1977:93, 94).

Hoffnung has described the "motherhood mystique" as reinforcing commonly held beliefs that women are fulfilled through the mother role, that the body of work assigned to mothers is noncontradictory, that in order to be a good mother a woman must consistently enjoy mothering, and that a woman's exclusive devotion to mothering is good for her children (1989). Feminists have countered the motherhood mystique by creating dialogue about the conflicts and tensions contained within the mother role. While the experience of mothering may be emotionally central and gratifying, it may also be conflictual and oppressive (Chodorow and Contratto, 1982). In some feminist accounts, the institutionalization of motherhood is viewed as the lynchpin of gender inequality: "Women's mothering is a central and defining feature of the social organization of gender and is implicated in the construction and reproduction of male dominance itself" (Chodorow, 1978:9).
In western, industrialized societies, social and economic changes have resulted in motherhood as an increasingly privatized experience. Mothering is largely an activity done by mothers alone, in isolation from the workplace, the community and the extended family. The rapidity with which theories of child care and child development change and a lack of support and assistance from family members has produced an increasing reliance on experts as mothers seek information on the latest childrearing techniques (Kitzinger, 1978; Dally, 1982; Maroney, 1986).

**Motherhood, Stigma, and Social Control.** A further unexamined myth of motherhood combines with the pervasive stigmatizing of women who violate gender norms to produce a double bind for mothers. The myth of the all-powerful mother is described by Chodorow and Contratto as perpetuating a paradox of blame/idealization. When mothers are regarded as the single most important influence in their children's lives and are assigned primary responsibility for parenting, excessive standards for maternal behavior are one result. Mothers are evaluated in their role performance by their children's behavior and by the extent to which they conform to the features of the mother role. There are multiple potential violations of maternity/motherhood norms which can result in extensive stigmatization, including voluntary childlessness, unwed motherhood, and "unfit" motherhood:
Almost any aspect of a woman's personal conduct—including her friendships, general life-style, drinking behavior, apparent psychological condition, and perhaps even physical appearance and self-presentation—may be cited to support a claim that she is an unfit mother (Schur, 1983:89).

Women who stray from the prescribed bounds of the mother role, either due to an inability to perform role responsibilities or because of feelings inconsistent with those expected of mothers, are therefore in danger of being stigmatized as deviant. The ultimate irony, according to Schur, is that mothers who do meet all of the demands of the mother role receive a low reward for their conformity. Thus the mother role may be seen as one which places women in a double bind; as mothers they are idealized but not supported socially, highly constrained but offered little recognition even for exemplary performance. The examination of postpartum emotional disorders in the context of the social construction of motherhood therefore offers important insights into the social control of deviance in mothers.

E. Theory: A Sociology of Knowledge and Feminist Approach

A sociology of knowledge approach is useful for comparing lay and professional constructions of postpartum emotional disorders because it emphasizes the influence of social and cultural forces in the development of ideas. In addition to focusing on the groups that create bodies of
knowledge, a sociology of knowledge paradigm considers the process by which different bodies of knowledge interact to create changes in ideas, beliefs and practices.

A Phenomenological Perspective. One type of sociology of knowledge perspective employed in studies of medicalization is that of phenomenology. The phenomenological perspective views reality as socially constructed, and acknowledges that conceptions of reality vary between individuals, groups, and societies. Berger and Luckman (1966) described reality construction as a three-step process. In the first stage of externalization, a cultural product emerges as a result of social interaction. The cultural product may be a material artifact, or something from the realm of ideas, such as a norm, a social institution, or even knowledge. Objectivation occurs when the cultural product begins to take on its own objective reality, and people begin to lose sight of its status as a cultural product. The process is complete in the stage of internalization, when the cultural product is passed on as a taken for granted component of reality via the socialization process.

Alfred Schutz made important contributions to the phenomenological perspective by elaborating on the taken for granted nature of social life. In Schutz's schema, humans possess a stock of knowledge composed of rules, norms and information which provide guidelines for acting in and
interpreting the world. Although stock knowledge varies among individuals, the presumption of a \textit{reciprocity of perspectives} leads actors to assume a shared perspective and lends social life a \textit{taken for granted} character. This presumption of a common world leads actors to engage in \textit{typification}, a process whereby stock knowledge is used to categorize others and adjust responses. Typifications facilitate the ease of social interactions as they preclude the necessity of examining every nuance of a situation and allow humans to make assumptions about one another (Turner, 1982).

A Feminist Sociological Perspective. Although some contest the existence of a formal body of feminist sociological theory, the structure and assumptions of much of what has been called feminist theory or a feminist social science perspective fits within the sociology of knowledge paradigm. A feminist perspective shares with a phenomenological perspective a questioning attitude toward features of social relations that are often taken for granted. Feminist theory adds to phenomenology a needed focus on the power dynamics of the process of reality construction, emphasizing gender as the key organizing principle.

Janet Chafetz (1988) argues that feminist theory is comprised of three elements. First, gender is the central focus or subject matter of the theory. Feminist theory is
concerned with the gendered nature of all patterns of social relations, institutions and processes. Second, gender relations are seen as problematic. An effort is made to apply theory to understand the relationship of gender to social inequities and contradictions. Third, gender relations are viewed as neither natural nor immutable; they are subject to change through human agency. Wallace (1989) has identified contributions made by feminist theorists in four areas: 1) the critique and reassessment of existing theories and research; 2) the discovery of new topics and concepts; 3) the establishment of interdisciplinary linkages; and 4) movement toward the creation of a new sociological paradigm.

Hess and Ferree argue that the experiences of individuals within gendered social structures are worthy of study (1987:17). The general objective of this study is to use feminist and phenomenological perspectives to reveal the influence of gender on the medicalization of postpartum emotional difficulties. The perspectives of mothers and medical professionals will be contrasted to determine the extent and effects of the medicalization of these problems.

F. OBJECTIVES OF THE STUDY

The specific objectives of the study are elaborated in the following research questions. These were developed as a means of guiding the research and they are organized in a
way that will lead to the development of grounded theoretical generalizations, presented in the final chapter.

1) How do mothers describe their postpartum emotional difficulties? What are the key dimensions of mothers' accounts of their problematic experiences?

2) How do mothers explain their discrepant emotions? What influences mothers' conceptions and how do they attempt to resolve their difficulties?

3) Do mothers seek or resist medical interpretations of their experiences? From the lay perspective of mothers, which factors increase the likelihood of medicalization and which factors work against it?

4) How do physicians conceptualize postpartum emotional disorders? What influences affect the conceptions of medical practitioners about these problems?

5) How do physicians treat instances of postpartum disorders? Do they seek to control emotional deviance in mothers by applying medical labels and treatments?

6) What conceptions of postpartum disorders are found in the medical literature? How closely aligned are the conceptions in the literature with those of practicing physicians?

7) Is medicalization occurring in the labeling and treatment of postpartum emotional problems? From the professional perspective of practitioners, which factors increase the likelihood of medicalization and which factors work against it?

8) What impact do gender and motherhood norms have on lay and professional discourses about emotional difficulties following the birth of a baby?
9) How does consideration of postpartum depression elaborate theoretical models for medicalization?

10) What is the role of gender ideology in the medicalization process? How is medicalization implicated in the social control of deviance in women?

11) How does a consideration of gender relations add to theoretical models for medicalization?
CHAPTER II
RESEARCH METHODS

This is the first study to examine the social construction of postpartum emotional disorders from lay and professional perspectives. Using data from a larger research project that were collected in 1984-85, conclusions were drawn on the basis of interviews with 44 mothers and 20 physicians as well as the analysis of over 1500 separate medical sources from 1975 to the present. Unlike the traditional positivistic frameworks used in most research on these problems, the underlying assumption of this analysis is that the subjectivity of participants' meanings is a valid and important area of inquiry.

The dangers of reifying knowledge produced through objective measures is made abundantly clear upon examination of the major shifts that occur occasionally in all scientific paradigms (Kuhn, 1970). The existence of anomalies—phenomena that do not fit or that contradict the dominant scientific paradigm—may lead to the emergence of a new paradigm if an alternative model accounting for all cases is available. Feminists have raised questions about
the applicability of research findings generated in a positivist, objectivist mode to the reality of women's lives (Nielsen, 1990; Harding, 1987). Nicholson (1985) specifically raised these concerns in her study of the relationship between women's accounts of their depression following childbirth and their scores on standardized measures of postnatal depression. Finding little relationship between the two, she came to advocate a woman-centered approach in which women's interpretations of reality are validated and seen as central.

The approach taken in the dissertation is unique in that women's social constructions for their postpartum difficulties are examined along with those of medical practitioners. Neither is assumed to be more objective than the other. At issue is the process through which mothers as laypersons and physicians as professionals conceptualize and act to resolve these difficulties.

Qualitative methods were chosen as the best means of producing the type of rich data necessary to meet the stated research objectives. Moreover, the theoretical framework of the dissertation necessitates a qualitative approach. Reconstructions of the subjective influences on human behavior and the motives, meanings and actions of individual actors are not compatible with the goals and notations systems of quantitative research (Schwartz and Jacobs, 1979). A final reason for using this type of research is to
avoid the limitations imposed by other studies on postpartum depression, which have often conceptualized such disorders narrowly, ignoring contextual features of these experiences and restricting the population to be studied because of preconceived notions of the definition of postpartum disorders.

Data for the study come from a two-year research project dealing with the experience and treatment of postpartum depression. As a research assistant on the project from its inception, I participated in the study at every level, assisting in the design of the interview guides, helping recruit respondents, interviewing mothers and medical practitioners, and transcribing, coding, and analyzing the data.

Four types of data were collected as a part of the larger project. First, interviews were conducted with 100 women who had become mothers within two years prior to being interviewed. The first sample of 50 women were selected because of their self-identification as having experienced emotional difficulties following the birth of a child. The second sample of 50 women served as a comparison group, and included both women who did and women who did not experience such difficulties. The purpose of these interviews was the reconstruction of women's emotional experiences after birth and the development of inductively derived descriptions of the nature, onset, duration, range of severity, and
consequences of postpartum disorders.

The second source of data were interviews with 56 medical, psychiatric, and mental health providers. Respondents included physicians (OB-GYN's, family practitioners, psychiatrists, and pediatricians), psychologists, social workers and nurses. The purpose of these interviews was to explore the ideas and behavior of those routinely providing services to women during the postpartum period.

The third source of data consisted of content analysis of popular literature on postpartum conditions. These data were gathered in order to understand the way postpartum depression is conceptualized and viewed in the popular literature on pregnancy and motherhood that is a major source of information for new mothers. (McCormick, 1985).

The final data source involved analysis of the relevant medical literature. Over 1500 separate medical sources from 1975 to the present were examined in order to elucidate the formal medical discourse on these conditions. Less than ten percent of the sources examined included references to postpartum conditions. These data capture current thinking on postpartum conditions and present the findings of studies done on emotional difficulties following childbirth by medical researchers and practitioners. The literature examined included medical textbooks, articles on postpartum depression in medical journals, medical reference books, and
books written about medical and psychological complications of the postpartum period.

As a study of lay and professional conceptions on postpartum conditions, the dissertation makes use of the interview data from the initial sample of mothers who experienced postpartum emotional difficulties, the interviews with physicians, and the medical literature. The following section describes these data in more detail and reviews the methodological procedures that were used to analyze them.

A. INTERVIEWS WITH MOTHERS

The data from women in this project were collected through in-depth, open-ended and semi-structured interviews so that mothers' own understanding of their experiences would be revealed (see Appendix A for the Interview Guide). Such procedures are in keeping with the principle of feminist research that women's experiences themselves should establish the reality against which hypotheses are tested (Harding, 1987). The interviews were tape-recorded, and lasted two hours, on average. Most interviews were conducted in the homes of the women (a few were conducted in public settings or in the offices of the researchers at the request of the interviewees), and in about one-third of the cases child-care was provided for by a second member of the research team. This enabled more women to participate in the
study and limited the infinite number of interruptions that are made possible when an infant is present during an interview. Although this cannot be demonstrated empirically, it was my feeling that doing the interviews in the women's homes added an important observational/experiential component to the study. In many instances some dimension of the postpartum experience mentioned by a mother was observable in the setting (e.g. a colicky baby, an unsupportive spouse, etc.) and this added to my own understanding of the experiences that were being related to me as a researcher.

An additional reason for the use of a semi-structured interview guide was to permit the emergence of unanticipated issues in the interviews. The interview guide was composed of a long list of open-ended questions, and each woman could answer as completely as she wished; details that were raised outside the parameters of the question were pursued if relevant. Silverman (1985) describes open-ended interviews as characteristic of interviewing in the interactionist tradition. This structure gives respondents more latitude to demonstrate their own definitions of reality. At the beginning of the study the interview guide itself was adjusted after three pilot interviews revealed important areas of inquiry not included in the earlier version.

Locating women to participate in the study presented some special difficulties and necessitated a novel sampling
strategy. We did not have the funds necessary to conduct the sort of large, random sampling procedure that would have guaranteed the representativeness of the findings, nor did an institutional setting offer an easy source of interviewees for two reasons. First, obtaining interviewees from a hospital setting would limit the analysis to short-term emotional reactions and this could have introduced spurious variables influencing mothers’ perceptions, such as reactions to the hospitalization experience or to a difficult birth. Secondly, the lack of diagnostic categories for postpartum disorders in the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (1987) and disagreements in the medical literature about the symptoms of postpartum disorders meant that locating treated cases through a medical or psychological practice was not feasible. Additionally it would have meant adopting wholesale medical definitions of postpartum conditions, contradicting our stated purpose of deriving mothers’ own typifications for their experiences.

The primary strategy chosen was the solicitation of women as volunteer interviewees through the dissemination of publicity about the study. Articles about the study appeared in newspapers in central Ohio and a good number of the initial interviews were done with women who called wanting to be interviewed after reading about the study (see Appendix B). Fliers requesting volunteer interviewees were
posted in a wide variety of locations where new mothers would be likely to see them (e.g. doctors' offices, health and social service agencies, hospitals, athletic facilities, etc.). The research team attended the annual Baby Fair held at the Aladdin Shrine Temple in Columbus, Ohio on two successive years to distribute information requesting volunteers for the study, and some referrals were made by physicians and mental health practitioners. There was no shortage of volunteers for the study (in both samples the 50 women interviewed were selected from a list of approximately 300 potential interviewees), and this fact was used to offset the problems with representativeness presented by a non-probability sample. Every effort was made to locate and include low income women and women of color in order to avoid having a sample of primarily white and middle class women although only three women of color were included among the 44 examined here.

The first sample of women was comprised of 50 mothers who self-identified as having experienced some form of emotional difficulty in the year following the birth or adoption of a child. Interviewees were chosen from among those whose children had been born in the past two years in order to preserve the freshness of their accounts and minimize the problem of selective recall. The findings from mothers are based on 44 interviews out of this initial sample of women.
The women ranged in age from 21 to 48, and had completed on average 15.3 years of education. The reported household incomes extended from less than $5000 to over $75,000, with a mean range of $25,000 to $29,000 for the group as a whole. Thirty-nine of the women were married, three were single and two were living with a partner. Nineteen of the women had one child, 18 had two, 4 had three children and 3 had four or more. Slightly more than half of the women were working outside the home for pay, while the rest identified themselves as "housewife." Those working outside the home included 13 professional employees, 8 clerical workers, 2 blue collar workers and one artist who was self-employed. In terms of race/ethnicity, the group included 41 Caucasians, one Black, one Native American and one "other." The religious affiliation of the women revealed a cross-section of backgrounds, including Protestants (15), Catholics (13), Jews (8), "other" (3) and five women who reported no religious affiliation.

B. INTERVIEWS WITH PHYSICIANS

In order to reconstruct the perspectives and experiences of medical practitioners regarding postpartum disorders, interviews were conducted and organized similarly to those with mothers. Data were gathered from these individuals in in-depth, open-ended and semi-structured interviews (see Appendix C for the interview guide). These
were tape-recorded and lasted 40 minutes on average. All of the interviews were conducted in medical settings, usually the office of the interviewee.

These interviews were subject to quite different constraints than the interviews with mothers, as the professional responsibilities of the interviewees interfered with a leisurely interview pace. I found myself in some cases not asking follow up questions in order to move the interview along if there were frequent interruptions, or if I sensed an impatience on the part of the interviewee with the length of the interview. However, I do not believe that the constraints imposed by the setting interfered much with the quality of information obtained. Most of the professionals interviewed had little of substance to say in response to questions, having encountered little evidence of such disorders in their practices and having received little or no training on these problems during their medical education. Those with a greater exposure to these problems or a specific professional interest were especially willing to speak at length concerning their views.

The selection of interviewees was based in part upon the relevance of their professional responsibilities to the issue of concern; thus a primary criterion for selection was a professional proximity to new mothers. Lists of potential interviewees were constructed including psychiatrists and other physicians from the variety of medical specialties
routinely involved in the childcare industry, including obstetrics and gynecology, pediatrics, internal medicine, and family practice. Some professionals were contacted because their name was mentioned by a mother who experienced postpartum depression as someone from whom she sought assistance or information, some were contacted because another professional mentioned them as specializing in the treatment of postpartum emotional difficulties, and some were contacted through their association with the Baby Fair that was such a successful source for mother contacts.

Letters were sent to a sample of groups and individuals from each list describing the study and requesting an interview. Follow-up phone calls were then made to schedule an interview. Roughly half of those contacted refused the interview, and the most frequently mentioned reason was a lack of knowledge or experience with the subject. The following quote from a woman psychiatrist was typical of those giving this response:

"I brought up your study on postpartum depression to the state group of psychiatric professionals, and they indicated that none of them had treated individuals they would characterize as having postpartum depression. It’s just not something they see among their patients. And I’ve not treated any cases myself. I’m not sure that interviewing me would be worth your effort."

The refusal to be interviewed by so many medical professionals makes it likely that those who were
interviewed had a greater interest in these problems or more experience in treating women's emotional responses to childbirth than a random assortment of practitioners. Another characteristic of our sample of medical practitioners that varies from the statistical norm is that women were well represented. Our success in finding female respondents may indicate a greater interest in the topic among female professionals, and this assumption was confirmed by the number of female medical professionals who spoke of their own personal experiences as mothers as well as from their professional perspective.

Of the twenty physicians who were interviewed, 10 were obstetrician-gynecologists, 3 were family practitioners, 3 were pediatricians, two were psychiatrists, one was certified in both psychiatry and OB-GYN, and one practiced in internal medicine. The demographic characteristics of the physician respondents were more varied than those of mothers. Three of the physicians were Black, one was Asian-American, fourteen were male and six were female. Additionally the types of medical practice were varied. Some of the physicians were engaged in private practice, some worked in a clinic or group practice, and some were associated with a medical school.
C. PROCEDURES OF DATA ANALYSIS: INTERVIEWS

Each of the tape-recorded interviews was initially transcribed into coding categories that were generated to organize the data. This information was recorded using as many direct quotes as possible in order to preserve the richness of the data. The transcriptions were then re-organized into categories that corresponded with the research objectives of the dissertation. For the mother interviews categories included mothers' descriptions of their discrepant postpartum emotions, mothers' explanations for these experiences, mothers' patterns of help-seeking and emotion resolution, and indications of the influence of gender and motherhood norms on mother's accounts. For the physician interviews categories included conceptions of postpartum disorders, physician knowledge of emotional difficulties in the postpartum period, physician views on etiology and treatment, and indications of gender and motherhood norms on practitioner perspectives.

In analyzing the data the "constant comparative method" of Glaser and Strauss' grounded theory approach was followed (1967). This approach emphasizes theory generation over theory verification and requires that data collection proceed concurrently with the development of coding strategies, initial data analysis, and beginning theory generation. Once the data were transcribed and organized
into categories, analytical memos suggested by the properties of the categories were generated, and these in turn were elaborated into theoretical memos. Comparisons were made among units of information and among units with categories until categories could be logically unified into higher level concepts and propositions. Eventually, at the point of theoretical saturation of the data, the concepts, propositions and memos were developed into grounded generalizations—inductively derived theoretical generalizations.

D. DATA COLLECTION AND DATA ANALYSIS: THE MEDICAL LITERATURE

The medical literature on postpartum emotional disorders was analyzed in order to derive a complete picture of medical conceptions of these problems. Few medical practitioners claimed to have much experience or knowledge about postpartum disorders, suggesting that the medical discourse about these problems may be better articulated in the research-oriented format of the medical literature. Furthermore, research suggests that there is a significant difference between the clinical practice of medicine and what is described in textbooks (Fitzpatrick, 1984). Finally, the role of the medical literature in shaping medical discourse justifies its inclusion. By presenting the findings from recent studies and by offering a forum for debates on the efficacy of various treatments, the medical
literature is established as the most up-to-date indicator of the current state of medical discourse about a given medical topic.

Three kinds of professional medical literature were examined. First, medical textbooks used in the education of physicians in the subspeciality areas of psychiatry, obstetrics/gynecology, pediatrics and family medicine were included. Second, journal articles dealing with postpartum psychiatric disorders were located through an Index Medicus search. Most of the articles came from journals in the areas of psychiatry, psychological medicine, psychosomatic medicine, and obstetrical-gynecological medicine. Third, books written about postpartum depression for a medical audience and medical reference books were examined. Analysis of the written sources was limited to articles and books published between 1975 and the present with some earlier pieces still frequently referenced in contemporary writing also included. A total of 225 separate medical sources containing references to postpartum emotional problems were studied. (See Appendix D for a complete listing of the medical sources used.) These references represent the ten percent of the sources consulted that contained any reference to postpartum disorders.

Data Analysis. Procedures of data analysis were similar to those followed with the interview data. The medical sources were examined and information was coded into the
following categories for analysis: conceptions of postpartum disorders, theories of etiology, strategies suggested for treatment and the influence of gender and motherhood norms. The constant comparative method of grounded theory was similarly applied. Furthermore, the conceptions found in the medical literature were carefully contrasted with those of practitioners.

The use of the above research strategies permitted the production of specific substantive information on the extent of medicalization in lay and professional conceptions of postpartum disorders as well as the generation of theoretical propositions dealing with medicalization and the social control of deviance in women.
"The physical and psychic weight of responsibility on the woman with children is by far the heaviest of social burdens. It cannot be compared with slavery or sweated labor because the emotional bonds between a woman and her children make her vulnerable in ways which the forced laborer does not know; he can hate and fear his boss or master, loathe the toil; dream of revolt or of becoming a boss; the women with children is a prey to far more complicated, subversive feelings" (Adrienne Rich, Of Woman Born, 1976).

Deviance was earlier defined as behavior that violates established social norms. One form that deviance may take is the violation of norms attached to a particular social role, such as that of mother. This deviance may be imputed by others in the form of publicly recognized and labeled deviance (Becker, 1963; Scheff, 1984), or it may be in the form of the self-labeling of emotional deviance (Thoits, 1985).

The emerging sociology of emotions perspective provides a useful frame of reference for interpreting emotional deviance in women following childbirth because it accounts for the self-labeling and management of troubling feelings.
and emotions (Taylor and McCormick, 1989). As articulated by Hochschild (1983a, 1983b), the sociology of emotions accounts for the process through which individuals come to recognize socially discrepant feelings in themselves and the "feeling work" that follows as an attempt to bring emotions into line with social expectations. Hochschild argues that emotion norms and expression rules determine individuals' assessments of the appropriateness of their feelings and emotional displays. From this perspective, postpartum emotional difficulties represent deviance from the feelings and behaviors expected of mothers. The sociology of emotions therefore describes the process by which laypersons such as mothers recognize discrepant emotions in themselves and attempt to manage or transform those feelings.

This chapter describes mother's conceptions of their postpartum emotional difficulties. First mothers' descriptions of the dimensions of their problematic emotional experiences are presented. Then mothers' explanations or typifications for their experiences are discussed. While a wide range of feelings, emotions and experiences were expressed, some clear patterns emerged from the coding and analysis of the data. These patterned responses can be treated as constituting a lay definition of postpartum depression.

Among the women in the study, half reported that their problems were resolved and half reported that their
difficulties were ongoing at the time of the interview. The
time of onset of these difficulties ranged from two days to
nine months postpartum, with half of the women experiencing
emotional difficulties beginning in the first week after the
birth of the baby. One-fourth of the women experienced the
onset of difficulties between two and three weeks
postpartum, and the remaining women experienced onset at
various later points up to nine months. While length cannot
be described in complete terms as half of the women had not
resolved their discrepant feelings at the time of the
interview, some statements about the duration of emotional
difficulties can be made. Women reported periods of
emotional upset lasting from three weeks to two years, with
half lasting three months or less. The average length of
women's postpartum emotional difficulties based on reports
at interview time was seven months.

Each of the problematic postpartum experiences
mentioned by mothers were organized into dimensional
categories. These categories were created as a means of
organizing and grouping the data, and they were constructed
to conform as closely as possible to the language used by
women themselves to describe their experiences. Some
categories were idiosyncratic of an individual woman's
experience while others were more commonly experienced. The
following is a listing, presented in order of decreasing
frequency, of the eight most common dimensions of mothers'


postpartum difficulties:

- Crying
- Disappointment
- Tiredness
- Anger and Resentment/Thoughts of Harming Others
- Depression
- Anxiety, Panic, Nervousness
- Mood Swings
- Feeling "Trapped"

A. MOTHERS' DESCRIPTIONS OF THEIR FEELINGS: 
THE DIMENSIONS OF POSTPARTUM DIFFICULTIES

Most of the women identifying as having experienced PPD reported difficulties that were classified in several of the categories, even if they described their problems as having been caused by a single factor (e.g. hormones). What follows is a discussion of the dimensions of mothers' postpartum emotional difficulties along with a discussion of the properties of each category.

Crying. The majority of the women who self-identified as experiencing emotional hard times after the birth of a child mentioned crying as one feature of these experiences. One mother, alerted to her postpartum difficulties by unexplained episodes of crying beginning three days after the birth that lasted for two months, described a typical episode of crying this way:

"There were times when that baby was laying there in that basinette screaming her lungs out, and he (her husband) was holding me and I was crying, and he was rocking me."
For many of the women it appeared that the crying was regarded as a problem primarily because they didn’t have an explanation for why they were doing it—their inability to control or understand their crying was a frightening experience:

"Just for no reason I would begin to cry. That frightened me, the fact that I couldn’t control whatever was happening to me. And it made me afraid to go out, to be with other people who wouldn’t understand why I was acting this way."

"I would just break out in tears and couldn’t stop. It really upset me because I was trying to cover."

For others the crying was perceived as an indicator of underlying problems and conflicts, such as the stress of adjusting to motherhood:

"I was so weepy and just wanted to go home and cry my guts out instead of trying to be brave. The fun was over. Then the reality set in. You know that for me this is a lifetime commitment. I’ve got her forever. And I think at that point in time I began to feel really weepy."

Crying was also clearly recognized as a discrepant emotional reaction by mothers. Many described attempts to cover up their crying episodes and present the image of a happy, glowing mother to the world:

"I would be here during the day and would just lose control and weep and feel like I didn’t have a friend in the world. People would call me and congratulate me and talk to me on the phone, and I would be holding back the tears and biting my tongue."
Although it was the most common dimension of mothers' emotional problems, crying was also the most transient reaction, preceding many of the other dimensions and persisting for a shorter time period. It both served as an indicator that something was wrong and became a problematic reaction in and of itself as women hid their crying episodes from others and attempted to determine the root cause of these reactions. Along with crying, most women also experienced other signs of postpartum distress, and most often these other feelings persisted long after the crying ceased.

**Disappointment.** A significant number of the women indicated that part of their postpartum difficulties involved feelings of extreme disappointment or dissatisfaction with the nature of their lives and experiences after the birth. One mother of two, a registered nurse taking time off from her profession to raise her children, expressed disappointment with the quality of her life at home with her children, especially in comparison with the lifestyle of her physician husband:

"My life isn't what I thought it was going to be at all, and that makes me mad. I feel like it is just a waste. I feel resentful. He (her husband) seems to have so much freedom to come and go—he is in an outside world. I just can't do that and it makes me angry."

Unlike reports of crying, reports of disappointment and dissatisfaction frequently contained implicit or explicit
"I'm a mother now and I feel old like my Mom. I felt like some of my young youthfulness left. If I want to go somewhere and do anything I've got to think about having a babysitter. I had to think about coming back in an hour to feed Jake (the baby). I felt restricted and tied down and I didn't know if I wanted to be restricted and tied down. My Mom was saying 'This little baby only has you to depend on,' and I thought 'Great.'"

According to Thoits (1985), reports of situational problems and conflicts accompanied by troublesome affective components constitute the majority of problems presented by psychiatric clients. Women often described various problems and conflicts they had experienced after the birth of the baby when asked to relate their postpartum emotional difficulties. The reported problems and conflicts included isolation, conflicts with work roles, stress caused by a "difficult" baby (e.g. a baby with colic), marital conflicts, conflicts over body image post-pregnancy, problems with breast-feeding, and a perception that the responsibilities of motherhood were overwhelming.

When mothers described disappointments, these feelings often appeared to involve conflicts between expectations versus the reality of motherhood. While such reports are not of emotional difficulties per se, they are congruent with work done in the sociology of emotion field that recognizes the place of situational factors in the self-labeling of
emotional deviance. Stressful situations can give rise to a discrepancy between feelings and feeling rules, and attention is likely to be directed to the feeling rather than its underlying cause (1985:234).

**Tiredness.** One of the longer lasting reactions reported by mothers was feeling tired. Many women indicated that a very troubling feature of their postpartum difficulties was a feeling of extreme tiredness and exhaustion, and a consequent inability to accomplish tasks like baby care, housework or maintaining personal hygiene to their satisfaction:

"I remember thinking 'Why even bother getting out of bed?' It just took me all day to get both the kids up and dressed and fed and the house cleaned up and me dressed and fed. It was a little bit frustrating. I tried to be supermom. I tried to do everything and be everything and it wore me out."

"I had a definite lack of energy, a lack of physical strength, I felt unsure on my feet, out of physical character, tired, fatigued. I'm sick and tired of being sick and tired."

Of the women reporting difficulties with tiredness, some attributed the feelings to sleep deprivation due to being awakened by the baby numerous times during the night, others to a slow recovery from a caesarian section procedure or other medical complications from the delivery. A few attributed their tiredness to the overwhelming responsibility of the new child.
"I'm much more tired here (at home) with her than I was at work. It's a 24-hour job, and I never really thought about it much. I have a lot more empathy for my mother."

Anger and Resentment. Although virtually all the dimensions of mothers' postpartum difficulties could be categorized as involving troublesome or unacceptable feelings, anger and resentment were clearly perceived to be highly incongruent with the feelings expected of mothers in American society. This could be due to the imposition of female gender scripts on the assessment of deviant behavior (including self-assessments of emotional deviance) and the resultant double standard of mental health that is produced (Schur, 1983). Writers such as Richardson have remarked that the female script prohibits aggression and hostility toward others: "It is safer and more feminine to be depressed than to be physically violent (1988:136)."

Women who reported feeling angry and resentful typically associated guilt and shame with these feelings, and these were the least normalized of all the dimensions of mothers' emotional difficulties. Fewer mothers were reconciled to feeling angry and resentful and few women had an explanation for these feelings in retrospect. For some, anger was a generalized reaction to their situation post-baby:

"I was angry that I didn't think I was a good mother. I didn't think I was organized or I didn't know what I
was doing half of the time. I didn't know what I was
doing being a mother. I was angry because I just felt
out of control. I was angry at everyone."

For others, the feelings were directed towards a
husband or partner. The following account was given by a
mother of three whose emotional difficulties had lasted 17
months at interview time. She and her husband had
experienced serious marital and financial difficulties after
she gave birth to twins:

"I was angry a lot because my husband is not real
supportive. He was just there. He was not any help as
far as father's go. He's old fashioned: 'It's okay if
you want to work and everything, but the kids are your
responsibility.'"

Another woman in quite different circumstances also
experienced anger towards her husband. A comfortable,
middle-class law student studying for the bar exam at the
time of the interview, this women found the change in her
relationship with her husband after the baby came to be hard
to accept:

"I felt resentful of him (her husband). I felt like he
was a stranger. My relationship with him during the
pregnancy was such a high, so that was the model
against which to compare our life afterwards. And I
think I felt resentful of that."

Most stigmatized of all were the feelings of anger,
hostility and resentment some women felt toward their
children:
"My resentment has to be, I think, the most difficult thing, because that breeds everything else. It breeds the guilt and self-deprecation. You can't resent your own children. That's a very unmotherly thing to do."

"I think that's what threatens a lot of women, if you don't like them (children) every second. I think that's why people deny the feelings that I was trying to find out (from other mothers) because they wanted to be in love with their kids. And believe me, there were times when I hated them."

One mother who battled fertility problems for years in order to conceive her baby felt that she understood her feelings intellectually, although she still found them to be unacceptable and troublesome:

"I felt that my baby had infringed on my life completely. I felt very resentful of him. I really wanted this baby—we worked hard to get him, and I was ecstatic when he was born—it was one of the nicest times in my life. But after a while I started to resent him because he was so much work, he just was so demanding."

Some mothers expressed concern about thoughts of harming their baby while stressing that they had not acted on these feelings:

"I could see myself in my mind visualize a violent act toward her but never actually acting on it.

"I couldn't give him a bath because I was afraid I would drown him. I didn't want to change his diaper because something kept saying 'Stick him with the pin.' Everything I did with that baby I was afraid to do. I just got paranoid."

"I could see where child abuse, if someone isn't wired
just right, you could say 'Goddamn kid, just shut up!' I'm over that now, but I tell you, I could have just slammed that kid up against the wall."

None of the women reported acting on hostile feelings toward a partner, and only a small percentage reported acting on such feelings toward a child. The following woman, diagnosed as manic-depressive before having her two children, admitted acting in this way:

"I've smacked them (her children), and I don't like doing that. But I'm a human being too."

Besides feelings of anger and resentment, other stigmatized feelings included fantasies about other men, wanting to run away, and guilt about the effect of one's feelings on the baby. Mothers' guilt feelings were especially punishing and long-lasting. The following mother, interviewed at five months postpartum, was still extremely upset at her inability to deliver her baby without accepting pain medication:

"It was kind of like I felt I had failed. Because I had read so many things about if you take medication it's going to affect the baby's learning abilities. I just remember saying to my husband 'I'll take responsibility for any damage to the baby,' and I just cried because I had wanted to have natural childbirth and I had ended up screaming for medication."

Depression. Some women characterized their difficulties in terms of depression. Similar to lay constructions of other health and illness concepts, mothers described
depression in informal, experiential and pragmatic terms (Fitzpatrick, 1984). Although most were familiar with the term "postpartum depression," only one woman characterized her emotional difficulties by using this specific term before it was introduced by the interviewer. Those who mentioned depression when asked to describe their feelings after the birth of their baby simply said that they were depressed:

"Then the next day (after the birth) it was like everything crashed down. I was real depressed. I just couldn't do anything. I cried all the time. All I did was hold the baby and cry. That was my whole existence. Jay would feed me and that was it. I couldn't get up."

Most focused on what the depression felt like to them, or its effect on their behavior:

"I'm an active person. I just couldn't do anything. I remember waking up and I'd feel a new day, have all this energy, and I'd get up and fix breakfast, and I would be wiped out. And all I wanted to do was sleep. Nothing interested me. I didn't want to do anything. I would say I was depressed for a year."

Such feelings were not only characteristic of biological mothers. One adoptive mother experienced similar feelings after traveling to Honduras to get her eight-year-old child:

"I think after I got back I was in kind of a depression. I think several months I just didn't feel like myself. You know, mild or moderate, not quite as bouncy or cheery, kind of like there's a dark cloud somewhere, that kind of stuff."
Another woman whose troublesome feelings didn't begin until nine months after the birth of her child described her depression in terms of what she felt it had resulted from rather than what the depressed feelings felt like:

"I was depressed about being stuck at home, and being useless, and her taking all my attention— I always said that having a baby is not going to affect me, but it does. There are just so many things that you can't do— maybe you can but it's not worth the trouble."

Although depression was mentioned with a frequency almost equal to that of reports of anger and resentful feelings, reactions of shame and guilt were far less common in response to feelings of depression. Two conclusions may be drawn from this finding. First, it could be said that mothers perceive anger and resentment to be more at odds with the feelings and behaviors expected of mothers than depressed feelings. Second, and in a larger sense, depression is both a more acceptable and a more common emotion for women to experience than are feelings of anger. Many studies have documented higher rates of depression among women than men (Gove and Tudor, 1973; Dohrenwend and Dohrenwend, 1974; Dohrenwend and Dohrenwend, 1976), although opinion is divided as to whether this may be attributed to sex-based differences in hormone levels (Wolinsky, 1980), gender-based differences in the willingness to report psychological symptoms (Phillips and Segal, 1969), a differential labeling process that is influenced by gender
norms (Schur, 1983), or role conflicts experienced by women stemming from gender prescriptions (Gove and Tudor, 1973; Spears, 1988; Rosenfield, 1989). Feminist writers such as Chesler (1972) and Weissman (1980) raise the possibility that women's higher rates of depression are attributable to sexism and oppressive life circumstances; hostility that women should direct outward toward the conditions of their role imprisonment become a means of, in Chesler's terminology, "keeping a deadly faith with their 'feminine' role" (1972:45).

Anxiety. Women also reported anxiety, nervousness and panic attacks as components of their postpartum emotional difficulties:

"I had waves of anxiety and panic."

Somatic symptoms were associated mainly with this category in that many of the women reporting anxiety and nervousness experienced physical sensations along with their feelings of anxiety:

"You can't stand up, you lose control of your whole body. My whole body would start burning or tingling, and I would just lose it."

One mother of four experienced emotional difficulties lasting one year after the birth of the last child. She reported that her most troublesome feeling was a persistent nervousness:
"I was nervous all the time. I would think about everything all at once and not come up with anything. I used to think of something I can do to make things better. I kept thinking that Jay should be understanding. The more he said ‘Things are going to be fine’ the more nervous I got because I knew he had no understanding of what it took to make everything fine."

Another mother of two with a prior history of depression and panic attacks as well as substance abuse found that her feelings of nervousness caused her difficulties in caring for her baby:

"If I sat down I felt like I was nervous again, so I tried to stay busy. And when it was time for her to be fed, instead of holding her, I would prop a bottle up because I just couldn’t sit still with her long enough."

While most women described feeling anxious and nervous apart from any attribution concerning the source of the anxiety, some women felt that their anxiety related to their uncertainty about how to care for a baby:

"I wish I had enjoyed him more those first few months. I was tense, I was nervous, I was afraid, I was anxious, I was everything else."

"I did not know what to do half the time to take care of him (the baby) properly. I wasn’t in control. That was what bothered me. And I’m the kind of person who has to be in control."

Each of the five women who were diagnosed by clinicians as suffering from postpartum psychosis experienced acute feelings of anxiety. The following mother experienced
postpartum emotional difficulties after the births of each of her three children and was hospitalized for one week in a psychiatric unit after the birth of her last child:

"I couldn't sit—it was like I wanted to climb out of my skin. I couldn't lay down even though I didn't want to get up. Everything was confusing to me. She (the baby) was crying and I would break out in a sweat. I couldn't sleep—I kept tossing and turning—it just kept getting worse and worse."

**Mood Swings.** Reports of disturbing and unpredictable mood swings characterized the problematic postpartum experiences of a number of women. For many women the alternating feelings were identical to the distinct emotional problems experienced by other women, such as depression, anger, tiredness and crying. Unlike the women who primarily experienced distinct and discrete problematic emotions and feelings, the women with mood swings experienced a range of problematic feelings in quick succession. It was in part the fluctuating nature of their emotions that was problematic:

"My moods started swinging. I would just blow up. I would blow up at Katie. I would blow up at Rick. I would sob uncontrollably and then I would also go into very deep depressions where I even thought about suicide."

One mother of three began to experience mood swings in the hospital after giving birth to twins. For her the fluctuations in mood lasted three months:
"It would vary. It would go to variant kinds of anger on my part to myself about myself to very depressed, very gloomy phases where I would be very tired, very lethargic, not wanting to do anything at all, not even wanting to get the children, feeling very resentful, crying a lot. Those black moods would just press down on me."

Feeling "trapped." Reports of feeling trapped by the circumstances of life after the birth of a baby were common among women with postpartum emotional problems. Like the following mother, some women associated feeling trapped with a depressed reaction:

"I did feel trapped. I felt trapped by marriage, trapped by responsibility, trapped by everything. As soon as the depression went away I didn't feel that way anymore."

Others identified feelings of confinement as the primary problem without mentioning other associated emotional reactions. One mother of two who experienced emotional difficulties after both children were born described the new limitations in her life that led to a feeling of being "caged up:"

"I don't like being caged up—not being able to leave when I want to. And part of it doesn't have to do with money at all, because you still have to arrange a babysitter and get somebody to take proper care of them."

A mother of one reported similar reactions, stressing her lack of options in adjusting to the new circumstances in her life as the situation that led to her feeling trapped:
"I think trapped, like my life had completely changed, that I would never be the same again. I felt that I had to learn to live with this, and I don't think I was happy either. I was trapped too because when I would feed her it would take a lot of time."

Other women experienced emotional reactions of this type upon realizing the extent of their responsibility for the child, like the following new mother:

"And then when I looked at this little person and thought 'Oh my God, I'm responsible for this. Oh wow.' And it hit me because my husband worked so many hours that I am the one who is responsible. I felt very trapped. I felt like the walls were closing in, and cabin fever hit."

In common with reports of disappointment and dissatisfaction with their mothering experiences and the nature of life post-baby, reports of feeling trapped involved implicit accounts of situational difficulties and conflicts experienced by the women in enacting the mother role. This finding could be interpreted in light of the assertion by psychiatrist Szasz that designations of mental illness constitute myths, and that mental illness actually is a response to "problems in living" (1961). The problems encountered by mothers that were associated with feeling trapped included isolation in the home and a lack of assistance with child care responsibilities.
B. MOTHERS' VIEWS ON CAUSATION: LAY TYPIFICATIONS OF THE CAUSES OF POSTPARTUM DISORDERS

In addition to their descriptions of the dimensions of their postpartum emotional difficulties, mothers also derived their own socially constructed explanations for the source of their troubles. Following Turner's recommendation for the use of a phenomenological perspective to account for the consciousness of individuals about their state of illness and how their knowledge of illness is constituted in everyday life (1987), the following section presents mothers' typifications of causation using their own terms. As in the analysis of the dimensions of mothers' emotional reactions, mothers' typifications were organized into categories of responses for purposes of comparison and analysis. Some women blamed themselves in some way for their emotional difficulties postpartum, some cited social-situational factors, some identified medical/biochemical causes, but most mentioned multiple causes involving various combinations of the above factors.

Mothers citing typifications involving self-blame located the reasons for their postpartum difficulties within themselves, usually in terms of something they had done "wrong," some feature of their personality perceived as interfering with their ability to cope with the stresses of motherhood, or assumptions that earlier patterns of behavior (such as earlier abortions on the part of one woman and drug
abuse on the part of another) were in some way responsible for later experiences of postpartum difficulty. One woman who blamed herself for her difficulties described feelings of worthlessness as her estimation of cause:

"I just think it is something in myself. I think it is me that has to think I am worthwhile before I am anything. I did feel worthwhile when I was working."

Another woman identified her failure to have a vaginal birth or to breastfeed her baby as leading to problems with self-esteem that she connected to her emotional problems:

"I think the mental problems that came along with it and the severe reaction were caused by the problems that I had (during the delivery) and my low self-esteem, thinking that I had failed. You've got women 30, 40 or 45 years old having babies now with no trouble at all. And the naturalness of having to have your birth so naturally is pushed. And it is the most wonderful thing if you can do it. But I think it mentally penalizes us women who can't do it, and it makes us feel like failures..."

When asked to account for their experience of emotional difficulties some women mentioned social-situational factors. Contained within this category, however, were a wide variety of situations women believed to have contributed to their difficulties including a lack of sleep, stresses caused by caring for a newborn baby, isolation, overwhelming responsibilities, conflicts with work roles, and a lack of help and support. One woman believed sleep deprivation was the cause of her postpartum difficulties:
"For myself, the first thing is the lack of sleep, whether there's kids around or not and if I just had a baby or not. If I'm real tired I don't function as well. To not have a good night's sleep for seven months, including when I was pregnant...for me that was the primary problem. I think postpartum depression studies should be done in a sleep lab."

Like a number of women who made mention of the overwhelming responsibilities of the mother role as a situation giving rise to discrepant emotions, the following mother described how her unrealistic expectations led to difficulties once she experienced the reality of motherhood:

"Maybe I expected to be supermom. Maybe I expected too much out of me instead of enjoying her. I felt like I was obligated to keep the house spotless, to cook meals. There are just not enough hours in the day."

Within the category of medical and biochemical attributions of cause was located the most commonly occurring single factor mentioned by mothers to account for their experience of postpartum emotional difficulties: hormonal fluctuations. For some women hormones were identified as causal seemingly because no other explanation occurred to them:

"...it is something that is just out of my control completely, and I just blame it on hormones because that is the only explanation I have."

A number of women relied upon their own informal empirical evidence to account for their postpartum distress:
"I do believe there must be some kind of chemical or hormonal imbalance, that my body is readjusting. That could be the reason why there is a fatigue or kind of depressed feeling in my body and maybe even in my mind."

Others were apparently influenced by information they received from various sources that attributed postpartum difficulties to hormonal causes:

"What I have found out now is that a lot of postpartum depression can be caused by chemicals during breastfeeding."

The frequency with which hormones were mentioned as a causal factor, either alone or in combination with some of the other typifications that have already been described, is indicative of a highly individualistic orientation for explaining women's problems. When women rather than society are blamed for their problems, it is women who must adapt and not the social structure. Kitzinger, a British anthropologist, relates this orientation to a lack of knowledge about the realities of mothering and a lack of social support for mothers themselves:

"There is so little social recognition of what is actually involved in the fatiguing task of being a mother that women are usually made to explain their postpartum experience entirely in terms of internal states, their hormones, their psyches and their own inadequate personalities instead of the realities of the situation as they adjust to the new occupational and emotional tasks of motherhood, tasks which are challenging for every woman, however experienced in housekeeping or nursing she was previously, and however 'balanced' and placid she may be" (1978:24).
Only one out of 45 women adopted such a perspective and identified the source of her troubles within the social structuring of the mother role. This mother of four viewed hormonal theories of cause as inherently sexist: likely to lead to disregard for the possible contribution of social factors to mothers’ difficulties as well as to the invalidation of mothers’ complaints:

"I find that those explanations reek of sexism. The feeling of our society being one where things can be explained away scientifically...therefore no help needs to be given to that person. The actual thing that’s happening does not have to be given validity."

Most of the mothers suggested multiple causes when asked to account for their experience of postpartum emotional difficulty. The following mother’s explanation was typical of these multi-dimensional accounts and involved biochemical, psychological and situational components:

"I think the loneliness, the challenge of having a baby, the hormones, the fatigue."

Another mother with four children and multiple stresses in her life, including medical problems, marital difficulties and work conflicts, cited a wide range of factors as her assessment of the origin of postpartum emotional difficulties:

"I don’t know that it’s any one thing. I think that it can be caused by a combination of things, of not having support and maybe a physical problem like a hormonal..."
imbalance or PMS type thing, or maybe that you're anxiety ridden because you don't know how to take care of a baby."

In addition to the typifications women offered when they were directly questioned about the causes of their postpartum difficulties, most women implicitly raised additional causal factors when responding to other questions. Some women who strongly held to a single typification of causation like hormones nevertheless stressed situational difficulties at other points in the interview. For example, the woman who believed her difficulties to have been caused by hormone changes associated with breastfeeding spoke at another point in the interview at length about the identity crisis she was experiencing as she compared her life at home with her children to the professional lives of her women friends:

"I think some women are born to be at home. Some women are very content being at home and being mothers and I was not. I almost felt like it was this put-down for me to be this intelligent person and I was a mother, although motherhood came easier the second time around as far as accepting my children. But being home was hard to accept. All of my college friends are professional people. I mean they're lawyers and nurses and doctors and making tons of money, and there was me. And that was real hard for me to accept."

Most frequently mentioned in this sense were limiting features of the mother role. Besides identity crises, most of the women in the study described at length the extent to which their expectations and experience of motherhood were
The following mother of two experienced emotional difficulties after both births resulting in a psychiatric hospitalization, on-going consultations with a psychiatrist and anti-depressant drug therapy:

"I thought I loved kids, whenever it was someone else's. For a while I thought being a mother was something that would come naturally. Then I went through a period that I didn't know if I wanted anything to do with it, that maybe I would be better in a different capacity, and that's probably where there is a conflict too."

Another mother could not account for her experience of postpartum distress aside from her assertion that it was more than hormonal, or as she put it, "It has to be more than just hormones--that doesn't last for 17 months." This woman did, however, describe being overwhelmed by the enormity of her responsibility as a mother at another point in the interview:

"All of a sudden you look at yourself and you realize 'Shit, I'm a mother.' I realized that my life was never going to go back to the way it was, that probably the rest of my life I'll have a big responsibility for these kids, even when they're thirty and married and stuff. If I fuck up I don't just fuck up for me, I fuck up for three other people."

The finding that mothers were least likely to connect their emotional difficulties postpartum to the societal organization of the mother role fits earlier findings by Bernard (1971) and Bart (1971) connecting the traditional female roles of wife and mother with a high rate of
emotional distress. Bart found in her study of depressed middle-aged women that it was the most traditionally feminine women who had the greatest likelihood of experiencing emotional problems when these roles proved unsatisfying. As with the finding in this study that the most heavily stigmatized emotional reactions were those at odds with the traditional feminine script, it could be that associating their difficulties with the structure of the mother role would be to challenge the female script—thoughts most women were incapable of having given their far-reaching implications. It was therefore more acceptable and less threatening for women to locate the source of their difficulties within themselves or in some isolated feature of their environment than to take on society and the construction of the mother role.

C. CHAPTER SUMMARY AND DISCUSSION

The lay definition of postpartum depression that can be constructed from mothers’ accounts of their experiences is distinctive in several respects. First, mothers’ descriptions of their feelings were highly contextual in nature. Mothers did not report their emotional difficulties in the form of discrete, isolated symptoms. Rather, they described feelings and emotions embedded in a web of relationships and experiences. Mothers’ accounts of their postpartum difficulties were so dependent on their social
context that in many cases, when asked to describe difficult emotional experiences women talked primarily about the problematic and limiting circumstances they found themselves in after the birth of a baby. For most mothers, the distinction between the difficulties they experienced and the emotions they felt were blurred.

Second, the impact of gender and motherhood norms was clear on mothers’ reactions to their problematic postpartum feelings and emotions. All of the dimensions of mothers’ postpartum difficulties were experienced as deviant or discrepant emotions.Thoits (1985) describes this as a condition of "norm-state discrepancy," viewing most mental illness as a situation in which individuals are aware of the discrepancy between their private experiences of emotion and the states prescribed by emotion norms. For the women in this study, it was apparent that the feelings most at odds with female gender scripts produced the most distress. Thus feelings of anger and resentment resulted in guilt and shame reactions that were not associated with other discrepant emotions such as depression.

Third, gender and motherhood norms also influenced mothers’ explanations for their discrepant emotions. Overwhelmingly, mothers attributed their problematic feelings to internal states such as hormones and psychological predispositions and only in isolated cases looked to situational factors, such as the conflict between
staying at home to care for a child and working outside the home for pay. The idea that the mother role in contemporary American society is structured in such a way so as to predispose women to experiences with conflict and emotional difficulty was not considered for the most part. Despite their awareness that postpartum emotional problems are very common, most mothers chose individualistic explanations for their difficulties, locating the source of their problems within themselves or within their immediate environment rather than in society. As a result, the status quo of the institution of motherhood is preserved and a call for meaningful social change is thwarted. The relationship between mothers' conceptions of cause and the emotion work and help-seeking processes they pursued to resolve their difficulties is the subject of the next chapter.
Chapter IV

LAY KNOWLEDGE AND THE RESOLUTION OF POSTPARTUM DIFFICULTIES

This chapter reviews mothers' assessments of the resolution of their postpartum difficulties. Particular attention is paid to lay knowledge and beliefs about emotional problems after birth and the relationship between this knowledge and the help-seeking processes and emotion work pursued by women in order to resolve their discrepant feelings. Combined with mothers' accounts of the dimensions of their postpartum difficulties, this information permits a complete reconstruction of a lay perspective on these problems.

Despite findings that the majority of physical symptoms and psychosocial difficulties are not presented to physicians or to other medical and counseling professionals (Zola, 1972; Scambler and Scambler, 1984), the major models of illness behavior presume that physician consultation is the logical final step in a lay process of sense-making. The Health Belief Model developed by Rosenstock (1966) and elaborated by Becker (1974) as well as Mechanic's general theory of help-seeking (1978) each seek to specify the
factors that influence the decision to seek medical care. In much the same way that Parsons' concept of the sick role highlighted the physician as the only legitimate care-giver for illness episodes, theories of illness behavior have overlooked lay-based patterns of care and resolution. Even Freidson's lay referral system concept (1970) perpetuates this assumption by emphasizing the ways in which lay patterns of advice and referral lead to professional consultations.

Dingwall (1976) attributes these deficiencies in theories of illness behavior to absolutist and scientist tendencies in the thinking of sociologists that lead to a failure to take lay beliefs seriously. The sociology of emotions perspective used in Chapter Three to interpret mothers' discrepant emotions does account for lay-oriented resolution processes by specifying the ways in which emotions may be consciously manipulated. Thoits' model asserts that conscious feelings are comprised of external situational cues, physiological sensations, expressive gestures, and cultural labels (1985). She theorizes that the manipulation of any one of these components through behavioral or cognitive means can help in the transformation or management of the troubling feeling. She also asserts that in the case of emotional deviance, professional consultations are most likely to occur when self-labeling and emotion-transformation techniques such as these
The failure of emotion work is likely to occur when the situations leading to discrepant emotions do not change and when others do not support individual emotion-work efforts.

A. LAY KNOWLEDGE: THE SOURCE AND CONTENT OF MOTHERS’ INFORMATION ABOUT POSTPARTUM EMOTIONAL DIFFICULTIES

At odds with scientific studies of postpartum difficulties that "test" a particular theory of causation followed by recommendations for treatment and resolution that are predicated upon the findings, a phenomenologically oriented approach stresses the importance of learning about mothers’ beliefs about resolution and the relationship between this lay knowledge and their emotion management and help-seeking practices. Because of the phenomenologically presumed relationship between the individual’s definition of the situation and their consequent behavior (Schutz, 1971; Berger and Luckman, 1966), I will begin by presenting an account of the source and nature of mothers’ information and awareness of postpartum emotional problems and then proceed to relate this knowledge to mothers’ help-seeking behaviors.

The vast majority of the women knew something about the occurrence of emotional disturbances in the postpartum period before their difficulties began. Only four women claimed to have no prior knowledge. One of these women, a mother of one who experienced a two-month bout with
depression after her baby was born, began a search for information shortly after her postpartum difficulties commenced. The difficulties she encountered in locating information about postpartum problems led her to believe that there exists a conspiracy of silence on the part of experts and mothers themselves about the realities of adjusting to motherhood:

"I hadn't heard anything about it. They keep it pretty hush hush. Everybody says they want a cute little baby. Nobody says 'Oh I felt like shit.'"

For some women, knowledge about postpartum difficulties came from female friends and family members. In some instances the perspective of a friend who had experienced similar feelings was helpful both in interpreting problematic feelings and in providing strategies for coping with and resolving the feelings:

"I think I got most of my answers from a girlfriend who had a baby three months before I did. And she had postpartum. She would say 'It's okay. Let her cry a little bit and see if she cries herself to sleep.' She would say 'Give her ten minutes—if she is not asleep, then there is something wrong.'"

For others however, the information provided by friends was not as helpful, sometimes seeming to diminish the seriousness of the mother's difficulties, or leading to confusion about the cause of the discrepant feelings. The following mother's co-worker friend described to her the
"baby blues," saying that such experiences were "ridiculous:"

"She said some women get depressed right when the baby was born. She said it's silly—you feel great—it won't happen to you. And it didn't happen to me. It took a while; it took months so I'm not even sure it's related, but I think it is."

A few women sought out information from medical practitioners in order to better understand what was happening to them. Most, like the following woman who questioned her doctor during her second pregnancy about difficulties she experienced after her first baby, found that physicians were unable to offer much illumination:

"He really didn't know a whole lot. He did say that if I went through it the first time, just from his experience with other patients, I would probably go through it again. He didn't know the reasons for it. He told me that sometimes it was severe enough to refer them for counseling, and he felt strongly about that. But other than that, he really couldn't offer me a whole lot."

In one instance a physician's response to a request for information was perceived as helpful by a mother when he confirmed that depressed feelings after the birth of a baby were "not normal:"

"Before I thought, well, this just happens to everybody, and I didn't see it in that light this time. There were a lot of people that were really concerned about me this time. And I never saw it before that something was really wrong."
However, the vast majority of women received their information on postpartum depression from the popular literature on pregnancy and motherhood, including parent's magazines, women's magazines, child care manuals, women's health care manuals, and pamphlets of the variety that are made available in doctor's offices. In her content analysis of the popular literature on postpartum depression, McCormick (1985) found a marked lack of consensus about the cause, characteristics and treatment of postpartum emotional problems. Although some authors were medical professionals and some were mothers, their identity was not predictive of the position they took on these issues; doctors and mothers were as divided within their own groups over medically-oriented versus experientially-oriented conceptions of postpartum conditions as there were divisions between the two groups.

From their recollections of their reading, mothers described two features of the popular literature that diminished its usefulness to them. First, many women dismissed the potential relevance of the information and case studies they read about while pregnant, citing the differences between their own situations from those of the women described in the articles. One mother recalled that ambivalence over pregnancy was stressed in an article she read as the cause of postpartum difficulties. Because she didn't feel ambivalent about having a baby she didn't expect
to have problems:

"I didn't expect it to happen to me because I wanted the baby so much."

Similarly, another woman remembered reading that PMS sufferers were predisposed to experiencing postpartum emotional difficulties:

"I thought that women who always had trouble with their periods were more likely to have some kind of postpartum trouble. And I felt that I had never had trouble with my period so I was less likely to have problems with postpartum symptoms."

Second, the narrow range of definitions and descriptions of postpartum emotional difficulties found in much of the popular literature led to confusion later for some women once they began to experience discrepant emotions themselves. The divergence of their feelings from what they read during pregnancy led some, like the following woman, to question what it was that they were experiencing:

"I think my assumptions were that PPD was a depression over not being pregnant any more. And so of course I didn't feel that way. Somehow that label postpartum—it just wasn't what I thought I was experiencing because that was so simple and this was so complex."

A few women were exposed to information about emotional difficulties in the postpartum period in their Lamaze and LaLeche League classes. While these classes were regarded as authoritative lay sources of information on childbirth and
breastfeeding techniques, the net effect of exposure was similar to that of exposure to the popular literature on postpartum disorders. The information presented was idiosyncratic of the course instructor and was not necessarily consistent from one class to another. For example, among women undertaking Lamaze training, some recalled that hormones were stressed as causal, while others remembered mention of social factors. Again, the information presented led some women to assume that they would not experience postpartum problems as was the case with several women who remembered assurances in LaLeche classes that breastfeeding women were immune from depression. Similar to the accounts of these women, the following mother felt that postpartum disorders were minimized and glossed over quickly by her Lamaze instructors, causing her to discount the potential relevance of the information:

"I had heard of the postpartum blues, but nothing like real serious. At my Lamaze class they said most women do and that you cry at the drop of a pin and all that stuff—that it's a day or two and that's it."

Three professional women with nursing or social work training recalled information they received during their schooling and later exposure to postpartum difficulties among their clients and patients. Each of these women remembered being taught that hormones were the primary cause of postpartum emotional problems, and yet none of these
women considered that they might experience similar difficulties themselves:

"I learned about postpartum depression as a natural occurrence after birth and if it lasts for more than six months that clinically there was more to it, but I didn't really think of myself as susceptible to it. I didn't really expect it."

The fact that mothers with formal training and clinical exposure to postpartum difficulties also discounted the relevance of their professional knowledge to their personal situations suggests that some additional factor contributes to the confusion women experience when confronted with feelings they did not anticipate after having a baby. One possibility is that the restrictiveness of gender and motherhood norms and the prevailing cultural ideal of the blissful, fulfilled mother leads women to only anticipate happy outcomes. The accounts of "other" women who experienced postpartum emotional difficulties can be discounted because "those" women did something wrong. To blame society for its lack of support for the mother role or to consider the possibility that motherhood may not inherently bring happiness is to challenge the essence of the concept of motherhood in our society.

By and large, most mothers had knowledge about the occurrence of postpartum emotional difficulties prior to their own experience with it. Because their information came from a variety of sources that did not offer a consistent
picture of the characteristics, causes or means of resolving such difficulties, it is not surprising that mothers' lay concepts of postpartum difficulties are also quite varied. As we saw in Chapter Three, mothers identified both social and bio-chemical factors as causal, and this parallels the theories of etiology to be found in the sources they consulted. The information that mothers described as most helpful came from sources that enabled them to label their difficulties in a meaningful and non-stigmatizing fashion, to normalize their feelings to some extent and to derive coping strategies. Information that was not perceived as helpful came from sources that diminished the seriousness of postpartum reactions or defined it so narrowly that mothers were unable to connect it to their experience. The influence of the non-helpful sources was to contribute to mothers' confusion over the cause of their difficulties and to increase their feelings of self-blame and guilt.

These findings about the sources of lay knowledge for postpartum emotional difficulties confirm the findings of research on the influence of cultural factors on lay concepts of illness. Lay concepts tend to be complex, pragmatic rather than theoretical, derived from a variety of distinct sources, and highly related to personal experience (Fitzpatrick, 1984). Mothers are exposed to a variety of sources of information about the occurrence of postpartum emotional difficulties. As was seen in the previous chapter,
these sources influence mothers' explanations for their discrepant emotions in a way that does not challenge the normative structure of the mother role. Because of the lack of consistency in the information that is available and the tendency on the part of women to dismiss the relevance of such information to their own situations, most women do not anticipate or plan for the possibility of emotional difficulties in the postpartum period. They are then left to cope with their difficulties in a manner consistent with their understanding of the problem using resources that are at hand. It is to these help-seeking and emotion-work processes that I now turn.

B. THE RESOLUTION OF POSTPARTUM DIFFICULTIES: HELP-SEEKING AND EMOTION WORK PROCESSES

Mothers sought a resolution to their emotional difficulties by pursuing four main types of strategies. These strategies included: 1) consultations with medical practitioners; 2) consultations with counseling professionals; 3) seeking support from friends and family members; and 4) various situational adjustments. Not all of these strategies were equally successful and not all were pursued consciously as the following discussion demonstrates.

The most common way in which mothers sought to resolve their postpartum difficulties was by consulting medical
practitioners, including physicians, psychiatrists, nurses and midwives. For those consulting physicians and psychiatrists the following formal treatments were prescribed: five women were hospitalized in a psychiatric hospital or unit; one was admitted to a hospital for "exhaustion;" eight were placed on anti-depressant drugs; and one woman voluntarily elected to be sterilized so as not to experience postpartum difficulties again.

Most mothers who consulted professional practitioners approached their physicians for assistance, and the overwhelming majority of these women reported unsatisfactory outcomes. Seventeen of the 20 women who consulted physicians described responses that were "no help at all" or worse; some of the women experienced conflicts with physicians that they perceived as adding to their difficulties. Based on mothers' accounts, these conflicts can be grouped into two categories: those related to the attitudes and style of the particular physician who was consulted and those related to the structural limitations of medical practice.

Mothers who felt that their lack of satisfaction was attributable to the personality or attitude of their physician described physician reactions that they perceived as intolerant, uninformed or lacking in compassion. One mother who experienced feelings of extreme anxiety beginning eight days after giving birth expressed her disappointment with the response of her family practitioner when she
consulted him about her feelings:

"...he told me I was crazy. I brought him an article (about postpartum depression) and he said 'That's just a bunch of women talking.' And he gave me tranquilizers and stuff. He said 'Go home and relax.' He was no help at all. As a doctor he is good, but when it comes to this he just had no compassion, no feelings at all. He acted like I was making it all up for attention or something."

Another woman reported a similar encounter with her OB-GYN, whom she felt was judgemental about her reaction to the difficulties she was experiencing. Although her physician warned her during her pregnancy of the possibility of postpartum emotional difficulties (citing her age, education and career orientation as predisposing factors), she was angered by his later response when she did experience emotional hard times:

"He got mad at me when I said she (the baby) is being a real bitch today. And he gave me this dirty look—you know, like I shouldn't say that. And I said 'You're not with her 24 hours. You don't have your sleep interrupted three or four times a night.' It's like we're meat. They see so many vaginas...It must get old hat to them....I think a lot of them forget the emotional aspect. They treat the treatment instead of the person."

Finally, some women, like the following new mother, believed that their doctors avoided dealing with the emotional problems they presented by deflecting attention to unrelated matters. She described feeling particularly devastated by comments her obstetrician-gynecologist made to
her both because they involved a topic about which she felt very sensitive (her weight) and because it had been especially hard for her to raise personal concerns with him:

"He was so into how fat I was, that's about all he would talk about. He was always telling me about all his other patients—what spectacular recoveries they had had."

These accounts from mothers indicate that physicians exercised social control in two ways in their responses to postpartum emotional problems. First, mothers tended to interpret doctors' lack of responsiveness as an indication that their problems were viewed as trivial and unimportant, and this led many women to seek support and resolution from non-medical sources, as we shall see. Silence and avoidance was also interpreted as a form of censorship for what mothers regarded as deeply deviant behaviors and this increased the sense of shame many women felt about their feelings. Second, doctors also communicated messages about appropriate maternal behavior in their subjective reactions to mothers' difficulties. In the examples cited above two women received messages about the inappropriateness of hostile feelings toward infants and personal appearance. The cumulative effect of these kinds of interactions was to reinforce the suppression of mothers' discrepant emotions and future avoidance of consultations with medical practitioners about these problems.
Other mothers complained that their physicians did not give them the time they felt they needed during an office visit to really discuss their troubling feelings. One mother who experienced depression and other emotional difficulties following the births of each of her four children sought help after her last birth from the doctors in the OB-GYN practice that she used. She reported that when she asked questions of the doctors she was made to feel "like I was being a pest in some way." Because she felt hurried, her questions were never answered to her satisfaction:

"They always acted like they were in such a big hurry and it was hard to even get out questions without feeling like I was being ridiculous."

Another mother who eventually was hospitalized in a psychiatric unit and given anti-depressant drugs first approached her child's pediatrician for assistance. When he offered her fifteen minutes to discuss her difficulties she declined, saying:

"It's going to take more than fifteen minutes."

A related problem mentioned by some mothers was the abrupt termination of professional medical attention for women during the postpartum period. The usual six-week check-up after the delivery marks the end of special medical attention to new mothers. Women who grew accustomed to numerous trips to their obstetrician-gynecologist during
pregnancy find that after the baby is born there is no logical care-giver who is readily available to address their emotional difficulties. After one or two follow-up visits to the OB-GYN for the purpose of checking that she is recuperating from the delivery, the only care-giver a mother is likely to see on a routine basis is the child's pediatrician or a family practitioner. The following mother experienced acute emotional difficulties beginning immediately after birth that lasted for three weeks. She spoke perceptively of just this problem as well as her view of a solution:

"Normally when you're released from the hospital you don't see a physician for six weeks or two months. So you're not really in contact with a medical person. I think that physicians need to be aware that emotional problems are very common, that they are not necessarily chemically related at all. And I think they should try and be aware of or be affiliated with support systems that people could use. I know if my doctor had said 'call this person and talk to her--she could help you' --I would have done it. Instead he said 'nothing is wrong with you--you're okay.'"

The frustration felt by some of the women who were confronted by highly discrepant feelings and physicians who were unable or unwilling to help was illustrated by the extreme course of action taken by one woman who became concerned about her potential for child abuse. Convinced that her stress was caused in part by her baby's "bad personality," she began spanking the child at four months. When she tried to discuss her fears about abuse with her
child's pediatrician she found him to be unresponsive to her concerns: "He talks to her—he doesn't talk to me." She eventually took matters into her own hands and reported herself anonymously to the child abuse society. Her physician, who was contacted by the authorities, finally responded in the way she wanted him to earlier:

"Then he called me and said 'How do you feel that these people came?' And I said 'It's okay—I called them.' He said 'You need a break, you need to maybe put her in childcare or get some help.' He suggested a person I could go to and said 'Maybe I could give you a prescription so that insurance could help pay for it. You should enjoy being a parent.'"

Although this was interpreted as a caring response by the mother, once again an element of social control can be discerned in the final comment made by the physician. By telling the woman that she should enjoy being a parent the doctor communicated a message about appropriate maternal feelings. The underlying assumption here is that women who do not consistently enjoy mothering are sick and in need of medication.

The dissatisfactions experienced by mothers in their consultations with physicians about postpartum difficulties can be attributed in part to a discrepancy between lay expectations of physicians and the realities of medical education and practice. Patients frequently seek emotional support as well as medical care in their consultations with doctors. Physicians are ill-prepared to provide this support
both because their medical education emphasized the
diagnosis of organic disease and technical proficiency over
interpersonal and counseling skills and because the heavy
patient loads characteristic of medical practice limit the
time that can be spent with each patient (Mechanic, 1978).
Additionally, research demonstrates a clear relationship
between physician communication styles and patient
satisfaction with medical care. Consultations with
physicians displaying affiliative communication styles—
involving friendliness, interest in the patient, warmth,
allocation of sufficient time and other indications of
caring—are associated with higher levels of patient
satisfaction. Consultations with physicians whose
communications styles emphasize dominance and control are
associated with lower levels of patient satisfaction (Ben-
Sira, 1980; Buller and Buller, 1987).

These findings are reinforced by the few accounts of
positive medical consultations given by women in the study.
Just six women reported positive feelings and outcomes
resulting from consultations with medical professionals, and
three of these were with midwives. Typical of the uniformly
positive stories told by women who obtained care and
emotional support before and after birth from midwives are
the accounts of the following two women who felt comfortable
raising their emotional difficulties with the midwives who
attended their home births.
"The first thing is they know you. They look at you, they see you, they do not see a patient. And they talk to you. They do not sound routine."

"They didn't give you their opinion. They would give you both sides of the issue and said here is all of the information, now you have to decide yourself."

Mothers described receiving more time, information and emotional support in their consultations with midwives. As quasi-professionals who bridge the gulf between medical practice and lay-based experience, midwives are less hampered by the features of medical education and medical practice that cause physicians to be ill-equipped to respond to the emotional needs of patients. However, due to legal restrictions limiting their ability to practice and their consequent unavailability, most women consult traditional physicians for their pregnancy and postpartum care (Boston Women's Health Book Collective, 1984).

The other three positive encounters mothers reported with medical practitioners during a consultation about postpartum difficulties were with a gynecologist, a high-risk obstetrician and a psychiatrist. In each case the consultations were distinguished by a willingness on the part of the practitioner to spend time with the patient and the mothers' perception that the practitioner regarded their difficulties seriously. As an example, one mother who felt that her postpartum difficulties were related to the conflicts she was experiencing between career demands and
her desire to care full-time for her baby received what she felt to be helpful advice from her male gynecologist:

"He said quit cleaning the house, quit cooking, just work if you want to and take care of the baby, but don’t do the rest."

In each instance of a positive interaction it was apparent that to mothers, it was more important that they be treated sympathetically and taken seriously than it was necessary for the practitioner to successfully "treat" their problem. In fact, few of the medical treatments prescribed by doctors, including hospitalization and drug therapy, were perceived by mothers to have directly helped in the resolution of their problems. It is ironic that physicians do not become more involved in assisting mothers with their emotional difficulties, since they are structurally and culturally in a position to intervene each level of emotion work included in Thoits' model (1985).

By virtue of their professional authority doctors were in a better position to intervene in more ways than any other category of persons from whom a mother might seek help. By supplying a label for mothers' difficulties, like postpartum depression, they were in a position to help mothers to normalize their feelings. By making suggestions about changes in routines and by supporting mothers in their efforts to receive assistance they could aid in altering the situational cues that may contribute to discrepant feelings.
By prescribing drugs or by making suggestions about other physical means of obtaining relief physicians could affect the physiological sensations associated with discrepant feelings. And by assessing and screening mothers' affective states after birth physicians could identify the expressive gestures that may signal postpartum disturbances and make appropriate suggestions for resolution. The fact that they did not do so appears to confirm arguments made earlier about the limitations of medical training and practice.

It was also the case that significant numbers of women did not chose to raise their difficulties with a medical practitioner. This indicates that mothers may have anticipated a less than helpful response from physicians. Seventeen women—the same number as women reporting unsatisfactory medical consultations—related that they chose not to raise their emotional hard times with a medical practitioner, pursuing other means of resolving their discrepant emotions instead. For some women the reason for not raising their difficulties with a practitioner was an aversion to discussing personal matters with a medical professional; for others it was because they felt a physician would not understand their problems or because their doctor was regarded as too impersonal. Others felt that their difficulties were not severe enough to warrant consulting a physician. Some, like the following woman whose emotional difficulties lasted for three months, were waiting
for their doctor to raise the subject first:

"If he asked I probably would have said something. He never asked."

Other women had highly personalistic reasons for not consulting physicians. For one woman the avoidance of physicians was due to the fact that her husband was also a physician. She did not wish to consult anyone she might see socially. Two women mentioned husbands who were opposed to professional consultations as their reason for avoiding any practitioner, whether physician or therapist. Finally, some women related that their feelings of shame over their postpartum difficulties kept them from sharing their problems with a doctor. A depressed mother of one was concerned over what her physician and others might think of her:

"Sometimes the depression was so severe that I was afraid that acknowledging it would make it even more real. And something a little contradictory to that was that they might not think very well of me."

Another woman who felt resentful of her baby and who had thoughts of harming him (although she had not acted on her feelings) was afraid that if she shared these thoughts with a physician that her baby might be taken away from her:

"I was afraid to tell my doctor because I was afraid he might try to take my baby away from me."
Finally, many of the women whose physicians suggested a referral to a psychiatrist were resistant to the idea, some due to associations of psychiatry with serious mental illness, and some because they wanted to be able to consult with a practitioner that they already knew and trusted, like the following woman:

"I wanted so desperately to have somebody that I knew and trusted to help me instead of constantly seeking strangers out. And at that time I didn't even think to go to a psychiatrist, you know, because it was all baby-related....I think if these OB's would get their act together and do a little research themselves they could help their patients out and not get to the point of psychiatric care."

Seven women consulted mental health professionals about their difficulties including psychologists, social workers and psychiatrists. Some of these consultations were referrals following upon initial consultations with physicians. In other cases mothers sought out mental health professionals on their own or pursued therapy on the recommendations of family members or friends. Women did not find mental health practitioners to be especially helpful with resolving their discrepant emotions, although there were fewer reports of conflicts stemming from consultations with psychologists and social workers than with physicians. One mother who experienced severe feelings of anxiety lasting for six weeks did not feel that the tranquilizers prescribed by her family doctor helped her. On the advice of
a friend she began seeing a psychologist, and reported that while the relaxation techniques she learned helped her to cope, she planned to curtail the sessions as the underlying feelings that caused her to seek therapy were still unresolved:

"I'm supposed to go see her tomorrow, but I think that's probably going to be the last time. Because it's good she helped me to relax, but she really didn't help me with anything else."

Consultations with psychiatrists were evaluated by mothers in much the same way as consultations with other physicians. The attitude and communication style of the psychiatrist appeared to be predictive of the satisfaction of mothers with the consultation. One mother who was hospitalized in a psychiatric facility for severe depression found the balanced nature of the relationship between she and her female psychiatrist to be helpful:

"Dr. _____ was probably the sweetest person I had ever met and really could just sit down and talk to her and not feel like I was talking to the doctor as the patient."

Another mother who experienced a six-month postpartum psychotic episode had a negative experience with a male psychiatrist during her first period of hospitalization. While she later had what she described as a productive relationship with a female psychiatrist, she recalled a difficult power struggle with the male:
"He made it basically a no-win situation. He had to win and I had to lose. I was sick enough to be willing to lose."

Mothers reported two other major means of resolving their discrepant feelings that did not involve consultations with professionals. These were seeking support and assistance from family members and various situational adjustments. While such resolution processes were not equally available to all mothers, for those who were able to make use of them they also undoubtedly account in part for the ability of some women to resolve their discrepant feelings without seeking professional advice.

A number of mothers mentioned emotional support from family members and friends as an important component of their ability to normalize their discrepant emotions and to cope with the difficulties they were experiencing. Mothers, sisters and female friends helped women by relating the stresses and feelings they themselves experienced after their children were born, by providing direct assistance to the new mother, and by making suggestions that made life easier. The following depressed mother described receiving important support from her sister who helped out by preparing meals and by serving as an uncritical and sympathetic listener:

"She (the sister) handles things. When everyone else goes to pieces she's still there."
For another woman, talking with her own mother helped to put her feelings into perspective. The fact that her mother accepted her feelings as normal and sympathized with her difficulties helped her to accept herself:

"Finally, little by little as I was telling her all of these things that had been happening to me I finally came to understand that maybe everybody has feelings like that but it just comes out in different ways."

Friends who had experienced postpartum emotional difficulties themselves sometimes provided the type of support characteristic of family members, but more importantly, they could help by providing a label for mothers' feelings:

"Once I realized what it was and what I needed to do about it it was a lot easier to deal with."

The need to legitimate deviant feelings with a medical label was common among women in the study. Mothers who were exposed to lay sources for such labels did not necessarily need to be officially "diagnosed" by a medical professional in order to derive the benefit of legitimation. In some instances self-labeling served the same purpose.

For several women, the understanding and support of their husbands was of paramount importance. One woman who experienced a psychotic episode and two psychiatric hospitalizations related that her husband's consistent support was critically important to her recovery:
"The only piece of real sanity in my life was basically Dick at that point. I mean that man was just absolutely fantastic. He's a totally grounded person. It made me reconsider what I had till that point thought about men -- that they were all evil, even the ones that were trying to be good."

Another woman could only accept the type of support she needed from her husband:

"I think that the husband's support is much more important than any friend. I think it's nice to have someone to talk to afterwards. I don't even think as close as I am to Doreen (a friend) it would have meant as much. I think you need the physical contact, and I'm not real comfortable hugging other women."

Despite the fact that emotional and physical support was perceived by some women as instrumental to their success in coping with and resolving their postpartum difficulties, the majority of women did not feel that they received adequate support and assistance from family members. One woman who was hospitalized with a diagnosis of postpartum psychosis found that her husband reacted with suspicion and hostility to her feelings and her consultations with physicians and psychiatrists. A pharmacist, he also pressured her to stop taking her anti-depressant medication:

"He told me I would get Parkinson's disease if I kept taking them. He said 'You'd better snap out of this or our marriage will be on the rocks.'"

A more common reason for a lack of supportive others, however, are the circumstances of contemporary family life
in western societies. The high degree of geographic mobility, the dramatic increase in the employment of women and the absence of extended family networks places new mothers in isolated circumstances. The absence of an extended family support structure can result in an increasing reliance on experts for information and assistance (Kitzinger, 1978).

The final means through which postpartum difficulties were resolved involved limited alterations in the structural circumstances in which women mother. Sometimes these situational adjustments were deliberately sought, as when women obtained childcare or returned to work. Some women also found that their circumstances naturally changed with time in a helpful way. An example of helpful changes such as these that were not consciously pursued included the growth and development of a demanding and dependent infant into a more interactive and communicative child. Situational adjustments were reported almost as often as medical consultations, the leading pattern of help-seeking and resolution. Some adjustments, such as obtaining childcare, involved a reallocation of time spent exclusively caring for the baby. In many instances childcare was sought out by women for the purpose of reducing their responsibilities and freeing their time for other pursuits. A number of the women who obtained childcare discovered that it helped to resolve their feelings either because it enabled them to return to
work, or because it afforded a respite from the stress of being constantly responsible for children. One mother with mild symptoms of depression found that returning to work made her feel more productive and consequently less depressed:

"I started getting some daycare for Ian which helped me get back to work and feel more productive. So that's helped the depression."

For another mother the chance to spend time alone away from the stress of constantly caring for her two children was made possible by a membership in a health club with a nursery:

"I joined a health spa with a nursery. I had been thinking 'gosh, I'm going to have that hour and a half or so where I'm not going to be responsible for them. I can take a shower...'."

Returning to work was an important situational adjustment for a number of women who found reclaiming their work identities to be helpful in the resolution of their postpartum emotional problems. Such changes were by no means a panacea for all women, however. In Chapter Three it was shown that a number of women described the conflict between staying at home and returning to the workplace as one component of the difficulties they experienced. For the women who did find resumption of employment to be helpful there was a perception that their self-concept was elevated
by re-assuming a valued social role along with the stimulation of fraternizing with adult peers, rather than toddlers. The adult stimulation to be found in the workplace was found to be helpful by one woman with mild postpartum difficulties:

"I went back to work because I just felt--my God--all I have to talk to is Jenny. It was just about once, maybe twice a week sometimes. So that helped a little bit."

For another woman who related persistent feelings of depression after her baby was born returning to work raised her self-esteem and this carried over into her feelings about mothering:

"After going back to work I felt really good about being a mother. I was using my mental intelligence and in my chosen vocation."

Being able to escape from the constant pressures of caring for her child enabled another woman to develop confidence in her mothering abilities:

"It (going back to work) gave me some self-confidence. It helped me to put things in perspective."

Some women found that as their baby got older and more independent that their troubling feelings lessened. An increase in the baby's responsiveness and the resolution of stresses such as the constant crying that often accompanies colic were some of the features that helped in this regard:
"I think she helped tremendously be growing stronger and getting more responsive and my learning from her what she needed and feeling more competent to care for her. Sleeping through the night was the first big milestone. That helped tremendously to get some rest on my part. But we learned how to communicate I think."

C. CHAPTER SUMMARY AND CONCLUSIONS

Mothers' awareness of the occurrence of postpartum emotional difficulties prior to their own experience of it came from a variety of sources ranging from lay others (female friends and relatives) to authoritative but non-professional sources (the popular literature on pregnancy and motherhood) to professional sources (physicians and other professional practitioners). Neither the type of source nor the content of the information obtained had a strong effect on mothers' help-seeking and emotion-work behaviors aside from encouraging individualistic remedies. By and large women did not connect their information about postpartum difficulties with their own feelings and behaviors. This may be due to the influence of powerful gender and motherhood norms that lead women to anticipate only positive feelings after having a child.

Both the information women had about postpartum depression and their processes of help-seeking and emotion work increased the likelihood that medical social control could be imposed. Women sought information that would enable them to interpret their feelings in a non-stigmatizing
fashion. Virtually none of the information women were exposed to on emotional difficulties in the postpartum period led them to question the configuration of the mother role, making individualistic explanations more likely. Of the individualistic explanations that are available, medical explanations offer the advantage of locating the source of emotions in organic phenomena like hormones. Identifying a physical cause over which women have no control makes it less likely that women will be stigmatized and blamed for their difficulties. As the leading process of help-seeking pursued by mothers, physician consultations also extend the potential for medical social control over women's discrepant emotions. However, from mothers’ accounts it was apparent that physicians did not exert this control through medical intervention, but through reinforcing norms for appropriate maternal behavior.

These findings suggest that part of the attraction to medicalization from the lay perspective of mothers is that it supplies a neutral label for feelings and behaviors that might otherwise elicit moral condemnation. Postpartum depression and the "baby blues" are more culturally acceptable labels for discrepant emotions in the postpartum period than are the labels "bad mother" or "unfit mother". The variety of discrepant emotions most likely to be morally condemned and therefore prone to medicalization are those involving violations of gender and motherhood norms. The
most significant factor working against the medicalization of postpartum depression stems from mothers' dissatisfaction with the outcome of the majority of their medical consultations and treatments for these problems.

The examination of mothers' patterns of resolution for their postpartum difficulties appears to conform more closely to Thoits' model of emotion work than to models of illness behavior. Thoits' theory contains two elements not present in theories of illness behavior that extend its applicability. First, it encompasses a wide variety of resolution processes rather than focusing solely on medical consultations. Secondly, it allows for the possibility of self-labeling processes in addition to the possibility of professional labeling. Thus it accounts for processes that lead to medical consultations, as do theories of illness behavior, while also explaining why many instances of emotional deviance may be managed totally outside of the health care system. The contribution of a self-labeling approach to models of medicalization will be taken up in the final chapter of the dissertation following the analysis of professional conceptions of postpartum disorders.
CHAPTER V
PHYSICIANS’ CONCEPTIONS OF POSTPARTUM EMOTIONAL DIFFICULTIES

"...when a veterinarian diagnoses a cow’s condition as an illness, he does not merely by diagnosis change the cow’s behavior to the cow, illness remains an experienced bio-physical state, no more. But when a physician diagnoses a human’s condition as illness, he changes the man’s behavior by diagnosis: a social state is added to a biophysical state by assigning the meaning of illness to disease. It is in this sense that the physician creates illness just as the lawmaker creates crime, and that illness is a kind of social deviance analytically and empirically distinct from mere disease" (Freidson, Profession of Medicine, 1970).

Its gender-restrictive language aside, Freidson’s illustration touches on key themes appearing in the literature on medicalization: the power of physicians to construct labels and meanings for human experiences that carry the weight of scientific legitimacy, and the social control functions inherent in the mandate of physicians to contain deviance occurring in the form of illness. Until recently, the power of the medical model resulted in unquestioned acceptance of the premise that medical practice is guided solely by the scientific values of rationality, objectivity and neutrality (Mischler, 1981).
Phenomenological and other social constructionist perspectives in medical sociology emphasize the influence of social forces on the practice of medicine, leading to expanded concerns about the appropriateness of physicians serving as agents of social control. If physicians are indeed influenced by subjective factors in their assessments of illness it then becomes important to place medical discourse and medical practice in its social context. Along these lines Wright and Treacher (1982) suggest that social scientists treat as problematic topics in medicine which formerly appeared to be self-evident and uninteresting.

Some authors propose that medicalization, or the re-definition and labeling of social problems as medical problems stems from imperialist tendencies within the medical profession. (Zola, 1986). Other writers argue that such criticisms are extreme—that medicalization is both less pervasive a process and less ominous than has been suggested (Strong, 1979). Few specifics are known about how medicalization proceeds, the forms it takes and its effect on those whose behavior has been reconceptualized in medical terms. Even less is known about the interaction of other processes of social control, such as the containment of gender violations in women with the medicalization process. In this chapter these are the issues that will be treated as problematic.
A phenomenological perspective calls attention to the behavior and subjective reality of the imputers of deviance as well as those who engage in the deviant behavior (Conrad and Schneider, 1980). Previous chapters analyzed mothers' conceptions of their postpartum emotional difficulties and how they affect their help-seeking and resolution processes. The reports of mothers about their consultations with physicians and other professional practitioners were also reviewed.

This chapter explores professional conceptions of postpartum depression. What factors influence physician perspectives about these disorders? How do social values and beliefs affect the behaviors and attitudes of practitioners consulted by mothers exhibiting symptoms of postpartum depression? Do physicians try to contain emotional deviance on the part of mothers by treating their emotional distress? Or do they fail to recognize and thereby ignore women's problems? What is the extent of the medicalization of postpartum emotional difficulties? These questions and others will be answered by analyzing two sources of medical information about postpartum disorders: the accounts of practicing physicians, and the conceptions found in the medical literature.
A. INFLUENCES ON PHYSICIANS' CONCEPTIONS ABOUT POSTPARTUM EMOTIONAL DIFFICULTIES

As with the reconstruction of lay knowledge and beliefs about postpartum depression in the previous two chapters, I shall begin by summarizing the sources of professional knowledge in order to assess their effect on the behavior and attitudes of medical practitioners. All of the physicians interviewed had information about the occurrence of emotional difficulties in the postpartum period, although several felt they had little understanding of these problems. A variety of sources of information were cited. Almost none of the physicians remembered lectures on postpartum emotional difficulties or related subjects in medical school, although a few recalled discussions of cases during internship or residency. Some recalled an article or articles in professional journals or a brief mention in an obstetrics or psychiatric text. Some reported forming their own client-based assessments of postpartum disorders based on interactions with their patients. A few interviewees reported making an effort to specialize or gain more expertise in this area because of an interest sparked by problems they observed in their patients or because postpartum disorders formed an interesting bridge between professional interests in OB-GYN and psychiatry. Finally, a surprising number were influenced by personal experiences.
with emotional difficulties in the postpartum period.

The lack of attention to postpartum emotional difficulties during medical training was consistently mentioned by the physicians who were interviewed. One male OB-GYN who was the head administrator of a university department of obstetrics and gynecology had this to say:

"We talk to medical students about it. We don't have a formal lecture topic on it. In individual discussions we talk about it."

Another male OB-GYN with a background in psychiatric research made this observation about the dearth of information presented on postpartum depression in medical school:

"We don't have a course that involves the feelings of pregnant women and spend very little time in the curriculum on it...all of us have had to kind of learn this on our own, and if we're not very sensitive, we're not going to learn it at all. We don't have anything on family living and on family life, and we're in a profession where the mortality rate is abnormally high because of the stresses."

A female family practitioner stated that her introduction to postpartum emotional difficulties didn't begin until she was exposed to the "real world" of medical practice during residency:

"I honestly don't remember a thing in medical school. I do remember a significant amount more in residency simply because I did obstetrics in my three years of residency, and so as a family physician trained in
OB-GYN, especially being trained in treating the whole family and psychosocial problems, that became very important. . . . So basically it was more after medical school and out in the real world."

Several physicians recalled reading something about postpartum affective disorders, although most could not remember any specific citations. Some assumed that the topic is covered in major OB-GYN and psychiatry texts. However one female psychiatrist who looked up postpartum depression in a psychiatry text just before the interview reported that it contained all of two lines out of 3,360 pages of text, and these were devoted to postpartum psychosis. A male family practitioner looked up postpartum depression in a new edition of a leading obstetrics textbook during the interview, fully expecting to find a lengthy discussion of these problems. He was surprised by the brevity of the reference that he found:

"Let's see if Williams has anything. I'm sure it does. This is a new copy--I'm sure they're together enough to at least have something on postpartum depression in it. There you go--one paragraph. That's it. That's the textbook in obstetrics."

Four of the physicians interviewed considered themselves to be experts on the phenomenon of postpartum affective disorders. One was a psychiatrist whose career began in internal medicine and maternal health, one was an obstetrician-gynecologist/psychiatrist, one OB-GYN had done
research in psychiatry, and one family practitioner developed an interest in women's emotional responses following childbirth through his training in holistic medicine. The male OB-GYN/psychiatrist explained how the carry-over between his OB-GYN practice and his interest as a psychiatrist in affective disorders led him to research and write about these problems:

"Well, during my residency and also during the time I was a full-time faculty member in psychiatry, I spent a great deal of time, most of it self-education, and also attending lectures, reading, and writing papers in the area of affective illness. And I gained my experience and expertise as a result of that. I learned little or nothing additionally about it, except by experience in my residency and subsequent practice. And I've recently reviewed the literature on this topic as part of a chapter preparation for a text on obstetrics that I just completed."

The female psychiatrist who started out in internal medicine pursued an interest in postpartum disorders during her residency in psychiatry because of her background in maternal health issues:

"Well, I did my training in internal medicine and then went back in 1967 to do a residency in psychiatry. I had already been doing medicine. But I had worked for many years in Planned Parenthood and maternal health. So I went back to a training program in 1967 in psychiatry and while I was there I did all the consultations for the OB-GYN service, so that's when I became interested. I was the person who did all the training."
For the most part, medical practitioners do not receive their information on postpartum depression during medical school. For psychiatrists, OB-GYN's, and to some extent family practitioners, their awareness tends to come later after they have begun medical practice. Even then, practitioners who are personally motivated to learn more about these problems have the most information and are most knowledgeable about the recent research findings. Pediatricians have the least information and, to some extent, this seems logical given their patient population. The lack of knowledge on the part of pediatricians may also explain why so many women have problems that are never presented to practitioners. While some women visit family practitioners rather than pediatricians for infant care, for many women the only professional medical contact they routinely have after the birth of their child is a pediatrician. Furthermore, the attention of these professionals is focused on the child and not on the mother.

Fully one-third of the doctors who were interviewed mentioned that personal experiences and observations of postpartum emotional difficulties were significant in the development of their awareness of and sensitivity to these problems. For one male pediatrician, his wife's bout with depression after the birth of their last child led him to believe that social factors are primarily responsible for
discrepant feelings:

"My wife had some problems after her delivery. Part of ours, I know, was because I was still busy and so I wasn't there to give her some support that she really wanted me to give. This was her third pregnancy, so it was tougher for her physically to get back to feeling good with this one than with the others, and that depressed her."

A female psychiatrist specializing in children's emotional problems developed an interest in postpartum disorders partly due to her close friendship with a woman who had experienced PPD:

"I had a kind of personal experience. I had a very close friend who was a very intelligent, very successful woman. When she had the third baby she was really incapacitated because of depression. When I got acquainted with her, she told me about how she was mistreated—not abused or anything. How she was not treated properly by male psychiatrists."

The personal interest she developed led her to consult with the director of the adult affective disorders program at the university hospital where she worked. He told her he had no experience with these types of disorders. His responses to her questions convinced her that the statements made by her friend were well founded:

"I was kind of surprised to hear that, so I asked him 'Where do these women go?' But he didn't have any idea how these women are treated or how they are recognized. So that is where we are."
A male OB-GYN found that his own emotional response to lifestyle changes after he and his wife had a child influenced his conceptions of postpartum difficulties. He also reported that he became more sympathetic to his wife’s feelings as a result:

"Adjusting to a child was new to me, because I had been foot-loose and fancy-free and then all of a sudden we have this child. The thing is you’re socializing with the boys, and then you’re called on: ‘Look why don’t you babysit?’ I think that my wife adjusted more so than I did. She went back to work in six months. The time that was difficult for her was the separation when she went back to work. I could tell that she was a little bit distressed about leaving the little one and going back to work."

A female family practitioner and mother who did not experience emotional hard times after birth reported seeking out lay-oriented sources of information on postpartum emotional problems rather than medical information during her pregnancy:

"When I was pregnant I read everything I could, and that’s really when I heard about postpartum depression. I didn’t read medical journals though, but popular things, baby magazines and women’s magazines. Here I was a doctor but I was getting most of my information about how I was going to feel after having the baby from women’s magazines. It’s kind of ironic, isn’t it?"

Fitzpatrick observes of general medical practice that it falls somewhere between formal medical knowledge and lay ideas. Doctors are influenced by folk models of medicine in addition to their professional training (1984). Friedson
(1970) also remarks upon the influence of subjective factors and the social characteristics of physicians on their inclinations in the diagnosis and management of various disorders. The findings presented above confirm the influence of personal experiences and lay sources of information on practitioners’ conceptions. Yet, as we shall see, it would not be appropriate to conclude that physicians’ conceptions simply mirror those of laypersons.

B. THE NATURE OF PHYSICIANS’ CONCEPTIONS OF POSTPARTUM DISORDERS

Physician conceptions of postpartum depression were clearly influenced by the imprint of their medical training even if that training did not involve much information on postpartum emotional problems. Most doctors characterized postpartum disorders in terms of the three-tiered definition that appears frequently in the medical literature. It was therefore common for physicians to make distinctions between the baby blues, postpartum depression and postpartum psychotic reactions, even if their terminology varied somewhat from these labels. The same female family practitioner who sought out information from women’s magazines and baby magazines during her pregnancy described her conception of postpartum disorders in these terms:

"I view it as an event that is kind of like a spectrum. Some women experience it in very mild forms and other
women experience it in psychotic forms, so there is a real wide variance that I've seen and heard about."

Another female family practitioner had the following conception of postpartum emotional problems:

"Postpartum depression is a 'catch-all' phrase for several different entities - anywhere from the postpartum blues that I see a lot of patients experiencing for a lot of different reasons, to severe incapacitating technical true depression, where somebody is catatonic and not functioning."

One difference between physician's professional conceptions and mother's lay conceptions was the fact that to physicians, labels for postpartum emotional disorders had very precise definitions. For example, many differentiated between a true clinical depression and a depressed mood. A male OB-GYN noted the distinction from his perspective:

"There are two major divisions in depression. There's the depression where the patient is really depressed and suicidal and has just a total break with reality. And that is certainly the more serious kind. And there's the kind where you just can't get the old motor running, and you just can't get going. You're down and crying. You're upset easily..."

For many physicians, especially those who were familiar with psychiatric definitions, the diagnosis of the type of disorder depended on the precise nature of the symptoms and their timing. Physicians frequently made reference to the definitions for psychological disorders found in the American Psychiatric Association's Diagnostic and
Statistical Manual of Mental Disorders (DSM III), even though postpartum disorders are not listed separately in this compendium. The following definition for postpartum depression, given by a male pediatrician, is typical of medical definitions in its specificity of symptoms and the timing of their appearance:

"Symptoms that a mother will demonstrate or exhibit in the immediate postpartum period up to essentially four or six weeks. Associated with the delivery of a baby the mother may either reject the child or have periods of excessive moodiness or inability to function well in her normal capacity either as a mother or wife or just have a lot of feelings of inadequacy due to decreased energy level."

It is also interesting to note the differences between this definition and the descriptions given by mothers of their postpartum difficulties. Mothers depicted their postpartum difficulties in terms of troubling feelings and conflicts they experienced rather than as symptoms or dysfunctional behaviors. This definition, in contrast, relies heavily on the inability of the woman to function as a mother or as a wife. In this sense it exerts a social control function by negatively sanctioning undesirable role behavior in women. It also fits the model of the sick role developed by Parsons where the inability of the individual to carry out normal role obligations is of major concern.

Physicians were not, however, completely unified in their views of postpartum conditions. Friedson points out
that variations in the stability and objectivity of the corpus of medical knowledge lead to wide variations in how physicians label and manage the same conditions (1970). When subjective and experiential influences are taken into account the possibility of medical variations is increased even more. Physicians were divided over whether postpartum conditions should be regarded as distinct clinical entities and whether or not the various postpartum reaction types are related. Some, like the following male OB-GYN/psychiatrist, argued that postpartum emotional disorders are not distinct from other emotional or psychiatric problems:

"No, there is no data to support that. The data that is available suggests that it is simply a major depression occurring in close relationship to the termination of a pregnancy or at near term."

Those who adopted this position felt that the only distinctive feature of postpartum depression is its appearance following birth. Others felt that postpartum difficulties do represent distinct clinical entities, usually citing the presumed role of hormones in the etiology of these problems. The perspective of the following male family practitioner was typical of those taking this view:

"It definitely is a distinct clinical entity. Depression is a term that applies to someone who's emotionally distraught, either extrinsically or intrinsically. And I think in postpartum depression, some of that may be intrinsic and some of that may be
extrinsic. That is, there may be some hormonal changes
that also influence what is increased responsibility—
taking care of a newborn—and something that can also
affect the family situation..."

Others were more divided in their opinions on this
issue, arguing that psychotic postpartum reactions are
distinct clinical entities while the more mild symptoms
associated with the baby blues are not true clinical
entities. This view was taken by one female psychiatrist who
was quite strong in her belief that postpartum depression is
a clinical entity. However, because she used a restrictive
medical definition for depression, she felt that postpartum
reactions that do not involve full-blown symptoms of
depression or of psychosis should not be regarded as
clinical entities:

"Oh well, that is something else. The baby blues is
what occurs on the third to fourth day in 80% of women
cross-culturally. And that is a very common feeling of
feeling low, let down, anti-climactic, crying, feeling
sad. I don’t put that into the classification of a
postpartum depression."

This view was seconded by a female family practitioner
who recognized classic symptoms of depression as distinct
clinical entities:

"I don’t think I’d have any trouble pointing out a real
clinical, full-blown depression as a clinical entity,
where somebody is not eating, sleeping all the time,
or not sleeping at all—you know, fitting the DSM
classification of depression."
Similar variations in physician conceptions appeared in the recognition of symptoms associated with postpartum depression. Again, a division was apparent between those using a formal set of clinical definitions versus those relying more on informal, experiential means of recognizing difficulties. Characteristic of those preferring formal, clinical definitions, the following male OB-GYN first described a profile for what he termed "neurotic postpartum depression" and then a profile for "psychotic depression:"

(Neurotic depressives): "These are people that are tired all the time. They have insomnia or they sleep too much. They're constipated or they have body function disorders." (Psychotic depressives): "They might consider hurting themselves. They might consider hurting the baby. They can have serious weight loss, hallucinations. They've lost normal human relationships."

The male OB-GYN/psychiatrist who wrote a chapter on postpartum depression for an obstetrics textbook also used a formal clinical definition of depression to illustrate the types of symptoms he recognizes as PPD. He spoke of a constellation of symptoms that may include "irritability or blueness or sadness," as well as "other vegetative symptoms of depression," like the following:

"Interruption or impairment in sleep, difficulty concentrating, loss of interest, cheerfulness, morbid ideation, loss of appetite or weight or increased appetite or weight."
A female OB-GYN used a different set of criteria for identifying postpartum depression that more closely resembled the informal lay definition of depression—or what several other physicians in the study referred to as "depressed mood." She also believed postpartum depression to be no different from any other type of depression:

"I think the same as depression in anyone else, inability to do their normal daily routine, being depressed, out of sync with what's really happening. Things seem to affect them a lot more. You know, they have crying, can't get out of bed, just seem unable to perform daily routine tasks. It may be related to their baby, but I think the depression symptoms are the same no matter when you see it."

Finally, some physicians totally opposed common medical conceptions of PPD, either because of a belief that the definitions are too imprecise, or because they questioned their scientific validity. One OB-GYN with a background in psychiatry objected to the overuse of the term postpartum depression, even among physicians. To him, PPD is an extremely limited clinical phenomenon involving full-blown symptoms of depression. In his view other types of postpartum reactions are primarily adjustment difficulties stemming from exhaustion:

"...it looked like most people were viewing postpartum depression as simply depression in the postpartum period. And the coding for that was situational depression, which is what I think it is...The thing that everybody calls the postpartum blues kind of
Another physician, an older OB-GYN who was at the time of the interview the chief administrator of a university medical school department, drew on his long years of practicing medicine and his experience working at a "bush hospital" in Africa to challenge common medical labels for postpartum disorders:

"The label postpartum depression is a bad label. I think it's supposed to mean something and it doesn't. We haven't really defined it very well....Postpartum depression most appropriately refers to someone who's had a psychotic break and ends up needing psychiatric care - but it's all a matter of degree. So if all women have it, the degree component of true postpartum depression is very rare and unusual in the classic sense. What we're talking about is a spectrum - a spectrum of a problem the most overt of course is true postpartum depression."

Data from interviews with physicians offer little evidence that postpartum emotional disorders have been medicalized, as would be predicted from Conrad and Schneider's medicalization model. While it was true that some physicians leaned more toward a medical or psychiatric perspective this was not characteristic of practitioners as a whole. Rather, many physicians are influenced by lay conceptions of postpartum difficulties. In order to more fully assess the extent of the medicalization of postpartum emotional difficulties by practicing physicians, two...
additional components of medical ideology and practice will be compared. Physician views on the etiology and treatment of postpartum depression offer the most direct evidence of the progress of medicalization as the new paradigm for these disorders.

The majority of the doctors believed the etiology of postpartum emotional disorders to be both social and biochemical. The next most commonly mentioned conceptions of cause were those that were exclusively social in nature. Next were those who said they had no idea of the cause of postpartum emotional difficulties, and finally the least frequently cited conceptions of cause were those that were exclusively biochemical or medical in nature. There were no discernable patterns among those arguing for one conception of etiology versus another; medical speciality, sex of the physician, and type of practice were not predictive of the positions taken by doctors on this issue.

Those who adopted a multi-dimensional theory of the cause of postpartum emotional difficulties argued that hormonal shifts following pregnancy set the stage for emotional problems. When various stresses occur for which the new mother may be unprepared or if she is inadequately supported, problems may occur. A female psychiatrist made the following observation about the causes of these problems, drawing an analogy with premenstrual syndrome:
"I think they're both involved (hormones and social factors). As in premenstrual syndrome, I think they both contribute. Hormonal variations, biochemical. There's some beautiful diagrams showing how hormones have a positive/negative feedback via the brain, the hypothalamus. Stress causes changes in the biochemistry of brain and hormones. I couldn't say whether one's 40% and one's 60%; I think they're both involved."

A female family practitioner's conception of cause involved biochemical and social components. She particularly believed that the milder postpartum disorders were hormonally induced, and cited their timing as an empirical justification:

"I would suspect that they're going to find out that it's multifactorial. I don't think you can confine it to one thing in particular. I know that, just from personal experience, hormones fluctuate so greatly that I can't help but think that part of it, especially the milder symptoms, is just the normal let-down of hormones. From my understanding, rarely do they see it before that third postpartum day, which would kind of correspond to the level....I'm sure it has to do with home environment or previous experiences, previous interactions with their own parents--probably a lot of different reasons."

The majority emphasized the role of social factors over biochemical influences in the development of emotional problems after childbirth. For example, one male pediatrician identified both sets of influences as having equal influence over emotional difficulties: "I do not believe anyone has been able to show one having more of a role than the other." Yet he went on to elaborate at length about the nature of the social influences throughout the
interview. The influence of hormonal factors was presumed and was not elaborated in the way the presumed social influences were:

"...women now have more expectations of themselves and may not be as comfortable with restrictive lifestyles or restrictive exposure to different career opportunities. This can lead to distress and disturbance. Mothers who are now at a point of high level education and have been in a career field and then have children feel real intense double bind situations, where they have—I can't explain why, I think it's hormonal—real attachment needs for the child. But yet they feel such emptiness when they're not back in their career field and they have a lot of guilt feelings about leaving the child and going back to work."

Those who held to a purely social explanation for the occurrence of postpartum emotional disorders emphasized stresses upon individual mothers and role strain in the process of adjusting to motherhood as significant. The following female OB-GYN articulated this explanation:

"It's such a complex thing. It's the social situation. It's the support. It's the person's personality and her ability to come to grips with life, her ambivalence about pregnancy, what that means for her in terms of lifestyle changes, how tired she gets, how physically able she is to do whatever she needs to do."

Several of those arguing for a purely social conception emphatically rejected hormonal theories, some because of what they felt to be a lack of scientific evidence to support such theories, and others because they object to the over-medicalization of women's emotional states. The former
position is exemplified in this statement from a male OB-GYN:

"I don’t think anyone has truly substantiated in a hormonal way that dealing with large doses of progesterone is going to alter this... There have been no randomized studies, so it is terribly unscientific."

Both positions were evident in the conception of the following male OB-GYN:

"I don’t think hormones have a thing to do with it. I think that hormones are the convenient scapegoat of everybody who wishes to say something about women—it always comes back to their hormones.... I don’t know that anybody has shown that women who bottle feed have less depression than women who breastfeed, and yet their hormones are more normal."

The minority of physicians arguing for a purely medical and biochemical etiology emphasized hormonal and other physical changes occurring in women after birth. The following view of causation was given by the OB-GYN-psychiatrist who wrote the chapter on postpartum emotional disorders:

"There seem to be enough data supporting the notion that there is some alternation in neurotransmitters in the brain that affect affective functioning on a variety of levels. And these may be transmitters involving serotonin, dopamine, norepinephrine, or other transmitters. And their alternation may be related to the endocrine changes that occur following delivery..."

Another male OB-GYN was equally certain about the relationship between emotional difficulties following birth
and hormonal fluctuations, although the evidence he presented was far less conclusive. Interestingly he concludes his comments about the role of hormones by pointing out an apparent inconsistency. Despite the prominent emphasis on the role of hormones in biochemical conceptions of cause, few physicians prescribe hormones as a treatment:

"I feel that it's probably related in some way to the low estrogen levels that are present after delivery. It especially could be prolonged in someone who might be breastfeeding. It possibly could be related to... premenstrual syndrome. And I think a lot of those characteristically have postpartum depression. And again I think that's hormonally related. I don't know on what other basis it would be on. But we don't treat it hormonally."

To conclude, most practitioners had views on etiology that included social elements. Only two physicians held to purely biochemical views of causation. Because of the close relationship between treatment modalities and theories of etiology, we would expect social remedies to predominate among the physicians in the study, and this was the case. Because few of the physicians had much experience treating postpartum difficulties many answered questions about preferred treatments on a speculative basis. Thus, they described what they would do if a patient in their practice consulted them about emotional problems after the birth of their baby.
C. PHYSICIAN RECOMMENDATIONS AND TREATMENTS FOR POSTPARTUM DISORDERS

The majority of the treatments physicians said they would recommend to a woman reporting emotional difficulties following childbirth were non-medical. These included referrals to psychologists or other mental health practitioners, the provision of emotional support and reassurance in conversations with the patient, referrals to support groups or other supportive counselors (such as ministers), and recommendations for situational adjustments or regimens that might help to alleviate the symptoms. A minority of the physicians recommended medically oriented treatments that included prescribing anti-depressants and making referrals to psychiatrists.

More than half of the physicians indicated that they would recommend an appointment with a psychologist or other mental health professional to women who appeared to be experiencing persistent and troubling symptoms of depression and other emotional problems. However, a number of those who had made such recommendations reported that few women followed through on the referral and made an appointment, even in cases where a counselor was available in the same building. The following female family practitioner experienced this conundrum:
"In some people where it is more severe...I usually try and recommend some type of counseling, but I have to tell you that I have not had one person follow up on it yet, and we have a counselor right here in the office."

Most physicians reported that the particular therapeutic remedy would depend on their assessment of the severity of the situation and the time constraints on their appointment schedule. A female internist indicated that her ideal conception of a treatment for postpartum emotional difficulties would be for the woman to seek emotional support and advice from other women who had experienced similar problems. Given the unavailability of such support groups, she would begin by discussing the problem with the patient herself on a limited basis:

"If it's something you feel you can talk out in 15 minutes and then walk away feeling refreshed and the patient feels good, then I do not make the referral."

However, if the problem seemed to be something that would not improve through informal discussions and support she would make a referral. The type of referral would depend on her assessment of the underlying difficulty:

"If I thought the patient truly had what I think is postpartum difficulty in adjusting, I might refer them either to mental health for assistance, or again to a gynecologist, if I thought it were obstetrically related."
A number of physicians felt that they had helped women by providing support and reassurance and by making simple suggestions for improving the stresses of the home environment. One female family practitioner recounted providing the following types of support and reassurance to her female patients:

"A lot of times it's nothing more than saying, if it's mild, 'Yea, a lot of women experience this.' It's a good supportive type of thing for them to know, that most likely it will pass and you need to get plenty of rest, eat nutritiously, take time out for yourself. Give them that support and encouragement and in the majority of cases, the women that I see, it's a mild form and it passes."

A male OB-GYN mentioned providing similar types of reassurance and referrals to his patients with postpartum emotional difficulties:

"I let them know that this is a very common situation and it will pass. Sometimes you can simply say, 'Look, I think you're doing everything all right, except you're not getting enough sleep...let the dust bunnies collect. Forget the announcements. Your main concern is you and the baby, and that's the only thing I want you to do.' 'Thank you,' they say to me, as if they needed somebody to tell them to do that because they were really unable to do that themselves..."

He also raised the difficulty of finding time in a full schedule to help patients to explore their feelings, and said:

"You don't really have time to help aim those patients in the right direction. I don't have time to correct
their problem. I don't think I'm really equipped for that. But I do have time to pick them up and say I think you really need to be seeing a counselor here to help you if these feelings are really significant."

Fewer physicians recommended medically oriented therapies for women with postpartum emotional disorders, and most were clear that these remedies were only appropriate for women with severe and incapacitating difficulties. Those recommending the prescription of drugs connected the type drug with the precise nature of the symptoms. Since most focused on depression, the category of drugs mentioned most frequently were anti-depressants. An OB-GYN/psychiatrist discussed three categories of drugs for what he regarded as three typical categories of psychiatric difficulties that occur in the postpartum period:

"For a major affective syndrome, the best treatment supported in the literature is, if it's a major depression, would be with anti-depressants. If it's the development of a manic syndrome, as can be seen in bipolar illness, then lithium carbonate is the treatment of choice. If people have a schizophrenic reaction following delivery then the appropriate treatment would be a phenothiazine-type drug—a major tranquilizer."

Significantly, this physician and others also mentioned support and counseling as appropriate for milder postpartum difficulties and as an important addition to drug therapy for women with more severe problems:

"Well, for postpartum blues, simply support, empathy, and education are all that is necessary. Every
individual is different, and some people do have psychological factors that influence any illness, whether it be a depressive syndrome or cancer of the cervix. So appraising an individual in the context of their other relationships and themselves is always important. But that needs to be done on an individual basis."

Several physicians said they would refer a patient to a psychiatrist in instances where severe and potentially dangerous symptoms were present (e.g. for those with apparent suicidal tendencies). Such referrals were also mentioned by those who believed psychiatrists to be the most appropriate prescribers of psychotropic drugs and in situations where the symptoms continued on for a long period of time. One OB-GYN who said he would prescribe anti-depressants for a severe depression mentioned that he would refer the patient to a psychiatrist if the drug therapy seemed not to be working:

"The ones that go beyond that point (one month) usually will need psychiatric care."

Five physicians—the same number as those advocating the prescription of anti-depressants and other mood altering drugs—were strongly opposed to such drug therapies for women with postpartum depression. For some, this was a matter of custom. They generally tried to avoid prescribing mood altering drugs for their patients and were only willing to do so as a measure of last resort. This was the case with one female psychiatrist who would only prescribe anti-
depressants if other non-medical remedies did not work:

"I'm very loathe to use medication in a woman who's either pregnant or nursing her baby. And I will see them quite regularly, talk to them, be supportive, bring a lot of family support. If it doesn't respond to that, then I think maybe they need some medication. We find a number of women, who getting a good night's sleep for three or four nights feel much better."

For others the aversion to anti-depressants stemmed from concerns about the intrusiveness of such therapies and concerns about their safety. Those who raised these concerns often talked about the possible side-effects of psychotherapeutic drugs and indicated reservations about medicating unhappiness they felt was socially induced. A male OB-GYN placed himself in this camp:

"I'm into taking patients off of medication rather than putting people on. I think the psychotherapeutic drugs are drugs that are so open to dangerous misuse, and being on the pharmacy and therapeutics committee, that stuff scares the life out of me. Those things are dangerous drugs."

D. SUMMARY AND CONCLUSIONS: THE CONCEPTIONS OF PRACTICING PHYSICIANS

The findings indicate that practicing physicians are not aggressively engaged in the medicalization of women's emotional states. A number of factors seem to work against such a process. The lack of formal medical training on postpartum disorders, the influence of personal experiences on practitioners' conceptions and the absence of clearly
identified medical treatments lead practitioners toward views of etiology and treatment that are largely nonmedical. While doctors' conceptions are distinguishable from lay conceptions by their location in a medical frame of reference, there is a lack of unity in the way practicing physicians conceive of and treat postpartum disorders that also works against the expansion of medicalization. These findings are congruent with Strong's position that medicalization is unlikely when financial incentives are absent and when effective medical treatments for social problems do not exist: "...in a situation where professionals of very low status are presented with vast numbers of patients with whom they can do little, demedicalization, not imperialism, is the strategy which serves their interests best—and also, perhaps, those of their patients (1979:210)."

The one way in which practitioners do exert social control over mothers' deviant emotions is through their willingness to indicate the parameters of appropriate maternal behavior. Doctors conceptions were in many instances influenced by assumptions about appropriate role behavior for new mothers. The authority of physicians to act as moral entrepreneurs thus places them in a position to label deviant behavior in mothers, and their behavioral prescriptions may be viewed as a limited form of medicalization.
If practitioners are restricted by the extent to which their role enables them to medicalize women's discrepant emotions, are there other forces in the medical profession pushing for the more aggressive medicalization of these conditions? In order to answer this question I now turn to an examination of conceptions from the recent medical literature.
CHAPTER VI

CONCEPTIONS OF POSTPARTUM EMOTIONAL DISTRESS

DEPICTED IN THE MEDICAL LITERATURE

As in any profession, the professional literature of medicine serves as a barometer of the current state of the field. It provides an up-to-date assessment of the thinking of leading researchers and practitioners, serves as a forum for the resolution of professional debates and disagreements, and influences professional readers by informing them of recent innovations in thinking and practice. Fitzpatrick (1984) describes a gulf between the clinical practice of medicine and what is described in the professional literature of the field: "...those who have sharply contrasted the medical model with lay perspectives may have failed to recognize the major differences that exist between medicine enshrined in textbooks and clinical practice." As we have seen, part of the discrepancy may be attributed to the impact of lay influences on the conceptions of practitioners.

Other researchers have analyzed the content and development of professional bodies of literature in order to
assess their ideological biases and social control functions. For example, Scully and Bart analyzed gynecology textbooks in order to reveal their depictions of female sexuality and prescriptions for female gender role behavior (1978). This segment of the dissertation assesses the conceptions of postpartum emotional difficulties found in the medical literature. The analysis focuses on the nature of gender prescriptions and explores the extent to which these conditions are medicalized.

Few relevant medical sources discuss postpartum emotional disorders. Even medical writers have commented that there is too little discussion of postpartum psychological difficulties in the literature of the medical profession (Pauerstein, 1987; Hamilton, 1984). While the situation has improved in recent years, a professional reader would have to search persistently in order to be well informed about current thinking on these problems. The information that is available is not totally consistent, although as we shall see there is more consistency to be found here than in the conceptions of medical practitioners. Most of the standard texts used in medical school and referenced by practitioners include little coverage of postpartum emotional disorders. For example, the venerable and often cited Williams' Obstetrics (Cunningham et al., 1989), in its 18th edition at the time of this writing, still devotes only one paragraph each to postpartum blues.
and postpartum psychosis.

In this chapter I begin by exploring areas of agreement and disagreement in the conceptions of postpartum emotional problems found in the medical literature from those of practitioners. Next the theories of cause and recommendations for treatment that are found in the literature are explored. Finally the activities of lay and professional activists who advocate the medicalization of postpartum disorders are examined.

A. HOW CONCEPTIONS FOUND IN THE MEDICAL LITERATURE DIFFER FROM THOSE OF PRACTITIONERS

One area in which there is general consensus between practitioners' conceptions and those found in the medical literature is the overall conceptualization of the varieties of postpartum affective disorders. Many authors recognize a three-tiered typology of women's emotional disorders following childbirth: the baby blues, postpartum depression and postpartum psychosis. On the less severe end of the continuum are the baby blues, also called the postpartum blues, maternity blues, third-day blues, and puerperal blues. Some writers also refer to these symptoms as transitional situational disturbances and adjustment disorders, following the classification system of the DSM III, which does not recognize postpartum disorders as distinct clinical entities. The following definition from a
textbook on high-risk obstetrics is typical of conceptions of postpartum blues found in the medical literature:

"The postpartum blues syndrome is a transient, mild depressive episode which is relatively benign, self-limiting, and ubiquitous. It is known to other cultures, and is a well-established recurring phenomenon occurring anywhere from the 3rd to the 10th day postpartum. It is characterized by a general state of dysphoria, marked by a lowered threshold for crying, fatigue, anxiety, irritability, deactivation, insomnia and a mild confusional state affecting cognitive functions in some women (Cetrulo and Sbarra, 1984)."

The authors who mentioned postpartum blues often cited its frequent occurrence (estimates of incidence range as high as 80 percent) and its documentation as a cross-cultural phenomenon to justify a conception of these experiences as a normative part of the adjustment to motherhood (Sciarrà, 1989; Cherry et al, 1985; and Brown, 1979).

Next in the typology comes postpartum depression, also referred to as puerperal depression, postpartum neurotic depression, puerperal neurosis, and adjustment disorder with depressed mood. This mid-range level of psychological disturbance was not mentioned in every source—some categorized depressive symptoms in the two other categories depending on their degree of seriousness. The fewer specific references made to these manifestations is probably due to the more formal orientation of conceptions in the medical literature which tends not to recognize depressed mood as a
distinct clinical entity. The following definition from a psychiatry text dealing with psychological care in pregnancy and the postpartum period is typical of the way postpartum depression is depicted when it is discussed as a distinct category:

"More disabling than the transient "postpartum blues" and considerably more common than the flagrant postpartum psychoses are a group of poorly defined depressive type symptoms which have their onset in the early postpartum months and which can persist for more than a year....The information available suggests that 10 to 20% of women develop a depressive type syndrome after delivery which persists for more than a few weeks. The symptoms most commonly noted are tearfulness, despondency, feelings of inadequacy, guilt, anxiety, irritability, fatigue, and anorexia (Brown, 1979)."

Despite the fact that the reported incidence of postpartum psychosis is relatively rare (estimates suggest that from 1 to 2 per 1000 women are affected), these disorders by far receive the most coverage in the medical literature. Postpartum psychotic disorders are also sometimes called puerperal psychosis, puerperal mental illness, postpartum perplexity, and atypical psychosis. A text on postpartum psychiatric disorders defined these severe manifestations of postpartum states in this way:

"The gravest form of postpartum psychiatric disorder is postpartum psychosis. As has been cited, it occurs with a frequency of one to three per 1000 births. The disorders begin within the first six weeks postpartum, with the highest incidence between days three and fourteen. The illness is characterized by insomnia, restlessness, exhaustion, depression, irritability,
headaches, and rapid fluctuations in mood progressing to a state of confusion, incoherence, and irrationality and ultimately to a full-blown psychotic episode with prominent delirium and mania (Inwood, 1983)."

One major difference between practitioner conceptions and what is found in the medical literature is the absence of obvious lay influences and experiential components in articles and textbooks. The literature is far more oriented to the formal diagnostic categories of the psychiatric profession where self-limiting disturbances of mood are not recognized. The result is an overwhelming emphasis on postpartum psychotic disorders and the neglect and trivialization of postpartum blues episodes. Only one-half of the articles and chapters mentioned the baby blues; most gloss over them as transient and self-limiting conditions and go on to devote far more discussion to psychotic episodes. The trivialization of postpartum blues is evident in the following obstetrics and gynecology text:

"Between the simple, virtually physiological mild third day depression and the true psychoses there is a gamut of neuroses that can occur in the puerperium. Some are trivial and do not require special care....During the first week, and usually on the third postpartum day, 70 to 80% of women encounter a transient depression, often accompanied by tearfulness....The condition is self-limited, and usually vanishes within a few hours or a day (Danforth, 1982)."

The greater adherence to formal diagnostic categories in the medical literature leads to another difference between the conceptions of practitioners' and those of
researchers and authors. Unlike practitioners, who were divided over whether postpartum disorders constitute distinct clinical entities, there is a consistent argument in the medical literature against such a conception. The prevailing opinion is that postpartum psychotic episodes are indistinct from other psychiatric difficulties in their etiology and symptomatology. This view was articulated in a recent text on clinical obstetrics:

"It is now reasonably well accepted that depressive symptoms in the postpartum period are similar, in terms of symptoms, to the depressive syndromes seen at other periods of life. For this reason there is no specific nomenclature in the DSM that separates depression during the postpartum period from that recognized at other times in life (Pauerstein, 1987)."

This view was especially characteristic of psychiatric articles and texts. The following textbook on clinical psychiatry argued that a predisposition to psychiatric disorder is 'touched off by the stresses of pregnancy, childbirth and early motherhood in the case of postpartum psychosis, just as other stressors at pivotal times may precipitate psychotic episodes:

"Mental disorder may be associated with pregnancy or the postpartum period. There are, however, no specific mental disorders related to either of these periods. Latent or repressed psychological material may, under the stress of maintaining physiological homeostasis and of the emotionally significant situation, prove too great for the patient's ego resources with the result that psychopathological reactions occur (Kolb, 1982)."
It should be noted that the view that postpartum psychoses are not distinct clinical entities does not mean that there is less advocacy for medical intervention in these disorders. On the contrary, because there is a vast psychiatric literature on the recognition and treatment of affective psychoses, recommendations for the treatment of similar episodes following pregnancy are nearly identical, although special precautions are often advised for women who are breast feeding.

The clearest divergence of the discourse of medical practice from that of the medical literature concerning postpartum disorders are seen in conceptions of etiology and treatment. Most medical practitioners believed the etiology of postpartum disorders to involve social and biochemical components, followed by those who mentioned exclusively social causal factors. The least frequently mentioned conceptions of cause by practitioners were those that were exclusively medical and biochemical. In contrast, conceptions of the etiology of postpartum psychiatric disorders are nearly reversed in the medical literature, where four general types of explanations for postpartum mental illness are found: organic/biological theories, multi-dimensional theories containing both biological and social components, theories of psychological predisposition to mental illness, and situational/social-environmental theories.
B. THEORIES OF CAUSATION AND RECOMMENDATIONS FOR TREATMENT IN THE MEDICAL LITERATURE

The most common conceptions of cause to be found in the medical literature were organic and biological in nature. These studies emphasize factors such as hormonal shifts following pregnancy, genetic influences, the physical traumas of birth itself, and the impact of sleep disturbances during the postpartum period. The influence of hormonal changes after childbirth on other biological processes was stressed in an article in a British medical journal which specifically stated the organic underpinnings as involving:

"...the possible interaction of thyroid and adrenal function with the high estrogen and progesterone levels of pregnancy and the abrupt termination of these high levels of sex hormones at parturition (Hayworth, 1980)."

The first major article on postpartum disorders to appear in the *Journal of the American Medical Association* emphasized similar biological processes, proclaiming the elimination of social and environmental factors as causal agents after citing inconclusive evidence of their inapplicability:

"With sociocultural and environmental factors largely eliminated as likely causes, researchers have turned for explanation to hormonal and other metabolic events following parturition, including changes in levels of thyroxine, estrogen, progesterone, and adrenal corticoids (Ziporyn, 1984)."
Multi-dimensional conceptions of cause were also common and these contained references to a wide variety of biological and social factors. However, most of these conceptions emphasized the role of the biological factors, only citing the presumed effect of social factors as an afterthought. Representative of these explanations is the following account from a recent textbook on gynecology and obstetrics:

"During pregnancy there are high levels of estrogen, progesterone, and cortisol that terminate at parturition. These hormones also interact with the adrenals and thyroid. The labor and delivery present the body with a generalized physiological stress. There can be dehydration, blood loss, and puerperal sepsis. It remains to be proved whether any of these factors plays a specific role in the genesis of postpartum illness. There is no doubt that there is a generalized emotional and physical stress on the mother, making her adjustment difficult (Sciarra, 1989)."

The third category of conceptions of etiology cite the effects of a personality predisposition to psychological difficulties on the part of afflicted women. These theories revealed the most clear evidence of the social control function of the medical profession and its enforcement of norms for appropriate maternal behavior. Frequently psychoanalytic, these explanations focus on what are believed to be unresolved conflicts in the new mother. Typical of these accounts is the following statement from a textbook on obstetrics and gynecology:
"The pregnant woman who contemplates her relationship with her mother must reexamine her feelings of dependency and learn to tolerate and even to enjoy them. Unless this is done, the new baby's total dependency may be intolerable (Benson, 1982)."

Many of the accounts stressing a psychoanalytic approach find that the "unconscious" underpinnings of these conditions are rooted in a rejection of femininity. The medical community has been slow to react to criticisms of the inherent sexism of such accounts. The following passage appeared in several editions of a popular obstetrics and gynecology text up to the 1983 edition. It was finally removed from the most recent edition in 1987:

"The mother may have unconscious hostility toward the child. It is seen as parasitic, only taking from her life. An immature woman might see it in a symbolic sense as competing for mother's breast; the mother wishes to be a baby herself. A baby can represent femininity and be resented because the woman has not accepted this role (Willson and Carrington, 1983)."

Yet another obstetrics and gynecology text offers a very similar analysis of the relationship between a mother's femininity and her successful adjustment to motherhood:

"...the underlying problem is the disintegration of personality structure, usually associated with personality maladjustment, fear, anxiety, and rejection of the pregnancy. A careful inquiry into the patient's history often shows long-standing problems in making social adjustments and in accommodating to the female role (Danforth, 1982)."
The unstated (and unsupported) logical conclusion of such statements is of course that women who are traditional in their gender role behavior will escape emotional difficulties in the postpartum period. These views direct the attention of physicians to the gender role behavior of their female patients, and suggest that there are "appropriate" feelings, behaviors and emotions that new mothers should display. When these feelings are absent, something is wrong—and when something is wrong, gender violations are implicated. It is unfortunate that a psychoanalytic approach predominates in the one sector of the medical literature that consistently addresses women's social roles. By focusing on the presumed rejection of femininity, these accounts reinforce restrictive gender and motherhood norms and increase the likelihood that mothers will be held personally accountable for their emotional difficulties.

The least frequently mentioned etiological theories appearing in the medical literature are those that are exclusively social in nature. This should not be surprising given the prevailing influence of the medical model over conceptions of cause in the literature of medicine. Some of the situational/social-environmental influences that were cited as causal included inadequate support for the new mother, marital difficulties and other situational stresses, and the strain of new maternal responsibilities. Virtually
none of the articles mentioning social influences adopted a perspective that was critical of the current configuration of the social role of mother. One notable exception to this trend was a recent British text on pregnancy and childbirth that began with this astonishing quote from feminist sociologist Ann Oakley: "The medicalization of unhappiness as depression is one of the great disasters of the twentieth century." The quote sets the tone for a lengthy chapter on unhappiness after childbirth that concludes:

"There is no persuasive evidence to support traditional explanations of postpartum depression: no intrinsic, biochemical explanation of women's unhappiness after childbirth has been uncovered, and psychoanalytic explanations of postpartum depression cannot be validated empirically. Although unsupported with evidence, however, these traditional explanations have reinforced some conventional social beliefs about women....Because many of the social factors leading to postpartum unhappiness are rooted in society's expectations of new mothers, the solutions lie mainly in social change."

As was the case with practitioners, the therapeutic recommendations found in the medical literature were closely connected with the leading conceptions of cause. Three treatment modalities were commonly mentioned in the articles and books. In the order in which they were recommended these were drug therapy, psychiatric referral, and psychotherapy. Some of the articles did not address the issue of treatment or management, and a minority mentioned the provision of emotional support and reassurance by physicians.
Given the disproportionate emphasis in the literature on severe manifestations of postpartum disorders, and the approval of medical intervention as the preferred treatment for such conditions, it is not surprising to find that similar treatments were recommended for postpartum psychotic episodes. One obstetrics and gynecology text stressed psychotherapy and psychotropic drug therapy to be followed by a psychiatric consultation should symptoms persist:

"Brief informal psychotherapy and the administration of appropriate psychotropic drugs suffice for most patients. If there are signs of psychosis and unremitting depression or severe anxiety, prompt psychiatric referral is indicated. After the patient adjusts well enough to get by, consideration may be given to more prolonged insight-oriented therapy (Benson, 1982)."

Some of the articles advocating medical intervention were quite specific about what interventions and which drugs were appropriate for each set of symptoms. These suggestions largely conform with currently favored treatments for the major affective disorders. A book dealing with complications of pregnancy suggested the following responses to symptoms:

"Major depression is best treated with an antidepressant agent or electroconvulsive therapy. Although hormonal treatment for postpartum psychiatric illness has been proposed, there have been no controlled or long-term studies of it. An acute manic episode may be treated with lithium and/or neuroleptic agents.... Even when somatic treatment is required, psychotherapy can still help the patient. She can grasp some of the dynamics, increase her self-knowledge and learn to recognize danger signals in the future (Cherry, Berkowitz, and Kase, 1985)."
A number of articles mentioned psychotherapy as a complement to drug therapy or as a possible preventive measure. As was seen with psychoanalytic conceptions of cause, the underlying assumption of such treatment is the proper adjustment of the woman to the mother role: "The major developmental task for the pregnant woman may be to learn to feel like a mother and function as one (Benson, 1982)." And how does a woman properly function as a mother? Benson tells us that:

"Acceptance of a capacity for mothering as a natural element...is a normal part of psychosexual development. This implies a willingness to accept the giving role as well as the physical discomfort and other sacrifices that pregnancy and motherhood impose on every woman (1982)."

Proper maternal behavior is therefore confirmed in stereotypical terms; mothers are endlessly giving, uncomplaining and sacrificing. Mothers who fail to approximate these behaviors are sick and maladjusted. It follows that women who experience the discrepant emotions and behaviors that are associated with postpartum disorders are in need of psychotherapy. Rather than society offering mothers more support and assistance it is mothers who must adjust to the circumstances of their mothering. By applying psychoanalytic perspectives and otherwise indicating desirable maternal behaviors and attitudes the medical literature codifies traditional conceptions of motherhood
and maintains the social control functions of medical discourse.

A few sources opposed traditional medically oriented treatments. Non-medical recommendations came primarily from sources that stressed multi-dimensional conceptions of etiology and as well as from British journals and textbooks. The recommendations from these few sources more closely resembled those of medical practitioners. For example, one major British obstetrics text was critical of the overprescribing of psychotropic drugs, advocating the less intrusive measures of support and reassurance first:

"Doctors all too often offer sedation or psychotropic drugs, when explanation, reassurance and advice would have been even more useful (Llewellyn-Jones, 1977)."

Popular writers like Dix have remarked upon the seemingly advanced state of knowledge about postpartum depression in Great Britain (1985). Structural differences in the provision of pregnancy and postpartum care and attitudinal differences regarding postpartum psychoses may be responsible for the broader perspective evident in many of the British sources. For example, in Great Britain midwives are far more integrated into the health care system, routinely providing pre-partum care and assisting in the delivery of many infants (Arms, 1975). Additionally, many psychiatric facilities have mother-baby units so that mothers with symptoms of postpartum disorders do not have to
be totally separated from their infants (Dix, 1985).
Finally, the Infanticide Act of 1938 provides for reduced penalties for women who kill their infants during the first year postpartum. The different perspective on postpartum depression in Great Britain illustrates the influence of cultural and structural factors on the status of scientific thinking.

A more recent American text made similar recommendations for treatment, citing the importance of "sensitivity to the needs of the patient." Furthermore, this text raised another reason for concern about the use of psychotropic drugs not mentioned in any other source—the possibility that a mother may suffer ill effects from having her feelings abnormal:

"It should be recognized, however, that the ordering of such drugs often labels such emotions as abnormal and gives the mother the feeling that she is unable to master the situation with her own resources (Sciarrara, 1989)."

Despite evidence that these are minority views, the presence of professional analyses such as these indicate that debates about the status of psychological difficulties in the postpartum period may persist for some time among medical researchers and writers. Although conceptions of postpartum disorders in the medical literature are generally more uniform and more oriented toward medical intervention than are those of medical practitioners, wholesale
medicalization does not appear to be taking place. As we saw with practitioners this is due to disagreements among authorities about the status of these conditions and because the incentives for medicalization are not completely present. The influence of one final set of players must be taken into account, however, before final pronouncements about the extent of the medicalization of postpartum depression may be made.

C. MORAL ENTREPRENEURS AND MEDICAL CLAIMS-MAKERS: ORGANIZED PROFESSIONAL AND LAY ADVOCACY FOR THE MEDICALIZATION OF POSTPARTUM DEPRESSION

Conrad and Schneider (1980) describe the important role played by moral entrepreneurs and medical claims-makers in the medicalization process. Central to their theory of medicalization is the concept of the "politics of deviance designation." In their view, social conditions that are conducive to medicalization are insufficient in themselves to produce a shift in scientific thinking. A necessary precipitating factor is active lobbying for the creation of new deviance designations on the part of politicized medical and non-medical claims-makers. These are individuals who have joined together because of common interests to press for a change in the designation of behavior categorized as deviant to that of illness.

Medical claims-makers are not typical professional practitioners. They are distinguished by research or
administrative interests in a particular problem they believe should be classified and treated in medical terms. Non-medical claims-makers often have a personal investment in the re-classification of the behavior under consideration which is cast in moral and humanitarian terms. The two groups may join together to plead their case even though each has a slightly different agenda (1980:267-272). A good illustrative example of a successful lobbying effort centering around de-medicalization from the early 1970's were efforts to remove homosexuality from the psychiatric profession's list of mental diseases. When homosexuality was removed from the Diagnostic and Statistical Manual of Psychiatric Disorders in 1973 it represented a triumph for the gay rights groups and claims-making psychiatrists who banded together to lobby for such a move (Bayer, 1981).

Postpartum depression has its own set of moral entrepreneurs and claims-makers, and their activities are visible in the medical literature, in professional conferences and in lay and professional organizations. Psychiatrist Dr. James Hamilton, a retired faculty member from the Stanford University School of Medicine, devoted much of his professional career to researching and writing about postpartum disorders. Beginning with the publication of his book Postpartum Psychiatric Problems in 1962, he consistently pressed for greater recognition of these disorders, and has been a staunch advocate for official
psychiatric classifications for mental illness in the postpartum period. In the book, written for the purpose of educating physicians about diagnosing and treating such conditions, Hamilton immediately established his claims-making orientation, questioning why there had previously been an "anomaly of neglect" of postpartum psychiatric problems:

"One (reason) is that postpartum psychiatric problems lie midway between obstetrics and gynecology and that these problems fail to receive the attention of specialists in either field. Another reason is that... no psychiatrist sees more than a few of them. A third reason is that patients who suffer from postpartum psychiatric illness usually bear at least a superficial resemblance to victims of one or another of the standard varieties of mental illness.... There is overwhelming evidence that the psychiatric illnesses which occur subsequent to childbirth have unique features, as compared with other psychiatric illnesses (1962)."

Hamilton joined together with other similarly inclined physicians, medical researchers and epidemiologists in 1980 to form the Marce' Society, named for the French physician who wrote the first book on postpartum psychiatric problems in the 19th century. Conceived of as a public service scientific body, one goal of the society is to influence medical opinion toward the position that postpartum disorders deserve a distinctive classification in the psychiatric nomenclature. The society continues to be active, sponsoring conferences and encouraging collaborative research efforts (Hamilton, 1982)."
Another early member of the society, British gynecologist and author Dr. Katharina Dalton, also has published and lectured widely about postpartum disorders. Dalton first gained public notoriety as a claims-maker for the recognition of pre-menstrual syndrome, a condition she believes to be caused by the hormonal fluctuations of the menstrual cycle and for which she advocates hormone therapy. In her 1980 book *Depression After Childbirth* she made similar claims concerning the uniqueness of postpartum disorders for which she also recommends hormone therapy:

"...postnatal depression should not be treated in the typical traditional way....The doctor must first satisfy himself that the patient is not having a recurrence of a previous depression, nor the first attack of typical endogenous depression. Having recognized it as postnatal depression and being satisfied with his diagnosis, he can then go on to treat it hormonally."

Dalton's work is similar to that of other claims-makers in that her assertions do not appear to be based on scientifically verifiable evidence. Much of the evidence she presents consists of reports of individual case studies from her own practice, supported by simple associations and argumentation. There are also apparent internal contradictions in her arguments. Despite her strong position in favor of hormone therapy, she also advocates support groups and psychotherapy, seemingly contradicting her exclusively biomedical conception of etiology.
These findings appear to confirm the view of Conrad and Schneider (1980) that the extension of medical social control is more a matter of politics than of science. While professional claims-makers may well be motivated by humanitarian impulses and a desire to help women cope with their troubling experiences, it could also be argued that successful medicalization will benefit some medical professionals by expanding the territory of clinical practice.

Non-medical claims-makers are also quite active in the effort to de-stigmatize postpartum depression and to legitimize it as a valid category of psychiatric illness. Often initiated by mothers who themselves experienced postpartum difficulties, lay-based support groups operate in many communities. One such group, Depression After Delivery, was originally organized in New Jersey by a woman who herself experienced depression and psychosis after the birth of her baby. It developed into a national organization with a newsletter, and group members occasionally lobby for more lenient penalties for women who commit infanticide while exhibiting symptoms of postpartum disorders (Dix, 1985).

A listing of similar support groups located throughout the country is included in a book written by non-professional claims-maker and health writer Carol Dix (1985). Her views are similar in many ways to those of medical claims-makers. She also argues in favor of hormonal
conceptions of etiology and the recognition of postpartum disorders as distinct clinical entities. However, at other points she appears to contradict a totally medicalized view by relying heavily on the subjective accounts of mothers to define postpartum depression and by making suggestions for lay-oriented self-help techniques. For example, she advocates that pregnant mothers who previously experienced mild to moderate symptoms of postpartum depression establish a prenatal plan during future pregnancies. The initial recommendation of the plan encourages mothers to normalize their discrepant feelings by accepting a hormonal explanation of cause:

"Accept that PPD can easily follow the birth of any child and adopt a nonjudgemental attitude toward yourself. The basis of PPD is hormonal and neurohormonal; it is not an indication of your failure. You should not feel guilt, shame or fear at unexpected emotional reactions to yourself as a mother or to your baby. You should expect to go through some ambivalence about becoming a mother and toward your baby."

The rest of the plan, however, deals with methods of increasing one's support network and other non-medical means of coping with troubling feelings. Inconsistencies such as these are common in the accounts of claims-makers and others who advocate medical intervention for postpartum emotional disorders. By reading between the lines it becomes apparent that from a lay perspective the medical definition of the condition is important chiefly because it is a means of de-
stigmatizing the symptoms. If women who experience discrepant emotions after the birth of a child are "sick," then they cannot be regarded as moral deviants or bad mothers. Ironically, the medical definition of the behavior can also lead to the legitimation of non-medical means of resolution and support through the reallocation of social resources (Taylor, 1987).

It can thus be argued that the consequent imposition of medical social control helps mothers by providing non-stigmatizing explanations for their discrepant feelings and by legitimating situational adjustments that may help mothers to cope. This comes at a price, however. By relying on medical authorities to define and legitimize their emotions, mothers lose the ability to define their own experiences. Extending medical social control over women's emotional states also obviates the possibility that the roots of women's unhappiness may be connected to the current configuration of the mother role. As Waltzkin says: "As medical management of social problems has increased, the societal roots of personal troubles become mystified and depoliticized."

D. CHAPTER SUMMARY AND CONCLUSIONS:

The conceptions of postpartum emotional problems found in the medical literature are less variable and more oriented toward the medical model than are those of
practitioners. The influence of personal experiences and folk models of medicine are not evident here. The medical literature is instead oriented toward the more formal diagnostic categories of the psychiatric profession. Moreover, the advocacy for medical intervention is high, in part due to the disproportionate emphasis given to the more severe varieties of postpartum disorders. A final impetus for medicalization comes from the psychoanalytic orientation of many of the authors who attribute deviant feelings and behaviors in mothers to violations of gender prescriptions.

Despite what appears to be a more fertile atmosphere for acceptance of extensive medical social control over mothers' discrepant feelings and behaviors following childbirth, there are also elements contained within the medical literature that work against such a development. These include the disregard of the milder and more common varieties of these disorders and the fairly uniform resistance to viewing postpartum psychiatric conditions as distinct from other psychiatric disturbances. Given the likelihood that severe postpartum disturbances would come to the attention of medical professionals in any event, and since there are no medical treatments for non-psychotic postpartum disturbances that are known to be effective, expansion of medicalization is neutralized. As with medical practitioners then, medical social control is most evident in prescriptions for appropriate maternal behavior.
It is apparent then, that the activities of claim-makers are critical to the expansion of medical social control over women's postpartum emotions. If they are successful in organizing opinion in the medical profession around acceptance of distinct diagnostic categories for postpartum states, the incentives for medicalization may expand.
CHAPTER VII
CONCLUSIONS AND IMPLICATIONS

As discussed in the introduction to the dissertation, medicalization is widely assumed to be emerging as the dominant paradigm for deviance designations in society currently. This implies that medical explanations and treatments now extend to increasing numbers of social problems that were not previously identified in medical terms. Because the study of medicalization is relatively recent, little is known about the process through which it occurs, its effects on individuals who are labeled in medical terms, and its relationship with other processes of social control such as the social control of deviance in women. The unique contribution of this dissertation is the placement of postpartum depression in a social context that reveals the factors favoring and discouraging the extension of medical social control over these experiences.

The application of a phenomenological and feminist perspective to the study of postpartum disorders permits reconstruction of the influences over lay and professional conceptions of these problems. Particular attention was paid...
to the influence of gender and motherhood norms on the responses of mothers and medical professionals to postpartum emotional difficulties. The use of a grounded theory approach of data analysis led to the development of theoretical generalizations that will be used to assess existing medicalization models following the summary of the substantive findings of the study.

A. SUMMARY OF FINDINGS

Mothers described their postpartum difficulties in terms of discrepant emotions and conflicts that were experienced following the birth of a baby. The eight most common dimensions mentioned by mothers included crying, disappointments, tiredness, anger and resentment, depression, anxiety/nervousness, mood swings and feeling "trapped." A sociology of emotions framework was used to interpret the process through which mothers recognized socially discrepant feelings in themselves. Mothers presented their postpartum difficulties in a highly contextual fashion, relating them to relationships and circumstances and blending reports of discrepant feelings with reports of situational conflicts. The feelings that were viewed as most discrepant and troubling were those most at odds with the female role, such as anger and resentment. Mothers' views of the cause of their discrepant emotions were primarily individualistic in nature. The most commonly
mentioned single attribution of cause was hormones, while the most common category of cause was multi-dimensional, including biochemical and situational components. Mothers were especially unlikely to locate the cause of their difficulties in society and in the social organization of the mother role.

Most of the mothers had some information about the occurrence of postpartum emotional problems prior to their own experience of difficulty. Sources of information included friends, medical practitioners, childbirth classes, professional training, and most commonly, the popular literature on pregnancy and new motherhood. Mothers recalled that the information found in these sources was highly inconsistent in the way postpartum disorders were conceptualized, and this parallels mothers' own conceptions for their problems. Information that was perceived to be helpful allowed mothers to label and define their feelings in a non-stigmatizing fashion. Information that was not helpful confused mothers, increased their feelings of shame and guilt or led them to dismiss the relevance of the information to their own situations.

Mothers pursued four primary strategies of help-seeking and emotion work in order to resolve their discrepant feelings. Foremost among these were physician consultations. These professional consultations led for the most part to unsatisfactory outcomes from the perspective of the women,
who described conflicts and dissatisfactions in their interactions with physicians. The conflicts described by mothers were related to the attitude and style of individual physicians and the structural limits of medical practice. A few women consulted mental health professionals. These consultations were no more successful than were physician consultations, although reports of problems and conflicts were less common. Women also sought support from family members and friends during their emotional difficulties and made various situational adjustments, such as obtaining childcare and returning to work that met with limited success.

Analysis of mothers' conceptions of their postpartum difficulties and their patterns of resolution reveal several components favoring medicalization. To mothers, their postpartum difficulties were experienced as deviant responses to childbirth. Especially stigmatized were reactions that were at odds with the female script, such as feelings of anger and resentment. These condemnatory responses to their feelings led mothers to seek labels to account for their feelings that would decrease the stigma they felt. As we shall see, medical labels are attractive because they offer conditional legitimacy in the form of the sick role (Parsons, 1951). Furthermore, as a reflection of the content of the information sources they were exposed to, mothers opted for primarily individualistic explanations for their
difficulties. Chief among these were multi-dimensional conceptions containing biochemical and social-situational factors followed by biochemical conceptions of cause. Additionally, by pursuing physician consultations ahead of other resolution processes, mothers increased the potential for medical, social control. The one factor that may work against medical social control is mothers' dissatisfaction with their physician consultations.

Physician conceptions of postpartum emotional disorders were not totally unlike the lay conceptions of mothers, although they were anchored more firmly in a consistently medical frame of reference. Physicians receive little or no formal medical training on emotional difficulties during the postpartum period in medical school or after. Although a few consider themselves to be experts in the diagnosis and treatment of these problems, most physicians learn about postpartum difficulties by observing their patients, and a surprising number are influenced by personal experiences.

Physician views of etiology and treatment do not reflect strong tendencies toward medicalization. Among those we interviewed, the foremost assumption of the cause of postpartum disorders were multidimensional theories containing social and biochemical elements, followed by social-situational theories. These views were matched by physicians' preferred treatment modalities where mental health referrals, emotional support and reassurance,
referrals to support groups and recommendations for situational adjustments predominated. Most physicians are hesitant to recommend more intrusive medical treatments such as psychotherapeutic drug therapy, and many felt such therapy was appropriate in only a small minority of severe cases. One way in which physicians do exert social control over mothers is in their willingness to indicate appropriate maternal behavior. Thus the evidence for medicalization on the part of practitioners is mixed. Aggressive medicalization, however, does not characterize the actions or attitudes of physicians concerning postpartum disorders.

The conceptions of postpartum emotional difficulties in the medical literature were more clearly dominated by medical theories and treatments. In the literature personal influences were absent and the more severe varieties of postpartum disorders were emphasized. There was a consistent argument against viewing postpartum disorders as distinct clinical entities due to a reliance on formal diagnostic categories for mental disorders. This orientation did not lead to recommendations for less intrusive therapy. Rather, the professional literature advocated the typical treatment regimens currently in vogue for major affective disorders, stressing psychotherapeutic drug therapy, referrals to psychiatrists and psychotherapy. Views of etiology were also quite different from those of practitioners with organic/biological conceptions predominating and social-
situational conceptions far less in evidence. The medical literature also identified standards of appropriate maternal behavior, especially by favoring a psychoanalytic approach to interpret instances of emotional deviance in women.

If the literature of the medical profession appears to advocate the application of medical social control more strongly than do practicing physicians, there is a distinctive group of medical and lay authors who even more actively champion the medicalization of postpartum disorders. These claims-makers lobby for the wider recognition of postpartum disorders and advocate official psychiatric classifications and medical treatments. Their work is visible in some segments of the medical literature and in professional and lay organizations such as the Marce Society and Depression After Delivery. What Conrad and Schneider refer to as the "politics of deviance designation" is most clearly evident in the activities of such groups and individuals.

B. Theoretical Implications of the Study

The findings of this study add to the elaboration of medicalization models particularly by specifying the role played by mothers as deviants and professionals as imputers of deviance in the medicalization process. In the study, models of illness behavior and a sociology of emotions framework were considered for their applicability to
mothers' processes of emotion resolution and help-seeking for postpartum emotional difficulties. It was determined that the sociology of emotions framework applied more closely, due to its emphasis on self-labeling and emotion resolution processes in addition to professional consultations. Models of illness behavior were limited because of the assumption that medical consultations are the end result in a lay process of help-seeking. The findings of this study indicate that self-labeling and emotion resolution processes can, in some instances, successfully contain the troubling feelings and conflicts associated with postpartum disorders. In some of these cases medical social control is sought by mothers themselves and is achieved outside of interactions with the health care system, as when a mother labels herself as suffering from postpartum depression. Thus medicalization models are extended through the inclusion of a self-labeling approach.

In what is one of the best articulated models of medicalization, Conrad and Schneider (1980) specify the stages through which medicalization progresses before it is institutionalized as the dominant designation for a particular type of deviance. First, the behavior in question is defined as deviant. Mothers and others clearly view the feelings and behaviors associated with postpartum emotional disorders as deviant and undesirable. Although it is inconsistent and inconclusive, the long history of the
professional literature on postpartum disorders also reinforces this view.

Second, prospecting, or the solicitation of professional attention occurs when the "discovery" of a medical conception of deviance appears in a professional journal. This is usually accompanied by newly created medical diagnoses, a new conception of a medical etiology and suggestions for medical treatment. These are abundantly available in some of the medical literature, especially that written by medical claims-makers like Hamilton and Dalton. Third, claims-making activities on the part of lay and professional entrepreneurs seek to expand the jurisdiction of practitioners in identifying and treating the problem. Again, organized claims-making activity is evident on the part of lay and professionals activists on behalf of postpartum emotional difficulties.

Fourth, legitimacy is sought for the newly medicalized deviance designation, usually in the courts and sometimes in other bureaucratic settings. This is the one stage where significantly less progress has been made with respect to postpartum disorders. In the United States legal battles for legitimacy have sometimes been fought by individuals and lay claims-making organizations on behalf of women convicted of infanticide and other violent behaviors when they were thought to be impaired by postpartum psychosis. Finally, if these stages are successfully achieved the deviance
designations is thought to have become the new paradigm for viewing the particular form of deviance in question (1980:266-271).

The findings of this study add to Conrad and Schneider’s model in two ways: by expanding understanding of the role of self-labeling in relation to medicalization and, by integrating gender as an important variable that influences the circumstances under which medical social control is applied. First, the study confirmed Riessman’s assertion that women may actively seek the medicalization of their problems (1983). The circumstances that appear to increase the likelihood of such individual solicitation of new deviance designations were those where mothers had great difficulty in normalizing their discrepant emotions. Mothers were least successful in their efforts to normalize feelings and emotions that were greatly at odds with gender and motherhood norms.

Second, the better fit of Thoits’ model of self-labeling and emotion work with mothers’ patterns of resolution than models of illness behavior indicates that medical social control does not always result from physician consultations and the application of medical treatments. In some instances mothers assumed their own label of postpartum depression or the baby blues as a means of reducing the stigma of their discrepant feelings. They did not necessarily require the official legitimation of a medical
practitioner in order to act on their own to reduce the stigma of their discrepant emotions.

Despite the fact that progress has been made in at least three of the stages of medicalization articulated by Conrad and Schneider, the status of postpartum emotional difficulties as a medicalized category of deviant behavior remains unclear. Inconsistencies in practitioners' conceptions of these disorders, the dissatisfaction of mothers with medical consultations and treatments and the influence of lay conceptions on physicians' views indicate that consensus has not yet been achieved concerning postpartum depression in the medical profession. Moreover, the likely effects of the imposition of medical social control for women remain to be seen. While medical definitions may indeed reduce the stigma of discrepant emotions and behaviors following childbirth, women may achieve such a benefit at a high price.

One pertinent concern raised by Riessman (1983) is the question of whether women's life experiences have been medicalized more so than men's. If postpartum disorders are successfully medicalized it could further extend medical control over women. One final contribution of the dissertation and its characteristic sociological and feminist analysis is to highlight an apparent paradox that follows from what appears on the surface to be a benefit of medicalization. By locating the source of women's emotional
difficulties in individualistic, organic conceptions of cause, it appears that the stigma of postpartum difficulties will be reduced. At the same time, the possible contribution of social arrangements, particularly the organization of the mother role to women's problems remain hidden. Where women's emotional deviance is concerned, medicalization merely changes the context in which blame is assigned; the cause of postpartum disorders is still located within individual women. In the final analysis it is once again women who must adjust rather than society that must change.
NOTES

1. While a variety of distinctive emotional disturbances occurring in the postpartum period have been described and labeled by researchers, the term postpartum depression is frequently used in a generic sense to refer to the entire range of experiences.

2. The medical model is frequently mentioned in sociological work on medicalization. It refers to the orientation of medical researchers and others influenced by medical thinking toward attributing all deviations in function to organic causes and to faith in the efficacy of biomedical interventions (Conrad and Kern, 1986).

3. A number of these organizations have sprung up across the U.S. in recent years. Dix (1985) includes an exhaustive list in her book *The New Mother Syndrome*.

4. Stock knowledge is a term from Schutzian phenomenology that refers to the type of social knowledge that is associated with a distinctive social role, including the norms for role enactment.

5. Data for the study come from a two-year research project funded by the Ohio Department of Mental Health: "Breaking The Emotional Rules of Motherhood: The Experience and Treatment of Postpartum Depression," Verta Taylor, Principle Investigator, 1987.

6. Out of the fifty interviews with mothers who self-identified as experiencing postpartum distress, six were excluded for technical reasons, including incomplete information and equipment failure during tape recording.
7. Glaser and Strauss (1967) describe this as the point at which comparison of groups of data yields repetitive findings. When comparison fails to reveal additional properties of the theory this serves as an indication that no new sampling is necessary.

8. Popular health writer Carol Dix quotes psychiatrist Dr. James Hamilton that the DSMIV, due out in 1993 will include postpartum psychosis as a distinctive diagnosis; to be categorized with conditions related to physical states, such as sleep and premenstrual disorders (1985:13).
BIBLIOGRAPHY


APPENDIX A

POSTPARTUM INTERVIEW

The purpose of our research is to learn more about the feelings and experiences of women who have given birth in the past two years. We will be asking questions about your life before, during and after your pregnancy.

The interview should last under two hours. Your responses will be tape recorded but are absolutely confidential. Only the research team will have access to our materials and you will never be identified in any way when our results are published.

If there is any question with which you are not comfortable, feel free not to answer or to ask me to switch the tape recorder off.

Do you have any questions before we start?

PART I: GENERAL QUESTIONS

I’ll begin by asking you some general questions about yourself and your life.

1. How old is _____ (name of baby)?

2. Do you have other children? What are their ages?

3. Are you married or in a relationship of some sort? How long have you been with this person? (explore: divorce, separation, re-marriage, etc.)

4. Do you work for pay outside the home?
   a.) what kind of work
   b.) work history - quit after baby, maternity leave, etc.
   c.) is (was) this work important to you? Why?
   d.) do you actively belong to organizations, clubs or do volunteer work? Are these activities important to you? Why?

5. Do you have close ties with:
   a.) family
   b.) friends
   c.) are these relationships important to you?

6. How was your physical health before your pregnancy?
   a.) any problems with periods?
b.) nutritional habits  
c.) exercise habits

7. Were you happy with yourself and your life before your pregnancy? Why or why not?

8. Did you ever have problems with moodiness before the pregnancy? If yes, describe.  
a. If yes, was this related to your menstrual cycle?

9. Were there any major problems or stresses in your life prior to your pregnancy? Explain.

10. Do religious beliefs of any kind play a significant role in your life? Please explain.

PART II: PREGNANCY

1. Was your pregnancy with ______ a planned pregnancy?  
a.) Are you and your partner in agreement on family size and spacing? (Explore disagreements)  
b.) Do you want to have more children?  
c.) How did you feel when you learned you were pregnant? How did your partner feel?

2. Had you planned on being a mother since you were a young girl? (If no: what changed your mind?)

3. How many times in your life have you been pregnant? (result of these pregnancies - deliveries, abortions, adoptions, miscarriages, stillbirths, etc.)

4. How did these earlier experiences affect your feelings about this pregnancy?  
a.) If already a mother did you experience any emotional hard times after the birth of the previous child? Explain.  
b.) If yes, how did you cope with these hard times?

5. Did you or your partner have a preference for the sex of the baby?  
a.) What was the reaction of each of you to the sex of the baby?

6. What type of professional care did you seek during the pregnancy and why?  
a.) What type of birth did you plan for and why did you make that particular choice? (hospital, caesarean,
home birth, hosp. birthing room, etc.)
b.) Were you pleased with the care you received from this person? Why or why not?
c.) Did you feel that you could discuss personal feelings or concerns with your doctor (or other care giver)?

7. How would you describe your general physical health during pregnancy?
a.) Did you do anything special to maintain your health during pregnancy? (Explore: nutrition, exercise, cutting back or giving up certain foods or habits)

8. Do you now, or have you ever:
a.) smoked cigarettes? If yes: type, frequency and quantity 
b.) consumed alcohol? Yes: type, frequency, quantity 
c.) consumed caffeine? Yes: type, frequency, quantity 
d.) engaged in extreme overeating or undereating, or binging and purging? (anorexia or bulimia) 
e.) used recreational drugs, such as marijuana, cocaine, speed etc.? If yes: type, frequency, quantity 
f.) regularly taken prescription drugs? If yes: type, reason, prescribed dosage, length of time taken 
g.) regularly taken any over-the-counter medications? 
   If yes: type, reason for taking, length of time taken 

9. At any time have you felt that your use of any of these substances was a problem for you, or that you used it to cope with problems in your life? If yes, explain.

10. Did your use of any of these substances change during or after your pregnancy?

11. How did you react to the experience of being pregnant? Explore:
a.) bodily changes as pregnancy developed 
b.) reactions of others to the pregnancy 
c.) changes in attitudes on the part of others 

12. Did you experience significant changes in your routine at home or at work? If yes, how did you feel about this?

13. During your pregnancy, were there changes in your personal or sexual relationship with your partner which were problematic? Did your own or your partner’s attitude about sex appear to change during this time? Describe.

14. From whom did you receive help and support during your pregnancy? What specifically did you find to be helpful?
15. For any questions you may have had about pregnancy or motherhood, where did you seek answers and were your questions answered to your satisfaction?

16. How do you perceive that your mother felt about her pregnancies and motherhood? Did she ever discuss this with you openly?

17. What plans did you make for the arrival of the new baby? (Explore: childbirth preparation classes, home prep, financial, work, child care, etc.)

18. What did you expect that your labor and delivery would be like?

PART III: THE BIRTH EXPERIENCE

1. Briefly describe your labor and delivery experience. Explore:
   a.) whether overall positive or negative
   b.) hospital or home birth and satisfaction with choice
   c.) complications
   d.) interaction with doctor, midwife, etc.
   e.) interaction with partner if present, birth assistants, etc.

2. How was your health and the baby's health after the birth?

3. If a hospital birth, how long was your stay?
   a.) Was this a positive or negative experience?

4. If a home birth, what were your feelings about the experience?
   a.) Contrast to previous hospital deliveries if any.

5. Did you nurse or bottlefeed the baby? Why? What was this experience like for you? Were you pleased with your choice?

6. How did you feel both physically and emotionally in the days after the birth of the baby? (Explore: specific feelings and duration)

7. How did your life change after you returned home with the baby? What was your reaction to these changes?
8. What were the major stresses you had to deal with after the baby was born? How did you cope with these?
   a.) Did you receive help and support from anyone or feel like you needed it?
   b.) What was, or what would have been helpful to you during this time?
   c.) Did you feel comforted by any religious beliefs, or other beliefs you may have

9. Please choose four words to describe yourself in the months following the birth of the baby.

PART IV: THE BABY

1. How has the baby’s health been, up until now?

2. How would you describe the baby’s attitude and personality during the first months/year? (Explore: happy, crabby, colicky, etc.)

3. How would you describe your relationship with the baby?
   a.) Differences from mother’s other children as babies
   b.) Connections between baby’s moods and moods of mother

4. Have you ever been concerned about harming the baby when you’re feeling frustrated?

5. Before the baby was born, had you heard about the baby blues, or postpartum depression — or the fact that some women experience a difficult emotional time following the birth of a child?
   a.) What had you heard and where did you get the information?
      (explore: which books or articles, other mothers, friends, own mother, physician, childbirth class, etc.)
   b.) Did you expect that you might experience emotional hard times yourself after the birth of ________?

6. Did you have an experience of this kind?

PART V: THE EMOTIONAL EXPERIENCE

(Skip this section if the answer to # 6 above was no. Proceed to section VI.)

1. Tell me about these emotional difficulties you
experienced after the baby was born.

a.) What happened and what were your feelings?
b.) Were there different stages to your emotional
difficulties and how long did these last? (Explore
specifically when each episode began, the nature of
symptoms and when symptoms were no longer present)
c.) Why do you feel you experienced these emotional
hard times? What different factors played a part?

2. What were your feelings toward others during this time?
(Explore: the baby, partner, friends, family, etc.)

3. Do you, or did you ever feel like taking your feelings
out on the child in any way, for example by shouting, or
by hitting the child?

4. Did you consult a physician, counselor, minister or
anyone else about your emotional difficulties and what
help/advice were you given?
a.) If yes, how did you make the decision to see this
person
b.) How helpful was this person?
c.) If no, do you wish you had sought counseling? Why
or why not?

5. How did you cope with these feelings?
a.) Was anything a help to you?
b.) Did you use alcohol, prescription drugs, recreational
drugs or any other substance to cope with your
feelings?
c.) Could you talk to family, friends or your partner
about how you were feeling? Did they help or seem
to understand?

6. Have your periods resumed since the baby’s birth? Have
you observed any relationship between your emotional hard
times and your menstrual cycle?

7. Have your emotional hard times disappeared?
a.) If yes, when and how were they resolved?
b.) If no, what do you think would help resolve them?

PART VI: GENERAL QUESTIONS - POST BABY

1. Have others changed in their attitude/treatment of you
in the time following the baby’s birth? Explain. How does
this make you feel? (Explore: partner, family, friends,
boss, etc.)
2. Has motherhood fit with your expectations? Why or why not?

3. Have there been changes in your personal or sexual relationship with your partner since the birth of the baby? If yes, have these been a problem for you or your partner? How are these being resolved?

4. How would you characterize the marital balance of power between you and your partner? (Who has more power to make decisions about important things in your relationship?) Has this changed since the baby was born?

5. Do you feel that you have adequate time alone for yourself, with your partner, or with friends?

6. How have you been feeling about yourself generally since the baby's birth?

7. What has been most difficult for you since the baby was born?

8. What has been most helpful to you since the baby was born?

9. Since you did/did not experience emotional difficulties postpartum, what do you think would be most helpful to other women who experience such problems?

10. Do you have any ideas on how such difficulties could be prevented or minimized? A.) Do you think women with these difficulties should seek counseling? Why or why not?

11. What are the most important relationships in your life right now? Describe these.

12. Would you say that overall you are satisfied with your marital/personal relationships? Please explain why or why not.

13. To conclude, is there anything you can think of that I didn't ask you about that you feel affects the emotional adjustment of new mothers after childbirth?

This concludes the oral phase of the interview. The final few questions I have for you are in written form. Thank you very much for all your help and patience in answering these questions.
The baby BLUES

When that bundle of joy brings a passel of problems

Dagmar Celeste pulls no punches. She has always, in her contemporary vernacular, told it like it is, even when it is dark and sad and not very pretty.

With her sixth child, Stephanie, a few months old, "all hell broke loose" in her head. That is how Mrs. Celeste, wife of Ohio Gov. Richard Celeste, described the postpartum depression into which she descended in 1978.

"My speech turned into riddles and rhymes, my body could not sit, stand or lie still, and my mind was racing while my soul was terrified," recalled Mrs. Celeste.

Following hospitalization for several months and extensive medication and therapy, she recovered. And when she tells the story now, as she did on a recent afternoon at the governor's residence in Bexley, Mrs. Celeste has moved in mind the some soul-shattering revelation or personal catharsis. She tells it because many other women — the exact number is not known, which is part of the problem, she said — suffer from the same intense melancholia that cornered Mrs. Celeste.

IT IS CALLED postpartum depression, or "the baby blues." And because it has received little medical attention, Mrs. Celeste said, the Ohio Department of Mental Health and Ohio State University recently awarded a $40,000 grant to a research team led by Dr. Vera Taylor, OSU psychology professor. The project will explore the symptoms of postpartum depression and try to determine how the mental health profession can help those who suffer from it.

Taylor said, "It is not a categorized illness. There's very little information about it."

What we do know, Taylor said, is that about 84 percent of all women who bear a child suffer some degree of "letdown" after the event. It ranges from a mild melancholia — the aptly named "baby blues" — to severe, incapacitating psychosis, such as Mrs. Celeste's long illness.

THE TWO-YEAR project will examine the social and cultural elements that contribute to postpartum depression. The presence of such elements means, among other things, that a father can suffer postpartum depression as well, Taylor said. If a man has the primary responsibility for raising a child, he may endure the same psychological trauma that often hounds women, she said.

Taylor hopes that women who have suffered depression after childbirth will participate in the study by contacting the OSU Women's Studies Department at 438-4321, to arrange a confidential interview. Child care will be provided during the interview, Taylor said.

"In our culture, when you have a baby, everything is supposed to be wonderful," said Chris Smith, an OSU graduate student in counseling who will assist Taylor. "Women feel there's something really wrong with them if they're not thrilled.

"The study of postpartum depression has kind of fallen between the cracks," Smith said.

RESEARCH THAT attributes postpartum depression solely to female hormones is disproved by women's experiences, said Kelly McCormick, an OSU graduate student in sociology. "If that were true, why would a woman have four births, and only have postpartum depression with one of them?"

Mrs. Celeste views postpartum depression as an outgrowth of the societal place in which contemporary women find themselves. In the 1960s, she said, the choices for women were clear: Marriage and motherhood — or a career, dedication to family — or to self.

"In the 1960s, things are different," she said. "Women are not frustrated by the narrow choices, but because there's too much to choose from. They have to do it all — marriages and family and home — and win the Nobel Prize.

"We women have come a long way, but we're taking all the expectations along with us. We haven't been able to shed any of it."

AND THE most likely candidates for postpartum depression, Mrs. Celeste said, are women who try to "do it all." At risk are women who take responsibility for things they can't control.

She recovered through the help of her husband, her children, some good friends and her own will to be healed, Mrs. Celeste said. And she has never been shy about recounting her psychological problems.

"One positive aspect of public life is that you are able to use your own experiences to help others," she said. The research project that was initiated by her interest in postpartum depression is a good example of turning private pain into public good.

Mrs. Celeste believes.

"I'm straightforward to a fault, almost by nature. And anything you keep in the closet is going to rattle you a lot more than what you let out."
APPENDIX C:
MEDICAL INTERVIEW GUIDE

DESCRIPTIVE:

1. What is your medical specialty?

   If a nurse or other health practitioner, what is your current position and what are your responsibilities? Do you have a specialty area?

   If a non-traditional medical organization or provider, ask for group’s origins, a description of what the group does, with whom it works, its philosophy and objectives, and the individual’s position and background training.

2. Do you treat or work with women who are pregnant or have young children? About what percentage of your patients/clients fit this profile? How do you get most of these patients/clients?

3. Do you think that it is normal for women who have given birth to experience changes in their emotions and affective states in the months subsequent to delivery? Please explain.

4. What can you tell me about postpartum depression?

5. Do you think that there are different types of postpartum disorders? Describe.

6. Specifically, what do you think causes postpartum disorders? Do you believe that PPD is primarily hormonally or socially induced, or both?

7. How long after the birth of a child do you believe a mother can experience postpartum emotional and affective disorders?
8. Generally, what percentage of postpartum mothers do you think experience these kinds of difficulties?

9. Have you seen women in your own practice who are affected by postpartum disorders? If yes:
   a. Generally, why are these women seeking help?
   b. What difficulties are reported as the presenting "complaint?" Is depressive symptomatology generally reported? Describe.
   c. Have you seen patients/clients who identify their difficulties as PPD? If not, how do they identify their problems?
   d. Are your patients/clients generally knowledgeable or naive about postpartum disorders?

10. Is there a typical profile for expectant mothers "at-risk" for developing postpartum disorders? Could you discuss what factors you think might contribute to increased risk?
   a. Is there any difference in the incidence and symptomatology on the basis of demographic factors, such as race, marital status, age, SES?
   b. Have you observed any relationship between PPD and alcohol/drug use?
   c. Have you observed any relationship between PPD and child abuse, physical and/or emotional abuse?
   d. Have you observed a condition resembling PPD in fathers?

TREATMENT:

1. Do you think that most postnatal conditions should be treated? (Probe for severity) How?

2. Do you tell women about postpartum depression and when do you share this information with them? (During pregnancy or postpartum?) What do you tell them generally?
3. How do you think postpartum depression should be treated?

4. Have you had patients/clients who were hospitalized for postpartum disorders? Why, and was this helpful?

5. Have you prescribed anti-depressants or other medications for postpartum disorders? Why, and was this helpful?

6. Do you refer patients/clients with PPD to agencies, physicians, therapists, counselors, support groups, etc.? Under what conditions would you make such a referral?

7. Do you think that it is possible that sometimes PPD is not identified by medical and mental health practitioners as a patient's/client's problem when it should be? Explain.

8. In an ideal situation, what services do you think would be most useful to women experiencing postpartum emotional and affective disorders? To help prevent these kinds of problems?

Training:

1. Could you describe briefly the training you received about postpartum disorders during medical school, internship and residency?

   a. If a nurse or other health practitioner, ask them about their professional training relevant to their current position.

   b. Also ask whether they received any specific education about postpartum emotional and affective disorders.

2. How have your training or experiences in working with postnatal women affected your view of these conditions?

3. Where would you turn to find out more about postpartum disorders?
1. Generally, do you believe that women with postpartum disorders seek treatment? Why or why not?

2. Do you think that appropriate services are available to women suffering postnatal emotional difficulties?

3. Do you think that women appear to display a higher incidence of mental illness than do men, especially during the reproductive life span? Why?

4. Have you had any personal experiences with postpartum depressive disorders? Explain.

5. Finally, is there anything that we haven't covered that you feel might be helpful to us in understanding postpartum disorders?
APPENDIX D:

MEDICAL BIBLIOGRAPHY

Textbooks:


204


Psychiatric Sources:


209


Medical Journal Articles:


