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Postpartum Depression: Deconstructing the Label Through a Social Constructionist Lens

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There is an increasingly widespread utilization of the term postpartum depression (PPD) to describe the emotional and mental turbulence that occurs after childbirth in western society. This paper seeks to analyze the emergence of the label PPD through the application of a social constructionist perspective, to compare lay interpretations with professional explanations, and to situate varied interpretations within a broader social, political and economic context. In doing so, the paper seeks answers to the following questions: (i) how did the label PPD emerge? and (ii) how is it changing now? The processes involved in the social construction of PPD pertaining to the social discovery of PPD, diagnosis and experience of illness, and treatment and outcomes are described and analyzed.

The findings reveal that the definitions, explanations and ever-changing constructions of PPD extend beyond biomedical criteria and involve historical, social, cultural and structural dimensions. The varied meanings and interpretations of PPD also reveal the embeddedness of race, class, ethnicity, and gender as they intersect with biomedical perspectives in the construction of PPD. PPD is an objective medical condition for some, while for others it is a social problem rooted in socioeconomic disadvantages, gender inequality and cultural ideals regarding motherhood. The label PPD precludes adherence to a particular intervention and requires social work practitioners to demonstrate flexibility and
creativity in dealing with clients. Implications for social work practice, particularly a need to recognize how the disorder known as PPD is socially constructed in the western world, are provided to deal with the multiple realities embedded in the label PPD.

KEYWORDS postpartum depression, social construction, labelling, mental illness, motherhood

The arrival of a child creates dramatic changes in the lives of women as self-perceptions, relationships, and worlds are often transformed while they negotiate this transitional phase (Ussher, 2005). Chrisler and Johnston-Robledo (2002) maintain that, during this period, many women experience forms of emotional and mental turbulence which are often described as “postpartum psychiatric disorders,” “puerperal mood disorders,” “postpartum depression,” and “postpartum mood disorders.” Three types of postpartum disorders are reported in the Diagnostic and Statistical Manual of Mental Disorders or DSM-IV (American Psychiatric Association, 2010). The least common is postpartum psychosis which reportedly occurs in about 1 in 500 to 1 in 1000 women within four weeks post-delivery. Infanticide is rarely linked to postpartum disorders but, when it occurs, it is most often associated with postpartum psychosis, which is characterized by hallucinations or delusions. Once a woman has experienced postpartum psychosis, the chances of recurrence are reportedly between 30% and 50%. The DSM-IV states that postpartum blues or “baby blues” affect up to 70% of women during the first 10 days post-delivery. Baby blues are believed to be transient in nature and to involve little or no impairment of functioning (American Psychiatric Association, 2000). Somewhere in the middle of this continuum of postpartum mood disorders is postpartum depression (PPD), which refers to a sustained depressive disorder in women following childbirth.

Cox and Holden (2003) have put forward the view that the current preoccupation with and the popularity of the label PPD in Western societies might reflect a greater concern about women's health issues, particularly within the context of the changing status of childbearing in society and the increased vulnerability of modern women due to a lack of rituals (e.g., mandatory rest period) and adequate support. Given the widespread utilization of the term PPD, this article seeks to analyze its emergence through the application of a social constructionist perspective. The article begins with a description of social constructionism and adopts its principles to trace how certain experiences of mothers have been associated with the label of PPD.
SOCIAL CONSTRUCTIONISM

The term “social construction” first appeared in the title of a book called *Social Construction of Reality* written by Peter Berger and Thomas Luckmann (1966). Since then the term has appeared in many forms throughout the social sciences and humanities, thus obscuring its meaning (Brown, 1995). Social constructionism can be interpreted as a social theory, a combination of several theories or an epistemological position. As Brown (1995) has noted, the wide variety of definitions and usages of social constructionism implies that there is no unitary social constructionist theory or epistemological position.

With the proliferation of constructionist analysis, Hacking (1999) suggested that constructionism served as an empty, vague, and superficial rhetorical device derived from the assumption that social life was “constructed.” Despite the criticism and confusion surrounding social constructionism, it is too important a concept to be ignored. Following the approach identified by Hacking (1999), an important aspect of constructionist analysis is for authors to articulate what is the focus of their constructionist analysis.

In order to simplify the ambiguity arising from the divergent meanings of social constructionism, Harris (2010) introduced two general forms of constructionism: interpretive social constructionism (ISC) and objective social constructionism (OSC). ISC has roots in diverse traditions including pragmatism, symbolic interactionism, phenomenology and ethnomethodology. The core principle of ISC is that the meaning of things is not inherent; rather meaning is constructed, learned, used and revised through social interactions that are coloured by people’s motives, purposes and perspectives. Hence, social phenomena are interpreted entities and there can be multiple meanings of the same phenomena.

On the other hand, Harris (2010) asserts that OSC treats social phenomena as real entities (i.e., objective entities), which are produced or constructed by the actions of individual actors or groups, by constraining social forces and by various structural factors including class, race, gender, politics, and religion. The underlying belief is that something is “socially constructed” when a real phenomenon, as opposed to an interpretation or meaning, derives its existence and its dimensions from other social factors. The difference between these two forms of constructionism can be summarized as follows: ISC focuses on how things are defined as they are. In contrast, OSC explains why things occur as they do. Harris (2010) suggests that, in spite of these differences, the ISC-OSC distinction is a matter of degree and both forms can be placed at each end of the continuum of social constructionism.
Brown (1995) views the social construction of mental illness as a central organizing theme with three distinct and interconnected versions being prevalent in medical sociology. The first version focuses on the making of meaning or definitions and does not address the conundrum as to whether an illness or condition is real or unreal. In this sense it is closer to the interpretive end of the social constructionism continuum described by Harris (2010). Based on this perspective, no behavior, experience, or personal attribute is inherently deviant or abnormal; rather, people’s actions and appearances must be defined as deviant to be seen that way (Hacking, 2004; Harris, 2010). Deviance or abnormality is not a “thing” waiting to be discovered; instead it refers to an ongoing interpretation of indeterminate events. Following Hacking (2004), this means that deviance is not a way of behaving, but a label attached to behavior. Similar to arguments put forward by Connor-Greene (2006) and Eisenberg (1988), this version of social constructionism enables us to understand how the fields of health and mental illness are rife with biased definitions and varied forms of social control. For socially powerful groups and institutions, definitions or labeling of behavior or experiences become a tool for social control. For Moncreiffe (2007), assigning names or labels is a starting point whereby parameters of normality and abnormality, forms of social interactions, professional and institutional boundaries, and service and resource allocations are determined.

A second version of constructionism is based on European postmodern theory, and is reflected in the works of Foucault (Brown, 1995). This form of construction deconstructs language and symbols in order to demonstrate how people work within the possibilities afforded by cultural discourses, create their social selves and take actions in their social worlds (Foucault, 1973, 1978). Hence, people cannot access a “reality” beyond that which exists in discourse. For Connor-Greene (2006), this means that mental health disorders are shaped by the very concepts that physicians (or at times lay people) employ to define and classify them. This perspective implies that the concepts invented by physicians or lay persons to account for disorders and diseases come to shape, not only assessments and treatments, but also the very manifestation of the illness itself. Hence, the definition may sculpt the features of mental illness as well as the enactment of those features by the person diagnosed with the illness (Eisenberg, 1988).

Hacking (1999, 2004) referred to this type of process as a *looping* effect that involved an interaction between classifications and the ways in which people are classified. With regard to the looping effect, not only do people who are classified change according to the ways they are classified, but they also change in ways that initiate modifications in the systems of classifications. In some instances, classifications and the classified emerge simultaneously, each engaging the other. Furthermore, as stated by Hacking
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(1998), mental illnesses can be “transient” in nature meaning that they may appear at a particular time, in a place, and later fade away only to reappear at another time.

Brown (1995) described a third version of social constructionism related to the sociology of science; it involves the study of professionals’ discovery of diseases and the development of medical technology with less focus on the elements of lay discovery and interactions between patients and the world of medicine. Based on this perspective, the production of scientific facts is the consequence of mutually conceived actions by scientists in the laboratory, combined with scientists’ efforts to promote their work in public and official venues. In this sense, as observed by Godderis (2010), professionals (e.g., clinicians, academicians) may engage in the creation of psychiatric knowledge, known as PPD. Consequently, the science of PPD may enable physicians to conduct assessment and diagnostic processes, and reorganize women’s narratives about difficult transitions; such processes thus transform motherhood into a treatable phenomenon.

PURPOSE

This article explores how the label PPD emerged and became defined over a course of time in Western society. While doing so, we situate ourselves closer to the interpretive end of social construction continuum developed by Harris (2010). Following Harris, we are not principally concerned with what PPD really means; nor do we intend to dispel “myths” or correct misunderstandings regarding PPD. Rather, we try to explore how the meanings and realities of PPD are produced by different members of Western society.

We do not intend to debate whether PPD is a real or an unreal entity, what qualities it may have, and what casual factors may shape it. According to Hacking (1999), “reality” and “construction” are not contradictory; rather, they interact with each other. In alignment with this assertion, we accept that women’s physiological, emotional, and interpersonal sufferings following childbirth are “real”; however, the label PPD is “constructed” to describe these experiences. Hence, we take a reflective approach to the medical model, but do not necessarily argue against the possible biomedical components underlying women’s experiences. Moreover, we refrain from making assertions as to whether the label PPD should be replaced with another terminology or should be completely abandoned from our lexicon. Rather, we present different perspectives on the label, while taking a non-committal stance.

In addition, like Harris (2010), we do not claim to possess a purely interpretive lens as we cross the boundaries of ISC and occasionally dwell in the realm of OSC by bringing certain realist assumptions into the analysis. Consequently, we examine the emergence of the label PPD, compare
lay interpretations with professional explanations, and situate varied interpretations in the broader social, political, and economic context. We look at what different stakeholders claim about the origin of PPD and how those claims have been advanced, confirmed or contested. We seek answers to the following questions: (i) How did the label PPD emerge? and (ii) How is it changing? In doing so, we utilize the analytical model developed by Brown (1995) delineated in the following section.

ANALYTICAL MODEL

Brown’s (1995) analytical model can be divided into two parts based on (i) a typology of conditions and definitions and (ii) the developmental process of construction. In regards to the first part, disorders, diseases and disabilities can be classified into four types of conditions and definitions with varying degrees of acceptability and applicability. The first type contains routinely defined conditions that are widely accepted and for which biomedical definitions are applied without much contention. The second type involves cases where the condition is accepted as a non-medical one, yet a biomedical definition is applied. The third type includes contested definitions where there are accepted conditions, but no widely applied medical definition. Lastly, the fourth type contains potentially medicalized cases, where medical conditions are not accepted and the medical definitions are not applied, yet there is a possibility for the medicalization of experiences or behaviors.

If the above categorization of diseases, disorders and disabilities is converted to a continuum, PPD appears to fall somewhere between the second and third types of conditions and definitions on the continuum. This will become evident as we sketch the process of the social construction of PPD by utilizing Brown’s (1995) analytical model. The process begins with the social discovery of disease, disorder or disability. This stage involves matters pertaining to diagnosis as well as illness experiences. This is followed by stages of treatment and outcome, which recursively affect the social construction of the condition. This process may further lead to issues of legitimacy through an appeal to state authority in legislatures and courtrooms.

In order to accomplish the above steps involved in the process, a wide range of literature was searched and critically reviewed over a period of three years. Various databases (e.g., Academic Search Premier, Social Services Abstracts, Sociological Abstracts, OVID databases, ProQuest) were searched and journal articles and book chapters were retrieved if they pertained to (i) a historical evolution of the term PPD, (ii) the debate about PPD as a distinct clinical disorder, (iii) perspectives of women about the label and lived experiences following childbirth, (iv) women’s perceptions and experiences with treatments and outcomes, and (v) perspectives of service providers and scholars. A wide array of quantitative and qualitative studies, as well as
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theoretical and conceptual literature, published between 1966 and 2011 was included in the review and analysis process. The literature was further scrutinized by utilizing the analytical model described by Brown (1995) and a constructionist lens, thus creating an intentional selection bias in the sampling of literature. In the following passages, we provide a description of the social discovery process, experiences of illness, and treatment and outcomes followed by implications for social work practice.

SOCIAL DISCOVERY

As the published literature attests, the social discovery of PPD, particularly identification and diagnosis, was driven by a combination of professional claims, self-labeling, and social movements, as described below.

Professional Claims

Professional claims include assertions in support of the discovery of PPD made by the medical fraternity (e.g., psychiatrists) as well as counter arguments resisting this discovery that were brought forward by some feminist scholars in recent decades. The history of medical claims can be traced to the 4th century BC when Hippocrates described postpartum mental illness, citing the case of a woman who had experienced severe insomnia and restlessness on the sixth day after giving birth to twins, became delirious on the eleventh day and died on the seventeenth day after becoming comatose (Berchtold & Burrough, 1990). Hippocrates postulated that physiological factors, such as milk diverted from the breast to the brain and suppression of lochial discharge, were causes of postpartum mental illness (Cox, 1986). However, the term PPD was not part of the description at that time.

In the mid-nineteenth century, several French physicians began detailing case studies of women with puerperal mental disorders with different and more changeable symptoms than mental disorders seen at other times in life (Cox, 1986; Jolley & Betrus, 2007). According to Chrisler and Johnston-Robledo (2002), these disorders occurring after childbirth were divided into two categories: (i) “puerperal” if the disorders happened within 6 weeks of childbirth, and (2) “lactational” if they occurred after 6 weeks. In 1858, Marcé, a French psychiatrist, argued for recognition of “postpartum illness” as a distinct psychiatric disorder that occurred within 12 months post-delivery (Chrisler & Johnston-Robledo, 2002; Cox, 1986). The term PPD gradually began to reappear in scientific writings when obstetrics and gynaecology emerged as medical specialties in the nineteenth century and male physicians began to compete with midwives (Chrisler & Johnston-Robledo, 2002). A feminist perspective on this competition between medicine and midwifery suggests that physicians attempted to secure economic, professional, and
political gains over midwives by perpetuating the idea that women’s minds and bodies were weak due to hormonal fluctuations especially after childbirth.

Hamilton (1992) noted that in the early years of the twentieth century, extensive efforts were made to connect medical and surgical diseases to their causes. Many diseases were given new names that reflected their perceived etiology. In psychiatry, efforts were made to uncover the etiology of major psychiatric illnesses and to develop a consistent nomenclature that reflected the causal attribution of the illnesses. However, Hamilton argues that the efforts to discover the causes of mental illnesses did not yield expected results. Consequently, the medical community was left to develop the naming and classification of psychiatric disorders on the basis of behavior patterns or clusters of symptoms as opposed to causal factors. Three broad categories of psychiatric disorders were conceptualized: (i) dementia praecox (later referred to as schizophrenia) was conceived as disorders in thinking; (ii) manic and depressive syndromes were perceived to be emotional or affective disorders; and (iii) toxic exhaustive psychoses (later called organic psychoses) were defined as illnesses in which toxic, metabolic, degenerative or traumatic agents interfered with the functioning of nervous system.

According to Hamilton (1992), it was believed that most illnesses could be named and classified in one of the three broad categories, except for psychiatric illnesses experienced by mothers after childbirth. The reason was that mothers with psychiatric illness following childbirth often exhibited behavioral patterns and symptoms which belonged to all three categories. Possibly due to the difficulties in defining and classifying postpartum psychiatric illnesses, in 1926, Edward A. Strecker, an American psychiatrist, suggested that the term “postpartum” and all of its symptoms should be expunged from the official lexicon of psychiatry (Berchtold & Burrough, 1990; Hamilton, 1992). Strecker further stated that there was no such thing as PPD (or postpartum psychosis) and that women showing such symptoms were suffering from the usual forms of depression, mania, or schizophrenia with certain symptoms being modified under the influence of labor (Hamilton, 1992).

Later in mid twentieth century, Pitt (1968) conducted a study involving a random sample of 305 maternity hospital patients who were given questionnaires designed to measure anxiety and depression at the seventh month of pregnancy and 6–8 weeks postpartum. Pitt found that 10% of the women were suffering from PPD. He also noted that the women’s depression was atypical as it was characterized by anxiety states or obsessive compulsive neuroses, irritability, guilt over not loving or caring enough for the baby and phobias (Pitt, 1968). Subsequently, several scholars asserted that PPD and postpartum psychosis were unique disorders and that the underlying physiological mechanisms (e.g., hormonal changes) were distinct from
the physiological and hormonal mechanisms involved in psychiatric conditions unrelated to childbearing (Dalton & Holton, 1996; Hamilton, 1992). Consequently, according to Brown (1995), the term PPD began to re-emerge in the scientific literature possibly due to professional expansionism by psychiatry. Godderis (2010) noted that, by the late 1970s and into the 1980s, research on PPD grew enormously with the development of key concepts and theories in this area. Consequently, the transition to motherhood became increasingly informed by scientific and medical discourses in Western society.

Miller, Pallant, and Negri (2006) state that, at present, postpartum psychiatric disorders (non-psychotic) are mainly conceptualized as PPD in the literature. However, there is a lack of consensus among professionals as to whether PPD is a separate clinical disorder or the same as major depressive disorder (MDD) occurring any other time in life (cf. Dalton & Holton, 1996; Hamilton, 1992; Jolley & Betrus, 2007; Whiffen, 1992). The Diagnostic and Statistical Manual (DSM V)) does not differentiate PPD from major depressive disorder (MDD) (American Psychiatric Association, 2010). In contrast, several clinicians and researchers assert that PPD is distinct from MDD as it involves insomnia, anxiety, panic attacks, verbal or violent irritability and agitation with depressive symptoms developing a little later (Beck, 2002; Beck & Indman, 2005; Dalton & Holton, 1996). Implicit in these competing claims about PPD as a distinct or a non-distinct clinical disorder is the assumption that certain experiences following childbirth qualify as mental disorder and should be diagnosed as either PPD or MDD with postpartum onset.

Self-Labeling or Self-Diagnosis

As noted by Chrisler and Johnston-Robledo (2002), in the climate of contesting claims by various professionals, PPD gradually became a vague entity which could easily be confused with postpartum psychosis, the baby blues, mal-adjustment to parenthood, preexisting conditions and any economic, interpersonal or other experiences that might occur during transition to motherhood. The term PPD and its definitions were so vague and elastic that every woman could see something of her own experience within them. Under such circumstances, some women self-diagnosed and thus validated the construct in the process.

Nicolson (1990) has observed that this form of self-diagnosis or self-labeling seemed to occur within the political contexts of the development of the institution of motherhood—that is, the development of certain expectations, practices, duties, and responsibilities regarding maternal work with limited power given to women—as well as increasing industrialization in modern Western society (Chrisler & Johnston-Robledo, 2002). The notion of the institution of motherhood includes assumptions that (i) women were naturally equipped with parenting skills due to maternal instincts and (ii) good mothers really enjoyed motherhood and all the work accompanying
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it (Nicolson, 1990). Chrisler and Johnston-Robledo (2002) assert that motherhood was romanticized and mystified by society as it served patriarchal interests of having happy, well-adjusted women who were content with their roles as primary caregivers.

Authors such as Chrisler and Johnston-Robledo (2002) viewed these patriarchal beliefs as being further highlighted in popular culture and the media including television shows, magazines, self-help books, and other forms of media. Such discourses established the categories of happy–healthy mothers and depressed–unhealthy mothers. This dichotomy seemed to be accentuated by medical and scientific discourses about PPD as a distinct medical illness that was qualitatively different from normal postpartum adjustment. Consequently, women whose experiences did not match the prevalent cultural beliefs about happy and joyous motherhood began to perceive their experiences as “deviant” or “abnormal” and sought an appropriate label to make sense of their suffering. Thoit (1985) argued that such self-labeling and treatment-seeking efforts implied that the women shared the cultural perspective of the larger society about motherhood, evaluated their behavior against the established norms that were transmitted through social interactions, and were motivated to adhere to the societal expectations.

According to Chrisler and Johnston-Robledo (2012), combined with the development of the institution of motherhood, the self-labeling process was immersed in modern societal values that encouraged people to believe that they had more control over their lives and bodies than may actually be possible. The preference for control, order and stability in industrialized Western societies viewed variability, unpredictability, and emotionality as inherently unhealthy. Consequently, women who felt “out of control” due to irritability, anger, and exhaustion within the context of motherhood were inclined to accept the label of PPD with regard to their experiences.

However, many women who accepted the label of PPD to account for their incapacitating experiences were not passive recipients of medical discourses; rather, they actively negotiated cultural, medical, and psychological knowledge regarding PPD. Sword, Busser, Ganann, McMillan, and Swinton (2008) maintain that the acceptance of the label PPD to account for post-natal experiences emerged within and through social interactions with health care providers (e.g., nurses, doctors), family members, and other mothers who convinced mothers that they were not their “normal” selves. Hence, legitimation and validation by others seemed to reassure some mothers that they were not going “crazy” but rather were suffering from a recognizable medical condition.

Nonetheless, not every woman who experienced emotional, interpersonal, or physiological difficulties in the context of motherhood was convinced about the applicability of the label PPD. Several scholars have asserted that women demonstrated considerable diversity in the ways in which they negotiated, accepted, resisted, or rejected the label, partly
because accepting the label PPD meant accepting the labels of being “mentally ill” and “unfit mother” (Mauthner, 1999; Sword et al., 2008; Verta, 2000). This was evident in a study by Lewis (1995) who found that women interpreted the diagnostic label of PPD in four ways; these included (1) accepting the diagnosis with relief, as liberating and as validating, (2) accepting the diagnosis but implicitly questioning it, (3) rejecting the diagnosis as inappropriate and, (4) wanting a diagnosis of depression in order to validate problems, but struggling with physicians who denied or resisted making a diagnosis of depression.

Social Movement

In addition to professional claims and self-labeling processes, social movement played an important role in the emergence and consolidation of the term PPD. Verta (2000) explained that, once a sufficient number of women recognized their experiences as PPD, they formed activist organizations (e.g., Depression After Delivery, Postpartum Support International) and initiated a self-help movement that linked women with support groups, national and regional conferences, and newsletters and other publications. Interestingly, Verta (2000) noted that participants in the postpartum support group movement came mainly from the White, educated, and upper-middle-class strata of the society; these women were struggling to balance work and family roles as their participation in paid employment caught up with that of African-American, single, and working-class women. According to Verta (2000), this self-help movement made use of “survivor” narratives to highlight the issues of gender subordination and the self-silencing of women who were submerged in traditional feminine roles. Consequently, PPD was redefined as an injustice linked to oppressive gender inequality and patriarchal standards regarding ideal and intensive mothering (Hays, 1996; Wall, 2010). At times, as Verta (2000) observed, women joining these self-help movements stated that it was not the reactions of physicians, nurses, or medical providers that led them to assess their feelings as signs of PPD; rather identification and self-diagnosis emerged from the discrepancy between gender socialization, which led them to accept the assumptions of ideal motherhood characterized by a natural, intuitive, and joyous experience and actual experiences of depression and anxiety following childbirth.

From Verta’s (2000) perspective, self-help movements provided a safe environment for women to express their negative and “deviant” emotions regarding motherhood, to challenge the myths of motherhood as a natural, essential and inevitable, to highlight the heavy demands placed on modern women, and to call attention to the way maternal “self-sacrifice” undermined women’s identities and well-being. Self-help activists asserted that PPD was a distinct disorder; consequently it provided a label to women for their deviant experiences and emotions following childbirth. Activists
publicized the personal tragedies and sufferings of women and their families during face-to-face encounters with physicians and administrators, at medical and mental health conferences, through aggressive letter-writing campaigns, and through media appearances on national talk shows. Paradoxically, the movement emphasized that maternal satisfaction was not inevitable, yet it reaffirmed cultural beliefs by promising to restore to women the happiness and joy of motherhood (Verta, 2000).

The above-noted efforts by professionals and self-help activists further led to the legitimization of PPD as mental disorder with the development of policy initiatives (e.g., National Perinatal Depression Plan, Australia), passing of legislation (e.g., Infanticide Act, Britain), and appeals to state authorities in the courtrooms regarding maternal suicide or infanticide in Western society (Chrisler & Johnston-Robledo, 2002; Hayes, 2010; Ushher, 2005). The discussion of these developments and their role in the dynamic process of construction of PPD is beyond the scope of this article.

ILLNESS EXPERIENCE

Once PPD was identified as a mental health disorder, the forms in which women subjectively experienced illness contributed to an ever-changing construction. For instance, as Beck and Indman (2005) explain, mothers’ narratives in the literature revealed that they experienced anxiety, irritability, anger, guilt, and intrusive thoughts along with sadness and crying. Many women found the label PPD a misnomer as it was not inclusive of the above experiences. Varied authors have noted that, as a result, terms such as “perinatal anxiety and depression” or “postpartum mood disorders” were proposed by scholars to be inclusive of women’s diverse experiences (Hayes, 2010; Matthey, Barnett, Howie, & Kavanagh, 2003).

Besides diversity in the perceived applicability of label PPD, women’s perceptions and the framing of the etiology of PPD varied considerably, thus giving rise to ever-changing constructions of PPD. Based on the published literature, many women felt that their symptoms of PPD were a normal part of motherhood and could be attributed to causes other than depression, such as fatigue, relationship difficulties, personal weakness, normal adjustment difficulties in the postpartum period (Sword et al., 2008), multiple losses related to identity and autonomy (Nicolson, 1990), lack of power in the devalued world of motherhood (Edhborg, Friberg, Lundh, & Widstrom, 2005), and unrealistic or unattainable myths of ideal motherhood (Bilszta, Eriksen, Buist, & Milgrom, 2010).

On the basis of women’s narratives, Nicolson (1990) argued that depression occurring after the birth of a child was not a pathological or abnormal medical condition; rather, it was a healthy grieving response in the context of multiples losses, powerlessness, and the paradoxical status of motherhood.
The latter was believed to actively prevent mothers from mourning their losses or acknowledging the negative emotions that contradicted the normative expectations about “joyous” motherhood. Under such circumstances, the emergence of a new disorder called PPD negated the significance of the social, cultural, and economic contexts surrounding childbirth and allowed medical professionals to acquire greater control and power over female bodies by medicalizing and pathologizing their experiences (Beck, 2002; Godderis, 2010). However, several writers argued that these claims about PPD being a normal grieving response seemed to trivialize some women’s experiences and feelings that they described as terrifying and abnormal (Amankwaa, 2003; Mauthner, 1999; Sword et al., 2008; Ussher, 2005). Furthermore, as Ussher (2005) states, the claims about PPD as a normal reaction seemed to create a misconception that depression was inevitable following childbirth and that mothers suffering from it probably did not require mental health care services or other forms of supports.

Mauthner (1999) asserted that women showed considerable agency and diversity in describing, defining, and labeling their difficulties following childbirth. Interviews with forty women revealed a range of emotional and interpersonal difficulties experienced by different women with some calling their experiences “debilitating and devastating depression,” while others described them as “manageable distress or low mood” (Mauthner, 1999). Among these 40 women, 18 acknowledged that the label PPD enabled them to make sense of their experiences and relieved them of self-blame as they could attribute their behavior and moods to a recognized medical condition. However, the picture of subjective illness experiences was far more complex than what initially appeared to be a dichotomy of acceptance or rejection of PPD as a pathological or non-pathological condition. Published literature indicates that women who accepted the label provided varied explanations for their illness experiences, including hormonal etiology (McIntosh, 1993), unwanted pregnancy (Leathers & Kelley, 2000), intimate relationship difficulties (Beck, 2001), income and financial problems, dissatisfaction with maternity care providers, and disruption in birthing plans (Benoit, Westfall, Treloar, Phillips, & Jansson, 2007). As Ussher (2005) noted, even those women who accepted the hormonal etiology admitted that there was more to their depression than mere biology—that is, interpersonal, social, and cultural factors were implicated in their depression.

Additionally, Abrams and Curran (2003) observed that illness experiences and their interpretations seemed to intersect with race, social class, country of residence and culture even though the popular literature portrayed PPD as primarily a White, middle-class, educated, professional, heterosexual, married woman’s affliction. Amankwaa (2003) explained that these biased portrayals were well reflected in the statements of African-American women who considered PPD a “White woman’s disorder” and believed that they could never suffer from it. Similarly, based on the work
of numerous authors, immigrant women showed considerable ambivalence about the applicability of the label PPD to their experiences of lack of energy, difficulties with normal activities, mood swings, and cognitive impairment (Nahas, Hillege, & Amasheh, 1999; Templeton, Velleman, Persaud, & Milner, 2003). According to Nahas et al. (1999), a large number of women stated that they had never heard of PPD until they migrated to a developed nation, attended clinics, and interacted with nurses or midwives.

Templeton et al. (2003) asserted that, once given a label by health care professionals, some immigrant women have accepted it, while others believed that their problems were due to migration to a foreign country, limited financial resources, increased child care responsibility, unavailability of family networks, lack of cultural rituals surrounding childbirth, and racial discrimination, rather than being due to a medical condition called PPD. Similarly black Caribbean women in the United Kingdom and African-American women did not necessarily identify with the label PPD; rather, they suggested that one of the most powerful counters to depression resided in their self-concept as “strong black women” and responses to the historical legacy of slavery in the face of which they had to be “strong” to protect their children. Authors such as Amankwaa (2003) and Edge, Baker, and Rogers (2004) further suggested that depression was an inappropriate and disproportionate response to any form of adversity, thus implying that a long history of adversity possibly raised black women’s endurance in dealing with multiple stressors. While not paying sufficient attention to cultural worldviews and historical legacies, some scholars assumed that women’s ambivalence toward or rejection of PPD could be attributed to a lack of knowledge and awareness about PPD, stigma attached to mental disorder, fear of being judged a bad mother, and fear of child protection services (Ahmed, Stewart, Teng, Wahoush, & Gagnon, 2008; Bilszta et al., 2010; Dennis & Chung-Lee, 2006).

In addition to ethnicity, race, and immigration status, the construction of PPD was shaped by social class. The literature indicates that many middle-class women seemed to explain their symptoms of PPD in terms of identity issues (Edhborg et al., 2005) and gender inequality (Verta, 2000); in contrast, low-income women, particularly young mothers, often described PPD in terms of socioeconomic disadvantages and stressors such as housing, employment, and financial difficulties (McIntosh, 1993). Moreover, young low-income women perceived themselves as suffering from normal and inevitable consequences of the burdens and pressures placed on them. These women did not consider themselves “ill.” Rather, these women perceived their problems as social in nature and saw no role for health care professionals in resolving them. The next section focuses briefly on treatment and outcomes as they form a link in the social construction process of PPD.
TREATMENT AND OUTCOMES

Discussion of treatment and outcomes in the context of social construction might appear somewhat out of place; however, they both seem to operate as feedback loops for the ever-changing constructions of PPD. Numerous authors have described how the continuous search for efficacious pharmacological (e.g., anti-depressants) and non-pharmacological (e.g., cognitive behavior therapy) treatment interventions strengthens approaches to the medicalization of women’s experiences (Cuijpers, Brannmark, & van Straten, 2008; Goodman & Santangelo, 2011; Longsdon, Wisner, & Hanusa, 2009).

In addition, as explained by Dennis and Chung-Lee (2006), while constructing their own definition of illness experiences, women also construct what they consider to be appropriate ways to respond to it and to treat it. Women’s choices for care depend not only on medical criteria, but also on other factors such as personal biographies, functioning level, informal support networks, social and economic conditions, personal health beliefs, perceived stigma, and consequences of seeking help. Even when women’s experiences are diagnosed as PPD, many women show considerable discretion about whether they seek medical treatment or not (Dennis & Chung-Lee, 2006).

Amankwaa (2003) stated that this was evident among African-American women who preferred to seek assistance from the kinship networks (e.g., grandmother of the baby, sisters), friends and neighbors while dealing with difficulties following childbirth instead of relying on the professional health care system. In a large multicultural study spanning 15 centers in 11 countries, Asian women in the United Kingdom considered professional or medical assistance inappropriate for treating postpartum depression (Oates et al., 2004). Similarly, Templeton et al. (2003) found that women belonging to an ethnic minority group in rural areas in the United Kingdom preferred to attend community centers and support groups where they learned English and went on shopping trips with other women instead of discussing their distress with health care professionals. Nahas and Amasheh (1999) contend that, among Jordanian-Australian women, the meaning of care included family and kinship support, preservation of customs surrounding childbirth, and support to fulfill traditional gender roles as mother and wife. Once again, women’s choices of care-seeking appeared to intersect with race, social class, and cultural worldviews that shaped their construction of experiences following childbirth and their responses to these constructions.

Furthermore, this discretion in treatment-seeking was often a matter of how the condition was constructed by larger societal, cultural and political forces. For instance, it has been argued that women have refrained from seeking help from health care professionals due to the fear of being judged “bad” mothers (McIntosh, 1993), stigma associated with mental illness
(Berggren-Clive, 1998), fear of being admitted to a psychiatric unit, concerns over the potential side effects of pharmacological interventions (Dennis & Chung-Lee, 2006), anxiety about the potential involvement of child protection services (Ahmed et al., 2008), concerns about destroying family honor and personal beliefs that the symptoms were self-limiting (Sword et al., 2008).

In contrast, other writers have stated that those women who sought services from health care professionals were usually prompted by the need to seek symptom relief and to restore impaired functioning levels which had deteriorated to an unacceptable level (Ahmed et al., 2008; McIntosh, 1993; Sword et al., 2008). According to Turner, Sharp, Folkes, and Chew-Graham (2008), women with a previous history of depression or PPD were more willing to accept the diagnosis and seek medical treatment, including pharmacological interventions. Turner et al. (2008) noted that, at times, women initiated pharmacological treatment reluctantly as they were afraid of side effects for infants and possible life time dependency on them. However, many women acquired more positive views towards medications on the basis of personal experience with medications and ongoing discussions with clinical practitioners.

Turner et al. (2008) asserted that the relationships of women with their general practitioners seemed to have a significant influence on their decision to take medications. However, these women were not passive recipients of prescribed medications; they often changed the dose as per their perceived needs, stopped taking them without consulting their physicians or relied on them beyond the prescribed time due to fear of relapse. On the other hand, several women with the diagnosis of PPD refused to take medications and preferred to accept counselling or therapeutic interventions as they needed someone with whom to talk about their issues. These women stated that they did not have friends or family members they could confide in (Turner et al., 2008). However, as Dennis and Chung-Lee (2006) found, decisions about help-seeking activities to obtain professional assistance were not always taken by mothers alone. At times, women’s concerns and anxieties were minimized or censored by health care professionals, partners, family members, and friends. Yet, Sword et al. (2008) noted that, in some instances, women were encouraged to seek professional help by their partners or by family members.

The above literature reveals that varied perceptions and beliefs regarding outcomes of help-seeking seemed to shape women’s construction of PPD and vice versa. Furthermore, treatment and outcomes or care-seeking were shaped by social interaction, cultural perspectives and structural forces. Consequently, treatment and outcomes recursively affected the construction of PPD as a medical or non-medical condition.
IMPLICATIONS FOR SOCIAL WORK PRACTICE

The above analysis of the emergence of PPD reveals that the definitions, explanations, and ever-changing constructions go beyond biomedical criteria and involve historical, social, cultural, and structural dimensions. The varied meanings and interpretations of PPD also reveal the intersections between race, class, ethnicity, and gender along with biomedical perspectives in the construction of PPD (Weasel, 2004). PPD is an *objective* medical condition for some, while it is a self-limiting form of situational distress for others. For some it is a serious psychiatric problem, while for others it is a social problem rooted in socioeconomic disadvantages, gender inequality and cultural ideals regarding motherhood. Given the competing and contradictory claims about PPD, it is apparent that the term falls somewhere between the second and third types of medical condition on the continuum presented by Brown (1995). Consequently, the label PPD precludes adherence to a particular intervention and requires practitioners to demonstrate flexibility and creativity in dealing with clients.

Under such circumstances, social workers need to honor the interpretations of clients, counter the hegemonic influence of the medical model and provide services that align with clients’ worldviews. In order to meet these aims, social workers may adopt such practice models as *narrative therapy* (White & Epston, 1990), *collaborative language systems* (Anderson & Goulishian, 1992), *reflexive family therapy* (Hoffman, 1992), and *constructive social work* (Parton & O’Byrne, 2000). These models allow practitioners to engage in dialogic, reflexive, and collaborative assessment and intervention processes aimed at co-constructing new possibilities for addressing meanings, feelings, thoughts, and actions (Cooper, 2001; Furman, Jackson, Downey, & Shears, 2003; Iverson, Gergen, & Fairbanks, 2005; Lit & Shek, 2002). In addition, social workers may adopt feminist (Ussher, 2005) and anti-oppressive practice approaches (Mullaly, 2007) that allow women to explore collaboratively the connections between individual and interpersonal difficulties on one hand and the larger social, cultural, and structural issues on the other hand. Practitioners may assist women to identify and challenge oppressive cultural constructions of a “perfect” mother who independently balances child care, household chores, and possibly work responsibilities with the greatest aplomb and who enjoys the tasks associated with child rearing. This means that social workers need to engage with mothers in bringing about greater awareness regarding the realities of childbirth and motherhood. Furthermore, women’s vulnerabilities following childbirth do not have to be framed as “illness” unless the mother accepts the medical model. In addition, social workers should be attentive to the social and discursive contexts of women’s lives and their personal agency along with dilemmas and paradoxical beliefs.
Since many Western countries have sizable populations of immigrant women, it is imperative that social workers become sensitive to their worldviews and needs (Larson, 2008). Women in non-Western cultures may not describe their postpartum vulnerabilities in terms of “mental illness,” may not subscribe to notions of gender equality, and may not possess unrealistic ideals about a “perfect” mother or intensive mothering. Many non-Western women are made aware of the hardships of motherhood by their family members (Kim & Buist, 2005), and may prefer to adhere to traditional feminine roles as mother and wife (Nahas & Amasheh, 1999). Under such circumstances, social workers should strive to create culturally safe environments in which women may securely express themselves, in situations in which there is no challenge to or denial of their identity (Williams, 1999). Such an approach should recognize how the disorder known as PPD has been socially constructed largely within the Western world.

REFERENCES


