

**Anatomy of an Illness – Part 2: Postpartum Depression**

Shreeja S. Vachhani

School of Social Work, University of Michigan

SW600-002: Behavioral, Psychosocial, and Ecological Aspects of Health, Mental Health, and  
Disease

Dr. Lydia Li

## **Meaning of the Illness/Condition**

In our society, there is a deeply ingrained belief that mothers are the “glue” of the family unit and they often sacrifice their own needs for the sake of their children. This expectation is particularly high in the Latina community, where postpartum depression (PPD) is not only stigmatized but also met with harsh judgment (Sampson et al., 2021). Latina women who experienced PPD described how people in their community labelled them “crazy” or “alone, loco, or seeking attention,” reflecting a lack of understanding and empathy surrounding maternal mental health (Sampson et al., 2021). While the importance of family support is widely acknowledged and valued within this community, it can further perpetuate stigma because if a mother with young children is depressed, people think that she must be isolated or lacking assistance from family members. In some cultural contexts such as Mexico, there is a tendency towards denial of the condition (by family and community) or labelling depressed mothers as “bewitched” (Sampson et al., 2021). These examples illustrate the beliefs and assumptions surrounding PPD within certain cultural frameworks. Women experiencing PPD often find themselves navigating various societal assumptions and negative beliefs that not only shape external perceptions but also affect their self-perception. Research shows that many women view PPD as a common occurrence, believing it is normal for them to feel sad during pregnancy and questioning their ability to be good mothers (Daehn et al., 2022). These attitudes reflect broader societal assumptions about maternal mental health wherein PPD is directly linked to women's innate ability to care for their children and their unrealistic expectations about motherhood (Branquinho et al., 2019).

In their research article, Shaikh and Kauppi (2015) examine the social construction of PPD through a historical lens. The history of PPD traces back to ancient times, with Hippocrates describing cases of women experiencing severe insomnia and restlessness after childbirth. The

specific term "postpartum depression" was not yet part of the medical vocabulary during his time. In the mid-19th century, French physicians started categorizing postpartum disorders into two groups, based on the duration during which they occurred after childbirth. In 1858, a French psychiatrist named Marce advocated for postpartum illness to be recognized as a distinct psychiatric disorder occurring within 12 months after delivery. The term PPD gradually started appearing as obstetrics and gynecology gained recognition as medical specialties. In the early 20th century, significant efforts were made to link medical conditions to their underlying causes. This included the categorization of psychiatric disorders into three groups: disorders in thinking, emotional or affective disorders, and toxic exhaustive psychoses. However, the psychiatric illness experienced by mothers post-childbirth was not able to be categorized within these definitions because these mothers often exhibited behavioral patterns and symptoms overlapping across all three categories. By the mid-20th century, scholars began to recognize the unique characteristics and mechanisms (e.g., hormonal changes) of postpartum psychiatric disorders. This led to a rise of interest in PPD within scientific literature along with a shift in power dynamics, as medical professionals gained authority in defining and treating maternal mental health. Currently, postpartum psychiatric disorders are conceptualized as PPD in scholarly literature. However, there is a lack of consensus among experts regarding whether PPD should be considered a separate clinical disorder or a subset of major depressive disorder (MDD), as the DSM V does not distinguish PPD as its own category from MDD. Within the societal context of motherhood, maternal roles often lack the power and value they deserve. When PPD became known as a disorder, it made people pay less attention to the big picture of how society, culture, and money affect childbirth. Moreover, it enabled medical professionals to exercise greater control and authority over women's bodies by pathologizing and medicalizing their experiences.

Health beliefs can significantly influence how individuals and families respond to and cope with PPD, with cultural and social identities playing a crucial role in shaping these beliefs. Certain families with negative attitudes towards help-seeking have strong beliefs that it is the family's responsibility to manage difficulties, and women are often discouraged from seeking help beyond their immediate circle (e.g., mothers and aunts) (Bilszta et al., 2010). Research also indicates that PPD is not viewed as a pathological or abnormal medical condition by some women; instead, it is seen as a natural response to the challenges of motherhood, including feelings of powerlessness and grief over multiple losses (Shaikh & Kauppi, 2015). Furthermore, women who accepted the label of PPD often provided varied explanations for their experiences, ranging from hormonal causes to interpersonal, social, and cultural factors (e.g., unwanted pregnancy, intimate relationship difficulties, and financial problems) (Shaikh & Kauppi, 2015). For instance, immigrant women are likely to feel ambivalent about whether the label of PPD applies to their experiences. They might attribute their symptoms to external factors such as migration, financial constraints, or racial discrimination rather than seeing them as solely medical issues. Social class plays a significant role in shaping beliefs about PPD, with middle-class women often viewing their symptoms in terms of identity issues and gender inequality, while low-income women viewing their struggles through the lens of socioeconomic disadvantages and stressors like housing or employment (Shaikh & Kauppi, 2015). This often leads to differences in women's perceptions of the illness and the role of healthcare professionals in addressing these issues. This is because some women might not recognize themselves as "ill" and see their problems as social in nature, hindering their engagement with healthcare systems.

The response of individuals and families to PPD can be influenced by broader cultural structures and environmental conditions, shaping their experiences with healthcare professionals

and treatment options. Condescending attitudes from health professionals can undermine the confidence of mothers and heighten feelings of frustration with the support and advice they receive (Bilszta et al., 2010). In some cases, general practitioners may attempt to normalize feelings of distress rather than actively treat or manage a woman's mood, leading to mothers feeling low self-esteem and guilt (Bilszta et al., 2010). Additionally, fears of judgment as "bad" mothers, concerns about being admitted to psychiatric units, and worries about the involvement of child protective services can deter women from seeking help from healthcare professionals (Shaikh & Kauppi, 2015). These concerns may appear as internalized beliefs or feelings within women, but in reality, they are shaped by broader structural and societal constructs because of society's assumptions about how women with PPD need to be dealt with. Moreover, the intersection of poverty and PPD adds another layer of complexity, as financial constraints impact women's ability to access healthcare, afford childcare, and make choices that promote their own well-being (Maxwell et al., 2018). For instance, in a study examining women's qualitative experiences of PPD, one participant expressed concern about returning to work too soon due to financial constraints, stating, "I didn't want to go back to work when he was six weeks old 'cause he's still a newborn, and that will make me feel even worse if I do something like that. Now I have to go back to work" (Maxwell et al., 2018). This study also revealed how cultural differences in birthing practices and postpartum care can intensify PPD symptoms, with culturally incompetent care contributing to feelings of distress. These findings highlight the importance of addressing systemic issues such as ableism, sanism, and racism within healthcare systems to provide more supportive and culturally sensitive care for individuals and families affected by PPD.

## **Psychosocial Impact**

The psychosocial demands of PPD significantly impact the continuum of care, having effects at various stages from diagnosis to potential end-of-life considerations. Upon seeking diagnosis and treatment, women returning to work after childbirth may encounter psychological job demands such as limited control over their work schedule, which can exacerbate PPD symptoms (Dagher et al., 2009). Throughout the treatment process, ending therapy or professional contact can lead to feelings of distress and anxiety, particularly if women feel they lack control over this decision or think they still have unresolved issues (Hadfield & Wittkowski, 2017). Furthermore, the feelings of social isolation associated with PPD (e.g., fatigue and worthlessness) can strain interpersonal relationships, leading to marital conflict, separation or divorce (Letourneau et al., 2012). Women may also experience intrusive thoughts about suicide and infanticide as they might feel burdened by the responsibilities of child rearing (Letourneau et al., 2012). Beyond treatment, the longstanding impact of PPD on household functioning and the prevalence of suicidal ideation among mothers highlights the need for holistic care approaches that address the various psychosocial demands associated with this condition.

People with PPD require various forms of support and resources to navigate their journey through diagnosis, treatment, and beyond. Antenatal education classes are seen as essential places to provide information on emotional changes after childbirth and guidance on seeking help (Bilszta et al., 2010). Women with PPD reported that a dedicated 24-hour telephone support line specific to postnatal mood disorders would also be helpful in offering immediate assistance. Additionally, having continuity of care between antenatal and postnatal services can foster a sense of community and support for women experiencing PPD (Bilszta et al., 2010). Women expressed that emotional validation and support would be crucial, granting them the "permission

to speak" about their feelings (Bilszta et al., 2010). They identified empathy, kindness, and a comprehensive understanding of available resources as essential qualities in health professionals assisting women with PPD. Women who experienced PPD thought that tailored interventions that consider individual needs, cultural backgrounds, and access to peer support are also ideal (Hadfield & Wittkowski, 2017). Moreover, research suggests that accessing support from peers who have experienced PPD first-hand can offer valuable insights and validation to women experiencing PPD (Hadfield & Wittkowski, 2017). By addressing these diverse needs, individuals with PPD can receive the comprehensive support necessary for their recovery.

Caregivers supporting individuals experiencing PPD, particularly fathers, typically experience emotional and practical challenges throughout the journey (Letourneau et al., 2012, Meighan et al., 1999). Fathers can experience symptoms of depression themselves as they support their partners through PPD. However, societal gender norms may discourage men from seeking professional help, which leaves them feeling caregiver burden and a range of negative emotions such as anxiety, fatigue, and powerlessness (e.g., inability to “fix” the problem). Fathers may also feel overwhelmed, isolated, and frustrated, which can lead to strained relationships and increased stress. They may make significant sacrifices to maintain family bonding during a difficult time, but commonly struggle with feelings of loss of control and intimacy. To address these issues, interventions targeting the whole family are considered essential. Caregivers require comprehensive information about PPD to effectively support their partners, yet little is known about effective therapies for fathers in the postpartum period. To meet the needs of caregivers at different stages, interventions should include prenatal screening, education, and counselling for both parents, along with practical support such as follow-up

telephone calls and access to support groups. Overall, increasing awareness and sensitivity to the needs of caregivers is crucial for effective management of PPD.

Women experiencing PPD can access a variety of resources, both nationally and locally, to support them through their journey. In response to the increasing popularity of telehealth, many of these resources are now available online for easy access. For instance, Postpartum Support International (PSI) offers free virtual support groups led by trained facilitators, providing a platform for parents to connect, share experiences, and access valuable information. Moreover, through their website, women and families can locate local resources and providers trained in treating perinatal mood and anxiety disorders. Similarly, online discussion boards like "What to Expect" offer a space for individuals to share their experiences, seek advice, and find validation from others facing similar challenges. Moreover, institutions like the University of Texas Houston's McGovern Medical School have compiled comprehensive lists of postpartum mental health resources, including emergency contacts, therapists, support groups, and recommended reading materials, catering to specific regions within Texas while also highlighting the abundance of resources available nationally.

Women experiencing PPD often seek support from various sources influenced by factors like race, social class, and cultural beliefs. Relying on familial relationships (e.g., grandmothers, sisters, and friends) are preferred by some women, particularly African-American women, over healthcare professionals for postpartum support (Shaikh & Kauppi, 2015). Social support from family members and friends is known to act as a buffer against PPD (Sampson et al., 2021). However, barriers to seeking professional help include the cost of treatment, stigma, and uncertainty about where to seek help (Daehn et al., 2022). Personal strengths and having a support system are crucial in coping with PPD, with some women finding comfort in focusing on



their children or seeking connections with other mothers who have experienced PPD (Maxwell et al., 2018). Relationships between healthcare providers and mothers also play a pivotal role in the quality of the PPD experience, emphasizing the importance of a non-judgmental approach and continuity of care from healthcare professionals (Hadfield & Wittkowski, 2017).

### **Social Work Role**

Social workers play a crucial role in supporting mothers experiencing PPD by providing culturally sensitive care and honoring their subjective experience of PPD. Using feminist and anti-oppressive practice approaches, social workers can challenge oppressive cultural constructions of motherhood and create safe environments for women to express themselves (Shaikh & Kauppi, 2015). Social workers can also provide psychoeducation to raise awareness about the realities of childbirth and motherhood, while incorporating faith-based, cultural, social, and community supports into treatment (Polmanteer et al., 2018). Social workers could use a trauma-informed lens to address the co-occurrence of trauma and PPD, particularly in vulnerable populations. Social workers are capable of meeting mothers' needs and expectations while promoting empowerment, person-centered practice, and dignity (Polmanteer et al., 2018). An integrated approach to caring for women experiencing PPD involves collaboration across multiple disciplines, including mental health, medicine, pediatrics, social work, nursing, and community support systems. This interdisciplinary approach emphasizes various components of women's wellbeing, such as lifestyle adjustments, counseling, nutrition, and social support. For instance, encouraging mothers to openly express their feelings and connecting them with individuals who can assist with childcare, household tasks, and errands can reduce some stressors. Social workers play a pivotal role in connecting women to these resources and

providing integrated care. Using a person-centered approach ensures that treatment is comprehensive, individualized, and considers the patient's preferences throughout care.

### **Final Personal Reflection**

This assignment has significantly deepened my understanding of PPD and its impact on women's lives. Initially, I underestimated the complexity of this condition, not realizing its behavioral, psychological, and ecological dimensions, as well as its subjective nature. I have learned that there is no one-size-fits-all approach to treating PPD; interventions must be comprehensive and tailored to individual needs. Moving forward, I recognize the importance of applying a person-in-environment perspective in my future practice as a social worker, acknowledging each person's unique circumstances and providing personalized care and resources. I aim to foster empowerment, empathy, and understanding while addressing stigma and societal barriers to effectively support women with PPD. Overall, this assignment has highlighted the importance of social support and access to resources in addressing the challenges associated with PPD.

## References

- Bilszta, J., Ericksen, J., Buist, A., & Milgrom, J. (2020). Women's experience of postnatal depression—Beliefs and attitudes as barriers to care. *The Australian Journal of Advanced Nursing*, 27(3), 44–54. <https://doi.org/10.3316/informit.909929185761432>
- Branquinho, M., Canavarro, M. C., & Fonseca, A. (2019). Knowledge and attitudes about postpartum depression in the Portuguese general population. *Midwifery*, 77, 86–94. <https://doi.org/10.1016/j.midw.2019.06.016>
- Daehn, D., Rudolf, S., Pawils, S., & Renneberg, B. (2022). Perinatal mental health literacy: Knowledge, attitudes, and help-seeking among perinatal women and the public – a systematic review. *BMC Pregnancy and Childbirth*, 22(1), 574. <https://doi.org/10.1186/s12884-022-04865-y>
- Dagher, R. K., McGovern, P. M., Alexander, B. H., Dowd, B. E., Ukestad, L. K., & McCaffrey, D. J. (2009). The psychosocial work environment and maternal postpartum depression. *International Journal of Behavioral Medicine*, 16(4), 339–346. <https://doi.org/10.1007/s12529-008-9014-4>
- Hadfield, H., & Wittkowski, A. (2017). Women's experiences of seeking and receiving psychological and psychosocial interventions for postpartum depression: A systematic review and thematic synthesis of the qualitative literature. *Journal of Midwifery & Women's Health*, 62(6), 723–736. <https://doi.org/10.1111/jmwh.12669>
- Letourneau, N. L., Dennis, C.-L., Benzies, K., Duffett-Leger, L., Stewart, M., Tryphonopoulos, P. D., Este, D., & Watson, W. (2012). Postpartum depression is a family affair: Addressing the impact on mothers, fathers, and children. *Issues in Mental Health Nursing*, 33(7), 445–457. <https://doi.org/10.3109/01612840.2012.673054>

- Maxwell, D., Robinson, S. R., & Rogers, K. (2019). “I keep it to myself”: A qualitative meta-interpretive synthesis of experiences of postpartum depression among marginalised women. *Health & Social Care in the Community*, 27(3). <https://doi.org/10.1111/hsc.12645>
- Meighan, M., Davis, M. W., Thomas, S. P., & Droppleman, P. G. (1999). Living with postpartum depression: The father’s experience. *MCN: The American Journal of Maternal/Child Nursing*, 24(4), 202.
- Polmanteer, R. S. R., Keefe, R. H., & Brownstein-Evans, C. (2019). Trauma-informed care with women diagnosed with postpartum depression: A conceptual framework. *Social Work in Health Care*, 58(2), 220–235. <https://doi.org/10.1080/00981389.2018.1535464>
- Sampson, M., Yu, M., Mauldin, R., Mayorga, A., & Gonzalez, L. G. (2021). ‘You withhold what you are feeling so you can have a family’: Latinas’ perceptions on community values and postpartum depression. *Family Medicine and Community Health*, 9(3). <https://doi.org/10.1136/fmch-2020-000504>
- Shaikh, A., & Kauppi, C. (2015). Postpartum depression: Deconstructing the label through a social constructionist lens. *Social Work in Mental Health*, 13(5), 459–480. <https://doi.org/10.1080/15332985.2014.943456>