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(Re)constructing Postpartum Depression (PPD) via Cross-Specialty Analysis and an Anthropological Lens of Subjectivity

By

Tanvi Shah

Dr. Jessica Ham
Advisor

Anthropology and Human Biology

Dr. Jessica Ham
Advisor

Dr. Sarah Blake
Committee Member

Dr. Ozawa-de Silva
Committee Member

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An abstract of

A thesis submitted to the Faculty of Emory College of Arts and Sciences

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Abstract

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Postpartum depression (PPD) and similar maternal mental health conditions often go undiagnosed due to individual and systemic barriers, along with an overall lack of identification in this unclear classification system of ranges of postpartum experiences that are grouped in with generalized depression despite the unique biological and psychosocial changes that arise with the aftermath of birth. To explore the existing gap in the care of PPD, under the theoretical framework of subjectivity, this thesis explores the dynamic institutional relations via policy measures and the responsibility of care cross-specialty in our healthcare systems and societal perspectives. Controversies of ideations and expectations of emotional processes and formations opposed to the subjective and personal memories of mothers themselves are further assessed via ethnographic interviews of providers across pertaining specialties to PPD: obstetrics & gynecology, pediatrics, primary care, psychiatry, and midwifery on their postpartum encounters professionally inside the healthcare system and personally outside the healthcare system. Summary templates on Microsoft Excel were used to evaluate patterns in such subjective experiences. The results indicate common themes of subjective findings like cultural variations, systemic flaws, and the medicalization of PPD. Overall, it was found that the emotional states of postpartum are all on a spectrum and hard to identify due to the difficulty in the classification of emotions and barriers of care. Through provider narratives, this ethnography illustrates considerations of PPD to illustrate the critical considerations of subjectivity to ultimately better identify, treat, and prevent PPD.

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Chapter 1: Introduction-- Establishment of the Barrier

I. Personal Statement and Motivations

In advance of introducing all the existing literature on subjectivity, provider impressions of postpartum depression (PPD), and the current policies around the matter in the healthcare field, I wish to first discuss my personal reasoning for why I am investigating this topic and what I hope to gain from this all in the future.

The tension filled the space in a smothering manner. No words were spoken. Yet, there was noise; the loudest noise unsaid in the silence. Twelve-year-old me sat in a crowded food court, looking up from the uneaten food on the white table which screamed emptiness, only to find my mother's face freely falling with tears as she sat statue-like. I stared at her blatantly, but it felt as though the table held an invisible wall that I was unable to cross. I felt useless. I could read the tension well, but I was useless–stuck on the other side of the barrier. And so, I continued to stare at someone who, although I've known her all my life, was essentially a stranger to me, us both remaining rooted in place while the outside world moved forward around us. What I didn't know looking back, was that this was around the time shortly after my brother was born, my father had officially left us, and my mom was dealing with the messiness of postpartum. The feeling of inability I had at that moment remains unforgettable. After this pure moment of shock, I started feeling more drawn into exploring the intersection of the body and mind because of my personal yet inevitable interest in mental and women's health.

Looking back, *"I clearly needed help and was lucky to make it through"*, are the words of my mother, present day, 21 years later after I was born. A young, 30-year-old, South-Asian woman had moved across the world overseas for an arranged marriage to honor and live up to the expectations of everyone else around her. Being a mother is difficult enough as it is, but with her life uprooted to an entirely new country, being married to a person who was extremely different behind closed doors, and starting a residency in obstetrics, the frustrations were piling on top of each other. This made managing stress difficult. It got so out of control to the point where work became the only outlet to get by and manage the sadness. A neglectful spouse only worsened the anxiety. A new baby with no parental support sat alone at home, uncertain of the future. Six years later, in a final attempt to do what was expected once again, my brother arrived into the world. This was a much easier delivery with no complications. Yet, once again, a career path to build a practice day and night coupled with an abusive spouse and neglected child remained in the background to surely but silently overwhelm the now not-so-young mother with deep anxiety.

This was the story of my mom, ironically an OBGYN herself and champion of women's health, despite sacrificing her own for the last two decades. This is not just her story, but a story for countless other women. Women who may or may not have been "officially" diagnosed with "postpartum depression" according to the ICD-10 Z39 code, but were just waiting for these complex feelings and varying postpartum experiences to someday pass. However, no situation or story is identical. When I started this project, my overarching research goal was to offer a streamlined approach to better predict and treat postpartum depression. As I further conducted my research, it became evident that this disease is circumstantial and subjective. There is no single, streamlined approach. There is no one diagnosis to label women going through different situations with diverse factors affecting their mental and physical health on an illness we still do not know much about, especially how it affects women- let alone new mothers. Thus, I wanted to take an anthropological approach with my study taking into account the theme of subjectivity which I will give more background on in the subsequent background sections. With that, I took a more qualitative approach, sitting down and talking with providers about their experiences as the diagnoser in the healthcare system but also as the diagnosed or their subjective experiences outside the system. This conversational approach was a more personal approach that allowed me to gather data that went beyond the basic diagnosis of "postpartum depression" as per the ICD-10 Z39 code.

II. Relevance: What is PPD?

According to the World Health Organization, 1 in 10 women between the childbearing ages of 18 to 44 experience postpartum depression (PPD), persistent feelings of sadness, and loss of interest after childbirth (World Health Organization, 2001). While "baby blues" may last for a week or two after a mother gives birth, feelings of sadness, anxiety, and loneliness, along with a multitude of other emotions can last for weeks and years at a time when considering PPD. While it may be normal for new mothers to experience "baby blues" as a result of their hormonal, physical, emotional, and psychological changes throughout pregnancy that require high levels of endurance, "baby blues" are separate from PPD in that they generally resolve and decrease within 2 weeks of the delivery (Beck, 2006). To take this to a greater extreme, postpartum depression is a more severe and longer-lasting form of depression that can occur anywhere from post 2 weeks of childbirth to up to a year post-delivery. Baby blues have no linkage to psychiatric history, environmental stress, cultural factors, support, or breastfeeding as it focuses more on sleep and appetite disturbances and generalized irritability and anxiety. However, with the former factors mentioned, women with the blues become more susceptible to spiral into a more serious depression for a greater amount of time, PPD. In fact, within the first year of childbirth, 20% of women with baby blues already develop the more grave condition of PPD (O'Hara & Swain, 1996). With these statistics, it is also important to note that many women experience a similar maternal health crisis to PPD that often goes undiagnosed due to cultural differences (ex: stigmatization), lack of seeking treatment at the moment, and overall lack of identification in this unclear classification system of ranges of postpartum experiences (Waters 2010). The idea here is that the emotional states of PPD and baby blues are all on a spectrum and hard to identify due to the difficulty in the classification of emotions.

III. An Anthropological Critique of PPD

What is Subjectivity?

Going beyond the investigation of the gap in care with PPD that exists on a more public health & healthcare oriented approach, as a budding medical anthropologist, I also have another more anthropological aim for this project given that much of the existing literature on PPD has such gaps in cultural care. Such an anthropological perspective provides context and understanding of human behavior, specifically health behavior linked to people's culture and social structures in society (Krumeich et al., 2001).

To characterize my findings, I needed to go beyond the basic medicalized responses that providers often share concerning PPD. The state of PPD and "depression" in general is an emotional state, but it is hard to conduct research on this illness and make care recommendations without understanding this state on a more personal, intimate level (Gilbert, 1992). This word "depression" in PPD and in general that we have socially constructed in a social science context and the clinical/medical curriculum is merely a single word that is used to describe the irresolvable pain and anguish of an intense disease that one can suffer and struggle with daily--one that can easily spin out of control (Gilbert, 1992).

PPD and many of the underlying emotions of mental illness like depression can be considered an "affliction of subjectivity" (Ozawa-de Silva, 2021). Fundamentally, this disease is still located to the individual; it is an internal experience of “self” that has evolved with external interactions and relationships with “others” and “other” of the surrounding world. Thus, I contextualized my research on PPD through the lens of subjectivity. While there are several ways to define this theoretical concept, I use a recent definition known in the anthropological community as “first-person experience and the internal structures of body and mind that shape experience” (Ozawa-de Silva, 2021). These internal and external processes are shaped by social structures like PPD and depression diagnoses and treatments we have in place which then also keep such experiences in perpetuation.

Despite the gap in literature specific to PPD, there are established theoretical frameworks that can still be applied in relation to postpartum depression. For the purposes of this thesis, I chose to focus on Gonzales Rey’s theory of subjectivity (*further expanded the next section) and Dr. Ozawa-de Silva’s further understanding of afflictions of subjectivity to understand the dynamic relations of the individual perspective of mothers themselves in comparison to the societal, institutional, and political perspectives that idealize and hold expectations of emotional processes and formations as oppose to the subjective and personal memories of mothers themselves (Goulart et al., 2021).

Every illness narrative affects people differently as established in prior literature (Martínez-Hernáez & Masana, 2022). While we have established that subjectivity is composed of both external and internal processes, there was an ethnography done that explores the internal processes of mothers: “intrusive thoughts” in the context of motherhood (Mason, 2022). Essentially, the work interspersed and explores these “intrusive thoughts”-- the fear, rage, and repulsion-- and “unthinkable images” that are common symptoms of perinatal mood and anxiety disorders like PPD and also postpartum obsessive-compulsive disorder (PPOCD). From Kleiman and Wenzel (2011, 24-25), *Dropping the Baby and Other Scary Thoughts*, here are examples to provide more insight into what are merely thoughts translating into later moral consequences:

- What if I take this pillow and smother the baby?
- What if I press so hard on his soft spot that it crushes his skull?
- What if I take this knife and stab the baby?
- What if I get so mad I shake the baby?
- What if I throw the baby over the railing or down the stairs?
- What if I just drive my car off the bridge with the baby inside?
- I could just snap her little neck with such little effort.
- I could pull off his limbs and see the blood spurting all over the place
- I could poke my baby's eye out.
- What would happen if I put the baby in the microwave or the freezer?

These authors are attempting to share these collective, subjective experiences that many mothers have had and the balance of what "intrusive thoughts" may or may not be in comparison to "psychotic thoughts" where you actually do not want to smother your baby (Kleinman & Wenzel, 2021). From this collection of thoughts of postpartum mothers across the United States, Mason has established that these thoughts are quite common and pervasive amidst mothers struggling with mental health after birthing a child (Mason, 2022). There is also a lens of morality that these authors share. Although these thoughts are common symptoms associated with PPD, PP-OCD, and PP-anxiety, it is the hardest thing for mothers to talk about and others to hear, despite also coming from a place of love- smothering love that leaves one paralyzed with fear. Lisa Tessman compliments this struggle with morality in her book, *Moral Failure*, where morality is not just actions or words, but also thoughts. Even though they are often morbid, thoughts intersect with motherly love that goes against the social construction of "innate maternal instinct" all women are born to have (Tessman, 2014).

For this study, this prior background on these thoughts gives insight into just how unique PP-anything is. It is not just PPD, but PP-psychosis, PP-anxiety, PP- OCD, and more. And these emotional states can intersect with each other; you do not need to be in a psychotic state to have these thoughts. This raises the stakes for healthcare professionals that are trying to gauge the line between “intrusive thoughts” in comparison to “ego-dystonic thoughts”, meaning more psychiatric/psychotic. This establishes a need to acknowledge the subjectivity in PP-anything where my research can add greater value because what truly goes on in a mother’s head is an experience of “self” that is unique to solely her in her internal, intrusive thoughts which are influenced in her external experiences as well. To treat and provide better PPD care, there has to be increased empathy and understanding for such thoughts and experiences.

PPD and depression are subjective diseases but also socially constructed experiences at the same time. Society, specifically the medical community, has done a great deal to construct depression (not as much exposure to PPD) as a clinical problem that can legitimize problematic experiences. However, it is still insufficient. A lack of explanation of the subjective experiences of depression and PPD still exists, which is often better understood in terms of social interaction, whether that be through the eyes of a patient but also the eyes of a provider because of their own subjective experiences and biases impact the way they give care. Noting this, I will interview and later analyze each participant's subjective and personal experiences on the matter to analyze how that impacts the care they provide along with their professional experiences in Chapter 3. Therefore, one aim of the study is to address this gap in theoretical knowledge that affects the gap in the actual care of depression (including PPD) in medicine.

While there has been some research in the anthropological community on the subjective experiences of depression as seen in the aforementioned sources above, there is little to nothing targeted toward PPD in particular. It is often generalized to motherhood or immediately jumped to PP-extremities of psychosis. This lack of research on PPD is a common theme in the way it is grouped with depression in the medical community. Yet, it is still isolated due to the specified, vulnerable afflicted population of mothers. Moreover, in a majority of the existing literature regarding PPD, due to this particularly vulnerable population, a recurring limitation is the use of a small sample size. This indicates that the external validity, the extent of generalizability, is often questionable in many of the past studies and findings of PPD. I do acknowledge that this study has a small, limited sample size as well, but there is still merit in adding to the existing bodies of literature on postpartum depression across medical specialties while opening up conversations on subjective minority group experiences as well that allow this study to offer additional value.

Inter-Subjectivity in terms of PPD Cultural Variability

In the medical anthropology and anthropology community at large, not much has been said in specific to address the gap in the care of PPD. Much of the research has come out this year itself and is still being developed as previously indicated. But, there has been a lot of reasoning on different themes and features of subjectivity. One such feature that I wish to consider for this research is an often neglected area of subjective theory; it is what Gonzalez recognizes as collective aspects of individual subjectivity (Gonzalez, 2020). This is the concept of intersubjectivity. Subjectivity is the idea of "self" and then "others", or the experience of internal and external processes which is different as mentioned before (Ozawa-de Silva, 2021). But, this experience itself is interpersonal and intersubjective because it is our nature to not have an isolated, independent subjectivity of "self". In actuality, it coincides with society and the subjectivities of others in society. So, while we may have these subjective experiences individually, they can also be dynamic as theorized by Gonzalez: "inherently collective and dependent on groups of others, just as groups of others depend on the individuals that comprise them" (Gonzalez 2020).

In response to this notion by Gonzalez, Karim Dajani takes intersubjectivity a step further, organizing these simultaneously collectivist experiences of subjectivity around the constructs of culture: cultural dislocation and cultural displacement (Dajani, 2020). Essentially, their commentary is surrounding this idea that culture can play a determinative role to shape individual subjectivity and intersubjectivity providing structure to such experiences that can clash and add tensions. In other words, the culture around us by the subjective experiences and perspectives of others can influence our own individual subjectivity. The implications here carry into how and what certain cultures may view depression and PPD in particular. This is a plausible explanation for the way mental illness at large, let alone PPD, is stigmatized in certain cultures and seen as less of something to treat or a disease. Culture, then, as an intersubjective representation that has been validated in its utility to explain human behaviors in prior studies, can mediate the way an individual responds and adapts to an illness (Chio et al., 2010 & Wan 2012). Acknowledging this, an imperative part of this study to address the gap in care of PPD would be to explore the cultural implications behind how PPD and depression as a whole are often stigmatized in certain cultures or even universally due to differences or lack of education on the matter.

PPD: Culture-Bound Syndrome (CBS)

Extending this cultural representation of intersubjectivity to specific groups of cultures, one of the few pieces of the literature mentions that the phenomenon of mild postpartum depression remains undocumented in the cross-cultural literature despite having high incidence and documentation rates in the United States and other industrialized nations (Stern &

Kruckman, 2022). This suggests that PPD may be a “culture-bound” syndrome. A culture-bound syndrome (CBS) is a way to encompass certain behavioral, affective, and cognitive manifestations seen concentrated in specific cultures(Stern & Kruckman, 2022). To elaborate, the lack of social structuring and recognition of postpartum events (ex: lack of mandated rest) and especially the individualistic culture of the United States in comparison to emphasis on familial support in other countries, and lack of structuring of a distinct postpartum time period or label in terms of diagnosis likely makes PPD more of a Western notion. It is clear that there needs to be a greater exploration into the social organization of mental illness in the United States society that pays little attention to new mothers and the few existing policies contracting this significant and astonishing role in the cycle that is the life course of a mother. This idea is enhanced by the idea that depression is considered to be a mere biological phenomenon in other countries rather than a mental illness like in India (Upadhyay, 2017), where mothers are often surrounded by familial support whether they like it or not with the aftermath of birth and values of “community care” are more powerful than notions of “self-care”, “burnout”, and popularization of mental health as seen in the United States. I bring up this cross-cultural comparison from the Western/United States and literature from the South-Asian community because quite a few of the participants that I interview are immigrants or identify as being a part of the South-Asian/Asian culture. Thus, aspects of the way each region views mental illnesses are essential to consider.

In another study on the cultural mediation of PPD in a different region (also not Western), it was found that both, at the cultural and individual level, there was no evidence of PPD in the study setting of a rural Kipsigis community of Kenya. A three-pronged model was used (1) a biological model evaluating hormonal or physiological changes, (2) a psychological model of mood developments and social interactions to gauge concern for PPD, (3) and lastly, a comprehensive affective functioning evaluation of reports of memories and dreams (often not used in Western settings). Despite this comprehensive model, it was highlighted that the cultural restructuring of how this culture views birth suggested that the absence of certain cultural circumstances perpetuated the absence of PPD. In this community, childbearing was not viewed as a biomedical event but rather a cultural, traditional event involving the family and community. Coupled with the distancing of the father and allowing the childbearing mother's own mother or mother-in-law as primary sources of support, allowed the women to feel free to feel emotionally dependent, the study found that PPD's etiology was more prominent at a Western level as a CBS where childbirth is more so viewed as a biomedical event (Harkness, 1987). One aim of this study is to factor in the United States or Central Jersey culture in specific that perpetuates PPD and address these cultural barriers to allow for better care.

While these theories on subjectivity may seem abstract and rather vague, especially if new to the anthropological community, I later point out key aspects of subjectivity like cultural variability using specific examples from participants in my findings that we will delve into in Chapter 3 and as we go along.

Researcher Positionality/ Subjectivity

Sticking to the anthropological framework of subjectivity, it is critical to acknowledge that my own subjectivity influences the findings and methodology of this research. In terms of reflexivity, I identified as a child (and still do) for the majority of my life and have experienced the cause-and-effect relationship on the child's side with a parent afflicted with postpartum experiences. To be frank, this project has forced me to come to terms with my childhood as I listen to the narratives of these providers describing their own parenting and postpartum experiences from having a partner they can work within a team to others having to drag their children to on-call rooms in the middle of the night because their other parent is absent. It has been bittersweet for my inner child to interview my mom where some family truths never spoken out loud have come to light, as has me listening to the stories of countless other patients and providers alike. Hence, I acknowledge this personal investment in witnessing the aftermath of PPD that incited my motivations in launching the study, to begin with, from the questions I sought to answer and the way I went about conducting my research.

While identifying as the other component in the mother-child relationship, I am also a separate entity in that I am a South-Asian female college student as well. As a college student surrounded by like-minded people, I acknowledge that I have opinions that may be more “liberal”. This impacts the way I view our healthcare system. Moreover, with the constant exposure I have to an open-minded environment where people readily and freely share their experiences with mental health, I understand that this is not universally applicable, especially to the older generations that the majority of providers are a part of. Conversely, this identity also clashes with my South-Asian identity where I have been brought up in a tight-lipped community where women’s health, let alone mental health, is less prioritized. At the same time, I think these positionalities allow me to enter the conversation and not be afraid to push for the stigmatization around mental health and question the system in place that lets PPD slip under the radar.

Recruitment Procedures

I began this project as a typical “pre-med”, aspiring anthropologist college student and general outsider to the actual medical community with providers who are well-established in their profession. It is not easy for such professionals in a high-stress healthcare environment to take the time to sit down with a college student and give an interview--especially given the fast turnaround time for this project. To combat this difficulty in accessibility, throughout this research, I have made significant headway in this community in New Jersey through my mother, a member of this community as an OBGYN with her practice via snowball sampling. She has given me behind-the-scenes access to this community since I was a child, dragging me to physician lounges forced to make small talk with her colleagues as I constantly waited around for her to finish hospital rounds. I have clocked countless hours myself at all three major hospitals in this New Jersey area that all these participants also have the practicing privilege(s)--one or more-- at: St. Peter's University Hospital, Hackensack Meridian Health- JFK University Medical Center, Robert Wood Johnson University Hospital New Brunswick. Specific to my research timeline, I have made greater strides in becoming much closer to them and gained more exposure to the other specialties in the vast medical community by using her as my access point. I believe this sense of familiarity with some of her colleagues rather than just cold-emailing providers aided me in the ability to establish rapport and trust where they felt more invested or the need to be more helpful rather than just being viewed as another typical "pre-med student". At the same time, I can acknowledge the social desirability bias that this may have yielded but also the option for more vulnerability/honesty.

To make my study more comprehensive, I also incorporated purposive sampling, meaning I targeted specific specialties in the field of medicine to allow for a greater understanding of the complexity of PPD in that it intersects many fields. Once a new mom delivers under the supervision of her OBGYN or midwife, she brings the baby to the pediatrician who also interacts largely with the mom to gain necessary information about the newborn. The mom may then be referred to a psychiatrist or her primary care physician based on the indicators that are picked up by other providers in the community. There is no one specific provider that assumes total responsibility for this population of new mothers with maternal mental health issues if studied closely. Moreover, I also wanted to gain more providers affiliated with hospitals and/or the training side to understand the education of the community which is why I added an extra participant in the OBGYN specialty, the faculty and resident Director OBGYN who also runs the OBGYN clinic at one of the aforementioned hospitals that I will leave unspecified for privacy. In essence, it balances out the potential bias of my mother's interview also in the OBGYN category. Thus, the purposive sampling of selected specialty quotas or roles in the medical community was utilized to add depth to this research analysis. However, it is not to say I was recruiting specific ethnicities or genders despite yielding a group of participants that were more so homogeneous in terms of diversity and females. Nevertheless, I was able to highlight variations amidst these identities in terms of religious identity, racial identity, political identity, and cultural identity to a specialty level as well.

Chapter 2: A Review of the Literature: PPD Classification and Policies

I. Subjectivity in terms of the Classification of PPD

To complicate the matter further, PPD also goes undiagnosed because there is a lack of consensus as to if postpartum emotional disorders are unique as opposed to normal emotional disorders that are not postpartum (ex: PPD vs general depression, not postpartum). This hesitancy in if the specific nature of PPD is shown in the way that PPD is still at the moment not defined as a distinct condition that is separate in the classification systems that medical professionals use to diagnose patients: Diagnostic and Statistical Manual of Mental Disorders-V (DSM- fifth edition) (American Psychiatric Association, 2013) and International Classification of Diseases-10 (ICD tenth edition) (World Health Organization, 1992). It is grouped in with the larger entity of affective or mood disorders with a sub-identifier of "peripartum onset" in the DSM-V that identifies affective or short-lived psychotic episodes during the postpartum period with onset if the episode occurs within 4 weeks following birth (American Psychiatric Association, 2013). In a similar situation, in the ICD-10, the episode has to be categorized in the larger primary diagnostic category of a major depressive disorder first to be correlated with the sub-identifier of the peripartum period.

This classification problem stems from the overarching argument that postpartum emotional disorders are unrelated to the physiological events of the actual postpartum period itself. It is proposed that this period that triggers such emotional disorders is not unique and applicable to other stressful life events (Riecher-Rössler & Rohde, 2005). There have been studies using Depression Anxiety Stress Scales (DASS; Lovibond & Lovibond, 1995) which gauge the full range of depression and anxiety in terms of core symptoms where the latent data of PPD is quite similar to that of the general population quantitatively (Cunningham et al., 2013). However, there is a missing knowledge gap in the qualitative understanding of the uniqueness or absence of such quality in postpartum vs postpartum groups aside from scales like DASS. Moreover, in a broader significance, reports of general depression and PPD are often inconsistent and incomplete across the board since not everyone is necessarily diagnosed or will report their symptoms given that mental illness is often stigmatized which only adds to why a consensus cannot be reached without a complete picture (Watters 2010).

Conversely, some consider PPD as distinct because of the different endocrinological changes unique to childbirth. Another pro-separation viewpoint of PPD is that it is considered to be milder than “normal” depression as it has a lesser degree of suicidal ideation but a larger emphasis on anxiety and irritability. This is likely due to the pressure the mother feels to live for her child and for having such a purpose in her life (Pitt 1968). This establishment of a role as a mother is often not the case for other conditions of depression where people often search for their purpose in life or lack of such a role.

All these viewpoints contribute to the vagueness in the actualities of classification of DSM and ICD-10 criteria, making it harder for mothers themselves, let alone providers, to characterize their feelings and experiences of subjectivity into if they have the burden of the diagnosis that is "postpartum depression", especially in the earlier postpartum moments when the hindsight has yet to be developed.

This debate of the contestation of PPD and how it should be screened can be applied using the lens of subjectivity. This can be applied to the importance of taking into account the unique illness narratives of PPD-afflicted mothers rather than numbers on a depression scale. At the end of the day, we still do not know much about the disease or the actual experiences of patients which is reduced to a biomedical model in our healthcare system when using scales for screening and psychiatric referrals as a primary source of treatment (Cessario 2018).

Using this theoretical framework, I argue that PPD is a complex, subjective production that goes beyond the biological and hormonal aspects of criteria like the DSM and ICD-10 for this project. It is further shaped by the individual subjectivity of each specific woman. Thus, I take the latter position for the argument in the literature that PPD is distinct because societal/scientific idealizations of motherhood differ from the actuality of the subjective product of motherhood that is experienced. To ultimately better prevent, treat, or predict maternal mental health like "postpartum depression", there then is an established need to identify the distinction of PPD in its unique criteria.

II. Existing PPD Policies

The subjectivity of PPD in terms of classification also extends to making policies to address care more comprehensively for different cultures and people. While I will address the subjectivity experiences that go unaddressed in policy in PPD later on during my interviews, and more on a systemic level in Chapter 4, it is important to get an idea of what health policy on PPD and maternal mental health look like in our healthcare system for background.

a. *National Legislative Efforts (Now)*

Major advances in the healthcare system have led to an increase in the identification of women with PPD. Early detection is essential to provide support if and when needed later on. The Patient Protection and Affordable Care Act (2009-2010) contains two sections for the implications of postpartum depression. The first, 2713, focuses on preventative services with all new health plans that cover comprehensive women's preventative care, including PPD screening. The MOTHERS Act, 2952, which is more specific to PPD, focuses on finances. An annual $3 million is authorized to support a national public awareness campaign on postpartum mental health, maternal mental health, PPD, and the benefits of PPD screening research (HR.3590-111th Congress, 2009-2010). With this, ten other states also had legislative provisions of the MOTHERS act and more were pending. All these state and national efforts were modeled on the formative efforts of New Jersey originally.

b. *Seminal New Jersey Efforts (Then)*

The New Jersey Postpartum Wellness Initiative in July 2005 was the original effort to raise awareness about PPD-- which is the inspiration for the national campaign via the MOTHERS Act. This initiative also increased clinical services targeting both providers via training 58% OB, 13% peds, 12% family medicine, and internal medicine in terms of screening and the public via outreach to women and their families: toll-free hotline, brochures, online resources, state-sponsored television commercials, and public service announcements. And, on October 10, 2006, New Jersey was the first state to require PPD screening of women who had recently given birth. Upon further expansion, the NJ PPD Act was then remodeled to require all licensed healthcare professionals to educate women and families before and after delivery as well as provide postnatal care (including physicians + midwives) to screen for symptoms before discharge from the hospital and again during the "first few" follow up visits.

c. Critiquing the Policy Strategy from NJ to Nationwide (Then to Now)

Unfortunately, it was found that NJ policies that were translated to these national and state policies were not as effective or able to be universally generalized elsewhere, especially when considering specific groups of women who are more vulnerable such as those low-income or having poor to no insurance (Backes, 2011). Implementation from one state to another can also vary if there is a universal screening assumption but no actual attempt to have demonstrative programs to assess the benefits of what actually translates from one place to another. It is also still unclear if it was the awareness campaign or the law of training and requiring providers to give a greater degree of care that is beneficial as the two are grouped. For a more comprehensive policy, there has to be a distinction in the campaign and law as well as more trial periods in each state to understand the actual source of benefit. There has to be a greater integration of mental health resources and a greater culturally competent outreach service to address the more vulnerable groups of patients. Further research into alternative prenatal care is worth looking into. Postpartum practices such as follow-up home visits in the United Kingdom have shown to have a greater success rate in comparison to the more individualistic centered of American postpartum mothers left without support and with the uncertainty of the time or means to return to the OBGYN office for a follow-up visit or actually use the referral they may receive for a physiatrist (Cheng et al., 2006).

d. Overall Policy Impact

i. Inside the Healthcare System

Upon a closer look, it was not as simple as even if providers are required to do such monitoring, the policy does not specify any consequences if they do not. There is no specific mechanism or plan to enforce adherence among clinicians. It is unrealistic in the United States healthcare system and the way it is structured privately and publicly, to expect clinicians who are already stressed and have time constraints to see as many patients as possible to provide an additional service without any financial compensation or no incentives. Moreover, there was evidence that highlighted how specific vulnerable populations of women like Medicaid recipients, did not have an increase in PPD treatment after screening and these legislative efforts, and were in fact, at increased risk for PPD (Leavens et al., 2011). This makes sense due to low Medicaid reimbursement rates and payment delays as a deterrent rather than an incentive for providers to provide the best education and postnatal care possible. It is clear that a larger acknowledgment of systemic factors concerning structures, power relations of who employs these providers, funding molecules, and more needs to occur for a greater degree of success with the implementation of these policies. It is easy to have laws and regulations in place, but if there is no accountability, then it is likely there will not be much change.

ii. Outside The Healthcare System

There is also a patient perspective to consider as though they may not be a structural part system itself, they are still directly affected by these policies. There are no patient-oriented incentives to instill the importance of screening or attention to educational information. Not to mention, the lack of addressing this universal screening procedure which groups all mothers together and does not have explicit considerations of the impact of specific social determinants of their health: low income, high stress, lack of support, and much more (Backes, 2011).

The burden of mental health disorders including PPD is generally higher in lower-income and middle-income countries for this reason. In a systematic review of PPD in India, to establish a greater cultural context for this study given that many of the participants of the study are immigrants from there and to compare with our Western ideals here, depression is simply a biological phenomenon because of factors like more complications from birth or the use of more reproductive technologies. Not to mention, healthcare workers often lack mental training as there is a clear priority of imminent risk patients. There were barriers to prompt recognition and management of the illness as culturally it is not discussed much in the first place: financial difficulties, the birth of a female child, marital conflict, lack of support from the family, history of psychiatric illness, high parity, complications during pregnancy and low maternal education. Moreover, it was found that a higher proportion of PPD in mothers resided in urban areas than in rural areas for various reasons: overcrowding, inadequate housing, breakdown of traditional family structures leading to fragmented social support systems, increased work pressure, high cost of living and increased out-of-pocket expenditure on health care. Another consideration was that a high proportion of pregnant mothers still deliver at home. If a mother stays at a hospital-based community, then only, are they likely to seek care and opportunity to express a need for help whereas at home she is not as likely to express a need for help in the first place (Upadhyay et al., 2017). All of these findings are not unique to India and can be applied across the board given the macro-level implications of such structural and cultural barriers at play.

These macro-level barriers were also found to be two-pronged: (1) patients' experienced racism and institutional discrimination due to the diverse and different cultural backgrounds at the hospital as well as (2) the fear of stigma from home and in their own cultural community where disclosing symptoms is an overwhelming experience. One study mentioned how PPD cannot be acknowledged or endorsed in populations of perinatal Black women. Black patients felt more fearful about taking the screening and answering its questions because of anxiety of perception, potential custody cases, and Child Protection Service (Hsieh Wan-Jung et al., 2021). All of these programs in the system currently designed to "help" have to be re-evaluated. It is clear to see that systemic approaches and changes are necessary when considering improving a patient's postpartum experience and health experience as a whole.

In a more specific study with a focus on disparities in PPD screening participation between immigrant and Danish women, over half, 54.7%, immigrant women lacked screening and experienced barriers for PPD due to several factors: refugee status, stigmatization and cultural misconceptions, lack of information, language barriers, and a different understanding of mental health symptoms (Marti-Castaner et al., 2022). Evidently, there is a need to prioritize the understanding of how to better recognize the mental needs of immigrant women who are not screened. Thus, policymakers and clinicians inside the system who are trying to implement these universal PPD screening policies should have increased awareness of potential inequality to examine and go about how to effectively screen and recognize more vulnerable groups of mothers such as immigrant women or other minorities.

There was also a qualitative study done in the United States to gauge patient's perceptions of perinatal depression screening (before and after birth - so including PPD) where many reported (1) perceived ineffectiveness and (2) provider disengagement with certain identifying reasons: lack of formality, privacy, followup, timing, and frequency of screening, communication about results, as well as persisting negative emotions associated with the screening and self-reliance to get the care they needed (Hsieh Wan-Jung et al., 2021). For starters, most screening generally takes place in the waiting room where a patient is given a form to fill out. The waiting room is not an ideal space to come to terms with revelations about one's mental health. Patients felt that it hindered the effectiveness of screening given the public location, denied individual attention, and increased anxiety potentially stemming from this space. They also could not comprehend that "the piece of paper" was meant to screen for depression (Hsieh Wan-Jung et al., 2021). And, if given such a "piece of paper" to fill out by staff in the waiting room, most providers did not explain or clarify the EPDS screening or establish an expectation of a resulting outcome from the screening. Many were not even aware of their scores and did not receive a second depression screening if scored high enough on the first one. This exposes a flaw where screening should be more spread out evenly across perinatal appointments as a whole to gain the full picture of a patient from start to finish. Moreover, a piece of paper does not equate to a real conversation with their providers and having their voices to be heard through open-ended questions.

Another conclusion made from this same study was that many patients felt that staff or social workers are better suited to administer screening as they border on imminent risk. Patients also recommended that medical providers receive specific training aimed at increasing the level of compassion they express during screening. They felt the providers were disengaged dismissively as if the screening was a number or paperwork before getting to the real job of focusing on patients with imminent risk (Hsieh Wan-Jung et al., 2021). This brings the question of responsibility of care for PPD women worth looking into who in the healthcare system (which specialty) or socio-healthcare system is ultimately responsible and most effective for screenings and PPD affliction of women.

Moreover, the overall screening needs to be revamped as more than just a “piece of paper” as it is perceived as a mechanical route without meaning where providers are not concerned about their emotional experiences. It becomes more like a box to check, where providers are not considerate in learning about the patient’s situation/additional support. Once the paper is handed to the front desk, most providers do not probe beyond the screening questions. As one participant shared, “*I took the test, and they told me that they felt I was suffering from postpartum and that was it* " (Hsieh Wan-Jung et al., 2021). This also affects how the patients themselves interact with the screening as they have no incentive to share their personal experience if they feel like a number. These negative emotions leave patients feeling unmotivated to provide accurate answers, unsupported by support systems. Overall, the dismissiveness of their feelings, especially when not presenting with imminent risk symptoms like suicidal ideation, needs to change whether it be making changes to training or shifting the responsibility to social workers or staff. This established a need to engage patients in real conversations about prevention treatment rather than merely filling out a form. A mechanism of engaging patients in a dialogue about screening results may also refine this process to make it more patient-centered rather than about the numbers on a depression scale.

In all of these screening policies, there is evidence that screening increases the detection and treatment of PPD, but there is no evidence for real outcomes after treatment. Another side to all of this effectiveness of policy research is if it is even effective at all for the end goal of outcomes. Screening consumes substantial resources, and though there may overall higher rates of detection, it is unclear if this outweighs the costs and challenges of implementing such screening policies mentioned prior. Identification/screening is merely the first step and a factor in getting help. Once (or if) the PPD is successfully identified, the actual treatment is where it often falls short. In addition, to begin with, PPD is not always identified as many go undiagnosed and slip not only due to the gap in policies and legislation but also the gap in actual healthcare discourse.

Rationale: Limitations of Existing Literature

Much of the existing literature on PPD has had a strictly patient outlook or practitioner outlook focus. Of course, this is not to say that there has not been substantial research done on PPD treatment within the various fields of healthcare or highly influential patient narratives on PPD. But, it has been one or the other. Less is known about the overlap of an outlook with a combination of both perspectives of working in the field of healthcare but also being treated (or going untreated) by the field of healthcare. Thus, this duality in being both the practitioner and physician is important to consider as it impacts the way they may view and treat PPD if also having been exposed to or witnessed it in a non-professional context. Moreover, hardly any research has been conducted to gain insight into PPD in a multi-disciplinary context across the various interdisciplinary fields and how they interact with each other in the realm of healthcare in one cohesive meta-analysis. While there have been well-known and critical analyses of PPD treatment by various physicians in various obstetric, midwifery, psychiatric, and pediatric journals, less is established about all these specialties in one place to search for common themes and patterns related to potential PPD care methods. It is important to understand how these specialties interact with one another to see who assumes responsibility for what parts of PPD treatment and how these different puzzle pieces of the healthcare system come together to alleviate this burden that mothers bear. Chapter 3 will explore these research goals by delving into each specialty interviewed to see the cross-correlation of various patterns on an intra-level, and then Chapter 4 will zoom out to view these specialty interactions on an inter-level with the healthcare system as a whole to address the existing care gaps of PPD.

Other scarce literature highlights how less has been examined on the way PPD afflicts certain minority groups as they have different subjective experiences regarding the matter as previously established. For example, due to my initial interest in South-Asian mothers with PPD given my own personal investment, I attempted to search for South-Asian patient population impressions of PPD and targeted treatment avenues for this specific group. Yet, I found that due to the large number of cultural factors involving internalization and stigmatization in the South-Asian population, there is a lack of research and a clear gap in identifying and contextualizing PPD in South Asian women which needs to be studied further. It is important to note that this gap in research extends to other minority groups such as the Black, Hispanic, and East-Asian communities as well. Thus, these are gaps in research that this study intends to address. My research is pertinent to these issues as it will interview providers across the disciplinary fields of healthcare, asking about both, their experiences inside and outside the healthcare system, specific to their field and broader to the system as a whole, all while encompassing a participant population from a diverse area of Central Jersey with a range of cultural backgrounds that will be shared in greater detail in Chapter 3.

Chapter 3: Challenges to Crossing the Barrier at an INTRA-Specialty Level

I. Introduction and Methodology

Experimental Design & Hypothesis

The study was performed independently from any pre-existing lab or project. It was created with the aim of (re)constructing the gap in the care of PPD amidst its pertinent specialties under the lens of subjectivity that providers (n=11) were able to provide insight too.

The goal was two-pronged (1) understanding potential avenues to mend the gap in care of PPD inside the healthcare system based on professional provider recommendations and (2) gauging understanding of subjective, personal experiences of providers outside the healthcare system to mend the quality of care with PPD. From the literature above, I argue and hypothesize that there has to be an increase in awareness of subjectivity and subjective experiences of PPD that are unique to mothers to treat and identify PPD better.

Participants

Over the course of December-January 2022-2023, I organized and conducted semi-structured interviews with 11 participants recruited via snowball processing from access points in the Central New Jersey Area. Participants were providers across the prominent specialties pertaining to postpartum depression: obstetrics and gynecology (n=3), pediatrics (n=2), primary care--family medicine/internal medicine subspecialties-- (n=2), psychiatry(n=2), and midwifery(n=2). Providers of all races, gender, and ethnic backgrounds were eligible for the study as long as they were affiliated with the specific specialties listed above and in the New Jersey area.

A significant portion of individuals self-identified as minorities. Ten individuals self-identified as minorities of the following descent: Black(n =2), East Asian (n=1), and South Asian (n=7). Moreover, the provider population was primarily composed of females (n=9). A significant portion of the participants were also immigrants (n=9) who had obtained their MD degree elsewhere--Philippines (n=1), Canada (n=1), and India (n=6)-- eventually going on to complete a residency in the United States to practice here. One participant obtained a certified nursing degree here in the United States after migrating from Haiti and going on to further specialize with a master’s in midwifery. The other two providers had completed all their schooling and were born and raised in the area (n=2). The age ranges from 36 to 59 years old was skewed to older individuals between 44-57 given the arduous training required of these professions with longer schooling and experience with life overall.

Due to the demographic area and access point, the majority of providers were private practice (n=8), though all (n=11) have experience with public hospital settings given the necessary training and privileges to perform specific procedures such as labor and deliveries or surgeries like C-sections which greatly impacted the patient's exposure types and experiences. This information collected for all providers interviewed can be seen in Table 1.

Table 1. Demographic Information for all Interviewees. The table includes the assigned participant number, pertaining speciality/practicing method, and other subjective identities that make up each individual.

Provider Number	Speciality	Gender	Self-Identified Ethnicity	Immigration Status	Personal Life (PPD Exposure)	Practicing method
1	OBGYN	Female	South-Asian	Immigrant	Has children	Solo Private Practice
2	OBGYN	Male	East-Asian	Immigrant	Has children	Multi- Private Practice
3	OBGYN	Male	White	Native	No children	Public Hospital
4	PEDS	Female	South-Asian	Immigrant	Has children	Solo Private Practice
5	PEDS	Female	South-Asian	Immigrant	Has children	Solo Private Practice
6	PC	Female	South-Asian	Immigrant	Has children	(Unknown) Private Practice
7	PC	Female	South-Asian	Immigrant	No children	Public Hospital

8	PSYCH	Female	South-Asian	First-Generation Native	No children	Solo Private Practice
9	PSYCH	Female	South-Asian	Immigrant	Has children	Solo Private Practice
10	MIDWIFE	Female	Black	Immigrant	Has children	Public Hospital
11	MIDWIFE	Female	Black	Immigrant	Has children	Public Hospital

Personal identifiers of patients were discarded after 24 hours and all participants interviewed were assigned participant numbers as listed in Table 1. Pseudonyms were not used for this study because I was uncertain about using certain names that may or may not inappropriately indicate ethnicities.

Conducting Virtual Interviews

It is a known fact that providers are notoriously busy and always on the go. The very last thing providers are likely to do is sit down for one to two hours at length to discuss issues with the healthcare system while they could be physically working on them at work. I am thankful for the access points and familiarity I have with some of these providers to be taken seriously to even be considered to have a semi-structured conversation with even if it often meant getting cut off at thirty minutes, constant rescheduling, interviews over the phone, interruptions, or being on “standby” when providers are on call to see if they have a slot to have a quick interview if and when a calm moment occurs during their shifts or office hours.

For these reasons, conducting research in a virtual setting was advantageous. Although I could sit down to gain insights into their practice/office setting or even just establish in-person connections, frankly, this was probably never a possibility due to a multitude of safety/clearance concerns upon entering the medical community and accounting for the time/business of our providers. Virtual communication via Zoom was more accessible given the flexibility and adaptability of being able to log on with minutes' notice or set scheduling reminders for the doctors based on their day-to-day schedule and preferences. Though it may have been a concern that the virtual setting may be disadvantageous to participants unfamiliar with Zoom, there was immediate reassurance that the use of Zoom had been normalized whether it be the straightforward instructions with a tap of the link sent via text (I found was the best, practical form of communication rather than email, once obtaining the phone number upon introduction) to log on via phone or the familiarity from the new age of telemedicine that a majority of providers evolved to partake in.

The camera tool on Zoom, if elected to be on at the discretion of the participant, also proved to be informative in terms of fieldwork, whether being taken into the private space of doctors in their personal homes, for which I am grateful for their vulnerability in showing me such a space, where I was able to visualize doctors as people outside the healthcare system, along with the frantic moments in the on-call room or the physician lounge where I actually could see the resources on women's behavioral health support groups stapled on the bulletin board behind them. Simultaneously, the disadvantage is that the camera could be off. In many instances where the participant was unsure of how to even turn the camera on or was concerned about their appearance, the camera was forgone--given that Zoom phone interviews were more predominant from the ease of clicking the button from the phone rather than getting set up and connected to the internet on a larger device. It was more "on the go" friendly and suitable for the lifestyle of many of these providers. However, I never felt that privacy was a concern, as the provider was able to establish the level of intimacy they wished to share. Despite not being able to read facial expressions or see hand gestures, I felt that I was able to get a good read on the situation and continue to make the conversation flow based on the tone and overall mood of the participants in the study. This range in the environment from interviews done in the car on the go to a full set up in the likes of a home office served more of a facilitator rather than a barrier in my interviews, expressing understanding at this, too, was a byproduct of a hectic healthcare system.

I learned through the trial-and-error process the importance of explaining exactly what the discipline of anthropology entails along with the less formality and more conversation-inclined semi-structured interview process rather than a typical five-question quantitative interview they were more predominantly used to. This also took up time in the already limited time slot I often had, but I found that it was more beneficial in the long run for the understanding of exactly what I was trying to probe qualitatively. I quickly realized that my two-pronged approach of wanting to understand providers' insights inside the system through work experiences and outside the system as parents/mothers/friends themselves in terms of PPD was going to be challenging. 30-45 minutes is barely enough time to get through one set of questions focusing on work experiences let alone an entirely new set of personal questions. I adapted to modify my questions to settle one vague question on if they wanted to share their personal experiences on the subject at the end depending on the progress we made in establishing rapport on going beyond the cultural script or the "doctor response". So, not all the interviews included all the questions I initially had, and some questions were skipped on a person-by-person basis at my discretion. Despite these inconsistencies, the basic structure of the interview to yield a complex analysis was centered around five key domains which I will highlight in the next section. For a greater in-depth interview protocol and to see the original questions, refer to the Appendix.

Interview Transcriptions and Analysis

To keep matters simple, I made sure to record all Zoom interviews to the cloud which generates an automated transcript rapidly within the same few hours the meeting concluded. Unfortunately, artificial generators are never fully accurate, especially with some participants who were multitasking during the interviews as mentioned before. For a greater degree of polishing, I cleaned up each interview and double-checked each transcription and different recording areas for accuracy and analysis. Though time-consuming, this allowed me time to reflect and commence my freestyle method to analyze and unpack the data that I had gathered.

Due to time and resource constraints, rather than using qualitative coding software like MAXQDA, I decided to take a summary-template approach where I manually organized the data using my own crafted table summarizing the main responses to questions I asked on Microsoft Excel across each participant and each specialty of medicine I studied. I used five key domains or guiding questions to allow me to put the general trends of each question for a side-by-side comparison of key patterns on what participants had to offer on the subject:

1. *Basic training/background*
2. *Experiences/encounters with maternal mental health/PPD in the professional field (including training)*
3. *Introduction of subjectivity framework and opinion on diagnosis/label of PPD (Should it be separate or grouped?)*
4. *Thoughts on systemic issues regarding PPD/care-- are the measures we have in place effective?*
5. *Personal Tie/ Identity /Culture (if wish to share)*

In this way, I could focus less on the coding and software details and more on what is said. Using this approach for analysis, I found the following identifiable theme to “code” into the summary table that has been previously discussed in my literature review: subjectivity. This overarching umbrella of subjectivity contained “subcodes” or “subthemes” like cultural variability, federal funding, education, awareness, social support, exposure, identification, treatment, and accessibility of care which will be further explained in the subsequent chapters.

II. Overview: Seats at the Table

The medical anthropological theme of subjectivity will now be explored further in each inter-specialty upon analysis of common topics. The discussion on the care of PPD looks different across the different specialties and groups of participants interviewed because they have different responsibilities and roles in the various stages of the treatment of PPD. For this reason, they have different subjective experiences to unearth. Thus, to fully examine the effectiveness of care surrounding maternal mental health, it is necessary to dive deep into perceptions about the state of PPD treatment in depth on a specialty-by-specialty basis with inter-specialty commonalities and divergences.

A. Obstetrics and Gynecology (OBGYN)

I would like to preface this section of findings with the acknowledgment that the participants set up for this section are different from the rest, given that there are three participants, unlike the rest which have only two. I specifically chose three to account for three reasons: (1) Participant 1 is my own mother in full disclosure and I wanted to account for potential biases that may arise from this selection (2) Participant 2 referred me to Participant 3 to gain a more administrative/unique setting outlook for my study given that Participant 3 is the OBGYN Residency Medical Director of the Public Hospital so they not only have insight into the inner-workings as a higher up in a predominately public setting rather than private practice setting unlike most of the other physicians, and (3) both Participant 2 and 3 are the only males in the study which I felt added diversity to the overall study of PPD, a disease that is traditionally legitimized in women more so than fathers/other caretakers. Rather than choose one provider over another, I felt all three participants offered a unique perspective that I needed to include in my research.

To offer a greater background, here is the basic background of all three OBGYN providers: (1) Participant 1 (female), who is originally from India and self-identifies as a South Asian, is a mother of two kids while owning a private practice run solely by her (2) Participant 2 9 (male), who is originally from China and self-identifies as East-Asian, is a father of two kids originally from China while being a part of a multi-group private practice that is evolving to focus more gynecology focused than obstetrics, and (3) Participant 3 (male) has no children, born and raised in New Jersey and self-identifies as White, and is the Director of Residency Program at a local public hospital as well as an OBGYN attending there (Table 1). Noting this, it is clear that there is a variation in subjective identities and experiences immediately that has therefore impacted their subjective experiences with PPD which I will expand on later.

1. Role

Of all the other specialties, OBGYN is the field that is most closely associated with PPD, despite limited follow-ups and a guaranteed 6-week gap of not seeing the patient directly after the event of childbirth as per routine healthcare procedures in place. Yet, there was not much said about PPD experiences in the interviews. Ironically, what is worth mentioning is that all three participants immediately jumped to providing the extremities of postpartum experiences: instances of what is classified as postpartum psychosis rather than PPD. Here are a few of the stories all participants instantly spoke upon:

> "I think there was a mom who, because of postpartum depression, took her children to the nearby river and drowned all of them. I think she had three kids and she drowned everyone with them and then she committed suicide as well. Now we screen" (Participant 1)

> "Now we screen for depression. But we had a patient before during my training that we encountered where she was missing, and she was found in the park naked in the freezing weather. That was the worst thing that we have

> encountered. Other than that we never encountered any patients that had tempted suicide or anything like that" (Participant 2)

> "I actually had one patient that did have you know, post postpartum psychosis. And you know, that was relatively scary, but we screen and 10-15% patients have it now" (Participant 3)

These were the immediate answers to my initial question to simply gauge experience with PPD which I explicitly asked about. Yet, I got answers corresponding to postpartum psychosis rather than PPD. With PPD, it almost felt as if it was swept under the rug and mentioned to associate with screening. Noting this, there had to be an imminent danger to the extent of psychosis to fully describe a patient's postpartum experience. This is enlightening in the way providers may view postpartum depression episodes as nothing out of the ordinary and the way we diagnose the condition if there is no imminent danger or extremities present when considering the wide range of illness narratives that mothers may face. Moreover, the provider's responses to a question that specifically asks about PPD rather than PP-psychosis show how the overall lines of different postpartum conditions and depression as a whole are rather blurry and confusing. This lines up with the literature on the struggle in how and where to classify PPD in the medical community further implying a lack of comprehensive policy on PPD versus PP-psychosis as well because we still do not understand how to differentiate these diseases that exist on a spectrum, much less enact legislation that can address the full treatment of all these health states.

With this in mind, it is evident that the groupings of depression, such as PPD as a subset of depression, show the neglect of a still serious disease if there is no suicidal ideation or psychosis present. To garner more attention for PPD, which is more common than psychosis, there has to be a more clear distinction between the illness, time-period, and acknowledgment of the range of subjective experiences that any postpartum experience may provide. As mentioned in the literature review, you could have "intrusive thoughts" about drowning your children but that is different from "ego-dystonic thoughts". This shows the need to have a greater degree of attention to PPD to avoid it potentially escalating into a psychosis state where the PP-experience is so great that the patient does actually commit such an act of drowning. If we isolate and attend to the lesser extreme PPD at first glance, the subjective recollection may go towards experiences with PPD rather than solely focusing on psychosis, suicidal ideation, and imminent danger postpartum episodes which are rarer and help more mothers understand how PPD is quite “normal” and common. There has to be a wider role that pays more attention to patients who go beyond the imminent attention necessary.

2. Subjective PPD Experiences

Shifting to the provider's own subjective experiences, rather than the extreme patient experiences of others, I was surprised by some of the results. Participate 1’s subjective experience struck a personal chord with me because despite the interview being with my mother, whom I witnessed firsthand struggle with her own postpartum experiences as the receiving end of the mother-child relationship, it did not go the way I hoped it would. My naivety at the start of this process led me to expect that it would be easy for all the participants to immediately give away their innermost secrets, controversial perceptions of the system, and share their personal mental health vulnerabilities. This was farther from the case, which was vividly shown by Participant 1. Despite interviewing my own mother, it was almost as if I was a stranger, or one of her patients, being spoken to about the textbook symptoms and treatment of PPD. This was a common theme across the rest of the providers that I will go into depth in Chapter 4 when discussing this “doctor response” and “medicalization of mental health” when channeling a part of their subjectivity of “self” that resonates with their provider identity.

After breaking through from Participant 1’s cultural script, I was able to shift from her professional medicalization responses when discussing PPD which was a large part of our interview to glimpses of her own, personal postpartum experience response. Participant 1 recalls her methods of social support as potential coping methods when particularly explaining her lack of support from a partner and ultimately becoming a single parent:

> "So, it was a very abusive relationship. My ex-husband was a violent person, angry person, and statistically, the abuse gets worse after delivery. So that feeling of helplessness that you know, you need to do so many things and not no help, that triggered blues feeling low and depressed, but not necessarily diagnosed depression as a long term, it's more situational".

> "I have to pretty much do everything by myself and it was a very abusive relationship, so I was lucky because my mom was there with me all the time. I would have been at high risk if I didn't have the support system to get through".

Before dissecting these forms (and absence in forms) of social support, these quotes from Participant 1 also reinforce the duality of her role as a provider and patient/mother outside the system. Even in her vulnerable stories when describing her partner's abuse, she references her cultural script with provider responses like "*statistically the abuse gets worse after delivery*" and offers almost a self-diagnosis on how she had the potential to be "*high risk*". And, then, to dive into her recounts of the structure of her social support system, we first see the descriptions of an abusive relationship complimenting her professional opinion of how the PPD feelings of helplessness can be "*situational*". This provider outlook on the situational basis of PPD corroborated by her personal circumstances adds to the overall research argument about the subjective nature of PPD in the variety of factors, including partner support or even abuse, which can deeply impact a vulnerable postpartum state.

Her details on her experience with her partner translated into how Participant 1 expressed PPD encounters when screening such as,

> "There have been occasions where I'll walk in, and I'll see a father filling it out. And, I always ask, is it from his perspective, or from the mother's perspective? And you know they're a little bit confused when I say that, because the father is always assuming that he knows more about the mother, and then you have to sort of put your foot down and explain and say, No, no, no! This form is for Mom to fill out."

This parallel of bringing up concerns regarding partner social support where Participant 1's subjective experience regarding spousal support (or lack of it) matches her mentioning of watching the husbands of her patients and making sure they are filling out the forms for themselves (not for their wives) in her profession. With this in mind, we see a visual representation of individual subjectivity and intersubjectivity at play. Participant 1's experiences of "self" and interpersonal interactions as a victim of an abusive relationship with her husband are translated into the way she externally provides care for "others" by placing emphasis on and paying attention to the spouses of her patients. Her personal life serves as a motivation to take an extra step at the individual level in the healthcare system in her professional life to make sure the screenings are accurately filled out by the correct audience to make sure her patients obtain the care they need and do not find themselves in a similar social situation like herself.

Another prominent idea that Participant 1, along with other providers who were often immigrants and from similar backgrounds, was the traditional form of social support in their culture-- specifically the South-Asian cultural traditions here. To provide context, Participant 1's private practice is located in Edison, New Jersey which is a region that is 50.0% Asian as of July 1, 20202 (United States Census Bureau, 2022), 29.7% of this percentage is South-Asian in particular. Thus, these numbers are especially reflective in the patient population of Participant 1 who is located in the heart of this ethnicity-populated region. Other subsequent participants are located in surrounding areas and bring about similar notions of cultural patterns, but the most prevalent is in the region that Participant 1 practices in, which is why I will elaborate on such cultural encounters heavily here. Participant gives content to:

> "See, for example, in India, traditionally, whenever the mom delivers the baby or when the mom is pregnant during the last couple of months, she moves back into her mom's house. She stays there until delivery. After delivery, she stayed there for at least two to three months. And then once the recovery phase is done, then she comes back to stay with her husband or the husband's family. So that's very common back home in India given such patriarchal roots.

> Here, now, we try to follow the same tradition by having her mom come from India or wherever and stay until she is back on her feet. Most of my patients have this support."

Similarly, Participant 1 later explains her situation following this tradition of having her mom come from India to stay with her, and how she would not have been at much higher risk in her postpartum state if she did not have this strong form of social support as we saw in the previous section with her quotes on her personal story. However, this strong presence of social support via their mom or mother-in-law established via Participant 1 in the South-Asian culture and other cultures as seen in the case study in rural Kenya in Chapter 1 can also cause cultural conflict and be strong in a negative way as well. Participant 1 went on to say,

> "If after delivery, the new moms used to be given certain kinds of food or certain kinds of medicines and the new moms now want to follow the current medical guidelines they may not want to do things that way. There might be clashes or there might be clashes about how to raise the child or how to breastfeed, when to breastfeed with cultural ideals or with their husband's family and mother-in-law. So there might be issues related to that. It's good and bad like everything else."

This demonstrates how even though social support can be a potential coping method for postpartum mothers, subjective interactions have the potential to perpetuate a state like PPD as well if not supported in an uplifting manner. Again, this proves the necessity of consideration of the subjective nature of patient experiences because it is not as easy to officially recommend ways to alleviate PPD by saying there needs to be a form of social support. We have seen two cases where social support can be detrimental depending on a unique mother's subjective, social situation: (1) abusive/harmful spouses and (2) cultural clashes with notions like a mother-in-law, husband's family, or even just family. These are just a few potential ways that social support may or may not form a negative impact on a postpartum mother more than a positive one. Though, we can see how that is demonstrated as well with having a spouse and family acting as a facilitator of care rather than a barrier.

With the discussion of culture and social support also comes their relations to religion. Participant 1 also expresses her coping methods amidst her difficult situation often due to religion, which was unique to her interview only:

> “We are Jains in Jainism. They teach us to do what is called *SAMTHA BHAV,* that you don't get overly happy when things are really going well, you don't get overly depressed and sad when things are not going well. You learn the coping mechanisms, you learn to deal with things better, you have a more sense of calm”

She goes on to also explain how this coping method also serves as her form of social support as religion can often give way to an entire religious community of like-minded people and how she was able to support in comradery but also a source of help to alleviate her burdens whenever she needed:

> “There are always people in the Jain community that I could talk to if I needed help. There was always help available for pick up, drop off, so things like that. To take care of the kids, I could turn to other people for help. And like they said, it takes a village to raise a child and I really made full use of the village and thank God for that help so I could get through when they were little”.

Therefore, going beyond culture, even a mother’s subjective religion, values, or beliefs can serve as a potential coping method. Yet again, it depends on the type of values and community available to her.

Participant 2’s interview was also particularly memorable given that he is the only male provider and only physician to specifically mention upfront his official PPD in the past. He candidly describes his condition where,

> “I did have PPD experiences as a father. I just had to deal with it and manage it on my own because I was alone here and my wife was back in China. I did not ask for any help after that. I cried and I cried.”

The blunt nature of Participant 2’s narrative drives home his matter-a-fact attitude toward the ordeal. This is connected to his identity as a physician in the way he copes with illness and his emotional state with resilience and simply “dealing with it”. Not only as a physician but his subjective experience of being a parent alone during his wife’s absence, he did not have time to break or ask for help. His only outlet was to cry and manage it alone all the while continuing his residency and taking care of his kids simultaneously which he mentions later on frankly. We see this recurrence in the theme that the methods to deal with PPD are circumstantial. Moreover, this interview shows a clear area that needs more research, education, and awareness. Men can have it too. Adoptive parents can have it too. Any sort of caretaker for a child can have PPD.

Participant 2's established PPD experience and subjective outlook on the matter translate into the way he connects with his patients and establishes care.

> "I encourage patients nowadays when I see them when they feel bad about this situation by telling them that my experience is that the more difficult the baby is and the harder time you have… well, maybe the kid is very smart. I have to tell them that because my son was the smartest, although he was the most difficult one to care for. It may not help, but that may have helped me with all of this during my residency and having my son".

We see how his way of caring for patients and showing his support during this time is to connect with them on a personal level by mentioning his own experience and how it turned out with his child being smarter. Thus, in the way that PPD is individualized and situational, treatment and care can also be individualized/customized based on provider subjectivities to establish connections with patients.

Participant 3 did not have any experiences of PPD personally himself or anyone close to home to share. But, I felt that was an accurate representation of his subjectivity of playing a more administrative role in the hospital setting rather than ever experiencing a potential encounter as a patient or parent postpartum. I was getting the cultural script through the entire interview of administration in the system which was harder to break through as well. I expand on this in Chapter 4.

B. Pediatrics (PEDS)

1. Role

Unlike the other fields, for the most part, the pediatric field has more of an indirect relation to PPD. The primary audience focus of this branch of medicine is children, not mothers. At the same time, PPD and the health of mothers are still important in the realm of pediatrics largely because of the implications of such mental illness and health problems on the mother-child/infant relationship. Routine infant healthcare visits are also the greatest form of regular contact that mothers have with the healthcare system, which is a brilliant opportunity to take advantage of when treating mothers afflicted with PPD. Hence, pediatrics is an integral setting to manage postpartum depression if implemented efficiently.

Yet, even though research and this timeline of infant checkups indicate the feasibility of PPD management in a pediatric venue, the actuality of this management based on pediatrician attitudes is a critical factor. One questionnaire-based study found that despite a majority of positive attitudes toward addressing these maternal depressive symptoms, there was a lack of PPD training where only 22.1% of the pediatricians in the study cohort were trained. Moreover, only 66.3% of pediatricians were able to recognize a mother at risk of PPD, and of the 66.3%, only 13% reported referring new mothers to mental health professionals (MHPs) (Yu & Sampson, 2019). There were two main reasons participants explained this gap in care: (1) 84% reported a lack of time and (2) 53.5% reported being unfamiliar with available mental health resources. Thus, this demonstrates a clear need for more comprehensive PPD training to improve PPD screening and referral amongst pediatric physicians for a greater interprofessional collaboration to address such an interdisciplinary illness.

2. Subjective PPD Experiences

Regarding the PPD experiences of both participants, 4 and 5, interviewed, there were quite a few noticeable differences between the way both physicians approached maternal mental health. After asking about their personal opinions and experiences on PPD in addition to their professional ones, I was able to establish a connection that their subjective personal experiences, of their own, or other people in their lives, mental health impacted their professional day-to-day approach to PPD, maternal mental health, and overall health at large.

Before understanding their personal experiences with mental health and PPD, it is important to set the scene of the background of the providers. Both are South-Asian immigrants that have settled in the central New Jersey area establishing their own solo private pediatrics practices in their professional lives for the last fifteen years as well as being mothers in their personal lives. Given the scaled nature of private-practice participants, I do want to acknowledge that these findings may not be the most comprehensive in comparison to also interviewing pediatricians who may also work in a hospital setting or work with different patient populations.

While neither participant had a specified personal experience of postpartum depression, I was still able to get some insight into the way mental illness and mental health at large have shaped their life in some form. To start off, Participant 4 explains her personal experiences (or lack thereof) with postpartum depression with herself as well as other people in her life outside the healthcare system:

> “My friends were just like me. No PPD. I'm not from here, most of my family is in India. So, the only way I could talk about it was over the phone. And, you see, our culture, the South Asian culture, we just take it. We don't share much of that issue, and we just resolve it on our own. Sometimes we don't even go get help. And, then we have a big social life, right, family. So your mom is there. She will take care of you. You're very close-knit is the idea. You can say that we don't need to go outside for a consultation.”

Based on these details that Participant 4 shares, we gain more insight into certain intricacies in South-Asian culture and community. The first key mention here is the social support theme. Across all specialties, all providers mentioned the necessity of social support in their professional responses for plausible avenues of the treatment of PPD. This was a good example of the way certain specific cultures have embedded sources of social support unlike the individualistic culture in America-- specifically the South-Asian culture. Another idea is the examination of the South-Asian social support mannerism. Crisis support is critical to consider because who one ultimately goes to in times of need can suggest ways to mend the care gap. Thus, if a South Asian patient population is keeping such a disease internal, inside the community, then maybe the solution lies inside the community to follow a community care model that I outline in potential solutions in Chapter 5.

Hence, a large part of studying this perspective is to take into account the individual's culture or background to gain a greater insight into reasoning their surrounding social companionship interactions. Therefore, when Participant 4 goes into her lack of experience of PPD with not only her but her surrounding friends and "*not going outside for a conflict*", it is very telling of South-Asian culture in terms of their nature towards this illness. Participant 4's background also tells how she prefers to talk verbally to the moms rather than use the screening tool. Participant 4 doesn't do screening because she does not see the need for a formal scale for a state that could vary and be temporary. She goes on to explain how she sees them every visit so she has seen them in emotional states like when they are in tears or when they are happy depending on the experiences of that day. At first, I thought this was not a great approach. But, in a cultural context, this approach has the potential to be better, serving as a way to establish trust and break down walls of distrust in the community, especially if they feel as though they are outsiders due to their ethnicity or immigration status. Perhaps her own subjective cultural experience of dealing with issues internally also carries over to the professional treatment of such things more subtly with conversation rather than official documentation that may scare off patients and do more harm than good.

Similarly, Participant 5 had no subjective experience of PPD of her own but opened up about a subjective experience with a colleague with alcoholism which catalyzed her enacting change at the individual level:

“Not related to postpartum depression, but one of my colleagues who had alcoholism as a problem. I-I feel like there is/was more support for that. But with that support comes more education. Yeah, I think that definitely changed my perspective to a lot of mental health.”

This impact translates to the quality of professional care she offers as demonstrated via a few experiences she animatedly shares:

“He's 23 years old. He called me and he asked, and he called my office, and he said, Dr. [redacted] told me I can call her any time, so my staff was like, oh, application! You got a call from somebody who said, You can call anytime, and we have a general rule in our practice that adolescent kids can call me anytime because that is there. That is my way of letting my kids know you're not alone. You call anytime to the office, and you ask for me, and you say who you are. You don't have to give too much of an explanation. Because then I know it's a psych emergency, or they really need to talk to somebody, or they don't have somebody that I know. I get out of the room, or somebody in the office would pick up the phone and talk to them and figure out what's going on and bring them “

“You know I had to learn, and I had to just come up with ideas on how to make it accessible. We don't have the care we need. Psychiatrists are not available. So the pediatrician, the back desk. Everybody becomes a therapist because you're all you all that it's about connecting.”

“We had people whose zoom was not working, and they didn't go to school. We said, okay, bring that laptop to our office. Let's see how to connect it. I had kids who were sitting in my office and doing school here the first couple of days. We helped them to connect because they couldn't connect right. Parents don't know. So you have to become resourceful but that's the beauty of my job. I’m the jack of all trades”.

While these resourceful methods are not explicitly mentioned to translate to mothers, it shows the attitude and approaches Participant 1 has to provide care where it is normal for her to go above and beyond, and easily can take a few extra seconds to talk to the mom and gauge her emotional state as she later mentions multiple times as well.

“So the biggest hurdle is to: make them understand that the screening was positive and that it's okay for them to feel the way they feel. And that's not something that they can control.”

> “It's sometimes a little bit tricky, because some of the medical information may not be readily available to me. It could be like. The parent was already having depression in the past and was already on medication, but does not want to reveal that to me. Then that becomes like a problem, right? There are a lot of barriers in all kinds of directions. There's a barrier between us because I am not the mother's physician, so I feel like there's a barrier. I have to sort of do it in a certain way where I'm not the physician for the mother. All that I'm doing is just screening and telling you to go”

> “Pediatricians are pretty much the first provided that the mother would see after they get discharged from the hospital. But then we are not. They're not doctors for the month. They are doctors for the baby, so it becomes a little bit much trickier for us to take care of the adult education because that's not my patient, but I'm still doing a screening. and I can't do anything after the screening. So it's a double-edged sword. So you're asking them to do the question, but you can only give them a referral for help. Yeah, I guess you have to refer them. I wish there was a way where you can just do it in-house, right in-house. So if I could provide, I have to have a social worker in the office to provide continuity of care, not just for the infant, but for the pregnant mother or for the post partner, mother, or father.”

This establishes a need for an easier mechanism at a systemic level. However, participant 5 still takes it upon herself to make sure her patients’ mothers follow up, firmly stating it only takes a few seconds. But, it is worth investigating if every provider would be willing to provide such care if they do not have a similar or shared subjective experience of being impacted by PPD or mental illness at large. So, you can see from these two different subjectivities how personal ideals on mental health from culture and past experience can shape the way you choose how to provide care. This is not to say that there is a superior method, but it also shows just how individualized care can be. Both interviews confirm how our inherent subjectivity impacts the way we approach the issue.

C. Primary Care (PC)

The disclaimer for this section, specifically about the participants’ subjective experiences, was that it was inconclusive. Both interviews were short and both participants felt they did not play much of a role in PPD, however, this in itself says a lot about the way they look at their role in PPD themselves and their perceptions of this primary care specialty. While Participant 6 did allow me to record the interview successfully, Participant 7’s interview had to be cut out due to Zoom logging her off-and-on through the duration of this much shorter 5-minute interview and then being unable to follow up afterward. Regardless, both participants were of similar backgrounds, female, South-Asian immigrant physicians with private practices in the Central Jersey area (Table 1), and yielded similar impressions on their minimal encounters with PPD professionally and personally. However, Participant 6 specializes in the internal medicine branch of primary care and Participant 7 specializes in family medicine. I was not as aware of these distinctions at the start of the interview, as the goal was merely to gain access to willing participants of this hard-to-reach, the more elite population of doctors that are already in high demand. Thus, I chose to prioritize the two physicians who identified as primary care physicians rather than considering their differences in specialization or lack of experience with PPD.

1. Role

While my interviews were not as informative in comparison to the other specialties, this allowed me to ponder about what the medical community defines as "primary care" and primary care physicians (PCPs), given the subspecialty variation within this specialty. First, to establish broadly the larger specialty, PCPS, and PC is defined as the medical doctors and specialists that "work at the first-line of healthcare delivery and provide generalist healthcare" (Bello et al., 2021). However, this notion of "first-line of healthcare" is rather open-ended and confusing depending on the context. According to the World Health Organization, primary care is a community approach to organizing and strengthening national health systems that are more centered around people's needs and respect their preferences. Ideally, it is supposed to be the most inclusive, equitable, and inexpensive way to provide universal health coverage. In essence, this notion of "first-line care" was found to vary, because it is customizable and subjective to people's needs. However, an ethnographic study done at a primary care clinic studying the quality of care in the United States, against the backdrop of our financialized healthcare system, revealed the ambiguity of care amongst PCPs that truly exists. The study found PCPs to hold two contradicting views: (1) healthcare as a commodity being pushed to meet patient quotas that they see for the day (2) a humanistic vision of their professional role to take the time to provide quality care for their community (Manelin, 2020). Another study based on COVID-19 highlighted the need for more structured support to PCPS who despite being considered first-line healthcare workers, were often feeling poorly, not confident, or had no direction and training when trying to deliver quality care to local communities (Bello et al., 2021).

When specifically considering primary care approaches to mental illness, this is also varied in communities for this consideration of healthcare as a commodity versus appealing to the human aspect of healthcare just like in prior pandemic contexts. An ethnographic research project examining the PC approach to depression in Rio de Janeiro depicted this variation in culture. Latin American community attitudes towards stigmatization of depression translated into polarized debates in understanding mental illnesses either as "brain disorders" or "socio-culturally determined entities". Reengagement work with family physicians sought to follow the customizability of primary care and move away from this polarized health model to remaining open to "the singularities of patients' experiences of suffering". Essentially, instead of having a set black-and-white category of classifying diseases like depression and PPD, they are also restructuring their system to be open to listening to the subjective experiences of a patient's life and suffering to determine the root of their disease and respective treatment approach. I believe this is something worth looking into here in the United States as a potential avenue for PPD treatment as well as to restructure family medicine and primary care treatment as a whole to be in tune with patient subjectivities to make healthcare decisions rather than worry about screening numbers of classifications of PPD and established procedures where its implementation can vary on a circumstantial basis (Wenceslau & Ortega, 2021).

For the purposes of this study, when considering the subspecialties of internal medicine and family practice, I will define what each field is. Family medicine doctors and internal medicine doctors (or internalists) are both primary care physicians. However, an internal medicine doctor cares for adults while family medicine doctors treat patients of all ages, oftentimes, an entire family at a time. Both conduct generalized treatment care. In a study that compared physician practice styles and patient outcomes between the two, it was found that there were significant differences in patient style. Physician practice styles for family medicine were more focused on health behavior and counseling and psychosocial aspects of care. Physician practice styles for internal medicine were more of a technical style emphasizing patient activation. Yet, despite method differences, there was no significant difference in patient satisfaction. It was the physician's individual behavior, not the specialty, that affected the patient outcomes (Bertakis et al., 1998). Thus, this establishes how the methods of the two are different, but also how subjective physician attitudes at the individual level matter greatly for care rather than entire specialty methods. This can be applied to PPD where it may be that individual physician attitudes can have more of an impact on care rather than systemic or cross-specialty findings which is explored in greater detail in Chapter 5.

Moreover, when considering their care in PPD, there has been debate about their potential role which was expressed in my interviews cross-specialty as well. To elaborate, one provider (Participant 5 from PEDS) mentions a strategy of care incorporating primary care into PPD referral treatment:

> “Then the next part of a positive screening test is to make sure that we connect her to her primary care provider. Sometimes it means I have to take a phone number and probably even help that mom to set up an appointment or make sure that she follows up.”

This was an interesting response given that most others shared responses along the lines of referrals to psychiatrists or therapists rather than primary care. I questioned Participant 5 on the motives of her election of primary care as a priority over psychiatry follow-up. Her response was that

> “So you don't necessarily need to go see the psychiatrist right away, because it's very difficult to find appointments. It might be a 3 months and 6 months waiting period. So, you might say, okay, let's go to primary care. And then, if the patient already has a history of depression and anxiety or adjustment disorders, or whatever else the primary care provider actually has those diagnoses because they are the generalized doctor with all patient information and can better help the patient a little bit faster, too”.

Her creative solution is to go around the idea that as a pediatrician, she is not, after all, the mother’s doctor so she likely would not have her patient history or information to help but primary care would likely have such information to at least get started on treatment like medication or set them up with a psychiatrist by knowing their health insurance and a sense of their compatibility with another potential provider. This highlights how medical practices at the primary care level should have untapped potential for a subjective community’s local needs and resources, which can maybe be a way to assume greater responsibility for PPD if a need is there in that community. This also reaffirms that this individual physician’s efforts, given certain subjective motivations mentioned in the previous section, to direct the patient to the follow-up and think outside of the box have a greater impact on improving PPD care, especially a present impact.

2. Subjective PPD Experiences

Internalist, Participant 6’s response to her subjective, personal encounters with PPD was the following:

> “I don't think so. I think I was all right, and, like you said. You know I did have family support here after both my children, so that probably also takes the edge off”.

Once again, the theme of social support is prominent when Participant 6 goes on to elaborate on her family eventually immigrating from India to be closer in proximity and this ultimately serves as her support system. I think brief uncertainty in the “I don’t think so” and “probably taking the edge" also furthers this notion of internalization and closed-off nature in the South-Asian community. Throughout the interview, Participant 6 kept answers rather short and brief and mentioned her family as social support. This translated to her professional experiences where she explains,

> "They themselves know that there is something going on with them that they feel no joy, even interacting with their new bonds. Those other patients that I feel you know that they don't get to help, or they don't come out to ask for it. Or they will come when it finally gets worse beyond management. I think it also depends on the environment or the family background that you come from. The background is like oh, you have to power through it. It's in your head. Then the patients have that in their head they will not seek treatment. This is common in my own patient population so I do not encounter it too much."

The accepting nature of this cultural mannerism of family backgrounds and powering through such an emotional state is something that parallels Participant 6's own South-Asian identity where she is well versed in the internal family operations to provide support and structure in dealing with postpartum aftermath. Thus, as a primary physician, part of her job to serve her community is completed when acknowledging and accepting that her patients may ignore it until it worsens or simply not seek treatment. This shared subjective identity of "self" that she has with her patients in terms of cultural patterns allows for greater empathy for why her patients make the decisions they make.

This is also carried over in Participant 6's past professional (or lack of it) experiences concerning PPD:

> "Not at all. I don't think I have any training in postponed depression. Per se, we had a psychiatry rotation during medical school, which was, I think, a month. So the 6 weeks decides that I have no experience with treating depression until I started Residency, and that, too, you just get posted on the site flows. I think 2 months at a stretch during medicine. So that was my only experience. I don't have any training in PPD at all. And, it is also not common with the adults I treat in this community".

If there is no administrative attention to PPD when training these professionals, then that translates to their attention later on in how they interact and pay attention to mental illnesses that are not only stigmatized in their community but also their education. This bias is likely to carry on then.

3. Stigmatization/ Specialty Clash

This stigmatization and isolation of fields like primary care emphasize front-line care despite being ambiguous for family medicine and internal medicine. The generalization of treatments is also often looked down upon by other specialties, and stigmatized. There has to be an overall restructuring of this subfield to integrate all specialties together if considering systemic changes, though at the same time, at the individual level, personal motivations and catering to community care can impact the quality of care greatly as well based on the literature and physician account mentioned before.

D. Psychiatry (PSYCH)

1. Role

The two participants interviewed here were unique in that they dealt more with the aftermath of identification. While the other specialties focused conversations more on identification via screening methods due to their role in referring rather than the treatment of mental illness, the psychiatrists focused more on discussing their treatment of the matter as mentioned previously whether than be talk therapy and medication (Participant 8) or solely medication and referring out if talk therapy was needed (Participant 9). I would like to talk about the controversy over medication and medication management--the primary, evolved role of psychiatrists. Paralleling the stigmas surrounding psychiatry, there are also stigmas surrounding medication usage in the field as well. To add to the controversy, given the misconceptions about the roles of psychiatrists versus therapists, there are also misconceptions about visiting a psychiatrist in assuming treatment plans like automatically seeking the need for therapy or medication. A similarity of both participants was their enthusiasm over the treatment starting with medication-- if there was an established need about assessing the patient.

However, prior to talking about medication, it is important to understand the patient population of both participants for further insight into psychiatric patients as a whole. Both participants established the commonality where their exposure to PPD patients did not simply have PPD. Participant 8 reported 60-70% of her patients were women with mental health issues across a multitude of settings of work throughout her work lifetime: private practice, hospitals, psychiatric state facilities, and more. She has encountered several patients afflicted with PPD who have been prescribed for the illness by their OBGYN or other providers and referred out. Simultaneously, she has encountered patients who have not been screened but whose symptoms are consistent with PPD. However, regardless of screening, her patients are often comorbid or have comorbidities where their ailments are not just limited to PPD.

For context, comorbidity is when a person can have more than one illness or condition at the same time. It is important to mean that these ailments could be physical, mental, or a combination of both as disease overlap is common. In the context of women afflicted with postpartum depression, it is important to acknowledge the relationship of new mothers going through the aftermath of the physically traumatic experience of birth along with the sleep disruption and deprivation experienced in the postpartum period. Moreover, there can be a comorbidity of other mental illnesses like anxiety, generalized depression, bipolar mania, and more. Thus, both psychiatrists interviewed and providers in the field in general as a whole must assess the entire story of the patient to get the full picture at hand. Participant 8 describes a standardized assessment below:

> “So when you're looking at depression in general, whether it's postpartum, or any other type of depression or mental health in general, you're always looking in 3 areas. so the **genetic component** to see if there's a family history, because if there is, that's often passed down. And that you can kind of explain away due to the triggers or stress? Or is there no purpose in life?
>
> And then there's the **psychological issues**? so you're looking at the psychological stressors to see what the person's unique stressors are in their situation. Are they pregnant? Have they lost their family and their job? Or is there something going on personally that might be contributing? And then you're looking at the **social issues?** So just to see what social factors are contributing to their current depression, or whatever psychiatric there is. and the amount of contribution from each of those assets varies…
>
> There's so many other variables that go into it including, you know, from a psychoanalytic perspective. Upbringing in terms of most patterns are formed in childhood. So you want to look at the person's relationships with their parents. their experience through school and with their peers, and to see what sort of you know, what sort of environment they grew up in, and then how it affected their mental state in terms of how their behavior is, and how their thought processes are, and how they deal with conflict and how much stress they experience in the face of conflict, given whatever circumstance they're in, based on those childhood patterns. So there's all that to look at, to really look at what's driving the depression. So it's not just the predominant stress, or at the time, or their thought process about it. But it's all these variables coming together.
>
> And then also, considering the circumstances of the pregnancy, Was it a wanted child? You know what other factors, you know. Are they in a good financial position? Are they not? All this has to be considered when you're treating someone”.

All of these conditions from the overarching classifications of genetic, psychological, and social issues are interconnected often and can go hand in hand. Every individual patient life course experience is circumstantial and subjective. It’s not always sufficient for a mere diagnosis or screening of PPD to reach a certain number threshold, which is why it is important to consider the subjective experience of PPD when identifying, screening, and treating the disease across all specialties. is not as linear or normal as we would like to think it is. Moreover, when asked about their opinions on the distinction of PPD from depression, they were against the separation given their job to consider all mental illnesses circumstantially in the initial assessment period. As long as the depressive symptoms met the criteria for a major depressive disorder, both providers 8 and 9 felt that there was no need for a separate DSM classification because, in their field of medicine, they treat every single patient and illness as subjective, considering the entire patient narrative before treatment no matter what type of depression or mental illness.

a. Treatment Approach: Medication First Outlook

Once the full, subjective assessment of each patient is assessed, each provider explains how they then approach the course of treatment. The precursor to treatment is to sit down with the patient and explain what exactly they have and are diagnosed with. This in itself can be a challenge if a patient has preconceived stigmas, and then you have to make them understand that this is very common, treatment is available, and help is available. Next, depending on the patient's presentation, if the depressive symptoms are severe enough, then they usually advise going on medication. Both participants favored medication treatment (if needed) first before therapy. Participant 8 asserts this pro-medication first viewpoint here:

> "I think it's always good to start with medication, so the person can get back to their normal level of function, because if someone is suicidal or completely hopeless and helpless and sleeping all day, and you know, and they can't take care of their child. That's not a good place to start from, so medication can often help the person get back to just the level of where they can cope with the stresses."

Essentially, the argument here is that to figure out and navigate the mental illness via processes like talk therapy and have the motivational drive to even attend a psychiatric appointment and function, the baseline of functioning of a person has to be reached. I would like to add that even just the diagnosis and acknowledging that there is a problem that is not physically identifiable is hard to do at the moment. It is easier to look back and reflect on something in the past and say, maybe I was depressed, which is something many of my participants said in more or fewer terms rather than easily be aware of such a state in the actual postpartum moment. Thus, medication can help alleviate that moment and offer time and space for reflection.

b. Hesitancy: Stigma of Patient Population

Another factor to consider in terms of medication is the stigmatization of this patient population of mothers. Participant 9 brings up this dilemma,

> "Of course, I would try my best to convince them to start the medication but there is the breastfeeding issue, and usually that trend is simultaneous. I would still strongly advise her to start the course but…"

upon which she trails off. This quote is to show the hesitancy and uncertainty around dealing with women, especially mothers in general, and the potential impact on the child. The mother-child relationship is critical to factor in when dealing with PPD because a lot of the harmful impacts on the mother such as delaying medication to breastfeed, breastfeeding in general, and sleep deprivation impact the health of the woman in the situation. At the end of the day, this is a vulnerable population that providers are scared to deal with. This alone serves as a strong barrier when getting care as seen with the overall hesitancy in tone when conversing with Participant 9 as well.

Yet, despite this fear of the implications of treatment with this patient population, the aftermath of diagnosis and treatment plan in terms of follow-up is not sufficient for a multitude of reasons. For one, there is a known shortage of psychiatrists given the stigmatization of the field itself even in the medical community as we established previously. From all of my interviews, these two participants were the hardest to get in touch and coordinate with, and from dealing with solely busy healthcare providers in all my interviews, I believe this says a lot. There is a bottleneck of patients in need and not enough providers here.

Participant 9, the solo practitioner, also explained how her follow-ups become less and less after giving mediation. This serves as a barrier for the patient because there is no single course of treatment from one source. It is up to the patient and their motivation to seek help from another therapist or psychiatrist who can provide the talk therapy if needed. Not to mention, having to start the entire assessment process again to convey their subjective story to another provider. Furthermore, at any point in time, the medication may be faulty or there may be environmental changes. There is still so much unknown about the etiology of PPD, let alone the aftermath of medication coupled with hormones or bodily processes like breastfeeding. And, there are other systemic factors as play with time and temporality being a key one when seeking help to spend the time setting up appointments where there are already limited options and availability often not well-suited to a patient's schedule or needs. Another concern is the finance of these appointments and care. With a new child to care for and a life to fund, paying out of pocket for mental health treatment is not a priority. Participant 9 explains how many psychiatrists do not accept insurance these days, especially Medicare. Given the high demand for psychiatrists but low supply, they feel justified in their practices and funds in this healthcare system. These barriers to access to the system like insurance, medications, unknown physiological variables, and cultural competency, all contribute to the inevitable lack of care or falling of patient check-ins.

2. Subjective PPD Experiences

I would like to give greater context into the field of psychiatry. The stigmatization of mental health extends to the stigmatization of mental health professionals and the mental health medicine field itself. Even amongst the healthcare providers themselves, psychiatry is one of the least respected medical specialties. (Scientfiic American, 2016). The black box of mental health is only now making public gains. A large part of this is due to the COVID-19 pandemic according to Participant 3's administrative input and the psychiatrists 8 and 9. But, that does not completely erase the stigmatization of the specialty for years, both inside and outside the field of medicine. Internally, it has taken a huge hit--being viewed as a pseudoscience rather than taken seriously to the point where the field has a shortage of psychiatrists. This overall negative outlook was hinted at immediately at the start of both my interviews when prompted for their training and background in their respective medical careers.

Upon introducing themself and their credentials, Participant 8 mentions how they had first matched into family practice residency and later on switched over to psychiatry residency in a different state later on. They further explain:

> "In medical school, I really liked psychiatry a lot. But I think you know I-I hadn't really experienced anything related to psychiatry, and there is a lot of stigma around it. So, coming from an Indian background, where there was a lot of stigma around psychiatry at the time, my parents. were really encouraging me to do something else other than psychiatry. So I thought I would get a taste of it by going into family practice. But then, once I started training and family practice, I realized I really missed really deeply going into psychiatry. So I finally decided to switch into the specialty that I really wanted to go into from the get-go,"

highlighting how attitudes towards psychiatry may have been perceived by medical school students like participants inside the healthcare system during stages like training and others like her parents' outlook outside the healthcare system. Here, it is important to note that Participant 8 brings up her Indian background, which she soon elaborates on being raised as a first-generation born South-Asian American rather than an immigrant like other participants. To clarify what I mean by this term, Participant 8 lived in America for almost all of her life (and was born there) and so part of her identity is rooted strongly in Western culture in comparison to her parents who identify more so immigrants with a youth tie to their home in South Asia. Thus, she was exposed to a different culture overlapping with South-Asian and American heritage from a young age. This unique, subjective experience serves as a motivator for trying to find a middle ground with a family practice at first--hoping to get a taste of psychiatry to finally making the switch into psychiatry for herself and going against the original wishes of her parents. (Upadhay, 2019). This motivator and genuine interest in the field is shown in the manner in which Participant 8 is invested in the specialty to the point where she is willing to repeat her training. This investment is furthered by Participant 8 sharing her further specialized fellowships in psychoanalytic psychotherapy training and addiction psychiatry. All of this is to say her subjective experiences in her unique culture and stigma around the psychiatric field and mental health in her personal life feed into Participant 8's responses when considering her role as a provider and her treatment decisions for her patients ultimately. This may indicate other providers' own subjective experiences in this field of such stigma and cultural backgrounds also impacting their decisions to pursue and treat psychiatric mental health medicine. However, it is important to acknowledge the nuance that Participant 8's story may not be able to be generalized to other providers given this trend established in a small interview sample in a suburban area of New Jersey.

Participant 9 also expanded on her background as a South-Asian immigrant struggling to match into a residency in medicine, not wanting to repeat her MD degree here. She went on to admit:

> "so to be very honest. I came here on H4 status. I got married and came here with my husband, so my husband was on H1 visa. So, there were quite a few immigration issues in the beginning with the visa, status and all that. And so at that time getting into any residency was quite difficult. And I got offered into this program. so at that point I guess I just grabbed it. And honestly, I had never imagined myself to be a psychiatrist but I guess I love it now,"

illustrating how the stigma perpetuating the shortage in this profession allows for an easier time or greater vacancy to allow for the matching of this profession for less traditional MDs. (Scientfiic American, 2016).In comparison to Participant 8, Participant 9 did not identify as a first-generation-born South Asian American but rather a South Asian immigrant. I want to acknowledge there is a range in terms of identifying a certain way and being South-Asian, American, and South-Asian American is all a spectrum that changes as life experiences change. Participant 9 spent a longer part of her lifetime in South-Asian being more accustomed to solely those social norms--where considerations in mental health and mental health medicine are taboo. The following career path after psychiatry training participant 9 fed into her decisions afterward where rather than specialize in psychotherapy, Participant 9 chose to invest her time in launching a private practice. She goes on to later elaborate on her treatment methods, but given that it is just her practice with less training in terms of therapy, she refers out to patients who need such a type of talk therapy and focus on medication treatment of her patients. I would like to highlight this correlation in terms of identity and background affecting what type of treatment she is comfortable with handing out in terms of the internalized self-stigma Participant 9 has admitted to having for the field herself until she grew to love it.

3. Speciality Clash:

Despite parents wishing their children to grow up to be a doctor serving as a common South-Asian stereotype, growing up to be a psychiatrist is not viewed the same. This feeds into several misconceptions and stigmatization about the field as mentioned before. There is also a misunderstanding of what the field of psychiatry is. I, myself, prior to the interviews, was unclear about the role of psychiatrists--especially in comparison to therapists. It is important to establish that the terminology of therapists versus psychiatrists cannot be used interchangeably. The key distinguishing factor is that psychiatrists can prescribe medication while therapists cannot. Psychiatrists are medical doctors more concerned with the biomedicine link, the complex relationship of both, mind and body, in mental health medicine. While some psychiatrists may provide psychotherapy and can be considered therapists, therapists cannot be considered psychiatrists. Another concept is that therapists also encompass a whole range of professionals that can provide mental health care: psychologists, mental health counselors, family therapists, social workers, and of course, psychiatrists. There is no one streamlined professional in the complicated field of mental health. This establishes the idea that it is up to the psychiatrists on what approach they wish to take, with medicine as a baseline for treatment, and the decisions of psychotherapy or referring to an outpatient therapist of sorts, are also at their discretion. This liberty in the range of treatment where psychiatrists can decide the course of treatment was seen in the variation of the course of PPD treatments/routine treatments for patients in general in the two participants interviewed where Participant 8 specialties in psychoanalytic psychotherapy and Participant 9 strictly focused on medication and therapy referrals likely stemming from their subjective experiences and preferences on mental health medicine.

c. Motivation/Self-Drivenness Factor

Circling back to the personal backgrounds of each provider impacting their outlook on care was interesting as well. Participant 9's background contributed severely to her self-motivation outlook on seeking help. There is also this idea of self-awareness I would like to explore in greater detail which is inherently tied to subjectivity and "self. This is the capacity to focus attention on oneself and self-evaluate.

- Positive effects: psychological function, taking the perspective of others, exercising self-control, producing creative accomplishments, experiencing pride, high self-esteem
- Negative effects: negative affect, depression, suicide, and dysfunction
- These facets of self-awareness are reconciled/have a friendly relationship when people are optimistic about meeting their standards

> "I will say, if the patient is motivated enough, they should be able to find a psych address and find a therapist given whatever barriers or hurdles there may be, you know. So now, these days there are also so many, I think, like tele-psychiatry sites that you can, you know, see somebody, and at least get started."

While there is great merit to Participant 9's outlook where at the end of the day, a person has to want to seek help and be willing to put in the effort to get better, at the same time, there has to be a consideration of empathy. No matter what, it is hard to have a positive attitude to seek help, especially when weighed down by the aforementioned structural barriers in place. Moreover, there is a relationship of motivation that comes from being educated and having the knowledge that PPD is common and it is okay to feel a certain way. Thus, there is a need to shift subjectivities and perspectives from viewing PPD and mental health as stigmatized or taboo from a lens of morality to a lens of medicine in that it is an illness. At the end of the day, it is a disease just like the others with more physiological symptoms.

E.Midwives (MVs)

Role & Stigmatization

Following the trend of the psychiatric field, midwifery is also heavily stigmatized as a professionl. A large part of this stigma is due to widespread misconceptions rooted in the origin of how midwives came to be. Historically, lay midwives worked this role of assisting in births without any formal training. However, the majority of midwives in the present day are licensed with master's degrees in addition to highly specialized training, in overall women's wellness, prenatal, labor and delivery, and postpartum care. The extent of specialization is seen in the way there are now different types of midwives as well: certified nurse-midwives, certified midwives, and certified professional midwives. Midwives go beyond providing solely obstetric care for pregnant women, as many provide comprehensive care. The majority of visits to certified nurse-midwives are actually for primary care including gynecological care like annual exams and reproductive health visits. Providers in this profession are highly trained to treat women throughout all life stages from adolescence to even after menopause, not solely during the pregnancy period.

Another notion in the public perception of this traditional, untrained midwife image that people have, is that midwives are only involved in childbirth, specifically natural childbirth. But, that is not an accurate representation of this specialty. The remarkable part of seeking out a midwife for care is that midwives adjust or can adjust more to suit a woman's needs at the individual level. While many women do choose midwives to pursue a natural birth with no pain medication, midwives can actually administer pain medication if their patient needs and/or wants it. IV pain medication and epidural anesthesia both can be provided and are available for births that are attended by certified nurse-midwives.

Moreover, another stereotype is the elitist image of midwives that some people also have in their heads. Not only was this viewed as a profession that can carry out childbirth at home, but it also holds the implications of privacy and luxury to carry out such a dangerous and life-changing act within the safety and comfort of your own home. Traditionally, it was also viewed as something that the wealthier social class would do. This feeds into the current misconception that midwives only deliver babies at home and are extremely expensive. But, this is a myth. Certified nurse-midwives practice wherever women give birth, including hospitals, free-standing birth centers, homes, and more. In 2014, the majority of births attended by certified nurse midwives (CNM) and certified midwives (CM) midwives were actually in hospitals (94.2%), and then 3% occurred in birth centers while 2.7% occurred in homes (American College of Nurse Midvies, 2016). Not to mention, this is not some form of healthcare that is highly privatized for the elite-- at least not anymore. Most major healthcare insurance companies and Medicaid cover midwife services. Financially, this is a sound economic decision because births that are overseen by midwives are less likely to require complicated and more costly interventions such as a cesarean section.

Speciality Clash

Then also comes the confusion due to the multiple care provider options: Obgyns vs midwives vs doulas. There are all these professionals but it is hard to determine who is ultimately qualified or the most qualified to deliver your baby and handle your care. Before taking a closer look at the intricacies of these overlaps in pregnancy care, it is important to establish what each role and the differences in the jurisdiction are. With that, then a baseline can be established for the stereotypes and why professions like midwifery are further stigmatized.

i. Doulas

With the rise of medical advancements and increased regulation to decrease the maternal mortality rate by 71% from 1939-1948 shifting the prevalence of home births to hospital births, the perspective on the event that is birth also changed (CDC MMWR Weekly, 1999). The outlook on birth as a rather natural event shifted to a risky event more like an illness rather than a natural life process due to the emerging and more frequently used intervention methods of cesarean deliveries, induction, epidural, artificially rupturing membranes, and episiotomy.

This shift in turn sparked a need for dedicated emotional support amidst both the alternative health beliefs of home births rising again as well as the stricter, often emotion-lacking conventional biomedical model of hospital births. And so, women began to invite their female friends, childbirth instructors, obstetrical nurses, and anyone that had that connection to help them during labor. Eventually, these types of people founded the non-profit organization Doulas of North America in 1992 to train and certify these people that can act as coaches and companions. It is important to distinguish here that a doula is not considered a healthcare professional and cannot provide medical care or advice. Rather, doulas provide constant and consistent communication and encouragement during labor and do not split their attention with multiple patients like other medically trained birthing staff such as nurses, midwives, or doctors. Studies have shown healthy birth outcomes with Doula-assisted mothers where this focused attention can empower mothers and have more satisfying experiences during labor, birth, and postpartum (Gruber et al., 2013). Oftentimes, doulas get thrown into the same category as midwives due to the stigmatization of both fields being seen as “lesser than” when compared to the MD or DO title that physicians in the obstetric field have. However, while both have critical purposes, midwives and physicians are healthcare professionals that provide medical care.

ii. Midwives

Despite these certifications and training to provide care, historically, midwives have faced exclusion and discrimination in their position by physicians who preferred to exclude them from the profession. Rather than collaborate as a team, it was and is often a competition--predominately by male medical practitioners. This is because of the traditional outlook where midwifery operated as a “female-dominated role” as a family profession or apprenticeship where the knowledge was passed down from generation to generation. In terms of culture, especially in the past, it was considered taboo for a man to be physically present at birth. Thus, obstetric care, the medical science of pregnancy, birth, and the postpartum period were often shunned and inadequate as a whole. Insufficiencies in obstetric education and training, lack of hygiene, and unsafe delivery methods fueled high maternal mortality rates and many of these deaths were preventable. Thus, though in many states maternal mortality rates are still high, the government has tried to make efforts to intervene by putting forth state health regulations for both midwives and physicians to comply with. In fact, in the present day, many times midwives and OBGYNS now work together in private practice and hospital settings to combine skills for efficiency. Both participants, 10 and 11, interviewed have worked in both private practice and hospital settings alongside OBGYNS, and Participant 10 also mentioned prior experience being a sole midwife for home visits as well. The implications here are also that you do not need to choose either: a doctor or midwife-- you can have both.

iii. Midwives vs OBGYNs

As an introduction to OBGYNS has already been established, I would like to use this section to jump into the distinctions between the two healthcare professionals by going straight to the professional opinion:

> “For doctors, they're trained in pathology, so the way they look at things is, how can I fix this? Midwives are trained to see birth as a normal physiological process. And so the way we approach it is that we're supporting a natural process as opposed to trying to fix it, You know. Sometimes I think doctors might look at birth as a sickness,

> and it really isn't, it's a normal process. and really our job is to support women through that normal process as opposed to intervening unnecessarily, which sometimes can cause some more issues, but because we focus just on the women. Sometimes with doctors, they do surgery. They do different kinds of things than midwives. We were focused more on the normal and really engaging women to be active participants in their care, educating them, supporting breastfeeding, all of those natural things that are part of what you go through. A woman in her lifespan is what we are really hoping to support."

As Participant 10 explains and given the historical trends, physicians are trained to view birth as an illness and something to solve whereas midwives have trained to guide the natural process that is already present around. Thus, each professional's subjective training and experience affects the way they approach a prospective patient. However, this is not to say that one treatment philosophy is superior to another.

To give context, Participant 11 offers an example of when she was a home visit midwife in training while working with only midwives. Her patient, Jane's baby began to descend during labor with his back against her spine, facing the wrong way. This is a common labor complication, though many babies turn the right way naturally. However, Jane was eight in every one hundred women whose baby was unable to turn due to the head taking up space and the shoulder being stuck. Thus, arises a problem that is necessary to fix using forceps or carrying out a cesarean section or commonly referred to as C-section. While midwives can assist in C-sections, they are not trained to do this because it is a surgical procedure requiring surgical training taught in the OBGYN training. Participant 11 recalls Jane's "screams of agony" while being rushed to the hospital, when it was almost too late after a failed forceps delivery was attempted, for an emergency C-section where she suffered a severe hemorrhage. This was a case where the midwives were unable to naturally manage Jane's dangerous symptoms and the reality was that she needed medical intervention.

This situation serves as the opposing side for the argument of "normal" birth being seen as better. In certain instances, even the lowest-risk pregnancies can become an emergency that can be avoidable if medicalized attention is given. Yet, neither natural childbirth nor medicalized labor is better than another. Participant 11 goes on to say that rather than having women getting caught in the "crossfire of a turf war" between midwives and obstetricians in terms of philosophy and scopes of practice and "poor working relationships" between the two, it is critical to ending this decades-long argument and stigmas against each other by working together to combine each approach and use all the tools in the toolbox when necessary for safe births at teams that train together. She goes on to highlight how this teamwork methodology is working in the integration of midwives and doctors in the hospital and private practice settings, slowly fighting the stigma and prejudice that midwives often face. In this way, both midwifery and doula focus on holistic health like nutritional health and emotional feeling -- all interconnected with PPD-- can be shared with physicians like OBGYNS and other medical staff. As such, this is a potential avenue to address the care gap.

2. Subjective PPD Experiences

Thus, given what has been established about differences in treatment pertaining to midwives, the two participants interviewed here stand out in their emphasis on holistic health which encompasses an emphasis on emotional feeling--particularly PPD. While other specialties are more focused on medical intervention and the immediate dangers of PPD, specifically the extremities of postpartum psychosis or the screening/treatment after a high score was received, here, both participants focused on their responses around forming and building relationships as well as a greater systemic barrier focus with flaws regarding the current medical interventions in place. This is not to say that the other specialties did not have similar responses, but these themes stuck out to me the most when interviewing participants of this specific midwife profession.

Before diving further into these responses in detail, I would like to dive into the personal accounts of their experiences with PPD outside their title in the healthcare system. Unlike psychiatry, I did not ask them why they chose their specific specialty as that newfound question spontaneously sprung in both those conversations. However, I did get a chance to ask about their personal experiences around the PPD subject as both mentioned being mothers. I believe these personal, subjective experiences also impact their decisions about their chosen profession and how they view and form relationships with their patients. Not a lot of the participants that I interviewed were able to recall or share any personal experience of PPD of them or anyone they knew outside of the system, and no single specialty had all/both the participants of that category highlight personal, outside the healthcare, experiences with PPD, expect for both the midwives I interviewed. While this could have been for a multitude of reasons, I believe that these subjective experiences were a necessary catalyst in their outlook on PPD and their patient relationships as well--specifically in their interests and passions for holistic health and emotional states in comparison to several other physicians I interviewed.

To start, Participant 10 gives insight into her own experience after giving birth:

> “I probably had a little bit of postpartum depression, but didn't really know how to identify it to be completely honest when my son was born. I was also a single mother with my son. Now I am married when I had my daughter and I don’t feel like I experienced any of what I experienced the first time, and I think probably some of what I was experiencing was mourning, the loss of a relationship, and then having real life. It just makes a world of difference to have someone to check in on you and someone who you can like, just listen to you and offer, you know, some kind of help and assistance”.

There is a lot to unpack with the narrative that Participant 10 opens up about. The first idea here is the clear demonstration of subjectivity and variation with PPD. PPD is on a spectrum of depression, everything can affect it from hormones, relationships, to social support as seen here when she mentions the further burden of grieving her lost relationship and being a single mother. Mental illness is also circumstantial and this is a prime example. Moreover, how Participant 10 discusses her story is one of reflection. She is looking back to determine whether she was afflicted by PPD or not, but at that moment in time, she likely did not officially diagnose herself as such. It is very hard to have the mindfulness, intentional present-focused awareness, necessary to self-realize or self-identify depressive states or symptoms that are in your own subjective consciousness. It is relative subjectivity to time in the way it is hard to understand what you are going through all at once in the thick of the turmoil. Many studies have established this positive correlation between reflection and depression, but there is a lot that is unresolved and other studies contradict this correlation or indicate there is no correlation (SOURCES< there were multiple). These conflicting findings are no match for understanding a mother's vulnerable, subjective state in the moment of postpartum coupled with decades after learned life experiences.

This process of inner-self reflection also corresponds to the concept of *reflective functioning* which involves increasingly complex awareness and human capacity to self-understand behavior in terms of mental states: thoughts, feelings, moods, intentions, and desires (Fonagy et al., 1998). Much of the research on this subject has played a significant role in interpersonal dynamics, especially family relations--including parenting. This encompasses the mother-infant relationship. In the realm of postpartum psychology, there has been research that suggests that *parental reflective functioning* is a critical explanatory mechanism between depressive symptomatology (including PPD) and mindful parenting skills (Nobre-Trindade et al., 2021). If there is a way to reduce depressive symptomatology, there was a positive correlation with improvement in parental skills (Nobre-Trindade et al., 2021).

While there is a multitude of ways of lowering symptoms like screening, talk therapy, medication, and social support, I argue a critical coping mechanism is also repression at a subconscious level in the given moment of need, especially for postpartum depression. A big idea around mental disorders like depression is that depression is inflexible where affective states are resistant to change and that is how people get stuck in this mental state (Koval et al., 2011). Yet, it may not be the exact case with PPD where there is a sense of duty as a parent. This adds to my initial argument on the need for separation of PPD from the major depressive disorder category for its unique subjective positioning affecting a caregiver with this duty rather than a person in terms of initial identification to treat it properly in our healthcare system. Often, especially with the mild onset of PPD, there is no room to ruminate and brood in this inflexibility There has been research done with diagnosed individuals with major depressive disorder (MMD) in comparison to a never-disordered control group (CTL) highlighting that participants with MDD endorsed more frequent use of expressive suppression as well as frequent use of rumination which gives insight into ways emotional regulation strategy use maintain psychological disorders (D'Avanzato et al, 2013). This can be applied to PPD in specific because there could also be potential emotional regulation using just the right amount of suppression to function as a parent. Subjective health perception and choices also matter. There is a reason why people say pain is relative and is hard to gauge from person to person. This applies to both physical and mental pain. PPD is a unique depression because the patient has a given set purpose in life: being a parent. The patient especially in baby blue or PPD rather than psychosis states is generally able to function as a caregiver figure to some extent. This role often serves as an identity they adopt and their purpose in life to be functioning members of society. Acknowledging their depression is often detrimental given their obligations, and it is often easier to suppress these emotions.

This can also be a cultural phenomenon where Participant 10 further mentions how *"In the black community, depression or PPD does not exist, we cannot afford it too"*. So, the priority is to be a mother first, only looking back was where the participant was able to reluctantly admit she might have had it given her training and education on maternal mental health also affecting her ability to recognize or even vulnerably share such thoughts. This may not be the case for women with less education or exposure to the healthcare system. Ultimately, it is important to keep in mind as mentioned prior that PPD and depression both have unknown variables in their etiology and a person's total encompassing subjectivity is a key factor in their emotion regulation strategy, including their cultural or surrounding societal expectations.

Another notion that Participant 10 mentions, later on, is how she is originally from Haiti so it was customary that when she gave birth at home she was surrounded by her mom, aunt, as well as a lot of her other community even as a single mother at the time of giving birth to her son. So, there was always someone to watch the baby when she was sleeping, someone to make meals, and a lot of social support in general even when she gave birth to her son as a single mother. Thus, she remarks "*what saved me is being supported*" and likely impacted the magnitude of her PPD in terms of having a "*little bit*" of PPD. She further mentions here a personal history of anxiety prior to delivery and her decision on having a home birth to be able to share her worries and dig deep in a safe space. Hence, Participant 10's subjective cultural community structure around her as well as her pre-existing history of anxiety in the decision to undergo a home birth offered coping mechanisms for her which carried into her emphasis on social support and serving as a home midwife for some time in her profession.

Unlike Participant 10, Participant 11 shares how she is the mother of four children but does not think she had PPD, and regardless "*nobody screened back the*n, I had family support though". This also shows her reflective functional reasoning of "*she does not think*" and lack of screening contributing to her uncertainty. PPD and depression are not straightforward mental states to decipher. Some women may feel tearful one day because the baby was unable to sleep and then elated the next because the first words from the child or something momentous happens the next. Just as it is not easy to identify let alone acknowledge that one may have symptoms pertaining to PPD or depression, it is also not easy to reflect back and be certain of exactly what mental illness (if any) you may or may not have had. This is not to say that Participant 10 did or did not have it, as her tone and later details of other stories on PPD indirectly that she witnessed affirm her words that most likely not. But, the brief hesitation reestablishes the gray area of depression and just how difficult it is to truly identify or screen for it-- especially during a time period where there was no screening in place and much more stigma.

This is not to say our screening measures are flawless anymore. In fact, both participants brought up one core issue of PPD care they felt strongly about with our screening system that is in place which is also based on both their subjective personal and professional experiences: (1) addressing language barriers on the screening forms (2) lack of federal funding to process and make something out of the screening results.

Participant 10 gives her personal background as a young immigrant from Haiti as well as her professional experiences in the New Jersey community. Of all the participants interviewed, Participant 10 had the most patient interaction in a hospital setting as many of the other providers were private practice. Though some had experience in hospital settings, it was more administrative or not their primary way of practicing care. This allowed Participant 10 to interact with more of the whole central Jersey community rather than a specific demographic or class that private practices generally reach, including a recent emerging Spanish immigrant population from Guatemala and Honduras. She goes on to dive deeper into exactly how this is a critical issue:

> “Here at our hospital, I know they have the scale in Spanish, but a lot of them are recent immigrants from Guatemala, Honduras, and so their education level is about fifth, sixth grade, and sometimes the questions are a little bit more than they can. so that's the other thing you can miss a lot of it just because they don't understand the questions. So sometimes somebody will score a 13, which is considered a high score, and then, when you probe, they don't understand what they just answer, They're just circling things to get you up there, you know, to get you off their back. Even some of the words on the form are foreign to me without medical training and being from Haiti my family members would have a difficult time gauging exactly what to circle.”

This goes to show that even with a translator or translated form, it is still not easy to accommodate every culture. Even how other cultures define "depression" can be difficult to put into words, let alone ranking these subjective emotions on a scale of numbers. This is paralleled with the literature mentioned earlier on cultural language variation in terms of mental illness or even how other cultures define "postpartum". Another key point that both participants, along with several other providers, brought up was the fine print on the scale. The scale actually is to gauge your mood within the span of the last 7 days, but if you do not sit with the patient to tell them, it is commonly missed. Understanding when you are being asked about how you felt is also vague and can vary based on drastic patient responses if the timeline is not made clear. As Participant 11 further mentions *``one day you may circle a 9 because the baby kept you up all of last night and next you can circle a 2 if you had a memorable moment"*. Upon viewing the form myself in informal participant observation settings, I actually did not see this 7-day disclaimer either. Thus, the timeline expectations of this screening exam need to be publicized more as well as it has to be adaptable cross-culturally going beyond the basic language translation.

Even once patients fill out said form, maybe correctly understanding and deciphering it, that is not to say the aftermath and processing of the form are necessarily smooth. Participant 11 then brings up another flaw in the screening system. Given her background of originally being from New York entailing working in the New York hospital system in comparison to the New Jersey system, she sheds light on the truth behind the postpartum policy mentioned earlier on from the literature:

> " I don't think it's adequate, I think, on paper. It looks very adequate. New Jersey is one of the weakest States in terms of caring for pregnant women. If patients don't have money for labs, the labs are not done and these screening forms for PPD are not processed. Believe it or not, it's like they can mandate a whole lot of things, but they're not paying for the services. So that's why, what's on paper, but what's on paper is not necessarily what's going through to the community."

Immediately, I was a bit taken aback and doubtful when hearing Participant 11's bold statement on the matter. I had spent so much time hearing from providers and through research on how initially New Jersey was one of the first states to enact PPD legislation effectively as demonstrated in the literature earlier. But, as Participant 11 goes on to further elaborate on her take in the matter, the key word here is "*paper*". This exemplifies how despite a system having legislation or procedures in place, it does not necessarily mean that it is carried out to its full potential actuality. Participant 11 goes on to compare her experiences on this matter in her current employment in the state of New Jersey versus her past employment involvement surrounding PPD and systemic issues at large in the state of New York. Here is the breakdown of how it generally goes in New Jersey based on Participant 11's testimony.

> "Here, when you have uninsured or underinsured patients, they are the ones that are definitely suffering because they do not have the money to pay a copay to pay, even if it's $20 a visit or followup on said screening results. They don't have it. So what's gonna happen? They're just not going to go. Yeah, it's not going to work. So they would miss visits because they need to feed their family. It doesn't mean that they don't care about their baby".

> "But yeah, I get the paper and response like this is what the legislation says we do, and we do. We follow it, and we check all the boxes, and we do the depression scale, and we offer the patient options. So, they leave with an appointment that they cannot pay for. Nobody calls them. Nobody follows up".

As a remark to the way our conversation took a turn with a closer examination of New Jersey policy, I was curious about this lack of follow-up in regard to the role of midwives. Generally, especially for the case of midwives attending home births, there is no gap in follow-up because this is the only patient for the midwife who they continue to see after delivery. In fact, rather than a 6-week gap after delivery to follow up with the new mother, midwives typically see the mother 2 days after birth, often conducting home visits. This is an impeccable turnaround time in comparison. This one on one interaction in the personal space of a patient is a critical example of intersubjectivity where there is a greater ability for the provider to understand the patient and the patient to understand the provider. The care connection is deepened through the ability of the midwife/provider to gain at least a glimpse of the subjective everyday life experience of their patient in their home environment in order to understand the potential context and implication of PPD behind closed doors. Given this ability for midwives to better be there for their patients oftentimes even in their own homes rather than account for unknown variables of the process of follow-ups, there is a greater likelihood of identifying PPD symptoms and also establishing trust with the patient to allow for future avenues of seeking help and treatment. The intersubjective nature of provider-patient relationships is essential to successful care as the value of each person in this dynamic is inseparable.

Thus, I further questioned Participant 11 on her opinions on integrating some of the values and roles that midwives bring like focusing on one patient and conducting these home visits to other specialties or more of our privatized model of healthcare. Her response using her New York experience breakdown from her past is as follows:

> "I wouldn't necessarily put it on the midwives, as the person doing home visits only… I used to work for a Home Care Agency many, many years ago and what this particular unit of hospitals set up in New York was any patients that went home. Every patient was offered home care services before they went home. They did not have to pay for it. If they were uninsured it was for free if they were insured, whatever the insurance paid for it, Medicaid, whatever it was. They will refer to a visiting nurse before they leave the hospital, and an appointment was set up within 2 to 3 days of leaving every single patient and somebody went to the house. They would weigh the baby. Talk about breastfeeding. Has a patient had any problems after leaving the hospital, and then you could actually look at the home. Look at if it's clean, look and see what supplies are for the baby, and you get a better sense if this baby is being cared for themselves, and you get 2 home visits, and If there's a need that's identified. Then you can actually get authorization from the insurance at that point to get more visits. It worked very very well. So any Home Care Agency could have gotten the referrals there in New York any State hospitals there, health and hospitals, Corporation, meaning any hospitals that are in different boroughs. They're all part of it, because it's a State run institution right. And so that was what they did for all of the patients that they sent home and delivered at their hospital that was offered for every patient. Not every patient did not take it a lot of times. People thought this was their third baby. They didn't need it. They were fine, but most first moms would often take it."

After further studying this Home Care Agency model, Participant 11 also introduced me to an affiliated program called Health First. The process is as follows:

> "If a mother goes back to their post-partum visit, they bring a card. We fill it out, and they send them a $50 gift card. Oh, wow! Incentive from the insurance company, because they understand **continuity of care.** If their patients go to the doctor, they get care. They will actually not end up in the emergency room and spending more money to try to take care of their patients. So they need to have 8 prenatal visits. They need to have their postpartum visit, and then they get like this, almost like an incentive to do it, and I would say over 90% of their patients always came back because of that…. It sounds terrible, but it's all legislation, and it's all funding. It's your elected officials. It's who you elect and where they're giving the money that we pay taxes for."

The important takeaway here is to understand that the treatment of PPD comes with a degree of willingness of the patient. In order to incentivize patients to seek the help that they need, it is important to understand the subjective motivations of patients. While it is hard to customize treatment plans for every single patient, an economic incentive is often a potential dominating solution--especially when patients often forgo treatment pathways due to huge financial reasons like insurance in the healthcare model of the United States. However, funding for such programs varies state by state as there is not yet federal funding for many maternal mental health issues like PPD. Not to mention, at the state level, legislation involving adding a postpartum extension on Medicaid is still lacking in several states and a work in progress in other states. Thus, there is a clear need for financial restructuring in New Jersey and many other areas where basic PPD screening is not yet in place either. There are a lot of intricacies of PPD care that go beyond the role of midwives and providers at large that most of the public is not often privy to. These are some of the systematic barriers preventing the care of PPD that I will discuss in Chapter 5. Our subjectivities are drastically different from the overarching governmental ones, and so, to make changes at such a level, it is important to meet them in the middle.

Chapter 4: Challenges to Crossing the Barrier at an INTER-Speciality Level

Subjectivitvity Considerations & Implications of PPD

To recap, of the initial providers recruited, four providers out of the eleven identified th having subjective postpartum/mental health experiences of some sort themselves (n=4) and one of the four providers subsequently (male physician) self-identified to having official postpartum depression (n=1). This is very telling on how and where you draw the line. The way providers themselves discussed their own experiences translates into how the medical community and society should shift their thinking in regard to PPD. It is not an easy issue to identify or diagnose.

If providers are uncertain or view PP and overall mental health experiences as having many gray areas themselves, then it is quite likely that patients also have an uncertain outlook on PPD based on their own personal backgrounds as well. Thus, where one mother may experience PPD with factors of lack of support from family and friends, another may experience PPD due to bio-hormonal changes and sleep deprivation, and another due to systemic issues of socio-economic issues. The point is that there is a spectrum and different combinations of cross-cultural factors that influence women with PPD, where it is not easy to just chalk PPD as a subset of a generalized depression in medical criteria or merely medicalize a disease that is still unknown in many of its parts.

Social Support

A common theme that came up was the necessity of social support regardless of background which then led to conversations about cross-cultural differences in care of mothers and stigmatization of mental illness in the way that it has the potential to heavily influence maternal health outcomes. This universal trend across all specialties mentions social support and its role as a coping method. I think in order to give context to the different cultures' mannerisms surrounding PPD as mentioned in the prior chapter, it is important to understand what social support could look like. Generally, social support systems are forms of interpersonal relationships classified into three groups: emotional, cognitive, and financial assistance in a voluntary fashion (Yurdakul, 2018). Emotional support involves trying to meet or accept people's basic needs like love, attention, trust, and ultimately offering a place for a greater sense of belonging. Cognitive support encompasses more of the logistics in these relationships like problem-solving and acting as a guiding source for helpful information. Lastly, financial support entails the basic necessities like providing money, food, and assisting in domestic work. This last notion of domestic work is an important factor when dealing with women with PPD because of the traditional expectations of women and what mothers are expected to do when providing free labor in terms of housework and raising a child--all free services. Generally, three main forms of these varied areas of social support have been reported in past research: family, friends, and significant others. And, the level and source of perceived social support (by providers and the healthcare system) that is measured with these social forms and types of support offered differs from their own (patient) subjective perception of social support. In other words, social support is not as simple as if the mom has a spouse, friends, or family. There is a spectrum of dynamics to consider like spousal roles, extended vs nuclear family support, and intimate friendship interactions. These interactions of confidant support are mediated by the person's own self-reflecting interactions that are mediated by self esteem or self efficacy (Pearlin et al. 1981). The inner-subjective impressions that the personal has on these social relations will ultimately impact their feelings and in turn their support that they receive on how they feel they are being helped during this time of need. Thus not only is it important to consider the structure of an individual's function, we need to assess the real function of this social support in the individual's point of view to understand if they have the support that they need.

The Doctor Response & Provider Subjectivity

As introduced in the methods section, to interview doctors is no easy task. While navigating this fieldwork, I felt myself hitting a wall or a barrier where I was not able to assimilate into this population naturally given that I have experienced the child side to PPD but never been the mother herself actually afflicted with such intense emotions nor am I an established provider of care in our medical system. I often got the basic medical jargon about PPD, such as the technical listing of symptoms and/or screening procedures almost if I was being spoken to as a patient rather than an anthropologist wishing to collect more reflections on the implications of the system or any personal reflections if they chose to offer. Many responses, especially the first half before trying to establish the rapport and break through to their personal experiences or merely to move past conversation about basic screening procedures, were identical. Essentially, their responses were cultural scripts or "the doctor's response". When inquiring about the gap in care associated with PPD, I found the knowledge amongst the doctors to be quite similar across covered specialties within the healthcare system. The only outlier was the midwife speciality, given their emphasis on establishing relationships to a greater degree and focus on holistic health. The repetitive response was that there are currently state laws, moreso in New Jersey, that "*mandate postpartum depression screening during the pregnancy as well as after the delivery*" coupled with "*self-reporting-- so we can act on them accordingly*". However, all providers made it clear that this is just the start which identifies patients who are in need of help, but that does not mean that patients can get the help or that they will have the support system to go through with it. This is often due to the lack of follow-up with a psychologist or psychiatrist for a multitude of reasons: insurance coverage, availability, time, inability to focus/care for oneself, and much more. The simple solution proposed to solve this after prodding was often to make the next step more streamlined such as having a direct number where someone can put patients in touch with a therapist rather than hand them a list of participating providers crafted by insurance companies. Other possible solutions were walkin clinics where anyone who has these PPD issues can walk in; "*it's like a psychiatric emergency room, so to speak"*. They indicated these responses in a direct and straightforward manner.

Another note was that many providers chalked it up to a systemic issue rather than explaining how they can make their own care streamlined and direct patients. I felt as if there was a simplification in their answers when considering the issue. However, based on the literature studied in the medical anthropological community, I believe it truly is much more complex. For example, it is important to consider the subjective experience of the time we are in now where our fractured healthcare system is embedded with structural violence. Women and other minority groups are consistently marginalized. In this atmosphere, the treatment that mothers may seek are undermined right now and under inspection with the politicalization of abortion and perinatal states like PPD in a larger extension. The climate is discouraging for women to seek any kind of health, let alone an issue in relation to mental state arising from having children. In the case study of the successful psychiatric walk-in clinic in New Jersey described by a physician, Universal Behavioral Healthcare, it is in a nicer area near a well-known college town of Rutgers University in New Brunswick. Everywhere cannot have the same feasibility of such a clinic due to structural barriers.

Medicalization of PPD via Intersubjectivity

This cultural script of sticking to streamlined, doctor-like responses contributed to the medicalization of PPD. Rather than focusing on the subjective, emotional postpartum states and the subjective structural barriers that potentially harm patients, there was more of an emphasis of overall discussion on screening, medication, and extreme postpartum experiences. This established a need to go beyond the biomedical model of PPD, a reducing nature where PPD is reduced to certain symptoms as a sub-diagnosis under depression in the medical community. Yet, we need to consider the individual subjectivity and social subjectivity of the socially idealized motherhood with what is actually subjectively produced which goes beyond hormonal and biological aspects of this illness. The motherhood experiences of frustrations and guilt cannot be just chalked up to “crying spells”; the spectrum and external factors vary tremendously. This was portrayed with interviewees sharing external factors shaping their postpartum experiences such as the passing of one mother, the presence of another mother-in-law, abusive spouses, career development, the duality of scientific belief and religious faith, and much more. It is extremely difficult to standardize experiences of motherhood to simplify solutions for the treatment of PPD as just a mere "streamlining" process when there are factors like cultural stigmatization and personal intense emotions that may be brought on by a multitude of factors.

In terms of themes of similarities, their personal stories, although limited, were quite common in the way their identity as physicians still shone through in their responses. One participant explained how "*as a physician, I have a much stronger personality that I could get through all of this*" and another interviewee expressed how they "*could make a phone call, and be seen the same day…if I needed to, I knew the help was right there".* Though all interviewees expressed awareness that their situation in terms of access to help and resources is different and not everyone outside the healthcare system has this luxury, I believe that their identity as a physician contributed to their tendency to medicalize PPD and mental health. For instance, this medicalization was shown through an interviewee's response when asked about PPD and their experiences, describing it as *"They don't feel like doing anything. They can't sleep, they can't eat, they have crying spells. I didn't have any of those symptoms".* The usage of "*they*" and then "*I*" reinforced the interviewees' identity as a provider and how they separately view patients.

The concept of intersubjectivity as previously introduced with a Janus-faced nature (two faces) of subjectivity shone through when the interviews differentiated and established a divide between what was "*self*" or the physician's identity and the "*other*" or patients they encountered. This sense of "othering" perpetuates the separation of providers and patients, leaving the emotional state of PPD often medicalized which isolates the patient. Even though a majority of interviewees have been in the shoes of patients, having gone through the birth process at least once, there was a generalization and almost dehumanizing, robotic language when discussing PPD and patients with such a diagnosis. Moreover, the discourse when discussing PPD was heavily symptom-based and othering to patients, despite trying to interview the providers' postpartum experiences as well. Science and medical information were the default even when discussing their personal postpartum experiences. This led me to believe that the cultural script or doctor response is what many interviewees were comfortable with and the way they, themselves, coped as mothers/parents/caretakers and witnessing their patients (or mothers of patients) going through this regularly possibly due to the tight-lipped nature of their mental health rooting from their cultural background. Based on this analysis, it is clear to the subjectivity of providers in comparison to mothers outside the system due to medical training and lingo is an important factor. At the same time, this consideration of subjectivity is limited because of the difficulty of breaking the barrier to understanding this experience of self and motherhood.

Chapter 5: Conclusion--Breaking the Barrier and Beyond

Potential Solutions (Systemic vs Individual)

One of the main aims of this study was to understand how to ultimately better treat and mend the gap in care of PPD. From the interview process, there was much uncovered about the systemic problems at play as well as some potential solutions. Potential avenues for progress in terms of PPD care is highlighted below:

1. There was a trend where providers who were personally impacted in some shape or form in terms of PPD and mental health experiences in general had a greater impact or went above and beyond to offer a greater quality of care. Thus, it starts at the individual provider. One of the participants brought up how, yes, there was not any training on PPD or mental health when it blew up during the pandemic, but she taught herself. It takes a few more minutes to establish rapport beyond the basic provider-patient relationship for connection and trust. It is really self-driven to provide such care at an emotional level. Yes, there are barriers that we constantly face like legislation that only looks good on

paper, lack of federal funding, the inability to cater to every single subjective patient culture and population (language, transportation, telehealth barriers. Yes, there are barriers in our healthcare system with physician burnout and costly, high insurance care. All of these are puzzle pieces with no movement to fit into a puzzle. But, if each individual provider does their part in this puzzle to above and beyond, then maybe we can mend the gap. Individual people can target individual subjectivities of "self". The bottom line: it's not all systemic and what physicians do at the individual level matters. Thus, the trend of shared subjective experiences is also how providers can connect. Long-term wise, the role and what it means to be a provider will change drastically. There is now a visual training element, participant observation/anthropological if you will, to be able to read and assess a patient in not just their spoken patient history but what goes unsaid.

2. On the other hand it is important to acknowledge why providers should be responsible. They already take on so much. And, if they do have shared subjective experiences of PPD and mental health, then why should we ask them to be more resilient than everyone else? There can be other alternatives to make such changes at an individual level.
    a. **Community Care:** Integrate members of the patient population and community in the postpartum care of mothers. Ultimately, the cultural viewpoint of childbirth and having these embedded sources of support will go a long way. Cross-referencing their preferences when making things like screening forms (language) or treatment options (medication) more adaptable to what the community is comfortable with. This may involve the restructuring of primary care as previously mentioned given their community care focus.

b. However, maybe the **role lies outside physicians** completely. Maybe there has to be an integration of a new position that can take time to conduct such follow-ups, and be there emotionally for the patient rather than passing the mothers back and forth between specialties.

c. Maybe there has to be a **defined role for each physician** of each speciality rather than the ambiguity that exists right now. For example, policy changes could be made to ensure that all specialties, including PEDS, are required to do screening. And, we still have to Figure out where primary care actually fits into all of this.We could also make clear the distinction between psychiatrists and therapists to understand how to help. Or, make clear the distinction of midwives and OBGYN. But, also integrate the professions. We can learn from each other. The combination of both biomedicine model and holistic health with home visit follow ups can be just as powerful. Maternal care requires a **collaborative approach** which shows how we are able to track care across specialties for this project. But, boundaries of responsibilities need to be redrawn and assessed to improve access and women's choices including PPD.

d. There has to also be a recognition of western cultural differences like **social support**. We need more embedded support groups that take more than ten people or waitlists, more community care, and more positive social forms to serve as coping methods that ensure the safety of women in these times where there is structural violence against women's health rooted in the system right now.

e. A need to **increase the education** on the matter to combat the stigma, while being mindful of the cultural differences. Following the community care model, it

> works better when members of their own community that share similar subjective experiences can explain what PPD is and how to treat the condition (however they choose to put it). Education increased public awareness which increases support and advocacy/willingness to partake in elections for such changes which increases the amount of lobbying to our legislators which can enact legislative change which can start implementing real change in theory (my Women's Health Policy takeaway, and it all starts with the low-hanging fruit and appealing to people on the human level). We all have women in our lives, mothers, daughters, wives, and friends. A humane appeal is all it takes sometimes.

Study Limitations

Aside from this theoretical framework of subjectivity contradicting the simplification from the several interviews so far, points of difference were limited due to nearly identical (little to no PPD) training in the healthcare system in the specialties of interviews. Points of difference only arose when it was established that the provider had personal, subjective experiences on the matter (or some interaction with PPD/mental health) which served as a catalyst to have a greater stake on the care of this disease shown through various personal subjective stories shared contributing to changes at the individual, provider level.

I am aware that the findings I asserted above are still generalizations that cannot fully answer my question on how to ultimately better treat, prevent, or predict PPD. This is a limitation given the small sample percentage of the percentage of medical practitioners that were also concentrated in New Jersey. Originally, I sought to investigate the treatment or training of mental disorders as well via interviews with providers in equal parts of New Jersey and Georgia, a state notorious for maternal morbidity rates and minimal attention to maternal health let alone maternal mental health like PPD to get a more comprehensive answer, but due to timing and the Institutional Review Board approval, it was not feasible. Thus, a future direction can be to look into interviews from other areas of the United States with different PPD and maternal mental health policies coupled with federal funding factors. It is also worth considering interviewing solely mothers of different cultural groups, mothers who are not providers to see their coping methods and cultural scripts on the matter at hand.

Concluding Remarks

The themes emerging with medicalized cultural scripts I received from the interviewees are excellent examples of the differences in subjectivity that truly exist and the importance of considering postpartum experiences. The healthcare policy and medical curriculum can only take us so far. While the policy is good on paper and we are able to screen for PPD on paper, it is time, based on all these provider narratives, to go beyond the paper and acknowledge the spectrum of mental health, maternal mental health, including PPD. There is no one straight form to diagnose and one straight method to treat PPD. Ultimately, to tend to this gap in care of PPD, which I initially chose to see how we could better predict or treat the condition, comes down to the awareness of subjectivity. The classifications of PPD may have more than one correct diagnosis code once we are able to better classify people's subjective experiences. For example, there may be a hormonal experience specific to women for PPD in comparison to a different PPD that can affect any caregiver including fathers as we saw through this study. This is a future avenue for exploring ways to diagnose and treat PPD in different contexts based on different subjectivities. Evidently, the influence of identity inside and outside healthcare sheds light on the spectrum of external, subjective factors that largely determines the subjectively produced experience of motherhood. Generalizations on the oversimplification of PPD treatment cannot yet be made, and the coping methods are much more intricately experienced than previously considered. I still sit in front of the barrier unable to do anything while staring at my mom as the world continues to move around this food court table, but I think I understand a little more, if only a little, her affective state during that time.

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Appendix A: Interviews

Interview Process

I started the interview by asking basic questions about their training and specialty. In several instances, this gave me information about why they chose the specialty they did, furthering my insight on their personal motivations. I then opened the discussion to general experiences and encounters on PPD. This also gave context to how their specific field and training pertained to the condition of PPD.

After establishing the general scene of the provider's experience on PPD, I transitioned the interview to questioning regarding the current PPD procedures and policies in place in order to gauge opinions on effectiveness. Hearing about these various outlooks give insight on the intricacies that compose the puzzle that is our healthcare system. It allowed me to get a range of professional viewpoints on current care and recommendations on ways to better the gaps in care affecting mothers.

We then shifted to discussing the various psychosocial factors at play when studying treatment approaches of PPD and maternal mental health that are critical to consider. This also allowed for an avenue for providers to offer their own cultural experiences in regard to healthcare were not often the streamline model of Western healthcare given the demographics interviewed which offered a glimpse into their lives outside the system.

This sharing of cross-cultural accounts allowed for a transition into their personal life in terms of PPD or simply broader mental health experiences pertaining to them or family/friends around then. It allowed for an integration of their subjective experiences as mothers, parents, or just human beings in general coupled with their objective experiences as providers taught to be neutral when providing such services of care. Hearing these personal anecdotes provided for an avenue for shared vulnerability and a way to connect with the participants in the study. The range of responses on their lives outside the system as providers were also informative on the impressions on their attitudes toward PPD inside the system as well.

This is not to say that I was always able to steer the conversations smoothly in a direction that I wanted. This process described above came from the repetitive nature of practicing these semi-structured interviews in dealing with the cultural script of “the doctor response” as described below. I had to combat this notion of “being spoken at” like a patient and rather “be spoken with” in a mutual conversation. I may not have always been able to break through the barrier to establish a vulnerable connection with my participants due to the cultural script or simply just time constraints in trying to be respectful of the providers' time. The expectations providers had been more for a quick quantitative interview in yes/no survey style rather than a semi-structured conversational anthropological style interview. Many were not even aware of anthropology as a discipline, let alone the anthropological process, which also often required me to start the process

Interview Questions

Honors Thesis Interview Script

Note: These interview questions are meant to guide the interview. Not all of them may be covered and not all of them may be relevant for every individual interviewed. The main purpose in writing a list of questions is to guide the conversation into a natural flow.

1. Do I have your consent to record this interview? You can choose to redact anything you say at any time and I will keep your name anonymous.

A.PROVIDER SCRIPT:

1. Just for me to get some background, what is your training and what is your speciality in the field of medicine?
2. Can you give me a sense of what experiences you have encountered to anything surrounding maternal mental health/ PPD you might have witnessed or helped provide services for during your time in the field?
3. Do you agree with the official diagnosis/label of PPD taught to you in the field of medicine? Or do you think this is a difficult thing to diagnose?
4. What are the current treatment or support options in place in the system for PPD? If the current method isn't the right form of support, what do you think could be a better way to help mothers?
5. How would you want the topic of PPD and maternal mental health to be better addressed in the general field of healthcare and your specialty specifically as well?
6. Do you know of any other stories or experiences that you have heard about from other colleagues that may have encountered maternal mental health?
7. Speciality specific gap in care questions:
    i. OBGYN:
        1. What are the followup procedures in place after a mom gives birth?
        2. How often do you see a mom after she gives birth? Do all mothers follow-up once the 6 month course of pregnancy is carried out?

3. What are your own follow-up procedures you tell your patients?
4. Do you think the system we have is good at assisting mothers when they are in a vulnerable state after going through a life event? If so, how do you think we can improve
5. What are some of the situations where cultural conflict arises during your experiences? Would you care to elaborate on your experience as a parent?

ii. Pediatrics:
   1. Are the children you see always accompanied by their parents? How much of the time is it mothers?
   2. When encountering mothers, do you also check in how they are doing? Are you supposed too as per the guidelines of your training?
   3. Have you ever sensed something off with mothers when they bring their children for check-in? What would you do in that instance?

iii. Family medicine:
   1. How often do you see women or treat them? Of those who are mothers? Are these visits child centric or more centered around mothers?
   2. The American Academy of Family Physicians (AAFP) advocates that ALL Family Medicine residents receive basic maternal/child care training. What did that look like for you? How do you think we can improve this training/ what are the challenges you face when considering maternal health?
   3. What are some of the situations where cultural conflict arises during your experiences? Would you care to elaborate on specific examples of your own personal experience with maternal mental health?

iv. Psychiatry:
   1. How often have you encountered mothers as your patients?
   2. How many are officially diagnosed with PPD? Do you think many mothers go undiagnosed with PPD?
   3. What are some of the treatment options or things you recommend to assist in their maternal mental health?
   4. What do you think about these treatment options across different cultures?
   5. What are some of the situations where cultural conflict arises during your experiences? Would you care to elaborate on specific examples?

8. If applicable: Are you a mom yourself or do you have experience with witnessing motherhood in your own personal life?
    a. Can you tell me about some sources of (social) support in your life?
    b. What makes [forms of social support/support methods] helpful for you?
    c. Do you have any friends or relatives who are going through a similar struggle? How does your culture or background shape how you view this label of PPD in our healthcare system today?
    d. How do the teachings in your professional life differ with the way you view motherhood/ maternal health/ PPD (or crises like PPD) in your own personal life?

B.MOTHERS SCRIPT:

1. Just for me to get some background, how long have you been a mother? How many kids do you have?
2. If you do not mind me asking, do you share a responsibility in raising your children?
3. What have been some of your thoughts and experiences so far with motherhood? You can share as little or as much as you like?
4. What are some of your fondest memories as a mother so far?
5. What are some of the struggles you may face in terms of your own experience as a mother?
6. Can you recall your feelings after a month? What was the transition period like?
    a. What physical symptoms did you feel? (Ex: sleep deprivation)
7. Can you tell me about some sources of (social) support in your life?
8. What makes [forms of social support/support methods] helpful for you?
9. Do you have any friends or relatives who are going through a similar struggle? How does your culture or background shape how you view motherhood and the rollercoaster of emotions it comes along with?
10. What do you know about PPD? Is anyone diagnosed officially in the system with it?
11. If you don't mind sharing, have you been diagnosed with PPD or do you think you may have a similar experience or experience like its description?
12. Do you think it is something everyone goes through and is normal? What are some of the ways you cope and balance being a mother?
13. How do you experience the healthcare system when you gave birth/get checked up with the way you view motherhood/ maternal health/ PPD (or crises like PPD) in your own personal life?

List of Acronyms

PP: postpartum

PP-OCD: postpartum obsessive compulsive disorder

PPD: postpartum depression

CBS: culture-bound syndrome

OBGYN: obstetrics and gynecology

PEDS: pediatrics

PC: primary care

WV: midwives

WF: midwife

PSYCH: psychiatry