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The Emerging Medicalization of Postpartum Depression: Tightening the Boundaries of Motherhood

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THE EMERGING MEDICALIZATION OF POSTPARTUM DEPRESSION:
TIGHTENING THE BOUNDARIES OF MOTHERHOOD

by

PAM REGUS

Under the Direction of Wendy Simonds

ABSTRACT

In this study, I conduct a multiple method content analysis of literature on postpartum depression (PPD) from two on-line sources, Medline and LexisNexis. The purpose of the study is to determine how the medical profession defines and frames PPD, and to consider the implications of its movement into the medical model. I use the theories of Foucault, Gramsci, critical constructionism, and postmodern feminism to examine the effect of the medicalization of PPD on women's lives. Using both simple descriptive statistics and qualitative analysis, I show the expansion of medical control over women's bodies in the childbearing years beyond the physical to include the emotional and psychological aspects as well, which results in standardized maternal behaviors and emotions that tighten the boundaries of motherhood.

INDEX WORDS: postpartum depression, motherhood, medicalization, expansion of medical control, maternal behavior, childbearing years

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PAM REGUS

A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of
Master of Arts
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CHAPTER 1

INTRODUCTION

In June, 2001, Andrea Yates committed the unthinkable when she purposefully and methodically drowned her five children in a bathtub (Hamill 2001). The shocking news of this tragedy inundated television broadcasts, newspapers, magazines, tabloids, and radio. Perhaps the most shocking aspect of the tragedy is that Yates transgressed every traditional notion about motherhood. She was charged with murder and faced a life sentence or possibly the death penalty. Her defense attorneys claimed Yates suffered from temporary insanity due to postpartum depression (PPD), a condition which is the disease du jour associated with pregnancy and childbirth. Although extreme, this case has become the hallmark for the potentially dangerous malady, prompting families and medical professionals to be alert to symptoms after the birth of a new baby. Public awareness of PPD was heightened in 2005 when Tom Cruise, an actor and a member of the church of Scientology, publicly denied the benefits of medicating women with PPD and discredited the field of psychiatry in general. He criticized actress/author Brooke Shields for her use of antidepressants during her recovery from PPD, provoking an exchange of opinions about the postpartum condition.

But what exactly is postpartum depression? Is it a disease? Does it have biological roots – such as the dramatic change in hormones that occurs after giving birth – or social causes – such as lack of support in the motherhood role? Is it a real condition or is it a myth? Information in both medical and popular sources portrays similar

characterization of the symptoms and treatments of the condition; however, a clear understanding of the causes of PPD is lacking. Without knowing the causes of PPD, medical professionals devise treatments aimed at alleviating symptoms. Such treatments typically include antidepressants or psychiatric counseling, or a combination of both (Puckering 2005; National Institute of Mental Health 2002; The National Women's Health Information Center 2002).

This study examines how the medical profession defines and frames PPD through a content analysis of articles contained in Medline, an on-line source for medical knowledge contained in the database of the U.S. National Library of Medicine (NLM), and with articles contained in the general news portion of LexisNexis. The articles on Medline are generally written by medical professionals – doctors, nurses, psychiatrists, medical researchers, PhD's, and others, and Medline is a particularly important source for analysis because of the authority which scientists and doctors wield. Analysis of the articles on LexisNexis allows for a comparison between “scientific” and “lay” press representations of PPD. Medline contains over 700 articles on PPD extending from 1950 to the present, and LexisNexis contains over 1700 articles for the same time period. To keep the study manageable, I examine a sample of articles chosen in five-year increments, beginning with 2005, then working back to 2000, 1995, 1990, and so on, back to 1950. Examining the articles in five-year increments reveals changing definitions and frames over time, illustrating the increasing medicalization of PPD.

This study is important for several reasons. First, medicalization, a process which “organizes a broad and ever growing range of behaviors and aspects of everyday life into categories of health and illness” (Haritty & Tiefer 2003: 43) can be a means of social

control, promoted by medical experts and/or pharmaceutical companies with the ulterior motive to benefit professionally or economically from including PPD in the field of medicine (Haritty & Tiefer 2003; Conrad 1992). Second, the medicalization of women's issues, visible in such life events as childbirth, PMS, menopause, and increasingly postpartum depression, among others, tends to pathologize women and "reframes women's experiences of their own lives and bodies" (Haritty & Tiefer 2003: 44). For example, Murphy-Lawless (1998), in *Reading Birth and Death: A History of Obstetric Thinking*, chronicles the medicalization of childbirth, illustrating the power that scientific knowledge has in shaping women's experiential knowledge of the birth process. Presenting women's bodies as faulty, medical experts promoted their science as a means of lowering the risk of death for mother and baby (though it did not), which gave greater control to obstetric practices and greater authority to male-midwives and, later, obstetricians. These practices "produced a complete scheme of labor management in 1920" (Murphy-Lawless 1998:172) which is still practiced today, including that the hospital remains the preferred place of birth, that obstetricians use forceps when necessary or convenient, and that the typical birth position is horizontal and immobile. In addition, episiotomies are routinely performed, drugs are available to ease the pain of labor, and the c-section rate is at an all-time high – 29.1percent of all births (Rubin 2005).

Third, just as the medical profession uses fear to gain women's compliance with obstetrics, analysis of the articles reveals that fear – of harm to the child, to the mother, to the family– is used to gain acceptance of PPD as a medical issue. And finally, the articles reveal the extent to which other family members are considered vulnerable to PPD, expanding the scope of postpartum depression beyond the mother.

THEORETICAL BACKGROUND

The theories of Foucault and Gramsci are applicable to the medicalization of PPD, as are critical constructionism and postmodern feminism. Foucault asserts that truth is constructed through discourse in the activities of everyday life, and that nothing has meaning outside of discourse. Individuals create and subscribe to regimes of truth, discursive formations that carry an assumption of authority with the power to deem knowledge as true or false, and they discipline and manage their bodies in order to perform according to these beliefs (Foucault 1979).

The transformation to docility is achieved through disciplinary technologies that create the knowing, the knowable, and the self-knowing individual. First, hierarchical observation categorizes, distributes, and creates a definition of what is normal or not normal, and the transformation of individuals to knowing individuals requires awareness of definitions of what is normal or not normal. Second, normalizing judgment allows understanding of self through biology, economics, and linguistics, with objectification of the body-as-thing complemented by the dividing practices instituted in spatial, temporal and social compartmentalizations. Normalization is evident in national standards for educational programs, medical practices, and industrial processes and products. And third, examination occurs as the individual turns self into subject, undergoing a process of self-understanding mediated by an external authority figure such as doctor, psychoanalyst, or priest (Foucault 1975). In contemporary societies, discourse becomes

an effective means of social control, instrumental in managing conformity through its normative operations. The process of separating the normal from the abnormal for the purpose of treating the abnormal serves as an enforcement of conformity for the normal rather than as punishment for the abnormal (Rabinow 1984).

Similar to Foucault's notion of conformity through docility, Gramsci's notion of hegemony indicates the willing acceptance of one social group's dominance and control by another through ideologies which become "common sense" in everyday practice. Gramsci maintains that power lies in the ability to gain willing participation through a combination of coercion and leading. Political society, or the state, projects ideological beliefs that make individuals feel connected and think that they have something to gain in preserving order. Civil society enforces the belief that individuals have something at stake and invokes conformity through the institutions of the family, the church, the media, education, and others. Self-identity is formed through association with these civil institutions which serve to control individual desires and impulses. Coalitions, rather than class consciousness, reflect how individuals make sense of their own lives based on shared beliefs, values, and commitments. Similar to Foucault's "expert eyes," Gramsci's concept of hegemony is political power that flows from intellectual and moral leadership to build consensus, which is a move away from physical control over the body to conformity through the individual's willing participation. "Articulation" is the political process by which individuals redefine their identities, which are not static but fluid and constantly changing. Individuals often choose to participate because "experts" deem certain actions to be in the individual's best interest. Additionally, the knowledge of

experts informs social policy which becomes the predominant course of action (Seidman 2004).

A third theoretical position that is applicable to the PPD issue is critical constructionism, a synthesis of conflict theory and social constructionism that focuses on how the meanings of social problems are constructed. Critical constructionism maintains that elite interests determine which phenomena are problematic; provide explanations for the causes of the phenomena; and persuade the public that the phenomena are problematic and, therefore, require action (Heiner 2002:9). Influenced by corporate sponsorship and driven by profits, the media serve as vehicles for influencing public opinion. By reporting on social problems caused by the less powerful but deflecting reports which implicate wrongdoing by their corporate sponsors, the media participate in shaping public response to social problems. Critical constructionism recognizes an imbalance of power between the elite and those with the least amount of power in society. From this theoretical perspective, those in power exert their influence to maintain the status quo, allowing their continued dominance.

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

Postmodern feminists often use texts (in varied forms), the products of dominant culture and signs of postmodernity, in conjunction with the view

of the oppressed, as the starting point of cultural interrogation...not in order to reconstruct another view of the social world (an exercise in power and colonization) but rather to unravel the social processes and relations that have constructed the social world in hierarchical ways. (Hesse-Biber and Yaiser 2004:19)

METHODOLOGY

For this study I conduct a multiple method content analysis of literature on PPD from two on-line sources, Medline and LexisNexis. The purpose of the study is to determine how PPD is framed by the medical community and how it is represented in medical literature compared to general news. I use simple descriptive statistics to illustrate its movement to the medical model, including the most common causes, effects, and recommended treatments. For the qualitative analysis, I examine the discursive elements shaping PPD as a disease by noting the authors' descriptions of PPD, of motherhood, and of the role of medical professionals. The importance that language plays in social life is the basis of the qualitative analysis, and the articles serve as narratives from which one can understand how the medical profession frames the issue of PPD. My intent is to examine the scope of discourse on PPD, noting the most common themes as well as those that are infrequent but informative indicators of PPD in medical and non-medical contexts, revealing ranges and patterns of defining PPD.

For example, in my notes several of the authors mention the need to screen mothers for depression beyond the traditional 6-week postnatal checkup because of the possibility that depression can occur later, and others suggest that depression may begin in pregnancy and suggest that screening begin before delivery. Combining the information on the prescribed periods of screening exposes the range and pattern

recommended by the authors and brings the realization that the postpartum period is being redefined as a longer timeline, extending to three months, six months, one year, two years, five years beyond delivery, as well as extending back into pregnancy. This finding adds depth to our understanding of medical control over the procreative process and its effect on women's lives, a finding that would have been missed with the quantitative study alone.

Data Collection

There are over 700 articles on PPD on Medline to date and, as previously noted, to keep the analysis manageable I select a sample from the articles in five year increments, starting with 2005 and proceeding back to 2000, then 1995, 1990, 1985, 1980, and 1950. There are no articles between 1980 and 1950, and the bulk of the Medline articles were printed in 1995, 2000 and 2005. After eliminating articles that were only available in a language other than English, as well as one article that had been withdrawn from publication, I chose to keep all of the articles from 1950 (1), 1980 (2), 1985 (2), and 1990 (14) in my sample. Medline has a total of 22 articles on PPD published in 1995, and 27 in 2000, of which I eliminate every third article so that a total of 14 articles represent the year 1995 and 18 articles represent the year 2000. In 2005, a total of 87 articles were published in Medline, and I select every fourth article for inclusion for a total of 18 articles from 2005. Thus, the total number of Medline articles on PPD in my sample is 69, and the number representing each year of my study is fairly even.

In addition to the Medline articles, there are 127 articles on PPD (as of November 2006) in the general news section of major newspapers in the LexisNexis database for the same years as the Medline articles. The bulk of the LexisNexis articles were printed in 2005, most centering around the disagreement between Brooke Shields and Tom Cruise over the legitimacy of PPD. Again, I keep all of the articles from 1980 (2), and 1990 (1) (there were no articles printed in 1985), but select a stratified random sample from the 12 articles printed in 1995, the 31 articles printed in 2000, and the 81 articles printed in 2005. For 1995, I eliminate every third article; for 2000 and 2005 I include the first articles and every fourth article thereafter. The total number of LexisNexis articles is 40, bringing the total number of articles in my sample from both databases to 109. Examining the articles in five year increments allows an analysis of changes in frequency and representations over time.

Coding

To facilitate coding for the quantitative portion of this study, I devised a code sheet (Appendix A) with nine sections. Section 1 includes identification of the article by number, database, and year published. Section 2 includes information on the author, including name, gender, and credentials (MD, PhD, PsyD, RN, LPN, LCSW, LPC, and others). It also includes sponsorship of the article, such as pharmaceutical company, medical practice, or professional organization, if available.

Section 3 references the etiological definitions of PPD, including its causes: biology (hormones, sleep deprivation, diet, and others), psychology (prior depression, coping skills, perfectionism, low self-esteem, childhood experience), and social (family

support, marital relationship, friends). Section 4 examines whether the article implicitly or explicitly infers that some groups are more vulnerable or at risk for experiencing PPD because of biographical characteristics (age, marital status, class, race, or ethnicity).

Section 5 codes for symptoms of PPD, including physical (insomnia, no energy/fatigue, appetite changes, headaches, chest pains, heart palpitations, hyperventilating); emotional (anxiety, excessive worry, confusion, sadness, feeling overwhelmed, feeling inadequate as a parent, incoherence, feeling of hopelessness, thoughts of suicide, hallucinations); or behavioral (crying, oversensitivity, irritability, panic attacks, hostility, paranoia). Section 6 examines the intensity (baby blues, PPD, or postpartum psychosis) and prevalence (in terms of percent of new mothers who have baby blues, PPD, or postpartum psychosis), and whether the article suggests that others can have PPD (fathers, other family members, friends). Vulnerability of fathers and other family members would implicate social rather than biological causes.

Section 7 codes for suggested treatments for PPD, including medication, counseling, social support, or a combination of the above. Section 8 codes whether the article uses fear to promote PPD as a disease by mentioning consequences of PPD (harm to child, harm to mother, harm to spouse, harm to family, harm to society), and whether it mentions extreme cases of PPD such as Yates. And Section 9 codes for whether the article advocates proactive intervention of medical professionals through screening (of new mothers, new fathers), educating (mothers, fathers, health care professionals), or supporting (new mothers, new fathers, or health care professionals). The final section allows for comments or quotes that inform the qualitative analysis of the articles.

Test-Retest of Reliability

For this analysis I draw upon coding categories that were reasonably clear cut and I strove to make the coding categories as concrete as possible to increase coding reliability; thus no additional coders were necessary. Some time after I completed coding, I selected one out of every 20 articles to check the test-retest reliability of the coding process, recoding a total of five articles. By making the coding categories as concrete as possible, I minimized (but not eliminated) the threat to reliability; the answers on the recoded articles were very consistent at an average of 98 percent.

Limitations of the Study

Perhaps because of commercial reasons, LexisNexis adds articles to its database, not because new articles are written as time goes by but rather articles from the same historical time period are added at later dates. Methodological implications include that the study would be difficult to replicate, as a researcher who today searches in LexisNexis for articles on postpartum depression in the general news section of major newspapers would find vastly larger sets of text than those included in my sample. Also, the few articles written before 1990, although extremely helpful in revealing the increasing focus on PPD, provide few cases from which to compare percentages (e.g., of authors who recommend social support as treatment) to later articles. For instance, 50 percent of articles in my sample from 1980 include two out of four, whereas 50 percent of articles in 2005 include 19 out of 38. Therefore, although the percentages are the same, many more authors are in agreement in their representations of PPD in the later

years. Despite these limitations, I think these materials provide rich textual sources for understanding the medicalization of postpartum depression.

CHAPTER 2

LITERATURE REVIEW

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

Similarly, Goer (1999) echoes the view that obstetrics empowers the mostly male-dominated field of experts while it discounts women's knowledge, intuition, experience, and role in the birth process. Goer states:

The typical obstetrician is trained to view pregnant and laboring women as a series of potential problems, despite the fact that pregnancy and childbirth are

normal physiological processes that are no more likely to go seriously wrong than, say, digestion. (Goer 1999: 3)

Both Goer and Murphy-Lawless reject the obstetrical belief that women's bodies are weak and need the obstetrician's medical intervention to rescue the baby from the mother's body. They posit that although scientific claims to objectivity and expert knowledge and practices are illusions, individuals nevertheless surrender agency to the experts in charge of medical care because of the legitimacy accorded to science.

A body of literature suggests that the subjugation of women continues in motherhood, beginning during pregnancy when many social controls are placed on the pregnant woman. Through the discourse of endangerment, the period of pregnancy is structured as part of the extended timeline of childhood, removing the focus from the woman and placing it on the developing fetus (Rothman 1982; Brooks Gardner 1994). The perception of childhood beginning before birth expands the mental construct of when life begins, setting temporal boundaries (Zerubavel 1991) that have profound political implications such as a tension between rights of the "fetus-infant" and the reproductive rights of the woman (Isaacson 1996: 472). The rhetoric of endangerment places sole responsibility on the woman to gain expert knowledge and to act responsibly so that a healthy infant results from the pregnancy (Rothman 1982; Brooks Gardner 1994:72). Socialization, through both medical experts and popular sources, obligates the pregnant woman to regard the fetus's health as more important than her own and to center every action, thought, and ingestion on giving the fetus every possible chance for optimum development.

In the United States, a woman's behavior during pregnancy becomes subject to many measures of control that emphasize the indirect consequences of her actions, thoughts, and feelings on the malleable fetus, which requires the

pregnant woman to self-impose restraints for the future good of the child. (Brooks Gardner 1994:71)

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

Similarly, Shields (2002), in a study of stereotypical gender differences in emotionality, posits that women's emotional expressions are often connected with weakness, making women more vulnerable to the dominance of medical experts. Bilirakis (2004) adds a biological root to depression, suggesting that hormonal factors contribute to the increased rate of depression among women, which is approximately twice the rate of depression among men. Stoppard and McMullen (2003) and Mauthner (2002) implicate social reasons for the increased rate of depression among women, arguing that women's depression is caused by cultural proscriptions about the "good mother" which prevent women from expressing any negative feelings about mothering. Others support this ideological argument, suggesting that discourse surrounding motherhood bolsters cultural expectations that having a baby should be a happy time in a woman's life (Kaur 2004; Meltz 2003; Smith 2004). Depression results because the reality of motherhood often contrasts sharply with idealized constructions of motherhood (Mauthner 2002).

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

Greater publicity around sensationalized cases, such as that of Yates, increases public awareness and concern and results in increasing numbers of women identifying with the symptoms as suggested by the experts. The news of “normal mothers” killing their children contributes to the fear that untreated PPD can lead to postpartum psychosis (Kaur 2004) and have a tragic end. PPD prevention programs are then established to train health care workers to identify women with PPD and get them into treatment (Smith 2004). Hubert (2002) suggests the result is that more women willingly collude in their own gender-biased diagnoses.

Defining Postpartum Depression

PPD is not a new phenomenon: Hippocrates described emotional difficulties of the postpartum period thousands of years ago; in the mid-19th century, studies again highlighted psychotic episodes but did not label PPD a separate illness (Kruckman and Smith 2000). Nor is PPD a condition unique to western cultures (Dennis 2004), as research shows PPD is reported to exist in a wide array of countries – among them France, India, Turkey, Mexico, Cambodia, Brazil, Germany, Taiwan, China, Czechoslovakia, Canada, Turkey, Malta, Sweden, and Korea.

In the United States today, the medical community does not label PPD a distinct disease but views it as an affective disorder with characteristics similar to general depression occurring in the postpartum period, generally six weeks following delivery

(Kruckman and Smith 2000). Although the Diagnostic and Statistical Manual of Mental Disorders (DSM) II listed PPD as a separate illness during the 1960's, it eliminated the category in 1980, stating that there was not enough evidence to consider it a distinct disease (Kruckman and Smith 2000).

Weitz (2004) suggests that the DSM is problematic in that it often politicizes diseases. She claims that although the DSM provides standardized diagnostic criteria for mental illnesses, clinicians are often biased when applying them to female and/or minority patients. A panel of experts decides what is considered a disease, which often reflects historically-situated norms and values. For example, the DSM listed homosexuality as a disease in the DSM until 1973, reflecting cultural values of that period (Ford and Widiger 1989). A result of this method of disease classification is that more African Americans than whites are diagnosed as paranoid schizophrenics with violent tendencies, and more women than men are diagnosed as having depression and histrionic personality disorder (Weitz 2004).

The *Mayo Clinic Complete Book of Pregnancy and Baby's First Year* (Johnson 1994), available in the birth and pregnancy section of national bookstore chains, categorizes PPD as an illness of the brain, which is susceptible to illness just like other organs in the body (Johnson 1994:426). In addition to describing the sudden change in hormones that occurs postpartum, the Mayo Clinic book, edited by a physician, lists social factors which may contribute to PPD, including disappointment at not having the mythical "perfect birth;" a response to postpartum pain or discomfort; a letdown from an exciting event; concerns about dealing with the new baby; or surprise about the amount of work involved in caring for the baby (Johnson 1994).

Similarly, *The National Women's Health Information Center* (2002) describes PPD as "... a range of physical and emotional changes that many mothers can have after having a baby." It separates PPD into three distinct categories: the "baby blues," which occurs soon after childbirth and continues for one to two weeks; postpartum depression, which starts anywhere from soon after to even a few months after childbirth and continues for as long as one year; and postpartum psychosis, an extreme form of PPD which usually begins within three months after childbirth. According to current medical wisdom, the baby blues affect an estimated 50-80 percent of all new mothers, postpartum depression affects between 3-20 percent, and postpartum psychosis affects approximately .1 percent (or 1 per 1000 births) (Kruckman and Smith 2000).

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

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

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

PSI offers an anthropological approach to its analysis of PPD, stating that the postpartum period in the United States is informally structured as compared to non-Western, rural cultures in which extended families provide support during the postpartum period. PSI characterizes the postpartum period in the United States as emotionally draining, stressful and fatiguing; the baby blues and mid-levels of depression result from modern birthing practices, the lack of clear role definition, and the lack of social support for the new mother (Kruckman and Smith 2000). However, PPD is not unique to Western culture, but is found in many non-Western countries as well.

The New Well Pregnancy Book (Samuels and Samuels 1996), a self-help book, surmises that PPD results from feelings surrounding the birth process. Some mothers expressed missing having the baby inside, as what once seemed to be a part of them was not anymore; some found that with delivery the focus of attention shifted from them to their babies. Other mothers reported feeling they were at fault for not having performed better during childbirth, or felt that the hospital or staff cheated them out of the kind of delivery they were expecting (Samuels and Samuels 1996). Another self-help book, *Conception, Pregnancy and Birth* (Stoppard 2000) surmises that the sudden change in hormone levels, personal or relationship problems, severe exhaustion, and the lack of potassium, can lead to PPD. The book recommends such self-help strategies as rest, proper diet, gentle exercise, and talking over feelings with others – especially one’s partner – as remedies for PPD. In addition, psychiatric help, which includes

antidepressants and mild sleeping pills, assists in recovery, according to the author (Stoppard 2000). Medication is endorsed even when alternatives are given.

Symptoms and Treatment for PPD

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

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

2004). Estimates of the prevalence of PPD vary due to unstandardized reporting practices as well as to the vagueness in defining PPD.

PPD and Legislation

Legislation plays into the issue in several distinct ways. First, postpartum depression is used as an insanity defense for some cases in which mothers harm or kill their children. As mentioned in Chapter 1, Andrea Yates' attorneys successfully employed this defense, saving her from the death penalty and sending her to prison for life (Colb 2003). The jury had to decide between two possibilities in determining her fate: either Yates was a good mother who experienced temporary insanity, or Yates was an evil monster who murdered her children (Colb 2003). Colb asserts that the insanity defense could not spare her a life sentence because to accept her actions as a lapse from sanity would shatter a benevolent view of motherhood, allowing the possibility that other mothers could commit similar atrocities. Therefore, the jury convicted her out of the need to hold her accountable and to keep other mothers from similar actions (Colb 2003).

In the Yates case, it is rarely disclosed that multiple factors converged that resulted in the tragic deaths. Yates was treated for schizophrenia and depression after the birth of her first child, and re-diagnosed after the birth of her fourth child. She, her husband, and four small children lived in a cramped bus converted into a living space, but shortly before the birth of their fifth child moved into a more spacious home. In addition, she was influenced by religious fanaticism that led her to believe she was a bad mother and that her children would be spared an eternity in hell if she murdered them. And her

physician warned her husband and her after the birth of their fourth child that an additional pregnancy could result in renewed mental problems; yet the responsibility of caring for five young children after the birth of the fifth child fell solely on her. In retrospect, Yates' husband said the family knew of her illness but thought she was doing well. They never suspected that she would kill her children (Couric and Morales 2005).

Legislation also enters into the PPD issue with the proposal of at least two bills, not yet passed, to address PPD. The Melanie Blocker-Stokes Postpartum Depression Research and Care Act (H.R. 846), introduced in February 2003 and referred to the House subcommittee on Health later that same month, proposes mandated screening for PPD. Its author, self-professed women's health advocate Rep. Bobby L. Rush, D-IL, states: "It's time for us to recognize postpartum depression for what it is – a mental health condition that requires medical treatment, not jail time" (Harris 2005). Rush states that the overturn of Yates' murder conviction in 2005 leads to a better understanding of postpartum depression by the public as well as law enforcement officials, and that the bill would help erase the stigma associated with PPD by recognizing it as a true illness (Harris 2005). A second bill, House Bill 1427, introduced in the January 2005 Regular Session and reintroduced in the January 2006 Regular Session, seeks funding for an outreach campaign to educate people about PPD (Cook 2005). The sponsor of the bill, Rep. Mary Helen Roberts, D-WA, said the bill would legitimate the condition as a disease and remove the image of PPD that is the focus of jokes about "raging hormones" (Cook 2005).

Even though it's common and very treatable, many women don't know about postpartum depression and are afraid to seek help. The stigma of mental illness hits doubly hard for women who are struggling with sadness at a time when everyone expects them to be thrilled with their new baby. (Cook 2005)

Impact of PPD on Family

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

Some literature on PPD finds that fathers can also experience PPD resulting from additional stresses such as the mother's depression, having an unsupportive relationship, or being unemployed (Ballard and Davies 1996). Kleiman (2006) finds that 62 percent of fathers suffer from the baby blues some time during the first four months following birth, and 10 percent suffer from PPD. Paulson (2006), in his Early Childhood Longitudinal Study involving 5,089 two-parent families, also asserts that approximately 10 percent of

new fathers suffer from PPD, causing decreased interaction between father and infant with implications for future development of the child. The deterioration of intimacy due to lack of communication about the stresses of a new baby causes postpartum depression in fathers, and 25 percent of all couples end their marriages within five years of having a child (Parks 2005). Some symptoms of PPD in fathers include dramatic weight gain or loss, difficulty sleeping, sadness, loss of interest in normal activities or hobbies, and difficulty making decisions, due to the shift to parenthood (Smyth 2003). The finding that fathers can experience PPD may rule out biological factors, such as hormones, as the cause of PPD and place more emphasis on social or structural factors (Kleiman 2006). A brief look at sociological literature finds no resistance to the concept that fathers can also have PPD.

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

Feminism and PPD

Some feminist authors theorize that PPD is caused by such social factors as isolation, severe stress, lack of partner support, and changing roles due to parenthood. According to Taylor (1996), the dominant discourse surrounding PPD overlooks the social construction of gender order as it expresses an essentialist belief in biological

differences between women and men, resulting in conventional gendered power dynamics.

As a structure, gender divides work in the home and in the wider economy, legitimates existing hierarchies of authority, organizes sexual expression and emotions, and structures every aspect of our lives because of its embeddedness in the family, the work place, the state, as well as in sexuality, language, and culture. (Taylor 1996:14)

Taylor stresses the role that media play in furthering discourse blaming mothers for all of the ills of society and in echoing current political conservatism that calls for a return to traditional family values. “Mothers, traditionally revered in the public discourse, are now being portrayed as much more complex, even wicked, beings” (Taylor 1996:4). The changing roles of women result in questions surrounding “appropriate” behavior regarding such contemporary issues as working mothers, lesbian motherhood, single motherhood, abortion and birth control rights, and the choice of self-identity outside of motherhood. Taylor further asserts that the structure of families in modern society creates problems of isolation and alienation. Support groups that arise in varied contexts illustrate the impersonal quality of relationships, further complicated by the loss of close extended family ties.

Modern social life is regulated more and more by the highly specialized, technical, and impersonal knowledges of science, medicine, mental health, the law, and other expert systems. These systems transmit technical knowledge that influences how we experience almost every aspect of our lives – the illnesses we suffer, the foods we eat, the medicines we take, the emotions we express, our recreational habits, even how we experience sexual desire. In modern self-help groups, people find a special space where they can develop their own explanations of, and solutions to problems based, at least in part, on everyday experience. (Taylor 1996:19)

Taylor (1996) finds that PPD support groups represent collective action for redefining gender relations, a struggle to reflect disadvantages of gender through shared experiences common in everyday life. Whereas obstetrical practices focus on biological

aspects of motherhood and replace women's experiential knowledge with scientific knowledge, Taylor asserts that support groups empower women to resist traditional ideologies of motherhood by allowing them to share their experiences of motherhood, to build solidarity with other women, and to question traditional gender relationships within the family. Such collective action represents "the renegotiation of motherhood taking place through the discussion of postpartum illness" (Taylor 1996:11).

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

Taylor advocates forming support groups for PPD in order to force the medical establishment to recognize PPD as a separate disease (Taylor 1996:154), which would offer the advantages of lenient legal defense for mothers who injure themselves or their babies as a result of PPD, insurance coverage for treatment, education projects for the public on PPD, training for health professionals to recognize and treat PPD, and funding for research on treatment and prevention (Taylor 1996:156). Additionally, support groups would allow women's experiential knowledge of birth and motherhood to counter the ideological representations of motherhood that confine women to idealized versions that often differ dramatically from reality.

Complicity of Drug Companies

Drug companies are business enterprises, requiring constant expansion of their markets through innovation in product and marketing (Engler 2003; Diller 2005; Thomas

2004; Johnston 2004). Their profitability relies on tweaking existing medications to form “new drugs,” on expanding disease categories (for example, generalized depression to include childhood depression and postpartum depression), and on marketing their products to medical professionals and to the public (Angell 2004). The amount that drug companies spend on direct-to-consumer advertisement more than tripled between 1996 and 2001, amounting to about \$2.7 billion in 2001, and today reaching approximately \$4 billion annually (Rowe 2006; Vendantam and Kaufman 2005). Dr. Lisa Schwartz remarks on the results of drug advertising: “We’re increasingly turning normal people into patients. The ordinary experiences of life become a diagnosis, which makes healthy people feel like they’re sick” (Rowe 2006). Advertising drugs brings medical problems to the individual level, medicalizing problems that once fell outside of the medical domain and offering medication as a “quick but ultimately patient-centered fix” (Tone and Watkins 2007: 7). Individuals pressure doctors to prescribe the advertised drugs, to the extent that the typical American had 12 prescriptions a year by 2004, up from seven prescriptions a year in 1994 (Rowe 2006).

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

Drug companies control academic medical research through contracts with academic institutions, and they receive government sponsorship of research projects, resulting in research bias that removes the objectivity of scientific research and endangers the health of consumers (Angell 2004; Krinsky 2003). Additionally, drug companies benefit from monopoly rights that include patent protection and tax breaks for research and development expenses.

In his book, *Let Them Eat Prozac: The Unhealthy Relationship between the Pharmaceutical Industry and Depression* (2004), psychiatrist David Healy maintains that depression replaced nervousness, the psychiatric illness prevalent during the first eight decades of the twentieth century. Tranquilizers were the preferred treatment for “nerves” and were available over-the-counter or through prescriptions, making them widely available to large numbers of individuals regardless of their socioeconomic status. Although the use of tranquilizers began to wane in the 1970’s, it primed the population for accepting psychotropic drugs to treat emotional symptoms. Healy states that depression was rarely heard of prior to the development of Prozac; in order to market antidepressants the pharmaceutical companies had to also market depression as a treatable illness (Healy 2004). SSRIs replaced tranquilizers as the preferred treatment for the new disease, depression.

Diller (2005) questions the practices of American psychiatrists in what he calls a “drug culture,” the dramatic change toward medicating disorders such as depression and hyperactivity which began in the early 1990’s. He finds that 9 out of 10 children under the care of American psychiatrists are on one or more psychiatric drugs, whereas European physicians and psychiatrists rely more heavily on other treatments (Diller 2005: 28). Although his study focuses on children’s health, he finds that drug companies influence medical professionals by funding national physicians’ conferences, by offering free samples of high-priced medications, by wooing physicians with free dinners and consultant fees. In addition, drug companies hire expert witnesses to affirm the efficacy and safety of their drugs, and they withhold findings which indicate ineffective, negative, or harmful effects. Although drug companies are required to file negative reports with

the Food and Drug Administration (FDA), they are not required to publish or make public harmful outcomes. Diller maintains that the profit-driven drug companies are most loyal to protecting the interests of their stockholders, even to the point of endangering their customers.

Similarly, Thomas (2004) exposes fraudulent marketing practices which drug companies use to gain profits, including suppressing research that contains negative data about their products. In addition, she finds that drug companies promote drugs for off-label use – that is, they encourage physicians to prescribe drugs approved for a specific ailment for many other ailments. For example, she cites a study that found the makers of the drug Neurontin, approved for the treatment of epilepsy, paid doctors to prescribe it for manic depression, restless-leg syndrome, and other ailments. The drug company hired ghostwriters to create articles promoting off-label uses of Neurontin and then paid honorariums of \$1000 to doctors who lent their names as authors to the articles. The company was sued when a patient diagnosed with bipolar disorder attempted suicide while taking Neurontin. Thomas asserts that the influence of drug companies is enormous: the proportion of doctors to drug representatives is 2 to 1, and there is one drug company lobbyist for every member of Congress (Thomas 2004).

The general public believes that drugs are federally regulated and therefore safe for consumers once they are approved by the FDA. However, a committee report by the Institute of Medicine, an affiliate of the National Academy of Sciences which advises Congress on public health issues, finds that the FDA has limited funds and authority to regulate licensed drugs once they are approved for consumer use (Nesmith 2006). Such limitations weaken the FDA's ability to protect and advance the public's health, and fail

to hold drug companies accountable for the safety of their products. The report criticizes the use of fees paid by pharmaceutical companies to fund the FDA's drug-approval process – authorized by the 1992 Prescription Drug User Fee Act – as a conflict of interest for the FDA which tilts the regulatory balance away from monitoring the safety of drugs once they are approved. Further, the failure of the FDA to release negative reports about the safety of drugs raises concerns about “the extent to which the pharmaceutical industry has permeated the agency and how it may be influencing the agency's policies, practices and regulatory actions” (Koski 2004: 24).

CHAPTER 3

FINDINGS

Analysis of the articles from both databases reveals that the medical profession perceives postpartum depression as a national health priority (Logsdon et al. 2005), a significant public health problem whose incidence is second only to that of C-sections as a birth-related complication (Buchwald 1980; Horowitz et al. 1995; Kirkey 1995; Forman et al. 2000). The authors describe PPD as a well-known clinical phenomenon that has always existed (Roland 1950; Unterman, Posner, and Williams 1990; Forman et al. 2000), a highly prevalent disorder (Nonacs et al. 2005), the “thief that steals motherhood” (Goldbort 2005: 378) and takes the woman and her family by surprise (Beck and Gable 2000). It is one of the “darkest secrets of motherhood” (Kirkey 1995: C3), a “noteworthy health problem” (Gentile 2005: 945), a “living nightmare” of uncontrollable anxiety attacks, consuming guilt, obsessive thoughts and mood disturbance comparable to a major depressive episode (Beck 1995).

PPD is compared to other “dysfunctions” of women’s bodies such as menopause (Roland 1950), premenstrual syndrome (Stowe 1995), “pregnancy dysphoria” which includes postpartum blues and antepartum elements (Saks et al. 1985: 731), and “premenstrual dysphoria” or PMS (Pearlstein et al. 1990: 132). Some “experts” believe PPD may be on the rise, resulting in “tears and fears,” and despair that grows deeper as time goes on (Bouchez 1995:7). The postpartum period is considered a time-limited experience of enormous physiological and psychosocial adjustments and changes (Chen et al. 2000), one of the most critical phases of a woman’s life beginning one hour after delivery of the placenta (Gentile 2005).

The articles in the LexisNexis database that are written by medical professionals or health reporters are similar in content to the Medline articles; however, there are three non-medical types of articles on PPD in LexisNexis that differ from Medline. The first contains news articles that report on related events such as deaths attributable to PPD or proposed legislation. The second consists of arts columns with celebrity gossip (such as the verbal exchange between Brooke Shields and Tom Cruise), art history (such as prehistoric art depicts PPD) or reviews of books, movies or plays about PPD (such as Shield’s autobiographical account of PPD, *Down Came the Rain*, or the movie *Cotton Mary* whose main character suffers PPD). And the third has articles with metaphorical references to postpartum depression. For instance, the term “postpartum depression” is used as an analogy in which a long-term project is compared to childbirth in two of the articles. The feeling of euphoria that one author experienced at a project’s completion contradicts the presumed negative feeling that follows childbirth: “They say postpartum depression is supposed to be painful...this doesn’t feel like pain” (Siegel 1990: 69).

Similarly, Asimov (2005: F1) describes a feeling of despair which his subject felt at the completion of a project, growing and harvesting grapes for his winery: “As he stared at the cabernet sauvignon vines, which had just been harvested of grapes the day before, he said, a sense of sadness and loss came over him. ‘It was the weirdest feeling, like postpartum depression.’” These references connote an image of marking time, a letdown occurring upon completion when the focus is no longer on the impending “birth” of the project and a new focus has not yet come into view. The common use of the term in non-medical sources indicates a general acceptance and understanding of the conditions inherent to PPD among non-medical populations.

Non-medical discourse on postpartum depression brings more attention to the issue, creating both proponents and opponents of the claim that it is a mental illness. For example, a LexisNexis article reports on a radio station in New Jersey that was censured after a disc jockey made flip on-air remarks about the postpartum depression that had afflicted the wife of N.J. Acting Gov. Richard J. Codey. The author stated that the station “has a long history of plunging into polarizing political issues, and shows no signs of letting up” (Bruder 2005: 7).

The polarity of discourse is evident in many of the 2005 articles in the LexisNexis database which refer to the debate between Tom Cruise and Brooke Shields over whether PPD is a mental illness. Flagler (2005) cites the Cruise/Shields debate and suggests that PPD is a potentially life-threatening illness, not a weakness, that can impair a new mother’s ability to interact with her baby. She asserts that if depression is viewed as a weakness, then women will not seek the help they need in fear that their baby may be taken from them, and that comments such as Cruise’s “feed more fuel into the fire of

denial” (Flagler 2005: C5). Shields rebuts Cruise’s criticism of the use of antidepressants: “To suggest that I was wrong to take drugs to deal with my depression, and that instead I should have taken vitamins and exercised, shows an utter lack of understanding about postpartum depression and childbirth in general” (Bone 2005: G-8; Miller 2005: CO3). Shields says she was overwhelmed by “feelings of doom,” and she asserts that once PPD is recognized as a serious medical condition, then treatment will become more available and socially acceptable (Bone 2005: G8). Shields also counters Cruise’s attack on psychiatry, “It’s not the history of psychiatry, but it is my history, personal and real” (Miller 2005: CO3).

In a review of Shields’ book on her experience with PPD, Neville (2005: G6) reveals that Shields discloses “so many truly aberrant emotions,” such as feeling jealousy, fear and rage when her husband held the baby while Shields was still on the operating table in serious condition. The ideology of the good mother contrasts with reality as Shields states she was expected to bond immediately with the baby but instead felt such strong negative emotions; medication “pulled her back from the brink” when the feelings continued over time (Neville 2005: G-6). Brody (2005: 7) also cites Shields’ book, stating that PPD is extremely treatable, beyond a mother’s control, and that drugs are “generally safe” even though they are excreted in breast milk and the effects are not well-studied. Grove and Morgan (2005: 24) side with Shields (“the star”) against Cruise (“the bit player”), sarcastically referencing Cruise’s vitamin cure for PPD: “Maybe the whole PR offensive will be a vitamin boost to his career.” An editorial in the *Omaha World-Herald* also refutes Cruise’s rant against psychiatry, stating that PPD is a “very real concern for some women” and that “sophisticated drug research” has improved the lives

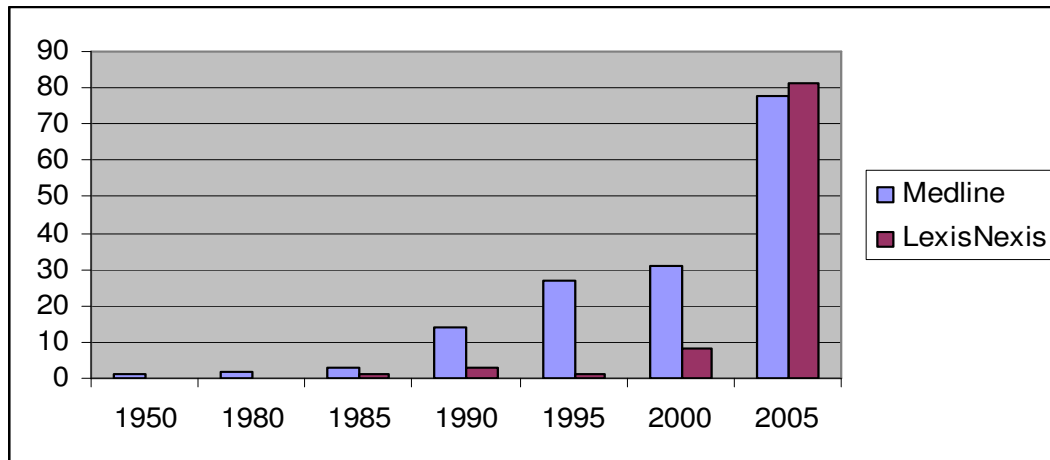
of mentally ill residents of Nebraska (*Omaha World-Herald* 2005). Further, an article in *The Tampa Tribune* calls Cruise a “know-it-all actor” who came unglued; a “zealous practitioner of Scientology” who has no medical degree, a self-absorbed actor playing with people’s lives, a strange and angry man.

Fortunately not many people will give him much credence. The view that modern medicine can be too quick to prescribe antidepressants is hardly out of the mainstream. But science has long proved that certain drugs can effectively treat mental illness. Postpartum depression, in particular, is treatable (*The Tampa Tribune* 2005: 12).

Expansion of Medical Control

We propose that thorough assessment of the mental health status of childbearing Women is just as important as the many evaluations of biologic indicators of health such as blood pressure readings, weight checks, and Papanicolaou smears (Horowitz et al. 1995: 275).

The articles from both databases illustrate the expansion of the medical profession’s control over pregnancy, childbirth and mothering beyond the physical to include emotional and psychological aspects as well. This expansion is visible in the increase in the number of articles published each year on postpartum depression (see Table 1). The increase in frequency began before 1990, well before Andrea Yates murdered her children in 2001, which indicates that PPD became a phenomenon without a sensationalized introduction. Only seven of the articles in the sample mention such sensationalized cases as Yates, although almost half suggest that PPD has dire consequences for the child, 40 percent suggest harm to the mother, and 25 percent suggest harm to the family.

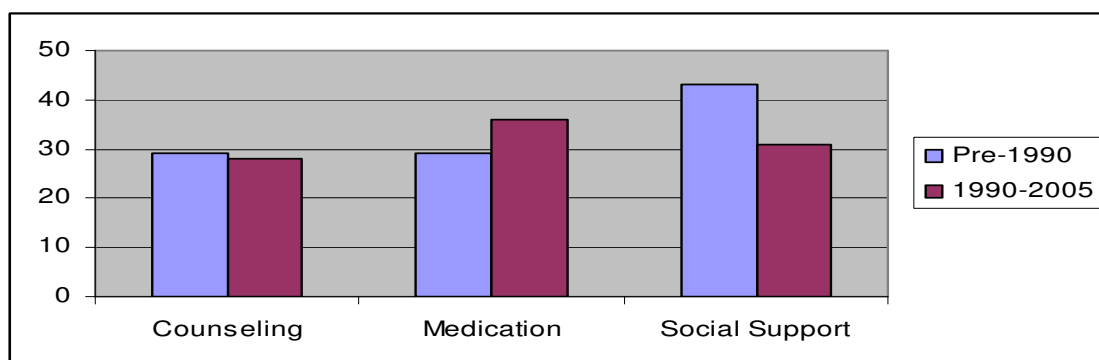
Table 1: Frequency of articles on PPD in the Medline and LexisNexis Databases

The articles in the sample up to 1990 indicate that physicians recognized PPD in some of their patients and tried remedies such as injections of the hormone alpha estradiol, electroconvulsive shock therapy, or hospitalization, with the assumption that PPD has biological causes such as hormonal imbalances (Roland 1950) or thyroid malfunctions (Unterman et al.1990; Claman 1990) Other articles implicate social causes of PPD, such as cultural expectations of motherhood that differ from reality (Beck 1995; Beck 1995; Berchtold and Burrough 1990; Feingold 1995; Beck and Gable 2000; Dankner et al. 2000; Leung, Martinson, and Arthur 2005; Goldbort 2005), body image issues that influence public perception of pregnant and postpartum women and lead to changes in their social lives, and the negative connotation of the term “housewife” (Tentoni and High 1980: 247); and new coping mechanisms that are required as roles, patterns, and relationships are renegotiated in parenthood (Gruen 1990).

Before 1990, remedies such as social support for new mothers exceed the recommendation for counseling or medication: 43 percent (or three) of the seven articles

up to 1990 recommend social support, 29 percent (or two of the articles) recommend counseling, and 29 percent (or two of the articles) recommend medication (such as hormone injections) as remedies (see Table 2). Practitioners offered

Table 2: Recommended treatment pre-1990 and 1990-2005.

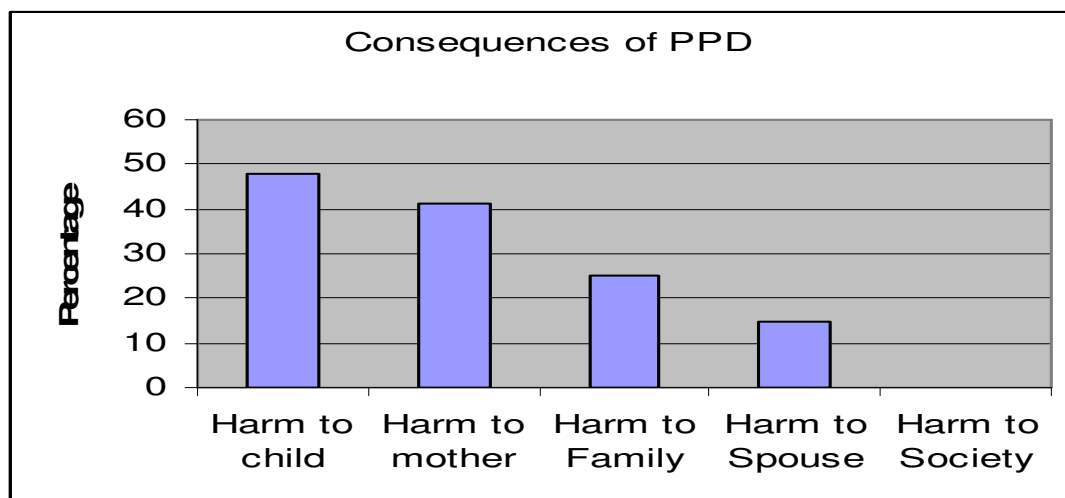


maternity/childbirth classes to dispel “myths” of pregnancy which women learned from other mothers, replacing experiential knowledge with “factual” knowledge (Tentoni and High 1980; Gruen 1990). The 102 articles in both databases from 1990 through 2005 recommend medication for the relief of symptoms more often (36 percent, or 36 of the 102 articles) than social support (31 percent or 31 of the articles) or counseling (28 percent or 28 of the articles). Support groups sponsored by medical personnel offered women a chance to share their experiences with other mothers to discover that they are not alone in their struggle with the illness, to feel less crazy, to learn that other women get relief through the use of medication which is often necessary for recovery (Gruen 1990).

The articles in the total sample contend that the physical and emotional well-being of the mother is vital for the health of the whole family (Ugarriza 2000), and harm to the child is the most cited consequence of PPD: 48 percent (or 52 of the 109 articles in the

entire sample) indicate that PPD causes harm to the child (see Table 3). Postpartum depression results in a woman minimally functioning in her role as mother,

Table 3: Percentage of articles stating negative consequences of PPD



afflicting the mother/infant bond (Vandenbergh 1980). The depressed mother's interaction with the infant promotes less-than-optimal development, and signs of PPD are experienced as baby problems: "floppy helplessness, irritability, and feeding problems" (Schwarzbeck 1995: 3E). Postpartum depression causes a mother to show little interest in her infant, to be less affectionate and more withdrawn or intrusive and hostile (Vandenbergh 1980), which interferes with the infant's later well-being and predisposes him/her to increased risk of suffering from "socioemotional, cognitive, and psychiatric difficulties later in life" (Gentile 2005: 944). Its negative effects continue through infancy into the teens and beyond. Postpartum depression also affects the spousal relationship as women with PPD withdraw communication with their partner, have decreased libido due to fatigue and dyspareunia (painful intercourse), and therefore the

couple loses the “sexual expression of support” for each other in their transition to parenthood (Martell 1990:92). Housework does not get done, babies become fussy, and the woman can become unattractive and run down by fatigue, causing the family sorrow, upheaval and disorganization (Martell 1990).

Postpartum depression is labeled “the most consistent predictor of future negative parenting behaviors” including yelling, hitting, shaking (Halbreich 2005: 1317), and children of depressed mothers are at increased risk of accidents, sudden infant death syndrome, and higher frequency of hospital admissions (Forman et al. 2000). Depressed mothers perceive their children as difficult, less adaptable to change, dependent and sober with negative emotionality; and children of depressed mothers are socialized to respond to mild stressors with anxiety (Whiffen 1990). Postpartum depression produces a “compounded assault on the offspring’s physical and mental development and long-term vulnerability to disorders” (Halbreich 2005: 1319).

The woman is subjectively portrayed in her role as mother, as solely responsible for the health and well-being of the whole family. The mother is “burdened by an overriding demand on her ability to love,” to focus on her sense of incapability to love or to love sufficiently, while her spouse and other children “need reassurance they are still recipients of love” (Vandenbergh 1980: 1109). Postpartum depression can incapacitate a woman to the point where she is unable to take care of the infant, and thus the family loses an “optimally functioning member;” by treating the mother, the entire family is supported (Martell 1990: 91).

A woman’s relationship with her own mother is associated with vulnerability to PPD, thus conveying the importance of establishing a strong mother/infant bond (Saks et

al 1985; Trad 1995; Buist, Norman, and Dennerstein 1995). Negative memories of her own experience with her caregiver may diminish a mother's ability to form a positive relationship with the infant, in turn affecting the infant's ability to form healthy relationships throughout life (Trad 1995). An emphasis on a mother's "interpersonal competence with the infant" suggests evaluating the mother's interactions with the infant and her "intuitive" parenting skills: visual cuing (maintaining eye contact), vocal cuing ("baby talk" and verbalizing appropriate narrative), and holding behavior (firm yet gentle grasp, holding infant close to body while gently caressing and verbalizing with infant) (Trad 1995: 141). A mother's failure to competently and confidently care for her infant because of a poor role model or negative childhood experiences (such as childhood sexual abuse) may lead to neglect and abuse with consequences that last a lifetime (Buist and Barnett 1995). The implication is that physical, cognitive, and psychological disorders are transferred from generation to generation through mothers, making PPD all the more threatening.

To a lesser extent, the articles highlight the harm that PPD causes to the mother: 41 percent of the articles from both databases (44 of the 109 articles) suggest that mothers suffer the effects of PPD. Postpartum depression is consistently associated with the difficult transition to motherhood and the mother's inability to adjust to her new role. The articles indicate that the transition to motherhood leads to erosion of self-esteem and feelings of inadequacy, possibly resulting from a sense of loss – of job or career, of freedom, spontaneity, identity (Tentoni and High 1980; Gruen 1990). A new mother loses control over many aspects of her life – relationships, lifestyle, bodily functions, personal time (Stover and Marnejon 1995). Roles, patterns, and relationships have to be

renegotiated, requiring new coping mechanisms (Gruen 1990). The woman experiences a fear of her unfamiliar “state of self” and a lack of trust in her new role, feels she is a bad mother who does not love her child enough, and struggles with the responsibilities associated with being a wife and mother (Gruen 1990: 262). Her quality of life is compromised because of the lack of positive emotions and interests, and she fears her life will never return to normal (Trad 1995; Beck and Gable 2000). She suffers covertly, enveloped in loneliness, consuming guilt, and obsessive thoughts (Beck 1995).

Just as medical professionals monitor the physical aspects of procreation from conception to the postpartum checkup in order to prevent malfunctions, the emotional and psychological aspects of childbirth are increasingly under medical control. This expansion of the medical profession’s domain is visible in several areas of the postpartum depression phenomenon, including its timing and its ever-growing list of symptoms. It is evident in the varied health care professionals who are being alerted to recognize its symptoms and implement the appropriate treatments, and in the development of new screening instruments and screening programs to more accurately and thoroughly diagnose PPD.

Reconstructing the “Post” Part of Postpartum

The DSM-IV defines PPD as “The presence of either depressed mood or decreased interest or pleasure occurring persistently for two weeks and resulting in a decline in functional status,” with onset occurring during the postpartum period, generally the first four or six weeks after delivery (Garg, Morton, and Heneghan 2005).

Childbirth is considered the “triggering effect” to PPD, and any emotional complaint after 10-14 days post-delivery should be considered abnormal (Stowe 1995: 640).

However, many researchers suggest that monitoring should be extended to include longer postnatal periods, asserting that onset can occur later than suggested by the DSM-IV, such as within three months after delivery (Roland 1950; Blenning and Paladine 2005), up to six months after delivery (Garg et al. 2005; Stowe, Hostetter, and Newport 2005), or a full year after delivery (Stover and Marnejon 1995). Handford (1985) finds that mothers are vulnerable to depression within three years after giving birth; similarly, Garg et al. (2005) find that many women with young children have symptoms of depression. Buist and Barnett (1995) posit that mothering does not end after the postpartum period, and Manfredi et al. (2005) suggest that not only childbearing mothers but grandmothers should be assessed for PPD. The timeline for depression is gradually extended well beyond the postpartum period, with some articles intimating an indefinite period of vulnerability to PPD.

Many of the articles support the extended timeline for the onset of postpartum depression. When the postpartum period is narrowly defined, women with late onset depression are left undiagnosed, affecting prevalence rates that are much higher than generally reported (Forman et al. 2000). Gruen (1990) asserts that PPD is rarely diagnosed even though it may affect up to 20 percent of families with new babies. Beck and Gable (2000) find that up to 50 percent of new mothers with PPD are undiagnosed; similarly, Vandenberg (1980) finds that up to 50 percent of new mothers may suffer PPD. The importance of establishing an extended timeline for onset is that a delay in

diagnosis and treatment results in longer duration of PPD episodes (Beck and Gable 2000) and a greater chance of recurrence (Trad 1995).

In addition to extending the timeline beyond the initial postpartum period as described by the DSM-IV, many articles assert that onset occurs during pregnancy and continues in the postpartum period (Vandenbergh 1980; Stowe 1995; Forman et al. 2000; Goodnick et al. 2000; Glasser et al. 2000; Halbreich 2005; Carroll et al, 2005; Agoub, Moussaoui, and Battas 2005; Stowe et al. 2005; Wissart, Parshad, and Kulkarni 2005; Garg et al. 2005). As many as 25-35 percent of women supposedly have depression during pregnancy (Goodnick et al. 2000), which increases the risk of PPD 2.5 to 4 times (Bloch et al. 2000). Further, women with PPD are at a substantially increased risk for depression in subsequent pregnancies (Bloch et al. 2000). A delay in diagnosis and treatment during pregnancy occurs because of several reasons: the symptoms of depression are often mistaken for normal conditions of pregnancy; women purposely avoid fetal antidepressant exposure; and antenatal screening is not routinely performed (Stowe et al. 2005).

Thus the articles convey an urgent need to begin screening for depression during pregnancy. They assert that early diagnosis and treatment produce the best obstetrical outcome and prevent negative consequences for the infant, the family, or the woman. Recommended treatment most often includes medication, with its risk of harm to the fetus or breastfed infant weighed against its benefit (Jermaine 1995; Rubin 2000). Rubin (2000) asserts that studies that emphasize harm to the fetus when women take drugs in pregnancy fail to note the implications when they do not take the medicine. Social

support and counseling are recommended less frequently than medication. “The impact of depression during pregnancy may still be controversial but the impact of stress/anxiety is quite well-accepted” (Halbreich 2005: 1313).

A theme repeated throughout the articles is that depression consists of recurring episodes. A prior episode of depression is the most often cited cause for developing PPD, and 31 percent of the articles in the sample implicate prior depression as a major cause of PPD. Medical professionals advise that early diagnosis and treatment are necessary to prevent depression from becoming a chronic illness and to lessen the chance of recurrence (Trad 1995). The finding that 53 percent of the women with PPD in one study were depressed five years after delivery suggests that women with PPD may be vulnerable to recurring episodes within four years, without undergoing another pregnancy (Pop et al. 1995). This finding conveys the need to continue surveillance beyond even the extended postpartum period, as exposure to subsequent relapse of maternal depression beyond the first year increases the risk of diminished cognitive development and future adversities for children when their mothers have PPD (Halbreich 2005; Logsdon et al. 2005; Gentile 2005). The risk of recurrence calls for a broad, comprehensive approach to address the “multidimensional interactive processes” involved in the disease of PPD (Halbreich 2005: 1319). With such dire consequences, doctors recommend the continued use of medication for 9 to 12 months after the depression remits in order to prevent relapse (Stowe 1995; Horowitz and Goodman 2005).

The postpartum period is considered a developmental period in the life course (Gruen 1990), temporal and transitional in nature, and some of the articles suggest that

PPD is also transitional and remits on its own. Goodnick et al. (2000) assert that most cases of PPD resolve naturally within three to six months; Blenning and Paladine (2005) find that if left untreated, PPD lasts generally about seven months; and Beck (1995) suggests that it remits within one year. However, these authors also suggest that better screening increases diagnosis rates and facilitates identification and treatment of high-risk women (Blenning and Paladine 2005); that medical professionals add to women's shame, embarrassment and guilt by suggesting that what they are feeling is normal (Beck 1995); and that symptoms go beyond the patient, from the mother/infant duo to the entire family (Goodnick et al. 2000). Thus, even though postpartum depression is considered a temporary condition, medical intervention is encouraged.

Some of the articles indicate a reluctance to medicate pregnant or breastfeeding mothers even while encouraging awareness and prevention of the disease. Corral, Kuan, and Kostaras (2000) suggest the use of bright light therapy in lieu of medicating breastfeeding mothers. Stowe (1995) finds that physicians are under consumer pressure to diagnose and treat such conditions as PMS and PPD, even though the effects on the infant's nervous system are unknown and the side effects of antidepressants are similar to PPD symptoms: anxiety, headache, and insomnia. Horowitz and Goodman (2005) find that although the use of antidepressants improved the symptoms of depression for the women in one study, other factors (such as the passage of time) may have contributed to their recovery. Thus while PPD is a temporally-situated condition that apparently resolves without treatment, and alternatives to medication exist, medical professionals focus on improving diagnosis and treatment that most often includes medication.

Tired, sleepless, happy...and other symptoms of PPD

The early articles tend to examine single biological, emotional, or social aspects as possible causes of PPD, while some of the later articles move toward a multifactorial focus on its causes. The most common causes of PPD (see Table 4) according to the sample articles are prior depression or lack of family support; 32 percent of all the articles in the sample suggest that a mother who suffered a previous episode of

Table 4: Causes of postpartum depression: percentages by year and by database

		1950	1980	1985	1990	1995	2000	2005
Hormones	Medline	100	50	50	43	29	33	28
	LexisNexis	0	0	0	0	63	13	24
Prior Depression	Medline	0	50	0	43	50	39	50
	LexisNexis	0	0	0	0	13	13	10
Stress	Medline	0	50	0	50	43	23	44
	LexisNexis	0	0	0	0	25	13	15
Family Support	Medline	0	50	50	65	50	28	50
	LexisNexis	0	0	0	0	63	0	10
Marital Relationship	Medline	0	50	0	57	36	22	45
	LexisNexis	0	0	0	0	50	0	5

Note: Percentages in Table 4 do not add up to 100 percent because some articles mention multiple causes of PPD.

depression is at greater risk for PPD, and 36 percent suggest that lack of family support is the main cause of PPD. Pop et al (1995) maintain that the most important predictors of

PPD are prior depression and a family history of depression. Marital status and age of the mother also make some women more vulnerable to PPD; 17 percent of all the articles indicate that unmarried mothers are at greater risk for developing PPD, and 16 percent suggest that young mothers have increased vulnerability, with the prevalence for adolescent mothers as high as 47 percent (Logsdon et al. 2005). Only four of the articles (six percent) suggest that fathers can have PPD, and three (four percent) suggest that other family members can have PPD.

The most cited biological symptoms include appetite changes, fatigue, and insomnia. Emotional symptoms most often include anxiety, as well as sadness and/or thoughts of suicide; behavioral symptoms include crying and irritability. Stover and Marnejon (1995) suggest that symptoms of PPD are pleas for help by women to cope with the emotional distress of motherhood. Horowitz et al. (1995) find that a “cluster of symptoms” is more common in PPD than other depressive disorders: feeling worse in evening, difficulty falling asleep; irritability; phobias; anxiety; OCD; sometimes suicidal thoughts and anxiety disorders (see Table 5).

Saks et al. (1985) suggest that the relative well-being, joy and euphoria that women feel immediately after giving birth may mask symptoms of depression and therefore clinicians may miss symptoms of depression when the patient is discharged from the hospital. “The relatively good mood shown by women at time of delivery is

Table 5: Symptoms of postpartum depression: percentages by year and by database.

		1950	1980	1985	1990	1995	2000	2005
Anxiety	Medline	0	100	100	43	50	34	28
	LexisNexis	0	0	0	0	50	13	5
Appetite Changes	Medline	0	50	100	22	36	28	34
	LexisNexis	0	0	0	0	13	0	5
No Energy/Fatigue	Medline	0	100	100	65	50	17	39
	LexisNexis	0	0	0	0	50	13	10
Insomnia	Medline	0	100	100	50	57	39	50
	LexisNexis	0	0	0	0	50	13	15
Sadness	Medline	0	100	100	43	29	17	28
	LexisNexis	0	0	0	0	38	0	5
Thoughts of Suicide	Medline	0	100	50	36	29	23	23
	LexisNexis	0	0	0	0	25	25	19

Note: Percentages in Table 5 do not add up to 100 percent because some articles mention multiple symptoms of PPD.

worth stressing,” and may be labeled “postpartum pinks” in order to distinguish such relation from the “normal” postpartum blues (Saks et al. 1985: 730). The positive emotions exhibited following delivery are also implicated as signs of bipolar disorder, as depression sets in after the initial highs of childbirth (Stowe 1995; Grof et al. 2000). Thus medical professionals assert that mothers may be depressed even when they are happy.

Several of the articles indicate that the symptoms of general depression are very similar to the “normal” postpartum period – fatigue, weight loss, disturbances in eating and sleeping patterns, mood disturbances, psychomotor retardation, change in body

image, and loss of libido (Stowe 1995; Horowitz et al.1995; Johnson 2000; Ugarriza 2000; Maes et al. 2000; Stowe et al. 2005; Leung et al. 2005; Garg et al. 2005). The overlap in symptoms associated with general depression and symptoms of the normal postpartum period may lead to a failure to diagnose PPD (Horowitz et al.1995). Further, women and their clinicians may mistake the symptoms of antenatal depression for those of pregnancy (Stowe et al. 2005). Some authors suggest that women with PPD exhibit more severe anxiety, panic attacks, crying spells, irritability, and hostility (Maes et al. 2000; Gentile 2005). For example, Boyer (1990) suggests that a new mother suffers depression if she has 15 or more episodes of crying in any 60 days before or after delivery. And Saks et al. (1985) find that depressed women self-rated themselves as more lonely, angry at themselves, distressed, lacking feeling of well-being, angry at others, shy, and defeated than non-depressed women. Thus medical researchers seek to identify unique symptoms that suggest depression in postpartum women. To distinguish between normal postpartum and antepartum conditions and PPD, Unterman et al. (1990) assert that the DSM revision should have a separate diagnostic category that considers the special problems that postnatal women have.

The distinguishing feature of PPD as proposed in the articles is mercurial mood lability and an inability to adjust to the new responsibilities of motherhood (Stowe 1995; Vandenberg 1980; Saks et al. 1985; Gruen 1990; Unterman et al. 1990; Casiano 1990; Trad 1995). The authors indicate that PPD is a form of “psychological morbidity” (Forman et al. 2000: 1215; Gamble et al. 2005), one of several disorders occurring in the antenatal and postnatal periods (Garg et al. 2005). Such disorders include bipolar disorder (Stowe 1995; Grof et al. 2000; Heron, Craddock and Jones 2005), eating

disorders (Franko and Spurrell 2000), post-traumatic stress disorder (Gentile 2005; Gamble et al. 2005), postpartum obsessive-compulsive disorder (Horowitz and Goodman 2005), and a wide spectrum of anxiety disorders (Gentile 2005). It appears that PPD is but one ailment that can negatively impact a woman's life. Thus, the postpartum period is "one of the most critical phases of a woman's life" in which she is most likely to develop PPD or severe psychiatric disorders, "especially the affective type" (Gentile 2005: 945).

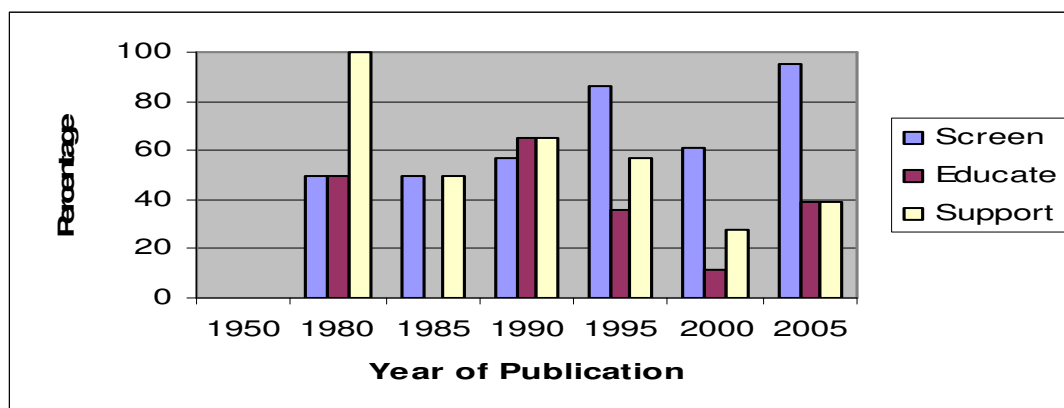
Verkerk et al. (2005) suggest that personality plays an emerging role as a risk factor for depression, asserting that neuroticism (characterized by tension, emotional lability and insecurity) and introversion (inhibition and shyness in social situations) predispose individuals to depression. Further, some women with depression are believed to have "avoidant personality disorder" (Pearlstein et al. 1990: 132), which consists of social inhibition, feelings of inadequacy, and sensitivity to negative evaluations; or they may have a personality disorder such as alcoholism or drug abuse (Casiano 1990).

Call the Doctor

Some authors suggest that every postpartum woman needs a mental health assessment just as she needs a physical assessment, and health care professionals have unique opportunities to assess the functioning and adjustment of postpartum women (Horowitz et al. 1995). However, health care professionals are just now becoming aware of PPD (Feingold 1995). As a result, health care providers rarely see signs of PPD or adjustment difficulties (Gruen 1990), possibly due to a lack of awareness or knowledge of the disease or for a lack of time spent with each patient (Glasser et al. 2000). Thus,

postpartum depression is rarely diagnosed even though up to 20 percent of families with new babies are affected (Gruen 1990). However, the role of medical professionals increasingly is to screen for depression (see Table 6).

Table 6: Recommended Course of Action for Medical Professionals to Mothers



The primary source for medical care of the pregnant woman is the obstetrician, who follows the progress of the pregnancy and the birth. The role of the obstetrician generally ends with the postpartum checkup six weeks after delivery; therefore, other health care professionals are being trained to recognize symptoms of PPD and identify and treat women who may be depressed. PPD education for all “points of service” – health care professionals in the obstetrical, primary care, and pediatric fields – provides opportunities for early intervention to prevent harmful consequences to the entire family (Garg et al. 2005: 592). The primary care physician, hospital support staff, nurses, and social workers are alerted to look for signs of depression that include the patient’s words, facial expressions, grooming, body language, and interaction with the infant (Auerbach and Jacobi 1990; Berchtold and Burrough 1990). Midwives and childbirth educators play an expanding role in the postpartum period by mentoring new mothers, educating them about postpartum symptoms that are beyond the “normal” adjustment to parenthood for

the sake of early detection and treatment (Feingold 1995). Clinicians are encouraged to ask specific questions regarding the transition to motherhood in conversational style that allows potentially depressed women to reveal stresses of their new parental roles (Beck 1995).

Casiano (1990) suggests that the goal of health care providers is to summarize symptoms and label the disorder as maternity blues, mild to severe postpartum depression, or postpartum psychosis, and to help the mother raise her children in a healthier environment. Stover and Marnejon (1995: 1471) assert that physicians should provide a comprehensive approach with “anticipatory guidance” for new mothers and their families which gives them a more realistic view of pregnancy, childbirth, and parenthood. Physicians are encouraged to focus on prevention through early identification and treatment (Feingold 1995).

The nurses’ role expands to include assessing the emotional adaptation of women to pregnancy and motherhood, and this assessment continues throughout the entire childbearing cycle as well as through subsequent pregnancies (Auerbach and Jacobi 1990). Their knowledge of PPD is an essential aspect of caring; through intuition and knowledge of PPD they can “make astute observations that something might be wrong with the mother” and refer her to the appropriate source, guiding her to the path of recovery (Beck 1995: 822). Nurses in the maternity hospital setting as well as those who have outpatient contact with mothers, such as pediatric, obstetrical, and primary care nurses, are asked to observe signs of maladaptation and to make appropriate referrals to medical professionals for treatment (Auerbach and Jacobi 1990). In conversational style, they convey empathy and assist the mother in obtaining support from family, neighbors

or friends who can “mother the mother,” giving her food and rest from the demands of motherhood (Auerbach and Jacobi 1990: 380; Kirkey 1995). They are encouraged to observe tone and body language of mothers to detect signs of depression in “women in the throes of illness,” to become educated about PPD by reading available literature and attending lectures or conferences, and to implement postpartum support groups in the hospital or community (Berchtold and Burrough 1990: 387). A further suggested role for nurses includes to police compliance with recommended therapies to ensure that depressed women follow through with the appropriate treatment (Horowitz and Goodman 2005). “Often the primary nurse must serve as the conduit through which the entire health care team considers all family members’ needs” (Auerbach and Jacobi 1990: 383).

Health care providers often consider their work done when the physical health of the mother and baby are attained after labor and delivery; however, their responsibility continues into the postpartum period to ensure their psychological and emotional health as well (Boyer 1990). A primary role for obstetricians and nurses whose patients are pregnant women is preventing PPD by dispelling myths of pregnancy which first-time mothers learn from experienced mothers (Tentoni and High 1980). Maternity or childbirth classes aim to replace lay knowledge with scientific, factual knowledge and thereby counteract negative views of pregnancy and motherhood. Women’s experiential knowledge is considered not only erroneous but harmful.

What’s your score?

Screening is a major component for diagnosing PPD, permitting intervention before symptoms become disabling to the mother and harmful to the child. Some authors

suggest the need for standardized screening instruments for optimal diagnosis, as well as a broader set of risk factors that are more sensitive to PPD (Horowitz and Goodman 2005; Halbreich 2005). A popular depression screening tool, the Beck Depression Inventory (BDI), is a 21-item questionnaire in which individuals self-rate their mood, conscious thought, and symptoms of depression (Saks et al. 1985). However, the BDI has been criticized because its questions are not specific to the childbearing experience, it may miss some cases of subclinical depression, and the symptoms of postpartum adjustment disorders are not differentiated from general depression (Horowitz et al. 1995). In addition, it may give false positives because it is sensitive to symptoms that are “normal” changes after childbirth, such as sleep disturbances, weight loss, fatigue, and loss of libido (Ugarriza 2000; Leung et al. 2005).

The Edinburgh Postnatal Depression Scale (EPDS) was designed specifically to screen for PPD; it improves identification of high-risk women and diagnosis rates, and it facilitates treatment (Ugarriza 2000; Blenning and Paladine 2005; Cox 2005). Its limitations include that it does not provide mothers with an opportunity to describe their symptoms fully (Beck 1995), that it only tests postpartum, not in pregnancy (Agoub et al. 2005), and that it lacks cultural relevance outside of western society (Banerjee et al. 2000).

Other screening tools include the Postpartum Depression Checklist (PDC), a “simple practical device” designed to engage a woman in conversation about her experiences with the 11 symptoms on the checklist (Beck 1995: 310), and the Antenatal Psychosocial Health Assessment (ALPHA). ALPHA was designed to systematically identify areas of psychosocial concern, listing 15 risk factors associated with woman

abuse, child abuse, PPD, and couple dysfunction; it doubles the detection of psychosocial concerns among pregnant women (Carroll et al. 2005).

Unterman et al. (1990) assert that women tend to underreport their symptoms because of shame, guilt, or embarrassment, and that because of limited direct observation by medical professionals, family members are responsible for recognizing symptoms of depression in the mother and seeking medical help when necessary. Women may be depressed at the postpartum checkup but unaware of diagnosis as they mistake distress as the blues or fatigue; symptoms then evolve into a major depressive episode with impaired functioning (Beck 1995). Psychosocial experiences interfere with a woman's ability to adjust to motherhood; therefore screening instruments with psychosocial values may identify women at risk (Unterman et al. 1990). Horowitz and Goodman (2005) suggest that the high prevalence and negative consequences of PPD require a change in healthcare policy to mandate universal postpartum screening as standard care in the U.S. Poor detection needs to be improved through tailored screening tools (Beck 1995) and universal screening programs.

CHAPTER 4

DISCUSSION

Although PPD was recognized centuries ago during the time of Hippocrates, it has only recently received much attention. The current sample of articles reflects a trajectory of increasing volume since 1990 that illustrates the social narrative occurring around the issue. That narrative changes over time, from examining the significance of

single etiological elements, such as hormones or lack of family support, to a combination of multiple factors that purportedly make women vulnerable to PPD. And although a definitive etiology remains elusive, treatment options change from social support for mothers in their childrearing responsibilities to medication as the current preferred treatment recommended by medical professionals.

The articles illustrate, map, and justify an expansion of medical control over women's bodies to include not only physical aspects of childbirth but psychological and emotional aspects of pregnancy and the postpartum period as well. The PPD issue parallels the movement of childbirth into the medical model as women's emotions are pathologized, and as medical experts promote their knowledge to allegedly lower the risk of harm to the baby, giving greater control to medical professionals while further eroding women's voice and agency. Just as Rothman (1982) finds it more difficult to have an uncomplicated pregnancy – not because of complications but because of medical intervention and innovative technology – it is becoming more difficult to be “normal” or symptom-free in the postpartum. The extended timeline for vulnerability to onset, the expanded list of symptoms specific to the postpartum, and the increased surveillance by multiple medical practitioners and vague screening instruments push more women into the complicated pregnancy category that includes clinical depression. And just as obstetrical practices carve procreative time into specific categories that delineate progression of the pregnancy, of the developing fetus, and of labor that disempower women in the process of childbirth (Simonds 2002), medical professionals establish time-defined periods of postpartum, of vulnerability to onset of depression, and of duration of the illness that affect women's diagnoses.

“Temporal differentiation” affects the way we classify the world, imbuing meaning that becomes reified in everyday social life (Zerubavel 1991: 10). The articles show an expansion in the timeline of surveillance of women’s moods, beginning in pregnancy and continuing through an extended postpartum period that remains open-ended. Temporality is evident in the portrayal of the childbearing years as a developmental period rife with vulnerability to psychiatric disorders, of which PPD is only one. Women are said to be vulnerable to depression anywhere from 10-14 days postpartum to three months, six months, one year, or five years and beyond, even into grandmotherhood.

Temporality is also evident in the definition of PPD, as the time of onset of symptoms lasting more than two weeks determines whether the woman is diagnosed with the “normal” condition of “baby blues” or postpartum depression. The difference appears to be not in the severity of symptoms but in the timing of onset and duration of symptoms. And although some articles refer to PPD as a time-limited experience and suggest that it readily remits without treatment within a few months to one year, the articles convey a sense of urgency and crisis that requires immediate medical intervention.

Intervention of medical professionals is encouraged through an education campaign that informs obstetricians, pediatricians, primary care physicians, nurses, social workers, hospital staff – and women – of the signs and symptoms of the disorder as well as the dire consequences that occur when the malady is left untreated. When the mother is fully functioning in her role, the infant supposedly attains optimal physical, emotional, and cognitive development; the spousal relationship thrives; and the whole family is

healthy, each member nurtured and loved by the mother. When the mother is not fully functioning, the infant is dependent, fussy, neglected or abused, with physical, emotional and cognitive impairment that affects future potential. The couple's relationship is threatened, filled with tension due to lack of communication, lack of sexual expression, and the mother's unattractive appearance. The family is disorganized, chaotic, stressed, and in crisis. The education campaign promotes the intergenerational transfer of depression with the assertion that the child's future potential is stunted by the mother's depression, that children of depressed mothers are socialized to react to mild stress with anxiety, and that a woman's own experience of being mothered shapes her ability to mother. Further, it conveys the urgency of curing depression for the sake of preventing future episodes of depression, as a family history of depression or a prior episode of depression is said to predispose women to PPD.

Medical professionals determine what is "normal" behavior for mothers, monitor their conformity to these behavioral norms by observing and conversing with them, and diagnose and treat those who are unable to fulfill such expectations. Personality, biology, biography, and other individual traits are said to make some more vulnerable to failure to develop an adequate maternal identity, thus causing PPD. The increased risk to certain groups – young, unmarried, previously depressed women, women who faced childhood adversities – is magnified in light of the ideology of the perfect mother, their vulnerability to depression heightened because they are further from the ideal to start with. The medical profession becomes a redeemer of sorts, the hero who removes the blame from the miserable woman who struggles with ineptitude at motherhood.

The influence of ideology on motherhood is ubiquitous. It causes mothers to feel incompetent, overwhelmed, isolated and afraid to express negative emotions about the mothering experience. The articles imply that the result of depression in mothers is harm to the child (developmentally, emotionally, physically, cognitively), harm to herself (in her maternal identity), and harm to the family (through stress, crisis, disorganization). With such dire consequences, mothers who lack confidence to adequately care for and love their infant succumb to medical control, possibly with relief through medication such as Shields indicated. Blame and stigma are lessened as the difficulties in the postpartum period are made real rather than imagined, given a name, common symptoms, and treatment options that offer the hope of recovery. Few of the articles in the total sample (six percent) indicate that fathers or other family members experience PPD, although they are adversely affected by the woman's depression.

It is important to note that the increase in frequency of articles coincides with the 1987 introduction of the first SSRI antidepressant, Prozac, to the U.S. market (Healy 2004; www.mayoclinic.com). The rate of depression in the general population since then has increased 1000-fold (Healy 2004). Similarly, Bouchez (1995) asserts that there has been either a true rise in incidence of PPD or an increase in those reporting its symptoms, as the prevalence rate is closer to 30 percent than the 10-15 percent normally reported. In addition, Hendrick (2000: 70) finds that the women with PPD in his/her study were 14 times more likely to be on two antidepressants than the non-postpartum depressed group, and suggests that "polypharmacy" shows greater physician concern for postpartum women that includes earlier use of additional psychotropic intervention. This finding contradicts past medical practices that carefully spell out what should and should not be

ingested during pregnancy and while breastfeeding. The suggestion that the risk of medication to the developing fetus is less harmful than the effects of a mother's depression is a complete reversal from the pharmacologic abstinence usually practiced during pregnancy.

While discourse surrounding postpartum depression opens the door for women to express negative aspects of mothering without the risk of social condemnation, the movement toward the medical model defuses pressure to remediate the tremendous and disproportionate responsibility that mothers bear for the physical, emotional, and cognitive development of their children. It leads to the diagnosis and treatment of individual women rather than a change in the societal expectation that women be perfect mothers. The focus is no longer on the difficulties of mothering and the dissonance between ideological representations of motherhood and reality but on the scientific representation of PPD as a disease. Women who fail to meet the standards of mothering simply become patients, and medical professionals offer the hope of recovery.

Applied Implications

The emerging constructions of PPD represent the expansion of social control over women's bodies, not through overt oppression but through the medical diagnoses of psychological and emotional disorders. In the spirit of inquiry about postpartum depression's effect on women's lives, I question whether defining PPD as an illness, and particularly prescribing medication as treatment, improves women's lives. Although medication may provide a "quick fix" for women suffering from depression in the

postpartum, the practice of medicating social problems removes the potential for social change as it locates the problem within the individual.

According to Taylor's (1996) model of PPD, women's self-help movements redefine gender relations and renegotiate motherhood through the discussion of postpartum illness in the popular advice literature. In support groups, women build solidarity with others with shared experiences, enhance their feelings and perceptions about themselves as well as their confidence when dealing with medical, legal, and other professionals, and promote social and personal change. While I agree with Taylor that support groups offer women a platform to convey their personal realities of motherhood and that competing discourses arising from their shared experiences challenge traditional notions of motherhood, I question whether social change would occur as a result. My analysis shows that the medical profession increasingly recommends medication over social support or counseling as the preferred treatment, which removes the impetus for social change and instead finds its remedy in treating the individual mother. The increased use of medication represents a change in direction of treatment since Taylor's book was published in 1996.

Ironically, Taylor finds that women are at the forefront of the push to have PPD recognized as a distinct illness with its own categorization in the DSM. My study also finds that more authors in my sample are women than men, and more medical doctors than any other credential, which seems an anomaly. After all, how can one say that the medicalization of PPD disempowers women and reflects the patriarchal nature of the medical profession when it is women who are writing the articles? Perhaps an answer may be found in Berger and Luckmann (1967: 85) who find that "subuniverses" of social

meaning result from melding institutional knowledge with biography, illustrating “a dialectic between social production and the objectivated world that is its product”:

A body of knowledge, once it is raised to the level of a relatively autonomous subuniverse of meaning, has the capacity to act back upon the collectivity that has produced it. For instance, Jews may become social scientists because they have special problems in society *as* Jews. But once they have been initiated into the social-scientific universe of discourse, they may not only look upon society from an angle that is no longer distinctively Jewish, but even their social activities *as* Jews may change as a result of their newly acquired social-scientific perspectives. (Berger and Luckman 1967: 86-87, emphasis in original)

Established disciplines such as medicine train candidates in their traditions, and regulatory practices such as review boards and certification requirements uphold the practice of those disciplines. Women who enter the medical profession acquire medical knowledge that is imbued with patriarchal values which influence their medical practice and their perceptions of illness and disease.

The diagnosis of PPD infers disease from behavior, specifically failure to conform to gender roles. When PPD is defined as an illness, women who receive a diagnosis escape condemnation for failing at motherhood, after all, medicine is there to help the mother, not to condemn. And a diagnosis has real advantages – in court, in building solidarity among women, and in furthering discourse surrounding motherhood. But locating women in the patient frame is helpful only up to a point; centering them in the medical model pathologizes their experiences and removes agency. Mothers with PPD are viewed as abnormal, deviating from the standards of maternal behavior. Women diagnosed with PPD may be viewed as “patients” first and political actors second, illustrating the potential for disempowerment because of the patient label. Having failed at mothering, even if through no fault of their own, the label can be stigmatizing, can limit their degrees of freedom and keep their primary status as “patient” rather than

“woman.” And as patients, their demands for social reform become less imperative as medicine is readily available to bring the struggling mother up to par. Medication pulls mothers “back from the brink” and restores their ability to function as mothers. If the behavior of women with PPD is viewed as irrational, it may lead others to view women in general as irrational much as the focus on moods during the menstrual cycle and menopause has negatively affected the perception of women’s emotional stability.

For an illness category so poorly defined and still debated, it is alarming and perhaps premature that such practices as mandatory depression screening for all postnatal women – legislated in New Jersey in 2006 and proposed in Illinois – are coming into play, especially in light of screening instruments that are vague and difficult to interpret. For instance, one of the 10 items on the Edinburgh Postnatal Depression Scale (EPDS) states, “Things have been getting on top of me,” to which mothers are asked to underline the response which comes closest to how they have felt in the past week:

Yes, most of the time I haven’t been able to cope at all
 Yes, sometimes I haven’t been coping as well as usual
 No, most of the time I have coped quite well
 No, I have been coping as well as ever (see Appendix B).

Responses are scaled, and the total score determines the presence and severity of depression, which then requires further clinical assessment.

The increasing rates of depression in pregnancy and the postpartum reflect problems in living rather than a disease, and the medical model individualizes what might be social issues of gender inequality. Clinicians should be aware that the diagnostic category of PPD has a short social history with its recent constructions, and the potential for over-prescribing medication exists, which can have detrimental effects on infant and

mother. Physicians rely on information supplied by pharmaceutical companies for new products and approaches to treating illnesses, yet the long-term effects of antidepressants on the fetus, on the breastfed infant, or on the mother have yet to be determined. The question remains as to who benefits from diagnoses of depression – the mother, the infant, medical professionals, or outside interests such as drug companies.

Theoretical Implications

Critical constructionists and postmodern feminists would recognize the imbalance between the authoritative medical professional and the vulnerable woman. For instance, women's emotionality is often referred to as the "affective type" throughout the articles, "aberrant emotions" associated with behaviors such as crying more than 15 times in any 60-day period. The gendered aspect of depression diagnoses is evident in the reference to "postpartum pinks," a state of elation immediately following childbirth that is said to mask depression and possibly be a sign of bipolar disorder. Ironically, women are said to be depressed even when they experience joy at childbirth. A comparable condition might be a "runner's high" which occurs following strenuous exercise or physical exertion; would the same implication of bipolarity or masked depression apply to athletes, whose composition includes both genders?

Medical professionals promote ideological representations of motherhood, bolstered by such scientific concepts as "intuitive" mothering behaviors, which shape maternal identities. Laden with ideology of the good mother, the articles romanticize motherhood and support an unreachable standard by which all mothers are judged. The focus is on the mother-infant dyad and intuitive mothering behaviors such as

instantaneous mother/infant bonding, vocal and visual cuing, and maternal patterns of empathic interaction with the infant. Idealized versions of motherhood and the perfect transition from couple to family are portrayed as the “normal” state of motherhood. Guilt, shame, depression, and sense of failure are the consequences of one’s failure to attain. The cultural expectation that women will become mothers despite societal attitudes that devalue motherhood creates a sense of disillusionment which new mothers often describe as feeling angry, entrapped, isolated, and hostile. The articles implicate the dissonance between such high expectations and reality, which creates a sense of failure for mothers. The influence of the medical profession on women’s maternal identities supports feminist and constructionist recognition of imbalances of power.

The assertion that mothers are unaware that they are depressed, that they mistake their symptoms for those of fatigue and lack of sleep supports Foucault’s theoretical assertion that individuals undergo a process of self-understanding mediated through an external authority figure, in this case the medical professional. Screening instruments assume knowledge of all women’s experiences in the motherhood role and assess their ability to adapt based on those assumptions. Foucault asserts that the individual is the ideological representation of society, but power (specifically biopower) produces reality, domains of objects and rituals of truth anchored in consensual relationships. Power, then, is not a pure and simple projection upon individuals but is enforced through a multitude of institutions – medicine, the family, religion, the state. Through scientific classification, the individual defines who they are; normative expectations tell us how to behave and what actions to take. The ideology of the “good mother” supported in the articles tells us what motherhood *should* be and what mothers *should* experience.

Presented as truth, experts present a normative ideal of motherhood that constructs the standards of motherhood. Thus, the power of medical experts' knowledge normalizes the expectations of motherhood by which all women are judged.

Women who undergo screening evaluate their own experiences through the preconceived representations on the screening instrument. Their mothering experiences are framed through the eyes of the medical profession and upheld through the influence of family, religion, and state policies, setting standards for mothering that shape maternal identities. Disciplinary power through surveillance – by medical authorities, family, and state policies – results in the objectification of women who self-diagnose according to the checklists of symptoms, and the individual woman regulates and achieves conformity to the normative expectations of motherhood by seeking medical intervention when necessary. As Foucault asserts, normalizing individuals occurs within the body of people and optimizes the well-being of each individual; it is used for the good of the state and to protect the lives of its people. This is visible in the issue of PPD, as the medical profession creates an image of motherhood which society accepts and allows it to shape its attitudes and actions toward motherhood. Medicalization operates as social control at the “capillary level” (Foucault 1980: 39), not from above or below but from all social relationships, constraining individual bodies and governing individual actions and attitudes through the discourse of PPD. Through ideological representations and medical categorization, women conform to societal expectations of motherhood; through medication, the depressed woman becomes a good mother for the protection and nurturing of the infant and the family. Thus the medical model and the current constructions of PPD produce Foucault's concept of docile bodies.

Conformity to the standards of motherhood occurs as discourse strengthens the ideal as the norm, as in Gramsci's concept of hegemony. Mothers willingly conform to treatment protocols because "experts" deem that treatment to be in their best interest for the health and protection of the infant and family. The authority which the medical profession exerts in the discursive formation of PPD can be seen in the Tom Cruise/Brooke Shields debate. Authors of the LexisNexis articles in the sample quickly renounced Cruise's statements as a rant and an irresponsible disservice to women. They pointed out his lack of a medical degree as evidence that he is unqualified to speak about the issue. Although his message may have been valid, the focus became his irrational behavior, awarding a point to the medical side and a penalty to those who would question medical intervention for PPD, furthering medical dominance and control in the postpartum debate.

CONCLUSION

Analysis of a sample of medical and popular literature on postpartum depression shows that the process of medicalization extends medical control over women's lives during the childbearing years beyond the physical to include emotional and psychological aspects as well. The articles in both the Medline and LexisNexis databases are similar in their medical representations of PPD; some of the articles in the LexisNexis database also present PPD in non-medical context. The common use of the term in non-medical sources indicates a general acceptance and understanding of the conditions inherent to PPD among non-medical populations.

The expansion of the medical domain is evident in the timing of onset – which now extends well beyond the traditional four- to six-weeks postpartum as well as back into pregnancy – and the evolving list of depressive symptoms unique to pregnant and postpartum women. The expansion is also evident in the number of professionals in various medical fields – obstetrics, pediatrics, family practice, nursing, psychiatry, social work – trained to diagnose and treat PPD, as well as in the development of new screening instruments and programs designed specifically to identify women at risk.

The emphasis on monitoring women's moods and treating women in order to support the family tightens the boundaries of motherhood, enforcing cultural ideologies of the good mother. The expectations of motherhood are more firmly set as the medical profession defines what emotions are normal in the transition to motherhood. The medicalization of PPD results in the treatment of individual women, most often with medication, with negative implications for women that include the label of "patient" that sticks and results in a lifetime of surveillance, the pathology of normal emotions as "aberrant" rather than human, and with such practical concerns as hindering the ability to obtain life insurance once diagnosed with PPD (Lieber 2007). The mother alone experiences PPD in the transition to parenthood; fathers and other family members are rarely diagnosed with PPD but are said to suffer the effects of the mother's depression. Ideological representations of motherhood – such as intuitive mothering behaviors and expectations of joyful mothering experiences – coupled with adverse, long-term consequences to the child and the family when such ideals are not attained compel women to seek treatment. Rather than ameliorating the effects of a difficult transition through social support, medication is the preferred remedy for the individual mother who

struggles in her motherhood role. Thus, medicalization standardizes emotions and behaviors that support idealized versions of motherhood and upholds gender inequality inherent in traditional parenting roles.

The increase in the frequency of articles and the education campaign to raise awareness about PPD coincide with the 1987 introduction of the SSRI antidepressant Prozac to the U.S. market. The shift away from social support to medication as the preferred treatment implicates the marketing of pharmacology in the push to establish PPD as a treatable disease. The education campaign to inform medical professionals and mothers about the signs and symptoms of PPD produces more “awareness” about the disease, and treatments are designed to prevent harm to the child and to lessen the risk of recurring episodes of depression. Women who experience an episode of depression will be under increased scrutiny during each subsequent pregnancy, postpartum period, and any future stressful life event, expanding medicine’s gaze into women’s lives. With this marketing strategy, the prevalence rates of mothers who are depressed increase...as do profits for the drug companies. Yet the fate of not only the present but the future remains heavily on the woman’s shoulders. The hierarchy of medical authority reinforces gender inequality as it more firmly establishes women’s role as the primary caregiver for children.

The push to screening for depression in the pre-partum and in longer periods postpartum and to medicating women who are diagnosed raises the alarm to unravel the process of medicalization rather than accept it. A close reading of a careful sample of both medical and popular sources reveals nuances in the ways that medicine and medicalization play out, not only furthering the scientific rationale for expanded controls

over women's lives, but also justifying pharmaceutical involvement. As a result, I come away with a picture of the process as entrenching the hierarchy of medicine and tightening the boundaries of motherhood.

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Appendix A: Code Sheet

Section 1

1. Article # _____
2. Location
 - 1 Medline
 - 2 LexisNexis
3. Year published (4 digits) _____
4. Month published 1 2 3 4 5 6 7 8 9 10 11 12
5. Day published (if more than 1 issue per month) _____
6. Published in (journal name) _____
7. Country of journal _____
8. Nationality of sample _____
9. Cross-cultural or multiple nationalities in sample 1 Yes 2 No 9 Don't know

Section 2Name of 1st author _____

10. Credentials of author:

- | | | | |
|---|---------|---|-----------------------|
| 1 | MD | 5 | LCSW |
| 2 | PhD | 6 | LPC |
| 3 | PsyD | 7 | Other (Specify) _____ |
| 4 | RN, LPN | 9 | Don't know |

- | | | | | |
|-----------------------|---|------------|----|----------------|
| 11. Gender of author: | 1 | Male | 2 | Female |
| | 9 | Don't know | 10 | Not applicable |

Name of 2nd author _____

12. Credentials of author:

- | | | | |
|---|---------|----|-----------------------|
| 1 | MD | 5 | LCSW |
| 2 | PhD | 6 | LPC |
| 3 | PsyD | 7 | Other (Specify) _____ |
| 4 | RN, LPN | 9 | Don't know |
| | | 10 | Not applicable |

- | | | | | |
|-----------------------|---|------------|----|----------------|
| 13. Gender of author: | 1 | Male | 2 | Female |
| | 9 | Don't know | 10 | Not applicable |

Name of 3rd author _____

14. Credentials of author:

- | | | | |
|---|---------|----|-----------------------|
| 1 | MD | 5 | LCSW |
| 2 | PhD | 6 | LPC |
| 3 | PsyD | 7 | Other (Specify) _____ |
| 4 | RN, LPN | 9 | Don't know |
| | | 10 | Not applicable |

- | | | | | |
|-----------------------|---|------------|----|----------------|
| 15. Gender of author: | 1 | Male | 2 | Female |
| | 9 | Don't know | 10 | Not applicable |

Name of 4th author _____

16. Credentials of author:

- | | | | |
|---|-----|---|------|
| 1 | MD | 5 | LCSW |
| 2 | PhD | 6 | LPC |

- 3 PsyD
4 RN, LPN
- 7 Other (Specify) _____
9 Don't know
10 Not applicable
17. Gender of author: 1 Male 2 Female
9 Don't know 10 Not applicable

Name of 5th author _____

18. Credentials of author:
- 1 MD 5 LCSW
2 PhD 6 LPC
3 PsyD 7 Other (Specify) _____
4 RN, LPN 9 Don't know
10 Not applicable
19. Gender of author: 1 Male 2 Female
9 Don't know 10 Not applicable

Name of 6th author _____

20. Credentials of author:
- 1 MD 5 LCSW
2 PhD 6 LPC
3 PsyD 7 Other (Specify) _____
4 RN, LPN 9 Don't know
10 Not applicable
21. Gender of author: 1 Male 2 Female
9 Don't know 10 Not applicable

Name of last author _____

22. Credentials of author:
- 1 MD 5 LCSW
2 PhD 6 LPC
3 PsyD 7 Other (Specify) _____
4 RN, LPN 9 Don't know
10 Not applicable
23. Gender of author: 1 Male 2 Female
9 Don't know 10 Not applicable

24. Sponsor of article:
- 1 Pharmaceutical company 4 Other (Specify) _____
2 Medical practice 9 Don't know
3 Professional organization

Section 3

What, according to the article, causes PPD?

Biology

25. Hormones? 1 Yes 2 No 9 Don't know
26. Sleep Deprivation? 1 Yes 2 No 9 Don't know
27. Diet? 1 Yes 2 No 9 Don't know
28. Other biological cause? (Specify) _____

	1 Yes	2 No	9 Don't know
Psychology			
29. Prior Depression?	1 Yes	2 No	9 Don't know
30. Stress?	1 Yes	2 No	9 Don't know
31. Coping skills?	1 Yes	2 No	9 Don't know
32. Perfectionism?	1 Yes	2 No	9 Don't know
33. Self-esteem?	1 Yes	2 No	9 Don't know
34. Childhood experiences or trauma?	1 Yes	2 No	9 Don't know
35. Other psychological cause? (Specify) _____	1 Yes	2 No	9 Don't know
Social			
36. Family support?	1 Yes	2 No	9 Don't know
37. Marital relationship?	1 Yes	2 No	9 Don't know
38. Friends?	1 Yes	2 No	9 Don't know
39. Other social cause? (Specify) _____	1 Yes	2 No	9 Don't know

Section 4

Does the article infer implicitly or explicitly that some individuals are more vulnerable or at risk for PPD based on biographical characteristics?

40. Age?	1 Yes	2 No	9 Don't know
41. Marital status	1 Yes	2 No	9 Don't know
42. Low SES	1 Yes	2 No	9 Don't know
43. Race	1 Yes	2 No	9 Don't know
44. Ethnicity	1 Yes	2 No	9 Don't know
45. Other biographical characteristics? (Specify) _____	1 Yes	2 No	9 Don't know

Section 5

What, according to the article, are the symptoms of PPD?

Physical:

46. Insomnia	1 Yes	2 No	9 Don't know
47. No energy / fatigue	1 Yes	2 No	9 Don't know
48. Appetite changes	1 Yes	2 No	9 Don't know
49. Headaches	1 Yes	2 No	9 Don't know
50. Chest pains	1 Yes	2 No	9 Don't know
51. Heart palpitations	1 Yes	2 No	9 Don't know
52. Hyperventilating	1 Yes	2 No	9 Don't know
53. Other physical symptoms (Specify) _____	1 Yes	2 No	9 Don't know

Emotional:

54. Anxiety	1 Yes	2 No	9 Don't know
55. Excessive worry	1 Yes	2 No	9 Don't know
56. Confusion	1 Yes	2 No	9 Don't know
57. Sadness	1 Yes	2 No	9 Don't know
58. Feeling overwhelmed	1 Yes	2 No	9 Don't know
59. Feeling inadequate as a parent			

	1 Yes	2 No	9 Don't know
60. Incoherence	1 Yes	2 No	9 Don't know
61. Feeling of hopelessness	1 Yes	2 No	9 Don't know
62. Thoughts of suicide	1 Yes	2 No	9 Don't know
63. Hallucinations	1 Yes	2 No	9 Don't know
64. Other emotional symptoms (Specify) _____	1 Yes	2 No	9 Don't know
Behavioral:			
65. Crying	1 Yes	2 No	9 Don't know
66. Oversensitivity	1 Yes	2 No	9 Don't know
67. Irritability	1 Yes	2 No	9 Don't know
68. Panic Attacks	1 Yes	2 No	9 Don't know
69. Hostility	1 Yes	2 No	9 Don't know
70. Paranoia	1 Yes	2 No	9 Don't know
71. Other behavioral symptoms (Specify) _____	1 Yes	2 No	9 Don't know

Section 6

Does the article reference a distinction in intensity of PPD?

72. Baby blues	1 Yes	2 No	9 Don't know
73. Postpartum Depression	1 Yes	2 No	9 Don't know
74. Postpartum Psychosis	1 Yes	2 No	9 Don't know

75. Does the article reference the prevalence of the baby blues (in terms of % of all new mothers)?

- 1 Yes (Specify range): From ____% to ____% of all new mothers
 2 No
 9 Don't know

76. Does the article reference the prevalence of PPD (in terms of % of all new mothers)?

- 1 Yes (Specify range): From ____% to ____% of all new mothers
 2 No
 9 Don't know

77. Does the article reference the prevalence of postpartum psychosis (in terms of % of all new mothers)?

- 1 Yes (Specify range): From ____% to ____% of all new mothers
 2 No
 9 Don't know

Does the article suggest that others can have PPD?

78. Father?	1 Yes	2 No	9 Don't know
79. Other family members? (Specify) _____	1 Yes	2 No	9 Don't know
80. Friends?	1 Yes	2 No	9 Don't know

Section 7

Does the article suggest an effective treatment for PPD?

81. Medication?	1 Yes	2 No	9 Don't know
-----------------	-------	------	--------------

82. Counseling?	1 Yes	2 No	9 Don't know
83. Social support?	1 Yes	2 No	9 Don't know
84. Combination (Specify) _____	1 Yes	2 No	9 Don't know
85. Other treatment (Specify) _____	1 Yes	2 No	9 Don't know

Section 8

Does the article mention consequences of PPD?

86. Harm to child?	1 Yes	2 No	9 Don't know
87. Harm to mother?	1 Yes	2 No	9 Don't know
88. Harm to spouse?	1 Yes	2 No	9 Don't know
89. Harm to family?	1 Yes	2 No	9 Don't know
90. Harm to society?	1 Yes	2 No	9 Don't know
91. Harm to other (Specify) _____	1 Yes	2 No	9 Don't know

92. Does the article mention extreme cases of PPD (e.g., Yates)?

1 Yes	2 No	9 Don't know
-------	------	--------------

Section 9

What is the role of medical professionals in PPD?

Does the article recommend proactive intervention such as
Screening...

93. for new mothers?	1 Yes	2 No	9 Don't know
94. for new fathers?	1 Yes	2 No	9 Don't know

Educating...

95. Mothers?	1 Yes	2 No	9 Don't know
96. Fathers?	1 Yes	2 No	9 Don't know
97. Health care professionals? (Specify) _____	1 Yes	2 No	9 Don't know

Support

98. for new mothers?	1 Yes	2 No	9 Don't know
99. for new fathers?	1 Yes	2 No	9 Don't know
100. for health care professionals?	1 Yes	2 No	9 Don't know

Comments about the article or selected quotes:

Appendix B

Edinburgh Postnatal Depression Scale (EPDS)

Taken from the British Journal of Psychiatry June, 1987, Vol. 150 by J.L. Cox, J.M.

Holden, R. Sagovsky

(In www.childbirthsolutions.com)

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

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

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

Instructions for users:

1. The mother is asked to underline the response which comes closest to how she has been feeling in the previous 7 days.
2. All ten items must be completed.

3. Care should be taken to avoid the possibility of the mother discussing her answers with others.
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.
5. The EPDS may be used at 6-8 weeks to screen postnatal women. The child health clinic, postnatal check-up or a home visit may provide suitable opportunities for its completion.

Name: _____

Address: _____

Baby's Age: _____

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

1. I have been able to laugh and see the funny side of things.
 - As much as I always could
 - Not quite so much now
 - Definitely not so much now
 - Not at all
2. I have looked forward with enjoyment to things.
 - As much as I ever did
 - Rather less than I used to
 - Definitely less than I used to
 - Hardly at all
3. * I have blamed myself unnecessarily when things went wrong.
 - Yes, most of the time
 - Yes, some of the time
 - Not very often
 - No, never
4. I have been anxious or worried for no good reason.
 - No, not at all
 - Hardly ever
 - Yes, sometimes
 - Yes, very often
5. * I have felt scared or panicky for not very good reason.

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

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

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

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

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

8. * I have felt sad or miserable.

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

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

Yes, most of the time
 Yes, quite often
 Only occasionally
 No, never

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

Yes, quite often
 Sometimes
 Hardly ever
 Never

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

Appendix C

Beck Depression Inventory (BDI)

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

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

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

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

	2 I get tired from doing almost anything. 3 I am too tired to do anything.		to be. 2 I am much less interested in sex now. 3 I have lost interested in sex completely.
18	0 My appetite is no worse than usual. 1 My appetite is not as good as it used to be. 2 My appetite is much worse now. 3 I have no appetite at all anymore.		

SCORING

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

11 – 16: Mild mood disturbance

17 – 20: Borderline clinical depression

21 – 30: Moderate depression

31 – 40: Severe depression

over 40: **Extreme depression**

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