

POSTPARTUM MOOD DISORDERS: A FEMINIST CRITIQUE

with specific reference to postnatal depression

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DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and has not previously in its entirety or in part been submitted at any university for a degree.

ABSTRACT

This review examines the medical model's conceptualisation of postnatal depression (PND) from a feminist perspective. The arguments are fourfold: Firstly, it argues that the fundamental problem underlying the concept of PND is its conception as existing on a continuum with psychosis at the most severe end and maternity blues at the least severe end. The link with psychosis implies that it is potentially pathological requiring medical and psychiatric intervention. On the other hand its link with maternity blues gives scientific credence to continued research on emotional sequelae of reproduction that are below the psychiatric threshold of urgency. Secondly, the medical model's construction of PND implies that women are predisposed to mental illness because of their ability to bear children and thus pathologises normal experiences of childbirth. Thirdly, the medical model's preoccupation with classification and categorisation has become little more than an exercise in labeling that has removed women from their own experiences. Focusing on birth as an activity that is separate from the rest of pregnancy objectify women and ignores the socio-political context within which they give birth and care for their infants. Fourthly, it is argued that a different way of researching postpartum mood disorders is necessary to overcome a reductionistic and pathological model of childbirth. This is important if healthcare delivery hopes to provide adequate treatment for all women in the postnatal period. Especially in South Africa, where the dominant culture has for many years defined the experiences of the 'other', it is important to generate research that should include the 'voices' of the 'other' to prevent hegemonic practice from assuming an expert understanding of PND. This review does not deny the contributions from the medical establishment, but argues that a critique of its underlying assumptions is important to prevent women from being further marginalised by ignoring the socio-political context in which their lives are embedded. The implications for research within South Africa are also addressed.

OPSOMMING

Hierdie oorsig ondersoek die mediese model se konseptualisering van postnatale depressie vanuit 'n feministiese perspektief. Die argument is vierledig: Eerstens blyk die konseptualisering van postnatale depressie, naamlik dat dit op 'n kontinuum bestaan, met psigose aan die mees disfunsionele kant en 'maternity blues' aan die minder ernstige kant, 'n fundamentele, onderliggende probleem te wees. Die verband met psigose impliseer dat postnatale depressie potensieel patologies is en mediese en psigiatriese insette benodig. Die verband met 'maternity blues' aan die ander kant, bied wetenskaplike begroning vir volgehoue navorsing op die gebied van emosionele aspekte van kindergeboorte wat nie van psigiatriese belang is nie. Tweedens impliseer die mediese model se konstruksie van postnatale depressie dat vroue 'n predisposisie tot geestesiektes het bloot deur die feit dat hulle die vermoë het om kinders voort te bring. Sodoende word patologiese kenmerke gekoppel aan normale ervarings van kindergeboorte. Derdens het die mediese model se beheptheid met klassifikasie en kategorisering verval in etikettering wat vroue van hul eie ervarings vervreem. Deur te fokus op geboorte as 'n aktiwiteit wat verwyder is van die res van swangerskap maak van vroue objekte wat verwyderd is van die sosio-politieke konteks waarbinne hulle geboorte skenk en sorg vir hul babas. Vierdens word dit beredeneer dat 'n nuwe benadering tot navorsing oor postpartum gemoedsteurings daar gestel behoort te word om 'n reduksionistiese en patologiese model van kindergeboorte te voorkom. Dit is belangrik as gesondheidsorgdienste hoop om toereikende behandeling te bied vir alle vroue in die postnatale periode. Veral in Suid-Afrika, waar 'n dominante kultuurgroep vir so lank die ervarings van ander omskryf het, is dit belangrik om navorsing voort te bring wat die 'stemme' van die 'ander' insluit om sodoende te verhoed dat die heersende praktykvoeringe van die dag 'n eensydige deskundige-verstaan van postnatale depressie voorveronderstel. Hierdie oorsig ontken nie die bydraes van die mediese model nie, maar beredeneer die feit dat 'n kritiese beskouing van die onderliggende aannames belangrik is om sodoende te verhoed dat vroue verder gemarginaliseer word deurdat die sosio-politieke konteks waarin hul lewens gegrond is, buite rekening gelaat word. Die implikasies vir navorsing binne 'n Suid-Afrikaanse konteks word dus ook ondersoek.

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INTRODUCTION

Pregnancy, childbirth and motherhood are significant life events for the woman who decides to have children, and can be accompanied by diverse and complex emotions. Birth itself can be painful and difficult, sometimes resulting in physical damage to the body while physiological, psychological and emotional changes are intertwined with changes in interpersonal relationships and social status (Brockington, 1996; Nicolson, 1998; Oakley, 1980; Raphael-Leff, 1991). While many women may experience these changes as exciting and pleasurable, others may experience anxiety, uncertainty and emotional distress. Often a melange of contrasting emotions co-exist, with confusion, exhaustion and fear mixing with euphoria and excitement (Raphael-Leff, 1991; Rich, 1986). The diversity of emotional responses to childbirth and the potential consequences of these to both mother and baby have led to a conceptualisation of childbirth as a time of high-risk for women. This has positioned medical and psychiatric intervention as necessary to monitor the multitude of complications that may develop (Cooper & Murray, 1997; Oakley, 1980, 1986a; O'Hara, 1997; Ussher, 1989).

Postpartum mood disorders are a part of the spectrum of possible emotional complications that may occur after childbirth (Brockington, 1996) and include postpartum psychosis, maternity blues and post-natal depression (PND). These three conditions are posited to exist on a continuum with maternity blues on the less severe end and postpartum psychosis on the most severe end (Brockington, 1996; Cooper & Murray, 1997, 1998; O'Hara, 1997). Maternity blues and PND are considered some of the more common 'disorders' that can develop after childbirth (Brockington, 1996; O'Hara, 1997) and the high incidence¹ has often been taken as evidence for childbirth as requiring specialised monitoring. While the painful effects and possible consequences on child development are not disputed, this view has resulted in a conceptualisation of childbirth as potentially pathological, marred by abnormal mood states and hampering the mother in her role as provider, nurturer and caregiver.

Although pregnancy and especially emotional complications after pregnancy have been the focus of study since the 4th century BC, the last 50 years have seen a prolific increase in research in this area. Between 1980 and 1990, more than 100 studies focused on postnatal depression alone (Whiffen, 1992). A search on PsychInfo, covering the period of 1977 to 2002 showed 81 studies on the category *puerperal*

psychosis, 97 on *postpartum psychosis* and 562 on *postnatal depression*. Similarly, a search on Medline from 1980 to 2002 showed 75 studies on *postpartum psychosis*, 85 on *puerperal psychosis* and over 350 on *postnatal depression*. This excludes the many books published on this topic. Interestingly, apart from a few critical studies that used a feminist approach (see Mauthner, 1998; Nicolson, 1998; Oakley, 1979) the medical and psychological studies hardly differ in their views of how PND is constructed, discussed and researched. In general, the only notable difference was that the medical research focused more on symptoms and aetiology whereas the psychological studies focused on psychosocial variables². Where the former is part of the biomedical model, the latter is part of the biopsychosocial model, but both are embedded within the positivistic paradigm³.

Postnatal depression (PND) has thus been widely discussed in the literature and a multitude of theories and explanations for its existence have been posited both from within and outside the medical model. This review will examine the themes regarding the conceptualisation of PND within mainstream literature. It seems that the current disagreements and confusions regarding PND revolve around its conceptualisation within the medical model as part of a continuum of mood disorders, with puerperal psychosis at the most severe end and maternity blues at its least severe end. This construction positions PND as a homogenous condition, with a specific pattern of onset, severity and symptoms. It also posits a model of causation based on these findings. Yet, the findings to date have been confusing at best, inconclusive and confounding at worst. At present, despite the numerous studies and abundant data, there has been little progress in the explanation of why women become depressed after childbirth (Brockington, 1996; Nicolson, 1998; Oakley, 1980, 1986a; Whiffen, 1992).

Regardless of the lack of a scientific model for PND, an implicit model has developed, based mainly on a hormonal or biological understanding. In those studies where social factors were acknowledged they were added to the biological hypothesis (Nicolson, 1998). This tension between scientific 'proof' (or the lack thereof) on the one hand and the implicit model on the other is clearly evident in the literature. For example, research to date has found no consistency regarding time of onset, duration or symptom pattern for PND. Yet it is implicitly understood to be similar to depression occurring at other times, with onset around 1 to 3 months after birth, and

duration between 3 to 6 months. The tension between an implicit and scientific understanding also results in contradictions within the medical model. For example, most researchers within the medical paradigm propose a biological hypothesis, and argue that PND is thus specific to childbearing, with a distinct nosology. But as yet, it has not been included in the American Psychiatric Association's (APA) fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (henceforth DSM-IV), since no scientific 'proof' has been found for its existence as a separate disorder.

This literature review will examine the continuum of postpartum mood 'disorders', with a particular focus on postnatal depression as an emotional reaction to childbirth. This conceptualisation of emotional distress as existing on a continuum is examined from a feminist and more specifically, a poststructuralist perspective. It is thus necessary to briefly state the theoretical assumptions underlying this approach.

A feminist perspective

According to Mitchell and Oakley (1986), feminism has shifted dramatically over the last century to the point where it actually becomes difficult to talk about feminism as a concept at all. While the feminist movement was at first a 'movement' focusing on 'gender issues' and the 'elimination of gender roles', the role and voice of feminism has shifted and become more complex. It seems that the political and social changes lobbied for by feminists have in the process also changed the nature of feminism. Delmar (1986) argues that it is more accurate to speak of a "plurality of feminisms" (p. 9) and therefore cannot be defined as a unitary, clearly defined movement with goals and objectives. Feminism is thus a continually shifting voice, incorporating a variety of views and orientations. Juliet Mitchell and Anne Oakley (1986) devoted a book to the question *What is Feminism?* They argue:

At the start of organised feminism [in the early 20th century] women believed they shared the same situation; yet, as they learnt to speak about it, they fast discovered their differences from one another ... Can feminism be defined simply by virtue of its object of concern – women? Is it not feminist to profess an interest in human welfare more generally? (p. 3)

Sue Wilkinson, one of the first feminists to write and formulate what a feminist psychology might entail argues that it is not enough simply to research women as an object of concern (Wilkinson, 1996). She argues that many researchers who work in

areas termed 'women's issues' have no interest in feminism whatsoever, and may even participate in reproducing and sustaining the status quo. Furthermore, the terms 'feminist (social) psychology' and 'psychology of women' are often used interchangeably, but this does not necessarily mean that the intent of their inquiry is feminist in nature. A feminist inquiry therefore has a specific social and political agenda:

Those who call themselves 'feminist social psychologists' often set out explicitly to differentiate themselves from the anodyne and acceptable face of 'psychology of women'. We use the term 'feminist' specifically to highlight the political aspects of our work. Feminist social psychologies (sic) challenge the discipline of psychology for its inadequate and damaging theories about women, and for its failure to see power relations as central to social life. (Wilkinson, 1996, p. 3)

Although feminism can be seen as a plurality of views and orientations as Delmar (1986) has argued, other authors, such as Ussher (1991) and Wilkinson (1996) argue that common themes can be identified.

- 1) Feminism places a high value on women and considers them worthy of study in their own right.
- 2) Feminism recognises the need for social change on behalf of women and thus has a clear political and ideological agenda and they make this agenda evident in their work.
- 3) Feminists acknowledge the power of psychology as a discipline to shape everyday understandings that has real, material effects on people's lives.
- 4) Feminists attempt to make visible how power relations oppress, pathologise and marginalise women's status in society and are therefore intent on showing how psychology as an individualising science can affect and further disempower women.

Feminist inquiry thus involves the critical study of women, with a broader social change strategy as its aim. It focuses on the social and political oppression of women and tries to change the status quo through rigorous academic research and political advocacy. It therefore overlaps in important ways with other ethnological traditions that adhere to postmodern and deconstructionist theories which examine the ideological, ontological and epistemological basis of claims to 'truth' (Burman &

Parker, 1993; Burr, 1995; Busfield, 1996; Parker, 1992; Ussher, 1991). It attempts, through the deconstruction of positivist ideas such as 'objectivity' and 'rationality', to show how ideology and power intersect and influence race, class and gender to shape notions of 'other' that have become reified as truths (Burman & Parker, 1993; Busfield, 1996; Foucault, 1972).

Poststructuralist feminists therefore argue that concepts such as 'women', 'motherhood' and 'childbirth' are socially constructed through multiple layers of discourses that embody political, social and deeply personal meanings (Burr, 1995; Nicolson, 1998; Ussher, 1989). These layers are built up historically and become embedded in our world-view. They intertwine, contest and complement each other and intersect at a nexus that collectively define 'women's experience'. Feminist research attempts to explore and unravel these processes and show how it affects the lives of women. This is especially true in the case of PND, where the medical paradigm has become the dominant discourse to understand and explain issues around women's reproductive health.

Aims of the review

This study therefore aims to critically discuss the dominant conceptualisations of postpartum mood disorders from a feminist perspective. Firstly, it will examine the current mainstream literature regarding the spectrum of postpartum mood disorders, namely postpartum psychosis, maternity blues and postnatal depression. Secondly, each chapter will highlight the issues related to its conceptualisation followed by a critical analysis of each. Lastly, the political and ideological issues underlying these current conceptualisations are explored. While postpartum psychosis and maternity blues are not the focus of this review, they have been included to show that the ideological and political issues are not particular to any condition but pervasive throughout the entire spectrum of proposed disorders in the postpartum period. It is also explored whether this proposed continuum is a valid concept for understanding postpartum distress. It is hoped that the reader will have a sense of the research findings from both paradigms with the major agreements, contradictions and gaps within each. The aim is to facilitate a dialogue between the different paradigms, not only to increase our understanding of women's reproductive experiences, but also to encourage more appropriate research in this area.

However, while a feminist analysis problematises the current conceptualisation of postpartum mood disorders on every level, it does not deny that emotional distress in the postnatal period is debilitating and an issue of concern. In fact, it agrees with the medical paradigm that women's distress in the postnatal period should be examined, but it is critical of the way in which this has been done up to now. The medical paradigm has done much to give credence to women's distress, by providing a label – an explanatory model for understanding what is happening to them. However flawed these explanatory models might be theoretically and ideologically, they provide relief to women; they now have expert validation that their difficulties are not due to their own incompetence or inadequacy. This poses a problem to feminist critique: Using the terminology originating within the medical establishment also acknowledges and gives legitimacy to the medical model's theoretical underpinnings. However, refuting the terms deny women an explanatory model of their distress. Nicolson (1998) highlights this predicament:

When I was working on my thesis I rejected the term 'PND' because it implied that women's experience of depression at this stage of their lives was pathological and intrinsically linked to female biology (Nicolson, 1998). I argued ... that PND does not exist because depression following childbirth is a rational, predictable and healthy response to loss. However, taking this position risks further marginalising the evidence of women's experience of the transition to motherhood and associated emotional responses. Recognition of this risk led me to use the term 'PND' to describe the focus of this work. This does not mean that my research and traditional approaches to the subject are entirely compatible: both are trying to make their own kind of sense of the same sets of behaviours and experiences. (p. 108)

Nicolson's predicament is also evident in this review in the use of terms such as 'disorder' and 'syndrome' thus making a brief discussion on terminology necessary.

Terminology

Language is the key-stone of poststructural theorists who argue that it is through language that 'the other' is constantly constructed and reconstructed. Language thus forms the basis for how we think, feel and understand the world (Burr, 1995; Foucault, 1972; Parker, 1992). The way terms are used is thus a very important aspect

of this review. Terms such as 'disorder', 'diagnosis' or 'illness' have specific connotations and meanings that are particular to the medical paradigm. Therefore some distinction is made in the text between medical labels and my own attempt to describe the phenomenon. When mainstream texts are discussed, mainstream terminology is used, but without capital letters (as a way of resisting formal labeling). When terms with a particular meaning within the medical model are used outside this context, it is placed in single quotation marks to highlight that the underlying meaning is not implied, while double quotation marks are used for direct quotes only. Medical terms or official diagnostic labels are printed in Italics for the first time, and thereafter without. However, the terms 'postnatal', 'postpartum', 'puerperal', and 'puerperium', although part of medical discourse, signify a time frame rather than a definition in relation to childbirth, and are used without single quotation marks. Also, where original arguments are proposed, scientific labels are avoided and instead replaced by more broader (and thus more vague) terminology such as 'emotional distress', 'postnatal distress' or 'emotional difficulty' in contrast to 'mental illness', 'illness', 'disorder' or other terminology based within the medical context. At times the word 'disorder' is used with single quotation marks when its implied meaning is questioned in that particular context. Words such as 'syndrome' and 'condition' are used without single quotation marks since they are more general terms that do not have specific meanings within the medical model. The terms 'paradigm' and 'model' are used interchangeably although they refer to two different concepts. In addition, the terms 'social constructionism', 'poststructuralism' and 'postmodernism', although suggesting slightly different aspects of the same paradigm are alternated in the text.

While this review connects with many other larger philosophic issues such as the assumptions embedded in positivist research versus postmodern approaches, certain delimitations were necessary to maintain the focus of discussion.

Delimitations

This review focuses specifically on issues regarding the conceptualisation of postpartum mood disorders and therefore does not include an exhaustive review of every aspect related to these conditions. For this reason, methodology, research designs and treatments are not examined in-depth, but only briefly discussed as it pertains to the main argument. Also, statistical significance levels (p-values),

statistical differences (r-and t-values) and sample sizes are only mentioned where they are directly relevant to the argument. The larger debate regarding the assumptions embedded in positivist science is also not explored, but briefly mentioned in footnotes where appropriate. Moreover, the full extent of feminist research on emotional distress during the postpartum period is not examined but only those main aspects that highlight the issues regarding the conceptualisation of PND. There are also many other important areas that intersect with this review that cannot be ignored, but will only be mentioned in brief.

Busfield (1996), Showalter (1987) and Ussher (1989) argue that a historical understanding of women's reproduction necessitates an examination of the history of women itself. Giving birth is the one accomplishment reserved for women and has become a nexus for the larger debates on gender and sex differences. These debates are often located in biological or social factors, but the broader historical processes whereby 'men' and 'women' became defined and contested as separate entities are less often examined in studies on childbirth and the postnatal period. According to Raphael-Leff (1991) women midwives, wise women and birth attendants oversaw the birth process and provided postnatal care for centuries. It was only in the 17th century with the development of the forceps that male midwifery became elevated into a medical profession. This process whereby control was wrestled from these female midwives and placed into the hands of male obstetricians is often discussed in the literature as the medicalisation of reproduction, but the underlying economic advantages to medicine is less often examined. Postnatal experiences, as part of the larger debate on reproduction, thus cannot be separated from the broader economic and political struggles and to do so is to strip women's reproduction from its historical context and reinforce the notion that it is a medical event. However, it is not possible to give adequate attention to all these factors in this review.

Apart from this conceptual separation of reproduction from the broader historical context, both medical and feminist researchers have also separated the mother from her infant. Most studies examine the postnatal period with very little attention given to the mother-infant dyad. It is certain that this 'fit' between mother and baby is also of importance. For example, infants who are physically ill, deformed or temperamentally very different to the mother, can influence the mother's postnatal experience but this has not been mentioned in any of the studies that examined postpartum mood

disorders. Unfortunately the possible reasons for this and the impact on women's reproductive experiences cannot be entertained in this review. In addition, different cultures understand childbirth and the postnatal period in very different ways and have developed intricate rituals to signify this event (Raphael-Leff, 1991). The way cultural rituals may mediate postpartum distress is an important aspect in the examination of PND but has not been entertained in this review. These delimitations, although not ideal, were important to maintain the coherence and focus of the argument given the vast and conflicting body of literature.

Outline of the review

As the previous section has shown, only those aspects that are related to the conceptualisation of postpartum mood disorders, with a particular focus on PND, will be examined.

Literature was obtained from the main medical and psychological databases such as PsychInfo and Medline. Unpublished doctoral and masters theses on the same topic completed in South Africa were obtained from local library databases such as PsychInfo and Nexus. There are at present many texts, both academic and popular on PND and this review has limited itself to academic journals and books. These books usually contain excellent reviews of the literature and reference will be made to the conclusions drawn from these texts, while at other times individual articles will be cited. Individual studies are cited to draw attention to the diversity of arguments while conclusive statements from other reviews are sometimes used to summarise the main findings on a mass of literature.

A personal note of reflection: While reading the text, the reader may be left with a sense of frustration due to the inconclusiveness of the findings and lack of agreement between studies, which makes it difficult to 'make sense' of the literature. This also mirrors my own experience of reading the medical texts. One review may only mention the literature to prove a certain finding, while another cited another set of texts to prove the opposite. At times, it seemed as if more studies did not clarify the position but merely added to the confusion. The balance between critique and review is thus a precarious one and part of the frustration encountered may be a result of an attempt to strike such a balance.

Chapter 1 briefly examines how female reproduction was viewed historically and contextualises the current conceptualisation of PND within a historical framework. The historical review will show how PND came to be positioned between puerperal psychosis and maternity blues and separated by variations in onset, duration and severity. It also forms the basis for exploring how these historical notions have endured in research on postpartum mood disorders.

Chapter 2 will review medical literature on postnatal psychosis. Since postpartum psychosis is not the primary focus of this review, only the main aspects related to its definition and aetiology will be discussed. The relationship between childbirth and mental illness will also be critically examined.

Chapters 3 and 4 will examine maternity blues and PND respectively. Each chapter will be organised in terms of the clinical picture and methodology, followed by a discussion of the different conceptualisations that have been proposed for their development. Lastly, these conceptualisations will be critically examined from a feminist perspective.

Finally, the conclusion will briefly set out the main arguments of this review together with the implications for research, particularly in relation to South Africa.

In the spirit of feminism this review attempts, not only to give credence to the material consequences of ideology, but also to effect political change by changing dominant notions of women in general. It is hoped that this will lead to a different approach to service delivery for women's healthcare in all areas of women's health, not only PND.

CHAPTER 1

**HISTORICAL OVERVIEW: CHILDBIRTH, MADNESS AND THE
CONSTRUCTION OF WOMEN**

Women become insane during pregnancy, after parturition, during lactation; at the age when the catemania (menstruation) first appear and when they disappear ... the sympathetic connection between the brain and the uterus is plainly seen by the most casual observer.

(Blandford, 1871, in Ussher, 1989, p. 5)

Feminist researchers assert that childbirth is not just a biological or medical event, but also a significant social event (Nicolson, 1998; Oakley, 1980; Raphael-Leff, 1991). Postmodern feminists argue that concepts such as 'childbirth' and 'motherhood' have been socially constructed through multiple layers of discourses that over time have become reified as 'truths' about women and their experiences (Burr, 1995; Nicolson, 1992; Oakley, 1986b; Ussher, 1989; Woollett & Marshall, 2000; see also Foucault, 1972). Especially in relation to pregnancy and childbirth these historical layers of experience have become blueprints for women to understand themselves and their experiences within society. These beliefs will necessarily differ in different societies and cultures (Raphael-Leff, 1991) and it should be noted that this review focuses mainly on a world-view propagated by western societies. Nevertheless, poststructuralist feminist researchers argue that these underlying assumptions about women and their reproductive experiences are pervasive throughout western society and has influenced how women and their reproductive concerns have been researched, conceptualised and understood through historical time (Burr, 1995; Nicolson, 1992; Oakley, 1986b; Ussher, 1989; Woollett & Marshall, 2000). A historical analysis of the way women's experiences have been understood in the past, thus yields some pointers towards the development of current constructions. Furthermore, it also provides insight into the underlying mechanisms involved in such constructions. This chapter will therefore examine how complications during childbirth were constructed as 'madness' or 'illness' and how childbirth came to be understood as a potentially pathological process that needs medical and at times psychiatric intervention.

The medical model: women's reactions to childbirth

Many studies from both the medical and feminist arena have described the multitude of emotional states that can be experienced during childbirth (Brockington, 1996; Nicolson, 1998; Oakley, 1971; 1980; 1986a; Raphael-Leff, 199; Rich, 1986). These can include relief, exhaustion, fear, joy, excitement, bewilderment, loss and confusion. Nevertheless, most women negotiate the birth process with little recourse to psychiatric intervention. However, the historical accounts of women's distress during and after childbirth have implications for how women understand their experiences today. It also has wider implications in terms of how women's reproduction has become linked to mental illness. A historical account from the medical paradigm is thus an important starting point to frame a feminist discussion on pregnancy and its aftermath.

Brockington (1996), a psychiatrist and researcher working in the field of pregnancy and childbirth, has written a comprehensive account of the multitude of disorders described in the historical literature.⁴ He mentioned about 20 postpartum disorders that included, among others, '*confusional states*', '*stupor*', '*delirium*', '*puerperal panic*', '*posttraumatic stress disorder*', and '*puerperal psychosis*'. A brief summary of his intriguing and comprehensive historical review follows.

1. Painful and traumatic reactions to childbirth

The majority of early presentations of puerperal mental illness were connected with painful and traumatic childbirth. Jeffery (1839, in Brockington, 1996) recounted the tale of a woman who became delirious after a five-day labour and "who continued to rave (sic) for two days thereafter" (p.139). In another example a 19 year-old woman gave birth to a boy after a 12-hour labour with contractions so intense that she was in a coma for 25 minutes after delivery. For other women the period of delivery lasted up to several days. This state of exhaustion and confusion (termed '*stupor*' in the early literature) after childbirth was commonly reported in the 19th century and Churchill named it *paraphrosyne puerperarum* which literally meant "being out of one's wits" (Churchill, 1851, in Brockington 1996, p. 141).

Others suffered symptoms closely related to present-day posttraumatic stress disorder (PTSD) with recurrent nightmares followed by "melancholy-stupor" (Savage, 1875, in

Brockington, 1996, p. 153). *Querulant disorder*, a case of “pathological complaining” (Brockington, p. 154) was sometimes associated with *Post-traumatic Stress Disorder* (PTSD) when newly delivered mothers became angry and ‘difficult’ with hospital staff and nurses. Their behaviour included threats of violence to the doctors and midwives or towards the hospital. Brockington (1996) described the ‘clinical picture’⁵ as such:

The substance of the complaints varied, but inadequate pain relief is the focus.... ‘Dehumanisation’ (sic) and ‘humiliation’ (sic) by procedures, which involved the most intimate parts of the woman’s body were often mentioned. In reaction to these offences, some mothers confined themselves to bitter verbal or written criticism, but others expressed fantasies of vengeance. (p. 155)

2. Complicated obstetrics

Other descriptions revolved around infections and complicated obstetrics. Infective delirium, for example, was noted as early as the 4th century BC Hippocrates was known to write about the clinical syndrome of “confusion, delirium, hallucinations and insomnia arising in the newly delivered mother” (Attia et al., 1999, p. 99; Brockington, 1996). As early as 1809 Burns (1809, in Brockington, 1996) tried to differentiate between infective delirium and puerperal mania (i.e. mania in the absence of organic⁶ complications). Brockington (1996) mentions that this is, at times, still the case. He summarises the clinical picture as follows:

In fulminating metritis one finds abdominal pain, constipation, rigors, intense fever and sweating; the severity of the mental disorder is proportional to the height of the fever. Convulsions begin after a few days, and there is rapid progression to coma, with death in 10-15 days. In puerperal mania, there is no fever or sweating, and the duration is measured in months. (p. 146)

He adds that the mistaken diagnosis in the past exaggerated the mortality rates of puerperal mania, since many of those who died were actually suffering from acute infections. However, Ur-Rehman, St Clair, and Platz (1990) compared the psychiatric case registers of a 19th century and 20th century population in Edinburgh and found that the prevalence of puerperal psychosis remained the same over the two centuries despite the advances made in medicine over the same period. They did find, however, that the intensity of the psychosis differed for the two populations.

Eclampsia was one of the feared obstetric complications and refers to convulsions around the time of delivery. It was considered relatively rare, occurring in 1/500 births (Spiegelberg, 1888, in Brockington, 1996) often resulting in post-eclamptic psychosis. It was believed that eclampsia was *the* cause of puerperal psychosis in the 19th century. It took the form of mania, depressive ‘stupor’ or melancholia. Brockington (1996) summarises the descriptions in the literature:

In most cases it took the form of an acute organic syndrome, with disorientation, and visual and auditory hallucinations, sometimes accompanied by delusions. Most patients were restless and some highly excited and in this respect their ravings resembled patients with puerperal psychosis. (p. 142)

3. Depressive reactions to childbirth

Whilst these examples described only the most severe cases, Brockington likened some of the milder presentations of psychiatric complications to maternity blues. He describe the clinical syndrome as milder, less severe and “taking the form of cognitive impairment, confusion, diminished mental functioning, an inability to sustain attention and poor recent memory” (Brockington, 1996, p.140). Where puerperal psychosis was easily identified, albeit confused with other organic states, this was less so with milder manifestations of puerperal distress.

The cause of these early puerperal confusional states is unknown. One cannot invoke infection in the absence of any signs of sepsis. One cannot attribute to them extreme pain, as in labour. The cause is a mystery. (Brockington, p.141)

Furthermore, the symptoms of exhaustion and cognitive impairment were seen as milder versions of catatonic unresponsiveness and delirium, leading to a confusion of clinical descriptions and diagnoses. Milder presentations were thus either ignored or presented as lesser versions of puerperal psychosis. *Melancholia*, the name given to severe depression in the early descriptions on mental illness, is an example of such a diagnosis.

According to Brockington the first case of postnatal depression, then termed *melancholia*, was recorded in 1551. It is difficult to underpin the significant features of melancholia as presented by Brockington since the early descriptions mirrored the descriptions of organic disorders such as infective delirium and eclampsia. Others resembled catatonia and mania. It is thus difficult to talk about postnatal depression in

these cases and they seem more akin to severe bipolar disorders or depression with psychotic features (Brockington, 1996; Kendell, Chalmers, & Platz, 1987; Meltzer & Kumar, 1985). These cases often involved suicide or attempted suicide of the mother that sometimes included the death of her infant. Bonnefous (1868, in Brockington, 1996) gave a case example of a woman who eventually tried to drown herself in the Seine:

A certain disorder of ideas followed her first delivery. They were more intense after her second, with incoherence, agitation and violence. After the third pregnancy she again became taciturn and eventually mute, was morose, and refused food. One day she suddenly tried to suffocate her two-year-old daughter, set fire to the house and disappeared: she was found in a cellar, her nightdress semi-burnt and bathing in a tub. Two days after the fourth delivery, she complained of insomnia and inexpressible sadness. She suddenly left her house, without any idea of what she was doing; she jumped into the water, 'weeping with joy at the sight of the river', because she was tormented with thirst. (p. 167)

The frequency of cases such as the one described above, is not clear, but it seems from Brockington's descriptions that they were noted for their severity and novelty value rather than for a need to develop a systematic understanding of mental illness associated with childbirth.

The medical model: diagnosis and treatment

Brockington's historical review showed mainly that older classifications of puerperal psychiatric complications were crude and focused largely on finding an organic aetiology. In addition, the tendency was to regard all puerperal mental illness as a unity and depression was not singled out as a separate disorder needing special treatment. Descriptions also highlighted oscillations between depression and mania, making identification of a unique syndrome difficult. According to Brockington, only the most severe cases received treatment, which meant little more than certification and removal to an asylum. This is in contrast to the feminist literature (see Ussher, 1989) discussed later in this chapter.

It will be shown that the current problem with the diagnosis of postnatal depression can be traced back to these historical roots. The same difficulties in identifying and describing the clinical syndrome are still evident today. The uncritical acceptance of responses to childbirth as pathological is also revealed, albeit implicitly. The striking feature of the case studies cited by Brockington is that they are reported without any reference to the context within which these women gave birth; their severe reactions to childbirth were assumed to be directly and causally related to the process of giving birth.

Feminist critiques: an alternative understanding

In contrast, Jane Ussher, a feminist researcher using a social constructionist approach, has written extensively about the conceptualisation of female reproduction within the medical paradigm. She argues that the uncritical acceptance of childbirth as pathological and marred by psychiatric complications is part of an ideology, rather than a scientific fact, that serves to subjugate women (Ussher, 1989). She forms part of a lineage of feminist authors who have critically examined the way the early medical descriptions located all women's madness, illness and deviant behaviour within the womb (Chesler, 1972/1997; Showalter, 1987; Ussher, 1991).

Women are treated for diseases of the stomach, liver, kidneys, heart, lungs etc.; yet in most instances, these diseases will be found on due investigation, to be, in reality, no diseases at all, but merely the sympathetic reactions or the symptoms of one disease, namely, a disease of the womb. (Direx, 1869, in Ussher, 1989, p. 4)

Hysteria, a Greek word for uterus, was a condition diagnosed mainly in women in the early 19th century, and was also directly related to an affliction of the womb. It was believed that the womb traveled through the body, acting as a sponge which drained the life or intellect of women, particularly those who did not exceed in their 'womanly duties' of child-rearing and domesticity (Ussher, 1991; 1992). Ussher argues that women's bodies were conceptualised within medical texts as sites of evil, degeneracy and illness; that women, due to their biology were in need of medical surveillance and treatment. *Hysteria*, rather than an illness, can be viewed as a way for women to express resistance to their oppression in an age that left them few alternatives (Chesler, 1972/1997; Showalter, 1987; Ussher, 1989, 1991). Although the focus of this review precludes an in-depth discussion of this argument, it is important to take

note of how historical views on women and their reproductive cycles inserted themselves into modern-day ideology.

Although Brockington does not discuss any treatments in his review, feminist authors, as part of their critique on the medical paradigm, have often cited case studies to show that treatments revealed deep-seated sexist views about women (Chesler, 1972/1997; Nicolson, 1992; Showalter, 1987; Ussher, 1989). These treatments make fascinating, if voyeuristic reading and were often brutal, involving lacerations or removal of the vulva, clitoris and/or the labia (Showalter, 1987; Ussher, 1989, 1992). Ussher (1991) uses these case reports as evidence to show that medical intervention was based on misogyny, or hatred of women, rather than science. She documents the comments of a famous gynecologist in the 1890s who advocated placing leeches on the vulva, or the neck of the uterus and cautioned the doctor to count them as they fell off, in case he loses some:

Certain adventurous leeches have been known to advance into the cervical cavity of the uterus itself. I think I have scarcely ever seen more acute pain than experienced by several of my patients under these circumstances. (Douglas Wood, 1973, in Ussher, 1989, p. 7)

The regime of treatments described by Ussher has clear political and ideological implications. They were randomly assigned to a wide variety of 'symptoms' from masturbation to 'being obstinate' or over-eating, and directed mostly against women who did not want to fulfil their domestic duties. When the divorce law came through in 1857, leeching of the vulva was prescribed as a cure for women who wanted to divorce their husbands (Showalter, 1987; Ussher, 1989, 1992).

Paradoxically, childbirth was also offered as a cure for women who did not want to fulfil their social and maternal role designated by Victorian society (Showalter, 1987). Yet, when these women became distressed as a result of childbirth (whatever the reason and life context) it was explained in terms of their faulty/diseased womb. The double-bind is therefore clear. Women are unable to escape the pathology of their nature: They are ill either because of their nature, or due to their resistance against their nature.

While the reality of distress during and after childbirth is not disputed, the way this distress has been conceptualised, understood and documented in the literature reveals a ideological bias that needs to be examined, as this has clearly impacted on modern-day constructions of women and their postnatal experiences.

Historical review: concluding comments

This chapter traced the historical literature regarding women's post-birth complications as cited in medical texts. This was explored from a feminist perspective to highlight how deep-seated assumptions about women have become part of the current understanding of postpartum distress. An historical review is therefore important for three reasons. Firstly, it shows that the classification of post-birth complications is a relatively recent phenomenon. Secondly, it shows how historical accounts mirror the current confusion regarding the conceptualisation of PND. Thirdly, it has shown how sexist views about women have been intrinsic to scientific practice in the past and has influenced how women's reproductive cycles have been understood and constructed within positivistic science. This historical account has also shown how childbirth became associated with mental illness and how this notion has prevailed and influenced current notions about childbirth and the puerperium.

The next chapter will briefly discuss puerperal psychosis as the most severe postpartum disorder that can occur during the postnatal period.

CHAPTER 2

POSTPARTUM PSYCHOSIS: BETWEEN PREGNANCY AND MADNESS

The chains removed from the insane by Pinel were reattached by the great psychiatric nosologists. To be sure, the new chains conformed to modern hygienic and humanitarian standards: they were not made of iron, but of words; their ostensible aim was not to imprison, but to cure. (Szasz, 1973, p. 212)

As the previous chapter has shown, a link between pregnancy and mental illness has been proposed since the 4th century BC. Whilst case reports and anecdotal descriptions of puerperal psychosis appeared in the literature for centuries, very little is actually known about this condition (Attia et al., 1999; Brockington, 1996; Meltzer & Kumar, 1985). The following section will review the literature pertaining to its definition and relationship to childbirth.

Clinical picture

Postpartum psychosis is located at the extreme end of the severity scale of postpartum mood disorders. Symptom presentation is usually acute and severe.

1. Onset

Onset of postpartum psychosis is reported to be between 1 and 6 weeks (Attia et al., 1999) although many authors reported that onset occurred within the first 2 weeks postpartum (Meltzer & Kumar, 1985; Terp & Mortensen, 1998).

2. Duration

The length of puerperal psychosis is reported to vary considerably. In some reports it is fleeting and self-resolving, while others reported cases where it lasted for months (Brockington, 1996; Steiner & Tam, 1999). Usually, due to modern medication, the psychosis lasts for no more than 3-4 days with in-patient treatment lasting about 4 weeks (Bagendahl-Strindlund & Ruppert, 1998; Brockington, 1996; Ur-Rehman et al., 1990). Ur-Rehman et al. (1990) found that the introduction of electroconvulsive

therapy (ECT) and the advancement of neuroleptic drugs in the 20th century have significantly shortened the duration of the symptoms and length of admissions compared to a 19th century sample.

3. Symptomatology

As was the case with onset and duration, the exact symptom pattern has also not been established. Postpartum psychosis is reported to be characterised by a mixture of delirium and psychosis with confusion, delusions and hallucinations (Attia et al., 1999; Brockington, 1996; Terp & Mortensen, 1998). Delusions can include thoughts of harming the baby and/or suicide and the risk of infanticide is thus high (Kaplan & Saddock, 1998; Steiner & Tam, 1999). Affective mood states, either manic or depressive with florid psychotic symptoms are often present. Many studies have reported symptoms that resemble those of acute organic brain syndrome⁷ which include confusion, distractibility, bewilderment, difficulty in concentrating, and delirium (Brockington, 1996; Ur-Rehman et al., 1990). This is similar to symptoms of psychosis with an organic⁸ origin and has led many researchers to claim that puerperal psychosis has a unique nosology and is thus different from psychosis observed at other times in the life-cycle (Attia et al., 1999; Brockington, 1996; Ur-Rehman et al., 1990). However, no study has been able to prove this and the debate continues (Meltzer & Kumar, 1985).

Nevertheless, the condition *puerperal psychosis* has been removed from the ninth revision of the International Classification of Diseases (henceforth ICD-9) on the grounds that psychosis occurring after childbirth cannot be distinguished from psychosis occurring at other times (Meltzer & Kumar, 1985). Similarly, specific diagnostic criteria are not included in the DSM-IV. Postpartum psychosis is therefore diagnosed as an episode of a mood disorder, usually depressive or bipolar with schizo-affective, delusional and anxiety disorders more rarely used as appropriate diagnoses (Kaplan & Saddock, 1998). However, a course specifier "*With Postpartum Onset*" has been introduced if the psychosis occurs in close temporal association with childbirth (APA, 1994, p. 155). Although 4 weeks postpartum has been specified in the DSM-IV, many authors have argued for an increased interval, ranging from 90 days (Kendell et al., 1987; O'Hara, 1997) to 6 months (Paffenberger, 1964, in Kendell et al., 1987). The diagnosis of "*Psychotic Disorder Not Otherwise Specified*" is made

when the symptom presentation does not clearly fit a specific diagnostic category (Kaplan & Saddock, 1998, p. 300).

4. Prevalence

Puerperal psychosis is thought to be rare and occurs in 1 or 2 cases per 1,000 births (Brockington, 1996; Kendell et al., 1987). Interestingly, this rate has been relatively stable for nearly two centuries despite the advances in science over the same period (Kendell et al., 1987). Furthermore, evidence suggests that the rates reported in different cultures are within the ranges reported in America and Europe (Attia et al., 1999; Brockington, 1996; Kumar, 1994). This suggests the possibility of an organic factor underlying postpartum psychosis (Kumar, 1994; Ur-Rehman et al., 1990).

Aetiology

While some researchers have argued for the existence of an underlying organic factor (Attia et al., 1999; Brockington, 1996; Kendell et al., 1987; Kendell, Rennie, Clarke, & Dean, 1981) others have found an association with psychosocial factors:

1. Obstetric and relationship factors

Kendell, Rennie, et al. (1981) and Kendell et al. (1987) found a link between postpartum psychosis and marital status (being divorced or widowed), having a first child (i.e. primigravid) and obstetrical complications. In contrast, Ur-Rehman et al. (1990) found a link with multigravid women but not with obstetric complications or primigravid women. An earlier finding claimed a link between puerperal psychosis and caesarian section but this was not found in a later study with a larger sample size (Kendell et al., 1987; Kendell, Rennie, et al., 1981).

2. Life events

In a study that controlled for parity, Dowlatshahi and Paykel (1990) found no significant differences in life events between two demographically matched groups, one suffering from postpartum psychosis and another symptom-free postpartum group.

3. Psychiatric history

The only consistent finding in the literature was having a family or personal history of psychiatric illness, especially a previous diagnosis of *Bipolar I or II* (Brockington, 1996; Kendell et al., 1987; Kendell, Rennie, et al., 1981; Meltzer & Kumar, 1985; Terp & Mortensen, 1998). It is argued that puerperal psychosis could be related to a distinct group of women suffering from manic-depressive illnesses, and are unrelated to schizophrenia or other depressive disorders⁹ (Brockington, 1996; Kendell et al., 1987; Meltzer & Kumar, 1985; Terp & Mortensen, 1998).

4. Biological hypothesis

The acute onset (about 2 weeks postpartum) of puerperal psychosis in women with previous psychiatric diagnosis of bipolar disorders have suggested a link with sudden changes in hormonal levels (Attia et al., 1999; Meltzer & Kumar, 1985). Strouse, Szuba, and Baxter (1992) have demonstrated how sleep deprivation triggered manic and hypomanic states in three women hospitalised for postpartum psychosis. Since sleep deprivation is a common phenomenon in new mothers during the postpartum period, and known to trigger manic episodes in vulnerable women, it has been postulated that postpartum psychosis could represent an underlying bipolar process (Strouse et al., 1992).

Regardless of the multitude of studies, researchers have not been able to establish if puerperal psychosis occurs due to biological or psychosocial factors. Attia et al. (1999) assert that as yet, not enough is known about puerperal psychosis to make any inferences regarding aetiology. Therefore, given the conflicting research findings on both psychosocial and biological variables, most authors have opted for a multiple aetiological hypothesis, where the interplay between psychological, genetic and social factors are thought to contribute to the presentation of postpartum psychosis (Attia et al., 1999; O'Hara, 1997).

Specificity to childbirth

Regardless of aetiology, many authors have argued that childbirth place women at an increased risk for serious mental illness. Kendell et al. (1987) found that women were almost 30 times more likely to be hospitalised for a psychotic episode in the first 30 days after delivery than at any other time in their life cycle. However, Terp and

Mortensen (1998) replicated this study and found that the rate of relative risk in their population was 10 times lower than found in Kendell et al.'s study. They found a much lower rate of readmission in postpartum women when compared to non-childbearing women with a previous diagnosis of *Schizophrenia* and bipolar disorders. They argue that childbirth could actually be a protective factor for women with a vulnerability to psychiatric illnesses. They therefore conclude that the risk of admission to a psychiatric institution following childbirth might be much lower than previously proposed.

Whilst some researchers have argued that the unique nature of puerperal psychosis suggested an aetiological link between childbirth and mental illness (Brockington, 1996), others have stated unequivocally that there was nothing unique about psychosis associated with childbearing (Strecker & Ebaugh, 1924, in Attia et al., 1999). Although some credence can be given to a hormonal hypothesis for puerperal psychosis, there is little evidence to explain *how* hormones are involved (O'Hara, 1997). More recently, researchers have argued that the nosology of puerperal mental illness is not yet known. Since it occurred close to childbirth, it was assumed to be the result of childbirth and therefore not systematically studied (Steiner & Tam, 1999). More research is thus necessary to distinguish puerperal mental illness from those occurring at other times in the life cycle.

Puerperal psychosis: concluding comments

This chapter examined postpartum psychosis as a condition on the most severe end of the continuum of postpartum mood disorders. Issues regarding clinical picture and aetiology were examined as well as the literature regarding the specific relationship between childbirth and psychosis. The following points emerge from this discussion.

Firstly, it seems that many studies on puerperal psychosis have uncritically assumed a biological (i.e. hormonal) aetiology despite the lack of evidence to prove such claims. Interestingly, these arguments are also currently used in medical explanations of premenstrual syndrome and menopause (Nicolson, 1992, 1998; O'Hara, 1997; Ussher, 1989, 1991, 1992; Yalom, Lunde, Moos, & Hamburg, 1968). Scientific claims for a hormonal aetiology underlying women's reproduction form part of powerful discourses about women and imply what Nicolson (1998) and Ussher (1989) termed

the 'raging hormones' theory. Although used in a variety of medical contexts to explain vastly different medical problems related to women's health, these discourses serve the same ideological function: It maintains the implicit assumption that women's hormones are essentially 'out of control' and the basis of emotional instability (Nicolson, 1992, 1998; Ussher, 1989, 1992).

Secondly, although puerperal psychosis has been shown to be a relatively rare condition, afflicting only one or two per thousand, it has been researched extensively, and often used as 'proof' that childbirth is a dangerous endeavor that needs continuous monitoring. More significantly, it also implies that childbirth predisposes women to mental illness.

Thirdly, it has been shown that the diagnostic nosology of postpartum psychosis varies considerably between studies and it has not been easy to differentiate adequately between psychotic and non-psychotic affective disorders in the puerperium (Attia et al., 1999). It is also difficult to establish if and how these conditions differ from psychosis at other times in a woman's life. Many authors argue that the nosology of postpartum psychosis needs to be studied as the phenomenology, comorbidity and other life events have not been adequately circumscribed in the literature (Attia et al., 1999; O'Hara, 1997). Yet, the implicit discourse of childbirth as somehow directly responsible for puerperal psychosis is still propagated.

Most importantly, it seems that psychiatry in particular, and medicine in general, have ignored the voices of women themselves; not just the phenomenology of their illness, but also the phenomenology of their lives. What factors do these women themselves regard as contributing to their inability to cope? Are these women defective, mentally ill and deviant due to their ability to bear children or are they being constructed as such through scientific eyes? (Ussher, 1989).

These questions are not limited to postpartum psychosis and become more important as this review ventures into areas of lesser postpartum emotional distress, such as maternity blues and postpartum depression. The next chapter will examine the less extreme end of the continuum of emotional distress after childbirth, namely maternity blues.

CHAPTER 3

MATERNITY BLUES: IN SEARCH OF A DEFINITION

It's always been classier, and a lot more dignified, to be a woman than a female. Thanks to 30 years of feminist striving, the category 'woman' has expanded to include anchorpersons, soccer moms, astronauts, fire fighters, even the occasional Senator or Secretary of State. But 'female' still tends to connote the oozing, bleeding, swelling, hot-flashing, swamp-creature side of the species, its tiny brain marinating in the primal hormonal broth.

(Barbara Ehrenreich, 1999, in Kolk, Bekker & van Vliet, 1999, p. 5)

In contrast to postpartum psychosis, maternity blues is positioned at the least extreme end of postpartum distress. Its link with psychosis reveals a significant historical shift in thinking within psychiatry and needs to be mentioned in brief. While puerperal psychosis has been described and discussed in the literature for centuries, it is only in the 20th century that the focus of psychiatry shifted into areas where emotional sequelae do not warrant a psychiatric diagnosis.

This shift in thinking about emotional distress corresponds to what Miller and Rose (1986) termed the shift from "hard psychiatry" (ECT, surgery, drugs) to "soft psychiatry" (psychotherapy, therapeutic communities) (Miller & Rose, 1986, p. 2). Rose (1986) summarised the shift very eloquently:

It is increasingly in psychiatric and psychological terms that we think and talk about our personal unhappiness. Psychiatry provides us with the very terms in which our problems are constituted through its elaboration of the norms and images of healthy mental life, and its characterisation of the features of pathology. These enable us to identify what is unhealthy, to classify and measure the problem, and to construe it as remediable. Mental life is now a domain that can be comprehended through, and may be managed by, scientific expertise. (p. 43)

This historical progression in thinking, and new language to talk about emotional health corresponded with the advancements in all areas of science, including medicine

and psychiatry. Many authors have discussed the institutionalisation and medicalisation of previously defined social endeavors such as motherhood and childbirth as a consequence of these shifts (Brockington 1996; Miller & Rose, 1986; Oakley, 1979, 1980, 1986b; Ussher, 1989).

It seems that although maternity blues is of little importance clinically, it is of great importance ideologically. It is positioned as a mild form of postnatal distress, so common that 'almost every woman develops it' (see Brockington, 1996; O'Hara, 1997) yet by being positioned as a psychiatric syndrome has implications for our understanding of women, childbirth and postnatal reactions. An examination of maternity blues is thus of importance for various reasons. Firstly, there is much overlap between many aspects of PND and maternity blues, such as the theories regarding definition, aetiology and relationship to childbirth. Secondly, it also provides insight in the ideological apparatus of the medical model, especially regarding the continued research on a syndrome that does not pass the threshold for a psychiatric disorder (Brockington, 1996; Kennerly & Gath, 1986; Nicolson, 1998). Despite this, maternity blues has been subject to a multitude of studies in the last 20 years (Brockington, 1996). Surprisingly, very little consensus exists about the phenomenon.

The term *maternity blues* is a relatively new addition to the continuum of postpartum mood 'disorders' and appeared in the literature for the first time during the 1950s in an article by Linn and Polatin (1950):

Many women display transitory episodes of tearfulness during the postpartum period. This is such a common occurrence that it is sometimes flippantly referred to by patients as 'maternity blues'. Obstetricians have verified that this occurs frequently, and are inclined not to take it too seriously. (p. 376)

Although this quote shows that maternity blues was not considered a condition worthy of serious attention, a multitude of research studies have examined almost every aspect related to this phenomenon. The next section will examine the literature in this regard.

Clinical picture

Maternity blues refers to a brief period of mood change that usually occurs a few days after childbirth. While researchers agree that it is mostly benign and self-resolving, there is little agreement on its precise definition such as times of onset and duration (Brockington, 1996; Kennerly & Gath, 1986).

1. Onset

Onset has been found to vary between 2 and 14 days after delivery (Brockington, 1996; Kennerly & Gath, 1986; Llewellyn, Zachary, & Nemeroff, 1997) with a peak around the third to fifth day¹⁰ (Brockington, 1996). Other researchers have shown a peak at any time within the first 10 days after delivery (Nott, Franklin, Armitage, & Gelder, 1976; Stein, 1980).

2. Duration

While onset is reported soon after delivery, the duration of symptoms varies between studies. Maternity blues has been known to be self-resolving and duration is reported to range from a few hours to a few days (Brockington, 1996) but most authors agree that it resolves by the tenth day postnatally (Kennerly & Gath, 1986; Pitt, 1973).

3. Prevalence

There are also many discrepancies in the literature regarding the prevalence of maternity blues and studies have reported prevalence rates ranging from 15% to 80% (Pitt, 1973). This range is so wide that it seems almost absurd – implying either that it is relatively rare, or that nearly every woman develops it! This is highly significant as this wide range mirrors the multitude of definitions and arguments observed in the literature. Most authors argue that the large discrepancy between prevalence rates in the literature is the result of the problems in defining the symptomatology and a more accurate prevalence rate has been estimated to be around 50% (Brockington, 1996; Kennerly & Gath, 1986; Pitt, 1973).

4. Symptomatology

The symptom pattern for maternity blues is also still unclear. There seems to be some agreement on the symptoms of irritability, confusion, weeping and lability of mood (Brockington, 1996; Kennerly & Gath, 1986; 1989a). However, there is uncertainty

whether depressed mood is characteristic of the blues. It seems that mothers themselves resisted the term 'depressed' and preferred to talk of themselves as 'low spirited'¹¹ (Kennerly & Gath, 1989a). Yalom et al. (1968) argue that most studies have confused tearfulness with depression. In their study, many women mentioned happiness or confusion as the reason for their tears rather than dysphoria. Some women could not explain the reason for their crying. According to them, these women were emotionally reactive rather than depressed or unhappy. Nott et al. (1976) observed that crying was more related to irritability and tension than to depressed mood. Stein (1980) reported that weeping in his study was brief and related to happiness or emotional sensitivity. Only a few women experienced severe weeping that was associated with depression. Kennerly and Gath (1989a) observed two types of crying: Brief crying without depressed mood and prolonged and severe crying with depressed mood. Women reported to experience both or either of these states. Brockington (1996), after a review of the literature concludes as follows:

The essence of maternity blues is not depression, but a sudden, fleeting and unexpected mood change. The main defining principle, therefore is the identification of a 'peak' of dysphoric symptoms around the 3rd to the 5th day, against a background of euthymia. (p. 148)

Brockington (1996) argues that it is difficult to define and study a syndrome of which the main symptom (crying) is ubiquitous and overdetermined. Furthermore, since there is no consensus about definition, studies have used different rating-scales depending on their own assumptions regarding the defining features of the blues (i.e. dysphoria, irritability or lability of mood). This has resulted in misleading and confusing results that add little to an understanding of the phenomenon (Brockington, 1996; Kennerly & Gath, 1986; 1989a; Miller & Rukstalis, 1999). The next section will discuss the methodology and more specifically the multitude of measuring instruments that have been developed to study maternity blues.

Research methodology

1. Measuring instruments

Table 1 lists the five scales developed for measuring maternity blues alongside its cluster of symptoms. From this table it is clear that the contents of the different scales vary considerably from 8 items (Pitt, 1973) to 13 items (Stein, 1980) with little

overlap between these. Kendell, McGuire, Connor, and Cox (1981) used a 6-item visual analogue scale. Other researchers have used the Present State Examination or the Standardised Psychiatric Interview (Cox, Conner, & Kendell, 1982). Kennerly and Gath (1986) did a review of all existing rating-scales and their administration. They found that the different scales had only three symptoms in common: Depression (sadness), anxiety (nervousness) and crying, suggesting that some or all of the scales may lack specificity. They consequently developed a 28-scale questionnaire using strict psychometric procedures. It incorporated most of the items in the other scales but was also tested for validity.

Table 1: Scales developed to measure maternity blues

Pitt (1973) – 8 symptoms	Fatigue, Crying, Anxiety, Confusion, Headache, Insomnia, Hypochondriasis, Hostility to husband, Depression
Handley (1980) – 7 symptoms	Dysphoric mood, Mood lability, Crying, Anxiety, Insomnia, Loss of appetite, Irritability
Stein (1980) – 13 items	Depression, Weeping, Restlessness, Anxiety, Fatigue, Tension, Irritability, Poor concentration, Forgetfulness, Confusion, Anorexia, Dreaming, Headache
Kendell, McQuire, Conner, & Cox (1981) – 6 visual analogue scales	Happiness, Depression, Tears, Anxiety, Irritability, Lability
Kennerly & Gath (1989a) – 28 item scale plus overall severity rating	Tearful, Mentally tense, Able to concentrate, Low-spirited, Elated, Helpless, Difficult to show feelings, Alert, Forgetful, Muddles, Anxious, Wishing to be alone, Mentally relaxed, Brooding, Feeling sorry for self, Emotionally numb, Depressed, Happy, Confident, Changeable spirits, Tired, Irritable, Unstoppable crying, Lively, Oversensitive, Up and down mood, Restless, Calm, Tranquil

Cluster analyses of Kennerly and Gath's 28-item scale revealed 7 clusters. The most frequent cluster, termed 'primary blues' contained 7 items: Tearful, tired, anxious, overemotional, up and down mood, low spirited and muddled thinking (Kennerly & Gath, 1989a). These were also the adjectives most often reported by newly delivered mothers (Brockington, 1996; Kennerly & Gath, 1986; O'Hara, 1997). This comprehensive study showed that while there is a period of increased emotionality associated with approximately the third to fifth day postpartum, exact symptoms could not be discerned (Brockington, 1996).

More recently, Miller and Rukstalis (1999) have argued that the problem with current research is that it assumes that maternity blues is in some way related to a dysphoric or depressed mood. According to them maternity blues and depression are both qualitatively and quantitatively different from each other and even the terminology, namely 'the blues', assumes that it is a mild form of depression, when it should rather be defined as "postpartum reactivity" (Miller & Rukstalis, 1999, p. 8). They argue that the term, maternity blues is limiting, as its conceptual link with depression hampers research into the phenomenology of the blues. This specifically results in current research ignoring positive mood states and emotional lability. Furthermore, the fact that maternity blues is linked with mild depression implicitly assumes that it is an abnormal or pathological mood state. Research tools focus exclusively on the pathological, trying to define the extent and severity of dysphoria rather than attempting to define the full spectrum of mood states during this period.

Miller and Rukstalis (1999) also argue that the current rating-scales used to measure maternity blues cannot detect euphoria, joy or happiness. For example, in the study by O'Hara, Schlechte, Lewis, and Varner (1991) positive affect was scored in reverse. Women who reported positive mood states thus scored lower on blues scores. It seems that mild depression was assumed to be a function of the blues, and reports to the contrary did not change the assumption, but only lowered the score. Moreover, scales that did include a separate rating for positive symptoms did not test for lability of mood (Miller & Rukstalis, 1999). Where lability was tested, it was defined in terms of time of peaking, but the symptoms responsible for the peaking could not be determined (Brockington, 1996; Kennerly & Gath, 1989a). Regardless of these critiques, most studies still assume a conceptual link with mild depression and research maternity blues as such.

Apart from these problems with the current measuring instruments developed to research maternity blues, Kennerly and Gath (1986) have also highlighted three other methodological issues that have hampered research to date, namely sample size, patient selection and the timing of observations. These will be discussed in turn.

2. Sample size

Kennerly and Gath (1986) argue that the sample sizes of many studies were too small to make any conclusive statement regarding definition or aetiology. Cox et al. (1982)

was the only study that used a large sample (more than 100 women) while other studies had fewer than 30 (Nott et al., 1976) or 40 subjects (Yalom et al., 1968).

3. Patient selection

Apart from small sample sizes, there were also problems with the selection of participants. For example, studies that tried to determine biological associations with maternity blues required women to be on a strict diet which could have influenced mood states and were thus not a representative sample (Kennerly & Gath, 1986). Other researchers used groups of women that remained in hospital for longer than 7 days, a length of time usually associated with obstetrical problems, and mood states may not have been due to maternity blues (Stein, 1980). Moreover, in many studies there were no screening for antenatal depression or negative life events before selections were made, thus complicating evaluation of findings (Brockington, 1996).

4. Timing of observations

Apart from sample size and patient selection the timing of observations was also criticised as a factor that has complicated research results on maternity blues. The different definitions proposed by the different studies affected how and when data was collected. For example, where dysphoria was taken as the characteristic feature of the blues, results may have confused postnatal depression with maternity blues (Kennerly & Gath, 1986; Miller & Rukstalis, 1999). However, where emotional lability rather than dysphoria was taken as the proposed definition, the timing of observations compromised results. Kennerly and Gath (1986) argue that to test for emotional lability, data should be collected concurrently (i.e. during the event) on a daily basis and not retrospectively (i.e. based on recollections after the event). However, most studies made use of retrospective data, sometimes as much as 5 to 6 weeks after delivery (Paykel et al., 1980). Kennerly and Gath (1989b) have shown that this type of data is often unreliable as women's subjective recall differs markedly from their actual experiences in the first few days postpartum. Those concurrent studies that attempted to test lability of mood, only collected data on 1 or 2 days in the postnatal period (Blumberg, 1980) and not daily as would be expected (Kennerly & Gath, 1986; Miller & Rukstalis, 1999). Other studies have based their observations on a single postpartum day (see Brockington, 1996).

This discussion on symptomatology and methodology has highlighted the difficulties in researching maternity blues since results will differ depending whether maternity blues is defined as lability of mood or a mild depression. These arguments have impacted on the current conceptualisation of maternity blues and will be examined in the next section.

The conceptualisation of maternity blues

Broadly defined two main streams of thinking regarding the conceptualisation of maternity blues can be discerned in the literature. The one stream argues that maternity blues is qualitatively different from depression and conceptualise it as characteristic of labile mood. These authors also propose that it is a normal response to childbirth since it is fleeting, self-resolving and unrelated to major psychopathology (Brockington, 1996; Miller & Rukstalis, 1999; Nicolson, 1998; Ussher, 1989). Research studies following this approach seem to explore the many factors involved in its aetiology rather than examining any particular hypothesis.

In contrast, another stream of thinking holds that the blues should be studied as a possible model for understanding affective disorders in general. These authors tend to conceptualise the blues as a mild form of depression and propose that it might be involved in other mental illness as well. Their approach is more akin to a pathological model where maternity blues is studied as an abnormal reaction to childbirth (Miller & Rukstalis, 1999). Research studies following this approach seem to examine pre-determined hypotheses rather than exploring the phenomena per se.

These debates are not uniform within any particular paradigm and medical and feminist critiques overlap in important ways. For example, from within the medical model researchers such as Miller and Rukstalis (1999) have criticised the conceptualisation of maternity blues as a pathological consequence of childbirth, while Yalom et al. (1968) have postulated that it is a natural, delayed response to stress that serves to release tension. Yet others have argued that it is part of a general feeling of demoralisation due to a lack of support (Brockington, 1996). These arguments are similar to feminists such as Nicolson (1998) and Oakley (1979, 1986a, 1989) who argue that emotional turmoil after childbirth is related to social factors (role strain, isolation and lack of support) and/or cultural factors (expectations and

meanings of motherhood)¹². Moreover, a small minority of researchers within the medical model have criticised the motivation behind researching a phenomenon that is known to be fleeting, self-resolving, and below the threshold of severity to warrant a psychiatric diagnosis (Brockington, 1996; Miller & Rukstalis, 1999). Feminists such as Nicolson (1998) and Ussher (1989) have also raised this issue.

In contrast, Kennerly and Gath (1986) have argued that it is important to study maternity blues even if it is not clinically significant, as it might give clues to the biological, psychological and social determinants involved in affective states at other times in the life cycle. They argue that since maternity blues is fairly frequent, and follows from a predictable life event (i.e. childbirth), it provides an opportunity to study the association between emotions and hormonal changes in the body.

When the differing arguments are examined, there seems to be three underlying questions that have fuelled research on maternity blues, namely:

- a) Is maternity blues universal or culture-bound to western societies?
- b) Is maternity blues specific to childbirth?
- c) Is maternity blues related to other mental illness?

These questions are important in the conceptualisation of maternity blues as it yields clues regarding the phenomena and its possible aetiology. It also highlights the underlying question whether childbirth itself may predispose women to develop mental illness. These issues will be discussed in the next section.

1. The universality of maternity blues

Studies have tried to establish if maternity blues is particular to western society or if similar mood-states can also be observed in other cultures. Since maternity blues have only been noted during the 1950s, researchers have speculated whether it was a modern-day phenomenon related to increased hospitalisation and use of technology as argued by Oakley (1980), or if it can occur in all cultures and in different settings. This would provide clues as to whether maternity blues is specific to childbirth or to cultural practices. Kumar (1994) has researched this question extensively and found that the blues has been observed in many cultures other than the West. He found that incidence rates were stable across cultures and reported to be around 50% (Kumar, 1994). Other studies have found similar results and included countries such as

Jamaica (Davidson, 1972), Tanzania (Harris, 1980), Brazil (Rohde et al., 1997) and Japan (Okana & Nomura, 1992). It therefore seems that maternity blues is not culture-specific but rather specific to the puerperium. This has increased researchers' speculation that maternity blues may be specific to childbirth and they have examined a multitude of studies in this regard.

2. Specificity to childbirth

Three main arguments can be discerned in the literature regarding the specific relationship between childbirth and maternity blues. These arguments are also closely related to the theories regarding aetiology. The first hypothesis is from Yalom et al. (1968) who proposed that maternity blues might be a stress reaction to childbirth with the aim of tension release. He argues that this reaction was not particular to childbirth and can also be observed in parachuters after a jump. The second hypothesis takes Yalom et al.'s hypothesis further and suggests that maternity blues may be the result of other social or psychological factors during the puerperium. In contrast, the third hypothesis argues that maternity blues may be related to factors intrinsic to childbirth, such as hormonal or biochemical mechanisms and proposes a biological model for understanding the condition. This model therefore suggests that it is childbirth *per se* and not associated factors during the puerperium that can account for the presence of maternity blues. These three hypotheses will be discussed in turn.

2.1 Maternity blues as a stress reaction

Researchers have attempted to test Yalom et al.'s (1968) hypothesis that maternity blues is a stress reaction with the aim of tension release, by systematically studying the reactions of a group of women after gynecological surgery. It showed that onset, duration and symptom pattern were remarkably different when compared to a control group of postpartum women (Iles, Gath, & Kennerly, 1989; Kendell, Mackenzie, West, McGuire, & Cox, 1984). This suggests that maternity blues is a specific response to childbirth and not a general stress reaction. Since it is known that women do show emotional distress after gynecological surgery, other social and obstetric factors have also been examined as a possible factor in the aetiology of maternity blues.

2.2 The psychosocial hypothesis

The psychosocial hypothesis asserts that it is not childbirth per se but rather other psychological and social factors that occur during the puerperium such as complicated obstetrics, social support or financial strain that may lead to maternity blues. These will be discussed in turn.

a) Obstetric factors

Oakley (1980) argues that obstetric factors, rather than childbirth were linked to maternity blues, resulting in a spate of studies examining this hypothesis. However, the evidence is conflicting. Nott et al. (1976) and Yalom et al. (1968) found a link between the blues and having a first child; Davidson (1972) found a link with multiparous women, while others found no link with either primiparous or multiparous women (Pitt, 1973; Stein, 1980).

The evidence regarding discomfort experienced during pregnancy is equally conflicting - some authors found a link (Davidson, 1972; Yalom et al., 1968) while others did not (Davidson, 1972; Kennerly & Gath, 1989b; Pitt, 1973). Kendell et al. (1984) did not find any difference between mothers who had caesarian sections versus those with normal delivery.

Hospital confinement also did not seem to be a factor as mothers of both home and hospital delivery groups experienced the blues (Harris, 1980; Yalom et al., 1968). This is in contrast to Oakley (1980) who found a strong link between the blues and so-called "bad births" (p. 144) characterised by intrusive, often painful interventions and hospital births.

Pitt (1973) found that difficulties in feeding the baby were associated with the blues, but this was not the case in the studies by Davidson (1972) and Yalom et al. (1968). In addition, no difference in the rates of the blues has been found between breast-feeding and bottle-feeding mothers (Cox et al., 1982; Harris, 1980).

Some authors did find a relationship between the blues and fear of labour (Davidson, 1972; Kennerly & Gath, 1989b; Stein, 1980). Others found a link between the blues and mood during the pregnancy, notably anxiety and depression (Davidson, 1972; Harris, 1980; Kennerly & Gath, 1989b; Nott et

al., 1976; Stein, 1980). However, Pitt (1973) found no link between the blues and attitude to either pregnancy or childbirth. Since no clear findings emerged from the literature, other demographic variables were also examined.

b) Demographic variables

Surprisingly, no link was found between the blues and demographic variables such as marital status, social class, social support (Kennerly & Gath, 1989b; Nott et al., 1976; Pitt, 1973; Stein, 1980), or marital problems (Kennerly & Gath, 1989b). Neither were current life stressors, such as negative life events and financial difficulties significantly linked to the presence of the blues (Davidson, 1972; Harris, 1980; Kennerly & Gath, 1989b; Paykel, Emms, Fletcher, & Rassaby, 1980; Pitt, 1973; Stein, 1980). This seems to suggest that the blues is qualitatively different from postnatal depression, which is usually associated with these factors (Kennerly & Gath, 1989b; Miller & Rukstalis, 1999).

The different methodologies used by these different studies make comparison and evaluation of the results difficult. However, an examination of the literature reveals the following broad themes. Firstly, evidence suggests that maternity blues is universal and occur in most women across cultures during the puerperium. Secondly, no direct link between maternity blues and psychosocial variables could be found. This suggests that maternity blues is aetiologically linked to the puerperium and has increased researchers' speculation that a biological aetiology, and specifically hormonal and neurotransmitter changes, underpin the phenomenon. This hypothesis is examined in brief.

2.3 The biological hypothesis

Hormonal and neurotransmitter changes have been postulated in the literature as the main factors involved with the onset of maternity blues, however research to date has not been able to substantiate this (Kennerly & Gath, 1986; Miller & Rukstalis, 1999). A multitude of studies has examined this hypothesis and next section will examine the literature in this regard.

a) Hormone levels

According to Miller and Rukstalis (1999) the most common hormonal hypothesis regarding the blues is that it is a mild abnormal state, called a "*pathophysiological*" state (p. 9). In this view, maternity blues is due to

hormonal withdrawal and the result of a sharp drop in the hormone levels after delivery, but no support for this hypothesis has yet been found (Harris et al., 1994; Kendell et al., 1984; Miller and Rukstalis, 1999; Nott et al., 1976). Other studies have therefore also examined the impact on neurotransmitters on the development of maternity blues.

b) Neurotransmitters

While earlier studies were unable to find any link between maternity blues and neurotransmitter changes, Miller and Rukstalis (1999) reviewed four later studies that found lower levels of free plasma tryptophan, a precursor of serotonin, in women with the blues. However, when L-tryptophan was administered to these women, blues symptoms did not diminish (Harris, 1980).

Miller and Rukstalis (1999) have argued that the underlying assumption in hormonal research has hampered progress to date. Since the medical model argues that hormonal changes are abnormal and cause mild depressive states, it has resulted in researchers focusing mainly on depressive symptoms at the expense of the detection of euphoria or lability. Therefore research findings could be more related to depression than the blues. Furthermore, studying a relationship between mood and physiological changes is extremely difficult as many confounding variables can modulate hormone, neurotransmitter and receptor functioning, making any finding difficult to evaluate. They conclude:

Studies involving postpartum women and mood must take into account the age of subject, time of day, the season of the year, diet, stress, use of prescription and/or recreational drugs, degree of protein binding, the source of the samples (e.g. serum, cerebrospinal fluid, saliva, platelets) concomitant illnesses, breast-feeding, sleep cycle changes, and site of action (e.g. peripheral or central) because each of these variables can alter hormone, neurotransmitter and receptor physiology. (Miller & Rukstalis, 1999, p. 10)

This quote shows the difficulty in conducting such research and has increased researchers' speculation that hormones must be involved but that current technology cannot detect this (Kennerly & Gath, 1986). Some authors have even proclaimed that they prefer to go with their 'gut feel' rather than the evidence (Brockington, 1996; O'Hara, 1997). Nevertheless, a review of the literature has shown that to date no evidence for a hormonal aetiology of maternity blues has yet been found.

Closely linked to the biological hypothesis is the notion that maternity blues may be linked to other mental illnesses. These arguments propose that apart from hormonal changes, other genetic factors may play a role in the development of maternity blues. These studies therefore assert that maternity blues may be a pathological process that is in some way related to either previous episodes of mental illness, or that it may predispose women to develop mental illness in the future (Kennerly & Gath, 1986; O'Hara, 1997).

3. Relationship to mental illness

Some researchers have argued that continued research of maternity blues is important as it provides an ideal opportunity to study the relationship between emotions, hormones and mental illness (Kennerly and Gath, 1986). These authors see maternity blues as a mild depression and study it as a possible model for understanding depressive and bipolar illnesses at other times in the life cycle. Both previous and future psychiatric episodes were examined in this regard.

a) Previous psychiatric diagnoses unrelated to childbirth

The first set of studies examined the psychiatric history of women who currently had the blues. An early study by Nielson (1970, in Kennerly & Gath, 1986) found a link between the blues and previous non-puerperal mental illness, but later studies found no link, either puerperally or non-puerperally (Pitt, 1973; Stein, 1980; Harris, 1980; Kennerly & Gath, 1989b). Stein (1980) and Yalom et al. (1968) found a link between maternity blues and previous episodes of depression, but it is unclear if the samples were screened for depression before delivery to rule out depression unrelated to childbirth. Other studies have found that a history of depression did not increase the likelihood of developing the blues (Davidson, 1972; Kennerly & Gath, 1989a). Since the research in this regard has been largely inconclusive the presence of subsequent episodes of mental illness in women who had the blues were also examined.

b) Subsequent psychiatric diagnoses in women who had maternity blues

While research could not find conclusive evidence for the relationship between maternity blues and a psychiatric history, others have argued whether the presence of the blues may predispose women to develop more severe mental illness in the future (Kennerly & Gath, 1989a). This question was asked specifically in relation to depression and it was wondered whether the presence of the blues is a possible predisposing factor in the development of a major depression in the future.

Although some studies found an increased likelihood to develop postpartum depression in women who had the blues (Miller & Rukstalis, 1999; O'Hara et al. 1991; Stein, 1980) this has not always been demonstrated (Kennerly & Gath, 1989b). Kennerly and Gath (1986) cautioned against interpreting findings from these studies as some used prospective and others retrospective data¹³. After an extensive review of the literature Kennerly and Gath (1986) conclude:

Despite careful and systematic research work, findings so far have been generally conflicting and inconclusive ... it is not clear from the conflicting findings whether or not the Blues (sic) is associated with a previous history of psychiatric disorder in the individual. However, there is some agreement, albeit incomplete, that the Blues (sic) may carry an increased risk of subsequent psychiatric disorder. (Kennerly & Gath, 1986, p. 14)

This review of the literature suggests that while maternity blues may be specific to childbirth, research to date has been unable to define the nature of this relationship (O'Hara, 1997). Apart from evidence that it is universal, occurs in most women directly after childbirth, and that it may be associated with the development of depression in the future, very little conclusive evidence regarding aetiology have been identified. Many authors agree that the lack of consensus in the literature is the result of the methodological problems and whether maternity blues is defined as reactive or depressed mood. However, while the previous sections have shown how the current problems have impacted on an understanding of maternity blues, the ideological and political implications underlying these theories have not been examined. The next section will briefly examine how the current conceptualisation of maternity blues may impact on the understanding women's reproductive experience in the postnatal period. These arguments form part of a larger debate regarding all postpartum mood disorders and a more comprehensive discussion will follow in chapter 4.

The conceptualisation of maternity blues: critiques and implications

It seems that at the heart of the criticism against research on maternity blues is the debate whether maternity blues should be defined as a mild depression or mood reactivity. Despite these arguments maternity blues is known to be a fleeting condition that self-resolves within a few days and is not of clinical importance. However, the continued research on this condition shows that it may be of political significance. It

also reveals an important way of thinking about women and their emotional reactions in the postnatal period.

a) Maternity blues as a political concept

There are three contradictions in the literature regarding maternity blues. Firstly, many researchers, from both the medical and feminist models have criticised the continued research on a syndrome that is not clinically significant, yet research has continued regardless. Secondly, despite mounting evidence that emotional reactivity is the defining feature of the blues, research studies have continued to conceptualise it as a form of mild depression. Thirdly, research suggests that maternity blues and PND may in fact be two very different conditions when its clinical picture and aetiology are examined. Yet, it is still conceptualised on a continuum with maternity blues positioned as a 'less severe' version of PND. This review asserts that it may have political significance.

The previous sections have shown that a link between childbirth and mental illness have been proposed by many researchers, despite the fact that this has not been substantiated by research. It seems that to enable mainstream researchers to maintain a conceptual link between childbirth and mental illness, the link between depression and maternity blues needs to be established. Therefore, if research can show that maternity blues is a mild form of PND, it can also suggest that more severe mental illness may follow from its presence. This positions childbirth as a potentially pathological process and legitimises research on a condition that is fleeting and self-resolving. This also has ideological implications.

b) The ideological implications of maternity blues

Chapter 1 has shown that notions of women's biology as pathological and closely linked to the presence of mental illness have been present for centuries. This can also be seen when the literature regarding maternity blues is examined. Firstly, researchers insist that hormonal or genetic factors must underlie its presence and maintain that childbirth must be involved in some way. This is very similar to the earlier notions that women are predisposed to mental illness due to their capacity to bear children. It can be suggested that for the medical profession to maintain their position as the experts on women's reproduction, they have to show that the birth process itself may have pathological consequences. While this may be the case for some women, many do not need medical or psychiatric intervention in the

postnatal period. This is of concern as it may result in a scenario where childbirth and women's reproductive experiences may become pathologised.

Furthermore, this overly pathological view of the postnatal period obscures the possibility that cyclicity of mood may be a 'normal', healthy reaction to childbirth at a time when huge hormonal changes are taking place. Many feminists argue that the literature on maternity blues defines 'normality' as the stability or even absence of emotion and that any display or cyclicity of mood is considered potentially pathological. These feminists argue that the medical model evaluate women from a position of 'other' – the norm defined by men, with a male-dominated view as the standard (Lee, 2000; Nicolson, 1992; Ussher, 1989; 2000). They propose that childbirth is not *just* a medical event, but a complex process with many biological, personal, social and cultural factors intersecting during this period. Biological responses may thus be part of these socio-cultural changes since the body does not exist in an ideological vacuum, but is intrinsically related to the social, political and cultural structures within which it is embedded (Dye, 2000; Nicolson, 1998; Roberts, 2000; Ussher, 1989, 1992).

Maternity blues: concluding remarks

This chapter has discussed the current problems and debates regarding the conceptualisation of maternity blues. Firstly, the arguments regarding its clinical picture were discussed with a brief examination of the current methodological problems in researching the phenomenon. A brief discussion on the current conceptualisation of maternity blues followed, and the literature regarding universality, aetiology and specific relationship to childbirth was examined. It was shown that maternity blues might be more akin to a period of sudden mood changes rather than dysphoria. However, many studies still conceptualise and research the condition as a form of mild depression. It was argued that maintaining a link between maternity blues and mild depression may be of political and ideological significance as it may imply that childbirth is potentially pathological and thus in need of continued monitoring and surveillance. It is argued that that this is problematic as it reduce women's postnatal reactions as being potentially pathological by ignoring the heterogeneous and social nature of postpartum experiences. This may in turn give added credence to the prevailing notion that childbirth predisposes women to mental

illness and thus, by implication, that women are predisposed to mental illness due to their capacity to bear children.

That some women do get depressed after childbirth is not disputed, but that *all* women who experience increased emotionality after childbirth are at risk for depression, and possibly more severe mental illness, is not necessarily a logical conclusion. The next chapter on PND will discuss these issues in more depth.

CHAPTER 4

POSTNATAL DEPRESSION: THE SEARCH FOR A DISORDER

Pregnancy, childbirth and the postnatal period have been pathologised in the same way, positioning women's experiences as an illness in need of intervention, and interpreting any distress or unhappiness as individual pathology. Since the male obstetrician wrestled control of childbirth from the women midwives as early as the sixteenth century, childbirth has been construed as a technological accomplishment on the part of the expert – the woman herself positioned as a passive recipient, the ubiquitous stirrups in which she was trapped helpless and splayed, symbolising her position as a vessel to be relieved of its burden.

(Ussher, 1992, p. 47-8)

The shift from “hard psychiatry” to “soft psychiatry” (Miller & Rose, 1986, p. 2), as discussed in chapter 3 also impacted on postnatal depression and how it became a focus for research. Miller and Rose (1986) argue that the aforementioned shift was accompanied, and in many ways fuelled by the advances in technology brought about by the Second World War. The 1950s saw a renewed interest in researching psychiatric conditions, developing new drugs to treat these conditions with an accompanied interest in classification and diagnosis (Miller & Rose, 1986). This also resulted in more attention being given to milder ‘disorders’ (Brockington, 1996; see also Miller & Rose, 1986)¹⁴. These new areas of exploration included abortion, infant death, adoption, maternity blues and postpartum depression (Brockington, 1996; Miller, 1986).

According to Brockington (1996), before the 1950s, the terms *maternity blues*, *puerperal melancholia* and *depression* were used interchangeably, with no standard assessment for severity, onset and duration. It was only in 1957 when Gordons (1957, in Brockington, 1996) studied 100 healthy mothers and took a thorough social history during and after pregnancy, that he was able to categorise the degree of emotional disturbance as ‘much’ and ‘slightly’ upset. This prepared the way for contemporary research to differentiate levels of affective impairment during the puerperium. Kline

(1955, in Brockington, 1996) writing about postnatal distress, summarised this new attitude clearly:

Many women who become emotionally ill following childbirth never reach the mental hospital to become part of its statistical tables. Many of these women struggle through their illness at home, some attaining spontaneous recovery, others remaining chronically handicapped by emotional illness.... One can only speculate on the true incidence of these disorders. If one includes the many women in whom milder, yet incapacitating, forms of emotional illness appear, it seems fair to presume that about 5% of women who become pregnant will have some form of emotional illness following the birth of one of their children. (p. 169)

Although this quote proposed that postnatal distress only affected a small percentage of women, psychiatry started paying attention to postnatal depression as an 'illness' associated with childbirth. In the last 50 years a proliferation of studies as well as books has been published on the syndrome. Especially Katrina Dalton's (1980) best-selling book *Depression after childbirth* has popularised the notion of postnatal depression and turned it into a household name (Brockington, 1996; Nicolson, 1998). However, despite the vast amount of research there is still little agreement on almost every single aspect pertaining to the syndrome termed PND. This chapter will not provide an extensive review of the literature but will focus specifically on the problems with the conceptualisation of PND.

Most significant in the literature are the debates regarding the clinical picture of PND. At present researchers are uncertain whether PND warrants a separate diagnosis or if it is similar to depression occurring at other times in the life cycle (Brockington, 1996; O'Hara, 1997). These arguments will briefly be examined as well as the measuring instruments that have been developed to research the phenomenon.

Clinical picture

In the medical literature PND is typically positioned between postpartum psychosis and maternity blues. For example, O'Hara and Zekoski (1988) defined PND as follows:

Postpartum depression constitutes those affective disorders whose severity falls in between the blues and psychosis. With respect to the validity of the distinctions among the three 'disorders' (sic), it is as yet unclear whether they are distinguishable on grounds other than severity and length of impairment. (p. 17)

In general, it is defined as a non-psychotic depressive episode of mild to moderate severity that starts after childbirth and extends into the postpartum period (Brockington, 1996; Cox, Murray, & Chapman, 1993; O'Hara, 1997). However, there are still many debates regarding its prevalence, onset and duration in the literature.

1. Prevalence

PND is thought to occur more frequently than postpartum psychosis, but less frequently than maternity blues. It is estimated to occur in 8-15% of newly delivered women (O'Hara, 1997). Other studies have reported rates of 20% and higher (Brockington, 1996). In a recent study of low-income women in a peri-urban settlement in South Africa, a prevalence rate of 34.7% (Cooper et al., 1999) was reported. According to O'Hara and Zekoski (1988) the difference in prevalence rates found in various studies may be the result of the multitude of definitions, the problems with measurement and methodology as well as the difficulty in determining specific periods of onset and duration.

2. Onset

There has been little agreement regarding the onset of PND and different periods have been postulated in the literature, ranging from 3 weeks (O'Hara, Neunaber, & Zekoski, 1984) to 1 year after delivery (Cooper, Campbell, Day, Kennerly, & Bond, 1988). Kumar and Robson (1984) argue that 3 months is a preferred cut-of period as three times as many women developed PND 3 months postpartum than at 6 months and 1 year postpartum. This has been substantiated by other studies (Brockington, 1996; Watson, Elliot, Rugg, & Brough, 1984). Certain studies have shown that onset was earlier, between 5 and 6 weeks (Cooper & Murray, 1995; Cox et al., 1993) and even as early as 3 weeks postpartum (O'Hara, Zekoski, Philipps, & Wright, 1990). In contrast, Najman, Anderson, Bor, O'Callaghan, and Williams (2000) found that their sample was relatively symptom-free in the six-month postnatal period. Where depression was noted it was due to an increase in symptoms that was already present in the pre-partum period. Despite these differences, PND is currently defined in the

DSM-IV as the presence of depressive symptoms occurring within 4 weeks after childbirth (APA, 1994).

3. Duration

PND also appears to persist over time, and is thought to take months and in some cases years to resolve (O'Hara, 1997). Pitt (1968) stated that although depression in his sample was mild to moderate, 43% of his cases did not improve after a year. Watson et al. (1984) reported that 25% of their sample had episodes lasting 3 months or more and another 25% had episodes for longer than 6 months. Cooper and Murray (1995) found that depression in their study lasted for 3 months. Kumar and Robson (1984) found that 50% of their sample had episodes that lasted for 6 months or more. Cooper et al. (1988) found that only 4% had depression lasting up to a year, while 15% lasted up to 6 months.

The question that needs to be asked when evaluating these research findings is for how long is the presence of depression after birth still conceptualised as postnatal depression? Clearly a woman who is still depressed 3 years after giving birth is qualitatively different from a woman whose depression self-resolves 6 months after childbirth. Cooper and Murray (1995) have shown that women who had previously suffered from depression unrelated to childbirth, were depressed longer than those subjects who had their first episode soon after delivery. They suggest that prolonged depression could thus be the result of a vulnerability to depression that is unrelated to childbirth. Similarly, Brockington (1996) mentions that brief depression could be related to the puerperium while prolonged depression could be due to vulnerability factors in the childbearing population that is unrelated to childbirth. O'Hara (1997) argues that these results gave some validity to the idea that postpartum depression is distinct from depression occurring at other times, but he cautioned this has not been substantiated by research.

4. Symptomatology

The debate as to whether PND is different to depression at other times in the life cycle is also visible when the literature regarding its symptomatology is examined. Pitt (1968) was the first author to argue that PND was a separate condition with a specific symptom pattern. According to him, PND usually started in hospital in mothers who felt physically unwell with symptoms such as fatigue, backache and discomfort. On

their return home, the depression became more evident and included “tearfulness, despondency, feelings of inadequacy, and inability to cope – particularly with the baby” (p. 1327). Feelings of guilt and self-reproach were common although suicidal thoughts were less common¹⁵. Feelings of hopelessness were also less frequent. Anxiety over feeding and health of the baby were prevalent and formed the basis for self-reproach and guilt, even when the babies were healthy and thriving. He proposed that the symptom pattern resembled “atypical” depression.

Atypical depression is a milder variant of physiological depression most often seen in younger women or immature personalities. It is atypical either because of the prominence of neurotic symptoms, such as anxiety, irritability, and phobias, overshadowing the depression or because some features are opposite to those of classical depression, e.g. worsening at the end rather than the beginning of the day, early rather than late insomnia. (Pitt, 1968, p. 1327)

Pitt therefore saw PND as different from depression in quite a number of ways when compared to the current diagnostic criteria in the DSM-IV.¹⁶ However, later studies did not find any difference in symptom patterns between PND and depression in non-childbearing women (Cooper et al., 1988; O’Hara et al., 1990). Beck (1992) found that symptoms were similar to depression occurring at other times in the life cycle, but that feelings of hopelessness were more prevalent. Wood, Thomas, Droppelman, and Meighan (1997) used a phenomenological approach in their study. They showed that the symptoms were similar to depression in the non-childbearing population but that thoughts and fears centered on the new infant: Obsessive thoughts, feeling overwhelmed, hopelessness and wishes to harm the baby were overriding themes. Other researchers argue that even though the symptom pattern is similar, the difference lies in the dyadic nature of the mother-infant relationship and therefore requires special attention (Beck, 1992; Wood et al., 1997).

As a result, a taskforce was appointed to ascertain if PND should be added as a separate diagnosis in the latest edition of the Diagnostic and Statistical Manual (i.e. the DSM-IV). After a comprehensive review, the taskforce concluded as follows:

Considering the dearth of evidence for symptom specificity, unique family history, biological correlates, or treatment response, it is questionable whether mild to moderate depression that occurs postpartum represents a distinct clinical

entity that should be afforded a separate diagnostic label in the DSM-IV (Purnine & Frank, 1996, p. 275).

PND is thus currently diagnosed in the DSM-IV as a *Major Depressive Disorder*, *Dysthymia* or *Bipolar I* (APA, 1994). The diagnosis of *Depressive Disorder Not Otherwise Specified* can be made when the symptom presentation does not meet the full criteria for a Major Depressive Disorder. A *Minor Depressive Disorder* falls under this category (Kaplan & Saddock, 1998). As with postpartum psychosis, a course specifier “*with postpartum onset*” is added if the depression started within 4 weeks of childbirth (APA, 1994, p. 167).

This debate whether PND is a syndrome that may warrant a separate diagnosis is complicated by the methodology and specifically the measuring instruments that have been developed to research the syndrome. The next section will examine the multitude of measuring instruments that have been developed to examine PND together with the methodological problems in this regard.

Research methodology

Snaith (1993) has commented that the confusion and contradictions regarding the definition of PND is related to its measurement. He argues that it is difficult to assess the presence and severity of psychiatric syndromes from rating-scales based on self-report measures. If symptoms are described too wide, the scales fail to measure the required syndrome adequately, while if they are described too narrowly, many subjects who have depression but do not fit the required criteria, fall by the wayside. Furthermore, most rating-scales predate the move towards increased standardisation of diagnostic criteria devised by the APA and hence have a heterogeneous approach to measuring depression (Condon & Corkindale, 1997; Snaith, 1993).

1. Measuring instruments

Since some researchers have argued that there is no difference in postnatal depression and depression occurring at other times in the life cycle, the same measuring instrument developed for measuring depression in the general population have also been used in research on PND. The Beck Depression Inventory (BDI), the Zung Self-Rating Depression Scale, The General Health Questionnaire (GHQ), the Hamilton

Depression Rating Scale and the Hospital Depression and Anxiety Scale are examples of rating-scales most often used (Beck, 1992; Condon & Corkindale, 1997; Harris et al., 1989). However, some researchers have argued that this is problematic as most of these questionnaires gave prominence to neurovegetative symptoms, such as 'loss of appetite', 'fatigue' and 'insomnia' that also occur in non-depressed postnatal women (Condon & Corkindale, 1997; Harris, Huckle, Thomas, Johns, & Fung, 1989). Questionnaires such as the BDI for example, include items such as 'irritability', 'feeling unattractive' and 'difficulty working' which are also observed in women who are not depressed after childbirth. Many studies have also shown that the lack of specificity (when non-depressed women are mistakenly diagnosed as depressed) and sensitivity (missing cases of PND) of the different rating-scales may have accounted for the different prevalence rates noted across studies (Brockington, 1996; Harris et al., 1989).

To overcome these problems Cox, Holden and Sagovsky (1987) developed the Edinburgh Postnatal Depression Scale (EPDS) (see appendix A). The aim was to develop a scale that excluded somatic symptoms that also occur in the postpartum period as well as items that focus on physical discomfort. After initial trials they ended up with a 10-item scale – five items that measure dysphoric mood, two items that measure anxiety, and one each for 'guilt', 'suicidal thoughts', and 'feeling unable to cope'. However, researchers have critiqued the presence of anxiety symptoms in a measure developed specifically for detecting depression (Condon & Corkindale, 1997; Harris et al., 1989). Brockington (1996) argues that some items do not measure what they propose to measure, for example in one item insomnia is used as a measure for unhappiness (item 7) while other items compare current emotional states with pre-pregnant states of happiness as a measure for depression (items 1 and 2). Nevertheless, subsequent studies have showed the validity of the EPDS in detecting PND (Harris et al., 1989; Murray & Carothers, 1990). The EPDS has been validated for many non-Western countries, including Chile (Jadresic, Araya, & Jara, 1995), Singapore (Kok, Chan, & Ratnam, 1994), China (Pen, Wang, Jin, & Fan, 1994) and even the United Arab Emirates (Ghubash, Abou-Saleh, & Daradkeh, 1997). The EPDS have also been validated for a South African cohort and translated into six different languages for this purpose (Lawrie, Hofmeyer, De Jager, & Berk, 1998).

More recently Beck and Gable (2002) have developed the Postpartum Depression Screening Scale (PDSS), a 35-item, likert-type, self-report instrument developed from a series of qualitative research studies. It contains seven dimensions: Sleeping/eating disturbances, anxiety/insecurity, emotional lability, guilt/shame, loss of self, cognitive impairment and contemplating harming oneself (see appendix B). A cut-off of 80 is recommended for major PND (sensitivity = 94%; specificity = 98%) and 60 for minor PND (sensitivity = 91%; specificity = 72%). When compared to the EPDS and the BDI, the PDSS outperformed both scales in positively identifying cases of PND (Beck, 2002).

Although PDSS purports to have been developed from qualitative data from women who were reportedly depressed (Beck, 2002), it includes both vegetative symptoms and vague psychic symptoms that can be a feature of many psychiatric complications other than depression. This critique has also been mentioned in regards to all scales developed for PND (Brockington, 1996; Nicolson, 1998; Snaith, 1993). Snaith (1993) argues that research on depression is beset by problems such as lack of specificity and multiple definitions where some researchers focus on somatic symptoms, while others include more vague psychic descriptions. He asserts that guidelines for appropriate research definitions for depression are necessary before attention can be given to PND as a research construct.

Although the problems related to measuring instruments in research on PND has had a significant impact in how we currently understand the syndrome, other methodological problems have also contributed to the current confusion.

2. Timing of observations

The timing of observations was also discussed in maternity blues as an issue that has complicated evaluation of findings. These include issues regarding the time period when data was collected and if participants were screened before this was done.

a) Prospective versus retrospective data

As was the case with maternity blues, the problem with prospective versus retrospective designs has also complicated evaluation of research on PND. Prospective designs refer to research studies that collect data at the time of the event (i.e. shortly after delivery) while retrospective data refers to research studies that collect data at some point after the event. Prospective designs have

advantages over retrospective designs in that participants are more likely to report current feelings and events accurately when compared to past emotions and events (Kennerly & Gath, 1989b). Although it appears from the literature that many recent studies have used prospective designs, others have used retrospective designs, especially when researching psychosocial variables (Brockington, 1996; Kumar & Robson, 1984; O'Hara 1986). These studies have asked women who are currently depressed about their experiences after delivery. Some of these women gave birth as long as 3 years ago. However, someone who is currently depressed is more likely to interpret the past in negative terms compared to when more positive mood-states prevail and this potential bias complicates evaluation of the results (Kennerly & Gath, 1989b).

b) Antenatal screenings

Furthermore, many studies did not include adequate screening for depression before delivery. It is therefore uncertain whether these women became depressed as a result of childbirth or if their depression was part of a set of symptoms already present in the antenatal period (Kumar & Robson, 1984; Najman, et al. 2000). It is necessary to track the presence of symptoms during the course of pregnancy and not only in the postnatal period. The type of research design is therefore also important.

3. Type of research design

A variety of research designs were used in studies on PND. Most studies used cross-sectional designs, i.e. where measurements were taken over a short period of time during the life cycle, and researchers have stated that more longitudinal designs and studies with control groups are necessary.

a) Longitudinal designs

Najman et al. (2000) argue that more longitudinal studies are necessary to track the course of PND to differentiate between antenatal depression, maternity blues and postnatal depression.

b) Control groups:

Brockington (1996) has criticised PND research due to their lack of a control group. Where control groups were added, O'Hara and Zekoski (1988) found that none of these studies have followed the control groups prospectively or assessed depression on more than one occasion.

Where the different research designs have made comparison of findings difficult, a more general problem, namely the use of questionnaires as the basis for information gathering is also problematic.

4. Self-report measures

Some researchers have argued that standardised self-report measures (such as the EPDS, the PDSS and the BDI) do not allow researchers to determine whether high scores are reflecting the severity of PND symptoms or some other condition such as physical illness, or thyroid problems (O'Hara & Zekoski, 1988; Parry, 1999). As discussed before, many scales also incorporate somatic symptoms that are common in childbirth (such as fatigue, sleep problems and negative body image) and their presence may not necessarily be related to PND. Furthermore, anxiety-based symptoms may be related to other affective disorders and not PND (O'Hara & Zekoski, 1988). Often the length of time or severity of symptoms is not evaluated in self-report measures. This results in a skewed picture where many cases of PND are reported when in reality only a few cases may have functional impairment and warrant clinical attention (Hopkins et al., 1984).

The previous discussion on symptomatology and methodology has highlighted the difficulty in researching postnatal depression. The debate whether PND is a separate disorder that warrants an official diagnosis or is similar to depression occurring at other times in the life cycle also impacts significantly on its conceptualisation. The next section will discuss these debates and its implication for understanding PND.

The different conceptualisations of PND

Broadly defined three main debates regarding the conceptualisation of PND can be discerned in the literature. The first argument revolves around the issue of the definition and diagnosis of PND and has been explored in-depth in the previous section. In summary, it has shown that although there is still much contention, the dominant voice from the mainstream medical literature suggests that there is currently no proof that PND is a homogenous condition with a uniform symptom pattern that deserves a separate diagnosis (Brockington, 1996; Purnine & Frank, 1996).

The second argument is related to the first and concerns the current focus of research on PND rather than depression per se. Many authors have argued that current research on PND have not examined the prevalence of depression in the antenatal period. The high prevalence of PND is then assumed to be related to childbirth while other factors, such as the high rates of depression in the population are ignored (Brockington 1996; Kruger & Smit, 2002; Kumar & Robson, 1984; Najman et al., 2000; Nicolson, 1998; O'Hara & Zekoski, 1988; Patel et al., 2002). Moreover, some researchers have argued that the exclusive focus on PND have obscured the fact that depression is a debilitating condition for women at any point in the life cycle and not only after the birth of an infant (Kruger & Smit, 2002; Najman et al., 2000; Oakley, 1986; Ussher, 1989). Others have questioned whether PND is such a mental health risk that it deserves the attention it is currently receiving (Brockington, 1996; O'Hara 1997; Najman et al., 2000).

The third argument revolves around the aetiology of PND. Although research has consistently found a relationship between PND and psychosocial variables, some researchers still insist on a biological aetiology, despite the lack of evidence for such a view and despite the fact that PND is purported to occur when the hormonal fluctuations have stabilised (Hendricks & Altshuler, 1999; Miller & Rukstalis, 1999). Feminist researchers, such as Nicolson (1998) have argued against the insistence on a biological aetiology of PND, cautioning that it may result in a scenario where childbirth is pathologised. A similar argument has also emanated from other researchers within the medical model (Brockington, 1996; Najman et al., 2000).

These issues are still much debated in the literature and the next section will examine the pitfalls and problems related to these debates. Firstly, the research regarding the universality of PND and its specificity to childbirth will be examined. Many researchers propose that if it can be shown that a) PND is universal and b) it is specific to childbirth, it suggests that factors intrinsic to childbirth may be involved in the aetiology of PND (O'Hara, 1997; O'Hara & Zekoski, 1988). This also provides a backdrop to evaluate the biological hypotheses proposed for the aetiology of PND.

1. Universality

In contrast to maternity blues, the universality of PND has not been extensively researched (Brockington, 1996). Kumar (1994) has reviewed the literature to date. He

found that while there were no major differences in the rates of PND across studies, the many methodological problems made it difficult to draw any definite conclusions. However, he argues that “the only common ground between all studies so far [was] that the main aetiological factors [were] to be found in the psychological and social domain” (Kumar, 1994, p. 256). This has led researchers to explore the relationship between PND and childbirth.

2. Specificity to childbirth

In order to show that PND is specific to childbirth, studies would need to show that there is an increase of depressive symptoms after childbirth and that this is directly related to childbirth and not a third variable (such as smoking or other environmental factors). However, this is very difficult to determine as women are reported to be 24 times more likely than men to become depressed during the childbearing years [aged 25-44] (Weissman, Leaf, Holzer, Myers, & Tischler, 1984). Whether this vulnerability is related to childbirth has not been established to date (Brockington, 1996; O’Hara, 1997).

O’Hara (1997) reviewed the literature and found that the earlier studies (pre-1985) revealed an increase in the rates of depression after childbirth but they could not show if the rates reported were higher than those reported in the general population. Later studies thus set out to test this. Cooper et al.’s study (1988) was the first to compare depression in childbearing women with non-childbearing controls. They found no significant difference in the rates of depression between the two groups. Other large studies in America (O’Hara et al., 1990) and England (Cox et al., 1993) had similar results. Furthermore, Troutman and Cutrona (1990) found no difference in the rates of major depression in adolescent mothers when compared to an adolescent control group. O’Hara (1997) concludes:

The results of four major controlled studies of the prevalence of postpartum depression converge to suggest that there is no elevation in the risk for nonpsychotic depression associated with childbearing... It is unlikely that bigger and better studies would demonstrate the level of increased risk for nonpsychotic depression that has been observed in the blues and psychosis. (p. 9)

Moreover, as stated before, Najman et al.’s later study (2000) showed that women were less depressed during pregnancy when compared to other times in the life cycle.

In their view pregnancy and childbirth could actually be seen as a period of relatively good mental health. Interestingly, similar findings were obtained in a study on low-income, inner-city women, normally associated with women who are generally deemed vulnerable to depression (Ritter, Hobfoll, Lavin, Cameron, & Hulsizer, 2000).

Furthermore, a recent study by Patel, Rodrigues, and DeSousa (2002) has shown that the high incidence of postnatal depression in a sample of Indian women was the result of the high incidence of antenatal depression. They conclude as follows:

Postnatal depression simply describes the presence of a depressive disorder in the period after childbirth. It does not, however, indicate any specific risk or aetiological role of childbirth in the onset of a depressive disorder. (Patel et al., 2002, p. 45)

These findings suggest that the high prevalence of PND may be related to the high rates of depression in the population and does not show any specific relationship to childbirth. Therefore, the research regarding both the universality and specificity of PND suggests that no aetiological link between PND and childbirth can be made. Nevertheless, researchers have continued their insistence that childbirth itself must be involved. They propose that, given the many dramatic physiological changes that occur during and after childbirth, biological factors may be causally linked to the presence of PND and many biological hypotheses have been entertained in this regard.

3. Biological hypotheses

Biological studies include mostly those that propose a hormonal and biochemical basis for the presence of PND. According to Hendrick & Altshuler (1999) the levels of oestrogen, progesterone, B-endorphins and cortisol rise during pregnancy, peaking near term. Since the placenta is a significant source of oestrogen, progesterone and gonadotropin (a follicle-stimulating hormone) its removal at delivery results in a sharp drop of these hormones. Furthermore, thyroid-stimulating hormones increase rapidly during pregnancy while breast-feeding influence prolactin levels (Brockington, 1996; Hendrick & Altshuler, 1999; O'Hara, 1997). The dramatic rise and decline of these hormone levels have thus been implicated as a possible determinant in the occurrence of PND and will be briefly discussed.

a) Progesterone

Progesterone withdrawal has been posited as the main causal factor in PND (Dalton, 1980). However, this has not been substantiated by further research. For example, Nott et al. (1976) found a link between PND and progesterone. O'Hara et al. (1991), in a larger study ($n > 147$) found no difference in progesterone levels between depressed and non-depressed postpartum women. According to Brockington (1996) and O'Hara (1997) the results of most studies have been inconclusive.

b) Oestrogen

Similar results are to be found in studies regarding the link between oestrogen and PND. According to Hendrick and Altshuler (1999) biologically active oestrogen include forms such as estradiol and estriol. During pregnancy, levels of these hormones increase about 100-fold and 1000-fold respectively. Animal studies have shown that estradiol enhances serotonin function and since serotonin is involved in mood regulation, researchers have tried to find an association between a drop in estradiol levels and PND. However, regardless of a variety of large studies, no relationship has yet been found (see Brockington, 1996; Hendrick & Altshuler, 1999; O'Hara, 1997; O'Hara et al., 1991).

c) Prolactin

Hendrick and Altshuler (1999) argue that prolactin levels drop quickly after childbirth in women who do not breast-feed, but remain elevated for several months in those who do. Eventually these levels decline despite continued breast-feeding. They reviewed studies that have shown that women with *pathologic hyperprolactinemia* (very high levels of prolactin) reported high levels of anxiety and depression. High levels of prolactin have thus been thought to be associated with PND. However, O'Hara et al. (1991) could not find any relationship even after controlling for the effects of breast-feeding. O'Hara (1997) remarks that due to the difficulty in measuring prolactin, studies have been able to reach any conclusion. Other studies have examined breast-feeding itself as a possible determinant due to its involvement with prolactin levels.

d) Breast-feeding

Again research to date has also been inconclusive. While some studies have found a relationship between PND and breast-feeding (Alder & Bancroft, 1988) or the cessation of breast-feeding (Susman & Katz, 1988), other larger studies found no such relationship (Cooper, Murray, & Stein, 1993; Misri, Sinclair, & Kuan, 1997).

Brockington (1996) reviewed the results of six studies and concluded that no consistent relationship can be found in the literature between breast-feeding and PND. This is also the case in studies regarding cortisol levels.

e) Cortisol

During pregnancy cortisol levels are high and drop precipitously with removal of the placenta at delivery (Hendrick & Altshuler, 1999). Although abnormal levels of cortisol have been proposed as an aetiological factor in PND, studies have as yet found no relationship between either free or bound cortisol and PND (Hendrick & Altshuler, 1999; O'Hara, 1997; O'Hara et al., 1991).

The studies focusing on factors specific to childbirth have been unable to find any conclusive link with PND and have led researchers to examine more general theories also proposed for depression unrelated to childbirth (O'Hara & Zekoski, 1988). These include neurotransmitter functions and medical problems such as thyroid dysfunction.

f) Neurotransmitter functions

Neurotransmitter functions have been established as a possible factor in the aetiology of depression and hormones such as oestrogen and progesterone have been known to influence these neurotransmitter functions. Since these hormones abound during late pregnancy and early postpartum they have been thought to suppress neurotransmitters such as tryptanone (Hendrick & Altshuler, 1999). Low levels of tryptanone have thus been thought to be associated with PND but to date research studies have been unable to establish this (see Brockington, 1996; Hendrick & Altshuler, 1999).

g) Thyroid dysfunction

Since hypo- and hyperthyroidism is associated with anxiety and depression in the population in general, and thyroid dysfunction have also been found in postpartum women at a higher rate than in the non-childbearing population, thyroidism has been postulated as a cause for PND. Moreover, it has been shown that postnatal women with thyroidism have increased symptoms of depression that resolved after thyroid normalisation (see Hendrick & Altshuler, 1999 for a list of studies). Thyroid dysfunction may thus be associated with PND in a sub-group of women who have wrongly been diagnosed with depression (Hendrick & Altshuler, 1999; O'Hara, 1997).

3.1 Biological studies: conclusions

A review of the literature shows that, to date, research has been unable to establish a biological aetiology for PND. In a comprehensive review of the literature, Hendrick and Altshuler (1999) conclude the following:

Because of the dramatic biological changes that occur at delivery, postpartum mood disorders have been attributed to a biochemical or hormonal imbalance. Some data suggest that estradiol or estriol may play a role in postpartum mood changes. For some women, thyroid dysfunction may be a contributing factor. For the majority of other biological variables thought to be etiologic, including progesterone, prolactin, cortisol and B-endorphins, *studies have been negative or contradictory and have yielded no clear evidence that these hormones play a part in postpartum depressive disorders.* Thus although researchers have speculated that the physiological changes that occur during and after childbirth may be directly linked to the development of postpartum mood syndromes, *the literature does not consistently support a hormonal etiology for postpartum depression.* (p. 77, italics added)

This statement shows that no relationship between hormonal and biochemical activity and PND has yet been found. However, as Miller and Rukstalis' (1999) demonstrated regarding maternity blues, it is very difficult to conduct such investigations. The next section will very briefly list the issues that can affect research in this regard.

3.2 Critiques on biological research

A variety of problems have been cited in the literature as complicating the evaluation of findings on biological research. These include problems with methodology, the timing of observations as well as the definition used when researching PND.

a) Methodological problems

Hendrick and Altshuler (1999) argue that mood changes may result from an abnormal ratio of hormone levels or sensitivity to a particular ratio, rather than any absolute levels. However, this is very difficult to research and at present studies have focused on isolating abnormal levels instead. Also, many studies

have assessed total hormone concentrations rather than free, biologically active hormone levels, while other studies assessed the absolute level of a hormone rather than the degree of change from pre- to postnatal states (Hendrick & Altshuler, 1999; O'Hara, 1997). Yet, other researchers have argued that most studies did not take the influence of breast-feeding, time of day, seasonal variation or medication into account when blood samples were taken (Hendrick & Altshuler, 1999; O'Hara & Zekoski, 1988).

b) Timing of observations

O'Hara (1997) and O'Hara and Zekoski (1988) argue that many hormonal studies on PND have occurred during a period more usually equated with maternity blues. It is therefore not sure whether findings are related to the blues or PND (Brockington, 1996; Hendrick & Altshuler, 1999; Miller & Rukstalis, 1999). Furthermore, Hendrick and Altshuler (1999) argue that to determine whether the change in levels rather than a particular level of hormone is involved in the presence of PND, measurements should be taken more frequently, such as hourly rather than daily (as were the case in most studies).

Nevertheless, despite of the lack of evidence to date, most authors *still* seem to profess that hormones must in some way be involved in the aetiology of PND, despite the fact that hormones have largely stabilised by the time PND is proposed to develop (Brockington, 1996; O'Hara, 1997; O'Hara & Zekoski, 1988). Hendrick and Altshuler (1999) argue that PND, due to its later onset may actually have a more multi-factorial onset. Similarly, O'Hara (1997) argues that biological, genetic and certain social factors may be interrelated and simplistic hormonal models cannot explain this interaction.

For this reason, other studies have attempted to explore the relation between PND and psychopathology to examine whether genetic factors rather than hormonal or biochemical mechanisms underlie the phenomenon. These authors have theorised that other variables such as a previous or subsequent mental illness may provide clues to the possibility of a genetic vulnerability in the development of PND.

4. Relationship to mental illness

O'Hara (1997) argues that even though no link between childbirth and PND could be found, childbirth could still act as a trigger and bring forward a depression in women who are genetically vulnerable to develop the condition. Both previous and subsequent episodes of depression and/or other mental illnesses were examined to test this hypothesis.

a) Previous psychiatric disorders and the development of PND

The evidence regarding a link between a previous history of psychiatric disorder and PND has been inconclusive. While some studies have found a link (O'Hara et al., 1984, 1991; Paykel et al., 1980) other studies did not (Kumar & Robson, 1984; Pitt, 1968). Similarly, evidence regarding a family history of psychiatric illness has also been inconclusive. While some studies have largely supported this link (O'Hara et al., 1984) other studies did not (Kumar & Robson, 1984). Interestingly, O'Hara (1997) mentioned a recent meta-analysis done by O'Hara and Swain (1996, in O'Hara, 1997) that suggest there is no relationship between a family history of psychopathology and PND. This has led researchers to examine the link between PND and the development of psychiatric complications in the future.

b) Subsequent psychiatric disorders in women who where diagnosed with PND

Cooper and Murray (1995), Kumar and Robson (1984) and Philipps and O'Hara (1991) have found that women who suffered from PND were at an increased risk for future depressions over a 5-year period when compared to a non-depressed postpartum sample. However, on further investigation these studies revealed an interesting contradiction.

Philipps and O'Hara's (1991) study showed that after a 4 ½ year follow-up, of those women who had PND, 8/10 women (reported as 80%), had a subsequent episode of depression, compared to 25/60 (reported as 42%) of a non-PND sample. This serves as proof that women with PND were more likely to suffer other psychiatric illnesses. However, what was not highlighted, was that 42% of the non-PND women *also became depressed*. In other words, becoming depressed after childbirth is not necessarily related to PND but could be due to other factors, such as the burden of caring and looking after children (see Brown & Prudo, 1981). Furthermore, it is unsure if those who had PND and were also depressed at follow-up were non-depressed at any point in those 4 years or if their depression were simply a continuation of the pre-existing symptoms.

Similarly, Cooper and Murray's study (1995) is especially important when results are investigated further. They separated 'first' episode from 'previous' and 'recurrent' episodes of depression. Results revealed that women whose postpartum episodes were their first, had depressed symptoms for a shorter duration and were "*significantly less likely to experience a subsequent non-postpartum episode*" (p. 193, italics added). Women with a history of depressive episodes were *not more likely to have PND* but more likely to have a non-postpartum depression in the future. This shows clearly that where dysphoric symptoms were present, these were not necessarily related to PND and where PND was noted, it did not necessarily lead to future psychiatric complications. In addition, this research suggests that women who were depressed before birth may actually experience pregnancy as an ameliorating factor, rather than a predisposing one, supporting the argument proposed by Najman et al. (2000).

4.1. Relationship to mental illness: conclusions

The review of the literature has shown that research has not been able to establish an aetiological link between PND and a previous psychiatric diagnosis, nor between PND and a family history of psychopathology. Furthermore, where a link between PND and the development of psychopathology at some point in the future was suggested, this link could not be maintained upon further scrutiny. In fact, further analysis of the research revealed that depression was a problem for both groups of women at follow-up, and suggests that childbirth may actually be an ameliorating rather than a predisposing factor.

However, this narrow conceptualisation of PND as exclusively related to biological or genetic factors has not escaped critics from both the medical and feminist model. These authors have argued that such a view of childbirth is reductionistic and suggests that childbirth is a pathological process and an aetiological factor in the development of mental illness. It does not take into account the multitude of social, psychological and cultural factors present during pregnancy and after delivery that may contribute to the development of PND (Cutrona, 1984; O'Hara & Zekoski, 1988; Najman et al., 2000; Nicolson, 1998; Ussher, 1989).

The biopsychosocial model has been a response from the medical model to rectify this skewed approach. Rather than focusing on mechanisms inside women, research studies using this model have tried to examine these women's lives in order to

determine the possible factors that may contribute to the development of depression. The biopsychosocial model thus focuses on psychosocial variables such as stressful life events, the quality of marital relationships and low social support to explain the presence of PND.

5. PND: A response to psychosocial stress?

The biopsychosocial model has thus, in an attempt to depathologise the experience of childbirth and prevent a reductionistic understanding of PND, examined the multitude of factors that may play a role in the development of PND. These findings are briefly reviewed.

a) Life events

Research has consistently shown that high levels of stressful life events such as financial worries, changes in living arrangements or abandonment by the partner, during pregnancy and after delivery have been associated with PND (Cooper et al., 1999; Martin, Brown, Goldberg, & Brockington, 1989; Paykel et al., 1980). However, some studies have failed to find a relationship between negative life events and PND (Pitt, 1968; Robson & Kumar, 1984). Nevertheless, both Brockington (1996) and O'Hara (1997) reviewed the literature and conclude that a strong relationship between adverse life events and PND has been found. The same seems to hold true for relationship problems.

b) Relationship problems

Marital problems, such as divorce, conflict and poor communication during pregnancy and after delivery have also been linked to PND (Cox et al., 1982; Paykel et al., 1980). Brockington (1996) mentions 17 studies that have found such a link between marital problems and PND. O'Hara et al. (1984) studied the link between PND and relationship problems in-depth. They found that depressed mothers were unable to rely on their spouses for support; they were less likely to discuss problems with their partners and partners were less available and less involved than the non-depressed sample. They conclude that there were a strong link between relationship problems and PND.

c) Lack of social support

Apart from marital relationships, other social support structures were also examined. Single parenthood (Paykel et al., 1980; Pitt, 1968) and a poor relationship with the maternal parents (Cutrona, 1984; Kumar & Robson, 1984; Righetti-Veltema, Conne-Perreard, Bousquet & Manzano, 1998) have both been

associated with PND. Cutrona (1984) showed that women's perceived lack of social support was the strongest predictor of postpartum depression. In a South African study, Spangenberg and Pieters (1991) found a significant relationship between PND and both marital dissatisfaction and a lack of social support in a postpartum depressed group, when compared to non-depressed controls. Other studies have again examined the influence of caring for other children after delivery as a factor for becoming depressed.

d) Parity

Parity has also been suggested as a risk factor for PND, but findings have been inconclusive. In a seminal study, Brown and Prudo (1981) showed that caring for three or more children under 14 is a high risk factor for depression. Similarly, Righetti-Veltema et al. (1998) found that multiparity was associated with PND but others found no such relationship (Paykel et al., 1980; Spangenberg & Pieters, 1991). It is possible that financial variables and other social support structures may mediate the influence of parity on becoming depressed (O'Hara, 1997).

e) Gynaecological and Obstetrical problems

Gynaecological and obstetric complications have been thought to constitute a stressful life event, but when tested separately research did not always find a relationship with PND (O'Hara, 1997). Many authors found a relationship between obstetric complications, such as caesarian section or invasive medical procedures during birth, and postnatal depression (Oakley, 1980; O'Hara et al., 1991; Righetti-Veltema et al., 1998) but other studies did not (Cox et al., 1982; Paykel et al., 1980; Spangenberg & Pieters, 1991).

5.1 PND and psychosocial variables: conclusions

A review of the literature shows that a link exists between PND and certain psychosocial variables such as negative life events, relationship problems and a lack of social support during pregnancy and shortly after delivery. Therefore, it can be deduced that it is not childbirth that predispose women to mental illness but rather their life-worlds, and the stresses they face in the postnatal period that may contribute to PND. However, to date the nature of the relationship between social factors and PND has not been established and while a breakdown of support structures may lead to PND the converse, namely that PND may be responsible for such a breakdown, is also possible (O'Hara & Zekoski, 1988). Apart from the fact that the direction of cause has not been determined in studies

on PND, many other methodological flaws have also complicated evaluation of results and a brief discussion follows.

5.2 Critiques on biopsychosocial research

Most critiques of research regarding psychosocial variables revolved around the criteria used to define and study PND.

a) Construct problems

In a critical review of PND, Hopkins, Marcus and Campbell (1984) have argued that almost none of the scientific papers set out a clear operational definition for PND. Hopkins et al. (1984) conclude that the literature “failed to distinguish between maternity blues, postpartum affective psychoses and mild to moderate postpartum depression” (p. 498). This is similar to Nicolson’s critique (1998) that most studies were guilty of “concept slippage” (p. 29) and occurred when inadequate separation between different affective disorders led to confounding results. However, in the studies that stipulated a clear definition, these definitions differed dramatically from one another making comparison of studies very difficult. Moreover, where standard diagnostic criteria were used, no distinction was made between different levels of impairment leading to a skewed or over-represented sample (O’Hara and Zekoski, 1988). Other researchers have stated that the problem in defining PND is a result of the difficulty in defining depression itself and is not particular to PND (Brockington, 1996; Hopkins et al., 1984; O’Hara, 1997; Snaith, 1993).

O’Hara and Zekoski (1988) argue that many studies did not actually specifically investigate depression but rather considered any emotional symptom that was detected. This gives credence to the feminist critique that the medical model’s exclusive focus on the body has resulted in a scenario where the presence of any form of emotion is deemed as potentially pathological (Lee, 2000; Nicolson, 1998; Ussher, 1989).

Research on PND is currently problematised on every level, and encompasses all aspects regarding its conceptualisation from methodology to politics and ideology. While the previous sections have primarily focused on the methodological issues, the next section will examine the ideological and political problems regarding research on

PND. These arguments highlight the crux of the debate regarding the conceptualisation of PND and show that current research practice has been unable to find a solution.

The conceptualisations of PND: critiques and implications

The previous sections explored the three main conceptualisations of PND. While the literature pertaining to these main arguments were criticised in terms of their methodological flaws, the underlying implications have not yet been addressed. This section will therefore briefly summarise and critically discuss these main theories in terms of their broader, political and ideological impact for understanding PND and women's mental health in general.

1. PND: the debate regarding diagnosis

The debate, whether PND can be classified as a separate condition that deserves a formal diagnosis in the official nomenclature, can be divided into two parts. Firstly, to prove that PND warrants a separate diagnosis, research will have to show that PND is a uniform condition with a distinct clinical picture in terms of symptom pattern, onset and duration. Secondly, it has to show that this condition is severe enough to be a mental health problem in its own right.

The first part of this chapter has shown that there is not enough evidence in the literature to prove that PND can be differentiated from depression occurring at other times in the life cycle. Brockington (1996) after a thorough review of the literature states that there is no scientific proof for the concept of PND as "it is hard to see any differences between the symptoms of postpartum depression and depression occurring at other times and in different contexts" (p. 170). This was also found by the DSM-IV taskforce (Purnine & Frank, 1996). Nevertheless, many authors have argued that there is evidence for the notion that PND is a distinct condition. Moreover, they argue that the presence of an infant makes this diagnosis valid and necessary (Beck, 1992; O'Hara, 1997; Wood et al., 1997). The debate in this regard therefore continues.

However, researchers have argued that for PND to warrant a separate diagnosis scientific studies have to show that the condition is a mental health risk in its own right. In other words, the question exists whether depression in the postnatal period

holds dangers to women that are different from depression at other times. This question is examined below.

2. PND: a mental health risk?

Najman et al. (2000) argue that for PND to constitute a separate diagnosis it has to be a mental health risk in its own right, i.e. the rate of depression in the postnatal period should exceed the rates normally observed in the general population. Moreover, the onset of depressive symptoms should be specifically related to childbirth and not be a continuation of symptoms that were already present in the antenatal period. Therefore, research should be able to show that the postnatal period is a time of increased risk for women to develop depression.

a) The postnatal period: a time of increased risk?

The previous section on the specificity of childbirth has systematically shown that depression was not more prevalent in childbearing samples when compared to non-childbearing women of the same age-group (Cooper et al., 1988; Cox, et al., 1993; O'Hara et al., 1990). Even those studies stating that the postnatal period was a time when women were more likely to develop depression, revealed on further scrutiny that depression was a problem for *both* postpartum and control groups (Cooper & Murray, 1995; Philipps & O'Hara, 1991). However, studies have shown that there are grave consequences for the infant of a depressed mother (Cooper & Murray, 1997) but research has not substantiated if this is more so with depression when compared to other psychiatric complications (Brockington, 1996).

Najman et al.'s study (2000) is very important, as it was the only study that specifically set out to examine whether PND constitutes a mental health risk. They found that while depressive symptoms were common in the postnatal period, these were not more so than prior to birth or five years after birth. Also, where PND was observed, it was often an exacerbation of symptoms already present in the antenatal period. Other studies confirmed these findings (Patel et al., 2002). Furthermore, Najman et al. (2000) argue that if PND is used to delineate a depression precipitated by childbirth or directly after childbirth, then the postnatal period was a time when women were less often depressed. They suggest that the postnatal period may actually be a time of increased mental health for women. Again, other studies corroborated this view (Ritter et al., 2000). Both Najman et

al. (2000) and Ritter et al. (2000) state that while depression may be a problem for women, there was no evidence that the postnatal period is a time when women are more likely to become depressed.

These studies beg the question whether PND deserves the current attention it is receiving and if the focus should not rather shift to the prenatal period instead? Other researchers have asked whether the diagnosis has any relevance at all (Brockington, 1997; Nicolson, 1998; Ussher, 1989) since no scientific evidence can be found to validate whether PND is a separate entity that poses significant mental health consequences for women in the postnatal period.

b) The utility of PND as a diagnosis

Both the medical and feminist models have debated whether the label PND is necessary and valid as a concept to denote depressive symptoms in the postnatal period. Brockington (1996) in his review of the literature concludes as follows:

The concept of 'postnatal depression' does not emerge from 30 years of research with much scientific credit. If postpartum psychosis is excluded, there is only a modest evidence of an association between depression and the puerperium. It has *not* been demonstrated that depression is more common after childbirth than at other times during the female productive period. From the scientific standpoint, the term 'postnatal depression' has dangers, which it shares with other loosely defined, excessively broad psychiatric categories. It tends to introduce into the minds of the unwary the notion that there is a homogenous disorder, which can be investigated and treated as if it has a single cause. (Brockington, 1996, p. 174; emphasis author's own)

Feminists such as Nicolson (1998) are in agreement with Brockington as quoted above. They argue that labeling the presence of depressive symptoms after delivery implies that it is a pathological reaction and ignores the fact that birth is a complex event that is accompanied by physiological, emotional, social and cultural changes. The presence of depressive symptoms may thus be part of a 'normal' process of reorientation and not a psychiatric disturbance (Nicolson, 1998; Smith, 1999; Ussher, 1989). Also, labeling gives added credence to the notion that childbirth itself may make women more prone to develop mental illness.

However, insisting that the label PND should be abandoned because it pathologises women's reproductive experiences, also has dangers. Brockington (1996) argues that merely because PND lacks validity as a scientific concept, it should not be abandoned as a term to describe women's distress after childbirth. He argues that the term can be an important political tool:

[The term PND] is useful and important, because it has legitimized maternal depression in the minds of the public, providing a valid explanation for role failure. It has diminished the stigma of the illness, and enabled mothers to know and accept that they are ill, and come forward for treatment... it is a slogan which can be wielded in the political struggle to obtain better services for mothers of young families. It has even served to explain otherwise inexplicable behavior, such as child neglect and infanticide. There is a need for such concepts which have widespread social and political influence. (Brockington, 1996, p. 174)

Brockington clearly asserts that the term PND has political significance in that it has absolved women from being stigmatised and responsible for their reactions after childbirth. However, underlying his argument is an ideological assumption about women. His quotation implies that women are innately and 'naturally' caring and that those who are not should be seen as ill and in need of treatment. This has also been the main critique from feminist researchers. They argue that the medical model has inherent assumptions about women that form part of a broader ideological apparatus that is not immediately amenable to scrutiny, but ultimately serves to marginalise and subjugate (Nicolson, 1992, 1998; Oakley, 1986a, 1986b; Ussher, 1989; Woollet & Marshall, 2000). What these assumptions ignore, is that women who maltreat their children may do so out of desperation and powerlessness, which is not an 'illness' but part of the larger context of women's repression. However, to refuse the terminology because it may have broader ideological consequences for women, results in a moral dilemma, highlighted by Nicolson's comment (1998) cited in the introduction of this text.

I argued... that PND does not exist because depression following childbirth is a rational, predictable and healthy response to loss. However, taking this position risk further marginalising the evidence of women's experience of the transition to motherhood and associated emotional responses. (Nicolson, 1998, p. 108)

The double-bind is therefore clear: By refusing to use the term PND, denies women a label to make sense of their distress. They experience their failure to give adequate care to their infants as proof of their own inadequacy that further serves to demoralise them. However, by using the label PND may contribute to a broader ideological view about women that pathologises their reproductive and mothering experiences.

However, the medical model should be credited for its attempt to depathologise the postnatal period. The biopsychosocial model provided a way to address the tendency to develop reductionistic models of women's reproductive experiences. Nicolson (1998) and Ussher (1989) argue that these attempts have largely been inadequate since the ideology about women and motherhood has remained intact and unexamined. This can also be seen when the arguments regarding the aetiology of PND is examined. The significance of these arguments will be discussed in more depth in the next section.

3. PND: the debate regarding aetiology

This chapter has provided an extensive examination of the research regarding the aetiological debates. As with maternity blues, it is thought that PND must somehow be linked to hormonal activity - given the dramatic hormonal changes during and after pregnancy. However, after almost 60 years of research no conclusive evidence for a biological aetiology of PND has been found (O'Hara & Zekoski, 1988). In contrast, research studies have been able to show a definite relationship between PND and psychosocial variables such as marital conflict and lack of social support. Yet, the hormonal hypothesis remains the most consistently used explanation for PND, both within the medical profession and in popular discourse (Nicolson, 1998; O'Hara, 1997). The next section will examine how this has come about and what the implications are for the conceptualisation of PND.

3.1 The biological hypotheses: a feminist response

Many feminist researchers have not so much argued against the idea that hormones *may* be involved in the aetiology of PND but have questioned the insistence with which such a narrow view is maintained, despite the fact that research showing a more complex process to be at work. They argue that the insistence on a narrow conceptual model of aetiology based on biology has far-

reaching implications for how women's reproductive experiences are viewed (Mauthner, 1998; Nicolson, 1992, 1998; Oakley, 1986a, 1986b; Ussher, 1989, 1992; Woollet & Marshall, 2000).

a) Implications for women's reproductive experiences

According to many feminist theorists the exclusive focus on biological mechanisms is reductionistic as it positions women's bodies as machines that do not always work as they should. It also positions the medical professionals as experts on the functioning of these 'machines' (Nicolson, 1998; Oakley, 1986a; Ussher, 1989). According to Oakley (1986b) this has allowed the medical profession to take control of women's bodies and has transformed childbirth, formerly a social experience into a medical one. Ussher (1989) adds that it has also contributed to making women's own knowledge about their bodies obsolete. As a result women are positioned as ignorant and powerless when confronted with their reproductive experiences. The implications are that women have been removed from the process of giving birth and they become the helpless attendants, ignorant and marginalised by their own bodies. Ussher (1989) and others argue that this is part of a larger process of marginalisation that has the subjugation of women as its aim.

The theme of women's biological inferiority has been both implicit and explicit in biological sciences since the time of Aristotle. It is ... an essential theme for the ideology and cultural practices of society that require women's subordination both in the home, as homemakers and mothers, and in the marketplace, as underpaid workers in the nurturing, helping and domestic professions. (Bleier, 1984, in Nicolson, 1998, p. 41)

These feminist researchers propose that biological theories form part of a larger political, economic and ideological apparatus that has repercussions far beyond female reproduction. They also assert that this may be the reason why the medical establishment has maintained its view that biology is the main aetiological factor even in the absence of proof (Nicolson, 1998, 1992; Ussher, 1989, 1992).

However, women themselves use the biological hypothesis, and do not experience it as an oppressive and marginalising explanation. On the contrary, it has become a powerful explanatory model for women who do suffer

postnatal distress. Nicolson (1998) for example, has shown in her study that women actually preferred the biological hypothesis as an explanatory model. She argues that it has become credible for women to talk about their distress in terms of their hormones, as it is simultaneously a way to make sense of their experience and to absolve blame from personal defect or 'inability to cope'. It has also become a way whereby they can ask for help. This highlights a contradiction, for where feminists argue that medical explanations serve to subordinate women; women themselves use these theories to feel more empowered.

The well-known poststructuralist philosopher, Michel Foucault, may provide insight into this dilemma. He has made his focus of study the way knowledge increases a person's power within social systems. He maintains that medical theory is a form of knowledge that increases a person's status in society (Foucault, 1972) and to understand this interplay between explanatory model and power, it is necessary to examine how medical hypotheses have become part of a political struggle for power¹⁷.

b) Explanatory models and the skirmish for power

According to Foucault (1972) medical knowledge, in this instance, gives one group power over another by providing them with a very particular way of explaining the world. This particular set of statements he termed discourse (Foucault, 1972) and according to Parker (1992) "a discourse is a system of statements which constructs an object" (p. 5). The objects in this case are women's bodies and the discourses are the biological explanations used to gain power over these bodies. According to Foucault, medical explanations are never just theories, but also powerful cultural notions that are intimately bound up with power. Any version of an event therefore brings with it the potential for social practices for acting in one way rather than another, and also for marginalising alternative ways of acting (Burr, 1995; Foucault, 1972; Parker, 1992). In this case, medical explanations of women's bodies are a way for the medical profession to gain power over them while at the same time silencing alternative views of the same event (i.e. alternative conceptualisations of PND). However, Foucault saw power not as a repressive force that served to actively subjugate and repress, but as constructive, where the other is actively involved in these discursive actions. The power of discourse is that the 'other'

becomes actively involved in its own subjugation. He states that discourses are pervasive and tolerable “only on condition that it masks a substantial part of itself. Its success is proportional to its ability to hide its own mechanisms” (Foucault, 1981, p. 86). Therefore, this brief summary of Foucault’s concept of discourse shows that women’s use of the hormonal hypothesis, may seem to be an act that aims to gain power, but in reality they have become actors in the drama of their own repression. In other words, he suggests that women’s use of the hormonal hypothesis shows the power of medical discourse to control while simultaneously preventing alternative discourses from becoming part of mainstream knowledge (Foucault, 1972; 1981).

It is for this reason that feminist researchers have insisted that other ways of looking at women’s reproductive experiences are necessary to expand the explanatory models currently available. This is necessary to prevent a scenario where women’s bodies are objectified as a medical problem and their individual postnatal experiences marginalised. However, the way research studies within the medical paradigm have attempted to do so, by way of examining social and psychological factors, are also problematic.

3.2 PND and social stress: a feminist response to the biopsychosocial model

Feminist researchers have launched an extensive critique on the biopsychosocial model’s attempt to depathologise PND (Mauthner, 1998; Nicolson, 1992, 1998; Oakley, 1986b; Ussher, 1989). They argue that the biopsychosocial model has failed to show *how* social stress may impact on women during the postnatal period, as it has not been able to examine the interplay between social, cultural and personal experiences. It has simply “added the social context to the biology and does not take women’s experiences as their focal point” (Nicolson, 1998, p. 34). This has resulted in a scenario where the social context has been pre-defined into discrete categories such as ‘relationship problems’ or ‘financial stress’ and imposed onto the biological context. In this way the background context of women’s lives has been edited out of mainstream literature and has implications for women in general (Nicolson, 1998; Ussher, 1989).

a) Women as victims of social stress

According to Mauthner (1998) and Nicolson (1998) the biopsychosocial model ignores the contexts within which women’s lives are embedded and

thereby positions them as helpless victims, powerless to effect any change or resist the pressures of the social world (Mauthner, 1998). PND is thus seen as a response to this social strain and the different ways in which women *do* resist and *do* have agency are ignored (Mauthner, 1998; Nicolson, 1998). Nicolson argues that PND is far more than *just* a reaction to childbirth and early motherhood.

It marks the way an individual makes sense of and copes with the circumstances surrounding motherhood - not just those which are directly connected to being a mother, but the things that are happening in her life at that time and how the total circumstances shape her view of what the future might have in store ... [we must] develop a rationale for looking beneath the surface to explore the interconnection between biographical context, social support, meaning and experience. (Nicolson, 1998, p. 40)

Mauthner (1998) adds that the current approach in research on PND is located within an individualist model and excludes the interrogation of the political and ideological framework of women's lives. Nicolson (1998) argues that part of this surface exploration of the social context reveals deep-seated assumptions about women.

It is easy to see that lack of support makes mothering even harder to accomplish and adds to any stress, but this view of lack of support contributing to an 'illness' is still based on the assumption that *all* women *naturally* make *good* mothers". (Nicolson, 1998, p. 34; emphasis author's own)

This notion that the medical paradigm reflects and incorporates assumptions about women in their research has been discussed extensively in the feminist literature under the rubric of 'myths of motherhood' (Oakley, 1979, 1980, 1986a; Ussher, 1989, 1991; Woollet & Marshall, 2000). This will briefly be examined.

b) Myths of motherhood

As shown in chapter 1, feminists have argued that constructions of women's reproductive experience have been around for centuries and that each epoch seemed to have refined and built these notions, through discourses and practices into constructions of self and other. These constructions have been

called 'myths' by certain feminist writers since they are not based on any intrinsic 'truth' but are the result of stories, ideas and beliefs about women that have persisted through the ages (Nicolson, 1992, 1998; Oakley, 1986a, 1986b; Ussher, 1989). These 'myths' have thus become the edifice of western society's knowledge base about sex, gender, women and men (Busfield, 1996; Chesler, 1972/1997; Ussher, 1991). This body of assumed knowledge has been termed ideology, as it constitutes the social and cultural notions against which individual women compare their own experiences (Oakley, 1979, 1980; 1986a; Ussher, 1989; 1991). This is especially true when pregnancy, childbirth and the postnatal period are examined, and research studies have shown that many women's identities have become tightly bound up with these dominant notions (Nicolson, 1998; Oakley, 1986b; Woollett & Marshall, 2000). Many women have no idea what motherhood might entail, but popular discourses abound with ideas that personal fulfilment, happiness and a sense of completion will follow the experience (Oakley, 1986b; Woollett & Marshall, 2000). Moreover, many women believe that they can only achieve adult, feminine status through becoming mothers (Nicolson, 1998; Oakley, 1986b; Woollett & Marshall, 2000).

However, while some women may experience childbirth and the postnatal period in this way, Nicolson (1998) and Oakley (1979) have shown that many women do not. Those who are disappointed and disillusioned are at odds with the dominant cultural notions and experience a sense of personal inferiority since their own experience do not measure up to these expectations (Mauthner, 1998; Nicolson, 1998; Oakley, 1980). Many researchers have thus argued that PND may be a consequence of this clash between ideological notions and personal experience in the postnatal period (Mauthner, 1998; Nicolson, 1998; Oakley, 1980; Raphael-Leff, 1991; Rich, 1986; Smith, 1992; Ussher, 1989). However, the extent to which this is true for other cultures and different societies have not been examined.

PND: concluding remarks

This chapter has examined the different debates regarding the conceptualisation of PND. The first section has summarised the literature regarding its clinical picture

while the second section explored the many issues related to its research methodology. Both these sections have highlighted the current problems and confusion regarding the debate whether PND is a separate entity that warrants a separate diagnosis in the current official nomenclature, which introduced the next section regarding the different conceptualisations of PND. This was explored in terms of its universality, specificity to childbirth, and the various aetiological models that have been proposed for this condition. A critique of these theories followed, highlighting the debates regarding diagnosis and aetiology as some of the main factors that impact on its current conceptualisation. Furthermore, and extensive critique from the feminist literature has emphasised the many political and ideological issues that beset the current research on PND.

CONCLUSION

This review examined the conceptualisation of postpartum mood disorders from a feminist perspective. It had two broad aims, namely to examine postpartum mood disorders as a medical construct and to explore the ideological and political implications of such a conceptualisation. It therefore made use of the medical model's concept of PND as part of a continuum of mood disorders, with postnatal psychosis at the one end, and maternity blues at the other as the basis for structuring this review.

Chapter 1 examined the historical roots of post-birth distress with specific reference to PND. It also attempted to show how conceptions of women were fostered by these early writings and that traces can still be discerned in current thinking about women's reproductive health.

Chapter 2 reviewed the medical literature on postnatal psychosis. Since postpartum psychosis is not the main focus of this review only the main aspects related to its definition and aetiology were discussed. A brief discussion of the underlying implication that childbirth may act as predisposing factor in the aetiology of mental illness followed. The main conclusion was that most studies on puerperal psychosis have uncritically assumed an underlying relationship between childbirth and mental illness or have actively tried to prove such an assumption. This chapter then also served as an introduction for the next two chapters on maternity blues and PND.

Chapter 3 and 4 examined maternity blues and PND respectively. Each chapter was organised in terms of clinical picture and methodology, followed by a discussion of the different conceptualisations that have been proposed for their development. Lastly, these conceptualisations were critically examined and the possible political and ideological implications were highlighted.

Three broad arguments can be traced throughout this review, which also form the main critique against the current medical conceptualisation of postpartum mood disorders.

Firstly, it was shown that PND is currently conceptualised in the medical literature as existing on a continuum between psychosis and maternity blues. It was argued that this is problematic as research has shown that these three conditions are qualitatively different from each other with different aetiological factors proposed for each. It is argued that this construction of postpartum psychosis as separated from PND only in terms of duration and severity, implies that emotional distress after childbirth may be potentially pathological, requiring constant medical and psychiatric intervention.

Furthermore, at the other end of the continuum, the high incidence of the blues (over 50% in some cases) gives scientific urgency to the studying of maternity blues and legitimises continued research on a syndrome that is below the threshold of a psychiatric disturbance. It also implies that pregnancy and childbirth may be times of increased vulnerability for women and positions medical expertise and constant surveillance as a necessity during this period.

Secondly, it was argued that this current conceptualisation of postpartum mood disorders on a continuum of distress pathologises the postnatal period and position women's bodies as inherently defective, while medical doctors have become the experts on the functioning of these 'machines'. Women's own knowledge of their bodies has become obsolete and their individual experiences marginalised.

The third argument examined the problems related to the biopsychosocial model's research in the postnatal period. It was argued that the preoccupation with classification and categorisation has removed women from their experience of distress. Research on post-birth distress has become an exercise in scientific labeling whereby social factors are seen as discrete entities that act on women. This denies the active process whereby women do resist and obtain power within their environments. Research to date has thus been unable to examine how social, cultural and personal factors interact to result in distress during the postnatal period.

Lastly it was argued that a different way for researching postpartum mood disorders is necessary to overcome these problems and prevent a reductionistic and pathological model of childbirth and postnatal experiences.

Implications for further research

This review has shown that future research on the postnatal period should attempt to examine the interplay of the multitude of factors that impact on women during this period. Firstly, this review has highlighted that there is a need for longitudinal studies to track the presence of symptoms during the entire duration of pregnancy and the postpartum period. Secondly, it has highlighted that it is as yet unclear how social factors impact on women during the puerperium to result in postpartum distress. Following Nicolson (1998) and Ussher (1989) this review asserts that women's own explanatory models need to be explored to examine the interplay between biological, social, cultural and personal contexts and how these may impact on the development of PND.

Qualitative research is an approach that allows for the exploration of interconnection between these different levels of analysis¹⁸ (Hollway, 1989; Nicolson, 1998; Ussher, 1989; 1991, 2000). It is also necessary to enable researchers to understand how women themselves make sense of their distress and to explore those factors that may contribute to resilience. In addition, an understanding of women's own explanatory models enable researchers to examine how women interact with healthcare systems when distressed and what they expect to gain from such an interaction. It also prevents the researcher from imposing pre-conceived assumptions and notions while professing to do otherwise¹⁹.

This is of particular importance in South Africa where the assumptions of white, middle-class culture have largely dominated research method and inquiry. These assumptions have led to skewed representations and misperceptions about the 'other' in the past and needs to be addressed if mental healthcare hopes to provide in the needs of *all* women during the postnatal period.

To date only a limited number of studies on the postpartum period have been conducted in South Africa. A significant number of these were unpublished theses and only four were published in national or international journals (see Appendix C). Only two studies have focused on PND: One on a white, middle-class sample (Spangenberg & Pieters, 1991) and another larger study on African mothers in a peri-urban setting (Cooper et al., 1999). The former, based on a white middle-class sample, mirrored

results found in the European and American literature. The latter showed that the incidence of PND was much higher than studies conducted with western samples. Although this study is of seminal importance for highlighting the issue of PND in South Africa, these researchers used a western-based diagnostic and assessment system and it is unclear how this may have influenced the results. As yet, very little is known about the majority (mostly African and other non-white) South African mothers' experiences of pregnancy, birth and its aftermath. There is thus a dire need for research in this area.

FOOTNOTES

¹ These rates will be discussed in depth at a later stage in the text.

² The psychosocial model will be critiqued in chapter 4 when discussing PND.

³ An exposition on positivism falls outside the boundaries of this review, but many feminist texts provide a concise critique of the effects of positivism and its underlying assumptions, see for example Hollway (1989) and Wilkinson (1996).

⁴ Brockington's review (1996) of puerperal mental disorders is the most comprehensive review found in the literature from a medical perspective. Most studies critique the treatment of women, while his review provide systematic lists and describe almost every aspect related to puerperal mental illness. Since the focus of this chapter is a descriptive overview, rather than an extensive review of the literature, it relies heavily on his work.

⁵ The term 'clinical picture' is placed in single quotation marks, as I am not sure if these complaints were without merit. The term, clinical picture assumes that the symptoms are the visible parts of an illness or pathology originating from within the women and unrelated to outside factors. Instead, the complaints of the women in the case studies presented by Brockington (1996) resonated clearly with the issues highlighted by Oakley (1979, 1980, 1986a) and in some instances by Nicolson (1998).

⁶ There are many debates within psychiatry regarding the relevance of *organic* versus *psychogenic/functional* aetiologies of mental illness. The earliest psychiatric textbooks classified mental illness in terms of origin and according to Hamilton (1974):

The first major classification of mental illness was based on the distinction between disorders arising from disease of the brain and those with no such basis i.e. organic versus functional states. These words are still used but like so many in psychiatry they have lost their original meaning. In their literal meaning these categories of classification are absurd, but they retain their usefulness because the syndromes so classified can be distinguished and the distinction is one of the clearest in psychiatry". (p. 8)

Due to the advances in biochemistry it is known today that most psychiatric disorders correspond to certain biochemical changes in the brain and aetiology is thus far more complex and an interactive process between body, psyche and environment. Nevertheless, the remnant of this thinking is still evident in the DSM-IV in terms of

the category *due to a medical condition*. The DSM-IV has substituted the term *organic* with this term to “convey a clinician’s opinion that a particular psychiatric symptom (such as depression) is probably primarily related to a specific nonpsychiatric disorder ... and requires its own treatment plan” (Kaplan & Saddock, 1998, p. 319). However, the ICD-10, the official nomenclature system used in Britain and Europe has maintained a view that is much closer to the original usage. “*Organic* in the ICD-10 implies only that the syndrome ... can be attributed to an independently diagnosable cerebral or systemic disease or disorder” (Kaplan & Saddock, 1998, p.320). While it is not possible to argue the use of these terms in more depth, their original intention is maintained when used in this text. The reader is also reminded that the epistemological basis underpinning these terms is not uncritically accepted. Rather, and more importantly, using these terms in their original meaning is essential in understanding the historical progression of psychiatric diagnoses and thinking about mental illness.

⁷ Acute organic brain syndrome describes a pattern of symptoms that is usually associated with a degenerative organic brain process such as dementia and has psychotic symptoms that are usually different from functional or nonorganic psychosis. For example, visual hallucinations (in the absence of psychotropic drugs) are not usually observed in functional psychosis and have often been observed in postpartum psychosis (Ur-Rehman, et al., 1990).

⁸ See footnote 10 on the use of the words ‘organic’ and ‘functional’.

⁹ All three studies, Kendell, Chalmers, & Platz (1987), Meltzer and Kumar (1985) and Terp and Mortensen (1998) have shown that very few women, previously diagnosed as schizophrenic became actively psychotic after childbirth. A few became psychotic during the early stages of pregnancy and were either stabilised before delivery or lost their children before term.

¹⁰ Brockington (1996) tabulated the number of studies and their findings regarding timing of the maternity blues and peaking. It is clear for this that there is no consensus between the studies and that the definition of onset and timing of the blues have been largely arbitrarily defined.

¹¹ This is the only study in which some attempt was made to find out how women themselves talk about their distress, but it was not done primarily to understand the phenomenology of the blues. Instead it was aimed at constructing a rating-scale that would mirror the way women think and talk about the blues. Kennerly and Gath (1989a) argue that mothers possibly used ‘low spirited’ to refer to a general state of

demoralisation, and 'depression' when referring to dysphoria of a much higher intensity. It would be interesting to consider what role the fear of being stigmatised, and the need of mothers to present themselves as capable and coping played in this choice of words. Also, the reader should be careful to think that this type of research is an attempt to give voice to women's own experience. Rather it should be seen as part of discursive practice (discussed at a later stage in the review) where women's views are incorporated into research methods whereby they become part of their own marginalisation. The power-struggle underlying this activity is thus hidden, and presents itself as 'for women's own good' (see Foucault, 1972, for a full discussion of discursive practices).

¹² However, the feminist researchers have not focused specifically on maternity blues and their arguments are thus more directly relevant to the debate on postnatal depression (see chapter 4).

¹³ *Retrospective studies* include those studies whose data depended on recall of participants and include Pitt (1973) and Paykel, Emms, Fletcher, & Rassaby (1980). In both studies a higher percentage of women who had postnatal depression had previously had the blues. However, Kennerly & Gath (1986) have shown that retrospective data is unreliable as women who are depressed are far more likely to depict the past in negative terms compared to women who are not depressed.

Prospective studies are studies where the participants are studied in the first few postpartum days to measure the blues and then followed-up after delivery at varying intervals and the subsequent psychiatric disorders detected. Kendell, Rennie, Clarke, & Dean (1981) found that the high rate of depression and lability of mood were correlated with the occurrence of depression 3 weeks postpartum. Cox, Connor, & Kendell (1982) have shown that severe blues symptoms were highly associated with later depression. Kennerly and Gath (1989b) found no such association but Kennerly and Gath (1986) argue that the different findings could be the result of the different scales used.

¹⁴ The advancement in psychiatry during the post-war years from 1950s onwards is a complex and important aspect in the social construction of mental illness and psychiatric discourse still prevalent today. Unfortunately, due to the constraints of this section a full discussion on this fascinating area in the history of psychiatry, psychology and medicine in general cannot be discussed here. For a more comprehensive discussion see Miller & Rose (1986).

¹⁵ Only two of the women in his sample of 33 had suicidal ideation and were hospitalised.

¹⁶ Where Pitt's (1968) definition of 'atypical' focuses on the presence of anxiety and neurotic symptoms, the current DSM-IV definition of atypical depression is related to the increased presence of vegetative symptoms, such as weight increase, rather than decrease, and sleeping more rather than less.

¹⁷ Foucault's writings are highly complex and the next section will only explore the main tenants related to this argument.

¹⁸ While qualitative research is much used in feminist research, the reader should note that there is no intrinsic relationship between qualitative research and feminism. It should also not be seen as an answer to research that provides the 'real truth'. As Kritzinger (1990) have shown, qualitative research can be as pathologising as quantitative research. The main impetus of qualitative research is that it is more interested in showing the contradictions and tensions within discourse than predicting, and finding causes (Nicolson, 1998). Wilkinson (1996) shows the variety of research methodologies currently used by feminist researchers, varying from psychodynamic case studies to both quantitative and qualitative research methods.

¹⁹ The method by which qualitative research achieves this is through reflexivity, and bringing the views, gender, social context and hidden assumptions of the researcher into the open. This is part of rigorous research methodology and cannot be discussed here in full, however there are many texts on the topic (see for example Hollway (1989) and Nicolson (1998) for a more systematic and thorough discussion).

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The Edinburgh Postnatal Depression Scale (EPDS)

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.

Here is an example, already completed.

I have felt happy:

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

This would mean: 'I have felt happy most of the time' during the past week. Please complete the other questions in the same way.

In the past 7 days

1. I have been able to laugh and see the funny side of things
As much as I always could/ Not quite as 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 no 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 in 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 symptom. Items marked with an asterisk* are reverse scored (3,2,1 and 0). The total score is calculated by adding together the scores for each of the ten items.

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Postpartum Depression Screening Scale (PDSS)

Manual

Cheryl Tatano Beck, D.N.Sc.
and Robert K. Gable, Ed.D.



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Please complete the following information:

Name (or ID number): Anna

Age: 26 years

What is the highest education you have earned?

- Less than high school graduate
- High school graduate
- Some college
- Four-year college degree or more

What is your race/ethnic group?

- White
- Black or African American
- Hispanic or Latino
- Asian
- American Indian or Alaskan Native
- Native Hawaiian or other Pacific Islander

Other (please specify) _____

What is your marital status?

- Single
- Married
- Partnered
- Divorced
- Separated
- Widow

Other (please specify) _____

Do you have a previous history of depression? Yes No

Have you ever been treated for depression (psychotherapy or medication)? Yes No

How many times have you been pregnant? once

How many biological children do you have? 1

For your most recent birth:

What type of delivery did you have? Vaginal Cesarean

What was the date of your baby's birth? March 4, 2000

How are you feeding your baby?

- Bottle feeding
- Breast-feeding
- Combination

PDSS

AUTOSCORE™ FORM

Cheryl Tatano Beck, D.N.Sc.
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Figure 1 (continued)
Example of a Completed PDSS AutoScore™ Form

Below is a list of statements describing how a mother may be feeling after the birth of her baby. Please indicate how much you agree or disagree with each statement. In completing the questionnaire, please circle the answer that best describes how you have felt over the past 2 weeks. Read each item carefully. Then circle the number that best fits your answer. Please give only one response for each statement, using the following scale:

- | | | | | |
|----------------------|----------|-------------------------------|-------|-------------------|
| 1 | 2 | 3 | 4 | 5 |
| Strongly
Disagree | Disagree | Neither Agree
nor Disagree | Agree | Strongly
Agree |

If you wish to change your response, completely mark through your first response with an "X." Then circle the response that best fits your new choice.

Strongly Disagree

Disagree

Neither Agree
nor Disagree

Agree

Strongly Agree

During the past 2 weeks,

- | | |
|---|---|
| 1.....2.....3..... 45..... | 1. I had trouble sleeping even when my baby was asleep. |
| 1.....2.....3..... 45..... | 2. I got anxious over even the littlest things that concerned my baby. |
| 1.....2.....3..... 45..... | 3. I felt like my emotions were on a roller coaster. |
| 1.....2..... 34.....5..... | 4. I felt like I was losing my mind. |
| 1..... 23.....4.....5..... | 5. I was afraid that I would never be my normal self again. |
| 1.....2..... 34.....5..... | 6. I felt like I was not the mother I wanted to be. |
| 12.....3.....4.....5..... | 7. I have thought that death seemed like the only way out of this living nightmare. |
| <i>Stop here if you were asked to complete only the Short Form.</i> | |
| 1.....2.....3.....4.....5..... | 8. I lost my appetite. |
| 1.....2.....3..... 45..... | 9. I felt really overwhelmed. |
| 12.....3.....4.....5..... | 10. I was scared that I would never be happy again. |
| 1.....2.....3..... 45..... | 11. I could not concentrate on anything. |
| 1 23.....4.....5..... | 12. I felt as though I had become a stranger to myself. |
| 12.....3.....4.....5..... | 13. I felt like so many mothers were better than me. |
| 12.....3.....4.....5..... | 14. I started thinking that I would be better off dead. |
| 1..... 23.....4.....5..... | 15. I woke up on my own in the middle of the night and had trouble getting back to sleep. |
| 1.....2..... 34.....5..... | 16. I felt like I was jumping out of my skin. |
| 1.....2.....3..... 45..... | 17. I cried a lot for no real reason. |
| 12.....3.....4.....5..... | 18. I thought I was going crazy. |
| 1.....2..... 34.....5..... | 19. I did not know who I was anymore. |
| 12.....3.....4.....5..... | 20. I felt guilty because I could not feel as much love for my baby as I should. |
| 12.....3.....4.....5..... | 21. I wanted to hurt myself. |
| 12.....3.....4.....5..... | 22. I tossed and turned for a long time at night trying to fall asleep. |
| 1.....2.....3..... 45..... | 23. I felt all alone. |
| 1.....2..... 34.....5..... | 24. I have been very irritable. |
| 1.....2.....3..... 45..... | 25. I had a difficult time making even a simple decision. |
| 1.....2.....3..... 45..... | 26. I felt like I was not normal. |
| 12.....3.....4.....5..... | 27. I felt like I had to hide what I was thinking or feeling toward the baby. |
| 12.....3.....4.....5..... | 28. I felt that my baby would be better off without me. |
| 12.....3.....4.....5..... | 29. I knew I should eat but I could not. |
| 1.....2..... 34.....5..... | 30. I felt like I had to keep moving or pacing. |
| 12.....3.....4.....5..... | 31. I felt full of anger ready to explode. |
| 1.....2.....3..... 45..... | 32. I had difficulty focusing on a task. |
| 1.....2.....3..... 45..... | 33. I did not feel real. |
| 1.....2..... 34.....5..... | 34. I felt like a failure as a mother. |
| 12.....3.....4.....5..... | 35. I just wanted to leave this world. |

Figure 1 (continued)
Example of a Completed PDSS AutoScore™ Form

SCORING WORKSHEET

	SLP	ANX	ELB	MNT	LOS	GLT	SUI	
1...2...3...4...5	4							
1...2...3...4...5		4						
1...2...3...4...5			4					
1...2...3...4...5				3				
1...2...3...4...5					2			
1...2...3...4...5						3		
1...2...3...4...5							1	
1...2...3...4...5	2							
1...2...3...4...5		4						
1...2...3...4...5			1					
1...2...3...4...5				4				
1...2...3...4...5					2			
1...2...3...4...5						1		
1...2...3...4...5							1	
1...2...3...4...5	2							
1...2...3...4...5		3						
1...2...3...4...5			4					
1...2...3...4...5				1				
1...2...3...4...5					3			
1...2...3...4...5						1		
1...2...3...4...5							1	
1...2...3...4...5	1							
1...2...3...4...5		4						
1...2...3...4...5			3					
1...2...3...4...5				4				
1...2...3...4...5					4			
1...2...3...4...5						1		
1...2...3...4...5							1	
1...2...3...4...5	1							
1...2...3...4...5		3						
1...2...3...4...5			1					
1...2...3...4...5				4				
1...2...3...4...5					4			
1...2...3...4...5						3		
1...2...3...4...5							1	
	10	18	13	16	15	9	5	86
	SLP	ANX	ELB	MNT	LOS	GLT	SUI	PDSS Total

Figure 1 (continued)
 Example of a Completed PDSS AutoScore™ Form

SCORING INSTRUCTIONS

1. Calculate the Inconsistent Responding (INC) index score (skip to step 2 if using Short Form).

Enter the response value for each item in the designated space. If the responses for an item pair differ by 2 or more points make a check mark in the blank space in the right-hand column. When you have done this for all 10 INC item pairs, count the number of check marks and enter the result into the space labeled "INC Raw Score."

INC Item Pairs		Difference ≥ 2
3	<u>4</u> 17 <u>4</u>	_____
4	<u>3</u> 18 <u>1</u>	✓ 2
5	<u>2</u> 26 <u>4</u>	✓
6	<u>3</u> 34 <u>3</u>	_____
7	<u>1</u> 14 <u>1</u>	_____
8	<u>2</u> 29 <u>1</u>	_____
11	<u>4</u> 32 <u>4</u>	_____
12	<u>2</u> 19 <u>3</u>	_____
15	<u>2</u> 22 <u>1</u>	_____
24	<u>3</u> 31 <u>1</u>	✓
INC Raw Score:		<u>3</u> 3

2. Use the Scoring Worksheet to calculate raw scores for the PDSS Total and the seven symptom content scales.

For full PDSS: On the Scoring Worksheet, check for any items where no response was marked, and circle the median response value (printed in bold type) for these items. Next, transfer the circled response for each item to the corresponding box printed in the same row. These boxes are arranged in columns labeled with the names of the seven PDSS symptom content scales. Add the values in the boxes going down each column, and enter the raw score for each symptom content scale in the space at the bottom of the column. Then sum these scores to obtain the raw score for PDSS Total, and enter this value in the corresponding space at the bottom right.

For Short Form: *Items 1 through 7 must be completed. If there are any missing responses, the Short Form may not be used.* Transfer each circled response for items 1 through 7 to the corresponding box printed in the same row. Sum the values in these boxes and enter the total in the box labeled *Short Total* (on the right side below the row for Item 7).

3. Transfer the raw scores to the PDSS Summary Sheet (other side of this form).

Enter the woman's name (or ID number) and the date on the Summary Sheet.

For full PDSS: Enter the INC index score in the labeled box at the upper left of the Summary Sheet, and follow the interpretive suggestions. Enter the PDSS Total score in the box on the upper left side of the Summary Sheet. Below this box is a "thermometer" scale representing the three interpretive ranges for the PDSS Total score. Mark an "X" in the triangle next to the range that corresponds to the respondent's score. The triangle points to interpretive suggestions for that range. Enter the raw scores for the seven PDSS symptom content scales in the corresponding boxes on the lower left of the Summary Sheet, and refer to the corresponding interpretive suggestions.

For Short Form: Enter the PDSS Short Total score in the box on the upper right side of the Summary Sheet. Below this box is a "thermometer" scale representing the two interpretive ranges for the PDSS Short Total score. Mark an "X" in the triangle next to the range that corresponds to the respondent's score. The triangle points to interpretive suggestions for that range. Enter the value from Item 7, (highlighted on the Scoring Worksheet) in the appropriate box at the bottom right of the Summary Sheet. Refer to the corresponding interpretive suggestions.

Please refer to chapter 3 of the manual for complete instructions on interpreting the PDSS.

Figure 1 (continued)
Example of a Completed PDSS AutoScore™ Form

PDSS

SUMMARY SHEET

Cheryl Tatano Beck, D.N.Sc.,
and Robert K. Gable, Ed.D.

Client name (or ID number): Anna

Today's date: April 18, 2000

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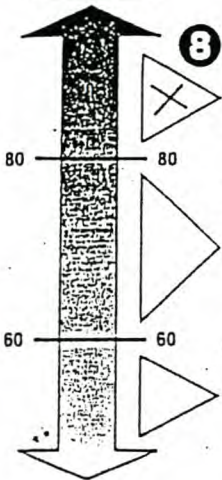
7 **INC Score** 3 If INC ≥ 4 , this woman may have had difficulty reading or understanding the PDSS, or may have had problems paying attention to the questionnaire from start to finish. Please see chapter 3 of the PDSS manual for more details on how to interpret the PDSS when INC ≥ 4 .

not scored for PDSS Short

PDSS Total
86

INTERPRETIVE RANGES FOR PDSS TOTAL AND SHORT TOTAL

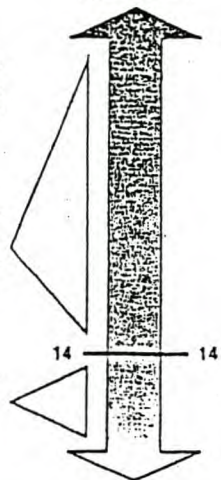
Short Total
14



8 **Positive Screening for Major Postpartum Depression**
(PDSS Total ≥ 80)
This woman should be referred as soon as possible to a mental health professional for further evaluation and treatment. If there is indication of danger to self (e.g., elevation on the PDSS Suicidal Thoughts content scale) or danger to others, the woman should be referred immediately for a psychiatric evaluation.

Significant Symptoms of Postpartum Depression
(PDSS Total = 60-79; PDSS Short Total ≥ 14)
This woman may need to be referred for a mental health evaluation, depending on other factors (see chapter 3 of the manual for more details on how to make this decision): If no referral is made, this woman needs to be educated about postpartum depression and to be provided with guidelines about what to do if her symptoms worsen. If Short Total ≥ 14 , the full-length PDSS should be administered.

Normal Adjustment
(PDSS Total ≤ 59 ; PDSS Short Total ≤ 13)
This woman does not need to be referred for mental health evaluation at this time. She may nevertheless benefit from education about postpartum depression.



SYMPTOM CONTENT PROFILE for PDSS Short, skip to SUI interpretive suggestions

9 **SLP Score** 10 **Sleeping/Eating Disturbances**
If SLP ≥ 14 , this woman is reporting significant disturbance in her normal appetite and/or sleeping habits. SLP ≤ 13 indicates little or no disturbance in appetite and/or sleep.

ANX Score 18 **Anxiety/Insecurity**
If ANX ≥ 15 , this woman is endorsing a high level of anxiety symptoms, which may include psychomotor agitation and feeling overwhelmed and/or isolated. ANX ≤ 14 indicates little or no problem with anxiety.

ELB Score 13 **Emotional Lability**
If ELB ≥ 15 , this woman is reporting that her emotions are unstable, and she may be irritable and/or subject to frequent crying spells. ELB ≤ 14 indicates little or no problem with emotional instability.

MNT Score 16 **Mental Confusion**
If MNT ≥ 14 , this woman is endorsing problems with mental confusion, as well as difficulties controlling her thought processes and sustaining attention on tasks. MNT ≤ 13 indicates little or no confusion or disturbance in attention.

LOS Score 15 **Loss of Self**
If LOS ≥ 13 , this woman is reporting changes in aspects of her personal identity. That is, she perceives herself as strange or abnormal, in comparison to the way she was prior to giving birth. LOS ≤ 12 indicates little or no change in the woman's perception of herself.

GLT Score 9 **Guilt/Shame**
If GLT ≥ 13 , this woman is endorsing significant feelings of guilt and/or shame for not measuring up to her own standards of "good mothering." GLT ≤ 12 indicates that the woman has little or no guilt or shame regarding her performance as a mother.

SUI Score 5 **Suicidal Thoughts**
If SUI ≥ 6 (or if Item 7 on PDSS Short is rated 2 or higher), this woman may be entertaining thoughts of harming herself. The clinician should interview the woman regarding her level of suicidality. Whenever this questioning yields confirmation of suicidal thoughts, the woman must be evaluated immediately by a mental health professional.

Short Item 7

Be sure to consult chapter 3 of the PDSS manual for complete information about how to interpret this questionnaire.

REMOVE THIS SHEET BEFORE ADMINISTERING QUESTIONNAIRE

Figure 1
Example of a Completed PDSS AutoScore™ Form

List of research studies, published and unpublished on PND or related aspects

Unpublished dissertations: PND				
Roelofse, L.	1996	An exploratory investigation of PND among a group of black women	No abstract	No abstract
Hargovan, D. C.	1994	PND and maternal adjustment: an investigation into some risk-factors	Low-income non-white sample	PND associated with low social support, negative life events. Overall decrease in neuroticism scores
Lacock, L.	1992	PND and related factors among Sotho- and Zoeloe mothers	Low-income, black sample	Found a significant difference between PND group and non-depressed group i.t.o demographics, interpersonal relationships and previous episodes of depression. No significant differences were found in relation to biological and obstetrical factors.
Sheldon, V. J.	1992	PND: A predictive study	?	Significant association between PND and previous history of depression, negative life events, lack of support. Most NB was negative events around time of birth of child
Cooke, W. L.	1985	Some determining factors of PND	White, middle class sample	Significant association with social support. No significance between demographics, obstetrics or birth risks.
Jansen van Rensburg, J. K.	Unknown	PND: The experience of first-time mothers	White, middle-class sample	No abstract attached
Unpublished dissertations: Related topics				
Tomlinson, M	2000	A critical evaluation of a community based mother-infant intervention project with special emphasis on infant attachment.	Low-income coloured community	Infant attachment, culture and application of the strange situation - discussion
Brookes, H. B.	Unknown	Experiences of childbirth in Natal Indian Women	Mixed sample of both middle-class & low income women	Examination of culturally prescribed behaviour in the puerperium Found a lack of recognition for nurse as midwife and persistence of cultural patterns despite education and acculturation
Mathebula, V. E.	1995	Postpartum self-care in a rural village	Rural sample of African women	Explore postpartum self-care in rural village during puerperium Found: Utilisation of health services up to birth, but decrease in use post-birth, despite presence of postpartum complications.

Appendix C

South African studies on PND: published in local and international journals

Cooper, P. J., Landman, M., Tomlinson, M., Molteno, C., Swartz, L., & Murray, L.	2002	Impact of a mother-infant intervention in an indigent peri-urban South African context	Unemployed, African women	No change in maternal mood Quality of mother-infant interactions improved significantly
Emmanuel, L.	1999	Effects of postnatal depression on the child	?	Examines effects of PND on mother-infant interactions
Cooper, P. J., Tomlinson, M., Swartz, L., Woolgar, M., Murray, L., & Molteno, C.	1999	PND and the mother-infant relationship in a South African peri-urban settlement	Unemployed, African women	High point prevalence of PND (34.7%) PND associated with poor emotional and practical support from the partner & insensitive engagement with infants
Lawrie, T.A., Hofmeyer, G. J., De Jager, M., & Berk, M.	1998	Validation of the Edinburgh Postnatal Depression Scale on a cohort of South African women	Low-income African women	EPDS translated into six SA languages Identified 100% of women with MDE and 70.6% with minor depressive episode.
Wolman, W.L., Chalmers, B., Hofmeyer, G. J., & Nikodem, V. C.	1993	PND and companionship in the clinical birth environment: A randomised control study		
Trotter, C., Wolman, W. L., Hofmeyer, J., Nikodem, et al.	1992	The effect of social support during labour on postpartum depression	Mixed sample	Randomised control trial. Results showed that birth companion significantly reduced PND scores
Spangenberg, J. J., & Pieters, H. C.	1991	Factors related to postpartum depression	Middle-class white sample	Compared a depressed and non-depressed group. Incidence rate of 27,2%. Significant differences were found between depressed and non-depressed group i.t.o social support, marital satisfaction, and premenstrual tension. No significant differences were found regarding age, parity, previous depressive episodes, Caesarean births and prematurity.