Women bring with them into their pregnancies, and ultimately into their experiences of motherhood, all of the same social, cultural, political, and relational complexities that were a part of their lives before they became pregnant, gave birth, and began raising children. This includes, to a large extent, their mental health. There was a time, not so long ago, when pregnancy, childbirth, and new motherhood were presented, as if in a fairy tale, as magical shrouds that would protect women from the strains and stresses of everyday life. Complicit in creating this imaginary vision was the way in which the “good mother” was constructed as a devoted, selfless, and self-sacrificing woman. We now see a turning of the tides as the mental health literature has begun to conceptualize pregnancy, childbirth, and new motherhood as risk factors with the potential to negatively affect women’s mental health. This shift in understanding and the new discourses surrounding motherhood and mental health could, as Dubriwny (2010) suggests, offer “a starting place to critique dominant constructions of motherhood” (p. 289). In other words, this new understanding that some women do not approach pregnancy and motherhood in a state of mental bliss could open up the spaces needed for re-evaluating discourses and essentialist assumptions surrounding constructions of the good mother, leaving room for more accurate descriptions of the realities of motherhood.
Mental health discourses are complex and do not always present unbiased representations of the well-being of individuals or even of societies. Pairing mental health and motherhood discourses could be seen as a bit like laying out a lovely summer’s day picnic on a beach of quicksand. We might imagine that the mental health machinery, on the side of goodness, is working to alleviate mothers’ distress, and will also help to alter current cultural assumptions surrounding what it means to be a good mother. Instead, however, we may find ourselves sinking ever deeper into a world where social inequities are ignored, with individuals continuing to bear the burden of the consequences of those inequities. As such, one might argue that the disorder paradigm serves to undermine the need for economic, social, and political reform while at the same time privileging psychiatrically constructed notions of normalcy. This chapter will explore the ways in which mothers and motherhood have been problematized from a mental health perspective.

DEFINING MOTHERS’ MENTAL HEALTH

In North America, what constitutes mental illness is largely defined by the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychiatric Association, 1980, 1987, 1994, 2000, 2013). Although the DSM does, in some rare instances, take into account contexts that might contribute to a “disordered” diagnosis, primarily it focuses on an individual’s emotional, cognitive, and behavioural deficits. Women have historically been the direct target for specific types of disordered diagnoses because of their biological differences from men as well as their socially and culturally constructed gender roles (e.g., Appignanesi, 2007; Chesler, 2005). Over the years, the DSM has been the object of criticism, with many of its detractors (e.g. Burstow, 2005; Caplan, 1995; Furedi, 2004; Kirk & Kutchins, 1992; Kutchins & Kirk, 1997) pointing out that while the DSM purports to be a scientific inventory defining mental disorders, it is in fact simply a “patchwork of scientific data, cultural values, political compromises, and material for making insurance claims” (Marecek & Hare-Mustin, 2009, p. 78). Most recently, Allen Frances (2013), chair of the DSM-IV task force, in the preface to his book *Saving Normal*, wrote in response to his concerns about the explosion of psychiatric disorders and the overuse of psychotropic drugs that “psychiatry needs to be saved from rushing in where it should fear to
tread. Normal needs to be saved from the powerful forces trying to convince us that we are all sick” (p. xx). In relation to a paucity of scientific evidence guiding decisions about what does and does not constitute mental illness, others have also raised valid concerns about the unprecedented growth of disorders that appear in each new edition of the DSM—from 198 categories in 1952 to 340 in 1994 (Marecek & Hare-Mustin). Along with this growth in the number of disorders, the DSM has expanded notions of pathology (Martin, 2006) while at the same time narrowing what constitutes normal behaviour (Frances; Malacek, 2006; Martin; Wakefield, 2005; Whitaker, 2010). Although socio-economic status (SES) is not a formal criterion that is used for diagnosing mental illness, “as one moves down the SES ladder, mortality and morbidity increase in almost every disease category, including psychological disorders” (Pope & Arthur, 2009, p. 56). Similarly, while gender is also not used as a formal diagnostic criterion, there is ample evidence of women being over-diagnosed in many of the categories outlined in the DSM (e.g., Kimerling, Ouimette, & Weitlauf, 2007; Stoppard, 2000, 2010; Ussher, 2010).

Not only is motherhood now being promoted as a new space for mental disordering, but mothers are also being targeted by the mental health profession as being primarily responsible for the mental health of their children (Ross, 2011, 2013). The number of adults and children currently disabled by mental illness is extremely high. Whitaker (2010), for example, has reported 1 in 76 adults in 2007 in the United States disabled by a mental illness—a figure double the rate in 1987 and six times the rate in 1955; in 20 years the number of children disabled by a mental illness has risen 35-fold. Depression, a disorder affecting disproportionately more women than men—by a purported ratio of 2:1 (e.g., Stewart, Cucciardi, & Grace, 2004)—is predicted by the World Health Organization (2012) “to be the second leading cause of global disability burden by 2020” (n.p.).

**WOMEN AND DEPRESSION**

“Depression today is everywhere. GPs diagnose it, celebrities reveal they suffer from it, children are given prescriptions for it, media articles debate it, soap opera characters wrestle with it. Yet forty years ago depression was hardly anywhere” (Leader, 2008, p. 11). The current version of the DSM, the DSM-5 (APA, 2013), describes the essential feature of a major
depressive episode as “a period of at least 2 weeks during which there is either a depressed mood or the loss of interest or pleasure in nearly all activities” (p. 163). Previously, in the DSM-IV-TR, the American Psychiatric Association (2000) reported lifetime rates of a major depressive episode for women ranging from 10% to 25% (5% to 12% for men), with prevalence rates on any given day of a year ranging from 5% to 9% (2% to 3% for men). The DSM-5 now suggests 12-month prevalence rates of 7% “with marked differences by age group” and females experiencing “1.5- to 3-fold higher rates than males beginning in early adolescence” (APA, 2013, p. 165). The American Psychiatric Association (2000) had previously suggested that “the prevalence rates for Major Depressive Disorder appear to be unrelated to ethnicity, education, income, or marital status” (p. 372). The DSM-5 (APA, 2013) is silent on this issue.

In Canada, live births reach close to 400,000 a year (Statistics Canada, 2012a); in the United States this figure is just shy of four million (Hamilton, Martin, & Ventura, 2013). Worldwide, over 200 million women become pregnant each year (Saeger, 2009). While depression during pregnancy and the postpartum period was not described in earlier versions of the DSM as a disorder distinct from other affective disorders, the most recent published version (APA, 2013) does allow for an additional “specifier” for the diagnosis of a major depressive disorder “With Peripartum Onset” that can be applied “if onset of mood symptoms occurs during pregnancy or in the 4 weeks following delivery” (p. 186). Although the previous version of the DSM (APA, 2000), the DSM-IV-TR, did not identify the number of women who might be affected by this disorder, it did note the importance of distinguishing “postpartum mood episodes from the ‘baby blues,’ which affect up to 70% of women during the 10 days postpartum” (p. 423). Reference to the frequency of the baby blues has been removed from the DSM-5 and incidence statistics have been added indicating that “between 3% and 6% of women will experience the onset of a major depressive episode during pregnancy or the weeks or months following delivery. Fifty percent of ‘postpartum’ major depressive episodes actually begin prior to delivery. Thus the episodes are referred to collectively as peripartum episodes” (APA, 2013, p. 186). As well, the baby blues have been incorporated into the disorder paradigm with the DSM-5’s proclamation that “mood and anxiety symptoms during pregnancy, as well as the ‘baby blues,’ increase the risk for a postpartum
depressive episode” (p. 187). In addition to the DSM highlighting both the ante- and post-natal periods as providing special circumstances for the onset of a major depressive episode, a vast extant published literature has been promoting the idea that these are unique times in a woman’s life for the onset of depression. No more is pregnancy seen as a time that protects women from psychological distress, but rather pregnancy, childbirth, and motherhood are now presented as times in a women’s life that put her at risk for a psychiatric disorder.

For pregnant women and mothers, concern about the impact of depression also shifts from an exclusive focus on the individual, turning attention to the fetus and ultimately to the offspring. Discourses arising out of this new imperative all too easily see women as a “container” whose primary responsibility in coping with an affective disorder is to protect her fetus and offspring. While postpartum depression has been a focus of much research, particularly over the last decade, a similar interest in depression during pregnancy is somewhat of a novelty. There is also a growing interest in other affective disorders, such as anxiety and post-traumatic stress disorder, with a concurrent focus on the negative effects of mother’s suffering on fetal and child development. While the proportion of women suffering from anxiety disorders now appears to have overtaken those suffering from depression, depression to date has still received the lion’s share of attention from the psychiatric, medical, and therapeutic communities.

PREGNANCY AND DEPRESSION

More and more today, we are being exposed to the notion that “pregnancy and postpartum are two periods of increased vulnerability to depression” (Le Strat, Dubertret, & Le Foll, 2011). Such statements, bandied about as if presenting unbiased facts carved in stone, have set the stage for empirical studies to look at frequency, severity, and consequences to the mother and her unborn child when depression is left untreated. Many of these studies also highlight risk factors contributing to women’s depression. Depression studies are generally framed by a medical model, and while they highlight the proportion of pregnant women at risk for a major depression, by reporting, for example, lows of just under 6% (Söderquist, Wijma & Wijma, 2004), to highs reaching 70% (Lindgren, 2001), these same studies generally tend to ignore the broader cultural contexts defining the lives of the women in
their samples. In fact the dramatic differences reported in the proportions of women at risk can often readily be accounted for by the economic and social contexts in which the women being studied are living their lives. Proportions of depressed women well under the expected 10–15% are found in studies conducted in countries like Sweden (Söderquist, Wijma, & Wijma, 2004; Rubertsson, Waldenström, & Wickberg, 2003) and Finland (Pajulo, Savonlahti, Sourander, Helenius, & Piha, 2001). As well, studies assessing women from higher socio-economic and advantaged status groups (Hoffman & Hatch, 2000; Rich-Edwards et al., 2011) and from groups of women who indicated they were surrounded by supportive and expansive social networks comprised of family and friends (Elsenbruch et al., 2006) show much lower proportions of depressed women than from those living in more difficult circumstances.

As might be expected, researchers looking at samples of pregnant women whose circumstances are largely defined by economic, social, and personal hardships report significantly higher proportions of women with elevated depression scores. Studies focused on groups of minority, unemployed, immigrant, and Aboriginal women, as well as disadvantaged teenagers, also show very high proportions of women with elevated depressive symptomology scores (Bennett, Boon, Romans, & Grootendorst, 2007; Bowen & Muhajarine, 2006; Canady, Bullen, Holzman, Brom, & Tian, 2008; Cheng & Pickler, 2010; Holzman et al., 2006; Lindgren, 2001; Ritter, Hobfoll, Lavin, Cameron, & Hulsizer, 2000; Séquin, Potvin, St.-Denis, & Loisell, 1995; Westdahl et al., 2007; Zayas, Jankowski, & McKee, 2003; Zelkowitz et al., 2004). As well, women who felt they had limited or no social support (Elsenbruch et al., 2006), who experienced mistimed or unwanted pregnancies (Leathers & Kelley, 2000; Orr & Miller, 1997), who suffered a previous perinatal loss (Armstrong, 2004), who were concurrently coping with HIV (Blaney et al., 2004), who had a history of being subjected to interpersonal violence (Records & Rice, 2007; Rich-Edwards et al., 2011; Rodriguez et al., 2008), and who were quitting smoking and/or drinking alcohol during pregnancy (Bowen & Muhajarine, 2006) have all been identified in the literature as groups of women with elevated depression scores. As suggested by the findings from these studies and contrary to earlier DSM (APA, 2000) pronouncements, depression should be considered a disorder that is intimately tied to a woman’s “ethnicity, education, income, [and] marital status” (p. 372).
In short, many of the research studies that look at depression during pregnancy identify poverty as a contributing cause of struggle, either directly through discussions of low levels of income, education or socioeconomic status, or indirectly through the practice of assessing historically disadvantaged minority populations. The oppression resulting from economic disadvantage contributes to the hostile environments in which women experience their pregnancies, and the resulting symptoms of depression (Ross, 2014). More recently, interest is being directed at trying to understand and manage pregnant women’s depression through the use of drug therapy, rather than by treating the problem as primarily a social issue (Bryant, 2012; Campagne, 2007; Coverdale, McCullough, & Chervenak, 2008; Dubnov-Raz, Hemilä, Vurembrand, Kuint, & Maayan-Metzger, 2012; Gentile & Galbally, 2011; Grzeskowiak, Gilbert, & Morrison, 2012). Because pregnant women have been historically excluded from large-scale clinical randomized drug trials, some have argued that the resulting shortage of empirical evidence has left us without the means to adequately assess the benefits that drug treatments might afford pregnant women suffering from depression. However, given the ample evidence of the damaging effects of non-prescription drugs (e.g., alcohol, tobacco-related toxins, heroin) as well as some prescription drugs (e.g., thalidomide) on fetal development, it is not surprising that pregnant women have previously been excluded from drug trials. And while ethical arguments have up to now helped to keep pregnant women out of drug trials, discussions are now shifting towards inclusion, rationalized by the fact that so many pregnant women are suffering from depression (Coverdale, McCullough, & Chervenak, 2008). At the moment, information about the effectiveness of specific drugs relies on retrospective epidemiological data as well as data drawn from relatively small samples of women who have reported having taken antidepressant medication during their pregnancies.

What we have right now to inform us about the risks and benefits of drug treatment are a relatively small number of studies that take one of two focuses. One group of studies attempts to compare fetal outcomes of non-medicated samples of depressed women with those of non-depressed women. In attempting to disentangle the effects of depression, not medication, on fetal development, Davalos, Yadon, and Tregallis (2012) systematically reviewed 14 such studies published between 1992 and 2010.
From these studies the authors concluded that antenatal depression is prevalent and that untreated depression during pregnancy imparts “significant consequences to a developing fetus with implications extending into childhood and possibly adulthood” (p. 12). Although it was not a focus of the study, these authors also made a brief suggestion, almost as an afterthought, that the findings may not in fact be a direct “product of untreated maternal depression” but rather a secondary consequence of poor “health maintenance habits during the prenatal period” (p. 12).

Another group of studies has looked at the effects of antidepressant use during pregnancy on fetal outcomes. Byatt, Deligiannidis, and Freeman (2013) reviewed 21 studies published between 2006 and 2011. These studies looked specifically at the risks of congenital defects resulting from exposure to antidepressants in utero. Overall, the authors concluded that “while some individual studies suggest associations between some specific malformations, the findings are inconsistent. Therefore, the absolute risks appear small” (p. 94). This same review summarized another 18 studies that looked at risks associated with maternal antidepressant use during pregnancy and infant postnatal adaption syndrome (PNAS). The authors concluded that “PNAS occurs in up to 30% of neonates exposed to antidepressants.” (p. 94). They also noted that “in some studies, PPHN [persistent pulmonary hypertension] has been weakly associated with in utero antidepressant exposure, while in other studies, there has been no association” (p. 94).

Comparing results of studies that look at antidepressant use during pregnancy is challenging. The challenges arise partly because the specific antidepressant (selective serotonin reuptake inhibitors, or SSRIs) being investigated varies from study to study. Also, determining whether or not women are taking a single or several different kinds of SSRIs during pregnancy is not always possible nor is determining the time frame in which women report having taken medication (pre-conception through to third trimester). And studies that have looked at the effects on fetal outcomes of mothers’ antidepressant use during pregnancy tend to look at a wide range of different neonatal outcomes. It is also quite common for pharmaceutical companies to fund research that is in their interest. In the case of the studies reviewed by Byatt, Deligiannidis, and Freeman (2013), the fact that 60% of these studies were funded by drug companies invites further skepticism of their findings (Ross, 2013). At this time, there is enough evidence
to suggest that antidepressant use during pregnancy is linked to increased risk of natural abortion, lower infant birth weights, increased risk of early term births, and increased risk of infant heart defects. As well, infants born to mothers who have used antidepressant medication during pregnancy suffer the risks of withdrawal. None of these factors suggests that full-scale clinical trials are desirable. Several high-profile studies have pointed to the corruption in research conducted by or on behalf of pharmaceutical companies, alongside the fact that drug companies have a vested interest in suppressing or downplaying the negative effects of their drugs, highlighting positive outcomes that could serve to open up brand new markets (Bass, 2008; Goldacre, 2012; Healy, 2012). These facts should not be ignored.

Perhaps one of the most important factors that should be informing studies related to drug treatments is that there is little evidence to support the notion that depression is a disease of the mind caused by a chemical imbalance. Not only have antidepressants, for many who have experienced depression, proven to be an ineffective treatment, but compelling evidence has surfaced from independent studies re-analyzing drug trial data that antidepressants are often a less effective treatment than placebo drugs (Kirsch, 2010). Further, some antidepressants not only fail to cure depression but have been found, in many cases, to exacerbate the symptoms of depression, which has led to devastating outcomes for patients and their families (Healy, 2003). Yet this evidence generally has not made its way into discourses about the risks and benefits of using medication to treat depression during pregnancy (Greenberg, 2010; Tone, 2009). Promoting the use of drug therapy to ostensibly correct an imbalance that does not exist makes little sense. Such a strategy obscures the social causes of the disorder and suggests that extreme caution should be exercised before promoting pharmaceutical interventions for pregnant women suffering from depression.

**Depression After Childbirth**

Postpartum mood disturbances have been largely categorized into three groups according to their increasing severity: postpartum blues, non-psychotic postpartum depression, and postpartum psychosis. As many authors have noted, while these three conditions are generally talked about as distinct illnesses, evidence suggests they would better be conceptualized as lying together on a continuum of less to more severe, respectively.
Post-partum “blues” is a term that has been used to refer to a “mild affective syndrome” (O’Hara, 1987) that, if it is going to occur, generally is seen within the first week following delivery. Persistence varies from a few hours to several days, and the symptoms can include mood swings, irritability, headaches, crying, and anxiety, as well as sleep and appetite disturbances. Experiencing the blues following the birth of a child, while it is still labelled by the psychiatric, psychological, and medical communities as a “mood disturbance,” is a common response to childbirth. Different authors have reported a range of prevalence figures based on studies that have used different samples and measures to assess the blues. The estimates of postpartum blues found in these studies range from a low of 30% to a high of 85% (e.g., Kammerer, Taylor, & Glover, 2006; O’Hara, 1987; Robertson, Celasun, & Stewart, 2003). Because postpartum blues is seen as a mild disorder and because the symptoms last such a brief period of time, treatment is not generally prescribed. Women can obviously benefit from being reassured that the state they are experiencing following childbirth is both common and temporary. Experiencing the blues following delivery does not appear to be associated with a psychiatric history of mental illness, environmental stressors, culture, breastfeeding, hospitalization, or demographic variables such as age, socioeconomic status, or birth of a first child (Robertson, Celasun, & Stewart; O’Hara). Rather, dramatic drops in estrogen and progesterone levels, particularly progesterone, following childbirth largely account for the symptoms (Kammerer, Taylor, & Glover). Once the effects of the drop in hormone levels following birth reverse, or are accommodated by women’s bodies, the symptoms tend to disappear. For the vast majority of women, postpartum blues is nothing more than a normal and predictable part of the birth process. Just as it would be preposterous to suggest that weight gain, an almost certain outcome associated with pregnancy, represents a physical illness, identifying the blues as a mental disorder is completely unwarranted and inappropriate.

As with research focused on the perinatal period, review articles and research studies looking at the period in women’s lives following childbirth often begin with such statements as: “The postnatal period is well established as an increased time of risk for the development of serious mood disorders” (Robertson, Celasun, & Stewart, 2003, p. 15); or “For many women and their families, birth is a time of excitement and great joy. Unfortunately,
some new mothers suffer beyond the typical concerns of parenthood and experience varying degrees of postnatal mental health problems” (Moore & Ayers, 2011, p. 443). Frequently cited in these articles are prevalence statistics gleaned from a review article written by Michael O’Hara in 1987 and published in the *Journal of Psychosomatic Obstetrics and Gynaecology*. O’Hara reviewed 11 studies that were conducted primarily in the UK, with several others from Ireland, the US, and Uganda. Sample sizes in these studies ranged from a low of 55 to a high of 401. Prevalence rates, in these studies, based on different criteria defining depression and assessed at different times following childbirth, ranged from 8.2% (US sample assessed 8 weeks postpartum, using DSM-III criteria for major depression) to a high of 24% (UK sample assessed 5 months postpartum, using the criterion of 2 or more depression symptoms lasting 2 or more weeks). O’Hara summarized the findings, noting that the prevalence of postpartum depression ranges between 10% and 15% of the population. In a later meta-analysis of 59 studies, O’Hara and Swain (1996) determined prevalence rates of postpartum depression to be approximately 13%. Although other review studies (e.g., Le Strat, Dubertret, & Le Foll, 2011) have reported rates that are significantly higher or lower than the proportions published by O’Hara and Swain, 13% has become the benchmark figure used by many of the studies looking at women and depression postpartum.

Postpartum depression, not surprisingly, shares all of the characteristics of a major depressive episode that might occur at any other time in a woman’s life. According to the DSM-5 (APA, 2013), this involves the presence of five or more symptoms, present for a two-week period, representing a change from previous functioning. At least one of the five symptoms has to be a depressed mood that is present at least most of the day, every day, for the two-week period; or there needs to be a marked and diminished loss of interest or pleasure in all or almost all activities for most or all of the day, nearly every day for the two-week period. Other diagnostic criteria include significant weight loss (not as a function of deliberate dieting) or weight gain or decrease or increase in appetite nearly every day; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or excessive or inappropriate guilt; diminished ability to think or concentrate or indecisiveness; and recurrent thoughts of death, suicidal ideation, or specific plans for suicide or suicide attempt (APA, 2013,
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pp. 160–161). With the exception of the last criterion, these symptoms need to be present every day or almost every day for a two-week period. There are some additional caveats that apply, such as that the symptoms need to cause significant distress or impairment in social, occupational, or other important areas of functioning; the symptoms cannot be due to physiological effects of a substance (like prescription or illicit drugs) or from a medical condition; and the symptoms must not be better accounted for by another disorder; and finally, that “there has never been a manic episode or hypomanic episode” which could signify bi-polar disorder rather than depression (APA, 2013, p. 161).

Depression prevalence rates applying to women in the postpartum period have been well established. As noted earlier, these figures tend to hover around 13%; reported in a slightly different way, 1.3 women out of 10 are expected to suffer from a major depressive episode following the birth of a child. Generally the literature on causes of postpartum depression (predictors and correlates) provides mixed evidence about the contributing factors. Socio-demographic variables, biological factors, gynecological and obstetric factors, stressful life events, interpersonal relationships, and psychopathology and personality factors have all been studied as possible causes. In his early review, O’Hara (1987) reported that the association between demographic variables and postpartum depression was not particularly strong. More recently, studies that tend to put far more emphasis on context as an important variable affecting mental health status suggest that demographic variables play a major role in postpartum depression. Until quite recently the impact of socio-economic status, for example, was underestimated in studies that looked at health disparities between racial and ethnic groups (Do, Frank, & Finch, 2012). The impact of modernity on mental well-being, including factors such as greater competition, inequality, and loneliness, are now being studied to account for rising rates of depression (Hidaka, 2012). Others have also found that poor-quality employment conditions, including those offering women no job security, control, flexibility or leave, are strongly related to postpartum depression for women returning to work following the birth of a child (Cooklin, Canteford, Strazdins, & Nicholson, 2011).

Biological factors in the few early studies reviewed by O’Hara (1987) showed no consistent results in terms of their relationships to postpartum
In recent reviews of the role of played by biological factors there is some evidence for reduced activity in the hypothalamic-pituitary-adrenal (HPA) axis, possibly as a consequence of reduction in estrogen following childbirth, as well as thyroid dysfunction related to hormonal changes and metabolic demands during and post-pregnancy; in addition, elevated levels of leptin related to obesity are now seen as worth exploring in trying to understand the onset of postpartum depression (Skalkidou, Hellgren, Comasco, Sylvén, & Sundström-Poromaa, 2012; Sylvén, 2012). Recent research also suggests that whereas investigations of psychosocial and epidemiological risk factors have been extensive, “the genetic risk factors underlying PPD essentially remain unknown” (Skalkidou et al., 2012, p. 10).

Early studies also showed few consistent links between postpartum mood disturbances and gynecological and obstetrical factors, such as menstrual problems, dysmenorrhea, previous abortions, or miscarriage but did find some evidence for a relationship between postpartum depression and stressful deliveries or complications during childbirth (O’Hara, 1987). Early studies identified caesarean section as the most stressful method of delivery, but in assessing the impact of stressful deliveries on postpartum depressive symptomology found that women undergoing caesarean sections reported the lowest levels of depressive symptomology (O’Hara, Rehm, & Campbell, 1982). The reason for this counterintuitive finding may be that women who undergo caesarean sections receive higher levels of social support postpartum, compensating for and ameliorating the possible effects of the stressful obstetric event. More recently, the impact of obstetrical factors can readily be interpreted, not separated from, but as part of a group of other stressful life events occurring in women’s lives. In studying the effects of stressful life events, several early studies found that higher levels of stressful life events both during pregnancy and following the birth of a child were, not surprisingly, associated with higher levels of postpartum depression symptoms and increased probability of clinical postpartum depression, although others failed to find any association between the two (O’Hara, Rehm, & Campbell). Although few early studies looked at the association between marital relationships and postpartum depression, of the handful of studies focusing on relationships, all but one suggested that depressed postpartum women report poorer marital relationships postpartum than do non-depressed women. While it is not a consistent finding, other early
studies further suggested that poor marital relationships during pregnancy were predictive of postpartum depression (O’Hara, 1987).

More recent evidence makes it very clear that stressful life events, including obstetrical and relationship stresses, are intimately related to postpartum depression. In reviewing dozens of recent articles, Wylie, Hollins Martin, Marland, Martin, and Rankin (2011) highlighted a number of factors that were strongly associated with depression post pregnancy. In addition to low social class, a woman’s or her partner’s unemployment, negative events specifically associated with the women’s pregnancy, including complicated pregnancy and birthing experiences, unplanned pregnancies, or ambivalent feelings about becoming a parent were all strongly associated with postpartum depression (Wylie et al.). Wylie and colleagues further noted how postpartum depression can often be connected with chronic stress. Situations contributing to chronic stress included, for example, mothers living in problematic or violent relationships with a spouse or romantic partner, lack of support from family and friends, a history of sexual abuse, poor relationships with their own mothers, and a prior history of psychopathology. Postpartum depression can also be associated with mothers who have infants born with particularly difficult temperaments. In short, and in much the same way as was evident with many of the factors predicting depression during pregnancy, almost all of the factors identified in the literature as major contributors to postpartum depression reflect the oppressive circumstances in which many women live and in which they are asked to care for their infants. It should not be surprising that these exacting environments can cause despair (Ross, 2014).

**Mothering In/With Anxiety**

The literature on motherhood and mental health has primarily been focused on depression, but interest in other affective disorders during pregnancy and following childbirth is beginning to surface. As with depression, concerns about anxiety disorders during the perinatal period have been emphasized in the literature not simply out of concern for the mother’s well-being but with a focus on the impact the mother’s poor mental health may have on child development outcomes, including impaired mother-infant relationships, delayed intellectual development, and psychiatric disorders in children. Two such disorders that have been receiving a
lot of clinical and media attention lately are anxiety and post-traumatic stress disorder (PTSD).

The DSM-5 (APA, 2013) defines anxiety disorders as those “that share features of excessive fear and anxiety and related behavioral disturbances” (p. 189). They also note that “anxiety disorders differ from one another in the types of objects or situations that induce fear, anxiety or avoidance behavior, and the associated cognitive ideation” (p. 189). Thus, there are ten discrete anxiety disorders listed in the DSM, but with the recognition that one may be comorbid with another. Generalized Anxiety Disorder (GAD) is a frequent diagnosis and is defined, along with a number of detailed criteria, primarily as “excessive anxiety or worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance)” (APA, 2013, p. 222). The DSM-5 notes a lifetime morbidity rate of 9% and further that “females are twice as likely as males to experience generalized anxiety disorder” (p. 223).

Recent evidence suggests the need to pay attention to perinatal anxiety symptoms that, according to some researchers, now appear to be very common (Grigoriadis et al., 2011). Through a review of current literature, Grigoriadis and colleagues suggest that significant numbers of women (over 20%) suffer from anxiety during pregnancy and about half of these women, from GAD. According to their review of the literature, anxiety generally, and GAD specifically, as in the general population, are now affecting up to 30% of women following pregnancy. Panic disorder, social phobias, and obsessive compulsive disorder (OCD) were found to be less frequent than other anxiety disorders mentioned and, not surprisingly, rates found in postpartum women were comparable to those in women in the general population. Rates for all of these other anxiety disorders were reported from a low of 0.2% (OCD) to a high of almost 11% (phobias). From their own study Grigoriadis and colleagues found, of the 62 pregnant and 29 postpartum women selected from an outpatient clinic caring for women with mood and anxiety disorders, that “the rates of depression alone were very low, and most of the sample had GAD comorbid with another disorder” (p. 330). They suggest that while depression is a concern following childbirth, many women suffer from disorders other than depression, comorbidity is not uncommon, and, perhaps most importantly, anxiety disorders may be more prevalent than depression.
Originally, PTSD appeared in the DSM in 1952 under the heading of “Transient Situational Personality Disorders” as “Gross Stress Reaction” and was intended to apply to individuals who had experienced stress as a consequence of either military combat or a catastrophe that occurred in civilian life (Lovrod & Ross, 2011). Today PTSD appears under Trauma and Stressor Related Disorders and is formally characterized by “the development of characteristic symptoms following exposure to one or more traumatic events” (APA, 2013, p. 274). Diagnostic features include “exposure to actual or threatened death, serious injury, or sexual violence” (APA, 2013, p. 271). Further, PTSD can result from these traumas in a number of different ways that include either direct experience with a traumatic event, the witnessing of others being traumatized, learning about others experiencing a traumatic event, or by repeatedly hearing aversive details of traumatic events from others. The inclusion in the DSM of a disorder specifically related to stress resulting from trauma was initially applauded by feminist theorists. They saw the disorder as a way of recognizing the results of trauma that many women experience as a consequence of systemic domestic and sexual violence (Burstow, 2005). However, the disorder has not been without its detractors. The PTSD diagnosis, like many others in the DSM, has been broadly criticized because of the way it deflects attention away from the social context in which the trauma occurs and instead pathologizes individuals’ responses to trauma.

Childbirth, and the traumatic circumstances surrounding birth, are now being highlighted as the basis for a PTSD diagnosis (e.g., Beck, Driscoll, & Watson, 2013), with claims not only about high prevalence rates but suggestions that “10% of women [meet] the criteria for a lifetime diagnosis of PTSD” (Sageman, 2002, p. 415). Others suggest that PTSD affects “about 8% of pregnant women” (Seng, Low, Sperlich, Ronis, & Liberzon, 2011), with approximately 5% who will experience PTSD within a month to six weeks postpartum and less than 5% six to nine months postpartum (Denis, Parant, & Callahan, 2011; Furuta, Sandall, & Bick, 2012). Issues not unlike those associated with pregnancy and depressions have been linked to PTSD in relation to pregnancy and childbirth, including fear of labour (tocophobia), depressive symptoms in pregnancy, history of psychiatric and psychological problems, primiparity (first birth), unplanned pregnancy, trait anxiety, history of sexual trauma, low self-efficacy, and low-support (Furuta, Sandall,
Labour and delivery factors related to the development of PTSD include mode of birth (i.e., emergency caesarean, instrumental delivery), partner not being present at the birth, women’s perception of receiving poor support from partner or staff, perceptions of poor care during labour and delivery, high level of fear for self or the baby, feelings of powerlessness, and a gap between the women’s expectation and her experiences of severe pain during the birthing process (Furuta, Sandall, & Bick). Birth trauma has been described by Beck (2004a) as “an event occurring during the labor and delivery process that involves actual or threatened serious injury or death to the mother or her infant. The birthing woman experiences intense fear, helplessness, loss of control, and horror” (p. 28). Using a thematic analysis of 38 mothers’ stories about trauma they experienced after childbirth, Beck (2004b) identified five trauma themes that she suggests describe “the essences of this experience for mother” (p. 219). These included ways in which women relived their birthing experiences through uncontrollable and distressing memories, flashbacks, and nightmares; considering themselves post-birth as only shadows of their former selves; expressing an intense need to find out all of the details surrounding the traumatic birth experience; spiralling into anger, anxiety, and depression; a distancing from their infants and support circle of other mothers; and removing hopes for more children. Although the DSM-5 does not specifically include birth experiences, the criteria for PTSD involve a typical subjective response such as intense fear, helplessness, or horror, and symptoms of PTSD do include hyperarousal, intrusion/re-experiencing, and avoidance/numbing (APA, 2013, pp. 271–274).

Post-event risk factors include the absence of available support and “additional stress coping” (Furuta, Sandall, & Bick, 2012, p. 2). Furuta, Sandall, and Bick also note the absence of studies looking at the relationship between “severe maternal morbidity” and “near-miss” experiences during childbirth. * Undoubtedly near-miss experiences are traumatic; however, these authors found from a thorough review of the available literature no

* Definitions of “severe morbidity” include, for example, major obstetric hemorrhage, eclampsia, renal or liver dysfunction, cardiac arrest, pulmonary edema, acute respiratory dysfunction, coma, cerebro-vascular event (e.g., stroke), unremitting seizures, anaphylactic shock, septicemic shock, anesthetic problem, massive pulmonary embolism, intensive/coronary care admission, and/or, severe preeclampsia, eclampsia,
“robust evidence regarding the relationship between severe maternal morbidity and PTSD/PTSD symptoms” (p. 24). Yet these findings did not stop the authors from concluding that “the results of our review suggest that maternal morbidity, particularly severe cases involving poor neonatal outcomes, may be followed by PTSD and its symptoms” (p. 24).

**Conclusion**

Critiquing the machinery that purports to define mental health status does not imply a lack of concern for the well-being of women and mothers who may suffer from a variety of mental health issues. Suffering, whether in the form of anxiety or depression or some other mental health issue, must be seen as very real. But compassion should not overshadow understandings about the ways in which psychiatric disordering profoundly affects how we have come to view and treat mental illness. Today, it is often the case that treatment will come in the form of “magic bullets,” pills that are offered to relieve symptoms. Adoption of the psychiatric paradigm defining mental illness brings with it a real risk of overlooking the social hardships women face and places the burden of mental health on the shoulders of the individuals who are suffering. In trying to deconstruct the complexity of an unprecedented rise in the rates of diagnosed depression, anxiety, and post-traumatic stress disorders in Western societies, two critical issues, one feeding upon the other, deserve attention. First, many disorders would occur with far less frequency but for the untenable social, economic, and political climates in which people are forced to live their lives. Second, psychiatry and the pharmaceutical industry continue to capitalize on people’s distressed responses to these situations by pathologizing moods, feelings, and behaviours that might otherwise be seen as normal and appropriate responses to harsh life circumstances.

The involvement of pharmacology in the mental health of women and mothers adds another layer of uneasiness to the disordered paradigm. It means that much of the concern about mothers’ well-being will not be addressed in the form of personal and social support or through political and economic reform but instead will translate into new drug therapies.

HELLP syndrome, severe hemorrhage, severe sepsis, and uterine rupture (Furata, Sandall, & Bick, 2012).

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And, if this seems a cynical statement, it is clear that an explosion of drug therapies has accompanied the mushrooming of disorders created in the DSM. Biopsychiatry now constitutes big business (e.g., Frances, 2013; Wakefield, 2005). In the same way that the DSM has benefited from the public’s acceptance of the power of science to discover and treat mental illnesses, drug companies have been privileged with a powerful cloak of approval. Yet two decades ago Harding (1991, 1993) made clear the flawed arguments that would have us believe that objectivity, the root of scientific inquiry, could provide protection from bias. As an alternative, feminist scholars asked that subjectivity be a required element incorporated into definitions of objectivity (e.g., Lather, 1991; Reinharz, 1992). In reality, “truth” is often a product that results from research based on bias at every stage of the process, including the questions guiding the research, how the study is designed, who is selected to participate, how the data is analyzed, what is reported, and what is not. Bias is perhaps more pervasive in pharmaceutical research than in any other contemporary area of science. Independent assessments of drug trial data are finally able to provide compelling evidence that drug treatments for depression are often less effective than placebo drugs (Kirsch, 2010). Over the long term, drug treatments have not only failed to cure or curb symptoms but have contributed to the current epidemic of mental illness (Whitaker, 2010). The mental health crisis we find ourselves in now has been over 50 years in the making. It is time we looked towards economic, social, and political reform, and away from pharmaceutical companies, for our solutions to many women’s mental health concerns.