Sadness and Support:
A Short History of Postpartum Depression

Robert Sparks Essay Contest
May 3, 2013

A famous case:

"Once upon a time, there was a little girl who dreamed of being a mommy. She wanted, more than anything, to have a child and knew her dream would come true one day. She would sit for hours thinking up names to call her baby….And then one day, finally, she became pregnant. She was thrilled beyond belief. She had a wonderful pregnancy and a perfect baby girl. At long last, her dream of being a mommy had come true. But instead of being relieved and happy, all she could do was cry."

Brooke Shields famously compared her tears following the birth of her daughter to the rain taking down the itsy-bitsy spider in the well-known children's song. The above quote is from the opening page to Shields' widely read memoir, *Down Came the Rain*, published in 2005.

Shields' book gave a public and famous face to a disease that women had suffered silently throughout all of history. In it, Shields shares in intimate detail her struggles following the birth of her daughter. She was helpless, sad, and scared. She lost all motivation to parent. She did not acknowledge her depression. For some time, she resisted professional help and medication and even contemplated suicide. And when she came out whole on the other side, after successful treatment with antidepressant medications and psychotherapy, she wanted to prevent others from suffering in silence.[1]

Now, nearly a decade later, thanks to Shields and a host of other celebrities, bloggers, researchers and political advocates, postpartum depression (PPD) has become a household term. Today, when women go to a physician for prenatal care, they see posters in the doctor's office explaining what PPD is and what they should do if they develop depressive symptoms after childbirth. As part of routine childbirth classes and when leaving the hospital after childbirth, women are given pamphlets about PPD and business cards for counselors and psychiatrists, should they need them. And pregnant women are

routinely screened for PPD at postpartum obstetrics follow-ups—and even by pediatricians during infant checkups. Such widespread awareness and acceptance of PPD did not always abound, however.

Recent research indicates that nearly 70-80% of women suffer from some depressive symptoms within the first two weeks following delivery. These depressive symptoms are now widely recognized as manifesting in various ways with varying degrees of severity. Tearfulness and mood lability seen soon after birth in many women has become known as the postpartum or "baby blues." The postpartum blues are considered a "normal" reaction to giving birth. However, some women experience true major depressive episodes in the weeks and months following birth that are more persistent, manifesting as loss of pleasure, interest, sleep, and self-worth. It is these episodes that are referred to as PPD, estimated to affect 10-13% of women during the postpartum period. Finally, beyond the postpartum blues and major depressive episodes, about 1 or 2 in 1000 women develop cognitive disturbances, bizarre behavior or hallucinations, and a severe condition known as postpartum psychosis. [2]

Depression following childbirth has long carried a social stigma. Many people think that a woman should be happy following the birth of a child—and when she is not, she is often looked upon unkindly.

Women have long tried to hide signs of depression, sometimes with dire consequences when their depressive symptoms turn into thoughts of harming themselves or their babies. A well-publicized example is that of Melanie Stokes, who killed herself in Chicago in 2001 after suffering postpartum mental illness.[3] Recent legislation to support PPD research and advocacy now bears her name.

Moreover, medical professionals have not long been supportive of treatment for depression following childbirth. The psychiatric community did not officially recognize depression in the postpartum period until the fourth edition of its Diagnostic and Statistical Manual, published in 1994. Even now, the DSM IV identifies depression with a postpartum onset as being only depression that appears within four weeks after delivery of a baby. However, many experts argue that PPD may develop anytime within the first year following delivery, and clinicians are encouraged to screen women for periods longer than just those four weeks following the birth of their children.[4]

Controversies and speculation about depressive symptoms following childbirth have existed since the earliest medical literature. Hippocrates made the first known reference to PPD in the fourth century B.C. and his hypotheses became dogma that survived for over a thousand years. He proposed that lochial discharge—the fluid that comes from the uterus after birth—if suppressed, could flow to the head and result in agitation, delirium and attacks of mania. He also thought that blood collecting at the breasts of a woman could indicate onset of madness.[5] Another early reference to postpartum mental symptoms comes from Trotula, a 13th century female physician, who believed that postpartum mental disturbances were due to increased moisture in the body following childbirth. She wrote "If the womb is too moist, the brain is filled with water, and the moisture running over the eyes, compels them to involuntarily shed tears."[6]

Even then, down came the rain.

Observations of postpartum mental disturbances continued throughout history. During the Middle Ages, women who exhibited melancholy during or after childbirth were thought to be witches or victims of witchcraft, as any other stigmatized individual might

have been. By the 16th century, descriptions existed of a "disturbance of the maternal instinct" following childbirth, and most reports were focused on mothers who killed their children. Known as "melancholic filicide," these deaths led physicians to increase study of postpartum mental disorders. One well-known 16th century physician, Castello Branco, described a case of postpartum melancholy as such: "The beautiful wife of Carcinator who always enjoyed the best of health, was attacked after childbirth by melancholy, and remained insane for a month, but recovered with treatment." Though Branco does not describe what type of treatment he used for the wealthy woman, reports of experimental treatments began to surface over the following centuries.[7]

An early case:

A 25-year-old woman gives birth to a child at home. She is accompanied in the birth by a local midwife, and the midwife comes back to check on her periodically following the birth of her child. The woman begins to feel very sad and overwhelmed in the weeks following the birth of her child. She ceases to cook and barely feeds her baby. Her neighbors become worried that the baby may die and call for the local physician to come see this woman in her home. The physician is unsure of why the woman is unhappy, even in light of having a new healthy baby, but he has seen other women act like this in past. He tells the woman to take lukewarm baths and he gives her a medication that he says will calm her mind.

In the mid-19th century, Jean-Etienne Esquirol became one of the first physicians to provide detailed case reports of postpartum psychiatric illnesses. He reported 92 cases of postpartum delirium and melancholy and suggested that the numbers of women suffering from postpartum mental disturbances was likely higher than the number of cases he observed in mental hospitals. He thought that mild cases were likely cared for at home and never reached his hospital. Esquirol suggested treatment that included careful nursing, tepid baths and purgatives—a common treatment for many medical ailments at the time.[8]

Esquirol, like most doctors of the 19th century, believed that two categories of postpartum illness could be defined: puerperal, which was said to occur within 6 weeks of childbirth, and lactational, meaning that it occurred greater than 6 weeks following delivery. These categories survived for decades despite the lack of any true scientific evidence for the division.

Around the same time, an American psychiatrist, MacDonald, objected to the rigid classification of puerperal mental illness based on time of onset and proposed classifying diagnoses based on acuteness of onset of symptoms. Symptoms observed included decreased strength and spirit, restlessness, sleeplessness, and irritability. His treatments also included tepid baths—specifically given between 94 and 98°F—as well as "large doses of opium" to calm the mind [9] The use of opium should not be too surprising—as with Esquirol's purgatives, opium was given for all variety of ailments at the time.

In 1858, Louis-Victor Marcé published the first formal paper devoted entirely to puerperal mental illness, his *Treatise On Insanity In Pregnant, Postpartum, And Lactating Women*. He wrote of 310 cases of pregnant and postpartum women that he had personally observed and became the first to systematically address categorization of their disorders. In his results, he reported that 9% of women developed depression during pregnancy, 58% in the puerperal period, and 33% in the lactational period. Marcé noted no major features distinguishing the psychoses of pregnancy from those in women in the non-pregnant state. However, he believed that postpartum cases of depression had many features that distinguished them from other mental illnesses and proposed that this should indeed be classified as a separate diagnosis. His main observation was that while most PPD symptoms could be found in other types of mental disturbances, the syndromes—that is, the

particular combinations of symptoms—were distinct. In line with Hippocrates and Trotula before him, Marcé hypothesized that postpartum psychological symptoms occurred in relationship with the profound organic and functional changes occurring in the female reproductive system following childbirth.[10]

Marcé is still remembered today through the Marcé Society, a group of physicians and researchers who unite to study PPD throughout the world. His work has had a significant impact on history of PPD—however, not always as might be imagined. Historically, Marcé's research was often used as early evidence that PPD was *not* a separate entity from other forms of depression, based on a misinterpretation of his statements that depression *in pregnancy* was not a separate entity.

During the 19th century, treatments for PPD changed in line with the medical ideas of the era. Many at the time suggested bleeding as a way to reduce inflammation and eliminate excess fluid in the body. Similarly, many recommended opium to calm the mind. Restraints and separation from the woman's infant were also popular. These were immortalized in Charlotte Perkins Gillman's story *The Yellow Wallpaper.* Gillman tells a story about a young woman suffering from strange thoughts following the birth of her child. The woman's husband places the woman in a room at a summer home, away from her child, to help her improve, but rather than get better, she proceeds to become even more delusional.[11]

In the early 20th century, three main lines of thought emerged regarding the description of mental disturbance and depression following childbirth. These three theories were eloquently summarized and discussed by Dr. James Hamilton, a preeminent

psychiatrist and founder of the Marcé Society, in his 1962 book, *Postpartum Psychiatric Problems.*

The first theory, proposed by Strecker and Ebaugh in 1926, suggested that depression following childbirth had no actual relationship to the pregnancy, delivery, or postpartum changes and was indistinct from other psychiatric illness. Strecker and Ebaugh believed that all cases of postpartum mental illness could be fit into other standard categories of psychiatric illness—dementia praecox, manic-depression, and delirium. They called on physician groups to eliminate "postpartum psychosis" from the psychiatric terminology, and the American Psychiatric Association and American Medical Association did indeed remove it from their diagnostic manuals based on these and other recommendations.

In his book, written several decades later, Hamilton pointed out perceived flaws in their research. For example, he noted that a large majority of cases categorized as manic-depressive had noticeable clouding of the sensorium – a symptom usually not seen in affective disease. Despite perceived flaws, however, the Strecker and Ebaugh study stood up for decades and even still contributes to controversy in perinatal psychiatric literature to this day.

A second theory, proposed by Zilboorg in 1928, used the psychogenic etiologies popularized by Freud and others at the turn of that century, to explain PPD. Zilboorg attributed PPD to pre-pregnancy frigid personalities. He and others suggested that there might be a potential relationship to suppressed homosexuality, unresolved Oedipal longings, or anal-regressive resultant-father identification. This theory was further developed by Franks in 1934, proposed that strong, unresolved incestuous drives, frigidity,

attachment to the father, and schizoid characteristics (among other hypotheses) might be the root of PPD. While such beliefs have not survived into modern day understandings of PPD, these psychologists did publish the first observations of personal history or family history of depression in women with postpartum symptoms—a legacy that may be found in current research supporting that women who have previously experienced depression, or who have a family history of mental illness, are more likely to develop PPD than women with no historical factors.[12]

Finally, the third theory of the time harkened back to the work of Marcé, as well as Hippocrates and Trotula before him, suggesting that physiologic changes in women's bodies surrounding the birth of the child may uniquely lead to postpartum psychiatric changes distinct from other illnesses. Kilpatrick and Tiebout in 1926 suggested that PPD might be due to "an unknown toxic process." They cited cases in which women had concurrent thyroid enlargement, menstrual difficulties, and excessive hair growth with PPD, and hypothesized that the processes were likely linked. Additionally, Kanosh and Hope in 1937 reported on asymptomatic periods following birth, and believed that psychiatric symptoms must be related to some chemical or hormonal change that occurred after a few days. They also suggested that PPD might possibly be related to lactation as they noted some cases of women who developed depressive symptoms only after weaning of their infant.[13]

Following the Second World War in the mid-20th century, many psychiatrists began studying milder forms of postpartum psychiatric diseases. It was noted that women often did not seek care for postpartum illness due to fears of being placed in a psychiatric hospital and separated from their husbands and children. As described in the example of

Gillman's story *The Yellow Wallpaper*, it had once been common to separate women suffering from depressive symptoms from their infants. In the late 1940s, however, psychiatric wards in Britain and Australia began successfully incorporating mother-and-baby units where mothers suffering from PPD could receive care, while remaining close to their infants.[14]

A modern case:

A 29-year-old female presents for her six-week postpartum check-up. She is accompanied by her healthy six-week old son. When asked how she is today, she tears up and responds, "Ok … I guess." She has filled out a mood-screening questionnaire that shows that she feels exhausted, has decreased interest in things, and has not been finding enjoyment in her normal activities. When questioned further, she reports feeling very down and teary during the last few weeks. She has lost interest in reading and knitting and finds it hard to even feed her child. She has had decreased appetite, increased anxiety, and cannot sleep even when her baby is sleeping. She's been feeling like this for several weeks and thinks it may be getting worse. Her physician discusses treatment with anti-depressant medications, though she acknowledges risks of such drugs while breastfeeding. She suggests the woman might see a psychiatrist and a counselor for help with her current symptoms.

In the later 20th century, many of the ideas and treatments that are still prevalent today began to develop, often building on the ideas of earlier physicians while incorporating new scientific research techniques to refine our understanding of PPD. In 1968, Brice Pitt described "atypical" depression in the postpartum. His was one of the first modern studies to draw attention to "less severe" depressions than postpartum psychosis. His study was designed in response to the work of community health visitors who went to check on new mothers in their homes after discharge from the hospital following childbirth. These nurses reported to him that many women dealt with varying degrees of depression following birth, but most did not seek treatment. Pitt's large cohort study was

the first community-based study of depression in the postpartum and he found that approximately 10.8% of women in the cohort suffered PPD. He called the depression "atypical" because the symptom profile was somewhat different than non-postpartum depression.[15]

In addition to the Western observations of PPD, many studies have shown that postpartum blues and postpartum psychosis occurs in fairly uniform ways across cultures. PPD varies depending on cultural demands placed on women postpartum, but most cultures have forms of PPD and various beliefs about its causes. In Uganda, for example, there is a recognized puerperal mental illness called "Amakiro," which is believed to be caused by promiscuity of the mother during pregnancy. Symptoms of Amakiro include restlessness, pallor, and mental confusion, as well as the notion that the mother wants to eat her baby. In Nigeria, there is a postpartum mental illness known as "Abisiwin," which is believed to be caused by too much heat in the body. [16]

Cross-cultural research has also pointed out that Western cultures often place high demands on women to re-integrate quickly into society following childbirth, while other cultures may keep woman at rest or in seclusion while elder women care for the new baby. Some have hypothesized that this social requirement for women to return to work and other stressful environments quickly following the birth of a child may contribute to higher rates of PPD in Western cultures.[17]

Over the past 40 years, there has continued to be much debate in psychiatry surrounding PPD. Questions have arisen such as "Is pregnancy protective against depression or a risk factor for depression?" "Should postpartum blues, depression and psychosis be viewed as distinct entities or a continuum of symptoms?" Literature from the

1980s and 90s continued to examine these questions. The idea first proposed many years ago by Marcé, preceded well before him by Hippocrates and Trotula, and developed by others in the early 20th century—that PPD is likely related to hormonal changes in the perinatal period—has become a leading theory in PPD research during recent years. Studies have shown that artificially inducing the hormonal changes associated with the postpartum period significantly increases risk of developing depression. Other studies have identified additional important risk factors for PPD, such as stressful life events, family history of mood disorders, and personal history of depression.[18]

Until the early 1990s, most psychiatric organizations still espoused the idea that there were not enough unique features of PPD to warrant a separate disease categorization in psychiatric diagnostic manuals. The DSM-IV, released in 1994, incorporated "postpartum onset" as a modifier to major depression, bipolar illness, and other psychiatric diagnoses; this specifier is used when such disorders appear within four weeks following the birth of a child. However, much current literature challenges the "postpartum" definition of 4 weeks following birth and suggests that PPD may still appear even months after giving birth.[19]

In addition to at least some formal recognition of PPD as a unique entity, treatment for depression in general also greatly improved in the 1990s, and the medications developed have also been successful in improving symptoms of PPD. Antidepressant medications came into widespread use for PPD in the late 1990s, and just as they became the first-line treatment for major depressive disorder, SSRIs are also now the first-line of medication treatment for PPD. Few controlled studies exist regarding the use of these

medications following pregnancy, but what does exist indicates benefit from the treatment. However, concerns regarding infant drug exposure through breastmilk still abound.[20]

Perhaps the greatest change in thinking surrounding PPD has been the shift to include more focus on screening, as well as the surge of advocacy surrounding the diagnosis. In the last decade, there has been widely increased focus on prevention of PPD via support groups and therapy. Screening at postpartum obstetrics visits and initial newborn visits to a pediatrician are now increasingly commonplace. And with the stories of Brooke Shields and other famous women in the mainstream media and less formal outlets on the Internet, there has been much wider acceptance in society of women who are not perfectly happy following the birth of a child. Increased discussion of the condition has led to more support, and the beginnings of a reduction in stigma, for women who suffer from PPD. Recent advances in this area include the Melanie Blocker-Stokes Act, which provides government funding for research and advocacy for PPD in the United States, legislation in New Jersey mandating screening for PPD, as well as a surge in popularity of blogs and support groups related to PPD, such as Katherine Stone's "Postpartum Progress," and the Postpartum Support International group.[21]

PPD is a common and treatable condition. However, it has been subject to controversy and stigma throughout much of history, leading to misclassification and lack of access to treatment for many patients. While many barriers, including stigma, still exist that limit this access for perinatal women,[22] further research and advocacy in this area will continue to improve treatment and access to care for women suffering from depressive symptoms following childbirth.

References

[1] Shields B. *Down Came the Rain: My Journey Through Postpartum Depression.* New York: Hyperion, 2006.

[2] Flynn HA. Epidemiology and Phenomenology of Postpartum Mood Disorders. *Psychiatric Annals* 2005. 35(7): 544-551.

[3] Elton C. Postpartum Depression: Do All Moms Need Screening? *Time*. 20 Jul 2009. Available via <http://www.time.com/time/magazine/article/0,9171,1909628,00.html> (Accessed 2 May 2013)

[4] Battle CL. Zlotnick C. Prevention of Postpartum Depression. Jul 2005. *Psychiatric Annals.* 35(7): 590-598.

[5] Hamilton JA. Chapter 12, History. In Postpartum Psychiatric Problems. St Louis: Mosby Harwin, 1962, p126.

[6] Trotula of Salerno, *The Diseases of Women*. A translation of *Passionibus Mulierum Curandorum* by Elizabeth Mason-Hohl, MD. Los Angeles: The Ward Ritchie Press;1940.

[7] Brockinton I. A Historical Perspective on the Psychiatry of Motherhood. In Perinatal Stress, Mood and Anxiety Disorders: From *Bench to Bedside*. Basel, Switzerland: Karger Publishers, 2005.

[8] Hamilton, 1962, p126-7.

[9] Hamiton, 1962, p 127.

[10] Hamilton, 1962, p. 127-30.

[11] Gillman CP. *The Yellow Wallpaper*, first published 1899 by Small & Maynard, Boston, MA.

[12] O'Hara MW. Postpartum Depression Causes and Consequences. New York: Springer-Verlag, 1995.

[13] Hamilton, 1962, p.132-136.

[14] Brockington, 2005.

[15] Pitt B. Atypical Depression Following Childbirth. *Brit J Psychiatr* 1968; 114: 1325-1335.

[16] Cox JL. Postnatal Depression. Edinburgh: Churchill Livingstone Publishers, 1986.

[17] Cox, 1986.

[18] Wisner KL, Parry BL, Piontek CM. Postpartum Depression. *N Engl J Med* 2002; 347(3): 194-199.

[19] Kendell RE, Chalmers JC, Platz C. Eipdemiology of puerperal psychoses. *Br J Psychiatry* 1987; 150:662-73.

[20] Miller LJ, ed. Postpartum Mood Disorders. Washington, DC: American Psychiatric Press Inc., 1999.

[21] Information about these initiatives can be found via: <http://www.state.nj.us/health/fhs/postpartumdepression> (NJ Screening law), <www.postpartumprogress.com> (Postpartum Progress Blog) and <www.postpartum.net> (Postpartum Support International)

[22] Kopelman RC, Moel J, Mertens C, Stuart S, Arndt S, O'Hara M. Barriers to Care for Antenatal Depression. *Psychiatric Services.* Apr 2008. 59(4): 429-432.

Postpartum Support International: Coordinators provide free, confidential advice and support, facts about PPD, and help finding local resources, such as therapists and support groups. You can also call (800) 944-4773. Perinatal mood clinic: Some hospitals have a clinic for new moms staffed with trained mental health professionals familiar with PPD.Â Previous history of depression â€“ this is the strongest indicator, with women who have been depressed in the past 20 times more likely to experience PPD. Depression or anxiety during pregnancy. Stressful life events during pregnancy or soon after giving birth.