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"A View You Won't Get Anywhere Else"? Depressed Mothers, Public Regulation and 'Private' Narrative

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Abstract The existence of 'postnatal' or maternal depression (PND) is contested, and subject to various medico-legal and cultural definitions. Mothers remain subject to complex systems of scrutiny and regulation. In medico-legal discourse, postnatal distress is portrayed as a tragic pathology of mysterious (but probably hormonal) origin. A PND diagnosis denotes 'imbalance' in the immediate postnatal period, although women experience increased incidence of depression throughout maternity. Current treatment patterns emphasise medication and tend to elide the perspective of the individual sufferer in favour of a blanket disease model. I emphasise the need for a feminist reassessment of maternal distress and the means available to 'testify' to its forms, and argue for PND to be analysed in biopolitical terms, perhaps as a 'habitus' materialising the low status and pervasive privatisation of Western mothers.

Keywords Embodiment · Medication · Motherhood · Narrative · Postnatal depression · Regulation · Testimony

Introduction

Conflicting cultural and regulatory representations of unhappiness in women who have children revolve around the problematic diagnostic category of the 'depressed mother', a women suffering from what is usually termed postnatal depression (PND), or simply depression, if it continues beyond one or at most two years after birth. I explore here the regulatory effects of existing representations of maternal depression in the various public and private, medical, legal and cultural spheres where image-making, subjective definition and social organisation (including the formation and disciplining of citizen-bodies) occur and intersect. The investigation

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of maternal difficulty, and the failure to 'fit' the pervasive cultural ideal of blissful, self-abnegating motherhood may, I suggest, assist us in the broader feminist task of understanding and perhaps even constructing concepts of an embodied female legal subject within the contemporary cultural and regulatory regimes which imagine and restrict her. In particular, I focus on the importance of depression to constructions of a contemporary maternal 'habitus': the ways of *being* and *feeling* oneself to be a mother, good or bad, functioning or malfunctioning, within contemporary psycho-pharmaceutical and confessional culture. Following Smart (1990, p. 201), we know that law "constructs and reconstructs masculinity and femininity…and contributes routinely to a common-sense perception of difference which sustains…social and sexual practices". In the complex (and all too frequently ignored) regulatory realms of psychiatry, cultural imaging, and legal control which govern maternity and female reproductive bodies, the unhappy mother represents an elusive and difficult embodied actor. Is she merely to be ignored by both mainstream and feminist constituencies: on the one hand, an unacceptable facet of femininity, a woman unsatisfied with 'woman's destiny', motherhood; on the other, an awkward fit with the unfettered ideals of contemporary feminism, a focus of mundane negativity and despair hard to organise around in any meaningful, political sense?[1]

Drakopoulou (2000, p. 200) writes of constructing a 'unitary' feminist legal subject and fitting women's 'real' bodily, mental and emotional lives into it:

> We remain confronted with having to fit the diversity of women's experience into the straitjacket of a unitary legal subject which still appears indispensable for the articulation of feminist critiques of law and the formulation of proposals for its development.

The feminist legal subject cannot occupy the supposedly 'neutral' legal territory which forms around male bodies and lives. In legal terms, she is most frequently a problem, a victim, subject or cause of trauma.[2] Her embodiment, historically

[1] I do not mean to imply here that all streams and facets of feminism are unfriendly to mothers: indeed, feminist movements can be persuasively said to have relied in no small part on the idealism and labour of mothers (Segal 2007). As I will go on to note, feminist discomfort with motherhood is complex, painful and multifactorial: Hirsch (1989) and Davis (1992) have carefully documented the problem of the culturally dominant 'daughterly' and child-centred perspectives which feminist theory finds so hard to escape (see also Miller 1995), while Kahn (1993) and Steedman (1986) have shed valuable light on the problem of individual adjustment to personal negative and even traumatic experiences of frustrated, difficult mothers, in order to clearly position 'mothers' as a construct and group. See further Quiney (Cain) (2007), and on the intractable personal and social problem of 'maternal ambivalence' toward children and the experience of mothering, Parker (1995).

[2] The depressed 'victim' or 'patient' in this article is female. The woman at law represents in many senses an anti-subject or "non-person" (Naffine 2004, pp. 638–639); the material facts of her gender and sexed/reproductive body require that she be differentiated from other recently postulated legal 'non-subjects', such as the archetypical, sacrificial non-person of Agamben's (1998) influential work [the subject of "bare life", "the baseline of biological existence that is stripped of legal identity" (Gies 2009)]. In Agamben's own work, the "bare" biological being is broadly identifiable with the victims of the Holocaust and recently, with terrorist suspects imprisoned beyond the jurisdiction of national or international law. An important topic, which this article lacks space to address, is the clear gendering of the subject of "bare life" as a male body (*homo sacer)* excluded and punished by the state, while the stripping away of legal identity could be theorised as a 'feminising' experience, one perhaps experienced in a culturally-specific form by mothers when their own subjectivity is effectively swallowed up by the

rendered inextricable from her subjectivity, is a particularly problematic point for feminist legal definition. In this context, postnatal depression, overwhelmingly defined as a sexual/reproductive disorder of mood or personality, becomes relevant to feminism and all women because "female sexuality and women's powers of reproduction are the defining (cultural) characteristics of women, and, at the same time, these very functions render women vulnerable, in need of protection or special treatment, as variously prescribed by patriarchy" (Grosz 1994, pp. 13–14). In this conflicted context, we need to consider other conflicts: those between official and personal or individual descriptions and narratives of maternal depression. A crucial question, which I will go on to investigate in more depth, is this: does the personal, individual traumatic narrative of depression, originating from the suffering subject, make 'truth claims' which regulatory narratives cannot? It becomes crucial to investigate how feminists might hear and respond to the testimony of the depressed mother, without succumbing to the numbing, wearying effects of what might (variously and incomprehensively) be termed 'compassion fatigue' (Berlant 2008), the transmission of depressive affect (Brennan 2003), or 'secondary' or vicarious trauma (Kaplan 2005).

Testifying to Postnatal Suffering

Although frequently restricted to apparently comfortable and even affluent domestic spaces, narratives of maternal misery are uniformly harrowing to hear or read, for example:

> It's nearly two years now since I had Jamie and I'm still not right… It comes in waves and I just cry, it's hard to describe. It's like being pre-menstrual all the time—I take it out on my husband the most. I'm amazed he stays with me. I have gone back to work, but I have no confidence. I feel so useless, and guilty about everything, a waste of space. Still I am told I have to get on with it. (Anonymous, quoted in Morrissey 2007, p. 1432)

> Late one afternoon, I stood washing up at the kitchen sink. The water was hot. The next thing I remember is that the water was cold and it was dark outside. I was glad that we lived near King's Cross Station, because there were lots of trains and I could walk under one. (Anonymous, quoted in Mind 1994, p. 2)

Confronted with such testimony of quotidian, unrelieved, anonymous misery, the listener may experience a numbed or even irritated effect. This, perhaps, is the painful affective overload of 'vicarious trauma' (Kaplan 2005). This difficult and inescapable 'transmission of affect' (Brennan 2003), I will argue, affects not only 'mainstream' perceptions of maternal unhappiness, leading to the common construction of unhappy mothers as deviant, harmful and unproductive citizens; it

Footnote 2 continued
prioritised child-subject, and they experience themselves as reduced to pure, sexed/gendered bodies (see further Quiney (Cain) 2007).

also afflicts feminism, when the transmission of depressive affect combines with the inescapable mundanity of maternal misery, presenting potential activists with subjects whose 'oppression' seems too dull and elusive to become a subject for advocacy, and who do not fit into readily readable victim-categories.

Extent of Postnatal Depression

Postnatal unhappiness is undoubtedly a mundane, quotidian female experience, at least in Western countries. If we accept depression statistics as the most accessible index of unhappiness (and it could be argued that we possess no other),[3] it would seem that the commonest unhappiness in the adult Western world is that experienced by women during the usual childbearing years (the years 26–44: Sichel 2003, p. 63). Most women will have children in their lifetime, and anything from one in ten to one in five of these women will experience unhappiness severe enough to be classified as depression (Keyes and Goodman 2006; Sichel 2003; Brown and Lumley 2000).[4] In recent years, the restriction of depression defined as 'postnatal' to a limited period of up to one or at most two years after birth has been challenged, as increasing numbers of women have testified in personal memoirs, essays and novels that "motherhood and depression are two countries with a long common border" (Thompson 2006, p. xiii).[5]

Explanations for the variety of 'symptoms' which comprise PND as a 'syndrome'[6] are many and complex. Its very existence as a separate, specific form of depression is doubted, even by medical professionals who specialise in treating it. The British psychiatrist R. Kumar commented that "what is not at all clear…is when postnatal depression becomes ordinary depression on the time scale after delivery, and whether there are any special clinical or other features which distinguish postnatal depression from episodes of depression" (quoted in Lee 2003, p. 191). Here, I hope to call attention to specific contrasts (and a few similarities) between the 'official' (legal/psychiatric) and personal strands of maternal depression discourse (whether the 'personal' testimony appears in published literary form or as fragmentary anonymous quotations). The terms 'PND' and 'maternal depression' are not interchangeable, nor are they mutually exclusive: rather, they

[3] Stoppard and McMullen (2003, p. 4) argue persuasively that the diagnostic language of depression provides only a starting point for generating scores on questionnaires or surveys, which researchers transform into numerical data and statistics…information about a depressed person's life circumstances and everyday activities is stripped away as unnecessary detail in a process that 'decontextualises' people's experiences.

[4] Of course, this ballpark figure excludes those who will never be tested or seek treatment for their unhappiness, an unguessable but probably considerable number of women (see further Sheffield 2000).

[5] On the recent literature of maternal distress and ambivalence, see further Quiney (Cain) (2007); Cusk (2001); Pullinger (2004); Shriver (2006); Hays (1998); Warner (2005).

[6] The symptom/syndrome model of diagnosing and conceptualising 'ill' health, particularly mental disorder, has come strongly under attack in recent years, with feminist theorists in particular arguing that it provides a means to oversimplify, normativise and restrict the life circumstances and chances of 'recalcitrant' subjects (Blackman 2007; Downs 1996; Burstow 1992, 2003).

represent differently medicalised and conceptualised forms of maternal mental suffering, as Tracy Thompson explains:

> [W]hile PND is a distinct form of maternal depression, not all maternal depression is PND. In fact, *most* of it isn't. After all, depression is an illness that frequently recurs, some kind of triggering life stress can happen anytime, and hands-on child-rearing is, for most women, an endeavour that takes the better part of two decades. (2006, p. 76)

The 'Biopsychosocial' Perspective on PND

In a recent essay on women and depression, Jean Hamilton and Nancy Felipe Russo argue for the development of "new biopsychosocial models that integrate physical and mental dimensions of health" (2006, p. 496). Another of my aims here is to locate possible biopsychosocial standpoints or perspectives (Harding 1986) from which to respond to accounts of maternal misery like those quoted above, and from which to analyse the truth claims of the centres of state, legal and medical power which attempt to define and treat this common misery.

> Because gender is a dynamic cultural construct that reflects the interplay of biological, psychological, and social factors, the blinders of a monocular biological perspective will be particularly detrimental to the understanding of the relationship of gender to mental health for both men and women. (Hamilton and Russo 2006, p. 508)

Tracy Thompson makes a similar point in specific relation to PND when, in her combined self-help manual and memoir, *The Ghost in the House: Mothers, Children and Depression* (2006), she puts forward the idea of 'maternal' depression as overflowing all regulatory definitions of postnatal distress. In the currently accepted psychiatric terminology (see further DSM IV, American Psychiatric Association 2000), PND covers a hierarchic triad of types of mental disturbance, from fleeting 'baby blues' at two to three days postpartum (affecting around 75% of mothers) to true 'postnatal depression' (15–20% of mothers, lasting for up to 2 years from birth), to postpartum psychosis (1 or 2 in 1,000), a delusional, dissociative state usually requiring hospitalisation (see further, for example, Wisner et al. 2003; Miller 2002). Postpartum psychosis will *not* necessarily involve violent or suicidal behaviour, but it is the most florid and thus most commonly discussed and reported form of postnatal disturbance. The heavy and frequently lurid reporting of the tragic story of Andrea Yates in Texas (see, for example, Picard 2001) is a case in point. In Britain, clinical management of maternal depression follows a fairly clear 'disease model': the guidelines of the National Institute for Health and Clinical Excellence (NICE) on 'antenatal and postnatal health' present maternal depression as a scale of disturbance requiring specific, tabulated (psychotropic) treatments, though other treatment modalities such as cognitive behavioural therapy are recommended for 'milder' cases (NICE 2007).

PND as Biological Disturbance

A diagnosis of PND thus remains one of *biological* disturbance. All accounts of PND except the feminist social-constructionist assessments (which I examine later) implicate combinations of hormonal or biochemical events affecting the brain in the postnatal period (whether or not we see the individual brain as particularly sensitised to such events): progesterone sensitivity, heightened cortisol, serotonin disruption (see, for example, Dalton 2001; Somerset et al. 2006; Sichel 2003).[7] In stark contrast to the complex and impersonal language of biochemistry, the multiple social determinants of postnatal distress have been heavily stressed by feminist theorists and by women writers. Feminism has a difficult relationship with maternity. There has been a surprising lack of feminist advocacy around the difficulties of motherhood. Partly, this may be explicable by the universality of biological maternity—a 'condition' or experience which truly crosses all boundaries (class, race, ethnicity) except that of bodily sex (and even that is debatable, now that men are more than ever likely to act and live in what would once have been referred to as 'motherly' ways). But there are deeper and less comfortable reasons. Many of the most compelling arguments of feminism have involved the deconstruction of gender and its attachment to bodily sex. Pregnancy and the birth and rearing of children are bodily events which (at least at present!) happen only to women. Thus, in considering them and their relevance for the subject who carries them out, we tap into an underlying feminist discomfort with the vulnerable reproductive body (Hausman 2003; Grosz 1994). Valid concerns about the compulsory and sacralised nature of maternity in patriarchal societies have joined forces with the deconstruction of simple gender/sex divisions[8] to practically theorise the 'feminist mother' out of existence. Feminists must now tackle a range of intractable and contradictory issues around reproduction, such as the intensification of ideologies of the nuclear family, with the permanently 'attached' mother sacrificing 'self-interest' to the

[7] Moore's (2004) *Guardian* article on PND provides a summary of recent explanations of the medical causality of postnatal distress, including a quotation from a medical professional in which the metaphor of the reproductive female body as a potentially disordered 'machine' (Martin 1987) is strikingly deployed:

> The most credited medical explanation is a failure to adjust to the epicendocrine changes following childbirth, which are unmatched by any other biological event in their speed and magnitude. "Through pregnancy, the placenta pumps out industrial quantities of hormones, and when it is removed those levels plummet", says Dr Oates. "What happens is a withdrawal effect, just as you get when you stop taking heroin or alcohol, or antidepressants".

The metaphor of addiction is also intriguing, aligning as it does difficult female reproductive 'syndromes' with the disorders of 'personality' perceived to afflict a growing number of other malfunctioning contemporary citizen-bodies, 'addicts' who cannot function alone and without medication.

[8] New reproductive technologies (NRTs) have been a powerful cultural contributor to realignment and resultant anxiety in the arena of reproductive possibilities and capacities—a topic which I lack space to discuss here, but see further Franklin (1991, 1997) and Farquhar (1999). Powerful counter-discourses, arraigning wrong-headed women who delay childbearing in hopes of availing themselves of these unreliable new technologies, have simultaneously appeared in popular and scientific media: see, e.g., the debate sparked by Bewley et al. (three well-established fertility practitioners who produced a much-reported editorial in the *British Medical Journal* stating that childbearing after 35 "defies nature and risks heartbreak" (2005, p. 588)).

wellbeing of her young (Bowlby 1973; Belsky 1986; Leach 2003; Hays 1998),[9] and the contrary patterns of demography and employment which have vastly increased the numbers of households where both parents of young children work full time (Crompton et al. 2007; Crompton 2006). Such patterns have, in particular, swelled the numbers of female-headed single-working-parent households (Silva 1996; Duncan and Edwards 1999; Kilkey 2000). In her autobiographical book *Making Trouble* (2007), the active second-wave feminist and contemporary theorist Lynne Segal has to emphasise that *all* the members of her feminist collective household in 1970s London were mothers—and that mothering was an essential part of feminist practice for her and her contemporaries. The contrast with today's academic regimes of 'gender studies' is implicit.

Gender studies remains, however, concerned with the disproportionate impact of gender norms upon women as far as these can be seen to cause material, physical or (more broadly and vaguely) emotional/mental damage, but after the spate of second-wave feminist analyses of the mental tortures of compulsory motherhood and domesticity (Gavron 1968; Friedan 1965; Oakley 1974a, b, 1980, 1981) there are few direct accounts of a feminist approach to maternal distress. *Pace* Paula Nicolson's excellent study of the social determinants of PND (1998), assessment of maternal suffering most often takes place in medical articles attempting to quantify the associations of maternal depression with poverty and/or addiction, and (in particular) its deleterious effects on the unfortunate child of the depressed mother. Documented ill effects of maternal depression (for the child, not the mother) range from delayed speech and cognitive development to behavioural disorders (read: antisocial and potentially criminal activity, particularly in boys) and increased risk of mental illness in adult life (Petterson and Albers 2001; Kurstjen and Wolke 2001; Newport et al. 2002). Mothering is no longer identified with feminism, if it ever truly was, and determination to free womanhood from the shackles of compulsory reproductivity and nurture may compete with the need to engage in the lives of women who, after exercising their 'free choice' to reproduce, find themselves held utterly privately responsible for the consequences. These women must then make another more difficult 'choice', whether to settle primarily for the role of 'wife and mother', or to try to compete in the workplace with childless women and men or with the still considerable numbers of men who have access to the childcare and domestic services of a non-working or part-time working wife. (There are, of course, women who now have the full time domestic services of a partner, but they are still so few that they cannot yet affect analysis.) The third option, which seems to be perhaps the commonest in Britain, is the appallingly but perhaps fittingly termed 'mummy track', in which women with children work flexible or reduced hours in order to fit in their caring responsibilities, and accordingly, come to populate the lower echelons of the organisations they work for. Meanwhile,

[9] Insofar as it represents one very popular practitioner-backed discourse on parenting (which is also echoed in 'alternative' philosophies of 'natural' parenting), the cultural prominence of 'attachment parenting' appears assured: it requires the care-giver, usually identified as a long-term-breastfeeding mother, to make herself bodily and emotionally available to her offspring at all times (Sears and Sears 2009; Hunt 2002; Schön and Silven 2007; Wolf 2007; Büskens 2001). See also, however, a guidebook to the rigidly 'unnatural', and equally popular, 'routine' method of early childcare (Ford 2002).

everyone except adult women with children, 'involved' fathers and childcare workers may remain effectively segregated for life from children. Feminism can hardly avoid the socioeconomic fact that the most materially successful women tend not to have children (or not to have them *yet*), while women who do have them feel discouraged from 'moaning' about their self-imposed burdens to others who find it hard to understand why children cannot be fed, protected, washed, occupied and educated easily and in the minimum of time. The unfettered, clean option of the 'child-free life' perhaps averts the spotlight from women who have had children and the subtle and not-so-subtle forms of regulation and coercion which come to govern their lives, from pregnancy (Marshall and Woolett 2000) to the complex medico-legal webs of 'normality' and 'unfitness' which span official questions of suitability for motherhood (Sawicki 1999; Rose 1999a).

The Compulsion of Self-Diagnosis

According to the psychiatrist Anne Dally (herself a mother of six children) anyone involved in childcare has to cope with "boredom, repetition, constant interruption, physical onslaught, destructiveness and demands… And all this has to be carried out in a state of physical exhaustion" (Dally 1982, p. 200).[10] *All* full-time carers, including fathers (Ballard and Davies 1996), experience heightened rates of depression, but current scientific theories tend to back up the official, medico-legal concept of postnatal disorder (below) as a hormonally determined state of temporary insanity, divorced from the social, cultural and individual conditions of the sufferer's life. A question I want to pose (but cannot definitively answer) in this article is whether the popular-scientific narrative, which, as I will discuss, has attained such determinative force that sufferers now speak and write of themselves in biochemical terms ("I am bipolar", "I have depleted serotonin", etc.),[11] can actually help us to recognise and treat real maternal suffering in its physical, 'chemical' manifestations as depressive affect, with all the terrible symptoms (tiredness, insomnia, obsessionality, suicidality, etc.) which this brings to the sufferer. Does it, as feminists such as Jane Ussher (1991, 1997) have argued, in fact desocialise female 'madness', removing it from the cultural context of low-status, isolating mothering and simply pathologising women who are labelled as impaired?

[10] It needs to be noted at this point that very little psychiatric literature on depression mentions social issues in a more than cursory way as impacting upon the 'disorder'; exceptional articles will attempt to factor social variables such as poverty and debt into the analysis (Reading and Reynolds 2001; Petterson and Albers 2001). Overwhelmingly, the focus of psychiatric literature is on the symptomatology and psychopharmacology of PND, or on the harmful effects of the 'depressed mother' on the child (see, e.g., Petterson and Albers 2001; Kurstjen and Wolke 2001; Newport et al. 2002). For a more balanced set of 'biopsychosocial' perspectives on women's depression, see further Keyes and Goodman (2006).

[11] Concepts of neurochemical literacy and self-understanding are crucial to the construction of the contemporary subject and his/her therapeutic consciousness, whereby the responsible citizen-self is conceived of as in continual striving for autonomous self-improvement and the detection and resolution of the psychological and medical risks which inevitably beset it under capitalism (see further Rose 1998, 1999a, b, 2007; Blackman 2007).

The language of cultural and medical discourse around depression as a whole encourages the compartmentalisation of depressive 'symptoms', and urges the sufferer to self-diagnose as chemically defective (Stoppard and Gammell 2003; and see further Grabham 2007). Or, as Clarke et al. (2003, pp. 161–162) have written:

> The growth of medicalization—defined as the processes through which aspects of life previously outside the jurisdiction of medicine come to be construed as medical problems—is one of the most potent social transformations of the last half of the twentieth century in the West… Major, largely technoscientific changes in biomedicine are now coalescing into what we call *biomedicalization* and are transforming the twenty-first century. Biomedicalization is our term for the increasingly complex, multisited, multidirectional processes of medicalization that today are being both extended and reconstituted through the emergent social forms and practices of a highly and increasingly technoscientific biomedicine.

In tackling biomedicalisation's relationship to gender and gendered diagnoses, we need to separate medicalisation conceived of as *disempowerment* (as per the feminist social constructionist and 'anti-psychiatric' rubric) from medicalisation as a reactive, embodied process (this process could also be called somatisation: the means by which social, cultural, emotional and other states become embedded and manifest in the body). It is clear that emotional states, traumatic experiences and other stressors can affect body chemistry and makeup to a remarkable extent: Tracy Thompson, a long-term depressive, recounts the 'odd' shape of her own hippocampus seen during a brain scan, and notes the permanent changes (including shrinking of brain tissue in specific areas) which are associated with depression (2006, pp. 119–120; see further Wolpert 2001).

The psychiatric treatment of postnatal depression also focuses squarely on the concept of malfunctioning brain chemistry. Diagnosis will take place either after self-report of depressive symptomatology, or after assessment by a health professional such as (in Britain) a health visitor or GP. The standard diagnostic tool is the Edinburgh Post Natal Depression Scale, a series of questions designed to uncover the presence of depressive symptoms such as hopelessness, suicidal ideation, anxiety, crying and sleeplessness (on the scale and its possible shortcomings, see further Guedeney et al. 2000). Although, as noted by the American psychiatrist Laura J. Miller, PND sufferers "require a comprehensive, multifaceted approach to treatment, including crisis intervention, pharmacotherapy, psychotherapy, and strengthening support networks" (2002, p. 764), in actuality treatment tends to be the same as for 'normal' depression in both sexes: primarily pharmacotherapy with selective serotonin reuptake inhibitors (SSRIs), the family of drugs of which the oldest and most famous is brand-named Prozac (fluoxetine hydrochloride). This is the standardised treatment model for the UK as represented in the NICE guidelines on antenatal and postnatal health, which notably focus on a "risk-benefit" (NICE 2007, p. 16) model for the treatment of women suffering depression during pregnancy and lactation. The primary risk here is to the wellbeing of the foetus, owing to the teratogenic potential of psychotropic medications commonly prescribed in the antenatal and postnatal

period.[12] Rose (1996) has identified the administration of risk as an increasingly important aspect of the politics of psychiatry in advanced liberal democracies; in the case of maternal depression, we see the mother constituted in terms of risk to another.[13] She becomes constituted in a specific and depersonalising sense as 'carrier' of risk to the future citizen within her body. The NICE guidelines state that "women with mental disorders during pregnancy or the postnatal period should have the opportunity to make informed decisions about their care and treatment in partnership with their healthcare professionals", a model which is termed "patient-centred care" (2007, p. 5): one which, as already noted, places the mother within a specific risk-relationship to the foetus as 'patient', and as exposed by her 'care' to teratogenic risk from the dominant psychotropic drug treatment regimes. State-funded alternatives to such regimes are sparse: in Britain, if the sufferer is lucky enough, and depending on the practice of the local NHS Trust, she may also receive short courses of counselling, a practice which the NICE guidelines mandate particularly for mild depression, or in combination with pharmacotherapy for more serious cases (see, for example NICE 2007, pp. 8, 23–24) As Lisa Blackman elaborates, treatment with SSRIs has become the "state-sponsored solution" to maternal unhappiness:

> Psychopathology is constituted as an object produced at the intersection between the biological and the psychosocial. Although this might point towards an engagement with a more complex relationality in understanding the production of psychopathology, this is covered over through what Orr terms the state-sponsored solution to the problem of mental distress. This is one where, as we have seen, psychopathology is framed as subject to change and transformation at the biochemical level, and psychopharmaceuticals have become the sanctioned and culturally valued intervention. (2007, p. 5, references omitted)

In line with this powerful regulatory logic, the 'good' postnatal depressive will medicate herself and thus be 'cured' in good time (see further Grabham (2007) on the management of bipolar disorder). The work of Moynihan and Cassels (2005) and Healy (1997) interrogates the actual pharmaceutical *construction* of (particularly mental) illnesses by collecting 'symptoms' and producing a marketable 'cure'.

[12] Since the NICE guidelines recommend treatment interventions for women already suffering antenatally, and for 'pre-clinical' patients, women with "subthreshold symptoms of depression and/or anxiety" (NICE 2007, p. 33), they follow the model of "predictive, preventive and personalized" medicine which Rose (2007) associates with contemporary biomedicine (see, e.g., p. 87, and p. 95 on 'treatment' through the "preventive administration of psychiatric drugs").

[13] The concept of maternal risk serves in one important sense to embody all 'mentally ill' women as potential mothers, regardless of whether they are or intend to become pregnant, as per the NICE guidelines (2007, p. 10):

> Healthcare professionals should discuss contraception and the risks of pregnancy (including relapse, risk to the fetus and risks associated with stopping or changing medication) with all women of child-bearing potential who have an existing mental disorder and/or who are taking psychotropic medication. Such women should be encouraged to discuss pregnancy plans with their doctor.

In this sense, healthcare practice effectively serves to force recognition of a 'mentally ill' woman's status as a gendered, reproductive being upon her, as part of a risk-minimising strategy.

This work is particularly interesting in connection with Rose's theories of the patient's self-identification as a subject in process of improvement: risk management extends to the pathologisation and 'removal' of troubling feelings arguably produced by the individualising stresses of hypercapitalism, which then steps in to provide a purchaseable 'solution' (Rose 1999a, 2007). The most common treatment route for depression in the UK and USA is to 'try out' a particular drug, changing it if the patient reports no effect, or excessive side-effects. SSRIs work by decreasing the reuptake of the chemical serotonin in the brain; in depressed states, serotonin is almost uniformly depleted. The causation of this depletion is unclear, and is likely to be complex: we may posit various combinations of childhood and adult stress-events or traumas, genetic vulnerabilities, social and environmental pressures and emotional involvements.

Flesh Effects

As well as coping with the complex and severe bodily effects and 'symptoms' of depression, as well as the immense pressures of childrearing as a 'post-feminist' woman in the West, PND and MD sufferers have to deal with specific 'flesh effects' (to adapt a term used by Grabham in her 2007 paper on the treatment of bipolar disorder) which are frequently not limited to the common symptomatology of depression, if they admit themselves or are admitted to psychiatric treatment. SSRIs have a wide range of documented side-effects, from insomnia and 'twitchiness' to obsessive-compulsive fantasies and suicidal ideation (Hu et al. 2004). If suffering from depression while pregnant, or if they have suffered in previous pregnancies, mothers may be expected or urged to take what can look like 'risks' to their foetuses or babies (given that they will have been issued with a blanket warning not to take medications or 'expose' the foetus to toxins), or to deprive them of the 'best' feeding choices (breastfeeding).[14] Thus the exercise of their own 'agency' inescapably affects a being they have been encouraged to see as totally separate from themselves and as demanding perfection from them. This is not to say that women suffering PND should not seek treatment with drugs to relieve their suffering, but that the contradictory disciplinary and regulatory aspects of their dilemma must be recognised. A serious problem here is that to recognise bodily/

[14] An important point to make (and one I do not have sufficient space to cover here) is that antenatal and postnatal depression often occur in the same women, suggesting a sort of perinatal depressive continuum (Heron et al. 2004; Austin 2004). Importantly, this is also the approach adopted by the NICE (2007) guidelines for antenatal and postnatal health, which refuse to use the term 'postnatal depression' (p. 5), referring instead to depression occurring at various stages during pregnancy and after (though specific psychotherapeutic treatment models, and their potential risks to the foetus, are laid out for pregnant women, these appear as continuous with those prescribed for lactating women, reflecting the concept of the continuum of perinatal disturbance *and* of bodily coexistence with the foetus/baby). SSRIs are the most commonly prescribed method of dealing with antenatal as well as postnatal depression. Studies of women who have taken SSRIs while pregnant or lactating have shown some evidence of potential harmful effects on the developing baby during pregnancy (as noted *passim* in the NICE guidelines), though the decision to treat a pregnant woman remains with the individual practitioner (Cipriani et al. 2007; Gentile 2007).

chemical changes associated with emotional and frequently gendered states may seem a step toward the acknowledgement of the pathology model, and this may appear to play into the hands of those who would caricature the 'hormonal', depressed woman as malfunctioning and dangerous.

Legal Caricature/Legal Concession

In the legal as well as popular imagination, such caricatures are clearly abundant. There appear to be few direct references in actual British case law to PND (except where it is used in general mitigation of offences such as theft, and in employment cases); but this reference in Lord Steyn's dissenting judgment in *Luc Thiet Thuan*[15] strikingly depicts PND as rendering a woman prone to violent behaviour, and reflects a popular blurring of distinctions between PND and the far rarer affliction of postpartum psychosis:

> Let me imagine the case where a woman shortly after giving birth to a child stabs and kills her husband during an argument. She wishes to put to the jury as part of her defence of provocation that she was suffering from postnatal depression which rendered her more prone to loss of self-control.[16]

There does not appear to be a case either preceding or following *Luc* which matches Lord Steyn's hypothetical example of postnatal husband murder. His hypothetical postnatal murderess clearly reflects the prevalence of 'simple' biochemical explanations for postnatal depression, as well as the pull of the old stories of hysterical female criminality. We know that women suffering from PND are rarely violent and that most struggle on alone and silently with feelings of despair, agitation, obsessional or intrusive thoughts, and crippling exhaustion, and that around 80% of women fulfilling the diagnostic criteria for PND are too ashamed, hopeless or mistrustful to declare their condition to medical professionals such as their health visitor (Stoppard and McMullen 2003; Littlewood and McHugh 1997, p. 164). The disciplinary construction of the murderous mother is very important for what it says about cultural attitudes to maternal 'failure' or 'disorder' more broadly conceived.

In this context, we have to discuss infanticide. The Infanticide Act 1938 also encodes assumptions of susceptibility to irrational and murderous behaviour in mothers up to one year after birth. Infanticide law is based in highly problematic notions of an unstable and 'hysterised' feminine body and mind: ideas active since Hippocrates mooted that postnatal 'madness' might be 'lactational insanity', milk going to the brain. Although there is scant evidence for insanity due to lactation, and the concept relates more to issues of exhaustion and malnutrition in poor working mothers which were urgent at the time of the original enactment of the Infanticide Act in 1922 (Ward 1999; Kramar and Watson 2006), the Law Commission recently refused to alter the Act to remove references to lactation (2006, p. 159). The law

[15] *Luc Thiet Thuan v R* [1997] AC 131.

[16] *Ibid* at 150.

still provides for a charge of manslaughter rather than murder if "at the time of the act or omission the balance of [the mother's] mind was disturbed by reason of her not having fully recovered from the effect of giving birth to the child or by reason of the effect of lactation consequent upon the birth of the child".[17] The Law Commission's recent report on homicide law reform cites but dismisses consultation papers from Justice for Women and Professor J. McEwen denouncing these provisions as pathologising women and requesting that they be absorbed into the general defence of diminished responsibility (2006, p. 164).

Despite the persuasive argument for infanticide law as a patriarchal instrument of pathologisation, and however archaic and essentialist the formulation of the combined offence/defence comprised by infanticide, I believe that we need to note carefully how infanticide charges and legislation are deployed in order to *prevent* convictions of women who are and have been suffering acutely. The British system compares very favourably to that in the US, where only a hard-to-prove insanity defence is available to mothers who kill (Meyer and Oberman 2001; Oberman and Meyer 2008; Picard 2001). Infanticide law denotes something more than judicial chivalry or pathologisation. Rather, it (imperfectly and partially) encodes a largely hidden cultural awareness of postnatal difficulty. It is the only legal acknowledgement we have of the social and bodily difficulties of birth and childrearing, issues for which we lack a feminist account which is not immediately laid open to charges of materialism and essentialism. Michelle Oberman and Cheryl Meyer's harrowing studies of contemporary mothers who kill foreground the powerlessness and silencing of infanticidal women both before and after their crimes (Meyer and Oberman 2001; Oberman and Meyer 2008). In her striking biography of a family member who killed her infant twins in the early twentieth century, *The Cruel Mother* (2004), Sian Busby notes that, in traditional narratives and balladry just as in the medico-legal literature and case notes, infanticidal women appear as "inarticulate and amnesiac, blank spaces on to which the details have been sketched by others" (p. 74). Any prolonged reading of recent law reports and case studies of infanticide and neonaticide, with their repetitive scenarios of maternal anger, depression, fear and panic, usually in circumstances where emotional and social support were sadly lacking, and recitations of terms such as 'dissociative state' and 'denial', will grimly reinforce this impression (Meyer and Oberman 2001; Oberman and Meyer 2008; Alder and Polk 2001). Oberman suggests that the situation repeats itself because desperate, infanticidal women represent the tragic results of mass denial of maternal suffering and ambivalence: "infanticide may be seen as a response to the societal construction of and constraints on mothering" rather than as a 'mere' pathological event (2003, p. 708). Busby makes a similar point about the regular suppression of filicidal feelings in women (and perhaps men too) when she asks: "Is there a mother on earth who has not at some point found herself in the middle of the night threatening her tiny child with a violent death?" (2004, p. 80).

[17] Infanticide Act 1922, s 1(1) and (2).

Avoiding 'Hormone Talk'

Thus, though the refusal of feminist 'anti-psychiatrists' such as Jane Ussher (1991, 1997, 2003) to accept the disciplinary smack of hysterisation and pathologisation is no doubt to be applauded, feminists following the 'social constructionist' version of depression (for example, Chesler 1972; Stoppard and McMullen 2003; Lee 2003) may perhaps minimise the huge physical, emotional and social shifts experienced differently by every woman who has or rears a child, refusing to engage in messy 'hormone talk' (in a peculiar echo of journalistic response to the Andrea Yates case, following which America was reported to be "tired of the hormonal defence" for child murder (Picard 2001, p. 30): "it sounds too menstrual, irrational and self-indulgent. The feminists don't like it because it implies that women cannot think when they are bleeding or lactating. The 'feminazi' haters don't like it because it reminds them of their mothers"). The effects on body chemistry of environmental changes and pressures, effects of upbringing, personality and the woman's longstanding observations and impressions of maternity, as modelled by her own mother and others, are near-impossible to pinpoint and massively prone to misunderstanding. In addition, women's depression exists within a broader hypercapitalist context, in which pharmaceutical companies have been accused of 'creating' and/or magnifying 'disorders' with the collusion of Western government health authorities, the better to 'sell sickness' to the suffering masses (Healy 1997; Moynihan and Cassels 2005). Thus, existing within a context in which 'depression' itself is contested as a product of capitalist interventions into the commodification of 'healthy' subjectivity, feminism lacks an account of 'hormonal'/emotional, bodily/subjective changes and shifts which does not elide the bodily as well as sociocultural experience of so many women. (The debate on the realities of Premenstrual Syndrome (PMS) in feminism offers another example of this sort of divisive problem, in which the bodily experience of disorder may be interpreted as an embodied interpretation of patriarchy's disapproval of femininity, or alternatively, as a reaction to the exclusion of women's embodied experience and testimony within capitalism and Western culture (see further, for example, Ussher 2003; Shuttle and Redgrove 2005).) In her book on contemporary debates about lactation and breastfeeding, Hausman (2003) notes an often fundamental feminist discomfort around matters of embodied sexual difference such as pregnancy and lactation. Her approach is to try to find a way for feminists to acknowledge scientific facts about the impact of certain bodily processes on the health of both mother and child. Can certain 'objective' scientific facts about the body ever apply to all women who give birth? For instance, every woman who is pregnant or gives birth is undeniably exposed to enormous alterations of hormones and tremendous, unprecedented bodily changes both before and after the birth (Moore 2004; Cusk 2001). Is it too dangerous to allow that we need to take account of the massive, universal chemical changes which have been monitored in women who have children? Do we in fact need to (at least) *pay attention* to an account of situational chemical change which narrates an *embodied* range of potential responses to social and cultural pressures? In this sort of model, an excessively anxious, stressed and/or restricted carer experiences chemical changes in the brain as a result of his or her

situation and the accompanying emotions; genetic and other factors may exacerbate or facilitate such change, and/or sensitivity to it, in different individuals. As Lois McNay writes:

> The body is the threshold through which the subject's lived experience of the world is incorporated and realised and, as such, is neither pure object nor pure subject. It is neither pure object since it is the place of one's engagement with the world. Nor is it pure subject in that there is always a material residue that resists incorporation into dominant symbolic schema. (1999, p. 98)

Very few feminist legal or sociological scholars are equipped to address the 'truth claims' of biochemistry and psychopharmacology, and I am no exception, but as noted above, intriguing work has been done linking the depletion of serotonin in the brain (a key indicator/symptom/cause of depression) with the long-term social or familial experience of abuse, rejection or low group status (Sichel 2003; Thompson 2006; Wolpert 2001). This is research of immense importance to those who want to study the effects of gender inequality and the types of 'habitus' (Bourdieu 1990), the permanent, embodied dispositions, it creates. Maternal 'habitus' might indeed be *produced* through the communicative and constitutive effects of our powerful narratives of postnatal disturbance as physical disorder or 'imbalance'. The 'responsive' changes in brain function which take place in depression perhaps constitute a body-experience of being/becoming depressive in our culture—an experience far more common in women of childbearing age and particularly those with young children. Obviously, I make no claims here that depression is *the* maternal habitus—maternity being too variable an experience, subject to too many differing factors and influences. The habitus of depression is only one possible maternal embodiment of the "complex of marketization, autonomization and responsibilization" which absorbs contemporary subjects (Rose 2007, p. 4). Indeed, the multiple distinctions which might be made between PND and the 'habitus' of modern mothers serve as illustrations of the complex nexus of incompatible truth claims[18] (for instance, those about the sublime, selfless satisfactions of motherhood versus the achievements of productive/entrepreneurial citizenship) which mothers today must find individual and generally solitary means to unravel.

The Depressed Mother in Confessional Culture

At this point, I will return to the individual narratives and testimonies with which I began. Is reading these the best way to reconstruct the subjectivity and 'habitus' of the depressed mother, and if so, how may we read them? In post-1990s confessional "traumaculture" (Luckhurst 2003), might depressed mothers now exercise an unprecedented right to speak and to challenge the official discourses, to present the "view you can't get from anywhere else" (Thompson 2006, p. 17)? There are clear and obvious hierarchies of trauma in mainstream and feminist thought: mundane, 'kitchen sink' or 'Sunday supplement' trauma (perhaps understandably) lies at the

[18] I am grateful to the anonymous reviewer of this article for *Feminist Legal Studies* for this phrase.

bottom of the scale, while the utterly victimised, faceless, 'Third World' or now 'East European' woman appears now to epitomise 'global' suffering for feminism, as once perhaps the captive housewife in 1950s America did. Yet the sheer, persistent number of women suffering from depression in all classes and locations in the Western world attests to the fact that affluence does not guarantee exemption from suffering, and that the facts and realities of feminine embodiment across class and race continue to be cast out of language and 'rationality', abjected (Kristeva 1982). As if to prove this point, multiple confessional narratives of the mundane traumas of everyday Western motherhood have recently appeared, foregrounding maternal sufferings previously confined to polite domestic oblivion (Cusk 2001; Pearson 2003; Warner 2005; Quiney (Cain) 2007). Cusk (2001) incurred public opprobrium by writing about the negative aspects of motherhood in the style and with all the claims to 'high' literary status of a 'mainstream', even male, memoirist. She describes pregnancy and birth as a process of shocking changes to self-image and gender identity. Her book is part of a recent outpouring of the personal in literature which has saturated literary and media culture with previously private emotions, neuroses and biomedical details, as noted by Nikolas Rose. Everyday interactions have become "neuroticized" in a "new culture of the self" (Rose 1999b, p. 91, 2007; Blackman 2007, p. 12). In the "intimate public sphere" (Berlant 1997) of celebrity culture, women such as Brooke Shields and Katie Price disclose experiences of postnatal distress within a biomedical narrative form, usually one of acute and unexpected suffering followed by recovery and/or conquest and a return to 'normal' maternal feelings. This 'victim to victor' story "maps a current concern by governmental and psychiatric agencies with the 'at risk' or enfeebled personality" (Blackman 2007, p. 3).

'Facialisation' of Injustice

Are such narratives really revelatory, or do they merely act to simplify, to conceal gaps in cultural understanding of the structural causes of distress? According to Berlant, "the continual placing of a personal, individual 'face' on an otherwise abstract issue" results in a 'facialisation' of injustice that "enables further deferral of considerations that might force structural transformations of public life". Such 'facialisation' of public, systemic crisis "can only symbolize (but never meet) the need for the radical transformation of national culture" (1997, pp. 187, 220). Similarly, "law's insistence on reducing events to manageable categories has the effect of collapsing their complexity and plurality" (Aristodemou 1997, p. 46): the official legal/psychiatric narratives with their distant, tragic and monstrous figures are alienating. Personal public testimony at least encourages women to recognise themselves in different, connected stories.

Amid these competing claims to testimony and authority, listeners have to deal with the intractable problem of 'contamination' by transmission of affect: the 'natural' turning away from the deadness of depression to which depressives and their intimates alike can testify. At a broader cultural level, avoidance and turning away is something more than an aggregate of individual, negative responses. In the popular discursive construction of 'malignant', disruptive unhappiness and dissatisfaction (and particularly in the context of motherhood) ignorance about depression

and its prevalence is allowed, valid and even encouraged, because 'normal' people (and particularly mothers) need not know of such things. As noted already in respect of the popular blurring of PND into postpartum psychosis, confusion between depression and conditions perceived as more florid or even as 'dangerous' (such as bipolar disorder and psychotic conditions) is rife. This is as clear in the *Luc Thiet Thuan* judgment as in innumerable media reports of 'tragic' postnatal behaviour. "Faulty beliefs like these explain why there are so many walking wounded [depressed women] who think they haven't got the real thing" (Sheffield 2000, p. 151).

Our Favoured Victims?

Care is also required in the (re)construction of 'faulty' feminist beliefs about 'our' favourite victims—"our efforts to project and understand the other…the temptation to perceive her as whole, changeless and uncomplicated" (Aristodemou 1997, p. 42). Maria Aristodemou's idea of a legal "aesthetics that refuses to adjudicate, satisfy and close" (p. 47) may help to combat the closure of communication, and of what can seem like the world itself, to depressed women with children. If we think in terms of the limited opportunities to speak and testify to her existence and feelings which such a woman has, there is both a usefulness and a frustration in "language with 'holes and spaces' for the reader to come in" (Aristodemou 1997, p. 48). In a post-9/11 culture saturated in trauma, the depression narrative, with its power to expose the gaps and negative spaces of subjectivity, may still backfire on the (non-)subject who tells it, especially when the mundane miseries of low social status and gendered restriction rank far lower in the accepted liberal scale of injustice than 'outright' victimisation through global poverty or actual violence.

Although the concept of the biopolitical imperative to self-improvement may be depressing in and of itself, with its sometimes deadly focus on self-regulation and de-emphasis on social or collective solutions to the problems of childcare and rearing, it offers some intriguing narrative vantage points from which feminists can view the lessons of PND. Tracy Thompson uses a hackneyed yet rather moving metaphor: "Depression is like a mountain standing in your way, and the path over it is risky. But for those who persevere…it is a journey that gives you a view you won't get anywhere else" (Thompson 2006, p. 17). Currently, the complex yet limited/limiting definition and regulation of maternal depression work to deny women that unique 'view'. The mundane horrors of maternal unhappiness and isolation are minimised or catastrophised across discourses and representations of maternal misery, which still means maternal failure. The "view you won't get anywhere else" remains restricted to those unusually lucky, determined or well-supported women who get through maternal depression and its fallout alone. Meanwhile, the 'breakthrough' narratives of contemporary confessional culture and feminist ethnography struggle to achieve the authority which still adheres to the medico-legal narrative of maternal unhappiness as an asocial, individual pathology.

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