

POSTPARTUM DEPRESSION AND THE CHAOS OF MORAL PARENTING

Rebecca Oxley & Ruth Fitzgerald

ABSTRACT

This paper explores the shared and personal experiences of postpartum depression (PPD) for five families in the lower east South Island, New Zealand. Despite the idealised accounts of recovery and community reintegration following depressive episodes which mark New Zealand's mental health awareness public campaigns, these families, whilst officially 'recovered', continue to live with the effects of PPD and moral uncertainty over their ability to safely parent once more. They recount a fundamental 'trigger' of PPD as the inconsistency experienced between expectations of parenting as projected via the commoditised world of the 'Huggies family' advertisements versus its reality of broken dreams encountered via its lived experience. These disjunctions lead families towards classical scenes of biographical disruption in which they experienced existential disturbances to identities, life histories, family dynamics and ideas of reproduction and from which they argue they have never fully recovered. The performance of moral parenting after such an experience requires a policing of the uncertainty over exactly what caused PPD and whether it will return once more; a somatic mode of attendance which remains arduous given the self ascribed 'bizarre', multi-aetiological character of PPD.

INTRODUCTION

...spatiotemporal discontinuity attends the movement to the singular core of the black hole; concomitantly there is ambiguity, all pervasive uncertainty. When the core is finally reached, the chaos can no longer be contained.

Rosen (2004: 61) on black holes.

This paper explores the shared and personal experiences of postpartum depression (PPD) for five families in the lower east South Island, New Zealand. We

seek to clarify how PPD is somatically understood, performed and attended to by eight heterosexual, Pakeha survivors, consisting of three married couples and two women who felt they had no significant support person. In doing so, particular attention is paid to the manner in which morally informed knowledges of PPD and parenting ideologies articulate with the lived reality of PPD, as well as the experience and the subjective outcomes of the provision of state funded health care. These aims were closely aligned with those of the participants who contributed to the study, in order to promote more experiential discussion of PPD. Certainly, the majority of literature within New Zealand and the wider English-speaking world seems to focus on generating nosological facts or correlations (e.g. Kozhimannil *et al.* 2009, Beard *et al.* 2005, Yim *et al.* 2009, Bloch *et al.* 2000), screens (e.g. Evins *et al.* 2000), quantifying statistical data (e.g. Thio *et al.* 2006, Webster *et al.* 1994) and advancing psychosocial sources (e.g. Ussher 2006:111, Kitzinger 1992, Sallinen *et al.* 2006:14), predictors and risks of postnatal distress (e.g. Beck 2001, O'Hara & Swain 1996, Righetti-Veltermann *et al.* 1998). As one informant so aptly declared: 'I know those [PPD] figures are around...but what's happening is different from the numbers... what I read in the books is different from what happened to us.'

PUBLIC ACCOUNTS OF PPD IN NEW ZEALAND SOCIETY

Understandings of PPD in New Zealand society are publicly linked to infanticide¹, violence and abnormal family relationships as part of a moral panic over child neglect and homicide (Ministry of Social Development 2008, Suebwongpat *et al.* 2008). Officially labelled a 'mental health condition' by the Ministry of Health and Mental Health Foundation, and reaffirmed as this by the New Zealand Postnatal Depression Family/Whanau Trust, dominant knowledges of PPD typically adhere to the classifications outlined by the American DSM-IV-TR, where PPD is considered a specified form of clinical depression. It exists as a 'catch-all diagnosis', consisting of three related but separate pathologies: short-term 'maternity blues', postpartum depression and puerperal psychosis (RANZCP 2004:392, Mental Health Foundation 2002). Of these – Maternity Blues – a transient phenomenon occurring in 50–80% of all new birthing mothers, is generally not treated, and so PPD usually only incorporates postpartum depression and puerperal psychosis. These latter forms of PPD have an incidence of around 10–15% of women and approximately 10% of men (Mental Health Foundation 2002: 5, Postnatal Depression Family/Whanau Trust 2009). The expression of PPD varies from mild to major depression and can last up to and over one year, with studies showing that 14% of mothers suffer severe depression three to five months after the birth, with a further 16% suffering a milder form for at least a month. No such statistics have been correlated for

paternal PPD. In comparison, puerperal psychosis is understood to be far more serious and is a rare disorder that develops at a later stage after birth, but lasts longer and occurs in one to two women per thousand births in New Zealand.

PPD is perceived to be a multi-aetiological condition in which the predictors and/or risks are considered to include: low socio-economic status, immigrant status, multiple births, a medical (or family) history of mental illness, anxiety, being a single or homosexual parent, poor social (including relationship) support, cigarette smoking, ethnicity, life stress or lifestyle change and other subjective factors (Beck 2001, Ross *et al.* 2005, McCoy *et al.* 2006). An additional risk for New Zealand includes living in cold, damp or 'leaky' housing (Butler *et al.* 2003) and a further concern in New Zealand is that 40% of women who develop PPD neither seek, nor receive any medical or psychological treatment (the numbers could be even higher for men). Delays in accessing care may lead to increased symptomatic severity, alcohol and drug abuse and poorer responses to therapy (Mental Health Foundation 1995: 6–7, Postnatal Depression Family/Whanau Trust 2009).

All treatments aim to promote 'recovery' from the episode of depression that is PPD, with the meaning of recovery being defined anonymously in a Mental Health Foundation brochure (2002: 14) on postnatal depression as:

...not just about getting rid of symptoms. It's about getting back any lost rights, roles, responsibilities, potential, decisions and support....
[It] is about reclaiming your roles as 'healthy' person, rather than living your life as a 'sick' one.

From a social science perspective, this suggests the transcending of the 'sick role' back to perceived normativity, with care and assistance from culturally legitimated healers. It involves a synthesis of healing and curative elements, in which the primary aim is to 'alleviate suffering' and corporeal disruption, so that bodily docility and social normalcy can be achieved (Egnew 2005: 255). Our project and the participants' voices trouble this notion of 'recovery' and suggest an alternative framing (and naming) of the process of living with the experience of PPD.

METHODS

Our approach to this topic has been phenomenological, viewing PPD as a 'sickness' or somatic phenomenon that is an unwanted threat to one's sense of self (Hahn 1995: 22). The results are drawn from eleven semi-structured interviews,

in which participants with no support person were interviewed once, but those in a couple were interviewed both together and separately, so that the different narratives might reflect shared and personal understandings of PPD, to reveal the sense ‘where the paths of [their] various experiences intersect, and also where [their] own and other peoples’ interact and engage with each other like gears’ (Young 2005:7). As Allan (1980:206) has also noted: ‘the more segregated the couple, and more intimate the data required, the more likely it is that individuals will reveal truthful information’ and this was a further consideration. Interviews were open ended, and if there was a second interview, questions were based on themes that had arisen previously. Interviews always started with the query ‘tell me your story’, and transcripts of interviews employed both thematic and narrative analysis.

Direct sufferers were either diagnosed with PPD by a medical professional or by their own estimation, and overall, seemed to experience a range of postpartum depressions. Most lived through the generalised PPD, but one participant experienced ‘paternal postpartum depression’, one, puerperal psychosis and one, both ‘baby blues’ and postpartum depression. Their experiences span thirty years, and all encountered PPD after the birth of their first child apart from one couple, when it occurred after their second. This study is an attempt to truly *listen* to experiences of PPD, and, hopefully, to learn from them, however the results cannot be generalised to the wider Southern New Zealand population.

RESULTS: ‘TRIGGERS’ OF THE BIZARRE

Experiences of PPD for the participants were consistently described as being ‘bizarre’ and in their narratives PPD became *the* bizarre: something ‘strikingly out of the ordinary’ that must be made sense of in order to reconstruct their life histories. This sense-making was still in process when the participants were interviewed, for some this was many decades after the initial event. For those with a support person the sense-making seemed to be a shared process.

The participants initially spoke of ‘realisations’ that things were different to the norm via a series of bodily signs, or ‘clues’ (Radley 1994: 61, Harberger *et al.* 1992: 41, 46). For one mother this occurred soon after her son’s birth, as she had experienced similar symptoms before with regard to her anxiety. For another, it was a slower process given her understanding that it was normal for the six weeks after birth to be bizarre (‘...[be]cause that’s the ugly time, you’re bonding and stuff’). While for others, realisations happened with the distressful phenomenon of ‘snapping’:

I know child abuse. I could have banged his head. I didn't. I just had reached the point where his head was missing the ground and I just wanted him to shut up... That's when I knew I had snapped... I didn't want to end my life or give my son up. I didn't want sympathy either. I wanted freedom. I wanted out.

After realisations that something was wrong (by direct sufferer or partner), and that this wrong-ness was of such magnitude that help might be required to return to right-ness, most of the participants went to see their local GP's with a complaint and began their conference with medical authorities. After making the diagnosis of PPD the primary elucidation which GPs offered back to participants became their starting points for explanatory understanding. Yet these medical explanations, grounded in physiology and biology, seemed to have left participants dissatisfied with the notion that such a distressful and random event as PPD might be solely due to such factors. One informant explained her experience as 'an enormous crisis of incompetence', an inability to be normative (in any sense, biological or social), or a normal mother, coping with all the things that were expected of her, while another participant remains puzzled over how to explain PPD:

I only know [PPD is] hormonal because the doctor told me it's hormonal, but he never gave me hard proof evidence of hormonal...I would probably also put it down to being that I was separated, I worried about having a miscarriage rarerarara...Can it all be hormonal? Because those that you think have huge stresses in their life don't get it and you look at them and go – they're more stressed than me and look at them! ... why did I get this?

To help answer such a question, the participants told of a series of justified, fluid and often hesitant 'triggers' that described the 'genesis' of their suffering. These triggers included aspects such as isolation, medical histories, personality traits, a lack of support and upsetting experiences prior to conception, but the majority related to differences between their anticipated experiences of birth and parenthood and the realities they lived through. For example, traumatic birth and hospital experiences were reported by the majority of participants. A couple spoke of the 'incompetence' of midwives leading to a longer length of time for the placenta to be discharged, halting crucial bonding time between mother and baby, while one participant shared how the early sickness of her son due to his Rh negative blood type left her feeling fearful, guilty and useless. Another mother, too, was left dissatisfied with the care she received during childbirth, due to its sterile impersonal setting in a hospital theatre

and the increasing concern that it was going to turn into an emergency birth. She recalled finding it incredibly difficult to push ([She] didn't want to come out!) with the doctor resorting to forceps and even 'putting his foot on the table' for leverage. Her husband, to this day, remains incensed at the service of the midwife at the birth:

I can remember the midwife saying 'What's the matter, didn't you go to antenatal classes?' I remember getting very angry at that at the time...whether that caused the postnatal depression. I don't know.

A further trigger was the distress over the differences between their expectations of a happy family and the realities of their role change. Participants felt deceived and also failures for not being the 'supermums' they saw reflected in the media, and some felt 'trapped' by the normative expectations of others. One mother talked about expectations her husband and mother-in-law had of her being an ideal wife and mother, whereas others spoke of the expectations that they themselves had of motherhood. Many had visions of the happy nuclear family, where a baby was the next step in a model relationship: good home, great marriage, nice car and economic stability. These realities were dismissed for one mother after the infertility of her husband (they had conceived after HART therapy) and his eventual abandonment of the marriage. She details:

You had sort of preconceived ideas of how it's supposed to be when you have a baby and then you think it's going to be sort of the whole 'Huggies ad' as I refer to it. Where you are mum and dad and baby sitting in the middle, but it wasn't like that at all.

Another trigger that affected almost all direct sufferers was unanticipated problems with breastfeeding. The participants not only expected that they would be able to breastfeed but felt a moral imperative to do so considering social understandings that 'breast is best' (Schmied and Lupton 2001: 234, Cooke *et al.* 2007: 75), something currently encouraged with the Ministry of Health programme 'Feeding our Futures' via posters, leaflets and televised advertisements. They also felt a great deal of shame, guilt and distress at being seen to 'choose' to stop breastfeeding when it became impossible to achieve. One mother elucidates:

The biggest thing was [that] I had trouble feeding him, and I'd never contemplated [that] prior to having him. I just thought bottles were for people that couldn't be bothered to feed their children the right

way... I didn't want to express. I thought it was the worst thing in the world.

DISCUSSION

It became increasingly evident in listening to these accounts that a great source of suffering was living with the everyday realities of 'uncertainty' which marked the PPD experience. Such 'uncertainty' provided instances of hope and of despair, with this dualism adding weight to the torment of negotiating illness. Uncertainty experiences were disorganised and told primarily in terms of the 'chaos narrative', the most disordered of Frank's (1995) three main illness narratives, particularly with regard to the syntactic structure of 'and then, and then'. For the 'support persons', uncertainty was primarily expressed in 'how' and 'will' questions: how are we going to get through this? How can I help? Will things ever be the same again? These questions were founded upon senses of moral concern and caused a great deal of anxiety. The questions arose again and again with no answer; the participants' coping tactics of looking through and beyond illness were weakened as they were thrust into the immediacy and 'bottomless depths' of disease (Frank 1995: 99). This uncertainty was not often consciously formed into questions at the time of illness (chaos may be beyond speech (Frank 1995: 101)), but instead was embodied and experienced as a form of 'biographical disruption' (see Williams (2000)) and expressed in terms similar to Csordas' 'somatic modes of attention' or 'culturally elaborated ways of attending to and with one's body in surroundings that include the embodied presence of others' (Csordas 1993: 138). For all participants, PPD was experienced as an event in which 'normal' performances, suppositions and stories became complicated or disrupted through illness and corporeal uncertainty (Bury 1982: 169, Williams 1984: 178–9). One support person likens the experience to existing within a 'black hole' of uncertainty:

I suppose it was like having fallen into a big black hole and not knowing whether you're going to get out of it. That would be my biggest memory [of PPD], just wondering whether or not we were actually going to get through it, get out that other side.

This sense of disturbance spread to all aspects of the participants' lives in illness, including their family dynamics, ideas of parenting and reproduction, temporality, identity and, as detailed earlier, their life histories.

The participants talk of contending with the tormenting corporealities of uncertainty in terms of inability to cope with illness and parenthood, and for

direct sufferers – a failure to trust themselves. They began to understand their body differently during PPD. In this regard, many direct sufferers experienced uncertainty in terms of sceptical and disruptive feelings of love. One mother, in chaos, found it hard to acknowledge that she had a baby, far less love her ('I guess it's like you've had a baby but it's almost like they've died cause they don't really exist in your head'), and one couple found uncertain love to be a significant factor of their distress, coinciding again with unreasonable thoughts and disillusionment with parental expectations:

I felt like I didn't have any love – where's this feeling of overwhelming love that you see on TV? Because we'd always wanted kids, and I'd been a teacher so I'd loved everyone else's children and I couldn't understand and yeah, I said '...I don't love him and I don't think I'll ever love him – I don't have any love.'

An element of uncertainty remains in the effect this had on the children who were 'caught in the middle'. This was voiced with great concern by a support person who acknowledged the greater love his wife holds for their first born, and also by another participant, who noted that she worried about the effect of her ambiguous love throughout her experiences of PPD and beyond:

It was irrational, things like the fact that David didn't get a tooth until he was a year old. I saw that as my fault- that he didn't cut his teeth. I thought he wasn't growing like he should, he wasn't putting as much weight on as he should.

Support persons' somatic responses to this uncertainty varied. One informant's bodily reaction to uncertainty regarding his wife and their relationship may have 'triggered' his own experiences of depression. Others lived through different realities, noting that they became extremely angry at not knowing how long PPD would last. Sometimes emotions became too much to bear and were discredited or lost, especially as these 'support persons' attempted to take on a leadership role of projected certainty and composed rationality ('Yeah, [he] did take over. He was sort of like the adult.'). This was to allow their wives' lives and theirs to 'keep going,' although they still remained unsure of themselves and their situation (Radley 1994: 76).

What is illustrated here in the suffering of the participants is not only the anguish of uncertainty, encountering themselves as 'bodies of chaos' in contrast to their identity as rational, predictable, citizens, but the way in which it (and they) became a source of danger. Frank (1995: 104) details that 'chaotic' bodies

are often victim to 'dominating' bodies, but in uncertainty the participants feared *becoming* dominating bodies- they feared the possibility of harming themselves, their children or partners, directing the *bizarre* or other sensations at a targeted object. They feared being *disruptive*. Their suffering is thus ultimately affected by embodied threats of biographical 'shattering' of their identity (Williams 2000: 60) or what Cassell (1991: 25) terms 'disintegration'; they feared themselves and/or their partners becoming irreversibly 'other' to their normal and certain 'usual selves' and the 'inability to accomplish their previously important purpose[s]', to be a model parent, loving husband or wife and 'normal'.

As identity is also expressed in purposeful action- in practice (Cassell 1991: 25), the participants also suffered from the inability to determine how and when feelings and their physical presence would occur. This arose in the narratives of the participants whilst detailing puzzling weeping episodes, frenzied episodes of insomnia, and with the formulation of 'good days' and 'bad days'. Bad days were days when feelings, symptoms and not coping, disrupted achievement of the minimum of what was expected of them by society and themselves, in the roles of wives/mothers and husbands/fathers. Good days were when 'everything would seem to make sense'. Yet control and coping in the illness experience is, capricious (part of the biographically-uncertain 'merry-go-round' (Williams 2000: 44)), and thus, as one sufferer noted, 'good days could [without warning] easily turn into bad days.' There were, however, some identifiable factors that contributed in changing 'good' to 'bad'; for addition to biographical disruption, the symbolic connotations of PPD led to the equally disruptive (yet nevertheless practical) response of 'stigmatisation'. This normalising process was experienced by the participants as a way of attending to and with the 'body-in-chaos'- one that has somatically transitioned from biographically normal 'phenomenological modes of bodily 'dis-appearance'...to a state of corporeal dys-appearance [or dysfunctional appearance]' (Williams 2000: 43). Indeed, Goffman (1963: 139) notes that 'stigma' ('the situation of the individual who is disqualified from full social acceptance' (Goffman 1963: i)) may act as a social control in situations such as parenting, where coping with and managing a lack of control becomes a moral activity.

Direct sufferers encountered such stigma in two particular ways, either through first hand experiences or through the fear of being castigated; the first due to an inability to govern the contingent body, the second as a result of its unpredictability. They experienced stigma particularly through attentive 'known-about-ness' (Goffman 1963: 48) and the threat of being seen to be abnormal/disruptive and as failing in parental ideals. This threat of 'being seen'

is carefully reported by one informant with respects to experiences of her son crying and bottle feeding in social situations:

Something I couldn't cope with very well in public was [my son] crying because I would relate it to him needing a feed and I didn't want to bottle feed in public – I think people would be looking at you as a bad parent...I used to go into the baby changing rooms in the [shopping centre] if I went to town... 'cause I wouldn't want to feed him in public.

In this situation, her son's impulsive crying becomes the difference between being stigmatised and 'passing for normal'.

In a similar manner self-objectification of the body occurred in the participants with the distancing of disease from themselves, detaching mental illness from the self as if PPD were a free floating 'entity' (Helman 2007: 123) parasitically invading a host body. This is how one direct sufferer understood her sense of self in illness as she stated that she was simply 'not in possession of [her]self'. She, as with other participants, was 'robbed' and 'cheated' by a thieving PPD that was out of her control; the pattern of good and bad days was the result of PPD 'teasing' her. These views may be regarded as biographical coping mechanisms (Bury 1982: 173), shifting some blame for being and falling ill from the self to an outward aggressor.

It is little wonder that the participants distanced themselves from illness, considering the predominantly negative public images of sufferers of postpartum depression and indeed, of mental illness in general (Schulze and Angermeyer 2003: 305). Participants noted that for them, social depictions of those with PPD are as bad parents, or worse, of unnatural 'monsters' and crazy lunatics who murder their children. Direct sufferers thus considered that their feelings and behaviours would more likely than not be stigmatised in social spaces that were inappropriate for their sick bodies. They were, as Goffman would profess, self-defined 'normal deviants' (Goffman 1963: 131); they managed themselves in a way that, if not leading to coping with PPD, would resist others witnessing this or disrupting their lives further. All direct sufferers designated 'safe spaces' that would limit stigma and unwanted views of their uncertain selves and, most importantly, where their pride and identity would not be further damaged. For one, his 'safe space' was his work, for others it was at home. One participant notes she was quite happy at home as she 'wasn't wanting to go and visit people'. For another informant, her 'safe space' was also home but included excursions to places like *The Warehouse* that had 'easy escape routes'.

Another function of these 'safe places', in most circumstances, was to limit discomfort for other people. Mixed social situations between those suffering from PPD and those who were normal resulted in 'anxious un-anchored interaction' (Goffman 1963: 18), awkward for both parties. One participant spoke of such social disruptions as occurring when she didn't know the appropriate time to leave appointments, meetings and friends' houses, but others found themselves in upsetting circumstances when trying to get their families to appreciate their suffering. One informant reports: 'My mother didn't really completely understand how I felt either. All she said was "Get on with it." Get on with what? Coping?'

Although PPD did influence the marital relationships of the participants, this was little to do with embarrassment or stigma *per se* (in pairings of direct sufferer and supporter), most probably because the support persons were what Goffman (1963: 28) terms 'the wise': 'persons who are normal but whose special situation has made them intimately privy to the secret life of the stigmatised individual and sympathetic with it, and who find themselves accorded a measure of acceptance.' It is in this sense that support persons became comforter, policer and supporters of their wives, but also stretched beyond 'the wise' into a domain more intimate.

Feelings of uncertainty and failure also disrupted direct sufferers ability for 'desire' as 'whatever desires they once had have been too frequently frustrated. In a world so permeated by contingencies that turn out badly, desire is not only pointless but dangerous' (Frank 1995: 103). In this sense disruption 'which arises in the loss of ability to pursue purpose, defeats purpose' (Cassell 1991: 25). Direct sufferers felt diminished (Frank 1995: 39) and this led them (at one stage or another) to give up 'hope' in the sense of concrete 'positive expectation[s] of realising desirable outcomes' (Barnard 1995: 47) and giving up the motivation of ever regaining certainties of themselves, becoming an acceptable parent to themselves and for society, or importantly. of getting better. This disruption of hope by direct sufferers was encapsulated, supplemented and eventually reinstated by their significant support persons; their hope practically became the hope of their wives. This shared experience (although unspoken), is well explained in the following quote by Weingarten (2000: 402) when she details conversing with a breast cancer patient:

...with tears streaming down her cheeks, she said, 'I am hopeless. I have no hope...' 'Of course, you feel hopeless,' I told her. 'It is not your job right now to feel hope. Rather it is the responsibility of those who love you to do hope with you.' ...Hope is something we

do with others. Hope is too important – its effects on body and soul too significant – to be left to individuals alone.

It is here that the strict classifications of Parsons' *sick role* become blurry and the lack of fit between 'recovery' from PPD in its mental health sense and its lived experience becomes apparent. The sick role details that doctors and patients each have two obligations and two rights, however the direct sufferers, excluding the participant who experienced paternal PPD, only fulfilled two of the patient's criteria – the legitimating of illness by medical professionals and the right of seeking competent help (Parsons 1991: 294). It is only together with their significant support person that the rest of the requirements were achieved. The obligation to want to get well was only accomplished through the allocation of hope from the support person, eventually turning into personal determination. It is thus the support person who stopped the direct sufferer of PPD from turning into a deviant 'malingerer' (Parson 1952: 437). The right of the sick person to 'exemption from normal social role responsibility' (Parsons 1952: 436) during the course of illness was also only available due to the temporary exclusion of support persons from their usual roles, and only in part, as mothering is too socially great a responsibility for sickness to obstruct. One support person, for instance, was allowed to decrease his hours at work in order to care for his wife and reduce her responsibilities of looking after their son – but only for a limited time or he would need to resign, which was 'unthinkable'. The sick role thus acts with stigma as a social control over the contingent body (Parsons 1991: 321).

The sick role as a way of managing or attending to illness thus assumes both individuality and culturally constructed 'rationality' as underlying criteria – which as the participants have detailed is not always possible. This is one reason why the sick role has been critiqued for chronic, mental and/or long-term illnesses (such as PPD) (Levine & Kozloff 1978, Crossley 1998, Williams 2005: 125), and yet, this seems to be the role that is promoted for sufferers of mental illness in New Zealand, advanced by public health policy and social pressure: for them to 'get out there, you know, take on life' (Aubrey, Like Minds, Like Mine television campaign, cited in Mental Health Foundation 2007).

The uncertain experience of PPD led the informants to somatically experience temporality differently; temporality became 'anti-temporality' (Turner 1982) where planning for a future was interrupted and the future had become ambiguous. The participants thus approached their lives, attending to and with their bodies, in a type of ritualised 'time outside time' (Turner 1982: 253), away from the rapid tempo of society, by utilising consciousness of a 'continuous present',

in the sense of ‘I’ve done that day and that’s one more day, so many more to go’. It is in describing this sense of time that the participants most clearly employ Frank’s chaos narrative. There is only an ‘incessant present with no memorable past and no future worth anticipating’ (Frank 1995: 99). Days became highly regimented, part of a mundane schedule to restore some sort of order to the chaos of their being. One couple noted that the day was programmed around breast or bottle feeding and Family Start visits and a support person notes that for him there was ‘this amazing routine which was bang-bang-bang-bang-bang that seemed to go on forever’. The experience of a continuous present was, however, still fringed with indecision, aligning with the chaos narrative’s ‘anti-narrative of time without sequence’ (Frank 1995: 98). One mother notes that for her PPD ‘seemed like a really long time, but it went really quickly...but it did feel like forever.’ Likewise others mentioned that PPD went ‘on and on’, not quite relating to chronological time.

This chaos narrative continues whilst the participants talk of debating whether to add more additions to their family after PPD. One couple dealt with this uncertainty by refusing to have any more children, considering the risks of a recurring depression too high, permanently disrupting their dreams of a large family. For others it caused considerable anxiety, such as with one support person who reacted quite differently from his wife. The thought of experiencing PPD again made him realise just how it had affected him:

I was very anxious when Pauline wanted another child. I got very anxious...gosh, I don’t know if I can go through this again. Possibly that’s when it hit me – just how exhausting it had all been. I don’t know if I want to go through it again. It’s scary stuff.

They, as with other participants, took the risk however, believing that PPD was encountered due to chance. This perception provided them with some much strived for ontological security, narratively reordering informants’ experiences of uncertainty, constructing new realities of living with PPD that became both a coping strategy for the present (holding the benefit of making sense) and also a way of communicating their story to others in a less chaotic narrative that is easier to listen to. It is a type of biographical ‘narrative-reconstruction’ (Williams 1984) to express the genesis of illness.

‘Chance’ thus becomes another probable cause of PPD in a life based partly on fate, a Homeric sense of destiny in which causation and outcome were explained through powerful forces but in which individuals might still influence their existence (‘I might have been going to get it anyway?’). This shifting

of the blame of illness from the self is a crucial intention of such constructed narratives as it once more distances the participants from moral judgment, as the stigmatised are often held accountable for their disreputable attributes and the social rupture that they cause (Goffman 1963: 3). In a similar manner one informant insisted that 'karma' created the chance of experiencing a bad birth, triggering PPD. Others considered 'luck' was implicit in their recovery. For the participants, constructing a reality of embodiment in such a world of mystery leads them to understand their mental illness as 'out of their hands' – quite the contrary of those public health messages that encourage rational self-management of mental illness (patient 'choice') along with certain responsibility for how to deal with it.

The participants also somatically dealt with their experiences of uncertainty and PPD through the practical response and 'strategic mobilisation of resources' (Williams 2000: 43) which we could consider as 'care'. While the participants did not experience 'preventative care' (based on practices of caution, awareness and education and involving EPDS² or PHQ-2(3)³ screening programmes) directly, care which is increasingly becoming a public health priority (Hosman 2004), their experiences were more influenced by self care, medical care and social care. Throughout the time span of thirty years that encapsulates the participants' experiences of PPD, it seems that what they regard as 'good care' is that which is detailed by Mol (2008) as closely following the 'logic of care', rather than the 'logic of choice'. Those types of care that caused them the most moral and practical difficulties were self-care and medical care; focused on individual rationality and autonomous self management.

Self-care is a highly encouraged type of care anchored in notions of bodily subjugation, of taming one's 'passions' (Martin 2007: 6). This type of 'rational' care may be taken for granted (to a certain degree) or encouraged by other types of care, as it involves the taking of pharmacological medications at the appropriate times and in prescribed quantities, the care to attend therapy sessions and ultimately the care to employ all necessary methods of care in order to get well. For many direct sufferers, their experience of self care only became a possibility when their recovery process was well underway, beforehand it was a shared care overseen by their support persons. This was explained by one such sufferer, saying 'when you are suffering from [PPD], you just don't care... you couldn't concentrate, couldn't think'. Thus the roles of support persons were as motivator, supervisor, carer and healer, acknowledging that:

Recovery from suffering often involves the borrowing of strength of others as through persons who have lost parts of themselves can

be sustained by the personhood of others until their own recovers.
(Cassel 2004: 43)

Contrary to their wives, the support persons did not detail any self care techniques specifically. Their focus, as with the majority of advice on postpartum depression was focused on the facilitation of recovery, and not with their own suffering.

The participants' experiences of medical care in the form of talking therapies, pharmaceutical medications and ECT were the most distressful in that they disrupted their experiences of parenthood further whilst recovering from PPD. For one mother this was due to her hospitalisation and initial separation from her child as well as the memory loss associated with ECT therapy, and for others, the realisation of a new and disturbing cyborg identity after treatment with anti-depressants. Another participant also details how drugs initially complicated but were ultimately effective in her recovery:

Just a few questions. That's all I remember him asking me. But what I do remember is what he said – 'Well, you must take these pills,' and he gave me a prescription for more and I protested. I said, 'Well I don't want to take those because they make me so sleepy. How can I be a mother and wife if I'm half asleep half the time?'.... He said 'If you don't take these, we'll have to think about sending you to Cherry Farm for shock treatment.' He said 'Just take them and the sun will shine.' That was the first encouraging thing anybody ever said. The sun will shine. And so I took them and I gradually did feel better.

In contrast, the participants positively emphasised the role of social care in their recovery, with the support from community organisations such as Family Start and Plunket as well as friends and family. They particularly noted the benefits of the Dunedin City Plunket home visit programme and PPD support group. Support persons do wish, however, that there was more couple inclusion in such support groups. They found social care more attuned to their needs, being fluid, adaptive, present on good days and bad days and, importantly acknowledged that their suffering was set in a collective (familial) situation. They preferred this care in practice due to its attentiveness and its lack of emphasis on bodily control and rationality, seeing them as themselves and not simply in the category of 'sick'. This is clarified by a participant detailing her frustrations of bad care:

Oh, if I had just had encouragement from any of those people in-

stead of being treated like an illness...I was treated too objectively. Like I was a non-functioning thing instead of a person. Just being treated as somebody who needed support rather than something that was malfunctioning...

Their narratives agree with Mol (2008:37) that good care 'meddles with every detail of our daily lives, and indeed tries to normalise our bodies. But it does not despise them. Care has little to do with repressing and all the more with cherishing our bodies'.

When the participants were interviewed, they were still in the process of re-constructing their identities, and this is where major gendered differences occurred in their somatic understandings of PPD for support persons who were all men, and direct sufferers who were predominantly women. Direct sufferers all purposefully positioned their identities as 'victims' and support persons as 'heroes' in ways that attempt to piece back the self in a socially and morally acceptable way, hinting at a refashioned mode of attending to the biographically disrupted body.

Support persons portray a 'supernormal identity' expressing their leading role in caring for their wives, and emphasising their masculinity (in the dominant cultural (Pakeha) ideal) through their rational and tactical approach towards care. A support person likens this role as 'opposite' to that of his sick wife:

Most of the time I think I switched into thinking of problem solving [and] just trying to do that bit, I mean, Pauline was having enough feelings for all of us! All over the place! So I think I took on the counter role, if you like, of trying to stay with it and thinking.

They identify as 'super dads' who, for a short time, were able to adequately fulfil the roles of both mother and father, and fulfilling the protective role as head of the household. They also saw the experiential good in PPD, noting the bond between their children and themselves:

[PPD] shapes your role as a dad and how much hands on you are and how much you end up doing. I have a lot of mates who have got three or four kids and have quite a full on job but at the end of the day they have never changed a nappy which I found really weird. So [because of PPD] it meant that we were more 50/50 parents even though I was working at the same time. But [PPD] is a good thing.

Direct sufferers who were women did not see such good in PPD. They saw themselves as 'victims' of disease, again deflecting the blame for illness. Whilst projecting passivity in the deflection of much of the responsibility of suffering PPD (excluding the 'triggers' that note medical histories and personality factors), this 'victim' identity is anything but passive. It is very much part of an active process of reconstructing a self that the participants can biographically live with. Noting feminist debates regarding differences between the passive or abject subjectivity of 'victims' and agency of 'survivors', here we see survivors as identified victims appealing to one of survivorships very definitions: 'taking responsibility for ending dysfunctional patterns in their lives, desisting in self-blame, and focussing on emerging from a traumatic event alive' (Dawn McAffrey, cited in Stringer 2001).

In this regard they do appeal to notions of women as the 'weaker sex' but do so to promote their normalcy and their humanity – they are not the PPD monsters that murder their children; they were simply ill but have recovered. In a somewhat contradictory way they do also consider themselves to be victims of society with the projection of the idealised super-mum. One mother describes her views of this, detailing the anguish of her marriage break-up and the fact that she was the one left 'holding the baby':

I felt cheated, I felt like he could walk away and I couldn't walk away from my child....He could walk out on the marriage and he had all the freedom where I was kind of stuck with the child. Not that I begrudge being stuck with the child, but I felt trapped....He walked away with all the freedom!

These identities of 'hero' and 'victim' become increasingly important in circumstances where the participants still relay that they consider themselves in a 'liminal' sphere, worrying that another episode of depression is just around the corner. One informant elucidates:

I think even when you do get over it, you know, you're feeling better – it never leaves you though. You'll think if something does go wrong, oh – is it that the postnatal depression that's caused it or is it just everyday life?

CONCLUSION

Although the participants have officially 'recovered' from postpartum depression, and have regained their acceptable roles in society, it seems premature

to suggest that they have healed. They have not yet meaningfully made sense of their bizarre experiences and answered the question ‘why me’? They are still suffering from the biographical consequences of PPD. When we think of Helman’s (2007) ‘symbolic healing’ that requires a certain knowledge of cause and a specific healer, it is little wonder their life histories have not been reconstructed. The continuing disruption that the participants face may also be hindered by the emphasis of public health care remaining on those with mental illness to transcend the ‘sick role’ with a quick recovery; to blend in with society, to be a functional and rational citizen: something particularly important for those with vital roles to fulfil in society such as parents. The participants acknowledge the moral chaos and stigma they experienced in living with PPD and their role in this research is to reduce this stigma and bring further awareness to PPD as part of preventative care. They feel they have a moral obligation to do so, and they wish to promote what they regard as ‘good care’ should they risk encountering the need for it again.

NOTES

- 1 The offence of ‘infanticide’ in New Zealand law (as per the Crimes Act 1961) is regarded as the killing of a child less than ten years old by the biological mother whilst suffering the effects of childbirth, which includes postpartum depression.
- 2 Edinburgh Postnatal Depression Scale.
- 3 Patient Health Questionnaire 2 (3).

REFERENCES

- Allan, G. 1980 ‘A Note on Interviewing Spouses Together’, *Journal of Marriage and the Family* 42 (1): 205–210.
- AUT 2004 ‘Good News on Samoan Maternal Mental Health’, www.aut.ac.nz/corp/newsrelease/?281.
- Barnard, D. 1995 ‘Chronic Illness and the Dynamics of Coping’, in S. Toombs, D. Barnard and R. Carson (eds) *Chronic Illness: From Experience to Policy*. Bloomington: Indiana University Press: 38–57.
- Beard, J.L., Hendricks, M.K., Perez, E.M., Murray-Kolb, L.E., Berg, A., Vernon-Feagans, L., Irlam, J., Issacs, W., Sive, A. and Tomlinson, M. 2005 ‘Maternal Iron Deficiency Anemia Affects Postpartum Emotions and Cognition 1’,

Journal of Nutrition 135: 267–272.

- Beck, C.T. 2001 'Predictors of Postpartum Depression: An Update', *Nursing Research* 50 (5): 275–85.
- Bloch, M., Schmidt, P.J., Dancaceau, M., Murphy, J., Nieman, L. and Rubinau, D.R. 2000 'Effects of Gonadal Steroid in Women with a History of Postpartum Depression', *American Journal of Psychiatry* 157: 924–930.
- Bury, M. 1982 'Chronic illness as a Biographical Disruption', *Sociology of Health and Illness* 4 (2): 167–182.
- Butler, S., Williams, M., Tukuitonga, C. and Paterson, J. 2003 'Problems with Damp Housing among Pacific Families in New Zealand', *New Zealand Medical Journal* 116 (1177), nzma.org.nz/journal/116-1177/494.
- Cassell, E.J. 1991 'Recognizing Suffering', *The Hastings Centre Report* 21 (3): 24–31.
- Cassell, E.J. 2004 *The Nature of Suffering and the Goals of Medicine*. New York: Oxford University Press.
- Cohen, L.S. and Nonacs, R.N. 2005 *Mood and Anxiety Disorders during Pregnancy and Postpartum*. Washington DC & London: American Psychiatric Publishers.
- Cooke, M., Schmied, V. and Sheehan, A. 2007 'An Exploration of the Relationship Between Postnatal Distress and Maternal Role Attainment, Breast Feeding Problems and Breast Feeding Cessation in Australia', *Midwifery* 23: 66–76.
- Crossley, M. 1998 'Sick Role' or 'Empowerment'? The Ambiguities of Life with an HIV Positive Diagnosis', *Sociology of Health and Illness* 20 (4): 507–31.
- Csordas, T.J. 1993 'Somatic Modes of Attention', *Cultural Anthropology* 8 (2): 135–156.
- Egnew, T.R. 2005 'The Meaning of Healing: Transcending Suffering', *Annals of Family Medicine* 3 (3): 225–262.
- Evins, G., Theofrastous, G. and Galvin, S.L. 2000 'Postpartum Depression: A Comparison of Screening and Routine Clinical Evaluation', *American Journal of Obstetrics and Gynecology* 182 (5): 1080–182.

- Ezzy, D. 2000 'Illness Narratives: Time, Hope and HIV', *Social Science and Medicine* 50: 605–617.
- Frank, A.W. 1995 *The Wounded Storyteller*. Chicago & London: University of Chicago Press.
- Goffman, E. 1963 *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs: Prentice Hall Inc.
- Hahn, R.A. 1995 *Sickness and Healing: An Anthropological Perspective*. New Haven: Yale University Press.
- Harbenger, P.N., Berchtold, N.G. and Honikman, J.L. 1992 'Cries for Help', in J.A. Hamilton and P.N. Harbenger (eds) *Postpartum Psychiatric illness: A Picture Puzzle*. Philadelphia: University of Pennsylvania Press: 41–60.
- Helman, C. 2007 *Culture, Health and Illness* (5th ed). New York: Oxford University Press.
- Hosman, C. 2004 'Guest Editorial: Prevention of Mental Disorders: Effective Interventions and Policy Options', SPINZ Newsletter 2 Summer 04/05, <http://www.mentalhealth.org.nz/newsletters/view/article/2/11/summer-04-05/>
- Kitzinger, S. 1992 'Birth and Violence against Women: Generating Hypotheses from Women's Accounts of Unhappiness after Childbirth', in H. Roberts (ed) *Women's Health Matters*. London & New York: Routledge: 63–80.
- Kozhimannil, K.B., Pereira, M.A. and Harlow, B.L. 2009 'Association between Diabetes and Perinatal Depression among Low Income Mothers', *JAMA* 301 (8): 482–847.
- Levine, S. and Kozloff, M.A. 1978 'The Sick Role: Assessment and Overview', *Annual Review of Sociology* 4: 317–43.
- Martin, E. 2007 *Bipolar Expeditions: Mania and Depression in American Culture*. Princeton: Princeton University Press.
- Mccooy, S.J.B., Beal, J.M., Miller, S.B., Payton, M.E. and Watson, G.H. 2006 'Risk Factors for Postpartum Depression: A Retrospective Investigation 4-Weeks Postnatal and a Review of the Literature', *Journal of the American Osteopathic Association* 106 (4): 193–98.

- Mental Health Foundation. 1995 *Postnatal Depression*. Wellington: Mental Health Foundation.
- Mental Health Foundation. 2002 MHINZ Booklet: *Post Natal Depression*. Auckland: Mental Health Foundation.
- Mental Health Foundation. 2007 'Like Minds, Like Mine: Discrimination', http://www.likeminds.org.nz/file/downloads/pdf/file_36.pdf
- Ministry of Social Development. 2008 'Preventing Physical and Psychological Maltreatment of Children in Families: Review of Research for the Campaign for Action on Family Violence: Summary of Findings'. Wellington: Centre for Social Research and Evaluation.
- Mol, A. 2008 *The Logic of Care: Health and the Problem of Patient Choice*. London & New York: Routledge.
- O'Hara, M.W. and Swain, A.M. 1996 'Rates and Risk of Postpartum Depression: A Meta-Analysis', *International Review of Psychiatry* 8 (1): 37–54.
- Parson, T. 1952 *The Social System*. London: Routledge & Kegan Paul.
- Parsons, T. and Turner, B.S. 1991 *The Social System* (2nd ed). London: Routledge & Kegan Paul.
- Postnatal Depression Family/Whanau Trust. 2009 'Mothers Matter: He Mana To Te Whare Tangata', www.mothersmatter.co.nz
- Radley, A. 1994 *Making Sense of Illness: The Social Psychology of Health and Disease*. London & Thousand Oaks: Sage Publications.
- RANZCP. 2004 'Australian and New Zealand Clinical Practice Guidelines for the Treatment of Depression', *Australian and New Zealand Journal of Psychiatry* 38:389–407.
- Righetti-Veltera, M., Conne-Perreard, E., Bousquet, A. and Mananzano, J. 1998 'Risk Factors and Predictive Signs of Postpartum Depression', *Journal of Affective Disorders* 49 (3):167–180.
- Rosen, S.M. 2004 *Dimensions of Apeiron: A Topological Phenomenology of Space, Time and Individuation*. London & New York: Rodopi Press.

- Ross, L.E., Steele, L. and Saprio, B. 2005 'Perceptions of Predisposing and Predictive Factors for Perinatal Depression in Same-Sex Parents', *Journal of Midwifery and Women's Health* 50 (6): e65–e70.
- Sallinen, B.A., Gilles, A.A. and Hayes, M.J. 2006 'Psychobiology and Culture in the Development of Postpartum Depression', in A.I. Rosenfield (ed) *New Research on Postpartum Depression*. New York: Nova Publishers: 1–28.
- Schmied, V. and Lupton, D. 2001 'Blurring the Boundaries: Breastfeeding and Maternal Subjectivity', *Sociology of Health and Illness* 23 (2): 234–250.
- Stringer, R. 2001 'Blaming Me, Blaming You: Victim Identity in Recent Feminism', *Outskirts* 8, <http://www.chloe.uwa.edu.au/outskirts/archive/volume8>.
- Sueb Wongpat, A., Standfield, L., Campbell, S. and Norris, S. 2008 'Screening for Postnatal Depression within the Well Child Tamariki Ora Framework: An Economic Analysis of Implementation of a Screening Programme', HSAC Report 1 (2): i–46.
- Thio, I.M., Browne, M.A.O., Coverdale, J.H. and Argyle, N. 2006 'Postnatal Depressive Symptoms go Largely Untreated: A Probability Study in Urban New Zealand', *Social Psychiatry Epidemiology* 41: 814–6.
- Turner, V. 1982 'Images of Anti-Temporality: An Essay in the Anthropology of Experience', *The Harvard Theological Review* 75 (2): 243–265.
- Ussher, J.M. 2006 *Managing the Monstrous Feminine: Regulating the Reproductive Body*. London & New York: Routledge.
- Webster, M.L., Thomson, J., Mitchell, E.A. and Werry, J.S. 1994 'Postnatal Depression in a Community Cohort', *Australian and New Zealand Journal of Psychiatry* 28: 42–49.
- Williams, G. 1984 'The Genesis of Chronic Illness: Narrative Reconstruction', *Sociology of Health and Illness* 6 (2): 175–200.
- Williams, S.J. 2000 'Chronic Illness as Biographical Disruption or Biographical Disruption as Chronic Illness? Reflections on a Core Concept', *Sociology of Health and Illness* 22 (1): 40–67.
- Williams, S.J. 2005 'Parsons Revisited: From The Sick Role to...?', *Health: An*

Interdisciplinary Journal for the Social Study of Health, Illness and Medicine
9:123–144.

Yim, I.S., Glynn, L.M., Schelter, C.D., Hobel, C.J., Chicz-Demet, A. and Sandman, C.A. 2009 'Risk of Postpartum Depressive Symptoms with Elevated Corticotropin-Releasing Hormone in Human Pregnancy', *Archives of General Psychiatry* 66 (2):162–169.

Young, I.M. 2005 *On Female Body Experience: 'Throwing Like a Girl' and Other Essays*. New York: Oxford University Press.