

Everybody Gets the Blues (Editorial)

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In February, when Britney Spears shaved her head and tattooed her wrist, the media went wild with voyeuristic speculation. I felt sorry for her and worried about her mother. At the time, I wondered if Spears was having a psychotic break and whether she might be bipolar. Apparently, she is.

Bipolar disorder is not a character flaw or the result of something someone did, or a sign of personal weakness or a lack of willpower. It is a mental illness—a chronic medical condition like diabetes or high blood pressure.

More than 30 medical conditions can cause the misperceptions commonly associated with mental illness. Most well-known are pellagra, hypothyroidism, folic-acid/B12 deficiency, sleep deprivation, and heavy-metal toxicity. Lesser-known medical conditions that can cause misperceptions include histapenia (low blood histamine), histadelia (high blood histamine), pyroluria (a familial double deficiency of zinc and vitamin B6), cerebral allergy (includes wheat-gluten allergy), and nutritional hypoglycemia.

Regardless of cause, mental illness carries with it a heavy stigma that assumes personal blame. This stigma underlies the nearly nonexistent health care and financial benefits available for people with mental illness. Every time Medicare benefits are cut, it is care for the mentally ill that is compromised.

In our town, a mentally ill person who cannot work must be homeless for three years before qualifying for shelter. State benefits provide for food stamps and a onetime payment of \$200. Federal Social Security benefits pay \$800 to \$900 a month, but only if someone is totally unable to work. A mentally ill person without family has little choice but to live on the streets.

For people who have recovered from mental illness, this preexisting condition disqualifies them for BlueCross BlueShield (BCBS) and other health-insurance policies. It disqualifies them not only for treatment for mental illness, but for any health insurance. And while some states have insurance pools that include everyone, regardless of preexisting conditions, these can be expensive and often do not allow free choice of practitioner.

No wonder, then, that we fear depression: Our society judges it cruelly, and provides no safety net when it occurs. Depression, however, accounts for one in five doctor visits, and is among the most common diseases. More women than men visit the doctor for depression, and women's depression often tends to be hormonally related. Depression can also be related to genetics. Early recognition of the symptoms of mental illness leads to earlier recovery; mental illness can, in fact, be treated successfully.

In late February, I attended a panel on postpartum depression (PPD), presented at the 13th Annual Congress of the Association of Pre and Perinatal Psychology and

Health (APPPAH). Members of the panel included Bethany Hays, MD; Gayle Peterson, PhD; Robbie Davis-Floyd, PhD; and Tom Verny, MD. I draw from their comments throughout this essay; an audiotape of the session is available at <http://www.mothering.com/interactive/audio/postpartumpanel.mp3>.

Because of our society's harsh judgment of depression, we seldom acknowledge that depression can be appropriate immediately after a woman becomes a new mother. According to Gayle Peterson, depression is a defense against overwhelming feelings that cannot be organized or categorized. She says that depression during the postpartum period is understandable, as this is a period of normal crisis and adaptation. Some cultures have rituals that provide automatic support for the new mother during this critical time.

Tragically, our culture does not provide this kind of ritualized support; it is no wonder that many new mothers feel depressed when isolated with a new baby. According to Peterson, women experience ambivalence as new mothers because they feel a sense of ultimate fulfillment at the same time that they are making tremendous self-sacrifices.

Add to this the fact that our culture's expectations of mothers are unrealistic. Mothers are measured by their child's performance, but society devalues mothering because it is unpaid work. Women themselves devalue their own work of mothering. They hesitate to spend money to help make things easier for themselves. Even when they work outside the home, mothers often still do the lion's share of household chores.

This overwork leads to depression. When we repeatedly ignore our own needs, depression is inevitable. Mothers in the US, however, often have no other choice because our national policies do not support women. The US offers 12 weeks of unpaid maternity leave. In a study conducted at Harvard University in 2004, 163 of 168 countries had some kind of national paid maternity leave.¹ Only Lesotho, Papua New Guinea, Swaziland, and the US offer no paid maternity leave.

In most industrialized countries, working parents are entitled to maternity leave, paternity leave, parental leave, and childcare leave. Of 22 countries surveyed in 2006, the period of maternity leave was mostly between 14 and 20 weeks, with payments between 70 and 100 percent of usual earnings.¹ Several countries offer longer maternity leaves: 24 weeks in Hungary, 28 weeks in the Czech Republic, 34 weeks in Ireland, and 52 weeks in the UK. In Germany and Italy, maternity leave is obligatory. Fifteen of the 22 countries reviewed have paid paternity leave of 2 to 10 days. Portugal provides 20 days of paternity leave, 5 days of which are obligatory.

In addition, all EU member states must provide at least three months leave per parent for childcare purposes. Four non-EU countries also provide parental leave, the exception being the US. In six countries, parents can take additional "childcare" leave after all parental leave has been exhausted.

In Australia, Belgium, Canada, Denmark, Greece, Iceland, Ireland, Italy, Slovenia, and the UK, the total of continuous leave available ranges from 9 to 15 months. In the Czech Republic, Estonia, Finland, France, Germany, Hungary, Norway, Portugal, Spain, and Sweden, continuous leave can run as long as 3 years.

The US has the longest average workweek and the longest average workday in the world. Canadians work 6 fewer weeks per year than we do, Swedes 11 fewer weeks. Here in the US, balancing work and family is becoming increasingly impossible.

Peterson says that we must stop this cycle of societal neglect of mothers and children. She suggests that we treat depression in all ways necessary, but especially preventively, with prenatal psychological and social interventions.

She also acknowledges that the postpartum period is a time of normal stress, and suggests that we support women through it. We need a national policy to support families to successfully balance work and family. We need to ease the economic and social pressures on families.

During the APPPAH panel, anthropologist Robbie Davis-Floyd talked about the fact that, throughout most of human history, we have raised children in community and in close physical contact with other adults. Postpartum depression was not evident before industrialism, but is now present in every industrialized country. According to Davis-Floyd, we are not genetically adapted to the nuclear family, which is a byproduct of industrialization.

In some ways, PPD is an adaptive strategy, a signal for help. It may enable the mother to negotiate more social support, because it is isolation and lack of social support—particularly from dad—that contribute to PPD. Problems with the infant, and/or any preexisting emotional problems the mother might have, can also contribute.

Mothers are helped by social support, by practical emotional support, and by having someone to talk to. Anything that diminishes a mother's social isolation helps. The extended family should be supported to take care of the new family, and in cases where this is not possible, we need to create new communities of peer support and new models of community resources.

One such model is Many Mothers, founded by Anne McCormick (www.manymothers.org). This volunteer, free-of-charge, community-based postpartum service is available to any family with a newborn, regardless of income level. The Many Mothers program of women-to-woman care is designed to ensure that new mothers are afforded every opportunity to attach to their infants. The program is easy to implement, and Many Mothers provides the necessary materials to set up cost-efficient, neighbor-to-neighbor support in your community.

A highly effective model of peer support is the Centering Pregnancy Program, founded by Sharon Schindler Rising (www.centeringpregnancy.com). The Centering Program brings women into groups for routine prenatal care. After an initial obstetrical exam, they join 8 to 12 other women or couples with similar due dates, and meet regularly throughout their pregnancies. The groups begin meeting at between 12 and 16 weeks of pregnancy, and continue through the early postpartum period. As a group, the women engage in self-care activities such as weighing themselves, taking their blood pressure, estimating gestational age, and recording all of this on their individual charts. They complete self-assessment sheets that serve as a stimulus for subsequent group discussions. The opportunity to meet for ten 90-minute sessions with the same group of expectant parents allows for

continued sharing, and the development of a support network that often extends into the childrearing period.

Modalities such as exercise, meditation, yoga, HeartMath, Pilates, Healing Touch, massage, and movement can help someone who is suffering from depression. Getting outside can help depression, as seasonal mood disorders are often related to a lack of sunshine. Most important, however, is learning to differentiate between temporary blues that pass within a few days or weeks, and feelings of depression that overwhelm us and affect our social functioning.

In either of these situations, and particularly in the latter, it is essential that we reach out for help, call a friend, ask a pal over for dinner. We are social animals. We need others, and we especially need them during times of important social transitions. When we feel that we can't do it all, we're usually right. We need help.

Find a way to enjoy your motherhood by joining in community with other new mothers and new families. When we can share it with our friends and loved ones, we can handle anything. Please don't be afraid to ask for help.

NOTES

1. Jody Heymann et al., "The Work, Family, and Equity Index: Where Does the United States Stand Globally?" Harvard School of Public Health, Project on Global Working Families (2004): www.nationalpartnership.org/site/DocServer/WFE_Index.pdf?docID=361
2. P. Moss and M. O'Brien, *International Review of Leave Policies and Related Research 2006*, Employment Relations Research Series 57 (London: UK Department of Trade and Industry, 2006), www.dti.gov.uk/files/file31948.pdf.