

The Institute of Ideas and SPIT-LIT present:  
**Does motherhood drive you mad?**  
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I've worked continuously in the NHS since the early 1980s – first as a midwife and for much longer – 15 years or so - as a health visitor. There was a lot of hostility at that time to any notion of medicalising or pathologising childbirth and motherhood. I remember clearly being taught during my health visitor training that most new parents adapted well, were pretty resilient, did the best by their children and that we should trust them to get on with it, offering advice, practical and emotional support when necessary. Psychological problems related to adjustment to motherhood was mentioned in the context of the common 'baby blues' and the rare 'puerperal psychosis'. Post Natal Depression (PND) was virtually a non-subject. We knew vaguely of Katrina Dalton's work exploring a possible link between PND and hormonal changes.

Subsequently a big part of my job entailed helping new mothers adjust to their new roles, giving advice about how to make bottle feeds or to breast feed, about childhood illnesses / vaccinations, introducing them to other mothers, helping them compete for the scarce childcare places that existed, helping them get re-housed, get the benefits they were entitled to etc. etc., and offering emotional support when the going got tough.

We were also taught to never take lightly or dismiss concerns that parents raised. This was before the emergence of a child-centred culture and the subsequent development of the notion of children's rights. We were nurses with additional training, playing a supportive and helping role. We were privileged in that we were welcomed into people's homes and sometimes their private lives.

There have been numerous social, political, policy and service changes since the 1980s however and the role of health professionals has changed. This was starkly reflected in the consultation document 'Every Child Matters' and is also portrayed in the new Children's Bill. Ostensibly the bill is about achieving reforms to bring about better outcomes for children. In reality however it assumes that a large number of families cannot bring up children without the involvement of myriad agencies who need constantly to exchange information about the children. It seems that the government and society now fundamentally mistrusts parents to bring up their children and thinks it can do better. Health professionals are influenced by this viewpoint also.

Motherhood is also now promoted as an ordeal and mothers, we are told, are hyper-vulnerable. Parenting too is considered problematic. Today it's considered to be almost normal to be depressed as a parent. Psychological needs are now blurred with mental illness.

There is also an exaggerated scale of human depravity in intimate relationships which supposedly justifies professional intervention. We're predisposed to the notion that abuse to women (some men) and children is widespread. Domestic violence is an example of this. One in four women are supposed to experience it at some time. Every man is therefore considered a potential abuser of his partner until we are convinced otherwise. That's if he's not being abused by her!

The private life of families is therefore no longer considered to be their business but ours too. Because of the insistence that the welfare of children must come first, its fertile ground for the involvement of and intervention by health professionals. We have lower expectations of parents. They might drink too much, take drugs, given their children inappropriate food, not parent well enough, abuse them ..... The notion that they can sort out their problems for themselves now seems anathema. We use our mental checklists to assess whether or not they're doing all right.

I think additionally that many of us (health professionals) have lost our ability and confidence to make common sense judgements. We seldom have the confidence to say 'all's well' or its 'good enough' and to leave well alone. Instead we cover our backs by constantly referring on to eg. GPs, who then refer on to consultants....

The belief of the hyper-vulnerability of people is behind the National Service Framework (NSF) for mental health. One in four of the population we are told will experience mental health problems during our lifetime. That's 25% of the population. Women are supposed to be more susceptible. 50% of us will experience a mental health problem in comparison with 25% of men. (Mental health problems are very broadly defined however and include psychological needs, alcoholism and drug addiction. Additionally minor illnesses that might involve a GP consultation only are lumped together with severe ones that might necessitate in-patient treatment.)

According to the Department of Health, 'the months surrounding the birth of a baby carry the greatest risk for women of developing mental illness. The most common is PND which 10-15% of mothers experience. We are also told elsewhere that 5% of women suffer post-traumatic stress disorder after childbirth.

It's official, therefore. Motherhood is now widely believed to be a cause of mental illness with one in between ten and fifteen women supposedly suffering from PND within a year of giving birth. This is alongside the other popular misconception that having a baby is meant to be the most exciting and joyful experience a woman will ever have.

Early detection is consequently considered vital in the interest of all – hence the need for early HP involvement, starting ante-natally, preferably.

PND is a poorly defined psychological condition and an entirely questionable one in my estimation and experience. There were 596 122 live births in England and Wales in 2002. Can 10 -15% of those mothers – 60 000+ annually - really suffer depression post-natally? And up to 75% of them go undetected by health visitors in Primary Care? I don't think so.

Healthcare professionals - Midwives, health visitors and GPs in particular - are charged with implementing aspects of this policy which takes the form of screening for and helping to detect PND in women, at about 6-13 weeks post-natally. They have targets to reach to demonstrate that they are taking it seriously. Childbirth is used as an anchor for the interview. The controversial Edinburgh Postnatal Depression Scale is used as a screening tool. This however has not been validated for use in practice.

This is a series of statements with four possible responses related to mood and feeling. Statements include 'I have been able to laugh and see the funny side of things'; 'I have felt worried and anxious for no good reason'; 'I have felt sad and

miserable'. A score of 14 or more out of a maximum of 30 indicates ground for concern, necessitating a referral to a GP.

Non-directive counselling skills are used by health visitors who undertake 'listening visits' weekly for four weeks to mothers identified as 'depressed'. Health visitors have been criticised for dwelling too much on the physical needs of the mother and baby and in the listening visits concentrate exclusively on the woman's emotional state. The emphasis is on listening not talking or giving advice. It's acknowledged that this may not solve the woman's problems but may help her tolerate them till she succeeds in changing them.

I believe that health professionals are wasting scarce NHS resources searching out 'PND' in women (and men) when evidence for the existence of this as a condition peculiar to the post-natal period, does not actually exist. The feelings and experiences of new mothers are presented as evidence that they are ill. They are instead pathologising the distress, difficulties and unhappiness that any mother can experience and labelling it PND.

In addition to identifying the distress that it causes adults, a major factor behind the need to detect PND is the supposed consequence that non-detection might have on babies / children. (After all bringing up children is supposed to be one of the most important and valuable jobs of all). Here we are told that the depressed parent can pose a risk to the child. A depressed parent cannot parent well, and good parenting is crucial to the child's psychological and long-term development. Emotional and behavioural problems are cited as the commonest problems – hyperactivity and attention deficit disorder. Deterministic arguments are made to justify this assertion, ignoring the reality that though parenting makes an important contribution to a child's development, it does not determine outcome. Social, environmental and cultural influences play an equal if not greater part in a child's development. There is therefore a supposed need for professional involvement to judge the quality of the parental interaction with the child. It's as if women should be expected to subordinate their needs to the mundane task of raising children.

Families are consequently no longer trusted or considered capable of sorting out their problems without the help and support of professionals, predominantly health professionals, but others also. An array of professionals can have contact with a family at any given time – GPs, midwives, Obs & Gynae, nurses, health visitors, health care assistants, psychologists, psychiatrists, social workers, child-care workers, Sure Start workers, play workers, teachers, housing workers etc – all of whom are encouraged to believe that the myriad problems listed above actually exist and they need to be searched for, so as to be able 'to help'.

## **Conclusion**

The government, in the interest of promoting the mental health of women, their children and even their men, is identifying more and more reasons for involving itself in the private lives of families through health care and other professionals. Families, we are led to believe, are finding life increasingly hard and need professionals to support and assist them to cope with it.

Certainly many mothers find coping with a new baby and all of the changes that this entails, difficult. Most need encouragement as well as practical and emotional support from health professionals. Their confidence might also need boosting as they adjust and adapt to their changed circumstances.

In my experience, the diagnosis is used promiscuously. Labelling women 'depressed' does nobody any favours. It encourages women to feel vulnerable and to believe that they cannot cope. They can get then trapped in labels and prolong the problems they are experiencing.

It can also put women off having babies if they are told to expect that they might suffer an associated depression.

Labelling these problems and the associated difficulties as 'PND' also contributes to undermining their self-confidence and delays them seeking out their own independent sources of support and developing coping strategies. It could also interfere in the relationship between a parent and child to the detriment of both by leading them to believe that ongoing professional involvement is a necessary part of parenting.

It also generates unnecessary work for already busy health professionals. Their expertise should be used instead to offer the factual, emotional and practical help that most women need and which stands them in good stead as they adjust to a new way of life. This might then release scarce NHS resources to support women (and their children) who are actually depressed but who happen to have had a baby. Women can only benefit when they are not defined by their vulnerability.