mothers when depressed, experience excessive guilt and lowered self-esteem. Cox (1983) believes therefore, that health workers be non-judgemental and able to tolerate the mother "who says her baby is a nuisance, that she wished it had not been born, or that she feels so angry she could shake it" (Cox, 1983, p.50). If this latter thought is expressed, then a careful assessment as to whether the baby is at risk is necessary, but to over-react may only increase the mother's already lowered self-view. Reassurance is the second factor of importance. Too early reassurance that recovery will be rapid is viewed as unwise, as are explanations that the depression is purely hormonal. Some mothers may then not participate in further discussion of psychological conflicts and family relationships which may be crucial in their recovery. However, an appropriate offering of reassurance may help the mother to feel less isolated and abandoned in her difficulty (Cox, 1983).

c. Practical support: The depressed mother may be unable to cope adequately with her infant's needs. This will reinforce her already negative self-view and may set up a dysfunctional cycle. It is therefore highly recommended that practical support be acquired to aid her in her varying responsibilities (Oppenheim, 1983).

Husband, family and friends should all be encouraged to support the patient, the object being to promote mothering skills and to reinforce her normal ability to cope. Hospital
staff, well-baby clinics and social welfare organisations may also offer educative and practical advice and encouragement in baby care, which may provide the mother with more confidence in her ability to care for her infant.

In Great Britain, self-help organisations are very active. The Association for Post Natal Illness, provides telephone volunteers who keep in touch with mothers. The varying approaches of the many different organisations ensure that individual needs are met.

Unfortunately, South Africa can boast of no such organisations designed specifically for depressed mothers. Thus a major challenge in the field of postpartum illness, is for the establishment of such groups. A recent South African book dealing with the adaptation to early parenthood (Chalmers, 1984), is an important development in filling this gap. Few such books exist which are written for mothers on how to deal with the new tasks and changes which they themselves are experiencing. Most tend to focus only on baby care 'per se', leaving a wide chasm in the field of mother care.

d. Marital therapy: Although not extensively employed in the treatment of postpartum depression, marital therapy is an important consideration. Here the husband may have the chance to voice his own frustrations and also gain more
insight into his wife's difficulties. Coping solutions can be jointly sought in the therapeutic environment and a stronger support unit established (Turner, 1981).

The above treatment methods all remain at early stages of development. Further research is needed before a unique and sound treatment plan is developed to deal with the special and varying needs of women suffering from postpartum depression. At present, all existing treatments must be considered and may be used in isolation or in conjunction with one another to ensure optimal recovery. Throughout all treatment phases the risk of suicide or infanticide must be carefully evaluated.
CHAPTER TWO

THEORIES OF AETIOLOGY

The question of "what causes postpartum depression" remains one of the most controversial in the field at present and has yet to be answered. Various hypotheses have been posed and tested over the years, yielding conflicting and largely inconclusive results. No unified, theoretical model exists which may be challenged, validated or rejected. Discussion of the aetiology of postpartum depression is therefore limited to presenting only these conflicting results. Further research is required before a more cohesive view of the aetiology prevails.

A review of the literature shows that the focus of research on the aetiology of postpartum depression extends to four broad areas, the physiological, the psychological, the social, and the obstetrical. This chapter will attempt to present the major research findings in each area and reveal the most pertinent issues arising in contemporary studies.

2.1 The Physiological Realm

"Maybe I just feel so bad 'cause of my hormones or something."
"My baby is so ill - they've given it everything - but I feel so sad - it doesn't seem like anything will be O.K."

The idea that postpartum depression has a physiological cause is not new. In 1835, Prichard discussed the theory that the normal redistribution of the circulation from uterus to breasts, which was assumed to take place in the first days after delivery, might be disturbed, with a consequent change in blood flow to the brain - and hence mental disorder. With greater knowledge of physiology, these ideas are easily dismissed, but they are nevertheless important because they prompt questioning as to whether the present hormonal theories are better founded. The physiological health of the infant has also been posed as an aetiological factor in postpartum depression.

2.1.1 Hormonal Theories

i. Endocrine changes in pregnancy and the puerperium

It is most appropriate at this point to begin with a summary of the endocrine changes which have been shown to take place between late pregnancy and the early puerperium. The most striking changes, and those which have received most attention in relation to mental illness, are in oestrogens and progesterone (Dalton, 1980; Gelder, 1978; Nott et al., 1976; Swartz, 1982). Nott et al. (1976) recorded endocrine changes in a group of women whose mental state was also being
studied. They found a precipitous fall in circulating oestrogen and in progesterone over the first few days of the puerperium.

Further changes have been described. Cope (1972), discusses complicated alterations in adrenal steroids. Total plasma 17-hydroxycorticosteroids increase throughout pregnancy to reach levels just before delivery which are about twice the normal. However, this change is accompanied by a doubling of corticosteroid binding globulin from 35 to 75mg/l probably as a response to rising oestrogen levels. The net result is an increase in morning level of free cortisol from 0.67 to 1.4mg/100ml (Nott et al., 1976). However, Burke and Roulet (1970) have shown that matters are even more complex because control of day/night rhythm in late pregnancy alters. Although levels of free cortisol return to normal soon after delivery, little is known about the readjustments of hypothalamic control of day/night rhythm, or of changes which take place in the proportions of free and bound cortisol as binding globulin and total 17-hydroxycorticosteroids find new levels; still less is known about individual differences in these adjustments (Burke and Roulet, 1970).

Both thyrotoxicosis and hypothyroidism are sometimes followed by mental disorder, therefore it has also been suggested that thyroid hormones are involved in postpartum depression. Lubin, Gardener and Roth (1975), have shown that although the placenta produces a "thyroid stimulating hormone", free
levels of tri-iodothyronine and thyroxin show little change in pregnancy, though thyroxin binding globulin and total thyroxin do rise. The increase in binding globulin is in turn related to high oestrogen levels in the mother. Individual differences in the readjustment of these hormones in the puerperium have not yet been studied (Gelder, 1978).

ii. Hormonal changes and postpartum depression

The complexity of hormonal changes in the puerperium is in itself daunting. It follows that the application of these changes to the onset of depression is an enormous task. No conclusive evidence has yet emerged.

Handley et al. (1980) found that subjects who failed to show a rise of total tryptophan during the first two days after delivery were more liable to develop postpartum depression. They postulated that an occult disturbance of tryptophan metabolism occurs in subjects susceptible to depression. Tryptophan has been cited as a precursor of 5-hydroxytryptamine, a biogenic amine thought to be involved in depression (Gelder, 1978). Based on the theory that depression might be prevented by the administration of l-tryptophan, Harris (1980) conducted a double blind study. However, his results show that this substance is not effective in preventing postpartum depression.
Katharina Dalton is recognized as the major proponent of progesterone deficiency as the cause of postpartum depression. This opinion is highly controversial (Loendersloot and Hilverink, 1983). The objections raised to it concern two main questions: why do not all women develop postpartum depression and why does postpartum depression not recur after each delivery (Loendersloot and Hilverink, 1983)? However, this theory is supported by the correlation between postpartum depression and premenstrual tension, a condition also ascribed to progesterone deficiency. Loendersloot and Hilverink (1983) conducted a study to test the plausibility of Dalton's theory. They prescribed progesterone suppositories according to her guidelines. Their results refuted her model, but prompted further hormonal research using dydrogesterone. Citing good results achieved in cases of premenstrual tension, they treated patients who had responded poorly to progesterone (52% of their sample) with dydrogesterone. Eighty-eight per cent of women responded positively to this treatment. However, Loendersloot and Hilverink (1983) discuss these favourable results as largely due to the moral support and reassurance given night and day by the research team, thus rejecting a purely hormonal aetiology.

The balance of research is less in favour of a hormonal aetiology for postpartum depression than for 'the blues' or psychoses. Gelder (1978) writes that
"this is the group of disorders in which hormonal causes are least plausible" (Gelder, 1978, p.88).

He argues that some cases cannot be separated clearly from an initial episode of maternity blues, but may begin later and therefore seem more clearly related to the psychological adjustments of motherhood and the burdens of bringing up the new baby. He describes his own clinical experience with women who have had lasting depression after childbirth and suggests that social stresses and supports may play a larger role than hormones in this type of depression.

In order to review a complicated subject within a short compass, this section has considered hormonal causes as if their action were independent of psychological or social factors. It is known, however, that psychological stimuli affect the neuroendocrine system (Gelder, 1978). It is also known that the effects of drugs which alter behaviour and emotions are modified by the psychological state of the subject and it is likely that the same might be true of hormones as well (Nott et al., 1976). While it is appropriate at this early stage of research to hold constant, social and psychological variables when examining endocrine factors, at a later stage, the interrelationships will have to be examined as well. Before conclusions can really be drawn, Gelder (1978) states that there is yet much to be done in adding to knowledge of individual differences in endocrine readjustments after childbirth, and in describing a reliable
way in which the separate depressive syndromes in the puerperium arise.

2.1.2 Neonatal Birth Risk Theories

A second theory of the aetiology of postpartum depression, falling within the physiological realm, is that of neonatal birth risk. This is a notably small area in the literature, yet there is strong agreement as to the effects of this factor on the postpartum adjustment of mothers.

Smith (1979), investigated whether parents of high risk babies differed from parents whose newborns did not require special attention at birth. Parental responses showed that the birth of a high risk baby frequently produced feelings of loneliness, sadness, disappointment, and grief. Mothers of high risk babies articulated a greater need for increased emotional support and were unanimous in their expression of negative affect associated with their feelings or memories about the birth experience. Blumberg (1980) and O'Hara, Rehm and Campbell (1983) confirmed Smith's (1979) findings that higher levels of neonatal risk are related to higher levels of depression and anxiety in the postpartum period.
Conclusion

These studies, all offering conclusive findings may have important implications for the development of an aetiological theory of postpartum depression. The effects of neonatal birth risk when assessed against other variables considered to play a role in depression has not been adequately explored. Thus a need exists in the field to locate the combined effects of neonatal birth risk with other variables and to assess whether the effects remain as great in a multiple model.

Aetiological studies within the physiological realm have highlighted hormone activity and neonatal birth risk as variables affecting postpartum depression. As stated, both require further investigation. Hormone theories lie within the medical dimension and the social scientist is not adequately equipped to work in this area. It follows that from a psychological research framework, the greatest challenge at present lies in evaluating theories of neonatal birth risk in conjunction with other postulated psychological variables. It is from this perspective that neonatal birth risk will be adopted as one of the independent variables in this study.
2.2 The Psychological Realm

"This is the most moving and emotional experience of my life."

Until recently, the psychoanalytic view of personality development predominated in the psychological literature concerning postpartum depression. Despite this predominance and in view of the rich analytic literature on depression and the expanding psychoanalytic studies of the psychology of pregnancy and parenthood, it is noteworthy that there have been few psychoanalytic empirical investigations of postpartum depression (Blum, 1978). This is consistent with psychoanalysis in general, which has offered many theories concerning various pathologies, yet little scientific validation of these theories exists. The methodological problems involved in evaluating unconscious dynamic conflicts are enormous. This is perhaps a reason for the dwindling popularity of psychoanalysis in the field of postpartum depression. Cognitive-behavioural views have emerged in the last decade as more popular. These views are less complex, more clearly defined, and therefore easily measurable. Although this study will be concerned with evaluating cognitive attribution style and postpartum depression, it is important that an understanding of the major psychoanalytic theories is grasped.
2.2.1 Psychoanalytic Theories

"I wish I had been closer to my own mother, then I'd probably know better what to do now."

"It's all over now and I still wish the baby was inside me - I feel sad and don't want to part with it."

Psychoanalytic theorists have recognized the importance of childbearing in the emotional lives of women and have understood motherhood and motherliness as being essential aspects of the emotionally mature woman. This orientation originated with Freud (1925), whose view it was that the most important tasks for a young girl were the renunciation of her wish for a penis and the substitution of the more realistic and attainable wish for a child. Later analytic writers such as Benedek (1970) and Deutsch (1945) have upheld the idea of placing motherhood at the centre of a woman's emotional development.

Postpartum depression is not viewed as a discrete and circumscribed entity, but rather as a symptom of an underlying pre-existent disturbance. This follows two major assumptions in analytic personality theory. Firstly, a belief in the existence of the unconscious, i.e. of a psychic system independent of the conscious system and exercising a determining influence on behaviour. Secondly, an emphasis on the importance of referring to ontogenetic
development and especially to the first years of life; this development is believed to be characterized by the existence of infantile sexuality, i.e. of erotic drives, the release of which produces pleasure; their progressive and conflicting development finally leads to the truly mature genital stage (Benedek, 1979; Chertok, 1969).

Motherhood is described as an 'integrative stage' in a woman's life, the favourable outcome of which is expressed by integration, at the highest possible level, of instinctual drives and ego potential (Chertok, 1969). Maternity is the mark of a progressive development culminating in a mother-child relationship. This maternal orientation, once achieved, became for Freud the hallmark of a healthy feminine sexual identity. Freud did not examine the actual experiences of conception, pregnancy, and delivery, possibly because of his apparent belief that once a positive orientation toward motherhood had been achieved, the rest follows naturally and spontaneously (Grossman, Eichler and Winickoff, 1980). It remained for later theorists who focussed more exclusively on the psychology of women to address the issue of the specific psychology of childbirth.

Deutsch (1945) advanced a theory of motherliness based on the premise that pregnancy is the natural fulfilment of the deepest, most powerful wish of women, and that healthy ego development for women is very closely related to the
development of the "motherly ego". Although Deutsch spoke of the enormity of the psychological task of successfully navigating the mothering role, it was Grete Bibring (1959) who, a decade after Deutsch's major work in this area, espoused a view of pregnancy and early motherhood as a time of normal psychobiological crisis that shares many features with the crises of puberty and menopause (Bibring, 1959). As such, all three of these crises revive conflicts of earlier developmental periods which now require new solutions. Success in conflict resolution at the time of giving birth is dependent upon the resolutions and integration of earlier conflicts. Mastery of the crisis of childbirth leads to a new level of psychological maturity and integration (Bibring, 1959). If this new reorganisation is not accomplished, the result is a generally less satisfactory level of functioning which can lead to problems in the woman. One of these resulting problems is postpartum depression.

Bibring (1959) states that pregnancy shares characteristics with other psychobiological crises but also views it as being unique in many ways. She claims that the psychological task of pregnancy is to turn one's emotional energy first towards oneself and then toward the foetus as well; as the foetus grows physically, the mother's emotional attachment to it increases. During the pregnancy the healthy woman is emotionally fused with the foetus. At delivery, she must separate herself psychologically as well as physically from
the baby and henceforth love her child as a person at least partially separate from herself. Birth appears as the final result of this struggle and may be valued as a triumph over all the fears and anxieties connected with the regressive potentialities of childbirth. Birth marks the end of the narcissistic merging period of pregnancy (Benedek, 1970). Bodily separation from the child, even though it prolongs and ensures the object-relationship already begun, cannot fail, at a certain level, to be experienced as trauma, rupture, or castration.

Benedek (1970) states that delivery must allow for free expression of deep-seated tendencies to rejection, of an aggressive destructive nature. Failure to integrate these tendencies, and their excessive repression, may make efforts at expulsion impossible and give rise to pathological behaviours. Delivery may also be experienced as a regression of the deepest kind in so far as the parturient woman identifies with her child as she relives the trauma of her own birth (Kernberg, 1970).

There is agreement in the psychoanalytic literature that childbirth reduces the cohesion and strength of the ego. The modes of adjustment and defense mechanisms brought into action in response to this regressive situation are varied (Blum, 1978; Chertok, 1969). The woman has to adjust to a biological process, to the behaviour of her required by the
environment, and to the new situation created by the arrival of the child. Two co-existing trends are noted as possible emotional responses (Chertok, 1969). The negative trend involves a feeling of severe loss, a disappointment, sometimes a sense of "paradise lost" bound up with identification with the child. If unresolved, this negative trend is believed to account for the onset of postpartum depression. The positive trend comprises, first, a brief phase dominated by a feeling of victorious achievement; and then, the relationship to the child, which cancels the negative trend and extends the relationship from its previous prenatal form with a speed proportional to the degree of accuracy with which it is anticipated (Chertok, 1969).

Blum (1978) discusses how patients yearning for a symbiotic relationship with their own mothers are more disposed to the development of postpartum depression. He discusses how a patient's feelings of loss of maternal closeness and support, separation-panic, helplessness and "negative ambivalence" led to depression after giving birth. He theorizes that regression to previous oral fixations and to oral ambivalent struggles over the loss and preservation of the fecal (narcissistic) object interfered with the mature psychological development of postpartum-depressed mothers.

Benedek (1970), Bibring (1959), and Deutsch (1945), like Blum (1978), emphasize a woman's historical relationship with her
own mother and believe that having a good relationship with a nurturant, loving mother allows a woman to accept her own femininity and this enables her in turn to become a psychologically healthy adjusted mother. Failure of the new mother in experiencing a good object in her own mother, will result in a possible rejection of femininity and rejection of the maternal role. Depression may arise out of these conflicts. Grossman et al. (1980) found that women who harboured more negative feelings towards maternity on a projective measure (Thematic Apperception Test) administered in pregnancy, showed poorer adaptation in the postpartum period.

Most analytic theorists stress the uniqueness of the birth experience for each individual (Blum, 1978). Thus, no single explanation for postpartum depression exists. Case studies form the basis of the literature and therefore prevent scientific conclusions in the field. Emphasis rests on the normal development of the new mother and postpartum depression is described as a maladjustment to this normative model. It is clear that the formulation of a more cohesive analytic theory of postpartum depression is required before further empirical research may be carried out to support or refute the present non-integrated claims. However, the potential validity of psychoanalysis in explaining postpartum depression cannot be ignored. The treatment implications for psychotherapy would be vast if a theory emerged, as a psychological aetiology may well have psychological solutions.
2.2.2 Social Learning Theories

Social learning theory is a theory of personality that attempts to integrate two diverse and significant trends in psychology - the stimulus - response, or reinforcement, theories on the one hand, and the cognitive, or field theories on the other. It is a theory that attempts to deal with the complexity of human behaviour while yielding the goal of utilizing operationally definable constructs and empirically testable hypotheses (Rotter, 1975).

There are four classes of variables in social learning theory: behaviours, expectancies, reinforcements, and psychological situations (Lefcourt, 1982).

"In its most basic form, the general formula for behaviour is that the potential for a behaviour to occur in any specific psychological situation is a function of the expectancy that the behaviour will lead to a particular reinforcement in that situation and the value of that reinforcement" (Rotter, 1975, p.57).

It is hypothesized in social learning theory that when an organism perceives two situations as similar, then his/her expectancies for a particular kind of reinforcement, or a class of reinforcements, will generalise from one situation to another (Lefcourt, 1982). This does not mean that the expectancies will be the same in the two similar situations, but that the changes in the expectancies in one situation
will have some small effect in changing expectations in the other. According to Rotter (1975), expectancies in each situation are determined not only by specific experiences in that situation, but also, to some varying extent, by experiences in other situations that the individual perceives as similar.

Social learning theory was first conceived of in the 1960's and has attracted much attention over the years. Arising out of this theory was the question of attributional style. 'Attributional style' refers to how people construe the causes of events in their lives, i.e. to what do they attribute control of events? This is a dimension that has been explored from two standpoints. These are: a. Rotter's theory of 'Locus of Control', and b. Seligman's theory of 'Learned Helplessness'.

2.2.2(a) Locus of Control

"I just leave it all up to God - he'll fix it up."

"I think I'm fated not to enjoy things. Now I don't even think I like this."

i. Defining the concept

Rotter (1966) devised a locus of control scale to assess the extent to which individuals perceive or attribute the control of their lives to themselves (internality) or to luck, fate.
or others (externality). In social learning theory this variable is viewed as a generalised expectancy relating behaviour to reinforcement in a large number of learning situations cutting across specific need areas. There are two aspects of locus of control with regard to the individual. The first is how her/his task performance is affected and her/his ideas about her/his task performance due to her/his locus of control. The second is the personality trait itself, i.e. whether one is an "internal" or "external" person and how this affects one's life. The two aspects are inseparable. Lefcourt and Ladwig (1965) in their review of the literature on this subject define external control as referring:

"...to the belief that reinforcements are unrelated to one's own behaviours and therefore beyond personal control. Internal control refers to a generalized expectancy that reinforcements occur as consequences of one's own actions and are thereby under personal control"


In accordance with social learning theory, reinforcements act to strengthen expectancies that a certain behaviour or event will be followed by a certain reinforcement in the future - a causal relationship develops in the mind. Rotter believes that a person's actions can be predicted on the basis of one's values, expectation of reinforcement, and the situation in which one finds oneself. In general terms Rotter's theory can be formulated as: \( NP = f(ER + NV) \). This reads as:
Author Cooke W L
Name of thesis Some determining factors of postpartum depression 1985

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