

**Pathologising fatherhood: the construction of post-natal depression as a ‘men’s problem’ in Britain**

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**Introduction**

Domain expansion – the process through which ‘the contents of a previously accepted social problem expand’ - has been considered to be an important aspect of the construction of contemporary social problems (Loseke 1999: 82). For Loseke the redefinition of ‘slavery’ illustrates this process, it being a condition which at first had a narrow meaning, but which grew to include the experience of immigrant labourers, women prostitutes, or welfare recipients who are required to work, since all of these groups of people have been labelled ‘slaves’. The example of ‘child abuse’ is detailed by Best, who argues that over the 1970s and 1980s, the domain of child abuse became more and more broad; ‘Originally used to describe parents’ physical brutality against small children, the term came to encompass neglect, sexual contacts, and – at least according to some claimants – a miscellany of other acts that might harm young people’ he explains (1990: 77-78).

More recently, this same concept has been discussed in relation to the process of ‘medicalization’. Conrad and Potter thus argue that ‘domain expansion’ can be usefully employed to consider examples where the contents of an already-existing medical category ‘expand to become broader and more inclusive’ (2000: 559). An example they detail is Attention Deficit Hyperactivity Disorder (ADHD), a diagnostic category originally developed to explain certain behaviours in children, but which has expanded to

apply to adults. Medicalization has progressed, they argue, as the domain of ADHD has expanded to include adults.

Scholarship has examined how the domain of other medical conditions has similarly expanded. The contents of the category 'addiction' now includes, as well as the experience of those who smoke cigarettes or use drugs, that of people who have a lot of sex, or spend a great deal of time shopping, gambling and using the internet, since they are all now labelled 'addicts' (Loseke 1999; Peele 1995; Fitzpatrick 2001). According to Sutherland (2002), while alcoholism and substance abuse remain at the core of the concept of addiction, 'sex addiction' has become the fastest growth area for groups advocating psychological treatment in the U.S. through the 12-step program, first established as treatment for alcohol addiction.

Post Traumatic Stress Disorder (PTSD) has proved to be a particularly expansive category. Originally developed to explain the experiences of Vietnam veterans, the term quickly spread to account for the effects other adverse life events – for example, rape, domestic violence, or civilian disasters (Shepherd 2000). Allan Young thus notes in his authoritative study of PTSD: 'Vietnam veterans...[were] followed by victims of other suppressed traumas such as childhood incest and domestic rape' (1995: 142). A key site for more recent expansion of this disorder has been emergency service personnel who, like the Vietnam veterans with PTSD, have not been not harmed themselves, but have witnessed others being injured or killed. Ambulancemen, policemen and women, paramedics, firemen and members of the armed forces are thus now regularly diagnosed with PTSD following the performance of their regular duties (Summerfield 2001).

This condition's domain has also expanded through the development of particular variants of it, each applicable to particular groups (Raitt and Zeedyk 2000). For example, Michael Jarmulowicz, a British opponent of abortion claims that women who have abortions can suffer from 'Post Abortion Syndrome', which he suggests is, '...a variant of 'Post Traumatic Stress Disorder', first described in Vietnam war veterans' (1992: 9). The American anti-abortionist Vincent Rue argues that, 'Other variants of PTSD, not dissimilar to PAS [Post Abortion Syndrome], are 'Rape Trauma Syndrome', 'Battered Wives' Syndrome', and 'Post-Hysterectomy Syndrome' (1995: 21). Birth, as well as abortion, is considered by some to be the cause of a form of PTSD, called Post Natal Stress Disorder (Ralph and Alexander 1994). Feminist writer Kate Figes argues PTSD, 'can follow anything such as a car crash, violent crime, an experience of war or an earthquake and symptoms include nightmares, insomnia, excessive irritability, anxiety and repeated recollections of the event...Many women have similar symptoms after birth' (1998: 32-3). Renowned childbirth 'guru' Shelia Kitzinger contends, 'After the Vietnam War soldiers on both sides who had not suffered any physical injury often became distressed....The same thing can happen after a birth.... [A woman] may feel as if she has been raped...This can happen even with so-called 'normal' birth' (n.d.). Downs termed the outcome the 'syndrome society', since 'seemingly every trend that involves conflict or potential emotional stress is designated a "syndrome"' (1996: 24).

This paper considers another case where the domain of an illness category has expanded, that of Post Natal Depression (PND). Until recently, PND has been a problem exclusively associated with women. This construction has, in recent years, come under pressure, however, from claims that present *men* as similarly subject to the development of this illness.

In August 2003 it was thus reported, of a new initiative in Basildon, Essex, that, ‘men are to be given counselling for postnatal depression on the NHS’ and a special leaflet is to be distributed to all prospective fathers in the area to alert to their risk of developing the condition (Sheringham 2003). South Essex Partnership NHS Trust, an organisation specialising in treating mental illness, including that experienced by mothers, had decided to establish the scheme, called ‘Fathers Matter, In Tune With Dads’, to provide such counselling. The following month the comment from a spokesman for the Trust, that, ‘We hope this will lead to a nationwide network of counselling for male postnatal depression’, was highlighted in the national media (BBC News Online 2003). In March 2004, more reporting took place when the scheme was actually launched, with comments from director of the scheme Mary Alabaster, a Consultant Nurse in Perinatal Mental Health, featuring centrally. ‘Postnatal depression can affect men just as it affects women’, she stated (McDougall 2004; Wright 2004). ‘Fathers Matter’ also gained a profile internationally with media coverage in Ireland, Toronto, San Francisco and Sydney (notably in the latter, feeding into discussion about an already-established set of activities in Australia about men and PND).

In the case of Fathers Matter, health professionals who have previously been concerned with new mothers’ mental health have come to make claims that fathers’ experience similar problems to those they encounter in mothers. The same pattern, where those who have an interest in depressed mothers shift their attention to father, is evident in advice books about PND. Those published until the late 1990s focussed solely on women, but books on the subject appearing since this time usually include a chapter about men and their experiences of PND. *Feelings After Birth* (Welford 2002), an advice book for expectant and new mothers written for the National Childbirth Trust, includes a chapter ‘Postnatal depression: your partner, your family’, which alerts women to the possibility that their husbands / partners might also be depressed following the birth of their baby. A chapter of Curham’s *Antenatal and Postnatal Depression* (2000) similarly discusses ‘the partner’, and their risk of experiencing depression.

PND has been ‘masculinized’ through other means too, as organisations established during the past decade have made claims about this putative problem. Fathers Direct, ‘the UK’s national information centre for fatherhood’, is one such organisation, and in the late 1990s it was commissioned by the U.K. Government to write the equivalent for men to the nationally available ‘Bounty’ information pack for new mothers. Titled *The Bounty Guide to Fatherhood*, it argued that while postnatal depression in women is a problem for one in 10, postnatal depression in men is a significant and unrecognised problem. ‘Between three and 10 per cent of new fathers become depressed’, this organisation claimed (BBC News online 1999a). Men’s Health Forum, founded in 1994 to ‘work to improve the health of men and men’s health services’ also claims that up to 10 per cent of

men suffer from depression following the birth of their baby. The Forum argues that it 'wants to see the subject of male depression discussed at ante-natal classes so that men know what they are suffering from if they develop the condition' (BBC News on line 1999b).

The figures quoted in these instances place the incidence of male PND as somewhat lower to that found in women. However, by 2004 – five years after publication of *The Bounty Guide to Fatherhood* – it was being reported that, 'as many as one in four new dads suffer from post-natal depression' (Rawles 2004). Male PND has thus, by this point, achieved the status of other recently emergent new epidemics (Fitzpatrick 2003). The emergence of the new epidemic of PND in men in this way is interesting because it indicates that the expansion of illness domains can include them crossing not just boundaries between children and adults, as was the case with ADHD (Conrad and Potter 2002), but also those based on gender. PND can be viewed as an archetypal 'women's problem'; its very name suggests an intimate connection between the illness and the experience of giving birth. Yet it is now a problem men suffer from. What appears at first sight to be a highly gender-bound illness turns out to be less so than it might appear.

As such, male PND joins a growing list of problems that have crossed gender boundaries. For example, wife-beating has been masculinized, since men are now considered victims of domestic violence, and gang-culture as been feminized through the emergence of the 'girl gang'. In regard to health issues, however, the process seems to entail most commonly a transfer of problems to men. Thus, breast cancer, the menopause, anorexia, self-harm and sexual health are all now designated men's problems. This development poses some questions in regard to existing conceptualisations of the process of medicalization, however, and it to this issue that we now turn.

### *Re-thinking 'medicalization'*

'Medicalization' has been described as the process through which a condition comes to be defined in medical terms, as an illness or disorder (Conrad 1992: 209). This phenomenon has been the subject of debate and interest for sociologists for over three decades, and attention has been paid to a large range of experiences and conditions that have come to be constructed in medical terms.

A significant part of this scholarship has concerned women's experiences, especially in relation to their reproductive lives, and women have been viewed as particularly subject to medicalization in this area especially. Dating from the 1970s and 1980s, 'Studies...have particularly emphasized the breadth of the medicalization of women's lives: battering, gender deviance, obesity, anorexia and bulimia, and a host of reproductive issues including childbirth, birth control, infertility, abortion, menopause and PMS', notes Conrad (1992: 222). Riessman, in her oft-quoted contribution on the subject, wrote that women are 'main targets' of medicalization processes. Of the 20<sup>th</sup> century she noted, 'A plethora of female conditions has come to be...reconceptualized as illnesses', citing 'sexual dysfunctions', pregnancy care, fertility, menopause, aging, teenage pregnancy and wife-battering, premenstrual syndrome, and weight (1983: 9-10).

Arguments that draw attention to the medicalization of women's experiences in this way have tended to situate the claims and activities of doctors, and more broadly the enterprises of medicine and science, as central to the medicalization process, and in turn as a manifestation of patriarchy (Oakley 1980; Corea 1985; Ardiiti et al., 1984; Katz Rothman 1986). Reismann thus summarises feminist scholarship about medicalization as that which emphasises the 'multiple ways in which women's health in the contemporary period is being jeopardised by a male-controlled technology-dominated medical-care system' (1983: 3). Rajan notes the prominence of complaints that, 'a panopoly of technology now pervades the field of reproduction', to the detriment of women's health (1996: 189). With reference to Stanworth (1987), she explains that women's reproductive lives have been represented as controlled through 'male' technologies, considered to include the Pill and the IUD; interventions in pregnancy and childbirth such as foetal monitoring and Caesarean sections and ante-screening; and those which address fertility problems such as IVF.

More recent literature about these same technologies has questioned this representation of them. It has drawn attention to the fact there is a great demand from women for these interventions, and that women experience gaining benefits from the use of them. Indeed, in her contribution, Reismann argued that, through her work, she wanted to extend the feminist argument by showing how it was inaccurate to focus simply on medical interests, since, 'women collaborate in the medicalization process because of their own needs and motives' (1983: 3). Much work written subsequently has developed this point, by explaining why and how women use such technologies. For example, women's experiences of *in-vitro* fertilisation (IVF) and ante-natal screening have been detailed (Denny 1996; Franklin 1997). Conrad (1992), in his summary of the literature, thus notes how, in regard to women's experiences, many have contested the notion that medicalization is primarily or centrally about a 'top down' expansion of medical control over women driven by doctors.

The underlying assumptions, however, have continued to be first, that medicalization has at its centre the enterprise of 'bio-medicine' and the activity of doctors (albeit activities and an enterprise that women may perceive to be helpful for them and play an active role in relation to) and second that medicalization primarily shapes *women's* lives. Reismann thus noted that while men's experience has been medicalized in some areas – for example through 'stress management' programmes targeting male executives - most routine areas of men's lives, for example hormonal cycles or baldness, have not. In particular, 'men's psychological lives have not been subjected to scrutiny nearly to the degree that women's emotions have been studied' she argued, and as a result, '...male violence, need for power, and overrationality are not defined as pathological conditions' (Reismann 1983: 15). Little work published subsequently has questioned this representation of men's experience.

The example discussed in this paper suggests, however, it is necessary to do so since men, it is being claimed, are just as subject to psychological problems resulting from their reproductive experience as women are. It might also be added that baldness has now been

medicalized, as have 'male violence' and 'need for power', and as noted above, male PND is but one example of a range of illnesses that come to be identified in men. It is also the case, as the brief discussion earlier suggests, that medicalization in the case of male PND does not appear to be a process that is centrally or exclusively driven by bio-medicine. Examination of the claims-makers involved in promoting the need to recognition of this illness shows they include lay groups representing fathers, female health professionals, and writers of self-help books. This also indicates it is necessary, therefore, to re-think the concept medicalization and re-analyse its dynamics.

An insight of recent sociological literature, that medicalization is not at the current time primarily or only about medicine and the activities of the medical profession, makes a useful starting point in this regard. Conrad, on the basis of his review of the literature published through the 1980s and early 1990s, suggested that medicalization is 'a sociocultural process', that it, 'may or may involve the medical profession' and may not be, 'the result of intentional expansion by the medical profession' (1992: 211). On the basis of their study of ADHD in adults, Conrad and Potter confirm that, 'Medicalization' it is not simply about doctors, 'colonizing new problems or labelling feckless patients'. They emphasise the 'bottom up' character of medicalization processes particularly, noting that for ADHD, where diagnosis in children has been largely as a result of referral to a physician by parents, amongst adults 'self-referrals are the norm....Many patients come to physicians apparently seeking an ADHD diagnosis' (1999: 569). They also note that a range of social actors including self-help and advocacy groups, social movements, health-related organisations, pharmaceutical companies, academic researchers and clinicians can all play a part in medicalizing experiences, a point also made by Williams and Calnan in their contribution on the subject (1996: 5).

Furedi has gone the furthest in arguing that medicine and the activities of doctors are secondary to medicalization at the current time. He argues the distinct feature of the recent evolution of the process is that it has developed through, '... 'discovering' diseases that are *nonphysical* and are to do with emotional problems', thus generating a situation where a medical label is used to interpret, 'virtually every human experience' [my emphasis] (2004: 100). He contends that the process is therefore better termed 'psychologisation' than 'medicalization', and that what is also new is that, in contrast with the past, there is a distinct lack of contest about the validity of defining experience this way. Argues Furedi, it is notable that 'grassroots campaigners' are more and more at the forefront of demanding diagnoses. Where there might once have been critics of medicalisation from this quarter, opposition to medicalised definitions of problems is now rare. In regard to those who are involved in framing problems and experiences in medical terms, he argues, therefore, that while there are self-interested dynamics meaning doctors and other health professionals may play a part, there are 'wider cultural forces' are at work. This means it has become possible to 'export... the ideas of illness and disease beyond the body to make sense of conditions and experiences that are distinctly cultural and social' (2004: 100). As a result, areas of life that were once understood in social, political, or economic terms, have now been constructed as psychological or emotional problems.

A striking feature of the claim that men suffer from PND conforms to this analysis, since a disease state has emerged that has no reference to the physical body. Men, of course, do not give birth. Yet they have become subject to a diagnosis that would appear, on the surface, to have an intimate connection to the body. It is a 'distinctly cultural and social' experience – fatherhood – that has been medicalised in this case. How has this illness definition emerged? What are the forces at work that have made it possible for PND to cross the gender divide in this way? To address these questions, we will first discuss the claim and its features in more detail. The bulk of the paper then considers the context for the claim. The paper aims, through doing so, to contribute to studies of medicalisation, by investigating the process through which the domain of PND has expanded, and highlighting the distinctive features of medicalisation in this case.

### The claim and its features

Too many young men, who are overjoyed about being a father, can also experience worry and anxiety, which can develop into depression and desperation. There's nothing macho about suffering in silence (Spokesman, West Ham United Football Club, sponsors of 'Fathers Matter').

Those associated with the 'Fathers Matter' scheme have been, to date, the most visible advocates of the need for recognition of male PND. They include the health professionals involved with the scheme, but also those who support the initiative, for example West Ham Football Club. The comment from the latter, above, well illustrates the first feature of male PND, namely what is considered to be its cause.

Male PND, it is argued, arises from the experience of 'being a father'. But it does not do so inevitably. Rather, depression emerges when feelings of 'worry and anxiety' – construed to be a normal aspect of fatherhood - turn into a mental health problem. The reason this can occur if nothing is said about the feelings being experienced. The real cause of the illness, therefore, is that which prevent this disclosure of feelings from taking place. It is 'suffering in silence' is the underlying cause of the illness.

This definition of the cause of the illness is closely connected to the second feature of the claim, its emphasis on the problem of the 'macho culture' or 'masculinity'. This is presented as, ultimately, the reason why men find it hard to discuss how they are feeling – it is why they 'suffer in silence' and thus why they become depressed. According to Mary Alabaster, the director of Fathers Matter, therefore, 'We know that traditionally perceived male characteristics such as being physically and emotionally strong and self contained impede the ability to either ask for help or show vulnerability' (Daniel, 2004: 209). In order to address male PND, therefore, it is necessary to address these 'male characteristics', and in so doing enable men to 'seek help' and 'show vulnerability'. This way of defining the cause of male PND is notable because it does not rely on a model of illness based in underlying physical / biological cause, resulting in a specific set of symptoms, the prevalence of which can be measured. The illness is wholly defined by reference to the social and cultural norms, considered to constrain men from expressing

their feelings. The origin of the illness lies in ‘the culture’, and men’s responses to it, rather than in organic malfunction.

This construction of the causes of male PND also gives rise to the third feature of the claim, namely the representation of fathers it entails. In the terms of this claim, they are ‘excluded’, and need to be, in contrast, ‘included’; fathers have been ‘frequently excluded’ from the ‘care package’ for parents when a baby is born, argues Mary Alabaster (Daniel, 2004: 208). ‘For many years, fathers have had a raw deal, because the focus is on the mother’, she contends (South Essex Partnership NHS Trust, 2004). Curham, author of an advice book on PND, make similar claims in her representation of fathers, arguing that men are ‘forgotten victims’ in regard to PND. While they can find themselves ‘quite depressed’ after the birth of a child, unlike women they have nowhere to go to find help. ‘Becoming a father can have a huge impact on a man and yet all the attention seems to be focused on the woman’, she argues (2000: 72). Welford, in her book on PND authored for the National Childbirth Trust also emphasises that men are left out. She thus recalls, of a conference in 1996, how a leading figure in discussion of PND, child psychotherapist Dilys Daws, asked, ‘Who supports the father? He is also prone to depression...as much as the mother....It is very easy for this apparently benign conspiracy of females to leave the father out at this point’. The author herself complains, ‘there is hardly any research work looking at men as new fathers or men as the partners of depressed new mothers’ (2002: 73).

Implicit in the construction of men as ‘excluded’ is the idea that institutions have collaborated in perpetuating the ‘macho culture’ that causes male PND. They have assumed that it is only women who are vulnerable following the birth of a baby, and thus only women who should be the focus for the work of institutions. A closely related further feature of the claim arises from this idea about institutions, about the purpose and nature of the services they provide. As Mary Alabaster explains it:

Let us include dads and advocate for this group in society...We need to tune in to fathers and can start that by addressing their psychological needs – that means *not* excluding them...and treating them as an inconvenience (Daniel: 208).

The claim that there is male PND carries with it, in this way, an agenda in regard to the project of institutions, for example those providing healthcare. They need to make efforts to ‘include’, not ‘exclude’, and this can take place if ‘psychological needs’ are addressed. The consequences to date of not doing so are, ‘difficult to quantify’, argues Alabaster, but they nonetheless points to, ‘a major failure on the part of healthcare professionals’. Addressing this failure needs to be a priority for those who interact with new parents, and thus they must make every effort to ‘include’.

To this end, ‘Fathers Matter’ has developed its own ‘screening tool’, a series of questions asked to new parents to identify those ‘at risk’ from PND, notably entitled the ‘Vulnerability Index’. Used by midwives and health visitors during the women’s pregnancy, prospective parents are encouraged through the questions to identify this aspect of themselves, and their situation, and become aware of their need for ‘treatment’.

Questions asked by those using the scale thus concern, 'awareness of possible changes that can occur in a relationship during the antenatal or postnatal period', with lack of awareness indicating 'vulnerability'. Participants are also asked, 'Do you drink alcohol?' and, 'Do you use any street or non-prescribed drugs?' Like the more frequently used scale to measure female PND, the Edinburgh Postnatal Depression Scale, these questions are broad and vague, and are thus liable to generate a large number of women and men considered 'at risk' suffering from PND (Lee 2003; Hehir 2001). Those it 'includes' on this basis are also subject, as Furedi (2004) argues, to a redefinition of the problems they face. They are not of an economic or social type, they are of a psychological order. They are not 'excluded' by merit of their social or economic position, but because their feelings have not been recognised.

The terms of the claim that there is male PND show, in summary, that the illness is defined entirely through reference to perceived problems in the realm of 'culture'. There is an associated set of claims that this type of illness carries with it. These include a particular construction of men, of the role and responsibilities of those who provide healthcare, and of the nature of the difficulties faced by parents. What is the context and background for this claim? What is the process through which it has emerged?

#### Developments in the construction of female PND

Male PND is an expansion of the domain of female PND. To take the discussion of the former version further it is necessary, therefore, to consider how the illness that precedes it is defined. There are two key domains in which PND as a woman's problem has been debated and defined, psychiatry and feminism, so these domains, and recent developments in the definition of female PND in them, are the subject of the next section of this paper.

#### *Psychiatry*

'Post Natal Depression' is in the first place a psychiatric concept. It is included in the Diagnostic and Statistical Manual of Mental Disorder (DSM) and the International Classification of Diseases (ICD), widely viewed as the 'anchor' for mental illness definitions (Conrad and Potter 2000; Kutchins and Kirk 1997). It is the inclusion of illness categories in such manuals that allows them to become 'real', and thus it is in this area that contest over definition has frequently occurred (Scott 1990; Figert 1996; Kutchins and Kirk 1997). The edition of the DSM published in 1987 (DSM III-R) states (rather tautologically) that PND is depression with 'postpartum onset'. In the most recent edition of the manual it restricts 'postpartum onset' to four weeks after delivery. However, wider time scales are used in many psychiatric studies, for example up to six months after birth (Hendrick 2003).

The definition of PND as a specific form of illness in this way is a recent development, not only in regard to inclusion in the DSM and ICD. 'Until the mid 1960s, there was little interest in this subject.... Puerperal psychosis was recognised....[at] the other extreme there was the blues', explain Dalton and Holton (2001: 5). It was not until 1968 that PND

was first named as specific form of illness, when the psychiatrist Pitt published what is widely viewed as the seminal study of depression in new mothers (Murray and Cooper 1997: px). Pitt's study found notoriety because only two of his 27 interviewees were found to have 'the classical picture of depressive illness', and he therefore decided to term the kinds of feelings and forms of behavior described by the mothers he studied 'atypical' and worthy of a specific diagnosis (Kumar 1982: 103). From this point, research into and discussion of PND – about its causes, symptoms, and whether there are particular 'risk factors' for its development – have featured consistently in psychiatric literature, with over 100 studies of 'post natal psychological illness' published in key medical and psychiatric journals between 1980 and 1990 (Nicolson 1998).

As Nicholson argues, however, psychiatry has found it difficult to find a precise definition of the illness, especially in relation to its causes. 'A major characteristic of the traditional research literature is that almost none of the scientific papers sets out a clear operational definition of PND', she explains (1998: 321). Indeed, uncertainty about how to define PND features throughout the period, from the early 1980s onwards, during which the amount of discussion about mothers and mental illness in psychiatric journals extended and increased. British psychiatrist Kumar, co-editor of the first dedicated book on the subject of PND, titled *Motherhood and Mental Illness*, thus asked in 1982, 'Is there really such a thing as postnatal depression?.....What is not at all clear....is when postnatal depression becomes ordinary depression on the time scale after delivery, and whether there are any special clinical or other features which distinguish postnatal depression from episodes of depression' (1982: 106-7). Fourteen years later the psychiatrist Ian Brockington wrote of PND, 'One must examine with scepticism, the scientific value of this concept. Depression after childbirth is clinically very similar to any other depression' (1996: 170). 'Significant questions have been raised that consider whether PPD is a distinct entity from nonpuerperal major depression', state Evins and Theofrastous more recently (1997: 241).

In particular, the causal link to childbirth has been a focus for psychiatric research and discussion, but this link has not been clearly proven to exist (Nicolson 2000: 323). The North American expert on PND O'Hara thus argues that psychiatric studies have not clearly demonstrated an association between depression and childbirth. He notes that studies (for example, carried out in Oxford in 1988, another in Iowa published in 1990, a second in the U.S. published in the same year, and a further study in Midlands in England published in 1993) in fact found no significant difference in prevalence rates of depression for childbearing and non-childbearing women. He argues that the reason for research findings that link childbirth and the onset of depression maybe that where childbirth is used as the 'anchor' for the interview, women identify that the symptoms began following the birth of child. Thus he suggests that the timing of the onset of depression is 'difficult to determine' and there may be, 'judgement biases by both subjects and investigators' at work (ibid: 10). The British authority on motherhood and mental illness John Cox argues that while there is 'substantial support' for the idea that biological changes associated with pregnancy and childbirth cause illness in mothers, 'the interaction between biological, psychological and social factors is extremely complex' (1986: 36-9). Following their discussion of the findings of research about PND Evins et

al. conclude (inconclusively) that it, 'represents a heterogeneous group of depressive disorders of which some are specific to the postpartum period' (1997: 242).

Overall, the consensus view seems to be that PND has many causes which may include childbirth but in a way that is complex, and that PND is hard to distinguish from 'regular' depression. The result in practice is that a definition in psychiatry of what 'counts' as PND has emerged, on the basis of the severity and duration of symptoms, where it lies mid-way between postpartum psychosis and the 'baby blues'. O'Hara has described this as a 'custom' in the literature, which 'distinguish[es] three phenomena: postpartum blues, postpartum psychosis and postpartum depression' (1997: 4).

If there is little agreement about what PND is caused by, psychiatry does appear confident, however, about being able to define a population of patients that has PND. The claim that appears most frequently in psychiatric literature on PND is that 10 per cent of mothers have the illness. 'How common is it?' asks a factsheet from the British Royal College of Psychiatrists. 'Very!' it replies. 'Again and again it has been found that no less than one in 10 women suffer depression after childbirth' (1997). In Britain a figure of 10 per cent would mean that, given there are 680, 000 live births per year, that 68 000 women experience PND annually (Hehir 2001).

This figure results from tests that have been developed to diagnose women as suffering from PND, and the most important of these is the Edinburgh Postnatal Depression Scale (EPDS). The scale was developed in 1987 by psychiatrists in Edinburgh for use in primary care (Brockington 1996: 175), and it has had a spread rapidly through psychiatry worldwide, to become influential in many countries. The scale is based on a series of 10 statements with four possible responses relating to mood and feelings. Responses to each of the statements are rated on a scale of zero to three, with the former constituting an absence of symptoms, the latter maximum severity. A score of 14 or more out of a maximum of 30 indicates that the mother may be depressed. 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; Things have been getting on top of me; I have felt sad or miserable; and I have been so unhappy that I have been crying.

This brief summary of PND as a psychiatric concept indicates there are, in fact, *potentially* few barriers to its application to men. The lack of 'operational definition', and in particular the fact that psychiatric studies have not clearly demonstrated a clear connection between giving birth and the development of depression, means that the difficulty posed by the notion that PND has a physical cause, namely childbirth, is not insurmountable. The cohering feature of the psychiatric concept is its definition as an illness that can be readily diagnosed through use of EPDS. This is theoretically relatively easily transferable to men too; the scale, or one like it, could be used with fathers to see if they have depression. There is little about the concept of female PND that presents an insurmountable barrier in regard to its expansion to men, therefore, but what role has psychiatry played in its expansion?

On the one hand, in so far as counter-claims that the illness afflicts men too have been made, they have emerged from this quarter, and they have emphasised the significance of physical and biological factors in the development of the illness. Psychiatrist John Cobb has thus argued, 'It is ...true that men may well get depressed after their wives have a baby, but this is the same as any other form of depression...In women postnatal depression is a separate entity from other type of depression because it involves major hormonal factors and major physical factors' (Sheringham, 2003). Other psychiatrists previously concerned with PND in women have, in contrast, come to apply the concept to male experience. Articles on the subject of the male version of the illness, authored by those who have known expertise in regard to female PND, have been published in the *British Journal of Psychiatry* (Ballard et al 1994; Aries et al 1996). The Royal College of Psychiatrists includes discussion of male PND in its 1998 leaflet about men and depression, 'Men Behaving Sadly', produced as part of its campaign designed to 'raise awareness' of how common mental ill health is, called '1 in 4'. 'We have known for many years that some mothers feel severely depressed after having a child', states the leaflet. 'It is only recently that we have realised that more than 1 in 10 fathers also suffer psychological problems during this time'. An article in 2001 described how the EPDS has been validated for use in men (Matthey et al. 2001) and the John Cox and Jeni Holden, widely viewed as experts on PND, include a section, 'Fathers and postnatal depression' in their recent book about use of the EPDS. 'Fathers may themselves become depressed', they write, although they emphasise it often appears to be a product of their partner's depression (2003: 7).

Psychiatry has, therefore, played a role in constructing PND as a men's problem. The development of the category PND in this domain has taken place in tandem with that in another, however. As PND's 'inventor' Brice Pitt (1985) noted, in the 1970s PND rapidly became 'a feminist issue'. Women's experience of pregnancy and in childbirth became the subject of feminist complaint, and their psychological experience as new mothers emerged as an aspect of this argument. From this point PND has maintained its presence in feminist accounts of the problem of motherhood, and it has been subject to some significant development in how it is defined. As we now discuss, as a result, feminism has played particularly decisive role the its expansion to men.

### *Feminism*

Feminist writing on PND from the 1970s and early 1980s emphasized that women should be critical of the concept PND as developed by psychiatry, since it masked the nature and origin of women's problematic experiences as mothers through labelling it an illness (Oakley 1979; 1980, Nicolson 1998, 2000). More recently, however, some feminists have come to use the term much less critically, and indeed now often promote the need for its diagnosis. This has taken place as PND has come to be defined less as a specific, abnormal aspect of women's experience as mothers – that is to say as illness - and instead as normal and common to women.

Naomi Wolf's *Misconceptions, Truth, Lies and the Unexpected on the Journey to Motherhood* (2001), *Life After Birth* by British feminist writer Kate Figes (1998), and

Susan Maushart's *The Mask of Motherhood* (1999) are all recently published books about motherhood which exemplify this trend. Figs thus argues: 'It [PND] is a sliding scale, starting with the 'baby blues' affecting 80 per cent of women, and ending with puerperal psychosis...The vast majority of women sit somewhere on this scale' (1998: 40). Naomi Wolf claims that 400, 000 American mothers each year are affected by depression after they have a baby, and highlights what she sees as 'medical complacency in the face of women's suffering', because routine screening for depression and counselling for pregnant women and new mothers is not normally provided in the U.S. (2001: 184). In these accounts, PND is normalized. Almost all women who have babies, it is argued, will experience it. The problem for women presented as a result is the lack of recognition of their experience. The extent to which motherhood makes women suffer is being ignored, it is claimed.

This argument, that PND needs to be more readily recognised and diagnosed, forms part of a larger argument in this kind of feminist literature, which emphasizes the problem of 'the mask of motherhood'; in other words the demand placed on women as mothers to 'put on a brave face' and act to the outside world in a way that does not communicate discomfort and unhappiness. In this vein, Kate Figs thus writes, 'The turmoil of new motherhood is still a taboo subject...It is almost as if there is a conspiracy of silence surrounding the transition to motherhood' (1998: 3), and Naomi Wolf contends: '...cultural reasons dictate we must not speak out loud' about the problems of being a mother, and that there is a '...taboo against voicing our fears and bowdlerizing our experience' (2001: 8). Susan Maushart complains of the 'collective denial about the chaos that is motherhood in contemporary society'. Her claim is that, 'we owe it not only to our own mental health but to the very future of the species to take motherhood seriously, to strip off the masks we have been wearing, and to see with clear eyes and speak with open voices about the realities we experience' (1999: xxi).

In these claims, the key complaint is that society is organized through a 'conspiracy of silence' in regard to mother's negative experiences. For Maushart, therefore, 'At least part of the problem is that our society propagates a ridiculously positive myth of pregnancy' (1999: 53). The strongest forces that constrain women, she argues, are those that, 'minimize the difficulties we face, insisting that motherhood is no big deal after all' (ibid: 36). Wolf writes scathingly of books that present motherhood in positive terms and that, in her view, do not talk enough about women's about negative feelings. *What to Expect When You're Expecting* is attacked on this basis, for what Wolf considers its problematic reluctance to make it clear to women that motherhood is an ordeal. What is most distressing she argues, 'is not the prospect of a woman hearing about some of the tougher aspects of labour and delivery...but, rather, the psychic cost to the mother-to-be of literature that is determined to focus on happy talk and sentimentality' (2001: 3). Figs' book is written as an attack on the 'taboos surrounding new motherhood', and she explain her aim is to 'emphasize the positive aspects of motherhood' but also 'be honest' by telling about the negative ones (1998: viii).

It is easy to see, in this approach, why the problem of PND appeals. It can give legitimacy and weight to claims that it is negative emotions that feature centrally in

women's experience as mothers. The problem of PND provides a means through which the claim can be made that motherhood is an ordeal in which negative feelings feature prominently, and for recognition of the fact this is the case. Since those drawing attention to the problem of it seek to elevate the extent to which culture prevents women's negative experiences from gaining recognition, they tend to use the term to describe a wide range of experiences. PND, in such feminist writing, is as a result, a diffuse and expansive category. Figes thus states: 'The medically defined symptoms of postnatal depression are all-encompassing: tearfulness, irritability, feelings of despondency and inadequacy, self-reproach, excessive anxiety and sleep disturbances. It is hard to find a new mother who does not suffer from some or all of these' (1998: 24). A *shift in culture*, towards creating a public discourse that has such emotional difficulties at its centre is the primary goal.

Self-help books about PND for pregnant women and new mothers can also be considered 'feminist' in that their aim is to 'give voice' to women's experience, and they tend to develop a similar line of argument. The visibility of PND has increased in part in the last decade through the publication of burgeoning body of literature of this kind, including titles such as *Surviving Post-Natal Depression*, *The New Mother Syndrome: Coping with Postpartum Stress and Depression* and *A Mother's Tears: Understanding the Mood Swings That Follow Childbirth*. The over-riding message of these books is that women have been left to 'suffer in silence', and it is vital that culture shifts to allow for recognition of the negative feelings that accompany being a mother. Attention is drawn in these books too, to the normality of depression amongst mothers. Kleinman and Davis Raskin (1994) thus state that PND is 'the most common complication of pregnancy'. Heather Welford contends in her book on PND that while psychiatric text books put the figure of women who suffer from PND at 10 to 15 per cent, 'if you include in your definition of postnatal depression all post-childbirth distress and misery, including the more shortlived forms, it's probable that the majority of mothers recognize many of the symptoms' (2002: 2).

In these accounts, as with those of feminist writers like Figes and Wolf, there is a significant modification of the three-part definition of the mother's mental states characteristic of psychiatry (psychosis, depression, and 'baby blues'). All become variations of a single illness. Thus Roan, author of the U.S. manual *Postpartum Depression: Every Woman's Guide to Diagnosis, Treatment and Prevention*, claims, 'It's no wonder that as many as 80 per cent of new mothers experience a period of depression popularly known as "the baby blues"' (1998). Welford argues that there are three different forms of 'post natal distress', the blues, PND and psychosis. Through this approach, PND come to be represented as common, in one form or another, to all mothers.

Discussion of men's emotional difficulties does not feature directly in most such literature. Indeed, Naomi Wolf only discusses men as fathers in order to emphasise how different their experience is from that of mothers. Nonetheless the illness definition in this domain is structured in a way that provides intellectual support for the claim that men can also suffer from PND. There is an obvious conceptual link between this kind of definition of female PND – the negative feelings women experience as mothers, which are not recognized in most public representations of motherhood – and the claim that men

get PND. In both instances, the problem is 'culture' and the way it disallows the public expression of feeling and emotion. The claim that men are 'suffering in silence' because of 'macho culture' can therefore be understood as a development of these feminist claims about the 'mask of motherhood'.

Feminism has, as a result, played a vital role in the emergence of male PND. Feminists have increasingly portrayed motherhood as a victimizing experience for women, one which carries with it substantial psychological costs which are insufficiently recognized and addressed. Without the emergence of this representation of women, it would have not been possible to pathologise new fathers as excluded victims whose psychological difficulties are insufficiently recognised. Once feminism had made this move, however, it becomes possible for this analysis to be transferred to men. The problematisation of 'masculinity' in discussion of male PND thus has feminism, and its claims about the experience of motherhood, as a crucial part of its context.

### Broader contexts

Developments in its definition of PND in the domains of psychiatry, and feminism in particular, show how a diffuse concept of the illness has come to the fore, and that a biologically-based construction of PND has failed to find favour. Other developments are highly significant for their role in encouraging the expansion of the domain of PND, however. Constructions of the problems of men's health, and parenting have obvious relevance to claims about men and PND. As the remainder of this paper will show, the way these problems have come to be constructed sheds a great deal of light on the reasons why male PND has emerged as a newly defined illness.

### *Men's health*

Clinical psychologist Ron Bracey said crying performs an important function by releasing stress hormones. Mr Bracey said, 'It is good to give emotions a good workout. Men often bottle things up and live with their problems longer than they need to. This can sometimes lead to stress-related illness...A lot of men know more about how a car works than their own emotions (Jackson 2004).

'Macho culture', as noted above, is key to the definition of male PND. This phenomenon has come to be identified as the cause of a much larger set of problems than this one, however (Scourfield and Drakeford 2002). Problems of discipline and behaviour at school are understood this way since 'masculine macho culture' is deemed to be what makes children think bad behaviour is 'cool' (Plomin, 2001). It also makes boys fail to work hard at school, and thus explains why they get poor exam results (BBC news online, 2000). The same problem is also the cause of the tensions experienced by working mothers in managing their 'work-life balance', since it is the 'macho culture' of the workplace that is considered to be what prevents them from being able to say they want to take time off work to spend with their children (Milne 1999). Police officers' working lives are blighted by it, too, because the 'macho culture' at work makes it difficult for them to talk about their experiences (Sarler 2003).

What 'macho culture' does in all these scenarios, it is claimed, is limit the expression of emotion and feelings, and it is for this reason that problems emerge. If the intellectual origins of the idea that 'masculinity' as cause of social problems in this way lies with a certain strand of feminism, a negative assessment of 'masculinity' is, as these examples indicate, now widely shared. As MacInnes notes, there is an 'astonishingly broad consensus' that advocates the abandonment of, 'what is imagined to be traditional masculinity in order to get in touch with....[one's] feelings and develop....emotional articulacy' (MacInnes 1998: 56). 'Getting in touch with one's feelings' has become a normative aspiration. The perceived significance of the failure to do so is demonstrated by the fact that the harm caused by 'masculinity' is considered to be far wider than that to the individual who refuses to reject it. It is represented as, '...a powerful force with damaging consequences for the whole of society' (Furedi 2004: 35).

For this reason, addressing the problem of the 'macho culture' has come to form part of the project of institutions. One area where this evaluation of problems has had particularly far-reaching implications is in understandings of health and ill health. As the extract above indicates, 'masculinity' and the 'macho culture' are viewed as, without doubt, a leading cause of men's health problems. For psychologist Ron Bracey, therefore, it is this that leads to 'stress-related illness'.

The same explanation for men's health problems is ubiquitous. As one widely-used textbook on men and health explains, 'Masculinity is among the more significant risk factors associated with men's illness...[It] is not only a risk factor in disease etiology but it is also among the most significant barriers to men developing a consciousness about health and illness' (Kimmel 1995: vii). Lee and Owens centre their analysis of men's health on the 'recognized health risks' they claim are associated with 'hegemonic masculinity', defined as 'toughness, unemotionality, physical competence, competitiveness and aggression' (2002: 3). Problematic behaviours associated with 'hegemonic masculinity', they claim, include 'relative reluctance to seek help for medical and psychological problems', 'avoidance of the expression of emotion' 'high level involvement in risky behaviours, which include both the socially sanctioned risks involved in dangerous sports and the more deviant masculine-typed risks such as crime and violent behaviour' (2002: 4).

In such accounts of men's health, the key problem identified is the absence of a sense of vulnerability on the part of men. It is for this reason, as Kimmel would have it, that men fail to be sufficiently conscious about their health. The absence of this sense about oneself is, for Lee and Owens also, the explanation for why men fail to seek help. Similarly, according to one men's health website (of which there are now many), it is 'male stereotypes' that damage men's health, the central of these being, the 'macho' individual, a stereotype that centres on 'an inability to admit vulnerability' (Sanitarium 2004). In this framework, the attainment of health is therefore coterminous with creating an alternative construction of what it means to be a man. As Sanitarium puts it, 'There is evidence to suggest that males who adopt a traditional masculine role are less receptive to health messages and more inclined to adopt behaviours which may put their health at

risk', it argues. It is through encouraging men to adopt a different role - crucially one that involves an acceptance of vulnerability – that better health can be attained.

The now taken-for-granted status of this representation of problem of men's health is indicated by extent to which claims that men need to become less 'tough' and 'invulnerable', more 'open' and more prepared to 'seek help' informs the approach of British health-related institutions. Health promotion programmes in Britain explicitly target men, and encourage them to become open to seeking help (Furedi 2004: 35). Key organisations promote this view about what needs to change. The Royal College of Nursing, the British Medical Association, the Department of Health all have initiatives that aim to encourage men to seek help. They, together with the All-Party Parliamentary Group on Men's Health also support and fund the Men's Health Forum, an organisation established because men are 'reluctant users' of health services, and which aims to 'enable men to change their risk-taking behaviours' and 'enable and encourage [men] to take better care of their own health and to make appropriate use of health services' (Men's Health Forum: n.d.).

This problem of men's health has also gained visibility as it has become politicised. David Hinchliffe MP, chair of the House of Commons' health select committee claims tackling this problem must be a priority for UK health policy. 'Men's attitude to their health is a very significant social problem', he argues. 'I think it ties into male violence, the fact that so much crime arises from young men – alienated young men... That all ties in with men individualising their problems, and ultimately committing suicide' (Eaton: n.d.). Depression in men, in particular, is predominantly framed in relation to the problem of masculinity. This has gained increasing resonance as an explanation for why young men commit suicide. Thus, argues the Royal College of Psychiatrists:

The way that men think about themselves can be quite unhelpful. Compared with women, they tend to be far more concerned with being competitive, powerful and successful. Most men don't like to admit that they feel fragile or vulnerable, and so are less likely to talk about their feelings with their friends, loved ones or their doctors. This may be the reason that they often don't ask for help when they become depressed (n.d.)

Claims that promote the need to encourage 'help-seeking behaviour' and overcome the barrier that 'masculinity' represents in relation to this goal are, thus, ubiquitous. This outlook is the mainstream one in discussion of men's health. It is perhaps unsurprising to find the same view has diffused shape health care provision for new families. This process of diffusion is encouraged by developments in another policy area also, however.

### *Parenting*

An area of claims-making and related policy innovation that has seen high levels of activity in recent years is that which addresses 'parenting' (Furedi 2001). In Britain, this theme has become particularly prominent in the political sphere since the election of the new Labour government; how parents bring up their children has become a politicised

issue. Related innovations during this time include the establishing of the National Family and Parenting Institute, on the basis of arguments put forward by the U.K. Government in its Green Paper, *Supporting Families* (Home Office 1998) and more recently the linking of child protection to the issue of parenting more generally in *Every Child Matters* (DfES 2003). This latter document presents interventions in relation to parenting that will affect around one third of British parents as necessary in order for children to be protected from harm.

The problem of ‘parenting’ comprises claims about two areas that are highly relevant to the construction of male PND. The first is the notion that bringing up children is just as much a male, as well as female, activity. This notion is widely viewed as underpinned by thoroughgoing changes that have taken place in regard to female participation in the labour force (Lamb et al, 1987). As MacInnes puts it, there has been a vast shift in, ‘...the historical context of men’s ability...to define childcare and domestic labour exclusively as a woman’s job’, and he notes, that, ‘In countries where women form a substantial part of the labour force, male breadwinner ideology has all but collapsed in terms of popular support (1998: 53). Burghes *et al.* argue similarly, that, ‘Fathers and mothers are expected to share breadwinning with caring for their children and doing the domestic chores, even if attitudes vary about how parents should divide these tasks between them...’ (Burghes 1997: 75).

Rejection of the notion that bringing up children is ‘women’s work’ does not, however, simply involve an assertion of the idea that tasks should be shared equally in order for women to be able to go to work. The argument for equality in child-rearing also comprises the claim that men must be encouraged to think of themselves in a different way. As Burghes points out, with reference to Hochschild, ‘One current view of the role of fathers holds that it should be much more child-centred and nurturing compared with an earlier model of the remote financial provider’ (1997: 10). He explains, of commentaries and policy initiatives in this area that, ‘A key emphasis today is on increasing the nurturing role of fatherhood’ (1997: 88)

A perception has emerged, therefore, that fathers must develop the ability to have close, caring, emotionally involved relationships with their children. At the extreme, it is advocated that a ‘new kind of man’ needs to come into being, who is ‘more like a woman’ (Lupton and Barclay 1997: 44), but it is more widely assumed that a transformation needs to take place in regard to assessments of about men’s capacity to nurture their children. Many experts believe men may well not act this way without intervention and guidance (Lupton and Barclay 1997: 35-61) or the fact that they can and often do is rarely recognised as measures need to be taken to raise the profile of the caring father (Fathers Direct, n.d). As Burghes (1997) indicates, it has become an objective of those concerned with ‘parenting’ and of social policy concerned with the family, to act in order to ‘increase’ this capacity on the part of men, and/or recognition of it, and thus generate a different image of the paternal role to that which is perceived to have existed previously.

Good fatherhood, then, is that which is carried out in an emotionally open style, a style clearly incompatible with acceptance of the tenets of 'macho-culture'. Indeed, in order for fathers to be emotionally open requires them to move away from what is deemed to be the previous 'macho' model of fatherhood, where the father is simply the 'breadwinner' and is either emotionally uninvolved with his children, or cold and distant. In this sense the over-arching contemporary construction of fatherhood lends support to the claims of those who advocate the need for recognition of male PND, in their rejection of 'traditional masculinity'.

Current definitions of the problem of parenting support the masculinization of PND in another way too, however. This is through the definition of the gender-neutral activity of parenting as one that cannot be successfully carried out in the absence of 'help' and 'support'. Indeed, the key feature of the definition of 'parenting' as policy issue is the notion that it is difficult, and that its difficulties are insufficiently recognized (Lee 2002). Parenting, in current social policy, is consistently defined as 'the hardest job in the world'. Similarly, according to 'Fathers Matter', this activity is 'harder than ever'. 'Parentcraft' classes currently offered to new parents are simply inadequate, argues Mary Alabaster. 'The expectation is that four two-hourly sessions can prepare prospective parents for a job which will last the rest of their lives', she complains. Her case is that the 'job' of bringing up children is far harder than this suggests, because, 'We are living in an era when the pressure of daily life are unprecedented...Is it any wonder that breakdowns in relationships occur in the early years following the birth of a child?' (Daniel 2004: 209). Thus interventions to address PND are framed as part of activities that fully recognise the difficulties parents encounter if they try to bring up their children without professional assistance.

Sociological analysis suggests that the reason why parenting has emerged as a problem defined this way is not, however, a simple response to an 'era where the pressures of daily life are unprecedented', since there are many points in time – for example during economic depression - where conditions were far worse. Rather, parenting has come to be viewed this way because of the development of a particular view of children. The child of our time has become the key focus for sensibilities associated with the 'risk society', and is therefore defined in a way that very strongly emphasizes fragility and vulnerability (Furedi 2001). In current conditions, where a perception of being 'at risk' is very strong, the life of the child has become a key arena through which this concern can be expressed.

What is especially significant, however, is that the risks children are deemed subject to are not just external, for example from the environment or from strangers. Rather, and increasingly, it is members of their own family, in particular their parents, who are deemed to place them 'at risk'. These risks are not just confined to clear cases of violence or physical abuse. As Hardyment (1995) explains it, risk has come to include hampered physical and/or emotional development if a baby is not breast-fed, read bedtime stories, cuddled enough, left to cry at night (or, alternatively allowed to sleep in the parents bed), the risk of cot death and of manifold health problems if babies and children are not given the right kind of diet.

The notion of the ‘child at risk’ from its parents has become very clearly codified in British social policy. This has taken place through growing emphasis being placed on the significance of the ‘early years’ – the first 12 months of a child’s life in particular. ‘By the time a child reaches his or her first birthday, much of the foundation for the rest of life will be laid...No other life stage is more risky, yet no other time offers greater opportunity for effective intervention’, argues a pamphlet authored by an influential social policy think-tank (IPPR 2003: 5). It is ‘Parents interactions with their children’, that ‘appear to have an important and lasting effect on this process [of child development]’, it continues. The claim made, therefore, is that the child’s development is on the one hand potentially placed at risk by the way the parent interacts with it, and on the other can be enhanced if that interaction is moulded through intervention. Thus, ‘...those who are concerned about how to improve the health, educational and social wellbeing of society are most likely to note that the earlier the intervention the effective...it is’ (Harker and Kendall, 2003: 9-10). Intervening to bring about a ‘positive parenting style’ in this way has become a key focus for social policy. In its major overhaul of policy, set out in its Green Paper *Every Child Matters*, the UK Government thus argues that, ‘The bond between the child and their parents is the most critical influence on a child’s life’ (DfES 2003: 39). This bond will not develop in a ‘healthy’ way without intervention, however and, therefore, it, ‘intends to put supporting parents and carers at the heart of its approach to improving children’s lives’. It will, to this end, create a ‘Parenting Fund’, and initiate, ‘consultation on a long term vision to improve parenting and family support’ (DfES 2003: 8).

As part of this emphasis on the significance of the early years, the issue of the mental health of parents has assumed greater prominence the past. Claims about it, as a particular risk factor for children, now appear regularly in Government and health policy agendas. ‘Parental mental health is one of the factors most likely to influence a parent’s interaction with an infant...Children of depressed parents have been shown to be two to five times more likely to develop behavior problems’, states *An Equal Start, improving support during pregnancy and the first 12 months*, published by the influential think-tank, the IPPR (2003: 20-21). ‘The academic results of boys are particularly affected of their mother has suffered from post-natal depression’, argues the Government (DfES 2003: 19).

Policy has, in fact, encouraged health professionals to be attentive to PND on this basis for some years, but the focus was, until recently, on the mother. The 1998 Government document ‘Supporting Families’ thus suggested that midwives and health visitors should be able to assess the quality of relationships between woman and their partners, to ascertain if factors are present that might contribute to PND in the former, and if so encourage the woman to seek help (Gerrard 2000: 1). Building on claims about ‘bonding’ and its effects for child development, the key claim about depression in mothers underpinning this approach links it to inadequate child development, with maternal PND therefore allegedly leading to problems in later childhood and possibly adult life (Cooper 2001; Murray 2001). ‘The real concern for those working in public health’, argues a briefing for British health visitors, ‘is the growing body of research highlighting the

potential long term effects of maternal depression on children and families' (Adams 2002: 263).

Just as the babies of mothers who fail to 'bond' with them have been considered at risk of poor emotional development, so the future of those who mothers experience depression are harmed irreparably. According to one summary of the literature, 'The negative effects of PND on the infant appear to happen very early in life...The behavioural effects are long lasting' (Shakespeare 2002). This, according to Gerrard, is why nurses in Britain need to be clear that PND matters. It is not just a 'woman's problem', but has 'ramifications for the family and society' (2000: 1). For Gerrard the real problem is the impact on the child because depressed mothers cannot parent effectively, which in turn leads to the development of social problems, in the form of the activities of disturbed young people. She draws particular attention to the effects of PND on, 'boys from lower socio-economic classes' who are 'most vulnerable' and are most likely to have socially damaging behavioural problems if their mothers are depressed (2000: 7).

Identifying PND has, on this basis, become more and more prominent in discussion of the role of the health visitor particularly. The Community Practitioners' and Health Visitors' Association (CPHVA) published Postnatal Depression and Maternal Mental Health, a public health priority in 2001, and has established a Postnatal Depression and Maternal Mental Health Network for its members, 'to support practice and service development in what the Association recognises is a key area of practice for our members' (CPVHA 2002: 143). New initiatives and services have been developed in many areas of Britain, funded through Government programmes that aim to improve mental health, within which a key aspect of contact with women is extensive use of the Edinburgh Postnatal Depression Scale (EPDS), to identify women at risk and ensure they are offered treatment, in particular counselling (Hehir 2001).

Such developments, more than anything else, account for the emergence of claims that stress the need to 'spot' and 'treat' depressed fathers. In a context where the role of men in parenting is strongly emphasized in social policy, and where policy agendas deem parental interaction with their children to be the axial principle in explanations of a person's future development and achievement, the emergence of the problem of 'PND' in men is easy to account for. It furthers a trajectory through which the problem of 'parenting' becomes detached from gender, and through which the emotional and psychological life of both sexes becomes medicalised and professionalised.

### Conclusions

The social problems game is played in the larger culture; what's happening in the larger culture influences the likely success of claims (Loseke 1999: 62).

As pioneering studies of the construction of social problems have shown (Best 1990), problems become increasingly visible where claimsmakers successfully co-opt and build on each other's claims. As a result, problem domains expand, and certain problems attain a powerful cultural dynamic. In other words, as Loeseke points out, whether or not a

particular claim about a putative social problem succeeds is to a large degree determined by the wider culture. This paper has shown how the claims that men suffer from PND and that this problem needs to be recognized have resonated with wider cultural trends. Those who have pioneered the expansion of the domain of PND have both drawn on, and have reinforced, constructions of men and of illness that have become dominant in a number of different settings and arenas.

It has been argued that as a result, in Britain at least, male PND has moved in about ten years from being a non-existent to a widely recognized problem afflicting new fathers. Some media discussions of the issue have included comments from those who express surprise at the suggestion that there could be such an illness. 'Political correctness gone mad' was, in this vein, the way that Dr Liam Fox, shadow health secretary for the Conservative Party described the Fathers Matter scheme (Lusher and Welsh, 2003). It is very evident this kind of response is marginal to developments, however. Overall, the review presented above of discussion about male PND in the media, and in health and social policy suggests there is a great deal of endorsement of the kind of approach schemes like Fathers Matter advocate. When it was launched in 2003, claims made for the need for such a scheme resonated strongly with various lobbies, including those involved with fathers' rights, men's health and parenting.

Male PND has resonated in this way because at its core is a representation of men that is common to all these arenas, that which emphasizes vulnerability and the importance of encouraging help-seeking behaviour. It is this representation that connects the expansion of PND to the wider process through which contemporary experience is medicalised. As Fitzpatrick (2001) has argued, it is a culture in which people are assumed to be, and also often consider themselves to be, fragile and vulnerable, that in general underpins the contemporary medicalization process in its many forms. Those who are vulnerable are, by definition, in need of help, and thus male PND also resonates with agendas that seek to promote help-seeking behaviour, for example in relation to parenting.

The specific development that, above all, has enabled PND to cross the gender boundary is in this arena; it is the pervasive and highly influential construction of parents as 'in need of support' in a routine, not exceptional, way. This notion is now highly institutionalized in Britain society. It is this that provides a very powerful impulse through which women's difficulties as mothers have been spread to men.

The expansion of PND to men that has emerged as a result carries with it a very significant re-definition of equality. Men and women are now increasingly deemed equal within the family. This is nowhere more the case, however, than in regard to the difficulties they are deemed to encounter when attempting to cope emotionally, and in the need for both sexes to receive professional intervention in order to enable them to parent. One conclusion that can be drawn from the expansion of PND is, therefore, that it suggests women and men have become at once more equal, and also more diminished in regard to their ability to act as responsible, autonomous adults.

## References

- Adams, Cheryl. 2002. 'Ante and postnatal depression: where are we now and where should we be going?' *Community Practitioner* 75 (7): 263.
- Arditti, R., Duellie Klein, R., and Minden S. (eds). 1984. *Test-Tube Women: What Future for Motherhood?* London: Pandora Press.
- Aries, M.E., Kumar, R., Barros, H. et al. 1996. 'Comparative incidence of depression in women and men, during pregnancy and after childbirth'. *British Journal of Psychiatry* 169: 30-35.
- Ballard, C.G., Davis, R. Cullen, P.C., et al. 1994. 'Prevalence of postnatal psychiatric morbidity in mothers and fathers'. *British Journal of Psychiatry* 164: 782-788.
- BBC news online. 2003. 'New advice service for fathers'. 27 December. [www.bbc.co.uk](http://www.bbc.co.uk)
- BBC news online. 2003. 'Advice for baby blues dads'. 24 August. [www.bbc.co.uk](http://www.bbc.co.uk)
- BBC news online. 2000. 'Making school cool for boys'. 9 February. [www.bbc.co.uk](http://www.bbc.co.uk)
- BBC News online. 1999a. 'Men suffer from baby blues'. 4 May. [www.bbc.co.uk](http://www.bbc.co.uk)
- BBC News online. 1999b. 'New fathers get advice'. 10 September. [www.bbc.co.uk](http://www.bbc.co.uk)
- BBC Three News. 2004. 'Basildon Bonding'. 23 March. [www.bbc.co.uk/bbcthree](http://www.bbc.co.uk/bbcthree)
- Best, Joel. 1990. *Threatened Children, Rhetoric and Concern About Child-Victims*. Chicago: University of Chicago Press.
- Brockington, Ian. 1996. *Motherhood and Mental Illness*. Oxford: Oxford University Press.
- Brockington, I.F. and Kumar, R. 1982. 'Preface'. Pp. vii-viii in *Motherhood and Mental Illness* edited by I.F. Brockington and R. Kumar. London, Toronto, Sydney, Tokyo, Montreal: Academic Press, Inc.
- Burghes, Louie, Clarke, Lynda and Cronin, Natalie. 1997. *Fathers and fatherhood in Britain*. London: Family Policy Studies Centre.

- Community Practitioner (news). 2004. 'Gender specific' approach needed to men's health'. *Community Practitioner* 77 (6), June: 203.
- Conrad, Peter. 1992. 'Medicalization and Social Control'. *Annual Review of Sociology* 18: 209-32.
- Conrad, Peter and Potter, Deborah. 2000. 'From Hyperactive Children to ADHD Adults: Observations on the Expansion of Medical Categories'. *Social Problems* Vol. 47, No4: 559-582.
- Corea, G. 1985. *The Mother Machine: Reproductive technologies for Artificial Insemination to Artificial Wombs*. New York: Harper and Row.
- Cox, John and Holden, Jenni. 2003. *Perinatal mental health, a guide to the Edinburgh Postnatal Depression Scale*. London: Gaskell.
- Cooper, Peter. 2001. 'The challenges of antenatal prevention of maternal depression'. Pp. 9-12 in *Postnatal depression and maternal mental health, a public health priority* edited by CPHVA. London: CPHVA.
- CPVHA. 2002. 'Use of the Edinburgh Postnatal Depression Screening Scale'. *Community Practitioner* 75 (4), April: 42-43.
- Curham, Siobahn. 2000. *Antenatal and Postnatal Depression, Practical Advice and Support for All Sufferers*. London: Vermillion.
- Dalton, Katharina and Holton, Wendy M. 2001. *Depression After Childbirth*. Oxford: Oxford University Press.
- Daniel, Karen. 2004. 'Fathers' psychological needs – a neglected area'. *Community Practitioner* 77 (6), June: 208-9.
- Denny, E. 1996. 'New reproductive technologies: the views of women undergoing treatment'. Pp. 207-227 in *Modern medicine: lay perspectives and experiences*, edited by S. J. Williams and M. Calnan. London: UCL Press.
- Department for Education and Skills (DfES). 2003. *Every Child Matters*. London: HMSO.
- Dhingra, Dolly. 2001. 'A problem shared'. *The Guardian*. 19 March.
- Downs, Donald. 1996. *More Than Victims, Battered Women, The Syndrome Society and the Law*. Chicago and London: The University of Chicago Press.
- Eaton, Lynn. 'Tackling male attitudes to health'. MHF magazine.. nd.

Evins, Grace G and Theofrastous, James P. 1997. 'Postpartum Depression: A Review of Postpartum Screening'. *Primary Care Update for Ob/Gyns* 4 (6): 241-246.

Fathers Direct, 'What Good Are Dads?', *Father Facts* Volume 1, Issue 1, n.d.  
www.fathersdirect.com

Figert, Anne E. 1996. *Women and the Ownership of PMS, The Structuring of a Psychiatric Disorder*. New York: Aldine de Gruyter.

Figs, Kate. 1998. *Life After Birth*. London: Penguin Books.

Fitzpatrick, Michael. 2003. 'Therapeutic pi', 18 February.  
www.spiked-online.com

Fitzpatrick, Michael. 2001. *The Tyranny of Health, Doctors and the Regulation of Lifestyle*. London and New York: Routledge.

Franklin, Sarah. 1997. *Embodied Progress, a cultural account of assisted conception*. London: Routledge.

Furedi, Frank. 2001. *Paranoid Parenting*. London: The Penguin Press.

Furedi, Frank. 2004. *Therapy Culture, Cultivating Vulnerability in and Uncertain Age*. London: Routledge.

Gerrard, Janice. 2000. *Postnatal Depression*. London: Nursing Times Books.

Hardyment, Christina. 1995. *Perfect Parents*. Oxford and New York: Oxford University Press.

Harker, L. and Kendall, L. 2003. *An Equal Start: improving support during the first 12 months*. London: IPPR.

Hehir, Brid. 2001. 'Is Motherhood More Depressing Than Ever?', 21 June.  
[www.spiked-online.com](http://www.spiked-online.com)

Hendrick, Victoria. 2003. 'Treatment of postnatal depression'. *British Medical Journal* 327, 1 November: 1003-4.

Home Office. 1998. *Supporting Families*. London: HMSO.

Jackson, Melissa. 2004. 'Men are not too macho to cry'. 4 July.  
www.bbc.news.online

Jarmulowicz, Michael. 1992. *The Physical and Psychological Effects of Abortion*. Leamington Spa: Life.

Katz-Rothman, B. 1986. *The Tentative Pregnancy: Prenatal Diagnosis and the Future of Motherhood*, London: Penguin Books.

Kimmel, Michael S. 1995. 'Series Editor's Introduction'. Pp. vii – viii, in *Men's Health and Illness*, edited by D. Sabo and D.F. Gordon. London: Sage Publications.

Kitzinger, Sheila. "Post Traumatic Stress Disorder". n.d.  
www.babyworld.co.uk

Kleinman, Karen and Davis Raskin, Valerie. 1994. *This Isn't What I Expected: Overcoming Postpartum Depression*. New York: Bantam Books.

Kumar, R. 1982. 'Neurotic Disorders in Childbearing Women'. Pp.71-118 in *Motherhood and Mental Illness* edited by I. Brockington and R. Kumar. London: Academic Press.

Kutchins, Herb and Kirk, Stuart A. 1997. *Making Us Crazy, DSM: The Psychiatric Bible and the Creation of Mental Disorders*. New York: The Free Press.

Lamb, M.E., Pleck, J.H., and Levine, J.A. 1987. 'Effects on increased paternal involvement on fathers and mothers'. Pp. 109-125, in C. Lewis and M. O'Brien, *Reassessing Fatherhood*, London: Sage Publications.

Leary, Carol. 'Men's Health – Worth Talking About'. N.d  
www.sanitorium.com.au

Lee, E. 2003. *Abortion, Motherhood and Mental Health: medicalizing reproduction in the United States and Great Britain*. New York: Aldine de Gruyter.

Lee, E. 2002. 'Should private life be the subject of public policy'. Paper presented at Private Lives, Public Policy, Marriage, relationships and commitment in Singleton Society, The London Voluntary Sector Resource Centre, 20 July (unpublished).

Lee, Christina and Owens, R. Glynn. 2002. *The Psychology of Men's Health*, Buckingham, Philadelphia: Open University Press.

Lewis, Charlie and O'Brien, Margaret. 1987. *Reassessing Fatherhood, New Observations on Fathers and the Modern Family*. London: Sage.

Loseke, Donileen R. 1999. *Thinking About Social Problems*. New York, Aldine de Gruyter.

Lupton, Deborah and Barclay, Lesley. 1997. *Constructing Fatherhood: discourses and experiences*. London: Sage Publications.

- Lusher, A. and Welsh, B. 2003. 'Men to get counselling for 'postnatal depression'', *Sunday Telegraph*, 24 August.
- MacInnes, John. 1998. *The End of Masculinity*, Buckingham, Philadelphia: Open University Press.
- Matthey, S., Barnett, B.E., Kavanagh, and Howie, P. 2001. 'Validation of the Edinburgh Postnatal Depression Scale for men, and comparison of item endorsement with the partners'. *Journal of Affective Disorders* 64: 175-184.
- McDougall, Liam. 2004. 'Fathers urged to admit that they get the baby blues too'. *Sunday Herald*, 14 March.
- Maushart, Susan. 1999. *The Mask of Motherhood*. London: Pandora.
- Men's Health Forum. 'About Us'. N.d.  
www.menshelathforum.org.uk
- Milne, Seumas. 1999. 'Women find balancing work and family life 'increasingly arduous', says survey'. *The Guardian*, 4 February.
- Murray, Lynne. 2001. 'How postnatal depression can affect children and their families'. Pp. 20-23 in *Postnatal depression and maternal mental health, a public health priority* edited by CPHVA. London: CPHVA.
- Murray, Lynne and Cooper, Peter J. 1997. *Postpartum Depression and Child Development*, The Guildford Press: New York and London.
- Nicolson, Paula. 2000. 'Competing Explanations of Postpartum depression: What are the benefits to women?', in *Women's Health: Contemporary International Perspectives* edited by J. Ussher. Leicester: BPS Books.
- Nicolson, Paula. 1998. *Post-Natal Depression, Psychology, Science and the Transition to Motherhood*. London: Routledge.
- O'Hara, Michael W. 1997. 'The Nature of Postpartum Depressive Disorders'. Pp. 3-34 in *Postpartum Depression and Child Development* edited by L. Murray and P.J. Cooper. The Guildford Press: New York and London.
- Oakley, Ann. 1980. *Women Confined: Towards a new sociology of childbirth*. Oxford: Martin Robertson.
- Peele, Stanton. 1995. *Diseasing of America, How we Allowed Recovery Zealots and the Treatment Industry to Convince Us We Are Out of Control*. San Francisco: Jossey-Bass Publishers.

Pitt, Brice. 1985. 'The puerperium'. Pp. 147-172 in *Psychological disorders in obstetrics and gynaecology*, edited by R.G. Priest. London: Butterworth & Co. (Publishers) Ltd.

Plomin, Joe. 2001. 'Don't look back in anger', *The Guardian*, July 19.

Raitt, Fiona E. and Zeedyk, Suzanne. 2000. *The Implicit Relation of Psychology and Law, Women and Syndrome Evidence*. London and Philadelphia: Routledge.

Rajan, Lynda. 1996. 'Pain and pain relief in labour: issues of control'. In *Modern medicine: lay perspectives and experiences*, edited by S. J. Williams and M. Calnan. London: UCL Press.

Ralph, K. and Alexander, J. 1994. "Post-traumatic stress disorder. Borne under stress". *Nursing Times* 90 (12): 29-30.

Rawles, Simon. 2004. 'Birthing Pains', *The Observer*, March 21.

Roan, Sharon L. 1998. *Postpartum Depression: Every Woman's Guide to Diagnosis, Treatment and Prevention*. Holbrook, MA: Adams Media Corporation.

Rue, Vincent. 1995. 'Post-abortion syndrome: a variant of post-traumatic stress disorder'. Pp. 15-28 in *Post-abortion Syndrome - its wide ramifications* edited by P. Doherty. Dublin: Four Courts Press.

Riessman, Catherine Kohler. 1983. 'Women and medicalization: A new perspective'. *Social Policy*, Summer: 3-17.

Royal College of Psychiatrists. 1997. Factsheet titled, 'Post Natal Depression', June. [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)

Royal College of Psychiatrists, 'Men Behaving Sadly'. N.d. [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)

Sarler, Carol. 2003. 'No more heroes, any more'. *The Observer*, 31 August.

Scott, Wilbur J. 1990. 'PTSD in DSM III: A Case in the Politics of Diagnosis and Disease'. *Social Problems* 37: 294-310.

Scourfield, Jonathan and Drakeford, Mark. 2002. 'New Labour and the 'problem of men''. *Critical Social Policy* Vol. 22(4): 619-640.

Shepherd, Ben. 2000. *A War of Nerves, Soldiers and Psychiatrists 1914-1994*. London: Jonathan Cape.

Sheringham, Sam. 2003. 'Men to get NHS counselling for Postnatal depression'. *PA News*, 24 August.

South Essex Partnership NHS Trust. 2004. 'Fathers Matter' (Press Release). 28 January. [www.southessex-trust.nhs.uk](http://www.southessex-trust.nhs.uk)

Stanworth, M. 1987. 'Reproductive technologies and the deconstruction of motherhood'. Pp. 10-35, in *Reproductive Technologies*, edited by M. Stanworth, Cambridge: Polity Press.

Summerfield, Derek. 2001. 'The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category'. *British Medical Journal* 322: 95-98.

Sutherland, John. 2002. 'Just can't get enough'. *The Guardian*, 17 June.

Welford, Heather. 2002. *Feelings After Birth*. London: National Childbirth Trust.

Wolf, Naomi. 2001. *Misconceptions, Truth, lies and the Unexpected on the Journey to Motherhood*. London: Chatto and Windus.

Wright, Oliver. 2004. 'Fathers at risk of postnatal depression as well'. *The Times*, 20 March.

Young, Allan. 1995. *The Harmony of Illusions: Inventing Post Traumatic Stress Disorder*. Princeton: Princeton University Press.