

**POSTPARTUM DEPRESSION:
The Convergence of Media Coverage and Community Activism
In Influencing Public Health Policy**

A Case Study in Assessment, Policy Development, and Assurance

TEAM SPIRIT

**Karnail Mudahar, Mentor
Ron Brown
John T. Carlsen
Gene Huber
Mary V. Muse
Vanessa Newsome
Hardy Ware**

**POSTPARTUM DEPRESSION:
The Convergence of
Media Coverage and Community Activism
In Influencing Public Health Policy**

Abstract

This case study considers the extent to which postpartum depression represents a public health issue. The estimated incidence of postpartum depression varies between 3% and 20% of all births. In recent years, a number of cases of mothers committing suicide or murdering their children have received media attention. In addition to placing new mothers and their children at risk for such harm, postpartum depression negatively affects the family, community and the broader society. The study is based on the case of Barbara Smith, a mother from the Midwestern United States, who committed suicide after a long battle with postpartum depression. It analyzes postpartum depression from the medical/psychiatric, legal/correctional, political, and economic perspectives and addresses issues of public health assessment, policy development, and assurance; community and political involvement; and public health education.

Case Study Development

A Title: POSTPARTUM DEPRESSION: The Convergence of Media Coverage and Community Activism In Influencing Public Health Policy

B Functional Areas of Focus: Assessment and Policy Development

- 1 Public Health does not currently collect information related to postpartum depression; data collection for assessment will need to be addressed;
- 2 Policy Development is dependent on the implementation of an assessment tool.

C Major Subjects Involved:

- 1 Increasing public awareness of the incidence and prevalence of postpartum depression in the community;
- 2 Focusing attention on gaps in the existing healthcare infrastructure that result in under-diagnosis, inadequate prevention, and unnecessary injury/death to new mothers and children;
- 3 Existing relationships among medical and mental healthcare providers;
- 4 Media coverage of postpartum depression/psychosis-related suicide and murder cases;
- 5 Community responses to media coverage;
- 6 Legal/correctional involvement in postpartum depression-related murder cases;
- 7 Political/legislative responses to media coverage.

D Setting of the Case:

- 1 Type of Health Department/Agency/Facility

Local husband and extended family lose wife/daughter to suicide in midwestern metropolitan city. Family members are involved in local church and residential community. Media coverage of suicide increases involvement of larger community to a national and international level. Core healthcare services are provided in community hospitals.

- 2 Relevant Geographic and Demographic Information

The case takes place in a midwestern metropolitan city with a population of over 8 million people. Family members include husband and two daughters, one a newborn infant, and wife's and husband's parents and siblings. Others involved include private hospital staff, community members, allied professional associations, and political activists/ legislators.

3 Divisions and Personnel (Positions) Involved

Medical/Mental Healthcare providers (Obstetricians/Gynecologists, Internists, Pediatricians, Psychiatrists, Social Workers, Psychologists)

Public Health Directors (federal, state, county, and local)

Media Reporters

Community Members/Activists

Legislative Representatives

4 Fiscal Resources

Budget for Proposed National, Regional, and local Programs is dependent on Legislative Approval and Appropriations

E Authorship Information

John T. Carlsen, Psy.D.
Assistant Director
Staff Psychologist
Chicago Department of Public Health
Beverly-Morgan Park Mental Health Center
1971 West 111th Street
Chicago, IL 60643

Vanessa D. Newsome, MSED
Program Coordinator
Will County Health Department
501 Ella Avenue
Joliet, IL 60433

Gene Huber, MPA
Grants Manager
Peoria City/County Health Department
2116 North Sheridan Road
Peoria, IL 61604

Mary V. Muse, MS, RN
Director of Nursing
Cermak Health Services
2800 South California Avenue
Chicago, IL 60608

Hardy Ware, MA
Administrative Assistant/Program Manager
East Side Health District
650 North 20th Street
East St. Louis, IL 62205

Ronald H. Brown, RN, BSN
Division Chief
Illinois Department of Public Health
535 West Jefferson Street
Springfield, IL 62761-0001

Karnail Mudahar, MVSc (Mentor)
Illinois Department of Public Health
Food Drug & Dairies
525 West Jefferson
Springfield, IL 62761

**POSTPARTUM DEPRESSION:
The Convergence of
Media Coverage and Community Activism
In Influencing Public Health Policy**

Introduction

In June 2001, U.S. Representative Richard Davis introduced The Barbara Smith Postpartum Depression Research and Care Act. This bill would expand research and coordinate programs focused on improving care for women suffering from postpartum depression and postpartum psychosis. Representative Davis presented this bill in the name of a young mother who had recently committed suicide as a result of postpartum psychosis. The case study addresses the question of whether or not postpartum depression is a public health issue. It also considers the core functions of assessment, policy development, and assurance issues related to the suicide of Barbara Smith, following her struggles with postpartum depression.

Background

February 2001

A successful pharmaceutical sales manager and the wife of an emergency room physician, Barbara Smith appeared well suited and prepared to raise a child. She had strong support from her husband, extended family, and her community; the necessary emotional and financial resource to provide for another child; and a belief that motherhood was her life's mission.

Also, she and her husband had demonstrated a commitment to raising children by enduring several treatments for infertility before this successful pregnancy. Her co-workers described her as someone who always encouraged her staff to pursue their goals and maintained a cohesive community around her. They said she had a strong religious faith, the ability to find good in every situation, and a belief that every situation would eventually lead to a positive outcome.

On February 23, 2001, Smith gave birth to a healthy baby girl. Although she had wanted another child, Smith displayed no emotional reactions toward her new infant daughter. Smith's mother recognized the lack of bonding love between her daughter and new granddaughter.

April - May 2001

Recognizing Barbara Smith's symptoms of postpartum depression was difficult even though her husband worked in the medical profession. Even early on, no one could clearly tell whether she, like many new mothers, was simply overworked from caring for a new infant who needed her mother to awaken every two hours to feed her, or if Barbara might be suffering from depression. Smith's husband responded as many husbands do, by assuming she was simply worn out from the additional responsibilities.

Yet, six weeks after the birth of her child, Smith was hospitalized with postpartum psychosis - an extremely rare form of post-delivery depression related to the rapidly changing hormonal levels

following delivery.

Over the following two months, Smith received inpatient treatment at three different hospitals for 7 to 10 days at a time. Her treatments included various medications and even electroconvulsive therapy, but she would not take the medication as prescribed. With each treatment, her family said, she would respond temporarily, only to relapse eventually into a deeper depression.

Her family reported that she gradually became fascinated with high-rise buildings. They admitted her to a fourth hospital for six days of treatment due to her suicidal tendencies. Following this last hospitalization, her family thought she had turned the corner on her illness. They believed that their approach was helping her and that she was getting better.

June 2001

On Saturday morning, June 9, 2001, Barbara disappeared from her home while her husband was at work. Although they were very concerned about her and made numerous attempts to locate her, Smith's family was unsuccessful and struggled as they waited to hear from her. Four days later, firefighters were alerted that a person was threatening to jump from a hotel near the city. When they arrived, they found her on a ledge of the 12th floor. Despite their efforts, and their hope that she was ready to go back inside the building, they were unable to save her. As they reached out for her, she fell to her death.

The Media Responds to the Smith Case:

On Tuesday, June 12, 2001, media coverage of the Barbara Smith suicide began to escalate, drawing national and, even, international attention to the issue of postpartum depression. The Smith case was the fourth high-profile postpartum-related suicide or murder of children, reported officials, within the past two months. In one instance, a husband came home from a business trip to discover his wife had placed their four-day old baby in the trash. She was confused, dirty and disoriented. She told him that "Satan had taken" their infant.

Almost immediately after her death, Barbara Smith's family was scrutinized in the news media. First came an outpouring of sympathy for her family, but accusatory statements quickly followed this. "Why didn't they do more...especially her husband, he was a doctor!" seemed to summarize the public sentiment. Her family became subject to attack in the media for not doing more to prevent her death. Thus, her family not only had to deal with her suicide; they were also subjected to feelings of guilt for not preventing it.

Next, media reports began to examine the role of Smith's obstetrician, Dr. Benton. Dr. Benton had been Barbara's doctor with her previous pregnancy...what was different this time? Had postpartum depression been a concern with her previous pregnancy? Had he noticed any symptoms of postpartum depression after Barbara's second child was born? If so, what had he done? What was the normal procedure for OB's in assessing for potential cases of postpartum depression? Again the media asked, "Couldn't the doctor have done more for Barbara Smith?" The general attitude, though not unsympathetic to the Smith case, emphasized that physicians (especially obstetricians and gynecologists) are trained to deal with the physical symptoms of

pregnancy, but postpartum depression is a mental health concern. Furthermore, most women have only one contact after delivery with their prenatal doctor, a brief check-up at six weeks postpartum.

Finally, the media converged on the mental health field, again questioning whether or not everything had been done that could have been done for Barbara Smith. Smith had been hospitalized with postpartum psychosis, a severe form of postpartum depression; yet, she had received treatment at four different hospitals for about 6 to 10 days each. Why was she treated at *different* hospitals? Wouldn't it have been better for continuity of care to keep her at the same facility in order to observe her treatment more closely? And, why was she released when, apparently, she was not making adequate progress?

June 18, 2001 - The Smith Family Responds to the Public:

On the Monday following Barbara Smith's death, her family began speaking out publicly and talking openly about her condition, hoping that doing so would help others understand the illness. At Smith's funeral, her father, David Black, expressed hope that other expectant mothers could learn from his daughter's battle with her mental illness. He told the congregation that he felt overwhelmed by the realization that postpartum depression was a term and, certainly, an experience that the family had known nothing about; that they fought to keep their daughter in the hands of the medical community but ultimately failed. He reminded the mourners that what had happened to their daughter could just as easily and randomly happen to any woman who experiences childbirth. Chris Black, Smith's mother expressed strong determination that she would not let her daughter "die in vain". She also expressed deep frustration that doctors had sent her daughter home too soon and without adequate medication and counseling.

June 20, 2001

Within one week of Smith's suicide, national media covered another serious postpartum depression-related tragedy, in which a young mother, Marion Louis, drowned her five children in the bathtub during a severe bout with the illness.

June 20 - June 30, 2001 - The Community Responds:

In the following days, various professionals in the community began to add their reactions to Smith's death. A local clinical psychologist and board member of Depression After Delivery, a national group that provides assistance to postpartum members, reported her finding that fewer than 10 local hospitals provided care and outreach specifically for postpartum depression or anxiety disorders. She also pointed out that most of the others simply provide new mothers with a brochure and a hotline number for postpartum support as they leave the hospital. Such a limited effort leaves the responsibility in the hands of the new mother, who may already be feeling anxious and depressed, to make extra effort to find help, and her unaware, uninformed family members.

A local certified nurse midwife reported that, in response to increased media coverage of the Smith case, she had received numerous phone calls from patients who had delivered babies in

the past year and were very concerned that they were still depressed. Social workers at local universities and childbirth educators at local hospitals began to develop plans for support groups for postpartum depression and to provide more information about the condition in every class for expectant parents. They expressed hope that such support and information would help new mothers to see the experiences of others and to recognize postpartum depression as a medical condition. They also expressed a strong dream that one day more of these kinds of classes would begin at an increased number of hospitals, with specific education about postpartum illnesses provided to medical doctors.

In addition, the American Academy of Family Physicians, among other professional associations, began recommending universal postpartum depression screening for all new mothers, acknowledging that few doctors used a standard protocol to screen patients for this condition.

Because of the media coverage, issues related to postpartum depression were now out in the open. The public was looking for answers about *why* these tragedies had happened and *what* could and/or should have been done to prevent them.

Some saw the issue of postpartum depression coming out into the open as a first step toward recognition and acknowledgment of the illness. Others, though, began to view postpartum depression as simply an excuse for destructive behavior, as in the case of the postpartum legal defense used in the case of the woman who drowned her children. Even those who took the issue seriously worried that over-use of postpartum depression as a criminal defense would quickly dilute efforts to promote recognition and treatment for the illness.

The media focus on postpartum depression brought out issues beyond those directly related to the Barbara Smith case: People started questioning if there was a way to determine who was at risk of developing postpartum depression, or worse, postpartum psychosis, as serious as Barbara Smith had experienced. And, if there were ways of screening for postpartum depression, who should be responsible for the assessment? And when? Was all of the responsibility on the victim to make someone aware of what was going on? Her family? Her physician? What about the stigmas associated with mental health treatment? Would they always prevent women from seeking help?

Questions also came out regarding insurance coverage for mental health issues. Several women's groups expressed concern that it had taken such tragedies to bring the issue of postpartum depression out into the open. They accused the medical profession of "soft-peddling" postpartum depression as a temporary condition, like the "baby blues", which many women may experience for a brief time after childbirth.

In short, the media exposure given to the Barbara Smith case asked more questions than it answered. And, after all of it, the basic question still remained in the public mind:

“Why didn’t SOMEbody do SOMEthing?”

June 27, 2001

U.S. Congressional Representative Davis reported that the Barbara Smith’s death had prompted him to introduce legislation in Congress that would provide more funding for research and treatment of postpartum depression. He stated that the bill would mandate more research by the National Institutes of Health (NIH) and the National Institute of Mental Health (NIMH).

His bill identified the following concerns related to postpartum depression and postpartum psychosis:

1. Postpartum mood changes affect over 400,000 women every year nationwide.
2. Despite years of research, the causes of postpartum depression remain complex and largely unknown. Current theories that focus on the effects of hormonal changes in the mother have little empirical basis, and no comprehensive psychosocial theories have emerged from existing research literature.
3. Milder forms of the condition, called “baby blues,” affect up to 80 percent of new mothers. More severe forms of the condition, including postpartum psychosis, affect 1 in 1,000 new mothers and can lead to the mother’s suicide and murder of her child or children.
4. Most victims of postpartum depression remain unaware of their condition and afraid to report symptoms to their healthcare providers. Factors that contribute to this lack of awareness and fear include: a) women’s inability to self-diagnose their condition, b) a general lack of knowledge and accurate information about postpartum depression and psychosis in the broader society, c) societal myths about motherhood, and d) continuing stigma regarding mental illness.
5. Postpartum depression is a treatable disorder if properly diagnosed by a trained healthcare provider and accompanied by a focused regimen of care.
6. No U.S. government institutions currently track the incidence, prevalence, and societal costs of leaving this disorder under-diagnosed and untreated. These costs include disruption of the infant’s physical and psychological development; child abuse, neglect, or death; and disruption of the family through substance abuse, divorce, loss of employment, and the mother’s self-destructive behavior and possible suicide.
7. No healthcare agency or organization currently ensures adequate awareness, training, and coordination of services among the various healthcare providers involved with mothers during the transition from pregnancy and childbirth to long-term adjustment to motherhood.

U.S Congressional Representative Richard Davis of the 1st District of Emerald City introduced

House Bill 2380, the Barbara Smith Postpartum Depression Research and Care Act. This bill called for the following:

1. Expansion and intensification of research and related activities of the National Institute of Mental Health to expand the understanding of the etiology and causes, frequency and natural history, differences in incidence among racial and ethnic groups, and cure for postpartum depression and postpartum psychosis;
2. Coordination of these activities with those similar activities conducted by other national research institutes and agencies of the National Institutes of Health;
3. Development of improved diagnostic techniques and clinical treatments;
4. Expansion of information and education programs for health professionals and the public;
5. Establishment of program grants to provide increased availability, effectiveness, and cost-efficiency of services to individuals with postpartum conditions - including outpatient and home-based health and support services, case management, screening and treatment, and family support/education services;
6. Integration of this new program with existing grant programs provided by the U.S. Secretary of Health and Human Services acting through the directors of the NIH and the NIMH;
7. Authorization of the appropriation of sums necessary to carry out these efforts in fiscal years 2002 through 2004.

Congressman Davis ultimately introduced this legislation in July 2001 and held a news conference at National Memorial Hospital and Medical Center in Emerald City to promote it publicly.

Diagnostic Perspectives on Postpartum Mood Disorders

Current diagnostic and treatment perspectives on postpartum mood disorders straddle the professions of general medicine and mental health. Medical researchers studying postpartum depression have tried to establish links between the symptoms of depressed mood and the sudden drop in mothers' hormone levels following delivery. At this point, no empirical evidence exists to support this perspective. Yet, inadequate funding, attention, and interest have prevented researchers from examining alternative explanations in more depth.

Researchers have identified three overlapping conditions within this category of illness. The mildest form, "baby blues," is considered a normal reaction to childbirth and affects the majority (up to 80 percent) of new mothers. This condition includes sluggishness, fatigue, exhaustion, sadness, depressed mood, hopelessness, appetite and sleep disturbances, poor concentration, memory loss, over-concern for or lack of interest in the baby, uncontrollable crying, irritability, guilt, feelings of inadequacy and worthlessness, fears of losing control or "going crazy", lack of interest in sex, and intrusive thoughts.

If these symptoms increase in severity and last longer than two weeks, professionals classify the condition as a more moderate form of postpartum depression. They then recommend a referral for a mental health screening, especially for those women who have a personal or family history of mental illness or have had a difficult pregnancy. This condition appears to affect between 10 and 30 percent of all women who give birth.

The most extreme form of this condition, postpartum psychosis, occurs in less than one percent of childbearing women. The severity of symptoms and potential for violent outcomes in this condition make it well-worth more intensive research, as illustrated by the cases in which mothers kill themselves and their children. Their typical symptoms include those of postpartum depression along with distortions of reality and thought, such as hallucinations and delusions, feelings of extreme agitation, severe insomnia and drastic departure from reality, increased risk of harming her child or herself and others.

Legal/Correctional Perspectives on Postpartum Depression

Postpartum depression comes to light as a legal or correctional issue only after a mother has taken the life of her child (children). In these situations, the child (children) is dead and the mother is arrested for murder and becomes involved in the criminal justice system. Until recently, issues related to postpartum depression had not been addressed in the courts or legal system, aside from those resulting from criminal action, such as murder. Legal professionals in Springfield County (one judge and two lawyers, two of which are state's attorneys) report never having a case resulting from postpartum depression. They also report never hearing about such cases argued by any of their colleagues.

In personal conversations, the lawyers reported that it would be difficult to argue a case of postpartum depression. They state that the lawyer would have to present an insanity defense. They further state that arguing an insanity defense is difficult: The defense attorney would have to prove that the client was insane at the time of the murder, and that insanity prevented the individual from determining right and wrong. Two such cases have been covered recently in the media. The legal system wrestled with this issue in each case.

Insanity was used as a defense in the 2001-2002 cases of both Jocelyn Marris, a mother accused of suffocating her four children, and Anne Morrow, a mother accused of drowning her four children. In each case, defense attorneys presented a picture of insanity and a history of depression. Prosecutors presented these individuals as calculating, methodical, planning and acting out the death of their children. In arguing the cases, both the defense attorney and the prosecutor presented experts in mental health. These were generally well known psychiatrists who could support their respective cases.

The area of medicine that has remained silent are the experts in women's health. Physicians in women's health might be able to add knowledge and understanding to cases of postpartum depression and its potential effects on women. In the end, legal/correctional decisions are left to the judge and the jury. Together, they must decide if a mother knew what she was doing and knew right from wrong or was insane and incapable of rational decision-making. In some of the most publicized cases, courts have found the mother to be guilty, even when postpartum depression was clearly present. The key determinant in these decisions was evidence that the mother knew what she was doing. The courts have found that jurors often respond with compassion toward the children who are now dead. The correctional response to women incarcerated for murder of their children related to depression has been to provide mental health services while incarcerated. If the courts find in favor of the mother, she is then remanded to a mental health facility. Mental health services are often provided before, during and after the trial. These women are placed in housing where they can be closely monitored and receive treatment.

Epilogue

1. Many local and regional hospital staff members started increasing the number of referrals for depressed new mothers to have mental health screenings and attend postpartum support groups.
2. Media publicity led to increased coverage of postpartum depression-related topics on numerous websites, including www.postpartum.net, <http://www.postpartum.net> a site developed by faculty and students at Indiana University of Pennsylvania, and www.ama-assn.org, (the American Medical Association).
3. Congressman Davis introduced the Barbara Smith Postpartum Depression Research and Care Act, (House Bill 2380) on June 27, 2002.

**POSTPARTUM DEPRESSION:
The Convergence of
Media Coverage and Community Activism
In Influencing Public Health Policy**

Teachers Guide

Consider the following questions for group or class discussion:

1. What are the implications in this study for the public health core functions of assessment? assurance? policy development?
2. What infrastructure is currently in place to provide assurance of proper diagnosis and/or treatment of postpartum depression? How does this case illustrate the need for a stronger Public Health infrastructure?
3. What types of data should be collected and maintained to monitor and assure that the issues related to postpartum depression are addressed adequately in the future?
4. Who (Public Health, Mental Health, or Primary Care Providers) should be responsible to collect/maintain data? What would ensure that this kind of collaboration becomes a priority?
5. What role does each of these professions play in using the data to assure adequate attention, prevention, and intervention in issues associated with postpartum depression?
6. What diagnostic tools should be used for screening? Who should select the diagnostic tools and ensure that providers use them properly and consistently?
7. Should all mothers be screened for postpartum depression? If so, who should perform the screenings and ensure that the results lead to proper treatment planning?
8. How could all medical care and mental health providers work together more effectively?
9. In the case of Barbara Smith, what warning signs could have been identified by her medical providers to predict or prevent her death? What signs could the family have identified?
10. What would increase the likelihood that families such as Barbara Smith's would know the warning signs and understand how to respond to them?
11. What different outcomes might have occurred in the case of Barbara Smith if all providers had communicated and worked together more closely?
12. What role(s) did/do media play in public health issues such as postpartum depression?
13. Which media roles are helpful? Which are harmful?
14. In this case, what impact did the media have on the current legislative act?
15. Discuss the role(s) of media and politics in developing public health policy.
16. How does media coverage of postpartum depression-related suicide and murder cases influence public opinions about mental health treatment versus retribution against the mother?
17. How does media coverage of court cases facilitate or inhibit efforts to involve more new mothers in postpartum depression screening and treatment?
18. Discuss whether or not and how the local public health department could have influenced the response(s) of the community to the problems associated with postpartum depression.
19. If the Barbara Smith Postpartum Depression Research and Care Act is passed in congress, what are the implications for the role of public health at all levels (national, state and local health departments)?