

# POSTPARTUM DISORDERS AND THE PSYCHIATRIC SUBJECT

by

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(Under the Direction of Celeste M. Condit)

## ABSTRACT

The presence of psychiatric discourse in the public vocabulary about mental illness during the postpartum period indicates that psychiatry, a controversial field of medicine, has a significant role in shaping public understanding of women during this period. In this project, my concern with psychiatric discourse about the period immediately following childbirth focuses on a particular subject: the patient. I contend that because psychiatric discourse about postpartum illnesses is currently in a state of crisis—i.e., psychiatrists are being pushed to recognize a disease that they cannot clearly diagnose—the image or representation of women with these diseases is also in flux. Through a rhetorical analysis of both psychiatric rhetoric and print and television news, this dissertation analyzes the articulation and rearticulation of the three subject positions for women during the postpartum period that emerge from psychiatric rhetoric: the vulnerable female, the patient, and the mother. These subject positions configure women's bodies, experiences, and relationships to others (particularly their children) in ways that are troubling, because they contain women within a biomedical paradigm—a paradigm solely focused on a biological understanding of human development—that limits broader social and cultural understandings of potential sources, implications, and solutions for postpartum disorders. The biomedical paradigm, however, becomes increasingly intertwined with a discourse of traditional motherhood in the rearticulation of the subject positions in print and television news. In this project I argue that it is precisely because distress during the postpartum period can be articulated as an antagonism that the position of mother becomes the space in which alternative visions of the postpartum subject can be articulated.

INDEX WORDS:     Feminism, Psychiatric Rhetoric, Postpartum Depression, Postpartum Psychosis, Articulation, Media

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## DEDICATION

To two special members of the Sooner Nation, Mom and Dad, with love.

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## CHAPTER ONE

### Postpartum Disorders and the Psychiatric Subject: An Introduction

In June of 2001, Andrea Yates murdered her five children, ages 6 months to 7 years, and was sentenced to life in prison in March 2002. Yates's actions went against cultural norms concerning motherhood; rather than protecting and nurturing her children, Yates felt the need to destroy them. Interestingly, Yates reported that by killing her children, she was actually saving them. Following directions from Satan, Yates reports that she drowned her children in an effort to save their souls (Spinelli, 2003, p. xvii). Yates's actions, while certainly garnering much media attention and public outcry, were (according to Yates's lawyers) symptomatic of a well-known mental illness: postpartum psychosis (O'Malley, 2004; Spinelli, 2003). The Yates case brings into sharp relief the problems on which this dissertation focuses. Specifically, the presence of psychiatric discourse in the public vocabulary about mental illness during the postpartum period indicates that psychiatry, a controversial field of medicine, has a significant role in shaping public understanding of women during this period.

In this project, my concern with psychiatric discourse about the period immediately following childbirth focuses on a particular subject: the patient. I contend that because psychiatric discourse about postpartum illnesses is currently in a state of crisis—i.e., psychiatrists are being pushed to recognize a disease that they cannot clearly diagnose—the image or representation of women with these diseases is also in flux. Through a rhetorical analysis of both psychiatric and popular mediated texts, this dissertation explores the various subject positions for women proposed by psychiatric discourse on the postpartum period. The



analysis will develop from a series of three related questions: What are the subject positions offered by psychiatric discourse in the psychiatric attempt to define and categorize the three stages of postpartum illness, the “baby blues,” postpartum depression, and postpartum psychosis?, How—through what strategies and modes of representation—are these identities then reflected and constructed in other fields of discourse?, and What are the implications of these representations for women and the current state of psychiatric research on postpartum depression? Ultimately, I view this project as an exploration in the current contests for meaning around the issue of postpartum disorders, with a focus specifically on the construction of female patients. The dissertation offers an analysis of subject positions for women through three case studies: psychiatric rhetoric, print news coverage of postpartum disorders, and television news coverage of postpartum disorders. Taken together, these case studies suggest that we cannot understand postpartum disorders as only medical phenomena. The subject positions that emerge draw from two complementary discourses: a biomedical discourse and a discourse of traditional motherhood. In the final chapter I present an alternative vision of the postpartum subject: the position of bio-social women.

How we understand any given disease affects how we understand those people with the disease; thus, the varied explanations of postpartum disorders create different identities, or subject positions, for women during the postpartum period (Gilman, 1988, p. 6). Mental disorders after childbirth constitute a complex and largely underdeveloped area of research in psychiatry. Although the numbers are not exact, researchers note that 20 to 40 percent of women experience depression or cognitive dysfunction during the immediate postpartum period (Sadock and Sadock, 2003, p. 870). Duffy (1983) reports that “of all psychiatric hospital admission for women, 6%-12% occur during the postpartum period” (as cited in Hostetter and Stowe, 2002, p.

133). Such numbers suggest that postpartum mental illnesses, while greatly varying in severity, are nonetheless frequent enough to pose a substantial health problem to women during the period following childbirth. The complexity of postpartum mental illnesses poses definitional problems to a host of researchers, including psychologists, obstetricians, and psychiatrists. If the medical conditions after childbirth are amorphous and not well understood by doctors or the public, what is undeniable is the importance of psychiatric discourse about postpartum illnesses in shaping the popular conceptions of postpartum illnesses. Indeed, postpartum self-help groups have actively advocated for medical definitions of postpartum illnesses, in part because of the felt need of women suffering from postpartum depression to have a recognizable and diagnosable disease (Taylor, 1996, p. 4). Further, psychiatric definitions of depression after childbirth are becoming more popular since the Yates case, as the recognition of postpartum psychosis as a disease would better enable the use of the insanity defense (see Connell, 2002).

In terms of postpartum depression and psychosis, Ingleby explains that “the ideology of work and motherhood, combines with the real stress of the situation to produce a clinical outcome instead of (Freud’s phrase) ‘ordinary unhappiness’” (Ingleby, 1983, p. 183). Such an understanding of disorders after childbirth as combining ideologies to produce a “clinical outcome” explicitly points to one of the main contentions of this project: that postpartum disorders are culturally constructed. I follow in a long line of scholars in a variety of disciplines (Ehrenreich and English, 1978; Szasz, 1974; Treichler, 1999) who contend that illness and disease are cultural constructions. Paula Treichler’s explanation of “cultural construction” in her search for theory in the AIDS epidemic is particularly relevant. She explains:

It [cultural construction] is a way of talking about how knowledge is produced and sustained within specific contexts, discourses, and cultural communities; it takes for

granted metaphor and other forms of linguistic representation; it presupposes that ideas are produced out of concrete contexts and have concrete effects; it takes for granted hermeneutical activity; it is a complex of ideas and operations sustained over time within a given community; hence, it is institutionalized. (1999, p. 173)

Treichler emphasizes both the rhetorical nature of disease and its materiality by recognizing that our understanding of the material reality of any given disease emerges from a scientific culture with its concomitant values and norms (p. 174). Susan Sontag describes this phenomenon in terms of illness as metaphor, and like Treichler, Sontag emphasizes the biological “reality” of disease: “My point is that illness is *not* a metaphor, and that the most truthful way of regarding illness—and the healthiest way of being ill—is one most purified of, most resistant to, metaphoric thinking” (1977, p. 3). Sontag’s desire to see illness discussed in non-metaphoric language is an impossible desire because diseases such as tuberculosis and cancer are “encumbered by the trappings of metaphor” (p. 5). The trappings of metaphor influence the very meaning of the disease, and this meaning travels out of the medical realm and into the social. Sontag explains, “Master illnesses like tuberculosis and cancer are more specifically polemical. They are used to propose new, critical standards of individual health, and to express a sense of dissatisfaction with society as such” (p. 72-73). As such, the metaphors of illness describe the illness and the patient, but also can be used to describe a society or social formations (see Black’s (1970/1999) discussion of the “cancer” metaphor during the Cold War). In terms of psychiatric illnesses, cultural construction is a particularly apt way of discussing what rhetoricians, or those scholars focused specifically on discursive processes, may interpret as the rhetorical invention of disease. I contend the psychiatric illnesses are born out of specific discursive structures, influenced by discourses of science, biology, capital, and gender, *and* as

such, illnesses emerge within specific “material” contexts and have specific “material” effects. By using the term “material,” I am not advocating a perspective that presumes a reality untouched by language. As I describe more fully below, my use of the term “discourse” includes both the linguistic and non-linguistic. Thus, my project recognizes that biological and physical “realities” impact our daily lives, but in a manner only meaningful through discourse. The disease—and our understanding of it—affects not only a patient’s body, but also her/his interactions with economic and political discourses.

Although psychiatric definitions of illness are most prevalent in psychiatric literature, such definitions appear in other fields of discourse as well. Thus, a theory of discursive movement is primary to this project as I contend that psychiatric rhetoric—specifically about the identities of women in the postpartum period—is influential in accounts of the postpartum period in both print and television news coverage. Briefly, I contend, like Derrida, that signs are iterable, that there is an “essential drift” that prevents any sign from being tied to one single context (1988, p. 9). When combined with Ernesto Laclau and Chantal Mouffe’s concept of articulation, I offer a theoretical stance that focuses on how articulations of subject positions in different discursive contexts differ.

This introduction to the larger project develops in two stages. First, I offer a literature review that will create a framework for understanding current contests for meaning about postpartum disorders, evaluate research on representations of mental illness and motherhood, and present the theoretical assumptions behind this project. Second, I will describe the methodologies to be used in this project and conclude by delineating the three sections of the dissertation focusing on psychiatric rhetoric, print news coverage of postpartum disorders, and television news coverage of postpartum disorders.

### *Postpartum Disorders: Contested Phenomena*

Literature on postpartum disorders cuts a wide swath through a variety of disciplines. The primary concern of most scholars is the categorization of causes of postpartum disorders and the search for the most effective treatment. Such literatures can be divided, roughly, into three overlapping areas: biological, psycho-social, and feminist. Before moving to a description of these three areas, I am going to briefly offer working medical definitions of the three significant postpartum disorders. As noted above, Sadock and Sadock report that anywhere between 20 to 40 percent of women suffer from some kind of emotional distress after childbirth, or during the postpartum period (2003, p. 870). However, the type, timing, and frequency of incidence of such emotional distress varies widely.

#### *Working Definitions of Postpartum Disorders*

The “baby blues” is widely regarded as the most common disorder, affecting anywhere between 50 and 80 percent (Martinez, Johnston-Robledo, Ulsh & Chrisler, 2000; Hostetter and Stowe, 2002) of new mothers. The baby blues are far more common than other postpartum disorders, and are often not included in general statistics (such as Sadock and Sadock’s 20 to 40%) of women suffering from postpartum disorders. The “baby blues” are characterized by “mild depression, irritability, confusion, mood instability, anxiety, headache, fatigue, and forgetfulness” (Hostetter and Stowe, 2002, p. 137) and are usually temporary. Such episodes occur anywhere within the first 10 days to the first two weeks after birth (Hostetter and Stowe, 2002, p. 137), but usually are transient and only last a few hours, a few days (Hostetter and Stowe, 2002, p. 137), or a few weeks (Miller, 2002, p. 762). For the purposes of this dissertation, I will use the term “baby blues” to refer to the transient mood changes that occur within the first two weeks of the postpartum period.

Postpartum depression affects fewer women, but is more severe. Miller reports that postpartum depression occurs in “approximately 10% to 20% of women in the United States within 6 months of delivery” (2002, p. 762). Hostetter and Stowe place the frequency at 7% to 17%, but suggest that the rates may be anywhere from 5% to 22% (2002, p. 138). The onset of postpartum depression also varies, from anywhere from the “first six weeks” to the “first year” after childbirth (Hostetter and Stowe, 2002, p. 138). Researchers differentiate postpartum depression from the “baby blues” by noting that postpartum depression is a “major depressive episode” (Hostetter and Stowe, 2002, p. 137; see also Miller, 2002; Lloyd and Hawe, 2003) that includes symptoms of “despondent mood, feelings of inadequacy as a parent, sleep and appetite disturbances, and impaired concentration” (Miller, 2002, p. 762; see also Gjerdengen, Froberg, & Fontaine, 1990). When used in the dissertation, postpartum depression refers to any non-transient major depressive episode that occurs within the first year after childbirth.

Finally, the postpartum disorder that has received much media attention but is actually quite rare is postpartum psychosis. Miller defines postpartum psychosis as “manifested by delusions, hallucinations, or both, occurring within the first 3 weeks of birth” (2002, p. 763). Postpartum psychosis is relatively rare, only occurring in 1 or 2 out of every 1,000 women who give birth (Hostetter and Stowe, 2002, p. 139). However, postpartum psychosis remains a serious problem. As Wisner, Gracious, Piontek, Peindl, and Perel report, “In the first 30 days after birth, a woman is 21.7 times more likely to develop psychosis than in the two-year period before birth” (2003, p. 36). Briefly, the working definition of postpartum psychosis refers to a psychotic episode with rapidity of onset, usually within the first 6 weeks after childbirth.

A useful term when discussing the baby blues, postpartum depression, and postpartum psychosis together is “postpartum disorders.” I use the term “postpartum period” to refer to the 2

year period after a childbirth in which rates of psychiatric admissions for women are significantly higher than before birth (Wisner et al., 2003, p. 37). Importantly, the first 90 days of the postpartum period are the most dangerous, as depressive and psychotic episodes seem to peak during this time (2003, p. 37). The definitions I have offered concerning postpartum disorders rely heavily on material from medical and psychiatric experts in the field. As the dissertation will focus on the contests for meaning within the psychiatric field, such definitions provide the appropriate starting point, though not an endpoint to understanding postpartum disorders. Indeed, while the symptoms of postpartum disorders go largely uncontested within all fields (see Nicolson, 2003; Miller, 2002; and Taylor, 1996), what differentiates the three areas—biological, psycho-social, and feminist—is the interpretation of why such symptoms occur.

*Biological Interpretations: The Medical Model*

Most frequently found in medical literature, biological interpretations of postpartum disorders seek to explain the incidence of the baby blues, postpartum depression, and postpartum psychosis by referencing a variety of biological functions. Martinez et al. explain, “The medical model posits biological variables such as hormones or neurotransmitters as the cause of postpartum mood disturbances” (2000, p. 39). Because the dissertation is in part a critique of this very discourse, this overview will be brief. Generally speaking, biological interpretations place emphasis on two ideas: first, that motherhood is a biological event, and second, that depression and psychosis are biologically grounded and can be treated with pharmaceutical drugs. A third area of emphasis I will discuss is the evolutionary perspective, which is also grounded in biology.

When motherhood is perceived as a biological event in reference to postpartum disorders, hormonal changes take center stage. As George and Sandler explain, “In theory, the search for

aetiological factors in puerperal mental illness should be a simple matter of systematically investigating the major hormones involved in pregnancy and correlating any postpartum changes with variation in mood and mentation” (1988, p. 78). Hormonal explanations of postpartum disorders are gaining wide acceptance by the medical industry. Sichel explains that hormonal changes during pregnancy can be drastic, as estrogen and progesterone levels reach their highest point in a woman’s life during pregnancy, and after the delivery of the placenta the levels drop almost immediately (2003, p. 72). Miller supports George and Sandler’s views, noting that the theory that mood changes are related to hormone withdrawal are supported by evidence indicating that changes in levels of estrogen and progesterone after delivery are related to a greater likelihood of developing postpartum depression (2002, p. 762). Studies have confirmed that treating women with estrogen injections during the immediate postpartum period can prevent the onset of postpartum disorders (Sichel, 2003, p. 73).

The second concept key to understanding the medical model is the biological definition of depression. O’Hara and Zekoski explain that research on the biology of postpartum depression is divided into two dominant views: “The first perspective views postpartum depression as sharing characteristics fundamental to depressions occurring at other times (‘non-specific biological factors’)....The second perspective is more concerned with the special features of postpartum mood disorders and potential hormonal dysfunction (‘specific biological factors’)” (1988, p. 37). Both perspectives look to biological processes to explain depression, the first to neurotransmitters and the second to hormonal changes due to pregnancy. The theory of depression based on neurotransmitters understands the brain as a system of “checks and balances” in which “[s]ome receptors have the ability to release the chemicals; some enhance absorption back into the cells, and others release enzymes, which break down neurotransmitters”



(Sichel, 2003, p. 67). The neurotransmitters in question are serotonin, norepinephrine, and dopamine, and during depression the medical model posits that receptors, or the regulators of chemical messages, are damaged or that such dysregulation resulted from one or more defective genes (Sichel, 2003, p. 65). When the faulty functioning of neurotransmitters is posited as the problem causing depression and other psychiatric disorders, the solution is drug therapy that “targets specific neurotransmitters and their receptors,” thus returning the brain to normal functioning (Sichel, 2003, p. 65).

Finally, the medical model occasionally enters into speculation about evolutionary processes that may cause postpartum disorders. Miller, for example, explains, “A second hypothesis is that postpartum blues stem from activation of a biological system underlying mammalian mother-infant attachment behavior” (2002, p. 762). Hrdy expands on this position, noting that if such hormonal changes developed to ensure mother-infant proximity, postpartum depression could be interpreted as a “response to modern procedures that interfere with her following this natural mammalian program of mother-infant proximity” (1999, p. 171). In addition to the mood swings associated with the baby blues promoting mother-infant attachment, scholars suggest that some postpartum disorders are adaptations. Hagen argues that the negative affect associated with postpartum depression could be a response to “social circumstances that were reproductively costly in ancestral environments,” and that major depressive episodes may actually function help the mother garner more social support from her community (2002, p. 326). In the latter case, depression can be seen as a “bargaining chip” which mothers play in an effort to increase the parental investment of their spouses (2002, p. 325). Because evolutionary biologists are primarily concerned with adaptive behaviors over time, their interpretations of postpartum disorders offer no easy cure such as treatment with pharmaceutical drugs.

Evolutionary biology continues to place emphasis on the biological functions of motherhood, but in such a way that “biology” includes both physiological and social/cultural processes.

The dominant voices offering a biological perspective are those in the medical industry positing that hormonal changes and neurotransmitter malfunction are responsible for postpartum disorders (Martinez et al., 2000, p. 39). However, it would be false to assert that such perspectives pay no heed to social and cultural processes. Psychiatric literature recognizes that a variety of social factors such as unwanted or unplanned pregnancies, lack of social support, and infant medical problems predispose women to have postpartum disorders (Hostetter and Stowe, 2002, p. 138). The psycho-social model, advocated by sociologists, psychologists, and anthropologists, places social and cultural factors at the center of discussions about postpartum disorders.

*Psycho-Social Interpretations: The Social-Scientific Model*

Key to understanding psycho-social interpretations of postpartum disorders is the view that childbirth is linked to a variety of changes and disruptions in family and work environments (Graham et al., 2002, p. 222). Such changes require that women change their relationships with their significant others, family members, and friends, and adapt to their role as primary caretaker of an infant (O’Hara, Stuart, Gorman, & Wenzel, 2000, p. 1039). Women’s responses—defined by the medical vocabulary as depression or psychoses—to their changing environment may be the result of biological factors such as hormonal changes, but “stressful life events” play a key role in understanding who is at risk for postpartum disorders and why. In other words, researchers using the psycho-social perspective see postpartum disorders as an opportunity to study the relationship of social and biological factors in the development of mental illness (Nicolson, 1998, p. 32). Michael O’Hara contends that the “literature is relatively consistent in

suggesting that there is a clear link between negative life events, which occur during pregnancy or the early postpartum period, and postpartum depression” (1995, p. 35). Two themes appear in the social-scientific model: first, scholars contend that childbirth is related to role changes and the destabilization of identity, and second, researchers offer a variety of social and cultural (not biological) risk factors associated with postpartum disorders.

Because of the vast numbers of physical and social changes a woman experiences after childbirth, a woman’s identity is necessarily in flux. Take, for example, Mauthner’s case study of Sonya, a woman experiencing postpartum depression. Sonya’s words are particularly insightful:

Because it’s my more natural personality to have part work, part Suzie [her newborn] but I kept thinking, “No, if I’m going to do this mother thing properly, I’m going to be at home, I’m going to watch *Neighbors* [soap opera], I’m going to make jam and I’m going to the local play groups.” What I did was again sort of sweep the business woman under the carpet and say, “Ah, I’m this now”....I was intent on this is my big sacrifice, this is me changing my life style for the good of Suzie and pushing my own needs to the bottom of the bag...” (Mauthner, 2003, p. 96)

Sonya’s decision to enact the identity of mother by sacrificing her identity as business woman created a stressful situation in which she, according to Mauthner, denied the person that she actually was (2003, p. 96). Sonya’s story points to the ways in which women juggle often conflicting roles during the postpartum period, from wife, mother, working woman, to friend, lover, and neighbor. Paula Nicolson, a psychologist whose work I will discuss thoroughly in the section on feminist perspectives, argues that such role changes can be understood through a paradigm of loss. Through interviews with women suffering from postpartum disorders,

Nicolson suggests four primary areas of loss: loss of autonomy and time, loss of appearance, loss of femininity and sexuality, and loss of occupational identity (2003).

In addition to identity changes, the postpartum period is full of risk factors that may increase women's chance of developing a postpartum disorder. As Nicolson notes, "It is also evident that socially isolated women from low socioeconomic status backgrounds, who live in poor housing and having marital difficulties, are more likely to experience depression at this stage of their lives than women who have good social support networks and who come from affluent backgrounds" (2003, p. 115). Social support has emerged as an important variable, as researchers have studied the ways in which social support has a moderating effect on stressful life events such as having a child (Hopkins, Marcus, & Campbell, 1984, p. 509). Both general and specific types of social support have been identified. Blumfield describes the importance of generalized social support, noting that in past centuries the stress associated with the arrival of a new baby was lessened by networks of female relatives ready to support and help the new mother (1992, p. 41). The network of relatives and family friends that help care for a woman and her child during the postpartum period have a positive effect on the woman's mental and physical health (Hopkins et al., 1984).

On a more specific level, women who have low social support from their relational partners (most often defined in this literature as "spouses" or "husbands") are also at an increased risk for postpartum disorders. Hopkins et al. report, "The presence of a supportive relationship with the husband seems to be particularly crucial for mothers with young infants who, because they may be housebound and drained by the demands of child care, may have difficulty obtaining adequate support from other network members" (1984, p. 510). On a related note, a woman's marital satisfaction is also a factor in her likeliness to develop postpartum

disorders. O'Hara (1995) reports that marital dissatisfaction may “interfere with a woman’s ability to care for her child” and lead to an increased risk of depression after childbirth (p. 35).

The emphasis on psychological and cultural factors in the development of postpartum disorders suggests a range of treatments and preventative measures. The social-scientific model advocates both the use of antidepressant pharmaceuticals and interpersonal therapy to alleviate symptoms (O'Hara et al., 2000, p. 1039). In an effort to prevent the occurrence of postpartum disorders, researchers suggest such methods as group interventions and new models of community-based postnatal care. Zlotnick, Johnson, Miller, Pearlstein, and Howard’s study on group intervention found that a four-session postpartum group intervention prevented the occurrence of major depression during the first three months of the postpartum period (2001, p. 639). MacArthur, Winter, Bick, Knowles, Lifford, & Henderson, et al. report that reshaping post-natal care to include frequent visits by midwives is associated with positive psychological health outcomes in women, although the physical health measures of women receiving the new community care and the previous model did not differ (2002, p. 383). The psycho-social and biological interpretations of postpartum disorders are the most dominant (Martinez et al., 2000, p. 39), but they are both limited by their lack of critical discussions of the cultural contexts in which postpartum disorders emerge. This critical perspective is offered by feminist scholars, who view postpartum disorders as developing in the context of patriarchal understandings of womanhood and motherhood.

#### *Feminist Perspectives: The Woman-Centered Model*

In a metasynthesis of qualitative research on postpartum disorders drawing from research in nursing, women’s studies, and psychology journals, Cheryl Beck points to four “perspectives” on postpartum depression: the incongruity between expectation and reality of motherhood, a

tendency of “spiraling downward,” making gains toward recovery, and reintegration and change (2002). Of these four perspectives, it is focus on motherhood—specifically, the cultural construction of motherhood as a “joyous” event—that receives the most attention from feminist scholars (see Nicolson, 1999; Mauthner, 2003). Feminist research on the construction of motherhood and postpartum disorders rests upon an assumption of patriarchal/male bias of medical and social-scientific research. In this section I will discuss the feminist perception of bias in the medical literature, and then move to an account of feminist perspectives on motherhood.

Briefly, the woman-centered model of postpartum disorders suggests that medical science is *not* woman-centered, but rather man-centered. Nicolson and Ussher explain, “More specifically the recent history of health care practice, particularly in relation to the development of medical and ancillary professions, has disadvantaged women in two ways: by excluding or undermining them as professionals and by relegating their self-identified needs to those that patriarchal institutions deem important” (1992, p. 2). The medicalization of childbirth (from a natural process to a technical activity), the pathologization of menstruation, and medicalization of menopause are all examples of the power of “patriarchal” medical definitions in women’s lives 1992, p. 2). Ussher’s interpretation of current understandings of postpartum depression as a medical syndrome are particularly revealing: “Pregnancy, childbirth, and the postnatal period have been pathologised in the same (convenient) way [as premenstrual syndrome], positioning women’s experiences as an illness in need of intervention, and interpreting any distress or unhappiness as individual pathology” (1992, p. 47). The intervention of the medical establishment into women’s lives is one that “places the female body” at the center of discourses that control and define women (Ussher, 1992, p. 31).

In terms of postpartum disorders, the masculinist bias of the medical industry has led to a misinterpretation of some of the key issues. First, while feminist scholars agree that the postpartum period includes intense identity and physical adjustment to drastically changed circumstances, they posit that not only is depression not a pathological reaction to these adjustments, but that any variety of interpretations may be found to explain the emotional highs and lows of the postpartum period. Nicolson (as discussed above) suggests that postpartum depression be interpreted as a reaction to loss. She explains, "Such critical changes in the life course, which demand psychological and physical adjustment to loss (e.g. dying, divorce, bereavement) have been recognized as periods of emotional lability, throughout which grief needs to be expressed and explored therapeutically in order to progress to a subsequent period of stability" (1990, p. 693). Hopkins, Campbell, and Marcus substantiate this view by noting that the line between the pathological "postpartum depression" and the normal period of "postpartum adjustment" is indistinct, as both have a similar set of symptoms, including appetite changes, sleep disturbances, and loss of sexual interest (1989, p. 251). Finally, Graham, Lobel, & DeLuca contend that because "the typical woman presented in psychological literature has a restricted range of responses to negative experiences," responses that all tend to be depressive in nature, research on the postpartum period has overlooked an important emotion: anger (2002, p. 222). Anger is defined as an "automatic reaction to aversive situations (Berkowitz, 1990), which may occur in response to the pain, exhaustion, and discomfort common to delivery and the postpartum period" (2002, p. 223). At six weeks postpartum, 35% of the women in their study reported high to moderate feelings of anger, contrasting with only 11% exhibiting similar levels of depression (2002, p. 229). As such, anger may play an important role in a woman's adjustment period after childbirth, but this more threatening emotion has been completely

understudied. All three of these studies point to the ways in which a masculinist bias prevents some interpretations of the postpartum period from entering into the medical and social-scientific discourse.

Feminist critiques of the research on the postpartum period often focus on the construction of motherhood. Rather than pointing to hormonal or neurochemical changes in the body, Ussher asks, “For is it not the actual fact of caring for a child, the isolation of motherhood, the change in identity, the realisation of the mismatch between the myth and the reality of motherhood which can lead to depression?” (1992, p. 50). This “mismatch” is key to understanding why women react the way they do during the postpartum period. Nicolson supports this view, arguing that the continued belief in a “maternal instinct” by both medical professionals and the lay population creates the expectation that motherhood is a universally happy event in women’s lives (1990, p. 694). Nicolson explains, “It [the theory of maternal instinct] is authoritative because it explains the ‘natural order,’ offering ‘truth’ (Boyle 1998) and clearly underlies political, clinical, and research agendas relating to childbirth, motherhood, fertility, contraception, and abortion and debates on the ‘nature’ of femininity (Nicolson 1995; Showalter 1996)” (Nicolson, 1999, p. 162). Such a theory suggests that normal behavior for women includes the desire to be mothers and concomitantly suggests that women as mothers naturally behave and feel in certain ways (see Nicolson, 1998, p. 14). Feminist scholars have critiqued motherhood as an institution, noting that expectations for women to take on the self-sacrificing role of mother as part of their natural duty as women constrains them to a “low-status” occupation in patriarchal societies (p. 19). Thus, as Nicolson suggests, although motherhood is often lauded as “the most important job in the world,” the everyday duties of motherhood—changing diapers, cleaning, and caring for others—as well as the psychology of



motherhood—the focus on others, not the self—are consistently “treated with a degree of disdain” (p. 19).

With this critique of the institution of motherhood in mind, Nicolson and others (see Ussher, 1992; Mauthner, 2003) present an understanding of postpartum disorders that suggests that part of the problem of the postpartum period is precisely the way the period is constructed. Rather than experiencing bountiful happiness, women experience exhaustion, anxiety, and anger. In an effort to live up to expectations of “good” motherhood, women deny their own identities as individuals (Mauthner, 2003). Nicolson concludes:

Depression thus is a potentially adaptive behaviour—it reflects the problematic context of mother/parenting brought about by the specifically patriarchal, capitalist systems of the USA and Western Europe. Women are depressed after motherhood because they lose power, choice, and autonomy. They become “woman” and/or “mother” once they have had a baby—an amorphous social construction that robs them of their identity (including that which relates to their specific views and choices about the conditions in which they would choose to mother) and economic and social independence. (1999, p. 178)

The de-pathologizing of depression in the context of motherhood by feminists implies that depression in such a context is a normal, if not always occurring, event. By this definition, the solutions for women with postpartum disorders lie in both women’s ability to adjust to their difficult situations *and* our ability, as a society, to reconstruct motherhood in more “realistic” and less patriarchal fashion.

#### *Discussion: Overlapping Models and Contested Meanings*

Paula Nicolson’s frustration with social-scientific work on postpartum disorders stems not only from her feminist/woman-centered perspective, but also from her recognition that

scholarship on postpartum disorders lacks unity, and as such, the range of disorders that can occur after a woman gives birth are still ill defined. In a 1990 article Nicolson noted, “Research on postnatal depression is inconclusive and characterized by four issues. These are the variety of its form, its temporal location, the incidence of the problem, and whether it is specifically linked to childbirth itself” (Nicolson, 1988, 1989a)” (1990, p. 689). As my review of the three dominant models concerning postpartum disorders and the working definitions I offered at the beginning of this section indicate, postpartum disorders remain a contested subject. These contests for meaning, involving a variety of competing interest groups—scientists, psychiatrists, obstetricians, feminists, patients, and patients’ families—form the “texts” for analysis in this dissertation.

In this sense, I follow Paula Treichler’s understanding of disease epidemics as not only epidemics of an infectious disease, but as “semantic epidemic[s]” in which diseases are invested with an abundance of meanings and metaphors (1999, p. 1). My concern with the “epidemic of signification” surrounding postpartum disorders suggests that understanding how such disorders emerge discursively is as important as the biological reality of postpartum disorders. Given the emphasis in this project on understanding how definitions of postpartum disorders are “culturally constructed,” I turn to a review of the literature in communication and cultural studies on similar subjects: namely, literature that discusses motherhood and mental illness.

### *Motherhood and Mental Illness: Mediated Representations and Social Movements*

Postpartum disorders are understudied in communication and cultural studies, but related issues, namely motherhood and mental illness, have received more attention. There are at least three areas of criticism on which this dissertation will draw: 1) the mediated representation of mothers who kill, 2) the mediated representation of mental illness, and 3) the postpartum

depression self-help movement. I will discuss each area in turn, although I should note that the areas frequently overlap.

Two studies of infanticide, Hasian and Flores's "Mass Mediated Representations of the Susan Smith Trial" and Nicholas A. Thomas's "The Political Imprisonment of Andrea Yates: Agency Calculus and Discursive Determinism," suggest that both psychiatric and legal discourse have powerful roles in the production of women's identities. Although Susan Smith was not suffering from postpartum disorders, her mental health was a key issue in her trial for drowning her two sons in a South Carolina lake. Hasian and Flores explain, "Eschewing theological explanations that centered on her sins, many sympathetic critics looked for scientific, historical, and cultural explanations for Susan Smith's behavior" (2000, p. 171). Such explanations focused on Smith's history of mental distress, including her father's suicide, her own suicide attempts, and the molestation of Smith by her stepfather (2000, p. 171). Hasian and Flores argue that the key to understanding the representations of Smith revolve around a single issue—motherhood—and the psychiatric and legal discourses—presumably objective—through which Smith's status as good or bad mother was interpreted (2000).

As the feminist perspective of postpartum disorders suggests, discourses of motherhood are central to understanding representations of women who do not "love" their children in the manner expected by society. Hasian and Flores's essay points to the intersection of discourses about motherhood with psychiatric and legal discourses, a theme that will also emerge in the dissertation. Hasian and Flores reach a conclusion that is remarkably similar to Thomas's work on Andrea Yates: "It is our contention that this was not simply a case about the criminal guilt or innocence about any particular victim—this was also a drama about social control and the need to make sure that we continue to see the difference between 'good' and 'bad' mothers" (2000, p.

173). Such a drama was repeated in the Andrea Yates case, in which Yates's position as mother and her deteriorating mental health served as the dominant themes of the media coverage.

Thomas's analysis moves the critique of the power of discourses about motherhood a step further by suggesting that Yates was a political prisoner because her destructive acts as a mother could disrupt the social order. Thomas explains, "Patriarchal institutions seek to avoid being implicated as potential causes or contributors of women's experiences of mental illness: if Andrea Yates' mental health and her actions could be squared with the conditions of her life in a domestic sphere, the political results could be extraordinary, unmasking the continuing subordination of women who 'choose' to be homemakers and mothers" (2004, p. 1). This analysis suggests that in the contests for meaning around postpartum disorders, certain guiding assumptions about motherhood dominate the discourse to the extent that acts that threaten the patriarchal definitions of motherhood threaten the entire social order.

I largely agree with Hasian and Flores and Thomas's interpretations of the Susan Smith and Andrea Yates cases, as both studies recognize the importance of discourses of motherhood and mental health to the public interpretation of their situations. Further, both point (albeit obliquely) to the ways in which Smith's and Yates's identities were constructed through these discourses. My dissertation is precisely a continuation, or expansion, of this point: namely, that psychiatric discourse about postpartum depression presents women with various (often restraining) subject positions. This point is reiterated by studies on the mediated representations of mental illness that suggest that the identities of people defined as mentally ill are constructed by the media in a largely negative fashion.

In mediated representations of the mentally ill, professional psychiatric discourse is combined with media practices such as sensationalism to construct biographies of the mentally

ill that focus on violent and sexualized identities (Wearing, 1993). Wearing argues that journalists and psychiatrists have the ability to define the mentally ill—their habits, emotions, and rights—for public consumption (1993, p. 96). Blood, Putnis, and Pirkis suggest that media constructions of mental illness not only represent mentally ill people as violent, but also equate mental illness with violence. Framing emerges as a key term in both articles, as it is through an understanding of how “media professionals ‘package’ information for audience reception” through thematic frames that the focus on violence in media coverage of mental illness develops (2002, p. 61). Although media professionals use a variety of frames for mental illness—“the bizarre and curious, medical and scientific marvels, moral tales, disorder, crisis and risk (especially depicting the mentally ill as dangerous to ‘others’), and lay wisdoms and commonsense strategies”—Blood et al. focus on violence as a prominent frame (2002, p. 63). Perhaps because of the old news adage, “if it bleeds, it leads,” stories of mentally ill people often focus on the violence they have done or could possibly do to themselves or others. As the most prominent news frame, “violence” in the coverage of the mentally ill continuously associates people with mental illnesses with violent acts, an association that is not representative of the mentally ill population (2002, p. 77). Given that media coverage of postpartum disorders has focused on the Yates case and other cases in which women hurt themselves or their children, Blood et al.’s recognition of violence as one of the dominating frames in media representations of mental illness is significant.

I have presented two studies of depictions of mental illness in the media, and I believe that they are representative. That is, through these two pieces we see the themes that occur in other pieces (see Reed, 2002; Signorielli, 1989): the importance of “expert” discourse in the news, the ways in which news frames develop specific understandings of mental illness, the

emphasis on hyper-sexuality and violence, and finally the construction of restraining identities for mentally ill individuals. News coverage of the mentally ill—ranging from stories on their violent acts, their health-care options, and their legal situations—does not differ in the case of women with postpartum disorders. As my own study of news coverage of postpartum depression and psychosis should indicate, representations of women with postpartum disorders emphasize the danger such women pose to themselves and society. Previous studies of media representations of mental illness in general support an important contention of this project: namely, that such representations have a broad impact, not only defining the people with the disease, but also suggesting policies and social standards for dealing with such people (Wearing, 1993). However, the focus on general disorders as represented by the media leaves out an important facet in understanding how women with postpartum disorders may be represented. Specifically, because the subject at hand is *women*, one should expect, as both Hasian and Flores and Thomas point out, that the gendered nature of their acts will receive attention.

There is a paucity of studies on the representations of postpartum disorders in the media. Martinez et al. explained in 2000, “No studies of the popular press coverage of postpartum depression or the baby blues have yet been published” (2000, p. 41). With the exception of Martinez et al.’s study, this statement remains accurate today. In part because of the lack of research on postpartum disorders and the media, Martinez et al. set out to answer several relatively straightforward questions: “whether magazines do cover this topic, whether the information they present is an accurate reflection of the research to date, how postpartum depression and the baby blues are defined and differentiated from each other and other forms of depression, which models of postpartum affective disorders are most likely to be presented, and what types of advice new mothers are offered” (2000, p. 41). Using content analysis, Martinez

et al. point to two issues that are relevant to my project. First, they note that the definitions of postpartum depression and the baby blues vary widely. The time frames in which depression occurs, the prevalence of postpartum depression in the general population, and the symptoms of the disorder varied, suggesting that a coherent definition for postpartum depression is not yet being offered by the media (2000, pp. 42-43). Second, using a framework similar to the biomedical-social scientific-feminist framework that I suggest above, Martinez et al. report that biomedical explanations of postpartum depression were mentioned most frequently; however, such explanations often coexisted with social, psychological, and feminist explanations (2000, p. 43).

Importantly, the Martinez et al. study supports theories offered by more general coverage of mental illness in the media studies. They report, for instance, “Articles that build stories around images of postpartum women as murderers may lead readers to believe that only ‘crazy’ women experience postpartum blues and irritability or cause readers to link PPD and the baby blues to infanticide rather than to feelings of loss and anger” (2000, p. 52). The lack of precision among the definitions of the baby blues, postpartum depression, and postpartum psychosis is problematic in that readers cannot distinguish between the three disorders, or, for that matter, between feelings that are normal and those that deserve psychiatric attention (2000, p. 52). Again, definitional problems take center stage, and this is not an issue only for mediated discourse about postpartum disorders. As Reed explains, science journalism has long been critiqued—particularly by the scientific community—for not only using frameworks that emphasize “doom and disaster, miracle cures, and fixation on machinery,” but also for not accurately representing scientific knowledge (2002, p. 44-45). Accurate representation of postpartum disorders, however, is complicated by the continuing contests for meaning among

experts—psychiatrists, psychologists, sociologists, anthropologists, and feminist scholars generally—who put forward very different definitions of postpartum disorders.

Martinez et al. provide an excellent framework for understanding how postpartum disorders are represented by the media, but their study only briefly touches on what seems to be an important area of discourse informing such coverage—conventional/dominant understandings of womanhood and motherhood. Such discourse is the focus of Verta Taylor’s book length study of the postpartum depression self-help movement, *Rock-a-by Baby: Feminism, Self-Help, and Postpartum Depression*. Taylor’s work describes the process of creating and sustaining a gendered social movement, one in which “American women are in the process of transforming their deviant emotions following the birth of a child into a collective challenge to the meaning of motherhood” (1996, p. 164). In the postpartum depression self-help movement, like other social movements, gender operates in a paradoxical fashion. Gender is used as a “mobilizing framework” which reinforces the categories that configure women’s subordination, and yet at the same time “gender distinctions, once in force, can also have the opposite effect by serving as a basis for resisting social control” (1996, p. 171). Although Taylor’s ultimate purpose is offering a theory of gendered social movements, because she uses postpartum depression as a case study, her book stands out as one of the only critical scholarly evaluations of discourse about postpartum depression. Taylor offers two insights that have helped shape my project: a reason for the importance of psychiatric explanations of postpartum depression and the reinforcement of the importance of gender and understandings of motherhood when discussing postpartum disorders.

In setting out one of her research questions, Taylor asks, “How and why are women searching for medical and psychiatric solutions for a set of problems that are so clearly



connected to broad social and collective processes altering the practice and meaning of motherhood in contemporary society?” (1996, p. 21). That women with postpartum disorders, their families, and their support networks are the “main force” behind the national campaign to raise awareness of postpartum disorders as psychiatric phenomena is particularly interesting given the historical feminist resistance to the medicalization of women’s health issues such as menopause and childbirth (Taylor, p. 4, see also Ehrenreich and English, 1978). Taylor explains that historically men and the medical industry more generally have been responsible for the medicalization of women’s lives; however, in this particular case such medicalization is encouraged and advocated by women themselves (1996, p. 4, 57). Such promotion by women of the medicalization of reproductive activities is not an infrequent occurrence (for example, abortion and premenstrual syndrome), but the power differential between medical experts and women suggests that the medical definitions of women’s issues may not always fall in women’s favor.

Taylor paints a complex picture of the relationship between women and psychiatric discourse on postpartum depression. Specifically, she argues that because psychiatrists did not recognize postpartum depression as a valid disorder until the 1994 edition of the *Diagnostic and Statistical Manual*, women had a large amount of control over how such a disorder was defined. She suggests through “self-labeling theory” that “the key to understanding women’s willingness to embrace psychiatric conceptions of their problems is in recognizing that new mothers make assessments of their own feelings and symptoms of distress based on their ideas about how mothers ought to feel” (1996, p. 34). Thus, mothers, in Taylor’s view, are as much responsible for our understandings of postpartum disorders as the psychiatric industry. Although I do not completely disagree with this view, I contend that Taylor’s equalization of the power held by

women and the psychiatric industry may be dated. Taylor may be correct in asserting that ongoing critiques of the medical validity of psychiatry have weakened psychiatry's "stronghold" on mental illness, but I contend that since 1996, the year in which Taylor's book was published, psychiatry, through biomedical discourse, has played a large and influential role in directing the meaning of postpartum disorders in part because of the current visibility of postpartum psychosis. In other words, I do not deny that women have played an important role in defining postpartum disorders, but at the same time I do not want to dismiss or underestimate the importance and the power of psychiatric discourse in defining and shaping women's lives.

Taylor's second emphasis, the idea that constructions of motherhood plays an important role in how women, psychiatrists, and society more generally understand postpartum disorders, is one with which I fully agree. Importantly, Taylor's work focuses—through interviews with women suffering from postpartum depression—on women's expectations of motherhood and their feelings of distress, anxiety, and anger when those expectations are not met (1996, pp. 24-58). Taylor's work is particularly valuable because of the emphasis she places on the female patient's position in and among multiple discourses about postpartum disorders. Among these, psychiatric definitions of postpartum disorders and dominant cultural understandings of motherhood play a central role in situating our understanding of women with postpartum disorders. She recognizes, like Martinez et al. and Nicolson and Ussher, that postpartum disorders are contested, and that this contestation crosses multiple fields, from the psychiatric literature, mediated representations of women with postpartum disorders, to popular self-help literature.

Taken together, this review of the literature concerning postpartum disorders, mental health, and motherhood leads to three conclusions. First, the few studies that have been

published about the mediated representation of infanticide and/or postpartum disorders suggest that concepts of mental illness and motherhood intersect in discourse about women with postpartum disorders. Second, such representations are often negative, portraying women and the mentally ill more generally as violent people who violate cultural norms. Finally, as Taylor suggests, the relationship between women and psychiatric diagnosis is complicated in the case of postpartum depression by the fact that women have played a large role in constructing the meaning of postpartum depression. This project takes these conclusions and moves them in a new direction by focusing in on psychiatric rhetoric and its construction of the female patient. A rhetorical understanding of how such a construction of the patient develops and circulates is fundamental to this project. In the next section, I turn to a review of the theoretical literature that suggests that language is essential to our understanding of reality.

### *Rhetoric and Reality: Articulation and Circulation*

Rhetoric is often described in introductory public speaking texts as simply persuasive discourse, but historically the meaning of rhetoric has been contested. Condit and Lucaites suggest that an appropriate question to ask is not “What is rhetoric?,” but rather, “What can a rhetoric be?” (1993, p. 19). This section will attempt to answer what rhetoric can be in the general context of the public understanding of medicine. Key here is the idea that rhetoric—whether through language, images, or other signs—constructs our understanding of reality. This does not deny that a material reality exists, but rather that our understandings of “reality” are rhetorically constructed. Brummet’s discussion of rhetoric is relevant:

Humans are necessarily involved in sharing and manipulating messages to give and gain meanings about experience. But what experience means is not by any means agreed upon. This ambiguity is a feature of the essentially rhetorical nature of reality.

Ambiguity generates conflict and disagreement about meaning and a constant striving to resolve these divisions. This striving is rhetoric; while rhetoric may be defined in many ways and on many levels, it is in the deepest and most fundamental sense the *advocacy of realities.*” (1999, p. 160)

Thus, reality does not exist in the objective sense, but rather reality is (to use Brummet’s concept) intersubjective. Brummet’s general concept of reality as a rhetorical phenomenon is shared by many scholars, and is not entirely unlike Burke’s point that humans are “symbol using” animals. Take, for example, Burke’s discussion of symbolicity, “And however important to us is the tiny sliver of reality each of us has experienced firsthand, the whole overall ‘picture’ is but a construct of our symbol systems” (1966, p. 5). This project proposes that rhetoric is essential to our understanding of reality precisely because it is through rhetoric that we come to the reality that we know. Moving forward with this position, I contend that it is also through rhetoric/discourse that we come to know and understand ourselves. In other words, rhetoric constructs not only our understanding of the reality around us, but also our understanding of who we are both as a community and as individuals.

The literature on rhetoric as constitutive points to the ways in which rhetoric constitutes identities for communities. McGee, for example, argues, “‘The people,’ therefore, are not objectively real in the sense that they exist as a collective entity in nature; rather, they are a fiction dreamed up by an advocate and infused with an artificial, rhetorical reality by the agreement of an audience to participate in a collective fantasy” (1999, p. 343). McGee does not deny that “people” exist, but rather that as a community, “the people” are constructed through rhetorical acts that involve both the speaker and the audience in the creation of a united group. Charland’s study of the *peuple quebecois* also supports this point. Charland explains, “From

such a perspective, we cannot accept the ‘givenness’ of ‘audience,’ ‘person,’ or ‘subject,’ but must consider their textuality, their very constitution in rhetoric as a structured articulation of signs. We must, in other words, consider the textual nature of social being” (1987, p. 137).

Both authors point to how communities are rhetorically constituted, and within each community individual identities are discursive as well.

Because this project is ultimately concerned with the identities of patients that are rhetorically constructed through both psychiatric and popular rhetorical texts, I have a concern with the political subject and how such subjects come to be. As Butler (1999) and Biesecker (1992) suggest, individuals exist within a discursive web that informs the creation of various subject positions. As such, no subject exists outside of discourse. Butler explains, “For this ‘I’ that you read is in part a consequence of the grammar that governs the availability of persons in language. I am not outside the language that structures me, but neither am I determined by the language that makes this ‘I’ possible” (1999, p. xxiv). Such an understanding of the subject emphasizes two key concepts: first, that all subject positions are the “products” of discourse and therefore are never stable or unified, and second, that any practice of resistance must occur in relation to these discursive structures. Biesecker explains, “‘resistance’ finds its conditions of existence in those virtual breaks or structures of excess opened up by practices performed within the already established lines of making sense that constitute the social weave or social apparatus” (1992, p. 357). This understanding of the subject offers a limited understanding of agency, one that notes that no “agent” has “agency” outside of a particular web of discursivity. As this project will demonstrate, medical discourse plays an important role in offering certain subject positions to women during the postpartum period. In sum, my position on rhetoric is that rhetoric and language more generally inform our understandings of reality, both of the outside

world and of ourselves. This basic understanding will inform the following literature review of the two most important theoretical content areas from which my project will draw: theories of the rhetorical construction of disease and the diseased and theories of discursive movement.

*Constructing Mental Illness and the Psychiatric Patient*

I understand postpartum disorders to be cultural constructions. In the vocabulary of rhetorical studies, what I mean by this is that postpartum disorders are rhetorically constituted, and thus the meaning of postpartum disorders comes not from the specific biological or cultural events that the biomedical and psycho-social perspectives see as contributing factors to postpartum disorders, but rather from the cultural meanings of such factors—hormonal imbalances, lack of social support, etc.—which are produced through various fields of discourse. The theory of mental illness as culturally constructed used in this project has two main contentions: first, that within the field of psychiatry, illnesses are created within a particular context that privileges biomedical psychiatric discourse, and second, that such constructions circulate in such a fashion as to offer plural and often contradictory meanings to a single phenomenon. This section of the literature review focuses on the first contention.

My understanding of psychiatric disorders as rhetorically constructed within a biomedical paradigm places emphasis on the power of such constructions in regulating social understandings of psychiatric patients. This position draws from a Foucauldian concept of the development of discourses of madness. In *Madness and Civilization* Foucault (1965/1988) traces the different constructions of madness throughout history, suggesting that madness is not a stable concept, but one influenced by different discourses in different social moments. For example, Foucault writes, "...in the Renaissance, madness was present everywhere and mingled with every experience by its images or its dangers. During the classical period, madness was shown, but on

the other side of the bars; if present, it was at a distance, under the eyes of a reason that no longer felt any relation to it and would not compromise itself by too close a resemblance” (Foucault, 1965/1988, p. 70). Foucault then points to the consequences of this re-visioning of madness. Treatment of madness, for example, depends on the understanding of madness. If madness is a result of a chemical imbalance, the appropriate treatment is the use of drugs to restore the balance (Mills, 2003, p. 99). Importantly, the differences between “madness” and “sane” are not already apparent—rather, they are constructed, the “result of social contradictions in which [humans are] historically alienated” (as quoted in Mills, p. 98). The more recent medicalization of madness, the transformation of madness to “mental illness,” is particularly important in terms of postpartum disorders. Sara Mills explains,

This change in the view of aberrant behavior has consequences as Foucault has shown; in previous periods, if people displayed aberrant behavior, they were largely left alone or stigmatised as being non-productive, but the medicalisation of mental illness results in sometimes enforced confinement and treatment and what, in the special issue of *Feminist Review* on mental illness, was termed “an individualizing, apolitical, biologicistic understanding of [distress]” (Alldred et al. 2000: 1). (Mills, p. 103)

The medicalization of distress allows for any aberrant behavior to be labeled as “mental illness.”

The field of psychiatry has been theorized as a rhetorical field acting as a scientific one (Vatz and Weinberg, 1994), a suggestion that points to not only an understanding of psychiatric diagnoses as rhetorically constructed, but also hints at the unsteady biological/scientific basis of psychiatry. Thomas Kuhn’s work can readily be used to support the contention that within psychiatry “illnesses” are rhetorically constructed. Take, for example, Kuhn’s explanation of the role of paradigms within science. He writes, “Normal science consists of the actualization of

that promise [of success], an actualization achieved by extending the knowledge of those facts that the paradigm displays as particularly revealing, by increasing the extent of the match between those facts and the paradigm's predictions, and by further articulation of the paradigm itself" (1996, p. 24). Paradigms guide what type of research is done and the significance that research takes on. Modern psychiatry is couched in a biomedical or diagnostic paradigm. Horwitz explains that before the publication of the *DSM-III*, psychiatry was seen as the study of "vague, opaque, and continuous unconscious mechanisms of the dynamic system" (2002, p. 210). Psychiatry underwent a radical paradigm shift with the publication of the *DSM-III*, shifting the focus to precisely defined, symptom-based diseases (2002, p. 210). The current biomedical paradigm suited the interests of psychiatrists, as it provided a justification for their position as medical doctors, and it was also supported by insurance companies (who are more likely to cover specific diseases rather than a vague problem) and pharmaceutical companies (2002, p. 211).

The biomedical paradigm of psychiatry suggests that certain explanations and areas of research are likely to be validated while others will go to the wayside. Cloud reports, for example, "Even when psychiatrists and psychologists acknowledged external sources of mental illness, they were far more likely to attribute the causes of such illness to hereditary genetic factors" (1998, p. 27). This movement is theorized by Cloud as a sign of our therapeutic culture, in which diseases are recognized by medical authorities and the culture at large, and yet the responsibility for the disease is located only in the individual (1998, p. 27). The predominance of biomedical explanations for mental illness also leads to what Horwitz calls the "raising of public consciousness" about diseases. He explains,

These template images of disease can lead individuals to seek professional help for these conditions and/or to join one of the many self-help groups that focus on the particular



diagnostic categories of the DSM. Ultimately, the classification system of diagnostic psychiatric can create the entities that it claims to represent (Fleck 1979 [1935]; Zerubavel 1997). Diagnoses that initially arose to provide researchers a useful tool for the reliable study of standardized sets of symptoms eventually become seemingly real conditions that people believe they suffer from. (2002, p. 213)

Considering the focus on patient identities of this project, Horwitz's assertion that people latch on to psychiatric diagnoses as a way of understanding their own situations is particularly useful, although his suggestion that the conditions are "seemingly real" muddles his argument. Such a suggestion points to an idea of a "real real," or that some diseases are "real" while others are only "seemingly real." To clarify, my position is that all diseases are "real" in the sense that they exist as discursive phenomenon. Horwitz also points in the direction that this project will travel: namely, how and where such "identities" appear outside of psychiatric discourse. However, the main point I wish to draw from Horwitz's work is that within modern psychiatry, the biomedical paradigm controls the direction of psychiatric research and thus the construction of mental illness, even if, as Thomas Szasz argues, there are no biological bases for what we currently call "mental illness" (Szasz, 1974, p. 101-102).

Thomas Szasz is perhaps the most well known voice critiquing psychiatry as a rhetorical, not scientific, project, and his work is particularly relevant to patient identities. Szasz contends that psychiatry is a moral and political enterprise (Vatz and Weinberg, 1983, p. 13), and that categories of mental illness develop not from biological symptoms but rather from political and moral notions of "good" behavior. Szasz's critiques of psychiatry—while quite correctly pointing to the rhetorical basis of psychiatric diagnosis—diverge from my own understanding of the subject position of the patient. Szasz's main argument for the powerful nature of psychiatric

rhetoric is based upon a humanistic vision of individuals. Szasz explains, “The crucial moral characteristic of the human condition is the dual experience of freedom of the will and personal responsibility” (1977, p. xiii). As such, patients and psychiatrists experience free will (they are not, as I contend, always located in specific discursive moments) and the result of psychiatric rhetoric is the violation of human rights at the most basic level. Szasz argues:

How are involuntary psychiatric interventions—and the many of medical violations of individual freedom—justified and made possible? By calling people *patients*, imprisonment *hospitalization*, and torture *therapy*; and by calling uncomplaining individuals *sufferers*, medical and mental-health personnel who infringe upon their liberty and dignity *therapists*, and the things the latter do to the from *treatments*. This is why such terms as *mental health* and the *right to treatment* now so effectively conceal that psychiatry is involuntary servitude” (p. xix)

Again, Szasz’s critique of the rhetorical nature of psychiatry is evident. He notes in this case how the process of labeling can change our understanding of “mental illness.” However, Szasz’s emphasis on freedom, liberty, and rights of individuals is an oversimplification of the situation of the psychiatric patient.

Instead of drawing upon Szasz’s humanistic understanding of the patient, this project understands the patient as existing within discourse, with certain (if limited) options for self-definition and resistance. Verta Taylor’s understanding of the postpartum patient approximates this position. Rejecting traditional labeling theory in which “mental illness does not exist apart from psychiatric diagnosis,” Taylor uses the self-labeling theory in which patients use their own experiences to define their situations (1996, p. 31). While labeling theory proposes a concept of “invented identities” for female patients—identities constructed mainly by medical institutions—

self-labeling theory places emphasis on the feelings of distress created by unrealistic expectations of motherhood and “provides a basis for understanding how women draw upon competing popular and professional discourses to give meaning to their symptoms” (1996, p. 34). However, Taylor’s lack of emphasis on psychiatric rhetoric (she denies, in part, the institutional power of psychiatry) means that she largely downplays psychiatric rhetoric as an important source of labeling for women’s process of self-definition. I suggest that psychiatric patients take up certain subject positions (see Barker, 2002, p. 33) by borrowing from their own experiences and their interactions with available discourses, including those of psychiatry and mediated representations of psychiatry. Postpartum patient subjectivities are not so much produced by the discourses of power intrinsic in psychiatric rhetoric, but rather are the combined articulation in certain contexts of ideologies of motherhood and psychiatric rhetoric.

Given my concern in this project with the process of medical discourse in constructing/creating subject positions for patients, attention to Michele Foucault’s work on the clinic and insanity is a necessary part of this project. However, I should clarify that this project is not in itself a “Foucauldian” reading of postpartum disorders, although it is at times influenced by some of Foucault’s key concepts, such as my discussion of madness above. Particularly useful when considering the subject is Foucault’s recognition that the individual as subject is intricately intertwined with historical medical discourses. This subject, of course, depended on not a live subject, but a dead subject. Foucault explains:

It will no doubt remain a decisive fact about our culture that its first scientific discourse concerning the individual had to pass through this stage of death. Western man could constitute himself in his own eyes as an object of science, he grasped himself within his language, and gave himself, in himself and by himself, a discursive existence, only in the

opening created by his own elimination: from the experience of Unreason was born psychology, the very possibility of psychology; from the integration of death into medical thought is born a medicine that is given as a science of the individual. (1963/1994, p. 197)

Death is at least partially reconfigured here as not the end of life, but rather an important part of life itself. Further, it is the opening up of corpses that allows the scientific, or clinical, gaze to focus not only the disease, but the disease within an individual. However, the individual body/subject is no less fundamental than concern for the disease itself. Foucault writes, “Doctor and patient are caught up in an ever-greater proximity, bound together, the doctor by an ever-more attentive, more insistent, more penetrating gaze, the patient by all the silent, irreplaceable qualities that, in him betray—that is, reveal and conceal—the clearly ordered forms of the disease” (1963/1994, p. 16).

Once corpses are open, the body—and the individual—become the object/subject of scrutiny. The disease is located within the individual, and with the lifting of the classificatory/nosological structure of previous medical history, it is the figure of the individual—the diseased individual—that is the object of the new “anatomo-clinical gaze”:

The figure of the visible invisible organizes anatomo-pathological perception. But, as one sees, in accordance with a reversible structure. It is a question of the *visible* that the living individuality, the intersection of symptoms, the organic depth, in fact, and for a time, render invisible, before the sovereign resumption of the anatomical gaze. But it is as much a question of this *invisible* of the individual modulations, whose extrication seemed impossible even to a clinician like Cabanis (an old-school physician), and which the effort of an incisive, patient, eroding language offers at last to common light what is

*visible* for all. Language and death have operated at every level of this experience, and in accordance with its whole density, only to offer at last to scientific perception what, for it, had remained for so long the visible invisible—the forbidden, imminent secret: the knowledge of the individual. (1963/1994, p. 170)

As the object of medicine, the individual is also the subject—a subject constituted through the anatomical clinical gaze. This subject is not limited, however, to the diseased human. Foucault explains,

Medicine must no longer be confined to a body of techniques for curing ills and of the knowledge that they require; it will also embrace a knowledge of *healthy man*, that is, a study of *non-sick man* and a definition of the *model man*. In the ordering of human existence it assumes a normative posture, which authorizes it not only to distribute advice as to healthy life, but also to dictate the standards for physical and moral relations of the individual and of the society in which he lives. (1963/1994, p. 34)

Two key insights should be drawn from this brief discussion of the subject as emerging through medical discourse. First, Foucault places emphasis on the workings of the anatomical clinical gaze, a point that will prove pivotal in my discussions of subject positions for women that emerge from psychiatric rhetoric. As Rendell explains, “Under the scrutiny of the gaze, in other words, under the observation of the ‘eye that knows and decides,’ the ‘eye that governs’ and the ‘eye’ that dissects, ‘isolate[s]’ and ‘classif[ies]’, the patient becomes the passive and silent object of knowledge” (p. 36). Second, however, is that the concept that as object of study, the patient is also a subject—in other words, that the patient takes up (or is placed in) a subject position, an identity of sorts, by the “power” of the anatomical clinical gaze. Foucault suggests a reading of the subject that is voiced above by both Biesecker and Butler: that a subject is produced through

discourse, and as such exists only within a particular web of discursivity. This dissertation suggests that it is not merely the anatomico-clinical gazes that subjectifies/places as subject women during the postpartum period; a discourse of traditional motherhood is also key to understanding the subject positions that emerge both in psychiatric rhetoric and news coverage of postpartum disorders. Unlike Verta Taylor's concern with how patients/women articulate their own positions—how it is, for example, that one reconciles experience with a medical diagnosis—this project focuses on how discourses combine, or join together, in certain contexts to give rise to an understanding of woman during the postpartum period

*Articulation and Circulation: Psychiatric Rhetoric in the Public Sphere*

The theoretical concepts of articulation and iteration provide what I see as the clearest concepts that allow for a theorizing of subjectivities as circulating in a relatively unrestrained manner through/within certain discursive fields. Given my interest in the implications of the “symbolic” on “material reality”—or, perhaps more appropriately, my refusal to entertain that what is material is not also symbolic—the theory of discourse and discursive movement must also disrupt the discourse vs. material reality dichotomy that pervades much of communication research and forms the basis for many current debates within communication (e. g. Cloud, 1996; Condit, 1994). As Laclau and Mouffe explain, “[T]he practice of articulation, as fixation/dislocation of a system of differences, cannot consist of purely linguistic phenomena; but must instead pierce the entire material density of the multifarious institutions, rituals and practices through which a discursive formation is structured” (2001, p. 109). The combination of articulation and iteration results in a theoretical stance that explains why/how certain subjectivities emerge/are articulated in particular discursive fields. This section provides an overview of articulation theory and concludes by suggesting that the use of articulation theory in

the context of postpartum disorders is particularly appropriate because of the ability of distress during the postpartum period to act as an antagonism to the larger discourse of traditional motherhood.

*Post-Marxist articulation theory*

Articulation theory has, in the past, been explicated by a variety of theorists (see Angus, 1992; DeLuca, 1999; Hall, 1989; Laclau and Mouffe, 1987, 2001) and all in some way point to articulation's relationship with and/or disturbing of Marxism. As Angus notes, both Laclau and Mouffe and Hall present articulation theory as a critique of the Marxist "reduction of all phenomena to class position" (p. 539). Laclau and Mouffe argue, for example:

Our examination of the history of Marxism has, in this sense, shown a very different spectacle from that depicted by the naive positivism of "scientific" socialism: far from a rationalist game in which social agents, perfectly constituted around interests, wage a struggle defined by the transparent parameters, we have seen the difficulties of the working class in constituting itself as a historical subject, the dispersion and fragmentation of its positionalities, the emergence of forms of social and political reaggregation--"historical bloc", "collective will", "masses", "popular sectors"--which define new objects and new logics of their conformation. (pp. 104-105)

If traditional Marxism does not (and cannot) account for strategies of new social movements or the difficulty of the "working class" in constituting itself as a subject, a partial reason for this inability is Marxism's humanist subject, its logical and linear understanding of society (including causal links between base, superstructure, and so forth), and its insistence on linking ideology to infrastructure and opposing it to truth (see DeLuca, 1999). As post-Marxist theorists, Laclau and Mouffe do not entertain notions of political economy, and, unlike Hall, who asserts, "[A] theory

of articulation is both a way of understanding how ideological elements come, under certain conditions, to cohere together within a discourse, and a way of asking how they do or do not become articulated, at specific conjunctures, to certain political subjects” (as quoted in Grossberg, 1996, p. 141), also do not position ideology at the center of articulation theory. Both the concepts of “political economy” and “ideology” suggest dualisms/dichotomies which Laclau and Mouffe attempt to avoid—that of material/symbolic and truth/fiction. Rather, as self-identified “post-Marxists,” they replace these concepts with those of “discourse,” “articulation,” “antagonism,” “element” and “moment,” and suggest that articulation theory, along with a theory of antagonism, combine to produce the concept of “hegemony”: “It is also necessary that the articulation should take place through a confrontation with antagonistic articulatory practices—in other words, that hegemony should emerge in a field criss-crossed by antagonisms and therefore suppose phenomena of equivalence and frontier effects” (p. 135).

If the post-Marxist answer to “Marxism” is “hegemony,” (given, a “radicalized” version of Gramsci’s original formulation) one must understand the basic structures (for lack of a better word) upon which articulatory practices—those practices through which a hegemonic field may occur—take place. Laclau and Mouffe theorize discourse in such a way as to avoid the condemnation of simply “retreating to language” (see DeLuca, 1999, p. 341) by noting that discourse, the “structured totality resulting from the articulatory practice” (Laclau and Mouffe, 2001, p. 105), is material as well as linguistic. They explain, “Our analysis rejects the distinction between discursive and non-discursive practices. It affirms...that every object is constituted as an object of discourse, insofar as no object is given outside every discursive condition of emergence” (p. 107). Within any given discourse there are “moments” or differential positions that are articulated, as well as “elements,” or a difference that is not articulated (p. 105), although



the transition from elements to moments is never fully complete, nor is any given moment ever completely stable (p. 110-111). Angus describes the relationship between element and field of discursivity as one of “theme/background” in which a theme appears on against a surrounding background (p. 557). Thus, although elements exist outside of articulation (they are “floating signifiers”), they can be articulated—seen against a background—in a way that modifies their character (DeLuca, 1999, p. 335). Articulation is thus theorized as a dual practice—speaking forth elements and linking elements (DeLuca, p. 335) and it is often a practice that is theorized from an anti-hegemonic standpoint. Antagonisms, or the “limit of the social,” make possible the rearticulation, or disruption of, hegemonic discourses. DeLuca explains, “Antagonisms are differences, limits, in a hegemonic discourse that must be articulated as antagonisms by groups in order to subvert or disarticulate the hegemonic discourse. Antagonisms are ‘natural’ relations of subordination articulated as socially constructed relations of oppression and domination” (p. 337). Because of its contingent nature, hegemony must be articulated with antagonism.

Articulation theory also provides a useful understanding of the emergence of the subject, an understanding much like that of Butler and Biesecker, which suggests that a subject is always becoming and never complete. As Laclau and Mouffe explain, “[T]he material character of discourse cannot be unified in the experience or consciousness of a founding subject; on the contrary, diverse subject positions appear dispersed within a discursive formation” (p. 109). Subject positions emerge within discursive formations, disallowing a concept of the human subject as the origin of social relations (Laclau and Mouffe, 2001, p. 115). However, as DeLuca notes, “To be clear, the decentering of the subject and intentionality that Laclau and Mouffe suggest is not the dismissal of these concepts. Agency and intentionality still must be accounted for, but in a manner that recognizes how they are forged in the complex conflux of commercial,

legal, property, philosophy, and literary discourses” (1999, p. 340-341). So, for example, the position of “Man” within humanist debates cannot be considered as having an “essence,” but rather must be seen as emerging within a variety of discourses: “...what is important is to show how ‘Man’ has been produced in modern times, how the ‘human’ subject—that is, the bearer of a human identity without distinctions—appears in certain religious discourses, is embodied in juridical practices and is diversely constructed constructed in other spheres” (Laclau and Mouffe, 2001, p. 116). Subject positions, I argue, act as one type of “nodal point” within Laclau and Mouffe’s larger theory of hegemony and articulation. They explain, “The practice of articulation, therefore, consists in the construction of nodal points which partially fix meaning; and the partial character of this fixation proceeds from the openness of the social, a result, in turn, of the constant overflowing of every discourse by the infinitude of the field of discursivity” (p. 113).

The theory of articulation itself provides one understanding of discursive movement, one that I think can be clarified by supplementing it with a Derridean theory of citationality. As Laclau and Mouffe might note, each “element” or “sign” can emerge (be articulated) as a moment in a variety of discursive formations. While the theory of iterability/citationality as described by Derrida does not emerge from the background of Marxism, it is certainly compatible with a particular understanding of articulation. As Laclau and Mouffe note, their insistence upon impossibility of absolute fixity or absolute non-fixity is consistent with Derrida’s own insistence upon the impossibility of fixing meaning (2001, p. 112). Further, Derrida also seems to hint at an understanding of discourse as used by Laclau and Mouffe that incorporates both “material” and “symbolic.” Derrida explains, “This was the moment when language invaded the universal problematic, the moment when, in the absence of a centre or origin, everything became discourse--provided that we can agree on this word--that is to say, a system in

which the central signified, the original transcendental signified, is never absolutely present outside a system of differences” (Derrida, 1978, p. 280). At the center of Derrida’s work is a theory of meaning that suggests that “meaning can never be ‘fixed’; rather, words carry multiple meanings, including the echoes or traces of meanings from related words in different contexts” (Barker, 2002, p. 33). Such an understanding of meaning places emphasis on context in which words, signs, and (for my purposes) subject positions appear. As the context changes, so the meaning of the sign changes, and the context and the meaning can change infinitely. Derrida argues:

Every sign, linguistic or nonlinguistic, spoken or written (in the current sense of this opposition), in a small or large unit, can be *cited*, put between quotation marks; in so doing it can break with every given context, engendering an infinity of new contexts in a manner which is absolutely illimitable. This does not imply that the mark is valid outside of a context, but on the contrary that there are only contexts without any center or absolute anchoring [*ancrage*]. (1972, p. 12)

No sign has a “real” context, or an appropriate/correct context in which it only exists (p. 9).

Derrida explains, “One can perhaps come to recognize other possibilities in it by inscribing it or *grafting* it onto other chains. No context can entirely enclose it. Nor any code, the code here being both the possibility and impossibility of writing, of its essential iterability (repetition/alterity)” (p. 9). For my purposes, Derrida’s work suggests that signs have any number of meanings that emerge in various contexts. Such an understanding of context suggests that no context is ever complete, but that signs are nevertheless “valid”—they can only be understood—within contexts. For example, our understanding of “hormonally imbalanced postpartum female” differs depending on how it is articulated in feminist discourse, psychiatric

discourse, and news coverage of postpartum disorders. My intention, then, is to supplement articulation theory with citationality to argue that while signs/subject positions are indeed iterable, they are nevertheless subject to the processes of hegemony. As such signs travel, their meaning is inevitably changed, and, at points, resisted. This theory of articulation thus provides both an understanding of how patient identities develop in psychiatric rhetoric, and why/how they appear in more popular texts. Articulation forms the groundwork for the critical method of rhetorical analysis that my project will employ.

*Articulation theory and postpartum disorders: Women's distress as antagonism*

Before moving to the overview of the case studies, it is important to situate the practice of articulation with the discursive context of postpartum disorders. Simply, this project claims that subject positions for women are articulated in both psychiatric rhetoric and mediated context, an assumption which itself relies on the idea that there is an antagonism present to make such articulations possible. DeLuca explains, “Antagonisms make possible the investigation, disarticulation, and rearticulation of a hegemonic discourse. Antagonisms point to the limit of a discourse. An antagonism occurs at the point of the relation of the discourse to the surrounding life world and shows the impossibility of the discourse constituting a permanently closed or sutured totality” (p. 226). Although antagonisms and articulatory practices are often looked at from the point of view of how any given antagonism can disrupt (through rearticulation) a hegemonic discourse, this project takes a slightly different angle. Specifically, through my analysis of psychiatric rhetoric and news coverage of postpartum disorders, the focus of this project is not resistive rhetoric, or rhetoric that offers rearticulation against the hegemonic discourse, but rather on hegemonic discourse itself. The articulations in psychiatric rhetoric of subject positions for women during the postpartum period, and the “rearticulations” of these

positions in the news, point to the ways in which a discourse maintains its status/power as a hegemonic discourse. Interestingly, it is not the discourse of bio-science that is primarily at risk in the discussions of postpartum disorders, but rather a discourse of traditional motherhood in which distress during the postpartum period can at times function as an antagonism. Of course, the biomedical discourse is uniquely intertwined with this discourse of motherhood, as the case studies will demonstrate. Importantly, in order for distress to function as an antagonism, it must be articulated as such. DeLuca explains, “Antagonisms are ‘natural’ relations of subordination articulated as socially constructed relations of oppression and domination” (p. 337). This dissertation does not focus on how distress is articulated as an antagonism, but rather assumes that it is articulated as an antagonism. This assumption is supported in part by my literature review of motherhood and mental illness (see above), but a clearer explication of distress as antagonism is necessary.

The discourse of motherhood that I refer to above is most clearly discussed (and critiqued) by Barbara Katz Rothman. She writes, “I believe that modern American motherhood rests on three deeply rooted ideologies that shape what we see and what we experience: the ideology of patriarchy, the ideology of technology, and the ideology of capitalism” (1989/2000, p. 13). These three ideologies do not stand alone, but are tightly braided together to form what I am calling the discourse of traditional motherhood. Such a discourse privileges what motherhood and babies signify to men, suggests an understanding of family as both an economic and political unit, and encourages an understanding of people as objects, machines that (re)produce (p. 14). As Rothman discusses what these ideologies mean to contemporary motherhood in terms of reproductive technologies, I argue that she also points to one of the core contentions of the traditional motherhood discourse. Central to this discourse is not the woman, but the child:

“From the view of the man, his seed is irreplaceable; the mothering, the nurturance, is substitutable” (p. 25). Woman is, as Emily Martin describes, reduced to a laborer who produces the baby under the watchful surveillance of the doctor/foreman (Rothman, p. 32). Rothman summarizes, “Babies, at least healthy white babies, are very precious products these days. Mothers, rather like South African diamond miners, are cheap, expendable, not-too-trustworthy labor necessary to produce the precious product” (p. 39). However, as the laborer/nurturer, the mother does have certain responsibilities. Perhaps because of the tightly braided ideologies/discourses described by Rothman, what these responsibilities and duties are drawn from stereotypical “feminine” qualities.

Sheri Thurer describes what she calls the ideology of good mothering as based upon a key feminine characteristics. She explains, “Today, we all want to be the mom in the baby food advertisements. (You know her: the mother who is always loving, selfless, tranquil; the one who finds passionate fulfillment in every detail of child rearing.) It’s only natural. The vulnerability of our children makes us want fervently to be our best selves, to embody tender nurturance and sweet concern” (1994, p. xiii). Thurer’s tongue-in-cheek account is repeated later in her book as she points to this problem: “When nurturance is given out of love, inclination, or a sense of responsibility, the assumption persists that whatever form it takes—dropping one’s work to minister to a sick child, baking a tray of chocolate chip cookies—the behavior expresses a woman’s biological essence” (p. 287). Thus, nurturance is part of women’s “maternal instinct”—an idea that, although contested, pervades our understanding of motherhood (Nicolson, 1999, p. 161). Nicolson defines maternal instinct:

1. All women have a biological drive towards conceiving and bearing children.
2. This is a precursor to the drive to nurture those children.

3. The skills/capacities required to care for infants/children emerge or evolve immediately after the birth without the need for training.

4. The existence of those skills and capacities is evidence of innate femininity. (p. 165)

The discourse of traditional motherhood with which my project is concerned depends on a concept of maternal instinct, for “[i]t [the concept of maternal instinct] conveys a specific image of the feminine woman, who blends the apparent female impulse to have and care for a baby, with the typically ‘feminine’ characteristics of nurturance, passivity, and dependence which are reflected in all other areas of her life” (p. 165). When referring to the discourse of traditional motherhood, I am pointing to two key ideas: the value of the child above the mother, and the mother’s natural instinct to care for her child, even above herself. Such a discourse represents what many mothers strive to be, but as Nicolson explains, all mothers fail to a lesser or greater extent in the efforts to achieve good motherhood (p. 177). Finally, I should note that implicit in my use of “traditional motherhood” is the understanding of motherhood as natural, or, in other words, a biologically instinctual event.

It is in this context—that of the discourse of traditional motherhood—that distress during the postpartum period can be articulated as an antagonism. Although motherhood is typically described as a joyful life event, it is often far from joyful, with new mothers experiencing dramatic biological and social changes. Thurer discusses this problem:

Maternal altruism is difficult to sustain. While our children fill us with cosmic joy, while we would defend them with the fierceness of a lioness protecting her cubs, they also provoke in us at times such anger and frustration that we hardly recognize the fury as our own. If motherhood is the dreamy relationship it is often billed as, then those flashes of hostility must be unnatural, traitorous, destructive of all that is normal, good, and decent.

The resulting self-doubt is not much talked about. Mothers may joke about it, but they do not talk about it seriously. It is a cultural conspiracy of silence. (Thurer, 1994, p. xiv)

Importantly, as Thurer notes, it is difficult to talk about the distress that accompanies motherhood, but it is specifically that “talking”—the joining and speaking—that can point to how such distress is evidence of a socially constructed oppression. When mothers, feminists, and others use distress during the postpartum period to point to the limit of the discourse of traditional motherhood, and to critique the larger “patriarchal” system of gender roles and power dynamics, distress is articulated as an antagonism.

The possibility exists that each case of a postpartum disorder could be articulated as an antagonism, as each woman could, individually, speak/perform the contradiction between the discourse of traditional motherhood and distress during the postpartum period. However, it is perhaps the Yates case that provides the clearest, most recent, and most widely publicized articulation of distress as antagonism. Thomas’s (2004) description of Yates as a political prisoner whose actions—the murder of her children—had the potential to disrupt the social order seems to recognize the possibilities for the Yates case in particular to act as an antagonism.

Susan Douglas and Meredith Michaels reflect on the reporting of the Yates case, and suggest that the reporting is revealing for what it says about the institution of motherhood. They write, “The case struck a nerve. Despite huge cover headlines like the one on *People* that screamed VILLIAN OR VICTIM? millions of women refused to reduce this to an individual question about whether this sole woman was a lunatic or an evildoer, and instead saw it as evidence that the institution of motherhood once again had to be addressed” (2004, p. 324). The hundreds of letters written to editors of newsmagazines and newspapers by mothers, as well as articles written by celebrity moms like Marie Osmond, acknowledged the difficulty of raising children



and urged each other, as well as journalists, politicians, and doctors, to “dispel the motherhood myth” (Osmond, as quoted in Douglas and Michaels, 2004, p. 324). If the Yates case in particular, and distress during the postpartum period in general, can be articulated as an antagonism, the “dominant” discourse on which this dissertation focuses can be interpreted as working to upholding the discourse of traditional motherhood. Articulation theory suggests that even hegemonic discourses are articulated, and it is precisely the presence of opposing discourses, or articulations, that make continual articulation of hegemonic discourses necessary. The analysis of psychiatric rhetoric is precisely an analysis of how subject positions for women are articulated within a hegemonic discourse in the face of a growing movement to recognize the “real” nature of motherhood—its frustrations as well as joys (see Rich, 1986; Rothman, 1989/2000; Taylor, 1996). The articulation of subject positions for women during the postpartum period can be read as a response to the possibility of distress as antagonism, and, perhaps not surprisingly, such subject positions reify the hegemonic discourse of traditional motherhood through a reinforcing of the biomedical paradigm as the most accurate way to understand distress.

#### *Articulation and Rhetorical Studies: A Methodological Overview*

Although articulation theory grounds the following analysis, an additional explanation of “method” is necessary. Turning Laclau and Mouffe’s theory of articulation into a “method” as recognized by the field of communication would be doing the theory itself a disservice, as such a method would inappropriately fix a theory that relies upon a recognition of contingency. Indeed, Laclau and Mouffe’s discursive social theory as voiced through ideas of articulation and hegemony suggests that articulation is a practice, not a method. In the context of new social movements, DeLuca argues that Laclau and Mouffe’s position is that “the new task of social

movements involves expanding the links between the different struggles against oppression and that articulation is this very practice” (1999, p. 345). The question then becomes, how does one analyze (and critique) the practice of articulation? Returning to the idea that articulation has two aspects—speaking and linking—a critic might endeavor to understand the context (discursive field) in which an “element” is spoken, and how such elements are articulated to create new meaning. DeLuca reminds us, “Though elements preexist articulation as floating signifiers, the act of linking in a particular discourse modifies their character such that they can be understood as being spoken anew...Articulating elements into a discourse can be understood as both attempts to fix meaning within the field of discursivity and attempts to fix the context, ‘an attempt to dominant the field of discursivity, to arrest the flow of differences, to construct a center’ (Laclau and Mouffe, 1985, p. 112)” (DeLuca, p. 335-6). An analysis based in articulation theory recognize the contingency of elements and the non-essential identities of subjects, as well as the always “becoming” process of articulation itself.

Within the field of communication, articulation has been used as a starting point and method by numerous scholars (e.g. Hanczor, 1997; Reich, 2002), but scholars using articulation theory largely draw from the work of Stuart Hall, who bases his theory of articulation on the theorizing done by Laclau and Mouffe. As explained by Nina Reich, articulation is the “process of forming connections between two different elements” (p. 293). Reich’s study is particularly useful to my project considering her interest in how articulation theory can be used to understand the “discursive constructions of women’s identities” (p. 293). In Reich’s study she challenges the “connections” made between two specific “elements”—woman and victim. After discussing the historical development (and contentions around) the woman as victim position—a discussion she develops under the label of “historical articulation”—she moves to an attempt to rearticulate

women's identities within the "woman as victim" discourse through interviews with women who had experienced domestic violence (p. 295-296). In terms of method, Reich suggests that "consistent with articulation theory, analysis was guided by what emerged from the interviews, which accords priority to respondents' perspectives and meanings rather than preexisting or *a priori* categories" (p. 297). Ultimately, Reich's analysis was based upon "themes" that emerged in the discourse in relation to her research questions—fluidity of labels, self-labeling, strategic labeling, and good and bad victims (p. 298). Although originally positioning her study as an attempt to rearticulate identities for women, she concludes by noting that her study offers "insight into how women's identities are currently being constructed" and how scholars might begin to "rethink, and hence, rearticulate women-as-victims" (p. 308). Two aspects of Reich's study stand out—her development of a historical account of the articulation of women-as-victims, and her attempt to describe through various themes how women-as-victims is currently being articulated. It would seem that Reich's analysis of her interviews necessitated an understanding of the "discursive field" in which women-as-victim was articulated, a field that she attempts to describe in the historical articulation section.

Taking a slightly different tack, Hanczor's study of the *NYPD Blue* controversy (also using Hall's concept of articulation) places emphasis on the ideological nature of the "elements" that are combined through articulation. Describing his use of articulation theory, Hanczor explains, "In other words, this mode of analysis can begin to recognize that social movement is a consequence of the articulations and relationships that political communities make in certain historical junctures. Consequently, it includes an identification of the tendential ideological forces involved as well as an analysis of the articulations made within the context of the debate" (1997, p. 7). With these two issues in mind, Hanczor's analysis has both "macro" and "micro"

aspects, as he notes, for example, the larger tendential forces (discourses) opposing *NYPD Blue*—science, liberal democracy, conservatism, Christianity, capitalism, and Americanism, as well as the groups and individuals (e.g., the American Family Association) that voiced specific arguments (e.g., harmful media effects) against *NYPD Blue* through specific “tendential forces” (e.g., scientism) (p. 21). Articulation theory is, as used by Hanczor, a “viable tool for mapping out the non-necessary and contradictory articulations that are strategically employed in the pursuit of social movement and change” (p. 25). To an extent, Hanczor’s analysis of the *NYPD Blue* controversy is similar to Condit’s (1994) suggested method of “critique of concordance.” Both rely on a Gramscian notion of hegemony, and both recognize the potential “coming together” of widely divergent forces to oppose or promote a particular social issue. Further, where Condit places her “critique of concordance” as an alternative to “dominant ideology” critiques, Hanczor makes a similar move in suggesting that an analysis of articulations be seen as new (and better) way to analyze controversy, as opposed to the agenda-setting model, the political economy model, and the rhetorical model (p. 2-4). In other words, both scholars propose a moving away from a traditional Marxist approach that relies on an antiquated understanding of ideology—ideology placed in opposition to “Truth” (see DeLuca, 1999).

Reich and Hanczor’s studies suggest that grounding an analysis in articulation theory need not inspire one “fixed” method, but rather should be an analysis that pays appropriate attention to the issues raised by articulation theory. Because this project is a rhetorical analysis of postpartum disorders, my “methods” will draw from rhetorical theory and criticism. Black’s analysis of the “communism as cancer” metaphor takes an approach similar to the one that I will use when analyzing texts. Black offers an analysis of the metaphor that takes into account its various potential meanings—communism as incurable, communism as affliction, communism,

the state as organism, communism as a natural phenomenon, communism as terrifying, and communism as a culpable illness (1970/1999, p. 337-338). The diverse meanings of the communism as cancer metaphor coalesce into rhetoric that supports zealous righteousness, suspiciousness, and morbidity (p. 339). The analysis of the articulations of subject positions for the postpartum woman will look at the variety of discourses that such subject positions encompass. Each analysis takes as its starting point the text with which I am working. Newspaper articles and television news reports are different than psychiatric rhetoric, and as such each text that I work with will be analyzed on its own terms. For example, my analysis of newspaper coverage of postpartum depression draws from the literature of news production and framing (see Tuchman, 1978). Such studies suggest that news is constructed in a certain manner, using frames that are attention grabbing and relying on “expert” voices to support assertions (Reese and Buckalew, 1995). I will detail these methodological issues at the beginning of each of the appropriate chapters.

### *Overview of Case Studies*

As I have suggested throughout, the dissertation will be based on a diverse set of texts that will allow for an analysis of the current contests of meaning over the subject positions of postpartum patients. The core of the dissertation will be made up of three separate case studies. The first, an analysis of psychiatric rhetoric about postpartum disorders in Chapter 2, is based on texts drawn from psychiatric journals. Psychiatric rhetoric articulates three overlapping subject positions for women—the vulnerable female, the patient, and the mother—that clearly draw from both psychiatry’s biomedical paradigm and a discourse of traditional motherhood. The analysis is shaped by Burke’s theory of dramatism, specifically the pentad, through which we can see different discourses dominating or appearing in different scenes. I conclude that each of the

three subject positions place women during the postpartum period in submissive relationships to those around them—their doctors, spouses/partners, and children.

The second and third case studies follow my suggestion that psychiatric discourse does not simply remain in the medical sphere. Rather, the identities that appear in psychiatric discourse reappear (are cited, to use Derrida's words) in other, more public, texts. These identities, however, have morphed. The purpose of these two case studies is to suggest how and in what ways the articulation of women's identity during the postpartum period draws from psychiatric discourse as well as other possible sources. In Chapter 3 I offer an analysis of newspaper and newsmagazine coverage of postpartum disorders. I have limited the texts to the years 2001-2004 because of the flurry of articles about postpartum disorders that occurred during and after coverage of the Andrea Yates case. Using a theory of news framing, I argue in this case study that the three subject positions articulated by psychiatric rhetoric reappear but are changed in particular ways to work within the context of the Yates case. Importantly, the analysis points to a split in the subject position of mother, suggesting that in the news one may find possible articulations of distress during the postpartum period as an antagonism. I conclude this chapter by focusing on the position of mother as the dominant position through which the articulation of the vulnerable female and the patient can develop.

The final case study, presented in Chapter 4, is an analysis of television news coverage of postpartum depression. This analysis takes a slightly different path than the analysis in Chapter 3. Because television news reports did not dramatically differ in content from newspaper and newsmagazine reports, this case study looks specifically at what is unique about the television reports: the images used. This analysis leaves behind the discussions of the vulnerable female and the patient to focus on the position of the mother, as I have suggested at the end of the

second case study that it is the mother that ultimately defines our understanding of the postpartum woman. The position of mother that is articulated in television news is quite specific: she is white, middle class, and heterosexual. Describing the images as operating as a naturalistic enthymeme, I argue that race becomes an issue precisely because of its visibility in television news. The articulation of the mother as white, middle class, and heterosexual proves problematic in that it provides very different constructions of motherhood and the postpartum period for different segments of the population.

The three case studies that make up the dissertation will allow for an analysis not only of different mediated representations of women, but also a comparison of how such articulations draw in distinct ways from psychiatric rhetoric and discourses of motherhood and femininity. The dissertation concludes in Chapter 5 with a discussion of the implications of the subject positions for women and psychiatry. Specifically, I offer a sketch of a possible new position, “bio-social women,” a position that could situate women in more productive ways with their surroundings. Given that the postpartum period has been defined as a time of “increased vulnerability” for women, and given that the nature of this vulnerability—its diagnosis as the “baby blues,” postpartum depression, or postpartum psychosis—is culturally constructed, comprehending the specifics of such construction—the interplay between psychiatric discourse and mediated representations of women with postpartum mental illnesses and the contests for meaning, or the “semantic and regulatory battles” (Treichler, 1999, p. 45), among psychiatrists, patients, and their families—is a necessary step in the current effort (e.g. Spinelli, 2003) to increase our knowledge about and understanding of postpartum disorders.

## CHAPTER TWO

### Reproductive Vulnerabilities, the Observed Patient, and Nurturing Mothers

By the late nineteenth century, two French psychiatrists, Victor Louis Marce and Jean-Etienne Esquirol, hypothesized a causal link between pregnancy, childbirth, and depression (Meyer & Oberman, 2001, p. 11). Marce's name has remained influential in the world of postpartum disorders. In 1980 a group of scholars in a variety of disciplines founded The Marce Society, an international society with the goals of "improving the understanding, prevention, and treatment of mental disorders" related to the postpartum period (Spinelli, 2003, p. 249). Certainly, what current medical language describes as postpartum disorders have existed for centuries, but what has changed is precisely the language used to describe such "disorders." Oberman explains, "Until the start of the twentieth century, [Western] societal responses to infanticide indicate that it generally was viewed as a crime committed by desperate and/or immoral women. The twentieth century introduced a dramatic new perspective on the crime—that of illness" (2003, p. 8). The biomedical language used to describe postpartum disorders describes not only the disorder itself (if one can even separate the disorder from the body in which it is inscribed), but also the women who have such disorders. It is the latter dimension of this "epidemic of signification" (to use Treichler's words) on which this case study focuses. In this chapter I will offer an analysis of the articulation of subject positions for the female patient within psychiatric discussions of postpartum disorders, focusing on the three relatively fixed and yet interrelated positions of the vulnerable female, mother, and the patient. As I will discuss in this chapter and in my larger project, the three subject positions that are articulated by psychiatric



rhetoric configure women's bodies, experiences, and relationships to others (particularly their children) in ways that are troubling, because they contain women within a biomedical paradigm—a paradigm solely focused on a biological understanding of human development—that limits broader social and cultural understandings of potential sources, implications, and solutions for postpartum disorders. This chapter proceeds in two sections. First, I situate my analysis within previous critiques of psychiatry and suggest that psychiatry, as a discursive field, will offer limited, if seemingly common-sense, articulations of subject positions for women. Second, I offer a Burkean analysis of the articulation of subject positions in psychiatric rhetoric. The analysis is grounded in articulation theory, and as such the analysis insists upon the contingent nature of the subject positions being articulated, as well as the possibility for future rearticulations.

### *Analyzing Psychiatric Rhetoric*

Postpartum disorders, unlike other psychiatric disorders, are both diagnosed and treated within a specific context of childbirth, and this context poses a number of problems for both doctors and women during the postpartum period. I think it would behoove us to tease out the different discourses that come together to form the three subject positions of female, patient, and mother that emerge in the psychiatric literature because such subject positions are ultimately constraining, and they reify our understandings of traditional gender roles. The discourse forming the center of psychiatric rhetoric (or the field of discursivity through which psychiatric discourse emerges) is a discourse of biomedicine that is voiced through the biomedical paradigm. However, also operating within this context are a variety of complimentary (and occasionally competing discourses) that provide a particularly interesting context for the emergence of subject positions for women.

With the publication of the *DSM III* in 1980, psychiatry deliberately took on the mantle of scientific authority, offering elaborate and specific diagnostic criteria for over 250 mental disorders compared to the vague descriptions of only 182 disorders in the *DSM II* (McCarthy and Gerring, 1994 p. 157). This movement is described not as a mere incremental change in the understanding of mental disorders, but rather as a paradigm shift that valued biological explanations instead of social/cultural and psychological explanations for mental disorders (McCarthy and Gerring, p. 157; see also Horwitz, 2002). The biomedical paradigm that prevailed was modeled after the work of Emil Kraepelin, an early twentieth century German psychiatrist and author of *Clinical Psychiatry: A Textbook for Students and Physicians* (McCarthy and Gerring, p. 158). The Neo-Kraepelinian movement had four key beliefs that, when successfully applied to psychiatry, enhanced psychiatrists' reputations as medical doctors by positing the biological basis of mental disorders:

1. Psychiatry is a branch of medicine and should base its practice on scientific knowledge.
2. Psychiatry treats people who are sick, and there is a boundary between the normal and the sick.
3. Mental illnesses are like physical illnesses, discrete entities with biologic components.
4. Diagnosis and classification are legitimate areas of research and diagnostic criteria should be valued and taught. (Klerman, 1978, as quoted in McCarthy and Gerring, p. 158)

The adoption of a strictly biomedical paradigm has not gone uncriticized by scholars. Indeed, the bulk of criticism of psychiatry suggests that it is precisely psychiatry's reliance on a biomedical

model that forms the base of much of psychiatry's problems. For example, the search for diagnostic reliability—one of the driving forces behind the revisions of the *DSM*—is only necessary when one situates psychiatry within a biomedical paradigm in which diagnostic reliability is key to the proof of psychiatry as “science” or, put another way, as a true medical field much like obstetrics, pediatrics, and neurology (Kirk and Kutchins, 1992, p. 2).

Critiques of the biomedical model suggest that many of the behavioral issues that are called “mental illness” by the *DSM* are actually “problems in living,” problems that may develop from biological events, but may also (and perhaps more likely) develop from experiences within a family, a society, and so forth (see Caplan, 1995, p. xvii). Of interest here is the discussion of “people who are sick” as crossing the boundary between the normal and the sick. Critics of the diagnostic methods of the *DSM* series note that the attempts to distinguish normality from abnormality or normal behavior from deviant behavior are an ever-changing and highly subjective process. Homosexuality is a prime example of a behavior/lifestyle that exists on the cusp of normal/abnormal, and this positioning may be responsible for the large amount of discourse concerning the origination and biology of homosexuality compared to heterosexuality (Raskin and Lewandowski, 2000, p. 18). If the transition of psychiatry into a biomedical paradigm has inspired many in the mental health field to offer full blown critiques of psychiatry (see Caplan, 1995), what is largely missing from these critiques is a focus on the details of “psychiatric discourse,” a focus that can be provided through rhetorical criticism.

The work that does appear within the communication discipline on what I am broadly categorizing as psychiatric discourse focuses on the various manifestations of the *DSM* and the ways in which the *DSM*'s influence is felt throughout the many operations of psychiatry. McCarthy and Gerring's 1994 study of the revision process that created the *DSM-IV* suggests

that the weight of scientific authority played an important role in both creating the revisions and “selling” the revised version of the *DSM* to the medical field. Task force leaders for the revision employed a strategy of persuasion that suggested through a narrative that the *DSM-IV* would be “significantly more empirical and scientific than any previous diagnostic taxonomy” (p. 164). Some accounts distanced the *DSM-IV* from its predecessors, suggesting that the *DSM-III* and *DSM-III-R* were somehow flawed, or based on contingent/non-scientific factors, while other accounts placed themselves in a linear relationship to the *DSM-IV*’s predecessors and drew upon a “progress of science” account (pp. 164-166). Both narratives place science at the center of the construction of the *DSM-IV*, but a contradiction remained:

On the one hand, to maintain the dominance of psychiatry and the neo-Kraepelinian view in a heterogeneous profession, they present *DSM-IV* as resting on an improved and more scientific foundation than its immediate predecessors. On the other hand, to assure the field that they will not disrupt practice or research currently underway, task force leaders present *DSM-IV* as a document introducing minimum change. (p. 168-169).

If the first part of McCarthy and Gerring’s study suggests what many scholars (Double, 2002; Kirk and Kutchins, 1992) confirm, that science plays an increasingly large role in the development of psychiatric diagnostic categories, the second half of McCarthy and Gerring’s study—focusing on the work group in the Revision Task Force that propelled the recognition of Binge Eating Disorder (BED) as a diagnostic category—also suggests that other factors are at play. McCarthy and Gerring point to three significant findings: first, that work groups follow “procedures designed to give psychiatry the appearance of a mature biomedical science,” second, that work group conversations appeared to be influenced not only by a desire to appear scientific, but also a desire to appear professional by privileging theory and research over practical wisdom

and standardizing its activities based on the research foundation, and third, that deliberations within the work group were not “neutral,” nor did they focus only on empirical data (McCarthy and Gerring, 1994). It is this third area that is of particular interest to my concern with the “epidemic of signification” surrounding postpartum disorders. McCarthy and Gerring suggest, “These forces included political concerns about the possible stigmatizing of a segment of the obese population, economic concerns about the willingness of insurance companies to pay for treatment, and social concerns about how the expansion of its patient base might effect public perception of psychiatry” (p. 171). That forces, or concerns, other than science enter into psychiatric dialogues is significant. However, McCarthy and Gerring focus on the forces that were voiced by group members (although often not explicitly acknowledged). The question remains as to whether un-voiced, or assumed, forces were also present—and what those forces might be.

A second study, Carol Berkenotter’s analysis of the field of psychiatry as a profession working within a specific “genre system,” suggests that the *DSM-IV*, and perhaps its predecessors, operates as a “meta-genre” in which a “constellation of professional activities (and their genres) are organized” (p. 339). Analyzing a vast amount of paperwork produced at a rural Michigan mental health clinic, Berkenotter argues that the *DSM-IV*’s influence can be seen in a variety of texts: the initial patient interview, insurance reports, reports from psychiatrist to case manager to supervisor, and from one therapist to another. These various texts function to provide a synchronized understanding of one case, and at the same time provide a paperwork trail that is (at this time) necessary for insurance and billing reasons. In one example of the initial patient interview, a therapist’s notes suggest the power of the *DSM-IV*: “One can also discern traces of *DSM-IV*’s shaping activity on the therapist’s inscriptions. As she takes notes on what the client is

saying, she is making inferences from the client's comments that will lead to the diagnosis that appears at the end of the Initial Assessment" (p. 337). Despite the fact that psychiatrists, psychologists, and social workers—who combined make up the bulk of mental health practitioners—operate from vastly different paradigms, the *DSM-IV* is positioned as the text that unifies all practitioners (p. 339). Taking a critical stance on consequences of the influence of the *DSM-IV* and its diagnostic categories, Berkenotter concludes, "In effect, the client becomes the sum of his or her presenting symptoms. In this fashion, the actions and events within the client's narratives are recontextualized through the highly nominalized grammar/lexicon of the therapist's representation of the client's problems in living" (p. 342). Emerging again as a different understanding of "mental illness," "problems in living" suggests, much like McCarthy and Gerring, that the dominance of science—the "biomedical paradigm"—has transformed aspects of human life into disease.

Much like McCarthy and Gerring, Berkenotter's piece is limited by what I would call a focus on the "seen"—what is observed, for example, in a therapist's notes, is what Berkenotter reports. However, as I mention in the introduction to this chapter, psychiatric discourse is produced not only through a discourse of science/empiricism, but also through one that encapsulates certain hegemonic understandings of the nature of sex and gender. Work critiquing psychiatry's "bias" in terms of race, gender, sex, and class supports my contention that the articulation of subject positions for women during the postpartum period by psychiatric discourse develop from a discursive field that relies on more than science to turn "normal" into "abnormal," to turn "problems of living" into "mental illness." Leading the research in the area of "bias in psychiatry," Paula J. Caplan suggests that racism, sexism, classism, ageism, mother-blaming, ableism, and many other "isms" are sustained through psychiatric discourse and

diagnostic processes (Caplan and Cosgrove, 2004, p. xxiv). Like the feminist critiques of postpartum disorders, which suggest looking for social rather than biological causes of distress, researchers in the area of bias argue that by reifying hegemonic understandings of “normal” through reference to the biomedical paradigm, the field of psychiatry avoids looking at the “real” issues underlying distress. Caplan and Cosgrove point to one challenge of this model, the Canadian Mental Health Association’s Women and Mental Health Committee’s report, *Women and mental health in Canada: Strategies for change*. They report, “They [the committee] dispensed with unvalidated systems of diagnostic labels, instead naming many of the known and proven causes of women’s suffering, including poverty, violence, and lack of social and political power and resources. They proposed that money and energy be channeled into eradicating these causes...” (p. xxiii). Like many challenges to the biomedical paradigm, the Committee’s report was out of print shortly after it was published and largely ignored by the psychiatric industry (p. xxiii).

Rather than review all of the research on the forms “bias” takes in psychiatry, I would like to point to one case that is particularly relevant to my own research on postpartum disorders: that of premenstrual dysphoric disorder (PMDD). Paula J. Caplan suggests that in its “self-appointed task of separating the normal from abnormal,” the American Psychiatric Association (APA) has created diagnostic categories for mental illness from guesswork, anecdotal clinical experience, and, at times, poorly conducted research (or poorly conducted reviews of research) into any given area of “mental illness” (1995, pp. 185-225). This unscientific research results in numerous “gatekeeping” techniques that propel the continued status of the *DSM* as a scientific enterprise while suggesting that opponents are the ones who lack scientific data. Caplan notes, for example, that while there was clearly “no sound empirical evidence” for the category of

PMDD, PMDD was recognized in the *DSM-IV*, listed under “Depressive Disorders Not Otherwise Specified,” through the machinations of a work group that downplayed scientific evidence suggesting that PMDD did not, in fact, exist, and largely ignored arguments made by opponents of the diagnosis who pointed to the gendered bias of such a diagnosis as well as the possible “real world” consequences of the diagnosis (Caplan, p. 126, 160). Where Caplan does see scientific evidence for the proof of a “premenstrual syndrome” is in the numerous studies reporting physical—not mental—changes during the premenstrual period, including cramps, lower back pain, and breast tenderness (p. 161). Maintaining that there is a difference between physical and mental, Caplan argues that, while chronic lower back pain may cause depression or irritability, it should not be categorized as a “mental disorder” (p. 165).

The acceptance of the category PMDD by the field of psychiatry begs the question of motivation—particularly the motivation of those psychiatrists and other experts working for the *DSM* revision task force. Caplan offers a variety of suggestions as to the motivations of the experts, many of which deal with pressure to maintain the status of psychiatry as a scientific enterprise or recognize the increasing force of capitalism, in the shape of pharmaceutical companies, in creating certain diagnostic categories (pp. 230-236). She is supported by Kirk and Kutchins, who suggest, “Biopsychiatry is an attempt to secure a more powerful base for psychiatry within the jurisdiction of both medicine and mental health” (1992, p. 10). Sociologists Phil Brown and Elizabeth Cooksey also argue that the scientific ethos and production of the *DSM* has allowed psychiatry to “solidif[y] the claim that it is ‘hard’ medicine worthy of government support for education and services, and for third party reimbursement” (1993, as cited in Caplan, p. 236). However, Caplan also suggests that some of the diagnostic



categories are influenced by less obvious motivations, motivations she describes as a desire to “veil social problems” (p. 237). Caplan explains,

For instance, those impelled by the wish to ignore the many social causes of women’s unhappiness would find it useful to invoke Self-Defeating Personality Disorder to imply that individual women’s unconscious needs lead them to bring misery on themselves. Those same diagnostic specialists would find Premenstrual Dysphoric Disorder a convenient way to attribute women’s unhappiness to their hormones or some mysterious tie to a cycle of moods. (p. 237)

Certainly, the veiling of social problems through psychiatric diagnosis works in hand with the more explicitly “capitalist” motivations, but I would suggest that it also points to a certain discursive stance, or a “bias” to use Caplan’s words, that reifies our notions of traditional/patriarchal femininity and womanhood. Caplan comes closest to noting this in her core argument against PMDD:

*Such a category carries social and political dangers for women.* There is no parallel category for men, no suggestion that well-documented mood and behavior changes that result from variations in “male hormones” should be given the label of mental illness (no “Testosterone-based Aggressive Disorder”). There is no sex-blind category for reasonably normal mood or behavior changes caused by physiological problems (no “Post-Influenza Depression”). At Senate confirmation hearings, job interviews, custody proceedings, and mental competence hearings, women could be asked, “Have you been diagnosed as having Premenstrual Dysphoric Disorder?” (p. 126)

Caplan notes here the differential treatment between women’s and men’s mood changes, suggesting that sexism is at least partially responsible for the creation of some diagnostic

categories. However, Caplan's focus is ultimately on the false pretensions of science, and it is here that her work is limited, particularly as voiced in her well-known book, *They Say You're Crazy*.

Taken together, Caplan's (1995, 2004) work as well as that of Kutchins and Kirk (1997) suggests that a biomedical discourse perhaps dominates psychiatric rhetoric but also co-exists with a variety of other motivations or discourses. Such discourses combine in the articulation of subject positions for the postpartum woman. Women as psychiatric patients, however, are contested subjects—feminist and constructivist critics point to differing understandings of disorder, distress, and behavior that reconstruct disorder not as an abnormal reaction, but a normal reaction to abnormal circumstances (Brown, 2000). In the case of female patients in the psychiatric system, Brown extends the problematics of constructing illnesses by reminding us that such definitions of illness are necessarily bound to the power structures from which they develop. She explains, "When the dominant group names the behaviors of the nondominant group, the naming process can be used to ascribe pathology and to make the ascription have the ring of truth and rightness" (p. 292). Simply put, "To diagnose, to name the distress for the person, is to hold the power to define another, to determine how that person may be treated both in- and outside of therapy" (p. 292). My analysis of psychiatric rhetoric points to the particular power found in the combination of the discourse of traditional womanhood and biomedical discourse in the articulation of subject positions for women during the postpartum period. Together, these discourses result in a "naming" of the nondominant group that results in the reification of traditional gender roles as well as the privileging of the scientific status of psychiatry.

*The Articulation of Subject Positions in Psychiatric Rhetoric*

In order to construct a sample of psychiatric discourse about postpartum disorders that represents the most influential pieces, I searched the Social Scientific Citation index database for “postpartum depression,” “baby blues,” or “postpartum psychosis.” The search resulted in 533 articles, of which 179 were from recognized psychiatric journals and 141 had been cited by at least one other article. My analysis of subjectivities is based upon the top 15% of the 141 articles, 21 in total. These articles were cited an average of 56 times each. My analysis proceeded in two stages. In the first stage, I reviewed the articles and noted the appearance of themes about the characteristics of women during the postpartum period. These characteristics included an emphasis on hormonal changes, previous history of depression, lack of social support, pregnancy and the postpartum period characterized as time of change/risk, the patient as mother, and many more. In the second stage of analysis, I grouped the various themes into three multi-dimensional “subject positions” for the postpartum woman. This process of collapsing is not unlike Reich’s research in which she discusses the articulation of women as victims through “themes” that emerged in her transcripts (Reich, 2002). Much like Michael McGee’s (1980) concept of “ideographs,” the subject positions that arise from these texts encompass psychiatry’s fundamental values about women, patients, and mental illness in general. The following analysis will detail the articulation of three subject positions in psychiatric discourse: female, patient, and mother, and trace the many dimensions within each position.

This analysis relies on a Burkean concept of the scene, in which the figure of the woman with postpartum depression changes as different aspects of postpartum period are emphasized. As Burke explains, “It is a principle of drama that the nature of acts and agents should be consistent with the nature of the scene” (1966, p. 3). The scene is only one part of Burke’s

pentad, and although Burke places “act” as the central term, he understands that the act can be interpreted in different ways according to which of the remaining four pentadic terms is used: agent, agency, scene, or purpose. A scenic emphasis, according to Tonn, Endress and Diamond, “reflect[s] a perspective that is committed to viewing the world as relatively permanent and deterministic” (p. 230). Tonn, Endress and Diamond explain, “Persons functioning within the scene are regarded as seriously constrained by scenic elements. Immutable factors in the nature or social landscape limit their ability to act on their own volition: free will is supplanted largely by fate, thereby reducing action to motion (*Grammar* 127-170)” (p. 231). Edward Kennedy, for example, emphasizes the scene to diminish his own responsibility for the death of Mary Jo Kopechne: “The situation described is, then, one of an agent totally at the mercy of a scene that he cannot control...If the audience accepted this entire description, it cannot conclude that Kennedy’s actions during the next few hours were ‘indefensible.’ The audience rather must conclude that Kennedy was the victim of a tragic set of circumstances” (Ling, p. 226). The analyses by Tonn, Endress, and Diamond as well as Ling suggest the power of the scene/agent and scene/act ratios in understanding rhetorical acts. Although I do not want to suggest that the scenes created in psychiatric rhetoric determine either the agent or the act, I do contend that such scenes offer subject positions for women during the postpartum period that while somewhat flexible remain ultimately constraining. The scene/agent ratio, as it develops in psychiatric rhetoric, is key to understanding the limited nature of the subject positions that are articulated.

### *The Vulnerable Female*

In their 1978 book *For Her Own Good: 150 Years of Experts’ Advice to Women*, Barbara Ehrenreich and Deidre English reflect on the dominant place of the uterus and the ovaries in medical accounts of female biology. Quoting doctors from the mid-nineteenth century,

Ehrenreich and English argue that the fascination and perhaps obsession with the female reproductive system led to a misunderstanding and thus mistreatment of a variety of illnesses in women. Two specific excerpts should aptly demonstrate the power of the ovaries in nineteenth century medical discourse:

Thus, women are treated for diseases of the stomach, liver, kidneys, heart, lungs, etc.; yet, in most instances, these diseases will be found on due investigation, to be, in reality, no diseases at all, but merely the sympathetic reactions or symptoms of one disease, namely, a disease of the womb. (Diriz, 1869, as quoted in Ehrenreich and English, 1978, p. 122)

Accepting, then, these views of the gigantic power and influence of the ovaries over the whole animal economy of woman.—that they are the most powerful agents in all the commotions of her system: that on them rest her intellectual standing in society, her physical perfection...her fidelity, her devotedness, her perpetual vigilance, forecast, and all those qualities of mind which inspire respect and love and fit her as the safest counsellor [sic] and friend of man, spring from the ovaries—.... (Bliss, 1870, as quoted in Ehrenreich and English, 1978, p. 120)

As medical and biological training advanced, the theory of the controlling ovaries was left behind, but the concept that women's biological body—the female body—is under the control of the larger reproductive system remains. Within psychiatric rhetoric, the first subject position that emerges is the “vulnerable female.” By using the word “female” as the signifier, I am deliberately pointing to the innate biological characteristics that (according to psychiatric researchers) are responsible for some women's “vulnerability” to depression in the postpartum period. The “vulnerable female” subject, or nodal point—to use Laclau and Mouffe's

terminology—is articulated through two related themes. First, authors create a system of demarcation to attempt to distinguish between postpartum depression and other forms of depression. Second, psychiatric literature proposes that the postpartum period is only one in a series of disruptive reproductive events in a woman’s life. The vulnerable female subject position operates as a synecdoche in which women’s reproductive functions—specifically their hormones—stand in for the larger and more complex picture of human development that might include other biological, relational, and cultural dimensions. In this case, woman is no longer ruled by her uterus or ovaries, but she is clearly influenced by her hormones.

One of the controversies surrounding postpartum disorders in psychiatric literature is the question of how—if at all—postpartum depression differs from depression that does not occur during the postpartum period. The lack of data on this subject has resulted in the inclusion of postpartum depression in the *DSM IV* as merely as an onset specifier which can be applied to a variety of “recognized” psychiatric disorders such as Major Depression. The *DSM IV* explains, “In general, the symptomatology of the postpartum Major Depressive, Manic or Mixed Episode does not differ from the symptomatology of nonpostpartum mood disorders and may include psychotic features” (p. 386). In other words, according to the *DSM IV*, depression during the postpartum period is distinguished by other depression simply by the timing of the depressive event. The *DSM IV*’s description of postpartum period as a purely temporal scene—the time after give birth—is not shared by most of the authors in this set of articles. These articles present the postpartum period as a time of biological flux, and many urge further research on the impact of hormonal changes during and after pregnancy as key biological reasons behind postpartum depression.

Demarcating postpartum depression from other forms of depression depends on an understanding of childbirth and the hormonal changes associated with it as forming distinct risk factors for women. Peter Cooper and Lynne Murray suggest that postpartum depression occurs in two distinct groups of women—one group in which the process of childbirth constitutes a distinct causative factor and a second group in which childbirth is unrelated to depression. To test this hypothesis, Cooper and Murray studied one group of women with postpartum depression in which their first episode of depression came during the postpartum period, and a second group of women in which their experience of depression in the postpartum period was categorized as a recurrence of depression. They conclude, “[A]mong those who had another delivery, the rate of postpartum depression was much higher for the group in whom the index episode had been the first onset than among those for whom the original postpartum depression constituted a recurrence of depression” (p. 194). Cooper and Murray offer several suggestions as to why childbirth may be a causative factor for some women and not for others, including psychosocial issues and hormonal changes (p. 194). The focus on hormonal changes is taken up by Bloch, Schmidt, Danaceau, Murphy, Nieman, and Rubinow in a study in which they hypothesize that the group of women for whom postpartum depression is a unique depression will respond with more sensitivity to changes in reproductive hormones. Their study seeks to answer two questions:

- 1) whether hormone withdrawal would precipitate symptoms in women with a history of postpartum depression but not in a comparison group of women without such a history,
- and 2) whether marked elevations in gonadal steroid levels during hormone addback would be associated with mood destabilization in women with a history of postpartum depression. (2000, p. 924)

Their findings suggest that compared with a control group, women with a history of postpartum depression had a differential response to the abrupt withdrawal of gonadal steroids, specifically estradiol and progesterone. They conclude: “This sensitivity appears to be a trait vulnerability that is not present in women without a history of postpartum depression. These data provide the first direct evidence in support of the pathophysiologic relevance of the reproductive hormones estrogen and progesterone in the onset of postpartum depression episodes” (p. 929). Stewart and Boydell also support investigations into the possible links between hormonal changes and affective disorders during the postpartum period. They suggest that it is imperative for doctors to “inquire from depressed women about previous depression associated with reproductive cycle events as it may help predict women who are vulnerable to affective disorders or other forms of emotional distress at these critical times in the life cycle” (p. 161).

The attempt to demarcate postpartum depression from “regular” depression largely occurs within a perspective that sees the postpartum period as only one of many risk periods in a woman’s life. This concern with all reproductive events—including the premenstrual period, pregnancy, the postpartum period, and menopause—coalesces in discussions of women’s “reproductive life cycle.” Thus, in the articles that are concerned with hormonal influences, the frame of concern shifts from the specific context of postpartum disorders to the larger context of a woman’s reproductive life cycle. As the scene, “reproductive life cycle” suggests that all reproductive events are times of risk and this concept is clearly expressed in a number of the articles. Stewart and Boydell note, “The association of depression and other forms of psychologic distress with female reproductive cycle events has been the subject of increasing interest over the past decade” (p. 158). The evidence supporting the scene of the reproductive event life cycle largely stems from studies like that of Bloch, et al. that confirm that women with



postpartum depression are more likely to have suffered from premenstrual depression and subsequent postpartum depression (2000). Stewart and Boydell's review of Steiner's study is also relevant. Steiner suggests, based on the higher prevalence rates of depression in women than in men and the fact that the rates for depression in women escalate at menarche and are highest between the ages of 18 and 44, that the menstrual cycle acts as "zeitgeber" or time giver which is involved in regulating women's moods (Steiner, 1992). In a key study cited by the Nonacs and Cohen article, Kendell and colleagues also argue for understanding the reproductive cycles as a time of risk, noting that psychiatric admissions for women peak within the first three months of the post partum period (p. 34). In the collection of 17 articles, perimenopause, the postpartum period, pregnancy, menopause, menstruation, and the use of oral contraceptives are all described as times of hormonal change that could be linked to psychological distress. O'Hara, Stuart, Gorman, and Wenzel simplify the issue by concluding: "Women of childbearing age are at high risk for depression" (2000, p. 1039).

The reproductive life cycle scene is delineated most clearly in the four articles that place postpartum disorders—including postpartum depression and obsessive compulsive disorder in the postpartum period—under the larger rubric of reproductive life cycle events. Williams and Koran's article, "Obsessive Compulsive Disorder in Pregnancy, the Puerperium, and the Premenstruum," suggests that the exacerbation of OCD symptoms in the postpartum and premenstrual periods are related to changes in gonadal hormones (p. 330). Stewart and Boydell—in an article focusing on menopause—suggest that women with high emotional distress during menopause were more likely to report having PMS and postpartum depression. In a unique article discussing risk factors for postpartum depression, Righetti-Veltma, Conne-Perreard, Bousquet, and Manzana (1998) extend the traditional understanding of the postpartum

period back into the final trimester of pregnancy, noting women diagnosed with postpartum depression were more likely during the third trimester interviews to describe the pregnancy experience as difficult or very difficult and to experience nervousness, aggression, and anxiety. The authors claim that their study supports the idea that the degree of depressive symptoms during pregnancy is the most sensitive predictive factor of PPD (p. 175).

Although reproductive life cycle events are almost universally considered times of risk, the reasons why some women and not others have psychiatric disorders during this time is less clear. Thus, several authors suggest that a particular group of women—women who are more vulnerable to hormonal changes—are the ones who become “ill.” Such a suggestion is interesting because the discourse recognizes that hormonal changes are natural during reproductive life cycle events. Llewellyn, Stowe, and Nemeroff argue, for example, that “pregnancy and childbirth represent naturally occurring life events accompanied by unparalleled neuroendocrine and psychosocial alterations” (1997, p. 26). What is then deemed abnormal are the reactions by some women—the “vulnerable females”—whose bodies are overly sensitive to the “normal” changes. The concept of “vulnerability” is expressed by Bloch et al. who suggest that women with postpartum depression are similar to those exhibiting the symptoms of PMS. These women have normal gonadal steroid levels and normal endocrine functions, yet seems to display a “differential sensitivity” to these normal functions. It is here that the subject position of “vulnerable female” is clearly articulated, using the scene of reproductive life cycle events in an attempt to demarcate postpartum depression from depression unrelated to hormonal changes. The vulnerable female subject position suggests that for some women, normal hormonal changes induce affective disorders. This subgroup of women—or what I am calling the subject position of the vulnerable female—performs as a synecdoche in that their reproductive cycles become the

explanation for affective disorders throughout their lives, beginning with their first period and concluding with the end of menopause. This suggests an entire range of female-specific psychiatric disorders, many of which have successfully made it into the DSM, including PMS. Further, the vulnerable female position presents us with a bit of paradox, one in which the very biological process that—according to these researchers—makes women women (i.e., their hormones) is also the process that results in some women's inability to conform with of dominant understandings of womanhood.

J. Clarke Rountree suggests in an article discussing the Burkean pentad that the “scene” can be more than merely the synonyms we associate with scene (the backdrop, the environment). Rather, Rountree suggests that the scene can be discussed as particular places, situations, or eras and that numerous other historical epochs, cultural moments, and social institutions (capitalism, for example) can be scenic (1998, p. 1). The scene that is produced through this psychiatric discourse—that of the reproductive life cycle—has particular consequences for the subject of the vulnerable female. If we consider the vulnerable female as agent, the woman/subject merely reacts to a scene that is constructed around her hormonal changes. It also possible, however, to understand the agent in this scenario as the hormones. Bloch et al., for example, write: “In this study, women with postpartum depression (but not the comparison group) showed increased symptoms in the addback phase with a peak during the withdrawal phase” (p. 928). Their study—which varied the hormone levels in women to “simulate” the postpartum period—suggests a direct correspondence between hormones and symptoms. Women may experience the symptoms, but ultimately the hormones are responsible for the symptoms.

I do not, however, wish to leave behind the woman as “agent” altogether. To a large extent, female hormones (estrogen, progesterone) are equated with women (see Martin,

1987/1992). Women, in this sense, are their hormones. Hormones play an important role in the biological processes of reproduction; however, some women simply do not respond “correctly” to the hormonal changes. The key here is that the vulnerable female subject position does not encompass all women, but rather focuses in on those particularly vulnerable to their hormonal changes. This subgroup of women can use of hormonal therapy attempts to soften the adjustment between pre-and post-pregnancy levels of estrogen and progesterone. This restoration of womanhood—through the essence of womanhood—has a relatively long history in medical treatments for menopausal women, in which hormone replacement therapy is, as Robert Wilson described in his 1968 book, one way to remain “feminine forever.” Emily Martin describes the more recent progression from understanding menopause in the 1950s as “not entailing any very profound alteration in the woman’s life” to that of the late 1960s and continuing through today, which suggests that menopause is a dramatic change in a woman’s life that can be categorized as pathological and labeled an estrogen deficiency disease (1987/1992, p.51). Like menopause, distress during the postpartum period has been labeled as disorder, although a distinct difference emerges in the agreement by the experts that childbirth is a natural process—one that only a few women react abnormally to. Of course, the normalization of childbirth is also problematic, for in noting that most women respond “normally,” psychiatrists first create a subgroup that defines the abnormal—those with increased sensitivity to their hormonal changes—and then suggest that, in the absence of such sensitivity, the postpartum period should be relatively free of disturbances.

Focusing in on the vulnerable female, the scene of the reproductive life cycle suggests competing and yet complimentary agents—women’s hormones, or women. The distinction is this: that hormones, as agents, act—they create the scene in an agent/scene ratio. Vulnerable females, on the other hand, perform within a scene/agent ratio in which woman reacts to her

reproductive life cycle. In fact, it could be argued that the scene/agent ratio incorporates *all* women—regardless of their status as a vulnerable female—by suggesting that both “normal” and “abnormal” postpartum experiences depend on a woman’s reaction to her reproductive life cycle. In the particular case of the vulnerable female, the representation of women’s hormonal changes during her reproductive life cycle as risk factors proposes a certain “negative” understanding of such a cycle, in that women’s reproductive capabilities are posited as the source of what is essentially a fragile womanhood—a woman forever and always on the brink of psychological distress. However, it is not merely the vulnerable female that emerges as under the control of their reproductive life cycle, as “normal” women are also always reacting to their reproductive hormones.

### *The Patient*

As my discussion of the subject position of the “vulnerable female” should indicate, many of the texts in this analysis were primarily concerned with locating the causes of postpartum disorders and the potential risk factors associated with postpartum disorders. It is the concern with risk factors that forms the basis of the second subject position that I will discuss today, that of the patient. Whereas the “vulnerable female” identity places women as the subject of their biology, this position places women as the object of the medical profession. In this subject position, the need for early diagnosis of postpartum disorders propels research into possible risk factors and a variety of survey instruments that can reliably identify such factors. The risk factors discussed are largely of two kinds: the psycho-social risk factors, such as marital difficulties, unplanned pregnancies, and socioeconomic status, and biological risk factors such as hormonal changes and previous histories of depression. This subject position places women in relation to an authority—the psychiatrist—who has the tools both to identify the risk factors that

exist in a woman's life and explain the diagnosis. It is this positioning of the woman in relation to her doctor that is the strongest evidence of the subject position of the patient. The articulation of the subject position of the patient arises through what Foucault discussed as the "medical gaze." In the case of psychiatric rhetoric, the use of the gaze allows for both an "objective" analysis of the illness and the body within which the illness is presented and an argument for the continual surveillance of women during the postpartum period. This gaze takes place in the scene of the clinic—a scene that encompasses both the discourses of clinical medicine and the actual hospital itself.

Although I briefly discussed the medical gaze in the first chapter, a more thorough explanation is necessary. Rendell explains the development of the modern medical gaze: "Foucault argues that the introduction of pathological anatomy and the reorganization of the 'clinic' into a place of observation and learning (as well as a place of healing) replaced classificatory medicine, and led to the ascendancy and 'sovereignty of the gaze' in modern medical experience (1972, p. 89)" (p. 35). This new gaze is distinct from the clinical gaze that preceded it. Foucault explains:

Nonetheless, considered on an over-all basis, the clinic appears—in terms of the doctor's experience—as a new outline of the perceptible and statable: a new distribution of the discrete elements of corporal space (for example, the isolation of *tissue*—a functional, two-dimensional area—in contrast with the function mass of the organ, constituting the paradox of the 'internal surface') a reorganization of the elements that make up the pathological phenomenon (a grammar of signs has replaced a botany of symptoms), a definition of the linear series of morbid events (as opposed to the table of nosological species), a welding of the disease onto the organism (the disappearance of the general

morbid entities that grouped symptoms together in a single local figure, and their replacement by a local status that situates the being of the disease with its causes and effects in three dimensional space). (1963/1994, p. xviii)

The arrival of the modern clinic with its focus on anatomy changed the relationship of doctor to patient—the originary question, as Foucault argues, moves from “What is wrong with you?” to “Where does it hurt?” (p. xviii). Critics using the concept of the modern medical gaze argue that it is intricately linked to Foucault’s idea of “disciplinary power” (Peckover, p. 370). Rendell’s analysis of Guibert’s depictions of his experiences in hospitals suggest that the “subordinating, silencing, and non-reciprocal gaze” is still very much alive in modern medicine (p. 36). Such a gaze is that which can bring the “truth” about a body to light in a process that is a “simple, unconceptualized confrontation of a gaze and a face, or a glance and a silent body; a sort of contact prior to all discourse, free of the burdens of language, by which two living individuals are ‘trapped’ in a common, but non-reciprocal situation” (Foucault, p. xiv-xv). The subject position of patient that emerges in psychiatric rhetoric is articulated by positioning *every pregnant woman* as a patient within the medical system and encouraging medical professionals to scrutinize women—using a variety of objective measures—for signs of risk in order to separate those women who are actually at risk from those who are not.

The dual concerns of diagnosis and prevention of postpartum disorders are concerns that place the body of woman—as well as her past history—under the scrutiny of the expert. A key point in this process is the recognition of risk factors. Warner, Appleby, Whitton, and Faragher’s study of demographic characteristics and risk factors associated with postpartum depression uses the Edinburgh Postnatal Depression Scale (EPDS) as a tool to measure depression. They then

compared women's EPDS scores with thirteen socio-demographic and obstetric variables that were collected during the first interview. They report:

There was a significant association with high EPDS scores for eight variables, the highest risk being associated with unemployment with both the woman and the head of household, and single status. Following a forward stepwise entry of the eight significant variables into a regression analysis, four variables remained significantly associated with high EPDS scores. They were having an unplanned pregnancy, no long breast feeding at six weeks, and unemployment in either partner. (p. 608)

These risk factors, as well as risk factors such as previous episodes of depression and depression during pregnancy (O'Hara and Swain, 1996) and psychological risk factors such as high interpersonal sensitivity and high neuroticism (Boyce, Parker, Barnett, Cooney, and Smith 1991) combine to suggest a "multifactorial etiology" for postpartum disorders (Righetti-Veltema et al. 1998, p. 175). What is revealing about this discussion of risk factors is the reinterpretation of women's lives through a medical gaze. In the above quotation from Warner et al.'s study, unplanned pregnancy, length of breastfeeding, and lack of employment are no longer merely "life events," but rather are very specific factors that could possibly point to one's likelihood of developing a postpartum disorder.

Righetti-Veltema et al. offer another example of how the medical gaze can transform both the life events/emotions and the women themselves in the comparison of women with postpartum depression (D-women) and without postpartum depression (ND-women): "Fewer D-women attended a complete antenatal preparation course during the present pregnancy than did ND-women (D 24.6% vs. ND 45.7%,  $p < 0.05$ ). In both groups, the majority of women felt a change in their emotions during pregnancy. Most of these changes concerned feelings of sadness



(more than 40% of *all* women). D-women felt more often nervous or aggressive (D 50% vs. ND 35.1%,  $p < 0.01$ ), and anxious (D 10.3% vs. ND 3.3%,  $p < 0.001$ )” (p. 172). For both “D-women” and “ND-women” sadness is interpreted from a medical perspective that, in this case, suggests that while sadness may be normal, anxiety and aggressiveness are not. Further, the use of the labels “D-women” and “ND-women” is troubling as the medicalization of their every emotion suggests that it is not only the “depressed women/D-women” who fall under the medical gaze, but rather all women. The issue of prevention forms the core of the Righetti-Veltema et al. study: “In order to simplify and standardize the procedure to detect these women at risk for PPD, we are now testing a predictive scale elaborated from the main risk factors revealed by this study, completed by some further research” (p. 178). Implicit in this statement is the idea that prevention of postpartum disorders may include giving tests to all pregnant women, and as a result treating all pregnant women as possible psychiatric patients. The process of determining those women who are at risk and those who are not at risk results in the surveillance of all pregnant women both before and after giving birth. Consider Righetti-Veltema et al.’s suggestion that “New mothers who present a PPD three months after childbirth differ from mothers who do not present a PPD, by certain characteristics, risk markers or risk factors which can be detected already during their pregnancy.” Righetti-Veltema et al. clearly associate detection with the job of experts, as they note earlier that an individual woman is not in the position to recognize her own symptoms because “she tends to minimize them and to interpret her psychological state in moral terms” (p. 168). Their article uses the Hopkins Symptom Checklist to suggest the possibility of prenatal diagnosis, noting that mothers who developed depression were more likely to experience anxiety, depression, interpersonal sensitivity, and obsessive compulsive traits during the last trimester of pregnancy (p. 174).

The benefits to be had from detecting risk factors come not only in early diagnosis of postpartum disorders, but also in the possibilities of prophylactic treatment. The options for prophylactic treatments vary, but three treatments are posited most frequently: the prophylactic use of hormones such as estrogen, testosterone, and progesterone, the use of antidepressant medication, and the use of interpersonal therapy. Wisner and Wheeler's study, for example, suggests that the use of antidepressant medication in asymptomatic women who have suffered previous episodes of postpartum depression will prevent or at least lower recurrences because "the antidepressant prevents a step in the cascade of bio-psychosocial events that result in the initiation of depression" (p. 1192). The study included 23 pregnant women who had previously experienced major postpartum depression. Two conditions were used, one in which the woman was monitored after childbirth and a second in which the woman was monitored and started on antidepressants within 24 hours after giving birth. Of the 15 women who chose the second condition, only one suffered a recurrence of postpartum depression compared with five of the eight women who chose not to take prophylactic antidepressants (p. 1194). Wisner and Wheeler's findings suggest that one way to prevent postpartum disorders is to identify risk factors and begin treatment before symptoms of the disorders emerge. Such treatments involve the identification of certain risk factors in a woman's history that should at least gain the attention of medical doctors if not encourage the use of prophylactic treatment. As Righetti-Veltima et al. suggest, certain factors such as a depressive mood and deleterious events during pregnancy should "alert the personnel involved with the care of the women" (p. 177).

Because of the possible benefits of prophylactic treatment, doctors are encouraged to monitor all pregnant women, a point that the Righetti-Veltima et al. study elucidates in its conclusion:

Regarding our results, we suggest that it is very important for all pregnant women to follow a prenatal preparation course which should include some time to discuss the psychological aspects of motherhood....Considering the new mothers' vulnerability, it appears also of great importance to continue to follow these mothers at home during the first weeks after delivery, as it is already the habit in some countries. (p. 178)

When following mothers home is not feasible for economic reasons, Zelkowitz and Milet suggest using the alternative of phone screening. They write, "From a practical standpoint, administration of a ten-item screening questionnaire over the telephone would not be difficult to incorporate into the routine practice of the community health nurses who now contact all postpartum women in the community. An EPDS score of 10 or over may warrant a home visit or additional follow-up" (1995, p. 85). Considering that the scene of this discussion is the clinic—both interactions with doctors and the hospital itself—the movement to suggest screening women outside of a primarily medical scene expands the gaze into the private lives/homes of individual women and their families. The scene—as clinic—should not then be interpreted as only occurring in doctor's office, for the subject position of patient is articulated as existing in the home.

The description of the objectifying practices of the medical gaze—and concomitant practices of surveillance—suggests again a scene/agent ratio in which women as patient act in ways appropriate with the scene. It is the agent as doctor that emerges as the one with agency—the means by which they can diagnose, treat, and prevent postpartum disorders. Of course, a doctor as active agent presumes the medical gaze as an intentional phenomenon, but Foucault would suggest that the observing gaze "refrains from intervening: it is silent and gestureless" (p. 107). For example, Neziroglu, Anemone, and Yaryura-Tobias report, "During interviews and

treatment of over 500 patients with obsessive-compulsive disorder by the two of us (F. N., J. A. Y.-T.), it was observed that the onset of obsessive-compulsive disorder for many women appeared during pregnancy” (1992, p. 947). Notice that Neziroglu, Anemone, and Yaryura-Tobias do not write, “we observed,” but rather, “it was observed” (p. 947). The medical gaze may be simply “there,” but it is nevertheless doctors who act upon the information that is filtered to them through the gaze. The relationship between women with postpartum disorders and the psychiatrists, other medical doctors, and nurses they interact with is a fundamentally unbalanced one. The subject position of the patient is no less restraining than that of the vulnerable female in which a woman reacts to her hormones, her biological “essence.” The position of the patient, however, relies precisely on that interaction with the doctor/nurse/expert to exist.

It should be noted that the screening practices that I have termed “surveillance” and largely understand as a disciplinary practice operate as a double-edged sword in which doctors/experts give support for new mothers while at the same time regulating them. The literature on health visiting work suggests the duality of this type of surveillance. Peckover argues that health visiting work can be understood in terms of social regulation (2002, p. 370). For new mothers, this process of surveillance takes on a particular meaning. Burman explains, “It is the adequacy of mothering that developmental psychology is called upon to regulate and legislate upon, and the continuity with which this issue crops up across the range of topics in developmental psychology is a manifestation of the widespread and routine subjection of women to the developmental psychological gaze” (1994, p. 3). Abbott and Sapsford present a similar argument: “Health visitors played a role in creating and identifying the ‘inadequate mother.’ They then became involved in programmes of reform to transform her behavior so that she became an adequate, a ‘good enough’ mother” (1990, p. 144). In sum, health visiting work is

based on normalizing discourses of motherhood, and this normalizing judgment, according to Peckover, is a central technique of disciplinary power (p. 371). Speaking to the other side of this duality, Zelkowitz and Milet argue, “Screening for postpartum depression in the community is warranted in order to identify cases and develop intervention strategies to promote the mental health of mothers and the optimal development of their infants” (1995, p. 80). What this suggests is that although my reading of the subject position of the patient as articulated within psychiatric rhetoric is one that points to the restraints offered by the position, such position also gives some women the care that they need during the postpartum period. It is, perhaps, the medicalization of life events, emotions, and biological occurrences along with the description of all women as possible patients that point to the dangers of the subject position of the patient: that women—as a group—are bound to the expert in what is a consistently subservient manner.

### *The Mother*

The final subject position that is articulated in psychiatric rhetoric about women during the postpartum period is that of the mother. That women are discussed as mothers during the postpartum period is not surprising; however, the characteristics of such a subjectivity are neither simple nor transparent. Indeed, what complicates the subjectivity of mother is the scene in which it is founded: the discourse of traditional motherhood that creates an unequal relationship between the mother and child. As a mother, women with postpartum disorders are often discussed in tandem with another person: her attitudes, symptoms are important not only to her, but also to her child. The subject position of mother develops in psychiatric rhetoric in two ways: the justification of research based on a concern for the child’s well-being and the construction of a risk/benefit paradigm for treatment that presents the patient as a dyad—mother and child.

The first articulation of mother emerges through a displacement of the woman as patient by foregrounding concern for the child and/or fetus through justificatory statements. Cheryl Tatano Beck's analysis is a unique example of a text that sees its primary concern as the impact of postpartum depression on the cognitive and behavioral development of the child. Beck begins by noting that researchers largely agree that postpartum depression can have an adverse effect on maternal infant relations up to 1 year, and then forwards the suggestion that such adverse effects may be prolonged, implicating children over 1 year (1998, p. 12). The effects of postpartum depression on children are seen to be wide ranging: insecure attachment, cognitive deficits, frequent temper tantrums, increased levels of neurotic and anti-social behavior, general behavioral difficulties, less affective sharing, and less initial socialability with strangers (p. 13). Beck's meta-analysis confirmed her hypothesis that postpartum depression had a small but significant adverse effect on cognitive and emotional development of children (p. 18). Beck reminds the readers that future research needs to be completed on sources of resiliency for children of mothers with postpartum depression, particularly the role of the father in decreasing the adverse effects. Beck's positioning of the child as the primary concern for postpartum depression is evidenced not only by her research questions, but also in the justification for the study. Encouraging practitioners to recognize and treat postpartum depression in women, she argues, "If interventions targeting specific predictors of postpartum depression can be initiated during pregnancy, perhaps the incidence of this postpartum mood disorder can be decreased and its adverse effects on children prevented" (p. 18). Beck also recognizes that treating women will likely have a positive effect on the entire family structure, decreasing stress on children and other family members such as spouses or partners (p. 18). What is remarkable about the subject "mother" is her positioning as a secondary member of a larger familial group. The concern for

children of women with postpartum depression is valid, for as Beck argues such depression does interrupt “normal” mother/infant interactions and, in the case of postpartum psychosis, the child’s life is often on the line. However, such a concern displaces woman as the primary object of care with her child. Justifying research on postpartum depression by noting the adverse effects on children suggests that the woman’s experience of depression is of lesser concern.

Although Beck’s article is the only article in the sample that focuses solely on the child, the use of children as justification for researching postpartum disorders emerges as a major theme in many of the articles. O’Hara, Stuart, Gorman, and Wenzel explicitly justify their study of interpersonal psychotherapy by referencing the child:

There is good evidence that mother-infant bonding is impaired by maternal depression.

Moreover, several studies have documented a link between postpartum depression and later problems in children’s cognitive and social-emotional development. Effective

treatment of postpartum depression is needed to prevent these problems. (2000, p. 1039)

Other researchers conclude that postpartum depression has adverse effects on not only the infant, but the “family” as well. Warner, Appleby, Whitton, and Faragher use this sentence to justify their study of risk factors: “Non-psychotic depression is found in 8-15% of women following childbirth (Pitt, 1968; Cox *et al*, 1982; Kumar & Robson, 1984, Watson *et al*, 1984; Cooper *et al*, 1988; Cox *et al*, 1993) and represents a considerable public health problem affecting women and their families” (p. 607). Likewise, O’Hara and Swain write, “Depression during the puerperium is a serious mental health problem for women and its consequences have serious implications for the welfare of the family and the psychological development of the child (Boyce & Stubbs, 1994; O’Hara, 1994; Phillips & O’Hara, 1991)” (p. 37). A key question here is not that we should not be concerned with the effects of postpartum depression on children, but rather why children play

such an important role in justifying studies of postpartum disorders. By taking children into consideration, I maintain that these articles suggest a subject position of mother that is articulated through women's relationships with others (the spouse, the newborn). Such justificatory statements are the first hint at a subject position in which concern for the family and child's well-being at times overwhelms concern with women themselves.

The use of justificatory statement is one place where the subject of mother emerges, but it is most clearly articulated in the risk/benefit paradigm that is created when considering the proper treatments for women with postpartum depression. Because the subject position of mother is articulated through a scene that relies on a discourse of traditional motherhood, the primary concern of women during the postpartum period is framed as the well-being of the child. Proper diagnosis is a concern because children with an undiagnosed (and untreated) mother with postpartum depression are at risk for a variety of developmental issues. On the other hand, treating postpartum disorders becomes a challenge precisely because of the importance of the welfare of the child. For example, in an article that discusses psychiatric disorders both during pregnancy and in the postpartum period, Cohen and Rosenbaum conclude, "Psychotropic medications may be used during pregnancy when the potential risk to the fetus from drug exposure is outweighed by the risk of untreated maternal psychiatric disorder" (1998, p. 24). For fetuses, psychotropic drugs hold three risks: 1) teratogenic effects such as gross organ malformation within the first 12 weeks of gestation, 2) neonatal toxicity, and 3) longer term behavioral sequelae (p. 18-19). In this particular case, Cohen and Rosenbaum weigh the benefits and risks of psychotropic drug use, and implicitly suggest using psychotropic drugs during pregnancy only during the most serious of depressive episodes. Llewellyn, Stowe, and Nemeroff concur with this approach for pregnant women, arguing that the key to an evaluation of pregnant



women is a “careful risk-benefit assessment” that considers both mother and fetus (1997, p. 27).

Psychotropic drug use during pregnancy is an issue of concern for researchers interested in postpartum depression because of the possible prophylactic qualities of beginning an anti-depressant drug regimen before women at high risk for postpartum depression give birth.

Llewellyn et al. explain:

A past history of depression or depression during pregnancy is associated with puerperal worsening of mood. Patients with past episodes of depression who discontinue medications during pregnancy need to anticipate the possibility of reemergent symptoms during the postpartum period. Those patients who have had severe major depression may benefit from prophylactic reintroduction of antidepressants either during the latter portion of the third trimester or immediately after delivery even though no abundant systematically derived data support the practice. (p. 32)

The hesitant suggestion to treat the most severe cases of depression with psychotropic drugs during pregnancy is indicative of the awareness of the possible negative side effects of these drugs on the fetus. Llewellyn, Stowe, and Nemeroff also highlight this problem (albeit implicitly) in their suggestions for how one can apply the risk/benefit paradigm:

We suggest that prior to initiation of treatment, except in emergent conditions, a medical workup of potential contributing disorders and a complete documentation of all medication and drug exposures be obtained. Whatever decision is realized by the clinician, patient, and significant other, the informed nature of the decision-making process should be documented in the patient’s chart. (p. 28)

That the decision making process is a careful and informed one, combined with Llewellyn et al.’s previous statement that parents may have a concern with the “essentially unknown effects of

pharmacologically treating or not treating the depression,” relieves the clinician of primary responsibility for the decision if negative side effects do appear.

The complications of psychotropic drug use are far higher for fetuses than infants, but breastfeeding also poses a substantial problem. The effects of psychotropic medications on nursing infants are believed to be relatively minimal, although the American Academy of Pediatrics has classified most antidepressants as “drugs whose effect on nursing infants is unknown but may be of concern” (O’Hara, et al., 2000 p. 1039). Given that breastfeeding is currently being promoted as a beneficial practice for infants, women often desire alternative treatments to medications (O’Hara et al., 2000). Interestingly, these other treatments are considered in the form of a risk/benefit analysis. O’Hara et al. (2000) suggest that interpersonal psychotherapy is a valid treatment precisely because it provides an alternative to taking psychotropic medications that may be attractive to women who wish to breastfeed (p. 1044). Wickberg and Hwang also suggest that alternatives to psychotropic medications be explored. They explain, “As new mothers are understandably reluctant to regard themselves as psychiatric patients and to take antidepressants during the breast feeding period, counselling [sic] could be useful as a first line of treatment of postnatal depression for those women who are clinically depressed but not seriously ill” (1996, p. 214). Llewellyn et al. suggest that electroconvulsive therapy (ECT) is an appropriate and safe treatment for both pregnant women and nursing mothers. In the case of pregnant women, they write, “Similar to the uncontrolled antidepressant data, 300 cases of ECT during pregnancy have been reviewed, and it appears that with proper preparation, ECT is a relatively safe and effective treatment for major depression in pregnant women” (p. 27). Likewise, ECT has been used with nursing mothers with “beneficial outcomes in treating depression”: “This method of treatment can be used on breastfeeding mothers without

risk to the nursing infant” (p. 30). Nonacs and Cohen agree with this evaluation of ECT, noting that treatment with ECT is also very “time-efficient” (p. 37). The positioning of ECT as an effective treatment is particularly interesting, as it is a controversial treatment that is recommended in this case precisely because of the benefits to the child/fetus despite the possible risks to the mother. In the United States in the 1940s and 1950s, the treatment was often administered to the most severely disturbed patients residing in large mental institutions (Cloud, 2001). More recently ECT has been used to treat only the most severely distressed or depressed patients (Cloud, 2001). Critics of psychiatry have warned that ECT is a risky practice, with little knowledge of why ECT works but much data on the side effects of ECT, including possible brain damage and memory loss (Cloud, 2001). The recommendation of using ECT as a treatment alternative to pharmacological drugs is one suggestion where the subject position of mother clearly works at the woman’s disadvantage.

The position of mother offers a perplexing problem. Feminist therapists and psychiatrists have offered a variety of critiques of psychiatry, and have proposed that one step in feminist understanding of distress is to move the focus away from the individual suffering distress and toward a larger understanding of how such distress operates in any given social milieu. In other words, as Brown (2000) argues, one needs to take into account a variety of factors in a given moment of distress, including the culture and the relationships around which distress forms. This movement away from the individual is partially accounted for in the subject position of mother, as the woman’s relationships within the family are taken into consideration. However, the position of mother does not extend into the larger social milieu—in other words, discussions of how and why certain aspects of motherhood are valued, and the concurrent value of children, are not mentioned. I contend that the articulation of “mother” in psychiatric rhetoric is particularly

problematic because it reflects two specific dominant assumptions about womanhood: first, that women's identities stem from their relations to others, and second that women as mothers are concerned with their child's well-being over their own (in other words, mothers are self-sacrificing). Adrienne Rich voices this problem in her book, *Of Woman Born*: "First, that a 'natural' mother is a person without further identity, one who can find her chief gratification in being all day with small children, living at a pace tuned to theirs; that the isolation of mothers and children together in home must be taken for granted; that maternal love is, and should be, quite literally selfless" (1986, p. 22). Beliefs such as these form the core of what Rich calls the institution of motherhood, in which the archetypal mother reinforces patriarchal values concerning gender roles and proper behavior. Within this institution of motherhood, Rich argues that women are placed as the sole caretakers of the child, and thus the one who has the most responsibility. She explains, "It is she, finally, who is held accountable for her children's health, the clothes they wear, their behavior at school, their intelligence and general development"(p. 53). The risk/benefit analysis suggested by some of the articles I reviewed draws upon this theory by asking women to consider the health of the fetus or newborn in conjunction with or before their own.

The dramatic focus on the child and his/her health differs from the treatment regimes of non-postpartum mental disorders. For example, while depression may adversely impact marital relations and possibly increase the likelihood of depression in the spouse (Kumar, 1994, p. 250), researchers do not argue that it would adversely impact the cognitive development of the spouse. On the other hand, it is precisely this focus on cognitive development and child well-being that postpartum discourse focuses on. There is, then, an assumed qualitative difference between the effects of a *mother's* depression compared to a wife's, husband's, father's, sister's or brother's

depression on the child. The subject position of “mother” suggests that women view themselves in relation to the people around them to the extent that those relationships guide their decisions for the types of treatments they choose and behaviors they exhibit. As an agent again operating in a scene/agent ratio, a mother’s actions are guided by the scene of traditional motherhood. Most significantly, women are encouraged to focus on the well being of their infants and take into consideration any adverse effects their actions may have on the infants’ development. Mothers (often with the guidance of their physician) are held responsible for the decisions they make and should recognize the impacts those decisions will have on their families. Simply stated, as a “mother,” a woman with a postpartum disorder is encouraged to come to a sense of self that incorporates others’ needs as well as (and perhaps before) her own.

*Discussion: Hegemonic Discourses and Preemption*

One reading of this case study would suggest that it is because of the dominance of the bio-medical model in psychiatric thought that all of the subject positions at some point draw upon a variety of biological explanations for why postpartum disorders occur. The predominance of biological explanations can then be interpreted as foreclosing other understandings of postpartum disorders as well as the formation of other subject positions. In fact, we might consider biomedical model itself as operating as a synecdoche in which biology stands in for the larger, more complicated system of human development. Critics of psychiatry and the bio-medical model have suggested that diagnosis does not necessarily have to be only about biology. Indeed, as psychiatrist Duncan Double argues “Although biological explanations are important—as the brain is the substrate for cognition, emotions, and behavior—understanding personal action is not helped by eliminating the meaning of people’s distress and the psychological and social origins of their difficulties” (p. 903). This process of elimination is

described by Raskin and Lewandowski as a process of preemption. They explain, “Because of the *DSM-IV*’s tremendous success and its traditional science foundation, it is often used in a preemptive manner. As a result, alternative constructions of disorder are sometimes not entertained, leaving new possibilities overlooked” (p. 17). The biological explanations for postpartum disorders thus preempt other possible constructions of the disorders, leaving psychiatric discourse with an understanding of postpartum disorders that is focused on only one of many explanations. Further, I would suggest that the subject positions that emerge in such biomedical discourse also preempt the formation of other subject positions. Even the position of mother, which is not overtly concerned with the biology of postpartum depression, remains squarely within biomedical discourse because of the “scientific” basis of such research and the search for medical treatments for women, including ECT and pharmaceutical drugs, that will not adversely impact the child.

This concept of preemption, however, needs a qualification to fully understand the articulation of the subject positions in psychiatric rhetoric. The three subject positions that are articulated in psychiatric rhetoric can preempt other positions because of their authority based in scientific/biomedical discourse *and* because they are also based on a discourse of traditional motherhood. In the articles reviewed for this case study, there is a general agreement that postpartum disorders, including postpartum depression, postpartum psychosis, the baby blues, and obsessive compulsive disorder during the postpartum period, are unique for at least one common reason: the context of the disorder. In his survey of the transcultural occurrence of postpartum disorders, R. Kumar suggests that studying cultural differences (and similarities) in rates and manifestation of postpartum disorders may actually be a far easier task than studying other mental illnesses such as schizophrenia. He explains:

No assumptions are needed to identify suitable candidates for research, the inclusion criterion is “pregnancy leading to live birth” and additional sets of subjects can be included, if required, such as those having miscarriages, therapeutic abortions, stillbirths etc. The problem of case identification and categorization is reduced down to devising methods for detecting and recording the presence of psychotic and non-psychotic disorder occurring in the puerperium. (1994, p. 251)

Pregnancy, and the resulting “live birth,” is central to Kumar’s understanding of postpartum disorders to the extent that he suggests such women can be classified simply by their status as *mothers* or *possible mothers*. In suggesting that postpartum patients can be understood first and foremost as “mothers,” Kumar touches on the one of the three subject positions for women during the postpartum period that are articulated in psychiatric discourse: the mother. That concepts motherhood plays a central role in psychiatric rhetoric indicates the subject positions for women that are articulated rely on more than a biomedical discourse that promises to find the physiological causes behind postpartum disorders.

The discourse about women in psychiatric literature is thus particularly interesting because of the dominance of social understandings of “women” in guiding the literature in its search for the causes, risk factors, and proper treatments for postpartum disorders. Although many critics of psychiatry, such as Duncan Double (2002), argue that psychiatry’s biggest problem is its reliance on the biomedical paradigm in which mental illnesses are defined as biological phenomena whose causes can be located and symptoms easily treated, what we see in the case of postpartum disorders is an interesting blending of this biomedical paradigm with traditional understandings of what it means to be female and a woman. I suggest that the interaction between these two forces—a biological understanding of human life as well as a

patriarchal (for lack of a better word) understanding of womanhood—can be seen in the different scenes through which discussions of women during the postpartum period take place. The clinical scene of the patient and the reproductive life cycle scene of the vulnerable female support psychiatry’s biomedical paradigm. In other words, it is through these scenes that a woman as biological being develops. Even “non-medical” life events are captured by the biomedical paradigm. Nonacs and Cohen, for example, recognize the importance of “social factors” while at the same time interpreting them through the medical gaze:

The extent to which a rapidly changing hormonal environment influences the emergence of affective illness has been considered by many; however, one cannot underestimate the importance of psychosocial factors and biologic vulnerability in the development of affective illness during the postpartum period. Given the multiplicity of these factors and the complexity of their interactions, it is extremely difficult to reliably predict who will experience postpartum mood disturbance. (1998, p. 35)

The psychosocial factors Nonacs and Cohen briefly refer to include the gap between expectations of motherhood and the “reality” of motherhood and a variety of “demographic” factors such as age, income, marital status, and education level (p. 35). For clinicians like Nonacs and Cohen, psychosocial factors are considered a part of a patient’s history and can be used, in conjunction with knowledge of biological factors, to predict those women who are at risk for postpartum disorders.

On the other hand, the scene in which the subject position of the mother is articulated—that of a traditional discourse of motherhood—provides room for an articulation of woman that relies on “patriarchal” understandings of womanhood. This scene does not need to be fundamentally biomedical (in other words, discourses of traditional motherhood can and do



develop outside of the medical/biological sciences), but in psychiatric rhetoric the scene of traditional motherhood is both supportive of and complementary to the biomedical discourses proposed through the reproductive life cycle and clinic scenes. Specifically, when we view the three subject positions that are articulated in psychiatric rhetoric in relation to each other, what emerges is a direct link between gender roles and biological sex. This link is suggested implicitly by discourses of traditional motherhood which suggests that mothers naturally (read, biologically) care for their children above themselves and it is supported by the discourse of biomedicine which suggests that women's hormones are the primary biological force in women's mothering ability, or inability in the case of postpartum disorders. The subject position of the patient is firmly articulated within biomedical discourse that privileges an expert (the psychiatrist) and the expert's gaze as necessary to understanding what biological system's malfunctions could result in a woman's "a-typical" lack of interest in her child, her visions of violence towards that child, and her general sadness and anxiety during the postpartum period. The interplay of the two dominant discourses—that of biomedicine and traditional motherhood—results in articulations of subject positions for women that constrain women's ability to live as women, not as mothers, patients, or females.

To suggest that the hegemonic power of discourses of biomedicine/science and womanhood/motherhood can preempt other subject positions suggests that the potential for other subject positions does indeed exist. Based on my own reading of the literature in this area, the discussions about postpartum disorders that are largely missing in psychiatric literature are those concerned with the impact of the cultural construction of motherhood on women's experiences of motherhood, and the larger power structures—relationships, institutions, etc.—that are the larger scene of postpartum disorders. A subject position that reflected the social location of

women—perhaps in a more critical way than psychiatric literature—might bring biology and culture together in a different fashion. Specifically, this subject position would posit that 1) women are biologically complex—like all humans—and that there may be no single easy explanation for the occurrence of postpartum disorders and 2) that women, like men, exist within a larger social framework that includes certain roles and expectations. This subject position arises frequently in feminist literature that suggests that offering a one-dimensional understanding of postpartum depression, particularly one that reifies our assumptions about sex differences and normalizes patriarchal gender roles, is a problematic and oversimplified depiction of what is a highly complex and contested phenomenon.

The key move here is not removing either biology or social expectations, but rather reshaping the relationship between these two to be interactive rather than a simple one way street in which biology determines what is woman. Several of the articles in this case study hinted at such a subject position. Nonacs and Cohen, as I note above, do recognize the importance of psychosocial factors in understanding the occurrence of postpartum disorders. O'Hara and Swain also pay attention to factors other than past histories of depression and hormone levels. Their description of the prototypical woman at risk for a postpartum disorder exemplifies this approach:

She is most likely to occupy a lower social stratum but women representing middle and upper social strata will also be abundantly represented. She is very likely to have experienced life stressors during pregnancy and may have had a more difficult than normal pregnancy or delivery. She will be experiencing marital difficulties and experience her partner as providing little in the way social support. Compounding the life stress she is experiencing and her poor marital relationship will be her perception that

others in her social network are not particularly supportive of her. Finally, her history will show evidence of psychopathology, in most cases major depression or dysthymia, and she will show evidence of being at least mildly depressed and anxious, and excessively worried. Obviously, the picture of the woman at risk is overly simple but it does represent a synthesis of the risk factors that have emerged from this meta-analysis of the postpartum depression literature. (p. 9)

It is precisely this “synthesis” that a subject position that considered both biological as well as social factors would attempt to capture, a synthesis that is largely missing from psychiatric rhetoric. Such a subject position would likely develop outside of psychiatric rhetoric, which, while it certainly has authority in this culture, is not the only source for understanding women with postpartum depression. The subject positions articulated by psychiatric discourse are likely to be found elsewhere because of the very nature of discourse. As elements, the subject positions of the vulnerable female, the patient, and the mother become moments—articulated “fixed” identities through articulation—not only in psychiatric rhetoric, but also in the news coverage of postpartum disorders. The next two case studies analyze how these subject positions are reframed and rearticulated in the media and attempt to identify other subject positions that may also be articulated. Of particular interest is the appearance, or perhaps absence, of the subject position mentioned above in which we see a synthesis of both biological and social understandings of postpartum disorders.

## CHAPTER THREE

### Postpartum Disorders in the News

As rhetorical texts, newspaper and newsmagazine articles provide an interesting insight into how postpartum disorders—and women with postpartum disorders—are characterized in a more public discursive context. As Nancy Signorielli notes, “The importance of cultural factors, particularly the media, in both imparting health information and impacting on the nation’s health has been noted for more than a decade” (1993, p. ix). Actually, “more than a decade” is an underestimation; Wade and Schramm’s 1969 article, “The Mass Media as Sources of Public Affairs, Science, and Health Knowledge” argues that both print and television news function to distribute information about politics, science and health to the public (1969, p. 202). Further, Wade and Schramm note the importance of gender to knowledge about health: “Responsibility for knowing about health seems to be part of the woman’s role in the family; knowing about science seems to be part of the role a man is expected to play” (p. 203). Women in 1969, for example, were more likely to read articles about health than were men (p. 202). Although Wade and Schramm’s study of the media as sources of knowledge is dated, certainly they belong to a long line of researchers interested in understanding how the media communicates issues of health to the public. Signorielli supports their conclusions about the importance of the media: “For the majority of Americans, the media have become a major source of health information” (1993, p. ix). This case study supports the contention that the voice of psychiatry is influential in the articulations of subject positions for women during the postpartum period in the news, and also suggests that other factors, or voices, come into play. My analysis of news stories about

postpartum disorders relies on the theory of news frames to argue that one frame unites all of the new coverage of postpartum disorders: the motherhood frame. After reviewing the literature on news framing and discussing my adoption of framing as one way to study articulation, I move to an analysis of the four subject positions that are (re)articulated within the motherhood frame: the vulnerable female, the patient, the mythical mother, and the “real” mother. Couched with the largely sympathetic nature of the news toward women with postpartum disorders generally, and Andrea Yates more specifically, are three subject positions for women—the vulnerable female, the patient, and the mythical mother—that ultimately support and draw from the discourse of traditional motherhood as described by theorists such as Adrienne Rich (1976/1986), Barbara Katz Rothman (1989/2000), and Sheri Thurer (1994). The mythical mother emerges as the central subject position in news coverage of postpartum disorders, and both the vulnerable female position and the position of the patient act as supporting positions for the position of the mythical mother. The appearance of the new subject position, the “real” mother, points to a possible space of resistance: letters to the editor.

*News Framing and News Routines: Articulation in the News*

To become “news,” any given story or element must have a certain set of characteristics. The old news adage, “if it bleeds, it leads,” suggests that quite often what becomes “news” are stories of violence, shock, and horror—stories that seem to stand out from the field of a “normal” news day. Of course, other stories—particularly world news and political news—do not have to “bleed to lead.” However, these stories are still influenced by how news is produced in this country and by a larger understanding of what news should do. For example, using a news routines approach, Reese and Buckalew (1995) focus on the ways in which the routine procedures and objectives of news workers promote certain story lines during the gulf war.

Reese and Buckalew note that routines are linked to content: the reliance on primarily military sources in their study of news coverage of the Gulf War meant that news workers often evaluated Gulf War events within a “military framework” (p. 42). Thus, in an effort to gather sources and write a story before the always impending deadline, news workers often rely on easily accessed sources which are often “institutional powers in society” (p. 42). This part of the news routine “provide[s] the underpinnings for ideological frames of reference” (p. 42). Tuchman explains:

News processing itself is routinized according to the way occurrences at legitimated institutions are though to unfold; predicting the course of continuing stories at legitimated institutions enables editors to plan which reporters will be available for spot-news coverage on any one day. *The news net is based in legitimated institutions.* (1978, p. 212, emphasis mine)

News routines form the base upon which a frame analysis is situated: namely, that certain frames will appear because of the ease with which they can be used.

### *Frame Analysis*

Through a “frame analysis” (as illustrated by Tucker, 1998 and Watkins, 2001), I argue that the frame that unites the coverage of postpartum disorders—the motherhood frame—creates a context that privileges the position of the mother. According to Watkins, “Frame analysis, in part, seeks to understand the social implications of how journalists organize their representations of the world” (2001, p.81). In particular, framing involves the selection of issues that are seen as more “salient” than others. Entman explains “To frame is to select some aspects of a perceived reality and make them more salient in a communicating text, in such a way as to promote a particular problem definition, causal interpretation, moral evaluation, and/or treatment recommendation for the item described” (1993, p. 52). Frames influence an audience's

understanding of any given issue by placing emphasis on certain words, symbols, stereotypes, and ideas (p. 53). Thus, one important aspect of framing is meaning-making: "...the frame determines whether most people notice and how they understand a problem, as well as how they evaluate and choose to act upon it" (p. 54). Frames, however, do not dictate what an audience knows and understands; rather, a frame analysis is concerned with the "potential" effects of frames, or any given frame's "capacity to make certain aspects of a problem appear more salient than others" (Watkins 2001, p. 85). Because of frames' meaning-making potential, understanding frames as ideological is particularly important: "At issue is the power of media frames to define particular aspects of reality in ways that support specific social interests within the field of public discourse" (Tucker 1998, p. 143).

Previous frame analyses have covered a wide variety of topics, including how frames are used to make meaning in realms as diverse as politics to fashion. Entman's discussion of framing in 1993 was aimed at using frame analysis to further our understanding of political discourse: "Framing...plays a major role in the exertion of power, and the frame in a news text is really the imprint of power—it registers the identity of actors or interests that competed to dominate the texts" (1993, p. 55). News frames are also important in coverage of health-related issues. Indeed, frames function in much the same way in health coverage as they do in coverage of political issues: namely, frames often support elite interests and power structures. Studies on media and health are often concerned with two main problems: first, how the media misrepresent health issues by distributing false and/or skewed information and thus create public confusion; and second, how the media can be used effectively to promote healthy lifestyles and to distribute correct information about health issues (Signorielli 1993, p. xi; Wallack, Dorfman, Jernigan & Themba, 1993, p. 5). In light of the definition of framing as a process concerned

with “selection” and “salience,” the problem of “skewed” information about health as related by the media becomes particularly interesting. Clarke notes, “Diseases are noticed and diagnosed, and both preventative efforts and treatment modalities exist within culture. Neither medical professionals (be they clinicians or researchers) nor laypersons (be they sufferers, journalists, or others) experience disease outside of language” (1999, p. 59). Frame analysis is thus seen as a particularly apt way to analyze health related news coverage because of the importance of any given audience receiving accurate health related information.

Julie Andsager and Angela Powers, in their article “Social or Economic Concerns: How News and Women’s Magazines Framed Breast Cancer in the 1990s,” offer one example of how a frame analysis can work in a health-related context. Because women’s health coverage has typically focuses on looks, diet, and care for the family, Andsager and Powers argue that the amount of news about breast cancer is not as important as the quality of the news (Andsager and Powers, 1999, p. 532). The framing of breast cancer differed depending on the genre of magazine: women’s magazines often used a frame of “personal stories” and news magazines used a frame of “insurance coverage” (p. 545). Both types of magazines, however, tended to emphasize the prevention of breast cancer (p. 545). The quantitative rise in breast cancer incidence over the past two decades has led to an impressive amount of coverage by the media; however, this coverage often differs depending on sources (women’s magazines or news magazines). My concern with Andsager and Power’s work relates to their use of frames:

Women’s magazines framed breast cancer in three general ways—coping with the disease and its effects, personal experiences, and risk factors involved in cancer. News magazines provided basic information about cancer and its treatment, research on causes



and prevention, and an economic frame focusing on insurance and political issues (p. 542).

Andsager and Powers compress the above frames into two overarching frames: the social and the economic. The social frame deals largely with women's experiences with breast cancer while the economic frame concerns issues related to the health care industry. Their article concludes with a brief discussion of the larger implications of the social and economic frames. Although the social frame provides information about breast cancer through the form of advice, the social frame does not place breast cancer within the larger context of the health care industry. On the other hand, the economic frame focuses mainly on insurance issues and the "politics" of breast cancer and does not give women specific information about breast cancer and the latest treatments. Thus, both frames have drawbacks because they both offer incomplete information about breast cancer (Andsager and Powers, 1999).

The concepts of "incomplete information" and "skewed information" that form the core of health-related frame analysis indicate that these analyses take as a fundamental assumption an idea that complete/full coverage of any given issue is possible *and* that, in the case of health issues, the accuracy of news coverage is of utmost importance. My analysis of postpartum disorders, on the other hand, would suggest that a complete and accurate understanding of postpartum disorders is not possible, not only because scientists/medical doctors cannot agree on "what" a postpartum disorder is, but also because such disorders are always being rearticulated. Thus, my use of framing comes not in the context of news accuracy, but rather in an attempt to understand the process through which the news, using frames, can articulate subject positions for women that reify dominant assumptions about womanhood/motherhood. Clarke's analysis is a good example of this alternative use of framing as she focuses on the way in which print

coverage of prostate cancer genders the nature of the disease (much like coverage of breast cancer) to the extent that prostate cancer is not seen as “neutral,” but rather “as a disease with particularly masculine attributes and consequences” (p. 70). Linking prostate cancer to “manliness” is similar to the approach taken in coverage of postpartum disorders, where issues of femininity play a central role in our understanding of women during the postpartum period. Like my use of the concept of scene in the previous chapter, my use of framing suggests that the frame used will impact the articulations of subject positions for women.

### *Framing Postpartum Disorders*

This analysis combines newspaper articles from *The New York Times*, *USA Today*, *The Houston Chronicle*, and *The Los Angeles Times* with newsmagazine articles from *Time*, *Newsweek*, and *U.S. News and World Report*. The four newspapers were chosen in an effort to have regional and national representation as well as maintain a feasible sample size. An additional justification for using the Houston Chronicle is the Andrea Yates case, which occurred in Houston and received more detailed coverage in *The Houston Chronicle* than other papers. The newsmagazines were selected based on their reputation as the top three newsmagazines in this country. To select newspaper articles, I ran a “general news” search on Lexis Nexis for “postpartum depression” or “postpartum psychosis” in the full text of the four newspapers selected for the years 2001-2004. The search resulted in 157 articles. Of these, three articles were listed as articles from the “Information Bank Abstracts” associated with the *Wall Street Journal* and were cut from the final total of articles. The resulting 154 articles all consider the issue of postpartum disorders at some point, but the majority involve reports of the Andrea Yates case. I used 2001 as a starting point to limit the number of articles because the Yates case initiated a flurry of articles about postpartum disorders. For example, in search of *The New York Times* for

“postpartum depression” or “postpartum psychosis” before the year 2001, only 64 articles appear from 1976 to 2000. The search for newsmagazine articles was a more difficult process. The Lexis Nexis search for the three newsmagazines proved limited because *Time* restricts the articles available through Lexis Nexis. Thus, I performed two searches. In the first, I searched Lexis Nexis for “postpartum depression” or “postpartum psychosis” in the full text of *Newsweek* and *U.S. News and World Report* for the years 2001-2004. The search resulted in 19 articles. In the second search, I searched the *Time* archives (located at <http://www.time.com/archives>) for the words “postpartum depression” or “postpartum psychosis.” The search resulted in four articles in *Time* from 2001-2004 with the words “postpartum depression.” The total number of articles used from newsmagazines resulting from both searches is 23.

As I suggest above, complementing frame analyses with articulation theory suggests that certain “elements” are moved into prominence in a discursive field, or are “articulated,” when certain frames are used. In the following analysis, I focus in on how subject positions for women are articulated through the frame of motherhood. The process of analyzing the articles in terms of framing was a largely inductive one. After reading the articles and taking close notes, I looked for thematic elements that differentiated the articles from each other. What resulted was a differentiation of the types of stories covered (legal, medical, social), but *not* in the frame used to cover the stories. Although many frame analyses (e.g. Andsager and Powers, 1999) use coding schemes to provide data on the number of frames used, the frequency of the frames, and the content of the frames, the process of recognizing a frame remains inductive. As a rhetorical scholar specifically interested in how discourse can constitute subjects, I have not coded for the frame of motherhood in terms of frequency. However, I do recognize the importance of understanding how a frame works—in other words, what “discourses” constitute a frame. Below

I offer a brief description of the motherhood frame used in the coverage of postpartum disorders and the Andrea Yates case.

The different story lines that make up the coverage of postpartum disorders and the Andrea Yates case are unified by the frame through which they are discussed: the frame of motherhood. Within this frame, the news reports, whether they are a report of Yates's life history, her mental status, or the legal machinations of the trial, are all concerned with what constitutes a "good" mother. This frame should not be mistaken with the discourse of traditional motherhood. Framing is described by Entman as both a process of selecting elements of a "perceived reality" and making them salient (1993, p. 52). The motherhood frame makes salient those elements that are linked to issues of motherhood. In other words, issues of good and bad mothering, models of appropriate mothering, controversies over what constitutes a "good" mother, and even motherhood's place as an institution are highlighted, or emphasized, in news stories using the motherhood frame. That motherhood is the uniting frame used in news reports about postpartum depression is apparent even in the titles of the articles reviewed for this case study. A selection of just a few of the titles—"Andrea Yates gets fair treatment on 'Mugshots: A Mother's Madness'" (McDaniel, 2002, p. 6), "Mother who drowned 5 children in tub avoids a death sentence" (Yardley, 2002d, p. A1), "Friends and family ask jury to spare Texas mother's life" (Yardley, 2002c, p. A14), "Despair plagued mother held in children's deaths" (Yardley, 2001c, p. A7), and "Mom charged in drownings moved to psychiatric unit" (Teachey, 2001, p. A19)—indicates that the press viewed Yates first and foremost as a mother. But the motherhood frame develops through more than simply the frequent use of "mother" as an appropriate descriptor for Andrea Yates. The focus on Yates as a mother influences the content and direction of the different story lines used to discuss Andrea Yates. In coverage of the Yates trial,

the question at hand is not “How do we punish a murderer,” or “Did she murder the children,” or even, “Did she know what she was doing,” but rather, “Why would a mother ever kill her child?” (Szegedy-Maszak, 2002, p. 23) Discussions of Yates’s medical history pose an answer to this question: mental illness. The mental illness that is discussed is not just any illness, but rather an illness intimately tied to motherhood. For example, Angle reports for the *USA Today*, “‘They have trouble eating, sleeping. They’re anxious and feel *guilty about not being a good enough mom*,’ Sanford [a psychologist] says. Eventually, some become suicidal” (2001, p. A2, emphasis mine).

The motherhood frame also shapes the coverage of the Yates family, in this case promoting a focus on the issue motherhood in the context of the role of a mother in the family and society at large. On the one hand, the Yates family—five children, mother, and father—received coverage as a family unit. Andrea Yates’s behavior as a mother was discussed, as well as her family’s presence (or absence) in their neighborhood, the Yates’s children’s personalities and characteristics, and the husband’s role at home as the traditional patriarch of the family. The inner workings of family life are also discussed in articles about Marie Osmond’s “battle” with postpartum depression, Brooke Shield’s forthcoming book on postpartum depression, and other (non-famous) women’s experiences with postpartum depression (often expressed in letters to the editor). On a larger scale, issues of motherhood were debated more generally in terms of how motherhood is conceived of by society. The Yates case formed a backdrop, or perhaps impetus, for these discussions, but was often not the singular focus of the articles. Letters to the editors of various newspapers and newsmagazines and editorials offering critiques of our “idealized” version of motherhood (i.e., Quindlen, 2001) and reports of NOW’s desire to fund research on postpartum psychosis also use the motherhood frame. What becomes clear within this frame is

that motherhood does not exist within a vacuum, and it is precisely our understanding of motherhood that is at stake in the discourse about postpartum disorders.

The motherhood frame rearticulates the three psychiatric subject positions for women during the postpartum period in ways that point to the importance of context. Given that the news is not as focused on the “science” behind postpartum disorders, the vulnerable female, the patient, and the mother play different “roles” in news coverage than they had in psychiatric rhetoric. What I mean by this is that in most cases, the elements that are articulated to make up the subject positions remain the same (for example, hormones and brain chemistry play a central role in the articulation of the vulnerable female in both psychiatric rhetoric and news coverage). What changes is the discursive location of the positions and thus the meaning and function of these positions. In other words, as Derrida suggests, although signs can be cited/iterated, the meaning of the sign at least partially depends on the context in which the sign is located. As an example, consider the implications of the meaning of the position of the mother in psychiatric rhetoric. The mother allows for the proposal of treatments that are harmful to women precisely because these women are *mothers* and thus should be concerned above all with the welfare of their children. The mythical mother position in the news coverage, on the other hand, works in conjunction with the vulnerable female to offer an explanation for Andrea Yates’s actions that does not disrupt the discourse of traditional motherhood. The rearticulation of the subject positions of the vulnerable female, the patient, and the mother in the context of print news—with its routines and demands for circulation—also opens up the three subject positions to new complexities, moving at least in part towards a more complex subject position as one that I suggested at the end of the previous chapter. I argue in this chapter that the rather restrictive positions of vulnerable female, patient, and mother are rearticulated to encompass more cultural

and critical dimensions—a recognition, for example, of the cultural factors that are risk factors for postpartum depression, as well as a recognition, voiced through editorials and women with postpartum disorders, that motherhood is not simply an easy and joyous life event. I have written the analysis, in an effort to flow with the previous chapter, in three major sections: the vulnerable female, the patient, and the mother. Within each section, I describe how the frame of motherhood is used to rearticulate the subject positions offered by psychiatric rhetoric. I conclude with a discussion of how the rearticulation of subject positions in the news defies easy demarcation of these very subject positions. Rather, these subject positions depend on/work with each other in such a manner as to place the mother as the central subject and to limit the ability of distress (whether it be Yates’s case of postpartum psychosis or the more general frustrations of motherhood) to function as an antagonism.

*From Vulnerable Female to Vulnerable Mother*

As articulated within psychiatric rhetoric, the position of the vulnerable female places women during the postpartum period under the control (or at least influence of) their hormones. Using the scene of the “reproductive life cycle,” psychiatric discourse positions women as at risk for experiencing mental distress during their premenstrual periods, menopause, pregnancy, and the postpartum period. The fluctuation in hormones during the postpartum period is largely recognized as a “normal” process, leaving the women with postpartum disorders characterized as “vulnerable females” because their bodies react differently, more extremely, than those of “normal” women. In the motherhood frame used in news coverage of postpartum disorders, the vulnerable female plays an important role in maintaining the discourse of traditional motherhood by offering a medical/scientific understanding of why women might kill their children or feel depressed during the postpartum period. Specifically, medical explanations of postpartum

disorders in the news coverage combine with coverage of the Yates trial to rearticulate the vulnerable female as a subject position that denies women's agency while at the same time providing a successful defense for women with postpartum disorders who murder their children.

Despite the fact that postpartum disorders exist in psychiatric rhetoric as a somewhat controversial subject, with issues such as the presence of postpartum depression in the *DSM* and proper treatment for postpartum disorder remaining largely unresolved, the treatment of postpartum disorders in newspaper articles suggests that postpartum disorders are far less controversial. In other words, postpartum disorders are described definitively in a way that does not open up room for questions. Most articles recognize the continuum of postpartum disorders, starting with the baby blues, continuing through postpartum depression, and ending with postpartum psychosis. Reporting for *USA Today*, Angle describes the three disorders:

There is often confusion about postpartum depression for women. Three separate conditions sometimes occur after childbirth. One condition, if it does arise, does not necessarily lead to another.

Postpartum blues. Affects about 85% of mothers. Starts within three days of giving birth and lasts up to 14 days. Mood swings.

Postpartum depression. Affects about 10% of mothers. Can start shortly after birth or up to two months later. Can last up to 1 1/2 years. These women feel fatigued and lonely. They don't enjoy motherhood and are frequently tearful. Mild eating or sleep disorders.

Postpartum psychosis. Occurs in about 1 in 1,000 mothers. Usually starts soon after giving birth. These women may be delusional and hear voices that say to kill the baby or that the baby would be better off dead. Often someone intervenes and separates the mother from the baby to prevent harm. (2001, p. A2)



Angle's description of the three disorders is short and concise, and is mirrored in Greenburg and Springen's discussion in *Newsweek*:

Unlike the "baby blues," a temporary period of weepiness that up to 80% of new mothers undergo, PPD is characterized by persistent feelings of anxiety, hopelessness and guilt, insomnia, lack of motivation and, sometimes, thoughts or fantasies of harming oneself--or even the baby. Doctors estimate that between 5 and 20 percent of all new mothers suffer from it. A much smaller number, about one woman in 1,000, experience the far more severe symptoms of postpartum psychosis, including hallucinations, paranoia and delusional, suicidal or homicidal, thoughts." (2001, p. 26)

Although a few aspects of these definitions differ from each other (for example, the differing estimations that 10% versus 5 to 20% of new mothers experience postpartum depression), they describe the basic symptoms and the incidence of postpartum disorders in a manner comparable to the "working definitions" I proposed in Chapter 1. Such working definitions give the readers a basic background for understanding postpartum disorders. Key, however, to the creation of the "vulnerable female" subject position is a search for the causes of postpartum disorders.

Although news reports of postpartum disorders recognize to some extent possible external causes of postpartum disorders, postpartum disorders remain clearly linked to a woman's physiological body. Feldman reports, for example, that "After giving birth, a woman's hormones, electrolytes and fluids are in flux--those are the biological reasons for the mild depression. There are practical reasons, too. New moms find themselves tied to home and hearth, like it or not, and they face new financial challenges, new family dynamics, new worries about their appearance and competency" (Feldman, 2001a, p. 1). By following the standard psychiatric explanation for postpartum disorders (hormones) with a societal/cultural explanation, this article

at least partially disrupts the dominance of the role of hormones in our understanding of postpartum disorders. However, hormones—and brain chemistry more generally—remain the key explanatory factors in postpartum depression. Susan Gilbert suggests in her article on the genetics of depression in women, “[S]everal genes probably work in concert with the ebb and flow of reproductive hormones to change brain chemistry in ways that might set the stage for depression, especially after an emotional ordeal” (2004, p. F1). Reporting postpartum depression in the frame I have previously discussed as the “reproductive life cycle frame,” Gilbert writes, “A leading theory is that sex hormones help induce depression in some women by affecting messenger chemicals in the brain that influence mood” (2004, p. F1). The reappearance of hormones as key to depression is perhaps not surprising, as most articles refer to experts—often psychiatrists—who support a hormonal understanding of postpartum disorders. Indeed, the reappearance of the scene of the reproductive life cycle suggests that in accordance with a theory of news routines, the reliance on “experts,” or institutionalized knowledge, results in a discussion of postpartum depression that imitates some of the psychiatric discussion. When hormones are not provided as the key factor in postpartum depression, other biological factors such as a history of depression or disease take center stage (see Brink, 2002, p. 68).

Like psychiatric rhetoric, in which postpartum disorders are understood to be physiological phenomenon and the proper treatment thus will counter or fix the physiological processes gone awry, treatments suggested in the medical frame of the news are largely medical treatments such as pharmaceutical drugs or hormone shots. Brink reports, for example, “Symptoms of depression improved for 80 percent of the women on the [estradiol] patch and for only 22 percent of women with the placebo patch” (2002, p. 68). Angle reports, “Postpartum depression is treated successfully with antidepressants and therapy, Sanford says. Patients’

symptoms usually can be brought under control with this regimen within weeks, she says” (2001, p. A2). I will discuss treatment in more detail in the section on the subject position of the patient below, but these two brief examples should suffice to substantiate my contention that postpartum disorders are primarily viewed as physiological events. This is a key contention of the biomedical paradigm as voiced by psychiatrists—that depression, for example, can be traced to differences in brain chemistry—and as such the biomedical paradigm that helps configure the vulnerable female remains largely unaffected. The occasional insertion of external factors—the Yates family’s living conditions, the amount of time and energy spent by Andrea Yates home schooling her children and taking care of her ailing parents—can be reduced to what psychiatrists would call a “life event” that propels, or begins, a set of chain reactions that results in the physiological event that psychiatrists and other medical doctors recognized as “depression.” In other words, the insertion of external factors does not necessarily disrupt the psychiatric understanding of postpartum disorders as physiological events.

The support for a physiological understanding of postpartum disorders has an important implication for the rearticulation of the vulnerable female through the motherhood frame. A key aspect of the vulnerable female subject position as articulated in psychiatric rhetoric was the issue of “control” or “influence,” depending on the source. Psychiatrists largely recognized, for example, that hormonal and brain chemistry changes can result in behavior changes that are “uncontrollable.” I discussed this in terms of an action/motion duality as described by Burke in which a woman’s “actions” (for lack of a better word) during the postpartum period if she was suffering from a postpartum disorder were actually motions—events that were largely controlled by her own biological body, or, in this particular case, her hormones. My use of the word “female” was meant to point to the emphasis on women’s biological bodies. In news coverage,

however, the interest in the female body is largely narrowed to one “type” of body: the maternal body. The motherhood frame thus articulates the vulnerable female as the vulnerable mother, and it is only the vulnerable mother who could be found not guilty by reason of insanity for the murder of her children. The vulnerable mother position is clearly articulated in stories concerning the Yates trial.

To be clear, a similar subject position might arise in the story lines concerned with law and justice in terms of the “vulnerable male” or perhaps even the “vulnerable body.” John Hinckley’s acquittal based on insanity defense in 1982 was the result of the defense’s ability to successfully argue that Hinckley’s mental illness prevented him from controlling his own behavior (see Parker, 2002, p. A11). However, Hinckley suffered from schizophrenia, a disease widely recognized to occur in both sexes. Insanity defenses using postpartum psychosis are based on the argument that postpartum disorders are a uniquely female event. This argument is one that is supported by 1) the common sense knowledge that only women bear children—i.e., go through the experience of pregnancy and birth, and 2) that it is the physiological event of pregnancy/birth that results in postpartum disorders. Legally, only Great Britain recognizes the postpartum period as one of increased vulnerability for women. As Szegedy-Maszak reports, “There [in Great Britain], a mother who kills her children within the first 12 months of life is unlikely to face jail—a legal nod to the fact that, as Duke University obstetrician and psychiatrist Diana Dell puts it, the period right after birth is ‘the most biologically vulnerable time in a woman’s life psychiatrically’” (2002, p. 23). If Great Britain is the only country that legally recognizes the “vulnerable mother,” the Yates case has apparently re-opened the debate on the insanity defense and what the “legal” definition of insanity should be.

After the acquittal of Hinckley, most states, including Texas, reverted from a “free will” standard of sanity, in which people could be acquitted if their mental illness controlled their behavior, to a “knowledge” standard in which legal insanity is defined by a defendant’s knowledge of right and wrong at the time of his/her actions (Parker, 2002, p. A11). In legal story lines, discussions of Yates and her possible sanity/insanity become articulations of the vulnerable mother subject position when Yates is depicted as a mother who had no control over her own behavior, behavior influenced by a serious illness that led to a horrific crime—that of a mother killing her children. In an article discussing mothers and murder, Marianne Szegedy-Maszak describes the crime of filicide as “baffling” and asserts that mental illness is often present when a woman kills her children (2002, p. 23). Mike Tolson, writing for the *Houston Chronicle*, declares: “The crime of maternal filicide is a challenge as much to justice as to biology. People kill for a variety of reasons, most of them understandable. But loving mothers don’t take the lives of their own children. And penal codes are not written with such homicides in mind” (2001, p. A1). Both reporters begin their search for understanding Yates’s action within a framework that cannot conceive of mothers killing their children unless mental illness is present. Mental illness thus plays a pivotal role in the defense of such mothers, including Susan Smith, who received a life sentence instead of the death penalty because of her history of mental illness (Meyer & Oberman, 2001, p. 69). The situation of women with postpartum psychosis is particularly interesting, for unlike Smith—who suffered from a range of mental disorders including depression—women with postpartum psychoses are discussed as having a specific type of mental illness: “maternal mental illness” (Szegedy-Maszak, 2002, p. 23). Such a category gives mothers a unique status—one different than men, and certainly different from other women with other mental disorders. Tolson reports, “Other countries give mothers a special status under the law if

they kill their young children. There's an assumption that such women are not right in the head and suffer from peculiar motivations" (2001, p. A1). Although the United States does not currently have a law like Great Britain's that recognizes the "vulnerability" of mothers during the postpartum period, courts are increasingly willing to recognize the "unique" situation of postpartum women. In a California case, a woman accused of attempting to drown her twin babies was given probation by a judge with this justification: "She [the judge] said Thompson [the mother] would be allowed supervised visits with the twins and her third child, a 3-year old boy. 'This is not a child abuse case. This is a postpartum depression case,' the judge told Thompson. 'We want to walk you through this nightmare you've been through'" (Mother, 2001, p. A13). Although Yates was found guilty despite her mental illness (her attempt to plead insanity was hurt by her calls to 911, which, according to prosecutors, suggested that she knew right from wrong), even Texas has a history of recognizing the special circumstances of maternal mental illness. Evonne Rodriguez, a woman who killed her four month old baby, was found not guilty by reason of insanity in Texas in 1997 (Korosec, 2004b, p. A1). Lawyers using the insanity defense based on postpartum illness take stances similar to that of Yates's lawyer, who, as reported by Yardley, suggests that Yates "regrets that this illness brought her to a place where she could kill her own children" (Yardley, 2002d, p. A1). This statement points to the key contention of the Yates defense: that postpartum psychosis prevented Yates as a mother from being able to control her own actions.

The special status often afforded to the "vulnerable mother"—a mother who, under the control of postpartum psychoses harms her children or herself—is also recognized, albeit indirectly, by the prosecutors in the Yates case. The decision to seek the death penalty was controversial, as it would be difficult for the prosecutors to prove that Yates was a continuing

threat to society. The justification to seek the death penalty was often voiced by the prosecutors as the desire to give the jury as many options as possible (Yardley, 2001b, p. A12). However, Yardley reports a different perspective:

“I think Harris County seeks the death penalty in so many cases where the defendant is a poor black guy,” said David Dow, a University of Houston law professor who has represented defendants in capital cases, “that not seeking it in this case would fuel the perception, not entirely unjustified, that only the disadvantaged are subject to this penalty. I think that is the only explanation. Normally, the death penalty is reserved for cases where we are worried that the murderer might murder again.” (2001b, p. A12)

In seeking the death penalty, and indeed, in choosing to prosecute the case, the prosecutors attempted to deny Yates’s special status as a mother with mental illness. As reported in the press, the prosecutors went to some length to treat the Yates case like any other case. Yardley reports, “Mr. Rosenthal [the district attorney] said that he did not keep statistics on other cases of mothers killing their children and that any such comparisons were of limited use. ‘You have to look at the specific evidence in a specific case, what’s provable,’ he said. ‘You can’t generalize to any other cases’” (2001a, p. A5). The refusal of the D.A. to compare the Yates case to other cases in which a mother suffered from mental illness points again to the refusal to allow Andrea Yates to claim a special status.

The rearticulation of the vulnerable female subject position as the vulnerable mother in the news develops in a context which draws from both legal discourse on the insanity defense and medical discourse on postpartum disorders. This rearticulation is not uncontested, as a controversy did arise as seen in that two perspectives on the Yates case developed in the news coverage: that Yates, and other mothers like her, deserved to be acquitted based on their maternal

mental illness—a perspective that would require a change in the current legal definition of insanity—or that Yates, and other mothers like her, should be treated simply like other criminals. Perhaps because of the news reporters’ dependence on institutional voices (i.e., psychiatric voices), the news produced largely sympathetic accounts of the Yates case, accounts which privilege the first position. Such accounts recognized the “horrific” nature of her actions, but go on to detail Yates’s extreme mental illness as a mitigating factor. One example, Charles Krauthammer’s editorial in the *Houston Chronicle*, suggests that Yates should be acquitted because she lacked free will:

In one sense, Andrea Yates obviously knew what she was doing when she drowned each of her five children slowly, horribly, deliberately. The jury found her guilty, concluding that her actions that day—waiting until her husband had left home, calling the cops immediately after she had killed her children—demonstrated that she knew the killings were wrong. It is a plausible line of argument, but I would argue differently. She clearly knew that what she did was illegal. And prohibited. And would cause her to be punished. But in the grip of a fantastic psychosis, she actually thought it was right. She thought she was saving her children from a worse fate, in this world and in the next. (2002, p. A38)

Krauthammer concludes, “This is not a matter of sympathy. I have infinitely more sympathy for the five innocents who died so terribly. This is a matter of justice. Guilt presupposes free will. Did Andrea Yates really have it?” (2002, p. A38). As a “former psychiatrist,” Krauthammer finds Yates “not guilty” because her mental illness clearly impaired her ability to act freely. This articulation of the vulnerable female as vulnerable mother is a reshaping of the psychiatric expression, although some key contentions remain the same. Like the psychiatric articulation, mental illness is pictured as a biological illness (brain chemistry and hormones play a central



role) that can dramatically change or influence people's behavior. Perhaps the biggest difference, then, is that the context has changed. The focus on brain chemistry has moved to a focus on actions/motions, and what those actions/motions might mean in the context of larger symbolic structures, such as the legal institutions of this country. As I noted above, it is only the vulnerable mother who is able to use the postpartum psychosis successfully as an insanity defense. The vulnerable female—as an element—is rearticulated through the motherhood frame used in both legal and medical story lines in such a way as to provide a defense for mothers with postpartum disorders while, as I will suggest in my conclusion of this chapter, maintaining a conservative vision of woman/motherhood.

### *The Patient*

The articulation of the patient in psychiatric rhetoric revolved around the evaluation, diagnosis, and treatment of a patient through an “objective” medical gaze and a concept of medical surveillance. I argued that the women who took up the subject position of the patient largely lacked agency, as doctors took the position of the agent and diagnosed, treated, and attempted to prevent reoccurrences or first appearances of postpartum depression. In the motherhood frame used in the news coverage of postpartum disorders, two key aspects of the patient are rearticulated to emphasize the patient's status as a mother: treatment guidelines and issues of surveillance.

Story lines concerned with defining and understanding postpartum disorders often suggest treatments that are, not surprisingly, medical treatments—hormone therapy, antidepressants, antipsychotics, and psychotherapy. Feldman for example, reports, “While the baby blues disappear without treatment, and postpartum depression can usually be handled with antidepressants and therapy, postpartum psychosis usually calls for antipsychotic medication and

hospitalization”(2001a, p. 1). The most widely recognized form of treatment appears to be the antidepressant in combination with some type of therapy. Greenburg and Springen report, “Doctors typically treat postpartum depression with medication, talk therapy, or both... ‘Interpersonal psychotherapy’--short term intensive counseling--has also proven successful with some PPD sufferers. For women with postpartum psychosis, doctors may prescribe a mood stabilizer, such as lithium, in addition to antipsychotic and antidepressant drugs” (2001, p. 26). Finally, Ackerman summarizes, “It [postpartum depression] is usually treated by a class of antidepressant drugs known as selective serotonin reuptake inhibitors. Prozac is the most commonly prescribed” (2001, p. A19).

Because the news cycle, while limited by the “news routine,” which largely brings article to the publishing stage by relying on experts and institutionalized sources, includes more voices than simply those of psychiatrists, the standard treatment options for postpartum disorders—hormone therapy, antidepressants, and therapy—are not the only options mentioned. In one letter sent in to the *Houston Chronicle*, a Houstonian, M.E. McConnell, voices this concern:

Back in the “golden years” when a new mother was treated for postpartum depression, the cause was treated mostly with hormone, vitamin, and calcium shots and phenobarbitol, a mild sedative. Psychiatrists were few at this time. No confinement, nor medications with their side-effects, aggravated the problem. The physical part was treated. Had Andrea Pia Yates had the time (she didn’t) to belong to a church community, volunteers with food and loving arms would have been a great help in her need. We need more treatment for the body and less camouflaging of problems with too powerful drugs and their costs. (2001, p. A21)

This statement is intriguing, and not only because of the inherent contradictions. Within the voiced desire to move away from “too powerful drugs” and back to the golden years of hormone shots and sedatives (which, apparently, do not have dangerous side effects like more recent psychiatric drugs) is a recognition of that responsibilities for treatment and the health of the mother do not fall solely in the hands of medical doctors. When M.E. McConnell tells the readers “volunteers with food and loving arms would have been a great help to her in her need,” the implicit recognition of “loving arms” as treatment is present. McConnell’s concern is echoed by Cindi Sutter, writing a letter to the editor of *Newsweek*:

Somewhere, right in your own neighborhood, is a mother of young children struggling to make it through each day. There are some very practical things that you can do to help. Make a meal and take it to the family. Do you have any idea how difficult it is to try to cook dinner with three little people crying, tugging on your leg, one of them in your arms? Give her an hour of your time...Let her read, go out of for a walk, shop or catch up on some much-needed sleep. No time? Drop off some takeout. Or hire a babysitter for her and her husband...Don’t criticize the unkempt house; help her clean it or treat her to a cleaning service. Do something, today, right in your own backyard, to help an exhausted, depressed mother. (Mail, 2001a, p. 14)

To be clear, I am discussing the urge to “help” the depressed mother as a type of “treatment” because the urge to “help” is seen, at least in part, as an important supplement to standard medical treatment. What develops in discussions of “help” and “treatment” is an expanded version of “treatment” that, while privileging the medical treatments that come by way of physicians and psychiatrists, also recognizes that the health of the postpartum woman can be “treated” outside of the hospital/clinic.

This dual concept of treatment is, notably, voiced largely through letters written by non-news professionals, suggesting that one way news coverage can be broadened to include non-institutionalized perspectives is through lay opinions. Kate Willard's letter to the editor of *Newsweek* aptly summarizes the case for a dual understanding of treatment:

It has been four years since I was diagnosed with and treated for severe PPD. Women will not seek treatment about PPD if they are not adequately informed about the disorder or are too ashamed to talk about their symptoms. PPD is treatable. Not a day goes by that I don't marvel at my brave, funny, gap-toothed blond beauty of a daughter and thank God that I finally overcame my own ignorance and shame and received the aggressive medical treatment I needed to heal and recover...PPD is not something that "other people" get. Our sisters, our daughters, our neighbors, our childhood best friends...nobody is immune. We need to be aware, unafraid and united in our quest to keep each other well. (Mail, 2001a, p. 14)

Willard writes from within a biomedical perspective. She suggests that PPD needs to be aggressively treated, and references her own medical treatment as an example. However, Willard ends her letter by noting that we need to be "unafraid and united in our quest to keep each other well." This statement implies that is not merely the doctor's responsibility to keep mothers well, but also the responsibility of neighbors, family, and friends. As Willard privileges her medical treatment, she opens the door to recognizing the importance of the everyday people around the postpartum woman and their possible role in "helping" her through her difficult time. The dual form of treatment is apparent outside of the letters to editors as well. Greenberg and Springen explain, "Giving a new mother lots of support is especially important. 'We know that social isolation is a big factor in a mom developing something like this,' says Sanford" (2001, p. 26).

The dual concept of treatment clearly suggests that helping a mother during the postpartum period need not be a strictly biomedical phenomena. However, the “help” or “assistance,” or even “treatment,” offered by neighbors, church members, and so forth still rests on the idea of the new mother as being particularly vulnerable to what Ripley calls the “mental slipperiness” of new motherhood (2001). Thus, the call for more “social support” for new mothers still, in these articles, depends upon a biomedical framework in which new mothers are seen as at a high risk for a specific illness: postpartum depression. What the broadened frame of treatment provides to the subject position of patient is both encouraging and discouraging: a recognition of the social isolation of new mothers (and isolation’s possible contribution to their mental illness) while at the same time extending the relatively agency-void subject position of the patient into homes, churches, and neighborhood picnics.

The movement of the subject position of the patient out of a purely “clinical” setting is perhaps seen most clearly in the controversy that develops around Russell Yates’s performance as husband and father. Although some writers were supportive of Russell Yates, many decried his failure to pay closer attention to his wife’s deteriorating mental status. The controversy evolved around the question of Russell Yates’s culpability—was he, in fact, at least partially responsible for what had happened to his children? Intriguingly, whether the answer is “no” as reporter Feldman (2004) argues, or “yes” as several letters to the editor suggest, both positions place the husband in the role as the authority figure of the household who is responsible for watching over his wife and children. Claudia Feldman takes a position that recognizes Russell Yates’s faults while at the same time placing the ultimate blame for the tragedy elsewhere. She reports,

Rusty, the leader and authority figure in the Yates household, is commonly blamed for other decisions—such as to home-school the children or live in a converted bus—that made life more difficult for Andrea. At times Rusty is bitter about the criticism he has received from near and far. He was a devoted nurse. He desperately wanted his wife to get well. Early on, he was ignorant about her mental health problems, but most Americans are slow to recognize the signs and symptoms. He tried to work and juggle his responsibilities to Andrea and the children. That he couldn't do everything and be everywhere was no surprise. Incompetent doctors, insurance companies more concerned about the size of the bill than the quality of treatment, a legal system seeking an eye for an eye—those are the villains in the Andrea Yates story, he said, not him. (2004, p. A1)

According to Feldman's version of events, Russell Yates did his best to watch over his wife, nurse her through the tough patches, and get her back on track. The lifestyle of the Yates family certainly made room for much of the criticism. Following a very traditional model of the nuclear family, Russell Yates worked while Andrea stayed at home, caring for the children and home schooling the two eldest. For an extended period of time the Yates family lived in a converted bus until they purchased their final home at 942 Beachcomber Lane. However, throughout the trial, Russell Yates was openly supportive of his wife. As della Cava and Oldenburg report, "Yates was hardly elusive in the aftermath of the tragedy, vowing to stand by his wife of eight years. The day after the murders, he spoke to the media, saying he didn't blame Andrea 'because that wasn't her.' The next day he joined a vigil in front of the house, where he told the crowd 'my wife is really suffering'" (2001, p. D1).

On the other side of the controversy, Cielo Perdomo, writing a letter to the editor of the *Houston Chronicle*, asks, "Where was Russell Yates when they took his wife off anti-psychosis

medicine? I am so anguished at this horrible loss. Yet it must be asked: Where was the dad?" (della Cava & Oldenburg, 2001, p. D1). Perdomo suggests generally that Yates was not careful enough and did not take the time necessary to keep his children and his wife safe. Other critics of Russell Yates are more specific in their criticism, noting the variety of things that Russell Yates did wrong: "He should never have left the children alone with a mother suffering from such serious mental illness, some said. He should not have continued having children with Andrea, given her history of severe postpartum depression. He should have helped more with the children. He was too controlling. Some have even suggested that the wrong parent was being prosecuted" (Snyder, 2002, p. A29). The condemnation of Russell Yates for failing to take care of his wife comes from all sides of the political spectrum. A leader of a Houston feminist group remarked, "The least, it seems, is that he could have been more vigilant about trying to get some equal responsibility or some sharing of all this, or even been more vigilant as far as her mental health," while a conservative man with three sons suggested that he was aghast at Russell Yates's "failure to take charge of the circumstances in his own home" (Snyder, 2002, p. A29).

Taken together, both the people who admired Russell Yates for standing by his wife and attempting to watch over her and their children while they were alive, and the people who criticized Russell Yates for his lack of attention to Andrea Yates and the demanding lifestyle he imposed on her, inadvertently focused on the same issue, one that relates directly to the issue of surveillance in the patient position. All voices agreed that Andrea Yates was mentally ill, and all voices agreed to that to whatever extent possible, Russell Yates was responsible, along with her doctors, for making sure his wife was not a danger to herself or others. The difference appears only in the degree people attributed to Russell Yates's efforts: he was, or he was not, watching over her to the fullest extent possible. In an related article published in 2004, the *Houston*

*Chronicle* reports: “The American Academy of Pediatrics today plans to advise its members to adjust their office hours and make other changes to encourage fathers to become more involved in their children’s health care...The statement also said fathers should be reminded to try to give mothers some time alone and to be aware of signs of postpartum depression in new mothers” (Doctors, 2004, p. A5). The policy statement issued by the American Academy of Pediatrics gives institutional support to the key contention of the voices that critiqued and applauded Russell Yates: that husbands and fathers must take some responsibility for the health of women and children in their homes. Responsibility comes not just in knowing the possible signs or symptoms of postpartum disorders, but also “trying” to behave in certain ways to accommodate the new mother’s fragile state. To be clear, Andrea Yates’s doctors also received a good amount of criticism for not properly diagnosing and/or treating her illness. However, the additional responsibility given to Russell Yates for his wife’s health suggest the subject position of the patient exists both at home and in the hospital. Amanda Ripley reports, “Asked by reporters whether he had missed some clue, Russell replied, ‘I suppose. I don’t know. I don’t know. I don’t know how to answer that question’” (2001, p. 30). But even if Russell Yates does not know how to answer that question, the question itself seems appropriate because the discourses when combine to articulate the subject position of the patient include surveillance responsibilities for the husband/significant other as well as the doctor.

The rearticulation of the subject position of the patient in the news easily coexists with the articulation of the patient in psychiatric rhetoric. Specifically, although the concept of treatment is widened to include help from non-medical sources and people outside of medical institutions are given some responsibility to watch over patients, both differences remain safely ensconced within a biomedical understanding of mental illness and both ultimately defer to the



expertise of the psychiatrist. That said, what is important about the rearticulation of the subject position of the patient is that the extension of the patient into the family sphere (rather than only the clinical sphere) is one that has potentially disastrous consequences, especially when we remember that this “patient” is a mother. Although the voices that combine to support an idea of the husband/father as partially responsible for his wife and children are well intentioned, and certainly some may even take a stance close to a “feminist” stance that urges the fuller participation of the father in the home, in this particular discursive context the result of a father’s activity or taking on of responsibility is not an equalization of the gender roles within the home, but rather a reification of the husband’s—as authority figure—ultimate responsibility for the welfare of all of those within his home. In other words, the existence of the subject position of the patient for women with postpartum disorders within the family setting further situates the postpartum woman as both fragile and dangerous and in a subservient position to all who watch over her—her husband, her friends, and, of course, her doctors. I should point out, however, that a reading of the subject position of the patient as articulated in the news should not overlook the space made for possible disruptions of the some of the very issues that the position seems to reify. Specifically, the broadened understanding of treatment could—perhaps in other discursive contexts—be articulated in such a way as to disrupt our traditional notion of “expert” and “expertise” by replacing this notion with one of care, nurturance, and, perhaps, common sense. Such a disruption does not occur in this particular articulation, in part because of the continued presence of the biomedical paradigm as the lens through which news workers perceive mental illness.

### *The Mother*

The subject position of the mother as articulated in psychiatric rhetoric relied on a discourse of traditional motherhood that characterizes the mother as a selfless, giving person with an (often unspoken) “maternal instinct”—an instinct that leads her to place her child and the child’s welfare before herself. This position was most clearly articulated in two areas: the use of concern for the child’s welfare as a justification for studies on postpartum disorders and discussions of treatment, where psychiatrists used a risk/benefit paradigm to propose treatments that were perhaps risky for the mother/woman but “safe” for infant. As I argued in the previous chapter, the risk/benefit paradigm resulted in the suggestions of treatments that privileged concern for the child’s welfare: the dangerous treatment of electroshock therapy and the more innocuous “talk therapy.” It is perhaps not surprising that concerns about motherhood also appear in news coverage of postpartum disorders, and that these issues are expressed through multiple voices—feminists supporting Andrea Yates, her doctors and lawyers, the prosecutors and experts testifying against Yates, as well as numerous “lay” voices of women describing their own experiences of mothering. This analysis focuses on how the mother develops in two different types of stories, legal stories and stories that focus on the appropriate role(s) of the mother. The frame of motherhood used in the news coverage of postpartum allows for competing articulations of the subject position of mother, which, for purposes of clarity, I will discuss as the “mythical mother” and the “real mother.” It is the mythical mother that most closely coincides with the psychiatric articulation of mother, as it is the mythical mother that draws upon the same discourse of a traditional motherhood.

*The mythical mother*

As articulated through the frame of motherhood, the mythical mother position gives mothers a number of characteristics: they are nurturing and selfless, hardworking and content. Thurer asserts in *The Myths of Motherhood: How Culture Reinvents the Good Mother*, “Motherhood—the way we perform mothering—is culturally derived. Each society has its own mythology, complete with rituals, beliefs, expectations, norms, and symbols” (1994, p. xv). The “good mother” is “reinvented as each age or society defines her anew,” (p. xv) and in her most recent reincarnation, the good mother is caught in a cultural moment that prizes domestic excellence (p. 287) and consumerism (p. 296), a moment in which the fetus is slowly usurping the mother in public consciousness (p. 294) and daycare is “proven” to have deleterious effects on a child’s development (p. 291). Douglas and Michaels describe this new cultural moment as “new momism”: “the insistence that no woman is truly complete or fulfilled unless she has kids, that women remain the best primary caretakers of children, and that to be a remotely decent mother, a woman has to devote her entire physical, psychological, emotional, and intellectual being, 24/7, to her children” (2004, p. 4). Within the moment of “new momism,” good mothering is most aptly described as “intensive mothering.” Douglas and Michaels write, “Intensive mothering insists that mothers acquire professional-level skills such as those of a therapist, pediatrician (‘Dr. Mom’), consumer products safety inspector, and teacher, and that they lavish every ounce of physical vitality they have, the monetary equivalent of the gross domestic product of Australia, and, most of all, every single bit of their emotional, mental, and psychic energy on their kids” (p. 6). It is the mother who performs intensive mothering that I am calling the “mythical mother” in this section. This is a self-sacrificing mother that, as the articulation of the “real mother” would like to suggest, does not in fact exist. Nevertheless, the

mythical mother is articulated—if only as a “model” of motherhood—and like the psychiatric articulation of mother, the articulation of the mythical mother relies first and foremost on recognition of the value, and primary importance, of children.

The Yates children play a central role in much of the coverage of the Yates case, and even when they are not spoken of directly, they are there, lurking in the background. As the innocent victims of their mother’s actions, they are “just wasted lives,” as one Houstonian, Velma Wilson, noted (della Cava & Oldenburg, 2001, p. D1). Through intimate descriptions of the children given by Russell Yates, the news stories of the Yates family sought to remember the children at their happiest times. Rendon’s report of the funeral of the five Yates children is particularly interesting, as she offers a list of the children and brief descriptions given by the father in an insert titled “A Father’s Words: Russell Yates Eulogizes his Children”:

Noah. “He loved to watch TV. His favorite shows were Scooby-Doo and Who Wants to be a Millionaire. He would sit and see how many questions he could get right.”

John. “From the beginning he was very physical and enthusiastic. He would make friends easily. He had a contagious smile, it was just a gap-tooth grin.”

Paul. “Perfect, perfect Paul. He was just a perfect child. Paul was cuddly and he gave the best hugs.” Nickname: “Bull Moose.”

Luke. “He was a little bulldozer. Of all the children, he had the hardest times with boundaries.”

Mary. “When Mary came out, I was stunned. I didn’t know what to do. I hadn’t been around girls very much. I’m so thankful I had a girl. I got to spend time with her. She’s so sweet.” (2001, p. A1)

In addition, many articles that recounted the Yates murders mention the children's names and ages at least once. Glen, et al. report, "The children killed Wednesday had biblical names: 6-month-old Mary; Luke, 2; Paul, 3; John, 5; and Noah, 7" (2001, p. A1). Teachey, Rendon, and Lezon take a similar approach: "Andrea Yates, 37, has pleaded not guilty by reason of insanity to two charges of capital murder in the deaths of Noah, 7, John, 5, and Mary, 6 months. She is not charged with the other children's deaths, but prosecutors plan to present evidence about the deaths of Paul, 3, and Luke, 2, during the trial" (2001, p. A1). Where the children are not mentioned directly, they are certainly present indirectly. Consider, for example, della Cava and Oldenburg's description of the Yates house: "Two basketball hoops loom in the driveway, one regulation, the other plastic and tyke height. Behind them is a mammoth motor home that served as the getaway mobile for trips around the country" (2001, p. D1). That the Yates children were the victims in this case makes their presence in the press expected; however, I suggest that they play a dual function in that they serve both as victims and as a continual reminder of Andrea Yates's status as a mother. This status is called into question by the title of Ripley's piece for *Time*, "A Mother No More," but even Ripley (2001) cannot consider the Yates case outside of the framework of motherhood as she relies on postpartum depression as the explanatory factor for Yates's "act of madness."

The death of the Yates children also receives detailed coverage. Analyzed in the context of articulation of the mythical mother, the recounting of the murders performs a particular function. The gruesome acts that led to their deaths are the "evidence" needed to support the key contention that facilitates the articulation of the mythical mother: that it was *not* Andrea Yates who killed her children. This contention was first explicitly voiced by Russell Yates the day after the murders: "My wife, I'm supportive of her. But on the other [hand], I know that the

woman here [he refers to a picture of his family that he is holding] is not the woman who killed my children....One side of me blames her because, you know, she did it. But the other side of me says, 'Well, she didn't, because that wasn't her; she wasn't in her right frame of mind'"

(Thomas, 2001, p. 20). The desire to understand Andrea Yates as not herself is propelled by the personification of her illness in the form of Satan. Roche reports for *Time*, "Holmes [a friend of Andrea Yates'] also believed that her friend had been possessed by the devil, something the two discussed after her 1999 illness, say sources close to the case. About this time in 2001, the sources say, Holmes was worried that the demons had returned a hundredfold" (2002, p. 49). As a "demon," postpartum psychosis literally tells Yates (through the form of auditory and visual hallucinations) what to think and what to do. Roche continues:

Later she told jail doctors that nothing could mute the patter that said she was a lousy mother. The death of her children, she said, was her punishment, not theirs. It was, she explained, a mother's final act of mercy. Did the Bible not say it would be better for a person to be flung into the sea with a stone tied to his neck than cause little ones to stumble? And she had failed to rescue her children. Only her execution would rescue her from the evil inside her—a state-sanctioned exorcism in which George W. Bush, the former Governor and now President, would come to save her from the clutches of Satan. (2002, p. 50)

Andrea Yates's claim that Satan has caused the murder of her children is supported directly by her husband. Roche's article includes this description of Russell Yates's understanding of his wife's illness:

But, he [Russell Yates] explains, "the Bible says the devil prowls around looking for someone to devour. I look at Andrea, and I think that Andrea was weak"—not morally

week but chemically weak, her resistance to the evil lowered by mental illness. “Think about a field of deer, and there’s one limping around, and that’s kind of the way I see it.

Andrea was weak, and he attacked her. Jesus says, Resist the devil, and he will flee from you.” But Andrea did not have enough strength to resist. (2002, p. 45)

Russell Yates’s description here is interesting because he invokes Yates’s chemically weak status (as interpreted by Roche), but at the same time suggests that the devil has “attacked” Yates.

Yates’s illness thus exists both as a vulnerability to the devil and as a personification in the form of devil itself. Roche concludes this section by noting, “On June 20, 2001, however, she was strong enough to realize a vision that had been in her head for two years” (2002, p. 45). Because Yates could not resist the devil, he did not “flee” from her, but rather inhabited her and was, perhaps, the one who gave her the strength to act out the vision of drowning her children.

Andrea Yates’s lawyers supported this version of events, arguing that their client was a loving, caring mother who had lost touch with reality because of postpartum psychosis (see Yardley, 2002a, p. A12). Indeed, even medical doctors appeared to agree with Russell Yates in that it was not Andrea Yates, or at least the Andrea Yates that he knew previously, that killed their children. As Carey reports, “‘Add fluctuating hormones, and you have someone who develops a postpartum depression and a psychosis that could drive them to do completely out-of-character, irrational things,’ Dr. Saltz said.” (2004, p. A18). Finally, friends as well as family rallied around the idea that Andrea Yates was not herself when she killed her children. Warren reports, “And friends say the haggard woman appearing in court in her jail-issued orange jumpsuit bears no similarity to the petite, pretty girl smiling in yearbook photos in the early 1980s” (2001, p. A1). Warren continues to quote Kelly Young, a friend of Andrea’s from high school: “This is not the Andrea we knew. She was warm and caring. She would not have ever

hurt anything, much less a child” (2001, p. A1). And Yardley reports that Yates’s brother, Patrick Kennedy, was shocked by the death of the children because he “had thought his sister a loving mother” (2002b, p. A16). Yardley continues, “‘The person I saw in jail was not my sister,’ he [Patrick Kennedy] testified” (2002b, p. A16). These statements suggest that Yates as a mother was a good mother—until she was not herself. Perhaps unintentionally, much of the reporting of the Yates case supports this contention by offering detailed descriptions either of the drowning of the Yates children or Andrea Yates’s previous acts as a mother.

I will begin by discussing Yates’s acts as a mother, for it is here that the foundation for the articulation of the mythical mother is laid. Jim Yardley reports, “Russell Yates, the defendant’s husband, described her as ‘a wonderful mother.’ ‘She’s the kindest and most caring person I know,’ Mr. Yates said, choking up. ‘She’s always concerned about the kids’ safety’” (2002c, p. A14). Descriptions of Andrea Yates that emerge characterize Yates as a caring person, one who cared for others while often not caring for herself. Thomas relies on extensive quotations from Andrea Yates’s mother to draw an image of what I maintain replicates the discourse of the traditional motherhood:

“She was always trying to be such a good girl,” Andrea’s mother, Jutta Kennedy, told a *Newsweek* reporter in an exclusive interview last week, wiping away tears while watering flowers outside of her modest, one-story home. “She was the most compassionate of my children. Always thinking of other people, never herself. She was always trying to care for everybody.” Jutta Kennedy recalled how every day, for seven or eight years, Andrea would come to her parents’ house to take care of her father, Andrea Kennedy, who suffered from Alzheimer’s... “Andrea was his baby. She was named for him. And she would do anything for him. She would change his clothes and wash him and help feed



him.” At the same time, Andrea was often pregnant, caring for her own growing family. Even as she coped with all this, when a neighbor needed help she would run next door, her mother recalled. (2001, p. 20)

As her mother seems to suggest, Andrea spent her days caring for others, and not just her children. Yates’s mother in one article suggests that there was “never a better person,” pointing to the homemade curtains in her home (made by Andrea Yates) as an example of Yates’s gifts of caring (Feldman, 2001b, p. A29).

The public is also offered a few descriptions of Yates caring for her children, descriptions that suggest that Yates was (attempting to be) the perfect mother. As Thomas reports, “Education, like faith, was centered at home. In addition to feeding, bathing and disciplining four rambunctious boys, Andrea taught them phonics and math with workbooks from a home-schooling service. Between caring for her father and her children, it is hard to think that Andrea ever had time for herself” (2001, p. 20). Certainly, Yates took on the burden of the teacher in addition to nurturer in her home, but it is the details of Yates’s nurturance that provide the clearest depiction of her love for her children. As one neighbor reports, “Yates was a model of mental stability and patience as she reared her children” (Bernstein & Garcia, 2001, p. A1). Indeed, Yates’s actions as a mother have a fairy-tale quality about them. Evan Thomas quotes Russell Yates’s description of Andrea Yates as a mother: “He spoke of how she showed her love for her children, how at Valentine’s Day she had made each one little books of coupons—‘one was good for a hug, one was good for a game of your choice’” (2001, p. 20). But the fullest report of Yates as a mother comes from Timothy Roche’s extended article in *Time*. Roche reports, “Andrea taught them to shuck corn and snap green beans. She wanted them to appreciate

the colors of the rainbow” (2002, p. 46). The following excerpt from Roche’s article is quoted in full, to capture the characterization of Yates as a mother:

She planted milkweed to attract the butterflies that she and Noah loved. In a rare confession, she told Rusty she felt she had “failed” at the simple life in the bus. But she turned the front den into a classroom to home school Noah and the other kids. When they studied horses, they read *Black Beauty* and went riding on real ones. When they were learning about Indians, she crafted a cardboard diorama including pretend deerskin stretched across twigs. To show off musical instruments, they paraded as a marching band so Daddy could see them. She insisted on buying extra workbooks to expand their home-schooling curriculum. “You make it more difficult on yourself,” Rusty says he told her. “You’re making it more complicated than it needs to be.”

Andrea baked elaborate birthday cakes from scratch and stayed up late sewing costumes for her friends’ kids, not just her own. The boys bragged about her chicken pot pie, and Rusty loved her chocolate-covered cookies. She traveled with the best-stocked stroller and diaper bag in the neighborhood, complete with apples cut into kid-size bites. (2002, p. 47)

In Roche’s description of Yates as a mother, we see that Yates is not merely a “good” mother—one who loves and cares for her children. Rather, Yates is a mother striving toward perfection, a mother practicing “intensive mothering,” a mother so focused on being a *mother* that she performs her motherly duties tenfold—with her own children she bakes cakes and takes them to ride horses, for other people’s children she sews Halloween costumes, for her father she steps in as a mother, cleaning and feeding him, and she decorates not just her home, but her parents’

home as well. This characterization of Yates is strikingly inconsistent with her final acts as mother—the drowning of her children.

The narrative of the drowning of the Yates children is reported in excruciating detail. Carol Christian, for example, begins her report of the trial with a description of the scene of the crime: “A tiny arm was sticking out from under a sheet on a mattress at Andrea Pia Yates’ home when police responded to her 911 call last summer, an officer testified Monday. ‘I saw what looked like four lumps in the bed,’ officer David Knapp said Monday during the first day of testimony in the Yates’ capital murder trial in the deaths of three of her five children, all of whom were drowned in the family tub” (2002a, p. A1). Christian also reports, “He said he pulled back the sheet and found the youngest four children, looking as if they had been tucked into bed. The officer said he knew that three of them were dead because they had a frothy substance coming from their noses and mouths” (2002a, p. A1). The fifth child, Noah, was found floating face down in the bathtub (Yardley, 2002a, p. A12). It is Noah’s story that is perhaps most horrific. Although not detailing Noah’s story, both Yardley and Christian note that the officer who arrived on the scene “saw wet footprints, seemingly of an adult and a child” in the hallway (Yardley, 2002a, p. A12). Thomas gives the most heart wrenching account of Noah’s attempt to flee:

Andrea Yates had just killed four of her children when the fifth one wandered into the bathroom, where his mother was kneeling by the tub. ‘What’s wrong with Mary?’ asked Noah, 7, eyeing his 6-month-old sister, who lay motionless in the water. Get in the tub, instructed the mother, according to the account she reportedly gave police investigators. The boy ran, but not beyond the reach of his mother’s once loving arms. Anyone who

has ever given a boy a bath may wonder at how she subdued the squirming, bony body of a 7-year-old and forced him to submit to the fate of his siblings. (2001, p. 20)

The details of the horrific chase that results in a skirmish with Noah in the family room and eventually leads back to the bathtub are part of the reason why the prosecutors insisted on the deliberate nature of Yates's acts. Testimony for the prosecution also included a description of Yates's hair in her son John's fist and details of the bruises on the bodies of her children, signs that the children had struggled and attempted to fight back (Yardley, 2002a; Yardley, 2002c). And, as Christian reports, "Four of Andrea Yates' five children were unconscious but still alive when she pulled them from the bathtub and laid them on a bed, a pediatric pathologist testified Saturday in an unusual weekend session" (2002b, p. A1).

The gruesome stories of the children's deaths are largely interpreted by the prosecutors as clear evidence that Yates was acting in a "determined, decisive and deceptive" as well as "organized" manner when she murdered her children (Christian, 2002b, p. A1). If Yates's defense lawyers disagreed with this interpretation, all lawyers agreed on the horrific nature of the crime and on Yates's status as a mentally ill person. Gesalman reports, "The prosecution argues Yates knew right from wrong and shouldn't get the insanity defense. 'There is no question that Andrea Yates had some form of mental illness,' prosecutor Joe Ownby told the jury. But, he added, 'you will hear evidence that she knew [murder] was an illegal thing. That it was a sin. That it was wrong'" (2002, p. 32). The recognition of mental illness is the key to connecting what seem to be the acts of two different people: that of a perfect mother, and that of a murderer. The contention by her friends, family, and lawyers that Yates was "not herself" when she murdered her children—that Yates was not "in her right mind" or had lost touch with reality—leaves what Yates was before the murders intact. The articulation of the mythical mother

develops, then, out of the seemingly contradictory nature of Yates's actions. Yates before her mental illness is very much represented as the mythical mother, and her actions are representative of what all mothers should do—home-school their children, make coupon books, and in general devote the majority of their time to raising their children. Her brutal acts against her own children, acts that are incongruous with her previous status as a mythical mother, are explained away as caused by her mental illness. In other words, Yates did not kill her children *because* mythical mothers do not kill their children, nor do they become frustrated with their children, angry with their children, and so forth. The killer of the Yates children was not Andrea Yates, the mythical mother.

The subject position of the mythical mother is not voiced only through the Yates case. Marie Osmond's dramatic act of running away from her family after the birth of her most recent child—an act incongruous with her status as a good mother—is explained through postpartum depression. Like the Yates case, Marie Osmond describes herself as not herself while sick. She writes for *Newsweek*, "When I saw myself in the mirror, it felt as if I were looking at the face of a stranger. My eyes were lifeless and hollow. I had lost all joy, and any hope had diminished to a distant memory. I literally could not recognize myself. Postpartum depression had stripped me to the very core of my being. Nothing seemed steadfast. I felt utterly alone" (2001, p. 28). Linking her own case to that of Yates, Osmond goes on to write, "I watched the news on Thursday morning as the image was played over and over again of Andrea Yates being led to a police car in handcuffs after she confessed to drowning her five small children. I wondered, if she had been watching the same footage, would she have recognized herself? I would guess not" (2001, p. 28). Osmond goes on to report that after her treatment, she began to regain her old self, most importantly her ability to sleep (2001, p. 28). The more recent case of Dena Audry

Schlosser, a woman accused of killing her 11-month-old daughter by cutting off her daughter's arms, also uses the "it was not her" contention to explain Schlosser's actions. Schlosser is described by neighbors as "like any other mother" on a family picnic: "Holding her baby. Attending to her needs" (Korosec, 2004a, p. B1). Again, the contradiction between the murder and Schlosser's former status of a good mother is explained through postpartum depression, leaving the subject position of the mythical mother intact. Perhaps the most important aspect of the articulation of the mythical mother is the reification of the traditional discourse of womanhood/motherhood that occurs. In this sense, this articulation is complementary to the psychiatric subject position of mother. However, given that the Yates case did not exist in a vacuum—and certainly, motherhood in general does not exist in a vacuum—there was room in the news for an alternative articulation of mother to take place. This articulation, that of the "real mother," offers a subject position to women during the postpartum period that recognizes the difficulties of mothering, as well as the imperfections of any given mother.

#### *The "real" mother*

Susan Douglas and Meredith Michaels suggest one reason for writing *The Mommy Myth*: "But like increasing numbers of women, we are fed up with the myth—shamelessly hawked by the media—that motherhood is eternally fulfilling and rewarding, that it is *always* the best and most important thing you do, that there is only a narrowly prescribed way to do it right, and that if you don't love each and every second of it there's something really wrong with you" (2004, p. 4). In other words, I would suggest that Douglas and Michaels are writing against the mythical mother, and in doing so suggest a position of the "real mother," one who simply does not match up to the current norm of intensive mothering. As articulated in the news, this "real mother" is clearly placed in opposition to the mythical mother. Like the articulation of the "mythical

mother,” the “real mother” develops around the Yates case. As I mentioned at the end of the first case study, because of the expanded discursive field in which the news is reported, new subject positions are likely to be articulated as the “old” subject positions, those of psychiatric rhetoric, are rearticulated. The “real mother” is the new position that is articulated, and it appears most clearly in editorials and letters to the editors.

Letters to the editor provide an important insight into the thoughts of the lay public instead of the news workers. Many of these letters were written in support, or understanding, of Andrea Yates. As Cindi Sutter of Cleveland, Ohio remarks, “A stay-at-home mother of three boys under the age of 4, I have to say that I understand the depression that gripped Andrea Yates” (Mail, 2001b, p. 10). Tina Godfrey of Kentucky also empathizes with Yates: “Although I have never suffered from postpartum depression, I have been consumed by overwhelming days filled with breastfeeding, dirty diapers and temper tantrums galore. For anyone who has condemned Andrea Yates as a bad mother or one who did not love her children, you must walk a mile in her shoes to know what her world was like” (Mail, 2001a, p.14). *Newsweek* staff acknowledged the outpouring of understanding for Yates inspired by their cover story: “Many readers condemned Yates’s murderous acts but sympathized with her circumstances. ‘Have we romanticized motherhood so much that we can’t acknowledge the harsh reality of what women actually experience?’” (Mail, 2001a, p. 14). But readers went further than simply sympathizing Yates’s act. Like the reader quoted above, many questioned why motherhood is consistently depicted through rose tinted lenses. Ioana Prundaru writes to *Newsweek*,

I am not looking for excuses for Andrea Yates’s killing of her children. But this extreme case, when a mother is so deeply distressed that she can kill her own kids, should at least draw attention to something rarely openly discussed—postpartum depression and the

difficulty for caring for a baby. When a mother gives birth and raises a child, there is a huge need for help, care and understanding....If you realistically look at what motherhood is, you are better prepared to face it. If women delude themselves with rosy dreams of doll babies that don't cry, don't get wet or sick but just smile at you, then the awakening to reality will be harsh. (Mail, 2001b, p. 10)

Meredith Berlin's letter focuses on a similar issue: "As the former editor in chief of *Seventeen*, and the mother of three children who were once simultaneously under the age of 3, I have always felt that women, women's magazines, indeed the entire media, must do a better job of telling the full story of what mothering is about—warts and all. Unless we start admitting to ourselves and each other that it's not always a walk in the park, our guilt, anger, fear, and depression will continue to go underground. And as we have learned, that is not a healthy place for them to be" (Mail, 2001a, p. 14). Berlin's cry for a more "realistic" understanding of motherhood is at least partially fulfilled in Anna Quindlen's editorial for *Newsweek*.

Quindlen begins her editorial by asking, "Isn't motherhood grand?" She then asks, "Do you want the real answer or the official Hallmark-card version?" (2001, p. 62). Quindlen's editorial suggests that the sugarcoating of motherhood is at least partially responsible for the situation Yates found herself in ("So that when someone is depressed after having a baby, when everyone is telling her that it's the happiest damn time of her life, there's no space to admit what she's really feeling"), and goes on to offer this depiction of "real" motherhood: "But there's another part of my mind, the part that remembers the end of a day in which the milk spilled phone rang one cried another hit a fever rose the medicine gone the car sputtered another cried the cable out 'Sesame Street' gone all cried stomach upset full diaper no more diapers Mommy I want water Mommy my throat hurts Mommy I don't feel good" (2001, p. 62). The pace of



Quindlen's words, the intensifying rapidity with which the problems develop, suggest what the mother—the “real mother”—is feeling: frustration and exhaustion. Quindlen continues, “Every mother I've asked about the Yates case has the same reaction. She's appalled; she's aghast. And then she gets this look. And the look says that at some forbidden level she understands. The look says that there are two very different kinds of horror here. There is the unimaginable idea of the killings. And then there is the entirely imaginable idea of going quietly bonkers in a house with five kids under the age of 7” (2001, p. 62). That other women understand hinges on this realization: “But just because you love people doesn't mean that taking care of them day in and day out isn't often hard, and sometimes even horrible.” (2001, p. 62). Further, the articulation of subject position of the “real mother” suggests that Yates herself was a “real mother” in that she, as any mother might, probably felt the frustration and exhaustion attendant with raising five children. Anne Barnstead-Klos's letter is a case in point: “This is a story that terrifies and horrifies and mystifies and confuses. Like Quindlen, I remember vividly the reality of that stage of new motherhood when all you want is a sense of adequacy, 10 minutes to take a shower and just one full night of sleep. Reading about Yates and twice reading Quindlen's column brought back such strong memories of love and desperation that I found tears in my eyes—and my ‘baby’ is 20 years old. My heart breaks for Andrea Yates and her poor children” (Mail, 2001a, p. 14).

The articulation of the real mother that develops from the editorials and letters to the editors consists of only a small fraction of the discourse on the Andrea Yates case, and yet I would suggest that it is significant. Such discourse suggests that women as “real mothers” have certain characteristics—they experience emotions such as frustration and anger and they often need help raising their children, especially after the birth of a child. This subject position is dramatically different than that of the “mythical mother” in which the discourse of women as

self-sacrificing caretakers of children is reified. The question then becomes, what was Yates—and what does she stand for? If for some women Yates was an example of the “real mother”—a mother who was imperfect in a terrible way—for many others, Yates was an example of the “mythical mother”—a mother who did it all until her fall into mental illness. Unfortunately, it is the “mythical mother” subject position that is dominant in the news—and not simply because of the greater amount of coverage it receives. There is a slippage in the “real mother” subject position, one that allows for its co-optation by the discourse of the mythical mother. Prundaru suggests (as I discuss above) in a letter to the editor of *Newsweek* that the Yates case should “at least draw attention to something rarely openly discussed—postpartum depression and the difficulty for caring for a baby” (Mail, 2001b, p. 10). This quotation suggests that two different issues—postpartum depression and the difficulty for caring for a baby—are raised by the Yates case, but Prundaru goes on to discuss the issues as if they were the same thing. This begs the question: is all distress during the postpartum period a result of mental illness? The “real mother” position would suggest not; rather, it is part of motherhood for mothers to feel distress in terms of anxiety, exhaustion, and frustration. But keeping the two issues separate is difficult, even for Quindlen. The mothers she talks to about Andrea Yates have two reactions: they are appalled, and yet they understand. But these mothers are not mothers who suffer from postpartum psychosis. They are mothers who, like Quindlen, have dealt with the endless cycles of dirty diapers, the baby vomit, and the temper tantrums. These are mothers who will admit that mothering is difficult and not always fun. Berlin’s letter, also discussed above, is another case in point. She notes that we must start talking about real motherhood or our “guilt, anger, fear and depression will continue to go underground” (Mail, 2001a, p. 14). Berlin’s letter opens the door for the medicalization of all distress during the postpartum period by equating a variety of issues

(guilt, anger, depression) with each other. If this door is open, and I suggest that it is, then the mythical mother subject position continues to govern our understanding of the postpartum woman, as the mythical mother discourse suggests that after treatment—after the distress has passed—mothers should behave in ways (selfless nurture, caregiver) most closely associated with the mythical mother.

*Discussion: The Centrality of the Mother*

In the conclusion of my analysis of psychiatric rhetoric, I suggested that a subject position incorporating both the social and biological context of postpartum disorders would be the most beneficial way to understand the postpartum woman. Such a subject position does not emerge in the news coverage of the Andrea Yates case, although we again see hints of the possibility of the position. For example, the broadening of the discussion of treatment as well as the incorporation of some social issues (lack of support) as risk factors into discussions of postpartum depression suggest that there is indeed room for “biosocial” subject to be articulated. What we do see clearly in the news is a resistance to the discourse of traditional motherhood through the subject position of the real mother. Indeed, it is precisely the voicing of the real mother that comes closest to an articulation of distress during the postpartum period as an antagonism. Simply stated, the experience of anger and frustration with children disrupts the discourse of traditional motherhood.

What is striking about both the articulation of the “real” mother and the expansion of the understanding of treatment in the articulation of the patient are the sources of these articulations. Letters to the editor and editorials make up the majority of voices in both cases. Karin Wahl Jorgensen suggests that one way print news allows for multiple voices and opinions to be heard is through letters to the editor. She explains, “The letters to the editor section historically has

been seen by both journalism scholars and practitioners as a central public forum; a place where democracy blossoms because regular citizens are allowed a voice of their own (2004, p. 90).

Print news coverage of the Andrea Yates case and postpartum disorders more generally relies heavily on institutionalized sources: psychiatrists, psychologists, and lawyers. However, letters to the editor escape some of the constraints of the news routine. Although Jorgensen recognizes that in major newspapers the letters that are published are only a small percentage of those sent in and that these letters must conform to certain “rules”—relevance, brevity, entertainment, and authority—she still maintains, as do the editors she interviews, that letters to the editor are one way to foster open and honest debate in a multicultural society (2002, p. 69; 2004, p. 90).

Letters to the editor are certainly a small portion of print news, but they are according to readership surveys one of the most popular items in newspapers (Hynds, 1994). Thus, the opinions, in this case on motherhood, that are voiced in letters to the editor are very likely to be heard. It is telling that the letters to the editor sections become the space for an ongoing debate about motherhood. Some letters forcefully supported the discourse of traditional motherhood that also dominated the reports by journalists. But other letters, as my analysis of the “real” mother indicates, clearly resist the discourse of traditional motherhood by articulating a position of mother that provides the much needed room for a mother to feel anxious, unhappy, frustrated, and even depressed after the birth of a child.

If the real mother position resists the discourse of traditional motherhood, it is the only subject position to do so. In fact, that it is within a conversation about motherhood that a resistant subject position appears confirms that it is concerns about motherhood that forms the core of the discourse about postpartum disorders in the news. All three subject positions that are articulated in psychiatric rhetoric and are rearticulated in the news through the frame of

motherhood—the vulnerable female/mother, the patient, and the mother—work together in creating this core focus. Although I discussed each subject position separately, they are clearly interrelated. The vulnerable female subject position and the subject position of the mythical mother, for example, suggest that women as mothers are naturally, biologically “good mothers” unless they are mentally ill. The diagnosis of a mental illness protects the status of the mythical mother by using a biomedical understanding of distress to explain any mother’s actions that do not support the discourse of traditional motherhood. Likewise, the subject position of patient as articulated in the news suggests that a woman as a mother should be carefully watched in her own home because of the frightful acts caused by her maternal mental illness. Protection of the children is the primary concern, and many editorials suggested as much (e.g., “He should never have left the children alone with a mother suffering from such serious mental illness,” Snyder, 2002, p. A29). Angle’s report on the causes and treatments of postpartum disorders also highlights the importance of the children: “A woman diagnosed with symptoms of postpartum psychosis usually would be placed under 24-hour observation, says psychiatrist Eva Ritvo...In many cases, the children would be taken away. ‘If I (were treating) a woman with postpartum psychosis, I wouldn’t leave her alone, let alone with an infant’” (Angle, 2001, p. A2). In sum, both the subject position of the vulnerable female and that of the patient lend support to the position of mythical mother.

Finally, the centrality of motherhood, whether articulated as the mythical or real mother, suggests that an articulation of an alternative biosocial subject position for women during the postpartum period will necessarily include a theorization of motherhood. One article in this case study points in a viable direction: a reinterpretation of the relationship between mother and child. Ripley reports, “While the idea of medicating a pregnant woman for mental disorders is

controversial, it is gaining credibility among doctors who believe the benefits to the mother and child outweigh the risks” (2001, p. 30). This view does not separate mother and child into competing beings, but rather works with them as one entity—“mother and child.” It is this view that comes closest to Rothman’s reimagination of mothering in which she suggests a reshaping of the relationship between mother and child in a way that sees them as connected without a privileging of the child. Rothman explains, “Motherhood is an experience of interpersonal connection. The isolated, atomistic individual is an absurdity when one is pregnant: one is two, two are one” (p. 55). This connection is currently configured in such a way that the woman is the lesser of the two, if present at all:

Patriarchy has blinded us to the relationship that is pregnancy...We see a baby ‘not here yet,’ a baby ‘expected.’ It is that blindness to the presence of the baby for the woman that allows us to discount the loss of the birth mother who gives up the baby for adoption. As long as she hasn’t held it with the outside of her body, we say she never held it at all. But it is not the fetus that is denied: the fetus is increasingly seen and valued, while the relationship with the woman in whom it resides is disvalued. And so the fetus becomes a patient, a captive, an ‘unborn child,’ needing protection—including protection from its mother. (p. 53)

But a diminishment of the mother is not necessary to recognize pregnancy and motherhood as relational and to recognize the connection inherent between a fetus and the mother. A revised understanding of this connection would be both affirmative of motherhood as well as the personhood of the mother (p. 53). It is perhaps this type of re-visioning that a new subject of the biosocial woman could draw upon, as I suggest in the concluding chapter.

## CHAPTER FOUR

### Visual Rhetoric and the Articulation of the Mother

In the conclusion of the previous case study, I pointed to the ways in which the position of mother moved to the center of the discourse on postpartum disorders in the news. The third case study, focusing on the visual elements of television news, takes up this contention and suggests that the discourse of traditional motherhood is the primary discourse through which discussions of postpartum disorders occur in both print and television news. Unlike the previous two case studies, this case study focuses only on the position of the mother because the mother is the central subject position for women during the postpartum period. After offering a discussion of visual rhetoric, articulation theory, and the naturalistic enthymeme, I move to an analysis of 21 news segments from the major networks concerning postpartum disorders and the Andrea Yates case. The subject position of the mother is articulated in television news through the interaction of visual and linguistic elements of the news. The addition of the visual to the discourse of postpartum disorders does little to disrupt the dominance of the discourse of traditional motherhood; in fact, it is the images of television news that function to ground the discussion of postpartum disorders in concepts of traditional motherhood and the “ideal” family more generally. This grounding occurs around three groups of images—those of children, women/mothers, and “home” (broadly interpreted as both the house and the family within it)—that articulate the mother as a white, middle class, heterosexual woman.

*Television News and Visual Rhetoric*

An analysis of the visual aspects of the discourse about postpartum disorders is an important project, as rhetorical scholars are increasingly paying attention to what many refer to as “visual rhetoric.” Hariman and Lucaites suggest that studies of the visual are all too often grounded in a “hermeneutics of suspicion” in which the visual is positioned as a threat to traditional democratic deliberation (2003, p. 35). Moving away from this traditional position, they suggest,

Because the public is a discursively organized body of strangers constituted solely by the acts of being addressed and paying attention (Warner, 2002, pp. 65-124), it can only acquire self-awareness and historical agency if individual auditors “see themselves” in the collective representations that are the materials of public culture. Visual practices in the public media play an important role at precisely this point. (p. 36)

Indeed, to ignore the visual is to, in part, deny that our communication processes today are any different than they were when Habermas originally theorized the public sphere. These differences include the practice of dissemination rather than dialogue as characteristic of current communication practices, as well as the simple fact that “most, and the most important, public discussions take place via ‘screens’—television, computer, and the front page of newspapers” (DeLuca and Peeples, 2002, p. 130-131). The screen at the center of this case study is the television screen. DeLuca and Peeples comment, “TV trades in a discourse dominated by words, a visual rhetoric. In our television culture, we are experiencing a shift from Rorty’s ‘linguistic turn’ to what Mitchell terms a ‘pictorial turn’ (1995, p. 11)” (p. 132). Like Hariman and Lucaites, DeLuca and Peeples suggest that the visual need not be interpreted as the end of democratic deliberation, but rather as the “beginning” of a different kind of deliberation: critique



through spectacle (p. 134). Interpretations and analyses of the visual—whether photograph, television, or film—generally assert that visual images “participate” in argumentation, although how that participation occurs is the subject of disagreement (see Cloud, 2004; DeLuca and Demo, 2000; Finnegan, 2001; Hariman and Lucaites, 2003). Cara Finnegan suggests a line of questioning, however, that is beneficial to *all* studies of the visual: “How do images embody codes of power, domination, spectatorship, or surveillance? What are images’ relationships to verbal language and text? How may we account for images’ complicated modes of proliferation and circulation?” (2001, p. 134).

The first two of Finnegan’s questions captures my concern with the visual aspects of the discourse of postpartum disorders. Specifically, this case study will analyze the verbal language of television news in concert with the images, looking specifically at the interactions between the two. Stein explains, “But the power of words in conjunction with images is in the spin each gives to the other, which can critically skew the meaning, or seeming neutrality, those words previously conveyed on paper” (2001, p. 258). This statement may suggest a separation of the verbal and the visual, but such a separation is only artificial. W. J. T. Mitchell suggests, “The interaction of picture and text is constitutive of representation as such: All media are mixed media, and all representations are heterogeneous; there are no ‘purely’ visual or verbal arts, though the impulse to purify media is one of the central utopian gestures of modernism” (1994, p. 5). For the purposes of my analysis, the interaction of visual and verbal in television news will be discussed through the theory of articulation. DeLuca explains, “Articulation has two aspects: speaking forth elements and linking elements. Though elements preexist articulation as floating signifiers, the act of linking in a particular discourse modifies their character such that they can be understood as being spoken anew” (1999, p. 335). Key here is an understanding of

images, or the visual, as a central part of discourse. Speaking refers not only to the “vocalizing” of elements, but also the visualizing of elements. To think of “elements” in terms of the visual suggests that images—whether photographs or home videos—are articulated when linked with other images, words, or signs.

This linkage occurs in specific contexts, so that the meaning of the image—how we understand, for example, a formal portrait of the Yates family—depends on its discursive location. In discussing Watkins’s photographs of Yosemite, for example, DeLuca and Demo write, “[T]his study considers them [the photographs] as political rhetoric and popular culture. In taking this position, this work is cognizant that Watkins’ landscape photographs are enmeshed in a turbulent stream of multiple and conflictual discourses that shape what these images mean in particular contexts” (2000, p. 242). DeLuca and Demo go on to claim that the pictures themselves constitute the context in which politics take place and create a certain reality (p. 242). To return to my example of the formal portrait of the Yates family (a portrait disseminated broadly on television news), we might ask, as DeLuca and Demo do, not “what do we see?” but “what do the images want?” (Mitchell, 1996, p. 540-544, as cited in DeLuca and Demo, 2000, p. 244). The portrait of the family tells a story of its own—one that reflects what a “family” looks like, what their emotions are, the roles of individuals within the family, and so forth—a story that is then shifted, or “rearticulated,” in different contexts. The portrait of the family takes on significantly different meanings when seen on the mantle of the family’s living room or in Russell Yates’s hands as he holds a press conference on his front lawn to discuss the murder of his children. My use of articulation theory in terms of visual rhetoric does not deny that images “speak” or “want,” but rather places emphasis on the context in which we as viewers and critics understand the varying meanings of those images. In sum, I contend that as an integral part of

any media text, images and verbal elements are juxtaposed in the articulation of subject positions for women during the postpartum period. In the context of this case study, my focus is on television news and the articulation—through the interaction of visual and verbal “signs”—of the position of mother.

### *The Images of Television*

In the context of television, the visual is both unique and yet similar to the visual of photography and film. Importantly, television images hold a unique claim to “liveness” that photography and cinema do not share. Heath and Skirrow explain,

The immediate time of the image is pulled into a confusion with the time of the events shown, tending to diminish the impression of the mode of presence in absence characteristic of film, suggesting a permanently alive view of the world, the generalized fantasy of the television institution of the image that is *direct*, and *direct for me*. (1977, pp. 53-54)

The attraction of the “liveness” is perhaps responsible for the emerging popularity of television shows like *American Idol*, which promise not only liveness, but increased possibilities for the public to interact with what happens on the screen. An additional factor to keep in mind when looking specifically at images of television is the concept of editing. John Corner explains, “Edits connect spaces and times, themes and moods, working to regulate the sense we make of images by providing us with a changing visual context for their interpretation, setting up lines of anticipation and prompting retrospective assessment” (1999, p.29). Brooke Barnett describes visual bias in the media as occurring in two forms: manipulation while capturing the image (through camera angle, lighting, etc.) and manipulation after capturing the image (cropping, editing, changing the speed, etc.) (p. 109). The use of images on television news is also

particularly interesting because most news stories incorporate not only the studio and the anchor, but also the correspondent reporting “live” from the scene. Sara R. Stein writes, “When coupled with the ‘reality’ claims of news programming in general and news magazines in particular, the visual image taken as a transparent window into unsullied fact plays a powerful role in shaping our cultural social perceptions” (2001, p. 251). Such images often “escape” the language that describes them. In the case of *60 Minutes*, Stein argues that the images often contradict the verbal and thus escape the “containment of the objective world” (p. 251). In other words, what Stein contends is that images play an important role in any news story, to the extent that considering only the language used is inappropriate. For example, a *60 Minutes* episode discussing immigration uses footage of two Pakistani travelers, footage that fits the stereotype of the “villainous Arab,” while verbally noting that it is impossible to know whether these travelers are murderers, terrorists, or have AIDS (p. 260). The image of the Pakistani immigrants combined with the use of the word “terrorists” reinforces an implicit claim that illegal immigrants, while supposedly fleeing from abusive governments, are actually arriving on U.S. soil with evil intentions. Contradicting journalists’ claim of objectivity, the images of television news offer an “excess of meaning” that is strongly ideological (p. 267).

Perhaps because television news cannot “show” postpartum disorders, it is figures of women, children, doctors, houses, and hospitals that fill the coverage of postpartum disorders. Images of people, as Stein suggests above, often have a particular power to fulfill or reify stereotypes. Indeed, television news is full of individuals. Stein explains, “The news magazines promote the myth of the individual through their selection of stories that feature individuals as criminals and/or as victims of faceless institutions or heartless bureaucracy” (p. 255). I maintain that postpartum disorders received coverage precisely because the postpartum criminal, Andrea

Yates, emerged in our current atmosphere of “tabloid justice.” Fox and van Sickel explain, “[W]e argue that the United States has entered an era of *tabloid justice*, in which the mass media, in both their traditional and emerging forms, now tend to focus on the sensationalistic, personal, lurid, and tawdry details of unusual and high profile trials and investigations” (2001, p. 3). A search of the Vanderbilt Television News Archives for “postpartum” retrieved only three news segments from 1968 to 2000—the years before the Yates case. In contrast, 21 news segments were available for the years 2001-2004, suggesting that postpartum disorders have become news largely because of the Andrea Yates case. As an individual, Andrea Yates is the focal point of much of the news segments analyzed for this case study, but she is not the only woman with postpartum disorders to be featured. The importance of the appearance of individual women (and their families) is the visualization of these women that occurs in television news.

Cara Finnegan suggests that images carry argumentative weight because of the naturalistic enthymeme. Like the photograph of the cow’s skull in Finnegan’s analysis, the images of individuals in television news are representations of the “real” unless clearly identified as re-enactments. Despite our knowledge of television’s prolific use of editing, television images can, I maintain, operate in a fundamentally similar way as the still documentary photographs that interest Finnegan. Finnegan explains,

To extend this notion [of the enthymeme] to the photograph, the viewer of the photograph “fills in the blank” with the assumption that the image is “real” in the three senses discussed above: that it is a representation of something in the world (*representational realism*), actually occurring before the camera at a particular time and place (*ontological realism*), captured by the camera with no intervention from the photographer (*mechanical realism*). (2001, p. 143)

In other words, I am suggesting that even though the television image is more clearly manipulated, it still maintains enough of an element of realism to operate as a naturalistic enthymeme. Understanding television news footage as a naturalistic enthymeme suggests that an audience/viewer will interpret the images as “reality.” Although not discussed as the operations of a naturalistic enthymeme, this contention is well supported by research on representations of race and class on television. African Americans, for example, are featured prominently in news stories about crime. Larson and Bailey write, “News about African Americans typically focuses on ‘black pathology’—presenting individuals as victims or villains. The common theme is of lawlessness—‘rampant inner city outlawry created by uncontrollable black marauders’” (1998, p. 488). Heavy television viewing is associated with a view of African Americans as lazy and criminally inclined (Entman, 1994). The representation of black crime on television thus creates a “reality” for television viewers, one that places African Americans as the source of crime and illegal drug use. This “reality” is in stark contrast with statistics available about race and crime/drug use. Reed writes, “Although 85 percent of illicit drug users are white, local television news will usually show blacks or footage of police raiding homes in black communities” (1993, p. 23). Television news reports thus have a particular power in the construction of reality, a power that is directly related to the visual elements of television. In a 1992 study of television images, Neuman, Just, and Crigler conclude that the visual elements of television are more salient, vivid, and attention-grabbing than the auditory information. Likewise, Graber (1998) reports that visual news messages are almost twice as likely to be recalled as verbal messages.

The ability of the visual footage of television news to act as a naturalistic enthymeme propels this case study. Specifically, I contend that in the interaction of the verbal and visual, an interaction which articulates subject positions for women during the postpartum period, the

visual is key to understanding the “reality” that is constructed. Introducing her study of prime time feminism, Bonnie Dow suggests, “My view is consonant with that of critics who claim that those who produce television programming function as ‘cultural interpreters’ (Newcomb and Hirsch, 1987, p. 458), and that television acts to ‘*articulate* the main lines of the cultural consensus about the nature of reality’” (Fiske and Hartley, 1987, p. 602)” (Dow, 1996, p. 8). Although Dow analyzes situation comedies, her statements remain close to my own understanding of how television news works to articulate various subject positions for women. Specifically, working with a theory of hegemony and articulation as voiced by Laclau and Mouffe, I would suggest that these articulations are not enforced, but rather produced, and, more specifically, that they are produced in the midst of competing discourses (see DeLuca, 1999, p. 95). Thus, although the analysis that follows in the next section points to the ways in which the hegemonic discourse of traditional motherhood gains a foothold through the interaction of image and text, this foothold is not stable or necessary to an articulation of subject positions for the postpartum woman.

The texts on which this case study is based are from the Vanderbilt Television News Archives. I searched for “postpartum” and “Andrea Yates postpartum,” returning 21 news segments from ABC, CBS, NBC, and CNN about postpartum disorders from 2001-2004. The news segments, including one half-hour episode of *Nightline*, total approximately 107 minutes of coverage. Like Mary Douglas Vavrus’s work on the representation of political women in the news in which she “explored the political identities articulated to political women in television and print news stories,” this case study explores how subject positions are articulated for women during the postpartum period through the interaction, or juxtaposition, of words and images. The analysis that follows discusses three key verbal/visual articulations of the subject position of

mother that occur in television news: verbal discussions of postpartum disorders/visual footage of children, verbal discussions of postpartum disorders/visual footage of women, and verbal discussions of postpartum disorders/visual footage of the home. Taken together, these articulations sustain four key elements of the discourse of traditional motherhood: the importance of the child, the mother as “machine,” the mother/child relationship, and the mother as nurturing center of the family home. In the conclusion I suggest a broader, and perhaps more important implication, of the visual coverage of postpartum disorders: that, acting as a naturalistic enthymeme, the visual footage suggests a reality of postpartum disorders that is centered on white, middle-class, heterosexual women.

### *The Importance of the Child and the Mechanical Mother*

As I have discussed in the previous case studies, one of the key elements of the discourse of traditional motherhood is the focus, and value, placed on children. This theme is materialized in television news on postpartum through verbal/visual juxtapositions that consistently foreground the child in the absence (or partial absence) of the mother. Perhaps not unexpectedly, photographs and home videos of the Yates children receive a substantial amount of airtime. When discussing the Yates children, photographs are shown identifying the children. For example, the *Nightline* special on the Yates case opens with footage of Russell Yates standing on his front lawn holding a framed formal portrait of his family (Wallace, 2001). This portrait becomes the backdrop for Russell Yates’s words:

Russell Yates: I got a call

Medium shot of Russell Yates standing in his front yard. He is holding a framed photograph of the family in his hands.

From my wife and she said, “You need to come home.”

Camera focuses on the photograph of the Yates family.

I said, “Is anyone hurt?” And she said, Yes.”

Camera returns to medium shot of Russell



And I said, “Who?” And she said Yates.

“The children.” And I—and I just—I mean, my heart just sank. Camera returns to photograph, focusing on each boy one at a time from left to right.

In the close ups of the photograph, the photograph takes up the entire television screen, removing the picture frame and disrupting our sense of the photograph as an object held by Russell Yates.

As Russell Yates continues to discuss his wife’s remarks, the camera pans across the photograph, moving from one child to the next. The use of the image of the Yates children in this segment allows the audience to literally see the children that are the focus of the verbal cues. This interaction of text and image is relatively straightforward, with the images of the children evoking sympathy for the husband as well as horror at the actions of the mother. Images of children are, however, not restricted to direct verbal discussions of children.

Images of children without their mothers—including photographs of the Yates children—are often the backdrop for discussions of both Andrea Yates’s crime and discussions of postpartum disorders more generally. In terms of the Yates case, the photographs of the Yates children become more than simple visual representations of the children themselves. The voiceover of an NBC segment (Brokaw, 2001), for example, announces, “A tragedy in Houston” accompanied by a photograph of the four Yates boys dressed up as Native Americans (we might assume for Halloween). The verbal “tragedy” combined with a picture of Yates’s children suggest that the children have begun to represent the crimes associated with postpartum disorders. Two segments compared the Yates case to a similar case in Houston in which a woman attempted to drown her seven children in a local bayou. In Randall Pinkston’s report for CBS (Mason, 2001) the footage of children being pulled from the bayou dominates the coverage:

Pinkston: That was the strategy that DeGuerin used in an eerily similar case 14 years ago. He Stock footage of rescue workers pulling bodies from the bayou.

defended Juana Leija, who attempted to drown her seven children in a Houston bayou.

Ms. Jauna Leija: I was very depressed, and I was having some delusional thoughts. I thought I was saving my children from this horrible world.

Footage of Leija speaking. The lighting is dark, and her face is not visible because of the shadows.

Pinkston: Rescue workers could not save two of her children –the others survive. DeGuerin presented evidence that Leija was clinically depressed and a victim of physical and sexual abuse by her husband.

Repeat of stock footage of rescue workers pulling bodies from the bayou.

Mr. DeGuerin: And eventually, the prosecutor’s office understood that she was sick and that she was not evil.

Footage of DeGuerin speaking from his office. Medium shot.

Pinkston: Leija received 10 years probation and mandatory psychiatric treatment.

Repeat of stock footage of rescue workers pulling bodies from the bayou.

The footage of rescue workers pulling the bodies of the children from the bayou is repeated three times. The footage itself is reflective of typical “live at the scene” coverage—the camera movements are jerky and the lighting is poor. Perhaps most importantly, as this section concludes, we hear the reporter discussing Leija’s punishment, but see again the children being rescued. As in the case above, the footage of the children represents the crime(s) caused by postpartum disorders. As victims of a crime, it is not unexpected that images of children reappear frequently. However, I contend that by emphasizing the children during discussions of the crime, these images also function to reorient the story from the mother to the children. Crimes that occur because of postpartum disorders are then ultimately about the children, not the mother. The image of the Yates children with the words “tragedy in Houston” clearly points to the death of the children as the most significant aspect of the tragedy. Imagine the other possibilities: a “tragedy in Houston” with the image of Russell Yates on his front lawn; a

“tragedy in Houston” with the formal photograph of the Yates family; or “a tragedy in Houston” with footage of Andrea Yates being walked to a police car outside of her home. All of these options offer a different visualization of “tragedy” and a different focus for the crime. But, as the Leija coverage suggests, the focus almost always returns to the children, even when the children (as in the last line of the Leija coverage above) are not directly spoken of.

If children are the perhaps expected visual focus of much of the coverage of the Andrea Yates case, they are also the (unexpected) visual focus on coverage of postpartum disorders more generally. In other words, when commentators discuss the medical “facts” behind postpartum disorders, the images that accompany these words are often those of infants or young children. Michele Norris reporting for ABC, for example, describes, “While the exact cause of serious postpartum depression is unknown, it can be treated, with counseling, medication, and early diagnosis” (Jennings, 2001). Accompanying Norris’s voice-over is footage of a hospital nursery. The camera slowly pans back so that the audience can see that twelve individual babies are currently housed in the nursery. The camera then focuses on the faces of several newborns, including one Caucasian newborn and one newborn of color. The images of newborns in this case contradict the verbal focus on postpartum disorders—a disorder of women, not of newborns. The use of anonymous hospital nursery footage reappears in the NBC coverage. As Kelly O’Donnell discusses the baby blues, images of babies in nursery are shown. In this case, all of the babies in the nursery are (or seem to be) Caucasian. The camera stays in nursery throughout O’Donnell’s discussion of postpartum psychosis as well (Brokaw, 2001). The following excerpts from an ABC segment (Wallace, 2001) suggests that even when anonymous infants are not the only images available, the images are repeated in such a way as to place emphasis on those very infants.

John Donovan: To the inevitable question, ‘How could this have happened,’ we’ve so far been offered only what seems a not quite complete answer, postpartum depression, not quite complete because it seems there has to be more to it.

Postpartum depression, after all—the depression some women encounter after giving birth—is often seen as just one of those things that comes with the stork, like a common cold, mild, short-lived, not all that treatable, something just to get over.

Only now, in Texas, a husband says he thinks that’s what led his wife to murder.

Aerial view of Yates home in Houston taken from a helicopter. Followed by camera footage from the ground showing police cars in a driveway and numerous police officers standing on the lawn.

Footage of a newborn being cleaned by hospital staff after birth. The doctors and nurses are seen from the back; the camera focus is on an African American newborn. This footage is followed by footage of Caucasian infants in a hospital nursery. Finally, footage is aired of Caucasian toddlers sitting in a row in high chairs (perhaps in a day care center) being fed by a “detached” hand.

Footage of Yates’s front yard with a focus on the media members present.

What is intriguing about this excerpt is the discussion of postpartum depression as something that “comes with the stork.” The visuals accompanying the verbal text also demonstrate something brought from the stork: the infant. Indeed, this footage follows the early days and then years of an infant in chronological order, starting with birth, removal to the nursery, and nurturance in the day care center. The “detached” hand is an issue that I will return to in a moment, but for now I should note that footage of infants and children along with verbal references to the stork clearly link postpartum depression with motherhood. In other words, this segment offers a visual argument that complements what psychiatric researchers suggested in the journal articles reviewed for the first case study: that postpartum depression is unique because of the context of childbirth in which it happens.

Of course, the other point to make about the insertion of footage of infants and toddlers during a discussion about postpartum depression is the continued emphasis of the child. This

emphasis is demonstrated by footage that occurs in the same program approximately three minutes later:

Ms. Huysman: And those are the women who are predisposed to suffer depression, either by—by virtue of their own history or their family’s history.

Medium shot of Ms. Huysman.

John Donovan: Traditionally, however, very few women with this degree of depression are being treated for it or even being offered treatment.

New footage of a newborn being cleaned by hospital staff.

Ms. Carol Bernstein: They don’t acknowledge that this is a real disorder, a medical condition just like many other medical conditions, and that there’s treatment.

Medium shot of Ms. Bernstein, identified as “Clinical Psychologist, New York University.”

Donvan: Often, many women don’t get help because it never occurs to their doctors.

Repeat of footage of infants in hospital nursery.

The very same footage used in the first excerpt to discuss postpartum depression as “from the stork” again appears in two discussions of treatment for women with postpartum depression.

Interestingly, mothers [with the possible exception of the detached hand] are not shown. For example, as Donovan discusses the possible treatment of women with postpartum depression, the camera focuses on the newborn being cleaned. Thus, even when the verbal cues discuss women directly, they are often replaced by images of infants and children. The repetition of the same footage of a hospital nursery in this ABC segment reemphasizes the importance of these anonymous children. However, it is important to note that although women are absent in these images, the subject position of mother is still very much present. This subject position takes on an important dimension through this coverage: that of race. Although at least two infants “of color” are depicted and the discussion of Leija case indicates through the images of the children being rescued that Leija is (perhaps) Hispanic, the majority of the images are of white/Caucasian

infants. What does it mean to discuss postpartum disorders through images of white infants? I would suggest that this feature of the news footage encourages the assumption that white infants have white mothers. This assumption is justified by the images of women/mothers that I will discuss in the following sections.

The examples above have suggested that footage of anonymous children without their mothers signals the importance of the (white) child, but the appearance of the detached hand in the ABC coverage points to an additional aspect of this type of coverage. Specifically, when the focus is on the child, the mother [or some other caretaker] is occasionally partially present. In one example from NBC (Brokaw, 2002), we see two different segments of the mother's body:

Dawn Fratangelo: Psychiatrist Meg Spinelli believes one solution, a simple questionnaire, like any patient fills out in a doctor's office, asking women if they're feeling depressed.

Close-up footage of a baby in a swing. The baby is swinging back and forth. The camera angle, focused on the baby, includes only the right female hand of the supposed mother.

Another line of defense, ob-gyns. Most often, the focus is on the physical condition of the fetus and pregnant woman,

Close-up footage of a woman receiving a sonogram. Camera focuses only on her mid-section, then moves to the screen and focuses on the image of the fetus.

while the mental well-being of the mother may be overlooked.

Camera spans over a series of pamphlets in a doctor's waiting room.

In the first image, the woman's (white) hand is clearly the source of the action on screen (it is responsible for the swinging motion of the baby), but the entire woman is not shown. The verbal cues suggest that the topic under discussion is possible questionnaires that could be filled out by women their doctor's office. In the second image, the part of the woman present is her obviously pregnant torso, and this is quickly eclipsed by a close-up of the image of the fetus on the screen. Rosalind Petchesky (1987) suggests that images of the fetus have increasingly served to displace mothers, and certainly in second verbal/visual juxtaposition, the woman is only as important as

her womb. In both cases, the woman is only partially present visually for a story that is about the possibilities for better diagnosis of postpartum depression in women. Like the detached hand above, this segmentation of woman serves to place the child/infant at the forefront of the discussion. The absence of mothers in prenatal discourse—from the proliferation of images of fetuses (Mehaffy, 2000; Petchesky, 1987) to the “erasure” of the pregnant woman in fetal surgery practices (Casper, 1998, p. 5)—is extended in the coverage of postpartum disorders to the postpartum period. This absence places mothers as humans in particularly difficult position—they are not “whole” creatures, but rather visualized as parts of bodies that, in the images shown, have particular functions: the hand feeds the baby, the hand pushes the baby, and the stomach carries the baby.

The mother as segmented machine—one responsible for caring for the child, but apparently not a full being—is a frequent image in the television news reports. A CBS (Roberts, 2004) report uses this segmented woman frequently in conjunction with footage of anonymous toddlers and infants:

John Roberts: As many of 80% of new mothers experience a brief period of moodiness many call the baby blues. But one in five fall into postpartum depression, a more serious condition that can stretch on for months.

Two pie charts detailing the percentages of women with baby blues and postpartum depression appear on screen. The charts are placed over a still image of infants in a hospital nursery.

Dr. Catherine Birndoff: They start to feel like nothing brings them pleasure. Everything is effortful.

Medium shot of Birndoff, from “Weill Cornell Medical Center.”

Roberts: What causes postpartum depression is still a mystery.

Footage from behind an unidentified woman walking with a toddler in a park. The shot is level with the toddler so that only the woman’s legs are visible.

Hormonal changes appear to play a role, but cultural expectations also push mothers to the edge.

Footage of two Caucasian toddlers playing in a sandbox.

In this particular case, we see one still shot of infants in a nursery, two toddlers playing in a sand box, and one toddler walking with his mother's legs. Legs in this case are the "tool" that allow a mother to walk her son. Women's legs are also key to their ability to push strollers. Donna Haraway has theorized the emergence of the cyborg subject, a subject that is a hybrid of machine and organism (1991, p. 150). Although Haraway posits the cyborg as a position that defies dualisms and can be seen as a potent myth for "resistance and recoupling," such a position is not necessarily liberatory (Haraway, 1991, p. 154; Balsamo, 1996). Drawing for Haraway's theory of a cyborg subject, Balsamo (1996) argues that recent reproductive technologies turn women into potentially pregnant bodies. Pregnant bodies are the window the womb as well as the nutrient providing "machine" for the fetus (Balsamo, 1996). The expansion of "woman as machine" into the postpartum period positions mothers/women as incomplete beings from the moment of conception until the "end" of motherhood—an end only possible in the death of the mother. Elizabeth Kaledin reports for CBS (Roberts, 2001), "Yates's case may be unique in the depth of its tragedy, but postpartum depression is not. Ten to fifteen percent of new mothers experience some degree of anxiety, sleeplessness, overwhelming feelings of guilt or sadness." This voice over begins with footage of Andrea Yates in a dark blue shirt walking in a courtroom. The footage then switches with the mention of postpartum depression to footage of an infant being pushed in a stroller. The shot is from the front with the focus largely on the infant. We do, however, see the feet and legs that are responsible for the forward movement of the stroller. This footage is followed by footage of another infant being pushed in stroller. Again, the focus is on the infant. In both cases, the infants are Caucasian.

The visualization of a partial woman in these news segments is problematic for a number of reasons. The subject position of mother that is articulated through these verbal/visual texts



suggest that parts of mother's bodies are essential for the care of the newborn and toddler. Although the part being discussed verbally is the mind, what we see is a segmentation of woman's visible body into very particular parts—the womb, the legs, the hands. Discussing the current ideology of motherhood, Rothman argues, "...We have seen that motherhood is perceived as work, and children as the product produced by the laboring of mothering. Mothers' work and mothers' bodies are resources out of which babies are made" (p. 39). Television news reports of postpartum depression extend this claim by suggesting that certain parts of mother's bodies are essential to the care of the child. Viewing the body—the mother's body—as a machine has important consequences for the subject position of mother. As Rothman notes, women's bodies are transformed into societal resources that provide the necessary care for a more important resource: the children. Emily Martin also points to the consequences of emphasizing/segmenting women's bodies, "Medical imagery juxtaposes two pictures: the uterus as a machine that produces the baby, and the woman as laborer who produces the baby. Perhaps at times the two come together in a consistent form as the woman-laborer whose uterus-machine produces the baby" (1987/1992, p. 83). Thus, a mechanistic view of the female body concomitantly supports the emphasis and value placed on children. The emphasis of the segmented body is clearly at odds with the proposed focus of these news stories: women's psychological well-being. In a clever envisioning of the mind/body dualism, women's minds are discussed while parts of their bodies are shown, suggesting that woman is forever and always trapped in her body, and by what her body does—care for, nurture, and above all, produce, children.

### *The Mother/Child Relationship*

If in parts of the television news coverage of postpartum disorders the focus is clearly on the child, supporting the discourse of traditional motherhood's emphasis on the value of the

child, this emphasis is somewhat muted by the visualization of women as mothers. Women do appear in the news coverage of postpartum disorders, and not only as segmented creatures with wombs, hands, and feet. Rather, when full shots of women (or at least images that include the face of the woman) appear, the verbal/visual points to the connection between mother and child as fundamental to our understanding of what is mother. Depending on the specific verbal/visual moment, this connection can be read as disrupting the hegemonic discourse of traditional motherhood and the subject of mother in which “mother” is above all a nurturing, selfless being devoted to the care of others. My analysis begins with discussions of Andrea Yates, and then traces the theme of the relationship between mother and child in broader coverage of postpartum disorders.

If we attempt to remember the coverage of the Yates case, certain images of Andrea Yates will likely spring to mind: Andrea Yates sitting in the courtroom during trial, Andrea Yates in the courtroom before the trial began wearing the orange county jail uniform, and perhaps even Andrea Yates in photographs of the Yates family. This memory is not far from the “reality” of the television news coverage in which we see two distinct versions of Andrea Yates: Andrea Yates as the criminal, and Andrea Yates as the mother. In what follows, I argue that these two versions of Yates cannot be separated; ultimately, Yates is a mother both before and after she achieves criminal status. The use of a series of images—those of Yates with her children and those of Yates alone in court—in the same news segment confirms Yates’s status as a mother. For example, in this excerpt from a CBS (Attkisson, 2002) news segment, we see all versions of Andrea Yates:

Maureen Maher: When Andrea Yates goes on trial this week...

Footage of Andrea Yates in orange jail uniform. She is seen from a distance sitting at a table.

Russell Yates: I didn't come prepared to talk today.

Maher: ...it may be her husband and doctors who end up having to answer the tough questions.

It's been eight months since the 37-year old mother confessed to

Drowning her four boys and

And infant daughter.

Unlike most murder trials, the question here isn't who did it, but why.

Her husband claims that Yates was suffering from severe postpartum depression.

The former nurse had been taking powerful antidepressants, twice tried to commit suicide and has been hospitalized on several occasions.

Yates is not expected to take the stand, but CBS legal analyst Andrew Cohen says her husband will.

Andrew Cohen: The defense wants to portray him as this overbearing husband who wasn't sympathetic enough to his wife, wasn't willing to help her enough, so that it's part of the reason why this awful thing occurred.

Russell Yates: The new mother.

Andrea Yates: Hello.

Maher: The defense also plans to pin much of the blame on the medical professionals, who they allege did not give Andrea Yates adequate care.

Both sides have been barred from speaking

Footage of Russell Yates arriving at the courthouse.

Footage of Yates in orange jail uniform. Close up shot of her face.

Still photograph of four boys in front of a Christmas tree.

Still photograph of infant Mary in red Christmas outfit.

Still photograph of Yates family (including all children, Andrea, and Russell) sitting informally on a couch.

Footage of Russell Yates walking on his front lawn to meet with the press the day after the murders.

Footage of Andrea Yates in dark blue shirt entering a courtroom. Yates approaches the bench.

Footage of Maher interviewing Cohen. We see Cohen from front, Maher from the back. The courthouse is in the background.

Medium shot of Cohen.

Home videotape of the Yates family in Andrea Yates's hospital room after Mary's birth.

Andrea Yates looks directly at the camera, smiles and waves, and says "Hello." Yates is wearing a white hospital gown. The camera then moves to focus on Yates talking and playing with her four sons.

Footage of DA Chuck Rosenthal walking in

about the case, but in a previous interview, DA Chuck Rosenthal did not dispute that Yates suffered from some form of mental illness, but he tells CBS news his office is seeking the death penalty because the facts of the case call for it.

This excerpt begins with a stereotypical “criminal” shot: Andrea Yates in her prison uniform. However, the segment ends with striking home video footage of Yates in the hospital after giving birth to her fifth child, Mary. This home video offers a dramatically different version of Yates. In the orange uniform, Yates’s face is expressionless and her hair is uncombed. The home video of Yates shows a mother with a giant smile, a hearty laugh, wavy hair, and avid interest in her surroundings. Although this coverage begins with Yates in the courthouse, it ends with Yates seen in relation to her family, and perhaps most importantly, with her children. The connection Yates has with her children is what makes the news story so riveting; it is the ghastly thought of a mother killing her children that forms the backdrop for the discussions of the case. Thus, the audience is consistently presented with photographs and footage that serve as reminders of Yates’s status as a mother. Although not every segment on the Yates case included both “versions” of Yates, many of them do. Take, for example, this single statement by CNN’s Ed Lavandera (Brown, 2002):

Ed Lavandera: Russell Yates wound his way to into the Houston Courts Building for the beginning of what will be a long and painful trial.

Footage of Russell Yates, swarmed by media members, entering the courthouse.

Andrea Yates isn’t wearing the orange prison uniforms in court anymore, and she showed no emotion as she sat face-to-face with 60 prospective jurors.

Footage of Andrea Yates wearing the orange prison uniform entering court and finding a seat.

Twelve of those people will decide whether she should die for drowning her five children.

Still photograph of Yates family (all members) sitting informally on couch.

We hear from Lavandera that Yates is not wearing her orange uniform, but we see Yates in an orange uniform. This is followed by a visual (as well as verbal) reminder of Yates's status as a mother: she sits, with her husband, on a couch surrounded by five children. The photographs and home video footage of Yates as a mother interact with the images of Yates in the orange in such a way as to consistently ground Yates in a relationship with her children.

In a recent essay discussing Laura Bush's use of the ideograph <women and children>, I suggest that the ideograph is based on women's relationship with their children. Although Bush discusses children and women separately, the ideograph functions to define "woman" through the mother/child relationship of motherhood by returning women to the domestic scene (Dubriwny, 2005). The photographs and footage of Andrea Yates with her children operate in much the same fashion, suggesting that Yates is best understood as a mother. For example, accompanying Kaledin's verbal statement, "Clearly, Andrea Yates was not feeling joy; she was in the clutches of a despair we may never understand," the camera focuses on Andrea Yates in a family photograph, then slowly zooms out so that we see Yates surrounded by her children (Roberts, 2001). The contrast between the images of Yates in the orange uniform and Yates with her family is particularly important. The orange uniform, as suggested by Entman (1992), reinforces an audience's impression of the accused's guilt. The orange uniform signifies Yates's conduct as both wrong and evil far more than the dark blue shirt that she wears in the earliest courtroom footage. The orange uniform, then, suggests that Yates's acts are monstrous, and when paired with photographs of Yates and her family, we understand exactly why these acts are monstrous: Yates, as a mother, has violated the natural relationship between mother and child. This point is made explicitly in a CNN segment in which Wolf Blitzer interviews Saul Faerstein, a psychiatrist (Blitzer, 2001c). Faerstein reports, "And she had a history of psychiatric disease.

She was treated for psychosis. She was hospitalized. She was on very powerful antipsychotic medications. She has had a long history of very severe psychiatric disease” (Blitzer, 2001c) The footage accompanying Faerstein’s words is of Yates entering a courtroom and taking a seat in the orange jail uniform (Blitzer, 2001c). A few seconds later, Faerstein continues, “It’s not possible to explain. It is one of the most unspeakable and inexplicable conduct that we can imagine. I cannot explain it. I think we can try to understand the degree of impairment she was experiencing at the time of the offense, but the maternal instinct is so strong, that is almost impossible to understand how somebody could do that” (Blitzer, 2001c). This statement is accompanied by a series of still photographs of the Yates children: the four boys standing side by side, a close-up of Mary, the four boys dressed as Indians on Halloween. Although Andrea Yates is not pictured in these photographs, her presence is strongly felt. Faerstein, after all, is discussing maternal instinct. And it is precisely this instinct that Yates has somehow violated, a violation Faerstein can only explain through reference to her mental illness. The relationship, or connection, between mother and child is guided by the maternal instinct—an instinct which should encourage mothers to protect and nurture their children.

If the maternal instinct is one understanding of the relationship between mother and child, it is not the only one. Some of the coverage of postpartum disorders that does not directly cover the Yates case (although is inspired by the Yates case) offers a slightly different understanding. To be clear, the version of the mother/child relationship that appears in the coverage of the Yates case is dominant. The idea of a maternal instinct can be read into my earlier discussion of the footage of anonymous children and their “partial” mothers in that it becomes the natural responsibility of the mother to care for the child. But two reports from NBC and CBS disrupt this trend. In the CBS’s Sunday Cover, “Rescuing Desperate Mothers and their Newborn

Children from the Grip of Despair” (Roberts, 2004), we are introduced to Alyson Herman and Cathy Gusmano, two Caucasian mothers who suffered from postpartum depression. The segment begins with Alyson Herman’s story:

Ms. Herman: My child, Cameron, he has the greatest personality.	Footage of Cameron, a toddler, walking and smiling at the camera.
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John Roberts: Alyson Herman couldn’t be more thrilled about her baby boy. But just a few mothers ago, she was overwhelmed, almost terrified.	Footage of Alyson Herman and Cameron playing together in a playroom.
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Ms. Herman: You really start to think, ‘Oh, my God, how can I get through this?’	Medium shot of Alyson Herman.
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Mr. Herman: It was frustrating because there was nothing I could do to try and make her feel better.	Medium shot of Mr. Herman.
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Ms. Herman: I was practically huddled in a ball in my own house.	Medium shot of Alyson Herman.
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In this excerpt, Herman is contained within the discourse of traditional motherhood. Ms. Herman offers a proud depiction of her child (he has the greatest personality) and is seen actively playing with him. Ms. Herman’s apparent distress at not being able to care for her child is seconded by her husband, who could not find a way to help his wife. But if this excerpt offers little resistance to the hegemonic discourse of traditional motherhood, the room for such resistance opens at the end of the segment:

John Roberts: Experts say that almost all women with postpartum depression can be successfully treated. Talking openly to others about their fears and stress is often the best medicine.	Footage of Cathy Gusmano and her children preparing a meal, followed by footage of Alyson Herman, her husband, and her son playing in their backyard on a miniature slide.
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Dr. Birndoff: It’s a very common problem.	Medium shot of Birndoff.
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Roberts: Cathy Gusmano and Alyson Herman	Footage of Alyson Herman playing with her
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now understand that their depression is hardly unique. That's been a key to lifting themselves out of despair to focus on what's really important.

son on the slide.

Ms. Herman: This is my life, my child.

Medium shot of Alyson Herman.

I'm going to do things the way it works for me and him, because I've realized that that's all that's important, is taking care of us.

Footage of Cameron Herman walking to his mother, then receiving a hug.

To be clear, this is not a radical departure from the depiction of the mother/child relationship in Yates case. Herman, represented as a good mother, shows the appropriate values of the good mother: she is seen playing and caring for her son, and, according to the reporter, Roberts, she focuses on what is "really important." This last statement is accompanied by images of Herman playing with her son, suggesting that what is really important is her son and her ability to care for him. But two moments of this excerpt deserve closer focus. First, both Roberts and Dr. Birndoff insist that postpartum depression is a "common problem," one that can be treated if women talk openly about their fears. It is this "talking" that, I suggest, could work to disrupt the discourse of traditional motherhood. Second, Herman's final statement suggests a revisioning of the connection between mother and child in a way that does not necessarily privilege the child. She concludes by arguing that what is important is "taking care of us." The other options—"taking care of him" or "taking care of me"—both ignore the relationship between mother and child. By positioning "us" as the central concern, Herman manages to negotiate a position as mother that allows concern for her own welfare in concert with that of her child. Unfortunately, the footage that accompanies this statement reinforces Herman's position as a caretaker of others instead of herself as she watches carefully as her son walks to her and then gives him a happy hug.



What I am suggesting here is that there is room in the articulation of the subject position of mother for a reconfiguration of the relationship of mother and child. That this space emerges infrequently is perhaps testimony to the power of the discourse of traditional motherhood. In a NBC news segment (Brokaw, 2002), this space also appears—this time in the story of Randy Berman, another Caucasian mother who suffered from postpartum depression and now runs a “business” in which she lends support to new mothers through phone calls:

Dawn Fratangelo (Reporter): The suicide of a Chicago woman who jumped from a hotel window has led to a bill in congress that would fund postpartum research and establish grants for special treatment centers.	Still shot of a photograph of the Chicago woman holding her newborn and smiling.
Randy Berman worries help won't come soon enough.	Footage of Berman, her husband, and her daughter playing in their backyard.
Ms. Berman: I'm fearful that might happen again. I really am.	Medium shot of Randy Berman.
Fratangelo: That's why Berman, recovered, and now a mother of two, is a personal life coach for women suffering from PPD.	Still photograph of Randy Berman's two children.
Ms. Berman: I just want to tell you that I am very proud of you.	Footage of Berman performing as a life coach, speaking on her phone to another woman.
Fratangelo: One woman, experienced in the pain of postpartum depression, on a mission to give women and outlet she believes may save them.	Footage of Berman, her daughter, and her husband walking in backyard, then pushing their daughter on a swing.

In this particular excerpt, the call for women to talk about their fear and stress is answered through Berman, whose own status as a woman who has suffered from postpartum depression may encourage others to speak more freely. This segment also offers an implicit acknowledgement that mothering does not occur in a vacuum. Mothers raise children in communities, and in this case the supportive community is represented by Berman, whose work

acknowledges the idea that individual mothers are not the only people responsible for the welfare of children. In the context of a reconfiguration of the relationship between mother and child, Berman's work suggests that while this relationship is important, it is not, nor should it be, the only relationship that matters.

The verbal/visual articulations of the subject position of mother that contain actual footage of women/mothers—not merely their body parts—suggest an interpretation of the mother that privileges “natural” instincts as the basis of the relationship between mother and child. However, such a privileging does not go unchallenged, for certainly both Berman and Herman's words, as well as images, suggest a more mutual relationship between mother and child that does not function as the “only” relationship of importance in a woman's life. What becomes clear, however, in this articulation of motherhood is that we are indeed discussing a very specific mother: the white mother. Berman, Gusmano, Yates, Herman, and (perhaps) the woman from Chicago are all Caucasian. As I will discuss in the next section on the “home,” it is not just race that matters for the subject of mother in postpartum discourse.

*The Mother as Nurturer: Gender Roles in the Idealized Family Home*

What is home? Shelley Mallett suggests that home has developed in the English language with two primary meanings: the homeland and the domestic home. It is this second aspect of home that the verbal/visual juxtapositions of television news elucidate. Mallett explains, “At the same time the idea of home became the focal point for a form of ‘domestic morality’ aimed at safeguarding familial property, including estates, women, and children” (2004, p. 65). Home may refer in part to a physical structure or dwelling, but the term “house” should not be uncritically conflated with home. The definition of home most appropriate for this study is one that recognizes the physical structure of the home as well as the social interactions

within it. Saunders and Williams (1988) suggest that a home is the “setting through which basic forms of social relations and social institutions are constituted and reproduced” (p. 82). Also important is a recognition that home exists in our social imagination. The ideal home is pictured as a haven, one that offers relaxation and comfort away from the political public sphere (Mallett, 2004, p. 71). This ideal home relies on specific concepts of gender, as it “belongs both materially and symbolically to the heterosexual couple who enact and promote particular gendered roles and relationships” (Mallett, 2004, p. 74). This discussion of home points to an important issue in the coverage of postpartum disorders: that it is not merely women and (perhaps more frequently) their children whose images accompany the discussions of postpartum disorders. Rather, these women and children are often situated or visually contextualized within the home, a contextualization that supports certain notions of proper family structure and gendered duties within the home. The homes featured in the television coverage replicate the imaginary “ideal home”: they are clearly homes of white middle class families. They are presented largely through two types of coverage—the “backdrop” accompanying reporters reporting the Yates case, and as a necessary supplement to the now happy families of women formerly suffering from postpartum depression.

The coverage of the Yates case frequently begins and ends with shots of the Yates family home. Ed Lavandera begins his report for CNN (Blitzer, 2001a), “In a tranquil suburban neighborhood south of Houston, police started the day responding to a 911 phone call from a woman asking for help.” Accompanying his voice-over is aerial footage of the Yates family home. Although the house itself is surrounded by police cars, interrupting the supposedly “tranquil” nature of the suburb, remnants of the tranquility can be found. The house is a simple one-story brick ranch house with a large front lawn dominated by an oak tree in the center.

Scattered at the back of the driveway is further evidence of what this house once was—a family home—with a plastic basketball hoop set up and a wagon standing nearby. Lavandera’s report continues with the Yates’s house clearly in the background:

John Cannon: A patrol Officer came to the door and a woman breathing heavily at that time said that I just killed my children.

Medium shot of Cannon (identified with on screen text as “Houston Police.”) Cannon is standing in the front of the Yates house.

Lavandera: When the officer walked into the house, he found

Footage of the Yates house, moving from left to right. We can clearly see that the house is brick, has blinds in the windows, and a wrought iron front door. Two police officers are standing outside of the house.

a 6-month-old girl and three boys between the ages of 2 and 5, dead in a bedroom. A second officer found a 7-year-old boy dead in the bathtub.

Camera zooms in slowly on the front door. The door is ornate wrought iron.

Police say their 36-year-old mother Andrea Yates drowned all five children.

Footage of Yates being led to a police car in her driveway. Yates is wearing a navy and white striped shirt. Police walk with her on either side. The side of the family home is visible. The garage door is shut and the grass looks freshly mowed.

The dominating presence of the Yates house is expected, as it is the scene of the crime. What is significant, however, is that it also becomes the scene through which Yates’s crimes are understood. When Russell Yates holds a press conference the day after the murders, he appears standing in front of his home holding a framed family picture. Segments of the press conference are aired on all four networks (ABC, CBS, NBC, and CNN). As an example, consider

Lavandera’s report the next evening (Blitzer, 2001b):

Ed Lavandera: Wolf, Russell Yates has been spending the day trying to find an attorney for his wife and making funeral arrangements for his five children. But as he has done that all day and he’s still working on that this evening,

Medium shot of Lavandera. He is standing outside of the Yates house. Yellow tape is has blocked off part of the yard. Also clearly visible is the large tree in the center of the front lawn, which is now surrounded by flowers and

he stood on his front lawn before the glaring cameras, and talked about the ordeal that he has had to endure during the last 36 hours.

stuffed animals.

In the drizzling rain, Russell Yates grabbed the teddy bears, flowers and prayers left at a growing memorial in front of his home, thoughts from unknown people who share his pain, and welcome support on a day Mr. Yates chose to share his thoughts about the tragedy, while clutching a family photo for comfort.

Footage of Russell Yates kneeling at the tree in his front lawn. He picks up both flowers and a teddy bear, then puts them back. Behind him are two unidentified people (believed to be his parents). Cut to footage of Russell Yates walking to the edge of his lawn, approaching a crowded media area.

Russell Yates: I said, "What's wrong, Andrea." And she said, she said, like, you know, like "you need to come home," and I said, "Is anyone hurt?" And she said, "yes." And I said, I said, "who?" And she said, "all of them." And I just, I mean, my heart just sunk.

Medium shot of Russell Yates. Yates is standing in front of his house. A basketball hoop is clearly visible behind him, as is the tree.

Two key elements of the family home are seen in this footage. First, we see again the basketball hoop, visual evidence of the children who once lived there. Second, the impromptu memorial is featured heavily in this coverage, with footage of Russell Yates kneeling at the tree and touching the items left behind by neighbors. The memorial itself serves as a visual reminder of the tragedy that has occurred.

In addition to the footage of the Yates house, it is significant that Russell Yates is also present. Referred to as both a husband and a father, Yates stands before the family home, holding the framed photograph of what was formerly the Yates family, and attempts to explain his wife's actions. In the formal family portrait, Russell Yates stands slightly behind his wife with his children surrounding them. Russell's left arm envelopes his eldest son, Noah, completing the circle. As the patriarch of the Yates family, Russell's position in this photograph is appropriate. Pictured in this family portrait is what looks like an ideal American family: smiling children, husband, and wife. The footage of the Yates house is thus supplemented by

our knowledge of the people within the house. In the news coverage, at least three different family photographs of the boys, two family photographs of Mary, and three photographs (excluding the formal portrait) of the entire family are broadcast. Other than the family portrait, the most frequently broadcast photograph of the entire Yates family is one of the family sitting together on a couch. This photograph is taken after Mary's birth (Andrea is holding Mary) and depicts the family in their "natural setting"—the family home. Unlike the formal portrait, Russell Yates does not stand over his family, but rather sits with them. The family pictured is still joyful and happy. Andrea Yates, while not offering her biggest smile, looks like the appropriate—and good—mother.

When taken together, the Yates family photographs as well as the frequent footage of the outside of the family house form a visualization of "home" that includes both the structure that houses the family and those who live within it. The structure/house is representative of an idealized American middle class family, and the structure/family within it is as well: the husband as breadwinner, wife as caretaker, and children. Certainly, within current American culture the term "middle class" has a variety of meanings; when surveyed, for example, most Americans identify themselves as middle class despite a wide range of incomes that potentially signify a wide range of classes—upper, middle, and lower (Drum, 2005). My description of the Yates family home as middle-class is one primarily based on what the home is not: it is not an apartment or trailer, and it is not a mansion. Falling between these two polar ends of the class structure is the middle class. hooks's description of lower and upper class housing places the Yates family somewhere in the middle:

The poor live with and among the poor—confined in gated communities without adequate shelter, food, or health care—the victims of predatory greed. More and more

poor communities all over the country look like war zones, with boarded-up bombed-out buildings, with either the evidence of gunfire everywhere or the vacant silence of unsatisfied hunger....The rich, along with their upper-class neighbors, also live in gated communities where they zealously protect their class interests—by surveillance, by security forces, by direct links to the police, so that all danger can be kept at bay. (2000, p. 2)

To describe the Yates house, a house located in a “tranquil suburban neighborhood,” as middle class is to recognize not the “middle class” as a class per say, but rather to recognize an idealized image of the American family. This “archetypal” American family is a white, middle class, nuclear family (Collins, 1994, p. 46).

This idealized middle class “home” reappears in the footage of Randy Berman’s family, Alyson Herman’s family, and Cathy Gusmano’s family. In the CBS report about Herman and Gusmano (Roberts, 2004), much of the footage takes place inside the families’ houses:

Cathy Gusmano: I didn’t know how to split myself into two people to take care of my daughter, who was almost four, and my newborn son.

Medium shot of Gusmano, sitting in her family room. We can see an elegant dark wood dining table behind her. Gusmano has short hair and wears a pastel collared shirt.

Steve Gusmano: There were some tough times at that point.

Medium shot of Steve Gusmano, identified as “husband,” in living room. Steve Gusmano is also “clean-cut,” and the living room, although in dim lighting, appears to be decorated in warm colors.

John Roberts: At her worst, Gusmano began to fantasize about driving her care into a highway divider.

Still photograph of Gusmano in hospital after giving birth. Gusmano is holding an infant and looks serene.

Cathy Gusmano: I just wanted to hit that, be injured and then be hospitalized, just so somebody could take care of me. I felt like I had lost myself.

Medium shot of Gusmano in living room.

Roberts: In the rarest of cases, women like Michigan schoolteacher

Footage of a large two-story Colonial Revival brick house with manicured front lawn.

Mary Ellen Moffitt lose all control. On Monday she suffocated her newborn daughter before killing herself.

Still close-up photograph of Mary Ellen Moffitt. Moffitt is Caucasian with a bobbed hair cut. In the photograph she is smiling.

Last month, another new mom reportedly at her limits led Wisconsin police on a highway chase that ended when she tried to jump off a bridge.

Footage of the chase. We see a dark sedan pull over on a bridge. The driver gets out, attempts to jump over the bridge, and is pulled back by a police officer.

And no other recent postpartum tragedies drew as much attention

Home video footage of Andrea Yates holding Mary and sitting on the home sofa. She plays with the boys who bounce around her.

Andrea Yates, who drowned her five children.

Footage of Yates in a dark blue shirt in a courtroom.

Ms. Joyce Venis: We are educated to this. We do know about it. Why is it still happening?

Medium shot of Venis in her office. The office includes several “feminine” touches—a floral patterned chair and a floral lampshade. She is identified as “Depression After Delivery.”

Roberts: Many, like postpartum specialist Joyce Venis, blame the embarrassment of seeking help. She says the Yates case stigmatized the more common forms of postpartum depression.

Footage of Yates in courtroom during trial. Yates is wearing a white sweater and stares straight ahead.

Ms. Venis: She had a postpartum psychosis. That happens in only one of 1000.

Medium shot of Venis.

Roberts: Experts say that almost all women with postpartum depression can be successfully treated. Talking openly with others about their fears and stress is often the best medicine.

Footage of Gusmano family. Cathy Gusmano and children are fixing a meal. The Gusmano kitchen opens into a large eating area. A glass door in the eating area, as well as several windows, allow a view of the backyard. Followed by footage of Herman, her son, and her husband playing in their backyard.

Like the coverage of the Yates family, the Gusmano, Herman, and Berman families conform to a particular idea of family: all women are presumably heterosexual and married (we either see or



hear from their husbands), all live in what are identifiable as middle-class houses (Herman's backyard, for example, is spacious and includes several play sets—a swing and a slide), and all are seemingly Caucasian. Even the brief reference to Mary Ellen Moffitt in this coverage supports this version of family—Moffitt's house is large and well kept, and Moffitt is also Caucasian.

In this extended clip from CBS, the Yates story is intersected with other women who have suffered from postpartum depression and have recovered. This recovery is, notably, based in their home. Gusmano, for example, discusses her illness while sitting alone in the family room. The only image we see of Gusmano outside of the family home is a still photograph of Gusmano in the hospital after the birth of her most recent child. As the segment concludes, the coverage suggests through the verbal/visual juxtaposition of (verbal) successful treatment with (visual) Gusmano cooking for her children in the kitchen that successful treatment returns women to the family home in their roles as satisfied, content, and nurturing mothers. There is perhaps no more stereotypical image than this footage of Gusmano cooking a meal with her children eagerly waiting. The mother who had at one time imagined driving into a highway divider is now reunited with her children. The image of the happy family home (a woman cooking, a husband and wife playing with their child in the back yard) is evidence of the successful treatment of postpartum depression in the same way that the now empty Yates home is clear evidence of what happens to a family whose mother does not emerge from her illness. Further, when placed in conjunction with the images of the Gusmano and Berman homes, the now empty Yates home stands as a reminder of a key function of motherhood: the glue that keeps a family together, happy, and in one house.

The articulation of the subject position of mother as seen through images of the home thus has two key elements. First, adding to the images of children and women (whether segmented or full), images of the home promote an understanding of the mother within postpartum discourse as white, heterosexual, and middle class. Second, the key role of the mother as the symbolic “nurturing” center of the family home—a role that receives little value in our culture but is nevertheless implicitly recognized—is visualized through images of happy women in happy homes after successful treatment of the postpartum depression. This second aspect reflects an idea of home as a safe haven, one in which mothers—those who preside over the “sacred temple of the hearth”—become the watchers of what is decent and good (Thurer, 1994, p. 182). Thurer, for example, describes the transformation of mother from “devil’s consort” to “angel of the house” in the eighteenth century: “Previously considered morally vulnerable, sexually voracious, emotionally inconsistent, and intellectually inferior, she metamorphosed into the True Woman—virtuous, genteel, devoted, asexual, limited in interests in creating a proper refuge from her family and to tenderly guiding her children along appointed ways” (p. 183). It is the home as refuge, the home as safe haven, in which the mother is the emotional backbone of family, and it is precisely this home that is articulated in television news coverage of postpartum disorders.

Of course, mother as the center of nurturance, the emotional backbone, of the family home does not disrupt the importance of the role of husband. Although this role is not clearly explicated in this footage, it is interesting that when husbands do appear, they either remain silent (we see, for example, Randy Berman’s husband but never hear him) or they verbally express confusion about their wives’ conduct. Mr. David Herman, for example, relates, “It was frustrating because there was nothing I could do to try and make her feel better” (Roberts, 2004).

Herman's words are accompanied by a relatively close up shot of Herman sitting in the family room. But why did Alyson Herman need to feel better? In the most basic sense, Herman needed to feel better because she was responsible for taking care of an infant. However, Herman's depression can also be read as disrupting her role as the emotional center of the family. David Herman states that there was nothing he could do to make her feel better, a statement that suggests that David Herman was unable to give his wife the emotional (and practical) support she needed. This is not to suggest that David Herman is an uncaring or unkind husband, but rather that his lack of ability to perform emotional support is related to the very subject position of mother in which the mother/wife—the woman—is the center of the emotional resources of the family home. Russell Yates's statements to the press also indicate an inability to help his wife (Wallace, 2001): "She—she went through a postpartum depression with our fourth child. And it was very serious then, and she had attempted suicide then, and they, you know, gave her medication. And her dad passed away about three months or so after she had our—our baby girl. And, you know, and that really just sent her spiraling down." At the beginning of this statement the camera focuses on Russell Yates standing in front of his house. After the first sentence, the camera moves to focus on Andrea Yates in the family photograph held by Russell Yates. Then, the camera slowly focuses on each of the children. What is remarkable about this verbal/visual juxtaposition is that although we see Russell Yates—he is talking, and he is in the family photograph—he never refers to himself in his verbal statement. Andrea Yates's condition is apparently something that Russell Yates had nothing to do with; he could observe her spiraling descent into depression, but he could not stop it. Russell Yates effectively distanced himself from the emotional turmoil in his home. By doing so he also effectively places responsibility for the emotional upkeep of his home on his wife, the mother of his children.

*The Mother Revisited*

Rather than consider the verbal and visual as separate texts in television news coverage of postpartum disorders, I have attempted to discuss them as one text, the verbal/visual juxtaposition. The verbal/visual juxtapositions of television news articulate the subject position mother in such a way as to reinforce the discourse of traditional motherhood in a manner not possible with print news, suggesting that although the verbal/linguistic elements stayed the same, the new verbal/visual texts articulate different elements of the mother. In its circulation, the mother morphs, picking up new characteristics while leaving others behind. Importantly, with only one exception, the subject position of mother articulated by television coverage is complimentary to that of print news coverage and psychiatric rhetoric in that the mother remains firmly ensconced in the discourse of traditional motherhood. The exception appears in coverage of women who have been successfully treated with postpartum disorders that offers a limited, but important, reconfiguration of the mother/child relationship. In the case of Alyson Herman, she suggests that she will do what is best for “us”—her and her child—while Randy Berman’s home business as a “life coach” suggests the importance of relationships that supplement that of the mother/child. In both cases, the homes of Berman and Herman become potentially disruptive spaces.

Interestingly, the visualization of the family homes and those people who make a house a “home”—mothers/wives, fathers/husbands, and children—combine in a performance of a naturalistic enthymeme that suggests that the “reality” of postpartum disorders is one of white, heterosexual, middle class women. This is a reality of which only parts can be discussed verbally. For example, we hear hints of class identification in the voice-overs of certain reporters (“the tranquil suburban neighborhood”), and the introduction of Russell Yates as

Andrea Yates's husband may signify her heterosexuality, but none of the women, children, or men are ever discussed in terms of race. The television news industry has made overt attempts to present "neutral" coverage of crimes by not verbally mentioning the race of the suspect, and Andrea Yates is certainly never discussed verbally as a white woman. Race, however, is a visual cue that cannot be denied. Despite current controversies about the meaning of race and the recognition by most academics and the lay population that race is a social construct, race continues to be understood as a visible difference—differences in skin color, hair texture, facial structure, and so forth (see Dubriwny, Bevan, & Bates, 2004). Of the women with postpartum disorders visualized by television news, only one (Leija) was clearly identifiable as not white. Of the dozens of anonymous infants and children, only two were clearly identifiable as not white (in addition to the footage Leija's five children). The reasons for the dominance of Caucasian/white women and children in the television news can perhaps be explained by Poindexter, Smith, and Heider's study of television news in which they find that African Americans (and, to a lesser extent, other minority groups) are used in the footage of news stories that deal specifically with African American culture, neighborhood, events, crimes or other news stories that center on the African American community or individuals (2004, p. 529). In news stories without a clearly African American focus (for example, a story covering a hot air balloon festival), the population of people in the footage shown was white (2004, p. 529; see also Campbell, 1995, p. 39). Given the assumed "un-raced" nature of postpartum disorders, news workers fill the screen with white people. This explanation may point to part of the "why" of the presence of white women, but I would also suggest that it is precisely because the subject at hand is (good) motherhood that white women are used in footage.

In the psychiatric journal articles reviewed in the first case study, women's race and class positions were discussed in terms of demographic variables. Warner, Appleby, Whitton and Faragher (1996), Righetti-Veltema, Conne-Perreard, Bousquet, and Manzano (1998), and Zelkowitz and Milet (1995) suggest that women with economic difficulties are at higher risk than those women who are financially stable. Zelkowitz and Milet's findings also suggest that recent immigrants and ethnic minorities may be at higher risk for postpartum disorders. Sexuality was not discussed in any of the articles reviewed. Instead, authors report on the marital status of the women (e.g. Righetti-Veltema, et al. discuss women as married, single, divorced, separated, or widowed), leaving the question of sexuality behind. With this in mind, it is striking that the majority of television news coverage features images of heterosexual Caucasian women and/or Caucasian babies as well as housing that is identifiable as "middle class." Features such as race and class are, in this articulation of mother, not a variable, but rather a certainty. The naturalistic enthymeme suggested by the images accompanying coverage of postpartum disorders claims that women who have postpartum disorders are white, heterosexual, and middle class, despite the psychiatric recognition of a "reality" of postpartum disorders that includes women of many races and class.

This articulation of mother is not surprising given the discourse of traditional motherhood on which it depends. This discourse has been critiqued by numerous scholars (Collins, 1991; Davis, 1993) as a discourse of white motherhood that contradicts the "realities" of motherhood for women of color. Patricia Hill Collins describes the "racialized" discourse of the nuclear family:

The archetypal white, middle-class nuclear family divides family life into two oppositional spheres: the "male" sphere of economic providing and the "female" sphere

of affective nurturing. This normative family household consists of a working father who earns enough to allow his spouse and children to withdraw from the paid labor force...Guided by the moral influence of the mother, the household/family serves as a haven from the pressures and demands of the impersonal, public sector. (p. 47)

This family includes a white mother who operates as the emotional center of the household. Importantly, this depiction of “good” motherhood relies on racist configurations of sexuality and reproduction in which white women’s “virtue” had to be protected from the African American men’s sexuality (Collins, p. 50). Current reproductive politics are still informed by the interlocking ideologies of racism, classism, and sexism. Angela Davis reflects,

If the emerging debate around the new reproductive technologies is presently anchored to the socioeconomic conditions of relatively affluent families, the reproductive issues most frequently associated with poor and working-class women of color revolve around the apparent proliferation of young single parents, especially in the African-American community. For the last decade or so, teenage pregnancy has been ideologically represented as one of the greatest obstacles to social progress in the most impoverished sectors of the Black community. (p. 361)

The result of the focus on advantages of reproductive technologies for white wealthy women and the problems of single motherhood for Black women is a clear valuing of motherhood and the products of motherhood—the child—for certain segments of society. If white affluent women are currently embroiled in a “motherhood quest,” Black women are increasingly punished (through restrictive welfare laws) for bearing children (Davis, 1993, pp. 356-357).

In terms of the discourse surrounding postpartum disorders, the visual presentation of white, middle-class motherhood as *the* location of postpartum disorders implicitly promotes

different understandings of distress during the postpartum period for different segments of the population. Consider, for example, the discussion of the Yates case by Yates's neighbors

(Brokaw, 2001):

Fredricka Whitfield: Tom, what everyone wants to know is what could have pushed Andrea Yates so completely over the edge that she is suspected of killing her own children.	Medium shot of Whitfield standing in front of the Yates house.
Today outside this suburban Houston home...	Footage of people bringing flowers and stuffed animals and placing them around the tree in the center of the Yates's lawn.
Unidentified Woman #1: My heart just hearts.	Medium shot of unidentified woman, standing in front of tree.
Whitfield: tears, flowers, and stuffed animals for the children allegedly drowned by yesterday by 36-year-old Andrea Yates,	Footage of Andrea Yates being escorted to a police car in her driveway.
appearing in court early this morning. Judge: You are charged with capital murder.	Footage of Andrea Yates wearing a dark blue shirt appearing in court.
Whitfield: And for the children's grieving father...	Medium shot of Whitfield.
Joe Blum: I'm sure he's going through a lot. I just want him to know everybody cares.	Medium shot of Blum, standing in front of tree. Identified as "neighbor."
Whitfield: an outpouring of sympathy.	Medium shot of Whitfield
Diane Bosson: And I don't see how anybody in their right mind would have done this, so she wasn't in her right mind.	Close up of Bosson, standing in front of tree, identified as "neighbor."

The reporter, Fredricka Whitfield, frames the story as one of outpouring emotional support Russell Yates. Interestingly, none of the neighbors condemn Andrea Yates. Bosson, the final neighbor to speak, notes that Yates must not have been in her "right mind." Yates's status as a good/mythical mother is preserved through Bosson's description, even as Bosson stands in front



of the memorial for the Yates children. The reference to Yates being not in her right mind performs the same function as it did in the print news coverage of the case: postpartum psychosis provides a mode of reasoning through the Yates case that does not disrupt the discourse of traditional motherhood. However, the coverage of the Yates case did not receive universal acclaim. In a revealing letter to the editor of *Newsweek*, Beverly Lyles writes,

The media's compassion for Andrea Yates strikes me as racist. This family had plenty of choices. If she was having such a hard time with all those kids, why didn't she just do what we ask all the poor women in this country to do: use better birth control, practice birth spacing? When one woman in the 'hood beats her child, in all probability she is suffering from some form of depression. But because she is poor and black, she'll have to settle for the label of "child abuser" and be cursed and maligned by everyone. Where, I'd like to know, is the media's compassion for her? (Mail Call, 2001a, p. 14)

The black mother, in other words, would not receive the same benefit of the doubt as the white woman—she would be automatically assumed to be a bad mother, not a “good mother” who was not in her right mind. By visually defining postpartum disorders as a white, middle class woman's disease, the television news coverage races and classes the subject position of mother to such an extent that white mother's distress during the postpartum period can be excused even while mothers of color are vilified for the same actions/feelings.

The issues of race and class that have emerged in this analysis should serve as an important reminder that the discourse of traditional motherhood upholds a diverse and interlocking set of assumptions about race, class, and sexuality that privilege white women's experience of motherhood over and above other's. Further, these issues are key to the development of a subject position for women during the postpartum period that does not simply

reify the discourse of traditional motherhood. I have suggested throughout that a “new” subject position must contextualize woman both biologically and socially, and this means that we must consider the intersections of discourses of race, class, sexuality, and gender in the creation of this subject.

## CHAPTER FIVE

### Conclusion: Articulation, Postpartum Disorders, and Bio-social Women

The analysis of the articulation of subject positions for women necessarily considers the discursivity of the subject, but such an analysis need not deny the “real” effects of such subject positions on the ways in which women live their lives. From the different types of treatment women may encounter for postpartum disorders (pharmaceutical drugs, talk therapy, electroconvulsive therapy) to their everyday interactions with spouses, partners, neighbors, and friends, understanding the postpartum woman as primarily a mother displaces the woman as patient in the doctor’s office, the woman as possible partner in the domestic setting, and the woman as “agent” in the larger social world. That the discourse of traditional motherhood plays such a substantial role in the articulation of subject positions for women during the postpartum period suggests that the understanding of “what is woman” remains tied to women’s reproductive functions. These reproductive functions—the menstrual cycle, pregnancy, labor, and so forth—are not in and of themselves necessarily oppressive. As Jane Gallop (1988) suggests, it is not the body that oppresses, but rather the ideological use of the body that is oppressive. With the possible exception of the “real” mother subject position discussed in the second case study, it is precisely the link between women’s bodies and a discourse of traditional motherhood that forms the articulation of subject positions that place women in a consistently submissive/secondary role—to their biology, to their husbands, to their children, and to their doctors. Articulation theory suggests that such articulations are neither stable nor necessary, which raises an interesting question: If not stable or necessary, why are these articulations so

dominant? After discussing the implications of the postpartum subject positions for articulation theory, I will offer one avenue of possible reconfiguration of the postpartum subject: bio-social women. Such a reconfiguration must necessarily take into consideration two key elements that have appeared in the case studies: the relationship between woman and child, and the race/class/sexuality of the postpartum woman. An articulation of bio-social women is possible in the antagonistic space opened by distress during the postpartum period.

Kevin DeLuca suggests that articulation theory is one way of “understanding social struggle in a postmodern world” (1999, p. 335). The struggle occurring around postpartum disorders, one that I introduced as an “epidemic of signification” (Treichler, 1999), is not limited to the discursive fields of psychiatry or print and television news. Rather, such a struggle also takes place in homes and offices, novellas and self-help groups, and hospital rooms and bedrooms. That I have limited this study to what one might consider “dominant” discourses points to a fruitful use of articulation theory. Specifically, part of what this dissertation ultimately suggests is *how* hegemonic discourses maintain power in the face/space of potentially articulatable antagonisms. In the case of postpartum disorders, the potential antagonism present is distress during the postpartum period. This distress signals a gap in the discourse of traditional motherhood, a discourse that configures motherhood as a joyous series of events. To consider distress during the postpartum period as a “natural” part of motherhood, to position the distress, anxiety, anger, depression, irritability, and frustration of mothers as key to understanding motherhood, is not simply to disrupt the discourse of traditional motherhood, but rather to disrupt the entire sex/gender system in which the institution of motherhood operates in such a way as to continually position women of all races and classes in a secondary position. Thus, the psychiatric and journalistic presentations of postpartum disorders can be interpreted as shoring

up and even strengthening the discourse of traditional motherhood as well as the larger discursive system in which traditional motherhood develops.

One of the key findings of *all* of the case studies is that the dominant understanding of postpartum disorders and women with postpartum disorders occurs in or is articulated through a specific concept of traditional motherhood. But this discourse of traditional motherhood does not exist in a vacuum. The strength of the discourse of traditional motherhood as articulated in the subject positions for women during the postpartum period is its ability to draw from, interact with, and support other discourses. In other words, a partial answer to the “how” of hegemonic power can be found in the interaction and interdependency of discourses. An excellent example is the articulation of the vulnerable female/mother in the second case study (print news). This articulation depends on an understanding of depression and psychosis as biological phenomena that literally control the woman, a woman who in this case is a mother. When combined with the discourse of traditional motherhood, the result is subject position that suggests that when a woman is under the “control” of an illness like depression, she can no longer be expected to act as a proper mother should. This understanding of the postpartum subject is then expanded on by television news with the visibility of race. The resulting combination of discourses of biomedicine, traditional motherhood, and racism configures postpartum disorders in such a way as to leave the stereotype of the black abusive welfare mother intact while at the same time privileging an idealized version of white motherhood.

Of course, this joining of discourses in the articulation of subject positions is precisely what articulation theory asserts, albeit indirectly. To return to Laclau and Mouffe, they write,

In the context of this discussion, we will call articulation any practice establishing a relation among elements such that their identity is modified as a result of the articulatory

practice. The structured totality resulting from the articulatory practice, we will call discourse. The differential positions, insofar as they appear articulated within a discourse, we will call moments. By contrast, we will call element any difference that is not discursively articulated. (2001, p. 105)

The subject positions I have discussed throughout this project can be interpreted as “moments” in a larger “structured totality.” This structured totality/discourse is bluntly described by bell hooks as the “white supremacist capitalist patriarchy” (hooks, 1994, p. 5). Barbara Katz Rothman points to much the same discourse when she asserts that motherhood is based on three interlocking ideologies: patriarchy, technology, and capitalism. What the study of postpartum subject positions points to, then, is the importance of unpacking the individual discourses that make up, in this case, the discourse of white capitalist patriarchy. Consider, for example, DeLuca’s discussion of the discourse of Industrialism—that “humanity, by dominating nature through the use of instrumental reason and technology, will achieve progress” (1999, p. 336). Within this discourse, capitalism and Marxism are two competing discourses, both of which operate within the discourse of Industrialism. DeLuca explains, “They are fighting over who should own the factory. Neither questions whether the factory should be built in the first place (nor whether nature should be conceived of as a storehouse of resources)” (p. 336). The moments of the vulnerable female, the patient, and the mother may all be supportive of the white capitalist heterosexist patriarchy, but their support draws from different parts of different discourses, most prominently biomedical discourse and a discourse of traditional motherhood.

That the subject positions of the vulnerable female, the patient, and the mother are not “stable” (small differences do appear as they circulate from psychiatric rhetoric to the field of journalism) does not imply that they do not always support the larger structured totality in which

they emerged. I suggested in the introductory chapter that the subject positions would circulate in a “relatively unrestrained” manner. The appearance and rearticulation of the “patient” in the news, as well as the vulnerable female and the mother, suggests that discursive movement can indeed blur the boundaries between discursive fields. However, the fact that these subject positions remain ensconced within a larger structured totality suggests that this movement can be more restrained, that articulation itself can be more restrained, in fields that limit the variety of voices present. The vulnerable female, patient, and mother are articulated in ways that support the white capitalist heterosexist patriarchy in both psychiatric rhetoric and media coverage of postpartum disorders precisely because these are “authoritative”/hegemonic discursive fields. The discursive context of an articulation, then, may be indicative of the ability of any articulation to draw from disruptive discourses. That the single “resistant” subject position—that of the “real” mother—is articulated in editorials and letters to the editors suggests, however, that the space for articulating antagonisms is present in what may seem to be “undisruptable” hegemonic discursive fields.

Notably, all points of “resistant” rhetoric arise from lay voices situated at least partially outside of the discursive fields of journalism and psychiatry. For example, the partial reconfiguration of the mother/child relationship by Alyson Herman in the *CBS* news segment draws directly from Herman’s own experience of being a mother with postpartum depression. The analysis that is needed to supplement this project is one of women’s voices, whether through postpartum depression self-help groups and books, short stories, interviews, or memoirs. It is in these fields that we are more likely to see an articulation of subject positions for women that do not directly correspond with or support the discourse of traditional motherhood. Without this analysis, what remains is an incomplete picture: the story of articulating against an antagonism,

not with it or through it. Throughout this project I have suggested a “new” subject position—that of the bio-social woman—is needed to for women during the postpartum period. Without turning to memoirs of postpartum depression or self-help books, I would like to suggest two possible areas for the reconfiguration of the postpartum subject that might arise in these works: the mother/child relationship and issues of race, class, and sexuality.

Part of the problem with the subject positions offered to women during the postpartum period is the way in which they can be inhabited. To call a woman during the postpartum period “mother” is to signify her secondary status to another being: the child. To call a woman during the postpartum period “vulnerable female” is to suggest that women are ultimately under the control over their bodies. To call a woman during the postpartum period “patient” is to place her in a submissive position relative to that of her doctor. These articulations of women during the postpartum period leave women with very little room to maneuver on their own behalf. Thus, I would suggest that we call women during the postpartum period *women*—a position that is already plural and recognizes the many different facets of the development of postpartum disorders. Feminist theorists have long dealt with the problem of discussing woman/women. Teresa de Lauretis offers a key insight in her search for the subject of feminism:

By the phrase “the subject of feminism” I mean a conception or an understanding of the (female) subject as not only distinct from Woman with the capital letter, the *representation* of an essence inherent in all women (which has been seen as Nature, Mother, Mystery, Evil Incarnate, Object of [Masculine] Desire and Knowledge, Proper Womanhood, Femininity, et cetera), but also distinct from women, the real, historical beings and social subjects who are defined by the technology of gender and actually engendered in social relations. (pp. 9-10)



For her purposes, de Lauretis wishes to leave aside both women and Woman, and focus on a feminist subject as a “definition or conception [that] is in progress,” one that accounts for processes if not for lived lives (p. 10). But it is precisely these lived lives that I am concerned with, and the disjunct between women with postpartum disorders (African American, lesbian, heterosexual, white, Hispanic, young, old women) and the Mother of postpartum disorder (white, heterosexual, and middle class) suggests that postpartum bio-social *women* is a subject position that could be articulated in such a way as to capture the complexities of the postpartum period.

Within a subject of postpartum bio-social women, biological and social forces join to create the lived “reality” of postpartum depression. For example, it is likely (if we take psychiatric research seriously) that hormones may have a role to play in the development of postpartum disorders. It is equally likely, however, that expectations of motherhood, lack of social support, and many other social factors may have a role in the development of postpartum disorders. The biological and cultural do not have to exist at polar ends of the nature/nurture spectrum. Rather, I would suggest that any one woman with postpartum depression may be experiencing many of these issues: her hormones may be fluctuating, her spouse or partner may be out of town, her neighbors may be holding loud parties, her infant may have colic, and so forth. To discuss the postpartum subject as bio-social women is (hopefully) to recognize that any group of symptoms may have multiple causes. Celeste Condit describes this phenomenon as the “MCME” (or multiple causes, multiple effects) model in which she suggests that narrowing the cause-effect model to one cause, one effect misses the relationship between nature and culture, between humans and the worlds in which they live (Condit, 2004).

One of the key relationships that perhaps needs to be reconfigured in the position of postpartum bio-social women is that of the mother/child relationship. As discussed by Rich

(1986) and Rothman (1989/2000), the mother/child relationship envisioned in dominant culture values the “product” of the relationship (the nurtured child) without valuing the act of nurturance or the nurturer. Mothers are responsible for the care and welfare of their children and women are told they will find their ultimate (and natural) fulfillment in entering the mother/child relationship. This relationship, however, does not develop in a vacuum. Women as mothers interact with other people, send their children to day care, go to work and go home, argue with friends and neighbors, *and* care for their children. Reconfiguring the mother/child relationship in our understanding of motherhood must, necessarily, disrupt the dominance of the child as a figure of value and importance in the relationship. Further, such a reconfiguration must also recognize that the mother/child relationship is only one of many relationships in which women take part. Barbara Katz Rothman describes her attempt to redefine motherhood:

A great deal of what I am trying to do is put together that which patriarchy, technology, and capitalism have taken apart: mind and body; public and private; personal and political; work and home; production and reproduction; masculine and feminine. I want us to move beyond the mind-body dualism, with its disdain for the body and its esteem for narrow, rational linearity. I want us to move beyond the division of the world into a public sphere (the world of men, work, and production) and a private sphere (the world of women, home, and reproduction). (1989/2000, p. 55)

What is intriguing about Rothman’s statement is the focus on the body. Rothman’s interest in “reclaiming” the maternal body leads to her suggestion that the mother/child relationship begins during pregnancy. Her explanation of the thalidomide disaster is particularly telling. Rather than using the tragedy to understand the fetus as an integral part of a mother’s body (a part that could be poisoned, injured, and hurt much like a kidney, heart, or brain), the medical industry

posited that the womb, once thought of as a safe haven carrying the fetus, was now a dangerous and inadequately protected nest (p. 58). The crack baby phenomenon can be understood in much the same way—drugs that are ingested by the mother are also “felt” by the fetus precisely because the fetus is a part of its mother’s body. Both the thalidomide tragedy and crack baby epidemic signals are interpreted, however, as proof that mothers are a potential source of harm for their “unborn children.” It is precisely this interpretation that Rothman attempts to counter by focusing on the fact that by existing within a woman’s body the fetus is a part of that body, not a separate being.

In taking a woman-centered view of the mother/child relationship, Rothman does not deny the importance of motherhood (or the experience of pregnancy) for many women, or the joy that can come from having a child. Beginning with the relationship of the fetus/mother in the body, she attempts to spread the value placed on the child to the mother as well. If the mother is the focus of Rothman’s understanding of pregnancy, she is also the focus of the mother/child relationship that develops after a child is born. Thus, after the birth of a child Rothman suggests that the mother/child relationship should be one in which mothers have “full medical decision making rights for the care of their newborns and very young children” (p. 203). But perhaps more importantly, as the child grows, the mother becomes only one of many nurturers responsible for the upbringing of the child. A father can, according to Rothman, only be a father when he nurtures—paternity, or genetics, does not constitute fatherhood (p. 203). Because Rothman’s view occasionally slides into an understanding of the mother/child relationship as unique (she does not, and cannot, call a “father” a “mother,” despite possible abilities to nurture), a turn to the discussions of mother/child relationships in black feminist theory is necessary.

Perhaps because of their recognition of the historic place of black women taking care of white babies, black feminist theorists are quick to recognize that a mother's nurturance alone cannot raise a child. Patricia Hill Collins explains,

In African American communities, fluid and changing boundaries often distinguish biological mothers from other women who care for children. Biological mothers, or bloodmothers, are expected to care for their children. But African and African-American communities have also recognized that vesting one person with the full responsibility for mothering a child may not be wise or possible. As a result, othermothers—women who assist bloodmothers by sharing mothering responsibilities—traditionally have been central to the institution of Black motherhood (Troester 1984). (1990, p.119)

Collins also makes reference to “organized, women-centered networks” that share in the responsibility of raising the community's children (p. 119). This view of motherhood places the role of nurturance in the hands of many women, rather than a single mother. That it is still women who are mostly responsible for the upbringing of children is problematic, but at the very least what this conception of the mother/child relationship recognizes is that it is *not* a relationship between two individuals. A reconfiguration of the mother/child relationship must include many people—adults such as day care workers who watch a child for a few hours each day, fathers who tuck the child in at night, aunts and uncles who bring gifts and lend support, and church/temple/mosque members who bring food, as well as children such as the child's playmates, siblings, cousins, bullies, and invisible friends. With so many people involved, it is impossible to see only the mother/child relationship as important. The woman's relationships with her partner, her office mates, her nieces and nephews, as well as her child combine to configure her everyday experiences.

That postpartum bio-social women live in an environment with many relationships and perform many “identity” roles (lawyer, mother, police officer, sister, niece, teacher, etc.) is precisely what my use of *women* is intended to express. Further, the use of women should also serve as a reminder that not every woman is white or middle class, a problem that becomes particularly clear in the analysis of television news coverage of postpartum disorders. In considering the relationship between race, sexuality, and gender, Judith Butler writes,

And here it is not simply a matter of honoring the subject as a plurality of identifications, for these identifications are invariably imbricated in one another, the vehicle for one another: a gender identification can be made in order to repudiate or participate in race identification; what counts as “ethnicity” frames and eroticizes sexuality, or can itself be a sexual marking. This implies that it is not a matter of relating race and sexuality and gender, as if they were fully separable axes of power; the pluralist theoretical separation of these terms as “categories” or indeed as “positions” is itself based on exclusionary operations that attribute false uniformity to them and that serve the regulatory aims of the state. (Butler, 1993, p. 116)

Thus, the discourse that positions women with postpartum disorders as white and heterosexual lends itself to and supports the articulation of “other” (read non-mythical) mothers. The discourse surrounding postpartum disorders is particularly vulnerable to the assumption of whiteness precisely because of the focus on the (mythical) mother. The mythical mother is always (if implicitly) construed as white in sharp contrast to the prototypical “bad” mother: the black welfare mother. Patricia Hill Collins describes the welfare mother: “Typically portrayed as an unwed mother, she violates one cardinal tent of Eurocentric masculine thought: she is a woman alone. As a result, her treatment reinforces the dominant gender ideology positing that a

woman's true worth and financial security should occur through heterosexual marriage" (p. 77). Much like the treatment of the welfare mother, the treatment of women with postpartum disorders also reinforces the "dominant gender ideology." Specifically, the subject positions that are articulated for women during the postpartum period assume a heterosexual, middle class, white woman—an assumption that configures postpartum women as the "mythical" mother while placing all other women as stereotypical bad mothers.

Critical consideration of issues of race, class, sexuality, and gender are a necessarily part of the position of postpartum bio-social women. Indeed, bio-social women is one way to configure "race" in such a manner as to avoid reifying racist ideologies. The lay population (including, I would suggest, numerous doctors, lawyers, and so forth) recognizes a woman's "black-ness" or "white-ness" as a biological phenomenon. However, this recognition comes in hand with the awareness that it is the social understanding of race that makes a person's skin color, hair texture, etc. important (see Dubriwny, et al., 2004). What I am pointing to is that the recognition of a woman's race is not necessarily "racist" in the traditional manner, but rather is an awareness that race matters. A woman's experience of postpartum depression may very well depend on her "race"—will she, as a white woman, be positioned as a patient and treated with pharmaceutical drugs, or will she, as a black woman, be arrested for child neglect? The position of bio-social women would perhaps allow for the black woman (if she wished) to be treated rather than arrested.

The position of bio-social women is intended to contextualize women with postpartum disorders in a different manner. Rather than placing all women with postpartum disorders in a clinical setting (a setting that extends into the home), this position points to the numerous social as well as biological relationships that make up a woman's life. Although I would suggest that

the articulation of bio-social women is a possible way of reconfiguring the postpartum woman and perhaps resisting the discourse of traditional motherhood, this position does not come with programmatic treatment guidelines for doctors and women. Instead, it is precisely the lack of programmatic treatment that may be necessary. For example, in the psychiatric biomedical paradigm, an illness is categorized and treated according to the *DSM*. Psychiatrists diagnose and then treat women with postpartum disorders based on a narrow understanding of such disorders and the women who have them. An articulation of bio-social women in psychiatric rhetoric (admittedly unlikely) would defy easy explanations of postpartum disorders as well as easy choices of treatments. Rather, a diagnosis (if there is one at all) would be based on the numerous characteristics of bio-social women, and treatments would take into account the numerous relationships women have—with friends, families, children, and bodies—instead of privileging concern for the child. If the articulation of the position of bio-social women is unlikely in psychiatric rhetoric, I believe that it may emerge in institutionalized works that approach postpartum disorders from a critical, feminist standpoint (see, for example, Nicolson, 1990), as well as memoirs written by women with postpartum disorders and postpartum depression self-help groups. This dissertation, then, can be best understood as only one part in what will be a larger project analyzing both institutionalized medical discourse as well as women's experience of postpartum disorders.

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