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PERSPECTIVE

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Spitting on my sources: Depression, DNA, and the ambivalent historian

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Abstract

While writing a book on the history of postpartum depression in the United States, I became interested in an ongoing study about possible genetic markers of postpartum mental illness. I participated in the first step, an online survey. When I qualified for the next step, saliva collection, I was torn over whether or not to continue. Making this decision required reflecting on some overlapping issues: gender, medicalization, genetic research, and the political functions of DNA donation. In this perspectives essay, I explore tensions around situating myself in my historical research project.

KEYWORDS
DNA, maternal mental health, postpartum depression, psychiatry, women's health

1 | INTRODUCTION

As historians, choices about what we do with our sources are constant. Should I read this literally or figuratively? Is this source trustworthy? Is it ethical to use this quote? But I recently found myself with an unusual source and a more unexpected research question. Staring at the source, a little plastic tube, I wavered back and forth. Should I spit?

The tube was part of a DNA collection kit for a genetic-oriented project on postpartum mental illness. I am writing a book on the history of postpartum depression in the United States, focused between the 1970s and 1990s. It details the emergence of postpartum depression as both a medical and a popular concept. At its heart is a question about how advocacy around postpartum depression came to have such a different political valence than advocacy around other women's health issues.

Whenever other academics ask me what inspired the research project, I am torn about what kind of story to tell. I try to read them. Some questioners ask nervously, clearly hoping for an academic answer. Hoping I will say I have no children and a clean bill of mental health and this popped into my head one day at random. They want to be reassured I am scholarly and unemotional, and that we can have an easy conversation about medicalization.

And other questioners ask anxiously, hoping I will confide a harrowing story of my depression. Sometimes this is because they have their own stories. Parents, especially mothers, might tell me about their own postpartum mood or anxiety disorder. More mothers tell me about their undiagnosed postpartum distress, often adopting diagnostic language anyhow. They are genuinely sharing, but also testing me a little. They want to know the story—their story—is in good hands. By which they mean *not* in dispassionate hands that will clinically analyze disease construction or diagnostic language. They worry I might misunderstand the seriousness of postpartum mental illness, not grasp the lived experience of pain, numbness, guilt, or fear. That I might not believe their illness is real.

In this essay, I think through my role as both a researcher of the American postpartum and someone doing that research while myself postpartum. In response to a history of postpartum mental illness not being treated as real, activists have focused intensely on proving its realness and legitimacy. Beginning in the 1980s, groups of psychiatrists, psychologists, and patient activists invested in the subject embraced medicalization to obtain that realness. They advocated for the American Psychiatric Association to include postpartum depression in the DSM-IV (Godderis, 2011). Where some elements of the women's health movement found psychiatry pathologizing, postpartum depression activists tended to see psychiatric alliances as more proof their problems were valid (Taylor, 1996, p. 91).

This has only intensified since the 1980s and 1990s. In this paper, I look at one version of this, recent research on possible genetic markers for postpartum depression. I focus on the stcampaign to encourage women's participation in these studies. Women are asked to self-identify as having postpartum depression, and then offer their genetic material to prove the "realness" of the disease. The history of the human sciences' critique of this kind of genetic determinism is necessary, but risks lacking empathy and missing context. What does it mean to raise questions about an illness when assertions of its realness have come to define it? And more to the point, what does it mean to do that as a feminist researcher sympathetic to a women's health project? What does it mean to write about this subject when too much empathy feels naive, and too much critique feels like spitting on your sources?

2 | DEPRESSION

I have a variety of origin stories I tell about my decision to research postpartum depression history. This is the reality of this project—of most projects—that there is no one origin story. I try to find the best one for each audience, but I am disappointing. In one version, I am all business. I was combing through archival papers on a different motherhood topic and found some sources about postpartum depression that did not line up with my thinking about the illness. I followed the trail of breadcrumbs and ended up here. It is a true, but also well-manicured, story.

In another version, I explain I was pregnant with my first child and, for the fourth year in a row, facing a grim academic job market. I needed an interesting second project. So I followed those archival breadcrumbs that led to postpartum depression research. But I add here that when I found those archival breadcrumbs, they resonated deeply. I was pregnant and doctors warned ominously I would probably experience postpartum depression. I had a "psychiatric history," as we euphemistically phrase it. This meant I was a documented "risky mother" from the start and was surveilled accordingly (Dubriwny, 2013). I was handed brochures about how maternal depression could damage babies' development.

The surveillance both miffed me and comforted me. I did not know it then, but now understand how that surveillance owes to the advocacy work of women in the 1980s and 1990s, the actors at the center of my manuscript. How desperately most of them wished they had been surveilled or red flagged as "risky mothers!" How hard they fought so I could be handed those brochures today. The historical fight for disease legitimacy shaped my contemporary experience, and my contemporary context shaped my understanding of the history (Mittelstadt, 2012, p. 151). I also see now how the surveillance that frustrated me was a monument to the health care my job, socioeconomic situation, and whiteness allowed.

Screening and surveillance are not universal in the United States. Women who might benefit from screening—women who ask for depression screening, even—still often fail to get it. Then there is the question of what to do with screening results. I knew how to navigate my health insurance and had access to mental health professionals. I knew how to pick and choose providers who matched my needs reasonably well. I skipped many appointments in the overwhelming postpartum period, but overall had flexibility to make time for this care. For me, the surveillance was frustrating but not threatening. Even at my worst, I did not worry the state would take my children away. History gives many Black, brown, poor, and disabled parents reasons to worry about how a mental illness diagnosis could be weaponized against them (Roberts, 1997; Rymph, 2017). In these ways, experience was both historically and culturally situated.

That story, usually offered in bits and pieces, conveys that my attraction to the subject was always personal. But it was also not quite personal enough. I had psychiatric care and medication throughout my pregnancies and my two postpartums, but no postpartum-specific diagnosis. In the first 6 months postpartum with my first child, I was undeniably in a bad place. My thoughts raced, I cried much of the day. I was also severely sleep-deprived, isolated, and disappointed. I was perhaps overly anxious, but as any new parent knows, the line between "overanxious" and "appropriately anxious" is impossibly thin. I do not expect to ever truly parse which emotions were acceptably unwell and which were unacceptably so, or what amount of unwellness was specific to the postpartum.

It became much harder to navigate between my psychiatric self and my historian self, though, when I got interested in a new postpartum depression research study. The study began in 2016, but in early 2020 they launched a new recruiting campaign. This is when I first came across it. Then I read through a series of promotional articles about this new study, articles from both 2016 and 2020. The study was called Mom Genes Fight PPD. Dr. Samantha Meltzer-Brody, a UNC Chapel Hill professor and one of the most influential researchers in perinatal psychiatry today, was leading it. Several researchers I interviewed had told me how much they respected Meltzer-Brody, and how she was "a real up and coming star" (O'Hara, 2019; Parry, 2019). This study was a big deal in the world of postpartum depression research.

3 | DNA

The investigators of the Mom Genes study wanted to look for common genetic markers across a large sample of women with diagnosed or self-diagnosed postpartum depression. The study built on other research into the genetics of Major Depressive Disorder, but the investigators proposed that the more homogenous population of women who experienced depression while in the postpartum period might yield clearer results (Guintivano, Krohn, Lewis, Byrne, et al., 2018, p. 260). Once they amassed enough samples, the researchers would individually genotype the samples (and the DNA of a control group) for "something like 600,000 genetic markers scattered throughout the genome" (Belluck, 2016). The hope was to find places where the genomes of women who experienced postpartum depression differed from those of the control group.

Preliminary literature from the study, like much postpartum depression literature, emphasizes postpartum depression as one of "the most frequent complications of childbirth" (Guintivano, Krohn, Lewis, Ploner, et al., 2018). This phrasing is common in both advocacy literature and medical literature, and it emphasizes the biological legitimacy of postpartum depression. The incredible emphasis on the biological legitimacy of postpartum depression comes in part as a response to a history of postpartum distress being dismissed as "baby blues" (Held & Rutherford, 2012). Explaining that shopping or getting her hair done would not fix a new mother's problems, that her distress must be taken seriously, frequently translated by the 1980s to meaning it needed to be treated as having clear biological grounding. Whether that was brain chemistry, hormones, or genes, the biological explanation is invaluable in emphasizing the "realness" of postpartum mental illness. In truth, psychiatric researchers invested in genomic explanations are open about the myriad contributors to postpartum mental illness, including poor sleep maintenance, problems with breastfeeding, and histories of trauma (Meltzer-Brody et al., 2013; Park et al., 2013;

Stuebe et al., 2014). They know not all causes are genetic or hormonal. Researchers' nuanced thinking about postpartum illness, though, was not translated to the public-facing elements of the Mom Genes study.

Promotions for the study emphasized the promise of genetic answers to the causes of postpartum depression and implied this could also lead to new treatment. One article explained how UNC Chapel Hill researchers "were the first to identify a genetic variant in people with Schizophrenia" in 2008. "This means they know a lot more about the illness now and can develop better treatments" (Shanahan, 2016). The translation of genetic knowledge into actionable medical knowledge has never worked so easily, though. And in psychiatric medicine specifically, issues like defining and bounding diagnoses have complicated genomic research (Lakoff, 2005). Postpartum depression, with its profoundly contested definiti, offers similar barriers to genomic research (Godderis, 2013).[1]

Discussions of Mom Genes Fight PPD/PPD ACT in medical journals are much more careful with their promises. They "hope" they could be on the path to better identification and treatment with their research, but do not elaborate on any of those potential treatments. "We are confident that we are well on the way to helping all women who suffer with postpartum depression," a preliminary article mostly about methods concludes (Guintivano, Krohn, et al., 2019, p. S841). In one paper, the US team sums up the state of genetic research into Major Depressive Disorder, which if anything has undermined the existence of a discrete disorder. Major Depressive Disorder, they write, is "not a distinct entity that neatly demarcates normalcy from pathology." Instead, it can be understood as "a useful clinical construct compellingly associated with a range of adverse outcomes and the end result of a complex process of intertwined genetic and environmental effects" (Guintivano, Putnam, et al., 2019). As sociologists of medicine have detailed, though, searches for genetic markers are a "self-reinforcing process" (Shostak et al., 2008). Even if researchers are attuned to the complexity of factors that influence depression, the larger public is primed to accept any genetic links that come out of a study like Mom Genes as evidence of the biological nature of the disease. It is true that the Mom Genes team's preliminary publications never promised "unlocking" genetic answers. The public-facing components of the study, though, promised exactly that.

While I was interested in the ambitious scale of the project (a goal of enrolling 100,000 women) and the innovative research method, I was skeptical overall. There is a robust body of Science, Technology, Society scholarship unpacking genetic medicine. This includes histories of eugenics, biological determinism, and genetic discrimination. It also emphasizes the point above, that genetic research has never lived up to the 1990s-era dreams of the Human Genome Project. Sociological and historical examinations of autism research illustrate the decline of that dream. As the search for genetic markers became more and more complicated, the idea that genetic or genomic research would lead to treatment seemed further and further away. Still, the idea of genetics as full of critical truths that just needed unlocking, has kept genomic work on autism as a high research priority for parent-activists. The amount of money spent on genomic research and databases dwarfs the amount spent on research into intervention and treatment (Singh, 2016, p. 6; Silverman, 2012).

Articles in *BuzzFeed*, *The Huffington Post*, *CNN*, and *The New York Times* all discussed the Mom Genes study. This amount of publicity is unusual for a university-run, National Institute of Mental Health-funded research project. In part, this was because the study had other backing. One partner was the advocacy website/blog Postpartum Progress. The blog is now defunct, absorbed into the larger advocacy organization Postpartum Support International. At that point, Postpartum Support International became a study partner. At the time of the study launch, though, Postpartum Progress claimed 2 million unique website visitors in 2016 alone.[2] Their involvement helped mark the study not merely as research, but as advocacy work.

4 | THE AMBIVALENT HISTORIAN

Of all the media on the Mom Genes study I reviewed, only the *New York Times* included any skepticism about the study. Genetic research on depression has "yielded few results so far," the journalist notes, though the team hopes the postpartum-specificity of their work leads to more results. The *Times* interviewed a genomic researcher not

involved in the study, who suggested the role of hormones and psychosocial stressors in the postpartum might make the illness a less promising candidate for genetic study (Belluck, 2016).

The study also partnered with the Foundation for Hope in Durham, North Carolina, a private funder offering grants to projects on "the biological, neurological and genetic bases of mental illness."[3] The final notable backer was Sage Therapeutics.[4] In 2019, Sage introduced the first drug specifically approved to treat severe postpartum depression, brexanolone (Zulresso) (Food and Drug Administration, 2019). Brody-Meltzer ran the clinical trials for the drug. Brexanolone received attention both for the novelty of a drug meant to treat postpartum depression distinctly from other depressions and for its extraordinary cost and difficult delivery mechanism (inpatient intravenous infusion only) (McGinley & Bernstein, 2019). Sage continues to develop related drugs that might be deliverable in pill form, which could make the medication much more accessible to suffering women—and of course much more lucrative for Sage. Sage is naturally invested in the possibility that postpartum depression is biologically distinct from other depressions. Genetic evidence that postpartum depression was distinct from general Major Depressive Disorder reinforced the potential value of distinct (and patented) pharmaceuticals like the ones they were researching. Sage was already using unbranded advertising, including one controversial advertising campaign featuring mothers silenced with pacifiers, to raise awareness and encourage treatment for postpartum depression.[5]

I was skeptical of the oversimplification and essentialism of this sort of research, the social and cultural issues it occluded, and the Sage investment. But I also could not walk away. While I study postpartum depression historically, its political history is inseparable from its political present. As the public profile of postpartum depression grew in the United States in the 1980s, psychological and psychiatric interest in postpartum depression also grew. Even as television talk shows in the 1990s promoted awareness of this illness, funding postpartum mental health research was extraordinarily difficult (Taylor, 1996). Specialized fellowships and training have come about much more recently, and all of this has been hard fought for. Now researchers scramble from all directions to make a coherent narrative about the causes of and best treatments for postpartum mental illnesses. They research neurosteroids and maternal immune activation. They also research peer support and intergenerational trauma. There is no one trend or direction in perinatal mental health. But genetics certainly get people excited.

The Mom Genes study's methods were unusual and innovative, which won mass media attention—and my attention. Promotional materials encouraged women to go to the app store on their iPhone and download the PPD ACT app (later rebranded as the Mom Genes Fight PPD app). The app included information on the study, permissions, and a survey. Advocates promoted the low bar to entry in the study as an important selling point. In a promotional *BuzzFeed* article, the founder of Postpartum Progress emphasized how "it doesn't have the restrictions of usual studies—we want to talk to moms who self-identified and those who were clinically diagnosed." It tapped directly into a neoliberal social narrative of women's self-empowerment through patienthood and owning one's diagnosis. The study design, she continued, "gives moms an opportunity to have a voice on this like never before" (Shanahan, 2016).

I had questions. What would they ask women? How would they distinguish between depressions, anxiety, and psychosis? With no formal diagnosis required, and no intake interview, how would this self-report of current *or* past mental health look? What would the ethics of the data collection involve? I downloaded the app. I signed a consent form on my screen with my finger.

The survey was a modified version of the Edinburgh Postnatal Depression Scale (EPDS), a scale first published in 1987. The Edinburgh scale was created as a quick (10 questions, 5 min) scale. It avoided questions in other depression scales about tiredness and pleasure in activities, the kind of questions ill-suited to a new parent (Cox, 2014, p. 21; Cox et al., 1987). The researchers lightly modified the survey so it could be taken after the depressive episode, rather than during it. Mom Genes study participants used the app on average 2 years after their reported postpartum depressions (Guintivano, Krohn, Lewis, Byrne, et al., 2018, p. 260). The study also wanted to include women who experienced postpartum psychoses, which the EPDS cannot assess.

At that time I was about 10 months postpartum. I answered the questions honestly. I submitted. I qualified.

5 | FIGHTING GENES

I received an email asking for an address to which they could send a saliva collection kit. This email I ignored. Taking an app quiz was one thing, spitting in a tube was another. I did not think the study could discover convincing genomic markers—that was simply not the result of most of these DNA digs. And if they claimed to find markers, they would be the markers of broad questions, based on recall, in a self-administered survey. I was skeptical about my qualification, and this use of the EPDS. The worst case, though, was that the study succeeded, that they could claim convincing genomic markers or significant overlap with other conditions. What would the implications be if they could produce some claim about hardwired risk factors? I was interested in the study as a historian and STS scholar but could go no further as a participant.

They sent several reminder emails. COVID-19 lockdown began, and depression was less abstract again. I questioned the line I so firmly drew. Yes, I was skeptical of the aims and methods of the study. But who was I to be so skeptical? Throughout my postpartum history research, I have struggled with balancing criticism and empathy. Even when psychiatrists and psychologists and activists have made choices I find problematic, they I admire the ways they work to improve women's health. I did not believe my spit would help them with that mission. But what if I was wrong, I wondered, what if it could?

I confirmed my address to receive a kit. I signed another consent form.

The kit arrived in a denim-colored mailer, designed to mimic "mom jeans." The mom jeans/mom genes pun unified their promotional pushes. It also contained a saliva collection kit, a return envelope, and some additional promotional materials (Figure 1).

The promotional materials included an iron-on patch that says "these are my fighting genes," and a postcard designed to be filled in and posted on social media. The postcard thanks participants for getting the researchers one step closer to stopping postpartum depression, and implores them to take the next step and spread the word about the study. The card encouraged participants to write down what Mom Genes are to them, then "snap a selfie" and share it with the hashtag #momgenes. They offered a few ideas, suggesting mom genes might be fierce, strong protectors, or "working for your family."

I grimaced at the postcard and its gendered emotional appeal: "From the bottom of our hearts, and for every mother-to-be, thank you." They wanted women to give their DNA freely, lovingly, without compensation (King 2008). And then to encourage other women to do the same. Were some treatments developed from all this study, of course, that love would not pay any medical bills. Instead, they offer opportunities for women to help fund the research study by purchasing "my genes fight like a mother" tee-shirts and tote bags from their online shop.

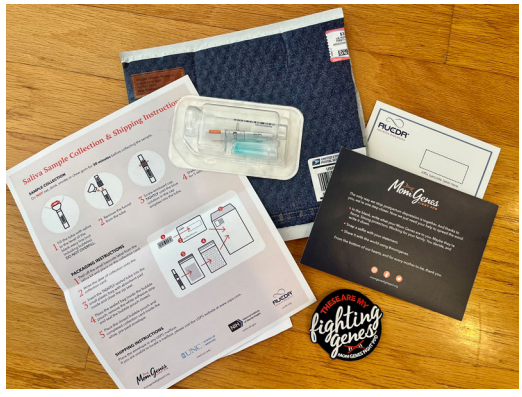

FIGURE 1 Author's image of the test kit and promotional materials

While I snarked on the economics of it, though, I still had respect and empathy for the thousands of women participating in the study. These were women who went through hell, and now they wanted that hell to be recognized and understood. They wanted to participate in something bigger than themselves and saw the concrete promise of genetic medicine as a step forward. As one participant explained online, "I felt like I was part of something really huge. I felt like I did my civic duty and voted" (Wallace, 2016). Postpartum Progress described study participation as "an opportunity for collective action" (Shanahan, 2016). The inclusion of the iron-on "these are my fighting genes" patch made a similar point. DNA donation worthy of a merit badge.

The promotional materials and study publicity alternated between these languages of activism and languages of motherly love.

The 2020 recruitment push included a polished YouTube advertisement.[6] In it, seven moms dance with expensive pink strollers against a bubblegum pink backdrop and a picket fence. They wear matching "mom jeans," the kind that are on-trend rather than frumpy. A retro-sounding pop song provides the narration. The song plays over the women, beginning with "I love my baby and my baby loves me." As the advertisement progresses, six women leave the scene. The one woman who remains grows increasingly sad, and the song lyrics highlight her depression: "I want my girl to have a better mom/I want my girl but I just can't stay calm/I want my girl, my brain's a ticking bomb/Can't have my girl, she's better off without me." The screen then flashes statistics on postpartum depression. The final bold line states that "a mom's genes could unlock the cure."

The advertisement's portrayal of postpartum depression is striking. In it, the depressed mother is an outlier. The six women who are not depressed illustrate a happy, put together, and easy postpartum. It includes a racially diverse cast, though the woman with postpartum depression appears white. All the mothers are attractive, well dressed, and wearing make-up and hot pink stilettos. They all, as the song reminds us, have an unqualified love for their babies. As Samantha King has discussed in the realm of breast cancer activism, framing such a gendered illness as deserving of public interest has meant presenting a particularly deserving kind of victim (2008, p. 77). In this advertisement, we see the crying white woman, her comfortable socioeconomic status, her commitment to family. The empathy we feel for her is, by design, mediated through this.

In this vision of postpartum depression, there is one crying, perhaps even suicidal woman, and six women who seem perfectly well. There is no continuum, there is no subclinical struggle with adapting to motherhood. This is a markedly unrealistic portrayal of postpartum experience, and of what nondepressed motherhood looks like. It is a strange choice for the study, although the advertisement was made by a firm and not the researchers involved. At their worst, these are the visions of easy postpartum adjustment that actually contribute to depression when women find that vision so unreachable. The lack of continuum, though, would be consistent with a pursuit of biomarkers of postpartum depression. If one in seven women experiences postpartum depression, and it is because of her genomic makeup, then her experience must be distinct from the other women's.[7] If you plan to test if the line between depressed and not depressed is genetic, that line best be very clear.

This advertisement and the promotional selfie card are examples of all the classic "postfeminist" ways we risk conflating medicalization with progress (Flore, 2019). The ongoing encouragement of women to self-surveil as empowerment, already heightened during pregnancy, is constructed here as vaguely in the greater good. The promotional materials encourage us to understand DNA-donation as collective action, part of our larger responsibilities of "biological citizenship" (Rose, 2007, p. 6). Confessional selfies as consciousness raising.

Selling DNA-collection-as-activism disturbed me. And the overall track record of psychiatric genomic studies meant I doubted it would all amount to much. But if it did produce some claim of genetic causality that would be worse. It would not have any clinical use in the short term, but if it was promising it could easily come to dominate postpartum research funding and conversations about postpartum etiology. Given all that, I still stared at the little test tube. I was still considering spitting.

There are a variety of reasons individuals contribute to disease-specific genetic research like this study. The existence of a large-scale genetic study is important for its implications about postpartum illness. If it could be proven genetic, it might be treated more like a somatic illness, resulting in less stigma. Contributions might be about

helping one's self or helping other women. In postpartum depression, it also builds on a gendered narrative that is common in postpartum self-help narratives, in which a woman's own healing comes through caring for other women. Sharing a DNA sample is both low-effort (they mail to it you, you spit at home and return the envelope) and symbolically enormous (you are contributing your body, yourself, to theoretically help others). The desire to give also has in it a medicalized feminism of sorts. Against a long history of both limited or sexist psych research into maternal mental health, here was a bold and exciting project led in the United States by a majority-woman team of psychiatric researchers. Postpartum advocates have pushed for increasing maternal mental health as a research priority since at least the 1980s. Even as research has developed in the area, advocacy groups note the interest in the subject still lags behind many other mental illnesses. Women who have experienced postpartum depressions must step-up, and vote with their feet (and spit) if they want more maternal mental illness research.

I do not know which of these motivations kept me holding on to the test tube and envelope. Keeping the tube, even considering spitting in the tube, marks me as overly invested, and feels inadequately critical of both this kind of knowledge production and the potential uses of any knowledge produced. How can I historicize the development of a disease category while also contributing to a project built on the naturalness and historicity of that disease category? The feminized, motherhood-centric framing of public thinking on postpartum depression shaped this as well, since both femininity and motherhood so often connote a lack of objectivity. And also the choice to not spit marks me as an outsider, someone looking in and critiquing the disease category that has been critical to so many women's ability to get their pain recognized, and to their own identities as survivors of that disease. I fear I mark myself as not quite understanding, perhaps even as being condescending about their own choices. I feel guilty for not spitting, like I am insulting the labor of postpartum researchers and activists I study.

This is where I left things with the study. I did not spit in the tube. But I understand, deeply, why so many women choose to do so. My hope is that this understanding will allow me to both do their stories justice, but alongside them tell the story of why there are such limited scripts we are encouraged to use when talking about postpartum distress.

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DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analyzed during the current study.

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ENDNOTES

[1] A number of aspects of defining postpartum depression are contested, including how long after birth the onset can be, what the duration can be, how severe the symptoms must be, and how distinct it is from "other" depressions.

[2] "About Postpartum Progress," https://postpartumprogress.com/about

[3] "What We Fund," https://walkforhope.com/what-we-fund/

[4] https://web.archive.org/web/20220203181947/ https://www.momgenesfightppd.org/

[5] The controversial ads from 2017 I refer to here were an unbranded campaign featured women silenced with pacifiers, under the tag line "PPD Sucks." Critics called it infantilizing, condescending, and unlikely to actually increase understanding of postpartum depression. https://www.huffpost.com/entry/why-moms-criticized-this-postpartum-depression-awareness-campaign_n_5947cf43e4b01eab7a2f1959. The more innocuous current awareness campaign is called Check on Mom, https://www.mycheckonmom.com

[6] https://www.youtube.com/watch?v=_9uBzFuz_ug

[7] Statistics for postpartum depression are all over the place, ranging between 1 in 5 up to 1 in 10. The different statistics hint at these definitional tensions. The experience of a woman with a very severe depression, perhaps a woman who is suicidal or hospitalized postpartum, might be unfathomable to women with easier postpartum experiences. But the distress of mild and moderate postpartum depressions is harder to delineate from "normal" postpartum adjustment, hence this uncertainty on how to estimate the illness.

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