

# Theoretical Perspectives of **Postpartum** **Depression** and Their Treatment Implications



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## ABSTRACT

Approximately 13% of new mothers experience postpartum depression. This crippling mood disorder wreaks havoc not only on the mothers themselves but also on their entire families. Between 25% and 50% of mothers with postpartum depression have episodes lasting 6 months or longer. The most significant factor in the duration of the postpartum depression is the length of delay to adequate treatment. The purpose of this article is to describe five different theoretical perspectives of postpartum depression and the interventions for treatment derived from each: the medical model, feminist theory, attachment theory, interpersonal theory, and self-labeling theory. Crucial to clinicians' choice of treatment of postpartum depression is the theoretical lens they use to view this devastating mood disorder. Nursing implications derived from these theoretical perspectives are addressed.

**Key Word:** Postpartum depression.

**A**s William Dean Howells (1920) wrote, her story is one to “freeze our...blood” (p. vii). The story to which he was referring is Charlotte Perkins Gilman’s terrifying account of her descent into postpartum depression, which at that time was referred to as her “nervous condition” (Stetson, 1892). Locked in the bedroom of her country home for a rest cure, Gilman chillingly described her journey into insanity after the birth of her baby.

Postpartum depression is a crippling mood disorder that erodes away at the joy and happiness of new mothers, leaving some women to contemplate self-harm as the only way out of their “living nightmares” (Beck, 1993). Approximately 13% of mothers experience postpartum depression (O’Hara & Swain, 1996). Husbands and partners, however, are often invisible victims of postpartum depression (Harberger, Berchtold, & Honikman, 1992). Evidence is accumulating that this mood disorder not only has an adverse effect on maternal-infant interaction during the first year of life (Beck, 1995), but may also have long-term effects on children over the age of 1 year (Murray & Cooper, 1997).

Twenty-five to 50% of mothers who experience postpartum depression have episodes lasting 6 months or longer (O’Hara, 1987). The most significant factor in the duration of the postpartum depression has been found to be the length of delay to adequate treatment (England, Ballard, & George, 1994). Effective interventions for postpartum depression not only need to be initiated as soon as possible, but also need to match the specific profile of depressive symptomatology of each individual mother. Affecting clinicians’ choice of interventions is the theoretical perspective of postpartum depression from which the clinician practices. The purpose of this article is to describe different theoretical perspectives of postpartum depression and the interventions derived from each perspective. These perspectives are: the medical model, feminist theory, attachment theory, interpersonal theory, and self-labeling theory (see Table 1). Because the medical model has been the prevailing perspective of postpartum depression for both physicians and nurses, it will only be briefly described. The other theoretical perspectives that have received less attention will be more fully discussed.

## Medical Model

### Theoretical Perspective

The medical model has been the dominant theoretical perspective of postpartum depression. From this vantage point, postpartum depression is considered an illness and a medical condition. This mood disorder indicates an individual pathology, and social or environmental conditions are rarely considered in its evolution. Using the medical model, clinicians focus on an individualistic approach. Postpartum depression is perceived as a pathological condition based on deficiencies in the individual mother. When clinicians see the individual as the basic unit of pathology, the social, political, and economic contexts of the mother’s life are excluded (Mauthner, 1998). Mothers are portrayed in the medical model as passive individuals; biological factors act upon them.

### Treatment Approach

This medical approach has significant consequences for the treatment of postpartum depression because the focus of desired changes will be intrapersonal. In this model postpartum depression is a disease to be handled by prescribed treatments such as psychopharmacogenics. Specific examples of interventions derived from the medical model include transdermal estrogen (Gregoire, Kumar, Everett, Henderson, & Studd, 1996), antidepressants (Wisner, Perel, & Findling, 1996), and electroconvulsive therapy (Cujajar, Wilson, & Mukherjee, 1998).

## Feminist Theory

### Theoretical Perspective

Feminist theory opposes the medical model’s approach to postpartum depression, and proposes that terms such as “disease” and “illness” hide the social nature of women’s problems (Nicolson, 1986; Oakley, 1981).

Feminist writers contend that postpartum depression is associated with the impossible standards of the motherhood mystique imposed by the medical model (Lazarre, 1997). Lazarre compellingly portrayed her fierce struggles with early motherhood in *The Mother Knot*. She described the “unspoken truths” of motherhood (such as anger) in the following passage: “I’d put him in the carriage so as to not harm him with my tentacles of rage, and I’d sit huddled on the couch, door slammed unsuccessfully against his cries, holding my ears and moaning with loss” (Lazarre, 1997, p. 29).

Feminist theorists view motherhood in a wider sociopolitical and cultural context and call for childbirth to be stripped of its masculine ideology and rather be seen through the eyes of women (Jebali, 1993; Mauthner, 1998). Because childbirth occurs in many simultaneous contexts (medical, social, and economic), the mother’s reactions to it are shaped by all of them. Oakley (1980) suggested that the medical control of childbirth reinforces feminine helplessness and increases the likelihood of postpartum depression.

### Treatment Approach

Creedy and Shochet (1996) proposed that feminist principles be incorporated in a framework for caring for mothers with postpartum depression. They identified feminist principles such as acknowledging the mother as competent, exploring and validating specific women’s issues, reinforcing a mother’s personal power, and encouraging self-nurturance and expressing anger, and propose an integrated feminist-cognitive approach to the treatment of postpartum depression. Such treatment would include four processes: (a) “debriefing the experience of pregnancy and birth, (b) managing conflicts about identity, (c) gaining a sense of survival, and (d) developing a new perspective” (p. 16).

In the first process (debriefing the childbearing experience), mothers’ voices need to be heard as they try to integrate the childbirth experience into their lives. Mothers need to be given the opportunity to express the negative or

**Table 1. Comparison of Theoretical Perspectives of Postpartum Depression**

	Medical Model	Feminist Theory	Attachment Theory
<b>Underlying Problem</b>	Biochemical/Hormonal imbalance	Social construction rather than a medical condition	A mother's attachment needs are not being met by her partner
<b>Possible Interventions</b>	Psychotropic medication <ul style="list-style-type: none"> <li>• antidepressants               <ul style="list-style-type: none"> <li>▪ selective serotonin reuptake inhibitors (SSRIs)</li> <li>▪ tricyclic antidepressant (TCA)</li> <li>▪ monoamine oxidase inhibitors (MAOI's)</li> </ul> </li> <li>• antianxiety agents               <ul style="list-style-type: none"> <li>▪ benzodiazepines</li> </ul> </li> </ul> Electroconvulsive Therapy Hormonal Therapy	Promote a more realistic concept of motherhood. Identify the sociopolitical nature and context of mothers' distress. Reinforce personal power, encourage self-nurturance and expression of anger	Emotionally Focused Marital Therapy <ul style="list-style-type: none"> <li>• deescalating negative cycles to facilitate emotional engagement.</li> <li>• explicitly reframing cycle and reprocessing negative affect in terms of attachment insecurity</li> <li>• creating positive cycles of contact and bonding events</li> </ul>
<b>Focus of Attention</b>	Within individual mother	Mother situated within social, political, and economic contexts of her life	Mother and partner

ambivalent feelings they may be experiencing in their new role as a mother. For the second process (managing conflicts about identity), it is important to provide opportunities for mothers to ventilate their feelings, and work through any guilt or grief they may be experiencing.

In gaining a sense of survival (the third process), a feminist approach would recognize the critical psychological work of enabling a mother to reestablish her separateness through understanding the emotions she is feeling. One cognitive strategy that can be employed is encouraging the mother to reflect on her own negative thoughts regarding her self-worth. Creedy and Shochet (1996) also highlight the importance of learned resourcefulness, which is a group of cognitive behavioral coping skills that promote a mother's daily functioning. In the fourth and final process (mothers developing a new perspective regarding their experience of childbearing), the work done through the first three processes results in the new perspective.

## Attachment Theory

### Theoretical Perspectives

Attachment theory is another theoretical perspective that has been used as a basis for the treatment of postpartum depression. Whiffen and Johnson (1998) propose that postpartum depression can develop when a mother's attachment needs are not being satisfied by her partner, whom she feels is irresponsible or inaccessible to her.

Originally attachment theory focused on the importance of the strong emotional bond between an infant and the primary caregiver, usually the mother (Bowlby, 1973). Ainsworth, Blehar, Waters, and Wall (1978) identified three styles of attachment: secure, avoidant, and ambivalent. Attachment theory has now been extended beyond the mother-infant relationship to explain adult relationships. According to Bowlby (1973), attachment needs to take front stage during times of uncertainty. Avoidant-attachment can be troublesome: Bartholomew (1990) identified two types of avoidant attachment in adults: fearful and dismissing. Fearful-avoidant adults have a desire to be close to their significant others, but fear they will be rejected by them. Conversely, dismissing-avoidant adults do not desire closeness with their significant others.

Using attachment theory as their framework, Whiffen and Johnson (1998) proposed that mothers and fathers rely on each other for support during the anxiety-filled transition to parenthood. When both mother and father are securely attached, they will respond to each other's needs for support. However, if either parent is insecurely attached or is avoidant attached, problems can occur that could lead to postpartum depression. The depressed mother may feel abandoned by her unresponsive spouse. Whiffen and Johnson warn that an especially dangerous combination producing depression in a new mother is a fearful-avoidant wife and a dismissing-avoidant husband. Whiffen and Johnson have also reported that during the postpartum pe-

Interpersonal Theory	Self-Labeling Theory
During their role transition new mothers have numerous disruptions in their interpersonal relationships and have discrepancies between desired level of support and level of support they receive	Discrepancy between a mother's feelings and society's expectations of motherhood. Violation of "feeling norms" and "expression rules"
Interpersonal psychotherapy (IPT) focuses on 4 different interpersonal problem areas, mothers can experience: <ul style="list-style-type: none"><li>• role transitions</li><li>• interpersonal disputes</li><li>• grief</li><li>• interpersonal deficits</li></ul> Specific IPT techniques include: <ul style="list-style-type: none"><li>• psychoeducation</li><li>• communication analysis</li><li>• role playing</li></ul>	Self-help groups, i.e., postpartum depression support groups Psychotherapy emotional management techniques: behavioral or cognitive management of <ul style="list-style-type: none"><li>• situational cues</li><li>• physiological sensations</li><li>• expressive gestures</li><li>• cultural label</li></ul>
Interpersonal relationships	Mother and society

riod, mothers who perceive a dramatic decrease in marital satisfaction and whose husbands are not actively involved in infant caretaking experience more depressive symptoms.

### Treatment Approach

Whiffen and Johnson (1998) proposed that interventions targeted for postpartum depression need to address the marital context, conceptualizing marital distress from an attachment theory framework. Specifically, they recommended Johnson's (1996) Emotionally Focused Marital Therapy (EFT) as an effective intervention for postpartum depression.

EFT focuses on the emotional responses underlying problematic interactional positions. These experiences are reprocessed to increase responsiveness and accessibility. By exploring important emotional experiences, the EFT therapist helps the mother experience new aspects of herself, which in turn will elicit new responses from her spouse (Johnson & Greenburg, 1988). Interventions in EFT for postpartum depressed women involve three stages of therapy: (1) the therapist aids the husband and wife to deescalate their negative cycles to facilitate emotional engagement; (2) the negative cycle is reframed, leading to reframing of the couple's negative interactional behavior; and (3) the couple develops positive cycles of interaction and bonding.

In summary, Whiffen and Johnson (1998) reframed postpartum depression in terms of the mother's unmet at-

tachment needs. If a woman's husband refuses to participate in marital therapy, individual therapy from an attachment perspective can be substituted. If a postpartum depression mother is unmarried, options other than EFT are available (e.g., interpersonal psychotherapy, as discussed in the following section).

## Interpersonal Theory

### Theoretical Perspective

Sullivan's (1953) interpersonal theory views humans as essentially social beings whose personalities are determined by interpersonal experiences rather than intrapsychic experiences. Sullivan proposed that persons use security mechanisms to decrease anxiety resulting from negative reactions of significant others. Sullivan's security mechanisms include selective inattention, dissociation, and sublimation. Use of these security mechanisms can result in an individual being unable to objectively evaluate behavior, and hindering positive changes in one's personality.

Sullivan purports that individuals develop the ability to interact effectively through what he calls the syntactic mode of experience characterized by logical thinking. This occurs through the process of consensual validation whereby people agree on the meaning and significance of specific symbols. Integrating tendencies are also important in Sullivan's (1956) interpersonal theory. These tendencies are behaviors such as eye contact and smiling, by which a person moves toward others. These integrating tendencies help a person feel secure and help to avoid anxiety.

### Treatment Approach

Interpersonal psychotherapy (IPT) is based in both Sullivan's (1953) interpersonal theory and Bowlby's (1969) Attachment Theory. This type of psychotherapy targets interpersonal relationships as a point of intervention and treatment. IPT attempts to modify relationships or expectations about relationships.

IPT for postpartum depression has been used effectively by Stuart and O'Hara (1995). Postpartum depressed mothers have numerous disruptions in their interpersonal relationships and have reported significant discrepancies between their desired level of social support for infant care and the level of support they actually received (O'Hara, 1994). Their lack of perceived support is most often focused on their relationships with their husbands.

IPT for postpartum depression is designed to focus on one or two of four different interpersonal problem areas: role transitions, interpersonal disputes, grief, and interpersonal deficits (Stuart, 1999). IPT is a short-term treatment, the primary aim of which is to alleviate depressive symptoms in the mother. As such, a limited number of problems can be addressed during the treatment sessions.

In session one the therapist assesses the depressive symptoms of the mother and begins an interpersonal inventory. The therapist places the mother's depressive symptoms in an interpersonal context. The interpersonal inventory focuses on the mother's expectations of social support she had prior to delivery and also on her expecta-

tions of motherhood. During this initial session the mother and therapist collaborate to identify the specific problem area that will receive focus in the future sessions. The mother and therapist must discuss an explicit contract for IPT; a firm 12-session limit should be established (Stuart & O'Hara, 1995).

Treatments in the sessions focus on one or two of the four possible IPT problem areas. In Stuart and O'Hara's (1995) experiences, most cases of postpartum depression can be conceptualized as role transitions. Specific IPT techniques for postpartum depression included psychoeducation, communication analysis, and role playing (Stuart, 1999). In the termination session, the therapist helps the mother develop a feeling of competence in dealing with interpersonal problems that may occur in the future.

## Self-Labeling Theory

### Theoretical Perspective

Thoits (1985) developed her self-labeling theory in mental illness to explain voluntary treatment seeking and short episodes of mental illness. Her theory of self-labeling processes in psychiatric illness involves reconceptualizing mental illness as emotional deviance, the result of unsuccessful emotion management attempts.

Thoits (1985) suggested that individuals who violate social norms or who actually engage in rule breaking do not depend on the reactions of other people to assess the meaning of their actions. Self-labeling is a private activity. It is unnecessary for the emergence of a deviant identity to have public labeling of a person's rule breaking. Three assumptions underlying self-labeling processes are: (a) the self-labeling person is a well-socialized individual who shares a cultural perspective of society and can identify breaking of rules or violating normative expectations, (b) there are known categories of norms, which when violated carry cultural labels that are applied to individuals who perform these behaviors, and (c) a person is motivated to conform to social expectations (Thoits, 1985).

Drawing from Hochschild (1983), Thoits (1985) includes emotion norms and expression rules in her self-labeling theory. Emotion norms are feeling rules that dictate the strength, range, and deviation of emotions appropriate to a given situation. Expression rules are norms that govern the display of emotional reactions. Stressful situations can lead to discrepancy between a person's feelings and feeling rules. Possible sources of this discrepancy can stem from problems from multiple roles, major role transitions/identity transitions, and structural strains between the ideal and the real. Thoits used the life event of childbirth to illustrate all three problems.

Behavioral or cognitive techniques, which Thoits (1985) calls emotional management techniques, can be used to alter an inappropriate emotional state. Examples of such techniques include (a) altering the situational circumstances that have induced the discrepant feeling, (b) altering physiological sensations in a cognitive manner such as biofeedback, and (c) reinterpreting situations to appear less problematic.

The theoretical lens a clinician uses to view postpartum depression has important treatment ramifications.

### Treatment Approach

Using the self-labeling theory, Taylor (1996) suggests that postpartum depression can be understood as a violation of "feeling norms" and "expression rules" (Hochschild, 1983). It is the mother's own recognition of the discrepancy between the emotions she is feeling and the emotions society perceives as normal for motherhood that initiates the mother's self-attributions of psychiatric illness. New mothers assess their own private feelings and symptoms of distress (such as guilt and anxiety) based on their perceptions of how mothers ought to feel, and the cultural myths that motherhood brings total fulfillment, joy, and instantaneous love for the infant. For many of the women in Taylor's research "the shame and guilt experienced when the overwhelming rush of love and instant maternal bonding they expected did not come right away" had such a corrosive effect that, as one woman wrote, it "steals away their sense of motherhood" (p. 41).

Thoits' (1985) self-labeling processes and the role of emotional deviance provide the basis for voluntary treatment seeking that Taylor (1996) portrays in mothers experiencing postpartum depression, linking self-help and feminism in the treatment of this mood disorder. Voluntary treatment seeking in the form of self-help postpartum depression support groups offer women alternatives to the traditional view of maternal caring and the myths of motherhood. Postpartum depression support groups challenge the ingrained myths of blissful motherhood in our society, and confirm the unexpected feelings of loss, anger, depression, guilt, and anxiety that postpartum depressed women experience.

## Summary and Nursing Implications

Five theoretical perspectives on postpartum depression and their respective treatment implications have been reviewed. The main premise of this article has been that the theoretical lens through which a clinician views postpartum depression has important ramifications on the treatment prescribed. As nurses, we are not necessarily held to the use of only one perspective. As some of the examples in this article illustrated, combinations of theoretical perspectives may be employed (e.g., IPT, which is based on interpersonal theory [Sullivan, 1953] and attachment theory [Bowlby, 1969]). Not only can a specific treatment for postpartum depression based on two theoretical perspectives be em-

ployed, a combination of treatments may prove to be the most effective for a mother. An example of this is treatment with antidepressants along with emotionally focused marital therapy. All the treatment approaches discussed in this article have been effective in helping mothers recover from postpartum depression. The challenge for the clinician is to find the right match for each individual mother and to refer the mother to a healthcare provider with the appropriate expertise.

Although some of the treatment approaches identified in this article seem only appropriate for clinicians such as therapists and psychiatrists, implications for perinatal nursing practice abound. It is the responsibility of maternal child nurses to help women experiencing postpartum depression to make informed choices regarding their treatment options. Nurses can teach mothers about the range of treatment approaches available.

Maternal child nurses can incorporate aspects of feminist theory into their interactions with postpartum depressed mothers. Feminist principles such as encouraging self-nurturance, encouraging expression of anger, reinforcing a mother's personal power, and exploring and validating women's issues are all well within the realm of nursing practice. When providing nursing care to postpartum depressed mothers, nurses should remember to place this mood disorder within a broader perspective that values the impact of the social, political, and economic contexts of the mothers' lives. For example, a mother's instrumental and emotional social support needs to be assessed. If a postpartum depressed mother perceives a lack of social support, nursing interventions can be tailored to help rectify this problem.

There are implications for nursing practice that can be derived from self-labeling theory (Thoits, 1985). Maternal child nurses can lead the movement to dispel the destructive myths of blissful motherhood in our society. These unrealistic norms for motherhood set women up to label themselves as failures as mothers. Encouraging postpartum depressed mothers to attend postpartum depression support groups is another appropriate nursing intervention. Nurses can provide mothers with a valuable handout of local names, addresses, and telephone numbers of self-help groups. Also included on this list can be the relevant information on the international and national organizations of Postpartum Support International ([www.chss.iup.edu](http://www.chss.iup.edu)) and Depression After Delivery ([www.depressionafterdelivery.com](http://www.depressionafterdelivery.com)). ♦

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