THE MELANIE BLOCKER-STOKES POSTPARTUM DEPRESSION RESEARCH AND HEALTH CARE ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

ON

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SUBMITTED MATERIAL

H.R. 20, THE MELANIE BLOCKER-STOKES POSTPARTUM DEPRESSION RESEARCH AND HEALTH CARE ACT

TUESDAY, MAY 1, 2007

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 12:00 p.m., in room 2123 of the Rayburn House Office Building, Hon. Frank Pallone, Jr. (chairman) presiding.

Members present: Representatives Green, DeGette, Capps, Schakowsky, Hooley, Rush, Deal, Pitts, Murphy, Burgess, Blackburn.

Also present: Representative Rush.

Staff present: John Ford, Jessica McNiece, Jesse Levine, Melissa Sidman, Lauren Bloomberg, Bobby Clark, Chad Grant, Katherine Martin, and Ryan Long.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Good afternoon. The hearing will come to order, and today the subcommittee is meeting to hear about H.R. 20, the Melanie Blocker-Stokes Postpartum Depression And Care Act. This bill is sponsored by my good friend Congressman Bobby Rush, who is joining us today, and I want to welcome him to the subcommittee and thank him for all the work he has done to develop this thoughtful and very important piece of legislation.

Postpartum depression is a devastating mood disorder, ranging from the baby blues to full-blown postpartum psychosis. Postpartum conditions strike many women during and after pregnancy. It is estimated that 400,000 women suffer from postpartum mood changes with baby blues afflicting up to 80 percent of new mothers.

Beyond the baby blues, postpartum mood and anxiety disorders impair around 10 to 20 percent of new mothers, and postpartum psychosis strikes 1 in 1,000 new mothers. The causes of postpartum depression are complex and unknown at this time. However, if diagnosed properly and treated with social support, therapy, and medication, relief is highly attainable.

All too often, however, postpartum depression goes undiagnosed because providers are not trained to detect the symptoms or the

condition goes untreated due to social stigma or embarrassment. Needless to say, we must be more aggressive in our efforts to increase awareness and improve education about women, as well as the health care providers so we can ensure that women suffering from postpartum depression receive the care and treatment they need to stay healthy.

And I am particularly grateful to New Jersey's—my notes say former first lady, Mary Jo Codey, but actually you are the current first lady since Governor Codey is now Acting Governor once again because our Governor Corzine had an accident. Although I am pleased to say that he came out of the hospital yesterday, but he still is not acting as the Governor. And so Senator Codey, who is our senate president in New Jersey is now Acting Governor once again. But Mary Jo Codey, who is here with us, has been a leader in raising awareness about mental health issues, particularly about postpartum depression. She and her husband have been tremendous advocates for those who suffer from mental illness in my home State of New Jersey.

Thanks to their efforts, New Jersey has a new postpartum depression and screening and education law, which took effect last October. Now, every pregnant woman in New Jersey is educated about maternal mood disorders before giving birth. The mother of every baby born in New Jersey will be screened for postpartum depression, and all licensed health care professionals who provide pre- and post-natal care would be educated about maternal depression. And I just want to thank her again. Mrs. Codey's personal dedication to bringing light to these conditions which are all to often overlooked and misinterpreted has had a great impact on our State.

I also wanted to mention that she is not only the current and former first lady, but also a member of the President's advisory counsel of Postpartum Support International. Now, she is going to be the first to tell you that our job is far from done. So much more research needs to go into what causes postpartum depression and how best to treat it, and that is why this legislation is critically important and why I support it. I wholeheartedly agree that appropriate research and attention needs to be devoted to this issue.

I pledge to work with Mr. Rush to move this bill to the floor as quickly as possible. As we will hear from our witnesses today, we can't afford to delay. Too many lives are on the line. I want to thank all of our witnesses for appearing before us today. I would like to extend a warm welcome to Ms. Blocker, the mother of the woman for whom this legislation is named in her honor. Thank you for being here today. I know you have a 2:00 flight to catch so we may not actually get to ask her any questions. She may have to leave before we get to the questions, but I want to thank you for sharing your and your daughter's story with us and for all the work that you do, Ms. Blocker, as an advocate on this issue. And I would now recognize the gentleman from New Jersey for 5 minutes.

OPENING STATEMENT OF HON. NATHAN DEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. DEAL. Thank you, Mr. Chairman.

This is the second piece of legislation dealing with women's health issues that this subcommittee is having a hearing on today. And we thank all of you for being here. For any of us who are parents, the old issue is baby blues is something that people used to joke about. But now we know that some 50 to 80 percent of all women suffer it in some form or other.

It is when the psychosis of the more serious kind sets in that we are primarily concerned with and focus our attention on today. And certainly it is not a joking matter. It is a very serious matter. It has consequences not only for the woman but the child and the family as a whole.

Fortunately, we have learned that we can treat it. We need to learn more about how we can come to understand it, to predict it, and to deal with it as early as possible. And this legislation, I think, is going to be helpful in that regard in directing the NIH to do more detailed research and studies about the causes and what can be done to deal with the depression. It also creates a grant program to include treatment and screening for the illness.

I thank the witnesses for their being here today, and I hope as we go through this hearing and the subsequent legislation itself that we can begin to advance the cause of understanding and dealing with a very serious issue that confronts every woman with the birth of a child, or as we will learn, I am sure, a woman who suffers an abortion or perhaps even just an involuntary termination of the pregnancy through no fault of anybody's part. All of the consequences of those acts are certainly dramatic, and we need to understand them better.

Thank you all for being here. Yield back.

Mr. PALLONE. I thank our ranking member and now recognize Ms. DeGette.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Mr. Chairman, thank you for convening this hearing today, and it is so wonderful to see this great panel. It is a critical issue to millions of women and their families throughout the country, and I am glad to see this committee really taking first steps towards passing this much needed and much overdue legislation. I also want to thank Congressman Rush for his continued efforts to pass this legislation into law.

Whenever women's groups come to see and say well, should I get the guys to help with this? I remind them we still have only less than 15 percent of women in Congress. So even though we are really good, we can't do it all ourselves, and we rely on our partners to make issues like women's health a high priority.

And, Mr. Rush, I hope that now with the new leadership of this committee we are going to be able to finally bring your goal of enacting this bill into law to reality.

Mr. Chairman, postpartum depression is a serious condition that affects millions of women, and while many women battle the baby blues shortly after the work of their children, this is really a misnomer for what many other face, which is far more debilitating postpartum depression. According to the Department of Health and

Human Services, postpartum depression can include symptoms such as sadness, lack of energy, trouble concentrating, anxiety, and feelings of guilt and worthlessness.

Left untreated, the condition can last a number of months, with some lasting over a year. This debilitating illness can prevent the mother from bonding with her new baby and starting her family in a positive direction, and it can do even worse to the woman and her family. The effects of postpartum depression can be quite devastating.

I look forward to hearing the testimony from our panel here today about ways that we can explore treatment and research for this condition and about how Mr. Rush's bill can expedite the process.

I must say while I am very pleased this hearing has been called, I wanted to voice my disappointment with the apparent attention of some to discuss an unrelated issue, as the ranking member just mentioned, so-called post-abortion depression. In contrast with the issue of postpartum depression, which has clearly been accepted by the psychiatric and psychological communities as a true mental health condition, this so-called post-abortion syndrome is recognized by none of the established professional medical associations. Neither the American Psychological Association nor the American Psychiatric Association's DSM-IV, the definitive manual of mental illnesses and psychological phenomena recognize post-abortion syndrome or any related category as an identifiable mental health condition.

And the debate is characterized by things that my good friend and respected colleague, Mr. Deal, just talked about where he said even pregnancies that are terminated at "no fault of the woman." This is offensive to women throughout this country, and it has no place in a legitimate debate like the discussion we are going to have today on postpartum depression.

As co-chair of the Congressional Pro-Choice caucus, I would be happy to debate the merits of maintaining a woman's right to choose at another time, but that is not the issue today. The issue today is postpartum depression, and I hope the witnesses before us will limit their discussion to the pressing issue at hand, H.R. 20, the Melanie Blocker-Stokes Postpartum Depression Research and Care Act. Women throughout this country have spent too much time waiting for this bill to be considered by us and passed by us to be distracted by political theater. It is time that we take up H.R. 20 now, and I yield back the balance.

Mr. DEAL. Would you yield to me since you mentioned my name? I am a cosponsor of the bill before us, I would point out to the gentlelady.

Ms. DEGETTE. I would not.

Mr. PALLONE. Let me mention that I gave you 5 minutes by mistake. We are only given—I think you used 4 of it, so it is only 3 minutes.

Ms. DEGETTE. Mr. Chairman, if you will give it to me, I will use some of it at least. I apologize.

Mr. PALLONE. It is not your fault. It is mine. OK, next is Mr. Pitts, I believe.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. Thank you, Mr. Chairman, and thank you for convening this hearing on such an important issue, and I would like to thank each of the witnesses for sharing their expertise with our committee today. Like all of us, I believe that postpartum depression is a very real and serious disease, and I commend the efforts of my colleague, Congressman Rush, to expand research and treatment of postpartum depression.

However, while attention is being focused on postpartum depression, it is sadly evident that post-abortion depression goes widely unrecognized and untreated. Because of the emotional issues that often surround a woman's decision to have an abortion, many women are reluctant to even talk about their experiences. And some women don't come to terms with the emotional impact of their abortion until years later, and this was evidenced in today's newspaper in the Washington Times that cited hundreds, even thousands, of anecdotes and affidavits referred to in the recent Supreme Court decision. I will submit that for the record.

I believe that increased research on post-abortion depression will lead to a greater awareness of this issue and the development of compassionate outreach and counseling programs to help post-abortive women. We continue to learn more about the psychological impact of giving birth and of miscarrying, and yet there is also much to be discovered about post-abortion depression. Women who choose to have an abortion should also be given the care and concern that is given to women who give birth or miscarry. Post-abortive women deserve the care and treatment that their unique circumstances demand.

While we know all too little about the extent and substance of post-abortion emotional response, everyone agrees that the decision to have an abortion is fraught with emotion. It only makes sense then to continue to explore the psychological impact of abortion on women that has recently begun to garner attention due to the courageous voices of women like Michaelene and the women of Silent No More campaign.

And the research is indeed giving statistical significance to what they have been saying. A study by a pro-choice researcher in New Zealand found that 78½ of 15- to 18-year-old girls who have abortion display symptoms of major depression, compared to only 31 percent of their peers who do not have abortions. This same study found that 27 percent of 21- to 25-year-old women who have had abortions have suicidal idealization compared to only 8 percent of peers who do not have abortions. Yet there is a need for comprehensive research in the United States to better understand the effects of abortion on women in the United States.

It is widely acknowledged that many medical procedures can affect not only the patient's physical state but the patient's mental state as well. And we need to be able to document the potential emotional impact of abortion. Women deserve to know the long-term effects of abortion on their mental and emotional well being. Women who have had abortions deserve to have mental health pro-

fessionals who acknowledge the emotional impact of abortion and have the tools to treat it.

Most of the advances in mental health in recent years have been preceded by increased awareness of specific mental health causes and triggers. Accurate research can foster awareness because it makes a problem concrete. Information about the emotional impact of abortion may also help us to determine early warning signs of depression for women who choose abortion so that these women can receive help as quickly as possible, not have to struggle alone for a long period of time.

I strongly support continued research of postpartum depression and miscarriage-related depression; however, I believe that we also need to devote Federal resources to research and treatment of post-abortion depression. Women who suffer from this type of depression deserve to have this tragic result brought out of the shadows and recognized in our culture.

No matter what pregnancy outcome a woman experiences, there should be help made available. This speaks to the emotional issues that she may be encountering. Mr. Chairman, I look forward to hearing from our distinguished witnesses, learning their views, recommendations on these important issues. And while I would like to thank all of our witnesses, I would specifically like to thank Priscilla Coleman for discussing important research on an issue that is often ignored, and Michaelene Fredenburg for having the courage to share such a personal difficult story that many women are unable to share. And I yield back the balance of my time.

Mr. PALLONE. Thank you. The gentlewoman from Illinois, Ms. Schakowsky.

OPENING STATEMENT OF HON. JAN SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. I want to thank you for holding this hearing, and I also want to express my gratitude to Representative Rush for his persistence and perseverance on the issue of postpartum depression research and care. I have co-sponsored the Melanie Blocker-Stokes Postpartum Depression Research and Care for the past four Congresses. This year the bill has over 100 co-sponsors, and it is time to pass this important legislation.

I am distressed that rather than address this important particular issue, some members of this committee seemed determined to change the subject to an unrelated issue that they know is certain to be controversial as well as unsupported by science. Postpartum depression is an all too common problem, affecting an estimated 10 to 15 percent of women in the postpartum period. Yet the problem is underrecognized and undertreated. This period of hormonal upheaval and life-altering lifestyle change and stress can place a woman at increased risk for mood disorders.

Unfortunately we know that many women suffer in silence. Research confirms that the majority of mothers experiencing postpartum depression do not seek help from anyone, and only one in five seek help from a health professional. In addition to the suffering that this causes new mothers at a time when they are expected to be happiest—and I remember that pressure and that feel-

ing—and most fulfilled, this disorder can have immediate and long-term consequences on the mother/child bond and the subsequent emotional and cognitive development of the child.

In other words, this is a woman's health issue and a children's health issue. Early identification and treatment can spare months of suffering and minimize the impact on both mother and child. The good news that we have an array of effective treatment options for mood disorders, including psychotherapies and a range of pharmaceutical options which can be used to assist women with postpartum depression.

On the other hand, we need to know more about factors contributing to the development of postpartum depression and postpartum psychosis as well as predictors and correlates of these disorders. Most importantly, we need to find effective means of promptly identifying women who are suffering from these conditions and engaging them in treatment. It is time that this health issue got the attention it deserves. This hearing is a first step in the right direction. I yield back.

Mr. PALLONE. Thank you. Dr. Burgess.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Thank you, Mr. Chairman. I don't know that I completely understood this morning we were delivering opening statements, and I apologize if I covered some of this in the previous panel. But let me just go back to one of the things that we were talking about from the last panel, and Dr. Bennett, I think, in her testimony for the American Heart Association talked about the alarming lack of awareness for heart disease. And certainly that applies to postpartum psychosis/postpartum depression.

Last Congress when we had a hearing on this and I learned of Mr. Rush's bill, I eagerly sought and was accepted as a cosponsor on this bill, and I have been this year as well. I think there are a number of good things that will come to bear if we can deliver this bill, no pun intended. Let me just talk about a couple things though, as far as the robustness of the information part.

We talked in title I, there is basic research, the mipodemalilogic studies. We talked about diagnostic techniques, some new therapies, all of which are important. But the line on information and decimating information to the public and to physicians is—I would like to see that a more robust section of this bill. And I hope to be able to work with the primary sponsor of this bill to make certain that we define some of the deliverables. We define some of the appropriate metrics that might be applied so that we can at least see that we are helping this situation.

I would just say from a 25-year practice in obstetrics, I did see firsthand how disruptive and how frightening it could be to have a patient with postpartum psychosis. And I know it was frightening for me, and I know it was frightening for the family and for the patient herself. I was very fortunate. I never lost a patient to this disease. I did lose a patient to her psychosis during pregnancy at 20 weeks, and as you can imagine, I also lost the baby at that point as well. So I do think we need to include in our discussion the entire spectrum of whether they be postpartum or midpartum

issues because the hormonal interplay can encompass such a vast number of issues.

And clearly as we get further down the road with our study of genomics and genomic personalized medicine, this is going to be an area where further research is certainly warranted. But I thank the chairman of my other subcommittee for bringing this bill to our attention and certainly look forward to working with him to make it the best bill possible when we pass it out of committee.

Mr. PALLONE. Thank you, Dr. Burgess. Mrs. Capps.

OPENING STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mrs. CAPPS. Thank you, Chairman Pallone. I am thankful for this hearing as I was for the one that preceded it, both having to do with issues that particularly affect women and those who care about them. I want to thank our witnesses today, those who are here to talk about postpartum depression, and also to thank the author of the bill, our colleague Mr. Rush from Illinois, and the namesake of the bill. A tragic story, as there are so many tragic stories.

This is an important women's health issue because particularly tomorrow, we will be observing Mental Health Parity Day. That topic certainly is related to the topic of our hearing. Postpartum depression, that is the serious psychological mental health issue that follows upon giving birth, for so many women is very real, has been documented, and on some level, affects most new mothers and their families. And we need more awareness for all women about what postpartum depression is.

As a nurse for many years, I have seen firsthand how much women and their families, their partners, have struggled with this difficult condition. Particularly in a program that I directed for teen parents, I saw the devastating effects of postpartum depression on an already stressed situation for young adolescent mothers.

To me, it is just tragic still, with as much as we know about this mental health condition, that there is such a great stigma associated with postpartum depression. So many women still feel so ashamed of the feelings that they are experiencing. This mainly comes because so many people don't understand the condition.

I am proud to be a cosponsor of H.R. 20 in order to expand research at the NIH into understanding postpartum depression further to provide grants for support services into the community. Access to treatment and support services is really most important, in my opinion, not only for women experiencing it, but for the entire family. This is information that should be widely disseminated across the country to mitigate some of the stigmas that are attached and to allow women and their families, who will sometimes be the first to observe symptoms, the opportunity for early intervention.

A mother who is debilitated by postpartum depression has trouble being a good mother, has trouble with their feelings of self-worth and this is something that is so treatable and so preventable. I can't stress enough how important it is to focus on care for the mother and other family members as they go through a rough time postpartum.

I look forward to hearing from our witnesses today, particularly those who will tell you their stories of postpartum depression so we can learn more about what is being done currently about this situation, how we can help provide access to services for women and their families. Every women who cannot access treatment for postpartum depression translates into the suffering of a whole family.

I think it is also demeaning, Mr. Chairman, that we have extraneous—this is such a serious topic in itself, and we can have other discussions of other issues. But postpartum depression deserves our full attention in this hearing. I yield back.

Mr. PALLONE. Thank you. Mr. Murphy is recognized.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Thank you, Mr. Chairman, and thank you for holding this hearing. I worked as a psychologist for over 25 years, and in that context, I saw countless children who really struggled in their relationship with their mothers. Many of those mothers were suffering symptoms of postpartum depression that unfortunately were oftentimes undiagnosed, untreated, except through denial, and we know that denial is not an adequate treatment for mental illness. We saw these mothers who were struggling, who were depressed, emotionally distant, rejecting, angry, sometimes abusive, ashamed, and loving all at the same time. Huge conflicts took place in their lives.

What is so important, as we try and grasp this, is that we understand that over half the cases of postpartum are untreated, many undiagnosed. It goes along also with what happens in other areas of mental illness where the mental health care is not integrated with the medical care. Or people are not paying attention to these issues, or they think it is all in their head and just a good night's sleep will take care of it or other sorts of—because treatment sometimes has not advanced us beyond the era of the Salem witch trials where we blame the patient for their problems.

We have to make sure that we are not ignoring all the problems that mothers experience. I hope we also include in these discussions such things as not only mothers who deliver a healthy baby, but those who have a child who is born with handicaps, those who have a premature infant, those who have experienced an abortion, those who also have a miscarriage. In any case, a mother feels a loss and problems that we have to deal with, and not get it caught up in other issues of how we may feel about those labels but understand it is a value, it is a life, it is a person with real emotions and real issues there.

In this context, I hope that we as a nation can come to better terms with how we view mental illness overall. We have to understand that it is an illness. We have to understand that it can be diagnosed, that it can be treated, that real lives are at stake, not only those who suffer the illness, but those who are family members. And we need, with compassion and care and concern, to put this into real policy that makes a difference for the millions of families across America who depend upon us for drawing the light to

this. Make sure that funding goes for research. Making sure that practitioners are out there with proper training to diagnose and treat this.

Along these lines, I hope that all of these are some of the outcome of H.R. 20, mental health parity issues, and other issues which this Congress will be dealing with. I look forward to hearing the testimony of today's witnesses, and I thank the chairman.

Mr. PALLONE. Thank you. I recognize our vice-chair, Mr. Green.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman, for holding the hearing to examine depression and mental health after pregnancy. Postpartum depression affects the majority of American families in one way or another, whether it is the form of baby blues or clinical depression or psychosis.

In my hometown of Houston, we learned all too well the dangers that can result from undiagnosed or mistreated postpartum depression. In 2001, Andrea Yates drowned her five children and was sentenced to life in prison. A native Houstonian, a valedictorian from Milby High School that is in our district, Andrea had everything going for her, a bright future as a registered nurse at the top cancer center in our country.

Yet Andrea's adult years were filled with warning signs about her tendency toward depression and psychosis. Because of her history of suicide attempts, hospitalizations, and drug therapies for her depressive episodes, the doctor warned her that additional children could spark more psychotic behavior. Nevertheless, she became pregnant a fifth time and stopped her drug therapy.

We all know the unfortunate end to this story, which shocked not only our community but the Nation at large. Sadly, families all across America are dealing with the effects of postpartum depression psychosis and are not getting the help they need. In general, women aren't getting the information they need to detect the warning signs of postpartum depression. Families and support networks are left feeling helpless about what they can do to help their loved ones, and access to mental health care is severely lacking.

As members of our subcommittee, however, we can take action. I have cosponsored the Kennedy-Ramstad bill to provide equal insurance coverage for mental health benefits, and I know we need the support there. Let us pass this bill and put our money where our mouth is when it comes to supporting access to mental health care.

In the meantime, however, we must realize the importance of awareness. I know a young woman who suffered from postpartum depression, yet resisted treatment because she thought of herself simply as a bad mother, failing to bond with her new son. These thoughts resulted not only from depression but also from the stigma that unfortunately still exists within our society when it comes to mental illness. Through education and awareness, we can make significant strides toward helping postpartum mothers identify their depression, seek the treatment they need, and get them on their way toward developing that all-too-important bond with their new children.

And again I would like to thank my witnesses for being here today, and particularly Ms. Blocker's willingness to share her family story with the subcommittee. I can only imagine the pain associated with telling your daughter's story and we are pleased to know that you are doing a world of good in educating us and the public about this important issue.

And I would also like to thank our colleague Bobby Rush for his persistence and dedication on this issue. And I yield back, Mr. Chairman.

Mr. PALLONE. Thank you. I recognize the gentlewoman from Tennessee, Mrs. Blackburn.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Mrs. BLACKBURN. Thank you, Mr. Chairman. And I really want to thank all of our witnesses for taking the time to be here today. As a mom, I have many, many times wondered why it seemed to be so difficult for people to define the baby blues or postpartum depression and why it was so hard and so difficult for so many of the medical community to realize what it was when it happened because having a baby should be such a joyous time.

But then you come through, and you have had 9 months of carrying extra weight. Your back aches. Your body changes. You have had nausea and all these different things that you have had to deal with through pregnancy. And then the baby arrives, and you get this overwhelming feeling because your life has changed. Your family responsibilities have changed. Maybe you are not going right back to work, or you are going back to a different description of your job.

All of this leads a woman into that pattern of doubting their own self-worth, doubting their self-esteem, and into that downward spiral where you feel like days never end. And it is difficult to get your hands around that as you try to care for a new baby and a new home life and wonder how in the world you are going to get yourself back to a normal routine.

It does put a very difficult situation in front of so many women who are not only first-time moms but many times second or third-time pregnancies with those new babies. And I appreciate the sponsor's work on the bill. I appreciate the committee taking a look at the bill. I do recognize and appreciate the intent of the legislation to expand and intensify the research activities around postpartum depression and postpartum psychosis.

I do hope however that the bill is not too prescriptive for the NIH and that it will allow the NIH the opportunity to decide the best ways to go about studying postpartum depression. And with that, Mr. Chairman, I yield back the balance of my time and look forward to the witnesses.

Mr. PALLONE. Thank you. I recognize Mr. Rush, the sponsor of our legislation.

OPENING STATEMENT OF HON. BOBBY L. RUSH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Mr. RUSH. Well, thank you, Mr. Chairman, and I want to thank you and Ranking Member Deal and all of my colleagues for this hearing and for highlighting the important issue of postpartum depression. Mr. Chairman, although I am not a member of this subcommittee, I really want you to know how appreciative I am for you allowing me and my witnesses to come forward before this subcommittee.

Mr. Chairman, I authored the Melanie Blocker-Stokes Postpartum Research and Care Act back in 2001, after being engaged, along with other members of my community, in prayer and interest and being engaged in seeking to find out the whereabouts of Melanie Blocker-Stokes. She had disappeared, I think, mid-week, and we knew the Blocker family. We knew the work that Mrs. Carol Blocker, the mother, had done in education, and she had been a teacher.

And we were all concerned, and then I believe it was on a Saturday afternoon, the news banner interrupted the normal broadcasting on the television and said that Melanie Blocker-Stokes had been found, that she had jumped out of a hotel window in the near north side of the city of Chicago and that she had killed herself. And we were all stunned as a community, and then upon further study and hearing the news, I heard for the first time about postpartum depression and postpartum psychosis. The tragic story of Melanie's suicide as a result of postpartum psychosis and the overwhelming support of the mental health community including Dr. Nada Stotland demonstrated for me that the Congress needed to add on this issue of postpartum psychosis and postpartum depression. It demonstrated a need for more research and service for mothers.

And so in 2001, I introduced the Melanie Blocker-Stokes Postpartum Care and Research Act. And, Mr. Chairman, 6 years later, this non-controversial bill to aid mothers and motherhood remains detained in this community. Mrs. Blocker said it best in her testimony. "Hundreds of thousands of women who have suffered from postpartum depression and psychosis are still waiting for Congress to act."

Mr. Chairman, I am hopeful that today's hearing and the support of all the subcommittee Democrats and Ranking Member Deal and others including just overwhelming support from over 100 bipartisan cosponsors. I really want to highlight Dr. Burgess for his early support of this bill.

This bipartisan support is a signal that change is on the horizon. As many of you know, the needs of researchers to combat postpartum depression are more and more significant each and every year. Research indicates some form of postpartum depression affects approximately 1 in 1,000 new mothers resulting in upwards of 400,000 new cases each and every year. Of the new postpartum cases this year, less than 15 percent of mothers will receive treatment; although, scientists argue with treatment, over 90 percent of these mothers could overcome their depression

Chairman Pallone, my legislation is bipartisan, and Congress must step up and meet this growing problem head on. It is scientifically established——

Mr. PALLONE. I have got to tell you you are over a minute.

Mr. RUSH. Recognized and endorsed. Mr. Chairman, I just want to go on and proceed. Thank you so very much for this hearing, and I yield back the balance of all of my time that is left.

Mr. PALLONE. Thank you. That concludes the opening statements by members of the subcommittee.

Any other statements by Members may be included at this point in the record as well as the text of H.R. 20.

[The prepared statements of Ms. Eshoo and Mr. Towns as well as H.R. 20 follows:]

PREPARED STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, thank you for holding this important hearing on H.R. 20 the Melanie Blocker-Stokes Postpartum Depression Research and Care Act. I commend you for your attention to this critical issue, and thank Rep. Rush for sponsoring this legislation.

Postpartum depression is a serious mental health condition which in various forms affects up to 80 percent of new mothers after childbirth. While there is no known cause of post-partum depression, experts believe the hormonal and physical changes that occur after childbirth, as well as the added responsibility of caring for a new life are factors that may lead to postpartum depression in some women.

While the "baby blues" are common in new mothers, a full-blown depressive episode is not a normal occurrence and requires active intervention. A woman suffering from postpartum depression needs treatment from her physician or therapist and emotional support from family and friends in order to recover her physical and mental well-being. Unfortunately, many women who suffer from postpartum depression don't receive the treatment they need because of the costs associated with mental health care.

There is also a social stigma attached to the "baby blues" that prevents many women from seeking the appropriate treatment. Some women don't tell anyone about their symptoms because they feel embarrassed, ashamed, or guilty about feeling depressed when they're supposed to be happy. They worry that they will be viewed as an unfit parent. If left untreated, this illness can lead to other health problems such as substance abuse and clinical depression. Postpartum psychosis, the most severe type of postpartum depression, can lead to suicide if untreated.

I'm proud to cosponsor H.R. 20, which intensifies and expands research efforts through the National Institutes of Health (NIH) in order to better understand the causes of postpartum depression. A main goal of research under this bill is to find better treatments and a cure for this mental illness. The bill also authorizes grant funding and increases clinical research in order to develop more cost-effective treatment programs for new mothers and their families.

This important legislation will go a long way to help women and families battle this all too common mental illness. I look forward to hearing from the witnesses today and urge my colleagues to support the bill.

Remarks for Congressman Edolphus "Ed" Towns

Subcommittee on Health H.R. 20 "Melanie Blocker-Stokes Postpartum Depression Research and Care Act"

12:00 PM 2123 Rayburn HOB

MR. CHAIRMAN, THANK YOU FOR BRINING THIS IMPORTANT LEGISLATION BEFORE THE SUBCOMMITTEE AND THANK YOU TO REPRESENTATIVE RUSH FOR INTRODUCING THIS CRITICAL LEGISLATION. I HAVE CO-SPONSORED THE MELANIE BLOCKER STOKES POSTPARTUM DEPRESSION RESEARCH AND CARE ACT – HR 20 ALONG WITH OVER ONE HUNDRED OF MY COLLEAGUES BECAUSE POST PARTUM DEPRESSION IS A CONDITION THAT DISPROPORTIONATELY AFFECTS MINORITY WOMEN. IN A RECENT STUDY, NEARLY ONE-HALF OF HISPANIC (47 PERCENT) AND BLACK (45 PERCENT) MOTHERS REPORTED DEPRESSIVE SYMPTOMS, COMPARED WITH

LESS THAN ONE-THIRD (31 PERCENT) OF WHITE MOTHERS. WE MUST NOT LET ANOTHER UNDIAGNOSED CASE OF POST PARTUM DEPRESSION TAKE THE LIFE OF A MOTHER. THIS BILL WAS NAMED AFTER AND INSPIRED BY CHICAGO NATIVE MELANIE BLOCKER STOKES – A 40-YEAR-OLD, AFRICAN AMERICAN WOMAN WHO TOOK HER OWN LIFE AFTER A LONG BATTLE WITH THIS DISEASE. IT IS CRITICALLY IMPORTANT THAT WE PASS THIS LEGISLATION TO PROVIDE THE IMMEDIATE HELP AND RESOURCES NEEDED TO FIGHT THIS DISEASE. TOO MANY WOMEN GO UNDIAGNOSED. IN ADDITION, THERE WILL BE *AT LEAST* 400,000 NEW CASES OF POSTPARTUM DEPRESSION THIS YEAR ALONE, MAKING THIS THE SINGLE MOST FREQUENT SERIOUS COMPLICATION OF PREGNANCY. OF THE WOMEN WHO SUFFER FROM THIS DISEASE, LESS THAN 15 PERCENT WILL RECEIVE TREATMENT AND AFRICAN AMERICAN WOMEN RECEIVE TREATMENT AT ONLY

ONE-THIRD THE RATE OF THE GENERAL POPULATION. MORE THAN LIKELY MANY MORE WILL GO UNTREATED IN MEDICALLY UNDERSERVED COMMUNITIES BECAUSE THEY HAVE NOT REPORTED SUFFERING FROM THE SYMPTOMS. THE FACT REMAINS THAT PERCENTAGE OF AFRICAN AMERICANS WHO RECEIVE NEEDED MENTAL HEALTH CARE SERVICES AND TREATMENTS IS ONLY ABOUT HALF THAT OF WHITES.

THIS BILL WILL HELP ENSURE THAT WE BEGIN TO RECOGNIZE THE MENTAL HEALTH CARE NEEDS OF WOMEN AFTER CHILD BIRTH. I STRONGLY SUPPORT THIS LEGISLATION AND COMMEND THE CHAIRMAN AND REPRESENTATIVE RUSH FOR BRINGING IT TO THE ATTENTION OF THE SUBCOMMITTEE.

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110TH CONGRESS
1ST SESSION

H. R. 20

To provide for research on, and services for individuals with, postpartum depression and psychosis.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 4, 2007

Mr. RUSH introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To provide for research on, and services for individuals with, postpartum depression and psychosis.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Melanie Blocker-Stokes Postpartum Depression Research and Care Act".

SEC. 2. FINDINGS.

The Congress finds as follows:

(1) Postpartum depression is a devastating mood disorder which strikes many women during and after pregnancy.

(2) Postpartum mood changes are common and can be broken into three subgroups: "baby blues," which is an extremely common and the less severe form of postpartum depression; postpartum mood and anxiety disorders, which are more severe than baby blues and can occur during pregnancy and anytime within the first year of the infant's birth; and postpartum psychosis, which is the most extreme form of postpartum depression and can occur during pregnancy and up to twelve months after delivery.

(3) "Baby blues" is characterized by mood swings, feelings of being overwhelmed, tearfulness, irritability, poor sleep, mood changes, and a sense of vulnerability.

(4) The symptoms of postpartum mood and anxiety disorders are the worsening and the continuation of the baby blues beyond the first days or weeks after delivery.

(5) The symptoms of postpartum psychosis include losing touch with reality, distorted thinking, delusions, auditory hallucinations, paranoia, hyperactivity, and rapid speech or mania.

(6) Each year over 400,000 women suffer from postpartum mood changes, with baby blues afflicting up to 80 percent of new mothers; postpartum mood

and anxiety disorders impairing around 10–20 percent of new mothers; and postpartum psychosis striking 1 in 1,000 new mothers.

(7) The causes of postpartum depression are complex and unknown at this time; however, theories include a steep and rapid drop in hormone levels after childbirth; difficulty during labor or pregnancy; a premature birth; a miscarriage; feeling overwhelmed, uncertain, frustrated or anxious about one's new role as a mother; a lack of support from one's spouse, friends or family; marital strife; stressful events in life such as death of a loved one, financial problems, or physical or mental abuse; a family history of depression or mood disorders; a previous history of major depression or anxiety; or a prior postpartum depression.

(8) Postpartum depression is a treatable disorder if promptly diagnosed by a trained provider and attended to with a personalized regimen of care including social support, therapy, medication, and when necessary hospitalization.

(9) All too often postpartum depression goes undiagnosed or untreated due to the social stigma surrounding depression and mental illness, the myth of motherhood, the new mother's inability to self-di-

agnose her condition, the new mother's shame or embarrassment over discussing her depression so near to the birth of her child, the lack of understanding in society and the medical community of the complexity of postpartum depression, and economic pressures placed on hospitals and providers.

(10) Untreated, postpartum depression can lead to further depression, substance abuse, loss of employment, divorce and further social alienation, self-destructive behavior, or even suicide.

(11) Untreated, postpartum depression impacts society through its affect on the infant's physical and psychological development, child abuse, neglect or death of the infant or other siblings, and the disruption of the family.

TITLE I—RESEARCH ON POSTPARTUM DEPRESSION AND PSYCHOSIS

SEC. 101. EXPANSION AND INTENSIFICATION OF ACTIVITIES OF NATIONAL INSTITUTE OF MENTAL HEALTH.

(a) IN GENERAL.—The Secretary of Health and Human Services, acting through the Director of NIH and the Director of the National Institute of Mental Health (in this section referred to as the "Institute"), shall ex-

pand and intensify research and related activities of the Institute with respect to postpartum depression and postpartum psychosis (in this section referred to as "postpartum conditions").

(b) COORDINATION WITH OTHER INSTITUTES.—The Director of the Institute shall coordinate the activities of the Director under subsection (a) with similar activities conducted by the other national research institutes and agencies of the National Institutes of Health to the extent that such Institutes and agencies have responsibilities that are related to postpartum conditions.

(c) PROGRAMS FOR POSTPARTUM CONDITIONS.—In carrying out subsection (a), the Director of the Institute shall conduct or support research to expand the understanding of the causes of, and to find a cure for, postpartum conditions. Activities under such subsection shall include conducting and supporting the following:

(1) Basic research concerning the etiology and causes of the conditions.

(2) Epidemiological studies to address the frequency and natural history of the conditions and the differences among racial and ethnic groups with respect to the conditions.

(3) The development of improved diagnostic techniques.

(4) Clinical research for the development and evaluation of new treatments, including new biological agents.

(5) Information and education programs for health care professionals and the public.

(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2008 through 2010.

TITLE II—DELIVERY OF SERVICES REGARDING POSTPARTUM DEPRESSION AND PSYCHOSIS

SEC. 201. ESTABLISHMENT OF PROGRAM OF GRANTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this title referred to as the "Secretary") shall in accordance with this title make grants to provide for projects for the establishment, operation, and coordination of effective and cost-efficient systems for the delivery of essential services to individuals with postpartum depression or postpartum psychosis (referred to in this section as a "postpartum condition) and their families.

(b) RECIPIENTS OF GRANTS.—A grant under subsection (a) may be made to an entity only if the entity

is a public or nonprofit private entity, which may include a State or local government; a public or nonprofit private hospital, community-based organization, hospice, ambulatory care facility, community health center, migrant health center, or homeless health center; or other appropriate public or nonprofit private entity.

(c) CERTAIN ACTIVITIES.—To the extent practicable and appropriate, the Secretary shall ensure that projects under subsection (a) provide services for the diagnosis and management of postpartum conditions. Activities that the Secretary may authorize for such projects may also include the following:

(1) Delivering or enhancing outpatient and home-based health and support services, including case management, screening and comprehensive treatment services for individuals with or at risk for postpartum conditions; and delivering or enhancing support services for their families.

(2) Delivering or enhancing inpatient care management services that ensure the well being of the mother and family and the future development of the infant.

(3) Improving the quality, availability, and organization of health care and support services (including transportation services, attendant care,

homemaker services, day or respite care, and providing counseling on financial assistance and insurance) for individuals with postpartum conditions and support services for their families.

(d) INTEGRATION WITH OTHER PROGRAMS.—To the extent practicable and appropriate, the Secretary shall integrate the program under this title with other grant programs carried out by the Secretary, including the program under section 330 of the Public Health Service Act.

SEC. 202. CERTAIN REQUIREMENTS.

A grant may be made under section 201 only if the applicant involved makes the following agreements:

(1) Not more than 5 percent of the grant will be used for administration, accounting, reporting, and program oversight functions.

(2) The grant will be used to supplement and not supplant funds from other sources related to the treatment of postpartum conditions.

(3) The applicant will abide by any limitations deemed appropriate by the Secretary on any charges to individuals receiving services pursuant to the grant. As deemed appropriate by the Secretary, such limitations on charges may vary based on the financial circumstances of the individual receiving services.

(4) The grant will not be expended to make payment for services authorized under section 201(a) to the extent that payment has been made, or can reasonably be expected to be made, with respect to such services—

(A) under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or

(B) by an entity that provides health services on a prepaid basis.

(5) The applicant will, at each site at which the applicant provides services under section 201(a), post a conspicuous notice informing individuals who receive the services of any Federal policies that apply to the applicant with respect to the imposition of charges on such individuals.

SEC. 203. TECHNICAL ASSISTANCE.

The Secretary may provide technical assistance to assist entities in complying with the requirements of this title in order to make such entities eligible to receive grants under section 201.

SEC. 204. AUTHORIZATION OF APPROPRIATIONS.

For the purpose of carrying out this title, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2008 through 2010.

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Mr. PALLONE. We will turn to our witnesses. I want to welcome all of you. We originally had two panels, but we are just going to have one, so everybody is together. And you are all there, so you realize it.

Let me introduce the members of the panel. First is Dr. Catherine Roca, who is the Chief of Women's Programs at the National Institutes of Mental Health. I would ask Mr. Rush if he would introduce Ms. Blocker, who is our next panelist. I will yield for the gentleman briefly.

Mr. RUSH. Well, Mr. Chairman, it is going to be hard to be brief, but I will attempt to be brief. I want to welcome one of the most extraordinary and superb women that this nation has ever called a citizen. Mrs. Carol Blocker was born and raised in Chicago, and for the past 30 years, she has been a public school teacher for the Chicago public schools. And I am proud to say that two of my grandsons were her students. Mrs. Blocker is the mother of two and a grandmother of two. And in 2001, the death of her daughter, Melanie Blocker-Stokes, was a defining moment. And she has been fighting for mothers ever since.

Mr. Chairman, Mrs. Blocker established the Melanie Blocker-Stokes Foundation, which educates and unites mothers, grandmothers, and families across this country to combat postpartum depression. I am proud to be her Congressman. I am proud to be the sponsor of this particular piece of legislation, and I am proud to call her my friend.

And, Mr. Chairman, I want to join with you in welcoming Mrs. Blocker to this subcommittee.

Mr. PALLONE. Thank you, and we welcome Ms. Blocker. I have already made several statements about our next witness, who is Ms. Mary Jo Codey, who—it keeps saying former first lady, but actually is the current first lady because Senator Codey is currently the Acting Governor. And she really has single-handedly brought to the attention of our State the whole issue of postpartum depression and mental health issues in general. She has just done so much so thank you for being here again.

And then next is Michaelene Fredenburg who is president of Life Perspectives from San Diego. And then we have Dr. Priscilla Coleman who is associate professor of human development and family studies at Bowling Green State University in Ohio. And then last is Dr. Nada Stotland, who is professor of psychiatry and obstetrics/gynecology at the Rush Medical College in Chicago.

Thank you all for being here, and I should mention we have 5-minute opening statements. They become part of the hearing record, but each of you may, in the discretion of the committee, submit additional brief and pertinent statements in writing for inclusion in the record. And I am going to start with Dr. Roca.

STATEMENT OF CATHERINE ROCA, M.D., CHIEF, WOMEN'S PROGRAMS, NATIONAL INSTITUTE OF MENTAL HEALTH, BETHESDA, MD

Dr. ROCA. Thank you, Mr. Chairman. Thank you for inviting me to speak today, and thank you, Ranking Member Deal and members of the subcommittee.

On behalf of the National Institute of Mental Health, part of the National Institutes of Health, an agency in the Department of Health and Human Services, I am pleased to present a brief overview of the current research for understanding and treating postpartum depression. And while I will be speaking primarily about research at National Institute of Mental Health, I want to acknowledge that research in this area is also being conducted elsewhere at the National Institute of Health, including the National Institute of Drug Abuse, the National Institute of Child Health and Human Development, the National Institute for Nursing Research, among others.

Postpartum depression is a serious brain disorder that poses health risks to both mother and infant. Postpartum depression is part of a spectrum of mood disorders that affect women after the birth of a child ranging from mild, such as we have heard about postpartum or maternal blues, to severe including postpartum depression and postpartum psychosis.

The maternal blues refers to a transient depressed mood that can last for a few days to a week. It is extremely common, affecting approximately 50 percent of new mothers. Postpartum depression describes a sustained period of 2 weeks or more of depressed mood that interferes with one's ability to perform day-to-day tasks and can be incapacitating. It is associated with a personal or family history of depression, depression during pregnancy, stress and lack of social support. Untreated postpartum depression has been associated with poor infant outcomes and poses a health risk to the mother, including the risk of suicide.

Postpartum psychosis, which is rare, is associated with a personal or family history of bipolar or schizoaffective disorder. It typically occurs usually, usually within the 2 weeks after childbirth and is associated with agitation, hallucination, and besides occasionally leading to violent behavior.

According to a recent report, of the Health and Human Services Agency for health care research and quality, approximately 14 percent of women experience a new episode of depression during the first 3 months postpartum. Understanding the causes of these mood disorders is important for developing new treatments, as well as creating preventive interventions. The National Institute of Mental Health is currently funding a number of studies that examine the role of stress, hormones, genetics, psychosocial and cultural factors that may contribute to the development of postpartum depression.

Because postpartum depression occurs in the context of a major change in reproductive hormone levels, there have been questions surrounding the role of estrogen and progesterone in postpartum depression. The National Institute of Mental Health's Intramural Research Program supports several studies in this area.

For example, one intramural research study follows women during the postpartum period to assess whether the onset of depression is associated with a change in reproductive hormone levels. A companion study will determine whether estradiol administration can relieve symptoms of postpartum depression.

And finally, researchers are exploring the role of reproductive hormone withdrawal as a potential cause of depressive symptoms

in healthy women. In addition to this intramural research, the National Institute of Mental Health supports a variety of extramural studies on postpartum depression. Investigators are encouraged to submit research grant applications through program announcements on women's mental health in pregnancy and in the postpartum period.

Depression that occurs during pregnancy poses some unique challenges for both the patient and health care provider. The National Institute of Mental Health has supported a number of studies, indicating that both interpersonal and cognitive behavioral therapies are effective in treating many women with depression during pregnancy and in the postpartum period.

However, not all women respond to or can take advantage of these therapies. Other research is examining the risk of stopping antidepressant use during pregnancy. Women with recurrent major depression who discontinue their medication during pregnancy have a fivefold greater risk of relapsing than those who continue on their medication.

Other studies raise concerns about the use of selective serotonin reuptake inhibitors during pregnancy. For example, selective serotonin reuptake inhibitors increase the risk of primary pulmonary hypertension, a rare but serious condition in newborns. However, untreated depression also poses risks to the newborn, including low birth rate and behavioral abnormalities. By cofunding a large center grant with the National Institute of Health Office of Research in Women's Health on medication use in pregnancy, NIMH is taking steps to obtain data on this important issue so that women and their doctors can be better informed as to the risks and benefits of antidepressant treatment during pregnancy.

To successfully influence treatment practice, data must also be decimated, and for this reason, NIMH has teamed with several other Federal agencies to provide information on postpartum for the public and health care providers. The National Institute of Mental Health has assisted in updating information for consumers on postpartum depression for the Health and Human Services Office on Women's Health Web site.

Additionally, the National Institute of Mental Health has worked with the Health and Human Services Health Resources and Services Administration staff to develop a consumer booklet on depression during and after pregnancy that was released on April 17, 2007. This brochure offers tips, identifying the condition in mothers, and six steps to help treat it successfully. Called "Depression During and After Pregnancy: A Resource for Women, their Families, and Friends," the booklet is designed to increase awareness among women and clinicians.

Overall, the National Institute of Mental Health supports an active research base to advance the understanding, treatment, and ultimately prevention of postpartum depression. This research continues to be a critical source of information for women, families, and health care providers seeking to better understand how to detect, manage, and treat this devastating illness.

Thank you for the opportunity to provide this information to you, and I would be happy to answer any questions that you have.

[The prepared statement of Dr. Roca follows:]

TESTIMONY OF CATHERINE ROCA, M.D.

Good afternoon, Mr. Chairman and members of the subcommittee. On behalf of the National Institute of Mental Health (NIMH), part of the National Institutes of Health, an agency of the Department of Health and Human Services (HHS), I am pleased to present a brief overview of the current research for understanding and treating postpartum depression. Postpartum depression is a serious brain disorder that poses health risks to both mother and infant. Postpartum depression is part of a spectrum of mood disorders that affect women after the birth of child, ranging from mild (maternal blues) to severe (postpartum depression and postpartum psychosis).

The "maternal blues" refers to a transient depressed mood that can last a few days to a week. It is extremely common, affecting approximately 50 percent of new mothers. [1]

Postpartum depression (PPD) describes a sustained period (2 weeks or more) of depressed mood that interferes with one's ability to perform day-to-day tasks and can be incapacitating. It is associated with a personal or family history of depression, depression during pregnancy, stress, and lack of social support. Untreated postpartum depression has been associated with poor infant outcomes and poses a health risk to the mother, including the risk of suicide. Postpartum psychosis, which is rare, is associated with a personal or family history of bipolar or schizoaffective disorder. It typically occurs early, usually in the first two weeks after childbirth and is associated with agitation, hallucinations, and bizarre ideas, occasionally leading to violent behavior.

According to a recent report of HHS' Agency for Healthcare Research and Quality, approximately 14 percent of women experience a new episode of depression during the first three months postpartum. [2]

Understanding the causes of these mood disorders is important for developing new treatments, as well as creating preventive interventions. NIMH is currently funding a number of studies that examine the role of stress, hormones, genetics, psychosocial, and cultural factors that may contribute to the development of PPD.

Because PPD occurs in the context of a major change in reproductive hormone levels, there have been questions surrounding the role of estrogen and progesterone in PPD. The NIMH's Intramural Research Program (IRP) supports several studies in this area. For example, one IRP study follows women during the postpartum period to assess whether the onset of depression is associated with a change in reproductive hormone levels. A companion study will determine whether estradiol administration can relieve symptoms of postpartum depression. Finally, researchers are exploring the role of reproductive hormone withdrawal as a potential cause of depressive symptoms in healthy women.

In addition to this intramural research, NIMH supports a variety of extramural studies on postpartum depression. Investigators are encouraged to submit research grant applications through program announcements on women's mental health in pregnancy and the postpartum period.

Depression that occurs during pregnancy poses some unique challenges for both the patient and the health care provider. NIMH has supported a number of studies indicating that both interpersonal and cognitive-behavioral therapies are effective in treating many women with depression during pregnancy and in the postpartum period. However, not all women respond to, or can take advantage of, these therapies. Other research is examining the risk of stopping antidepressant use during pregnancy. Women with recurrent major depression who discontinued their medication during pregnancy had a five-fold greater risk of relapsing than those who continued on their medication. [3]

Other studies raise concerns about the use of selective serotonin reuptake inhibitors (SSRIs) during pregnancy. For example, SSRIs increase the rate of primary pulmonary hypertension, a rare but serious condition, in newborns. However, untreated depression also poses risks to the newborn, including low birth weight and behavioral abnormalities. By co-funding a large center grant with the NIH Office of Research on Women's Health on medication use in pregnancy, NIMH is taking steps

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1 Henshaw, C. Mood disturbance in the early puerperium: a review. Archives of Women's Mental Health. 2003 Aug; Suppl 2:S33–42.

2 Gaynes, BN, Gavin N, eta l. Perinatal Depression: Prevelence , Screening Accuracy, and Screening Outcomes.

3 Cohen LS, Altshuler LL, Harlow BL, Nonacs R, Newport DJ, Viguera AC, Suri R, Burt VK, Hendrick V, Reminick AM, Loughead A, Vitonis AF, Stowe ZN. Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment. JAMA. 2006 Feb 1; 295(5):499–507

to obtain data on this important issue so women and their doctors can be better informed as to the risks/benefits of antidepressant treatment during pregnancy.

To successfully influence treatment practice, data must be disseminated. For this reason, NIMH has teamed with several other Federal agencies to provide information on PPD for the public and health care providers. NIMH has assisted in updating the information for consumers on postpartum depression for the HHS Office on Women's Health Web site, *www.womenshealth.gov*. Additionally, NIMH worked with HHS' Health Resources and Services Administration staff to develop a consumer booklet on depression during and after pregnancy that was released on April 17, 2007. The brochure offers tips on identifying the condition in mothers and six steps to help treat it successfully. Called "Depression During and After Pregnancy: A Resource for Women, Their Families, and Friends," the booklet is designed to increase awareness among women and clinicians. The companion Web site may be found at *http://mchb.hrsa.gov/pregnancyandbeyond/depression/*

Overall, NIMH supports an active research base to advance the understanding, treatment, and ultimately prevention of postpartum depression. This research continues to be a critical source of information for women, families, and healthcare providers seeking better ways of detecting, managing, and treating this devastating illness.

Thank you for the opportunity to provide this information to you. I would be happy to answer any question you may have.

Mr. PALLONE. Thank you, Dr. Roca. Ms. Blocker.

STATEMENT OF CAROL BLOCKER, MOTHER OF MELANIE BLOCKER-STOKES, CHICAGO, IL

Ms. BLOCKER. Good afternoon, Chairman Pallone, Ranking Member Deal, Congressman Rush, and members of the subcommittee. My name is Carol Blocker, and I am the mother of Melanie Blocker-Stokes, the proud grandmother of Summer Skyy, and an advocate for all women, mothers, and grandmothers, throughout this country who has suffered from postpartum depression.

Melanie Blocker-Stokes, the inspiration for Congressman Rush's postpartum depression bill, took her life on June 11, 2001, less than 5 months after giving birth to her first daughter, my grandchild, Summer Skyy. Today, 6 years after the introduction of this bill, Melanie and hundreds and thousands of women have suffered from postpartum depression and psychosis. I am still waiting for Congress to act.

We want justice, Mr. Chairman, and that is why I ask for the House Energy and Commerce Subcommittee on Health to immediately pass H.R. 20, the Melanie Blocker-Stokes Postpartum Depression Research and Care Act.

Congressman Rush has truly championed this cause, and I commend him for honoring my daughter's life and legacy through this legislation. I also want to thank every Democrat of this subcommittee for cosponsoring H.R. 20 and thank the Republican Ranking Member, Congressman Deal. H.R. 20 has over 100 cosponsors, demonstrating it is not a political issue. It is a public health issue.

Many of you may recall my daughter's story from my September 2004 testimony. However, it bears repeating.

My daughter Melanie was born and raised in the city of Chicago. As both a child and an adult, she was beautiful, accomplished, and the light of my life. She was educated at St. George Private School in Hyde Park. She went to the Immaculata High School in Chicago and Spelman College in Atlanta, Georgia.

After she completed Spelman College, Melanie returned home to Chicago and went to work for Astra Zeneca Pharmaceutical Com-

pany where she rose to become a sale manager. And she married Dr. Sam Stokes. Sam and Melanie were so happy in their marriage and their lives together. And they were even happier when they learned in 2000 that a child was on the way. Their whole family, Sam's family and ours, were ecstatic.

When my granddaughter, who Melanie named Summer Skyy, was born on February 23, 2001, my daughter's pregnancy was normal. But 6 weeks after Melanie gave birth, at the routine postpartum checkup, she said that she felt hopeless and she retreated to her room. And we couldn't get her to go back to the doctor or back to her job or back into the world.

One day, I found Melanie in her bedroom, and she was hollowed-eyed and gaunt, and she was rocking in her glider. And her lips and tongue were peeling from malnutrition because Melanie couldn't eat or sleep. When I went to her bathroom to get her a cold towel, I found a butcher's knife, and I asked Melanie—I said what are you going to do with this? And she looked at me, and she said she didn't know, but she thought she was going to have to die.

At that moment, I knew that something was very, very wrong with Melanie, and I called her doctor. And her doctor said she was suffering from postpartum depression. Over the next 7 weeks, Melanie was hospitalized three times, and each time, the doctors prescribed different combinations of anti-depression and anti-anxiety and anti-psychotic medications. But Melanie's depression had deepened to the point where she couldn't or wouldn't take the pills.

She talked about suicide and looked for ways to harm herself. Once she even asked her brother to buy her a gun. Another time, she took the screen out of my high-rise apartment window while visiting me. And another time, we found that she had snuck away from her house and had tried to drown herself in Lake Michigan.

And each time, we went to the doctor, and each time, there were more prescriptions and more assumptions, but we never heard the word postpartum psychosis. When Melanie came home after her third stay at the hospital, she seemed to have been a little bit better, but I was still worried. And my fears were founded. On the night before Melanie disappeared, I told her husband Sam, I said don't you let her out of your sight. But Sam had to leave for a meeting the next morning, and when he left, Melanie fled.

The day was June 10, 2001, less than 6 months after Summer Skyy was born. We searched Chicago looking for her all weekend. We posted fliers. Sam went on local television news pleading for Melanie to come home. Your baby needs you, and I need you. But Melanie didn't answer. While we searched, Melanie went to a hotel in Chicago and checked into a room on the 12th floor. She then wrote six suicide notes, and the notes included one to God, one to Sam, and also six of them were lined up on the nightstand in her room. We found them after she was dead.

On June 11, 2001, as the sun rose over Lake Michigan, my beautiful daughter stepped out of a 12th floor window to her death, and I think my heart died that day. After hearing my daughter's story, Congressman Rush asked what could have been done to prevent my daughter's tragic end and what additional resources were needed to help physicians and families recognize and understand and

treat this terrible syndrome, postpartum psychosis, which affects about 1 in every 1,000 new mothers.

I discussed the symptoms with Congressman Rush, and I talked to him about how Melanie began losing touch with reality and suffered from disoriented thinking and delusions and battle hyperactivity and mania. I told him about how her psychosis became like a monster that entered my daughter's brain, and it couldn't be controlled.

Even in the milder forms of postpartum depression, this disease manifests itself with lack of interest in newborn child, fear of harming the child, fatigue, sadness, hopelessness, guilt, inadequacy and worthlessness.

Some research indicates that between 50 to 75 percent of all new mothers suffered with this baby blues, yet little is known about how we as families can prevent the tragedy that fell on my family. Chairman Pallone and Ranking Member Deal, this legislation bipartisan. It is scientifically established and recognized by the mental health community. The bill will expand and intensify itself in the National Institute of Health and National Institute of Mental Health on the causes, diagnoses, and treatment of postpartum depression and postpartum psychosis.

This bill would provide much-needed money to groups who are educating our communities and working directly with women who suffer from a postpartum depression and postpartum psychosis.

In closing, Mr. Chairman, this legislation is long overdue. If this legislation had been in place in 2001, we might have recognized my daughter's troubles and prevented her death, and maybe my granddaughter would have her mommy today.

Mr. Chairman and members of the committee, I hope and pray that you will finally act on this legislation and spare countless other women and their families from this horrible consequence of this disease. I implore you to do the right thing, answer my prayer, and honor my daughter's life and save the lives of hundreds of thousands of other women and children and families throughout this country. I hope you have the political will to pass H.R. 20, the Melanie Blocker-Stokes Postpartum Depression Research and Care Act. Thank you.

[The prepared statement of Ms. Blocker follows:]

STATEMENT OF CAROL BLOCKER

Good Afternoon Chairman Pallone, Ranking Member Deal, Congressman Rush and members of the subcommittee.

My name is Carol Blocker, and I am the mother of Melanie Blocker Stokes, the proud grandmother of Sommer Skyy, and an advocate for all women-mothers-and grandmothers throughout this country who have suffered from postpartum depression.

Melanie Blocker Stokes, the inspiration for Congressman Rush's postpartum depression bill, took her life on June 11, 2001, less than 5 months after giving birth to her first daughter, my grandchild, Sommer Skyy.

Today, 6 years after the introduction of this bill, Melanie and hundreds of thousands of women, who have suffered from postpartum depression and psychosis are still waiting for Congress to ACT.

We want justice Mr. Chairman, and that is why I ask for the House Energy and Commerce Subcommittee on Health to immediately pass H.R. 20, the Melanie Blocker Stokes Postpartum Depression Research and Care Act.

Congressman Rush has truly championed this cause and I commend him for honoring my daughter's life and legacy through this legislation.

I also want to thank every democratic member of this subcommittee for co-sponsoring H.R. 20—and thank the Republican ranking member, Congressman Deal. H.R. 20 has over 100 cosponsors, demonstrating it is not a political issue—it's a public health crisis.

Many of you may recall my daughter's story from my September 2004 testimony; however, it bears repeating.

My daughter, Melanie, was born and raised in the city of Chicago. As both a child and an adult, she was beautiful, accomplished, and the light of my life.

We educated her at St. George private school in Hyde Park; she went to the Immaculata High School in Chicago, and Spelman College in Atlanta, Georgia. After she completed Spelman College, Melanie returned home to Chicago and went to work for Astra Zeneca Pharmaceutical Company, where she rose to become a sales manager, and she married Dr. Sam Stokes.

Sam and Melanie were so happy in their marriage and their lives together. They were even happier when they learned, in 2000, that a child was on the way. The whole family, Sam's family and ours, were ecstatic when my granddaughter—who Melanie named Sommer Skyy—was born on February 23, 2001.

My daughter's pregnancy was normal.

But, 6 weeks after Melanie gave birth, at the routine postpartum checkup, she said that she felt "hopeless" and she retreated to her room. We couldn't get her to go back to the doctor, or back to her job, or back into the world.

One day I found Melanie in her bedroom and she was hollow-eyed and gaunt, and she was rocking in her glider. Her lips and her tongue were peeling from malnutrition, because Melanie was not eating or sleeping.

When I went to her bathroom to get her a cold towel, I found a butcher's knife, and I asked Melanie, I said, "What are you doing with this?" She looked at me and said she didn't know, but she thought she was going to have to die.

At that moment, I knew that something was very, very wrong with Melanie and I called her doctor. Her doctor said she was suffering from postpartum depression.

Over the next 7 weeks Melanie was hospitalized three times, and each time the doctors prescribed different combinations of anti-depression, anti-anxiety and anti-psychotic medications, but Melanie's depression had deepened to the point that she wouldn't or couldn't take the pills.

She talked about suicide and looked for ways to harm herself. Once she even asked her brother to buy her a gun.

Another time she took the screens out of my high-rise apartment windows while visiting me.

And another time we found that she had snuck away from her home and tried to drown herself in Lake Michigan. Each time we went back to the doctor, and each time there were more prescriptions and more assumptions, but we never heard the words postpartum psychosis.

When Melanie came home after her third stay in the hospital she seemed to be a bit better, but I was still worried, and my fears were founded.

On the night before Melanie's disappearance, I told her husband Sam, "Don't you let her out of your sight." But Sam had to leave for a meeting the next morning, and when he left the apartment Melanie fled. The day was June 10, 2001, less than 6 months after Sommer Skyy was born.

We searched Chicago looking for her all weekend. We posted flyers and Sam went on the local television news, pleading, "Melanie, please come home. I need you. Your baby needs you." But Melanie didn't answer.

While we searched, Melanie went to a hotel in Chicago and checked into a room on the twelfth floor. She then wrote six suicide notes. The notes included one to God and one to Sam, and all six of them were lined up on the night stand in her room. We found them after she died.

On June 11, 2001, as the sun rose over Lake Michigan, my beautiful daughter stepped out of a twelfth floor window to her death.

And I think my heart died that day.

After hearing my daughter's story, Congressman Rush, asked me what could have been done to prevent my daughter's tragic end, and what additional resources were needed to help physicians and families recognize, understand and treat this terrible syndrome—postpartum psychosis—which affects about one in 1,000 new mothers.

I discussed the symptoms with Congressman Rush. I talked to him about how Melanie began losing touch with reality, suffered from distorted thinking and delusions, battled hyperactivity and mania.

I told him about how her psychosis became like a monster that entered my daughter's brain, and it could not be controlled.

Even in the milder forms of postpartum depression, this disease manifests itself with lack of interest in a newborn child, fear of harming the child, fatigue, sadness, hopelessness, guilt, inadequacy and worthlessness.

Some research indicates that between 50 to 75 percent of all new mothers suffer with these "baby blues," yet little is known about how we, as families, can prevent the tragedy that fell on my family.

Chairman Pallone, Ranking Member Deal, this legislation is bipartisan. It is 'scientifically established", and recognized by the mental health community.

The bill will expand and intensify research in the National Institutes of Health and National Institutes of Mental Health on the causes, diagnoses and treatments of postpartum depression and postpartum psychosis.

This bill will provide much needed money to groups who are educating our communities and working directly with women who suffer from a postpartum depression and postpartum psychosis.

In closing Mr. Chairman, this legislation is long overdue. If this legislation had been in place in 2001, we might have recognized my daughter's troubles and prevented her death.

Maybe my granddaughter would have her mommy today.

Mr. Chairman and members of the committee, I hope and pray that you will finally act on this legislation and spare countless other women and their families from the horrible consequences of this disease.

I implore you to do the right thing—answer my prayers and honor my daughter's life. Save the lives of hundreds of thousands of other women, children, and families throughout this country by finding the political will to pass H.R. 20, the Melanie Blocker Stokes Postpartum Depression Research and Care Act.

Mr. PALLONE. Thank you so much, Ms. Blocker. Thank you for both sharing the story of your daughter, but also for having the fortitude to come forward and make us do something about it so it doesn't happen to others. We certainly appreciate it. I know that you have to leave and catch a plane. She has indicated to us that she will take any written questions that we forward to her, but she has to leave at this time. Thank you again.

Ms. BLOCKER. Thank you.

Mr. PALLONE. And now we will have Ms. Codey. Thank you for being here.

STATEMENT OF MARY JO CODEY, MEMBER, PRESIDENT'S ADVISORY COUNCIL OF POSTPARTUM SUPPORT INTERNATIONAL, WEST ORANGE, NJ

Ms. CODEY. Mr. Chairman, Ranking Member Deal, and members of the subcommittee, thank you for calling this important hearing and inviting me to testify on behalf of those who suffer from postpartum mood disorders. I am a member of the President's Advisory Council of Postpartum Support International and a kindergarten teacher in the West Orange Public School System.

I was first introduced to postpartum depression, or PPD, through my own experience after I delivered my oldest son, Kevin, 22 years old. Nothing prepared me for what has been the worst experience of my life. Not even having breast cancer could compare.

One of the worst aspects of PPD is that it strikes at a time when you expect to be overjoyed. When you aren't, you feel shame, guilt, inadequacy, and isolation. No matter how much support you receive from those around you, you lose touch with them and with yourself. You fail to bond with your baby. You can't function, and you have no idea what is happening or where to turn for help.

Although I had all the signs of PPD, no one seemed to know what was wrong. After I began to have terrifying intrusive thoughts about hurting my son, I checked myself into a mental in-

stitution for a month but found no help there. Eventually I found a psychiatrist who did know about PPD. For months, we tried different antidepressants, but the intrusive thoughts increased until I couldn't stand it and resolved to commit suicide. As a last ditch effort, the psychiatrist prescribed a MAO inhibitor. Within weeks, the intrusive thoughts began to recede and finally disappeared.

In total, it took me almost a year to get better, but I endured depression again with my second and final pregnancy, during which I underwent 11 rounds of shock therapy. When it was all done, I came to be angry that so little was known about this disorder. I thought it was unfair for women and their family not to be educated about it.

PPD isn't a woman's illness. It is a family illness, and I didn't want anyone to have to go through what my family and I had experienced. So I began sharing my story with medical and mental health professionals, women's groups, and the media. And I began working with PPD support and mental health groups. My husband also is a long-time advocate for the mentally ill, and circumstances gave us a window of opportunity.

During his 14-month of tenure as Governor, New Jersey created a comprehensive campaign called "Recognizing Postpartum Depression: Speak Up When You're Down." And I am proud to be the spokesperson for this campaign. New Jersey's postpartum depression screening and education law, which was signed by Governor Corzine a year ago and took effect in October, is an outgrowth of the efforts that began during my husband's administration.

Now, every pregnant woman in our State has to be educated about maternal mood disorders before giving birth and screened for PPD after. All licensed health care professionals who provide pre and post-natal care have to be educated about maternal depression. Health organizations around our State have received funding to develop programs that respond to the law, and they continue to expand their services even as we meet here today. I am proud that our law, which is the first of its kind, has become the model for other States that seek to develop programs. But that is happening slowly. Meanwhile, too many cases are going undiagnosed and untreated.

Maternal depression is one of the most common complications of childbirth. It strikes without regard to age, race, education, or economic background. It robs women of the ability to bend with their new babies and isolates them from their loved ones. It robs children of mothers who can provide the love and care they need. Congress has a moral obligation to women and their families across the whole country to provide more research to determine the full extent of this public health crisis. More education, screening, treatment and support is needed to avoid needless suffering. It will take a Federal mandate to do that effectively.

I have supported Congressman Rush's bill since it was first introduced, and I am proud that New Jersey's law inspired Senator Menendez to introduce the Mother's Act.

I urge you with all my heart to expand the work we are doing in New Jersey by giving us a national law. Thank you and sorry.

[The prepared statement of Ms. Codey follows:]

TESTIMONY OF MARY JO CODEY

Mr. Chairman and members of the subcommittee, thank you for calling this important hearing and inviting me to testify on behalf of those who suffer from postpartum mood disorders. My name is Mary Jo Codey. I am the wife of Richard Codey, former governor, current acting governor, and senate president of New Jersey. I am also a member of the President's Advisory Council of Postpartum Support International, and a teacher in the West Orange Public School System.

I was first introduced to postpartum depression—or PPD—through my own experience after I delivered my oldest child, Kevin, 22 years ago. Nothing prepared me for what has been the worst experience of my life. Not even having breast cancer could compare.

One of the worst aspects of PPD is that it strikes at a time when you expect to be overjoyed. When you aren't, you feel shame, guilt, inadequacy, and isolation. No matter how much support you receive from those around you, you lose touch with them and with yourself. You fail to bond with your baby. You can't function. And you have no idea what's happening, or where to turn for help.

Although I had all the signs of PPD, no one seemed to know what was wrong. After I began to have terrifying, intrusive thoughts about hurting my son, I checked myself into a mental institution for a month but found no help there.

Eventually, I found a psychiatrist who did know about PPD. For months, we tried different antidepressants, but the intrusive thoughts increased until I couldn't stand it and resolved to commit suicide. As a last-ditch effort, the psychiatrist prescribed an MAO inhibitor. Within weeks, the intrusive thoughts began to recede and finally disappeared.

In total, it took me almost a year to get better. But I endured depression again with my second and final pregnancy, during which I underwent 11 rounds of shock therapy.

When it was all done, I came to be angry that so little was known about this disorder, which strikes an estimated 11,000 to 16,000 women a year in my state alone. I thought it was unfair for women and their families not to be educated about it. PPD isn't a woman's illness; it's a family illness. And I didn't want anyone to—have to go through what my family and I had experienced. So I began sharing my story with medical and mental health professionals, women's groups, and the media. And I began working with PPD support and mental-health groups.

My husband also is a long-time advocate for the mentally ill, and circumstances gave us a window of opportunity. During his 14-month tenure as governor, New Jersey created a comprehensive campaign called "Recognizing Postpartum Depression: Speak Up When You're Down." I am proud to be the spokesperson for this campaign, which features

- a 24-hour helpline;
- a bilingual Web site with valuable information for women, their families, and medical professionals;
- literature;
- and public-service announcements.

New Jersey's Postpartum Depression Screening and Education law—which was signed by Governor Corzine a year ago and took effect in October—is an outgrowth of the efforts that began during my husband's administration. Now, every pregnant woman in our state has to be educated about maternal mood disorders before giving birth and screened for PPD after. And all licensed health care professionals who provide pre- and post-natal care have to be educated about maternal depression. Health organizations around our state have received funding to develop programs that respond to the law, and they continue to expand their services even as we meet here today.

I'm proud that our law, which is the first of its kind, has become the model for other states that seek to develop programs. But that is happening slowly. Meanwhile, too many cases are going undiagnosed and untreated.

Maternal depression is one of the commonest complications of childbirth. It strikes without regard to age, race, education, or economic background. It robs women of the ability to bond with their new babies and isolates them from their loved ones. It robs children of mothers who can provide the love and care they need.

Congress has a moral obligation to women and their families across the whole country to provide more research to determine the full extent of this public health crisis and more education, screening, treatment, and support to avoid needless suffering. It will take a Federal mandate to do that effectively.

I urge you to expand the work we are doing in New Jersey to the national level by passing H.R. 20. Thank you.

Mr. PALLONE. No, thank you so much. Thank you for all that you do because you really prove that getting out there and working on this issue makes a difference based on what we did in New Jersey and now in supporting the Federal bill. So thank you again. Mrs. Fredenburg.

STATEMENT OF MICHAELENE FREDENBURG, PRESIDENT, LIFE PERSPECTIVES, SAN DIEGO, CA

Ms. FREDENBURG. Mr. Chairman, good afternoon. My name is Michaelene Fredenburg. I am the president of Life Perspectives. I live in San Diego, California.

I am very grateful that you are considering H.R. 20 as it is critical to study and to treat postpartum depression, and I am also grateful for the opportunity to tell my story today.

As a teenager, I assumed that abortion was necessary for women to complete their educational and career goals. So it is not surprising that when I became pregnant at 18 that I considered abortion. I also thought about adoption; however, when I talked to my live-in boyfriend, he was furious that I was pregnant and demanded that I have an abortion or he would kick me out.

I turned to my employer for advice. She was another woman. And after listening to my story, she really urged me as well that it was really a logical solution to the situation that I was in. And she offered to set up the appointment for me.

My experience at the abortion clinic was painful and humiliating. It was nothing like what I had thought of when I had defended a woman's right to choose. I was completely unprepared for the emotional fallout after the abortion. I thought that the abortion would erase my pregnancy. I thought I could move on with my life, but I wasn't able to.

Although I didn't feel this way before the procedure, it was now clear to me that the abortion ended the life of my child, and I soon found myself in a cycle of self-destructive behavior that included an eating disorder. I experienced periods of intense anger, followed by periods of profound sadness. For weeks and sometimes months at a time, I was too fatigued to do more than eat or take a shower during the day. I lost interest in food, and my weight fell dangerously low.

There were also periods where I was able to pull myself together and lead a normal life, at least outwardly. I did see a number of doctors for the fatigue and the weight loss. They tested me for everything from cancer to lupus to AIDS. I didn't tell them about the feelings I was having as a result of the abortion because I didn't see a connection. And this continued for the next few years until suicidal thoughts began to scare me, and that is when I finally reached out to a therapist for help.

And with the help of that therapist and other supportive friends, my time of self-condemnation and self-punishment came to an end, and I was finally able to enter into a healthy grieving process. In addition to grieving the loss of my child, I slowly became aware of the impact that my choice had on other family members.

My parents believed that somehow they had failed me, and they still grieve over the loss of their grandchild. When I first told my sister, she cried and said she just didn't want to know. She didn't want to know about the niece or nephew that is missing. My oldest son found out when he was quite young, and he still struggles with the loss of the sibling and the reality that I am the cause of that loss. My youngest son hasn't been told yet, and it breaks my heart that some day he will have to deal with this loss.

In addition to coping with the fallout that my abortion has caused to my family, there are still times that are painful for me. After all, healing doesn't mean forgetting. Mother's Day is particularly difficult.

Over the years, I have heard many heartrending stories about abortion. Although each story is unique, a common thread moves through all of them, and that is that abortion changes you. Yet there is no form in place to help abortion participants and those closest to them to explore this tragic truth. Planned Parenthood says one out of four women of childbearing years has had at least one abortion in this country.

Although abortion has touched many of us, we rarely share our personal experiences. Shame or guilt may play a role in secreting our abortions. The rancorous public debate certainly doesn't encourage dialog. We also lack the language to discuss the conflicted emotions that trouble us. Whatever the reason, silence perpetrates the myth that we stand alone in our abortion experiences or at least that we stand alone in our emotional debris.

Very recently, a pro-choice group that tries to stay neutral on this issue released a line of e-cards to women who have experienced abortion. Within the first 7 days, hits on their Web site went from 200 to 15,000 a day, and over a 1,000 of those e-cards were mailed out.

There are tens of millions of women who are hurting, and we are beginning to understand that. But if they don't have a safe place to deal with their emotions, she may need to repress or numb them in order to cope. And that is when she can find herself dealing with prolonged feelings of sadness, nightmares, loss of self-esteem, perhaps eating disorders or substance abuse or even attempted and completed suicides.

Although some women are able to move on from their abortion, many are left with physical or emotional scars that impact them for years and sometimes decades. In all the noise that surrounds abortion, women are often forgotten. I believe it is time to stop that noise and start listening to women who have experienced pregnancy losses.

I have been grateful that you have taken time today to listen, and I do urge you to take steps to understand the impact abortion and other pregnancy losses have on women. Thank you very much.

[The prepared statement of Ms. Fredenburg follows:]

STATEMENT OF MICHAELENE FREDENBURG

Mr. Chairman, good afternoon; my name is Michaelene Fredenburg, I am the president of Life Perspectives, and I live in San Diego, California. I am grateful that you are considering H.R. 20, as it is a critical to study and treat post-partum de-

pression. I am also grateful for the opportunity to testify before this Committee today.

As a teenager, I assumed legalized abortion was necessary for women to attain their educational and career goals. So it's not surprising that when I became pregnant at 18, I thought about having an abortion. I also considered adoption.

My 28-year-old live-in boyfriend was furious when he discovered I was pregnant. He immediately demanded that I have an abortion or he would kick me out. I turned to my employer for advice. After I told her about my situation, she recommended abortion. She said it was the only logical option and offered to arrange one for me.

My experience at the abortion clinic was painful and humiliating—nothing like I'd imagined when I defended a woman's "right to choose." Although the young women awaiting their abortions were anxious and tearful, the clinic staff was cold and aloof. I met briefly with a "counselor" who characterized my 8-week pregnancy as a "couple of cells" and the "products of conception." As I lay alone in the procedure room, I could hear footsteps move down the hall and turn into a room. This was repeated several times, each time the footsteps were louder and closer. My anxiety steadily built and then peaked when the abortion provider and her assistant entered the room. I began to have second thoughts, and I asked the assistant if I could have a few minutes. The doctor yelled, "Shut her up!" and started the suction machine.

It was not an empowering experience. I felt violated and betrayed.

I was completely unprepared for the emotional fallout after the abortion. I thought the abortion would erase the pregnancy. I thought I could move on with my life. I was wrong. Although I didn't feel this way before the procedure, it was now clear to me that the abortion ended the life of my child.

The mere presence of my boyfriend caused deep hurt and pain. I found it difficult to work. I soon found myself in a cycle of self-destructive behavior that included an eating disorder.

Desperate for a fresh start, I broke up with my boyfriend, quit my job, and moved from Minnesota to Hawaii. Although Hawaii was breathtakingly beautiful and bursting with life, I felt dead inside. It didn't take long for me to realize I couldn't escape from myself.

I experienced periods of intense anger followed by periods of profound sadness. For weeks and sometimes months at a time, I was too fatigued to do more than eat a meal and shower during the day. I lost interest in food, and my weight fell dangerously low. There were also periods when I seemed able to pull myself together and lead a normal life—at least outwardly.

I saw a number of doctors for the fatigue and weight loss. They tested me for everything from lupus to cancer to AIDS. I didn't tell them about the feelings I was having as a result of the abortion. I didn't see a connection between the abortion and my current physical symptoms. This continued for the next few years until suicidal thoughts began to scare me. That's when I finally went to see a therapist.

With the help of counselors and supportive friends, my time of self-condemnation and self-punishment came to an end. I was finally able to enter into a healthy grieving process.

In addition to grieving the loss of my child, I slowly became aware of how my choice to abort had impacted my family. A choice they only learned about when I decided to go public with my experience.

Although I repeatedly assured my parents that I never doubted their willingness to provide support and assistance if I'd decided to carry the baby to term, they still believed that somehow they'd failed me and they were at least partly responsible for the death of their grandchild. When I first told my sister, she cried and said she wished she didn't know about the niece or nephew who was missing.

My oldest son found out when he was quite young, and he still struggles with the loss of a sibling and the reality that his mother was the cause of the loss. My youngest son hasn't been told yet. It breaks my heart that one day he'll also have to deal with a loss that I inflicted.

In addition to coping with the fallout that my abortion has caused in my family, there are still times that are painful for me. After all, healing doesn't mean forgetting. Mother's Day is particularly difficult. The year my child would have graduated from high school was also filled with pain.

If my child had gone to college, she would have graduated this year. This child would now be a young woman with gifts and abilities, hopes and dreams—her whole life ahead of her. There will always be a hole in my heart—a hole in the fabric of our family and our community.

Over the years I've heard many heartrending stories about abortion. Although each story is unique, a common thread moves through them all—abortion changes

you. Yet, there is no forum in place to help abortion participants and those closest to them explore this tragic truth.

Planned Parenthood claims that 1 out of 4 women of childbearing years in the United States have had at least one abortion. Although abortion has touched many of us, we rarely share our personal experiences. Shame or guilt may play a role in secreting our abortions. The rancorous public debate certainly doesn't encourage dialogue about this personal and extremely sensitive topic. We also lack the language to discuss the conflicted emotions that trouble us. Whatever the reason, silence perpetuates the myth that we stand alone in our abortion experiences or at least that we're alone in the emotional debris.

It is normal to grieve after a pregnancy loss whether the loss is caused by a miscarriage, stillbirth, adoption, infertility or an abortion. Most of us know someone who has suffered the loss of a child through miscarriage. The loss in an abortion is similar except for two important factors: the woman opted for the abortion, many times succumbing to pressure from others, and the abortion is often kept a secret. An important part of grieving is talking. Since an abortion is typically a secret, it is more difficult to talk about it.

Even when she does want to talk about the abortion experience, her efforts are often met with resistance. Her partner typically doesn't want to talk about it. Well-meaning family and friends may try to "help" her by encouraging her to move on with her life and forget about the abortion. She may fear that pro-life individuals will condemn her and pro-choice individuals deny her feelings. With no safe place to deal with her emotions, she may need to repress or numb them in order to cope.

This repressed grief can lead to prolonged feelings of sadness, nightmares, loss of self-esteem, eating disorders, substance abuse, destructive relationships, an inability to bond with future children or even attempted and completed suicides. If the abortion loss is followed by additional pregnancies losses such as a miscarriage or infertility, the multiple losses will only increase the inner chaos and pain.

Although some women are able to move on from their abortion, many are left with physical or emotional scars that negatively affect their lives for years and sometimes decades.

In all the noise surrounding abortion, women are often forgotten. It is time to stop the noise and start listening to women who have experienced pregnancy losses. I am grateful that you have taken the time to listen and I urge you to continue to take steps to understand the impact abortion and other pregnancy losses have on women.

Mr. PALLONE. Thank you. Dr. Coleman.

STATEMENT OF PRISCILLA K. COLEMAN, PH.D., ASSOCIATE PROFESSOR, HUMAN DEVELOPMENT AND FAMILY STUDIES, BOWLING GREEN STATE UNIVERSITY, BOWLING GREEN, OH

Ms. COLEMAN. Good afternoon, Mr. Chairman, members of the Health Committee. My name is Priscilla Coleman, and I am an associate professor of human development and family studies at Bowling Green State University in Ohio. I have published extensively in both national and international peer-reviewed journals on the psychological effects of abortion. Thank you for the opportunity to address you today.

H.R. 20 pertains to postpartum depression which has fortunately gained attention in recent years with a few highly publicized cases. The psychological suffering experienced by many women and their families following childbirth has been seriously understudied, and this issue is before you today in hopes of expanding research and intervention efforts.

In contrast, the psychological suffering endured by many women post-abortion has received minimal focused attention by lawmakers and governmental agencies. And the emotional distress experienced by countless women is often denied or obscured at various levels of society, despite well-documented scientific evidence.

Abortion is experienced at least once by approximately 35 percent of women by age 45. There is consensus among most social and medical science scholars that a minimum of 10 to 30 percent of women who abort suffer from serious, prolonged, negative psychological consequences. With nearly 1.3 million U.S. abortions each year, the conservative 10 percent figure yields approximately 130,000 new cases of mental health problems each year.

The results of the three largest studies in the world have shown that abortion is associated with an increased risk of mental health problems when compared the childbirth. A proliferation of smaller empirical studies published within the last 10 years in peer-reviewed psychology and medical journals has likewise documented the adverse psychological consequences of abortion. When compared the childbirth, the option of abortion carries an increased risk of depression, anxiety, sleep disturbance, and other forms of mental illness, in addition to suicide, substance use and abuse, relationship problems, parenting difficulties and even suicide.

I would like to highlight one particularly strong study conducted by New Zealander David Ferguson and colleagues. Results of Ferguson's longitudinal study indicated that 42 percent of the women who had aborted reported major depression by age 25. Thirty-nine percent of post-abortive women suffered from anxiety disorders. In addition, 27 percent reported suicidal ideation. Seven percent indicated alcohol dependence, and 12 percent were abusing drugs.

In the published article, Ferguson, an outspoken pro-choice individual, sternly challenged the American Psychological Association's recent conclusion that "well-designed studies of psychological responses following abortion have consistently shown the risk of psychological harm is low" noting that this strong conclusion was based on a small number of studies, which suffer from significant methodological problems as well as a general disregard for studies showing negative effects. Dr. Ferguson was quoted by the New Zealand Herald as saying "if we were talking about an antibiotic or an asthma risk and someone reported adverse reactions, people would be advocating further research to evaluate risks" and "I see no good reason why the same rules don't apply to abortion."

My colleagues and I have diligently, designed, executed and published studies that have addressed the flaws of earlier research. Please see appendix A submitted with my testimony. Among the collective strengths of the studies are the following: use of appropriate control group, unintended pregnancy carried to term, or other forms of perinatal loss, control for preexisting psychological problems, controls for personal and situational factors associated with the choice to abort, use of long-term data collection strategies, use of medical claims data with diagnostic codes assigned by trained professionals, which eliminate the problem of concealment found to be as high as 60 percent in the older abortion studies and large samples, most in the thousands. The need for a large, nationally representative, longitudinal study of women faced with an unintended pregnancy has been voiced repeatedly by researchers, including the former Surgeon General C. Everett Koop in the Reagan administration.

Sociopolitical agendas permeating the design, publishing, funding and dissemination of research have undoubtedly thwarted research

progress. However, in the interest of the millions of women who undergo one of the most common surgical procedures currently available in the United States and elsewhere throughout the world, it is clear that more intensive study is warranted. Such research will continue to be a target of political attacks. Nevertheless, as Thorbin colleagues noted in 2003, "a commitment to such research would seem to be morally neutral common ground upon which both sides of the abortion choice debate would agree is critical." Thank you.

[The prepared statement of Ms. Coleman follows:]

H.R. 20, the Melanie Blocker-Stokes Postpartum Depression and Care Act

Expanded Testimony of Priscilla K. Coleman, Ph.D.

Submitted to the Health Subcommittee,

Committee on Energy and Commerce

U.S. House of Representatives

Washington, DC

May 1, 2007

1. My name is Priscilla Coleman. I am currently an Associate Professor of Human Development and Family Studies at Bowling Green State University in Ohio. My Ph.D. is in life-span developmental psychology and I have published extensively in both national and international peer-reviewed journals on the psychological effects of abortion. The opinions expressed herein are based upon my education, the psychological research I and others have conducted, and my extensive and ongoing review of the world literature on abortion. Thank you for the opportunity to address you today.

2. H.R. 20 pertains to postpartum depression, which has fortunately gained attention in recent years with a few highly publicized cases. The psychological suffering experienced by many women and their families following childbirth has been seriously understudied and this issue is before you today in hopes of expanding research and intervention efforts.

3. In contrast, the psychological suffering endured by many women post-abortion has received minimal focused attention by lawmakers and governmental agencies and the

emotional distress experienced by countless women is often denied or obscured at various levels of society, despite well-documented scientific evidence.

4. Childbirth is the natural conclusion of a human pregnancy; whereas abortion is an unnatural intervention causing the termination of the human fetus. As such, it is reasonable to conclude that the latter might carry increased mental health risks for women, particularly among those who believe they have ended a human life. Indeed, when compared to childbirth, the option of abortion carries an increased risk of depression, anxiety, and other forms of mental illness in addition to substance use/abuse, relationship problems, parenting difficulties, and even suicide. In the text that follows, I will share the contemporary scientific evidence indicating that abortion poses serious psychological risks to a significant percentage of women.

5. Abortion is one of the most common medical procedures in the U.S. and it is experienced at least once by approximately 35% of women by age 45 (Finer & Henshaw, 2006.) There is consensus among most social and medical science scholars that a minimum of 10 to 30% of women who abort suffer from serious, prolonged negative psychological consequences (Adler et al., 1990; Bradshaw & Slade, 2003; Major & Cozzarelli, 1992; Zolese & Blacker, 1992.) With nearly 1.3 million U.S. abortions each year in the U.S. (Boonstra, et al., 2006), the conservative 10% figure yields approximately 130,000 new cases of mental health problems each year.

6. The results of three of the most methodologically sound (i.e., largest record-based) studies in the world have shown that abortion is associated with an increased risk of mental health problems when compared to childbirth. In 1981 David and colleagues reported in *Family Planning Perspectives* that the overall rate of psychiatric admission (a

worst case scenario) was 18.4 and 12.0 per 10,000 for women who had aborted and delivered respectively. For those who were divorced, separated, or widowed, the psychiatric admission rate was 63.8 per 10,000 for women who aborted versus 16.9 for those who delivered.

7. The remaining two studies were conducted in the U.S. using data from over 54,000 low-income women on state medical assistance in California. In the first study published in the *American Journal of Orthopsychiatry*, women who had an abortion in 1989 had significantly higher rates of outpatient psychiatric diagnoses than women with only birth experience and no history of subsequent abortions after eliminating all cases with psychiatric claims 12-18 months prior to the initial pregnancy (Coleman, Reardon, Rue, & Cougle, 2002a). This difference was apparent when data for the full time period were examined (17% higher) and when only data from women with claims filed on their behalf within 90 days (63% higher), 180 days (42% higher), 1 year (30% higher), and 2 years (16% higher) of the pregnancy event were considered.

8. Data from the same sample and focusing on inpatient claims revealed similar findings (Reardon, Cougle, Rue, Shuping, Coleman, & Ney, 2002.) The study was published in 2002 in the *Canadian Medical Association Journal* (CMAJ) and publication resulted in immediate criticism directed at the editors of CMAJ. In response, they published an editorial stating "In light of the passion surrounding the subject of abortion we subjected this paper to especially cautious review and revision." The editors and peer-reviewers obviously came to the conclusion that our study was methodologically sound and worthy of publication in Canada's top medical journal.

9. The CMAJ editors also reminded the readership that scientists continue to play a unique and vital role in understanding the association between abortion and health: "This debate is conducted publicly in religious, ideological and political terms: forms of discourse in which detachment is rare. But we do seem to have the idea in medicine that science offers us a more dispassionate means of analysis. To consider abortion as a health issue, indeed as a medical "procedure," is to remove it from metaphysical and moral argument and to place it in a pragmatic realm where one deals in terms such as safety, equity of access, outcomes and risk–benefit ratios, and where the prevailing ethical discourse, when it is evoked, uses secular words like autonomy and patient choice." *This letter has been submitted with my testimony.*

10. In addition to these three large scale studies, a proliferation of smaller empirical studies published within the last 10 years in upper echelon peer-reviewed psychology and medical journals has likewise documented the adverse psychological consequences of abortion. One study published in January 2006 by New Zealand researcher David Fergusson and colleagues in the *Journal of Child Psychology and Psychiatry and Allied Disciplines* stands out.

11. Fergusson's longitudinal study followed 1265 children born in Christchurch in 1977 and is strengthened by the use of comprehensive assessments of mental health using standardized diagnostic criteria, considerably lower estimated abortion concealment rates than in previously published studies, and the use of extensive controls. Variables that were statistically controlled in the primary analyses included maternal education, childhood sexual abuse, physical abuse, child neuroticism, self-esteem, grade point average, child smoking, history of depression, anxiety, and suicidal ideation, living with

parents, and living with a partner.

12. Results of the Fergusson et al. study indicated that while 42% of the women who had aborted reported major depression by age 25, 39% of post-abortive women suffered from anxiety disorders. In addition, 27% reported experiencing suicidal ideation, 7% indicated alcohol dependence, and 12% were abusing drugs. Compared to the pregnant/no abortion group, the abortion group scored significantly higher on all these variables except anxiety. Compared to the never pregnant group, the abortion group scored significantly higher on all variables. For all outcomes (except alcohol dependence) rates of disorder did not differ significantly between the never pregnant and pregnant/no abortion groups.

13. As noted in the *New Zealand Herald*, Fergusson said there is little evidence that abortion improves mental health and he told CNSNews.com "It is a very sensitive and emotive subject. People have cherished beliefs that they don't want challenged" and "There's a distinct possibility – more than a distinct possibility – that abortion may have mental health consequences." Dr. Fergusson was further quoted by the *New Zealand Herald* as saying "If we were talking about an antibiotic or an asthma risk, and someone reported adverse reactions, people would be advocating further research to evaluate risk." And "I see no good reason why the same rules don't apply to abortion."

14. In the published research article, Fergusson, a pro-choice researcher, and colleagues sternly challenged the American Psychological Association's recent conclusion that "well-designed studies of psychological responses following abortion have consistently shown that risk of psychological harm is low," noting that this strong conclusion was based on a small number of studies, which suffer from significant

methodological problems as well as a general disregard for studies showing negative effects. Fergusson et al. concluded: "the present research raises the possibility that for some young women, exposure to abortion is a traumatic life event which increases longer-term susceptibility to common mental disorders." *The Fergusson et al. paper has been submitted with my testimony.*

15. Peer-reviewed scientific evidence also indicates that women who abort are more likely to abuse substances when compare to women who have not previously aborted. Using data from a nationally representative sample, my colleagues and I found that pregnant women with a prior history of abortion, compared to women without a history, were 10 times more likely to use marijuana, 5 times more likely to use various illicit drugs, and were twice as likely to use alcohol. (Coleman, Reardon, Rue, & Cougle, 2002b). *A copy of this article is submitted with this testimony.* In another paper using a national data set, I found that adolescent women who aborted, when compared to those who carried an unintended pregnancy to term, were six times more likely to use marijuana. *For a review of literature linking abortion to substance use, see Coleman (2005), which is included with this testimony.*

16. Studies have further shown that abortion is related to an increased likelihood of sexual dysfunction, partner communication problems, and separation or divorce (Barnett, Freudenberg, Wille, 1992; Freeman, 1980; Lauzon, Roger-Achim, Achim, & Boyer, 2000; Rue, Coleman, Rue, & Reardon, 2004). For example, in a recently published study, we found that 6.2% of Russian women and 24% of American women sampled reported sexual problems that they directly attributed to a prior abortion (Rue et al., 2004).

17. Research suggests that emotional difficulties and unresolved grief responses associated with perinatal loss may hinder effective parenting by reducing parental responsiveness to child needs, by interfering with attachment processes, and /or by instilling anger, which is a common component of grief. Three of our recent studies have linked abortion with compromised parenting (Coleman, Maxey, Rue, & Coyle, 2005; Coleman, Rue, Coyle, & Maxey, 2007; Coleman, Reardon, & Cougle, 2002). *These articles are summarized in Appendix A.*

18. Several large scale studies have revealed a higher risk of suicide associated with abortion compared to childbirth. These studies are summarized in the table below.

	Control group	**Magnitude of effect**
Fergusson, D. M., Horwood, J., & Ridder, E. M. (2006). Abortion in young women and subsequent mental health. *Journal of Child Psychology and Psychiatry*, 47, 16-24.	Those who delivered and were never pregnant used as comparison groups. Statistical controls for maternal education, childhood sexual abuse, physical abuse, child neuroticism, self-esteem, grade point average, smoking, prior history of depression, anxiety, prior history of suicide ideation, living with parents, living with partner	27% of women who aborted reported experiencing suicidal ideation This effect was significant at the >.001 level, meaning there was on a 1 in 1000 chance that the result was due to chance. The risk was 4 times greater for women who aborted compared to never pregnant women and more than 3 times greater than women who for women who delivered
Gilchrist, A. C. et al (1995). Termination of pregnancy and psychiatric morbidity. *British Journal of Psychiatry* 167:243-8	Comparisons included women who were refused abortion and women who chose abortion but changed their minds.	Among women with no history of psychiatric illness, the rate of deliberate self-harm was significantly higher (70%) after abortion than childbirth
Gissler, M., et al. (1996). Suicides after pregnancy in Finland, 1987-94: Register linkage study. *British Medical Journal*, 313, 1431-4	Compared women who aborted to those who delivered, miscarried, and the general population.	Suicide rate was nearly 6 times greater among women who aborted compared to women who gave birth
Gissler, M., et al. (2005). Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000. *European Journal of Public Health*, 15, 459-463.	Compared women who aborted to those who delivered, miscarried, and were not pregnant. Distinguished the level of risk associated with suicide and other forms of death.	Abortion was associated with a 6 times higher risk for suicide compared to birth.
Reardon, D. C., et al. (2002). Deaths associated with delivery and abortion among California Medicaid patients: A record linkage study. *Southern Medical Journal*, 95, 834-841	Use of homogenous population. Controlled for prior psychiatric history, age, and months of eligibility for state medical coverage	Suicide risk was 154% higher among women who aborted compared to those who delivered

19. Despite this evidence, claims that abortion mortality rates are lower than maternal mortality are often made. The data employed to make such claims is problematic as different standards and methods of data collection are used to assess death rates associated with abortion and delivery. The National Center for Health Statistics (NCHS) through its National Vital Statistics system provides maternal mortality information and the Center for Disease Control (CDC) provides abortion mortality statistics.

20. Specific problems include the following: 1) When a death is violent, a recent birth may not be recorded and a recent abortion is even more unlikely to be mentioned; 2) The International Classification of Diseases (ICD-9) defines maternal death as one that occurs during pregnancy or within 40 days of the termination of pregnancy, regardless of outcome, with "incidental" deaths excluded. The exclusion requires subjective interpretation and it may be unclear what role the pregnancy played in suicide, homicide, and accidents; 3) Coding rule 12 of the ICD-9 required deaths due to medical and surgical treatments be reported under the complication of the procedure (e.g., infection) rather than the treatment (e.g., elective abortion.)

21. No single study has the power to provide definitive answers to the causal question on a topic of this nature because randomized trials are not possible. Instead examination of the cumulative evidence related to the magnitude of effects and consistency of evidence across the strongest studies linking abortion and adverse mental health enables the best possible answer to the causal question. Thus, the studies reported above must be given considerable weight given the nature of public health and risk prevention.

22. In an extensive review of the literature, Bradshaw and Slade (2003) concluded

"The proportion of women with high levels of anxiety in the month following abortion ranged from 19-27%, with 3-9% reporting high levels of depression. The better quality studies suggested that 8-32% of women were experiencing high levels of distress." (p. 941). *Three recent reviews of evidence are submitted in conjunction with this testimony (Bradshaw & Slade, 2003; Coleman, 2006; Thorp, Hartmann, & Shadigian, 2003.)*

23. My colleagues and I have diligently designed, executed, and published studies that have addressed the flaws of earlier research *(please see Appendix A.)* Among the collective strengths of the studies are the following: (a) use of an appropriate control group (unintended pregnancy carried to term or other forms of perinatal loss); (b) controls for pre-existing psychological problems; (c) controls for personal and situational factors associated with the choice to abort; (d) use of long-term data collection strategies; (e) use of medical claims data (with diagnostic codes assigned by trained professionals, which eliminate the problem of concealment found to be as high as 60% in abortion studies); (f) and large samples (most in the 1000s) many of which were nationally representative. When these studies are viewed in conjunction with the world literature, the conclusion that abortion increases mental health risks is reasonable and scientifically accurate.

24. The need for a large nationally representative, longitudinal study of women faced with an unintended pregnancy has been voiced repeatedly by researchers (e.g., Cougle, Reardon, & Coleman, 2003; Speckard & Rue, 1992; Thorp et al., 2003.) including the former Surgeon General, C. Everett Koop, in the Reagan Administration (January 9, 1989 letter to the President). The design of an extensive study of this form would benefit from an effort to include all the demographic, individual, relationship, situational, social, and

cultural factors with possible relevance to abortion decision-making and adjustment over the long-term. In addition, systematic utilization of the existing data that has accumulated should provide useful direction pertaining to variable selection and design specifics. In a review paper published in 2005, my colleagues and I outlined the most pressing research needs pertaining to the psychology of abortion (Coleman et al., 2005)

25. Given the clarity of research needs for advancing our understanding of the meaning of abortion in women's lives that has been evident for quite some time, the socio-political agendas permeating the design, publishing, funding, and dissemination of research have undoubtedly thwarted progress. However, in the interest of the millions of women who undergo one of the most common surgical procedures currently available in the United States and elsewhere throughout the world, it is clear that more intensive study is warranted. Such research will continue to be the target of political attacks. Nevertheless as Thorp and colleagues (2003) noted "A commitment to such research would seem to be morally neutral common ground upon which both sides of the abortion/choice debate would agree is critical." So too argued Surgeon General Koop in 1989(b): "To do such a study which would be credible to both sides of the abortion argument would consume a great deal of time and would be expensive." (p.8) The time has indeed come.

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Mr. PALLONE. Thank you, Dr. Coleman. And our last witness is Dr. Nada Stotland.

STATEMENT OF NADA STOTLAND, M.D., PROFESSOR, PSYCHIATRY AND OBSTETRICS/GYNECOLOGY, RUSH MEDICAL COLLEGE, CHICAGO, IL

Dr. STOTLAND. Thank you. Chairman Pallone and members of the House subcommittee, thank you for the opportunity to speak with you today. I commend the subcommittee for holding this hearing on postpregnancy mental health in women, and I also commend my Congressman, Representative Bobby Rush, for reintroducing the Melanie Blocker-Stokes Postpartum Depression Research and Care Act and for his personal efforts to move this bill through Congress. I greatly appreciate his leadership on this vital issue.

My name is Nada Stotland, M.D., M.P.H. I serve as vice president of the American Psychiatric Association, the medical specialty society representing more than 38,000 psychiatric physicians nationwide and have been a practicing psychiatrist for more than 25 years. I have devoted my career to the psychiatric aspects of women's reproductive health care, and I have treated many women suffering profoundly painful and disruptive psychiatric disorders following what should be a joyous experience, childbirth.

To appropriately treat patients, psychiatrists depend on accurate diagnostic tools to help us identify the mental illnesses suffered by our patients and to determine the care our patients need. The diagnostic and statistical manual of mental disorders, or DSM, has become a central part of this process. DSM provides the most comprehensive diagnostic framework for defining and describing mental disorders and is included in over 650 State and Federal statutes and regulations. DSM-IV is based on decades of research, including systematic empirical studies conducted through 12 field trials involving more than 88 sites in the United States and internationally and the evaluation of more than 7,000 patients. A 27-member task force worked for 5 years to develop the manual, and I was a member of the work group addressing premenstrual dysphoric disorder.

Let us clarify our terms for a moment. When used to describe a mood, the word depression refers to feelings of sadness, despair, and discouragement, which are feelings normal for any person to experience from time to time.

But depression is also a clinical and scientific term, referring to a mental disorder. DSM-IV classifies depression by severity, recurrence, association with mania, and the time of its occurrence specifically including postpartum or after the birth of a baby.

Mental symptoms following childbirth can occur in the form of baby blues or as mental disorders such as postnatal depression or psychosis. Postpartum depression, which is clinical depression occurring after childbirth, is an agonizing and disabling disorder that affects the whole family. It significantly impacts the mother's general and mental health and increases the risk of negative parenting behaviors that measurably impact the child's social, emotional, and behavioral development.

Postpartum psychoses are psychotic disorders arising after childbirth. These are acute, severe illnesses triggered by the biologic

and psychological stresses of pregnancy and delivery that occur after 1 or 2 of every 1,000 births.

Symptoms include severe agitation, mood lability, confusion, thought disorganization, hallucinations, and sleeplessness. The results of misdiagnosis or lack of access to effective treatment can be horrific, with some mothers committing infanticide followed in up to 62 percent of the cases by suicide. Sadly, several such cases have occurred among Representative Rush's constituents.

But since the subject came up, let me comment briefly on the so-called post-abortion depression and psychosis issue. I am familiar with many of the studies advocates for federally funded research use to support their efforts. Many are conducted under the auspices of or by individuals employed by organizations whose purpose is fundamentally political and anti-abortion in nature.

We should be cautious about politicizing Federal research. I want to be clear here. Advocates of earmarked Federal research for post-abortion and depression and psychosis are using a diagnosis that does not exist. The DSM-IV does not recognize any such disorders. H.R. 20, however, deals with very real mental illness that brings needless anguish to tens of thousands of new mothers every year.

Postpartum depression and psychosis are real, and the need for additional research and access to mental health services is widely acknowledged. I hope the subcommittee will not allow itself to be diverted from the agenda of the Melanie Blocker-Stokes Postpartum Depression Research and Care Act that is so deserving of your support.

We need to take postpartum mental health care seriously. All new mothers should be evaluated for depression. Educating physicians, health professionals, patients, and families about the warning signs of serious postpartum conditions is a key aspect of this goal.

I want to call your attention—it was mentioned earlier—to a recent publication from Health Resources and Services Administration entitled "Depression During and After Pregnancy: A Resource for Women, their Families and Friends." This resource addresses postpartum mental health in a straightforward way to help women recognize that they may need help. I have provided a copy of the document for the subcommittee, and I hope it can be included in the record of today's hearing.

This Government document is an excellent resource that should be widely disseminated. I urge you to move H.R. 20 to enactment. It would provide essential funding to develop programs and systems of care to treat postpartum depression and postpartum psychosis. If I may, I would like to suggest that the bill also include funding for programs that will train physicians and other health professionals to recognize serious postpartum mental health issues so patients may be referred to mental health professionals for appropriate care. And we would be happy to work with you to develop this provision.

Finally, the subcommittee and Congress as a whole must recognize that quality care is useless if women can't access treatment because their health insurance discriminates against mental illnesses. It is time to end the artificial divide between mind and body in insurance coverage and to provide treatment for mental ill-

ness in the same manner as other medical and surgical care. I commend the bipartisan majority of this subcommittee for cosponsoring the Paul Wellstone Mental Health and Addiction Equity Act of 2007, H.R. 1424, and I urge all the members of the subcommittee and of the House of Representatives to promote mental health parity.

In conclusion, postpartum depression and the rare postpartum psychosis cause avoidable hurt, misery, and in the extreme, serious injury and death. This act offers hope and practical solutions for women who need help, and I hope the subcommittee will move forward with the agenda in this bill.

Thank you again for the opportunity to speak with you today. I would be happy to answer any questions the subcommittee may have. Thank you.

[The prepared statement of Dr. Stotland follows:]

TESTIMONY OF NADA L. STOTLAND, M.D., M.P.H.

Good afternoon, Chairman Pallone, Vice Chairman Green, Ranking Member Deal, and members of the Health Subcommittee. I am honored to appear before you today.

My name is Nada L. Stotland, M.D. I hold Doctor of Medicine and Master of Public Health degrees and have been a practicing psychiatrist for more than 25 years. Currently, I have a private clinical practice and have devoted most of my career as a physician to the psychiatric aspects of women's reproductive health care.

I speak today on behalf of the American Psychiatric Association (APA), where I presently serve as an elected member of the Board of Trustees. APA is the medical specialty society representing more than 38, 000 psychiatric physicians nationwide. Our members are on the front lines of treating mental illness across the country. They serve as clinicians, academicians, researchers, and administrators.

By way of personal background, my interest in women's reproductive health issues began with the personal psychology of pregnancy, labor, and childbirth. I gave birth to four wonderful daughters, now adults, and I was determined that their births be as safe as possible. I studied methods of prepared childbirth, used them, and became the Vice President of the national Lamaze prepared childbirth organization. My daughter Naomi is now an obstetrician/gynecologist and the mother of two children of her own.

I commend the Subcommittee for holding this important hearing on post-pregnancy mental health in women. Before I begin my testimony, I want to take a brief moment to acknowledge the determined persistence of my own Congressman and a member of the Committee—Representative Bobby Rush—in reintroducing H.R. 20 and in continuing his personal efforts to move his bill through the House. I greatly appreciate his leadership on this vital issue, particularly with respect to the impact of untreated depression in minority populations, including minority women. This is an important and sorely neglected issue.

MENTAL HEALTH ISSUES AND WOMEN

Before focusing on post-pregnancy depression, it would be useful to discuss some general issues related to women's mental health. Burt and Hendrick, writing in their "Concise Guide to Women's Mental Health," put it succinctly, noting that "Women use more health care services than any other group in the United States. They make more visits to doctors' offices than do men, fill more prescriptions, have more surgeries . . . and spend two out of every three health care dollars."

Specific gender differences in the prevalence of mental illnesses in the United States are well recognized. This is true of prevalence rates for some disorders, but also in the way in which some disorders present at the diagnostic interview, and also in comorbidities. For example, not only are depression and dysthymia (a chronic form of depression) more common in women than men, but both are more likely to be accompanied by anxiety disorders in women than men. And the features of psychiatric illnesses present in women are likely to be different than when present in men.

The landmark Surgeon General's Report on Mental Health, issued by then-Surgeon General David Satcher, M.D., in 1999, provides much valuable information. Anxiety disorders (panic disorder, phobias, obsessive compulsive disorder, panic dis-

order, PTSD, etc.) are the most prevalent disorders in adults and are found twice as often in women as in men. Panic disorder is about twice as common among women as men, with the most common age of onset between late adolescence and mid-adult life. In the general (non-military) population, the 1-year prevalence rate of posttraumatic stress disorder is about 3.6 percent, with women accounting for nearly twice the prevalence as men. The highest rates of PTSD are found among women who are the victims of crime, especially rape.

Mood disorders take a huge toll in the form of human suffering, lost productivity and suicide. They rank among the top ten disabling conditions worldwide. The most familiar mood disorders include major depression, dysthymia and cyclothymia (alternating depression and manic states that do not rise to the level of bipolar disorder). Again, with the exception of bipolar disorder, mood disorders are twice as common in women as in men, and in the case of seasonal affective disorder (depression occurring in the late fall and winter), seven times more common in women than men. Victims of domestic violence (an estimated 8 to 17 percent of women in the United States each year) are at increased risk for mental health problems. The mental health problems of domestic violence include depression, anxiety disorders including as noted PTSD, eating disorders, substance abuse and suicide.

Few would doubt the huge impact of depression alone on society and on the economy. Major depression is a seriously debilitating illness. Depressed persons see their physicians more often than others, and misdiagnosed depression can lead to extensive, expensive diagnostic tests (with obvious implications for health care costs). The most serious consequence of untreated depression is suicide. Major depressive disorders account for up to one-third of all deaths by suicide. While men in the U.S. commit suicide four times as often as women, women attempt suicide four times as often as men.

THE IMPORTANCE OF THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM)

Psychiatrists and other mental health professionals depend on accurate diagnostic tools to help them identify precisely the mental illnesses their patients suffer, an essential step in deciding what treatment or combination of treatments the patient needs. The Diagnostic and Statistical Manual of Mental Disorders (or DSM) has become a central part of this process. DSM is, simply, the internationally-recognized standard for the diagnosis of mental disorders. As such, it provides the most comprehensive diagnostic framework for defining and describing mental disorders. DSM-IV is embodied in over 650 state and Federal statutes and regulations.

The DSM-IV is based on decades of research and was developed through an open process involving more than 1,000 national and international researchers and clinicians drawn from a wide range of mental and general health fields. The special 27-member DSM-IV Task Force worked for five years to develop the manual in a process that involved 13 work groups, each of which focused on a section of the manual. I myself was a member of the work group addressing late luteal phase dysphoric disorder, or premenstrual dysphoric disorder, as it came to be known. The work groups and each of their advisory groups of 50 to 100 individuals developed the manual in a three-step process.

The first step in the three-stage empirical review was the development of 150 reviews of the scientific literature, which provided the empirical database upon which DSM-IV decisions could be made. In the second step, task force work groups reanalyzed 50 separate sets of data which provided additional scientific information to that available in the published literature. Finally, the task force conducted 12 field trials with funding from the National Institute of Mental Health, National Institute on Drug Abuse, and the National Institution of Alcoholism and Alcohol Abuse, involving more than 88 sites in the United States and internationally and evaluations of more than 7,000 patients. As you can see, the DSM-IV is based on systematic, empirical studies.

The DSM-IV's codes are in agreement with the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD–9-CM). ICD–9-CM is based on the ICD–9, a publication of the World Health Organization, used worldwide to aid in consistent medical diagnoses.

The DSM-IV's codes often are required by insurance companies when psychiatrists, other physicians and other mental health professionals file claims. The Centers for Medicare and Medicaid Services (CMS) require mental health care professionals to use the DSM codes for the purposes of Medicare reimbursement.

DSM and Depression and Psychosis

One of the more unfortunate aspects of our culture is that we tend to use diagnostic terms in everyday language. We say, for example, that a student who gets a "C" on a mid-term is "depressed," or that someone who is acting in an agitated way is "psychotic." Doing so underscores a misunderstanding of the terms and thus embodies the stigmatic way in which we too-often approach mental illnesses. For purposes of today's hearing it may be useful to briefly discuss depression and psychosis in the context of the DSM.

Depression: When used to describe a mood, the word "depression" refers to feelings of sadness, despair, and discouragement. As such, depression may be a normal state of feelings which any person could experience from time to time. "Depression" is also a clinical and scientific term, and in these contexts may refer to a "symptom" seen in a variety of mental or physical disorders, or it may refer to a "mental disorder" itself. DSM-IV classifies depression by severity, recurrence, association with mania, and time of occurrence, including after the birth of a baby.

Psychosis: Psychosis is part of a severe mental disorder and is characterized by a person's gross impairment in perceiving reality. A psychotic person may be delusional or may experience hallucinations, disorganized speech, or disorganized or catatonic behavior. Psychosis may show up, for example, in patients who are suffering from schizophrenia, delusional disorders, and some mood disorders including manic-depression or bipolar disorder.

Postpartum Psychiatric Disorders

Mental disorders following childbirth was first mentioned over 400 years before the birth of Christ, by Hippocrates, who described the case of a woman in Cyzicus who "gave birth with difficult labor," became sleepless and wandered at night, eventually suffering great distress before becoming rational again.

Today we know from research that disturbances can occur in the postpartum period in the form of "baby blues," or more seriously as postnatal depression or psychosis. Onset of baby blues occurs within days of delivery and can impact a significant number (some suggest 28 to 80 percent) of mothers across cultures. Features include emotional lability; it is unrelated to past history, and the symptoms are self-limited. Women with baby blues benefit from reassurance that the symptoms are common and will quickly disappear, but should be advised to seek help if symptoms are severe or persist for more than two weeks.

Postpartum depression is an affective disorder lasting more than two weeks, typically with an onset beginning two to four weeks postpartum, the severity of which meets criteria for DSM-IV designation. Special attention to postpartum depression is warranted because—in addition to the impact on maternal general and mental health—it increases the risk of negative parenting behaviors and puts children at risk for adverse outcomes in social, emotional, and behavioral development. Many cases are missed because new mothers are discharged so quickly from the hospital, and thereafter most care is provided by physicians focused on the care and wellness of the infant, and many families are uninformed about the nature and occurrence of the disorder. The literature shows risk factors including financial hardship, physical and emotional abuse, and a previous history of depression, particularly depression occurring antepartum.

Postpartum psychoses are psychotic disorders arising after childbirth. These are acute, severe illnesses occurring after one or two of every 1,000 births. Symptoms include mood lability, severe agitation, confusion, thought disorganization, hallucinations and sleeplessness. Most researchers believe that postpartum psychosis is a manifestation of bipolar disorder. These episodes of psychotic illness are triggered by the biologic and psychological stresses of pregnancy and delivery. The results of misdiagnosed psychosis occurring postpartum or lack of access to effective treatment can be, frankly, horrific, with some mothers committing infanticide followed (in up to 62 percent of the cases) by suicide. Sadly, several such cases have occurred among Representative Rush's constituents.

One important factor in responding appropriately to postpartum disorders is to call attention to their existence. New mothers need to understand the difference between "the blues" and feelings of overwhelming and persistent sadness. Physicians can help by preparing their patients with some reassuring but straight talk about the fact that childbirth and new parenthood can indeed be stressful and reactions to motherhood can't always be predicted. Peripartum emotional support is important; families should be included in education efforts, assessment of possible risks, and in the provision of supports. In particular, efforts by policymakers to call attention to the problem are most welcome and helpful.

WHAT CAN BE DONE TO HELP?

Postpartum depression (and the rarer postpartum psychosis) cause needless hurt, misery, and at the extremity, serious injury and even death. First, we need to recognize that these illnesses are absolutely real. As I suggested at the start of my testimony, we have a tendency to incorporate psychiatric terminology into everyday use, using words like "depressed" or "psychotic" in non-clinical ways that misstate and distort their meaning. The same is true of the overuse of the term "baby blues" to colloquially mean anything and everything from transient mild sadness to severe and persistent postpartum depression. Both examples reflect stigma about mental illness and desensitize us to the potentially serious consequences of untreated postpartum depression or psychosis.

Second, we need to take postpartum mental health seriously. If there is any evidence of postpartum difficulties, new mothers should be screened for depression. To achieve this objective, we need to help educate patients, families, and health professionals about the warning signs that a new mother's "baby blues" may, in fact, be a much more serious condition.

I want to call your attention to a recent press release from the Health Resources and Services Administration (HRSA), announcing a publication entitled "Depression During and After Pregnancy: A Resource for Women, Their Families, and Friends." This 20 page booklet can be downloaded in PDF format at *www.mchb.hrsa.gov/pregnancyandbeyond/depression.*

It is a well-written resource that addresses postpartum mental health in a straightforward, non-alarmist way that even includes a simple self-assessment screening instrument to help women recognize that they may need help. I have a copy with me and would be glad to leave it with you for inclusion in the record of today's hearing. It really ought to be widely publicized to physicians, nurses, clinics, hospitals, and community health and mental health centers. I'd like to commend HRSA for producing the pamphlet.

Third, the Subcommittee should move forward with H.R. 20, which Representative Rush has pursued so passionately. The bill lays out a straightforward agenda for research, resource coordination, and improved services to improve the diagnosis and treatment of postpartum depression, and—most importantly—to fund programs to establish and operate programs and systems of care for treating post-partum depression and postpartum psychosis. These include:

- Outpatient and home-based health services
- Case management
- Screening
- Comprehensive treatment services
- Inpatient care management
- Assisted homemaker services
- Respite or daycare
- Family supports

These practical and mostly low-cost proposals would go a long way toward bringing care where it is needed, particularly to lower-income and/or minority populations who may not have the necessary access to services or the means to secure what is needed.

If I might, I'd like to make one suggestion, and that is to include provisions to fund programs to ensure that physicians and other health professionals are fully trained to recognize the possible presence of serious postpartum mental health issues, and thus be able to refer for appropriate follow-up and treatment by psychiatrists or other mental health professionals qualified to provide such care. APA would be glad to work with the Subcommittee if it would be helpful.

Finally, the Subcommittee and the full Congress must recognize that the best diagnostic criteria are useless if women can't get treatment because their health insurance discriminates against treatment of mental illness. It is long-past time to eradicate stigma-driven insurance discrimination and provide for treatment of mental illnesses in the same way that we do other medical/surgical care. Patients should not have to pay more for mental health care, and they should not get less of what they need. Committees in the House including your own are poised to take up mental health parity legislation, and as you know the Senate Committee on Health, Education, Labor and Pensions has already approved the Kennedy-Domenici bill, S. 558. I urge the House to quickly follow suit, and to follow the Kennedy-Ramstad bill with legislation to end similar discrimination against psychiatric care in the Medicare program.

Mr. Chairman, as a woman, as a physician, and particularly as a psychiatrist, I have great sympathy and compassion for all of my patients, women and men, adults

and adolescents, who struggle with mental illnesses. The Melanie Blocker-Stokes Postpartum Depression Research and Care Act offers hope and practical solutions for women who need help, and I hope the Subcommittee with move forward with the agenda in the bill.

Again, if this Congress wants to take one single action that would make a world of difference for all women—for all persons—seeking treatment for mental disorders, I respectfully suggest that the right action would be to enact a Federal law requiring non-discriminatory coverage of treatment of mental illnesses as part of all insurance. It is time to end the artificial mind/ body split in insurance coverage. Well over half the House of Representatives and more than two-thirds of the Senate have cosponsored legislation in this or previous Congresses to achieve this result. On behalf of my patients, I respectfully urge you to address the unmet mental health needs of the nation's women, and men, children and adolescents, by enacting non-discriminatory coverage of treatment of mental illnesses.Thank you again for the opportunity to speak with you today. I would be happy to answer any questions you or other members of the Subcommittee may have.

Ms. DEGETTE. Mr. Chairman, I would ask unanimous consent that the document Dr. Stotland referred to, the HRSA document, be placed in the record.

[The information appears at the conclusion of the hearing.]

Mr. PALLONE. Without objection, so ordered. Sure, we will try to get you a copy. I don't know if we have enough for everyone, but we will get one to you. We are going to take questions now, and I will start out myself with some questions of Mrs. Codey.

I noticed that in your testimony you mentioned the doctors were unable to diagnose you with postpartum depression even though all the signs and symptoms were evident you indicated. So what more do you think this Congress can do to make sure that health care providers are more educated about postpartum depression? I don't know actually if it was the providers who weren't aware. But what can we do so that women don't go undiagnosed?

Ms. CODEY. When I had postpartum depression, I had no idea what it was or that anyone could possibly be down after having a baby, and I think if health care providers in the hospital were educated about postpartum depression, they could have said to me there is this disease called postpartum depression, and we think you have it because you have unplugged your phone and you are withdrawn. I think if they were educated, they could reach out a hand to someone in need and do a lot for women because there was a lot of self-blame on my part.

Mr. PALLONE. So it is not a question of the doctors doing something differently. They just weren't aware?

Ms. CODEY. No, not at all.

Mr. PALLONE. Now, that is significant. I really think that is very significant. Now, in terms of Mr. Rush's bill, the one that we are considering for the H.R. 20, and I know you have the New Jersey bill that has now become the law. How does that dovetail? Do you think that this Federal bill would help women suffering from postpartum depression or even decrease the number of women suffering from it, or is there anything that we should add to the bill? And again I am referencing the New Jersey law, but we don't have to reference that.

Ms. CODEY. I think the way it is worded is excellent, and I just pray that it goes through. I think that postpartum depression, to diagnose it, it sounds so complicated. It is really maybe 10 questions that you have to ask a new mother and just making her

aware that it exists. And maybe somewhere along the first year after birth, she may experience it, is really great. It is a lifesaver.

Mr. PALLONE. OK, thanks a lot really. Thank you so much. Now, there are so few people that experience something, are able to describe it so well, and then are able to lead to changes in the law that are meaningful. So I just want to thank you again.

I wanted to ask Dr. Roca a couple questions. You testified 14 percent of women experience a new episode of depression during the first 3 months of postpartum. What types of studies has National Institutes of Mental Health currently funding to examine the role of stress, hormones, and other factors that might contribute to the development of postpartum depression?

Dr. ROCA. Yes, I did mention, because of the part of the testimony that our intramural program is actually looking specifically at the interplay between reproductive hormone change and stress hormones.

Mr. PALLONE. So tell us a little bit about those studies.

Dr. ROCA. Well, there are studies that are looking at, for example, there seem to be a subgroup of women who are susceptible to mood state changes with reproductive hormone change, drops in estrogen, progesterone, which of course happen at the time following delivery. These reproductive hormones, we know, modulate the stress hormone axis, and so there are some studies ongoing. They are examining the relationship between these two systems, and the reason that is important is that we know in depression of other types, that the stress response in many individuals is disregulated, I guess you could say. It is not acting in the same sort of way that it usually does, so that usually people, when they are stressed, they for example get an increase in cortisol.

People who are depressed appear to have sort of that system in overdrive if you will, that there is this sustained stress response that you don't have under normal circumstances. And so that is one of the things that our intramural researchers are looking at. Now, that is the biological aspect of stress.

We also have some additional extramural studies that are looking at, for example, animal models, again looking at biological stress. Some of the environmental factors that could be stressors, such as domestic violence situations for example, economic stressors, because we know that rates of postpartum depression can be higher in groups of women who are in the lower economic scales.

Mr. PALLONE. OK, thank you very much. I appreciate it. Mr. Deal.

Mr. DEAL. Thank you, Mr. Chairman. First of all is I would like to point out is that I have not only been a sponsor of this current bill but have been a sponsor of it in previous Congresses. And I have no intention of politicizing this issue, and I somewhat am offended that my colleague would think that I am doing that. I am not. I have no intentions of doing so, but I do think we should have empathy for and understand any consequences of the termination of a pregnancy, regardless of the reasons for it. And miscarriage is listed as one of the findings in this bill itself as one of the areas that ought to be looked at perhaps.

In fact, during my wife's four pregnancies, I was the most empathetic father-to-be you could ever imagine. I got morning sickness. She didn't. After the children were born, I even got roseola, which my pediatrician said was not supposed to be anybody other than infants that got it, but I got it. I was empathetic. Thankfully, neither of us suffered from postpartum depression. I did suffer from sticker shock when I got the bill from my second child, who—my wife had become pregnant when I was in the Army, and I had my first child at the Government's expense. It cost me $7 and had no insurance when I got out of the Army and had the second child. I had sticker shock, but I didn't have postpartum depression.

But it is a serious issue, and it is one that deserves serious consideration. And one of the things, Dr. Roca, that I guess we all need to understand, as we dealt with some structural changes at NIH during the last Congress, one of the things we were trying to achieve was to get the institutes to categorize findings to share information. You mentioned a number of different studies that were going on, and I presume those were in different institutes. Has that sharing of information occurred? Is there more that needs to be done in that area?

Dr. ROCA. I think the communication between the institutes has actually been pretty good in this area. We do have a coordinating body through the National Institute of Health's Office for research in women's health. And we also, through a Federal working group called the Safe Motherhood Work Group, coordinate efforts with a number of other Federal partners such as the Center for Disease Control, as I mentioned, the Agency for Health Quality, and also as I mentioned, the booklet that Dr. Stotland showed to the subcommittee was an effort that combined a number of Federal partners that was put out by HRSA.

Mr. DEAL. So we are not duplicating? We are sharing information when it is appropriate?

Dr. ROCA. Yes, I would say that.

Mr. DEAL. All right, is there any prohibition now for NIH undertaking further studies on postpartum depression? There is nothing that would prohibit NIH from doing that, is there?

Dr. ROCA. No, there isn't, and we actually have a program announcement, as I mentioned, that encourages investigators to submit research in this area, both at the, what we call the R0–1 or the Investigator-Initiated Large Grants, as well as the R–21, which is a mechanism that encourages new, smaller studies for people to get pilot data, for example.

Mr. DEAL. All right, so but this legislation would be encouraging at least and assist in that undertaking of this specific area?

Dr. ROCA. I can't comment on the legislation because that is at the level of policy.

Mr. DEAL. All right, I got you. Well, Mr. Chairman, I don't think I have any other questions except to thank the ladies for being here and your input into this issue and discussion and to thank my colleague, Mr. Rush, for his persistence in this and for allowing me to be a part of the process as we attempt to move this issue forward and hopefully see it signed into law. Thank you. I yield back.

Mr. PALLONE. Thank you. The gentlewoman from Colorado.

Ms. DEGETTE. Thank you so much, Mr. Chairman. Sometimes we feel like it is deja vu all over again in this committee. My staff just thoughtfully pulled the testimony from Wednesday, September 29, 2004 at which many of us were present, including myself and Dr. Stotland. And at that hearing—I won't mercifully read everything, but Mrs. Capps and I said at that hearing how the testimony of Ms. Blocker was some of the most compelling testimony that we have ever heard in Congress. And even though this is the second time I have heard it, I would say that again.

It is so compelling, and to think about what you said, Ms. Codey, about how you have this new, little infant, and you are checked into a psychiatric hospital for a month. And they still can't figure out what is the matter with you. It shows two things. Number 1, we really need legislation and research. And No. 2, we really need to do it now. This testimony was from 2½ years ago, and here we still sit here today.

So I want to thank all of the witnesses, and I do want to say to Ms. Fredenburg and Dr. Coleman, I too think that we should really do dispassionate and value-neutral research on anything that would cause a mental disorder. And I especially appreciate you, Ms. Fredenburg, coming in, talking about your own personal issues. I did have some questions for Dr. Stotland, and, Dr. Stotland, I wanted to ask you in her written testimony, Dr. Coleman said that there are three studies, the David and colleagues study in family planning perspectives, the American Journal of Orthopsychiatry, and then a study from 2002 done by Dr. Coleman and some others in the "Canadian Medical Association Journal," which she says show that abortion is associated with an increased risk of mental health problems when compared to childbirth. Are you familiar with those studies?

Dr. STOTLAND. I am familiar in general with that study at the moment.

Ms. DEGETTE. What is your opinion on that general body of literate?

Dr. STOTLAND. Well, let me contradict what Dr. Coleman said about there being no consensus. There is a strong consensus in the psychiatric and psychological communities that there may be a chronological relationship but no causal relationship between abortion and mental health problems. Remember that people who have abortions are generally in difficult circumstances, and we do have deep empathy for that situation. And we do hope that anybody who has any situation before or after any procedure, if we have mental health parity, can get care for it. But there is a consensus, a strong consensus that there is not a causal relationship between abortion and mental disorders.

Ms. DEGETTE. Now, in your last testimony, I asked you the question about these studies, and you had said to me that those studies don't control for the patient's previous mental state. Do you recall that answer?

Dr. STOTLAND. Yes.

Ms. DEGETTE. Would that answer still be true today, or have there been intervening studies in the last——

Dr. STOTLAND. There have been attempts to control for that. There are many other methodological difficulties with the studies,

most prominently that we have to compare women who have abortions with women who would want to have an abortion and are not allowed to. To compare women who have abortions with just women at large or women who have babies is not appropriate. Women who have babies, by and large, want to have those babies, find themselves in better circumstances to support that. And that is a serious methodological problem with much of the negative research.

Ms. DEGETTE. And would you agree with the assertion that Dr. Coleman and others have made that the issue of post-abortion syndrome has not been really studied?

Dr. STOTLAND. No, I would not agree. It has been studied quite a lot, and that is why there is no official diagnosis because there is not a valid body of scientific information to warrant investigating further.

Ms. DEGETTE. Now, I would assume that you would, like me, support any kind of value-neutral research that would lead to the causes of mental health disorders?

Dr. STOTLAND. Overall?

Ms. DEGETTE. Yes.

Dr. STOTLAND. Certainly.

Ms. DEGETTE. And so if there was an adverse effect in general of abortion on people's mental health, I would assume that would be something you would want to have researched and then want to have some protocols around?

Dr. STOTLAND. Well, I have two concerns. One is that we not legislate psychiatric diagnoses because we have a very intense scientific process for doing those. So we not put a label on reactions, which women have many of. And I am also a bit concerned that when we do put a label in erroneously or invent a diagnosis that we frighten a lot of people who are trying to make difficult medical decisions.

But to study the causes of mental illnesses is, of course, something we are all about.

Ms. DEGETTE. And just one last question is how would you see that then as different from what we are trying to do in this hearing today, which is talk about postpartum depression?

Dr. STOTLAND. Well, as you heard from my colleague at the NIH, you have to focus your studies. There are infinite number of things you could study, and you develop further studies on the basis of basic studies that are accepted as valid and go forward from there. You can't study absolutely everything.

Ms. DEGETTE. Thank you. Thank you very much, Mr. Chairman.

Mr. PALLONE. Thank you, Ms. DeGette. Mr. Pitts.

Mr. PITTS. Thank you, Mr. Chairman. Dr. Coleman, your research and that of others like Dave Ferguson from New Zealand seems to be showing that abortion is riskier to women's mental health than childbirth, yet older studies fail to show this. How do you account for this discrepancy? And then secondly, many people tend to think that any negative effects of abortion are mild and short-lived. Is your research indicating that some women may have significant difficulty getting beyond the experience?

Ms. COLEMAN. Thank you for the questions. They are important questions. Actually since 2002, the group that I work with has pub-

lished 14 studies in tab peer-review journals. One was published in the "American Journal of Obstetrics and Gynecology" the No. 1 OB/GYN journal in the world. In that study, we found that women who had a prior abortion had 10 times the marijuana usage and a subsequent pregnancy. That is just an example of one of the findings, but what we have systematically tried to do is to look at the shortcomings of the research in this area, which were dramatic prior to about 10 years ago.

High attrition rates. There were studies published in journals that have the politically correct findings, indicating that women didn't have any problems with abortion. There was one study published in the premier social psychology journal that had a 60 percent dropout rate 3 weeks post-abortion. How can you possibly conclude anything when you lose more than half your sample?

And so there was high dropout rates. Women often conceal an abortion. About half of the women studied don't reveal an abortion. Controlling for previous psychological problems is another issue that we actually have done in six of our studies. We have also look at predictors of the choice to abort, like violence in the home, sociodemographic factors. We have attempted to rule out or to remove those compounds so we have a pure analysis of the association between the abortion and any mental health problems.

So there are all these methodological issues that we have tried to address. We have nationally representative samples that we have used. There are studies where the data was collected by labor department, other bodies, and we happen to find reproductive history in the variable list. But these studies are insufficient in that we are not asking enough questions. We are not getting at the heart of the suffering. We are getting a general picture, and actually Dr. Stotland said that the consensus is that there is not a causal relationship.

Well, if you look at the body of literature, and, yes, we have done longitudinal studies now. Your second question asked about the possibility that women may not get over this or it may not resolve quickly. And actually our longitudinal studies are indicating that prior to the last 10 years, I think the farthest out was about 2 years that were sampled. So the topic has been insufficiently studied, but I would say that we definitely need more research energy funneled into this.

But I would say that the studies that are out there now provide a pretty good case for causality because the perspective, we see that the abortion precedes the mental health problems. We are controlling for extraneous factors. So you can't determine causality with any psychological variable that you can't manipulate. We can't randomly assign women to have an abortion or a baby. That is unethical.

So you work from what you have, and we are building a case, and women are suffering.

Mr. PITTS. Thank you. Michaelene, when you sought help, was the therapist able to adequately diagnose you, and prior to your decision to see a therapist, did anyone suggest that you might be suffering from post-abortion depression? How do you think your experience would have been different had the post-abortion depression been diagnosed earlier on?

Ms. FREDENBURG. Excuse me. I do believe that I would have been spared really years of suffering, and I don't think that even the symptoms would have gotten as far along as they were if we were able to catch it earlier. Part of the problem is that I had never heard anybody talk about this experience or actually any experience after an abortion. And so I didn't even know there was such a thing or to reach out.

When I finally did, it was to someone who I felt was a safe person, and she had said to me that there may be a connection between the two and it was something to investigate. And that something, fortunately she was able to refer me to a therapist, that over time we were able to deal with that. So but I certainly, not knowing—and I find out from so many women, I still hear it 35 years later, that they had no idea that there would be any type of negative, emotional ramifications afterwards. And that is what keeps them suffering in silence for years and decades, and there is no need for that.

Mr. PITTS. What helped you most in your recovery process?

Ms. FREDENBURG. Well, I felt like I was halfway there when someone was able to help me with making a connection between the cause. And once that had happened, there was a lot of work to do after that, but suddenly there was a structure around it. And I had hoped that I could overcome these difficulties. So that to me was the most important thing, and then after that, it was just having the proper care and support and diligently working through this, knowing that there was hope. And then at some point, the hope that I could help others, and I think that is pretty common when we have been through something difficult. If you believe that you can help somebody else, that gives you that extra to push through.

Mr. PITTS. Thank you, Mr. Chairman.

Mr. PALLONE. Thank you. Mr. Rush.

Mr. RUSH. Thank you, Mr. Chairman. Dr. Roca, in your testimony, you stated "NIMH supports an active research base to advance the understanding, treatment and ultimately prevention of postpartum depression. This research continues to be a critical source of information for women, families, and health care providers, seeking better ways of detecting, managing and treating this devastating disease." My question to you is is it safe to assume, based on your testimony, that NIH and the National Institute of Mental Health would benefit from additional dollars and attention in the area of postpartum depression?

Dr. ROCA. I hesitate only because I am here for the science and not the policy. I should mention though that research in this particular area of postpartum depression does benefit from research in other areas of mental illness. For example, a lot of the studies that have been done on depression, major depression, and bipolar disorder, do also inform the work that is being done in postpartum depression. So just to, while we are funding much in this more narrow area, to let you know, that the information that we are gaining in other areas of research will impact this area as well.

Mr. RUSH. Well, do you find that the current research and studies that have been funded include a diverse pool of mothers from

urban and rural areas and multiple ethnicities and various social and economic backgrounds?

Dr. ROCA. This has been a problem overall, trying to make sure that the research is really addressing the broad scope of the American population. I would say in the past that most of the research has been done on white, middle-class subjects. However, we are taking steps to really try to broaden our research.

There is a mandate, if you will, for NIH as a whole, to make sure that all groups are broadly represented in clinical studies and that the National Institute of Mental Health, in particular, we have been taking a look at this early on in grants, making sure they have a diverse pool of subjects.

And also if they are having trouble with recruitment, trying to get them some strategies that they can use to work with communities. And one example of that, for example, is we have a program announcement on community participatory research, and that is really geared towards helping researchers partner with communities so that we can get the diverse background so that our research does apply to all segments of the population.

Mr. RUSH. In the area of educating mothers and families, what strategies do the NIH or NIMH implement to deal with mothers who lack access to the Internet?

Dr. ROCA. Well, I am not sure exactly what studies we have with regards to this area, but I could submit something for the record. In general, much of our work, in terms of disseminating information, is done in partnership with other Federal agencies so that we are not duplicating or spending the resources twice.

Mr. RUSH. Thank you. Dr. Stotland, again I want to welcome you to this committee. Would you discuss the existing resources for the treatment of women with postpartum psychiatric illnesses, both public and private, and their families? Do you find that the existing resources are adequate now, or are they inadequate for the dissemination of information?

Dr. STOTLAND. Thank you for asking that. For both information and treatment, the resources are very sadly lacking. We have had a drastic decrease in both private and public psychiatric beds. Some of the people we have heard about before might not be able to get into a hospital now because there aren't beds. And part of that is because there isn't adequate public or private reimbursement for the hospitals to keep those beds open.

And so we have a crying need for better mental health resources all the way around.

Mr. RUSH. And from your testimony, I have deduced the fact that you believe that health insurance should be extended to include more protection, more funding for mental health issues.

Dr. STOTLAND. Yes, right now, there is terrible discrimination. Most people have no idea. If you went home and looked at your insurance policy today—not yours. Yours is a bit better, I think. But the average person has no idea until somebody in their family gets into trouble that they have fewer visits, fewer days, lower reimbursement. In Medicare instead of a 50 percent co-pay, you would have a 80 percent co-pay if you are going for mental health care. There is gross discrimination going on against people who have these ailments.

Mr. RUSH. It has been testified earlier that one of the conditions, determinant conditions, that exist is stress. Stress plays a very important role in the area of postpartum psychosis of postpartum diseases, illnesses rather. Can you give me some idea about is there any relationship between postpartum psychiatric illness and race and ethnicity?

Dr. STOTLAND. I am glad you asked that question. You asked it a few moments ago as well. We don't have nearly enough information about that. We know that postpartum depression and psychosis, as we just heard from Mrs. Blocker, can happen to anybody of any status. However, we know that people of color don't have as much access to care. We know they are more likely to be poor. We know they are more likely to be subjected to violence. We know that they are more likely to have less support in society and all those things. Plus the fact that there is increased stigma in communities of color about seeking care in the first place.

So there is a very strong need for us to find out those differences and to address those people who are afraid to seek care where we have care.

Mr. RUSH. Thank you very much. And I yield back, Mr. Chairman.

Mr. PALLONE. All right. Dr. Burgess.

Mr. BURGESS. Thank you, Mr. Chairman. I want to thank everyone. This has really been a well thought out and well conducted panel, and I have certainly learned a lot. And I thought I knew a lot coming in, but Dr. Roca, let me ask you because we heard—and unfortunately Ms. Blocker wasn't able to stay with us, but it really seemed to be a problem in her mind that the differential diagnosis between postpartum depression and postpartum psychosis was not made. How critical was that?

Dr. ROCA. It is a critical distinction because postpartum psychosis is a psychiatric emergency. Obviously postpartum depression needs treatment as well, but because postpartum psychosis is often associated with, for example, command hallucinations, in other words, hearing voices to harm their child or with intense suicidal ideation, it is an emergency. So it is a critical distinction to make diagnostically.

Mr. BURGESS. Through three hospitalizations and multiple medical therapies, surely this had to be considered in the differential at some point in a patient who is not responding to what otherwise would—she held the bag up, and I didn't get to see what was in it. But I have got to assume there was maximum medical therapy exerted for postpartum depression within the confines of that plastic bag. Don't you think?

Dr. ROCA. She did mention, I believe, that there were antipsychotics in there. I don't know——

Mr. BURGESS. Well, let me ask you this. Are there cases that are just with treatment that no matter how hard we try and how much we recognize and how much we do that they are just tough cases and they don't respond to treatment? I don't know. I am not a psychiatrist, so I am asking you.

Dr. ROCA. In any psychiatric or medical condition, there are cases that are more difficult to manage, yes.

Mr. BURGESS. Yes, I believe that is true as well. Again I referenced in my opening statement that I lost a patient at 20 weeks who took her own life. And obviously that wasn't postpartum, but it was clearly, even to this day, some of it was pretty hard on me as her caregiver. And just imagine what her family went through. I have just got to tell you. I don't think I have ever prescribed a monomenoxabase inhibitor in my entire life. I didn't even know they were still around. But is that one of the things that is out there in the armamentarium?

Dr. ROCA. Yes, MAO inhibitors are still used.

Mr. BURGESS. Are they any better than the norepinephrine reuptake inhibitors?

Dr. ROCA. Well, it depends on the individual. They are effective treatments, just as the SOIs or tricyclics are. But again it depends. One of the problems that we have is that in psychiatry as well as other areas of medicine, trying to understand which medication is right for which patient is quite difficult.

Mr. BURGESS. And I alluded to the promise of genomic medicine at some point, which perhaps will unlock some of those secrets for us. Ms. Codey, were you prescribed the monomenoxabase inhibitor again during the second pregnancy or after the second pregnancy?

Ms. CODEY. Yes.

Mr. BURGESS. And did it have the same beneficial effect the second time as it did the first time?

Ms. CODEY. Yes.

Mr. BURGESS. So he knew that was the right medicine? It just took a long time to figure it out?

Ms. CODEY. Yes

Mr. BURGESS. Let me, Ms. Fredenburg, and I do appreciate you being here as well. I will just have to tell you that I started medical school about 2 years after *Roe* v. *Wade* passed. So it was always part of the background during my medical practice, but just as you, probably about 1989, 1991, I became aware that I was seeing patients who had a problem around an anniversary date or a Mother's Day or the graduation of their child, their oldest living child, from high school, which clearly related back to an episode that they had suffered in the past.

And, Dr. Roca, you alluded, I think, post-traumatic stress disorder, we would argue, has a hormonal basis to some degree at least at the initiation because of the rapid outpouring of cortisol and hormones. So there is some point a hormonal basis for the late onset of whatever we want to label it, the adult situational reaction, the delayed post-traumatic stress disorder, or the post-pregnancy lost disorder that Ms. Fredenburg identified. And again I think she did a good job about identifying it.

My experience, those conditions were relatively amenable to treatment. They obviously weren't psychotic episodes. They were depressive episodes but relatively amenable to treatment such that the average trained OB/GYN could handle those cases.

Dr. Stotland, let me ask you a question. You have studied late luteal phase dysphoric disorder?

Dr. STOTLAND. I have. We don't call it that anymore, but yes.

Mr. BURGESS. What do we call it now?

Dr. STOTLAND. We call is premenstrual dysphoric disorder.

Mr. BURGESS. Well, I love the DSM too, but premenstrual syndrome, for those who like to read the magazines, DMS is the popular vernacular.

Dr. STOTLAND. A more severe form.

Mr. BURGESS. And what is it about the late luteal phase, do you think, that makes it a time that a woman is particularly vulnerable to that dysphoria?

Dr. STOTLAND. Well, let me say two things. One of the reasons we changed the name is because we really couldn't link it to the precise hormonal levels at different times of the menstrual cycle, especially the late luteal phase. And some very interesting and creative studies were performed on that. But let me also say that there seems to be a group of women who are particularly sensitive to times of hormonal change.

Mr. BURGESS. And I would agree with that statement very much. But it has always seemed to me, and I don't know that I am smart enough to know the answer or how the modulation occurs. But progesterone, and estrogen level to some degree, but progesterone seems to be a recurrent theme in premenstrual tension or premenstrual syndrome, postpartum depression.

The placenta is an organ that can produce progesterone under—the ovary can't even possibly keep up with what the progesterone that a placenta is able to produce on an average day. And as soon as the placenta is delivered, those levels plummet like a rock. So it is always in my mind—I have associated that perhaps there is some sort of trigger mechanism.

But I will also say I was never universally successful at treating postpartum depression with additional progesterone and the promise of progesterone supplements an even what I used to call late luteal phase dysphoric disorder, never seemed to be quite as complete as I would have liked. But still progesterone was sort of a common thread running through those things, and again I will acknowledge that estrogen levels are as well. But does it not seem reasonable to include the woman who lost a pregnancy, either through a spontaneous or an elective termination of pregnancy? Does it not seem reasonable to include that progesterone or that hormonal event in the broad spectrum of conditions that we are considering today?

Dr. STOTLAND. Well, we have heard that hormonal studies are underway at the NIMH in terms of postpartum depression. Postpartum depression has been described since the time of Hippocrates. Of course, an overall look at the effects of times of hormonal changes. A lot of dispute about menopause. There is a lot of dispute about—or discussion I should say—about contraceptives, hormonal contraceptives.

Mr. BURGESS. So the science is far from settled.

Dr. STOTLAND. Right. And so, of course, studying the effects of hormonal change is important, and it has been frustrating that it would seem obvious that something is missing. And yet when you put it back, at least by mouth, it doesn't solve the problem.

Mr. BURGESS. But by——

Mr. PALLONE. We are going to have to stop here. We are almost——

Mr. BURGESS. What——

Mr. PALLONE. Three minutes. No, you are almost at 3 minutes over.

Mr. BURGESS. But the chronological issue here is one that I think is particularly important. And I will submit that question in writing, Mr. Chairman. I thank you for your indulgence. You are very kind.

Mr. PALLONE. Anybody gets anything in writing will be pleased to follow up in writing. I recognize Mrs. Capps.

Mrs. CAPPS. Thank you, and what a terrific panel this has been, and I appreciate all of your testimonies. I am always struck because I have heard Carol Blocker speak before about that poignant, dramatic situation, and former first lady or first lady—currently—Codey of New Jersey. It is very brave for someone actually experiencing this to be—and especially someone public like yourself—to be willing to campaign in the way you are. And that is wonderful that you are championing what many women want to have said on their behalf because they are not as able or willing to do it as you are, and it is very eloquent.

I want to ask questions of Dr. Roca and Dr. Stotland, and I wish I had—I will be like Dr. Burgess and want way more time.

Mr. BURGESS. I will give you more time.

Mrs. CAPPS. Yes, you would, but I don't think the chairman will. Dr. Roca, your testimony is excellent. You mention the effects in it of not treating depression that occurs, the effects on the infant. That is what I would like to see, and on the family constellation. If treating depression while a woman is pregnant is ignored or not noticed, what impact is this likely to have in this sort of fragile time of a newborn coming home?

Dr. ROCA. Well, there is a literature that suggests that women who are depressed in the postpartum, in that early bonding period, that there can be some cognitive and behavioral changes in the infant, depending on how able that mother is to interact with that child.

Now obviously people have different levels of depression and different ability to interact. But that is a concern that untreated depression can affect that early development in the newborn.

Mrs. CAPPS. OK and that has huge ramifications on the whole family setting I am sure. Dr. Stotland, you were nodding during that, and I remember very well your testimony in a similar panel here in the last Congress. We have got this new addition today of discussion on post-abortion depression. To me, there is a lot of issues about women and mental health that we have not come to terms with. We need to address many issues. I am very concerned about the effects on PTSD on women in the military, for example. It is coming, and there might be some similarities. If you would identify the kinds of studies that have been sort of dwelling on post-abortion depression, but then there is this dramatic situation of full-blown psychosis. And is that purely distinctive—that is associated with giving birth. Is that unrelated? Would that have responded to mental health therapy during the pregnancy?

Dr. STOTLAND. Exactly. Let me see if I can tease out something I can answer. First of all, yes, there are adverse effects to not treating depression both during pregnancy and after. It can result in small babies, prematurity, et cetera. Ask me another question.

Mrs. CAPPS. The one that has to do with is this the same as post-abortion?

Dr. STOTLAND. Well, in terms of postpartum psychiatric illnesses meet the same criteria as illnesses occurring at other times, but since that is a particularly vulnerable time, they have been noticed, as I said, since the time of Hippocrates. And they are basically—not everybody who has a first episode of postpartum psychosis, like Melanie Blocker-Stokes, has any warning. It can just happen after delivery.

Mrs. CAPPS. So there could be this out-of-the-blue kind of experience?

Dr. STOTLAND. Absolutely.

Mrs. CAPPS. And that is clearly a psychosis?

Dr. STOTLAND. Yes.

Mrs. CAPPS. Not just an extreme form of depression?

Dr. STOTLAND. No, although some people get depressed and depressed and depressed, as you heard again from Mrs. Blocker, and then the psychotic symptoms begin to come out. And that is called psychotic depression.

Mrs. CAPPS. I see.

Dr. STOTLAND. Many women who have postpartum depression without psychosis have had depression during pregnancy, and we need to pick that up. That is going to an important part of our research as well. Right now, the American Psychiatric Association and the American College of Obstetricians and Gynecologists have a joint task force working on the treatment of depression during pregnancy because of the concerns about medication and, in fact, just yesterday, we were having a conference call.

Reference was made to interpersonal therapy and cognitive behavioral therapy, and I had to say on the call but nobody can get them. Those are the ones we have evidence for, and there are not enough people trained, never mind that your insurance won't pay for it, to provide that care. So we need training and treatment money as well as research money.

Mrs. CAPPS. So this hearing today is the tip of the iceberg?

Dr. STOTLAND. Yes, it is.

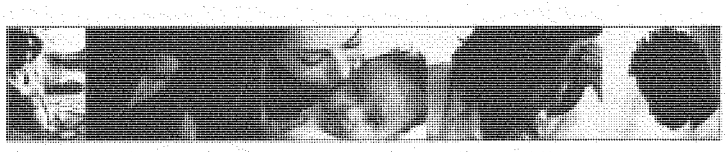
Mrs. CAPPS. Thank you very much. Thank you all.

Mr. PALLONE. Thank you. Well, the panel was very important not only in terms of our getting at the issue of legislation before us, but I think just in general in terms of educating us all about the type of research and what needs to be done in the future. And I want to thank you all for having the courage to come here and talk about your personal situations in some cases, and the other cases, with those who have the professional expertise. That has also been very enlightening. So we do intend to move this bill fairly quickly, so you know. We know that it has been hanging around far too long, as some of the Members have suggested. So you are not just here today for the hearing. You are here to help us move this bill as quickly as we can.

Thank you very much. I will just remind members that you can submit additional questions for the record to be answered so the witnesses may get additional questions. We should have those within the next 10 days or so. And without objection, this meeting of the subcommittee is adjourned.

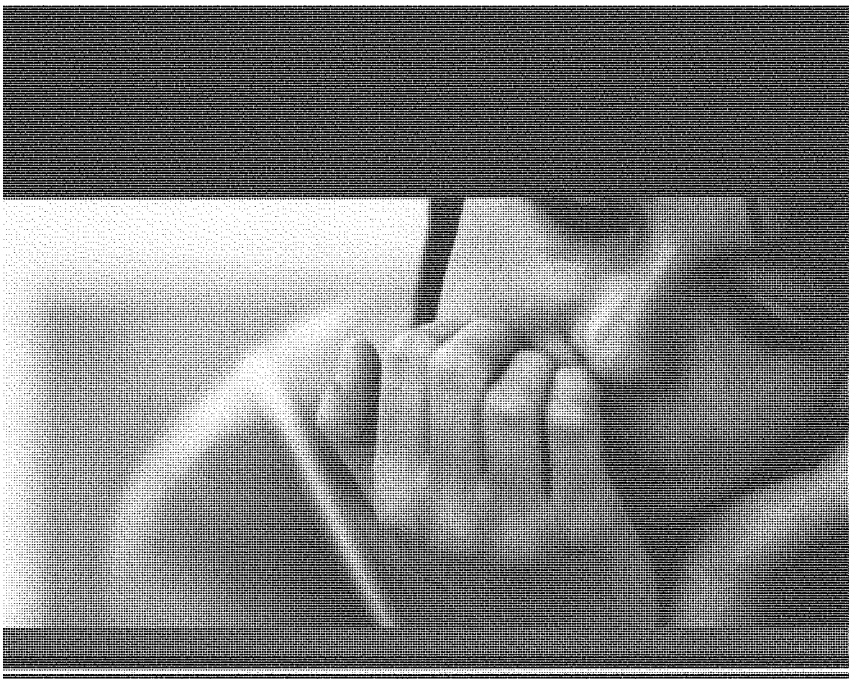
[Whereupon, at 2:25 p.m., the subcommittee was adjourned.]
[Material submitted for inclusion in the record follows:]

Depression During and After Pregnancy



A Resource for Women, Their Families, and Friends

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration



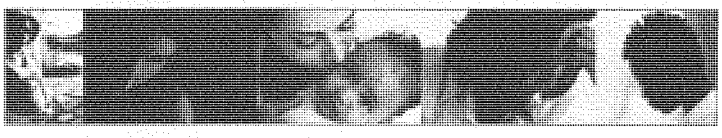
"I have trouble eating and sleeping. I feel lonely, sad, and don't have the energy to get things done. Sometimes I don't even want to hold my baby. If this is supposed to be the happiest time of my life, why does everything feel so wrong?"

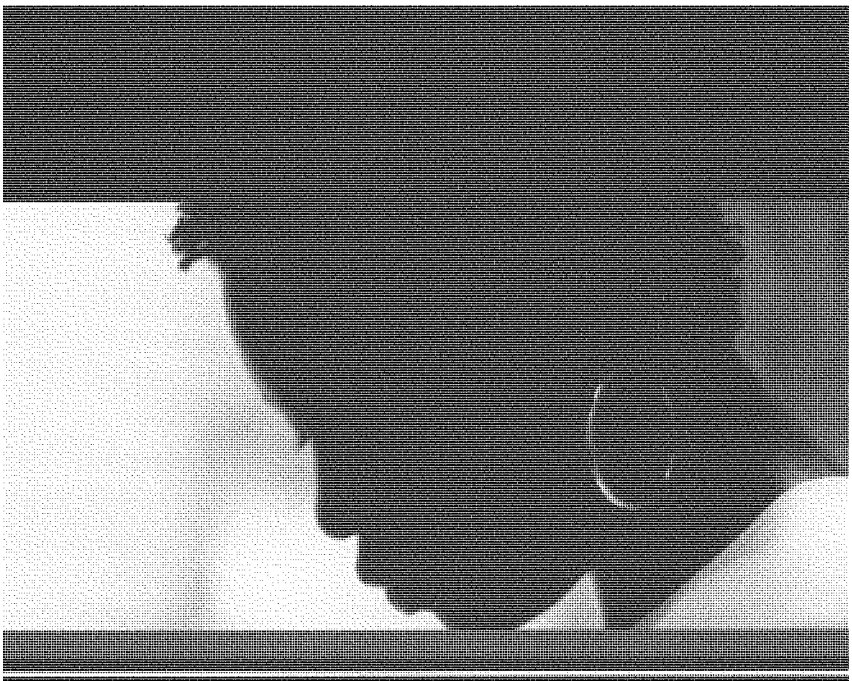
For many mothers, the experience of pregnancy and childbirth is often followed by sadness, fear, anxiety, and difficulty making decisions. Many women have difficulty finding the energy to care for themselves, their infants, and their families. Some even have feelings about harming themselves and their children.

If this sounds like you or someone you know, there are two important things you should know.

You are not alone.

Help is near.

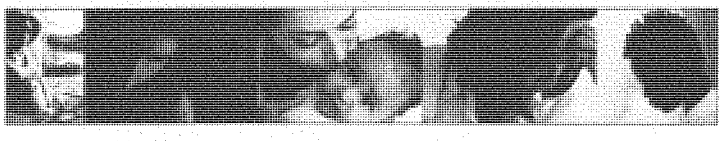


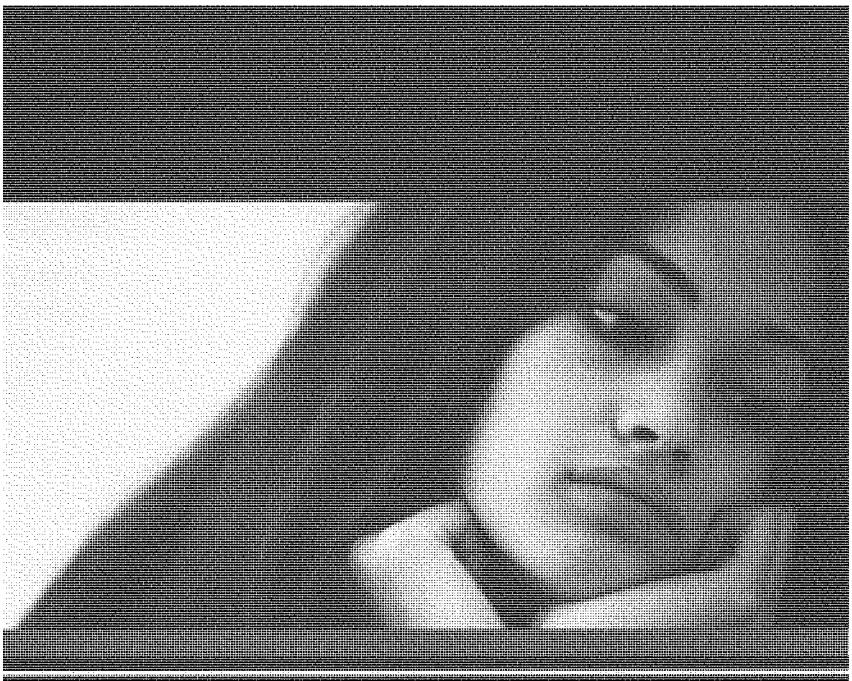


Did things change after you became pregnant? Are things different than you expected as a new mother? Are you tired, anxious, sad, and confused? This booklet will begin to explain the possible causes for your feelings—and more importantly— how to find the help you need.

Depression during or after pregnancy refers to a broad range of physical and emotional struggles that many women face. You may have heard this called the "Baby Blues," Postpartum Depression, Maternal Depression, Prenatal Depression, Postnatal Depression, or Perinatal Depression. In this booklet, we will call it **Perinatal Depression.**

Perinatal Depression can be mild, moderate or severe. It can occur during pregnancy or within a year after the end of your pregnancy. Without treatment, symptoms may last a few weeks, months, or even years. In rare cases, the symptoms are severe and indicate potential danger to the mother and baby. **In all cases, help is available.**





"Everybody expects me to be the perfect mother, but I just can't do it. Sometimes I feel like I can't even care for my baby."

What Causes Perinatal Depression?

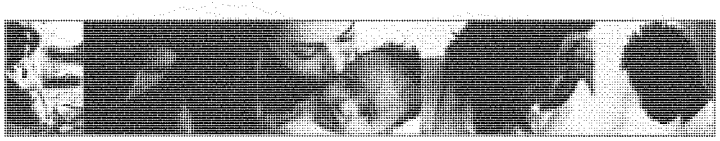
There are a number of reasons why you may get depressed. As a woman, your body undergoes many changes during and after pregnancy. You may experience mood swings. A new baby will change your sleeping schedule and your lifestyle. In addition, there are many pressures to be the perfect mother.

Some women have family members with depression, some women have had depression in their own past, and for some women, the cause is unclear. But for every woman who suffers Perinatal Depression, the causes are as unique as she is.

Perinatal Depression – It's More Than the Baby Blues

Many new mothers experience the Baby Blues. This is a very common reaction during the first few days after delivery. Symptoms include crying, worrying, sadness, anxiety, mood swings, trouble concentrating, difficulty sleeping, and not feeling yourself.

The Baby Blues is not the same as Perinatal Depression and does not require medical attention. With time, patience, and the support of family and friends, symptoms linked with the Baby Blues will usually disappear within a few days or within 1 to 2 weeks. If they don't, it may be a sign of a bigger problem, and you should seek medical help.



"I was so excited I decorated the nursery months before the baby arrived. But when she came, it was not a dream. I had no energy to smile or even to cry. I didn't even want to pick her up. This was not how I thought it was going to be, and I was ashamed of how I felt."

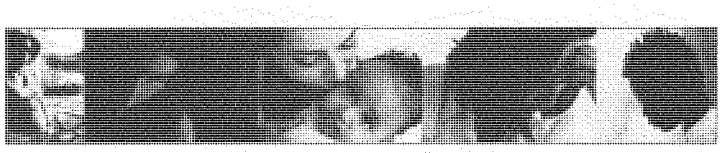
Who Is at Risk?

Perinatal Depression can affect any woman—regardless of age, race, income, culture, or education. It affects women who breastfeed and those who don't. It affects women with healthy babies and those whose children are ill. It affects first-time mothers and those with more than one child. It affects women who are married and those who are not. Women who had problems during pregnancy—and those who didn't—may experience depression. Because Perinatal Depression is a health problem, **it is not the fault of any woman.**

A family history of depression or bipolar disorder, a history of alcohol or drug abuse, a recent stressful event, relationship or financial problems, or a previous pregnancy with Perinatal Depression increases a woman's chances of having Perinatal Depression.

Types of Perinatal Depression

Even before the arrival of the baby, some women experience **Depression During Pregnancy**. Pregnant women commonly face a large number of challenges, including morning sickness, weight gain, and mood swings. Symptoms such as feeling really tired, appetite changes and poor sleep are often dismissed as "just part of pregnancy," but if the things you do every day are affected, you should consider seeking help. Whether the pregnancy was planned or unexpected, the changes that your body and emotions go through during pregnancy are very real—and so are the risks of Perinatal Depression during this time.



“I just wish that I could laugh and be happy. When will my sadness go away?”

About one in eight women suffers a form of Perinatal Depression known as **Postpartum Depression.** Symptoms can begin at birth or any time in the first year after giving birth.

Common symptoms for perinatal depression include:

- Sad feelings
- Feeling very anxious or worrying too much
- Being irritable or cranky
- Trouble sleeping (even when tired) or sleeping too much
- Trouble concentrating or remembering things
- Trouble making decisions
- Loss of interest in caring for yourself (for example, dressing, bathing, fixing hair)
- Loss of interest in food, or overeating
- Not feeling up to doing everyday tasks
- Frequent crying, even about little things
- Showing too much (or not enough) concern for the baby
- Loss of pleasure or interest in things you used to enjoy (including sex)

A very small number of women (one or two in 1000) suffer a rare and severe form of Perinatal Depression called **Postpartum Psychosis.** Women who have a bipolar disorder or other psychiatric problem may have a higher risk for developing this form of Perinatal Depression. Symptoms of Postpartum Psychosis may include:

- Extreme confusion
- Hopelessness
- Cannot sleep (even when exhausted)
- Refusing to eat
- Distrusting other people
- Seeing things or hearing voices that are not there
- Thoughts of hurting yourself, your baby, or others

If you or someone you know fits this description, please seek medical help immediately. This is a medical emergency requiring URGENT care.

Am I a Good Mother?
"I was worried about what would happen if people thought I couldn't be a good mother. But when I got help, I realized that I was still the one in control."

How Do I Know if I Have Perinatal Depression?

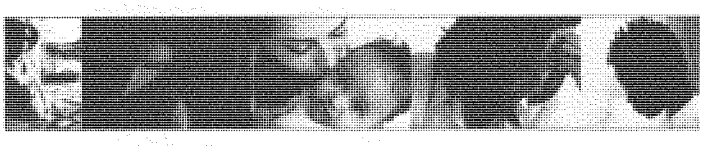
Only a trained health care or mental health professional can tell you whether you have Perinatal Depression. However, the following checklist can help you know whether you have some of the common symptoms. Mark the box if the statement sounds familiar to you.

During the past week or two –

- ☐ I have been unable to laugh and see the funny side of things.
- ☐ I have not looked forward to things I usually enjoy.
- ☐ I have blamed myself unnecessarily when things went wrong.
- ☐ I have been anxious or worried for no good reason.
- ☐ I have felt scared or panicky for no good reason.
- ☐ Things have been getting the best of me.
- ☐ I have been so unhappy that I have had difficulty sleeping.
- ☐ I have felt sad or miserable.
- ☐ I have been so unhappy that I have been crying.
- ☐ The thought of harming myself, my baby, or others has occurred to me.

Did you check more than one box? If so, we encourage you to visit with a trained health care or mental health care professional who can help determine if you are suffering from Perinatal Depression and advise a course of action.

Checklist adapted from the Edinburgh Postnatal Depression Scale. Cox, J.L., Holden, J.M. & Sagovsky, R. (1987). "Detection of Postnatal Depression: Development of the 10-item Edinburgh Postnatal Depression Scale." British Journal of Psychiatry, 150,782-876.



"Some of the symptoms sounded just like me. I knew it was important to talk to my doctor."

If I Have Perinatal Depression, What Can I Do?

Some women may find it hard talking about Perinatal Depression. They may be unsure if they have it or how to discuss it. They may wish to deal with their problem secretly and hope that it goes away on its own.

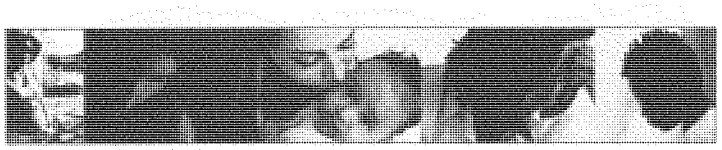
These feelings are more common than one would expect. However, every woman must realize that she is not alone. Perinatal Depression affects thousands of women and can be treated successfully. It *is* possible to feel better. Here are some things that can help.

1. Lean on Family and Friends

There are many ways that family and friends can help you. A few hours of weekly child care can give you a much-needed break. Get help cleaning the house or running errands. When you share your feelings openly with friends and family, it allows them to provide the important support that you need.

2. Talk to a Health Care Professional

Screening for Perinatal Depression should be a routine part of your health care during and after pregnancy. Health care professionals—such as your doctor, your baby's doctor, a nurse, or other health care provider—are familiar with Perinatal Depression. They know ways to help, and can explain your options to you. An easy way to raise the subject is to bring this booklet with you to the provider's office. Show the items that you checked and discuss them. Say that you were reading the booklet and some of it sounds familiar to you. If you feel that your provider does not understand what you are going through, please do not give up. There are many excellent providers who *do* understand Perinatal Depression, who are ready to listen to you, and who can put you on the road to recovery.



"Meeting with my support group is the best part of the week. When I found women going through the same things as me, I didn't feel so lonely any more. Now we are moving forward together, hand in hand."

3. Find a Support Group

Although you may not know it, there are probably other women in your community suffering from Perinatal Depression. Finding them can give you a chance to learn from others and to share your own feelings. Ask your health care professional how to find and join a support group.

4. Talk to a Mental Health Care Professional

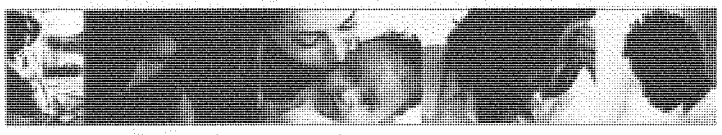
Many mental health professionals have special training to help women with Perinatal Depression. They can give you a safe place to express your feelings and help you find the best ways to manage and even get rid of your symptoms. When choosing counselors or other professionals, ask if they have experience in treating Perinatal Depression. They have helped other women with depression and they can help you too!

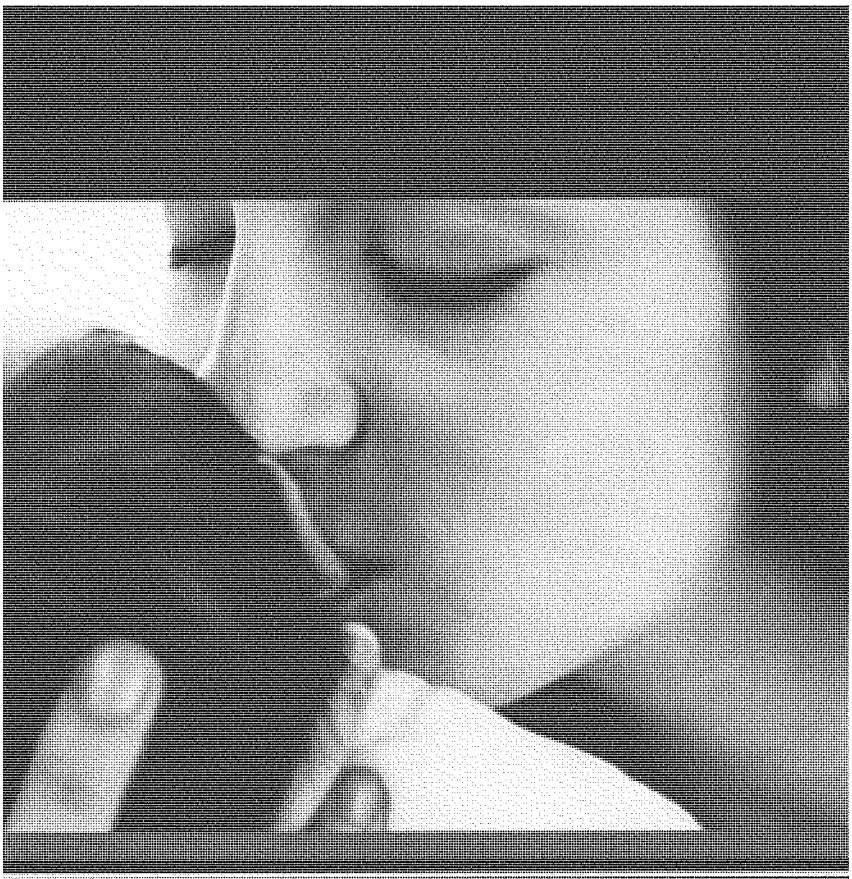
5. Focus on Wellness

An important step toward treating Perinatal Depression is taking care of your body. A healthy diet combined with exercise can help you gain your lost energy and feel strong. Consider these suggestions:

Food

- Eat breakfast in the morning to start your day right
- Eat a variety of foods from all food groups, including two servings of fruit and three servings of vegetables each day
- Choose healthy snacks like non-fat milk, yogurt, fruit, and nuts
- Avoid alcohol use





"When my doctor suggested taking medicine, I wasn't sure. But it turned out to be the best decision for me. I feel so much better now."

Exercise

- Invite your friends to go on walks in your neighborhood or to the park
- Try a new activity, such as swimming or biking
- Take time to stretch and strengthen your muscles

In addition, by prioritizing the most important things in your life and letting go of what is least important, you can clear your mind to focus on your own health and well-being.

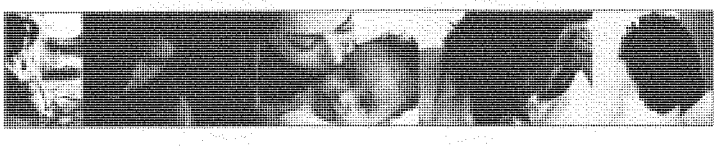
6. Take Medication as Recommended by Your Health Care Provider

Sometimes medications are necessary in the treatment of depression. As with any medications or medical treatment, you should talk to your health care provider about which medication, if any, may be best for you. Become an educated consumer and find out information about treatment options.

Additional information resources are available on page 21 of this booklet.

How Can Perinatal Depression Affect My Baby and My Family?

The symptoms of Perinatal Depression often create a very difficult situation for families. For infants, the effects of Perinatal Depression can be serious. There is a greater chance of babies arriving too small or too early, or having problems in learning and behavior as they grow older. Older children suffer when they lose the attention and support of their mother. Loved ones suffer because they don't know what to do or how to help. Other family members are often called upon to fill the gap. Because Perinatal Depression affects the entire family, it is critical that family members recognize the symptoms and help their loved one seek help.



"Something wasn't right in our family. She felt so much sadness instead of joy. Together we decided to get help. Now that I understand what is happening, I can offer her more of the support she needs."

Advice for Fathers, Family, and Friends

If you know a woman who has the symptoms of Perinatal Depression, this is how you can help.

As a Spouse or Partner:

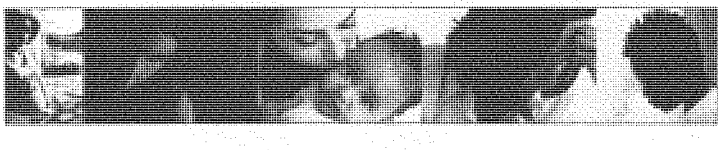
- **Encourage her to seek help.** This is the quickest path to recovery.
- **Offer support and encouragement.** Your positive actions and words can reduce some of her suffering.
- **Listen.** Her feelings are real. Let her express them to you.
- **Allow her to focus on her own needs.** Physical and social activities help women suffering from Perinatal Depression feel stronger, more relaxed, and better about themselves.
- **Take time for yourself.** It is important for spouses and partners to continue with their work, hobbies, and outside relationships.

As a Friend or Family Member:

- Ask the mother how you can help, including baby-sitting and house cleaning.
- Let her know you are there for her, even if she doesn't like talking.
- Understand that the father may also feel stressed from the changes that come with being a new father or by a partner who is suffering from Perinatal Depression.

Where Can I Get More Information?

There are many excellent resources on Perinatal Depression. At your local public library, you can use the Internet or check out books to get important information. There are telephone hotlines and support services where you can ask questions. Also, your health care provider may have additional resources. The more you understand about Perinatal Depression, the better you will be able to care for yourself and the ones you love. A list of resources is located on page 21.



"I recognized the symptoms and took charge. It was not easy, but with support from my family, friends, and doctors, and drawing on my own personal strength, I overcame Perinatal Depression and today I am moving forward. My family is well. My baby is well. And most importantly, I am well."

Where Help is Available

Postpartum Support International
Phone: 800-944-4PPD (800-944-4773) / Internet address: http:// www.postpartum.net
For information on treatment, support groups and resources in the United States and 25 countries.

Postpartum Education for Parents
Phone: 805-967-7636 / Internet address: http://www.sbpep.org
A 24-hour support line is available for one-to-one support, from basic infant care to the baby blues and other perinatal topics.
(This may be a Long Distance call.)

1-800-311-BABY (1-800-311-2229)
(In Spanish: 800-504-7081)
For information on prenatal services in your community.

Additional Resources

National Mental Health Association
Phone: 800-969-NMHA (800-969-6642) / Internet address: http://www.nmha.org
For information on Perinatal Depression, including a locator to find a mental health center or provider in your area.

SAMHSA National Mental Health Information Center
Phone: 800-789-2647 / Internet address: http://mentalhealth.samhsa.gov
For information on depression, including a locator to find a mental health center in your area.

National Women's Health Information Center
Phone: 800-994-WOMAN (800-994-9662)
Internet address: http://www.4woman.gov or http://www.womenshealth.gov
Frequently asked questions about depression and pregnancy are available on the Web site.

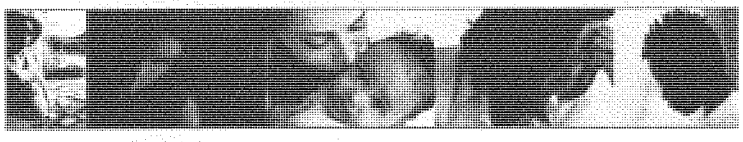
National Institute of Mental Health
Phone: 866-615-6464 / Internet address: http://www.nimh.nih.gov
The Web site has links to health information and research studies on depression.

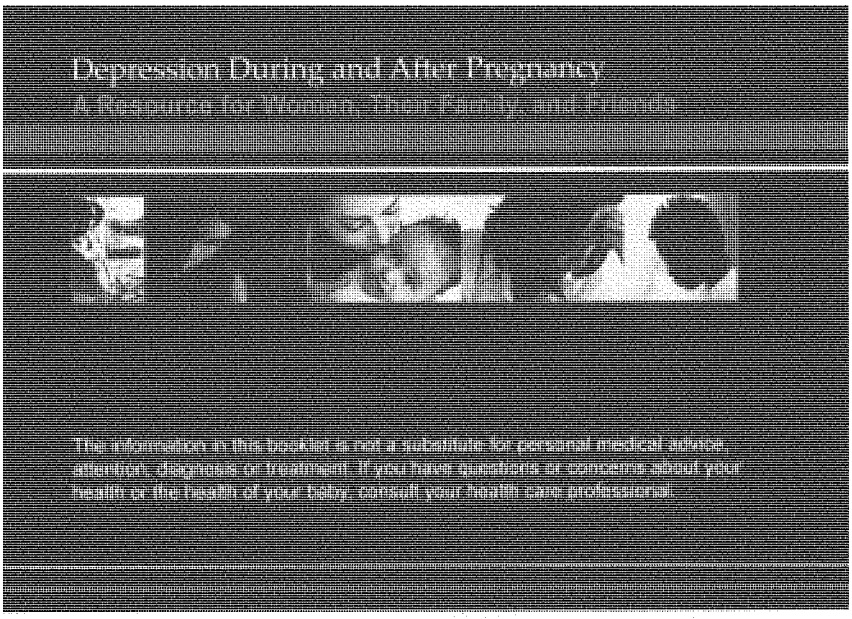
American College of Obstetricians and Gynecologists (ACOG)
Phone: 800-762-2264 / Internet Address: http://www.acog.org
Resources for you and your health care provider.

Books

Beyond the Blues, by Shoshana S. Bennett and Pec Indman (Moodswing Press, 2006)
Available in Spanish

Beyond the Birth, by Dawn Gruen, Rex Gentry, Abby Meyers, and Sandra Jolley (Depression After Delivery, 2003)
Books are available online at: http://www.ppmdsupport.com/resource.php





U.S. Department of Health and Human Services
Health Resources & Services Administration
5600 Fishers Lane
Rockville, MD 20857

November 2006

This booklet is available at www.mchb.hrsa.gov/pregnancyandbeyond/depression
Print Copies can be obtained from the HRSA Information Center 1-888-Ask-HRSA

ONE HUNDRED TENTH CONGRESS

U.S. House of Representatives
Committee on Energy and Commerce
Washington, DC 20515–6115

JOHN D. DINGELL, MICHIGAN
CHAIRMAN

May 21, 2007

Nada L. Stotland, M.D., M.P.H.
Professor of Psychiatry and Obstetrics/Gynecology
Rush Medical College, Chicago
5511 South Kenwood Avenue
Chicago, IL 60637

Dear Dr. Stotland:

Thank you for appearing before the Subcommittee on Health on Tuesday, May 1, 2007, at the hearing entitled "H.R. 20, The Melanie Blocker-Stokes Postpartum Depression Research and Health Care Act." We appreciate the time and effort you gave as a witness before the Subcommittee on Health.

Under the Rules of the Committee on Energy and Commerce, the hearing record remains open to permit Members to submit additional questions to the witnesses. Attached is a question directed to you from a certain Member of the Committee. In preparing your answer to this question, please address your response to the Member who has submitted the question and include the text of the Member's question along with your response.

To facilitate the printing of the hearing record, your responses to these questions should be received no later than the close of business **Friday, June 1, 2007**. Your written responses should be delivered to **316 Ford House Office Building** and faxed to **202-225-5288** to the attention of Melissa Sidman, Legislative Clerk/Public Health. An electronic version of your response should also be sent by e-mail to Ms. Melissa Sidman at **melissa.sidman@mail.house.gov** in a single Word formatted document.

Thank you for your prompt attention to this request. If you need additional information or have other questions, please contact Melissa Sidman at (202) 226-2424.

Sincerely,

JOHN D. DINGELL
CHAIRMAN

Attachment

cc: The Honorable Joe Barton, Ranking Member
Committee on Energy and Commerce

The Honorable Frank Pallone, Jr., Chairman
Subcommittee on Health

The Honorable Nathan Deal, Ranking Member
Subcommittee on Health

The Honorable Michael C. Burgess, Member
Subcommittee on Health

The Honorable Michael C. Burgess

1. Given our knowledge of the role that hormone levels play in depression, what is the problem with considering the disorders discussed today as a continuum of issues ranging from premenstrual syndrome to post-partum psychosis, and including post-miscarriage/post-abortion depression?

American Psychiatric Association

1000 Wilson Boulevard
Suite 1825
Arlington, VA 22209
Telephone 703.907.7300
Fax 703.907.1085
E-mail apa@psych.org
Internet www.psych.org

May 31, 2007

The Honorable Michael Burgess
U.S. House of Representatives
1224 Longworth House Office Building
Washington, DC 20515

Dear Representative Burgess,

Recently a staff member of the House Committee on Energy and Commerce contacted American Psychiatric Association President-Elect, Nada Stotland, M.D., with a follow-up question in reference to her testimony before the Committee earlier this month on H.R. 20, the Melanie Blocker-Stokes Postpartum Depression Research and Care Act. The question submitted to her was:

Given our knowledge of the role that hormone levels play in depression, what is the problem with considering the disorders discussed today as a continuum of issues ranging from premenstrual syndrome to post-partum psychosis, and including post-miscarriage/post-abortion depression?

Dr. Stotland has given the following response and has asked APA Department of Government Relations to relay it to your office.

The American Psychiatric Association would not consider that we discussed "disorders", plural at the hearing. Post-partum depression is a 'disorder.' Premenstrual syndrome is not a recognized psychiatric disorder. A particularly severe form of mood change associated with the menstrual cycle, 'premenstrual dysphoric disorder,' is listed in the appendix of the Diagnostic and Statistical Manual of Mental Disorders (DSM, fourth edition) as a possible diagnosis requiring further study. The American Psychiatric Association devotes up to ten years, the work of hundreds of experts, and several millions of dollars to the study of the evidence for the existence and nature of mental disorders and the production of each edition of the DSM. Although, as I stated in my testimony, women may be sad after an abortion (or miscarriage), this is very different from post-partum depression. To-date, there is no credible evidence that there is any psychiatric syndrome specifically associated with or caused by abortion or miscarriage, and there is credible evidence that abortion does not have a causal relationship with psychiatric illness. Therefore, to posit the existence of a psychiatric syndrome following abortion is to declare a disorder without a scientific basis. This is then used to advance the political and social agendas of

individuals and organizations that misrepresent their personal beliefs as scientific fact.

Please feel free to contact me directly if you have any further questions or concerns.

Sincerely,

Nicholas Meyers

Director, Department of Government Relations