

Maternal Mental Health and Mindfulness

Mental health problems result in disease and disability (Afifi 385). When looking at the data across cultures, women are more likely to report mental health symptoms, access available supports, and receive treatment for mental health disorders (Lesesne and Kennedy 755). Research on maternal health has suggested that “the burden of mental health disorders peak in the child bearing and midlife periods” (Lesesne and Kennedy 756). Biology is often implicated in this presumed psychological vulnerability, given that throughout a woman’s life, she experiences pronounced hormone-driven cycles, including menstruation, pregnancy, a postpartum period, and menopause. However, even after exhaustive studies exploring a number of sex-related variables, there is a lack of consensus regarding the significance hormones have in influencing women’s mental health challenges (Hendrick et al. 93; Schiller et al. 49). Some scholars contend that the focus on biology and hormones are an easy way to discount the negative experiences that disproportionately affect girls and women. Discrimination, poverty, sexism, abuse, exploitation, and caregiving burdens work to undermine women’s mental health. Women’s mental health should, therefore, be understood by evaluating all aspects of women’s lived experiences—physical, sociocultural, economic, and interpersonal. Informed by the diathesis-stress model, this article reconsiders the social, political, and economic stress that adversely affects women’s wellbeing. Specifically, this article posits that Buddhist-derived interventions, such as mindfulness, can fortify and empower women. Evidence from neurobiology provides a meaningful framework supporting this approach to health and wellness.

Mental health challenges often result in disease and disability throughout the world (Afifi 385). When looking at the data across cultures, women are more likely to report mental health symptoms, access available supports, and receive treatment for mental health disorders (Lesesne and Kennedy 755). Women in developed countries are more often diagnosed with a variety of emotional disorders, including mood instability, anxiety conditions, eating disorders,

and personality disorders. Research on maternal health in the United States has suggested that “the burden of mental health disorders peak in the child bearing and midlife periods” (Lesesne and Kennedy 756). Indeed, during pregnancy up to 25 per cent of women in the West may meet criteria for a mental health disorder (Swanson et al. 553); however, fewer are ultimately identified as such (Vesga-Lopez et al. 805). A recent review of the perinatal depression literature concluded that this form of depression is highly prevalent in the prenatal and postnatal period, yet it is often undiagnosed and untreated. The status of mental health exists in a socioeconomic context in which gender differences predispose females to a plethora of challenges, including economic and educational hardships (Knack 81). A number of feminist scholars have posited that “everyday aspects of contemporary culture have become potentially pathogenic for women and should be examined as ongoing sources of traumatic stress” (Berg 970). Of note, women’s rate of reported PTSD is twice that of comparable males (Berg 972). Women’s mental health should, therefore, be understood by evaluating all aspects of women’s lived experience: physical, sociocultural, economic, and interpersonal. This article explores the prevailing reasons cited for the increased mental health challenges facing women in the West, highlights conventional medicine’s inherent patriarchal bias, and, finally, considers the benefits of feminist trauma treatment, including mindfulness, in promoting the health and wellbeing of mothers.

Women and Mental Health

A number of theories have been put forth to explain women’s higher rate of mental health challenges. Biology is often implicated as a main factor in this presumed psychological vulnerability, given that throughout a woman’s life, she experiences pronounced hormone-driven cycles, including menstruation, pregnancy, a postpartum period, and menopause. However, even after exhaustive studies exploring a number of sex-related variables, there is a lack of consensus regarding the significance hormones have in influencing women’s mental health challenges (Hendrick et al. 93; Schiller et al. 49). Some scholars contend that the focus on biology and hormones are an easy way to discount the negative experiences that disproportionately affect girls and women. Discrimination, poverty, sexism, ableism, abuse, exploitation, and caregiving burdens work to undermine women’s mental health (Satyanarayana, Chandra, and Vaddiparti 350). Research suggests that these hardships are central to women’s mental health struggles both immediately and in the long term as well (Rudenstine et al. 124).

Rather than a singular focus on biology as the determinant of mental and emotional vulnerability, the interplay of both genetics and the environment provides a more accurate and comprehensive picture. The diathesis stress

model is a theoretical framework which postulates that each person carries a differential genetic predisposition to a host of mental and physical health conditions (Colorado-Conde et al. 1591). However, whether the disorder is expressed is partially contingent upon the individual's life events. The ultimate stress that is experienced will either push the person towards manifesting the disorder or serve to safeguard and buffer the person, thus reducing the risk of disease expression (Monroe and Simons 407). Based upon this model, the power of negative environmental variables and their detrimental influence represent risk factors for a number of psychiatric disorders. Therefore, women's disproportionate experiences of hardship and trauma are seen as potent risk factors for mental health challenges. These risks increase when children—more often girls—are exposed to adverse events early in life, including physical abuse, sexual violation, and lack of schooling (Stewart et al. 14)

Stress is an inevitable and a predictable part of the life experience and is known to affect children's developing brain (Franke 391). Positive stress includes challenges that are appropriate for the child's cognitive and emotional level of function (Franke 391), which may include common interpersonal and school-based challenges. Tolerable stress is more intense and beyond what is considered normative, such as the death of a family member or exposure to natural disasters. The effects are more significantly felt and for a longer period of time (Franke 391). However, even these more powerful stressors can be successfully negotiated with the support of a caring and responsive family system. In contrast, toxic stress includes recurrent traumas, such as physical abuse, sexual abuse, and neglect, which are especially aversive and psychologically damaging. They are considered neurobiologically harmful to the developing child, given the negative influence on the neuroendocrine-immune network (Franke 392). This type of stress can harm the child's developing brain and result in negative emotional and physical outcomes (Freeman 546). Oftentimes, toxic stress occurs in more challenging family systems, in which there are typically lower levels of adult nurturance and support. These early life circumstances exponentially increase the potential for a lifetime of maladaptive health outcomes (Freeman 546).

All children are at risk for exposure to adverse events, but the specifics of these occurrences have been shown to differ based upon gender. Although both male and female children are victims of sexual abuse, this violation is much more common in females and, on average, occurs at a younger age (National Sexual Violence); indeed, one in four girls in the United States will be sexually abused before the age of eighteen (National Sexual Violence). Research also suggests that girls are at greater risk of being sexually abused by a family member, whereas boys' victimization more often occurs outside of the home (Maikovitch-Fong and Jaffee 431). The specifics of the traumatic event may also exert a differential effect on the abused child in both the short and

long term. Generally, it has been theorized that childhood victimization poses a significant risk for later depression, anxiety, and substance abuse (Rudenstine et al. 124). However, the abuse has the potential to be more devastating when children experience what traumatologists refer to as “complex trauma” (Godbout et al. 91). This type of trauma often occurs within what should be a secure space, such as a child’s home, by a person who is presumed to be safe, such as a family member—father, uncle, grandfather, or brother. The experience of repeated sexual abuse is universally regarded as an overwhelming and damaging traumatic event with the potential for long-standing emotional and interpersonal impairment. This abuse is consistent with the experience of interpersonal violence, which is the intentional use of aggression—both physical and sexual—by family members, partners, friends, or acquaintances. Notably, over 30 per cent of women in the United States report to being a victim of interpersonal violence (Kelly and Garland 312). Although a significant number of these women suffer this abuse prior to the age of twenty-five, epidemiological data indicate that a subset of these women experience revictimization throughout their lifetime, which results in a wide-ranging symptom profile (Kelly and Garland 312).

Childhood maltreatment potentially denies women the opportunity to establish a healthy relational template and increases the likelihood of emotional dysregulation, which is associated with the development of mental health disorders (Dvir et al. 152). Emotional dysregulation refers to the inability of a person to control or regulate their responses to material or experiences they deem to be emotionally provocative (Rudenstine et al. 125). At times, however, this emotional difficulty is outside of the current situation and is instead due to the distortion or overresponse to elements in the environment. Oftentimes, the person with emotional dysregulation reacts in an exaggerated manner to minor frustrations and interpersonal challenges; thus, the person is quick to anger, cries easily, is accusatory, demonstrates passive-aggressive behaviour, and creates chaos and conflict in environments in which they live and work. Despite current research that suggests that the majority of mental health disturbances in adults have their origins in childhood and adolescence, in clinical settings, women’s historical victimization is often not considered in attempts to understand this behaviour as well as other challenging psychological conditions (Brown 464).

Conventional Medicine and Patriarchy

For the ancient Egyptians, and later the Greeks and Romans, women’s bodies, specifically the uteri, were blamed for strong emotional responsivity. The uterus was believed to have the ability to roam or migrate throughout the female’s body, causing anxiety, depression, and irritability. Therefore, medical

intervention was geared at coaxing or facilitating the uterus to return to its rightful place within the body in order to quell women's distress (Tasca 111). Noted authorities, such as Sigmund Freud, claimed that the emotional reactivity was not medical but psychological in nature. Females suffered from what Freud called "hysteria" due to the absence of a penis—a condition later termed "penis envy." This malcontent was believed to be remedied through marriage, which included frequent copulation and the birth of a child—preferably a male (Tasca 118). Hysteria continued as a mental health diagnosis found in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders until 1980.

Although these practices may be understood as a misguided artifact of the past based upon misogynistic pseudoscience, there continues to be a perception that female medical complaints have a basis in emotional exaggeration or hysteria (Werner et al. 1036). Examples of this misattribution include the autoimmune disorder of multiple sclerosis (MS). Even though it afflicts many more women, up until the 1920s and the advent of the MRI, which provided clear evidence of the disease, more men were diagnosed with the disorder (Lines). Sadly, women presenting with MS symptoms were often regarded as suffering not from a real physical illness but from a psychological disorder. Although the diagnosis of hysteria was removed from the Diagnostic and Statistical Manual as a psychological disorder, the misbelief about female hyperemotionality continues. When confronted with unexplained medical complaints, women are significantly more likely to receive a diagnosis of conversion or somatoform disorder, which is modern-day nomenclature for hysteria (Cherry). Even today, women who present with vague symptomology are often left untreated and are misdiagnosed for longer periods of time before an accurate diagnosis is made. The unfortunate history of misogynistic medical theory allows for the ignoring of female suffering and instead promotes a culture of victim blaming. From a modern perspective, this thinking appears misguided and puerile; however, its application damages, demeans, and victimizes women—all in the name of medical science.

Feminist Treatment

Given the gender bias prevalent in medical and psychological diagnoses and treatments, the remedy must be systemic, ongoing, and capacious. Nevertheless, we cannot wait until these overarching changes are made to address the suffering of women. Hence, we argue that one way to support women is for health practitioners to adopt a feminist treatment approach, which offers a corrective to traditional subjugating practices that dismiss female voices and experiences. Specifically, a feminist approach to healthcare is multifaceted, as it addresses a wide range of women's needs. Instead of rendering the gender

bias invisible, a feminist therapeutic approach centralizes the injury to the female psyche and respects all sites of injury (Brown 465). In so doing, women's experiences are validated through the use of an egalitarian framework. This philosophy is not prescriptive but meets the needs of individual clients. According to a relational-feminist model, empathic attunement and responding are essential components in the therapeutic relationship, which allows for healing and growth (Freedberg 253).

A central tenant of feminist therapy is the empowerment of women (Brown 465). In feminist therapy, a meaningful intervention could include a psychoeducational component, so a survivor of sexual assault, for example, would have a better understanding of the ruminative propensity and resultant body reactivity after the assault. Specifically, in a feminist trauma model, the survivor of the violence would be the focus of therapeutic attention and would receive individual or group-based support. Nonetheless, the systemic variables of patriarchy, sexism, and aggression would clearly be identified as cultural forces that damage women and society at large. This integrative model would include a priority on the raising and development of a feminist consciousness. This ideology would serve to connect the personal experience to the awareness of the overall system of inequity and fortify the woman's right to resist it. One way in which healthy and empowered resistance can be realized is by recognizing the toxicity of patriarchal institutions that have circumscribed women's lives and, in so doing, create independent ways of valuing the self.

Feminism and Mindfulness

A particularly effective way to foster female empowerment is through the development of a mindfulness practice. Mindfulness serves as an antidote to the damaging effects of hegemonic systems, given that it allows women to shift the terrain of power and harness their own strength (Davis and Hayes 200). This is not to suggest that mindfulness alone can counter the power of these structures, but it does maintain that women's collective empowerment, gained through the practice of mindfulness, can shift the balance of power in their own lives. Consistent with feminist trauma treatment, the adoption of Buddhist-inspired practices, such as mindfulness, has gained currency in the treatment of many mental health disorders in the West. Mental health professionals, influenced by this treatment philosophy, are charged with translating and adopting these lessons and practices to promote wellness.

Regarded as a religion, philosophy, and psychology, Buddhism is appreciated as a powerful instrument for healing (Lee et al. 113). Some even regard the Buddha as a psychotherapist of sorts, having provided therapy to millions of adherents throughout the centuries. The introduction of Buddhism to modern Western psychology began in 1900 by Rhys Davids, who translated Buddhist

texts into English. Subsequent exposure occurred with renowned Buddhist teachers and mental health clinicians and scholars, including Jung, Fromm, and Kornfield (Aich 167). Later, Chogyam Trungpa was recognized for drawing the connection between the teaching of Buddhism and Western psychology. More recently, in the 1990s, Kabat-Zinn popularized select Eastern practices for their relevance to mental healthcare in the Western world (Lee 218). Since that time, there has been a significant increase of Buddhist thought and practice in mainstream mental health treatment (Lee et al. 114).

Due to increased research funding, meditation and mindfulness have become integral treatment in fostering emotional wellness. These and other Buddhist-derived interventions (BDIs) have received considerable clinical attention. BDIs have been shown to be beneficial in clinical studies for the treatment of depression, anxiety, bipolar disorder, sleep disorder, and substance-use disorders (Nagy and Baer 353). The basis of BDIs is to teach clients effective management of difficult thoughts, perceptions, and experiences. When used therapeutically, mindfulness interventions can increase a person's capacity to manage negative emotions and foster mental wellness (Davis and Hayes 198), which is especially relevant for women, as the healing occurs within her control and outside systems that may patronize or misconstrue her symptoms and concerns.

Both mindfulness as a Buddhist practice and feminist philosophy are similar in that they share a commitment to the transformation of society by increasing social justice and decreasing "senseless suffering" (Keefe 62). The practice of mindfulness may be used independently or incorporated with other treatments to serve as a therapeutic intervention to enhance women's coping repertoire and fortify their resilience. Mindfulness practice is sometimes paired with cognitive behavioral therapy (CBT), but each is unique in terms of process and treatment. The practice of mindfulness focuses on teaching participants to carefully attend to their own moment-to-moment experiences, bringing into awareness their emotional reactivity, which may precipitate ineffective or maladaptive responding (Bauer 327). It is theorized that through awareness of the circumstance and the emotional response that follows, the most effective and self-preserving behavior may be chosen. CBT intervention also focuses on becoming aware of the circumstance. However, this treatment uses the material gained from this stage of awareness to evaluate the accuracy of what is perceived and refute dysfunctional or negative thoughts and self-statements. It is through this therapeutic process that thinking about the circumstance and perceptions of the self are transformed. By contrast, in mindfulness, there is no attempt to change or refute the experience but to recognize it and respond as deemed appropriate.

The Neurobiology of Mindfulness

The effectiveness of BDIs has been explained through the framework of neurobiology. Specifically, the way in which the brain responds to emotionally provocative stimuli is important in understanding the therapeutic value of BDIs. Stated simply, the awareness of life events—stimuli in the environment—sends information for processing to two distinct regions of the brain: to the hippocampus for a quick appraisal and to the prefrontal cortex for a more thorough assessment (Hanson and Mendius 34; Tabibnia and Radecki 61). Brain-based research suggests that the “automatic processes of the brain tend to be fast, spontaneous, and largely sensory, [whereas] controlled processes tend to be slow, effortful, often language-based, and intentional in nature, such as problem-solving and self-control” (Tabibnia and Radecki 60). Thus, information that is perceived to be potentially threatening elicits an emotionally charged response summoned by the amygdala—that is, the emotional brain speaks first (van Marle, et al. 649; Phelps and LeDoux 179). After further consideration, however, a more dispassionate, logical brain centre is activated to analyze the situation, connect relevant material, and direct future action (Hatchard et al. 43). Ultimate resilience and functionality rest on the interaction between these two systems: the limbic or immediately responding emotional brain and the prefrontal cortex that offers the final and most reasoned assessment of the information (Hanson and Mendius; Tabibnia and Radecki 60).

The logical brain center can provide a disinhibiting function; it can reduce emotionality and impulsivity and support greater emotional regulation. Nevertheless, the more primitive, emotional brain is necessary, as well as adaptive, when faced with novel, stressful, and emotionally provocative stimuli (Tabibnia and Radecki 63). Painful memories are uniquely powerful: they are emotionally laden, explicit, and devoid of associated content. When distressing remembrances are triggered by stimuli or brought to the fore through memories, emotional distress is reignited and perpetually reexperienced (LaBar and Cabeza 54; Tambini, et al 276.).

Given this neurobiological reality, many people strive for equilibrium by avoiding or ignoring the difficult material presented by life events. As a result, distraction from the self and related material can come to be regarded as a useful and necessary mode of living. This distancing from the self is a limiting and perilous option. With this mental disconnect, a person’s thoughts and actions become driven by a reactive process, which is the desperate attempt to repress, overlook, or squelch uncomfortable thoughts and experiences. Some researchers have proposed that specific forms of psychopathology may be associated with this unhealthy reactive process (McCormack and Thomson 157). One’s neurobiological system may become impaired by the experience of adverse early life events. Given that women disproportionately endure

traumatic experiences, for some, there is the potential for resultant emotional dysregulation. This presentation may result in the diagnosis of more severe and challenging conditions with limited attention paid to the historical antecedents.

Eastern philosophy holds that emotional suffering may be the result of two separate but uniquely related conditions. The first, as previously referenced, is the unwillingness to face difficult material in life, and hence ignoring and avoiding it at all cost: “Pain comes and goes in life. But that is not suffering. Suffering is the product of pain and our resistance to it” (Bien 87). The second source of pain is, in essence, the opposite. Rumi postulated that “the cure for the pain is in the pain” (Rumai 205). Instead of running away, a person must see, feel, and experience the difficulties of life. Through such deliberate, nonreactive contemplation, the situation is faced, accepted, processed, and worked through (Hanson and Mendius 60). When mental equanimity exists and is accompanied by insight and awareness of the feeling tone, one is better able to understand relevant choices and take subsequent actions with intentionality (Young 54). Moreover, there is the potential to experience greater insight, wellbeing, and, ultimately, freedom from suffering (Nagy and Baer 353; National Institute of Health). Although this is certainly an aspiration goal, it is imperative to recognize the ongoing oppressive institutions and practices that exist both inside the domestic sphere and in medical and psychological institutions at large.

Mothers and Multitasking

Although the practice of mindfulness—directing attention to the present experience—is believed to be essential for improving mental health, it is nonetheless a challenging skill to master. This is especially true given how media-rich the current culture is, with its infinite distractions encouraging disconnection from the here and now. Even within moments of quiet reflection, cultural conditioning may lead us to seek extraneous stimuli. It is within this media context that there is increased pressure on the work-home balance, given the ease by which communication flows from the workspace to home. For mothers, the demands of negotiating multiple life spaces and tasks represent a significant form of gender inequality. In dual income families, for example, mothers, when compared to fathers, spend on average ten additional hours weekly engaged in childcare and household activities (Offer and Schneider 828). Interestingly, in many cultures, there is a false assumption that multitasking, either serially or concurrently, is more easily performed by women. This gender stereotype flies in the face of research that has found there is no specific sex difference in multitasking proclivity and performance (Hirnstain et al. 292). Nonetheless, mothers are typically enduring more

responsibility for the care of their young in addition to other household activities (Offer and Schneider 823). This expectation for multitasking increases parenting stress and negatively affects the wellbeing of mothers.

Although some regard multitasking as a sign of cognitive strength, it is a misguided presumption. People—regardless of gender—can only effectively process and manage one task at a time. In her study, Suzanne Powell finds that multitasking was associated with a 40 per cent reduction in the participants' productivity, intellectual capability, and even the volume of grey matter in the brain (61). Importantly, a consistent mindfulness practice may help ameliorate some of the more damaging effects of a highly distractive environment.² Britta Holzel et al. show that mindfulness may increase gray matter in the brain and improve functions involved with learning and memory, modulation of emotional control, and the process of awareness (41). Additionally, it is hypothesized that mindfulness facilitates the connectivity and synergy of the brain, mind, and body, which benefits both mental and physical health (Carlson et al. 479; Creswell et al. 187). For example, several studies have found these practices influence aspects of psychological wellbeing by improving mood, increasing positive emotions, and decreasing anxiety (Spijkerman, Pots, and Bohlmeijer 111; Vollestad, Morton, and Nielsen 242). Recent studies suggest that mindfulness may positively influence heart and brain health and immune system functioning (Carlson et al. 479; Creswell et al. 187).

Mindfulness is a practice of conscious living in an effort “to raise awareness of the self in the present moment” (Lee et al. 123). Mindfulness practice, in fact, is increasingly integrated into mental health treatment due to research that has shown it to be effective. For example, mindfulness-based stress reduction is now a standard approach for helping clients manage life's demands. Mindfulness-based cognitive therapy and other approaches target specific treatment areas, such as depression, anxiety, substance abuse, eating challenges, and self-harming behaviours, all of which are seen more frequently in women. As previously mentioned, the fact that women experience these mental health challenges at a higher rate is likely due to gender-based violence and oppression.

In its purest form, mindfulness involves a nonjudgmental appraisal of events in the here and now, with the goal of increasing an accepting attitude towards these experiences and the capacity and willingness to stay in contact with them, even when they are aversive (Farb et al. 71). As a result, it becomes possible to reduce overidentification with avoidance through greater acceptance of the situation as it is, without judging it according to one's expectations (Bergomi et al. 22). Through this increased clarity, there is the potential for healthy and life-enhancing decisions. Mindfulness practice, in fact, is increasingly integrated into mental health treatment due to its focus on self-efficacy, healing, and resilience. As described by Laura Brown, women's

individual experiences of trauma are representative of larger, systemic and institutional forms of oppression (468). It is within this context that mental health treatment for women should comprehensively support consciousness-raising efforts to engender insight and promote the assertion of individual power and control. Within this paradigm of feminist awakening and empowerment, the practice of mindfulness may be especially useful to women during pregnancy and as mothers. Mindfulness interventions during pregnancy have been shown to decrease levels of depression and anxiety and to improve women's capacity to manage stress (Snyder et al. 714).

Conclusion

The maltreatment and traumatic experiences of girls and women in sexist and oppressive institutions may result in emotional suffering and the manifestation of mental health challenges. Instead of medical and physical health professionals appreciating the oppressive dynamics of women's lived experiences as contributing factors to their psychopathology, diagnosis is often rendered absent the context of this systemic and institutionalized victimization.

The effects of oppressive medical, psychological, sociocultural, and economic institutions must be recognized and ameliorated; nonetheless, it is also imperative to focus on daily support to women. This is where healthy interventions, such as mindfulness, may have efficacy. Mindfulness—a strategy for empowerment that alleviates suffering in part by reducing ruminative thinking and advancing coping mechanisms—allows for women to wrest some measure of control from these patriarchal macro institutions, which can increase their physical and emotional health and wellbeing.

Endnotes

1. As with all treatment plans, the licensed mental health practitioner would evaluate the client and ascertain the appropriate treatment intervention.
2. This is not an easy task, however, as mothers receive a lot messages about self-care and managing their own mental health while the gender imbalance in caregiving and multi-tasking continues, which mitigates against prioritizing such practice of self-care (Yavorsky 674).

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