Postpartum Depression Course

Postpartum depression affects women of childbearing age without regard to socio-economic strata, educational, racial, ethnic backgrounds or specific age range in western societies, except that adolescent mothers experience an increased risk for PPD. It is interesting to note that postpartum depression occurs at significantly lower levels in non-western cultures. Presumably this difference is due to a greater, extended social support structure for mothers in non-western cultures, along with less conflicted roles for women as mothers, both psychologically and economically.

Our society pressures women to be "good" mothers, but simultaneously devalues the work of nurturing. Although lip service has been given to the importance of motherhood and staying home to raise children, especially in the first year of a child's life, women in the United States fare worse than their European counterparts in Sweden, France, Canada and other countries that offer government support programs to help families raise children. With little public debate, the United States has chosen a radically different approach to maternity leave than the rest of the developed world.

"The United States and Australia are the only industrialized countries that don't provide paid leave for new mothers nationally, though there are exceptions in some U.S. states.

Australian mothers have it better, however, with one year of job-protected leave. The U.S. Family and Medical Leave Act provide for 12 weeks of job-protected leave, but it only covers those who work for larger companies.

To put it another way, out of 168 nations in a Harvard University study last year, 163 had some form of paid maternity leave, leaving the United States in the company of Lesotho, Papua New Guinea and Swaziland. "

US Today 7/26/05

(full article: http://www.usatoday.com/news/health/2005-07-26-maternity-leave_x.htm)

see article: http://www.thirdworldtraveler.com/Europe/European_Model_Families.html

"The European Model: What we can learn from how other nations support families that work" by Marcia K Meyers and Janet C. Gornik, in The American Prospect magazine, November 2004

"In Sweden, parents have a right to 15 months of paid parental leave that can be shared between mothers and fathers; parents also have a statutory right to work six hours per day (at prorated pay) until their children turn 8…Nearly half of children between the ages of 1 and 2 are in public care, as are 82 percent of those between the ages of 3 and 5, and virtually all 6-year-olds. Quality standards, set nationally

by the Ministry of Education and Science and adapted to local communities by municipalities, ensure high-quality care, which is provided by well-trained workers who earn wages at about the national average for all women workers.

France and several other continental European countries combine somewhat shorter periods of paid leave with dual systems of public child care (for the under-3s) and preschool (from 3 until school age). In the French policy package, mothers are entitled to 16 weeks of paid leave at the birth of first and second children (26 weeks at the birth of subsequent children), with 100-percent wage replacement; fathers have a right to ii days of paid paternity leave. French parents are also entitled to share three years of job-protected parental leave with low flat-rate benefits. Leave benefits are coupled with a dual system of early childcare and later public preschool. ..teachers in French écoles have the equivalent of graduate training in early education and earn wages that are above the average for all employed women."

Compared to other industrialized nations, the United States falls far short of the support for mothers that are a part of national policy in other countries.

Still, women are under pressure in our society to provide all that is needed to a new baby. Cultural pressures, along with the invisibility that women experience in the work of nurturing can result in a breeding ground for postpartum depression in the weeks, months and year following the birth of a baby, whether it is a first baby or a subsequent childbirth. There is no increase in the incidence of postpartum depression for first time mothers over other women who already have a child or children, and vice versa.

CATAGORIES OF POSTPARTUM DEPESSION

Baby blues

Feeling intense emotional swings in the first 2 weeks after giving birth, along with teariness and some feelings of sadness occurs in up to 80% of women. These swings are attributed to the physical changes, especially hormonal swings that occur during this period. The baby blues usually resolves within 2-3 weeks without treatment.

Postpartum Syndrome

Postpartum depression syndrome which is marked by continued teariness, feelings of sadness and sometimes angry outbursts, accompanied by suicidal feelings and sometimes a fear of hurting herself or the baby, or feelings of inadequacy to care for the baby can occur as early as one month, but commonly begin between one and 4 months. The

depression generally lasts through the first year, and if left untreated, can continue beyond one year. PPD is serious and needs treatment. It occurs in up to 15% of mothers.

Postpartum Psychosis

Postpartum Psychosis may be marked by an inability to take care of the baby, severe risk of suicide and/or hurting the baby, hallucinations, and thought disorder. It occurs in only 1-2 per one thousand of women and, unlike postpartum syndrome, *it occurs at the same rate for both western and non-western societies.*

Clinically, postpartum syndrome is the category that the psychotherapist will most likely be dealing with in depth. For that reason, we will begin with a summary of symptoms and treatment for postpartum syndrome, and then move to psychosis.

Postpartum Depression Syndrome

Although we see women in regular prenatal care for an average of 6 months prior to delivery, we do little to help them prepare for the psychological task of motherhood, which is the psychological work of pregnancy, along with the preparation for childbirth itself. Our traditional prenatal care is focused on the physical aspects of pregnancy. However, by adding 2-4 counseling sessions to the prenatal care program, (see : http://www.askdrgayle.com/html/counseling_services4.html and the book "An Easier Childbirth" for description of the Peterson Prenatal Preventative Counseling model) a therapist trained in addressing perinatal issues can provide benefit not only to identify women at risk for postpartum depression, but also to help all women experience a smoother, more satisfying transition to motherhood. Sadly, we not only miss this opportunity for prenatal screening of postpartum depression, but when women recount to their medical practitioners that they are having a hard time with motherhood they are more often than not simply reassured that this is normal. Repeatedly, women who complain of symptoms of postpartum depression are turned away without referrals or further intervention or assessment of any kind.

Cultural Loading of Motherhood

In truth, all women experience some difficulty with integrating the role of mother in their lives. It is a continuum of difficulty. Ambivalence is normal in motherhood and definitely understandable in our culture. Motherhood is a greatly underestimated transition and one of the most profound in a woman's life. Our society pressures women to be good mothers, but simultaneously devalues the work of nurturing.

The cultural loading of motherhood and its effects on women is greatly overlooked. Yet, it is fact that women experience a much greater sense of responsibility (translate into "worry") for the outcome of their children than do fathers. This does not mean that fathers do not love a care for their children, however they do not feel the weight of society's eyes upon them!

For example: Women who have crying babies in public areas, such as a grocery store report more often than not irritated looks by other adults who do not offer to help. Fathers, on the other hand, with the same situation experience smiles and friendly offers of support or even help. Is it any wonder that mothers feel more " to blame" if something is not going right in a child's life? Society punishes women and judges them around the concept of "good mother" at a much higher rate than fathers. Although this awareness of fathers' involvement and responsibility is increasing, it is ever so slowly catching up the level of scrutiny women absorb in the role of "mother".

See my articles on cultural loading:

Becoming a Family:
Placing Love in Equal Relationships to
the Primacy of Work in Modern Day Society
http://www.askdrgayle.com/html/becomfam.html

When Women Become Mothers
And the Impact of Family Self-Esteem
http://www.askdrgayle.com/html/wwbm.html

Husband is Great but
I still have to "Ask" for Help
http://www.askdrgayle.com/html/qa3.htm

Women experience cultural pressures to be "good mothers" in a society that devalues the basic work of mothering. This situation sets up a breeding ground for low self esteem and for depression in women. The cycle reveals itself in women's behavior that is a result of the internalization of these pressures.

Example: Women that I see in my practice who are not working outside the home, often do not feel they are entitled to paying for childcare in order to get a needed break or to develop any other part of themselves as women. I encourage them to take back their **rights to decision-making on how to spend the family income** and to take care of themselves. Loss of decision-making power is one sign of this internalization.

Likewise, women who work outside the home, often continue to carry the responsibilities for making all the doctor appointments, school conferences and house chores without sufficient help from a spouse/father, despite asking for help! Couples therapy is in order for **an over loaded mother!**

Overloading and loss of power in the family decision-making when a woman becomes a mother, relegates her to a compromised position in the family, **which promotes depression.**

When left untreated, postpartum depression infiltrates the family relationships, causing stress on marriage, mother-infant relationships and vital family processes. Ongoing postpartum depression erodes a woman's self-esteem and all family relationships as well as negatively impacting child development affected by depression in the major caretaker. *When left untreated, more than 15 % of women will remain depressed at one year following childbirth.*

Symptoms:

1. Recurrent, regular crying spells
2. Over-irritability
3. Recurrent angry outbursts
4. Fears of hurting the baby or self
5. Feelings of inadequacy as a mother
6. Fatigue
7. Loss of interest in pleasurable activities
8. Feelings of overwhelm, hopelessness or despair
9. Loss of appetite or weight gain
10. Excessive worrying
11. Obsessing about the baby, despite reassurances
12. Difficulty with breastfeeding
13. Difficulty bonding to the baby
14. Nightmares, flashbacks regarding traumatic childbirth or other previous trauma

Causes:

Biological: It is important to send a woman for a physical work-up to assess whether there are any physical problems that need to be addressed that could be contributing to postpartum depression. The two below are specific to postpartum.

Hormonal imbalance
Although tests can be run on hormonal levels, little is usually done to treat depression from this standpoint. Still, it is important to rule out excessive imbalances.

Thyroiditis
10% of postpartum women experience a dysregulation of thyroid function following childbirth. Appropriate medication may be required to help a woman balance her system. The thyroid tests, however, must include a full battery of thyroid screening (by an endocrinologist, as thyroid problems can be very difficult to diagnose.

(see:
http://www.thyroid-info.com/articles/postpartum.htm

http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&list_uids=1515829&dopt=Citation

The normal thyroid pattern after pregnancy is for the thyroid to go into hyperactivity for the first 3-4 months, then into hypoactivity for the next 3-4 months, and to stabilize at pre pregnant levels by 7-8 months after birth. However, women may respond to thyroid dysregulation at different levels of intensity. Biological screening and treatment can help women who experience depression related to thyroid dysregulation.

Symptoms that relate to thyroiditis can include:
Hair loss
Debilitating fatigue
Depression
Anxiety
Insomnia
Low milk supply

Still, psychosocial factors appear to be the largest contributor to postpartum depression syndrome.

Psychosocial Factors

1. Lack of social support network, including help with caretaking
2. Marital discord, lack of spousal and father support
3. Loss of freedom
4. Cultural/gender programming resulting in: overwork for the mother and/or loss of decision-making power in the family
5. Unresolved childhood relationships (childhood neglect, conflicted mother-daughter relationship, childhood losses
6. Past history of depression and/or other mental illness
7. Past postpartum depression
8. Past family history of mental illness, particularly if disrupted the mother-daughter relationship, such as hospital stays that created absences, postpartum depression in the mother's mother.
9. Traumatic or negative childbirth experience (women who have cesarean births are at greater risk for PPD)

Childbirth is often ignored as a significant event in a woman's life. Because it is not a neutral event, it is one that must be processed (positive or negative) if a woman is to integrate it into her development as a person. It is a critical and overlooked (likely devalued because it is feminine) life process. (see my article: http://www.askdrgayle.com/html/com.html

Below is an excerpt from the article above:

"The experience of pregnancy and childbirth is uniquely female. Not all women give or want to give birth. However women who do give birth whatever the circumstances, are faced with the reality of one of nature's most powerful events. The fact that women can express extremely **negative** or incredibly **positive** experiences of childbirth is evidence of the generic power of the experience itself. This most basic fact, that childbirth is a powerful force to be respected, has been lost in the overall devaluation of the feminine in our society.

Women often feel alone with the responsibility of motherhood, even when they have supportive partners. Mothers are criticized quickly when things go awry in childrearing, while their positive contributions go unsung. In fact, many aspects of female development remain invisible to our culture at large. Childbirth is no exception. *The message of our society is that the experience of childbirth is unimportant* .

Countless women have come to see me in my practice because they could find no one to talk to about their childbirth experience. Their psyches called out for an integration of this very powerful event, that brought their babies into their lives, their hearts and their minds. But they are questioned for their need to process it, as if the tremendous physical transformation of a newborn emerging from within their bodies were not significant enough to address. Their obstetricians often express dismay that they should want to talk further about the experience for any reason, because after all they have a healthy baby! Women are left with the implication that to continue to have any need to discuss the experience means they don't really care about the baby, or they have missed the point of it all. Again, this is a way of saying that the experience of giving birth should not matter to a woman. This gives women the message that *their own development does not matter once they become mothers.*

To not take a woman's needs seriously, is to contribute to a lowered sense of self esteem which may also have effects on her available energy for bonding and enjoying her baby, and may even contribute to postpartum depression. Without a way to integrate the experience, *women are left to try to feel better by denigrating childbirth.* This approach serves the overall social structure which itself devalues the process. But in the end it undermines a woman's sense of the worth of her own significant life events.

DEVALUATION OF FEMALE EXPERIENCE

Because our culture devalues that which is feminine, even the most intimate and basic processes of women's lives become targets for judgment. Our society encourages competition in every aspect of life. Mothers themselves are exploited to compete with one another, making their own birth experience a valid or invalid one, arguing whether the experience of giving birth is sacred, beautiful and powerful or a denigrating process to endure, even a worthless joke on women. Women comedians sarcastically attack women who want to experience natural birth, "You are stupid women! You have nothing to prove. You're not a man!" It makes for good entertainment, but this polarization distorts the continuing problem of devaluation at the heart of our experience of womanhood. When a mother's self esteem is undermined, family relationships suffer as well. Perhaps it is possible for us to validate and share our female experiences in a manner that would build rather than devalue a woman's sense of self.

Childbirth is and always will be a woman's experience. This does not mean that men are not participants, involved in the process, but they do not undergo the transformation of physicality inherent for their mate. For this reason, childbirth **is** feminine. It is an experience of sufficient power to generate tremendous amounts of anxiety, fear, excitement and anticipation. Labor is not by it's nature, a neutral event. Our experience of ourselves and our sense of personal identity is in constant flux with our life's unfolding. Because of the intensity of such an experience as childbirth and all that it entails, it is one that will help formulate a woman's identity. Like any powerfully significant event in our lives, it has the potential for mastery or overwhelm, empowerment or devastation. Getting trapped in a battle about "the right way to give birth" or "the right way to feel about your childbirth experience" misses the very real need to integrate the experience. A woman needs opportunity to explore the relationship to her changing body and identity, as she becomes a mother, if she is to feel at all "ready" for childbirth. There is no right method or experience. There is a basic need to psychologically *metabolize* all that is happening!"

Treatment

A. Biological work-up for thyroid and other physical problems

B. Counseling/Psychotherapy to address past unresolved trauma including:

Childbirth, mother- daughter relationship, and childhood loss issues

C. Antidepressant medications only if needed to augment psychotherapy.

Several antidepressants have been found to be safe in pregnancy and breastfeeding, including: Zoloft, Paxil, ,Prozac and Celexa. The benefits of breastfeeding have been found to far outweigh any possibilities of risk to the infant.
Reference: "Beyond the Blues" : A guide to Understanding and treating Prenatal and Postpartum Depression" by Shoshan Bennett, PhD and Pec Indman, MFT, moodswingspress, 2003… www.beyondtheblues.com

D. Group support: a group for postpartum depression is by far the most effective, rather than a mother's support group in general. Most moms with PPD feel isolated and increased anxiety when attending a regular mom's group as opposed to a specifically designed program for depression. Visit: http://www.postpartum.net/ for help finding a postpartum depression group in your area.

E. Involve the Father!

Couples therapy focused on the father having a primary caretaking role is essential to the health of the marriage and therefore, the baby in the long term. It is necessary for a father to experience changing diapers, dealing with a crying baby, learning how to soothe his child without the mother present so that he develops not only an appreciation for the role of caretaking, but is a competent parent to his child. This not only relieves stress on the mother, but supports bonding between father and child. Without this primary nurturing role, a father is likely to become peripheral to the family, depressed himself and feeling outside of the "heart" of the family life. (refer to my article: http://www.askdrgayle.com/html/becomfam.html) for more on this family dynamic.

Postpartum Psychosis

Psychosis refers to a woman being out of touch with reality. When coupled with motherhood, this category of mental illness can be deadly. Psychosis occurs in 1-2 per thousand of mothers with an onset of 2-3 days postpartum. This disorder has a 5 % suicide rate and a 4 % infanticide rate.

Symptoms:

1. Auditory and/or visual hallucinations
2. Thought disorder with delusional thinking (need to kill baby, taking care it somewhere inappropriate, speaking of killing baby or self)
3. Delirium and/or mania

Risk factors:

1. Previous postpartum psychosis or bipolar episode or diagnosis of schizophrenia
2. Family history of psychosis, bipolar or schizophrenia

Treatment:

1. Antipsychotic medication, such as haldol (recommended as safe for breastfeeding mothers

2. Mood stabilizers: lithium depakote, tegretol (Tegratol and depakote are approved by the American Academy of Pediatrics for breastfeeding. Lithium is not recommended.)

3. Psychotherapy

4. Family therapy to increase support and awareness of safety issues for caring for the baby.

Conclusion

Postpartum disorders

Baby blues, which resolves in the first few weeks after birth does not require treatment. However: Encouragement for mothers in their caretaking role, and processing the childbirth event are important in a woman's development and in the service of increasing her confidence in herself as a mother and her satisfaction in the role. Also, addressing the cultural loading of motherhood is a benefit to all mothers and families, regardless of whether postpartum depression is diagnosed.
See: **http://www.psychceu.com/Peterson/hypnosis.html**
for further training in addressing the posttraumatic stress of childbirth and prenatal counseling for improved psychological preparation for birth.

Postpartum depression syndrome occurs in up to 15% of mothers with onset at one month to one year. Without treatment, postpartum depression can damage family relationships and women remain depressed at a rate of 15% by one year.

It is crucial that women get the help they need when dealing with the transition to motherhood, the postpartum period. Preventative measures are best, providing counseling for women prenatally to give them the opportunity to process the psychological work of becoming a mother and what it means to each woman with respect to her history and to her present family relationships, in particular her relationship with spouse or partner.

As a psychotherapist working with individuals, it is important to recognize this transition to parenthood when it comes up in the lives of your client. Awareness of the issues facing women and men, in the postpartum period will help you better help them navigate this

important change which can make a difference in the lives of children and their children to come.

Give appropriate referrals to support groups, physicians, and therapists specializing in this life transition when red flags are identified in your client's psychotherapy. If you are interested in providing treatment to women who suffer from postpartum depression, obtain further training in this area. Experience and information are critical at this juncture in the family life cycle. It is a very rewarding path, should you choose to specialize, but do not take it lightly. It is necessary to get appropriate training to address this very important disorder, and to have a background of knowledge about the particular concerns of women becoming mothers today.

Post Test

1. Postpartum depression affects:
    a. women over 35
    b. teenage mothers
    c. women who have conflicted mother-daughter relationships
    d. a and c
    e. all of the above

Answer: E

2. Which of the following statements is/are true?
    a) Postpartum depression syndrome onset is usually in the first 2-3 days after birth.
    b) Postpartum psychosis usually resolves by one year.
    c) The antidepressant Paxil can be safely used while nursing a baby
    d) Antidepressants should be the first choice of treatment for postpartum syndrome
    e) Marital discord is not a cause for postpartum depression

Answer: C

3. Cultural gender programming affects postpartum depression syndrome:
    a) True
    b) False

Answer: False

4. Which of the following is not a direct cause of Postpartum Depression Syndrome?

    a) Unresolved conflict in the mother-daughter relationship
    b) Childhood neglect or abuse
    c) Loss of a parent through absence or abandonment
    d) Traumatic childbirth

e) Thyroid imbalance
f) Single motherhood

Answer: F

5. Women who give birth by cesarean are more likely to be at risk for Postpartum Depression.

a) true
b) false

Answer: True

6. Cultural loading with respect to motherhood refers to:
    a) Mothers feelings of being competitive with one another
    b) A woman's experience of being a mother is more charged because of her competition with her own mother
    c) A mother's feeling that she is responsible for her child's outcome due to pressure to be a "good" mother, coupled with the devaluation of nurturing in society and lack of support to mother
    d) The same parameters for self evaluation as it does for fathers
    e) All of the above

Answer: C

7. The loss of freedom as it relates to motherhood is:
    a) True for teenage mothers only
    b) Affects women who have not come to terms with motherhood
    c) Is less true for American mothers than European mothers
    d) True for all women across socioeconomic, ethnic and educational backgrounds
    e) A and c

Answer: D

8. Ambivalence in motherhood is common in our culture

    a) True
    b) False

Answer: A

9. Baby Blues:

    a) Does not require medical treatment

b) Occurs in the first two weeks after childbirth, resolves by one month
c) Occurs in up to 80% of mothers
d) Is thought to be related to hormonal changes following childbirth
e) All of the above
f) None of the above

Answer: E

10. Which of the following are not symptoms of postpartum depression syndrome:
    a) recurrent crying spells
    b) onset one month to one year after birth
    c) feelings of inadequacy as a mother
    d) fatigue
    e) delusions and hallucinations
    f) depression and anxiety
    g) fears of hurting the baby or self

Answer: E

11. Childbirth experience is not a significant event in a woman's life other than she has a baby and becomes a mother.
    a) True
    b) False

Answer: B

12. The following percent of women have thyroid imbalance postpartum:

    a) 15%
    b) 1-2%
    c) 12%
    d) 10%
    e) 80%

Answer: D

13. Postpartum Depression Syndrome is:
    a) More prevalent in western vs non-western cultures
    b) More prevalent in teenagers than any other age
    c) Treatable
    d) All of the above

Answer: D

14. Postpartum psychosis occurs in:

a) 1.5% of the population
b) 1-2 per thousand, but twice that much in western societies
c) 2%
d) 1-2 per thousand across cultures
e) less than 1%

Answer: D