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# Peripartum and Postpartum Depression

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## DESCRIPTION OF PERIPARTUM & POSTPARTUM DEPRESSION

During pregnancy, depression can occur prenatally (anytime from conception to birth), during peripartum (the last month of gestation to first few months of delivery), or postpartum (from delivery, up to a year after birth). Approximately 12% of women will develop depression during pregnancy, and 21% will develop depression following pregnancy (Wisner et al., 2013). It is important to differentiate between the *baby blues*, which is a normative increase in emotionality due to hormone fluctuations in the week following birth, and Postpartum Depression (PPD). PPD involves escalated depressive symptom severity and duration, and the onset can be up to a year after birth.

Moreover, research shows that perinatal depressive disorders do not generally resolve without some type of intervention (Woolhouse, Gartland, Perlen, Donath, & Brown, 2014). If left untreated, PPD may negatively affect fetal development, prenatal care, bonding between mother and baby, self-care, nutrition and sleep, and drug, alcohol, and tobacco use. PPD carries a risk of infanticide, perinatal suicide and maternal suicide (Claridge, 2014).

### Resources:

- <http://www.helpguide.org/articles/depression/postpartum-depression-and-the-baby-blues.htm>
- <http://www.postpartumprogress.com/>
- [www.postpartumdads.org](http://www.postpartumdads.org)
- [www.postpartummen.com](http://www.postpartummen.com)

## IDENTIFICATION/ ASSESSMENT STRATEGIES

PPD is often identified and assessed by obstetricians, midwives, pediatricians and primary care physicians, who have the most encounters during the highest risk postnatal period. Unfortunately, many providers do not routinely screen new mothers for PPD (LaRocco-Cockburn, Melville, Bell, & Katon, 2003). Additionally, new mothers may be less likely to seek assistance for depression themselves and may conceal symptoms because of the taboo nature of PPD (Feeley, Hayon, Zelkowitz, & Carrier, 2015).

Traditional depression assessment tools can be used to assess new mothers for depression. However, three commonly used assessment tools for assessing PPD are: the Edinburgh Postnatal Depression Scale (Cox, Holden, & Sagovsky, 1987), the Postpartum Depression Screening Scale (Beck & Gable, 2000), and a short form of the Patient Health Questionnaire called the PHQ-9 (Kroenke, Spitzer, & Williams, 2001).

Another best practice assessment strategy is for medical professionals to assess clients' risk factors and provide PPD psychoeducation, ideally at their first obstetrician appointment, so that the new mother and her partner are better able to identify symptoms should they present. In addition to biological factors that contribute to PPD (e.g., change of hormones and thyroid function), there are several other risk factors (des Rivières-Pigeon, Séguin, Goulet & Descarries, 2001; Lee, Liu, Kuo, & Lee, 2011; Stewart, Robertson, Dennis, Grace, & Wallington, 2003). These risk factors are listed below, with the moderate-to-strong predictors appearing in bold font:

- Demographic: age (young mothers), low Socio-Economic Status.
- Clinical: **past history of depression, depression and anxiety during pregnancy** strongly predicts postnatal depression.
- Psychological: **neuroticism, low self-esteem**, cognitive incongruence between expectations and reality of motherhood.
- Obstetric: unplanned pregnancy, fertility difficulty/ IVF, pregnancy or labor complications, emergency c-section.
- Infant: **childcare stress, difficult infant temperament**, Breastfeeding struggles, disappointment with gender of infant.
- Social: **perceived lack of informational, practical and emotional social support, adverse life events**, marital strife, single mothering, **high stress**, financial, occupational changes, being a stay at home mother.

#### Resources:

- PPD Assessment Tools: <http://postpartumstress.com/professional-development/assessments/>
- Patient Health Questionnaire: [http://phqscreeners.com/pdfs/02\\_PHQ-9/English.pdf](http://phqscreeners.com/pdfs/02_PHQ-9/English.pdf)
- Online Screening Test: <http://www.postpartumhealthalliance.org/screening-test>

## INTERVENTION STRATEGIES

A scarcity of quality research exists on empirically-based interventions for PPD (Stewart et al., 2003). However, there are standards of best practice and guidelines for treatment that are important to consider (Yonkers et al., 2009).

### Treatment Guidelines

Once PPD has been diagnosed, the guidelines are as follows (Guille, Newman, Fryml, Lifton, & Epperson, 2013):

1. A suicide assessment must be completed immediately and on a regular basis.
2. If any psychotic symptoms are present or a mother describes strong negative feelings about her child, a referral to inpatient treatment should be considered. Possible homicidal ideation should always be evaluated.
3. Clients should immediately be placed in individual counseling, and group-based counseling if appropriate and accessible. It is important to note that counseling may be brief for those who experience mild PPD.
4. Psychopharmacotherapy needs to be considered carefully in the context of pregnancy and breastfeeding; if a mother is on anti-depressant medication, close monitoring and frequent consultation with a psychiatrist should occur. There are few studies of the use of antidepressant medication with this population. Although some studies suggest medication can be somewhat effective, women who are pregnant or breastfeeding are generally excluded from research, thus making it difficult to understand their efficacy (Abreu & Stuart, 2005).

### Individual Counseling

As a preventative strategy, counselors should prepare pregnant women and new mothers for the possibility of PPD and normalize difficulty transitioning to parenthood; doing so reduces the stigma of PPD. Education can also help facilitate early intervention and awareness.

Although traditional depression interventions, such as Cognitive Behavioral Therapy and Person-Centered Therapies are effective in treating those who have been diagnosed with PPD, research suggests that Interpersonal-Based Therapies (IPT) are the most effective (Claridge, 2014; Miniati et al., 2014; Stuart, 2012). IPT focuses on interpersonal disputes, grief, loss, and role transitions, making it well suited for mothers struggling with PPD symptoms. Because new mothers often lack social support, and may be influenced by taboos associated with PPD, they may struggle to ask or seek help. New mothers also traverse a significant role change (either the transition to mothering or being a mother of an additional child), and they may grieve the loss of their pre-maternal life. Processing grief and loss associated with previous pregnancies, whether they were miscarriages or abortions, may also be important (Stewart et al., 2003).

Individual IPT should begin with the identification of interpersonal problem areas moving to the formulation of a list of issues that are contributing to the client's distress (Fitelson, Kim, Baker, & Leight, 2011; Miniati et al., 2014; Stuart, 2012). IPT is particularly concerned with identifying emotions, expressing emotions, and processing past, unresolved emotional struggles. Individual counseling for PPD is short-term, acute with a present focus, collaborative with the client, and supportive and directive in nature. Sessions are scheduled weekly, then moved to biweekly when the client is stable. In order to prevent relapse, maintenance and management sessions may still be needed intermittently after counseling has concluded. The focus of counseling when treating PPD is the mother's relationships with her infant, partner, family of origin, partner's family, and friends (Miniati et al., 2014; Stuart, 2012). Most mothers are reluctant to discuss their conflicted feelings towards their new infant – ones of love and attachment combined with resentment, fatigue and loss of self. Quality of one's partnerships, including sexual intimacy, may have changed dramatically since the birth of a child, and this may also need to be addressed. Family issues may arise as disputes and criticisms of the new mothers' parenting practices, particularly breastfeeding and sleeping practices, emerge. Loss of friendships or a lack of social engagement may also present as problems during the postpartum period.

Specific, effective interpersonal techniques include psychoeducation, communication analysis (i.e., reviewing interpersonal disputes and reviewing communication strategies and mistaken assumptions) and role playing.

Research suggests that it may be helpful to involve the mother's partner in individual counseling sessions (da Rosa Silva, Prado, & Piccinini, 2013). By bringing her partner into session, the mother can address problematic feelings with her partner in a safe environment and explore issues surrounding sharing responsibility. Additionally, the counselor can serve to educate the mother's partner on the normative experiences of parents, and provide psychoeducation on PPD.

#### **Resources:**

- Interpersonal Psychotherapy: <http://www.goodtherapy.org/interpersonal-psychotherapy.html>
- Psychotherapy Essentials to Go: Interpersonal Psychotherapy for Depression: [http://www.amazon.com/Psychotherapy-Essentials-Go-Interpersonal-Depression/dp/0393708292/ref=sr\\_1\\_2?ie=UTF8&qid=1428700102&sr=8-2&keywords=interpersonal+psychotherapy+and+postpartum+depression](http://www.amazon.com/Psychotherapy-Essentials-Go-Interpersonal-Depression/dp/0393708292/ref=sr_1_2?ie=UTF8&qid=1428700102&sr=8-2&keywords=interpersonal+psychotherapy+and+postpartum+depression)

#### **Group Counseling**

Emerging research indicates that support groups and counseling groups, where infants are welcome, can be effective in the treatment of PPD and they may facilitate building a stronger relationship between the infant and mother (Goodman & Santangelo, 2011). It is important to allow infants to be present at groups because childcare can be a significant barrier for women in seeking treatment (Ugarriza, 2004).

Groups can have many themes, but should provide: (a) education and information, (b) stress reduction techniques, (c) development of support systems and resources, and (d) cognitive restructuring (Pessagno & Hunker, 2013; Ugarriza, 2004). The combination of interpersonal and cognitive techniques appear to be particularly effective in group settings as well (Goldvarg & Kissen, 2011).

Peer support can be phone/text-based; when women receive peer support via phone or distance-methods, they may experience relief of depressive symptoms (Dennis et al., 2009).

#### **Other Interventions**

Researchers have suggested complementary and alternative treatments for PPD such as: bright light therapy, herbal medicine/homeopathy, omega-3 fatty acids, placental encapsulation, relaxation and imagery, acupuncture and massage therapy, yoga, aromatherapy, biofeedback and exercise. However, there is insufficient data to consider these treatments as empirically-based interventions despite promise as potentially effective supplemental interventions (Fitelson et al., 2011; Stewart et al., 2003).

Finally, there is a web-based intervention currently being studied called the MomMoodBooster (Danaher et al., 2013) by a research team at the University of Iowa. This program is designed to reach mothers who are busy or are isolated in rural areas, and to provide online counseling opportunities. Clients receive calls from a coach each week, and may use the program independently to assess their symptoms and learn brief interventions designed

to help women manage their moods and negative thoughts, as well as planning and accessing resources. The intervention has some promising initial results, and suggests that distance or phone-based support may be helpful in the treatment of PPD.

## Resources

### *For Counselors*

- Postpartum Support International: <http://www.postpartum.net/>
  - PSI Certificate Trainings: <http://www.postpartum.net/professionals/psi-certificate-training/>
- Postpartum Stress Center: <http://postpartumstress.com/>
  - Professional Development: <http://postpartumstress.com/professional-development/course-check-list-resources/>
- Mothering the New Mother: [http://www.amazon.com/Mothering-New-Mother-Feelings-Childbirth/dp/1557043175/ref=sr\\_1\\_8?ie=UTF8&qid=1428709918&sr=8-8&keywords=postpartum+depression+support](http://www.amazon.com/Mothering-New-Mother-Feelings-Childbirth/dp/1557043175/ref=sr_1_8?ie=UTF8&qid=1428709918&sr=8-8&keywords=postpartum+depression+support)
- I'm Listening: A Guide to Supporting Postpartum Families: [http://www.amazon.com/Im-Listening-Supporting-Postpartum-Families/dp/0692305807/ref=sr\\_1\\_11?ie=UTF8&qid=1428709918&sr=8-11&keywords=postpartum+depression+support](http://www.amazon.com/Im-Listening-Supporting-Postpartum-Families/dp/0692305807/ref=sr_1_11?ie=UTF8&qid=1428709918&sr=8-11&keywords=postpartum+depression+support)
- STEP-PPD Online Training: <http://www.step-ppd.com>
- Pregnancy and Postpartum Mood and Anxiety Disorders Video Training: <http://www.pesi.com/ECommerce/ItemDetails.aspx?ResourceCode=RNv046870>
- MedEdPPD (NIMH funded Professional Development Organization): <https://www.facebook.com/mededppd.org>

### *For Clients*

- MomMoodBooster Online Program: <https://www.mommoodbooster.com/public/us/>
- The Mother to Mother Postpartum Depression Support Book: [http://www.amazon.com/Mother---Mother-Postpartum-Depression-Support/dp/0425208087/ref=sr\\_1\\_1?ie=UTF8&qid=1428709855&sr=8-1&keywords=PPD+support+group](http://www.amazon.com/Mother---Mother-Postpartum-Depression-Support/dp/0425208087/ref=sr_1_1?ie=UTF8&qid=1428709855&sr=8-1&keywords=PPD+support+group)

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