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Article 24

Postpartum Depression: What Counselors Need to Know

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Abstract

This paper presents descriptions of the types of Postpartum Mood Disorders (PPMD) and calls counselors to be effective providers to women, spouses, and families struggling with PPMD. A basic understanding of the symptoms of each disorder and associated risk factors are presented. Finally, the counselor's role in prevention strategies and effective treatment modalities for working with women with PPMD as well as with their spouses and families is discussed.

Keywords: Postpartum Mood Disorders, Maternity Blues, Postpartum Blues, Postpartum Depression, Postpartum Psychosis, Depression with Postpartum Onset

Counselors around the world have and will be faced with the opportunity to provide services to women who are struggling with mental health issues surrounding the birth of their children. In order to do so effectively, counselors must understand each of the postpartum mood disorders, risk factors potentially contributing to the disorders, identifiable symptoms, current best practices, and the counselor's role in addressing prevention and treatment of postpartum mood disorders. This paper serves to provide basic information needed for counselors to serve as helpers to this population, their spouses, and their families.

Types, Symptoms, and Risk Factors of Postpartum Disorders

Postpartum mood disorders (PPMD) have been reported since the 4th century B.C. (Hamilton, 1962) when Hippocrates speculated that suppressed lochial discharge could travel toward the head and cause agitation, mania, and delirium. In the 11th century, a female gynecologist wrote the following concerning a postpartum disorder: "If the womb

is too moist, the brain is filled with water, and the moisture running over to the eyes compel them to shed tears” (Mason-Hohl, 1940, p. 350). During the 19th century, postpartum disorders were given even more attention. Marce’ gave a detailed account of puerperal psychosis describing cases of postpartum mania, melancholia, mixed states of psychosis, and cognitive difficulties (Stein, 1982). Throughout the early 20th century, PPMD were considered to belong to bipolar illnesses, schizophrenia, or other established states. PPMDs are now considered a subtype of Major Mood Disorders in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM IV-TR*; American Psychiatric Association, 2000). Briefly, PPMD can be broken into three types: maternity blues, postpartum depression, and postpartum psychosis.

Types

Maternity blues.

Maternity blues (MB; also known as “baby blues”) is a transient alteration in the mood state of new mothers. This condition occurs within the first 10 days following childbirth with a peak of onset on the 3rd day (Kraus & Redman, 1986; Pitt, 1973; York, 1990; Bennett, 1994). The cause of this condition remains unknown though several hypotheses have been considered. These include biological factors (O’Hara, Schlechte, Lewis, & Wright, 1991; Stein, 1982), the “end reaction” occurring after any emotional or physical stressor or major life event (Iles, Gath, & Kennerley, 1989; Kennerley & Gath, 1989; Stern & Kruckman, 1983); parity (Gard, Handley, & Parsons, 1986; Gelder, 1978); a general predisposition to anxious or dysphoric mood (Harris, 1980; Nott, Franklin, & Armitage, 1976); and environmental factors such as an unexpected move, financial stressors, or broad-scale social situations such as war (Cruickshank, 1940; Gordon & Gordon, 1967; O’Hara et al., 1991; Uddenberg & Nilsson, 1975). No matter the cause, 50% to 80% of new mothers experience the symptoms of the blues within a few days of the postpartum (Brockington, 1992; O’Hara et al., 1991; Saks et al., 1985; Yalom, Lunde, & Moos, 1968).

The symptoms of postpartum blues vary by case in intensity and duration. They include crying, anxiety, insomnia, irritability, headache, confusion, minimal clouding of consciousness, dysphoria, emotional lability, fatigue, anger, tension, poor sleep (not related to baby care), and a sense of vulnerability (Hopkins, Marcus, & Campbell, 1984; Kraus & Redman, 1986; Stern & Kruckman, 1983).

Treatment for these symptoms is negligible. Generally, postpartum depression is not treated as an illness because it is considered a normal reaction following childbirth. Furthermore, hormonal and other pharmacological treatments have proven futile. Support and comfort given by spouses and others (including nurses while hospitalized) are welcome, but little seems to reduce the symptomatology (Kraupl-Taylor, 1980; Kraus & Redman, 1986). Finally, the only deleterious consequence of postpartum blues is that it may contribute to the later development of postpartum depression (Brockington, 1992; O’Hara et al., 1991). This threat is more potent for single mothers who have no spouse to soothe or comfort them when the blues strike.

Postpartum depression.

Postpartum depression (PD) is a psychiatric disorder sharing some moderated and some exacerbated characteristics of general depression (Cohen et al., 2010; O'Hara, 1987). Less anger, less self-rated emotion, less suicidal ideation, early insomnia as opposed to late insomnia, extra anxiety about the baby, more hypochondriacal complaints, and more animation are some of the reported differences between postpartum depressed and other depressed patients (Brockington, Margison, & Schofield, 1988). A diagnosis of Major Depression with Postpartum onset is the diagnostic label for this disorder when symptoms warrant (American Psychiatric Association, 2000). Approximately 10% to 20% of the general population experiences a depressive episode during the life span (Boyd & Weissman, 1981) while rates for PD specifically approach 30% (Campbell & Cohn, 1991; O'Hara et al., 1991; Phillips & O'Hara, 1991).

PD has an insidious onset and more persistent symptoms in comparison to MB (Affonso & Domino, 1984). The onset is generally between 2 weeks and 1 year following childbirth. In an assessment of women with long-term PD, however, one study reported that 13% exhibited an onset of depression before delivery, whereas an additional 35% demonstrated sufficient symptoms for a diagnosis of depression within the first 2 weeks. If the woman received treatment, the disorder may subside within a few weeks to months. If the symptoms go undiagnosed and subsequently untreated, the disorder may persist beyond the first postpartum year (Kerfoot & Buckwalter, 1981; Pfof, Stevens, & Matejcek, 1990).

Regardless of the onset and duration of PD, little has been concluded regarding its origin. Rather a set of risk factors has been developed. These factors include recent stressful life events (Marks, Wieck, Checkley, & Kumar, 1992; O'Hara, Neunaber, & Zekoski, 1984; Paykel, Emms, Fletcher, & Rassaby, 1980); internal conflicts and personality variables dependent on the prototype given by one's own mother (Bibring & Valenstein, 1976); depression during pregnancy (Elliott, Rug, & Watson, 1983; Feldman & Nash, 1984; Graff, Dyck, & Schallow, 1991); marital disharmony (Gotlib, Whiffen, Wallace, & Mount, 1991; Marks et al., 1992); concerns and panic about pregnancy (McNeil, Kaig, & Malmquist-Larsson, 1983); boredom and isolation which may be a particularly strong factor for single mothers (Leifer, 1977); high levels of neurotic symptoms prior to pregnancy (Cox, Conner, & Kendall, 1982; Graff et al., 1991); the experience of childbirth as a loss (e.g., loss of freedom and youth; Campbell & Cohn, 1991; Nicolson, 1990; Richman, Raskin, & Gaines, 1991); young or old age (Gordon & Gordon, 1959; Paykel et al., 1980); primiparity (Campbell & Cohn, 1991; Gordon et al., 1965); multiparity (Davidson, 1972; Kaij, Jacobson, & Nilsson, 1967; Tod, 1964); marital status such as divorced or single (O'Hara, 1987); previous psychiatric history (Ballinger, Buckley, & Naylor, 1979; Marks et al., 1992; Paykel et al., 1980; Tod, 1964); and reduced social and familial support (Graff et al., 1991; Nicolson, 1990; Yalom et al., 1968).

When considering non-Western cultures regarding childbirth and postpartum issues, lower rates of PPMD are commonly found. While caution is necessary in interpretation of findings, it has been speculated that the difference in prevalence rates are at least partly due to the lack of psychosocial support in Western cultures. For instance, in China, the period directly following delivery is a time for the new mother to be doted on and supported by other family females and within her social network. This time of

support is called, “Zuo yuezi” or “doing the month.” No evidence of PD was found when studies were attempted in China where this support was provided (Pillsbury, 1978; Holroyd & Chung, 1997).

Other possible risk factors found in further studies include the inability of the new mother to meet her own and her perceived family’s expectations that she should be having a “wonderful time.” The notion that she should be “ultimately fulfilled” or “intuitively” in the know of mothering behaviors has been proposed to cause increased states of anxiety, guilt, and other symptoms of depression (Diskin, Doress, Bell, & Swenson, 1976; Ditzion & Wolf, 1978; Gilliam, 1981; Tentoni & High, 1980; Watzlawick, Weakland, & Fisch, 1974).

As noted above, symptoms of PD and other types of depression nearly completely overlap (Cohen, et al., 2010; Hirst & Moutier, 2010; O’Hara, Rehm, & Campbell, 1983; Spitzer, Endicott, & Robins, 1978). These symptoms include worry, tension, irritability, anhedonia, loss of concentration, tearfulness, labile mood, fatigue, insomnia (early onset) or hypersomnia, anxiety, inability to cope (particularly with the baby), suicidal thoughts, sadness, guilt, negative self-image, hypochondriasis, lethargy, and appetite changes (Beck, 1992; Brockington et al., 1988; Feggetter, Cooper, & Gath, 1981; Kraus & Redman, 1986; O’Hara, 1987; Pfof et al., 1990).

Treatment for these symptoms has ranged from increasing environmental support, including increased paternal care of the infant (Feggetter et al., 1981; Gordon & Gordon, 1967), to hospitalization when the new mother cannot be maintained at home (Halonen & Passman, 1985; Lee, 1982). Pharmacological interventions designed to elevate mood, decrease apprehension, correct sleep disturbances, and control agitation are useful and are employed when breast-feeding is not a current practice or when it is determined that the potential risk from the medications is minimal or outweighed by the potential benefit (Carbary, 1984). Psychosocial interventions have focused on empathic listening and environmental management (Halonen & Passman, 1985; Lee, 1982). Insight-oriented psychotherapy aimed at resolving underlying conflicts of motherhood also has been utilized (Deutsch, 1974). A final, well developed treatment strategy comes from an interactional/problem-solving viewpoint, and it consists of seven tactics (accepting conflicting complaints, normalizing these complaints, assessing significant others for the possibility of change, reframing depression as positive but costly, deriving adaptive behaviors from maladaptive premises, involving others in childrearing, and predicting and preventing relapse (Cohen, et al., 2010; Kraus & Redman, 1986). Albright (1993) suggested that the most crucial factor for treating patients with PD is a complete psychological assessment in order to identify the variables involved in each case; then interventions addressing specific variables should be formulated. Furthermore, there is little research addressing primary interventions aimed at PD before delivery that focuses on single mothers. One study currently under investigation involves five sessions of individual and group psychotherapy and some psychoeducation aimed at a select group of soon-to-be mothers ruling out of the study women with particular risk factors listed above as critical to the development of such disorders (Zlotnick, 2008).

Nonetheless, those women with PD who are accurately diagnosed and who receive proper treatment can generally expect to recover within 6 months (Kerfoot & Buckwalter, 1981). Those who do not receive treatment may become less affectionate with their children and less responsive to vocalizations—behaviors necessary for healthy

infant bonding and the development of secure attachments. Such women may also end breast-feeding and its benefits earlier than otherwise (Margison & Brockington, 1982). Some long-term more damaging effects also may ensue such as later behavioral disturbances in the child or nonaccidental injury to the infant (Margison & Brockington, 1982; Phillips & O'Hara, 1991; Wrate, Rooney, Thomas, & Cox, 1985). Furthermore, it has been hypothesized that unrecognized and untreated PD may contribute to postpartum psychosis (Brockington, Winokur, & Dean, 1982; Kendell, Rennie, Clarke, & Dean, 1981).

Postpartum psychosis.

Postpartum psychosis (PP) is rare (1:500) and manifested by the most severe symptoms of the PPMD (Sit, Rothschild, & Wisner, 2006). Those experiencing this PP have markedly impaired functioning due to hallucinations, delusions, extreme symptoms of depression and cognitive confusion (Brockington, 1992, O'Hara, 1987). It may be that PP is experienced no differently than other psychotic disturbances though there are some noted differences in the frequency of symptom occurrence. These include higher levels of euphoria, activity, incompetence, confusion, odd affect, paranoia, systematization of delusions, social withdrawal, and hostility for those with PP than those with other psychotic issues (Brockington, 1992).

Though the etiology for PP is not certain, the symptoms have a rapid onset in that they occur usually within the first two to four weeks post childbirth (Sit et al., 2006). The risk for women having their first child has been reported to be twice as high as for those having more than one child. This, however, may be because women who have had PP choose not to have further children. Indeed, the baseline risk for women who have had one prior postpartum psychotic episode rises to 1:7 for further episodes. The mean age of onset for PP is 26.3 (Sit et al., 2006). Related factors may include a previous diagnosis of bipolar affective disorder, family history of psychopathology, stillbirth or perinatal death, increasing maternal age, short gestation, and difficult labor (Brockington, 1992; Strouse, Szuba, & Baxter, 1992; Jones & Craddock, 2001). PP has been classified in the *DSM IV-TR* as a severe form of depression or a psychotic disorder with postpartum onset. However, more current research has suggested that PP presents more similarly to bipolar disorder with a postpartum onset (Sit et al., 2006). The impact of the psychotic state including related poor judgment can compromise safety for both mother and child or children making the identification of the disorder and early treatment much more critical than may be the case for MB or PD (Wisner, Peindl, & Hanusa, 1994).

Treatment for PP has received moderate attention in the literature over the last two decades. Once effectively diagnosed and organic causes for the psychosis ruled out, best practices include psychoeducation for the patient and family, psychopharmacological treatment for the woman with the disorder along with supportive treatments, and an ongoing assessment of the client's safety and functioning (Sit et al., 2006).

The Counselor's Role

The role of the counselor is invaluable in the application of preventative measures, screening, assessment, and treatment modalities or current best practice for postpartum mood disorders.

Prevention

The role of the counselor is to provide primary intervention whenever possible to assist in the normal development and functioning of people in the least invasive and restrictive manner. Prevention also applies to counseling activities that remove barriers to services thus preventing worsened outcome. In any case, prevention is the avoidance of illness (Rose, 2001) and counselors take measures to decrease the incidence of postpartum mood disorders.

Fisher, Wynter, and Rowe (2010) provide an analysis of universal preventive trials resulting in two primary modalities that have proven to be most effective and which can clearly be activities fitting to the counselor role. These included postnatal visits to the client by a midwife who provided listening support, and community interventions to denote physical and mental health issues with timely and appropriate referral to needed services.

Other researchers note the potential effectiveness of assessing specific potential issues and providing preventive measures to fit the individual. These include increasing the client's knowledge of stressors and potential stressors with a focus on particular stress reduction, problem solving, stress inoculation and relaxation training, physical health interventions such as nutritional guidance and exercising, and goal planning and time management (Pfof, Stevens, & Matejcek, 1990).

Psychoeducation and counseling aimed at modifying the client's negative expectations of the entire process from pregnancy through early infant care and negative self-statements regarding the client's capacity can assist in prevention of PPMDs. Assisting the client and the father of the baby to increase communication skills, negotiating tasks of child care and household management, and revamping role assignments to fit the couple's specific situation, and increasing problem solving skills can all serve as means of reducing the stress associated with PPMD. Further, increasing the client's social support network to extended family and beyond may provide needed preventative measures (Pfof et al., 1990).

A preventive service that precedes the application of the above noted activities is community education to normalize the need for assistance for mental health issues. Many individuals experience shame at the recognition of emotional or mental difficulties and, therefore, do not seek assistance until the difficulties have grown into disorders (Foulkes, 2011). Counselors can work with medical professionals to educate their patients regarding the normalcy of seeking assistance before issues mount.

Screening

Not all women will need such services as noted above, nor is it affordable to provide universal services in today's economy. Noting which women would benefit from preventative or tertiary care requires screening. A recent study (Yawn et al., 2012) provided an exhaustive overview of the screening processes utilized in 54 programs around the world regarding postpartum mood disorders. Results indicate that the Physician's Health Questionnaire-2 and -9 (PHQ-2 and PHQ-9) are the most often utilized early screening tools which are both followed by the Edinburgh Postpartum Depression Schedule (EPDS) when the PHQ result indicated likelihood of a PPMD. Such screening can be successfully completed in the physician's office which is often where PPMD is initially diagnosed. Counselors can utilize these tools with minimal training for a client

who presents with symptomatology and/or risk factors should the client present to the counselor without prior diagnosis. The PHQ-2 is a two-item tool that assesses the frequency of the client's depressed mood and anhedonia. The PHQ-9 is a nine-item tool that further assesses for symptoms and severity of symptoms (Yawn et al., 2009). The EPDS is a 21 item self-report measure by which women assess the presence and severity of their postpartum depressive symptoms. It is available in the public domain online without cost and has been administered in person, electronically, and over the phone with success (Horowitz, Murphy, Gregory, & Wojcik, 2011). As previously noted, early screening may lead to higher rates of successful intervention.

Further assessment for PPMD diagnosis requires application of the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; *DSM IV-TR*; APA, 2000). An uncomplicated display of maternity blues will not require diagnosis as it is considered a normal primarily hormonally driven state. Postpartum depression and psychosis can be diagnosed utilizing the Mood Disorder diagnostic schema to determine the depressive or bipolar base and the specifier of "with postpartum onset" (*DSM IV-TR*, pp. 422-423). A glaring omission from the current *DSM* is the availability of hypomania with the postpartum onset specifier, which may be included in the upcoming *DSM-5* (Sharma & Burt, 2011).

Treatment Modalities

Once screened and then successfully diagnosed, the counselor can play a key role in the application of, and compliance with, successful intervention strategies for a woman with a PPMD. Current best practice involves psychoeducation for the client and family, supportive counseling, and pharmacological interventions prescribed by the medical professional.

Psychoeducation.

Once a PPMD has been identified, the client and family are assisted by learning about the symptoms, available treatment, potential outcomes, and relapse prevention strategies. This provides client and family much needed structure and inoculation for the events to come. Understanding the symptoms can decrease fears and worries. Such education can increase compliance as the client and family gain accurate expectations regarding treatment and outcome (Sit et al., 2006).

Supportive counseling.

Interpersonal counseling, cognitive behavioral therapy, nondirective counseling, and peer and partner supportive counseling have each proven to be equally effective therapeutically for mothers struggling with PPMD. Interpersonal counseling is time limited (12-20 weeks) and addresses the relationship between one's mood and one's social context within four problem areas including role transition, role dispute, grief, and interpersonal deficits. Counseling aims to problem solve new approaches to social contexts and adjustments to new roles and conditions. For those with postpartum depression the focus is often on the mother-infant relationship, mother-partner relationship, and the mother-work transition (Stuart & O'Hara, 1995).

Cognitive behavioral approaches are based on the notion that thoughts, behaviors, and moods are linked. The focus is on adjusting distorted patterns of thinking leading to

behavioral changes that create stress reduction, promote positive coping strategies, and result in elevated mood states (Hollon, 1998).

Non-directive counseling is unstructured and relies on empathy and non-judgmental listening. The focus is directed by the client who explores issues as deemed important to the client in a warm and supportive environment (Fitelson, Kim, Baker, & Leight, 2010).

Peer and partner support have been noted as essential to PPMD recovery (Di Mascio, Kent, Fiander, & Lawrence, 2008). Activities that enhance the existing social support networks both within the family and outside the family may prove to provide alleviation of stress. This may be especially so when the client is able to express her needs, vent her stresses, and receive the needed support. Couples counseling and collateral visits may assist in both building communication skills and in supportive practices. For those without social support, providing connections to social outlets and to supportive systems and encouraging social connections may be necessary steps. Group counseling for both individuals and couples may provide additional social networking, modeling of effective social support and need expression, and social connections.

Psychopharmacology interventions.

Maternity blues appears to be the result of the normal hormonal fluctuations that occur within the first few days of the postpartum period. While the symptoms are uncomfortable, they are normal. No medical regimen is specified for the treatment of MB. Rather, rest and understanding are the primary means of support.

Pharmacological treatments for postpartum depression are generally mood stabilizers or antidepressants which have been found to be as effective as the non-pharmacological treatment (Payne, 2007). Antidepressants most commonly prescribed for PD include fluoxetine, paroxetine, nortriptyline, sertraline, venlafaxine, nefazodone, fluvoxamine, and bupropion each of which have been found to be similarly effective in reducing and managing symptoms. One major consideration of any medication is the impact on the fetus postpartum and the infant through breastfeeding postpartum. Because much is yet to be known about antidepressants and the impact on the infant, many doctors and many women refuse such treatment. Still, for some women non-pharmacological interventions remain ineffective (Fitelson et al., 2010). Such decision-making is not within the scope and practice of the counselor; still, the counselor is in a role to assist the client in processing the risk factors and in supporting the medical regimen as prescribed in order to help the client be compliant and be aware of potential issues such as differentiating between normal side effects and those indicating a need for immediate return to the medical professional for care.

Hormonal treatment is another course of pharmacological treatment available to the non-breastfeeding mother. Treatment studies with estrogen and progesterone throughout the postpartum period have yielded results indicating that some women are susceptible to hormonal changes that may lead to depressive symptoms, which may be abated by hormone treatment. Additional research is pending regarding the overall efficacy of hormonal treatment for PPMD (Moses-Kolko, Berga, Kalro, Sit, Wisner, 2009). Again, the counselor can be a sounding board for the mother who is decision-making regarding breastfeeding and the potential use of this modality.

Other nonpharmacological alternative medical modalities that have been shown to have at least some beneficial impact as treatment of PPMD symptoms include electroconvulsive therapy, bright light therapy, Omega-3 Fatty Acid, acupuncture, massage, and exercise (Fitelson et al., 2010). The counselor can support and assist the client in utilizing these modalities by appropriate referrals and can incorporate the extra therapeutic value of these treatments in the counseling session.

In short, there are many modalities with at least some measure of noted success available to the client suffering from symptoms of PPMD. The counselor must be aware of the risk factors for PPMD, the symptoms associated with each type of PPMD, and the potential treatments available for each type as well as for partners and families of those with PPMDs. The role the counselor can play in providing best practice services and supporting other service providers may be the critical ingredient in assuring efficient and effective recovery for the mother and the family.

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Note: This paper is part of the annual VISTAS project sponsored by the American Counseling Association. Find more information on the project at: http://counselingoutfitters.com/vistas/VISTAS_Home.htm