

Postpartum Depression

The Hidden Problem of New Moms

By: Susan Kendig, RNC, MSN, WHCNP and Diane G. Sanford, PhD.

Overview

The birth of a baby signifies major changes in a woman's life, presenting new challenges and demands. While this event is often met with joy, each woman responds differently to the stress of the postpartum period. This article is designed to enhance childbirth educators' understanding of the range of postpartum emotional adjustments women may experience. Three levels of postpartum distress will be described. Prenatal and postpartal risk factors which indicate vulnerability to postpartum adjustment problems will be discussed. Strategies for increasing awareness of postpartum adjustment problems and suggestions for proactive interventions will be explored.

Objectives

Upon completion of this article readers will be able to:

1. Describe three characteristics of postpartum blues, postpartum depression, and postpartum psychosis.
2. Identify a minimum of three prenatal risk factors indicative of vulnerability to postpartum adjustment problems.
3. List a minimum of three symptoms of postpartum adjustment problems warranting referral to a mental health professional.
4. Discuss a minimum of two strategies for including education regarding postpartum adjustment issues in childbirth preparation classes.

Every woman hopes for the perfect pregnancy, birth, and postpartum experience. However, the fatigue, new sense of responsibility, changes in familiar routines, and strong desire to excel in the role of mother can combine to make early parenthood one of the most challenging periods in a woman's life. After the baby is born, the new mother may experience tearfulness, irritability, anxiety, mild to moderate mood swings, loss of appetite, or sleeplessness. These feelings, coming when she expects to feel joyful, can be confusing and alarming to the new mother.

The prevalence of postpartum adjustment disorders is difficult to determine, as the condition is not reportable and many women do not seek professional help. During the 1980s, Brockington (1987) suggested a prevalence rate of about 20 percent, while Cox

(1986) suggested a prevalence of 10-15 percent for postpartum depression and 50-70 percent for postpartum blues. Other studies suggest a postpartum depression prevalence rate of 9-11 percent (Holcomb, et al., 1996). One Australian study (Stamp, Williams and Crowther, 1996) found an incidence of 58 percent for vulnerability to postnatal depression. Clearly, postpartum emotional adjustment problems are a significant concern for healthcare professionals working with pregnant and parenting women.

Levels of Postpartum Distress

Adjustment to the postpartum period is exhibited in a wide scope of behaviors and emotional reactions which nevertheless take on definite patterns. Related sets of symptoms have been identified as part of a continuum of postpartum adjustment disorders. Postpartum distress has been stratified primarily into three levels on the continuum: postpartum blues, postpartum depression, and postpartum psychosis (Bing & Colman, 1994).

Postpartum Blues

Postpartum blues or “baby blues” has been described as a mild change in mood which occurs within 24-48 hours following birth and usually resolves within two weeks. Occasionally, mild symptoms of postpartum blues will persist for up to six weeks after delivery. Tearfulness, irritability, difficulty sleeping, emotionality, anger, tension, restlessness, and slight anxiety characterize postpartum blues. This picture is in direct conflict with society’s portrayal of motherhood as a serene, blissful state where the woman is always in control. Unrealistic expectations placed on women by family, friends, the media, and most of all, herself, only add to the confusion and stress she experiences (Dunnewold & Sanford, 1994).

“Normal postpartum adjustment” may encompass an extension of these symptoms throughout the first two months, as the new mother tries to regain her physical equilibrium while coping with the care of a new infant. Women commonly experience episodes of tearfulness, irritability, body image concerns, doubts about parenting skills, and even sleeplessness, mood swings, appetite changes, and loss of sexual interest as they cope with the fatigue of new parenthood (Dunnewold & Sanford, 1994).

Many of these reactions are related to the rapid physiologic and hormonal changes accompanying the postpartum period. During pregnancy, progesterone levels rise to 20-30 times their normal concentration (Ford, 1992). Prolactin and adrenal hormones also increase, and changes are noted in every body system. Following the birth, estrogen and progesterone decrease dramatically, while prolactin levels rise to support lactation. Even if a woman does not breastfeed, prolactin levels may continue to stay at an increased level for up to two months, thus suppressing normal estrogen and progesterone production (Filer, 1993). These physiological changes accompanying birth, combine to affect not only her physical condition, but also self-image and psychological status.

Awareness of possible reactions during the postpartum period is important in helping women recognize and cope with “baby blues.” Prenatal interventions include education and dialogue regarding postpartum expectations. Postpartum interventions include emotional support, education regarding normal postpartum reactions, and problem-solving to find effective coping mechanisms.

Rest: Fatigue can decrease coping abilities, but finding the time to rest can be difficult. Sleeping when the baby sleeps, involving family members and friends in household chores and baby care allow the new mother to get the rest she needs.

Frequent Breaks: It is difficult for the new mother to find time to do even simple things for herself, such as bathe leisurely or have a quiet cup of tea. Yet these activities are replenishing. Encourage new mothers to do something for themselves each day: go for a walk, have lunch with a friend, simply sit quietly for a while. It is also important for parents to plan time away from the baby to nurture their relationship as a couple.

Share Positive Feelings: Encourage woman to notice and cultivate feelings of happiness and contentment, and share them with their partner, family, friends and other new parents. This is a time of great joy and recognizing positive emotions validates the specialness of this time in parents’ lives.

Give negative emotions air time: Tears can be healing and relieve stress. Give women permission to experience and talk about sadness, anger, and frustration.

Develop a support system: A supportive system of friends and family helps a woman cope with postpartum changes. Identify community resources such as mothers’ groups, babysitting co-ops and classes to assist new mothers in successfully navigating postpartum transitions.

Case Example: Jessica came in for counseling when she was six months pregnant with her second child. After being discharged from the hospital with her first child, Murphy, she had no appetite and lost 10 lbs. in the first two weeks. She slept poorly at night. During the day when Murphy slept, she still couldn’t relax, afraid he would wake up crying and she wouldn’t know what to do. She felt lonely and isolated in a new city where she had only lived for a year. Before motherhood she had been a person who rolled with the punches: now she was edgy and felt a complete loss of control. She was surprised by how much work Murphy required. “I felt resentful about being ordered around by a baby. Breastfeeding was a lot tougher than I thought—being tied to him all the time. He didn’t nap for more than 15 minutes at a time during the day, and cried more than average. I found myself saving my affection for the baby, and not having much energy for my husband. We went out once when Murphy was one week old, and then probably didn’t go on another date for a year.”

At two months postpartum, Jessica returned to work. Gradually things got better. She felt more in control. The babysitter got Murphy on a nap schedule and he was not as cranky. Jessica started to revise her expectations of being the perfect mother. She learned to deal

with the guilt of being away from Murphy and became more comfortable with learning what he needed. By six months, Jessica felt adjusted to this major life change and felt more like her old self.

With her second pregnancy, Jessica decided to get help early. In counseling she developed a postpartum plan which included getting increased support, getting out more during the day, having her husband participate more in household responsibilities, and spending more time with other adults.

When Jessica brought her new daughter, Amanda, home, she had some difficulty sleeping and relaxing, but she never developed appetite problems. She reported that her mood was “pretty good” and she was not having crying spells. Nighttime was worse because she worried about not being able to fall asleep, a common concern for many new mothers, whose normal sleep patterns are disrupted by the newborn. She took breaks from childcare and her husband gave Amanda her late night feedings. With prenatal intervention, Jessica experienced a normal case of the “baby blues,” as most mothers do, but it did not lead to more serious postpartum adjustment problems.

Postpartum Depression

The risk for developing clinical depression increases during the first month postpartum. Cox and colleagues (1993) reported a threefold increase in risk of depression during this time. Approximately 10 percent of women exhibit symptoms of clinical depression during the first few months following childbirth (Gregoire, Kumar, Everitt, Henderson and Studd, 1996).

Postpartum depression usually includes the same symptoms as “baby blues” but at a more intense and enduring level (Bing & Coleman, 1994). Generally, postpartum depression will resolve within six months with appropriate treatment, although studies indicate that up to 25 percent of affected women will continue to exhibit symptoms for longer than one year (Gregoire et al., 1996). In addition to a worsening of normal adjustment symptoms, women with postpartum depression may also exhibit panic disorders, panic attacks, extreme anxiety and physical symptoms such as shortness of breath, dizziness and tremors (Dunnewold & Sanford, 1994). Tearfulness, crying spells, short attention span, inability to concentrate and mood swings are common. Changes in sleeping and eating patterns may also occur. Difficulty returning to sleep after feeding the baby is of particular diagnostic significance. Irritability, loss of interest in previously enjoyed activities, increased sensitivity and decreased energy are hallmarks of postpartum depression (Dunnewold, 1996). Suicidal thoughts or thoughts of harming the baby may also be present. The woman may feel tremendous guilt and embarrassment related to her difficulty coping with motherhood.

Mild postpartum depression may be categorized as an adjustment disorder. A major depressive disorder, with postpartum onset as defined in the DSM-IV (1994), includes the following criteria:

1. depressed mood most of the day, nearly every day
2. markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
3. significant weight loss (or gain) when not dieting, or decrease/increase in appetite nearly every day
4. insomnia or hypersomnia nearly every day
5. psychomotor agitation or retardation nearly every day
6. fatigue or loss of energy nearly every day
7. feelings of worthlessness or excessive or inappropriate guilt nearly every day
8. diminished ability to think or concentrate, or indecisiveness, nearly every day
9. recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or suicide attempt or a specific plan for committing suicide.

The presence of five or more of the above symptoms during a two week period, representing a change from previous functioning, is indicative of a major depressive episode if at least one of the symptoms is a depressed mood or loss of interest or pleasure (APA, 1994).

Women exhibiting extended “baby blues” or other signs of postpartum depression should be referred to a behavioral health professional for immediate evaluation and treatment. Women with postpartum depression respond well to supportive counseling and individual psychotherapy. Antidepressants may also be helpful. It has been hypothesized that postpartum depression may be linked to the extreme hormonal changes associated with pregnancy and childbirth. At least one study has shown improvement in postpartum depression with administration of transdermal estrogen (Gregoire et al., 1996).

Case Example: Gwen had only been home from the hospital for a few days when her postpartum depression occurred. After two weeks Gwen could barely get out of bed in the morning. She felt incompetent to care for her baby and her other children and had to muster all her energy just to take a shower. She would cry for hours at a time with no immediate idea of what was troubling her. She described herself as extremely forgetful and said that her mind wandered so much she could not complete simple tasks, such as taking her older children to buy shoes. Gwen had always excelled at being a mom and thought of herself as a “strong person.” Her other pregnancies six months’ bedrest, yet she had never suffered postpartum depression.

Her postpartum problems began with labor and delivery experience that was very different from the one she had planned. Her water broke in the middle of the night and she had to urgently call neighbors to watch her children. “I thought I would be at the hospital when my heavy labor started. I thought my kids would already be taken care of. I thought I would have my suitcase packed. I thought it would be more normal. I was in shock when they put me in the wheelchair to go up to labor and delivery. The next thing I know, they’re pulling my clothes off and the baby is beginning to crown. I didn’t have time to get ready. I can’t believe what I went through.”

Already at risk for postpartum depression because of her family history, Gwen went steadily downhill after returning home. Her obstetrician recommended a psychiatrist, who put her on medication. Initially, the side effects of the medication intensified her depression. She was dizzy, had visual disturbances, and could not coordinate dressing her baby.

“I felt like I was grieving and I didn’t know why. Nothing was said about how terrifying my labor and delivery had been. The psychiatrist wanted me to stop breastfeeding so he could increase my medication, which made me feel even worse. He didn’t seem to understand that I had so much emotional pain, the thought of weaning my child seemed and unbearable loss.”

At this point, Gwen and Jeff sought a psychologist whose expertise was in pregnancy and postpartum adjustment. She reviewed the events of Gwen’s pregnancy, labor and delivery, and postpartum experience. She explained that this, in combination with her family history, could account for the severity of her depression. Together, they developed a plan with the initial goal of reducing Gwen’s depressive symptoms and improving her self-care. It was hard for both Gwen and Jeff to be patient with their expectations. It was equally difficult for Gwen to accept that she had a clinical depression without blaming herself for being weak and incompetent.

After a year of counseling and medication, Gwen recovered. Her recovery was marked by multiple periods of improvement followed by relapse. Over time, other psychosocial stressors were identified and addressed, including relationships with in-laws, time together as a couple, and Gwen’s strong desire to “be perfect.” When she completed her treatment, Gwen commented, “I would never wish what I went through on anyone. Still, I learned a lot about myself as a person and I feel better off for it. My marriage is stronger and I’m taking better care of myself than ever before. I’m much better at setting limits and saying no. I know these changes will be with me for the rest of my life.”

Postpartum Psychosis

Postpartum psychosis is at the extreme end of the continuum, affecting approximately 1-2 women per 1,000 births. The disorder occurs within 6 weeks after birth, usually in women with no prior mental illness and no psychiatric symptoms during pregnancy. Onset of the illness may occur as early as 24-72 hours postpartum. Primiparas appear to be most vulnerable (Dunnewold, 1996).

In addition to all of the symptoms of baby blues and postpartum depression, the woman with postpartum psychosis may also experience debilitating confusion, hallucinations, and delusions (Bing & Colman, 1994; Dunnewold & Sanford, 1994). Symptoms can progress rapidly from mild to severe, and can be life threatening to both mother and baby if abnormal thought processes turn toward suicide and infanticide. A 5 percent suicide rate and 4 percent infanticide rate have been associated with postpartum psychosis (Knops, 1993). Immediate referral to a mental

health professional is critical at the first signs of postpartum psychosis. Because women with a personal or family history of bipolar disorder are at increased risk of developing postpartum psychosis, they should be collaboratively monitored by their obstetricians and a mental health professional throughout the prenatal and postpartum period (Dunnewold, 1994).

Case Example: Lisa and her husband were happy beyond their wildest dreams to have a child. Unfortunately, their happiness was not to last. After an uncomplicated labor and delivery, Lisa began having symptoms of postpartum psychosis. The nurses noticed that she seemed to have an overabundance of energy atypical for a woman who had just gone through 15 hours of labor, but attributed this to her excitement. They also remarked that it was difficult to understand what she said sometimes because she spoke rapidly and her thinking was a little confused, but thought this was an after-effect of the analgesia she had received. She couldn't sleep for more than 30 minutes at a time and insisted on having her baby, Meghan, with her every moment.

When Lisa came home from the hospital her symptoms intensified. She did not sleep, except for short naps, could not sit still and ran from task to task without getting anything done. She would go for long periods without eating and still did not feel hungry. She was overly excitable and would blow up at minor situations. She thought she was the only one who could adequately care for Meghan and got edgy if someone else attempted to help out. As days passed, she grew more confused and disoriented. It was difficult to understand what she said, either because she spoke so fast or didn't fully make sense. Her family and friends were concerned, but figured that once she got more sleep, things would be better.

Even in such a frenzied state, Lisa knew something was not right. She made an appointment to see a psychiatrist, but canceled it when her well-intentioned husband told her this would pass. "I knew I was in over my head but couldn't tell him that for fear he'd take my daughter from me." By the end of her fourth postpartum week she had fallen apart. She began hearing voices telling her that her family and friends were in a conspiracy to kill her. Her dead father cautioned her not to trust her family and friends because they intended her harm.

Convinced she was in danger of losing her life and her child, Lisa decided that the only way to keep Meghan close to her was to end both their lives so they could be "safe with God in heaven." She dressed Meghan in her christening gown, gently laid her head on a pillow and suffocated her. Then Lisa took what was left of the sleeping pills prescribed for her insomnia and lay down beside her daughter. She woke up several hours later in the hospital with her stomach pumped. After two weeks of psychiatric intervention her mania stabilized and she was released from the hospital. She was tried for manslaughter and received a 20-year prison sentence. "I really wanted my baby. I really loved my baby. I suffer every day, knowing that she is gone."

Primary Prevention of Postpartum Reactions

Early identification and intervention can prevent tragedies like Lisa's. It is the professional and ethical responsibility of all healthcare providers to learn to recognize the symptoms of postpartum psychosis and mania and refer these women for treatment.

The way in which motherhood is romanticized in our culture fosters many unrealistic expectations, which women often strive to achieve. Rather than rejecting society's expectations as unrealistic, women tend to see themselves as the problem (Dunnewold & Sanford, 1994). When women fall short of these standards, they often decide that they are bad mothers, inadequate as women and failures as people. These feelings intensify emotional reactions at a time that is already challenging enough.

To diminish postpartum stress and prevent problems, society must adopt a new view of motherhood which acknowledges that the postpartum period involves tremendous physical, psychological and relationship changes. The joys of having a baby are frequently offset by the challenge of meeting a newborn's endless physical and emotional demands.

Recognize Risk Factors: Recognizing factors for development of postpartum adjustment disorders and subsequent prevention of the associated emotional pain begins during the prenatal period. Biological, psychological and relationship factors may predispose a woman to postpartum problems.

Childbirth educators are in a unique position to introduce information regarding strategies which promote healthy postpartum adjustments. Discussion of potential risk factors, or completion of a simple risk identification tool, such as the *Postpartum Adjustment Risk Assessment*, may assist women in identifying individual risk factors and begin to take steps to avert a problem.

Develop a Support Plan: Have each woman list three sources of support that she can call upon if she is having difficulty coping with the demands of new motherhood. The list may include friends or relatives to call for emotional support, resources for childcare, or someone to help with housework. The list, developed when the woman is not feeling as emotional, is a valuable resource at times when she may be stressed or fatigued.

Educate Women on PPD: Women need prenatal education which acknowledges that mothering is a learning process. If they understand the challenges and stresses inherent in having a newborn, they may view their difficulties not as a personal defect, but as part of a normal adjustment process. If they are less likely to blame themselves when problems arise, they may be more inclined to ask for help from

family and friends. If they learn that postpartum adjustment is exceptionally demanding for any new mom, they may be more willing to ask for assistance with childcare tasks and household responsibilities. By being less critical of themselves, they will feel more empowered to face the task of adjusting to postpartum changes.

Parenting is an acquired skill, but women rarely learn this. It takes time and practice to become a great mom. But most first time mothers expect themselves to know it all and blame themselves when they don't. Even veteran moms may fall short of their expectations, because each baby is different and what worked with one child may not succeed with another. Making mistakes and struggling over what to do is not a reflection of personal incompetence; it is a normal part of the process of becoming a parent. Women can and should replace their shame and guilt over perceived inadequacies with patience and understanding, knowing that becoming a good mother requires practice, persistence and learning from one's mistakes.

The "Supermom" myth is a great obstacle to a healthy postpartum adjustment. "Supermom is loving but firm, ...in control of her feelings...informed and active...an emotional giant. She always knows the right thing to do and does it perfectly... She is the standard of success. Hers is the image many women compare themselves to. No wonder they feel so bad" (Dunnewold & Sanford, 1994).

Reality Checks for New Moms

In childbirth education classes women need to learn that there is no right way to mother. Perfection is an impossible and ridiculous standard to attain. Striving for an unattainable standard only adds to feelings of inadequacy and self-reproach. This undermines the mother's ability to tackle the demanding, often exasperating, tasks for new moms to face. As educators, it is important to encourage women to be guided by their own personal vision of what is right and good. By endorsing these new attitudes about motherhood and by recognizing risks, planning support and giving referral information, childbirth educators can help to endure a better postpartum transition for women.

*For a complete bibliography, please send a stamped, self-addressed envelope to:
Childbirth Instructor magazine at 124 East 40th St., Ste. 1101, New York, NY 10016.*

Resources for Further Information

Depression After Delivery

P.O. Box 1282
Morrisville, PA 19067
1-215-295-3994
1-800-944-4PPD

Postpartum Support International

927 Kellogg Avenue
Santa Barbara, CA 93111
1-805-967-7636

The Marce Society

Department of Psychology
University of Iowa
Iowa City, IA 52242
1-319-335-2405

Women's Healthcare Partnership, Inc.

7700 Clayton Rd. Suite 310
St. Louis, MO 63117
1-314-781-3913

Risk Factors

Biological risk factors: The normal physical and hormonal changes accompanying pregnancy and childbirth, a family history of mental illness or postpartum adjustment problems, previous postpartum reaction, complications of pregnancy and childbirth, breastfeeding and weaning, premenstrual syndrome, and thyroid imbalance.

Psychological cues: Normal psychological changes accompanying childbirth, expectations about motherhood, lifestyle factors, personal or family history of mental illness, unresolved issues from mother's own childhood (such as her relationship with her own mother), unresolved losses, recent stressful life events, or ineffective self-care and coping strategies.

Relationship factors: Normal relationship changes following childbirth, quality of relationship with the baby's father, quality of social support system, being a single mother, quality of the relationship with the baby, and relationship with other children.