



Life Lines

Improving your quality of life, one step at a time

Issue #05:

POSTPARTUM DEPRESSION



In a review of forty-eight papers from eight longitudinal studies focusing on women's social and emotional health in the first year after birth, postpartum depression (PPD) was found to be a severe condition that potentially affects ten to twenty percent of women worldwide.¹

The same review found that the two strongest predictors for postpartum depression and anxiety were the previous history of depression and poor partner relationships. Additionally, while becoming a mother at a young age is by itself not a risk factor, it could be when coupled with social disadvantages. We can't ignore that research has shown single mothers to be at higher risk for both physical and mental health disorders, as compared to mothers that are in established relationships.²

Rates of PPD can be as high as 1 in 3 among the subpopulations of adolescent, veteran, or socioeconomically disadvantaged women.

It is important to remember that depression during and after pregnancy (also called perinatal depression) is treatable, and women with the proper treatment do recover. There are several treatment options to explore depending on the severity of the indicating symptoms and socio-economic factors. In this article, we identify indicators, long-term risks and courses of action for the treatment of postpartum depression, including talk therapy. There's a growing awareness among obstetricians and pediatricians about the need to address perinatal depression. Still, like all other mental health disorders, it is something the family must work on together.



Symptoms and signs of postpartum depression

The common mild postpartum mood changes known as "baby blues" can be caused by the effects of sudden hormonal withdrawal. The postpartum mother may experience mood swings, crying spells, anxiety and difficulty sleeping. The baby blues can be expected to last for a few weeks unless the mother has a pre-existing mood disorder that allows this period to linger slightly longer.

On the other hand, postpartum depression and its myriad of mood disorders is an amplification of these symptoms that can come on stronger and last longer than postpartum mood changes. Symptoms can include a persistent low mood, accompanied by trouble performing daily tasks, and the mother feeling detached from her newborn baby. Left untreated, postpartum depression can become chronic and, in some cases lead to thoughts of harming one's self, spouse, or child, and suicidal ideations.

Think you're experiencing postpartum depression? You are not alone. About one in seven women experiences depression during or after pregnancy. The sudden hormonal withdrawal after a woman gives birth is just one factor in this universal and unpredictable condition. Individual experiences with postpartum mood disorders will vary between mothers, sometimes even between pregnancies.

Poor maternal-infant bonding and the long term implications

National Public Radio recently produced a segment for their podcast, Life Kit, which talks about five things families need to know about perinatal depression, its symptoms and treatment options. In this podcast, Jennifer Payne, a psychiatrist and the director of the Women's Mood Disorders Center at Johns Hopkins University is quoted as saying, "I always say if mom's not happy, no one's happy."

Perinatal depression has been associated with certain conditions like premature delivery and low birthweight babies, and studies have shown that PPD is associated with cognitive delays in the child. However, one of the more fundamental processes affected by perinatal depression is breastfeeding, where the condition results in a mother experiencing less satisfaction from their infant feeding method, and are more likely to stop breastfeeding.³

Like many mood disorders, the impact is felt throughout all relationships. In regards to PPD specifically, we focus on the effect it has on the maternal-infant bonding, but the spouse

sometimes gets forgotten because it is accepted that this relationship is already established. What gets buried are the hurt feelings, distorted thoughts, misinterpreted intentions and lack of clarity and joy that depression can bring into the home.

Trusted literature highlights some approaches to keeping the partner bond intact and strong during times when either parent is experiencing depression. These approaches include open communication, compassion, and taking steps to keep the depressed partner healthy when depression makes it difficult for them to engage in self-care.

Causes, outcomes and how PPD differs from other depressions

Mental health problems are never considered the mother's fault or failure. They are complications of pregnancy and childbirth, like preeclampsia and gestational diabetes, with PPD being even more prevalent. Researchers don't fully understand what causes PPD, but like all mental illnesses, biology and environment are contributing factors to how a mother experiences its symptoms.

Hormones play a significant role in PPD cases. Levels of certain hormones, mainly progesterone and estrogen and increase throughout pregnancy. Once the baby is born, the levels of progesterone and estrogen fall dramatically. That drop in hormone levels is likely responsible for the mental health symptoms many women experience during this time.

Exacerbating factors that affect PPD specifically are the constant needs of the newborn baby that tend to disrupt the regular routines of life that keep our mental health stable. Childbearing is challenging and in some instances expecting mothers may face complications. Add in sleepless nights and various lifestyle and personal sacrifices to take care of a new baby. If they lack the family support and financial means to distribute duties of care, these exacerbating factors can create pressures from the complex emotions facing new mothers.

Postpartum Depression

Young, single mothers in precarious economic circumstances are more likely to experience mental health conditions. Other risk factors include, marital stress, birth trauma and a history of abuse.

It is very easy in some cases for postpartum depression to go undiagnosed, unacknowledged, and untreated. Psychotherapeutic modalities, pharmacologic and psychosocial interventions cost money and are less accessible to vulnerable populations like young, single mothers. Another reason is that the mother may already have a mood disorder that masks, dovetails with, or confuses the symptoms of PPD she might otherwise be able to identify. Her depression may also set in during pregnancy, upsetting what we think we know about PPD, that it only occurs after a mother gives birth.

Postpartum depression isn't a weakness of character. It's merely a complication of pregnancy and giving birth. The anxiety and excitement over baby wanes and the hard work begins. Low-energy, lack of rest, lack of motivation, no time for self-care, and resources may be rationed in order to put baby first. If you have or suspect you have postpartum depression, getting treatment early can help you manage your symptoms and help you bond with your baby. One major hurdle that many women face in seeking treatment is convincing their families that they have an illness and that they need help. The stigma alone, along with feelings of helplessness, guilt, and anxiety, can create an overwhelming barrier between the mother and the dedicated treatment she requires and deserves.



How to move forward & manage treatments

It has been concluded that women in low and middle-income situations are more susceptible to experience medically unexplainable physical symptoms known as somatoform disorders with anxiety and depression.⁴ Physician recommendations suggest you look for these risk factors: a history of depression, current depressive symptoms and socioeconomic risk factors like being low income, very young or a single parent. In Canada, we have many professional resources at our disposal, most of which are covered by provincial health care programs.

OB-GYNs, pediatricians and general practitioners can screen for depression and help women get treatment at the earlier signs of perinatal depression, or in the case of prolonged postpartum depression that requires outside help.

Midwives also play a critical role in the identification, support and referral of women experiencing mental health problems.⁵ Many women do not seek help from mental health services when needed, therefore the potential for a midwife to have an impact on women's mental health warrants further examination, and a possible recommendation for treatment

In terms of psychotherapeutic modalities, two kinds of talk therapy — cognitive behaviour therapy (CBT) and interpersonal therapy (IPT), may prevent PPD in at-risk women. CBT works by changing a patient's thought patterns and actions, and IPT helps a patient improve relationships by assisting them in improving their communication skills.

Pharmacologic and psychosocial interventions also exist. Antidepressants, for instance, may be considered as effective and safe during pregnancy and breastfeeding. Medication, in combination with talk therapy, is more effective than medication alone. We are all unique and may react differently to medications. Before taking medications, consult with your

physician or primary care provider to ensure they are safe for both you and your child.

If consultation with a physician is not possible, what can you do?

You can turn to an organization like Postpartum Support International, a nonprofit that helps women and their families find support for postpartum depression, to learn more and connect with others in a similar circumstance.

On your own, making a routine of self-care has been shown to improve mental health symptoms like those experienced in PPD by improving overall health, so you can cope better with the stress of taking care of a newborn. Self-care means eating regularly and staying hydrated, getting adequate sleep, and taking breaks during the day when possible; exercising, which can be solo-time or used to bond with the baby; seeking out community and social support.

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