Maternal Postpartum depression and anxiety: How do we treat it?

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Introduction
Maternal psychological changes during pregnancy and childbirth have a profound effect on mothers, with 25% of women experiencing postpartum depression (PPD) and up to 45% experiencing postpartum anxiety (PPA) (Lee et al., 2007). With such high prevalence rates, it is imperative that clinicians understand best practices for both the assessment and treatment of PPD and PPA. When perinatal mood and anxiety disorders are not identified and treated appropriately, there are a number of risks to the mother, child, and marital relationship that may negatively impact treatment outcomes (Reichman, Corman, & Noonan, 2015). This poster will serve as a clinical guide of the common features of PPD/PPA and outline counseling objectives for practitioners.

Defining PPD/PPA
A diagnosis of PPD includes depressive symptoms that cause personal impairment, or distress and disability within work, educational, or social settings. Onset of depression symptomology would present during pregnancy or approximately 4 weeks after giving birth.

A diagnosis of PPA includes symptoms of anxiety with signs of personal impairment or a disruption in normal work, educational, or social endeavors. Onset of symptoms of anxiety would be during pregnancy or approximately 4 weeks after giving birth.

Diagnosing
Approximately 50% of women experience an increase in sadness and anxiety after giving birth. Most women indicate crying throughout the day, having poor attention when completing task, and having trouble falling and staying asleep. Around twenty to thirty percent of mothers are diagnosed with postpartum depression and almost fifty percent indicate symptoms of anxiety after giving birth. This number increases when a women has delivered preterm, experienced a traumatic delivery, experienced depression earlier in life, is of advanced age (over 35), or has been diagnosed with a medical condition during pregnancy such as gestational diabetes (Silverman et al., 2017).

Implications of PPD/PPA
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Prevalence
PPD and PPA are linked together in multiple ways creating a host of negative outcomes that are often felt by the entire family. Women with PPD/PPA are more likely to experience poor infant bonding, a negative breastfeeding relationship, a negative infant temperament, a decrease in marriage satisfaction, and have a decrease in maternal behavioral and emotional sensitivity (Stein, et al., 2014). The majority of the difficult changes that occur after the birth of a child are still socially placed on women; when social support and healthy coping skills are not in place, tension is increased across the marital dyad thus linked to a decrease in marital satisfaction (Hoseini, Panaghi, Habibi, Davoodi, & Monajemi, 2015). Children whose mothers have more depressive episodes and children whose mothers are currently depressed have significant negative social, emotional, and personal outcomes. Although timing of depression is important, the residual effects of prior maternal depression can have negative consequences for later child behavior (such as a decrease in ability to self-regulate) (Elgar et al., 2004).

The beginning of treatment
The next thing that a counselor should do is to evaluate the client’s basic functioning including ability to plan, eat, sleep, exercise (only if released by a medical doctor), and getting outside to absorb direct sunlight therefore increasing vitamin D level. Each of these areas help to level out hormones and can allow a client’s brain to return to a “normal” state (Daley, MacArthur, & Winter, 2007). An emphasis should be placed on helping the client achieve a healthy sleep schedule; when sleep is disturbed negative alterations happen in the balance of major neurotransmitter systems in the brain such as: serotonin, norepinephrine, histamine, dopamine, melatonin, γ-aminobutyric acid and acetycholine (Ross, Murray, Steiner, 2014). An imbalance in these hormones are positively, and significantly correlated to anxiety and depression. A client should be encouraged to eat a diet rich in fiber, fruits, and vegetables throughout the day. If a client is having trouble with this, a referral to a nutritionist should be given. A specific daily routine should be established including meals, sleep, and outside activities to regulate hormones (Fries, Dettenborn, & Kirschbaum, 2009). Lastly, clients should hear how normal it is to have some level of PPD/PPA and be encouraged to join a PPD/PPA support group. These items should be discussed in every session. Although CBT has traditionally been used for treatment of PPD/PPA some research based on systematic modalities of treatment have been found to significantly reduce PPD/PPA and increase marital satisfaction (Barnes, 2006; Clout & Brown, 2016).

Continuing therapy
By utilizing an attachment based modality of treatment the counselor can first focus on the client’s fear. For many PPD/PPA clients this fear is, “being crazy”, “being a bad mom”, “this will never end”, or “something will happen to baby.” Discussing where that fear comes from and how the client is processing her role in continuing the fear is helpful. Also, increasing a client’s ability to be present in moments (such as skin to skin contact) helps to increase maternal bonding and deflect from her internal, fearful dialogue. Then (when appropriate) having the client’s significant other in session can be helpful to both PPD/PPA and the relationship. Having the client turn toward the significant other and share her fear can increase closeness and shared connection.