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A staggering 85% of women may experience the “baby blues,” characterized by mild tearfulness, or sadness, anxiety, irritability, mood swings, and fatigue.* Sounds pretty normal for the first couple of weeks after a baby is born, right? Hormones are in full migration, and sleep is at a premium, so most new mothers don’t show up at church or the mall with makeup and clean clothes.

The human body is nothing if not resilient, however, and after a couple of weeks, a routine has settled in and things look brighter. That is, unless you have postpartum depression or psychosis.

The baby blues become full-blown postpartum depression (PPD) when they last for more than about 10 days. Some

Not Just the Blues

Perhaps because PPD is thankfully so rare, the usual assumption is that a child is “at least safe” with a PPD mother. The child of the PPD parent, however, is at risk for many side effects that, while not usually fatal, are extremely serious.

Child advocates agree that children with depressed caregivers face many risks. A study published in *Child Development* in 1999 showed that babies are less interested in the speech of depressed mothers, resulting in less than normal speech development. Other studies have shown that babies who have difficulty learning early in life often have problems with behavior and school performance.

baby blues

10%–20% of women will suffer from postpartum anxiety or PPD, an often-undiagnosed illness that affects the whole family. A very rare and very serious form of PPD, postpartum psychosis (PPP) affects only 2 or 3 in 1,000 women, but these women need hospitalization—this form of PPD can be deadly to both mother and child.

Sadly, PPP has received little attention, and most new mothers are unaware of the warning signs. The women affected are often left to suffer in silence, with help coming only after they have harmed themselves or their children. Recent high-profile cases of infanticide have drawn attention to the disorder, but they are clouded in the emotion and horror of the acts themselves. Many mothers disbelieve the existence of the disorder. Experts agree those closest to the new mother should be aware of the symptoms and be able to help a mother get mental health care when she cannot help herself.

“We know from research that depressed moms often have depressed babies,” says psychologist Deborah Issokson. “This is a generality, but it is based on the idea that if you have a caregiver who is depressed...she will not be adequately engaged with her child, she will not provide appropriate stimulation, because she is on automatic and not paying enough attention to the baby’s responses.” Issokson provides counseling to parents and training and consultation to childbirth and other health care providers in the Boston area.

A baby’s cues—that all-important first link of communication between child and caregiver—can be affected to by the caregiver’s mental health, Issokson stresses. “Depressed moms often do not pick up [on their] baby’s cues.” The baby may stop putting out cues or may become less responsive to stimulation, Issokson says, “because the baby has gotten used to not having a reciprocal relationship.”

* Sources for statistics cited in this article are available from *Children’s Voice*. E-mail voice@cwla.org

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Turn deadly

By Christine Hansen and Sheri Wallace



Psychotherapist Tina Tessina points out that many effects can result from a depressed caregiver. "Problems can range from severe neglect, to a mom who can't get out of bed or function, to simple nonresponsiveness—not interacting with, smiling at, or talking to her child in a normal way."

Tessina adds that children react differently. Severely neglected children may fail to thrive, "becoming nonresponsive, not growing normally, and not passing the usual milestones—sitting up, creeping, crawling, walking, or talking—or achieving them later than normal." Children of mildly depressed mothers may either "become depressed themselves or become abnormally quiet and withdrawn. Or, in an attempt to get attention, they can exhibit hyperactive behavior, temper tantrums, and irritability."

"In general," Issokson says, "a depressed mother who is untreated is not as responsive to a child of any age, is not emotionally available, and may have a low threshold for frustration, a low threshold for tolerating the child's affect, and will not be able to teach a child affect regulation." She emphasizes, "PPD needs treatment, whether that be medication, therapy, acupuncture, homeopathy, or support groups. Some PPD will resolve by itself and not turn into ongoing depression. But for some women, PPD is the beginning of an ongoing depression that needs to be addressed and treated."

Foster Moms and Grandmothers

Although PPD depends on pregnancy and childbirth, caregivers don't have to give birth to become depressed. Experts agree that any caregiver who is raising an at-risk child should be evaluated for depression.

Nada L. Stotland, an expert on PPD and speaker for the American Psychiatric Association, says depressed caregivers fall into the same category as women suffering from PPD in that they are still not able to fully perform the duties of childrearing. "For one thing," she explains, "a depressed guardian is

much less able to protect a child from the degradations of others than a nondepressed guardian."

Although no studies show how many depressed women are taking care of children, experts have no doubt the number is shocking. "In almost every case where the family situation of an at-risk child is evaluated," Stotland says, one can probably find a depressed caregiver.

Screening for Depression

Just because PPD is triggered by pregnancy and birth doesn't mean it goes away in a reasonable amount of time. An estimated 25% of women who have untreated PPD will still be depressed one year later; women with a history of depression tend to experience PPD the longest.

Issokson suggests a depression screen should be on every pregnant mother's intake form. "There are PPD screenings already published, [as well as] general depression inventories readily available that care providers could incorporate," she says. "The issue is whether health care providers are willing to take on the responsibility of doing these screenings and whether they have relationships with mental health providers [to refer women to]. If these screenings are routine, then everyone participates, and no one is stigmatized or singled out."

Instead of a standardized depression screen, Tessina says, "pregnant women should be questioned about their support systems and encouraged to seek friends and family who will be helpful." She suggests that childbirth classes and prenatal care include realistic information about the first few months of child rearing, and that fathers be strongly encouraged to participate. "Health care workers," she notes, "can help by aiding the formation of postpartum support groups, finding ways to provide in-home support for new parents, and letting the new mother know they're available to talk on the phone and help her should she need it."

Recognizing PPD and PPP

The symptoms of postpartum and clinical depression include:

- persistent sad, anxious, or "empty" mood
- loss of interest or pleasure in activities, including sex
- restlessness, irritability, or excessive crying
- feelings of guilt, worthlessness, helplessness, hopelessness, or pessimism
- sleeping too much or too little or early-morning awakening
- appetite or weight loss, or overeating and weight gain
- decreased energy, fatigue, feeling "slowed down"
- thoughts of death or suicide, or suicide attempts
- difficulty concentrating, remembering, or making decisions
- persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorder, and chronic pain

The most severe form of PPD, postpartum psychosis, is very rare. It only affects one to three women in a thousand. It is a deadly disease, however, and immediate intervention is essential. If there is even the slightest suspicion of PPP, contact a mental health provider immediately.

Symptoms:

- hearing or seeing things that aren't there
- the baby "tells" the mother to hurt him or her
- severe insomnia
- obsessive about baby
- thoughts of suicide or homicide

Source: National Women's Health Information Center
www.women.gov

No Magic Pill

The battle to provide children with a depression-free environment doesn't end with identifying the problem alone. Women who are depressed, particularly those in less-than-desirable circumstances, typically have many reservations about beginning a treatment program—especially one that includes medication.

Often, Stotland says, the most important part of beginning treatment is simply respecting the mother's reservations. "Given the stigma attached to mental illness, it's understandable that these women will be hesitant to accept a diagnosis of depression or anxiety," she explains. "Also, if you're already dealing with a social worker or similar agency, it's unlikely you would want to voluntarily do anything else that might make you look like a less competent parent."

Stotland advises those who work with depressed caregivers to take these reservations seriously and accept that so-called traditional treatment methods may not be feasible. The lifestyle of the depressed caregiver may not permit regular medication intake, or the caregiver might be receiving advice from her clergy to simply "pray about the situation." Stotland says educating everyone in the circle—from clergy, to medical personnel, to family and friends—is the only way to remove some of the stigma involved and get treatment information into the hands of women with PPD and clinical depression.

Tessina advises friends and family of depressed caregivers, "Listening is what's important. If a person is depressed, spend time with them, draw them out, and encourage them to talk.

Don't feel you have to come up with answers—the solutions will probably be overwhelming to a depressed person anyway." She adds that it's important to reassure the caregiver that feeling overwhelmed is normal.

"What really helps is understanding and reassurance, information, and actual physical help," Tessina says. "Do the dishes, change some diapers, let her take a nap. I urge all my pregnant clients to make connections with other moms of infants and toddlers, and to spend time together. The moms can become the extended family that is so missing these days, and help each other. Moms who have this kind of support and connection rarely have problems with depression."

Removing the Stigma

Although medical science has made great advances in developing better medications for depression, antidepressants still have a stigma attached to them. Issokson combats this by educating her patients about PPD and its treatments.

"Antidepressants will not change [a person's] core personality. They will change brain chemistry so the symptoms of depression are no longer debilitating."

Even with education, some patients resist medication. Issokson tells her patients she will honor and respect their treatment decisions but that she'll continue to share information on what

believes is the best treatment for them. "I validate her fears about drugs and teach her about the benefits, trying to dispel

any myths about drugs she may have," says Issokson, who often includes the woman's partner in discussions. Even if the patient declines medication, Issokson ensures that the patient has access to support groups and helpful resources.

Medication can alleviate some symptoms of depression, but some form of therapy usually is necessary as well. "While medication can change the brain chemistry," Issokson says, "it does not take away or address the interpersonal or social issues that may be contributing to the depression. For those who refuse medication, therapy will be one of their primary sources of support."

Lifelines

Support groups are essential to helping people overcome depression. "Depression is a disease of isolation," Tessina says. "It happens when people feel alienated from themselves, and therefore everyone else. Depressed people have unrealistic expectations of how great they should feel, and few skills to change their own moods. Close contact with friends, family, and support groups can show them that other people struggle too, give them examples of what can be done, and, best of all, give them hope that they can feel better."

Jane Honikman, founding director of Postpartum Support International, says support groups may offer the only real treatment available to some women. "If professional mental health care is unavailable or too expensive, a support group may be these mothers' last hope."

Honikman urges all social service agencies and health care providers to either provide support groups with trained facilitators or refer women to such groups. Attending a support group, she says, offers new mothers peer support and access to information on parenting and community resources, as well as other specialized services that may be needed. "Caregivers who attend regular support groups feel their efforts and triumphs are validated," she explains. "The support group can also help erase the stigma of mental illness surrounding depression, and the trained facilitator can screen for serious problems such as PPP."

An excellent support group can operate on an ongoing basis for very little money, Honikman adds. "Even in situations where funding is almost nonexistent, a support group could probably be started." And women who attend support groups regularly need less one-on-one interaction with caseworkers and health care providers, making support groups both a program and personnel savings measure, as well as an effective treatment option.

Educating the Community

Since depression is an illness that affects the family, it also affects the community. Community leaders who work with families, such as clergy, should be enlisted to help screen for depression. "Clergy can be helpful in sanctioning the use of therapy and medication," Issokson says. "Clergy should educate themselves about risk factors for PPD and take note when they are meeting with new parents."

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Tessina adds that clergy need to establish connections with professional psychotherapists in the community. "Clergy have neither the time nor the expertise for long-term counseling. People come to them in crisis, but when someone needs more help than clergy can provide, they should know the resources around them."

Unfortunately, more "visible" mental illnesses, such as schizophrenia or bipolar disorder, can take priority for treatment over depression—especially in populations where mental health treatment is limited. "Depression is a serious mental illness that has repercussions for the entire family and must be taken seriously, just like other mental illnesses," Issokson says. "When a baby is involved, it's crucial for the mom to get treatment because the baby's developing mental health is also

at risk. Unlike bipolar illness or schizophrenia, depression can often be quiet, private, yet extremely dangerous."

In the end, awareness and availability of treatment may come down to dollars and cents. "The more treatable—and coverable by insurance—a mental illness is," Tessina says, "the more likely it is to be diagnosed and treated. The more visible disorders are more easily quantifiable, and it's easier to make a case for giving drugs, so it's easier for the insurance/medical system to make money from them; therefore, they get more attention. Depression responds best to the slower and less spectacular process of therapy, where the patient learns to help him- or herself. This makes less money for drug companies and is more difficult for HMOs to handle, so it's not encouraged."

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Resources

Online

Counseling for Reproductive Health and Healing

www.reproheart.com
info@reproheart.com
617/926-5176

Resources for parents and professionals on issues from preconception to postpartum.

Depression After Delivery

www.depressionafterdelivery.com
91 East Somerset Street
Raritan NJ 08869
800/944-4PPD

Support, information, 24-hour referrals to local professional volunteers.

ePregnancy's Postpartum Depression Contract

www.epregnancy.com/tools/depressioncontract.htm
Contract for mom to sign, links, information for family and friends, and information on PPP.

Books

Ann Dunnewold and Diane G. Sanford. (1994). *Postpartum Survival Guide*. Oakland, CA: New Harbinger Publications.

Karen R. Kleinman and Valerie D. Raskin. (1994). *This Isn't What I Expected: Overcoming Postpartum Depression*. New York: Bantam Books.

Shaila Misri. (1995). *Shouldn't I Be Happy? Emotional Problems of Pregnant and Postpartum Women*. New York: Free Press.

For Fathers

James Douglas Barron. (1999). *She's Had a Baby—And I'm Having a Meltdown: What Every New Father Needs to Know About Marriage, Sex, and Diapers*. New York: Quill.

Online PPD Support Group

www.geocities.com/Wellesley/4665/index.html
Information, e-mail list, resources, and peer support.

Postpartum Stress Center

www.postpartumstress.com
kkleiman@aol.com
1062 Lancaster Avenue, Suite 8
Rosemont PA 19010
610/525-7527

Includes checklists of symptoms, risk factors, and resources.

PostPartum Support International

www.postpartum.net
Information on local support groups, identification and treatment of PPD and PPP, self-assessment surveys, and information for fathers.

Sally Placksin. (2000). *Mothering the New Mother: Women's Feelings and Needs After Childbirth: A Support & Resource Guide*. New York: Newmarket Press.

Linda Sebastian. (1998). *Overcoming Postpartum Depression & Anxiety*. Milford, CT: LPC.

Karen R. Kleinman. (2001). *Postpartum Husband: Practical Solutions for Living with Postpartum Depression*. Philadelphia: Xlibris Corporation.

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