PSYCHCEs

Depression in New Mothers



Most women who become pregnant prepare physically and emotionally for the birthing process. A great deal of time is spent considering the ideal birth, what supports will be needed, and what the timeline will look like. So much time is spent preparing for this moment that often women forget to prepare for what happens after birth for their own health. They are, rightfully so, fully consumed by the love and excitement of having a newborn that they might forget to focus on their mental health and wellness.

When new mothers experience sadness or depression after childbirth, we refer to this as either the baby blues or postpartum depression. It is not uncommon for women to experience depressive symptoms after childbirth. It is especially important that mental health professionals are trained to appropriately intervene as needed during this time because it is such a special time between the new mother and the newborn. Mental health symptoms could impact the mother's ability to attach with the child, which will pose more struggles later on. Because of this and because her health is at risk if untreated, it is necessary to be well educated as mental health professionals and prepared for how to work with new mothers experiencing depression.

PSYCHCE

What is Depression in New Mothers?

As previously mentioned, there are two main presentations of depressive symptoms that professionals have identified in new mothers. These include what has been nicknamed "the baby blues" and a full diagnosis of postpartum depression.

70-80% of women might experience some symptoms consistent with the baby blues within the first week of giving birth or having their child and these seem to taper off within a few weeks (Postpartum Depression, 2020). The rate of women experiencing a full postpartum depression diagnosis is much lower at 10-20%. While this number appears much lower, this is still 1 in 5 women with a diagnosis of depression that could be greatly affecting their health and safety and their ability to attach to their newborn. Approximately 4 million births occur each year in the United States. This means that 600,000 women are experiencing postpartum depression and will benefit from accessing services (Postpartum Depression, 2020). It is necessary that they access services from professionals who are well educated and know how to properly intervene.

Let's discuss the presentation of symptoms in both the baby blues and a postpartum depression diagnosis.

What Are the Symptoms of the Baby Blues?

According to the March of Dimes (2020), the baby blues will naturally go away on their own within a few weeks. While new mothers absolutely can access mental health services during this time to support themselves, they do not need to for these symptoms to go away the same way they likely would with a diagnosis of postpartum depression. The symptoms for baby blues present as the following:

- Feeling sadness or cranky
- Mood changes that appear to be unprompted
- Having a difficult time sleeping, eating, or decision-making the same way you were prior to giving birth
- Feeling overwhelmed
- Feeling as though you are not doing well for your baby

PSYCHCES

These are difficult feelings to have for a new mother who just wants to do everything right by her new baby. This is especially true for first time mothers who are experiencing everything for the first time and may be fearful about being perfect or doing the wrong thing as a new mom.

New motherhood is a huge change. It is perfectly normal for mothers to struggle adjusting to broken sleep, their body being shared with their new child, and managing any other responsibilities such as a household. This is a time of transition and transitions or adjustments are hard. The baby blues seem to be a reflection of just how hard this can be.

For women experiencing the baby blues, the following are helpful interventions that do not require accessing mental health services:

- Sleeping as much as you are able to
- Asking for help when it is needed
- Taking time for self-care
- Connect with other new mothers who can offer advice and support because they have experienced it as well

- Avoid drinking alcohol, using drugs, or other maladaptive coping strategies that will likely make these symptoms much worse and affect your baby as well
- Reduced concentration
- Difficulty eating regularly

The Baby Blues: A Case Study

Natalie is a 27 year old first time mother. She lives alone in New York City with her fiancé and newborn daughter, Melody. She gave birth last week and the initial excitement of giving birth is slightly wearing off for Natalie. She is beginning to feel exhausted, fearful, frustrated, and alone. These feelings are making her feel guilty and like she wants to isolate herself. She has been feeling these symptoms for approximately four days.

After doing research online and talking with other new mothers, Natalie self-diagnosed herself with the baby blues and emailed her doctor to check in. She reported to her doctor these symptoms. Her doctor recommended she ask her partner to take the evening shifts with Melody so she could get a full night's rest. Natalie began pumping her breast milk in the day time so that her fiancé, Mark, can feed Melody at night so that Natalie can sleep. After a few days, Natalie began to feel less stressed and less frustrated but she continued to feel isolated.

Natalie decided to reach out to her girlfriends from college whom she has strong bonds with. While she isn't ready to leave her apartment to visit any friends, they opened a text thread and set an evening FaceTime appointment for a few days in a row. After about 10 days of the combination of sleep and regular connection with her friends, all of Natalie's baby blues symptoms began to disappear and she was establishing a helpful routine with Mark. While Natalie and Mark did not continue with him being up every night, they decided to set a schedule where they would switch off every other night until Melody began sleeping through the night.

What Are the Symptoms of Postpartum Depression?

A diagnosis of postpartum depression is clinically significant and will be much more distressing to the mother than the baby blues are. This is because symptoms can occur shortly after giving birth and last for months. This can be very dangerous to mom's health, her relationship with her infant, and her relationship with her partner (if she has one). Common symptoms experienced by women with postpartum depression include the following:

- Depressed mood or severe mood swings
- Crying excessively
- A difficult time establishing a bond or connection with her newborn
- Isolating self from friends and family who could provide support
- Loss of appetite or overeating
- Inability to sleep or oversleeping
- Feeling fatigued and without energy
- Lacking interest in activities that once brought her joy and energy
- Irritability or anger
- Fear that she isn't going to be a good mother
- Feeling hopeless
- Feeling worthless, shame, or a sense of inadequacy
- Thinking is not clear or the inability to concentrate
- Difficulty making decisions
- Feeling restless
- Experiencing anxiety or panic attacks
- Thoughts of harming herself or her baby
- Suicidal ideation or suicidal planning

PSYCHCES

What Are the Risk Factors for Postpartum Depression?

Unfortunately, some women are at higher risk for postpartum depression than their similar age peers. Any new mom can develop postpartum depression after giving birth, but those with the following risk factors have a higher chance of experiencing it:

- A history of depression at any point in life
- A diagnosis of bipolar disorder
- Experiencing postpartum depression in a previous pregnancy
- A family history of depression or mood disorders

- A stressful life
- Pregnancy complications
- A baby born with special needs or health problems puts the mother at higher risk
- Twins, triplets, or multiples born
- Having a difficult time breast feeding
- Having issues in your relationship
- Having a compromised immune system
- Experiencing financial hardship
- Having a pregnancy that was unplanned or unwanted

If a pregnant woman has experienced any of these risk factors, they should work with both a medical doctor and a mental health professional during and after her pregnancy. It is the job of the medical doctor and mental health professional to monitor the new mother for signs and symptoms at all of her obligatory check-ups after giving birth as well as the appointments leading up to her birth. It is a good idea to administer a PHQ-9 (seen in Appendix A) or other standardized test for measuring depressive symptoms.

It is also helpful for mental health professionals to talk with the new mother about how they feel they are bonding and attaching to their baby. If a new mother is having a difficult time bonding, she will likely struggle with guilt, anger, sadness, and frustration because she will blame herself. The mental health professional should teach her appropriate skills to utilize for bonding with her newborn to reduce the likelihood of her experiencing any depressive symptoms as well as the child experiencing any attachment related struggles.

Postpartum Depression: A Case Study

Nellie is a 36 year old female mother of two. She gave birth to her daughter three months ago. It was a wonderful birthing experience and she was really looking forward to having her newborn at home with her and her four year old son. Nellie's husband is often gone on work trips but he has been home for the first three months of her daughter's life. Nellie has no history of depression or mental health symptoms and although she experienced a few days of the baby blues with her first child, she has never sought mental health services.

After returning home from the hospital with her newborn, Nellie very quickly began feeling sad. She attributed these few days of sadness to the baby blues and being tired often. After feeling sad, angry, frustrated, and alone for more than four weeks, Nellie realized she might be experiencing depression for the first time in her life. She recently noticed she had gone several days without showering, which was not the norm when her older child was a newborn. She has been isolating from her husband and family and taking every opportunity to sleep instead of bond with her infant.

Nellie is not sure about where to go for help but she acknowledges she needs support because she has been feeling recently as though her family would be better off without her.

Nellie's symptoms have lasted for approximately 10 weeks total.

What Are the Symptoms of Postpartum Psychosis?

Some women who have postpartum depression may also experience postpartum psychosis. Postpartum psychosis presents with the following symptoms:

- Disorientation
- Confusion
- Obsessive thoughts about her baby
- Hallucinations or delusions
- Difficulty sleeping
- Excessive energy or agitation
- Paranoia
- Attempts to harm self or harm her baby

PSYCHCE'S

Postpartum psychosis tends to be much more dangerous than postpartum depression because the presence of hallucinations, delusions, or paranoia can lead to impaired decision making more than depression does. Regardless of whether the new mother experiences depression or psychosis, she should seek services as soon as possible to reduce the length of her symptoms and learn skills to appropriately manage them. She may also desire to access medication that could be helpful during this time such as an anti-depressant.

Postpartum Psychosis: A Case Study

Amy is a 21 year old female who just gave birth to her first child. She is a single mother with few friends or family who live near her. She works full-time as a nanny and she is able to bring her newborn to her workplace. She has a history of depression and anxiety but no psychotic symptoms.

About two weeks after giving birth, Amy started experiencing symptoms that made her a tad nervous. On an almost daily basis, Amy was having severe paranoia about the city's water potentially being contaminated. After a month of paranoid thoughts about contaminated water, Amy became convinced that the city she lives in is attempting to poison her newborn. She spent several hundred dollars purchasing pre-bottled, filtered water. In fact, this was almost all of her rent money for the month. Because of the purchase of water, Amy's rent is late and she is unsure if she will be able to stay in her apartment.

Upon seeing her child's pediatrician to discuss her fears about water contamination, her pediatrician asked that Amy see a psychiatrist for support. She was diagnosed with postpartum psychosis and was beginning to get support for treatment.

PSYCHOSES

Postpartum Depression and Attachment

Many community members might struggle to really understand the impacts that depression in a mother during a child's infancy could have. This does not only affect this time but it affects the child's future if mom has a difficult time supporting her infant in a way that promotes secure attachment. Research completed in 2010 supports that children in infancy and their toddler years who are supported by a mother with depressive symptoms are more likely to experience insecurity in their attachment than children who are not (Toth, Rogosch, Sturge-Apple, & Cicchetti, 2010). This impacts development, sense of self, and self-worth as the child grows into adulthood (Toth, Rogosch, Sturge-Apple, & Cicchetti, 2010).

Mental health professionals who support new moms should be fully educated about attachment theory. Attachment refers to the bond that occurs between an infant and its primary caregiver. In most cases, this will be the infant's mother. Their ability to bond so that the child feels safe, supported, and cared for, refers to the child's attachment styles. There are four primary attachment styles. Research suggests that

the attachment a child has will impact their health and decision-making in later adult life. The four attachment styles are as follows:

1) ***Secure attachment*** – the child was raised in a comfortable, and close relationship with their primary caregiver. When they needed something, their mother responded with care and promptness. Their mother also allowed them to explore the world around them without hovering too much or too little. This leads them to trust others and depend on others as needed. They do not generally struggle with rejection or closeness. People with secure attachment are tolerant, forgiving, and generally communicate with ease. They prefer honest and open conversations. They adaptively cope with emotions and have strong insight. (Levy, 2017)

2) ***Avoidant attachment*** – this child was raised in a distant and rejecting relationship with their primary caregiver. Their parent was emotionally unavailable or unresponsive to them most of the time. The caregiver would disregard their child's needs, especially when their child was hurt or sick. This leads the child to growing up and becoming emotionally distant in their own relationships. They might keep their partner at "an arm's length". They prefer autonomy and might shy away from true partnerships as they do not want to have to rely on another person. They manage well in crisis and will take charge without emotional responses.

3) ***Anxious attachment*** – this child was raised with primary caregivers who struggled to consistently meet their needs. This is a result of inconsistent parenting behaviors. For example, at times the parent or caregiver was highly attentive and available and other times they were emotionally unavailable, insensitive, or cold. They were slow to respond to their infant's needs. This leads the child to grow into adulthood where they are constantly worried about rejection and abandonment. They become needy and this can scare potential partners away. They might ruminate about the past and their family traumas. They can become extremely sensitive to friends and partners and take their behavior more seriously than they should. This can scare friends and potential partners away. They struggle to collaborate and have a difficult time setting appropriate boundaries. They might be perceived as moody, anxious, and inconsistent.

4) ***Disorganized attachment*** – this child was raised with parents who may have been emotionally, physically, or sexually abusive. They would often send mixed signals to their child by responding initially with love and care when the child

PSYCHCES

> needed them but then laughing at the child, yelling, intimidating, or mocking the child who was in distress. This leads to a child who grows to have unresolved struggles. They might develop post-traumatic stress disorder. They can be argumentative, full of rage, and have a difficult time regulating. They will struggle with emotional closeness with others. They are at risk for experiencing depression, anxiety, dissociation, and other mental health symptoms. They might prefer to spend time alone, have little to no empathy, become narcissistic, and struggle with substance use or criminal behavior. They are more likely to mistreat their own children. (Levy, 2017)

It is recommended that mental health professionals who are working with soon-to-be mothers, help them understand the importance of attachment. This work could include discussing the way they were raised and identifying their own attachment style. They should discuss any risks in their own parenting as related to how they were raised. For example, a woman with disorganized attachment is less likely to parent in a way that leads to disorganized attachment in her newborn if she receives mental health support and skills training on her path.

Attachment and Mental Health

PSYCHCES

Most people do the very best with what they can in life. It is important to understand the negative health outcomes that can come from attachment related issues. It is also important to not blame or shame the mother for what happened in life to get the baby (or perhaps who the baby grew into) to where they are. Shaming does not promote recovery. With that being said, there are attachment related disorders that are serious mental health concerns.

Infants and children who were raised with attachment styles that are not secure are at risk for these disorders. Often times a mother will bring children with attachment issues to see their doctor. They might present with the following: colic, feeding difficulties, inability to gain weight, detached behavior, unresponsive behavior, difficulty with comfort, defiant behavior, hesitancy with social interactions, and a desire to be close to strangers (American Academy of Child and Adolescent Psychiatry, 2020). Some of these symptoms can be easily explained by other things and it may be overlooked what their attachment style is. However, when a child presents with disinterest or struggles in relationships at an early age, this is a clear sign that attachment could be a concern.

There are two kinds of attachment disorders that could be discussed: Reactive Attachment Disorder (RAD) or Disinhibited Social Engagement Disorder (DSED).

Reactive Attachment Disorder presents in children or young adults with the following symptoms that have stayed consistent over time:

- Lack of interest in forming relationships with others
- Inability to self-soothe
- Lack of interest in being comforted from caregivers when upset
- Little to no emotional presence
- They might appear unhappy, sad, irritable, or scared
- They likely prefer to be alone

Disinhibited Social Engagement Disorder presents in children or young adults with the following symptoms that have stayed consistent over time:

- Lack of fear when meeting someone for the first time
- They might be overly friendly to strangers (they could even hug them)
- They allow others to pick them up, feed them, or give them toys
- They will not check in with parents or caregivers
- They will approach people they do not know

If a child presents with any of the symptoms from either disorder above, they require a mental health assessment immediately. Parents or caregivers should have them seen by a doctor, psychiatrist, and counselor to develop an appropriate treatment plan. Treatment will involve both individual and family therapy for the young person. The therapist will identify why there are attachment related issues between the child and caregiver and identify interventions to address them. This will include attempting to repair any damages that occurred in their relationships that led to the attachment issues. It may not be helpful for some children to repair. For these children, skills based treatment will be necessary and parents will have to reinforce positive behavior instead of being frustrated for negative behavior that the child presents. This can be very challenging for parents (American Academy of Child and Adolescent Psychiatry, 2020).

If children who experience attachment related issues do not get appropriate treatment, they are at risk for becoming adults who greatly struggle in relationships and the world (American Addiction Centers, 2020). These symptoms in adults include:

- Impulsivity

- Resistance to guidance and affection from others
- Difficulty trusting others
- Substance use
- Resentment and anger
- Inability or difficulty processing feelings

Many of these symptoms could lead to lawbreaking activities, substance use struggles, and other chronic issues in adulthood (American Addiction Centers, 2020). Because of this, it is necessary that parents who identify their children as struggling with attachment, get support right away. Remember it is not the mother's fault when she struggles with postpartum depression but it can impact her ability to bond with her newborn. Lack of bonding can lead to lifelong struggles for the newborn. It is essential that the mother and infant get all the support and assistance they can have.

How to Diagnose a Woman With Postpartum Depression

PSYCHCES

As a mental health professional, it is necessary to understand how to diagnose a woman with postpartum depression because it can be easy to disregard a true disordered experience with the baby blues. There are standardized screenings available to support professionals in this process.

First, a professional will meet with the new mother because they have been established with care or because the mother's medical team has referred her for mental health services. The mother is eligible for a diagnosis of postpartum depression if she has had symptoms within two weeks or more from giving birth. These symptoms have to have lasted through the baby blues period to be eligible for a diagnosis. They will also impact functioning and her ability to parent her child effectively. First, you will discuss the risk factors that the mother has in order to capture an accurate clinical picture (MedlinePlus, 2020). You should discuss the following:

- Mother's mental health history (history of depression is especially important)
- The psychosocial support she has had available to her
- Her age and development
- The health of her baby

- Her birthing experience
- Her family history

If a mother has any of the above identified risk factors, you might be more inclined to offer her a diagnosis or follow her more closely for mental health services. The mental health provider will then identify her symptoms. If she has several of the following symptoms and they have lasted consistently for longer than two weeks, she can be eligible for a diagnosis:

- Feeling sad for most of her day
- Crying often
- Difficulties maintaining a normal appetite
- Difficulties maintaining a normal sleep pattern
- Isolating herself from her support system
- Feeling disconnected from her baby
- Struggling to complete daily tasks
- Consistent feelings of guilt or being a bad mother
- Fear of hurting herself or potentially hurting her baby (please note if this is identified a mental health professional needs to safety plan right away for both the safety of mother and child)

PSYCHCES

There are tools that can help a mental health professional identify postpartum depression. The Edinburgh Postnatal Depression Scale is one tool that is widely used. It includes ten questions for the mother to identify her mood and anxiety symptoms. Another tool used for depression is a Patient Health Questionnaire (PHQ-9) or the Beck Depression Inventory (BDI). While these are generally used for all types of depression, it can help gather data about symptoms for the mother.

Upon identifying symptoms and discussing risk, it is essential that the mother has a full physical and has her labs taken. There are symptoms that could be explained by health conditions other than mental health. For example, thyroid functioning can impact energy, interest, and happiness. If a woman has a thyroid that isn't functioning properly, she might display symptoms consistent with depression and be treated for depression without seeing much improvement because she actually required treatment for her thyroid.

If the mother's labs come back normal, the mental health professional should prepare to offer a diagnosis of postpartum depression (or postpartum psychosis if those symptoms are present) to the mother. It is recommended that the mental health professional discuss this with the mother. Often the mother's qualitative data about diagnosis will offer the most accurate diagnosis. For example, the following conversation could be a good example of this:

Mental health professional: "Your labs came back normal, which is a really good sign"

Mother: "That is great. I am glad to hear that. But why am I feeling so bad right now"

Mental health professional: "Well, that is what I would like to talk to you about. I am wondering how you feel about a diagnosis of depression. It seems to me that this is what fits you best but I want to know how you feel about this".

Mother: "I was afraid of this, but honestly I have felt this was the most accurate depiction of what is going on with me. It is true that I am depressed but I love my child very much and I want to get better"

Mental health professional: "I absolutely believe that to be true and while I am sorry you are feeling this way, I am excited that you are engaged in care. I want to offer you this diagnosis of postpartum depression and help get you connected to the right treatment for you. Does that sound like a good plan to you?"

Mother: "Yes, I think that sounds like a very good plan"

Upon offering a diagnosis to the mother, it is important to quickly begin treatment planning with her and her support system. Remember that this mother will be the best supported if her family and peers are aware of her treatment plan and can help support her in a functional and adaptive way. Upon offering her a diagnosis, you should offer her immediate safety planning. She should leave the mental health professionals office with her local and national suicide prevention line information and contacts for who to call in the event she wants to harm herself, her baby, or anyone else. An example of this safety plan could look like this:

Patient name: Jane Doe

Triggers: Feeling alone, sadness for more than a few days, worrying about being a good mother, and disruptions in sleep/eating/hygiene

What to do when triggered: Contact therapist, discuss with partner, practice meditation, read a book, attend new mommy meeting, or take a nap

If I am unable to self-soothe and am unsafe because I want to harm myself or someone else: Contact National Suicide Prevention Lifeline at 1-800-273-8255 or Multnomah County Crisis line at 1-503-988-4888 or contact 911

It can be helpful for many women to have a laminated safety plan card like this to put in their wallets for immediate reference in a mental health emergency. This should be completed as soon as possible after the mother receiving a diagnosis and during discussions about treatment for health and safety purposes. Important information to include in a safety plan involves symptoms for the mother to notice she is approaching crisis, ways she knows she can soothe herself, people in her life she can reach out to as she approaches crisis, and then ultimately the contact information for her therapist, local crisis line, and national suicide prevention hotline. It is recommended that women program these numbers into their phones as well so that they never go without support if they approach crisis.

The diagnosis process is important for the mother to understand what she is experiencing, how it affects her newborn, and planning for the future. Upon receiving a diagnosis, the mother should commit to a treatment plan to ensure the best long term outcomes for her health and her family's health as well as the development of her newborn. To avoid any future attachment issues, treatment is essential. It is important to note that women with varying cultural and spiritual backgrounds may prefer to participate in treatment in a way that is different than the western medical perspective. The treatment discussed here may need to be adjusted and modified depending on the mother's upbringing, cultural background, and other specific identities.

PSYCHICES

There are several different domains that should be included in a comprehensive treatment approach to navigating the woman's postpartum depression. These include, but are not limited to, individual therapy, family therapy, skills training, peer support, lifestyle support, and medication management. The mental health professional should discuss all possible options with the mother as well as help her find providers who are in-network to her insurance (if she is insured) and are providers she believes to be a good fit. For example, a queer mother might prefer an affirming therapy with experience working with queer parents. This could be limited based on the location of the mother and her insurance network. A mental health professional should help her find the provider she is looking for to ensure the best outcomes from therapy possible.

Therapy

Individual therapy will be one of, if not the most important, tenets of the treatment plan for the new mother. There are various types of therapy that can be helpful for mental health professionals to provide, but they should not forget the most important aspect of therapy with the new mother: to establish a trusting and validating

relationship. This will help the mother achieve recovery quicker than anything else in services. It is essential she feels safe and comfortable during the therapeutic process. During any therapy program for a mother with postpartum depression, it is important to include a component of psychoeducation. The new mother's body is changing rapidly upon getting pregnant and giving birth. She should understand the science behind what she is experiencing. This will help to normalize her feelings, fears, and physical body symptoms. Regardless of what modality is used in therapy, this must be included.

The following are common treatment modalities that are used with mothers experiencing postpartum depression and are found to be statistically beneficial:

Interpersonal Therapy

This therapy was researched by Fitelson, Kim, Baker, and Leight (2010) and found to be clinically beneficial for women with postpartum depression. In this treatment, the therapy addresses the postpartum depression through interpersonal problems and mood. The therapist and patient will together explore four different interpersonal problems. These include role transition, role dispute, grief, and interpersonal deficits. This therapy typically occurs in weekly sessions for up to 20 weeks and focuses on developing strategies to help the mother address problematic approaches in her relationships that could be promoting depression. They will work on developing strong social supports for the mother and develop adaptive and helpful bonding techniques for the mother to use with her infant. This modality is especially helpful for new mothers because it is time limited, focuses on skills and processing, and will help her in her transition back into her life after giving birth. For example, she will likely have completed this therapy by the time she chooses to re-enter the workforce. According to the Fitelson, et al. (2010) study, women who completed therapy using interpersonal therapy were more likely to have a statistically significant decrease in depressive symptoms as measured by the Hamilton Depression Scale compared to the wait-list group.

Cognitive Behavioral Therapy (CBT)

Cognitive behavioral therapy is an extremely common modality used in the field of mental health. CBT believes that mood and perspective directly impacts behavior. For the therapist utilizing CBT with a mother experiencing depression a focus of treatment will be her beliefs about herself and motherhood. If the therapist and new mother can retrain and refocus her thinking, then eventually her depressive symptoms will reduce and she will function better. By reducing negative thoughts and developing

more adaptive coping strategies, women are likely to recover from their postpartum depression. Research shows that women who attend at least six CBT-based sessions will have a much greater reduction in depressive symptoms. This is not treatment that will inherently fix a woman's depression. There will be ongoing work for challenging thought processes and homework in between sessions in order to have the best outcomes from therapy (Fitelson, 2010).

CBT generally follows these steps:

Work with the patient to identify problems (Mayo Clinic, 2020)

Women might come to therapy during new motherhood with many different problems. Each woman will be unique and bring with her all the expectations that she had prior to giving birth, the reality of motherhood, and the feelings that have occurred since. It is important as the provider working with her to have no expectations or preconceived ideas about her problems.

During the first few sessions, you should focus on getting to know the new mother and asking her to identify the problems occurring in her life. Let's work through the following example:

Taylor is a 29 year old new mother with postpartum depression. She brings the following problems to therapy: consistent depressive symptoms, fear about motherhood, and frustration with her inability to breast feed. These problems have been ongoing for the first four months of motherhood and she is just now seeking support.

Ask the patient to identify their thoughts about the problems

In this second phase of treatment, the therapist and Taylor work together to form a safe and trusting relationship so that Taylor feels she can identify her thoughts about these problems.

Eventually Taylor shares with the therapist that she feels like a complete failure because of her inability to breastfeed. She worries that her child will never feel loved because she had to use formula. This causes her to feel hopeless about her future in parenting. It is as though Taylor believes she will never do anything right by her child. The thoughts are obtrusive and make it difficult for Taylor to function. She is frequently tearful and beginning to have anxiety when her partner is at work and she is alone with her child. Taylor has had thoughts of harming herself because she does not have any other coping skills at this time.

Work with the patient to identify the inaccurate thinking that is occurring

Now that the patient and therapist are bonded and clearly understand the problems and thoughts about the problems, it is important for the therapist to teach the new mother about the thoughts she is having that simply are not true. These are the distorted and inaccurate thoughts. Sometimes it can be simple to help the new mother to identify the distorted thoughts by asking her to imagine a friend who confided in her about these kinds of thoughts. What does she suggest to the friend in this position? Surely she doesn't suggest to the friend that she is a worthless new mother who will never do anything right. Now, the question becomes, how can she extend the same grace and kindness to herself that she would extend to another person? This is difficult work.

Let's return to Taylor's case. Taylor and her therapist have identified her obtrusive thoughts about problems. These are as follows:

- *Taylor's inability to breastfeed makes her a failure*
- *Taylor's child will never feel loved because she used formula*
- *Taylor's future in parenting is hopeless*
- *Taylor is alone in her thoughts*

PSYCHCES

Work with the patient to reframe their thought processes that are inaccurate

Now that the therapist and patient have identified the inaccurate thoughts, they have to reframe her thoughts (Mayo Clinic, 2020). In our case, Taylor and her therapist have agreed upon the following reframing transitions:

- *Taylor's inability to breastfeed makes her a failure -> Taylor's body does not want to produce milk and that does not mean she loves her child any less*
- *Taylor's child will never feel loved because she used formula -> Taylor loves her child so very much that she was willing to stop trying to force her child to breastfeed*
- *Taylor's future in parenting is hopeless -> Taylor has many, many more years to learn to parent the best that she can*
- *Taylor is alone in her thoughts -> Taylor's life is full of love and hope and she will always have a therapist to turn to for support*

Taylor and her therapist agreed that each time Taylor had one of the thoughts to the left above that she would remind herself of the new thought to the right. She took many months of practicing and reminding herself of these thoughts. Eventually she thought and believed the statements on the left so much less frequently than she had

before treatment and her depressive symptoms were greatly reduced. She learned to have more space for herself and allow her to be okay with life's messiness. She began to lean in to the discomfort of understanding that she is not perfect and her life is not perfect. She began to believe that she was trying her best and she accepted that her best was good enough.

While there are many ways that a therapist could work with a patient to reframe negative patterns of thinking, this is just one example that can be helpful.

Acceptance and Commitment Therapy (ACT)

ACT believes that behavior and emotion can exist independent of one another (Dewane, 2008). In this modality, therapists work with patients to take action without changing their thoughts about the action. This is a different thought process than CBT or other behavioral modalities. While CBT believes that in order to change behavior you must change thoughts, ACT believes that you can change behavior without changing thoughts or emotions but that by facing fears you may eventually reduce negative thinking patterns.

For example, the therapist working with Taylor might instead of developing re-framing thoughts suggest to Taylor the following: "how would it feel to offer your child formula while still feeling like you are a failure because of it? Is it possible that you can feel like a failure but still do what you think you need to do? And, is it also possible that after a while you might find that you feel less like a failure because providing formula is just your new normal?"

PSYCHICES

The main point here is that a person can feel something and still do something that isn't led with their feelings because they have the right to choose to do it anyway.

There are six core processes in ACT. They are as follows:

Acceptance - techniques that are consistent with understanding that some things must be done instead of avoiding doing them

Cognitive defusion - redefines thinking and understands it as an ongoing process. For example, ACT will recognize thoughts as thoughts and nothing more or less important

Being present - a person must be fully present to understand their thoughts, feelings, and identify behavior that can be impacted through avoiding

Self as Context - teaches the client that who they are is not defined by their experiences

Valuing - asking the client to identify what gives their life meaning and purpose

Committed action - giving up fighting and avoiding and allowing life to be what it may be, while still having a deep purpose in the world

With these six core values in mind, ACT generally follows this process:

1) Clients present their problems and goals

   For example: Taylor's problems include depressive symptoms, inability to breastfeed, feelings of failure and worthlessness, thoughts of self-harm, and lack of coping skills. Her goal is to reduce these symptoms and enjoy new motherhood

2) Client and therapist identify the strategies that have not been successful

   Taylor was not successful with forcing herself to try to breastfeed over and over again. It left her feeling like a failure even more than she was already feeling. She has tried to talk with her partner about it but he was unable to really understand her thoughts and struggled to validate her feelings. Taylor identifies that isolating has not been strategic or helpful and neither would self-harming

3) Establish control with different strategies

   Taylor is going to practice the following: avoiding isolating by doing things with her child, partner, and family; using formula and stopping forcing breastfeeding; practicing mindfulness and daily meditation; attending therapy regularly

4) Identify the self as context

   Taylor and her therapist work to identify her observant self. This is the part of her that can watch her life from the outside without feeling too fused with what is going on. This involves her practicing watching her thoughts, behavior, and actions with thoughtfulness and presence

5) Choosing a direction and being willing

   In this step, Taylor identifies the things she must be willing to do, despite her feelings of worthlessness or lack of desire

6) Staying committed (Dewane, 2008)

   Taylor chooses to remain invested in therapy, these processes, and the healthy outcomes that she may experience

PSYCHICES

Nondirective Counseling

This modality is provided through one-on-one counseling in a way that is incredibly supportive and encouraging (Registered Nurses Association of Ontario, n.d). The therapist provides the following:

- Active listening and encourages the patient to find solutions that work for them, despite any advice that they may have been previously given
- A positive relationship with the patient
- A focus on the person's experience
- Motivates the patient to solve their own problems and to manage their own situation
- Offers a clear understanding of the person's perspective
- Is open to any and all communication
- Provides transparency
- Provides referrals to other supports as needed (a kind of case management) (Registered Nurses Association of Ontario, n.d)

PSYCHCES

In our Taylor case, the therapist who provides nondirective counseling will use a much less structured approach than any of the previous therapists. For example, the therapist might refer the patient to a professional who could support her with breastfeeding issues. The therapist will work with Taylor to develop a safety plan for reducing any thoughts of harm or working through them as they arise. The therapist might also refer Taylor to a psychiatrist for medication management or family counselor. They would validate Taylor in her sadness and listen to her in her struggles. They would really process any experiences that might have led to these depressive symptoms and work together to prevent any future similar experiences.

This is an approach that many patients enjoy because it is so safe and allows them to come to each appointment with perhaps new needs and thoughts without throwing off the treatment plan.

Interpersonal Psychotherapy (IPT)

This is a modality that is found to be very effective for women with postpartum depression. The goal for therapy in this modality is to treat the symptoms and find

relief. The therapist will use a direct approach and offer insight to the new mother regarding her distress. IPT identifies four problem areas:

1) ***Grief*** - acknowledges that the new mother is experiencing the loss of her sense of self, changes in her relationships, changes in her body, and changes in her lifestyles as related to having a newborn (Postpartum Progress, 2018). The therapist will provide support to her in this time of grieving these things.

2) ***Role transitions*** - acknowledges that the new mother is having to transition in her life from one role to another. Perhaps she was previously a CEO of a large company. Now she is a mother preparing to stay at home for a few months before she goes back to work. This will be a difficult transition for anyone. The therapist will work with the new mother to identify the areas she feels she has lost her independence and promote that she still feels a sense of normalcy, control, and connection to previous social networks that will remain important to her.

3) ***Interpersonal disputes*** – acknowledges that the new mother might be transitioning in her marriage or partnership. Often parents struggle because they lose a sense of intimacy that they had before experiencing a newborn. For example, they might no longer feel energetic or interest in sex and might prefer to nap instead. The therapist will work with the mother and even the couple to transition through these disputes in their relationships and struggles.

4) ***Interpersonal deficits*** – acknowledges that the new mother might struggle to maintain her attachment to people other than her newborn. This could be causing distress to her and other people in her life. The therapist will work to identify these issues and process through them. IPT prefers to teach communication skills, relationships skills, and develop strong social supports for the new mother. This will increase her confidence and sense of self so that she feels empowered during this time of transition. If a mental health professional is interested in IPT treatment, it is a manual-based program and there are trainings available (Postpartum Progress, 2018).

Solutions Focused Brief Psychotherapy

This is a treatment modality that is not intended to process great traumas or difficulties, but rather to address needs and struggles on an ongoing basis and problem solve them to move on. The goal is to problem solve issues and promote positive change for the mother. For example, a woman might come to therapy who is simply exhausted because her child isn't sleeping. Together the therapist and the new

mother might address this issue and develop several different plans to attempt to find what will be the best solution for both the new mother and baby to get rest. Of course if the mother isn't sleeping, she is going to struggle with her mental health. Therefore, this will be a problem to navigate in therapy.

Another example might be for a new mother who really wants to practice intimacy with her partner again after giving birth but is having a difficult time initiating that intimacy. Together with her therapist, they might identify the blocking points and develop a plan to navigate through them.

This is not an appropriate modality for someone who is presenting with severe depressive symptoms or someone who has experienced great traumas that they need to process. This is appropriate for women with low-level symptoms that are related to transition or lifestyle change who need extra support identifying their path forward.

Family Therapy

Often postpartum depression is complicated for the woman because of her partner or family's inability to understand and best support. This is not the fault of her partner or family. Most often it is simply a reflection of their lack of understanding or education about mental health.

PSYCHICES

Psychoeducation in family therapy can be very helpful. This includes the therapist teaching the partner and/or family about what the new mother is experiencing. Together they will work to process any struggles that are coming up in their relationships and develop better methods of communicating and working together to best support the new mother.

This could involve developing a schedule or setting expectations with one another around parenting. If the new mother feels she is doing everything on her own, she might have resentment or anger toward her partner. It could also involve healing through past relationship traumas or struggles. Whatever the couple needs together to reduce the mother's depression is what they should work through in family therapy.

Skills Training

Much like our case example, Taylor, many new moms struggle with depression symptoms simply because they feel they are not strong parents. If this is true, there are many programs out there that teach new mothers new skills for parenting support. A therapist and a patient could work through these feelings and work

together to learn parenting skills to make the mother feel confident in her ability to parent.

Some examples include: boundary setting, healthy and safe discipline, effective communication, developing secure attachments, and other skills as necessary.

Lifestyle Support

Some mothers may be experiencing depression related to their difficulties transitioning to new motherhood. This is a good example of when a therapist or mental health professional can work with her to develop a lifestyle that accommodates her transition into new motherhood. For each woman this could look very different, however the following questions should be considered:

1) What does your ideal experience with parenting look like?
2) Is your current lifestyle conducive with your answers to the question above?
3) If it is not, how can you create a lifestyle that is better suited for the lifestyle you are seeking to create? Considerations for this question include the following: people the new mother spends her time with, activities she does, ways she spends her money, etc.

PSYCHICES

It can be very helpful as a mental health professional to engage the woman's partner in treatment if she has one. Because the mother is who carried the baby, their partner will not experience the changes in hormones that she is. They will not be able to understand what her body is going through in learning to breastfeed, experiencing the loss of carrying the baby, and all the other physical adjustments that are happening.

It can be especially helpful to teach the mother's partner about postpartum depression and her lifestyle needs. This can involve asking the partner to read data about postpartum depression, having them be involved in lifestyle discussions, developing plans together, and generally just teaching the mother how to effectively communicate her feelings to her partner. This will hopefully promote her partner to provide extra help during her time of need.

Peer Support

Peer support is an incredibly popular modality in the mental health community. Peer support specialists are certified to help and provide assistance to people who are struggling with experiences they may have also struggled with. For example, a mother

who has had a baby in the past few years might support a new mother in her transition time.

Common peer support interventions are as follows:

- Groups led by peer support specialists with the help of a mental health therapist to identify problems, interventions, and how it is going for those who are actively working through the problem or how to start for those who need to begin working through it (Peers for Progress, 2015)
- Informal support groups for gathering and sharing of experiences and coping mechanisms
- One-on-one peer support that is highly person centered to the new mother's needs. This is most often provided in a community mental health setting where there may be more peer support specialists available than a private practice setting
- Telephone based peer support or texting peer support
- Web-based peer support (Peers for Progress, 2015)

Medication

PSYCHICES

So often therapy is an essential component of treatment but it may not support all of a woman's needs. This is okay. Some women will benefit from pharmaceutical supports to best engage in therapy. This is true for women with high acuity needs or those who have been experiencing the desire to harm themselves or someone else (especially their newborn).

Common medications for women with depression include selective serotonin-reuptake inhibitors (SSRIs) (AADA, 2018). Common examples of SSRIs include Prozac, Lexapro, and Zoloft. Some serotonin-norepinephrine reuptake inhibitors have been found to be helpful as well. An example includes Venlafaxine.

Many women may fear using medication with infants who they are breastfeeding. It is recommended that each woman discusses her specific symptoms and treatment planning with both her therapist and psychiatrists. While some studies suggest she can use the medications safely while breastfeeding, this is a decision only she can make with her providers (AADA, 2018).

While some women may be hesitant to accept a prescription for their depression, research shows that 80% of people have an improvement in depressive symptoms

within four to six weeks of starting prescription medication geared at reducing symptoms of depression (DBSA, 2020).

Advocacy

Any provider working with a mother experiencing postpartum depression should be prepared to advocate for her care. She may be extremely uninterested or unwilling to attend inpatient or intensive outpatient programs and the mental health provider might feel they are necessary. The mental health provider should advocate and teach her to self-advocate for what she needs.

Depending on how long it has been since a woman gave birth, she might be experiencing physical health symptoms that are related to complications of birth or other post-birth symptoms that are complicating her mental health. The counselor and patient should work together to identify what she should advocate for. For example, it is perfectly reasonable if a mother is expressing difficulties with breastfeeding to ask the patient to advocate for accessing a skilled professional who can support her. The therapist might help her to identify resources local to her who could provide support.

Another example would be if a woman is grieving a birthing process that did not go how she and her doctor agreed it would go. This can be very traumatic for women. The therapist might advocate or teach the patient to advocate for following up with the doctors who worked with her during birth to get clarification and asking additional questions. This could help her to process and grieve the birth so that she can move on and experience less depression. Whatever a woman needs during this time, the therapist might help advocate for.

PSYCHCES

Inpatient vs. Outpatient Treatment

Regardless of what service or combination of services a new mother is accessing, she will have the ability to access it on either an outpatient basis or in an inpatient treatment facility. There are pros and cons to both kinds of treatments that should be considered.

PROS for outpatient treatment	CONS for outpatient treatment
More affordable treatment	Takes much longer to implement strategies than inpatient treatment

Allows for mother to see baby everyday	Scheduling conflicts with the provider may arise that make a woman go one to two weeks between sessions
Allows for attachment and bonding with baby	A woman might need medication and wait months to see a psychiatrist

PROS for inpatient treatment	CONS for inpatient treatment
Ensures fastest path to recovery	Extremely expensive and time limited
Psychiatrists on staff to see patients immediately	Mother and baby will be separated
Keeps new mother who has suicidal ideation safe	Family may have to plan for childcare

If a woman is experiencing severe suicidal ideation and is unable to keep herself and her baby safe, it is recommended in the mental health community that she access inpatient treatment or intensive outpatient services as soon as possible. A woman should visit her local emergency department if she is having active planning and has intent to attempt suicide.

PSYCHCES

Outpatient Services: A Case Study

Leslie is a 37 year old mother of five. She has struggled with postpartum depression several times before. She gave birth two months ago and noticed that her baby blues symptoms never quite went away. Leslie presents with sadness, frustration, loneliness, and feeling like she isn't quite able to do it all.

When Leslie noticed that her symptoms were not going away, she reached out to the therapist she worked with after her last child was born. Together they developed a plan to support her. Because Leslie presents with no desire to harm herself and anyone else and she feels she can be safely supported in the community, Leslie is a good candidate for outpatient services. She also feels strongly that she needs to be home with her children every day. Therefore, Leslie has opted to receive her counseling services by telehealth.

Leslie and her therapist plan to utilize a nondirective counseling approach. Leslie is not struggling with intense feelings of self-worthlessness nor negative thought patterns that might prompt her therapist to use another, more supportive modality.

Instead, Leslie is struggling with this transition and experiencing sadness around it. She requires processing time and validation. Each week they discuss whatever Leslie prefers to bring to sessions. This has consisted of feeling alone, some sadness, and anxiety about not being able to parent well for all of her children. Leslie has strong social supports in her husband and family. In the beginning and end of each session, Leslie and her therapist complete a meditation practice and a mood rating. Over a few months of weekly sessions, Leslie reports a mood that is much better than when she started counseling, less sadness, and feeling overall more prepared to parent all of her children equally. Leslie discontinues therapy after 12 weeks but knows she can return if she requires ongoing support.

Inpatient Services: A Case Study

Mariah is a 24 year old mother of one. She gave birth two months ago and has struggled with overwhelming fear, depression, and sadness since she gave birth. Mariah is a military wife and her husband is on deployment. He missed the birth of their child and she feels resentful of this. Mariah has a history of depression, anxiety, and inpatient hospitalization for a suicide attempt at 14 years old. She has been connected to outpatient mental health services for years and remained accessing counseling through her entire pregnancy.

PSYCHICS

Mariah did not expect to feel so alone and exhausted after the birth of her newborn. She presented in her last one-on-one counseling session with suicidal thoughts and intent. She reported that for the last few weeks she had been thinking about leaving her baby with her parents and completing suicide. She had a plan that included a local bridge on the military base that she lived on. Her plan is feasible and appears well thought out. When her therapist heard her plan, she validated the pain that Mariah must be feeling to get to this point. Her therapist and Mariah immediately began processing and developing a plan.

Mariah's symptoms are far too advanced for outpatient mental health services. Because she has a plan, intent, and access to a method for ending her life, her therapist believes that inpatient hospitalization is an appropriate next step. Mariah agrees. During this session, Mariah and her therapist contact her parents to explain what is going on: her therapist has contacted the local psychiatric unit on base at the hospital. They have a bed awaiting Mariah and are hoping for Mariah's parents to look after her baby. Her parents agree.

Mariah admits to the psychiatric unit and begins an intensive program for depression and anxiety. Her treatment includes ongoing Cognitive Behavioral Therapy for

identifying negative thought patterns and reprocessing them. It includes skill building for emotional regulation, distress tolerance, and developing social supports in the community. Finally, it involves medication management. Mariah decides to stop breastfeeding because she feels safest taking medication and not breastfeeding. Her psychiatrist prescribes an SSRI and over a few days is able to get her onto an adult dose.

Within three weeks of inpatient hospitalization, Mariah begins to greatly improve her status. She no longer has an active plan for suicide, reports having skills that make her feel she can better manage her life, and she is starting to find joy in pieces of everyday.

Mariah discharges after four weeks in the hospital and returns to parenting her newborn. She begins seeing her therapist two times per week for ongoing support after discharge and within a year has made a full recovery where she no longer reports depressive symptoms that are impacting her functioning and her parenting.

If Mariah were not to access inpatient hospitalization services at the time that she did, her health and safety would be at an immediate risk as well as the health of her child.

PSYCHCES

Postpartum Depression and Substance Use

Unfortunately, women experiencing postpartum depression are at a greater risk for substance use issues. Nearly 15% of women who have had a baby within the last 12 months report binge drinking (American Addiction Centers, 2020). 9% of women report binging with other drugs.

Depression and substance use often go hand in hand. This is because the high or drunk feeling from substances can temporarily soothe the sadness, anger, frustration, and numbness that women might feel during depression. This might be the only time they report feeling alive, excited, interested, or like the person they were before they gave birth. While it is understandable that women might turn to substances, it is not healthy or safe. It is important that if you notice your patients struggling with substance use after having a baby, that you advocate for them accessing appropriate treatment.

Substance use treatment for women experiencing postpartum depression might look slightly different than a person with depression or a substance use disorder. It will

likely be more extensive. In order to identify if a woman has a substance use disorder, you can ask her the following questions:

- Do you use drugs or alcohol for longer or in larger amounts than you anticipated? (Psycom, 2020)
- Have you tried to cut back your use unsuccessfully?
- Do you spend a lot of time using, obtaining, or recovering from drugs or alcohol?
- Do you experience cravings to use or drink?
- Does substance use interfere with work, school, or home life?
- Do you continue using even though substance use causes problems in relationships?
- Do you use drugs or alcohol in situations where it is physically hazardous to do so?
- Over time, do you need more of the substance to create the desired effect? (Psycom, 2020)

You can also utilize the AUDIT tool for screening alcohol use (SAMHSA, 2020). It is seen in Appendix B.

PSYCHCEs

If a woman presents with depression and substance use behaviors postpartum, mental health providers should utilize a multidisciplinary approach or a cross-systems approach (American Addictions Centers, 2020). This means that the mental health provider working with the new mother to address her depression should loop in a provider who works specifically in dependency and substance use. Together these clinicians will work with the patient to identify the most appropriate use for moving forward.

This integrated approach will utilize the following interventions:

- Withdrawal management as needed. For example: if a woman is addicted to heroin, she might consider utilizing a medically assisted treatment program (MAT) where she takes Suboxone or Buprenorphine as prescribed to manage withdrawal and life without heroin
- Inpatient residential treatment for substance use if the mother is unable to access sobriety through outpatient services or her withdrawal symptoms could be life threatening

- Medication for depressive symptoms or any other underlying mental health and physical health conditions
- Oversight by a physician who is familiar with substance use
- Individual therapy and potentially family therapy if needed
- Group therapy for individuals who struggle with substance use
- Participation in a recovery 12-step program such as Alcoholics Anonymous or Narcotics Anonymous
- Case management services
- Skills training (such as vocational supports or education supports)
- Other services as needed

The goal of all services for the mother in postpartum with substance use is to reduce her use altogether or to a rate that she can effectively parent and bond with her newborn while simultaneously addressing her depressive symptoms. First and foremost, we want to keep this mother safe. Women with depression and substance use may engage in risky behaviors such as self-harm, inappropriate sexual behaviors, impulsive behaviors, or others. They might also be more likely to attempt or plan for suicide. It is important that the mental health providers working with this mother are providing very supportive oversight and have safety planned appropriately. It is also necessary that they safety plan not only for the mother but for the child. If this mother is unable to provide a healthy and safe environment for the child, the mental health professionals working with her may be legally required to contact child services until she can safely parent (American Addictions Centers, 2020).

Closing Information For Mental Health Providers

It is clear that women with newborns are at risk for depression and disordered symptoms. Regardless of if a woman presents with extreme symptoms or not, she will benefit from treatment to return to a healthy and safe normal. While her life may look greatly different than it did before, it is possible for her to find a mental health baseline that looks similar to before pregnancy or even better.

Mental health professionals who are working with women in a postpartum period should understand the signs and symptoms to look for in postpartum depression. They must understand how to diagnose and treatment plan around the new mother in order

to best support her. This may or may not include any of the treatment modalities referenced, such as cognitive behavioral therapy, acceptance and commitment therapy, or others.

What is most important is that the mother is able to address her symptoms so that she and her baby can bond and attach appropriately. Attachment issues can lead to lifelong mental health struggles and disordered experiences for the children.

Mental health professionals who are working with new mothers are ethically responsible for educating themselves on the particular modalities and needs for this population of women. This also means that providers should understand how to develop cross-systems teams or interdisciplinary treatment teams. Therapists should identify local resources when working with patients that they might also require. This could include, but is not limited to, state funded case management services, substance use services, psychiatry, physical healthcare, skills training, WIC (Women, Infants, and Children programs), and others as needed.

PSYCHCEs

References

American Addiction Centers. (2020). *The connection between postpartum depression and substance use*. Retrieved from

https://americanaddictioncenters.org/treating-depression-substance-abuse/post-partum

American Academy of Child and Adolescent Psychiatry. (2014). Attachment disorders. Retrieved from

https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Attachment-Disorders-085.aspx

Depression and Bipolar Support Alliance. (2020). *Depression statistics*. Retrieved from

https://www.dbsalliance.org/education/depression/statistics/

Dewane, C. (2008). *The ABCs of ACT — Acceptance and Commitment Therapy*. Retrieved from

https://www.socialworktoday.com/archive/090208p36.shtml

Fitelson, E., Kim, S., Baker, A. S., & Leight, K. (2010). Treatment of postpartum depression: clinical, psychological and pharmacological options. *International journal of women's health*, *3*, 1–14.

https://doi.org/10.2147/IJWH.S6938

Levy, T. (2017). *Four styles of attachment*. *R*etrieved from

https://www.evergreenpsychotherapycenter.com/styles-adult-attachment/

March of Dimes. (2017). *Baby blues after pregnancy.* Retrieved from

https://www.marchofdimes.org/pregnancy/baby-blues-after-pregnancy.aspx#

Mayo Clinic. (2020). *Cognitive behavioral therapy.* Retrieved from

https://www.mayoclinic.org/tests-procedures/cognitive-behavioral-therapy/about/pac-20384610

Mayo Clinic. (2019). *Postpartum depression*. Retrieved from

https://www.mayoclinic.org/diseases-conditions/postpartum-depression/symptoms- causes/syc-20376617

Medline Plus. (2020). *Postpartum depression screening*. Retrieved from

https://medlineplus.gov/lab-tests/postpartum-depression-screening/

Peers for Progress. (2015). *Models of peer support*. Retrieved from

http://peersforprogress.org/resource-guide/models-of-peer-support/

Postpartum Depression. (2020). *Postpartum depression statistics*. Retrieved from https://www.postpartumdepression.org/resources/statistics/

Postpartum Progress. (2018). *Eight types of psychotherapy for postpartum depression treatment*. Retrieved from

https://postpartumprogress.com/8-types-of-psychotherapy-for-postpartum-depression- treatment

Registered Nurses Association of Ontario. (n.d). *Nursing best practices guidelines*. Retrieved from

https://bpgmobile.rnao.ca/node/1305

SAMHSA. (2020). S*creening tools. R*etrieved from

https://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs

PSYCHCES

Smith, K. (2020). *Substance abuse and depression*. Retrieved from

https://www.psycom.net/depression-substance-abuse

Toth, S. L., Rogosch, F. A., Sturge-Apple, M., & Cicchetti, D. (2009). Maternal depression, children's attachment security, and representational development: an organizational perspective. *Child development*, *80*(1), 192–208.

https://doi.org/10.1111/j.1467-8624.2008.01254.x

Appendix A

Patient Health Questionnaire – 9: PHQ9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Not at all = 0, Several days = 1, More than half the days = 2, Nearly every day = 3

1. Little interest or pleasure in doing things

   0 1 2 3

2. Feeling down, depressed, or hopeless

   0 1 2 3

3. Trouble falling or staying asleep, or sleeping too much

   0 1 2 3

4. Feeling tired or having little energy

   0 1 2 3

5. Poor appetite or overeating

   0 1 2 3

6. Feeling bad about yourself or that you are a failure or have let yourself or your family down

   0 1 2 3

7. Trouble concentrating on things, such as reading the newspaper or watching television

   0 1 2 3

PSYCHCES

8. Moving or speaking so slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual.
0 1 2 3

9. Thoughts that you would be better off dead, or of hurting yourself
0 1 2 3

TOTAL _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Somewhat difficult Very difficult Extremely difficult
Not difficult at all

PHQ-9 Patient Depression Questionnaire For initial diagnosis:

PSYCHICES

1. Patient completes PHQ-9 Quick Depression Assessment.

2. If there are at least 4 3s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder - if there are at least 5 3s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder - if there are 2-4 3s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.

2. Add up 3s by column. For every 3: Several days = 1 More than half the days = 2 Nearly every day = 3 3. Add together column scores to get a TOTAL score.

4. Refer to the accompanying PHQ-9 Scoring Box to interpret the TOTAL score.

5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention. Scoring: add up all checked boxes on PHQ-9 For every 3 Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3 Interpretation of Total Score Total Score Depression Severity 1-4 Minimal depression 5-9 Mild depression 10-14 Moderate depression 15-19 Moderately severe depression 20-27 Severe depression

Appendix B

Alcohol Use Disorders Identification Test: AUDIT Screening tool

PSYCHCES

The Alcohol Use Disorders Identification Test (AUDIT), developed in 1982 by the World Health Organization, is a simple way to screen and identify people at risk of alcohol problems.

1. How often do you have a drink containing alcohol?

(0) Never (Skip to Questions 9-10)

(1) Monthly or less

(2) 2 to 4 times a month

(3) 2 to 3 times a week

(4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

(0) 1 or 2

(1) 3 or 4

(2) 5 or 6

(3) 7, 8, or 9

(4) 10 or more

3. How often do you have six or more drinks on one occasion?

(0) Never

(1) Less than monthly

(2) Monthly

(3) Weekly

(4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

(0) Never

(1) Less than monthly

(2) Monthly

(3) Weekly

(4) Daily or almost daily

PSYCHCES

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

(0) Never

(1) Less than monthly

(2) Monthly

(3) Weekly

(4) Daily or almost daily

6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

(0) Never

(1) Less than monthly

(2) Monthly

(3) Weekly

(4) Daily or almost daily

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?

(0) Never

(1) Less than monthly

(2) Monthly

(3) Weekly

(4) Daily or almost daily

8. How often during the last year have you had a feeling of guilt or remorse after drinking?

(0) Never

(1) Less than monthly

(2) Monthly

(3) Weekly

(4) Daily or almost daily

PSYCHCES

9. Have you or someone else been injured as a result of your drinking?

(0) No

(2) Yes, but not in the last year

(4) Yes, during the last year

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?

(0) No

(2) Yes, but not in the last year

(4) Yes, during the last year Add up the points associated with answers.

A total score of 8 or more indicates harmful drinking behavior.



The material contained herein was created by EdCompass, LLC ("EdCompass") for the purpose of preparing users for course examinations on websites owned by EdCompass, and is intended for use only by users for those exams. The material is owned or licensed by EdCompass and is protected under the copyright laws of the United States and under applicable international treaties and conventions. Copyright 2023 EdCompass. All rights reserved. Any reproduction, retransmission, or republication of all or part of this material is expressly prohibited, unless specifically authorized by EdCompass in writing.