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Unexpected: Identity transformation of postpartum women

Laura J. Cammaroto
James Madison University

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Unexpected: Identity Transformation of Postpartum Women

Laura J. Cammaroto

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Abstract

This purpose of this paper is to explore the physical, emotional and societal issues women face as they transition to motherhood and the accompanying redefinition of self. Themes of acceptance of new roles and responsibilities, resolution of losses, adjusting marriage/partnership, renegotiation of relationships and professional standing are discussed. Women experiencing postpartum depression and anxiety appear to have difficulty navigating or adapting to the new maternal identity. Therefore, this paper summarizes some of the physical responses of the postpartum period as well as possible puerperal mental disorders such as: postpartum dysphoria (Baby Blues), postpartum depression disorder (PPD), post traumatic stress disorder (PTSD), and postpartum psychosis (PPP). Implications and recommendations for counselors to consider when assisting this population are also discussed.

Introduction

The rite of passage of becoming a mother can be fraught with emotions, ranging from joyful to outright panic. The list of associated feelings is infinite and the process can be disorienting. Women undergo intense physical and emotional changes during pregnancy, childbirth, and throughout the postpartum or postnatal period. Motherhood is not easy, yet women are taught that achieving it is so innate and natural; it is a virtual birthright that most women possess. The perception is that a woman is securely and blissfully a mother the moment the infant is placed in her arms. In spite of this prevailing myth, most women do not immediately feel this way and some may never feel that way at all. This simplistic view does not give voice to the process of becoming a mother, which along with joy can be full of challenges, self-doubt, confusion and exhaustion. Due to feelings of fear, shame and guilt, the array of emotions women feel during this period may be hidden or not discussed, thus sabotaging her transformation into a confident and secure mother.

This paper ultimately explores the transition into the role of mother. In addition, the physical, emotional and societal issues women face during the transition will be discussed. Finally, the recommendations for counselors will be considered when assisting this population. For the purposes of this paper, the term “family” includes the various familial constellations that exist beyond the traditional structure. In addition, with the exception of the physical reactions of pregnancy, childbirth and breastfeeding, the identity transformations discussed in this paper can be applicable to adoptive mothers or male primary caregivers of same-sex couples. However, this paper does not examine the additional considerations and accommodations that go along with becoming an adoptive

or same-sex parent. And finally, the influence a mother can have on her child's emotional, social and cognitive development is recognized in physical and social sciences alike (Ainsworth, 1979; Bee & Boyd, 2002; Bowlby, 1951; Winnicott, 1953). There is a century's worth of literature, research and social commentary explicitly supporting the importance of motherhood.

In 1965, Donald W. Winnicott used the term "primary maternal preoccupation" to describe the psychological state he noticed women go through during the perinatal period, the weeks shortly before and after childbirth. He described it as a time when a woman becomes intuitively aware of her infant's physical (hunger, sleep, excretion) and emotional needs (love, comfort, fear). This preoccupation decreases over time in response to the child's increased independence (Winnicott, 1953). As Winnicott stated (2005), "The good-enough mother starts off with an almost complete adaptation to her infant's needs, and as time proceeds she adapts less and less completely, gradually, according to the infant's growing ability to deal with her failure" (p. 14). Anthropologist Dana Raphael conceptualized the transitional process of becoming a mother as matrescence in her 1973 book *The Tender Gift: Breastfeeding*. According to Raphael, there are some cornerstones to matrescence, which begins at pregnancy and continues until the woman feels like she has successfully transitioned into a mother. Regardless of varying terms, the fact that it is transitional is the one consistent aspect to this maternal period. Like the transitional period of adolescence, the transition to motherhood varies from person to person. One woman may feel love at first sight of her infant while another woman finds it takes more time. One woman may feel overwhelmed by the emotions and fatigue, and another may

feel proud and confident right away. The path to motherhood is a unique and personal journey.

Erik Erikson suggested in his *The Life Cycle Completed* that during each stage of psychosocial development, a person confronts a crisis or conflict that needs to be resolved (Erikson & Erikson, 1987). The successful resolution of each conflict builds the foundation for the next stage. Furthermore, based on the work of James Marcia, identity achievement occurs with a commitment to a new role or value after a period of crisis, adjustment and reevaluation (Bee & Boyd, 2002). The process of becoming a mother, like any other stage of development, has its conflicts to resolve. There are emotional conflicts individuals need to resolve during this developmental process. Below is a list that was compiled by Becvar and Becvar in 2006 which reflects how the addition of a child truly does change everything.

- 1) Self-Acceptance and resolution of losses
- 2) Acceptance of new roles and responsibilities
- 3) Adjusting marriage/partnership to make room for child(ren)
- 4) Renegotiation of relationships with family and friends
- 5) Renegotiation of social and professional standing with self and community

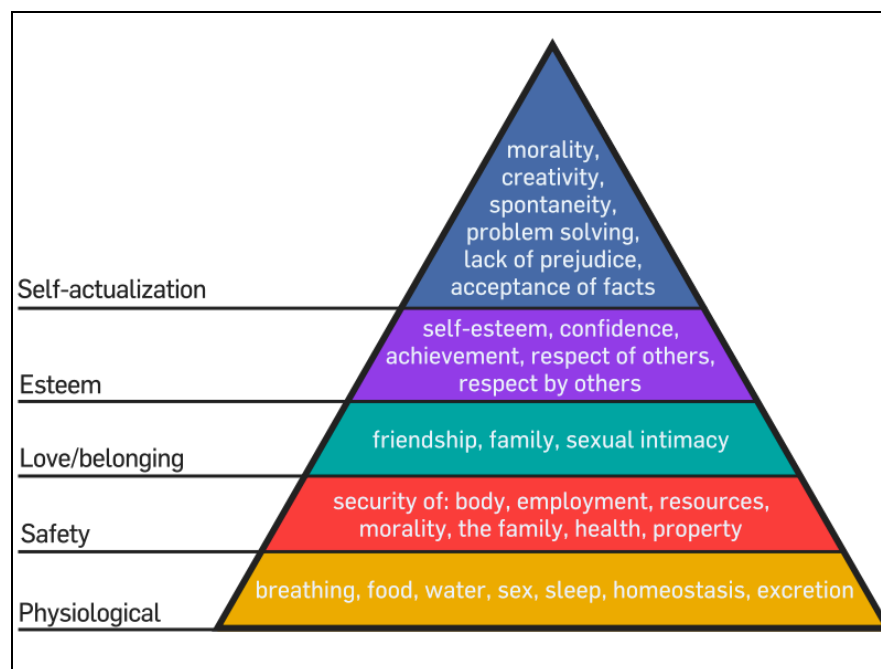
The concept of Maternal Role Attainment (MRA) was first introduced by Reva Rubin in the late nineteen sixties (Rubin, 1967). She defined MRA as a dynamic process that is learned, shared, and interactive. In 1986, Ramona T. Mercer extended the process to 12 months postpartum and redefined it as a “process in which the mother achieves competence in the role and integrates the mothering behaviors into an established role set” (p. 198). She also emphasized the importance of objective and subjective

competencies, which are influenced by a woman's ability to take on new roles, her range of skills, and the complexity of her self-concept (Mercer, 1985). Walker, Crain, and Thompson, (1986a) suggested that maternal identity is shaped by the quality of the reciprocal (cognitive and affective) relationship between mother and infant. Recently, Mercer advocated for the term to change from "maternal role attainment" (MRA) to "becoming a mother" (BAC). Her argument was that maternal role attainment did not adequately convey the process of becoming a mother, which evolves as the child grows, as does her sense of her competencies and self-confidence (2004). So more to the point, maternal role attainment is mercurial in a dynamic system. Eileen R. Fowles (1996) suggested becoming a mother is a complex process that involves cognitive, affective and behavioral changes (p. 75). For the remainder of this paper, both maternal identity and becoming a mother will be used with the understanding of the dynamic nature of the process.

Much like Abraham Maslow suggested in his Hierarchy of Needs (Figure 1), before facing the emotional concerns of security, social belonging and esteem, the physiological needs associated with giving birth and caring for a new infant must be addressed (Maslow, 1954). Consider the physiological needs he outlined required for human survival: breathing, food, water, sleep, sex, homeostasis, and excretion. I would say without exception that I have never heard a mother's personal account of her first year of motherhood without hearing about her difficulties sleeping, eating, having a bowel movement, urination, bathing, having sex or even breathing. As Maslow proposed, a person cannot begin to address the needs of the next levels without getting the very

basic needs met first. When considering a new mother attending to the physical and emotional needs of her infant, the process can get tricky.

Figure 1. :Maslow's Hierarchy of Needs



The very act of giving birth, whether vaginally or by cesarean, results in physical pain and discomfort. There are many reasons why mothers may experience pain, fatigue and exhaustion after childbirth. For example, no matter how natural or “textbook” a childbirth may seem, it is physically traumatic to both mother and child (Brown, 2002). Recovery is needed, yet at the same time a new baby requires attention. The associated pain can come from a combination of: muscle soreness, perineum pain (episiotomies or tearing), hemorrhoids, engorged breasts, pain during elimination urine and bowel and/or displacement of the coccyx (tailbone) (Brown, 2002; Placksin, 2000). Any combination could make it difficult for a new mother to easily focus on the needs of her new baby.

Adding to general level of exhaustion and weakness women experience after giving birth is the dramatic drop in hormones, vitamins and minerals. Due to the fact that the placenta was producing most of the hormones in the body, a woman's hormone production drops rapidly after giving birth (Brown, 2002). The hormonal shifts that occur during pregnancy can potentially last up to 6 months to a year after birth. While estrogen and progesterone drop off dramatically with the expulsion of the placenta, others take months to leave the body. Still more hormones, like prolactin and oxytocin, are triggered if the mother is breastfeeding (Brown, 2002). So, while the absence of some hormones has one series of effects, the presence of another has other effects making it difficult for homeostasis to occur physically or emotionally (Brown, 2002; Klier, Muzik, Dervic, Mossaheb, Ulm, & Zeller, 2007). The way in which each person physically adjusts to the rapid change is different. The most commonly associated reactions to hormonal fluctuations are the effects to physical being (body) and mood (mind) (Brown, 2002).

In general, interrupted sleep is something new mothers have to navigate. Just ask new parents how they are feeling and they will inevitably mention the lack of sleep and exhaustion they are experiencing. During this first month or two of life, the average newborn needs to feed every two to three hours if being breast-feed or three to four hours if formula-feed (Brown, 2002). Although the feeding schedule decreases during the first year, it is demanding, particularly on breastfeeding and single mothers. Factoring in all the feedings and diaper changes, a baby's need for comfort, and adjustment to circadian rhythms adds up to significant amount of interrupted sleep.

Sleep-deprived individuals are at increased risk for emotional problems, as indicated by elevated reports of depression, anxiety, and stress (Chua & Richdal, 2009;

Norman, 2009). Insufficient or irregular sleep can change the hormones and protein levels that affect mood and appetite (Norman, 2009; Yegneswaran & Shapiro, 2007). Additionally, there is a correlation between children's sleep problems and parental sleep disturbance and stress (Chua & Richdal, 2009). Other associated reactions to sleep deprivation are reduced alertness, shortened attention span, decreased reaction time, poor judgment, reduced awareness of the environment, poorer decision-making skills, poor memory, and reduced concentration (Yegneswaran & Shapiro, 2007). A possible consequence of these reactions over a long period time could easily be a reduction in overall self-esteem and confidence. It is important to note that decreased energy and fatigue are not always a result of lack of sleep. They can also be linked to insulin sensitivity or anemia, which are both common in postpartum women (Brown, 2002).

For mothers who are breastfeeding, there are other possible reactions. The early stages of breastfeeding can be painful and discouraging for some women. Mastitis, an infection in the breast, is frequently caused by breastfeeding. Although mastitis is more common during the first 6 months, it can happen at any time while breastfeeding (Brown, 2002). An infection can leave a new mother feeling tired and run-down. If breastfeeding continues to be difficult or painful some women may quit altogether. If a woman stops breastfeeding for this reason, she may feel like a failure or inadequate as a mother (Placksin, 2000). A woman's self-confidence may diminish as a result of her difficult breastfeeding, so does her sensitivity and responsiveness to her infant (Walker et al, 1986a).

Self-Acceptance and resolution of losses

A woman's body acts, looks and feels different after pregnancy and childbirth, and not all of the changes are temporary. A common change women experience as a result of pregnancy is weight gain. Although this is not a permanent change, it can be an enduring one. The location where a woman's body holds excess body fat may change (Brown, 2002). Breast density and shape change as well. This is especially the case if the mother is breastfeeding. There is also a musculoskeletal transformation, which occurs to accommodate the growing fetus that may not readjust. The effects of increased intravascular pressure can cause varicose veins and hemorrhoids, which may not dissipate over time. Some women are awed by their body's ability to give birth, while others feel frustrated with the changes and wish for the return of their pre-pregnancy or "normal" body. Her ability to adjust to these changes depends on her own self-acceptance, the validation and acceptance she receives from others, as well as the values she attributes to her physical being (Bee & Boyd, 2002).

The physiological affects of the postpartum period are only some of the hurdles an individual faces on her journey to motherhood. The new responsibilities of motherhood, combined with fatigue, are challenging to an already established identity. Prior to becoming a parent, one's self-concept may have been defined by a collection of attributes such as: independence, self-sufficiency, patience, efficiency, etc. Those beliefs, or self-imposed expectations, have to be reevaluated considering the new information and responsibilities. The idea that they must also go through a reevaluation of self adds to the concept that women establish their maternal identity through commitment (affect) and involvement (behavior) in their new role (Mercer, 2004).

Acceptance of new roles and responsibilities

There are countless new responsibilities that come with being the nurture/caregiver of a new infant. A mother's subjective and objective evaluation of how she is doing affects her overall confidence in her new role. There are three major influences on a person's self-esteem (Bee & Boyd, 2002; Maslow, 1954). One is the discrepancy between what people believe they can do and what they actually achieve. The second is the amount of support and acceptance they receive from others. Third is the value attached to the skill or quality. These aspects of self-esteem can easily be applied to the success or failure anyone feels in a new role. It is not hard to image an expectant mother daydreaming about her child, how she will be as a mother, and the connection she will have as mother and child. If those valued assumptions do not compare with reality, or if her abilities in her new role are not received well by the important people in her life, then a woman can be left with a negative evaluation of herself as a mother. However, if she is able to successfully soothe and nurture her baby, she will continue to acquire new skills and gain confidence; her identity as a mother will evolve (Mercer, 2004). The results from Walker, Crain, and Thompson's (1986a) study confirm that self-confidence in new mothers was related to successful maternal feeding, age, education, and socioeconomic status (SES).

Adjusting marriage/partnership to make room for child(ren)

The addition of a new baby is perturbing to the existing dyadic system. A couple may experience a change in the amount of time and energy they are able to devote to each other. Couples, who are not encountering other additional life stress, experience a significant decline in marital satisfaction with the arrival of their first child (Cowan &

Cowan, 1995). The three major factors that affect how couples adjust are: pre-existing expectations about parenthood, changes in communication, and pre-existing marital difficulties.

Renegotiation of relationships with family and friends

How a person relates to the world changes after having a baby. This ultimately means that relationships with friends and family may need to be renegotiated. The postpartum period is a time when it would be nice for a new mother to depend on others for care, food and safety. While some may relish the assistance if available, others might find it frustrating to relinquish control or ask for help. Again, it depends on how they saw themselves before motherhood. Like the reduction in attention couples experience with each other, friends and family may feel the effects of the new role as well. While it is ideal if friends and family are supportive and accepting of the change, that may not always be the case.

The early postpartum period can be isolating (Brown, 2002; Placksin, 2000). Therefore, it is important for new mothers to feel a sense of love, belonging and acceptance by their community. According to Maslow, the absence of these elements leaves a person susceptible to loneliness, anxiety and depression (1954). In addition, there are major cultural differences in how women are nurtured during this period. The mother's cultural and social network can mean the difference between isolation, the casserole brigades or having a close family member living with them for months. Another reason it is important to have social interaction is that women are more likely to form their identities based on a combination of the information they receive through relationships and internal beliefs about themselves (Bee & Boyd, 2002). Consequently, if

a woman is accepted and supported by her friends and family, she is more likely to view her new identity as successful.

Renegotiation of social and professional standing with self and community

New mothers need to renegotiate their social and professional personas within themselves and their community. The values and priorities associated with their work identity versus their family identities are taken into consideration. Today's families have to negotiate and balance powerful emotions associated with returning to work. For example, a stay-at-home mother may be happy about her choice but may have been unprepared for isolation and the loss of her previous work identity. On the other side, a working mother may enjoy the personal growth and satisfaction associated with her job but may feel guilt and loss about not being with her child. There are many reasons individuals return to work. While some families do not have a choice in the matter due to financial reasons, others enjoy their work. In addition to a paycheck, work can also offer a structured and familiar identity that is a relief for some who feel unsuccessful or overwhelmed by the new demands of motherhood. Whatever the decision, there are conflicting emotions that need to be addressed and related losses that need to be accepted.

In addition, how families navigate these potentially competing roles of work and family is a complicated and personal process. Equalitarian marriages, maternity/paternity leave, vacation, telecommuting options, and flexible or part-time work are strategies for managing conflicting demands of work and family roles. A current study by Buzzanell, Waynes, Tagle and Liu in 2007 suggests that the ethnic or cultural background is an integral part of determining an individual's postpartum work identity. For example, Asian American respondents in this study valued their presence in the workplace and wished to

extend their maternity leave by shifting to part-time work. On the other hand, Hispanic American respondents preferred telecommuting or taking family medical leave to stay home longer with their infant. African American respondents preferred private forms of childcare, like family or friends, as opposed to onsite childcare (Buzzanell et al, 2007). Although not all employers are flexible and not everyone has options, the ability to choose can help families integrate two roles in a way that supports their emerging parental identity.

What happens to women if there are barriers in the process?

New motherhood is a time full of surprising emotions, self-questioning and frustration. The process of becoming a mother is a dynamic and intricate process that is unique to the individual. Loss of identity, freedom, and confidence are all possibilities if there are barriers along her journey. As mentioned earlier, a mother's sense of competence is won through experience and mastery of her new role and skills. The support, acceptance and respect a woman receives from friends and family assist her in feeling more comfortable in her maternal role, while helping her retain a sense of independence and freedom. Deprivation of these needs can lead to feelings of inferiority, depression and anxiety. These can affect the mother-infant bond and ultimately the child's wellbeing.

There can be various impediments that can restrict a woman's process in becoming a mother. Maternal age, SES, perception of the birth experience, early mother-infant separation, social stress, social support, personality traits (temperament, empathy, and rigidity), self-concept, child-rearing attitudes, prenatal attachment, perception of the infant, role strain, and health status have all been recognized as variables that affect a

mothers confidence (Fowles, 1996; Mercer, 1985, 1986, 2004; Walker et al, 1986a, 1986b). For example, the role strain experienced by mothers, who had difficulty balancing the roles of mother, wife, and employee in some cases results in increased feelings of incompetence (Mercer, 1986). Isolation and persistent marital conflicts have been related to detrimental identity transformation. Decreased maternal self-esteem was also linked to a woman's lack of control of her bodily function and capacity. As mentioned earlier, there is also a decrease in self-confidence in mothers who have difficulty breastfeeding her newborn (Walker et al, 1896a). A study by Mercer and Ferketich in 1994 found significant interdependence between perceived parental confidence and attachment feelings toward the infant. The inference being drawn is that the process of maternal identity formation is interconnected, integrative and inter-relational.

Not surprisingly the variables associated with becoming a mother are similar to the identified 13 risk factors linked to Postpartum Depression (PPD), which are prenatal depression, low self-esteem, childcare stress, prenatal anxiety, life stress, low social support, marital/partner dissatisfaction, history of previous depression, infant temperament, maternity blues, marital status (i.e. being single), low SES, and unplanned or unwanted pregnancy (Beck, 2004, 2006; Kim et al, 2207; Forman et al., 2007; Oppo et al, 2009). Additionally, the CDC reported in 2008 that certain groups are more likely to report PPD: teenage mothers, women with less than 12 years of education, Medicaid patients, smokers, victims of physical abuse before or during pregnancy, women under traumatic or financial stress during pregnancy, mothers having a low-birth-weight baby, and mothers with infant(s) admitted to a neonatal intensive care unit. Fowles found a

strong negative correlation with PPD and maternal role attainment (Fowles, 1996). The women who suffer from PPD and other puerperal mental disorders also seem to struggle with maternal identity.

What should counselors do to help?

Becoming a mother, even under the best circumstances, can amplify existing vulnerabilities and cause distress. The assistance and support of a loving partner, family and friends make it easier for a new mother to focus on the needs of her infant(s) and develop a close attachment bond, which increases her sense of maternal identity. However, that is not always the case and the new mother may need the additional support of a counselor.

One of the first steps toward understanding a client's world is to gain a contextual understanding of that individual culturally, socially, intrapersonally and interpersonally. Embracing a client's cultural identity is imperative. It seems even more relevant when addressing identity transformation, as is the understanding that everyone's journey from pregnancy, to birth and motherhood is different. Since all individuals experience adolescence differently, we cannot expect new mothers to experience the transition to motherhood in the same way.

It is beneficial for counselors helping this population to increase their understanding of the various emotional possibilities of motherhood. An obvious way is to educate themselves to develop a more diverse view of the postpartum period (See Appendix C for suggested reading list). This is one way for counselors to become familiar with the birth/adoptive process and gain perspective and understanding about diverse experiences.

Rubin suggested, in her early work of MRA, that as a woman observes behaviors in herself and other mothers, she incorporates the ones she finds functional into her schema and rejects the ones she no longer finds useful (Rubin, 1967). Some women may feel a sense of loss or resentment about the pieces that no longer fit, depending on the value she places on them. To continue the process of growth and transformation, she has to grieve the lost pieces of self (Mercer, 2004).

Puerperal Psychological Disorders

The challenge clinicians face when aiding this population is to determine whether the client is just adjusting to the physiological effects and emotional shifts associated with having a new baby, or whether she is actually experiencing more significant psychological issues that could seriously impact on her or her child's development. There is a range of puerperal psychological disorders. The symptomology and contributing factors are similar to non-puerperal mental disorders; however, the triggers and onset are specific to new mothers.

The most common is postpartum dysphoria, also known as "Maternity or Baby Blues", which affects 50% to 75% of new mothers (Beck, 2006; Obata, 2009; Bloch, Schmidt, Danaceau, Murphy, Neiman, & Rubinow, 2000). This can occur within 2 to 14 days after giving birth. It is linked to the sudden withdrawal of estrogen, progesterone and other hormones women experience after birth. Similar to the emotional reactivity of premenstrual syndrome (PMS), the symptoms include tearfulness, anxiety, irritability, fatigue, and fluctuating moods (Beck, 2006; Obata, 2009; Bloch et al, 2000). As a woman's body adjusts to the new hormonal levels and recovers from childbirth, the effects dissipate without any medical treatment within 10 days (Beck, 2006; Obata,

2009). Although baby blues are a risk factor associated with postpartum depression, it is not predictive of PPD unless unusually severe.

Postpartum Exhaustion (PPE) is a complication of hormonal changes and sleep deprivation after giving birth. The level of fatigue varies from mild to severe and is typically seen in women with colicky infants with irregular sleep patterns (Brown, 2002). Although PPE is not considered postpartum depression, it has been regarded as one of the possible root causes. PPE generally only lasts from 1 to 20 days and can be remedied with minor medical assistance and consistent sleep (O'Hara & Swain, 1996). Being exhausted can have an emotional effect on a new mother who was expecting this time in her life to be blissful.

Some clients may continue to feel depressed several weeks or months after childbirth due to hormonal changes, role changes, negative breastfeeding experiences, difficult birth experiences, premature or critically ill baby, lack of sleep, and loneliness. Recent studies indicate that postpartum depression affects 10 to 15% of new mothers (Beck, 2001, 2006; O'Hara & Swain, 1996; Sit & Wisner, 2009). Supporting those findings is the Centers for Disease Control and Prevention (CDC) 2004 to 2005 data analysis of the Pregnancy Risk Assessment Monitoring System (PRAMS), which reported that 11.7% to 20.4% of women suffer from PPD (CDC, 2008). Because infants with depressed mothers are at risk for social, cognitive and emotional problems, it is imperative to diagnosis PPD as early as possible to reduce impairment of both mother and infant (Beck, 2001, 2006; Kim et al, 2007; Forman et al., 2007; Oppo et al, 2009).

Postpartum depression is considered a major depressive disorder (MDD) and can occur anytime during the postpartum year (Beck, 2004). According to the Diagnostic and

Statistical Manual of Mental Disorders, fourth edition, text revision (DSM-IV-TR) a woman may be diagnosed with MMD with the postpartum onset specifier if she is experiencing two weeks or more of persistent depressed mood, loss of interest in daily activities and five or more of the following symptoms: appetite disturbance, sleep disturbance, psychomotor agitation or slowing, fatigue, feelings of worthlessness or inappropriate guilt, poor concentration, and suicidal ideation. Although the DSM-IV-TR states that PPD begins within four weeks of afterbirth, it can occur up to a year after childbirth (Beck, 2006; Sit & Wisner, 2009).

Depression is a normal emotional response to stressful periods in life. However significant maternal depression places both the mother and child at risk. (Beck, 2006; Forman et al 2007). Therefore early screening is imperative. There are two postpartum depression-screening scales: the Edinburgh Postnatal Depression Scale (EPDS) and the Postpartum Depression Screening Scale (PDSS). The EPDS, by Cox, Holden and Sagovsky (1987) is the most commonly used screening tool. It is a self-report instrument that contains 10 items ranked from zero to three, which reflect the client's emotional experience over a period of one week (see Appendix A). Although not for diagnoses, the EPDS is a quick and cost effective screening tool for use during the postpartum year. The PDSS, by Beck and Gable is used to measure severity and type of depressive symptoms. Since prenatal depression is the most significant risk factor associated with PPD, the use of these screening tools during the prenatal period is recommended (O'Hara & Swain, 1996; Oppo et al, 2009). The EDPS-Partner can be a helpful screening tool with a partner who has relational understanding of the mother's depression.

An extremely traumatic labor and delivery can cause Post-Traumatic-Stress Disorder (PTSD), particularly in situations where a woman believes she or her baby are at risk of serious injury or death (Beck, 2004; Creedy, Schochet, & Horsfall, 2000; Gamble & Creedy, 2004). Medical interventions can feel scary and potentially leave the mother feeling powerless, ignored or mistreated. The symptoms of PTSD are the same as with victims of combat or violent crime. They include anxiety, flashbacks, an exaggerated startle response, anger, and difficulty sleeping and concentrating (APA, 2000). The number of women who meet the formal criteria for PTSD after giving birth ranges from 1.5% to 6% (Beck, 2006; Creedy, et al 2000). In addition, there is a higher rate of medical interventions reported in women who are experiencing PTSD (Beck, 2004).

The most serious mood disorder associated with new mothers is postpartum psychosis (PPP). It occurs in 0.1% of new mothers within the first four weeks after birth. There is a strong correlation with preexisting Bipolar Disorder (Beck, 2006). Symptoms can include delusions, hallucinations, thoughts of harming self or baby, extreme agitation, confusion, inability to eat or sleep, exhilaration, and rapid mood swings. Because some of the symptoms are similar to PPD, it is important to differentiate between the two. Immediate hospitalization is necessary for PPP due to the associated risk of suicide and infanticide (Kendal et al, 1987). Women experiencing PPP usually quickly respond to anti-psychotic medication (Beck, 2006).

Anxiety, panic and obsessive-compulsive disorders can also be triggered or exacerbated during the postpartum period. The additional distress these disorders cause can impair a woman's ability to successfully achieve the transition into motherhood (Beck, 2006).

Education, Support and Guidance

Educational programs that provide information about parenting, child development and health can be immensely helpful to new parents. Cowan and Cowan found that prenatal education programs help create realistic expectation that increased postpartum satisfaction (1999). Providing mothers with practical information about the postpartum period, including the range of emotions and stories from other mothers, can be beneficial. Educational brochures, suggested reading lists, local support groups and online resources also ease the transition (See Appendices B, C, & D).

Since isolation can be part of the early postpartum period, interaction with other adults can be a vital lifeline. Organizations like La Leche League International (breastfeeding support network), Mommy and Me Play Groups, Stay-At-Home-Moms Meet-up Groups, and Birthing Circles are great places for mother-to-mother support in which to share stories, resources, and helpful tips. It is also an opportunity for women to gather together and nurture, celebrate, pamper and recognize each other. Home counseling visits can be a supportive option for a mother, who is having difficulty with childcare or depression. However, going to counseling may be the only opportunity a new mother has to get out of the house and do something for herself.

Another growing venue for mothers with Internet access are online forums, chat-rooms and blogs. Not only do they provide useful and normalizing information, they offer a way to reduce isolation by connecting with other parents. It can also be a journaling medium for mothers to share their story and feelings while their child is napping.

While support groups and other complementary resources are helpful, the first place mothers go with their concerns is often a caring physician/pediatrician, midwife or doula. Most likely these relationships are already in place. Depending on the level of respect and support a woman feels from the relationship, they can be validating to her emerging identity. It is also important to note that philosophies of care can vary, so it can be helpful to notice if the woman feels supported in these relationships. Not only can these sources provide valuable assistance, they may be the first to recognize a need for counseling and medication.

In-home support for mother, newborn and family is an option and can last from a couple days postpartum to several months. After mothers are released from the hospital, the hospital's breastfeeding consultants are available by phone or email. Even though midwives and doulas are recognized as birthing assistants, they provide postpartum assistance and support as well. Postpartum midwives and home health nurses provide general medical evaluation for both mother and newborn. They can also offer consultation on lactation, feeding, sleep, nutrition, wellbeing and bonding. Postpartum doulas are trained to care for new families in the first few weeks after birth. In cases of postpartum depression, infants with special needs, or multiple infants, their assistance can last several months up to a year. Doulas can offer household assistance, advice on newborn care and feeding, and emotional support. As counselors it is helpful to know about these options because the relief and instruction they provide can facilitate mother infant bonding and the process of becoming a mother.

Family Therapy

As mentioned earlier, the decline in marital satisfaction upon the arrival of a new baby is common (Cowan, 1999). There is correlation between early distress in the family and negative child developmental outcomes seen in the pre and elementary school periods (Cowan et al., 1994). The transformation to parenthood not only affects each partner but the developing family. Couples therapy, group therapy and programs that focus on the parent–child bond can help family members navigate the challenges and ease the transition. It gives them an opportunity to share their experiences with each other, which can strengthen their bond. It also can help the couple work out role responsibilities if disparities exist. Providing the couple with information about parenting, early child development, and typical changes that occur to a marriage during the transition is helpful. However, assisting them in making sense of their experiences as partners and new parents is ultimately more sustaining to the relationship and family (Schulz, Cowan, & Cowan, 2006).

Couples support groups offer new parents a chance to share their challenges, uncertainties, and disappointments. Couple process groups facilitate discussion, encourage couples to discover their own solutions and provide a safe environment in which to try new behaviors. Regardless of the kind of group, they help parents recognize the common challenges and help them make sense of this life transition (Schulz, Cowan, & Cowan, 2006).

In addition to treating mothers, interventions should target the mother–infant relationship as well. Forman, O’Hara, Stuart, Gorman, Larsen, and Coy (2007) found that interventions that focused on maternal depression alone were not enough to improve the

mother-child relationship. The addition of parenting techniques and parent-child attachment intervention improved maternal responsiveness and sensitivity and had better long-term results (Forman et al, 2007).

Narrative Construction: The Birth Story

For the most part, childbirth is considered a positive life event. It can generate powerful emotions. After childbirth women find listening, support, counseling, understanding, and explanation helpful (Gamble & Creedy, 2004). Traumatic or painful births, or lack of birth satisfaction (epidural, caesarian or still birth), can result in negative birth experiences. Women who perceive their childbirth experience negatively are at greater risk of developing psychological problems (Selkirk, McLaren, Ollerenshaw & McLachlan, 2006). Inviting mothers to tell their birth story and develop a birth narrative soon after birth is validating to their journey. This process can also be used with adoptive parents by inviting them to tell their adoption story. It is essential to recognize and respect all her associated feelings whether negative (fear, doubt, and shame) or positive (love, joy, and hope). It is beneficial to focus on the strengths and abilities they need to cope and adjust to new experiences. Helping clients connect their emotions to their successes, courage and resilience, promotes feeling of resolve and self-efficacy (Presbury, Echterling, & McKee, 2002).

In the hospital settings midwives and nurses use single session debriefing interventions in efforts to reduce the occurrence of depression and post-traumatic stress. However, evidence suggests that single session debriefing sessions can increase a woman's distress and possibly trigger symptoms of PTSD (Gamble & Creedy, 2004; van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002). In contrast, women reported

that an opportunity to talk with someone about their birth experience was helpful in facilitating recovery once they returned home. Therefore timing and consistency seem to be important factors (Gamble & Creedy, 2004).

Developing a Postpartum Plan

Constructing a postpartum plan can provide new mothers with a sense of control. Some women may be familiar with this concept if they developed a birth plan prior to going into the hospital. It is important to assist clients in developing their own plan. Helping them think of concrete steps they can take to ease their transition can do this. Additionally, helping a woman clarify what she needs may increase her ability to ask for assistance. Here are some suggestions to put in writing for the new mother, but ideally the plan should be based on her individual needs.

- List of strengths and personal resources
- Organize help with housework and childcare
- Strategies on finding time for yourself
- Tips on getting out of the house
- Strategies to talk back and cope with negative thoughts and worries
- Relaxation techniques and self nurture
- Moving on tips: Accept all emotions and thoughts
- Promoting resilience: not focusing on the negatives
- Strategies for healthy communication and decision-making
- Approaches to nurturing existing and new relationships
- Sources for advice and reassurance
- Developing parenting skills

Nurturing the Nurturer: Complementary and Alternative Therapies

After months of sleep deprivation, hormonal and emotional changes, a mom could easily say, “It’s time for a time-out”. Who could blame her? Some mothers become so focused on the needs of their infant that they forget to fulfill their own needs. It is not unexpected for a new mother to ignore her needs due to the requirements of her new role. In many cultures the support of extended family is common, but in the more individualistic society of the United States, parents are expected to take it on solo with limited support from friends and family. As counselors, it may be helpful to have some complementary and alternative resources available at a time when a woman needs to be replenished, protected and honored.

The world of complementary and alternative therapies, or Complementary and Alternative Medicine (CAM), includes: massage therapy, acupuncture, Tai Chi, Chi Gong, yoga, pilates, exercise, music therapy, aromatherapy, progressive muscle relaxation, imagery, hypnosis, biofeedback and meditation. Based on Tiffany Field’s 2009 book *Complementary and Alternative Therapies Research*, there is compelling evidence from peer-reviewed journals that show significant positive results for both mother and infant. For example, the use of massage therapy on postpartum women was associated with the reduction of depressive and anxious symptoms. Reduced anxieties, improved sleep and mood, decreased heart rate, increase alertness and less pain were also reported. The improvements are in part due to the reduction in the cortisol, stress hormones, norepinephrine, and epinephrine levels and increase in dopamine and serotonin levels. The addition of massage therapy for either mother or infant has been shown to increase responsiveness in both mother and infant, which improves mother-

infant interactions (Field, 2009). Interestingly a study by Diego, Field, and Hernandez-Reif, (2005) there was more benefits associated with giving a massage to an infant than receiving. Long valued in Asian and Pacific Island cultures, infant massage was introduced in the United States in the 1970's. Its use has increased with the rise of natural childbirth, midwives and doulas. There are some countries, such as India, where infant massage is practiced for the first 18 months of life. Infant massage has also been associated with increased weight gain, sleep and vagal tone and decreased stress behavior (fussing, crying, hiccupping) and heart rate (Diego, Field, & Hernandez-Reif, 2005).

Conclusion

The need for quick and effective interventions is essential when assisting new mothers. They help reduce long-term impact to mother, child and family. Although in-depth psychotherapy has its place in emotional growth, brief interventions that promote resolution seem well suited to the needs of this population. There is benefit to finding out the origins of recent problematic behaviors, as this can help target appropriate interventions or education. Care should be taken when recommending a possible evaluation for medication due to the fact that weaning may have to occur if the mother is breastfeeding, which can be considered a significant loss to both and child (Kendall-Target, 2002). Protecting, facilitating and supporting the mother-infant relationship has lasting outcomes for mother and child (Moehler et al, 2006). The healthier a mother's emotional and physical health, the more she is able to show loving sensitivity and responsiveness to her infant's needs. The resulting improvements facilitate a mother's growing confidence in her new role (Ainsworth, 1979; Bowlby, 1951; Mercer, Fowles).

Mercer stated in 2004, “The stage of personal and maternal identity is characterized by the mother’s sense of harmony, confidence, satisfaction in the maternal role and attachment to her infant.” (p. 227). Through successful resolution of crises, increased skills, and improved mother-infant interactions, new mothers are free to tackle the next task or problem with creativity and confidence. Evaluation, renegotiation and acceptance seem to be essential parts of the dynamic transformation. By doing so, moms just may be ready to take on the unexpected.

Appendix A

Edinburgh Postnatal Depression Scale¹ (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- Yes, all the time
- Yes, most of the time This would mean: "I have felt happy most of the time" during the past week.
- No, not very often Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

- | | |
|---|---|
| <p>1. I have been able to laugh and see the funny side of things</p> <ul style="list-style-type: none"> <input type="checkbox"/> As much as I always could <input type="checkbox"/> Not quite so much now <input type="checkbox"/> Definitely not so much now <input type="checkbox"/> Not at all <p>2. I have looked forward with enjoyment to things</p> <ul style="list-style-type: none"> <input type="checkbox"/> As much as I ever did <input type="checkbox"/> Rather less than I used to <input type="checkbox"/> Definitely less than I used to <input type="checkbox"/> Hardly at all <p>*3. I have blamed myself unnecessarily when things went wrong</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time <input type="checkbox"/> Yes, some of the time <input type="checkbox"/> Not very often <input type="checkbox"/> No, never <p>4. I have been anxious or worried for no good reason</p> <ul style="list-style-type: none"> <input type="checkbox"/> No, not at all <input type="checkbox"/> Hardly ever <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Yes, very often <p>*5. I have felt scared or panicky for no very good reason</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, quite a lot <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> No, not much <input type="checkbox"/> No, not at all | <p>*6. Things have been getting on top of me</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time I haven't been able to cope at all <input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual <input type="checkbox"/> No, most of the time I have coped quite well <input type="checkbox"/> No, I have been coping as well as ever <p>*7. I have been so unhappy that I have had difficulty sleeping</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Not very often <input type="checkbox"/> No, not at all <p>*8. I have felt sad or miserable</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time <input type="checkbox"/> Yes, quite often <input type="checkbox"/> Not very often <input type="checkbox"/> No, not at all <p>*9. I have been so unhappy that I have been crying</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time <input type="checkbox"/> Yes, quite often <input type="checkbox"/> Only occasionally <input type="checkbox"/> No, never <p>*10. The thought of harming myself has occurred to me</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, quite often <input type="checkbox"/> Sometimes <input type="checkbox"/> Hardly ever <input type="checkbox"/> Never |
|---|---|

Administered/Reviewed by _____ Date _____

¹Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

²Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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Edinburgh Postnatal Depression Scale¹ (EPDS)

Postpartum depression is the most common complication of childbearing.² The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool.

Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt **during the previous week**. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)

Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)

Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

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Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

¹Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

²Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Appendix B

Family needs and postpartum depression

If not treated in time, postpartum depression may have serious consequences. Some studies have shown that children of depressed mothers may have developmental and language delays.

Available treatments

If you believe you suffer from postpartum depression, it is important that you talk with your healthcare provider. Individual or group counseling therapy used along with medications has proven to be the most effective treatment for postpartum depression.



What is Postpartum Psychosis?

This is a more severe but a much less common type of postpartum illness (one to two cases per 1,000 births). It can strike a woman **very soon after the birth of a child, often during the first 48 to 74 hours after delivery.** The woman may experience extreme mood swings, disorganized, irrational behavior, hallucinations or delusions. Postpartum psychosis is a **MEDICAL EMERGENCY** that requires **immediate medical attention** of the mother because of the immediate risk of self-harm or hurting the baby.



RESOURCES

Postpartum Health Alliance (310) 915-7028
 Los Angeles
 Center for Postpartum Health (818) 887-1312
 Depression after Delivery (800) 944-4773
 Postpartum Support International (805) 967-7636
 National Institute of Mental Health (800) 421-4211

Orange County

OCHCA Behavioral Health Services
 Aliso Viejo (949) 643-6900
 Anaheim (714) 517-6300
 Costa Mesa (714) 850-8463
 Fullerton (714) 447-7000
 Laguna Beach (949) 499-1877
 Santa Ana (714) 480-6767
 Westminster (714) 896-7566
 Emergency Treatment Services (ETS) (714) 834-6900

Postpartum Adjustment Support Group (949) 365-2144
 Mission Viejo, Tuesdays 10 AM-11 AM

Other Support Groups/Counseling
 MOMS Family Resource Center (800) 787-5858
 Turning Point (714) 547-8111
 Latino Psychological Services (714) 834-0757
 Human Options (949) 737-5242
 Catholic Charities (714) 542-7347
 Mariposa Women's Center (714) 547-6494
 Families Costa Mesa FRC (949) 574-3970
 FACES (714) 547-7345
 CHEC FRC (949) 661-5221
 Center of Hope (714) 898-8155

The information in this pamphlet is provided for educational purposes only. It is not intended to replace seeing a healthcare provider.

DTP209 (11/02)



Postpartum DEPRESSION

What YOU Should Know



An Educational Pamphlet for Pregnant and Postpartum Women



Orange County Health Care Agency
 Public Health Field Nursing

Introduction

Pregnancy and childbirth are important changes in a woman's life. But they can also be very stressful for some women. There is help available in the community to help pregnant and postpartum women adjust to these changes.

Approximately half a million mothers in the US experience what is called postpartum depression each year.

The majority of women experience the "baby blues" after giving birth

Eight out of 10 women feel tearful and have mood swings after giving birth. One minute they feel happy, the next minute they start to cry for no reason. These symptoms are usually normal during early motherhood. These feelings usually start by the third or fourth day after delivery and should go away within two weeks. Some women may have worse symptoms or the symptoms may last longer. This is called postpartum depression.



What is postpartum depression?

It is an illness that develops approximately two weeks after the birth of a baby. It is a **serious condition** that can affect a woman's ability to function as a new mother. Two out of 10 women experience this illness. It can last months or sometimes years if it is not treated in time.

What are the symptoms of postpartum depression?

Symptoms last longer and are more severe than the "baby blues." If you are **experiencing any of the following symptoms** during pregnancy or after giving birth, **you should talk to your health care provider or a person you trust as soon as possible:**

- Loss of appetite
- Loss of interest or pleasure in life
- Problems with falling asleep or staying asleep even while the baby sleeps
- Sleeping more than usual
- Crying for no apparent reason
- Lack of energy and motivation to do things
- Difficulty with concentration or making decisions
- Feeling restless, irritable, anxious or "on edge"
- Feeling worthless, hopeless, or helpless
- Feelings of not being a good mother
- Feelings of disinterest or being overprotective toward the baby
- Having thoughts about hurting yourself or the baby

What causes postpartum depression?

There can be multiple causes or reasons why women develop postpartum depression. However the exact cause is not known.

What are some risk factors?

- Hormonal changes after giving birth
- Previous history of postpartum depression
- Pregnancy loss
- Unwanted pregnancy
- Prenatal anxiety/depression

- Stressful life events during pregnancy or after childbirth (domestic violence, relocation, divorce, problems with partner)
- Lack of support from family and friends
- Previous history of depression not related to pregnancy or childbirth
- Infant temperament (baby difficult to calm down)
- First time mother or teen mother



What can you do to help yourself?

- Talk to your health care provider, or a person you trust, about your feelings during pregnancy and after delivery
- Attend support groups for pregnant and new moms
- Ask friends and family to help you with household chores, child care, and errands
- Keep phone numbers available for agencies in the community that offer support groups and counseling
- Practice self-care activities (walking, sleep and eat well, play or read with your other children)
- If possible, exercise every day
- Taking care of a newborn can be demanding; **ask for help** when things seem too overwhelming

Appendix C

Resources:

Suggested Books

- *2008 Medications and Mothers' Milk*, by Dr. Thomas W. Hale
- *A Mother's Circle: An Intimate Dialogue on Becoming a Mother*, by Jean Kunhardt
- *And Baby Makes Three: The Six-Step Plan for Preserving Marital Intimacy and Rekindling Romance After Baby Arrives*, by John Gottman
- *Becoming a Calm Mom: How to Manage Stress and Enjoy the First Year of Motherhood*, by Deborah Roth Ledley
- *Belly Laughs: The Naked Truth About Pregnancy and Childbirth*, by Jenny McCarthy
- *Down Came the Rain*, by Brooke Shields
- *Misconceptions: Truth, Lies, and the Unexpected on the Journey to Motherhood*, by Naomi Wolf
- *Momfidence!: An Oreo Never Killed Anybody and Other Secrets of Happier Parenting*, by Paula Spencer
- *Mothering the New Mother, Women's Feeling and Needs After Childbirth a Support and Resource Guide*, by Sally Placksin
- *Mothering without a Map*, by Kathryn Black
- *The Birth of a Mother: How The Motherhood Experience Changes You Forever*, by Daniel N. Stern
- *The Bitch is in the House: 26 Women Tell the Truth About Sex, Solitude, Work, Motherhood, and Marriage* edited by Cathi Hanauer
- *The Mommy Myth*, by Susan Douglas and Meredith Michaels
- *The Post Pregnancy Handbook*, by Sylvia Brown
- *This Isn't What I Expected Overcoming Postpartum Depression*, by Karen R. Kleiman & Valerie D. Raskin.

Appendix D

Suggested Online Support:

Well-Being

- www.thecalmmom.com
- www.onefitmama.com
- www.metropolitanmoms.com

Mood Disorders

- www.postpartum.net/
- www.womenshealth.gov/faq/postpartum.htm
- www.charityadvantage.com/depressionafterdelivery/Home.asp

Anxiety Disorders

- [www.adaa.org/GettingHelp/MFarchives/MonthlyFeatures\(January\).asp](http://www.adaa.org/GettingHelp/MFarchives/MonthlyFeatures(January).asp)

Support Groups

- www.lli.org/
- www.momchats.com/
- www.mommychats.com/
- www.mommyandme.com/
- www.momswhothink.com/

Doulas

- www.heavensentdoulas.com/resources.html

Breastfeeding Pharmacology

- <http://neonatal.tuhsc.edu/lact/>

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