Postpartum Depression Post Andrea Yates

Patricia R. Luca

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Ed Barker, Ph.D.
Chairman of Thesis

Fred Volk, Ph.D.
Committee Member

Monica Rose, D.Min.
Committee Member

Judy R. Sandlin, Ph.D.
Asst. Honors Program Director

April 27, 2007
Date

Abstract

Scientific research does not occur without influence from media and culture. Certainly, changes in funding decisions and publishing patterns are not immune to the influence of a single fantastic case. Andrea Yates' gruesome murder of her five children is just that type of case. The present paper focuses on the influence of that case on postpartum depression research in terms of both content and volume. The explosion of research on postpartum depression since Yates murdered her children is inarguable, the content of that research was organized into three areas: application of postpartum depression, mother-child relationship, and related constructs and discussed in detail.

Postpartum Depression Post Andrea Yates

People have different methods for coping with life and its stressful events. The level of security in a person is directly proportional to the method of coping with difficult situations. The degree of stress does not change, what changes is the way one approaches the situation. One of these stressful events is the arrival of a newborn in a family. For the mother, giving birth follows a completely new set of challenging demands (Muslow, Caldera, Pursley, Reifman, & Houston, 2002). The degree of stress depends upon the past experience of the parents and on their perception of parenting. For some parents a new baby is a joy and for others it is merely added stress. This stress is one of the risk factors for postpartum depression, which impacts the mother and the child, as well as their relationship. Women experiencing postpartum depression often have trouble in their new parenting role because their expectations of motherhood do not match reality (Feske et al., 2001).

Statistics

The prevalence of postpartum depression has been estimated to be between 10 and 15% among women who gave birth (Bloch, Rotenberg, Koren, & Klein, 2005). This type of depression occurs within the first 12 weeks after childbirth. Depression is more prevalent between the ages of 18 and 44. This range of years is also the range for childbearing years (Godfrey, 2005). In other countries the prevalence rates for postpartum depression are 21% for Arab women, 11% for Indian women, 11.2% for Chinese women, 22.4% for Chilean women, and 12% for Brazilian women (Faisal-Cury, Tedesco, Kahhale, Menezes, & Zugaib,2004). The consequences of postpartum depression are not only present in mothers, but also in their families, and their infants.

Therefore, prompt and efficient help is necessary from medical personnel in order to help and support the families affected by postpartum depression.

Defining Postpartum Depression

Faisal-Cury et al. (2004) found that despite the alarming data on the prevalence of postpartum depression, the diagnostic criterion is very controversial and its etiology remains unknown. It can be concluded that postpartum is not classified identically in all states and has certain variables that can change (Inandi, Bugdayci, Dundar, Sumer, & Sasmaz, 2005). The occurrence of postpartum depression in the United States depends on the definition given to it, the evaluation criteria used and the geographical position of the clients. A modification in the definition of postpartum depression may occur as a result of further research conducted in this area. Wikipedia.com (2007) defines postpartum depression as "a form of major depression which can affect women, and less frequently men, after childbirth. It is widely considered to be treatable" (¶ 1).

At one time it was believed that postpartum depression was caused by hormonal changes, however, today's research has found no sustaining evidence for this supposition (Reich, Silbert, Spence, & Siegel, 2005). Research has increased greatly within the past five years. Psychologists and psychiatrists are able to assess and treat postpartum depression in a more efficient way with better results. The Edinburg Postnatal Depression Scale was developed following recent research, and it is used to assess women who are potential candidates for postpartum. Overall research is increasing in the area of postpartum depression but there are still some gray areas that need further research (Dennis, 2004).

The Case of Andrea Yates

One example of a real life tragedy that has been used to increase the amount of research in postpartum depression is the crime committed by Andrea Yates. Yates and the murder of her five children has been a monumental event that brought postpartum depression to the attention of society. In 2001, Andrea Yates drowned her five children in a bathtub in her home in Houston, TX. The nation was shocked and the world responded. During her delusional state she felt as if Satan told her that if she would kill her children she would spare them from hell. Andrea had a history of mood instability and bipolar disorder in her family. Being pregnant and breastfeeding for seven years describes why she shifted into postpartum depression and psychosis. She also had a hypereligious preoccupation with Satan. Her psychiatrist stopped treatment immediately prior to the murders, which might have played a role in her committing this act. She was found guilty of capital murder. She was spared the death penalty but she was subject to prison for life. Her case attracted international attention. Organizations worldwide developed plans for the treatment and prevention of postpartum depression. They requested clarification of postpartum depression criteria, improved medical education, and established guidelines for treatment. (Spinelli, 2004).

Rationale

The research rationale of this paper is to observe whether research in postpartum depression has increased post Andrea Yates. There has been an incredible increase of research done in the area of postpartum depression, but because the amount of articles published before Andrea Yates is limited in number the study will focus on the literature published after her case. Most of the research has been done within the last five years

which indicates that the case of Andrea Yates has had a tremendous impact in psychology.

Literature Review

During the postnatal period certain psychiatric disorders can occur. These disorders may be divided into maternity blues, postpartum depression, and postpartum psychosis (Manfredi et al., 2005). Unlike baby blues and postpartum depression, postpartum psychosis affects between one and two women per thousand. Compared to postpartum psychosis, postpartum depression affects 10 to 13% of new mothers, followed by baby blues or maternity blues which affects 50 to 70% of postpartum mothers (Sit, Rothschild, & Wisner, 2006).

Baby Blues

The baby blues occurs in approximately 50 to 70% of women in their first six to eight weeks after giving birth. It is important to point out that baby blues does not affect a mother's judgment as it is not a disorder, nor a disease. Baby blues can be summed up as a elevated emotional state with depression symptoms. Some of the general symptoms of depression are fatigue and crying. Other symptoms are unfounded tearfulness, high irritability levels, emotional unstableness, mood swings, fatigue and increased sensitivity. Baby blues does not need any kind of treatment, nor hospitalization as it goes away by itself with time. The peak period for the occurrence of baby blues is usually in the fourth and fifth day of postpartum and it is gone by the tenth day. The symptoms of baby blues are not rooted in psychopathology, therefore the mother is still able to attend to her parental needs (Clay & Seehusen, 2004).

Postpartum Depression

General description. Clay & Seehusen (2004) found that postpartum depression is a type of reactive depression and is more likely to persist for approximately one year in over half of the women who gave birth. Postpartum depression starts within three to six months from giving birth. The major symptoms that occur are depressive moods, anhedonia, weight changes, sleep disturbances, low level of concentration, indecisiveness, agitation, inappropriate guilt, feelings of worthlessness, and suicidal or death thoughts. Other symptoms include loss of appetite and sleep, feeling sad and hopeless, lacking energy and interest in the every day activities, negative thoughts, thoughts of harming one self, and concentration difficulties. Some of the factors that may increase the prevalence of postpartum are previous episodes of depression, difficulties within relationships, stressful events that occurred during the birth, and unrealistic expectations of the mother baby relationship (Craig, Judd, & Hodgins, 2005). Clay & Sheehusen (2004) state that in the DSM IV postpartum depression is a term used in correlation to" major depressive disorder, bipolar disorder or brief psychotic disorder beginning within four weeks of delivery" (p.157).

Screening and risk factors. Reich et al. (2005) found that the diagnosis of postpartum depression can be difficult because the majority of the symptoms are common with general depression and the regular sequelae of giving birth. Some symptoms like mood swings are expected to occur and are considered normal postpartum. In the present, the origin of postpartum depression is not clear. Past hormonal changes were believed to lead to the occurrence of postpartum depression; however no reliable data has been found to support this claim. Current research shows that one of the more reliable antecedents to

postpartum depression is the presence of a stressful life and stressful events, particularly those which change the woman into a mother, such as birth complications and childcare demands.

Manfredi et al. (2005) found that some of the risks of postpartum depression are previous depressive episodes during the pregnancy, family history of depression, increased levels of stress (social and psychological), marital problems, and the lack of social support. The following factors have not been demonstrated to affect the onset of postpartum depression educational level, infant gender, type of delivery and socio-economical background. It is interesting to note that postpartum depression can be experienced by the fathers as well which suggests that the marital relationship plays an important role in the occurrence and maintenance of postpartum depression.

Craig et al. (2005) found that there is a difference between an infant's development with a mother who suffered from postpartum depression and a non-depressed mother. Mothers who experience postnatal depression tend to feel as if they have failed to be a parent and they experience a high degree of guilt. Some of the mothers are disappointed in the infant's gender, and have high and unrealistic expectations for the mother-child bond. A postpartum depressed mother may a) attempt to connect with the child and not experience anything, b) have difficulty enjoying her child, c) be incapable of soothing the child or d) have harmful thoughts towards the child.

Treatment. The treatment of postpartum depression is similar to the treatment of major depression. A few therapies have been proven to be efficient and these are: psychotherapy, electroconvulsive therapy and pharmacotherapy. All three therapies have been proven equally efficient when used separately or together. Choosing the form of

therapeutic instrument should be done after assessing the patient's personality as each personality works better with a specific treatment. If the marital relationship is also stressful for the parent then marital counseling should be offered as well. It is important for the parents to be able to support each other and to use their marriage as a source of strength and not an added stressor.

Clay & Seehusen (2004) found that medication might be necessary for some patients and these might include fluoxetine, paroxetine and sertraline. These medicines are considered top choices in treating major depression due to their efficacy and safety as well as not affecting breast feeding in mothers. Typically, medication begins with a certain dosage and is increased after two weeks. Clinical improvement normally occurs within six to eight weeks of treatment. If the patient is not improving, she should be referred for further psychiatric investigation. If not cured, the patient might move into postpartum psychosis.

Postpartum Psychosis

Postpartum psychosis is present in one to two of every one thousand births. Two consequences of postpartum psychosis may be suicide and infanticide (Connell, 2002). Clay & Seehusen (2004) found that some of the early signs of postpartum psychosis are insomnia for more than one night, infant avoidance, high state of agitation and irritable moods. If delusions and hallucinations are present they most likely involve the infant. Mothers who are not cured from postpartum psychosis commit infanticide at a rate of 4%.

This type of psychosis is characterized by a major deviation from normal thought processes. In order to protect the mother and the child, hospitalization is necessary.

Postpartum psychosis was believed to be similar to a psychosis suffered by a man or a woman who did not give birth. The evidence is that women who gave birth were showing more delusional episodes with disorientation and agitation (Connell, 2002). At advanced ages, first time mothers have been found to have a higher rate of postpartum psychosis. There is an apparent connection between increased age and an increased possibility of psychosis. Among this set of women, more of them were living without their husbands. The psychotic disorder rates in a general female sample were twice as high in women with lower level of education compared to women with higher levels.

The presence or absence of the father played a significant role with first-time mothers in preventing or generating psychotic disorders. In general, increased age and the absence of the father of the child are associated with a high level of possible hospitalization for postpartum psychosis in the case of first-time mothers. It is possible also, that due to some hormonal and biological factors, older age increases the risk of postpartum psychosis (Nager, Johansson, & Sundquist, 2005).

Symptoms, onset and treatment of postpartum psychosis. Some of the symptoms that postpartum psychosis manifests are delusions, hallucinations, mood instability, disorganization on the cognitive level, and an evident appearance of bipolar illness. The onset of postpartum psychosis is very rapid; beginning as early as the second or third day following birth. Some other symptoms that occur in this type of psychosis are impaired thinking, delusions, especially paranoid or bizarre, and disorganized behavior.

The majority of data proposes that postpartum psychosis in an explicit presentation of post-delivery bipolar disorder. Sit et al. (2006) has found that 72 to 88% of the mothers who develop postpartum psychosis immediately after birth have bipolar or

schizophrenic disorders. It is important for medical personnel to be aware of screening and testing for postpartum psychosis in new mothers as this type of psychosis is considered an emergency that requires psychiatric evaluation and possible hospitalization. The treatment guidelines for postpartum psychosis are outdated and the development of better treatment strategies is required. In the case of postpartum psychosis, the focus of treatment is on the underlying diagnosis. An explicit example of postpartum psychosis and the underlying diagnosis is the aforementioned case of Andrea Yates.

The focus of the present research is to analyze the effect that Andrea Yates' crimes have had on the present research in the area of postpartum depression. Yates' case was chosen because it has been so dramatic and because it has drawn international attention to the severity of postpartum depression.

Method

The purpose of this paper is to research the different ways in which postpartum depression literature has changed after the year of 2001. Content analysis was the appropriate way of analyzing the literature and identifying the new ways in which research literature has changed.

Selection of Articles

Out of 402 research articles on postpartum depression published between 2001 and 2006 from ten journals 30 articles were selected as shown in Table 1. The articles were chosen based on the frequency of the journal that published them. They were also chosen only if the research was done in the United States.

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Table 1

Journal Articles Selected for Research

Journal	Articles Published	Articles Selected
Archives of Women's Mental Health	48	7
Birth: Issues in Perinatal Care	10	3
Journal of Reproductive and Infant Psychology	13	3
Journal of Women's Health	5	2
Journal of Affective Disorders	25	5
MCN: The American Journal of Maternal/Child Nursing	5	2
Primary Psychiatry	10	2
Psychiatric Annals	8	2
Psychopathology	5	2
Women & Health	5	2

Content Analysis

Content analysis is a technique used for drawing conclusions by systematically and objectively identifying certain characteristics of the manifest content. In order for the research to be objective the analysis has to be executed on strictly formulated rules which would allow others to replicate the analysis and obtain the same results. The inclusion

and exclusion of criteria depends on how consistently the selection criterion is applied. The purpose of content analysis is to identify certain pattern, trends or themes occurring within the text (McMahon, & Allen-Meares, 1992). Typically content analysis is performed on forms of communication, such as newspapers, books and transcripts of dialogues. Content analysis is found not only in the psychological field, but also in education, journalism, history and art, requiring a great amount of planning before writing the research (Leedy & Ormrod, 2005). There is a growing array of researchers who are using content analysis with an augmented frequency (Neundorf, 2002). The increased use of this technique can be found in: PsychInfo, ProQuest Digital Dissertations and Social Science Citation Index databases. Another area in which the frequency of content analysis is increasing is the writing of theses and dissertations (Neundorf, 2002).

Procedures

Only the articles that referred strictly to postpartum were selected, the rest of the articles that did not fit the criterion were excluded. The articles were read and categorized and were all used in the review. The categories were randomly sampled and 31 of them will be chosen for content analysis. The criteria used to select these articles is based on the Brown and Brown (1980) and consisted of two basic rules: (a) the articles had to be published after 2001 in a local or national referenced journal and (b) the articles had to research or measure the behaviors related to postpartum depression. The articles chosen for research were selected according to the criteria of the definition of postpartum depression. Postpartum depression is as an affective disorder that manifests in women after giving birth. Defining postpartum depression as a depressive episode that develops

during the postpartum period, 4-6 weeks, is restrictive. It was found that the period considered at a very high risk for developing postpartum depression is the first year after giving birth therefore this whole year needs accurate research (Manfredi et al., 2005).

Data Analysis

All the articles that met the screening criteria were first content coded into the following categories: case study (CS), review article (R), experimental research (ER), and method or program explanation (PD). Once each article was placed into one of these categories, its frequency was measured by years starting with 2001 and ending with 2006. (Brown & Brown, 1980).

The following stage was to read the articles via random selection and to identify a coding process. Coding was done based upon the reading of the articles and upon the main areas that were targeted in research. This coding was used to determine the main areas in which research has increased in the case of postpartum depression.

Results

ER is the most common article, as seen in the Table 2, and it is preferred because it allows the researchers to determine different factors and their implication to postpartum depression. These factors are the guidelines for approaching and treating postpartum depression and they are used in treatment methods. For this reason, the second most common article type is PD. Research has increased with years, as seen in Table 3, with the highest frequency in the years 2004 and 2005. With this finding it can be concluded that research is still looking for some definite guidelines for postpartum depression.

Table 2

Journal Articles Researched

Type of Research Articles	Number of Articles
Case Study	1
Review Article	6
Experimental Research	18
Method/ Program of Explanation	6

Table 3

Year Frequency of the Articles Published

Year of Publication	Number of Articles
2001	1
2002	1
2003	5
2004	13
2005	11

Through the content analysis process three major areas emerge: works that focused on applications of postpartum depression, those articles that attempt to address mother-infant relationship and works that addressed the comorbidity of postpartum depression with related issues. Application of postpartum depression includes prediction, prevention, screening and treatment of postpartum depression. The mother-infant

relationship addresses an overview of postpartum depressed mothers, maternal attachment, the effects postpartum depression has on the baby and the need for future research. Related construct is the last area and it comprises four different factors and their relation to postpartum depression.

Application

When it comes to the research of postpartum depression, the first area targeted is its prediction. Women can be divided into high-risk and low-risk according to the presence or absence of risk factors. There is an increased risk of depression during the first three months postpartum, especially in mothers who have been previously depressed. Therefore, when screening for postpartum depression the most accurate time is at three months postpartum. It has been found that there is a difference between the mothers who are depressed in late pregnancy and the mothers who were not depressed during that period the difference being that the first group has a higher risk of becoming postpartum depressed. In addition, personal history of depression and depression during late pregnancy are two major factors that predict postpartum depression (Verkerk, Pop, Van Son & Heck, 2003).

Bloch et al. (2005) found that the following factors were not related to postpartum depression: marital and economical status, ethnicity, number of children the mother has, whether or not the pregnancy was planned, whether or not the fertilization was natural, and the method of delivery, the presence of family history of affective disorders and personal history of postpartum depression were not related to postpartum depression.

Factors that may lead to postpartum depression are personal history of psychological trauma related to hormonal imbalance. The relationship between

postpartum mood disorder and certain hormones was studied and it was found positive. It was also found that women who suffered from postpartum depression were less likely to become pregnant again. Other studies have found that certain women may have a predisposition to postpartum depression due to family history of mental problems. Along the lines of chemical dependency and whether or not it has an impact on the mother there was found a positive correlation between smoking and postpartum depression (Freeman, Wright, Watchman, Wahl, Sisk, Fraleigh, & Weibrecht, 2005). There has also been found a positive correlation between postpartum depression and income status. Low income women are not able to receive routine screening for postpartum depression due to the length of their insurance.

Women with low income are deprived from receiving the help they need because their insurance coverage does not last long enough. Postpartum depression has a span of 12 months after birth and the insurance terminates after six weeks of check-up routine. In some cases postpartum depressed mothers lost their medical insurance as soon as their child was born.

While economic status is not the result of pregnancy or giving birth, stress is. Stress, on one hand, has been proven to be one of the risk factors that lead to postpartum depression, on the other hand, stress is one of the natural outcomes of pregnancy and giving birth. The economic status of a family may increase the stress due to: lack of a job, paying bills, transportation problems, and lack of relief or constantly having to take care of the infant. Consequently, since stress is present in a mother's life postpartum and it can be heightened by her financial status, more attention should be given to providing

financial support. This is one area where the U.S. government could intervene and provide more support and assistance (Boury, Larkin, & Krummel, 2004).

The second area targeted is the prevention of postpartum depression. The first option of preventing postpartum depression is treating large number of women, which can be costly, or only treating women who are at a high risk. If monetary gain or loss is kept in consideration, the second option of prevention would be the treatment of strictly the women who have already developed postpartum depression. Some simple interventions might be the presence of social and family support. The present literature is lacking in studies targeting the prevention of postpartum depression. There are two main factors that need special attention and these are correct selection of women at high risk and aggressive methods of keeping the patients in treatment. The literature stresses the need for further research in the area of prevention (Stuart, O'Hara & Gorman, 2003).

The third area regarding the application of postpartum depression is screening. Freeman et al. (2005) found that there are many women who go unrecognized and untreated for postpartum depression. Since prevention is better and more effective than treatment the main attention falls on screening women for postpartum depression. The most accessible place for screening to take place is the maternity ward and it can be done with the aid of properly trained doctors and nurses. This is where accurate training is necessary in order to enable hospital personnel to detect women at risk or suffering from postpartum depression. Help should be given to mothers as soon as possible in order to prevent the disorder from developing.

Pediatric clinics have been found to be another place for accurate screening. Mothers have to bring their newborns for regular check-ups and while that is taking place

the mothers can be evaluated as well. This method is time and cost effective, and it can reach a large number of mothers. The high rate of participants in this study was due to the collaboration between pediatricians and mental health professionals. This positive correlation reinforces the value of screening when it is done in the pediatric clinics

After discussing which is the most efficient location for screen of postpartum depression the next area is the method. Screening not have to be time consuming nor intrusive, simple question scan be used such as asking about the family life to detect women who are at high risk. Rivieres-Pigeon, Saurel-Cubizolles and Lelong (2004) have found three questions to be useful in screening for postpartum depression. The questions that need to be addressed are the presence or absence of anxiety, presence or absence of depression and the level of serenity. Out of these three questions the only factor related to postpartum depression was the presence of anxiety.

Freeman et al. (2005) found that screening should be done in a relaxed manner in order to prevent mothers from feeling overwhelmed. Some of the mothers may not even be aware that they are experiencing depression. On the other hand, if they are aware of their depression they may be extremely embarrassed or ashamed. Therefore the research finding stresses upon screening done in a discrete matter in order to detect as many mothers as possible with little discomfort on the mothers' part.

The last area related to the application of postpartum depression is its treatment. The major concern that patients have in general, when suffering of depression, is whether or not medication is necessary. The same concern is with the postpartum depressed patients, only with a few different reasons. Due to the fact that most mothers breastfeed,

it has been found that the ones who are postpartum depressed prefer treatment over antidepressant medications.

As far as treatment goes, in the case of women with mild symptoms, group therapy has been found to be more beneficial than individual therapy. Due to the fact that symptoms are mild, they can be ameliorated from the support group. For more severe symptoms of postpartum depression well-defined treatments are preferred. These treatments would be given by specially trained professionals. Other persons who would be able to provide intervention in treating postpartum depressed mothers are nurses and social workers (Kopelman & Stuart, 2005).

Boath, Bradley & Anthony, (2004) compared the treatment given in a parent and baby unity to the treatment given by general practitioners. One of the advantages of the parent and baby unit was the peer support that was available in group therapy. There is a great need for mothers with postpartum depression to talk to other mothers who are going through the same situation. The parent and baby unit treatment is a new approach and may serve as a model for treatment. In conclusion, even though mothers prefer psychological treatment over antidepressants, the present research is lacking in the area of nonpharmacologic treatment. Kopelman & Stuart, (2005) found that for future research therapy with medication need to be addressed more in order to observe whether or not there may be some benefits.

From a cost-effective standpoint the preferred treatment is the step-wise progression. Overall, the treatment of postpartum depressed women depends on the severity of depression. If the symptoms are mild, then even the nurses would be able to assist the mothers. If the symptoms are more severe then they should be given therapy

along with antidepression medication. Treatment is most effective when postpartum depressed mothers can be recognized as soon as possible. Therefore most of the research is targeted in accurate screening and prevention of postpartum depression, though it is not accurately distributed. From the research done in the area of screening, predicting, preventing and treating postpartum depressed mothers, it can be concluded that the results are divided and they do not build upon each other. Most of the researchers try to come up with a new method of research but few of them take previous research and try to expand it.

Mother-Infant Relationship

The first year postpartum. The first area to address under the mother-infant relationship is their first year postpartum. Postpartum depression taken as an overall influence on both mother and child after birth seems to affect them differently. It has an influence on the psychological health of the mother, but it does not seem to affect as much the overall development of the infant or the development of the family (Wang, Chen, Chin & Lee, 2005).

The second area to discuss is the effect it has on the parents, especially on the mother. Cooper and Murray's study (as cited in Murray, Cooper, & Hipwell, 2003) researched the mental state of parents caring for infants and they found that depression is at its high peek in the first three months postpartum. Ten percent still show evidence of postpartum depression even after one year of delivery. In their review on Lowe-Vandel's study (as cited in Murray et al., 2003) found that the strongest predictors of postpartum depression are a personal history of depression, lack of personal relationships, depression and anxiety during pregnancy. Other factors that seem to contribute to postpartum

depression are a low economical income and the returning of the mother to work not long after giving birth.

Along with the factors that lead to postpartum depression, certain effects occur as well. Cooper's study (as cited in Murray et al., 2003) found that one of the effects of postpartum depression on the mother's side is that she gives up breast feeding sooner than a non-depressed mother. Field's study (as cited in Murray et al., 2003) found that another effect of postpartum depression is misplaced focus. Due to postpartum depression mothers are more focus on their own feelings resulting in the lack of attention when their children's behavior changes. The babies appear to be withdrawn and disengaged due to the mothers' states. When mothers engage in play with their babies they might be rough without realizing it. The mothers persist in getting their babies' attention in an unhealthy way because they fail to recognize when their babies are in discomfort. Gaffan and Martins' study (as cited in Murray et al., 2003) found evidence that the emotional and cognitive development of the baby is affected by a postpartum depressed mother. Alper and Lyons-Ruth and Essex's study (as cited in Murray et al., 2003) found that children whose mothers suffered from postpartum depression during the first year post birth presented problems when they started school. One of these problems was the presence of anxiety. Murray et al. (2003) point out that a parent with a unresponsive behavior affects the infant's capacity to maintain attention. If a depressed mother acts intrusively it may affect the child's cognitive development even the memory functions. Margison's study (as cited in Murray et al., 2003) found that there is a concern about maternities and the number of caregivers that a new born baby has. Separation from the mother and the presence of other care givers affects negatively the new born.

In addition, it has been shown that postpartum depression has an effect on the relationship between mother and infant. Future studies need to expand on the effect that the maternal attachment style has on the mother-child interaction and how the effects of this interaction will be experienced by infant in later years. Research is believed to take the direction of longitudinal studies on the mental state of the mother and the child and how the quality of mother-infant relationship can be improved. There is still no clarification on how maternal depression directly affects the child and the implications it has on all the areas of the development of the infant.

Postpartum depression and its effects on the mother. One of the major effects of childbirth and taking care of a new born is the lack of sleep. It has been found that sleep deprivation during the first eight weeks is one of the causes that lead to postpartum depression. Getting six hours of sleep per night is not enough for a new mother especially during the first eight weeks postpartum (Dennis & Ross, 2005). In Murray's study (as cited in Hippwell, Reynolds, & Crick, 2004) it was found that if the baby is in an irritable state then it can add to the onset of postpartum depression. It would be interesting to put the lack of sleep finding together with the baby's irritable state and observe what the level of influence on each other is.

Hippwell et al. (2004) researched the issue of cognitive vulnerability to postpartum depression. In Cutrona and O'Hara's study (as cited in Hippwell et al., 2004) it was found that mostly hormonal factors are the cause of postpartum depression. In Teasdale's study (as cited in Hippwell et al., 2004) it was found that mothers who have a low self esteem and who tend to devaluate themselves are more prone to postpartum

depression. Motherhood has a series of new roles which are stressful and if a low confidence is added to that stress it can easily lead to postpartum depression.

Postpartum depression has an array of effects on mothers, out of which negative feelings is one of them. Among these feelings are disgrace, refutation, and discomfiture and they are one of the reasons that may prevent the mothers from seeking help. Because of the difference in the psychological framework of each person, some mothers appear to be more vulnerable to depression than others. Vulnerability would not be a problem if other risk factors would not be present. These factors are abuse, poverty, violent behavior from family members, and failing to meet the expectations of motherhood. All these factors have an effect on the psychic of the mothers, but depression does not affect only the psychic. Somatic symptoms may be another indication of postpartum depression and they can help increase the accuracy of detecting postpartum depressed mothers. In order to be able to accurately detect postpartum depressed mothers, the physicians and mental health therapists must be well trained and aware that mothers tend to neglect themselves postpartum. This neglection is due to the arrival of the new infant in the family and it is not done on purpose. For this reason, help is needed from the medical and mental health personnel in order to assist the depressed mother (Godfrey, 2005).

One of the main factors that have constantly been found to lead to postpartum depression is the lack of family support. This finding is best described in a case study done on a mother with infants. Her husband was substance abuser which overtook his role as a parent and as a husband. The mother had four children but she expressed how distressed she was being pregnant with her twins because she did not desire any more children after her first two. Her symptoms of severe postpartum depression occurred after

breastfeeding her twins, and they included confusion, delusional beliefs about her role as a mother and nihilistic thoughts about the future of her twins. Due to these manifestations she had a difficult time attending to the needs of her children (Benvenuti et al., 2001). This example replicated the findings of previous research on the effect that postpartum depression has on the mother. Overall, it can be concluded that the factors that lead to postpartum depression are in general the same factors that accompany the arrival of an infant. Therefore, more attention should be given to informing and preparing the mothers because it is more efficient to prevent than to cure.

Postpartum depression and its effects on the baby. The first effect was found in Brazelton's study (as cited in Herrera, Reissland, & Shepherd, 2004) and that is that the infant's capability to be responsive to the environment and its stimuli depends on the level of interaction with the mother.

The second effect of postpartum depression is on maternal touch, touch that is vital to the child. Herrera et al. (2004) found that infants with depressed mothers compared to infants with non-depressed mothers have been found to touch their skin more often. This action can be translated as a self-comforting behavior in order to compensate the lack of maternal touch. Stack, Muir and Pelaez-Nogueras' study (as cited in Herrera et al., 2004) found that maternal touch has a particular significance because it is a mean of communication for the infant as early as three months. A mother's touch has a positive affect and can reduce the negative effect that postpartum depression has on the child. The only downfall of this finding is that a mother who is postpartum depressed would not desire to touch he child often. The positive side of this finding is that postpartum depressed mothers can be informed of their touch and the effect it has on their

child. If they are trained, then they can act upon it and go against the natural tendency of withdrawal. Along with the withdrawal tendency that postpartum depression has on the mother is the tendency to interact different with the infant. Malphurs, Field and Cohn's study (as cited in Herrera et al., 2003) found that the mother might be intrusive and over-stimulating in her interaction with her infant. She might act extremely opposite though, being withdrawn and under stimulating with her infant.

The third effect that a postpartum depressed mother has on the baby is in the area of language development. In Cox and Child Care Research Network's study (as cited in Herrera et al., 2003) it was found that children with depressed mothers compared to children with non-depressed mothers have some type of problems in expressive language. This might be due to the lack of interaction with the mother, but future research is needed to prove this correlation.

The fourth effect of postpartum depression is on the child's behavior. Benvenuti et al. (2001) found that children of postpartum depressed mothers tend to imitate the mother's behaviors. When the children were placed in a room to interact with other people and play they were presenting the same withdrawing behavior as of their mother's. In Hay, Kumar and Murray's study (as cited in Benvenuti et al., 2001) it was found that boys are more susceptible to the effects of a postpartum depressed mother, meaning that they would tend to imitate their mother's behavior more than the girls would.

Future research is required in the area of mother-child relationship. Faisal-Cury et al. (2004) found that longitudinal studies are needed especially for the first year postpartum. Right now it is unclear whether dysfunctional behavior in the mother-child

relationship is due to the mother's depression. It is also unclear whether or not the dysfunctional behavior can be changed to treatment. More research is also needed in the area of father-infant relationship and how it affects the infant's development (Reck et al., 2004). Most of the research done reflects the need of replicating their study on a larger scale in order that their results may be relevant.

Related Construct

This category of research encompasses a few studies which correlated different factors to postpartum depression. These factors are anxiety, depressive symptoms in both parents, history of personal violence and lesbian mothers.

Researching anxiety and it prevalence at eight weeks postpartum was done for several reasons. The first reason was to asses the rate the occurrence of general anxiety in a sample of childbearing women who were not selected specifically for postpartum depression. The second reason was to establish the degree to which anxiety was related to postpartum depression. The third reason was to identify the most prevalent reasons that cause depression in postpartum women. Their results showed that most of the depressed women were experiencing anxiety as well. Most of the women who were presenting anxiety were not necessarily presenting depression symptoms. It was found that over thirty percent of women at eight weeks postpartum were presenting anxiety symptoms. Most of the depressed women reported anxiety symptoms out of which two thirds denied experiencing depression with the anxiety symptoms. It is suggested that postpartum general anxiety is much more prevalent in the general population that postpartum depression. With general anxiety and postpartum depression, half of the women declared

that the onset was postpartum. In women who presented symptoms before conception and through pregnancy it was most like a personal history of psychopathology.

In conclusion, this study found that high levels of anxiety are present in postpartum depressed women. The study needs to be replicated in larger sample sizes for future research (Wenzel, Haugen, Jackson & Robinson, 2003).

The second factor discussed in this section is depression in both parents and the impact it has on the child. From the research it was found that the father can minimize the consequences a depressed mother can have on the development of the infant. A father who is not depressed can counterbalance a depressed mother. From this connection it is important for the healthcare to be aware whether or not both of the partners are depressed in order to provide the right assistance. In such as a way as a mother suffers from the baby blues so can a father. The father's symptoms can be caused by a reaction to tension and lack of sleep due to the birth. It was also found that at certain times fathers can have a more difficult time relating to the child emotionally than mothers do. The fathers evaluated their children as being more unpredictable than the mothers. The major concern is that the father can be depressed if the mother is depressed therefore outside care would be needed. Even though the level of depression in fathers might not be so high, fathers still have a difficult time bonding with the infants. For future research it is suggested to have better follow up with both of the parents in order to provide efficient help to both of them (Edhborg, Matthiesen, Lundh & Widstrom, 2005).

The third factor linked to postpartum depression was a history of personal violence. There was no relation found between a history of physical or sexual violence and the onset of postpartum depression (Cohen et al., 2002).

The fourth factor linked to postpartum depression was lesbian couples. Ross (2005) found that lesbian mothers were more likely than heterosexual couples to seek help for psychological problems. In Cochran's study (as cited in Ross, 2005) it was shown that homosexual men and women have a higher rate of psychiatric disorders than heterosexual people. In Robertson, Grace, Wallington and Stewart's study (as cited in Ross, 2005) it was found that lesbian couples the lack of social support has been proven to be one of the risk factors that would lead to postpartum depression. The results of this study were not generalized due to the size of the sample. For future research this study should be built upon and developed since there are not many researches done in the area of lesbian couples and postpartum depression.

Summary

The overall research done on postpartum depression can be summarized with the following observations. The first one is that research post Andrea Yates has increased in size but has not improved in quality. The basic and strong research was done before 2001 and it is constantly used as a referral for present research. The new results from research replicate the research before 2001 but they do not greatly enrich previous research. The second observation is the lack of communication that exists among the researchers. Very few take previous studies and built upon them. Most of the research starts as an independent study and it comes to the same results that the rest of the studies come to, and that is that more research is needed. This lack of communication will not lead to an integrated approach of postpartum depression. It will also hinder mental health professionals from giving the full potential of their therapeutic help to the suffering mothers. The third and last observation is that research done after 2001 is not expanding

enough. Research is circular therefore the same shortcomings are pointed out but no improvement is found. In order for research, in the area of postpartum depression, to evolve it requires broadening its horizon.

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