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**Systematic Literature Review:
A Family Approach to Postnatal Depression**

Honors Thesis

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Abstract

Through a systematic review of literature, this research project explores a family approach to postnatal depression (PND). Within the first year of giving birth, seven to 15 percent of woman experience postnatal depression. Postnatal depression does not solely affect new mothers, but also fathers and babies. In conducting a systematic review of Cumulative Index of Nursing and Allied Health Literature (CINAHL), Boston Public Library Electronic Resources, and Education Resources Information Centre Database (ERIC), along with Google and Google Scholar, nine peer-reviewed studies were ultimately selected for inclusion in this review. The systematic literature review revealed the benefits of a family approach to postnatal depression. Three main themes emerged from the research: 1) social and relationship support; 2) paternal PND; and 3) PND stigma. According to the results found in this review, teaching about PND should be focused on the all-new families in addition to the new mother. These results demonstrate teaching interventions should occur during the prenatal and postnatal time to reduce PND instances in both women and men.

Keywords: Postnatal Depression (PND), family interventions, paternal PND, PND stigma

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Introduction

Effective mothering, particularly immediately following birth, are imperative for raising healthy and happy children who turn into healthy and productive adults in society. Postnatal Depression (PND) is a severe threat to effective mothering, and it has consequences that ripple through entire families. Maternal depression, particularly immediately following delivery, is a vexing public health problem with potentially severe consequences for both mothers and children. Minor or major depression is experienced by seven to 15 percent of women in the first three months postnatal (Hirst & Moutier, 2010). Postnatal mood disorders are defined as “disturbances in function, affect or thought processes that can affect the family after childbirth” (McKinney & Murray, 2013, p. 683), yet patient teaching focuses on the new mother (Camp, 2013). There is limited education targeting postnatal mood disorders (Murray & McKinney, 2013). Although some women are educated on the signs, symptoms, and affects of postnatal mood disorders through both pre- and postnatal visits, there is limited emphasis on the teaching for new fathers and other family members on these disorders (Murray & McKinney, 2013).

New fathers, partners of the mother, or family members living with the new mother and infant are often left out of the postnatal depression discussion (Camp, 2013). It is important to shift the teaching focus of postnatal mood disorders from mother-centric to family-centric (Letourneau, Dennis, Benzies, Duffett-Leger, Stewart, Tryphonopoulos, Este, & Watson, 2012). Family-centered teaching is crucial to promote positive health outcomes for new babies and their families. Early intervention is key for optimal

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outcomes regarding postnatal mood disorders. Although there are three main types of mood disorders (postpartum blues, postnatal depression, and postpartum psychosis) this thesis paper will focus on postnatal depression, which is also referred to as postpartum depression.

The purpose of this thesis project is to explore, through literature, the effects of postnatal mood disorders on partners and family members, and study the importance of taking a family-approach when providing interventions for PND. For this thesis project, a literature review was conducted on the impact of postnatal depression on families and the importance of family-centered teaching. Teaching fathers and other family members about the signs, symptoms, and impact that postnatal depression can have on every member of the family, including the newborn infant, may lead to earlier medical intervention. Providing more information about where to receive help may also increase the number of women diagnosed with postnatal depression, as she may feel more comfortable with her family's understanding and support.

Background of Study

Epidemiology of Postnatal Depression

Prevalence and Impact

Postnatal mood disorders are characterized by an abnormal period of emotional disturbance, following childbirth (American Psychological Association [APA], 2015).

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These disturbances can range from a mild, two-week period of depression, to a bout of psychosis threatening the life of both the new mother and her infant. According to the American Psychological Association, 70 percent of postnatal mothers experience some sort of mood disturbance (2015). It is common for women to experience the “baby blues,” which translates into feeling stressed, sad, anxious, lonely, tired or weepy following their infant’s birth. Some women experience more serious mood disorders. Unlike the “baby blues,” more severe postnatal mood disorders do not recede on their own. They are serious medical problems that require immediate interventions. Symptoms may appear days or even months after delivering an infant and can last for many weeks or months if left untreated. Postnatal depression can even be diagnosed as much as a year after a woman gives birth (Murray & McKinney, 2013). Postnatal depression does not discriminate: it is present in every socioeconomic class, race, and age; among women with easy pregnancies or problem pregnancies; first-time mothers and mothers with one or more children; women who are married and women who are not (APA, 2015; Camp, 2013).

These mood disorders can make it hard for a new mother to get through the day, and it can affect her ability to take care of her infant or herself, which places more responsibility on the new father (APA, 2015). Postnatal depression can be associated with poor communication between parents, less optimal interactions with their children and feelings of being overwhelmed, isolated, stigmatized and frustrated (Letourneau et al, 2012).

Experts postulate that postnatal mood disorders are under-diagnosed (Clay & Seehusen, 2004), with one study reporting a detection rate of less than 33% (Coates et al.,

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2004). One reason for this is the lack of screening for these disorders by obstetricians, pediatricians, and family physicians (Webster, Linnane, Dibley, Hinson, Strrenburg, & Roberts, 2000). Another reason for the under-diagnosis of postnatal mood disorders lies in parents' unwillingness to admit to experiencing such symptoms; this disorder is sometimes referred to as 'the smiling depression' because women choose to hide their symptoms to avoid the associated stigma (APA, 2015). Camp explains, "there is an extreme social stigma associated with mothers or families that are not overwhelmed with joy at the birth of a new child, and families may be embarrassed to admit these thoughts as they are regarded as unconventional," (2013, p. 45).

Types of Postnatal Mood Disorders

There are three types of postnatal mood disorders: postpartum blues; postpartum or postnatal depression; and postpartum psychosis. Postpartum blues, also known as "baby blues" affects 70%-80% of new mothers (Murray & McKinney, 2013). Symptoms can begin first week postpartum and last up to two weeks. The exact cause is unknown, but may be due to a mother's emotional letdown afterbirth, postpartum discomforts, fatigue, anxiety about caring for the infant, and body image concerns; but is not related nor caused by hormonal fluctuations, contrary to common belief (Murray & McKinney, 2013).

PND lasts at least two weeks, affects 10 - 15% of postpartum women and usually develops in the first three months but can occur at any time during the first year postpartum (Murray & McKinney, 2013). To classify as PND, symptoms must last for at

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least two weeks and include the following: a loss of pleasure or interest in once enjoyable things, eating more or less than usual, anxiety/panic attacks, racing thoughts, feeling guilty or worthless, blaming oneself, excessive irritability, anger or agitation, sadness and crying uncontrollably for long periods of time, fear of not being a good mother, fear of being left alone with the infant, inability to sleep or sleeping too much, disinterest in infant, family and friends, difficulty concentrating or making decisions, and thoughts of hurting oneself (Camp, 2013).

Psychosis is defined as a “mental state in which a person's ability to recognize reality, communicate, and relate to others is impaired,” (Murray & McKinney, 2013 p. 685). Postpartum psychosis affects 1 or 2 women per 1000 births and can occur as soon as two days after delivery. Experts consider postpartum psychosis as a psychiatric emergency requiring hospitalization. Signs and symptoms of postpartum psychosis include: agitation, irritability, rapidly shifting moods, disorientation, disorganized behavior, delusions about infant, and hallucinations.

Etiology of Postnatal or Postpartum Depression

Although postnatal depression has an unknown causes, there are many risk factors associated with the disease. These include but are not limited to include: depressive symptoms during pregnancy, previous PND, first pregnancy, personal or family history of depression, mental illness or alcoholism and personality characteristics such as immaturity and low self-esteem (Murray & McKinney, 2013). PND is frequently more problematic by concurrent feelings of anxiety experienced by the mother (Camp, 2013).

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The Centers for Disease Control and Prevention (CDC) (2013) explains that having a difficult birth with either long recovery time for the mother, or having additional worry associated with preterm delivery, may influence a mother to fall into postnatal depression. Teen pregnancy, giving birth to an infant with birth defects or injuries that require immediate hospitalization can also affect a mother's postnatal recovery and cause her to develop postnatal depression (CDC, 2013). Though there are numerous risk factors, it is important to highlight that even a mother with a normal pregnancy and easy childbirth can experience PND (CDC, 2013).

Diagnosing Postnatal Depression

According to the American College of Obstetricians and Gynecologists (2010), screening for antepartum or postnatal depression should be strongly considered by physicians, although evidence is lacking to support a recommendation for universal screening. The most commonly used screening tools are the Edinburgh Postnatal Depression Scale and the Postpartum Depression Screening Scale (Camp, 2013). The Edinburgh Scale has 10 questions, including: I have been able to laugh and see the funny side of things; I have looked forward with enjoyment to things; I have blamed myself unnecessarily when things went wrong; I have been anxious or worried for no good reason; I have felt scared or panicky for no very good reason; things have been getting on top of me; I have been so unhappy that I have had difficulty sleeping; I have felt sad or miserable; I have been so unhappy that I have been crying; and the thought of harming myself has occurred to me. Answers range from much as "I

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always could or did,” to “No, not at all.” The scale scores each question on a scale from zero to three, 30 being the maximum score. In women without a history of postnatal depression, a score above 12 has a sensitivity of 86 percent and specificity of 78 percent for postnatal depression. The Postpartum Depression Screening Scale asks questions about whether the mother has recently been overly anxious, worried or panicky for no apparent reason (Murray & McKinney, 2013). A woman’s OB/GYN usually administers both tests during a follow-up visit, at 6 to 8 weeks postpartum. Neither test diagnoses a woman with postnatal depression, but suggest that further clinical evaluation is needed in order to establish a definitive diagnosis (Lehne, 2010).

Nonverbal cues may prompt the need for further evaluation. These cues may include: the mother looking un-kept, flat affect, does not hold her infant, inability to follow simple commands or focus, and appearance indicates she has been crying, or she lacks sleep (Camp, 2013). In order to diagnosis a woman with postnatal depression, symptoms must includes at least 4 of the following: changes in appetite/weight, sleep or psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; and recurrent thoughts of death of plans or attempts of suicide (Murray & McKinney, 2013).

It is difficult to diagnose postnatal depression because many women are in denial or refuse to seek treatment. The OB/GYN does not see women often enough for early identification of symptoms (Murray & McKinney, 2013). Pediatricians assume more responsibility for identifying postnatal depression in mothers as part of assessment during child visits as they see the mother more frequently (Murray & McKinney, 2013). Early

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identification of postnatal depression and appropriate treatment is significant to the prognosis of the woman with postnatal depression (Murray & McKinney, 2013).

Treatment of Postnatal Depression

Two treatments are available for women diagnosed with postnatal depression: cognitive behavioral therapy and pharmaceuticals (Camp, 2013). Mothers sometime use other holistic treatments such as herbal supplements, massage, exercise and acupuncture, but they are not common (Camp, 2013). American Psychological Association (2015) recommends that psychotherapy be the first line of treatment for these women, though pharmacotherapy options are also available and are particularly effective when used in combination with behavioral therapy.

Cognitive behavior therapy uses a trained therapist to work with the mother on her thoughts, beliefs, and behaviors that may cause the depression after the childbirth (Camp, 2013). This therapy aims to help the mother better verbalize her feelings, both positive and negative. An individualized plan is set forth for the mother to focus on making changes in her new life of motherhood including adjustments made with childcare. Therapy should include fathers or partners to increase support, which is said to have the greatest positive impact of all therapies (Camp, 2013).

Similar to other forms of depression, postnatal depression is best treated by the combined use of anti-depressant medication, social support and psychotherapy (Murray & McKinney, 2013). The treatment goal of these medications is to “normalize mood and optimize maternal and social functioning,” (Lehne, 2010 p. 388). Selective serotonin

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reuptake inhibitors (SSRIs) such as Zoloft (sertraline) or Prozac (fluoxetine) or tricyclic antidepressants are most commonly prescribed in treatment (Lehne, 2010). Common side effects of pharmaceutical therapies may deter their use. It is important to advise breastfeeding mothers that all antidepressants are present in their breast milk and can produce side effects in the infant such as colic and impaired weight gain (Lehne, 2010). Taking SSRIs can lead to side effects such as headaches, nausea, weight gain, and sexual side effects, such as sexual dysfunction and lack of sex drive (Lehne, 2010). Tricyclic antidepressants may cause side effects such as dry mouth, constipation, urinary retention and similar sexual side effects like SSRIs (Lehne, 2010). New mothers may also fear that pharmaceuticals will harm their infant. The side effects of the medications may also make mothers hesitant to take these medications or deter them away from taking them all together. As previously stated, psychotherapy and social support should be viewed as the initial treatment for postnatal depression. If those treatment types fail, then pharmaceuticals should be prescribed.

Effects of Postnatal Depression on Mother

As society and history demonstrate, the mother is usually seen as the primary caregiver of their children. “The maternal role is vitally important to ensure the infant’s safety, survival and well-being,” (Logsdon, Wisner, & Pinto-Foltz, 2006 p. 652). No matter race, age, culture or income, the mother is always the carrier of the infant, as biology only allows women to do so. “A warm, engaged, responsive mother who understands and encourages a child’s development creates an environment that is

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conducive to producing healthy, productive children and citizens,” (Logsdon, Wisner, & Pinto-Foltz, 2006 p. 654).

So what happens when the mother is experiencing symptoms of a loss of pleasure or interest in once enjoyable things; anxiety/panic attacks; racing thoughts; fear of not being a good mother; fear of being left alone with the infant; disinterest in the infant, family and friends; difficulty concentrating or making decisions; and thoughts of hurting herself or the infant?

A woman’s skill as a mother becomes impaired as she suffers through the symptoms of postnatal depression. “Effective mothering is a public health concern, and health care providers must understand conditions such as PND that adversely affect a women’s ability to care for her infant,” (Logsdon, Wisner, & Pinto-Foltz, 2006 p. 652). Depressed mothers have two predominant interaction styles: withdrawn or intrusive (Field, 1998). These two interaction styles negatively affect a mother’s ability to interact with her infant. Through daily interactions with their mothers, infants learn about their external environment. The mother responds to the child’s cues as she focuses on the child’s activity. A mother with postnatal depression fails to complete these tasks as the weight of her emotional burden can become too heavy.

Ideally, a mother will develop sensitivity to her infant and will smile, talk, touch, and kiss her infant. She will come to understand the infant’s sleep/wake cycle, attention span, responses to stimuli, and reflexes, which will increase her maternal confidences (Logsdon, Wisner, & Pinto-Foltz, 2006). A woman with postnatal depression has a hard time interacting with her infant and may have fears of being left alone with her infant. Her maternal confidence is limited and does not develop, as it should. Findings from a

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research study demonstrate that mothers who report more symptoms of depression had less maternal gratification (Killien, 1998). Their PND symptoms interfere with their ability to interact and connect properly with their infant.

If a mother chooses to breastfeed, there are additional set of limitations she may experience because of her postnatal depression. The mother must first decide if she wishes to continue to breastfeed. Many women, especially women with PND see breastfeeding as another obstacle to their mental well-being. They feel overwhelmed with the infant's feeding schedule, as breastfeeding does not allow mothers to take breaks during mealtimes, allowing another person feed the infant as bottle feeding does. Troubles with breastfeeding can act as a trigger, causing more PND symptoms (Roberts, 2005).

However, breastfeeding may serves as the only positive thing that a postnatal depressed mother feels that she does correctly, as it could be the only time she feels connected and bonded with her infant (Roberts, 2005). While the mother makes the decision to breastfeed, it is important to consider whether this mother would want to take medications to treat her PND. In recent years, new research studies found that mothers can safely take anti-depressants with minimal or no effect on the breastfeeding infant (Robert, 2005) as recent medical indications claim that little, if any, of the medications taken for PND, such as Zoloft (sertraline), Paxil (paroxetine), and Celexa (citalopram), pass through the breast milk to the feeding infant. The only medication that could be prescribed that has that potential for passing through breast milk would be Prozac (fluoxetine) (Roberts, 2005). Varying pharmacotherapy treatment options

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are available, each with unique benefits and consequences that should be made clear when teaching a patient about PND and treatment.

Effects of Postnatal Depression on Father

Prior to the 1950s, fathers were not allowed into the labor and delivery rooms, as it was a female or health professional only domain (Davey, Dziurawiec, & O'Brien-Malone, 2006). The thought that PND had any correlation to fathers is a relatively new idea, as there is a recent increase in expectations of paternal involvement in all-prenatal and postnatal care. Paternity leave, in conjunction with maternity leave from employers is becoming an increasingly popular benefit (Westen, 1995). The transition into fatherhood is a period of adaptation due to the changes in lifestyle and roles. With an added stressor of PND, the father may face some difficult challenges rarely, if ever spoken about by health care professionals.

The stress from a mother's PND symptoms puts more emphasis on the father caring for the infant. Maternal PND affects fathers in negative ways, as evidenced by higher levels of depression and parent stress (Goodman, 2008). Fathers are typically less likely to have knowledge about the infants' development and age-appropriate nurturing and sensitive parenting, and are less likely to perform literacy enrichment activities, as well as more likely to engage in risky parenting practices (Letourneau et al, 2012). Some men with partners diagnosed with PND have reported increasing stress and fatigue associated with the demands from their new roles (Letourneau et al, 2012). Some have feelings of anger and resentment towards their partner as they attempt to cope with the demands of

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their mental illness, along with an infant and possibly other children, along with employment commitments (Letourneau et al, 2012). These feelings negatively affect father-infant interaction, as maternal mood influences the interaction (Goodman, 2008.) The father may have a hard time bonding with the new child and be unable to interact in a positive way with the infant.

PND can adversely affect marital quality. In fact, marital dissatisfaction is a strong risk factor for maternal and paternal depression (Letourneau et al, 2012). These marital difficulties can be associated with poor communication, less optimal interactions with their children, feelings of being overwhelmed, isolated, stigmatized and frustrated. These men have reported fear, confusion, and concern for their partner as they have noted significant changes in their partner's behavior. Their inability to help their partner's recovery from PND has led to feelings of frustration and helplessness (Letourneau et. al, 2012). Matters such as paternal aggression, intimate partner violence, substance abuse and economic stress may increase the likelihood of paternal depression, associated with maternal PND (Letourneau et. al, 2012).

Effects of Postnatal Depression on Infant

The newborn infant is affected negatively if their mother, father or both experience postnatal depression. Within the first year after birth, the child will grow and develop more rapidly than any other time in their lives. It is essential for the infant's caretakers to actively engage during this development period as it directly affects their futures. After birth, infants of mothers with PND are more likely than those of non-depressed mothers

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to experience abuse or neglect, diagnosed with failure to thrive, hospitalized with health issues like asthma, and have sleep-related problems (Letourneau et al., 2012). The affects of PND can be seen in most areas of a child's development. PND negatively affects infant performance of measures of cognitive development, learning tasks, and object permanence. Researchers have observed impairments in attachment of infants and children affected by PND in 12-month to 18-month old infants (Letourneau et al, 2012).

Later in life, these children grow to have lower vocabulary scores and lower cognition scores (Letourneau et al, 2012). PND negatively influences children's social-emotional development, as evident by the rates of psychiatric disorders among children of depressed parents, which are two to five times above average (Letourneau et al, 2012). They child can have adjustment problems too, internalizing problems such as anxiety and depression (Letourneau et al, 2012).

Children with a mother diagnosed with PND are prone to more antisocial, active, aggressive, hyperactive and distractible behaviors in preschool and kindergarten (Letourneau et al, 2012). These children also have hyperactivity problems and less creative play, regardless of whether the mother recovered (Letourneau et al, 2012). There is a noticeable difference in children who have been affected by PND, as there is reduced affective sharing, sociability to strangers and responsiveness in interactions (Letourneau et al, 2012). PND affects the behavioral development as exhibited by negative expressions, protests, and disruptive behaviors during play interactions at 4-6 years old (Letourneau et al, 2012).

Methodology

Study Selection and Inclusion Criteria

This thesis project utilizes a dual-step process in its study selection to choose appropriate sources of texts for review and use for the project. The first step included screening titles and reading of abstracts of the electronic texts retrieved for inclusion. Studies were chosen for inclusion if they met any part of the criteria that follows: (1) interventions that addressed the issue of postnatal depression, (2) affects of postnatal depression on mother, father, and/or infant of a family unit, (3) research on affects of social support on the outcomes of postnatal depression diagnosis, and (4) discussion of the societal stigma associated with postnatal depression. Although this project focused on understanding the family approach of postnatal depression, the search for text was not limited to family support of postnatal depression, as to gain a better understanding of other factors associated with diagnosing, managing, and recovering from postnatal depression.

The second step of the selection and inclusion process involved reading the full text of the articles found to determine whether they were relevant and appropriate for review for this project. Literature that did not meet the criteria in the first step, as well as those that did not seem appropriate or relevant during the second step of the selection and inclusion process was excluded from this review. Some of the texts may have been used exclusively as sources of background information for the previous *Epidemiology of*

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Postnatal Depression section, while others were used as both sources of background information and sources for the systematic review.

Literature Search

Several electronic searches were conducted to locate appropriate and relevant text for this project. These searches took place on the 4th of January 2015, the 3rd and 29th of March 2015, and the 8th of April 2015. The following keywords were used: postnatal depression, postnatal depression with the additional keywords of treatment, intervention, teaching, support, father, and stigma. Experts in the field at the Salem State University library were consulted and relevant and appropriate texts were found. The search included the follow three databases: Cumulative Index of Nursing and Allied Health Literature (CINAHL), Boston Public Library Electronic Resources, and Education Resources Information Centre Database (ERIC). A search of full text articles that were published within the last 15 years was made. Google and Google Scholar were also utilized searching the same keywords to expand the search for texts and appropriate and relevant websites to be included in the review for the project. The limitations faced were that all texts had to be in English, they had to be available with full text by PDF, and had to be published within the last 15 years.

The result of the search yielded a total of 5,932 texts variously collected from multiple different databases. Ultimately, only nine articles met the selection and inclusion criteria and were selected to be used for review in this thesis project. Articles with the following topics were eliminated: tools used for predicating postnatal depression in

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women, mortality rates of mothers and babies in association with postnatal depression, occurrence of partner abuse associated with postnatal depression, managing partner abuse associated with postnatal depression, and birth control usage associated with postnatal depression outcomes.

Results and Findings

A summary of the findings can be seen in Table 1.

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Table 1. Overview of Research Findings

Author	Study Population	Time Period	Independent Variable	Intervention	Diagnostic Tool	Dependent Variable
Webster et. al (2000).	574 women with mean age of 27.2 years	One time within 20 weeks post gestation	Social support	None	Maternity Social Support Scale, Edinburgh Postnatal Depression Scale, & Postnatal Questionnaire	Health during/after pregnancy, postnatal care and PND in mothers
Logsdon & colleagues (2010).	43 hospital-based perinatal nurses	One time mailed survey	Self-efficacy of perinatal nurses	Increase patient teaching about PPD	Rosenberg Self-Esteem Scale, Attitudes Toward Seeking Professional Psychological Help Scale, & Stigma Scale for Receiving Psychological Help	PND teaching for mothers
Dennis, & Ross, (2006).	396 women over the age of 18 years old with a mean age of 29	Multiple follow-ups at 1, 4, & 8 weeks postpartum	Maternal views of conflict & relationship with specific support from her partner	None	Social Provisions Checklist, Postpartum Partner Support Scale, Quality of Relationships Inventory & Edinburgh Postnatal Depression Scale	Development of PND in mothers
Serhan & colleagues (2012).	110 women & men couples	One time interview	Relationship between parents	None	Mother Introduction Form, Father Introduction Form, & Edinburgh Postnatal Depression Scale	Development of PND in mothers & fathers
Boath, & colleagues (2013).	15 women ages 16-19 years old	One time interview	Social support	None	Edinburgh Postnatal Depression Scale	Development of PND in mother
Davey, & colleagues (2006).	13 men who's partners had been diagnosed with PND, a mean age of 29.8 years old	One round of interview	Males voices of PND	Men's' support group	None	Thoughts of males regarding support and stigma of PND
Goodman, (2008).	128 mother-father-infant triads	Multiple meetings at 2 & 3 months postpartum	Development of PND in mother	None	Edinburgh Postnatal Depression Scale, Nursing Child Assessment Teaching Scale, Dyadic Adjustment Scale & Parenting Stress Index-Short Form	Development of PND in father, and father-infant interaction
Dudley & colleagues (2001).	193 women & men couples, 6 months postpartum	Individual interviews.	Development of PND in mother	None	Edinburgh Postnatal Depression Scale, Beck Depression Inventory, & General Health Questionnaire	Development of PND in father
Dennis, T., & Lewis, B., (2006)	5 women ages 22-50 years old	Individual interviews.	Women who experienced PND	None	None	Thoughts of women experiencing PND

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Serhan and colleagues (2012) examined the relationship between the new mother and father to understand the development of postnatal depression in both mothers and fathers. They studied 110 women and men couples during a one-time appointment. These couples were given the Mother Introduction Form, Father Introduction Form, & Edinburgh Postnatal Depression Scale to fill out and return. Overall, their results found mothers to be significantly more depressed than fathers. Mothers who said that their relationships with their husbands were moderate or bad, felt partly sufficient or difficulty in their infant care, felt anxious about motherhood and reported that they had not received support from anyone for infant care were more depressed than mothers who had better support from their partners and had more positive relationships with the infant's father.

Goodman (2008) studied 128 mother-father-infant triads within the first 2 and 3 months postnatal. Using the Edinburgh Postnatal Depression Scale, Nursing Child Assessment Teaching Scale, Dyadic Adjustment Scale & Parenting Stress Index-Short Form, the development of postnatal depression in the father and the father-infant interaction were studied. Goodman found that men with depressed partners had significantly higher depression scores than men whose partners were not depressed. Partners of women who were depressed had higher parenting stress and less optimal father-infant interaction.

Dudley and colleagues (2001) interviewed 193 women and men couples that were 6 months postpartum. Using the Edinburgh Postnatal Depression Scale, Beck Depression Inventory, & General Health Questionnaire, the diagnosis of PND in mothers was examined to understand how that affected the development of PND of

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in fathers. Through their studies, it was found that there was a relationship between maternal and paternal postnatal depression, as they were positively correlated. Sexually abused mothers were found to have a greater amount of depression than non-sexually abused mothers.

Dennis and Ross (2006) surveyed 396 women over the age of 18 years old with a mean age of 29 over multiple follow-ups at 1, 4, & 8 weeks postnatal. They use maternal views of conflict and relationship with postnatal-specific support from her partner to determine whether or not these women would develop postnatal depression. The Social Provisions Checklist, Postpartum Partner Support Scale, Quality of Relationships Inventory & Edinburgh Postnatal Depression Scale were used in this study. The results showed that women with depressive symptoms at 8-weeks postnatal had lower perceptions of relationship-specific support and of postnatal-specific support and a higher level of conflict than those who were not depressed.

Boath, Henshaw, and Bradley (2013) interviewed teenaged mothers to understand how social support influenced the development of postnatal depression. The focused on 15 women ages 16-19 years. This was the only text that focused on teenaged mothers. The researchers used the Edinburgh Postnatal Depression Scale to find that women with less social support encountered more negative consequences of teenage motherhood such as stigma, perceptions of being judged, and lack of knowledge about PND.

Webster (2000) focused on 574 women with mean age of 27.2 years, with approximately 48% of those women being married. Using the Maternity Social

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Support Scale, Edinburgh Postnatal Depression Scale, & Postnatal Questionnaire, social support was studied to understand its influence of maternal health during and after pregnancy, along with postnatal care and PND development in mothers.

Through completing one round of interviews within 20 weeks postnatal, it was found that women with less social support throughout pregnancy reported poorer health during pregnancy and postnatally, to schedule postnatal care appointments late and be more depressed postnatally than women with more social support.

As examined in a study by Dennis and Moloney (2009), five women, ages 22-50, were interviewed one-time, about their experience with postnatal depression. They all agreed that they felt it would never happen to them. One participant stated that she felt fully prepared by childbirth classes and her friends' stories of childbirth and breastfeeding, but she had no expectation of the feelings of depression that came. Another participant stated that "it was like I couldn't find myself; I had lost myself," (Dennis and Moloney, 2009 p. ***). In all cases examined, the women felt that had inadequate support in dealing with this postnatal depression.

Davey, Dziurawiec, and O'Brien-Malonec (2006) explored the thoughts of males regarding support and stigma of postnatal depression. A one-time male support group was held, where thirteen men with partners diagnosed with PND, and with a mean age of 29.8 years old, discussed their points of views. The men interviewed revealed a desire to keep up an appearance that "everything is fine," as they claimed there is a lack of support for men in their position, and that when there was an outlet, they were embarrassed to admit their participation to family and friends.

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Logsdon and colleagues (2010) investigated 43 hospital-based perinatal nurses' self-efficacy. The researchers' goal was to understand how that affected the PND teaching for new mothers they performed. After increasing the amount of PND teaching and using the Rosenberg Self-Esteem Scale, Attitudes Toward Seeking Professional Psychological Help Scale, and Stigma Scale for Receiving Psychological Help, a one time survey was distributed. They discovered that nurses taught new mothers about PND more because it was an expectation from their supervisors, rather than their mastery of the subject and vicarious experiences. Few nurses had personal experiences with PND or had chosen to pursue continuing education related to PND. A majority of the nurses surveyed admitted to rarely or never teaching new mothers about PND, as it was found that 58 percent confirmed this. The researchers recommended nurse leaders directly communicate to nursing staff that new mothers need to be taught about PND, and that PND continuing education programs should become mandatory for perinatal nurses.

Findings and Best Recommended Practices

After performing this literature review, three main themes were found: 1) relationship and social support; 2) paternal PND; and 3) PND stigma. The finding of relationship and social support are the only intervention discussed in all of the academic articles. Paternal PND and PND stigma were two issues that were commonly found in the academic articles selected.

Relationship and Social Support

Most articles suggested that an increase of relationship and social support related in fewer instances of postnatal depression in women. Amongst all, more depressive symptoms were found in women who felt that they lacked support from others (Boath, Henshaw, & Bradley, 2013; Dennis, & Ross, 2006; Webster, 2000). In these cases, the Edinburgh Postnatal Depression Scale was used solely or in conjunction with other diagnostic tools. Higher scores on the Edinburgh Postnatal Depression Scale were found in women who felt that they had lower perceptions of relationship-specific support and postnatal-specific support.

These women also reported a higher level of conflict (Dennis & Ross, 2006). A woman diagnosed with PND was less likely to perceive that their partners were available for companionship and to provide a feeling of connection and inclusion. When a prenatal intervention was introduced and partners were asked to discuss potential difficulties they could encounter postnatally, women had lower depression scores and reported that their partner was more involved and aware of their feelings. These mothers had a greater satisfaction with their partner sharing in household and infant care activities.

In Webster (2009), physical health of the mother was focused on as it related to the woman's mental health. Women with less social support throughout pregnancy reported poorer health during pregnancy and postnatally. They also scheduled appointments later for postnatal care than women with more social support did, so the health of their newborn would suffer as well. They found by

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administering the Maternity Social Support Scale early in the pregnancy would allow for more time to be referred to social workers and other social agencies to ensure new mothers to have better support.

Sexual abuse in women made for higher rates of PND (Dudley, Roy, Kelk, & Bernard, 2001). The sexual abuse had a lasting impression on these women as they were found to have maternal difficulties with coping with motherhood and events associated with it. The same was associated with past adverse pregnancy and labor and delivery experiences. Post-traumatic stress from such events increases the likelihood of having PND (Murray & McKinney, 2013).

Paternal Postnatal Depression

Traditionally, it is thought that PND only occurs in the mothers after they give birth. After further investigation through this literature review, it was apparent that new fathers could have depressive symptoms during the postnatal period as well. Most included articles demonstrated that the when instances of maternal PND increased, the instances of paternal PND also increased (Dudley, Roy, Kelk, & Bernard, 2001; Goodman, 2008; Serhan, Ege, Ayranci, & Kosgeroglu, 2012). Although the rate of PND is higher in women, it still was existent in men. It was found that men whose partners were depressed had significantly higher depression scores than men whose partners were not depressed (Dudley, Roy, Kelk, & Bernard, 2001; Goodman, 2008).

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Partners of depressed women had higher parenting stress and less optimal father-infant interaction (Goodman, 2008). This negatively impacts the health and development of the newborn infant. The findings by Goodman (2008) were that fathers do not improve their interactions with the infant in a way that might buffer and protect the infant when the mother is depressed. They act in an opposite manner and have poorer interactions with their children too.

In addition to influencing father-infant interaction, maternal depression was increased paternal parenting stress as observed in this study. Goodman (2008) urges for a family focused approach to assessment and treatment of PND as timely interventions may help prevent or decrease paternal depression and paternal parenting stress while the mother is depressed. Early intervention is the key to lowering the number of diagnosed PND cases (Goodman, 2008).

Postnatal Depression Stigma

There is a serious stigma that is associated with PND. It can be the reason that women or men are in disbelief of their symptoms, are too afraid to tell their family, and seek treatment, and why health professionals lack the knowledge associated with PND. These supported findings can be found in Boath, Henshaw, & Bradley (2013); Davey, Dziurawiec, & O'Brien- Malone (2006); Denis & Moloney (2006); and Logsdon, Foltz Pinto, Scheetz, Myers (2010).

Denis & Moloney (2006) and Davey, Dziurawiec, & O'Brien- Malone (2006) both held support groups and conducted interviews with their focus gender. Denis

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& Moloney (2006) held a discussion between 5 women who all discussed their experience of dealing with PND. The main themes came up as they felt: (1) they had no idea it would happen to them, (2) they were losing themselves, (3) it was a bad place to be, and (4) the only way out was to work their way through their symptoms. The 13 men, who were studied in Davey, Dziurawiec, & O'Brien-Malone's research (2006) concurred on themes of feeling: (1) they had to keep the appearance that everything is fine, (2) they felt they have no support for themselves, and (3) when they found an outlet they were embarrassed to admit their participation to family and friends. Both studies underscore similarities between mothers and fathers with regard to the paucity of PND teaching provided for these groups, a feeling that there was no source of true help, and shame when in admitting that they had a problem to their family and friends even after finding help.

In Boath, Henshaw, & Bradley (2013), the teenaged mothers studied admitted to lacking PND information because they felt too ashamed to reach out for help and to become educated. They carried a perception of being judged for not only being teenage mothers, but for also having PND along with it. They feared their infant being taken away and would hide their child and not go out in public for the first few months after the birth. These results demonstrated that these women had trouble utilizing support and finding help because they were unaware of what was there to help them.

The stigma towards mental health illnesses was examined in Logsdon, Foltz-Pinto, Scheetz, Myers (2010), as they examined how perinatal nurses viewed PND. They found that there is not enough education for perinatal nurses on PND. They are

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not learning enough about the signs, symptoms, and the affects PND can have on families. They are not being educated enough on what interventions to use to teach their patients and their families about PND. The stigma associated with PND causes nurses to teach their patients less about PND unless their supervisors specifically tell them to conduct the teaching.

Discussions and Limitations

This study of the literature revealed that postnatal depression does not just affect the new mother, but all members of the family. Though relatively small in scale, the existing literature base suggests a family based approach to PND would benefit all members of the family, and preventive education may even decrease the instances of new cases of PND. Perinatal nurses must be better educated on the subject of PND and be better equipped with knowledge to successfully teach about the topic. Future research is needed to better understand how to translate clinical guidelines into effective perinatal education about PND.

The limitations of this study include the small number of studies evaluated and the largely qualitative nature of those studies. To date, no population-level surveys in the United States or elsewhere have documented diagnoses of PND in either mothers or fathers, and no quantitative research could be found within the parameters of this review.

An additional limitation of this review is a lack of sources written by nurses, limiting the perspective of PND to exclusively that of mothers and fathers, and the researchers who evaluated them.

Conclusion

In this thesis project, the relationship and social support a woman receives was found to directly correlate with her likelihood of being diagnosed with PND. A mother diagnosed with PND directly correlated with the father having depressive signs and symptoms as well. The stigma associated with PND resulted in not only a lack of reported cases of PND, but a lack of admitting there is any problem at all among couples who are suffering. The systematic literature showed that the evidence found was beneficial to identify the benefits of taking a family approach to intervene with PND, but requires more observational research to provide concrete evidence on the benefits of a family approach to PND. This study is still beneficial, as the data found can be considered helpful as connections were made between PND, family support, and social stigma.

To conclude, the importance of taking a family approach to PND has been highlighted. The significance of increasing perinatal nurse teaching in order to eliminate stigma associated with PND has been comprehended. Increasing family based teaching practices has been justified. Lastly, encouragement for more research studies to be conducted in this topic, as to create more concrete data that supports a family approach to PND, should have been provoked.

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