



## CAUSES AND CONSEQUENCES OF POSTPARTUM DEPRESSION AMONG WOMEN

Mary Gloria C. Njoku

Godfrey Okoye University Enugu

### Abstract

*The causes and consequences of postpartum depression were explored in this paper. Researchers have found that childbirth is joyful for some women but emotionally disturbing and stressful for others. Genetic, environmental, and biological variables have been implicated as factors that influence the experience of postpartum depression among women. However, due to a lack of consensus about the relationship between these factors and postpartum depression, the nature and causes of postpartum depression is still unclear. The lack of consensus is due in part to variations in the types of postpartum mood disorder described in studies. There is a need for systematic studies that explore causes and consequences among high-risk population and women of diverse ethnic backgrounds. Current problems in understanding diverse and contradictory findings will ultimately be resolved with long-term follow-up studies examining the genetic, environmental, biological and psychosocial factors among control groups without postpartum depression and those with postpartum depression.*

**Keywords:** Postpartum depression, causes, consequences, women

Generally, child bearing mothers are sources of joy in families and cultures. For example, women in my tribe, Igbo are respected and honored after childbirth. Inability to bear children is looked upon as a curse and the barren woman (by choice or not) is seen as a source of contempt and insult to her parents. Most families strive to take proper care of their pregnant women. Among the Igbos, this care is given only to married women. Unmarried women are often disinherited and their mothers are held accountable for the daughter's out of wedlock pregnancy. A few weeks prior to childbirth and three months after, the mother stays with her daughter for a period of catering known as *ile omogwu*. The mother makes sure that her daughter feeds very well and that the newborn is properly taken care of (special meals are usually prepared for the woman by her mother). I had wondered why my maternal grandmother always completes this duty with great care each time my mother gave birth to a baby. As I gained insight into the enormous task associated with child bearing, I began to understand why this custom need to be upheld. Not only is the process of childbearing painful for women, some women have died in the process, while others have experienced mild to severe emotional disturbances.

While the birth of a child is a joyful event to most women and families, for some women, the period following childbirth (postpartum period) is a time of sorrow; a time when some women are beset by emotional distress of varying degree that often leave them disconsolate and unhappy. The November/December 2002 issue of *Psychology Today* featured an article by Levy, Sanders, and Sabraw on postpartum emotional disturbances titled "Moms who kill: When depression turns deadly." This article was released right after Andrea Yates was sentenced to life imprisonment for killing her five children by drowning them in a bathtub. Incidences such as this have prompted media attention to postpartum disturbances. Women, families and many concerned citizens sought answers to questions about the nature of postpartum mood disorders and its causes. The answers are still unclear as medical consensus has not been reached on causes. The reality, however, is that many women suffer alone because of lack of awareness of the nature of this disorder.

### Postpartum Depression

Depression is one of the major emotional distresses experienced by childbearing women.





Often, postpartum depression is used to refer to the varied forms of emotional distress experienced by women after childbirth which include postpartum blues, postpartum depression and postpartum psychosis. Postpartum psychosis, usually involving hallucinations or delusions the most severe disturbance experienced by women within 6 to 12 weeks after child delivery (O' Hara, 1994). Postpartum blues, which presents with symptoms such as crying, confusion, and anxiety, is the mildest form of distress experienced by women mainly during the first week after child birth. Postpartum depression is often marked by appetite and sleep disturbance, severe fatigue, suicidal ideations, and concentration and thought difficulties. Its onset ranges from pregnancy period to after childbirth (O' Hara, 1995).

To be diagnosed with postpartum depression, a woman must meet the criteria for major depression during the weeks following delivery. Symptoms of a major depressive episode include depressed mood most of the day, considerable decreased interest or pleasure in most activities most of the day, weight loss, sleep difficulties, loss of energy and fatigue, feelings of worthlessness, cognitive difficulties, thoughts of death or suicidal ideation and psychomotor difficulties. The Diagnostic and Statistical Manual of Mental Disorders (DSM) stipulates that presence of five or more of these symptoms which must include depressed mood or lack of interest nearly every day within the same two week period is required for this diagnosis. In addition, the symptoms should cause considerable impairment and must not be due to effects of a substance or medical condition, or bereavement and must not meet criteria for a mixed episode. (American Psychiatric Association, 2000).

#### **Etiology, Consequences and Nature of Postpartum Depression**

According to Myers et al (1984), the experience of mood disorder and childbirth can be very stressful. Due to the association found between postpartum depression and adjustment of children, it has become increasingly important to study postpartum depression from varied perspectives including its impact on the child, the mother and the family. Not only are these studies necessary for the

advancement of science, they are important for providing information on the causes and consequences of this disorder in order to prevent or reduce incidences of postpartum depression among women.

Several studies have examined the prevalence rates of postpartum depression. In a study of postpartum women of an inner-city community maternal health clinic, Yonkers et al. (2001) found that 50% of the women with depressive disorder developed their episode after deliver while 25% developed depression during pregnancy. They also found a point prevalence rate estimated at 6.5% and 8.5%. Among Hispanic women, the rates were between 4.8% and 7.4% while African American women have rates estimated at 6.8% and 12.3%. Rate of onset of postpartum depression for their sample was 3.2% to 4.2%.

Several hypotheses have been generated to account for postpartum depression. For example, it has been suggested that the hormonal change observed in women a few days after childbirth impacts their risk of experiencing postpartum depression. The hypothesis implicating hormonal dysfunction posits that the rate of change (too high vs too low; too fast vs not fast enough) of hormones such as estrogens, prolactin, progesterone and cortisol from puerperium to postpartum period affects the mood of women after childbirth. Other biological etiologies suggested that variables such as Tryptophan and Thyroid dysfunction may be associated with postpartum depression. Tryptophan is an antecedent of serotonin, implicated in the etiology of major depression in a study by Mann et al. (1992). Insufficient release of serotonin might be caused by poor supply of Trptophan. Thyroid dysfunction has also been linked to postpartum depression in studies of depression that met the DSM-III and RDC criteria (Harris et al., 1989; Pop et al., 1991).

Other etiological variables hypothesized in postpartum depression include gynecologic and obstetric variables. Researchers such as Playfair and Gowers (as cited in O'Hara, 1995) found an association between premenstrual problems and postpartum disturbances. In addition, childbirth complications, previous miscarriage, and abortion were found to be related to postpartum depression. While some studies found an association between





these variables and postpartum depression (Campbell & Cohn, 1991; Playfair & Gowers, 1981), other studies have not found associations (Cox et al., 1982; Kumar & Robson, 1984).

In addition to biological, gynecologic and obstetric factors, stressful life events have been linked to postpartum depression. Stressful events such as unemployment, severe financial setbacks, and abandonment by significant others have been found to predict postpartum depression. Researchers have found that stressful life events that are of higher degrees are related to higher postpartum depression symptoms (Cutrona, 1983; O'Hara et al., 1984). Marital relationship, parental conflict (especially mother-daughter relationship), and lack of social support also predicted higher levels of postpartum depression (Campbell et al., 1992).

In a study of psychosocial predictors of postpartum depression in a sample of African American and Caucasian mothers of preterm and term infants, Logsdon and Usui (2001) found that social support, closeness of partner, and self-esteem significantly predicted postpartum depression. They also found that Caucasian mothers of preterm infants and low-income African American mothers had greater evidence of depression. Personal and family history is also associated with greater risk of postpartum depression. Several researchers have found a relationship between previous experiences of psychiatric disorders, family history of psychopathology and postpartum depression (Campbell et al., 1992; O'Hara et al., 1984).

Other studies suggested that fatigue is a predictor of postpartum depression. For example, Bozoky and Corwin (2002) in a study of postpartum fatigue and its relationship to postpartum depression with a predominantly Caucasian sample found that early postpartum fatigue predicted later postpartum depression. Significant correlations were found between fatigue symptoms at days 7, 14, and 28 and postpartum depression at day 28. The researchers suggested that fatigue screening should be used to identify women who are at more risk of developing postpartum depression.

Cognitive-behavioral theories of depression such as self-control styles, dysfunctional attribution style, and maladaptive cognitions have also been tested to explore their association with postpartum

depression. Studies in this area have yielded mixed findings. While some studies found an association between attributional style and experience of postpartum depression, others have not (Cutrona, 1983; O'Hara et al., 1982; Manly et al., 1982). O'Hara et al. (1982) examined how the cognitive behavioral depression models accounted for postpartum depressive symptomatology in a sample of 170 women. The models tested were the cognitive model, learned helplessness/attributional model, behavioral model and self-control model. The researchers found that the attributional style significantly predicted postpartum depression among their participants. Pregnant women who attributed negative events in their lives to stable factors that are significant and internal to them were likely to experience increased levels of postpartum depressive symptoms. This study suggested that the adjustment of women after childbirth is impacted by the way they view the world while they were pregnant.

In another study linking cognitions to whether or not women seek treatment for postpartum depression, Whitton, Appleby and Warner (1996) found that some women held the belief that accepting help in order to cope with their postpartum mood disorder is a sign of weakness and inability to fulfill their roles as mothers. This type of cognitive distortion hindered women from seeking treatment for their disorder. To this effect, the researchers recommended that regular check-ups for postnatal depression and counseling should be incorporated into postnatal care of women.

While some researchers have investigated causes of postpartum depression, others have explored the consequences of this disorder for the mother and the child. For the mother, studies have found that women who experience postpartum depression are more likely to experience depression in the intervening years. For example, in a four and half year follow up of women who experienced postpartum depression, Philips and O'Hara (1991) found that 8 of the 10 women sampled experienced another depression at follow-up time. For the child, consequences of postpartum depression include developmental difficulties and immediate distress (O'Hara, 1995). According to Kumar and Robson (1984) studies, children of women who had postpartum depression were more likely to



experience cognitive difficulties than children of women who did not have postpartum depression.

As in other issues related to postpartum depression, studies of consequences of postpartum depression have yielded mix findings due to both timing issues and whether the study was short or long term (O'Hara, 1995). Regardless of this, we know that postpartum depression has been implicated in severe emotional distress, increased risk of future depression for the mother, and cognitive developmental difficulties for the infant. For these reasons, studies of prevention and course are greatly needed.

Although no known study has explored the impact of *ile omogwu* on postpartum depression, it is possible that this form of instrumental and emotional social support provided by mothers to their daughters according to the custom of the Igbos ameliorates postpartum emotional disturbances. It would be interesting to examine its effect by looking at the postpartum emotional experiences of women whose mothers complete this custom and those who for one reason or the other (most likely death of mother) are unable to have their mother available for *ile omogwu*. It is very likely that the process of having the mother of the woman instead of the mother-in-law fulfill this three months or more live-in tradition shields the woman from feelings of guilt and distress since her mother is available to help her with infant care. The fact that this tradition is not only fulfilled at the time of a woman's first child suggests that the goal goes beyond helping the woman to learn how to take care of herself and the newborn baby. It is certain that the Igbos recognizes, that pregnancy and childbirth period are stressful by nature and therefore instituted a custom that gives the women ample time to rest, feed well and have the needs of the newborn met.

A study that investigated a concept that is somewhat similar to the Igbos' custom of *ile omogwu* examined the usefulness of providing companionship to women during labor. This companionship was provided to women who did not have companions of their own. Wolman, Chalmers, Hofmeyr and Nikodem(1993), hypothesized that women are more likely to lose confidence in their ability to be competent mothers due to stress associated with childbirth. They found that those women who had companionship during labor experienced increased

confidence in their ability to be competent mothers and reduced postpartum depressive and anxious symptoms

### Methodological Issues in Postpartum Studies

The strengths of studies on causes and consequences of postpartum depression lies in concrete efforts that researchers have made in designing studies that answer questions that are relevant for advancement of science. One of the good things that have resulted from different studies is the knowledge that some women suffer remarkable emotional distress after childbirth. It is apparent that women have been suffering in silence until studies began to examine postnatal emotional difficulties. The ability to name this disorder and distinguish levels and severity of each level has also contributed to the provision of relevant treatment. Studies on prevention of postpartum depression have also contributed significantly to science by demonstrating positive effects of childbearing and some measures that could be taken to reduce emotional distress among childbearing women. Current studies have also explored high-risk populations for this disorder finding that women who had mental illness during pregnancy or have had past history of depression or anxiety are at higher risk than others and need to be monitored. In addition, findings implicating several variables associated with postpartum depression are helpful in establishing future directions of studies in this area.

Although researchers have examined the causes and consequences of postpartum depression, the lack of consensus in findings have been problematic for the prevention and diagnosis of this disorder. Several methodological issues have impeded research in these areas. One of these issues is variability in the types of measures used. For example, studies of obstetric effects on postpartum depression often use different outcome measures (i.e., inventories and open-ended questions) in interviews. Due to methodological issues in stress theories of postpartum depression, it is difficult to ascertain the relationship between stress and postpartum depression and other variables such as family history. Another methodological issue raised by Swendsen and Mazure (2000) is the question of whether stress should be evaluated with subjective self reports from



the mothers or by independent raters. Subjective measurement of stress depends on individual characteristics such as personality, behavior and history of psychopathology. Other methodological issues involve timing, magnitude, severity and chronicity of stressors, as well as the individual's own actions. All of these factors pose considerable threats to the reliability and validity of findings.

In studies of hormonal variables, methodological issues have also been implicated for the lack of consistency in findings. Inconsistency of postpartum mood disorder measured is a problem. For example, findings from postpartum blues, postpartum psychosis and postpartum depression differed. These different diagnoses have different symptoms and severity levels as well as presentation so combining studies of all three disorders yield conflicting results and is not appropriate. As in stress studies, the timing of the measurements constitute methodological problem and may have affected findings from varied studies. Another difficulty in the study of postpartum depression is the problem of identifying pathways of causal variables correctly. For instance, hormonal models proposed in the etiology of postpartum depression may not necessarily be associated with the disorder. This is because findings from studies of hormones may be reflecting the impact of other variables such as biological, psychological or environmental variables or interaction of all factors involved.

### Recommendations and Conclusion

Although the findings of the studies discussed are promising, future studies should endeavor to use representative samples of women from diverse ethnic backgrounds. There is a need for systematic studies that look into causes of high-risk population, and there is also a need for long-term follow-up studies of postpartum depression. Women as well as their families should be examined for risk factors and consequences. In addition, more prevention studies for defined postpartum mood disorder (e.g., postpartum depression) should be undertaken.

Given that studies are yet to explore differences in the prognosis of women who experience postpartum depression and those who do not, it is essential to investigate variations among

these groups of women. Probably, it might lead to an understanding of the influence of biological, genetic, environmental and psychosocial factors on this disorder. Future studies might also consider measuring the severity, chronicity, symptom variations and duration in examining the nature, causes and consequences of postpartum depression. This might lead to more consistent findings across studies of postpartum depression.

Since research has shown that the birth of a child is not a joyful period for all women, and that some women experience mood disturbances, it is important that families, and professionals involved in the life of childbearing women to be aware of available information in order to avoid or minimize the impact of postpartum depression. It is clear that women need a lot of support during pregnancy and after childbirth to cope with the stress of childbearing. Women also need to be informed and educated on how they can minimize distress, better manage themselves, and ask for help when they need it. Apparently, there is still more to be done in the area of research particularly using stringent methodologies that might allow for consistent results. Hopefully, the field of psychology and medicine will advance and reach consensus over issues of causality, consequences and prevention of postpartum depression.

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