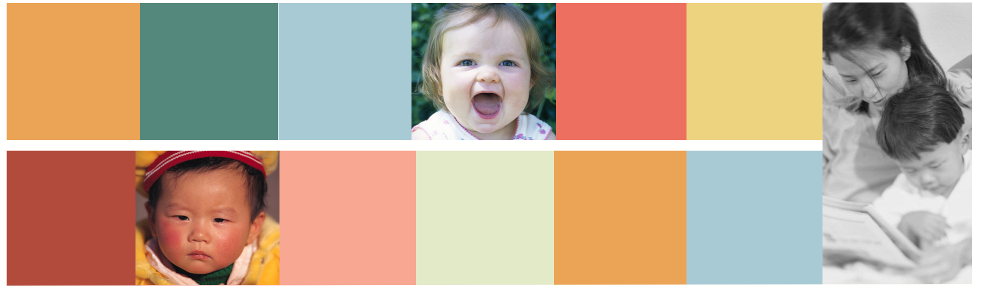

Building Bridges: Linking Practice and Research on Home Visitation

WINTER ■ 2005

Post Partum Depression and Clinical Depression

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LeCroy & Milligan Associates, Inc. is a Tucson-based research, evaluation, and training firm.

Our goal is to provide useful evaluation information to help organizations become more responsive and effective in delivering services.

Fathers and Depression

By Judy Krysik, Ph.D.

MOST RESEARCH ON PARENTAL DEPRESSION AND HOW IT RELATES TO CHILDREN IS FOCUSED ON MOTHERS. WHAT ABOUT THE FATHERS? ARE THEY MORE LIKELY TO EXPERIENCE DEPRESSION IN THE PERIOD FOLLOWING THE BIRTH OF A NEWBORN?

The answer is yes — rates of depression among fathers are also higher after the birth of a child than before the birth, and are higher than rates reported by males overall. Estimates of fathers' postpartum depression range from 10% in the general population to 30% among first time fathers.

Most onsets of depression among men occur when they are in their 20s and 30s, so age is also a factor. Like women, the likelihood of experiencing postpartum depression is much greater for those who experienced prior symptoms or episodes. Higher income groups have much lower rates of depression, suggesting that financial strain and employment factors are also associated with depression. Unemployed fathers of newborns report financial worries and develop more depressive symptoms than fathers without those concerns (Wilson and Brooks-Gunn, 2001). Relationship factors are also important. Relationship characteristics including disagreement with the mother

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We are pleased to provide this newsletter to family support programs, decision makers, and researchers through the partnership of LeCroy and Milligan Associates, Healthy Families Arizona, and the Western Regional Healthy Families America Center. It is our goal to encourage the integration of current research into practice to improve outcomes for children and families.

From the Editor:

Depression is one of the biggest mental health problems in this country. Imagine being overwhelmed by negative thoughts and feelings, physically being unable to do simple things like getting out of bed or taking a shower, or refusing to talk to anyone because you can't get up the motivation to have a conversation. Now imagine you are a parent as well trying to care for an infant. It doesn't take long to realize that depression can take a big toll on individuals, infants and children, and families. The bright spot in all this is that depression is something the mental health community knows how to treat. We can help parents overcome depression. The challenge is getting depressed people to seek help and take advantage of the resources for treating depression. Healthy Families workers are in a good position to identify depression and help individuals obtain help that can drastically improve their lives. This newsletter is designed to bring greater awareness of depression, provide some screening tools for depression, and help us do a better job of tackling this crippling disease. Let us know what you think!

Craig W. LeCroy, Ph.D.
Executive Director
LeCroy & Milligan Associates

Fathers and Depression

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about the pregnancy and substance use problems greatly increase the likelihood of a father experiencing a major depressive episode.

Here are several compelling reasons why home visitors should attend to the depressive symptoms of fathers:

- High correlations are found between depressive symptoms and physical aggression among married partners (Felbau-Kohn, Heyman, & O'Leary, 1988).
- Stress negatively affects men's attachment to their infants (Cuist, Morse & Durkin, 2003).
- Fathers with lower levels of depression have more involvement with their infants than fathers with higher levels of depression (Roggman et al., 2002).
- Depression has negative consequences on the short and long-term development of children.
- Parental depression is positively correlated with infant hospitalization (Guttmann, Dick & To, 2004).
- Fathers who are depressed have lower levels of empathy toward their infants (Lutenbacher, 2002), and report more frequent thoughts of harming their infants (Jennings et al, 1999), exhibit more aggression toward their children, and mistreat them more frequently (Bishop & Leadbeater, 1999).
- Employed persons with depression have significantly more absences and lower productivity (Kessler, et al., 1999).

National Institutes of Mental Health (NIMH) has launched the *Real Men, Real Depression* campaign, which features publications and public service announcements about depression and how to get help.

Call toll free: 1-866-227-6464 or browse to: menanddepression.nimh.nih.gov

Home visitors should provide fathers and mothers with information on the warning signs of depression and available treatment resources, and make special efforts to reach young and unmarried fathers, those who have relationship problems with the mother, and those with substance abuse problems. ¶

Based on:
Huang, C., & Warner, L. A. (March, 2005). Relationship characteristics and depression among fathers with newborns. *Social Service Review*, 95-118.

Improving Practice: Healthy Families Intervention with Depression

By Craig W. LeCroy, Ph.D.

DEPRESSION IS A MAJOR CONCERN WITH MANY OF THE FAMILIES SEEN BY HOME VISITORS, 10% of women will have postpartum depression and this figure does not include others who will also suffer from a major depression. It is widely known that depression is under treated. The disturbing fact is that treatment for depression can be quite effective but we are not treating a large number of people who could benefit from help.

A major role for home visitors in the treatment of depression is providing support to the individual and reducing barriers to proper treatment. Many people do not like the stigma associated with being labeled a person with "depression." Depressed individuals often are afraid to acknowledge their own distress. They can deny or minimize the symptoms suggesting that it is the stress they are experiencing, a failure of willpower, and feeling like it is an untreatable condition.

Physicians and mental health providers also create barriers. Some believe depression is not "real" or that it represents something else (e.g., anger at a history of child abuse). Mental health professionals sometimes suggest the use of "positive thinking" unaware of the research evidence regarding proper treatment.

There are also barriers to proper diagnosis of depression. Many physicians and mental health workers dismiss postpartum depression suggesting to women they have the "baby blues" even though their symptoms may be reported 3 months after delivery. Also, because of the context of the person's life professionals may miss an appropriate diagnosis. Lastly, there are significant barriers to treatment.

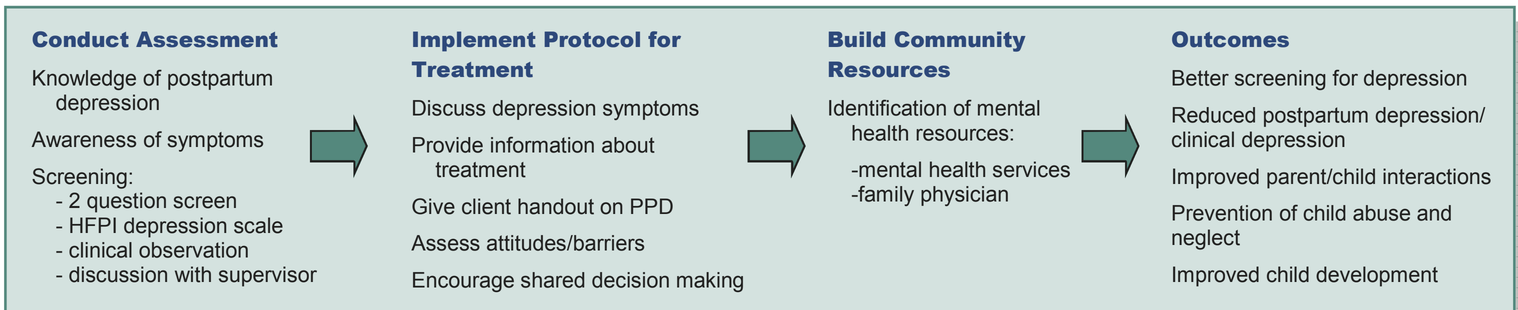
The most difficult aspect of getting people to treatment is convincing them to get help in the first place. They don't want to face the stigma or fear receiving medication not wanting to become "addicted" or "needing a crutch." Psychotherapy may be rejected because it is seen as only for the "weak," too intrusive, too complicated, or overly concerned about childhood issues.

Home visitors can help reduce barriers so that individuals get the help they need. Some of the things a worker might do include:

- ✓ **discussing confidentiality** when people seek treatment
- ✓ **discussing the symptoms** and possible outcomes of depression ("the best thing for your baby is for you to feel better")
- ✓ **discussing barriers** to the treatment of depression during the postpartum period including: limited child care, issues with medication and breast feeding, facilitating an understanding of the seriousness of the problem ("this may not go away—it is not common for all moms to feel like this"), sharing resource materials such as a handout on postpartum depression (see: http://www.lecroymilligan.com/healthyfamilies.htm), and facilitating direct referrals for treatment.

Women can be encouraged to help themselves by turning to friends and family, getting proper rest, eating properly, getting exercise, making time for themselves, and talking about their thoughts and feelings. ¶

A conceptual model for how home visitors can address depression is provided below.



Women and Depression

By Craig W. LeCroy, Ph.D.

Women and depression is a topic that has become increasingly discussed by health professionals because of one simple fact: women are about twice as likely as men to suffer from depression.

Why do women have higher rates of depression? The exact reasons are not clearly known but most experts agree that there is a constellation of gender-specific factors that are likely to be the culprit. These include biological differences like the influence of hormones and different brain chemicals, differences in cognitive styles especially ruminating on negative thoughts, and social issues such as the role of women in society and economic status. The specific risk factors associated with depression in women are listed below:

Risk factors for Depression in Women

- ✓ Family history of mood disorders
- ✓ Personal past history of mood disorders in early reproductive years
- ✓ Loss of a parent before age of 10 years
- ✓ Childhood history of physical or sexual abuse
- ✓ Use of an oral contraceptive, especially one with high progesterone content
- ✓ Use of gonadotropin stimulants as part of infertility treatment
- ✓ Persistent psychosocial stressors (e.g., loss of job)
- ✓ Loss of social support system or the threat of such loss

Although the diagnostic criteria used to assess depression is the same for men and women; compared to men, women may more often experience seasonal depression and what is known as symptoms of atypical depression such as carbohydrate craving, weight gain, heaving feeling in one's arms and legs, evening moodiness, and initial insomnia. Women also have a high incidence of hyperthyroidism, a condition that can cause depression.

Depression is a significant risk factor for suicide attempts in both men and women. While women more often attempt suicide men are more often to complete the act of suicide. The male-to-female ratio for completed suicide is 4:1. It is most often believed that this is due to women's use of less lethal methods. The most common method employed for attempted suicide in women is self-poisoning. This is used by 70% of all suicide attempts by women. The following risk factors are associated with suicidal behavior in women:

Risk for suicide attempts:

- ✓ Less than 30 years old
- ✓ Threatened loss of intimate relationship
- ✓ Living alone
- ✓ Presence of psychosocial stressors
- ✓ Substance abuse
- ✓ Personality disorder
- ✓ Clinical depression

Risk for completed suicide:

- ✓ Clinical depression, especially with psychosis
- ✓ Substance abuse
- ✓ Past history of suicide attempts
- ✓ Suicidal ideation or plan
- ✓ Divorced or widowed
- ✓ Presence of active or chronic medical illnesses
- ✓ Panic disorder or severe anxiety
- ✓ Hopelessness ¶

For more information, see:

Bhatia, S. C., & Bhatia, S. (1999). Depression in women: Diagnostic and treatment considerations. American Family Physician, 60, 225-240.

Korstein, S. G. (1997). Gender differences in depression: Implications for treatment. Journal of Clinical Psychiatry, 58, 12-18.

Seeman, M. V. Psychopathology in women and men: focus on female hormones. *American Journal of Psychiatry, 154*, 1641-1647.

Pajer, K. New strategies in the treatment of depression in women. *Journal of Clinical Psychiatry, 56*, 30-37.

Leibenluft, E. et al., (1995). Gender differences in seasonal affective disorder. *Depression, 3,* 13-19.

Hirschfeld, R. M., & Russell, J. M. (1997). Assessment and treatment of suicidal patients. *New England Journal of Medicine, 337,* 910-915.

Moscicki, E. K. (1994). Gender differences in completed attempted suicides. *Annuals of Epidemiology, 4*, 152-158.

Postpartum Depression: Brooke Shields Sends a Message to Us All

By Craig W. LeCroy, Ph.D.

THANKFULLY, POSTPARTUM DEPRESSION HAS GOTTEN SOME RECENT ATTENTION BECAUSE BROOKE SHIELDS SPOKE OUT BASED ON HER OWN PERSONAL EXPERIENCE.

How to Assess Postpartum Depression

If you observe any of these characteristics in the mothers you serve they could have postpartum depression and should be referred for further treatment:

- **History of depression or premenstrual dysphoric disorder (Premenstrual dysphoric disorder is a condition associated with severe emotional and physical problems that are linked closely to the menstrual cycle.)**
- **Young at the time of pregnancy—the younger a mother is the higher the risk**
- **Living alone**
- **Limited social support and contacts**
- **Children—the more children a mother has the more likely she is to be depressed in a subsequent pregnancy**
- **Ambivalence about having a baby**
- **Relationship conflict especially with the husband or boyfriend**
- **History of depression during pregnancy—approximately 50% of depressed pregnant women will have postpartum depression**

Because of the way this depression takes hold it is difficult to admit, individuals often feel shame, guilt, and a sense of helplessness all wrapped up in blanket of secrecy.

Shields knew something was wrong as she felt severe sadness, withdrew from friends and family, and was engulfed by a sense of failure. Her mothering ability was gone—when the baby cried she didn't feel like responding. In fact, she cried more than the baby did.
Why would a successful model and actress like Brooke Shields end up with postpartum depression?

Her history reveals some classic risk factors.

- ✓ **She had a difficult labor**—an emergency C-section and her uterus herniated during the surgery leaving her with a large loss of blood.
- ✓ **She recently had experienced a loss**—3 weeks before the baby was born her father died of prostate cancer.
- ✓ **She was under considerable stress**—she had in-vitro fertilization and other doubts about getting pregnant. She had highly publicized divorce and no additional support at home after the baby's birth.
- ✓ **She also had a history of depression in her family**—a clear risk factor.

Brooke Shields broke free of her depression by seeking therapy, taking medication, and reconnecting with her baby (she attributes a lot of her success to breast feeding which gave her a physical connection that she needed—see related article on medication and breastfeeding). Her inspiring story is documented in her recent book, *Down Came the Rain.* Postpartum depression is different from the "baby blues," which is characterized by frequent bouts of

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Screening for Depression

By Craig W. LeCroy, Ph.D.

YOU CONDUCT A HOME VISIT AND YOU IMMEDIATELY SUSPECT THAT THE MOTHER IS DEPRESSED.

Is there some way to do a quick screening for depression? Recent research has found that simply asking 2 questions resulted in good "sensitivity" and identifies more than 90% of clients with major depression.

However, because it also identified people who do not have depression, it requires a follow up interview or additional questions. The two question screen includes the following:

1. During the past month, have you often been bothered by feeling down, depressed or hopeless? ____ yes ____ no

2. During the past month, have you often been bothered by little interest or pleasure in doing things? ____ yes ____ no

If the answer to either question is "yes" then additional data should be collected to determine if the person is clinically depressed.

The Healthy Families Parenting Inventory (HFPI) is a good place to look for further evidence of depression. Four questions that make up part of the depression scale can be examined for a clear pattern.

Discussions with your supervisor and referrals for mental health treatment are recommended if a participant answers "good part of the time" or "always or most of the time" to the following statements from the HFPI:

- *I feel sad.*
- *I feel hopeless about the future.*
- *I feel unhappy about everything.*
- *There isn't much joy in my life.* ¶

For more information, see:

American Family Physician (2003). Putting prevention into practice: An evidence-based approach. Screening for Depression.

LeCroy, Krysik, & Milligan (2004). Healthy Families Parenting Inventory.

First Person Accounts Of Depression

"I would have been happy to die the most painful death, though I was too dumbly lethargic even to conceptualize suicide. Every second of being alive hurt me. Because this thing had drained all fluid from me. I could not even cry. My mouth was parched as well. I had thought that when you feel your worst your tears flood, but the very worst pain is the arid pain of total violation that comes after the tears are all used up, the pain that stops up every space though which you once metered the world, or the world, you. This is the presence of major depression." From: A. Solomon, *The Noonday Demon: An Atlas of Depression*, p. 19.

"Depression is an insidious vacuum that crawls into your brain and pushes your mind out of the way. It is the complete absence of rational thought. It is freezing cold, with a dangerous, horrifying, terrifying fog wafting throughout whatever is left of your mind. In the beginning I tried to ignore it, to force my eyes and mind to read or get dressed or make breakfast in spite of the encroaching monster. Then I got tired—or it got bigger—and I stopped trying. The warp and woof of my mind disintegrated before me and I could do nothing to stop, ameliorate, or affect the vaporization." From D. Karp, *Speaking of Sadness*, p. 23.

"Depression steals away whoever you were, prevents you from seeing who you might someday be, and replaces your life with a black hole. Like a sweater eaten by moths, nothing is left of the original, only fragments that hinted at greater capacities, greater abilities, greater potentials now gone. Nothing human beings value matters any more—music, laughter, love, sex, children, toasted bagels and the Sunday New York Times—because nothing and no one can reach the person trapped in the void. You have no idea of what will happen next, when it might be over, or even where you are now. Suicide sounds terrific, but much too difficult to plan and complete." From. D Karp, Speaking *of Sadness*, p. 24

The effect of depression on infants

By Craig W. LeCroy, Ph.D.

MATERNAL DEPRESSION IS A SERIOUS EVENT THAT CAN HAVE A LASTING INFLUENCE ON THE INFANT'S COGNITIVE, SOCIAL, AND EMOTIONAL DEVELOPMENT AND ON A WOMAN'S CONFIDENCE IN HERSELF AS A MOTHER. Research studies have shown that a depressed mother is less responsive to her infant's cues for hunger, boredom, or interest in stimulation. The influence extends in all spheres of the child's development and can lead to behavior and learning problems in school. Cognitive skills and expressive language development are adversely affected by maternal depression. Infants as young as 3 months of age can detect the affective quality displayed by their mothers and modify their own affective displays in response to it. Early detection and treatment are critical for both the mother and baby. ¶

For further information, see:

Cohn, J.F., Tronick, E. Z. (1983). Three-month old infants' reaction to simulated maternal depression. *Child Development, 54*, 185-193.

Whiffen, V. E., & Gotlib, I. H. (1989). Infants of postpartum depressed mothers: temperament and cognitive status. *Journal of Abnormal Psychology, 98, 274-228.*

Cox, A. D. et al. (1987). The impact of maternal depression in young children. *Journal of Child Psychology and Psychiatry, 28,* 917-928.

We want to hear from you! This newsletter was designed with you in mind. If you have ideas for future newsletters, comments or suggestions about what you have read here, please send them to Kerry Milligan at: kerry@lecroymilligan.com. ***Thank you!***

Postpartum Depression

(Continued from page 5)

crying for no apparent reason, sadness, and anxiety. The baby blues are common—anywhere from 26 to 85% of women will experience it.

The baby blues typically begin in the first week after delivery and is resolved by the 10th postnatal day. Detecting postpartum depression is complicated because there is a normal period of adjustment after having a baby. Also, pressure to be a "good mother" makes women afraid to admit their true feelings because of shame and fear. In serious cases, it is not uncommon for women to think they are "going crazy" and express fear that they will loose their baby because of how they are feeling.

One in 10 women will experience postpartum depression.

Healthy Families can make a difference in the identification and treatment of this problem.

If a participant in the prenatal program has depression she needs ongoing support because it is very likely she will experience postpartum depression. Advise women to talk with their family doctors.

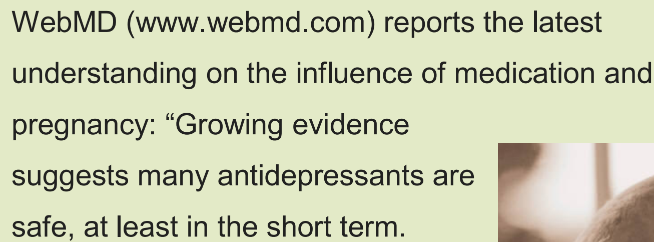
The symptoms of postpartum depression are similar to the general symptoms of depression and include:

- depressed mood
- lack of pleasure or interest in things
- insomnia (sleep disturbance)
- weight loss
- loss of energy
- agitation
- feelings of worthlessness, intense feelings of guilt
- inability to concentrate or indecisiveness
- frequent thoughts of death or suicide ¶

For more information, see:

Epperson, C. N. (1999). Postpartum major depression: Detection and treatment. *American Family Physician*, 59, 1-11.

IT'S A FACT: Medication and Pregnancy



WebMD (www.webmd.com) reports the latest understanding on the influence of medication and pregnancy: "Growing evidence suggests many antidepressants are safe, at least in the short term.

Some studies show withdrawal-like symptoms in newborns that go away in days, and trace levels of the drugs can be passed on to babies in breast milk. Most experts say the risks from depression during and after pregnancy outweigh any risks from the drugs. Untreated depression can lead to poor health for mother and child."

Source: Web MD, 2005, p. 23.

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