



Barbara Sanchez

Major:
Psychology

Minor:
Forensic Studies

Mentor:
Dr. Agustina Bertone

*Postpartum Depression in Women
of Color*

Biography

Barbara Sanchez received a Bachelor of Arts degree in Psychology with a minor in Forensic Studies from San José State University in 2022. Her research focuses on Postpartum Depression (PPD) in women of color and the barriers they face seeking appropriate treatment. She has completed an internship at Thaddeus Resource Center, where she supported marginalized mothers by connecting them to a range of community resources. As a Ronald E. McNair Scholar and a STAR Scholar the University of Michigan, Barbara has also served as an Educational Opportunity Program Mentor. She was awarded the Robert and Maralee Hick's Scholarship in 2021 for presenting her research journal at the Western Psychological Association Annual Conference and the University of California, Los Angeles. This scholarship is awarded for psychological research that motivates a societal change and impacts society. She is a first-generation Latina student who will continue to further her academic career in the field of psychology.

Postpartum Depression in Women of Color

Abstract

Postpartum Depression (PPD) is a mental health complication experienced during pregnancy and/or in the months following childbirth. Women may struggle to seek treatment due to lack of education, unstable relationships, lack of support, and being low-income. Some of these factors may be particularly salient for women of color. Cultural nuances may also deter these women from seeking treatment and finding support to help manage their PPD symptoms. Treatment options and therapy have demonstrated a reduction in symptoms for women experiencing PPD. Future directions are also discussed.

Keywords: postpartum depression, mothers, PPD, infants, depression

Introduction

Postpartum Depressive Disorder (PPD) is characterized as a mood disorder affecting approximately 10 to 15% of women during pregnancy and/or after giving birth (Bloch et al., 2006). PPD symptoms include sadness, uncontrollable crying, difficulties sleeping (beyond those associated with caring for a baby), changes in appetite, lack of motivation, and lack of interest in one's baby or previously pleasurable activities (Dorlen et al., 2021). In addition to these symptoms, women may also experience mood swings, anger, irritability, and feelings of guilt and shame. Studies show that giving birth to a child has significant effects on the mother psychologically, physically, and socially (Winstone et al., 2020). According to the Center for Health Statistics (2008), it has been estimated that at least one out of five women will experience PPD in their lifetime (Goyal et al., 2010). Postpartum depression can occur during and after pregnancy, especially for first-time mothers (Bloch et al., 2006) due to the many new stressors involved in new motherhood, including financial changes and a potential lack of support and resources (Goyal et al., 2010).

At the outset, it is important to clarify that mood changes that sometimes arise out of childbirth do not necessarily result in PPD. Sixty to eighty percent of women report experiencing "baby blues" after giving birth (Allen et al., 2019). This is characterized by crying, lack of sleep, feeling alone and disconnected, mood swings, and anxiety (Allen et al., 2019). The emotional changes associated with baby blues can begin immediately after childbirth and typically recede after two to three weeks with proper support and rest (Allen et al., 2019). If symptoms do not remit within this timeframe, mothers may benefit from additional mental health support and PPD screening, as they may be experiencing clinically significant symptoms.

More than one in five women experience PPD (Dorlen et al., 2021) and it is considered one of the most common disorders associated with childbearing (Bloch et al., 2006). Despite its relative prevalence, there remains stigma and shame surrounding those who experience PPD (Bloch et al., 2006). Research demonstrates that women may experience feelings

of shame due to the lack of support they receive and the low self-esteem they may experience with PPD (Goyal et al., 2010). Mothers have reported feeling “mom-shamed” because symptoms can cause them to feel disconnected from their baby and unable to experience the joy that mothers often say they should be experiencing (Goyal et al., 2010). “Mom-shaming” is described here as criticizing a mother based on her parenting choices and styles (Allen et al., 2019). When examining this data, it is crucial to consider that these statistics are based on women who report their symptoms to their doctor. It is also important to note that PPD does not affect a “certain type” of mother (Allen et al., 2019). There are higher risks of developing postpartum depression if the woman herself has suffered from depression in the past prior to becoming pregnant, or if their own mother experienced PPD (Winstone et al., 2020).

Women of Color and PPD

Women of color generally demonstrate a higher incidence of PDD (Winstone et al., 2020). Young women of color tend to experience PPD at higher rates with their firstborn due to several factors: struggles with financial income, unstable relationship status, and housing insecurities (Winstone et al., 2020). In a study found by Lodsdon and associates, women of color often reported feeling stressed regarding their inability to find proper childcare being unable to afford the basic necessities for their newborns (Logsdon et al., 2009). Additionally, they also reported difficulties affording or finding transportation to see another therapist elsewhere when seeking treatment for PPD (Logsdon et al., 2009).

The barriers that can contribute to developing PPD include lack of emotional support, relationship insecurity with a significant other, and the stress of being a good mother (Winstone et al., 2020). In 2010, Goyal and colleagues found that PPD had significantly decreased in communities of higher income (Goyal et al., 2010). In a study by Logsdon and associates, young adolescent Latinx and African American girls who were 6 months postpartum described their symptoms after

giving birth. One African American mother stated that she felt frustrated that her relationship with her baby's father was unstable and felt that he was not supporting her in any way (Logsdon et al., 2009).

Oftentimes, Mexican families have strong cultural values concerning motherhood (Banker et al., 2014). Family negativity can compromise a mother's well-being and psychological health by being criticized and being put in distress (Winstone et al., 2020). For Latinx immigrant families, research has shown that there are higher levels of family disagreements with parenting styles due to traditions and intergenerational conflicts (Winstone et al., 2020). Regarding Latinx and Black communities, research demonstrates that there is often a stigma present behind accessing mental health services (Banker et al., 2014). This is important because minority communities have a higher percentage of experiencing mental health issues and often never receive treatment for them (Banker et al., 2014). Winstone and colleagues found that women who come from Mexican households carry extremely high values of maintaining close family bonds that often lead to holding high expectations of how a woman should act with their children (Winstone et al., 2020). Subsequently, this may lead to mothers struggling with depressive symptoms because they often feel as though they can never reach the high expectations set by their families.

Receiving treatment for postpartum depression can markedly improve outcomes for women (Frieder et al., 2019). Without treatment, a woman and her newborn can experience significant negative impacts (Frieder et al., 2019). PPD can negatively impact emotional, cognitive, and behavioral functioning in a woman's newborn through emotional strain on the mother and infant's bonding experience and relationship (Frieder et al., 2019). There are high-risk factors for infants whose mothers have PPD. For example, an infant may exhibit low birth weight, increased awakenings, and develop physical health concerns (Smith et al., 2012). Approximately 20% of women experience suicidal thoughts while being diagnosed with postpartum depression (Griffen et al., 2020). Left untreated PPD can—in the worst of circumstances—lead to maternal suicide and sometimes

infanticide (Garcia et al., 2010). Studies have also found that suicide is the most common cause of death in women during the first year after giving birth to their children (Griffen, 2020).

Treatments for Postpartum Depression

There are many forms of treatment available for PPD, including psychopharmacological interventions, psychotherapy, and transcranial magnetic stimulation. Psychotherapy provides women emotional with support and can assist with helping a mother express her emotions and openly share what she is going through (Clark et al., 2010). Psychotherapy is often the first line of treatment to target PPD, as taking medication can present challenges if the mother is breastfeeding (Clark et al., 2010).

PPD can affect relationships associated with the women who are experiencing this disorder. One of the relationships that can be affected is with a significant other/partner (Banker et al., 2014). Without proper communication and emotional support, women may experience an increase in PPD symptoms (Banker et al., 2014). If women have higher levels of support from their partners, then the likelihood of developing PPD decreases (Banker et al., 2014). Couple's therapy has been proven to help couples who are struggling with PPD (Banker et al., 2014) by assisting them in learning how to communicate with each other and offering psychoeducation about the nature and impact that PPD has on their relationship (Banker et al., 2014). It also helps couples identify triggers or potential warning signs that they can look out for if they notice any changes over time (Banker et al., 2014).

Interpersonal psychotherapy (IPT) is a highly effective form of psychotherapy used to help with mental health issues and different forms of depression (O'Hara et al., 2000). Research demonstrates that IPT can be an effective form of treatment for women with postpartum depression. Research demonstrates that it can decrease symptoms of depression over a 12–16-week period (O'Hara et al., 2000). This form of psychotherapy is utilized to help target current stressors and not focus on past stressors that have been affecting the patient (O' Hara et al., 2000). Interpersonal

psychotherapy aims to help strengthen current relationships in the patient's life and support them in managing their current life and relationships which are affecting their mental health (O' Hara et al., 2000). IPT can be an effective treatment for women suffering from PPD because it decreases the use of antidepressants (O'Hara et al., 2000).

Cognitive Behavioral Therapy (CBT) is another form of therapy that targets reduction in PPD and decreases depressive symptoms. This form of therapy is structured to help the patient manage negative and intrusive thoughts and tackle presenting concerns straight on (Sockol et al., 2015). CBT can be performed as group therapy where one can discuss with other women who are also struggling with PPD and share their experiences (Sockhol et al., 2015). Studies have also found that women who do individual cognitive behavioral therapy sessions have better results than in group therapy (Sockhol et al., 2015). CBT teaches these women how to learn about their emotional patterns and unlearn destructive behaviors that can create unhealthy beliefs and result in symptoms of depression (Sockhol et al., 2015). These sessions can range from about five to up to twenty weeks and are often about an hour-long (Sockhol et al., 2015).

Child-Parent Psychotherapy (CPP) is another form of psychotherapy that works primarily with the mother and her child. This usually involves children from ages 0-5 years old who have experienced some sort of traumatic experience or their parents are suffering from a mental illness (Lieberman et al., 2019). CPP has parents reflect and change their unhealthy parenting strategies (Lieberman et al., 2019). This form of therapy supports parents in learning how to not abuse their child and build healthy relationships with their child to help them feel safe and loved (Lieberman et al., 2019). This form of therapy typically ranges from 4 to 6 sessions and each session is approximately 50 minutes (Lieberman et al., 2019). CPP also helps parents reflect on their own traumatic experiences and teaches them how to intervene in toxic cycles of making similar mistakes that their parents made with them (Lieberman et al., 2019).

Psychopharmacologic treatment is also an option for treatment but is often avoided, as women are often breastfeeding in the postpartum period

and medication can affect breastmilk (Clark et al., 2010). The types of antidepressants that some women are put on to help treat PPD are SSRIs (selective serotonin reuptake inhibitors). SSRI medications are also known for helping treat OCD (obsessive-compulsive disorder), PTSD, anxiety disorder, social anxiety disorder, and panic disorders (Rahimi et al., 2006). Taking antidepressants during pregnancy carries a small risk of affecting the infant's development (Sunnqvist et al., 2019). Antidepressants have been found to help treat more severe cases of PPD (Sunnqvist et al., 2019). Most cases of PPD can be treated with cognitive-behavioral therapy if women choose to opt out of taking antidepressants (Sunnqvist et al., 2019). Untreated PPD can cause infants to be born with low birth weight or prematurely (Sunnqvist et al., 2019).

Another treatment that targets PPD is transcranial magnetic stimulation (TMS; Garcia et al., 2010). Repetitive Transcranial Magnetic Stimulation (rTMS) was first developed in 1991. TMS treatments stimulate a pulse sensation to the side of the brain that is affected by depression (Garcia et al., 2010). There are no side effects and the intervention is noninvasive (Garcia et al., 2010). This treatment is recommended for people that suffer from depression and have not responded to antidepressants (Garcia et al., 2010). The patient generally starts to exhibit signs of positive results in 2-4 weeks (Garcia et al., 2010). Each session lasts about 30+ minutes and many patients have reported feeling little to no discomfort at all (Garcia et al., 2010). A study had proven that women who were suffering from PPD had found positive results while doing TMS and preferred it over taking antidepressants (Garcia et al., 2010).

Postpartum Depression Screenings

To help identify women with PPD, extra screenings should be conducted to help evaluate symptoms of PPD and support women in accessing treatment when necessary. One way to identify mothers who may be experiencing PPD is to screen them during pregnancy and post-partum appointments with their obstetricians. According to the Association of Advancement of Psychology guidelines, the proper way to screen mothers

for PPD is by using the Edinburgh Postnatal Depression scale to accurately determine if women need further evaluation (Sorg et al., 2019). The guidelines also state that screenings should be conducted during the first and second visit, as well as a six-month check-up (Sorg et al., 2019). A study in Indiana tested these screenings with women of color and found an 88% improvement in diagnosing women with PPD due to the consistent checkups with their health care providers (Sorg et al., 2019). Although many barriers remain for women of color to access treatment for PPD, with mandatory screenings similar to the study above, more women may be identified and connected with appropriate mental health services.

Future Direction for Treatment and Diagnosing

The field of maternal mental health remains an important area of work. There are multiple avenues to inform women and their families about PPD. For example, educating adolescents in schools may serve as a way to prevent long-lasting consequences for women who experience PPD by providing a safe and open environment for adolescents and young adults to learn this information. Increasing awareness of PPD at a young age in school systems and in classroom settings can help empower young women who experience symptoms during pregnancy and postpartum in the future. It would also help prepare and inform young adults on how to handle PPD if they do happen to encounter this disorder within their lives.

Another way to ensure that women experiencing PPD receive the support they need is through instilling mandatory screenings during pregnancy and soon after childbirth. Most women do not seek treatment or assistance from healthcare providers because of cultural differences, lack of knowledge, fear of being judged or ridiculed, and/or not feeling supported by loved ones. If mandatory screenings were done on women during pregnancy and post-partum, the percentage of women diagnosed with PPD would increase (Tackett et al., 2009). Women that go undiagnosed and untreated can experience detrimental and impactful consequences for themselves, as well as their child and family. Continuing to center maternal mental health can help mothers and their families feel

supported throughout the pregnancy and postpartum process and reduce the negative impacts of PPD.

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