A Holistic and Complementary Approach to Postpartum Depression

Ohlone Herbal Center Therapeutics Program

Pathology Report

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I. Introduction

Perinatal mood and anxiety disorders are some of the most common found in those of woman of reproductive age. (2) The experience of pregnancy, birthing, and postpartum is accompanied by an extreme range of emotions that a mother goes through in the journey of becoming a mother. Common circumstances of the postpartum period such as: the inability to sooth her crying newborn, breastfeeding troubles, anxieties around baby's breathing, sleeping, eating, her relationship with her postpartum body, her relationship with her partner and the necessity to surrender to the lack control over time can leave a mother feeling isolated, alone, and with a sentiment of being a failure.Fierce love, exhaustion, acclimation, drastic hormonal and physical changes can leave a mother with the feeling of being overwhelmed, without the time or space to process her experience. A woman experiencing postpartum depression may externally look like she is a happy, radiant new mother, whether it be her first or third pregnancy. However, internally she could be dealing with debilitating fear around caring for her child, battling to hold back tears, and constantly trying to find the courage to resist causing harm to herself or even her child. The use of a holistic approach, including the use of herbal analysis and therapeutics, nutrition, and lifestyle changes in the management strategy of postpartum depression, along with the possibility of working in conjunction with allopathic or traditional phycological treatment, can be extremely beneficial in allowing a mother to have a healthy, and loving relationship with both their child as well as them self.

II. What is Postpartum Depression (PPD)

A. Postpartum Depression Defined

1. Postpartum depression is mood disorder, often typified in the same way as depression, that can affect a new mother anywhere from the day after to one

year after giving birth. It usually occurs between 4 to 6 weeks, but can also not present until the first 6 to 12 months after birthing and may continue for a long period of time.(1, 2) It is one of the most common problems experienced by new moms and about 1 in 7 or 5 -15% of woman will experience Postpartum Depression. (3) Moreover, it is difficult for many clinicians to diagnose postpartum depression as the demeanor of a postpartum woman, characterized by lack of desire to engage sexually with their partner, lack of appetite, affect on sleep patters, and extreme fatigue, is often seen common among new mothers and thus the behavior can be indistinguishable from normal. (2) Additionally, while symptoms may at first appear to be similar to those of depression, neurobiologically the conditions are polar opposites. While fMRI scans show increased activity in the amygdala in those who struggle with severe anxiety and depression, the scans show there can be decreased activity in woman with postpartum depression. (4) Major determining factors of postpartum depression are when it affects the whole family, including the woman, her partner, and other children as well as the inability for the woman to care or more importantly safely care for both her self as well as her child or children. (2)

B. <u>Postpartum Depression and Postpartum Blues</u>

1. In addition those behavioral patters seen as normal in the postpartum period, the postpartum blues is a juxtaposing condition to postpartum depression that can often lead to a difficulty or a prolonging in the diagnosis of postpartum depression. Moreover, of the disorders classified under perinatal mood and anxiety illnesses, the most common is postpartum blues. Up to 80% of women experience the postpartum blues, which is often referred to as the “baby blues.” (6,5) Similarly to postpartum depression, postpartum anxiety is paradoxically both common and difficult to diagnose because the symptoms are analogous to symptoms that typify the postpartum period. Signs of postpartum blues are often similar to some of those seen as signals of postpartum depression, including: exhaustion, anxiety, sometimes anger, changes in appetite, emotionally uncontrollable, and insomnia; however, there are clear dif-

ferences between the two. (7) The postpartum blues can appear as early as 3 days postpartum and usually subside shortly after, within the first two weeks of the postpartum period, without medical intervention. Additionally, the mother is able to safely care for herself and her child, there are no suicidal thoughts presented in the mother, neither verbalized by nor suspected and these symptoms are overall vastly more mild than those seen in postpartum depression. (2, 6)

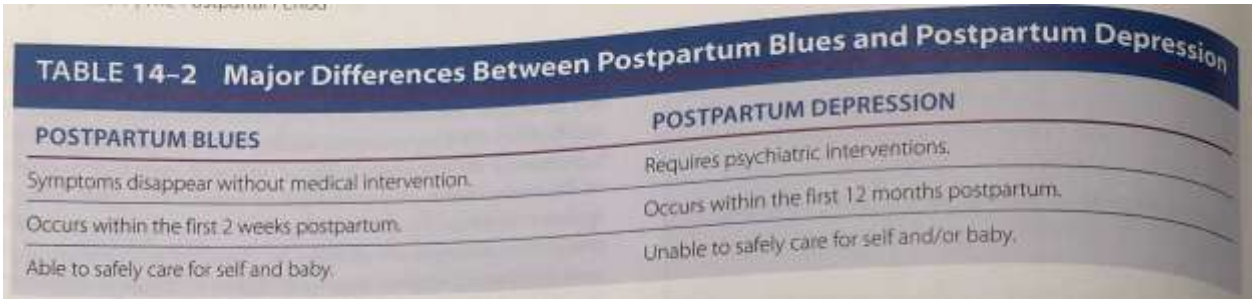

TABLE 14–2 Major Differences Between Postpartum Blues and Postpartum Depression

POSTPARTUM BLUES	POSTPARTUM DEPRESSION
Symptoms disappear without medical intervention.	Requires psychiatric interventions.
Occurs within the first 2 weeks postpartum.	Occurs within the first 12 months postpartum.
Able to safely care for self and baby.	Unable to safely care for self and/or baby.

Linda Chapman. Maternal-Newborn Nursing: the Critical Components of Nursing Care. F.A. Davis Company, 2019. Components of Nursing Care. F.A. Davis Company, 2019.

III. Causes and Risk Factors Associated with Postpartum Depression

Postpartum depression is extremely complex. It is a byproduct of many factors biologically, physically, emotionally, socially, genetic as well as case specific circumstances which render the etiology of the disorder unclear. However, there is evidence to show correlation between postpartum depression and contributing elements which are discussed as follows. (11)

Hormones secreted by glands of the endocrine system, including ovarian hormones (estrogen and progesterone) as well as those affiliated with the thyroid and HPA axis have shown relation to the provoking of and risk for postpartum depression. Sex hormones drastically change with pregnancy as the placenta develops and begins to produce progesterone to form a mucus plug, relaxin to prevent contractions until its release at the end of pregnancy to aid in birth and with preparation of the body for birth, and human

chorionic gonadotropin (hCG) which raises estrogen and progesterone level throughout pregnancy. (15) After birth and the subsequent expulsion of the placenta, these hormone levels plummet as the body begins to try to find pre pregnancy homeostasis. Thus, this radically affects the endocrine system, and creates a postpartum hormone withdrawal that can be instrumental in postpartum depression. (16 17)Thyroid function's role as a component of postpartum depression is that there is correlation between increased thyroid antibodies present in cases of depression during early gestation, postpartum, and perimenopause. (11 12) Further, in cases of those with postpartum thyroiditis, 30% of them will go through a period of hyperthyroidism which could manifest as a manic episode with the potential to turn into hypothyroidism which will show itself as depression. (13) With the introduction of the placenta during pregnancy, as an endocrine organ, the hypothalamic-pituitary-adrenal- axis undergoes substantial change. In turn, the change in hormones brought on by the placenta affects the HPA axis's ability to manage and balance the hormone secretions of its positive feedback loop. Further, the lack of regulation results in both a greater cortisol levels in prenatal woman as well as in placental corticotropin- releasing hormone can be useful as tools to indicate cause and aid in the prediction of those who are more at risk to experience postpartum depression. (14) Also, it is important to note that stress also releases the cortisol hormone, and that the amount of stress and consequent level of this hormone produced via the hypothalamus and pituitary can be a marker of those with a greater potential to suffer from postpartum depression. (18)

Environmental, social, and external circumstances additionally play a large part in exposure to postpartum depression. Lack of familial support, particularly from a partner increase, feelings of isolation particularly in first time mothers and marital status all be applied in the predication of postpartum depression. (19 20 10) Pregnancies that were either unplanned or unwanted, education, socioeconomic status, particularly those of low income show a higher likelihood of developing postpartum depression. (21 10) Woman who have previously suffered from a phycological disorder, particularly depression and anxiety and trouble child temperament, showed greater probability for postpartum depression. (10 23) Finally, woman who had unmet expectations, pain during the birthing

process, problems with or not breastfeeding at all, cesarean sections, use of forceps, and vacuum extractions showed can be agents in the transpiration of postpartum depression. (2 23 24)

IV. Signs, Symptoms and Diagnosing Postpartum Depression

It is exceedingly important that care providers take the time and the space to inquire as to how the mother is doing in the postpartum period. More often than not a woman who has just stepped into a new role as a mother feels overwhelmed and "…the extent to which a new mom is permitted to express her real feelings in a nonjudgmental atmosphere may affect the ease or difficulty of her adjustment." (25) Generally, a Postpartum Depression Screening Scale, the Edinburgh Postnatal Questionnaire and a Patient Health Questionnaire are the primary tools used to diagnose postpartum depression. (3) Yet, known and well documented causes and risks in addition to giving a mother the chance to communicate her experience of pregnancy, birthing, and postpartum have the potential to identify more cases of postpartum depression. Particularly because "less than 20% of woman who were diagnosed with PPD freely reported symptoms to their primary care provider." (2) In addition, because of the potential association between thyroid dysfunction and postpartum depression, a thyroid function test could be advantageous to obtaining a proper diagnosis. (13)

Signs and Symptoms of postpartum depression include:

- Agitation
- Anxiety or panic attacks
- Chronic exhaustion
- Emotional numbness
- Feelings of guilt
- Less responsive to the infant
- Loss of pleasure in normal activities
- Suicidal Thoughts
- Clumsiness
- Confusion
- Decreased or extreme changes in appetite

- Extreme cravings
- Difficulty relaxing or concentrating
- Hopelessness
- Inability to cope
- Frequent crying or inability to cry
- Inability to function
- Insomnia
- Loneliness
- Memory loss
- Nightmares
- Withdrawal from social contacts
- Joylessness
- Irrational over concern with baby well being
- Mood swings
- Detachment or withdrawal from infant

(6 7)

Moreover, if these symptoms being within the first month or even up to a year after birth, persist for longer than two weeks and are moderate to severe, it is likely that the woman is enduring postpartum depression. (6 7)

V. Treatment

As major depressive disorder, of which postpartum depression considered, there is not necessarily a cure; however, the objective with treatment is to manage it and maintain remission. The best way to mitigate postpartum depression is to recognize it either before it fully manifests or as early as possible. For many woman it is debilitating and terrifying to feel the way one does in the struggle with postpartum depression and even harder sometime to either see it or talk about these ideations. (6)

Despite the multifaceted and enigmatic nature of postpartum depression, the conventional resolution to postpartum depression includes two main tools: psychotherapeutic intervention and pharmaceuticals. The two psychotherapeutic interventions include

cognitive behavior therapy (CBT) and interpersonal therapy (IP). Cognitive behavioral therapy pertains to “how a person's thoughts, beliefs, and attitudes affect their feelings and behaviors.” (26) Interpersonal therapy is rooted in the two primary notions that depression is not the patients fault, they are not broken, helps delineate the problem as well as relieve help the individual let go of self blame. Also, interpersonal psychotherapy seeks the interface between the “ life events that either trigger or follow from the onset of the mood disorder.” (27) The second main source of relief in the traditional paradigm is the use of antidepressant drugs, primarily SSRIs or selective serotonin repute inhibitors. The main SSRIs used are Citalopram (Celexa), Escitalopram (Lexapro), Fluoxetine (Prozac), Fluvoxamine, Paroxetine (Paxil), and Sertraline (Zoloft). However, numerous studies and it is well documented that there are several negative implications of use of antidepressants while breastfeeding on infant development and behavior. (28 29 6) It is always important, in any model of care, to consider the simple impact of stress on the mother or trigger effect that breastfeeding has.

There is a greater context that a holistic lens can offer when working with a protocol for postpartum depression. Offering suggestions on prevention, alternative models of care for pregnancy in low risk woman, emotional support, use of herbs, use of flower essences, nutrition and supplements can greatly benefit a mother struggling with postpartum depression’s capability to cope. (6) Moreover, this framework of thinking about postpartum depression and the subsequent approach of care has great potential to creating happiness, joy, love, and and health in the relationship between the mother and her child as well as with the mother and herself. Furthermore, taking into consideration other externalities including barriers to care such as income and ethnicity as well as deep ancestral trauma which can genetically impact the next generation are instruments that are generally overlooked in the overall plan of care in a strictly conventional approach. (30 31)

A. Herbal actions and herbs to consider when working with postpartum depression, formulation, and treatment plans (6 32 33 34 35)
    1. Herbs to reduce anxiety and relax the nervous system
        a) Chamomile (Matricaria recutita)
        b) Lavender (Lavandula angustifolia)

c) Linden (Tilia sp.)
d) Milky Oats (Avena Sativa)
e) Motherwort (Leonurus cardiaca)
f) Passionflower (Passiflora incarnata)
g) Blue vervain (Verbena hastata)
h) Skullcap (Scutellaria lateriflora)
i) Valerian (Valeriana officinalis)
j) Kava kava (Piper methysticum)
k) St. Johns Wort (Hypericum perforatum) (if not using antidepressant therapy)

2. Tonic herbs for the nervous system
   a) Chamomile (Matricaria recutita)
   b) Lavender (Lavandula angustifolia)
   c) Milky Oats (Avena Sativa)
   d) Lemon Balm (Melissa officinalis)
   e) Eleuthero (Eleutherococcus senticosus)
   f) Ashwagandha (Withania somnifera)
   g) Ginseng (Panax ginseng)
3. Herbs for depression
   a) Saffron (Crocus sativus) , specifically indicated for use in postpartum Depression
   b) Eleuthero (Eleutherococcus senticosus)
   c) Ginseng (Panax ginseng)
   d) Gingko (Gingko biloba)
   e) St. Johns wort (Hypericum perforatum) (if not using antidepressant therapy)
   f) Rosemary (Rosmarinus
   g) Lemon Balm (Melissa officinalis)
   h) Cinnamon (Cinnamomum verum)
   i) Rose (R. canina)
4. Herbs that support functioning of the HPA axis, Adaptogens

a) Eleuthero (Eleutherococcus senticosus)
b) Ashwaghanda (Withania somnifera)
c) Ginseng (Panax ginseng)
d) Tulsi (Ocimum spp.) (best used in cases of ancestral trauma)

5. Herbs to aid with sleep
   a) Chamomile (Matricaria recutita)
   b) Passionflower (Passiflora incarnata)
   c) Skullcap (Scutellaria lateriflora)
   d) Lavender (Lavandula angustifolia)
   e) Hops (Humulus lupulus)
6. Ovarian/ sex hormone regulation herbs
   a) Vitex (Vitex agnus-castus)
   b) Dong quai (Angelica sinensis)
   c) Peony (Paeonia lactiflora)
7. Herbs to generally build blood, energy, and stamina
   a) Nettle (Urtica dioica)
   b) Fo-ti (Polygonum multiflorum)
   c) Dong quai (Angelica sinensis)
   d) Ginseng (Panax ginseng)
   e) Schisandra (Schisandra chinensis)
   f) Peony (Paeonia lactiflora)
   g) Licorice (Glycyrrhiza glabra)
8. Herbs to support the thyroid
   a) Ashwaghanda (Withania somnifera)
   b) Motherwort (Leonurus cardiaca),

Flower Essences that can be extremely helpful in supporting the emotional being in a struggle with postpartum depression.

<u>Flower Essences</u>

1. Buttercup: low self-esteem, seeing women traditional roles as inferior
2. Alpine Lily: feeling estranged from female body and deep feminine

3. Elm: despair about one's ability to fulfill responsibilities and expectations, over striving, for perfection fear that one will let down or disappoint other
4. Larch: fear of failure, paralyzed by anxiety
5. Olive: Depression steming from physical exhaustion
6. Pink Monkeyflower: fear of expression real feelings; fear of expressing real feelings; fear of judgement
7. Sweet Chestnut: intense personal anguish and suffering which presses the soul to a breaking point
8. Borage: cheerful courage
9. Arnica: easing shock and trauma of physical injuries
10. Mariposa Lily: receptive to human love, maternal nurturing; ability to mother and be mothered

(44)

Nutrition, Supplementation, and Lifestyle

In terms of nutrition and supplementation getting enough essential fatty acids (omega 3 and 6), B vitamins, zinc and iron can be seen helpful in treatment of postpartum depression. Making sure the mother is eating a nutrient dense diet that meets her caloric needs and making sure her blood sugar levels is helpful. Exercise, acupuncture, meditation and yoga can also help alleviate PPD. (6)

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