Postpartum Depression:
A Reflective Review of a Practicum completed with
St. Joseph’s Hospital

A Field Practicum Report
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Abstract

For every woman, having a baby is a challenging time, both physically and emotionally. It is natural for new mothers to have mood swings after delivery. They may experience feelings of joy one minute and desperation the next. These feelings are sometimes known as the “baby blues”, and often go away within 10 days of delivery. However, some women may experience a deep and ongoing depression which lasts much longer. This is called postpartum depression (PPD). This Practicum report is a review of the Practicum I completed, in conjunction with St. Joseph’s Hospital, in Estevan, Saskatchewan. The Practicum took place between the months of August 2010 to April 2011. The goals for this Practicum included the following: to ascertain whether there is a need for a PPD Support Group in Estevan, to facilitate a six week PPD Support Group, to gain an in depth understanding of PPD and its effects on women and their families, to improve my clinical skills, to strengthen my skills in program development, to create a hospital newsletter to help educate staff on PPD, to provide education at prenatal classes offered by Public Health, as well as to provide education at the Baby and Me classes offered at the Family Place. This report is divided into nine sections which include ideology, theory, values, ethics, relationships, strategies, skills and visions. I conclude that, with a combination of education and supportive services, postpartum depression can be de-stigmatized which would, in turn, encourage women to access services rather than living a life of hopelessness and despair.
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My parents, your support and unwavering love has helped build me into the woman I am today. Thank you for always encouraging me throughout my post secondary education, you taught me that I could succeed at anything I put my mind to. To my siblings, Jay and Darcy, I appreciate your love and support through this process. To Wayne and Karen, thank you so much for your support and encouragement. I feel extremely lucky to have you all in my life.

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Introduction

According to Beck (2002a), postpartum depression (PPD) can be likened to a “dangerous thief that robs mothers of the love and happiness they expect to feel towards their newborn babies” (p. 453). The devastating familial consequences of postpartum depression, along with the media attention given to women who have killed themselves or their children while depressed, have led to a heightened public awareness of this issue. Here in Saskatchewan a working group was developed to address this issue. According to the Maternal Mental Health Strategy (2010), the MotherFirst Working Group was created to “address the issues of inconsistent identification and treatment of women with maternal mental health problems” (p. 12). The goal of the Group is to make policy recommendations to the Saskatchewan Ministry of Health in order to better identify and treat maternal mental health issues. Currently, there are no provincial policy guidelines or treatment protocols regarding this issue.

According to the World Health Organization (2010) maternal depression is an increasingly urgent health concern and is identified as a leading cause of disability for women. According to Marcus, Flynn, Blow and Barry (2003) up to 20 percent of women suffer from depression related to pregnancy and childbirth. This would mean that approximately 2600 women living in Saskatchewan are affected by postpartum depression every year (Maternal Mental Health, 2010).

As a clinical social worker I have been working with women who have suffered from postpartum depression for almost nine years. This topic has always been of interest to me. In 2009 I attended a workshop which focused on postpartum depression entitled “The Smiling Mask” which was hosted in Regina, Saskatchewan. The women who
hosted the workshop were from the Regina area, and each one had been diagnosed with postpartum depression. These women discussed their experiences at the workshop. They subsequently wrote a book entitled *The Smiling Mask: Truths about Postpartum Depression and Parenthood* (O’Reilly, Paterson, Bird, & Collins, 2008). Throughout the workshop there was much discussion regarding the lack of resources in Saskatchewan for women suffering from postpartum depression. The women stated that they would not have been able to recover without treatment from the medical community, including support provided by counsellors (O’Reilly et al. 2008). During the workshop, these women also discussed the benefits of attending a Postpartum Depression Support Group facilitated in Regina. When it came time for me to propose a practicum I chose to focus my studies on PPD. In Estevan, the only support for these women is the Mental Health Clinic. Therefore, I proposed a practicum placement at St. Joseph’s Hospital with the focus being on whether there is a need for a Postpartum Depression Support Group in Estevan. I thought this would be an opportunity not only to provide a service to these women, but to also learn how the needs of this population can best be met in a community the size of Estevan where the population is approximately 10,000 people (Statistics Canada, 2006). I also saw this as an opportunity to extend and enhance my own skills as they relate to postpartum depression and its effects on women and their families. I developed several goals for my practicum:

1. To ascertain whether there is a need for a PPD support group in Estevan, Saskatchewan.

2. To facilitate a six week pilot PPD Support Group.
3. To gain an in depth understanding of PPD and its effects on women and their families.

4. To improve my clinical skills.

5. To strengthen my skills in program development.

6. To create a hospital newsletter to help educate staff on PPD.

7. To ensure that there is information on PPD readily available on the Obstetrics Unit at St. Joseph’s Hospital.

8. To be more visible to staff at St. Joseph’s Hospital.

9. To hang information posters specific to PPD as designed by the Maternal Mental Health Committee in each room on OBS as well as in the Emergency Room, Public Health and Mental Health.

10. To provide education at the prenatal classes offered by Public Health.

11. To provide education at the Baby and Me classes offered at the Family Center.

12. To complete a review of online resources available on PPD and create links to the Sun Country Health Region website.

13. To advocate for St. Joseph’s Hospital to provide a copy of “The First 100 Days of Motherhood” to all first time moms.

As my practicum placement was arranged in conjunction with St. Joseph’s Hospital, it is important to provide some information on the Facility. Seventy years ago, the Sisters of St. Joseph of Peterborough opened the first St. Joseph’s Hospital in Estevan. The Sisters were instrumental in both the funding and the staffing of the new state of the art facility. Although the Sisters are no longer active in the day-to-day operations of the Hospital, their spiritual presence is a testimony to their perseverance.
and faith. A new hospital was built in 1991 and presently accommodates the community’s medical needs and houses many of the Sun Country Health Region programs such as Home Care, as well as the Public and Mental Health Clinics. St. Joseph’s Mission is: "To Provide People with the Highest Quality of Holistic Care" – Our Vision: "A Welcoming and Healing Place" (St. Joseph’s Hospital, 2009).

This report will describe my practicum at length. This will include information on signs and symptoms of postpartum depression as well as risk factors and the effects of PPD on women and their families. I will then discuss the ideological and theoretical frameworks that directed my work. I will also discuss values and ethical issues as they pertain to my practicum. In addition, I will discuss the various relationships that evolved from the practicum and how they relate to the hospital, community and clients. Finally, I will discuss the strategies and skills I used and learned throughout the practicum. The report will conclude with my vision, as a social worker, as to how the needs of this population can best be met. I will make recommendations of my own as well as outline those suggested by the Maternal Mental Health Strategy (2010). Throughout the report I will quote testimonials from women, living in Saskatchewan, who experienced postpartum depression. These testimonials were taken from the Maternal Mental Health website, they were obtained during the interviews that group did as part of their research. These women’s words can give an accurate idea of how consuming and life altering postpartum depression was for them and their families.

_A testimonial from Sherry - North Battleford, SK_

_With each of my four pregnancies I experienced a different, but progressively worse form of Maternal Depression. It started with extreme weight loss and anxiety after our first_
baby was born. With our last pregnancy, I experienced Antenatal Depression, which means it started during my pregnancy with high anxiety, mostly at night, that someone would take our third child. I had a routine of checking on him and making sure doors and windows were locked, even through the night. I was working hard to avoid anxiety and depression I had had previously, but shortly after I gave birth a close family friend passed away and my brother checked into a rehabilitation center.

My Post Partum Depression was the deepest and darkest it had ever been. I never wanted to harm my children, I lived every moment in fear that someone else would. Paranoia, fear, and anxiety were my core emotions and I put on a numb smile for my children. Even with a history of Post Partum Depression, I struggled to find help. When I was brave enough to ask for it, I could not find it.

My family physician was our only saving grace; he understood Post Partum and how I was feeling. With hesitation, I began the medications he prescribed and the healthy lifestyle suggestions. I avoided triggers, journaled, ate healthy, exercised, did daily devotions, and got as much rest as possible. Together my husband and I found our way out of the darkness by talking with our support team, working hard every day on a healthy lifestyle, praying together, and becoming educated about Maternal Depression (Maternal Mental Health Strategy, 2010).

**Ideology**

Postpartum depression is a term used to cover a variety of emotional problems that can affect the mother after giving birth. In my opinion, it is imperative to provide information about this population and their experiences. In this section of the report, I
will discuss PPD including signs and symptoms of the illness, risk factors as well as long
term consequences of PPD on women, their families and children.

According to Corwin and Pajer (2008), there is no single definition of postpartum
depression but rather it is described as a group of symptoms that can negatively affect the
mother once her baby is born. The authors suggest that symptoms women experience
after giving birth may change their mood, behavior and outlook on life. Leis, Mendelson,
Tandon-Debroah and Perry (2009) state that postpartum depression can begin in
pregnancy, after birth, or anytime within the entire first year; and that the symptoms
range from mild blues to total despair. Serious depression is considered to be a constant,
intense, sad feeling that lasts two weeks or more (Corwin & Pajer, 2008). It is important
to note that postpartum depression is a treatable illness (Corwin & Pajer, 2008; Leis et al.
2009). Signs and symptoms of postpartum depression can include depressed mood or
extreme sadness, severe mood swings, feelings of shame, guilt or inadequacy, feelings of
worthlessness or hopelessness, crying spells for no apparent reason, thoughts of harming
self or baby, feelings of inadequacy or resentment towards the baby, difficulty bonding
with the baby, excessive worrying, panic attacks, changes in sleep or appetite,
restlessness, lack of energy, difficulty concentrating, intense irritability or anger, and
withdrawal from family, friends, and social interactions (Wiegartz & Gyoerkoe, 2009).

Forman, Videbech, Hedegaard, Salvig and Secher (2000) outline several risk
factors for postpartum depression which may include a previous history of major
depression or postpartum depression, family history of depression or psychiatric illness,
diagnosis of Bipolar Disorder, hormonal fluctuations, chronic sleep deprivation, recent
stressful life events during the past year, including illness, job loss or pregnancy
complications, financial problems, high expectations of self, lack of support from family or friends, isolation, as well as medical complications for the mom and baby. In addition, women can be at risk for developing postpartum depression if their birthing experience does not go as planned or if they have a colicky or hard to care for baby. Lastly, it is important to point out that many women struggle after giving birth due to their loss of freedom, identity and self esteem which may also trigger postpartum depression (Forman et al. 2000).

According to Wan and Green (2009), postpartum depression is a serious illness which, if not treated, can have long term consequences for both the mother and her infant. If the woman’s postpartum depression remains untreated, she may go on to develop a chronic mental illness thus diminishing her quality of life. If the postpartum depression is severe, the mother is at an increased risk of suicide (Wan & Green, 2009). Wan and Green (2009) suggest that, in severe cases of postpartum depression, some women may experience postpartum psychosis which is a rare but serious mental stress disorder triggered within a few months after childbirth. A mother suffering from postpartum psychosis may experience hallucinations, irrational thoughts, and sleep deprivation. According to Wiegartz and Gyoerkoe (2009), women experiencing postpartum psychosis are unable to distinguish reality from their intrusive thoughts and are at an increased risk of infanticide, or even suicide. Both of these potential outcomes are tragic consequences of an untreated illness that is quiet treatable. Wachs, Black and Engle (2009) point out that, infants are exquisitely sensitive to the emotional states of their mothers. The infant of a chronically depressed mother may develop insecure attachments with subsequent difficulties in interpersonal relationships. Infants of mothers who are depressed may
typically cry more, look away or show less emotion than infants of mothers who are not depressed (Wachs, et al. 2009).

Korja et al. (2008) argue that there are serious physical and emotional consequences for untreated maternal depression for mothers, infants, and families. Postpartum depression may impact risk behaviors during pregnancy, fetal development, birthing outcomes, the establishment of relationships, the development of infants and the well being of other family members. Women who are depressed are more likely to self medicate with alcohol, drugs, and tobacco and are less likely to have adequate prenatal care. Their pregnancies are more likely to end prematurely, and they are more likely to have obstetrical complications. Their babies are also at increased risk for lower birth weight, and less frequent and shorter duration of breastfeeding (Korja et al. 2008).

According to Stewart (2007) and Bonari et al. (2004), postpartum depression is a significant risk factor affecting the healthy development and well-being of infants and young children. The babies of depressed women are at increased risk for pre-term birth and low birth weight. Wiegartz and Gyoerkoe (2009) point out that a mother’s experience of depression affects her ability to bond and interact with her infant. Mothers who are depressed may have trouble caring for their children. They may be loving one minute and withdrawn the next or they may not respond at all to their child, or respond in a negative way. Postpartum depression can and often does affect a mother’s ability to care for her child (Wiegartz & Gyoerkoe, 2009).

According to Bonari et al. (2004) and Kurstjens and Wolke (2001) postpartum depression can affect attachment, which is important for a child’s development. Bonari et al. (2004) describe attachment as a deep emotional bond that an infant forms with the
person who provides most of their care, which is often the mother. A secure attachment develops quite naturally. A mother responds to her crying infant, offering whatever she feels her baby needs which can include feeding, a diaper change and cuddling. Bonari et al. (2004) point out that secure attachment helps the infant protect against stress and is an important part of an infant’s long-term emotional health as it makes them feel safe and secure as well as helps them to learn to trust other people. If a woman is depressed, she may have trouble being loving and caring with her infant; this in turn can lead to attachment issues which can cause problems later in childhood (Bonari et al. 2004; Kurstjens & Wolke, 2001).

According to Bonari et al. (2004) and Stewart (2007) children of mothers who are depressed are more likely to experience growth, attachment, psychological, cognitive, behavioral, and developmental problems than the children of mothers who are not depressed. Stewart (2007) and Talge, Neal and Glover (2007) point out that these children are more likely to have attention deficit hyperactive disorder, depression and autism. There is also a connection with increased criminality and social and school difficulties for these children (Feinberg et al. 2006; Goodman & Gotlib, 1999; Stewart, 2007). Long term physical effects are also possible, as there is evidence that the prenatal environment exerts influence on fetal health that, in turn, impacts the health of the adult many decades later (Stewart, 2007; Talge et al. 2007).

Kurstjens and Wolke (2001) discuss areas in which developmental problems may arise in children whose mothers experience postpartum depression. The researchers found that young children of depressed mothers have been rated as more drowsy, passive, more temperamentally difficult, less able to tolerate separation, and more afraid or more
anxious, than children of nondepressed mothers (Kurstjens & Wolke, 2001). As mentioned earlier, mothers suffering from postpartum depression are often less involved with their children (Bonari et al. 2004; Kurstjens & Wolke, 2001). In these cases the women have found to be slow to respond to overtures for verbal or physical interactions by their children, they are more critical towards their children and have difficulty in encouraging the child’s speech and language facility (Kurstjens & Wolke, 2001; Trapolini, McMahon, & Ungerer, 2007). In addition, these women often have difficulty asserting authority and setting limits with their children which affects the child’s ability to learn how to regulate his or her behavior. The authors point out that these women interact less with their children and derive less pleasure from them (Trapolini et al. 2007). They talk less to their infants, have difficulty in providing appropriate stimulation and are often less aware of and responsive to their infant’s cues (Kurstjens & Wolke, 2001; Trapolini et al. 2007). On the other hand, Kurstjens and Wolke (2001) point out that some depressed mothers interact excessively and overstimulate their infants. In either understimulation or overstimulation, mothers are not responding appropriately to their infant’s cues and thus are not providing the appropriate feedback that enables infants to learn to adjust their behavior. Children mirror their mother’s moods and, even at a young age, the children of depressed mothers have been shown to be overly sensitive to their mothers negative moods (Kurstjens & Wolke, 2001; Trapolini et al. 2007). Given their struggles, some mothers draw the child into inappropriate closeness and inappropriate identification with their own mood. Children who are preoccupied with the reactions of their mothers may not learn to seek or accept comfort for their own needs. As a result,
their own activity and ability to express emotion may not develop appropriately (Kurstjens & Wolke, 2001; Trapolini et al. 2007).

The consequences of postpartum depression also affect partners of depressed women. According to Goodman (2004), up to 50% of women who are diagnosed with postpartum depression have partners who also experience depression. The author suggests that maternal depression was identified as the strongest predictor of paternal depression. This compounds the effect on infants as both parents struggle to achieve mental well-being (Goodman, 2004). As explained in this section of the report, the effects of PPD can be devastating, not only for women, but for their children and families as well.

**Theory**

In this section I will describe different theoretical perspectives of postpartum depression and the interventions derived from each perspective. Lasiuk and Ferguson (2005) describe theory as being the creative structuring of ideas that project a view of a certain phenomena. Theory serves to organize knowledge and to advance the development of that knowledge. Theory may also identify the parameters of a discipline, provide means for addressing disciplinary problems and provide ideas about a certain phenomena of interest to that discipline. Theory is abstract, and it is a mental conception or an idea that represents things or events that are happening in the world (Lasiuk & Ferguson, 2005). According to Lewis and Bolzan (2007), theories in social work attempt to explain situations and social relationships. These theories were developed after it became clear that there were similar patterns or repeating cycles of behavior in people’s lives.
Lewis and Bolzan (2007) suggest that theory can help guide therapeutic practice in that they can help clinicians make sense of a situation. Using theory, clinicians can generate ideas about what is going on, why things are as they are, and so on. Using theory can help to justify actions and explain practice to service users, carers and society in general. In work with individuals, making use of the theories which may relate to their specific situation will give clinicians more direction in working with clients. Using theory can give an explanation about why an action resulted in a particular outcome. This can help clinicians review and possibly change practice in an attempt to make the outcomes more effective; which shows that theory is an important part of a clinician’s therapeutic practice. I will review four theoretical perspectives in this section of the report. These perspectives include the medical model, feminist theory, attachment theory and interpersonal theory. I chose to focus on these theories as the literature shows that they are used the most in current treatment of postpartum depression.

**Medical Model**

Although the medical model is not a theory, I have chosen to include it in this section because it is the model many professions still utilize when treating postpartum depression. According to Berggren-Clive (1998), the medical model is a widely used perspective in attempting to understand and treat postpartum depression. From this point of view, postpartum depression is considered to be an “illness and a medical condition” (Beck, 2002b, p. 283). According to Berggren-Clive (1998), it is suggested by the medical model that, following birth, estrogen and progesterone levels drop significantly. As a result, according to this perspective, these hormones play a direct role in areas of the brain related to depression and they also may affect neurotransmitters related to
depression. In addition, levels of thyroid hormones also drop after birth which the medical model suggests can cause depressive symptoms. This perspective further adds that an imbalance of neurotransmitters, independent of hormone levels, may also be a cause of PPD (Berggren-Clive, 1998). Mauthner (1993) and Beck (2002b) further suggest that, in this approach, postpartum depression is best treated by pharmacological interventions such as antidepressants.

Using this model, social and environmental conditions are rarely considered, and instead, the focus is put on the individual and their medical condition (Beck, 2002b; Berggren-Clive, 1998). According to Beck (2002b), the medical model views postpartum depression as a “pathological condition based on the deficiencies in the individual mother” (p. 283). In addition, Mauthner (1993) suggests that economic, social and political contexts of the mother’s life are excluded when using the medical model. Hightet and Drummond’s (2004) research both supported and advocated for the application of psychological treatment of postpartum depression rather than strictly using the medical model. They argue that it is important to offer alternatives to medication stating that many women prefer not to take an antidepressant, especially when they are breastfeeding. Mauthner (1993) argues that the medical model portrays women as passive individuals who are suffering from biological deficits. There are several therapies and approaches that fit with the medical model and are utilized accordingly. I will discuss light therapy and pharmacological interventions (medications) as they relate to the treatment of postpartum depression within this perspective.
**Light Therapy**

Oren et al. (2002) discuss the treatment of light therapy in women suffering postpartum depression. Light therapy has been shown to stimulate alertness and increase production of antidepressant neurochemicals in the brain. Some depressed mothers have experienced an improvement in their symptoms of postpartum depression after exposure to these bright, artificial lights. This light is the equivalent of being outside on a sunny day. Exposure in the morning for thirty minutes for four weeks has been shown to be effective for PPD (Oren et al. 2002). Further research still needs to be conducted about light therapy but this is an option to be considered (Oren et al. 2002).

**Medications**

Hendrick, Altshuler, Strouse and Grosser (2000) discuss the use of antidepressants in the treatment of postpartum depression. Antidepressant medications work to regulate the levels of various neurotransmitters that are related to mood. There are different groups of antidepressants, each having a slightly different effect on the neurotransmitters. These medications can be prescribed by a family physician or a psychiatrist. It may take four to six weeks to discover if the antidepressant will actually work for the individual and in some cases, it is necessary to try more than one medication. There are often side effects related to the use of antidepressant medications, and both doctor and patient should weigh the benefit of using the drug against the possible side effects. The most commonly used antidepressants in postpartum depression are Selective Serotonin Reuptake Inhibitors (SSRI), such as Celexa, Paxil, and Prozac (Hendrick et al. 2000).
Feminist Theory

Hill and Ballou (1998) suggest that, because many of the risk factors of postpartum depression are psychosocial in nature, then a logical treatment would utilize an approach based on feminist theory. According to Beck (2002b), feminist theory opposes the medical model’s approach to postpartum depression stating that terms like “disease and illness hide the social nature of women’s problems” (p.283). Beck (2002b) and Hill and Ballou (1998) state that feminist writers argue that postpartum depression can be related to the high standards of motherhood which they see as being imposed by the medical model.

Highet and Drummond (2004) and Davis-Gage, Kettmann and Moel (2010) propose that feminist counselling was developed as a response to a discontent with more traditional services being offered to this population. In this context, feminist counsellors are seen to be more knowledgeable about problems that women may typically experience, and how these problems may be related to their experiences of postpartum depression. The authors argue that feminist counselling takes into account the client’s individual experiences and then helps her to understand these experiences within the context of society. Feminist counselling respects the world view of women in that women tend to focus more on caring for others and relationships than they do on individual achievement and accomplishments. In addition, the feminist approach acknowledges that most problems addressed in a counselling setting are influenced by expectations put on women by society and their culture (Highet & Drummond, 2004; Davis-Gage et al. 2010).
Davis-Gage et al. (2010) and Mauthner (1993) suggest that empowering the client is a central feature of feminist theory. Feminist counselling utilizes techniques the client can use to take charge of her condition, thus the client is encouraged to become the expert regarding her individual needs. According to Davis-Gage et al. (2010), women tend to value relationships and integrate these relationships into their decision making process. Understanding this is key when counsellors are working with this population of women from a feminist perspective. According to Davis-Gage et al. (2010), goals of feminist counselling include: equality in relationships as well as gender roles, empowerment of self, and acknowledgement of cultural differences. Working with partners and families of women experiencing postpartum depression from a feminist perspective can create space for examining dynamics in the relationship. This can be of importance when working with couples who are adjusting to their new roles of being parents and looking at how this has affected their roles as partners.

Creedy and Shochet (1996) outline four processes of treatment when using a feminist cognitive approach to the treatment of postpartum depression. Utilizing feminist theory with a cognitive approach can help the woman recognize which life problems are critical, and which are minor. This type of therapy can also help the woman to develop positive life goals and a more positive self-assessment. Using a feminist cognitive approach to treat postpartum depression would include debriefing the experience of pregnancy and birth as mothers need to be given the opportunity to express feelings they may be experiencing in their new role as a mother. The second aspect of this process focuses on dealing with conflicts about the woman’s identity which include venting her feelings and working through these feelings. The third step is to gain a sense of survival
and the development of a new perspective. Throughout this step the feminist cognitive behavioral counsellor would assist the mother in reestablishing her own identity through developing an understanding of the emotions she is feeling. The last step of this process is for the mother to develop a new perspective regarding her experiences of childbirth. It is thought that the steps of this process will result in the woman acquiring a new perspective of this experience and see it in a more positive manner. (Creedy & Shochet, 1996).

In summary, the feminist approach to counselling for the treatment of postpartum depression would provide the clients with the skills and knowledge necessary to manage expectations related to traditional gender roles that may be contributing to their suffering (Highet & Drummond, 2004; Davis-Gage et al. 2010). While maintaining a respect for cultural differences, this approach encourages women to break free from traditional expectations of motherhood which often expect them to balance the responsibilities of caring for their children while maintaining their home. The feminist model argues that empowering clients to challenge power imbalances in their relationships leads to increased feelings of self worth which could help decrease their symptoms of postpartum depression (Highet & Drummond, 2004; Davis-Gage et al. 2010; Kettmann & Moel, 2010).

Attachment Theory

According to Whiffen and Johnson (1998), attachment theory provides an interpersonal framework for conceptualizing and treating postpartum depression when it occurs in the context of relationship distress. Attachment theory developed originally as a description of infant-caregiver relationships. The term attachment is used to describe
the affective bond that develops between an infant and a primary caregiver (Whiffen & Johnson, 1998). It was believed that this attachment was one of four behavioral systems that are innate and necessary for the survival of humans. Whiffen and Johnson (1998) point out that the quality of attachment evolves over time as the infant interacts with his or her caregivers. In recent years, attachment theory has been extended to the study of intimate relationships and it is now also being applied to the treatment of clinical problems in couples and families (Whiffen & Johnson, 1998).

According to Goodwin (2003), attachment theory assumes that an adult who has been neglected as a child will have a difficult time developing genuine, affectionate relationships. In this case, these people have a difficult time getting close to others or are convinced that they are not worthy of love and therefore distrust anyone who tries to get too close. Goodwin (2003) points out that these feelings can lead to symptoms of depression and feelings of worthlessness. Bettmann (2006) suggests that trusting attachments with others provide a sense of worth and esteem for those who are convinced they are unlovable. The author believes that there is a correlation between trusting attachments in relationships and the elimination of depressive symptoms (Bettmann, 2006).

As suggested by Goodwin (2003), attachment theory proposes that children learn that they are lovable and that others are reliable and responsive to their needs by having parents or other attachment figures who treat them with love and demonstrate an interest in them and a concern for their safety. In today’s society, an individual’s life partner is the primary attachment figure for most adults (Whiffen & Johnson, 1998). Partners who are warm and emotionally available may mirror an image of themselves as being lovable
and worthy. In contrast, those partners who are cold, critical and disengaged give their spouse the impression that they are unlovable, defective and unworthy. If interactions with attachment figures tell the individual that they are unlovable or unimportant, they naturally become distressed. Human beings will still attempt to meet their needs for connection and validation in their closest relationships. However, when these relationships are distressed, their attempts may inadvertently maintain or exacerbate their emotional distress (Whiffen & Johnson, 1998).

In relation to postpartum depression, the thought is that a woman may develop postpartum depression when her attachment needs are not being met by her partner (Beck, 2002b; Whiffen & Johnson, 1998). The authors propose that mothers and fathers rely on each other for support, especially during parenthood. When both individuals are securely attached to one another, they will respond appropriately to each other’s needs for support and reassurance. However, if either parent is insecurely attached, then problems can occur that could lead to postpartum depression. In this case, the depressed mother may feel abandoned by her unresponsive spouse. This feeling can be exacerbated in cases where men are not actively involved in daily care of the infant (Beck, 2002b; Whiffen & Johnson, 1998).

A treatment approach for PPD which incorporates attachment theory would argue that improving the marital relationship is the main concern, and that the attachment between mother and father needs to be re-established. Beck (2002b) and Whiffen and Johnson (1998) suggest that a way to do that is through emotionally focused marital therapy (EFT). According to Dessaulles and Johnson (2003) and Denton (2008), emotionally focused marital therapy enables couples to identify and break free of their
destructive emotional cycles, such as when one person in the couple criticizes and the other withdraws. This therapy helps couples build trust in one another, and can also help the mother get to know herself again, which in turn may elicit new responses from her spouse. According to Dessaulles and Johnson (2003), the therapist then uses EFT attachment-based interventions to shape new interactions and new emotions between the couple. This can help the couple move from being angry to a point where they can express feelings of fear and longing which can cause the other partner to feel care and compassion which fosters the contact the couple longs for (Dessaulles & Johnson, 2003).

Denton (2008) describes EFT as an attachment-oriented therapy which assumes that reshaped emotions and emotional signals and new sequences of responsive interaction are necessary in order to transform an attachment relationship. This approach addresses this issue as core to forging satisfying and meaningful relationships. Attachment longings are wired into our brains and the tendency to reach, trust, comfort and care are always there, even if unrecognized or denied (Denton, 2008). The tendency to respond to hurtful disconnection by shutting down or attacking is also always there, and can become habitual for all of us. According to Denton (2008) the therapist guides the couple into positive cycles of engagement and trust. The therapist also helps the couple to connect with their own fears and longings, and then express these feelings to their partner in a way that draws them closer to one another.

According to Johnson, Hunsley, Greenberg and Schindler (1999) and Denton (2008), when couples can connect, positive bonding will take place. Partners begin to see each other more fully and are more authentic and compassionate with each other. Their connection empowers each of them and opens the door to all the benefits that will come
with feeling a sense of attachment from a spouse. Denton (2008) states that EFT leads to a new understanding of how to create forgiveness for injuries in attachment relationships. A new understanding of love also extends the reach of the couples therapy according to this perspective. EFT is used to create safe-haven relationships for those who are traumatized. The thought is that, if individuals can heal relationships, they can also create relationships that heal. The author states that a safe, loving relationship can help ease the woman’s symptoms of postpartum depression. If a mother is feeling more connected to her partner and child, she is going to be happier in her day to day life (Denton, 2008).

**Interpersonal Theory**

According to Grote, Bledsoe, Swartz and Frank (2004), interpersonal theory (IPT) views humans as social beings whose personalities are determined by their interpersonal experiences. The theory proposes that people use feelings of security to decrease anxiety which results from negative reactions to people they see as being significant in their lives. Interpersonal theory does not presume that psychopathology arises exclusively from problems within an interpersonal realm. It does emphasize however, that these problems occur within an interpersonal context that is often interdependent with the illness process (Grote et al. 2004).

According to Grigoriadis and Ravitz (2007), the application of interpersonal therapy for the treatment of postpartum depression is useful for several reasons. First, many pregnant and breastfeeding women prefer not to use medication under any circumstances for fear it will adversely affect their child. Second, it is well documented that postpartum depression is associated with the development of attachment and
behavior problems in children. Similarly, depression during pregnancy is associated with poor prenatal health and a risk for delivery complications. Consequently, the authors argue that interpersonal psychotherapy is an effective and well accepted alternative to antidepressant medication (Grigoriadis & Ravitz, 2007).

Grote et al. (2004) have found interpersonal therapy useful to conceptualize most cases of maternal depression as it pertains to role transitions. Placing postpartum depression within this problem area provides a reasonable rationale for women to understand their problems. The authors suggest that this type of therapy makes sense to most women (Grote et al. 2004). Role transitions in the postpartum period are typically associated with the need to develop new parenting skills and the ability to manage new responsibilities while attempting to maintain old relationships. The authors believe that new mothers may find themselves in the position of having to juggle several different roles, each with increasing demands (Grote et al. 2004). A decrease in self-esteem is often the result, as well as confusion regarding which relationships and responsibilities should be given priority. Though it is infrequent that familiar social supports are lost entirely, the thought is that these supports may have to be modified (Grote et al. 2004).

According to Grigoriadis and Ravitz (2007), a typical example of role transition during the postpartum period may be that of a working woman who is now faced with the role of being a mother in addition to her previous roles of a spouse and an employee. In such a situation, the woman may become overwhelmed if she is unable to reconfigure her time, priorities, and emotional commitments. A difficult spouse or employer could easily exacerbate the problems faced by a woman experiencing postpartum depression. Grote et al. (2004) discuss a strategy often used to assist women with understanding the types of
relationships she has with her spouse and her employer, and her expectations about those relationships. The mother is assisted with developing a balanced view of her needs, and the degree to which they are being met. The therapist then assists the patient to clearly communicate her needs to her significant others as the relationships are re-negotiated (Grote et al. 2004).

According to Grigoriadia and Ravitz (2007), through the use of interpersonal therapy, the woman learns that other people in her life have also undergone significant role transitions. The mother’s husband or significant other must also make significant adjustments as he takes on the role of father. The same is true to a lesser degree for extended family members. The authors suggest that interpersonal disputes are also quite frequently associated with women suffering from postpartum depression (Grigoriadia & Ravitz, 2007). Pre-delivery, disputes frequently involve changes in the woman's relationship with her significant other. Grigoriadia and Ravitz (2007) stated that this is particularly true of women with poor social supports, and those from lower socioeconomic backgrounds. Typical postpartum conflicts involve disputes between the woman and her partner regarding child care responsibilities, and conflicts with extended family members regarding the management of her newborn. The authors suggest that therapists thoroughly explore the expectations the patient had prior to delivery, as well as examining the communication patterns found within the conflict (Grigoriadia & Ravitz, 2007).

Grote et al. (2004) suggest that it might be helpful for the therapist to include the woman’s significant other in one or two therapy sessions, especially when role transitions or interpersonal disputes are an issue. The purpose of this includes obtaining information
about the mother’s behavior, examining in detail the alternative point of view of the other party in the dispute, and allowing the therapist to examine interactions between the woman and her significant other. The authors suggest that psychoeducational information can be provided to the partner as well. This may involve information about the effects of delivery on the body, including normal sexual changes and sexuality during the postpartum period (Grote at al. 2004).

According to Grigoriadis and Ravitz (2007), many of the interpersonal problems of social adjustment women with postpartum depression face can be addressed by interpersonal therapy because it focuses on current personal relationships. The authors point out that, although interpersonal therapy recognizes the role of biological and psychological factors in the cause of and vulnerability to depression, it focuses on social factors and working through interpersonal problems to alleviate depression (Grigoriadis & Ravitz, 2007). According to Miller (2002) and Bledsoe and Grote (2006), interpersonal therapy offers an effective, specific, problem-focused, short-term approach to the treatment of postpartum depression. Bledsoe and Grote (2006) argue that strengths of this therapy include the empirical support; the focus on universal relational experiences of loss, change, or conflict; and the fact that the goals and techniques of interpersonal therapy are easily accessible for clinicians. The authors point out that interpersonal therapy manuals clearly articulate the goals of therapy and standardized techniques (Bledsoe & Grote, 2006).

Grote et al. (2004) note that brief therapies, including interpersonal therapy, are not suitable for all patients. Accessing interpersonal therapy can be difficult, especially in rural or remote regions. The authors suggest that there is room for development of
alternative methods of delivering psychotherapy, such as by telephone or over the Internet. Grote et al. (2004) suggest that this therapeutic approach is a relevant and effective treatment for women suffering from postpartum depression because it helps address the many interpersonal stressors that arise during the postpartum period. The principles of interpersonal therapy can be integrated easily into primary care settings given that this therapy is pragmatic, specific, problem focused, short-term, and highly effective (Grote et al. 2004).

There are many other therapies, approaches and interventions that fit with feminist, attachment and interpersonal therapy discussed earlier in this section. Given the fact that many of these strategies are often used in conjunction with feminist, attachment and interpersonal therapy, I feel it is important to give a brief overview of these other approaches. To this end, what follows is an overview of the Edinburgh Postnatal Depression Scale, marital therapy, cognitive behavioral therapy, psychoeducation and group therapy.

**Edinburgh Postnatal Depression Scale**

The Edinburgh Postnatal Depression Scale (EPDS) has been developed to assist primary care health professionals to detect mothers suffering from postpartum depression. According to Bunevicius, Kusminskas, Pop, Pederson and Bunevicius (2009), the EPDS was developed at health centers in Livingston and Edinburgh and consists of ten short statements. The mother is directed to identify which of the four possible responses that are provided is closest to how she has been feeling over the past week. The lowest score on the Scale is 0, meaning the woman is not showing symptoms of PPD and the highest is 30 which means the client is displaying all the symptoms of
PPD. Most mothers complete the scale without difficulty in less than 5 minutes. The authors argue that the EPDS score should not override clinical judgment, and that a clinical assessment should always be carried out as well as consultation with a medical doctor who is qualified to diagnose PPD (Bunevicius et al. 2005). The scale indicates how the mother has felt during the previous week and, in cases where the clinician cannot get a clear sense of the client’s state, it may be usefully repeated after two weeks. Dennis (2004) feels that, in light of time constraints and limited resources, the quality of care provided to new mothers could be “significantly enhanced” by the use of the EPDS in conjunction with clinical evaluations (Dennis, 2004, p. 168).

**Family and Marital Therapy**

Marital and family problems are common when dealing with postpartum depression (Misri, Kostaras, Fox & Kostaras, 2000). Marital therapy assists couples in working more effectively as a couple and in cultivating mutually acceptable problem-solving strategies. A marriage is similar in its development to individual and family development in that there is a marital life cycle that has fairly predictable stages. After the birth of a baby, the husband or partner also goes through an adjustment period. For some couples, according to Misri et al. (2000), a baby can strengthen a couple’s relationship, while for others, having a baby can cause strain on the relationship. The roles of the partner and family are essential if the mother is experiencing postpartum depression. Misri et al. (2000) point out that a stable marital relationship helps new parents adapt to the demands of raising a child together and the impact this can have on the marriage. In comparison, a poor marital relationship can contribute to depression and
anxiety. Techniques for marital and family therapy most often involve psychoeducation, behavioral approaches and supportive counselling (Misri et al. 2000).

**Cognitive Behavioral Therapy (CBT)**

According to Miller (2002), cognitive behavioral therapy (CBT) is an action oriented form of psychotherapy that assumes faulty thinking patterns cause negative emotions. The treatment focuses on changing an individual's thoughts, or cognitive patterns, in order to change their behavior and emotional state. Cho, Kwon and Lee (2008) demonstrate the efficacy of CBT in patients with postpartum depression. CBT changes negative cognitive distortions and aids in the development of coping behaviors. Cho et al. (2008) point out that cognitive behavioral therapy tends to help people take an active role in dealing with their depression. Miller (2002) points out that CBT has no side effects. It is important to note that, for CBT to work, the individual needs to have some motivation that many women experiencing postpartum depression may not have, especially if their depression is severe (Miller, 2002; Cho et al. 2008).

**Psychoeducation**

Psychoeducation is one component of many types of psychotherapy for postpartum depression. Education for women experiencing symptoms of postpartum depression, as well as their families, is an important part of all treatment programs whether they include counselling, medical intervention, self-help or a combination of approaches. The main goal of psychoeducation is to help the woman and her family understand postpartum depression, available treatment options, and ways to manage their symptoms successfully (Wiegartz & Gyoerkoe, 2009).
**Group Therapy**

According to Parkinson (2009), group therapy can provide emotional and social support for women experiencing similar difficulties with motherhood. It is argued that a Postpartum Support Group gives social support while reducing a sense of isolation by mothers with babies. This is particularly important for women living in rural Saskatchewan where weather often limits their ability to socialize and interact with other women. Parkinson (2009) points out that a Postpartum Support Group is “invaluable” as it helps normalize the women’s experiences and helps them address feelings of guilt and inadequacy (p. 7). Parkinson (2009) states that there is no specific psychological intervention that is more effective than others while facilitating a group. She does suggest, however that there are some disadvantages to adhering to a rigid group outline and suggests that the facilitator go with the flow of the group. Wiegartz and Gyoerkoe (2009) and Dennis (2003) suggest that a group of this nature is a place to learn about postpartum depression as well as teach a variety of skills. Dennis (2003) suggests a homework component during the group to strengthen skills practiced in session as well as an exploration of resources in the community. Group therapy can also provide the opportunity to educate spouses about postpartum depression (Wiegartz & Gyoerkoe, 2009; Dennis, 2003). As demonstrated in the literature and through my practicum experience, Postpartum Support Groups are an effective way of providing support, education and therapy to women experiencing postpartum depression.

As shown in this section of the report, there are a wide variety of theories that can help explain postpartum depression and offer guidelines on how to treat women suffering from this illness. In my opinion, there is no one theory or therapy that best explains or
treats postpartum depression. Women need to be treated on an individual basis dependent on what is best for them and their situation. It is, however, extremely important for clinicians to educate themselves on evidence-based therapies and interventions in order to ensure these women are getting the best treatment possible.

**A testimonial from Tami – Saskatoon, SK**

I knew I was in trouble when my racing thoughts and anxiety attacks led me to five days with no sleep and I was on day six without eating. This was a very dark and lonely time for me. I did not see a future I could see no light.

This was until I was introduced to the women of the postpartum depression group. I immediately made connections with the other mothers and the facilitators. I found a place where I could express the feelings I was having without worry of judgment or disappointment. The facilitators in the group offered education and advice. They were the foundation I so desperately needed. The other mothers offered support and hope, the light I so desperately craved.

*My life after postpartum depression is enriched with happiness and love. I am able to find the connection I need with my family and myself. I owe my recovery to the love and support of my friends at the maternal mental health program* *(Maternal Mental Health Strategy, 2010).*

**Values**

The purpose of this section is to explore the role of values within my practicum, both personal and professional. Much of social work is based on values. The Canadian Association of Social Workers (CASW) Code of Ethics (2005) is what guides social workers in the province of Saskatchewan. This document requires registered members to uphold the values as established by the CASW, and adopted by the Saskatchewan
Association of Social Workers (SASW). The CASW Code of Ethics outlines four values that include: respect for the inherent dignity and worth of persons; pursuit of social justice; service to humanity; and integrity of professional practice (2005).

At times throughout my practicum placement, my alignment with the social work value that “social workers uphold each person’s right to self-determination, consistent with that person’s capacity and with the rights of others” (CASW, 2005, p. 4) caused some difficulty between me and the hospital where I was completing the practicum. As St. Joseph’s Hospital is a Catholic hospital, I often struggled with their ideology and how it could, at times, conflict with what is best for women diagnosed with postpartum depression. Although it is abundantly clear that the Hospital cares about the patients they are treating, their ideology precludes certain medical practices which women may seek. Two examples include the fact that St. Joseph’s does not perform abortions, nor do they perform tubal ligations unless there is a clear argument that without the procedure the woman’s health would be at risk. As a social worker, and as a female, I strongly believe that women should be able to choose what is best for their body. As such, my values were not necessarily supported by the institution where I was completing my practicum. During this practicum placement, the issue of breastfeeding was raised on several occasions. This is also a topic that causes much distress among women who have given birth. There appears to be a push by some factions of the medical community that women should be encouraged to breast feed. The term “breast is best” is communicated to women early on in their pregnancies when, in fact, breastfeeding may not be what is best for all women (Wolf, 2011). An inability to effectively breast feed then may make a woman feel that she is failing as a mother. These feelings of failure may exacerbate
conditions of PPD. Another social work value states that “social workers respect the client’s right to make choices based on voluntary, informed consent” (CASW, 2005, p. 4). This value clearly led me to argue the point that women should be educated on the pros and cons of breastfeeding and that it should be made clear that the choice was ultimately their own. I would expect that medical professionals would then respect the choice the mother makes; unfortunately, this is not always the case.

Throughout this practicum, it became very clear that hospital staff struggle with having women showing symptoms of postpartum depression on the Obstetrics Unit because it can give a bad impression of motherhood and intimidate the other patients. I found this upsetting because postpartum depression is the reality for so many women. In addition, the Obstetric Ward is portrayed as being a warm and cheerful place. There are Anne Geddes pictures, with babies as the focal point, throughout the unit. A woman suffering from postpartum depression might not experience this type of environment as being welcoming. Prior to me hanging posters with information and symptoms outlining postpartum depression, all available information on PPD was located in a back office on the unit, and was not visible.

When a young mother, who was a patient/client on the unit during my practicum, had a psychotic break, one staff member suggested that she would have preferred if this incident had happened at another hospital rather then St. Joseph’s. Admittedly, many of the hospital staff find it difficult to work with women displaying symptoms of postpartum depression. Many of them are fearful of working with this population as they see them as being unpredictable with erratic behavior. Other professionals, besides hospital staff at St. Joseph’s, have concerns about where women experiencing symptoms of postpartum
depression should be admitted. There is only one psychiatric facility in all of Sun Country Health Region and it is located in Weyburn. Some of the staff on the psychiatric unit expressed concern over having these women admitted into this unit. If women experiencing symptoms of PPD are not welcome in Weyburn, or the Obstetrics Unit at St. Joseph’s Hospital, then where would they be expected to go should they need hospitalization? In my opinion, this is yet another way to keep postpartum depression hidden away and in the dark. Ignoring these women will not solve the problem. Acknowledging that women suffer from postpartum depression and educating staff is necessary to ensure that these women’s needs are met.

The value within the Code of Ethics (2005) that specifies integrity in professional practice was also a source of tension for me at times throughout this practicum. As mentioned above, I believe that some staff push the option of breast feeding onto women. It has also been my experience that some professionals can, at times, focus more on the baby rather than on what is in the best interest of the mom. This was often a cause of tension between myself and my colleagues who are a part of the nursing profession. I strongly believe in the importance of advocating on behalf of the mother and if she is unable to breastfeed, or chooses not to breastfeed, I will support her no matter my personal thoughts regarding breastfeeding. This was upsetting for some hospital staff as they felt I should always be encouraging women to breastfeed. In my opinion, what these staff members saw as an offer of encouragement could also be interpreted as pressure.

For the most part, Public Health was very supportive regarding my practicum. It did however come to my attention that one staff member was feeling “territorial” about my involvement in providing education to this population and made it clear that she did
not feel I should be involved in this process. Not only did I find her attitude unprofessional, but it was clear that her personal beliefs were interfering with what could be in the best interest of the client population that was the focus of my practicum placement.

Society gives the impression that motherhood is a wonderful experience and that women are supposed to be happy as new moms. The fact that few people talk about the many struggles of being a new mother only adds to the feelings of failure for women who do struggle with the transition into motherhood. It is important for professionals to inform women on the realities of motherhood. A good example of this involved one of the PPD group members. She informed the rest of the group that a Public Health nurse was a family friend. When she was unable to make one of the prenatal classes she asked what information she would be missing. The nurse told this woman that they would be discussing numerous issues including postpartum depression. The staff member then went on to tell this woman that she did not need to worry as she would never suffer from postpartum depression. Although I am sure that this comment was meant with the best of intentions, it ultimately ended up haunting this woman throughout the next several months. Although she suspected she was suffering from postpartum depression, the Public Health nurse’s comments kept coming back to her, causing her to deny and ignore the symptoms that she was experiencing.

I often thought about my own personal values throughout this practicum placement. My social location is one that privileges me as a white, middle-class, professional female. Although I can relate to the pressures society puts on women, I am not able to relate to how the mom suffering from postpartum depression may feel as I do
not have children of my own. I am a minority in that I am a woman in my mid thirties and do not have a family. I think this creates both pros and cons when working with women experiencing symptoms of postpartum depression. On one hand, the participants may look at me and think “she cannot know how we feel” because she does not have children. Or else they might see it as a positive because they know I am not comparing my own experiences, to their experiences. Although I cannot fully understand their circumstances I can certainly empathize with these women. I too, feel a certain amount of pressure from society, the community, family and friends to have a family of my own. These feelings of pressure often leave me second guessing decisions I have made. This is never a good feeling no matter who you are or what your circumstances are at that point in your life.

In addition, I think my values may differ from those of other generations. In my opinion, my generation is not content to have our lives consumed by the family. Many women who are my age work and are expected to balance their professional life with family. It is important to point out that family values have changed over the years and this directly impacts upon the circumstances under which women decide to have children.

**Ethics**

As suggested by Freud and Krug (2002) ethics refers to standards of right and wrong, and what each of us ought to do in terms of rights and obligations, benefits, common good and social justice for all. Ethics also refers to the ongoing study and continued development of one's ethical standards. As practitioners involved in a social work relationship, we are expected to pursue, examine and reflect upon our beliefs and actions from a moral standpoint. According to the Canadian Association of Social
Workers (2005) the social work profession’s foundation rests on the belief that social workers should respect the inherent worth and dignity of all people. The right that underlies this belief is the right to self-determination and participation. Our professional conduct as social workers must reflect this belief and promote the right to self-determination. This is a key aspect in one’s autonomy in efforts to control one’s future, and thus to grow and prosper. Self-determination is not only perceived to be a right of control in one's destiny but also, in holistic terms, of one's health and survival.

Everyone has a basic moral right to self-determination, to participation in his/her development and through that participation, to control what happens in their lives. All people must be viewed as capable of self-determination and as possessing an inherent right with regard to that capability. Principles of human rights are fundamental to social work. The right to self determination should remind all of us that ethics have an important place in the profession of social work.

St. Joseph’s Hospital has its own set of ethical considerations as outlined by the Catholic Health Association of Canada (2000). This document states that:

"We honour the dignity of every person, and listen and understand with respect. We value collaboration and cooperation, and work as a team to manage the hospital's resources in a professional, responsible manner" (Catholic Health Association of Canada, 2000).

In addressing ethical decisions I always refer to the Canadian Association of Social Workers (2005) Code of Ethics. There were a number of areas outlined in the CASW Code that pertained specifically to my practicum placement experience. They include confidentiality within professional practice, respect for the inherent dignity and
worth of persons, pursuit of social justice and competence in professional practice. I will discuss each area in detail as it related to my practicum.

**Confidentiality in Professional Practice**

I would deem the women I was working with during the practicum placement as being vulnerable. Each member expressed the fact that they were feeling like a failure since becoming a mother. They felt alone and were unsure of their ability to make decisions and care for their children, and they felt isolated from family and friends. Each group member admitted that their self esteem was almost non existent when the group first started. Because of this, it was extremely important for them to be able to trust me, as well as the other group members. As a result, I made sure to discuss the importance of confidentiality at the first group meeting. It was made clear to participants that they would be expected to keep the names of their fellow participants, as well as identifying information, confidential. I also discussed confidentiality as it pertains to my professional Code of Ethics (2005). I made sure to inform them that any identifying information would not be discussed in this report, nor with any of my fellow professionals, nor with the referring agencies.

Confidentiality is an extremely important issue, especially when working in a small community like Estevan. According to Pugh (2007) and Green (2003), there has been much discussion about the special ethical challenges faced by social workers who practice in rural settings. A recurrent theme is how rural social workers manage confidentiality and dual relationships given that they are often integral members of their small communities. As there was always a chance that I would see the group members in the community or at social events, I felt it was important to discuss this issue. I informed
the members that, should I see them in the community, I would not address them unless
they addressed me first. I explained that this was in order to protect their confidentiality,
but also made clear that I did not have a problem should they choose to talk to me. The
group participants expressed that they were appreciative of this information being
addressed. Interestingly, I saw two members shortly after the group started while
shopping. As promised, I did not approach the women but both of them did make a point
of saying “hello” to me.

**Respect for the Inherent Dignity and Worth of Persons**

In the field of Social Work, social workers work with a wide variety of clientele. Given the diverse nature of the PPD group members, it was extremely important for me to respect the differences between individuals, especially as the women had diverse backgrounds. One woman had completed post secondary education; whereas, another had not completed her grade 12 education. Two of the women were married while the other was living in a common law relationship. One of the women described an incident where the police had to be called to her house due to domestic violence and it appeared that this was shocking to one of the group members. As a social worker, I have been trained to respect the choices clients make and not to judge them. Although this is a value that comes easily to me, it is not always the same for other individuals. During the group, a member inquired about a choice one of the members made to sleep in a separate bedroom from her husband. She asked whether the couple worried that their sleeping arrangements could impact their child’s view of marriage. The other member explained that she did not see this as an issue. I took this as an opportunity to discuss the fact that individuals and couples are different and that each person needs to focus on what works
best for them and their families instead of allowing social pressures to dictate how they parent and interact with family. Although there was a minute where things appeared tense between the two group members it quickly passed as we moved onto another topic of discussion. At the end of that particular group, I overheard the women discussing their children’s sleep patterns and providing each other with suggestions. It appeared that there were not any lingering feelings of conflict between them.

_Pursuit of Social Justice_

According to the Maternal Mental Health Strategy (2010), the needs of women suffering from postpartum depression have not been adequately met in the Province of Saskatchewan. As outlined by Connelly at al. (2010) postpartum depression has lasting effects on women, their children and families in general. Fortunately, the local Mental Health Clinic in Estevan recognized this need and changed their intake process so that women experiencing symptoms of PPD are prioritized and are seen within five to seven working days. Aside from the Departments of Mental Health and Public Health, there are no other resources available for women experiencing PPD in the Health Region. I envisioned the Postpartum Depression Support Group as a way to meet the needs of this population. I plan to advocate to have the Group continue to be offered in the Health Region on an “as needed” basis, either by applying for grant money, or by having the group facilitated under the auspices of Mental Health Services.

_Competence in Professional Practice_

One of the goals of this practicum was to ascertain if there was a need for a Postpartum Depression Support Group (PPD Support Group) in the community of Estevan. Before facilitating the pilot Group, I spent a great deal of time educating myself
on the subject of postpartum depression, best practice in developing and running such a group, as well as the specific interventions that would help this population. In addition, I have had eight years of clinical practice which I feel helped me to provide the best support I could to these women. It is essential for social workers to continue to educate themselves throughout their careers. Client’s deserve the best quality of care that social worker’s can give them.

This section of the report discussed ethics as they pertained to my practicum. As mentioned, I often referred to the Canadian Association of Social Workers (2005) Code of Ethics and found that many of the areas outlined in the CASW Code pertained to my practicum placement experiences.

A testimonial from Tania – Regina, SK

Every mother anticipates the birth of her baby - my traumatic delivery at 31 weeks left me with feelings of disappointment and incompetence as a mother - I could not even carry my baby to term! These feelings were further amplified when I was unable to provide breast milk for my daughter due to medications. I spiraled into despair, sadness, and depression. Self-hatred turned into obsessive thoughts of homicide, infanticide, and suicide. I wanted to leave the situation entirely and take those I loved the most with me. Depression is a mild word for the depths of despair, isolation, pity, and self-loathing I suffered with for 14 long months. What I craved was encouragement and validation - to be recognized as a human being - emotional, spiritual, mental and physical. I needed to come to terms with my disease, forgive myself, release the guilt and learn to love not only myself, but my husband and my daughter again (Maternal Mental Health Strategy, 2010).
Relationships

As indicated by Trevithick (2000), an effective social work relationship with any client is heavily based on trust. The client places her confidence and trust in the social worker, and often depends on the social worker's judgment or counsel. The social worker is expected to practice with integrity and to act in accordance with her professional standards of conduct as well as respect the inherent rights and dignity of the client (Canadian Association of Social Workers Code of Ethics, 2005). Often, this relationship is based on unequal power and responsibility; it is the social worker's obligation to acknowledge that there is a power differential between worker and client and to resist abusing this power and to practice in an ethical manner (Bar-On, 2002). According to Trevithick (2000), relationship building skills are a necessary attribute when working in the field of social work. Early on I realized that the success of my practicum would depend a great deal upon my relationships with the community, the hospital, the clients and with other professionals. Fortunately, I work and live in this small community and have worked at the Estevan Mental Health Clinic for eight years. When I contacted various professionals to inform them that I was planning on facilitating a Postpartum Depression Support Group, I was met with a very positive response. In this portion of the report I will discuss the various relationships that developed during my practicum experience.

Worker-Agency

As discussed earlier in this report, the clinic in which I work is located in St. Joseph’s Hospital. My relationship with the Executive Director and the Director of Patient Care had already been well established - not only because I worked in the
Hospital, but also because I have sat on the St. Joseph’s Ethics Committee since 2009. From the beginning, both the Executive Director and the Director of Patient Care made it clear that they were willing to assist me in anyway they could. I feel that the practicum experience strengthened my relationship with both professionals.

My main concern regarding relationships within the Agency was my relationship with the nursing staff. As I work in a small community, my ties to mental health are well established. In my opinion, the relationship between hospital unit staff and the Mental Health Clinic has changed over the past few years. Due to a high level of referrals, Mental Health hired an intake worker to provide effective triage. This has caused some friction between Hospital staff and the staff at the Mental Health Clinic. Whereas they used to be able to call the clinic and speak to a clinician directly, they are now expected to send all referrals to the intake worker. As a result, the hospital staff has voiced their annoyance with this process. In addition, there is approximately a four month long wait list to be seen by the Mental Health Clinic. In the past, hospital staff were accustomed to being able to make a referral and have their patient seen that same day. As this is no longer the case, the relationship between staff at the Mental Health Clinic and hospital staff has been strained.

During my practicum it became clear that some hospital staff were upset with the fact that staff from the Mental Health Clinic are not available after hours and on weekends. It should be noted that Mental Health Psychiatry is on-call twenty four hours, and that local general practitioner can contact the on-call psychiatrist after normal clinic hours. Despite this, there appeared to be some conflicted feelings that developed amongst the staff. This was made clear to me when I circulated the letter outlining the
Postpartum Support Group. Although many of the hospital staff were positive about the Group, one stated that “it was a little too late” for a woman who had been treated over the weekend. It was after that comment that both my field and academic supervisor decided that a goal of my practicum should be focused on creating more visibility of myself to hospital staff. I made an effort to stop by and talk to staff on the Obstetrics Unit and to inquire as to how they are doing, and so on. As I was made aware that many hospital staff would be attending a telehealth presentation on postpartum depression, I also attended despite the fact that I had already attended the same presentation previously. This sparked dialogue between myself and staff members. They were well aware of my practicum, and my presence at the presentation further created opportunities for them to express interest in the PPD Support Group. My goal was not only to improve the relationship between staff, but to make it well known that I am willing to be a contact person should they have questions about postpartum depression. I feel that my practicum has helped improve the relationships between staff at the Mental Health Clinic and hospital staff.

Worker-Community

When I accepted a position at the Mental Health Clinic, I wondered how my growing up in Estevan might affect my relationship with potential clients. Although these concerns continued into my practicum, it does not seem to have caused a problem. It was noted in one of the referrals sent from a fellow professional that the woman she was referring knew me through the community. The referring agency noted that this woman felt more comfortable attending the PPD Support Group because she knew who I was. As a result, I realized that my ties to the community can also be a positive attribute.
It also reminded me that, in a small community, it is important for social workers to remember that how they act can directly impact their professional reputation. It has become common knowledge within the professional community in Estevan that I am working on my Master’s degree in Social Work, and that I am very interested in postpartum depression. Since the word has spread, I have been approached by community members, some of whom have suffered from postpartum depression and others whose loved ones have, offering to share their stories. I was also recently contacted by a woman asking for services at the Mental Health Clinic stating that she initially refused to access services until a member of the Postpartum Support Group suggested she see me. As discussed later in this report, postpartum depression referrals to the Mental Health Clinic have increased since I first began my practicum. Although I am honored by the community’s reaction, and am relieved that women are willing to access help, it also created a relationship-based dilemma for me. As this shift began to occur, I immediately began to feel pressured to provide a service to these individuals. I also worried about how this would impact my co-workers at the Mental Health Clinic. We are already overwhelmed with referrals in Adult Services and struggle to see the clients who are already on the wait list. As women displaying symptoms of postpartum depression are seen as high priority, I wondered how staff would manage the influx of referrals. I also worried about the strain this would put on myself and my co-workers. I was concerned that my co-workers would resent me as they would be expected to see some of these referrals. Luckily I work in an extremely supportive work environment. I voiced my concerns to my fellow Adult Services clinicians and they were supportive, which went a long way toward reassuring me.
Worker-Client and Client-Client

Because I had not facilitated a Support Group on my own before, I had feelings of anxiety about the process. First of all, I was afraid that I would not get more than three participants and that the Group, and subsequently my practicum, would be a “flop”. Second, I was afraid that the participants would come to the first group session and then would not return for subsequent sessions. As such, I felt it was extremely important to make a good impression at the first session, and was determined to come prepared with educational handouts, information on postpartum depression and anything else I could possibly need. The group was scheduled to start at 7:00 p.m. By 7:05 no participants had arrived, and I had convinced myself that the group was indeed a flop. However, shortly after, the group members began arriving and I was able to breathe a sigh of relief. I did introductions and reviewed the group rules.

In the end, the Support Group consisted of three women who had different backgrounds and lifestyles. Given the small size of the group, I wondered how each member would interact with one another. Immediately, it became apparent that it did not matter if the participants were different, they had several things in common: they all felt overwhelmed; they all questioned their ability to parent their child or children; and they all wondered if they would ever “feel the same again”. I was surprised by how open the participants were, and this openness created some great discussion. I was pleased by how positive the women were to the idea of a Postpartum Support Group. All three returned and stated that they had been looking forward to the Group all week long. Ultimately, the Group had an easy going feel to it, sometimes there was laughter and other times there were tears. As there were times throughout the duration of the group when things got
tense, my skills as a clinician were necessary. I was pleased to see that the members were able to “agree to disagree” while maintaining a friendly rapport with one another.

Towards the end of the PPD Support Group sessions, members were bringing coupons for diapers to one another and trading secrets for quieting their children. The feeling in the group was positive; I also received positive comments from all the members – some in writing and some by telephone. The only relationship-based dilemma between myself and the Group members was when the woman that I know from the community called me “Kel” as many of my acquaintances do. I had a moment where I wondered how the other members would interpret this, as they seemed to be taken aback by the reference which suggested a different kind of “friendship”. The moment passed and I did not feel it was worth addressing. The only other dilemma that arose was the fact that I already knew all of the group members in some way, whether it was from the community or on a professional level. I had to make sure that I did not let on that I knew them individually within the Group, and interestingly, none of the group members disclosed that they knew me outside of the group.

Client-Society

It was clear throughout the group process that these women had separated themselves from community, family, friends and often their partners. All of them stated that they felt like “failures” for struggling after the birth of their children, and they were unsure what was “wrong” with them. All of the women felt they would be judged if they talked about their feelings so they kept them to themselves. The participants looked at other women in the community and assumed they were enjoying the experience of being a new mom. One of the participants remembers hearing her family talk about how much
she was going to love being a new mom and how she would fall in love with her baby the moment she saw him. Therefore, the client felt there had to be something wrong with her when she did not want to even see her baby immediately following his birth. The consensus amongst Group members was that these women felt they did not belong with other moms. It was clear that the Group members were unsure of where they fit within society and their families. This left them feeling alone and vulnerable. I think that education on postpartum depression is key, not only for women giving birth, but for their families, partners and society as a whole. If social workers better understood the issue, they could provide better support to the populations most affected by it. This section of the report clearly shows that relationships are significant in the field of social work and my practicum. For the most part I found relationships made or fostered throughout my practicum to be positive.

**Strategies**

This section of the report focuses on the different strategies I utilized throughout my practicum in order to achieve my goals and learning objectives. Initially, the main strategy of my practicum was to ascertain if there was a need for a Postpartum Support Group in the community of Estevan. After meeting with both my academic and field supervisor(s) it was apparent that providing education to St. Joseph’s Hospital staff, as well as the community in general, was an important part of my practicum. The first step was to decide how I was going to make contact with potential group members. The first thing I did was to contact the coordinator of the Postpartum Depression Support Group in Regina, Saskatchewan. This individual has facilitated this Group for close to twenty years. I spoke to her at length and found the information she shared to be informative
and helpful. The coordinator informed me that her group size usually ranged anywhere from four to eight people. She was curious about how a group of this nature would operate in Estevan, given the size of the community. According to Statistics Canada (2006) Regina’s population is approximately 180,000 whereas the population of Estevan is approximately 10,000 people.

I think it is important to point out that St. Joseph’s Hospital does not employ a medical social worker. If there had been a medical social worker, I would have naturally approached that person with the hopes of having them involved with my practicum. Instead, I felt the most logical choice was to contact the Executive Director of St. Joseph’s Hospital and the Director of Patient Care. Both were known to me as the clinic where I work is located in the hospital. Both were positive about my practicum and offered to support me in any way they could, especially when they learned that the practicum focus was on postpartum depression. Before proceeding with the Support Group, I presented my proposal to the St. Joseph’s Hospital Ethics Committee. This group is made up of staff as well as community members. I think it is important for me to indicate that I currently sit on the ethics committee and am well known to the members involved. Nevertheless, I was expected to present to the group and obtain support and approval from them before continuing with the group. The ethics committee was supportive of the PPD Support Group, as well as the work I was doing on the topic of postpartum depression. The presentation sparked a great conversation on the subject and the committee vote was unanimous in favor of the development of the Support Group. At this time, I was contacted by the Regional Director of Mental Health and Addiction Services. This individual had heard about the group and stated that he felt the proposal
Postpartum Depression

for the group needed to be presented to the Sun Country Health Regional Ethics Committee as I was asking various health professionals, employed by Sun Country Health Region, to refer their clients to the Support Group. This individual sits on the Regional Ethics Committee and stated that he would present the information to the group for approval on my behalf.

Following the approval of the relevant local ethics committees as outlined above, the next step was to establish contact with potential group members. I drafted a letter (see Appendix A) which was sent on September 1, 2010 to general practitioners, Public Health, and Mental Health staff throughout the Sun Country Health Region. The letter was also sent to the Ministry of Social Services, school counsellors, the Estevan City Police Department, Salvation Army, Family Centers, churches, Envision (which is a non-profit counselling and support center), as well as the White Bear Reserve. I asked that the referring agencies have potential participants contact me directly or, if the participants preferred, the agencies could send written referrals and that I would contact the potential participants. The group was scheduled to begin in the middle of October and run for six weeks. Over the next several weeks I received five referrals. The referrals were from all areas of the region, including, Weyburn, Carlyle, Estevan, Lampman and Carnduff. I made contact with all of the women except one who resided in Weyburn. A letter was sent to her but she did not respond. At the first Group session, I was expecting four participants to attend. Unfortunately, one of the participants did not show up, and the group went on with three participants.

I will admit that I was disappointed in the small number of referrals that I ultimately ended up with for the Support Group. However, there were several potential
obstacles that presented themselves during the process of seeking referrals. First of all, it is important to note that Estevan’s primary Obstetrician was off work for six weeks prior to the Group starting. Therefore, during this time, the majority of women from the Health Region delivered their babies in Regina. As she was off work, the local doctor did not complete her regular six week check up on these women. I was counting on this doctor to be a primary referral source and feel her absence could have impacted the Group size. In addition, I learned several weeks into the Support Group that the Public Health Nurses in Estevan had been given direction by their manager not to refer to the Group. I heard about this through the “grapevine” and, as a result, I approached a Public Health staff member. This staff member informed me that she had received an e-mail from a manager informing her not to refer to the Group stating that I had not received approval from the Regional Ethics Committee. Upon further investigation, there had been a miscommunication which resulted in the information not going to the Regional Ethics Committee. Soon after, the proposal was sent to the committee members and was approved. Unfortunately, the PPD Support Group was in its third week by this point. I cannot help but wonder if I would have had a larger Group if these unfortunate events had not occurred. Nevertheless, the Group ran for the full six weeks and I feel it was a success despite the small group size.

After talking to coordinator of the PPD Support Group in Regina, I made the decision to develop and prepare “module-based” information for the group participants but decided that the Group would be open and not follow a specific schedule. Therefore, the first session was spent getting to know one another and providing general information and education about PPD. Group rules were identified. According to the Families
Matter Postpartum Support Model (2009) group rules are used to provide a safe setting, boundaries, and to encourage a non-judgmental and supportive atmosphere. They rules I outlined were as follows:

1. The right to pass. There may be times that members may not want to participate in the discussion. If there are too many passes the facilitator may approach and discuss whether needs are being met (i.e. safe place to talk).

2. The right not to be responsible for other people’s stuff. Everyone comes with their own story and no one’s story is less or more important than another’s story.

3. Everything shared in the group is confidential.

4. All values and beliefs are respected.

5. Respect must be maintained. This rule expects the participants to respectfully “agree to disagree” on certain topics and to appreciate another’s point of view.

6. No cross conversations are permitted when someone is speaking.

7. Participants are to be patient with one another.

8. The members are to be an active participant in their learning.

Participants were encouraged to make suggestions as to what information or topics they wanted to discuss in the Group. As a result, some topics addressed during the Group included medication, education on anxiety and postpartum depression, partner relational issues, and balancing family life with maintaining a sense of self. In addition, all three participants asked that the group spend some time discussing how they felt their stay at St. Joseph’s Hospital could have been improved. The participants wanted hospital staff to:

1. Introduce themselves to the patient.
2. Acknowledge a woman if she is visibly upset.

3. Interact with the women, for example to ask the baby’s name.

4. Validate the women’s feelings.

5. For there to be open communication between staff and patient, like telling the patient why the staff is putting in an I.V. and so on.

6. Involve the women in the decision making process.

7. Take time and listen to the women about any concerns and fears they might have.

8. Respect the patient’s decisions.

I want to make it clear that the intention of the participants was not to criticize staff but to make suggestions that they felt would help to foster positive staff and patient relationships. The participants acknowledged that many of the staff who treated them displayed the above suggestions, but they also admitted that several did not.

In addition to the work specific to the PPD Support Group, I also provided education to the community-at-large. The staff at the Public Health Clinic was supportive during this process. Public Health nurses stated that they provided education on postpartum depression throughout their prenatal classes offered at St. Joseph’s Hospital, as well as the Baby and Me classes they offered at the Family Center. Despite this, the nursing staff wondered if it would be helpful for me to present information to both groups which are offered every few months. Fortunately, I was able to present to the Baby and Me class in December of 2010, and there were approximately 18 new moms in attendance. I developed this presentation so that it was informal. I discussed postpartum depression and gave warning signs to look for. I normalized feelings they might be experiencing and encouraged them to seek support. The women were made
aware that, although I was presenting this information as part of my practicum, I was also an adult social worker at the Estevan Mental Health Clinic. I gave each woman a pamphlet on postpartum depression as well as the contact information for Sun Country Health Region’s Intake Services. Intake Services triages all new mental health referrals and refers them to the appropriate program or agency.

Although there is currently a wait list for Mental Health Services in Estevan, women experiencing symptoms of postpartum depression are deemed to be presenting at a Level Two, in terms of urgency or risk, which would mean that they are placed at the top of the wait list and are usually seen within five to seven working days. Within a two week period following the presentation I made to the Baby and Me class, Mental Health Intake received ten new referrals from women displaying symptoms of postpartum depression. I cannot prove that the referrals were related to the presentation I provided, but it is not typical for Intake to receive this many postpartum depression referrals in such a short period of time.

In January of 2011, I did a presentation to the prenatal class at St. Joseph’s Hospital. There were approximately 15 couples in attendance who were all expected to deliver over the next two months. The presentation provided education on postpartum depression, warning signs the couple could look for, as well as provided information about supports they could utilize. The group was also told how they could access services through the Mental Health Clinic and were given a pamphlet on postpartum depression.

As outlined earlier in this report, additional goals of this practicum were to provide education/information to staff on postpartum depression, as well as for myself to
be more visible to staff as a Mental Health clinician working in the area of PPD. I created a newsletter which included information about postpartum depression as well as helpful tips staff could use when treating this population. As it is extremely difficult to get the staff together for a presentation, I placed the newsletter in the Hospital cafeteria as the majority of staff eat and take their coffee breaks there. In addition, I spoke to staff on the Obstetrics Ward about information they had readily available for women showing symptoms of postpartum depression. I made sure to ask if the staff were in need of further information and made it clear that I would be available should they have further questions relating to postpartum depression. Lastly, I ordered posters which were designed by the Maternal Mental Health Strategy which outline symptoms of postpartum depression and supports women could access. I laminated these posters, attached intake information for Sun Country Health Region and hung them in all of the Obstetric Ward rooms in the hospital as well as in the Emergency room, and the Mental Health and Public Health Clinics.

In this section I discussed the different strategies used throughout my practicum. I also utilized specific interventions and therapies. They included cognitive behavioral therapy, interpersonal therapy, group therapy, psychoeducation as well as the Edinburgh Postnatal Depression Scale. I found all of these tools helpful during my practicum and see them as essential when providing services to women suffering from postpartum depression.

Skills

This practicum allowed me to improve and enhance skills applied to the profession of Social Work. According to Trevithick (2000), social workers have to be
highly skilled given the complex nature of the field. I feel much better equipped as a professional after completing this practicum. Trevithick (2000) discusses several skills necessary for social work practice. In this section of the report I will discuss some of the skills Trevithick (2000) mentioned as well as the role I played as an educator. In addition I will discuss the knowledge I gathered on the topic of postpartum depression, as well as the analysis I completed on several interventions suggested for the treatment of PPD.

**Communication and Listening Skills**

According to Trevithick (2000), communication and listening skills are crucial in the profession of social work. In my opinion, these skills are imperative when facilitating a group of any kind. I found that asking open ended questions generated a lot of interesting and informative dialogue between the PPD Support Group members. Although much of the Group session time was spent listening to the members speak and offering them opportunities to vent and discuss issues of importance to them, it was often necessary for me to keep the conversation flowing and to make sure each member had an opportunity to participate. I found the skills I obtained during my education and throughout my career as a clinician to be vital during this process.

Diplomacy was another skill that was necessary throughout my practicum, whether I was conversing with another professional or with a client. During the PPD Support Group one of the members decided that she felt she would benefit from trying an antidepressant. She had informed the rest of the Group members that her general practitioner had referred her to a psychiatrist but that she had yet to hear from his office. As I was concerned about this individual, I offered to advocate on her behalf with the psychiatrist. I spoke with the psychiatrist and respectfully asked that he see this woman
sooner rather than later. As the psychiatrists in the Health Region are extremely busy, I had to be very diplomatic when consulting with him. In the end, the client was offered an appointment in two weeks time. In this case, I view my communication skills as an asset in that I was able to advocate effectively on behalf of the Support Group participant. A social worker has to be able to balance the client’s needs while maintaining a respectful relationship with other professionals; this is not always easy (Trevithick, 2000).

Throughout the community presentations I gave during the practicum, it was necessary for me to be eloquent when speaking to women who had either just delivered or to couples who were expecting. Throughout these presentations, it was clear that the various groups were not comfortable discussing postpartum depression. This required me to balance a desire to ensure that they were being realistic about parenthood, and to also do so in a way that did not frighten them. This was a difficult balancing act, especially as there was no discussion from the participants at either of these presentations.

**Analysis**

Although this practicum did not require me to gather a large amount of data I did spend a great deal of time analyzing different therapies and interventions which could benefit this population. I had planned to have the PPD Support Group participants complete a survey, but this became impossible given the fact that the last group was cancelled due to poor weather conditions. However, given the positive feedback I got from group members, both through telephone calls and e-mail, I was able to conclude that the group members found the time they spent together to be beneficial. I believe there is a need for such a Support Group in Estevan, even if it were to only run three to four times per year.
Knowledge

The majority of my practicum was spent educating myself about postpartum depression. My goal was to be as knowledgeable about this subject as possible. I attended various presentations, read countless research articles, familiarized myself with the most recent interventions and asked the women in the PPD Support Group about what helped them the most during the group experience. As a result, my interest in postpartum depression began to spread. Fellow colleagues have asked me for information on this subject and I was recently asked to sit on a committee which is being formed in the Sun Country Health Region to develop strategies for the Region to better meet the needs of these women.

Providing Education

I spent a great deal of my practicum in the role of educator. I provided education to hospital staff through the newsletter and conversations on the wards, at the Public Health Clinic, with women at the Baby and Me class, with couples at the prenatal class, with women in the PPD Support Group, as well as the community in general through the posters I hung up throughout the hospital. In addition, women and their families are now able to access information and resources on postpartum depression through the link I created on the Sun Country Health Region website. I spent a great deal of time trying to de-stigmatize postpartum depression as well as dispelling myths that people have about this issue.

Interventions

As discussed in the section of this report on Strategies, much of the practicum was spent researching and utilizing various interventions for the treatment of postpartum
Postpartum Depression

Some of the interventions I explored included the Edinburgh Postnatal Depression Scale, psychoeducation, cognitive behavioral therapy, interpersonal therapy, group therapy, crisis intervention techniques, supportive psychotherapy and family therapy.

**Facilitation Skills**

Much of my practicum work related to facilitation. I facilitated the PPD Support Group, meetings with other professionals, meetings with the hospital staff as well as the various other community groups I presented information to. Facilitation skills require professionalism, active listening skills and the ability to work through conflict when it arises (Trevithick, 2000). I think these skills were highlighted throughout my facilitation of the PPD Support Group. It was not easy to keep participants on task and to ensure that each member’s individual needs were being met. Although this was often a challenging task, the rewards were substantial when the group members learned and found support in talking to one another. As mentioned above, this practicum allowed me to strengthen my skills as a social worker as well as a clinician.

**Visions**

After completing this practicum, there are numerous visions related to the issue of postpartum depression that I have developed for the future. First, I will discuss my vision in regards to the community of Estevan. I think it is imperative that the issue of postpartum depression be pushed to the forefront of health care. This could be done through the provision of education as well as through continuing to improve the partnerships between the Mental Health Clinic, the Public Health Clinic and the local doctors. It is critical to normalize postpartum depression with the hopes that doing so
will encourage women to access help rather than hide their symptoms. In my opinion, it would be beneficial to have the Postpartum Support Group continue to be offered as a resource in the community of Estevan, and it would be especially helpful to find a way to connect women experiencing symptoms of postpartum depression. According to the Sun Country Annual Report (2010), Estevan is made up of a transient population; therefore, some women experiencing postpartum depression do not know anyone in the community. Perhaps programming through organizations like the various churches, the library, and the Family Center could help in connecting these women in non-threatening ways.

Given that Saskatchewan is made up of a large rural population, where it can be difficult to access support services, an online forum for moms to interact within the Health Region could be a great support. An interactive website might also be beneficial for this population. For women living in smaller communities, interacting online might be preferable to face to face interactions, as many may actually be known to one another. Bennett-Levy and Perry (2009) discuss the option of providing cognitive behavioral therapy online to individuals living in rural communities. The authors see this as an opportunity to provide support without the client having to travel. This would be of benefit for rural communities surrounding Estevan. There also needs to be more education and information made available about services that women can access in the community. In a community as small as Estevan, many women are concerned about how they will be judged if they disclose that they are not enjoying motherhood. I cannot stress enough the need to de-stigmatize postpartum depression, as I truly believe that women will access support if they know they have nothing to be ashamed of. This idea, as I have demonstrated elsewhere in this report, is supported by the literature.
Second, I will discuss a vision for the Province of Saskatchewan. The extensive review of the literature that I completed during my practicum has led to my support of the four strategies as outlined by the Maternal Mental Health Strategy (2010). The goal of this group was to present their recommendations to the Saskatchewan Ministry of Health with the hopes that new policies will be implemented which will better meet the needs of women. The four recommendations include education, screening, treatment, as well as sustainability and accountability (Maternal Mental Health Strategy, 2010).

As stated, the first recommendation offered in the Strategy was related to education. The Maternal Mental Health Strategy (2010) suggested that the Province needs to increase awareness of maternal mental health. They argue that particular attention needs to be focused on the frequency, impact, and treatment of maternal depression through ongoing access to evidenced-based materials. Education needs to be provided to professionals, women, their families, and to the general public. These groups could access information through printed material, electronic resources or educational programs. It would be beneficial to have this material include information on postpartum depression, signs and symptoms, services women can access and programs in the Province which offer parenting classes and professional training. Education can help to decrease the stigma that many women suffering from postpartum depression experience. The hope is that these efforts will encourage women to seek help (Maternal Mental Health Strategy, 2010).

The second recommendation focuses on the importance of universal screening for depression and anxiety in pregnant and postpartum women (Maternal Mental Health Strategy, 2010). The Maternal Mental Health Strategy (2010) argues that The Edinburgh
Postnatal Depression Scale (EPDS) is the most effective way of screening for postpartum depression. The members of this strategic planning group suggest that the EPDS should be used consistently at regular intervals during routine health care visits in pregnancy and postpartum. The Maternal Mental Health Strategy (2010) suggests that any woman who scores a 12 or higher should be seen by a professional as soon as possible, while those who score an 10 or 11 receive some sort of follow-up by a professional, and women who score 9 or less should have access to support whether it be through a support group, a professional or educational material. Lastly, the Maternal Mental Health Strategy (2010) suggests that partners of women who score positive for depression, 12 or more, should be offered support as well.

The third recommendation involves the treatment of postpartum depression. The Maternal Mental Heath Strategy (2010) document argues that these women need to be seen as a priority and that this should be reflected if they attempt to access Mental Health services. The Maternal Mental Health group argues that timely treatment of postpartum depression is essential and that a stepped care strategy can help provide a “cost-effective service by matching the severity of the symptoms to the appropriate level of treatment” (Maternal Mental Health Strategy, 2010, p. 3). They feel that this will ensure that pregnant and postpartum women will have access to effective treatment and support. I think it is important to point out that Mental Health Services in Estevan had already put this recommendation into place approximately two years ago (Maternal Mental Health Strategy, 2010).

The fourth and final recommendation from the Maternal Mental Health Strategy (2010) involves sustainability and accountability, meaning that maternal health should
remain a priority within Saskatchewan. The group argues that there is a need for policy that ensures health regions are providing a quality service to this population. The group suggests that advisory groups be developed at the provincial and regional levels. They also suggest that improved data collection within the Mental Health Information Systems will be able to track whether these recommendations have been implemented (Maternal Mental Health Strategy, 2010).

**Conclusion**

This practicum report illustrates the impact postpartum depression can have on women, their children, families as well as society as a whole. According to Leiferman, Dauber, Heisler and Paulson (2008), women are vulnerable to mental health problems during pregnancy and after the birth of their child. Untreated depression in this population not only impacts all aspects of the family but it also causes increased personal, social and economic costs. Women suffering from postpartum depression have an increased risk of pre-term birth, difficulties with the pregnancy, problems breastfeeding, as well as attachment issues with their child. As suggested by Stewart (2007), children of a mother who has struggled with postpartum depression can experience developmental and cognitive difficulties. In addition, the partners of women who are depressed also experience a higher risk of developing depression themselves (Goodman, 2004).

According to the Maternal Mental Health Strategy (2010), the Province of Saskatchewan does not currently have a provincial policy regarding the treatment of postpartum depression. Because of this, these women and their families are not provided the support they both need and deserve. It is essential that all women have an opportunity to receive quality care and support. I believe my practicum proved that
education, support and the availability of resources are important when providing services to this population. As the majority of Mental Health programs find themselves under-funded with overworked staff, it is currently difficult to provide this type of care in Saskatchewan. With a combination of my experiences throughout this practicum, and the recommendations made by both myself and the Maternal Mental Health Strategy, I am confident that professionals can improve the quality of services given to this population.
References


Postpartum Depression


Appendix A: Introductory Letter

St. Joseph’s Hospital letterhead

September 1, 2010

To Whom It May Concern:

I am a student researcher at the University of Regina. I am undertaking a pilot project towards the completion of my Masters Degree in social work. I have been employed at the Estevan Mental Health Clinic for the past eight years. I have decided to focus my research on Post Partum Depression. To this end, I have decided to facilitate a Post Partum Support Group, in collaboration with St. Joseph’s Hospital, in Estevan, Saskatchewan. The group will be held at St. Josephs Hospital. I hope to start the group in the middle of October; it will run for six weeks.

If you have any patients/client’s who you feel would benefit from this group please let me know as soon as possible. This would include women experiencing any of the following symptoms: anxiety, anxious thoughts, worrying, feelings of dread, changes in appetite, sleep difficulties, difficulties bonding with baby, difficulties coping, thoughts of harming self or baby, difficulties adjusting to life with the baby to the point where it is affecting day to day functioning for the mom. Once I have received a referral from you I will contact the mom to see if she is interested in attending the group.

The information gathered from the group will be used for educational purposes only and will be kept confidential. There will be no data used that could link the participants with the group. I plan to use the information for my project report as well as to determine if there is a need for this type of group in Estevan. Participation in the group is voluntary and the women can withdraw at any time.

Thank you very much for your consideration of my request. If you have any questions or concerns, please contact me at 637-3610 or kpierson@schr.sk.ca. Referrals can also be faxed to 634-2015. You can also contact my Academic Advisor, Nuelle Novik, at the University of Regina, 585-4573.

Sincerely yours,

Kelly Pierson