WHERE TO START

Three Building Blocks for Working with Postpartum Clients

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What makes working with a postpartum* clientele so rich is also what makes it so challenging: there is just so much to attend to. Emotion-intensifying hormonal shifts? Check. Debilitating exhaustion? Check. Cataclysmic role transition? Check. Upheaval in the marriage? Check. Topping it all off, there's also a baby to care for.

"I feel like I just started a new job I was never trained for," one of my clients once wearily explained. "It's around the clock, and while I'm frantically trying to figure everything out, my new boss is hollering incessantly in my ear. And I can't quit."

New parents, men and women, biological and adoptive, come to me mired in an emotional vortex of love, fear, loneliness, anger, guilt, joy, and helplessness (to name a few). They feel overwhelmed, and, frankly, sitting across from them, often I do as well.

"Where to start?" I often ask myself. With the anxiety-laden attachment patterns? With the yammering inner critic, almost drowning out the screaming baby? Or, as I size up their puffy eyes, with immediately accessible coping strategies? By the time clients reach out to me, their struggles have often reached critical mass. A compassionate presence is absolutely necessary but is not sufficient. We also need to identify tangible therapeutic targets. The following exploration is of three cornerstones that help guide me in approaching my clients' struggles in a meaningful, engaging, pragmatic way.

Let's start with what brings new parents into therapy in the first place.

POSTPARTUM STRUGGLES: WHAT DO THEY LOOK LIKE?

Postpartum depression (PPD), a subset of major depressive disorder, presents in roughly one out of eight new mothers in the year following childbirth.[1] Women experiencing PPD exhibit the typical depressive symptoms of low motivation, sad mood, anhedonia, hopelessness, changes in sleep patterns, and isolation from others. Kleiman notes anxiety is also a prominent feature in mothers with PPD.[2] A UBC study found that 16 per cent of pregnant women and 17 per cent of new mothers experience severe anxiety symptoms, including postpartum obsessive compulsive disorder.[3] Typical postpartum anxiety (PPA) symptoms include constant worrying, mental and somatic tension, disturbing "what if" thoughts, and a frequent sense of dread. Postpartum psychosis, a much rarer and far more serious psychiatric condition requiring medication and/or hospitalization, is not typically treated with psychotherapy.[4]

Often missing from the taxonomy of clinically relevant issues is the more widespread postpartum adjustment, a "psychological reorganization after the birth of a child which is a required and necessary adaptation to a change in the structure and homeostasis of the individual and the family."[5] This represents the subclinical postpartum struggles: stress, emotional fluctuations, and shifts in identity as new parents attempt to incorporate their massive new role into other well-established aspects of themselves. In her book, *Mating in Captivity*, Esther Perel observes, "having a baby is a psychological revolution that changes our relationship to almost everything and everyone, from our sense of self

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**While different definitions exist for what constitutes the postpartum period, for the purpose of this article, it is the first 12 months postnatal.*

and identity to our relations with partners, friends, parents, and in-laws."[6] I see how couples struggle after their first (or second or third) child is born. This is often unexpected and the disconnect can intensify challenges inherent in the transition. Invariably, working with a postpartum client involves couples counselling.

RISK FACTORS

While most new parents experience some disruption to their homeostasis during that first year, many manage to regain equilibrium and thrive. So what, then, sets apart those who struggle?

Myriad risk factors contributing to postpartum challenges have been identified. Among these are previous episodes of depression and anxiety,[7] a history of insecure attachment, instability in the marriage, grief and loss,[8] a perfectionist personality style, difficulty breastfeeding,[9] a difficult birth,[10] and an extremely fussy or colicky baby.[11]

This, of course, occurs in our current culture of child rearing, which has elevated and analyzed parenting styles and the parent-child bond to an astonishing level.[12] Feelings of inadequacy and incompetence create an uncomfortable dissonance in the mother who loves her baby and wants desperately to do right by him. One of the darkest, deepest fears many mothers feel nowadays is that they are "bad mothers," that they are failing their children and falling short of their own ideals.[13] It's not surprising, then, that postpartum depression and anxiety are under-reported,[14] and postpartum women hesitate to expose their vulnerabilities to their peers.

THREE ESSENTIALS

When our clients present with myriad issues, each calling for our attention, it is helpful to have a means by which to organize the therapeutic process so that we, too, don't feel overwhelmed. Years of clinical practice and self-guided research have helped distil these three essential tools.

1) ASSESSMENT

After the most important variable of counselling is met — a warm and engaged therapeutic relationship — we help our clients become more stable, connected, and effective. To get there, we start by asking the right questions to elicit the full range of feelings about motherhood, as well as appreciate the broader historical context in which her struggles might be rooted. Some aspects of a client's personal history that are important to capture include:

- previous history of depression, anxiety, or other mental-health issues;
- attachment history (early losses, trauma);
- attachment style

- family-of-origin dynamics;
- work and career path; and
- examples of coping with adversity in the past.

This history can shed light on the struggles clients are experiencing now and can be used to draw awareness to overriding patterns influencing their current experience of parenthood.

Other important features to capture include:

- What is it like when the client is alone with her baby?
- What have her best moments been since the baby was born? Her worst?
- How does she spend her time in a typical day?

As an adjunct to a narrative assessment interview, I often have clients fill out the Edinburgh Postnatal Depression Scale as one of their intake forms.[15] Many clients who feel vulnerable and exposed telling their darkest thoughts to a new therapist are able to circle a multiple-choice response, which I can then follow up with more personalized inquiry.

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Because worry and anxiety are such a prominent part of the postpartum experience, I also find self-report scales that assess worry, intolerance of uncertainty, and problem-solving help hone in on the most useful aspects of anxiety to target therapeutically.[16]

While these screening tools can augment our understanding of a client's experience, the therapeutic conversation remains the most data-rich and, ultimately, healing tool of psychotherapy. It is critical, particularly with postpartum depression, to ask about suicidal thoughts.** Usually I say, "Sometimes when people feel as desperate or alone as you do, the thought of suicide occurs to them. Have you ever thought about killing yourself?" I have never had a client react with shock, and the ones who respond in the affirmative seem grateful I've asked.

1 in 8 

new mothers suffer postpartum depression (PPD), a subset of major depressive disorder, in the year following childbirth.

2) INTERPERSONAL INVENTORY

In his book *The Gift of Therapy*, Dr. Irvin Yalom identifies finding out how a client's life is "peopled" as one of the most important early tasks of therapy.[17] Borrowed from interpersonal psychotherapy, the interpersonal inventory is a register of current relationships potentially relevant to the client's life and, thus, their psychological distress.[18] This inquiry is typically carried out through unstructured interview and can be woven into the dialogue about presenting concerns. At present, interpersonal psychotherapy is considered the best evidence-based treatment for postpartum depression,[19] and its emphasis on interpersonal relationships cannot be overstated. In conducting the interpersonal inventory, explore the following: [20]

- significant contemporary relationships, including recent losses;
- specific details of the history of difficult relationships, as well as the history of particular problem areas;
- details about social support;
- the gap between expectations and reality in key relationships; and
- current communication problems.

This provides an opportunity to focus on the relationship between the client and her partner, as well as with her baby, family of origin, and social network.

***For information on duties to report, please consult* Duties to Report and Protection When Reporting*: http://bc-counsellors.org/app/uploads/2015/10/Practice-Summary-Duties-to-Report-Updated-June-2015.pdf*

3) SYMPTOM RELIEF

In the initial session, I start by asking the open-ended question, "Tell me about what led you to reach out for counselling right now." The "right now" invites them to share the tipping point that made counselling necessary.

It is important that the "here and now" be the initial focus of work. Given the high stakes of needing to care for a baby with a limited emotional reserve, symptom relief is a critically important therapeutic objective. Stability comes first, and long-term exploration of psychodynamic influences or family-of-origin difficulties is better reserved for later, once the client's symptoms have sufficiently lessened.[21]

Kyla, a 38-year-old mother with a 10-week-old son, was referred to me for anxiety and depression concerns. She reads parenting literature all the time and wants to be prepared for everything. Here is a snippet from our first session.

Elana: *Kyla, tell me what it's been like for you since we spoke on the phone a few days ago.*

Kyla: *I've been super tired and irritable. I feel like I can't get it right. There's so much to attend to, and it all falls on me. My husband just doesn't get it.*

Elana: *So you're exhausted, feeling tightly wound, and so bogged down by all the details of parenting. It sounds, too, like you feel alone with this burden: nobody understands what it's like for you. That sounds so lonely.*

Kyla (tearing up)**:** *Yeah.*

Elana: *Tell me about who else you spend time with these days. Friends?*

Kyla: *I have a few friends, but spending time with them sometimes makes me feel worse. It's easier for them.*

Elana: *Have you opened up to your friends about your struggles?*

Kyla: *No way. I would never let on that I'm at a breaking point.*

There are so many rich themes to dig into here: the disconnect in her marriage, her difficulty exposing her vulnerability, her notion that there is a "right way" to do things. But Kyla's worry is unrelenting. She believes, as many people with anxiety do, that worrying serves an important purpose. It is a way of ensuring she doesn't drop the ball. Her constant thinking is exhausting her, and I'm concerned Kyla's frayed nerves are interfering with her ability to cope with daily life. Thus, our first therapeutic task is to target her worrying and tension.

We incorporate mindfulness-based and somatic interventions to observe her moment-to-moment escalation, as well as some cognitive therapy to address the worrying. So far, this appears to be helping her catch herself before becoming completely hijacked by her worries, and she is consequently less reactive and more able to hold a space for imperfection.

More work is needed when it comes to her marriage and unrelenting standards, but this work is more accessible when Kyla is less anxious.

A FOUNDATION TO WORK FROM

The postpartum period is a time in which biological, psychological, and social domains intersect at an intensified level. These three initial steps pave the way to a deeper understanding of the client's context, while honouring the importance of alleviating debilitating and distressing symptoms. ■

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