A Reflective Article

When 'Challenges' Become More Than That:

A Journey of Post-Natal Depression: How can we as humanistic therapists help?

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Some years ago I wrote of the death of my best friend by suicide. I struggled to come to terms with that article because I usually write academically but in it I allowed myself to combine personal grief with its application in therapy. This time I make no apologies for the personal aspect of this article. This is my journey, just as it is the journey of far too many women.

This article has three aspects, facts about post-natal depression (PND), my own journey including therapy; the good, the bad and the useful, and how humanistic therapists can help mothers with and without PND. It also implores person-centred therapists to be aware of the signs of serious distress and remember that non-directive does not equal non-action-taking.

PND – What is it?

PND describes feelings of depression and/or anxiety after having a baby. Clearly having babies brings huge change to parents' lives with many feeling unsure of their new circumstances. Generally for approximately 50-85% of women this changes after a couple of weeks (MGH Centre for Women's Mental Health: n.d.). But for mothers with PND things do not get better quickly and life can become extremely difficult. The timescale for PND to develop is generally within the first few months up to a year after birth but it may also start before delivery. Statistics say 10/15 women in every 100 are affected by PND (Association for the Improvement of Maternity Services – Ireland, n.d.).

Possible causes of PND?

It seems that there is no one cause and but rather influencing factors. These include:

- Birth experience: traumatic/ difficult birth and/or birth that wasn't as good or was different from what was expected.
- Having premature baby/babies.
- Hormonal factors post-delivery.
- Recent stressful events in a mother's life, e.g., bereavement, serious illness, isolation from their families, an unsupportive partner.
- Previous history of depression.
- Images and expectations of motherhood: these suggest mothers should be radiant, energetic, and living in perfect homes with supportive partners. Mothering is perceived as instinctive. Therefore women who find the weeks and months after childbirth difficult often imagine that they are the only ones not coping. This can lead to overwhelming feelings of inadequacy, a sense of failure and isolation that can contribute to deep emotional stress (Postnatal Depression Ireland, n.d.).
- Sleep deprivation.

How do we feel with PND?

Persistently low mood and/or mixture of moods changing from low to high and even elation. Many women feel irritable, angry and/

or exhausted all the time. Many experience difficulty falling and/or staying asleep, even when there is the opportunity, because of worry. Many report loosing interest in themselves and/or not feeling close to the baby(ies). Anxiety is very common as is the feeling of no longer wanting 'this' life. Women may not want to engage with others as well as experiencing changes in or loss of appetite and sex drive and report feeling utterly overwhelmed and unable to cope.

Post-Natal Anxiety (PNA)

Much debate exists as to whether PNA is a different disorder to PND. It has similar factors to PND and additional factors such as having had IVF and babies in Neonatal Intensive Care Unit are thought to influence it. According to Nurture symptoms include:

> *Constant worrying about the baby, parenting skills, partners' parenting skills, the future, feeling dread and having racing thoughts, Dizziness, hot flashes, sweating, rapid heartbeat, rapid breathing, nausea, stomach and digestion problems, tight chest or throat and/or tension headache, feeling you need to be holding or with your baby all the time, feeling afraid to be alone with your baby, feeling like you have to be in control of every situation.*
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> (Nurture, n.d.)

My meeting with PND

In 2014, following one miscarriage and three unsuccessful IVF treatments, I became pregnant with twins. At seven weeks, following a bad bleed, nurses told me one had died and I grieved the lost little life. Less than a week later the next scan re-found that little heart beat! I was thrilled and confused all at once. I began to worry what would happen at the next scan, the next appointment? I know now this anxiety was a huge factor in what happened after the birth.

Constant nausea until two weeks before delivery, worry about bleeds and from week 21 concern about the disparity in sizes between my pair made this pregnancy difficult. During this time female clients told me of their pregnancies, it was as if my pregnancy opened up a whole new connection between us.

At 26 weeks my consultant was concerned about one of my 'littleys'. He estimated her size as *"tiny"* and every two days I would hold my breath while he scanned me. At 30 weeks I had an emergency C-section.

Ten doctors, nurses and paediatricians, my husband and I awaited these two little ones. I was told to prepare myself as *"the outcome might not be good"*. At 3.54pm my son was born at 3lbs 4oz and at 3.56pm his little sister entered the world weighing just 1lb 9oz. For the next seven weeks, the NICU and Special Care wards were our home. We lived in a maze of monitors, alarms, respirators and incubators. Once again I found myself holding my breath as I rounded the corner each time to go through the alarmed doors.

I look back on photos of two little people, my tiny daughter only needed 15 minutes of help breathing as opposed to a day for my little boy. She contracted jaundice only once while her poor brother was repeatedly sunbathing under the lights! As determined as she had been to live, she seemed determined to show the world she was okay and feisty.

After seven weeks we were all home. That should have been an amazing time, but for me it wasn't. It was the start of a hell that I now know began during pregnancy. Sleep deprivation was huge, I was expressing eight times a day with only an hour-and-a-half sleep in any one stretch. Reflux entered the fray. But more than this, my obsession to ensure everything was 'right' took on epic proportions. Life became a military operation with time as its Sergeant Major. It was my only way to protect these two little lives that I was now responsible for. Very soon, every cry became something to worry over, every feed recorded, I knew I needed to reduce expressing because I was so exhausted but all the medics told me they wouldn't tolerate formula so I became panic-striken at the thought of it. The GP visited me, she recommended anti-depressants. I fought her, eventually took them and felt like a failure.

My twin sister saw me going through this emotional and physical decline and along with three amazing friends came over to help. By this time I was so scared that I couldn't sleep even when I didn't have to feed. Within 11 weeks I lost four stone in weight, panicked when my husband even left me to have a shower. I started to dread waking up from the very limited sleep I was getting. Within 11 weeks I became suicidal. My shame was huge. I work as a group facilitator with people who are suicidal or contemplating suicide. I couldn't put into place any of the things that help, I could only sit and cry in terror and despair.

I found a humanistic therapist who specialised in PND. My experience was dreadful. I was told to breathe, walk, sleep and spend time as a family. I know now these suggestions are useful for mild-to-moderate PND but not when PND is severe which mine was. The therapist failed to understand I was terrified my babies would die. There was no understanding of the terror, just blanket suggestions. I know I was a difficult client – so agitated I couldn't even sit. I paced and it was a relief when the hour was up. Our only agreement was both acknowledging I wasn't going to take on her suggestions. I couldn't, I wasn't capable of taking in information by then. I left far worse than I had going in because whatever hope I had slipped away as the therapist told me there wasn't much point in scheduling another session. My shame was compounded even further. The fear I was going mad and nothing could help, was now a reality.

Two weeks later, on Easter Saturday I was hospitalised with a dual diagnosis of severe PND and

PTSD. More crying, more shame. My sister likened this to my Calvary.

I will never forget my experience within the hospital and what I learned from some patients. I met many women who although now hospitalised for other issues had previously struggled with PND. I was humbled and amazed at the strength of some of the patients I came to know. I discovered the battles so many fight silently and secretly. I came to understand the importance of a kind word and saw incredible humour and fortitude.

With the help of the correct medication, therapy (that I fought for) and much needed rest I began to recover. In our first session, the family therapist said she didn't know when but she knew I would get better. Even though I was doubtful I clung to that hope and on really bad days I reminded myself of it and then slowly I began to feel it. During that time, I developed a grudging respect for my psychiatrist. I initially deplored his authoritarian way, his refusal of therapy. In time he shared his reasoning for this; his belief was that my depth of shame, combined with my physical depletion, not to mention my *"over-achieving"* personality would be a recipe for disaster with therapy and I needed to rest first and foremost. After three weeks therapy began, it was painful, practical and profoundly empathic. Over time we explored some of my anxiety and personality and in all of that I was held with great competence and care.

Ten weeks later I returned to my family, still struggling, but stronger. On World Suicide Prevention Day, September 10th 2014, I returned to work from my maternity leave aware of how fortunate I was.

Our Interventions as Therapists

An important parallel exists between the birth of a baby and rebirth of a woman into a mother. In this I see an opportunity for rich therapeutic work without ever post-natal depression being present. The learning that mother and baby go through is huge. A baby learns to live outside the womb in both a different environment and relationship with his/her mother moving from a 1:1 relationship to a multiplicity of relationships. Mother must learn to attend to this tiny new human being who depends on her for everything.

A new life brings both deep love and corresponding responsibility and this can be a time of great growth for women. It can be an opportunity to connect to ancestoral archtypes of 'Mother' to which she never before belonged. What an opportunity this provides! And what an amazing privilege it is for therapists to walk beside a woman as she experiences this.

We also have a role with women who are suffering from PND. Catterall (2005) looks at central issues of new motherhood and the changes it brings to a woman's identity which undergoes a fundamental shift. I believe we can work with a woman to integrate these shifts into her sense of who she is and work with difficulties that this may entail for some women.

At the societal level we can also explore the impact on a woman of the 'myths of motherhood' where everything 'should' be wonderful, a time of bonding and quiet time at night feeding your child/children, etc. This ignores another reality which is sleep deprivation, isolation and feeding issues, a consistently crying baby, amongst others, which may be present in this new dyad. When a woman experiences this time in her life as difficult she can feel alone, ashamed and terrified. Here is the strength of the humanistic approach. Here is where our commitment to be truly non-judgemental comes into its own. Here, by allowing ourselves to truly meet this woman we can show we hear her and convey that she is not alone. This is priceless and in time I hope would allow our client to be able to face these painful feelings in herself.

We can also help when a woman's locus of evaluation is so externalised that people in her life and society itself dictate what a 'good mother' is and, importantly, explore how she may feel because she is not reaching these often unobtainable heights. She may have struggled with feelings of not being enough previously and now being a new mother may have exacerbated these feelings. Previously I often managed to overcome difficulties as a result of willpower and hard work. But now I could no longer rely on myself to cope I didn't know who I was anymore and that brought huge anxiety because if I didn't know who I was how could I possibly care for two tiny babies who could do nothing for themselves?

However, I also believe that we client-centred therapists may be limiting how we help women who are severely distressed in this case by PND. Mearns and Cooper in their book, *Working in Relational Depth*, say of clients: *"The secret is to meet them on their terms"* (2005: x). This for me is the heart of humanistic therapy. However, sometimes I believe because we (correctly) try not to interfere with the autonomy of the client, a central core message of non-direction has become one of rarely taking action in any circumstances. So how do we deal with the paradox that meeting the client 'on their terms' may in fact mean taking action, with the client's involvement and agreement, if that is what is required if a person is in severe distress?

I fully uphold the core tenants of the client-centred approach that the client has all the answers inside and we can disempower them should we interfere/guide decision-making, and that giving direction to clients on how to live their lives does nothing to help them find/re-instate their own locus of evaluation. However, as a result of my own experience, I am questioning the validity of non-direction when a client is in extreme distress.

As therapists we accept the concept of 'normalising' a client's

experience, helping him/her to realise that they are not going out of their minds when they are experiencing pain. Therefore I believe that psycho-education does not run contrary to the person-centred approach when someone is in distress and neither does it disempower. I believe severe PND may require additional support from a therapist, e.g., the containment aspect of the relationship may need to be stronger than in relationships with less-distressed clients, where the therapist can become an attachment figure in reverse if you like. This is not about forging a dependence but offering a space where women can come to know that they are not *"going mad, not alone in their experience and that they will get better"* (Catterall, 2005, p. 219).

Once we are not rushing in to rescue or being an expert and importantly we are not filling any needs of our own I don't believe this goes against person-centred counselling. For a period of time we are offering a space where there is an element of re-assurance. I believe in time we will be able to work with the deeper dynamics behind the despair and anxiety but this can come later. First anxiety must be reduced before defences against it can be relinquished and it can be used as Rollo May suggests *"as stimulation to increase one's awareness"* (May, 1950, p. 371). Because as Lake says, although anxiety can be constructive: *"nothing is more destructive in those whose power of being cannot contain it"* (Lake, 1991, p. 90).

I am not suggesting we look to fill every: *"possible gap in the woman's experience"* (Catterall, 2005, p. 210). I am suggesting we allow ourselves become part of her support system, exploring the possibility of her joining PND support groups, working with other professionals, accepting we form part of her support. One-to-one therapy may not be enough. This is not a fault of our form of therapy. PND (and other forms of deep distress) may need more than any one support. This is particularly relevant if suicidal feelings are present and we must remember we have a duty of care to both mother and baby.

I fully accept the above may be difficult for us as therapists, I find myself constantly questioning could an unhealthy dependence be forged, could I disempower a woman by working in this way? It is this commitment to my own potentially unconscious processes that leads me to keep therapy healthy and my client's needs to the forefront.

I am now working with a wonderful person-centred therapist who has allowed me to do the things I have suggested above that can exist within a therapeutic relationship. We work with my fears on two levels – a practical level which I call the-learning-how-to-be-a-mother level and, at a deeper existential level, to talk of what these fears mean to me and how they have been present in other ways in my life. The birth of my twins brought these fears to me in a way that was impossible to ignore. In none of these sessions have I been disempowered, I have felt a healthy nurturing of my new role as well as a thorough commitment to understanding what may lie deeper.

In time parents learn to allow their children to take steps on their own. We as therapists can mirror that for women in distress too – our help will become less needed as the new mum gains strength as well as insight. I believe, as therapists, we can offer so much to women as mothers and to mothers who are suffering and in distress from PND.

Three years on my son and daughter are big, blonde, bold, happy and healthy. They are an absolute joy and sometimes an absolute nightmare with their antics times two! There are days I still struggle with anxiety particularly if they aren't eating or sleeping well but I can help myself now through mindfulness, breathing, walking, eating well and seeing friends. I know now it's okay to ask for help and I urge all mothers struggling to do the same. Similarly I urge all therapists to offer that help even if it feels like we are stepping outside of 'how we do therapy' because it will be short term.

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