Postpartum Depression: How Childbirth Educators Can Help Break the Silence

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ABSTRACT

The voices of women suffering from postpartum depression are often silent. Women are reluctant to reveal to others that they are unhappy after the birth of their babies. Much has been written on possible causes, risk factors, and treatments for postpartum depression, but little has been done to investigate why women take so long to seek help. Early detection and treatment are key to a full recovery. Childbirth educators are in the position to offer anticipatory guidance on possible complications of the postpartum period, including postpartum depression. This article explores why women with postpartum depression choose to suffer in silence and suggests how childbirth educators can help new mothers find their voices.

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Pregnancy, the postpartum period, and parenting present a multitude of challenges for many women and their partners. Findings from the *Listening to Mothers II* survey demonstrate that many new mothers experience a variety of physical and emotional symptoms after birth (Declercq, Sakala, Corry, & Applebaum, 2006). Survey results found that “improving the knowledge and skills of childbearing women” (p. 14) must be a priority, in addition to providing reliable and trustworthy maternity care.

POSTPARTUM DEPRESSION

Pregnancy, labor, and birth are perhaps the most significant life experiences that a woman and her partner will encounter. It is a time of extreme physical and emotional transition with intense hormonal, psychological, and biological changes, all of which can have an effect on the central nervous system (Studd & Panay, 2004). The puerperium

may be a time of high vulnerability for women, coupled with feelings of loss of control. Tremendous changes occur in the mother’s interpersonal and familial world. The birth of a new baby is expected to be a joyful milestone in a woman’s life, but that is not always the case. Some women experience minor adjustment issues, and others experience a grave and debilitating mood disorder, known as postpartum depression. More than half of the women with PPD go undetected and undiagnosed because the new mother may be unwilling to reveal how she is feeling to her provider or close family members, including her spouse (Beck, 2006). She may be embarrassed by her symptoms, or afraid that, if revealed, she will be institutionalized and separated from her baby (Kennedy, Beck, & Driscoll, 2002).

Postpartum depression occurs in approximately 13% of new mothers (Gaynes et al., 2005; O’Hara & Swain, 1996). It is usually detected between 2 and 6

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weeks postpartum and can last up to 2 years. Beck (2006) describes PPD as a “crippling mood disorder” (p. 40) often overlooked by health-care providers, which can cause the woman anxiety and confusion.

CHILDBIRTH EDUCATION AND POSTPARTUM DEPRESSION

Morton and Hsu (2007) investigated ways for childbirth educators to enhance the curricula in their classes in order to remain current and accommodate a new generation of consumers. Childbearing couples are attending childbirth education classes with a new set of eyes. Young couples today are more technologically savvy and have many alternatives to education, including the Internet (Declercq et al., 2006). Many of those who do attend childbirth education classes have broader interests than simply learning the Lamaze way of breathing (Morton & Hsu, 2007). Childbirth educators are modifying their curricula to support the social and cultural changes of the childbearing community and including topics such as postpartum care, newborn care, and the prevention and identification of early signs of postpartum depression.

Childbirth education classes provide an opportunity to teach a new mother to anticipate the help and support she might need for the birth of her child. According to Day (2007), depression and abuse are not adequately attended to prior to childbirth, and weaknesses exist in identifying and supporting women at risk. Day (2007) suggests ways to improve communication and support among childbirth education class members, including maintaining contact via e-mail, sending photos to each other, and even getting together for a reunion. All of these techniques may help to keep the lines of communication open. It is known that social isolation as well as the strong desire for social support during the postpartum period are related to the development of postpartum depression (Martinez-Schallmoser, Telleen, & MacMullen, 2003).

Lothian (2007) notes that childbearing women want information regarding complications and risks of childbirth, including caesarean section, epidural analgesia, and induction. Although often a hidden occurrence of illness, postpartum depression is believed to be the leading complication of childbirth today (Gaynes et al., 2005). It is an illness that is often undetected and usually obscured by the woman,

which causes her to suffer in silence. The new mother who is depressed is deprived of the pleasures and joy of giving birth and caring for her newborn baby (Kennedy et al., 2002).

Childbirth educators can play a significant role in helping to break this silence, first by providing the necessary education to help women and their partners recognize the early signs and symptoms of postpartum depression (PPD). Second, educators can help increase a woman's understanding of how to meet her own needs. This approach can improve a woman's overall state of mental wellness, thereby possibly preventing or lessening the experience of PPD. Although prevention of PPD may not be completely possible, health professionals can help recognize and reduce key risk factors. Dennis (2004) found that several interventions—including providing antenatal classes, information during the antenatal period, intrapartum support, early postpartum checkups, and continuity of care—may have significant nonpharmacological preventative results. Ogrodniczuk and Piper (2003) conducted a literature review to analyze results from studies that examined the relationship between prevention of PPD and selective interventions. Interventions assessed included postpartum debriefing, continuity of care in the postpartum period, education in the prenatal period, early postpartum checkups, support at home following childbirth, and social support in the postpartum period. An overview of such studies provides support for introducing and discussing these topics and preventative methods during childbirth education classes. The childbirth education class is an ideal environment because the educator usually has the attention of both parents or a mother and her significant other.

The overall subject matter of childbirth education should include the postpartum period as well as newborn and infant care and expectations (Kattwinkel et al., 2004). Through childbirth education, health-care professionals can also reach out to new fathers. Men often complain about not being an integral part of the childbirth experience. In a study conducted by Premberg and Lundgren (2006), fathers felt that the information obtained through childbirth classes was inadequate for their particular needs. However, they also reported that the classes not only helped prepare them for the labor and birth experience, but also gave them anticipatory guidance for what to expect when bringing the newborn infant home. A new mother may be overwhelmed and sleep deprived while caring for her newborn;

thus, it is often the father (or partner) who may recognize the early signs and symptoms of PPD. The new mother may not want to admit to having these symptoms, but the father/partner can encourage or urge her to seek help when needed. If the father or partner learns about the early warning signs of PPD during classes, he or she will be in a better position to assess and notice these changes and to encourage the new mother to seek help.

POSTPARTUM MOOD DISORDERS AND SYMPTOMS

Bennett and Indman (2003) classify postpartum mood disorders into five categories: (1) postpartum depression and/or anxiety; (2) postpartum obsessive-compulsive disorder; (3) postpartum panic disorder; (4) postpartum psychosis; and (5) postpartum posttraumatic stress disorder. Each disorder presents a range of mood changes and physical complaints. Bennett and Indman (2003) also note that postpartum “blues” is not considered a disorder; it is regarded as part of the normal postpartum adjustment.

Postpartum “Blues”

According to Bennett and Indman (2003), normal postpartum adjustment and the “blues” represent normal biological and psychosocial adjustments to giving birth and do not impair the daily functioning of the mother or impinge on the maternal-newborn bonding experience. Approximately 80% of postpartum women experience the “blues,” which are mild hormonal changes that take place within the first 48 hours after giving birth. These symptoms may last up to 6 weeks (Bennett & Indman, 2003). Symptoms of the “blues” include mood instability, weepiness, sadness, anxiety, lack of concentration, and feelings of dependency (Beck, 2006). If symptoms last longer than 6 weeks or worsen during the 6-week interval, a woman meets the criteria for being diagnosed with PPD.

Postpartum Depression and/or Anxiety

Symptoms of PPD and anxiety are presented in a number of ways. They may include excessive worry or anxiety; irritability or short temper; feelings of being overwhelmed; feeling very sad, guilty or phobic; hopelessness; sleep disturbances (either too much or too little sleep); excessive physical complaints; loss of focus or concentration (frequently missing appointments); loss of interest or pleasure in anything; lack of libido; and changes

in appetite (weight loss or gain) (Bennett & Indman, 2003).

Postpartum Obsessive-Compulsive Disorder

Postpartum obsessive-compulsive disorder presents in 3% to 5% of new mothers (Bennett & Indman, 2003). The primary symptom consists of repetitive and unrelenting thoughts, fears, or images. The thoughts appear spontaneously and may or may not involve harming the baby either intentionally or accidentally.

Postpartum Panic Disorder

Postpartum panic disorder occurs in about 10% of postpartum women (Bennett & Indman, 2003). Feelings come on suddenly, and the woman experiences extreme anxiety. An episode includes physical symptoms such as shortness of breath, chest pain, and sensations of choking, dizziness, derealization, hot or cold flashes, trembling, restlessness, palpitations, numbness, or tingling (Beck & Driscoll, 2006).

Postpartum Psychosis

According to Bennett & Indman (2003), postpartum psychosis is the most extreme of all the postpartum mood disorders. It is rare, occurring in 1 to 3 mothers per 1,000 births. Onset is within the first 24 to 72 hours after giving birth. Postpartum psychosis has a 5% suicide and a 4% infanticide rate. Afflicted women have an abnormal thought process and lose touch with reality. Considerable confusion, poor judgment, delusions, and hallucinations are noted, usually with a religious quality. Postpartum psychosis can be life-threatening to both the mother and the baby (Bennett & Indman, 2003).

Postpartum Posttraumatic Stress Disorder

According to Bennett and Indman (2003), postpartum posttraumatic stress disorder is usually connected to a specific trauma relating to the birth of the baby or an event from the woman’s past. A new mother who is reminded of this past trauma can often suffer from panic attacks. Symptoms may include recurrent nightmares, extreme anxiety, or reliving past traumatic events, including sexual trauma, physical or emotional trauma, and childbirth (Bennett & Indman, 2003).

A COMPLEX HEALTH PROBLEM

The occurrence of PPD is rapidly being recognized as a major public health problem (Gaynes et al.,

2005). Furthermore, the occurrence of PPD is an apparent paradox. It is an unusual disparity for a woman to become clinically depressed just weeks after giving birth, a time when one would assume the new mother is happy and joyous. Although PPD mimics a traditional clinical depression, there are major symptomatic differences between the two disorders. Women who suffer from PPD usually manifest symptoms that are much more severe than women who suffer from a major depressive disorder that is unrelated to the postpartum period (Jacobsen, 1999).

Mauthner (2002) conducted interviews and found that women with PPD perceive themselves and those around them with trepidation. These women assume a passive attitude, and they will often isolate themselves from others due to fear and a lack of understanding of their illness. Women with PPD would rather separate themselves from friends and loved ones than reveal what they are experiencing, especially when it goes against social and cultural standards and expectations. Their fear of being labeled as a nonperfect mother creates the silence that makes their illness difficult to endure and their recovery complex.

SIGNS, SYMPTOMS, AND BEHAVIORAL CHANGES IN WOMEN WITH POSTPARTUM DEPRESSION

A variety of symptoms of PPD contribute to the silence in sufferers. The experience from one woman to the next varies tremendously, which results in confusion for the woman who tries to distinguish and understand what she is experiencing (Venis & McClosky, 2007). Some women may feel that they do not have PPD because they do not feel “depressed.” Instead, they may be experiencing severe anxiety, disrupted sleep, loss of appetite, and obsessive thoughts about their newborn. Some women actually feel as if they are “going crazy” because their symptoms do not match what they read or hear about, and they are afraid to reveal the things that are really going on inside their heads. These symptoms can lead to feelings of worthlessness and of being a bad mother, no interest in previous enjoyable activities, little interest in her newborn, and obsessive worry over the baby’s health. If left

untreated, a new mother can begin to experience repeated thoughts of death or suicide, which can occur in any major depressive illness (Beck, 2002).

Postpartum depression has become a type of psychological block for women who suffer. According to Gilligan (1982), when a girl grows into womanhood, she is expected to become a selfless individual. Attachment or bonding is fundamental in the development of a loving and trusting relationship between a mother and her newborn baby. What new mothers do not realize is that bonding with their infant can take some time and effort. A new mother’s expectation of an immediate bonding can cause her to feel incompetent. A combination of physical, psychological, and biopsychosocial factors can cause this bonding experience to go awry. The social stigma of a lack of bonding or the possibility of a new mother not feeling complete bliss over the birth of her child causes the woman to remain silent. “This loss of relationship leads to a muting of voice, leaving inner feelings of sadness and isolation. In effect, the young woman becomes shut up within herself” (Gilligan, 1995, p. 125). The woman with PPD may feel a loss of relationship with her newborn, spouse, friends, and even her own mother. Women have described feeling totally alone, unaware that they may be causing their own isolation.

WHY THE SILENCE?

Women with PPD tend to suffer with their symptoms for quite some time before admitting to their symptoms or seeking help. Some women never get help and just wait until the symptoms dissipate with time. Many choose to suffer alone, unable to tell their friends, spouse or health-care provider what is happening. They often struggle with this decision, knowing that by not seeking help they are being irresponsible, placing themselves and their new baby in possible danger, yet they still choose to remain silent.

Mauthner (2002) found that many new mothers are afraid to admit to their symptoms of PPD and are disinclined to seek any form of medical or psychotherapeutic help because they are fearful of the consequences. These women know that, if they admit to having thoughts of harming their newborn or themselves, they will be hospitalized. They are also terrified of having their baby taken away from them. These women are concerned about the public humiliation. They do not want to feel different from other mothers, and they are apprehensive about

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the stigma related to depression and being under the care of a mental health provider. Some women, especially those who grew up in a cultural community that has high expectations of motherhood and parenting, may be afraid of disapproval by others in their society. They are gravely concerned about their future relationship with their child and how their depression will affect the child's development.

Childbirth education classes provide information about the process of pregnancy, childbirth, and the early stages of becoming a parent. The purpose is to help expectant couples gain awareness and prepare for their birthing experience and to provide them with comfort and pain-management skills (Nichols & Humenick, 2000). Although the general philosophy of Lamaze International (2007) is to promote normal birth, according to Lothian (2007), childbirth educators have a captive audience and can broaden their curricula. Childbirth classes are an ideal time to introduce the possibility that things may not go as planned and to provide content about signs and symptoms of PPD.

Mauthner (1999) argues that women, in general, are deeply concerned with relationships and become somewhat vulnerable and dependent on others. Their vulnerability intensifies when they have a new baby and realize that the workload, sleep deprivation, responsibilities, and social isolation are not what they anticipated. This creates a sense of loss of control, causing depression to set in. Mauthner (1999) believes that mothers are constantly belittled, and motherhood is viewed in a negative light. Women who are career-oriented are looked upon more favorably in the public eye and are viewed as independent. Mauthner (1999) states, "Postpartum depression occurs when women are unable to experience, express and validate their feelings and needs within supportive, accepting and non-judgmental interpersonal relationships and cultural context" (p. 160).

In Lauer-Williams' (2001) phenomenological research study on women with PPD, a general theme that emerged was guilt, humiliation, and a feeling of not being an average mother. These women wanted to fit in with everyone else and felt somewhat disgraced by the fact that they did not. Lauer-Williams (2001) concludes that women with PPD who choose to remain silent are more concerned about their exposure to the public than they are about what is going on inside of themselves. They seem to have high expectations of themselves around caring for their

newborn, tending to their physical appearance, their homes, breastfeeding around the clock, and so on. Their silence may stem from that fastidiousness, vying for perfection, and not being able to admit that they might be less than a perfect mother.

Edhborg, Friberg, Lundh, and Widstrom (2005) found that the new mothers in their study tried so hard to manage their newborn and their feelings that they were afraid to show any kind of weakness. The women were not willing to discuss their feelings with anyone, even close friends and family. Mauthner (1999, 2002) found that women with PPD are often thankful when they discover they have a diagnosable illness as opposed to being "crazy" or "bad mothers." Lamberg (2005) notes that health-care providers may not be able to pick up on symptoms of depression because the symptoms often mimic other perinatal disorders, such as anemia, thyroid disease, and gestational diabetes. Women with PPD may not report their symptoms to their health-care provider due to stigmatization, and they may refuse psychotropic medications, thinking the medication will harm their newborn if they are breastfeeding. Most of the studies on PPD have included women who presented with symptoms in their health-care provider's office or clinic. Study results reveal that not many women seek treatment on their own. Women who do seek treatment are probably more symptomatic than those who do not, and they may also have had a prior history of depression (Battle, Zlotnick, Miller, Pearlstein, & Howard, 2006).

Edwards and Timmons (2005) found that five out of six women in their study were reluctant to come forward about their illness and, therefore, did not receive treatment for PPD in a timely manner. The women all felt that their symptoms were a reflection of them as mothers, and if they were perceived as unable to cope with motherhood, their babies would be taken from their care. They felt that they did not have the natural maternal instincts that other mothers reported, and even though they were caring for their infants in a mechanical way, they feared that even those tasks might become difficult as their illness progressed. Once the women were told that they actually had a treatable illness, they were quite relieved.

Childbirth educators can offer anticipatory guidance and instruction by increasing awareness of possible mental health changes in the postpartum period. According to results in a study by Roux, Anderson, and Roan (2002), postpartum women are unprepared for the feelings of stress, loneliness,

and seclusion that they experience. Ho and Holroyd (2002) found that the women in their study who attended childbirth education classes did not feel prepared for motherhood. Although they felt confident in their knowledge regarding self and newborn care, they were unprepared for the demands of the first postpartum month. However, couples who attended a subsequent class on emotional issues felt prepared for the demands of bringing home a newborn, as well as the possibility of mood disorders, and were told to alert their spouses for help if symptoms of mood disorders became apparent. According to Roux et al. (2002), childbirth and Lamaze educators need to be upfront with couples and provide information on postpartum changes and possible mood disorders, offering them appropriate resources on where to get help if the need arises.

PRACTICE IMPLICATIONS

Nurses and childbirth educators in all clinical areas need to be aware of the signs and symptoms of PPD and increase awareness that PPD is a treatable disorder. By teaching women and their partners about symptoms of PPD, educators can increase the chance that an afflicted woman will receive proper screening, diagnosis, and treatment. Couples who have been educated about the signs and symptoms of PPD will be aware and alert if and when the disorder occurs. Knowing that PPD is an illness that does happen on occasion, and the odd feelings they may experience are all part of the syndrome, will help new mothers come forward and not feel stigmatized. This knowledge will enable them to ask for help and to seek out the necessary resources for their care.

INCORPORATING POSTPARTUM DEPRESSION CONTENT INTO THE LAMAZE CURRICULUM

According to Humenick (2002), it is during the prenatal period that couples are most receptive to the changes that are happening in their lives, and they are willing to take in and absorb a great deal of information on their pregnancy and beyond. Even though educators try to maintain a sense of “normalcy” in childbirth and do not want to instill fear in couples, approaching the possible challenges cou-

ples may face in the postpartum period may prevent serious consequences that can happen from delayed diagnosis and treatment.

Stress Importance of Advance Planning Prior to Birth

The topic of PPD can be added to the last class in the series when the discussion mostly focuses on preparation for labor, the hospital, bringing the newborn home, and what to expect in the postpartum period. Couples can be encouraged to do some after-birth planning such as interviewing pediatricians, preparing their hospital bag, and stocking up on all the necessities and paraphernalia that they will need for their arrival home from the hospital with their newborn. This is also a good time to discuss breastfeeding.

The last class may also be reserved for discussions on how couples can prepare their home in order to make life as easy as possible. Most new couples are unaware of the magnitude of bringing a newborn home. Educators can suggest that the couples prepare meals in advance or obtain takeout menus from local restaurants. Most of all, they can be encouraged to arrange in advance for domestic help during the postpartum period. Many new mothers are unaware of how tired, sore, and overwhelmed they will be during the postpartum period. There is also always the possibility of having an unplanned caesarean section, which can further immobilize the mother in the first few days after birth. By making advance arrangements—with her mother, mother-in-law, or even hired help such as a doula—the new mother can anticipate the ability to get the rest that she needs. According to Simkin (2001), a new mother’s most important tasks in the early postpartum period are to initiate a good feeding relationship with her newborn, to get enough rest, and to eat properly in order to give both partners an opportunity to get to know their newborn.

Stressing the importance of planning in advance for help during the postpartum period may prevent the fatigue, sleep deprivation, and/or social isolation that can sometimes create vulnerability in postpartum women and, in turn, may make them more likely to develop PPD. According to Sichel and Driscoll (1999), women may have various psychological or psychosocial issues or stressful life events that occur over time. The weight of these life events can disrupt the balance of the brain biochemistry, resulting in a sort of “emotional earthquake” (Sichel & Driscoll, p. 99).

Childbirth educators can offer anticipatory guidance and instruction by increasing awareness of possible mental health changes in the postpartum period.

Introduce Possibility of Developing Postpartum Depression

Studies have shown that many physiological, biological, and psychosocial factors may contribute to the etiology of PPD. Some of the physiological factors include fatigue, pain, thyroid abnormalities, weakened immune system, and elevated cholesterol (Kendall-Tackett, 2005). Some of the psychosocial factors include alterations in self-esteem, expectations of motherhood, a sense of loss, prior psychiatric diagnosis, family history of psychiatric illness, history of abuse or violence, parenting difficulties, stressful life events, socioeconomic status, social support, and cultural rituals (Kendall-Tackett, 2005).

Again, the final childbirth education or Lamaze class, which typically focuses on the postpartum period, is an appropriate time to introduce the possibility of developing PPD. A brief discussion of normal postpartum adjustment issues and postpartum blues can be presented, followed by a discussion of more severe emotional reactions such as PPD. Because the spectrum of symptoms can vary, it is important to review the five categories of postpartum mood disorders, as described by Bennett and Indman, (2003). Sometimes, a postpartum woman will feel a variety of symptoms and not be aware that she is experiencing PPD because she is having more anxiety than depression. Providing a list of warning signs (Table 1) will help couples understand what to look for and when to know to seek help. It is important to emphasize that early detection and treatment is the fastest way to recovery. It is also important to explain to the couples how to differentiate between normal postpartum adjustment, postpartum blues (Table 2), or a postpartum mood disorder.

It is probably wise to approach the subject of PPD gently and to ease it into an already established curriculum. Some childbirth educators and Lamaze instructors address postpartum emotions during the class scheduled for discussion of possible complications in labor and caesarean sections. Potential complications in the postpartum period and warning signs such as increased bleeding and fever are typically discussed; this would be a good opportunity to mention the possibility of developing postpartum blues, which is very normal, and, if the depression worsens, that a small percentage of women can develop PPD. A discussion of risk factors (e.g., prenatal depression, childcare stress, life stress, a lack of social support, prenatal anxiety, marital conflicts,

TABLE 1
Warning Signs of Postpartum Mood Disorders (Onset May Occur at 4 Weeks up to 1 Year)

- Increasing insomnia, even when the baby is sleeping
- Extreme emotional lability, crying excessively
- Overeating or undereating
- Increasing depression or irritability
- Thoughts of hurting themselves or their newborn
- Becoming increasingly socially withdrawn
- Not interacting with the baby, feeling discomfort in the role of motherhood
- Anxiety or panic attacks
- Hypomania or mania symptoms—no need for sleep, speaking very fast, hyperactive
- Psychotic break—hallucinations/delusion (extremely rare)

a prior history of depression, postpartum blues, single parenting, and low self-esteem) can alert parents to their risks of developing PPD and increase their awareness of these factors (Beck, 2006).

Many different resources are available to postpartum women. The two largest national organizations are Depression After Delivery and Postpartum Support International. These organizations focus on helping women through education, information, support, and referrals in the event of difficulties after birth. They also offer support-group information, conferences, recommended reading lists, and lists of mental health providers in every state. Postpartum Support International has a Web site that includes information about PPD and offers self-help suggestions. Web sites are a good source of information for childbirth educators to keep up on current information regarding postpartum mood disorders. They are also helpful for couples to access information on their own, so they can recognize their symptoms and not feel as if they are completely alone. A list of Internet resources is presented in Table 3.

CONCLUSION

The veil of the stigma associated with PPD will slowly lift as more women struggle to find their voice. Childbirth educators and Lamaze instructors

TABLE 2
Postpartum Blues (Lasts from a Few Days to 3 Weeks)

- Mood swings
- Weepiness
- Mild anxiety
- Fatigue/Low energy
- Worry
- Mild sleep disturbances

TABLE 3
Internet Resources for Postpartum Depression

Postpartum Depression – Information from the Mayo Clinic

- <http://www.mayoclinic.com/health/postpartum-depression/DS00546>

Postpartum Depression – Information from MedlinePlus,
a service of the U.S. National Library of Medicine and the
National Institutes of Health (available in English and Spanish)

- <http://www.nlm.nih.gov/medlineplus/postpartumdepression.html>

Postpartum Support International (PSI)

- <http://postpartum.net/>
- Includes the PSI Postpartum Depression Helpline: 1-800-944-4PPD

**Postpartum Depression and the Baby Blues – Information
from the American Academy of Family Physicians**

- <http://familydoctor.org/online/famdocen/home/women/pregnancy/ppd/general/379.html>

Depression after Delivery, Inc. (DAD)

- <http://depressionafterdelivery.com>

are in the front line to alert expectant couples to the possibility of a postpartum mood disorder. Many obstetrics and pediatric offices now provide screening tests for women who exhibit signs and symptoms of PPD. However, many of these women will still be reluctant to admit to or come forward with their symptoms. By educating them in their prenatal classes, it is hoped that these women will be empowered to admit that they are having a problem. Likewise, their spouse or significant other will also be more aware of the signs and symptoms and encourage the new mother to seek help.

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