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THE ROLE OF EARLY PSYCHOLOGICAL INTERVENTION IN THE PREVENTION AND TREATMENT OF POSTPARTUM DEPRESSION

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Summary

Perinatal mood disorders are a common phenomenon among young mothers: postpartum depression affects about 13-20% of women, prenatal depression occurs even in 19% of pregnant women. However, in Poland, there are no systemic solutions regarding screening, diagnosis, and treatment of patients suffering from postnatal depression. From 2019, new standards of perinatal care are introduced to Poland, imposing the obligation to monitor the mental state during pregnancy and in the postpartum period. Furthermore, the Ministry of Health is launching a nationwide program for the prevention of postnatal depression which will include, among others, screening tests and free diagnostic consultations. After the introduction of the screening system, the question arises: what treatment should be offered to women with the diagnosis of postnatal depression? Understanding postnatal depression as a phenomenon of complex etiology, including biological and social factors, to answer this question, we will devote special attention to the psychological dimension. Based on the theoretical background, research results, and our own experience, we formulate practical guidelines for the implementation of short-term, early psychological interventions. We also present examples of the application of our guidelines in practice.

In this work, we present early psychological interventions as a method of prevention and treatment of postnatal depression. As affective disorders have a complex etiology, including biological, psychological and social factors, among others, in our work we focus mainly on the psychological dimension of this disorder. Our understanding of psychological factors is based primarily on psychodynamic concepts, emphasizing difficulties in reconciliation with loss and deficiencies in thinking about emotions as elements influencing the development of postnatal depression. Having outlined the psychological understanding of the background of depressive disorders associated with childbirth, we present a short review of evidence-based data concerning the effectiveness of psychological interventions in the perinatal period, indicating the important role of early psychological interventions in the treatment of affective disorders in this period. We will formulate a few practical guidelines, emphasizing particularly the role of early responses, both

diagnostic and therapeutic, on developing depressive experiences. Early interventions are effective, even if they are limited in time. The literature review will be illustrated by clinical examples presenting the practical application of early interventions for those experiencing developing or fully developed postnatal depression.

Postpartum depression

Perinatal mood disorders are a common phenomenon among mothers [1,2]. The continuum of postpartum depression extends from the gentle and transient forms of the so-called baby blues, a state not requiring specialist intervention, which is experienced by 50-80% of women, through typical depression with mild or moderate symptoms, up to cases of postpartum psychosis, understood as a deep depressive episode with psychotic features [3], often requiring hospitalization, experienced by 50-80% of women, up to postpartum psychosis, often requiring hospitalization. Among the forms of mood disorders is postnatal depression. Most common symptoms include anxiety, irritability, difficulties in thinking and memory, anhedonia, fatigue, insomnia, anxiety, guilt, and suicidal thoughts. These symptoms are often accompanied by a decrease in self-esteem, worrying about the child's health, fear of taking care of the child, feeling of being worthless as a mother, lack of self-confidence, and unrealistic expectations of oneself. Postpartum depression affects about 13-20% of women [1-4], however, the patients often do not link symptoms of depression directly with the delivery.

We will illustrate this definition with a rather typical clinical situation in our practice: In the first interview with the therapist, [L.K.], Mrs. C. reported difficulties in the relationship with her husband as her main problem. She complained that in the last six months, she has been feeling empty and had the impression that her life had lost all colors. She also mentioned the overwhelming feeling of chronic fatigue and tension, which did not leave her regardless of the actual amount of time spent on rest. Tormented by her condition she has become more and more irritable, and her explosive mood has led to numerous quarrels with her husband. Asked during the consultation, she noticed that after the birth of her first child she had not lost the ability to enjoy life, and the relationship with her husband remained good. It was not until the first contact with the psychologist when she associated her distinct depressive symptoms with the fact of the birth of her second child and especially with the emotional meaning of this event, recognizing that “something has just broken down, maybe because we have less time.”

Less known than postpartum depression but similarly common is prenatal depression, which is experienced by 12-19% of pregnant women [5, 6]. Additionally, depression during pregnancy is a major factor in predicting the risk of developing depression after the birth of a child. Taking this regularity into account, the DSM V classification does not mention postpartum depression as a

separate disease but distinguishes depression with the onset in the perinatal period: during pregnancy or during the first four weeks after delivery [7]. According to the European classification ICD-10, postpartum depression is a disorder occurring in the first 6 weeks after delivery [8]. Many researchers and practitioners, however, state that the ICD-10 criteria should be changed to take into account a longer time of onset of symptoms, up to 6 months [9] or even one year after childbirth [10].

Postpartum depression is a significant threat to public health and social well-being. Untreated depression, both prenatal and postnatal, has significant consequences for both the mother and the child. Depression during pregnancy doubles the risk of preterm birth [11-14], pre-eclampsia [15] diabetes [16], and cesarean section [17, 18]. In the long term, it also has a negative impact on the child's emotional and social development. In the first weeks after delivery, the newborn is absolutely dependent on its main caregiver (in the vast majority of cases – the mother). Maternal depressive disorder is associated with higher parental stress and an increased risk of undertaking negative parental practices by the mother. This has a long-term impact on the development of the child: The Avon Longitudinal Study of Parents and Children (ALSPAC) population study (n = 9848) has shown that postnatal depression has negative and lasting developmental consequences - also seen in the children at the age of 18 years [19]. Particularly endangered is the group of children, whose mothers have suffered from depression between their 2nd and 8th month of life. These women were much more likely to be diagnosed with depression even 11 years later. Their children 4 times more often had problems with behavior between the 3rd and 4th year of age, twice the risk of math problems at the age of 16 years and 7 times higher risk of depression at the age of 18 years [19].

The research team under the direction of Beebe [20] demonstrated that the mother's depression changes the interaction patterns in the mother–infant dyad as early as in the fourth month of the child's life. For example, in the pairs of depressive mothers and their infants, there is lower coordination of visual patterns than in non-depressed mothers and their children, as well as a common pattern of visual withdrawal. The pattern of looking by babies of depressive mothers has been defined as "watchful." The mothers and infants are, therefore, less predictable interaction partners: they look at each other longer, but they synchronized their behavior less. In addition, these mothers become overly excited when their children show positive affect and are overly disappointed when their children are irritable or have a bad mood.

The quoted results also show how the mother's depression interferes with the child's expectations of interaction and create a situation in which the child becomes overly alert to the signals sent by the other person, what disturbs the development of self-regulation in the child, is

associated with a greater risk of developing an insecure attachment style and, therefore, has long-term consequences for their further development.

Psychological background of postpartum depression

Before making a few comments on the psychodynamic understanding of the emotional background of depressive disorders, we would like to emphasize clearly that we share the opinion that depression is a disease of complex etiology. We recognize and appreciate the contribution of biological, genetic, and social factors as risk factors for the onset of depressive episodes. The following considerations are not, in our understanding, an attempt to completely explain the causes of postpartum depression but serve to describe one of the aspects – the emotional dimension.

The background to understand postnatal depression from the perspective of the psychoanalytic theory is the general understanding of depression formulated by representatives of this approach. The basis of the psychodynamic approach to depression are Freud's observations and statements, formulated in his classic work from 1917 [21]. Freud noticed that a depressive person is someone, who in their childhood directed her or his love to another person and was disappointed (what is called "losing the object of love"). As a result, she or he does not accept the loss and identifies herself/himself with the lost object, "incorporates" it into the area of her or his ego. Anger, originally felt towards the lost object, is directed at herself/himself. Subsequent experiences of loss may lead to the onset of depressive symptoms: directing aggression towards the inside may result in lower self-esteem, self-accusation, suicidal thoughts, or even suicide.

Maintaining Freud's classic work as a basis for understanding depression emerges not only from its clinical usefulness in psychotherapy, confirmed by numerous case studies [22, 23] and the results of research on the effectiveness of depression therapy in the analytical convention [24] but also from the possible relationship between Freud's observations and modern neurobiological and psychiatric knowledge [25].

Although the issue of depression is frequently undertaken in the psychoanalytic literature, relatively few publications have been devoted to the psychoanalytic understanding of the narrower phenomenon of postnatal depression. The review of literature by Blum [26] identifies three general themes in the psychodynamic understanding of postpartum depression. In a simplified way, we can distinguish emotional conflicts related to dependence, experiencing anger, and motherhood. Conflicts related to dependence usually take the form of its rejection, anger-related problems are associated with feelings of guilt and the inhibition of anger, and maternity-related issues include the problematic identification of a woman with her own mother. Blum [26] also formulates a valuable observation to which we will return later: she notes that due to the patient's conflicts related to dependence, a patient with postnatal depression may be reluctant to the proposal of long-term

therapy, which includes a strong dependency.

Generally speaking, the conflicts indicated by Blum [26] may contribute to the onset of postnatal depression in the case of an insufficient ability of the patient to think about their emotional experiences. If difficult emotions related to dependence, anger, and motherhood can be embraced by thoughts, the risk of unconscious discordance with loss and the development of depressive symptoms remain low. However, if it is not possible to reflect these feelings, depression can be an attempt to avoid their explosive influence. The ability to create mental representations for difficult feelings is a technique of work recommended in the treatment of depressive disorders in various branches of the psychoanalytic theory, *e.g*. in trends developing the concept of mentalization [27], in the contemporary British school, especially in the continuation of Bion's thoughts [28], or in the American intersubjective and relational psychoanalysis [29]. It is worth mentioning that postnatal depression is associated not only with the maternal impairment to think about her internal experience but also about the child's experience – this difficulty is referred to as "hypomentalization" [27], which can be defined as the inability to understand internal states in terms of feelings, desires, intentions, or motivations. The internal experience becomes concrete; during consultations, mothers suffering from depression may focus mainly on their somatic experiences, fears about their own health, etc.

To illustrate the difficulties in thinking about painful emotions associated with loss and changes we present another example from our practice. Mrs. B was referred for consultation by a lactation consultant. Throughout the first consultation, Mrs. B focused on detailed descriptions of the series of treatments and rituals she took to avoid breast inflammation, perceived by her as a potentially life-threatening state. At the same time, these treatments aimed at maintaining the ideal flow of milk, the only food a baby can accept. During the first consultations, the therapist [M.Ch.-D.] focused primarily on listening carefully to Mrs. B. In her comments, she introduced the possibility of noticing and thinking about the feelings accompanying the beginning of motherhood: the fear of losing control over the body, anger related to dependence; the feeling that the child will make it completely impossible to continue even elements of her earlier life; about experiencing contradictory feelings towards people whom Mrs. B initially presented as "exclusively perfect". During 10 sessions of Mrs. B's monologue, the reports of feeding-related treatments and fears took up less and less space. The patient could start talking about the fact that she had not planned pregnancy or children, the feeling of injustice and anger at her husband, whose life was not affected in by taking care of the baby as much as hers, and about the relationship with her mother, who she initially described as perfect. The sessions focused on discussing changes related to the birth of her child and the accompanying feelings, which enabled Mrs. B to accept her ambivalence towards the

child and the situation of using support. The patient also gained the opportunity to use her anger to set boundaries for her relatives and their expectations. During the short work with Mrs. B, the three conflicts highlighted by Blum [26] emerged, regarding dependency, anger, and the role of motherhood. In the therapist's opinion, the most helpful element was the opening for the possibility of thinking about ambivalence towards motherhood and the infant, which allowed her to accept those contradictory feelings.

The need to strengthen the ability to think about painful emotions in patients suffering from postnatal depression is important because of the risk suggesting the possibility of developing deeper, psychotic forms of depression in this sensitive period. In this study, we do not distinguish between psychotic depression in the postpartum period and postpartum psychosis as separate disease entities. There is no consensus in the literature on the subject whether to use these concepts as synonyms or to differentiate between them. We adopted the understanding proposed by the authors of the literature review on the mental health of mothers and children, implemented by the World Health Organization [3]. The authors state that: "the term 'postpartum depression' refers to a nonpsychotic depressive episode that begins in the postpartum period" 3, p. 21], while "very severe depressive episodes which are characterized by the presence of psychotic features are classed as postpartum psychotic affective illness or puerperal psychosis. Those are different from postpartum depression in their etiology, severity, symptoms, and treatment" [3, p. 17].

Lucas [30], referring to the results of statistic studies [31,32], suggests that psychotic postpartum depression, also in the form of puerperal psychosis, is underestimated and occurs much more frequently than the generally accepted number of one case per 500 births. He estimates that the frequency of psychotic depression exceeds the number of three cases per 100 births; usually, however, patients are not hospitalized.

Psychoanalytic authors dealing with psychotic disorders, including psychotic depression, clearly indicate the great value of early interventions, allowing to reduce the destructive power of the psychotic crisis, and in some cases stop the development of the psychotic process [33].

In the practical dimension, we get the impression that one of the most important problems in working with patients suffering from perinatal depression, is the difficulty to accept numerous losses associated with the transition to motherhood. In addition to the relatively obvious losses associated with reformulation of the current way of life, limitation of professional activity, increased dependence on other people, and intense and aggravating physiological changes, the patients have to deal with complex losses associated with the reconstruction of their previous intimate and family relationships and the confrontation of imaginations about themselves with reality. We believe that an important dimension of psychological help is to support patients in

thinking about these losses. The social context, suggesting that motherhood should be a time associated only with happiness and profits and not with losses, seems to additionally contribute to these difficulties.

Effective psychological interventions for postpartum depression

According to an economic analysis conducted in Canada, the costs of untreated depression of pregnant women, including discontinuation of antidepressant drugs are valued at USD 14 billion per year [34]. In Poland, so far, there is no data concerning the costs of untreated depression, but above all, we do not have any systemic solution in the field of screening and treatment of parents suffering from pre- or postnatal depression. From January 1st, 2019, however, the Ministry of Health introduced changes that brought Poland closer to the health policy conducted in most European countries. Thanks to European Union funds, the Ministry of Health launched a national program in the field of education and prevention of postnatal depression. Physicians, midwives, and pediatric nurses are trained in perinatal mental health issues, screening for postpartum depression, and ways to encourage vulnerable mothers to contact a psychologist. The ministerial program finances three diagnostic consultations for women, who will receive higher results in the Edinburgh Postpartum Depression Scale which will be used for screening [35]. According to the Ministry's recommendations, the goal of the consultation is to confirm the diagnosis of depression. The need to identify effective psychological interventions for mothers with the diagnosis of postnatal depression and the formulation of practical guidelines for the implementation of these interventions becomes even more urgent.

Stephens et al. [36] noticed that 90% of mothers receiving help due to postnatal depression received help in primary care facilities. Pharmacotherapy was beneficial, but patients rarely used it, so Stephens' team focused on studying the effectiveness of psychological interventions [36]. The analysis of 6,000 published research results led to the isolation of 10 research projects meeting strict methodological criteria: random control trial type tests; carried out in primary care facilities; including mothers with the diagnosis of depression or an elevated Beck depression score/ Edinburgh Postpartum Depression Scale. Meta-analysis showed that psychological interventions (cognitive-behavioral, interpersonal therapy, counseling, other therapies) lead to a reduction in depressive symptoms in a significantly larger range than in the case of control groups. The result was maintained both immediately after the intervention (mean difference -0.38 at $p = 0.05$) and after half a year (-0.21 at $p = 0.005$). There were no significant differences between the different types of intervention.

In another study comparing the effectiveness of various interactions with postnatal depression, the combination of the effectiveness of counseling, psychodynamic, cognitive–

behavioral, and standard care indicates the highest effectiveness of psychodynamic psychotherapy [37]. When patients are willing to use pharmacotherapy, both forms of treatment are effective. For example, Logsdon [38] showed a significant reduction in depressive symptoms 8 weeks after pharmacological treatment (nortriptyline and sertraline). The use of psychotherapy and psychosocial interventions reduces the severity of postpartum depression symptoms by 30% [39].

It is also worth emphasizing that psychotherapy should be the first choice treatment of mild or moderate depression [40]. Also in the case of prenatal or postnatal depression, it is recommended that women with moderate severity of symptoms should receive intensive psychological intervention [41]. According to researchers, psychological interventions contribute to reducing the intensity of depression symptoms immediately after termination of psychotherapy, and their effects persist also 6 months later [36].

Directions for intervention

Based on the above-mentioned research results, the theoretical background, and our own clinical experience, we would like to present and discuss some practical guidelines for psychological interventions in relation to patients with psychological depression. Attention should be paid to:

1. direct, early intervention
2. short-term nature of the intervention
3. widespread and costless availability of the intervention
4. focus on supporting the ability to think about emotions
5. progressive nature of help and strengthening of patients' independence

We will briefly develop these recommendations to justify their formulation and make it easier to put them into practice:

1. **Direct, early intervention.** The cited research results clearly indicate that mothers reaching for support due to postnatal depression do not seek specialist help but help which is easily available (in Western countries – in primary care centers). It is therefore important to allow the easiest access to psychological interventions. Psychoanalytically oriented researchers [42, 43] emphasize that the period after childbirth is a time of special emotional sensitivity, openness, and flexibility for new ways of thinking, which increases the possibility to benefit from help and gives hope that even short-term intervention may be helpful. Bydlowski [43] described the phenomenon of "maternal mental transparency", which is established already during the first weeks of pregnancy, and which is characterized by the returning to the consciousness of childhood memories and experiences related to the child's relationship with the mother. According to this author [43], this phenomenon is characterized by clinical affective states,

however, it is natural for pregnant women and makes conflictual feelings more easily available for examination and overwork. On the other hand, in the case of deeper and more serious depression problems that may lead to the development of postpartum psychosis, early intervention can reduce the extent of damage caused by a psychotic episode or stop the development of this episode [33].

2. **Short-term nature of the intervention**. Postpartum depression, constituting a specific form of the developmental crisis [42], often does not require long-term therapeutic interventions [36, 44]. Different, often time-limited forms of help are effective: individual and group therapies, interpersonal therapies (psychotherapies derived from psychoanalytic concepts: attachment theory and Sullivan's ideas) and behavioral and cognitive therapies, as well as psychosocial interventions including the mother, mother and infant, and the whole family. An example of such an intervention can be Families First – a Finnish preventive parenting program for parents with their first child in their first year of life, which includes both of them [45]. It supports their competencies related to parental mentalization: understanding one's behavior as a parent, mutual relations in a couple, and the behavior of an infant. This program is not strictly therapeutic but prophylactic: it assumes supporting parents at the time of an important life change. Interventions involving both parents seem particularly important because conflicts, violence in the relationship, and lack of social support are risk factors for developing postpartum depression [46]. In this article, we cited, among other things, the results of research proving the effectiveness of short-term psychodynamic interventions in primary care [36], also in Poland [2] As mentioned above, conflicts related to dependence may additionally discourage patients from long-term forms of therapeutic help, which are associated with greater dependence.
3. **Widespread and costless availability of the therapy**. The data on the prevalence of postnatal depression in the general population as well as on the social and economic costs of this disorder clearly indicate the need to ensure universal and costless access to pharmacological and psychological interventions. as early interventions usually lead to beneficial effects, do not require highly specialized experts, and may be limited in time. Wherever possible, psychological interventions for postpartum depression should be included in the system of costless help financed by a National Health Fund or social help.
4. **Focus on supporting the ability to think about emotions.** The psychological background of postpartum depression presented in this article, referring to psychodynamic concepts (*inter alia* the concept of mentalization and the idea of depression as an inability to think about losses), allows formulating the most important guidelines regarding the technique of work during the intervention. **We consider supporting patients in the possibility of thinking about painful**

emotions inscribed in early motherhood as the most important element of psychological interventions in postnatal depression. In practice, this means first and foremost listening attentively to patients, who are often unable to freely share their experiences that depart from social expectations: anger and hatred for the baby, reluctance to motherhood, the desire to turn back time and have no child, doubts about their own competence, longing for a dyadic relationship with their partner, disappointment with the loss of dependence and opportunities for professional development. Where patients are unable to speak (and perhaps think for themselves) about such feelings, the psychologist can support this ability by asking questions about this type of experience and, above all, by their own initiative, emphasizing their naturalness. By means of these simple measures, a person who does not have specialized preparation is able to support mentalizing skills of patients in thinking about experienced losses and the complexity of feelings associated with the transition to motherhood, which we consider to be the essence of effective, short-term psychological intervention.

5. **Progressive nature of help and strengthening of patients' independence.** In our opinion, one of the important dimensions of early interventions is also the ability to terminate them at a time when patients are able to deal with the challenges of early motherhood alone (or with the help of relatives). We believe that due to the prevalence of postpartum depression, this condition should not be pathologized, and unnecessary prolongation of intervention time may result in a secondary intensification of the patient's sense of doubt in her own competence. As in the case of working with other crises, we believe that the purpose of the intervention should be to bring about the situation where the patient returns to the ability to independently cope with her life and thinking about her own experiences.

Example of an effective, short psychological intervention in the face of postpartum depression

At the end we will present an example of applying the above guidelines in practice – we will describe an effective intervention carried out in a short time by a person without highly specialized preparation, working in a public support system.

Mrs. A, a 27-year-old woman with higher education, reported to the crisis intervention center 2 months after the birth of her first child. Among the reported symptoms, she was overwhelmed by the feeling that something was wrong with her because she could not love her child and had recurring thoughts about throwing the baby out of the balcony. The intervention included 12 sessions, carried out over three months, in the rhythm of one meeting a week.

Before the pregnancy, Mrs. A had moved to the city where the intervention was carried out, from another part of Poland. The move was related to the decision about having a child. Mrs. A and

her husband had been married for four years. They met at work and both of them had an active professional life. After several years of being together, Mrs. A began to talk more about a child and put pressure on her partner. She emphasized that the air in Pomerania is good for health; in addition, her family lived in the region and the patient counted on their support. For this reason, decided to quit her job and her partner moved to the local branch of his company. Mrs. A had a healthy pregnancy, with regular gynecological examinations. Mr. and Mrs. A. prepared the apartment for the birth of their child, however, their relationship became more tense. There were some differences between them, they argued more often. Until that time, the area of their good agreement was professional matters, but since Mrs. A did not work, she wanted to talk more about their relationship, the child, plans for the future - whereas Mr. A wanted to live their earlier life, focused more on professional plans and previous ways of spending their free time. In addition, Ms. A, after re-establishing closer contact with her parents, felt that she could count on the care, but she also had to take into account attempts to take control over her life.

The childbirth proceeded without complications, after a few days Mrs. A was discharged home. She was more and more worried that contact with her daughter did not give her any pleasure, and the most frightening thing to her was that she could not love her child. The baby's crying made her nervous. However, she applied for help only when she was terrified by a vision she had suddenly experienced: she saw an indistinct black figure in the room who, in A's sense, wanted to throw her daughter out of the balcony. Mrs. A, convinced that she was going crazy, immediately reported to the crisis intervention center. In conversation with the psychologist, she described her situation and asked for help. The intervention involving 12 meetings was conducted by a young, sensitive psychologist with little clinical experience, Ms. K[1]. The psychologist realized her work in accordance with the guidelines formulated during a consultation with one of us [L.K.], based on ideas that we have formulated together in this work. The consultant discussed this work with the psychologist three times: after the first meeting with the patient, after the seventh meeting and, briefly, after the end of the work.

After the first meeting, the psychologist needed to determine the direction of psychological intervention. She collected the information presented above about the patient's situation but she wondered how to continue this contact. We recognized that we are dealing with a situation in which postnatal depression becomes more severe and psychotic, however, the patient's resources and contact with the psychiatrist allow for outpatient assistance. The consultant encouraged the intervener to offer her as frequent meetings as possible, with several main goals: first, to encourage Mrs. A to talk about feelings experienced in her contact with the child, paying special attention to

[1] In the text we will interchangeably refer to the psychologist as psychologist, intervener, or Mrs. K. [author's note].

those emotions that aroused Mrs A's fear: dislike of the child, the impression of inadequacy or helplessness. The consultant proposed such an attitude for Ms. K, recognizing that Ms. A, who had expected something special after childbirth, was scared by her natural feelings. Therefore, the second suggestion of the consultant was to suggest that the psychologist ought to talk to the patient about her previous ideas about being a mother. The third issue that aroused the curiosity of the consultant was the issue of parental control – he asked the psychologist to talk to Mrs. A about the possibility of profiting direct family help in caring for her child.

The next supervision meeting with Ms. K took place after seven more visits with Mrs. A. The psychologist had mixed feelings: when she started to carry out the suggestions presented by the consultant, on the one hand, Mrs. A made better and more frequent contact with the baby and the "black figure" never appeared again – but on the other hand, Mrs. A cried a lot at the sessions and filled them with desperate, repeating stories that she was not good enough, could not love her child, would never be a good mother, will never match her mother, and so on. The psychologist was worried that it was hard for her to bear Mrs. A's recurring complaints and wondered if she was actually going in the right direction, despite the evident improvement in Mrs. A's direct contact with the baby and the withdrawal of delusions. The consultant offered the intervener a perspective, according to which what was happening in their contact was a healing and helpful factor. The psychologist, listening to Mrs. A's fears, made room for what Mrs. A had been running away from natural fears of taking on the role of a mother and the difficulty in attuning to the infant. What is more, the psychologist herself provided her with an important model by her attitude: she showed that one could accompany someone in tears, although she could not help her directly – and Mrs. A was very tormented by the thought that she could not help her baby. The psychologist intuitively implemented an important dimension of therapeutic work, although she was not sure whether she was doing the right thing. The consultant gave her the above point of view and encouraged her not to give up her current attitude. Additionally, he encouraged the psychologist, if she had the opportunity, to share with Mrs. A her observation that together they were able to endure difficult feelings, even if they did not have direct solutions, just like Mrs. A could endure difficult feelings in contact with her child, which she does not always know how to soothe immediately. The psychologist seemed to be very uplifted by the comment that showed the value of her previous efforts. Then she described the family motif: as the consultant had suggested, she asked Mrs. A for her relationship with her parents. Mrs. A said that she had always perceived her mother as perfect, though a bit over-protective. In her opinion, her mother had always perfectly dealt with the care of three children, she had combined childcare with work and never complained about anything. Now, after Mrs. A had given birth to her daughter, her mother spent a lot of time with her and helped her

taking care for the baby but also gently criticized her, indicating that some things could be done better and more efficiently. In this topic, the psychologist was able to find an adequate understanding on her own – she tried to support Mrs. A in a realistic assessment of her own competence as a mother who had been in this role for only a dozen of weeks, and encouraged her to elaborate a certain distance from the ideal image of her mother, stressing that she knew that her mother had been a good mother to children and teenagers, but she could not know what kind of mother she was to babies.

The third meeting with the consultant with the intervener took place after finishing work, to summarize this intervention. The psychologist emphasized that the most emotional moment of the 12-sessions intervention was when the psychologist had compared their mutual enduring of difficult feelings with the work that Mrs. A herself performed with the baby. From that moment, Mrs. A's mood has been improving. Her situation took the character of a self-perpetuating positive circle: the better she felt, the more efficiently she dealt with the baby, and the more pleasure with the contact she had, the less her mother's slight criticism hurt her and the better she benefited from her mother's support. Thanks to the additional work of the psychologist, the patient actively involved her partner in the support network, and in consequence, she gained some time to relax, which was even more conducive to her well-being. On the course of this short-term psychological intervention, the psychiatrist decided to end pharmacotherapy, which the patient had obtained in minimal dose.

Recapitulation

In this article, we presented the role of early psychological interventions in the prevention and treatment of postnatal depression. We described the nature and typical course of postnatal depression and the frequency of this phenomenon. The literature review was illustrated with clinical examples. Additionally, we suggested several insights on the psychological background of postpartum depression, referring to psychoanalytic theories. We presented clinical guidelines of these conceptualizations which can be helpful in the direct contact with the patient emphasizing a general look at the issue of early psychological interventions: the need for universal access to this form of support and empirical evidence of its effectiveness. Based on the theoretical background, research findings, and our own experience, we have formulated some practical guidelines for the implementation of early psychological interventions. Finally, we presented an example of the application of our guidelines in clinical practice.

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