Understanding & Treating

Perinatal Mood & Anxiety Disorders

Christina G. Hibbert, Psy.D.

Author, *This Is How We Grow*

Founder, Arizona Postpartum Wellness Coalition

christina@drchristinahibbert.com

www.DrChristinaHibbert.com

facebook.com/drchibbert; Twitter: @DrCHibbert

Why is this an important issue?

Statistics

Why is this an important issue?

- **75 - 80%** of women experience emotional changes following childbirth.
- **10-20%** will experience a Perinatal Mood/Anxiety Disorder.
- "The most common complication associated with childbirth"

Why is this an important issue?

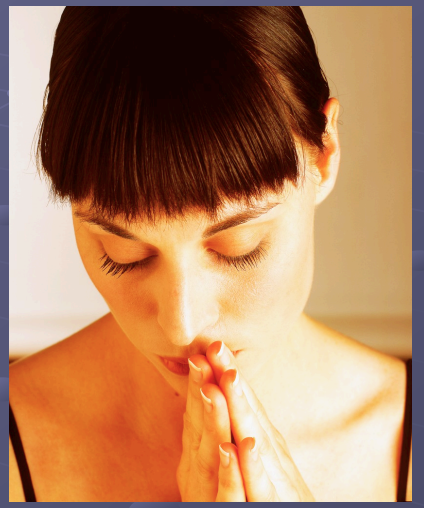
- Untreated → Chronic
- Chronic depression→ significant effects on mother-baby attachment and bonding
- Maternal depression→ future behavioral and developmental problems in the child
- Maternal depression= #1 predictor

What are Perinatal Mood Disorders?

Symptomatology

Depression in Women

- Depression in women:
  - Lifetime: 21% women vs. 13% men
  - Rate rises rapidly after puberty in girls
  - Increased prevalence during reproductive years
  - Increased risk in women 45-54 years old (perimenopause)
  - Decreased rates after menopause



Pregnancy Depression

- 15-21%
- Higher rate in low SES women
- 50-75% relapse after discontinuing medication when pregnant
- Symptoms similar to Major Depression and Postpartum Depression

THE BABY BLUES

- **75-80%**
- “mild depression interspersed with happier feelings,” “an emotional roller-coaster”
- Onset = 2-3 days postpartum
  - Peaks around 7-10 days
- The “Baby Blues” is not considered a “disorder,” should not require professional treatment , and should subside within two weeks after delivery.

THE BABY BLUES

- Symptoms may include:
  - Fatigue/ Exhaustion
  - Feelings of sadness
  - Crying spells
  - Anxiety
  - Mood swings/ Irritability
  - Confusion
  - Feeling overwhelmed
  - Inability to cope
  - Oversensitivity
  - Inability to sleep
  - Feelings of loneliness

POSTPARTUM DEPRESSION

- **10-20%**
- Onset = anytime during first year
  - Highest incidence of onset = 4 - 8 weeks postpartum
- Duration = 3 to 14 months or longer if untreated
- If a woman experiences PPD, her chances of PPD with subsequent children are 10-50%.

POSTPARTUM DEPRESSION

Symptoms

- Sadness/ Frequent crying
- Insomnia
- Appetite changes
- Difficulty concentrating/ making decisions
- Feelings of worthlessness
- Lack of interest in usual activities
- Anger, fear, and/or feelings of guilt
- Obsessive thoughts of inadequacy as a person/parent
- Agitation/ persistent anxiety/ racing thoughts
- Feeling a loss of control
- Feeling disconnected from the baby
- Possible suicidal thoughts

POSTPARTUM ANXIETY

- 6% Pregnant; 10% Postpartum *(PSI)*
- Generally under-diagnosed, since many people think that anxiety is a normal part of motherhood
- Symptoms:
  - Constant worry
  - Feeling that something bad is going to happen
  - Racing thoughts
  - Disturbances of sleep and appetite
  - Inability to sit still
  - Physical symptoms like dizziness, hot flashes, and nausea

POSTPARTUM PANIC DISORDER

- Up to **10%**

Symptoms include:

- feelings of extreme anxiety
- recurring panic attacks, including shortness of breath, chest pain, heart palpitations, agitation
- excessive worry or fears (fear of dying, going crazy, or losing control)

POSTPARTUM OBSESSIVE-COMPULSIVE DISORDER

- **3-5%**

Symptoms include:

- repetitive obsessions (intrusive and persistent thoughts or mental images) and
- compulsions (repetitive behaviors performed with the intention of reducing the obsessions)
- a sense of horror about these thoughts
- Fear of being alone with baby
- Hypervigilance about protecting baby

POSTPARTUM OBSESSIVE-COMPULSIVE DISORDER

- The *most under-reported and under-treated disorder of childbirth.*
  - Symptoms are horrifying or embarrassing to the mother and she may fear that others will think she is a risk to her child

- ***Unlike*** Postpartum Psychosis, these mothers know their thoughts are bizarre and are ***highly unlikely*** to ever indulge in the imagined behaviors

The most common obsession

thoughts/mental images of harming or killing baby

The most frequent compulsion

bathing the baby often or changing the child's clothes

POSTPARTUM PSYCHOSIS

- **1-2 of every 1,000** births (.1%)
- Onset = usually first 4 weeks
- Due to an increased risk of harm to the infant and/or mother, immediate treatment is imperative.
- Women with a history of bipolar illness have a 40% chance of developing Postpartum Psychosis after their first child is born.
- Almost all women with previous episodes of Postpartum Psychosis will experience repeat episodes in subsequent pregnancies. ***Preparing for this ahead of time is key.***

POSTPARTUM PSYCHOSIS

Symptoms:

Acute onset of psychotic symptoms including:

- Delusions and/or hallucinations
- Extreme agitation/ Hyperactivity
- Insomnia
- Mood changes
- Confusion/ Poor judgment
- Irrationality
- Difficulty remembering/ concentrating

OCD vs. PSYCHOSIS

- Postpartum OCD:
  - More gradual onset
  - Women recognize thoughts/images are unhealthy
  - Extreme anxiety related to thoughts/images
  - Overly concerned about “becoming crazy”
- Postpartum Psychosis:
  - Acute onset- sudden noticeable change from normal functioning
  - Women do not recognize actions/thoughts are unhealthy
  - May seem to have less anxiety when indulging in thoughts/ behaviors

POSTPARTUM POSTTRAUMATIC STRESS DISORDER (PTSD)

- 1-6%
- May not originally present as PTSD (depression, anxiety)
- Symptoms include:
  - Traumatic Childbirth Experience
  - Re-experiencing trauma (flashbacks, nightmares)
  - Avoidance of stimuli associated with event (thoughts, feelings, people, places, details)
  - Persistent increased Arousal (hypervigilance, exaggerated startle response)
  - Anxiety/Panic Attacks
  - Sense of unreality or detachment

POSTPARTUM BIPOLAR DISORDERS

Bipolar 1 Disorder:

- May appear at first to be productive
- Women report feeling “speeded up”
- Usually appears days after birth
- Postpartum mania typically not characterized by euphoric or elated mood but rather irritability and excitability
- Faulty reasoning, poor judgment, and distorted perceptions can quickly progress to impaired level

POSTPARTUM BIPOLAR DISORDERS

Bipolar 2 Disorder:

- "PPD Imposter"
- Hypomania during pregnancy and/or after birth followed by severe depressive symptoms 2-3 weeks later
- Hypomanic symptoms often missed due to depressive symptoms

What causes Perinatal Mood Disorders?

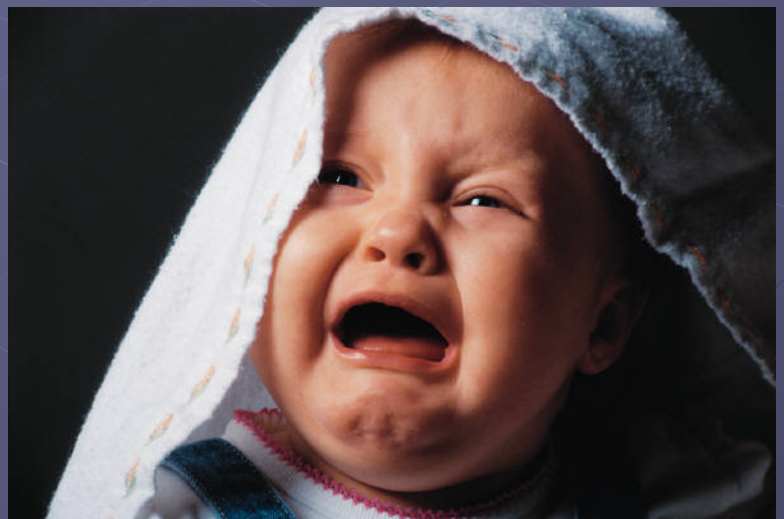
Etiology

CAUSES: What causes a perinatal mood disorder?

- General consensus = A combination of:
  - Physiological factors +
  - Psychosocial factors +
  - Preexisting vulnerability

CAUSES: Physiological

- **Changes in Hormones:**
  - Hormone levels 20-30 times greater than normal
- **Thyroid levels:**
  - Symptoms can mimic depression
- **Physical Exhaustion of Labor/ Delivery**
- **Sleep Deprivation**



CAUSES: Psychological

- **“Myths of Motherhood”:**
  - Motherhood is a “happy time”
  - Childbirth is an event from which a woman should “bounce back” within a few days.
  - Myth of the perfect mother
  - Myth of the perfect baby
  - Baby will bring you closer to partner
  - Perfect mothering instinct/ immediate bonding with baby
  - For many women, after the baby is born these expectations are met with feelings of depression or anxiety that can lead to extreme feelings of guilt and shame.

CAUSES: Psychological

- Psychological Stressors:
  - establishing successful breast/bottle-feeding
  - forming an attachment to the child
  - re-negotiating family relationships and responsibilities
  - preparing to return to work
- Feelings of loss:
  - loss of freedom or independence/ feeling tied down
  - loss of an old identity
  - loss of control
  - loss of a slim figure/ sense of attractiveness
- Birth Complications/ Defects:

CAUSES: Preexisting Vulnerability

- Mental Health History:
  - personal or family history of a mood/ bipolar/ or psychosis
- Hormone Sensitivity:
  - significant PMS symptoms
  - mood changes on birth control
- Relationship problems:
  - the most common non-biological cause of PMADs

Who is at Risk?

Risk Factors

RISK FACTORS

History:

- *Personal/family history of PMAD, bipolar or another mood disorder
- Previous aversive reaction to oral contraceptives or severe PMS
- History of infertility
- History of abuse

Support:

- *Unstable relationship with partner and/or with parents
- Poor support system
- Poor relationship with own mother

RISK FACTORS

Trauma:

- *Traumatic childbirth experience
- Recent trauma/ stressful event

Expectations/ Personality:

- *Unrealistic expectations of parenthood
- *Unrealistic expectation of oneself
- “Perfectionist” or “High Achiever” Personality

Practical Concerns:

- Perceived financial stressors/ low SES
- Cultural concerns (recent immigrant, etc.)

RISK FACTORS

First-time moms are at a higher risk for PMADs
However, may develop no symptoms with 1st yet still experience a PMAD with 2nd, 3rd, or subsequent pregnancies.

What happens if PMADs go Untreated?

Consequences

Untreated PMADs:

1) Harmful to Mothers

- Depression/ Anxiety in Pregnancy:
  - Functional impairment
  - Poor nutrition
  - Inadequate weight gain
  - Adverse behaviors
    - Smoking (20.4%)
    - Alcohol use (18.8%)
    - Drug use (5.5%)

- *20-30 times more likely* to be hospitalized for a psychotic episode in the first 30 days

Harmful to Mothers (cont.)

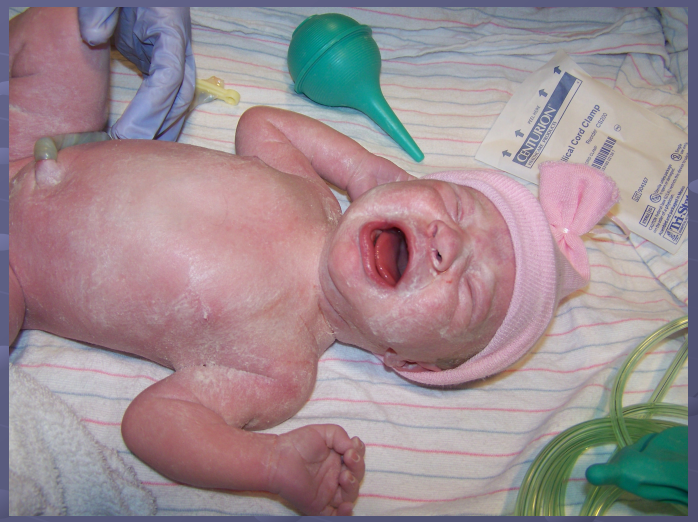
- There is a 5% suicide rate associated with postpartum psychosis.
- We must look at a PMAD as a potentially life-threatening illness.

Untreated PMADs

2) Harmful to Infant

- Psychopathology in pregnancy has physiological consequences for the fetus
  - Spontaneous abortion
  - Bleeding
  - Increased uterine artery resistance
  - Low Apgar scores
  - Admission to NICU
  - Spontaneous early labor
  - Low birth weight/ SGA

Harmful to Infant (cont.)



- Severe anxiety in pregnancy is associated with:
  - Constriction in placental blood supply
  - Heightened startle response in infants
  - Newborn is more inconsolable.

Harmful to Infant (cont.)

- Postpartum Psychosis is associated with a **4% infanticide rate**!
- Maternal depression is the number one predictor of future cognitive and emotional problems in the child.
- Long-term PPD exposure: Children's problems do persist, even when moms show a natural recovery (Goodman, 2010)

PMADs & Children

Link between PPD & inadequate parenting.

- Depressed mothers were just as likely to follow:
  - Safety practices
  - Feeding practices
- Depression reduced the odds of:
  - continuing breastfeeding by 27%,
  - showing books by 19%,
  - playing with the infant by 30%,
  - talking to the infant by 26%,
  - following two or more routines by 39% ($p < 0.05$ for all)

Arch Pediatr Adolesc Med 2006;160:279-284.

PMADs & Children

- PPD associated with failure to learn/poor acquisition of associations in children
  - Infants, 5-12 months, showed poorer acquisition of a voice-face association when they heard speech of their depressed mother or an unfamiliar depressed mother
  - They did learn when they heard speech of nondepressed male or nondepressed father. (Kaplan et al, 2004)

PMADs & Children

Maternal mental distress affects bonding & attachment:

- Impacts "monitoring" activities
  - Monitoring enhances parent's awareness of child/ communicates parent is concerned, interested, available. (Leiferman et al, 2005)
- Absence of normal dyadic mother-child interaction. (Child smiles, mother turns toward child)
- Poorer Mimetic Behavior of mom (holds child's attention, lively vocalization, mirroring)
- In non-depressed mom, early interactions have good attunement with baby (Reck et al, 2004)

PMADs & Children

- Link between PPD & child abuse.
- “We should be concerned about the functioning of children of depressed parents.” (O’Hara, 2010)
  - More stressful family life (Goodman & Gotlib, ’02)
  - PPD has an effect on the child “for sure”
  - The infant can affect mothers too (Murray & Cooper, 1997)

Untreated PMADs

3) Harmful to Family

- Partner, infant, other children and entire family unit suffer as well.

This is a familial disease.

- First year postpartum= highest rate of divorce than any other time

Harmful to Family:
This Is How We Grow

Untreated PMADs

4) Harmful to Father

- It is important to recognize that when a woman is experiencing a PMAD, her partner is affected as well.

PMADs and Fathers

- He may feel:
  - "Pulled" between the demands of work and home
  - He can't do anything right
  - His efforts go unnoticed by her
  - He is taking on the role of the "mother"
  - He may fear his wife will never be the same
  - He may feel angry that his wife is not "pulling her weight" at home
  - He wants to "fix" this problem and is frustrated because there is no apparent solution

PMADs & Fathers: PPND

Paternal Postnatal Depression (PPND)

- Fathers=⇧ risk pre/postpartum (Paulson & Bazelmore, 2010)
- PPD in Men (PPND) is a "significant problem" (Goodman, 2004)
  - PPND=10% worldwide; 14% US (Paulson & Bazelmore, 2010)
  - 1-25% community; 24-50% PPD partner (Goodman, 2004)
- Maternal depression=strongest predictor of PPND (Goodman, 2004)
- PPND=little attention in research
- Men less likely to seek help (Letourneau, 2012)

Postpartum Couples DVD

www.DrChristinaHibbert.com

FATHERS AND PMADs

- Fathers are often in the perfect position to help the mother obtain the help she needs.
- A father must also find a way to take care of his needs in order to prevent mood symptoms in himself.

What Can He Do?

- Learn all he can about perinatal mood disorders.
- Recognize she is not making up her symptoms and that this is not her fault.
- Talk with her, letting her know that he loves her, supports her, and is there for her.
- Help with the care of the baby as much possible
- Enlist others, such as family, friends, and/or community
  - Help with care of the baby, other children
  - Meals, housework

What Can He Do?

- Have patience
  - understand she may not be interested in sex and that he loves her and enjoys holding her
- Take some time for himself and encourage his partner to do the same.
- Help monitor her symptoms
  - seek professional help when needed
- Remember she will be well

Screening, Diagnosis and Referral

SCREENING

- **Early detection:**
  - can significantly reduce the duration and severity of symptoms
  - can prevent progression to a more dangerous condition

- **Routine screening:**
  - is crucial in early detection and treatment
  - helps reduce the stigma for many mothers and helps them feel they are not alone

Who Should Screen?

OB/Gyns

- Have an established relationship with the mother
- Have contact with mother at 6-week check-up
- However, most women experiencing a PMAD have significant symptoms long before 6 weeks

Pediatricians

- See infants and their mothers immediately following childbirth and routinely thereafter
- However, they do not have an established relationship with the mother

Who Should Screen?

Hospitals:

- Can administer screener following childbirth
  - May miss significant symptoms that develop at home
- May implement "check-up calls" at 2-4 weeks and administer screener
- Need a referral network in place

Any provider who may come in contact with a mother during the first months to year following childbirth should consider implementing a screening program

Edinburgh Postnatal Depression Scale

- Ten item scale can be completed in minutes
- Readily available; validated in many languages
- Addresses depression and anxiety traits
- Used widely during pregnancy and postpartum
- Sometimes criticized as being too brief (may miss some significant symptoms)

In the past 7 days:

- Things have been getting on top of me:
- I have been so unhappy that I have had difficulty sleeping:
- I have felt sad or miserable:
- The thought of harming myself has occurred to me:

Use of the EPDS

- Validation testing done at 6-8 weeks postpartum
- A score of 12/13 indicates the mother is probably clinically depressed
- For screening purposes in the community setting, a score of 9 is considered at-risk
- A screening tool should be followed by careful clinical assessment

Screening vs. Diagnosis

Important:

- Screening Tools are not Diagnostic tools
- A positive screen does not in itself make a diagnosis
- Women who screen positive for a Perinatal Mood Disorder should be referred to a *qualified* mental health professional for a clinical evaluation and formal diagnosis.

Clinical Assessment

Be prepared to ask the tough questions:

- Detailed personal and family medical and mental health history
- Ask directly about the following:
  - Suicidal ideation
  - Thoughts of harm to infant
  - OCD thoughts/images
  - Sleep habits
  - Eating habits
  - Mood during pregnancy and pre-pregnancy functioning
  - Hormones in the past
  - Past/current medications
  - Drug/Alcohol/Caffeine use
  - Trauma (Previous birth trauma; History of abuse)
  - Childbirth experience

Referral Process

- Can be extremely difficult
- It is important to support the client through this process. Help her understand:
  - It may take some time to find the right professional
  - Trust your instincts. If you feel uncomfortable look for someone else.
  - Involve the entire family/support system.

Prevention

Elements of Prevention

During or before pregnancy:

Relevant, reliable, accurate information on reality of childbirth, parenthood, and emotional changes

- Screening in Pregnancy/ Postpartum
- Connection with support systems and professional resources

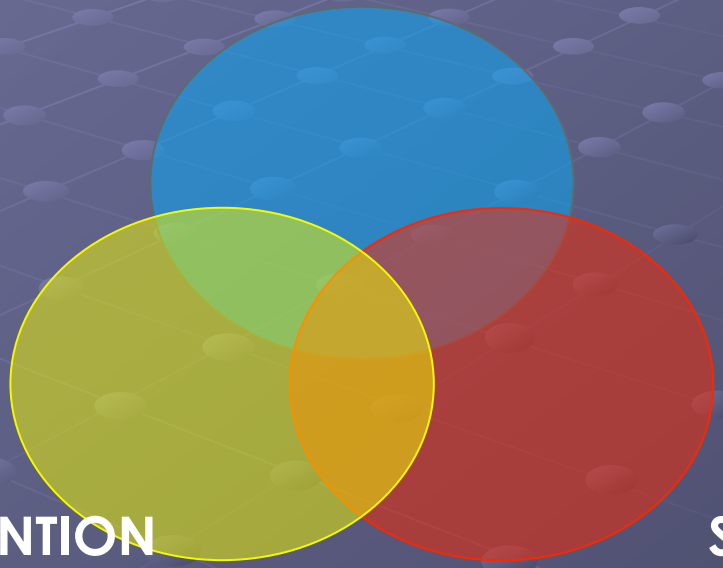
Elements of Prevention

- **Practical support**
  - Help with childcare and housework so mom can sleep
- **Emotional expression** and support
- Set aside **additional funds** for emergencies and/or take out food or babysitters
- Physical **wellbeing in Pregnancy**
  - Good nutrition
  - Rest
  - Exercise
  - Informed medical care

Treatment Options

TREATMENT:
Three Critical Components

MEDICAL INTERVENTION



THERAPEUTIC INTERVENTION

SOCIAL SUPPORT

- Self-Help

Self-Help Options

- Practical assistance with child care and/or demands of life
- Sleep
- Support groups
- Exercise
- Emotional Expression and support
- Time for self
- Get out of the house
- Sunlight therapy
- Omega 3's

9 Steps to Wellness

(Jane Honikman, "I' m Listening")

- Education
- Sleep
- Nutrition
- Exercise and Time for Myself
- Sharing with Non-Judgmental Listeners
- Emotional Support
- Practical Support
- Referrals to Professional
- Plan of Action

- Role of Social Support

Cultural Influences

- PMAD's affect mothers of all cultures and races equally; however, these mothers may have different needs, based on their cultural norms.
- Always consider cultural needs when recommending treatment options
- *"Mutual self -help groups replicate many of the components of support found cross-culturally, and they have the potential to cushion or prevent expression of moderate depression." (Kruckman, 1992)*

Support Groups

- Mothers supporting mothers
- Provides safe place for emotional release
- Other mothers can support new mom/ model behaviors
- Mother can see recovery of others, giving hope
- Facilitator is not providing therapy

- Professional Treatment

PROFESSIONAL TREATMENT OPTIONS

- Individual psychotherapy
- Group psychotherapy
- Couple’s therapy
- Psychotropic medications
- Hospitalization in Psychosis

MEDICAL INTERVENTION

- Rule out other medical causes
- Rule out postpartum thyroiditis (Free T4, TSH, Anti-TPO, Anti-thyroglobulin)
- Psychotropic medication evaluation by medical professional, preferably trained in PMAD's

Best Therapeutic Approaches for Perinatal Mood Disorders

Therapy + Medication (as needed)= best practice

- Interpersonal Psychotherapy (IPT)
- Cognitive-Behavioral Therapy (CBT)
- Couples Therapy
- Group Psychotherapy

- Complementary Alternative Modalities

Alternative Modalities: What's available?

- Massage and Relaxation
- Herbal medicine and dietary supplements
- Traditional Chinese Medicine
- Acupuncture
- Nutrition and Exercise
- Light Therapy
- Omega-3's

Conclusion

What can I do?

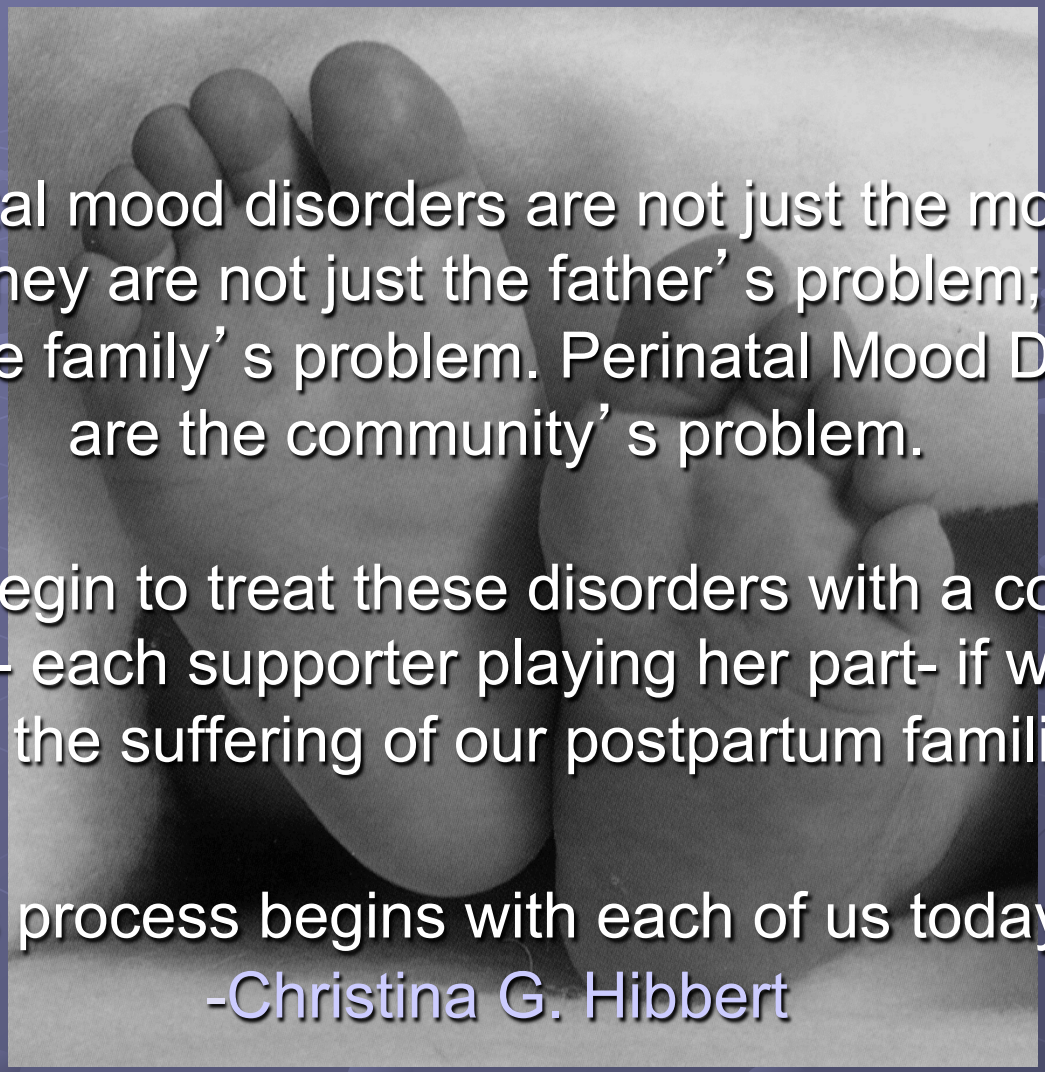
Support and Understanding

Postpartum Support International's Universal Message:

You are not alone.

You are not to blame.

With help, you will be well.



“Perinatal mood disorders are not just the mother’s problem; they are not just the father’s problem; they are not just the family’s problem. Perinatal Mood Disorders are the community’s problem.

We must begin to treat these disorders with a community approach- each supporter playing her part- if we are to ease the suffering of our postpartum families.

This process begins with each of us today.”

-Christina G. Hibbert

“The Light of a Little Girl”

AZ Postpartum Support *Warmline*

888-434- MOMS (6667)

RESOURCES

Arizona Postpartum Wellness Coalition:

- Warmline: (888) 434-MOMS (6667)
- Website: www.azpostpartum.org

Postpartum Support International (PSI):

- Website: www.postpartum.net

Dr. Christina Hibbert contact:

Website/Blog: **www.drchristinahibbert.com**
Email: christina@drchristinahibbert.com
Social Media: facebook.com/drchibbert; @DrCHibbert

Book: This Is How We Grow, Amazon.com