Perinatal Mood & Anxiety Disorders

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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?

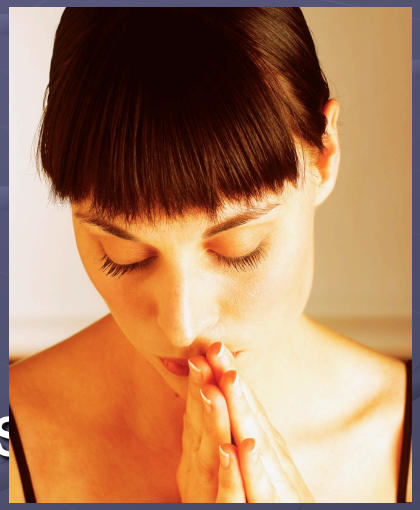
- Untreated → Chronic
- Chronic depression→ significant effects on mother-baby attachment and bonding
- Maternal depression→ future behavioral and developmental problems in the child
- Maternal depression= #1 predictor

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



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

Pregnancy/ Postpartum DEPRESSION

- 10% **pregnant** & 15% **postpartum** women
  - Rates higher in low SES women & twice as high for teen moms (postpartum.net)
- 50-75% relapse after discontinuing medication when pregnant
- **Onset** = anytime during pregnancy or 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%.

Pregnancy/ Postpartum DEPRESSION

Symptoms

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

Pregnancy/ Postpartum ANXIETY

- 6% Pregnant; 10% Postpartum (postpartum.net)
- 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)

Pregnancy/Postpartum OBSESSIVE-COMPULSIVE DISORDER (OCD)

- **3-5%**

<u>Symptoms include:</u>

- Obsessions: intrusive/persistent thoughts/images, *and*
- Compulsions: repetitive behaviors to reduce obsessions
- A sense of horror about these thoughts/images
- Fear of being alone with baby
- Hypervigilance about protecting baby

Pregnancy/Postpartum OCD

- Most *under-reported* and *under-treated* disorder of childbirth
  - Symptoms are horrifying, embarrassing, &/or fearful to mother

- *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= images of harm to baby

*The most frequent compulsion=*bathing/changing clothes & "checking"

More on PPOCD: www.DrChristinaHibbert.com

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 w/ history of bipolar illness have a 40% chance of developing Postpartum Psychosis after 1st 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:

- "Speeded up"- May appear productive at first
- Usually appears days after birth
- Postpartum mania typically not characterized by euphoric/elated mood but rather irritability & excitability
- Faulty reasoning, poor judgment & distorted perceptions can quickly progress to impaired level

Bipolar 2 Disorder: *"PPD Imposter"*

- Hypomania during pregnancy &/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?

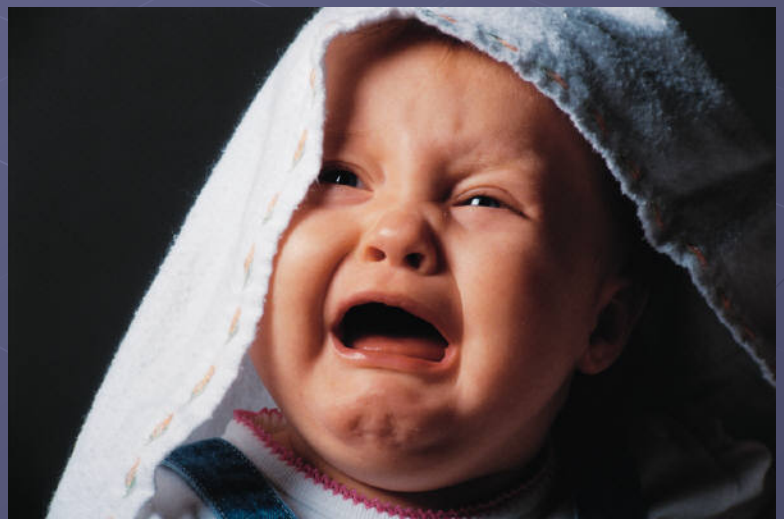
Etiology

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”
  - Mom should “bounce back” from childbirth 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/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/ Life Stressors

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 other mood disorder
- Sensitivity to oral contraceptives/ 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, many 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.)

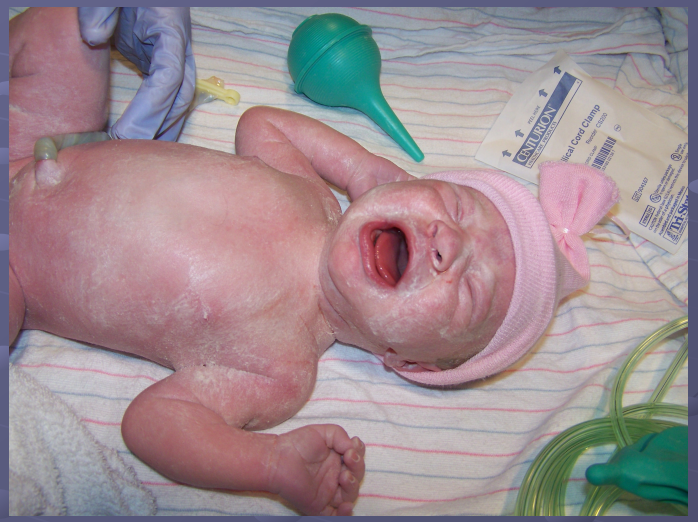
- There is a 5% suicide rate associated with postpartum psychosis.
- We must look at a PMAD as a potentially life-threatening illness.

Untreated PMADs

2) Harmful to Infant

- Psychopathology in pregnancy has physiological consequences for the fetus
  - Spontaneous abortion
  - Bleeding
  - 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/ Partner

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

- *Though there is limited research on lesbian couples, many lesbian partners have a similar experience to fathers.

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**

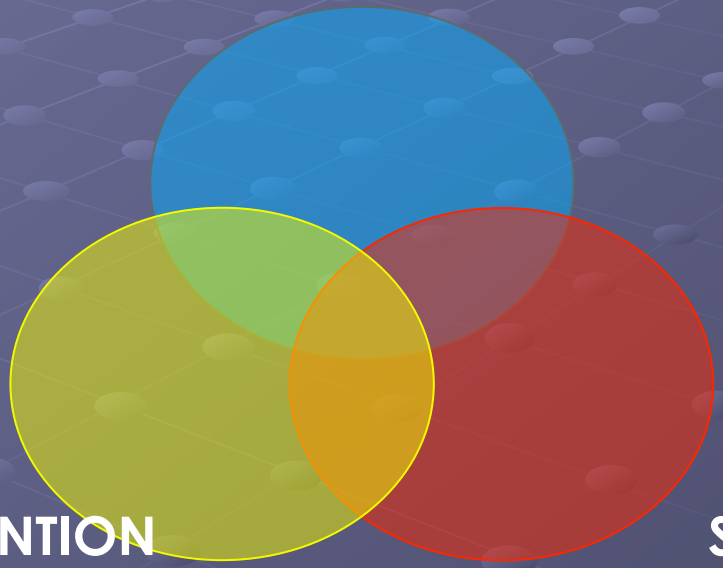
Elements of Prevention

- **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 support/talking
- 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

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 (*8 Keys to MH Through Exercise*)
- Light Therapy
- Omega-3's

Conclusion

What can I do?

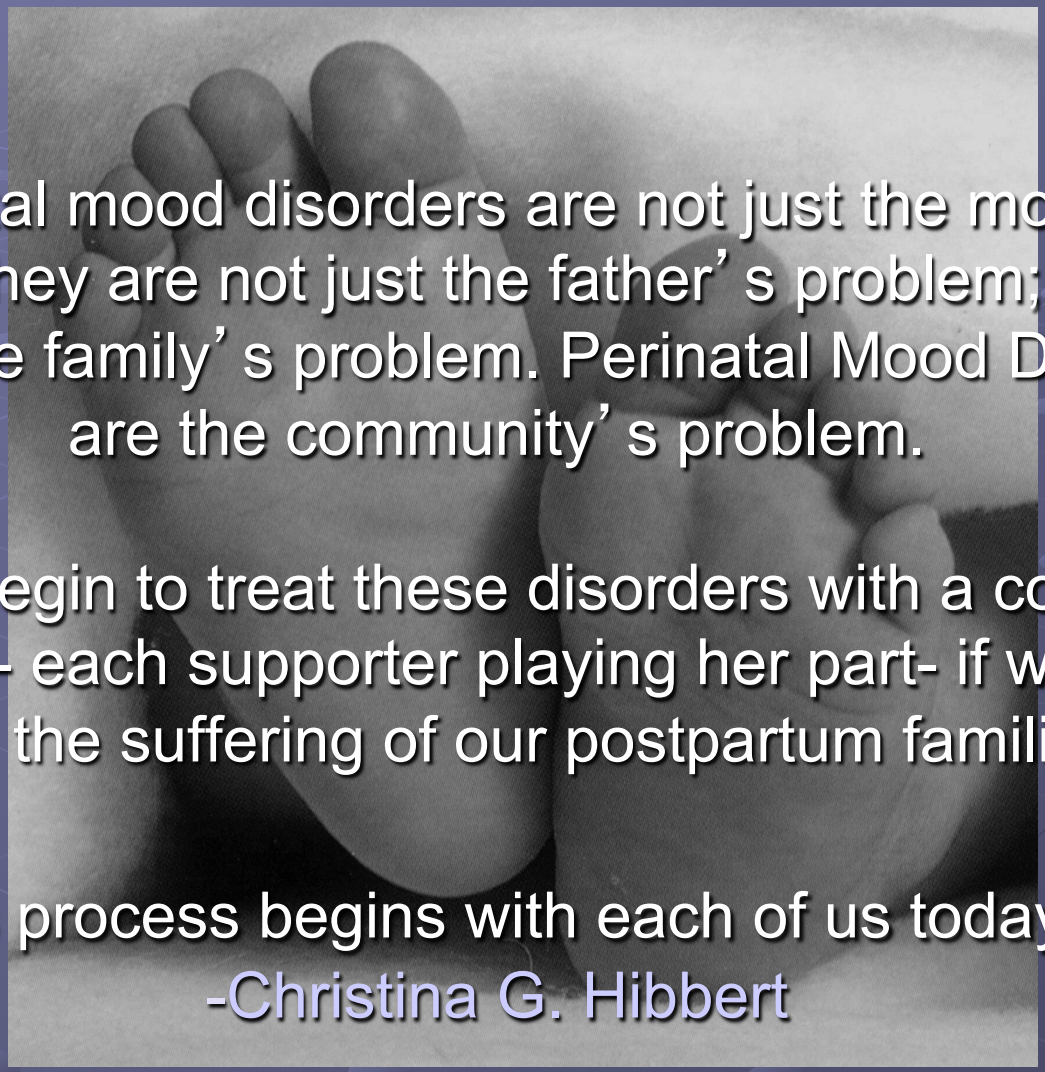
Support and Understanding

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/ PSI-AZ:

- Warmline: (888) 434-MOMS (6667)

Postpartum Support International (PSI):

- Website: www.postpartum.net

Dr. Christina Hibbert contact**:**

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YouTube Channel: Dr. Christina Hibbert
WebTalkRadio.net: "Motherhood" radio show

Books: *This Is How We Grow*; *Who Am I Without You?; 8 Keys to Mental Health Through Exercise* (Amazon.com)