Depression in Pregnancy and Beyond

Identifying Perinatal Mood and Anxiety Disorders

Sarah Atchison, MA, LMFT
Maternal and Infant Mental Health Specialist
satchison@childtherapynow.com

Perinatal Mood and Anxiety Disorders (PMADs)

• A PMAD can develop in any new parent, including mothers, fathers, and adoptive parents
• PMAD can develop in mothers who recently terminated a pregnancy, lost a baby through miscarriage, and in mothers/fathers who experienced any other neonatal loss

Prevalence

• 20% of all pregnant and postpartum women in the general population may experience some form of Perinatal Mood Disorder (PMD) (Gavin et al., 2005; Marcus, 2009; Misri, Pregnancy Blues, 2005)
• May occur for the first time during pregnancy, recur if she has a previous history, or present itself for the first time in the postpartum period (Misri, Pregnancy Blues, 2005)
• 10% of Men in US experience PPD (Paulson, Dauber, and Leiferman, PEDIATRICS Vol. 118 No. 2 August 2006, pp. 659-668)

Using WA PRAMS* data:

• Teen mothers: 28%-67% were depressed
• Early Head Start: 48% who were pregnant or had infants under one year of age were depressed.
• Women on Public Assistance: 47%, Major Depressive Disorder

Incidence in Military Families

• Pregnant women with deployed spouses were 2.8 times greater to experience PPMD than for other pregnant women with spouses who are not deployed.

(Powell M, Millove, M.D.; Rabbokl, M.D.; Lom-A Shlomo, M.D., Leonard K. Co., R.N., Robert McLay, M.D., Ph.D., Association of Post Partum Depression with Spousal Military Deployment and Isolation APA Poster; May 2007; San Diego Naval Medical Center)

• 2006 study screened for PPD in active duty women with the Postpartum Depression Screening Scale (PDSS)

• Nearly ½ scored positive for PPMD upon delivery, with 40% still experiencing PPMD by 6-8 weeks postpartum. (Rychnovsky J, Beck CT. Mil Med. 2006 Nov;171(11):1100-4)

PMADs Are Found Within Every:

• Culture
• Age
• Income level
• Education level
• Ethnic group
• Religious affiliation
PMADs are more common than Gestational Diabetes (2-5%), Pre-Eclampsia (5-8%), and Preterm Delivery (12%) (Kathryn Leopold, MD and Lauren Zoschinick, MD, Article: "The Female Patient: Postpartum Depression").

This makes PPMD the #1 Complication of Pregnancy!

(Melissa A. Schiff and David C. Grossman, 2006) (Gaynes et al. 2005; Miller & LaRusso, 2011)

Suicide rates in women increase 44% in the postpartum year (Melissa A. Schiff and David C. Grossman, 2006) (Kauppi, Kumpulainen, Vanamo, Merikanto, & Karkola, 2008; Paris, Bolton, & Weinberg, 2009).

Dr. Annie Imlay-Spangler
- Pharmacist & Retired Captain in the Naval Reserves
- After 10 years of trying to get pregnant, Baby Johnathan was born in March 2004.
- On June 17, Dr. Imlay-Spangler shot herself in the parking lot of a grocery store.

The last thing she said to me before she went to sleep was, “Don’t worry, Michael. I won’t do anything stupid.” Michael said, “She was the most honest person I have ever known. How could I know that for the first time in our life together, she was lying to me?”

Mental Illness during Pregnancy
- Pregnancy is not protective!
- Existing psychological disorders either stay the same or worsen during pregnancy (especially anxiety disorders and OCD)
- Women with mental illness during pregnancy have increased risk for pre-term delivery, twice the rates of epidurals, c-sections and low birth weight babies & babies admitted to NICU following birth

Spectrum of PMADs
- Depression: 15-20%
- Anxiety/Panic: 10%
- OCD: 3-5%
- Bipolar Disorder: 3-5%
- PTSD/ Birth Trauma: 6%
- PP psychosis: 1-2/1000 deliveries
- Baby Blues’’: 80%
Is this Blues or a PMAD?

- Moodiness which generally resolves without treatment. Blues will improve quickly with adequate self care such as rest (2 REM cycles of sleep per day) and good nutrition.
- Blues always resolves in 2-3 weeks. Unresolved mood issues beyond this should be screened for PMAD (Buist, 2006).
- True postpartum depression often is co-morbid with other mood disorders such as anxiety or OCD. (Abramawitz et al., 2010; Siguenza, Fernandez-Maldonado Díaz, 2011; Romanó Silva, Silva Neves, & Correia, 2005).

Symptoms of Baby Blues

- Decreased Appetite
- Lack of sleep
- Lack of energy
- Irritability
- Oversensitivity
- Sadness

Symptoms of Perinatal Depression

- Depressed mood
- Lack of energy
- Mental confusion
- Frequent crying
- Low self-esteem
- Feelings of guilt or shame
- Feelings of worthlessness
- Irritability or anger
- Feeling overwhelmed
- Forgetfulness
- Diminished absent sex drive
- Anxiety
- Feelings of hopelessness
- Sleep difficulties (too much/little)
- Eating issues (too much/little)
- Suicidal thoughts

Pregnancy & Postpartum Depression

- Postpartum depression onset peaks at 3 months Postpartum but can occur at anytime during the first year, and may last well into the 2nd year if untreated/mistreated.
- May become a chronic long-term illness if left untreated (Einarson et al., 2001). Agitation vs. Depressed mood

Effects of Antidepressant Discontinuation in Pregnancy

- 75% of pregnant women with recurrent depression relapsed upon discontinuation of antidepressants.
- Another study (N=201) found 68% of women who discontinued their medication during pregnancy relapsed vs 26% of those maintained on medication.
- In a sample of 36 pregnant women, 1/3 contemplated suicide when their antidepressants were stopped abruptly. 4 required hospitalization.

Pregnancy & Postpartum Anxiety

- Anxiety disorders often can start in pregnancy
- Are often over looked and under diagnosed as mom might not be experiencing depression
- Normalized- Oh, she’s just a new mom, or a ‘worry-wort mom’ or a ‘smother mother’
- Include Panic Disorder
Symptoms of Perinatal Anxiety

- Excessive worry or concern that is difficult to control (often presents as excessive concern re. health/safety of baby)
- Feeling restless or on edge
- Being easily fatigued
- Difficulty concentrating
- Irritability
- Muscle tension
- Sleep disturbances
- Panic attack (Sx often confused with heart attack)

Perinatal Obsessive-Compulsive Disorder

- Recurring, persistent, intrusive & disturbing thoughts, ideas or images (scary images of accidents, abuse, harm to baby) that cause extreme anxiety and distress
- Ritual behaviors done to avoid harming baby (e.g., put away knives) or to create protection for baby (e.g., only wear white, don’t leave the house) constantly checking the baby, house, etc.
- Hyper vigilant (e.g., can’t sleep for fear that something will happen to baby; constant “fight or flight” mode)
- Person cannot control thoughts, fear “going crazy”
- Person understands that to act on these thoughts would be wrong
- Often misdiagnosed as psychosis

Bipolar Disorders

- Characterized by intense mood episodes that include one episode of Depression and one episode of Mania or Hypomania
- 60% of bipolar women present initially as depressed (if prescribed antidepressant alone, can induce cycling into mania)
- 50% of women with bipolar are 1st diagnosed in the postpartum period
- 85% of bipolar women who go off their medications during pregnancy will have a bipolar relapse before the end of their pregnancy
- Can become Psychotic

Bipolar Disorders- Sx of Mania

- Changes in mood for a distinct period of time (feeling extremely and unusually happy, optimistic, euphoric or irritable)
- Change in thinking (racing thoughts, unrealistic self-confidence, difficulty concentrating, grandiose plans, hallucinations, or delusions)
- Changes in behavior (increased activity or socializing, immersion in plans or projects, pressured rapid speech, impulsivity, impaired judgment)
- Changes in physical condition (less need for sleep, increased energy, fewer health complaints)

PTSD/ Birth Trauma

- Sx usually occurs quickly after birth and include-
  - Re-experiencing
  - Avoidance
  - Increased arousal

- Etiology-
  - Prior traumatic event
  - Traumatic labor/delivery
  - Neonatal complications

Postpartum Psychosis

Occurs 1-2 per 1,000 women
Most likely is a Bipolar Event

This is a medical emergency: Requires immediate treatment often including hospitalization and medication

Typically occurs within hours to two weeks following delivery

5% suicide and 4% infanticide rate (Kongag, Kaukkula, Vuorela, Herlin, & Kalimo, 1998; Paris, Bolton, & Weinberg, 2009).
**Postpartum Psychosis Sx**

- Hallucinations
- Delusions
- Disordered thinking
- Sleep disturbances
- Agitation
- Social withdrawal
- Behavioral changes
- Loss of motivation
- Severe and rapid mood swings
- Incoherence
- Blunting or affect or emotions
- Inability to differentiate hallucinations from reality

**Who is at Risk for PMADs**

- Women who have had a prior PPD, have 40-80% risk of Depression during next pregnancy (Wisner KL, Perel JM, Peindl KS, et al., 2004)
- Personal or family history of mental illness, 60% increased risk (Coelho et al., 2011) (Nagy et al., 2011) (Comasco et al., 2011)
- Risk factors-
  - Physiological
  - Stress and issues of social support
  - Interpersonal
  - Family history

**Physiological Risk Factors for Developing a PMAD**

- Hx of PMS
- Hx of sensitivity to hormonal shifts
- Hx of mental health problems
- Hx of PMAD
- Depression or Anxiety during pregnancy
- Family Hx of Mood Disorders
- Hx of eating disorders
- Thyroid disorder or Diabetes (including Gestational)

**Risk Factors that involve Stress and Issues of Social Support**

- Miscarriage/neonatal loss
- Previous termination of pg
- Past infertility
- Adoption
- Unplanned/unwanted pg
- Ambivalence regarding pg
- Birth trauma
- Medical problems baby or parent
- Challenging infant temperament
- Change in job or loss of career
- Poverty and economic pressure
- Recent immigration
- Previous death of close family member
- Separation from parent in childhood
- Marital difficulties
- Current of past abuse of any type
- Poor social support
- Young marital age
- Single parenting
- Recent move

**Interpersonal Risk Factors**

- Negative outlook on the world
- External sense of control
- Overly eager to please others
- Very task oriented
- Rigidity
- Perfectionist tendencies
- Negative expectations of birth or parenting
- Very high expectations of birth or parenting
- Interpretation of the infant’s temperament as being the fault of the parent
- Inadequate or ineffective coping skills

**Family History Risk Factors**

- Hx of physical, sexual, or emotional abuse
- Hx of substance abuse
- Hx of domestic violence
- Poor mother/daughter or father/daughter relationship
- Low self-esteem
- Personal experience of being poorly parented
- Family Hx of mental illness
Consequences of untreated PPMD during pregnancy on the child

- Low Vagal tone (Monk, 2001; Field, et al, 1995; Field 2010)
- Increased uterine artery resistance (Tolouie et al, JAMA 1999)
- Increased rates of miscarriage & spontaneous preterm birth (Benani et al, Can J Psychiatry 2000; 45(1): 726-33)
- Neuroendocrine Abnormalities (Tronick & Rock, 2009; Diego, Jones, & Field, 2010)
- Impaired recognition, memory & habituation (Wadhwa et al, 2001; Tronick & Rock, 2009; Diego, Jones, & Field, 2010)

Untreated PMAD Impact on Child

- Depressed mothers have less affectionate contact with infant and less time mutually engaged with child as toddler (Barratt & Heying, 2001; Campbell et al, 1995)
- Less responsive to infant cues (Campbell et al, 1995; Ikeda, 1998; Field, 2010)
- Were withdrawn w/flat affect or were intrusive or hostile towards infant (Field, 2009; Field, Hodes, Goldberg & Gathorne, 1993)
- Negative effect on infant attachment (Kalter, 2010; Conner et al, 2011; Wiener et al, 2003; Sears et al, 1995)
- PMAD moms less likely to breastfeed, read/sing to infants, bring babies to doctor visits, and use safety practices with infants (Field, 2010)

PMAD Assessment

- Screening tools:
  - Edinburgh Postnatal Depression Scale (EPDS)*
  - Postpartum Depression Screening Scale (PDSS)
  - PHQ-9* or PHQ-2
  - *See handouts

Barriers to Care

- Stigma
- CPS
- Misinformation
- "Cinderella Syndrome"
- Poor access to Community Resources & Access to care
- Screening not universally implemented

Peer & Group Social Support

www.postpartum.net (Nat’l & Int’l resources)
www.ppmdsupport.com (WA State)

Postpartum Support of WA Core Services

- Toll-free telephone support line 1-888-404-PPMD (7763)
- Free Support Groups
- Referrals:
  - List of Health care providers specializing in PPMD (as identified by screening questionnaire)
- Educational Services:
  - In-services, Conferences, Seminars
  - Newsletters
  - Publications: Beyond the Birth: What No One Ever Talks About (English & Spanish)
- Dawn Gruen Support Fund:
  - For low-income families or families w/o insurance
  - Pays for either therapy, Doctor appointments for medication management, or postpartum doula care
Useful Websites for PPMD

- Postpartum Support International (PSI) www.postpartum.net
- Postpartum Support of WA State www.ppmdsupport.com
- WA State “Speak Up When You’re Down” PPD Awareness Campaign www.speakup.wa.gov
- MedEdPPD.org is a professional education, peer-reviewed Web site developed with the support of the National Institute of Mental Health (NIMH) to foster the education of primary care providers who treat women who have or are at risk for postpartum depression (PPD). http://www.mededppd.org (includes a free CEU activity)
- Trauma and Birth Stress www.tabs.org.nz
- Virginia Department of Health (includes a free CEU activity) www.prenataldepression.org

- New Jersey Department of Health www.njdspeakeup.gov
- Toronto Public Health www.toronto.ca/health/pp Depression.htm
- Dr. Shaila Misri, MD, FRCP; www.wellmother.com
- Massachusetts General Hospital Center for Women’s Health http://www.womensmentalhealth.org/topics/postpartum.html
- Tricare Military Benefits https://www.hnfs.net/provider/manuals/cqm/studies/postpartum Depression.htm