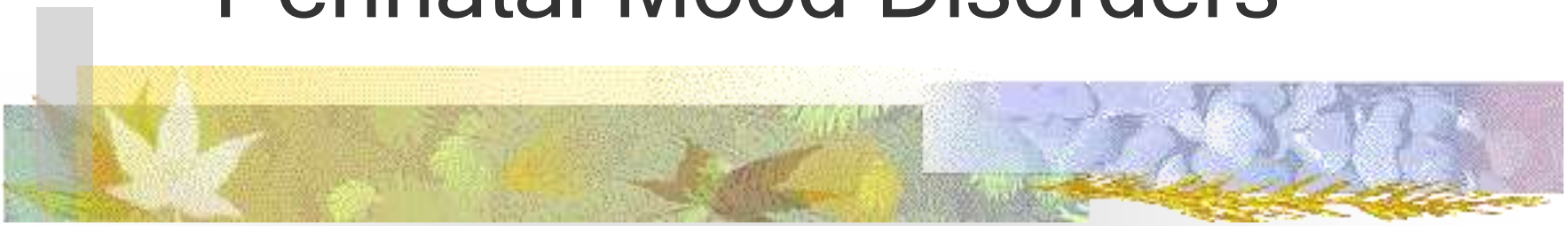
Beyond the Birth: Understanding and Assisting Families Experiencing Perinatal Mood Disorders



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PSI of WA's Mission

" To overcome the effects of Postpartum Mood Disorders (PPMD) through early identification and treatment, thereby ensuring a healthy environment in which both mother and baby can thrive together."

PSI of WA's Objectives

- Perinatal Awareness
- Collaboration and Partnership
- Education and Training
- Public Policy and Advocacy
- Direct services for parents

PSI of WA State Offers

- Parent Support Groups
- Toll-Free Peer Support Warm line 1-888-404-PPMD
  "Talk to a Mom who's been there" (volunteers)
- Health Care Provider Referrals
- Free Brochures
- Booklets "Beyond the Birth"
- Parent and Community Lectures
- Professional In-services & Conferences
- Consultation for Health Care Providers
- Online resources and downloads
- Online newsletter

PSI (International) Offers

- www.postpartum.net with online resources and downloads
- Trained State and International coordinators to find local resources
- Toll-free Help line 1-800-944-4PPD in English and Spanish
- The pen pal network supporting women incarcerated for infanticide
- www.postpartumdads.org PSI's father website
- www.ppdsupportpage.com online support group forum
- Newsletters, brochures
- Conferences, in-service trainings

ALASKA STATE PSI COORDINATOR

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PSI's Universal Message

You Are Not Alone

You are not to blame

With help, you will be well

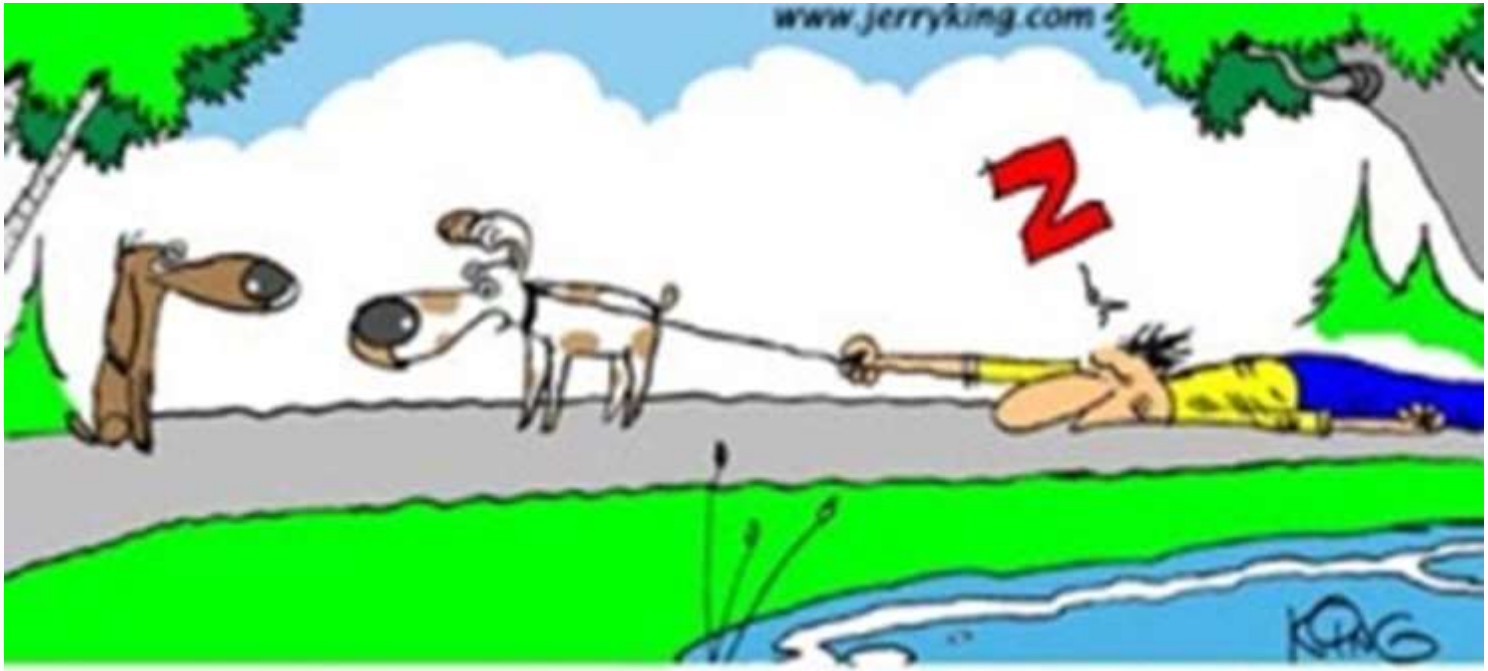
Realistic Preparation for Parenthood

Myths of Parenting

- The birth will be easy or complication free
- That I'll instantly love my baby
- Being a mother will complete me
- That it's natural/Instinctual
- That I won't be like MY parents or like one of "THOSE parents" (fill in the blank – crunchy Earth mama or cry-it-out or bottle-feed or breast feed for years or I'll make my own baby food, or cloth diaper, or disposables, or …..
- That I'll sleep when the baby sleeps OR I'll get so much done when the baby sleeps
- That it will bring us closer together as a couple

Wanted:

- Woman to care for small children. Must be willing to work 24/7, with no vacation or sick time. Short breaks only if life threatening. Must be able to tolerate loud, incessant noise and interruption, lack of privacy, blame and criticism with grace and humility.
- Must have valid driver's license. Self-motivation, organization and multi-tasking mandatory. Must require little sleep and demonstrate physical and emotional stamina. Does not require external validation.



"I think his sleeping during our walks has something to do with his new baby."

Reality – Impact on Couples

- Couples often enter parenthood without realistic expectations for changes that lie ahead – changes in individual identity, couple roles/impact, and real life with a baby
- In the western culture, the transition to parenthood is typically a time in which most couples show a SIGNIFCANT DECLINE in marital satisfaction….especially women (Schultz, Cowan and Cowan,2006)

- Couples -- Partnership roles are eclipsed by parenting roles in the first year.
- “Bids for connection” (Gottman) go the baby instead of to each other, thus depleting the strength of the couple’s emotional attachment to one another

Reality

- Sleep Deprivation
  - Frequent feeds
  - Difficult feeds
  - Hard to soothe baby
  - Reflux
  - Babies are noisy
  - Heightened senses and lighter sleep patterns

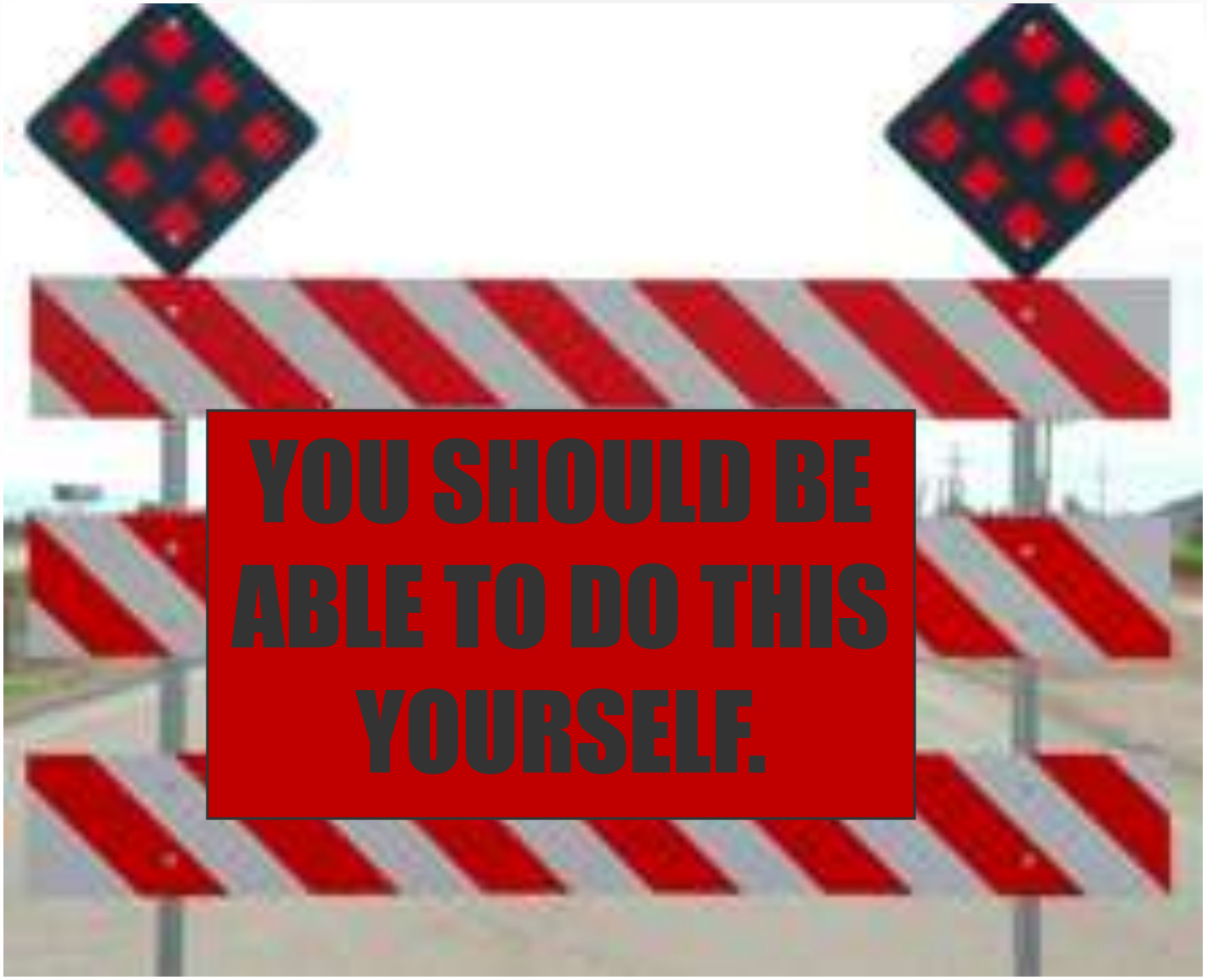
http://www.plokta.com/plokta/issue23/torture1_large.png

Reality . . .

- What happened to my body?
  - Breasts
  - Birth recovery – vaginal or c-sect
  - Weight
  - Strength & Stamina
  - Hemorrhoids
  - Varicose veins, stretch marks

Reality . . .

- Western culture stresses individuality – not community (very high expectations for being able to do things expertly, immediately, and without help).
- This belief system creates MENTAL ROADBLOCKS to seeking the type of help and support that are necessary to make a successful transition to parenthood.



http://www.mspbusinessmanagement.com/webinar/may-webinar-avoiding-internal-sales-road-blocks

Reality…

- Money issues
- Career impact
  - Maternity Leave
  - Childcare dilemmas
  - Stay at home mother transition

Reality . . .

- Societal Support:
  - No guaranteed Paid Maternity Leave,
  - No SSI, no pension, no salary,
  - Government services cut
- Family support:
  - Geographic limitations
  - Grandmothers are often employed
  - Maternal pride – I can do it myself
  - Family dysfunction

Social pressures and expectations

- Trends in infant care
  - Breast vs. Bottle
  - Attachments parenting
  - The family bed vs. crib
  - Sleep training
  - Baby Carriers: Slings – front packs – strollers – car seats
  - Cloth vs. Disposable diapers
  - ETC

Expectations . . .

- Do ‘it all’ gracefully – and make it look easy.
- Never let ‘em see you cry and don’t complain.
- You should be grateful.

The Emotional Stew

- Disappointment: *failure* to fulfill an expectation, hope or desire
  - In the birth experience
  - In the baby
  - In the partner
  - In her family
  - In the attendants
  - In herself

The Emotional Stew

- Grief:
  - What she has lost
  - What she can’t have
  - How she feels or doesn’t feel

The Emotional Stew

- Resentment & Anger
  - This isn’t fair
  - I don’t like motherhood or my baby
  - Why doesn’t he . . .
  - Mommy Wars

The Emotional Stew

- Guilt:
  - Socially imposed: society holds mothers to a very high standard.
  - Pressure on the mother as most responsible for the outcome of her children.
  - I dislike motherhood and my baby

The Emotional Stew

- Guilt:
  - Family imposed
    - Naming
    - Visitation
    - Holidays
    - Traditions
    - Feeding
    - Discipline
    - etc

The Emotional Stew

- Guilt:
  - Partner Imposed
    - Be productive
    - Let's have Sex!!!
    - Be like my mom
    - Don't need me to . . .
    - Don't expect me to . . .
    - I work all day. When I come home I want to relax.

http://www.thediaperlady.com/postpartum-depression.htm

The Emotional Stew

- Guilt:
  - Self Imposed
    - Be organized
    - Be productive
    - Be like/don't be like my mother
    - Be selfless
    - Be accommodating and flexible
    - Don't need any help – Do it myself
    - Look like I have it together – at all costs

Moving Toward Balance

Create a safe place where the truth is honored

- Mothers need connection with other mothers to integrate their new role into their identity (Motherhood Mayhem Meetings!)
- There needs to be room for her whole experience, her whole self, ALL HER FEELINGS – the good, the bad, the ugly
- Creating an image that is **REAL WITHOUT SHAME**

Easing the Transition

- Nurture Her physical body
  - Nourishment
  - Rest
  - Exercise
  - Light
  - Relaxation
  - Space
- Her emotional body:
  - Understanding
  - Validation
  - Rest
  - Empathy
  - Truth
  - Hope
  - Help

Nurturing

- Her spiritual body
  - “Soul Food”
  - Meditation
  - Prayer
  - Any practice that helps the mother focus on her own self (art, gardening, reading, etc.)
- Her intellectual body
  - Information
  - Resources
  - Brain challenge
  - Creativity
  - Companionship

Guidance & Assistance

- Our society is not mother friendly. Offering support, care and help are integral parts of tradition in many countries.
- Accepting help and care are not admission of failure or weakness
- Creating community and connection to support the new role
- Reaching out to welcome and include new mothers
- Mentoring new mothers

Attachment Issues

- What is attachment? It is the way you "live your love." The way you believe and act about whether people can be counted on, whether they will care for you, and how. (Secure, Anxious, Avoidant, Disorganized)
- It is a pattern of behaviors and beliefs that are usually "set" in infancy and childhood, and continues to influence how we are in ALL relationships for the rest of our lives
- Parents can have significantly different attachment styles
- Either parent may become absorbed by "ghosts in the nursery" – (Legacies of our FOO or losses such as miscarriages, loss of a previous child)

http://www.funnyanimalworld.net/The-warm-moments-of-animals-family/The-warm-moments-of-animals-family-2

- Dan Siegal, M.D. (author of Parenting from the Inside Out and The Whole Brain Child) says, "**PERCEPTION IS 90% MEMORY**"
- With this in mind, we can understand the importance of couples becoming familiar with their own attachment histories and styles, so that they may address possible conflicts in advance.

“No Escape” Reality Crisis

- For many women, having a baby is the first experience of a lifetime from which they cannot get away.
- The “Holy Sh#t what the F%&k did I just get myself into?!” Phenomenon
- This can cause a lot of anxiety, as well as a sense of failure as they are forced to confront disappointments in themselves or others (specifically spouse or baby).

The Image/Reality Gap

- Parents must be able to LET GO OF THE UNREAL in order to appreciate what IS real, and to find strategies that allow for love and satisfaction to develop with THIS baby, and THIS parent, at THIS time.
- Recognize parents have their own developmental phases and stages
- Cultivate “not yet” and “what went well today” mindsets

http://www.scienceofrelationships.com/home/2013/5/2/new-parents-were-on-the-same-team.html

Etiology & Symptomology of Perinatal Mood Disorders

"I started to experience a sick sensation in my stomach; it was as if a vise were tightening around my chest. Instead of the nervous anxiety that often accompanies panic, a feeling of devastation overcame me. I hardly moved. Sitting on my bed, I let out a deep, slow guttural wail. I wasn't simply emotional or weepy, like I had been told I might be. This was something quite different. This was sadness of a shockingly different magnitude. It felt as if it would never go away"

Down Came the Rain: My Journey Through Postpartum Depression, by Brooke Shields, 2005

Learning the Lingo

- PPD (Postpartum Depression – **DON'T USE ANYMORE**)
- PPMD (Pregnancy and Postpartum Mood Disorders)
- PMD (Perinatal Mood Disorders)
- PMAD (Perinatal Mood and Anxiety Disorders)

PMAD's are the #1 complication of Pregnancy

PMADs are more common than

- Gestational diabetes (2-5%)
- Pre-eclampsia (5-8%)
- Preterm delivery (12%)

(Kathryn Leopold, MD and Lauren Zoschinick, MD,
Article: "The Female Patient: Postpartum Depression.“)

Etiology

- Biological
- Psychological
- Social/Environmental
- Spiritual/Existential Crisis
- Cultural Myths of Motherhood

Biology

- Genetics
  - Mood disorders run in families
  - At higher risk if mother, siblings or other family members had PMADs or other mental health disorder
  - At higher risk if already have an existing mental health disorder
  - At higher risk if have History of PMS or PMDD

Biology

- Fluctuations of estrogen across the menstrual cycle and at other points in a women's reproductive life may disrupt the balance of the neurotransmitters and affect a woman's mood

Sichel, D. & Driscoll, J. (1999). *Women's Moods.* New York, NY: William Morrow and Company.

Biology

- PMADs may be psycho-neuro-immunological disorders that come from an exaggerated inflammatory response to labor and delivery.
- The body attempts to limit damage from stress, injury, or infection by releasing both pro-inflammatory and anti-inflammatory cytokines.
- Pro-inflammatory cytokines are linked to fatigue, hypersomnia, fever, decreased appetite, and depression.

Biology

- Early postpartum is a state of serotonin deficiency (Bailara, 2006).
- Studies show that women with postpartum depression have decreased tryptophan levels, decreased platelet serotonin (Maurer-Spurej, 2007) and altered binding of platelet serotonin transporter sites (Newport et al, 2004).
- Cortisol, estradiol, and progesterone all have an impact on the serotonin system, and the latter two decrease precipitously after birth.

Biology

- Ilona Yim at UC-Irvine has found a correlation between the rapid release of cortico releasing hormone at 25 weeks and the development of postpartum depression.
- This hormone is typically produced by both the placenta and the hypothalamus.

Spectrum of PMADs

- Depression
- Anxiety/panic
- OCD (Obsessive/Compulsive Disorder)
- Bipolar Disorder
- PTSD (Post Traumatic Stress Disorder)
- PP psychosis 1-2/1000 deliveries (usually is either Bipolar or Schizophrenic)

Pregnancy vs. Depression

- Labile mood, teary
- Self-esteem normal
- Sleep disruptions: bladder or heartburn, can fall back asleep
- Energy – may tire, but rest restores
- Pleasure: joy and anticipation
- Appetite increases
- Appropriate worry

- Mood: dark, gloomy, down
- Anhedonia
- May have suicidal ideation, or plans with intention
- Low self-esteem, guilt
- Sleep disruptions – can't fall back asleep, often early a.m.
- Energy low – rest not restorative, chronic fatigue
- Poor appetite

Baby Blues

- About 75-80% of postpartum women may experience this
- Peaks 3-5 days postpartum
- self-correcting moodiness, tearfulness, fatigue, sleep deprivation
- Feeling overwhelmed with transition to motherhood
- Predominant mood is happiness

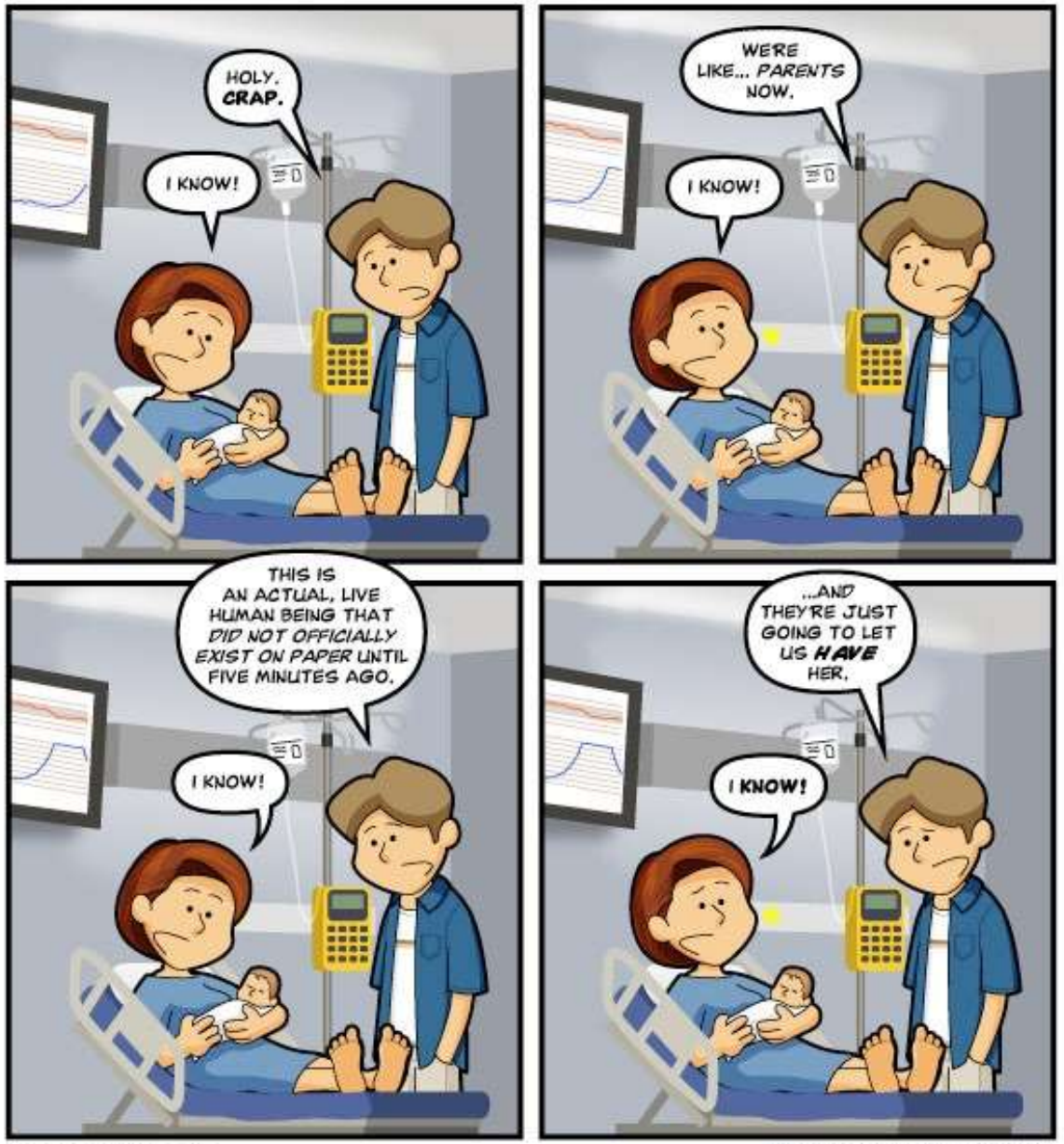
Is this Blues or PMAD?

- **Timing – Severity - Duration**
- Blues will improve quickly with adequate self care such as rest (2 REM cycles of sleep per day) and good nutrition.
- Blues always **resolves within 2 weeks**. Unresolved mood issues beyond this should be screened for PMAD
- True postpartum depression often is co-morbid with other mood disorders such as anxiety or OCD. Blues is not.

Adjustment Disorders

- Is a DSM V classification
- I tend to refer to this as

  "Holy S*#t! What did I get myself into?"
- Can have mild depression & anxiety but usually not warranting meds – if it does, I tend to then give either a Major Depressive Disorder Dx or Anxiety Dx


HOLY. CRAP.
I KNOW!
WE'RE LIKE... PARENTS NOW.
I KNOW!
THIS IS AN ACTUAL, LIVE HUMAN BEING THAT DID NOT OFFICIALLY EXIST ON PAPER UNTIL FIVE MINUTES AGO.
I KNOW!
...AND THEY'RE JUST GOING TO LET US HAVE HER.
I KNOW!
reallifecomics.com
RealLife ©2011 Greg Dean

Incidence Rates of PMADs

- Approximately 15 - 20% of all **pregnant** and **postpartum** women may experience some form of PMAD (higher amongst high risk pops)
- Anxiety may now be more prevalent that depression (2013, Paul, Downs,Schaefer, Beiler, Weisman, Pediatrics)
- 10-14% of Men in US experience PPD
- However, studies show if mom has PMADs, the fathers' rates of depression was 24 - 50%

- 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)
- About 1/3 start during PREGNANCY – often predominantly Anxiety
- Can be late onset: 3-12 months postpartum

- PMADs onset **peaks at 3 months** postpartum but can occur at anytime during the first year
- May last well into the 2nd year or longer if untreated/mistreated.
- ***May become a chronic long-term illness if left untreated***

(Gruen, Gentry, Myers & Jolley, Beyond the Birth, 2003)

PMADs & Pregnancy

- Over 40% resume medication during pregnancy (Cohen, 2004)
- Most cases are undetected and untreated (Marcus, 2009)
- 50-75% relapse during pregnancy if discontinue existing psychiatric medications (Cohen, 2004)

PMADs & Pregnancy

- Rates = 10-18% in average population
- Up to 51% in low SES populations

(Bennett, et al, 2004)

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

Risk Factors

- Prior Hx -- 50-80% risk of Depression during next pregnancy
- Personal or family history
- History of Hormonal mood disorders – PMS, PMDD, reactions to hormonal birth control
- History of eating disorders & self harm
- Complicated/High risk pregnancy/bed rest
- Endocrine Dysfunction
  - Thyroid disease
  - Diabetes

Risk Factors

- Unresolved losses (especially reproductive in nature – i.e., miscarriage, infertility, abortion)
- History of sexual or physical abuse or neglect
- Recent stresses (i.e., an illness in self/family; divorce; a move; a change in jobs; death, change in financial status, etc.)
- Perfectionist personality; very task oriented; inflexible
- “Challenging baby” (i.e., colicky, high needs, temperament differences, illness/injury, developmental delays)

Risk Factors

- Multiples birth (twins+)
- NICU
- Traumatic or disappointing childbirth experience
- Breastfeeding difficulties
- Social Factors
  - isolation, Poor support system
  - Financial difficulties
  - Teen pregnancy

Exacerbating Factors

- Pain
- Lack of Sleep
- Abrupt discontinuation of Breastfeeding
- Childcare stress
- Marital stress
- Career vs. Motherhood stress

- Technological/medicalized aspects of birth leading to feelings of loneliness, helplessness, and betrayal – which can lead to depression, anxiety, and posttraumatic stress

Adoptive Families & Post Adoption Depression (PADS)

- "But they did not give birth?"
- Hx of infertility treatments & miscarriage
- Family history of mood disorders–a "sensitive brain"
- Sleep loss
- Greater expectations
- Less likely to discuss feelings (shame)

Bipolar & Pregnancy

- 71% had recurrent episodes during pregnancy
- Women who stopped mood stabilizers had TWICE risk of reoccurrence, FOUR times more rapidly than women on meds
- Most reoccurrences were depressive or mixed, often in 1st trimester

(Viguera et all, 2007)

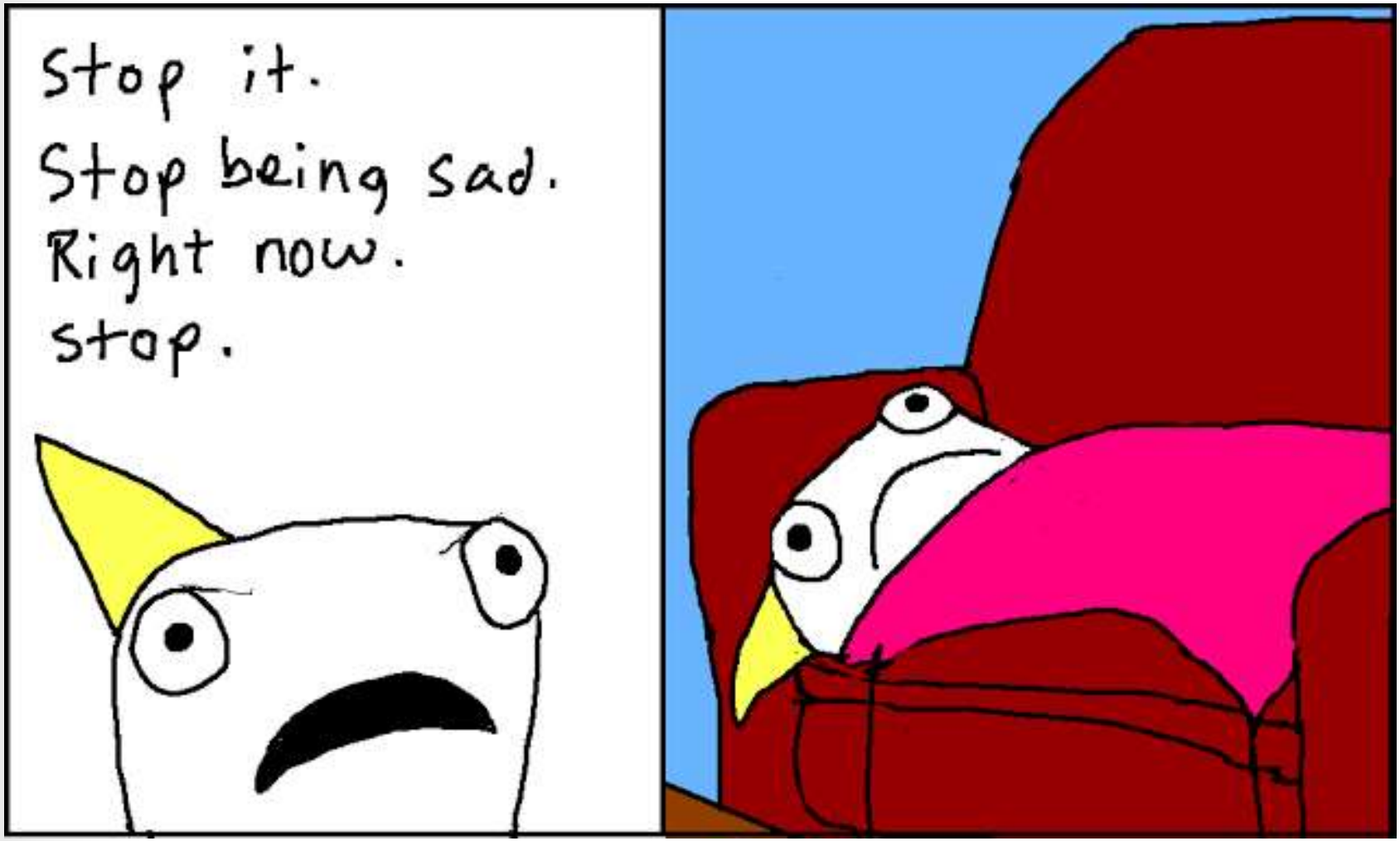
Consequences of Unmanaged Anxiety and Depression in the Mother

- Poor prenatal care
- Risk of medical / obstetrical complications
- Exacerbation of psychiatric illness through postpartum
- Self-medication / substance abuse
- Impaired bonding

(Stewart DE. CMAJ 2006; 174(3):302-303; Marcus SM et al. J Womens Health 2003; 12:373-80; Orr ST et al. Pediatric & Perinatal Epidemiology 2000; 14:309-13)

Depression Symptoms

- Sadness, crying
- Somatic complaints
- Suicidal ideation
- Overwhelmed
- Appetite changes
- Sleep: hypersomnia or insomnia
- Irritability & anger
- Hopelessness, despair, helplessness
- Guilt & shame
- Feels ‘numb’ towards baby
- Difficulty taking care of self or family
- Loss of pleasure, interests
- Anxiety co-morbid
- Isolation, agoraphobic
- Feelings of worthlessness

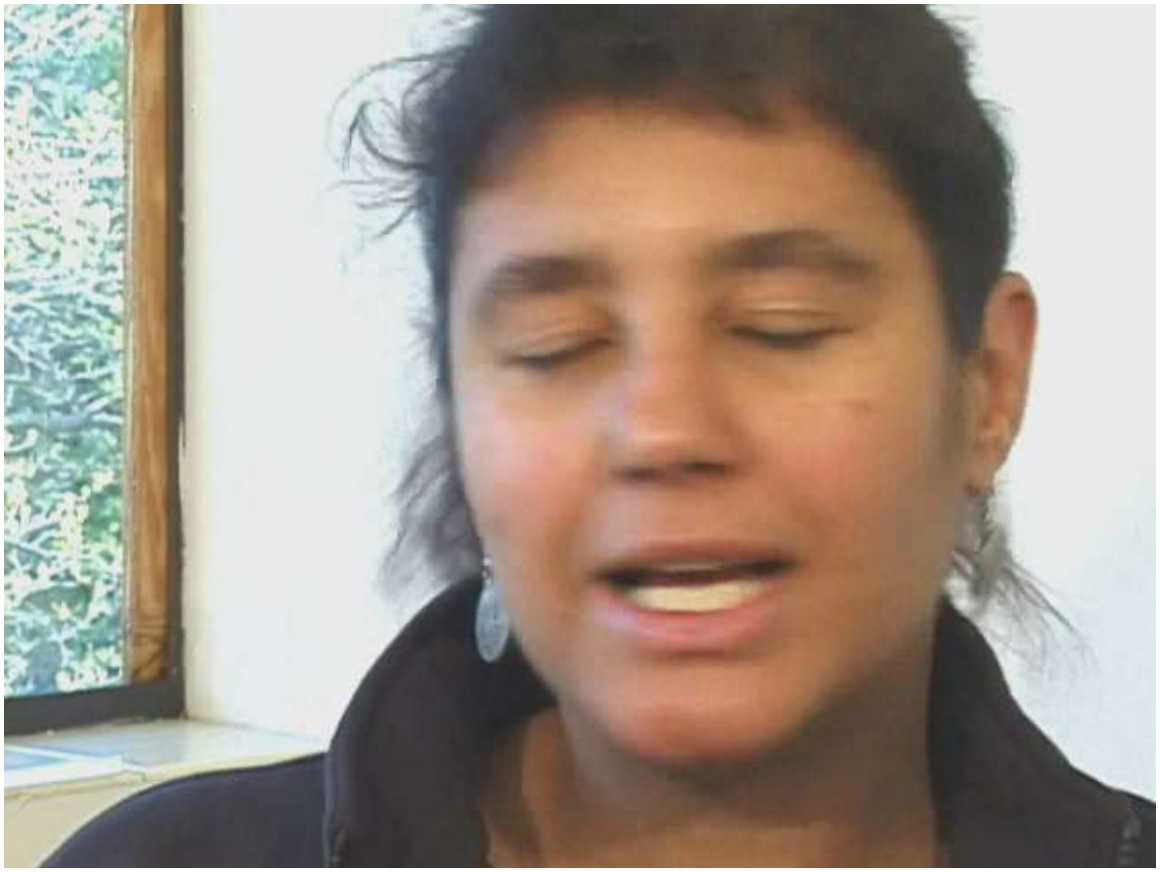


http://hyperboleandahalf.blogspot.com/

Video Clips of Postpartum Depression

Altered Perception of World

Stories of Postpartum Depression



Postpartum Depression & Shame

Postpartum Depression

Anxiety Symptoms

- Agitated
- Excessive worries – often about baby or own health
- Hypervigilent
- Mind Racing
- Rapid weight loss
- Difficulty falling/staying asleep
- Shortness of breath
- Heart palpitations
- Diarrhea
- GI disturbances

You Know You're a Mom When...

You hear about Hurricane Sandy and you think...
Oh no, all of that frozen breastmilk:
DOWN THE DRAIN! Those poor moms.

Panic Symptoms

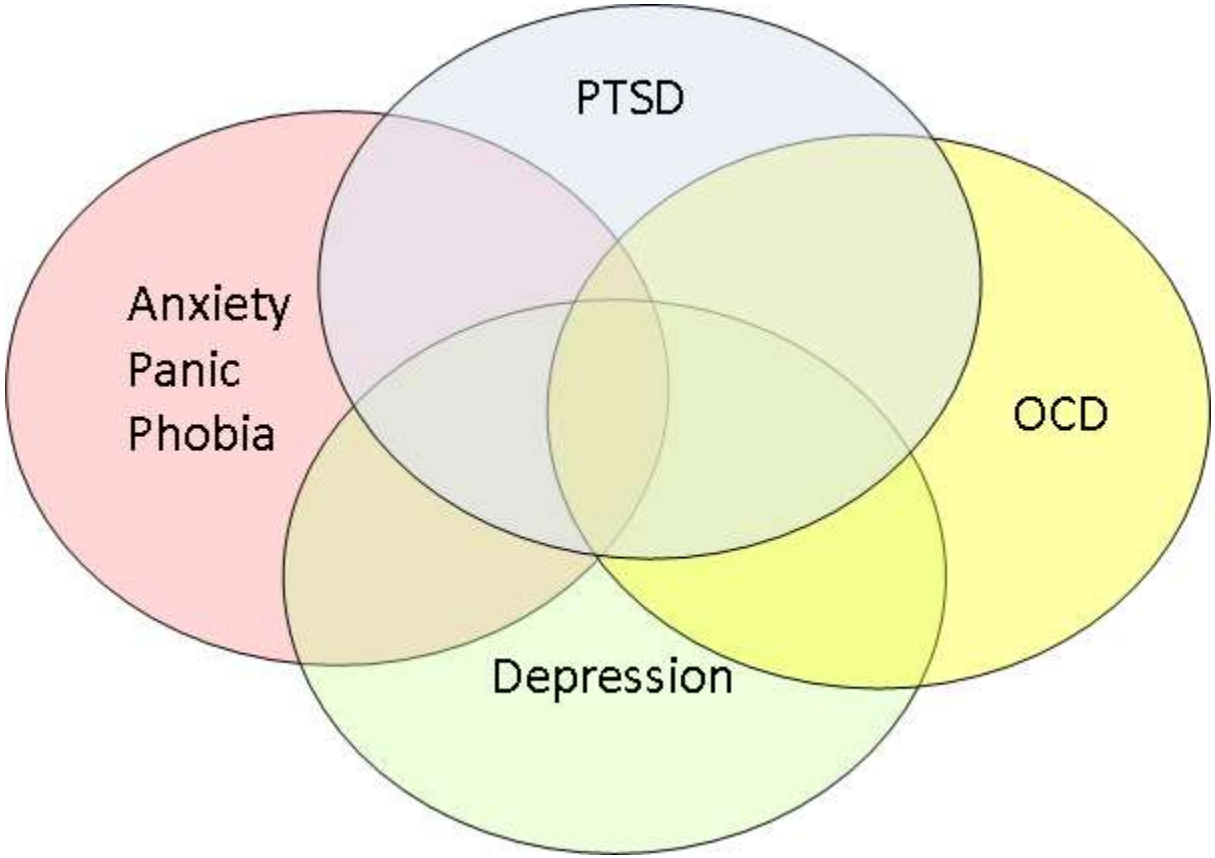
- Episodes of Extreme Anxiety
- Shortness of breath, chest pain, sensations of choking, dizziness
- Hot or cold flashes, shaking, tremors, rapid heart rate, numbness or tingling sensations
- Restlessness, agitation, irritability
- Excessive worry or fear, catastrophic thinking
- Can wake them up

Panic

3 greatest fears:

1. Fear of dying
2. Fear of going crazy
3. Fear of losing control

Co-Morbidity



Obsessive Compulsive Disorder

Approximately 9% of mothers develop OCD

(Abramowitz, et al; Anxiety Disorders, 2006; Zambaldi, et al; Comprehensive Psychiatry, 2009)

OCD – Classic Symptoms

- Cleaning
- Checking
- Counting
- Ordering
- Obsession with germs, cleanliness
- Checking on baby
- Hypervigilence

Obsessive-Compulsive Disorder

- Recurring, persistent & disturbing thoughts, ideas or images (scary images of accidents, abuse, harm to baby)
- Ritual behaviors done to avoid harming baby (e.g., put away knives, counting) or to create protection for baby (e.g., excessive cleaning, doesn'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)

Obsessive-Compulsive Disorder

- Intrusive thoughts, fears, images
  ("Scary Movie in my Head")
- Person cannot control thoughts
- Horrified by thoughts, Tremendous Guilt and Shame
- Person understands that to act on these thoughts would be wrong (hence she is in her 'right' mind)
- **Educate Mom that thoughts do not equate with action**
- Often misdiagnosed as psychosis

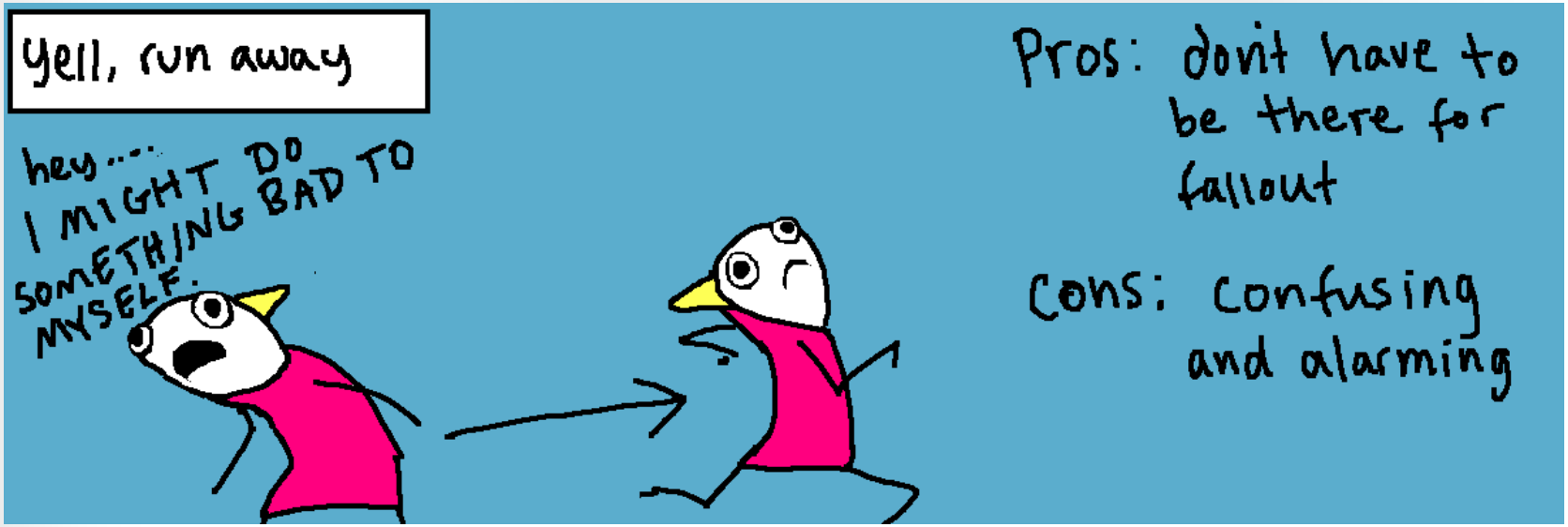
Video Clips of Postpartum Anxiety & OCD

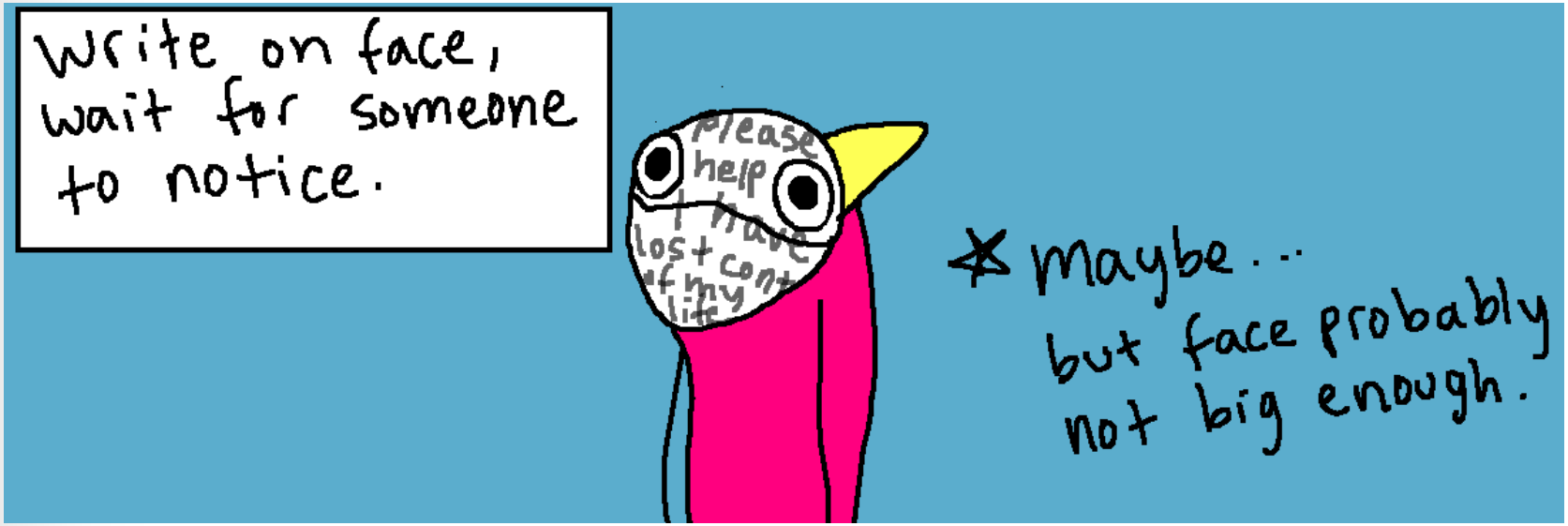
Stories of Anxiety and OCD

Nightmares

Anxiety and Hyper-vigilance

Scary Obsessive Intrusive Thoughts


yell, run away
hey.... I MIGHT DO SOMETHING BAD TO MYSELF.
Pros: don't have to be there for fallout
Cons: confusing and alarming


write on face, wait for someone to notice.
please help
lost cont
of my life
* maybe... but face probably not big enough.

Bipolar Disorders (Type I & II)
"Manic/Depressive"

- Can have symptoms of all the other PMADs
- Cycles of depression and Mania (type I) or Hypomania (type II)

Mania

- Abnormally and persistently elevated, euphoric mood
- Agitation or irritable mood
- Inflated self-esteem or grandiosity
- Decreased need for sleep
- More talkative than usual or pressured speech
- “Flight of ideas” or racing thoughts
- Distractibility
- Increase in goal-directed activity & productivity
- Excessive involvement in pleasurable activities that have a high potential for painful consequence
- **May have psychotic features (delusions, hallucinations, paranoia or disorganized thinking – not oriented x3)**
- Must last at least 7 days in length or require hospitalization

Hypomania

- Can improve their functioning “Feels Great!”
- More irritable mood
- Inflated self-esteem or grandiosity
- Decreased need for sleep
- More talkative than usual or pressure to keep talking
- “Flight of ideas” or mind racing
- Distractibility
- Increase in goal-directed activity or psychomotor agitation
- Excessive involvement in pleasurable activities that have a high potential for painful consequences (Sex, drugs, gambling, etc.)
- Episodes up to 4 days in length

"The longer I was untreated, the worse my cycling became. One night, I repainted my entire kitchen while I had mind-racing insomnia. If I couldn't get things done RIGHT NOW, I would spin out of control with rage. I was obsessively hypervigilant about my baby's safety. My sleep was full of nightmares that something horrible happened to my baby, and I was at fault for not protecting her."

By the time my daughter was 2 years old, I had attempted suicide 3 times

Bipolar Disorders

- 60% of bipolar women present initially as depressed – “PPD Imposter” (if prescribed antidepressant alone, might 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

Why is this Important?

- Over 60% misdiagnosed with Major Depressive Disorder
- Over 35% suffered for 10+ years with incorrect diagnosis (Bipolar Depression, Current Psychiatry, 2004)
- Bipolar Disorder is a chronic life long illness, high rates of psychosocial dysfunction
- High rates suicide

Clinical interview tips for Bipolar

- Get a good family history
- Get history FROM family when possible
- Don’t just ask postpartum depression oriented questions – ask about manic symptoms – this is why it is important to have a paradigm shift to PMADs, not just PPD

Psychosis

- Occurs 1-2 per 1,000 women
- **Requires immediate treatment often including hospitalization and medication**
- Most likely IS Bipolar Manic Event (unless mom is schizophrenic)

Risk Factors for Postpartum Psychosis

- Personal or family history of Bipolar Mood Disorder
- Personal or family history of Psychosis
- Other factors include:
  - *First child*
  - *Perinatal death*
  - *Advanced maternal age*
  - *Premature delivery*
  - *Low birth weight*

A word about Sleep & Psychosis

And the need for REM Sleep (Two 3-5 hr blocks)

"Your wife's on the phone. She wants to know if you can watch the baby later so she can get in her daily 4 hours of sleep."

Psychosis

- Paranoia
- Delusions (about baby)
- Hallucinations
- Irrational thoughts
- Impulsivity
- Refusal to eat
- Poor judgment, Lack decision-making
- Break with reality
- Severe insomnia
- Confusion
- Higher risk if bipolar disorder in self or family

OCD vs. Psychosis

OCD:

- Low Risk Harm to Baby
- Recognizes thoughts/images are wrong, and experiences worry and anxiety about thoughts
- Mother takes steps to protect baby

Psychosis:

- High Risk to Harm Baby
- Mom might have delusional beliefs about the baby
- Thoughts of harming baby are ego syntonic (she thinks they are reasonable and has urges to act on them)

Symptoms of Postpartum Psychosis

- “I heard voices while I was in the shower telling me I should go ahead and just kill myself.”
- “I thought the devil was living inside of me–that my children would be better in heaven with God than with me.”

Example of Postpartum Psychosis

- Vancouver, WA: Mother of 3 (2006)
  - Misdiagnosed as depressed only, despite documented hallucinations and psychotic ideations
  - Went off her meds
  - Hallucinations that baby was possessed by the devil. Believed that through her baby, Satan was going to kill her older children
  - Stabbed her infant to death in effort to "protect" her other two children

And the response by the Lummi Nation (in WA, 2006) to postpartum psychosis and infanticide

Infanticide

- Rare -- 4% rate – greater risk with psychosis
- Rarely has a history of abusing children
- Most often part of a suicide attempt
  - 54-67% coincide with suicide attempt
  - 83% killed or tried to kill all their children
  - No anger towards child, wishes not to abandon child, often a severely distorted attempt to “save the child”

Postpartum Psychosis: Treatment

- Potential severe consequences
- Rule out medical etiologies
- Mood stabilizers and neuroleptics
- Prophylaxis
  - in pregnant Bipolar patients
  - continue treatment

Suicide Rates increase 44% in the postpartum year

(Melissa A. Schiff, MD, MPH and David C. Grossman, MD, MPH; PEDIATRICS Vol. 118 No. 3 September 2006)

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.” 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?

Suicidal Thoughts

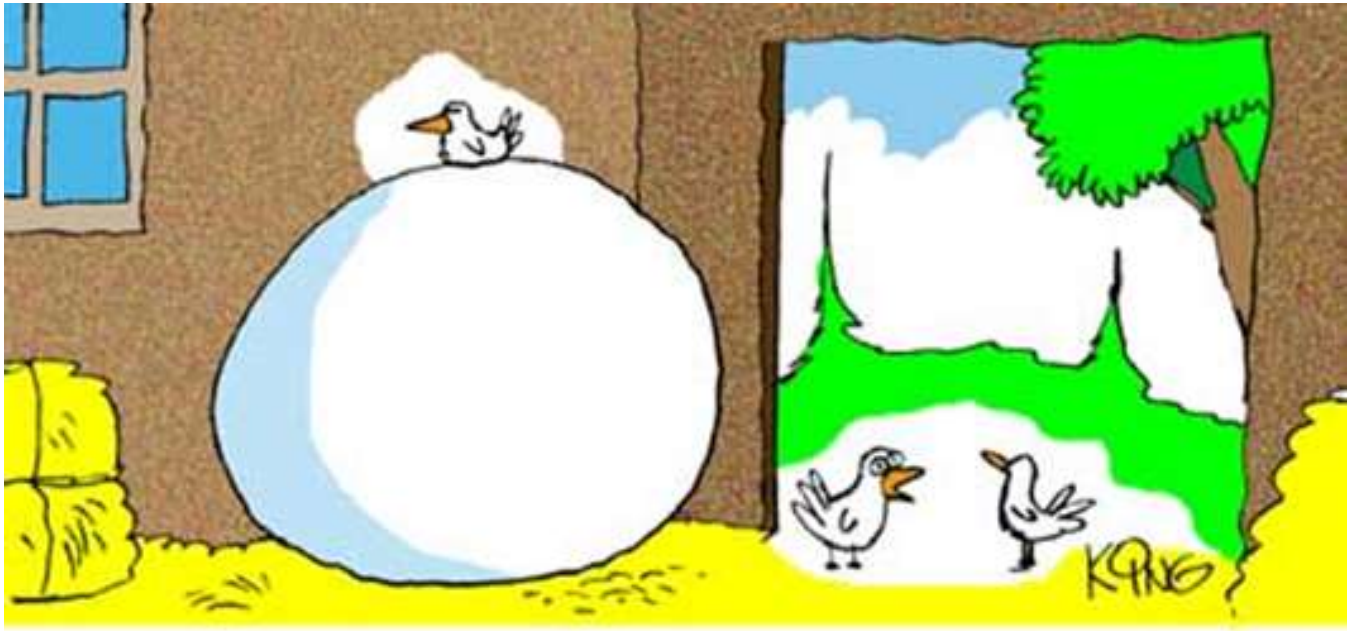
Suicide Risk in Pregnancy

- Risk increases when
  - Pregnancy is unwanted, especially when woman wanted an abortion but could not obtain one
  - Partner abandoned woman during pregnancy
  - Woman has had prior pregnancy loss and/or death of children
  - Medications stopped abruptly

(Czeizel et al, 1999, Lester & Beck, 1988, Marzuk et al, 1997)

Take a BREAK!

Birth Trauma & PTSD



"I hear it was a difficult birth."

Definition of traumatic birth

"an event occurring during the labor and delivery process that involves actual or threatened serious injury or death to the mother and her infant. The birthing woman experiences intense fear, helplessness, loss of control, and horror."

Cheryl Beck, 2004

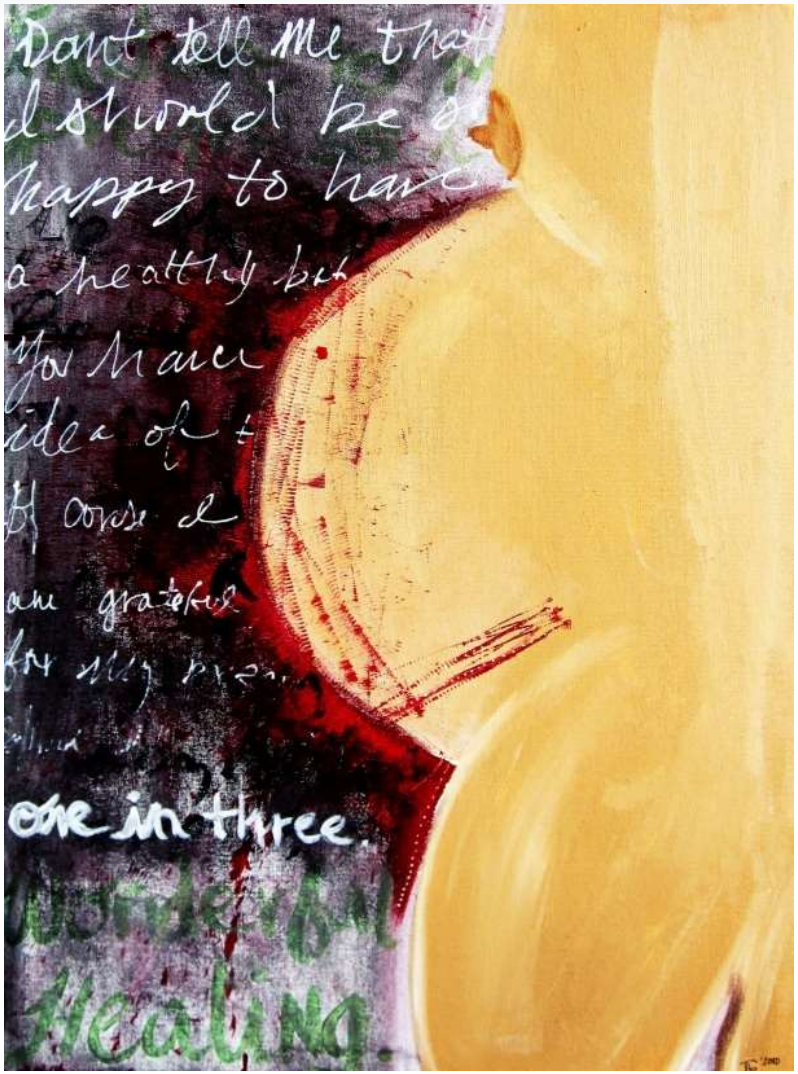


Photo: http://spiriteddoula.blogspot.com/2010/04/healing-from-traumatic-birth.html

Birth Trauma Incidence & PTSD

- Between **20 and 50%** of women report that their births were traumatic
- **20 – 50%** of those women will develop a level of mental and physical distress that falls slightly short of diagnosable PTSD but nevertheless exerts an extremely negative influence on their lives
- **2 - 6%** of them will go on to develop full blown PTSD

This OFTEN occurs during births that medical personnel consider to be quite “normal,” which indicates that trauma may reside as much in the woman’s experience and perception, as in any mutually agreed upon definition of the word.

PTSD is a complex mix of:

- Your inherited mental health risks, such as an increased risk of anxiety and depression
- Your life experiences, including the amount and severity of trauma you've gone through since early childhood. PTSD can result from a **cumulative effect** of multiple traumas over a lifetime.
- The way your brain regulates the chemicals and hormones your body releases in response to stress

Post-Traumatic Stress Disorder

- Usually occurs quickly after birth
- Cumulative impact –
  - Previous trauma Hx (recent or in the past: abuse, accidents, etc.)
- Sometimes occurs with traumatic birth experience

General Risk factors for PTSD

- Being female — women are more likely to experience intense or long-lasting trauma
- Having experienced other trauma earlier in life
- mental health history in self or family
- Lacking a good support system of family and friends
- History of abuse (such as childhood abuse, sexual abuse, rape)
- Combat exposure
- Physical attack
- Being threatened with a weapon
- Car accident, plane or train crash
- Life threatening experience (such as natural disaster, critical injury, medical crisis, attack, mugging)

Number and type of obstetric interventions

- Forceps delivery
- Vacuum assisted delivery
- Episiotomy
- C-section – especially unexpected, emergency

Photo: http://www.cafeoflifepikespeak.com/pregnancy_and_birth.htm

- Maternal health emergency, such as:
  - HELLP Syndrome
  - Extreme Gestational Hypertension
  - Maternal hemorrhage
  - Extensive (3rd or 4th degree) lacerations
- Infant health emergency
  - Pre-term birth
  - Resuscitation
  - NICU stay

Vicarious Trauma

- Husband or Partner
- Medical staff – OB, Midwife, Nurses, Anesthesiologist, Doula

Photo: Tammra McCauley via Flickr/Creative Commons

Symptoms of PTSD

- Flashbacks of the event — vivid and sudden memories
- Nightmares
- Insomnia
- Fears of recurrence
- Emotional numbing
- Panic attacks
- Inability to recall important aspects of the event — psychogenic amnesia
- Exaggerated startle response, hyper-arousal, always on guard
- Hyper-vigilance, constantly looking around for trouble or stressors
- Avoidance of reminders of the traumatic event
- Intense psychological stress at exposure to events that resemble the traumatic event

Postpartum PTSD Themes

- Perception of lack of care/respect by providers
  - Feeling abandoned
  - Stripped of dignity
  - Lack of support and assurance
  - lack of continuity of care providers
- Poor Communication
  - perceived lack of communication by medical staff
  - Mom feels invisible

Postpartum PTSD Themes

- Feeling powerless or out of control
  - Feels decisions made FOR her, not BY her, or procedures done TO her, not WITH her– lack of choice or consent
  - Betrayal of trust
  - Didn't feel protected, safe
- Do the ends justify the means?
  - "all that matters is your baby is healthy"

(Creedy DK, Shochet IM, Horsfall, J. Childbirth and the development of acute trauma symptoms: incidence and contributing factors. Birth, 27, 104-111. 2000. ; Beck, 2004 Birth Trauma: In the Eye of the Beholder, Nursing Research Vol 53(1))

Causes Of Fear Of Childbirth

- Biological — fear of pain
- Psychological — due to previous traumatic events, personality factors, feelings of helplessness, anxiety about parenthood
- Social — lack of support, low educational level
- Cultural — the medicalization of childbirth, ‘horror stories’ being passed on
- Secondary — caused by previous childbirth experiences.

(2011, Otley; Fear of Childbirth: Understanding the Causes, Impact and Treatment; The British Journal of Midwifery)

Pain + Fear = SUFFERING

- "Pain is Inevitable. Suffering is optional." – Buddhist saying
- The neuropsychiatry of pain perception is based on cumulative life experience, linguistic and social constructions (Beecher, 1957; Biro, 2010; Oakley, 1980; Rich, 1986, *Of Woman Born: Motherhood as Institution)*
- Pain is in the eye of the beholder: Our life experiences and resulting "stories in our head" – how we learn to categorize information to make sense of it - influence our perceptions and management of pain, fear and whether or not suffering may occur.
- This can be the difference between "Failure To Progress" and a difficult childbirth experience perceived as a traumatic childbirth experience, potentially resulting in PTSD

More Realistic Pain Scale

http://hyperboleandahalf.blogspot.com/

Pain and Negative Birth Experience

- Karlstrom, et al., (2007)
  - 78% of (N= 60) women post Cesarean reported pain inadequately controlled.
- Eisenach (2008)
  - Post-birth pain in (N = 1,288) women (vaginal and Cesarean) reported acute pain as three-fold risk to developing PPD.
  - Higher scores of pain for instrumental vaginal births with perineal lacerations.
- Khaskheli & Baloch (2010)
  - 66% of (N = 400) women reported birth as unacceptable, exhausting, painful experience
    - 23.95% (n = 69) were dissatisfied with pain relief (non-epidural)

Fear & Childbirth

- "A number of causes of fear of childbirth emerge from the research, including negative stories and fear of pain in labor which is associated with suffering, shame, loss of control and helplessness (Fenwick et al, 2009)
- The most common reasons for childbirth fear were a lack of trust in obstetric staff and feeling excluded from decisions. (Sjögren, 2000)
- "This emphasizes the importance of good care, which has the potential to improve women's experiences of pregnancy and childbirth by offering information, choice, agency and advocacy." (Otley, 2011; Fear of Childbirth: Understanding the Causes, Impact and Treatment; The British Journal of Midwifery)

Fear contributing to "Failure to Progress"

- If mammals sense danger of any kind, labor can stop. Fear, anxiety, not feeling safe increase catecholamine levels and can shut down our labors.
- Pain as state dependent (Emotional and cognitive state)
  - Those who are distracted tend to experience less pain.
  - Those who are anxious tend to experience more pain.

Fear & Childbirth

2012 British Journal of Obstetrics & Gynecology

- Women who have a fear of childbirth spend longer in labor than women who have no such fear
- Between 5 and 20% of pregnant women have a fear of childbirth. Various factors have been associated with increased prevalence of fear of childbirth, including young maternal age, being a first-time mother, pre-existing psychological problems, lack of social support and a history of abuse or adverse obstetric events.
- Women with a fear of childbirth endure a longer labor

- Research shows that around 1 in 10 women in the developed world is affected by severe and disabling fear of childbirth during pregnancy (Saisto and Halmesmaki, 2003)
- There is a significant link between fear of childbirth and caesarean section. (2011, Otley; Fear of Childbirth: Understanding the Causes, Impact and Treatment; The British Journal of Midwifery)
- Fear is also associated with a reported negative birth experience.

Tokophobia

- Definition = Fear of pregnancy and birth (and go to extreme measures to avoid it)
- 2% experience Tokophobia

Video Clips – Birth Trauma

Impact of Traumatic Birth

Emotional Numbness Impairs Bonding with Baby

Impact of Birth Trauma

- Avoids postpartum care
- Impaired bonding with baby
- Vicarious trauma – partner (and doulas/staff)
- Sexual Dysfunction
- Avoidance of future pregnancies
- Heightened Anxiety & exacerbation of symptoms in future pregnancies
- Elective c-sects in future pregnancies

Themes with Birth Trauma and Breastfeeding

- Themes **Supporting** nursing:
  - Proving oneself as mother
  - “My body can do this”
  - Atonement to infant
  - Healing Mentally

(Beck & Wilson, 2008, Nursing Research)

Themes with Birth Trauma and Breastfeeding

- Themes Impeding nursing:
  - Flashbacks
  - Dissociation & detachment from infant
  - Physical pain
  - Feeling violated
  - Insufficient Milk Supply

(Beck & Wilson, 2008, Nursing Research)

PTSD in NICU moms

- Risk Factors
  - Neonatal complications
  - Pre-term delivery
  - Greater length of NICU stay
  - stillbirth
- Prominent Symptoms
  - Intrusive memories of infant's hospitalization
  - Avoids reminders of child's birth

Subsequent births after Traumatic Childbirth Experience

- Cheryl Beck (Nursing Research Journal, 2010)
  - 23% of moms opted for homebirth following prior traumatic birth
  - Found trauma from birth perceived similarly across a variety of countries and nationalities

Clinical Case Study

1st pregnancy resulted in miscarriage. Next pregnancy -- C-section. Post-op complications – OB had nicked her intestines, causing an ileus and massive infection, resulting in 3 more surgeries and removal of part of her intestines.

Pain: Doctors initially minimized her report of pain post-op and sent her home twice, “it was normal to have pain after a c-sect”. Ended up over 3 weeks in hospital unable to hold or breastfeed baby. Took a year to feel bonded to her baby.

Her experience of pain during the pushing stage influenced perception of “my body can’t do this. It is broken.” “This must be hurting my baby” (Fear) influencing a C-section. Her pain with a purpose (post-op) was not taken seriously. Stories in her head: (Shame, guilt, fear) “My body failed me/is broken (miscarriage and birth experience).” “If only I could have lasted longer and did a natural childbirth, this wouldn’t have happened to me”. “People don’t listen to me when I am in pain” “I put my family through this.” “I am a bad mom because I missed my baby’s first month.” “I should not complain about my pain” “This is punishment for me being a bad person.” (continues to have chronic pain for over 2 years postpartum – multiple scar adhesions have formed around her intestines and uterus). Has decided to not have any more children.

Clinical Case Study

5th baby, 1 prior forced abortion, 1 prior miscarriage. 5th birth was perceived as traumatic (prior births were not). Had midwifery care and planned the birth at birth center. "Failure to Progress" with heart decels in baby. Transferred to hospital. C-section.

Client has a history of severe childhood sexual abuse, ritual abuse, and date rape resulting in birth of first child

Perception – felt procedures were done TO her, not WITH her

"felt like rape", "a violation", "I was out of control of my body"

Triggered Dissociative Identity Disorder Resurgence

Clinical Case Study

3rd baby – planned c-sect. Patchy epidural due to spinal scar tissue from previous car accident. Could feel the entire surgery. Felt SUPPORTED AND VALIDATED by staff. Event was still traumatic, but mitigated by her perception of support by the medical staff.

Treatment Options

- Psychopharmacology can be helpful (including sleep aids)
- Psychotherapy:
  - Bi Lateral Simulation
    - EMDR
    - LifeSpan Integration (birth story integration)
  - Somatic Resourcing
  - Interpersonal Psychotherapy
  - Cognitive Behavioral Therapy
  - Mindfulness & Meditation
  - Journaling
  - Art Therapy
- Social Support
  - Caring OB's & Midwives taking the time to understand mother's history and trauma experience, reviewing her records
  - Doula support – birth and postpartum
  - Support Groups

It’s not all bad news…

- “Post Traumatic Growth” field of research
  - Studies the experience of individuals whose development has surpassed what was present before the struggle or crisis (“What does not kill us, makes us stronger”)
  - Finding greater appreciation of life, sense of personal strength, purpose and spiritual growth
  - Using their experience as empowering to become an agent of positive change

Useful Organizations & Websites:

- Prevention and Treatment of Traumatic Childbirth (PATTCh) www.pattch.org
- The Birth Trauma Association: www.birthtraumaassociation.org.uk
- Trauma and Birth Stress (TABS): www.tabs.org.nz
- PTSD After Childbirth: www.ptsdafterchildbirth.org

High Risk Populations

- Teen Moms
- Low SES/Poverty
- Sexual Abuse Survivors
- Domestic Violence
- Military Families
- NICU/Loss

Teen Moms

- PMAD incidence rates = 29 to 48% (Logsdon, 2005, Birkeland, Thompson, and Phares, 2005)
- Some teen moms report Sx of Depression for up to 4 years (Schmidt 2006)
- 44% increased risk of subsequent pregnancy compared to non-depressed teen (Yozwiak, 2009)
- Remember too, teen populations in general are at higher risk for eating disorders

Other Risk factors for PMADS in Teens

- Untreated depression in their mom (gma)
- Pre-existing mood disorder in self
- Social isolation
- Family Conflict
- Weight/body image difficulties
- Low self- esteem

Effects of PMADs on Teens

- Interference with developmental tasks of adolescence
- Stresses relationships with family and friends
- Decreased maternal role functioning
- Disrupts school and work plans

Recommendations working with Teen moms

- Support with parents, but not necessarily friends is associated with increased mastery and satisfaction with life, decreased depression and anxiety
- Providing UNWARRANTED support might convey she is deficient in her mothering ability and undermine self-esteem
- Support offered needs to match her needs
- Is the baby's father involved? Support teen dads too
- Be mindful of dating violence
- Help them talk with their families
- School based supports
- Multidisciplinary and integrated treatment approach targeting the multiple areas of their lives (family, peers, school, work, transportation, finances)

Books for Teen Moms

- Hope…Joy (and a Few Little Thoughts) for Pregnant Teens: Consciously Creating your Legacy, by Rachel Brignoni
- Your Baby's First Year, A Guide for Teenage Parents, by J. W. Lindsay

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**

Data analysis by Dr. Rebecca Kang, PhD, 2004, UW SON CIMHD

* Pregnancy Risk Assessment Monitoring System by the WA Department of Health

Get your state PRAMS info: http://www.cdc.gov/prams/

Impact of Sexual Abuse History in Pregnancy, Birth and Postpartum

Sensitivity for Self-Care

- At least 1in 4 women in U.S. have been sexually assaulted at least once in her life.
- PTSD life time prevalence rate ranges from 32-80% among sexual assault survivors.
- PTSD rates are twice as high among adolescent females. (Resnick, et al. 1993, J Consult Clin Psychol 61(6)
- At time of interview regarding childbirth & PTSD symptoms, 43.8% of women reported the 'most troubling traumatic event' associated with current PTSD had occurred more than 10 years in the past. (Stein, et al, 1997 Am J Psychiatry, 154(8)

History of Sexual Abuse History Correlates with:

- More problematic pregnancies
- More teen pregnancies
- More unplanned pregnancies
- Greater risk of maternal depression
- Greater risk of substance abuse
- Greater risk for Low Birth Weight Babies
- Increased rates of Premature birth
- Less social support during pregnancy
- Breastfeeding Difficulties

(Loeb, et al. 2002; Child Sexual abuse: Associations with the sexual functioning of adolescents and adults. Annu Rev Sex Res 13:307-45)

Pregnancy may be a trigger

- Having a child might suddenly bring up bad memories of child sexual abuse.
- Baby gender reactions: if girl, mother may fear not being able to protect her; if boy, mother might fear she's growing 'the enemy' (if abuse was by male)
- Sleep disturbances of pregnancy and postpartum may remind mom of abuser coming in at night when she was sleeping
- Pelvic exams might trigger abuse memories, especially if perceived as 'done to you' (no body control) vs. 'done for or with me' (respect for body)
- Miscarriage or pregnancy loss may resurrect prior trauma from previous forced abortions from sexual abuse.

Potential Postpartum Impacts of Prior Sexual Abuse

- Sexual Disorders
  - Repulsion with feared sexual connotations of breastfeeding
  - Excessive Pelvic Pain
  - Sexual Dysfunction
  - Worry over touching baby's genitals

Potential Postpartum Impacts of Prior Sexual Abuse

- Physical & Medical Problems
  - Sleep disorders
  - Loss of appetite
  - Extreme fatigue
  - Newborn failure to thrive
  - Prolonged recovery
  - Breastfeeding difficulties

Psycho-Social Impacts of Prior Sexual Abuse

- Projection of fears, etc. onto child
- Fear of hurting baby (fear of abusing their child – avoiding diapering, bathing, being alone with child)
- Bonding difficulties
- Vulnerable child syndrome
- Projection of baby as perpetrator
- Fear of being alone
- Anger at health care providers & partners (perceived "perpetrators")
- Relationship problems
- Self-image as bad/incompetent mother

Dissociation

- Defined by DSM IV as the 'disruption in the usually integrated functions of consciousness, memory, identity or perception of environment'
- Form of self-anesthesia and coping, useful when fight or flight is not possible.
- Example:

  assisting breastfeeding with a mom survivor of childhood sexual abuse – reminded of someone constantly demanding her body that she could not avoid, tugging and pulling, pain, felt she had little control of her own body anymore (following an emergency C-sect where she felt she had lost control over her body.)

Potential Benefit to Capitalize on

- Women who have the ability to dissociate are often quite successful using self-hypnosis during childbirth as a coping strategy to manage labor.
- This can also be useful strategy postpartum if baby's cries of hunger or colic trigger the mother.

Long Term Consequences

- Parental mental illness, *especially that of the mother*, was the most significant other adversity contributing to the risk of a child sexual abuse survivor developing mental health problems herself as an adult.

- Women survivors of child sexual abuse reported 1.8 times higher rates of depression, and 10.2 times as likely to have PTSD.

(Molnar, Buka & Kessler, 2001. Child sexual abuse and subsequent psychopathology: Results from the National Comorbidity Survey. Amer Journal of Public Health 91(5)

Learning from Survivors

- After trying to tell parents of sexual abuse, and being ignored, Hope reported: “It was then that I internalized two very profound teachings: 1) It was ok for people to hurt me, and 2) It was not ok to tell anyone about it.
- These learned lessons made it difficult for her to tell her Health Care Provider her needs during pregnancy and childbirth.

(from Survivor Moms: Women’s Stories of Birthing, Mothering and Healing after Sexual Abuse, 2008 by Mickey Sperlich & Julia Seng)

- Recovery is a long term process and may not be complete when childbearing occurs.
- The inability of their parents providing protection from abuse as a child has long term consequences:
  - Impairs the current mother's ability to trust in her own mothering experiences
  - Can impair ability of current mother's ability bonding and forming healthy attachment with current baby.

Domestic Violence and Abuse During Pregnancy and Postpartum

Heidi Koss, MA, LMHC

Domestic Violence during Pregnancy

- 21% of women abused by a current or previous partner were assaulted during pregnancy.
- Pregnancy is more likely to have the opposite effect: 1 in 6 abused women reports that her partner first became abusive during pregnancy
- Pregnant women are 60.6% more likely to be beaten than women who are not pregnant. ("Battering and Pregnancy" Midwifery Today 19: 1998)
- Women who were abused during pregnancy were 4x as likely as other abused women to say they experienced very serious violence (beating, choking, gun/knife threats, sexual assault).
- homicide during pregnancy now surpasses automobile accidents and falls as the leading cause of death

Domestic Violence during Pregnancy

- for some women, their very pregnancy may itself be a form of abuse: a pregnancy conceived through sexual assault, marital rape, or from the woman's inability to negotiate contraceptive use
- During labor and delivery, an abuser may try to control a woman's decision to have an epidural, pain medication, or other interventions. He may demand that doctors restore his partner's vagina to its pre-birth state

Domestic Violence during Pregnancy

- Studies have shown that during pregnancy, an abuser's attacks will generally focus on the breasts, abdomen, and genitals, resulting in serious consequences on the mother, fetus, and newborn and giving rise to maternal mortality and morbidity.
- Linked to an increased risk of miscarriage, low birth weight, fetal injury, and fetal death.

Other complications may include:

- Uterine prolapse
- Antepartum hemorrhage
- Premature rupture of membranes
- Premature labor
- Placental abruption
- vaginal infection from forced or unprotected sex with someone who has an infection
- increased first and second trimester bleeding
- headache
- irritable bowel syndrome
- chronic pelvic pain
- increased risk of contracting a sexually transmitted disease.

The Abusive Partner may:

- sulk or put her down when she spends time w/baby
- fail to support her or to help with the baby
- demand sex soon after birth
- make negative comments about her sexuality, attractiveness, and appearance
- blame her because the infant is the "wrong" sex
- put down her parenting ability
- threaten to or actually abduct the baby

The Abusive Partner may:

- tell her she will never get custody of the baby
- make her stay at home with the baby
- prevent her from taking a job
- make or threaten false child abuse accusations
- withhold money for supplies
- blame her for the baby's crying
- force her to or forbid her to breastfeed

Signs a pregnant woman has been or is being abused may include:

- a delay in seeking pre-natal care
- reluctance or refusal to attend pre-natal education
- unexplained bruising or damage to her breasts or abdomen
- continued use of or addiction to substances such as cigarettes, drugs or alcohol—all known to be harmful during pregnancy
- recurring or unexplained psychosomatic illnesses
- history of physical illness

- Unfortunately, during this time of increased risk of violence, women may be less likely to leave. Women tend to feel vulnerable during pregnancy and are often more hesitant to break free of a damaging relationship during pregnancy.

- National Domestic Violence Hotline

  1.800.799.SAFE (7233) **www.ndvh.org** **or** **www.thehotline.org**

Military Families

Heidi Koss, MA, LMHC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Women Veterans

- Women now represent 15% of the military forces on active duty, with a majority being of childbearing age. [1]
- The female combat-exposed soldier is a relatively new phenomenon
- Many female soldiers are returning from combat and transitioning into the private and community health care systems
- Postpartum depression more prevalent among these women
  - May have comorbid combat related PTSD

[1] Rychnovsky, Jacqueline, and Cheryl T. Beck. "Screening for Postpartum Depression in Military Women." Military Medicine Nov. 2006: 1100-104.

Incidence in Military Families

- pregnant women with deployed spouses were 2.8 times greater to experience PMAD than for other pregnant women with spouses who are not deployed.

(Jeffrey H. Millegan, M.D. NMCSD, Daniel Robrecht, M.D.; Lynn Leventis, M.D.; Crescitelli Jo, R.N.; Robert McLay, M.D., Ph.D.; Associations of Post Partum Depression with Spousal Military Deployment and Isolation APA Poster; May 2007; San Diego Naval Medical Center)

In Active Duty Military Women

- 2006 study screened for postpartum depression in active duty women with the Postpartum Depression Screening Scale
- Nearly ½ scored positive for PMAD upon delivery, with 40% still experiencing PMAD by 6-8 weeks postpartum.

(Rychnovsky J, Beck CT. Mil Med. 2006 Nov;171(11):1100-4)

Schachman & Lindsey (2013)

- More than one half of the participants (50.7%, n = 36) scored above the cutoff point for elevated depressive symptoms suggestive of PPD. Examination of the risk and protective factors showed that military wives with depressive symptoms had greater family changes and strains, lower self-reliance, and lower social support than those without depressive symptoms.

Schachman K, Lindsey L., 2013, J Obstet Gynecol Neonatal Nurs. A resilience perspective of postpartum depressive symptomatology in military wives.

Deployed Spouse vs. Non-Deployed

Smith, et al, 2010:

- At initial prenatal visit, risk for depression higher in women whose partners were preparing for or were returning from deployment than not deployed (9.6%, 14.8%, and 6.1%, respectively).
- At 28 to 32 week visit, women with spouses who were deployed or returning were more likely to be at risk for depression than women in the control group (13.6%, 20.8%, and 4.3%, respectively).
- In postpartum women, having a currently deployed partner was associated with higher rates of depression than was having a non-deployed partner (16.2% vs. 8.1%).

Smith DC et al. Effects of deployment on depression screening scores in pregnancy at an army military treatment facility. Obstet Gynecol 2010 Sep; 116:679

Resources for Military & PMADS

- PSI Military Coordinators http://www.postpartum.net/Get-Help/PSI-Support-for-Military-Families.aspx
- Operation Special Delivery
  - nationwide program to provide free doula support to military moms during and after birth, even if the husband is home from deployment. http://www.operationspecialdelivery.com

NICU Parents

NICU Parents at high risk for postpartum mood disorders

- Parents with babies in the NICU have an increased risk of BOTH depression and anxiety as well as an increased risk of impaired attachment to the baby (Loo, 2003; Peebles, 2000; Meyer, 1994)

NICU Parents at high risk for postpartum mood disorders

- Postpartum mood disorders are also more prevalent in mothers of multiples (Leonard, 1998) and mothers of premature babies (Gennaro, 1988; Logsdon, 1997; Vedovi, 2001) which means that PPMD will be overrepresented in mothers with babies in the NICU.

Perinatal loss

- In miscarriage, many may not know of pregnancy
- In later loss, since baby “unknown” by others, it is easy for social circle to ignore, deny, or make light of the loss. No else misses the baby. No one has comforting memories to offer the parents.

Addition of trauma to the loss

- Most perinatal loss requires some medical intervention or exposure to sights/sounds/smells that are new and anxiety provoking to us
- If the loss occurs during a traumatic birth process, wherein the mother or baby were physically compromised or could have died, special intervention will be necessary.

Need for ritual and connection

- Grief is the emotional we feel inside ourselves; mourning is the social process through which we share that feeling with others and they with us ……mourning is part of what allows us to know that our loss is REAL.
- It is important to help families find ways to mourn with others and with each other

Take a BREAK!

Impact of PMADs on Children, Family Systems & Marriage

Heidi Koss, MA, LMHC

Consequences of untreated PMADs during **pregnancy** for the baby

- Low Vagal tone (Monk, 2001; Field, et al,1995)
- Increased uterine artery resistance (especially with anxiety disorders) (Teixeira et al. BMJ 1999)
- Intrauterine hypoxia -fetus is deprived of an adequate supply of oxygen. (Glover & O'Connor, 2002, Chung et al, 2001)
- Increased rates of miscarriage & spontaneous preterm birth (Bonari et al. *Can J Psychiatry* 2004)

Consequences of untreated PMADs during **pregnancy** for the baby

- Low birth weight (Hoffman, et al 2000; Wadhwa, et al 1993)
- Small Head Circumference (Steer, Journal of Cinical Epidemiology, 1992; Orr, Am J Prev Med, 1996, Zuckerman, J Dev Behav Pediatrics, 1990)
- Low Apgar Scores (Steer, Journal of Cinical Epidemiology, 1992; Orr, Am J Prev Med, 1996, Zuckerman, J Dev Behav Pediatrics, 1990)
- Delayed Fetal Heart Rate Responsively (Monk, 2002)

Consequences of untreated PMADs during **pregnancy** for the baby

- Neuroendocrine Abnormalities (Chrousos & Gold, 1992)
- Elevated Cortisol and catecholamine levels in the newborn (Lundy, Infant Behavior Development, 1999)
- Lower levels of dopamine and serotonin in newborn (Field, Infant and Behavior Dev, 2004)
- Impaired recognition, memory & habituation (Wadhwa et al., 2001)

PMAD onset

Timing determines what developmentally appropriate parenting practices are impacted

(Phelan, et al, 2007)

PMAD Impact on Child - **Postpartum**

- Less self-quieting/self-regulating ability; more difficult to console (Field et al, 1995; Porges, 1992; Portales et al, 1992; Lundy, Infant Behavior Development, 1999)
- Higher heart rates during interaction with moms (indicates distress) (Field, Pediatrics, 1998)
- More sleep disturbances (Field, Pediatrics, 1998)

PMAD Impact on Child - **Postpartum**

- Cognitive deficits (Stein et al, 1991)
- Impaired development of frontal lobe and right hemisphere of infant brain (executive functioning and ability to self-regulate) (Tiffany Field et al, 1995; Jones et al, 1997; Dawson, Frey, et al 1999)

PMAD Effects on Infants

- At 1 week, & 3 months, babies showed abnormal EEG changes that remained at 3 years
- More negative interactions with a friendly stranger
- Less vocalizing
- Less exploration
- More irritable (gaze aversion, sad/angry expressions)
- Infants had increased salivary cortisol indicating stress (Diego, et al, 2002)

PMAD Effects on Infants

- Brain activity looks same as in clinically depressed adults
- More than twice as likely to experience depression and anxiety than children exposed when older

(Diego, et al, 2002)

Effects on Toddlers

- Insecure attachment with mother
- Less social interaction with peers
- Inappropriate interactions
- Lower self esteem
- More behavior problems
- Higher risk for affective disorders
- Poor peer relationships
- Poor self-control
- Neurological delays
- Attention problems
- Symptoms mimic mom's depressed behavior

(Pediatric Child Health, 2004)

Effects on Preschoolers

- Insecure emotional attachment with mom
- Poorer attention
- Lower frustration tolerance and anger control (aggressive)
- Poorer cognitive processing
- Poorer social behavior
- Poorer performance on verbal comprehension
- Poorer expressive language skills
- Less cooperative (not willing to share)

(Pediatric Child Health, 2004)

Effects on School Age Children

- More conflict with peers and siblings
- More aggression and uncontrollable anger
- Poor cognitive processing
- Poor school work
- Enuresis (bed wetting)
- Sleep problems
- Withdrawal, passivity
- Anxiety

(Pediatric Child Health, 2004)

Long-Term Consequences of Untreated PMAD on the Child

- 4 and 6 year olds: correlated with behavioral/emotional problems
- 8-9 year olds: correlated with ADHD, externalizing problems and self-reported anxiety
- 14-15 year olds: correlated with impulsivity on testing and poorer scores on Intelligence subtests

O'Connor et al. *Br J Psychiatry 2002;* 80: 502-8; O'Connor et al. *J Child Psychol Psychiatry* 2003; 44(7): 1025-36; Van Den Bergh et al. *Neurosci Biobehav Rev* 2005*;* 29(2): 237-58; Van Den Bergh & Marcoen. *Child Dev* 2004 Jul-Aug;75(4):1085-97.

Effects on Adolescents

- More anti-social behavior
- More conflict with parents, siblings and peers
- School problems
  - Truancy
  - Dropping out
  - Learning Disabilities
  - Failing Grades
- Sexual Problems
- Stealing
- Psychiatric Symptoms
  - Psychosomatic complaints
  - Anhedonia
  - Sleeping problems
  - Eating problems

Safety Practices

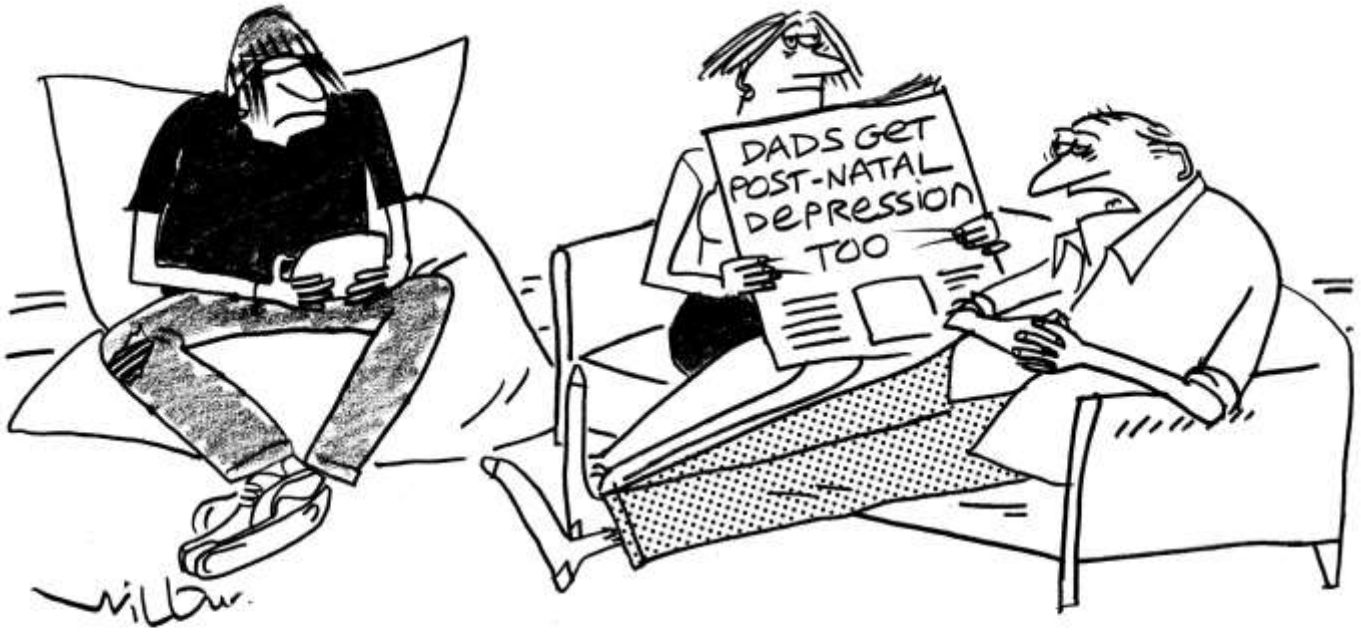
- Moms with depression at 2-4 months
  - Less likely to use car seat
  - Less likely to reduce water temperature
- Moms with depression at 30-33 months
  - Less likely to have safety latches
  - No difference in car seat use

(Phelan, et al, 2007)

Depressed Moms & Dads

- Less likely to put infants to sleep on their backs
- More Likely to put infants to bed with bottle
- Dads are less likely to sing songs daily or play outside

(Paulson, 2006)



"I've had it for the last seventeen years."

Parenting Styles of Depressed Moms

- Withdrawn Style
  - Disengaged
  - Distant
  - Unresponsive
  - Flat affect
  - Does little to support and encourage their infant's activities
- Intrusive Style
  - Rough handling
  - Angry/hostile
  - Actively interferes with their infants activities

(Field, 1998; Pediatrics)

Discipline Practices

- Moms with PMAD at 2-4 mo used harsher discipline at 30-33 months
- Moms with PMAD at 30-33 mo had greater than twice the odds of face slapping or spanking with an object and using harsher discipline

(Phelan, et al, 2007)

Childhood Injury

- PMAD correlates with increased risk of child injury
- Child behavior did not mediate the association between maternal PMAD symptoms and injury risk

(Phelan, et al, 2007)

Bonding and Attachment

- Depressed mothers have less affectionate contact with infant (Campbell et al, 1995)
- less time mutually engaged with child as toddler (Goldsmith & Rogogg, 1997; Breznitz & Friedman, 1988)
- Less responsive to infant cues (Campbell et al, 1995; Bettes, 1998)
- Were withdrawn w/flat affect or were intrusive or hostile towards infant (Field, Healy, Goldstein & Guthertz, 1990)
- Negative effect on infant attachment (Stein et al, 1991)

Bonding and Attachment

Postpartum Depression reduced:

- Continuing breastfeeding by 27%
- Showing books to infant by 19%
- Playing with Infant by 30%
- Talking to the infant by 26%
- Following 2 or more routines by 39%

(Arch, 2006; Pediatric & Adolescent Medicine)

Bonding and Attachment

- PMADS affect “monitoring” activities (daily routines, enrichment activities)
  - Monitoring enhances the parent’s awareness of the child’s activities and communicates to the child that the parent is concerned, interested, available (Leiferman, 2005)
  - Similar to Gottman’s “Love Maps” concept in marital relationships

Bonding and Attachment

PMADs correlate with:

- Absence of normal dyadic mother-child interactions
  - Example: baby smiles, mother turns toward baby
- Poorer Mimetic Behaviors of moms (inadequate stimulation of mirror neurons in baby)
  - Example: mirroring facial expressions & vocalizations

(Reck, et al, 2004)

Relationship Predictors of PPMD

- Less secure attachment and dissatisfaction with partner support were associated with higher levels of postpartum depression and posttraumatic stress. (Iles et al., 2011)
- Domestic Violence ("Battering and Pregnancy" Midwifery Today 19: 1998)

CO-RELATION OF DEPRESSION BETWEEN PARTNERS

- Results indicated that (postpartum depressive and posttraumatic stress) symptoms were significantly related within couples. Men's acute trauma symptoms predicted their partner's subsequent symptoms of posttraumatic stress. (Iles et al., 2011)
- PPMD may result in spousal depression (Posmontier & Waite, 2011)
- Goodman (2004) found that between 24% and 50% of men whose partners have PPD also experience depression in the first year after birth.
- THE #1 PREDICTOR OF PATERNAL DEPRESSION IS MATERNAL DEPRESSION

"You don't understand, doctor, the baby's fine. It's my husband here who's cranky, stays up all night and cries when things don't go his way."

MOM PMAD IMPACT ON DAD

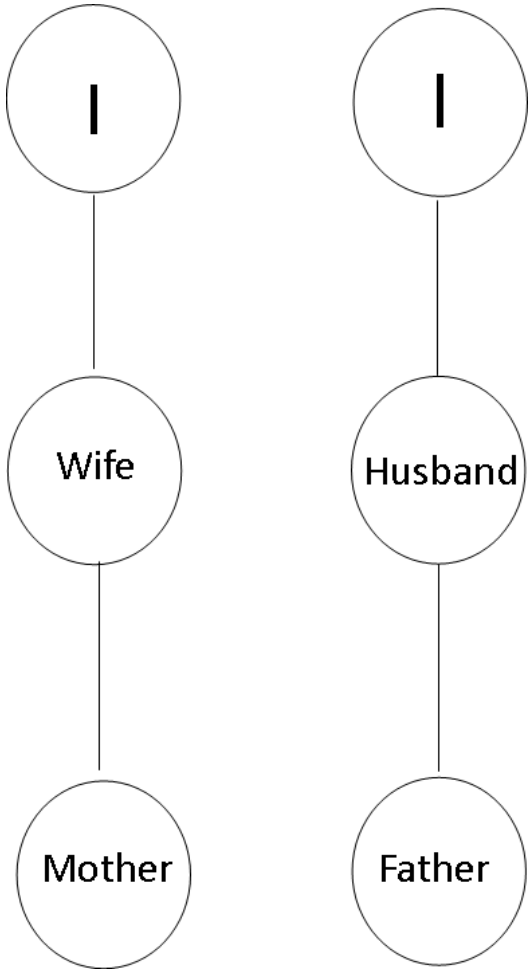
- Many fathers discussed feelings of anger, frustration and anxiety associated with their lack of understanding and helplessness to do anything about their partners' PPD. (Letourneau et al., 2011)
- …these can all end up leading to PDD in the dad!

The 1st postpartum year has the highest rate of divorce than at any other time during a marriage

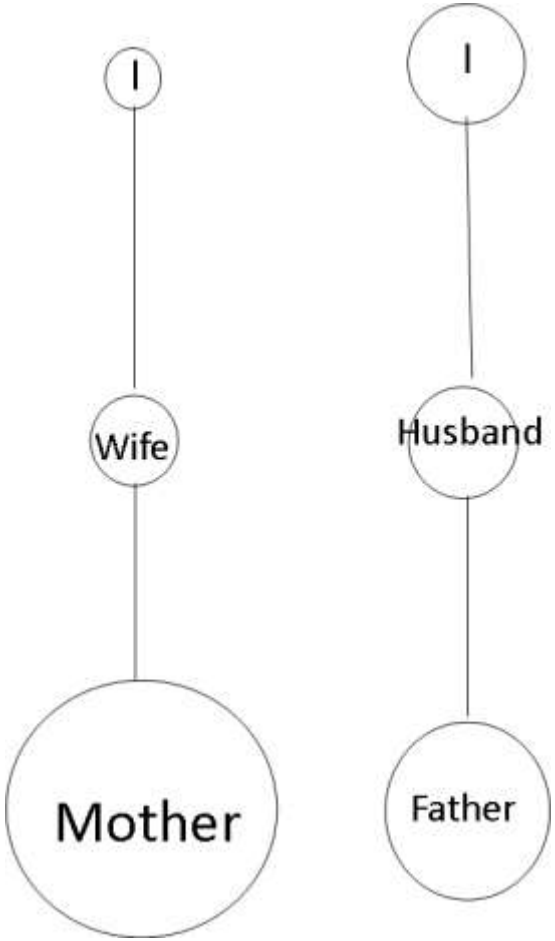
Sample Couples/Parent Ed program

- Findings from a random clinical trial study examining the effectiveness of the Bringing Baby Home program indicate that couples have higher relationship quality, less interpersonal hostility, and markedly lower maternal post-partum depression and baby blues (22.5% compared to 66.5% in the comparison group). (Gottman & Gottman)

Role Balance – “Ideal”



Typical Postpartum Perception/Reality of Mother



Interventions

- Non-PMAD caregivers (father, grandparents, etc.) may provide a buffer to mitigate PMAD effects
- Positive Effect of activities that are mood-altering for moms and arousal reducing for infants (Field, 1998)
  - Massage
  - Music

Infant Massage Therapy with Teen Moms

1-3 mo old infants of depressed TEEN Moms

- Given 15 min massage 2 days/week for 6 wks
- Compared to “rocked” infants (control)
- Had more active alert/awake states
- Decreased crying, cortisol, norepinephrine
- Improved weight gain, increased serotonin, improved temperament dimensions

(Field, 1996)

A CROSS-CULTURAL LOOK AT PMADS

Cross Cultural & Social Diversity

- Western methods of screening are culturally insensitive & increase the risk of missing signs or symptoms prevalent in non-Western cultures

Halbreich U. & Karkun S., Cross Cultural and Social Diversity of Prevalence of Postpartum Depression and Depressive Symptoms. *Journal of Affective Disorders*, vol. 91, 2006, p. 97-111

New Immigrants may suffer more

- New immigrants are at higher risk for PMADS as they are often suffering from isolation and lack of traditional support system even before the pregnancy and birth. They may already be psychologically “compromised” before the baby is born.
- The level of acculteration is correlated with the level of risk for PMADS.

New immigrants particularly need:

1. Community Support
2. Place of Worship
3. Company of other Women

https://www.facebook.com/iwchamilton/photos_stream

Cultural Sensitivity a Must

Providers must knowingly suspect their own cultural biases and test out their hypotheses about the status of their culturally diverse clients:

1. What do these behaviors mean to you?
2. In your culture, how would your difficulties be taken care of?
3. Is the client actually “typical” of their culture as you have come to know it?

Providers must have culturally sensitive knowledge that informs their care.

1. South Asian women have a high rate of thyroid disturbance and anemia; these can contribute to PMADs
2. Sri Lankan women have a 20% occurrence rate for postpartum psychosis – due to a high rate of cortical venous thrombosis

Cultural Variations in the Expression of PMAD

- European, North Americans: more affective symptoms
- Japanese: physical complaints or worries about childcare
- Chinese: head numbness, wind inside head, wind illness
- Nigerian: nausea/vomiting & feeling hot headed
- Bengali: screening question “have you ever felt that life isn’t worth living” has no meaning since it is not a possibility

Indigenous Populations

- Long history of oppression and maltreatment from (white) health care systems makes it hard to disclose to non-indigenous providers
- Importance of preserving birth and postpartum traditions
- More Communal approaches to care

PMADS and Latina Populations

- PMADS may be denied by Latina mothers when interviewed by a clinician, despite feelings of depression (Kumar, 2004).
- Women are under social pressure to express contentment; there is a belief that expression of negative feelings may bring bad luck.

http://blogs.longwood.edu/spain2011/2011/06/01/women%E2%80%99s-role-in-the-workplace-and-at-home/

PMADs and Latina populations

- Clients may more readily endorse physical symptoms (back-aches, headaches, pervasive tiredness, little energy and difficulties sleeping). These expressions of distress are acceptable as they are "outside of her control," and don't hint of personal failure or difficulty coping with one's life (Gureje et al, 1997).

(LATINO FAMILIES IN THE PERINATAL PERIOD. CULTURAL ISSUES IN DEALING WITH THE HEALTHCARE SYSTEM; J.M. Martin Maldonado-Durán MD, M. Munguía-Wellman, MSW., Sari Lubin, OT, Teresa Lartigue, PhD http://www.kaimh.org/latino.htm)

African American Population

- Long history of oppression and maltreatment from (white) health care systems makes it hard to disclose to non African American providers.
- Already a sense of so many racially bound stigmas (welfare queen, Jezebel, mammy) that a woman doesn't want to add "poor mothering" or "weakness" to the list of things that African Americans can be criticized for.

(Schreiber, Stern, & Wilson, 2000)

PMADs among African-American women

- Depression means that you are crazy and "crazy" in African culture is an insult of the greatest magnitude. Women who have depression fear that they are going crazy, which may result in consequences of losing their children, not being normal again or accepted, and not being able to obtain or maintain employment

(Amankwaa, 2000)

PMAD among African-American women

Depression is:

- What “white women have”
- A disgrace to the race
- A failure to embody the powerful qualities that allowed the black race to survive

(Amankwaa, 2000)

http://www.shecircle.org/depression.php

Asian Cultural Traditions

- Some believe the energy of the yin-yang gets out of balance. When they have a baby all the heat goes out of their body. So they have to eat only warm foods and dress warmly to put the heat back into their bodies
- One Month postpartum lay-in period
- Stoicism; Chinese tended to be quiet and suppress expressions of pain and feelings.

Muslim Populations

- There is a need for Muslim women to practice modesty (Hejab), in both dress and comportment.
- Because of this, someone may accompany the mother during all her visits, and there is a preference for female attendants
- If her husband accompanies her, he may answer questions for her in order to protect her from having to embarrass herself by answering things of a personal nature.
- Visiting by others (Hadith)
  Every family member has to come and see the Arabic woman when she has a baby ... when it is Ramadan... they come at all hours and late into the evening.

(Jane Cioffi, Caring for Women From Culturally Diverse Backgrounds: Midwives' Experiences; J Midwifery Women's Health 49(5):437-442, 2004)

Lesbian Parents

- Lesbian parents often have “accumulated” stress due to years of stigmatization and difficulties related to sexual orientation.
- Are at a higher risk for postpartum mood disorders than equivalent heterosexual couples (Trettin et al, 2005).

- Histories of depression, substance abuse, and lack of social support (all of which may predispose one toward a difficult postpartum) are more prevalent in lesbian women than in heterosexual women.
- There may be role difficulties as both women are taking on a mothering role. Often the person who returns to work first, or who works full time, feels particularly “disallowed” to fully participate in mothering. This can lead to conflict and distress in the couple.

Breastfeeding and PMADs

Heidi Koss, MA, LMHC

- It may be the only thing she feels good about
- Dispel myths about PMADs and Breastfeeding
- If she wants to wean, recommend weaning slowly over 2-3 weeks to mitigate worsening PMAD symptoms

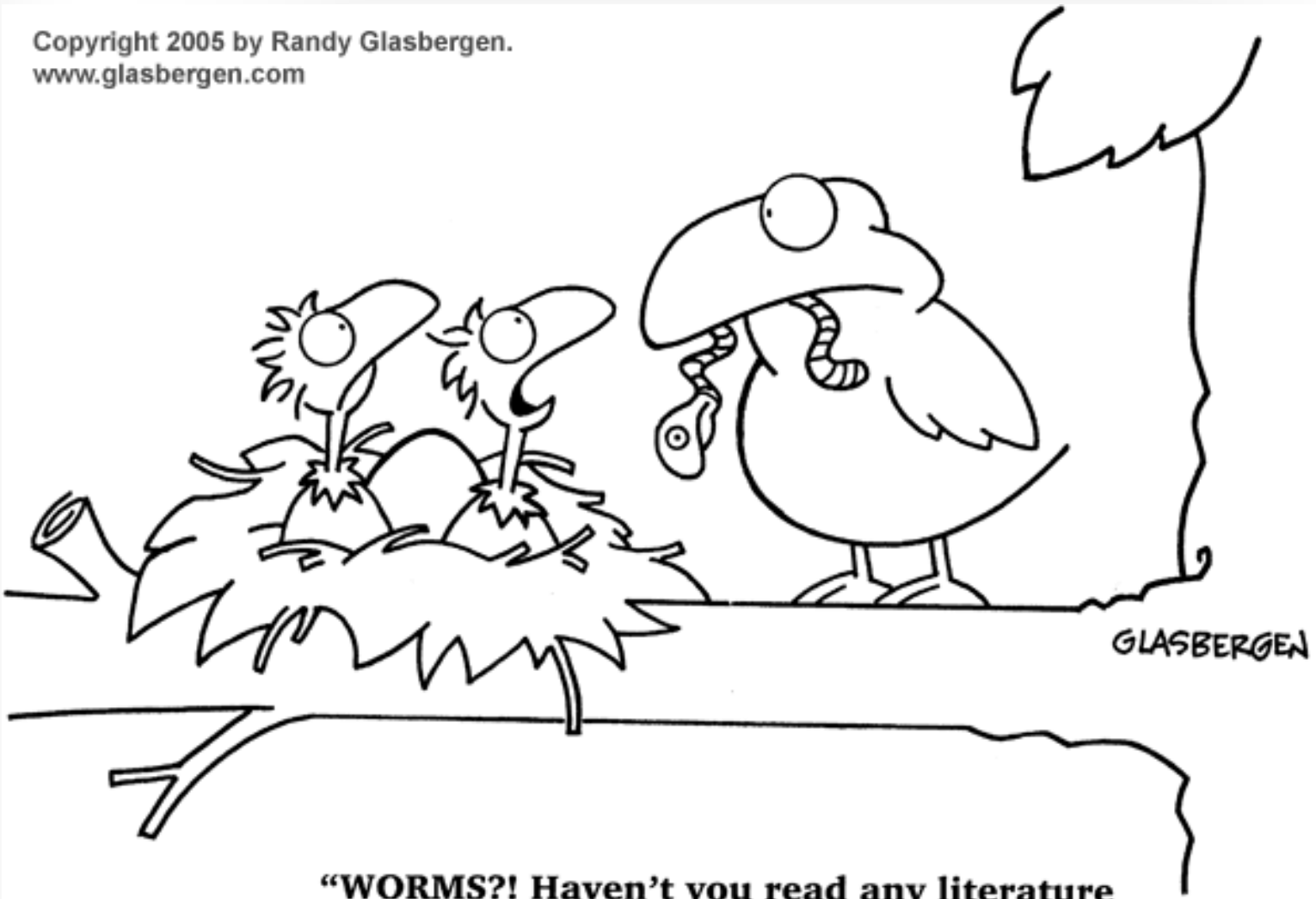
“Letting women know that they have the right to choose not to breastfeed without guilt or judgment is the other equally important half.”

(Beck & Wilson, 2008, Nursing Research)

- Research: The onset of depression **preceded** cessation of breastfeeding (Misri, et al, 1997)
- "Breastfeeding has been shown to reduce maternal stress and protect maternal mood." (Kendall-Tackett, 2007, A new paradigm for depression in new mothers, Int'l Breastfeeding Journal)

Difficulties Breastfeeding

- Pumping & mood
- Sleep deprivation & mood
- Insufficient Milk Supply Correlated with
  - PMADs
  - Birth Trauma
  - Sleep deprivation
  - Inadequate Nutrition
  - Anorexia
- Compounding Guilt/Shame of NOT breastfeeding



"WORMS?! Haven't you read any literature on the benefits of breast feeding?"

“Failure to thrive baby”

- ALWAYS consider that it may be a symptom of mother’s mental health, not an issue with the baby or latch

- treating the mother’s mental health might resolve feeding issues

Hormones

- Both mood and lactation might be triggered by the same neuroendocrine mechanisms, or the same hormonal shifts
- Estrogen, progesterone, prolactin, thyroid, and cortisol shift dramatically after birth.
- These very hormones also have a direct impact on both the brain chemicals that are responsible for emotional wellness and also milk production. Sometimes these hormones work together in helping both mood and lactation, and sometimes they work in conflict.

(Stuebe , et al, 2012; Failed lactation and perinatal depression: common problems with shared neuroendocrine mechanisms? J Womens Health)

www.postpartumprogress.com/postpartum-depression-and-breastfeeding-challenges-the-connection

D-Mer: Dysphoric Milk Ejection Reflex

- characterized by an abrupt dysphoria, or negative emotions, that occur just before milk release and continuing not more than a few minutes
- Preliminary testing shows that D-MER is treatable if severe and preliminary investigation shows that inappropriate dopamine activity at the time of the milk ejection reflex is the cause of D-MER.

www.d-mer.org

Clarifying D-MER: What It Is Not

- D-MER is not a psychological response to breastfeeding.
- D-MER is not nausea with letdown or any other isolated physical manifestation.
- D-MER is not postpartum depression or a postpartum mood disorder.
- D-MER is not a general dislike of breastfeeding.
- D-MER is not the "breastfeeding aversion" that can happen to some mothers when nursing while pregnant or when nursing older toddlers.

Infant Feeding Resources

- www.withinreachwa.org/what-we-do/healthy-communities/breastfeeding
- www.llli.org
- www.womensmentalhealth.org
- www.ibreastfeeding.com
- www.mothertobaby.org
- www.infantrisk.org
- www.motherrisk.org
- www.kellymom.org
- www.fearlessformulafeeder.com

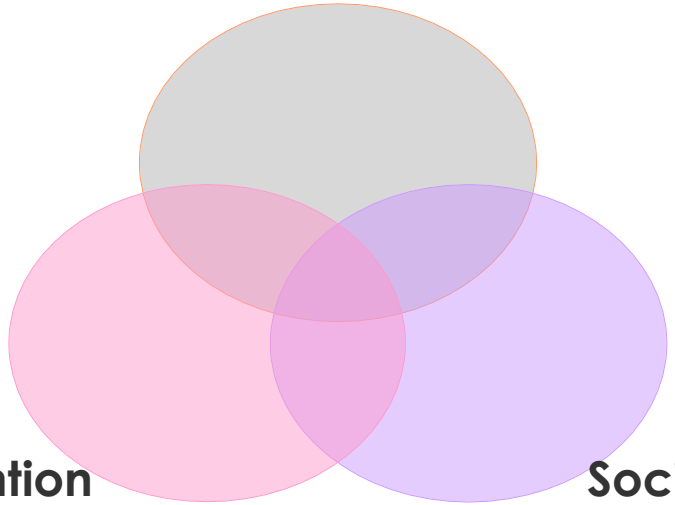
Take a Break

Treatment Components to Recovery: Medical, Therapy, Social Support

Heidi Koss, MA, LMHC

Three Critical Components to Recovery

Medication Management



Therapeutic Intervention

Social Support of Others

Integrated Model of support

Ideal Team Model:

- Starts prenatally
- Includes follow up and continuity of care
- Respects confidentiality of the family
- Family feels the team is working together and not in conflict
- Accessible & flexible to meet unique needs

Prevention & Intervention

- Education for mothers is essential
- Continuity of health care
- Social support is critical
- Realistic preparation for parenthood
- A plan of action for the family

Potential Barriers to Care

- Patient load: Pandora's box
- No training in mental health dx & tx
- Patient factors: stigma, CPS, refuse tx, insurance
- Lack of efficacy data in pregnancy
- Mental health services not available

Gaps Currently in the US

Lack of perinatal mental health represented in and collaborated with with:

- Childbirth organizations: APA, ACOG, AWHONN, ILCA, NASWDC, NACPM, MANA, ACNM, AAP, AMHCA, ICEA, DONA, CAPPA, etc.
- Standardized Professional Education in PMADS: OB's, midwives, ND's, Nurses, IBCLCs, therapists, doulas, CBEs, etc.
- Social Services Agencies (DSHS, WIC, First Steps, etc)
- Coordinated are across fields
- These are improving, but slowly and regionally, not always nationally
- These leave families, confused, overwhelmed, and isolated

Ideal Treatment & Support Team

- Healthcare Providers
- Mental Health Providers
- Pharmacists
- Social Service Agencies
- Parent/Child Educators
- Family/Friends Supports
- Spiritual Support
- Practical Support (food, cleaning, childcare)

Medical Team

- Psychiatric Prescribers (ARNP's and MD's)
- OB/GYNs
- Midwives
- Pediatricians
- Naturopathic Doctors
- Family Practitioners
- Nurse Practitioners
- Physician Assistants
- Pharmacists
- Endocrinologists

Medical Interventions

- Medications
- Hospitalization
- Day Treatment Programs
- Treat Thyroiditis
- ECT
  - can be useful in depression, mania, psychosis
  - No known adverse effects on baby

Medication Prescribers

- Should be informed of current research and best practices during pregnancy and lactation
- Use full informed consent (effects of meds AND of untreated illness)
- Guidance regarding side-effects and adjustment periods
- Collaborate with other providers
- Follow-up care

http://hyperboleandahalf.blogspot.com/

Mental Health Providers

- Psychologists
- Psychiatrists
- Clinical Nurse Specialists
- Social Workers
- Counselors (LMHCs & LMFTs)
- Infant Mental Health Providers
- Pastoral Counselors

Therapy Interventions

- Individual
- Couples
- Family
- Group
- Mother/Baby Dyad
- Light Therapy

Psychotherapy

- Understands the unique needs of the perinatal period
- Understands perinatal loss and grief
- Understands the impact of trauma – birth or past abuses or reproductive experiences
- Ability to offer support or referrals for partner or couples

Social Support

- Family & Friends
- Peer support groups
- Faith communities
- Telephone Warmlines
- Childcare providers
- Parent Educators
- Doulas
- 12-step programs

Parenting Coaches & Educators

- Postpartum Doulas
- Childbirth Educators
- Lactation Consultants & LLL Leaders
- Infant mental health consultants
- Parenting help with older siblings
- Parenting coaches

Social Support Approach

- Offers resources, not recommendations/advice
- Knows scope of practice – does not offer medical or psychological advice
- Support women's right to choose her treatment approach and providers
- Encourages her to ask for support, treatment and informed care
- Knows limits and gives available emergency contacts

NURSE Program – Self Care

N = Nourishment

U = Understanding

R = Rest and Relaxation

S = Spirituality or “Soul food”

E = Exercise

Sichel & Driscoll, “Women’s Moods: What every woman must know about hormones, the brain and emotional health”

Clinical Assessment

- Support System
- Symptoms
- Life Stressors
- Sleep
- Eating/Appetite
- Mental health & Trauma history
- Family history
- Health/Habits
- Reproductive History & Birth Story
- Risk Assessment
- Drug & Alcohol Use
- Domestic Violence

Screening and Risk Assessment

- EPDS – Edinburgh Postnatal Depression Scale
- PDSS - Postpartum Depression Screening Scale
- PPQ – Perinatal Posttraumatic Stress Disorder Questionnaire.

Edinburgh Postnatal Depression Scale (EPDS)

- Self-Report Scale
- Consists of ten statements designed to elicit the mother's degree of depression
- The statements pertain directly to mother's mood (i.e., sense of sadness, difficulty sleeping, sense of coping well, frequency of tears, etc.)
- An overall score of more than 10 indicates the presence of depression, but does not necessarily specify severity

Free downloads of the EPDS

- English: http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf
- Spanish: http://www.cdph.ca.gov/programs/mcah/Documents/MO-CHVP-EPDS-Spanish.pdf
- 18 Other Language Translations: http://www.rikshandboken-bhv.se/Dokument/Edingburgh%20Depression%20Scale%20Translated%20Gov%20Western%20Australia%20Dept%20Health.pdf

Out of four possible responses to each question, the mother selects the one that most accurately represents her experience over the past week.

***Since it only reveals one week in time :

it must be accompanied by conversation about whether or not it accurately reflects the "big picture."

Photo: http://biffno.deviantart.com/art/Mood-Swings-153447019

#10 must be investigated at once if the answer is anything other than "never"

10. The thought of harming myself has occurred to me:

1. Yes, quite often
2. Sometimes
3. Hardly ever
4. Never

Photo: http://bestdemotivationalposters.com/waiting-suicide/

EDPS cont.

- Has been validated on more than 7000 women from SE Asia, 3000 from Southern and Central Europe, 2000 from Africa, and 1000 from the Middle East.
- Is the most widely used self report instrument for screening depression in pregnant or postpartum women (and their partners)

EPDS does NOT replace a clinical interview or judgment

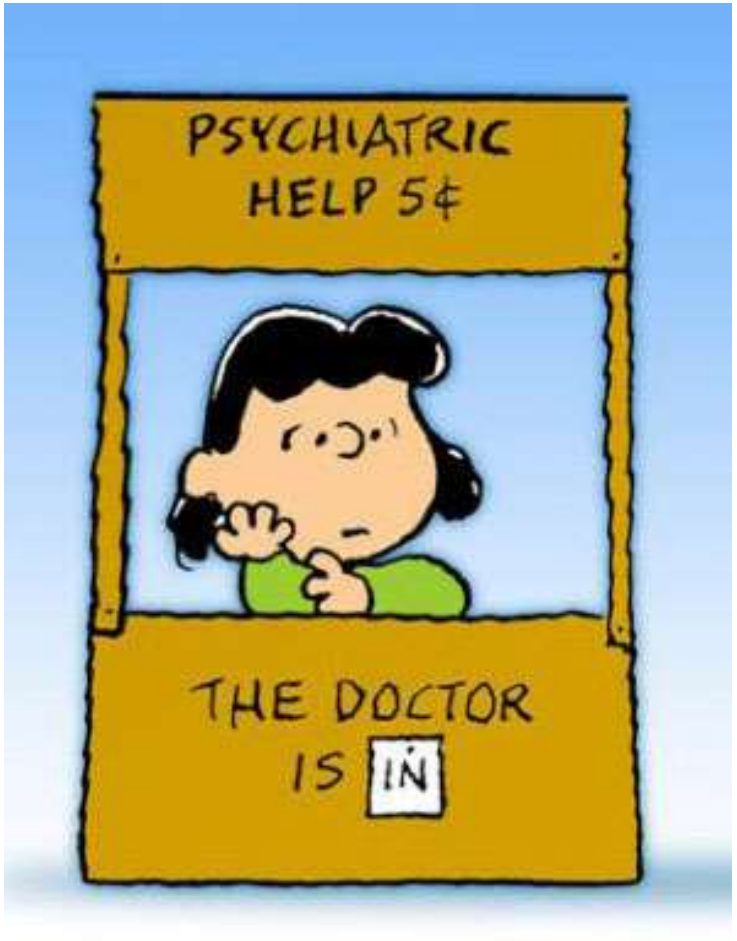


Photo: http://wanggo.wordpress.com/2012/07/11/the-writer-is-in/

Postpartum Depression Screening Scale (PDSS)

- The PDSS was developed by nurse-researcher Cheryl Beck and psychometrician Robert Gable
- Is a 35 item Likert type scale (strongly agree to strongly disagree) designed to assess the presence of postpartum depression and anxiety

PDSS Administration

Takes approximately 10 minutes to complete

The first seven items can function as a “short form” of the test

Can be administered as early as 2 weeks postpartum

Photo: http://blog.placentabenefits.info/index.php/2013/05/blood-test-may-predict-which-moms-will-suffer-from-postpartum-depression/

Has 7 subscales, each with five items

- Anxiety
- Emotional Lability
- Loss of Self
- Guilt/Shame
- Suicidal thinking
- Sleep/Eating Disturbance
- Mental Confusion

Because these subscales give us a symptom profile, it can be exceptionally helpful in generating a focused treatment plan

The PDSS has yielded the highest combination of sensitivity and specificity in terms of identifying women with postpartum depression (versus the EPDS and the BDI)

Photo: http://www.acupuncturewell.com/2012/12/acupuncture-treatment-plan/

- Sensitivity measures the ability to correctly identify a case;

- Specificity measures the ability to correctly identify a non-case.

Comparison of EPDS and PDSS

EPDS

- Sensitivity = 59 – 100%
- Specificity = 49 – 100%

PDSS

- Sensitivity = 91 -94%
- Specificity = 72 – 98%

PERINATAL POSTTRAUMATIC STRESS DISORDER QUESTIONNAIRE (PPQ)

- Developed by Michael Hynan and modified by Jennifer Callahan (originally “yes or no” format; now a Likert scale (0-4)

- Scores range from 0 – 56.

Women with scores of 19 or higher are nearly twice as likely to require referral to mental health services

A 14 item measure assessing
~ intrusive symptoms
~ re-experiencing symptoms,
~ avoidance behaviors
~ hyperarousal
~ numbing of emotion.
~ one item pertaining to guilt

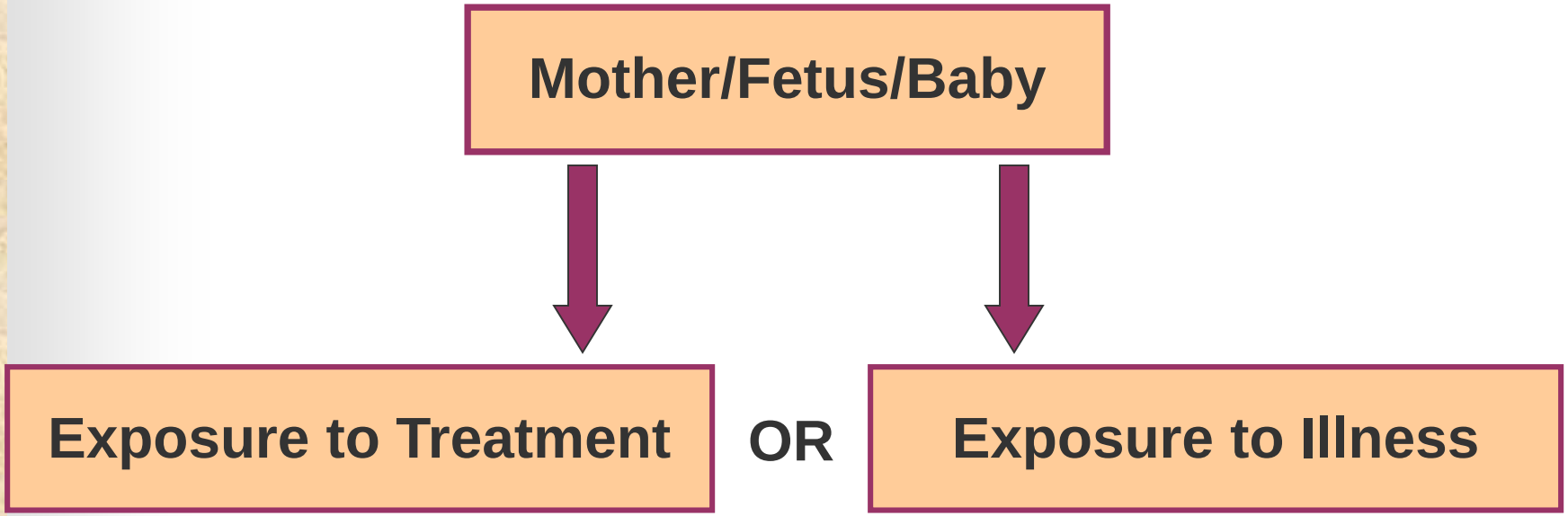
Photo: http://www.redorbit.com/news/health/2053903/new_blood_test_diagnoses_depression/

The PPQ is the only measure thus far designed to quantify symptoms of PTSD specifically related to childbirth.

Photo: Used with permission: Jodi Kuchar

Pharmacological treatments of Perinatal Mood Disorders, Pregnancy, Postpartum, Lactation

To Treat or not to Treat: A Clinical Conundrum



There is no such thing at no exposure

Use during pregnancy, postpartum when benefits outweigh the risks

(informed consent)

Classifications

- Antidepressants
- Benzodiazepines
- Mood Stabilizers
- Antipsychotics
- Hormone Tx: Estrogen Patch
- ECT

Antidepressants in the Perinatal Period

- All antidepressants are secreted in the amniotic fluid and cross the placental barrier
- All concentrations are lower in amniotic fluid than in maternal serum and umbilical cord
- Too early to interpret and conclude the extent of fetal exposure

Hostetter, et al. Biol Psychiatry 2000; 48:1032-34; Kim et al. Br J Clin Pharmacol. 2006; 61 (2): 155-63

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.

Cohen LS, et al. CNS Spectr 2004; 9:298-16; Cohen et al, JAMA 2006 295(5) 499-507; Einarson A., et al. J Psychiatry Neuroscience 2001; 26:44-48

Med Discontinuation

- In mother
  - Avoid “cold turkey” – Taper
  - “Discontinuation Syndrome” – flu like Sx, insomia, nausea, irritability, sensory disturbances, hyperarousal
- In neonate (upon birth, when in-utero exposure)
  - Symptoms: fussy, reflux, cry
  - Up to 2 weeks
  - No long term effects

Medication Management During Pregnancy

- Dose adjustment across the pregnancy may be required
- Mood fluctuations during pregnancy
- Physiological changes: plasma volume, metabolic changes, hepatic enzymes

Hostetter, et al. *Depress Anxiety* 2000; 11:51-7; Wisner KL. *Am J Psychiatry* 1993; 150:1541-1542

Medications and Breastfeeding

- Informed Choice
- Most Anti-depressants are considered safe with breastfeeding
- Proceed with Caution with other categories of medications such as mood stabilizers, anti-psychotics and sleep meds

Meds & Breastfeeding Resources

- www.mothertobaby.org
- http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT (LactNet)
- www.motherisk.org/women/breastfeeding.jsp
- www.breastfeedingonline.com/meds.shtml#sthash.xnAA8JDa.dpbs
- www.infantrisk.com (Thomas Hale)
- www.uppitysciencechick.com/PPD-Treatments-Medications.html (Kathleen Kendall-Tackett)

Suicidal or psychotic symptoms require immediate psychiatric evaluation and treatment

Psychotherapy in combination with Medication Management is best practices.

Medication Management is usually not sufficient.

Social Supports and Steps to Wellness

Social Support

- Family and Friends
- Peer Support Groups
- Faith Communities
- Doulas
- Phone Support
- Parent Educators

PSI's 9 Steps to Wellness

- **Education** (see list of recommended reading)
- **Sleep** (REM sleep for brain "repair" of serotonin levels)
- **Nutrition** (you must eat so your medications can be absorbed, proteins aid mood stability)
- **Exercise and Time for Yourself** (even a short walk or an hour away – put yourself on the "list")
- **Sharing with Non-Judgmental Listeners**
- **Emotional Support** (i.e. therapy, talking with family and friends)
- **Practical Support** (help with household chores, errands, etc…)
- **Referrals to Professionals**
  - Medical provider
  - Therapy provider
  - Support groups
  - Doulas, IBCLCs
- **Plan of Action**

  "Look back over your list. What's working well and what could be better?"

  "What are you going to do when we finish talking?"

Adapted from "I'm Listening"–by Jane Honikman Founding Director, Postpartum Support International

Peer Phone Support

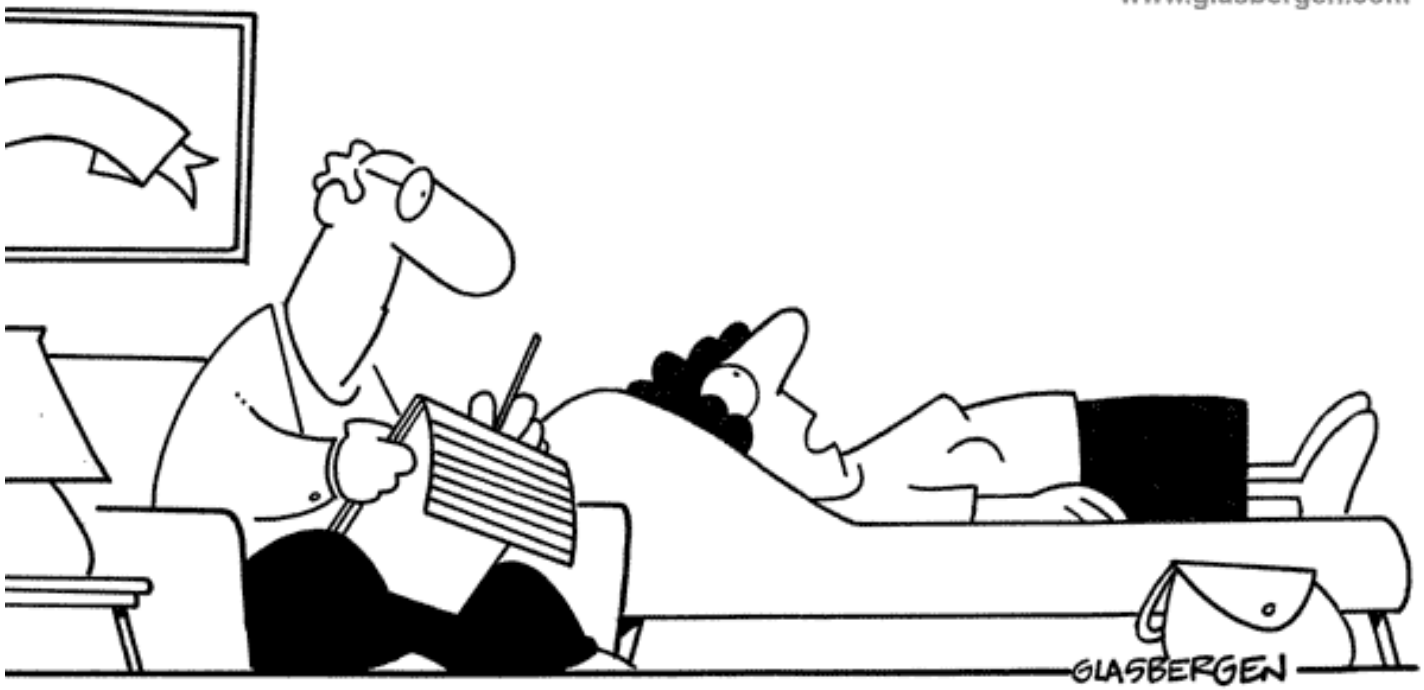
Dennis, et al, (2010) *Postpartum depression peer support: Maternal perceptions from a randomized controlled trial*; International Journal of Nursing Studies

- **RESULTS:** Interactions provided by the peer volunteer included the provision of **emotional (92.7%), informational (72.4%), and appraisal (72.0%) support**. Mothers reported high levels of positive relationship qualities such as **trust (83.6%) and perceived acceptance (79.1%)**. Most (80.5%) mothers indicated they were very satisfied with their peer support experience.
- **CONCLUSIONS:** The majority of mothers perceived their peer volunteer experience positively lending further support to telephone-based peer support as a preventative strategy for postpartum depression

Social Support in the Home

(in-home postpartum doula care, nursing visits or HELPFUL Family)

- PPD moms received 6 weekly visits by a Child Health Clinic nurse, who acted as a supportive listener.
- Compared with the control group, ***the treatment group experienced a higher rate of recovery from PPD (80% vs 25%).*** (Gjerdingen, 2004)



**"Actually, I only come here to lie down.
I can't get any rest at home!"**

Social Support in the Home

- Mothers receiving home-visits interacted more responsively w/other mothers & their babies than control

- Their infants also faired better in emotional regulation/response to stimuli, language development, mental development. (Olds, et al. 2002)

"I'd like to trade my 15 minutes of fame for 15 minutes of peace in the bathroom without any kids pounding on the door."

Community Social Support

- Support groups (PSI of WA, parent-baby groups, LLL, etc)
- Faith Communities
- Friends

Setting up YOUR Perinatal Community: building perinatal coalitions & networks, support groups, collaboration, online presence (Who, What, How)

– Interactive Discussion

Engagement:
Identify key stakeholders

WHO – The Practitioners

- Therapists (MSWs, LMHCs, LMFTs, PhDs)
- Doctors (Psychiatrists, OBs, Pediatricians, Family Docs)
- Midwives
- Naturopathic/Complementary Care
- Nurses, IBCLCs
- Doulas, Childbirth Educators
- Let’s List others!

Who – The Organizations

- Department of Health
- DSHS & WIC
- Child Protective Services
- Hospitals
- Social Service Agencies (list them!)
- Non-Profits (list them!)
- For Profits (list them!)
- Higher Education (Universities, etc)
- Early Intervention & Learning Agencies
- Local & State Level
- Advocacy Agencies
- Crisis Services
- Foundations
- Teen Parent Programs
- Cultural & Minority Agencies
- Let's List others!

What & How

- Create Perinatal Community Collaborative Coalition
- Joint Awareness Outreach Campaigns (see Speak Up When You're Down)
  - New Jersey: http://www.state.nj.us/health/fhs/postpartumdepression/
  - Washington: http://www.del.wa.gov/development/strengthening/speakup.aspx
  - Los Angeles, CA: http://maker.good.is/projects/SpeakUp
- Collaborative Trainings
- Referral Networks
- Pass Legislation

Perinatal Community Collaborative Coalition

- Consists of Key Stake Holders from as many inter-agencies as willing
- Monthly or every other month in-person meetings
- Online communication email network and collaboration
- Share information distribution

This is the **Zero** in “0 to 3” Programming

- Make Mental Health part of ALL health care services and programming for parents and infants

Address Barriers

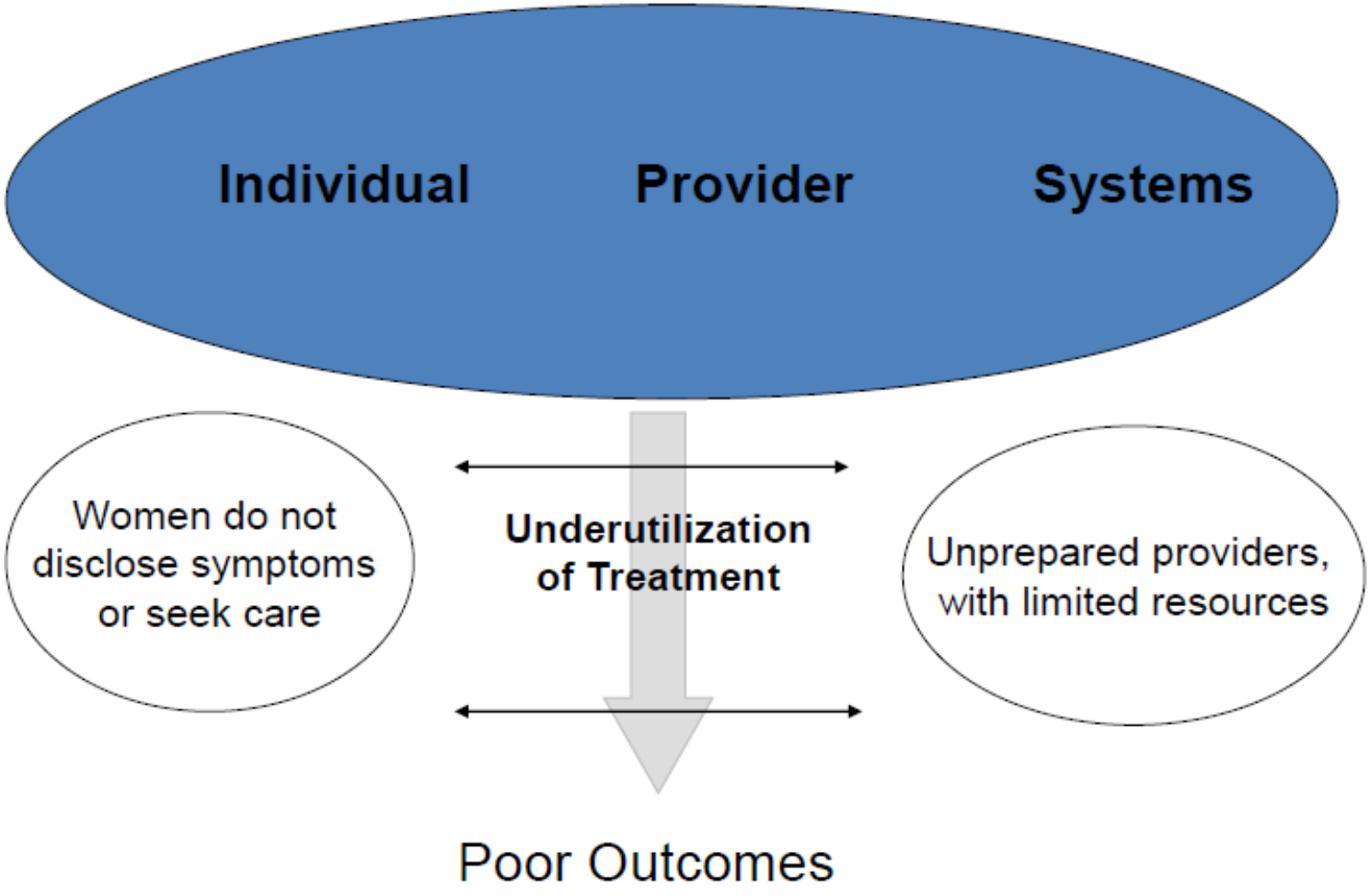
- Provider-level Barriers
  - Lack of adequate guidance and follow up
  - Report inadequate mental health training across medical disciplines
  - Limited access to mental health resources and referral sources
  - Policies

System-level Barriers

- Lack of collaboration with mental health providers
- Lack of referral system
- Lack of integration between systems of care
- No infrastructure support, guidance or expectations

Policy-level Barriers

- Lack of Health Insurance policies on reimbursement
- Lack of universal protocols, policy and recommendations
- Lack of cross-system coordination (early intervention, public health and mental health)
- Contradiction in policy across medical associations


Individual
Provider
Systems
Women do not disclose symptoms or seek care
Underutilization of Treatment
Unprepared providers, with limited resources
Poor Outcomes

Enlist and Coordinate All Intervention Levels

- Individual → Educate & Support Mothers
- Provider → Train Providers (competent understanding, screening, interventions, referrals, treatment)
- System → Implement effective protocols, Integrate systems, Increase Access and Capacity
- Policy → Develop policy to support interventions

Action: Assessment

Individual Organization Assessment _____

Professional training	• How many? • What kind?
Resource and Referral	• How are referrals currently handled? • What resources do providers have?
Triage protocols	• What triage protocols are in place? • Are all providers familiar with protocols?
Public Education	• What materials are available? • Other approaches are being implemented?
Support groups	• Are support groups in place? • Any kind of peer support?
Screening	• Is screening being done? Is it universal? • What tool is being utilized?

PMAD does not need to be a terminal illness.

This is a *treatable* illness.

With treatment, families can be WELL

Postpartum Support Group & Network Resources

- Dennis, PhD, MScN, BScN, et al, *Postpartum depression peer support: Maternal perceptions from a randomized controlled trial,* International Journal of Nursing Studies, Volume 47, Issue 5, Pages 560-568, May 2010
- HRSA Booklet: *Depression During and After Pregnancy,* in English and Spanish. www.mchb.hrsa.gov/pregnancyandbeyond/depression/
- Honikman, *A Guide to Organizing a Postpartum Parent Support Network in Your Community*. 2012 http://janehonikman.com/jane-honikman-books/
- Honikman, *I'm Listening: A Guide to Supporting Postpartum Families,* 2002
- Isaacs, M. (2004). *Community care networks for depression in low-income communities and communities of color: A review of the literature.*Submitted to Annie E. Casey Foundation and the Howard University School of Social Work and the National Alliance of Multiethnic Behavioral Health Associations (NAMBHA).
- Lara, M.A., Le, H-N., Letechipia, G. and Hochhausen, L. (2009). *Prenatal depression in latinas in the U.S. and Mexico.* Maternal and Child Health Journal, volume 13(4), p 388–404
- Mental Health America, *Substance Abuse and Mental Health Services Administration (SAMHSA). Maternal Depression Making a Difference through Community Action: A Planning Guide.* http://www.mentalhealthamerica.net/go/maternal-depression

Postpartum Support Group & Network Resources (Cont.)

- Pacific Postpartum Support Society, *Postpartum Depression and Anxiety: A Self-Help Guide for Mothers (2005)*
- Pacific Postpartum Support Society: *Telephone Support Reference Manual anual* www.postpartum.org/guide.htm
- Pfeiffer, *Efficacy of peer support interventions for depression: a meta-analysis,* General Hospital Psychiatry - January 2011, Vol. 33, Issue 1, Pages 29-36.
- Postpartum Education for Parents(PEP): *Baby Steps Project* www.babystepsproject.org
- Postpartum Support International, *PSI Guidebook on Developing a Sustainable Perinatal Support Network in your Community,* 2011http://www.postpartum.net/Resources/PSI-Guidebook-for-Support-Networks.aspx
- Potter, C.L., *Systematic literature review of the use of lay support models in postnatal depression,* European Psychiatry, Volume 26, 2011, p.1105. Abstracts of the 19th European Congress of Psychiatry.
- Poulin, Sandra, *The Mother-to- Mother Postpartum Depression Support Book* (2006)
- Spectrum Health Medical Center, Michigan: *Program Development Toolkit for Postpartum Depression*
- University of Kansas, *Work Group for Community Health and Development,* The Community ToolBox

Useful Websites for PMAD

- Postpartum Support International (PSI) www.postpartum.net
- Postpartum Support of WA State www.ppmdsupport.com
- 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)
- Multi Lingual Pregnancy and Postpartum Handouts http://www.mhcs.health.nsw.gov.au/mhcs/topics/Pregnancy_and_Post_Natal.html
- Trauma and Birth Stress www.tabs.org.nz
- New Jersey Department of Health www.njspeakup.gov
- Registered Nurses Association of Ontario. Best Practice Guidelines. Interventions for Postpartum Depression. http://www.rnao.org/Page.asp?PageID=828&ContentID=806
- Dr. Shaila Misri, MD, FRCP; www.wellmother.com
- Father Support www.postpartumdads.org
- Massachusets General Hospital Center for Women's Health http://www.womensmentalhealth.org/topics/postpartum.html