Healthy Mom, Happy Family
Understanding Perinatal Mood & Anxiety Disorders

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Overview of Presentation

- Types of perinatal mood and anxiety disorders (PMADs)
- Why we should care
- Prevalence of PMADS
- Consequences of unidentified PMADs
- Universal screening recommendations
- Questions and discussion
Perinatal Mood & Anxiety Disorders (PMADs)

- Heterogeneous group of mood and anxiety disorders that occurs during pregnancy through the first year following childbirth.

- The following disorders are the most common:
  - Major Depressive Disorder
  - Bipolar Disorder I or II
  - Obsessive Compulsive Disorder
  - Generalized Anxiety & Panic Disorder
  - Post-Traumatic Stress Disorder
  - Psychosis

[For a comprehensive review see The Lancet, Perinatal Mental Health Series (Nov 2014)]
The “Normal” Experience: Baby Blues

- “Normal” emotional experience
- Common, benign, transitory
- Mild sx's occurring in the first 10 days (begin day 3-4, peak day 4-5)
- Occurs in as many as 85% of new mothers
- More pronounced than normal daily fluctuations in mood
- Most recover within 2-3 weeks
- Support from other Mothers

SYMPTOMS

- Weeping *
- Emotional lability *
- Sadness
- Irritability
- Anxiety
- Lack of affection
- Envy/Hostility towards husband
- Feelings of dependency
- Sense of “unreality”

(Robinson & Stewart, 2001; Stanton et al., 2002; Stanton & Gallant, 1995)
Postpartum Depression

- 10-15% prevalence (1 in 7)
- Usually begins within 1-6 months after delivery
- Onset:
  - May “grow” out of postpartum blues
  - May have initial period of well-being following delivery

Risk Factors:
- History of mood disturbance before or during pregnancy *
- Abrupt weaning
- Social Isolation or Poor Support (poor marital relationship)
- Lower family income, occupational status
- Coexistence of excessive life stress
- History of PMS or PMDD
- Sudden Discontinuation of Psychiatric Medication

(Robinson & Stewart, 2001; Stanton et al., 2002; Stanton & Gallant, 1995)
Postpartum Depression:

**DSM-5 Criteria**

- Depressed Mood
- Anhedonia
- Appetite and/or weight changes
- Sleep Problems
- Psychomotor changes
- Fatigue/low energy
- Excessive guilt/feelings of worthlessness
- Impaired concentration
- Suicidal ideation
- *Onset of episode is w/in 4 weeks postpartum*
How do depressed new mothers FEEL?

- Depressed, sad, mournful
- Anxious, Panic
- Feelings of unreality, “Numb”
- Resentful, Irritable or Angry
- Regretful, “What have I done?”
- Hopeless
- Lonely
- Feelings of Loss, Missing “old life”
- Guilty/Worthlessness
How do depressed new mothers THINK?

- Unrealistic expectations for motherhood
- Unrealistic expectations for baby
- Preoccupation with baby’s safety & vulnerability
- Profound negativity
- Thoughts of death (own or child’s)
- Egodystonic thoughts of harming baby (i.e., “scary thoughts”)

- Preoccupation with baby’s safety & vulnerability
What do depressed new mothers DO?

- Avoidance of sex and/or physical affection
- Crying
- Conflict or strain with spouse
- Diminished or absent bond with baby
- Near frantic efforts to gain control
- Sleep problems
- Breastfeeding difficulties
"...be sure to sterilize nipple before feeding baby."
Postpartum Anxiety Disorders

- Large prospective English study (N=8400) showed 21.9% of pregnant women were symptomatic (Heron et al., 2004)
- 64% of those with high anxiety in pregnancy associated with high anxiety postpartum
- Antenatal anxiety predicted PPD at 8 weeks and 8 months, after controlling for AD
- Most commonly:
  - Obsessive-Compulsive Disorder (OCD)
  - Panic disorder
  - Post-traumatic Stress Disorder (PTSD)
Postpartum Anxiety Disorders

**OCD**
- Symptoms
  - Intrusive, repetitive, and persistent thoughts or mental images
  - Thoughts are often about hurting or killing the baby
  - Tremendous sense of horror over thoughts
  - Thoughts may be accompanied by behaviors to reduce anxiety
  - Counting, cleaning, checking behaviors

**Panic disorder**
- Symptoms
  - Episodes of extreme anxiety; excessive worry or fear often without trigger
  - SOB, chest pain, sensations of choking or smothering, dizziness
  - Hot or cold flashes, trembling, rapid HR, numbness or tingling
  - Restlessness, agitation, irritability
  - Panic attack may wake her up
  - During panic attack: fear of going crazy, dying, or losing control

**PTSD**
- Symptoms
  - Reliving past traumatic events: Intrusive, repetitive, and persistent thoughts or mental images of event
  - Recurrent nightmares
  - Extreme anxiety
  - Desperate attempts to avoid reminders of trauma
Postpartum Psychosis

- Rare, 2 in 1000
- First month is time of elevated risk (10-20X)
- Most begin w/in first 2 weeks
- Usually asymptomatic for 2-3 days postpartum
- Presentation is typically in the form of a severe mood disorder
- Primary risk factor = prior history of bipolar disorder (38-55% chance of PPP)
- Treated as a psychiatric emergency, requires hospital admission

SYMPTOMS

- Impairment in reality testing
- Delusions
- Hallucinations
- Tearfulness
- Psychomotor retardation
- Excessive guilt/worthlessness
- Sleep & appetite disturbances

(Robinson & Stewart, 2001; Stanton et al., 2002; Stanton & Gallant, 1995)
Why we should care

- PMADs are the #1 medical complication related to childbearing
- Each illness in the spectrum is highly treatable
- Opportunity to help women with prior undiagnosed mental illness who are at risk for continued mental illness
- Leads to increased costs of medical care and inappropriate medical care
Why we should care

- 10-20% of new mothers develop depression in the postpartum period *
- An estimated 50% of cases postpartum depression go unrecognized and untreated
- Each year 400,000 infants are born to depressed mothers
- The adverse effects of PMADs are far reaching and impact the entire family

* Estimates are as high as 25-60% in low-income, minority, and teenage pregnancies
Prevalence of PMADs

- 2013 US Birth Rate: 3,957,577 births
- 1 in 7 (10-15%) of those will develop a PMAD
- 1 in 3/4 (20-25%) of lower SES mothers will develop a PMAD
  - 10%: 395,758
  - 15%: 593,637
  - 20%: 791,515
- If left untreated, symptoms persist
  - 16.1% depressed at 2-4 months postpartum
  - 15.5% depressed at 30-33 months postpartum

(Phelan et al., 2007)
Consequences of untreated or undiagnosed perinatal depression and anxiety...
Impact of Depression & Anxiety in Pregnancy

**Mother**
- Non-compliance with prenatal care
- Self-medication with drugs, alcohol, tobacco
  - 10-12% smoke tobacco
  - 14-15% use alcohol
  - 3% use illicit drugs
- Poor bonding with baby
- Impact on family
- Self harm/suicide
- Post-partum depression

**Fetus**
- Pre-term labor
- Premature birth (<37 wks)
- Low birth weight
- Small for gestational age, small head circumference (stress state)
- Low APGAR scores
- Neonatal complications
- NICU admissions
- Fetal demise

Consequences of untreated PMADS in Immediate Postpartum Period

- Decrease in developmentally promoting activities
  - Breastfeeding
    - Less likely to breastfeed
    - Early cessation of breastfeeding
    - More negative emotions towards breastfeeding
    - More negative experiences with breastfeeding
  - Parenting Behavior
    - Decreased maternal responsivity and sensitivity
    - Less emotional availability
    - More negative mood (intrusive/hostile), modeling negative affect
    - More Inconsistency in discipline
    - Inability to assist with emotional regulation
Impact of Depression & Anxiety on Newborns

- Risk of impaired bonding and attachment
- Elevated cortisol in newborn (stress state)
- Increased infant crying, greater reactivity
- Decreased eye gaze toward the mother
- Less reciprocity in interactions
- Less exploration
- More drowsy or fussy

Consequences of untreated PMADS in the Postpartum Period

Parenting styles of depressed mothers:

- **Withdrawn:**
  - Disengaged
  - Distant
  - Unresponsive/Flat affect
  - Offers little encouragement or support for child’s activities

- **Intrusive:**
  - Harsher discipline practices (over 2X more likely to face slap or spank with object)
  - Rough handling
  - Angry/hostile
  - Actively interferes with infant’s activities

Consequences of untreated PMADS in Postpartum Period

- Depression in mothers leads to decreased safety precautions
  - Improper car seat use
  - Less use of safety latch
  - Less likely to reduce hot water heater water temperature
  - Less likely to place back on its back to sleep
Impact of untreated PMADS on Young Children

- Toddlers:
  - Insecure attachment with mother, inhibition & fear, clinginess
  - Less social interaction with peers
  - Inappropriate interactions, less pleasure
  - Lower self esteem
  - More behavioral problems, including aggression
  - Motor delays associated with chronic maternal depression

Impact of PMADS on Older Children

- **Preschoolers**
  - Greater anxiety and aggression
  - Behavioral problems and conduct disorders
  - Deficits in cognitive development

- **Older Children**
  - Increased peer conflicts
  - Poor cognitive processing
  - Lower IQs, grades, test scores
  - ADHD, anxiety, impulsivity
  - Sexual activity
  - Psychiatric symptoms and psychosomatic complaints

Effects of Maternal Depression on Children

Effects on offspring

- 50% - 80% of offspring have significant problems
- Exposure in early life appears to confer more risk
- Duration and severity of mother’s depression affects children’s severity of impact
- Even mild depression associated with child problems

Anderson & Hammen, 1993, Goodman & Gotlib, 1999; Timko et al., 2002; Riley, et al, 2002;
A “Perfect Storm”

- Unrealistic expectations
- Hormonal changes
- Sleep Deprivation
- Single biggest identity transition for women
- Possible difficulties in pregnancy or birth
- Possible predisposition for depression or anxiety (prior depression is biggest predictor for PPD)
What treatments can we offer pregnant and postpartum women?
General Principles in the Treatment of Depression in Pregnancy

- Women with a history of depression should seek consultation prior to pregnancy (perinatal psychiatrist)
- Mild-Mod symptoms = non-pharmacologic interventions
- Non-pharmacologic interventions preferred
- Medication should be considered for the treatment of disabling or serious depression, threatening maternal or fetal well-being.
- Treatment for depression in pregnancy protects against postpartum depression

Greene MF: NEJM 2007; 79:301-308
Depression Relapse in Pregnancy: Cohen et al. 2006:

- 43% of the women experienced relapse during pregnancy
- 26% who maintained medication relapsed
- 68% who discontinued medication relapsed

Weighing the Risks and Benefits *

Treatment decisions: Balancing of TWO RISKS: Weigh the risk of untreated illness against risks of pharmacologic intervention

- Risk of untreated mental illness
- Risk of relapse of psychiatric illness
- Effects of psychiatric illness on the fetus
- Teratogenicity of psychotropic medications
- Neonatal toxicity or withdrawal syndromes
- Limits of reproductive safety data for medications

* Based on an extensive review of existing research, ACOG and APA offer recommendations for the treatment of women with depression during pregnancy. The report, "The Management of Depression During Pregnancy: A Report from the American Psychiatric Association and The American College of Obstetricians and Gynecologists," is published in Obstetrics & Gynecology (September 2009) and General Hospital Psychiatry (September/October 2009).
Weighing and Presenting the Evidence

- There is no such thing as *ZERO* risk
- There is no specific algorithm
- The goal is to minimize fetal medication exposure, and maximize mental health
- Even experts vary on interpretation of the current evidence.
Postpartum Treatment
Considerations

- Extensive literature examining the treatment of PPD
- Treatments address both biologic and psychosocial factors
- Serotonin reuptake inhibitors are considered first-line therapy after it has been determined that the proper diagnosis is not bipolar disorder
- Strong evidence of effectiveness for psychotherapeutic interventions
- Recent research suggests psychotherapy should be the first line of treatment, rather than medication

Nonpharmacological Treatment Interventions

- Elimination of caffeine, nicotine, & alcohol
- Adequate sleep
- Facilitating communication physician
- Reduction of psychosocial stress
- Relaxation techniques
- Connection to community resources

Psychosocial Treatments:
- Cognitive-Behavioral Therapy (CBT)
- Interpersonal Therapy (IPT)
- Support groups-Mothering the Mother
- Couples therapy
Screening

Does the prevalence and outcomes of PMADs warrant a screening?

Yes! Other risk factors in pregnancy are routinely screened for.

By comparison:

- 4.8% of pregnant women develop gestational diabetes
- 5% of pregnant women have hypertension in pregnancy
Screening

- Less than 25% of ObGyn patients had their psychiatric diagnoses recognized (Spitzer et al., 2000)

- Less than 20% of pregnant women with psychiatric diagnoses were treated (Kelly et al., 2001)

- More than 50% of pregnant women on antidepressants were symptomatic due to suboptimal treatment (Markus et al., 2005)
Starting the conversation

How are you feeling about being a new mother?

How are you coping with the additional stress of a new baby?

Are you able to sleep when the baby is sleeping?

How is your appetite?

Do you have enough energy to do the things you need to do for yourself, your baby and your work?

Have you been feeling sad or depressed over the past week?

Have you been feeling anxious, worried or afraid over the past week?

Do you find yourself crying for no reason?

Have you had any thoughts that have scared you?

Screening Methods

- EPDS, Edinburgh Postnatal Depression Scale (Cox et al., 1987)
- PDSS, Postpartum Depression Screening Scale, (Beck & Gable, 2000)
- PHQ-9, Patient Health Questionnaire (Spitzer et al., 1999)
- PHQ-2 (Kroenke, Spitzer & Williams, 2003)
The Association College of Obstetricians and Gynecologists (June 2010) and the American Academy of Pediatrics Recommends Screening for Postpartum Depression (Nov. 2010)

Edinburgh Postnatal Depression Scale (EPDS)

Name: ____________________________ Address: ____________________________
Your Date of Birth: __________________ Baby’s Date of Birth: __________________
Phone: ____________________________

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- Yes, all the time
- Yes, most of the time
- No, not very often
- No, not at all

In the past 7 days:
1. I have been able to laugh and see the funny side of things:
   - As much as I ever did
   - Not quite as much as I ever did
   - Not at all
2. I have looked forward with enjoyment to things:
   - As much as I ever did
   - Rather less than I used to
   - Hardly at all
3. I have blamed myself unnecessarily when things went wrong:
   - Yes, most of the time
   - Yes, some of the time
   - No, not at all
4. I have been anxious or worried for no good reason:
   - Yes, most of the time
   - Yes, some of the time
   - No, not at all
5. I have felt sick orChangeEvent: 13:32

Screening ABC’s

- Screen *all* mothers
- Use a specific screening tool
- Screen *not* diagnose
- Discuss results
- Provide education and support *not* treat
- Make necessary referral
- Circle back at next appointment
Screening

- Recommended screening time points:
  - Preconception
  - First prenatal contact
  - Every trimester
  - During childbirth hospitalization
  - First postpartum contact
  - Well baby visits
Screening
Results of using Screening Instruments:

Detection of hidden symptoms:

- With screening, detection rate was 35.4%
- Without screening, spontaneously detected rate was 6.3%
Screening ABC’s

- Screen all mothers
- Use a specific screening tool
- Screen not diagnose
- Discuss results
- Provide education and support not treat
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Perinatal Mental Health Resources

- Postpartum Support International
  - http://www.postpartum.net
  - Provides specific information on support groups and providers by region

- Postpartum Support Maryland
  - http://www.postpartummd.org
  - Provides local resources to families suffering from postpartum depression raises awareness within the community. Offers support groups for mothers with PPD.
Regional online directory of Perinatal Mental Health Professionals, Programs, and Support Resources in the DMV

- Project Leader: Kisha Semenuk
- Project Team: Aimee Danielson, Lynne McIntyre, Helen Conway, Dina Karellas

A gift from us to you and our communities!

- Frontline Healthcare Providers
- Mental Health Professionals
- Pregnant Women
- Mothers/Fathers
- Support Systems
Websites

- **Postpartum Support International.** Provides specific information on support groups and providers by region.  [www.postpartum.net](http://www.postpartum.net)

- **Postpartum Progress.**  [www.postpartumprogress.org](http://www.postpartumprogress.org)

- **Online PPD Support Group.**  [www.postpartumdepression.yuku.com](http://www.postpartumdepression.yuku.com)

- **Mass General Women’s Mental Health Center.**  [www.womensmentalhealth.org](http://www.womensmentalhealth.org)


- **Motherisk.** Provides evidence-based information and guidance about the safety; or risk to the developing fetus/infant; of maternal exposure to drugs, chemicals, diseases, radiation and environmental agents.  [www.motherisk.org](http://www.motherisk.org)
Additional References


National Alliance on Mental Illness (2009). [Women and Depression Fact Sheet]

National Alliance on Mental Illness (2014). [NAMI Top Story: Postpartum Depression Affects 1 in 7 Mothers; Bipolar Rate Strikingly High, Study Finds]


The New York Times (2012). [How to Mother a Mother]