Perinatal Mood Struggles: From the Baby Blues to Postpartum Depression, How to Recognize and Refer

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OVERVIEW

• Importance of pro-active identification
• The Range of Perinatal Mood Disorders
• Risk Factors
• How to recognize behavioral, emotional, and physical symptoms of these conditions
• The impact of untreated maternal mood disorders
About 1/7 women experience symptoms linked to a spectrum of illnesses known as perinatal mood disorders.

All of these mental health conditions used to be referred to as solely postpartum depression but truly include clinical diagnoses for anxiety, depression, bipolar disorder, and psychosis.
Need for Pro-Active Identification and Referral

• Perinatal women across all demographics are vastly underserved in their mental health needs and **50% of the women suffering from them are not recognized**, even when interacting with other medical and healthcare services. Considering the perinatal period has such a high amount of interaction with health care, this is a striking and disturbing statistic.

• We need to pro-actively identify women potentially needing help, ‘catch’ them in a safety net from other services (Peds, OB, social work, lactation consultation etc.), and help link them to mental health care.

• Sooner ‘caught’ less duration of disorder.

• **Role of non-mental health providers beyond crucial!!**
Perinatal Mood Disorders: An Introduction…

Perinatal mood disorders are the most common serious psychiatric illness in childbearing women (Le, Perry, & Sheng, 2009).

These mood disorders include both emergent and triggered antenatal and postpartum mood disorders, such as depression, anxiety, obsessive compulsive disorders, bipolar diagnoses, and psychosis.

Other issues requiring mental health support, like eating disorders, may also require intervention in the perinatal period.
The perinatal period is a time of tremendous flux in self-identity and a time of enormous physiological and psychological transition and change.

These changes may include a dramatic drop in hormones, changes in metabolism, and sleep deprivation, among numerous other biological, psychological and sociological factors.

For many women, these shifts in body chemistry and functioning contribute to the development of perinatal mood disorders like depression and anxiety as well as the exacerbation of other mental health conditions such as bipolar disorders, psychosis, or eating disorders.

With a drop in resources, and increase in needs and stressors, ‘Fault lines’ in the self can turn into chasms ....
For many women and their partners, having mood regulation difficulty during the perinatal period is their first encounter with mental health needs requiring intervention. This is often very hard to recognize and accept...let alone respond to.

While about 80% of women experience the ‘baby blues, most studies find that another 15 – 23% of women go on to develop a perinatal mood disorder needing clinical treatment.

Profound stigma and shame over ‘not just being happy with baby’ make treating these conditions difficult to address.

Pro-active questions and discussion initiated by medical staff profoundly facilitates women- and their partners- comfort with getting help.

In fact, Perinatal Mood Disorders are THE most common medical complication from childbirth. (Sharing this can help with decreasing the unfortunate stigma often prevalent in response to mental health needs)
Improving RECOGNITION

- Since these conditions have for so long been referred to as ‘Postpartum Depression’…their true, broader range of presentations have often been missed.

- Pre-natal Mood Disorders…their onset during pregnancy is now recognized as more common and also related to the severity of the postpartum condition. Research shows the earlier a women gets treated, the disorder may shorten in duration and severity.

- Anxiety in Perinatal Mood Disorders…not just depression. There can also be ways that depressive symptomology manifests more as irritation and less as sadness.
Risk Factors

Variables that are associated with INCREASED risk

- Childbirth complications – e.g. emergency c-section (for some women, deviations from their desired birth plan and experience is akin to a medical PTSD and they replay their traumatic or disappointing births).
- Relationship and financial concerns.
- Breastfeeding issues.
- Lack of Social Support.
- Conflicted feelings about pregnancy, body changes, identity, work-life balance etc.
- Premature infant.
- Infertility treatments (IVF).
- Women who identify as having PMS
- Mothers of multiples.
- Women with diabetes (Type 1, 2 or gestational).
- Women who have conflictual relationships with their own mothers
- Recent Immigration or estrangement from culture of origin.
- Women who idealize the experience/expectations of pregnancy/parenting/partnership
The Baby Blues

- Childbirth is a major life change and stressor.

- Majority of women experience the “baby blues.”
  - Baby Blues (Kleiman, 2008).
    - Up to 80% of new mothers experience.
    - Mild and transient, does not require medical attention.
    - Reported symptoms include crying, mild anxiety, insomnia, restlessness, and exhaustion.
    - May last up to two weeks.
    - Baby Blues are “normal” and normally do not require additional medical attention, although counseling during this time of transition may be helpful.
Perinatal Depression and Anxiety

Construction of Perinatal Depression and Anxiety “Bio-Psycho-Social”

BIOLOGICAL contributors...

PSYCHOLOGICAL contributors...

SOCIOLOGICAL contributors...

Needs up / Resources down idea
Perinatal Anxiety / OCD

- In anxiety-laden perinatal mood disorders (research shows related to OCD), it is not unusual to have some **intrusive thoughts or images** about harm coming to self or baby. The vast majority of women suffering from such thoughts are horrified by them and passionately express commitment that they would never act of them.

- A good diagnostic risk question is to ask if these thoughts feel like they come from within (ego-syntonic) or from outside (ego-dystonic). Risk is much lower if the woman experiences the thoughts as coming from outside.
Bipolar Spectrum Disorders

Bipolar spectrum disorder includes Bipolar I, Bipolar II, and Bipolar NOS (not otherwise specified). Bipolar I is defined by recurrent episodes of mania and depression, while bipolar II is characterized by recurrent episodes of depression and hypomania.

- The possibility of bipolar disorder should be considered in women with current or past symptoms of mania, whether or not they have had a depressive episode, especially if the woman has a personal/family history of bipolar disorder.

- Many women who are Bipolar I come to the pregnancy period knowing their diagnosis and dealing with challenges around medication decision making or adjustment to changes or discontinuations in their medication regime during conception, pregnancy and breastfeeding. Monitoring carefully for relapse is crucial.

- It isn't uncommon that women who are Bipolar II may never have received a diagnosis and encounter their condition for the first time during the perinatal period. Hypomania can be confused with euphoria and anxiety in new motherhood.

- Minimising stress and maximising sleep are vital
Perinatal Psychosis

- Postpartum Psychosis is a rare illness, compared to the rates of postpartum depression or anxiety. It occurs in approximately 1 to 2 out of every 1,000 deliveries, or approximately .1 -.2% of births. The onset is usually sudden, most often within the first 2 weeks postpartum.

- Symptoms of postpartum psychosis can include: Delusions or strange beliefs; Hallucinations (seeing or hearing things that aren’t there); Feeling very irritated; Hyperactivity; Decreased need for or inability to sleep; Paranoia and suspiciousness; Rapid mood swings; Difficulty communicating at times.

- The most significant risk factors for postpartum psychosis are a personal or family history of bipolar disorder, or a previous psychotic episode.

- Of the women who develop a postpartum psychosis, research has suggested that there is approximately a 5% suicide rate and a 4% infanticide rate associated with the illness. This is because the woman experiencing psychosis is experiencing a break from reality.

*Material taken from Postpartum Support International*
Eating Disorders

- Pregnancy is a critical time for women struggling with disordered eating and weight concerns. For the majority of women with eating disorders, symptoms improve during pregnancy. Other women, particularly those with either subclinical or binge eating disorders, are at risk for an escalation of pathologic behaviors, putting both mother and fetus at risk for negative birth outcomes.

- However, many medical complications are associated with eating disordered behaviors during pregnancy, such as: preterm delivery, low birthweight, intrauterine growth restriction, Caesarean birth, and low Apgar scores (James, 2001).

- Women may develop new disordered eating patterns in the postpartum as they may begin to overly restrict intake in attempts to ‘lose the baby weight’. In the overwhelming and out of control experience of new infant needs, weight may be one thing within their control and become an issue needing treatment.
Symptoms

- Many new mothers might not recognize depression or anxiety because they are tired, overwhelmed, or simply adjusting to life with a baby. *It's hard for new moms and families to know what is ‘normal mom’ stuff and what is a symptom of depression or anxiety.*

- When the expected glow of pregnancy or postpartum does not arrive, **mothers tend to blame themselves and feel embarrassed.** They fear admitting to negative feelings during the perinatal period may lead to their children being taken away or they will be labeled as bad mothers. There is stigma and sometimes great shame, in acknowledging this very real medical condition.

- Women experience unique situations and unique symptoms. Some new mothers are sad and teary; some feel overwhelmed and irritable; some bond well with their babies while others feel distant; some sleep all the time while others have insomnia. **The up-and-down nature of symptoms also makes it difficult to recognize** or admit perinatal depression or anxiety. Waxing and waning symptoms are often emblematic of PMDs.
Symptoms (con’t):
‘I just don’t feel like myself’

- Loss of appetite.
- Insomnia.
- Intense irritability and anger.
- Overwhelming fatigue.
- Lack of joy in life.
- Feelings of shame, guilt or inadequacy.
- Severe mood swings.
- Difficulty bonding with the baby.
- Withdrawal from family and friends.
- Thoughts of harming yourself or the baby.
Emotional Symptoms

- Increased crying and irritability. Partners sometimes say that a woman is ‘lashing out’ more than usual.
- Exhaustion
- High levels of guilt
- Fear-Dread-Despair: “This wasn’t what I expected” or “I’ll never be able to pursue my own stuff ever ever again”
- Feeling overwhelmed, unable to cope, or hopeless
- “I just don’t feel like myself” or “I’m in a fog”
Physical Symptoms

- Decreased energy or motivation
- Headaches, chest pains, trouble breathing, irregular and rapid heartbeat
- Trouble with eating or sleeping not related to care of the baby (A great diagnostic question I ask is “when the baby is asleep, can you sleep?”)
- Especially with higher levels of anxiety in the condition, some women have panic attacks or GI changes.
Behavioral Symptoms

- Lack of interest in the baby or overly concerned for it
- Poor self-care or ADLs (activities of daily living), feelings that one can’t manage or function
- Loss of interest or pleasure in activities
- Fear of harming one’s child or oneself- actively or passively
Key Issues in Treatment

- Shame, stigma, and under diagnosis:
  Fears about speaking up “I don’t want anyone to think that I don’t love this baby” or ‘I don’t want anyone to take the baby away from me’.

- Impact of untreated maternal psychiatric illness.

- Best of Preventive Psychiatry.
Impact of Untreated Perinatal Mood Disorders

On child development...

- Increase in adverse pregnancy outcomes, including premature birth, low birth weight, fetal growth restriction, and postnatal complications that require admission to neonatal intensive care units.

- Long-term effects on attachment and bonding.

- Increases risk for child to experience depression/anxiety later in life (STAR-D study)

- Cognitive and behavioral problems in later childhood.
Physiologic profiles of newborns of depressed mothers mimic those of their mothers, showing elevated cortisol levels, decreased peripheral levels of dopamine and serotonin, lower vagal tone, and abnormal patterns of brain activation. Further, children of mothers with untreated anxiety disorders during pregnancy have been shown to have decreased development scores and slowed mental development at two years of age in comparison to their peers.

Untreated maternal psychotic illness has been associated with several devastating obstetric outcomes, including an elevated risk of postnatal death. School-age children and adolescents with depressed mothers are at higher risk than their peers for having impaired adaptive functioning and psychopathologies, including conduct disorders, affective disorders, substance abuse, anxiety disorders, ADHD, and learning disabilities.

From a child development perspective, the need to intervene is clear as studies have suggested a link to lifelong cognitive and emotional effects on children of mothers suffering from perinatal mood disorders (Beck, 2002, Hanna et al., 2004).
Impact of Untreated Perinatal Mood Disorders (con’t)

- Fewer positive parent/infant interactions

- Affects the entire family system, including, partner/Dad, siblings and immediate family.

- In extreme examples, can result in death of Mom and even baby (most common with post-partum psychosis).

NB: Note media stories tend to focus on tabloid-like reporting on postpartum psychosis....many women are afraid to discuss their mental health struggles for fear of being perceived as ‘crazy’ or dangerous...having their kids removed etc.
Empirically Validated Screening Tools


- Postpartum Depression Predictors Inventory-Revised (Beck, 2002)
Conversational Screening Approach: Initial identification of most perinatal mental health issues
S.I.G.E.C.A.P.S. (acronym)

“Tell me about your X; do you feel like yourself?”

S - SLEEP are you able to when you’re tired and have an opportunity to? (A big red flag is when baby is asleep and mom can’t fall asleep when she wants to)

I - INTEREST (Anhedonia) Lack of pleasure in activities usually experienced as enjoyable

G - GUILT Ask women to associate (unearths levels of overwhelm and internal conflict)

E - ENERGY Have there been significant increases or decreases?

C - CONCENTRATION Have there been significant increases or decreases?

A - APPETITE Have there been significant increases or decreases?

P - PSYCHOMOTOR AGITATION Are you physically restless (foot tapping, picking, antsy)

S - SUICIDIALITY I find it most helpful to ask, ‘do you find yourself thinking anything that disturbs or bothers you”?
Conclusion....

- Getting help quickly if you’re struggling is the best of preventative psychiatry for two generations and can have a tremendous impact on your baby’s development and attachment.

- Providers across all disciplines can de-pathologize the need for extra mental health support during the perinatal period and help pro-actively link them to services.

- In the Perinatal Care Program at CPMC, we found that in our marketing and outreach- many moms were reluctant or resistant to getting mental health support for themselves in the pre or postpartum....but when we discussed the negative consequences of an untreated maternal mood disorder for their child, they were much quicker to pursue treatment.