Perinatal Mood and Anxiety Disorders

Overview and Impacts

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DISCLOSURE

- In order to obtain nursing contact hours, you must attend the entire program and complete the evaluation form
- No conflicts of interest were identified for any member of the planning committee or any author of the program content
- OBRC obtains CNEs from the Oklahoma Nursing Association, an approved provider of nursing continuing professional development by the Midwest Multistate Division, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

What are Maternal Mood Disorders?

- Maternal Mood Disorders is the umbrella term for mood and anxiety disorders that occur during pregnancy or up to one year postpartum
- These terms encompass women (and men) who experience postpartum depression (PPD), postpartum anxiety, postpartum OCD, postpartum blues, and postpartum psychosis

Perinatal Mood and Anxiety Disorders (PMADS)

- Baby Blues vs Postpartum Depression
  - Baby Blues and PPD share many of the same symptoms:
    - Irritability, insomnia, change in appetite, sadness, mood swings, less energy, increased crying, persistent anger/rage
  - However, Baby Blues differs from PPD in severity and onset
    - Baby blues should not last longer than two to three weeks after delivery; will impact most mothers (70%)
    - PPD will be more intense, and most importantly will result in significantly impaired functioning (i.e; crying more often vs crying all day for multiple days)

Perinatal Mood and Anxiety Disorders

- Postpartum Depression (PPD)-
  - Postpartum depression is the number one complication in pregnancy
  - Impact of PPD is wide and does not discriminate based on age, income, or education
  - 15-20% of new mothers in the U.S. experience symptoms of postpartum depression
  - 15% of new mothers in Oklahoma reported symptoms

Postpartum Depression vs "traditional" depression

- There is no difference in the clinical presentation
- And yet, the context is very different
- Complications from pregnancy, birth, or breastfeeding can exacerbate symptoms

Perinatal Mood and Anxiety Disorders

- Perinatal Anxiety: A range of anxiety disorders, including generalized anxiety
  - Slightly less common than baby blues or PPD, impacts a reported 10% of new parents
    - Increasing and disruptive fears and worries (that make daily life much more difficult)
    - difficulty concentrating and focusing
    - Restless sleep
    - Panic attacks
    - Irritability
    - Muscle tension, upset stomach, increased heart rate, tightness in the chest

Perinatal Mood and Anxiety Disorders

Intrusive thoughts

- Negative, repetitive, unwanted, intrusive thoughts or images that can "pop into" your head at any time.
- Women with past histories of high levels of anxiety or an OCD diagnosis may be more susceptible but this is not a prerequisite
- These thoughts can be indirect or passive (something might happen to the baby) or they can imply intention (thoughts or images of you throwing the baby against the wall)

Perinatal Mood and Anxiety Disorders

Intrusive thoughts (continued from prior slide)

- These thoughts are NOT an indication of psychosis. They may make you feel like you are going crazy but you are not.
- They can be a part of postpartum OCD (postpartum obsessive-compulsive disorder) diagnosis or they may occur in absence of this diagnosis
- These thoughts will make you feel like you are a bad mother. They will make you feel guilty and ashamed. Please remind mothers that this is a common symptom and to try and not beat themselves up about this.

Perinatal Mood and Anxiety Disorders

- Intrusive thoughts

Perinatal Mood and Anxiety Disorders

- Postpartum Obsessive-Compulsive Disorder: Intrusive repetitive thoughts that are scary and do not make sense to the mother. Compulsions (i.e; handwashing, counting) may not be present
  - 11% of moms reported postpartum OCD symptoms at two weeks postpartum
    - Other symptoms include tremendous guilt and shame
    - It is important to educate the mother that these thoughts do not need to equal action

Perinatal Mood and Anxiety Disorders

- Postpartum Psychosis: sudden onset of psychotic symptoms following childbirth
  - Much more rare (0.1% of mothers) and often more acute in symptomology
    - Requires immediate psychiatric evaluation and medical attention
    - Hallucinations (seeing someone else's face instead of your baby's)
    - Delusions (feeling as though your baby is possessed or "evil"
    - Confusion/disorientation about your reality
    - Waxing and waning (there are periods of "normalcy" in between psychotic symptoms)

Who is at greater risk for PMADs?

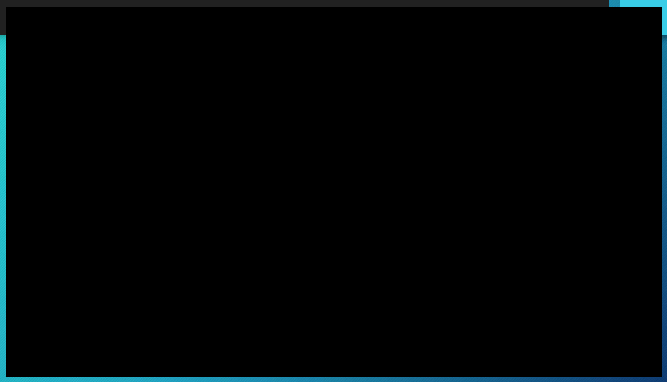
- Women who have an unplanned pregnancy
- Parents of Young children
- White non-Hispanic women
- Mothers under age 30
- Adolescent mothers
- Women with low incomes
- Women with a history of a thyroid imbalance
- Mothers with poor social support
- Sleep deprivation
- Women with a difficult pregnancy, labor, or delivery
- Women with a family history of PMADs
- Personal history of depression/anxiety
- Prior PPD has been shown to lead to a potential 30-50% increased risk
- Women with anxiety about returning to work
- Women who have difficulty breastfeeding
- Women with unmet or unrealistic expectations about motherhood

Media Misinformation

Tully

- Charlize Theron plays Marlo, a mom of three who hesitantly accepts the help of a night nanny named Tully.
- Tully is a great support to Marlo, she connects with the baby right away, helps Marlo get her house organized, and eventually becomes her friend.
- The film then reveals that Tully is not real. Tully is actually Marlo's younger-self, who Marlo has imagined into another person.
- A doctor diagnoses Marlo with postpartum depression. The problem is that Marlo does not have postpartum depression—she has postpartum psychosis.

What does it really look like?



Perinatal Mood and Anxiety Disorders

Impact the whole family

Impacts on the infant/child

- Premature birth (<37 weeks)
- Low APGAR scores
- Low birth weight
- Increased cortisol
- Neonatal complications
- NICU admissions
- Poor school outcomes
- Reading achievement suffers
- Poor grades
- Cognitive functioning
- Higher rates of psychiatric problems in adolescents
- Inability to assist with emotional regulation
- Withdrawal; avoidance in toddlers

Impact on mother's role

- Postpartum depression and anxiety symptoms may result in:
  - Compromised parenting skills
  - Poor establishment of routines from impaired parenting decisions
  - More frequent and overt displays of frustration
  - Mother be less emotionally engaged
  - May result in increased use of alcohol/drugs
  - Mother may be have fewer social interactions, present as withdrawn

Impact on breastfeeding

- What is the relationship?...
  - Complicated
  - Studies have looked at the interplay between the neuroendocrine transition from pregnancy to lactation (specifically *Stuebe et al., 2012*)
  - Directly following birth, progesterone levels that have been increasing during pregnancy drop dramatically (up to 200 times pre-pregnancy levels) in order to initiate the start of milk production
  - When a baby starts to nurse, the suckling stimulates, oxytocin and prolactin, while there is a drop in progesterone. While the progesterone plays an important part in milk production, it is also required in the maintenance of healthy brain chemistry.
  - So in many cases this drop in progesterone coincides with many moms becoming sad or anxious. Unfortunately for many first-time (or even second, third, etc.) moms their initial challenges with breastfeeding are now more difficult to tolerate because of their symptoms.

Impact of hormonal shifts

- Estrogen
  - Estrogen levels also drop dramatically, and remain low throughout lactation. Low levels of estrogen therefore, may be necessary for milk production. However, like progesterone, estrogen levels are also tied to brain chemical balance and unfortunately these low levels of estrogen may also contribute to the development of postpartum depression and/or anxiety in some women.
- Oxytocin
  - Oxytocin is the hormone that leads to feelings of pleasure, comfort, and maternal security. Oxytocin production also stimulates let-down in the breastfeeding mother. Studies have also suggested that moms who are depressed or anxious during pregnancy have lower levels of oxytocin. So here again, they are also likely to have challenges with let-down and may also not feel that initial sense of connection to their babies.
- Prolactin
  - Prolactin levels increase during pregnancy and the early postpartum period. Over time, baseline prolactin levels drop, but each time a baby suckles, prolactin levels are increased briefly in order for milk production to be stimulated. Prolactin is also thought to play a role in the emotional wellness of a new mom as high prolactin triggers a maternal response in caretaking of a baby. Conversely, it has been found in some studies that women who have low levels of prolactin during pregnancy are prone to higher levels of anxiety. So low prolactin may lead to both anxiety and low milk supply.

Impact of hormonal shifts

- Thyroid
  - As many of five percent of women will develop an imbalance in their thyroid levels postpartum. This is a concern as some studies have found a link between low thyroid levels and poor milk supply. Low thyroid levels have also been shown to induce depressive symptoms in women. So here again, a disparity in thyroid levels after birth may find that both her mood and her milk production have been impacted.
- Cortisol
  - During pregnancy, the stress hormone cortisol increases. After childbirth, these levels typically drop, and successful milk production and let- down involve an adequate circulation of cortisol, so when cortisol levels are not balanced out appropriately, both milk production and mood can be affected: higher cortisol levels are linked to higher levels of anxiety and stress.
- So the takeaway appears to be, in many (but not all) mothers the hormonal shifts necessary to initiate breastfeeding also trigger/exacerbate anxiety and depressive symptoms

Impact on breastfeeding

- Alison Stuebe and her colleagues conducted a study in 2019 specifically looking at breastfeeding cessation and the role of depression and anxiety
  - They found that maternal symptoms of depression and anxiety during pregnancy were associated with earlier cessation of exclusive and any breastfeeding
  - Also concluded that women with a history of trauma, poor prenatal sleep, and disordered eating were at additional risk
- Ensuring the support of the mental health of all women before, during, and after their pregnancies *as well as* their physical health is the clear conclusion

Medications & Breastfeeding

- Some medications used to increase milk supply (Galactagogues) can cause depression, Metoclopramide (Maxolon) specifically been found specifically to increase risk of depression by 7 times
- Most medications are considered compatible while breastfeeding, including many antidepressants and mood stabilizers. In fact, in many cases it can be more harmful to cease these medications while pregnant and put the mother's mental health at greater risk.
- However, best practice is to consult with a perinatal trained psychiatrist. PSI hosts a free Perinatal Psychiatric Consult Line staffed by specialists in treating PMADs for consultations with medical providers (OBGYNs, Psychiatrists, GPs)

Resources for medication & Breastfeeding

- Mothertobaby: (866) 626-6847 www.mothertobaby.org
- Infantrisk.com: (806) 352-2519 www.infantrisk.com
- LactMed Drug and Lactation database https://www.ncbi.nlm.nih.gov/books/NBK501922/ also available as an app through Apple & Android devices here: toxnet.nlm.nih.gov/help/lactmedapp.htm
- E-Lactania (Spanish language database resource on compatibility of breastfeeding with medical prescriptions, plants, toxins, and diseases): http://www.e-lactancia.org/ingles/inicio.asp
- LactFacts: Institute for the Advancement of Breastfeeding and Lactation Education (IABLE)

Dysphoric Milk Ejection Reflex (D-MER)

- Dysphoric Milk Ejection Reflex (D-MER) is an abrupt emotional "drop" that occurs in some women just before let down and continues for not more than a few minutes.
- The feelings are described as a “wave” of emotion that are often described as having a pit in their stomach, or churning. There have been feelings of anxiety, agitation, and self-loathing reported in some women.
- Thankfully although these feelings are very real, thankfully they only last for a few minutes after their onset.
- It is important to note that although some women experience both, there does not appear to be a connection between postpartum depression (or other PMADs) and D-MER

Mindfulness in the message

- While a wonderful day for many mothers, those who have a traumatic birth have trauma entangled with childbirth that will carry through other experiences
- This trauma includes the breastfeeding experience, and as Beck and Watson (2008) found in their study; there are some mothers who did not want to breastfeed as it triggered their feelings of being violated through loss of control of their bodies
- Education about the benefits of breastfeeding is while avoiding shaming language that disregards these concerns is an important distinction and crucial to promote maternal mental health

Impact on infant and child development

Social Emotional Development

- Immediate Impact
  - Maternal depression compromises bonding
  - Babies often avoid interaction; attachment is at risk
  - The mother-child relationship creates an environment for the infant in which s/he withdraws from daily activities
  - Emotional and social development, as well as intellectual, language, and physical development is at risk

Social Emotional Development

- Long-term Impact
  - When mothers experience depression, the children often experience:
    - Poor self-control
    - Poor peer relationships
    - School problems
    - Aggression
    - Special education needs
    - Grade retention
    - Early school exit

Postpartum Depression in fathers

- 2006 study of 5,000 families published in the journal of pediatrics found depression in 10% of new dads
- Postpartum depression in fathers more than twice as common than in the general adult male population
  - Incidence of depression is higher when the mother has PPD
  - If both parents experience depression; effect on the children is compounded
  - A father who is not depressed can be a protective factor

Contributing factors to father/partner depression

- Feeling burdened or trapped
- Financial responsibility felt as a burden
- Feeling outside the circle of attention
- Missing sexual relationship
- Sleep deprivation
- Isolation and loneliness
- Partner is often the closest friend
- Men often have fewer individuals in their support networks

Impact on father's role

- Postpartum depression and anxiety symptoms may result in:
  - Increased anger/conflict
  - Poorer understanding/modeling of appropriate emotional regulation
  - May impact father's ability to work
  - Increased use of alcohol/drugs
  - Isolating from the family
  - Increased impulsivity—reckless driving, extra-marital relationship
  - Conflict between self-perception of "maleness" vs perceived reality

Equity in care

- Striving for equity in the treatment and education provided to women and men impacted by PMADs is a vital component to consider
- This includes being aware of your own biases when engaged in your work, as well as engaging in being mindful of those biases of the providers and colleagues you work with
- Also critical to encourage engagement with communities of color to look at assessing any health disparities that may be present in your work and to be as culturally competent as possible

Equity in care

- Kozhimannil (2011) and her colleagues found that a disproportionate number of black women and Latinas who suffer from postpartum depression do not receive needed services. As is the case in other areas more study is needed, but the differences are in part related to outreach, detection, service provision, quality, and processes of postpartum mental health care.
- This is another argument in favor of universal screening of those in your care utilizing a validated measure (i.e; EPDS, PHQ-9) and to avoid screening those who "appear to need screened"

Have a postpartum plan

- A postpartum plan is a plan that includes a set of preemptive strategies the mother will identify to have ready and available to her identified support system
- This can include:
  - Scheduled sleep (naps with alternative caregiver available)
  - Snacks/nutrition/hydration
  - Schedule of calls/visits (socially distant/masked) from a support system (family, church, support group, friends, etc.)
  - Sunlight/getting small but important amounts of walking in the sun to increase vitamin D levels

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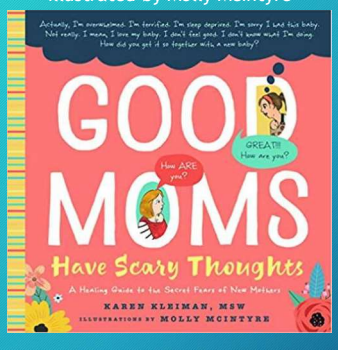
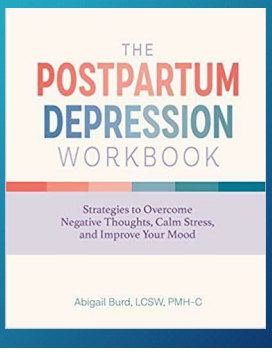
Treatment

- Medication
- Counseling
  - Interpersonal Therapy
  - Cognitive Behavioral Therapy
- Structured support groups
- Peer support
- Family support
- Self-care activities

Other Resources

- Good Moms Have Scary Thoughts, written by Karen Kleiman and illustrated by Molly Mcintyre
- The Postpartum Depression Workbook written by Abigail Burd





Digital copies of awareness/education material now available!

- The "Are you ok, mom?" one-sheet and Maternal Mental Health Matters booklet are available for download on the OSDH website here: https://www.ok.gov/health/Family_Health/Improving_Infant_Outcomes/Maternal_Mental_Health/index.html
- Request printed copies from James Craig at jamescc@health.ok.gov

Referral resources

- Postpartum Support International
  - weekly phone chat for moms each Wednesday, the Chat Number is: 1-800-944-8766 and Participant Code 73162; http://www.postpartum.net/chat-with-an-expert/#Schedule
- PSI perinatal psychiatric consultation line 1-877-499-4773
  - NAMI
  - Crisis text line is free and available 24/7; text "NAMI" or "HOME" to 741-741

PSI (postpartum support international) support groups

- PSI offers five different free online support groups led by PSI trained facilitators, often who have personal experience with the topic
  - **Perinatal (Pregnancy & Postpartum) Mood Support Group**
  - Designed for connection with other parents, to talk about your experience, and learn about helpful tools and resources. The group description indicates that you are able to talk through stress, adjustment to parenting, Baby Blues, or pregnancy or postpartum depression/anxiety.
  - **Pregnancy Mood Support Group**
  - This group is designed specifically for those currently pregnant. Similarly to the perinatal mood support group, it is arranged to help you connect with other parents, talk about your experience, and learn about helpful tools and resources. This group is also led by a PSI trained facilitator

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  - **NICU Parents**
  - The NICU group is intended for parents of babies who are currently or formerly in the NICU. Connecting with others who have experienced the uniquely stressful environment of a NICU will provide parents with understanding, as well as helpful tools and resources. Whether your baby is currently in the NICU or you have finally returned home, our NICU parents support group is here for you.

PSI (postpartum support international) support groups

- **Military Moms**
- Although dealing with stress, adjustment to parenting, Baby Blues, or pregnancy or postpartum depression/anxiety are still a focus of this group; it is tailored to military spouses, active duty personnel and veteran mothers. These facilitators are military spouses and understand the unique stress of the military family life.
- **Pregnancy and Infant Loss**
- These groups provide connection for mothers grieving the loss of their baby. Led by PSI trained facilitators, this group helps bereaved mothers find support as well as provides useful information and resources to help them navigate the pain of their loss. Losing a baby can be a lonely experience and this group helps provide an avenue for healing and hope.
- **Link for support groups**
- https://www.postpartum.net/get-help/psi-online-support-meetings/

Where is the need?

- Stigma reduction: awareness of the scope of perinatal mood disorders is low partially due to the stigma attached to mental health and mother's fear of judgement and lack of support
- Screening: failure to recognize the symptoms and lack of universal screening results in many mothers (and fathers) suffering in silence
- Treatment resources: tied to screening, many screenings are not done due to lack of referrals available for treatment providers with the knowledge and training to provide the treatment

Thank you!

Questions?

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