Depression & Anxiety in New Mothers

The American College of Obstetricians and Gynecologists, Women’s Health Care Physicians, Committee Opinion, June 2016
Complications with Postpartum Care

- Fragmented communication and care among maternal and pediatric health care providers
- Communication between inpatient and outpatient settings inconsistent
- Failure to include support system (partner or other)
- Incomplete care plan (care team, scheduled visit, contact information, feeding plan, reproductive life plan, contraceptive plan, pregnancy complications with follow-up recommendations, mental health recommendations, postpartum recommendations, chronic conditions treatment plan)
- Poor communication among health care providers
- Failure to screen, assess, educate and recommend referral
- 40% fail to attend a postpartum visit
- Misdiagnosis / failure to differentiate

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Strategies to Increase Postpartum Visit

- Discuss importance of postpartum visit during prenatal care
- Use peer counselors
- Intrapartum support staff
- Postpartum nurses
- Discharge planners to encourage
- Scheduling visits during prenatal care or before hospital discharge
- Use technology to remind to schedule visit

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Failure to optimize anticipatory guidance during pregnancy
- Delays (early postpartum follow-up is recommended with high risks)
- Unmet needs
- Less than ½ report receiving enough information at their postpartum visit about postpartum mood disorders, birth spacing, healthy eating, importance of exercise
- Changes in sexual response
- Emotions
- Failure to involve mother’s support system

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Pregnancy is supposed to be one of the happiest times of a woman’s life, but for many women this is a time of confusion, fear, stress, and even depression. According to (ACOG), between 14-23% of women will struggle with some symptoms of depression during pregnancy.

Depression is a mood disorder that affects 1 in 4 women at some point during their lifetime, so it should be no surprise that this illness can also touch women who are pregnant. But all too often, depression is not diagnosed properly during pregnancy because people think it is just another type of hormonal imbalance.

Assumptions can be dangerous for the mother and the unborn baby. Depression in pregnancy is an illness that can be treated and managed; however, it is important to seek out help and support first.
During the first two weeks after delivery, most women experience emotional highs and lows caused by fluctuating hormone levels.
- Difficulty concentrating
- Difficulty sleeping
- Feelings of hopelessness
- Fears of being a bad mom
- Many women find themselves "crying for no reason."

History should be known 1st (Proactive)
- Record and review prior history, and familial history
- Talking to family, friends or other new mothers and finding time for self-care can resolve the postpartum blues.
- If condition continues past two weeks or worsens, a postpartum mood disorder should be considered.

Categories: Postpartum Mood Disorders
- Baby blues
- Postpartum depression (PPD)
- Postpartum psychosis (PPP)
- Postpartum anxiety (panic disorder, social phobia, generalized anxiety)
- Postpartum obsessive-compulsive disorder (OCD)

Rule Out Postpartum Mood Disorder

- The following symptoms last for 2 weeks or more
  - Persistent sadness
  - Difficulty concentrating
  - Sleeping too little or too much
  - Loss of interest in activities that you usually enjoy
  - Recurring thoughts of death, suicide, or hopelessness
  - Anxiety
  - Feelings of guilt or worthlessness
  - Change in eating habits

Postpartum Depression (PPD)

- PPD presents with the same symptoms as those of depression in other circumstances. However, take into account that some of the symptoms associated with depression can be normal in the early postnatal period (sleep disturbance, tiredness, anxiety about the baby). Symptoms of depression include:
  - Low mood
  - Loss of enjoyment and pleasure
  - Anxiety
  - Disturbed sleep
  - Loss of appetite
  - Poor concentration
  - Low self-esteem
  - Worthlessness
  - Inappropriate feelings of guilt
  - Low energy levels
  - Loss of libido
  - Thoughts of death/suicidal thoughts
Reported Difficulties Related to Postpartum Depression?

- Anxiety or panic attacks
- Difficulty feeling close to your baby
- Feeling overly involved or "obsessed" with everything connected to your baby
- Difficulty sleeping or eating
- Isolating yourself
- Feeling like a failure as a mother
- Feeling angry, guilty, irritable, sad or overwhelmed
- Thoughts of harming yourself or your baby

Without treatment, it can continue for more than a year and may interfere with your ability to parent effectively.
Postpartum Psychosis

- Often associated with bipolar disorder or schizophrenia, but may occur with severe depression.
- 1 in 1,000 women are said to develop postpartum psychosis after childbirth.
- Usually occurs in the first few weeks after childbirth.
- Significantly common in women who have a past history or family history of postpartum psychosis.
- May be associated with depressive, manic or mixed symptoms of mood disorder, along with psychotic features. These can include paranoia, delusions, hallucinations, loss of inhibition, agitation and loss of contact with reality.
- It is a psychiatric emergency and usually requires admission to a specialist mother and baby unit, and mood-stabilizing and antipsychotic medication.

Hypomania

- Failure to detect hypomanic symptoms frequently results in bipolar postpartum depression being misdiagnosed as major depressive disorder (Ghaemi et al. 2001).
- The consequences of misdiagnosis can be particularly serious in the postpartum period:
  - The use of antidepressants may precipitate mania or a mixed state and thereby increase the risk of further disability and possibly psychiatric hospitalization at a crucial time in a mother’s life.
  - There is also a concern that antidepressants are not as effective in the treatment of bipolar depression as in major depressive disorder.
  - Failure to recognize the bipolar diathesis of postpartum depression can thus lead to treatment refractoriness and chronicity.
  - More importantly, the unopposed use of antidepressants in women with bipolar disorder may increase the risk of suicide (Akiskal et al. 2001) and infanticide (Kim et al. 2008).
  - Unfortunately, despite data supporting high attendant morbidity and mortality, there is a common impression that bipolar II disorder and bipolar disorder NOS are milder forms of bipolar illness.
Hypomanic symptoms are a common occurrence in the postpartum period. Estimates of the prevalence of postpartum hypomania in non-clinical populations have ranged from 9.6% to 20.4% on day 3 postpartum (Sharma et al. 2009). Symptoms of postpartum hypomania include elation, increased goal-directed activity, over-talkativeness, racing thoughts, decreased sleep requirement, distractibility, and irritability. Childbirth appears to be a specific trigger for hypomanic symptoms, as the prevalence of hypomania is eightfold higher in the first week after delivery than during pregnancy.

Baby Blues vs. Major Depression Disorder
Hypomania vs. Unipolar Depression
Psychosis vs. OCD
Postpartum psychosis episode vs. delirium

Failure to Differentiate
Inappropriate medication
Ineffective treatment
Epidemiology

- Meta-analyses of studies mainly based in the developed world found the prevalence of PND to be around 10-15%.
- Higher rates are found when self-reported questionnaires versus structured clinical interviews are performed.
- Higher rates occur in developing countries.\[5\]
- As few as 15% of women with symptoms of PND seek or obtain medical advice.\[1\]

- Management of perinatal mood disorders; Scottish Intercollegiate Guidelines Network - SIGN (March 2012)
- Jones I, Shakespeare J; Postnatal depression. BMJ. 2014 Aug 14;349:g4500. doi: 10.1136/bmj.g4500.

Strongest Risk Factors for Developing A Postpartum Mood Disorder

- Previous history of mental health problems
- Psychological disturbance during pregnancy
- Poor social support
- Poor relationship with partner
- Baby blues
- Recent major life events
Other Risk Factors for Developing A Postpartum Mood Disorder

- Unplanned pregnancy
- Unemployment
- Not breast-feeding
- Antenatal parental stress
- Antenatal thyroid dysfunction
- Longer time to conception
- Depression in the father of the child
- Having two or more children
- Current, or history of, substance misuse
- Neonatal low birth weight or illness, stillbirth and sudden infant death syndrome (SIDS).

Weak Associations For Developing A Postpartum Mood Disorder

- Obstetric complications
- History of abuse
- Low family income
- Lower occupational status
Negative Outcomes Related to Postpartum Depression

- Suicide
- Self-harm
- Harm to baby
- Mental health risks

Failure to Identify Postpartum Mood Disorders

- Postpartum mood disorders go unreported and undiagnosed due to:
  - Lack of knowledge of symptoms
  - Lack of education of mothers, partners, and family
  - Misdiagnosis of symptoms
    - Assigning blame to childbirth
    - Assigning blame to lack of sleep
  - Failure to acknowledge symptoms as abnormal
    - By mothers
    - By family
    - By healthcare providers
  - Fear of loss of child
  - Fear of family response
  - Failure to return to post-op
Disclosure Difficulties: Why?

- NICE warns that health professionals should be aware that women may be unwilling to disclose symptoms of depression and other mental health problems or reluctant to engage due to:
  - fear of stigma
  - fear the baby may be taken into care
  - concern that they will be perceived as a poor mother
  - the nature of the condition or problems with alcohol or substance dependence

Fighting Postpartum Mood Disorders

- Be proactive
- Act preventatively
- Use fast action (Delay = Increased Duration)
- Evaluate / past (previous diagnosis; family history; past outcomes; self-care behaviors)
- Assessment with verbal follow-up questions
- Be caring and supportive
- Identify health risks – to mother; child; family
Family History

Impact of Postpartum Depression and Anxiety

- Mother
- Infant Development
- Mother-Infant Relationship
- Family Relationship
- Partner
Mother-Infant Relationship

- PND can interfere with the behavioral and emotional interactions – a necessary component of a successful mother-infant relationship.

- Mothers with depression might
  - be less sensitive to the needs of their babies.
  - feel less close to their baby.
  - be less responsive to the baby's communications.
  - be withdrawn.
  - be overly intrusive with the baby as she tries to care for him/her.

Mother

- The mother's feelings towards her baby may be inconsistent as the symptoms of depression fluctuate.
- Sometimes the feelings make the mother feel numb, as if she has nothing to give.
- Sometimes the mother may feel overwhelmed or trapped by the demands of the baby and resent the baby.
- She may not be able to relax or switch off from the needs of the baby, needing to be constantly vigilant about his/her well being.
Impact on Family Relationships

- Changes in mother with PND can cause conflict in her relationships.
- Often a woman with PND will not tell members of her family about how she feels because of the response she feels she may receive.
- It takes an enormous amount of energy to hide PND, and the mother may have to isolate to hide symptoms.
- Many family members can identify that
  - a woman has changed
  - is not her normal self
  - Does not seem to be coping effectively
  - Does not seem to be enjoying life
  - Inadequate child care
  - Poor self care

- Ripple effect of PND
  - Parents
  - siblings
  - extended family

PND may trigger strong responses of distress or concern because of their own associations with depression or parenting.
- Some may not understand PND, and may not be open to learning more about it.
- Most family members just wish the mother would be happy.
- Some find it hard to understand why a mother can not “snap out of it”.

STRESS
Impact on Partner

- Increase in Workload
- Distress and frustration
- Anxiety related to wife’s coping
  - Fear for child’s care
    - Isolation
    - Loneliness
- Feelings of inadequacy in how to help

Partner

- The relationship between the parents may become very stressed or even threatened by the conflict created by the mother's symptoms and intense needs.
- The father's struggles to know how to support his partner may create conflict.
- Important decisions about the relationship should ideally be postponed until the depression has improved.
- "It may not be that a difficult relationship causes depression; rather that depression can cause problems in the marital relationship."
Partners

- Partners living with a woman experiencing PND
  - need a lot of support
  - are at risk of developing depression
  - feel confused, lost and helpless
  - can be the target of their partner's distress and irritability
  - is often expected to know how and when to listen to her, support her, and to know exactly the right things to say.

Infant Development

- Difficulties in mother-infant interaction over extended periods of time may compromise many aspects of the infant's development.
- Problems may include
  - increased fussiness
  - withdrawal
  - brain pathways development deficits
  - cognitive and social skills deficits
Infant Development

• Untreated PND can impact on the child's later
  ▫ cognitive and language development
  ▫ social competence
  ▫ behavioral problems
  ▫ parenting difficulties

• Parent-child relationships may be damaged due to
  ▫ the mother's withdrawal or volatility
  ▫ parental conflicts
  ▫ inconsistent parenting

It is important that partners be included by the support services and health professionals treating women with PND.

Partners are much more supportive if they understand the problem, and what they can do to help.

Partners need support and encouragement
Support vs. take over mother's care for her baby

- Acknowledge and encourage small gains and huge efforts to interact with or care for her baby
- Reinforce her special role as the baby’s mother
- Remind her that the symptoms of depression and anxiety are not reflections of her as a mother

Inquire about symptoms in a sensitive way

- Ask about behavior changes directly
- Research symptoms of PND and present
- Make contact with organizations, support groups, education groups, mental health professionals on behalf of the mother to seek information and strategies to help
- Be patient
- Listen unconditionally to feelings and concerns
College of OBGYN recommends screening patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool, with follow-up and treatment, to include medical therapy and referral to behavioral health resources as indicated.

- The American College of Obstetricians and Gynecologists, Women’s Health Care Physicians; Committee Opinion, May, 2015

Edinburgh Postnatal Depression Scale
- Postpartum Depression Screening Scale
- Patient Health Questionnaire 9
- Beck Depression Inventory II

*Note:
1) Normal scores for tearful patients with flat affect does not exclude depression.
2) Depression scales may miss symptoms of OCD, Psychosis, and/or Hypomania.
3) The Edinburgh includes anxiety symptoms, a prominent feature of perinatal mood disorders.
4) The Edinburgh excludes constitutional symptoms of depression, such as changes in sleeping patterns, that are common in pregnancy and the postpartum period.
Assessment: New Mom Checklist for Maternal Mental Health

- Created by Postpartum Progress to:
  - Empower mothers to help themselves.
  - Facilitate conversations that can be difficult for mothers to start with their doctors and other care providers.
  - Reinforce the variety of recognized, evidence-based symptoms of perinatal mood and anxiety disorders to both mothers and clinicians.
  - Reinforce the variety of recognized, evidence-based risk factors of perinatal mood and anxiety disorders to both mothers and clinicians.
  - Help clinicians get a clearer picture of how to best assist their patients.
1) Time between onset and treatment, 2) rapid remission impacts long term outcomes

The more severe the symptoms, the longer the recovery

Underlying health problems, substance abuse, family understanding and support, sleep, nutrition

Taking medication as directed, balance, implementing coping skills, expression of feelings and needs

Factors in Recovery Time

Individualized, type of therapy, mental health professional, medication, self-care, support groups and family

Effectiveness of treatment

Life Situation

Compliance

Postpartum Support International

- PSI Input to the DSM 5 committee:
  “We continue to support the recommended addition of a specifier, “With Postpartum Onset,” that can be applied to a current or most recent Major Depressive Episode, Manic, or Mixed Features in Major Depressive Disorder, Bipolar I Disorder, or Bipolar II Disorder, or to Brief Psychotic Disorder, and that the onset of the episode be extended to within 6 months postpartum.”
Postpartum Support International

- Recommend to the DSM 5 committee the addition of the 6 month onset specifier to the Mixed Depression and Anxiety Disorder and Obsessive Compulsive Disorder
  - In general many postpartum women present with a mixed depression and anxiety picture so the Mixed Depression and Anxiety Disorder seems to be a recognizable diagnosis for primary care doctors and obstetricians who will see many of these women in their practices.
  - It is important for doctors and other mental health professionals to be trained to diagnose postpartum depression, anxiety, OCD and psychosis to insure the proper treatment and education of their patients and their families.
  - Many families do not understand the nuances of these conditions in the Perinatal time period and depend on solid information and diagnosis to help them know how to support their loved ones.
  - Many women who develop OCD in the postpartum period often have intrusive thoughts about hurting themselves and/or their infants.
  - General practitioners and obstetricians will utilize the DSM 5 to help them recognize this OCD in the context of postpartum depression and anxiety.

Response to DSM 5:

“This official recognition of depression during pregnancy represents a significant step forward! It is however disappointing that the period following delivery was not extended to recognize that real suffering often occurs during the first year, as PSI and others had lobbied.”
DSM 5; Major Depressive Disorder, with peripartum onset: This specifier can be applied to the current or, if full criteria are not currently met for a major depressive episode, most recent episode of major depression if onset of mood symptoms occurs during pregnancy or in the 4 weeks following delivery.

Fifty percent of “postpartum” major depressive episodes actually begin prior to delivery. Thus, these episodes are referred to collectively as peripartum episodes. Women with peripartum major depressive episodes often have severe anxiety and even panic attacks.
Prospective studies have demonstrated that mood and anxiety symptoms during pregnancy, as well as the “baby blues,” increase the risk for a postpartum major depressive episode.

Mood episodes can have their onset either during pregnancy or postpartum.
Although the estimates differ according to the period of follow-up after delivery, between 3% and 6% of women will experience the onset of a major depressive episode during pregnancy or in the weeks or months following delivery.

Note: The Postpartum Progress Nonprofit advocates consider these numbers (3%-6%) low. The organization suggests it’s more like 10-15%. 
Prospective studies have demonstrated that mood and anxiety symptoms during pregnancy, as well as the “baby blues,” increase the risk for a postpartum major depressive episode.

Peripartum-onset mood episodes can present either with or without psychotic features.

Infanticide is most often associated with postpartum psychotic episodes that are characterized by command hallucinations to kill the infant or delusions that the infant is possessed.

Psychotic symptoms can also occur in severe postpartum mood episodes without such specific delusions or hallucinations.
Postpartum mood (major depressive or manic) episodes with psychotic features appear to occur in from 1 in 500 to 1 in 1000 deliveries and may be more common in primiparous women (1st Pregnancy).

The risk of postpartum episodes with psychotic features is particularly increased for women with prior postpartum mood episodes but is also elevated for those with a prior history of depressive or bipolar disorder (especially bipolar 1 disorder) and those with a family history of bipolar disorders.
A postpartum episode with psychotic features, increases the risk of recurrence, with each subsequent delivery is between 30 and 50%.

Postpartum psychotic episodes must be differentiated from delirium occurring in the postpartum period, which is distinguished by a fluctuating level of awareness or attention.

Diagnosis of Delirium requires a baseline or mental functioning, an observable sudden change in mentation, and caused by an organic process.

The postpartum period is unique with respect to
- the degree of neuroendocrine alterations
- the degree of psychosocial adjustments
- the potential impact of breast-feeding on treatment planning
- the long-term implications of a history of postpartum mood disorder on subsequent family planning
Disorders with a cognitive component (OCD) have an “insight” specifier in the DSM 5 for rating patients’ insight into their disorder-related beliefs.

- Some patients with OCD may know that their house won’t burn down even though they feel compelled to check multiple times that the stove is off before leaving (“good or fair” insight);
- Some may believe that the house probably will burn down (“poor” insight);
- Some may be absolutely convinced that the house will burn down (“absent insight/delusional” beliefs).

Patients with delusional beliefs as a symptom of one of these disorders are sometimes diagnosed with a psychotic disorder, which may lead to inappropriate treatment with antipsychotic medication only (Phillips, 2013).

The specifier will emphasize that patients with delusional beliefs that may occur as a symptom of these disorders do have OCD. Those with OCD should be treated with an SSRI rather than antipsychotic monotherapy (Phillips, 2013).

http://www.psychiatry.org/dsm5.

Recommendation

- Mothers suffering from postpartum mood disorders should
  - Be treated by a mental health professional (not just your regular doctor)
  - Be patient
  - Be willing to try different methods of treatment
    - Different types of therapy
    - Different medications
    - Trying a sleep and exercise program
    - Nerve stimulation
    - Trans-cranial magnetic stimulation.”
**Recommendations**

- Family, friends and healthcare providers need to be able to approach areas of potential risk by:
  - gently, but firmly, asking direct questions encourage open communication
  - avoid overreacting to responses
  - Implement immediate interventions

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**Summary: Prevention**

- **NICE recommends**
  - Women be proactively screened for mental health problems and high-risk patients identified.
  - That when women present for booking and at the postnatal check, health professionals (including midwives, obstetricians, health visitors and GPs) should ask questions to screen for depression and anxiety

- **At the first contact they should also ask about**:
  - Past or present severe mental illness including schizophrenia, bipolar disorder, psychosis in the postnatal period and severe depression.
  - Previous treatment by a psychiatrist/specialist mental health team including inpatient care.
  - A family history of severe perinatal mental illness in a first-degree relative.
  - SIGN recommends that enquiry about depressive symptoms should be made (as the minimum) on booking and postnatally at 4-6 weeks and 3-4 months.
  - Women identified as at high risk of developing severe depression, or with a history of severe mental illness, should be referred to secondary care mental health services.

*Antenatal and postnatal mental health: clinical management and service guidance, NICE Clinical Guidelines (December 2014)*
*Management of perinatal mood disorders: Scottish Intercollegiate Guidelines Network - SIGN (March 2012)*
Postpartum mood disorders pose health risks for mother and infant and impair family relationships.

Mental health assessments should be incorporated into postpartum care.

Screening and counseling for disorders such as postpartum depression (PPD), anxiety, and obsessive-compulsive disorder (OCD) can prevent potentially serious consequences is needed.

Healthcare providers should be proactive in identifying women at risk.

Healthcare professionals should providing appropriate counseling, referral, or both.

Support Organizations

- Postpartum Progress
- Postpartum Support International
Panel Discussion

- Participants Stories
- Questions regarding experiences
  - Level of prior education for mother and family
  - Types of assessment
  - Identified support
  - Identified support for partner/family
  - Provider/treatment
  - Level of communication
- Participants expectation for audience awareness