Perinatal Mood and Anxiety Disorders

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Disclosures

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Objectives

1. State the frequency of PMADS and discuss risk factors/contributing factors.
2. Describe how PPD, PPA, PPP, and PPPTSD present in an outpatient setting.
3. Discuss the differences between intrusive thoughts, obsessive-compulsive thoughts and psychotic thoughts.
4. Discuss how to use a functional analysis to assess for PMADs.
5. Describe treatment options including psychotherapy and psychotropic medications.

PMADs: The Basics

Perinatal Mood & Anxiety Disorders ("PMADs")

Mood Disorders
(depression, bipolar disorders, postpartum blues, etc.)

Anxiety Disorders
(panic, generalized anxiety, OCD, PTSD, etc.)

Psychosis
(schizophrenia, mania, depression, etc.)

About PMADs

- 70-80% of new mothers will experience the baby blues
- 15-20% will experience postpartum depression
- 10-25% will develop an anxiety disorder
- 0.1-0.2% will develop postpartum psychosis

(PSI, 2018)

- Of all women who will experience depression in their lifetimes, **50%** will have their first episode after having a baby. (APA, 2018)

- When do symptoms present?
  - Anytime within the first 12 months, often in the first 2-4 months postpartum, sometimes during pregnancy.

What is the Risk of Developing PMADs?

Like most mental health conditions, a previous history of psychiatric illness increases risk for developing PMADs.

- No history of psychiatric illness: *10-20%*
- History of major depression: *25%*
- History of depression during pregnancy: *35+%*
- History of bipolar disorder or postpartum depression:
  - *23+% if meds continued*
  - *66+% if off meds*
  - *17+% will be severe illness*
- History of postpartum psychosis:
  - *30-90%*
  - *29+% will be severe illness*

Several Factors May Increase Risk of PMADs

- Past psychiatric illness
- Depression during pregnancy
  - A very strong predictor of postpartum depression
- Early postpartum (first 3 months)
- Pregnancy complications
  - Pre-eclampsia
  - Hyperemesis gravidarum
  - Gestational diabetes
  - Pre-term birth
  - C-section delivery
  - Fetal stress
  - Postpartum hemorrhage
- Socioeconomic stress
- Younger age of mother
- Limited social supports
- Breastfeeding challenges
- Colic in the newborn

Causes of PMADs

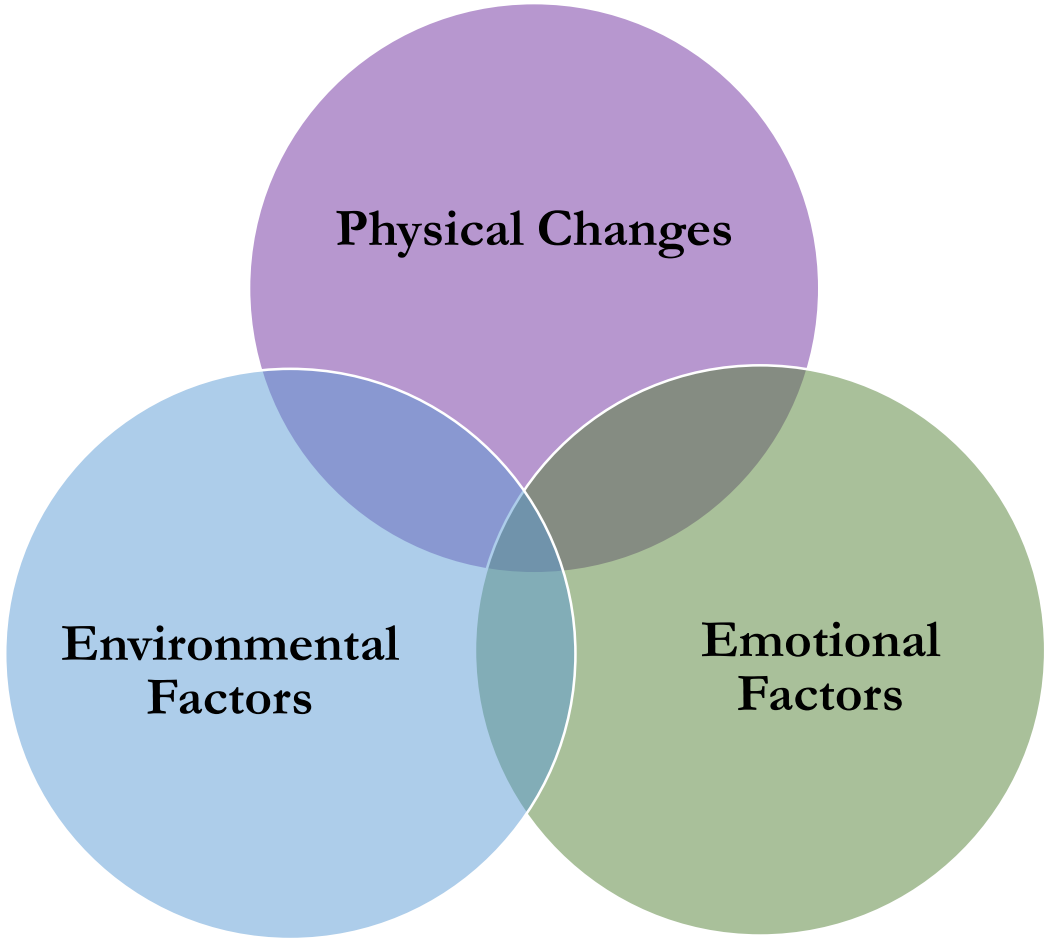
The specific cause of PMADs is unknown, but it is likely multifactorial.

Physical changes such as a dramatic drop in progesterone, thyroid dysregulation, changes in blood volume and pressure, changes in metabolism and immune functioning may all contribute to mood changes.

Emotional factors such as anxiety about caring for the newborn, sleep deprivation, a sense of loss of control, or a struggle with one's sense of individual identity, also may contribute to the onset of depression and anxiety.

Environmental factors such as a colicky baby or "demanding" older child, financial problems, difficulty with breastfeeding, relationship problems, or other stressors may play a role as well.

Discontinuation of an antidepressant during, or just prior to pregnancy, increases the risk of PMADs. Up to 68% of women who stop medication will relapse within a few weeks. (Cohen, et al., 2006)



PMADs Screening Recommendations

The American Congress of Obstetricians & Gynecologists (ACOG) & Postpartum Support International (PSI) suggest the following guidelines for screening:

- At first prenatal visit
- At least once in second trimester
- At least once in third trimester
- At 6-week postpartum obstetrical visit (or first postpartum visit)
- Repeated screening at 6 and 12 months in OB and primary care settings
- At 3, 9, and 12 month pediatric visits

The PHQ9 and EPDS are validated instruments for use with a perinatal population.

The EPDS has the advantage of not having somatic items (which, with a perinatal population can lead to False Positives).

Diagnosis & Assessment

The Baby Blues

The **Baby Blues** are characterized by mild, transient symptoms of depression/anxiety with *no impairment in functioning*. It occurs during the first 2 weeks postpartum in up to **80% of women**, *(PSI, 2018)*.

Symptoms tend to peak around the 4th or 5th day & gradually remit on their own.

The Baby Blues do not indicate pathology & no treatment is needed other than family support.

Severe blues can be difficult to distinguish from early signs of postpartum depression or psychosis.

Typical Symptoms:

- Mood reactivity
- Irritability
- Anxiety
- Tearfulness
- Trouble sleeping
- Poor concentration
- Easily overwhelmed

Postpartum Depression

Postpartum Depression (PPD) is much more serious than the Baby Blues because it impairs the mother's functioning (her ability to care for herself, the baby and other children and/or to perform other daily tasks).

It affects approximately **15%** of women, *(PSI, 2018)*.

Symptoms typically begin 2 weeks to 4 months after delivery.

- However, some women (for reasons unknown) have a delayed onset – so symptoms can occur any time within the first year.

Typical Symptoms:

- Intense irritability, anger, or mood swings
- Sad mood
- Crying spells
- Insomnia
- Loss of appetite or overeating
- Overwhelming fatigue
- Loss of interest
- Difficulty making simple decisions
- Withdrawal from family & friends
- Guilt & negative thoughts about her mothering
- Ambivalent or negative thoughts towards the baby
- Thoughts of harming herself or the baby

Postpartum Anxiety

10-22% of women will experience **Postpartum Anxiety** (PPA), which can manifest as obsessive thinking, excessive worries, panic attacks, severe insomnia, distorted thinking, and/or intrusive thoughts. (PSI, 2018)

Intrusive Thoughts: having scary thoughts about the baby's safety or images of harming the baby.

- These should be assessed thoroughly, but in most cases, they do not indicate that the baby is unsafe or that the mother is at risk for following through with the thoughts.
- **40% or more** of mothers with PPD or PPA report having these types of thoughts. (Kleinman & Wenzel, 2010)
- Women are often ashamed of these thoughts or worried that CPS will become involved if she reveals them to someone.

With PPA, the woman's mood is not necessarily low or depressed & thus her symptoms are often not picked up on screening tools.

Typical Symptoms:

- Racing, ruminative thoughts
- Inability to relax
- Poor sleep
- Fatigue
- Irritability
- Excessive worry
- Excessive checking on baby

Common Themes of Anxious Thoughts:

- The baby dying in its sleep
- Harming the child with a knife or by shaking
- Accidents or mistakes leading to injury or death
- Sexual misconduct involving the child
- Contamination

Intrusive Thoughts v. Dangerous Thoughts

- “You are having thoughts that are scary to you?”
  - “Are you having any thoughts that are scaring you about hurting yourself or your baby?”
  - “Are you having any troubling thoughts that seem to come out of nowhere over and over again?”
- Thoughts make her uncomfortable – are ego-dystonic
- Being worried/upset about these thoughts is a good sign
- https://postpartumstress.com/admin/wp-content/uploads/2012/02/ScaryThoughts-1.pdf

Private Self v. Public Self

The bottom line…

Postpartum depression and anxiety are the result of a <u>huge life transition</u>.

…It’s not just about hormones.

Postpartum Psychosis

Postpartum Psychosis (PPP) is an acute, severe illness occurring in **1-2 women/1,000** births *(PSI, 2018)*.

- It is notable for its abrupt onset; 1/3 of women have symptoms by postpartum day 3.

Thoughts or attempts to harm baby or self are often relayed as thoughts that the baby would be "better off" dead or if mom was not around.

- These thoughts may be due to religious delusions, the mother's belief that she is incapable, or that the baby is "defective."

Typical Symptoms:

- Confused & disorganized thoughts
- Extreme mood lability
- Insomnia
- Paranoia
- Hallucinations & delusions
- Thoughts of, or attempts to, harm self or baby

Differentiating OCD from Psychosis

Postpartum OCD

- Thoughts are ego-dystonic
- Distressed by thoughts
- Avoid objects/triggers or being with their newborn
- Very common
- Minimal risk of harm to baby

Postpartum Psychosis

- Thoughts are ego-syntonic
- May not be distressed by thoughts
- May not show avoidant behaviors
- Uncommon
- High risk of harm to baby

Postpartum psychosis is a **PSYCHIATRIC EMERGENCY** & requires immediate assessment by a qualified mental health professional.

In one study, up to 5% of PPP women committed suicide & 4% committed infanticide. (Friedman & Resnick, 2007)

Most women (72-80%) with postpartum psychosis have psychosis as a feature of bipolar disorder or schizoaffective disorder.

Postpartum PTSD

- Approximately **9-17%** of women experience **Postpartum PTSD** following childbirth (PSI, 2018, Shaban et al., 2013).

- Symptoms include those typical for PTSD and include:
  1. intrusive distressing memories/dreams of the event
  2. dissociative reactions (e.g., flashbacks)
  3. avoidance
  4. feelings of detachment or estrangement from others
  5. inability to remember important aspect of the event
  6. distorted cognitions that lead the person to blame themselves or others for the event
  7. irritable behavior and angry outbursts (with little or no provocation)
  8. hypervigilance
  9. exaggerated startle response
  10. sleep disturbance

What is Traumatic Childbirth?

Traumatic childbirth is often overlooked so there is a shortage of information. Some reports indicate that **up to 34%** of women report having a traumatic birth. And the rates are even higher for high-risk mothers. (Beck, Watson Driscoll & Watson, 2013)

"…an event occurring during the labor and delivery process that involved actual or threated serious injury or death to the mother or her infant. The birthing woman experiences intense fear, helplessness, loss of control and horror." (Beck, 2004)

Factors Contributing to Postpartum PTSD

1. Previous history of PTSD or exposure to traumatic events.
    - Women who have experienced a previous trauma, such as rape or sexual abuse, are at a higher risk for experiencing postpartum PTSD.

2. A complicated birth (*for baby or mom*). For example:
    - Prolapsed cord
    - Unplanned C-section
    - Use of vacuum extractor or forceps
    - Baby going to NICU/Special Care Nursery
    - Severe physical complication or injury (e.g., severe postpartum hemorrhage, unexpected hysterectomy, severe preeclampsia/eclampsia, or perineal trauma)

3. Feelings of powerlessness, poor communication and/or lack of support and reassurance during the delivery.

In the eye of the beholder…

- Trauma, and particularly traumatic childbirth, must be viewed through the patient's perspective.
  - **What will be traumatic to one patient, will not to another.**
  - **What would be considered a successful L&D to the medical professional, could be traumatic to the patient.**

Functional Analysis for PMADs

Screen for symptoms during pregnancy **and** postpartum

Ask about:

- When (and how) the baby was born
  (to understand how long the sx have been present & when they started)
- Daily mood
  - Depressed mood often characterized by feeling empty, disengaged, uninterested in the baby….but not always
  - Anxious mood can be characterized by irritability, impatience, moodiness OR excessive worry about the baby
- Whether she has an adequate support system
- Feeding/nursing/breastfeeding
- Daily activities and parenting
- Sleep (can she sleep when given the opportunity?)
- Feelings of being overwhelmed, helpless, hopeless
- Poor appetite often presents as a lack of interest in food, also is connected to feeling overwhelmed ("I can't find time to eat")
- Thoughts of suicide
- Thoughts of violence
- Violence or abuse in the home

Clinical Take-Aways

Listen for:

- “I don’t feel like my normal self.”
- “I’m not doing a good job.”
- “I’m so tired but I can’t sleep.”
- “I have no one to help me.”
- “This isn’t what I expected.”
- Difficulty with feeding (breast or bottle) and/or worries about baby’s weight gain

Ask: **“How are you coping?”** (NOT “How are you doing?”)

Quick Thoughts on Medications

- There is a large body of research that indicates that antidepressants are safe during pregnancy & lactation. (MGH Center for Women's Health, 2018)

- Patients should never go off their psychiatric medications "cold turkey."
  - Exception…Depakote which needs an urgent plan.

- Yes – there are risks (as there are with any medication). However, we must weigh the risks-benefits of untreated depression & anxiety, which we know have prenatal & long-term consequences to mother & baby.

- Encourage moms not to make decisions based on what they read on the internet, or have heard from a friend, & instead consult their care provider.

Questions?

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