ICEA
International Childbirth Education Association

ICEA Position Paper

Perinatal Mood and Anxiety Disorders

Position

Pregnancy, birth and postpartum are times of significant changes for a woman and family. Hormones, loss of sleep, changes in family dynamics and stress/inflammation may contribute to mood and anxiety disorders. International Childbirth Education Association (ICEA) recognizes that these disorders are common and treatable. Traditionally education was related solely to postpartum depression. It is now known that depression is only one component of a range of mood and anxiety disorders taking the name, Perinatal Mood and Anxiety Disorders (PMAD). Promoting awareness of this range of disorders, enables clients and their caregivers to recognize the various symptoms and initiate coping strategies if this becomes a part of the perinatal/postnatal experience.

Background

Thoughts of pregnancy and parenthood often prompt images of excitement and bliss; the joy of having a new baby. Overlooked are the realities of lack of sleep, caring for a crying baby, and the decreased time for self-care. Rarely do women hear about the possibilities and realities of experiencing a perinatal mood or anxiety disorder. Yet, according to Postpartum Support International (PSI), women in their childbearing years account for the largest group of Americans with depression. It is the most common complication of childbirth. To put it in perspective, there are as many new cases of mothers suffering from maternal depression each year as women diagnosed with breast cancer. Despite this prevalence, maternal depression goes largely undiagnosed and untreated. The American Academy of Pediatrics has noted that maternal depression is the most under diagnosed obstetric complication in America. They go on to state that "Every year, more than 400,000 infants are born to mothers who are depressed… Postpartum depression leads to increased costs of medical care, inappropriate medical care, child abuse and neglect, discontinuation of breastfeeding, and family dysfunction and adversely effects early brain development." (2015 White & Smith, AAP 2016) Not recognizing, addressing, treating and educating about Perinatal Mood and Anxiety Disorders negatively impacts the health of women, the family and society.

Definition

Baby Blues and Postpartum Depression are what people tend to think about when a woman is experiencing challenges after having a baby. PMAD should be separated from the Baby Blues which affect up to 80% of women after giving birth. Baby Blues, also called postpartum blues, are the result of hormonal changes and the stresses of being a new parent. This condition is transient; it comes on around 2-3 days after birth and lasts around 2 weeks. During this time, a women feels overwhelmed, tearful, exhausted, hypo-manic or irritable. With support, rest and good nutrition, Baby Blues resolve naturally. (March of Dimes 2017)

To differentiate, perinatal mood and anxiety disorders are not limited to the time immediately following birth. In one study of 10,000 women, 21% qualified as having postpartum depression. Of that 21%, first onset symptoms were evaluated. 26.5% emerged prior to pregnancy (long term

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chronic depression cases). 33.4% emerged DURING pregnancy. 40.1% emerged in the postpartum period. This translates to 60% of those who developed PMAD began having symptoms during pregnancy. Additionally, the symptoms are not limited to depression (PSI 2017). PMAD may exhibit as any of the following:

- Psychosis- Thought Disorder or Episode
- Major Depressive Disorder
- Bi-Polar Disorder
- Generalized Anxiety
- Panic Disorder
- Obsessive Compulsive Disorder
- Post Traumatic Stress Disorder

According to the National Institutes of Health, 2016, diagnosis of DSM-5 is not specific to PMAD but rather the subject must meet the criteria for a Major Depressive Disorder with peripartum onset; the specifier applied is during pregnancy or within four(4) weeks of birth. However, research shows that PMAD may occur up to twelve(12) months postpartum. Therefore numerous cases of PMAD may be missed or misdiagnosed.

For 10-25% of women, the experience they have is beyond mild and transient hormonal swings. They experience depression, anxiety, OCD or other mood disorders that significantly impact their life and ability to cope.

In Perinatal events, women experience similar symptoms of general mood disorders including:

- Agitated depression
- Disinterest in activities for self
- Hopelessness
- Guilt
- Tearfulness
- Irritability
- Anger/rage
- Insomnia

In the perinatal period, there are additional experiences such as:

- Always an anxious component
- Anhedonia usually not regarding infant and children
- Looks "Too good"
- Often highly functional
- Hidden Illness
- Intense shame
- Passive/Active suicidal ideation

It is important to consider two specific factors for perinatal PMAD. First, the case where "mom looks too good." Women who are dressed to perfection, are wearing make-up with beautifully done hair and the baby is also made to look "perfect" are often times compensating for their feelings of inability or suffering from postpartum OCD and/or anxiety. The other statement to be aware of is, "I just don't feel like myself." Women will not report that they feel depressed or anxious but rather that they do not feel normal.

Risk Factors

Factors associated with increased risk of perinatal depression and anxiety include:

- A history of depression, anxiety, or other mental health problems
- Family history of depression, anxiety, or other mental health disorders
- History of severe PMS
- Traumatic pregnancy or birth experience
- Multiple births, including twins or higher order multiples
- History of pregnancy/infant loss
- Poor partner relationship quality
- Lower socioeconomic status
- Low levels of social support
- High levels of stress
- Unintended pregnancy*
- Teen pregnancy
- Military service
- Domestic violence
- Nutritional deficiencies
- History of substance abuse
- Endocrine dysfunction

**over 50% of pregnancies annually in the US are considered unplanned or unintended*

Although the above factors increase the risk of PMAD, it can occur in any woman who is pregnant or has recently given birth. It is becoming more evident through Psychoneuroimmunology (PNI) that the greatest factor for PMAD is inflammation. Cytokines increase during the third trimester of pregnancy leading to an increase in systemic inflammation. Inflammation, compounded with rising stress, increases the risk for perinatal and/or postpartum mood and anxiety disorders. (Kendall-Tackett 2016)

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In addition to the effects of depression, women are at risk for other adverse outcomes. Prenatally, these include:

- Poor nutrition
- Poor prenatal medical care
- Risk of suicide
- Harmful health behaviors (e.g., smoking, misuse of alcohol or other substances)

These effects affect the fetus to varying degree depending on the duration and intensity of the disorder.

Postpartum effects are typically disruptions in the maternal-infant interactions leading to delays in cognitive and language development, and/or social engagement, stress level, and fear reactivity. (Kendall-Tackett 2016)

Post Traumatic Stress Disorder

Post Traumatic Stress Disorder (PTSD) is often characterized by persistent re-experiencing of traumatic events (dreams, nightmares, flash backs) and avoidance of associated stimuli. Women experiencing PTSD postpartum may exhibit persistent symptoms of increased arousal such as difficulty sleeping, hyper vigilance, exaggerated startle, and difficulty concentrating. This disorder has prevalence rates that range from 1.5%-5.6% (AWHONN 2015) It often occurs after a traumatic birth or a birth that includes high levels of medical interventions, long and painful labors, and/or perceived lack of support. Risk factors also include perinatal depression/anxiety, history of trauma and/or a history of mental health problems.

Factors that Exacerbate PMAD

- Pain
- Lack of Sleep
- Abrupt discontinuation of breastfeeding
- Childcare stress
- Relationship stress
- Neonatal death, stillborn, selective termination, elective abortion
- Complication in pregnancy, birth or breastfeeding
- Health challenges in baby or self
- Temperament of baby
- Age related stressors (adolescence and perimenopaus)
- Climate stressors (seasonal depression or mania)
- Perfectionism/high expectation (“Supermom Syndrome”)
- Returning to Work

Recommendations

Pregnancy and postpartum depression along with mood and anxiety disorders can be managed and treated with proper screening and referral. The American Congress of Obstetricians and Gynecologists (ACOG) 2015 Committee Opinion recommends women be screened at least once during the perinatal period for depression and anxiety. Additionally, ACOG recommends that clinical staff in obstetrics and gynecology practices be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both.

The American Academy of Pediatrics, based on a 2010 clinical report, encourages pediatric practices to screen mothers for postpartum depression, use community resources for the treatment and referral of the depressed mother, and provide support to the mother-child relationship.

The Association of Women’s Health, Obstetric and Neonatal Nurses recommends that all women be screened for mood and anxiety disorders. Nurses are in key positions to screen women, to provide education regarding perinatal mood and anxiety disorders to pregnant and postpartum women and their families, and to ensure appropriate referrals.

The most common screening tools are the Edinburgh Postnatal Depression Scale (EPDS), Postpartum Depression Screening Scale (PDSS), and the Patient Health Questionnaire (PHQ-9). Any woman who screens positive should be referred to an appropriate provider for treatment and/or medication.

In addition to the screening tools, PSI recommends collaborative screening, such as: screening both mom and partner at the initial prenatal visit and once per subsequent trimesters. Additional screening during childbirth education classes, at discharge, and in the pediatric clinic may be also be considered.

Treatment

A variety of treatment options are available. Many women don’t seek treatment because they are concerned that treatment options require medication. Psychotherapy, particularly, cognitive-behavioral and interpersonal psychotherapy are shown to have satisfactory results. Psychosocial interventions such as peer support and nondirective counseling may also have merit. A variety of non-pharmacological treatments are available and can be explored with an appropriate care provider.

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Adult education may introduce the acronym, SNOWBALL (White and Smith 2016)

- **S**leep
- **N**utrition
- **O**mega-3
- **W**alk
- **B**aby breaks
- **A**dult time
- **L**iquids
- **L**aughter

This reminder of common self-care may have a significant impact on depression and PMAD.

Breastfeeding and Depression

The relationship between breastfeeding and depression continues to need study. Many studies show that depression and mood disorders are reduced or less prevalent in breastfeeding women. Kathleen Kendall-Tackett (2015) states that breastfeeding may heal past trauma. Other studies find that for some women breastfeeding may exacerbate the mental health symptoms. The decision to breastfeed or wean should be made with careful consideration and under guidance from a health care professional and a lactation consultant.

Pharmacological treatments can be safe with breastfeeding. For medication information and effects on a breastfeeding infant, it is important to obtain information from a reputable source such as: Lactmed http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT, the Infant Risk Center http://www.infantrisk.com/ or Mother to Baby www.mothertobaby.org Each of these resources are available for professionals and parents for information and current research on medications and herbal therapies.

Role of the Allied Professional

Doulas, lactation specialists and childbirth educators are in the unique position to increase awareness of mood and anxiety disorders during and after pregnancy. Current information and resources provided by these birth professionals increase client exposure to PMAD symptoms and available treatments facilitating early awareness and intervention.

During classes and consults, it is appropriate to provide clients and their partners access to screening tools such as the EPSD; however, any screening tool should be paired with resources and referrals for those who screen positive. Treatment, counseling or therapy are outside the scope of practice for most allied birth professionals. However, remaining connected to the local healthcare community, will make the birth professional an excellent source and advocate for PMAD awareness.

A Final Note

Pregnancy and the postpartum experience impacts the entire family. Studies have shown that up to 10% of men will experience 'male postpartum depression'. But what about partners in same sex relationships or those with an adoption plan? ICEA recognizes that any individual going through the transition of parenthood has the potential to experience some type of change in mental health. Thus it is imperative to remember the whole family when discussing and educating about the expectations and realities of parenthood.

References

American Congress of Obstetricians and Gynecologists (2015) Screening for Perinatal Depression 2015 ACOG Committee Opinion Number 630 available at http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Screening-for-Perinatal-Depression

AWHONN Position Statement 2015 Mood and Anxiety Disorders in Pregnant and Postpartum Women JOGNN Vol 44 Issue 5 PP 687-689

Earls, Marian F 2015 Incorporating Recognition and Management of Perinatal and Postpartum Depression into Pediatric Practice Pediatrics 135 (4) e1105

Jacobson, H (2016) Healing Breastfeeding Grief: How mothers feel and heal when breastfeeding does not go as hoped.

Kendall-Tackett (2016) A Breastfeeding-Friendly Approach to Postpartum Depression

March of Dimes (2017) Baby blues after pregnancy

McKelvey, M (2013) The Other Mother: Anarrative Analysis of the Postpartum Experiences of Nonbirth Lesbian Mothers. Doctoral Dissertations. 33 http://digitialcommunications.uconn.edu/dissertations/33

Nauert, R (2015) Postpartum Depression in Adoptive Parents Psych Central

Postpartum Support International 2017 accessed at www.postpartum.net

White, AR & Smith E 2016 The Breast is Best Paradigm and Maternal Mental Health: Best Practices in Psychotherapy and Lactation PSI International Conference

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