Perinatal Mood and Anxiety Disorders

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Teni Davoudian, PhD, ABPP, is a board-certified health psychologist specializing in reproductive mental health. In 2014, Dr. Davoudian obtained her PhD in Clinical Psychology from Marquette University. Currently, Dr. Davoudian is an Associate Professor in the Departments of Obstetrics & Gynecology and Psychiatry at Baylor College of Medicine and serves as the Director of Psychological Services within Baylor's Division of Reproductive Psychiatry. She provides psychotherapy and assessments to perinatal, fertility, uterine transplant, and perimenopausal patients.

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Disclosures/Conflicts of Interest

- PENDING INPUT FROM PRESENTER:
- I have no conflicts of interest to disclose.
- Generative AI was not used for the development or content of this presentation.

Learning Objectives

1. Identify risk and mitigating factors of perinatal mood and anxiety disorders.
2. Discuss appropriate screening measures for perinatal mood and anxiety disorders.
3. Design evidence-based treatment plans for perinatal mood and anxiety disorders.

Perinatal Mood and Anxiety Disorders (PMADs)

Depressive spectrum:

- Baby blues
- Antenatal depression
- Postpartum depression

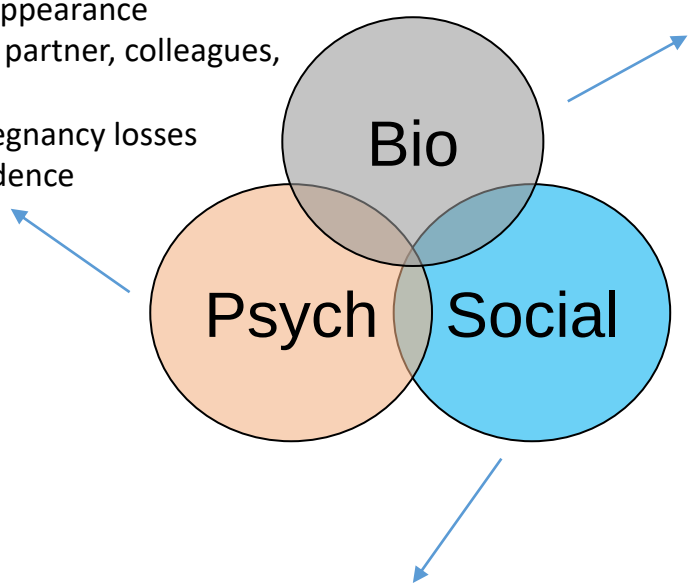
Anxiety spectrum:

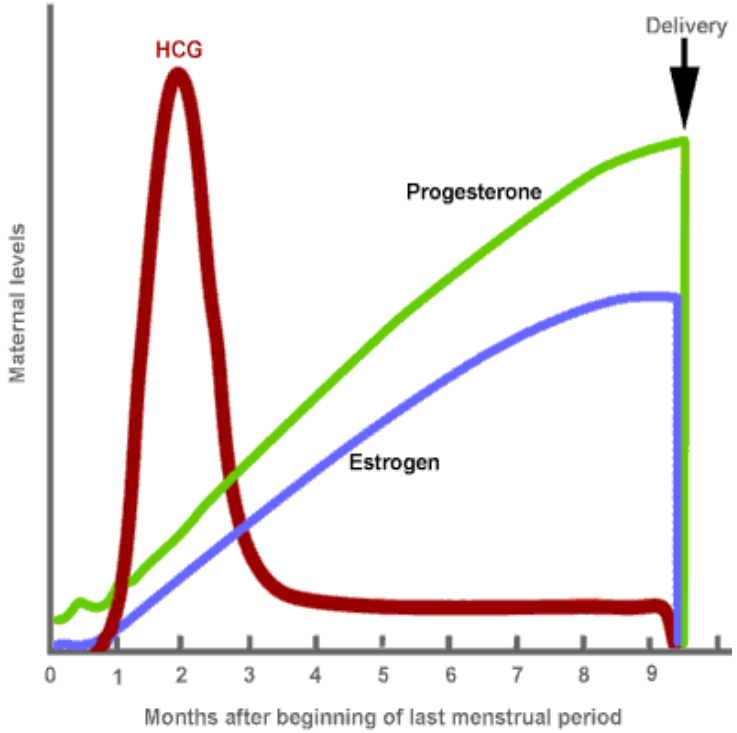
- Generalized anxiety
- OCD
- Panic Disorder
- PTSD

Postpartum psychosis

Etiology of PMADs

- Exacerbation of underlying psychopathology
- Anxiety about pregnancy & motherhood
- Intergenerational issues
- Depression about physical appearance
- Changing relationships with partner, colleagues, friends
- Grief related to previous pregnancy losses
- Grief about loss of independence





- No/little paid maternity and/or paternity leave
- Mothers expected to resume total self-care within a few days
- Financial concerns
- Limited social support

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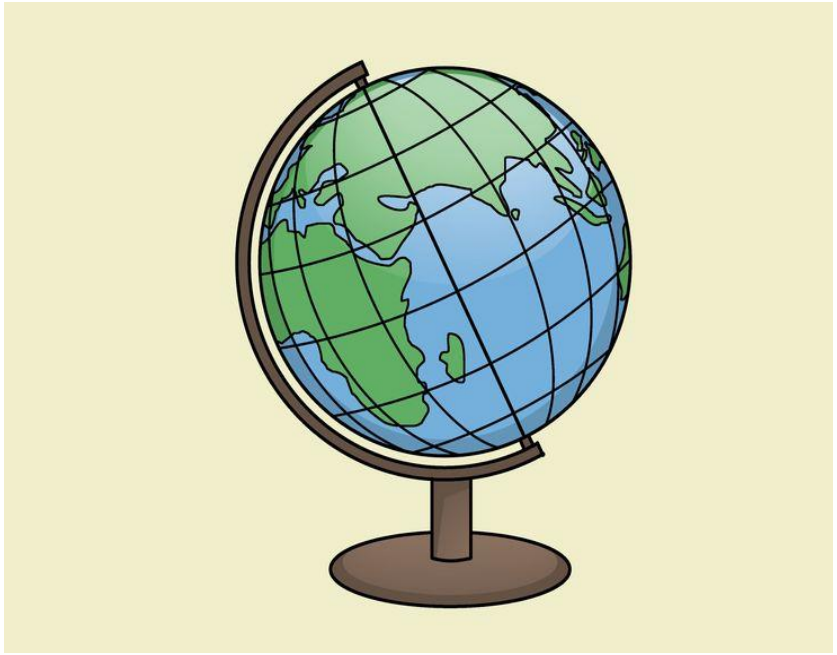
Postpartum Across the Globe

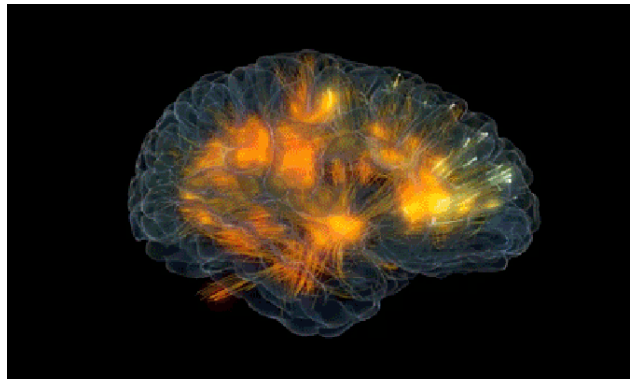
***Zuo Yue* -China**
*M*onth-long postpartum recovery to restore the balance of yin (properties of female, dark, cold) and yang (properties of male, bright, hot) within their bodies.



Sam Chul - Rural Korea
Thick rope referred to as the fetal line is hung over the doorway of homes to signify that the new mother is in social seclusion.

***La Cuarenta*- Mexico**
40-day rest period that includes protective seclusion; proscription from household chores, shopping, and sexual intercourse; and assistance and education from female relatives.

Pregnancy & Postpartum Neuroplasticity



Synaptic pruning: Eliminates certain connections between brain cells to encourage the facilitation of new connections.

Reallocate cognitive resources to the parts of the brain that control "theory of mind"

Adaptations that enable the development and survival of the offspring:

- Linked to aspects of maternal caregiving
- Related to mother-infant bonding
- Mother becomes more protective

Same adaptations confer a vulnerability for the development of mental disorders

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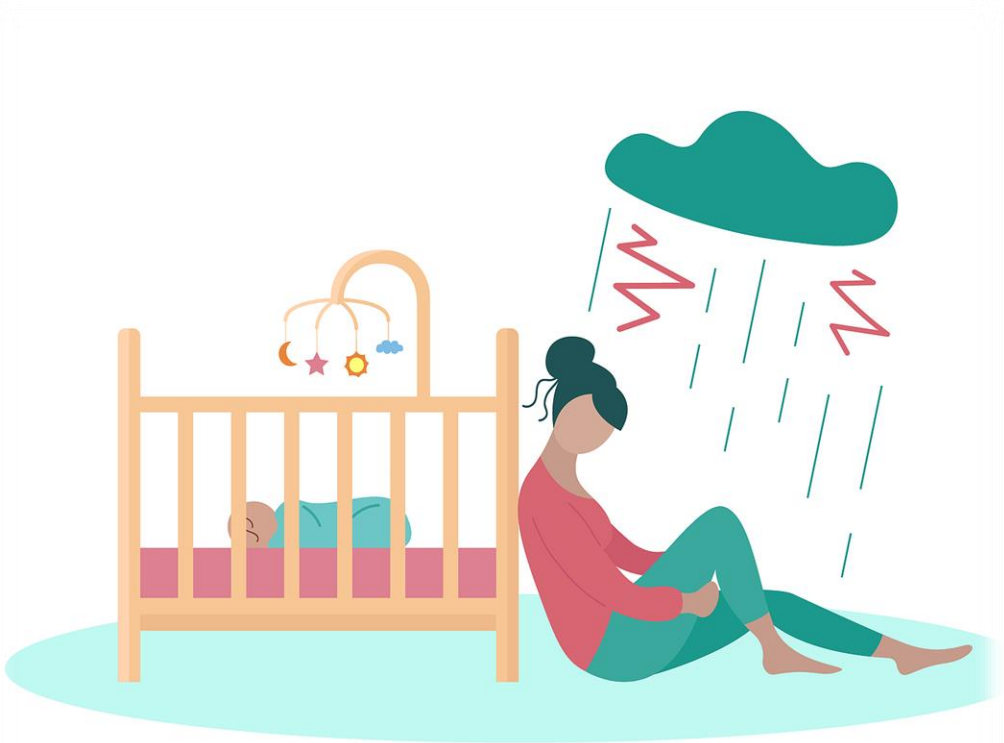
Implications of Untreated PMADs

Prenatal Care	• Fewer prenatal visits • Inadequate maternal weight gain/poor nutrition • Poor maternal self-care • Possible substance use
Obstetrical Complications	• Intrauterine growth restriction • Miscarriage • Preeclampsia • Preterm labor and birth
Neonatal Outcomes	• Low birth weight • Higher levels of reactivity • Disorganized sleep patterns • Difficult temperament • Neuroaffective issues
Parenting	• Physical and psychological unavailability • Limited sensitivity toward infant's needs • Overly sensitive and reactive parenting (anxiety) • Impaired bonding

PMADs Risk Factors

- Personal/familial mental health history
- History of hormonal sensitivities
- Childhood sexual trauma
- Negative attitude or ambivalence toward pregnancy
- Intimate partner violence
- Limited social support
- Multiparity
- Obstetrical complications
- NICU stay
- Characterological patterns (neuroticism, perfectionism)
- Spouse deployment



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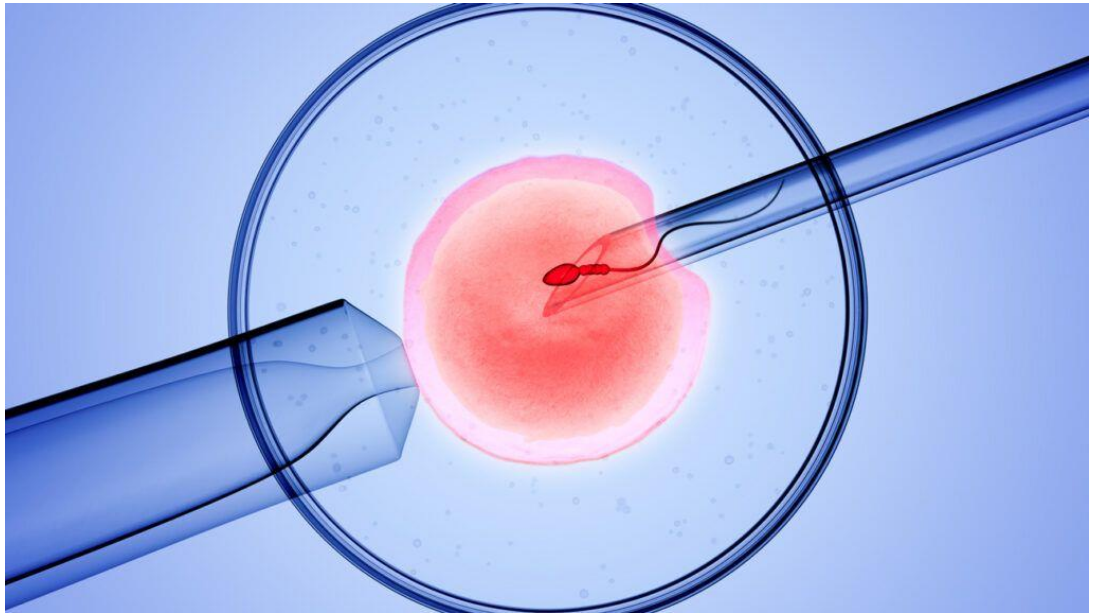
Assisted Reproduction



- No significant difference in perinatal anxiety and depression in medically assisted conception groups and control groups

- Assisted reproduction aspects that may impact mental health
  - Lower relationship satisfaction due to stressors of ART
  - Multiparity
  - More reproductive traumas?
  - Idealization of parenting?

Parents of Medically Fragile Infants

- Separations from baby/limitations on touch
- Stressors of NICU environment
- Grieving loss of "healthy" infant
- Changes in hopes and expectations
- Burden of updating family and friends
- Emotional disconnection from parents with healthy infants
- May not be able to recruit childcare from support network given infant requires advanced care
- Screen for PMADS + PTSD

NICU Environment

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Breastfeeding & PMADs

- Increases, decreases, or does not impact risk of PMADs?

- Systematic reviews and meta-analyses yield conflicting evidence
  - Discordance between breastfeeding expectations vs actual experience
  - Lack of support and advice from healthcare professionals
  - Intention to breastfeed

- Referral to lactation consultants

- Compassionate care for mothers who do not desire to or are unable to breastfeed
  - Avoid demonizing formula-feeding!

- Fedisbest.org

Baby Blues or Postpartum Depression?

Baby Blues	PP Depression
Rate: 80%	**Rate:** 10-15%
Onset: 3-5 days postpartum	**Onset:** 2 weeks – 6 months postpartum
Course: Transient, taper off by week 2 or 3 postpartum	**Course:** Symptoms persist for at least 2 weeks
Sx: Feeling overwhelmed, uncertain, irritable, mood swings, lonely Mother still able to care for child	**Sx:** Consistent sadness, worthlessness, lowered self-esteem, hopelessness, lack of interest in baby, SI Symptoms interfere with ability to care for self and child
Recovery: With support, rest, and good nutrition, the Baby Blues resolve naturally	**Recovery:** Symptoms persist despite support, rest, and nutrition

Perinatal Depression

- 1 in 7 women experience depression during pregnancy and/or postpartum
- Higher rates among:
  - Adolescents
  - Immigrants
  - Low SES
  - Hispanic and Black women
  - Sexual minorities

- Screening for perinatal depression, particularly in women of color and women from disadvantaged backgrounds, is imperative!
- DSM V specifier “with peripartum onset”

Perinatal Suicidality

- 15% report thoughts of self-harm during pregnancy and postpartum
- Leading cause of death in perinatal women

Obstetrical Risks

- Uninteded/unwanted pregnancy
- Fetal demise (3-fold increased risk of suicide)
- Severe vaginal laceration

Social Risks

- Younger maternal age
- Intimate partner problems
- Low income
- Low education level
- Non-Caucasian
- Discrimination and inequities

Mental Health Risks

- Psychiatric hospitalization within 1 year postpartum
- Insomnia
- History of suicide attempts
- IPV
- Depression
- Substance use
- Postpartum psychosis

Postnatal Depression - Leanne's Story (NHS England)

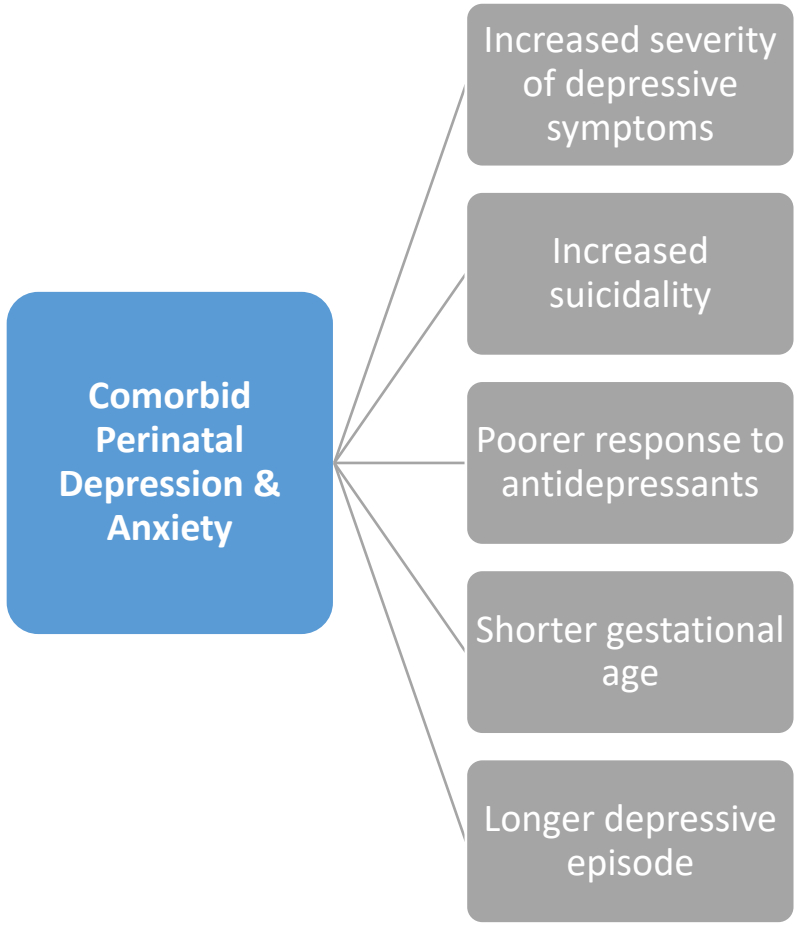
Case #1- Isabella

- What are the risk factors?
- What other info would you like to know?
- What is the diagnosis?
- What is your treatment plan and why?

- 38 yo married Hispanic woman
- 3 weeks postpartum with first child
- Delivered vaginally at 35 weeks gestation
- Labor and delivery complicated by loss of epidural pain management while pushing
- Baby was in NICU for 7 days for low birth weight
- Difficulties breastfeeding. Pumping 12x/day
- Husband works 12 hr days and had to return to work after baby was discharged from NICU. No family or other supports nearby
- Referred to psychologist after reporting that she is "not feeling like [her]self", frequent tearfulness and consistently feeling like "a bad mom"
- Difficulties emotionally bonded to baby

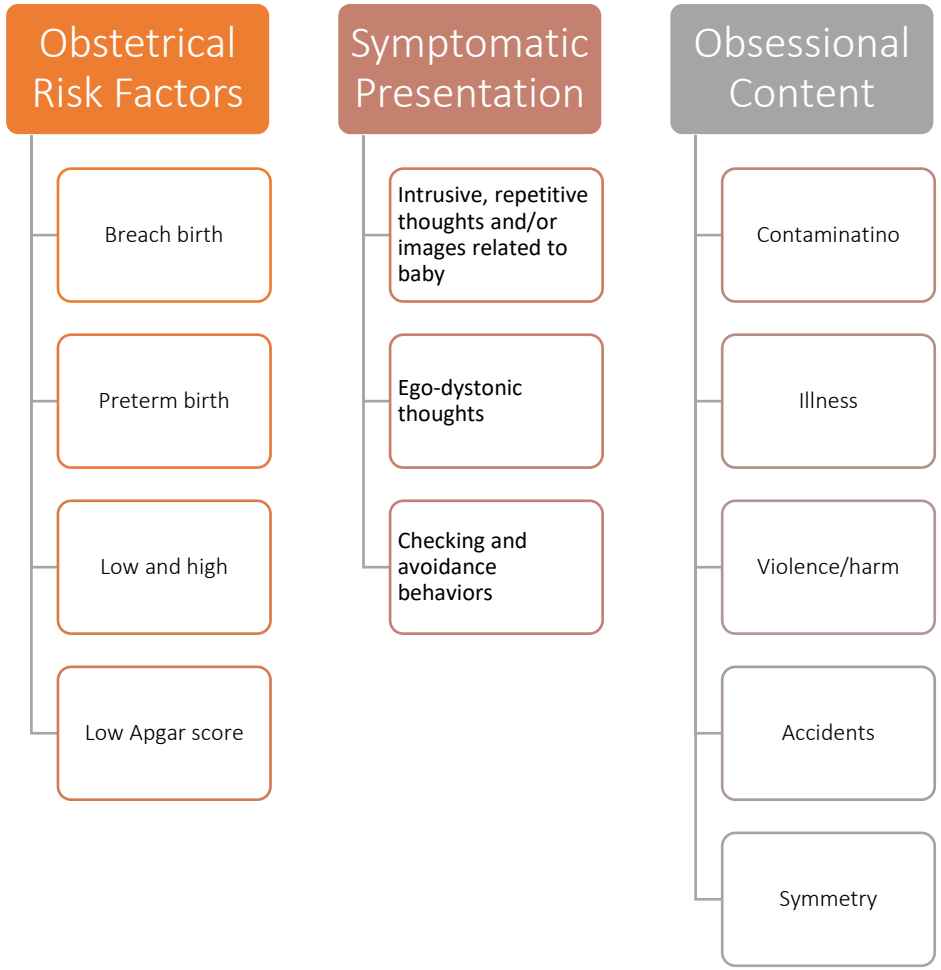
Perinatal Generalized Anxiety

- 10-15% prevalence in pregnancy and postpartum
- Symptoms
  - Excessive, uncontrollable worry
  - Excessive reassurance seeking
  - Difficulties sleeping when baby sleeps
  - Functional impairment
- Sx decrease 1 year postpartum (corresponds with reduced hormonal shifts)
- High rate of comorbid perinatal depression and anxiety



Perinatal OCD

- High risk period for new onset OCD and exacerbation of underlying OCD
- Peak incidence: 2-4 weeks pp (rapid onset)
- CBT with ERP
- ACT: Thoughts/images ≠ facts or actions
- Referral to reproductive psychiatry



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Prenatal and Postpartum PTSD

- Undetected and untreated in vast majority of affected pregnant individuals
- Pregnancy and childbirth often acts as trauma triggers for survivors
- Effective psych interventions during pregnancy:
  - Treatment trials exclude pregnancy women
  - Safety – arousal during exposure therapies versus daily arousal of PTSD?
- 1 in 3 women report birth trauma and 1 in 16 meet diagnostic criteria for PTSD
- Prevalence of postpartum PTSD
  - High risk perinatal population: 16%
  - Following IUFD: 25%
  - Following NICU or PICU death: 35%

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Case #2-Whitney

- What are the risk factors?
- What other info would you like to know?
- What is the diagnosis?
- What is your treatment plan and why?

- Caucasian single mother by choice. Attorney.
- 2.5 months postpartum with first child
- Underwent IVF with donor sperm. Recurrent pregnancy loss.
- Pregnancy complicated by hyperemesis gravidarum and pre-eclampsia
- Difficulties sleeping
- Does not drive with baby out of fear of getting into car accident
- Has thoughts of drowning baby while bathing him and now asks her mother to bathe baby. Shame and fear about these thoughts
- Ample social support

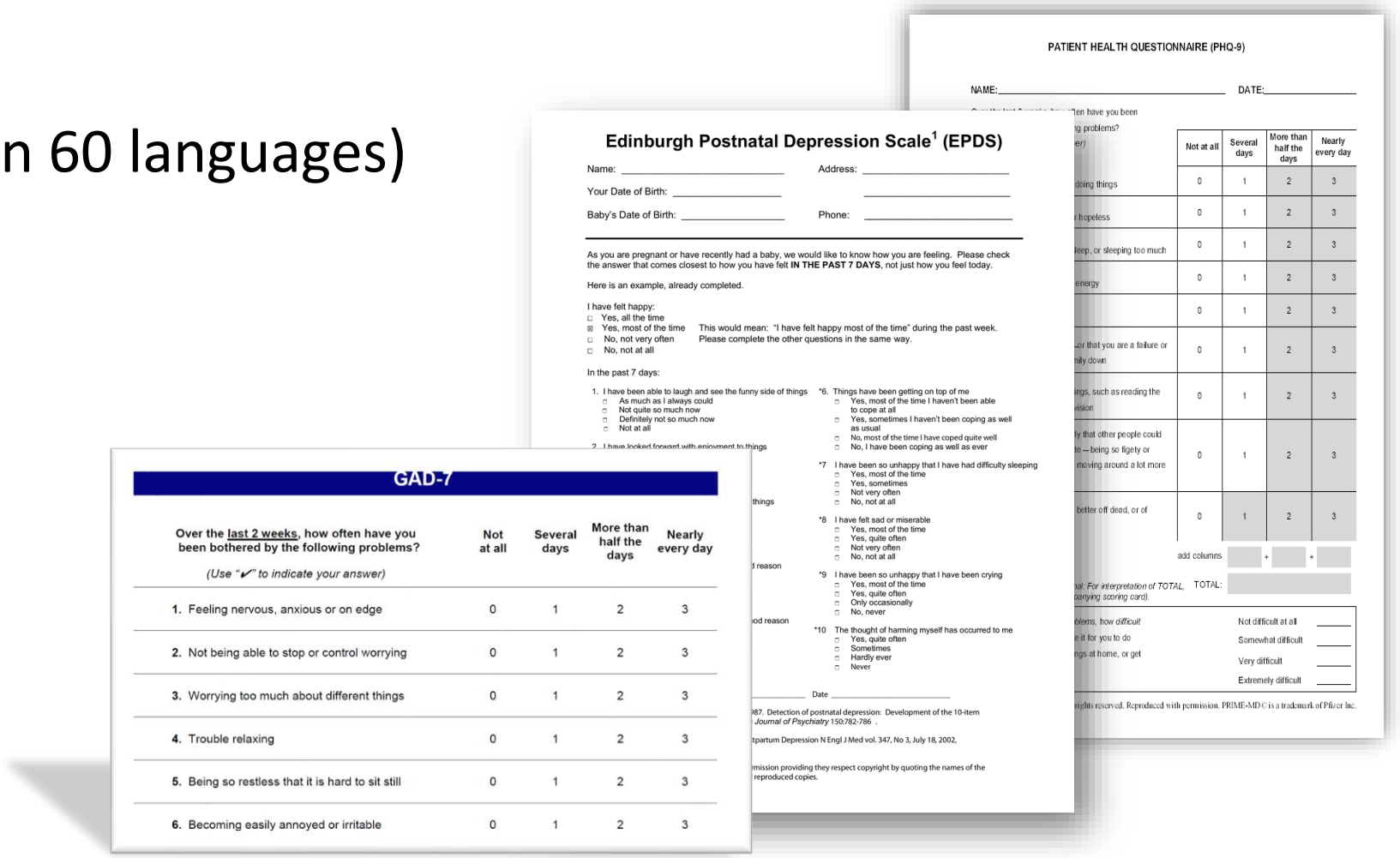
Case #3-Kalani

- What are the risk factors?
- What other info would you like to know?
- What is the diagnosis?
- What is your treatment plan and why?

- 7 weeks postpartum with 3rd child
- Emergent C-section with general anesthesia and postpartum hemorrhage
- Husband calls clinic expressing concern about the impact of labor/delivery and NICU on wife's mental health
- Kalani comes in with husband and denies experiencing distress. Does not remember the C-section or hemorrhage
- Husband describes the C-section in detail to provider and appears distressed while doing so

Screening and Monitoring Instruments

- EPDS (available in 60 languages)
- GAD-7
- PHQ-9
- PCL-5 (PTSD)
- Y-BOCS (OCD)
- CIDI-3 (Bipolar)



Postpartum Psychosis

- Perfect storm of hormonal disequilibrium + neurological changes + sleep deprivation + high stress
- 1-2/1,000 childbearing women
- Psychiatric emergency: 5% infanticide/suicide rate
- History of bipolar spectrum– 7x more likely to experience PP psychosis
  - Less than 5% have schizophrenia
- Not a separate disease entity in DSM-V "brief psychotic disorder with postpartum onset"
- First line treatment: mood stabilizer and/or antipsychotic

Postpartum Psychosis

- Rapid onset: 1-4 weeks postpartum

- Symptoms:
  - Odd beliefs and delusions (e.g., baby possessed by demon, breastmilk is poison)
  - Hallucinations
  - Insomnia
  - Agitation
  - Mania
  - Confusion/disorientation
  - Rapid mood swings
  - Waxing and waning (can appear and feel normal for stretches of time in between psychotic symptoms)

Postpartum psychosis: a mother's story (Wellcome)

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Postpartum Psychosis Treatment

- Rapid inpatient psychiatric hospitalization
- Around the clock supervision by family member
- Sleep preservation
- Rule out underlying organic disease
- Antipsychotic agents and mood Stabilizers
- ECT
- Ongoing assessment of suicidal/infanticidal ideation

Postpartum Obsessions vs. Psychosis: Similarities and Differences

OCD	Psychosis
Intrusive thoughts that cause distress (Ego dystonic)	Aggressive thoughts without guilt or distress (Ego syntonic)
Anxiety, hypervigilance	Confusion, agitation
Fear of acting on or thinking the thoughts	Hearing voices or seeing things that other people don't see
Avoidance or rituals	Bizarre or violent behavior
Personal or family history of anxiety	Personal or family history of bipolar disorder
No history of violence, over controlled	History of violence, impulsivity
Rapid Onset of Symptoms	Rapid Onset of Symptoms
Peak incidence 2-4 weeks PP	Peek incidence first 3 weeks PP
May screen negative for depression	May screen negative for depression

Postpartum Psychosis: Our Personal Experiences (Action on Postpartum Psychosis)

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Case 4-Belle

- What are the risk factors?
- What other info would you like to know?
- What is the diagnosis?
- What is your treatment plan and why?

- 28 yo med resident
- 10 days postpartum with first child
- Clinic receives a call from Belle's wife stating that Belle is acting "strange."
- Belle has not been sleeping more than a couple of hours per night. Paces and cleans the house most of the night
- Belle inexplicably began smashing their plates and cups in their front yard
- Voiced concerns about next door neighbor intending to break into the home to kidnap baby
- Orientated x4 and thoughts are organized during clinical interview

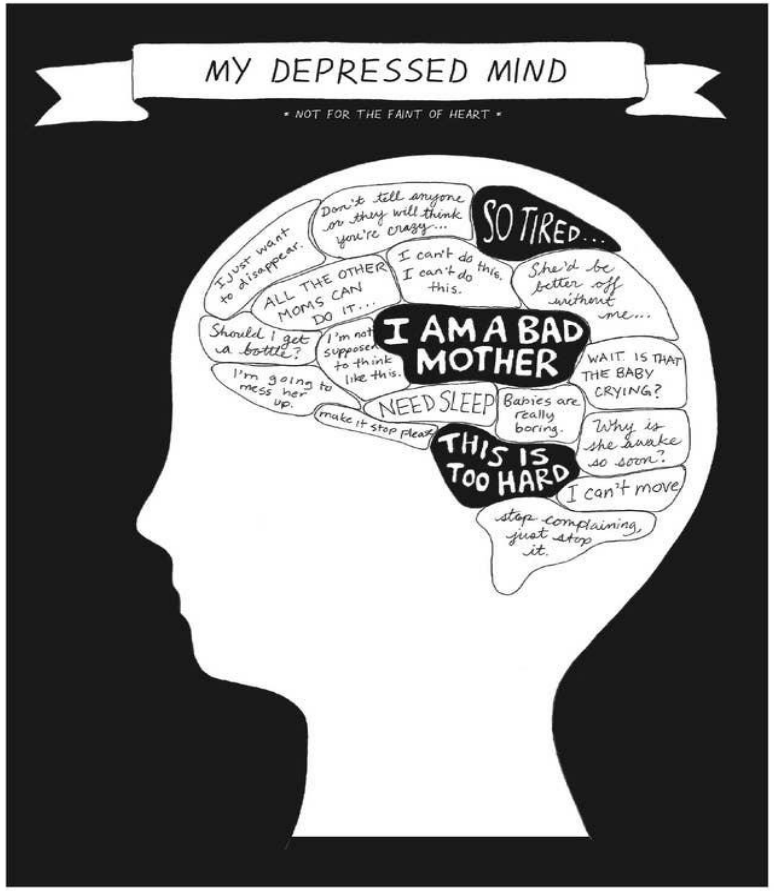
Seeking Mental Health Treatment

- Barriers:
  - Fear of losing parental rights
  - Expectations to experience joy
  - Normalization of symptoms
  - Socioeconomic issues
  - Limited knowledge of PMADs
    - Misinterpreting symptoms as signs of poor parenting skills

- Facilitators:
  - Availability of childcare
  - Flexible treatment options
  - Rapport with referring provider
  - Culturally sensitive care
  - Collocated mental health and OBGYN care

Psychotherapy Themes

- Evolving roles and identity
- Expectations vs. reality
- Perfectionism and comparison
- Improving communication
- Reconnecting with needs, values, and boundaries
- Loss/grief resolution
- Self-compassion



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Perinatal Psychotherapy – Keep it simple!

- Psychoeducational
- Supportive and flexible
- Involve partner and baby in session (if patient consents)
- Be directive to patient and partner, if needed
- Here and now
- Supplement with support group(s)
- Culturally informed/sensitive

General Psychologic Interventions

Remember the two S's:

SLEEP+SUPPORT

- Sleep preservation (important for all PMADs)
    - Poor sleep associated with pp depression and anxiety when controlling for other risk factors
- Mobilizing current support and widening support
    - Identify sources of instrumental, emotional, and informational support
- Improve maternal self-care
- Facilitate maternal-infant bond
- Praise maternal competency
- "Good enough" parenting
- Improve communication with partner, in-laws, friends, etc
- Referrals to reproductive psychiatry, social work faith community, pelvic PT, lactation consultants, doulas, etc

Evidence-Based Psychotherapies

- Cognitive Behavioral Therapy (CBT)
- Interpersonal Therapy (IPT)
  - Goals:
    - Identify maladaptive patterns of communication
    - Learn to communicate needs and emotions
    - Evaluate expectations
    - Explore positive and negative aspects of previous role
    - Develop new attachments

Cognitive Distortion	Example
Fortune Telling: Predicting that something negative/unwanted will certainly happen (without concrete evidence)	"My baby will have colic."
All-or-Nothing/Black-and-White Thinking: Seeing things as only right or wrong, good or bad, perfect or terrible	"Unless I do every single thing that the pediatrician suggests, I'm a bad mom."
Filtering: Focusing only on the negative aspects of a situation and ignoring anything positive or good	"My baby cries all of the time."
Overgeneralization: Thinking that a negative situation is part of a constant cycle of bad things that will always happen. One negative event is seen as a never-ending pattern of defeat.	"I didn't enjoy the first few days of motherhood so I likely won't enjoy being a mom from now on ."
Catastrophizing: Believing that the worst case scenario is the inevitable outcome of a situation and that you will not be able to cope.	"The pain of childbirth is going to be unbearable. I won't be able to manage it."
Personalization: Seeing yourself as the cause of some negative external event	"The baby pushed me away because she doesn't like me"
Should Statements: Telling yourself how you should, ought, or need to act and/or feel.	"I just had a baby. I should be really happy."

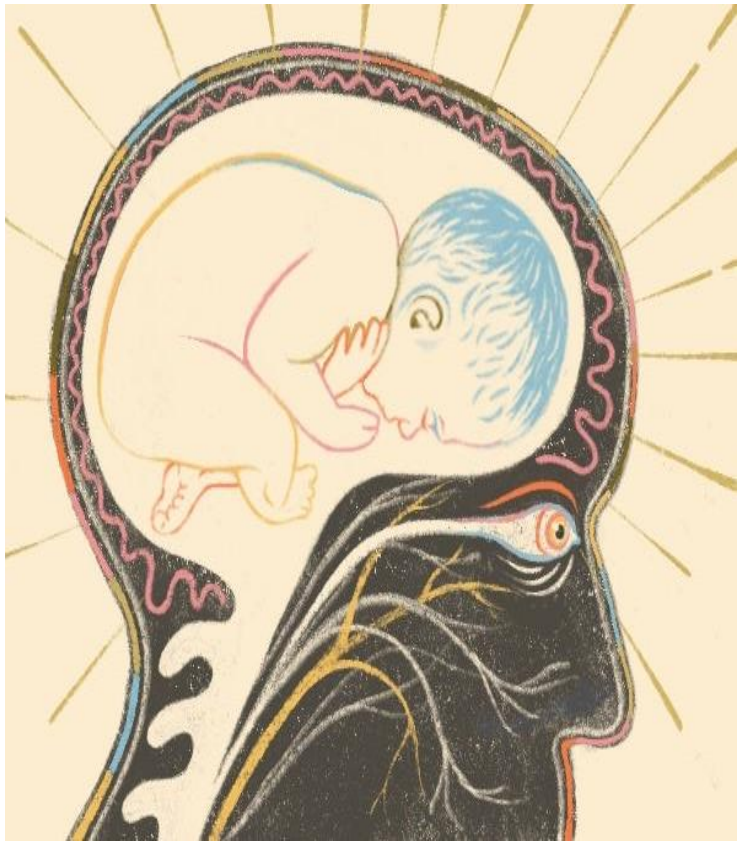
Paternal Depression

- 5% to 13%
- Symptoms often emerge between 3-6 months postpartum
- High comorbidity with maternal postpartum depression
- Risk factors:
  - History of mental illness
  - Tobacco or MJ usage
  - Financial strain
  - Infant w/ difficult temperament
  - Marital satisfaction
  - Low social support

Paternal Anxiety

- Under-researched

- Correlates of paternal anxiety:
  - Baby's health
  - Feeling excluded from antenatal health
  - Lack of under sting of what is expected of new fathers
  - Childbirth complications
  - Financial concerns
  - Changes to intimate relationship postpartum
  - Mental health of partner



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Postnatal depression in men (BBC Stories)

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Clinical Resources

- Postpartum Support International
  - Support groups
  - Directory of perinatal mental health providers
  - Trainings and webinars
  - Provider directory
  - Perinatal IOPs
  - Paternal mood and anxiety disorders
  - Resources in Spanish, French, German, Hebrew, Chinese, Farsi, Punjabi
- Hand to Hold (NICU parents)
- National Maternal Mental Health Hotline
  - 1-833-TLC-MAMA

Clinical Resources

- **The Pregnancy & Postpartum Anxiety Workbook**
  by Pamela Wiegartz, PhD, and Kevin Gyoerkoe, PsyD

- **Cognitive Behavioral Therapy for Perinatal Distress**
  by Amy Wenzel, PhD

- **Expecting mindfully: Nourish Your Emotional Well-Being and Prevent Depression during Pregnancy and Postpartum**
  by Sona Dimidjian, Sherryl Goodman, and Samantha Meltzer-Brody

Q&A With Dr. Davoudian

- We will now discuss select questions that were submitted via the Q&A feature throughout the presentation.
- Due to time constraints, we will not be able to address every question asked.

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