OUT OF AN ESTIMATED 4.3 MILLION LIVE BIRTHS

- In 2009 “…approximately 430,000 to 645,000 women in the United States experienced postpartum depression; compare this with the estimated 192,280 men who were diagnosed with prostate cancer…” (Zittel, 2010)
- Only reflects live births. Does not include mental health concerns due to pregnancy loss or infertility (Wenzel & Kleiman, 2015)

SIX RECOGNIZED TYPES OF PMAD

POSTPARTUM/PERINATAL:
- Depression
- Anxiety
- Psychosis
- Obsessive Compulsive Disorder
- Panic Disorder
- Post Traumatic Stress Disorder

(Perinatal PMAD symptoms (PPD & PPA))

- Irritability
- Inability to sleep/Insomnia
- Intrusive, “scary” thoughts
- Excessive worry
- Deep sadness
- Confusion/Brain Fog
- Anger/Rage
- Obsessive Thoughts/Compulsive Behavior
DSM-V MAJOR DEPRESSIVE DISORDER
- Five or more must be present, two weeks or longer
  - Depressed mood most of the day, nearly every day
  - Diminished interest or pleasure in most activities
  - Significant weight loss, or marked increase or decrease in appetite
  - Insomnia or Hypersomnia every day
  - Psychomotor agitation or retardation
  - Fatigue or loss of energy
  - Feelings of worthlessness or excessive or inappropriate guilt
  - Diminished ability to think or concentrate, or indecisiveness
  - Recurrent thoughts of death, recurrent suicidal ideation

ANXIETY
- DSM-V does not specify Postpartum Anxiety as a disorder
- Generalized anxiety disorder is characterized as “extreme worry that is difficult to control”
  (APA, 2000)
  - Feelings of being on edge or restless
  - Exhaustion
  - Difficulty concentrating
  - Irritability
  - Sleep difficulties
  - Intrusive/“scary” thoughts/worry

OCD
- The perinatal period is the highest risk of developing these symptoms in the life cycle
- Intrusive thoughts are usually centered around harm coming to the baby
- Feelings of guilt and shame for having these thoughts
- Horrified by these thoughts
- Hypervigilance
- Engage in behaviors to avoid harm or minimize triggers
- Compulsions are commonly handwashing and sanitizing baby’s environment
  (Zintel, 2010)
Obsessive images of having hurt one’s baby were the most common symptoms of Postpartum OCD

(Postpartum Support International [PSI], 2014)

**POSTPARTUM PSYCHOSIS**

- 1-3 women per thousand
- Occurs very early in the postpartum period, usually in the first 2-4 weeks, but can occur as early as the first few days after birth
- Delusions (often religious in nature) & hallucinations
- Disordered behavior and cognitions
- Paranoia
- Confusion
- Insomnia
- Severe mood swings

(Sit & Wisner 2006)

**HOW PMAD SYMPTOMS MIGHT PRESENT IN NEW MOMS:**

- Feel sad and worthless
- Have sleeping difficulties
- Eat less or more
- Withdraw from friends
- Cry excessively
- Feel tired
- Lose interest in activities
- Lose sexual desire
- Be very irritable
- Have physical complaints

- Have anxiety attacks or feel anxious all the time
- Feel guilty
- Feel inadequate
- Feel angry
- Criticize her partner frequently
- Fail to notice her partner's efforts
- Fail to respond to reassurance

(Klaeman, 2013)
RISK FACTORS & IMPACT

RISK FACTORS OF PMAD

- Socioeconomics (low-income)
- Relationship dissatisfaction
- Lack of support
- Stressful life events
- Unwanted or unplanned pregnancy
- History of depression
- Young or advanced maternal age
- History of abuse or domestic violence
- Tendency toward perfectionism or worry
- Gender disappointment
- Solo parenting
- Challenging pregnancy

- Difficult infant temperament
- History of thyroid issues
- Trouble breastfeeding
- Weaning
- Hormonal changes
- Birth trauma
- Extreme weight gain during pregnancy
- PMDD
- Challenges with fertility
- History of addiction or eating disorder
- Financial concerns or unemployment

(Scobie, 2015)

RATES & RISKS FACTORS FOR BIRTH TRAUMA

- Between 9 and 44% of women report having traumatic birth experiences
- 3 – 15% of women qualify for Post Traumatic Stress Disorder (PTSD) diagnosis
- Can experience symptoms of PTSD without qualifying for diagnosis
- Rates of PTSD are higher in high risk groups

(Griff et al., 2018; Reck, 2014)

- History of mental illness or mood disorder (15–20%)
- Mood disorder during pregnancy (1–4%)
- Operative births (4–23%)
- Negative feelings about birth prior to birth/fear of childbirth (11%)
- History of trauma (> 30%)
- Preterm birth (10–15%)

(NIMH, 2016; Andersson et al., 2003; Clark et al., 2007; Marcon et al., 2015; Bösser et al., 2017; de Graaf et al., 2014; Ayers et al., 2015)
**RISK FACTORS: AFRICAN AMERICAN WOMEN**

- Low Socioeconomic Status
- Lack of Support System
- Single parenthood
- Cultural Factors
  - Religious Beliefs/Practices
  - Societal Pressures
    - Fear of being stamped as an “unfit parent” by community
    - Fear of involvement from Child Protective Services

(Karras, 2018)

**MORE ON RACIAL DISPARITIES**

Among economically disadvantaged women in the US, rates for depression may be nearly twice as high as those in the overall population of women. (Freed, et. al., 2012)

African American women are also less likely to receive treatment:
- Less than half of symptomatic A.A. women received counseling or medication 6 months postpartum compared to white women. (Harvard Medical School and Harvard Pilgrim Health Care Institute, 2011)

Cutoff scores 2-3 points lower are recommended to be used for Black and Latina women in order to improve the identification of depression and anxiety. (National Perinatal Association [NPA], 2018)

**IMPACTS/EFFECTS ON CHILDREN - DEPRESSION**

1 in 10 children are parented by a depressed mother
- Depression and depressive symptoms can cause:
  - Withdrawal from the baby, minimal eye contact
  - Irritability in the mother, less patience
  - Providing minimal comfort, more likely to ignore
  - More hostile parenting behaviors
  - Unhealthy feeding practices, difficulties breastfeeding

(Trussel, et. al., 2018)
IMPACTS/EFFECTS ON CHILDREN - ANXIETY

“Babies of moms who suffer from anxiety during pregnancy have been found to have more difficult in new situations and behavioral and emotional problems in preschool years.”

- Anxiety during pregnancy and/or postpartum in moms can:
  - Lead to difficult temperament in infants
  - Make babies difficult to soothe
  - Correlate to attention deficits and impulsivity in children up to age 15

(Wiegartz & Gyarko, 2009)

PMAD IMPACT ON BREASTFEEDING

- Symptoms of PMAD make everything harder.
  - Sleeping, accessing self-care, eating well, exercising, feeling confident and competent
  - Having symptoms of a mood disorder postpartum increase the likelihood of early breastfeeding cessation
  - “Postpartum depression symptoms may also affect breastfeeding outcomes differently by race, by exacerbating financial, relational, or physical stressors experienced by some racial/ethnic groups more frequently than others”

(Wouk et. al., 2016)

BREASTFEEDING IMPACT ON PMAD

- Overall protective – WHEN IT IS GOING WELL
  - Induces calm (yay oxytocin!)
  - Lessens reaction to stressors
  - Increases nurturing behavior
  - Protects babies from the effects of depression (moms don’t disengage)

(Gren, et. al., 2002)

Early intervention when problems arise is crucial!

How we should be screening parents to optimize best outcomes.

OBSTETRICS

- ACOG Committee Opinion 2018:
  - Emphasized the importance of the “fourth trimester”
  - Anticipatory discussions should begin in pregnancy.
  - Postpartum Care Plan should address:
    - Well-woman care
    - Transition to parenthood
    - Future pregnancy intentions and reproductive plans
  - Ideally contact with a maternal care provider within the first 3 weeks postpartum
  - Considerations should be made for women with complicated pregnancies and health conditions
  - Comprehensive postpartum visit including a biopsychosocial assessment no later than 12 weeks postpartum, individualized and woman centered
  - Postpartum care should be ongoing and not limited to one visit

BIOPSYCHOSOCIAL

Retrieved from http://sigmanutrition.com/biopsychosocial
BARRIERS TO SCREENING

- Limited time and resources
- Underutilization of postpartum care (40% do not attend)
- Women are uncertain as to whom they should contact for concerns
- 23% of women return to work within 10 days of giving birth
- Availability of referrals
- Policies do not support ACOG endorsement of parental leave
- Reimbursement issues
- Scope

(ACOG, 2018)

PATIENT BARRIERS TO SCREENING

- Inadequate or no prenatal care
- Lack of comprehensive health insurance
- Less than a high school education
- Less than 26 years of age
- Household income of less than $20,000
- Multiple children
- Logistical barriers such as inaccessible transportation, long waits during appointments, and lack of child care

(DiBari et al., 2014)

- Birth Trauma (avoidance is a symptom)

(PSI 2016)
PEDIATRICIANS

- "Pediatricians may be the only medical provider many mothers see during the child's first year of life.”
  (DC Collaborative for Mental Health in Pediatric Primary Care, 2017)
- Between 61% and 83% of women attend well-child visits for infants
  (Selden, 2006 & Cheng et al., 2006)
- Mothers who bring their infants for frequent non-routine visits to the doctors office or ER are more likely to be depressed.
  (Freed, et al., 2012)

WHY PEDIATRICIANS?

- Trusting relationship formed with doctor
- 85% of mothers would welcome screening and referral from their pediatrician
- Ideal position to provide psychoeducation
- Yet least likely to screen compared to OB/GYN and Family Medicine Providers
- Frequency of well-child visits
- Most frequent contact with mother throughout postpartum year
- Screening at 2 months avoids false positives
- Risk increases over the postpartum year
- Symptoms peak at 6 months

TO CONSIDER

- Follow-up care is critical
- Screening alone is not shown to be effective – women with a positive screen MUST be referred to a Mental Health Professional
- For women with PMAD, 19.3% endorsed thoughts of self harm – and suicide is one of the top three causes of maternal death
  (PSI, 2014 & 2016)
BARRIERS TO CARE - Peds

- Treatment is outside of pediatric scope
- Psychoeducation is well within scope
- PMAD is a maternal condition
- Pediatricians report lack of confidence in management
- Documenting maternal mental health in child’s chart
- Reimbursement and financial limitations for screening mother
- Lack of community referrals

(Olo, et al., 2017)

SCREENING TOOLS

- Edinburgh Postnatal Depression Scale (EPDS)
- Patient Health Questionnaire (PHQ-2 & PHQ-9)
- Postpartum Depression Screening Scale (PDSS)
- Beck Depression Inventory (BDI-I & BDI-II)
- Generalized Anxiety Disorder (GAD-7)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Zung Self-Rating Depression Scale (Zung SDS)
EDINBURGH POSTNATAL DEPRESSION SCALE

- Most validated screening tool for Perinatal Mood Disorders
- Valid during pregnancy and the first year postpartum
- Valid in women and men (adults and teens)
- Available in 18 languages
- Self-Administered
- FREE
- Anyone can screen – this is NOT a diagnostic tool
  (Bergink, et al., 2011)

EPDS

- Validation study shows that a score above 10 suggests a parent is likely to be suffering from a depressive disorder
- Does not screen for anxiety or OCD (Frequently co-occurring with depression), nor is it linked to the DSM-V diagnostic criteria
  (PSI, 2014)
- Shows how s/he has been feeling in the last 7 days
- The parent should complete the screening themselves

PATIENT HEALTH QUESTIONNAIRE

- PHQ is a self-administered 2 or 9 question survey that ties directly to the DSM-V diagnoses for various mental illnesses
  - Major depressive disorder
  - Other depressive disorder
  - Panic disorder (PHQ-9 only)
  - Other anxiety disorder (PHQ-9 only)
  - Bulimia nervosa (PHQ-9 only)
  - Probable alcohol abuse/dependence (PHQ-9 only)
  - Somatoform (PHQ-9 only)
  - Binge eating disorder (PHQ-9 only)
  - Valid for men and women
  - Available in over 30 languages
  (Spitzer & Kroenke, 1999)
PHQ-2

- Little interest or pleasure in doing things
  0 = Not at all
  1 = Several days
  2 = More than half the days
  3 = Nearly every day

- Feeling down, depressed or hopeless
  0 = Not at all
  1 = Several days
  2 = More than half the days
  3 = Nearly every day

PHQ-9

- Validity studies show that it screens for depression ranging from mild to severe, based on scores.
- Does not screen for OCD
- Covers feelings from the prior two weeks
- Free
- A modified version (PHQ-A) is valid for teens
- Anyone can screen – this is NOT a diagnostic tool
  (Spitzer & Kroenke, 1999)

RECOMMENDED SCREENING SCHEDULE

- The EPDS should be administered at least once during pregnancy, but ideally in each trimester, as well as at the 6-week postpartum visit
- Screening for “Baby Blues” at 10-14 days after birth to facilitate early identification and treatment of postpartum depression
- Screening should, at a minimum, be administered with the EPDS at the 2, 4, and 6 month well baby visit for both mother and partner, or in the NICU if the baby has not yet been discharged
- Adolescents should be included in the screening population
  (NPA, 2018 & ACOG, 2018)
THE EASIEST QUESTION TO ASK?

How are you feeling emotionally?

FURTHER EDUCATION

RESOURCES & TRAININGS

• Postpartum Support International
  ▪ State Coordinators (Volunteers)
  ▪ Listed by state on postpartum.net
  ▪ Psychiatric Warm Line
  ▪ 800-944-4773 ext. 4
  ▪ Available for medical providers only
• Frontline Trainings for Primary Care Practitioners
  ▪ 2 – 2 hour webinars
• Seleni Institute
  ▪ “Screening for Perinatal Emotional Distress”
  ▪ 30 minute FREE training
MORE RESOURCES

- MotherToBaby: 866-626-6847 www.mothertobaby.org
- Mass General Women's Health: www.womensmentalhealth.org
- PHQ Screeners: https://www.phqscreeners.com/select-screener

MORE TRAINING OPPORTUNITIES

- PSI Components of Care 2 Day Training
  - April 11 & 12 Johnson City, TN
- Advanced Psychotherapy April 13 Johnson City
- Other dates and locations throughout the year
- 2020 Mom Certificate Training - Online
- Postpartum Stress Center – Pennsylvania
- Various dates throughout the year

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