CBT for perinatal anxiety disorders

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What do we know about anxiety in pregnancy and postpartum?

- Up to 16% of women will have an anxiety disorder during the perinatal period (Wenzel et al., 2005, Anxiety Disorders)
- Maternal anxiety during pregnancy can have negative impact on fetus and infant (Beijers et al., 2010, Pediatrics)
- PPA is associated with increased c-section rates, reduced breast-feeding duration, and increased maternal health care service utilization (Paul et al., 2013)
- May be more common than PPD
- Prenatal anxiety is a risk factor for PPD

- see Goodman, Watson, & Stubbs (2016, J of Affective Dis) for review and meta-analysis of the literature examining postpartum anxiety disorders
Why are anxiety and pregnancy/postpartum associated?

- Shifting hormones during pregnancy and the postpartum period may affect/initiate anxiety and/or panic
  - Increased estrogen and progesterone may stimulate respiration and lead to hyperventilation
- Physical symptoms of pregnancy may trigger anxiety
  - May interpret symptoms during pregnancy as indication that something is wrong with the fetus
- Pregnancy and the postpartum period are associated with significant life changes/stress
Treatment of perinatal anxiety: What we know

• Developing area but still not much awareness/treatment for women with perinatal anxiety

• Some evidence that CBT is useful with this population
  • RCT (N=34) demonstrating that intensive individual CBT is effective; low drop-out rate; superior to TAU for postpartum OCD (Challacombe et al., 2017, Psychological Med)

• CBT group for perinatal anxiety
  • Pilot study of 6-session program; significant reduction in anxiety and depression; high acceptability and satisfaction with treatment (Green et al., 2015, Arch Womens Mental Health)

• Preliminary evidence that mindfulness based interventions may be helpful
  • Pilot study of 8 session mindfulness-based CBT group with pregnant women (Dunn et al., 2012, Arch Womens Mental Health)

• Consideration of web-based interventions
  • RCT of Australian intervention (iWaWa) – very high drop out rates with only 2 of 26 mothers completing all 9 modules
Perinatal Anxiety Services at the SBH Anxiety Disorders Clinic

- Referrals from primary care, PHN, midwives, psychologists, psychiatrists
- Pregnant and postpartum women prioritized
- Seen for individual intake assessment within 2 months of referral
- Individual CBT, perinatal anxiety CBT group, regular anxiety groups
- Treatment modality determined by diagnosis, clinical presentation, availability, patient preference
Perinatal anxiety diagnoses seen in our service

- GAD
- Panic disorder
- OCD
- Health anxiety
- PTSD
- Social anxiety

• Pre-existing anxiety or related to the perinatal period?
Prenatal Anxiety: Common Presentations

Panic disorder:
- Recurrent panic attacks and/or persistent worry about having future panic attacks
- Shortness of breath, difficulty breathing, chest pains, tingling sensations, nausea, dizziness, racing thoughts, feeling unreal…
- Panic symptoms may be interpreted as something wrong with baby

GAD:
- Excessive worry about a variety of issues, e.g., Parenthood, financial difficulties, baby prep
- Worry about safety of pregnancy – especially common with history of miscarriage, pregnancy issues
- Worry about L & D – esp. with previous traumatic L & D

Health Anxiety:
- Worries about their own health, the health of the unborn baby
- Reassurance seeking from family/doctors, checking for symptoms online and lots of reading
Postpartum Anxiety: Common Presentations

OCD:
• Health related checking behaviors, cleaning to avoid contamination
• Safety related obsessions and checking
• Harm obsessions

PTSD:
• Related to traumatic labor and birth experiences
• Flashbacks and nightmares
• Grief and loss re hoped for birth experience
• Self blame

GAD:
• Similar presentation as during pregnancy

Panic:
• Unclear if panic changes, improves, or worsens postpartum
CBT in perinatal period

• Substantial interest in non-pharmacological tx for this life phase
• Side-effect profile more desirable
• CBT for anxiety disorders focuses on developing strategies for managing the anxiety and coping effectively
• CBT during perinatal period is much the same as it would be those who are not pregnant or postpartum, with some refinements
Important considerations with this population

- CBT can still be exposure-focused, no need to be afraid of exposure with this population
- Some interoceptive exposure exercises not appropriate during pregnancy
- More focused on anxiety management:
  - cognitive strategies
  - relaxation techniques
  (Chen et al. 2009, some risk to neonates among PD mothers with panic attacks during pregnancy)
- More gradual exposure
- Focus on lifestyle issues
- Importance of self-care
- Increased focus on trauma related to pregnancy and L&D
- Especially important to consider social support network (e.g., partner)
Assessment and Treatment Targets
Examples of Avoidance

- Shaking people’s hands
- Certain foods
- Pumping gas
- Chemicals, cleaning products
- Changing diapers
- Allowing others to touch/hold baby
- Play groups
- Plastic toys
- Trusted caregivers
Common checking behaviors

• Double checking ingredients in food to ensure they have healthy ingredients.
• Rechecking temperature of milk in bottle.
• Vacuuming repeatedly to avoid dust inhalation.
• Watching husband with care giving to make sure he does it right.
• Weighing baby daily.
• Monitoring fetal movements.
• Recording input and output of baby.
Typical reassurance-seeking behaviors

- Checking the internet for miscarriage information.
- Frequent doctors appointments to ensure health of the baby and self.
- Asking the same question frequently to other moms.
- Seeking constant reassurance from partner.
Examples of typical worries

• Health of fetus/baby
• Effect of new baby on older sibling
• Coping with L & D
• Fear of developing post-partum depression
• Finances, maternity leave
• Relationship with husband
• Will I connect with baby?
• What if I lose baby?
• What if I harm baby (by accident)?
• What if I become psychotic and harm my baby?
Group Treatment
Our CBT group for perinatal anxiety

- For pregnant and postpartum women
- 6 sessions, 1 ½ hours per session
  - Leaders: psychologist + trainee
- Originally limited to 6 participants per group, can bring baby
- CBT Workbook: “Overcoming Anxiety in Pregnancy and Postpartum” (Furer & Reynolds, 2015)
Outline of group sessions:

1. Understanding anxiety during pregnancy/postpartum
   - Anxiety and PPD
   - What is CBT?
   - Anxiety cycle

2. Self-care
   - Caring for yourself is caring for baby
   - Identifying self-care needs and whether they are being met
   - Mom’s Bill of Rights
   - Accessing support
   - Formal relaxation strategies

3. Setting goals and facing fears
   - Identifying areas of avoidance
   - Checking and reassurance seeking
   - Goal setting
   - Exposure - imaginal & in vivo
   - Daily practice assignments
Group sessions (continued):

4. Nurturing the developing relationship with baby
   • Increasing bond with baby
   • Dealing with perfectionism
   • Encouraging bond btw baby and dad/partner

5. Coping with negative thoughts and worries
   • Normalizing worry
   • Productive vs unproductive worry
   • Cognitive work
   • The Myth of the Supermom

6. Relapse prevention
   • Coping with setbacks
   • Additional resources
Key Points about Self-Care

**Self-care** is non-negotiable.

**Self-care** is an essential part of parenting.

**Self-care** allows you to be a better and healthier parent.

**Self-care** needs to be part of your life on a daily basis.
Mom’s Bill of Rights

I have the right to:

• Take care of myself. This is NOT selfish. It will allow me to take better care of my baby/family.

• To take time just for myself. It is OK to participate in activities that do not include my baby/family.

• To set realistic expectations for myself.

• To reject attempts made by others to make me feel guilty for not doing enough.

• To notice the parenting gains that I feel good about and to take pride in my hard work.
Evaluation of our perinatal group

- Women referred to ADC for assessment/treatment; perinatal women prioritized
- Seen by intake clinician for diagnostic interview; complete background questionnaires
- Collaborative decision between patient and clinician re appropriateness for perinatal group

- Pre-post measures administered in sessions 1 & 6:
  - Perinatal Anxiety Stress Scale (PASS)
  - Edinburgh Postnatal Depression Scale (EPDS)
  - Treatment Acceptability/Adherence Scale administered in session 2
- Consumer satisfaction measure administered in session 6
Group participants’ diagnoses

- N=40
- All with perinatal anxiety concerns but main issues varied
- Primary diagnosis:
  - GAD: 20 (50%)
  - Panic disorder: 10 (25%)
  - Health anxiety: 4 (10%)
  - OCD: 4 (10%)
  - Social anxiety: 1 (2.5%)
- 65% had comorbid diagnoses
  - Including 27.5% with depression
Group participants

- N=40, 7 treatment groups (4-7 per group)
- Mean age: 31.4 yrs (21-40)
- 34 women (85%) completed the group program; have post-data on 30

- Completers (>=3 sessions) attended mean of 5.1 sessions
- Non-completers (< 3 sessions) attended mean of 1.7 sessions
Results: Perinatal Anxiety Stress Scale & Edinburgh Postnatal Depression Scale (N=30)

* indicates $p < .01$
PASS severity ratings (n=30)

**Pre-treatment**
- 64% Severe
- 33% Mild-Mod
- 3% Asymptomatic

**Post-treatment**
- 27% Severe
- 40% Mild-Mod
- 33% Asymptomatic
PASS subscales

<table>
<thead>
<tr>
<th>PASS subscale (possible range)</th>
<th>Pre-Test Mean (SD)</th>
<th>Post-Test Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excessive Worry and Specific Fears (0-30)</td>
<td>17.6 (6.2)</td>
<td>11.7 (5.4)</td>
</tr>
<tr>
<td>Perfectionism, Control &amp; Trauma (0-24)</td>
<td>11.7 (4.8)</td>
<td>7.6 (4.8)</td>
</tr>
<tr>
<td>Social Anxiety (0-15)</td>
<td>8.2 (3.5)</td>
<td>5.0 (3.4)</td>
</tr>
<tr>
<td>Acute Anxiety and Adjustment (0-24)</td>
<td>11.0 (4.3)</td>
<td>6.6 (5.2)</td>
</tr>
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Pre–post decreases on each subscale are all significant at .000
EPDS (n=30)

Pre-treatment

- Probable depression: 83%
- Not depressed: 27%

Post-treatment

- Probable depression: 30%
- Not depressed: 70%
Treatment Acceptability/Adherence Scale (TAAS)

- 10 item questionnaire administered at second group session (Milosevic, Levy, Alcolado, & Radomsky, 2015, *Cognitive Behaviour Therapy*)

- \( M = 55.26, \ SD = 5.29 \) (max possible score =70)

- Participants felt they could complete the treatment (Item 1) \( M = 6.94, \ SD = .23 \)

- Participants would recommend the treatment to a friend (Item 9) \( M = 6.21, \ SD = .79 \)
Participant feedback: satisfaction ratings

- Our measure:
  - 4 items on 0-4 helpfulness scale
  - 2 yes/no questions
  - 2 open-ended questions

- Positive consumer satisfaction ratings
  - Helpfulness of sessions (mean rating=3.4), group (3.4), & workbook (3.2)
  - Value having a group program focused on unique needs of perinatal population (mean rating = 3.5)

- 100% of completers said they would recommend this group to others
- 94% said they would consider doing the group again
Participant feedback: What they liked about the group

• Not being alone with anxiety experience
• Shared experiences
• Similar issues
• Problem-solving with other moms
• Sharing advice and tips regarding parenting and anxiety
• Being able to bring baby
Participant feedback: sample comments

- Made me think logically about my anxiety. Use of workbook when calm, not just think of anxiety when in the panic state.
- Finally knowing I wasn't alone. Finally being taught tools to heal. Knowing I'm not damaged, it's just thought patterns. Having support, setting goals, measuring progress
- Being able to connect with moms having the same issues
- That it was specific to my current life circumstances. It was helpful with identifying where I need to work on my anxiety. It provided a nice sense of community with others going through similar life changes.
- The group aspect and support was the best part for me
- I liked being able to relate to the experience of others and also benefitted hearing from those with different experiences
- Safe space. Material in workbook was VERY relatable, was strengths based and accessible
Participant feedback: suggestions for change

- More than 6 sessions
- Longer! I wish it was a longer session! Or more sessions!
- Possibly longer; a follow-up session
- Hard to do the workbook at times
- Would love to see one of six classes involve partners/care providers/support people. Would be good to give husbands/partners perspective
Perinatal Depression and Related Adjustment Disorders: Assessment and Treatment Issues from a Clinical Health Psychology Perspective

Dr. Carrie A. Lionberg, C.Psych., Registered Psychologist and Assistant Professor
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Rady Faculty of Health Sciences - University of Manitoba

CHP Grand Rounds: September 20, 2018 – 3:00-4:30 PM, Fredric Gaspard Theatre, Basic Medical Sciences Building
Dr. Carrie Lionberg, C. Psych.
Registered Psychologist & Assistant Professor

Women’s Health Psychology Services
Department of Clinical Health Psychology

- Perinatal mental health assessment and psychological treatment
- Medical or voluntary termination due to fetal anomaly or a medical condition incompatible with life or quality of life
- Termination due to mother’s medical condition
- Miscarriage and pre-term delivery
- Birth trauma
- Late-term, stillbirth, and neonatal loss & grief
- Chronic pelvic pain
  - dyspareunia, vaginismus, vulvodynia, interstitial cystitis, etc.
Spectrum of ‘Perinatal Mental Health’

- ‘Perinatal Mental Health’ defined as period beginning with conception to 2 years postpartum
  - Comprehensive term which conceptualizes the impact of perinatal mental health, including depression, on the mother, child and family system
  - Also encompasses a preventative approach
  - Depression *during* pregnancy: 25-40% of women with postpartum depression report mood disturbances beginning while pregnant

- Postpartum Mood Disorders:
  - “Baby Blues”
    - affects 30-75% of mothers
  - Postpartum Depression
    - affects 10-15% of mothers and may involve anxiety ranging from feelings of panic to racing thoughts to excessive worry and perhaps, obsessions.

- Postpartum psychosis
  - affects 1-2 per 1000 women
  - (0.1 - 0.2% deliveries)
Depression During Pregnancy

- Most vulnerable periods are the first trimester and the first nine weeks after delivery.

- Risk factors for depression in pregnancy:
  - Prior depressive illness (especially PP mood episodes)
  - Psychiatric disorder
  - Family history of mood disorder
  - Pregnancy complications
  - Detection of a fetal anomaly

- “Pregnancy Myths” may be obstacle to help seeking

- If there is a history of depressive illness, assess for symptoms at regular intervals and counsel for risk of recurrence.

- Impact of untreated depression during pregnancy:
  - Prenatal development
  - Poor self-care and nutrition, less weight gain
  - Poor compliance with prenatal care
  - Self-medication, Alcohol, Drugs
  - Impact on family relationships
  - Lower APGAR
  - 3:1 risk for
    - Small-for-gestational age
      - (<10th percentile)
    - Premature birth
      - (<37 weeks)
    - Low birth weight
      - (<2.5 kg)
    - Risk of developing Postpartum Depression
    - Risk of attachment problems
    - Risk of suicide, infanticide
“Baby Blues”

- Regarded as a ‘normal’ postpartum phenomenon attributed to
  - (1) expected hormonal shifts as biochemistry begins to return to pre-pregnancy level
  - (2) adjustment to stress of postpartum as major change/life event

- Occurs in 30-75% of deliveries
  - Sadness and tearfulness
  - Anxiety, irritability, agitation, fatigue
  - Disturbances in sleep and appetite
  - Difficulty concentrating, confusion

- Transient
  - Occurs within 48 hours of delivery
  - Worsens days 5-7
  - Resolves within two weeks of delivery, without psychotherapy or psychiatric intervention
  - Supportive care and reassurance aid transition
Postpartum Depression (PPD)

- Rates of 10-15%
- Most common complication of childbearing
- Symptoms of PPD generally regarded by many healthcare providers as no different than symptoms of Major Depression
  - Onset greatest at 3 months, decline somewhat months 4 - 7
  - Usually requires treatment by health care professional
- Under diagnosed in as many as half of affected women
  - Because somatic symptoms of depression mimic physiologic changes associated with childbearing
  - Routine screening may not be performed
  - Adjustment and mental health issues frequently not recognized
- Symptoms may be underreported because of shame and stigma
- Women may not consider what’s happening to them to be PPD
Other Potential Postpartum Disorders

- **Postpartum psychosis (PPP)**
  - Depersonalization, feeling removed from your baby, other people and your surroundings.
  - Disturbed sleep.
  - Extremely confused and disorganized thinking increasing your risk of harming yourself, your baby or another person.
  - Drastically changing moods and bizarre behaviour.
  - Extreme agitation or restlessness.
  - Hallucinations or visions, often involving sight, smell or touch.
  - Delusional thinking that is not based in reality.

- **Postpartum obsessive-compulsive disorder (OCD)**
  - Intrusive, repetitive and persistent thoughts, usually about something bad happening to the baby.
  - Tremendous sense of anxiety, horror and disgust about the these thoughts.
  - Repetitive behaviour in an attempt to reduce the anxiety resulting from these thoughts.

- **Panic Disorder**
  - Recurrent unexpected panic attacks.
  - Persistent concern about having additional attacks.
  - Worry about the implications of the attack or its consequences.
The Context of Perinatal Mental Health Issues: Contributory Factors

- PMH is multidimensional and is related to multiple situational, psychological, and physiological issues
  - Perinatal physiological changes
  - Pre-existing mental health conditions
  - Sleep deprivation
  - Role transition and sense of loss of former self
  - Unresolved past trauma or loss
  - Unrealistic / unmet expectations
  - Unidentified early signs and symptoms of PMH issues
The Context of PMH: Risk Factors (cont’d)

No Effect as risk factors

- Ethnicity

- Maternal age
  - (exception: extremes of ages*)

- Sex of child
  - (Western societies*)

- Level of education

- Number of children
  - (multiple young children in home*)
Edinburgh Postnatal Depression Scale

- I have been able to laugh and see the funny side of things.
- I have looked forward with enjoyment to things.
- I have blamed myself unnecessarily when things went wrong.
- I have been anxious or worried for no good reason.
- I have felt scared or panicky for not very good reasons.
- Things have been getting on top of me.
- I have been so unhappy that I have difficulty sleeping.
- I have felt sad or miserable.
- I have been so unhappy that I have been crying.
- The thought of harming myself has occurred to me.
Unstructured Assessment Interview Topics

- Physical and emotional symptoms, when they started
- Family history
- Personal history of depression or any other mental illness or mood disorders
- Worries or concerns about present family life, marriage or current relationship, current level of stress and social support
- Sleep patterns/eating habits
- Level of depression and anxiety
- Thoughts (if any) about harming self or baby
- Experiences during pregnancy, labor, and delivery
Structured Interview Screening: The Antenatal Psychosocial Health Assessment (ALPHA)

‘Family Factors’ (excerpt)

- **Social Support (CA, WA, PD)**
  - How does your partner/family feel about your pregnancy?
  - Who will be helping you when you go home?

- **Recent stressful life events (CA, WA, PD, PI)**
  - What life changes have you experienced this year?
  - What changes are you planning during this pregnancy?

- **Couple’s relationship (CD, PD, WA, CA)**
  - How would you describe your relationship with your partner?
  - What do you think your relationship will be like after the birth?

CA: Child Abuse, CD: Couple Dysfunction, PI: Physical Illness, PD: Postpartum Depression, WA: Woman Abuse

(Carroll, et al., 2005)
The Context of PMH: Risk Factors

**Strong Predictors**
- Depression or anxiety during pregnancy
- Stressful recent life events
- Lack of social support (perceived or received)
- Previous history of mental health disorders
- Family history of mental health disorders
- Extremes of ages
  - Adolescent and older mothers

**Moderate-Weak Predictors**
- High levels of childcare stress (Multiple children in home under age of 5 years*)
- Low self-esteem
- Difficult infant temperament
- Medical problems with fetus/infant
- Negative cognitive style
- Relationship status quality
- Obstetric/pregnancy complications
- Lower SES
An Emerging Area of Perinatal Mental Health: Birth Trauma

- Birth trauma is an event that occurs during any phase of the childbearing process that involves actual or threatened serious injury or death to the mother or her infant.

- The trauma can be classified as a negative outcome, such as postpartum hemorrhage, or psychological distress. Experiencing this extremely traumatic stressor, a woman’s response can be intense fear, helplessness, loss of control, and horror.

- Lengthy or short and very painful labour

- Induction

- High levels of invasive medical intervention (w/wo pain relief)

- Traumatic or emergency deliveries

- Lack of privacy / dignity

- Stillbirth

- Birth of injured baby / severe complications

- Baby’s admission to NICU
Postpartum Depression and Birth-Trauma Posttraumatic Stress: Is It an Either-Or Issue?

- Postpartum Depression (PPD) is the most common complication of childbirth.

- Posttraumatic Stress Disorder (PTSD) is a diagnostic term that can be applied to a variety of traumatic experiences.

- Birth Trauma Posttraumatic Stress Disorder (BT-PTSD) is an increasingly used term to indicate posttraumatic stress disorder due to childbirth.

- Birth Trauma Posttraumatic Stress Effects (BT-PTSE) is another increasingly used term to indicate presence of a symptomatic syndrome which does not meet full criteria for BT-PTSD (i.e., a milder form of BT-PTSD).
Is Birth Trauma a Form of PTSD or PPD?

Differentiating PTSD from PPD

**PTSD**
- Posttraumatic stress disorder occurs when a person experiences an event during which he or she perceives a threat to his or her own life, the life of a significant other, or his or her physical integrity, and the person responds with intense fear, helplessness or horror.

- Traumatic event is persistently re-experienced.

- Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness.

- Persistent or increased arousal

- Secondary depression

**Postpartum Depression (PPD)**
- Depressed mood

- Diminished interest or pleasure in activities

- Sleeping/eating disturbances

- Anxiety/insecurity

- Emotions on a roller coaster

- Fatigue or loss of energy

- Guilt

- Concentration problems

- Loss of self (not normal self, don’t feel real)

- Recurrent thoughts of death, suicidal ideation

- Possible recurrent thoughts of harming baby or of harm coming to the baby
The Rates of BT-PTSD

- Medical advances have resulted in more lives saved during high-risk births

- The number of home births, births at birthing centres, and a preference to opt for “natural childbirth” have also increased in recent years

- The incidence of BT-PTSD has not been widely studied, although we do know that most women do recover from the birth experience

- However, survey studies have shown that 25% - 34% of women who have given birth experienced some sort of trauma, and 18% of women report partial symptoms (i.e., BT-PTSE)

- Studies have also shown that between 3.4% - 9% of women giving birth meet criteria for BT-PTSD
## Risk Factors

### Pre-existing vulnerabilities

- History of trauma
- History of sexual trauma/abuse
- History of mental health problems
- Fear of childbirth
- Prior still birth/injury to infant
- Anxiety during pregnancy / anxious personality
- Rigid expectations of what birth will be like
- Unwanted pregnancy

### During birth

- Emergency Caesarean or assisted delivery
- Blood loss, long labour, high level of pain, ++medical interventions. Fear of dying
- Subjective loss of control and/or not being heard
- Perceived poor support/lack of care
- Coping by dissociation

### Following the birth

- Lack of support from friends, family, health professionals may hinder recovery or possibly cause stress and increase symptoms
Birth Trauma: Potential Reactions and Impact on Functioning

- Potential negative impact on woman’s overall sense of well-being and the relationships with their partner, new infant and/or other children in family

- Women with negative experience of their first birth may have longer interval to, and fewer, subsequent children

- Potential negative impact:
  - ability or willingness to breastfeed (infant may have become trigger to BT-PTSD or previous PTSD symptoms/reaction)
  - ability to form strong attachment/bond with infant
  - ability or willingness or to resume sexual relations
    - due to fear of pregnancy/giving birth again, lingering pain, continued physical recovery, etc.

- Negative self-worth

- Self-isolation

- Feeling no one understands
Psychological ‘Themes’ Based on Women’s Stories in Therapy

- Childbirth and Motherhood are natural, so why am I having problems?
- Lingering pain and difficult recovery
- Mourning the loss of having a vaginal delivery, my body has failed me
- Am I sure that this really is my baby?
- Problems in breast-feeding, D-MER (Dysphoric Milk Ejection Reflex)
- I’ve failed/harmed my baby
- I worry that I may harm my baby when I get frustrated or angry
- Sleep deprivation; conditioned insomnia
- I shouldn’t accept or need help
- I can’t ask for help, or here is no help available
- I am not a good mother
- I resent my baby/my partner
- My baby is trying to ruin my life
- Shame, guilt, anger, perfectionism, unrealistic expectations, enduring feelings of loss of control
- No one will understand what I’m feeling… It’s unnatural
- Self-isolation (from the world of “idealized” motherhood)
- I don’t want reassurance, I want to be heard and understood
- I need more time to adjust or heal than others are willing to give me
Psychological ‘Themes’ (Continued)

- My husband/partner is not supportive and doesn’t understand what I’m going through
- “Resurrected” grief over the loss of a parent (especially a mother) or other family member
- Rumination regarding family of origin issues
- Sadness, anger, confusion related to intensified memories of past trauma
- Fears that an infant daughter may experience the same negative or traumatic events that they have experienced
- Concern about the impact that their perinatal depression may have had on their infant or other children in the home
- Shame related to not breastfeeding
- Fear that I am being judged when in public with my baby
- Worry that their husband/partner is also experiencing a postpartum depression
- Worry that they are no longer attractive to their husband/partner or that their spousal relationship is failing due to the impact of their depression
- Concerns that an older child(ren) are being deprived of the attention they had previously been given
- Guilt and shame that they are not contributing to the support of their household
- Guilt that they are feeling unfulfilled in the role of new parent and would like to be back working (“Career Woman” needs)
- Resentment that family or friends are not supportive of remaining in contact with them
Myths Of Motherhood: Obstacles to Adjustment or Seeking Help

- Becoming a mother means you’ll feel happy all the time.
- Bonding with your baby will happen instantly and effortlessly.
- Breastfeeding is easy because it’s natural.
- Being a mother is easy because it’s natural.
- There’s one right way to be a good mother.
- You won’t miss the life you had before becoming a parent.
- Motherhood is all you should think about after having a baby.
- The relationship with your partner will be better than ever.
- Parenting books will be helpful.
- Good mothers can do it all on their own.
- PPDAM: Postpartum Depression Association of Manitoba
- www.ppdmanitoba.ca
I’m thinking about having a baby, but I have battled with depression in the past, which means I am doomed to getting PPD. FALSE!
Although having a past history of depression or mental illness can increase your risk of developing a perinatal mental illness, it does not necessarily mean you WILL develop one. There are some proactive steps you can take to be prepared if a perinatal mental illness does hit. The first step is being honest with your partner, doctor and public health nurse.

PPD can only happen to women. FALSE!
New studies show that 1 in 10 men can experience some degree of paternal PPD. Approximately 50% of men whose partners have PPD are at risk of becoming depressed themselves.

Women with PPD look depressed and cry all the time. FALSE!
PPD is not a one size fits all illness. The symptoms are unique for every woman and while it’s true that some women with PPD may cry a lot, many don’t. With the lack of awareness in society about PPD and related illnesses, many mothers feel too ashamed and guilty to admit their PPD for fear of being labeled as a “bad mother”. Many women mask their illness and suffer in silence.

I have PPD – therefore I am a bad mother. FALSE!
PPD is an illness. Just like diabetes is an illness. Having diabetes doesn’t make you a bad mother, so why would having PPD? This is not your fault and it does not make you a bad mom. You did not choose this. It is the most common complication of childbirth and it can happen to anyone. You are not to blame. You are the best mother for your child and it’s okay to ask for help.

I would get better if I could just get more sleep. TRUE & FALSE!
Though insomnia and fatigue can worsen PPD, simply getting a good night’s sleep will not fix the problem. Getting adequate sleep is vital to recovery, but generally treatment requires a combination of treatment options such as counselling, support groups, increasing social support, improving self-care, talk therapy, cognitive behavioural therapy, group therapy and/or medication.

I had PPD with my first, so I am doomed to get it again. FALSE!
The bad news is that there is a 50% chance that you will develop PPD again. But the silver lining is that there is also a 50% chance that you won’t. And just think of how much better prepared you will be the next time around. You will have many more tools for your mommy toolbox.

www.ppdmanitoba.ca
Additional Challenges in Detection and Treatment of PMH Problems

- 44% of Ob/Gyns often-always screen for depression
- PMH problems often confused with normal adjustment

- 8% of Pediatricians routinely query
- Woman may be reluctant to disclose due to stigma and shame

- Women not always referred for further evaluation or treatment
- PMH problems may not be validated in some cultures

- Only 20-50% of women identified w/PMH concerns sought or accessed further services with health care or mental health professionals
- Lack of education regarding range of PMH problems

- When disclosed, PMH symptoms may be dismissed or not acknowledged by the mother, her family, friends and/or health care professionals

NIHCM Foundation, 2010
Obstacles to Seeking or Accessing Treatment

- Women may fear loss of parental rights, stigma, involuntary psychiatric hospitalization

- Patient-centered variables
  - Stigma
  - Child-care & time constraints
  - Transportation (costs, access)
  - Nonadherence, lack of follow-through

- Physician-centered variables
  - Lack of time
  - Competing demands
  - Insufficient training/knowledge

- Systems barriers
  - Infrequent follow-up visits
  - Separation of primary care and mental health services
When to Refer for Psychological Treatment

**Indicators**

- Signs and Symptoms noted
- Difficulty interacting/caring for infant
- Difficulty caring for self
- Persistent vague pelvic pain which may not be related to physical recovery but may be a symptom of a trauma reaction
- Problems in relationships
- Unexplained anger
- Thoughts of harming self or baby

**Potential Focus of Treatment**

- Concept of interdependence between physical and emotional well-being
- Behavioral activation, self-care skills, reframing thinking, strengthening of adaptive coping strategies, decreasing avoidance
- Relaxation training, accessing social support, modifying expectations, preparation for anticipated changes
- Process emotion, address trauma and/or unresolved issues, explore interpersonal patterns,
Promote Self-care Strategies

- Self-care strategies can be a focus in psychological treatment and promoted by support people in the woman’s life
  - Prioritizing self-care not as a luxury but as a necessity
  - Become self-aware of unrealistic expectations about motherhood
  - Get as much rest as possible
  - Seek and accept support and help
  - Eat well
  - Get moderate exercise
  - Build a strong support network
  - Relaxation and stress reduction techniques
Cognitive Behavioral Model of Psychotherapy

**Cognitions**
What a person thinks

**Behaviors**
What the person does...
The person’s actions

**Emotions**
How the person feels...
The person’s emotions

**Bodily State**
How the person feels physically
3 – 5 session CBTs for PPD

- **Including Fathers**
  - 1) Partners and PPD
    - Aims of treatment session: What is PPD?
  - 2) The Couple Relationship
  - 3) Doing it on Own

- **Including Infants**
  - 1) Play and Physical Contact
  - 2) Learn About Baby: Observing and Understanding Baby’s Signals
  - 3) Examine Feelings—Parental Responses to Cues

- **Individual Treatment: a Flexible Approach**
  - Phase 1) Extended Assessment
  - Phase 2) Goal Setting
  - Phase 3) Treatment (1-3 sessions)
  - Final Session
Interpersonal Therapy (IPT) for Depression

- IPT may focus on: (1) role transitions, (2) interpersonal disputes, (3) grief, and (4) interpersonal skill deficits.

- Goals for role transitions: mourn and accept loss of old role; regard new role as more positive; restore self-esteem by developing sense of mastery regarding demands of new roles.

- Strategies for role transitions: review/relate depressive symptoms to difficulties in coping with recent life change; explore feelings of loss/change; encourage release of affect and develop social support system and new skills called for in role, etc..

- In general, IPT helps women to understand and change within their important relationships in order to secure needed emotional support, help, and understanding.
Adaptations of IPT for PMH

- Pregnancy is framed as a role transition characterized by both physical transformation and the life changes pregnancy produces.
- Role disputes often involve the baby’s father, disorders of the mother-infant relationship, and recall of old disputes with the family of origin.
- There may be difficulty in bonding with fetus, particularly if unplanned pregnancy.
- Interpersonal deficits may address the situations leading to an unwanted pregnancy or anticipated problems in interacting with a child.
**Additional Related Issues in PMH**

- Loss due to miscarriage or stillbirth and risk for developing PMH and adjustment difficulties
  - Impact on subsequent pregnancy
    - Anxiety
    - Problems with attachment
    - Fear of first loss being forgotten

- Paternal PMH:
  - Mood and adjustment
  - Grief with loss

- Adolescent perinatal issues
Resources

- **In rural Manitoba:**
  - Visit the Government of Manitoba website for a list of crisis services and contacts broken down by the various regional health authorities.

- **In greater Winnipeg area:**

  - **WRHA Mobile Crisis Service (24 hr)**
    - (204) 940-1781
  - **WRHA Crisis Response Centre**
    - 817 Bannatyne Ave., Winnipeg, MB
    - (204) 786-8686
    - Toll Free: 1 (888) 322-3019
  - **Klinik Crisis Line (24 hr)**
    - 1-877-435-7170
  - **Manitoba Suicide Line (24 hrs)**
    - 1-877-435-7170
  - **Winnipeg Emergency Services Operator**
    - 911
Resources

- PPDAM: Postpartum Depression Association of Manitoba (http://www.ppdmanitoba.ca)

- Women’s Health Clinic Mothering Program at 204-947-2422 ext. 113. Inquire about the *Coping with Change* Workshop (free)
  - Inquire about their free & low cost counselling services

- Consider E.A.P. benefits if available

- Publically funded psychological services
  - http://mps.ca/publically-funded-psychologists

- Private practice (cost) psychological treatment http://mps.ca/private-practice-psychologists/# for a list of private

- Winnipeg Mental Health Resource Guide. See the link for more details. http://www.cmhawpg.mb.ca/resources.html

- Postpartum Support International Help-line at 1-800-944-4773

- Mood Disorders Association of Manitoba PPD Warmline at 204-391-5983
Selected References


Next steps

• RCT with qualitative component
• Consider weekly monitoring of self-care, safety behaviors or other targeted specific behaviors to get more detailed monitoring of change
• Follow-up assessments
• Follow-up with drop-outs
• Comparison of pregnant vs postpartum women – does this group work equally well for both?
• Delivery of group program in hospital vs community sites