

2020  
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## Maternal Mental Health and a Transition to Parenthood

Training for childbirth educators  
on Maternal Mental Health  
by Diana Lynn Barnes Psy.D LMFT



## **Diana Lynn Barnes, Psy.D**

Diana Lynn Barnes, Psy.D, LMFT is an internationally recognized expert on the assessment and treatment of perinatal illness. A past president of Postpartum Support International, she currently sits on the President's Advisory Council for that organization. She is a member of the Los Angeles County Perinatal Mental Health Task Force, a core faculty member of their training institute, as well as an InnerCircle member and supporter of 2020 Mom.



In 2009, she co-founded The Motherhood Consortium, an interdisciplinary network of professionals working with mothers, infants and young families. In addition to private practice specializing in all facets of women's reproductive mental health, Dr. Barnes frequently consults with legal counsel on cases of infanticide, pregnancy denial, neonaticide, child abuse and neglect.

Dr. Barnes is the editor and a contributing author of *Women's Reproductive Mental Health Across the Lifespan* (Springer, 2014) and co-author of *The Journey to Parenthood, - Myths, Reality and What Really Matters* (Radcliffe, 2007).

Dr. Barnes is a fellow of the American Psychotherapy Association, and a clinical fellow of the California Association of Marriage and Family Therapists and the American Association of Marriage and Family Therapists. Her papers have been published in a number of academic journals and she contributed the entry on infanticide for *The Encyclopedia of Motherhood* (Sage Publications, 2010).

Dr. Barnes is the 2007 recipient of an award presented by Postpartum Support International for her outstanding contributions to the field of reproductive mental health, and the 2009 recipient of a Lifetime Achievement Award presented by the Eli Lilly Foundation for her work in the area of child-bearing illness.

2020 Mom Presents:

## **Mental Health During Pregnancy and the Postpartum Period**

*A Brief Training Manual for Clinicians and Childbirth Educators*

By Diana Lynn Barnes, Psy.D, MFT

(Please distribute Handouts A and B.)

Postpartum depression (PPD) affects as many as 800,000 new mothers each year. It is a different and much more serious condition than the “baby blues,” a far more common condition (experienced by three out of four women) that generally disappears without medical or psychological intervention.

The differences between depression and the baby blues are in the onset, duration, and severity. The baby blues, caused by the natural shift in hormones that occurs following birth, generally sets in two to three days postpartum and lasts from two to three weeks. Symptoms include tearfulness, rapid mood swings, anxiety, irritability, sleeplessness, and exhaustion. Most women with the baby blues start to feel better when they have support and reassurance, along with good self-care, including rest, exercise, and good nutrition. The baby blues is so common, affecting so many new mothers, that it is considered a normal part of postpartum adjustment.

Postpartum depression, however, can occur any time in the first year postpartum. Its symptoms are sometimes overlooked because in its milder forms it is often confused with difficult adjustment or new-parent anxiety.

One in five women giving birth (20%) develops **postpartum depression with anxiety**, one of the most common presentations of PPD. Symptoms include changes in sleep or appetite, weight loss, fogginess, confusion, an inability to cope, often paralyzing anxiety, overwhelming sadness and emotion, fear of being left alone, suicidal thoughts, feelings of inadequacy, hopelessness and despair, and emotional detachment from the baby.

One in ten new mothers (10%) experiences **postpartum depression with panic disorder**. Symptoms include extreme panic and anxiety, chest pains, difficulty breathing, even sweating and tingling around the face and hands. It can feel like a heart attack and some women feel as though they are dying. These episodes of panic can often awaken a woman from sleep.

New mothers who have **postpartum depression with obsessive compulsive features** (3 in 100 mothers) are often anxious. To help manage their anxiety, they frequently engage in repetitive behaviors, such as constantly checking the baby’s breathing or repeatedly counting bottle or diapers. They may become hyper-vigilant (watchful), always thinking the baby is sick or that something bad is going to happen to the baby. At times, they may experience intrusive and repetitive thoughts, often of a destructive nature. The mental images that appear usually involve harm coming to themselves or their baby: for example, a mother may envision herself dropping the baby, or that a knife she is holding could slip and cut the baby.

The difference between postpartum depression with obsessive compulsive features and postpartum psychosis is that mothers with PPD OCD know that their thoughts are foreign; they are generally horrified by them, and they take steps to do whatever necessary to avoid what they believe to be inevitable harm to their infant, even if it means avoiding all contact with him or her.

There have been stories in the media about women who kill their children as a result of postpartum psychosis. This is different from postpartum depression and is extremely rare (1 or 2 out of every 1,000 births). With postpartum psychosis, there is often a refusal to eat, an inability to sleep, paranoia, agitation, delusions, auditory hallucinations (hearing voices), suicidal thoughts, and thoughts of killing the baby. *Although uncommon, postpartum psychosis is considered a life-threatening medical emergency that necessitates immediate treatment to safeguard the lives of mother and infant.*

Maternal depression is so important to recognize and treat because it not only affects the mother and her ability to enjoy and care for her child, but it often has long-term consequences for the baby. Babies of depressed mothers often experience poorer health: They have more infections and don't feed as well, and, as they grow older, are twice as likely to become depressed themselves.

Risk factors for a woman developing postpartum depression include a personal or family history of depression, depression during pregnancy, or mood disorders related to menstruation or fertility treatments. Previous unresolved pregnancy loss may interfere with attachment, because the threat of repeated loss is there in a subsequent pregnancy. If a woman has any of the identified risk factors, she and her partner should be on the lookout for symptoms of depression. They are not always obvious, and they do not generally announce themselves all at once.

There are also risk factors for depression during pregnancy. Contrary to popular belief, pregnancy is not protective against mood disorders. In fact, 14-23 percent of women experience depression during pregnancy. Depression or anxiety during pregnancy is often overlooked because the symptoms resemble some of the normal changes of pregnancy. For example, there may be a loss of appetite and sleeplessness. As with postpartum depression, it's important for the mother to be treated for her depression, because anxiety and stress can be passed on to the baby through the placenta. Mothers who find themselves struggling with depression and anxiety during their pregnancy increase their risk for premature delivery and low birth weight of their infant.

There are other mental health disorders a new mother may encounter. Occasionally, childbirth can cause symptoms of post-traumatic stress or even full-blown PTSD. This can be the result of an earlier trauma (like sexual abuse) that is revived by the birthing process, or trauma caused by a difficult birth. What a woman experiences as a trauma can be very individual: for some, an unplanned Caesarean birth or the use of forceps will be traumatic. Or it may be a stillbirth, an unusually painful labor, loss of blood, or an infant in distress or danger. These can have a lasting effect on the mother and can cause PTSD.

What's most important is that if you suspect depression, you should consult a health professional at once. **[Indicate the list of resources on Handout B.]** It's not only for your benefit, but for the baby's. Perinatal depression is highly treatable, and there are a range of treatment options. These generally include a combination of antidepressant or anti-anxiety medications, along with a short course of

psychotherapy; modalities may include interpersonal psychotherapy and cognitive behavioral therapy. Many medications are compatible with breast-feeding; consult with a professional to determine what is right for your situation. Women who are already on antidepressants when they are trying to conceive are generally encouraged to remain on a low dose during their pregnancy to avoid a depression relapse or what has been termed “discontinuation syndrome.”

Mental health in general is often overlooked or not addressed because of the stigma that still exists in our society. In fact, it is just like physical health. No one is immune from a mental health disorder; 50 percent of all Americans will experience a mental health disorder sometime in their lives. Some occurrences will be mild and pass without intervention; other illnesses are chronic, even life-threatening.

The transition to parenthood is a stressful time, and fathers may also experience mood disorders. In fact, 10 percent of fathers suffer from depression in the postpartum period. The point is, be sure to consult a professional and get the help you need, because it is important not only for your own health and well-being, but the health and well-being of your partner and your baby.

Depression and anxiety are true disorders. It’s important to know that environmental stress can have an effect on how well you and your partner cope. Women with postpartum depression who have a strong social network tend to experience less distress and milder symptoms. Communication is important. Feelings of isolation compound negative moods. Self-care is essential during this vulnerable time. Diet, rest, exercise, and emotional and practical support can make a big difference in the way a woman feels and in her ability to care for her baby.

Handout A

## **Mental Health During Pregnancy and the Postpartum Period**

### *Depression Risk Factors, Definitions, and Symptoms*

Risk factors for developing postpartum depression (PPD) or depression during pregnancy include:

- A previous personal or family history of depression, or other mental health concern
- Mood disorders (depression and/or anxiety) related to menstruation or fertility treatments
- Previous unresolved pregnancy losses (abortion, stillbirth, miscarriage)
- Difficulties with the pregnancy (including depression during pregnancy) or the baby's health

Additional factors may also make women vulnerable: emotional loss, physical or sexual trauma, and lack of a social support network.

**Postpartum depression has a language of its own.** Key phrases depressed mothers may use to describe their symptoms include: "I feel like I'm in a fog," "I'm on an emotional roller coaster," "I'm going through the motions," "I made a mistake having this baby," "My husband and baby would be better off without me," and "I can't make the simplest decisions."

**Symptoms of postpartum depression with anxiety (1 in 5 women) include:**

- Changes in sleep or appetite
- Fogginess
- A sense of confusion and disorientation
- Inability to cope
- Paralyzing anxiety
- Overwhelming sadness and emotion
- Fear of being left alone
- Suicidal thoughts
- Feelings of inadequacy
- Hopelessness and despair
- Emotional detachment from the baby

Symptoms of postpartum depression with panic disorder (1 in 10) include panic attacks, chest pains, which can feel like a heart attack, difficulty breathing, sweating, tingling around the face or hands, a feeling as if she were dying.

Symptoms of postpartum depression with obsessive compulsive features (2 in 100) include:

- Engaging in repetitive behaviors (counting bottles or diapers, continual checking of the baby's breathing)
- Hypervigilance (extreme watchfulness)
- Extreme worry that the baby is sick or in danger
- Intrusive, destructive images, usually of harm to herself or the baby – for example, a mother may envision herself dropping the baby, or that a knife she is holding could slip and cut the baby.

*The difference between postpartum depression with obsessive compulsive features and postpartum psychosis is that mothers know that these thoughts are bizarre and they take steps to do whatever necessary to avoid what they believe to be inevitable harm to their infant.*

There are other mental health disorders a new mother may encounter. Occasionally, childbirth can result in post-traumatic stress disorder (PTSD).

The point is, be sure to consult a professional and get the help you need. It is important not only for your own health and well-being, but the health and well-being of your baby and your partner.

Handout B

**Mental Health During Pregnancy and the Postpartum Period**

*Local Mental Health Resources*

Note: You are responsible for compiling Handout B for this session, listing up-to-date information on psychotherapists, physicians, and other professionals who specialize in perinatal mental health.