WHAT IS PERINATAL?

Pregnancy

Through first postpartum year

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PMAD not PPD

PERINATAL (Maternal)

MOOD (depression and bipolar)

ANXIETY (GAD, panic, OCD, PTSD)

DISORDERS

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THE PRESSURES OF MOTHERHOOD

• Being the perfect mother
• Having the perfect baby
• Being the perfect wife/partner
• Motherhood=Selflessness

PERFECTIONISM VS. EXCELLENCE

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Strong & Independent

and

It takes a village
Every year, more than 400,000 infants are born to mothers who are depressed, which makes perinatal depression the most under diagnosed obstetric complication in America. Postpartum depression leads to increased costs of medical care, inappropriate medical care, child abuse and neglect, discontinuation of breastfeeding, and family dysfunction and adversely affects early brain development.

Pediatrics 2010;126;1032-1039
THIS MAY BRING UP FEELINGS!
PRACTICAL BARRIERS

- Cost of treatment
- Limited time
- Loss of pay from work
- Poor access or transportation
- Childcare
- Provider ignorance (Kim JJ, Am J ObstetGynecol 2010;202:312.e1-5)
PSYCHOLOGICAL BARRIERS

- Illness itself
- Social Stigma
- Fear
- Lack of information
- Opposition to treatment (lack or poor support)  

(Dennis, CL and Chung-Lee, L. Birth 2006;33(4):323-331)

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RACISM & HEALTH DISPARITIES

• Racism increases the “risk of risks”
  • Limits economic opportunity
  • Limits access to social resources
  • Increases exposure to dangerous work and living environments

• Poverty

21% had postpartum depression

- 26.5% of the episodes began before pregnancy and had a more chronic pattern
- 33.4% of the episodes had their onset during pregnancy
- 40.1% of the episodes began during the postpartum period

STUDY OF 10,000

- 68.5% primary diagnosis was unipolar depression
- 66% with MDD had comorbid anxiety disorders, most commonly generalized anxiety disorder
- 22.6% of the women were diagnosed with bipolar disorder
- 19.3% of the women endorsed thoughts of harming themselves

Wisner KL, Sit DKY, McShea MC, et al. JAMA Psychiatry March 2013
CROSS CULTURAL RATES

- African American women highest rates
  - Reported less partner support, more stress
- American Indian/Native Alaskan women
- Caucasian women mid range
- Hispanic women reported highest levels of partner support, more breastfeeding

• Race/ethnicity is a significant predictor of depressed mood controlling for:
  • Age
  • Marital status
  • Income
  • Educational level
  • Infant health outcome

Segre L. et al. Journal of Reproductive Infant Psych, 2006;24(2)99-106
PREVENTION OF PMADS: There is no excuse!

WE KNOW:

• Who is at risk
• How to screen (preconception, every trimester in preg and well baby visits in 1st year).
• How to engage Preventive Tools (continue treatment, sleep, physical activity, etc)
• Reliable Treatment Methods
PREGNANCY OR DEPRESSION?

• Mood is up/down, teary
• Self esteem is normal
• Sleep: bladder or heartburn may awaken. Can fall asleep
• No suicidal ideology
• Energy: may tire, rest restores
• Pleasure: joy and anticipation (appropriate worry)
• Appetite: increases

• Mood: persistent gloom
• Low self-esteem, guilt
• Sleep: early a.m. awakening
• Suicidal thoughts, plans, or intentions
• Energy: rest does not restore. Fatigue
• Anhedonia (no joy/pleasure)
• Poor appetite

DEPRESSION IN PREGNANCY


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DEPRESSION IN PREGNANCY RISK

- Women depressed at 18 wks gestation had 3x risk of PPD
- Depression at 32 weeks-6x risk

ANXIETY

- Subsequent pregnancy
- Hx of GAD, OCD, panic disorder
- Unwanted pregnancy
- Domestic violence, abuse survivor
- Poverty, racism, other chronic stressors
• 50% bipolar women who discontinued meds relapsed in first 3 months of pregnancy,

• 70% relapsed by 6 months (Viguera A. et al. Am J of Psychiatry, 2007 Dec;164(12):1817-24)

• Valproic Acid has up to 5% risk neural tube defects

• Lithium has 0.05% risk of Ebstein’s anomaly in 1st trimester. Good choice for bipolar disorders

• Lamictal (lamotrigen) also used

• Preconception counseling is critical
Suicide in Pregnancy

- Suicides represented 41% of pregnancy associated violent deaths

(National Violent Death Reporting System, February 11, 2010)
POSTPARTUM “BLUES”

- 50-80%
- Onset in first week postpartum
- Symptoms may persist from several days to a few weeks
- *Mild* mood swings
BLUES OR BEYOND?

- Timing
- Duration
- Severity
SYMPTOMS OF THE BLUES

- Mood instability
- Weepiness
- Anxiety
- Lack of concentration
- Feelings of dependency

MILD AND TRANSIENT

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Causes of the "Blues"

- Rapid hormonal changes
- Physical and emotional stress of birthing
- Physical discomforts
- Emotional letdown after pregnancy and birth
- Awareness and anxiety about increased responsibility
- Sleep deprivation
- Disappointments-including the birth, spousal support, nursing, and the baby
POSTPARTUM DEPRESSION/ANXIETY

- 21% and 26-32% adolescents

- Onset is usually gradual, or can be rapid, and can occur any time in the first year
- Symptoms often peak at 3-6 months
- Can become chronic
SYMPTOMS OF POSTPARTUM DEPRESSION/ANXIETY:

- Sad mood, guilt, irritability, excessive worry, anxiety, or feelings of being overwhelmed
- Sleep problems (often insomnia), fatigue
- Symptoms or complaints in excess of, or without physical cause
- Discomfort around baby, or lack of feelings towards baby
- Loss of focus and concentration (may miss appointments)
- Loss of interest or pleasure
- Appetite changes—poor appetite or weight gain

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FREQUENT SYMPTOMS IN PRACTICE


1. “felt really overwhelmed”
2. “felt like my emotions were on a rollercoaster”
3. “have been very irritable”
4. “felt all alone”
5. “felt like I wasn’t normal”
RISK FACTORS FOR PPD

- 50-80% risk if previous postpartum depression
- 50% risk if depression or anxiety during pregnancy
- Personal and/or family history of depression or other psychiatric disorder
- History of severe PMS or PMDD
- Social isolation/poor support system/teens/NICU/low SES

Suicide causes more deaths than obstetric complications like hemorrhage or eclampsia.


• Related to psych illness, substance abuse

• Less associated with unemployment, adversity, single status and divorce

TREATMENT FOR POSTPARTUM DEPRESSION/ANXIETY

- Individual therapy
- Group support/social support
- Medication for sleep
- Treat thyroiditis
- ECT

INADEQUATE TREATMENT CAN LEAD TO CHRONIC DEPRESSION OR RELAPSE

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POSTPARTUM OBSESSIVE-COMPULSIVE DISORDER (OCD)

• Up to 11% of new mothers develop obsessive symptoms and meet criteria for OCD

• 2.3% reported new postpartum onset

• Frequent co-morbid depression

SYMPTOMS OF PERINATAL OCD

• Intrusive, repetitive, and persistent thoughts or mental pictures

• Thoughts often are about hurting or killing the baby

• Tremendous sense of horror and (ego alien)

• Thoughts may be accompanied by behaviors to reduce the anxiety (such as hiding knives)

• Repetitive counting (diapers in the bag), checking (baby’s breathing), cleaning

TREATMENT FOR OCD

• Psychoeducation
• Psychotherapy
• Medication (SSRIs, anti-anxiety medications, anti-psychotics)
POSTPARTUM PANIC

- May occur in about 10%
SYMPTOMS OF PANIC

• Episodes of extreme anxiety: excessive or obsessive worry or fears
• Shortness of breath, chest pain, sensations of choking or smothering, dizziness
• Hot or cold flashes, trembling, palpitations, numbness or tingling sensations
• Restlessness, agitation, or irritability
• During attack may fear she is going crazy, dying, or losing control
• Attack may awaken her from sleep
• Often no identifiable trigger for panic

TREATMENT FOR PANIC DISORDER

- Psychotherapy
- SSRIs
- Antianxiety medication
POSTTRAUMATIC STRESS DISORDER (PTSD)

- May occur in 1-6% (Beck CT. Nursing Research. July/Aug 2004; 53(4):216-224)

- Up to 38% report traumatic birth (Beck C & Watson S, Impact of Birth Trauma on Nursing, Nursing Research 2008(57);4:228-236)
TRAUMATIC BIRTH

- Up to 34% of moms report a traumatic birth (Beck C. and S. Watson, Nursing Research July/August 2008 Vol 57, No 4, 228–236)

- Up to 9% of women met DSM-IV criteria for PTSD

- Up to 18% showed high levels of postpartum PTSD symptoms (Beck C. et al. Birth. September 2011;38:3)
NICU Families

• Up to 70%

• Common to experience PTSD, PMADs
SYMPTOMS OF PTSD

- Recurrent nightmares
- Extreme anxiety
- Reliving past traumatic events
  - sexual
  - physical
  - emotional
  - childbirth

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TREATMENT FOR PTSD

- Psychotherapy
- SSRIs and/or antianxiety medication
Bipolar Disorder

- Postpartum rates range up to 82% in women with BD
- Time of increased vulnerability for relapse
- Closely associated with postpartum psychosis
- Most women misdiagnosed!

SYMPTOMS OF BIPOLAR

• Mania and hypomania ("moody")
• Depression
• Rapid and severe mood swings
• Postpartum depression imposter

“It was the seventh deadly sin. My children weren't righteous. They stumbled because I was evil. The way I was raising them they could never be saved. They were doomed to perish in the fires of hell.”

Andrea Yates, mother of Noah, John, Luke, Paul & Mary
RISK FACTORS FOR POSTPARTUM PSYCHOSIS

• Personal (20-50% risk) and/or family history of psychosis or bipolar disorder
• 80% risk if previous postpartum psychotic or bipolar episode
• First baby

POSTPARTUM PSYCHOSIS

- Occurs in 1-2/1000
SUICIDE RISK WITH PPP

- 2/1000 women with PPP complete suicide
- Homicidal behavior rare
- Cognitive disorganization may contribute to neglect and unsafe infant care
TREATMENT FOR POSTPARTUM PSYCHOSIS

- Requires immediate hospitalization
- Antipsychotics
- Mood stabilizers (antidepressants as needed)
- Psychotherapy
- ECT

WHY SCREEN?
BENEFITS OF SCREENING

• Normalization of mental health issues
• Sets expectations for future screening
• Opens the door to dialogue
• Provides opportunities for education and risk management
• Improves detection!!!
WHAT IS SCREENING?

• Screening is a tool to aid in
  • Assessment of who needs further evaluation and treatment
  • To review progress in treatment

SCREENING IS AN INDICATION OF SYMPTOMS AND IS NOT DIAGNOSTIC

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HOW DO YOU INTRODUCE SCREENING?

What do you say?
PRENATAL SCREENING

• Edinburgh Postnatal Depression Scale (EPDS), 1987 by Cox, et. al. (validated for prenatal depression)
POSTPARTUM SCREENING

- **Edinburgh Postnatal Depression Scale (EPDS), 1987 by Cox, et. al.**
  - Free, used in preg, over phone, translated
  - Score of $\geq 12$ refer for evaluation

- **PHQ-9** [http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/](http://www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/)
  - Free, used in medical settings, translated
  - Not as validated for perinatal use

- **Postpartum Depression Screening Scale (PDSS), 2002 by Cheryl Beck D.N.Sc.**
  - Costs, Eng/Spanish www.wpspublish.com 800-648-8857
Underline answer closest to how you have felt in the **past 7 days**.

### Edinburgh Postnatal Depression Scale

1. I have been able to laugh and see the funny side of things:
   - As much as I always could: 0
   - Not quite so much now: 1
   - Definitely not so much now: 2
   - Not at all: 3

2. I have looked forward with enjoyment to things:
   - As much as I ever did: 0
   - Rather less than I used to: 1
   - Definitely less than I used to: 2
   - Hardly at all: 3

3. I have blamed myself unnecessarily when things went wrong:
   - Yes, most of the time: 3
   - Yes, some of the time: 2
   - Not very often: 1
   - No, never: 0

4. I have been anxious or worried for no very good reason:
   - No, not at all: 0
   - Hardly ever: 1
   - Yes, sometimes: 2
   - Yes, very often: 3

5. I have felt scared or panicky for no very good reason:
   - Yes, quite a lot: 3
   - Yes, sometimes: 2
   - No, not much: 1
   - No, not at all: 0

6. Things have been getting the best of me:
   - Yes, most of the time I haven’t been able to cope at all: 3
   - Yes, sometimes I haven’t been coping as well as usual: 2
   - No, most of the time I have coped quite well: 1
   - No, I have been coping as well as ever: 0

7. I have been so unhappy that I have had difficulty sleeping:
   - Yes, most of the time: 3
   - Yes, sometimes: 2
   - Not very often: 1
   - No, not at all: 0

8. I have felt sad or miserable:
   - Yes, most of the time: 3
   - Yes, quite often: 2
   - Not very often: 1
   - No, not at all: 0

9. I have been so unhappy that I have been crying:
   - Yes, most of the time: 3
   - Yes, quite often: 2
   - Only occasionally: 1
   - No, never: 0

10. The thought of harming myself has occurred to me:
    - Yes, quite often: 3
    - Sometimes: 2
    - Hardly ever: 1
    - Never: 0

WHEN SHOULD WE SCREEN?

• Ideally, preconception!
• Each trimester of pregnancy
• All well-baby checkups in first year
• High risk groups (NICU, Teens)
healthy mom, happy family

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TREATMENT FOR PERINATAL MOOD/ANXIETY DISORDERS
THE TREATMENT TEAM

Medical Intervention

MOM + Family

Psychological Treatment

Social Support

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Common Characteristics of Postpartum Cultural Practices

Distinct postpartum period recognized as a time when mothers are supposed to recuperate

Protective measures and taboos reflecting the new mother’s vulnerability such as the offering of special soups or meals and keeping the mother and infant warm, e.g., Hot/Cold beliefs

A period of social seclusion and mandated rest which typically lasts 6 to 8 weeks
“It is interesting that women’s status has been considered relatively higher in Western cultures than in non-western cultures, yet paradoxically less recognition seems to be given to new mothers in the United States”

(Kim-Goodwin, YS. American Journal of Maternal Child Nursing 200328(2),74-78)
WHO IS ON YOUR TEAM?
TREATING PMADS
TREATMENT CONSIDERATIONS

• History of the illness
• Degree of current illness
• Risks and benefits of treatment options
• Patient/family’s history and preferences, cultural beliefs
RISK BENEFIT RATIO

Risks of Untreated Illness Treatment vs Risks of Medical Treatment

NO RISK-FREE ZONE!!!
What Is Evidence-Based?

- Practice supported by research findings and/or demonstrated as being effective through a critical examination of current and past practices
**PSYCHOTHERAPY MODELS**

- **Interpersonal Psychotherapy (IPT)**
  
  
  [http://www.psychology.uiowa.edu/labs/idcrc/Library/IPT.pdf](http://www.psychology.uiowa.edu/labs/idcrc/Library/IPT.pdf) and [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2234626/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2234626/)

- **Cognitive-Behavioral Therapy (CBT)**
  

- **Couples Therapy, Partner Assisted Therapy**
  

- **Group**
  
  [http://www.jppr.psychiatryonline.org/cgi/content/abstract/10/2/124](http://www.jppr.psychiatryonline.org/cgi/content/abstract/10/2/124) and [http://ajp.psychiatryonline.org/cgi/content/abstract/158/4/638](http://ajp.psychiatryonline.org/cgi/content/abstract/158/4/638)

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Motivational and Ethnographic Interviewing

- One session intervention
  - Asks the “story”
  - Gives feedback and psychoeducation
  - Tx history, experience & hopes for this tx
  - Barriers-what would make it hard...

• Therapeutic alliance
• Instills and nurtures hope
• Collaborative goals (behavioral, do-able)
• Psychoeducation
• Skills building

COGNITIVE-BEHAVIORAL THERAPY

- CBT is thought or symptom based
- Teaches clients to identify, evaluate, and change dysfunctional patterns of thinking, so that changes can occur in mood and behavior.

MIND (thoughts)

BODY (feelings)

MOOD

BEHAVIOR

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CBT View of Depression

A

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Culturally Relevant IPT-B Prenatal Depression

- Sessions 1-2 (up to 8 sessions)
  - Her experience and views on causation
  - Sociocultural context of understanding
  - Views on treatment
  - Social problems; acute and chronic stressors
  - Assessment
  - Psychoeducation
  - F/U @ 6 months postpartum

Grote, N. et al. Psychiatric Services, 2009: 60(3)
SOCIAL SUPPORT

- On-line computer support: message boards, live web groups
- Visiting nurses, health workers, WIC, other moms
- Local hospitals
- Community centers
- Support groups
TELEPHONE SUPPORT

• Telephone-based peer support effectively decreased depressive symptoms in new mothers.

• High maternal satisfaction with and acceptance of the intervention.

(Dennis CL et al, Effect of peer support on prevention of postnatal depression among high risk women: multisite randomised controlled trial, 2009 BMJ 2009;338:a3064)
HOME VISITORS

- Trained to do postpartum depression screening
- Trained to do brief psychotherapeutic interventions
- Reduced depression scores found at 6 and 12 months compared to usual care (Morrell, JC. et al. BMJ 2009;338:a3045)
Objective: Social support has a positive influence on women’s childbearing experience and is shown to be a preventive factor in postpartum depression. This study examined the perceived value and types of social supports that characterize the discussions of women who participate in postpartum depression online discussion groups.
Conclusions: Online support groups provide women experiencing postpartum depression a safe place to connect with others and receive information, encouragement and hope.

Practice implications: Education strategies are needed to address the many questions regarding PPD medical treatment. Recommending vetted links to PPD online support groups will create opportunities for women to share their experiences and obtain support.

Serotonin is normally removed from the synapse by reuptake sites on the presynaptic neuron. SSRIs block the serotonin reuptake sites, allowing serotonin to remain active in the synapse longer.
WHAT THE MEDIA SAYS:

Antidepressant SSRI birth defects may merit a defective drug lawsuit for Paxil, Zoloft, Prozac, others.

No one is more tiny, innocent or helpless than newborn babies -- babies who inspire fierce protectiveness in their parents. But some giant pharmaceutical companies have no such concerns. Rather, their fierce focus is making money, even if it means harming tiny, innocent, helpless babies to make more money.

Such companies may cause serious birth defects of the heart, brain, spinal cord, lungs and other vital organs. And they may be doing it in the form of antidepressant drugs which some mothers take during pregnancy.
Did You Use Prescription Drugs like Paxil®, Zoloft®, Prozac®, or Celexa® while pregnant and have a child with a Birth Defect? You may be entitled to Substantial financial compensation for your child’s condition.

Medical journals and the FDA report numerous drugs are reported to have an increased risk of birth defects in newborns if used before or during pregnancy!
SSRI’s in PREGNANCY

• “Our findings do not show that there are significantly increased risks of craniosynostosis, omphalocele, or heart defects associated with SSRI use overall.”

• “Maternal use of SSRI’s during early pregnancy was not associated with significant increased risks of congenital heart defects or of most other categories of birth defects.”

• “It should be recognized that the specific defects implicated are rare and the absolute risks are small.”

The New England Journal of Medicine June 28, 2007; (35)
DO SSRI’s CAUSE AUTISM (ASD)?

- Population-based case-control study (n=20)
- Medical records of prescriptions written
- Often no mental health diagnosis charted
- Smoking or alcohol use not included in study
- < 3% ASD cases “may be attributed” to SSRI’s
- “Prenatal SSRI exposure very unlikely to be a major risk factor for ASD”

Croen, L. et al. 2011, Arch Gen Psychiatry
When a psychiatric condition necessitates pharmacotherapy, the benefits of such therapy far outweigh the potential minimal risks of cardiac malformations, primary pulmonary hypertension of the newborn, or poor neonatal adaptation syndrome. (Koren, G., Nordeng, H., American Journal of Obstetrics and Gynecology (2012), doi:10.1016/j.ajog.2012.02.009)
PRENATAL MEDICATIONS

• As blood volume increases in pregnancy, medications are diluted.

• Dosage may need to increase in 3rd trimester
BREASTFEEDING AND ANTIDEPRESSANTS

• AAP now recommends 1 year of breastfeeding

• “Paxil and Zoloft usually produce undetectable infant levels.” (Weissman AM. et al. Am J Psychiatry 2004;161:1066-1078)

• “…most are found at a very low levels and are not clinically relevant for the neonate.” (ACOG Practice Bulletin, April 2008, (92)

TREATMENT GUIDELINES

• Always r/o bipolar spectrum before starting SSRI’s  
http://www.psycheducation.org/depression/MDQ.htm

• Start at low dose and work up

• F/U frequently and treat to **wellness**!

• Meds work best **with** therapy
RESOURCES

- www.mothertobaby.org 866-626-6847 (fetal and breastmilk exposure Specialists-free patient handouts)
- www.motherisk.org (fetal and breastmilk exposure)
- www.infantrisk.org (fetal and breastmilk exposure, phone app!)
- www.womensmentalhealth.org (Harvard/Mass General)
WHAT ABOUT DADS/PARTNERS?
FATHERS

- In a national studies reported in 2006 and 2010, 10% of new fathers scored in the range of moderate to severe depression.

- Maternal depression increased the risk of paternal depression.

CONSEQUENCES OF UNTREATED Perinatal Mood and Anxiety Disorders

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Prenatal anxiety and postpartum depression represent *separate* risks for behavioral/emotional problems in children age 4 and act in an additive manner.

FIGURE 1. Summary of evidence on depression, anxiety and stress. GA, gestational age at birth; LBW, low birth weight; PTB, preterm birth.
PRENATAL ANXIETY

- Anxiety at the 2nd & 3rd trimesters predicted lower birth weight and shorter birth length
- Anxiety reported in 3rd trimester predicted shortened gestational age, controlling for confounders
- Women who report chronic, severe trait anxiety are at the highest risk of having shorter gestations and delivering smaller babies.

Prenatal Stress

- Impaired fetal growth
- Preeclampsia
- Placental abruption
- Maternal bereavement increases stillbirth risk 18%

CONSEQUENCES PRENATAL DEPRESSION

- Preterm birth
- Low birth weight
- Intrauterine growth retardation
- NICU admissions

(Grote N. et al. Arch Gen Psychiatry. 2010 Oct;67(10):1012-24)
PRENATAL DEPRESSION

• Study looked at women depressed in pregnancy and not postpartum.
• Prenatal depression: 50% increase of developmental delay at 18 months on modified developmental screen.

(Deave, T. et al. BJOG 2008;115:1043-1051)
BREASTFEEDING CONSEQUENCES

• Depression and anxiety levels related to likelihood of breastfeed cessation
• Breastfeeding cessation predictive of postpartum depression & anxiety

Ystrom E. BMC Pregnancy and Childbirth 2012, 12:36
http://www.biomedcentral.com/1471-2393/12/36

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Depressed Moms

• Less likely to
  – Put infants to sleep on their backs
  – Use car seats, electrical outlet covers, smoke detectors

• More likely to
  – Put infants to bed with a bottle
  – Use spankings
  – 3 times more likely to have an infant hospitalized in first year of life (Chung, E. PEDIATRICS Vol. 113 No. 6 June 1, 2004 pp. e523-e529)
Depression Continues..

- Field found 75% moms still depressed at 3 yrs postpartum

(Emotional Care of the At-Risk Infant: Early Interventions for Infants of Depressed Mothers, Field, Pediatrics, suppl Nov 1998102(5):1305-1310)
DEPRESSED DADS

• Depression in fathers in the postpartum period was significantly associated with psychiatric disorder in their children 7 years later (most notably oppositional defiant/conduct disorders)

Parenting Styles of Depressed Mothers

Intrusive Style:

• Rough handling
• Angry/hostile
• Actively interfere with their infants’ activities
Parenting Styles of Depressed Mothers

Withdrawn style

• Disengaged
• Distant
• Unresponsive/flat affect
• Do little to encourage or support their infants’ activities
Effects on Infants

• Higher levels of stress hormones
• Higher heart rates during interaction with their mothers
• More sleep disturbance

Effects on Infants

- Brain activity looks the same as in clinically depressed adults
- More than twice as likely to experience depression and anxiety than children exposed when older (Hammen C. and Patricia Brennan, Arch Gen Psychiatry, 2003;60:253-258)

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Effects on Toddlers

- Insecure attachment with mother
- Less social interaction with peers
- Inappropriate interactions
- Lower self esteem
- More behavior problems

(Beck CT. 1999;29:623-629)
Effects on Preschoolers

- Insecure emotional attachment with mother
- Poorer attention
- Poorer frustration tolerance and anger control (aggressive)
- Poorer social behavior & less sharing
- Poorer performance on verbal comprehension
- Poor speech skills
Effects on School Age Children

- More conflict with peers and siblings
- More aggression and anger
- Poor cognitive processing
- Poor schoolwork
- Enuresis (bed wetting)
- Sleep problems
- Withdrawal, passivity
- Anxiety

Effects on Teens

• Psychiatric symptoms
  • Psychosomatic complaints
  • Less pleasure and fun
  • Sleeping problems
  • Eating problems
  • Depression and Anxiety

(Hammen, C. and PA Brennan. Arch Gen Psychiatry 2003;60:253-258)

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DEPRESSION BURDEN

• Depression in women 15-44 yrs old make up the leading cause of disease burden worldwide

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TREAT DEPRESSED PARENTS!!!
Join PSI!

www.postpartum.net

1-800-944-4PPD

Postpartum Support International
Postpartum Support International
www.postpartum.net

- 1-888-948-4PPD support Eng/Spanish
- Free “chat with expert” phone calls
- Resource map
- Accurate information; training programs
- Annual conference **June 19-22, 2013** Minneapolis, Minnesota
- DVD in Eng/Span
RESOURCES

- www.womensmentalhealth.org
- www.mededppd.org (professionals and consumer info)
- Online Training- www.step-ppd.com

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• Beyond the Blues, Understanding and Treating Prenatal and Postpartum Depression & Anxiety (2010 Indman and Bennett)

• Life Will Never Be the Same: The Real Mom ’s Postpartum Survival Guide (2010 Dunnewold and Sanford)

• The Prenatal and Postpartum Anxiety Workbook (2009 Gyoerkoe and Wiegartz)

• Therapy and the Postpartum Woman (2008 Karen Kleiman)
Books

• *Dropping the Baby, and Other Scary Thoughts*, 2011, by Kleiman & Wenzel

• *Anxiety in Childbearing Women*, 2011, by Amy Wenzel

• *When Survivors Give Birth: Understanding and Healing the Effects of Early Sexual Abuse on Childbearing Women*, 2004, Simkin & Klaus
Internet based therapy and support groups for moms with perinatal mood and anxiety disorders.

www.regrouptherapy.com