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# Perinatal Depression: Breaking Barriers to Treatment

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# PERINATAL DEPRESSION—

Breaking barriers to treatment

Colchester Family Medicine  
Project by Florence Lambert-  
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July 2-August 10, 2018  
Mentors: Dr. Anya Koutras, Dr.  
Sarah Guth, and Sandy Wood  
APRN

# PROBLEM

- **1 in 9 women** experience symptoms of postpartum depression worldwide (Ko JY et al. 2017)
- A 2012 report from the Pregnancy Risk Assessment Monitoring System (PRAMS) revealed that **10.1% of new Vermont moms** experience postpartum depression (Ko JY et al. 2017)
  - In addition, more than **50% of Vermont women** have screened positive for Perinatal Mood and Anxiety Disorders in the third trimester (VT Department of Health 2014).
- Suicide is the cause of 20% of postpartum deaths and is the second most common cause of mortality in postpartum women (Wisner KL et al. 2013).

## Definitions

- **Perinatal:** the period before and after birth, usually between 20-28 weeks of gestation and 1-4 weeks postpartum
- **Perinatal Mood and Anxiety Disorders (PMADs):** includes depression, anxiety, and psychosis in the perinatal period.
- **Postpartum depression:** refers to depression specifically following giving birth; does not include time while pregnant

\* The focus of this project is on **perinatal depression** which includes postpartum depression

# PROBLEM — BARRIERS TO SEEKING HELP

- In the US, a significant barrier to diagnosing and treating perinatal mental illness is that women are reluctant to admitting they have depression, and they tend to minimize their symptoms
  - There is a lot of shame, fear of being labeled “mentally ill” and **stigma**. Women do not want to be perceived or think of themselves as “bad moms.”
- Perinatal depression can be hard to distinguish from “baby blues” and the new stresses of motherhood
  - Studies have shown that women **misidentify their depression** as the normal struggles of being a new mother

(Dennis 2007)

# COSTS OF PERINATAL DEPRESSION

- **Increased risk of not breastfeeding**
  - More likely to discontinue 4-16 weeks postpartum
  - Moms more unsatisfied with breastfeeding
- **Poor maternal-child bonding**
  - Touch infants less frequently and less affectionately
  - More negative touch: pulling, tickling, poking
  - Vocal changes: more negative mood, fewer explanations, and less repetition
  - Less likely to tell stories and play peek-a-boo
- **Poorer healthcare of child**
  - Infants receive fewer preventative visits, such as well-child checks
  - Fewer immunizations at 24 months

(Field 2009)

# COSTS OF PERINATAL DEPRESSION

- **Cognitive impairment and psychopathology in child**

- poorer language development (Brand 2009)
- impaired executive functioning: eg attention, working memory (Pearson 2016).
- Multiple studies show post-partum depression is associated with conduct disorder, oppositional defiant disorder, ADHD, anxiety, and depression in the child. (Brand 2009).
- The prevalence of psychiatric disorders at age 11 years was four times greater in children of depressed mothers than controls (Pawlby 2008)

- **Maternal suicide**

- Suicide is the second most common cause of mortality in postpartum women (Wisner KL et al. 2013).

- **Monetary costs**

- Women diagnosed with postpartum depression had 90% higher health care costs than non-depressed women; depressed women were four times more likely to visit the emergency room (Dagher 2012)

# COMMUNITY PERSPECTIVE-

## AWARENESS AND STIGMA

- **Perinatal Mood and Anxiety Disorders (PMADs) are prevalent in Vermont**, more common than all the other things we screen for in pregnancy, including hypertension and gestational diabetes
- Perinatal depression is not often on women's radars
  - "Women are really focused on the birth, and that's only a tiny part of it... it's hard to get women to think about the transition to life after the birth"*
- Women believe they are alone
  - "Women often compare themselves and think, 'Everybody else seems to be figuring it out, but I can't'"*
- Many have trouble admitting to a mental health issue due to feelings of **guilt**
  - "New moms say, 'I should be stronger...I shouldn't be feeling like this' –a lot of 'should' statements. 'I should be able to do this by myself.' ...A huge thing is to get them to let go and accept help."*
- Several have **misconceptions** about what it means to be diagnosed with PMAD
  - "DCF will come take my baby away"*

**Quotations and information provided by Sandra Wood APRN, CNM, PMHNP**

Sandy is a certified midwife and nurse practitioner specializing in psychiatry. She currently works at UVMHC as a perinatal psychiatrist.

# COMMUNITY PERSPECTIVE-

## LACK OF PREEMPTIVE CARE

- There is so much we know we can do to decrease the risk of perinatal depression, and we are doing a lot to screen for it. Our focus needs to shift to things we can do **prenatally** to set women up with good support
- We should identify risk factors in women to address them as part of their care: poverty, previous depression and anxiety, history of trauma, complications of birth, poor social support, history of PMDD on oral contraceptives, women with thyroid autoantibodies, ongoing stressful life events, etc.
- Set up women with resources **early** and educate them about what they can do to help themselves.
  - Women should talk about their mental wellbeing with their providers. Many don't know that they can talk to their PCP or OB/gyn about this, not just a therapist.
  - Women should establish care with a therapist, especially if they have risk factors for perinatal depression
  - Perinatally and postnatally, physical activity reduces risk of PMAD
  - Prenatal yoga decreases the rates of postpartum depression, as does mindfulness and being part of a community
  - “Women who have planned ahead tend to have a good postpartum period”

Quotations and information provided by Sarah Guth, MD

Dr. Guth is a child and perinatal psychiatrist currently practicing at UVMHC



# INTERVENTION – EDUCATIONAL PAMPHLET FOR PREGNANT WOMEN AND NEW MOMS

1. To address the issue of misdiagnosis of depression as “baby blues”: pamphlet includes information about the signs/symptoms of postpartum depression that go beyond the more benign, earlier changes in mood from being a new mom
  - Help moms identify postpartum depression in themselves so that they may seek help earlier
2. The pamphlet will aim to normalize perinatal depression and remove some stigma surrounding having depression as a mom
3. Emphasize preemptively looking out for personal risk factors for perinatal depression and establishing care, such as with a therapist, *before* the baby is born
4. Provide inexpensive/free and local resources for mothers and encourage them to seek help. Mention of postpartum support groups also aims to make them understand that this is a common issue for mothers

# RESULTS

- Resources are specific to Chittenden county and two out of the three options are free of charge

- The First Call hotline is important for women to know about should they find themselves in crisis

## Resources in Chittenden County



1. **New Moms Support Group** (FREE – must schedule): Mondays 11 am-12:30pm in Williston VT; visit [www.RachelTotten.com/support-groups](http://www.RachelTotten.com/support-groups)
2. **Postpartum Adjustment Support Group** (FREE, walk-ins welcome): Every other Wednesday, 12:30-1:45pm in the Janet S. Munt Family room at the UVM Medical Center; visit [www.thefamilyroomvt.org](http://www.thefamilyroomvt.org) or call 802-862-2121
3. **Evolution Yoga**: a family yoga center with both prenatal and postnatal classes; Locations in Burlington and Essex Junction; Call 802-899-0339 or visit [evolutionprenatalandfamily.com](http://evolutionprenatalandfamily.com) for more info

### Other contacts

1. **First Call**: if you have thoughts of suicide or self-harm, call **802-488-7777**
2. **Burlington District Office of the Vermont Department of Health**: **888-253-8803** or **802-863-7323**. To find resources in your area for postpartum support, call this number and ask for the Maternal-Child Health nurse



Created by: Florence Lambert-Fliszar with the help of Sandra Wood, APRN CNP PNHMP, Sarah Guth, MD, and Anya Koutras at the Larner College of Medicine at the University of Vermont



## Your Mental Health as a New Mom

Pregnancy and the transition to motherhood are **beautiful yet challenging** experiences. Depression during pregnancy and after pregnancy are unfortunately common and can have lasting effects on both you and your baby. Read more to learn how to tackle this issue early and be your best self during this critical time.

# RESULTS

- First column emphasizes preemptive measures to seek help and establish care while pregnant
- Second column aims to educate about worrisome symptoms to look out for

Pamphlet is distributed at the Colchester Family Practice and to mentors Sandra Wood and Dr. Sarah Guth, who will keep it in their offices

## Start early- think about your mental wellness now

Identify any of the following that may put you at risk for developing perinatal depression:

- Financial difficulties
- Stressful life events, like marital problems
- Family and friends are far or not supportive
- Current or past pregnancy complications, including pregnancy loss
- History of mood changes during your period or on hormonal birth control
- History of mental illness, such as depression or anxiety
- History of physical, sexual, or emotional trauma<sup>1</sup>

### I may be at risk... What's next?

- Talk about it! Discuss mental wellness and life stressors (including financial difficulties) during and after pregnancy with your primary care provider, OB/GYN, midwife, or therapist. Make sure to **see a provider regularly** throughout your pregnancy.
- Develop an after-birth plan with your healthcare provider -what will life look like with the new baby?
- Physical activity, yoga, mindfulness exercises, and forming a support system **during** your pregnancy have shown to decrease the risk of depression later on. Check out the resource page for support groups

## BABY BLUES VS. DEPRESSION

There is a line between normal "baby blues," which up to 85% of women get, and perinatal depression, which affects about **10% of women** in Vermont.

It is **normal** if you feel:

- Tearful/crying for no apparent reason
- Irritable and impatient
- Tired
- Confused
- Feeling like you're "not yourself"
- These symptoms usually occur within the first 10 days of giving birth, and usually go away within 2 weeks of giving birth

Talk to your healthcare provider if you have any signs of **depression**:

- Overwhelming sadness most of the time
- Loss of interest or pleasure in life
- Loss of appetite
- Less energy or motivation to do things
- Trouble sleeping
- Having little interest in your baby
- Feeling like life isn't worth living
- Guilt
- Symptoms have lasted **2 or more weeks**
- Symptoms can show up **before** giving birth, and even up to 1 year after giving birth.

You're not alone!



"So many women struggle with this. A lot of new moms say, 'I should be stronger...I shouldn't be feeling like this, I should be able to do this by myself...'

A huge thing is to get them to let go and **accept help.**"

- Sandy Wood, perinatal psychiatric nurse practitioner at UVMMC

# EVALUATION OF EFFECTIVENESS

Due to the time constraints of this project provided the time frame of the family medicine rotation, effectiveness of the intervention was not assessed

Future assessment may involve

- 1. Survey to women Chittenden county VT in the perinatal period after reading the pamphlet. Questions regarding:
  - their ability to understand it
  - whether they learned new information from it
  - whether they identified depression in themselves from having read it
  - whether they are more likely to seek help after reading it
  - whether the resources provided were appealing to them and accessible
- 2. Focus group of Chittenden county women in the perinatal period who can comment on the pamphlet

# LIMITATIONS

- This pamphlet addresses pregnant women and new moms, while the issue involves education and participation of providers as well
- There is a wide range of perinatal mood disorders and anxiety disorders that are not addressed by this project, which focuses on depression. These include anxiety, panic disorder, psychosis, OCD, PTSD, all of which are equally important to address
- Effectiveness of this intervention relies on adequate distribution of the pamphlet



# RECOMMENDATIONS

1. Another significant barrier to diagnosing depression is in lack of provider knowledge and screening for symptoms (Dennis 2007)
  - Educating providers during grand rounds or via presentations at primary care clinics may be a good next step to raising awareness of perinatal depression. In addition to screening for symptoms, however, one might consider educating providers on screening for **risk factors** for perinatal depression and making referrals to preemptive therapy when appropriate
2. The focus of this project is on depression, but we know that women can suffer from a wide variety of mood disorders. Expansion of this project may involve exploring other very important disorders of the perinatal period, like anxiety, psychosis, or OCD.
3. Fathers can get postpartum depression too! One meta analysis showed that up to 10% of fathers are also affected (Paulson J, et al. 2010). Another project may try to dive into addressing this issue in men as well

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# INTERVIEW CONSENT FORM

**Thank you for agreeing to be interviewed. This project is a requirement for the Family Medicine clerkship. It will be stored on the Dana Library ScholarWorks website. Your name will be attached to your interview and you may be cited directly or indirectly in subsequent unpublished or published work. The interviewer affirms that he/she has explained the nature and purpose of this project. The interviewee affirms that he/she has consented to this interview. Yes  / No  If not consenting as above: please add the interviewee names here for the department of Family Medicine information only. Name:**

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- Sarah Guth, MD
- Sandra Wood APRN, CNM, PMHNP