Maternal Mental Health: 
A Key Factor in Baby Health

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Presenters: PSI-ARIZONA

PSI-Arizona

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Presentation Overview

1. What to look for: Overview of symptoms/risk factors for perinatal mood and anxiety disorders (PMAD)
2. Spectrum of impaired parenting and risk factors for neglect and abuse
3. Effect of PMADs on pregnancy and infants/young children
4. Villain or Victim: The other side of abuse/neglect
5. Plan of Care for mom and family
6. Home Visitor Tool Kit
Perinatal Mood and Anxiety Disorders

- #1 medical complication related to pregnancy and childbearing

“Every year, more than 400,000 infants are born to mothers who are depressed, which makes perinatal depression the most underdiagnosed obstetric complication in America.” – Marian F. Earls, Pediatrics, 2010

- 1 in 7 mothers experience serious symptoms of depression or anxiety during pregnancy or postpartum
- PMADs estimated to affect up to 48% of women living in poverty

Arizona Department of Child Safety

Risks for Entering Foster Care

- Infants are placed in foster care at a higher rate than children of all other ages
  - 3 times more likely than teenagers to be placed in foster care
- Infants placed in foster care are more likely to be:
  - Born to mothers under the age of 25
  - Born preterm or low birth weight
  - Have low APGAR scores at birth
  - Have mothers who smoke
  - Have mothers who had late or no prenatal care

Perinatal, not just postpartum

- During pregnancy
- After a pregnancy loss
- Up to one year postpartum
- For many women, problems with mood or anxiety begin during pregnancy

Mental Health during Pregnancy

- Rates of PMADs during pregnancy as high as postpartum
  - Estimated that 1/3 of pregnant women will experience a mood or anxiety disorder
  - Pregnancy (and perinatal loss) can cause significant psychological distress
- Many don’t recognize what they are experiencing
- Symptoms discounted by providers as normal pregnancy complaints
It’s not just hormones...

<table>
<thead>
<tr>
<th>Pregnancy symptoms</th>
<th>Depression symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood: labile, teary</td>
<td>Mood: persistent, gloomy</td>
</tr>
<tr>
<td>Normal self-esteem</td>
<td>Low self-esteem, guilt</td>
</tr>
<tr>
<td>Can fall asleep; may awaken due to</td>
<td>Insomnia early AM awakenings; unable</td>
</tr>
<tr>
<td>physical discomfort</td>
<td>to return to sleep</td>
</tr>
<tr>
<td>Energy: Tired, but restores with</td>
<td>Energy: Fatigued; rest does not</td>
</tr>
<tr>
<td>rest</td>
<td>restore</td>
</tr>
<tr>
<td>Shows pleasure, expresses joy</td>
<td>Does not show pleasure; anhedonia</td>
</tr>
<tr>
<td>Increased or normal appetite</td>
<td>Poor appetite</td>
</tr>
<tr>
<td>No suicidal thoughts</td>
<td>Suicidal thoughts</td>
</tr>
</tbody>
</table>

Mental Health in Postpartum

- Up to 20% of women will experience moderate to severe depression or anxiety after childbirth
- Moms often feel guilty and embarrassed about thoughts and feelings that accompany depression/anxiety
- May be discounted as normal postpartum symptoms
  - "You’re just tired. Sleep when the baby sleeps"  
  - "Everyone worries about their baby. You’ll adjust"

Baby Blues

- Normal postpartum occurrence, related to hormone fluctuations, lack of sleep and fatigue
- Approximately 50%-80% of women will experience baby blues in the first few weeks after childbirth
- Lasts 2 days to 2 weeks
- Symptoms: tearfulness, mood swings, feeling overwhelmed and uncertain, anxiety, forgetfulness
- NOT mild depression; differs in timing, severity, duration
Types of PMADs

Depression

- Approximately 20% of perinatal women
  - Persistent sadness, crying
  - Irritability, agitation, anger
  - Mood swings
  - Apathy – no interest in anything
  - Feeling overwhelmed – unable to act
  - Hopeless, helpless, guilt and shame
  - Exhaustion (can include physical pains)
  - Sleep and appetite disturbances
  - Suicidal thoughts

Anxiety (with or without panic)

- Approximately 8.5% of perinatal women will experience generalized anxiety symptoms
- Approximately 1%-2% of perinatal women will experience panic disorder, although up to 11% may experience panic symptoms
  - Excessive worry (intense, persistent, interfering)
  - Racing thoughts
  - Insomnia and low appetite
  - On edge, hyper-vigilant, agitation, restless
  - Fears of losing control, danger, illness (self, baby, family)
  - Physical symptoms of panic
**Obsessive-Compulsive Disorder**

- Approximately 3-5% of postpartum women
- Higher in women with pre-existing OCD
  - Intrusive, repetitive thoughts, usually of harm coming to baby or family
  - Tremendous guilt and shame
  - Horrified by thoughts of harm coming to baby – unwanted thoughts
  - Hyper-vigilance: always on edge
  - Engaged in behaviors to avoid or minimize triggers

**Common OCD Fears**

- Fear of acting on unwanted urge to harm or kill baby
- Fear of acting in sexually inappropriate manner with baby
- Fear that irresponsibility will lead to baby’s death
- Postpartum OCD **NOT** associated with increased risk of harm to child
- Unwanted fears – no desire or intention to harm

**Post-Traumatic Stress Disorder**

- Approximately 1%-6% of women experience PTSD following childbirth
  (up to 34% report traumatic birth)
- Approximately 12% of women in general population experience PTSD
- Triggered by a real or perceived trauma
  - Birth trauma (actual or threatened injury or death)
    - C-section, prolapsed cord, forceps/vacuum, maternal injury
  - Previous trauma (rape, sexual abuse)
  - Intense fear, loss of dignity, helplessness, loss of control, terror
PTSD Symptoms

• Intrusive re-experiencing of past traumatic event
• Flashbacks or nightmares
• Avoidance of stimuli associated with event
  - May avoid office, elect for C-section, avoid sex/sexual dysfunction, avoid further pregnancies
• Persistent increased arousal – hyper-vigilance, irritability, difficulty sleeping, exaggerated startle
• Anxiety and panic attacks
• Sense of unreality and detachment (numbing, dissociation)
• Inability to remember key aspects of the event

Bipolar Disorder

• Previously undiagnosed bipolar disorder may be triggered by birth experience and lack of sleep
• Approximately 9%-20% of postpartum women experience hypomania or mania
• 1 in 4 women with bipolar disorder will experience postpartum psychosis
• 1 in 2 postpartum women with bipolar disorder and family history of psychosis will experience postpartum psychosis
• Up to 70% of women with a history of bipolar disorder will relapse in first 6 months postpartum
  - Periods of depression
  - Periods of euphoria
  - Little need for sleep, high energy
  - Racing thoughts
  - Over confidence; delusions, grandiosity
  - Impulsive, poor judgment

Psychosis

• 1 to 2 per 1000 births; rare but a medical emergency
• Onset usually in first 2-3 weeks postpartum
• 35-fold increase in risk during 30 days after first childbirth
• 5% rate of suicide; 4% rate of infanticide
  - Delusions – odd/unusual beliefs not based in reality
  - Paranoia
  - Hallucinations
  - Confusion/Distraction; Disorganized speech/behavior
  - Inomnia
  - Rapid mood swings, easily angered. May be violent
Triggers of PMADs

- Emotional & Practical support
- Childcare stress
- Financial
- Living Situation
- Violence/Trauma
- Expectations
- Self-efficacy
- Psych History
- Hormones
- Genetics
- Sleep
- Medication

Biological
Psychological
Social
Environmental

Risk to Moms

- Suicide is the leading cause of death in perinatal populations
  - Suicide: 2.0 deaths per 100,000 live births
  - Hemorrhage: 1.7 deaths per 100,000 live births
  - Homicide: 2.9 deaths per 100,000 live births (IPV)
- 11%-12% of maternal deaths associated with psychiatric causes (1997-1999)
- 31% maternal deaths due to intentional self-harm (2000-2006, Australian sample)
- Infanticide, although rare, often part of suicide attempt – wish not to abandon baby or burden family

Risks to Parenting
Reasons for Children Coming into Care

- Physical Abuse: 16.7%
- Neglect: 12.0%
- Sexual Abuse: 2.2%
- Emotional Abuse: 0.1%


Bonding and Attachment

- Symptoms of PMADs associated with reduced maternal engagement, sensitivity
- Fewer vocalizations, reduced mirroring/imitation, reduced monitoring and safety behavior
- Moms may express negative perceptions of the baby, and/or negative perceptions of herself as a mother

Parenting Styles

Withdrawn
- Disengaged
- Distant
- Unresponsive to infant
- Little physical contact
- Flat affect
- Does little to support infant’s activities

Intrusive
- Rough handling
- Angry/hostile
- “Trying too hard” – in baby’s face, interfere with infant’s activities
- Over-anxious, controlling
- May be overcompensating due to guilt, but not reading baby’s cues
Inadequate Caregiving & Safety Practices

- Undesirable feeding practices
- Less preventative health care
  - Well-child visits and vaccinations
  - Postpartum visits for mother
- Shaken Baby Syndrome
- Not as likely to take common safety precautions
  - Using car seat
  - Lowering water temperature
  - Using safety latches and electric outlet covers

Field, 2010

Substance Use

Chapman & Wu, 2014

- Postpartum Alcohol Use – 40.1% - 49%
  - Binge drinking and frequent use
- Postpartum Drug Use – 4.5% - 8.5%
  - Marijuana and opioids most common
- Among mothers with substance use problems, 19.7 – 46% had PMAD symptoms
- 31% - 60% of children in care, drug/alcohol use cited as reason for removal
  - More likely to be in out-of-home care, and stay in care longer

Risks for Babies
Prenatal Risks

- Pregnancy complications
  - Maternal functional impairment – poor nutrition, poor weight gain, adverse behaviors (drinking, smoking)
  - Preterm birth
  - Impaired fetal growth/low birth weight
  - Pre-Eclampsia
  - Gestational diabetes
  - Placental abruption
  - Bereavement increases still birth risk 18%

- Mental health problems are MEDICAL problems

Risk Factors

- Prematurity
- Low birth weight (LBW)
  - 50% of infants born at LBW are potentially connected to psychosocial risks
  - 7% of infants born at LBW to mothers receiving case management and psychosocial support services during the prenatal period (Krans, Moloci, Housey & Davis, 2014)

Postnatal Risks

- Prenatal depression associated with 50% increase in developmental delay at 18 months
- Increased colic, sleep disturbance
- Higher levels of stress hormones, heart rates
- Abnormal EEGs (depression-like)
- Motor delays
- Less social interaction, more behavioral problems
Developmental Risks for Children

- Childhood mental health problems (Sayal et al., 2009)
  - Predisposed to cognitive problems
  - Predisposed to emotional problems (Lee et al., 2015)
- Childhood learning
  - Toddler behavior problems
  - Externalizing vs. Internalizing behaviors
  - Hyperactivity
  - Inattentivity
  - Irregularity
  - Reduced cognitive functioning
  - Conduct problems
  - Lower IQ
- Young adult psychiatric disorders (Bar et al., 2006)

Children at Risk for Abuse/Neglect

Infants with high levels of stress over time have difficulty with inhibitory control and self-regulation of emotion and behavior.

Gunnar, 1997; 1998

Villain or Victim

Moms with mental illness and the child welfare system
Risks to mothers with mental illness

- Research has shown that mothers in the child welfare system (largely poor/low income) have a high rate of mental illness

- Midwest longitudinal study over 15 years asked:
  - Is risk for maltreatment reporting higher for children of mothers with mental illness?
  - Is risk of foster placement higher for children of mothers with mental illness?
  - Is there a relationship between child outcomes and the mother’s diagnosis?

Findings from longitudinal study

- Majority of the mothers were diagnosed after first report of maltreatment
- Recurrence of maltreatment was higher in women with mental illness
- Mood and anxiety disorders increase the risk of new reports
- Risk of placement in foster care is greater if mom has mental illness
- Black mothers are more likely to have child placed in foster care than White mothers
- Anxiety doubles the risk of having a child in foster care

Myths of the “Good Mom”

- Not mentally ill
- Always available to her children
- Guide, support, encourage, and provide highest level of physical care
- Put child’s needs before their own
  - Based on culturally dominant, middle class values (white)
  - Impossible to achieve
  - Deviation from this is considered abnormal
Challenges for the mom with mental illness

- Biases inherent in society
  - These moms often end up in child welfare systems as first line of defense
  - Dominant ideology of “good mom” is not easily attained when mom is ill
  - Mom with DCS report is blamed for not protecting the child from harm

- Mental illness does influence parenting style
  - Depression does increase risk of coercive or hostile parenting/abuse
  - Anxious mom may show less warmth or engagement, may be more critical, controlling

- Once in the child welfare system, there is little help with treatment for mom’s illness and her life as a mom is forever changed

Key factors that impact parental functioning

- Parent’s personal developmental history, personality, and psychological well being

- Child’s characteristics

- Contextual sources of stress and support including marital relationship and social networks.

Parenting and child welfare programs

- Parent training is the most frequently offered service of child welfare programs

- Stress is largely associated with poor parenting and child maltreatment

- Little is known to the worker about the mother’s reason for involvement

- Impact of parent training on neglect/abuse rarely studied

- A comparison study of women taking parenting skills training and/or family counseling and those who did not take the training
Results

<table>
<thead>
<tr>
<th>Parenting services</th>
<th>No parenting services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 35% had major depression</td>
<td>• 30% had major depression</td>
</tr>
<tr>
<td>• 25% abused as children</td>
<td>• 21% abused as children</td>
</tr>
<tr>
<td>• 60% poor</td>
<td>• 60% poor</td>
</tr>
<tr>
<td>• 35% experienced intimate partner violence in past year</td>
<td>• 34% experienced intimate partner violence in past year</td>
</tr>
<tr>
<td>• No change in parenting or spanking</td>
<td>• No change in parenting or spanking</td>
</tr>
</tbody>
</table>

Casaneuva et al., 2008

DCS Worker and the Mother

• DCS workers lack education/support that can meet the needs of the mothers they investigate
  o Tend to be biased, discriminatory and blaming
• For a mother who thought she would have an advocate, she is instead met by ignorance and stereotyping

• Majority of women in DCS system:
  o Poor
  o Minority race
  o Immigrants
  o Direct or secondary victim of family violence
  o Suffer some sort of mental illness

DCS is not law enforcement

• Child protection agencies cannot open a criminal case against the perpetrator
• Mom is accused of "failure to protect"
• DCS does have the power to remove the child
• DCS standard is a "low evidence burden of proof" in which mother is held accountable for the abuse of the other adult in the household
• Case example: Child molested by step-father as mom was watching TV in another room
• Mother knew or should have known this was going on?
When mother is the non-offending parent

- Maternal depression is frequently found in families where father is violent either to the mother or the children
- These families are frequently reported to child welfare systems
- Mom may report the father to get help to keep her family safe
- Mom may be viewed as co-perpetrator rather than co-victim
- These cases do not have the desired result
- Mom becomes the one who is investigated and mandated to attend classes to regain custody of child or prevent removal of child

Mandated reporters

- Physicians, PAs, behavioral health professionals, nurses, psychologists, counselors, social worker, clergy, peace officer, parent/guardian, school personnel, DV victims advocates
- In a 6 months period in AZ, child abuse hotline received 26,455 calls
- Number of children increased from 17,592 - 18,657 (2015)
- Majority of children involved are 1-5 years old
- 25% of children in foster care have been out of home 13-24 months

To report, or not to report

- Mandated reporters in AZ have a choice of reporting to law enforcement or DCS: ARS 13-3620A
- If the abuser is the dad, it is best to report to law enforcement so that the offending violent parent is held accountable
- DCS will not deal with the offending father, but rather mother will become the targeted parent with allegation of failure to protect
- Mothers who talk about scary thoughts of harm need mental health treatment, not DCS reporting
- Only concerns about child abuse or neglect are required to be reported
- Safe Haven: infant 72 hr or < who is unharmed can be brought to hospital, firefighter, EMT, child welfare agency, adoption agency
**Advocacy for moms with mental illness**

- Moms already in DCS or moms with mental illness who are not in the child welfare system can be well served by home visitor relationships
- Home visitors can develop trust with the mother and make strides in areas of parenting, child health, mental health, school readiness, and positive parenting
- Reducing risks for child abuse and neglect

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**Benefit of home visitor: Mom’s Perspective**

- Felt visitor would be less likely to think she might harm herself
- Felt visitor would be less likely to report her to DCS
- Felt more trusting of her than her doctor
- Likes that she takes her time and listens

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**Other benefits of home visiting**

- Can make calls for appointments for mom
- Mom does not have to worry about transportation or child care to have the service
- Mom feels more in control in her own home
- Warm, supportive relationship helps the depressed/anxious mom
- WIC serves as a recruitment base for home visitor services as 94% of infants in poverty with severely depressed moms live in a family served by WIC
Linking mom to mental health services

- There are not enough programs or trained practitioners to meet the needs of mentally ill moms.
- Referring provider needs help in knowing where to refer.
- Grassroots still prevail: those who care about perinatal mental health in the community must remain abreast of who serves these moms, where trainings are held, and emerging partnerships.
- The home visitor is in a unique, trusted position to support the mom in her home. Helping her feel comfortable with conversations about mom’s true feelings is key.
- Moms report they are relieved when providers ask the tough questions.

Linking mom to care

- Pregnancy is the time to identify moms with depression/anxiety.
- Many home visitors are already screening.
- Screening opens the door to more conversations about how the mom is feeling and coping.
- Visitor can educate mom about the benefits of treatment if needed.
- Can inform mom about what is “reportable” (intentional harm or neglect) and that taking antidepressants or just having depression are not reportable to DCS.
- Promising home visitor programs have mental health teams that visitor can refer to and then mom is served at home.
- Home visitor can be at the first home visit with the mental health counselor to help the mom feel more comfortable.

Prevention Efforts

- For all women, and especially those who are at risk:
  - Mobilize support network:
    - Family, friends, doulas, home visitors, support groups
    - Professional resources (counseling)
  - Access resources if needed:
    - Medicaid, WIC, financial assistance, housing assistance
  - Self-care:
    - Adequate sleep/rest – 4-5 hour blocks
    - Adequate exercise and nutrition
    - Time for self, relaxation
    - Taking breaks and reaching out for help.
9 Steps to Wellness

Jane Honikman – Founder of Postpartum Support International
“I’m Listening” (2002)

- Education
- Sleep
- Nutrition
- Exercise and Time to Self
- Sharing with non-judgmental listeners
- Emotional Support
- Practical Support
- Referrals to professionals
- Plan of Action

Treatment Options

Traditional treatment
- Medication
- Individual therapy
- Couples therapy
- Perinatal support groups

Alternative modalities
- Massage
- Acupuncture
- Bright light therapy
- Nutrition
- Herbal remedies
- Exercise
- Yoga
- Doula care
- Home visitor

Treatment decisions: To medicate or not?

Impact of the medication
- Mom often has fear of medication during pregnancy or lactation
- Mom fears the label and stigma associated with taking medication (naming the illness)
- Many OBs and PEDS are not educated about medication safety and may discourage use

Impact of the illness
- “I spent too many years worrying about the impact of the medication. I should have been more concerned about the impact of the illness.”
  Zachary Stowe, MD
- Untreated maternal mental illness can have grave consequences for the mother, family, and offspring

Untreated maternal mental illness can have grave consequences for the mother, family, and offspring
Discussion of Risks & Benefits

- MotherToBaby Arizona: University of Arizona College of Pharmacy, Tucson, AZ
  - FREE telephone service.

- Pregnant or breastfeeding moms may wonder about taking prescription or over the counter medication, herbs, or vitamins, as well as seek info on risks of:
  - smoking or using drugs
  - diseases or infections
  - chemical, pesticide, radiation exposure

- 888-285-3410 Monday through Friday, 8:30-4:30

Education, Research, Referrals

The Home Visitor Tool Kit

What to say during a home visit
Develop a Relationship

- Sensitive and receptive to her experience
- “Teach me” approach
- Awareness of own judgments, assumptions, expectations, and beliefs about motherhood and parenting
- You have good information to share, but need for sensitivity about how you share it. Need understanding of her unique needs

This baby deserves you as the parent

You are a good mom!

You are a good dad!

Things to say

- I am sorry you are suffering
- With help, you can feel like yourself
- I am here for you
- Give mom permission to accept help from others
- Help Mom identify family members or friends to pitch in
  - What would be most helpful for her?
Online tools

- www.postpartum.net
  - Get help
    - Help in my area: Support map
    - Tools for mom
    - Closed Facebook group

- Professional tools
  - Screening tools
  - Toolkit for healthcare providers

Screening Tool

- Edinburgh Postnatal Depression Scale
  - Maximum score: 30
  - Possible Depression: 10
  - Always look at item 10 and address risk for self-harm or suicide

Tips, approaches, and strategies to support new moms and dads
Importance of Self-Care

- Give parents permission to take care of themselves
  - Stress the importance of basic self-care

  NO SUPERWOMAN/MOMS ALLOWED!!!!

Self-care ideas to share

- Practical Care
  - Help with cooking
  - Help with cleaning
  - Help with caring for baby
  - Help with shopping
  - Time to take a short walk
  - Time to go to an appointment

- Emotional support
  - Someone to listen
    - Coach partners/spouses on the importance
  - Hugs
  - Encouraging words
    - "Look at how your baby looks at you"
    - "Hang in there. As you get to know your baby better and as your baby gets to know you better, things will be easier"
Creating a plan

- Have mom write down a list of people she believes will provide some level of support. This can be:
  - A partner or spouse
  - Neighbor
  - Extended family
  - Religious community
  - Postpartum group
  - YOU

- Have helpful phone numbers nearby and encourage parents to use them:
  - PSI-AZ: 1-888-434-MOMS (6667)
  - Birth to Five Helpline & Fussy Baby Program: 877-705-KIDS (5437)

- Give websites:
  - Psiarizona.org
  - Postpartumcouples.com

- Leave a PSI-AZ brochure

You are not alone

You are not alone. You are not to blame. With help, you will feel better

Postpartum Support International

English and Spanish Support
Connects with local support volunteers and resources
“Chat with an Expert!” Phone forums for Moms and Dads

Educational Materials
www.postpartum.net
1-800-944-4PPD
1-800-944-4773
Internet Resources

- Postpartum Support International: www.postpartum.net
- Postpartum Progress: www.postpartumprogress.com
- Social Support and Steps to Wellness: www.janehonikman.com
- Postpartum Dads: www.postpartumdads.org
- MCH Library, Non-English: www.mchlibrary.info/nonenglish.html
- Grief Watch: www.Griefwatch.com
- Fussy Baby Program: www.swhd.org/programs/health-and-development/fussy-baby/

Information about medication during pregnancy and breastfeeding

- MOTHERISK: 877-439-2744
  www.motherisk.org/ped/drugs.jsp
- InfantRisk: 806-352-2519
  http://www.InfantRisk.com/
- OTIS: 866-626-6847
  www.Otispregnancy.org
- Mass General Women’s Health
  www.womensmentalhealth.org
- MotherToBaby Arizona
  http://mothertobaby.org/
  Call Us Toll Free: 866-626-6847
  Text Us: 855-999-3525

References

- Casaneuva, Cecilia et al. 2008. “Parenting services for mothers with child protective services: Do they change maternal parenting and spanking behaviors with young children?” Children and Youth Services Review 30(861-878).