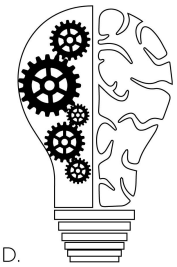
# Episode 033: Perinatal Mood and Anxiety Disorders with Dr. Kelly Rivinius

*Mikyla Cho, David Puder, M.D., and Kelly Rivinius, Psy.D.*

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## Introduction

For many, motherhood is a beautiful, unique, and meaningful experience. The mother-child bond is a relationship that has the potential to be a deeply loving and positive experience for both the mother and child. However, motherhood can be distressing, which is why it is imperative that we, as providers, understand the unique psychiatric issues that are associated with this time period in a woman's life.

Perinatal mood and anxiety disorders, or PMAD for short, is the term used to describe mood and anxiety disorders that affect women during the perinatal period, which is the timeframe from pregnancy to 12 months postpartum. PMAD encompasses a variety of disorders, such as anxiety, depression, obsessive-compulsive disorder, bipolar mood disorder, psychosis, and PTSD.

Dr. Rivinius has both lived it and overcome it. When Dr. Rivinius was pregnant with her first child, she experienced intense postpartum OCD and anxiety. Perinatal OCD centers on intrusive thoughts about the mother-infant dyad. For example, there can be fears and thoughts about harming the baby, and the mother progressively sees herself as harmful. (However, it should be noted that a mother suffering from perinatal OCD does *not* have the actual intention of harming her child. There is no break from reality as the mother realizes the obsessive thoughts are ego dystonic. This is in contrast with perinatal psychosis.) These persistent intrusive images and thoughts facilitate the development of a conflicting, difficult bond between the mother and her child. A mother can also continually check on her baby. For example, she may obsess about her baby's diaper rash or constantly check to see if her baby is breathing when asleep.

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Dr. Rivinius' OCD centered on whether her baby was constipated. She always worried that her baby was not having enough bowel movements. Despite being a fellow at a psychoanalytic clinic, she had a hard time recovering during the first year of her daughter's life. However, after further training and research about PMAD, her second pregnancy was a completely different experience, and since then she has been motivated to make the perinatal experience positive and meaningful for other women.

# Who Can Develop PMAD: Looking At The Risk Factors

There are a variety of risk factors that predisposes a woman to developing PMAD. The three-pronged approach to treating PMADs—medications, therapy and social support—helps us understand what the risk factors are.

### MEDICAL HISTORY

Firstly, it is imperative to obtain a thorough genetic and family history from the mother at the first visit to a care provider, whether it is an obstetrician, psychotherapist, psychiatrist, etc. Additionally, any personal history of psychiatric illnesses can correlate with whether a mother will develop a PMAD in the perinatal period.

One prospective longitudinal study found that anxiety and depressive disorders prior to pregnancy were the strongest predictors for whether a woman would develop a peripartum anxiety or depressive disorder (Martini et al., 2015). The odds ratio that a mother with prior anxiety would develop an anxiety disorder in pregnancy was 14.31 (95% CI of 7.45-27.52) and the ratio that they would develop depression during pregnancy was 2.40 (95% CI of 1.00-5.74). The odds ratio that a mother with prior depression would develop an anxiety disorder in pregnancy was 1.79 (95% CI of 1.10-2.94) and the ratio that they would develop depression during pregnancy was 10.79 (95% CI of 3.60-32.33).

Another important aspect to consider is if a woman has a history of diseases caused by hormonal imbalances, such as polycystic ovary syndrome, diabetes, or gestational diabetes, because hormones play a crucial role in the reproductive process and in the first year postpartum as the balances shift. Reactions to fluctuating hormones in 80% of

women leads to “baby blues,” a transient depression that occurs several days after childbirth that can last up to two weeks postpartum. One paper (O’Hara & Wisner, 2014) found that the prevalence rate for major and minor depression was up to 20% of pregnant women during their pregnancy and three months postpartum.

## BIRTHING EXPERIENCE

Another risk factor is the type of birth a mother experiences. Traumatic births are especially distressing and imply a higher risk of PMAD. One study (Furtardo, 2018) found that difficult deliveries are particularly associated with new onset perinatal anxiety and PTSD. However, we must keep in mind that traumatic births as a risk factor do not necessarily fit the objective definition of trauma. For example, they do not have to conform to the criteria of PTSD. Instead, we focus on whether the birth was *subjectively* traumatic for the mother:

- Was the mother scared for a large portion of the pregnancy?
- Did the birth not go according to plan?
- Did something unexpected happen?
- Did the mother feel like she had lost all control?

If the mother did have an experience that was personally distressing, she will likely have a difficult time processing those traumas. This can devolve into fear, intrusive thoughts, depression, and detachment from her child. Incidentally, this may be why some women prefer midwives rather than hospitals, as they can give birth at home in a familiar, controlled environment. Conversely, some women prefer hospitals because of the lower risk associated with more monitoring and availability of emergency measures.

## SLEEPING PATTERNS

Inadequate sleep is another risk factor for developing PMADs. Most new mothers wake up to feed their child several times during the night, but they are still able to return to a normal sleep cycle. In contrast, we are concerned about the mother who obsesses and


panics during the night to the point where they are unable to fall back asleep, leaving them with very little time in between the normal sleep cycles of the infant.

When assessing PMADs we look for severe disorders which have poor sleep, such as bipolar with mania (mothers will be up doing grandiose things) and psychosis (mothers will have delusions and hallucinations). If these things are going on, then an emergency psychiatric consult is indicated.

For women with sleep issues, the partner can make a positive impact. Partners can offer more help around the house, such as with chores, cooking, and spending time with the infant while the mother rests. Additionally, doulas can also be extremely helpful because they help create free time for the mother so that she can attend to her needs without feeling burdened.

## BREASTFEEDING

It is widely known that breastfeeding has a positive impact for both the mother and infant. One article (Allen & Hector, 2005) found breastfeeding to be a protective health factor for the baby, decreasing the infant's risk of issues such as infectious diseases, asthma, atopy, and childhood obesity. For the mother, breastfeeding was found to be protective against breast and ovarian cancer and rheumatoid arthritis, and it helped stimulate postpartum weight loss.

Oxytocin stimulates the let-down reflex for breast milk and facilitates a nurturing and loving bond between mother and child. In this way, breastfeeding is especially protective against developing postpartum depression and against developing ambivalent feelings towards the child.

However, what happens when breastfeeding goes wrong or is not a viable option for the mother? At times, a culture can promote all the benefits of breastfeeding but leave little room for a mother whose complex issues may not allow her to breastfeed. For example, what if the child has difficulty latching or if the mother cannot produce enough breast milk?

A small study done by Mezzacappa and Katkin (2002) found that breastfeeding significantly decreased ($p < 0.05$) a mother's perceived stress and negative mood, while

bottle-feeding decreased a mother's positive mood. The researchers also compared oxytocin to an "endogenous antidepressant," illustrating how the lack of oxytocin in bottle-feeding can negatively affect a mother's mood. Therefore, a woman who cannot breastfeed loses the protective effects of oxytocin on her mood.

In one cross-sectional study done by Groer (2005), mothers who breastfed perceived less stress "right now" and "since the baby was born" when compared to mothers who used formula ($p < 0.05$ and $p < 0.01$, respectively). When compared with formula-feeders, the study found that breastfeeding women actually reported increased stress related to managing their life and their relationships. However, those who breastfed also reported a significantly higher number of daily positive events ($p < 0.01$). The study also found that breastfeeding mothers had lower depression, anxiety, and anger scores when compared with formula-feeders ($p < 0.01$). Although these studies found statistically significant differences between the two groups, an odds ratio or effect size was not determined. Ultimately, breastfeeding is difficult.

Like sleep, this is another potentially modifiable risk factor with the help of lactation consultants. It may be helpful for the expectant mother to visit a consultant even before the baby is born so that she knows the consultant's style, personality, and what to expect. It would not be surprising for a mother to visit a consultant with each pregnancy, as every pregnancy and every child is different.

## Psychological Factors

In his study, psychiatrist Lawrence Blum (2007) reported psychoanalytic literature that reviewed some of the psychological factors in postpartum depression. He found that women who had anger towards a neglectful mother, were reluctant to ask for help during the postpartum period, and encountered psychosexual conflicts had developed postpartum depression. Blum highlighted that it is not enough to focus on biological risk factors but that psychological risk factors also play a large role in the development of PMADs.

Other issues that cause increased stress for developing a PMAD include adverse childhood experiences, particularly sexual trauma, and disengagement from the partner


or family. Ultimately, however, we must remember that although a woman may not have any particular risk factors, they may still be susceptible to developing a PMAD. Therefore, it is imperative that we as care providers keep our minds broad and open to that possibility so that we may intervene.

## CONSIDERATION OF DEEPER PSYCHOLOGICAL CONFLICTS

Many women experience a triad of emotional conflicts that revolve around dependency, anger, and motherhood (Blum, 2007). Women who are used to being independent and taking care of their own needs may especially struggle with the dependency conflict because this conflict acknowledges that a woman herself must be taken care of before she can take care of her own child. Some women adapt to their new stresses with "counterdependence," believing that they themselves do not need help because they are taking care of the baby, the housework, etc. This way of thinking is particularly dangerous because once the demands of reality become too great for the mother, she will inevitably be pushed beyond her current capacity, potentially triggering PMAD.

Anger conflicts arise when the mother feels guilty for being angry or is too scared to express it. This can devolve into anger that is redirected at the child, which in turn makes the mother feel even more shameful. Motherhood conflicts make up the last component of Blum's triad, and it addresses the unstable relationship a woman may have with her own mother. It acknowledges that if a woman did not receive adequate love and care herself, it will be difficult for her to nurture her baby in that way, whether this is conscious or not.

## TREATING PMADS

Failure to treat PMADs is not only harmful to the mother, it is also harmful for the child. One article (Pearlstein, Howard, Salisbury, & Zlotnick, 2009) states that untreated postpartum depression leads to "poor cognitive functioning, behavioral inhibition, and emotional maladjustments in infants and children. . . [and] psychiatric and medical disorders in adolescence." The mother's subsequent difficulty in connecting with her infant can lead to the child developing negative attachment styles, such as anxious, avoidant or disorganized. This can further affect the child's future relationships with


others. Although no odds ratio or effect size was given, one study that looked at longitudinal data on maternal depression in general and young children (Ruiz, Harris, Martinez, Gold, & Klimes-Dougan, 2018) found that maternal functional impairment, such as from a mood disorder, was a significant predictor for a child's anxious attachment ($p = 0.03$), which further predicted a child's functional impairment ($p < 0.001$) compared to mothers who did not have functional impairment. In *Treating Attachment Disorders: From Theory to Therapy* author Karl Brisch (2012) discusses how one study by Scheuerer-Englisch found that children who were categorized as having an insecure-avoidant attachment at one year of age were still displaying an avoidant attachment style at age ten, reflecting how infant attachment styles can predict future attachment styles.

In the book *Origins on Attachment,* Beatrice Beebe and Frank Lachmann (2014) noted that "parental inconsistency, and maternal unavailability to respond to infant distress, were key components of the picture of disorganized attachment" and that a mother's withdrawal and affective errors at 12-18 months hinder the child from organizing their experiences. That is to say, if the mother fails to recognize their child's distress and needs and provide a predictable and loving environment, the infant will go unrecognized, leading to his or her inability to integrate his or her experiences. Beebe and Lachman believe that it is this inability to organize and integrate their experiences that leads children to dissociation difficulties in adulthood.

Ed Tronick, author of *The Neurobehavioral and Social-Emotional Development of Infants and Children* (2007), discusses how in normal circumstances infants are constantly experiencing interactive error, which can be defined as the discoordinated interactive state between the infant and caregiver. Interactive error is normal and occurs frequently, but it is also frequently alleviated by interactive repair, which is the transition from the discoordinated state to a coordinated one. Tronick states that "in interactions characterized by normal rates of reparation, the infant learns which communicative and coping strategies are effective . . . . the infant develops a representation of himself or herself as effective . . . . [and] these representations are crucial for the development of a sense of self that has coherence, continuity, and agency and for the development of stable and secure relationships."

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For depressed mothers there is a more difficult time in creating a mutually regulatory interaction between themselves and their infants, which parallels the results of the still face observations by Bowlby and Spitz. Tronick found that children of withdrawn depressed mothers developed a negative affective core characterized by sadness and anger and saw themselves as ineffective and helpless. In contrast, children of intrusive depressed mothers were more angry and easily frustrated.

So, how can we treat a mother with a perinatal mood and anxiety disorder? The best method is to use the three-pronged treatment approach, which includes medications, social support, and therapy. We can supply medications specific to the mother's type of PMAD, and they help enhance the therapeutic process. Additionally, social support from the mother's partner, friends, family, and community is also an important aspect of treatment.

In a Cochrane review meta-analysis, authors Cindy-Lee Dennis and Ellen Hodnett (2007) evaluated nine trials with 956 women and found that both psychological and psychosocial interventions were just as effective as standard treatment, such as medications, in treating postpartum depression. Although further research is needed, current data shows that cognitive behavioral therapy, interpersonal therapy, and psychodynamic therapy are all viable and beneficial treatment options, especially for mothers looking for alternatives to medications.

Although there are a variety of psychotherapy options we can provide, transference-based psychotherapy is likely the most effective at healing attachment wounds. Transference-based psychotherapy emphasizes the relationship between the patient and therapist and encompasses the dynamics that occur between them. The patient brings all their emotions and experiences into the room and directs them towards the therapist. The therapist, however, is strong, solid, and ethical enough to be able to contain those emotions and provide a safe zone for the patient. Intuitively, this makes sense. If the issue is developing relationships with others (i.e. attachment wounds), then it is reasonable to assume that the therapy for this would be to begin by focusing on the patient's relationship with the therapist.

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Transference-based therapy may be especially suited for women who are counterdependent or are experiencing components of the triad of emotional conflicts outlined above, as it allows them to freely and safely admit their needs and gives them a place to heal. Additionally, maintaining a strong therapeutic alliance with the patient is imperative, as research has consistently shown that the success of therapy is associated with the quality of therapeutic bond (Brisch, 2012).

Let us look at a specific example. A mother comes into your office with a past trauma that has led her to have an anxious and ambivalent attachment style. How would this manifest? Perhaps the mother has a difficult time making decisions. She schedules appointments with you, but repeatedly cancels at the last minute, or she may call you multiple times but never answers when you call back. Already we can observe the patient's communication style, though we have never met them in person. When you do finally see this patient, you help them understand their interpersonal and intrapsychic dynamics and progress to healing their attachment wounds. When the patient begins to open up and lays out their emotions and experiences to you, you remain firm and solid. Even if the patient shows aggressive and negative emotions, you create a safe place for them to release their tension. By doing this, you act like a container and show the patient that they are not overpowering you, that they are not too much to handle. In this way, they can begin to heal.

We can parallel this with British psychoanalyst Donald Winnicott's ideas about a baby's aggression toward their mother. When a mother can handle a baby's aggression and anger by continuing to be a stable figure and not become vindictive towards the child, the child will learn that they are in a safe environment to express themselves and that they are not "too much" for the mother. They are given a protected surrounding to develop a secure attachment style. When practicing transference-based psychotherapy, we must also be aware of our own humanity. We must continue to be an open and welcoming presence for the patient and recognize and address any complete reactions we have towards a patient, whether they are positive or negative.

If we can successfully treat mothers suffering with a perinatal mood and anxiety disorder, we can also treat her child. Karl Brisch (2012) found that helping parents analyze and interpret their interactions while changing their infant's diaper made the


parents more attuned with the child's signals and their own behavior, allowing the parents to better care for their child compared to parents who fail to recognize their child's needs. This illustrates that maternal sensitivity is not rigid and can instead be increased. Additionally, Brisch quotes Friedman and Boyle who quoted the National Institute of Child Health and Human Development:

When mothers' quality of parenting *improved* (emphasis in original) over time, children with insecure attachment in infancy showed fewer teacher-reported externalizing behaviors than did children with insecure attachments who received stable or declining qualities of parenting. When parenting quality *declined* (emphasis in original) over time, the children with insecure infant attachment were reported by teachers to have higher levels of externalizing behavior than insecure children who experienced improved parenting quality over time. For children with early secure attachment to their mothers, declining parenting quality was not associated with increased classroom externalizing behavior. These findings are significant in terms of clinical implications for interventions.

Ultimately, treating a mother suffering from a PMAD not only helps the mother but can even undo the negative consequences to her child.

## Planning Is Prevention

Although we can treat PMAD, we can also prevent its development through thorough and consistent planning. Plan for potential perinatal issues before the woman becomes pregnant. Then the woman can plan for both the pregnancy and postpartum period, and any needed therapeutic work can be started early. The woman can work on changing a negative attachment style before undergoing the process of bonding with her own child, making motherhood a more enjoyable time.

If the patient cannot be seen early, any attempt should be made to see them as early as possible in their postpartum period. Perhaps the most useful first step in preventing PMAD is consciously screening for it. Healthcare providers can actively seek out women who are prone to developing PMAD and attempt to lower their risk factors early.

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When we help a mother plan, what exactly is it that we help them plan for? The answer is practically everything. The goal of planning is to foresee any potential problem areas and create concrete, specific plans for resolving them. Planning begins with helping the mother become aware of the realities of motherhood. For example, if we are helping a mother plan for sleep, she must be educated that an infant wakes up frequently. It would be considered unusual for an infant to sleep for long stretches of time without waking up.

After the mother creates a connection with reality, we help the mother create categories and lists of what her needs will be in the postpartum period, and we can again go through the realities of each area. Sleep, personal hygiene, meals, exercise, and work might be areas that need be addressed and accommodated for. Once the categories are created, we can help the mother expand and map out each area and think of solutions for each issue.

A mother's social support system is also extremely crucial to plan for. Who can the mother call on for some meals? Who can hold her baby while she sleeps? Is there someone who can help with her housework? Can someone take care of any older children in the house? Again, we help the mother create categories such as these and try to find at least two people for each category. It is extremely helpful to have this part completed before giving birth so that the mother can contact the people in each category beforehand to alert them that she may need their help in the postpartum period.

Related to a mother's social support system is her system of care providers. The mother should also create a list of providers, such as her obstetrician, psychiatrist, lactation consultant, and breastfeeding support groups and create at least one point of contact for each category. Although planning may seem like a daunting task for the mother, it is useful to remember she does not do this alone. Planning is done with the help of those like a provider, therapist, and partner and is done over time.

Planning should ideally always involve the partner. Additionally, the partner should also be doing his or her own planning. For example, they can plan what meals they can cook for the tired mother, how they can occupy the infant while the mother rests, and how they can support the mother at her appointments. Although the postpartum period is a


stressful time for all involved, it can also be a meaningful opportunity for the partner to illustrate their love and connection to the mother. Partners have the ability to be a source of deep strength and encouragement when they choose to be an active participant during this time.

## The Provider's Role

Perhaps the most important thing we can do as providers is to screen for PMAD. Postpartum Support International recommends using some type of screening at the first obstetrician appointment, once in the second trimester, once in the third trimester, and once at least six weeks postpartum. However, for moms who have a vulnerability for developing PMADs, it may be wise to screen earlier than six weeks in the postpartum period. With consistent and multiple screenings, we as providers can accumulate important data and prevent PMAD early once a screen is positive. For a mother with a positive screen, we can begin an open discussion about the need for a possible referral to a PMAD specialist, therapist, or psychiatrist either during pregnancy or shortly after giving birth. The referral process, however, may be difficult for the patient. They may feel embarrassed or ashamed because of the stigma associated with PMAD, or they may simply feel overwhelmed and confused. Therefore, we as providers can also intervene in this step to create a positive experience for the mother. For example, we can make the first referral call with the mother in our office to show that we truly care for the mother and her wellbeing.

## Closing Thoughts

Perinatal mood and anxiety disorders are not simple issues. They affect both the mother and infant and their bond, and their consequences can extend far into the future. They can even been seen as a public health concern, as untreated PMADs can cause a child to develop insecure attachments and trauma for the baby, which will accompany them as they grow into adults. Incidentally, some patients with psychiatric issues have acknowledged a history of difficult connection with their parents. Therefore, when we treat a mother with PMAD—or even better prevent its development—we are simultaneously treating the child. Ultimately, we as clinicians can help increase the

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awareness of PMAD, eliminate the surrounding stigma with increased screening and normalization, and essentially facilitate a healthy and positive motherhood experience.

Connect with Kelly Rivinius: here

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