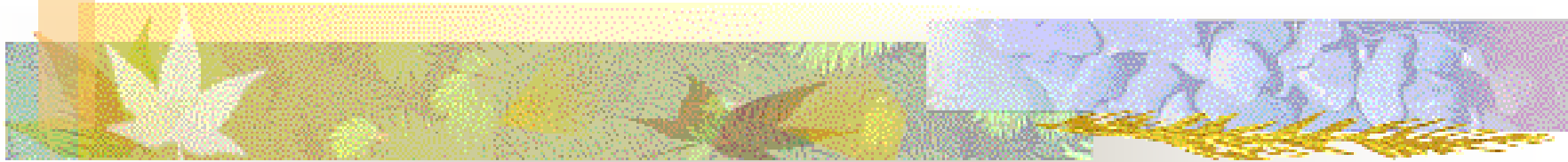


Perinatal Depression, Maternal Depression



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Perinatal Depression

- Classified among mood disorders
- More frequent in women
- More frequent after menarchy
- Genetic predisposition
- Importance of early life experiences
- Importance of psychosocial situation and stress factors



Perinatal Depression

- Depressive episodes prior to pregnancy?
- Depression during pregnancy?
- History of losses, including pregnancy losses?
- Distinguish from Postpartum blues
- Puerperal depression? (postpartum)



Depressive mood

- Depressive mood is a dimensional symptom
- There are different degrees of sadness
- Are there additional symptoms, e.g. neurovegetative signs? (insomnia or hypersomnia, appetite disturbance, etc.)
- Severity, how it affects psychosocial functioning dictate if a “disorder”.



Perinatal depression

- Effects on the woman?
- Effects on the infant?
- Effects on the spouse?
- Long term Effects for the affected woman and for the child?



Perinatal Depression

- How to recognize it?
- Are there cultural differences in its manifestations?
- What are the risk factors?
- What are the protective factors?
- How to intervene?
- How to help the baby?



Depression--Phenomenology

- Low mood, sadness, easy crying
- Pessimistic outlook, negative thoughts
- Anhedonia. Diminished pleasure with positive events, indifference
- Irritability. Easily angry, annoyed, frustrated
- Negative thoughts about self, negative self-evaluation, feelings of guilt.



Depression. Phenomenology 2

- Neurovegetative signs:
- *Hypothalamic disturbance?
- Sleep affected: Insomnia, frequent awakenings, waking too early in morning, inability to go back to sleep or
- Excessive sleepiness, sleeping long periods of time. Need for a lot of sleep



Depression Phenomenology 3

- Neurovegetative signs: Appetite
- Loss of weight
- Hyporexia, diminished appetite
- Or
- Excessive appetite, special cravings, e.g. chocolate, sweets, other foods



Depression Phenomenology 4

- Diminished amount of energy to carry out activities
- Or Agitation, inability to sit still, pacing, etc.
- Difficulty concentrating and focusing
- Thoughts of disappearing, going away, ending life, dying, suicide



Melancholia

- Severe neurovegetative signs
- Inability to get up, very low energy
- Worse in the morning, improved mood in the evening or night
- Severe lack of appetite
- Feelings of emptiness, futility, lack or purpose, severe anhedonia



Cultural Factors-Perinatal Period

Cultural value of having a baby

Cultural value of being pregnant

Perinatal period “should” be happy and joyous

Guilt feelings about not feeling happy

Fear of social disapproval if expression of
unhappiness or sadness

Culturally not sanctioned to be depressed



Cultural Factors

2

- Latina woman, African American Women, or women from traditional societies
- Less symptoms of “guilt” and negative thoughts
- More somatic symptoms: tiredness, back pain, frequent headaches, diminished amount of energy, tingling sensations, etc



Cultural factors

3

- Verbalization of ambivalence or negative feelings re: baby, self, spouse, situation
- Externalization of the cause of symptoms: situational, induced by someone else,
- Manifestations of envy, of ill-will in someone else, being mistreated, etc.



Severe depression

- Melancholia
- Psychotic features in depression
- Delusions: false beliefs that cannot be “reasoned” with e.g. being the worst person in the world, the worst sinner, being rotten inside, having cancer or a terrible disease
- Hallucinations. Voices deprecating the person, persecutory themes, etc.



Post-partum “blues”

- Not really a “disorder”
- Occurs in up to 50 or 60% of women
- Sadness, easy crying, emotional lability
- Doubts about ability to care for baby
- Feeling burdened, uncertain, afraid of future
- Sadness about termination of pregnancy



Postpartum blues

- Appears most often in the 4th or 5th day postpartum
- Does not require “treatment”
- Requires psychosocial support, reassurance
- “mothering” the mother
- Role of sudden suppression of progesterone?
- Improves spontaneously over weeks



Failure of mother to infant bonding (Kumar)

- Many mothers manifest initial feelings of anger or rejection toward baby (up to 10%) that last a few hours or one or two days
- Failure of mother to infant bonding is long-lasting
- Absence of maternal feelings or warmth, or tenderness toward the baby



Failure or bonding

- Absence of maternal feelings
- Mother usually keeps these perceptions quiet, due to guilt
- Taking care of the child “as a doll”
- Child is well taken care of, but the mother does not feel an attachment toward the baby



Postpartum depression

- The problem is frequent
- 15 to 20% of women suffer depression in the post-partum period
- In some groups, the figure is higher
- It is largely a psychosocial problem
- To a lesser extent a biological problem



Post-partum depression

- Clinicians working with infants must take into account the possibility of depression
- Think of risk factors and protective factors
- Think of psycho-somatic manifestations of depression
- Observe the mother's demeanor, mood and level of energy



Risk Factors

- CURRENT LIFE CIRCUMSTANCES
- Small children at home
- Poverty and stress associated with it
- Unsupportive partner or husband
- Single mother or abandoned
- Other sources of stress (multiplying effect of stressors)



Risk Factors

- PREVIOUS EXPERIENCES
- History of physical or emotional maltreatment
- History of losses before age 10
- Poor school history
- More separations from parents during childhood



Risk Factors

- Previous history
- Poorer relationship with parents during childhood
- Less satisfaction with occupation
- Previous history of depressive episodes



Risk Factors

- Main factors are psychosocial
- Biological factors:
 - Sudden decrease in hormones after delivery, e.g. decrease in progesterone
 - Possible role of anti-thyroid antibodies (10% of women)
 - Possible role of thyroiditis after delivery
 - Role of increased levels of cortisol?



Effects of depression in mother and infant

- Duration of depression, I.e. whether several months or throughout the first year of baby's life
- Clinical features of depression: e.g. withdrawal socially , isolation, unresponsiveness vs
- Irritability, less patience, agitation



Effects on infant. Short Term

- First few months
- Infant may “appear depressed” (Field et al.)
- Less emotional availability, “conversations”, animation
- Less stimulation and less responsiveness
- Baby may become “flat” or dejected



Early effects of maternal depression

- Less emotional availability of the mother
- “Still –face” situation and effects on infant behavior
- Less responsiveness
- Less stimulation, joy, mirroring
- Less reciprocity



Effects on the infant

Young infant: (L. Murray)

More infant crying,

More inconsolable crying

More sleeping difficulties

More “difficult” child

More irritability in infant



Effects on infant. First year

- Second semester. Infant becomes more mobile and more “intentional”
- Infant becomes more autonomous
- More possibility of challenges and conflict of wills
- More negative effects in second semester ?
- Child demands more activity and interaction



Effects on infant

- If withdrawal and less energy in the mother:
- More “distance maneuvers”
- More coercive techniques
- Child perceived as more demanding, difficult and as “work”.
- Little joy in the relationship



Effects on infant

- If mother is more irritable and has mood shifts:
- More parent child conflict
- More possibility of negative interactions, anger in the relationship
- More perception of child's negative attributes



Long-term effects of maternal depression

- More negative effects on boys as a whole, but also on girls (L. Murray)
- More possibility of negative and angry behaviors in the child at 7 years of age
- More hyperactivity and restlessness in the child
- More difficulties academically, attention, reading, learning in general



Maternal depression-Spouse?

- More possibility of husband or partner also being depressed
- More possibility of marital conflict
- More possibility of distant relationship if spouse is also depressed
- Effects of a positive relationship with at least one caregiver



Interventions

- Early identification
- Early Intervention
- Role of the primary health care staff
- Role of lactation consultant, pediatrician, visiting nurse, home visitor
- Asking questions and observing actual interactions



Interventions

- Psychosocial interventions are primary
- Emotional support
- Normalization
- Understanding
- Providing information about depression
- Seeking supplementation of what is missing



Intervention

- Supportive relationships
- Confiding feelings, losses, previous experiences
- Role of “containing” and listening to stories
- Role of being emotionally available
- Role of giving practical help




Intervention

- Maternal need for “mothering”
- I.e. support, understanding, care, etc.
- Eliciting participation from extended family and companion, spouse, etc.
- Role of interpersonal relationships eg.
- Interpersonal psychotherapy



Intervention

- Cognitive and behavioral interventions
 - Psychodynamic interventions
 - Role of group of peers
 - Other adults, other mothers.
 - Help coping with infant needs and problem-solving
 - Alleviation of stressors
- 



Intervention

- Role of medications
- Selective Serotonin Reuptake Inhibitors (SSRI)
- Indications for medication. Severity, absence of support, important neurovegetative symptoms.
- Suicidal ideation



Intervention

- Issue of complicating factors, e.g. domestic violence
- Personality problems
- Co-morbid conditions: attention deficit, anxiety disturbances, other conditions
- Role of hormones?