The Perinatal Period: Problems and Possibilities

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June 22, 2016

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Psychology of the Perinatal Period

- Time of Psychological, physical, cultural, social, and relational reorganization, transition, development.

- normal period of increased anxiety, reevaluation of life, and emergence of unconscious conflict.

- Upheaval may encourage self-evaluation to support more sensitive care to newborn (Klaus, Kennel, & Klaus, 1995).

- "**The ghosts in the nursery**" experience (Fraiberg, 1975): parent's unconscious memories of childhood experiences impact parenting style.

Psychology of the Perinatal Period

- When a baby is born, a mother is born: Time of "Maternal Rebirth" (Stern, 1988).

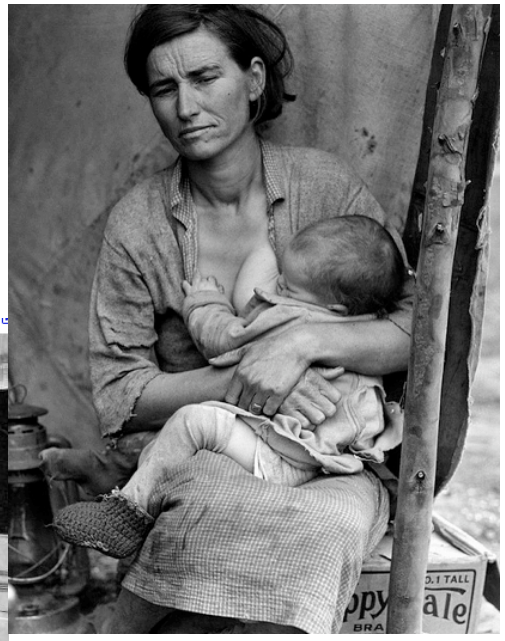
- Increased physical and psychological stressors

  - Physical and psychological stressors increase inflammation. Puerperal women especially vulnerable because proinflammatory cytokines significantly increase during the last trimester. common experiences of new motherhood: sleep disturbance, postpartum pain, and past or current psychological trauma, are stressors that cause proinflammatory cytokine levels to rise (Kendall-Tackett, 2007).

Developmental Considerations: Transitioning to Motherhood

"What’ ll I do with it now”

➢ **Birth into motherhood is filled with personal evaluation and powerful myths, images and expectations, that are often sanctioned by cultural assumptions about motherhood and "good mothers:"**



Related Contemporary Research

Women who received **strong social support from family** during pregnancy **did not manifest** sharp **increases in stress hormone**, **protecting** them **from postpartum depression.** not true for women with poor social support from families (Hahn-Holbrook, 2013).

Increased maternity leave after childbirth, up to six months, better **protects** a woman **from postpartum depression** (Dagher, R.K., 2013).

Fetuses exposed to high levels of cortisol, did not show negative developmental effects if mother provided sensitive and nurturing care postpartum. **Securely attached infants did not suffer from the impact of this stress hormone.** Infants exposed to high levels of stress, with insecure attachments to their mothers, were impacted negatively (O'Connor, 2010).

Increased pregnancy fears and **anxiety**, not general stress, related to **pre-term births** possibly from elevated corticotropin-releasing hormone (Dunkel-Schetter & Mancuso, 2010).

Fear of childbirth in low risk women, with no history of depression, **predicted postpartum depression** (Räisänen S, Lehto SM, Nielsen HS, et al., 2014).

Children whose **mothers** were **self-reflective** about their early histories when three months pregnant demonstrated **secure attachment** at eighteen months. (Fonagy, et. al, 1993).

Mothers with significant **adversity** and deprivation—but **high reflectiveness** ratings, regarding their histories, had **secure children**. only 1 out of 17 deprived mothers, with low reflectiveness ratings, had secure children (Fonagy, et. al, 1991a).

Psychological Challenges in Perinatal Period:

- **anxiety**
- **Trauma** including **Post-Traumatic Stress Disorder**
- **Bonding** and **Attachment** Problems:
  - Detached or overly, inconsistently, or chaotically attached
- **Developmental challenges** and transitions
- **Grief and loss**
- **Depression**
- **Relationship/Marital/Partner** Issues
- **Unresolved Past** Issues
- **Concerns** about **Parenting**
- **Pregnancy Related** Concerns
- **Psychosomatic** Problems
- **Eating** Disturbances
- **Substance Abuse**
- **Addictions**

I think I' m having pre-traumatic stress disorder

Psychological Struggles in the Perinatal Period

Personality Characteristics and Patterns:

- Relationship/Attachment Patterns
- Perfectionism
- High Expectations
- Critical
- Obsessive Compulsive
- Rigidity/inflexibility
- Jealous
- Helpless/dependent
- Self-reliant/independent
- Avoidant
- Overinvolved
- controlling
- Self-negligent
- Self-absorbed
- Narcissistic

"The baby's nice, but it's not the narcissistic rush I thought it would be.

Perinatal Struggles

- **Normal, universal, challenging** part of **developmental process.**
- **Severity** on **continuum. Significant struggles** occur in over **25%** of women; often co-occur in partners and children.
- Up to **75%** of mothers of preschoolers report **anxiety** and feelings of **entrapment** while **27%** experience some kind of **anxiety disorder** (Schreier, 2008; Maushart, 1999).
- Between **30-80%** of mothers complain of **depression** while **10-15%** develop a **mood disorder** (Beck, 2001; Maushart, 1999).

Transitioning to Parenthood:

Marital conflict increases dramatically, and marital quality decreases for **40-67%** of couples within the first year of baby's life.

- "Bringing Baby Home" program **decreased postpartum depression** (22.5% versus 66.5% in control group). **Targets couples relationship, educating** on **infant development, involving fathers** in infant care. (Shapiro & Gottman, 2005).

"I was on hormone replacement for two years before I realized that what I really needed was Steve replacement."

Factors Associated with Perinatal Distress

- **Physical factors:**
  - Previous psychiatric history and care
  - Physical problems: thyroid, hormones, nutrients, neurotransmitters, anemia
  - Fatigue and disrupted sleep
- **Socio-cultural factors:**
  - Inadequate social/cultural/familial recognition
  - Absence of traditions/rituals
  - Insufficient social support and social isolation
  - Socioeconomic problems
- **Birth and Infant Factors:**
  - History of obstetric problems and treatment for infertility, stillbirth, or miscarriage
  - Difficult or traumatic pregnancy, labor or birth
  - Twins and multiple births
  - Discrepancy between expectations and subsequent experience
  - Disappointment with birth and birth professionals
  - Problems with infant
  - Infant characteristics especially when poor match with mother
  - Complications, dissatisfaction, or disliking breastfeeding

Factors Associated with Perinatal Distress

- **Psychological Factors:**
  - Poor relationship with partner/marriage
  - Negative perceptions of parental care during one's childhood
  - Poor relationship with parents
  - Absent/poor mother-daughter relationship
  - Less paternal involvement and support of infant's care
  - Ignorance of infant development
  - Distorted self-esteem and self-efficacy (high or low)
  - Unrealistic expectations
  - Lack of satisfaction with educational or professional achievement
  - Little previous contact with babies
  - Prolonged conception period
  - History of sexual or physical trauma and abuse
  - Fear of childbirth
  - Unresolved traumas or losses
  - Stressful events
  - Maternal age (younger and older)
  - Lack of control over returning to work
  - Parenting style

PERINATAL POST-TRAUMATIC STRESS SYMPTOMS/DISORDER RISK FACTORS:

(Garthus-Niegel, 2013; Beck, 2011; Waldenstrom 2004; Soet, 2003;Creedy, 2000; Thom, 2007; Soderquist, Wima 2002; Olde 2005: Ayers, 2007; Gamble, 2005; Gross, 2005; Cigoli, 200)

- Subjective birth experience
- Unexpected medical problems
- Unplanned pregnancy
- High level of obstetric intervention
- Cesarean birth especially planned cesarean
- Pressure to have labor induced or pressured into epidural
- Perception of inadequate labor support
- Instrumental delivery
- Infant in NICU
- Poor experience with pain
- Lack of choice and loss of control over labor
- Unmet expectations especially without explanation
- Negative interactions with hospital professionals and staff
- Poor partner support
- Feelings: powerless, alone, defeated, thoughts of death
- Prenatal depression and anxiety
- Traumatic life events and (childhood) sexual trauma history
- Dissociative Tendencies or Dissociation
- Prenatal depression and anxiety
- Negative reactions to breastfeeding or minimal/no breastfeeding

PERINATAL ANXIETY, TRAUMA, & POST-PARTUM POST TRAUMATIC STRESS SYMPTOMS/DISORDER (PTSS/PTSD):

➢ EXPERIENCE OF CHILDBIRTH WHERE ONE BELIEVES HER OR HER BABY'S LIFE WAS THREATENED; AND FEELING HELPLESS, OUT OF CONTROL, ALONE, AND UNSUPPORTED.

- REVIEW OF **31 STUDIES: COMMON** AND **UNDER-RECOGNIZED** (OLDE, 2005).

➢ RATES OF POSTPARTUM POST-TRAUMATIC STRESS DISORDER RANGE FROM 1.5-9%.

- **25%-34%** OF WOMEN REPORT **TRAUMATIC BIRTHS** AND 1.5-3% OF WOMEN WITH NORMAL BIRTHS DEVELOPED **PTSD** (SOET, ET AL, 2003, CREEDY, 2002, CZARNOCKA, 2000, BECK, 2005, 2006, AYERS, 2007).

➢ WOMEN'S SUBJECTIVE BIRTH EXPERIENCE (N= 1,499): BIGGEST PREDICTOR OF POST-PARTUM POST TRAUMATIC STRESS DISORDER (GARTHUS-NIEGEL, ET AL, 2013).

- OBJECTIVE FACTORS CONTRIBUTE TO POSTNATAL TRAUMA; SUBJECTIVE APPRAISAL OF THE BIRTH IS MORE SIGNIFICANT.

Perinatal Post-Traumatic Stress Disorder

- Nationwide study of 1,573 postpartum women found (Beck, 2011):
  - **9%** met diagnostic criteria for **PTSD**
  - **18%** had significantly **elevated posttraumatic stress symptoms—PTSS**
- variables associated with higher PTSS:
  - Low partner support
  - Elevated postpartum depressive symptoms
  - More physical problems since giving birth
  - Less health promoting behaviors
  - Did not exclusively breastfeed one month after birth or breastfeed as long as desired.
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Perinatal Posttraumatic Stress Disorder

- **Variables that significantly differentiated women with elevated ptss from those who did not:**
  - No private health insurance
  - Unplanned pregnancy
  - Pressure to have an induction and epidural analgesia
  - Planned cesarean birth
  - Consulted with a clinician about mental well being since birth
  - Not breastfeeding as long as wanted
  - Not exclusively breastfeeding at one month
    - (Beck, et., Al, 2011)

- "postpartum posttraumatic stress symptoms may develop following a negative childbirth experience. It frequently manifests when the childbirth experience is emotionally overwhelming, does not meet expectations, and kindles or re-stimulates sexual, physical, and emotional traumas" (Marlo, 2013).

"We're planning on sending him away to be reared by experts."

"Your mother and I are feeling overwhelmed, so you'll have to bring yourselves up."

Intervention and Treatment

- Incorporate an understanding of a woman's biological, psychological, sociocultural, and spiritual development, and an understanding of the psychology of birth, pregnancy, and motherhood.

- **Preventive care:** Preparation before/during pregnancy. Address family of origin issues, unresolved traumas, losses, relationship patterns.

- **Professionally facilitated support groups** have been especially helpful with perinatal problems (Jaffe & Diamond, 2011).

- "**Mentoring Mothers**," group provides mentoring, education, consultation, community, and support And focuses on fostering emotional and psychological development for a **more conscious transition** to motherhood.

- **Integrative Treatment:** Psychosocial and educational interventions, **individual** and **group psychotherapy, medication, peer interventions, trauma therapies; somatic work/psychotherapies**; and **integrative/ complementary medical** and **psychological treatments:** relaxation therapy, **yoga, massage, mindfulness, meditation**, and **hypnosis** are effective with perinatal problems (Jaffe & Diamond, 2011; Siegel, 2003).

- **Psychotherapy: Brief** to **long-term**. May involve **individual; parent-infant psychotherapy; couple**; or **family** and include integrative or complementary treatments.

Intervention and Treatment

- Women who struggle with a couple of issues are often responsive to self-help strategies or concrete interventions.
  - support groups: **Mentoring Mothers**
  - developing a relationship with a trusted health professional
  - addressing nutritional depletion
  - improving sleep
  - natural remedies; herbs, supplements, and psychiatric medications
  - yoga
  - massage
  - learning about infant development (in contrast to a parenting method) and involving the partner/father
  - addressing marital/couples issues
  - incorporating touch and massage; meditation
  - practicing mindfulness
  - developing emotional attunement and empathy
  - enhancing emotional development and intelligence
  - connecting with spiritual practices
  - cultivating one's creative imagination

Intervention and Treatment

- Women who struggle more intensively benefit from integrative, treatment that includes individual or group psychotherapy.

  - Promote an **integrated approach** to her health: target one area that is within her capacity to influence. Affirm benefits of earlier treatment to her and her child.
  - Recognize role of trauma and **PTSS/PTSD** symptoms
  - address the "ghosts in the nursery."
  - Affirm the "**the reproductive story:**" The, "at times conscious, but largely unconscious, narrative" created "about parenthood." (Jaffe & Diamond, 2011) and the value of working mindfully with it.
  - Name the **healing power of telling her story**. create a "coherent narrative." differs from story a woman may readily know or tell.
  - mother who **develops** and **articulates** a "**coherent narrative**" of her **life story** has **greater mental health, healthier parenting, improved relationships** with partner and children, and more secure children with better interpersonal relations (Siegel, 2003).