Normal Postpartum Adjustment and PMADs: Understanding the Difference

Kate Kripke, LCSW
Historical Context for This Talk

The needs assessment process for CDPHE Maternal-Child Health Block grant identified pregnancy-related depression as one of 9 priority areas for Colorado’s Maternal and Child Health Program. Through this process, it was recognized that many women go through an adjustment period that does not equate to a clinical diagnosis of depression- [perhaps one that is, though characterized by periods of distress, entirely “normal”]. There are concerns that women are being inappropriately diagnosed with PPD and have then lived with a diagnoses that is inaccurate.

This has encouraged a need for more understanding and awareness around the difference so that PPD is not under, over, or misdiagnosed.

- Krista M. Beckwith, CDPHE
The Goals of This Talk

1. GREATER UNDERSTANDING: differences between normal postpartum adjustment, PPD, and the possibilities in between

2. GREATER ABILITY TO ASSESS: increases in levels of distress in new moms that warrant additional support

3. ADDITIONAL TOOLS FOR SUPPORT: for all new moms but especially women who are experiencing distress that exceeds what is expected in a healthy postpartum adjustment
Understanding the difference is confusing, because it is confusing!

(There is a vast overlap between “normal” and “pathological” postpartum experience)
Multiple words to describe a complicated issue:

Words to describe a new mom in distress:

Postpartum depression, postpartum mood disorder, major depression with postpartum onset, postpartum distress, post-natal distress, post-natal depression, maternal depression, perinatal depression, peripartum depression, postpartum emotional challenge and “the blues” (this last one is an inaccurate description)
Why is the distinction between “normal adjustment” and “PPD” important?

- **Under-diagnosis**
  - Significant distress in early motherhood assumed to be “normal” and women don’t get the support they need b/c it is assumed that all new moms suffer
  - Further fuels the myth that some women can’t tolerate motherhood
  - Moms are left feeling as though they struggle because they are “bad moms” rather than because of a real and legitimate illness

- **Over-diagnosis**
  - Unnecessarily medicating moms who struggle
  - Further fuels the myth that the new mom should always be happy
  - Potential of life-long label (real or perceived)
Why Are Diagnoses Important?

- Accurate and appropriate treatment planning
  - Best practice psychotherapies
  - Medicine treatment differs for some diagnoses
- Insurance reimbursement
  - Insurance companies require diagnoses for reimbursement
- Collaboration between providers
  - Clear understanding aids in appropriate cross support
But Do They Really matter?

What matters is that women who need support get support. When we are observing and listening with curiosity and intent, we will usually master in supporting women to get what they need during this time of distress.

Sometimes, when we focus too much on what to call it, we miss the point.
What we DO know: THE BABY BLUES

- 2-3 weeks following birth
- Emotional vulnerability thought to be caused by hormonal shifts following birth coupled with the stress of returning home for the first time
- Normal and expected part of early postpartum experience (85%)

- IMPORTANT: When vulnerability lasts longer than 2-3 weeks it is no longer considered “the blues” or “the baby blues”
What We Do Know: Normal Postpartum Experience

- Includes some anxiety, uncertainty, isolation, emotional vulnerability for all women

- (However, when moms feel these symptoms more often than not, there is usually something else going on. New moms should not suffer)
What we DO know: DSM V

- Major Depressive Disorder:

  The essential feature of MDE is a period of at least 2 weeks during which there is either depressed mood or loss of interest or pleasure in nearly all activities. In children and adolescents, the mood may be irritable rather than sad. The individual must also experience at least four additional symptoms drawn from a list that includes: changes in appetite or weight, sleep and psychomotor activity, decreased energy, feelings or worthless or guilt, difficulty thinking, concentrating or making decisions, or recurrent thoughts of death or suicidal ideation, plans or attempts. To count toward a Major Depressive Episode symptoms must either be newly present or must have clearly worsened compared with the person’s pre-episode status. The symptoms must persist for most of the day nearly every day for at least 2 consecutive weeks. The episode must be accompanied by clinically significant distress or impairment in social, occupational, or other important areas of functioning.
DSM V Continued:

- Currently, the DSM includes criteria: with peripartum onset: mood symptoms occurs during pregnancy or within 4 weeks following delivery”

- “Fifty percent of “postpartum” major depressive episodes actually begin prior to delivery. Thus, these episodes are referred to collectively as peripartum episodes. Women with peripartum major depressive episodes often have severe anxiety and even panic attacks.”

- There is no specific diagnostic criteria for postpartum OCD, Postpartum PTSD, postpartum Psychosis

- We are not being accurate when we diagnose all moms with moderate to severe distress as having PPD (for many of these moms, depression is not the primary symptom)

What Perinatal Mental Health Experts Know

- Postpartum Mood and Anxiety Disorders include a range of mental health issues that can occur any time in the first 12 months postpartum
  - PPD
  - PPA
  - PP Panic Disorder
  - PP PTSD
  - PP OCD
  - PP Psychosis

Diagnosing these issues use the criteria for mental illnesses as categorized in the DSM. These “diagnoses” cause severe distress that impedes in a mom's ability to function appropriately.

Approx. 20% women will suffer from a diagnosable postpartum mood or anxiety disorder.
And What Lies in Between?

Adjustment Disorder or “Postpartum Stress Syndrome”

(Karen Kleiman, MSW, LCSW)

These moms are struggling more than we would expect them to (their distress is persistent and does not lessen with reassurance) but they do not fit the criteria for diagnosis of Major Depressive Episode or Anxiety Disorder or any of the other PMADs.
Adjustment Disorder: DSM Criteria

- “A psychological response to an identifiable stressor that results in the development of clinically significant emotional or behavioral symptoms. The symptoms must develop within 3 months after the onset of the stressor...indicated by either marked distress that is in excess of what would be expected given the nature of the stressor or by significant impairment in social or occupational functioning.”

- “A reaction to a stressor that might be considered normal or expectable can still qualify for a diagnosis of AD if the reaction is sufficiently severe to cause significant impairment.”

- “Symptoms may exist for a prolonged period (longer than 6 months) if they occur in response to a chronic stressor or to a stressor that has enduring consequences.”
“Postpartum Stress Syndrome”:

- “Falls between the relatively minor baby blues and the relatively severe PPD”
- “. . . PSS is marked by feelings of anxiety and self doubt coupled with a deep desire to be a perfect mother. This enormous expectation of being the perfect mother, perfect wife, in control at all times, combined with the very real feelings of inadequacy and helplessness, can create unbearable stress.”
- Most common in women who are experiencing high levels of external stress (sick newborn, difficult birth, relationship challenges, major life change, etc)
- Without appropriate support, postpartum stress syndrome will often lead to PPD.

Kleiman & Raskin (1994).
The New Motherhood Myth

- Birth is easy because women’s bodies were made to deliver babies.
- Breast feeding is easy because women’s bodies were made to breast feed (and women love to do it).
- There is instant attachment and bonding when mom and baby meet for the first time.
- Mothering comes instinctively.
- Vision: peaceful baby sleeping soundly in mom’s arms after quiet and relaxed breastfeeding session. Mom is happy and relaxed. The sky is blue and the sun in shining. Visitors surround mom bringing gifts.
Newsweek 2.21.05 cover story
“The Myth of the Perfect Mother”
New Mom Reality

- New motherhood is considered by some as a “life crisis,” “psychic trauma” and “earthquake”
- Birth is rarely as moms expect it to be
- Breastfeeding comes with challenges for almost every new mom
- Role conflicts (mother, worker, wife) cause initial discomfort/distress
- 1\textsuperscript{st} year of parenthood hardest on marriage/partnerships (Gottman, 2007)
- Sleep disturbance and loss of sexual interest is common (Hopkins, et al. 1989)
- Normal feelings of ambivalence, guilt, doubt that come and go
New Motherhood Scenarios

1. **THE MYTH**: new motherhood includes no distress and all happiness

2. **THE HEALTHY (“NORMAL”) POSTPARTUM ADJUSTMENT**: New motherhood includes some emotional vulnerability and periods of distress that are expected and that mom can tolerate

3. **ADJUSTMENT DISORDER or POSTPARTUM STRESS SYNDROME**: New motherhood includes periods of distress that are expected. Mom has difficulty tolerating these “normal” emotional challenges (due to brain chemistry imbalance, high expectations/perfectionist thinking, and/or inadequate stress responses) but she still maintains some ability to function appropriately. Sx do not fit criteria for major depressive episode

4. **POSTPARTUM MOOD DISORDER LIKE PPD**: Mom suffers from symptoms of depression/anxiety that interfere her ability to function appropriately (Sx interfere with basic needs, work, childcare, relationships, etc)
The Consequence of Missing the Need for Early Support Around Postpartum Adjustment:

A normal adjustment can turn into a problematic adjustment when mom assumes that her experience is abnormal. Symptoms of depression and anxiety develop quickly in moms who feel shame and self judgment.
“Distress” and “Suffering” are Subjective

When a mom is experiencing any form of distress, we must rely on the mom’s interpretation of her experience in our assessment as to whether what she is experiencing is “normal” or not. This is why assessing the new mom is so confusing.

What matters most is mom’s interpretation of what she is experiencing, regardless of whether or not her experience is considered “normal.”
The Postpartum Stressed Mom
(Or the mom in question)

- Is not, necessarily, in crisis
- Manages to meet most expectations of daily life (work, child care, maintaining relationships)
- Often looks “together”- is showered, dressed, made-up. She may appear to be fine
- May not disclose specifics of her distress unless asked directly
- Behind closed doors she suffers from irritability, anxiety, difficulty making decisions, insomnia, and she feels overwhelmed
The Subtle Shift from “Normal” to “Problematic”

Often caused by:

- Unrealistic expectation and shame
- Cognitive distortions (Ambrosisi et al, 2011; Weingartz & Gyoerkoe, 2009)
  - Perfectionist thinking, catastrophic thought, should statements, all-or-nothing thinking
- Inadequate social support
The Non-Mental Health Provider’s Role in Supporting the Mental Health of the Postpartum Mom

- Provide validation, debunk myths, help with realistic expectations
- Encourage basic needs
  - Sleep, nutrition, water, exercise, breath
- Check for and support biopsychosocial strengths and challenges
  - Assess and support physical wellbeing
  - Assess and support cognitive distortions
  - Assess and support community needs
- Assess for level of distress and refer out to appropriate mental health support when necessary
When assessing for level of distress, we look at the

INTENSITY

FREQUENCY

DURATION

of symptoms
In every diagnoses (from the Baby Blues through adjustment disorders/ *Postpartum Stress Syndrome* to PPD), there is a range of distress from mild to severe.

Typically, milder symptoms of postpartum distress will be relieved with reassurance, validation, and support. More moderate or severe distress often needs more extensive mental health support (often including medication for severe PPD).
When is Mental Health Support Necessary?

- Mom isn’t improving with reassurance
- Mom knows what she needs to be well but can’t access these tools
- You (the provider) begin to feel uncomfortable and that your support may no longer be within your scope of practice
- Mom is having scary thoughts about harm to herself or her baby
- You have concerns about mom-baby attachment
- Distress is chronic and is affecting her ability to function as necessary
- Mom can not access important basic needs because of her sx severity
WHEN IN DOUBT, REACH OUT!

Unless you are a medical or mental health provider, your job is to ASSESS for DISTRESS and not to DIAGNOSE.
In Assessing Levels of Moms Distress

- Ask questions
- Watch for signs
- Include others

Your best tools for assessment and support = AWARENESS AND CURIOSITY

The very best thing that you can do for the mom who you support is to **watch** this with her and help her **identify** problems if they arise.
Biopsychosocial strengths assessment:
Biological/physical considerations

- Is mom able to sleep when baby sleeps?
- Is mom’s appetite in check to appropriately nourish herself?
- Is mom drinking plenty of water?
- Does mom understand effective breathing techniques?
- When appropriate, is mom engaging in healthy exercise?
Biopsychosocial Strengths Assessment: Psychological considerations

- Is mom engaging in any “cognitive distortions” that affect how she feels emotionally?
- What are mom's beliefs about herself and motherhood?
- Does mom have access to healthy coping techniques? Is she open to learning?
Biopsychosocial assessment:
Social Considerations

- Does mom have a support network?
- Does mom’s partner/family know how she is feeling?
- Is mom able to connect with others?
- Is mom able to request help/support when necessary?
- What do you notice about mom-baby attachment? (Eye contact? Appropriate response? Touch? Language?)
Assessing for *Postpartum Stress Syndrome*

- “Are you concerned about the way that you feel?”
- “Are you having any thoughts that are scaring you?”
  - Silence
  - “Oh no I don’t want to hurt my baby or anything like that. I love my baby.”
  - “Yes. I’m scared that I won’t feel better”
  - Well, sometimes it scares me that something bad will happen. Like I could snap and do something terrible”
  - “What do you mean? Like what? You mean, do I want to hurt my baby? Never!”

Watching for Early Signs of Increased Postpartum Distress

- Mom begins to pull away from community
- Mom is unable to take breaks from caring for baby although she has a great need to do so
- Mom begins to show an increased need for control over situations that are uncontrollable
- Mom’s hope and optimism begins to fade (cognitive distortions increase)
  - “This will never get better”
  - “I just don’t feel like myself”
ASSESS for (level of) DISTRESS

- Ask questions
- See for yourself
- Stick by her side
- Explain the facts (de-bunk the myths/ educate on PPD)
- Support basic need functioning (sleep, nutrition, exercise, water, breath, stress management)
- Share the concerns (and refer when necessary)
ASSESS for DISTRESS (when distress is identified)

- Debunk the myths about adjustment disorder/postpartum stress syndrome and PPD
- Identify needs
- Share an ear
- Talk about potential for recovery
- Refer to a medical provider or mental health expert if high level distress continues
- Explain the process
- Share the story when appropriate (with mom’s support team)
- Stay by her side as a part of her team
Providing Support

- Helping mom maintain protective factors
- Supporting basic needs to enhance brain health
- Encouraging biopsychosocial wellness
- Supporting community
- Helping mom to understand the degree of her distress
Providing Support:
PMAD Protective Factors

| The willingness to “Put oxygen mask on first” |  |
| Adequate sleep |  |
| Adequate nutrition |  |
| Adequate exercise |  |
| Appropriate stress management techniques |  |
| Adequate family/community support |  |
Providing Support: Basic Needs for Brain Health

- **Sleep**: At least 4 hours of uninterrupted sleep for reduction of risk (Goyal et al, 2008)

- **Nutrition**: supports serotonin production and protects against sx depression/anxiety (Walsh, 2011)

- **Water**: Dehydration and anxiety have been linked (Armstrong et al, 2011)

- **Exercise**: Reduces risk and supports symptoms (Dowd et al, 2004)

- **Breath**: Adequate oxygen intake changes body’s physiological response to stress (Brown & Gerbarg, 2012)
Providing Support: Planning for *Biopsychosocial* Health

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Challenges</th>
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<tbody>
<tr>
<td>Biological</td>
<td></td>
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<tr>
<td>Psychological</td>
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<tr>
<td>Social</td>
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Providing Support: Assessing Community

- Community opportunities (classes, groups)
- Neighbors, friends, colleagues
- Health providers (Ob/midwife, therapist, doula, lactation etc)
- Core crises support (partner, family, close friends)
- Informational support (web, books)
Providing Support: Helping Mom Understand the Degree of her Distress

<table>
<thead>
<tr>
<th>Symptoms that are not serious</th>
<th>Serious Symptoms</th>
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<tbody>
<tr>
<td>Several days of the baby blues</td>
<td>Feeling very down/anxious for &gt; 2 weeks</td>
</tr>
<tr>
<td>Occasional worries that come and go</td>
<td>Relentless anxiety that never goes away</td>
</tr>
<tr>
<td>Neg feelings and thoughts that come/ go</td>
<td>Neg feelings that outweigh the pos ones</td>
</tr>
<tr>
<td>You can take care of yourself/baby</td>
<td>You are unable to cope with your life/baby</td>
</tr>
<tr>
<td>Some escape fantasies</td>
<td>Thoughts about harming yourself/baby</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Not being able to sleep when baby sleeps/ needing to stay in bed all the time</td>
</tr>
<tr>
<td>Some forgetfulness</td>
<td>Severe inability to concentrate/focus</td>
</tr>
<tr>
<td>Moments of sadness</td>
<td>Intense feelings of sadness that don’t go away</td>
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(Dalfen, 2009)

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<td>Avoiding your baby</td>
</tr>
<tr>
<td>Wanting to limit visitors/ activity</td>
<td>Withdrawing and becoming isolated</td>
</tr>
<tr>
<td>Occasional irritability and anger</td>
<td>Feelings of intense anger and irritability</td>
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Normal Postpartum Adjustment, AD/Postpartum Stress Syndrome, and PPD: In Summary

- The Baby Blues lasting (2-3 weeks) is part of a “normal” adjustment.

- Healthy/“normal” postpartum adjustment includes a level of emotional vulnerability or distress that is tolerable (it is temporary, it comes and goes, it lessens with reassurance).

- Moms who have difficulty tolerating expected levels of distress postpartum may fall within the range of AD/Postpartum Stress Syndrome.

- The difference between “normal” postpartum adjustment and an Adjustment Disorder/postpartum stress syndrome is subtle and depends on mom’s interpretation of her experience.
- DSM V diagnoses for clinical depression is relatively clear (though still up to interpretation)

- The DSM does NOT have adequate diagnostic criteria for PMADs

- Any mom who is concerned about the way she feels needs support

- Your role, unless a medical or mental health provider, is to assess for distress (and not diagnose) - *when in doubt, refer out*
Thank you!

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References


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