

A Family's Story: Perinatal Depression

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By Amy Timm

"It's not just about mothers; it's about families and children." -Mary Howorth

After the birth of Mary Howorth's second child she felt on edge and detached and, eventually, she realized she needed help. She had trouble connecting with her children and felt like she couldn't read her new baby's signals. Mary became obsessed with her newborn's sleeping patterns. She was uncharacteristically short-tempered, and spent entire days crying. "I thought, 'It's because I'm not sleeping. I should be able to snap out of this, get myself together,'" Mary says. "At first I didn't realize how severe it could be, how bad it could get."¹

Mary was diagnosed with perinatal psychosis and struggled to find the help and support she needed to overcome this illness and reconnect with her family. Each year thousands of Illinois women suffer from some form of perinatal depression. And, like Mary, many of these women are uninformed about the frequency of perinatal depression and signs and symptoms to watch for, and they struggle with how and where to find help.

Effects on Mothers

There are three categories of depression that can occur around the time of pregnancy: the "baby blues," perinatal depression, and perinatal psychosis.

Up to 80 percent of new mothers experience the "baby blues," the most common of the three categories, during the first few days after delivery. Symptoms usually include sadness, crying, mood swings, worrying,

trouble concentrating, and difficulty sleeping. It is important for mothers with the baby blues to seek the support of family and close friends, but symptoms of the baby blues end within one to two weeks after delivery and do not require medical attention.

Approximately one in eight mothers will experience perinatal depression, sometimes referred to as postpartum depression, during or soon after pregnancy.² In Illinois, more than 22,000 mothers suffer from perinatal depression each year.³ Perinatal depression is a period of sustained sadness, depressed mood, or inability to feel happy or pleased with life lasting more than two weeks. It is commonly accompanied by a variety of other symptoms including irritability, decreased energy and fatigue, emotional withdrawal, indecisiveness, and feelings of worthlessness, despair, or doubt about one's competency as a mother. Perinatal depression requires medical attention, as it will not go away on its own.

Perinatal psychosis affects only about one in 1000 mothers each year.⁴ It is a very serious condition that requires immediate medical care, and it often affects women with a history of bipolar disorder, depression, or other mental health concerns. However, perinatal psychosis also affects women like Mary Howorth, who have no history of mental health problems and no experience with depression in previous pregnancies.

Symptoms of perinatal psychosis can include extreme confusion or hopelessness, manic behavior, hallucinations, paranoia, and suicidal or infanticidal thoughts.

The causes of perinatal depression are not fully understood by scientists, and many different types of women are affected, but there are some known risk factors that may make a woman more vulnerable. Heredity is one of these, as women with a biological family history of depression or anxiety – especially perinatal depression – are more likely to experience perinatal depression or psychosis themselves. Changes in hormone levels during and after pregnancy may also cause perinatal depression, and women who experience premenstrual mood changes are more likely to experience major mood changes around the time of pregnancy. Stress is also a risk factor, particularly if there is a lack of meaningful emotional supports such as family or close friends or the presence of other external stressors such as major life changes, financial or relationship stress, or the death of a loved one. Though all of these factors can increase a woman's risk for experiencing perinatal depression or psychosis, many women are affected without any apparent risk factors, including those who did not experience any depression or psychosis in previous pregnancies.



Risks for Children

As well as being harmful and debilitating for women, perinatal depression can also greatly impair a mother's ability to care for her child and undermine the

creation of the important emotional bond between mother and infant. This bond is essential to help an infant feel secure in himself and his surroundings, and to develop the ability to regulate himself physically and emotionally. Perinatal depression causes many mothers to be irritable, emotionally withdrawn, and to doubt their competency as mothers.⁵ These symptoms often result in less attentive and engaged maternal care, a lack of affection and higher degree of frustration toward the infant, and a more ambivalent attitude about the important task of mothering.⁶ Even mothers who consciously realize that something is wrong, like Mary Howorth did, can feel strangely disconnected from their children and unable to interact the way they want to with their new infant.

Many times, the effects of these symptoms in mothers can be clearly seen in their young children. There is significant evidence that infants of depressed mothers – particularly of those mothers who are withdrawn or react more negatively toward their baby – also exhibit symptoms of depression themselves. As early as 2 months of age, for example, these infants may have trouble engaging in social interactions. Generally, infants and young children of depressed mothers can be fussier, less physically active, and less able to regulate their emotions than other infants. At age 1 many of these children have poorer performance on developmental tests⁷, and by age 3 many perform poorer on both cognitive and linguistic measures.⁸ Depressed mothers and their infants are less likely to share in positive social behaviors such as smiling and sustaining eye contact with each other.⁹ More often, their mood and behaviors do not match or are simultaneously negative. This lack of shared, positive social interaction with another person can impair an infant's ability to interact positively with others and can lead to decreased self confidence in social interactions.

There may also be evidence of the effects of perinatal depression on more long-term social, emotional, and cognitive development of children. Multiple studies have indicated that children whose mothers had been severely depressed postnatally had significantly lower cognitive performance than other children their age – both at 4 years¹⁰ and 11 years of age.¹¹ Though there are other important family factors that may play a role in these findings, they suggest that children’s early observed delays in cognitive development may persist throughout the school-aged years. The impact of a perinatal depression on older children and on family dynamics as a whole can be similarly severe and far-reaching. Additionally, a mother’s depression or anxiety *during* pregnancy can have persistent negative behavioral effects on her infant at birth¹², highlighting the importance of considering depression perinatally – during and after pregnancy – rather than just postnatally.¹²

Protecting Families

Not all children are affected by perinatal depression in such a dramatic way. Considerable evidence shows that infants are not negatively affected by a mother’s depression when her condition is not manifested through emotionally withdrawn or less sensitive behavior toward her infant. There is also significant evidence that children whose mothers are fully treated for depression and mothers and infants who receive early attachment-focused intervention are to a large extent protected against the adverse affects of perinatal depression. “This is one area where we really do know how to help,” says child development expert Linda Gilkerson, Ph.D., professor and director of the Irving B. Harris Infant Studies Program at the Erikson Institute. “Intervention during the perinatal period has a good chance of success, and we can’t make a better

investment than early non-stigmatizing treatment for these women and children.”¹³



Early intervention and joint mother-infant therapy can go a long way toward reconnecting mother and child, even while the mother’s symptoms persist. However, the mother-infant relationship is not yet a priority in the treatment of perinatal depression. Therapy focusing on the parental couple, older siblings, or the family as a whole is similarly beneficial in protecting families from the adverse effects of perinatal depression. But many times medication or individual therapy for the mother is the extent of the treatment, and if a mother is hospitalized for perinatal depression or psychosis there are virtually no facilities that will also accommodate her infant or family. Mary Howorth spent more than two weeks in the hospital with very little contact with her children and she felt even less connected with her newborn daughter after such an extended period apart. Many other mothers, especially those who are unmarried, fear that their children will be taken away from them if they admit feeling depressed or inadequate.

First Steps

Landmark legislation in 2003 created the Illinois Children’s Mental Health Partnership (ICMHP) to develop and monitor implementation of a statewide plan for better supporting children’s social and

emotional development. This plan, finalized and sent to Governor Rod Blagojevich in June 2005, outlines a series of recommendations for the state including increasing the public and private sector responses to maternal perinatal depression.

The effort to increase screening opportunities for mothers in Illinois was notably improved in 2004 when the Department of Public Aid (now the Department of Healthcare and Family Services) began Medicaid reimbursement of perinatal depression screenings. This policy reimburses health care professionals for perinatal depression screenings conducted at either mothers' or infants' doctor visits, as covered by the state's medical programs.¹⁴

Three years later, Illinois State Senator Don Harmon successfully sponsored the Perinatal Mental Health Disorders Prevention and Treatment Act in response to the experience of his constituent, Mary Howorth. The new law, signed in September 2007, aims to raise awareness and education about perinatal depression and increase early detection so other mothers have a better and more supportive experience than Mary. It mandates that all healthcare professionals who provide prenatal or postnatal care to mothers or pediatric care to infants make available educational materials about perinatal depression to mothers and families, and invite each mother, at her choosing, to complete a screening questionnaire.¹⁵

Healthcare providers throughout Illinois are also joining in the effort to provide information and support to mothers suffering from perinatal depression. The Illinois Perinatal Mental Health Project at the University of Illinois at Chicago was designed to increase the capacity of the state's healthcare system to diagnose and treat perinatal mental health disorders by training health professionals in Illinois to screen, assess, and treat these disorders. The project provides follow-up training, on-site support, and a consultation line which offers advice

and guidance about screening, assessing, and treating women. The Illinois chapter of the American Academy of Pediatrics (ICAAP) also trains pediatricians on screening and referring mothers for perinatal depression. Many other sites across Illinois have free hotlines and support groups for mothers and families affected by perinatal depression, including assistance in finding medical and mental health treatment. This support comes in the form of formal services, such as the Evanston Northwestern Healthcare Network's 24-hour support hotline, and informal help, including numerous mothers' groups, religious support groups, and even on-call childcare for depressed mothers.



Moving Forward

“This new legislation in Illinois, and nationally, around perinatal mental health issues is a good step toward increasing awareness, education and research around perinatal depression and anxiety disorders,” says Michele Shade, project coordinator of the Illinois Perinatal Mental Health Project. “With this legislation, though, it is imperative that there is training and support available for health care providers to be able to serve these women.”¹⁶ The UIC project, which is funded by the state, federal, and private foundation support, aids in this process by conducting training workshops – nearly 20 of them, for more than 500 health care providers in the last year, according to Shade.¹⁷ This project, along with the ICAAP trainings, continues to offer professionals the opportunity to learn how to screen

mothers for depression and how to establish screening protocols in their individual sites. But there are still many providers across the state without the appropriate supports to carry out this legislation.

“There’s some great work being done, but it’s scattered. You really have to go searching for it yourself,” says Mary Howorth.¹⁸ Both the Medicaid coverage policy and the new legislation are important first steps in creating a comprehensive system for identifying and treating perinatal depression. However, more work must be done to ensure that all Illinois mothers with perinatal depression have the knowledge and resources necessary to find help if they need it, and to make certain that the mental health and emotional development of the *children* of mothers with perinatal depression becomes a priority in perinatal depression treatment.

New Momentum

“It’s not just about mothers,” says Mary, “It’s about families and children.”¹⁹ Mothers, children, and families in Illinois are at risk of living with unrecognized and untreated depression and all of the social, emotional, and developmental concerns it may cause. At a recent summit on perinatal depression – hosted by the Early Childhood Committee of the ICMHP – healthcare, social work, and advocacy professionals and families from across the state met to discuss the current condition of perinatal depression work in Illinois. From a dialogue on both the strengths of current work and the challenges in sustaining and improving work on perinatal depression came four key categories on which to focus future efforts:

1. Workforce education and development about the prevalence, risks, and effective detection and treatment options for perinatal depression (including health and

mental health care providers, social workers, and early intervention specialists);

2. Collaborative care with effective linkages among different types of service providers and with a strong focus on the mother-infant relationship;

3. A widespread public awareness and education campaign, including a directed effort to combat negative and harmful stigma;

4. Increased local, state, and federal funding to create a public awareness campaign and to provide better and more equal access to services

The solutions are not simple, but we have a clear picture of how to move forward. Public education and awareness will help reduce the stigma and fears associated with perinatal depression and encourage mothers and families to watch for signs of depression and seek help if they need it. An educated professional workforce will have the knowledge and experience to successfully help mothers who seek treatment – by emphasizing the importance of the mother-infant relationship and by effectively linking mothers to different types of services. Equal access to these resources will improve the experience of all families affected by perinatal depression. Ultimately, efforts and actions focused on these goals for improving our work with perinatal depression will help the parents and children of Illinois to lead happier, healthier lives.

Perinatal depression goes by many names, including “maternal depression” and “postpartum depression.” Because this type of depression begins with pregnancy, and because its effects on mothers and children can be seen even before the mother gives birth, we use the term *perinatal* to refer to the period during pregnancy and for up to a year after delivery.

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Endnotes

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About Voices for Illinois Children

Voices for Illinois Children works as a catalyst for change across all issue areas to improve the lives of children of all ages throughout our state so they grow up healthy, happy, safe, loved and well educated. We are committed to the well-being of every child. All children, regardless of circumstances, are vital to the preservation of a vigorous democracy. We believe children do well when they grow up in strong, supportive families, and that families do well in supportive communities. We believe in focusing on preventing problems by employing comprehensive, well-researched strategies for education, health care and social services.

Voices raises awareness of the needs facing children and families, builds broad support for solutions, and convenes stakeholders to explore data and generate public will for needed improvements. Our research and leadership development guide our collaborative advocacy campaigns.

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