



Maternal Mental Health: A Brief Review for Criminal Justice, Forensic Mental Health, and Legal Professionals

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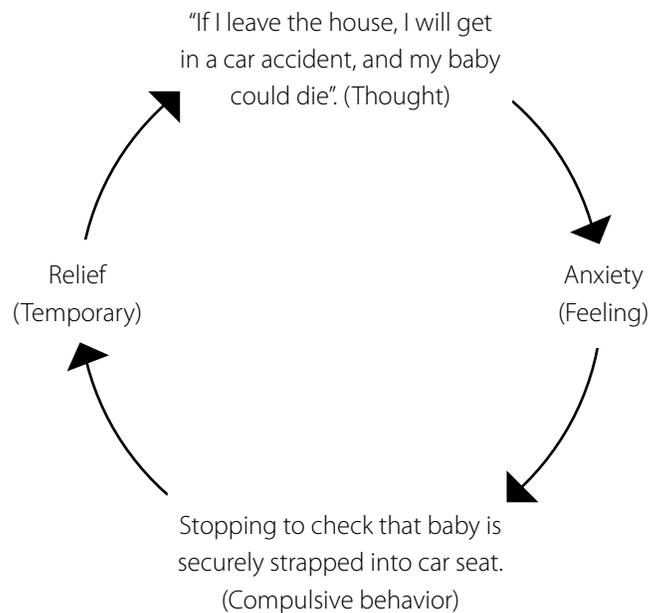
The public is gaining more and more familiarity with Perinatal Depression (usually referred to as ‘postpartum depression’, or PPD), thanks to better education as well as celebrities speaking out about their stories, which is reducing the stigma of perinatal mental health. Negative attention from media continues, however, with misinformation about tragic cases involving suicide or infanticide that are mislabeled as Perinatal Depression. There is an entire spectrum of mood and anxiety disorders that can occur during and after pregnancy, and since these disorders can play a role in the forensics world, it is beneficial to understand the differences.

Perinatal Depression (15-20 percent) is often characterized by a depressed or sad mood, though others describe it as an agitated or irritable mood, versus sadness or hopelessness. There may be a change in appetite (generally suppressed), difficulty sleeping or wanting to sleep too much, and detachment from baby. There may also be thoughts of self-harm that differ from general depression. In perinatal clients, mom often believes that the baby will be better off without her, or that she is a burden to others.

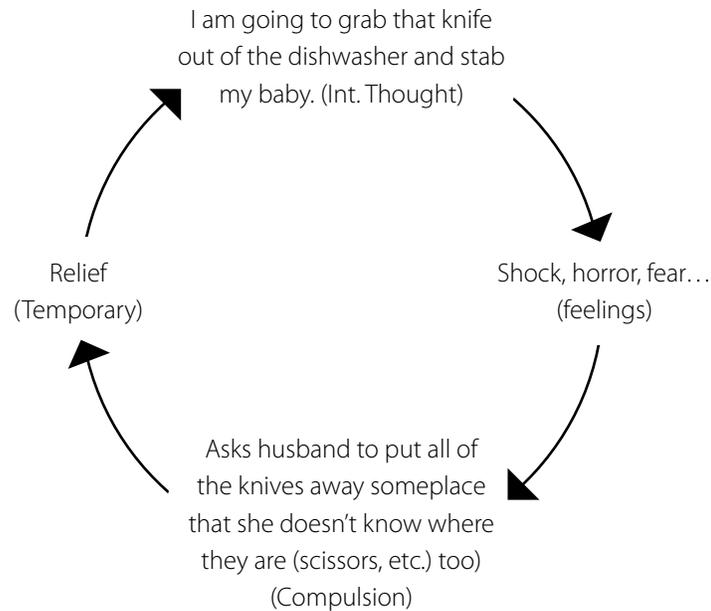
Also, along the depression spectrum is Perinatal Bipolar Disorder, which manifests as cycling between depression and mania (or hypomania, a lower level of energy than mania), which involves racing thoughts, risk-taking behaviors, and often vacillates between depression, anger and elation. Mom may appear very productive and energetic, even with very little sleep, which is appealing to hear, and often prevents her from recognizing that it can be a sign of mental illness. In many cases, the mom's first manic episode occurs in the postpartum period, which can make it very tricky to diagnose. It is very important to know that women who have a personal or family history of bipolar disorder, or develop it in the postpartum period, are at particularly high risk for suicide and postpartum psychosis (see below).

Perinatal Anxiety (10 percent) often presents as a feeling of restlessness, and difficulty living in the moment. Anxiety is about the future or the past – not the present. Moms will have difficulty falling asleep, or staying asleep, and have a hard time turning off their brain. You can see how this can further complicate having a new baby, where it is often mom waking to feed the baby, and then cannot return to sleep. Anxiety is further exacerbated by not getting enough sleep. Many moms who struggle with Perinatal Anxiety will describe themselves as a “Type A Personality” and struggle with the numerous unknowns of pregnancy as well as the lack of predictability and schedule that comes with having a new baby.

Perinatal Obsessive-Compulsive Disorder (OCD) (3-5 percent) is on the spectrum of anxiety disorders. It takes anxiety and makes the brain think about the same thought over and over until the mom engages in some kind of behavior that gives a temporary false sense of relief that the obsessive thoughts have stopped . . . Until they start again, and need to repeat the cycle, until it has interfered with their usual level of functioning. The obsessive thoughts are almost always about something happening to the baby, to themselves or someone they care about. Here is a common example:



Sometimes, the thoughts become very distressing, and the mom will experience 'intrusive thoughts'. These thoughts are unwanted and will pop uninvited and unexpectedly into her mind. Even more upsetting, they generally involve horrific things happening, and in some cases, that she sees herself as the one doing these things. They are often so upsetting that she does not tell anyone that she is having these thoughts, for fear that they will think she may harm herself or her child, but then the thoughts get trapped inside. The only way for her to find relief is engaging in the compulsive behaviors. Here is an example:



Other common examples are that the baby has stopped breathing, will get hurt, or sick, or drowning in the bathtub. These moms do not want to hurt the baby, which is why the thoughts are so distressing to them, and it's important to know that moms with intrusive thoughts are not the ones who hurt their children. They go to such great lengths to avoid harm that it can impact self-care and the ability to bond with their babies in a healthy way.

Perinatal Post-Traumatic Stress Disorder (PTSD) (9 percent) can occur if a woman has had a history of trauma (particularly a history of sexual abuse or assault) that is reactivated during pregnancy/childbirth, or experienced trauma during her labor/delivery/postpartum experience. Since trauma is in the eye of the beholder, what may not appear traumatic to an outsider feels very different to her. Common examples are loss, medical emergency, unexpected interventions, c-sections and having a baby in the NICU. Warning signs are avoiding facing or talking about what happened, having nightmares or flashbacks, being overly aware of her surroundings, hypervigilance about the baby or isolation.

Perinatal Psychosis (.1 percent) is fortunately rare, however, when it does happen, it is a medical emergency. Onset is rapid and early, usually within the first two weeks postpartum. Moms having a psychotic episode will

be having thoughts that sound bizarre or irrational to others yet make sense to them. She may believe that her baby is possessed by a demon (religious thoughts like these are most common) or experience visual or auditory hallucinations. She believes that what she is experiencing is real, which is how she can be at risk of harming herself or her baby. Even if her thoughts are not about harming, they are still out of touch with reality (example: believing that the FBI is going to kidnap her baby) and needs to receive immediate medical attention to address the psychotic thoughts.

It is important when working with a woman who is pregnant, or had a child within the previous year, that undiagnosed and untreated mental illness can lead to poor outcomes. If we don't know, we can't help, and you can't tell just by looking. Appropriately identifying and treating perinatal mental health requires advanced training, collaboration and support for the whole family. Find the resources in your own community. [Postpartum Support International](#) is a great place to start!

Author Biography:

Crystal Clancy is a Licensed Marriage and Family Therapist and owns a group private practice in Burnsville, Minnesota specializing in perinatal mental health, infertility, pregnancy complications, loss, attachment and trauma. Exploring this specialty came out of her personal struggles with both infertility and postpartum depression. She is certified in Accelerated Resolution Therapy (ART) and Aromatherapy. She is a founding member and director of Pregnancy and Postpartum Support MN (2006), which became the fifth state chapter in the U.S. of Postpartum Support International (2016). She has been the state co-coordinator for PSI since 2010 and is part of PSI's Justice & Legal Advocacy Committee.