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Mental health and substance use information you can trust

visions

BC's Mental Health and Addictions Journal

Vol. 7 No. 3 **2012**

having a baby

depression in pregnancy and postpartum: early treatment yields good results

postpartum depression: fathers get hit by it too

visions

Published quarterly, *Visions* is a national award-winning journal that provides a forum for the voices of people experiencing a mental illness or substance use problem, their family and friends, and service providers in BC. It creates a place where many perspectives on mental health and addictions issues can be heard. *Visions* is produced by the BC Partners for Mental Health and Addictions Information and funded by BC Mental Health and Addiction Services, an agency of the Provincial Health Services Authority.

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letters to the editor

I read the edition of eVisions on Borderline Personality Disorder and found it incredibly informative. Thank you for such an easy to read and comprehensive coverage of this disorder. My sister in England was diagnosed with borderline personality disorder about 20 years ago and I have never really known much about it or understood the diagnosis so I found the info contained in the newsletter very interesting and it has helped me to better understand her. I also loved the book reviews and have ordered the Family Guide for Healing & Change from Amazon which I hope will help me to support her! She is one of those success stories—having gone from being institutionalized for many years to now living independently in the community.

—Sue MacPhail, Surrey

glossary

- **perinatal** - during pregnancy up to the time right after birth
- **postpartum or postnatal** - after birth
- **caesarean section or C-section** - when a woman's abdomen and uterus are cut surgically to deliver a baby

footnotes reminder

If you see a superscripted number in an article, that means there is a footnote attached to that point. In most cases, this is a bibliographic reference. For complete footnotes, see the online version of each article at www.heretohelp.bc.ca/publications/visions. If you don't have access to the internet, please contact us for the footnotes by phone, fax or mail using the contact information on page 2.

editor's message

I went on maternity leave—my first—last summer. In many ways I was prepared. I had great support from my husband, family, friends and workplace. I practiced healthy eating, sleeping and exercise habits. I went through all the right books and prenatal classes. Because of my history of depression, my doctors and loved ones were monitoring me closely for signs of relapse in pregnancy or after the birth. I'd been well for a long time, but I knew I was high risk. I was warned to let go of expectations around a lot of things. I expected sleep to be bad and showers to feel luxurious, so neither shocked me too much when they happened.

But there were a lot of things I didn't expect the first six months. I didn't expect to feel like I was back at high school when I went to mom and baby drop-in groups. I didn't expect there to be such enormous pressure to breastfeed exclusively (even though I had twins, I still felt I had to justify why I nursed and used a bottle). I didn't expect it to be so hard to live on parental leave benefits. I didn't expect that four weeks of colic could be so hard. I didn't expect to feel different in my marriage. I didn't expect my girls to stop breastfeeding before I was ready to stop. No one talked about these things openly. No one said 'me too.'

When no depression came after three months, we all thought I was in the clear. So it surprised me that I went into a moderate depression at six months. It was different than my past episodes: more guilt, more grief, more inadequacy. And bad days peppered with some normal days so you think you're coming out of it (I've since learned that's a common feature of postpartum depression). My episode only lasted a few weeks because I got help right away. I knew I needed to connect with other moms who could talk about the deep stuff and not just the cutest new baby gear. My recovery came in finally hearing 'me too.'

This issue of *Visions* had a long gestation but I'm humbled by the courage, passion and resilience of our contributors. And I count myself in their mix. My husband and my baby girls are the joy of my life, probably more so because the path to joy was winding.

Sarah Hamid-Balma

Sarah is Visions Editor and Director of Mental Health Promotion at the Canadian Mental Health Association's BC Division. She also has personal experience with mental illness.

Starting Conversations

FIVE MESSAGES FOR WOMEN AND THOSE WHO CARE FOR THEM

Guest Editor Shaila Misri, MD, FRCPC

Joy, anticipation and excitement are some of the feelings experienced by women who have travelled the path of pregnancy and childbirth.

Shaila is a Clinical Professor of Psychiatry/ Obstetrics & Gynaecology at UBC and the Founder/former Medical Director of the Reproductive Mental Health Program at BC Women's and St. Paul's Hospitals in Vancouver. She is the author of Pregnancy Blues and Shouldn't I Be Happy? Shaila is the mother of two sons

Carrying a healthy baby to term and developing a strong attachment with the newborn is our primary goal. The journey of motherhood, however, may be fraught with uncertainty and emotional turmoil from the moment of conception.

Research shows that pregnancy doesn't protect women from mental illness. The occurrence of depression in pregnancy is reported to be around 10%, while after birth it's about 13%.[1] More frequently than not, mood disorders or depressive symptoms are accompanied by anxiety.

Nobody knows why some women are more predisposed to perinatal and postpartum mental illness compared to others. Many factors can be involved, including prior personal or family history of mental illness and stressful life events. Hormones and changes in brain chemistry appear to play a role in the onset of mood and anxiety disorders in vulnerable women.

The effects of untreated psychiatric illness on the mother and baby are a growing concern to clinicians and researchers alike. Untreated depression in the mother can lead to poor prenatal care, increased substance use, medical complications, and thoughts of harming oneself. For the child, there can be bonding issues, excessive anxiety or behavioral problems, etc. Exposure to a mother with ongoing untreated mental illness can result in emotional upheaval in the growing child.

> The occurence of depression in pregnancy is reported to be around 10%, while in the postpartum it's about 13%.

A message for women who are pregnant or planning to be and who have a history of mental health problems

If you are pregnant, it is in your best interest to share any recurrent emotional changes—however unimportant they may seem—with your health care providers. The rationale for sharing such information is to minimize the reoccurrence of depression and anxiety in pregnancy and the postpartum if you have a prior history of such illness. In addition, those women who are planning a pregnancy should also share their history of previous episodes with health care providers, as the chance of the disease reappearing during pregnancy or postpartum is likely.[2-3] And, needless to say, those women currently receiving psychiatric treatment should disclose this information to their maternity doctor so their course can be monitored through the different stages of pregnancy and childbirth.

Most women are hesitant, apprehensive, and at times, frankly embarrassed when it comes to disclosing present or prior psychiatric history and that of our family members. We are fearful of being judged and labelled. But we have to make a concerted effort to overcome this barrier and share pertinent information of any illness, be it diabetes, high blood pressure or depression.

A message for women who don't have a psychiatric history but unexpectedly face mental health challenges in pregnancy or postpartum

Unexpected onset of psychiatric symptoms with no prior warning can evoke a sense of shock, disbelief and skepticism. Without previous notice, it is not easy to accept this emotional upheaval at a time when we least expect it. In fact, it is extremely challenging.

Once the realization sinks in, treatment should be sought immediately to lessen the impact of the disease. This illness, if left untreated, can disrupt our lives. We should be our own best advocates in seeking help when necessary.

A message for partners, family members and other loved ones

More often than not, dealing with a mother-to-be or mother with mental illness is a taxing and overwhelming experience. Acceptance of this illness is daunting—time and time again partners want an explanation as to why their loved one is suffering. Partners and family members need to be reassured that with proper treatment this illness can be controlled. They can be guided to look for early signs in order to help prevent further worsening of the symptoms.

Ideally, one's partner will be an ally throughout this tough course. Once educated about the illness, partners can be engaged in the treatment—a process that will alleviate their own fears and anxieties. Research reveals that the recovery from postpartum depression is accelerated by partner support.[4] For those who are lucky enough to have a partner by their side, this battle becomes easier. And it's very important that partners and loved ones take good care of themselves as well.

A message for health care providers who work with this population, but may not intimately work with them on the mental health side

In Canada, we are fortunate to have a diversity of health care providers involved in the treatment of pregnant and postpartum mothers. However, not all may be familiar with the psychological aspects of maternal well-being. And sometimes, the health care providers' personal biases can interfere with early recognition and treatment intervention. Doctors who specialize in the field of perinatal mental health should shoulder the responsibility of educating their colleagues such as midwives, obstetricians, family physicians or nurse practitioners.

After thirty-odd years of clinical experience, my message to fellow clinicians is, "Look for psychological signs during pregnancy and the postpartum. Don't ignore the symptoms, because they don't go away!"

A last message to all

There are many effective resources available for women and their families. If a family doctor is providing the prenatal care, make sure you are carefully monitored for your mood. Midwives in BC are very efficient in recognizing the emotional changes and are prompt in finding resources—so talk to them. The obstetricians are tuned in to your overall well-being; make sure you take them into confidence. In addition, don't be shy to talk to the public health nurses or the health care providers at your local health unit.

Self-care is an important tool for you! v

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Depression in Pregnancy and Postpartum

EARLY TREATMENT YIELDS GOOD RESULTS

Jules Smith, MA and Jasmin Abizadeh, BA

You have likely heard and read about postpartum depression—depression that happens any time within the first 12 months of childbirth. You may even have a close friend or family member who has experienced a postpartum depression. But you may not have heard about depression during pregnancy, yet that's when postpartum depression often starts.

In the past people believed that pregnancy only made women feel happy. Now we know that a woman may feel tired or sad or may actually be depressed during pregnancy. Research suggests that 12% to 23% of women may experience depression during this time.[1-2]

How does depression in pregnancy and postpartum affect a mother?

Like depression in general, depression during pregnancy and postpartum affects how a woman feels, her activities, her thoughts and physical well-being. She will often feel down or empty, will find herself crying a lot, and may lose interest in the things she usually enjoys. Depression may impair a mother's bond with the new baby[3] and her capacity to nurture and meet the needs of her baby and any other children.

Many women who experience depression during pregnancy and postpartum may also have symptoms of anxiety such as feeling on edge and a racing heart. They may also have upsetting thoughts or images of harm to the baby, as result of harming the baby herself or someone or something else harming her baby. This makes depression during this time different than depression at other times in a woman's life. Some of the symptoms of depression and signs of pregnancy are closely linked, which can make it difficult to detect depression. (See sidebar for a symptom checklist.)

Women who are depressed during pregnancy are more likely to avoid prenatal care and therefore not get the care they need. They may not sleep or eat well. These factors, plus the stresses that go along with depression, may lead to medical difficulties such as premature labour and small-birth-weight infants.

Additionally, women who struggle with troubling thoughts and feelings of despair may use alcohol or drugs to cope. This behaviour often results

Jules is a clinical counsellor who has worked for nearly a decade in the area of depression and anxiety during pregnancy, after the birth of a baby or adoption of a child. She is currently a community and student counsellor on the Sunshine Coast, where she lives with her husband and daughter

Jasmin is currently pursuing her master's degree in counselling psychology at the University of British Columbia. She has worked in reproductive mental health research for over three years and is currently a research coordinator at the Reproductive Mental Health Clinic in Vancouver

Women who are depressed during pregnancy are more likely to avoid prenatal care and therefore not get the care they need.

related resources

BC Reproductive Mental Health Program (2011) *Coping with Depression During Pregnancy and After The Birth of Your Baby: A Cognitive Behaviour Therapy-Based Self-Management Guide for Women.* **www.bcmhas.ca** and click on Programs/Services > Reproductive Mental Health

in making poor choices that can have all kinds of costs to a woman's health, including more exposure to sexually transmitted diseases and violence. These unhealthy coping methods add additional risks to the baby's well-being, either by affecting the growing fetus or by putting the newborn in risky situations after birth.

'Why me?'

A woman's mental health during pregnancy and postpartum can worsen for a variety of reasons. Some of these factors can be related to a woman's culture, income, education, age, sexual orientation, self-esteem, life stress, or social support.[4-8] In particular, social support when not available from the partner, family members or friends adds to the woman feeling overwhelmed and not supported by those around her.

It's important to consider the realities of women's everyday lives. A woman is at higher risk of developing depression during pregnancy and the postpartum period if she:

- Has had depression or anxiety in the past
- Has family member(s) who have had depression or anxiety
- Has taken medication for depression or anxiety and stops before/during pregnancy
- Has poor support from friends, family and community for things like meal preparation or someone to talk to
- Has conflict in her relationships with partner, friends and family
- Finds herself alone a lot of the time and/or separated from loved ones
- Has experienced or is experiencing violence and/or abuse
- Has a history of using alcohol or other substances to help her deal with things
- If others around her have unrealistic expectations of her as a mother
- Has had a complicated pregnancy, or she or her baby had or have health problems

Get help early!

Depression in pregnancy and postpartum can be treated. If left untreated, depression in pregnancy will likely get worse. A subsequent postpartum depression may take longer to respond to treatment because symptoms have had time to become more severe. The length of response to treatment varies, but it is best to start treatment as soon as possible. Untreated depression may also affect how the mother interacts with her baby. The negative effects of depression on the new infant can include problems with bonding[3] and negative impacts on the way the child thinks, behaves, and relates to others into toddlerhood[9-10] and even school-age years.[11-12]

If a woman seeks help during pregnancy, she will reduce the risk of depression following the birth of the baby. It's important to be aware of how you feel during your pregnancy and after, so you can get the support you need to have good physical and mental health for you, your baby and your other children if this is not your first child. If you think you may be depressed, it's important that you talk to your doctor about your symptoms.

If you experience depression during pregnancy and/or postpartum, you may need counselling and/or medication. Counselling includes educating you about your illness, providing non-judgmental listening and support, and assisting you to develop strategies for coping in this stressful time such as helping to confront negative thinking patterns.

With more severe depression, or when counselling does not decrease the symptoms of depression, the doctor or psychiatrist may prescribe medication. This always involves weighing the risks versus the benefits, which is a discussion best to be had between the woman experiencing depression and her health care provider. The doctor will be able to provide information on the specific medication and the information that is known (or not known) about it in pregnancy and postpartum and weigh this information against the consequences of untreated depression.

Remember that the goal of treatment is to reduce your symptoms and increase your overall well-being so that you can take care of yourself and those who are important to you.

NESTS—A recipe for self-care

Self-care is a way to make some positive changes in your life that will help to lessen your depression. An easy way to remember the basic

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ingredients of self-care is to think of the acronym "NESTS."[13]

Each letter stands for one area of self-care:

- **Nutrition** – Eating nutritious foods regularly throughout the day will help you to feel better and carry on your daily activities.
- **Exercise** – Regular physical activity can reduce stress and boost your mood. Even a small amount like 10 minutes of walking once a week can help.
- **Sleep and rest** – Sleep and rest are very important for both your physical and mental health. It's worth the effort to work on getting a good night's sleep. Asking a partner or friend to watch the baby while you sleep, creating a bedtime routine, and giving yourself permission to sleep are a few tips that other women have found useful.
- **Time for yourself** – Taking some time to care for yourself is an important part of self-care and a necessary step in helping you to better manage your symptoms of depression.
- **Support** – Social support plays an important role in helping you make it through the many life changes that go along with becoming a mother. This includes practical support like child care, emotional support like someone who can remind you of your strengths, and informational support such as finding out about resources in your community.

What can your partner and others do to support you?

You may want someone you trust to go with you to your doctor appointments so that you can learn together. It can also be helpful to discuss what you learn with loved ones who can help you to think through the advantages and disadvantages of your treatment options and how these would fit your life.

Family and friends can listen to your concerns, hold you and comfort you. You may need more help with the responsibilities of daily chores around the house, such as cooking or cleaning. If you have other children, you will need additional help from your partners, family and friends.

Remember…

The early detection of depression in pregnancy is best. Most women who experience depression in pregnancy and receive treatment do improve. They do better after their babies are born, are less likely to develop depression following the birth of their baby, and are better able to meet both their own needs and their babies' needs. v

symptoms of depression

In pregnancy and postpartum

- Depressed or sad mood
- Can't enjoy things/find pleasure
- Irritability
- Anxiety
- Insomnia
- Difficulty concentrating
- Complaints of poor memory
- Crying
- Feeling overwhelmed
- Feeling hopeless/worthless
- Thoughts of death (own or child's)
- Loss of appetite or wanting to eat all the time *
- Trouble sleeping or sleeping too much *
- Extreme fatigue

Unique to postpartum

- Can't enjoy the baby
- Can't sleep when baby is sleeping
- Feeling worthless or guilty as a parent
- Unpleasant thoughts of harming the baby
- In extreme circumstances, may believe that baby would be better off with another mother

* These symptoms may be mistaken for normal symptoms of pregnancy, e.g. having trouble sleeping due to feeling physically uncomfortable versus being depressed.

Intrusive Thoughts? Not What We'd Planned...

Jolene H

I was in my first trimester when I started to get intrusive thoughts. At the time, I didn't know such a thing could happen in pregnancy, so was totally taken by surprise. I thought I was, for lack of a better term, going 'crazy.'

Jolene lives with her husband and son in the Lower Mainland. She has been with her husband for 11 years, three as a married couple. Her son is now 20 months old

I have a family history of mental illness, so I've seen what bipolar disorder, schizophrenia and a "nervous breakdown" can look like close up. I was wondering if something like this was happening to me. I was completely panicked.

This was a planned pregnancy with my husband, and we were both ecstatic to be having our first baby. So why was I having terrible thoughts of hitting my stomach? Why was I having the urge to hurt my baby that was growing inside me?

It became my horrible secret. I thought that I was a terrible person and that I was going to be a bad mom. These thoughts kept getting bigger and bigger and occurred more and more often.

One day, it got so intense that I was actually gripping the couch to keep myself from following through on the thought. I knew then that I had to tell my husband. When I did tell him, it definitely took some of the power of the thought away—it wasn't such a dirty secret anymore; someone else now knew the truth.

My husband listened and didn't show any judgment towards me whatsoever. I'm not sure how things would have turned out if my husband hadn't been so understanding. He encouraged me to speak to the midwife, which was the second best decision I made about this ordeal—the first being that I told my husband.

The midwife referred me to the BC Reproductive Mental Health Program at BC Women's Hospital. The wait was three months—which goes to show how many women need such services—but it was such a huge relief to hear from various medical professionals that this can be common and that I wasn't alone.

I was given quite a bit of information and teamed up with a great psychiatrist and a student counsellor who was specializing in intrusive thoughts. Most of my sessions took place with the student, doing cognitive-behavioural therapy (CBT), which helped immensely.

Working also helped most of the time. It kept my mind busy, so I had less time to dwell on the terrible thoughts. (Work was not a refuge when I returned after maternity leave, but more on this later.)

Postpartum—maternity leave

My healthy baby boy finally arrived. I was in awe and so looking forward to my year at home with him. But I hadn't realized how much I was hoping the intrusive thoughts would go away after the birth. I had the irrational belief that because I had suffered so much in my pregnancy, I wouldn't continue to

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suffer in the postpartum, even though I was told it was a possibility. I sure was wrong. I was devastated.

I got hit with significant "baby blues," as well as other symptoms that included racing thoughts, distress and panic—in other words, with postpartum depression and anxiety. My intrusive thoughts just changed into different ones, all centring around the safety of my baby, particularly with me. I could be quietly rocking my son and suddenly get struck with the thought of throwing my son against the wall or crushing the soft spot on his head.

I just tried to suffer through it alone; I was too busy with the new baby to continue with the CBT and the psychiatrist. This all took a huge toll on my husband—I still have a lot of guilt about that. But I'd call him at work in distress, and he'd drop everything and come home to help me out. He also did a lot of the household work. He was a marvellous support.

But, eventually, I started getting better—after discovering the Pacific Post Partum Support Society (PPPSS) during an infant-parent group at Pacific Spirit Community Health Centre when my son was about five months old. There was another two months to wait, but then I started attending a weekly group meeting for moms suffering from postpartum depression and/or anxiety—my third-best decision! I met a lot of amazing moms who I connected with in a way that I couldn't with moms outside the group. It was a safe place to hear other experiences that so related to mine and to voice my own experiences without being judged. I can't thank PPPSS enough for providing a weekly refuge for me.

I regained contact with my psychiatrist and connected with another student counsellor. My mother also came to stay for three weeks when I needed her. I realized that the more help I got, the better.

I did end up taking some sick leave at the end of my maternity leave. I wasn't well enough to go back to work and my psychiatrist wanted me to try medication to help with my anxiety and depression—fourth-best decision!

The return to work

I was off work for about 16 and a half months and then completed a gradual return-to-work schedule. Unfortunately, when I started a full-time schedule, my support diminished rapidly. The employer had me classified as "medically cleared" and expected me to be performing at the same level as prior to my maternity leave, with very few exceptions. At the same time, the level of scrutiny and judgment, both formal and informal, stepped up to beyond normal levels. What was intended to be a supportive daily check-in with my supervisor for a month after starting full-time quickly came to feel like policing and mistrust. Though I worked with a team of people, I was directed to not raise questions or issues with my co-workers, but to go directly to the supervisor. The way I was talked to and handled increased my anxiety, big time! I was in serious threat of relapsing.

Work has slowly gotten better, and I love being a working mom for the most part. Thankfully, I had a great medical professional team. In addition to my psychiatrist and counsellor, I saw a psychologist through my employer's benefits program, who supported me and had my back. Also, calling in the union representative resulted in an improvement in how I was treated.

Moving forward

I still meet up with some of the absolutely amazing moms from the PPPSS meetings, which I attended for about a year, until I was comfortably back into full-time work. We have our weekly "tea chats."

I feel more balanced now. An intrusive thought still occurs now and again, but I now believe it is "just a thought" and has no other meaning. I just watch it—like watching a sailboat pass by. V

I got hit with significant "baby blues," as well as other symptoms that included racing thoughts, distress and panic—in other words, postpartum depression and anxiety.

Having It All, Together—A Love Story

Sara Levy

My name is Sara Levy. I'm an 18-year-old Aboriginal mother who grew up in foster homes—until I had my son. He is my motivation and inspiration.

Sara and PJ with their son Robbie at the park

Sara is a young mother, busy with raising Robbie, loving PJ and pursuing her education to enrich the future of them all

Acknowledgement: Marijke de Zwager, a midwife who loves working with moms and babies in East Vancouver, provided logistical support so Sara could tell her story

It was May 9, 2010, when I kept thinking, "Why don't I want to drink?" Finally, at the end of May I found out I was pregnant! If I hadn't been pregnant I would have ended up drinking and partying. I was really hooked on drinking, beating up my boyfriend PJ's exes and not giving a damn. It was hard having those cravings to pick up a bottle, but every time I'd want to give up I'd say, "You're not a baby; you don't need a bottle, Sara."

All I could think when I found out I was pregnant was, "I'm going to be a mom." I chose to have this baby and I wanted to give him the safest and most secure welcome in this world. Through my pregnancy I'd have moments of wondering: What if I'm not good enough? Will he be healthy? Am I capable of this? The thoughts running through my head overwhelmed me, and it made it much worse knowing that I didn't have any family here in Vancouver.

The Ministry of Children and Family Development (MCFD) wanted me to live in a home for mothers for the first two years of my child's life, without my baby's father. I was a permanent ward of the province, which means I was supposed to be cared for by MCFD until I was 19 years old. They said I was still too young and threatened to take my baby away at birth if I chose not to live at the mothers' home.

They should have been proud that my baby's father, PJ, wanted to support his family. Instead, they tried to separate us. We fought for our rights at meeting after meeting with the social workers before our baby was born.

They can't just assume because of past precedent that I'm not dedicated to what I want. Sure I got sent to school after school when I was growing up, both before and after I became a ward of the ministry. I was beaten from age three and a half to 14; I was used to whatever came at me: wooden spoons, shoes, chairs, books and, most famously, hands. One day, my sister and I got called to the principal's office, and there were two cops, smiling, telling us our stuff was packed and we were leaving. My sister Paula and I said our last words to each other at a giant building with a flag bigger than our school. I spent the next hour with a random person in a random car going to a random place. I went from foster home to foster home, getting kicked out of school after school. I got into scraps and a whole lot of not caring—until

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Christmas Eve 2009 when I got the news that my real mom had passed away. Until I met PJ a few months later, I didn't care about anything.

Eventually PJ and I convinced the social workers to let us live together, and they opened a support file. They were surprised once they saw we were in love and showed the two main things needed to raise a child: support and respect. PJ worked all through my pregnancy, we got a house and we were happy we got to live together. I saw my midwife and other support workers regularly.

I believed I'd give birth naturally, with no pain medication, but when I was eight months pregnant my midwife told me my baby was breech. All the stress of my past—the drinking, my family, the living situations—came to the surface . . . and now a breech baby! I weighed out my pros and cons. Pretty much having a natural birth with the breech position could risk my baby dying. I was so mad and scared. But I knew it was better for my son if I got a Caesarean section. I thought to myself, "You're not a child anymore, Sara. You need to grow up from drinking, not caring and being foolish, even though there will be drama and obstacles."

On March 4, 2011, at 9:30 a.m., I was crying in the lobby of BC Women's Hospital. I had woken up the night before with tears in my eyes and I knew I must have been thinking about my baby. Just like my baby would always move to songs I played when I was pregnant. The song that stuck out at that moment was "Sweet Dreams" by Beyoncé, because she says "you can be a sweet dream or beautiful nightmare." When I dreamt of holding my baby it was a sweet dream; yet when I realized he was still inside me I froze, knowing I'd have to get a C-section, and that was a beautiful nightmare.

I jumped up, closed my eyes and took deep breaths, then said, "Okay, let's go." It was 9:40 a.m. PJ and my midwife Marijke were right by my side the whole time and kept reassuring me and telling me to breathe. Just when having surgery started to get weird, it was over. I started to ask, "Is he okay?" when I heard our baby cry. At 9:55 a.m. our beautiful baby boy was born: Robbie Joseph Levy-Mccurdy!!!

Robbie looked just like PJ when he was born, the same ears, nose, lips and eyebrows. I knew he would have my cheeks, hair and eyes, but it was too early to see his eyes then. When I finally got to hold and feed him, it felt so magical.

I had a mother's instinct and I knew it would be hard for a few months, but I also knew PJ and I could be the best parents. All those times watching PJ kiss and listen to my stomach had paid off. As PJ, Robbie and I left the hospital three days later, I kept thinking how far PJ and I had both come.

One night when Robbie was about three months old I was up breast-feeding him at 2 a.m. There wasn't much PJ could do to help (LOL). I had to feed Robbie three times, change his pukey clothes and change his butt. He waited until I was done changing him to do another poop. Then, when I laid him down after burping and feeding he got the hiccups! I tried to relax and do my deep breathing, but that night it wasn't working for me. It was the first time I really struggled to deal with all this parenting stuff and it was difficult. But it was well worth it.

Looking Back

My son is now 18 months old and I am now 20. When I look back I realize it was quite the journey. I breastfed Robbie until he was 10 months. He started sitting up at five and a half months, crawling and walking along things at eight months. When he was 14 months, he started walking fully, and now he is learning to talk. I have a baby album where I record everything he does. Right when you get used to them doing one thing, it changes.

When Robbie was eight months, part of me I was like, "I can't wait to drink." But I got so attached to my son that I didn't want anybody else watching him. I'd have sick thoughts of somebody hurting him, so instead of going out drinking I'd stay home with him.

Before my son was born, I would come across haters and I'd do what everyone else does: mean-mouth them. But it gets old after a while. I catch myself caring less and less about what others talk about and am more focused on my son as he grows. Just the other week I was squatting down by Robbie's stroller when I noticed a couple of girls. All I could do was look away and smile at my son, knowing he feeds off my energy. I was completely surprised that I didn't have a pissed off nerve in my body.

Some people say I'm missing out on life, but I say I have my whole life in front of me, with my son Robbie and my best friend, my support, my love of all time, PJ. Even though PJ and I only have Robbie as family here in Vancouver, it is enough to be fully satisfied for a lifetime. Robbie can be a real brat some days, but we are learning to work it out. As PJ often says, "We may not have it all together, but together we have it all. V

Postpartum Depression—Fathers Get Hit By It Too

*Albert

My wife and I became parents for the first time in 2010. For the first nine months following our son's birth, Jeanne* went through postpartum depression (PPD). And I did too—without being aware of it. I had heard about PPD in women, but had never heard about its effects on new fathers.

Albert lives in North Vancovuer

*pseudonym

At the hospital, Jeanne spent a whole night coping with the pain of labour. After 17 hours of labour, the baby had moved into a dangerous position, and Jeanne was given an epidural anaesthetic by injection in her back. Exhausted, she passed out right away, then they pulled her into the operating room for an emergency Caesarean section. I thought she was dying!

Thankfully, the baby was born, alive and healthy. But it was four hours before Jeanne woke up and we could hold our baby together for the first time.

Jeanne breastfed our son night and day for eight months. I could feel the strong connection between them. Many times, when she was breastfeeding the baby, I'd approach to kiss them, wanting to be part of this connection. My wife would often say, "Don't be so close. You're in our space, don't you see?" But I couldn't help my desire to kiss them and to be close to my wife and my child. I started to feel rejected and not welcome in this new relationship.

The disrupted nights and resulting sleep deprivation over the months of breastfeeding didn't make our life easier. I'd had mood swings since the birth. We argued so many times. Tension built up between us, and I became frustrated and angry.

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Jeanne seemed dramatically different than she was before the birth. I didn't recognize the woman I had dated and been living with. I felt so close to her during the pregnancy, and so much closer during the labour and the C-section. But after the birth, she seemed far away, deeply absorbed in her thoughts. She was in a bubble, still choked by her experience at the hospital.

Every day, I wanted to hug her. I believed I could help relieve her suffering and reconnect with her, but Jeanne kept slipping farther away from me.

Since the birth, we haven't had a life as a couple. We've stopped dating and stopped making love. I really love my wife. I still have intense desire for her, even stronger than before. For many months, Jeanne barely touched me and rarely held my hand when we were walking together with our baby, and she rarely kisses me with true love. She may still love me as the father of her son, but is she still in love with me? Am I still attractive to her?

"Do you love me?" I asked her.

"I don't know," she said. "Something is broken."

Is she mad at me? I wondered. She endured everything at the hospital. She was in pain, not me. She could have died, not me.

I had become a father, and strangely, I lost my self-esteem and confidence as a man. Doubts popped up in my mind: "She may want to leave me."

I had become a father, and strangely, I lost my self-esteem and confidence as a man. Doubts popped up in my mind: "She may want to leave me. I may not have been a good lover and partner for her."

Bitterness filled my heart. I wanted to be in control of the relationship. I started to ask Jeanne for sex. I thought I was tender. I was abusive, actually. It put pressure on her.

My wife doesn't recognize me either. I struggle to focus on my job: I have memory troubles, confusion, overwhelming concerns, difficulties concentrating . . . My appetite has decreased during the daytime.

Frustrated, disappointed, resentful and lonely—this is how it has been for both of us. Several times we've been on the edge of separating.

We both strongly love our son, but my dreams to build a family together sometimes vanish. I feel like I've spoiled everything. I feel alone, stupid and sad. Happiness has faded away in my life, like a stone falling in the ocean depth.

Coda: Albert is not alone in his experience of postpartum depression as a father. The thoughts and feelings shared above were written about one year after Jeanne and Albert's son was born. Now, over a year later, Jeanne and Albert have moved forward. They attend sessions with a couples counsellor to defuse the anger and resentment they have shared during the past year and to build a strong and happy family.

A Careful Treatment Plan Helped Dreams Come True
MANAGING LITHIUM IN PREGNANCY

Julianne

Having children was always one of my goals. Because I'm a woman who was diagnosed with bipolar affective disorder when I was a teenager, this goal was eventually questioned—not by those who knew me, but by those who believed some of the myths that still exist. Yes, doubts continue to linger regarding the limitations of people with mental illness.

Julianne is a 36-year-old mother of three, who coordinates a peer-based mental health program in the Okanagan. She completed a Bachelor of Arts in Psychology in 1999

I was well aware of the stigma but chose to follow my heart and be the mother I knew I could be, regardless of my diagnosis, my 'scarlet letter.'

Me and meds

I respond well to medication and have been a compliant patient from the time I was 13, when I was hospitalized for what was considered a stress breakdown. Depression and anxiety have plagued me more than any other health issue. Early on I was treated with antidepressants, which later complemented lithium treatment. I've had brief periods of mania, although years apart. I've also been diagnosed with post-traumatic stress disorder, which I believe directly affects my symptoms of bipolar affective disorder. It has been eight years since I've been hospitalized for mania; I've dealt with depression out of hospital. Currently I experience a pattern of mild depression in the winter months, but function quite well despite this.

Pregnancy—stigma was the hardest part

Becoming pregnant unexpectedly in my last year of university was a very difficult experience, largely due to stigma. It took enormous strength to get through it.

At the time of my first pregnancy, I was being treated with lithium and Tegretol. My physician at the time recommended abortion. Her stated rationale was that this pregnancy was inconvenient: I was in my graduating year, and my fiancé was temporarily unemployed. She never expressed what I considered to be legitimate concerns, so I felt her reason for recommending abortion was my mental health diagnosis. I didn't agree with her recommendation, and was left feeling overly anxious.

Doing some research of my own was critical for peace of mind—I didn't have an appointment to see my psychiatrist until the second month of my pregnancy. In a few days of research at the university library I found no convincing argument for ending my pregnancy.

After graduating, I moved back to my hometown and saw my family doctor there. I was six months pregnant at this point, so abortion wasn't even a possibility. But she would not have recommended abortion, and I felt much more at ease in her care.

However, I did feel some underlying stigma regarding having more children.

Since I was a child, I had dreamt of having at least two children. I've found that the general practitioners I've seen over the years were much less

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supportive than my psychiatrist was. The stigma was subtle, and maybe it was just that they were less familiar with the territory, but I sometimes felt that my doubts were supported better than my dreams.

During my third term, someone I knew well suggested that I might give birth to a deformed child. This kind of comment was deeply offensive, even though I knew in my heart that this had no basis. When my daughter was born, my family doctor exclaimed how beautiful she was, and she was in excellent health.

Managing the lithium

I tapered off Tegretol right away, but my psychiatrist and I decided I should continue with the lithium. Early on my psychiatrist evaluated the latest research and I was informed of the risks and benefits of taking lithium and what could be done to resolve them. We agreed that a manic episode that would likely take six to 12 months to recover from emotionally outweighed any benefits to my child if I were to discontinue this medication.

My psychiatrist had explained that I could continue with the pregnancy with minimal risk as long as I complied with more frequent blood testing. She worked closely with me to monitor my lithium levels, to prevent toxicity for me and my baby, but also to ensure that the levels were high enough to be effective. Some of the things that happen in pregnancy physiologically, like holding water, can affect the levels. Blood tests were taken more frequently (from one to four times a month, compared to once every three to four months), and my lithium dose was adjusted appropriately. During this time I felt stabilized and excited about the birth of my child.

My psychiatrist did not recommend breastfeeding. It would have been an option if I had agreed to regular blood testing of my infant to prevent toxicity. But I decided to use formula rather than put my baby through this regimen. I was content to follow her recommendation. My only regret is that I missed out on the convenience and cost benefits of breastfeeding. However, this was a small price to pay for the reassurance that the medication I took would not cause concern for my baby after birth.

My oldest child is now 13 years old, intelligent, multi-talented and a natural-born leader.

Subsequent pregnancies

Having found a successful route with the first pregnancy, subsequent pregnancies flowed smoothly with the same treatment plan. My second and third births were much less anxiety provoking. When I lost a fourth child mid-pregnancy due to a ruptured appendix, my doctor—a different GP than I'd had for my first child—shed tears along with me. I didn't experience depression or mania during or after any of my pregnancies.

Each of my children was at least a pound heavier than I was at birth and all born very healthy. I experience significant weight gain with lithium and have wondered if this medication affected my babies in a similar way. My children are now ages six, 10 and 13 and all are of normal weight. They don't appear to have been adversely affected by my being medicated while pregnant.

Working to eradicate the stigma

It has been a joy to have children. Overcoming my fears has proven very rewarding! I would never look back with regret on my decision to have children despite the stigma that so clearly exists in our society.

We agreed that a manic episode that would likely take six to twelve months to recover from emotionally outweighed any benefits to my child if I were to discontinue this medication.

We must question myths and stereotypes! Eradicating this stigma can only benefit others on similar journeys. I am currently involved with mental health programs that target stigma and provide support to individuals affected by mental illness. I share my story to help erase the stigma—I'm living proof that the myths are not warranted in every case. It's when people see me only as my illness that I've experienced discrimination. People who know me are confident in my ability to parent well.

I understand how the decision to parent (or not) causes conflicted feelings. A concern commonly expressed is passing on "defective genes." I often sense that others think it's selfish to have children and risk passing on a disorder. When speaking for themselves, they say that not having children is the "responsible" choice, and my views are often met with awkward silence. I've also heard regret from those who chose to not have children. They wish they had overcome the fear and had children, as they've managed their illness quite well.

Research shows about a 15% risk of a parent passing on bipolar disorder.[1] Genes are part of the package, but so are environmental factors. There is an interaction between biological and environmental factors. Chronic stress and trauma can result in the emergence of a disorder if the individual has a genetic risk. This needs to be acknowledged and more attention needs to be given to prevention.

I share my story to help erase stigma—I'm living proof that the myths are not warranted in every case. It's when people see me only as my illness that I've experienced discrimination. People who know me are confident in my ability to parent well.

As a parent, I'm very mindful of my children's emotional health. I can do my part to maintain an emotionally supportive household and help reduce stress. If my children do develop a mental illness, I will be there to support them in every way. I didn't have this kind of support, but it can make all the difference to health management.

Despite the challenges inflicted by mental illness, those of us who follow our treatment plans are able to have successful pregnancies and are absolutely capable of raising our children in a healthy environment. My children and I tell each other often how much we love and appreciate one another. It is possible to have children responsibly and dispel the myths that still exist. One day, fear and stigma will be a thing of the past. v

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The Weight On My Shoulders—And When It Lifted

Gail Johnson

When I was pregnant with my first child, I'd never been happier. Although I'd always been prone to anxiety, I'd overcome much of it by the time I met my then-future husband. I was feeling healthier, fitter and stronger, physically and mentally, than ever before. My pregnancy was perfect.

My delivery? Not so much.

After 16 hours of labour—labour that should have never happened in the first place—the night doctor came on shift, gave me a quick examination and said a C-section was urgent. My baby was transverse, meaning he was lying horizontally across my abdomen, making a vaginal delivery physically impossible.

I burst into tears.

I didn't stop crying for about six months.

I shed those initial tears because I'd envisioned a natural birth, and it never occurred to me that I might need to have surgery. I was filled with an immense sense of grief over not getting to experience such a quintessential moment of womanhood.

Although I was blessed to have a healthy boy in my arms, I wasn't the same person leaving that hospital as I was going in. I went home with a new baby and a severe case of postpartum depression (PPD). The diagnosis came some time later, but the effects of the PPD were immediate.

I cried and cried and cried. I was exhausted, but I couldn't sleep. I devoted every ounce of energy I had to ensuring my son was fed, changed and put down for a nap, all in that order, in a rigorous routine.

But I couldn't concentrate on anything else. I shut out friends and family members. I didn't want to go out, anywhere, not for walks or to the park or for coffee with my husband. I couldn't focus on cooking and relied mostly on my spouse's efforts and fast food (being a health-conscious foodie, that last factor was a sure sign that something was wrong).

I was anxiety personified. I worried about breastfeeding, even though it was fine. I worried about my son's health, even though it was fine. I worried about money, even though we were fine. My mind would ultimately become locked on the subject of finances, with an endlessly replaying loop in my head. My husband and I had just purchased our first home, and in my sleep-deprived state, I was convinced we'd made a grave, irreparable error.

So I nursed and worried, worried and nursed.

Several hellish months like this passed. Finally my husband and I decided to go to emergency, where we saw and came under the care of an extraordinary, young, affable and able psychiatrist. He prescribed medication, but more importantly, he offered support. He never appeared to be in a rush, but

Gail is a mother of two, fitness instructor and award-winning journalist living in Vancouver

rather took time to listen. He offered my whole family compassion.

Almost exactly six months after my son was born, I felt like me again. I can't explain why I felt the weight lift off my shoulders on that particular fall day, but it was a very distinct moment. A cognitive-behavioural psychologist my husband and I had been seeing, at the recommendation of the psychiatrist, claimed that PPD has a distinct beginning and a distinct ending. This certainly seemed true for me. It also probably helped that I was getting used to the rigours of caring for a newborn and learned how to function during the day despite getting little sleep at night.

What still haunts me . . .

Looking back at the experience, I certainly learned a lot, and not just about why lack of sleep is considered a torture technique.

Say the term postpartum depression and the first question that usually comes up is: "Did you want to hurt your baby?" It pains me to think that people around me might have been worried, even remotely, that my child was ever in any danger. He wasn't.

Media reports about women who kill their newborn babies don't help. Those rare, terrible stories create harsh and misleading stereotypes (and in such instances, women are more likely to be suffering from postpartum psychosis than postpartum depression).

Then there were people's reactions to my state of health (or lack thereof). We had a unique frame of reference, given that my husband had been through two rounds of cancer before he turned 35, enduring a stem-cell transplant following his relapse. Throughout his ordeal, we were inundated with offers of all kinds of support from all kinds of people, some of whom we knew well and others we didn't know at all.

Although we are fortunate to have a few friends who brought us home-cooked meals, more commonly, people don't really think about sending food or flowers when the problem is depression.

People tend to be in quiet awe of cancer survivors, who gain a kind of heroic status. But it's different with mental illness. People usually don't know what to say, so they end up saying nothing at all. They tend to retreat. Although we were fortunate to have a few friends who brought us home-cooked meals, more commonly, people don't really think about sending food or flowers when the problem is depression.

That silence only makes someone who has PPD more self-conscious and ashamed. I think that's the element that still hurts the most: I'm embarrassed. I wonder if people—friends, coworkers, my husband's pals—see me differently, if they view me, to this day, as unstable or, well, 'crazy.'

My son is now seven and a brother to a five-year-old. I had a scheduled C-section for my second birth, and while it wasn't "natural," I chose to have an elective C-section because I didn't want to risk going through the same kind of PPD twice. While vaginal birth is always an option, and is even encouraged after an initial C-section, I was too scared of something going wrong, resulting in another terrible postpartum period. To me, an elective C-section seemed safer. My obstetrician was supportive of me. My second child was delivered with a whole lot of joy—which persisted.

That first experience sometimes still haunts me. But mostly I feel incredibly lucky to have a family and a life that I love. I've never been happier. V

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I Was Hoping for a Fairy Tale, But What I Got Was Stinky Poo[1]

Linda Foster

According to a 2006 report by the BC Reproductive Mental Health Program at BC Women's Hospital & Health Centre, "one in five women in BC will experience significant depression related to her pregnancy and childbirth."[2] I was one of them.

In hindsight, I know now that I had perinatal anxiety starting mid-way during my pregnancy. I was in such denial, thinking I was in control. I was too ashamed to admit that I wasn't enjoying pregnancy. Truthfully, I was overridden with worry and anxiety as a result of several medical complications occurring during my pregnancy. I lived in fear that I would lose my baby.

I was also freaked out about being a new mom. My own childhood was less than perfect: I grew up with a narcissistic and abusive single mother, was put into foster care as a teenager, and struggled with undiagnosed depression until my late teens.

And, with my life-long history of major depression, doctors advised me that I was at high risk for postpartum depression.

Supermom—not!

Once my son Ethan was born, I couldn't deny my misery and pain. I woke up the first morning after arriving home from the hospital with Ethan and broke out crying hysterically. I couldn't stop crying. I felt so alone. I was now responsible for this little being and I felt paralyzed.

I believed I couldn't be a good enough mom, let alone achieve my dream of being a perfect one. Prior to giving birth, I had imagined bonding and playing with my baby. My vision of perfect motherly ways included making my baby's food from scratch, with only organic veggies and fruits. I had what I

Linda is a mother and mental health advocate. She is a Resource Development & Events Coordinator at the Canadian Mental Health Association, BC Division and on the board of the Pacific Post Partum Support Society. Linda helped launch Eat, Shop, Love for Moms to raise funds and awareness for postpartum support services

My baby and I at the height of my postpartum depression/anxiety. Appearances are deceiving. I appeared happy, but felt ashamed and guilty.

now call the "Supermom Syndrome." In reality, my husband and those around me expected me to intrinsically know everything about caring for a newborn and to be content to be alone with him all day. But I couldn't enjoy bonding with my baby. I couldn't face being alone with Ethan for fear of the daily panic attacks. And I had no mother figure I could ask for help and guidance, and no support system. I was completely on my own.

The sadness and pain were so debilitating that I couldn't function. Many days, I was unable to get out of bed, take a shower, eat or take care of myself. The guilt of not being able to take care of my baby ate away at me. I was losing the will to live and felt suicidal.

I had reoccurring intrusive thoughts, which included falling down the stairs while holding Ethan and crashing my car into a building while driving with him. Knowing clearly that I would never act on them, I still kept these "scary out-of-control thoughts" hidden. I was afraid that someone would think I was an unfit mother—or, worse, report me to the Ministry of Child and Family Development, who would take my baby away. To this day I still get a lump in my throat when I talk about it.

Ethan was a colicky, anxious baby, unable to sleep during the day or the night for long periods. He cried so frequently that I heard "phantom crying" while lying in a constant hyper-alert state at night. I tried many infant sleep training techniques without success. For Ethan to rest or self-soothe, he needed to be held in my arms. For months I sat and slept in the rocking chair, holding my son for hours at a time.

My marriage also took a drastic turn for the worse shortly after Ethan's birth. I was disappointed and devastated, and felt even more alone. My world was shattering around me.

I went to my maternity doctor seeking help within days after Ethan's birth. I was already on antidepressants, had been during and since pregnancy. Meaning well, my maternity doctor stressed the importance of asking for help and building a support system for child care. I had limited resources in both areas, but was able to rally some support by investing in paid help. I gave myself permission to hire a nanny for the much-needed breaks from 24/7 baby care. Yet this didn't eradicate my illness.

Where I found support

The turning point came when I discovered a local women's support group led by Pacific Post Partum Support Society (PPPSS). I found the group online by googling "BC women support group postpartum depression."

I was a mess, like spilt milk on the floor, when I went to my first group. It was so hard to get out of the house and go. I remember being terrified to talk, so I stayed quiet for a long time. But I soon realized I wasn't the only mom feeling this way. The other women in the group appeared intelligent and sane. Most importantly, they felt safe to share their raw, real, disturbing emotions and thoughts. What came out of my mouth the first time I shared was a blur of words and lots of tears, because I felt so ashamed, worthless and scared. I had been a successful career woman pre-birth, and now I believed I was a failure as a mother.

I continued to go to the support group because it was the one thing I could commit to without failing. I found relief, gentle kindess and non-judgement among this safe haven of women who completely emphathized with, and understood, my misery and despair.

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pacific post partum support society (PPPSS)

The Pacific Post Partum Support Society (PPPSS) has been supporting women and their families experiencing perinatal/postpartum distress, depression and anxiety for over 40 years. Their mission is to end the isolation and distress experienced by many women and their families with the profound life change that accompanies the birth or adoption of a child. PPPSS is a non-profit, charitable organization that offers a range of free and low-cost services, including a toll-free BC telephone support line, weekly women's support groups, community outreach, workshops/trainings, and publications/resource materials, and partner information sessions. To find out more, visit **www.postpartum.org**.

The telephone support line is available Monday to Friday from 9:30 a.m. to 4:30 p.m. and there is on-call service Saturdays from 12 noon to 4 p.m. Call 604-255-7999 in Metro Vancouver or toll-free 1-855-255-7999 in the rest of BC.

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Help for Perinatal Depression and Anxiety

WHAT YOU CAN EXPECT FROM A PSYCHIATRIST

Tricia Bowering, MD, FRCPC

Many people think that pregnancy and the postpartum period are a time of joy. Often, they are, but for a significant proportion of women, this is not the case: their joy and anticipation is mixed with symptoms of either pre-existing or new mental health issues.

Tricia is a psychiatrist specializing in reproductive mental health. She is the Physician Leader for the Reproductive Mental Health Program at St. Paul's Hospital in Vancouver and directs the Reproductive Mental Health Program at Royal Columbian Hospital in New Westminster

These are the women I see in consultation and follow-up in the reproductive mental health programs where I work.

Postpartum depression occurs in at least 13% of women.[1] Increasingly, we hear about postpartum depression in the media from the many women who speak out about their experiences with this difficult condition. But many people are surprised to learn that the incidence of depression in pregnancy itself is 10% to 15%.[2]

Anxiety disorders, which can be severe and disabling, are also reasonably common in both pregnancy and after the birth.

Women with bipolar and other psychiatric disorders who plan to get pregnant should be aware there are risks of worsening mental health during this time.

Though women often experience new onset symptoms or a worsening of illness during this time, it is not inevitable. A sound preventative plan will yield great benefits for wellness.

Assessing and planning

When I receive a referral from a midwife or physician, I first sit down with my patient and do a full assessment. I gather important information, such as her past history of mental health issues and her current symptoms. Most importantly, we talk about how her symptoms might be causing distress for her, her children or family, and how they affect her daily functioning.

Symptoms can be mild, moderate or severe. Severe symptoms of depression may include marked mood disturbance, withdrawal from activities of daily life, impairments in eating or caring for oneself or one's children, or suicidal thinking. Severe anxiety may include debilitating panic attacks, obsessions or compulsions, or scary thoughts about the safety of a newborn. Less commonly, women can experience manic symptoms or psychosis.

Establishing a diagnosis is only the first step to treatment. Together, we establish a preventative plan that combines both evidence-based counselling and support, and careful medication strategies when needed.

Self-care and support

I often start by teaching self-care strategies. Self-care includes striving for adequate sleep, good nutrition, moderate exercise and building in time for oneself. This can be difficult during pregnancy, as sleep disruption, nausea and the responsibilities of career and child care can be hard to work around. However, it is often more challenging after the baby is born, because parenting a newborn 24 hours a day (often while sleep deprived) can be tough to manage.

The transition to parenthood can be jarring, and finding time to eat regularly, shower and even get a little quiet time takes planning. Self-care is always a core part of treatment, and for more mild-to-moderate symptoms, it can be very effective.

There is much evidence for the effectiveness of counselling and support in the treatment of mood and anxiety disorders in pregnancy and postpartum. Groups that offer peer support (often facilitated by a group leader) are invaluable to women who might not realize that other women are going through the same thing. This starts to address the guilt that many women feel about not being "happy" during this time in their lives.

More specific counselling, such as cognitive-behavioural therapy and interpersonal therapy, are shown to be effective treatments for postpartum depression and anxiety. Cognitive-behavioural therapy starts with self-care and then moves on to challenging negative or anxious thought patterns. Interpersonal therapy focuses on dealing with role transitions.

Medication during breastfeeding and pregnancy

Some women seek advice regarding the use of psychiatric medication during pregnancy and breastfeeding. For new onset mild mood or anxiety disorders, I tend to suggest using the non-medication strategies above.

If symptoms are moderate to severe, I discuss the risks of the medication for both my patient and her fetus in pregnancy, or for her child when breastfeeding. The other side of this equation is the risk of untreated mental health disorders for the patient, her pregnancy or child. These can present a substantial risk as well. Once my patient and I discuss these issues, she can make an informed decision about whether or not she will use medication.

Many women are already being treated for a mental health condition with medications, and may have a planned or an unplanned pregnancy. I encourage women who are taking psychiatric medications to talk to their doctors when planning a pregnancy in order to determine the risks and benefits of continuing medication in pregnancy. I see many women in my clinic referred to me for this reason.

Generally, if a woman's mental health symptoms have been moderate to severe, she should choose the safest medications for a pregnancy and breastfeeding at the doses that ensure her stability. For less severe current symptoms or illness history, each woman needs to make an informed choice about the best options, be it

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slowly reducing or discontinuing medications (with close medical supervision) or staying on maintenance medications. This can be a complex decision, best made between each woman and her doctor.

Not uncommonly, a woman has an unplanned pregnancy while taking psychiatric medications. The most important thing in this situation is a visit to a health care provider to discuss the situation, rather than abruptly stopping all of the medications. Even if the ultimate decision is to decrease or stop medication, doing so abruptly increases the chance of relapse.

The most common medications that are used in pregnancy and lactation include antidepressants or anti-anxiety medications. Mood stabilizing medications or antipsychotic medications are also used when needed. Each medication has a unique safety profile in pregnancy or breastfeeding, so it is important to sit down with your doctor and choose the safest option.

What is the safest option? This is a difficult question, because the answer depends on each woman's symptoms and history of medications that she's tried in the past. Often (but not always), the safest options are medications that have been around for a number of years rather than newer medications with less data about their use in pregnancy and breastfeeding. For example, the first-line medications to treat a more severe depressive episode or anxiety disorder would be the specific seritonergic reuptake inhibitors (SSRIs), the first of which (fluoxetine, or Prozac) was approved for use in the United States in 1987.

The treatment options for bipolar disorder are more complex and require an in-depth discussion to determine the safest options. But it is clear that some medications should be avoided throughout pregnancy—and if you might become pregnant—most notably, valproic acid/valproate.

A reliable source for information on the safety of medications in both pregnancy and breastfeeding is Motherisk (www.motherisk.org).

Managing transitions

I am always mindful of transitions that women face during pregnancy and postpartum, even the less obvious ones. Weaning from breastfeeding may be a time of increased risk for the emergence of mood or anxiety symptoms. Return to work, which often occurs after up to a year of maternity leave, can be a positive time of regaining balance in one's life, but it can also provoke sadness and loss. Women with a seasonal pattern of worsening mood in the winter may benefit from the addition of light therapy.

Remember . . . reach out!

Depression, anxiety and other psychiatric disorders are common in pregnancy and postpartum. Acknowledging this fact is the first step in fighting the isolation and guilt that so many women feel when experiencing these symptoms during this important time in their lives. You are not alone. Reach out to a family physician, midwife, nurse, mental health professional or other supportive person in your life. Then, the journey to recovery and wellness can begin. v

Problematic Substance Use in Pregnancy

THE VANCOUVER APPROACH

Ron Abrahams, MD, FCFP

Society has always blamed mothers who are pregnant and use drugs. Such attitudes have meant that the babies were separated from their mothers right after birth.

Ron is a family physician in Vancouver. He is a Clinical Professor in the Department of Family Practice at University of British Columbia and Medical Director of Perinatal Addictions at BC Women's Hospital, as well as Consultant Physician at the Sheway program

*Sheway is a Coast Salish word meaning "growth"

These babies then were withdrawing—not from drugs that their mothers used, but from not being with their mothers. Not only was this hard on the babies, it was also hard on the moms.

This standard of care led to the mothers not coping and being further traumatized than they already were in their lives. It also meant that the babies—who exhibited abnormal newborn behaviour because of the separation from their mothers—were treated for long periods of time in hospital. Subsequently, most of the babies would end up in foster care. Most of the mothers would end up using and/or on the street, and the cycle would start all over again.

In Vancouver, we understand that with a non-judgmental, caring approach, this negative cycle of blame can be reversed. By stopping this blame cycle and supporting these moms in their desire to care for their babies, we can ultimately discharge them home with their babies.

Sheway*

Over the last 20 years, we developed the Sheway pregnancy outreach project in Vancouver's Downtown Eastside. It is based on the following principles:

- Supporting the moms to decrease the amount of drugs they use
- Rooming-in the babies and mothers together following birth
- Providing food, housing and health care
- Continuing ongoing supportive care of these families in their community
- Providing specific counselling programs in the context of trauma-informed care

In the Sheway program, a multidisciplinary team provides the women with health care, a drop-in centre, hot lunches, social work support, infant development and parenting support, legal help, and alcohol and drug counselling.

By providing trauma-informed care, we demonstrate our understanding that these women can be redefined from a dual diagnosis context. Through working with these women, we have learned that they are quite capable but suffer from the ongoing trauma and stress in their lives (e.g., sexual abuse, abusive families, foster care). This is a harm reduction program. It reduces the bad things that these women experience.

for footnotes go to www.heretohelp.bc.ca/publications/visions

related resources

Hodgson, Z.G. & Abrahams, R.R. (2012). A rooming-in program to mitigate the need to treat for opiate withdrawal in the newborn. Journal of Obstetrics and Gynaecology Canada, *34(5)*, 475–481. **www.jogc.com/abstracts/full/201205_HealthPolicy_1.pdf.**

Abrahams, R.R., Kelly, S.A., Payne, S.et al. (2007). Rooming-in compared with standard care for newborns of mothers using methadone or heroin. Canadian Family Physician, *53(10)*, 1722-1730. **www.cfp.ca/content/53/10/1722.full.**

With counselling and support, we have shown that the women use drugs less, and more importantly, that we don't have to prescribe medicines that can affect their babies (e.g. antidepressants or anti-anxiety drugs).

When these moms need to be in hospital, we admit them to Fir (Families in recovery) Square at BC Women's Hospital. We also deliver their babies at the hospital and room-in their babies with them immediately after birth. We help the mothers with breastfeeding and holding and cuddling their babies.

We only let moms and babies go home if they have a safe home to go to. If they don't, we keep them in hospital until housing has been arranged for them.

When the system cares

This is a program that brings together community and hospital to improve health outcomes for these families.

This program means that fewer babies are treated for withdrawal, more babies are breastfed, and fewer babies go into foster care. Over the last 10 years, about 1,200 women and their babies gone through Fir Square.

This program is governed by a partnership between Vancouver Coastal Health, the Ministry for Children and Family Development, Vancouver Native Health Society and the YWCA of Vancouver.

We are an example for every community in BC and Canada about what happens when the system cares for these women rather than blames them. v

CONTINUED FROM PAGE 22

Outside of the weekly group meeting times, it was comforting to know that if I needed to talk to a facilitator, I could call the PPPSS telephone support line. The support line facilitators are women who have experienced postpartum depression and/or anxiety themselves. They now work or volunteer to support other struggling mothers or family members or friends of struggling mothers.

On average, recovery may take weeks or months for most moms. Recovery from postpartum depression and anxiety for me took years.

The support group was instrumental in my recovery and healing. When I was ready, I settled on an approach that integrated mind, body and spirit. It was a combination of meditation, challenging my negative thoughts through cognitive-behavioural therapy, psychoanalysis, mindfulness, exercise, nutrition, medication, Buddhist practice of patient acceptance, and naturopathic treatments.

Recovered, different and making a difference

After full recovery, I was forever changed for the better. I learned that I was stronger than I thought or believed I was. I can be my authentic self now, not what others want me to be or what I thought I should be to make my family happy. I don't need to be someone else's vision of the perfect mom or the perfect wife. I give myself permission to put my needs and self-care first so I can then take care of those I love.

Today, I can enjoy the ups and downs of being a newly single mother to a spirited five-year-old boy. Ethan knows that he can talk about any dark thoughts or feelings, as well as joyous ones, and that I will always be there to listen and won't judge him.

I get great satisfaction from volunteering as a board director for PPPSS and working in fundraising at the Canadian Mental Health Association, BC Division. These endeavours allow me to transform a horrific period in my life into something profound. I live out my passion to end the stigma of mental illness by sharing my personal story about a taboo topic. Mothers, remember you are not alone. There's no reason to feel shame. And recovery is possible. v

resources

Services and Organizations

BC Reproductive Mental Health Program
www.bcmhas.ca
For women and their families who experience mental health concerns related to pregnancy, reproductive health, menstruation and menopause. This program is based at BC Women's Hospital and Health Centre in Vancouver but is available to all BC residents with a referral from your doctor or midwife. To learn more, call 604-875-2025 or visit www.bcmhas.ca and click on Programs/Services > Reproductive Mental Health. Free resources on this site include:

- ***Coping with Depression During Pregnancy and Following the Birth: A cognitive behaviour therapy-based self-management guide for women***
  For women and their health care providers. This guide discusses depression, different treatment options, self-management strategies grounded in cognitive-behavioural therapy, and self-care.
- **Factsheets for expecting mothers and new mothers**
  Learn more about depression during pregnancy, postpartum depression, and treatment options for perinatal depression.
- ***Addressing Perinatal Depression: A framework for BC's health authorities***
  For leaders and policy-makers. This guide describes a framework for action to support health authorities in providing effective education, diagnosis, treatment, follow-up care, and support.

Pacific Post Partum Support Society
www.postpartum.org
Support, resources and education for mothers and families who experience postpartum depression or anxiety. They offer BC-Wide weekly support groups in the Lower Mainland, and a telephone support line. Call 1-855-255-7999 (toll-free in BC) or 604-255-7999 (in the Lower Mainland). Available Monday to Friday from 12:00 am to 4:00 pm.

Perinatal anxiety self-help
www.anxietybc.com/perinatal
At the end of 2012, AnxietyBC will be launching a new section of their website with self-help resources for new and expectant mothers on coping with anxiety.

Healthy Choices in Pregnancy
www.hcip-bc.org
Healthy Choices in Pregnancy offers education and resources for women who use substances during pregnancy, for community service providers and for clinicians. You'll find factsheets, toolkits and information on different supports available in BC.

Reports

Supporting Pregnant and Parenting Women who use Substances: What communities are doing to help
www.bccewh.bc.ca/publications-resources/
This resource describes unique support programs in communities across Canada and discusses how the programs started, how they operate, and what lessons they've learned through their work.

This list is not comprehensive and does not imply endorsement of resources.

heretohelp
Mental health and substance use information you can trust

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