Anxiety in New Parents—the silent epidemic

Interview with Dr. Joanna Cheek

Can you tell us about yourself?

I am a psychiatrist with a special interest in mindfulness and psychotherapy. I work a lot with expecting and postpartum parents, what we call the peripartum period, in addition to working with people struggling with trauma and complicated mood, anxiety, and personality disorders. I am a Clinical Assistant Professor with the Faculty of Medicine at the University of British Columbia and an Associate Assistant Professor with the Island Medical Program at the University of British Columbia. I am particularly interested in making psychotherapy and mindfulness more accessible in our communities and have co-created mindfulness and cognitive behavioural therapy programs, in addition to a post-partum mindfulness program here in Victoria, BC, where I live with my own family, with a three and five year old at home.

I am excited that postpartum depression has been in the public spotlight to raise awareness of this common and treatable condition, yet today I'd like to talk about anxiety in expecting and new parents, a topic that hasn't yet received the same amount of attention.

What does anxiety look like in pregnancy and the postpartum period?

Before we talk about anxiety disorders, it's important to recognize that all of us, whether we have a clinical anxiety disorder or not, struggle at times with anxiety and worries.

Psychologist and mindfulness leader Dr. Ronald Siegel shows this by describing the double edged sword of having a human mind. He speaks of how back when our ancestors were hunters and gatherers, if they looked out into the distance and saw something, they would wonder, "Hmmm…is that a rock or a lion?" Those with the motto, "Don't worry, be happy," decided it was a rock and kept on dancing…well, those weren't really our ancestors. The ones that did survive more often were the worriers, those who went into fight-or-flight mode to protect themselves just in case it was a lion, which it frequently was. We call this survival skill *the negativity bias*, where we pay attention to the one thing that is potentially going wrong and ignore the 99 things that are going just fine. Psychiatrists and psychologists have a saying, "We've evolved to survive and not to be happy".

Similarly humans are a tribal species, so not getting kicked out of the tribe has also been essential to our survival. Therefore the negativity bias will have us over-focusing on any signs that we are not enough, constantly comparing ourselves to others, fearing rejection at all times.

So you can see how this negativity bias, that is so essential to survival, could lead us to being very anxious, always on the lookout for signs of danger or signs that we are not enough just as we are. In mood and anxiety disorders, this negativity bias becomes overactive, which is particularly difficult in the peripartum period, when there are so many potential threats and so many ways we could see ourselves as a not good enough parent.

What makes it even harder is that even if this present moment seems safe, rather than relaxing, our mind has the capacity to move to the past or future and look for threats and evidence of not being enough there. While this allows learning from our past and planning for the future, I think most of us can attest that it really isn't that helpful on a calm Sunday morning to relive that embarrassing thing you said last week one hundred times or, when looking at your baby, to imagine all the horrible things that could happen to them in their lifetime.

We call this our *default mode network* that is, when we are not mindful to the present, our mind goes fishing for problems to solve in the past and future, and it's often very painful and very personal! Neuroimaging studies have shown that people with anxiety and mood conditions get stuck in this default mode network.

And that's all just the first arrow. Then we add in what we, in mindfulness circles, call the 'second arrow'. Rather than having compassion for our difficulty, as we may with a physical illness, we often have the tendency to actually increase our suffering by feeling shame for feeling this way, getting mad at ourselves, or denying or trying to get rid of the experience, rather than allowing it to be there with kindness and compassion.

What are the different ways anxiety may present in new parents?

Generalized anxiety disorder is when anxiety and worry focus on multiple themes, often sickness, safety, finances, everyday performance, especially with an intolerance of uncertainty. In pregnancy and postpartum, when there is a need to tolerate a lot of uncertainty and a lot of potential risks, generalized anxiety is really common. Generalized anxiety leads to insomnia, difficulty concentrating, irritability, physical symptoms such as gastrointestinal distress, headaches, body aches and tension, and fatigue, as it's so exhausting to be in the fight-or-flight mode all the time. Unfortunately these symptoms look a lot like typical pregnancy and postpartum symptoms, so they are often shrugged off, despite being very impairing.

Sometimes anxiety can escalate into a *panic attack*. Anxiety comes with lot of physical sensations from the fight-or-flight response being set off, like heart racing, tunnel vision, shaking, chest pain, or numbness and tingling, or difficulties thinking, such as a blank mind. When we interpret these symptoms as dangerous, our bodies dump even more adrenalin into the mix, creating a cycle of more symptoms, then more interpretations that this is dangerous and so on until there is a panic attack with severe, incapacitating symptoms of anxiety, feeling like we are dying or losing control. Because panic is so frightening, we often fear having another one and become very avoidant, or we may over-monitor our bodies for panic symptoms, which may actually cause more panic as we interpret normal body noise as dangerous and set off the panic cascade.

I also would like to mention *OCD, or obsessive-compulsive disorder*, a condition of intrusive unwanted repetitive thoughts, or obsessions, and compulsions that are repetitive behaviors to try to get rid of those obsessions. In pregnancy, OCD often focuses on fears of death of the fetus or contamination fears with germs and exposures. Consequently, we see compulsions of needing multiple checks of the fetus (like ultrasounds or compulsively counting baby kicks) or excessive avoidance of foods or hand washing. In the post-partum period, mothers often

struggle with intrusive thoughts of contamination again, or fears of the baby stopping breathing, with a compulsive need to check on the baby. This can make sleep and driving really difficult.

One of the types of OCD in new parents that I always like to mention is *Harm OCD*. In this disorder, a parent, like all parents, may experience a fleeting thought of harming their child (e.g. dropping them, getting in an accident, or having an image of shaking their baby, when angry, or losing their baby). All parents occasionally have these thoughts, but in parents without OCD, they wouldn't believe that having this thought was bad, so they don't think twice about it. However, people with OCD are very morally conscious and assign great meaning and responsibility to this thought, judging themselves as a horrible parent or believing it will come true. They try to push the thought out of their mind, but unfortunately, whatever you try NOT to think about is actually the first thing to come into your mind. For example, try not to think of a purple elephant— chances are it is all you can think about! The more we try not to think a harm thought, the more we get it stuck in our heads. So, often parents will become consumed with these thoughts and assume they are a dangerous person for having them. A similar thing can happen when someone with OCD looks at a baby's genitals and for a moment thinks, "I shouldn't look there or I will be a pedophile". They interpret their action as dangerous, but the more the parent tries not to think of the genitals, the more they can't get the idea of looking at them out of their head, and then they worry they really are a pedophile, despite having no sexual desires towards children.

In both these cases, parents are very scared to access help. They fear others will learn about these thoughts and assume they are unfit to parent. What we like to educate parents about is this: intrusive, unwanted thoughts, with no intent of actually acting on them, can be a symptom of Harm or Sexual OCD, which is very treatable. I often like to tell my patients, who solely have OCD, that they are the people I am least worried about ever harming their child.

It's important to note how OCD is different from suicidal or infanticidal thoughts **of severe depression or psychosis**. With severe depression or psychosis, we sometimes can become so hopeless, and our thoughts can become so distorted, that we truly believe that life is not worth living and our children would be better off dead. These sorts of thoughts do put mothers and babies at risk of harm and are **a medical emergency**. In contrast, as mentioned above, a parent who has OCD thoughts, that is, they struggle with intrusive thoughts but do not actually want to harm themselves or their child, are not significant risk factors for harm. We call OCD thoughts "egodystonic" because the obsessions are inconsistent with their true beliefs and wishes. In fact, people with OCD are typically the least likely to ever act on their intrusive thoughts.

How common is anxiety in expecting and new mothers?

A recent study from BC showed 16-17* percent of women had a clinical anxiety disorder in their pregnancy or post-partum period [which fits with the international consensus of rates around 9-22%], exceeding that of post-partum depression, with a prevalence around 7-15%, depending on the study.

> *[*Fairbrother, Nichole et al. Journal of Affective Disorders, 200:148-155. Available at https://www.jad-journal.com/article/S0165-0327(15)31132-0/abstract]*

It's important to note that there are many more people who have what we call *sub-clinical anxiety symptoms*, distressing symptoms that don't make the strict cut-off to qualify as a disorder.

The rate of OCD in this study was 3.9% in perinatal period, versus the general population's risk of 1.6% in that same 1-year period. So new and expecting mothers have more than double the risk for OCD than at other times in their lives.

Similarly, more than 10% of fathers and partners experience anxiety and depression during their time as new parents.

What are the causes of increased risk in the perinatal period?

We always talk about mental health conditions as having many causes, something we frame in our "bio-psycho-social model". Everyone has a unique genetic vulnerability to mental health difficulties inherited from our parents that cannot be explained by one or two genes, but rather by a large number of genes that each carries a small cumulative risk. Over the years, environmental factors, such as traumas and stressors, physical illnesses, or social learning from those around us, can predispose us further to mental health symptoms.

Then, during the perinatal period, biological changes such as fluctuating levels of reproductive hormones and lack of sleep can make us very vulnerable to anxiety and mood conditions.

Additionally, social factors such as a major shift in one's identity, roles, and relationship patterns can make us more vulnerable to anxiety. For example, rates of anxiety are higher in parents with their first baby, when parents feel unprepared and simply not "good enough" to keep this precious baby alive and healthy.

Additionally, our relationships abruptly shift. For those of us with partners, we may change from lovers to co-workers overnight, now needing to negotiate job-sharing the demanding task of watching a baby 24/7.

Sometimes, parents are too anxious to let others help them, or feel that they 'should' be able to manage alone. Sometimes parents don't have any social supports, with no family or friends close by. One of the explanations for increasing rates of mental health conditions in society these days is a growing sense of disconnection and isolation in our communities. The anxiety and shame of not being a good enough parent thrive in isolation. Rather than having others quickly say, "It's okay, I feel like that too sometimes", new parents in isolation can believe they are the only ones who struggle, which magnifies their anxiety and shame.

Why is treating anxiety so important?

Many parents are concerned about the potential for negative effects of treatments on their baby, especially medications. However, recent studies show that there are even stronger negative effects on the baby for not treating a parent's mental health conditions. Like depression, anxiety in pregnancy and the postpartum period has negative effects on both the parent and infant.

Untreated anxiety in pregnancy is the strongest predictor of post-partum depression and can also relate to pregnancy complications.

We are now learning that *epigenetic effects*, that is, how our environments can modify how our genes are expressed**,** can explain long-lasting effects of early life experiences, even in utero. For example excessive stress in the mom in pregnancy can change the stress response in her children years later.

Also, difficulties with parental mental health can change caregiving and attachment, which are fundamental to the optimal development of a child. Symptoms of anxiety and mood may lead to difficulties in being available and responsive to the baby.

This is a hard discussion to have because I worry that parents with anxiety may then have more anxiety and shame about the effects of their anxiety on their baby, which only makes things worse. That is why it is very important to frame the discussion in a way that does not blame the parent. When you look at the causes of anxiety and mood conditions, just like physical health conditions such as cancer or appendicitis, the factors leading up to a mental health condition are largely out of a parent's control. The condition is in no way their fault, nor is it a sign of weakness. I like to reframe it more as a 'perfect storm' of many risk factors, largely outside their control.

Consequently, as clinicians, our guidelines strongly emphasize aggressively treating mental health conditions.

Can you tell us about the treatments for anxiety in new and expecting mothers?

It's important to see anxiety problems as lying on a spectrum from feeling temporarily overwhelmed in the context of a stressful day to feeling completely incapacitated by anxiety for weeks on end.

In mental health, we talk about "stepped care". In stepped care we try to match the support offered to a parent to where the parent is on this spectrum. We start with exercise, nutrition, scheduling in breaks for themselves, building a support network and then we move on to mindfulness, talk therapy, and medications, if needed.

The first step is recognizing a problem and having an open discussion with one's support system (including family, friends and health care professionals). Naming that there's a difficulty can be very therapeutic, especially when it is received by people who are validating and supportive.

One obstacle is that mental health challenges—and the struggles of parenthood in general—tend to be accompanied by shame. Dr. Brene Brown, who's famous for her work on shame and vulnerability, describes the antidote to shame as knowing your shame triggers, knowing when shame is present and sharing our shame stories with others who "deserve" to hear this – that is, people who will be supportive. I know for myself and many other parents, my shame trigger is any situation that I interpret as "I am a bad mother". Often shame resilience is as simple as telling a friend how you feel shame because your baby rolled off the couch or you couldn't console them for 8 hours straight, and the friend saying "Me too, I've been there". Brene Brown

talks about the need for the 3 c's in combatting shame: courage to be open with our difficulties, connection to others, and compassion for both ourselves and others.

[https://brenebrown.com]

This links closely to another researcher and psychologist, Dr. Kristen Neff, who has helped us understand the power of self-compassion. Rather than self-esteem, which focuses on how we compare to everyone else, self-compassion is taking comfort in recognizing that we are flawed, imperfect and messy, just like everyone else, and being especially loving towards those messy, hurting parts, rather than struggling to hide them.

[http://self-compassion.org]

Kristen Neff defines self-compassion as having three steps:

1) Being mindful to your experience—often as new parents, we forget that we too exist, and are also along for the ride as feeling, thinking beings. This can be as simple as when your baby is up all night screaming, saying, 'Ouch. This hurts. This is really hard', rather than blaming yourself for not being good enough.
2) Universality—remembering that 'other people feel this way too, it's not just me', to target the associated shame that can arise from suffering.
3) Kindness—asking yourself, 'how can I be gentle and kind to myself in this moment'. So rather than getting mad at ourselves for not coping better, perhaps offering gentle encouragement, asking for help, or taking a break.

The research of self-compassion is extremely positive for pretty much every good outcome in life, and Dr. Neff's research shows that it is something that can be learnt with practice, even if it initially feels unnatural.

Self-compassion is also connected to the larger topic of mindfulness, which has become very popular and well-researched in medicine and many other areas of society.

Mindfulness is defined as noticing what you are experiencing while you are experiencing it—so becoming aware of the present as it unfolds, but also in a certain way—with curiosity, compassion and non-judgment.

You can see how this is targeting some of the difficulties I mentioned when introducing anxiety. I mentioned how we often get stuck in our default mode network, that painful place where we ruminate on the past and future in a negative way and make it very personal. In mindfulness we try to get out of that default mode and back into the present. Studies have shown that we can spend much less time in that painful default mode if we "work out" our mindfulness muscle by continuing to notice when we have left the present, and by returning to the present, again and again. This is one of the explanations for how mindfulness helps anxiety and mood conditions.

This can also be helpful for coping with stressful situations, such as if your baby is in the NICU. The tendency is to get stuck in reliving the scary moments and ruminating about worst outcomes. Instead, we can try to take respite in the present by noticing what's going on around us, perhaps the sensation of holding our baby's hand, or noticing what our coffee tastes like, practicing returning our attention back to the present whenever our mind becomes hijacked by past and future.

Other mindfulness strategies can help with the negativity bias I introduced earlier. We can help to minimize this by simply noticing worry thoughts as thoughts, not necessarily truths, and perhaps even labelling them as 'top ten tracks'. We have a saying in mindfulness that "thoughts are not facts" and "don't believe everything you think". So, rather than assuming your thoughts are true, it is helpful to remember that our minds are geared to survival and worst case scenarios. We can try saying 'thanks mind for that scary story', noticing it and then returning our attention back to the present, perhaps even giving ourselves a moment of self-compassion if the story was particularly painful.

We can also use mindfulness to get out of our heads and into our bodies. Often, when we are experiencing big, painful emotions, the worst parts are the thoughts that accompany them, especially when we add in scary thoughts of past and future. So rather than riding those trains of thoughts to their painful destinations, we can notice a distressing feeling is here, and bring our attention to our bodies—which are always in the present—and like a scientist, investigate the body sensations: 'what is the temperature? Is it moving? Are there areas of tension or heaviness?' And then asking ourselves: 'Can I tolerate this physical sensation in this moment?' And while moments of distress can often feel intolerable when they are a big blob of confusing thoughts and feelings, breaking them down like this can help make them feel very manageable. In this way we build confidence in being able to tolerate and experience emotions without having to push them away or avoid them.

Mindfulness also helps us be more effective parents. Managing our own emotions and being able to be present as part of our daily practice allows us to be present and appropriately responsive to our babies, helping us with bonding, as we feel we can tolerate being the compassionate container to hold their big emotions.

Cognitive Behavioral Therapy (CBT) is very similar to mindfulness in that we notice our thoughts, feelings and behaviors and work on more skilful responses. When working with thoughts, we can challenge some of the scary stories our mind comes up with. We know our mind hates uncertainty, so it frequently fills in the gaps with our negativity bias. CBT tries to ask, 'is that really true?' So when you have the thought, 'my baby won't stop crying, there must be something horribly wrong with her', we come back to a place of uncertainty, with, 'Ouch. That's a scary thought. There are hundreds of explanations for what may be wrong, and it's so hard not knowing'. It's important to note we don't just paint a happy picture of 'don't worry, be happy, everything's perfect forever' but rather try to have more realistic thoughts. CBT practitioners often say, "you can't control your first thought, but you can create your second one".

CBT also has behavioural strategies, such as gradually approaching what you are scared of. We talk about the 'false promise of avoidance' and how avoiding scary things just makes them bigger and scarier. It's the reason why so many of us hate Mondays, because we've been avoiding work all weekend. This may mean gradually exposing ourselves to leaving the house, or social outings where the baby may scream, or for OCD, driving or bathing with your child. Then we learn that we actually can cope with the threatening situations.

Finally, another important therapy for this period is Interpersonal Therapy (known as IPT). In IPT, we look at transitions in our social roles, relationships and causes of our symptoms. We explore how to better communicate our expectations and needs from others to effectively

mobilize our support network. We also explore the new role of parenthood, including grieving what old roles may be lost and how to adapt to new roles.

Finally medications are often very useful in treating anxiety. Sometimes it's impossible to be mindful or skillful with a waterfall of thoughts and emotions pounding at you. Medications can bring these thoughts and emotions to a manageable level where you can then have the capacity to use the strategies I just explored. Anxiety conditions are first treated with antidepressants, the SSRIs, or serotonin-reuptake inhibitors. The general consensus is that the benefits of treating anxiety and mood conditions during pregnancy and the postpartum period typically outweigh the potential risks of exposure of medication to the developing child. Unfortunately, studies shows that the mainstream media coverage and social media tend to overestimate the risks of antidepressants medication during pregnancy and breastfeeding, while undervaluing the risks of untreated mental health symptoms in moms.

Parents with anxiety also have a tendency to overestimate the risks of treatment, especially when it comes to taking medications for which there are still uncertainties in our understanding. As fear of uncertainty and potentially harming the baby are at the root of anxiety conditions, it is often very hard for parents to allow themselves to take medications, even when they really need them to function.

I like to work with parents to have an open discussion about the pros and cons of medications so they can voice all their concerns and make an informed choice. I try to help parents see that when an anxiety or mood disorder is moderate or severe in intensity, we are likely doing more harm to the baby and mom by not treating it.

Another challenge is that antidepressants often make you worse for the first 1-2 weeks, briefly increasing anxiety before they make you better, which takes 2-6 weeks. People often notice improvements in energy, appetite, sleep and motivation first, and not until a month or so do they notice a change in their thinking and emotions.