Five Facets of Mindfulness During Pregnancy and Postpartum Periods

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Psychological Distress in Pregnancy

- Two-thirds of women with a preexisting mood disorders report at least one episode during pregnancy or postpartum, in particular bipolar I (Di Florio et al., 2013).

- Hospital admission for any mental disorder during pregnancy and postpartum periods is highest during the first 0-3 months after conception or giving birth (Munk-Olsen et al., 2006).

- Psychiatric disorders during the postpartum period can have lasting effects on the mother (psychological distress) and baby (issues with bonding; Sutter-Dallay et al., 2011).

- Mortality rates of pregnant mothers with psychiatric disorders are 4x as high as mothers without psychiatric history; unnatural causes (suicide and accidents) account for 40.6% of deaths in women with psychiatric disorders (Berg et al., 2003).
Treatment of psychological disorders in pregnancy and postpartum

Common treatment method: Psychopharmacological approach
• Balances mood fluctuations between mania and depression or mixed episodes
• *But many must change or quit medications due to teratogenic effects during pregnancy* (Viguera et al., 2011) and *expression of medications through breast milk during the postpartum period* (Dodd et al., 2005).

Mindfulness as a treatment in pregnancy and postpartum?
• Mindfulness-based practices have shown to be effective in mood disorders (Segal et al., 2018), and also in pregnancy (Luberto et al., 2017), and parenting (Potharst et al., 2017).
• Clinical and general understandings of mindfulness often involve decontextualized practices

Five Facets and their relationship with psychological disorders
• *Acting with Awareness*: significantly less depressive and anxiety symptoms (Brown et al., 2014)
• *Non-judging*: moderately less depressive symptoms (Brown et al., 2014; Kantrowitz-Gordon, 2018).
• *Non-reactivity*: moderately less anxiety symptoms (Kantrowitz-Gordon, 2018).
• *Describing*: small increases in depressive symptoms.
• *Observing*: no relationship with symptoms (Brown et al., 2014; Kantrowitz-Gordon, 2018).
Participants

- Women that have given birth within the last year or are currently pregnant, 18 years+; Final N=779
- \( M \) age = 29.4, SD = 3.9, range 18-46
- 71% currently pregnant; 19.6% not pregnant
- 52.5% White/Caucasian, 11% Black/African American, 8.2% Asian, 4.9% Hispanic/Latinx, 4.7% multiracial, 3.6% American Indian or Alaska Native
- Last given birth: 11.3% 0-3 months, 15% 4-6 months, 12.5% 7-9 months, 12.7% 10-12 months

Recruitment

- Social media groups
- NAMI Washington
- $5 Amazon Gift Card Raffle

Design

Self-report surveys on common mental health challenges during pregnancy/postpartum and mindfulness practices including the five facets of mindfulness.

Measures

7 up 7 down: Depression & mania symptoms (Youngstrom et al., 2013)
- E.g. “Have there been times of several days or more when you were so sad that it was quite painful or you felt that you couldn't stand it?” (0-Never or hardly ever, to 3-Very often or almost constantly).

Hospital Anxiety and Depression Scale (Zigmond, 1983)
- E.g. “I get a sort of frightened feeling as if something awful is about to happen” (0-Not at all, to 3-Very definitely and quite badly).

Five Facets of Mindfulness (Baer et al., 2006)
- E.g. “I perceive my feelings and emotions without having to react to them” (0-never or very rarely true, to 5 very often or always true).
Results: As predicted, overall mindfulness was associated with reductions in all symptoms

Table 1. Correlations between Five Facets of Mindfulness by symptoms in all participants

<table>
<thead>
<tr>
<th></th>
<th>Overall Mindfulness</th>
<th>Observe</th>
<th>Describe</th>
<th>Act with Awareness</th>
<th>Non-judgement</th>
<th>Nonreact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mania</td>
<td>-.14**</td>
<td>.33**</td>
<td>-.01</td>
<td>-.43**</td>
<td>-.48**</td>
<td>.40**</td>
</tr>
<tr>
<td>Depression</td>
<td>-.21**</td>
<td>.36**</td>
<td>-.09*</td>
<td>-.51**</td>
<td>-.43**</td>
<td>.33**</td>
</tr>
<tr>
<td>Anxiety</td>
<td>-.22**</td>
<td>.32**</td>
<td>-.07</td>
<td>-.46**</td>
<td>-.44**</td>
<td>.31**</td>
</tr>
</tbody>
</table>

Table 2: Correlations between Five Facets of Mindfulness by symptoms in pregnant participants

<table>
<thead>
<tr>
<th></th>
<th>Overall Mindfulness</th>
<th>Observe</th>
<th>Describe</th>
<th>Act with Awareness</th>
<th>Non-judgement</th>
<th>Nonreact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mania</td>
<td>-.10*</td>
<td>.31**</td>
<td>-.23</td>
<td>-.38**</td>
<td>-.42**</td>
<td>.37**</td>
</tr>
<tr>
<td>Depression</td>
<td>-.14*</td>
<td>.36**</td>
<td>-.04</td>
<td>-.48**</td>
<td>-.40**</td>
<td>.31**</td>
</tr>
<tr>
<td>Anxiety</td>
<td>-.13**</td>
<td>.26**</td>
<td>-.00</td>
<td>-.40**</td>
<td>-.40**</td>
<td>.35**</td>
</tr>
</tbody>
</table>

Table 3: Correlations between Five Facets of Mindfulness by symptoms in postpartum participants

<table>
<thead>
<tr>
<th></th>
<th>Overall Mindfulness</th>
<th>Observe</th>
<th>Describe</th>
<th>Act with Awareness</th>
<th>Nonjudgement</th>
<th>Nonreact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mania</td>
<td>-.28**</td>
<td>.39**</td>
<td>-.07</td>
<td>-.54**</td>
<td>-.66**</td>
<td>.44**</td>
</tr>
<tr>
<td>Depression</td>
<td>-.42**</td>
<td>.39**</td>
<td>-.26**</td>
<td>-.64**</td>
<td>-.55**</td>
<td>.37**</td>
</tr>
<tr>
<td>Anxiety</td>
<td>-.47**</td>
<td>.45**</td>
<td>-.26**</td>
<td>-.72**</td>
<td>-.53**</td>
<td>.17</td>
</tr>
</tbody>
</table>

* Indicates $p < .05$; ** $p < .01$

But also facets matter:
- Acting with awareness and nonjudgement was significantly related to decreases in all symptoms.
- Observing and non-react was associated with increased symptoms. Describing was non-significant.
- Postpartum showed stronger correlations than pregnancy.
Implications: Mindfulness appears to be effective, but facets matter

Considerations in a global context:

• History and context of mindfulness practices should be included when considering mindfulness practices.
• Future research should look at cultural variations in practices, attitudes, and feasibility in different populations.

Considerations for clinicians:

• Determining the difference between “what” (e.g., observe) skills and “how” skills (e.g., nonjudgement) is important in how mindfulness is practiced.
• The improvements in mania may be due to characteristics in mania itself, and not actually improvements.

Considerations outside of medicine:

• Mindfulness can be practiced without a prescription but those practicing should be educated in mindfulness effects.
• Western practitioners of mindfulness, mindfulness apps, and other sources run the risk of appropriation and all mindfulness practices should be re-contextualized within the roots of the mindfulness practice.
References


