"Pain and mental health during and after pregnancy and its associations with child brain and behavioral development"
Jillian Miller
University of Calgary, Canada
Mental Health Symposium 2026
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[2026/06/25 14:29] Elektra Panthar: Hello everyone.
Today's presentation is being transcribed so those without audio or who require text only can participate in real time.
A little explanation about this service.
Voice-to-text transcriptionists provide a translation of the key ideas discussed, NOT a word for word transcription.
Voice-to-text services provide an in-the-moment snapshot of ideas and concepts, so that those who are unable to hear or to understand the audio program are able to participate in real-time.
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Elektra Panthar
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The following initials in the transcription record will identify the speakers:
JM: Dr. Jillian Miller

[2026/06/25 14:30] Annelies Fratica: Hello everyone,
I am Anzu and I live in Belgium. I have had psychosis two times.
I am on Second Life for 19 years now and I mainly use it for social contact. I am also co-hosting a weekly art show and tell at a mental health group in SL.
In real life I have two main hobbies: playing the hurdy gurdy and learning Japanese.
I have the honor to introduce the next speaker to you.
Dr. Jillian Vinall Miller is a Developmental Neuroscientist in the Department of Anesthesiology, Perioperative & Pain Medicine at the University of Calgary.
She leads the Pediatric Anesthesia, Imaging & Neurodevelopmental Science (a.k.a. PAINS) lab at the Alberta Children's Hospital.
Her talk is titled: Pain and mental health during and after pregnancy and its associations with child brain and behavioral development.
Please welcome Dr. Miller to the stage!

[2026/06/25 14:33] Elektra Panthar: JM: Thank you everyone! this is a great conference
I wanted to share something about myself
I lead the PAINS lab
I have 3 goldens, and do dog agility

What is pain?

An unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage
Raja et al. PAIN. 2020

Pain is described by the International Association for the Study of Pain (IASP) as a subjective, unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage.
Primary focus of my research is chronic pain
Primary Chronic Pain: without underlying condition
Secondary Chronic Pain: linked to a condition like arthritis or cancer
Chronic pain is defined as pain persisting for greater than 3 months in duration.
There are 2 types of chronic pain. It is interesting to note that the International Classification of Diseases (ICD-11), came out with a definition in 2019, to help to discern chronic pain as a symptom or a disease.
The first is chronic primary pain, which is pain with no clear underlying condition, or pain (or its impact) that appears to be out of proportion to any observable injury or disease.
Secondary Chronic Pain however is pain linked to an underlying condition - such as pain from cancer, surgery or arthritis.

Chronic pain interferes with every aspect of daily living, including social, emotional, cognitive, behavioral, and work/school functioning.

Chronic pain in Canada
1 in 4 Canadians will experience chronic pain
Canadian Pain Task Force Report 2020
Estimated direct and indirect costs of chronic pain were $40 billion in 2019

It's important to note that chronic pain is a growing epidemic. 1 in 4 Canadians aged 15 years or older are estimated to be affected by chronic pain at some point across their lifespan.
If left unmanaged, it can lead to significant pain-related disability and extensive healthcare utilization. Globally, chronic pain is the leading cause of years lived with disability.
The direct and indirect costs of chronic pain in Canada due to lost productivity and increased health care utilization were estimated to be $40B CAD in 2019 alone

What Caused Your Pain?
The majority doesn't know, can't identify a precise source
What Are the Mechanisms and Factors?
I want to see what causes pain to go from acute to chronic
I developed a model about influences that could bring chronic pain, social factors, biologic, parental, etc

Priming of the Stress System
Prenatal stress, neonatal pain exposure and inflammation, postnatal stress, maternal separation, and resource scarcity, and lower maternal caregiving*
Sometimes the pain comes before even birth - mother presence is very important in serotonin secretion
Fewer receptors in the hippocampus, the more stress hormones circulate in the body and then can develop in disease obesity etc

Maternal Deprivation Study
Dr. Richelle Mychaisuk, Professor in Neuroscience, Monash University
Greater sensitization and anxiety-like behavior in maternally separated animals (Salberg et al. Developmental Psychobiology. 2020)
Neonatal rat brain = 3rd trimester of human brain development

Stress during critical periods of development primes the CNS
Neonatal/prenatal stress exposure increases the risk for anxious behaviors and sensitization
Pathway for intergenerational transmission of stress behaviours and maybe pain
Intergenerational transmission of pain is understudied

At 35 days, adolescent, the rats were sleep deprived, like it happens to human adolescents, then they did an incision on a paw under anaesthesia
The rats sensitized to stress had worse reaction
Sleep deprivation worsens the stress considerably
If you have highly stressed parents it might have been passed on to you

Pain during Pregnancy
Physiologic changes during pregnancy may cause recurrent pain
This impacts 30-85% of pregnant individuals

The body changes, posture, muscle-skeletal changes, it causes pain
Given increased reports of pain based on sex/gender, pregnancy is a unique period to evaluate pain incidence. The rapid hormonal and physiological changes occurring during a normal pregnancy give rise to recurrent, and sometimes constant pain for women. For example, musculoskeletal changes as a result of gestational weight gain, or postural changes to accommodate a growing fetus have been linked to causing pain. Overall, there is a broad presentation of pain during pregnancy, with reports of pain in the truncal, lower body, and head/neck regions.
However, pain during pregnancy is not well characterized. Reports of pain prevalence widely vary in the literature (from 30 – 85%) depending on how, when, and what kind of pregnancy-related pain was measured.

Pregnancy Pain, Anxiety, Depression and Insomnia
Pain in pregnancy is associated with anxiety, depression and insomnia
Additionally, pregnant women with chronic pain are more likely to report internalizing mental health conditions such as anxiety and depression, in addition to insomnia - but more on this later.

Anxiety and Depression during Pregnancy
Prenatal anxiety impacts 16-43% of pregnant individuals
Prenatal depression impacts 7-23% of pregnant individuals

We do however have better characterization of prenatal mood disturbances. Pregnancy is often regarded as a vulnerable period in an individual's life, with increased pressures and worries related to pregnancy, labour, delivery, the wellbeing of the child, which may lead to anxiety and depression.

Previous studies indicate that anxiety symptomology is present for 16-43% of pregnant individuals in the perinatal period, whereas 7-23% of pregnant individuals may develop prenatal depression symptomology.

Between 10 and 75% of pregnant individuals have been identified as having both anxiety and depression during pregnancy.
The postpartum presents as an interesting period for evaluation of pain experience due to continued varying physiological processes.

As a part of labour and delivery, tissue damage at the site of incision as part of Caesarean section, or at the perineum from vaginal delivery have been associated with greater pain. Alterations to daily activities such as breastfeeding, or the persistence of pain first experienced during pregnancy have also been implicated in postpartum pain reports. Postpartum pain after childbirth has been inconsistently described in the literature due to varying definitions regarding type, duration and timing of report of pain. Previous reports suggest that 15-80% of postpartum mothers experience some type of pain, with the assumption that pain resolves for most individuals beyond one-year postpartum. However, few studies examine pain throughout pregnancy and into the postpartum, beyond 1 year. Majority of focus when evaluating pain in this population has been restricted to Caesarean scar pain, vaginal pain and perineal pain.

Implications of Postpartum Pain
Postpartum pain impacts:
Quality of life
Mood
Self-care/hygiene
Physical functioning
Sleep
Cognition
Work performance
Infant care

Unresolved acute pain in the early postpartum increases the risk of the development of chronic pain in the months following childbirth.
Persistent pain in the postpartum has been associated with a profound interference on quality of life, which may impact a mother's ability to engage in self-care activities and hygiene, physical functioning, sleep and cognition, and may hinder work-related performance and the care of an infant.
Prenatal anxiety and depression are considered strong predictors of postpartum mental health conditions,
However psychosocial factors including maternal support and maternal self-efficacy, or the self-belief and confidence that a mother has in their ability to care for their infant, are strongly associated with maternal mental health.
Postpartum Anxiety is present in 8-17% of mothers, and postpartum depression is present in 17-19% of mothers.
Mood disturbances in the postpartum can greatly impact maternal functioning. Postpartum depression and anxiety are significantly associated with poorer household, personal and social functioning.

Disruptions in maternal-child interactions have also been associated with anxiety and depression. Mothers with mood disorders have been found to report more unsettled infant behaviours, have more challenges with breastfeeding, and worse maternal bonding. Some work has indicated that there may be relationships between postpartum pain, anxiety, and depression, but more research is needed on these topics.

INTERGENERATIONAL TRANSMISSION OF PAIN
Genetics
Neurobiology
Pain-specific learning
General Parenting
Stress exposure

It is known that children of parents with chronic pain are at risk for poorer physical health, and worse psychological and functional outcomes, and the heritability of chronic pain is 38-50%.
The intergenerational transmission of pain risk from parents to children has been described in a model, with 5 proposed mechanisms associated with the relationship between parental chronic pain and pediatric chronic pain and adverse outcomes:
(1) genetics
(2) alterations in neurobiological development
(3) pain-specific social learning, (4), general parenting and family health, and
(5) exposure to a stressful environment

The component of this model that has been studied the least is alterations in neurobiological development in children of mothers with chronic pain.
White matter undergoes constant remodelling across the lifespan, with modifications occurring during the processes of learning or activity, and across development and aging. Changes in white matter have been observed in pain populations, and have been used to forecast pain persistence, as well as used to predict the transition from acute to chronic pain. Specifically, white matter changes have been found in tracts connecting areas of the brain involved in pain perception, such as tracts connecting the thalamus and brainstem, and sensorimotor tracts.
Despite what we know of white matter changes in pain, and the ability of white matter to change across the lifespan, no studies to date have explored the association between maternal pain and child neurodevelopment of the white matter microstructure.

Overall Aim
To investigate trajectories of maternal pain, anxiety and depression in the perinatal and postpartum periods, and possible associations with child white matter development at 2 years
This was led by Jenna Jessa, MD/PhD Candidate
University of Calgary
Today there are few studies in the influence of pain in the development of the child and the mother in post partum perios

Methods
Maternal Participants
5,181 pregnant individuals from across Canada
Data was collected at 3 Timepoints:

Baseline, 12 months postpartum and 24 months postpartum

Included in the present study are 5,181 maternal participants from across Canada. Maternal participants were included if they were greater than 17 years old, resided in Canada and could read/write in English or French. Participants expecting multiples were included in this analyses. There were no additional exclusion criteria.

The initial enrolment survey collected sociodemographic information. Questions about pain were asked at follow-up survey 5 (our Timepoint 1), which was sent to participants 5 months after intake. Subsequent surveys collecting information on pain were completed by participants at 12 months postpartum (our Timepoint 2), and 24 months postpartum (our Timepoint 3).
Overall, this sample was quite homogenous. Majority of participants were white, and were highly educated. Close to 50% of participants were overweight or obese prior to pregnancy.

Ethnicity, education and BMI are quite aligned with census data of the average Canadian population, with rates of ethnicity and education slightly higher in this population than average, and rates of being overweight or obese slightly lower.

At Timepoint 1, 1720 participants were still pregnant and 1703 were no longer pregnant. The median gestational age of participants was 33.7 weeks (range: 24.8 weeks gestation to 5.2 weeks postpartum). Given this, we tested for differences in pain intensity between individuals who were still pregnant versus those who delivered. No significant differences in pain intensity at Time 1, Time 2 or Time 3 were observed between individuals who had already given birth, versus individuals who were still pregnant at Time 1.
Participants completed surveys that included measures of sociodemographic variables. Socioeconomic status was obtained by z scores of education, household income and food shortage.
Previous medical history including a self-reported diagnoses of anxiety or depression prior to pregnancy, and self-reported gestational anxiety, depression, hypertension or preeclampsia during the current pregnancy were reported.
Self-reports of pain for at least 3 months, and subsequent pain intensity were collected.
Baseline anxiety and depression symptomology from the PROMIS Anxiety Scale and the EPDS were reported.
In terms of statistical analyses, we utilized Latent class mixed modelling, which was the modelling I explained previously, to visualize multiple distinct outcome trajectories within a single population, alongside adaptive lasso to identify which variables were most critical to the models predictability.
For pain intensity, our best fit model here including a 3 group model. The weighting of our trajectory groups was 16% of individuals in Trajectory 1, or our late postpartum pain group, which is shown in red, 8% in Trajectory 2, or our early postpartum pain group which is shown in blue and 77% in Trajectory 3, our no pain group which is shown in yellow.

Pain intensity
Age, BMI, education, Socioeconomic status (SES), baseline pre-pregnancy diagnoses of anxiety or depression, gestational diagnoses of anxiety or depression during the current pregnancy, reports of chronic pain at baseline, baseline depression symptomology as determined by the EPDS total score, and baseline anxiety symptomology as determined by the PROMIS Anxiety T-score, all significantly differed between trajectory groups.

Mothers with a BMI classification of overweight or obese, a highest educational level of high school or less, lower socioeconomic status, a self-reported pre-pregnancy diagnosis of anxiety or depression, gestational anxiety, or depression during the current pregnancy, report of chronic pain at baseline, and higher baseline symptomology of anxiety by the PROMIS Scale or depression by the EPDS were more likely to belong to the early postpartum pain group or the late postpartum pain group then the no pain group.
Adaptive lasso revealed that lower SES, baseline chronic pain, and a pre-pregnancy self-reported anxiety diagnosis were the most significant predictors of belonging to the early postpartum pain group.
Baseline depression symptomology, as measured by the EPDS total score was the most significant predictor of belonging to the late postpartum trajectory group.
PdP maternal study participants who delivered full-term infants (≥37 weeks) residing in the Calgary area were invited to have their children participate in MRI neuroimaging at 2 years of age.
Children with major birth complications, significant cognitive impairment, congenital anomalies, or contraindications to MRI were excluded.

A total of 63 maternal-child dyads were included in this analyses.

Child Characteristics
Age at scan: 29 months
Sex: 24 Female (39%)

We used diffusion MRI to examine white matter tracts, or connections present in the brain.
We have great software called Tractseg, that is able to automatically analyze tracts.
The main value that we looked at from Tractseg is fractional anisotropy, which tells us the ratio of directional diffusion relative to non-directional diffusion. In white matter tracts, we expect water diffusion to be directional, as cellular membranes, axon packing and myelination limit water movement perpendicularly to tracts.
Specifically, we collected diffusion data, in 5 areas of interest based on previous studies of white matter and pain. These tracts included the thalamo-parietal, thalamo-precentral, thalamo-postcentral, cingulum and uncinate fasciculus tracts in both the left and right hemispheres

Statistical Analyses
Differences in FA based on maternal pain trajectories
Linear regression models

It is very important to interpret the following findings with caution, given this exploratory sub-analyses was in a very small sample size!
But, of the 5 white matter tracts we examined, significant differences were found in the left cingulum, which is shown here. The cingulum connects the frontal, parietal and temporal sites, and is involved in sensory, emotional and cognitive components of pain perception.
Specifically, lower FA was found in the left cingulum of children with mothers that belong to the late postpartum pain trajectory group, and reported chronic pain at 2 years postpartum, which comprised 10% of our sample. And this was as compared to children with mothers that belonged to the no pain group. This may mean that a ‘less mature’ pattern of white matter microstructure is present for children whose mothers reported a chronic pain problem at 2 years postpartum.

[2026/06/25 15:00] Katie Velvetpaw: JM: Heterogenous pain experience up to 2 years postpartum
Pre-pregnancy and gestational internalizing mental health reports are predictive of pain
There may be a relationship between maternal pain and child white matter development
There are subgroups of pregnant individuals with heterogenous pain experiences throughout late pregnancy/early postpartum up to 2 years postpartum.
Higher reports of pain in the postpartum period are related to pre-pregnancy anxiety, pre-pregnancy depression, gestational anxiety and gestational depression.
Lastly, to be interpreted with caution, there may be a relationship between maternal pain and child white matter development.

Overall aim
To investigate trajectories of maternal pain, anxiety and depression in the perinatal and postpartum periods, and possible associations with child white matter development at 3 years
Maddison Tory, BHSc
University of Calgary
led this study

Maternal Participants
5,720 pregnant individuals from across Canada
Data was collected at 4 Timepoints:
Baseline, 12, 24 and 36 months postpartum
Demographics largely similar to earlier study
New study on the right
The three pain groups still remain
Genu fractional anisotropy, a measure of white matter maturation was higher in the no pain group vs. late pain group

Higher genu fractional anisotropy related to less socioemotional problems
The genu - connecting left and right hemispheres
Exposure to maternal pain led to less communication between the hemispheres
Going back to the earlier study
The question is what happens now with new stressor exposure?
How will that change responses to pain?
Preoperative anxiety and pain catastrophizing is associated with greater postoperative pain
Leading to increased risk for chronic postsurgical pain (CPSP)
Unknown are the neurobiological drivers of this relationship
(Salzmann et al. 2023; Friedrich et al., 2022; Theunissen et al., 2012)

Feeling helpless in the face of pain
Little is known about these pain relationships
Pain after Surgery Study
Overall aim
Determine whether perioperative anxiety, pain catastrophizing and brain responses predict postoperative pain following major surgery in adolescents
For this study, recruited youths between 10 and 18 years old
Questionnaire before surgery and MRI, then also following the surgery
Shown pictures with fearful vs neutral expressions
Pain After Surgery Study

N=26
Mean age = 14.76 years
85% Female
80% White
73% with chronic pain
77% received spinal surgery
The surgery was to correct scoliosis
There were 26 children in the study
Before surgery there were more correlation with the fearful-face pictures - post surgery there was less life-interfering pain
Greater pain catastrophization before surgery did correlate to more pain after surgery
However
Bridging pain service used to try to prevent greater post-operative pain

Intensive Interdisciplinary Pain Treatment (IIPT):
3-week (8hrs a day, weekdays only) structured, team-based rehabilitation program
Integrates physical, psychological, and medical care to restore function and reduce disability
Chronic pain ≥3 months
No resolution after trying 2–3 prior evidence-based treatments
Pain caused major functional impairment
Required commitment to active, self-management-based IIPT
Previously conducted a study of youth, before and after IIPT
Reduced middle frontal gyrus (MFG) activation in response to emotional stimuli from pre- to post- IIPT
rTMS treatment/protocols most commonly targets the DLPFC, primarily located withing MFG
Reduction in pain interference.
Simulation target: left DLPFC
60-minute rTMS session per day, 5 days/week for 3 weeks
High frequency stimulation (10Hz) applied for 4 second-long “train”
Stimulation intensity began at 45%, increased by at least 1-2% every session
3000 stimulations per sessions, 45000 over course of IIPT
To rebalance neural activity
To reduce depression
How great would it be to target the same part of the brain to target chronic pain
And reduce pain symptoms
Administering stimulation to the brain
This was led by Si Chen Pan, Undergrad
University of Calgary
The aim: Examine whether the addition of rTMS to IIPT was associated with reduced brain over-activity and lower pain interference after program completion

13 youth with chronic pain, aged 10-18; 9 underwent rTMS, 4 did IIPT without rTMS
Referred to the Alberta Children’s Hospital
Completed 3-week IIPT
Received rTMS once every weekday
Underwent MRI scans and filled out questionnaires pre- and post- IIPT
Age ($\bar{x}$=15.56, SD=1.199)
Female n=6 (66.7%)

Pain interference significantly decreased from baseline (62.97 [SD=8.80]) to discharge (57.33[SD=6.51])
Neural activity decreased across all significant clusters following treatment
Greater neural activity in response to emotional stimuli overtime is associated with greater pain interference
We saw much greater pain reduction in the group that received BOTH types of treatments
Now tying it all together:
Pediatric chronic pain is common, and difficult to prevent and treat
Risks for pediatric chronic pain may even precede birth, and can be exacerbated by life experiences
Individuals may be at risk for developing chronic pain if they have an overstimulated central nervous system leading them to be hyper-responsive to stimuli and potentially resistant to treatment
The combination of treatments may be effective in treating and possibly preventing chronic pain
Thank you to those who invited us here today, and all the people who have worked on these trials
And now I will take questions

[2026/06/25 15:16] Anzu (Annelies Fratica): clap clap clap
[2026/06/25 15:16] Lorin Tone: Bravo!

[2026/06/25 15:16] Mook Wheeler: QUESTION: I may have understood this wrongly, but it seems like there was some challenge in distinguishing between intrauterine biological stress and postnatal environmental factors? Also, self-reporting of the psychological metrics is problematic. And it seems like there is some risk of attrition bias?
[2026/06/25 15:17] Katie Velvetpaw: JM: yes, that is absolutely true.
We have found an association with the late pain group and brain development, which points to post-pregnancy pain being the greater cause than pre-natal
Did do a study on stressors during the Pandemic, and brain development, but we were limited on what we could ask about pain
We now are writing up a grant to study the pain during pregnancy vs post-partum more thoroughly
Self-reporting of psychological metrics is problematic, yes
What I find really important for our research is that the self-reporting does correlate to the visible biometrics
There is attrition bias, yes. We do try look at contributing factors as to why people leave a study, and the most common reason why there were non-finishers was because it was during the Pandemic, so couldn't do many of the second MRIs.

[2026/06/25 15:22] Gentle Heron: Thank you for sharing your research, Dr. Miller. QUESTION- Some mothers chastise their (usually teen) children saying things like "I was in labor for 33 hours..." So maybe it's true that that can affect behavior of the child and therefore the relationship between mother and child?
[JM: Yes, that's I think that's a great point. With another research colleague, we do a lot of research around our memories for pain and how that influences our future responses to our future experiences to pain and how we respond to pain and then even how we model pain for our children for example. And in that research we found that individuals who tend to remember pain as worse than it was reported at the time - so a negative bias - tend to be at

higher risk for chronic pain and tend to have more negative relationships with pain and pain behaviors and even future avoidance of other painful experiences like going to get vaccines and things like that. So I think there is a lot of negative repercussions that can happen from magnifying pain memories and talking about pain in a negative light especially with children and how that's modeled to their kids and how that could potentially influence their relationship with pain in the future. So a lot to unpack in that comment. But yes, I agree. I don't think it's a helpful way to talk about pain with your kids or teens. And it can like re-emphasize pain-related fears and experiences that involve pain.]
[2026/06/25 15:24] Katie Velvetpaw: JM: there are a lot of negative repercussions with magnifying pain experience, and that is not a helpful way to talk about birthing pains with children
Pain support for giving birth - we don't have to be just accepting of pain, and it can have repercussions on the children
[2026/06/25 15:23] Gentle Heron: Another instance of "folks wisdom" being confirmed by research!
[2026/06/25 15:23] Katie Velvetpaw: three cheers for the epidural!
Just saying
[2026/06/25 15:24] Orange Planer: Gentle - is that another form of "I had to walk uphill, in the snow, in a 30 MPH wind to school, both ways!"
[2026/06/25 15:25] Gentle Heron: Probably Orange, but in the case of painful labor it might actually be truly impacting the kid
[2026/06/25 15:27] Katie Velvetpaw: JM: yes, there are a lot of ways that we can communicate about pain. But how it is talked about can lead to problems in pain avoidance.

[2026/06/25 15:24] Mook Wheeler: QUESTION: sorry to ask this haha, but did the Pediatric Anesthesia, Imaging & Neurodevelopmental Science (PAIN) [name] come about by amazing serendipity (at least for this conference), or from careful intention?
[2026/06/25 15:26] Katie Velvetpaw: JM: had an amazing supervisor during undergrad training, and she had created the acronym OUCH lab, and so [I] chose the acronym PAIN - it just came together very well

[2026/06/25 15:27] Gentle Heron: Any other questions for Dr. Miller? If not, please give her a good round of applause
[2026/06/25 15:28] Buffy Beale: So interesting, thanks for your work and waving from British Columbia!
[2026/06/25 15:28] DrJillVMiller Resident: jillian.miller1@ucalgary.ca
[2026/06/25 15:28] Gentle Heron: Thank you for sharing your contact information.
[2026/06/25 15:28] Katie Velvetpaw: JM: any last minute questions? or you can reach out to the email address above
[2026/06/25 15:28] Anzu (Annelies Fratica): clap clap
[2026/06/25 15:28] Orange Planer: Thank you, Dr. Miller. Great talk!
[2026/06/25 15:28] Gentle Heron: Applause!
[2026/06/25 15:29] Katie Velvetpaw: JM: this has been a great experience, and so happy I could be here today
[2026/06/25 15:29] Kalia Annie Starling-Hax (Kalia Anatine): Thank you for your time and wonderful presentation.
[2026/06/25 15:29] Elektra Panthar: ♫♪♫♪ Applauds ♪♫♪♫
[2026/06/25 15:29] Mook Wheeler: Thank you!
[2026/06/25 15:29] Buffy Beale: cheering!
[2026/06/25 15:29] Katie Velvetpaw: ♩♪♫♬ APPAWS! ♩♪♫♬

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