Perinatal Mood & Anxiety Disorders:

Prevention, Screening,Treatments, Resources

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What are PMADs?

PSI Indiana

P

Perinatal

Pregnancy to 1 year postpartum

M

Mood

Depression, Bipolar Disorder, or Psychosis

A

Anxiety

General Anxiety, Panic, OCD, PTSD

D

Disorder

Interferes with functioning and day-to-day life

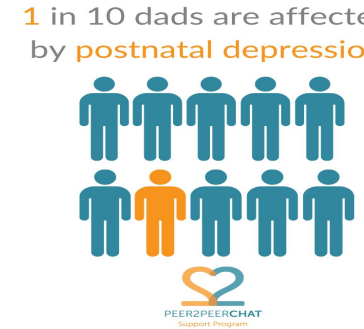
The Facts about Perinatal Mental Health Disorders

> G-HTN, G-DM, + pre-eclampsia combined

1 in 3 women of color

84% pregnancy-related deaths are preventable, 40% re: PMADS & SUD

most under-diagnosed, under-reported, under-treated complication of childbirth



can extrapolate similar rates to non-birthing partners

contributing factors:

- MH stigma
- lack of trained HCP
- unsure where to turn
- fear of medications

intergenerational trauma via poor bounding & intrauterine programming via elevated gestational cortisol

The Problem

- **1 in 5** (15 – 20%) women will experience a PMADs
  - vs 1 in 8 U.S. women (~ 13%) will develop invasive breast cancer
- Attention on mom during pregnancy shifts to baby shortly after delivery.
- A 15-m, 6-w postpartum check up cannot adequately assess moms' physical & mental status and provide education & support necessary during postpartum.
  i. ACOG recommends more, but gap in care continues
- Lack of support from partner/ family, poor sleep, life stressors increase risk;
  i. partner struggling can impact mother's PMAD & vice versa = significant implications for family
- Untreated PMADs may increase risk of:
  - SAB, infant death, preterm delivery, low birth-weight, preeclampsia, substance use, gestational hypertension, excessive bleeding, need for C-section or instrument-assisted delivery
  - Psychiatric, behavioral, cognitive, developmental, social issues in children via increased fetal exposure to cortisol, catecholamines & poor bonding
  - Child neglect, abuse, infanticide, suicide, chronic depression, martial issues
- ~80% of women have pregnancy by 40; 45% of pregnancies unintended in US (risk factor)

www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Postpartum-Care; PSI 2020, J Obstet Gynaecol Can 2015;37(1):56–63; Brookings Institute 2019

Risk Factors (an incomplete list)

- History
  - Personal/family hx mental health/substance use d.o., including PMDD; PMADs 50-80%
  - Endocrine issues: DM, hypo/hyperthyroidism, PCOS, endometriosis
  - PTSD, sexual trauma or abuse
- Pregnancy and birth factors
  - Infertility, traumatic pregnancy or delivery, miscarriage, infant loss
  - Multiples or NICU
  - Challenges with breastfeeding
- Life stressors (~risks for any MH disorders)
  - Relationship issues
  - Single and/or teen mother
  - Little/no social support
  - Major events: job loss, move, financial struggles

Symptoms

Start anytime during pregnancy→ 1y postpartum, lasts 3y in 5% (DSM-5 = 1st 4m PP) Basically same symptoms as in psych disorders at other times of life; can overlap

Depression 20%

- Guilt, shame, hopelessness, anger, irritability, sad
- Lack interest in baby or general anhedonia
- Appetite and sleep disturbance
- Thoughts of harming baby/self (SI 10%, SC 5%)
- **~15% have significant depression postpartum.**
- 50-75% risk relapse off RX; 66% concomitant anxiety d.o.

NOTE: Not **"baby blues":** feelings of sadness 2-14 days after delivery; from hrmn flux, sleep deprivation stress from L&D; ~80% usually clear without treatment.

Post-Traumatic Stress Disorder 10%

- non-birthing partners too; Prev trauma = higher risk
- Real/perceived trauma infertility, delivery, postpartum
- Intrusive re-experience/nightmares of traumatic event
- Avoid stimuli associated with event
- Irritability, insomnia, hypervigilance, startle response

Anxiety 15-20%

- Worry, racing /intrusive thoughts, restless
- Disturbance of sleep/appetite
- Physical sxs: dizziness, SOB, palpitation

- ***Postpartum Panic Disorder*:** anxiety w/panic attacks
- ***Obsessive Compulsive Disorder***
  - Obsessions, intrusive/repetitive thoughts/images
  - Compulsions: repetitive behaviors done to reduce stress; cleaning, checking, counting
  - Fear of being alone w/ infant
  - Hypervigilance
  - Aware thoughts are abnormal, unlikely to act (vs postpartum psychosis)

Symptoms-2 It is not imperative to differentiate between these, it's important to get help

Bipolar Spectrum Disorder ~3%

- **20% of women exp 1st episode of BSD in perinatal period; 55% perinatal relapse; >60% misdiagnosed**
- higher risk with personal/family history BSD, personal PCOS/PMDD
- Severe depression/irritability alt with (hypo)mania; can look like severe depression or anxiety, may confuse for unipolar depression, Mood DO Questionnaire (MDQ) differentiates
- Rapid speech/thoughts, poor concentration, hyposomnia, high energy, overconfidence, impulsive, poor judgement, delusions (grandiosity paranoia)

Psychosis 0.1 -0.2%

- higher risk with personal/family BSD, psychotic episode/d.o..
- Onset is usually sudden, often within 2w-3m postpartum
- Delusions or strange beliefs/paranoia, hallucinations (visual/auditory)
- Irritability, hyperactivity, decreased need for or inability to sleep
- Psychosis is an emergency

Screen for substance use disorders, may be self-medicating; Cannabis is NOT safe in preconception/pregnancy/lactation

www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2017/10/marijuana-use-during-pregnancy-and- lactation.pdf ; https://womensmentalhealth.org/posts/essential-reads-cannabis-and-breastfeeding/

Perinatal Mental Health Discussion/Screening Tools

PSI Perinatal Mental Health Discussion Tool (English and Spanish)
www.postpartum.net/resources/discussion-tool

Edinburgh Postnatal Depression Scale
https://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf

Mood Disorder Questionnaire
https://www.ohsu.edu/sites/default/files/2019-06/cms-quality-bipolar_disorder_mdq_screener.pdf

Self-screener for Expectant/New Parents
https://screening.mhanational.org/screening-tools/postpartum-depression/?layout=hide_progress&ref

Philosophy of Care

Low risk, evidenced-based interventions offered with attention paid to mom's severity of symptoms and treatment preferences.

- Identify, screen, educate, support, refer, treat
  - Screen - preconception, each TM, postpartum intervals, subsequent pregnancies
  - Screening normalizes psych sxs, opens communication, allows for education
  - Education of patient:
    - Risks of untreated illness vs risks of medical care
    - Self-care of mom promotes family bonding.
    - Treatment improves wellness, QOL, & ability to be person she wants to be
    - Proactive- vs reactive-based interventions

  Need to connect with women before crisis

  - Heightened level of suspicion for those demonstrating mild symptoms; allows to plan for issues common in postpartum & have resources handy to address

First Things First: Prevention

"Don't let perfection be the enemy of good" Derivative of Voltaire

"An ounce of prevention is worth a pound of cure." Benjamin Franklin

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Support |Sleep | Nutrition | Mindfulness | Activity

SLEEP

Sleep is crucial for new parents' mental health, protected sleep is key

Options

- CBT
- Melatonin 1-3mg, may improve sleep cycles of infant (LactMed)
- Valerian 400-800mg may improve sleep, anxiety, and "baby blues" (LactMed)
- Acupuncture (J Clin Nursing 2016 Feb, Sleep Med 2017 Sept)
- Postpartum doulas
- Gabapentin 300-600mg (J Human Lact 2006), Zolpidem 6.5mg (if used in past) (LactMed), diphenhydramine 25mg,

Nutrition

Underweight, overweight, & obesity risk; myth lactation ⇒weight loss in all

80/20 rule, no one “right” diet to follow or harmful foods that need to be avoided, save for sugar, alcohol (sugar), refined foods (sugar), caffeine which can contribute to PMADs sx

- “Unhealthy” dietary choices has been linked to depressive symptoms in PG (Matern Child Nutr Jan 2017) , PMADs (Appetite Aug 2015) , child emotional- behavioral dysregulation (Psychol Med Jul 2015)
- Gestational hyperglycemia has been correlated to prenatal depression (Paediatr Perinat Epidemiol July 2015)

Encourage expectant moms to stock pantry/freezer with quick-grab healthy food options prior to delivery, Consider RDN referral

- Nuts, protein bars, orgain, smoothie ingredients
- Home-delivery meal service gift cards for shower gifts
- Lactation consultants can help here too, consider referral to RDN

Postnatal Depletion? micronutrient deficiencies contribute to PMADS possibly through psychoneuroimmunology (Nut Res Rev June 2012, J Am Diet Assoc September 2009)

- **Folate, iron, selenium, zinc, vitamin D, B2, B6, B12, calcium, magnesium** may play a role in PMADs (Nutrients, April 2018; Matern Child Nutr 2017; Yale J Biol Med, June 2013; Arch Iran Med, May 2012; Arch Womens Ment Health, April 2016; Psychiatry Res, April 2016; BMC Pregnancy Childbirth, Aug 2016; Pharmacol Rep, Jul-Aug 2006)
- PNV may avoid deficiencies but some women may need more, If vegan/vegetarian, suspect & check iron/ferritin, B12
- **Omega-3 fatty acids** deficiency in pregnancy/lactation (PLoSOne Sept2015) & consumption can decrease PMADs via reducing inflammation (Behav Brain Res Sept 2014)
- R/DB/CT **Lactobacillus rhamnosus** (6x109cfu) decrease PMADs (EBioMedicine, Oct 2017; GDM, BV, group B strep in mom, atopic sensitization & eczema in baby (BMC Pregnancy Childbirth, Jun 2016)

TAKE HOME: Stay on PNV, O3, probiotics, folate until done childbearing

Just relax

Abnormal function of HPA axis contributing factor to PMADs (Neurosci Bull Jun 2015) ; intrauterine programming of fetus & across generations via epigenetic mechanisms Handbook of Perinatal Clinical Psychology

- Prenatal stress is consistently noted as the strongest predictor of PMADs Handbook of Perinatal Clinical Psychology
- Practical assistance w/ childcare, housekeeping, work duties, selfcare, postpartum doula, FMLA

Encourage to take time for self; outdoor activity, meditation & journaling shown to improve mood & general wellness.

- *Expectful, Calm, Insight Meditation Timer* (free) apps have general anxiety, depression, pregnancy-related content
- Meditation (Mindfulness NY, Jan 2017), & parenting classes shown to improve anxiety, depression, wellbeing (BMC Preg Childbirth Feb 2017)
- 12w social support group starting at 22w dec depression, anxiety, anger, cortisol & other hormones (J Body Move Ther Oct 2013)
- Prenatal yoga, “mommy & me”, stroller striders, Fit4Mom, etc provide all-levels, community support, group exercise.
- Exercise in PG was linked with a lower risk of PMADs and PMADs requiring RX (J Clin Psych 2009 Dec) by up to 67% (Br J Sports Med Nov 2018) , lower risk PPD (Birth Sept 2017)
- Yoga classes 2x/w x 8w led to a 78% improvement in depressive scores over waitlisted controls (Complement Ther Clin Prac May 2015))

Several studies show effectiveness of acupuncture in PMADs (J Affect Disord, Feb 2019; J Clin Med Res, Jun 2017; PLoS One, March 2017; J Affect Disord, Dec 2021; Cell Mol Neurobiol, Nov 2011) , & comorbid issues like insomnia, swelling, breech, recovery after C-section, poor lactation

- Therapeutic relationship lends to screening/education
- Can be combined with other interventions, especially in those that may take time to affect change

When self care isn’t enough

Treatment Options

- 1st line: 1:1 or support group therapy, online in person (Obstet Gyn 2020)
- 1:1 or support group therapy, online in person
- Medication
  - Hormonal, including thyroid, Allopregnenolone
  - Antidepressant/Antianxiety
- Multidisciplinary approach is often best

Medications

Abrupt withdrawal of hormones after delivery may be very triggering for women are sensitive to hormonal fluctuations (h/o PMS, PMDD),

- Hormone testing does NOT guide treatment
- Exception Thyroid Function Tests
- OCPs with & without estrogen have been used for treatment of PMADs; esp women w/ good experience in past & require contraception,
    - POP if lactation, drospironone
    - Elevated testosterone levels correlated to PMADs, OCP decreases (Asian J Psychiatr, Oct 2015)
    - Some studies suggest synthetic progesterone may worsen (Cochrane Database Syst Rev, Oct 2008, J Obstet Gynaecol, Jul 2003, Psychosomatics, March-April 1998))
- Mood disruption can occur during lactation (dysphoric milk ejection, dec DOPA, inc PRL) or during/after weaning & resumption of menses
- Zuranolone/allopregnenolone via IV and just FDA approved as 2w orally

After discontinuation of psychiatric RX when TTC/pregnancy – 70% relapse;

- Risk of untreated PMADS and underdosing as pregnancy alters increases metabolism of RX;
- Discourage patients from stopping RX; refer to reproductive psych for more info;
- Antidepressants: risks/benefits considered vs. known risks of untreated illness to mom/fetus
    - No increased risk of teratogenesis or neurobehavioral sequelae with SSRIs/SNRIs, absolute risk of exposure is small & safety data exceeds data for most RXs; many more studies with reassuring vs concerning findings J Obstet Gynaecol Can 2015;37(1):56–63
    - Guidance to use lowest effective dose and maximize nonmedication tx
    - If patient stable on meds prior when TTC or early pregnancy, usually don't change RX unless paroxetine, benzodiazepines, valproate, lithium, carbamazepine, TCAs; if patient on these and TTC or +pregnancy, refer to reproductive psych
    - Venlafaxine associated with the highest number of defects, req confirmation given the limited literature *JAMA Psychiatry.* 2020;77(12):1246-1255.

All antidepressants are excreted in breast milk, but exposure lower than in utero. If planning to breastfeed, Expert Consensus Guidelines recommend sertraline, fluoxetine, escitalopram MGH lecture 2020, J Clin Psych 2014

Medications -2

- Plan in advance if prior history, use medication/dose that was previously effective
- If stopped antidepressant due to pregnancy & depression recurs, restart previously effective medication at last dose (past history guides treatment).
- If stopping benzodiazepines, always taper to discontinue
- If never treated before, start fluoxetine, sertraline, escitalopram - antidepressant/anxiety effects
- Maximize use of one medication as opposed to polypharmacy, again refer to reproductive psych if on many or contraindicated medications
- Don’t undertreat; remission goal; avoid exposure to both drug AND continued psychiatric symptoms, risks of exposure not dose related
- May be able to decrease after delivery, but rec. continuing for 1y postpartum

PSI national: www.postpartum.net
AZ chapter: www.psiarizona.org

Support for Families

Support for Providers

Education & Training

Advocacy & Outreach

PSI State Chapter: Arizona

- **Mission** of PSI- promote awareness, prevention & treatment of mental health issues related to childbearing in every county & tribal community statewide.
- **Vision** of PSI -that every woman & family statewide will have access to culturally appropriate information, social support & informed professional care to deal with mental health issues related to childbearing.
- For newsletter, volunteer, find out about trainings, etc:
  - psiarizona.org
  - www.facebook.com/psiazchapter | IG @psi_Arizona

Support for Families

PSI HelpLine (not crisis) for Support Coordinators 24/7

- Call
  - English/Spanish 800.944.4773
- Text
  - “HELP” to 800.944.4773
  - “AYUDA” to 971.203.7773

National Maternal Mental Health Hotline

- 1.833.TLCMAMA/ **1-833-852-6262**
- Call/text; English/Spanish - 24/7
- Education, support, referrals

National Suicide Prevention Line
Call/text 1.800.273.8255

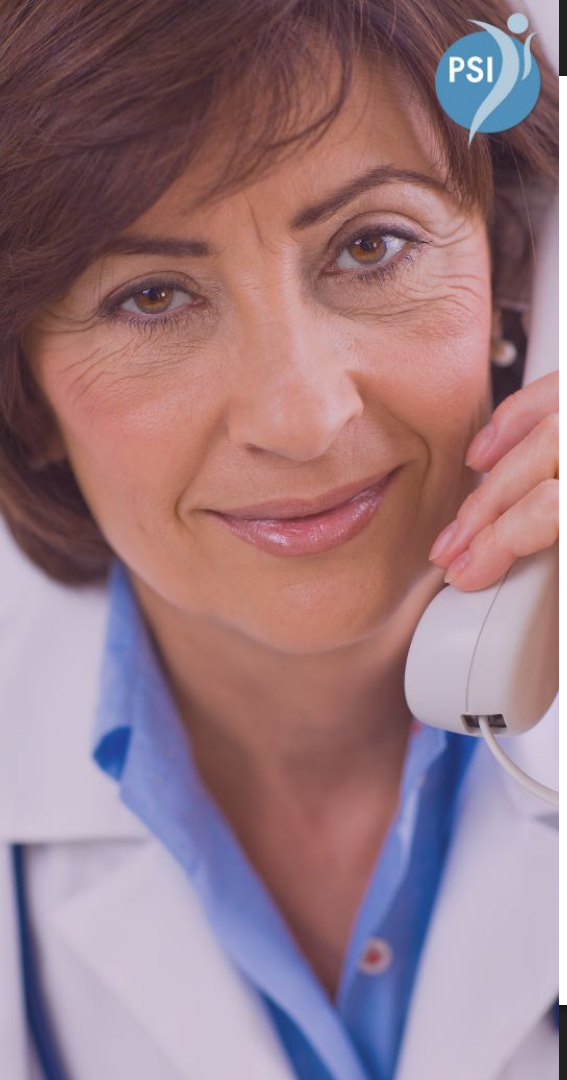
PSI Peer Mentor Program

www.postpartum.net/get-help/peer-mentor-program

A resource for parents struggling with perinatal mental health challenges. This program pairs moms or dads in need of support with a trained volunteer who has experienced & recovered from PMADs

Weekly communication over six-months, peers & mentors build a strong relationship that removes isolation, provides education, breaks down stigma.

Support for Providers



Perinatal Psychiatric Consult Line

- 877-499-4773 to schedule appointment
- Free consultation line for questions about mental health care of pregnant, postpartum, pre-conception pts
- Staffed by PSI reproductive psychiatrists
- ***Available for medical providers only***

www.postpartum.net/professionals/perinatal-psychiatric-consult-line

COLLEGE OF MEDICINE TUCSON

Arizona Perinatal Psychiatry Access Line

About Us ▾ Toolkits ▾ Trainings ▾ For Providers ▾ For Moms & Families Lee en Español

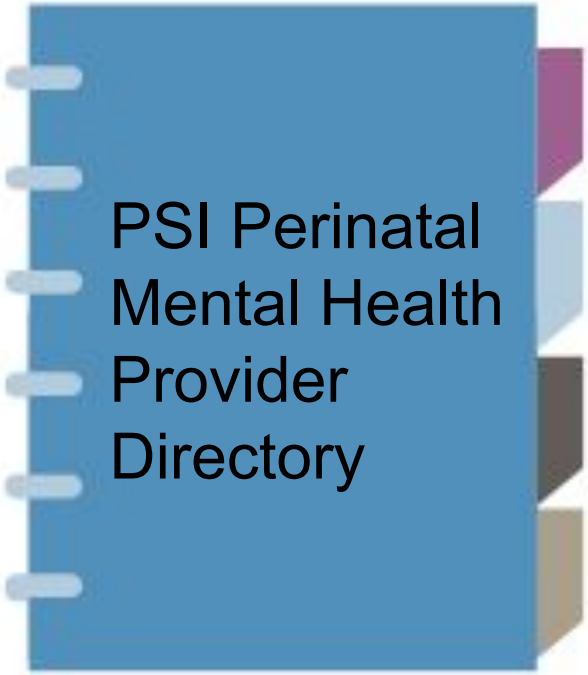
Arizona Perinatal Psychiatry Access Line

www.apal.arizona.edu

APAL is a statewide perinatal psychiatry access line. We assist **medical providers** in caring for their pregnant and postpartum patients with mental health and substance use disorders. Perinatal psychiatrists are available by phone, Monday-Friday from 12:30 p.m.-4:30 p.m., to answer provider questions and review treatment options.

Call 888-290-1336

The line launches on June 1, 2023.



- Free directory of perinatal mental health specialists, via zip code
- Share listing as mental health provider, a healthcare provider, childbirth professional, support group.
- https://psidirectory.com/

New in AZ 2023

Perinatal Mental Health Alliance for People of Color

- A program within PSI created to fill a gap in support services for professionals and communities of color around PMADs

https://psiarizona.org/perinatal-mh-alliance-poc

Education & Training

AHCCCS
Arizona Health Care Cost Containment System

Maternal Mental Health Advisory Committee
Report of Recommendations

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I.	**Create and Sustain a Perinatal Psychiatric Consultation Line**	8
II.	**Increase the Diversity of the Perinatal Behavioral Health Workforce**	10
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X.	**Increase Postpartum Support International Certified Perinatal Providers**	27

2023
Perinatal Mental Health Certification Trainings

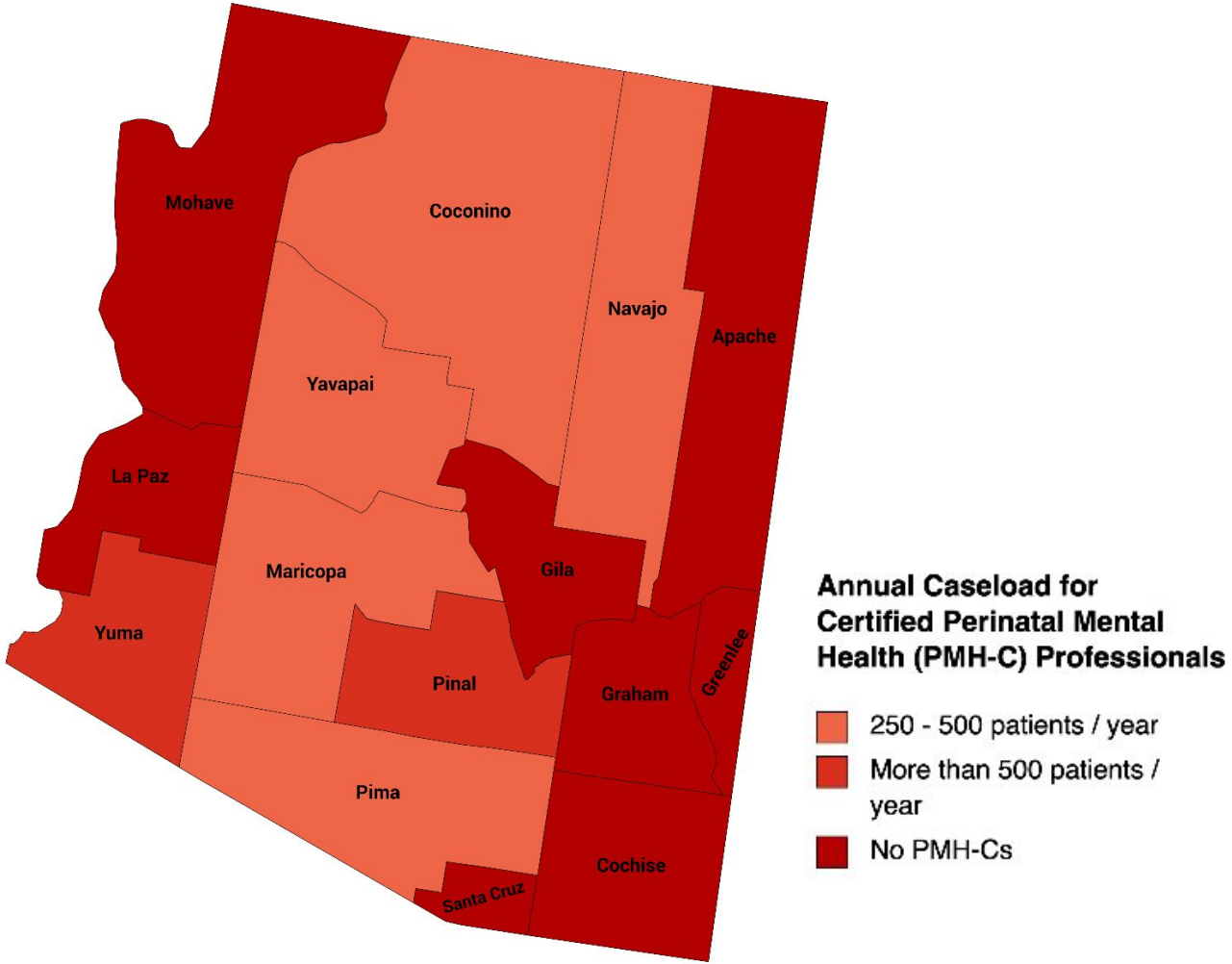
Virtual | August
Tucson | Nov 15 - 17

State of the State:
Perinatal Mental Health
Certified Providers by County

Key Takeaways:

1) *Currently, the **ENTIRE** state is a perinatal mental health desert.*

2) Eight AZ counties still have ***NO*** Perinatal Mental Health certified (PMH-C) behavioral health / mental health providers!



Certificate Trainings

www.postpartum.net/professionals

STEP ONE: EITHER ONE

- MMH Online certificate course with 2020Mom
- 2-day Certificate Training for Perinatal Mood and Anxiety Disorders: Components of Care

STEP TWO: THERAPISTS

- Advanced Psychotherapy

PRESCRIBERS

- Advanced Psychopharmacology

Perinatal Mental Health Certification Training Tracks for PMH-C

Tracks	TARGET AUDIENCE	STEP 1 (both in any order)		STEP 2	STEP 3
		Experience	Inital Training		
AFFILIATED PROFESSIONALS	Acupuncturists Chiropractors Doulas Massage Therapists Lactation Consultants Nurses Medical Assistants Peer Supports Physical Therapists	2 years of practice	**Components of Care 2-Day Training** online: live [$425*, 14.5 CEU] -OR- **PSI / 2020 Mom MMH Online Certificate Course** online: live or recorded [$480*, 16 CEU] -OR- (or approved alternative; 14 hrs)	**Advanced Psychotherapy** virtual or in-person [$250*, 6 CEUs] (or approved alternative)	Certification Exam $500
MENTAL / BEHAVIORAL HEALTH PROVIDERS	Therapists Psychologists Social Workers LMFTs LACs LPCs			**Advanced Psychotherapy** virtual or in-person [$250*, 6 CEUs] (or approved alternative)	
PRESCRIBERS	Physicians Nurse Practitioners Physician Assistants Psychiatrists			**Advanced Psychopharmacology** virtual ONLY [$250*, 6.25 CEUs]	

Closing Thoughts

- If you work with women, especially specializing in preconception | fertility | pregnancy | postpartum, get more education PSI, MGH-CWM (see resources)
- Develop a network of trusted referrals & refer (PSI provider search in your area)
- Therapists, prescribers, support/activity groups, lactation consultants, doulas
- If patient has h/o mental health issues and TTC or pregnant,
- Check in during each TM and during postpartum
- Asking reduces stigma/normalizes, opens communication
- “I may not be the one to help you, but I will get you the help you need”
- Refer to therapy for proactive care; monitoring for PMADs
- Support pts by w/ facts about psych RX & risks to TTC/pregnancy/baby
    - REAL risks of psych RX vs untreated PMADS (reproductive psych)
    - Do not encourage d/c of RX when TTC/pregnant/lactation, if unsure refer to repro psych

Reproductive Psychiatry Resources

- PSI-AZ & PSI Central
- Perinatal mental Health Toolkit: ACOG (7/2023)
  www.acog.org/programs/perinatal-mental-health
- Consensus Statement Perinatal OCD (6/2023)
  www.ncbi.nlm.nih.gov/pmc/articles/PMC10155656/pdf/737_2023_Article_1315.pdf
- Mass General Center for Women's Mental Health - www.womensmentalhealth.org
  - weekly newsletter: www.womensmentalhealth.org/subscribe/
  - prescriber training programs: www.womensmentalhealth.org/educational-programs-2/
  - virtual rounds: Wednesdays
    www.womensmentalhealth.org/educational-programs/virtual-rounds-at-the-cwmh/
- Handbook of Perinatal Clinical Psychology
- MGH statement on safety of meds in pregnancy & breast feeding:
  https://womensmentalhealth.org/ specialty-clinics/breastfeeding-and-psychiatric- medication/
- LactMed evidenced-based information on safety of drugs/supplements in lactation
  https:// www.toxnet.nlm.nih.gov/newtoxnet/lactmed.htm

You are not alone.
You are not to blame.
With help, you will be well.

Important numbers:

National MMH Hotline (call/text, 24/7)
1.833.TLCMAMA/ **1-833-852-6262**

If suicidal crisis,1-800-273-TALK
(1-800-273-8255) (call/text, 24/7)

APAL- 1.888.290.1336 (M-F 1230-1630;
for prescribers)

www.psiarizona.org
www.postpartum.net
psi.arizona1@gmail.com

PSI POSTPARTUM SUPPORT INTERNATIONAL