# Perinatal Mood & Anxiety Disorders:

# Prevention, Screening, Treatments, Resources

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# What are PMADs?

## 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

**PMADs are the #1 complication of pregnancy and childbirth**

Nationally, PMADs affect up to **1 in 7** pregnant and postpartum women

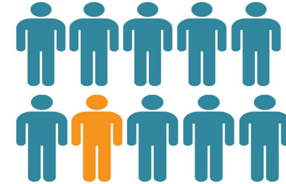
> G-HTN, G-DM, + pre-eclampsia combined

1 in 3 women of color

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

most underdiagnosed, underreported, undertreated complication of childbirth

1 in 10 dads are affected by postnatal depression



can extrapolate similar rates to non-birthing partners

**Half of perinatal women with a diagnosis of depression do not get the treatment they need**

contributing factors:

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

**Untreated PMADs in the U.S. are costly and have multigenerational consequences**

An estimated **$14.2 billion** for all births in 2017

intergenerational trauma via poor bonding & 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.
  1. ACOG recommends more, but gap in care continues
- Lack of support from partner/ family, poor sleep, life stressors increase risk;
  1. 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 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)
- 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 just FDA approved as 2w oral medication for PPD

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

- Risk of untreated PMADS and underdosing as pregnancy progresses may alter 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

MGH lecture 2020, PSI Adv Psychopharm 2023

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

Support for Families

Support for Providers

Education & Training

Advocacy & Outreach

# PSI State Chapter: Arizona

- <u>**Mission**</u> of PSI- promote awareness, prevention & treatment of mental health issues related to childbearing in every county & tribal community statewide.
- <u>**Vision**</u> 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

PSI HELPLINE
800.944.4773

The PSI HelpLine is a toll-free number anyone can call or text '**HELP**' to get basic information, support, and resources for perinatal mental health (this is **NOT** a crisis line). Our volunteers are here to help, listen and connect you with a PSI Support Coordinator in your state (local resources).

Caller → HelpLine → Coordinator

Postpartum Support International | www.postpartum.net | 800.944.4773

- 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

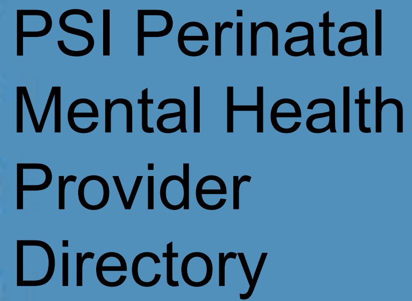
www.apal.arizona.edu

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.

Text




- 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

# Maternal Mental Health Advisory Committee Report of Recommendations

**Committee Recommendations** 7

I. Create and Sustain a Perinatal Psychiatric Consultation Line 8

II. Increase the Diversity of the Perinatal Behavioral Health Workforce 10

III. Increase Cultural Competency Trainings for Health Care Professions 12

IV. Expand Maternal Peer Support Coverage 14

V. Expand Home Visitor Coverage 16

VI. Expand Doula Coverage 19

VII. Expand Community Health Worker Coverage 21

VIII. Expand Traditional Healing Services Coverage 23

IX. Expand Lactation Support Coverage 25

X. Increase Postpartum Support International Certified Perinatal Providers 27

## 2023 Perinatal Mental Health Certification Trainings

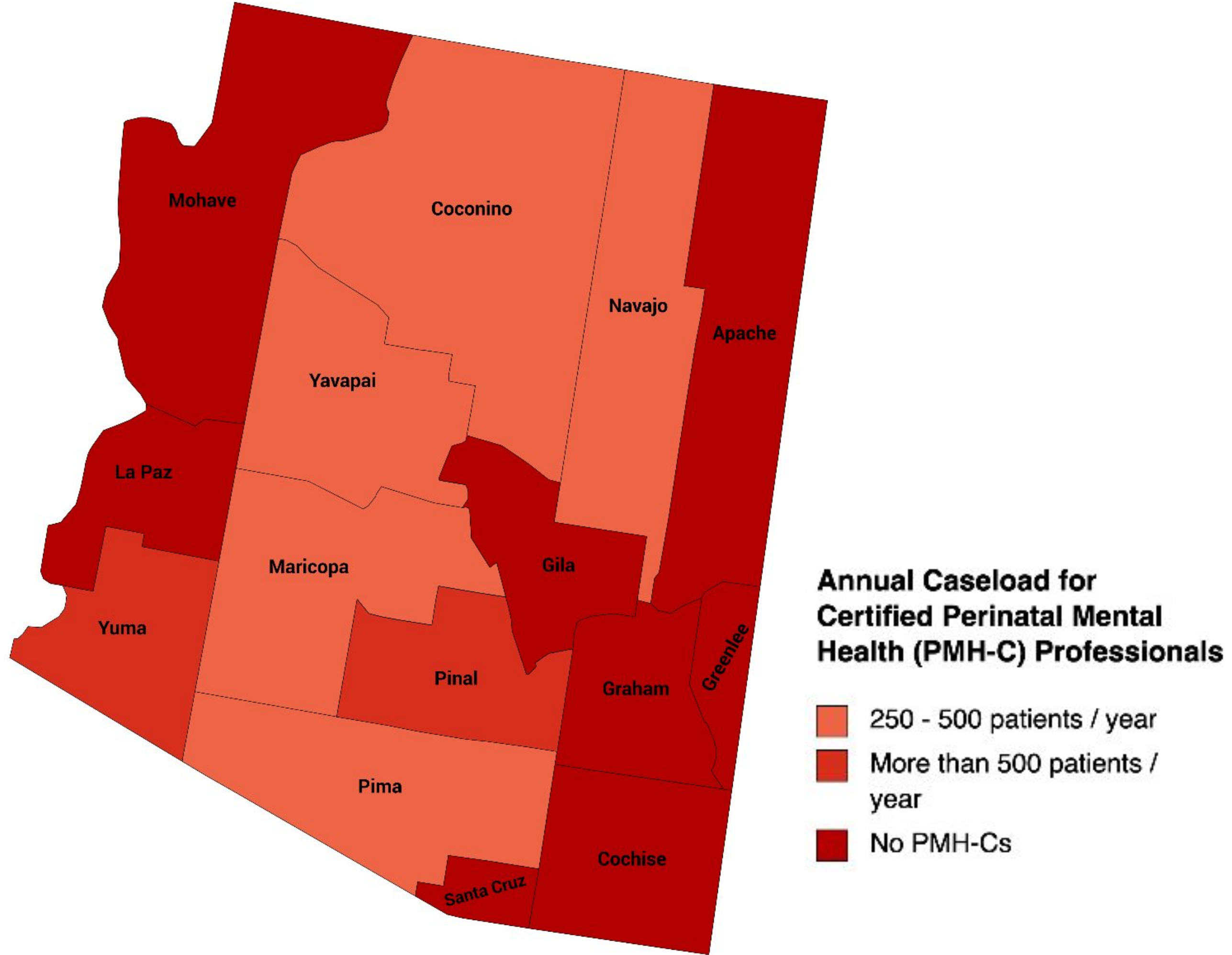
Virtual | August
Tucson | Nov 15 - 17

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

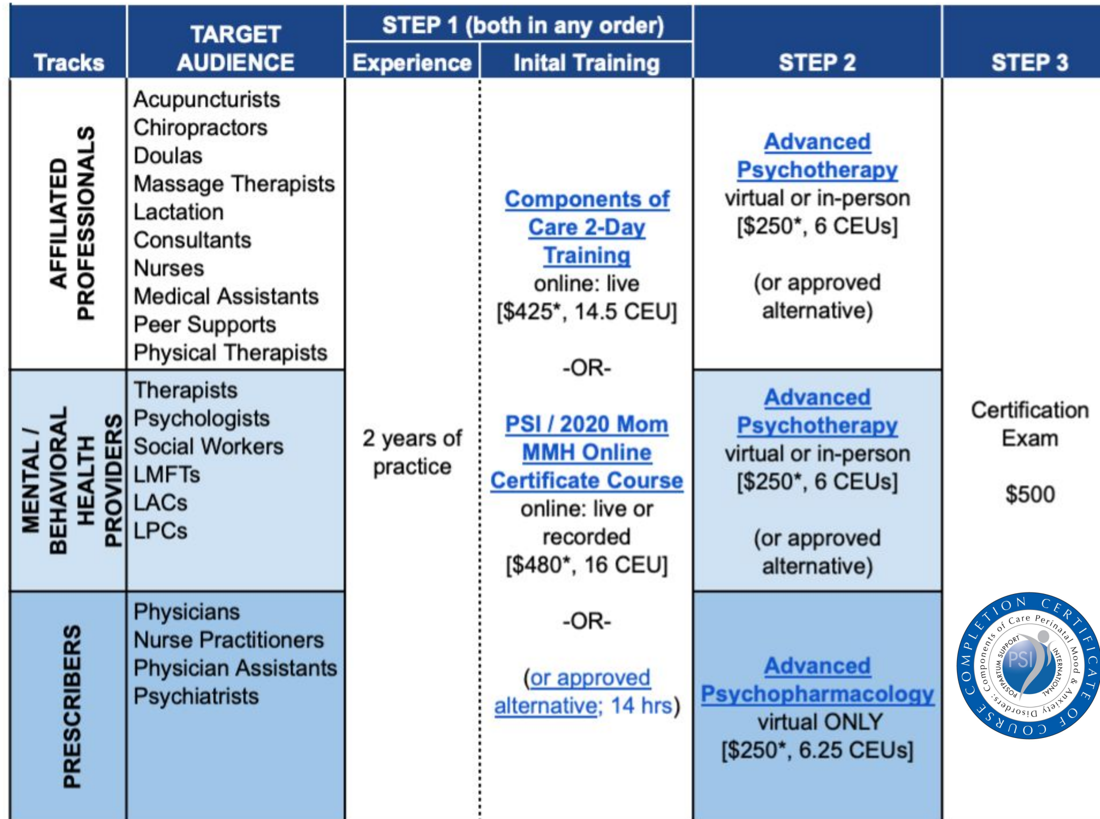
STEP TWO: THERAPISTS

- Advanced Psychotherapy

PRESCRIBERS

- Advanced Psychopharmacology

# Perinatal Mental Health Certification Training Tracks for PMH-C



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

POSTPARTUM SUPPORT INTERNATIONAL