Perinatal Mood & Anxiety Disorders: Impact, Prevention & Treatment

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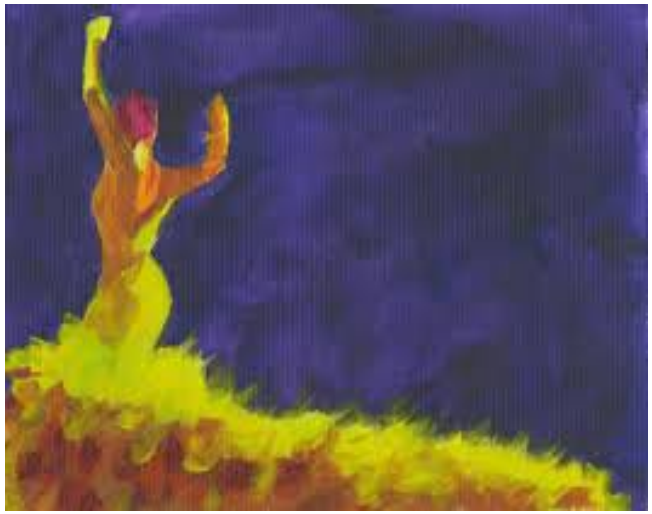
Session Objectives

- Understand the symptoms, prevalence and impact of mood & anxiety disorders on new moms
- Provide prevention strategies and treatment options

Utah Maternal Mental Health Collaborative

- Utah Resources
- Utah PSI Chapter
- Multi-agency stakeholders
- Ideas, information exchange
- Project development
- Social support
- Policy change/Advocacy

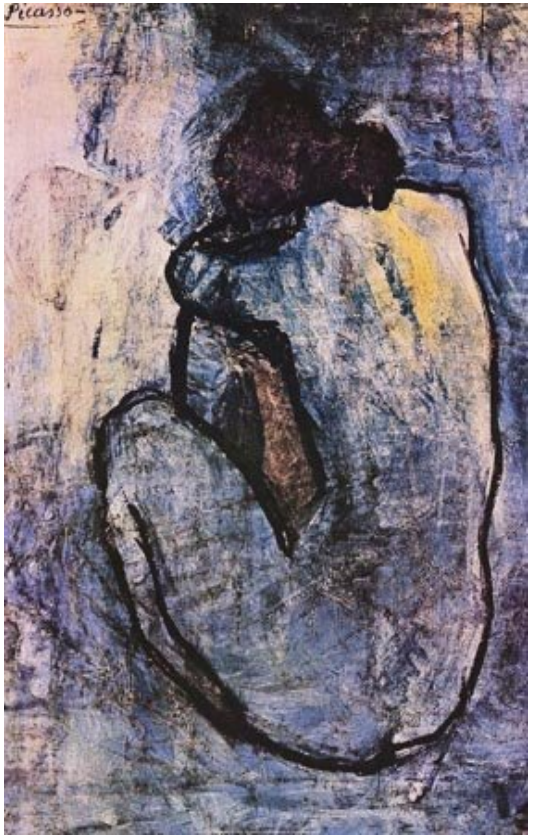


Defining the issue:

What is Maternal Mental Health?

Perinatal Mood, Anxiety, and Psychotic disorders

Why is it relevant in primary & obstetric care?

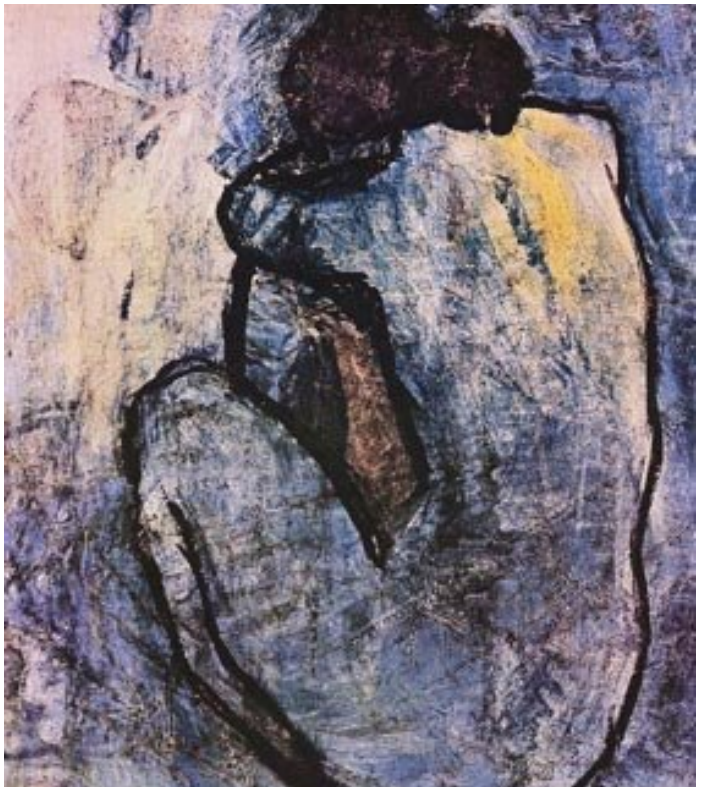


Issues in primary, obstetric, and pediatric care

- ICD-10
- DSM V
- Who is the patient?
- Little mental health training
- Lack of familiarity with perinatal literature
- Separation ~ medical and mental health
- Personal bias
- Stigma

What didn't we learn in graduate education?

- No perinatal mental health training programs in US
- DSM makes little/no distinction between perinatal psychiatric illness and others
- "Postpartum Onset" specifier limited to first 4 weeks PP.
- No specifier for pregnancy
- Old myths perpetuate



DEPRESSION IN WOMEN

- Leading cause of disease-related disability
- Reproductive years- highest risk
- Most amenable to Tx

Did you know…

- Women in their childbearing years account for the largest group of Americans with Depression.
- Postpartum Depression is the most common complication of childbirth.
- There are as many new cases of mothers suffering from Maternal Depression each year as women diagnosed with breast cancer.
- American Academy of Pediatrics has noted that Maternal Depression is the most under diagnosed obstetric complication in America.
- Despite the prevalence Maternal Depression goes largely undiagnosed and untreated.

Maternal Mortality

Suicide is the second leading cause of death in the first year postpartum

Perinatal Mood, Anxiety, Obsessive, & Trauma related Disorders

Pregnancy and the First year Postpartum

- Psychosis- Thought Disorder or Episode~ 1-2%
- Major Depressive Disorder~ 21%
- Bi-Polar Disorder~ 22% of PPD
- Generalized Anxiety~ 15%
- Panic Disorder~ 11%
- Obsessive Compulsive Disorder~ 5-11%
- Post Traumatic Stress Disorder ~ 9%

Disparities in prenatal screening and education

Preterm birth (<36wk): 11.39%
(National Vital Statistics 2013)

Low birth weight (<2500 g): 8.02%
(National Vital Statistics 2013)

Preeclampsia/eclampsia: 5-8%
(Preeclampsia Foundation, 2010)

Gestational Diabetes: 7%
(NIH, National Diabetes Information Clearinghouse, 2009)

Perinatal Mood Disorders

- Baby Blues – Not a disorder
- Major Depressive Disorder
  - Most researched
- Bipolar Disorder
  - Mania high risk for Psychosis
  - Immediate Assessment

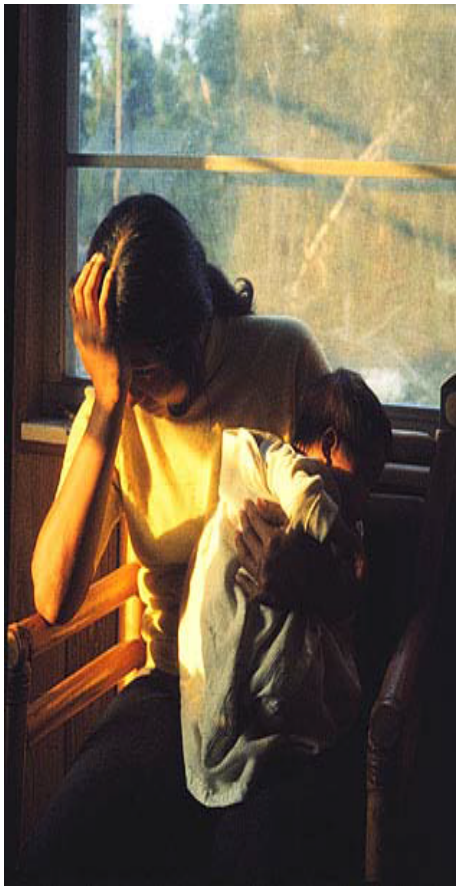
Baby Blues

- 80%
- Transient.
- Overwhelmed, tearful, exhausted, hypo-manic, irritable
- With support, rest, and good nutrition, the Baby Blues resolve naturally.
- Persisting beyond 2 weeks, likely PPD or related disorder.

Antenatal Depression Prevalence 10-20%

- 14%

  (JAMA 2013)



JAMA 2013

- 1 in 7 women = PPD
- 30% episode before pregnancy
- 40% >1 during pregnancy
- Over two-thirds of the women also had signs of an anxiety disorder
- One in five of the women had thoughts of harming themselves
- 20 percent of the group studied was diagnosed with bipolar disorder
- http://seleni.org/advice-support/article/largest-postpartum-depression-study-reveals-disturbing-statistics#sthash.CI8AwKFJ.dpuf

Antenatal Depression Characteristics

- 60%+ PMADs begin in pregnancy
- Starts 1-3 months postpartum, up to first year
- **Timing may be influenced by weaning**
- 60%+ PMADs start in first 6 weeks
- Lasts months or years, if untreated
- Symptoms present most of the time
- Can occur after birth of any child-not just 1st
- DSM V recognizes episodes in pregnancy and in the first 4 weeks PP with "peripartum onset" specifier

DSM V ~ Five or more out of 9 symptoms (including at least one of depressed mood and loss of interest or pleasure) in the same 2-week period. Each of these symptoms represents a change from previous functioning, and needs to be present nearly every day:

- Depressed mood (subjective or observed); can be irritable mood in children and adolescents, most of the day;
- Loss of interest or pleasure, most of the day;
- Change in weight or appetite. Weight: 5 percent change over 1 month;
- Insomnia or hypersomnia;
- Psychomotor retardation or agitation (observed);
- Loss of energy or fatigue;
- Worthlessness or guilt;
- Impaired concentration or indecisiveness; or
- Recurrent thoughts of death or suicidal ideation or attempt.
- b) Symptoms cause significant distress or impairment.
- c) Episode is not attributable to a substance or medical condition.
- d) Episode is not better explained by a psychotic disorder.
- e) There has never been a manic or hypomanic episode. Exclusion e) does not apply if a (hypo)manic episode was substance-induced or attributable to a medical condition..

Perinatal Depression

Perinatal Specific

- Agitated depression
- Always an anxious component
- Anhedonia usually not regarding infant and children
- Looks "Too good"

Perinatal Specific

- Typically highly functional
- Hidden Illness
- Intense shame
- Sleep disturbances
- Passive/Active suicidal ideation

Perinatal Depression

Perinatal Specific

- Disinterest in Baby
- Inadequacy
- Disinterest in sex
- Over-concern for baby
- Hopelessness & shame

BIPOLAR DISORDER in Pregnancy

7x more likely to be hospitalized for first episode of Postpartum Depression (Misri, 2005)

•High relapse rates with continued treatment:

45% (Bleharet al., 1998)

50% (Freeman et al., 2002)

•High relapse rates with Lithium treatment discont.:

50% (about same as non-pregnant)

(Viguera& Newport, 2005)

Bipolar Disorder – Postpartum Psychosis Link

- 100x more likely to have Postpartum Psychosis (Misri, 2005)
- 86% of 110 women with Postpartum Psychosis subsequently diagnosed with Bipolar Disorder (Robertson, 2003)
- 260 episodes of Postpartum Psychosis in 1,000 deliveries in women with Bipolar Disorder (Jones & Craddock, 2001)

Perinatal Anxiety Disorders

- Posttraumatic Stress Disorder (PTSD)
- Obsessive Compulsive Disorder (OCD)
- Generalized Anxiety Disorder
- Panic Disorder

PTSD or Depression? Or both?

PTSD or Depression?

Symptoms for post-traumatic-stress disorder, or PTSD, differ from post-partum depression, and can be severe.

PTSD

- The person persistently re-experiences the traumatic event (in this case childbirth) in one or more of the following ways: recurrent and intrusive distressing recollections of the event; recurrent distressing dreams and nightmares; flashbacks; intense psychological distress and/or physiological reactivity on exposure to cues that resemble the traumatic event.
- Persistent avoidance of stimuli associated with the traumatic event and numbing of general responsiveness as indicated by efforts to avoid thoughts/activities/places or people that arouse recollections of the trauma; feelings of detachment.
- Persistent symptoms of increased arousal, including difficulty falling or staying asleep; irritability or outbursts of anger; difficulty concentrating; hypervigilance; exaggerated startle response.

Post-partum depression:

- Depressed mood
- Diminished interest or pleasure in activities
- Sleeping/eating disturbances
- Anxiety/insecurity
- Emotions on a roller coaster
- Fatigue or loss of energy
- Guilt
- Diminished ability to concentrate
- Loss of self (not normal self, don't feel real)
- Recurrent thoughts of death, suicidal ideation

Sources: DSM IV-Text Revision (2000); American Psychiatric Association; Cheryl Beck of University of Connecticut School of Nursing.

OCD - General

- Obsessions
  - Intrusive thoughts/ images
  - Ignore or suppress
  - Awareness
- Compulsions
  - Repetitive behaviors/ mental acts
  - Reduce stress
  - Prevent dreaded event

Perinatal OCD

- Pregnancy: 0.2 –1.2%
- Postpartum: 2.7 –3.9%
- (Gen. Pop. 2.2%)
- Ego-dystonic obsessional thoughts about harming the baby (Abramowitz et al., 2003)
- No documented case of infanticide (Ross et al., 2006)
- Careful assessment & close monitoring if :
  - severe comorbid depression
  - family or personal history of Bipolar Disorder, Thought Disorders or Postpartum Psychosis

Postpartum OCD (Often misdiagnosed at psychosis)

Obsessive thoughts

- Content related to baby
- Mother extremely distraught
- Ego-dystonic
- "Am I going crazy?"
- "Is this Postpartum Psychosis?"
- "Am I going be *that mother* on the news?"

Compulsive behaviors

- Keep baby safe
- Repetitive, excessive
- Reduce distress
- Order, control

POSTPARTUM OCD Characteristics

- No intent to act on thoughts
- Mother rarely discloses
- Usually does not describe content
- Suggestibility
- Functioning/ infant care compromised
- Only obsessions or only compulsions or both
- Lifelong mild symptoms
- Obsession with safety vs harm
- "But it could happen"

Perinatal Psychosis

- As part of :
- Major Depressive Disorder
- Bipolar Disorder –a variant of?
- Psychotic Disorder
- 4% Infanticide
- 5% Suicide

Perinatal Psychosis
1-3 per thousand births

- Agitation
- Swift detachment from reality
- Visual or auditory hallucinations
- **Usually** within days to weeks of birth
- Etiology: Manic phase of Bi-polar I or II
- High risk
- Suicide 5%
- Infanticide 4%
- Immediate Hospitalization

POSTPARTUM OCD vs. PSYCHOSIS

- OCD: overprotective mother
- PSYCHOSIS: danger to harm
- Obsessing about becoming psychotic

Myths:

- Postpartum OCD is great risk to harm baby
- OCD may turn into psychosis

Issues:

- Misdiagnosis by untrained professionals
- Reporting, hospitalization = victimization

Other perinatal considerations…

Although not well researched or included in most data set, the following populations and reproductive health events also experience and represent risk for PMADs.

- Same-sex parents
- Fathers
- Miscarriage (Any length of pregnancy)
- Stillbirth
- Adoption
- Infertility
- Abortion

Depression/anxiety during pregnancy is a strong predictor of postpartum mood and anxiety disorders

MYTH:

Pregnancy protects women from psychological disorders

Epigenetic Biomarkers of Postpartum Depression

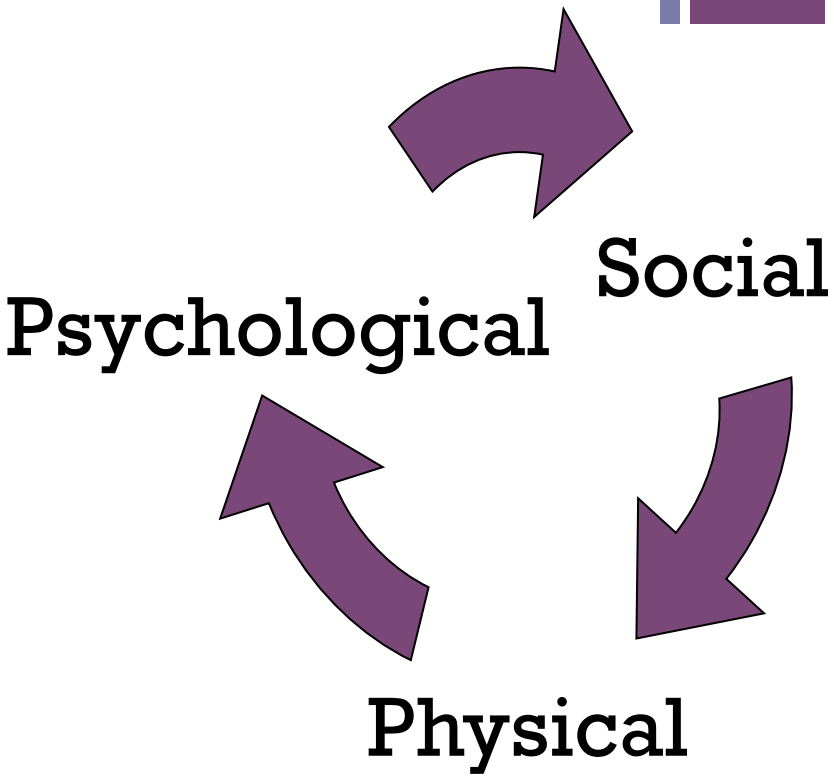
- Biomarker loci at *HP1BP3* and *TTC9B*
- Predicted PPD
- Leptin- A fat-derived hormone that signals satiety
- Serum leptin level measured 48 h after delivery is associated with development of postpartum depressive symptoms

Neuropsychopharmacology. 2014 Jan; 39(1): 234. Published online 2013 Dec 9. doi: 10.1038/npp.2013.238

Chen C, Gao J, Zhang J, Jia L, Yu T, Zheng Y.
Serum leptin level measured 48 h after delivery is associated with development of postpartum depressive symptoms: a 3-month follow-up study. Arch Womens Ment Health. 2016 Jun 13. [Epub ahead of print]

Etiology of PMADs

- **Genetic** Predisposition
- **Sensitivity** to hormonal changes
- **Psychosocial** Factors
  - Inadequate social, family, financial support
- Concurrent **Stressors**
  - Sleep disruption
  - poor nutrition
  - health challenges
  - Interpersonal stress



Etiology- Current theories

- Neuroendocrine vulnerability/sensitivity
- Progesterone withdrawal
- Retrovirus reactivation
- Stressors combined with the above = HPA axis dysregulation

GLANDS INVOLVED IN MOOD REGULATION

Adrenal Gland- Adrenal cortex produces cortisol and heightens arousal, also vital in CNS and metabolic function (helps control insulin release).

- Pituitary Gland- released ACTH which triggers the production of cortisol
- How does stress effect the thyroid function?
- When the adrenal glands become stressed inflammatory cytokines are released which inhibit production of THS, T3, and T4
- Enzymes in the gut that normally convert T4 to T3 are inhibited when the body is stressed and result in thyroid resistance

Important R/O

- PTSD
  - Birthing Trauma
  - Undisclosed trauma or abuse
  - ACE questionnaire
- Thyroid/Endocrine imbalance
- Anemia
- Side effects of other medicines
- Alcohol or drug use/abuse

Inflammation and PPD: The new etiology paradigm

- Psychoneuroimmunology (PNI) = new insights
- Once seen as one risk factor; now seen as THE risk factor underlying all others
- Depression associated with inflammation manifested by ↑ pro-inflammatory cytokines
- Cytokines normally increase in third trimester: ↑ vulnerability
- Explains why stress increases risk
- Psychosocial, Behavioral & Physical
- **Prevention and treatment to ↓ maternal stress & inflammation**

(Kendall-Tackett 2015)

Pro-inflammatory Cytokines

- ⇧ Third Trimester
- ⇧ Risk
- ⇧ Pre-term Birth
- ⇧ Preeclampsia

IMPACT OF DEPRESSION DURING PREGNANCY

- Prematurity
- Low birth-weight
- Disorganized sleep
- Less responsiveness
- Excessive fetal activity
- Chronic illness in adulthood

- Growth Delays
- Difficult temperament
- Impacted development:
- Attention
- Anxiety and depression

American Academy of Child Adolescent Psychiatry. 2007 Jun; 46(6):737-46.

IMPACT OF ANXIETY DURING PREGNANCY

- Stress, Anxiety (↑ cortisol)

  →Maternal vasoconstriction

  →Decreased oxygen and nutrients to fetus

  (Copper et al., 1996)

  - Consequences on fetal CNS development

  (Monk et al., 2000; Wadhwaet al., 1993)

- Pre-term delivery (<37wks)

(Kendall-Tackett 2015; Dayan et al., 2006; Hedegaardet al., 1993; Riniet al., 1999; Sandman et al., 1994; Wadhwaet al., 1993)

IMPACT OF POSTPARTUM DEPRESSION: Infant Development

- Poor infant development at 2 months

  (Whiffen& Gotlib, 1989)

- Lower infant social and performance scores at 3 months

  (Galleret al., 2000)

- Delayed motor development at 6 months

  (Galleret al., 2000)

- More likely to have insecure attachment styles

  (Martins & Gaffan, 2000)

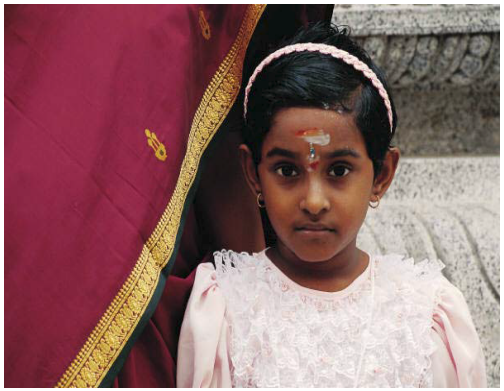
Etiology of fetal impact hypothesis:

Potential Mediating variables:

- Low prenatal maternal dopamine and serotonin
- Elevated cortisol and norepinephrine
- Intrauterine artery resistance
- Heritability – ADHD, anti-social behavior

IMPACT OF POSTPARTUM DEPRESSION: Older Children

Children exposed to maternal depression as infants:



- More conduct problems

  (Beck C.T., 1999: Meta-analysis of 33 studies)

- Lower perceptual performance scores at age 4

  (Brennan et al., 2000)

- More behavior problems and lower vocabulary scores at age 5

  (Brennan et al., 2000)

- More likely to express negative cognitions of hopelessness, pessimism and low self-worth at age 5

  (Murray, Woolgar, Cooper, & Hipwell, 2001)

- Lower levels of social competence at ages 8-9

IMPACT OF POSTPARTUM DEPRESSION cont.

- More frequent non-routine pediatrician visits (Cheet al., 2008)
- Current depression is associated with larger effect than past depression
- Infants of depressed mothers experience more impaired parenting than older children of depressed mothers
- Economically disadvantaged mothers experience negative effects of their depression to a greater extent (Lovejoy et al., 2000)
- Significantly more likely to discontinue breastfeeding between 4 and 16 weeks postpartum. (Field 2008) (Ystrom 2012)
- PPD and low support leads to early weaning Mathews et al JHL 30(4) 480-487

Protective benefits of breastfeeding

- Attenuates stress
- Modulates inflammatory response
- Protective affect on the neural development of infants

Dennis & McQueen, (2009), Hale (2007)

Kendall-Tackett, Cogig & Hale, (2010)

Kendall-Tackett (2015)

Potential negative impact of nursing on depressed mothers

- PNI research suggests that the natural inflammatory response on pregnancy, combined with inflammatory process such as stress and pain, i.e.: nipple pain, can increase risk and severity of symptoms.
- When nursing is going well= protective.
- When nursing is very stressful and/or painful= increased risk.

Kendall-Tackett (2015)

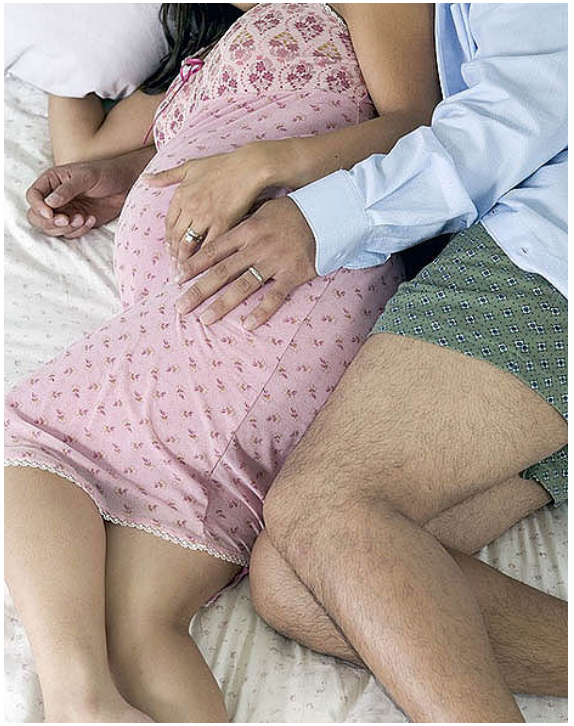
PREVENTION – Primary Prevention Model

- Risk factors are known
- Screening is inexpensive
- Risk factors for PMADs are well-documented
- Many risk factors amenable to change
- Some are genetic, others are psychosocial and thus can be impacted with primary prevention strategies
- Known, reliable, effective treatments exist

PREVENTION

All women need:

- Information
- Exercise
- Rest
- Sound nutrition
- Social support



PREVENTION Research

- Mixed results examining interpersonal therapy, group support, home visits
- Prophylactic psychopharmacology-
- PPD prevented with use of Sertraline immediately postpartum for 24 women w/history of PPD.
- Initial dose 25mg, Maximum dose 75mg

PREVENTION
Global Goals

Global goals for prevention and treatment

- Reduce maternal stress
- Reduce inflammation
- Below support/treatment strategies generally considered anti-inflammatory

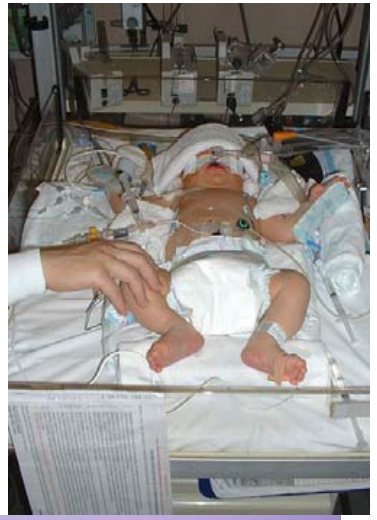
Universal Primary Prevention in practice

- Educate "If you're not feeling like yourself"
- Screen - EPDS or PDQ 9
- Refer – www.utahmmhc.org
- Provide info/resources – UMMHC Brochure
- Wellness planning - SNOWBALL

Identifying risk

Antenatal Depression Risk

- All cultures and SES
- First year postpartum
- Higher rates:
  - Multiples
  - Infertility
  - Hx Miscarriage
  - Preterm infants
  - Teens
  - Substance abuse
  - Domestic Violence
  - Neonatal complications



Trauma Hx and risk

- Statistically significant link between childhood sexual abuse and antenatal depression
- Atenatal depression predicted by trauma Hx – dose-response effect.
- > 3 traumatic events = 4 fold increased risk vs. no T hx
- Long-term alterations in concentrations of corticotropin-releasing hormone (CRH) and cortisol
- Dysregulation of the HPA axis + neuroendocrine changes of pregnancy
- Increasing levels of CRH = ↓ Mood
- ACES Questionnaire significant

Wosu AC, Gelaye B, Williams MA.
History of childhood sexual abuse and risk of prenatal and postpartum depression or depressive symptoms: an epidemiologic review. Arch Womens Ment Health. 2015 May 10.

Robertson-Blackmore E, Putnam FW, Rubinow DR, et al.
Antecedent trauma exposure and risk of depression in the perinatal period. J Clin Psychiatry. 2013 Oct; 74(10):e942-8.

Predictive Risk Factors

- Previous PMADs
  - Family History
  - Personal History
  - Symptoms during Pregnancy
- History of Mood or Anxiety Disorders
  - Personal or family history of depression, anxiety, bipolar disorder, eating disorders, or OCD
- Significant Mood Reactions to hormonal changes
  - Puberty, PMS, hormonal birth control, pregnancy loss

Risk Factors cont.

- Endocrine Dysfunction
  - Hx of Thyroid Imbalance
  - Other Endocrine Disorders
  - Decreased Fertility
- Social Factors
  - Inadequate social support
  - Interpersonal Violence
  - Financial Stress/Poverty

NICU Families

- PTSD preterm delivery 7.4%
- no ptsd 8%
- with past ptsd 9.2%
- with current ptsd 16,334 VA deliveries
- PTSD and major depressive disorder is 4 fold increase in prematurity 2654 women

Risk Factor Check List
From Oregon Prenatal and Newborn Handbook 2015

Check the statements that are true for you:

- ❑ It's hard for me to ask for help.
- ❑ I've had trouble with hormones and moods, especially before my period.
- ❑ I was depressed or anxious after my last baby or during my pregnancy.
- ❑ I've been depressed or anxious in the past.
- ❑ My mother, sister, or aunt was depressed after her baby was born.
- ❑ Sometimes I don't need to sleep, have lots of ideas and it's hard to slow down.
- ❑ My family is far away and I don't have many friends nearby.
- ❑ I don't have the money, food or housing I need.

If you checked three or more boxes, you are more likely to have depression or anxiety after your baby is born (postpartum depression).

SCREENING –What tool?

- Edinburgh Postnatal Depression Scale (EPDS)

(Cox, Holden & Sagovsky, 1987)

  - 10 item self-screen
  - Pre & postnatal use
  - Copyright-free
  - Not a diagnostic tool
  - Not to override clinical assessment
  - Available in 23 languages

- Postpartum Depression Screening Scale (PDSS)

(Beck & Gable, 2000)

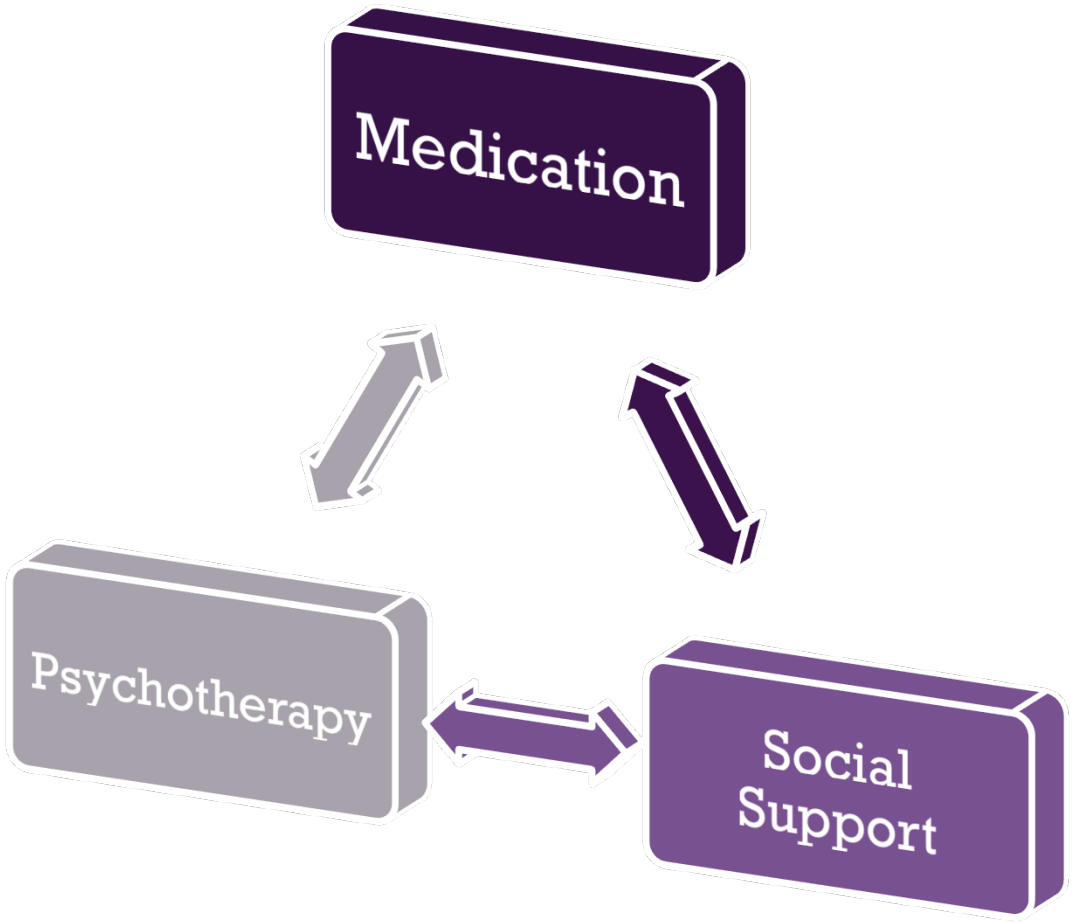
- Patient Health Questionnaire (PHQ-9)

Screening: When?

SCREENING –How?

- Do not make assumptions
- Educate
- Ask every woman: "At least 10% of pregnant and postpartum women have depression and or anxiety. They are the most common complications of childbearing."
- More than once
- Give screening tool with other paperwork
- Ask about personal and **family** history of depression & anxiety
- Document
- Give printed resources with phone numbers and websites

Treatment: The Gold Standard:



BEHAVIORAL & SOCIAL SUPPORT TREATMENT

Psychotherapy:

Crisis intervention

IPT, CBT, MCBT, DBT

Individual, couples, family

Support groups

Phone/ email support

HOSPITALIZATION

- When safety/functioning level warrant
- Outpatient care
- Multiple factors should be considered while inpatient
- Always needed for psychosis and active suicidality

Treatment Options for Perinatal Patients with moderate-severe sx

- Ideal –specialized out-pt and in-pt options
- Mother-baby day tx offers high-profile tx while promoting attachment and the infant/mother relationship.
- Lowers impact of trauma of PPD
- Assures safety
- Contextualized tx much more appealing to new moms

Hospital-based prevention programs

- 16 states currently offer hospital-based prevention and treatment programs for PMADs
- Screening all PP women
- Follow-up phone calls
- Referrals to MDs
- In-hospital support groups

Canada: Mt. Sinai Hospital Perinatal Mental Health Program

- Toronto
- 5 day 5 night program for high-risk moms
- Hx of PPD, or Bi-polar
- Emphasis on monitoring and sleep
- Based on clear link between fatigue, sleep deprivation and sx worsening/mania.

BEHAVIORAL & SOCIAL SUPPORT TREATMENT

IPT, CBT, DBT

MBCT

Support groups

ECT

Phone/email support

Short term CBT as effective as Fluoxetine

Social Support: Prevention & Intervention

- New Canadian research
- 9 phone call model
- RN supervised peer support training program
- RN's provided Debriefing and clinical assessment re: suicidality

- Mean depression significantly declined from baseline, 15·4 (N = 49), to mid-point, 8·30 and end of the study, 6·26.
- At mid-point 8·1% (n = 3/37) of mothers were depressed
- At endpoint 11·8% (4/34) were depressed suggesting some relapse.
- Perceptions of social support significantly improved and higher support was significantly related with lower depression symptoms.

MEDICATION

- Prescribed by
  - Psychiatrist
  - Primary Care Physician
  - Psychiatric Nurse Practitioner
  - OB

- Potential effects weighed while pregnant or nursing
- Often a process
- Multiple types of PMAD medications
- **Adjunctive use of benzodiazepines ~ clonazepam, lorazapam**

Non-Pharmacological Tx

- **Mindfulness CBT**
- **Omega 3s**
- **Acupuncture**
- **Doula Care**
- **Bright light**
- **Yoga**
- **SAM-E**
- **St. Johns Wort**
- 5-HTP
- Hypnotherapy
- Meditation
- Herbs
- Massage
- Homeopathy
- Placental Encapsulation?

OMEGA 3 FATTY ACIDS

- Safe for pregnancy and nursing
- Proven effective for depression and bipolar disorder
- Supports proper brain function and mood
- Omega 3s related to mood found mostly in fish oil
- EPA & DHA
- Combined therapeutic dosage: 1,000-3,000 mg (up to 9000)
- Must be high quality supplement source

(Kendall-Tackett, 2008)

Rule outs & Tx resistant considerations

- **Thyroid**
- **Nutritional deficiencies (Omega 3-s, B-12, Iodine, ferritin, magnesium, calcium)**
- **Glucose intolerance**
- **Other biological causes**
- Food allergies
- Serotonin imbalance (amino acids, 5-HTP)
- Endocrine/Hormone imbalance (Progesterone, Estrogen, Testosterone)

PHARMACOLOGICAL TREATMENT OPTIONS

- SSRIs
- Anti-anxiety agents
- Mood stabilizers
- Anti-psychotic agents

"I have spent the last 10 years of my career worrying about the impact of medications. I've been wrong. I should have been worrying more about the impact of illness."

-Zachary Stowe, MD. Department of Psychiatry, Emory University 2007

- For information on medication while breastfeeding, call Pregnancy RiskLine:

~ Mother-to-Baby

Salt Lake: 1-800-822-BABY (2229)

PSYCHOTROPIC MEDICATIONS IN PREGNANCY & LACTATION

Why Many Women Don't Seek Treatment

- Afraid they will be told to stop breastfeeding
  - Most women know that breastfeeding is best for their infant
  - Rather "get through it" than give up nursing
- Afraid of impact on neonate
- Stigma
- Are not given:
  - Adequate information about risks/ benefits
  - Chance to discuss it with others
  - Authority to make final decision

CULTURAL CONSIDERATIONS

- Language Barrier
  - PSI website www.postpartum.net translatable
  - EPDS available in 22 languages
  - "Beyond the Blues" in Spanish
  - "Healthy Moms, Happy Families" video- PSI. www.postpartum.net
- Other barriers
- Local community resources

Prevention & Tx:
CONCRETE STRATEGIES

Prevention & Treatment Wellness Planning

- **S**leep
- **N**utrition
- **O**mega-3s
- **W**alk
- **B**aby breaks
- **A**dult time
- **L**iquids
- **L**aughter

See www.utahmmhc.org

Treatment Options for Perinatal Patients at high risk for suicide

- Ideal –specialized out-pt and in-pt options
- Mother-baby day tx offers high-profile tx while promoting attachment and the infant/mother relationship.
- Lowers impact of trauma of PPD
- Assures safety
- Contextualized tx much more appealing to new moms
- **St. Marks Perinatal IOP: (801) 268-7438**

Screening: EPDS

- Edinburgh Question #10: "The thought of harming myself has occurred to me."
- If she answers with anything other than 0, the provider must follow up to address threat of harm
- Ask questions, clarify - "Thoughts of self-harm are pretty common"
- Frequency, intensity, duration
- http://www.mededppd.org/CarePathwaysAlgorithm.pdf
- Immediate Perinatal Mental Health Assessment
- Do not avoid questions that are uncomfortable

Stanley Safety Plan Template

- https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf
- https://suicidepreventionlifeline.org
- 1-800-273-8255

Hotlines

1-800-PPD-MOMS

www.1800ppdmoms.org/

National Hopeline Network

1-800-784-2433 (800-SUICIDE)

www.hopeline.com/

National Suicide Prevention Lifeline

1-800-273-8255

Best options in Utah

- Nearest ER
- 911
- Give options
- Know limits of role
- Let go of outcome

- SLC:
- UNI Mobile Crisis Team
- Assessment in home
- (801) 587-3000

No imminent danger- high risk

- Ideally makes a safety plan for 24 hr care while waiting for an assessment with a specialist
- Help Me Grow ~ www.helpmegrowutah.or

  801.691.5322
- Plan to check back in with in 24-48 hrs
- Utilize PSI coordinators list for safety planning and follow up
- See www.utahmmhc.com
- www.postpartum.net
- 1-800-PPD-MOMS
- Encourage checking ins panel and UMMHC website as well as PSI

Psychiatric Hospitalization: Key Considerations

- R/o psychosis
- Undiagnosed Bi-Polar
- OCD vs Psychosis
- PPD vs. PTSD
- Pts that look "too good"
- Careful suicide screening
- Prescriber ed re: pregnancy and lactation
- Support for family

- Consider pt demographics
- Breast pump available
- Lactation support
- Support choices
- Baby visits
- SLEEP
- Careful d/c planning
- Specialized referrals

In Patient Hospitalization

Key considerations!

- Careful case coordination
- D/c planning
- F/u appointment made
- Linked up with local support groups
- PSI coordinator
- List of resources, websites etc.
- Wellness plan in writing
- Given to family etc.
- Concrete strategies

Provider Resources

- www.mededppd.com – CDC sponsored site for providers and families. Excellent current research and free Ces.
- www.womensmentalhealth.org MGH Center for Women's Mental Health: Reproductive Psychiatry Resource and Information Center. Harvard Medical School.
- www.motherisk.org Medication safety and resources.
- (800-944-4773) -Postpartum Support International. Largest perinatal volunteer organization with free phone support/ groups in every state and most developed countries. www.postpartum.net
- St Marks Perinatal IOP - (801) 268-7438

PMAD resources

- www.utahmmhc.com - Utah Maternal Mental Health Collaborative. Interagency networking, resource and policy development. See website for many resources, free support groups, etc.
- www.postpartum.net - Postpartum Support International. 2020mom partner and largest perinatal support organization. Resources and training for providers and families. Free support groups, phone, and email support in every state and most countries.
- http://www.mmhcoalition.com -National Coalition for Maternal Mental Health- Social Media Awareness Campaign, ACOG, private & non-profit.

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- What will YOU do in your scope of practice to increase detection and treatment?

Additional Resources

The following slides are for additional information for help and support

PSI Support for Families

- **PSI Support Coordinator Network**
- www.postpartum.net/Get-Help.aspx
  - Every state and more than 40 countries
  - Specialized Support: military, dads, legal, psychosis
  - PSI Facebook Group

- **Toll-free Helpline 800-944-4PPD** support to women and families in English & Spanish

- **Free Telephone Chat with an Expert**

PSI Chat with an Expert

- www.postpartum.net/Get-Help/PSI-Chat-with-an-Expert.aspx

- **Every Wednesday** for Moms
- **First Mondays** for Dads
- **New Chats** in development
  - Spanish-speaking
  - Lesbian Moms

PSI Membership

www.postpartum.net/Join-Us/Become-a-Member.aspx

- Discounts on trainings and products
- Professional and Volunteer training and connection
- PSI Chapter development
- Members-only section of website
  - List your practice or group, find others
  - Conference Presentations
  - Worldwide networking
- Professional Membership Listserves
  - PSI Care Providers; International Repro Psych Group
- Special student membership discount
- Serve on PSI Committees

PSI Public Awareness Posters

"You are not alone"

http://postpartum.net/Resources/PSI-Awareness-Poster-.aspx

PSI Educational Brochures English & Spanish

www.postpartum.net/Resources/PSI-Brochure.aspx

PSI Educational DVDs

99

Healthy Mom, Happy Family

13 minute DVD

Information, Real Stories, Hope

1-800-944-4773

www.postpartum.net/Resources

Support for Fathers

- Chat with an Expert for Dads: First Mondays
- Dads Website www.postpartumdads.org
- Fathers Respond DVD 8 minutes

Contact psioffice@postpartum.net to purchase DVD

Provider Resources

- www.2020momproject.org -California Maternal Mental Health Collaborative.
- www.postpartum.net - Postpartum Support International. 2020mom partner and largest perinatal support organization. Resources and training for providers and families. Free support groups, phone, and email support in every state and most countries.
- http://www.mmhcoalition.com -National Coalition for Maternal Mental Health- Social Media Awareness Campaign, ACOG, private & non-profit.
- www.womensmentalhealth.org MGH Center for Women's Mental Health: Reproductive Psychiatry Resource and Information Center. Harvard Medical School.
- www.motherisk.org Medication safety and resources.