Perinatal Mental Health:

Screening, Connecting, and Supporting Families During and After Pregnancy

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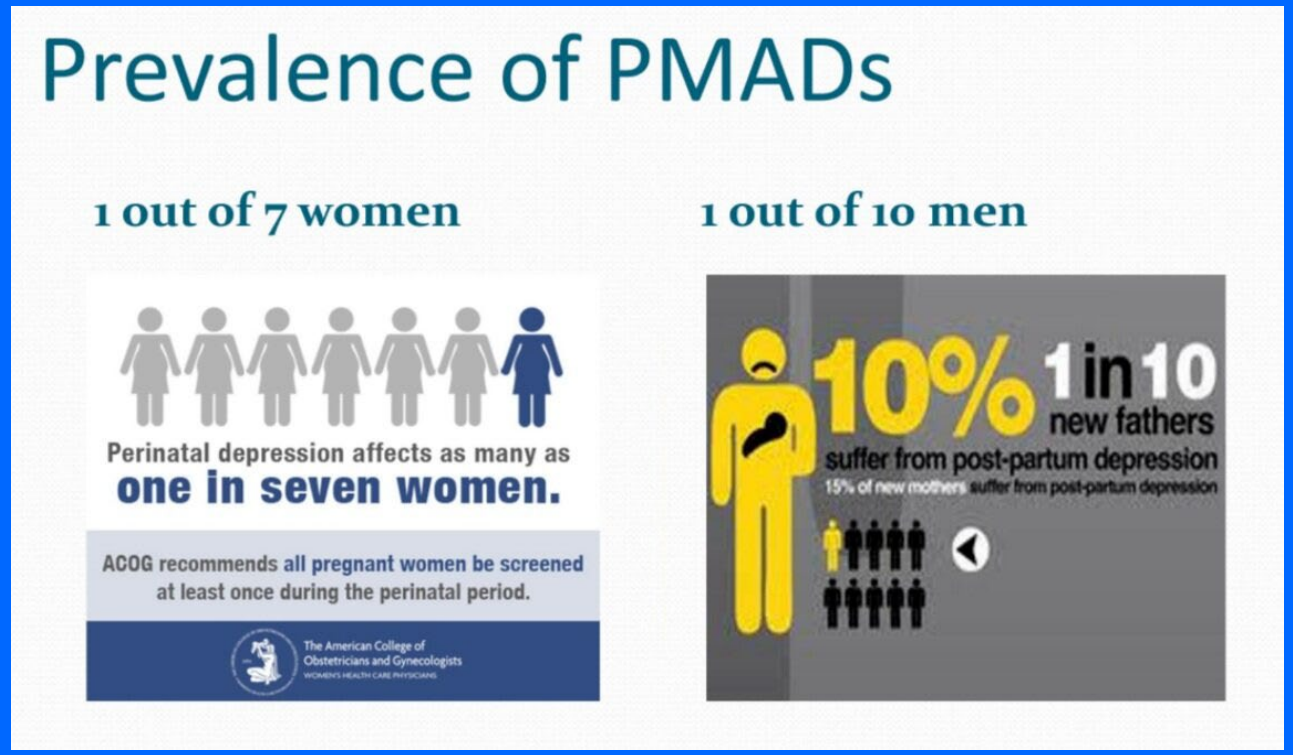
Objectives

1. Enhanced knowledge of perinatal prevalence and risk factors.
2. Participants will gain understanding of when and how to utilize screening tools to identify patients.
3. Participants will gain knowledge of existing resources for both providers and patients.
4. Enhanced empathy for the perinatal patient population.

Introduction to PMADs

- What is a PMAD and what do we know about prevalence?
- **P**erinatal: Occurring in pregnancy or the postpartum period
- **M**ood: Can include depression, bipolar, and psychosis
- **A**nxiety: Can include GAD, panic disorder, OCD, and PTSD
- **D**isorders: Symptoms and distress levels impact daily functioning

Prevalence of PMADs



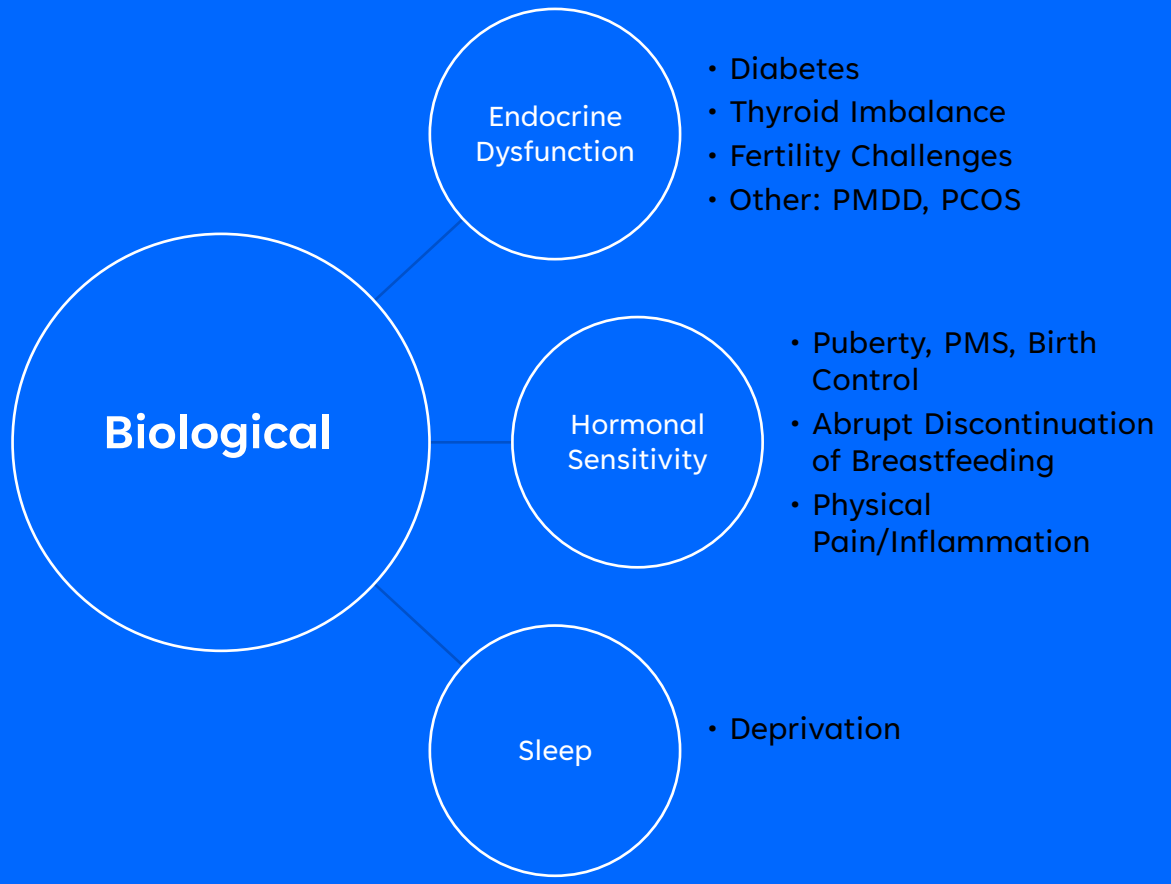
An estimated 15–21% of pregnant and postpartum women experience PMADs, with 1 in 7 affected by perinatal depression and 13–21% affected by perinatal anxiety

(Fairbrother et al., 2015; Byrnes, 2018)

Who is Impacted?

- Research demonstrates that postpartum depression is a universal experience.
- Studies continue to identify similar rates of perinatal depression in women throughout the world in comparison to the US and Western Europe.
- Additional studies in relation to global epidemiology seek to differentiate rates based on factors such as country or region development and country or region income.

Risk Factors: Biological



Risk Factors: Psychosocial

Psychological	Social/Environmental	Psychiatric History
• Relationship with own mother • Self-Image • Ambivalence to parenthood	• History of trauma • Poor social support • Institutional or structural racism	• Family or personal history of PMADs • Family or personal history of depression, anxiety, OCD, eating disorder, bipolar, etc. • History of childhood sexual abuse

Exacerbating Psychosocial Risk Factors

Interpersonal Violence	Relationship Stress	Financial Stressors/Poverty	Childcare Stressors	Recent Move or Relocation
Barriers to Care	Institutional Racism	Seasonal Depression/Mania	Complications in Pregnancy, Birth, or Breastfeeding	Health Challenges (Infant or Parents)
Temperament of Baby	Returning to Work	Recent or Unresolved Grief/Loss	Estrangement/Loss of Own Mother	Past Infant/Pregnancy Loss or Abortion

Depressive Disorders

Baby Blues: *the non-disorder*

- 60-80% of new mothers
- *NOT* mild depression
- Attributed to hormone fluctuation and acute sleep deprivation
- Onset and duration 2 days through 2 weeks post birth

Major Unipolar Depression *with Peripartum Onset*

Common peripartum onset presentation:

- •Overwhelmed, unable to cope
- •Inability to take care of self and/or family
- •Frequent co-morbidity with anxiety
- •Isolation, social withdrawal
- •Agitation, irritability
- •"This doesn't feel like me"
- •Increase in somatic symptoms

Bipolar I/II *with Peripartum Onset*

- Over 69% misdiagnosed with unipolar depression
- Peripartum onset recognized in DSM-5
- 50% of women with bipolar disorder are first diagnosed during postpartum period
- 71% relapse during pregnancy *(Viguera et al, 2007)*
- 70% relapse within 6 months postpartum *(Sit et al, 2006; Bergink et al, 2015)*
- Stopping mood stabilizers during pregnancy increases the risk of re-occurrence

Baby Blues or Depression?

Baby Blues is characterized by tearfulness, mood lability, reactivity, and exhaustion. Predominant mood is still happy, and self-esteem is unchanged.

When differentiating for diagnosis consider:

1. Severity/Intensity
2. Timing/Onset
3. Duration/Chronicity

*If symptoms persist *after* 2 weeks postpartum this is *NOT* the Baby Blues!

Healthy Mom Happy Family

Anxiety Disorders and OCD

Generalized Anxiety Disorder

- Remember to consider the circumstances when evaluating the excessiveness of worry. (Medically fragile example)
- Prevalence for prenatal anxiety is 15.8%

(Fairbrother et al.,2016)

Panic Disorder

Three Greatest Fears:

- Fear of dying
- Fear of going crazy
- Fear of losing control

Obsessive Compulsive Disorder

- Perinatal women are 1.5-2X greater risk for OCD onset than general population. *(Oguz, 2011)*
- 65% have co-morbid depression *(Miller et al., 2013)*
- Ego-dystonic thoughts may include thoughts of harm coming to the baby. These thoughts create *distress* for the mother.

“That first night, after we returned from the hospital, I suffered my first anxiety attack,” she recalls. “I felt like I had already disappointed my child. I felt like I failed as a mother, since I was not able to give birth vaginally or nourish him with the breast milk that had not come in yet. My heart raced. My stomach seized up. I felt like I was dying.”

Alyssa Milano

Common Perinatal Presentations of OCD

- 41% Fear of Deliberate Harm
- 29% Contamination
- 18% Accidental Harm
- 6% Ordering/Arranging
- 3% Religious
- 3% Checking

Risk of OCD Thoughts of Harm

LOW Risk

The parent does ***not want*** to harm the baby

LOW RISK

LOW Risk

The thought is obsessive in nature and odd or frightening to the individual

LOW RISK

LOW Risk

Parent has taken steps to protect the baby

LOW RISK

LOW Risk

Parent has ***NO*** delusions or hallucinations

LOW RISK

HIGH Risk

Parent has delusional beliefs about the baby

HIGH RISK

Thoughts *do not* Equal Action

Providers *MUST* ask about *scary* or *unusual* thoughts!

- Educate the individual that thoughts ***do not*** equal action.
- Thoughts are just thoughts.
- Nearly 70% of health care practitioners did not accurately identify obsessions of harming the infant, and 30.8% misidentified these symptoms as psychotic. (Mulcahy et al., 2020)

Video: Shoshana's Story

Perinatal Psychosis: Prevalence

1-2 in 1,000 postpartum women will develop Perinatal Psychosis

- Of those women affected by perinatal psychosis:
  - 5% die by suicide and 4.5% commit infanticide *(Brockington, 2017)*
  - 50% of first-time mothers who experience psychosis had no previous psychiatric hospitalization *(Valdimarsdottir et al., 2009)*
  - Onset usually occurs within the first two weeks post-birth *(Manzon et al., 2014)*

Presentation of Postpartum Psychosis

Onset	• Usually within 2 weeks postpartum
Cognitive	• Poor Concentration imparied sensorium*, disorientation
Behavioral	• Agitated, hyperactive, emotionally distant, aloof, lack of self-care
Mood	• Elated, labile, dysphoric or less often depressed

*acute dysfunction in the brain

Presentation of Postpartum Psychosis (continued)

Speech	• Rambling
Thought Content*	• Delusions • Thought broadcasting, ideas of reference, persecutory, jealousy, paranoia, being controlled, grandiosity
Though Process*	• Disorganized thinking, flight of ideas
Perceptions*	• Hallucinations • Commanding auditory, organic (visual, olfactory, tactile)

*acute dysfunction in the brain

Postpartum Psychosis Risk

Risk Factors

- First baby
- Discontinuation of mood stabilizer
- Perinatal or neonatal loss
- Previous bipolar episodes, psychosis or postpartum psychosis
- Sleep deprivation
- Family history of bipolar disorder or postpartum psychosis

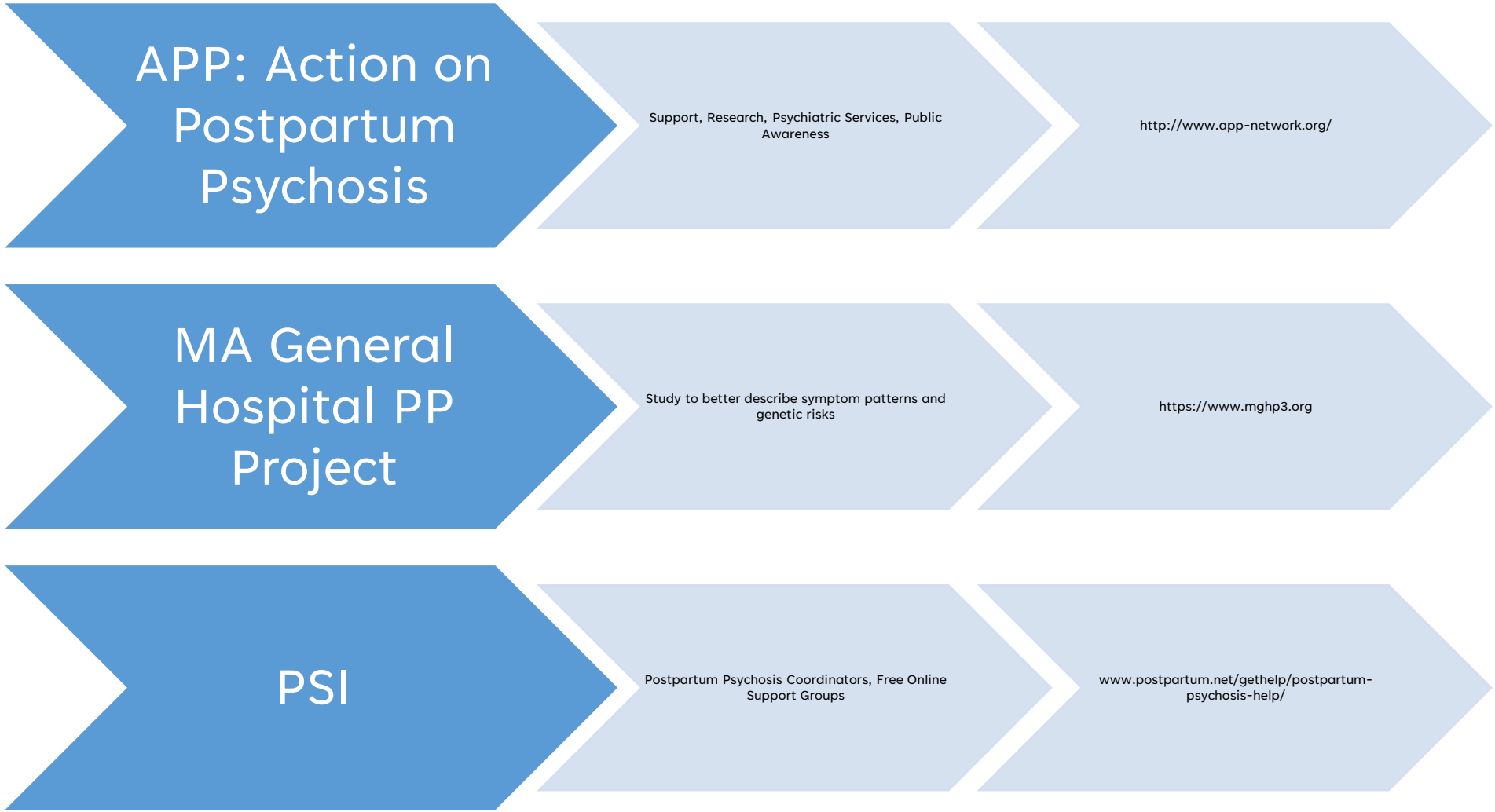
Reducing Risk

- Remain on medication for bipolar disorder throughout pregnancy
- Initiate preventative treatment immediately postpartum for women with a history of postpartum psychosis
- Protecting good quality sleep

Recurrence Risk

- Limited information on longitudinal disease course after first onset postpartum psychosis. *(Gilden et al,. 2020)*
- 29% recurrence risk with history of PP in subsequent pregnancy *(Gilden et al., 2020; Wesseloo et al., 2016)*
- Estimated 43.5% of women with postpartum psychosis ***did not*** have episodes outside the perinatal period in a 16 year follow up period. *(Gilden et al., 2020)*

With intervention and adequate treatment, *nearly all* individuals experiencing postpartum psychosis *achieve full remission* and the majority achieve *good functional recovery*



Fathers Talk About Postpartum Psychosis

What About Trauma?

Perinatal PTSD Prevalence

Community samples show mean prevalence of prenatal PTSD was 3.3.%

The reported prevalence of postpartum PTSD was 4% in community samples and 18.5% in high-risk groups.

**High risk being defined as current maternal depression, history of psychiatric illness and infant complications.*

Yildiz et al., 2017

Birth Trauma

An event occurring during the labor and birth process that can involve actual or threatened serious injury or death to the mother or her infant or the women being stripped of their dignity.

The birthing person may experience intense fear, helplessness, loss of control, and horror. *(Beck et al., 2013; Beck 2004)*

The reported prevalence of PTSD due to birth trauma was 3% in community samples and 16% in high-risk samples. (Grekin & O'Hara, 2014)

Maternal Mortality

In 2021, 1,205 women died of maternal causes in the United States compared with 861 in 2020 and 754 in 2019. (*CDC, 2023)*

The maternal mortality rate for 2021 was 32.9 deaths per 100,000 live births, compared with a rate of 23.8 in 2020 and 20.1 in 2019. (*CDC, 2023)*

Approximately 50,000 women suffer severe maternal morbidity factors that are near-fatal. *(CDC, 2020)*

Potentially Traumatic Perinatal Events

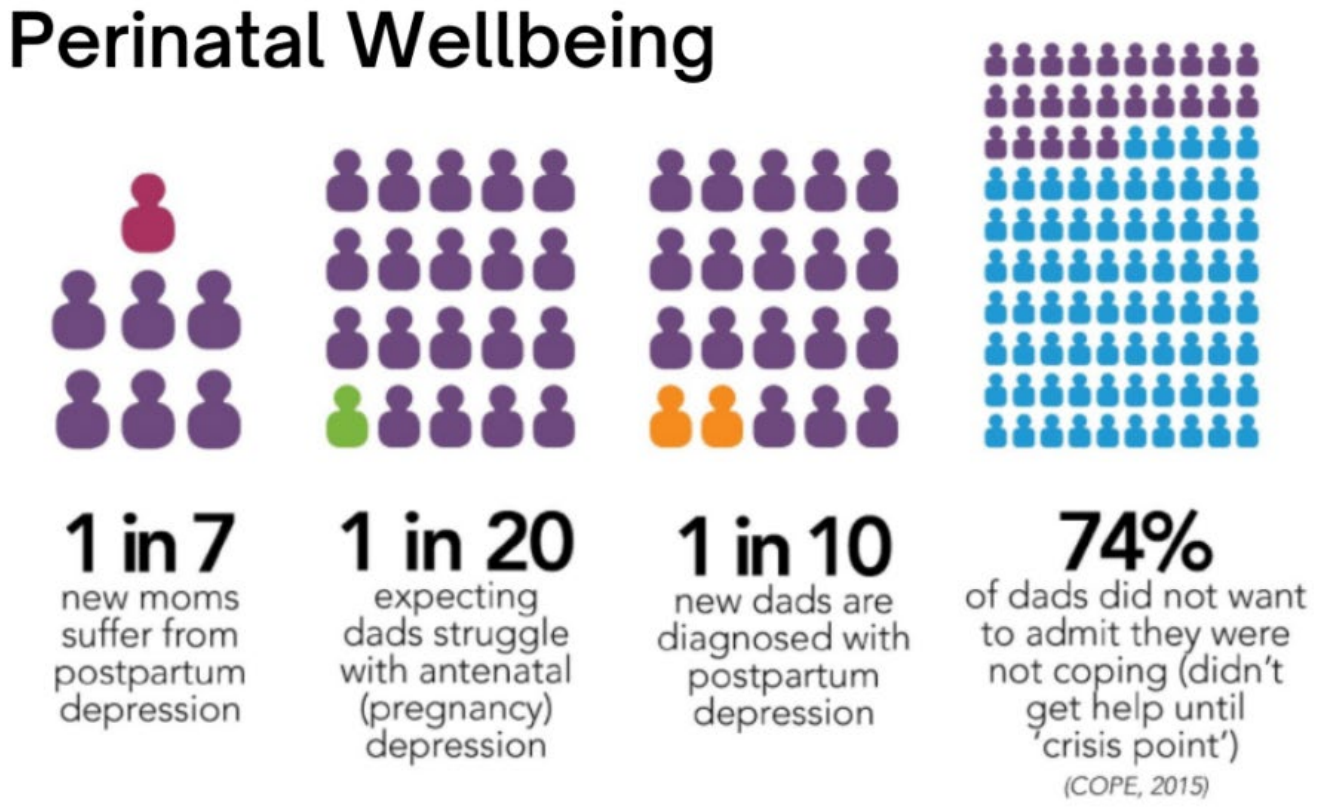
- Emergency Caesarean Delivery
- Traumatic Vaginal Birth
- Postpartum Hemorrhage
- Prematurity or Stillbirth
- Unexpected NICU Admission
- Forceps/Vacuum Extraction
- Severe Pre-eclampsia
- 3rd or 4th degree laceration
- Fetal anomaly diagnosis in pregnancy
- Witnessing partner's birth experience
- Shoulder Dystocia
- Long labor process
- Failed pain medication or poor response to anesthesia
- Maternal near miss
- Hyperemesis Gravidarum

Impact of Trauma and PTSD

Potential Consequences							
Avoidance of postpartum care	Impaired parental-infant bonding	PTSD in partner who witnessed traumatic birth	Sexual dysfunction	Avoidance of further pregnancies	Elective cesarean births in future pregnancies	Breastfeeding challenges	Annual reminder of trauma

Can fathers and non-birthing partners have PMADs too?

Prevalence Rates of Paternal Perinatal Depression



Paternal Risk Factors

Maternal Depression	Relationship Dissatisfaction	Finanacial Burden
Sleep Deprivation	Isolation/loneliness	History of Depression

Paternal Presentation

- Often Masked: irritability, aggression, hostility
- Distancing: "Checked-out" or isolated
- Distractions or Habits: Increased substance use

Contributing Factors

- Hormone Shifts (especially 2 and 9 months postpartum)
- Sleep deprivation
- Increased stressors

Consequences

- Associated with adverse child outcomes
- Increased negative parenting and decreased positive parenting behaviors

Support

- PSI Dad's Chat with an expert
- www.postpartumdads.org
- www.postpartum.net/get-help/resources-for-fathers/
- www.postpartum.net/get-help/resources-for-fathers/dads-mental-health/

Cultural Considerations and Special Populations

- BIPOC Parents and Families
- LGBTQIA+ Parents and Families
- Adolescent Parents
- Military Families
- NICU Parenting
- Parenting Multiples
- Parents with Disabilities
- Parents with Substance Use Disorders
- Single Parents
- Adoptive Parents (PADS: Post Adoption Depression Syndrome)

Cultural Factors to Consider

Cultural Differences

- Diversity of symptom expression and reporting
- Level of safety and comfort seeking help
- Maternal expectation based on sociocultural norms

PPD Prevalence

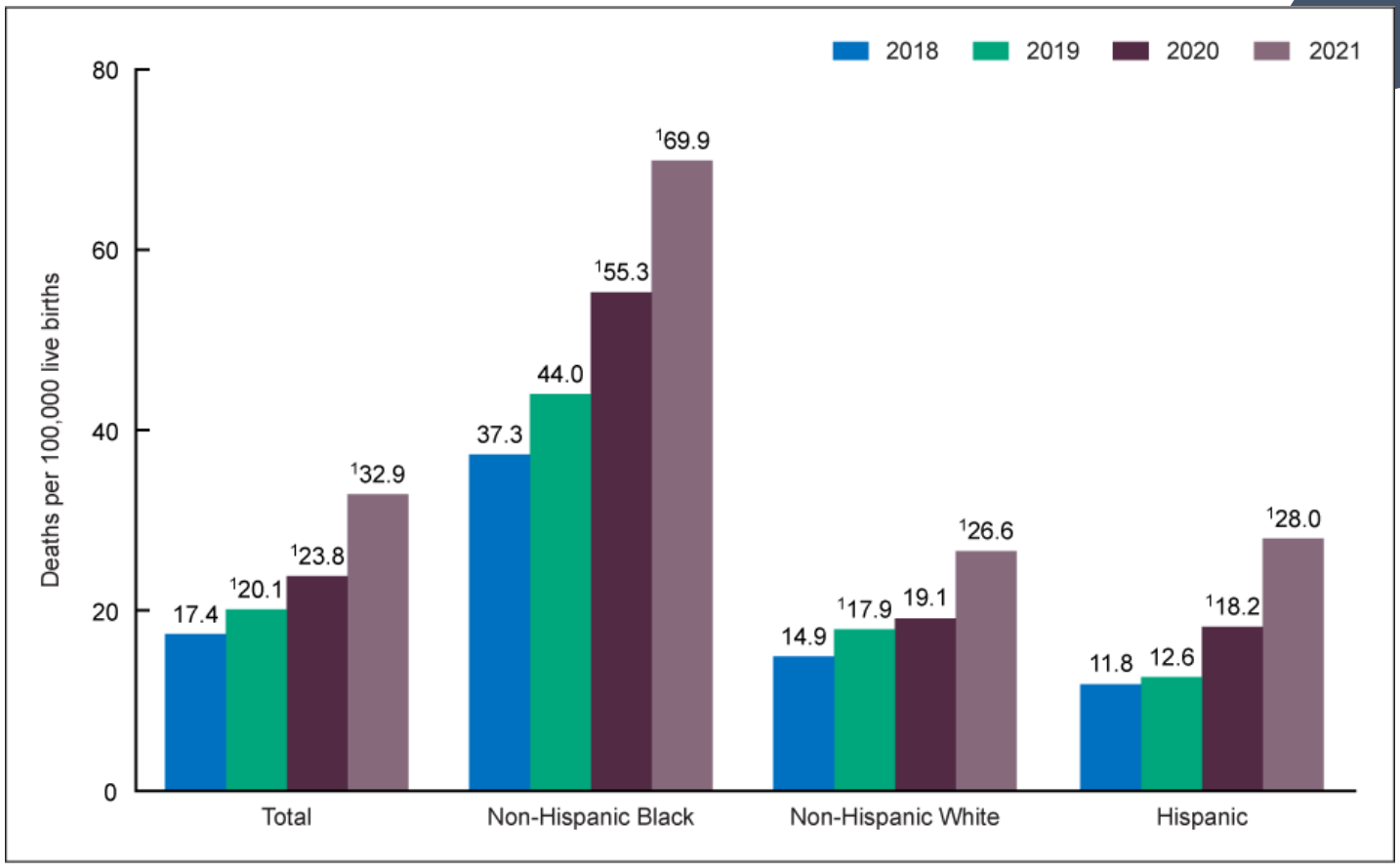
- Rates not well studied in BIPOC women
- Estimated at 6.8-52% of Black women
- Estimated at 14-29.7% of American Indian/Alaska Native women
- Estimated 4.6% Asian American women vs. 3.5-63.3% of Asian woman across Asian countries

Black mothers in the US are 4x more likely to die from maternity related complications compared to white mothers.

Maternal Mortality in the US

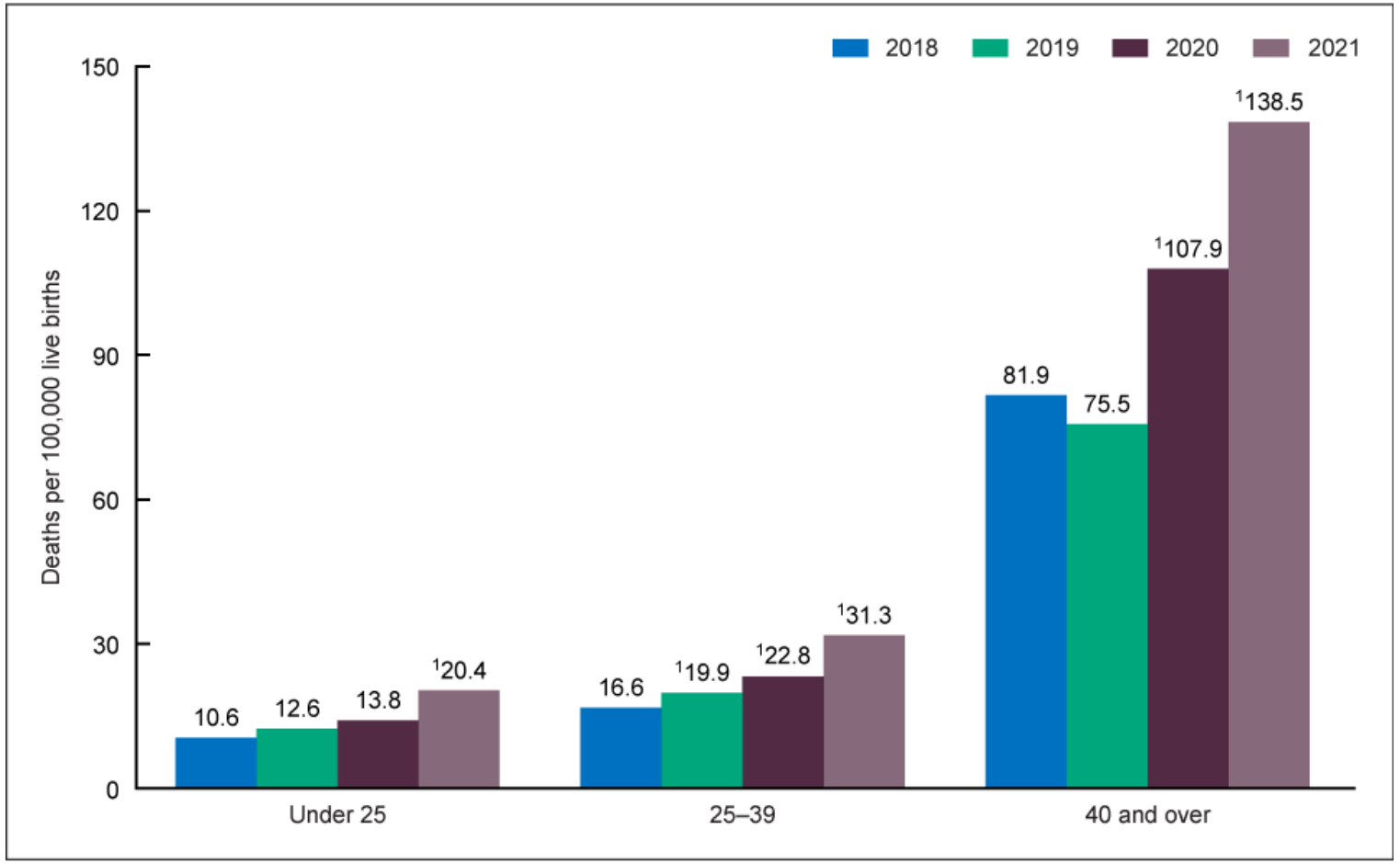
- 43.5 deaths per 100,000 live births for Black women
- 14.4 deaths per 100,000 live births for women of other ethnic/racial groups
- 12.7 deaths per 100,000 live births for White women

Maternal Mortality Rates by Race



[1]Statistically significant increase from previous year ($p < 0.05$).
NOTE: Race groups are single race.
SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

Maternal Mortality Rates by Age



[1]Statistically significant increase from previous year ($p < 0.05$).
SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

Prevention through Screening

Why

- No visual indicators
- High prevalence rate
- Risks of untreated PMADs are well documented
- Easily identified risk period (pregnancy-1 year post birth)
- Risk peaks at 3 months post birth
- PMADs are treatable!

When

- First prenatal visit
- 2nd Trimester
- 3rd Trimester
- Six-week postpartum OB visit/first postpartum OB visit
- 6 and 12 months postpartum (OB or PCP)
- Routine pediatric visits (3, 9, 12 months)

How

- Discussion tools
- Evidence based screeners/other screening tools
- Private and safe environment
- Explain screener and that entire population is screened
- Mindful of cultural and literacy differences
- Clinical judgement
- Safety planning

Screening Tools for PMADs

EPDS	PHQ9	PASS	PDSS
Edinburgh Postnatal Depression Scale	Patient Health Questionnaire	Perinatal Anxiety Screening Scale	Postpartum Depression Screening Scale
Validated	Validated	Western Australia	Must buy it to administer
Most Common	Broad Range	Longer: 31 questions on likert scale	35 items, 5 pt Likert, with 7 subscales
Easy to score	Easy to Score	Overall anxiety and differentiates types of anxiety	Given 2 weeks postpartum

Positive Screen for Suicidal Ideation

- **EPDS**
  - Question 10: "The thought of harming myself has occurred to me."
- **PHQ-9**
  - Question 9: "Thoughts that you would be better off dead..."
- **If the answer is anything other than 0:**
  - **Assess**: Use a more comprehensive suicide assessment and create a safety plan
  - **Refer**: Clarify your role, give resources (crisis lines, medical evaluation, urgent care, etc.)
  - **Follow up**: Ask for permission to include a support person in the safety plan and follow up. Set a time to check in with patient/client again (phone, session, etc.)

In an emergency you do not need permission to communicate about safety

“Oftentimes, the main difference between the mother who kills herself and the one who doesn't is whether it'll be better for the baby. The thing that raises the hair on the back of my neck is the woman who tells me she thinks her baby will be better off without her. She is at very high risk for suicide.”

Raskin & Kleiman, 2013

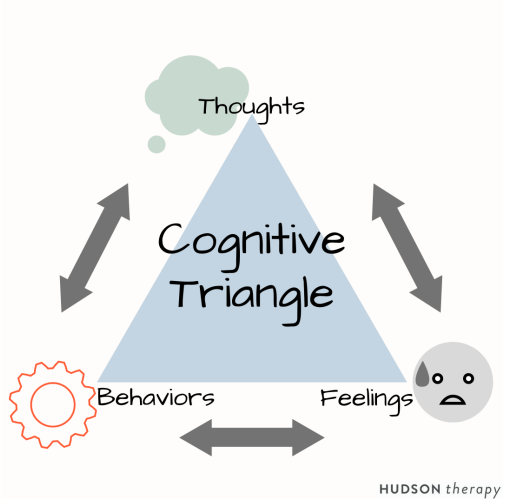
Suicide is one of the leading causes of maternal mortality in the US

- More likely to endorse suicidal ideation
- Increased risk indicated by:
  - Unwanted pregnancy, denied abortion
  - Intimate partner violence
  - Less than 12 years of education
  - History of pregnancy loss or death of a child
  - Psychiatric illness or stopping medication abruptly

Evidence Based Psychotherapeutic Treatment Models- CBT

Cognitive Behavioral Therapy (CBT)

- Identify, evaluate, and change dysfunctional patterns of thinking.
- Best for perinatal depression and anxiety
- Mindfulness-Based CBT is especially helpful for relapse prevention



Common Components

- Client/Therapist Collaboration
- Relaxation Training
- Psychoeducation on CBT Model
- Assertiveness Training
- Fostering Resilience
- Desensitization/Exposure Therapy
- Cognitive Restructuring

Evidence Based Treatment- Interpersonal Psychotherapy (IPT)

General Overview

- Based on attachment theory
- Helps modify disrupted relationships and/or expectations
- Empirically validated, time-limited therapy (12-16 weeks)
- IPT-P (perinatal): manualized for perinatal depression treatment
- Treatment goals: symptom relief and reintegration

Evidence Based Treatment- Interpersonal Psychotherapy (IPT)

Grief: "What have I lost?"

- Grieve old role and rejection or poor adaptation to new role
- Identify feelings and normalize experience
- Explore conflicted feelings about loss

Role Transitions:

"Where am I now?"

- Identify psychosocial and physiological changes
- Recognition of life-cycle and social transitions
- Develop new coping skills
- Develop new attachments and social supports

Interpersonal Role Disputes: "What Do I Need?"

- Modify communication patterns
- Reevaluate expectations in relationships
- Learn to effectively communicate needs to others
- Often includes couples counseling

Evidence Based Psychotherapeutic Treatment Models- Attachment and Parent-Infant Therapies

Program Examples

- Watch Wait and Wonder
  - https://watchwaitandwonder.com
- Child Parent Psychotherapy
  - https://www.nctsn.org/interventions/child-parent-psychotherapy
- Circle of Security
  - https://www.circleofsecurityinternational.com

Positive Attachment Goals

- Experience the infant as a vital and contributing individual in the relationship
- Experience the infant's behavior without insecure projection and negative interpretation
- Accept the infant's behavior and feelings and tolerate own feelings
- Develop reflection, patience, and acceptance
- Learn that the infant can have their own thoughts and feelings

Evidence Based Psychotherapeutic Treatment Models- Couples Therapy

Benefits

- Individual feels it is not just her/his problem
- Models collaborative problem-solving and supports compromise and long-term conflict resolution.
- Partner takes a role in treatment and becomes an active support

Goals

- Create a safe space for each partner to share
- Educate the couple
- Normalize both individual and dyadic experiences
- Therapist serves as a "translator", "coach", and grief counselor.
- Help establish support systems

Challenges

- Setting up childcare
- Partner's willingness to attend and participate
- Neutrality by the therapist
- Modeling transparency (no secret keeping by the therapist)

*Couple's therapy is ***contraindicated*** when interpersonal violence is present within the relationship.

RESOURCES:
Professional Organizations

- PSI: Postpartum Support International
- International Marce Society of Perinatal Mental Health
- Marce of North America
- Pregnancy Loss and Infant Death Alliance
- National Association of Perinatal Social Workers
- American Society for Reproductive Medicine
- North American Society for Psychosocial Obstetrics and Gynecology
- Association of Women's Health, Obstetric and Neonatal Nurses
- American college of Obstetrics and Gynecology
- Maternal Mental Health Now

RESOURCES:
PSI Provider Resources

- Frontline Provider Training: Ob/Gyn, PCPs, NPs, Midwives, PAs, Nurses
  - Assess, treat, and connect
  - 6-hour course: in person and online options providing CMEs or CNEs
- Frontline Provider Consult Line
- Perinatal Mental Health Alliance for People of Color
- La Alianza: The Alliance continues to close the gap in perinatal mental health support services by expanding its reach to the LatinX and Spanish-speaking community.
- Virtual Peer Consultation and Supervision (PSI Members)
- Perinatal Psychiatric Consult Service: 800-944-4773, ext 4
  - http://www.postpartum.net/professionals/perinatal-psychiatric-consult-line/

RESOURCES: Further Training

- Postpartum Stress Center: Karen Kleiman
  - Karen Kleiman Training Center | Postpartum Stress Center
- PSI: Certificate training with tracks for different professions, as well as ongoing trainings.
- PESI: Guiding Women Through Postpartum Depression, Perinatal Loss, Grief, PMDD, and More
  - Features training by Hilary Waller, MSW, LPC Faculty at the Postpartum Stress Center

RESOURCES:
PSI Client/Patient Resources

PSI: Postpartum Support International: www.postpartum.net

- Help Line
  - Call 1-800-944-4773 (4PPD) #1 En Español or #2 English
  - Text in English: 800-944-4773 Text en Español: 971-203-7773
- Online Provider Directory: qualified perinatal mental health professionals and groups in the United States and Canada.
- Support Coordinators: In every state and in more than 40 countries.
- Facilitated Virtual Peer Support Groups
- Chat With an Expert: Weekly group phone calls for moms and dads (2 separate group calls)

PSI: Chat with an Expert for Moms

- FREE Live Phone Sessions
- Every Wednesday
- During these sessions you can connect with other moms and talk with a PSI expert about resources, symptoms, options and general information about perinatal mood and anxiety disorders from the privacy of your own phone. There is no need to pre-register or give your name. These sessions, facilitated by licensed mental health professionals, are informational only and open to anyone with questions and concerns. Limited to the first 15 callers.
- Chat Number: 1-800-944-8766
    - Participant Code: 73162

PSI: Chat with an Expert for Dads

- FREE Live Phone Sessions
- Monthly on the first Monday of the month
- What can I do to support my partner? Am I the only guy who's struggling with becoming a dad? Join our Chat with an Expert phone forum the first Monday of every month for reliable information, support, and resources.
- This is a place where dads, partners, extended family members or other support people, and professionals can find some answers and support from an expert – and from other men. You'll find honest and compassionate talk about the adjustment to parenthood, information about how fatherhood can affect you, and some helpful advice.
- Chat Number: 1-800-944-8766
    - Participant Code: 73162#

PSI: Peer Mentor Program

Dedicated Support From A Parent Who Has Been In Your Shoes

PSI has a new resource for parents struggling with perinatal mental health challenges—the Peer Mentor Program. This program pairs individuals in need of support with a trained volunteer who has also experienced and fully recovered from a Perinatal Mood Disorder (PMD). Establishing a one-to-one connection with someone who has journeyed through a PMD offers invaluable insight, encouragement, and hope.

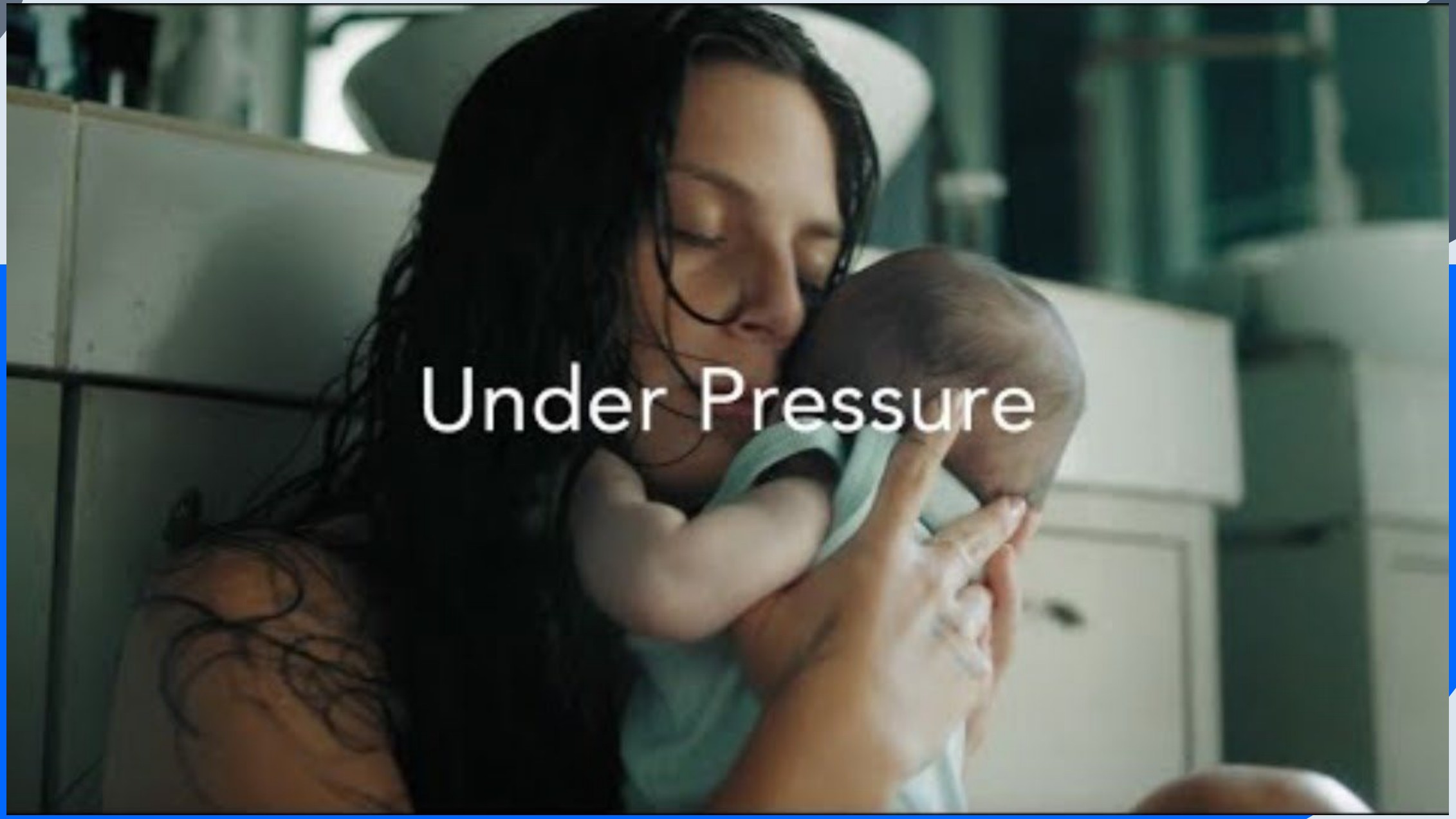
Peers and Mentors build strong relationships that remove isolation, provides education, and breaks down stigma through weekly communication while in the program. Peers and Mentors are thoughtfully matched. Perinatal experiences, family context and other individual nuances are all considered to create a safe peer-to-peer environment that fosters trust, support, and connection.

PSI: Online Support Groups

- All groups are FREE and virtual
- What to Expect
  - 90 minutes (1.5 hours) in length
  - The first ~30 minutes is providing information, education, and establishing group guidelines.
  - The next ~60 minutes is “talk time,” in which group members share and talk with each other.
- Student and clinical observations are ***not*** allowed in our group spaces due to confidentiality and creating a safe space
- 50+ Groups: Examples include Birth Trauma, BIPOC, Latinx, NICU Parents, Stillbirth and Infant Loss, Postpartum Psychosis, Pregnancy After Loss, and many more!

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

Postpartum Support International


Under Pressure

Thank you

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