Perinatal Mental Health Disorders: Fundamentals in Psychotherapy
Utah Maternal Mental Health Collaborative

- www.utahmmhc.com
- Utah Resources
- Utah PSI Chapter- social support services
- Multi-agency stakeholders
- Ideas, information exchange
- Project development
- Meets Bi-monthly on first Fridays 8:30-10am
Motherhood is exactly what I thought it would be.

Said no one ever.
Session Objectives

- Understand the symptoms, prevalence, & impact of mood & anxiety disorders in perinatal women

- Describe evidenced based treatment options and concrete wellness tools

- Explain key components of perinatal mental health assessment, treatment & wellness planning

- Describe resources for families and providers
Defining the issue:

What is Maternal Mental Health?
Not only depression
Not only postpartum!
Perinatal Mood, Anxiety, Obsessive, Trauma, & Psychotic disorders
Why is it relevant to psychotherapists?
What didn’t we learn in graduate school?

- No graduate level perinatal mental health training program in US
- DSM V makes little/no distinction between perinatal psychiatric illness and others
- “With Peripartum Onset” specifier includes pregnancy but PP limited to first 4 weeks PP.
- Old myths perpetuate
Why do therapists need specialized training for perinatal clients?

- Symptomatology unique to perinatal period
- Current research and understanding outside DSM V
- Lack of masters level training
- Assessment and intervention methods unique
- Perinatal factors influence treatment and assessment decisions
- Greater risk of psychological harm w/o background
- Pregnancy & nursing particularly relevant to Tx
- 50% of women with PMADS will not seek tx - first contact crucial
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
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.

The 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.
DEPRESSION IN WOMEN

- Leading cause of disease-related disability
- Reproductive years - highest risk
- Most amenable to Tx
Suicide is the second leading cause of death in the first year postpartum.
PMADs
Demographics & Statistics

Every:
- Culture
- Age
- Income level
- Educational level
- Ethnic group
- Religious affiliation
JAMA 2013 ~ 22%

- 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
PMADs

15-20%

- 800,000 women a year in U.S.
- 1/3 PMADs begin in pregnancy
- Teenage & low income mothers
Utah PRAMS data 2000-2001 ~ 60%?

Self-Reported Postpartum Depression

- None: 31%
- Slightly depressed: 4%
- Moderately depressed: 3%
- Very depressed: 18%
- Very depressed and needed help: 44%
Percentage of Utah Women Who Reported PPD Symptoms, PRAMS 2004-2008
Percentage of Utah Women Who Experienced Postpartum Depression Symptoms and Did Not Seek Help, 2004-2008
PRAMS data cont.: Barriers to help-seeking

- A lack of awareness of what depression feels like and how to seek help
- Negative attitudes and misconceptions about depression
- Lack of affordable and appropriate treatment

(SAMHSA); Mental Health America. Maternal Depression: making a difference through community action: a planning guide. SAMHSA monograph 2008.
“In addition, women whose prenatal care was covered by Medicaid were twice as likely to report PPD as were women whose prenatal care was covered by private insurance. Because most women lose Medicaid coverage within 60 days of delivery, many women suffering PPD are left without a source of payment for needed services.”
PMADs
Common Comorbid Disorders

- Alcohol abuse
- Substance abuse
- Smoking
- Eating disorders
- Personality disorders

- Frequently referenced, poorly researched (Stone, 2008)

- In women with MDD in general population, up to 60% suffer from comorbid disorders

(US Dept. of Health and Human Services, 1999)
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, Anxiety, Obsessive, & Trauma related Disorders

- Psychosis- Thought Disorder or Episode
- Major Depressive Disorder
- Bi-Polar Disorder
- Generalized Anxiety
- Panic Disorder
- Obsessive Compulsive Disorder
- Post Traumatic Stress Disorder

Pregnancy and the First year Postpartum
Perinatal Mood Disorders

- Baby Blues – Not a disorder
- Major Depressive Disorder - Most researched
- Bipolar Disorder
I went to the doctor for fatigue and forgetfulness, and I was diagnosed with Motherhood.
Depression/anxiety during pregnancy is a strong predictor of postpartum mood and anxiety disorders

MYTH:

Pregnancy protects women from psychological disorders
PREGNANCY DEPRESSION/ ANXIETY
Risk Factors

- Prior depression/ anxiety
- Unwanted pregnancy
- Domestic violence
- Substance abuse
- Abuse
- Discord with partner
- Medical complications in mother

- Prior perinatal loss
- Complications in baby
- Social isolation
- Poor support
- Discontinuing anti-depressant (50-75% relapse)

10%
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 Thx
- 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


PREGNANCY DEPRESSION/ANXIETY IMPACT

Illness crosses the placenta

- Anxiety $\rightarrow$ Uterine Artery Resistance
  $\rightarrow$ Decreased blood flow to placenta
- Low birth weight/lower APGAR scores/smaller size
- Miscarriage
- Pre-term delivery/other obstetric complications
- Heightened startle response
- Relationship with partner
- Postpartum Mood & Anxiety Disorders (↑ by 80%)
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
Trimesters of pregnancy:

1st: Sick and tired.
2nd: Awww baby kicks!
Baby Blues

Not a disorder

- 80%
- Transient
- Often PPD is normalized as BB
Baby Blues

- 3rd - 5th day
- Few hours/ days
- Good periods
- Overwhelmed, tearful, exhausted, hypomanic, irritable

With support, rest, and good nutrition, the Baby Blues resolve naturally.

Persisting beyond 2 weeks, likely PPD or related disorder.
You're making it difficult for me to be the parent I always imagined I would be.
Postpartum Depression Prevalence
15-20%

22%
(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
Postpartum 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 296.xx (F32.x and F33.x)

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
Coding ~ DSM V & ICD-10

- “With anxious distress”
- “With peripartum onset” ~ pregnancy finally included
- Defined as the most recent episode occurring during pregnancy as well as in the **four weeks** following delivery.
- Note discrepancy between known clinical presentation and our diagnostic and coding systems
- ICD-10-CM code F53 (puerperal psychosis) should be reported for a diagnosis of postpartum depression. “Though the description of ICD-10 code mentions the term “puerperal psychosis,” a more severe form of postpartum illness, it can still be used to report postpartum depression.”
- F33 most commonly used
Coding ~ DSM V & ICD-10

- “With peripartum onset”
- Major Depressive
- Manic or Mixed Episode of Major Depressive Disorder
- Bipolar I Disorder
- Bipolar II disorder
- Brief Psychotic Disorder
DSM VI: Future considerations?

- Retaining onset specifier for peripartum
- Add to OCD
- For bi-polar keep duration to 4 weeks for manic or mixed episode
- For unipolar extend duration for 6 months PP
- Mixed depression and Anxiety Disorder??
DSM V considerations/frustrations cont.

- Conflicting research/poor research design—conflicting results challenging what is observed in clinical practice

- Debate over increase in depressive episodes during pregnancy

- Clear link between Bi-polar and increased risk in the perinatal period as well as differentiated presentation (psychosis)

- No mention of PP OCD
DSM IV-Diagnostic challenges

- Work within existing framework.
- Add specifier if sx began in first 4 weeks – careful hx gathering
- “With anxious distress”
- W/ peripartum component
- “Perinatal Mental Health Assessment”
What really matters

- Treatment progresses appropriately regardless of how coded.
- Perinatal considerations within assessment & treatment
- Clients are informed about increased risks, norms for sx of dx in the time period.
- Clients given range of support/information options
- Insurers need client/provider feedback about the need for specialists
Postpartum Depression Risk

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

- Previous PMADs
  - Family History
  - Personal History (30%)
  - Symptoms during Pregnancy

- History of Mood or Anxiety Disorders
  - Personal or family history of depression, anxiety, bipolar disorder, eating disorders, OCD, or thought disorders

- Significant Mood Reaction to hormonal changes
  - Puberty, PMS, hormonal birth control, pregnancy loss, abortion
Risk Factors, cont.

- **Endocrine Dysfunction**
  - Hx of Thyroid Imbalance
  - Other Endocrine Disorders
  - Decreased Fertility

- **Social Factors**
  - Inadequate social support
  - Interpersonal Violence
  - Financial Stress/Poverty
  - TRAUMA
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](https://doi.org/10.1038/npp.2013.238)

Epigenetic Biomarkers of Postpartum Depression

- Estrogen - closely tied to both the hypothalamic pituitary adrenal (HPA) axis as well as inflammation

- Further research may unify disparate explanations

- Common etiology of estrogen sensitivity/vulnerability
Bipolar Disorders
DSM 296 etc. F30-34

22% of depressed postpartum women have BP

(Wisner KL, Mc Shea, et al JAMA Psychiatry 2013)

Bi-Polar I

- Depression + Manic Episodes
- Mania is high risk for Psychosis
- Immediate Psychiatric Assessment
- Bipolar I vs. Bipolar II “Hypomanic episodes”
- Bipolar II “PPD Imposter”
Bipolar I and II;

- A Major Depressive Episode includes at least 5 of the following symptoms occurring over the same 2-week period and must include either #1 or #2:

  - Depressed mood most of the day, nearly every day, as reported by self (i.e. I feel sad or empty) or others (i.e. he appears tearful) Note: in children and adolescents, can be irritable mood.

  - Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.

  - Significant weight loss or gain, or decrease or increase in appetite nearly every day. Note: in children, consider failure to make expected weight gains.

  - Insomnia or hypersomnia nearly every day (difficulty or delay in falling asleep or excessive sleep).

  - Psychomotor agitation (such as pacing, inability to sit still, pulling on skin or clothing) or retardation (such as slowed thinking, speech or body movement) nearly every day that can be observed by others.

  - Fatigue or loss of energy nearly every day.

  - Feelings of worthlessness or excessive, inappropriate, or delusional guilt nearly every day.

  - Diminished ability to think or concentrate, or indecisiveness, nearly every day.

  - Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
Bipolar I and II;

- A Manic Episode includes a period of at least one week during which the person is in an abnormally and persistently elevated or irritable mood. While an indiscriminately euphoric mood is the classical expectation, the person may instead be predominately irritable. He or she may also alternate back and forth between the two. This period of mania must be marked by three of the following symptoms to a significant degree. If the person is only irritable, they must experience four of the following symptoms.

  - Inflated self-esteem or grandiosity (ranges from uncritical self-confidence to a delusional sense of expertise).
  - Decreased need for sleep.
  - Intensified speech (possible characteristics: loud, rapid and difficult to interrupt, a focus on sounds, theatrics and self-amusement, non-stop talking regardless of other person’s participation/interest, angry tirades).
  - Rapid jumping around of ideas or feels like thoughts are racing.
  - Distractibility (attention easily pulled away by irrelevant/unimportant things).
  - Increase in goal-directed activity (i.e. excessively plans and/or pursues a goal; either social, work/school or sexual) or psychomotor agitation (such as pacing, inability to sit still, pulling on skin or clothing).
  - Excessive involvement in pleasurable activities that have a high risk consequence.
Bipolar I and II;

- A Hypomaniac Episode is very similar to a manic one, but less intense. It is only required to persist for 4 days and it should be observable by others that the person is noticeably different from his or her regular, non-depressed mood and that the change has an impact on his or her functioning.

- A Mixed Episode would fulfill the symptom requirements for both a Major Depressive Episode and a Manic Episode nearly every day but the mixed symptoms only need to last for a 1-week period.
Bipolar I and II; The Difference

The main difference between BP I and BP II is full mania (7 days) v. hypomania (4 days). Once a person experiences a full manic episode, they will receive a BP I diagnosis.

Bipolar I Disorder

The Bipolar I diagnosis, (with Manic Episode) - six different sub-diagnoses

Defined by which type of episode the patient is currently in or has most recently experienced and which types of episodes (if any) they have experienced in the past. Two of the six diagnoses do not require the experience of any Major Depressive Episodes.

Bipolar II Disorder

For a Bipolar II diagnosis, (no Manic Episode) the person must have experienced at least one Major Depressive Episode and at least one Hypomanic Episode.
BIPO LAR DIS ORDER in Pregnancy

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

• High relapse rates with continued treatment:
  45% (Bleha et al., 1998)
  50% (Freeman et al., 2002)

• High relapse rates with Lithium treatment discontin.: 50% (about same as non-pregnant) (Viguera & Newport, 2005)
Bi-Polar disorder in Pregnancy

- High rates of postpartum mental health difficulties
- Importance of proper diagnosis to assure proper treatment
- Early intervention to avoid psychiatric emergency
- Close monitoring by psychiatrist & OB/midwife
- Rule out thyroid disorders
- Medication use: psychiatrist & OB to weigh risks-benefit ratio
- Physician experience or willingness to learn is crucial
- 50% relapse rate in pregnancy if untreated
Bipolar disorder postpartum

Postpartum

- High risk of exacerbation postpartum
- Sleep deprivation can trigger manic symptoms
- Risk for psychotic symptoms

- Link between Bipolar Disorder & Postpartum Psychosis
  - 260 episodes of Postpartum Psychosis in 1,000 deliveries in women with Bipolar Disorder (Jones & Craddock, 2001)

- Important to consider Bipolar Disorder in differential diagnosis with new onset of affective disorder postpartum
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)
BIPOLAR II

- Depression + Hypomanic Episodes
- More common in women
- More fluctuating moods than Bipolar I
- ↑ risk for severe depressive symptoms postpartum
- ↑ unstable, temperament
- Often first diagnosed after years of “treatment resistant” depression
- Importance of empathetic health care team
Perinatal Anxiety Disorders

Generalized Anxiety Disorder
Panic Disorder
Risk: Thinking styles correlated with perinatal anxiety disorders

- Perfectionistic tendencies
- Rigidity (an intolerance of grey areas & uncertainty)
- An erroneous belief and pervasive feeling that worrying is a way of controlling or preventing events

(Kleiman & Wenzel, 2011)

- An erroneous belief that thoughts will truly create reality
- An underlying lack of confidence in one’s ability to solve problems
- Intrusive thoughts - such as from post-traumatic stress
- Poor coping skills
Perinatal GAD
Generalized Anxiety Disorder 300.02 (F41.1)

- Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

- The individual finds it difficult to control the worry.

- The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms having been present for more days than not for the past 6 months):
  - Restlessness, feeling keyed up or on edge.
  - Being easily fatigued.
  - Difficulty concentrating or mind going blank.
  - Irritability.
  - Muscle tension.
  - Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).

- The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism). The disturbance is not better explained by another medical disorder.
Perinatal GAD
8-15%

General
- Constant worry
- Racing thoughts
- Overwhelm
- Tearfulness
- Tension
- Irritability
- Insomnia
- Panic attacks

Perinatal Specific
- Ruminating thoughts on baby’s well-being
- Difficulty leaving the house
- Controlling parenting style
- Intrusive attachment patterns
Postpartum Panic Disorder

~11%
Panic Disorder
300.01 (F41.0)

- Panic Disorder (includes previous diagnoses of Panic Disorder with Agoraphobia and Panic Disorder without Agoraphobia)

- A. Recurrent unexpected panic attacks

- B. At least one of the attacks has been followed by 1 month (or more) of one or both of the following:
  
  1. Persistent concern or worry about additional panic attacks or their consequences (e.g., losing control, having a heart attack, going crazy).
  
  2. Significant maladaptive change in behavior related to the attacks (e.g., behaviors designed to avoid having panic attacks, such as avoidance of exercise or unfamiliar situations).

- C. Panic Attacks are not restricted to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism, cardiopulmonary disorders).

- Not related to another mental disorder
Perinatal Panic disorder

Symptoms

Panic Attacks: Episodes of extreme anxiety

- Shortness of breath, sensations of choking/smothering
- Chest pain, dizziness
- Hot/cold flashes, trembling,
- Rapid breathing/heart rate, numbness/tingling
- Nausea, vomiting
- Restlessness, agitation, racing thoughts, irritability
- Excessive worry/fear
Perinatal Panic disorder

- Perinatal Prevalence: 11%
- Panic attacks
  - severe anxiety with physiological symptoms
  - fear of losing control or dying
  - poss. agoraphobia
- Related to fetus/infant
Postpartum Panic Disorder
Characteristics

• Panic attack may wake her up at night
• Poss. Agoraphobia

Three Greatest Fears
1. Fear of dying
2. Fear of going crazy
3. Fear of losing control
Additional perinatal considerations

- Women with Hx of mild sx may have worsening in first 2-3 week pp
- R/o mitral valve prolapse and hyperthyroidism

**Primary Themes**

- Greater impairment in cognition during attacks
- Panic management exacerbates fatigue
- Preventing further attacks becomes paramount
- Negative impact on lifestyle and self-image
- Fear of permanent impact on family (Beck & Driscoll 2006).
Perinatal Posttraumatic Stress Disorder (PTSD)

+ Trauma & Stressor related Disorders
Postpartum Post-Traumatic Stress Disorder (PPTSD)

18-34% of women report that their births were traumatic. (PTSE) A birth is said to be traumatic when the individual (mother, father, or other witness) believes the mother’s or her baby’s life was in danger, or that a serious threat to the mother’s or her baby’s physical or emotional integrity existed.

POSTPARTUM PTSD

Three primary influences:

1. Traumatic labor/delivery
2. Prior traumatic event
3. Neonatal complications

(Beck 2004)
POSTPARTUM PTSD
Secondary to labor/ delivery

- “In the eye of the beholder” (Beck, 2004)
- Full PTSD in 0.2-9% of births
- Partial symptoms in about 25%-35% of births
- Often mistaken for PPD
- Not a separate diagnostic category in the DSM V
Risk Factors

Higher risk populations:

- African-American women
- Non-private health insurance
- Unplanned pregnancies
- Trauma survivors

Simkin (2011)
Risk Factors cont.

- Infertility & Loss
  - Increased rates of all PMAD sx
  - Similar sx-no psycho-ed
  - PTSD- 50%
  - Abortion
  - Miscarriage
  - Isolation
  - Minimization
**PTSD**: DSM-5 309.81 (F43.10)

**Criterion A: stressor**

- The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows: (one required)
  - Direct exposure.
  - Witnessing, in person.
  - Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.
  - Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.
Criterion B: intrusion symptoms

- The traumatic event is persistently re-experienced in the following way(s): (one required)

- Recurrent, involuntary, and intrusive memories. Note: Children older than six may express this symptom in repetitive play.

- Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).

- Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.

- Intense or prolonged distress after exposure to traumatic reminders.

- Marked physiologic reactivity after exposure to trauma-related stimuli.
Intrusion symptoms

- Repetitive re-experiencing of the birth trauma through flashbacks, nightmares, distressing recollections of the birth experience, and psychological distress following birth
**Criterion C: avoidance**

Persistent effortful avoidance of distressing trauma-related stimuli after the event: (one required)

- Trauma-related thoughts or feelings.
- Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).
Avoidance symptoms

- Attempts to avoid reminders of the birth experience such as doctors' offices as hospitals, people associated with birth experience (sometimes including the baby), thoughts about the birth experience
Criterion D: negative alterations in cognitions and mood

- Negative alterations in cognitions and mood that began or worsened after the traumatic event: (two required)

- Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol, or drugs).

- Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous").

- Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences.

- Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt, or shame).

- Markedly diminished interest in (pre-traumatic) significant activities.

- Feeling alienated from others (e.g., detachment or estrangement).

- Constricted affect: persistent inability to experience positive emotions.
Affective sx

- Feelings of impending doom or imminent danger
- Difficulty concentrating
- Guilt
- Suicidal thoughts
- Depersonalization - Feeling a sense of unreality and detachment
- Looks like PPD!
Criterion E: alterations in arousal and reactivity

- Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event: (two required)
  - Irritable or aggressive behavior
  - Self-destructive or reckless behavior
  - Hypervigilance
  - Exaggerated startle response
  - Problems in concentration
  - Sleep disturbance
Increased arousal symptoms

- Difficulty sleeping, heightened anxiety, irritability, and concentration challenges, mood swing (Looks like BPI or II)
- Anger and impulsivity towards children!

(Beck et al. 2011)
Trapped in flight, flight or freeze...

**Lizard Brain**
- Limbic system over-activated
- Difficulty accessing self-soothing strategies

**Wizard Brain**
- Prefrontal cortex engaged. Central nervous system soothed
PTSD cont.

- **Criterion F: duration**
  - Persistence of symptoms (in Criteria B, C, D, and E) for more than one month.

- **Criterion G: functional significance**
  - Significant symptom-related distress or functional impairment (e.g., social, occupational).

- **Criterion H: exclusion**
  - Disturbance is not due to medication, substance use, or other illness.
Specifiers

- **Specify if: With dissociative symptoms.**

- In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:
  - Depersonalization: experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream).
  - Derealization: experience of unreality, distance, or distortion (e.g., "things are not real").

- **Specify if: With delayed expression.**

- Full diagnosis is not met until at least six months after the trauma(s), although onset of symptoms may occur immediately.
Risk factors related to delivery

- Major hemorrhage
- Severe hypertensive disorders (preeclampsia/ecclampsia)
- Intensive care unit admission
- NICU stay
- Unplanned Cesarean

Contributing risk factors cont.

- Unexpected hysterectomy
- Perineal trauma (3rd or 4th degree tear)
- Cardiac disease.
- Prolapsed cord
- Use of vacuum extractor or forceps
POSTPARTUM PTSD

Risk cont.

- Feeling out of control during labor
- Blaming self or others for difficulties of labor
- Fearing for self during labor
- Physically difficult labor
- Extreme pain
- Fear for baby’s well-being
- High degree of obstetrical intervention

(Furuta, Sandall, Cooper, & Bick (2014))
POSTPARTUM PTSD
Risk factors secondary to prior trauma

- Sx related to past trauma triggered by childbirth
- Hx of emotional, physical abuse or neglect
- Hx of sexual abuse
- Hx of rape
- Hx of PTSD
- ACEs score significant
POSTPARTUM PTSD

Risk factors secondary to neonatal complications:

- Greater severity of neonatal complications
- Lower gestational age
- Greater length of stay in NICU
- Stillbirth
- Significant in fathers as well
NICU Families at risk

- PTSD preterm delivery 7.4%
- PTSD and major depressive disorder is 4 fold increase in prematurity 2654 women
- Mothers- 15%-53%
- Fathers- 8%-33%
- http://www.preemiebabies101.com
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.
POSTPARTUM PTSD Impact

- Avoidance of aftercare and related trigger
- Primary reminder of the birth?? The infant
- Impaired mother-infant bonding
- Sexual dysfunction
- Avoidance of further pregnancies
- Symptom exacerbation in future pregnancies
- Elective C-sections in future pregnancies

POSTPARTUM PTSD
Subsequent Pregnancy

- Different care providers
- Different birthing location
- Emphasis on relationship development with providers
- Comprehensive birth planning around unique needs

(Beck & Driscoll, 2006)
Impact of birth trauma on breast-feeding

Major themes:

- Proving oneself as a mother: sheer determination to succeed
- Making up for an awful arrival: atonement to the baby
- Helping to heal mentally: time-out from the pain in one's head
- Just one more thing to be violated: mothers' breasts
- Enduring the physical pain: seeming at times an insurmountable ordeal
- Dangerous mix: birth trauma and insufficient milk supply
- Intruding flashbacks: stealing anticipated joy
- Disturbing detachment: an empty affair

(Beck & Watson, 2008)
Perinatal Obsessive Compulsive Disorder (OCD)

~OC, Stereotypic and related disorders
Perinatal OCD

(Gen. Pop. 2.2%)
Thanks for always thinking about me to the detriment of your own mental health.
OCD
DSM-5 300.3 (F42)

- **Obsessions are defined as:**
  - Recurrent and persistent thoughts, impulses, or images that are intrusive and cause marked anxiety or distress; but are not excessive worries about real-life problems;
  - The person attempts to ignore, suppress or neutralize these thoughts, impulses, or images;
  - The person is aware that the obsessional thoughts, impulses, or images are a product of his or her own mind, as opposed to delusional in nature.

- **Compulsions are defined as:**
  - Repetitive behaviors or mental acts that the person feels driven to perform in response to an obsession;
  - The behaviors or mental acts are directed at preventing or reducing distress or a dreaded event or situation;
  - These behaviors or mental acts may not always be associated with the content of the obsessional theme. For example, if the theme is Contamination, the ritual may involve mental rehearsal or counting;
  - The symptoms of OCD are not the result of another psychiatric disorder present or caused by a medical condition or substance abuse.
OCD - General

- Obsessions
  - Intrusive thoughts/images
  - Ignore or suppress
  - Awareness

- Compulsions
  - Repetitive behaviors/mental acts
  - Reduce stress
  - Prevent dreaded event
  - “thought-action fusion” (TAF)
POSTPARTUM OCD
(Often misdiagnosed as 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”
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
Theory on Etiology

- Oxytocin, implicated in bonding and nurturing, has been found to be elevated in the cerebrospinal fluid of patients with OCD.

- Cingulate gyrus, which is part of the OCD brain circuitry, is rich in oxytocin receptors.

- Maternal behavior resembles an obsession in that mothers are preoccupied with the care and protection of infants.

- Oxytocin may impact the obsessional nature of mothers’ behaviors. In women with PP OCD, the brain may "overshoot" this process, causing hypervigilance, excessive fear of harm and excessive triggering of protective instincts.

(Patricia Perrin, PhD, Presentation at Postpartum Support International Conference, Houston, 2008)
Perinatal Psychosis

- As part of:
  - Major Depressive Disorder
  - Bipolar Disorder – a variant of?
  - Psychotic Disorder
  - 4% Infanticide
  - 5% Suicide
Brief Psychotic Disorder
DSM-5 298.8 (F23)

- Schizophrenia Spectrum and Other Psychotic Disorders

- Short term, gross deficits in reality testing, manifested with at least one of the following symptoms:
  - Delusions- strange beliefs and ideas which are resistant to rational/logical dispute or contradiction from others.
  - Hallucinations- auditory, or visual.
  - Disorganized Speech- incoherence, or irrational content.
  - Disorganized or Catatonic behavior- repetitive, senseless movements, or adopting a pose which may be maintained for hours. The individual may be resistant to efforts to move them into a different posture, or will assume a new posture they are placed in (American Psychiatric Association, 2013).

- Sx must persist for at least one day, but resolve in less than one month.
5 specifiers

- **With marked stressors**: the psychotic episode appears following an acute stressor, or series of stressors, which would overtax the coping skills of most individuals.

- **Without marked stressors**: there is no apparent stressor preceding the psychotic episode.

- **Post-partum**: this disorder can appear during pregnancy or within one month following childbirth. *(Not always!)*

- **With catatonia**.

- **Severity**: The clinician can rate the severity of the psychotic episode during the last seven days using a five point scale—Zero (Absent) to Four (Present and severe) *(American Psychiatric Association, 2013)*.
Perinatal Psychosis
1-2 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 Psychosis Symptoms

- Extreme agitation
- Paranoia, confusion, disorientation
- Inability to sleep/ eat
- Losing touch with reality
- Distorted thinking
- Delusions
- Hallucinations (tactile, auditory, visual)
- Disorganized behavior
- Psychomotor agitation
- Incoherent speech, irrational thinking
POSTPARTUM PSYCHOSIS
Risk Factors

- Psychotic Disorders (20-50%)
- Bipolar Disorder (20-50%)
- Postpartum Psychosis (50-70%)

***WARNING SIGN: Extreme sleep loss***
PPP implications

- Women with PPP feel that the postpartum aspect of their illness sets them apart from other women with psychotic symptoms → Significant implications for hospitalization on general inpatient psychiatric unit!!!

- Issues of loss (control, functioning, competence)

- Fear due to inexperience of medical community with PPP
POSTPARTUM PSYCHOSIS

Diagnostically

- Heterogeneous group of disorders
- Mostly: Bipolar or MDD with psychotic features
- In one study 86% of women with PPP met the criteria for bipolar mood disorder. So, PPP “is not a discrete illness, but rather a postpartum presentation of an underlying mood disorder”
  
  (Roberton, 2002 in Misri 2005)
- Can be Schizophrenia spectrum disorders (rare)
- Medical conditions (thyroid disease, low B12)
- Drugs (amphetamines, hallucinogens, bromocriptine)
POSTPARTUM PSYCHOSIS Impact

- Self-esteem
- Sense of motherhood
- Inadequacy as a mother
- Bonding
Postpartum Psychosis and psychiatric hospitalization

- PPP psychiatric emergency
- 4% infanticide
- 5% suicide
- Ct must not be left alone.
- Occasionally prior intensive support plan including medication used in past may prevent admission.
- Multiple perinatal considerations important.
- Communication and support for family crucial.
- Prenatal education essential.
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
Shower Schizophrenia:
The constant belief that you hear a child crying while you're trying to take a shower.
D-MER
Dysphoric Milk Ejection Reflex

- Dysphoric Milk Ejection Reflex (D-MER) is an anomaly of the milk release mechanism in lactating women. A lactating woman who has D-MER experiences a brief dysphoria just prior to the milk ejection reflex.

- These emotions usually fall under three categories, including despondency, anxiety and aggression.

- Physiological, not psychological.

- Not a PMAD.

- Majority of mothers with D-MER report no other mood disorders.

- Can be co-morbid with PMADs.
D-MER
Dysphoric Milk Ejection Reflex

- Hollow feelings in the stomach
- Anxiety
- Sadness
- Dread
- Introspectiveness
- Nervousness
- Anxiousness

- Nervousness
- Anxiousness
- Emotional upset
- Angst
- Irritability
- Hopelessness
- Something in the pit of the stomach.
D-MER Treatment

- Awareness, understanding, and education
- Decreases likelihood of early weaning
- Supporting dopamine levels
- Nutrition
- Herbs
- Medication
D-MER Resources

- D-MER.org
- Healing Breastfeeding Grief: How mothers feel and heal when breastfeeding does not go as hoped. (2016 Jacobson, Hilary)
- https://www.facebook.com/DMERORG/?fref=ts
“Postpartum” Fathers

- ~10%
- 10.1% (Matthey et al., 2000)
- 28.6% (Areias, et al., 1996)
- With spousal postpartum depression:
  - 24% (Zelkowitz & Milet, 2001)
  - 50% (Lovestone & Kumar, 1993)
- Depression in fathers during the postnatal period:
  - Emotional & behavioral problems in 3-5 yo children
  - Increased risk of conduct problems in boys
    (Ramchandani, 2005)
PMADs in Fathers cont.

- Common symptoms:
  - Overwhelm
  - Anger
  - Confused
  - Concerned with mother and baby

- Any symptom mothers have

~10%
PMADs in Fathers cont.

When mother screens positive ≥12

Screen Father!!!

EPDS cut-off >6!
Post-Adoption Depression Syndrome (PADS)

No:
- Hormonal changes
- Pregnancy

Additional concerns:
- Adoption process related stress
- Issues re: inadequacy
- Financial
- “Whose baby?”
Other perinatal considerations...

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

- Infertility
- Same-sex parents
- Birth Mothers
- Miscarriage
- Stillbirth
- Adoption
- Abortion
Etiology, Impact and Tx basics
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
- **HPA axis dysregulation**
Hormones During Pregnancy

Concentrations

- hCG from syncytiotrophoblasts
- Human placental lactogen: 6000 ng.ml⁻¹
- Progesterone binds to LH-receptors
- Prolactin
- Oestradiol

Corpus luteum
Placenta

0  12  14  28  42 weeks

ng.ml⁻¹

50 I.U. ml⁻¹

Fig. 29-3
Perinatal hormone changes

- Estrogen - 50x higher by last 3 mo
- Drops to near pre-pregnancy levels within 72 hrs
- Progesterone - 1-x higher by end of preg
- Drops to normal levels by 1\textsuperscript{st} week
- Cortisol - 2-3x higher during preg
- Slowly decreases after birth
- Prolactin - 7x higher during pregnancy
- Declines during 3 mo PP, weaning
Oxytocin (OT): Peripheral Effects

- Uterine contraction
- Milk ejection
OT as a Neuropeptide Neurotransmitter

- Receptors concentrated in limbic system
- New receptors are induced by estrogen during pregnancy
- OT induces intense maternal behavior
- OT antagonists block initiation of maternal behavior
Posited Relationships Between the “Blues” and PPD

- A subset of women may be vulnerable to mood disorders at times of hormonal flux (premenstrual, postpartum, perimenopausal) regardless of environmental stress.

- The normal heightened emotional responsiveness caused by OT may predispose to depression in the context of high stress and low social support.
Ruling Out Other Causes

- PTSD
  - Birthing Trauma
  - Undisclosed trauma or abuse
  - ACE questionnaire
- Thyroid or pituitary imbalance
- Anemia
- Side effects of other medicines
- Alcohol or drug use/abuse
- Hormone imbalance
- Adrenal Fatigue
Thyroid disorders

Thyroid dysfunction occurs in about 10%

Lab work to rule out thyroditis:

- Free T4
- TSH
- Anti-TPO
- Anti-Thyroglobulin antibodies
  (Bennett & Indman, 2006)
Naturopathic considerations

- Dramatically rising progesterone and Estrogen levels followed by a dramatic drop.
- Estrogen may remain high while progesterone stays low.
- Result is estrogen dominance.
- Estrogen dominance causes the liver to produce increasing levels of thyroid-binding globulin (TBG) - binds thyroid hormone.
- Once thyroid hormone is bound in the blood, it is no longer free to enter the cells to be used as energy for the body = postpartum thyroiditis and the symptoms of low thyroid prior to giving birth.
Naturopathic considerations cont.

- High levels of estrogen causes an increase in levels of cortisol-binding globulin—binds cortisol in the blood.

- The amount of free cortisol available to enter the cell membranes and activate receptors inside the cell is now greatly diminished.

- Estrogen dominance interferes with the release of cortisol from the adrenal cortex = adrenal fatigue.
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
The Impact of PPD:

Nationally, suicide is the second leading cause of maternal death

The first is homicide

Center for Disease Control (2011)
Impact of Untreated Postpartum Depression/Anxiety

- First year is critical time of cognitive development
- Long term/ adverse implications if untreated
Impact of Untreated Postpartum Depression/Anxiety

Effects on mother’s interactions with infant

- ↓ affectionate behavior
- ↓ responsive to infant cues
- Flat affect, hostile/intrusive

Logitudinal research suggests general increase in behavior problems and lower cognitive functioning
Impact of Untreated Postpartum Depression/Anxiety

Effects on infant

- ↑ cortisol & norepinephrine
- ↑ fussy/ discontent/ avoidant
- ↑ insecure attachment
- Neurologic delay (6 mo)
- Lower weight percentiles (2 mo)
- ↓ responsivity to facial expressions
- ↓ vocalizations, play & exploratory behavior
Impact of Untreated Postpartum Depression/Anxiety

Effects on childhood development -
Longitudinal research up to 13 yo

- ↑ behavior problems
- ↓ cognitive functioning
- ↓ social competence
- ↑ salivary cortisol levels
  - predicts depression
Impact of Untreated Postpartum Depression/Anxiety

Effects on mother

- Impaired self-image
- Guilt
- Shame
- Fear
Untreated maternal depression is associated with:

- Increased risk of substance abuse
- Increased rates of Preeclampsia/Preterm
- Increased rates of infant neglect and poor mother-infant attachment/bonding
- Increased risk of ER visits, psychiatric hospitalizations, and suicide
- Increased rates of infanticide
- Poor developmental impact on all children in the family
- Increase risk of abortion or adoption
- Negative long-term impact on maternal well-being and self-esteem
- Negative effects on marriage stability
- Lowered ability for mother and partner to return to work
IMPACT OF DEPRESSION DURING PREGNANCY cont.

- 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

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; Wadhwa et al., 1993)

- Pre-term delivery (<37wks)
  
  (Kendall-Tackett 2015; Dayan et al., 2006; Hedegaard et al., 1993; Riniet al., 1999; Sandman et al., 1994; Wadhwa et 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
  (Galler et al., 2000)

- Delayed motor development at 6 months
  (Galler et 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
LINK BETWEEN DEPRESSION AND ALCOHOL

- 15% of women from 2002-2003 data reported binge alcohol use
- 8.5% reported illicit drug use
- Women who experienced depression showed higher rates of use
- Women who used previously showed higher rates of depression

(Chapman and Wu, 2013)
EATING DISORDERS DURING PREGNANCY

- 1 in 20 pregnant women
- 25-30% show signs of disordered eating
- Many cases not identified – up to 93.3% in one study!
- Reduction in symptoms? Binge Eating Disorder (BED)
- Impact on fetal development?
Protective factors

Lowered cortisol levels and improved developmental outcomes associated with:

- High levels of positive maternal engagement
- Treatment in the first year – effect may not be enduring
- Serve return
- Fathers
- Grandparents
- Importance of parent infant interaction guidance!

Bad moments don't make bad mamas.

— Lysa Terkeurst—
Unglued
Postpartum Depression and Breastfeeding: The impact
Postpartum Depression and Breastfeeding: The impact

- Significantly more likely to discontinue breastfeeding between 4 and 16 weeks postpartum. (Field 2008) (Ystrom 2012)

- More likely to give infants water, cereal, and juice during that time.

- More likely to experience feeding difficulties.

- More likely to report being “unsatisfied” with breastfeeding and lower rates of self-efficacy.

- PPD and low support leads to early weaning Mathews et al JHL 30(4) 480-487
Impact of sx on rates of exclusive breastfeeding:

- Anxiety at 3 months reduced odds of Ex BF by 11% at 6 mos. Adedinséwọ et al. JHL 2014 30(1) 102-109

- Complex pregnancy ~ greater than 30% lower odds of EBF.

- Supportive hospital increased the odds by 2-4 times
  - Birth interventions matter
  - Elective cesarean increased depression and anxiety
  - Planned cesarean is higher than emergency and nearly double unplanned
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)
Lactation Issue!

Maternal Mood Disorders and Lactation are NOT incompatible

Lactation can help with healing if addressed with sensitivity
Infant Feeding

- Mothers' tx will be impacted by every interaction with medical professionals.
- The decision to nurse or not must not be made for her.
- Ignorance about medication and nursing abounds.
- More women nurse exclusively when their sx are caught early and treated appropriately.
“There are several ways to feed a baby but only one YOU.”
Infant Feeding cont.

- Weaning—especially early and abrupt can be related to and increase in sx
- Dramatic decrease in prolactin and oxytocin
- Beware the hormone sensitive brain!
"Babies were born to be breastfed"
(U.S. Dept. of Health and Human Services 2004)

OR

"Babies were born to be loved by a mother who felt supported"

(letter to the editor, Herald-Sun by William Meyer, Associate clinical professor in Dept. of Psychiatry at Duke University Medical Center)
Because of their illness women will hear...

- “If you choose not to breastfeed...you’re not a good mother.”
- “If you have difficulties breastfeeding, you’re doing something wrong.”
- “If you don’t enjoy breastfeeding, your maternal instincts are impaired in some way.”
- “If the breastfeeding relationship does not go along smoothly, you are unable to do what comes naturally to all other women.”
- “If you quite breastfeeding, you will continue to fail as a mother.” (Kleinman, Karen MSW 2007)
We must balance what we know to be optimal nutrition for babies with what we now know to be optimal for the survival of mothers and the well-being of the family:

Sound Maternal Mental Health
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
Global goals for prevention and treatment

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

- Doula care
- Childbirth classes
- Prenatal visits
- Normalize
- Give it a name
- Explain reality
- Handouts/EPDS
- Resources/Websites
PSYCHOEDUCATION: an Ethical Obligation?

Women and their families deserve accurate information on risks, signs & treatment prenatally.
Treatment of Perinatal Mood and Anxiety Disorders
Treatment: The Gold Standard

- Medication
- Psychotherapy
- Social Support
CULTURAL CONSIDERATIONS

- Beliefs/ traditions re: pregnancy, childbirth, postpartum
- Concepts of “mental health”
- Concepts of “mental health treatment”
- Seeking help outside of the family
- Beliefs re: “paths to wellness”
- Variation among individuals
- Degree of acculturation
- Your own cultural biases

(Munoz & Mendelson, 2005)
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
CULTURAL CONSIDERATIONS

Culturally Relevant Interventions

1. Therapeutic principles & techniques with universal relevance
   
   (e.g., CBT, IPT, Support Groups)

2. Culturally appropriate intervention approaches
   - Involve members of culture in planning/development
   - Address relevant cultural values (e.g., familism, collectivism)
   - Religious & spiritual traditions
   - Acculturation
   - Acknowledge reality & impact of racism, prejudice, discrimination

3. Empirical evaluation of intervention outcomes

(Munoz & Mendelson, 2005)
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
BEHAVIORAL & SOCIAL SUPPORT TREATMENT

IPT, CBT, DBT

MBCT

Support groups

ECT

Phone/email support

Mother-baby dyadic work

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 ~ cloazepam, lorazepam
Non-Pharmacological Tx

- Mindfulness CBT
- Omega 3s
- Acupuncture
- Doula Care
- Bright light
- Yoga
- SAM-E
- St. John's Wort
- 5-HTP
- Hypnotherapy
- Meditation
- Herbs
- Massage
- Homeopathy
- Placental Encapsulation?
Rule outs & Tx resistant considerations

- Thyroid
- Nutritional deficiencies (Omega 3-s, B vitamins, low iron, magnesium, calcium)
- Glucose intolerance
- Other biological causes
  - Food allergies
  - Adrenal fatigue
  - Serotonin imbalance (amino acids, 5-HTP)
  - Hormone imbalance (Progesterone, Estrogen, Testosterone)
**Patient/Family Barriers**

Why women and Families may not seek help...

- Confused about symptoms- “I’m just a bad mom”, “My doctor said it’s just the blues”, “My midwife says this is normal”, “I don’t feel depressed”.

- General stigma of mental health

- Fear of medications as only option

- Supermom Syndrome

- Fear removal of children

- Don’t understand impact on fetus/infant health

When moms do speak up, help often isn't available or harm is inflicted by provider ignorance.
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
PSYCHOTROPIC MEDICATIONS IN PREGNANCY & LACTATION

Why Many Women Don’t Seek Treatment
PSYCHOTROPIC MEDICATIONS IN PREGNANCY & LACTATION

- 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
PSYCHOTROPIC MEDICATIONS IN PREGNANCY & LACTATION
The Unknown

- Clinical significance of medications transferred via breast-milk
- Long-term effects
- No large randomized trials- primarily case studies
- Constantly changing information
- Drugs can get “demoted” the more they’re studied
- Safety classes can be misleading
PSYCHOTROPIC MEDICATIONS IN PREGNANCY & LACTATION

SSRI Use in Pregnancy

- Commonly cited adverse short-term adverse effects: infant irritability, poor-quality sleep & poor feeding
- Most of these effects documented in case studies
- Larger sample sizes generally find no adverse effects
- Neonates whose mothers used anti-depressants during pregnancy had increased rates of respiratory distress, feeding difficulties, low birth-weight due, in part due to neonatal withdrawal

(Cipriani et al., 2007; Looper, 2007; Louik et al., 2007)
SSRIs do not significantly increase risk of birth defects overall

(Sloan Epidemiology Center Birth Defects Study: Louik et al., 2007)

Women who discontinue anti-depressants during pregnancy are more than twice as likely to relapse

(Looper, 2007)

Risks associated with untreated maternal depression

Risks associated with not breastfeeding
“Given the extent to which depression during pregnancy predicts risk for postpartum depression with its attendant morbidity, and in light of the robust data describing the adverse effects of maternal psychiatric morbidity on long-term child development, clinicians will need to broaden the conceptual framework used to evaluate relative risk of SSRI use during pregnancy as they navigate this clinical arena with patients making individual decisions to match patient wishes.”

~ Lee S. Cohen, MD; Ruta Nonacs, MD, PhD 2016

http://jamanetwork.com/journals/jamapsychiatry/article-abstract/2566201
Perinatal clients and medication—what clients report:

- Provider ambivalence and anxiety
- Total ignorance around pregnancy, lactation, and psychotropics
- Zoloft not compatible with pregnancy & breastfeeding
- Discontinue mood-stabilizers cold-turkey
- Black and white decision making
- No information about risks/benefits
- “You’re no longer postpartum—not my patient”
- Our role—give a competent referral and warn clients about the process!!!! Be a resource for medication information w/o giving medical advice.
“Maternal psychiatric illness, if inadequately treated or untreated, may result in poor compliance with prenatal care, inadequate nutrition, exposure to additional medication or herbal remedies, increased alcohol and tobacco use, deficits in mother-infant bonding, and disruptions within the family environment.”

ACOG 2008
“Which is greater: the risks of medicating or the risks of not medicating?”
When symptoms are severe, the benefits most likely outweigh the risks. (Geddes et al., 2007)
For information on medication while breastfeeding, call Pregnancy RiskLine:

~ Mother-to-Baby

Salt Lake: 1-800-822-BABY (2229)
Sage Reports Positive Top-line Results Including Demonstration of 30-Day Durability from Phase 2 Clinical Trial of SAGE-547 in Severe Postpartum Depression

- SAGE-547 is an allosteric modulator of both synaptic and extrasynaptic GABA<sub>A</sub> receptors.
- Intravenous agent administered via inpatient treatment as a continuous infusion for 60 hours.
- Primary endpoint achieved with statistical significance at 60 hours maintained through 30 days
- 70% remission achieved at 60 hours of SAGE-547 treatment and maintained at 30-day follow-up
- Company expects to pursue further development of SAGE-547 and SAGE-217 for PPD in a global clinical program
- Samantha Meltzer-Brody, M.D., M.P.H., Associate Professor and Director of the UNC Perinatal Psychiatry Program of the UNC Center for Women's Mood Disorders ~ primary investigator for the PPD-202 Trial. https://clinicaltrials.gov/show/NCT02614547.
There was a direct link between childhood trauma and adult onset of chronic disease, as well as mental illness, doing time in prison, and work issues, such as absenteeism.

About two-thirds of the adults in the study had experienced one or more types of adverse childhood experiences. Of those, 87 percent had experienced 2 or more types. This showed that people who had an alcoholic father, for example, were likely to have also experienced physical abuse or verbal abuse. In other words, ACEs usually didn’t happen in isolation.

More adverse childhood experiences resulted in a higher risk of medical, mental and social problems as an adult.
The ACES Study
http://www.acestudy.org

- Depression during pregnancy: A child’s first adverse life event?

Research on early stress and trauma now indicates a direct relationship between personal history, breakdown of the immune system, and the formation of hyper- and hypocortisolism and inflammation.

Screening: Community recommendations
National Screening Recommendations


- ACOG recommends that clinicians screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool. (2015)

- The U.S. Preventive Services Task Force recommends screening for depression in the general adult population, including pregnant and postpartum women. “Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.” Jan. 26th 2016.
On May 11, 2016, the Centers for Medicare and Medicaid Services (CMS) issued an informational bulletin on maternal depression screening and treatment, emphasizing the importance of early screening for maternal depression and clarifying the pivotal role Medicaid can play in identifying children with mothers who experience depression and its consequences, and connecting mothers and children to the help they need.

State Medicaid agencies may cover maternal depression screening as part of a well-child visit.
SCREENING

Who?

- Early interventionists
- Home visitors
- Nurses
- Social workers
- Midwives
- Doulas

- Childbirth educators
- Parent educators
- Pediatricians
- OBs
- PCPs
SCREENING IN PREGNANCY

- Edinburgh Postnatal Depression Scale (EPDS) (Cox, Holden & Sagovsky, 1987)
- Postpartum Depression Predictors Inventory (PDPI) Revised (Beck, 2002)
- PDQ 2 or 9
PERINATAL SCREENING

Edinburgh Postnatal Depression Scale (EPDS):

- Not a diagnostic tool
- Not to override clinical assessment
- What it identifies accurately
- What it does not identify
- Useful to track Tx efficacy concretely
EPDS 3 ~ Less could be more

- Better sensitivity and negative predictive value
- In the two studies to date numbers of women with probable depression increased 16% & 40% more
- I have blamed myself unnecessarily when things went wrong
- I have been anxious or worried for no good reason
- I have felt scared or panicky for no very good reason

Kabir K, Sheeder J, Kelly LS. *Identifying postpartum depression: are 3 questions as good as 10?* Pediatrics 2008; Sep;122(3): e696-702.

Bodenlos KL, Maranda L, Deligiannidis KM. *Comparison of the Use of the EPDS-3 vs. EPDS-10 to Identify Women at Risk for Peripartum Depression.* Obstetrics & Gynecology 2016; May 127: 89S-90S.
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).
Perinatal Mental Health Assessment

Asking the right questions
But first... babies in sessions!!??!!

- Is your office baby friendly?
- What are your biases about having infants present?
- Concern for impact on infant
- Too distracting - for whom?
- Respite for mom
- Assessing attachment
- Developmental impact
- If baby can’t come than neither can she!
- Anxiety
Setting up a baby friendly environment

- Baby proofing - Outlets, corners, high surfaces, blinds
- Warm, inviting, clean and cared for - client feels important
- Details matter
- Snacks for mom - protein (nuts, fruit, chocolate)
- H2O
- Surfaces safe to fall on
Setting up a baby friendly environment cont.

- Nursing pillow
- Blankets, quilts
- Nursing covers
- Baby wipes
- Infant/toddler toys
- Disinfecting wipes
- Tissues up high!

- Items hidden, mindful of fertility triggers, stay neutral as possible
Setting up a baby friendly environment cont.

- Consider your comfort level
- Accept disarray
- You may be her only break
- Explore expanding conventions in traditional tx
- Modeling interactions
- Fake it till you make it
- May have to put notes on hold
- Supporting asking for and accepting help!
- Check in with clients about how this feels/works for her
Perinatal Mental Health assessment basics

+ 

after many years of therapy, waldo finally finds himself.
Perinatal Mental Health assessment basics:

- History of presenting problem
- Mental status
- Family history
- DV
- Work history
- Living circumstances
- Current stressors
- Spirituality - how supportive?

- Psychiatric history
- Psychiatric treatment plan
- Current health care providers
- Substance abuse history
- Diagnostic impression
- Goals
- Immediate short term treatment plan
- Immediate short term goals
- Patient strengths/limitations in achieving goal
Perinat ally spe cific!

- Hormonal Hx (control, menstruation, terminations, fertility, miscarriage)
- Relationship to baby
- Pregnancy
- Fertility
- Feeding story
- Birth story

- Child temperament
- Mother/baby relationship
- Attachment style
- Recent losses
- Pertinent medical history
- Relationship impact
- Current medications
Screening & Assessment Methods

- EPDS, PDSS, PHQ-9 or 2.
- Check-lists
- Helpful for ct
- Ease of written assessments & diagnosis
- Initial interview-1.5 hr
- On-going
- Dynamic, fluid, continual
The unique role of the psychotherapist: What matters

- Communicate that she’s in the right place. You know why she’s there and how to help.
- “I understand your suffering.”
- “This has a name.”
- “We will make a plan.”
What Matters cont.

- Prioritize based on her complaint/ issues
- Listen to her story
- Consider body language
- Quality of connection is crucial
- Be “The Good Mother”.
The first session - Key issues with a perinatal focus

The Big Four:

1) Suicidal ideation
2) Scary Thoughts
3) Attachment
4) Sleep
Suicidal ideation

- Any thoughts of hurting self?
- Thoughts you are afraid of?
- Better off not here?
- Baby better off?
- Fam or personal hx of ideation or attempt?
Scary thoughts?

- Clarify
- Expand
- “Afraid to tell anyone?”
- “Worried about hurting self or baby?”
- “Anything afraid to tell me or anyone else?”
Attachment

- Call baby by name?
- Hold baby?
- Affect match body language and words?
- Over-intrusive or uninvolved?
- Talking to baby?
- Touching?
- Sx of anx related to baby
Sleep

- How much prenatally?
- Sleep when baby sleeps?
- Can get back to sleep?
- Causes of waking?
- Uninterrupted sleep less than 4-6 hours?
- Less than 4 for the night?
Emphasize Perinatal Considerations

- Perinatal history
- Reproductive Hormonal Events
- Pregnancies (Births, Losses)
- Birth Plan
- Shame, guilt, self-blame
- Last physical exam
- Beware the pretense of perfectionism
- Breastfeeding
Assessing Interpersonal Relationships: The Partner

- Encourage client to bring partner to initial sessions or long term. Screen for DV when alone.
- Be available for support/info
- Psychoeducation a must
- Books, handouts [www.postpartumdadads.com](http://www.postpartumdadads.com) (See tips for partners)
- Info on Postnatal Paternal Depression: [www.postpartummen.com](http://www.postpartummen.com)
- Assess capacities for support ie sleep plan etc.
- Make contingency plans
Emphasize the present

- “How bad are you feeling right now?”
- “My job is to help you feel better as soon as possible”.
- Focus on current level of functioning and sx-not in-depth hx or psychoanalysis, Jungian work etc.
- Women want to get in, get better, & get on with life.
Understanding past Hormonal Events: The Earthquake Modal of Assessment

- Geologic phenomenon of earthquakes: pressure, eruption, settlement, tremors

- Tremors: stressful environmental, physiological or hormonal events
  - Reminders of vulnerability
  - May not require medical attention but increase vulnerability
  - Can be viewed as normal “life stresses”

- Pregnancy & Postpartum events are often triggers of “earthquakes”

- 3 Critical areas of assessment:
  - Brain biochemistry
  - Reproductive hormonal biology
  - Life events/ stressors & her responses to them

- Brain strain: fatigue, anxiety, headaches, feeling overwhelmed, etc. (Beck & Driscoll 2006)
Screening for Bi-Polar Disorders

- Careful Hx essential
- Mis-diagnosed MDD will present as tx resistant
- Inappropriate prescription of SSRIs may trigger a manic episode putting ct at risk for psychosis
- Teasing out hypomania most difficult
- Over multiple sessions
- Family members involved important
The “Good Mother”

- Our clients need to care for and be cared for
- Stirs up unmet dependency needs
- Needs nurturing
- Unconditional positive regard for our client’s abilities to mother, both themselves and their children, cannot be underestimated
- Balancing Good Mother role with what the ct is comfortable with & with appropriate boundaries
- “You are a good mother.” “Your baby looks loved”
- Reflect evidence-affect with baby care, efforts to heal, reach out etc.
- “Who cares for you?”
- Create a sense of control for the client
PRIORITIZING NEEDS & SERVICES

- Safety
- Needs of mother & family
- Recognize own scope of practice & role
- Implement threat of harm protocol
- Recognize potential for suicide with every client
- Identify concrete ways to offer appropriate help
Goal Setting

- Short Term: Simple, do-able, concrete
- Focused on sx reduction
- Based on ct’s priorities
- Involve concrete planning
- In-writing w/copies for family
In-Between Sessions

- DBT techniques involving high-profile guidance during initial therapeutic phase.
- May include phone contact 2-3x weekly
- Engage phone support network (family, friends, TH & write down plan).
- Support group when ready
- Email contact as often as needed. Can be more feasible for TH.
+ Boundaries, Biases & Pitfalls to avoid
Questioning Dogma

- Sharing personal information
- Giving advice
- Focusing session material
- Being available outside session for non-crises
- Touching
Reducing Stigma

- Sharing personal experiences when relevant
- Related to your level of recovery and ct’s best interests
- Modified info
- Message is of hope and possibility
- Normalizing what’s common for women with PMADs.
- Place in cultural context
Instilling Hope

- Does not mean making promises
- Creates assurance that one is on the right track
- Validates rocky road of recovery
- Steady, supportive presence and willingness to pursue alternatives essential
Modeling Recovery

- Engaging ct support from other survivors can be critical lifeline.
- “Mother-to-Mother PPD book” by Sandra Poulin
- PSI- www.postpartum.net
- Groups, phone/email support
- If TH a survivor share at appropriate intervals
Personal Biases

- Breastfeeding
- “It’s just grief”
- Not asking the perinatal specific details
- Single moms
- Same sex parents
- Adoptive parents
- The couple that looks “too good”
- Birth Mothers
Undermining self-determination

- Feeding, sleeping, parenting, medication management etc. are all decisions that the client should be allowed to be in charge of.

- Highly anxious/depressed women will have trouble making decisions.

- Be very mindful of motivation when directing cts in choice making

- Information is power
Be aware of suicide risk potential in every patient
“Often times the 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 mother who tells me she thinks her baby will be better off without her. She is at very high risk for suicide.”

(Valerie Raskin, “This isn’t What I Expected”)
Infanticide: Assess for Severe Depression vs. Psychosis

- We can’t prevent if we don’t ask
- We can’t prevent if we don’t know the signs
- Remind clients about mandatory reporting laws and their exceptions (OCD vs. active plan)
- Every question is essentially psychoeducation
- “Are you having any thoughts that are scaring you?”
- “It’s not unusual for the women we see to have thoughts of harming their child, so, I ask everyone.”
- “Some feel so angry, anxious and overwhelmed they just want the baby/child to go away sometimes. Have you ever felt this way?”
- Then assess for level of risk and plan for safety
- Look for observable signs of abuse/neglect
Suicide Risk – cont.

- Can you describe the thoughts to me?
- Differentiate between active and passive
- Who could you plan to tell if the thoughts change? If you can’t stop yourself?
- What do you think you need to be safe?
- What would that look like for your baby, partner?
- Are there weapons in your home?
- Other means to hurt yourself?
- Does anyone know how you feel?
Empowering Through Safety Planning

- “Do you think it would be helpful to remove these items/have your partner remove them?”
- “Would being in the hospital for a while help you feel safer?”
- Give every opportunity for patient input before directive planning
- Does your family know how bad you are feeling?
- Bringing family on board: in session, on phone, meet at ED
- Follow-up!!
- Do not leave patient alone if she is unable to assure safety
- Make a plan for 24 hr care until assessed
Beware of harm to pts ~ know the difference

No/Low risk

- OCD sx with no active plan – clearly ego dystonic
- Graphic dreams of harm with ego dystonia
- Appears oriented to self and others
- Clear mental status exam
- No severe co-morbid depression
- No hx or fam hx of thought disorders or bi-polar
Beware of harm to pts ~ know the difference

- Moderate-High

- Severe comorbid depression plus reported feelings of rage, out of control, high reactivity

- Severe insomnia

- Pt reports feelings of harming baby are disturbing and she wants help
Beware of harm to pts ~ know the difference

- High-time to hospitalize
- Thoughts of harming baby with active plan to do so – not willing to safety plan
- Ego syntonic thoughts of harming self or others
- Uncontrolled anger towards baby with poor insight, evidence of past abuse, resistant to intervention and treatment
- Hx or fam hx of psychosis, thought disorder, or BP I or II
Beware of harm to pts ~ know the difference

High- time to hospitalized

- Psychotic sx

- Active plan to harm self or others- unwilling or unable to safety plan

- Severe depression, functioning highly impacted, mother does not feel safe for herself or others

- Pt cannot commit to safety plan

- Unless there is clear evidence of child abuse, DCFS reports may do more harm than good ~ enlist 211 and Help Me Grow to refer to needed services ~ parenting, CD etc.
Beware of harm to pts ~ know the difference

- High-time to hospitalize
- Inadequate outpatient care
- Risk variables + profound sleep-deprivation
Safety Planning

- “It’s a symptom of the illness.”
- “Let’s make a plan for you both to be safe.”
- Thoughts vs actions
- “Your baby is so lucky to have a mom brave enough to reach out for help.”
Safety Planning cont.

- Anger management—concrete strategies
- Help client recognize warning signs, retreat, affect regulation skills (DBT, MBCBT)
- Help client communicate with family member re: safety planning and “time out”
- Support system mobilization—referrals
- Medication referral when indicated
Psychosis

- Any signs of psychosis =>
  - Immediate Psychiatric hospitalization!
  - Nearest ER
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
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
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
Psychiatric admission: Role of the perinatal psychotherapist

- Perinatal Mental Health Assessment greatly helps admitting staff.

- Write up as much as your time permits.
- Little information is better than nothing.
- Symptoms, psychosocial circumstances, history.
- Emphasis is on the perinatal specifics (sleep, nursing, psych hx, loss, prior meds, bonding etc.).

- If start anti-psychotic meds: Advise not to make decision about stopping at this time of crisis, but pump’n’dump for now.

- Psychoeducation: client, family, staff.
Psychiatric Hospitalization: Key Considerations

- R/o psychosis
- Undiagnosed Bi-Polar
- OCD vs Psychosis
- PPD vs. PTSD
- Pts that look “too good”
- Careful suicide screening
- Prescribed 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
Treatment Planning into “Wellness Planning”
A focus on the concrete
PSYCHOTHERAPEUTIC MODELS – PMADs: Initial Sessions

- Establish rapport and trust
- Explain cognitive model and therapy process
- Educate client about illness
- Normalize difficulties and instill hope
- Determine and clarify expectations about therapy
- Collect additional information about presenting issues
- Develop a goal list

(Beck, 1995)
Sign That You're a Mom: 
You have to write 
"take a shower" on 
your to do list.
ACCESS COMMUNITY RESOURCES

- Medicaid/ OHP
- Food Stamps
- Domestic violence support
- Alcohol and drug recovery programs
- Additional financial reserves for emergencies/ take-out food/ paid help
Everyone's all like "Look at my garden, made-from-scratch cake, and respectful children." I'm over here like "We're breathing."
Psychoeducation

- Normalize
- Give it a name
- Explain reality
- Handouts
- Resources/ Websites
- Impact of Trauma hx
- Earthquake metaphor
- Tailor to ct’s educational level and cognitive capacities
SUPPORT FOR MOTHER-CHILD RELATIONSHIP

- Educate clients about effect of PMADs on children with compassion
- Model & encourage appropriate interactions
- Provide info on normal child development
- Encourage other caregivers to interact/care for baby
- Refer to resources which support attachment & early child education
- Circle of Security
- 211 & Help Me Grow
PRACTICAL HELP

- Mobilize/ Expand support network
- Family/ Friends
- Postpartum Doula/ Mom’s helpers
- Healthy Start-home visitation program
- Support groups
- Professional resources
- Wellness planning
HOUSEHOLD HELP

- Engage partner in support
- Housework re-prioritize
- Respite from baby care
- Arrange transportation to appointments
- Help her avoid detrimental influences
- Mom-baby groups often not helpful
What works for the client

- Wellness planning starts at the first contact
- Concrete, simple, brief, and in writing.
- Copies for family members and for your records.
- Differentiate between what’s needed for ins. Vs clients.
PHONE, EMAIL & GROUP SUPPORT

- Accessible
- Free
- First line of information and validation
- Addresses biggest fears “crazy”
- De-stigmatizes and normalizes
- Creates social bonds outside of group
- Empathy
- Information
- Practical help
“Social support is essential to assure the mental health of women, children and their families during pregnancy & the postpartum period”
From Postpartum Internationals Statement on Social Support, June 2001

“You are not alone”
“You are not to blame”
“You will get better”
Wellness Planning

- Sleep
- Nutrition
- Omega-3
- Walk
- Baby breaks
- Adult time
- Liquids
- Laughter
- Spirituality

See www.utahmmhc.com
**SNOWBALL**

- **Sleep**
  - 4-6 hr stretch ~ Eye mask, ear plugs, sounds machine, sleep aid?

- **Nutrition**
  - Protein & fat @ every snack and meal, prenata ls, Vit D & B-12, iron?

- **Omega-3**
  - 1-9000 mg combined epa/dha through fish oils ~ Barleans, Carlsons etc
SNOWBALL

- **Walk**
- **Baby breaks**
- **Adult time**

- Daily gentle exercise, don’t push self
- 30-60 minutes of down time alone
- Social support, calling friends, groups, online support, FB etc, Dates with partner!
SNOWBALL

- Liquids
- Laughter
- Spirituality

- Two large pitchers of H2O daily, avoid alcohol & caffeine
- Funny movies, comedy on spotify, what used to make you laugh...if not any longer...seek help!
- What nourishes you – may have changed or not. Don’t make assumptions, get creative here, nature, scripture, church, mediation, yoga etc.
PSYCHOTHERAPEUTIC MODELS - PMADs – brief review and case studies

"Put out the fire before you rewire the house"

(Susan Hickman, Ph.D., M.F.C.C.)
PSYCHOTHERAPEUTIC MODELS - PMADs

- Crisis intervention if indicated
- Immediate resources/referrals
- Interpersonal psychotherapy
- Cognitive behavioral therapy
- Dialectical Behavior Therapy
- Mindfulness Based Cognitive Behavioral Therapy
- OCD - ERP
- PTSD - EMDR, CBT
- Mother baby dyadic work
PSYCHOTHERAPEUTIC MODELS FOR PMADs

Cognitive Behavioral Therapy (CBT)

- Thought or symptom based
- "Automatic negative thoughts" or images that often proceed, accompany & follow depression/ anxiety/ panic
- Teaches clients to identify, evaluate & change dysfunctional patterns of thinking
- Results: changes in mood and behavior
PSYCHOTHERAPEUTIC MODELS – PMADs: CBT for Anxiety & Panic

Anxiety = Perceived Danger or Threat

- We overestimate the danger or threat
- We underestimate our coping skills and ability
PSYCHOTHERAPEUTIC MODELS – CBT for Anxiety & Panic: Goals

- Reduce physical hypervigilance
- Breathing and relaxation training
- Take away the danger
- Focus on objective evidence
- Distinguish true versus false alarms
- Increase perceived control

- Problem-solving and available options
- Recognize anxiety as an alarm
- See it for what it is
- Tolerate the signal
- Exposure to feared symptoms and situations
- “Fine tune the smoke alarm”
PP PTSD Treatment Modalities

- No reliable treatment data specifically on PP PTSD
- Anecdotally, many treatments shown effective for general PTSD are helpful for PP PTSD: EMDR
- Promising anecdotal reports on an Energy Psychology technique for perinatal clients: Emotional Freedom Techniques (EFT)
- Special considerations relevant to reproductive health events & PMADs
Most common & effective treatments for general PTSD

- EMDR
- CBT
- Medication (SSRIs)

Note:

- Exposure therapy may be re-traumatizing for perinatal women and **contraindicated** (Bennett 2007)
Supportive Perinatal Psychotherapy

- Essential for “big picture”
- Healing power of “the relationship”
- Honors need to retell story, be heard & validated (monitor for re-traumatization)
- Goals of tx: Active help with managing/extinguishing sx, mourning birth experience, validate perceptive reality, mobilize support team, implement SNOWBALL model of care.
Supportive Perinatal Psychotherapy

- Tasks may include writing the birth story, writing “letters” to caregivers expressing feelings & asking questions (may choose to edit, or send or not send)

- Art therapy (symbols/ picture of birth experience followed by artwork depicting how she would have liked the birth experience to be)

- Teach concrete symptom management techniques (deep breathing, calming visualizations, containment)

- Address delayed PTSD

(Klaus & Simkin 2004)
Medications for PTSD

- Address biological symptoms of anxiety, insomnia, irritation, fear & phobias
- First-line SSRIs
- TCAs and MAOIs helpful when SSRIs fail
- SSRIs generally treat range of symptoms
- Used for at least a year
- Adjunct anti-anxiety meds useful
- Alterations in HPA axis seen in women w/ PTSD
- No research to date on endocrine function and treatment for this population (Beck & Driscoll 2006)
Emotional Freedom Techniques (Energy Psychology)

- Similar to acupuncture without needles
- Based on concept of negative emotions reflection of “stuck” energy in the body’s meridian system
- “Tapping” on set sequence of nine points sends electrical charge through system unblocking meridian (Craig 2008)
- Anecdotally, intensity of affect and associated symptoms are reduced
- Results in reduction of Subjective Units of Distress (SUD) scores in relation to traumatic event
- Easy to learn, can do anywhere (Bennett, 2007)
- No solid research on EFT and PMADs
- Anecdotal evidence for Tx of PTSD promising
PP PTSD prevention in sexual abuse survivors

Birth Counseling

- Avoiding re-traumatization
- Opportunity for birth as healing

PP OCD Specific Tx- ERP
Compulsions raise anxiety over time

- Checking, hiding knives, washing, avoidance etc.
- Lower anxiety
- Obsession returns
- Higher anxiety
- Compulsion returns
- Obsession comes back
- Sense of loss of control
- Anxiety goes higher
- Cycle repeats...
PP OCD Specific Tx- ERP

- CBT-Exposure and Response Prevention
- Habituation of anxiety or discomfort related to obsessions
- Extinction of rituals and compulsions by eliminating negative reinforcement
E/RP in practice

- Confront most fear situations, images, or thoughts
- Preventing or voluntarily blocking compulsive thoughts, rituals, and behaviors.
- Teach coping skills
- Create a hierarchy
- Imaginal
- In-vivo
- While using new coping skills
ER/P Intervention

- Prevention/Blocking of rituals and behaviors
- Anxiety goes up, stabilizes, & lowers on its own
- Practice decreases time between anxiety increase and decrease
- Over time trigger becomes imperceptible
Case Example: Postpartum OCD

- Sx: Fear of throwing baby in river, drowning her etc.
- Avoided being alone with daughter near water.
- Avoided driving by river - (Lived near major)
- Would not bathe baby alone
Case Study: Postpartum OCD

- Treatment: Week 1 & 2
  - Imaginal exposure to driving by river 3x weekly
  - Imaginal exposure to being with baby by water.
  - Imaginal bathing her alone
  - CBT for meaning of thoughts ("They are just thoughts-sx of the OCD")
Case Study: Postpartum OCD

- Treatment weeks 3, 4 & 5
- Drive by river with partner 3x week
- Drive in passenger seat 3x week
- Drive alone 2x in one week
- Have partner be in next room while bathing baby
- Followed by bathing her alone for 2 minute, 5, 10 etc. until no longer triggered.
Case Study: Postpartum OCD

- Ct reported being able to drive by river alone within 3 weeks of tx.

- Within 5 sessions was bathing baby alone.

- Tx was combined with Zoloft 100mg.
Panic and GAD specific Tx in Perinatal Women

- CBT

- “The Pregnancy & Postpartum Anxiety Workbook.” (Pamela S. Wiegartz)

- “Mastery of Your Anxiety and Panic” “Worry” Barlow & Craske

- Cognitive Restructuring - Over-estimating and Catastrophizing

- Exposure - Interoceptive & Situational

- Relaxation training for GAD

- Insight Timer App
PP GAD: Case example

- 35 y/o mother, First child
- Lifelong Hx of anx
- Mother dies at 8y/o
- Raised by father w/A&D addiction
- Anx sx increased last tri-mester
- Fears of being in car, parenting, bridges increased at 6 mo PP
PP GAD case study cont.

- Sleep hygiene plan
- Basic wellness planning
- Partner psychoed
- Evaluated attachment
- CBT
- Identified thoughts, situations related to worst sx
- Identified bodily sensations
- Cognitive restructuring related to bodily sensations
- Identified persistent anxious self-talk
- Mantra
PP GAD case study cont.

- Stop sign for anx
- EFT
- Assertiveness skill building
- Self-care
- Adrenal/Amino acid supplementation through naturopath
- PRN Ativan
- Outstanding sx associated with sleep deprivation
CBT & Anxiety Tx Organizations


- International Association for Cognitive Psychotherapy- [http://www.the-iacp.com](http://www.the-iacp.com)

- Obsessive-Compulsive Foundation (617) 973-5801 [www.ocdfoundation.org](http://www.ocdfoundation.org)

- Anxiety Disorders Association of America (240) 485-1001 [www.adaa.org](http://www.adaa.org)
Dear Health Practitioner,

About 10% of postpartum women develop thyroiditis. Sometimes this is temporary, and sometimes it becomes chronic (Hashimoto’s thyroiditis). The symptoms of thyroiditis are often similar to that of postpartum depression/ anxiety.

Would you please screen for thyroiditis with the following tests:

- Free T4
- TSH
- Anti-TPO
- Anti-thyroglobulin.
Key Points:

“You are not alone”
“You are not to blame”
“You will get better”
PMAD resources- providers

- [http://mail.ny.acog.org/website/DepressionToolKit.pdf](http://mail.ny.acog.org/website/DepressionToolKit.pdf) - ACOG Provider Toolkit and CME

- [www.MedEdppd.com](http://www.MedEdppd.com) - CDC sponsored research, training opportunities, care algorithms and a portal for patients

- [www.womensmentalhealth.org](http://www.womensmentalhealth.org) - The MGH Center for Women’s Mental Health - Reproductive Psychiatry Information Resource Center provides critical up-to-date information for patients in the rapidly changing field of women’s mental health.

- [https://www.mcpapformoms.org](https://www.mcpapformoms.org) - MCPAP for Moms promotes maternal and child health by building the capacity of providers serving pregnant and postpartum women and their children up to one year after delivery to effectively prevent, identify, and manage depression
Local resources

  ~ Screens all callers with the EPDS and makes referrals

  ~ Home visiting services for eligible families support child development

- Early Childhood Utah: http://childdevelopment.utah.gov
  ~ Provides a variety of early intervention and developmental services
PMAD resources

- [www.postpartum.net](http://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](http://www.mmhcoalition.com) - National Coalition for Maternal Mental Health- Social Media Awareness Campaign, ACOG, private & non-profit.
PMAD Resources


- 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.
PMAD resources for families

- [www.utahmmhc.com](http://www.utahmmhc.com) - Utah Maternal Mental Health Collaborative. Interagency networking, resource and policy development. See website for many resources, free support groups, etc.

- Therapists

- Support groups

- Self-test

- Resources - training, posters, handouts etc.
PMAD resources for families

Crisis:

- **University Of Utah Neuropsychiatric Unit Crisis Line** (801) 587-3000. Free confidential support, including a mobile crisis team able to come to a residence when needed.

Parenting babies:

- **Erikson Fussy Baby Network** (888) 431-BABY (431-2229) – Provides both Spanish and English support and advice for parents regarding infant fussiness, crying, and sleep issues.

Fathers:

- [www.postpartummen.com](http://www.postpartummen.com) - This website is for fathers who are experiencing symptoms of postpartum anxiety and depression which is often called Paternal Postnatal Depression.
PMAD resources for families

- Adoption:
  - www.adoptionissues.org/post-adoption-depression.html

- For Birth Mothers:
  - http://www.lifeafterplacement.org
  - Provides support resources for women after placing a baby with adoptive parents. Also offers resources for hospitals to facilitate emotional healing for birth mothers at the time of placement.
PMAD resources for families

**Infertility:**

- **American Society for Reproductive Medicine (ASRM)**
  Call 205-978-5000 or visit [www.asrm.org](http://www.asrm.org)

  Professional organization for infertility specialists publishes guidelines and hosts meetings about the medical management of infertility. Its Mental Health Professional Group focuses on the psychological and emotional aspects of infertility treatments.

- **RESOLVE: The National Infertility Association**
  Call 703-556-7172 or visit [www.resolve.org](http://www.resolve.org)

  Provides education, support, publications, and advocacy for women and men facing infertility.
PMAD resources for families

- PTSD:
  - [http://pattch.org](http://pattch.org) ~ Prevention and Treatment of Traumatic Birth – PATTCh
  - [www.tabs.org.nz](http://www.tabs.org.nz) ~ Trauma and Birth Stress New Zealand
  - [www.solaceformothers.org](http://www.solaceformothers.org) ~ Support groups, stories, referrals etc.
  - [www.samhsa.gov/nctic/trauma-interventions](http://www.samhsa.gov/nctic/trauma-interventions) ~ Trauma informed care federal guidelines
  - [http://pattch.org](http://pattch.org) ~ Prevention and Treatment of Traumatic Birth
  - [https://blogs.city.ac.uk/birthptsd/](https://blogs.city.ac.uk/birthptsd/) ~ International network for perinatal PTSD research
PMAD resources for families

Online Support


- **www.ppdsupportpage.com** – Provides online support groups for women suffering from Pregnancy and Postpartum Mood & Anxiety difficulties.

Childcare:

- **Family Support Center** – 801-955-9110
  : [www.familysupportcenter.org/](http://www.familysupportcenter.org/)

  Free 24/7 care for children when parents are overwhelmed (Crisis Nursery). Three locations in Midvale, Sugarhouse, and West Valley
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
PSI Educational DVDs

Healthy Mom, Happy Family

13 minute DVD

Information, Real Stories, Hope

1-800-944-4773

www.postpartum.net/Resources
PSI Support for Families

- **PSI Support Coordinator Network**
  - 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


- **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
“Perinatal Mood Disorders are not just the mother’s problem; they are not just the father’s problem; they are not just the family’s problem. Rather, Perinatal Mood Disorders are the community’s problem. We must begin to treat these disorders with a ‘community team’ approach - each supporter playing its part - if we are to truly ease the suffering of our postpartum families. This process begins with each of us today.”

Christina Hibbert, Psy.D., Arizona Postpartum Wellness Coalition
What can YOU do in practice to better support maternal mental health?
(541) 337-4960
arwslctherapist@gmail.com
Utahmmhc@gmail.com
Utahmmhc@gmail.com
www.utahmmhc.com
Appendix A: Supporting attachment in psychotherapy
Attachment: Assessing impact of Sx on quality and patterns of the Mother/Infant dyad

Relevant whether sx began immediately PP or within first year
Attachment:
An instinct, throughout the life-span, to seek proximity to a specific person who will comfort, protect, and/or help organize one’s feelings.

(Cooper, Hoffman, Marvin & Powell 2001 www.circleofsecurity.org)
Quality of attachment strategies set the stage for personality development and propensity towards healthy psychological functioning or psychopathology.
Primary Attachment Strategies

- Secure infant experiences confidence that physical and psychological needs will be met, emotions will be tolerated & organized, and that exploration will be supported.
Primary styles cont.

- **Ambivalent** - Overemphasis on proximity and closeness. Inhibited exploration.

- **Avoidant** - Overemphasis on exploratory behavior. Inhibited demonstration of emotional needs.

- **Disorganized** - Child perceives caregiver as afraid or frightening or both. Behavior under stress demonstrates disorganized attempts at meeting emotional needs.
Attachment-based Therapeutic Interventions

- Observe and assess for SE needs in session
- Assess for quality of attachment
- Prioritize treatment focus and needs of client and children.
- Collaborate with family members to support infant development and promote secure attachment while mother’s symptoms are being addressed
- If attachment impacted individual TH not sufficient to repair relationship
Circle of Security
Glen Cooper
www.circleofsecurity.org/
Attachment promoting in Tx

- If you feel qualified:
- Provide simple, compassionate information about supporting the infant/mother relationship
- Give ct permission to prioritize
- And to “fake it”
- “Parenting well while you’re depressed” (Nicholson & Henry, 2001)
- Give concrete feedback about interactions related to depressive and/or anx sx.
Utilizing handouts

- Circle of Security-downloadable handouts
- Appropriate when acute sx addressed.
- Attachment strategies a family affair
- “Building a Secure Attachment for your baby”.
- “Circle of Security”
- “Circle of Repair”
Always be:
BIGGER, STRONGER, WISER & KIND

Whenever possible:
Follow my child’s lead.

Whenever necessary:
Take charge
OR, find someone who can

Acknowledge pain of sx related to relationship and provide consistent feedback about abilities and capacity for connection to child
Balancing Maternal & Infant needs in treatment

Safety
Attachment
What’s practical
Referrals
Modeling
Follow-up
Appendix B: Medication Literature Review
Reviewing the Literature: Cardiac Teratogenicity

Reading the Literature Critically with Our Patients and Our Colleagues

The Concept of “Confounding by Indication”
Malm et al Case Control Study:

- Study suggests confounding by indication with depression may have predisposed to adverse outcome rather than SSRI itself.

- Problem with study design: SSRI-exposed depressed women were compared with unexposed non-depressed women.

- Study that needs to be done: Randomized control data where depressed women are randomized to SSRI or placebo – but unethical in pregnancy

- This is the problem with case control data-based linked studies.

Vivien K. Burt MD PhD The Women’s Life Center Resnick Neuropsychiatric Hospital at UCLA
June 2016
Conclusion: Antidepressants and Risk for Cardiac Defects - (NEJM 2014)

- When adjusted for diagnosis of depression AND depressive-equivalent markers:
  - No statistically significant risk of any cardiac malformation with first trimester exposure to any antidepressants (SSRIs, SNRIs, bupropion)
  - SSRIs
    - No significant association between use of paroxetine and right ventricular outflow tract obstruction
  - No significant association between sertraline and ventricular septal defect

Vivien K. Burt MD PhD The Women’s Life Center Resnick Neuropsychiatric Hospital at UCLA
June 2016
Reviewing the Literature: Yet Another Issue - Autism
If ADs increase ASD risk, this information must be told!

- Keep in mind: Although studies do not prove that ADs increase ASD risk, women deciding whether or not to take ADs while pregnant understandably concerned.

- Although case-control studies may identify associations, they often overestimate magnitude of risk.

- Depressed women more likely to smoke, drink alcohol, take illicit drugs (generally not controlled).

- Apparent risk may actually be a result of confounding by indication.

- What we explained and discussed: No study is perfect – all are subject to confounders – including presence and severity of maternal illness (i.e., confounding by indication).

- Expectant mother’s health is important for health of mother and baby in pregnancy and the postpartum, and throughout the lives of mother and child.
Revisiting Issue of Autism

- New large Danish registry study
- Data from >600,000 children born 1996-2006
  Nearly 9000 prenatal exposures to SSRIs, over 6000 with maternal affective history
- Autism outcomes:
  - With prenatal SSRI ≈ 2%, without SSRI ≈ 1.5%

- If data restricted to children of mothers with prenatal affective disorder: no statistically significant risk in ASD with prenatal SSRI exposure
- Comparing siblings with and without ASD, prenatal SSRI exposure not significant contributor to ASD risk
- Conclusion: After controlling for confounding factors, no significant association between prenatal SSRI exposure and ASD in offspring.
Second new Danish study also suggests no risk of ASD

Large cohort study

1996-2005 (f/u through 2009)

Found that SSRIs prior to pregnancy rather than during pregnancy was statistically significantly associated with increased ASD risk.

Conclusion- any increased risk was due to confounding by indication rather than by effect of SSRIs - i.e., maternal depression, not ADs increase risk for ASD

Other Issues to Consider

- No increased risk of miscarriage (Large systematic review and meta-analysis of pregnancy and delivery outcomes after exposure to antidepressants)
- No increased risk of stillbirth, neonatal mortality, post-neonatal mortality with antenatal SSRIs
- SSRIs and untreated maternal depression do not cause clinically significant lower birth weight.
- There is small statistically significant but probably not clinically significant reduction in length of gestation (about 3 days) with antidepressants and/or depression exposure in pregnancy

Neonatal Adaptability – 3rd Trimester Use of ADs

- Poor adaptability* (15-30%): Transient perinatal adverse events*: jittery, muscle tone, resp distress, suck – mostly mild, transient

- Infants exposed to antidepressants should be monitored after birth for 48 hours for additional care as needed.

- Prospective follow-up of affected infants: no adverse impact on intelligence, aberrant behaviors, depression, anxiety) at ages 4-5

- 12/14/2011: FDA update: after review of different studies, it is premature to reach any conclusion about a possible link between SSRI use in pregnancy and PPHN.

- Recommendation: FDA advises health care professionals not to alter their current clinical practice of treating depression during pregnancy.