

Perinatal Mental Health Disorders: *More than “Just” Depression*

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1. Perinatal Mental Health:
 - a. An umbrella term for mental health during pregnancy and up to 1 year after birth, includes a spectrum of mood and anxiety disorders (PMADs)
 - i. Antepartum depression & anxiety
 - ii. Postpartum depression
 - iii. Postpartum anxiety
 - iv. Postpartum OCD
 - v. Postpartum PTSD
 - vi. Postpartum bipolar
 - vii. Postpartum psychosis (v. rare; only 1-2%)
2. “Baby blues” is a period of mood swings and feeling of overwhelm, occurs in 80% of new mothers, last only 2-3 weeks and usually resolves on own
 - a. If symptoms last more than 2 weeks or are making it difficult to function at anytime, might be a symptom of something more significant
3. Most common symptoms of Perinatal Mood and Anxiety Disorders
 - a. Perinatal Depression - Excessive Sadness/Crying, Anger/Rage, Appetite & Sleep Disturbances, Mood Swings, Isolation/Withdrawn
 - b. Perinatal Anxiety - Racing Thoughts, Excessive Worry, Agitation, Difficulty Sleeping/Quieting Mind, Restlessness
 - c. Postpartum OCD - High Anxiety, Unwanted & Graphic Intrusive Thoughts, Hypervigilance/Compulsion (over thoughts), Fear of Caring for Infant alone, Guilt/Shame
 - i. Moms recognize that thoughts are scary/bizarre
 - d. Postpartum Psychosis - Delusions (strange beliefs/thoughts), Hallucinations (hearing/seeing things), Extreme Irritation, Mania (mood swings/racing thoughts), Paranoia/Suspiciousness
 - i. Moms do not typically recognize that these thoughts are unhealthy or ask for help (often partner is the one who brings it up)
 - ii. This is considered a crisis that requires immediate medical intervention

4. Significance of Perinatal Mental Health Disorders
 - a. At least 1 in 5 women will experience a perinatal mental health challenge - biggest complication during the perinatal timeframe (more than gestational diabetes) - roughly 800,000 women a year in the US
 - b. These numbers are grossly underreported, undiagnosed, and untreated (only 30% receive proper treatment)
 - c. Undiagnosed and untreated PMADS have significant public health impact
 - i. Risks to pregnancy and birth outcomes
 - ii. Risks to mother and maternal outcomes
 - iii. Risks on infant development (short and long term)
 - iv. Financial impact on society
 - d. Important risk factors include personal or family history or mental illness, lack of healthy social or family support, history of trauma, abuse, or infertility/loss, significant life stressors, issues with pregnancy, breastfeeding, or birth, colicky baby/"high needs," and sleep deprivation
5. Perinatal Mental Health and Breastfeeding
 - a. Breastfeeding can have protective qualities for mental health
 - b. Women experiencing perinatal mental health challenges may have trouble or stop breastfeeding sooner, or not at all
 - c. The decision to breastfeed is not always simple
 - i. If breastfeeding is helping a mom feel better vs. contributing to her symptoms, then her treatment can and should be built around protecting that breastfeeding relationship
 1. Many medications are safe for a breastfeeding mom
 2. Breastfeeding may be the one thing that she feels she can give the baby at this time
 - ii. However, if breastfeeding is contributing to a mom's symptoms, she should not feel guilty if she chooses to seek alternative forms of feeding (may help improve sleep and support, reducing symptoms)
 - d. Women who experience birth trauma have increased risk of PPD/PPA, which can negatively affect length of breastfeeding:
6. Screening Recommendations
 - a. PSI recommends **Universal** screening for PMADs in prenatal, postnatal, and pediatric settings, using an evidence-based tool such as the **Edinburgh Postnatal Depression Screen (EPDS)** or **Patient Health Questionnaire (PHQ-9)** - Cut off score to screen positive on both is typically "10"
 - b. All women should be screened routinely by their healthcare providers during and in the months following pregnancy:
 - i. First prenatal visit
 - ii. At least once in second trimester
 - iii. At least once in third trimester

- iv. Six-week postpartum obstetrical visit (or at first postpartum visit)
 - v. Repeated screening at 6 and/or 12 months in OB and primary care
 - vi. 3, 9, and 12 month pediatric visits
7. Normalize Perinatal Mental Health
- a. Display and offer resources (brochures, handouts, posters)
 - b. Remind mom she is not alone, she is not to blame, with help she will be well
8. Considerations for Dads & Partners
- a. Include dads and partners in keeping eye on mom for symptoms
 - i. Crying more than normal for her
 - ii. Unable to sleep (even when given opportunity)
 - iii. Not caring for basic needs (shower, eating, drinking water)
 - b. Keep an eye on dads too
 - i. 10% of new dads experience paternal depression during pregnancy or postpartum
 - ii. This rate can increase to 50% when a partner also has perinatal/postpartum depression!
9. Treatment Options
- a. PMADs are highly treatable and can be managed with a variety of treatments (Peer/Social Support, Psychotherapy, Medication, Hospitalization, Alternative Therapies)
 - b. Can refer to PSI, Mental Health Providers (psychotherapists & psychiatrists) who specialize in perinatal mental health, or Medical Providers
10. Free PSI Referrals & Training
- a. Free **PSI HelpLine 1-800-944-4773(4PPD)** (call or text)
 - i. Someone will return message within 24 hours
 - b. Free **online weekly support groups**
 - i. <https://www.postpartum.net/get-help/psi-online-support-meetings/>
 - c. Visit **PSI** for additional mental health resources
 - i. Search [free online directory](#) of trained and vetted providers
 - ii. Locate a [PSI state coordinator](#) in client's community for other local resources and assistance
 - d. Medical prescribers can call [PSI Perinatal Psychiatric Consultation Line 1-800-944-4773, ext 4](#) and schedule consult with experts on medication management
 - e. Additional PSI trainings available to providers - <http://www.postpartum.net/professionals/>