“To Address Perinatal Depression, Anxiety and Related Behavioral Health Disorders”

An Introduction to Mental Health Care During Pregnancy and Postpartum

Dr. Mary Kimmel
Medical Director of NC Maternal Mental Health MATTERS
Co-Director of the Perinatal Psychiatry Program
Assistant Professor
University of North Carolina at Chapel Hill

Dr. Kimmel has no conflicts of interest to disclose.

Women's Reproductive Lifecycle

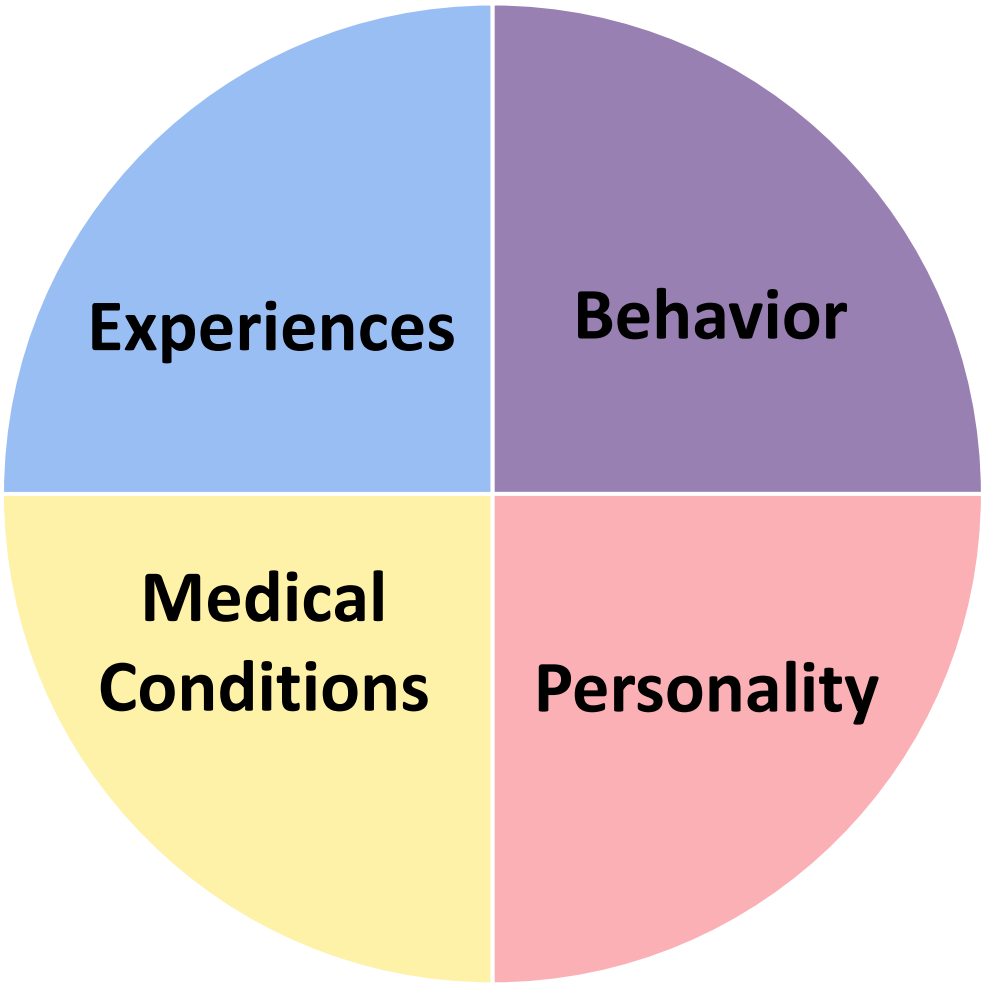
Pregnant, Postpartum and Mental Health

Mental Health: An Overview

- Mental health is a **dynamic state of internal equilibrium**:
  - Demonstrate basic cognitive and social skills;
  - Recognize, express, and modulate emotions;
  - Empathize with others;
  - Cope with adverse life events;
  - Function in social roles;
  - Posses harmonious relationship between body and mind

Galderisi et al., 2015.

Four Aspects of Mental Wellness



Treating the Whole Person

Medical Traumas

- Previous miscarriage, stillbirth, and/or child death
- Pregnancy-induced preeclampsia, HELLP syndrome, postpartum hemorrhage
- Child in NICU

Impact on Women

- **Re-experiencing cues**: labor suite, follow-up appointments, photos, questions about birth/NICU, etc.
- **Avoidance**: medical appointments, baby, sexual activity, future childbearing
- **Changes in mood**: self-blame (body, assertiveness), loss of memory, detachment, sense of foreshortened future
- **Hyperarousal**: inability to relax, hypervigilance to health-related cues (panic)

Treating the Whole Person

Sexual Assault and Intimate Partner Violence

Impact on Women

- **Re-experiencing cues**: vaginal exam, mode of delivery, breast feeding
- **Avoidance**: attending appointments, complying with treatment plans, bonding
- **Changes in mood**: fears of becoming a perpetrator, inadequacy in motherhood, concerns about safety/danger outside of home, detachment, numbness/strong emotions
- **Hyperarousal**: anger/rage, inability to sleep, hypervigilance to infant and his/her safety

Treating the Whole Person

Cultural Competence

- Culturally competent care acknowledges the importance of culture and adapts services to meet culturally unique needs.
- Interpersonal trust between patient and physician is a critical determinant of care
- Historic mistreatment of Black people, Indigenous people, communities of color, and minority groups by the medical field affects perception of trustworthiness
- A patient's unique health history must include and be contextualized by their unique cultural history, their language proficiency, their citizenship status, etc.

Cuevas, O'Brien, & Saha (2018); Howell, Pinckney, & White (2020)

Perinatal Mood and Anxiety Disorders

PERINATAL MOOD AND ANXIETY DISORDERS (PMADS)

Perinatal: Anytime during pregnancy through the first year postpartum

- Depression (PPD)
- Anxiety (PPA)
- Panic Disorder
- Obsessive Compulsive Disorder (OCD)
- Postpartum PTSD
- Bipolar Disorders
- Postpartum Psychosis

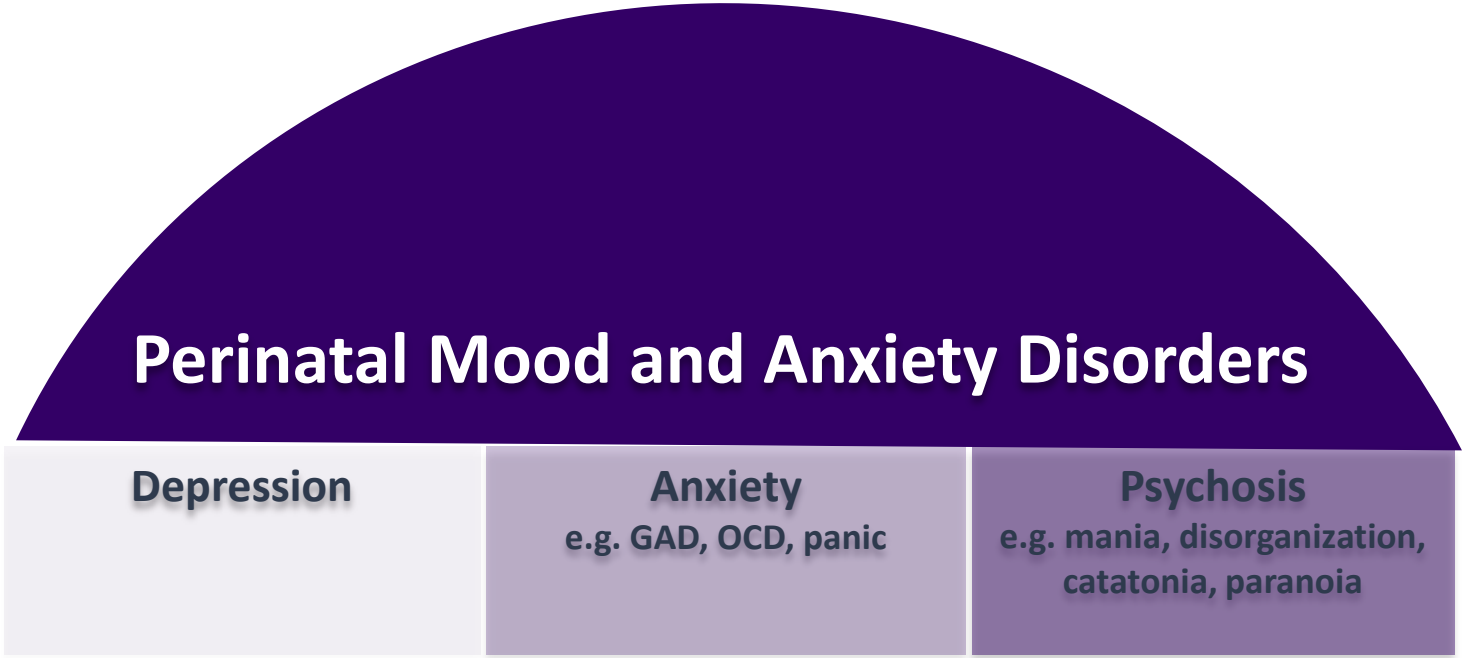
SYMPTOMS

- Feelings of guilt, shame or hopelessness
- Feelings of anger, rage, or irritability, or scary and unwanted thoughts
- Lack of interest in the baby or difficulty bonding with baby
- Loss of interest, joy or pleasure in things you used to enjoy

- Disturbances of sleep and appetite
- Crying and sadness, constant worry or racing thoughts
- Physical symptoms like dizziness, hot flashes, and nausea
- Possible thoughts of harming the baby or yourself

TREATMENT OPTIONS

- Counseling
- Medication
- Support from others
- Exercise
- Adequate sleep
- Healthy diet
- Bright light therapy
- Yoga
- Relaxation techniques


Perinatal Mood and Anxiety Disorders
Depression
Anxiety
e.g. GAD, OCD, panic
Psychosis
e.g. mania, disorganization, catatonia, paranoia

General PMAD Prevalence

- PMADs are the most common complication during and after pregnancy
- They are the leading cause of morbidity and mortality among childbearing women
- 20% of mothers experience PMAD during the perinatal period; 25-40% for women of low SES
- Symptoms can last for 6 months
- Some studies define postpartum depression occurring up to 4 years postpartum

Accortt & Wong (2017); Bonacquisti, Cohen, & Schiller (2017); Karras (2020); VanderKruik et al. (2017)

PMAD Risk Factors

- Psychiatric history
- Family history of PMADs
- Lack of support system
- High conflict environments
- Younger Age
- Substance use history
- Unemployment or SAHM
- Workplace Adversity
- Other adverse events
- History of trauma
- Obstetric complications and loss

Consequences of Not Treating During Pregnancy

Pregnancy is not protective!

Increased impulsivity, substance abuse, poor nutrition and self-care	Increased risk for preeclampsia, pre-term births, low birth weight, IUGR	Congenital defects/ malformations; toxic stress of the newborn
Disability depression or anxiety	Suicidality, self-injury	Psychotic symptoms, poor judgment, delusional beliefs
	Infanticide	

Consequences of Not Treating Postpartum

Toxic stress of the newborn	Lactation failure	Insecure attachment
Poor bonding	Lower cognitive scores in the child	Affect dysregulation in the child
Increase rates later in life of suicidality	Higher rates of ADHD and conduct disorder in the child	Impacts on Family Dynamics, higher rates of divorce and other discord

The Baby Blues

- **Normal emotional experience**
- Occurring in first 10 days
  - Typically begins days 3-4
  - Peak days 4-5
- Up to 80% new mothers
- Most recover in 2-3 weeks

Symptoms

- **Weeping**
- **Emotional liability**
- **Sadness**
- **Irritability**
- **Anxiety**
- **Lack of affection**
- **Envy/hostility toward partner**
- **Feelings of dependency**
- **Sense of "unreality"**

Degner (2017)

Depression

- **Perinatal/Postpartum Depression** is a serious condition characterized by:
  - **Strong feelings of sadness**
  - **Worry**
  - **Tiredness**
  - **Impaired concentration**
  - **Loss of enjoyment**
  - **Suicidal ideation**
  - **Sleep difficulty and appetite changes**

Depression

- Unrealistic expectations of motherhood and/or for baby
- Preoccupation with baby's safety/vulnerability
- Profound negativity
- Thoughts of death (self and/or baby)
- Egodystonic thoughts of harming baby (i.e., "scary thoughts")

Anxiety

- **Perinatal/Postpartum Anxiety** is the most common PMAD and often goes undiagnosed.
- Symptoms to look for include:
  - **Excessive worrying**
  - **Racing thoughts**
  - **Feelings of dread**
  - **Feeling overwhelmed**

Anxiety

Other symptoms to screen for:

- **Difficulty concentrating**
- **Trouble sleeping**
- **Changes in eating/sleeping patterns**
- **Rapid heartbeat**
- **Sense of memory loss**
- **Nausea, dizziness, hot flashes**

Annivero et al. (2013)

Stress from COVID-19

Fear and anxiety about a disease can be overwhelming and cause strong emotions in adults and children.

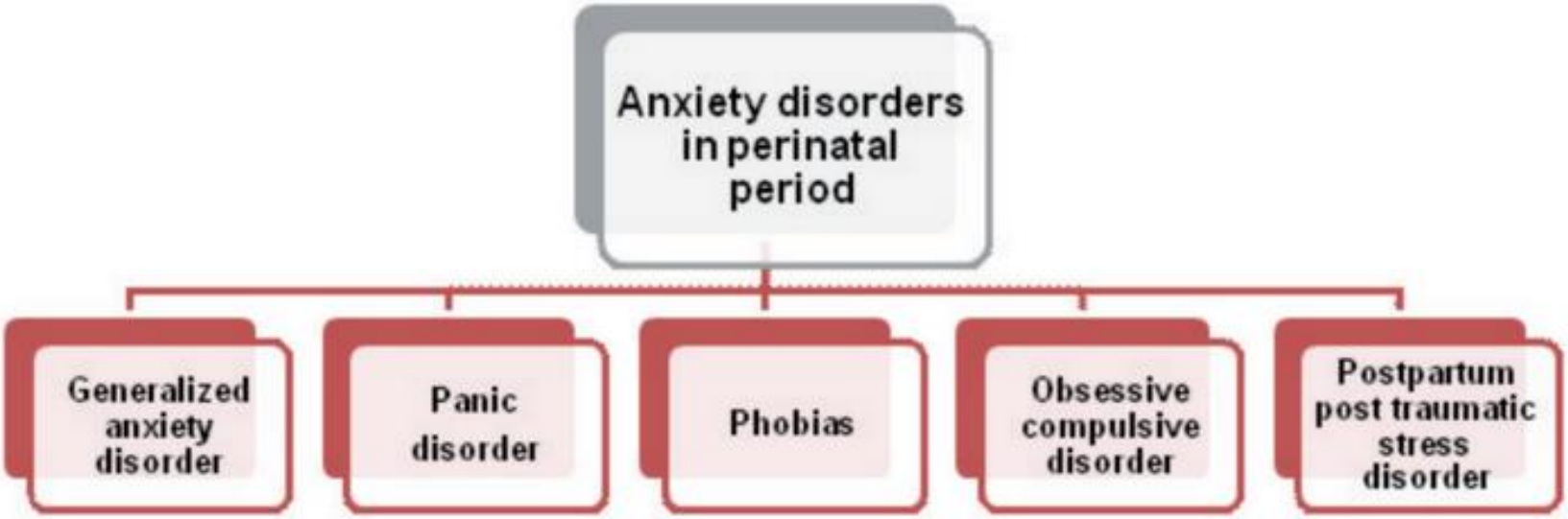
Mental health concerns can present as:

- Physical complaints (e.g., headaches, stomachaches)
- Cognitive problems (such as having trouble concentrating).

Stress during an infectious disease outbreak may include:

- Fear and worry about her health and the health of her family
- Changes in sleep or eating patterns
- Difficulty sleeping or concentrating
- Worsening of chronic health problems or mental health conditions
- Increased use of tobacco, alcohol, or other drugs

Source: CDC.gov


Anxiety disorders in perinatal period
Generalized anxiety disorder
Panic disorder
Phobias
Obsessive compulsive disorder
Postpartum post traumatic stress disorder

Field (2017)

PMADs Onset

Onset can be anytime during pregnancy or first year postpartum.

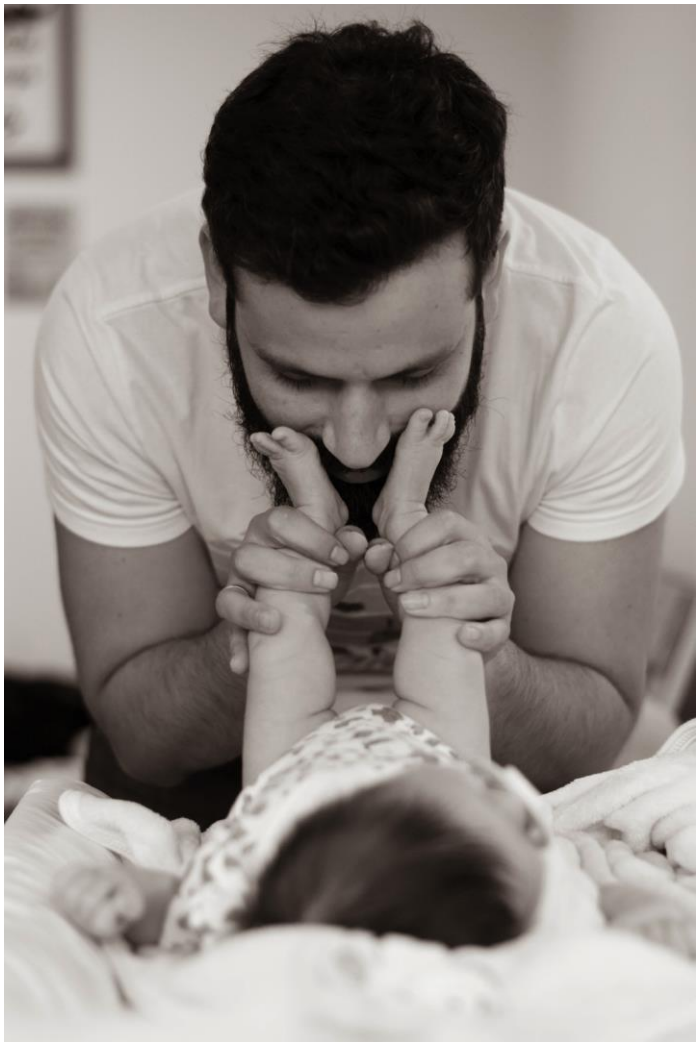
Peaks at 3-4 months postpartum.

Can also be triggered by weaning and/or when menstrual cycle resumes.

Field (2017)

PMADs and Families

- Partners are affected by postpartum depression by supporting and coping with their partner's symptoms:
  - **Confusion**
  - **Anger**
  - **Fear**
  - **Feeling overwhelmed**
- May also experience depression:
  - **1 in 10 fathers experience depression in the first year**

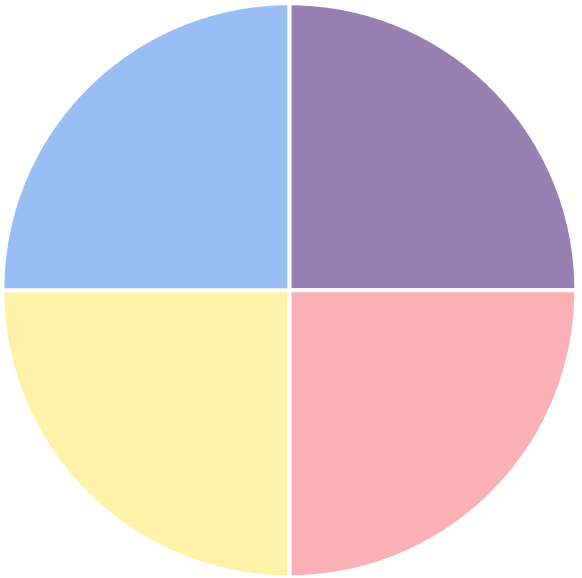


Paulson & Bazemore (2010); Kessler et al. (2003)

“Other Related Behavioral Health Disorders”

Substance Use	Eating Disordered Behavior	Intense Reactions, Relationship Problems	Attention and Cognition	Non Affective Psychosis	Trauma

- Each one deserves its own lecture (more than one lecture)
- Co-morbidity >>> More Complex Needs

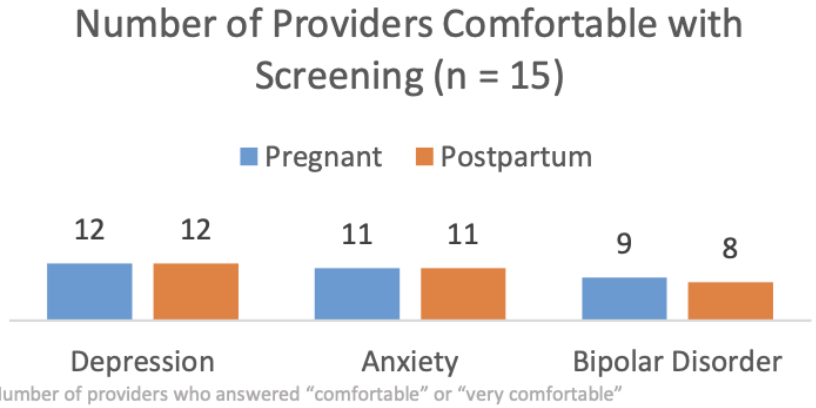


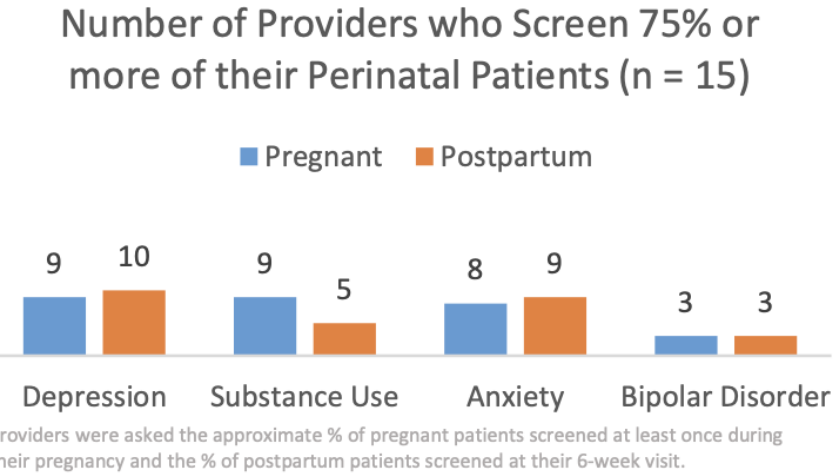
Baby Steps Toward Improving Outcomes

Elizabeth Q. Cox, MD[a,*]; Nathaniel A. Sowa, MD, PhD[a];
Samantha E. Meltzer-Brody, MD, MPH[a];
and Bradley N. Gaynes, MD, MPH[a]

Women with Postpartum Depression who…	Antenatal	Postpartum
are identified in a clinical setting	50%	31%
Receive treatment	14%	16%
Receive adequate treatment	9%	6%
Achieve remission	5%	3%

Barriers to Treatment





Barriers to Screening and Assessing

Providers discussed experiencing a variety of barriers to screening and assessing mood disorders and substance use concerns in their pregnant and postpartum patients.

- **Limited focus on moms during postpartum period**: patients are generally only seen once at their six-week postpartum visit, and a greater emphasis is placed on the physical health of the new baby
- **Logistical barriers in the office**: there is some difficulty with increased paperwork, integrating screenings into the work flow of the office, appointments being too short, and sometimes resistance amongst long-practicing providers to add another task
- **Structural barriers**: transportation, childcare, insurance coverage, legal status, racism, and mistrust of the medical system
- **Language barriers**: the EPDS and other screening tools may not translate well for non-English speaking patients, and there are challenges with building trust and rapport across languages
- **Lack of referral options**: some providers have limited options for referrals for positive screens, so may opt to not screen

Barriers to Treatment

Barriers to Managing and Treating

Providers discussed various barriers to managing and treating the behavioral health concerns of their pregnant and postpartum patients.

- **Complex needs of patients:** patients may be facing additional needs such as homelessness, socioeconomic concerns, and interpersonal violence
- **Discomfort with grief/loss of infant/pregnancy**: some providers expressed difficulty handling extreme grief due to infertility, miscarriages, infant death, or unwanted adoption
- **Mistrust in medical providers:** undocumented people and communities of color may not trust doctors nor be honest about mental health concerns
- **Lack of referral options:** long wait times for referrals or a complete lack of resources may result in providers not knowing what to do for patients that require treatment beyond what they can comfortably offer them
- **Stigma of mental health concerns:** mental health concerns and disorders carry a greater stigma than physical disorders, and patients may feel uncomfortable seeking treating
- **Discomfort with certain disorders:** many providers said they are uncomfortable treating and managing bipolar disorder and more complex diagnoses

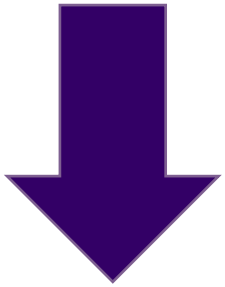
Barriers to Treatment

Illustrative Quotes

- "The amount of time that you have with the patient...you already have so many things to cover, it's hard to be able to sit down and.... it takes some talking to get at exactly what's going on with them...there is a stigma and they're afraid to bring it up. They have to make sure it's safe. And you know, I think that takes time."
- "Language is an issue. That tool [the EPDS] doesn't work when it's translated, I've found. People can't translate their grief or their depression into English....because some of it is a cultural experience."
- "If you have a tool and identify someone, then what are we going to do with it...because it doesn't help to identify somebody if there aren't resources."
- "It's ok to have high blood pressure, but it's not ok to be bipolar."
- "I'm trying to help and manage as much as I can, knowing they're not going to be seen for 2-3 months if I refer them."
- "For the prescriber...we want what's best for the patient, and what's best for the patient is someone who feels comfortable with the meds they're prescribing."

Barriers to Treatment

Patient	Provider	Systems
• Lack of disclosure • Fear/stigma • Limited access to care	• Training • Comfort level • Resources/time	• Lack of integration • Screening not routine • Isolated providers



NC MATTERS

Continuing education, screening, assessment, and treatment support and resources.

Healthy Mom is Critical to Healthy Baby (and also because she deserves to be Healthy too)