Perinatal Mental Health

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Objectives

- Introduction to Perinatal Mood and Anxiety Disorders
- Prevalence, Impact and Screening
- Introduction of the Consult Service of Vermont
- Treatment Principles in Pregnancy and Postpartum

Perinatal Mood and Anxiety Disorders

This is any mood disorder, including depression, bipolar disorder or an anxiety disorder.

CDC Depression Data from 2020 and 2021:

	Prenatal Depression	Postnatal Depression
Vermont	22%	9%
NH	19%	12%
Maine	22%	12%

Studies suggest that only 50% of women with prenatal depression are identified and 14% recieve treatment
31% of women with PPD are identified and 16% will get treatment

Perinatal Mood and Anxiety Disorders: Impact

On Birthing Parent:
Increase in pre-eclampsia, preterm birth, longer maternal hospital stays, suboptimal breastfeeding, productivity loss, and.....suicides

Perinatal Mood and Anxiety Disorders Impact

On Child:
Increase in emotional problems, social problems, obesity, asthma, behavioral problems, lower academic achievement

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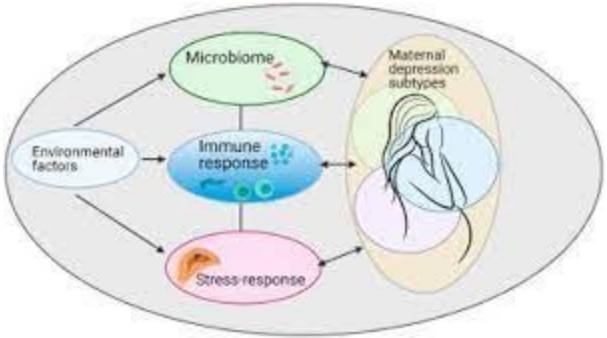

Psychoneuroimmunology in the context of perinatal depression - Tools for improved clinical practice,Brain, Behavior, & Immunity - Health,Volume 17, 2021,

Perinatal Mood and Anxiety Disorders Impact

On society:

In 2017 estimated cost of PMADs over a five year span was 14 billion dollars in the US;

In 2020 the estimate was 48 million in Vermont

PMADs Screening

Edinburgh Postnatal Depression Survey
Should be done in OB offices **prenatally** and postpartum
Also done at many pediatric offices

10 Item Questionnaire
Available Free online
High Risk Score 10 or higher
3 Specific Anxiety Questions
1 Self Harm Question

Validated for partners also

Vermont Perinatal Psychiatry Consultation Service

802-847-4758

Sandra Wood, APRN, CNM

Sarah Guth, MD

Consult Service

Free assessment, diagnostic and treatment advice in one business day based on MCPAP in Mass

Evidence-based medication management in pregnancy, postpartum and preconception patients

This may be a single exchange or a longitudinal discussion; occasional face to face assessments

We offer PMAD education for practices and case discussions

We are not available to assist with crises but we can provide guidance on how to plan ahead for potential crises

Cases
To
Illustrate
Treatment
Strategies
Getty

Cases: SSRI in Pregnancy

Woman presents after finding out she is pregnant, she is taking fluoxetine.

"I don't know if it is doing much, maybe I should stop it?"
"Should I switch to something safer like sertraline?"
"My PCP told me I should stop it"

Prenatal Effects of SSRIs

Issue Studied	Results	Comments
8 Original studies looking at major **congenital malformations**	**No increase**	Consensus in most studies that, in general, there is no increase in the rate of major malformations
14 Original studies looking at cardiac malformations	**Equivocal**	Issue in debate: Large studies are generally positive, especially demonstrating an increase in rare, severe, cardiac malformations. Other studies have shown a similar increase in untreated mothers with depression
7 Original studies looking at **miscarriage and stillbirths**	**Generally no increase**	The slight increase is related to maternal disease or gestational age at study
9 Original studies looking at **preterm birth and low birth weight**	**Generally no increase in preterm birth and no effects on fetal growth**	The slight increase in preterm birth and possible decreased fetal growth are related to maternal disease

Postnatal Effects

Issue Studied	Results	Comments
5 Studies considered Poor neonatal adaptation	SRI may interfere with neonatal adaptation • Irritability • Abnormal crying • Tremor, jitteriness • Respiratory distress • Poor tone and color	Present in **up to 30%** of newborn infants. Generally no long-term sequelae
6 Studies looked at Persistent Pulmonary Hypertension of the Newborn (PPHN)	SRI may increase the rate of PPHN	Less than 1%, Number needed to harm 1615 pregnant people

Cases: SSRI in Pregnancy

Key Principle- **Stability**

Recommend good consideration for keeping things as they are.

Medication appears low risk.

Biggest issue is transient neonatal adjustment symptoms 30%. No improvement in those who discontinued in third trimester. SNRI's have similar profile.

Cases: SSRI in Pregnancy

Sertraline is not necessarily safer, it just has more data; once destabilized by a switch it can be hard to regain euthymia

Atypical antidepressants such as Mirtazapine, Bupropion, Lamotrigine all have less data than SSRIs but existing observations appears reassuring.

Cases: SSRI in Pregnancy

If a patient does choose to stop their medication, make sure they are engaged in nonpharmacologic strategies to boost mental health:
-psychotherapy
-exercise
-yoga
-social support (natural or groups)
- consider light therapy for SAD

Cases- Pharmacokinetics

A woman presents in the third trimester having been stable for three years on the same dose of SSRI, now having depression or anxiety.

Cases- Pharmacokinetics

Some medications are metabolized differently in pregnancy and dose may have decreased.

CYP induction and inhibition
Blood volume
Pharmacogenomics
CYP2D6 and CYP2C19

Consider a simple increase in medication (sometimes temporarily over the max recommended dose)

Cases- Bipolar Disorder

Patient is newly pregnant, new to your practice and says they have a history of bipolar disorder. They are on a mood stabilizer and are hoping to stop it for pregnancy.

Cases- Bipolar Disorder

With bipolar disorder there is often diagnostic ambiguity.

Treatment path for someone with *True* Bipolar I disorder vs other diagnoses very different.
Screens are not easy to use.
Bipolarity Index

Mimics: PTSD, ADHD, Borderline Personality Disorder

Cases- Bipolar Disorder

Positive Clues:

- History of hospitalization for mania or depression
- History of psychosis
- Episodes last *at least 7 days* where patient slept little and wasn't tired
- History of periods of reckless and uncharacteristic decisions (not related to drug use)

Cases- Bipolar Disorder

Negative Clues:

- Patient was diagnosed under 15 (had angry outbursts)
- Patient describes rapidly fluctuating moods on a day to day basis
- Manic behavior was always in context of substances
- Patient has had long periods of time maintained on SSRI's vs. Mood Stabilizers

Cases- Bipolar Disorder

Without a clear picture of discrete and severe mood episodes, and a patient unsure how helpful a medication has been it might be okay (with good psychotherapy) to stop mood stabilizer.

If patient has been hospitalized for a mood episode or has other positive indicators recommend intense caution around stopping.

Bipolar Disorder in Pregnancy

- Increased risk of preterm birth and small or growth restricted babies
- Increased risk of placenta previa and antepartum hemorrhage
- Increased risk of gestational diabetes mellitus and pre-eclampsia
- 70% of pregnancy women with BD have mood episode
- Depression more common in pregnancy
- Mania most common in postpartum period (about 50% risk)
- Women with BD are more likely to have babies admitted to the NICU and more likely to experience impairment in the maternal role accounting for adverse child outcomes

Bipolar Disorder in Pregnancy

- Patients with Bipolar Disorder need close psychiatric follow up in Pregnancy and a very careful Postpartum plan. Involve family, other care providers to help monitor for symptoms.
- Aside from Valproic Acid and Carbamazepine very few medications off the table. Lamotrigine safe profile but won't prevent mania.
- Antipsychotics are first line. Best studied with no clear risks other than neonatal adaptation symptoms.
- For lithium the risk of Ebsteins Anomaly is smaller than previously thought. The risk ratio was 1.11 (95% CI, 0.46 to 2.64) for a daily dose of 600 mg or less, 1.60 (95% CI, 0.67 to 3.80) for 601 to 900 mg, and 3.22 (95% CI, 1.47 to 7.02) for more than 900 mg. 2018 NEJM 2018
- (Absolute risk is 6/1000 vs 1.8/1000).

Postpartum Treatment Strategies: Case

Patient presents in early postpartum period and their mood is very low but they are maxed out on an SSRI they have been on for years. They are wondering if switching to something else would help?

Postpartum Treatment Strategies: Case

Key points:

- Switching SSRI's can be very destabilizing
- Sleep may be a big driver
- Think of augmentation strategies

Postpartum Treatment Strategies: Case

Lack of sleep

- Is that patient sleeping when there is an opportunity (anxiety, racing thoughts?)
- Is there an opportunity or room for strategizing?

Postpartum Treatment Strategies: Case

Augmentation

- Many agents can be added to SSRIs
- Will need more information to guide the direction

Postpartum Treatment Strategies

No energy, no motivation, not enjoying anything

Bupropion

Dark thoughts- baby would be better off without me, suicidal ideation

Antipsychotics

Racing thoughts, constantly worried about the baby, intrusive images

Clonidine, Buspar, Benzos, Antipsychotics

Postpartum Treatment Strategies

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EPDS Can Guide You

1. I have been able to laugh and see the funny side of things
2. I have looked forward with enjoyment to things
3. I have blamed myself unnecessarily when things No, not at all went wrong
4. I have been anxious or worried for no good reason
5. I have felt scared or panicky for no very good reason
6. Things have been getting on top of me
7. I have been so unhappy that I have had difficulty sleeping
8. I have felt sad or miserable
9. I have been so unhappy that I have been crying
10. The thought of harming myself has occurred to me

Augmentation with Antipsychotics

- Good for acute distress, especially in cases where you worry about safety or feel someone would benefit from hospitalization

-Some are very sedating- good if there is ample support and anxiety or depression is causing insomnia- **quetiapine, olanzapine**

- When sedation is not preferable- a**ripiprazole*** 5 mg in the morning can help with very bad anxiety, SI or OCD. r**isperidone** is also not too sedating and can be used as scheduled but also helpful when PRN is needed- can address ruminative or racing thoughts in the moment

High long term side effect profile- weight gain, metabolic disruption, but short term less problematic. Watch for early weight gain and restlessness (abilify). All RID safe in breastfeeding *Aripiprazole may be related to low milk supply.

Intrusive Thoughts

"I keep seeing myself throwing my baby down the stairs"
"I feel like I can barely look at her or be alone with her
I'm so scared"
"Am I going crazy?"
"Do I have postpartum psychosis?"

What is your answer?
Rule out other signs of psychosis-
Disorganization, paranoia? If patient is just anxious the answer is probably postpartum OCD. MUCH more common.
In postpartum psychosis there is a 4% risk of infanticide
In postpartum OCD there is no risk to infant, just distress for mom.

Treatment is Sleep, SSRIs and sometimes antipsychotics depending on acuity.

Cases-Trauma-Informed-Care

32 year old woman, history of OUD pregnant, has two kids out of custody, and one baby at home. Just found out she is pregnant and her partner is abusive.

You want to help. You want to deliver prenatal care but she comes in late if at all and sometimes gets very upset, making staff uncomfortable.

Cases-Trauma-Informed-Care

Potential adverse effects of trauma:

-decreased stress tolerance

-heightened emotional or behavioral responses

-hyperarousal or numbing, dissociation

-impaired trust, and distorted thinking or perceptions.

Cases-Trauma-Informed-Care

Four Main Strategies:

-acknowledge what the patient has gone through/is going through

-recognize that her behaviors are likely related to the trauma

-seek to create a safe and trustworthy environment

-avoid re-traumatization

Cases-Trauma-Informed-Care

Six Principles:

Safety
Trustworthiness (transparency)
Collaboration (avoid paternalism, give risk and benefits)
Peer support- support groups, doulas
Empowerment- note the positive
Cultural sensitivity- acknowledge racial and ethnic differences and be curious

ADHD Treatment?

In the past decade, human studies of stimulants in pregnancy appear reassuring in terms of pregnancy outcomes. No neurodevelopmental studies.

In breastfeeding, methylphenidate is preferred given much lower RID.

Zuranolone

What is it?

Allopregnanolone, a neuroactive Steroid that acts on GABA pathways.
A metabolite of progesterone that drastically falls postpartum.
Different mechanism of action.

What is different about it?

Works very quickly (relief on day 3).
Individuals take it 14 nights in a row and then stop and the effect continues afterwards.
Not trialed in breastfeeding

Who is eligible for it?

Anyone whose depression began no earlier than the first trimester and no later than four weeks postpartum
Severe depression (okay to be on other meds and to have other symptoms though not necessarily helpful for psychosis)
Unclear who insurance will cover

Effect

75% of women had “response” to it (50% decrease in the HAM-D scale)
55% of women had remission at day 45
Significant decrease in anxiety as well
Similar to SSRIs

Resources

- MotherToBaby: Provides up-to-date information about the risks of medications (not limited to psychiatric), chemicals, herbal products, illicit drugs during pregnancy and while breastfeeding.
- The National Institutes of Health's (NIH) LactMed® database has information on chemicals and drugs that breastfeeding mothers may be exposed to, including levels and possible adverse effects
- • MGH Center for Women's Mental Health's Reproductive Psychiatry Resource & Information Center: Provides a range of current information, including discussion of new research findings in women's mental health and how they inform clinical practice.
- Postpartum Support International offer a variety of resources, including patient warm lines and moderated online peer support groups

Resources

- MCPAP for Moms

https://www.mcpapformoms.org/Toolkits/Toolkit.aspx

How to evaluate risk associate with thoughts of harm to self or baby
https://www.mcpapformoms.org/Docs/Key%20Clinical%20Considerations%207-21-17.pdf

Considerations around starting medicine
https://www.mcpapformoms.org/Docs/Recommended%20Steps%20and%20AD%20Tx%20Algorithm%2010.10.17.pdf

Resources for Patients

Mother to Baby
This is a non-profit program that offers evidence-based information to mothers, health care professionals, and the general public about medications and other exposures during pregnancy and while breastfeeding.

Postpartum Support International (PSI)
Information for mothers, families and professionals. Prenatal and postpartum resources. Includes lists of support groups online and in your area, as well as therapists and other providers who specialize in postpartum mental health. Help line: 1-800-944-4773 Call or text "help"

Action on Postpartum Psychosis
APP is a network of over 600 women who have experienced postpartum psychosis and experts focused on this field of study. APP provides information about the latest in research and services for postpartum psychosis, while also hosting a forum for women to share their experiences and stories.

Talking Postpartum Depression: US Office on Women's Health website, has many resources as well