Beyond the Blues: Understanding the Spectrum of Perinatal Mental Health Conditions

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Agenda

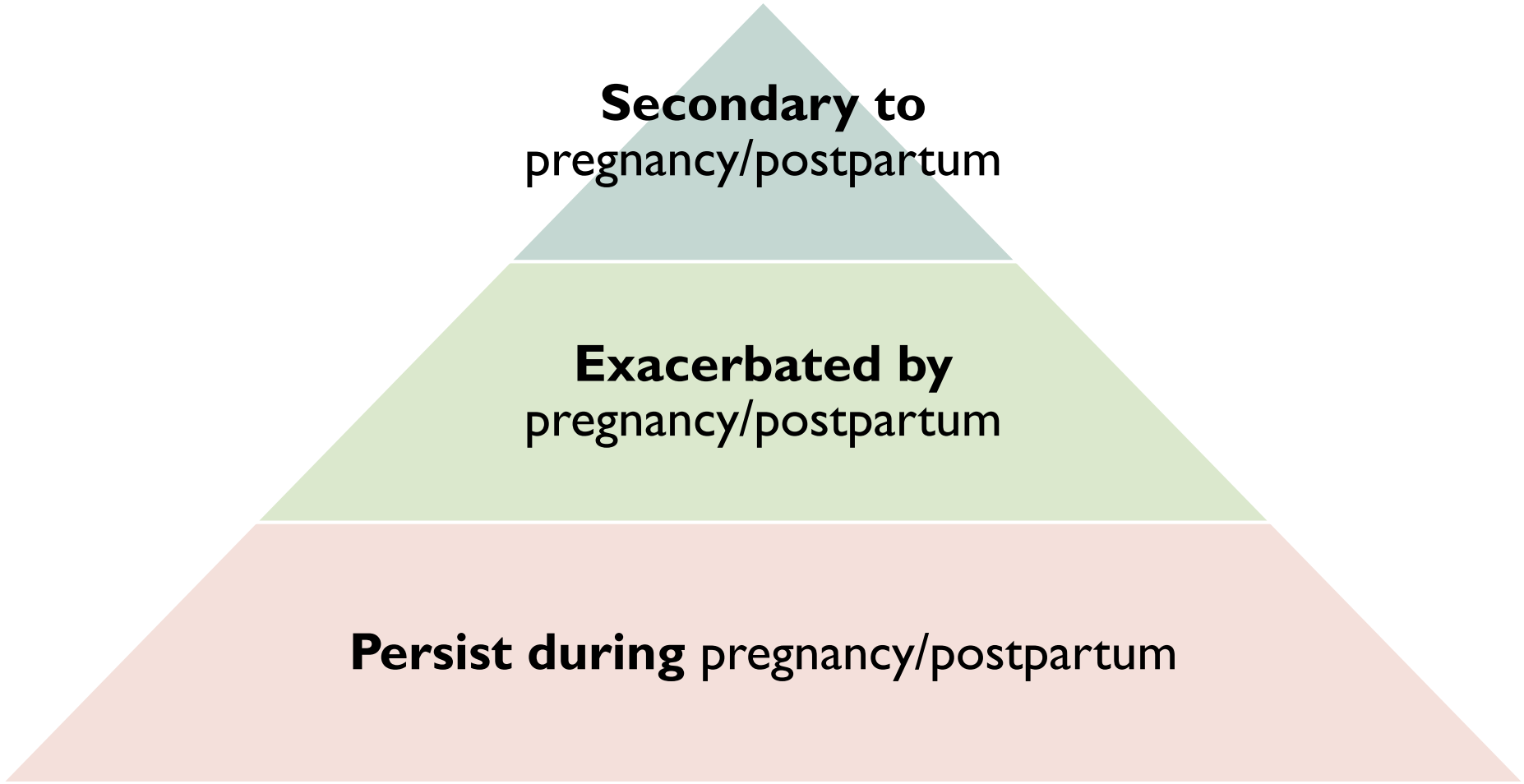
- Why is the postpartum period so high risk?
- Overview of PMHDs
- Suicide in the perinatal period
- Identification and Treatment of PMHDs

Mental Health and Substance Use Disorders in the Perinatal Period

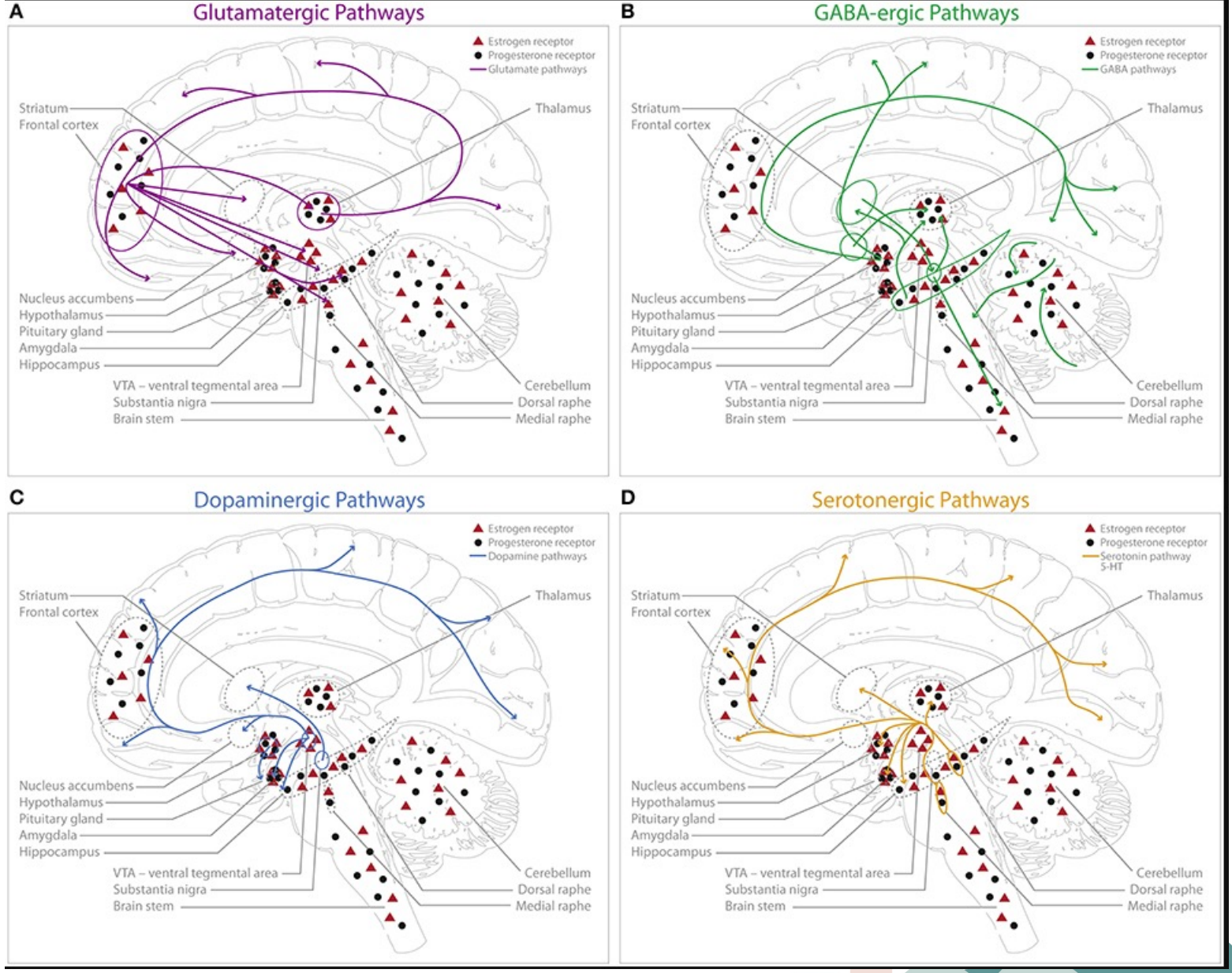
OFTEN CO-OCCURRING

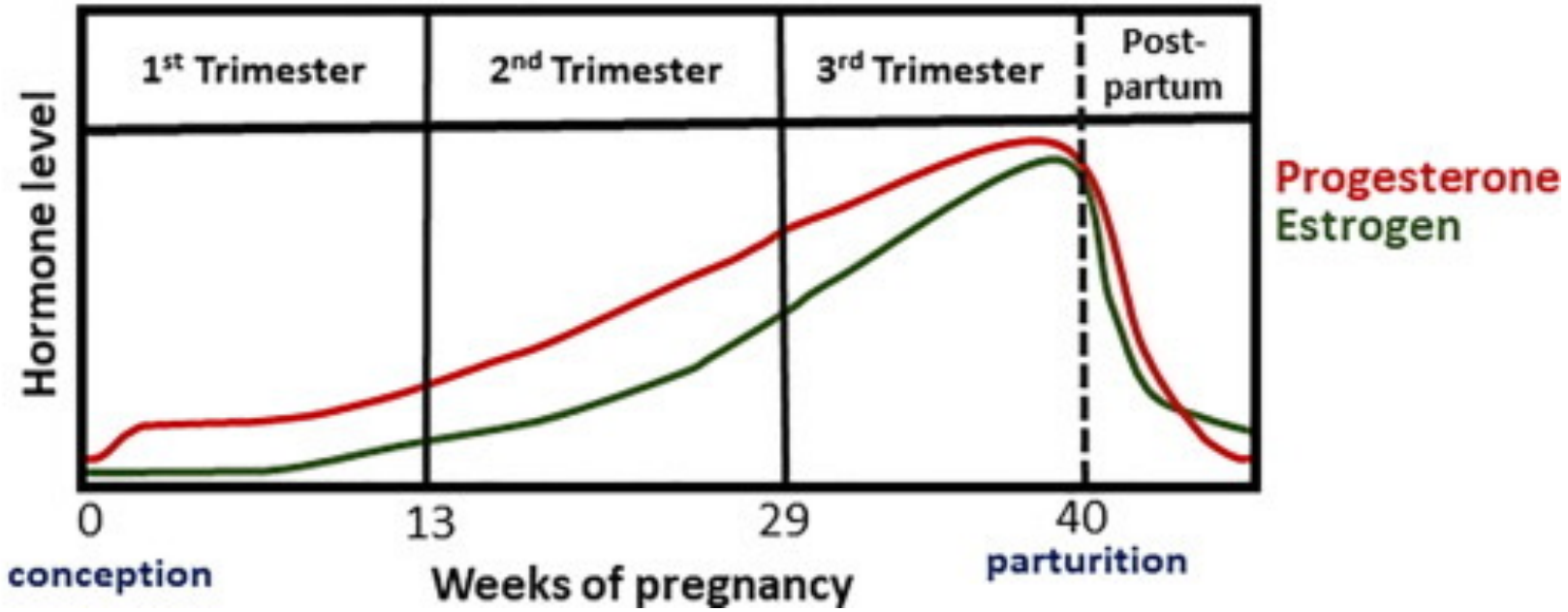
MHDS MAY TRIGGER CONTINUED USE OR RELAPSE OF SUBSTANCE USE

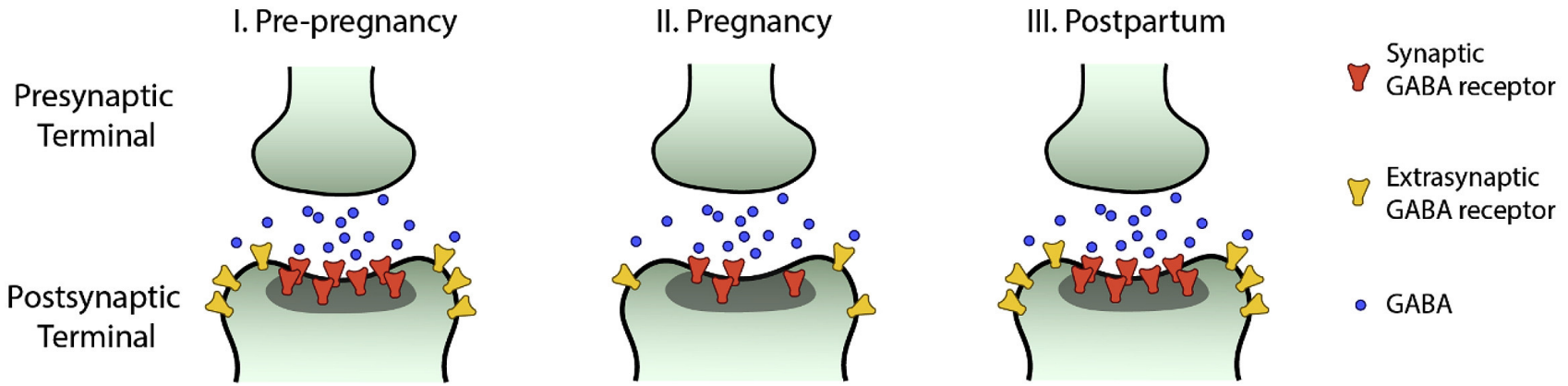
CO-OCCURRING MHDS AND SUDS MAY EXACERBATE ASSOCIATED ADVERSE EFFECTS


Secondary to pregnancy/postpartum
Exacerbated by pregnancy/postpartum
Persist during pregnancy/postpartum

Reproductive Hormones and the Brain




1st Trimester
2nd Trimester
3rd Trimester
Post-partum
Hormone level
Progesterone
Estrogen
0
13
29
40
conception
parturition
Weeks of pregnancy


I. Pre-pregnancy
II. Pregnancy
III. Postpartum
Presynaptic Terminal
Postsynaptic Terminal
Synaptic GABA receptor
Extrasynaptic GABA receptor
GABA

Sleep

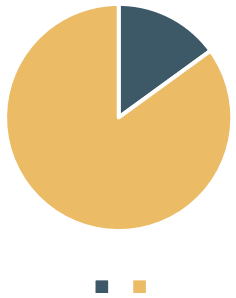
- Sleep is critical to all areas of health and cognition.
- Poor sleep
  - increases risk for mood and anxiety disorders
  - can be a symptom of a mood and anxiety disorder
  - makes mood and anxiety disorders more difficult to treat
  - is a risk factor for suicidal behaviors
  - Is often normalized during pregnancy and postpartum

Psychosocial Changes Related to Pregnancy and Postpartum

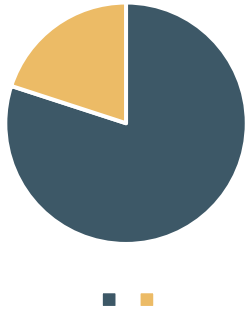
- Role transition within a partnership, family or origin and extended family
- Increased sense of dependence and/or vulnerability
- Increase in household chores/work
- Increased financial stress
- Reconfiguration of work/life balance
- Change in relationship to one's body
- Invasive physical exams or medical treatments

Postpartum Mental Health Conditions

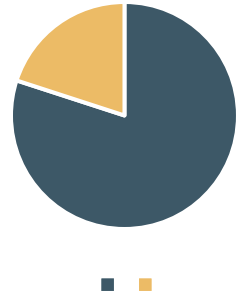
Baby Blues: 50-85%



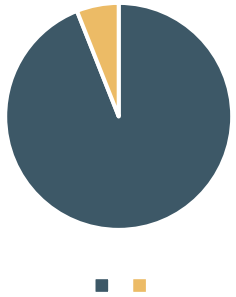
Postpartum Depression: 10-20%



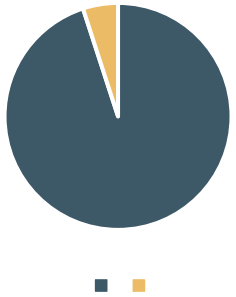
Postpartum Anxiety: 15-20%



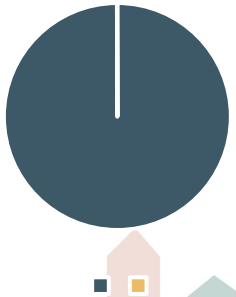
PP-PTSD 6%



PP- OCD 5%



PPP 0.06%



Anxiety Disorders in the Perinatal Period

- Most common mental health conditions experienced in the perinatal period.
- Most common anxiety disorder is GAD followed by Panic Disorder.
- Highly comorbid with perinatal depression.
- SSRIs are the gold standard treatment for anxiety disorders during and outside of the perinatal period.

Postpartum PTSD

- **PTSD that develops as a result of a traumatic birth experience.**
- Prevalence 4.6-6.3%
- Strongest risk factor is a previous **personal history of PTSD**

Presenting symptoms:

- **fear** of pelvic exams or fear of childbirth (tokophobia) in future pregnancies
- distressing **nightmares or flashbacks** of specific aspects of her birth experience
- **emotional numbing** in her relationship with her infant or partner
- **avoiding reminders** of her birth experience (e.g., the hospital, prenatal appointments)
- **avoiding her baby** altogether.

Postpartum OCD

- The postpartum period is associated with an increased risk for new onset OCD or a worsening of existing OCD.
- Prevalence rates for OCD in postpartum range 3-9%, with much higher rates of obsessive/compulsive *symptoms*
- Core features
  - Obsessions
  - Compulsions
  - Symptoms recognized as excessive/unreasonable
  - May be associated with avoidance

Postpartum Psychosis

PPP occurs in 1-3 of every 1,000 births

Classically described with onset in the first 2 weeks postpartum

Early symptoms: insomnia, decreased need for sleep, mood fluctuation, irritability, anxiety

With progression: frank mood and psychotic symptoms

Hutner LA, Catapano LA, Nagle-Yang SM, Williams KE, Osborne LM, editors. Textbook of Women's Reproductive Mental Health. American Psychiatric Pub; 2021 Dec 7.

Postpartum Psychosis

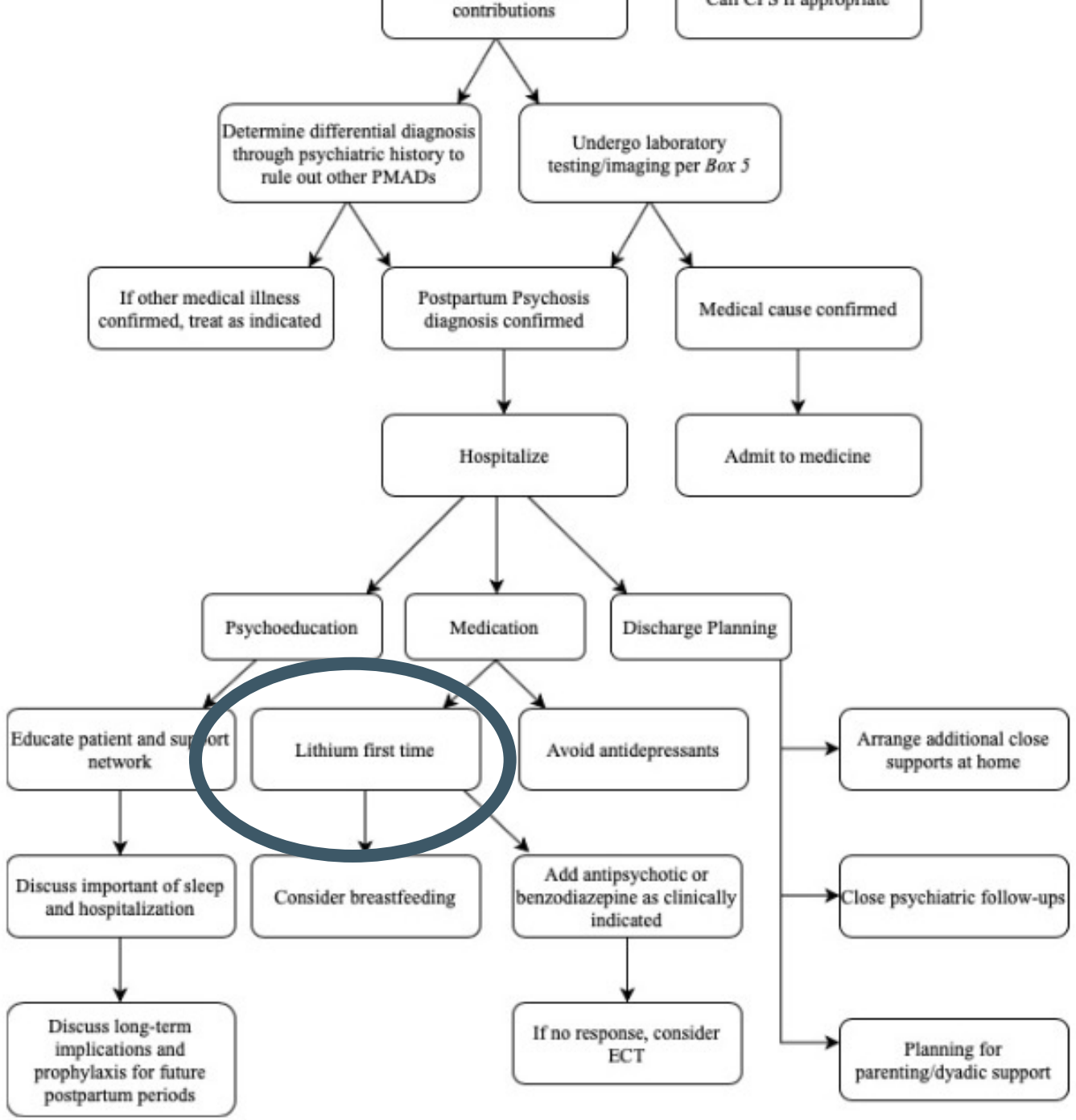
- Mood symptoms may be depressed (41%), manic (34%) or atypical (25%)
- Atypical presentation characterized by delirium-like symptoms
- Anxiety/agitation nearly universal
- Psychotic symptoms are commonly delusions focused on the infant
- SI present in up to 50% of cases and up to 4% of mothers with untreated PPP commit infanticide

Postpartum Psychosis and Bipolar Disorder

- After an incipient postpartum affective psychosis,
  - 60-80% go on to develop a subsequent psychiatric disorder, typical a BD
  - 20-40% will have disease limited to postpartum period.
- Recurrence rate in subsequent pregnancy 33%

Bergink 2012, Bergink 2016

PPP Treatment



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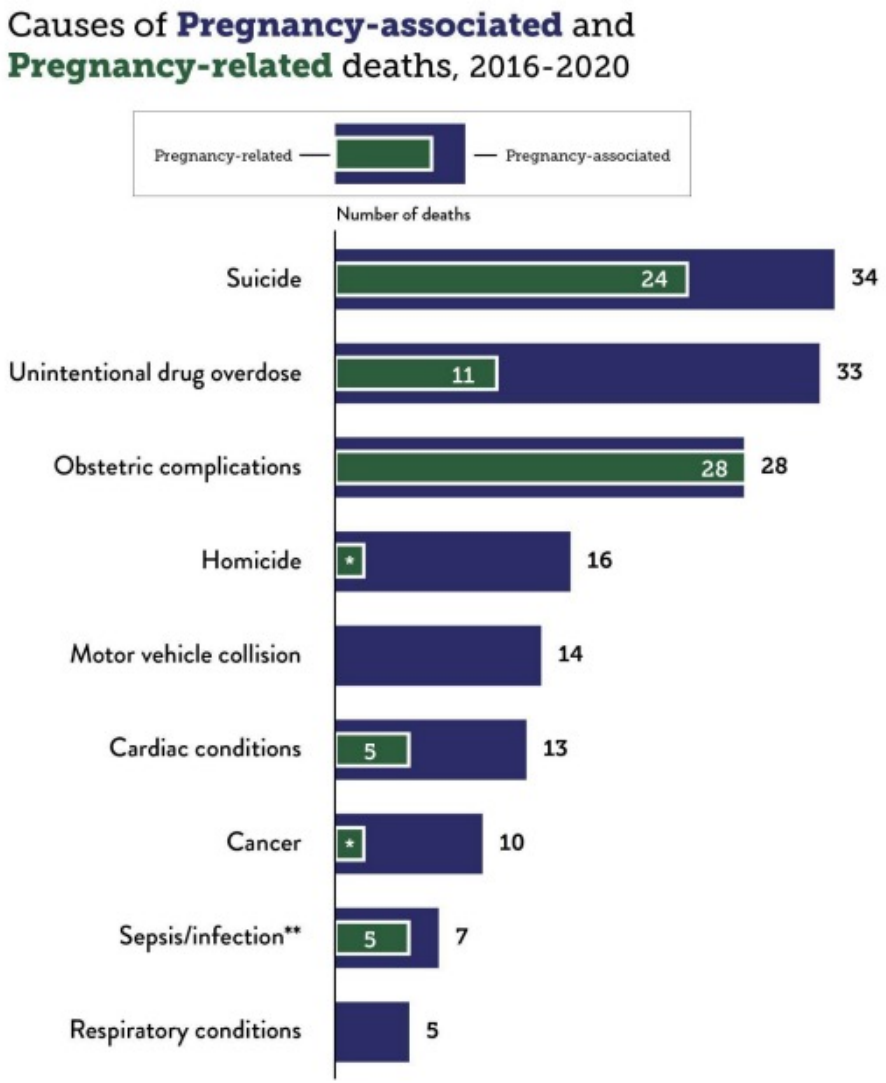


Maternal Mortality in Colorado, 2016-2020. CDPHE. 2023.

Perinatal depression and risk of mortality: nationwide, register based study in Sweden

Naela Hagatulah,[3] Emma Bränn,[3] Anna Sara Oberg,[4,5] Unnur A Valdimarsdóttir,[3,4,6] Qing Shen,[1,2] Donghao Lu[3,4]

ABSTRACT

OBJECTIVE

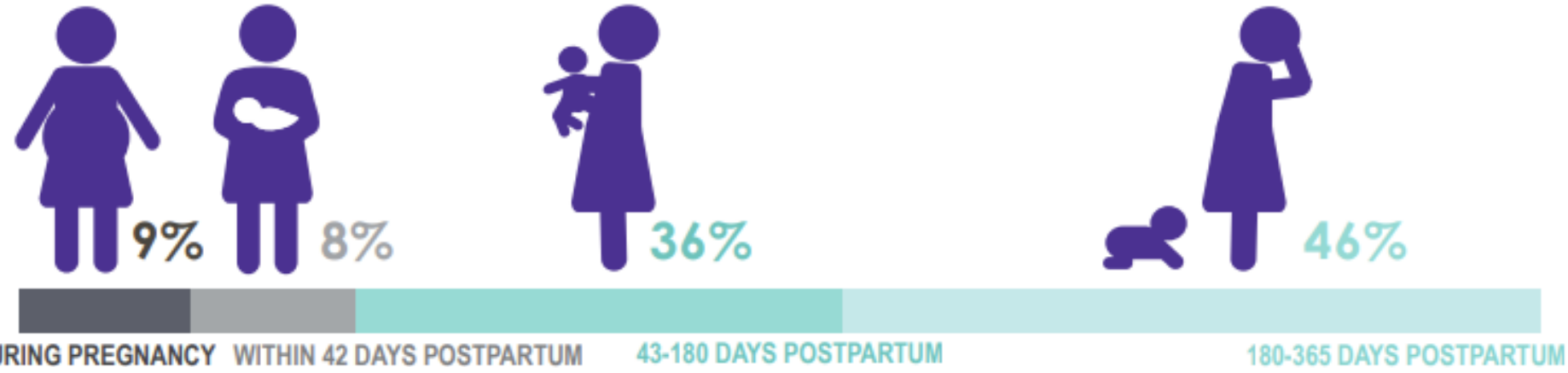
To determine whether women with perinatal depression are at an increased risk of death compared with women who did not develop the disorder, and compared with full sisters.

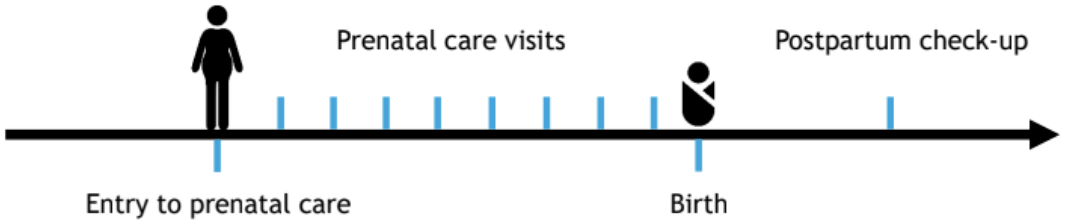
reported among women with perinatal depression diagnosed at a median age of 31.0 years (interquartile range 27.0 to 35.0) over up to 18 years of follow-up. Compared with women who did not have perinatal depression, women with perinatal depression were associated with an increased risk of death (adjusted

CONCLUSIONS

Even when accounting for familial factors, women with clinically diagnosed perinatal depression were associated with an increased risk of death, particularly during the first year after diagnosis and as a result of suicide. Women who are affected, their families, and health professionals should be aware of these severe health hazards after perinatal depression.

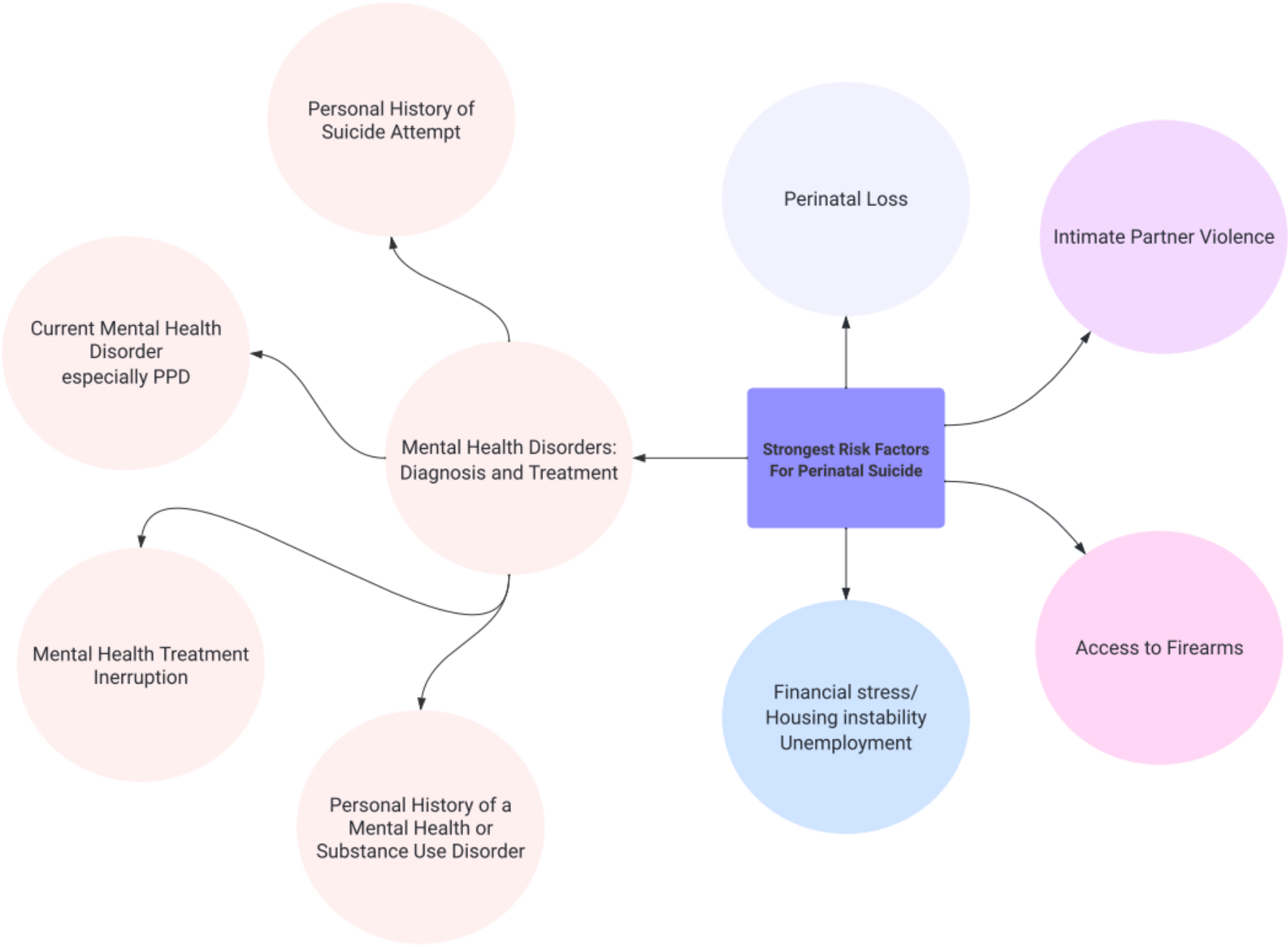
STAGE WHEN MATERNAL SUICIDE OCCURS[7]





Source: Maternal Mental Health Alliance

What are the strongest risk factors for Perinatal Suicide?



Screening

AIM

ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

Perinatal Mental Health Conditions

Commonly used validated screening instruments for perinatal **Anxiety** include:

- General Anxiety Disorder 7 Screen (GAD-7), 7 questions
- Edinburgh Postnatal Depression Screen (EPDS) anxiety sub-scale, usually questions 3, 4, & 5
- State-Trait Anxiety Inventory, state and short version (STAI-6), 6 questions

Validated screening instruments for **Bipolar Disorder** include:

- Mood Disorder Questionnaire (MDQ), 3 questions, the first question has 13 items
- Composite International Diagnostic Interview (CIDI), 2-3 questions with branching logic, provider-administered

** When concern exists for suicidality due to response in depression screening tool or interaction with patient, further assessment is required. This is done with a clinical interview and can include a suicidality specific screening instrument.

Validated screening instruments for **Suicidality** include:

- Columbia Suicide Severity Rating Scale (C-SSRS), 2-5 questions plus additional with branching logic, provider-administered
- Patient Safety Screener (PSS), 3-9 questions with branching logic, provider administered

Positive EPDS screening will identify women with Bipolar Disorder

ORIGINAL ARTICLE

Onset Timing, Thoughts of Self-harm, and Diagnoses in Postpartum Women With Screen-Positive Depression Findings

Katherine L. Wisner, MD, MS; Dorothy K. Y. Sit, MD; Mary C. McShea, MS; David M. Rizzo, MSW; Rebecca A. Zoretich, MSEd; Carolyn L. Hughes, MSW; Heather F. Eng, BS; James F. Luther, MA; Stephen R. Wisniewski, PhD; Michelle L. Costantino, MHA; Andrea L. Confer, BA; Eydie L. Moses-Kolko, MD; Christopher S. Famy, MD; Barbara H. Hanusa, PhD

Importance: The period prevalence of depression among women is 21.9% during the first postpartum year; however, questions remain about the value of screening for depression.

Objectives: To screen for depression in postpartum women and evaluate positive screen findings to determine the timing of episode onset, rate and intensity of self-harm ideation, and primary and secondary *DSM-IV* disorders to inform treatment and policy decisions.

Design: Sequential case series of women who recently gave birth.

Setting: Urban academic women's hospital.

Participants: During the maternity hospitalization, women were offered screening at 4 to 6 weeks post partum by telephone. Screen-positive women were invited to undergo psychiatric evaluations in their homes.

Main Outcomes and Measures: A positive screen finding was an Edinburgh Postnatal Depression Scale (EPDS) score of 10 or higher. Self-harm ideation was assessed on EPDS item 10: "The thought of harming myself has occurred to me" (yes, quite often; sometimes; hardly ever; never). Screen-positive women underwent evaluation with the Structured Clinical Interview for *DSM-IV* for Axis I primary and secondary diagnoses.

Results: Ten thousand mothers underwent screening, with positive findings in 1396 (14.0%); of these, 826 (59.2%) completed the home visits and 147 (10.5%) completed a telephone diagnostic interview. Screen-positive women were more likely to be younger, African American, publicly insured, single, and less well educated. More episodes began post partum (40.1%), followed by during pregnancy (33.4%) and before pregnancy (26.5%). In this population, 19.3% had self-harm ideation. All mothers with the highest intensity of self-harm ideation were identified with the EPDS score of 10 or higher. The most common primary diagnoses were unipolar depressive disorders (68.5%), and almost two-thirds had comorbid anxiety disorders. A striking 22.6% had bipolar disorders.

Conclusions and Relevance: The most common diagnosis in screen-positive women was major depressive disorder with comorbid generalized anxiety disorder. Strategies to differentiate women with bipolar from unipolar disorders are needed.

Trial Registration: clinicaltrials.gov Identifier: NCT00282776

JAMA Psychiatry. 2013;70(5):490-498.
Published online March 13, 2013.
doi:10.1001/jamapsychiatry.2013.87

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	❍	❍
...you were so irritable that you shouted at people or started fights or arguments?	❍	❍
...you felt much more self-confident than usual?	❍	❍
...you got much less sleep than usual and found you didn't really miss it?	❍	❍
...you were much more talkative or spoke much faster than usual?	❍	❍
...thoughts raced through your head or you couldn't slow your mind down?	❍	❍
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	❍	❍
...you had much more energy than usual?	❍	❍
...you were much more active or did many more things than usual?	❍	❍
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	❍	❍
...you were much more interested in sex than usual?	❍	❍
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	❍	❍
...spending money got you or your family into trouble?	❍	❍
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	❍	❍
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.* No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	❍	❍
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	❍	❍

Screening isn't good enough

Have you ever been diagnosed with a mental health condition? If so, what diagnoses have you had?

How have those been addressed?

Have you ever needed to go to the hospital for a mental health reason?

Have you ever struggled with thoughts of wanting to die?

Have you ever hurt yourself either to relieve stress or because you wanted to die?

1. Assessment of mental health history
2. Assessment of current severity
3. Direct inquiry of suicidality
4. Readiness for safety planning
5. Assessment of response to treatment

Columbia Suicide Severity Rating Scale

Always ask questions 1 and 2.	Past Month	
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts about killing yourself?		
If **YES** to 2, ask questions 3, 4, 5 and 6. If **NO** to 2, skip to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on them?	High Risk	
5) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	High Risk	
Always Ask Question 6	Life-time	Past 3 Months
6) Have you done anything, started to do anything, or prepared to do anything to end your life? *Examples*: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself; or collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump, etc. **If yes, was this within the past 3 months?**		High Risk

Perinatal considerations

- "If you were to harm yourself, what would happen with your children?"
- "Its common for moms to experience thoughts about harming their children. Does that ever happen to you?"

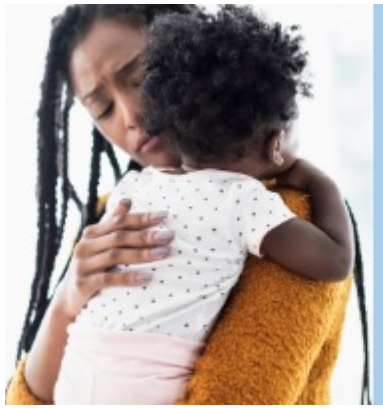
Table 2 Percentage of mothers reporting specific thoughts of intentional harm

	4 weeks n=91 % (of 91)	12 weeks n=84 % (of 84)
Screaming at your baby	19.78	9.52
Shaking your baby	16.48	5.95
Giving your baby away	13.19	2.38
Intentionally hitting your baby too hard when burping him/her	12.09	0
Dropping or throwing your baby out the window or off the balcony	8.79	1.19
Touching baby's genitals in an inappropriate way	8.79	0
Intentionally puncturing the soft spot on your baby's head	7.69	0
Throwing or dropping your baby on purpose	7.69	0
Stabbing your baby	5.50	1.19
Slapping or hitting your baby	5.50	2.38
Intentionally allowing your baby to fall under water in the bath	4.40	1.19
Intentionally smothering your baby	4.40	0
Burning your baby with hot water on purpose	2.20	1.19
Leaving baby somewhere where he/she may not be found right away	2.20	3.57
Strangling your baby	1.10	0
Stepping on your baby on purpose	1.10	0
Other (idiosyncratic)	4.40	4.76

Risk assessment: Infant Harm

Assessing Thoughts of Harming Baby	
Thoughts of Harming Baby that Occur Secondary to Obsessions/Anxiety	**Thoughts of Harming Baby that Occur Secondary to Postpartum Psychosis /Suspected Postpartum Psychosis**
•Good insight •Thoughts are intrusive and scary •No psychotic symptoms •Thoughts cause anxiety Suggests **NOT** at risk of harming baby	•Poor insight •Psychotic symptoms •Delusional beliefs with distortion of reality present Suggests **IS at risk** of harming baby

Safety Planning and Suicide Prevention



National Maternal Mental Health Hotline

HRSA
Health Resources & Services Administration

MIMIND TOOLS

Understanding and Helping Someone Who Is Suicidal

GUN STORAGE FOR YOUR LIFESTYLE

As a gun owner, you can choose from multiple options for safely storing and protecting your firearms when they're not in use.

Use this guide to determine which mechanism best suits your lifestyle, priorities and environment.

A RANGE OF OPTIONS

CABLE LOCK
Price Range: $10–$50

A cable lock can be used on most firearms, allows for quick acess in an emergency and offers security from theft. The cable runs through the barrel or action of a firearm to prevent it from being accidentally fired, requiring either a key or combination to unlock it.

- AFFORDABLE
- ACCESSIBLE
- THEFT DETERRENT

GUN CASE
Price Range: $10–$150

For those looking to conceal, protect or legally transport a registered firearm, a gun case is an affordable solution available in a variety of materials including plastic, fabric or metal. Be sure to lock it with an external device for added security.

- AFFORDABLE
- PORTABLE
- PROTECTS FROM DAMAGE

LOCK BOX
Price Range: $25–$350

With integrated locks, storage boxes provide reliable protection for firearms, and allow gun owners to legally transport them outside of their home.

- PORTABLE
- ACCESSIBLE
- PROTECTS FROM DAMAGE

ELECTRONIC LOCK BOX
Price Range: $50–$350

Electronic lock boxes are an effective way to store or legally transport firearms, and they also prevent theft since only the person with the code can access the contents. Some electronic lock boxes are specially designed for quick access to stored firearms.

- PORTABLE
- THEFT DETERRENT
- PROTECTS FROM DAMAGE

FULL SIZE AND BIOMETRIC GUN SAFES
Price Range: $200–$2,500

A gun safe protects its contents from the elements and allows owners to safely store multiple firearms in one place. Gun safes of all sizes are now available with biometric options to ensure only certain people have access.

- THEFT DETERRENT
- PROTECTS FROM DAMAGE

VEHICLE STORAGE

CONSOLE STORAGE
Price Range: $250 - $300

A solution for those who need a truly secure place to store their firearm in a vehicle. These custom-fitted devices provide concealment to deter prying eyes and would-be thieves. Various access options are available, including biometric.

CARGO AREA STORAGE
Price Range: $500 - $1,500

Effective for transporting firearms to the range or field, cargo area storage models are available for sedans, SUVs and trucks. These devices allow for locked storage, concealment and protection from bumps and jostling.

SECURE STORAGE ACCESSORIES

WIRELESS GUN SAFE MONITOR
Price Range: $150 - $200

An electronic monitor can provide awareness and alert you if anyone is accessing your storage device or handling your firearm without your authorization. Some sound an audible alarm, others can be connected to your smartphone.

ELECTRONIC HOLSTERS
Price Range: $200 - $300

Electronic holsters are a new type of secure storage device that enable fast access along with security to prevent unauthorized access. Holsters can be mounted or used independent of a mounting system and feature a programmable finger or thumbprint scan.

PLEASE HELP PREVENT ACCIDENTS. STORE FIREARMS RESPONSIBLY.

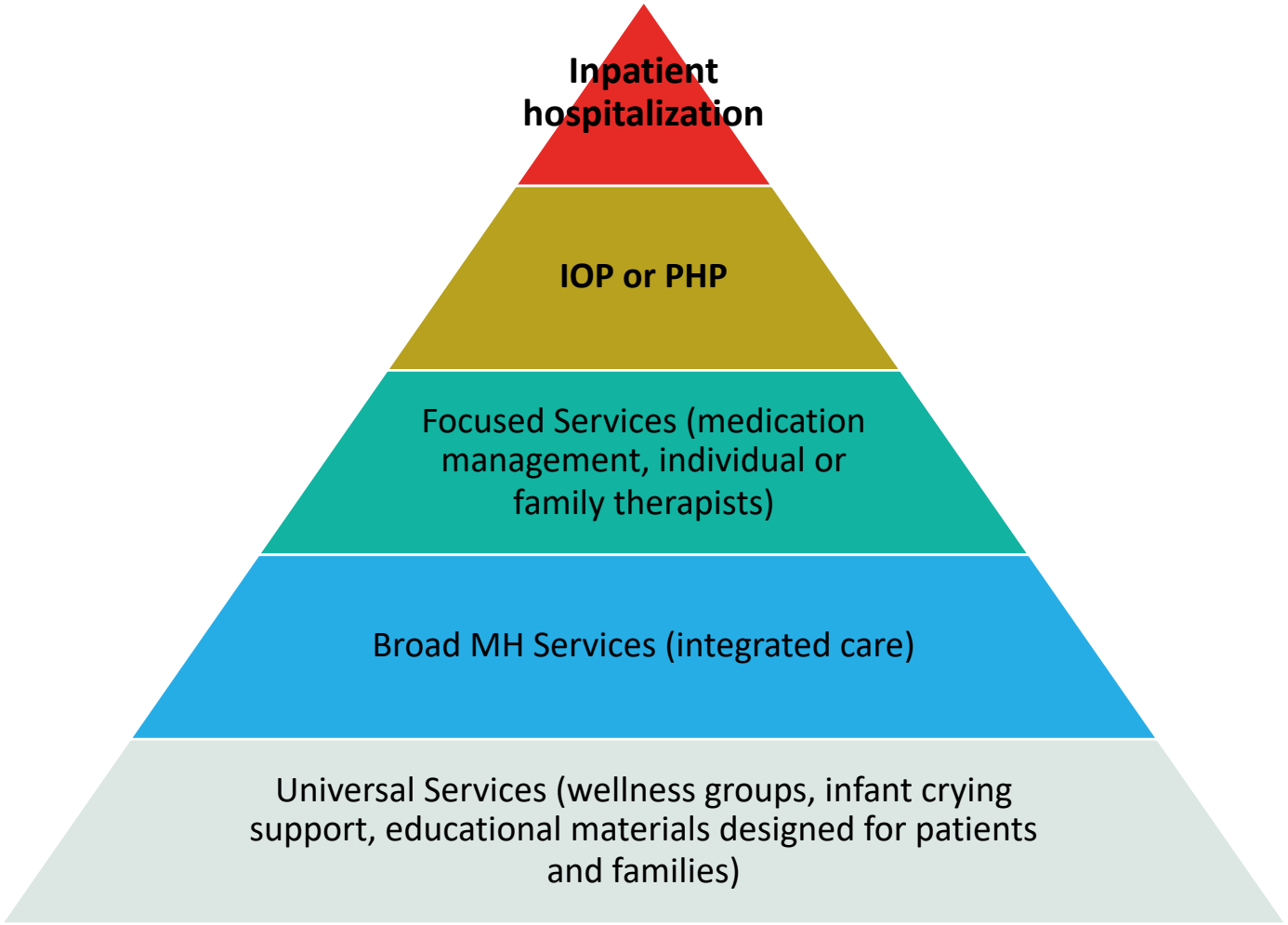
These are just a few of the storage options available to firearms owners. For the greatest level of security, consider using a combination of safety mechanisms and educate family members about handling firearms properly.

To learn more about firearms safety, visit ProjectChildSafe.org

PROJECT CHILDSAFE

Project ChildSafe is a program of the National Shooting Sports Foundation®

NSSF
The Firearm Industry Trade Association



Access to Specialty and Intensive Services

New CO Services

- Colorado PROSPER
- Healthy Expectations Perinatal IOP

Lived Experience: From Crisis to Healing (Meghan Cliffel)

- Life-saving involuntary commitment
- Medication
- Empathy and communication of goals in care
- Thoughtful transition back to daily life
- Identification of trauma and support for PTSD (EMDR)
- Writing, meditation, movement (yoga)
- Knowledgeable psychiatric care
- Cultivation of self compassion; post-traumatic growth/meaning making
- A third pregnancy!

Systemic change: Building a compassionate system that values caregiving (i.e. well-being of caregivers centered) and is able to provide quality and knowledgeable care.

QUESTIONS?