WHAT YOU CAN DO TO ADDRESS THE MATERNAL MENTAL HEALTH CRISIS

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OBJECTIVES

1. Describe the maternal mental health crisis in the United States
2. Recognize warning signs of perinatal mood and anxiety disorders
3. Create an approach to begin the conversation with patients around perinatal mental health concerns

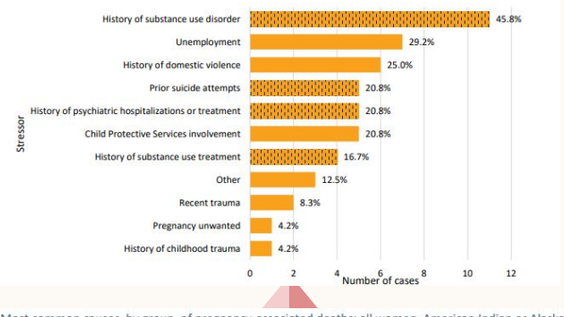
Epidemiology: Where are we now?

- Maternal health crisis in US
  - US has the highest maternal mortality of any developed nation
    - 2/3 deaths in the postpartum period
      - 1/3 of these in 7-weeks to 12-months after delivery
  - One of the leading causes of death in postpartum period is death related to mental health disorders, addiction
- Perinatal mood and anxiety disorders (PMADs) are now **the most common complication of pregnancy**
  - ~20-30% of pregnancies affected by these disorders
- Gaps in the structure of the healthcare system lead to issues in **identification, referral to treatment, receipt of treatment**, and then **follow-up of treatment response**
  - **Post partum: <30% of patients are identified, about 1 in 5 receive treatment, <5% are treated to remission**
- After the 6-week postpartum visit, the adult patient's care is unstructured. Parents often make it to Pediatric appointments and prioritize this over their own healthcare.
  - Pediatricians become the main healthcare contact for new parents after ~6 weeks postpartum

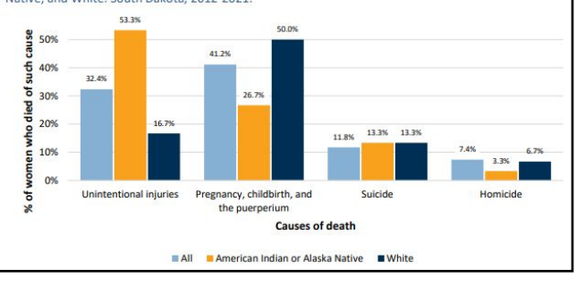
OUR REGION

- MN maternal mortality data:
  - 2/3 of all pregnancy-associated deaths occurred after the 6-week OB visit
    - 21% of these deaths due to mental health/addiction, second only to injury (35%)
    - Pregnancy-related deaths: 11% attributable to mental health
- ND data: mental health conditions are leading cause of pregnancy-related death (23%)
  - Among American Indian population, this increases to 31.3%
- Racial disparities and isolated communities
- Rural areas with higher risk
- Limited access to treatment providers, especially culturally-competent options
  - Perinatal specialists tend to be clustered in academic/metro areas
  - Many do not accept Medicare/Medicaid

Frequency of selected stressors identified during pregnancy-associated death reviews.



Most common causes, by group, of pregnancy-associated deaths: all women, American Indian or Alaska Native, and White. South Dakota, 2012-2021.



Brief overview of perinatal mood and anxiety disorders (PMADs)

- Depressive and anxiety disorders with similar rates and prevalence. **Anxiety disorders may be more common!**
- We think many disorders **begin during pregnancy** but are not reported or detected until postpartum
- Anxiety Disorders: OCD, PTSD, GAD, panic
- **Prior history** is best predictor of future risk
  - Genetics, psychosocial stressors, parenting difficulties, and relationships with domestic partner are also risk factors
- Bipolar 1 disorder at very high risk in the postpartum period
- Postpartum psychosis is one of the few psychiatric emergencies

WHAT IS YOUR ROLE?

1. Know the difference (between "normal" and "abnormal")
2. Watch for warning signs
3. Understand urgencies/emergencies
4. Combat common misunderstandings
5. Provide a listening ear, when needed
6. Provide problem-solving and resource options, when needed
7. **Be a part of the Village with maternal mental health First Aid tools**

WHAT IS "NORMAL"??

Baby Blues
- first 2 weeks after delivery
- Tearfulness
- Mood shifts
- Sleep disturbance
- Feeling irritable and "not like myself"

Intrusive Thoughts
- Unwanted thoughts that pop into your head
- Thoughts are NOT WELCOME and can be upsetting
- Usually centers around safety of the child

Insomnia and Poor Sleep

Worry

WHEN DO THINGS BECOME ABNORMAL?

Depression
- "Baby blues" persist past 2 weeks postpartum
- Feelings of guilt, shame, inadequacy
- Disconnection from baby due to fear of being an inadequate or "bad" parent
- Suicidal thoughts

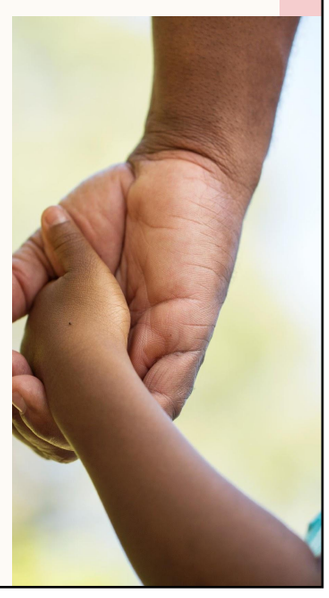
Anxiety Disorders
- Changes in behavior (avoidance, rituals, etc) secondary to intrusive thoughts or worry
- Inability to sit still or to rest at reasonable intervals
- Inability to sleep when able to do so
- Distress, impairment from intrusive thoughts

WHAT IS AN URGENCY OR EMERGENCY?

- Thoughts that baby/family would be better off without parent around
- Suicidal thoughts
- No sleep for 3+ days
- Psychosis

COMMON MISUNDERSTANDINGS

1. **Pregnant people should be "glowing" and happy after birth** → **Pregnancy, the newborn period, and parenting can be HARD!**
2. Psychiatric medications are dangerous during pregnancy and during breastfeeding → Only several psychiatric medications are unsafe in pregnancy and breastfeeding, and these are rarely used
3. **Supplements and natural treatments are safe** → **We know very little about the safety data of unregulated supplements**
4. Postpartum is "just hard", and you should feel rough → Yes, it can be hard, but there is no reason to be suffering or miserable



MEDICATION MYTHS

I'm a failure if I take medication
Medication will change who I am
I don't want to become addicted to medication
Taking medication is a sign of weakness
The side effects will be miserable

- **STIGMA**: Do we have these same thoughts for other medical conditions?
- Medications do not change someone's personality!
- You don't have to suffer through side effects. Talk to your practitioner.
- Very few psychotropic medications have habit-forming potential.
- Exposure to untreated psychiatric symptoms results in adverse outcomes for parent and child(ren).
- **BACKGROUND RISK IS NEVER ZERO**: Risk of birth defects is very low. Remember, birth defects can develop spontaneously

MEDICATIONS IN PREGNANCY AND BREASTFEEDING: KEY POINTS

Planning begins before pregnancy!	If it's not broken, don't fix it	Use the lowest effective dose
Avoid exposures to multiple medications and to symptoms	May need higher doses later in pregnancy	Discuss plans for breastfeeding early and consider these plans when starting a medication

MEDICATIONS WE AVOID

- Valproic acid (Depakote) – should be strongly avoided in patients who could become pregnant
- **Daily** benzodiazepines
- Clozapine is contraindicated in breastfeeding
- Lithium can be used in pregnancy but is more difficult in breastfeeding
- **Melatonin** is contraindicated
- Modafinil and armodafinil are contraindicated
- All products containing **THC**

LISTENING

- Mood is persistently low and not changing
- Finding it hard to be present
- Dislike or regret becoming a parent
- "*I cry for no reason*"
- "*I don't want to see anyone*"
- "*I yell about everything; I feel like I am always on edge*"
- "*I have nothing left to give*"
- "*I don't bring the baby into the kitchen because he could get hurt there*"
- "*I keep picturing my baby getting hurt*"
- "*I can't relax, even when the baby is sleeping. I worry she will stop breathing*"
- "*Maybe I wasn't meant to be a mother*"
- "*When my baby cries, I feel like a failure*"
- "*I can't take the time to take care of myself*"

KNOWLEDGE IN ACTION

Susan is a 32-year-old woman who is 7 months postpartum with her second child. You see that she appears strained and edgy. She has dark circles under her eyes. You sympathize with the difficulty of having two young children while being a working parent and ask how she has been doing. She pauses before she lets out a sigh and begins to cry. She talks about how she feels she is barely making it through each day. Her infant is still not sleeping through the night, she has continued to pump breast milk after returning to work, and childcare is constantly changing. She feels like her mind is constantly juggling 10 things and is exhausted, but she is very resistant to let anyone, including her husband, take care of the children to allow her some time to herself. She and her husband have been arguing more. She says that she has lost herself and doesn't know if things will ever feel good in her life again. She has a history of generalized anxiety disorder and was doing well on sertraline but stopped this when she learned she was pregnant.

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HOW TO BE A FIRST RESPONDER

We know:

- PMADs are the most common complication of pregnancy
- Many feel shame and fear stigma (or worse) if they disclose symptoms
- Parenting in our society can be profoundly isolating

We can make changes by:

- Providing a nonjudgmental space
- Being informed about evidence-based recommendations, resources, and common misunderstandings
- Come equipped with knowledge for detection and prevention of PMADs

MAKING A VILLAGE: PROTECTIVE PRINCIPLES

- Be well-informed about pregnancy, birth, the fourth trimester, and PMADs
- Create a circle of support. Can be unconventional!
- Connect with other mothers to normalize experiences
- Be flexible with expectations
- Prioritize realistic self-care
- Learn effective, peaceful communication skills with partner
- Think about strategies for common postpartum problems (breastfeeding, sleep deprivation, colic) ahead of time
- Know where to turn for additional support and know when things are "abnormal"

SURVIVAL TOOLS

- Build time for enjoying baby
- Parental leave: Communicate with partner so they are also spending time alone with baby. As baby gets older, practice spending more time away from baby
- Breathing exercises
- Massage
- Prayer, connect with spiritual practices
- Visualization
- Physical activity, fresh air
- Nutrition
- Light therapy: 20 minutes of bright light in the morning. Contraindicated in bipolar disorder

SURVIVAL TOOLS: SELF-PRESERVATION IDEAS

- Enjoy a hot tea or cold cucumber water
- Take a hot shower
- Take a walk
- Run an errand alone
- Cuddle with your pet
- Put lotion on your body
- Reach out to a friend
- Meditate for 10 minutes

SURVIVAL TOOLS: SLEEP

- Continuous sleep is more important than the overall quantity of sleep
- Basic sleep hygiene techniques:
  - Avoiding alcohol, caffeine, screens before bed
  - Guided meditations
  - Get sunshine in the mornings and regular exercise
- Create a nap plan
- Work with partner to create overnight sleep plan
  - Divide the night into "shifts": "5&5 Technique"
    - 10p-2am one adult "on call"/ 2am-7am other adult is "on call"
  - Feeding plans may need to change to accommodate this. Exclusive nursing is not compatible with mother being able to achieve adequate sleep in first few months of life
  - *Every adult in the home needs sleep*; not just the adult working outside the home
- Establish a bedtime routine for baby early
- If you're taking a medication that can cause sedation, make sure there is a back-up adult available for childcare
- Supplements are not recommended for sleep during pregnancy or lactation

MAKING A VILLAGE: RESOURCES

- 24/7 Crisis line 1-833-TLC-MAMA (1-833-852-6262): specially-trained crisis team for maternal mental health concerns
- Fussy Baby Network 1-888-431-BABY (2229): parent coaching
- Postpartum Support International: database of support groups, therapists, and psychiatrists. Lots of resources, including for dads
- Pregnancy Loss: Star Legacy Foundation
- NICU support: Hand to Hold; Graham's Foundation
- Lactation: Le Leche League; KellyMom; Fed is Best Foundation
- Medication information: Mother To Baby (downloadable fact sheets); Mass General Center for Women's Health
- Smartphone Apps: Headspace; Calm; CBT-I Coach (Insomnia)
- Parental leave information: Mindful Return
- Groups working for paid parental leave: Paid Leave For All; Chamber of Mothers
- Legal protections for breastfeeding at work: Pregnant@Work
- LOTS OF BOOKS! *Motherhood Survival Manual*, by Jill Zechowy MD

PUTTING IT TOGETHER: SUSAN

- You make a plan to meet up in a park with your kids every week
- Susan and her husband find online virtual support groups
- Susan reaches out to her pediatrician for resources to improve infant sleep; they create a new sleep plan for the baby which goes well after several weeks of consistency
- She and her husband create a plan for him to have the two children alone for increasing periods of time. After one month, she feels comfortable being away for 2 hours at a time

THANK YOU!

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