UVM Project ECHO
Perinatal Mental Health
Preconception Through the First Year Postpartum

May 31, 2022

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• RECORDING OF SESSION TO BEGIN
Agenda

• Introductions
• Objectives
• Didactic Presentation (~20-30 min)
• Case presentation
  • Clarifying questions
  • Participants – then faculty panel
• Discussion
• Recommendations
• Summary
• Closing Announcements
  • Submission of new cases
  • Completion of evaluations
Series Objectives

Learning objectives for this ECHO series include the ability to:

• Explain clinical knowledge about presentation of perinatal mental health complications

• Discuss treatment and management approaches

• Apply appropriate diagnostic and treatment strategies for the perinatal population, with an emphasis on diversity, equity, and inclusion

• Describe statewide resources that can assist patients who may experience perinatal mood and anxiety
CME Disclosures

University of Vermont (UVM) Office of Continuing Medical and Interprofessional Education (CMIE) is approved as a provider of Continuing Medical Education (CME) by the ACCME. UVM designates this internet live activity for a maximum of 1 AMA PRA Category 1 Credits.

UVM CMIE is accredited by the American Nurses Credentialing Center (ANCC) to provide CE for the healthcare team. This program has been reviewed and is acceptable for up to 1 Nursing Contact Hours.

As a Jointly Accredited Organization, The Robert Larner College of Medicine at the University of Vermont is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. The University of Vermont maintains responsibility for this course. Social workers completing this course receive 1 continuing education credits.

This activity was planned by and for the healthcare team, and learners will receive 1 Interprofessional Continuing Education (IPCE) credit for learning and change.

Participants should claim only the credit commensurate with the extent of their participation in the activity.
CME Disclosures

**Interest Disclosures**: As an organization accredited by the ACCME to sponsor continuing medical education activities, UVMCMIE is required to disclose any real or apparent conflicts of interest (COI) that any speakers may have related to the content of their presentations.

**Meeting Disclaimer**: Regarding materials and information received during this educational event, the views, statements, and recommendations expressed during this activity represent those of the authors and speakers and do not necessarily represent the views of the University of Vermont.
Postpartum Psychosis

Sarah Guth, MD
Perinatal Psychiatrist
Vermont Center for Children, Youth and Families, University of Vermont Medical Center
Session Objectives

- Epidemiology
- Description of symptoms and differential diagnosis
- Risk factors
- Treatment
- Long term implications
It is frightening, but it is NOT common

Very uncommon: 1-2/1,000 women you’ll see

Much MORE common:

Postpartum Depression: ~1/9

Postpartum OCD: ~1/11

Postpartum Delirium: In the case of infection or other illness

Postpartum intrusive thoughts: Up to 9/10 women (occur more frequently within OCD but also in the absence of the full disorder).
Intrusive Thoughts

Very common among both mothers and fathers

Over 90% women report “seeing” harm befall their infants

50% of women see themselves harming their infant

Usually happens very early after delivery, and continues through at least the first three months

Risk factors: Higher parenting stress; Lower support; Postpartum depression and anxiety.

There is no known correlation between intrusive thoughts and harsh parenting, or risk to the infant’s safety.
Brain Plasticity

Postpartum brain changes in a way that may increase vulnerability to positive stimuli (mesolimbic reward processing) and negative stimuli (threat detection).

This allows women to adjust to a new role as caregiver but also confers risk for symptoms of mental illness.

Two main changes that occur related to threat detection:

Changes in activity in the Amygdala (**fear center**)  
Functional changes in the Paralimbic Network (**salience circuits**)
June is a 24 year old woman with a history of anxiety in college but no previous concern for psychosis or bipolar disorder. She and her husband brought home a healthy son from the hospital, and he went back to work immediately, leaving her home with the baby. They had moved to Vermont several years ago and had no family in the area.

First there was difficulty with breastfeeding: a recommendation was made to supplement with formula and pump with each feeding. June was awake all night with the baby trying to nurse, pump and wash bottles.
Within a week her husband noticed she didn’t seem like herself. She was saying things that sounded confused, and usually very neat with housekeeping, but suddenly the house was a mess. This was their first baby- he didn’t know what to expect.

Over the second week, June began avoiding the telephone and any visitors. She was afraid to take the baby to the pediatrician’s. She slept about two hours per night.

She had a prior job working at the hospital and she started talking about the circumstances of losing that job and how she felt like all of her care through UVM might be affected.

By the end of the second week, June had a hard time speaking to anyone and she was struggling to care for herself or the baby. She believed that people from work were going to take her baby.
Postpartum Psychosis: Description

Usually begins in the first 2-4 weeks following delivery. After 4 weeks, it is considered a different entity.

Marked by:

- Cognitive alterations (confusion, poor memory)
- Strange beliefs, delusions
- Disorganized behavior
- Seem to be responding to internal stimuli (hallucinations)
- Odd affect, withdrawn (pure psychosis)
- Highly active, energetic (mania w/psychosis)
- Grandiosity is less common
Postpartum Psychosis: Diagnostic Clarity

Extremely difficult to tell acutely

“Pure psychosis” from Mania with psychotic features, and not too important for treatment.

Clues: personal history, family history, hypersexuality, grandiosity, elated mood point to mania
Postpartum Psychosis: Risk Factors

Pre-existing:
- History of bipolar disorder in self or family *take a careful history*
- Hospitalizations? Describe episodes of mania? Med History
- History of postpartum psychosis in self or family member
- Primiparity

Environmental:
- Sleep loss, marital discord
- +/- Low socioeconomic status
- 50% of women have no risk factors
What should we worry about?

Many studies quote 4% infanticide and 5% maternal suicide among psychotic women. This has NOT appeared to be replicated/confirmed over the years.

Suicidality is higher, and women use more violent means.

Infanticide is higher, though still very rare; Neonaticide highest among women who deny pregnancy.

Neglect due to withdrawn/disorganized behavior is much more common.
Postpartum Psychosis: When you suspect it

"In a number of maternal deaths, symptoms of the underlying physical condition were attributed to psychiatric disorder."


Consider Eclampsia or infection first- any other sx??
CBC
Electrolytes
BUN, creatinine
Glucose
Vitamin B12
Folate
Thyroid function tests
Calcium
Urinalysis and culture in the patient with fever
Neuro Exam and Imaging (r/o stroke)
Spinal tap (anti-NMDA encephalitis) (if fever and HA)
Postpartum Psychosis: How do you confirm it?

Mood Disorder Questionnaire (MDQ)—this is considered the gold standard, but clinically probably not super useful

**Careful History**

Talk to everyone you can who knew the woman before and has spent time with her since delivery (women WILL attempt to downplay symptoms)

Reassure a woman that seeking help does not mean automatically losing her child

Call psychiatry as quickly as you can
Postpartum Psychosis: Treatment

This should almost always consist of inpatient care either on psychiatry units or obstetrics.

The only times this can be treated as an outpatient are with very supportive families who can care for infants.

Women should not be left alone with their infants:

For safety of the infant

For recovery of the mother- she will need to sleep and may need to take sedating medicines.

Family members or other supports must be highly available.
Treatment:

Most current stepwise guidelines from Mt Sinai, a leader in treating postpartum psychosis:

1. Try benzodiazepine (titrate to sleep) for two nights.
2. Add atypical antipsychotic: olanzapine and quetiapine most common (titrate aggressively).
3. Add lithium.

98% of women remitted within 40 days and 78% remained in remission at 9 months
Atypical Antipsychotics pretty safe

- Seroquel and Olanzapine low RID
- Still watch for fussiness, sleep or eating changes, tone changes

Lithium is complicated

- Very controversial regarding whether infants’ serum should be measured
- Some cases of transient hypotonia, increased infant TSH and increased infant BUN/Creatinine

Involve the pediatrician
What does the future hold? Will it happen again?

Risk of relapse: Two independent studies estimate about 60% will go on to have another severe episode outside of postpartum.

Best practice suggests Lithium best prevents relapse in the first year.

What is the diagnosis? 40-70% will be diagnosed with bipolar disorder; The rest Postpartum Psychosis

Genetic studies suggest these are distinct entities


References

Di Florio, A. Genetic basis for postpartum psychosis, Biomarkers of Postpartum Psychiatric Disorders, 10.1016/B978-0-12-815508-0.00011-4, (149-158), (2020).


Discussion and Q & A
The discussion and materials included in this conference are confidential and privileged pursuant to 26VSA Section 1441-1443. This material is intended for use in improving patient care. It is privileged and strictly confidential and is to be used only for the evaluation and improvement of patient care.
Case Presentation Format

Case presentation from a participant (a real-world case, from the field)
Then
Clarifying questions about the case from group to case presenter
Then
Ideas, suggestions, recommendations from participants
Then
Ideas, suggestions, recommendations from ECHO faculty team
Then
Additional discussion, if any (All)
Then
Summary of case discussion
(course co-directors: Katherine Mariani, MD, MPH and Jill Davis, MA)
• RECORDING TO BE STOPPED FOR CASE PRESENTATION
Prep for Next Session

Prior to each session, if you have specific questions for our faculty expert(s), please let us know and we will pass along ahead of time.

**SESSIONS ARE ON TUESDAYS FROM 12:00PM TO 1:00PM**

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Conclusion

- Slides are posted at www.vtahec.org

- Volunteers to present cases (this is key to the Project ECHO model)
  - Please submit cases to Katherine.Mariani@uvmhealth.org

- Please complete evaluation survey after each session

- Once your completed evaluation is submitted, CE information will be emailed to you.

- Please contact us with any questions, concerns, or suggestions
  - Katherine.Mariani@uvmhealth.org
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