

UVM Project ECHO Perinatal Mental Health

Preconception Through the First Year Postpartum

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Course Co-Directors: Kathy Mariani, MD, MPH
Jill Davis, MA

ECHO Director: Elizabeth Cote

Series Faculty: Sandy Wood, CNM, PMHNP
Sayida Peprah, PsyD
Amy Wenger, RN
Elizabeth Gilman
Carol Lang-Godin, BA
Maria Rossi, CLC, CLD, BS
Sarah Guth, MD
Fiona Griffin, LCMHC
Kathryn Wolfe, LICSW, LADC



- 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.



Depression and Anxiety in the Postpartum Period

Sandra G Wood, APRN, CNM, PMHNP

University of Vermont Medical Center

Burlington, VT

Sandra.wood@uvmhealth.org

[I have no conflicts to disclose.]

Depression and Anxiety in the Postpartum Period

Session Objectives:

1. Understand the diagnostic considerations for mental health disorders in the postpartum period
2. Describe treatment strategies in the postpartum period
3. Apply the Principles of prescribing psychotropic medications in in postpartum and or lactating persons



Incidence: the most common complication of the perinatal period

- Up to 1 in 5 women suffer from Perinatal Mood or Anxiety symptoms
- More common than many of the risks we screen for regularly in pregnancy
- Two thirds of PMADs begin before birth
 - 27% onset prior to pregnancy
 - 33% onset in pregnancy
 - 40% onset postpartum with a common peak at 3 months postpartum

Perinatal Mood and Anxiety Disorders

- Perinatal:
 - Preconception
 - Pregnancy
 - The first year post partum
- Spectrum of Emotional Distress
 - Depression
 - Anxiety
 - Obsessive Compulsive Disorder
 - Post Traumatic Stress Disorder
 - Bipolar disorder
 - Psychosis



Depression and Anxiety in the Postpartum Period

- PMADs behave somewhat differently
- Normal symptoms of postpartum can mimic the neurovegetative symptoms of depression and the physiologic symptoms of anxiety.
- The changes/stresses of the birth and transition to parenthood may uncover biological risks
- Postpartum symptoms may include:
 - Multiple and severe physical complaints
 - Excessive worries that lead to
 - Insomnia
 - Prevent the birthing person from accessing tools
 - Isolating self
 - Inability to enjoy parenthood.



Biological Risk Factors

- Previous episode of perinatal onset of mood or anxiety disorder
- Symptoms of anxiety or depression during pregnancy
- Personal or family history of psychiatric disorders
- History of menstrual related mood symptoms or other hormonally related mood changes
 - Hormonal contraceptives
 - Infertility treatment
- Endocrine dysfunction
 - Diabetes, thyroid, infertility



Factors that compound risk

- Pregnancy complications or postpartum health challenges for infant or birthing person.
- Lactation/Feeding challenges or complications.
- Trauma related to the pregnancy/birth
- Infant temperament
- Seasonal stressors
- Perfectionism or high expectations
- Childcare stress
- Sleep deprivation



Expectation vs Experience







Maternal Mental Health During Covid-19 Pandemic

- Family planning
- Loss of coping tools and support systems
- Significant impact on the Social Determinants of Health
- Increasing numbers of women with risk factors for mental health complications.
- Increased symptoms of anxiety and depression
- Telemedicine and implications for pregnancy and postpartum period
- Infertility treatment and the pandemic



Symptoms may include depressive or anxious features

- Persistent sadness
- Anxiety
- Feeling overwhelmed or “empty”
- Crying episodes
- Panic attacks
- Chronic fatigue
- Loss of interest in previously enjoyable activities
- Avoidant behaviors
- Persistent self-doubt
- Changes in sleeping and/or eating patterns
- Feelings of hopelessness, helplessness, guilt
- Experiencing irritable and/or angry moods
- Fear of being alone or separated from baby
- Problems with concentration or making simple decisions



Post Partum Blues - Not a disorder

- 50-80%
- Found in all cultures
- Unrelated to past mental health or psychosocial stressors
- May last a few hours to 14 days
- Responds to supportive interventions
- Still future oriented, worries are not unmanageable, predominant mood is happiness
- Symptoms:
 - Tearfulness
 - Mood fluctuation, sadness, irritability
 - Anxiety
 - Increased emotional reactivity and intensity



Depression

- Symptoms \geq 2 weeks
- Low mood
- Lack of interest in past pleasurable activities
- Guilt, worthlessness, helplessness
- Changes in appetite and sleep patterns
- Interferes with functioning
- Can lead to suicidal thoughts



Bipolar disorder

- A disorder that causes unusual lows and highs in a person's mood, energy, and ability to function. Different from the normal ups and downs, the symptoms of bipolar disorder can be severe
- Women with preexisting diagnosis are at high risk for relapse
- High risk for postpartum psychosis
- This disorder can present for the first time postpartum.
- 22% of women who screen positive for perinatal depression in the postpartum period are likely to be suffering from Bipolar Disorder
 - All women should be screened if presenting for medication management.
- Can look like Depression or Mania



Anxiety

- General Anxiety
 - 6% in pregnancy
 - 10% postpartum
 - 2X greater incidence than in general population
 - PP onset greater than the rate of depression



Anxiety

- Excessive or constant worries
- Racing thoughts
- Agitation, restlessness
- Physical sensations of dizziness, shortness of breath, palpitations, gastrointestinal symptoms
- Feeling of dread
- Difficulty sleeping, falling or staying asleep.
- Changes in appetite, rapid weight loss



Obsessive Compulsive Symptoms

- Scary thoughts: Negative, Repetitive, Intrusive thoughts or mental images of some form of harm happening to the baby
 - Can be indirect or passive or imply intention
- These thoughts are very distressing and the mother is aware that the thoughts are unreasonable and she will do what is needed to keep the baby safe
- Up to 10% of PP women may experience
 - Obsession- intrusive thoughts
 - Compulsion-checking
 - Horror about the obsession
 - Fear of being alone with the infant
 - Hypervigilance in protecting the infant
- Risk factors
 - Personal or family history of anxiety or OCD
- Dropping the Baby and Other Scary Thoughts Breaking the Cycle of Unwanted Thoughts in Motherhood

By: Karen Kleiman, MSW and Amy Wenzel, PhD



Post Traumatic Stress Disorder

Traumatic Childbirth

An event occurring during the labor and delivery process that involves actual or threatened serious injury or death to the mother or her infant. Unexpected, unpredictable, uncontrollable. The Birthing woman experiences intense fear, helplessness, loss of control, or horror.

- ✓ Persistent re- experiencing of the traumatic event
- ✓ Persistent avoidance of stimuli associated with the trauma/numbing of general responsiveness
- ✓ Alterations in cognitions or mood associated with the event
- ✓ Persistent symptoms of increased arousal

- Up to one third of women report a labor/birth that fulfills the criteria for a traumatic event
- By 6 weeks postpartum
 - 9% screen positive for the criteria for PTSD
 - 18% experience elevated levels of PTSD symptoms



Other Diagnostic Considerations

- Comorbidity
 - Substance abuse
- Medical
 - Thyroid disorders, Anemia, Nutritional/Vitamin deficiencies, Diabetes, Autoimmune, or other medical disorders
- Medication Side effects
 - Galactagogues
 - Contraceptives
- Dysphoric milk ejection reflex



Prevention and Treatment

- Prevention: all women and their families need the tools to prevent and recognize perinatal mood and anxiety symptoms.
 - Educate
 - Anticipate
 - Screen
 - Psychosocial supports
 - Psychotherapy
 - Medications
- Intervene early

Steps to Wellness

janehonikman.com

- Education
- Sleep
- Nutrition
- Exercise/time for self
- Nonjudgmental sharing
- Emotional support
- Practical support
- Referrals and other resources



Fathers, Partners, Caregivers, and Families



Fourth Trimester Project

[4th Trimester Project \(newmomhealth.com\)](http://newmomhealth.com)



- Parenting Resources for Mom and Dad (menexcel.com) | research and practice focus on men's mental health with emphasis on reproductive psychology and the transition to fatherhood
- Postpartum Dads | Helping Families Overcome Postpartum Depression



Psychotropic Medications

The Golden Rules of Treatment

- Every child deserves a healthy parent
- Psychiatric illness and psychiatric medication each pose a risk to the birthing person, newborn, and family
- Treatment decisions are always a risk benefit analysis on a case-by-case basis
- The best treatment strategy is to minimize or eliminate one of the exposures when ever possible
- There is no one medication that is safest or best for use during breastfeeding
- No single study tells the whole story, all of the data must be read in context.



General Guidelines

- All psychiatric medications or metabolites are secreted into breastmilk
- Decisions need to take into account
 - The benefits of breastmilk feeding for the birthing parent and the infant.
 - Birthing person's preference for breastmilk feeding
 - The severity and risks of the psychiatric illness for the parent, infant, and family
 - What is know about the safety of the medication



Lactation Considerations

- Exposure during pregnancy is much greater than through breastfeeding. Breastfeeding has major short and long-term public health benefits for the mother and infant.
- Informed consent to include risks of untreated depression/anxiety or not breastfeeding.
- Monitor the infant for changes in arousal, feeding difficulties, especially in younger, exclusively breastfed infants and when using combinations of psychotropic drugs.
- Mothers taking psychotropic medication during pregnancy and postpartum may have more difficulty breastfeeding and may need additional breastfeeding support.
- Breastfed infants exposed during the third trimester of pregnancy have a lower risk of poor neonatal adaptation than formula-fed infants.



Additional Considerations for Lactation

- Medication properties affect the amount of drug in milk
 - Molecular weight > 600 less likely to transfer.
 - Lipid solubility increases transfer
 - Volume of distribution
 - pH (plasma 7.4 milk 6.8)
 - Weak acids are not attracted, weak bases are
 - SSRIs, Bupropion are weak acids
 - Shorter half life drugs are better.
 - Higher protein binding transfer less readily into the milk
 - Plasma level
 - Milk plasma ratio < 1 is better
- “Dose” infant receives is also dependent on
 - Infant absorption, detoxification, excretion
 - Milk volume
 - Stage of lactation
 - Drug Half life
- Relative infant dose
 - RID = infant dose/maternal dose
 - < 10% best



Relative infant dose in breast feeding

- < 10 % maternal dose
- Examples
 - Fluoxetine 1.6 -14.6% (no harmful effected note at upper range)
 - Other SSRIs 0.4 -7.9% extensive data
 - SNRIs 0.1- 8.1%
 - Quetiapine 0.02 to 0.1%
 - Bupropion < 2% data limited
 - Mirtazapine < 6.3% data limited
 - Lorazepam < 3 %



Selective Serotonin Reuptake Inhibitors

- Pregnancy
 - Zoloft/Sertraline
 - Celexa/Citalopram
 - Lexapro/Ecitalopram
 - Prozac/Fluoxetine
 - Paxil/Paroxetine
 - Luvox/Fluvoxamine
- Lactation
 - Zoloft/Sertraline
 - Paxil/Paroxetine
 - Luvox/Fluvoxamine
 - Lexapro/Ecitalopram,
 - Celexa/Citalopram,
 - Prozac/Fluoxetine



Screen for bipolar disorder

Has there ever been a period of time in your life 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?

If YES to more than one of the above, have several of these ever happened during the same period of time

Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder



Sleep

- Sleep is essential “medicine”
- Medications
 - Diphenhydramine (Benadryl) Doxylamine (Unisom)
 - Not effective for all patients, especially if anxiety or depression is not fully treated
 - Hydroxyzine/Vistaril/Atarax
 - Trazodone
 - May cause morning grogginess
 - Highly effective for many people
 - No addictive potential
 - Quetiapine (Seroquel)
 - Atypical antipsychotic -Low doses effective for insomnia and anxiety
 - Mirtazapine (Remeron)
 - Inverse relationship between dose and sedation
 - Used for Insomnia, hyperemesis gravidarum
 - Stimulates appetite



Benzodiazepines

- Fewer/no active metabolites (lorazepam) may be safer
- Try to avoid longer-acting benzos
- Safer than newer sleep agents – more data



Stimulants

- Current recommendations are to minimize stimulant use and optimize behavioral interventions during perinatal period
- Risks
 - Limited, but reassuring long-term developmental data
 - Small amounts passed through to breastmilk



Mood stabilizers

- Lithium and lamotrigine have documented reproductive safety profiles, low absolute risks
 - Lithium for women who require an anti-manic agent
 - Lamotrigine for the prevention of depressive episodes
- Lithium and Breastfeeding
 - Bipolar disorder in mother that is stable. Lithium monotherapy
 - Healthy infant
 - Collaborative pediatrician with infant monitoring
- Lamotrigine and Breastfeeding
 - Blood levels can be higher than seen with SSRIs
 - No adverse effects formally reported, including risk of rash.
 - Considered compatible with breastfeeding



Mood Stabilizers and Breastfeeding

Medication

- Carbamazepine
- Valproic acid
- Lamotrigine
- Lithium

AAP

- Usually compatible with breastfeeding
- Usually compatible with breastfeeding
- Unknown, but may be of concern
- Significant side effects, should be used with caution

Infant monitoring during lactation

Drug

Carbamazepine

Valproic acid

Lamotrigine

Lithium

Typical antipsychotics

Atypical antipsychotics

Infant Monitoring

CBZ level, CBC, liver enzymes

VPA level (free and total), liver enzymes, platelets

Rash, liver enzymes

BUN, CRE, TSH, CBC, li

Stiffness, CPK

Weight, blood sugar

Atypical Antipsychotics

- Limited data
- levels in breast milk have generally been found to be low
- <https://womensmentalhealth.org/posts/atypical-antipsychotics-breastfeeding/>



Cannabis and Lactation

- Risks:
 - Drop in IQ and cognitive abilities
 - Animal studies show disruption in brain development
 - Possibility of slowing down of fast dividing cells such as a fetus
 - Prenatal marijuana exposure is associated with decreased attention span and behavioral problems
- Presents challenges with psychiatric diagnosis and treatment planning in Mood and anxiety disorders, attention deficit disorder.
 - Why is the client using cannabis? Anxiety, insomnia, chronic pain.
 - Offer alternative evidence based researched treatment or treatments with known safety profiles
- <https://cdphe.colorado.gov/marijuana-health-care-provider-resources>
- Metz TD, Borgelt LM. [Marijuana Use in Pregnancy and While Breastfeeding.](#) *Obstet Gynecol.* 2018 Nov;132(5):1198-1210.



Others...

- Brexanalone Zulresso
 - Neurosteroid, an analogue of allopregnanolone, which is a novel type of antidepressant, acting as an allosteric modulator of GABA-A receptors.
 - Approved in March 2019 as the first FDA-approved treatment for postpartum depression.
 - Due to two serious adverse events: suicidal ideation after the infusion in one subject and syncope/altered consciousness in another patient. Only will be available through a restricted distribution program at certified health care facilities
- Hormones...





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Discussion and Q & A

Cases/HIPAA

DO NOT INCLUDE:

- Names
- Address
- DOB
- Phone/Fax #
- Email address
- Social Security #
- Medical Record #



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



- Add case slides

Questions and Discussion from the group....



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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		
DATES	SESSION	DIDACTIC TOPICS (in addition to case review)
Jan 11	TeleECHO Session 1	Depression & Anxiety in the Prenatal Period (Sandy Wood, CNM, PMHNP)
Feb 8	TeleECHO Session 2	Cultural Considerations in Perinatal Mental Health (Sayida Peparah, PsyD)
Mar 8	TeleECHO Session 3	Depression & Anxiety in the Postpartum Period (Sandy Wood, CNM, PMHNP)
Apr 12	TeleECHO Session 4	Resources & Referrals (Amy Wenger, RN, Elizabeth Gilman, Carol Lang-Godin, BA, and Maria Rossi, CLC, CLD, BS)
May 10	TeleECHO Session 5	Bipolar Disorder in the Peripartum (Sarah Guth, MD)
May 31	TeleECHO Session 6	Postpartum Psychosis (Sarah Guth, MD)
June 14	TeleECHO Session 7	Birth Trauma/Perinatal Grief & Loss (Fiona Griffin, LCMHC)



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
 - Elizabeth.Cote@uvm.edu

