Perinatal Mood and Anxiety Disorders (PMADs)

• What Are They?
• How do they impact Families?
• How can We help?
What are Perinatal Mood and Anxiety Disorders (PMADs)?

PMADs are mood and anxiety disorders that occur during pregnancy and/or the first year after giving birth. PMADs can occur at any point during the perinatal period. Approximately 15% of women giving birth will experience one or more. 10% of men will experience one.

- Depression
- Anxiety or Panic Disorder
- Obsessive-Compulsive Disorder
- Post-Traumatic Stress Disorder
- Bipolar Disorder
- Psychosis
<table>
<thead>
<tr>
<th>PMADs</th>
<th>Symptoms may include:</th>
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<tr>
<td><strong>Depression</strong></td>
<td>Sadness, crying, appetite changes, sleep disturbances, poor concentration/focus,</td>
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<td>(The most diagnosed PMAD: 21% of those</td>
<td>irritability and anger, hopelessness and helplessness, guilt and shame, unexplained</td>
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<td>diagnosed-68% unipolar, 22.6% bipolar)</td>
<td>physical complaints, suicidal thoughts</td>
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<td>66% of those diagnosed also had Anxiety.</td>
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<td><strong>Anxiety</strong></td>
<td>Agitation, inability to sit still, excessive concern about baby’s or her own health,</td>
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<td>(15.8% prenatally, 8-20% postpartum)</td>
<td>high alert, appetite changes – often rapid weight loss, sleep disturbances, constant</td>
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<td>worry, racing thoughts, shortness of breath, heart palpitations</td>
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<td><strong>Obsessive Compulsive Disorder (OCD)</strong></td>
<td>Intrusive, repetitive thoughts – usually of harm coming to baby. These are &quot;ego-</td>
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<td>(11%; 30% is new onset and 65% with co-</td>
<td>dystonic&quot; thoughts-Moms are horrified by these thoughts, have tremendous guilt and</td>
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<td>morbid PPD).</td>
<td>shame, are hyper-vigilant, and engage in behaviors to avoid harm or minimize triggers</td>
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<td>) Other OCD behaviors: cleaning, counting, hypervigilant about all baby care</td>
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<td>Disorder:</td>
<td>Symptoms may include:</td>
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<td>Post-Traumatic Stress Disorder (PTSD) (12% of those diagnosed with PMAD)</td>
<td>Intrusive re-experiencing of past traumatic event, isolation from family and friends, “emotional numbing,” hyperarousal/hypervigilance, avoidance</td>
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<td>Bipolar I (Defined as at least one lifetime episode of mania along with major depressive episodes)</td>
<td>Includes symptoms of major depressive disorder, Hypomania (less pronounced), mania (at least 7 days in length, more severe symptoms including psychotic symptoms often requiring hospitalization) - onset is often in perinatal period</td>
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<td>Bipolar II (Defined as one or more major depressive episodes with one or more episodes of hypomania)</td>
<td>Includes symptoms of major depressive disorder, hypomanic episodes may last 1-6 days, Irritability, rage, anxiety, insomnia, excitability (no symptoms of mania) – onset often in perinatal period</td>
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<td>Symptoms may include:</td>
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<td>Psychosis</td>
<td>Delusions (e.g.: baby is possessed by a demon), hallucinations (e.g.: seeing someone else’s face instead of baby’s face or hearing voices), insomnia, confusion/disorientation, rapid mood swings (more than non-postpartum psychosis), waxing and waning (can appear and feel normal for stretches of time in between psychotic symptoms)</td>
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<td>1-2 in 1,000</td>
<td>(50% of them are first time Moms with no prior history)</td>
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# Why Should We Care About PMADs?

1. **#1 Medical Complication related to Childbearing**

   Treating mental health issues at this time can prevent domestic violence, child neglect, abuse and trauma, developmental delays, even suicide, infanticide and homicide.

2. **By preventing childhood trauma, we can impact the overall health of our population** (high Adverse Childhood Experiences (ACE) scores are associated with a multitude of negative health outcomes).

3. **Screening helps detect so treatment can occur** (about half have no MH history).

4. **Opportunity to help those with prior undiagnosed issues when motivation is often high**.

5. **Moms Can Die from PMADs**.
Mental health conditions other than substance use disorder (SUD) contributed to over one-fifth (n =18/80, 22.5%) of pregnancy-associated deaths in Connecticut in the period between 2015 and 2020.

Mental health condition "probably" contributed to an additional (14%) pregnancy-associated deaths.

Of 18 pregnancy-associated deaths in which mental health conditions definitively played a role, two-thirds (n = 12/18, 66.7%) were determined by the CT MMRC to be pregnancy-related—that is, causally related to pregnancy or its management.

Data from Connecticut Maternal Mortality Committee (MMRC) brief from 2015-2020.
"Preventable" Deaths

Continued Data from Connecticut Maternal Mortality Committee (MMRC) brief from 2015-2020

CT MMRC determined that all 18 deaths were preventable.

"Accidental overdose" was the most common cause of death among pregnancy associated deaths in which mental health conditions other than SUD played a role.

Half (n = 9/18) died of an overdose

One-third (n = 6/18) died by suicide

Other causes of death: unintentional injury and embolism.
Women of Color and in Lower Social Strata are Overrepresented

(Continued) Data from Connecticut Maternal Mortality Committee (MMRC) brief from 2015-2020

• Race: 44% White; 28% Black; 28% Hispanic/Latinx.

• Education: 11% of decedents held a Bachelor’s degree or higher

• Employment: 2 of 18 (11%) held a professional job; 28% were not employed outside of home; 11% were students; 50% were employed as technicians, service workers, or in sales, or administrative positions

• Health Care: 72% had Medicaid insurance
Essential Screening did not occur

(Continued) Data from Connecticut (MMRC) brief from 2015-2020

Most had two or more mental health diagnoses on record: Those with a MH diagnosis prior to pregnancy are at greater risk for an exacerbation of symptoms during pregnancy and postpartum.

One third died during pregnancy; Two thirds died during the postpartum period

Although 10 of the 12 women had mental health diagnosis prior to their pregnancy and death, only 2 were screened at any of their ER visits

All received prenatal care, but only two were screened prenatally by their obstetric providers

Only half were screened in the hospitals of labor & delivery of babies

Half were not screened during delivery or in the postpartum period; despite having a history of mental health concerns
Care and "Net" of Community Support

A "Buffet" of Interventions:
- Technology Enabled Help: Apps
- Telehealth Support
- Mommy Activity Groups
- Home Visitation: Nurses, Doulas, Parent educators, lactation consultants, social workers, therapists
- Peer-led Support Groups
- Individual Therapy
- Clinician-led Support/therapy Groups
- Intensive Outpatient Program
- Partial Hospitalization
- Hospitalization
- Supported Housing Specific to Needs

Connecting the Net: "Pie in the sky"
- Universal Screening: OB, ED, Pediatric, Every health care setting
- Communication between Care Providers
- Universal Electronic Health Record
- Training for Care Providers: PMADs, Trauma sensitive, Racially sensitive, Collaborative care
- Communication/Training about Community Resources & Programs
- Devoted Social Workers to connect Moms and Families to "the next step" resources and programs
- Increased Public Health Education Campaigns to Increase Awareness of PMADs, impact, and effectiveness of treatment
Common Themes in Intensive Treatment

• Training in Perinatal Care of all Providers
• Interdisciplinary Teams which include Psychiatric Specialists, Psychologists, Nurses, Occupational Therapists, Recreational Therapists, and More
• Primarily Group treatment
• Individual assessment and treatment
• Family Psychoeducation and Services
• Baby Care & Bonding Psychoeducation and Support
• Lactation/Feeding Support
• The Best Treatment Centers have Baby Care on site
• Most have access to family housing near the site (Ronald McDonald houses or others)
Inpatient Perinatal treatment programs in the US

Arkansas: Little Rock, AK
Women’s Inpatient Unit

California: Mountain View, CA (near San Jose)
El Camino Health Women’s Specialty Unit

North Carolina: Chapel Hill, NC
UNC Perinatal Psych Inpatient Unit

New York: Glen Oaks, NY
Northwell Health Perinatal Psychiatry Service
California
• Los Angeles: UCLA CA Resnick/Maternal Mental Health Program
• Mountain View: El Camino Hospital Maternal Outreach Mood Services (MOMS)
• Newport Beach: Hoag Hospital Maternal Mental Health Clinic
• Pasadena: Huntington Memorial Hospital Maternal Wellness Program
• San Diego: UC San Diego Maternal Mental Health Program

Colorado
• Aurora: HealthOne Behavioral Health and Wellness Center

Florida
• Gainesville: Better Beginnings Mommy & Baby Day Program

Illinois
• Hoffman Estates: AMITA Health Perinatal IOP at Alexian Brothers Women & Children’s Hospital

Michigan
• Grand Rapids: Pine Rest Mother and Baby Program
IOP Units in the United States (Continued)

**Minnesota**
- Brooklyn Park: PrairieCare Perinatal Mental Health Clinic
- Minneapolis: Hennepin Mother-Baby Day Hospital

**Missouri**
- St. Louis: Mercy Birthplace Mother-Baby Intensive Outpatient Program

**New Jersey**
- Long Branch: Monmouth Medical Center Perinatal Mood & Anxiety Disorders Program

**New York**
- New York City: The Motherhood Center of New York
- Queens, Nassau, and Suffolk Counties: Perinatal Psychiatry Services at The Zucker Hillside Hospital and South Oaks Hospital
IOP Units in the United States (Continued)

Pennsylvania
• Philadelphia: Drexel University Mother Baby Connections Intensive Outpatient Program
• Pittsburgh: Aleixis Joy D’Achille Center for Women’s Behavioral Health (West Penn Hospital, Allegheny Health Network)

Rhode Island
• Providence: Brown University / Women & Infants Hospital

Utah
• Provo and Riverton: Serenity Recovery and Wellness
• Salt Lake City: St. Marks Outpatient Perinatal Program
• Salt Lake City: Huntsman Mental Health Institute / University of Utah
• South Jordan: Reach Counseling

Washington
• Seattle: Swedish Perinatal Center for Perinatal Bonding and Support
Resources (Non-exhaustive)

**ACCESS Mental Health for Moms**: Statewide program works with obstetric, primary care, and psychiatric providers to support their capacity to identify, screen, assess, treat, and refer women with behavioral health concerns up to one-year post delivery.

**Connecticut Coalition Against Domestic Violence**: A statewide network focused on advocacy, outreach and education to prevent domestic violence.

**Postpartum Support International (PSI)**: PMAD education, Online Support Groups, Professional Trainings, Helpline, National Maternal Mental Health Hotline, Perinatal Psychiatric Consultation Line, Provider Directory to local providers trained in PMADs, Annual Conference, Grants, Advocacy

**Postpartum Support International Connecticut Chapter** (PSI-CT): Local Support Groups, Local Advocacy and Awareness Campaigns (e.g.: Climb Out of Darkness) Local Professional Trainings

**American Psychological Association Fact Sheet**: 

**2-1-1 Connecticut**: 2-1-1 is a free, confidential information and referral service that connects people to essential health and human services 24 hours a day, seven days a week online/phone.

**Suicide Hotline- 988**: Free, confidential support for people in distress, prevention and crisis resources, and best practices for professionals.