PMAD (Perinatal Mood & Anxiety Disorders)

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Disclosure

- The speaker has no conflicts of interest to disclose.

Learning Outcomes

By the end of the presentation, the participant will be able to:

1. Explain PMAD, its prevalence and possible causes/consequences
2. Differentiate PMAD from other perinatal conditions
3. Recognize the perinatal risk factors associated with PMAD
4. Describe tools for screening and Non-Rx/Rx treatments
5. Health disparities that exist and how we are beginning to address them
6. Review current resources available for moms, families and care providers

Perinatal Mental Health

- **PPD**=

  Depression + Postpartum = Postpartum Depression

- **PMAD**/PPMD**=

  Mood disorders* during **pregnancy**, and **up to a year*** after delivery (including loss) = Postpartum Mood (and Anxiety) Disorders

- **Important postpartum facts:**

PMAD-most common complication of childbirth (10-20%).***

40-80% of PMAD cases are mod-severe.

25-40% of mothers with a depression history will experience PMAD.

40% of mothers with a PMAD history will experience PMAD in future pregnancies.

https://www.acog.org/-/media/project/acog/acogorg/files/pdfs/publications/2018-postpartum-toolkit.pdf

Why are we talking about PMAD?

- We need to break the silence
- If untreated,

devastating **consequences** for the mother, her baby, her family and society.

REMEMBER…

- You have **two** patients
- Treatment can benefit both mother and baby
- Not treating can poses potential risk to mother and baby

‘Baby Blues’ vs. PMAD

	‘Baby Blues’	PMAD
Prevalence*:	Approx. **75%** of all new mothers	Approx. **20%** of all new mothers *
Duration:	Days **1-14** postpartum	Longer than **2 weeks (can last up to a year after birth)**
Symptoms:	Mood lability- crying/anxiety/irritability, insomnia	DSM-5 criteria for MDD **(Physical symptoms:** ie**.** CP, HA, racing heart beat**)**
Treatment:	Support, reassurance, adequate sleep	Rx and Non-Rx (but rarely seek treatment)

Howard et al.(2017).Cleve Clin J Med.;84(5):388-96

Clinical Presentation:

- Mood lability
- Insomnia/hypersomnia
- “Brain fog”
- Rage
- Anhedonia
- Somatic complaints
- Appetite: too little/too much
- Isolating
- Poor bonding with her infant
- Shame
- Intrusive thoughts*

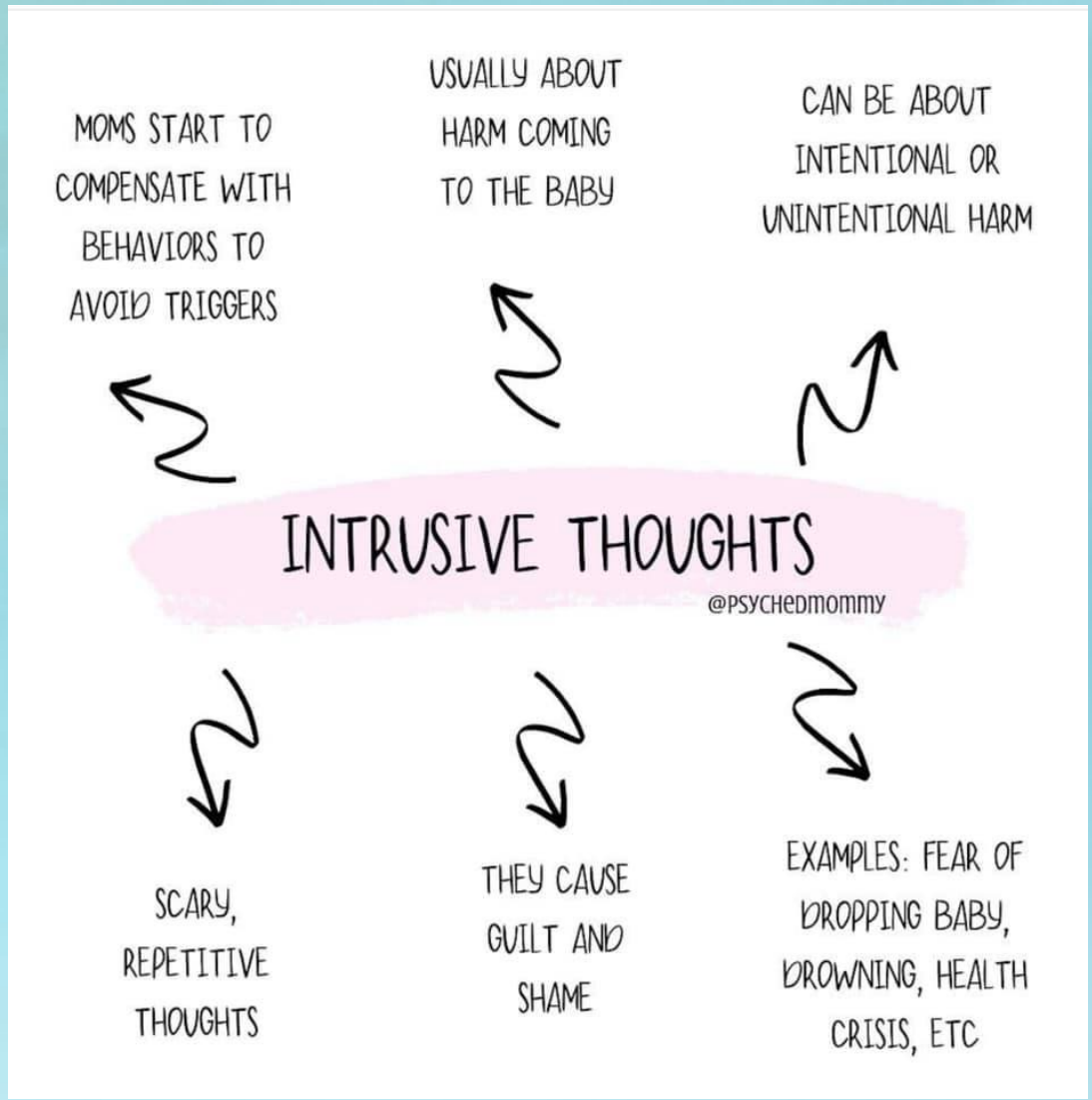
Payne, J.., & Maguire, J. (2019). Pathophysiological mechanisms implicated in postpartum depression. *Frontiers in Neuroendocrinology, 52*, p. 165–180.
Stewart, D., & Vigod, S. (2019). Postpartum Depression: Pathophysiology, Treatment, and Emerging Therapeutics. *Annual review of medicine, 70*, p.183–196.

Clinical Presentation (con't):

*Intrusive Thoughts ('IT's)-
Unwanted/repetitive/scary
Horrified/violent/disturbing
Moms keep them to yourself*

Can be sexual in nature

'IT's are THOUGHTS NOT ACTIONS



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Postpartum Psychosis

- 1-2 in 1000 postpartum women will develop
- Serious/rare disorder
- Occurs within 3-14 days following the birth
- Serious and requires immediate medical attention

Symptoms can include:

- Hallucinations/Delusions
- Manic mood/Low mood
- loss of inhibitions
- feeling suspicious or fearful
- Restlessness
- feeling very confused
- behaving in a way that's out of character

IT vs Psychosis:

"The disorder creates a disconnect from reality, so patients can't tell the difference between their mind and the voices—which could tell them their child is better off without them. That raises the risk for suicide (5%) and infanticide (4%), making it a **medical emergency**." (https://www.cedars-sinai.org/blog/difference-between-postpartum-anxiety-ocd-psychosis.html)

Maternal Mental Health: “It’s not all about hormones”

- Biological/Psychological/Social Stressors
- Barriers to Care

Risks of untreated PPD/PMAD, Does it really matter?

- Increased maternal morbidity and mortality/Infant mortality-

Suicide is the second leading cause of mortality in postpartum women.

- Impaired **child** emotional and cognitive development
- ↓ Quality of sleep
- ↓ Cognitive/Language development
- ↑ Health concerns
- ↑ Behavioral problems

- **Mothers** "never forget/shame" LT
- ↓Physical/Psychological health
- ↓ Quality of life
- ↑ Relationship problems
- ↑ Risky behavior

Mother-Infant Interactions

↓ Bonding and attachment
↓ Maternal care
↑ Breastfeeding problems

Cost*

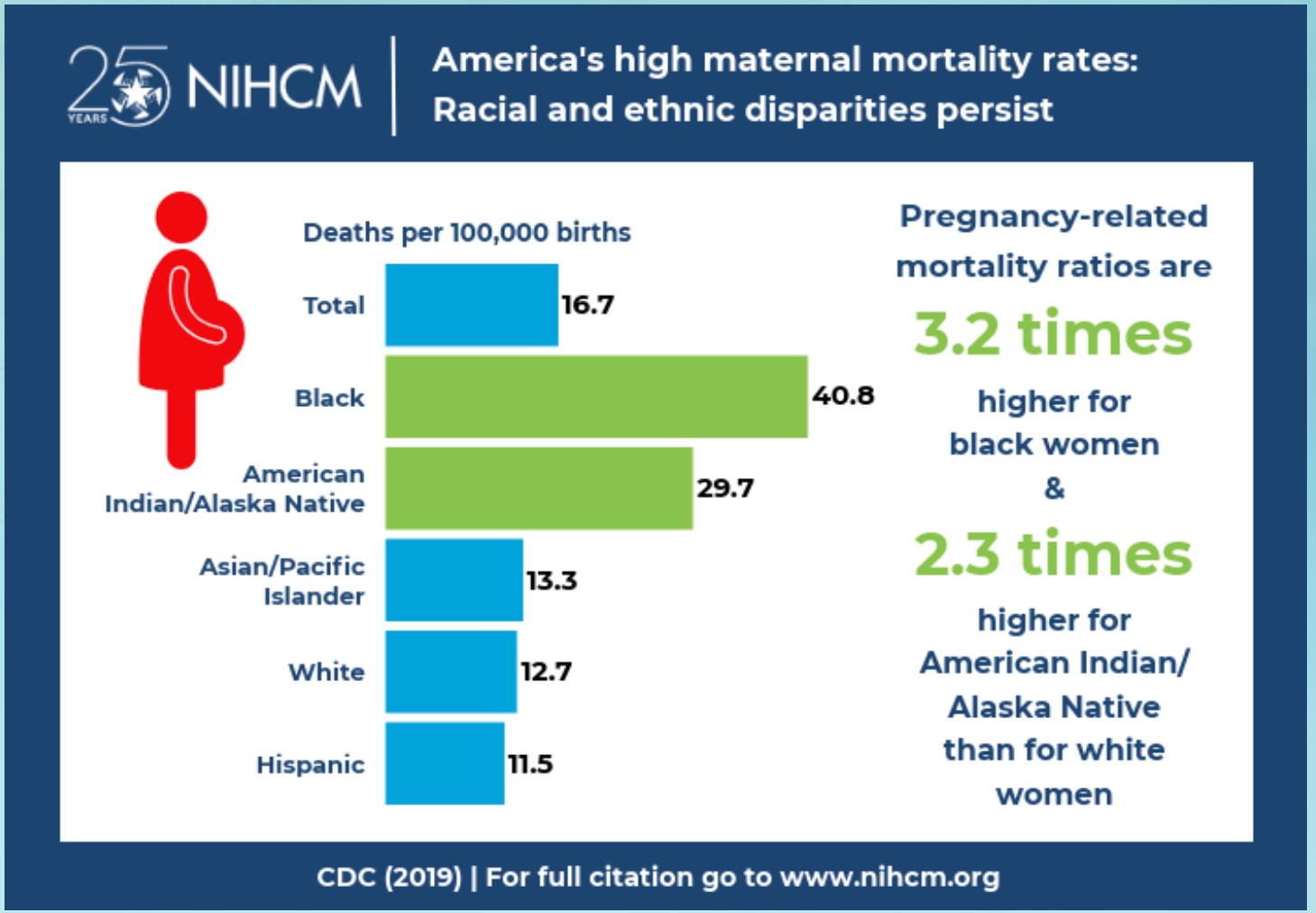
Slomian, J., Honvo, G., Emonts, P., Reginster, J.., & Bruyère, O. (2019). Consequences of maternal postpartum depression: A systematic review of maternal and infant outcomes. *Women's health (London, England), 15, 1745506519844044.*

Health Disparities: In Low-income and Minority Populations

- Much higher rates of PPD compared to general population
- 2 x as likely to be diagnosed with gestational diabetes

- Less likely to be screened, diagnosed or get treatment for PPD

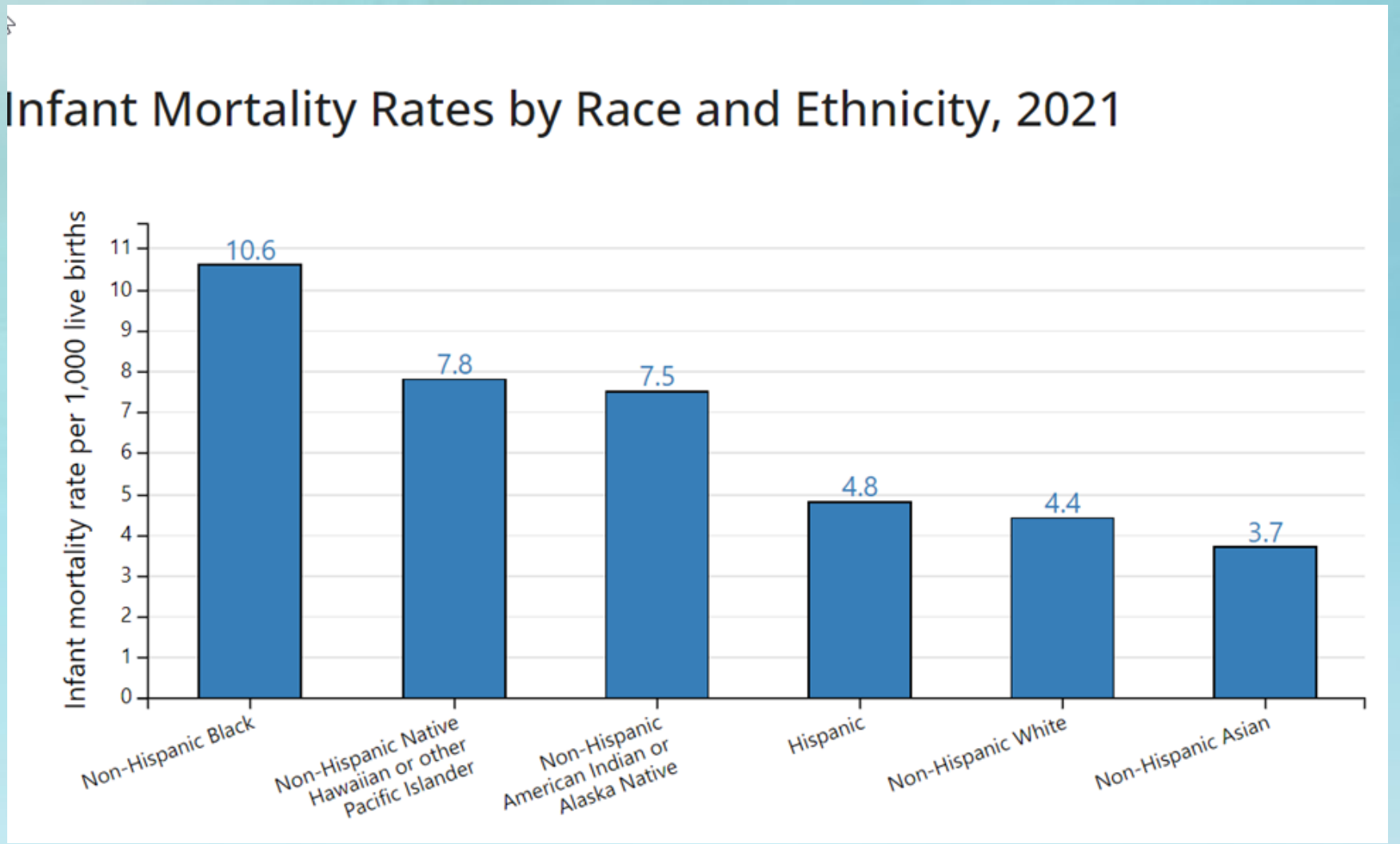
Black babies:
- 2 x as likely to have LBW
- 2 x as likely to die (in 1st year)
- 54% (as opposed to 74%) receive breastmilk



Dagher, R., Pérez-Stable, E., & James, R. (2021). Socioeconomic and racial/ethnic disparities in postpartum consultation for mental health concerns among US mothers. Archives of Women's Mental Health, 24(5), p. 781–791.

Preterm Births and Infant Mortality Rates in the U.S.

Preterm births:
16.5% Blk, AA
10.3% White
10.2% Asian, Pac. Islander



https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm

Health Disparities: In Low-income & Minority Populations, "Why is it happening & how can we reduce the #s?"

Limited research but what we are learning so far is:

- lack of **screening** for these populations
- limited **access to care**
- Lower rate of **prenatal care**
- **Unintended** pregnancies (above)
- Lack of **insurance** +/or **finances** for care
- **Stigma** r/t mental illness; Fear HCPs

Common Barriers that transcends race/ethnicity:

- Guilt/Shame- should be **"joyful"**
- Refusal to take **Rx** (pregnancy/lactation)
- Fear of baby being **taken away**
- **Support Systems** ("don't get it" MIL)
- **Cultural** influences

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Treatment: It depends on the type and severity of a woman's symptoms

Psychiatric evaluation (appropriate practitioner)

Psychotherapy +/or Rx

(Individual/couple's counseling)

Referrals sources

Goal: Healthy Mom, Healthy Baby

Every baby deserves a healthy mom/ Every Mom deserves to enjoy parenthood.

Management of Anxiety and Depression

SSRIs (Selective Serotonin Reuptake Inhibitors): 1st line

Sertraline (Zoloft)

Citalopram (Celexa)

Escitalopram (Lexapro)

Paroxetime (Paxil)

Fluoxetine (Prozac)

SNRIs (Serotonin-Norepinephrine Reuptake Inhibitors): 2nd line

Duloxetine (Cymbalta)

Venlafaxine (Effexor)

Desvenlafaxine (Pristiq)

Management of Anxiety and Depression

Bupropion (Wellbutrin)

Mirtazepine (Remeron)

Vortioxetine (Trintellix)

TCAs (Tricyclic Antidepressants)

MAOIs (Monoamine Oxidase Inhibitors) rarely used

Management of Anxiety (Non-Benzo/Anxiolytics)

Buspar- (use with Hx SUD)

TCAs (Tricyclic Antidepressants)

MAOIs (Monoamine Oxidase Inhibitors) rarely used

Management of Anxiety (Benzo/Anxiolytics)

Xanax- short ½ life, acute panic

Klonopin- longer ½ life, “a bridge”

Ativan- short ½ life

“How are you sleeping?”

Essential

No improvement without sleep

Rxs don’t work if mom not sleeping

Minimum 4-6 consecutive hrs.

What support system does she have?