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Perinatal mental health: life beyond six weeks

Disclosures

- Potential for conflicts of interest: none

Our roles

- Chandra – started a new role as an NP at Women's hospital in June of 2019 and set out to create a program that would better support our patients struggling with mental health concerns during the perinatal period. A second NP joined in April 2020.
  - The Perinatal Mental Health Nurse Practitioner Program is a referral-based program where clinicians can refer perinatal patients who may be presenting with or require management of mild to moderate mood disorders
  - A note on nurse practitioners – we are **autonomous** providers with a graduate level degree who can diagnose and treat illnesses and mental health disorders. We can order diagnostic tests with the only limitations being some nuclear medicine scans. We can prescribe and manage medications, and can refer to specialists as needed.

Our roles

- Dr. Ashdown
  - Perinatal Mental Health & Addictions at HSC
  - Interdisciplinary Perinatal Clinic with Dr Watson
  - Treating Psychiatrist in Bunibonibee and Manto Sipi Cree nations
  - Medical support for Bell Hotel Managed Alcohol Program

Land Acknowledgement

- We acknowledge that we are gathered on ancestral lands, on Treaty One Territory. Manitoba is located on traditional territory of Anishinaabeg, Cree, Oji-Cree, Dakota, and Dene Peoples. We acknowledge Manitoba is located on the Homeland of the Red River Métis. We acknowledge that our water is sourced from Shoal Lake 40 First Nation.

Land Acknowledgement Acknowledgement

- Reconciliation cannot come without truth.
- Acknowledgement of the land we live and depend on must come with embracing the truth about what past and ongoing harms exist as part of upholding Canada.
- As people from settler backgrounds, we are aware that our societal advantages have come and continue to come at the disadvantage of Indigenous peoples. We are responsible for working collaboratively to dismantle oppressive structures within our institutions, at work and at home.

Land Acknowledgement Acknowledgement

- Maternal mental health continues to be deeply impacted by the multiple forms of harm related to colonization, including the attachment traumas inherent in criminalizing ceremony, language and cultural health and wellness practices, residential schools, the 60's scoop, forced relocations, restricted movement by Indian agents, the gendered inequities in the Indian Act and the disproportionate effects of infectious and chronic disease as well as incarceration and separation through the child and family services system- among many other factors.

21. We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools, and to ensure that the funding of healing centres in Nunavut and the Northwest Territories is a priority.

22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

23. We call upon all levels of government to:

    i. Increase the number of Aboriginal professionals working in the health-care field.

    ii. Ensure the retention of Aboriginal health-care providers in Aboriginal communities.

    iii. Provide cultural competency training for all health-care professionals.

24. We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the *United Nations Declaration on the Rights of Indigenous Peoples*, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

Determinants of health are the broad range of personal, social, economic and environmental factors that determine individual and population health. The main determinants of health include:

1. Income and social status
2. Employment and working conditions
3. Education and literacy
4. Childhood experiences
5. Physical environments
6. Social supports and coping skills
7. Healthy behaviours
8. Access to health services
9. Biology and genetic endowment
10. Gender
11. Culture
12. Race / Racism

The facts

- Pregnancy and the birth of a new baby does not protect against mental illness
- Without treatment, mental illness can contribute to a variety of pregnancy and childhood complications:

    - Worsened prenatal care
    - Higher risk of obstetrical complications
    - Substance related disorders
    - Compromised mother-infant bonding
    - cognitive-/neuro behavioural impairments in the early years
    - In rare cases it can contribute to:
    - Maternal suicide
    - Infanticide

Prevalence

- Perinatal period = conception up to one year postpartum
- 1/5 will suffer from substantial depression during the perinatal period
- Perinatal depression (PND) is most commonly diagnosed
- Rates for depression are the same in perinatal and non-perinatal populations
- Rates for anxiety and bipolar disorder higher in perinatal population
- Rates for schizophrenia similar in perinatal and non-perinatal population (ie. Perinatal period not vulnerable time for relapse)
- Postpartum psychosis: rare
  - Occurs in 1-2 per 1000 live births

Clinical significance

- Possible impacts on families:
  - Undesirable views on parenthood
  - May view baby's behaviour as 'difficult'
  - They may not recognize their baby's cues and may not respond appropriately to them
  - Breastfeeding length of time may be shortened
  - Substances can be used as a coping mechanism
  - At bigger risk of future episodes of depression or other mental health issues
  - Risk of suicide (particularly in PP psychosis)

Clinical significance

- Potential impacts on babies:
  - Behaviour disturbances
    - Faster to cry, and cry louder and longer
    - Spend less time in 'quiet and alert' phase (and this is when they learn the most about their surroundings)
  - Development delays
    - May walk and talk later than others
  - Social issues
    - May have more struggles creating secure relationships
    - Might be socially withdrawn
  - Risk of infanticide (rare)

Clinical significance

- Possible impacts on partners/family members
  - Increased risk of separation, divorce
  - Partners may also be depressed, may require tx
  - Partner depression in the perinatal period has similar poor impacts on relationships, family, and the baby

Barriers to treatment

- May include but are not restricted to:
  - Stigma
  - Absence of familiarity with normal adjustment
  - Minimizing symptoms
  - May not be aware that mental illness is treatable
  - May not be aware of implications
  - Language or cultural limitations
  - Fears of baby being removed from care
  - Accessibility
  - Lack of existing services

Baby blues vs perinatal depression

- Baby blues
  - up to 50-80%
  - Usually between 3-5 days PP
  - Excessive crying, mood swings, anxiety
  - 'Normal'
  - Symptoms usually resolve within 1-2 weeks and do not need treatment
  - Only a small portion progress to PPD

Perinatal depression

- What is it?
  - a major depressive episode during pregnancy and/or after the birth or adoption of a baby
  - Up to 16% during the perinatal period
  - May occur anytime in pregnancy or within the first year PP
  - Might start with similar symptoms to baby blues – but the symptoms don't resolve, and they become more severe
  - Requires treatment

Perinatal depression

- PND is defined as a subcategory of MDD
- Signs and symptoms:
  - At least one x 2 week period
    - Depressed mood
    - Anhedonia
  - At least five or more x same 2 week period
    - Feeling sad
    - Decrease in pleasure or interest in activities
    - Changes in appetite
    - Sleep disturbance
    - Psychomotor agitation or slowing down
    - Lack of energy
    - Feelings of worthlessness, guilt
    - Hard time concentrating
    - Thoughts of suicide

Perinatal depression: risk factors

- Major
  - Hx of depression
  - Hx of PPD in previous pregnancy
  - Family hx of depression
- Contributing
  - Excessive anxiety in pregnancy
  - Poor social supports
  - Relationship or family conflict
  - Recent adverse life event
  - Life/financial stress
  - Intimate partner violence
  - Unintended pregnancy
  - Infants with health problems, perceived 'difficult' babies
  - Anxiety
  - Chronic/acute maternal health problems

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Perinatal depression: prevention

- Antenatal depression:
  - Intervention (in the absence of risk factors) not supported by evidence

- Postpartum depression:
  - Those who receive psychosocial and psychological intervention much less likely to develop PPD than those who receive standard care

Perinatal depression: diagnosis

- Exclude medical conditions that might cause symptoms
- r/o substance related disorders (of course, may be co-occurring)
- Complete a diagnostic assessment interview
  - Confirm the diagnosis with the DSM-V criteria
- Diagnosing depression in this phase of life is challenging!
  - Normal emotional fluctuations and responses may be mistaken for depression or may hide depressive symptoms

Perinatal depression: treatment

- Treatment depends on a variety of aspects including:
  - Severity of symptoms
  - Previous response to treatment
  - Support, resources, and desires of the patient
- General guidelines:
  - **Mild-moderate** – non-pharm treatments recommended first, and if not effective, then pharm treatments
    - Psychoeducation, self-care, CBT, interpersonal therapy, psychodynamic therapy, group therapy, parent-infant psychotherapy, couples or family therapy

Perinatal depression: treatment

- General guidelines
  - **Severe symptoms**: medications may be used as first-line treatment, followed by non-pharmacological therapies when the woman is more stable
  - Acutely suicidal patients may require intensive home treatments or hospitalization

Perinatal anxiety

- What is it?
  - When anxiety becomes overpowering and overwhelming - it is referred to as an anxiety disorder
  - Persistent and severe worry in situations where most people would not feel persistent and severe worry
    - You can experience more than one type of anxiety disorder at the same time

Perinatal anxiety

- Clinical cues of anxiety disorders in the perinatal period are just like those in non-pregnant and postpartum women
- Rates for anxiety disorders in the perinatal period are high, and might be as high as PND rates
- Diagnosed much less often than depression in perinatal period despite known prevalence

Postpartum psychosis

- Sudden onset of psychotic symptoms after childbirth
- Onset – quick and unanticipated (but can occur anytime within the first year PP)
- Additional risk for the baby
- Requires hospitalization and medication
- Rare – 1-2 per 1000 live births

- **Psychiatric and obstetrical emergency**

Pharmacotherapy

- Psychotropic medications in the perinatal period
  - Often necessary in combination with therapy and education
  - The pros/cons of potential effects on the fetus/baby must be weighed
  - There is a lot of negative information
  - Even HCPs are misinformed (don't be one of them!)
  - Women may come in with preconceived opinions or misinformation
- As many as 68% of those who discontinue antidepressant use in pregnancy have been found to relapse – compared to 24% when choosing to stay on meds in pregnancy

Pharmacotherapy

Background risk (aka risk of developing clinical problems in the general pregnant population)

- Major congenital malformation: 3%
- Spontaneous abortion: 15%
- Prematurity: 4%
- Low birth weight: 8%
- Cardiac defects: 1%
- Neural tube defects: 0.1%
- Persistent pulmonary hypertension of the newborn: 0.1-0.2%

Pharmacotherapy

- Most SSRIs and SNRIs are pregnancy risk category C
- The exception is paroxetine, which is risk category D (and therefore not recommended – despite newer studies possibly debating this)
- There are no controlled studies on the effects of psychotropic medications for antepartum mental health disorders
- In obstetrics – twofold increased risk viewed as clinically significant

Pharmacotherapy

- So, what do we know about the risks?
  - Largest meta-analysis to date in 2013 shows no increased risk of SAB
  - Risk of teratogenicity not large
  - ? very slight risk of cardiac defects: 1% in general population, increased to 2% with SSRIs (of note: newer studies show NO increased risk)
  - Small increased risk of persistent pulmonary hypertension of the newborn: 0.1-0.2% in general population, increased to 0.3% with SSRIs
  - Breastfeeding is NOT contraindicated!!!!!

Neonatal abstinence syndrome

- 1/3 of newborns who have been exposed to SSRIs/SNRIs in utero will experience NAS
- Presents within a few hours of birth
- Usually mild and transient
- Managed with supportive care

- Neither Women's Hospital nor St. B specifically scores newborns for NAS who have been exposed to SSRIs/SNRIs

Non-pharmacological options

- CBT
- IPT
- DBT
- Support Groups
- Bibliotherapy
- Engagement with culture and ceremony
- Addictions treatment and harm reduction services

Referral pathways

- Centralized Intake can be referred by GP or specialist (ideally GP who will continue to follow)
- NP group at HSC through Women's Hospital providers
- Perinatal Anxiety group through Psychology at St Boniface

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