Evidence-based psychological and pharmacological interventions for perinatal mood and anxiety disorders

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ROGERS Behavioral Health

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Quick overview of logistics

Our speakers will give a 75-minute presentation.

Following the presentation, there will be a dedicated time to answer your questions.

- Please use the **Q&A feature**, located in the toolbar at the bottom of your screen, to send your question to the moderator.
- The moderator will review all questions submitted and select the most appropriate ones to ask the presenter.

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Disclosures

Ajeng Puspitasari, PhD, and Hemalatha Rajanna, MD, have each declared that they do not, nor does their family have, any financial relationship in any amount occurring in the last 12 months with a commercial interest whose products or services are discussed in the presentation.

The presenters have each declared that they do not have any relevant non-financial relationships. Additionally, all planners involved do not have any financial relationships.

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Learning objectives

Upon completion of the instructional program, participants should be able to:

1. Summarize the socioeconomic burden of PMAD for individuals with intersectional identities
2. Identify at least three psychological and pharmacological strategies that can be used to help individuals with PMAD
3. Describe four common barriers of PMAD management and implementation strategies to increase access to treatment

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What we'll cover in this webinar

The socioeconomic burden of PMAD
- Current prevalence
- Existing research on the socioeconomic burden
- Social determinants for individuals with diverse intersectional identities

Psychological and pharmacological interventions for PMAD management
- Cognitive Behavioral Therapy (CBT) strategies
- Behavioral Activation and Exposure Therapy to target depression and anxiety symptoms
- Medication management

Strategies to implement PMAD management for diverse clinical settings and patient populations
- Common barriers to receive PMAD interventions
- Implementation strategies to support PMAD management

Moderated Q&A

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The socioeconomic burden of PMAD

Please use the Q&A feature to send your questions to the moderator.

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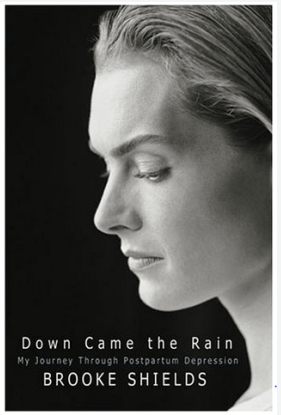
*At first I thought what I was feeling was just exhaustion, but with it came an **overriding sense of panic** that I had never felt before. Rowan keep crying, and I began to **dread the moment when Chris would bring her back to me**. I started to experience a sick sensation in my stomach; it was as if a vise were tightening around my chest. Instead of the nervous anxiety that often accompanies panic, a feeling of **devastation** overcame me. I hardly moved. Sitting on my bed, I let out a **deep, slow, guttural wail**. I wasn't simply emotional or weepy…*



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Perinatal Mood and Anxiety Disorder (PMAD) includes depression and anxiety disorders during pregnancy and 1-year postpartum

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Case example

Charlie is a 32-year-old woman* 3-month postpartum with her first daughter (Skylar). She had a vaginal delivery without medical complication. She had Skylar in 2020 during COVID and around 3-week post-partum started to experience significant changes in her mood. She struggled with challenging thoughts such as “I’m failing as a mother”, “What if my baby stops breathing”, “What if my baby gets sick”, “My baby is better off without me”. As a result, she often avoided engaging with baby during the day though repeatedly checking on her baby throughout the night to make sure that she was breathing.

* Cultural considerations: cisgender, heterosexual, white, partnered

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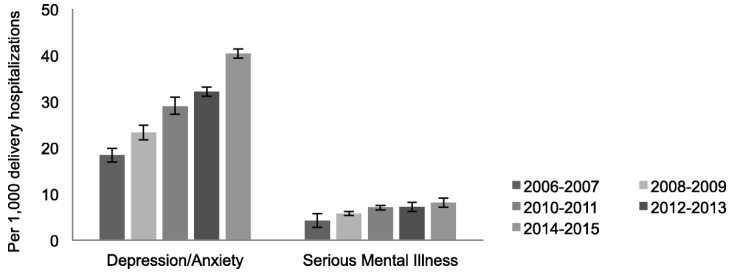
Between 2006 and 2015, PMAD prevalence increased from 18.4 to 40% in the United States



(Mckee et al., 2020)

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PMADs impact

- PMADs are the ***#1 complication*** of pregnancy and childbirth
- PMADs affect up to ***1 in 7*** pregnant and postpartum individuals in the United States
- It is estimated that the total societal cost for untreated PMADs was ***$14.2 billion*** for all births in 2017

(Luca et. al., 2019)

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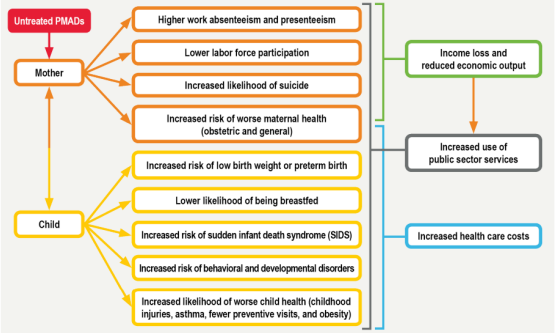
Conceptual model of how untreated PMADs influence maternal, child, and societal outcomes



(Luca et. al., 2019)

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Socioeconomic burden of PMAD

- Increase risk for placental pathology, fetal growth issues, preterm delivery
- Risk of suicide and infanticide
- Poor attachment with baby and adverse developmental outcomes
- Some association with child's emotional and behavioral difficulties, low levels of cognitive development, and poor physical and growth development

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Postpartum depression rates for diverse groups

Groups	Rates (%)
Adolescents	61
Immigrant Women	0.5-60
Fathers	8-25
Black	43.9
Asian	1-20
Taiwanese	21
East Indian	23
Japanese	17
White	31.3
Latine	46.8
Native American	10.5

(Clare & Yeh, 2012)

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PMAD among adolescents

- Postpartum depression affects up to 61% adolescents compared to 38% perinatal adults.
- Potential compounding effects of stressors related to perinatal and adolescent period.
- Higher social isolation and parenting stress.
- Physical, emotional, and financial demands of parenting.
- Alteration in vocational and career aspirations.
- Difficulties with attachment with baby.
- Higher suicide behaviors and substance use

(Clare & Yeh, 2012)

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PMAD among immigrant women

- Little is known on the experience of immigrant women during perinatal period
- Potential unique challenges related to migration status, race and ethnicity, and cultural differences
- Potential lack of support from extended family
- The impact of sociocultural context of childbirth and parenting
- Expression of symptoms in culturally specific terms and metaphors.
- Lack of established social network, job deskilling, a lack of stable housing, and financial difficulties
- Pre-migration and post-migration trauma

(Clare & Yeh, 2012)

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PMAD among fathers/partners

- Overall prevalence of paternal perinatal depression is 10.4%
- Consider assessing partner's PMAD symptoms (e.g., EPDS-Partner)
- An area that needs further research
- Paternal depression has been associated with behavioral problems in their children

(Clare & Yeh, 2012)

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PMAD among BIPOC

Significant disparities in access to behavioral health care for BIPOC individuals

- Statistically post-partum depression can be ranked from high to low in Native Americans, Whites, Blacks, and Latine
- Higher likelihood that BIPOC individuals do not seek help for PMAD
- The importance of PMAD screening during perinatal period

(Clare & Yeh, 2012)

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PMAD among transgender people

A qualitative study on the experience of trans individuals during perinatal period found

- Significant and persistent loneliness
- The process of navigating identity required considerable energy and attention
- Not having clear role models of what a positive, well integrated, gender variant parental role might look like
- Conflicts between gender identity and social norms
- Constant tension about the need to manage others' perceptions and either disclosing or not disclosing what they were experiencing

(Ellis et al., 2015)

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Psychological and pharmacological interventions for PMAD management

Please use the Q&A feature to send your questions to the moderator.

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Perinatal depression: Signs and symptoms

- Persistent sadness, anxiety, or “empty” mood
- Loss of interest or pleasure in hobbies and activities
- Irritability
- Feeling guilty, worthlessness, hopelessness, and helplessness
- Fatigue or restless
- Difficulty concentrating, remembering, making decisions
- Difficulty sleeping
- Significant changes in appetite, weight, or both
- Thoughts about death, suicide, or harming oneself or the baby

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Considerations for perinatal depression

- Perinatal depression prevalence ranged from 6.5% to 12.9% (Gavin et al., 2005)
- High co-morbidity with perinatal anxiety
- Some symptoms are common experience during perinatal period (e.g., fatigue, appetite and weight changes, difficulties sleeping)

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Panic disorder

- Intense fear and abrupt onset of physical symptoms such as shortness of breath, racing heart, and dizziness
- Anticipatory worry over the possibility of additional attack
- Worry about the consequence of the attack (e.g., “I will die”)
- Change in behavior as a result of the attacks (e.g., avoidance)

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Considerations for perinatal panic disorder

- Prevalence rate for panic disorder during pregnancy (2%) and postpartum (1.4 to 2.7%) (Smith et al., 2004; Matthey et al., 2003; Wenzel et al., 2005)
- Experiences of tachycardia, sweating, dizziness, and shortness of breath during perinatal period
- Higher possibility to misinterpret these physiological symptoms for significant medical event
- Pregnancy may increase the recurrence of panic attacks for those with a history of panic disorder

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Obsessive-compulsive disorder (OCD)

- Unwanted intrusive thoughts, ideas, images, doubts, or impulses that evoke anxiety (obsessions)
- Urges to neutralize intrusive thoughts with some other behavioral or mental act (compulsive rituals)

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Considerations for perinatal OCD

- Prevalence rate for postpartum OCD is 2.7% (Wenzel et al., 2005).
- Perinatal period may increase the risk for OCD (Abramowitz et al., 2003).
- Individuals and partners experience of subclinical obsessions during postpartum (Abramowitz et al., 2003).

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Perinatal OCD themes

- Fear that baby is dying from sudden infant death syndrome (SIDS)
- Fear of harming the baby
- Fear of baby getting contaminated
- Excessive checking of baby well-being
- Increased reassurance seeking on parenting strategies
- Avoidance of caring for baby

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Perinatal OCD vs psychosis

- Both may involve thought of harming self and/or baby
- Actual hallucinations and delusions are rare and not observed in OCD
- Perinatal psychosis often involves other features: bizarre behaviors, mood liability, agitation, confusion
- With psychosis: ego-syntonic ideation, not associated with fears or rituals, increased risk of aggressive or harming behaviors
- With OCD, rituals often function to reduce intrusive thoughts and prevent feared consequences from happening

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Perinatal PTSD

- Experiences of intense distress upon being subject to or witnessing a life-threatening event
- Re-experiences of the event (though nightmares or flashbacks)
- Avoidance of cues eliciting memories of the event
- Hyperarousal

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Considerations for perinatal PTSD

- PTSD prevalence during pregnancy ranged from 1.7% to 8.1% and 1.5% to 2.8% postpartum (Ayers & Pickerin, 2001; Smith et al., 2004)
- Previous history of PTSD
- Traumatic experiences during pregnancy and labor

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Generalized anxiety disorder (GAD)

- Excessive and uncontrollable worry for more than half the days for six months or longer
- Worries about multiple life domains
- Experiencing physical symptoms such as restlessness, irritability, muscle tension

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Considerations for perinatal GAD

- Prevalence rate of 8.2% for postpartum GAD (Wenzel et al., 2005)
- Significant changes in multiple life domains, work, romantic relationship, social support, finance
- Devotes a significant time and psychological resources to worry

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Social anxiety

- Marked distress in social and/or performance situations because of the fear of being embarrassed or negatively judged by others
- Avoid social situation or endure it with high distress
- Avoidance and/or distress interferes significantly with occupational and social functioning

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Considerations for perinatal social anxiety

- Prevalence of perinatal social phobia is 4.1% (Wenzel et al., 2005)
- Reasons that increase barriers to social activities: childcare, fatigue, health concerns, breastfeeding
- Diagnosis of social anxiety should be made if the person reports avoidance of social situation due to fear of criticism or embarrassment

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Postpartum "baby blues" vs PMAD

- Postpartum "baby blues" can affect up to 80% of postpartum individuals
- "Baby blues" typically occurs 2-3 days after birth and lasts around two weeks
- Feeling overwhelmed, tearful, exhausted, hypo-manic or irritable
- "Baby blues" typically resolve naturally

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PMAD: High comorbidity

Thoughts	Emotions	Behaviors
• I will drop my baby • My baby will stop breathing • I am failing as a mother • Baby doesn't love me • My doctor doesn't care	• Anxious • Anxious, sadness • Shame, depressed, anger • Depressed, irritability • Anxious, anger, betrayed	• Avoid holding baby • Compulsive checking • Isolating, disengaging • Avoid caring for baby • Avoid seeking help

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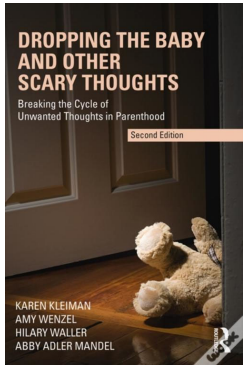
Common "scary thoughts"

- Rumination
- Excessive worry
- Obsessive thoughts
- Intrusive memories
- Catastrophic misinterpretations of bodily sensations



(Kleiman, Wenzel, Waller, Mandel, 2020)

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PMAD management is defined as the provision of behavioral health assessment and intervention (e.g., psychotherapy and pharmacotherapy) to perinatal individuals (Puspitasari et al., 2021)

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PMAD management: Current recommendations

- Screening for PMAD symptoms during the perinatal period
- Increasing frequency of visits when elevated symptoms are identified
- Referring patients to appropriate psychotherapy or pharmacotherapy resources

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Evidence-based psychotherapy for PMAD

- Cognitive behavioral therapy (CBT) (Maguire et al., 2018; Sockol., 2015)
- Behavioral activation for perinatal depression (Dimidjian et al., 2017)
- Exposure therapy for perinatal anxiety (Hudepohl et al., 2022)
- Interpersonal psychotherapy (Stuart et al., 2012)
- Mindfulness-based therapy (Shi & MackBeth, 2017)

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CBT for PMAD: Core components

- Integration of cultural responsiveness approach
- Assessment and Measurement-Based Care (MBC)
- Psychoeducation of PMAD
- Behavioral Activation
- Exposure Therapy
- Relapse Prevention

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Cultural responsiveness and intersectional approach

A	Age
D	Disability (Congenital)
D	Disability (Acquired)
R	Religion (spirituality or no affiliation)
E	Ethnicity (or race)
S	Social status
S	Sexual orientation
I	Indigenous heritage
N	National origin
G	Gender (gender identity and expression)

(Hays, 2008)

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Assessment

Standardized Self-Report Measure	No. of Items	Approximate time to complete (min)	Symptoms
Edinburgh Postnatal Depression Scale	10	<5	Depression
Postpartum Depression Screening Scale	35	5-10	Depression
Patient Health Questionnaire 9-item	9	Less than 5	Depression
Beck Depression Inventory-II	21	5-10	Depression
Quick Inventory of Depressive Symptomatology	16	5	Depression
Center for Epidemiologic Studies Depression Scale	20	5-10	Depression
Generalized Anxiety Disorder 7-item	7	Less than 5	GAD
The Yale-Brown Obsessive Compulsive Scale Symptom Checklist	10	5	OCD
Liebowitz Social Anxiety Scale	24	7	Social Anxiety
Reiss Anxiety Sensitivity Index	16	3	Panic/Anxiety

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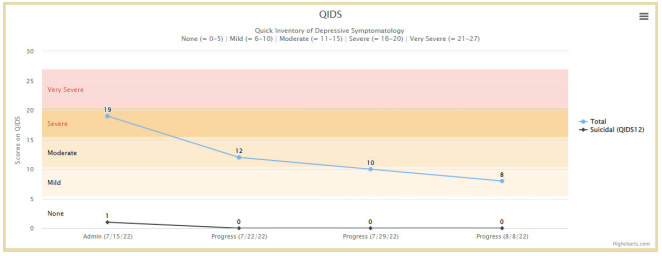
MBC: Core components

- Administer standardized self-report measures routinely
- Review and discuss results with patients
- Incorporate results to treatment planning



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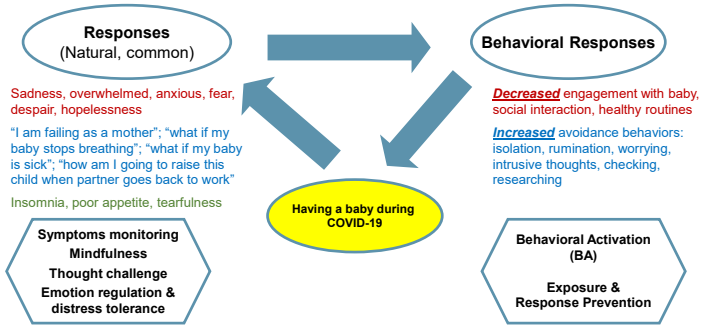
Providing psychoeducation on the CBT Model of PMAD



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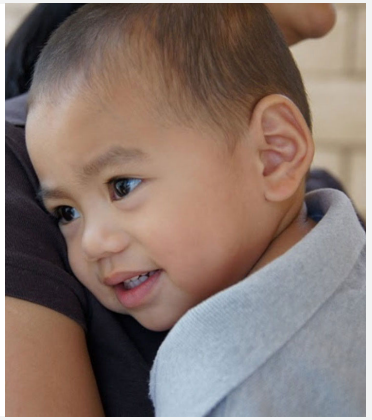
Values: The way you live your life

A meaningful life is a life filled with contact with diverse and stable sources of positive reinforcement
(Kanter, Busch, Rusch, 2009)

The goal of Behavioral Activation (BA) is to help people engage in meaningful activities that are in line with their values using behavioral strategies
(Martell, Addis, Jacobson, 2001)



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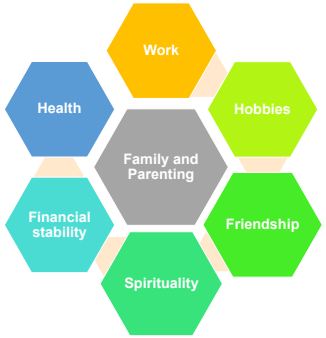
Diverse sources of positive reinforcement



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BA: Hierarchy example

Activities	Difficulty Level (0-7)	Activity Type	Value Areas
Taking a shower once a day	3	Routine	Health
Eating three meals a day	4	Routine	Health
Sleeping 5-6 hours total at night (between nursing)	5	Routine	Health
Watching 1 Netflix show for 1 hour, once a week	3	Pleasurable	Health
Calling bestfriend for 20 minutes, once a week	6	Pleasurable	Friendship
Mindfulness while nursing baby	5	Value	Parenting
Playing with baby (instead of handing baby to partner after nursing) for 15 minutes	6	Value	Parenting

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Exposure therapy

Exposure:

Repeatedly and systematically confronting the object or situation of fear

Response Prevention:

Refraining or resisting compulsions, avoidance, escape or safety behaviors

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Exposure therapy

Responses
(Natural, common)

Anxious, overwhelmed

"I will accidentally drop my baby"
"I will fall down the stairs while holding baby"
"I will trip if I hold my baby while walking"
"I will get hit by a car if I cross the street while holding baby"

Behavioral Responses

Decreased spending time holding baby; going anywhere outside

Increased reassurance if holding baby correctly; handing baby off to partner; staying in the room; always use a baby carrier

Holding baby

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Exposure therapy: Hierarchy example

Activities	Difficulty Level 0-7
Holding baby for 5 minutes while sitting down and partner is in the room	2
Holding baby for 5 minutes while sitting down alone	3
Holding baby for 5 minutes while standing up (not walking)	3
Holding baby for 5 minutes while walking	4
Holding baby while going down the stairs	5
Holding baby for 10 minutes while taking a walk outside	5
Going to a shopping mall alone without partner	7

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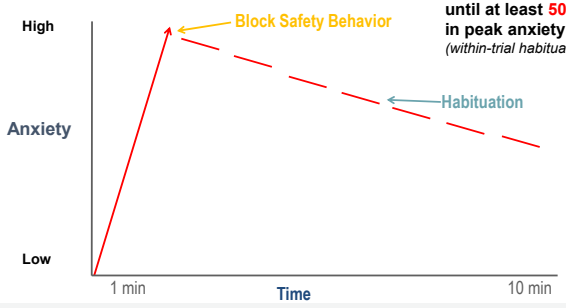
Progression throughout hierarchy

During each exposure, individual remains engaged until at least 50% reduction in peak anxiety
(within-trial habituation)



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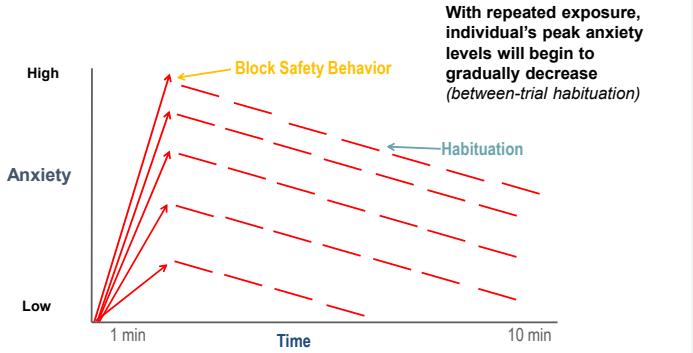
Progression throughout hierarchy



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Strategies to implement PMAD management for diverse clinical settings and patient populations

Please use the Q&A feature to send your questions to the moderator.

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Pharmacotherapy in PMAD

- During pregnancy, either no medications or minimal medications are recommended considering evidence-based research is minimal with pregnant women
- First trimester is considered most crucial for organ development and any type of medications are not recommended
- Most of the studies are retrospective studies and not randomized control studies
- Multiple confounding factors must be considered while inferring conclusions

Always must consider risks vs benefits for the mothers and the impact on the newborn in the process

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Drug categories in pregnancy

A	Adequate and well controlled studies have failed to demonstrate a risk to fetus in the first trimester (and there is no evident risk in later trimesters)
B	Animal reproduction studies have failed to demonstrate a risk to fetus but there are no adequate and well controlled studies in pregnant women
C	Animal reproduction has shown an adverse effect on fetus but there is no adequate and well controlled studies in human, but potential benefits may warrant use of drugs in pregnant women despite potential risks
D	There is a positive evidence of human fetal risk based on adverse reaction data from investigational or marketing experience or studies in human, but potential benefits may warrant use of drug in pregnant women despite potential risks
X	Studies in animals and humans have demonstrated fetal abnormalities and/or there is positive evidence of human fetal risk based on adverse reaction data from investigational or marketing experience, and the risks involved in use of drug in pregnant women clearly outweigh potential benefits

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Pharmacotherapies

Antidepressants/Anti-anxiety medications
(SSRI'S, SNRI's, Benzodiazepines)

- All SSRIs are rated pregnancy category C, with exception of paroxetine which is a category D
- There is most experience with sertraline and fluoxetine
- Paroxetine may be less safe than other SSRI'S

Antipsychotics/Mood stabilizers
(Typical vs atypical class of drugs)

- Using old psychotropics like Haloperidol is preferrable
- Also using High potency drugs vs low potency drugs

Depakote/lithium are <u>not</u> recommended due to documented teratogenicity in newborns

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Pregnancy outcomes with medication use

- Teratogenicity: cardiac defects, cleft palate, organ dysplasia
- Spontaneous abortion
- Hypertensive disorders
- Postpartum hemorrhage
- Preterm birth
- Low birth weight
- Consider possible withdrawal symptoms or sedation that these medications could cause in newborns

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Informed decision is the key

Decision regarding medication choice, dose, and duration must be based on

1. Balancing severity of the illness
2. Chronicity and impact if not treated

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Stigma of using medication during pregnancy

Providing support to patients dealing with societal stigma

- Educating family and providing support
- Multidisciplinary approach by all providers throughout the pregnancy and post-delivery

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Remember…

Half of perinatal women with a diagnosis of depression do <u>not</u> get the treatment that they need!

(Luca et. al., 2019)

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PMAD management: Barriers to implementing

Only around 50% of clinicians routinely screen for PMAD

- Lack of PMAD Management Training. Clinicians reported to be ill-equipped to initiate further intervention, provided referrals or both
- While most patients preferred psychotherapy, current estimates showed that 75% of perinatal patients were referred for pharmacotherapy only

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PMAD management: Barriers to implementing

A cross-sectional survey with clinicians who treat PMAD patients:

- 34.7% never received PMAD management training
- 66.3% had less than 10 years of experience
- 47.8% of clinicians reported providing PMAD management to less than 30% of patients with PMAD
- 40.7% conducted screening only when patients expressed PMAD symptoms

(Puspitasari et al., 2021)

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PMAD management: Barriers to implementing

- Stigma to seek behavioral health care
- Limited insurance coverage
- Attitudes towards PMAD screening among clinicians
- Limited access to specialty PMAD care

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PMAD management: Implementation recommendations

- Provide appropriate training and supervision for clinicians
- Engage relevant stakeholders (e.g., leadership, community, family)
- Establish a culturally responsive, trauma informed, affirming environment
- Identify and implement PMAD screening tools
- Educate clinicians on measurement-based care
- Provide PMAD psychoeducation to those who may be affected
- Activate an emergency referral protocol for patients with suicidal and homicidal ideation
- Coordination of care among multidisciplinary team

(Kendig et al., 2017)

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Time for questions and answers…

- Please use the Q&A button – *not the chat* – to submit your question
- If we don't get to your question, please feel free to send an email to **webinars@rogersbh.org** and we will follow-up with you

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Where to get additional information…

ACOG
The American College of Obstetricians and Gynecologists

ADAA
Anxiety & Depression Association of America
Triumphing Through Science, Treatment, and Education

https://adaa.org/find-help-for/women/perinatalmoodisorders

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About the presenters….

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