



Welcome to
Perinatal Mood & Anxiety Disorders 101

THE TRAINING WILL BEGIN SHORTLY! WHILE YOU'RE WAITING...


Icebreaker Question
(answer in the chat)
What's something you want to get better at?

Survey & Certificate of Completion
Available following the training.

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Hi, We're CalTrin!

Who we are

- The California Training Institute
- Funded by the State of California, Dept. of Social Services, Office of Child Abuse Prevention (OCAP) to support child abuse prevention through professional development and extended learning opportunities.
- Designed for staff of family strengthening and child abuse prevention organizations in California, including Family Resource Centers, Child Abuse Prevention Councils, community-based organizations, and other child and family serving systems.

What we offer

- Live webinars & small group training
- Virtual, self-paced courses
- Job aids & other resources

This training was made possible with funding from the California Department of Social Services, Office of Child Abuse Prevention. Any opinions, findings, conclusions, and/or recommendations expressed are those of the CEBC, CalTrin and do not necessarily reflect the views of the California Department of Social Services.

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UPCOMING TRAININGS
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-  **May 6:** Part 1 – Essential Employee Conversations
May 9: Part 2 – Difficult Conversations
-  **May 28:** Debriefing and Mutual Support
-  **May 14:** Effectively Welcoming LGBTQIA+ Youth Into Our Work
-  **June 5 & 6:** The Growing Brain
-  **May 15:** Social & Emotional Competence of Children

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Before We Begin...

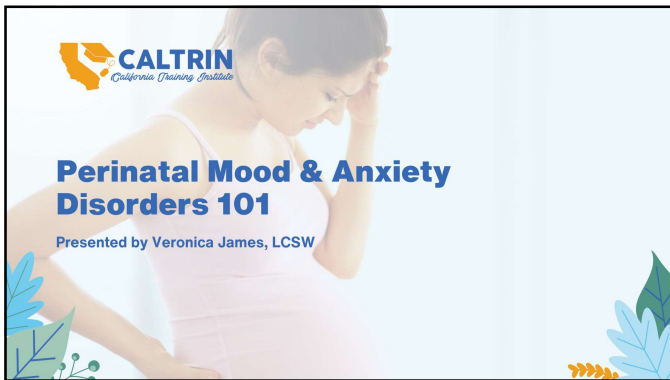
<p style="text-align: center;">DURING</p> <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;">  <p>Access the slides now! The link can be found in the chat. The slides will not be shared after today's training.</p> </div> <div style="text-align: center;">  <p>Review interactive features for today's session. Locate the controls on the toolbar at the bottom of your screen.</p> </div> </div> <div style="display: flex; justify-content: space-around; margin-top: 20px;"> <div style="text-align: center;">  <p>This presentation is being recorded for administrative purposes only.</p> </div> <div style="text-align: center;">  <p>External AI assistants are not allowed in CalTrin trainings due to California privacy laws.</p> </div> </div>	<p style="text-align: center;">AFTER</p> <div style="text-align: center; margin-bottom: 20px;">  <p>Complete the survey at the end of this webinar to receive your Certificate of Attendance.</p> </div> <div style="text-align: center;">  <p>A follow-up email will be sent to all participants within two days.</p> </div>
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Perinatal Mood & Anxiety Disorders 101


Presented by Veronica James, LCSW



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Speaker SPOTLIGHT




- Worked at Sharp Mary Birch Hospital for Women and Infants for 26 years as a clinical social worker in the Clinical Counseling Dept.
- She supports families dealing with various challenges, including high-risk pregnancies, babies in the intensive care unit (NICU), birth trauma, adoption, loss, substance use, and mental health issues like PMADs.
- Veronica also runs support groups for postpartum women and NICU parents.


Veronica James, LCSW

Sharp Mary Birch Hospital
Clinical Social Worker

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Perinatal Mood and Anxiety Disorders 101

The Postpartum Health Alliance is a non-profit 501(c)3 and has no personal or financial interests to declare. The Postpartum Health Alliance has no financial support from any industry source for this presentation

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Today's Trainer Information




Veronica James, LCSW
she, her(s)

Veronica is a Licensed Clinical Social Worker at Sharp Mary Birch Hospital for Women and Infants specializing in the pregnancy and postpartum period, birth trauma, pregnancy loss and infertility, NICU and high risk pregnancies. She has served on the board of the Postpartum Health Alliance and enjoys speaking regularly on Perinatal Mental Health.

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Vocab and Disclaimer

- Perinatal- Refers to the timeframe associated with the pregnancy and postpartum period.
- Postpartum- Refers to the first 12-24 months following the birth of a child.
- PMADs - **P**erinatal **M**ood and **A**nxiety **D**isorders

Disclaimer:
As most of the currently available research is gendered, we will use gendered language to maintain the accuracy of those citations when referenced and provide clarifications throughout.



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TAKE CARE OF YOURSELF


Trigger warning - given the high incidence of PMADs, there is a strong likelihood that one of you or someone you know experienced a PMAD and the nature of this material can sometimes be triggering.

Please take care of yourself during this training and if you need to, please take breaks.

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Learning Objectives

- Explain the difference between PMADs symptoms vs. "typical" perinatal distress
- Discuss PMADs' risk factors and other cultural considerations
- Assess and identify concerning levels of perinatal distress (aka potential PMADs)
- Recall a local and national resource that provides personalized perinatal referrals.

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Your role: "Planting the Seed"

Provide a Safe Environment
Assess for PMADs
Educate on PMADs
Provide Resources

Unless you've received specialized training and it is within your scope of practice, you are **NOT** responsible for treating or addressing PMADs.

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Agenda


- 1.The negative impact of untreated PMADs
- 2.The History and Prevalence of PMADs
3. Identifying the "Baby Blues" and various other PMADs
- 4.PMADs Risk Factors
- 5.Cultural Competency and PMADs
- 6.Assessing Perinatal Distress
- 7.Screening Recommendations and Tools
- 8.Empathetic Communication and Support
- 9.San Diego Resources

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WHY SHOULD YOU CARE?

The Negative Impact of Untreated PMADs



I can't stand the way I feel. I just want to sleep and never wake up. My baby is screaming in pain. I can't do this for the whole day. You just have to live to find my suffering and find it the things things.

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Created by Steve Klemmer and Emily Rodriguez for The Postpartum Health Center

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PMADs are a Public Health Crisis

Left undiagnosed or untreated PMADs can have a long lasting and detrimental impact on:

The Parent	The Child	The Family	Society
Life Satisfaction Daily Functioning Self Care Parenting	Physical Health Mental Health Life Trajectory Life Satisfaction	Relationship Satisfaction Stress Levels Safety	Productivity Losses Healthcare Expenditures Annual Economic Cost: \$14 billion USD, with an average cost of \$31,800 per mother-child pair

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Research shows that the optimum development of an infant's social and emotional health hinges on the responses of and relationships with their caregivers. (Bornstein, 2012)

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PMADs Impact on Parenting

Untreated PMADs effect the amount of engagement the parent has with the baby

- 27%** Will see a decrease in **BREASTFEEDING** or length of breastfeeding
- 39%** Will see a decrease in the amount of **ROUTINES** established or started
- 19%** Will see a decrease in the amount of **READING** to and with baby
- 26%** Will see a decrease in the amount of **TALKING** and engagement with baby
- 30%** Will see a decrease in the amount of **PLAY** with baby

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The Impact of PMADs on Children

Embryo	Newborn	Child	Adult
IUGR	Premature labor	Obesity	Metabolic syndrome
Pre- eclampsia	Low birth weight	Affective Disorder	Type 2 diabetes
Gestational diabetes	Increased activation of fight or flight response	Difficulties learning	Hypertension
Increased exposure to stress hormones	Insecure attachment	Low impulse control	Mental illness
		Poor social skills	Relational problems
		Teen substance use	Job instability
		Increased risk-taking	Substance abuse
		Self-harm	Addiction
			Self-harm

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HOW COMMON ARE THEY?

The History and Prevalence of PMADs

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Created by Nora Kline and Billy McElroy for The Postpartum Stress Center postpartumstress.com

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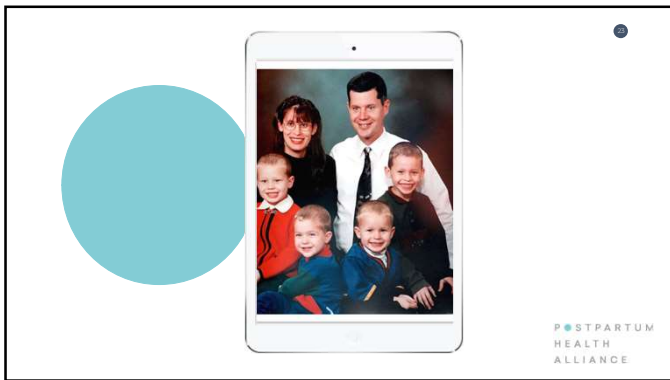
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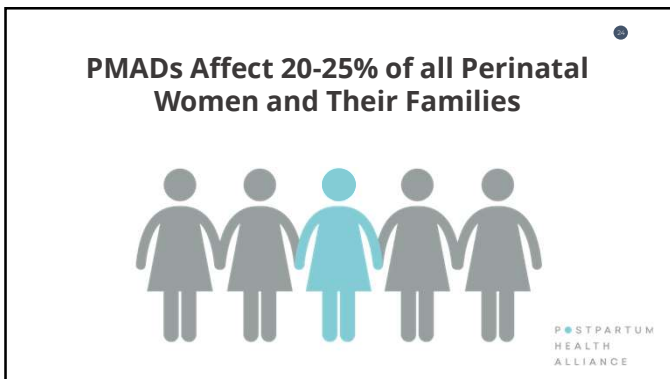
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PMADs can appear in pregnancy and up to two years postpartum

60% of women/birthing-individuals with PMADs go undetected and undiagnosed

75% never receive treatment

PMADs are common but NOT NORMAL and often needs support from professionals

Most common complication following childbirth, yet:

- Under-recognized
- Undiagnosed
- Untreated (although HIGHLY TREATABLE)
- Stigmatized

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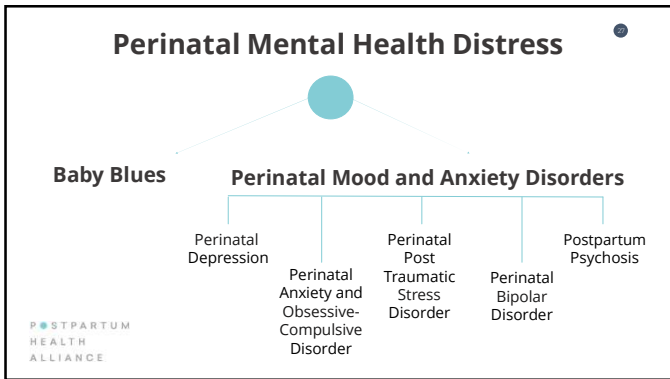
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WHAT ARE THEY?

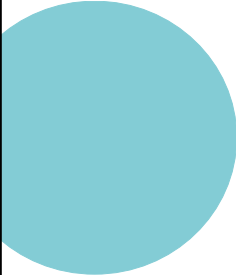
Identifying the Baby Blues and Various Other PMADs

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Baby Blues

- Experienced by up to 80% of birthing individuals
- Hormones drop 4-5 days postpartum
- Acute Sleep Deprivation or Fatigue
- Does not affect functioning
- Usually resolves around 2-3 weeks postpartum
- Predominant mood is happiness

Common Symptoms May Include:

- Mood instability or reactivity
- Crying or tearfulness
- Feeling uncertain or irritable

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Perinatal Depression

- 1 in 7 women (~15- 21%)
- 1 in 10 men (~11%)

For half of women diagnosed with PPD, this is their first episode of depression

50-75% relapse after discontinuing medication when pregnant

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Perinatal Depression


Common Symptoms May Include:

- Depressed or sad mood
- Numb or void of emotion
- Loss of interest in usual activities
- Feelings of worthlessness/incompetence
- Irritability
- Sleep disturbance
- Change in appetite
- Poor concentration
- Suicidal thoughts
- Unexplained physical complaints
- Sense of Hopeless or helplessness
- Guilt and Shame

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Perinatal Anxiety

Prevalence for prenatal anxiety: 13-21%
Prevalence for postpartum anxiety: 11-20%

Common Symptoms May Include:

- SSD/IAD Somatic Symptoms Disorder/Illness Anxiety Disorder (formerly Hypochondriasis) excessive worry about own health or baby's
- Constant worrying about baby, avoidance of activities
- Panic attacks
- Trouble sleeping
- Agitated, Irritable
- Inability to sit still
- Racing thoughts
- Heart palpitations, shortness of breath

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Perinatal Obsessive-Compulsive Disorder

Perinatal women are 1.5-2x more likely than general population to develop OCD
Prevalence for postpartum: 5-11%

Common Symptoms May Include:

- Intrusive, repetitive thoughts; such as, harm coming to the baby (Very low risk of harming baby)
- Guilt and shame as a result of these thoughts
- Hypervigilance
- Compulsive acts to avoid harm or minimize triggers
- Compulsions may include mental rituals, avoidance, and excessive reassurance seeking

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Perinatal Post Traumatic Stress Disorder

9% of birthing parents are affected however... Birth can be a trigger for past trauma and/or traumatic in itself.
25 - 34% experience subsyndromal symptoms Traumatic event can also be birth-related, i.e. breastfeeding, NICU, interactions with staff, etc.
Up to 34% report a traumatic birth

Common Symptoms May Include:

- Flashbacks
- Distressing thoughts or feelings about events
- Recurrent dreams or nightmares
- Avoidance of triggers
- Persistent and distorted sense of blame
- Numbing
- Hyperarousal/Hypervigilance
- Heart palpitations, shortness of breath

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Perinatal Bipolar I Disorder

71% of women diagnosed with bipolar disorder will experience a reoccurrence during pregnancy.

Women who go off medication during pregnancy are 2x the risk of reoccurrence & 4x more rapidly than those who remain on medication.

50% diagnosed for the first time during the postpartum period and 60% are often misdiagnosed with depression

Bipolar Disorder is a chronic disorder with high rates of relapse, suicide and psychological dysfunction.




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Perinatal Bipolar I Disorder

Common Symptoms May Include:

Highs	Lows
<ul style="list-style-type: none"> • Decreased need for sleep • Increased productivity • Racing thoughts • Trouble concentrating • Increased energy • Elevated mood • Pressured speech • Irritability • Impulsive and reckless • Grandiose thoughts • Delusions/hallucinations 	<ul style="list-style-type: none"> • Sadness/crying/depression • Changes in sleep and appetite • Trouble concentrating • Anger, worry, agitation • Pessimism • Irritability • loss of energy • Feelings of guilt and worthlessness • Thoughts of death and suicide



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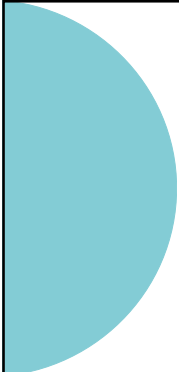
Perinatal Bipolar Disorder II

Often misdiagnosed as depression

Risk of cycling into mania if prescribed an antidepressant rather than mood stabilizer

Milder bipolar: highs are not so high - If you don't look for it, you won't find it

Moody / mood swings



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Perinatal Psychosis

Rare – 1 or 2 in 1,000 women
 Sudden onset, as early as a few days after birth
 Risk of infanticide (4.5%) and suicide (5%)
Should be treated as an emergency


Common Symptoms May Include:

- Rapidly changing moods (manic-depression)
- Delusional beliefs
- Visual or auditory hallucinations
- Insomnia
- Disorganized behavior
- Thoughts about harming baby that aren't identified as irrational
- Waxing and waning (presents normal for stretches of time in-between psychotic symptoms).

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WHAT IS AN EMERGENCY?



Signs of postpartum psychosis

Any thoughts involving a plan of suicide

Any urges to harm baby or another person

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WHY DO THEY HAPPEN? PMADs Risk Factors



Thank you!
 Congratulations on your new baby!
 Your life is now complete! Look what you have!
 How sweet of you to say.

Look at all I have? What about what I've lost? I've lost all connection to my former self, my career, my baby time with friends, alone time with my husband, any sense of who I am, my spontaneity, intimacy, and financial security. I have no privacy, no confidence, no freedom to leave and go, I have no idea what I'm doing, no time to do anything I used to do. I'm trying to be grateful, but I miss ME and the life I had before.

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Cultural Diversity

There are four levels to culture diversity that influences all aspects of our conscious and unconscious activities.

It's important to understand how your culture influences you and to educate yourself in the cultures of the individuals you serve.

Be mindful not to generalize

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Limitation within the Perinatal Field

Most of the research on PMADs has been conducted on heterosexual, childbearing, cisgender women.

Minority populations are underrepresented in imagery and reference. (Dominate imagery of white heterosexual families; use of mama vs. birthing parent and father vs. partner)

Disparities impacting perinatal care: Treatment cost, loss of pay from work, transportation issues, childcare, provider and consumer ignorance, stigma (mental health and medication)

Provider bias and systemic racism within the medical and mental health field resulting in inequality of care.

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PMADs and Men

While limited, existing research is centered on cisgender, heterosexual men.

1 in 10 men experience PPD, with the highest rates being around 3-6 months and the lowest being the first 3 months.

Maternal depression doubles a man's chances of developing depression.

Common symptoms in men are irritability, self-isolation, overworking, increased substance use, aggression, "checking out", distracting, and hopelessness.

Unique Vulnerabilities or Risk Factors:

- Feeling left out (partner receives attention and support)
- Missing sexual connection/relationship
- Isolation and loneliness (sense of losing partner and best friend)
- Feeling burdened or trapped
- Financial responsibility

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PMADs & Transgender Individuals

In general, transgender people report higher rates for anxiety and depression (30-50%) and suicide (40%) = PMADs risk factors

Stressors in the medical and mental health system, in addition to gender assumptions and bias in postpartum may contribute to gender dysphoria.

Introduce yourself and your pronouns and ask how they want to be addressed.

Unique Vulnerabilities or Risk Factors:

- Perinatal language, "maternal" "maternity," focus on womanhood and femininity
- Negative experiences with providers when identities are disrespected
- The microaggressions in misnaming and misgendering people
- Issues with documents and insurance coverage (Birth certificate = mother/father)
- A frequent sense or experience of being unseen and unvalidated

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PMADs and LGBTQ+

While limited, there is research to suggest that LGBTQ+ parents may experience higher levels of perinatal anxiety and depression than other population groups.

Bisexual women may be more likely to experience PPD than heterosexual or lesbian women.

Unique Vulnerabilities or Risk Factors:

- Cultural biases around same sex parenting.
- Concerns about being judged further if they seek mental health support.
- Lack of professional, knowledgeable, and non-judgement care
- Having their roles, method of conception, or ability to parent questioned
- Friendship groups may not include many parents
- Lack of family support or re-triggering FOO issues
- Barriers to access or difficulties and the stress of IVF, surrogacy, donors or co-parenting arrangements
- Lack of access to support services and help for non-biological parent

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PMADs and BIPOC

Research on racial and ethnic groups in perinatal mental health (and mental health in general) is lacking, and the majority of what exist focuses on postpartum depression.

Studies have shown that women of color experience postpartum depression at a rate of close to 38% (vs. ~19% for white women)

Efforts to dismantle the stigma and shame associated with mental health is important; professional mental health care must be promoted and supported.

Racial disparities in perinatal care and treatment:

- Prejudice and discrimination in the health care system
- Misdiagnosis, inadequate treatment and mistrust of mental health professionals.
- Workplace Disparities: Gender wage gap (.63-.54 to every \$1) hourly/shift work, lack of sick days/paid family leave/ flexible schedules
- Socioeconomic exclusion from health, educational, social and economic resources.

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PMADs and Black Women

3-4x more likely to die in childbirth than white peers

Half as likely to receive mental health treatment as white peers

Black mothers are the primary or sole head of the household and single black mothers are 6x more likely to develop PPD

Studies show that black women often overlook symptoms of depression and other mental health issues and may be more likely to identify and describe physical symptoms related to mental health problems.

Unique Vulnerabilities or Risk Factors:

- Racism, discrimination and inequity as a stressor or trauma
- "Strong Black Woman": Pervasive stigma around mental health in the black community.



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PMADs and Hispanic/Latinx Women

Estimated to be 2-3x more likely to develop PPD (~37%)

More likely to trust a clergy person, a trusted elder figure in the community, another peer, or a social worker versus a psychologist or psychiatrist

Despite being translated in several different languages, the Edinburgh Postnatal Depression Scale (EPDS) has been criticized as not being sufficiently comprehensive (some symptoms mimicking depression could be misdiagnosed and actually fulfill the criteria for anxiety).

Unique Vulnerabilities or Risk Factors:

- Low-socio economic status and it's related stress
- "Marianismo"- pressure to be a perfect mother, like the Virgin Mary
- Cultural preference to keep personal or family information private
- Language Barriers
- Immigration or legal status



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Special Consideration: Breastfeeding

Parents should make an informed decision about breastfeeding. It is their personal decision to make.

Support looks like balancing information, encouragement and resources to breastfeed, while letting parents know they have the right to choose not to breastfeed without guilt or judgement.


Breastfeeding can both buffer and exacerbate PMADs

PMADs, breastfeeding and medication considerations

PMADs can worsen when weaning. To help, encourage weaning slowly over 2-3 weeks period.



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 **Special Consideration: Infertility and Loss**


Loss associated with childbearing: Miscarriage, Stillborn, Infertility, Elective Abortion, Termination for Medical Reasons, Adoption

Unique Vulnerabilities or risk factors:

- Success after long periods of trying
- Idealized expectations
- Subsequent Pregnancies
- High risk pregnancies/ multiples
- Strained sexual relationship
- Unresolved trauma or grief
- Heighten anxiety surrounding prenatal appointments, infant's health & safety, and anniversary of previous loss.
- Trouble attaching to baby

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 **Special Consideration: Adoptive Parents**


Post Adoption Depression Syndrome (PADS)

Unique Vulnerabilities or risk factors:

- Years of waiting and heartache
- Pre-adoptive expectations
- Lack of hormonal response
- Child's attachment issues
- Family transition
- Added financial stress
- Unknown
- Unresolved grief
- Lack of support or understanding
- Tendency to "suffer in silence"

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 **Special Consideration: NICU Parents**

NICU moms: 39% had PPD, 43% reported moderate to severe anxiety, 33% reported suicidal ideations, and 15% were diagnosed with PTSD.

NICU dads: Reported being angrier and more freighted, but less reactive. 30% of dads screened positive for depression.


Both babies and their parents may experience a stay in the NICU as a traumatic or 'toxic stress'

Unique Vulnerabilities or Risk Factors:

- Potential traumatic labor or birth
- High risk/anxiety pregnancy
- Sense of having a "fragile" infant at home
- Assumption that everything is ok once home.
- Isolation due to infant's risk of illness

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 **Special Consideration: Multiples**

Parents of multiples experience heightened symptoms of depression, anxiety, and parenting stress.


Women who gave birth to more than 1 infant had 43% greater risk of developing PPD.

Unique Vulnerabilities or Risk Factors:

- High risk pregnancy
- Stress of caring for more than one baby
- Delivery complications
- Financial problems
- Marital stress
- NICU stay or ill infant(s)

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 **Special Consideration: Adolescent Parents**

Almost half of teen moms experience depressive symptoms in the early postpartum period. 36.7% at three months postpartum.


Almost 90% of those who reported depressive symptoms at 4 years postpartum had experienced these symptoms at 12 months postpartum.

Unique Vulnerabilities or Risk Factors:

- Childhood trauma
- Stigma and perception of being judged
- Decreased quality of life
- Interference with normal developmental tasks
- Stressed parent relationship
- Disruption of school or work plans
- Solo parenting
- Barriers to support

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 **Special Consideration: Military Families**

Pregnant Veterans are 2x as likely to experience PMADs and 42% more likely to experience suicidal thoughts than non-vets with PPD

66% of military spouses "worried that looking for assistance for their own issues would harm their loved ones' chance of promotion."

Unique Vulnerabilities or Risk:

- Stressors: deployment, emotionally/physically unavailable partner, fear of welfare for self or partner, single parenting, childcare
- Inadequate support: Separated from family/friends, recent or frequent relocation(s), lack of providers who understand military culture/for beneficiaries/who accept insurance
- Military Mentality: "small town feel," lack of peer support due "Amy Strong" mentality, Focus on active-duty member's psychological issues

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Cultural Sensitivity looks like:

- Adopt a "one-down" position in which you are the learner and your client or loved one is the expert
- Respect perspectives and values without biases
- Ask about what they would like in a provider, including the importance of race/ethnicity.
- Interpret screenings cautiously
- Recognize the impact of discrimination and racism
- Be mindful not to generalize individuals or their families based on culture, race, or ethnicity

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HOW DO YOU KNOW?

Assessing Perinatal Distress



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ASK

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Duration

Intensity

Frequency

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**Blues Vs. PMADs
(Duration of Symptoms)**

Blues { Two to three weeks postpartum

PMADs { Lasting more than two weeks

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**Blues Vs. PMADs
(Intensity of Symptoms)**

Blues { Are they able to fall asleep and care for themselves?

PMADs { Are racing thoughts keeping them awake? They are isolating? Do they still feel tired after getting sleep?

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Blues Vs. PMADs (Frequency of Symptoms)

Blues	{	How often are they crying? Are they experiencing joy in between?
PMADs	{	Are the symptoms often enough they are interfering with their ability to meet basic needs? (Racing thoughts, constant worry, weepiness, obsessions over baby's temp, cleanliness of the house etc.)

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Blues Vs. PMADs (Suicidal Ideation)

PMADs	{	Suicidal thoughts are NEVER normal, not a part of baby blues
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Crisis Response: Your Role

1. Ask (see suicide risk assessment handout)
 - If possible, build rapport before assessing
 - Be direct and specific
 - Listen and support- Don't try to fix or challenge thoughts
2. Help identify support team (family, friends, professionals)
 - Notify others
 - Don't promise to keep a secret or leave parent alone
3. Ensure parent is safe
 - Encourage parent to go to ER
 - If needed, be prepared to Call 911 yourself

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WHEN SHOULD YOU ASSESS?

Screening Tools and Recommendations

Created by Karen Klineken & Mally Mackay for The Postpartum Stress Center (Families), March 1, 2019

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EPDS (Edinburgh Postnatal Depression Scale)

PASS (Perinatal Anxiety Screening Scale)

MDQ (Mood Disorder Questionnaire)

Mood Disorder Questionnaire

Please answer each question to the best of your ability.

1. Has there ever been a period of time when you were not your usual self and...

	YES	NO
you felt so sad or so upset that other people thought you were not your normal self or you were so happy that you got into trouble?	<input type="checkbox"/>	<input type="checkbox"/>
you were so irritable that you shouted at people or started fights or arguments?	<input type="checkbox"/>	<input type="checkbox"/>
you felt much more uncomfortable than usual?	<input type="checkbox"/>	<input type="checkbox"/>
you got much less sleep than usual and found that you didn't really enjoy it?	<input type="checkbox"/>	<input type="checkbox"/>
you were very irritable or spoke much faster than usual?	<input type="checkbox"/>	<input type="checkbox"/>
thoughts came through your head or you couldn't think your mind down?	<input type="checkbox"/>	<input type="checkbox"/>
you were so easily disturbed by things around you that you had trouble concentrating or thinking clearly?	<input type="checkbox"/>	<input type="checkbox"/>
you had more energy than usual?	<input type="checkbox"/>	<input type="checkbox"/>
you were much more active or did many more things than usual?	<input type="checkbox"/>	<input type="checkbox"/>
you were much more careful or judging than usual, for example, you thought friends in the middle of the night?	<input type="checkbox"/>	<input type="checkbox"/>
you were much more interested in sex than usual?	<input type="checkbox"/>	<input type="checkbox"/>
you did things that were unusual for you or that other people might have thought were excessive, foolish, or silly?	<input type="checkbox"/>	<input type="checkbox"/>
something someone said to you or your family in trouble?	<input type="checkbox"/>	<input type="checkbox"/>

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? YES NO

3. How much of a problem did any of these cause you (this being unable to work, being lonely, misery or legal trouble, getting into arguments or fights)?

no problem minor problem moderate problem serious problem

This document is designed for screening purposes only and is not to be used as a diagnostic tool. Approved for general use with permission.

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When to Screen?

The American College of Obstetricians and Gynecologists (ACOG), The American College of Nurse Midwives, U.S. Preventive Services Task Force, and the American Academy of Pediatrics (AAP) recommend routinely screening pregnant and postpartum women for Perinatal Depression.

In 2013, the National Perinatal Association (NPA) recommended that fathers be screened for postpartum depression at least twice during the first year postpartum. In 2018 NPA's statement specified that fathers should be screened between 3-6 months postpartum.

While these specific recommendations refer to screening mothers and fathers, it's important that all birthing and non-birthing parents are screened. Adoptive parents included.

Please Note: Screening is not diagnosing. Results indicating the possibility of a PMAD should be confirmed by a qualified healthcare professional.

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Screening Considerations

NPA recommends a lower EPDS cutoff score of 2-3 points be considered for Black and Latina women. Ideally, this adjustment will improve the identification of perinatal distress and increase the likelihood of support and treatment

Given that research has demonstrated that the EPDS as useful in the detection of PMADs for adolescents, NPA recommends screening for perinatal mood and anxiety disorders should be inclusive of adolescent mothers

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Who Should Screen?

Perinatal specialists (e.g. Obstetricians, Pediatricians, Neonatologists, Nurses, Occupational Therapists, Physical Therapists, Psychologists, Social Workers, Speech Language Pathologists, Doulas, Lactation Consultants, etc.) who contribute to maternal-infant care.

Anyone. Self-assessment is encouraged as well.

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WHAT CAN YOU DO?

Empathetic Communication and Support



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Prevention and Early Intervention



Ask! **Identify Risk Factors** **Screen**

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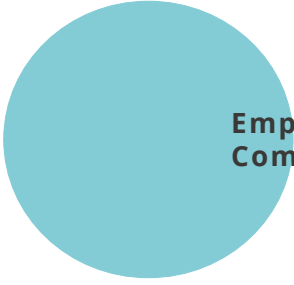
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<p>Ask and Screen</p> <p>Edinburgh PPD Scale and PASS</p> <p>Follow up screen with clinical assessment or referral</p> <p>Be comfortable and at ease when screening</p>	<p>Educate</p> <p>Normalize the issue NOT the symptoms</p> <p>Give her stats. Remove the blame</p>	<p>Provide Resources</p> <p>Postpartum Health Alliance</p> <p>Postpartum Support International</p> <p>Adjunct support (i.e. ILBC, doula, support group?)</p>	<p>Treatment</p> <p>Psychotherapy</p> <p>Medication</p> <p>Homeopathic treatment</p> <p>Support groups</p>
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Empathetic Communication

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Empathic Communication

- Non-verbal Communication
- +
- Verbal Communication
- +
- Reflective Listening
- +
- Prenatal Education
- +
- Provide Resources



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Case Study Practice

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WHO CAN HELP?

Perinatal Resources



Created by Karen Korman & Mely Molyneux for The Postpartum Stress Center (Florida), March 1, 2018

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You know...

1 in 5 or 20-25% experience PMADs

Most PMADs are underdiagnosed or untreated

PMADs impair function, negatively impact the family and threaten bonding and development of the child

PMADs can happen to anyone. There are many risk factors.

Treatment and support helps!!!

So, what support is available?

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Postpartum Health Alliance

*The mission of Postpartum Health Alliance is to increase the capacity of San Diego's perinatal health service community to **recognize, understand and respond effectively** to the mental health of pregnant and postpartum mothers, fathers and their families.*

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We're here to help.

What we do...

PROFESSIONAL MEMBERSHIP INCREASE AWARENESS EDUCATE PROVIDERS PROVIDE RESOURCES HOST A "WARMLINE"

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619.254.0023 Hablamos Español

ABOUT PHA SUPPORT RESOURCES TRAININGS GET INVOLVED MEMBERS ONLY

PHA'S MISSION FIND A PROVIDER COMMUNITY GROUPS

We provide mental health awareness, education, and referrals to San Diego parents and providers.

Despite being the most common complication of childbirth, Perinatal Mood and Anxiety Disorders (PMADs) continue to be under-recognized, undiagnosed, untreated (although highly treatable), and stigmatized.

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Our Warmline System

- 1 Call or Email**
Available to leave a confidential message 7 days a week, 24 hours a day.
- 2 Get Support**
A trained PHA volunteer will contact you within 48 hrs and offer:
 - Non-judgmental listening
 - Normalization
 - Encouragement & hope
- 3 Receive Referrals**
A trained PHA volunteer will contact you within 48 hrs and offer:
 - Psychiatrist
 - Therapist
 - Community Resources

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National Resource

Postpartum Support International (PSI)

- National Helpline that'll connect you to your local resource
- National Provider Directory
- National, free online support groups

Go to: www.postpartum.net to learn more.

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Crisis Response Resources


Remember, you are not alone. Crisis response hotlines and trained professionals are here to help. Use them.

San Diego Access & Crisis Line
1-888-724-7240; TTY: 619-641-6992


The Psychiatric Emergency Response Team (PERT)
(Pairs licensed mental health clinicians with uniformed law enforcement officers/deputies and provides emergency assessment and referral.)
Call 9-1-1 or your local law enforcement agency, and request a PERT Unit

National Suicide Prevention Lifeline
1-800-273-TALK(8255); Spanish/Español: 1-888-628-9454

Always provide crisis resources to EVERY parent




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Training Resources

Advanced Training in Perinatal Mental Health


- Postpartum Support International (PSI)
 - 2-Day Component of Care Training
 - 1-Day Advanced Psychotherapy Training
- PSI/2020 Mom
 - Online Maternal Mental Health Certificate Course
- Maternal Mental Health Now
 - Online Introduction and Advance Certificate Training



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Become a PHA Member


Perfect for clinical provider (Psychiatrists, psychologists, LMFTs, LCSWs, LPCs, etc.) and allied perinatal wellness provider (Midwives, nurses, MDs, doulas, birth or parent educations, lactation or sleep consultants, etc.)

BENEFITS INCLUDE:

- Entry in our [online provider directory](#)
- Priority listing in our warmline directory
- Free attendance at our educational workshops. 3-4 held yearly.
 - BONUS GIFT: FREE CEUs when applicable!
- Free attendance at our annual networking-social.
- On-going peer-support- Exchange resources, referrals, and clinical consultation through our active, members-only listserv.
- A digital PHA member badge to publicly showcase your affiliation and commitment to supporting local, new moms and families.
- Establish yourself as a local expert- Write about perinatal wellness topics for our blog!



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Volunteer for our Warmline


If you aren't a perinatal professional but you have a passion for Maternal Mental Health and want to help us make a meaningful difference, please consider becoming a trained Peer Support Specialist!

BENEFITS INCLUDE:

- Volunteer remotely and around your own schedule
- Gain training and experience in providing peer support and Parental Mental Health
- Make a difference - Be the first point for contact and a voice of support for a local parent in need.




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Donate Today

Want to support us but can't spare any of your time or talents? We get that. Please consider donating to our organization! Due to the small size of our organization, every dollar ensures PHA can continue to be an easy, free and trusted San Diego resource.



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THANK YOU

Thank you to past and current PHA Board members
Gretchen Mallios, LCSW, Bethany Warren, LCSW, PMH-C., Rachel Rabinor, LCSW,
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their time and insight to help ensure this training is in line with PHA's diversity and inclusion
standards.



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PMADs Training 101 Evaluation

We welcome your feedback as it is important for the assessment and
planning of future trainings. If you have a smartphone, you can easily
download a QR scanner, like QR&OCR Reader, to complete the evaluation.



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Thanks for joining us!

WHAT'S NEXT?

- Survey and certificate in the chat now
- Follow-up email with resources within two days
- Watch your inbox for the next issue of *CalTrin Connect*



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VISIT CALTRIN.ORG &
SCAN TO LEARN MORE



FOLLOW US! AND CHECK OUT
TRAINING REPLAYS ON YOUTUBE!



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