TTAC

NYC Early Childhood Mental Health

Training and Technical Assistance Center

Perinatal Mental Health and Psychiatric Supports

Presented by
Damali M. Wilson, PhD, APRN
Dilice Robertson, DNP, PMHCNS-BC, PMHNP-BC
Elizabeth Murphy Fitelson, MD

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Who We Are

The New York City Early Childhood Mental Health Training and Technical Assistance Center (TTAC), is funded by the NYC Department of Health and Mental Hygiene (DOHMH).

TTAC is a partnership between the New York Center for Child Development (NYCCD) and the McSilver Institute for Poverty Policy and Research

- **New York Center for Child Development** has been a major provider of early childhood mental health services in New York with expertise in informing policy and supporting the field of Early Childhood Mental Health through training and direct practice
- **NYU McSilver Institute for Poverty Policy and Research** houses the Community and Managed Care Technical Assistance Centers (CTAC & MCTAC), Peer TAC, and the Center for Workforce Excellence (CWE). These TA centers offer clinic, business, and system transformation supports statewide to all behavioral healthcare providers across NYS.

TTAC is tasked with building capacity and competencies of mental health professionals and early childhood professionals in family serving systems to identify and address the social-emotional needs of young children and their families.

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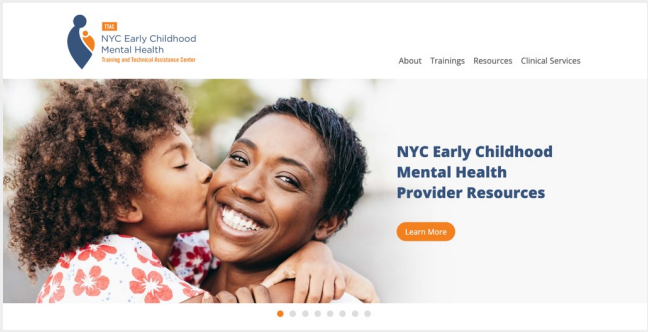
Updated TTAC Website



Explore all the provider resources at ttacny.org

A Selection of Features:

- Seamlessly filter, toggle and search through upcoming and archived content, trainings and resources
- View videos, slides, and presenter information on the same training page
- Contact the TTAC team by clicking on Ask TTAC and filling out our Contact Us form
- And more!

Have questions or need assistance? Please contact us at **ttac.info@nyu.edu** and we'll be happy to assist you

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OVERVIEW & SIGNIFICANCE

- Perinatal period marked by vulnerability for new and recurrent mental health disorders
- Most common complication of pregnancy and childbirth
- Treatable, yet often undiagnosed and untreated
- In NYC, mental health conditions cited as a leading cause of pregnancy-associated death

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TERMS & DEFINITIONS

- PMADs: Perinatal mood and anxiety disorders
- Women/mothers and birthing people: Individuals with the capacity for pregnancy and childbirth
- Pregnancy-associated: Event occurring in pregnancy, childbirth, or postpartum
- Pregnancy- related: Event from pregnancy complications, started by or aggravated by condition
- EPDS: Edinburgh Postnatal Depression Scale
- GAD-7: Generalized Anxiety Disorder Assessment

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Perinatal Mental Health:

Ask, Listen/Observe & Intervene

Dilice Robertson, DNP, PMHNP-BC

Clinical Associate Professor/Program Director

Psychiatric Mental Health Nurse Practitioner Program

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Objectives

Understand the importance of mental health screening and communication strategies for birthing individuals.

Overview:

- Early recognition and intervention can greatly enhance outcomes for parents, infants, families, and the broader community.

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The Case of "Aliya"

- Meet **Aliya**, a 30-year-old birthing individual, pregnant with her first child at 28 weeks.
- She has no significant prior history of mental health issues but reports she's having a rough time.
- She works full time, cares for her aging grandmother, has a supportive partner and often is called on by friends and family as part of their support system.

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Perinatal Mood and Anxiety Disorders (PMAD)

Prevalence:
Studies show up to **1 in 5** birthing individuals experience mental health issues during the perinatal period.

Importance of Early Intervention:
Addressing mental health issues early can improve parent-infant bonding and overall family well-being.

Impact on the infant:

- Preterm birth
- Low birth weight
- Smaller head circumference
- Delayed developmental milestones
- Increased risk of behavioral problems
- Difficulty regulating emotions
- Disrupted sleep patterns

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Key Questions to **Ask**: Screening (Aliya at 28 Weeks)

Key Screening Questions

- "How have you been feeling lately?"
- "Are you experiencing any worries, fears, or concerns about your pregnancy?"
- "Do you feel supported by family and friends?"
- "How have you been coping with managing all your responsibilities?"

Screening Tools: Use standardized tools such as
Edinburgh Postnatal Depression Scale (EPDS)
Generalized Anxiety Disorder-7 (GAD-7).
ACOG screening for mood changes during pregnancy and after giving birth

Validation: Reassure Aliya that many birthing individuals experience anxiety and mood changes during pregnancy. Open a door for further conversation if necessary.

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Use Active **Listen**ing Skills

Create a safe, non-judgmental environment. Build trust by using empathetic listening skills and maintaining confidentiality.

Aliya reports the following symptoms:

- Feeling anxious and overwhelmed about becoming a mother.
- Trouble sleeping
- Feeling restless, and often overthinking.
- Mood swings.

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Pay attention to the signs: **Observe**

Non-verbal signs of distress:

- Tearfulness
- Flat affect
- Changes in grooming and behavior.

Observe for Common Symptoms:

- **Mood swings**
- **Irritability**
- **Sleep disturbances**
- **Difficulty concentrating**
- **Loss of appetite or overeating**
- **Thoughts of self-harm or harming the baby**
- **Anxiety or panic attacks**

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Intervene

- Immediate supportive strategies
- Safety planning if necessary
- Educate about available resources

Plan: Postpartum Care Plan

Communication with Families:

- Offer guidance on baby care, but reinforce that Aliya's emotional health is just as important as Noah's.
- Provide clear instructions on self-care and signs to watch for regarding postpartum depression.
- Validate and encourage Aliya to ask for help from loved ones.

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Ask/Listen/Observe/Intervene: Postpartum Mood and Anxiety (Aliya at 3 Weeks Postpartum)

Aliya's Birth Story: Aliya delivered a healthy baby boy, Noah, but she is still struggling with feelings of exhaustion and overwhelmed with responsibility in the days following birth.

Screening Tools: Use the **Edinburgh Postnatal Depression Scale (EPDS)** again in the postpartum period.

Aliya's New Symptoms:

- Feelings of detachment from Noah.
- Increased anxiety about her ability to care for him.
- Difficulty sleeping and frequent crying spells.

Action:

- **Screening**: Aliya scores higher on the EPDS this time, suggesting moderate postpartum depression.
- **Referral**: Recommend therapy (CBT, DBT) and possibly medication (SSRIs).
- **Offer Support**: Encourage participation in a new parent support group or accessing resources like **Postpartum Support International**.

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Ongoing Care: A Holistic Approach (Aliya at 6-12 Months Postpartum)

Aliya has begun therapy and her anxiety symptoms are improving, but she still experiences moments of sadness and exhaustion.

Continued Monitoring:

- Use regular check-ins, even beyond the immediate postpartum period.

Communication with Family:

- Encourage Aliya's partner and family to share baby care tasks to reduce stress and provide ongoing support.

Resources Connection:

- Provide Aliya with resources to build community support while encouraging regular physical activity and healthy lifestyle practices.

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Key Takeaways

- **Perinatal Mental Health is Critical**: Mental health challenges are common, but treatable with the right care.
- **Effective Communication is Key**: Create an open, supportive environment where parents feel safe to share, knowing their experiences are validated.
- **Screening Tools**: Use validated tools (EPDS, GAD-7) to assess mood and anxiety throughout pregnancy and postpartum.
- **Ongoing Support**: Continuous check-ins during the first year postpartum ensure that mental health needs are being met.

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- Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). *Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale.* The British Journal of Psychiatry, 150(6), 782–786. https://doi.org/10.1192/bjp.150.6.782
- Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). *A brief measure for assessing generalized anxiety disorder: The GAD-7.* Archives of Internal Medicine, 166(10), 1092–1097. https://doi.org/10.1001/archinte.166.10.1092

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Resources

- **American College of Obstetricians and Gynecologists**. (n.d.). *Patient screening*. ACOG. Retrieved February 26, 2025, from https://www.acog.org/programs/perinatal-mental-health/patient-screening
- **Postpartum Support International**: A national organization providing support for parents with perinatal mood disorders.
- **National Maternal Mental Health Hotline**: **833-TLC-MAMA (833-852-6262)**
- **New York State HOPEline.** Funded by the Office of Addiction Services and Supports. **1-877-8-HOPENY(467-369)**. https://oasas.ny.gov/hopeline NY state resources specifically for assistance with substance use and gambling.
- **Postpartum Resource Center of New York.** State-wide Helpline **1-855-631-0001** https://postpartumny.org

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Perinatal Mood and Anxiety Disorders

Elizabeth Fitelson, M.D.

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Disclosures

No relevant disclosures

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Perinatal Mood and Anxiety Disorders (PMADS)

- Is pregnancy a time of emotional wellbeing for women?

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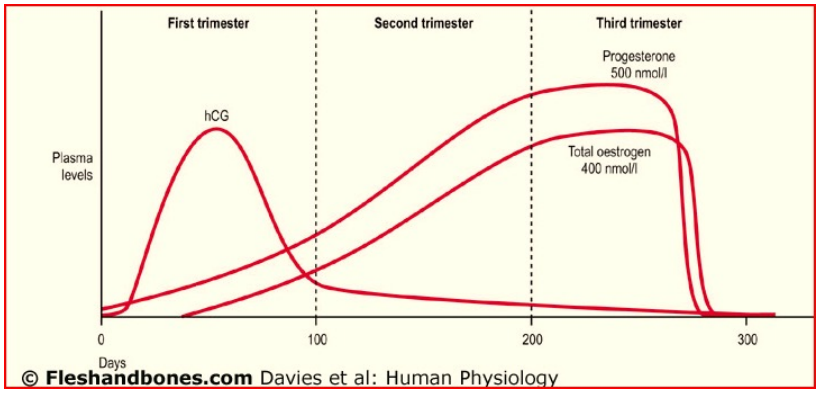
Hormone levels and Pregnancy



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Why is understanding perinatal mental health so important?

- Mental illness is a source of tremendous suffering for our patients, and they deserve the care we can offer regardless of reproductive status
- Maternal and parental wellbeing is critical for children's physical, cognitive and emotional development
- Fetal Origins of Health and Disease (FOHaD)
- Pregnancy and childbearing is a "stress test" of the individual, family, social, and health care systems
- Mental health disorders are a major contributor to adverse maternal morbidity and mortality outcomes… and most of these are preventable

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Infant Attachment

https://www.youtube.com/watch?v=apzXGEbZht0
"Still Face Experiment"

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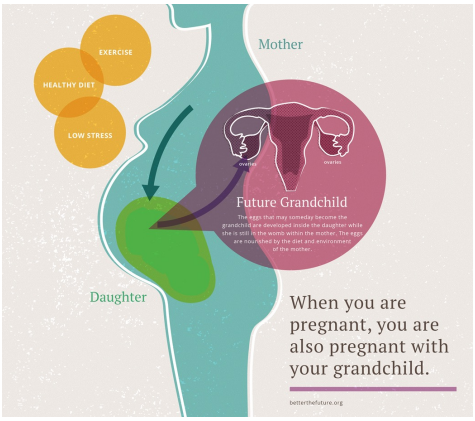
Fetal Origins of Health and Disease



Stress and distress (including that experienced in psychiatric disorders) can have long-lasting impact on the development of the future child

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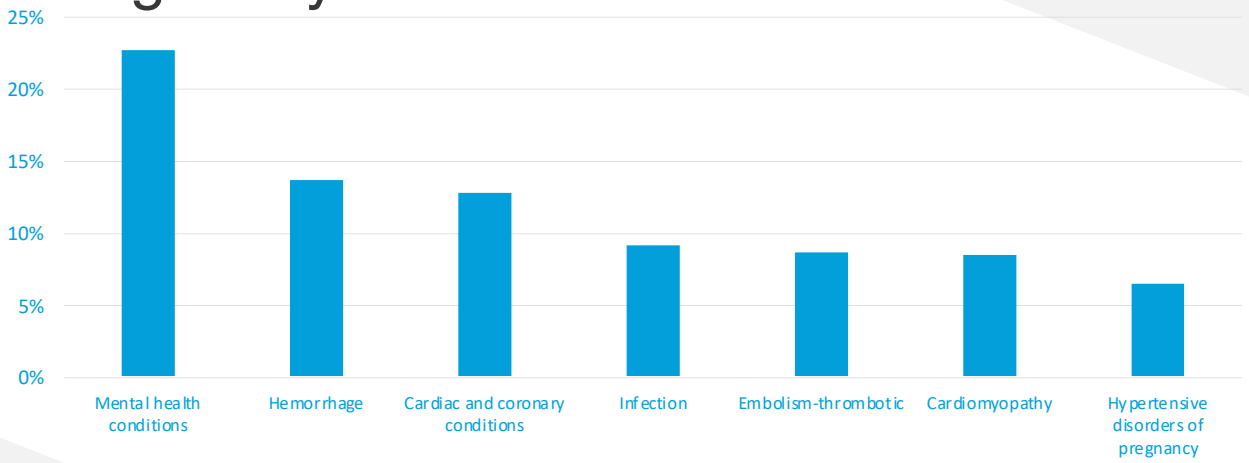
Pregnancy-Related Deaths 2017-2019



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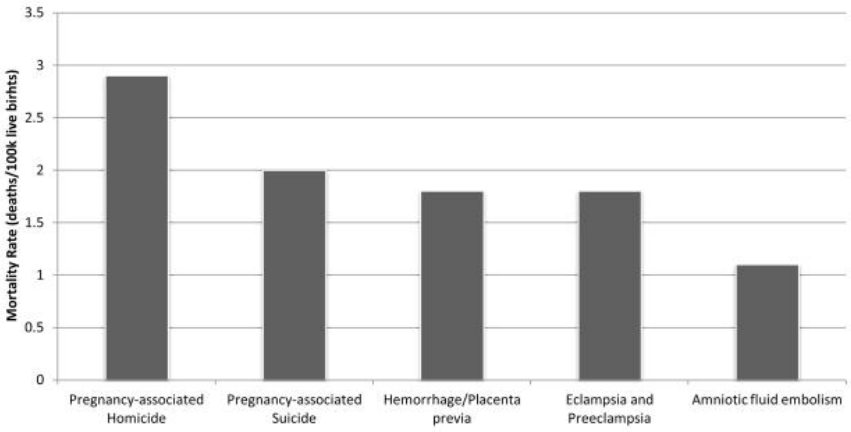
Maternal mortality and suicide, homicide



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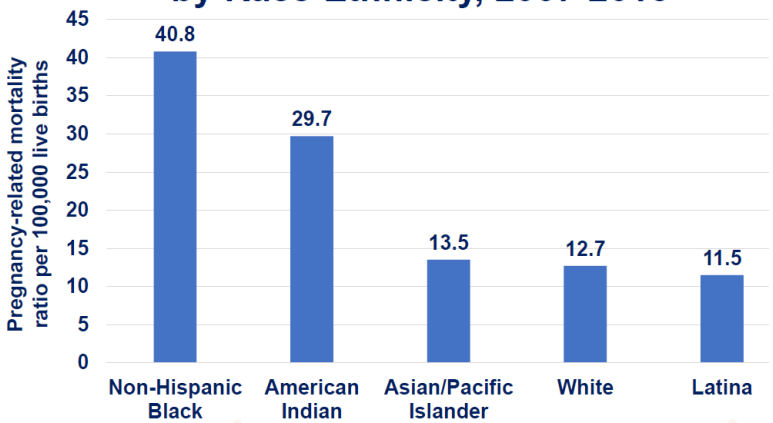
Pregnancy-Related Mortality Ratios by Race-Ethnicity, 2007-2016



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Pregnancy and Mood

- Pregnancy is NOT protective against psychiatric illness
- Rates of Major Depression during pregnancy 10-15% Anxiety disorders may be higher.
- High rate of relapse when antidepressant medications are stopped during pregnancy (~50-70%)
- Pregnant Bipolar women have same risk for relapse off meds as non-pregnant Bipolar women. Post partum risk 4x higher.

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The Postpartum Period

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Postpartum Blues
aka "Baby Blues"

- Occurs in 50-85% of women
- Characterized by mood lability, tearfulness, anxiety and irritability
- Symptoms peak at day 4-5
- May last a few hours to several days
- Symptoms do not interfere with functioning
- Reassurance rather than treatment
- If symptoms persist > 2 weeks, patient should be evaluated for a more serious mood disorder

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Postpartum Psychosis

- Occurs in 1-2 per 1000 live births
- Onset usually 24hrs – 3 weeks postpartum (though can be later)
- Rapid mood swings, insomnia, obsessive thoughts
- Delusions, hallucinations, impaired reality testing. Delusions involving infant are common
- Shifting mental status , disorientation, confusion, disorganized behavior
- High risk of suicide and/or infanticide
- Psychiatric emergency – needs evaluation immediately
- Differential: medical causes of delirium, PPD, SCZ
- >70% appears to be a presentation of bipolar disorder. Bipolar women at very high risk of PPP

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Postpartum Depression

- Estimates of prevalence between 10-15%
- Risk factors:
  - Prior episodes depression or anxiety, including during pregnancy
  - Partner relational problems
  - Undesired pregnancy
  - Infant medical problems
  - Lack of social support
  - Trauma, low SES, financial instability
- Differential: anemia, diabetes, thyroid

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Postpartum Depression

Symptoms:

- Depressed mood
- Tearfulness
- Loss of interest in usual activities
- Feelings of guilt
- feelings of worthlessness or incompetence
- Fatigue
- Sleep disturbance
- Change in appetite
- Poor concentration
- Suicidal thoughts

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"PMADS: Perinatal Mood and Anxiety Disorders"

- Milder cases overlap with normal feelings in the postpartum period – i.e. fatigue, altered sleep, appetite, energy
- Hopelessness, worthlessness, suicidal ideation are *not* normal in the postpartum period
- Comorbid anxiety with obsessional thoughts about the baby is very common and often the presenting symptom
  - Important to distinguish from psychosis
- Edinburgh Postnatal Depression Scale
  - 10-item self-rating scale measuring mood, anxiety and SI

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Risk Factors for Depression in Pregnancy

- Past history of depression
- Poor overall health
- Greater alcohol use
- Smoking
- Single
- Unemployment
- Lower education level
- Poor social support
- Trauma, domestic violence
- Unplanned pregnancy

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Risks of Untreated Perinatal Mental Illness

Maternal

- Poor health care and treatment adherence
- Preeclampsia
- Increase risk of smoking and substance use
- Poor nutrition
- Loss of interpersonal and financial resources
- Antepartum depression anxiety → Increased risk of PPD and anxiety
- Maternal Suicide (5% in untreated PPP)
- Delayed attachment
- Abuse of child
- Infanticide 4% in untreated PPP
- Neonaticide

Child

- Low birth weight
- Preterm delivery
- Lower APGAR scores
- Smaller head circumference
- Cognitive delays
- Difficulty engaging in social and object interactions
- Show less positive and more negative affect
- Lower activity levels
- Greater physiologic reactivity
- Increased cortisol and catecholamine levels
- Increased rates of NICU admissions
- Dysregulation of HPA axis
- Behavioral problems
- Disruption in development
- Increased risk of psychiatric problems later

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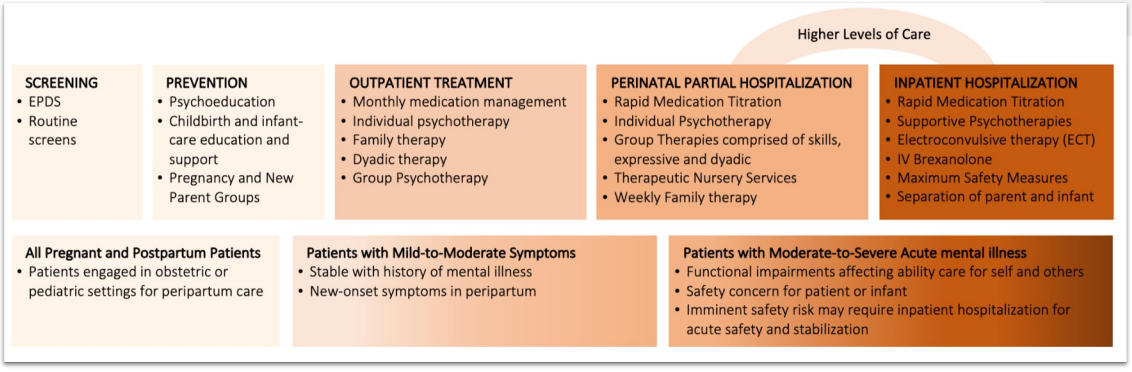
Treatment Approach for the Perinatal Patient



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Prevention Strategies

Psychoeducation

- Provide information on PMADs
- Discuss and prepare for the perinatal period
  - Pregnancy, birthing, and/or parenting classes
- Specialized preventative interventions
  - PREPP
  - Healthy STEPs

Peer/Family Support Network

- Engage in family meetings
- Help patient identify family and friends that can offer emotional support and/or practical support (i.e childcare)
- Support groups (i.e New mother groups, mothers with depression groups, etc)

Perinatal Services

- Doulas (pregnancy, birthing, and postpartum)
- Lactation consultants
- Baby/Night Nurse
- Nurse Family Partnership (NFP)

Financial and Work Support

- Parental leave - access varies based on state and employment
- Special Supplemental Nutrition Program for Women, infants, and Children (WIC)

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Psychotherapy in the Perinatal Period

- Interpersonal Therapy (IPT)
- Dyadic Therapy
- Trauma Therapy
- Family therapy

The peripartum period can be an important time to either start or continue psychotherapy with goal to help prevent and minimize risk and effects of PMADs.

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Factors in Considering Medication Treatment for PMADS

- Severity
- Acuity/chronicity
- Comorbidity
- Prior treatments and response
- Social supports
- Patient values/preferences
- Effects of psychiatric symptoms on patient, family system
- Access to therapy, other treatments and psychosocial interventions
- Screen for bipolar illness/family history

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When to Consider Medication Treatment for PMADS (severity)

Mild-Moderate	Moderate-Severe
• No suicidal ideation • Able to access psychotherapy and/or other nonmedication treatments • Prior good response to psychotherapy • Good social supports • Able to care for self/baby • Sleep disruption responsive to more support	• Suicidal ideation** • Difficulty functioning caring for self/baby • History of severe depression and/or suicide attempts • Severe sleep disruption despite behavioral interventions and support • Comorbid anxiety disorder, panic attacks • Obsessional thoughts about harm • Subjective distress, impact on family systems • Psychotic symptoms**

**Needs immediate assessment, consider activating emergency response

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Is it safe to take psychiatric medications in pregnancy?

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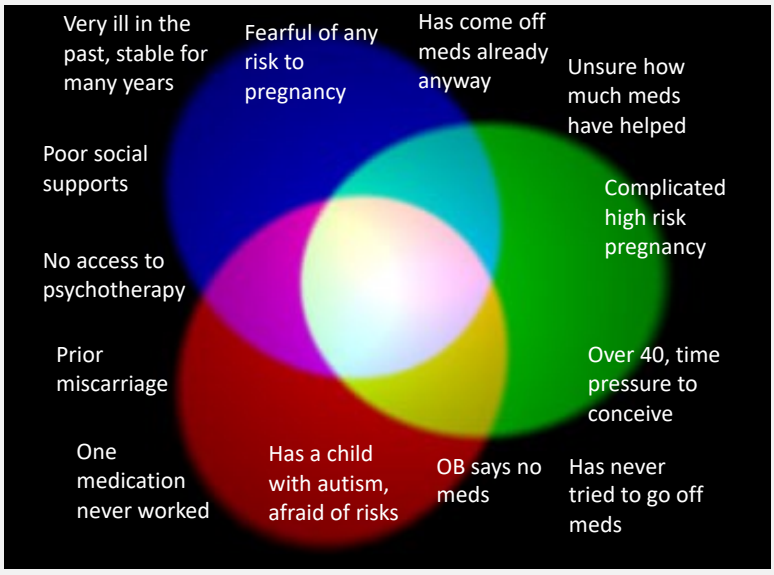
The reality is even more complicated



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Treatmen scribing Psych ancy

1. Know what you are
2. There are no risk-fr ness, there is risk.
3. Cases by case, "ris s of treatment"
4. Maximize non-med n when meds indicated
5. The best medicatio for the patient
6. Avoid polypharmac
7. Use the lowest EFF
8. Re-screen, monitor puerperium
9. Involve family/partner when possible, consider family system in risk
10. Communication and education with patient, supports, treatment team

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Risks of SSRI's in Pregnancy

- SSRI's are among the most studied medications in pregnancy
- First trimester: signal in some studies of small increased risk of cardiac defects, but not supported in meta-analyses and large studies controlling for confounding
- Both untreated depression/anxiety and SSRI exposure are associated with slightly higher rates of miscarriage, (late) preterm birth. No association with stillbirth
- Persistent Pulmonary Hypertension of the Newborn:, baseline risk 1-2 per 1000, unclear association with SSRI exposure after 20 weeks when controlling for other confounders
- Neonatal Adaptation Syndrome (PNAS): transient, usually mild symptoms, resolves with support after 48-72 hours in most cases. Estimates 15-30%
- Long-term neurodevelopmental effects: No clear association with ASD, no association with cognitive deficits or behavioral deficits in children, ongoing research into long-term effects on affective/anxiety spectrum

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Choice of Antidepressant

- If patient has had a good response to a prior antidepressant, that is likely the best choice
- No clear differences known between most SSRIs in pregnancy (sertraline, fluoxetine, citalopram, escitalopram)
- Sertraline has lowest transmission in breastmilk so is often our first line in patients who have not had prior medication trials
- With anxiety, start at a low dose (25mg sertraline, 5mg escitalopram, 10mg fluoxetine) and increase to therapeutic range over 1-2 weeks depending on how tolerated

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Monitoring antidepressants in pregnancy/postpartum

- Monitor for effect: antidepressant effect in 2 weeks (anxiety sometimes sooner), depending on acuity check in with patient 1-2 weeks after initiation to ask about tolerability, early effects
- Re-screen and check in about effectiveness of meds at every prenatal visit
- Due to blood volume and metabolic changes, blood levels of SSRI's (and other meds) decrease by 20-30% by 3rd trimester; consider dose increase if breakthrough symptoms
- Consider 2-week postpartum visit if you have treated for PMAD in pregnancy

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Resources

- Project TEACH website: https://projectteachny.org/
- LACTMED: https://www.ncbi.nlm.nih.gov/books/NBK501922/
- Mother To Baby: https://mothertobaby.org/
- Postpartum Support International: https://www.postpartum.net/
- Postpartum Resource Center of NY: https://postpartumny.org/

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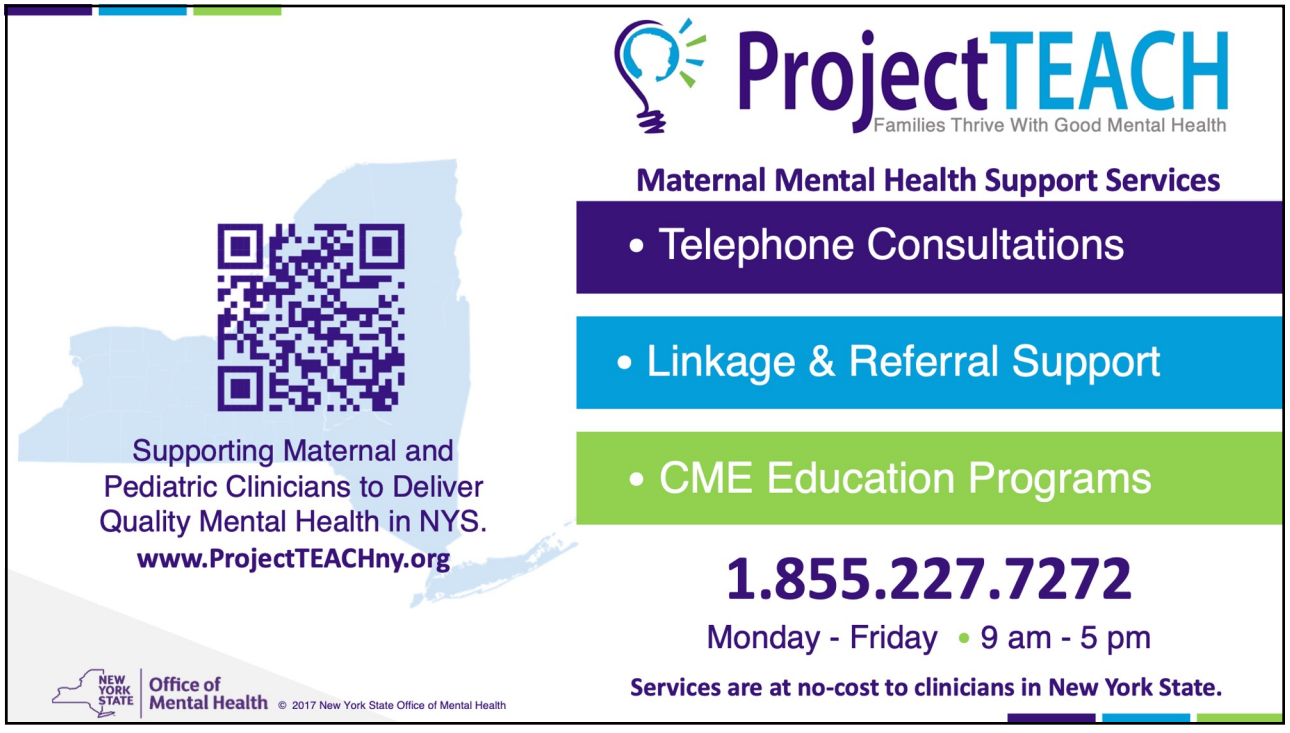

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