December 4, 2020

Postpartum Depression, Anxiety, and other Mood Disorders:

Diagnoses and Treatment in the 4th Trimester and Beyond

Sage N. Saxton, Associate Professor
Cheryl Milford, Director of Development + Outreach, National Perinatal Association

Sage N. Saxton, PsyD

Associate Professor, Departments of Pediatrics and Neonatology

Training Director, LEND Program

Director, NICU Follow Up Program

Cheryl A. Milford, EdS

Educational Neonatal Psychologist

Director of Development + Outreach, National Perinatal Association

GOALS

- Increase knowledge related to PMAD symptoms
- Improve ability to assess for PMADs
- Increase awareness of resources and referral options to treat PMADs

DISCLOSURES

N O N E

“The worst kind of sad is not to be able to explain why.”

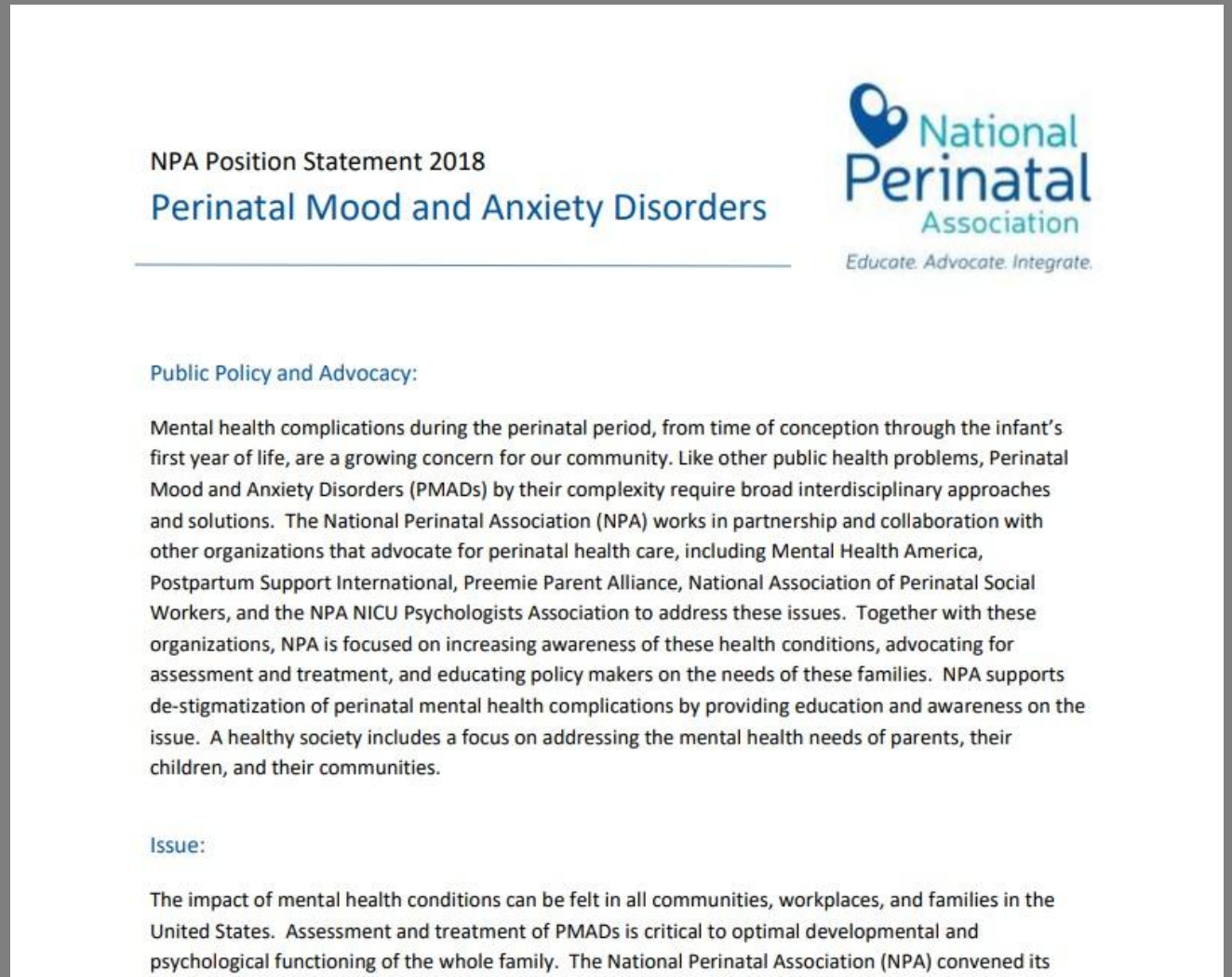
2018 NPA Position Statement

Perinatal Mood and Anxiety Disorders

- Position statement
- Information on screening for PMADs
- Resources for those in crisis

in partnership with
Postpartum Support International
+ Mental Health America

www.nationlperinatal.org/mental health



NPA Position Statement 2018

Perinatal Mood and Anxiety Disorders

National Perinatal Association

Educate. Advocate. Integrate.

Public Policy and Advocacy:

Mental health complications during the perinatal period, from time of conception through the infant's first year of life, are a growing concern for our community. Like other public health problems, Perinatal Mood and Anxiety Disorders (PMADs) by their complexity require broad interdisciplinary approaches and solutions. The National Perinatal Association (NPA) works in partnership and collaboration with other organizations that advocate for perinatal health care, including Mental Health America, Postpartum Support International, Preemie Parent Alliance, National Association of Perinatal Social Workers, and the NPA NICU Psychologists Association to address these issues. Together with these organizations, NPA is focused on increasing awareness of these health conditions, advocating for assessment and treatment, and educating policy makers on the needs of these families. NPA supports de-stigmatization of perinatal mental health complications by providing education and awareness on the issue. A healthy society includes a focus on addressing the mental health needs of parents, their children, and their communities.

Issue:

The impact of mental health conditions can be felt in all communities, workplaces, and families in the United States. Assessment and treatment of PMADs is critical to optimal developmental and psychological functioning of the whole family. The National Perinatal Association (NPA) convened its

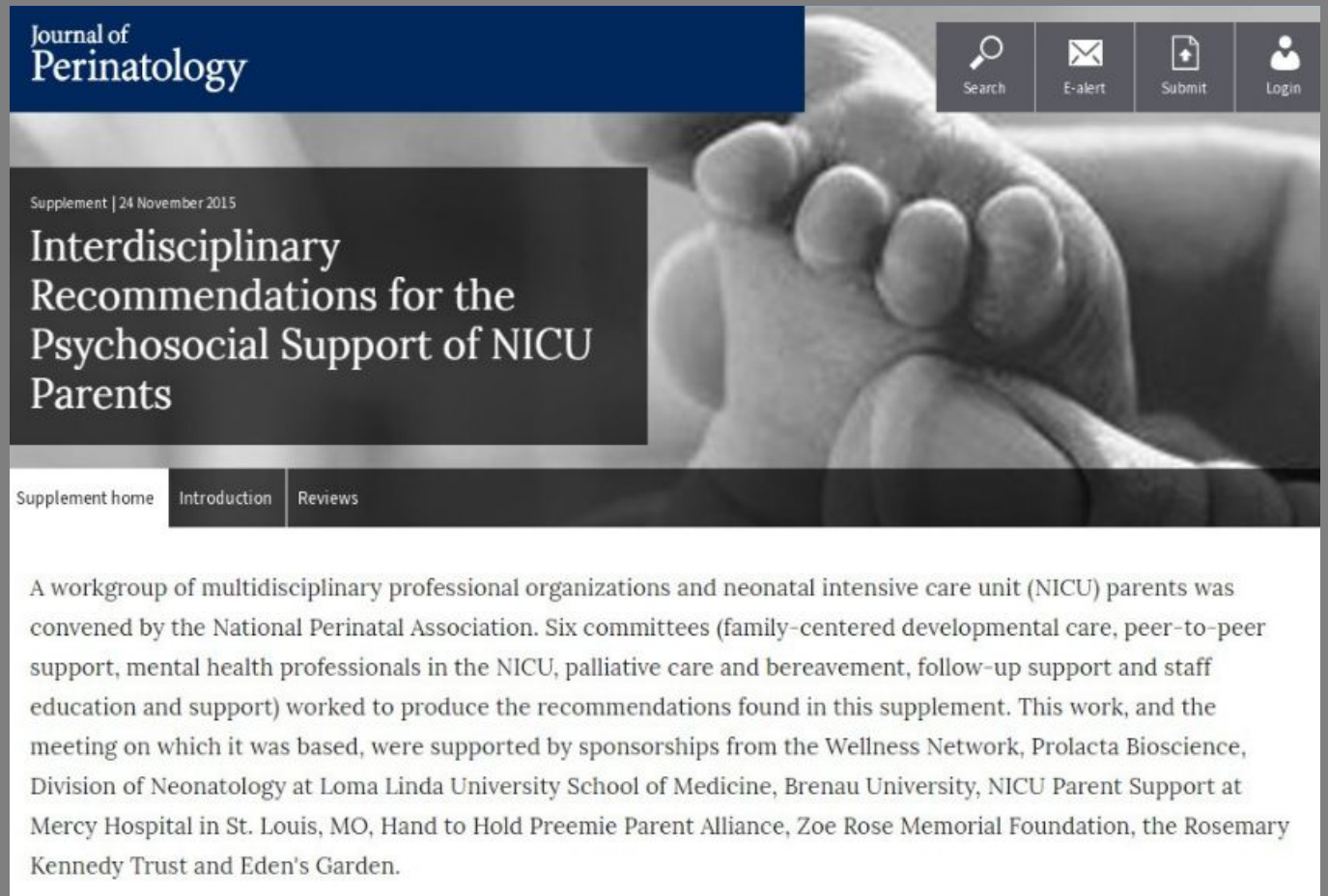
Interdisciplinary Recommendations for the Psychosocial Support of NICU Parents

OPEN ACCESS

Supplement 24 | November 2015

- family-centered developmental care
- peer-to-peer support
- mental health professionals in the NICU
- palliative and bereavement care
- follow-up support
- staff education and support

www.nature.com/collections



MOTHERHOOD

MYTHS

- You can get pregnant right away
- All pregnancies are wanted
- A healthy pregnancy means a healthy baby
- Pregnancy will deliver fulfillment
- You will instinctively bond with your baby
- Motherhood is easy, instinctive, and enjoyable
- Being a mom comes naturally

… and countless more

REALITY

- Loss of freedom
- Loss of identity
- Loss of bodily autonomy, integrity, image
- Loss of career and opportunities
- Loss of control
- Loss of self-efficacy, esteem, acceptance

WANTED: Woman to care for small children

- Must be willing to **work 24/7** with no vacation or sick time.
- **Short breaks…** *only if life threatening*.
- Must be able to tolerate **loud, incessant noise** and **interruption**, **lack of privacy**, **blame** and **criticism** with grace and humility.
- Must have **valid driver's license**.
- **Self-motivation**, **organization**, and **multi-tasking** mandatory.
- Must require **little sleep** and demonstrate **physical and emotional stamina**.
- **Must *not* require external validation**.

** Pay is non-negotiable. No benefits. No vacation. No workers compensation.*

PMADs and DIFFERENTIAL DIAGNOSIS

Perinatal immediately before and after birth *22 weeks gestation*

Postpartum following childbirth up to 1 year post-delivery

WHY PMAD ?

The term is not just newer; it’s more accurate.

It recognizes that anxiety, depression, OCD, and PTSD are complex, interrelated disorders that can manifest before, during, or after pregnancy.

WHY SHOULD WE CARE?

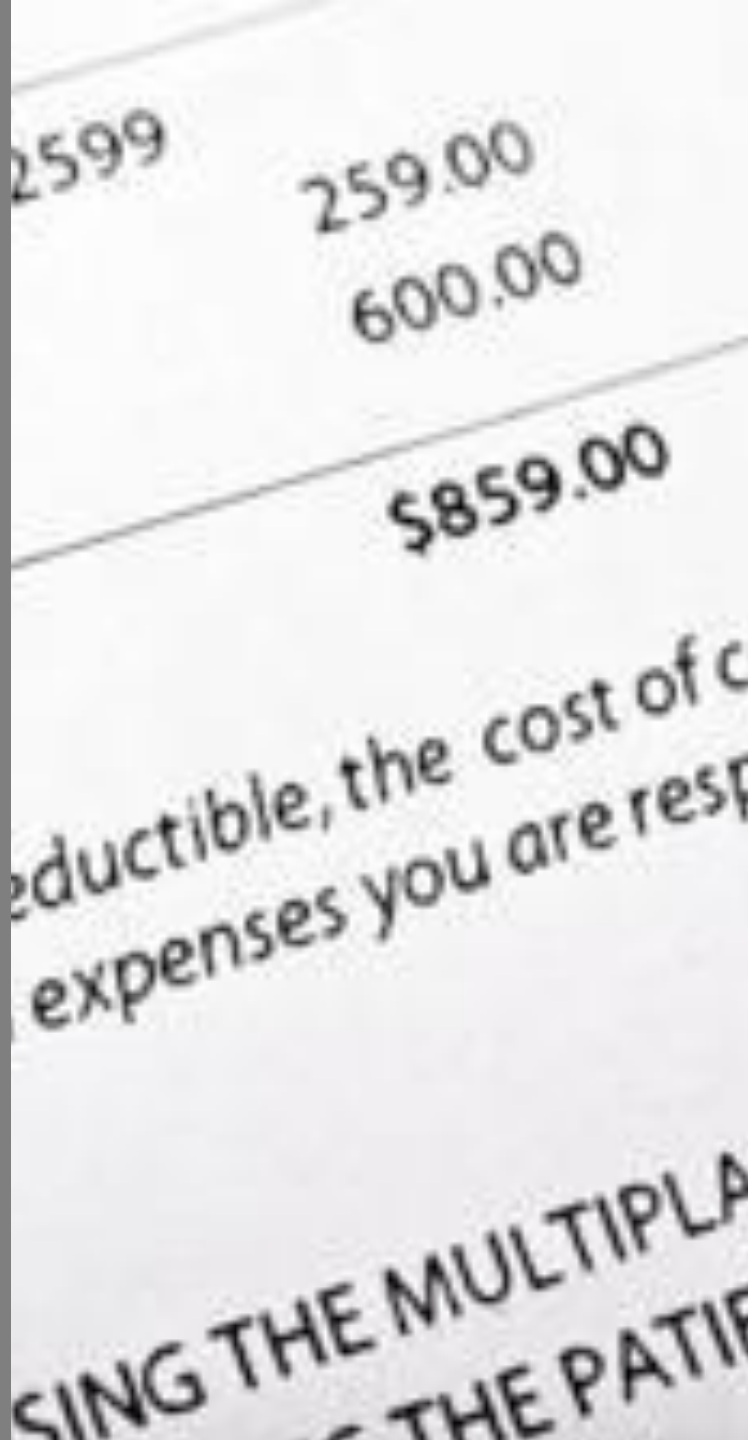
PMADs are the most common morbidity associated with pregnancy.

- They are detectable
- They are treatable
- They are expensive

Average cost of PMAD around $106,000 for first 5 years

- $33,000 relates to the mother
- $73,000 relates to the impact on the child

Bauer, A. et al, 2014. The costs of perinatal mental health problems. London PSSRU and Centre for Mental Health.



WHY SHOULD WE CARE?

- Attachment difficulties with baby or other children
- Diminished responsiveness to infant cues
- Elevated stress hormone in babies *(i.e. cry more, difficult to console)*
- Poor self-care, including not following through with healthcare recommendations
- Increased risk for substance misuse, suicide attempts, and future depressive episodes
- Fear of having another baby
- Financial worries due to inability to work/disability/unemployment

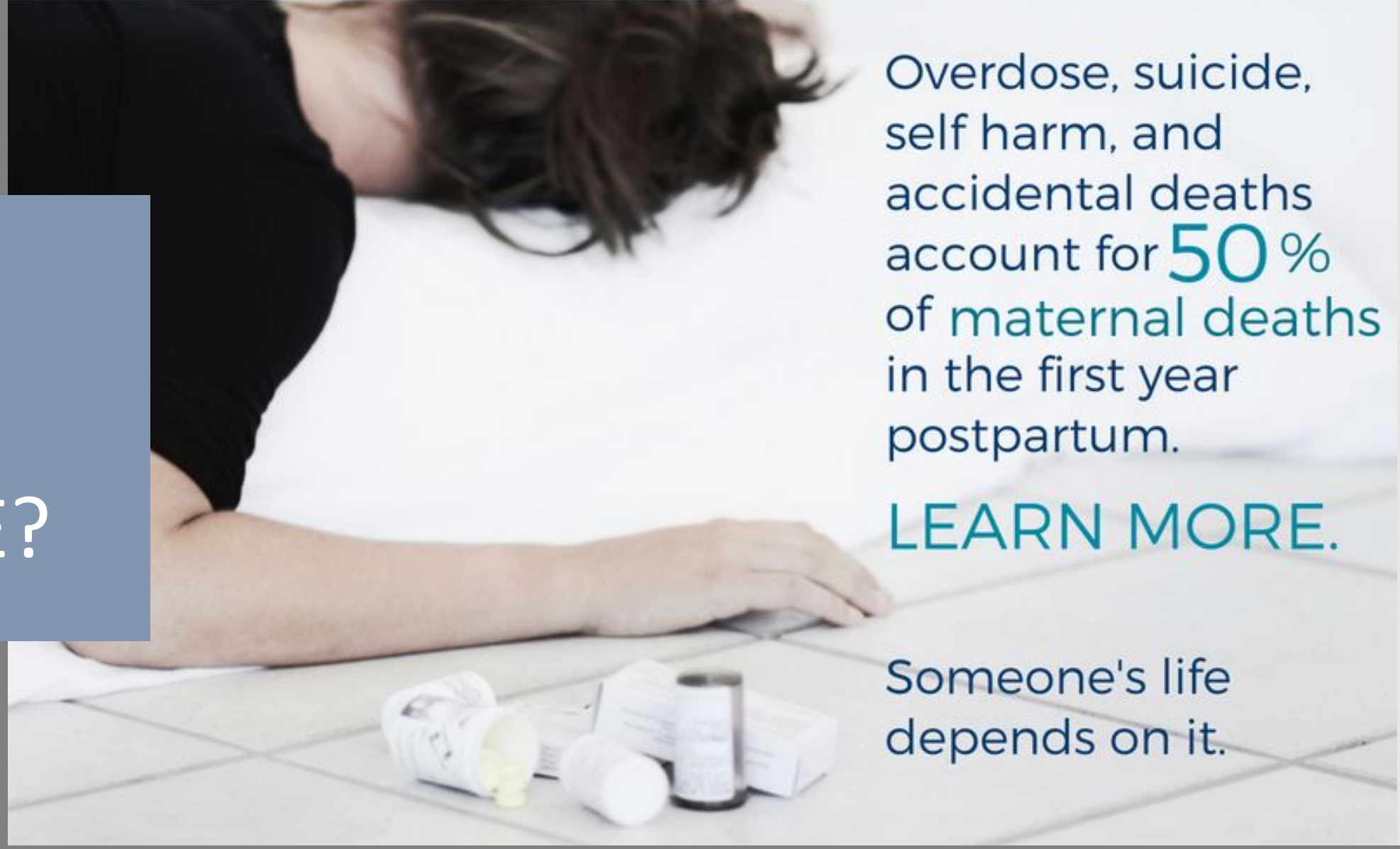
WHY SHOULD WE CARE?

- Relationship Stress

  the first year postpartum sees the highest rates of divorce

- Child Abuse and Neglect
- Suicide…Homicide…Infanticide
- Developmental Delays
- Behavioral Problems

WHY SHOULD WE CARE?



These disorders kill.

PARENTING STYLES of DEPRESSED MOTHERS

INTRUSIVE STYLE

- rough handling
- angry
- hostile
- actively interfere with their infant's activities

WITHDRAWN STYLE

- disengaged
- distant
- unresponsive
- flat affect
- do little to encourage or support infant activity

Also less likely to put infants to sleep on their backs and more likely to put infants to bed with a bottle.

EFFECTS on FATHERS

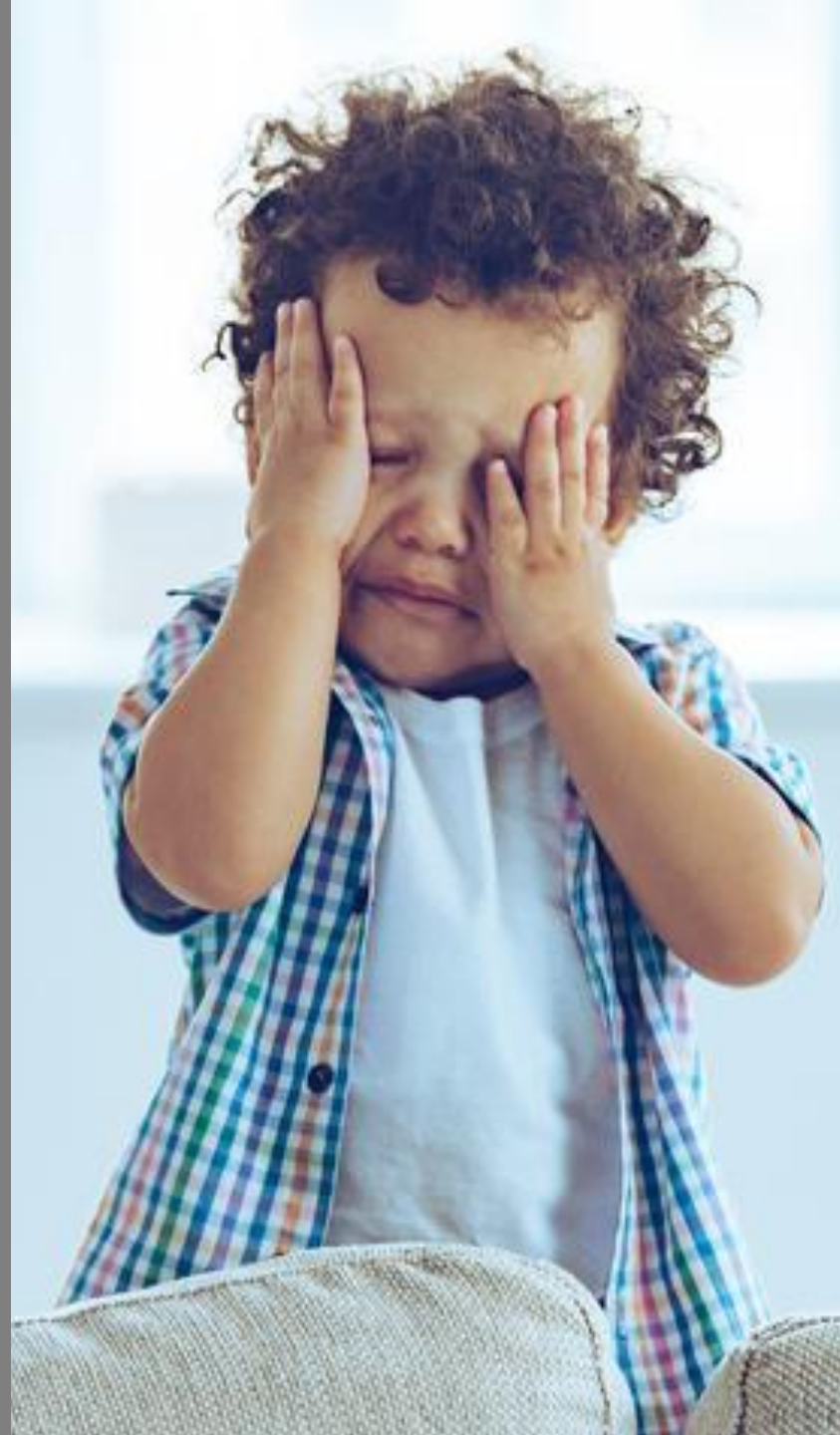
When the mother is unable to care for herself or the baby, the father may feel:

- pulled between work and home demands
- that he cannot do anything right
- that his is efforts go unnoticed
- he is taking on the role of the “mother”
- worry that his wife may never be the same
- angry that his wife is not pulling her weight at home
- that he wants to fix this problem
- frustrated because there is no apparent solution

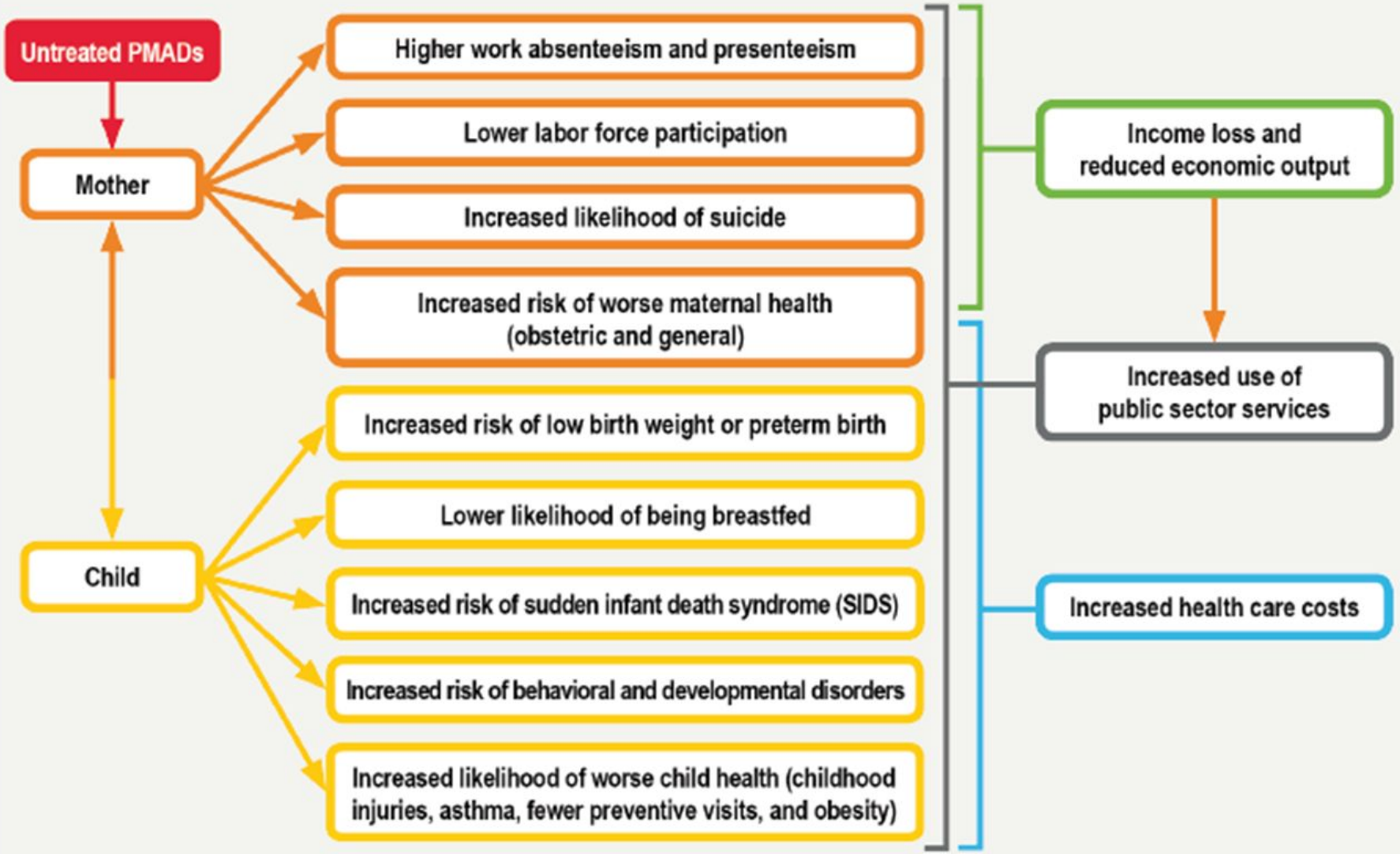
www.postpartumdads.org

EFFECTS on TODDLERS

- insecure attachment with parents
- less social interaction with peers
- inappropriate interactions
- lower self esteem
- neurologic delays
- increased behavioral problems
- attention problems
- symptoms mimic mom’s depressed behavior



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



Pregnancy vs. Depression

PREGNANCY	DEPRESSION
mood: labile, teary	mood: persistent gloom
self-esteem is normal	low self-esteem: guilt
sleep: bladder or heartburn may awaken, can fall asleep	sleep: early morning awakening
no suicidal ideology	suicidal thoughts, plans, or intentions
energy: may tire bed rest for stores	energy: rest does not restore
pleasure: joy in anticipation (appropriate worry)	fatigue, anhedonia
appetite: increases	poor appetite
	overwhelmed, mood swings

BABY BLUES

- typical, normal, anticipated, brief
- affects 60-80% of new moms
- lasts 2 days to 2 weeks
- crying, feeling overwhelmed, being uncertain
- acute sleep deprivation and fatigue
- predominant mood is happiness
- self-esteem is normal

PMADs are not the BABY BLUES

SEVERITY TIMING DURATION

- suicidal thoughts
- appetite change
- sleep disturbance
- poor concentration/focus
- irritability and anger
- anhedonia
- poor appetite
- loss of interest
- loss of joy
- loss of pleasure.

PMADs PREVALENCE

Onset can be any time and is usually gradual. But it can be rapid and begin anytime within the first year to be considered postpartum.

Study of
10,000
women

- 21% had postpartum depression
- 26% had depression before pregnancy
- 33.4% had onset during pregnancy
- 40% had episodes that began during the postpartum period
- 22% diagnosed with Bipolar Disorder
- 19% endorsed thoughts of self-harm

Wisner KL, Sit, DKY, McShea MC et al. JAMA Psychiatry March 2013.

RISK FACTORS for PMADs

- prior mental health history
- higher ACE scores
- unplanned/unwanted/mistimed pregnancy
- unemployment
- marital dissatisfaction
- Lack of social support
- young maternal age: nearly 50% of teen mothers may experience PPD
- stressful life events within past 2 years, such as a death in the family, divorce, or relocation
- stress regarding childcare for the new baby or other children
- fetal anomaly or infant illness
- trauma related to the pregnancy or birth
- current or past physical or sexual abuse

“The single most important thing a husband can do for his wife who is suffering from postpartum depression is to be with her. To simply be with her.”

- Kleiman, 2006

But…

Paternal Postnatal Depression (PPND)

- Paternal Postnatal Depression (PPND) affects up to 10% of new dads throughout the world and as many as 24% of dads in the US.

  Paulson et al, 2010

- Only 3.2% of fathers sought help for mental health concerns.

  Isacco, Hofscher, & Molloy, 2015

- Greatest risk factor = depressed mom

PATERNAL POSTPARTUM DEPRESSION

- irritability
- isolating, withdrawing from relationships
- working a lot more or less
- low energy
- fatigue
- low motivation
- poor concentration
- changes in weight or appetite
- impulsivity
- risk-taking behaviors
- problematic substance use
- physical symptoms headaches, muscle aches, stomach + digestion issues
- anger and outbursts
- violent behavior
- suicidal thoughts

* *Women can exhibit these symptoms too.*

PERINATAL ANXIETY

- agitated
- constant worry
- shortness of breath
- sleep disturbance onset + duration
- appetite changes
- high alert

PERINATAL PANIC

- extreme anxiety
- hot or cold flashes, trembling, rapid heart rate
- restless, agitated, irritated
- fear of dying, going crazy, and losing control most common
- panic may cause waking
- excessive worry or fear

Beyond the Blues, Indman & Bennett, 2015

PERINATAL OCD

- 11% screened positive at 2 weeks

  Miller, ES, J Reproductive Med 2013

- may have a history of OCD
- traditional: cleaning, checking, counting, and ordering
- intrusive thoughts - *often of harm to baby* - tremendous guilt and shame
- horrified by these thoughts
- educate mom that thoughts ≠ action
- providers must ask about scary thoughts

PERINATAL PTSD

- 9% postpartum met PTSD criteria

  Beck, CT Driscoll, JW, Watson, S. Traumatic Childbirth, 2013 New York Routledge
- re-experiencing, spontaneous memories
- numbing or hyperarousal
- common to have body memories
- dissociation
- risk factors: neonatal complications, lower gestational age, NICU, stillbirth
- trauma is in the eye of the beholder

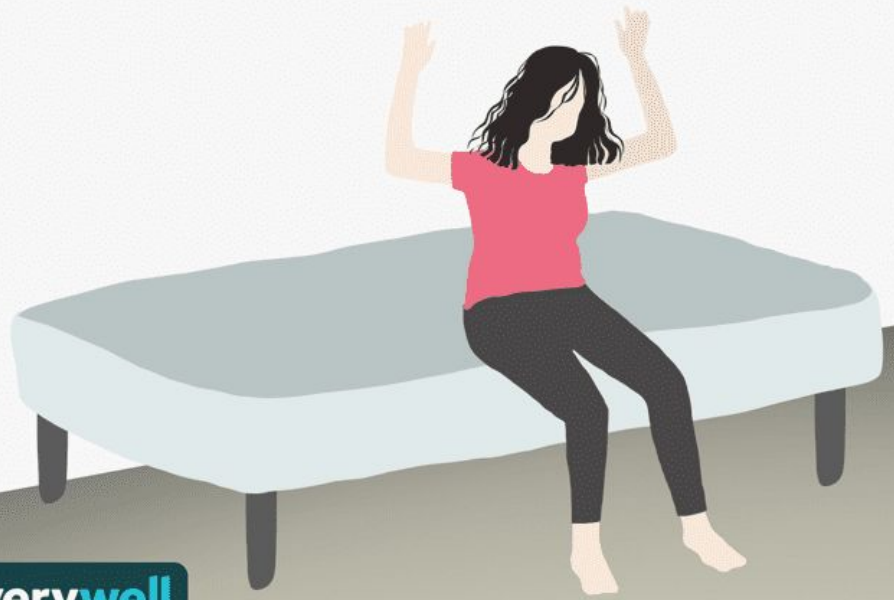
PERINATAL BIPOLAR DISORDERS

- 60% present as depressed initially
- types:
  Bipolar I: at least one episode of mania
  Bipolar II: no mania
- irritable, racing thoughts, hypomania, mood swings

Bipolar Disorder Symptoms

Mania

- talking excessively
- racing thoughts
- hostility
- less sleep
- delusions



Depression

- extreme fatigue
- prolonged sadness
- memory loss
- poor nutrition

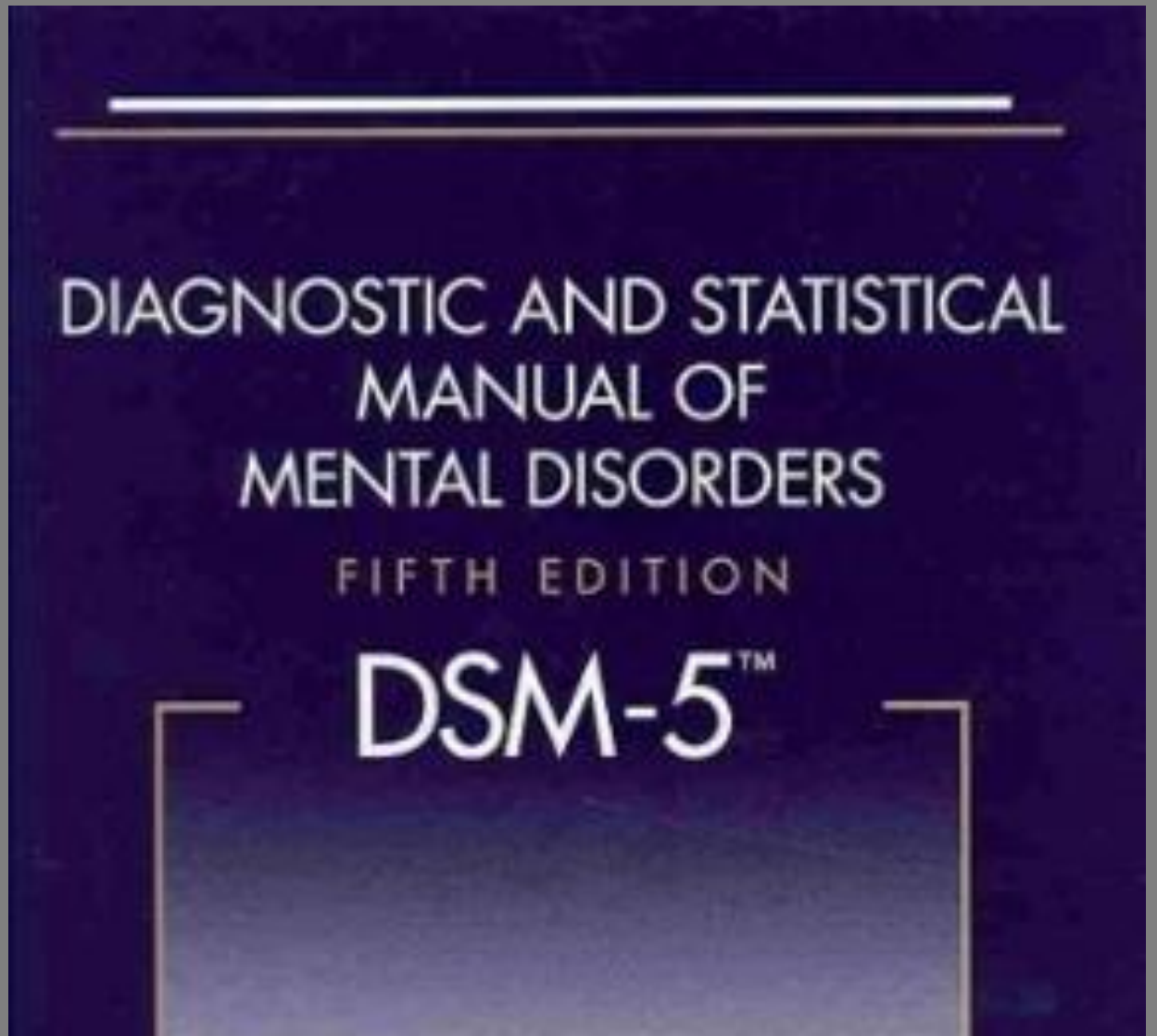
verywell

PERINATAL PSYCHOSIS

HIGH RISK

- 1-2 in 1,000 postpartum women
- onset typically within first 2 weeks post delivery
- delusions, insomnia, hallucinations,
  rapid mood swings
- they DO NOT recognize their thoughts and actions are disordered and may be tempted to act on them
- half of the time this is the first manifestation of a mental health disorder in their history

DIAGNOSTIC EXAMPLES



CONSIDER A DIAGNOSIS

A new mother says extremely tired and feeling overwhelmed.
She becomes tearful during your interview. She is 21 years old and gave birth 1 week ago.

CONSIDER A DIAGNOSIS

A father tells you he’s concerned that his wife is not sleeping, is waking in the middle of the night, and seems to be in a constant state of high alert.

CONSIDER A DIAGNOSIS

A first-time mother presents as reserved, quiet, and nervous.

When appropriately asked by you, she indicates thinking about drowning her baby in the bathtub.

She is embarrassed, guilty, and horrified by these thoughts. She begins to cry.

CONSIDER A DIAGNOSIS

A mother of two indicates feeling overwhelmed. After appropriate questioning from you, she indicates that voices are telling her the devil is influencing her children and making them disobedient.
She is concerned that her children could never be saved with the way she was raising them.

Postpartum Psychosis

Postpartum psychosis is rare, with a rate of 1 to 2 cases per 1,000 births Bergink et al., 2016, Kendell et al., 1987 and relatively little focus has been given to the illness and its survivors.

With proper assessment and treatment, postpartum psychosis can be treated with positive outcomes.
Bergink et al., 2016

Postpartum Psychosis

It is estimated that only 4% of women who suffer from postpartum psychosis harm their infants.
Parry, 1995, Porter and Gavin, 2010

These women often languish in jail with inadequate legal representation and without mental health assessment by trained professionals. They are sometimes charged with capital murder, which leads to a life sentence.

This situation is not as common in other nations where this particular form of psychosis is recognized. Porter and Gavin, 2010, Spinelli, 2005

JOGNN: January 2018 Volume 47, Issue 1, Pages 75–83

INTAKE + INTERVIEW

INTAKE + INTERVIEW

- How can we help families when they don’t know what’s wrong?
- How can we reassure families when they are afraid to disclose that they need help?
- How can we reduce shame and normalize the need for support?

INTAKE + INTERVIEW

- demographic information
- how are they feeding their baby
- number of pregnancies + children
- was this a planned or expected pregnancy
- what is their “birth story”
- what symptom is troubling them the most
- what is their relationship with alcohol + drug use
- do they have a history of trauma (physical, emotional, sexual)

INTAKE + INTERVIEW

- what medications are they using – are there any they've stopped using
- changes in sleep patterns
- prior perinatal loss, adoption, abortion of desired pregnancy
- spiritual + belief system + traditions
- exercise + activity level
- eating habits + relationship with food
- source(s) of emotional support – social integration
- how do they manage intrusive thoughts (help normalize)
- trauma, loss, or changes in the past year

"If you can't sleep, rest!"

- Wendy Davis

THOUGHTFUL OBSERVATION

- flat affect
- disconnected + distant
- anger + agitation
- solicitous of advice + guidance + affirmation while unsure of their own perceptions
- hyper-confident, “extremely put together”
- other…

MANAGEABLE TASKS

BREAK THINGS DOWN…

- *What does the rest of your day look like?*
- *When we get off the phone today what is something that you might want to do?*

SCREENING FOR PMADs

Because you can't always tell by looking.

WHY SCREEN

- high prevalence rates
- screening tools are readily available
- normalize + reduce stigma
- empower parents + families
- mitigate negative impact + long-term consequences

WHO SHOULD SCREEN

All healthcare professionals who have contact with pregnant or postpartum parents

- primary care + internal medicine providers
- nurse practitioners + certified nurse midwives
- hospital staff
- home visitors + promatoras + health workers
- childbirth educators + lactation consultants
- early interventionists
- OB/GYN providers
- pediatricians
- licensed clinical social workers
- WIC programs

DID YOU KNOW?

Despite an average of 14 contacts with healthcare providers, nearly half of 176 postpartum women, who were coping with PPD were not identified. Hearn G et al, Br Journal of General Practice, 1998

PMADs are more prevalent than gestational diabetes 4.8% and hypertension 5% which are routinely screened for

Only New Jersey 2006, Illinois 2008 and West Virginia 2009 have legislation requiring screening. Rhodes, MNS & Segre, L

BARRIERS TO SCREENING

- not enough time to do everything
- never taught; have no experience
- not sure how to bill + no code
- fear of liability
- unfamiliar with screening tools + measures
- unsure how to refer + limited providers
- lack of resources

NPA POSITION STATEMENT

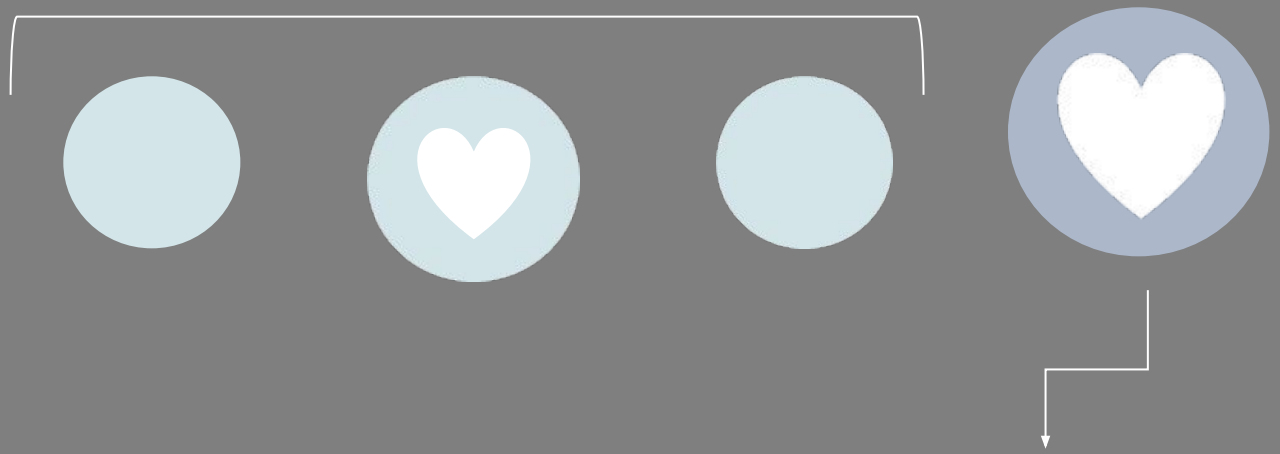
Routine screening of pregnant and postpartum women for perinatal depression has been recommended by the **American College of Obstetricians and Gynecologists (ACOG)**, The **American College of Nurse Midwives**, **US Preventive Services Task Force**, and the **American Academy of Pediatrics (AAP)**. ACOG recommends universal screening for depression for all women, both as a part of routine gynecological care and during the perinatal period. AAP recommends screening for postpartum depression at **1, 2, 3, and 6 months post-delivery**. ACOG's Committee Opinion also adds that women at high risk of depression – for example, those with a history of depression or anxiety – warrant especially close monitoring.

The necessity of universal screening becomes even more apparent when considering that only a small percentage of women will disclose symptoms of a PMAD.

NPA SCREENING TIMELINE

PREGNANCY PROVIDER

at least one – each trimester is better



OB/GYN

6-week postpartum visit

PEDIATRICIAN

2-month 4-month 6-month

birthing parent

partner

IMPORTANT REMINDERS

- screening is not diagnostic
- follow-up care needs to be arranged, as appropriate
- explanation for screening *“I screen all new moms….”*
- provide privacy during screening
- some screenings can be self-administered
- billing codes will vary by state

REFERRAL PROCESS

- Does the professional have specialized training? Certification?
- What is the provider's theoretical orientation? CBT + IPT are validated
- Do they understand the communities they serve? Culturally-informed?
- Are you able to contact the professional to discuss referral concerns and needs?
- Do they take Medicaid? Private insurance? Is a sliding fee scale offered?
- Help the client make the call if possible. Or call on their behalf.
- Make sure to give multiple referral options.

REFERRAL PROCESS

- Are you insured? Uninsured? Or under-insured right now?
- Is the cost of services a barrier?
- Is transportation a barrier?
- Is child care a barrier or burden?
- Are there other barriers that we have not talked about that we need to remove to help you get services and support?
- Who is in your “circle of support”?

COMMON SCREENING TOOLS

- Patient Health Questionnaire (PHQ-9) www.phqscreeners.com
- The Mood Disorders Questionnaire
- Postpartum Depression Screening Scale www.wpspublish.com
- Beck Depression Inventory www.pearsonclinical.com/psychology
- Zung Self-Rating Depression Scale www.mentalhealthministres.net/resources/flyers/zung_scale/zung_scale.pdf
- Center for Epidemiologic Studies Depression Scale www.chcr.brown.edu/pco c/cesdscale.pdf
- Paternal Involvement with Infant Scale (PIWIS) singley@menexcel.com
- Self Efficacy in Infant Care Scale
- Parenting Sense of Competence Scale (PSOC)
- Edinburgh Postnatal Depression Scale

Edinburgh Postpartum Depression Scale (EPDS)

- most thoroughly validated
- FREE … *as long as you cite authors*
- validated with many cultures, ages, and pre- and post-delivery
- 10 item self-report
- available in 18 validated languages
- not linked to the DSM criteria and does not diagnose PMADs.
- women: 0-6 none/minimal; 7-13 mild depression; 14-19 moderate depression, 19-30 severe
- men: 5-6 for anxiety/depression cutoff Matthey, Barrett, Kavanagh, & Howie, 2001
- use 2-3 point lower cut off for minority populations

EPDS

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- ☐ Yes, all the time
- ☒ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week.
- ☐ No, not very often — Please complete the other questions in the same way.
- ☐ No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying

ASSESS REFER FOLLOW UP

- Ask uncomfortable questions:

"Are you thinking about killing yourself?"

- Ask Ideation frequency, intensity, duration *When do these thoughts happen?*
  Plan timing, location, method *Is there a gun in the house? Opiates? Alcohol?*
  Behaviors past attempts *Have you come close before? Did someone you love?*
  Intent *Do you think you will do it? What could reduce the chances you will?*

♥ "What keeps you from acting on these thoughts?"

Responding to SUICIDE RISK

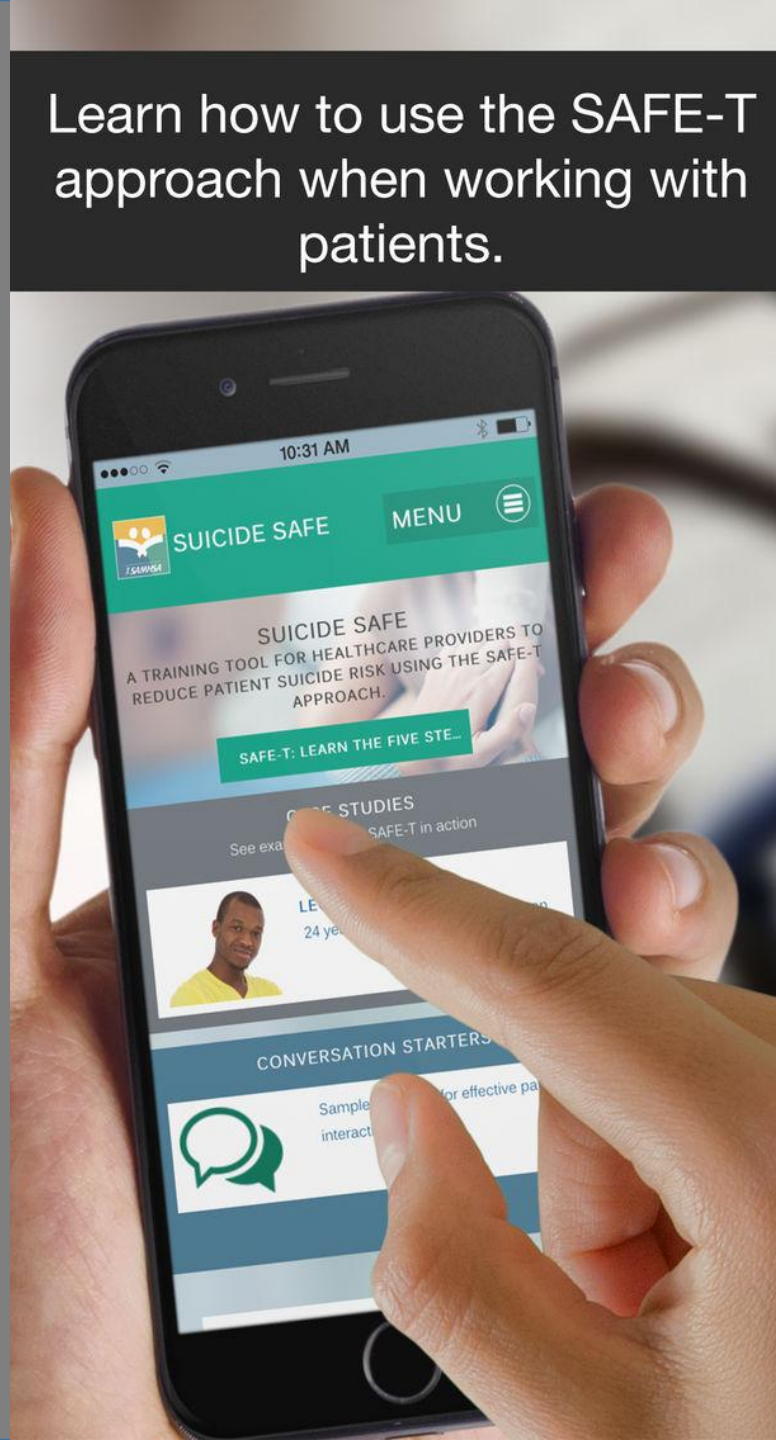
- Assess if this is an intrusive thought or non-lethal wish
- Obtain history of personal or familial suicide attempts
- Provide resources
  - 24-Hour Support National Suicide Prevention Hotline 1-800-273-8255 (TALK)
  - Emergent Care

What would help you feel safer?

SAFE-T

- Suicide Safe App (SAMHSA)
- identify risk factors
  - *can be modified*
- identify protective factors
  - *can be enhanced*
- conduct Suicide Inquiry
- determine risk level and appropriate intervention
- document

www.integration.samhsa.gov/images/res/SAFE_T.pdf



SELF CARE for PROVIDERS

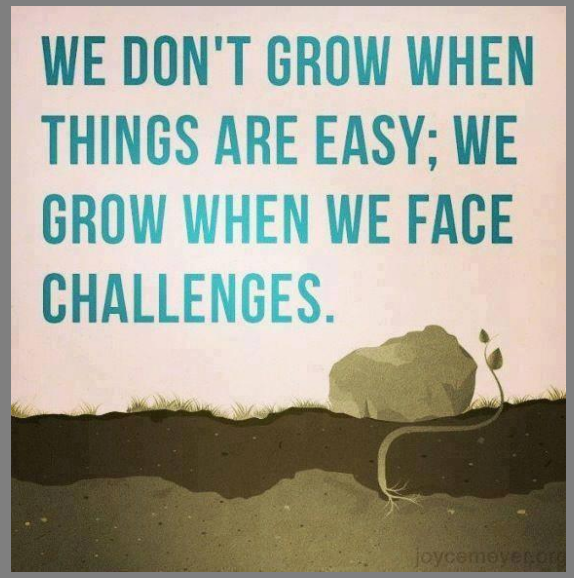
Secondary Traumatic Stress Scale

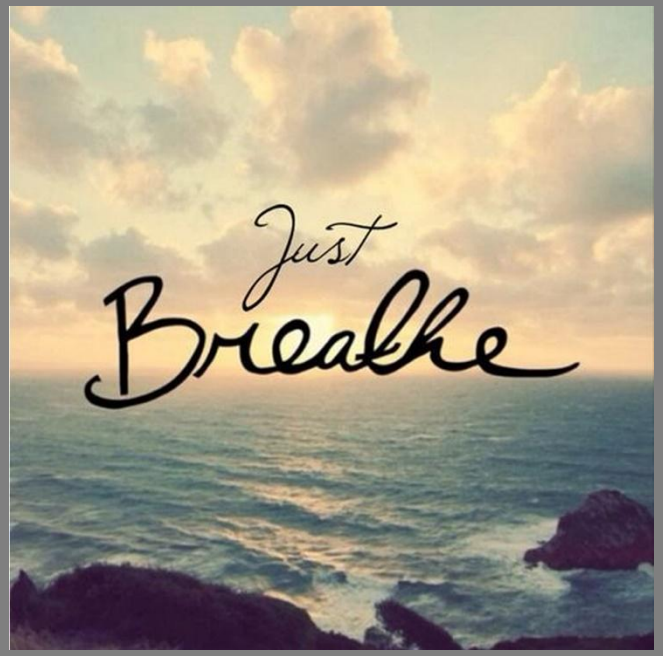
	never	rarely	occasionally	often	very often
• I felt emotionally numb					
• My heart started pounding when I thought about my work with clients					
• It seemed as if I was reliving the traumas experienced by my clients					
• I had trouble sleeping					

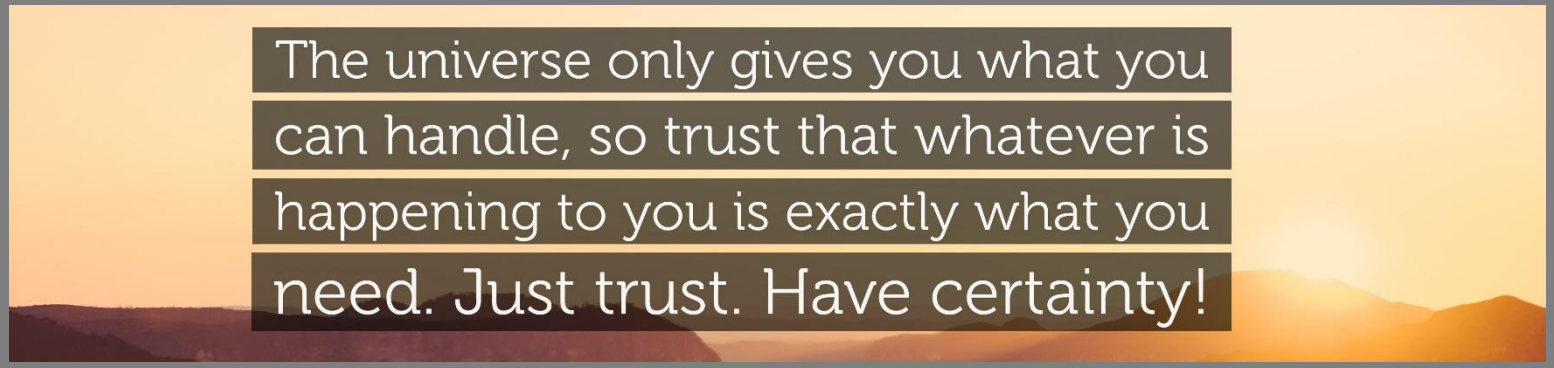
Bride, B.E., Robinson, M.R., Yegidis, B., & Figley, C.R. (2004). Development and validation of the Secondary Traumatic Stress Scale. Research on Social Work Practice, 14, 27-35.

CONNECTING WITH SUPPORT

NO PLATITUDES







SUPPORTING ATTACHMENT

- Pay attention to how baby responds to mother:

  Look, at how he looks at you when he hears your voice.

- Pay attention to mom's response to baby:

  How do you feel when you are with your baby? What do you enjoy?

- Support the attachment:

  What questions do you have about ways to connect or play with your baby?

  This is normal, you will feel better with time. Let's take this one step at a time.

TYPES OF SUPPORT

- social media support
- psycho-education groups
- support groups peer-to-peer
- therapy groups led by provider
- peer support specialists
- warmlines + hotlines
- telemedicine + technology-based

HOME-BASED INTERVENTIONS

- night nurse
- nanny
- doula
- home visitor
- visiting nurse
- family

- being in your body

  Any movement is helpful; don't call it "exercise"
  Let's sit out on the porch for 5 minutes tomorrow.

- nourishment

  What 3 foods will help you sustain your body right now?

  Would you like to take a nap?

TREATING PARTNERS

- identify self-care struggles: nutrition, sleep, exercise, time for self, time away, etc.
- explain how self-care enriches the relationship
- teach couple importance of working together to meet self-care needs
- use “permission giving” to help couple take time for selves
- help with practical solutions to improve self-care

RESOURCES

- Postpartum Support International

  www.postpartum.net

  Helpline 800-944-4773 #1 En Español #2 English

  Text 503-894-9453

- National Perinatal Association

  www.nationalperinatal.org

- Mental Health America (MHA)

  www.mentalhealthamerica.net

RESOURCES

- Massachusetts Child Psychiatry Access Program (MCPAP) for Moms
  www.mcpapformoms.org/Toolkits/Toolkit.aspx
- National Alliance of Mental Illness (NAMI)
  www.nami.org
- National Institute of Mental Health (NIMH)
  www.nimh.nih.gov/health/publications/depression-in-women/index.shtml
- The Blue Dot Project Maternal Mental Health Toolkit
  www.thebluedotproject.org/mmh-week-2018-tool-kit

RESOURCES: MEDICATIONS

- LactMed toxnet.nlm.nih.gov/newtoxnet/lactmed.htm
- MothertoBaby (866) 626-6847
  www.mothertobaby.org
- ReproTox
  www.reprotox.org
- PSI Perinatal Psychiatric Consultation Line
  (800) 944-4773 ext. 4

SKILLS TRAINING

- PSI 2-Day Perinatal Mood and Anxiety Disorders Training
- PSI Advanced Perinatal Mental Health Trainings
- PSI Certification in Perinatal Mental Health
- PSI + 2020 Maternal Mental Health Certificate Training
- NPA Curriculums (www.myperinatalnetwork.org)

  Caring for Babies + Families: Providing Psychosocial Support in the NICU

  Caring for Patients During Pregnancy, Labor, and Delivery

  Coping with COVID-19

We can support parents and partners by:

- asking how they are doing
- providing couples therapy
- using inclusive language
- encouraging ongoing research
- asking to hear their stories
- providing support groups
- providing online support + therapy

“Perinatal mood disorders are not just the mother’s problem.
They are not just the father’s problem.
They are not just the family’s problem.

Rather perinatal mood disorders are the community’s problem.
We must begin to treat these disorders
with a “community team” approach each supporter playing its part
if we are to truly ease the suffering of a postpartum families.

This process begins with each of us today.”

- Christina Hibbert

THANK YOU

Sage Saxton, PsyD

saxtons@ohsu.edu

Cheryl Milford, EdS

cmilford@nationalperinatal.org