

Navigating Perinatal Mental Health

Pilar M. Sanjuan, PhD, PMH-C – Psychologist, Associate Professor
UNM HSC Department of Family and Community Medicine
Board member of Postpartum Support International – New Mexico

Cole Martin - Community Doula
Indigenous Full Spectrum Birthworker



Acknowledgment



Indigenous Peoples' Land and Territory Acknowledgement.

Founded in 1889, the University of New Mexico sits on the traditional homelands of the Pueblo of Sandia. The original peoples of New Mexico – Pueblo, Navajo, and Apache – since time immemorial, have deep connections to the land and have made significant contributions to the broader community statewide. We honor the land itself and those who remain stewards of this land throughout the generations and also acknowledge our committed relationship to Indigenous peoples. We gratefully recognize our history.

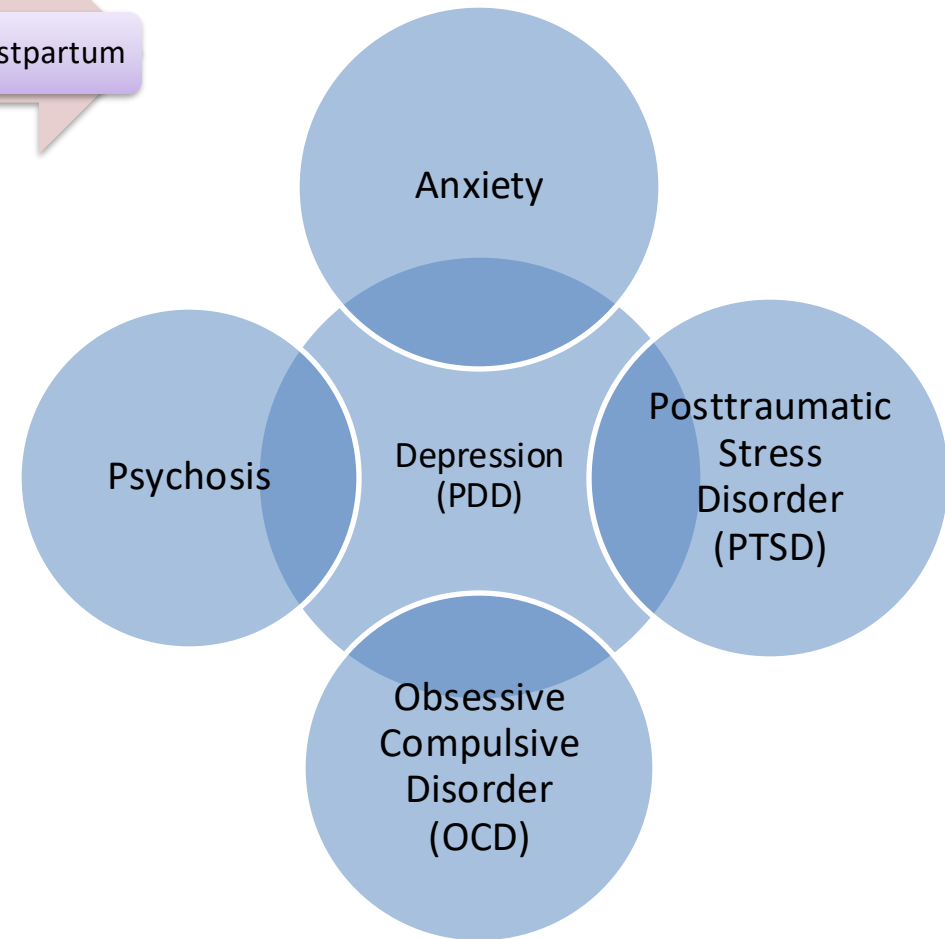
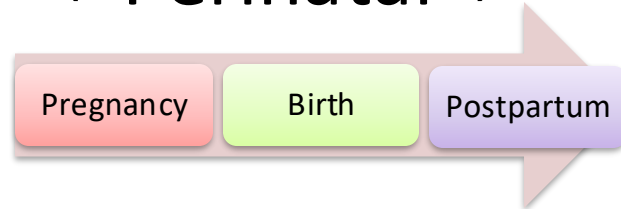
Developed by the Special Assistant for American Indian Affairs to the UNM President in consultation with the Native American Faculty Council. Approved and adopted by President Garnett S. Stokes, February 2020.

We have no financial conflicts of interest to disclose.

Perinatal Mental Health Disorders



↔ Perinatal ↔



Postpartum Depression (PPD)

- ❖ 1 out of 7 new moms will be diagnosed with PPD



- ❖ 1 to 2 out of 10 pregnant moms experience anxiety
- ❖ 7 to 8 out of 10 new moms experience “baby blues”
- ❖ 1 to 2 out of 10 moms will still have PPD one year after the birth
- ❖ 1 to 2 out of 100 moms experience PPD with psychosis
- ❖ Perinatal mood disorders are associated with preterm birth and low birth weight – in both directions
- ❖ PPD can last up to 3 years after giving birth

4th Trimester

After the baby is born:
Critical but neglected period
for new mothers and family

Critical	Neglected
Breastfeeding	Maternal care: frequent → infrequent
Intense newborn care at home	Medical care: mom-focused → baby-focused prenatal → pediatric
Mother/baby bonding	Loss of continued care from doctor or nurses and loss of resources
Mood changes, lack of sleep, physical changes (healing from birth, hormones)	Insurance and welfare changes
Cultural beliefs about an ideal mother are different from reality of parenting a newborn, which is hard work	

- Doulas, lactation consultants, and home visitors can play an important role in bridging this gap.

Baby Blues



Approximately 60-80% (6-8 out of 10) of newly postpartum people will experience baby blues

Due to fluctuating hormones and sleep deprivation postpartum

Usually lasts from 2 days to 2 weeks after giving birth – peaking 3-5 days after the baby is born

Includes crying, rapid mood changes, exhaustion

Predominately happy and self-esteem is unchanged

Normal adjustment - resolves without medical treatment

If it lasts longer than 2 weeks after giving birth, then it's not Baby Blues

Postpartum Depression

PPD is most common underdiagnosed postpartum complication



Warning Signs



Having a hard time eating or sleeping

Sadness and depressed mood

Irritability, crankiness

Anger

Difficulty bonding with baby

Anxious, panicky

Recurrent upsetting thoughts

Feeling 'out of control'

Feeling like you are 'going crazy'

Feeling like you should not have had a baby, gotten pregnant, or become a parent

Worried you might hurt yourself, your baby, or someone else

If these continue for more than a week or two or get in the way of daily activities of living (taking care of yourself), you could have postpartum depression

Social/ Environmental Risk Factors

- Not enough support caring for the baby
- Financial stress
- Poverty
- Marital stress
- Pregnancy, birth, or breastfeeding complications
- Other major life event—move, job loss, loss of family member
- Parenting multiples (twins, triplets)
- Baby in NICU
- History of infertility, difficulty getting pregnant



Medical/ Mental Health Risk Factors

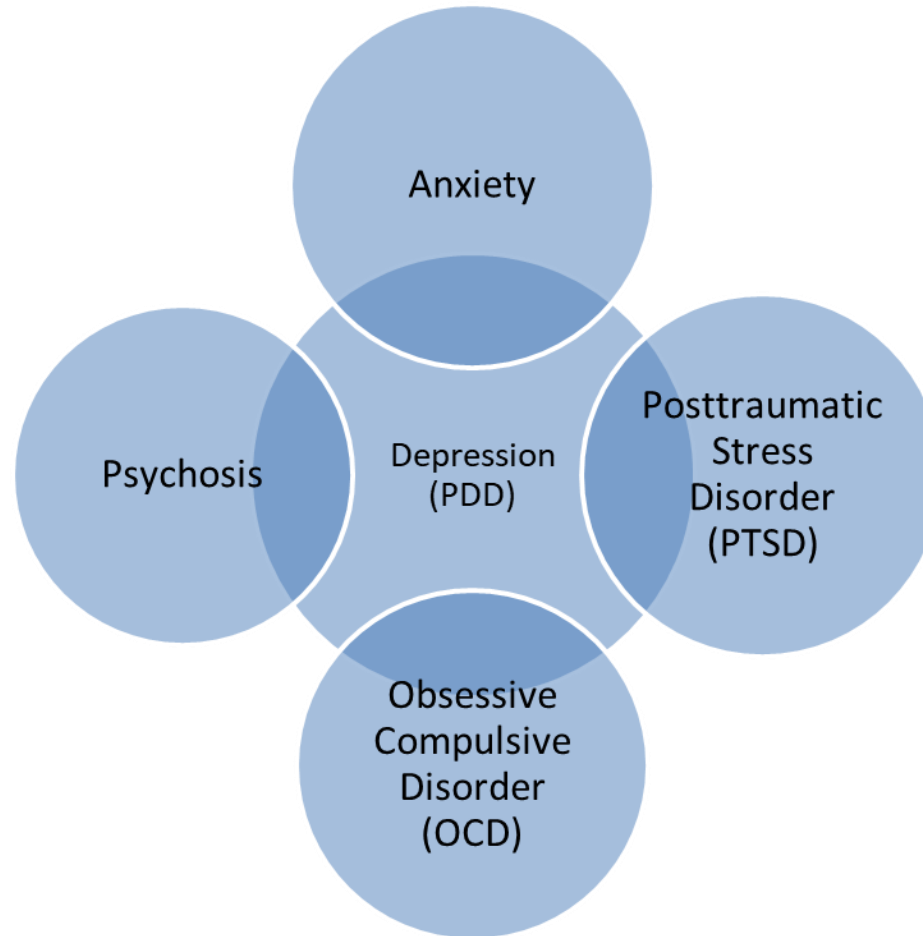
- Thyroid disorder
- Diabetes—gestational, type 1, type 2
- Personal or family history of depression, anxiety or prior postpartum depression
- History of premenstrual dysphoric disorder (PMDD/PMS)
- History of substance use disorder
- Prenatal posttraumatic stress disorder (PTSD)
- History of sexual trauma



Postpartum Anxiety/OCD



- Prevalence
 - Prenatal onset 16%
 - Postpartum onset 8-20%
 - Can be at the same time as depression or by itself
- Generalized anxiety disorder
 - Excessive anxiety and worry that is difficult to control (often about one's own or baby's health)
- Panic Disorder
 - Episodes of quickly escalating intense fear with physical reactivity
 - Shortness of breath, chest pain, air hunger, dizziness, hot or cold flashes, rapid heart rate
 - Fear of dying, fear of going crazy, fear of losing control
- Postpartum Obsessive Compulsive Disorder
 - Recurrent thoughts, urges, or images that won't stop and are unwanted, cause distress, and can't be ignored (ego-dystonic)
 - Ego-dystonic: felt to be distressing, unacceptable, and inconsistent with one's self-concept
 - Usually of harm coming to the baby via deliberate harm, contamination, injury, ordering/arranging, religious, checking
 - Guilt and shame – "I am bad mom."
 - Repeated behaviors that a person feels forced to do when they have the obsessions (sometimes without obsessions)
 - Examples: Handwashing, checking, counting



Postpartum PTSD



- Trauma sources
 - Prior or during pregnancy sexual or physical violence, combat, accident, disaster
 - Traumatic birth or pregnancy event – NICU risk
- Most people with a trauma do not develop PTSD – **trauma alone is not an indicator of PTSD** – must also have symptoms in all 4 of these categories:
 - Re-experiencing (nightmares, intrusive thoughts, flashbacks, negative response to reminders of trauma)
 - Avoidance (of reminders)
 - Mood disturbance (guilt, numbing, anhedonia, detachment, strong negative beliefs, persistent negative emotions)
 - Hyperarousal (insomnia, irritability, exaggerated startle, inability to concentrate, hypervigilance)
- Can happen together with depression and/or substance use disorder

Postpartum Psychosis

! Medical emergency!
**High risk of suicide or child
harm**

- Delusions
 - Beliefs that don't make any logical sense, often about the baby, that can't be changed even when shown proof they aren't true
 - Ex: Baby is evil, people want to steal the baby, God/Devil orders them to harm baby
- Hallucinations
 - Seeing or hearing things that other people do not see or hear
 - Vivid and clear (not hearing murmurs or people talking but you can't tell what they are saying – oversensitivity to white noise)
 - Not normal for culture/religion (seeing ghosts/spirits)
 - Ones that you hear are most common
- Disorganized thought/speech
 - You can't follow what they are saying, may be completely incomprehensible
 - May have derailment (moving randomly from one thought to another or by rhyming)
- Grossly disorganized or catatonic behavior
 - Agitation or childlike behaviors, or don't move at all or other very strange behaviors that interfere with activities of daily living
- **OCD versus Psychosis**
 - **OCD – recognizes thoughts/images are unhealthy, extreme anxiety related to thoughts/images, highly concerned about going crazy = low risk of harm to baby**
 - **Psychosis – may not recognize actions/thoughts are unhealthy, may seem to have low anxiety during thoughts/behaviors, may not recognize thoughts are distorted = high risk of harm to baby**

Substance Use Disorders

Substance use in and of itself in pregnancy or postpartum is NOT defined as child abuse in NM.

Substance use disorders include alcohol and tobacco – not just drugs like cannabis, meth, or opiates.

Perinatal substance use disorder often co-occurs with anxiety, depression, or PTSD.

Substance use can be how someone tries to manage perinatal depression or PTSD.

- May be a red flag for other perinatal mental health disorders

People with alcohol or drug use prior to pregnancy, even if they did not use these during pregnancy, are at high risk of relapsing after the baby is born.

Medication for opioid use disorder, such as methadone and buprenorphine are first line of treatment during pregnancy and postpartum



Treatments

- Cognitive Behavioral Therapy (CBT)
 - Traditional CBT
 - Mindfulness therapies
- Medication
 - Antipsychotics safe and necessary for psychosis
 - Methadone and Buprenorphine are first line of treatment for opioid use disorder
 - SSRIs have abundant research supporting their safety during pregnancy
- Doulas
 - Prevention and navigation
- Breastfeeding consultation/support
 - Prevention and support
- Social support—MAJOR!
 - Home visiting (example: home visiting nurses, community health workers/peer support workers)
 - Support groups – see PSI online groups
- Not all of these are ideal for all people.
- If one treatment option isn't working, then try other options.



Resources

National Maternal Mental Health Hotline - 24/7

- 1-833-TLC-MAMA - Can call or text

Postpartum Support International <https://www.postpartum.net>

- Help Line 1-800-944-4773
- Peer mentor program
- List of providers for help
- Local support people
- Virtual support groups
 - Depression, OCD, Substance Use Disorder, etc.
 - BIPOC
 - Loss & bereavement
 - LGBTQIA
 - NICU groups
 - And more

New Mexico Breastfeeding Task Force <https://breastfeedingnm.org/>

- Support Groups
- Local provider directory

New Mexico Doula Association <https://nmdoula.org/>

- Provider directory

Tewa Women United <https://tewawomenunited.org/>

- Doula support

Native American Professional Parent Resources (NAPPR) <https://www.nappr.org/>

- Tribal Home Visiting Program

Southwest Women's Law Center - <https://swwomenslaw.org/get-legal-assistance/>

- Free Legal Services for Native Women experiencing domestic violence or intimate partner violence