

PMH: An Overview
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Indiana University Health, Indianapolis, IN
Indiana University Health
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1

PSI's Vision

It is the vision of PSI that every woman and family worldwide will have access to information, social support, and informed professional care to deal with mental health issues related to childbearing. PSI promotes this vision through advocacy and collaboration, and by educating and training the professional community and the public.

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2

PSI's Needs of Childbearing Women/People

- **A companion or advocate** to provide support during pregnancy, birth, and the first year of postpartum
- **Supportive professionals** who are knowledgeable about mental health and will access help for a patient with a mood disorder
- Having a **time and place to talk** about the pregnancy, the birth, and the continuing postpartum experience

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3

Why should we care about PMAD's?

- #1 Medical complication related to childbearing
- Illness is detectable
- Opportunity to help women with prior undiagnosed mental illness or those at risk for continued mental illness.

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4

Risks of Untreated PMADs

ACOG Consensus Bundle on Maternal Mental Health 2017

- Relationship problems
- Disability/Unemployment
- Poor adherence to medical care
- Child neglect and abuse
- Exacerbation of medical conditions
- Developmental delays/behavioral problems
- IPV/separation/divorce
- Tobacco, alcohol and drug use
- Loss of interpersonal and financial resources
- Infanticide, Homicide, Suicide

(Kendig et al., 2017)

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5

Position Statement AWHONN

Position:

The Association of Women's Health, Obstetric and Neonatal Nurses maintains that individuals should be screened for mood and anxiety disorders, especially during pregnancy and the postpartum period. It is imperative that on-going screening and referral to treatment occurs in both the perinatal and pediatric setting. Nurses are in key positions to screen individuals and provide education regarding Perinatal Mood and Anxiety Disorders (PMAD). To effectively impact PMAD, it is crucial for health care facilities, especially those serving women and children, to have policies and processes that address screening, interventions, referral to treatment and education for those assessing for or impacted by PMAD.

6

AWHONN Role of the Nurse

Nurses can optimize the level of care by doing the following:•

- Assess PMAD risk factors during the perinatal period
- Develop comprehensive protocols for PMAD screenings at various points throughout the perinatal and postpartum period using evidence-based screening tools.
- Develop a plan of care using evidence-based interventions for positive screens, including emergency protocols for those that screen high risk.
- Provide patient education on symptoms of PMAD including what actions to take if symptoms appear, medication safety during and after pregnancy, and during lactation period, and when to consult a healthcare provider before discontinuing any medications.
- Develop, maintain, and provide a current list of community resources for referral to assess and treat patients who may experience PMAD.
- Serve as a champion for change to support delivery of high quality, evidence-based care for individuals experiencing PMAD.
- Advocate for the expansion of treatment resources in their communities.

7

Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019

- Among the 1,018 pregnancy-related deaths, an underlying cause of death was identified for 987 deaths — accounted for over 75% of pregnancy-related deaths
- The 6 most frequent underlying causes of pregnancy-related death — mental health conditions (22.7%), hemorrhage (13.7%), cardiac and coronary conditions (12.8%), infection (9.2%), thrombotic embolism (8.7%), and cardiomyopathy (8.5%)

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8

Leading underlying cause of death varied by race and ethnicity

- Cardiac and coronary conditions were the leading underlying cause of pregnancy-related deaths among non-Hispanic Black persons
 - Mental health conditions were the leading underlying cause of death among Hispanic and non-Hispanic White persons
 - Hemorrhage was the leading underlying cause of death among non-Hispanic Asian persons
- Over 80% of pregnancy-related deaths were determined to be preventable.**

Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 US States, 2017–2019 (c) 2024 Postpartum.net

9

Underdiagnosed and Undertreated

In a systematic search to identify articles regarding diagnostic rates through March 2015:

- 49.9% of women with antenatal depression and 30.8% of women with postpartum depression were identified in clinical settings
- 8.6% of women with antenatal depression and 6.3% of women with postpartum depression received adequate treatment (Cox et al., 2016)

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10

Perinatal Mood and Anxiety Disorders

- Depression and Anxiety Disorders can occur anytime in pregnancy or the first year postpartum
- PMAD is new term replacing the narrow definition of PPD
- Perinatal Mental Health (PMH) can also be used

11

Prevalence


- Research says - about 80% of new mothers experience normal "baby blues" in the first few weeks after the baby arrives.
- At least 1 in 7 mothers experience serious depression or anxiety during pregnancy or postpartum.
- 1-2 of 1,000 have postpartum psychosis.
- 1 in 10 fathers experience PPD

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12

Prevalence of PMADs

1 in 7 women




Perinatal depression affects as many as **one in seven women.**

AODG recommends all pregnant women be screened at least once during the perinatal period.

The American College of Obstetricians and Gynecologists

1 in 10 men



10% 1 in 10 new fathers suffer from post-partum depression

1 in 10 new fathers suffer from post-partum depression

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13

PMADs can impact anyone

"Not only was I accepting some tough personal stuff, but I just was in a funk," she wrote. "Mostly, I felt like I was not a good mom." - Serena Williams, 2015

- PMADs do not discriminate
- PMADS can impact anyone
- Money/SES are not protective

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14

Myths about POSTPARTUM DEPRESSION

- It's only postpartum and it's only depression
- It means I don't love my baby/want to kill my baby
- It's all about crying
- Andrea Yates drowned her 5 kids
- It'll go away on it's own
- Anxiety and depression don't happen during pregnancy
- Physical/Mental illness
- "Postpartum" --new label

Birdie Gunyon Meyer, RN,MA,PMH-C

15

Myths of Motherhood

- Getting pregnant – Easy/hard
- 50% pregnancies are UNPLANNED
- Becoming a mother
- Being pregnant
- Labor & delivery
- Breastfeeding
- The baby will sleep all the time
- Perfectionism

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16

Myths of Motherhood (con't)

- Happy all the time
- Myths about the couple
- Media images

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17

MYTHS OF PREGNANCY

- All pregnancies wanted
- Pregnancy = live baby
- Pregnancy = love in relationship
- Pregnancy = healthy baby
- Pregnancy = fulfillment

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18

Pregnancy - Psychological & Physiological Changes

- “It’s all about me,” with little awareness of how much that will change
- Hormonal changes
- Prenatal classes
- Preparing for parenthood
- Dreams and expectations
- Not always happy, “glowing” time

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19

Postpartum - Psychological & Physiological Changes

- Focus on baby / forming attachment
- Fatigue / sleep deprivation
- Loss of freedom, control, and self-esteem
- Hormonal changes
- Birth not going as expected
- Learning new skills
- Role transitions
- Dreams and expectations

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20

Postpartum Psychological/Physiological Changes (Cont’d)

- Facing fears and feelings
- Renegotiating responsibilities and relationships
- Relying on support systems
- Insecurities about parenting abilities
- Establishing breast or bottle feeding
- Physical healing from labor/delivery

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21

Postpartum Psychological/Physiological Changes (Cont'd)

Feelings of Loss:

- Loss of freedom/ Feeling tied down
- Loss of an old identity
- Loss of control
- Loss of a body image
- Loss of self-esteem
- Loss of financial means
- Loss of image of career/career potential

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22

“In our lives, we have seasons of giving and seasons of receiving.... As a new parent, you are in the season of receiving.”

Birdie Gunyon Meyer, RN, MA, PMH-C

- PSI Past-President
- PSI Volunteer Coordinator: Indiana
- PSI Certification & Training Director

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23

A Variety of Perinatal Mood Disorders

- Depression
- Anxiety or Panic Disorder
- Obsessive-Compulsive Disorder
- Post-Traumatic Stress Disorder
- Psychosis
- Bipolar

These disorders can affect people at any time during their lives. However, there is a marked increase in prevalence of these disorders during pregnancy & the postpartum period.

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24

STUDY OF 10,000

21% had postpartum depression

- 26.5% of the episodes began before pregnancy with more chronic pattern
- 33.4% of the episodes had their onset during pregnancy
- 40.1% of the episodes began during the postpartum period

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

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25

STUDY OF 10,000

- 68.5% primary diagnosis was unipolar depression
- 66% with MDD had comorbid anxiety disorders, most commonly generalized anxiety disorder
- 22.6% of the women were diagnosed with bipolar disorder
- 19.3% of the women endorsed thoughts of harming themselves

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

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26

Postpartum “blues”:

Not a mild form of depression

- Features: tearfulness, lability, reactivity
- **Predominant mood: happiness**
- Peaks 3-5 days after delivery
- Present in 50-80% of women, in diverse cultures
- Unrelated to stress or psychiatric history
- Posited to be due to hormone withdrawal and/or effects of maternal bonding hormones

Miller and Rukstalis,

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27

Baby Blues: The Non-Disorder

- Affects 60-80% of new moms
- Symptoms include crying, feeling overwhelmed with motherhood, being uncertain, MILD
- Due to the extreme hormone fluctuation at the time of the birth
- Lasts no more than 2 days to 2 weeks
- Acute sleep deprivation
- Fatigue

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28

Depression Symptoms

- Sadness, crying
- Unexplained physical complaints
- Suicidal thoughts
- Appetite changes
- Sleep disturbances
- Poor concentration/focus
- Irritability and anger
- Hopeless and helpless
- Guilt and shame

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29

Perinatal Depression – Symptoms

- OVERWHELMED
- Lack of feelings toward the baby
- Inability to take care of self or family
- Loss of interest, joy, or pleasure
- Anxiety
- Isolation
- “This doesn’t feel like me”
- Mood swings
- Worthlessness

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30

Anxiety Symptoms

- Agitated
- Inability to sit still
- Excessive concern about baby's or her own health
- High alert
- Appetite changes- often rapid weight loss
- Sleep disturbances (difficulty falling/staying asleep)
- Constant worry
- Racing thoughts
- Shortness of breath
- Heart palpitations

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31

Panic Symptoms

- Episodes of extreme anxiety
- Shortness of breath, chest pain, sensations of choking or smothering, dizziness
- Hot or cold flashes, trembling, rapid heart rate, numbness or tingling sensations
- Restlessness, agitation, or irritability
- Excessive worry or fear
- Panic may wake her up

Beyond the Blues by Indman and Bennett (2019)

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32

Panic: Three greatest fears

- Fear of dying
- Fear of going crazy
- Fear of losing control

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33

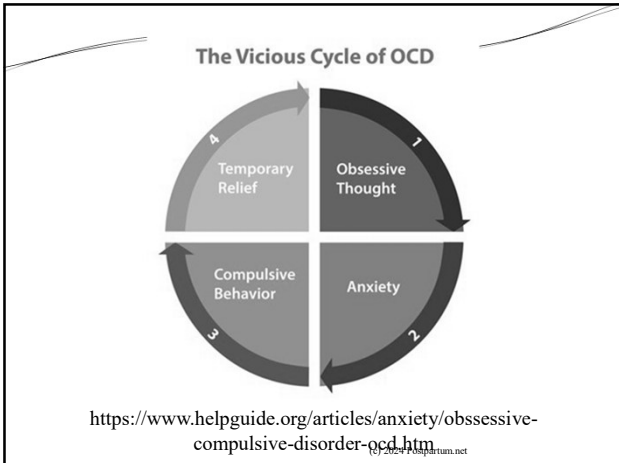
PERINATAL OBSESSIVE-COMPULSIVE DISORDER

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34

- ## OCD: Classic Symptoms
- Cleaning
 - Checking
 - Counting
 - Ordering
 - Obsession with germs, cleanliness
 - Checking on baby
 - Hypervigilance
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35



36

Perinatal Obsessive-Compulsive Disorder

- Intrusive, repetitive thoughts – usually of harm coming to baby (ego-dystonic* thoughts) (Abramowitz et al., 2010)
- Caught in a spiral of “What if” thinking
- Tremendous guilt and shame
- Horrified by these thoughts
- Hypervigilance
- Mothers **engage in behaviors to avoid harm** or minimize triggers

*Refers to thoughts, impulses, and behaviors that are felt to be distressing, unacceptable, or inconsistent with one's self-concept.

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37

“I’m a bad mom.”

- What if her neck snaps?
- I’m not fit to be her parent
- Maybe if I shake her she’ll stop crying
- I’m having sexual thoughts about her
- What if I drown her in the tub?
- What if I drop her?
- What if I accidentally hurt her
- She deserves a different mom
- I’m scared
- What if she dies?
- What if I fall down the stairs with her?
- Maybe if I scream she’ll shut up

@moomysmilk

38

Perinatal OCD: Common Presentations

- 41% Fears of Deliberate Harm
- 29% Contamination
- 18% Accidental Harm
- 6% Ordering/Arranging
- 3% Religious
- 3% Checking

(Challacombe, 2014)

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39

Exposure and Response Prevention (ERP)

- The “gold standard” for treatment of OCD
- Long term OCD treatment that specifically targets the source of a person’s obsessions by directly exposes them to it.
- Often incorporates Mindfulness and Acceptance Commitment Therapy
- Specialized training required (e.g., The Behavior Therapy Training Institute)
- NOCD Therapist Directory
- International OCD Foundation Therapist Directory

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40

Providers **must** ask about scary or unusual thoughts

Educate the individual that thoughts do not equal action

Thoughts are just thoughts

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41

OCD Thoughts of Harming Baby: Low Risk

- Parent does NOT want to harm the baby.
- The thought is obsessive in nature and odd/frightening to the individual
- Parent has taken steps to protect the baby
- **Parent has no delusions or hallucinations.**

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42

Psychotic Thoughts of Harming Baby: High Risk

- Parent has delusional beliefs about the baby (e.g., that the baby is a demon).

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43

Incorrect Diagnosis

- As many as half of primary care physicians may misidentify OCD, with 80% misidentifying harm obsessions. (Glazier, Swing & McGinn, 2015)
- Nearly 70% of health care practitioners did not accurately identify obsessions of harming the infant, and 30.8% misidentified these symptoms as psychotic. (Mulcahy et al., 2020)

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44



PERINATAL OCD SUPPORT FOR MOMS
Pregnant & Postpartum

1ST & 3RD TUESDAYS AT 8:30 P.M. (EST)

Our perinatal (pregnancy & postpartum) OCD group for moms is here to help those dealing with symptoms of OCD, like intrusive thoughts, obsessions and compulsions. Here you will connect with other moms, talk about your experience, and learn about helpful tools and resources. You do not have to have an official diagnosis to attend the group.

Held in partnership with the International OCD Foundation, this group is led by PSI-trained support group leaders who have lived experience. You are not alone. We are here to help.

Postpartum Support International | www.postpartum.net | 800.944.4773

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45



Perinatal Post Traumatic Stress Disorder

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46

What is PTSD?

An anxiety disorder after a terrifying event or ordeal in which grave physical harm occurred or was threatened.

“It’s in the eye of beholder”
Beck, CT (2004). Birth Trauma: In the Eye of the Beholder, Nursing Research, 53, 28-35.

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47

Birth Trauma

- An event occurring during the labor and birth process that can involve actual or threatened serious injury or death to the mother or her infant or the women being stripped of her dignity.
- Birth trauma can be both psychological and physical (Beck, 2015).
- The birthing person may experience intense fear, helplessness, loss of control, and horror. (Beck et al., 2013; Beck, 2004)
- The reported prevalence of PTSD due to birth trauma was 3% in community samples and 16% in high risk samples (Grekin & O’Hara, 2014)

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48

Potentially Traumatic Perinatal Events

- Emergency Caesarean delivery
- Postpartum Hemorrhage
- Prematurity or Stillbirth
- Unexpected NICU admission
- Forceps/Vacuum Extraction
- Severe Pre-eclampsia
- 3rd or 4th degree laceration
- Hyperemesis Gravidarum
- Traumatic Vaginal Birth
- Fetal anomaly diagnosis in pregnancy
- Witnessing partner's birth experience
- Shoulder dystocia
- Long labor process
- Failed pain medication or poor response to anesthesia

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49

Postpartum PTSD Themes

- **Perception of lack of caring**
feeling abandoned
stripped of dignity
lack of support and reassurance
- **Poor Communication**
Moms felt invisible
- **Feeling of powerlessness**
Betrayal of trust
Didn't feel protected by staff
- **Do the ends justify the means?**
Healthy baby justifies traumatic delivery???

Beck, CT (2004). Birth Trauma: In the Eye of the Beholder, Nursing Research, 53, 28-35.

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50

PTSD Due to Traumatic Perinatal Events: Potential Consequences

- Avoidance of postpartum care
- Impaired parental-infant bonding
- PTSD in partner who witnessed birth
- Sexual dysfunction
- Avoidance of further pregnancies
- Exacerbation in future pregnancies
- Elective cesarean births in future pregnancies
- Difficulties with breastfeeding
- Yearly anniversary of traumatic birth

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51


TRAUMATIC BIRTH

- Up to 34% of moms report a traumatic birth (Beck C. and S. Watson, Nursing Research July/August 2008 Vol 57, No 4, 228-236)
- Up to 9% of women met DSM-V criteria for PTSD
- Up to 18% showed high levels of postpartum PTSD symptoms (Beck C. et al. Birth. September 2011;38:3)

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52

SURVIVORS OF ABUSE



- Repugnance of blood/secretions
- Fear of unknown
- Body memories of abuse
- Fear of invasive procedures
- Hypervigilance
- Dissociation
- Increased risk PTSD, breastfeeding problems

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53

PTSD in NICU Parents

Risk factors

- neonatal complications
- lower gestational age
- greater length of stay in NICU
- stillbirth

Prominent symptoms

- intrusive memories of infant's hospitalization
- avoidance of reminders of childbirth

Beck CT. Recognizing and Screening for Postpartum in Moms of NICU infants. Adv Neonatal Care. 2003;3(1)

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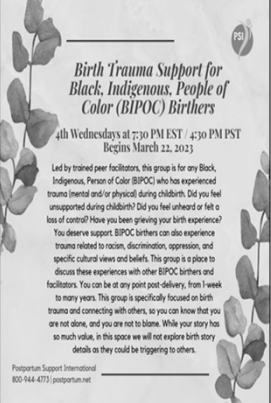
54

PTSD Websites

www.tabs.org.nz
www.solaceformothers.org
www.PATTCh.org
www.ican-online.org
www.homebirthcesarean.org
www.birthtraumaassociation.org.uk
www.HelpHer.org (Hyperemesis)

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55




Birth Trauma Support for Black, Indigenous, People of Color (BIPOC) Birthers

4th Wednesdays at 7:30 PM EST / 4:30 PM PST
Begins March 22, 2023

Led by trained peer facilitators, this group is for any Black, Indigenous, Person of Color (BIPOC) who has experienced trauma (mental and/or physical) during childbirth. Did you feel unsupported during childbirth? Did you feel unheard or felt a loss of control? Have you been grieving your birth experience? You deserve support. BIPOC birthers can also experience traumas related to racism, discrimination, oppression, and specific cultural views and beliefs. This group is a place to discuss these experiences with other BIPOC birthers and facilitators. You can be at any point post-delivery, from 1 week to many years. This group is specifically focused on birth trauma and connecting with others, so you can know that you are not alone, and you are not to blame. While your story has so much value, in this space we will not explore birth story details as they could be triggering to others.

Postpartum Support International
800-944-4773 | postpartum.net



Birth Trauma Support

View Schedule & Register:
[BirthTraumaSupportGroup](#)

Led by trained peer facilitators, this group is for any birthing person who has experienced trauma (mental and/or physical) during childbirth. Birth trauma is based on your perception of the experience, and no formal diagnosis is needed to join this group. Some common symptoms, but not all, that can occur after birth trauma are: repeating memories, avoiding talking about the event, and having negative thoughts/feelings about the event. You can be at any point post-delivery, from 1-week to many years. While your story has so much value, in this space we will not explore birth story details as they could be triggering to others. In this group, we will discuss the effects of trauma, our emotions, and coping skills.

Postpartum Support International
800-944-4773 | postpartum.net

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56

Maternal Mortality

“In 2020, 861 women in the US suffered complications during pregnancy or childbirth that proved fatal.”

“...and each year approximately 50,000 women suffer severe maternal morbidity factors that are near-fatal”
(CDC, 2020)

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57

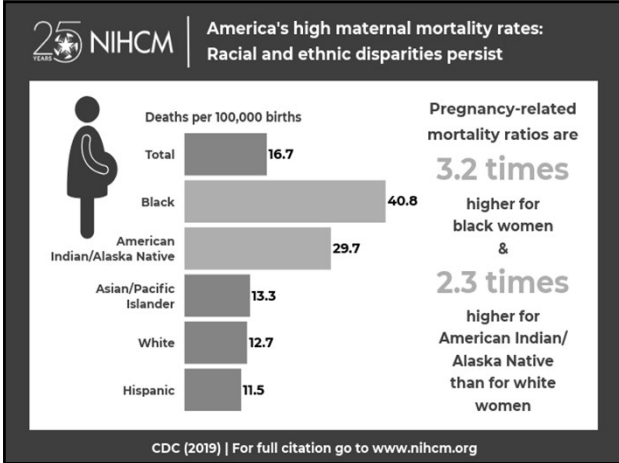
Maternal Near Miss Survivors

PSI FB Closed Group

- A maternal near miss is an event where an individual nearly dies due to pregnancy or childbirth related complications. The events are often unexpected and may leave the survivor isolated and alone. *(Kalhan et al., 2017)*
- A near miss is a trauma that may likely affect how a person responds to future pregnancies, labor and birth experiences.

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58



59

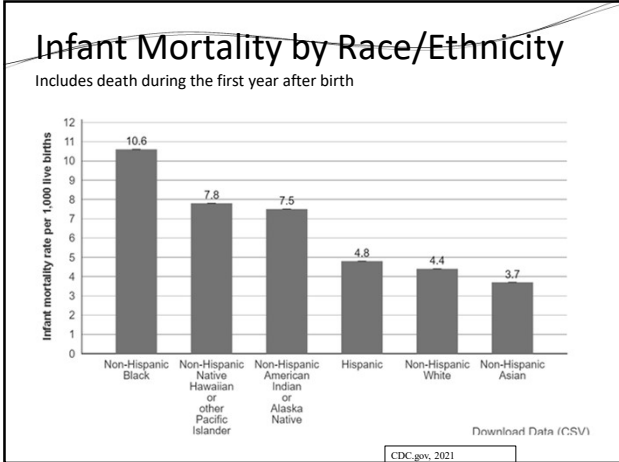
Blue Cross Blue Shield: The Health of America Report on Racial Disparities in Maternal Health

- Black mothers in the US are 4x more likely to die from maternity related complications compared to White mothers.
- The rate of severe maternal morbidity (SMM) in majority Black communities was 63% higher in 2020 than in majority White communities.
- Increased fears of seeking out medical/prenatal care, distrust in giving birth in hospitals.

<https://www.bcbs.com/>

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60



61

Perinatal Bipolar Disorders

22.6% of women who screened positive for postpartum depression had a bipolar disorder (*Wisner et al., 2013*)

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62

Perinatal Bipolar Disorders

- Over 69% misdiagnosed with unipolar depression (*Hirschfeld et al., 2003*)
- Over 30% suffered for 10 or more years with incorrect diagnosis (*Hirschfeld et al., 2003*)
- Bipolar Disorder is a chronic disorder, high rates of relapse, suicide, psychosocial dysfunction (*Jones et al., 2014; Viguera et al., 2007*)
- DSM-5 now recognizes that there can be peripartum onset of bipolar disorder (*Pope et al., 2014*)

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63

Bipolar I Disorder aka “Manic/Depressive”

A study with 89 pregnant women with Bipolar I Disorder:

- 60% of women with Bipolar Disorder present initially as depressed
- If prescribed antidepressant alone, might induce cycling into mania
- **50% of women with bipolar disorder are first diagnosed in the postpartum period** (Viguera et al., 2007)

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64

Bipolar II Disorder (Hypomania)

- The importance of taking a good psychosocial history!
- If you don't know about it, you won't look for it and you won't find it
- It is often referred to as the “PPD Imposter” as it often presents with depressive symptoms and can be resistant to SSRI medication (Phelps, 2016; Beck & Driscoll, 2006)

www.Psycheducation.org

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65

Bipolar Risk

- Type I or Type II Bipolar Mood Disorder pose a huge risk
- Psychosis occurs in 20% to 30% of women with known Bipolar Disorder (Monzon et al., 2014)
- 45-52% of women with Bipolar Disorder experienced a relapse or an exacerbation of symptoms during pregnancy (Viguera et al., 2007)
- 70% of women with Bipolar Disorder relapsed within the first six months postpartum (Sit et al., 2006; Bergink et al., 2015)

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66

BIPOLAR SUPPORT FOR
Perinatal
Moms & Birthing People

TO HELP PREGNANT AND POSTPARTUM PEOPLE NAVIGATING SYMPTOMS OF BIPOLAR, LIKE DEPRESSION "LOWS" AND MANIA "HIGHS".

Starting January 12th
on the 2nd & 4th Wednesday of the Month 5 PM ET / 8 PM ET



Postpartum Support International | postpartum.net | 800.944.4773 | @postpartumsupportinternational


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67

Bipolar Support for Perinatal
(PREGNANCY AND POSTPARTUM)
MOMS AND BIRTHING PEOPLE

Our perinatal (pregnancy & postpartum) bipolar support group for moms and birthing people is here to help those navigating symptoms of bipolar, like depression (lows) and mania (highs). Our online groups are here to help you connect with others, talk about your experience, and learn about helpful tools and resources. You do not have to have an official diagnosis to attend the group. These groups are led by PSI-trained support group leaders who have lived experience and/or professional experience. They understand the emotional challenges of pregnancy and postpartum as a mom or birthing person living with bipolar disorder. Our groups are conducted using a peer-to-peer support model, and are not intended for those experiencing a mental health crisis.

Please reach out to the National Suicide Prevention Lifeline (1-800-273-8255) if you are in need of crisis support.
You are not alone. We are here to help.



BIPOLAR SUPPORT FOR
Perinatal
Moms & Birthing People

TO HELP PREGNANT AND POSTPARTUM PEOPLE NAVIGATING SYMPTOMS OF BIPOLAR, LIKE DEPRESSION "LOWS" AND MANIA "HIGHS".

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View Schedule & Register: bit.ly/FindSupportGroup

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68

@psi_alianzaespanol

Encuentro

**SOBREVIVIENTE PP
Y DESORDEN BIPOLAR**

 **SEGUNDO JUEVES
DE CADA MES**

 **8:00 PM
HORA NY**


**Evento Online,
Confidencial y
Gratuito.**



Postpartum Support International en Español
800-944-4773 | postpartum.net

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69



Perinatal Psychosis

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70

Postpartum Psychosis is a Medical Emergency!

- 1-2 in 1,000 postpartum women will develop PPP.
- Psychosis occurs in 20% to 30% of women with known Bipolar Disorder (Monzon et al., 2014)
- Women experiencing postpartum psychosis are at higher risk of harming themselves or others (including their infant); however, it should be noted that the vast majority do not.
- No current research has been done on those statistics

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71

Risk Factors for Perinatal Psychosis

- First baby
- Discontinuation of mood stabilizer
- Obstetric complications
- Perinatal or neonatal loss
- Previous bipolar episodes, psychosis or postpartum psychosis
- Family history of bipolar disorder or postpartum psychosis
- Sleep deprivation

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72

Clinical Features	Postpartum Psychosis Symptoms
Onset	Usually within 2 weeks postpartum
Cognitive	Poor concentration, impaired sensorium*, disorientation
Behavioral	Agitated, hyperactive, emotionally distant, aloof, lack of self-care
Mood	Elated, labile, dysphoric or less often depressed
Speech	Rambling

*acute dysfunction in the brain
(Sit et al., 2006; Manzon et al., 2014)

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73

Clinical Features	Postpartum Psychosis Symptoms
Thought Content*	Thought broadcasting (thoughts can be heard by other) Ideas of reference (false beliefs that random events are directly related to the individual) Persecutory, jealousy, paranoia Of being controlled Delusion of grandiosity
Thought Process*	Disorganized thinking, flight of ideas
Perceptions*	Hallucinations; commanding auditory Organic (visual, olfactory, tactile)

*acute dysfunction in the brain
(Sit et al., 2006; Manzon et al., 2014)

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74

Postpartum Psychosis: Reducing Risk

- Women with Bipolar Disorder should remain on medication throughout the pregnancy to avoid postpartum relapse
- Initiate treatment immediately postpartum in women with a history of psychosis limited to the postpartum period
- Protecting good sleep is essential *(Bergink et al., 2012)*
- With an adequate treatment regimen, nearly all individuals experiencing postpartum psychosis achieve full remission *(Bergink et al., 2015)* and the majority achieve good functional recovery *(Burgerhout et al., 2017)*

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75

Action on Postpartum Psychosis (APP)

- <http://www.app-network.org/>
- Project run by women who have experienced PPP and academic experts from Birmingham and Cardiff Universities (Ian Jones, MD)
- Support, research, psychiatric services, public awareness

#PPTalk

Connect with others affected by Postpartum Psychosis



Click to visit the online forum

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76

Pregnancy & Postpartum Psychosis PPP Awareness Day

Held the First Friday in May

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77

Massachusetts General Hospital Postpartum Psychosis Project

- <https://www.mghp3.org/>
- For women who experienced an episode of psychosis within six months of giving birth within the past 10 years
- Study participation involves a telephone interview and providing a DNA sample with a saliva collection tube sent by mail
- The purpose of the study is to better describe the symptom pattern of postpartum psychosis and to examine the genetic contributions to risk for this disorder

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78

Virtual Rounds at the CWMH - MGH Center for Women's Mental Health (womensmentalhealth.org)

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79

PSI's Postpartum Psychosis Coordinators

- PSI has several **Postpartum Psychosis Coordinators** to provide additional assistance to women and families who are not in an emergency situation.
- www.postpartum.net/get-help/postpartum-psychosis-help/

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80

PP/PPP Taskforce

- PSI's Perinatal Psychosis Taskforce is a group of individuals with both learned and lived experience, whose mission is to support those affected by perinatal psychosis through advocacy, education, and community building.
- <https://www.postpartum.net/about-psi/perinatal-psychosis-task-force/>

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81

Online Support Group
Perinatal & Postpartum Psychosis

7:30 PM ET / 4:30 PM PT WEEKLY: EVERY MONDAY!

This group is to support those in recovery from PPP. You do not need a diagnosis to seek help & support! Join us! Register today.

Postpartum Support International | www.postpartum.net | 800.944.4773

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82

PREGNANCY AND POSTPARTUM PSYCHOSIS SUPPORT FOR SURVIVORS (MOMS & BIRTHING PEOPLE)

We invite those who are no longer in active psychosis and in recovery to join for support, so that you can experience connection and support from other Pregnancy and Postpartum Psychosis (PPP) Survivors. This group is intended for those who are in recovery (no longer experiencing psychosis). Because PPP occurs less often than other perinatal mood disorders, survivors can go their whole lives without meeting another PPP survivor. In response, PSI has created an online peer-to-peer support group for PPP survivors. Like so many mental health emergencies, symptoms and individuals vary greatly, but PPP is generally marked by a loss of touch with reality. This can include symptoms such as mania, hallucinations, paranoia, and/or delusions. If you are looking for more information on PPP, please visit this webpage. Whether your PPP experience was relatively recent or years ago, you are welcome to attend our free, online peer-to-peer support group. Our online groups are here to help you connect with other parents, talk about your experience, and learn about helpful tools and resources. If you are still experiencing psychosis or a mental health emergency, we encourage you to reach out to 988.

View Schedule & Register:
bit.ly/FindSupportGroup

Postpartum Support International | www.postpartum.net | 800.944.4773

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83

SUPPORT FOR FAMILIES TOUCHED BY PERINATAL & POSTPARTUM PSYCHOSIS

Perinatal and postpartum psychosis impacts the entire family. Supporting your loved one through a mental health crisis is taxing and you also deserve support. Led by PSI-trained facilitators, this group helps family members find support for themselves as well as provides useful information and resources to help them navigate their loved one's experience with PPP. Whether your family's PPP experience was relatively recent or occurred years ago, you are welcome to attend our free, online peer-to-peer support group.



VIEW SCHEDULE & REGISTER:
bit.ly/FindSupportGroup

Postpartum Support International | www.postpartum.net | 800.944.4773

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84

PSI Educational DVDs

Healthy Mom, Happy Family

- In English and Spanish
 - www.postpartum.net/resources/psi-educational-dvd/
 - Buy or watch online at www.vimeo.com/ondemand/postpartumvideo

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85

Consequences of Paternal PMADs

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86

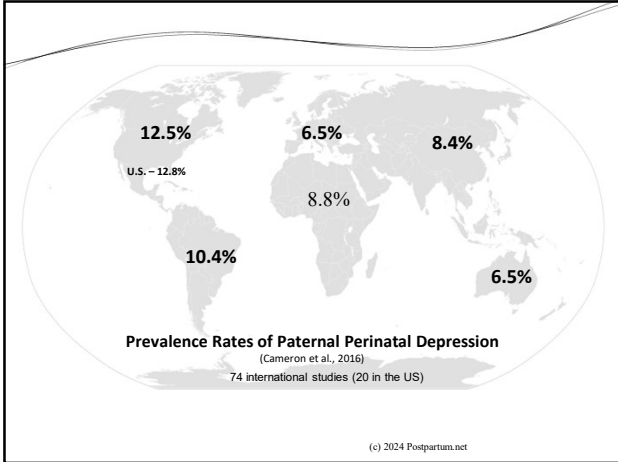
Fathers and Depression

- In national studies reported in 2006 and 2010, 10% of new fathers scored in the range of moderate to severe depression.
- Maternal depression increased the risk of paternal depression and was the strongest predictor of paternal depression even beyond the father's own history of depression.

(Paulson et al., 2006; Paulson & Bazemore, 2010)

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87



88

Depressive Symptoms in Fathers

- Fathers' depressive symptoms tend to spike between 3-6 months postpartum
- "Masked" Male Depression: Rather than sadness, men may increase substance use, be more likely to be irritable, aggressive, and hostile
- Distancing: "Checking Out;" increased self-isolation
- Distractions and Habits

(Singley & Edwards, 2015; Paulson et al., 2006)

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89

Possible Factors in Partner Depression

- Feeling burdened or trapped
- Financial responsibility felt as burden
- Feeling outside the circle of attention
- Missing sexual relationship
- Sleep deprivation
- Isolation and Loneliness
 - Partner is often closest friend
 - Poor social support network

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90

Support For Fathers

- PSI Dad's Chat with an expert on first Mondays at 8:00 p.m. Eastern
- Additional Father Resources
 - www.postpartumdads.org
 - www.postpartum.net/get-help/resources-for-fathers/
 - www.postpartum.net/get-help/resources-for-fathers/dads-mental-health/

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91

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92

Foundations in Paternal Perinatal Mental Health

2-day training

Foundations in Paternal Perinatal Mental Health | Postpartum Support International (PSI)

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93

Risks for Single Parents

- **Single Mothers:**
 - Maternal depression associated with higher risk of maltreatment, increased likelihood of unmet healthcare needs (*Barnhart & McGuire-Jack, 2016; Irvin, 2017*)
 - Perception of lack of quality childcare options associated with maternal depression (*Johnson & Padilla, 2019*)
 - Twice as likely as partnered mothers with children [ages 0-3] to report symptoms of depression, anxiety and parenting stress (*German study, Liang et al., 2019*)
- **Single Fathers:**
 - Single fathers had 3X mortality rate of single mothers, or partnered parents; more likely due to binge drinking, hypertension, and risk-taking behaviors (*Canadian study, Chiu et al., 2018*)

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94

LGBTQ+ Parent Experience

- Queer people's experiences of conception, birth and parenting are under-recorded and under-researched
- Research on pregnancy continues to be centered within heterosexual relationships (*Charter et al., 2018*)
- Numbers of LGBTQ+ people having babies is unknown in most countries due to universal data rarely being collected on the gender or sexual orientation of those who are pregnant or their partners (*HFEA, 2019*)

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95

Growing Populations

- In the UK, birth registrations identify that lesbian couples are one of the fastest growing groups within maternity services, with fertility treatment and live births including 15-20% in this group (*HFEA, 2019*)
- Pregnant trans men may also be a growing population with maternity services (*Riggs et al., 2016*)

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96

97

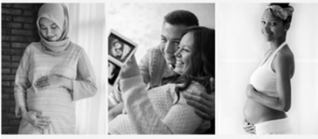
98

99

Postpartum Support International


Postpartum Planning Class

1st and 3rd Wednesday of Each Month




Is your family growing, and you're interested in learning how to prepare for the postpartum period? Join us for a 2-hour Postpartum Planning class for 2nd & 3rd trimester expecting parents. We welcome moms, birthing people, non-gestational parents, partners, couples, and single parents. Unlike most birth and postpartum classes, the intended focus is on the parents' emotional well-being during the postpartum period. The class will include education, discussion, a review of a postpartum plan, and resources. The main topics covered will be postpartum physical recovery, partner support, self-care, support networks, lactation and emotional well-being, and perinatal mood and anxiety disorders.

Scan here for more information!



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100



Screening for Perinatal Mood and Anxiety Disorders

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101

Why Should We Screen?

- You can't tell by looking
- High prevalence rate
- Effective screening and treatments are available
- Increases rate of detection
- Reduces relative risk of continued depression at 3-5 months by 18-59%
- Risks of untreated PMADs are well documented

(Learman, 2018; Gjerdingern & Yawn, 2007)

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102

Screening Links to Intervention

We know:

- Who is at risk
- How to screen
- That screening raises awareness
- How to engage preventive tools
- Reliable treatment methods
- Early detection can greatly reduce the duration and severity of symptoms

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103

Would Universal Screening Help?

- Despite recommendations from professional organizations, rates of perinatal mental health screening continue to be low; lack of validated screening instruments used *(Yeaton-Massey & Herrero, 2019)*
- There is public perception that OB/GYNs carry the most responsibility in screening; however, most OB/GYNs do not view themselves as most responsible to screen for PMADs *(Larsen, 2018)*

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104

Assessment by Pediatricians?

- Evaluation of PMADs at well-baby visits
- Fewer than one half of pediatricians (46%) attempted to identify maternal depression in a 2013 American Academy of Pediatrics Periodic (AAP) Survey *(Kerker et al., 2016)*

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105

Who Should Screen?

All healthcare professionals that have contact with pregnant or postpartum people and their partners, including:
Anyone who meets with childbearing families

Professionals listed around the central graphic include: Pediatricians, Home Visitors/Health Workers, Physician's Assistants, Pharmacists, Hospitals, Therapists, WIC Programs, Nurses, Licensed Clinical Social Workers, Childbirth Educators, Physicians, Lactation Consultants, OB/GYN Providers, Certified Nurse Midwives, Doulas, and Primary Care/Internal Medicine Providers.

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106

What is the Standard of Care?

Increasingly, pediatricians, family practitioners, and obstetricians agree screening and referral is important and should be done; however, there is no consensus or published algorithm on screening mothers for postpartum depression:

- **American Academy of Pediatrics:** to screen at 1, 2, 4, and 6 month visit
- **ACOG:** Screen patients at least once during the perinatal period. Screening for perinatal depression and anxiety occur at the initial prenatal visit, later in pregnancy, and at postpartum visits
- **Annals of Family Medicine:** Repeated PPD screening at 6 and 12 months postpartum

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107

PSI Recommendations for Screening

- First prenatal visit
- At least once in second trimester
- At least once in third trimester
- Six-week postpartum obstetrical visit (or at first postpartum visit)
- Repeated screening at 6 and/or 12 months in OB and primary care settings
- 3-, 9-, and 12-month pediatric visits

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108

PSI PMH Discussion Tool

- www.postpartum.net/resources/discussion-on-tool
- As many as 1 in 7 moms (1 in 10 dads) experience symptoms of depression and anxiety during the postpartum period. People of every age, income level, race and culture can develop Perinatal Mood and Anxiety Disorders (PMADs) during pregnancy and within the first year after delivery. This tool can help track your symptoms and discuss them with your healthcare provider.
- Being your own advocate is okay and you deserve to be well. Download or bring our discussion tool to your provider.
- If you would like to help us translate this tool, please contact communications@postpartum.net

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109

Evidence Based Screening Tools

The most well researched and validated perinatal measures:

- Edinburgh Postnatal Depression Scale
- Patient Health Questionnaire 9

Margaret Spinelli, Pec Indman, John Cox, Wendy Davis, and Birdie Gunyon-Meyer at the 2010 PSI-Marce Meeting

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110

Edinburgh Postnatal Depression Scale (EPDS)

- Most commonly used validated screening tool
- Cost effective - free to copy if original authors cited (located in back of manual)
- Designed for postpartum use, but can also be used in prenatal period
- Ten item self-report, easy to administer and score
- Validated with many cultures
 - Available in 60 languages
 - Cut off score varies by population/culture
- Validated with teens, fathers, pregnant women
- Screening for depression or anxiety disorders in fathers requires a two-point lower cut-off than screening for depression or anxiety in mothers, and we recommend this cut-off to be 5/6 (*Matthey et al., 2001*)

(Cox et al., 1987, 2014; Wisner et al., 2013; Chaudron et al., 2010)

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111

Edinburgh-Postnatal Depression Scale

Name _____ Baby's Birthdate _____

Today's Date _____

Please circle the answer that best describes how you have felt over the **past 7 days**.

<p>1. I have been able to laugh and see the funny side of things.</p> <p>0 As much as I always could 1 Not quite so much now 2 Not so much now 3 Not at all</p> <p>2. I have looked forward with enjoyment to things.</p> <p>0 As much as I ever did 1 Somewhat less than I used to 2 A lot less than I used to 3 Hardly at all</p> <p>3. I have blamed myself unnecessarily when things went wrong.</p> <p>0 No, not at all 1 Hardly ever 2 Yes, sometimes 3 Yes, very often</p> <p>4. I have been anxious or worried for no good reason.</p> <p>2 Yes, often 1 Yes, sometimes 0 No, not at all</p> <p>5. I have felt scared or panicky for no good reason.</p> <p>3 Yes, often 2 Yes, sometimes 1 No, not much 0 No, not at all</p>	<p>6. Things have been getting on top of me (too much for me)</p> <p>3 Yes, most of the time I haven't been able to cope at all 2 Yes, sometimes I haven't been coping as well as usual 1 No, most of the time I have coped well 0 No, I have been coping as well as ever</p> <p>7. I have been so unhappy that I have had difficulty sleeping.</p> <p>3 Yes, most of the time 2 Yes, sometimes 1 Not very often 0 No, not at all</p> <p>8. I have felt sad or miserable.</p> <p>3 Yes, most of the time 2 Yes, quite often 1 Not very often 0 No, not at all</p> <p>9. I have been so unhappy that I have been crying.</p> <p>3 Yes, most of the time 2 Yes, quite often 1 Only occasionally 0 No, never</p> <p>10. The thought of harming myself has occurred to me.</p> <p>3 Yes, quite often 2 Sometimes 1 Hardly ever 0 Never</p>
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(Gib, J.L., et al. Detection of postnatal depression: development of the 10-item Edinburgh-Postnatal Depression Scale. *British Journal of Psychiatry* 1982; 150:782-786)

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112

Severity Ranges for the EPDS

- None or minimal depression (0-6)
- Mild depression (7-13)
 - Cutoffs may vary between 10-12
- Moderate depression (14-19)
- Severe depression (19-30)
- Consider score along with the assessment of the health care provider

(McCabe-Beane et al., 2016)

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113

Patient Health Questionnaire (PHQ-9)

- Nine item self report questionnaire
- Useful for broad range of patients developed for Family Practitioners
- Easy to score
- Validated for prenatal use
- Correlates with DSM 5 diagnoses
- Multiple languages available

(Kronk et al., 2001; Sidebottom et al., 2012)

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114

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "0" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

File name: PHQ-9-0-1-2-3-4-5-6-7-8-9 *Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

115

PHQ-4

Over the past 2 weeks have you been bothered by these problems?

	Not at all	Several days	More days than not	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3

The thought of harming myself has occurred to me (circle one) No Yes

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116

Shortened Versions

Assessing for anhedonia and major depression only

PHQ-2 - Short Version – Over the past 2 weeks, how often have you been bothered by any of the following problems?

- Little interest or pleasure in doing things
 - 0=Not at all
 - 1=Several days
 - 2=More than half the days
 - 3=Nearly every day
- Feeling down, depressed, or hopeless
 - 0=Not at all
 - 1=Several days
 - 2=More than half the days
 - 3=Nearly every day

EPDS-2 - Short Version – Please underline the answer that comes closest to how you have felt in the past 7 days.

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

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117

Brief Screening Tools

- EPDS-2 is highly accurate at identifying postpartum depression among adolescent mothers *(Venkatesh et al., 2014)*
- PHQ 2 has the highest sensitivity of all the screening tools *(Ukatu et al., 2018)*
- Important to note that neither of these brief measures assess for suicidal ideation

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118

Postpartum Depression Screening Scale (PDSS)

- Thirty-five item, 5 point Likert scale
 - First 7 questions are short form
 - If score is > 14, long form should be completed
- Can be completed in 5 to 10 minutes
- Written at a 3rd grade reading level
- Used after two weeks postpartum
- Available in English and Spanish

- Seven Subscales
 - Sleeping and eating disturbances
 - Anxiety and insecurity
 - Emotional lability
 - Cognitive impairment
 - Loss of self
 - Guilt and shame
 - Contemplating self harm

(Beck & Cable, 2001)

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119

Postpartum Depression Screening Scale (PDSS)

- Time efficient, a more thorough measure of symptoms
- Validated for telephone screening
- Hungarian and Portuguese perinatal versions studied
- Translated into Chinese with excellent properties *(Zhao et al., 2015)*
- Excellent consistency and good reliability for use with mothers carrying babies with fetal anomalies *(Cole et al., 2016)* and in the NICU population *(McCabe et al., 2012)*

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120

Underdiagnosed Bipolar I Disorder

- 22% of women who screened positive on the EPDS at ≥ 10 had a diagnosis of Bipolar I Disorder according to the Structured Clinical Interview for DSM 5 (SCID; Wisner et al., 2013)
- 50% of women with “treatment resistant” postpartum depression suffered from Bipolar I Disorder (Mandell et al., 2016; Sharma et al., 2008)

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121

Bipolar Screening

- Mood Disorder Questionnaire (MDQ) (Hirschfeld et al., 2000)
- Addition of the MDQ + EPDS improved the distinction of unipolar depression from bipolar depression at the level of screening in 50% of women with traditional MDQ scoring
- And by nearly 70% when the MDQ was scored without the impairment criterion (Clark et al., 2016)

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122

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

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 good or so hyper that other people thought you were not your normal self or you were so hyper 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 self-confident than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you got much less sleep than usual and found that you didn't really miss it?	<input type="checkbox"/>	<input type="checkbox"/>
...you were more talkative or spoke much faster than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...thoughts raced through your head or you couldn't slow your mind down?	<input type="checkbox"/>	<input type="checkbox"/>
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	<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 social or outgoing than usual, for example, you telephoned 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 risky?	<input type="checkbox"/>	<input type="checkbox"/>
...spending money got 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?	<input type="checkbox"/>	<input type="checkbox"/>

3. How much of a problem did any of these cause you - like being unable to work, having family, money or legal troubles, getting into arguments or fights?

No problems Minor problem Moderate problem Serious problem

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123

**Screening
≠
Treatment**

“It’s only a piece of paper... It’s about education and referral and treatment.”

Wendy N. Davis, PhD, PMH-C
PSI Executive Director

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124

**Suicide Risk and
Safety Assessment**

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125

Ask questions...clarify

“Oftentimes, the main difference between the mother who kills herself and the one who doesn’t is whether it’ll be better for the baby. The thing that raises the hair on the back of my neck is the woman who tells me she thinks her baby will be better off without her. She is at very high risk for suicide.”

(Raskin & Kleiman, 2013)

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126

1 IDENTIFY RISK FACTORS
Note those that can be modified to reduce risk

2 IDENTIFY PROTECTIVE FACTORS
Note those that can be enhanced


3 CONDUCT SUICIDE INQUIRY
Suicidal thoughts, plans behavior and intent

4 DETERMINE RISK LEVEL/INTERVENTION
Determine risk. Choose appropriate intervention to address and reduce risk

5 DOCUMENT
Assessment of risk, rationale, intervention and follow-up

National Suicide Prevention Lifeline
1.800.273.TALK (8255)

Crisis Text Line:
Text HOME to 741741
988



<http://www.integration.samhsa.gov/clinical-practice/screening-tools>

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127

Suicide Risk Factors in Pregnancy

- Pregnant women are more likely than the general population to endorse suicidal ideation
- Suicide risk increases when:
 - Pregnancy is unwanted, especially when the individual wanted an abortion but could not obtain one
 - Issues of intimate partner violence
 - <12 years education
 - Prior pregnancy loss and/or death of children
 - Psychiatric illness (e.g., major depression) or medication stopped abruptly

(Paladino et al., 2011; Thornton, et al., 2013; Fuhr et al., 2014; Gelaye et al., 2016)

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128

Responding to Suicide Risk

- What is a "positive" screen?
 - EPDS question #10: "The thought of harming myself has occurred to me."
 - PHQ-9 question #9: "Thoughts that you would be better off dead..."
 - If answered with anything other than 0, provider must follow up to assess threat
- How to respond to a positive screen? Assess, refer, and follow-up
 - Always proceed with same-day more comprehensive Suicide Risk Assessment
 - Document all interactions, recommendations provided, and safety plan
- Consider using the Columbia Suicide Severity Rating Scale
 - Free Online Training for Communities and Healthcare Providers (Csr.s.Columbia.edu)

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129

When a Client is Unsafe

- First priority is safety; consider hospitalization.
- Talk with colleagues/team for assessment but trust your instincts.
- Advise client and family that it is your job to ensure safety.
- In an emergency, you do NOT need patient consent to contact their others.
 - Can you find somebody to take care of the baby and the other children?
 - Instruct others that individual is not to be left alone
- When you cannot assure yourself that children are safe:
 - You can call CPS and ask for consultation without identifying information.

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130

Send to Emergency Department or Call 911

- Suicidal or homicidal ideation with active plan and/or intent
- Acute mania
- Psychosis (hallucinations, delusions, incoherence)
- Remember: intrusive thoughts are just thoughts, not intent.
- Call Emergency Department directly to facilitate psychiatric evaluation and/or inpatient admission (e.g., calling in “an expect”)

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131

Screening

EDUCATION !!!

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132

Complications of Pregnancy

- Gestational Hypertension 6-8%

- Gestational Diabetes 6-8%

- Pre-eclampsia 6%
NIH/National Heart, Lung, and Blood Institute
Nhlbi.nih.gov

- PMADs 21%
Wisner KL, Sit DKY, McShea MC, et al. *JAMA Psychiatry* March 2013

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133

It's Not All About Hormones . . . Risk Factors For Perinatal Mood Disorders

- Biological / Physiological
- Psychological
- Social / Relationship

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134

Evidence Based Risk Factors

- **Previous PMDs**
 - Family History
 - Personal History
 - Symptoms during Pregnancy

- **History of Mood Disorders**
 - Personal or family history of depression, anxiety, bipolar disorder, eating disorders, or OCD

- **Significant Mood Reactions to hormonal changes**
 - Puberty, PMS, hormonal birth control

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135

Evidence Based Risk Factors

- **Endocrine Dysfunction**
 - Hx of Thyroid Imbalance
 - Other Endocrine Disorders
 - Decreased Fertility
 - Diabetes
- **Social Factors**
 - Inadequate social support
 - Interpersonal Violence
 - Financial Stress/Poverty
 - Recent Loss or Move
- **High Stress Parenting**
 - Military Families
 - Teen Parents
 - Parents of Multiples
 - Single Parents
 - Black and Indigenous families
 - Temperament of baby

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136

Exacerbating Factors for PMADs

- Complications in pregnancy, birth, or breastfeeding
- Age-related stressors
 - Adolescence
 - Perimenopause
- Climate Stressors: Seasonal Depression or Mania
- Perfectionism/high expectations/“Superwoman syndrome”

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137

Possible Exacerbating Factors

- Pain (Inflammation)
- Lack of sleep
- Abrupt discontinuation of breastfeeding
- Childcare stress/Relationship Stress
- Losses-miscarriage, neonatal death, stillborn, selective reduction, elective abortion
- History of childhood sexual abuse

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138

Possible Exacerbating Factors

- Culture Shock—career vs motherhood
- Unresolved grief or attachment with Mother
- Returning to work

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139

Ruling Out Other Causes

- Thyroid or pituitary imbalance
- Anemia
- Trauma
- Side effects of other medicines
- Alcohol or drug use

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140

FREQUENT SYMPTOMS IN PRACTICE

- Review of 133 women (Beck C and Indman P., JOGNN, Sept/Oct 2005;34(5):569-576)
1. “felt really overwhelmed”
 2. “felt like my emotions were on a rollercoaster”
 3. “have been very irritable”
 4. “felt all alone”
 5. “felt like I wasn’t normal”

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c. 2023 PSI

141

Treatment Options Critical Components to Recovery

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142

PSI Motto

- **You are not alone (validation)**
 - Other mothers experience this
 - Connection and support will help you
- **You are not to blame (reassurance)**
 - This is not something you caused
 - This is not a reflection of your ability as a mother (or father)
- **With help, you will be well (hope)**
 - All symptoms are treatable
 - It is a sign of strength to reach out
 - It will get easier

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143

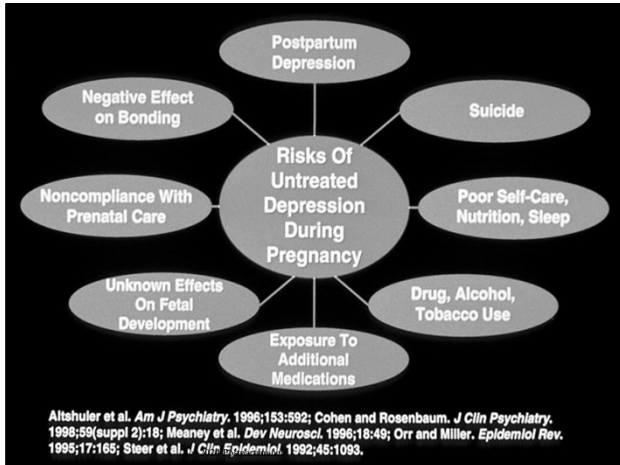
Why Is Understanding Untreated Perinatal Illness So Important?

Has significant impact on the mother, fetus, child, father/partner, family and society.

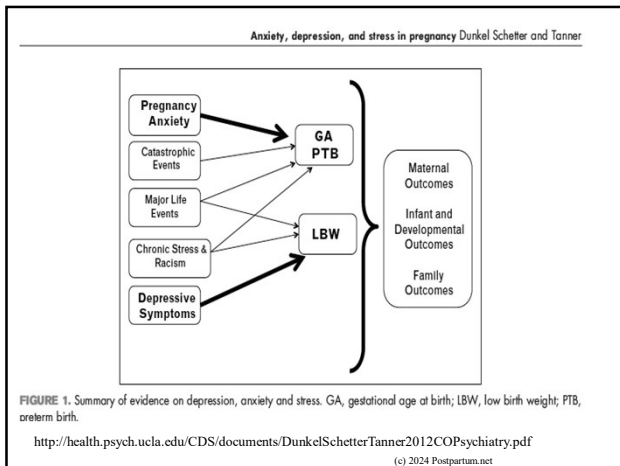
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144



145



146

Women and their Partners should make an informed decision regarding breastfeeding

- Community benefits
- Benefits to Mother
- Benefits to Infant
- Benefits to Family

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147

“The decision to breastfeed is not, however, always so simple, especially for women who suffer from depression and are taking psychotropic medications”

Pregnancy Blues – Shaila Misri, M.D.

(c) 2024 Postpartum.net

148

Three Choices . . .

- 1) Expose the baby to medication through the breast milk.
- 2) Expose the baby to the adverse effects of untreated depression in the mother
- 3) Take antidepressant medications and don't breastfeed the baby

Pregnancy Blues – Shaila Misri, M.D.

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149

Breastfeeding and PMD

- It may be the only thing that she feels good about
- DO NOT tell her she can't breastfeed with PPD
- If she wants to wean, DO NOT let her wean abruptly
- Delayed PPD due to cessation of breastfeeding

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150

Supporting Choice Around Breastfeeding

“Providing support, information, and encouragement to nurse (breastfeed) is half of the clinician’s responsibility..”

“...Letting women know that they have the right to choose not to breastfeed without guilt or judgment is the other equally important half.”

(Beck & Watson, 2008)

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151

Breastfeeding Resources for Black Mothers

- Black Mother’s Breastfeeding Association
- Facebook Groups:
 - Black Moms Breastfeeding Support Group
 - Black Pumping Mamas
 - Milk Like Mine
 - Normalize Breastfeeding
 - Black Women Do Breastfeed
 - Black Moms Breastfeed
 - Black Breastfeeding Mamas Circle

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152

Breastfeeding Resources for Non-Binary Gender Nonconforming and Trans Chestfeeding Individuals

- La Leche League: Transgender & Non-Binary Parents
- Facebook Groups:
 - Birthing and Breast or Chestfeeding Trans People and Allies
 - Queer Liquid Gold

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153

Apps for Breastfeeding and Medication

- **Mother to Baby:** Organization of Teratology Information Specialists (OTIS)
- **Infant Risk:** Mommy Meds free, InfantRisk Center Health Care Mobile Resources (\$9.99)
- **LactFacts:** Institute for the Advancement of Breastfeeding and Lactation Education (IABLE)

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154

Resources for Medications in Pregnancy and Breastfeeding

- **MotherToBaby:** <https://mothertobaby.org/>
866-626-6847
- **InfantRisk Center:** <https://www.infantrisk.com/>
806-352-2519
- **Ammon-Pinizzotto Center for Women's Mental Health at Massachusetts General Hospital:**
<https://womensmentalhealth.org/>
- **Reprotox:** <https://reprotox.org/>
- **LactMed Drugs and Lactation Database:**
<https://www.ncbi.nlm.nih.gov/books/NBK501922/>
- **E-Lactancia:** <http://www.e-lactancia.org/>
- **Toxicology Data Network (TOXNET):**
<https://www.nlm.nih.gov/toxnet/index.html>

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155



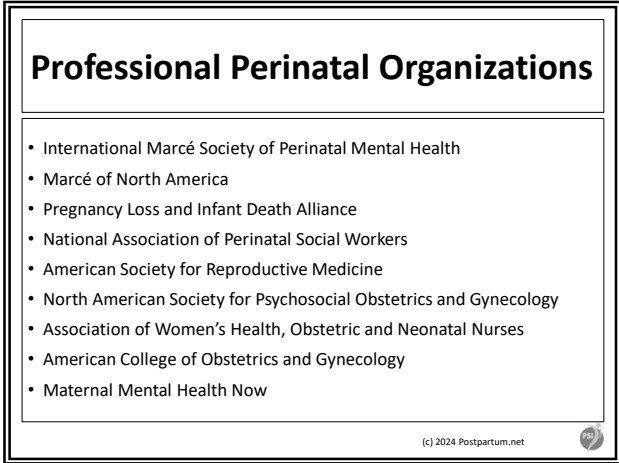
Professional Resources

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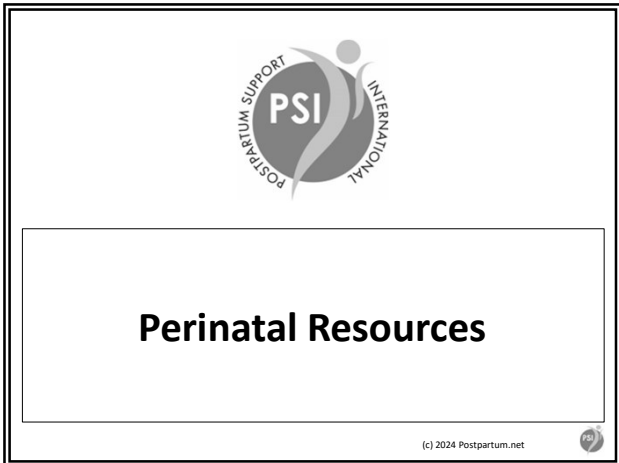
156



157



158




159

PSI App
“Connect by PSI”


Download the app

Connect with PSI for:


- ✓ Community at your fingertips
- ✓ Instant access to HelpLine/hotline
- ✓ Directory of trained providers




Connect by PSI




Download on the App Store



GET IT ON Google Play

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160



Get Help


Call the PSI HelpLine:
1-800-944-4773
#1 En Español or #2 English


Text “Help” to 800-944-4773 (EN)
Text en Español: 971-203-7773

GET HELP

Web Suicide & Crisis Helpline National Maternal Mental Health Hotline (24/7 only)
*The PSI HelpLine does not handle emergencies. People in crisis should call their local emergency number or the National Suicide Prevention Hotline at 1-800-273-TALK (1525).




Resources for Families




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161

National Maternal Mental Health Hotline
1-833-852-6262
1-833-TLC-MAMA

- National MMH Hotline launched by HRSA; PSI is the Contractor
- 24/7/365; Call or Text
- English & Spanish; other languages by request
- Staffed by licensed mental health and healthcare clinicians, certified peer specialists and childbirth professionals

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162

PSI Support Coordinators

- Provide education, empathy, and resource referrals to those seeking support related to PMH.
- Respond within 24 hours.
- Provide appropriate referrals for further help, including PSI Programs.
- Join us! To see areas of need and apply, visit PSI's Get Involved section:
<https://www.postpartum.net/join-us/volunteer/supportcoordinator/>

<p>Support (local) Coordinators</p> <p>Provide general PMHD support to those in their community.</p> <p>Share local resources to support Perinatal Mental Health. (PMH-trained therapists, psychiatric providers, doulas)</p> <p>Refer to Specialized Coordinators when helpful.</p>	<p>Specialized Coordinators</p> <p>Support focused on specific conditions, roles, experiences related to potential increased PMHD risk. <i>(examples on next slide)</i></p> <p>Not bound by location –resources related to their area of specialization. For local resources, PSI will connect with the help seeker's nearest Support Coordinator.</p>
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163

Specialized Coordinators

ADHD, Parents with Adoptive Parents Advanced Maternal Age Babies with Special Needs Bed Rest Birth Mothers Birth Trauma Breast-/Body-Feeding Challenges Christian Parents Dads Disabled Parents Eating Disorders Fertility Challenges Foster Parents	Gestational Surrogates & Intended Parents Grandparents Hard of Hearing/deaf Parents Hindu Parents Hyperemesis Gravidarum LGBTQIA+ Maternal Near Miss Military Parents (each branch) Multiples, Parents of Muslim Parents Neurodivergent Parents NICU Parents OCD, Parents with Orthodox Jewish Parents	Perineal Tear Post Abortion Postpartum Psychosis Preeclampsia & Long-Term Complications Pregnancy and Infant Loss Pregnancy and Infant Loss: Early Loss & Pregnancy After Loss Pregnancy and Infant Loss: Stillbirth Pregnancy Termination for Medical Reasons PTSD Single/Co-parents South Asian Parents Teen/Young Adult Parents Unplanned C-Section
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164

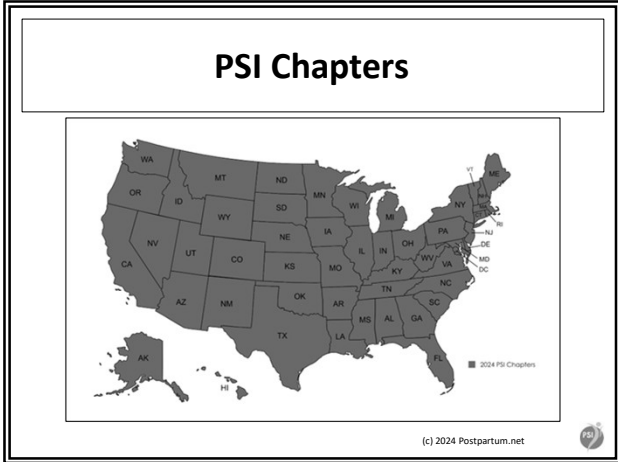
International Support

- List of PMH-focused Organizations on PSI website
- International Volunteers and PSI Team assist parents to find local resources

Australia Bermuda Botswana Czech Republic Dominican Republic of the Congo Egypt France Germany Ghana Greece Haiti India Indonesia Ireland	Italy Japan Jordan Kenya Latvia Lithuania Malaysia Netherlands New Zealand Nigeria Poland Portugal Romania Saudi Arabia Singapore	Slovakia South Africa Switzerland Taiwan/Indonesia Tanzania Trinidad and Tobago Turkey Ukraine United Kingdom United Kingdom - Ireland United Arab Emirates Zimbabwe
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165



166

PSI USA Chapters Program

PSI Chapters further the mission of PSI on a state/local level:

- Each state/territory is unique with its own systems, barriers to care and opportunities
- By providing the structure and support of the Chapters Program, PSI empowers advocates to create change in their own state
- Chapter leaders work to **build community, raise awareness, create resources, and advocate for change**

We have chapters in all states, as well as Washington DC!

If you are interested in connecting with your local chapter, please contact chapters@postpartum.net

<https://psichapters.com/>

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167

PSI Provider Directory
<https://psidirectory.com/list-your-practice>

Share with Families + List Your Practice

US and Canada Providers apply and approved by PSI

Integrated with PSI Support Network

Psychotherapists
 Psychiatry
 Physicians
 Support Groups
 PMH-Cs

Postpartum Support International | www.postpartum.net | 800.944.4773

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168

There are 29 statewide and regional Perinatal Psychiatry Access Programs with the potential to cover 2.5 million or 68% of the 3.7 million births in the US



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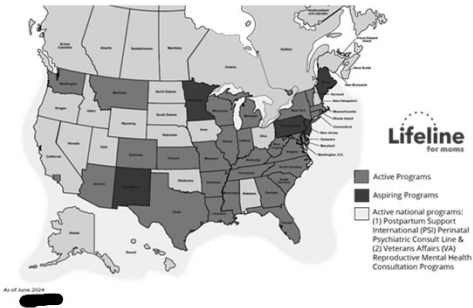
169

These and other Access Programs have come together as a network



170

These and other Access Programs have come together as a network




171


The Climb®
www.postpartum.net/join-us/climbout/

The world's largest event raising funds and awareness for mental health of new families.

- Trained Climb Leaders lead local events
- Events hosted in the summer & fall
- Fundraised approx. \$400,000 in 2023
- Funds divided equally between PSI & State Chapters
- Participants who fundraise \$100 can earn a t-shirt
- Survivors, providers, friends, and family participate
- Connection, community-building, resource-sharing




Find a Climb Near You:



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172

Support for Parents



Peer Support Services

Helpline

- Toll-free number that anyone can call or text
- Available 24/7 for information, support, & resources
- Available in-person at select locations
- Available in Spanish & English
- Available by appointment or drop-in
- Free
- Confidential & not reported unless you report

Online Support Groups

- Free weekly online support groups on various topics
- Free and facilitated either peer-led or staff support
- Open to all ages
- Available in-person at select locations
- Free
- Confidential & not reported unless you report

Chat with an Expert

- Free live phone support offered 24/7
- No registration required, limited hours of service
- Free live support for mental health professionals
- Connect with other parents, ask questions, & get information on local resources

Support Coordinators

- Provide education, referrals, and resources either in-person or via phone/text
- Local DPs have had to know all resources in their geographic area
- Available in-person at select locations
- Available 24/7 via phone
- Provide support for a variety of topics related to pregnancy, birth, or postpartum

Social Media Groups

- PSI offers resources, videos, for support & peer education
- PSI Daily Check-Ins provide support & peer education
- Available on Facebook, Instagram, and Twitter
- Available in-person at select locations
- Available 24/7 via phone
- Provide support for a variety of topics related to pregnancy, birth, or postpartum
- Available in-person at select locations

Peer Mentor Program

- Free one-on-one support offered 24/7
- Available in-person at select locations
- Available 24/7 via phone
- Available in-person at select locations
- Available 24/7 via phone
- Available in-person at select locations

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173



PSI
 POSTPARTUM SUPPORT INTERNATIONAL
PEER MENTOR PROGRAM

For more information visit:
www.postpartum.net/peer-mentor-program

Postpartum Support International | www.postpartum.net | 800.944.4773

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174

PSI Closed Facebook Group

- 22,000 members
- 10 trained PSI Volunteer Moderators and Staff
- A safe space for sufferers and survivors to share, normalize and comfort one another
- Moderators monitor the discussion, review member requests and comments prior to posting, and handle emergency situations when they arise
- <https://www.facebook.com/groups/25960478598>

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175

Closed Facebook Group for Dads

- PSI has a closed Facebook Group for dads, where members can get a lot of great support and information from other dads.
- <https://www.facebook.com/groups/682525349518226>

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176


PSI
Facilitated
Virtual
Peer
Support
Groups




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177



Resources for Providers

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181

PSI Member benefit highlight


Professional Peer Consultation Groups

Included in PSI membership

Meet with other providers to improve knowledge and skills relating to the treatment of perinatal mood and anxiety disorders, birth trauma and perinatal loss.

Peer Consultation groups for:


- **Mental health providers** (in English and in Spanish, and a group for BIPOC providers)
- **Prescribers** (facilitated by reproductive psychiatrists)
- Stay tuned for additional groups in development, including one for doulas!

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182

Medical Provider Training

- For Medical Providers — Obstetricians/Gynecologists, Family Practice Physicians, Internists, Nurse Practitioners, Midwives, Physician Assistants, Nurses
- The CME training, provided by PSI experts, is designed to equip frontline providers with the skills necessary to assess patients for perinatal mental health complications and, as appropriate, provide treatment or connect individuals with additional resources and care.
- Available as either a single-day, onsite, 6-hour course or via two 2-hour-long on demand recorded webinars.
- Continuing Education Credits: CMEs, CNEs
- [Perinatal Mental Health Training for Medical Providers - Postpartum Support International \(PSI\)](#)

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183




POSTPARTUM SUPPORT INTERNATIONAL
**PERINATAL
 PSYCHIATRIC
 CONSULT LINE**

877.499.4773

A free consultation line for medical professionals with questions about the mental health care of pregnant, postpartum, and pre-conception planning patients. Call today to speak with one of our expert reproductive psychiatrists.


This service is available for medical providers only.



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184


Perinatal Mental Health Alliance for People of Color (PMHA-POC)



Vision: To provide a safe space for clients, families, and professionals of color around perinatal mental health. Every person of color will be heard and supported around perinatal emotional wellness.


<https://www.postpartum.net/professionals/perinatal-mental-health-alliance-for-people-of-color/>

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185


Alianza de Salud Mental Perinatal para Personas de Color (PMHA-POC, por sus siglas en inglés)



Visión: Proporcionar un espacio seguro para los clientes, las familias y los profesionales de color en torno a la salud mental perinatal. Todas las personas de color serán escuchadas y apoyadas en torno al bienestar emocional perinatal.


<https://www.postpartum.net/la-alianza/>

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186

The Blue Dot Project



TheBlueDot
p.r.o.j.e.c.t

PSI


TheBlueDotProject is program of Postpartum Support International

The blue dot is the symbol of perinatal mental health survivorship, support, and solidarity.

The Purpose of TheBlueDotProject


- Raise awareness of perinatal mental health disorders
- Proliferate the blue dot as the symbol of solidarity and support
- Combat stigma and shame

Learn more




TheBlueDotProject.org

Let's make the blue dot as recognizable as the pink ribbon is for breast cancer.




Get your blue dot




Shop

BlueDot Ambassadors


BlueDot Ambassadors serve as the "boots on the ground" advocates to help proliferate the blue dot symbol and spread awareness surrounding perinatal mental health.



Sign up





The official host of:



Maternal Mental Health AWARENESS WEEK

A global mental health event for the week of May





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187

PSI Legal Justice Program

- <https://www.postpartum.net/about-psi/legal-justice/>
- Video: Advice For Lawyers - Postpartum Mental Illness and the Criminal Justice System
<https://vimeo.com/253536312>




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188

Primary Care Toolkits


- **ACOG Perinatal Mental Health Toolkit**
<https://www.acog.org/topics/perinatal-mood-and-anxiety-disorders>
- **McPAP for Moms – OB Provider and Ped Provider Toolkits**
<https://www.mcpapformoms.org/Toolkits/Toolkit.aspx>

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189



PSI Educational Materials

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190

PSI Public Awareness Posters








www.postpartum.net/resources/psi-awareness-poster/


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191

PSI Educational Fliers and Posters English and Spanish

<https://postpartum.app.neoncrm.com/np/clients/postpartum/catalog.jsp?catalog=1>

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192

PMH Flyer

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196

PSI Educational DVDs

Healthy Mom, Happy Family

- In English and Spanish
- www.postpartum.net/resources/psi-educational-dvd/
- Buy or watch online at www.vimeo.com/ondemand/postpartumvideo

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197

PSI Social Media

- **PSI Facebook Open Page:** <https://www.facebook.com/PostpartumSupportInternational/>
- **PSI Facebook Closed Group:** www.facebook.com/groups/25960478598/
- **X (twitter):** <https://x.com/PostpartumHelp>
- **Instagram:** <https://www.instagram.com/postpartumsupportinternational/>
- **TikTok** <https://www.tiktok.com/@postpartumhelp>
- **Vimeo:** <https://vimeo.com/postpartumsupport>
- **YouTube Channel:** <https://www.youtube.com/user/postpartumvideo>
- **LinkedIn:** www.linkedin.com/company/postpartum-support-international
- **I Am One Podcast**

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198

PSI en Español
www.postpartum.net/en-espanol/

Únase a PSI en nuestras nuevas cuentas de redes sociales en Español:

Instagram: https://www.instagram.com/psi_alianzaen espanol/

Facebook: <https://www.facebook.com/psialianzaen espanol/about>

Closed Spanish FB group: <https://www.facebook.com/groups/595053181756279>

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199

Videos





- **PSI Educational DVDs (promo/trailer):**
 - <https://vimeo.com/ondemand/postpartumvideo>
- **PSI Public Service Announcements:**
 - www.postpartum.net/news-and-blog/publicserviceannouncements/

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200

PSI Bookstore

- Check out the PSI Bookstore for highly recommended perinatal books, PSI gear, and more!
- www.postpartum.net/resources/store/
- PSI members receive 25% off of Springer Publishing books and journals.



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201

Professional Development
Training | Postpartum Support International (PSI)
<https://www.postpartum.net/training/>

- **PSI and Policy Center Online MMH Certificate Course:**
 - www.postpartum.net/professionals/trainings-events/mmh-online-certificate-course/
- **Two-Day Perinatal Mood and Anxiety Disorders Training:**
 - www.postpartum.net/professionals/psi-certificate-training/
- **Advanced PMH Psychotherapy:**
 - www.postpartum.net/professionals/trainings-events/psi-advanced-psychotherapy-trainings/
- **Advanced PMH Psychopharmacology:**
 - <https://www.postpartum.net/professionals/trainings-events/advanced-pmh-psychopharmacology/>
- **Medical Provider Training (online or on-site):**
 - www.postpartum.net/professionals/trainings-events/frontline-provider-trainings/
- **PSI President's Advisory Council Webinar Series:**
 - www.postpartum.net/professionals/pac-web-series/

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202

Perinatal Loss: Clinical and Supportive Care
Perinatal Loss: Clinical and Supportive Care - Postpartum Support International (PSI)
www.postpartum.net/training/perinatal-loss-clinical-and-supportive-care/

- This comprehensive perinatal loss training for birth workers, therapists, nurses, and other psychotherapy and medical providers. This course takes you into the world of perinatal loss, inclusive of miscarriage, stillbirth, complex congenital anomalies, and pregnancy decision making.
- Participants will explore trauma-informed strategies, clinical techniques, and practical interventions to support bereaved parents, families, and providers impacted by loss.
- Due to the sensitive nature of the subject matter, we kindly ask that you do not bring babies or children to this training.

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203

Paternal Perinatal Mental Health
Foundations in Paternal Perinatal Mental Health - Postpartum Support International (PSI)
www.postpartum.net/training/paternal-perinatal-mental-health/

- PSI's Foundations in Paternal Perinatal Mental Health presents you with key information regarding paternal perinatal mental health with an emphasis on psychosocial dynamics and evidence-based interventions with fathers.
- Psychotherapists, medical providers, and allied birth professionals will gain valuable knowledge of the key psychological, interpersonal, and systems-level factors related to fathers as they navigate the transition to parenthood.
- Participants will learn to apply intersectional, multicultural, and gender-sensitive approaches to psychotherapy, screening, case conceptualization, and treatment planning with fathers via interactive lecture, multimedia demonstrations, and discussions of case studies.


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204

PMH 101

<https://www.postpartum.net/training/mmh-online-webinar/>

- Learn about the various Maternal Mental Health Disorders, the differences between them, risk factors, and treatment options. The course is designed for providers, administrators, and public health employees, though all are welcome. CEUs/CMEs are not available for this event.
- All webinars are scheduled on Thursday mornings from 10:30 am - 12:00 noon PT.
- RSVP for one of the sessions. You will be sent instructions with the webinar link after registering.

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205

www.postpartum.net/professionals/psi-conference



Save the Date!

July 9-13, 2025 | New Orleans


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206

Volunteer with PSI

- Support and Specialized Coordinators
- Online Support Group Facilitators
- Helpline
- Peer Mentor Program
- PSI Chapters
- ...and more!

www.postpartum.net/join-us/volunteer



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207

PSI Membership

www.postpartum.net/join-us/become-a-member/

PSI Members are around the world, in a wide range of professions: Therapists, midwives, doulas, psychiatrists, psychologists, lactation consultants, PAs, NPs, OTs, pediatricians, researchers, students, and more. All are welcome and valued. Do you refer help-seekers to PSI for free peer-support services? Membership is a way to further strengthen the support network, both financially and by engaging with other members in our learning/sharing community.

- Join as an individual or as part of an organization/company group
- Tiered for financial accessibility; same benefits at all levels
- Forum/listserv groups and virtual peer-consultation groups for providers
- Discounts on PSI trainings & conference registration
- Connection with PSI's PMHA-POC program and Chapters
- Discounts with our partners
(Training discounts with Mass. General Hospital Ctr for Women's Mental Health and other CE partners; membership discounts with ADA, NPA, & NAPS; and more.)

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208

Member benefit highlight

Professional Peer Consultation Groups

Included in PSI membership

Meet with other providers to improve knowledge and skills relating to the treatment of perinatal mood and anxiety disorders, birth trauma and perinatal loss.

Peer Consultation groups for:

- **Mental health providers** (in English and in Spanish, and a group for BIPOC providers)
- **Prescribers** (facilitated by reproductive psychiatrists)
- Stay tuned for additional groups in development, including one for doulas!

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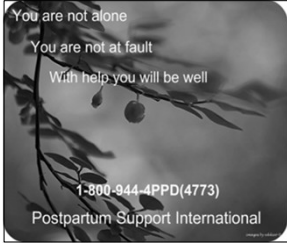
Become a PSI Member!

Membership dues support PSI as a whole as we provide direct peer support to families, train professionals, and provide a bridge between them.

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210

PSI Bridges the Gap



- We provide direct peer support to families, train professionals, and provide a bridge to connect them
- www.postpartum.net

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