Ruth Adewuya, MD (host):

Hello. You are listening to Stanford Medcast, Stanford CME's podcast where we bring you insights from the world's leading physicians and scientists. This podcast is available on Apple Podcast, Amazon Music, Spotify, Google Podcast, and Stitcher. If you're new here, consider subscribing to listen to more free episodes coming your way. I am your host, Dr. Ruth Adewuya. This episode is part of our hot topics miniseries. And today, I will be chatting with Danielle Dawes on the important topic of perinatal mood and anxiety disorders. Danielle graduated in 2009 as a women's health nurse practitioner from Vanderbilt University School of Nursing. She has practiced in the maternal field medicine subspecialty with a focus on high-risk obstetric patients since 2011. She also holds additional certification and training in perinatal mental health. She joined Stanford in the fall of 2020, where she is helping to create a dedicated OB psych program. Prior to joining Stanford, she practiced at Long Beach Memorial where, in addition to her clinical responsibilities, she led the multidisciplinary fetal care and perinatal mental health programs. Thank you so much for chatting with me today.

Danielle Dawes, RN (guest speaker):

Thanks so much for having me. It's really a pleasure to be here.

Ruth Adewuya, MD (host):

A great place for us to start is some definitions. Let's start with, what is perinatal mental health and why is it so important?

Danielle Dawes, RN (guest speaker):

Perinatal mental health is really an umbrella term that refers to all psychologic and psychiatric concerns in the perinatal period. It's important to define the perinatal period of which is any time from conception to one year postpartum. And it's also important to note that this timing refers to the onset of symptoms. It does not refer to the duration, which really can be variable and is certainly impacted by how quickly the symptoms are identified and appropriate treatment is initiated. The rates of perinatal health are really astounding. There's data demonstrating a rate of one in five, so about 20%, especially when we look at the data greater than three months out from birther delivery.

Ruth Adewuya, MD (host):

Can we define another term, which is PMAD, perinatal mood and anxiety disorders, and what is it and what does it mean?

Danielle Dawes, RN (guest speaker):

Sure. So PMAD is the acronym really used to refer to all perinatal mood and anxiety disorders. And it's really an expansion of what we've considered postpartum depression and really aims to take into account some of our implicit bias related to this diagnosis by expanding it further as we get more data that it impacts different populations other than just birthing mothers. So it includes all parenting individuals regardless of gender or age. It includes adoptive parents in addition to birth parents. It also includes the prenatal period in addition to the postpartum period, which has always been highlighted first. And it includes diagnoses other than just depression.

Ruth Adewuya, MD (host):

What are the other diagnoses that are included in this bucket?

Danielle Dawes, RN (guest speaker):

There are two subcategories within perinatal mood and anxiety disorders, hence its name. So there are the mood disorders and the anxiety disorders. Some of the mood disorders include depression, so unipolar depression, bipolar depression, and actually postpartum psychosis. And then as far as anxiety disorders, it includes not only more your generalized anxiety disorders, it includes postpartum PTSD or childbirth related PTSD. Birthing in isolation for some people has really been a trigger. It also includes a subtype of anxiety called postpartum OCD, obsessive compulsive disorder. I think it's really important and interesting to highlight that PTSD is in the eye of the beholder and how the patient perceives the situation. Working in this field for 12 plus years, I've really been shocked by the patients that have terrified me with what I felt was a near death experience and are not phased. And then someone who had an unplanned but standard reason to move to an unscheduled but not necessarily emergent C-section, for example, are sometimes the ones experiencing the greatest PTSD from the situation. So it's important to be witness to that information however your patient [inaudible 00:04:44].

Ruth Adewuya, MD (host):

Yeah. I think that's a really important fact that it's an individualized experience. And clinicians are having to pay attention to that when they are in the process of caring for patients in this space. I want to go back to what you said about how common this is and that 20% number. Since it's so common, why do you think there is still such a stigma and shame in discussing this topic?

Danielle Dawes, RN (guest speaker):

Unfortunately, there's such a stigma associated with all mental health issues in general. And it's certainly no different in the perinatal period. If anything, I think the stigma's actually worse because there's a perception that should be really especially joyful time. And to make matters worse, many people really think that postpartum depression is synonymous with postpartum psychosis because this subtype of perinatal mood disorder attracts the most media attention, and sometimes is someone's first if not only encounter with perinatal mood or anxiety disorder.

In addition to this stigma, there are additional unique barriers to reporting concerns or seeking help. Some women experiencing symptoms fear that voicing concerns or seeking help will automatically lead to involvement with the Department of Child and Family Services, and that therefore be at risk for losing their children. It's really important to reassure patients that this is not the case. In some instances, I actually find it beneficial to review the reporting responsibilities of a mandated reporter with the patient and highlight that, even when DCFS does need to be involved, they make every effort to keep the family unit together and really look favorably on being proactive in seeking help.

Ruth Adewuya, MD (host):

You surfaced a couple of good points. One of the things is the unrealistic expectations that are placed on parents and the joy of the experience and how people think that should be the main emotion that's happening there. Another thing that you surfaced is the fear of voicing concerns or seeking help. And I like how you phrased it that there are instances where there is need for reporting, there's legal processes that need to come into place. But in the same breath, you mentioned that, more often than not, it is done with this level of care and intentionality to keep the unit together. But when you look at the news, I could see why people are afraid because it's immediately the negative side of things, right?

Danielle Dawes, RN (guest speaker):

Yeah.

Ruth Adewuya, MD (host):

I wonder, how do clinicians navigate that?

Danielle Dawes, RN (guest speaker):

I mean, I think they just really need to set the background of this safe space in saying these are the parameters of what we're talking about when I would need to report something out and why, and then what the follow-up will be. And give the patient the space to internalize that and therefore feel safe in the conversation and telling you anything that they need to tell you.

Ruth Adewuya, MD (host):

You're right. It goes back the need for providers to develop trust with their patients. And ultimately, if that's the foundation of their relationship, then there's that feeling of safety between both parties. Another term that we've heard around this topic is baby blues. And baby blues are said to be common for women after giving birth where they feel these blues a couple of weeks after a delivery. At what point does this diagnosis become classified as postpartum depression?

Danielle Dawes, RN (guest speaker):

Baby blues is really more or less isolated to the first two weeks postpartum when it's triggered by the abrupt change in hormones and the change in sleep patterns. And it affects about 80% of new parents. So again, it's considered more or less a normal physiologic response because it is just so common. If after that two-week point mood begin to get worse as opposed to better, that really should be a red flag.

Ruth Adewuya, MD (host):

And what are some of the signs and symptoms that clinicians may see that may be specific to that postpartum period and not the typical depression or anxiety presentation?

Danielle Dawes, RN (guest speaker):

That's really a great question because symptoms of postpartum depression or anxiety are not necessarily any different. It's really the timing of onset that differentiates it. Again, being any time from conception to that first year postpartum. So it's important, as a clinician, if you're evaluating our constitutional symptom like insomnia, I try to specify, are you able to easily fall asleep in a dark, quiet room when the baby is sleeping? Insomnia or fatigue for that matter can obviously be related to lack of sleep from multiple overnight awakenings for feedings in the newborn period.

However, patients that are experiencing postpartum anxiety will often have difficulty sleeping overnight in a dark, quiet room despite being exhausted. A manifestation that is actually unique of postpartum anxiety can present as avoidance of situations that the patient perceives to carry increased risk of accidental harm to the baby. Some things that I've seen are avoiding baths due to fear of drowning, avoiding steps due to fear of falling, so isolating in one part of the house, avoiding car travel or going out of the house due to fear of some kind of car accident or something happening in an unknown space, or unfamiliar space for that matter.

Ruth Adewuya, MD (host):

That's really helpful. I think those are very specific things that clinicians can be on the lookout. Can you talk a little bit about screening in this context?

Danielle Dawes, RN (guest speaker):

That's really another great question because you don't know if you don't ask. There continue to be increased recommendations for screening provided by all the governing bodies in obstetrics, pediatrics, and family practice, with really different very specific recommendations on when and how to screen depending on your governing body. That's said, in all of these situations, screening is really moving towards becoming the standard of care. There are many different validated screening tools. The one that's most commonly used in obstetrics and therefore the one that I'm most familiar with personally is the Edinburgh Postnatal Depression Scale.

Despite its name, this tool has been validated for use both postpartum and in pregnancy. It requires a very low health literacy level and takes less than five minutes to complete. The lack of resources for a screen positive patient has previously been identified as a real barrier to formal screening, but we're now really lucky to have a new national maternal health hotline as of September of 2021 in addition to the 988 general mental health crisis line as of July 2022. So both of these hotlines are federally funded and have effectively addressed the lack of resources as a barrier to screening. And there is now a resource for everyone really, regardless of insurance or level of acuity.

Ruth Adewuya, MD (host):

You mentioned a couple of things that I wanted to highlight. One was the Edinburgh Postnatal Depression Scale for clinicians, correct?

Danielle Dawes, RN (guest speaker):

Yes.

Ruth Adewuya, MD (host):

And then on the patient side you mentioned, which I wast unaware of, this national maternal health hotline. What's that number?

Danielle Dawes, RN (guest speaker):

That number is 1-833-9-HELP4MOMS.

Ruth Adewuya, MD (host):

1-833-9-HELP4, the number four, MOMS. That's really exciting. I was aware of the 988 crisis line, which is just excellent, but great to hear that a specific one that is for maternal mental health hotline for new moms. You mentioned in how you defined who can be impacted by PMAD. You really talk about all parenting individuals regardless of gender and age.

Danielle Dawes, RN (guest speaker):

Sure.

Ruth Adewuya, MD (host):

How often do you see males?

Danielle Dawes, RN (guest speaker):

There's actually statistics on that, and that's the other population that's best studied. So the rate right now that they've identified in men is one in 10, so that's still a very high, alarming number. I don't think we have good statistics on other populations that I'm aware of as far as grandparents that are serving as a primary parent, adoptive parents that are primary parent. But again, on men, we do have good statistics. And the number one risk factor actually for a father getting postpartum depression or a perinatal mood and anxiety disorder is if the mother is also experiencing one. That being said, it can happen without that, but that's just the number one risk factor.

Ruth Adewuya, MD (host):

Let's talk about risks factors. Are there are specific risk factors that make some individuals more susceptible to postpartum depression than others?

Danielle Dawes, RN (guest speaker):

Yeah, absolutely. There are many known risk factors for all perinatal mood and anxiety disorders, but the leading risk factor is really having a history of anxiety, depression, or any kind of mood disorder or psychiatric illness outside of pregnancy. Other risk factors that have been identified are things like unplanned pregnancy, domestic violence, lack of social support, a traumatic birth experience like we talked about previously, or the need for neonatal intensive care unit and mission. But these are only some of the other risk factors on the list. My favorite on this list is, quote, life stress. And this literally comes from a published list compiled from the American College of Obstetrics and Gynecology and the American Academy of Pediatrics. It's almost laughable to me because who isn't experiencing some level of life stress with this type of big life transition?

Ruth Adewuya, MD (host):

Yeah.

Danielle Dawes, RN (guest speaker):

Really, I think it's just to highlight that anyone and everyone is really at risk for a perinatal mood and anxiety disorder, which really speaks to the need to standardize screening and make it routine practice.

Ruth Adewuya, MD (host):

Let's just screen everybody and make sure that everyone's getting the help that they need if they need it. For this conversation, I was looking at some articles and some things about breastfeeding and whether there's some kind of causality or relationship with PMAD. Can you talk about that and what your thoughts are in that topic?

Danielle Dawes, RN (guest speaker):

I find that, in my clinical practice, breastfeeding is really a mixed bag. There are certainly a number of studies that demonstrate that breastfeeding is protective against postpartum depression and anxiety. But again, in my own practice, I've found that breastfeeding is protective when it's going well. I've also seen it be its own trigger in patients who are very well-educated on the newborn health benefits of breast milk, very motivated to breastfeeding and feeling tremendous pressure to do, but are significantly struggling with supply or latch. That said, some patients do feel significant sadness when they discontinue breastfeeding, but others feel a lot of relief. And the American College of Obstetrics

and Gynecology actually cites breastfeeding difficulties as one of those other risk factors for perinatal mood and anxiety disorders. As it relates to the length of breastfeeding among patients, it's so variable. And the triggers for perinatal mood and anxiety disorders are so multifactorial that I don't think we have good, clean data to answer this question.

Ruth Adewuya, MD (host):

Thanks for clarifying that. And I think it speaks to just the nuances of caring for patients that clinicians have to navigate, but that's very helpful. Let's switch our conversation to, what are the available therapies? Are there strategies or proactive therapeutics that might help to anticipate and alleviate the effects of postpartum depression and anxiety?

Danielle Dawes, RN (guest speaker):

There's a lot to talk about in this category. I would say psychotherapy and psycho-pharmacology are certainly the mainstays of treatment, but there is also good data on the benefits of good nutrition and exercise, yoga and meditation. And we absolutely cannot forget the importance of sleep as medicine. It's crucial to stress the importance of naps and good sleep hygiene with your patients. Without good sleep, any kind of these other modalities, they won't be able to have their full benefits. And then as far as proactive therapeutics, again, psychotherapy or counseling is always helpful during any life transition. And that can be in the form of group counseling or support groups or in individually counseling. There's really benefits that have been identified. And it depends on your patient, their specific situation, and who they are as a person and what could benefit them or they feel like are helpful the most. Of course, there is absolutely zero risk to a fetus or newborn with counseling. There are also a number of medications that are considered really low-risk in pregnancy and breastfeeding.

Ruth Adewuya, MD (host):

I know we can't do a deep dive into all of them, but what are some of those medications that you would consider low-risk in pregnancy and breastfeeding?

Danielle Dawes, RN (guest speaker):

I think the category of medication that is most widely studied, prescribed, and useful is the category of selective serotonin reuptake inhibitors. There have been studies on really all the medications that fall into this category. And it's important to know that within this category there are nuances to how the patient responds and benefits to these medications. There are a little less data as far as really specific concerns of one medication to another in this category. And so therefore, we really try to use a medication that the patient has previously benefited from as opposed to experimenting with a new medication because, when we look at medications in pregnancy, we look at the number of medications and exposures as opposed to a dose effect.

The other thing is that this category of medications, despite it being a medication that we prescribe daily, it's proven to be, I should say, of lower-risk than medications that fall into the category of benzodiazepines because they more readily cross the placenta and into the breast milk and have a more profound effect on the fetus or newborn. That said, there are some instances in which they are very much an appropriate medication.

Ruth Adewuya, MD (host):

Can you also talk about patients that are already taking medication for bipolar, a major depressive disorder, generalized anxiety disorder? What are some of the implications for their management?

Danielle Dawes, RN (guest speaker):

I think the knee-jerk reaction in pregnancy for a lot of clinicians, patients for that matter, actually, is to stop medications because of perceived risks. This may be appropriate depending on the patient, the psychiatric history, the severity of their mental health illness or specific medications that they have been taking. But simultaneously, you really need to keep in mind that there are few things that are potentially more harmful than a suicidal mother. And in September of 2022, the Centers for Disease Control and Prevention issued its latest report on maternal mortality, which highlighted that the leading cause of pregnancy related maternal mortality are actually mental health conditions at 23% of all deaths.

That is an alarming statistic, so it's taken into account the risk of untreated illness versus the risks of medication, not the risks of medication against a healthy control. And that even in a patient with more mild disease, there's increasing evidence of fetal programming or imprinting and the long-term effects of depression and or anxiety on a child. You really have to look at the bigger picture. And again, not just the risks of medication in isolation, but again, this risks of medication versus disease severity, things like that.

Ruth Adewuya, MD (host):

That is excellent.

Danielle Dawes, RN (guest speaker):

Yeah.

Ruth Adewuya, MD (host):

And I think that it's a little bit of a framework for clinicians to use as they navigate the complexity of this individualized management.

Danielle Dawes, RN (guest speaker):

And even in speaking about the medications themselves, how we look at the medications and interpret the data that we have is really important. We look at the risks of medication in pregnancy and lactation according to gestational age. For example, the fetal heart forms by eight weeks gestation, even though we can't view the anatomy very clearly on ultrasound yet. And a majority of organogenesis or organ development is complete by the end of the first trimester. So it's important to keep this timeline in mind when talking about the teratogenicity or increased risk of birth defects with certain medications.

Ruth Adewuya, MD (host):

You made a really good point because when I was in medical school, that was the A, B, C, D, and X. That was our framework. That's what I was taught.

Danielle Dawes, RN (guest speaker):

Absolutely. It's the same thing when I was in training. But I can't tell you the number of times I see that referenced when I have a patient coming from an outside provider that is seeking maternal fetal medicine care and looking for subspecialty input. As you highlighted, it's really very patient specific. So it's important for providers, and patients for that matter, to be advocates and know how to access

appropriate specialists. The organization Postpartum Support International can really help anyone connect with specialists through their website, postpartum.net.

Ruth Adewuya, MD (host):

Thank you for sharing that resource. I'll also make sure that we link it out in the notes for the episode. That's very helpful. What should clinicians be on the lookout for when they are having conversations with a pregnant or postpartum patient?

Danielle Dawes, RN (guest speaker):

It's really a great question because you can't always tell by looking. Unfortunately, we don't have objective vitals like blood pressure or temperature when it comes to evaluating mental health. So every provider really should make an effort to screen. There was a study all the way back in 2000 that looked at 400 patients in an outpatient obstetric practice. And even then, without a screening tool the rate of detection of perinatal mood and anxiety disorders was 6.3%. And then with the use of the Edinburgh as a screening tool, the rate went up to 35.4%.

Ruth Adewuya, MD (host):

Wow.

Danielle Dawes, RN (guest speaker):

So there really is a very significant difference. The other thing that I'll say is, especially depending on your specialty, if you do not have access to a validated questionnaire, I would recommend that you directly ask a patient about their mood. There's data that even if you don't have all the answers or the resources, that there are benefits to screening alone, as inviting this discussion really normalizes or demystifies the diagnosis, which really carries so much stigma.

Ruth Adewuya, MD (host):

This has been an excellent and a rich discussion on this topic. And I know that we are barely scratching the surface of everything that you can talk about here. But as we wrap up our conversation, do you have any other takeaways that you would like to share about the importance of perinatal mental health or any other points that you would highlight as we wrap up?

Danielle Dawes, RN (guest speaker):

It's important that we continue to have these conversations, continue to bring these things to light, to talk about them more, and to de-stigmatize. I also really want to highlight the resources that are available again to all patients and providers. And I would like to make sure everybody has access to is, again, this National Maternal Mental Health line, which is free, confidential, and staffed by maternal and child mental health specialists 24/7, which is 1-833-9-HELP4MOMS. Also, the Postpartum Support International helpline, which is also to be used in pregnancy as well. That number is 1-800-944-4773. And then last but certainly not least is the more general National Mental Health Crisis line, that's 988.

Ruth Adewuya, MD (host):

Thank you so much. We will definitely highlight these numbers and these resources wherever we can. And thank you for surfacing all of this. This is a great conversation. Thank you so much for chatting with me today.

Danielle Dawes, RN (guest speaker):

Absolutely. Thanks again so much for having me.

Ruth Adewuya, MD (host):

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