Assessing Perinatal Mental Health

Score patient screening document

Depression (PHQ-9/EPDS) ≥ 10

Bipolar disorder (MDQ) “Yes” ≥ 7

Anxiety (GAD-7) ≥ 5

PTSD (PC-PTSD-5) “Yes” ≥ 3

+ Self-harm question

+ Depression screen & self-harm question

Stop*

+ Score on MDQ

1. Explain: This screen indicates that your mood may go up and down. We can help you get the care you need.
2. If negative depression screen, mood changes may be related to PTSD. The PC-PTSD-5 is part of the screener. Can also administer the PCL-C. See above right and page 32.
3. Do not prescribe antidepressant.
4. Refer to therapy.
5. Call for psychiatric consultation or refer to psychiatrist as indicated. See pages 24 & 25.

Consider administering PCL-C. See page 32.

To assess for presence and severity of perinatal mental illness, ask about:

- Recent stressors
- Symptom frequency
- Symptom duration
- How symptoms impact daily functioning
- Current treatment (meds/therapy)
- Prior symptoms
- Feelings of hopelessness, helplessness
- Current suicidal ideation, plan, intent
- Family history
- Previous suicide attempt(s)
- Past psychiatric treatment (meds/therapy)
- Previous psychiatric hospitalization(s)
- See pages 29-31 for more on perinatal mental health conditions

Determine Illness Severity

MILD
Depression screener score 10-14
GAD-7 score 5-9
PC-PTSD-5 score < 3
No suicidal ideation
Not feeling hopeless, helpless, worthless
No previous psychiatric hospitalization
No or minimal difficulty caring for self or baby

MODOERATE
Depression screener score 15-19
GAD-7 score 10-14
PC-PTSD-5 score ≥ 3
Suicidal ideation present
Sometimes feels hopeless, helpless, worthless
Previous psychiatric hospitalization
Some difficulty caring for self or baby

SEVERE
Depression screener score >19
GAD-7 score ≥15
PC-PTSD-5 score ≥ 3
Suicidal ideation, intent and/or plan
Previous suicide attempt(s)
Often feels hopeless, helpless, worthless
History of multiple psychiatric hospitalization(s)
Often feels unable to care for self or baby
May experience hallucinations, delusions or other psychotic symptoms (e.g., major depression with psychotic features or bipolar disorder with psychotic features)
History of multiple medication trials

For mild, moderate, and severe illness:

- Start treatment, see page 22.
- Check for underlying medical condition - order TSH, B12, folate, Hgb, Hct
- Assess for substance use or medications which can cause or worsen mood/anxiety disorders

*If all screens are negative, tell her they were negative and say, “If something changes, please let us know. We are here.”

Continue to other side

EPDS = Edinburgh Postnatal Depression Scale; GAD = Generalized Anxiety Disorder; MDQ = Mood Disorder Questionnaire; PHQ = Patient Health Questionnaire
PTSD = Posttraumatic Stress Disorder; PC-PTSD-5 = Primary Care Post Traumatic Stress Disorder; PCL-C = PTSD Check List-Civilian

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Authors: Byatt N., Mittal L., Brenick L., Logan D., Masters G., Bergman A., Moore Simas T.
## Consider treatment options based on highest level of illness severity

If severity of symptoms overlap, clinical decisions should be based on the assessment, with strong consideration of higher level treatment options.

<table>
<thead>
<tr>
<th>MILD</th>
<th>MODERATE</th>
<th>SEVERE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapy referral</td>
<td>Therapy referral</td>
<td>Therapy referral</td>
</tr>
<tr>
<td>Consider medication treatment</td>
<td>Strongly consider medication treatment</td>
<td>Medication treatment</td>
</tr>
</tbody>
</table>

- If onset of depression symptoms occurs in 3rd trimester to 4 weeks postpartum and if the patient is <6 months postpartum at screening, consider postpartum brexanolone (IV allopregnanolone infusion over 60 hours in an inpatient setting). See page 20.
- If onset of depression symptoms occurs in 3rd trimester to 4 weeks postpartum and if the patient is <6 months postpartum at screening, consider postpartum brexanolone (IV allopregnanolone infusion over 60 hours in an inpatient setting). See page 20.

### Therapy and support options

- All women who screen positive, regardless of illness severity, should be referred to therapy or be advised to continue therapy
- Always discuss and encourage prevention and support options (e.g., peer and social supports and groups, sleep hygiene, self-care, and exercise). See page 27.

### How to educate patients about treatment with antidepressants

#### Antidepressant use during pregnancy:

- Does not appear to be linked with birth complications
- Has been linked with small but inconsistent risk of birth defects when taken in the first trimester, particularly paroxetine
- Has been linked with transient (days to weeks) neonatal symptoms (tachypnea, irritability, insomnia)
- Has inconsistent, overall reassuring, evidence regarding long-term (months to years) neurobehavioral effects on children

#### Under-treatment or no treatment of perinatal mental health conditions:

- Has been linked with birth complications
- Can increase the risk or severity of postpartum depression
- Can make it harder for moms to take care of themselves and their babies
- Can make it harder for moms to bond with their babies
- Can increase risk of mental illness among offspring
- Has been linked with possible long-term neurobehavioral effects on children

### Medication treatment (when indicated)

**Antidepressant indicated?**

**Currently on antidepressant?**

- Yes
  - Symptons improving, but not resolved
  - On max dose for ≥ 4 weeks?
    - Yes
      - Maximize other treatments (e.g., therapy)
      - In late pregnancy, consider increasing dose of antidepressant above usual therapeutic range (e.g., sertraline [Zoloft] 250 mg rather than 50-200 mg).
      - If side effects, consider tapering and then discontinue current medication; simultaneously start new medication. See page 20.
      - To learn about other strategies, call Perinatal Psychiatry Access Program or consult with or refer to psychiatric clinician.
    - No
      - Increase dose
  - Taper and discontinue current med and simultaneously start new one. See page 20.

- No
  - Refer to therapy (see above)

**History of taking antidepressant that helped**

- Yes
  - Prescribe med that helped before
  - Start new med. See page 20.

- No

**Continue to next page**

### Call Postpartum Support International (PSI) at 1-877-499-4773 to schedule a consultation by phone with a perinatal psychiatry expert

- Call a Perinatal Psychiatry Access Program, if one is available in your state. Check at [https://www.umassmed.edu/lifeline4moms/](https://www.umassmed.edu/lifeline4moms/)

- If symptoms are mild and patient is able to follow through, direct patients to call their health insurance company or contact Postpartum Support International (PSI) for resources: 1-800-944-4773 (voice in English or Spanish), 800-944-4773 (text in English), 971-203-7773 (text in Spanish), or direct patients to search online at [https://psidirectory.com/](https://psidirectory.com/)

### Antidepressant indicated?

- Yes
  - Currently on antidepressant?
    - Yes
      - Refer for therapy (see above)
    - No
    - History of taking antidepressant that helped
      - Yes
        - Prescribe med that helped before
        - Start new med. See page 20.
      - No
        - Increase dose
  - No
    - Refer for therapy (see above)

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Starting Treatment for Perinatal Mental Health Conditions

Pharmacological Treatment Options for Depression, Anxiety, and PTSD

- Choose antidepressant that has worked before. If antidepressant naïve, choose antidepressant based on table below with patient preference in consideration. Antidepressants are similar in efficacy and side effect profile.
- In late pregnancy, you may need to increase the dose above usual therapeutic range (e.g., sertraline [Zoloft] 250mg rather than 50-200mg).
- If a patient presents with pre-existing mood and/or anxiety disorder and is doing well on an antidepressant, do not switch it during pregnancy or lactation. If patient is not doing well, see page 21.
- Evidence does not support tapering antidepressants in the third trimester.
- Minimize exposure to both illness and medication.
  - Untreated/inadequately treated illness is an exposure
  - Use lowest effective doses
  - Minimize switching of medications
  - Monotherapy preferred, when possible

First-line Treatment Options for Mild, Moderate, or Severe Depression, Anxiety Disorder, and PTSD

<table>
<thead>
<tr>
<th>Medication</th>
<th>Starting dose and timing</th>
<th>Initial increase after 4 days</th>
<th>Second increase after 7 more days</th>
<th>Reassess Monthly</th>
<th>Therapeutic range***</th>
<th>Individualized approach to titration</th>
</tr>
</thead>
<tbody>
<tr>
<td>sertraline* (Zoloft)</td>
<td>25 mg qAM (if sedating, change to qHS)</td>
<td>↑ to 50 mg</td>
<td>↑ to 100 mg</td>
<td>50-200 mg</td>
<td>Slower titration (e.g., every 10-14-days) is often needed for patients who are antidepressant naïve or with anxiety symptoms</td>
<td></td>
</tr>
<tr>
<td>fluoxetine (Prozac)</td>
<td>10 mg qAM</td>
<td>↑ to 20 mg</td>
<td>↑ by 50 mg</td>
<td>20-80 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>citalopram** (Celexa)</td>
<td>10 mg qAM</td>
<td>↑ to 20 mg</td>
<td>↑ by 50 mg</td>
<td>20-40 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>escitalopram** (Lexapro)</td>
<td>5 mg qAM</td>
<td>↑ to 10 mg</td>
<td>↑ to 10 mg</td>
<td>10-20 mg</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Lowest degree of passage into breast milk compared to other first-line antidepressants; **Side effects include QTc prolongation (see below); ***May need higher dose in 3rd trimester and when treating an anxiety disorder
In general, if an antidepressant has helped during pregnancy, it is best to continue it during lactation. Prescribe a maximum of two (2) antidepressants at the same time.

Second-line Treatment Options for Mild, Moderate, or Severe Depression, Anxiety Disorder, and PTSD

<table>
<thead>
<tr>
<th>Medication</th>
<th>Starting dose and timing</th>
<th>Initial increase after 4 days</th>
<th>Second increase after 7 more days</th>
<th>Reassess Monthly</th>
<th>Therapeutic range ***</th>
<th>Individualized approach to titration</th>
</tr>
</thead>
<tbody>
<tr>
<td>duloxetine (Cymbalta)</td>
<td>30 mg*** qAM</td>
<td>↑ to 60 mg</td>
<td>↑ by 30 mg</td>
<td>30-120 mg</td>
<td>Slower titration (e.g., every 10-14-days) is often needed for patients who are antidepressant naïve or with anxiety symptoms</td>
<td></td>
</tr>
<tr>
<td>venlafaxine (Effexor XR)</td>
<td>37.5 mg qAM</td>
<td>↑ to 75 mg</td>
<td>↑ by 75 mg</td>
<td>75-300 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>fluvoxamine (Luvox)</td>
<td>25 mg qAM</td>
<td>↑ to 50 mg</td>
<td>↑ by 50 mg</td>
<td>50-200 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>paroxetine</td>
<td>10 mg*** qAM (if sedating, change to qHS)</td>
<td>↑ to 20 mg</td>
<td>↑ by 10 mg</td>
<td>20-60 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>mirtazapine (Remeron)</td>
<td>7.5 mg qHS</td>
<td>↑ to 15 mg</td>
<td>↑ by 15 mg</td>
<td>15-45 mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bupropion HCL (Wellbutrin XL)</td>
<td>150 mg qAM</td>
<td>↑ by 15 mg</td>
<td>↑ by 150 mg</td>
<td>300-450 mg</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

***May need higher dose in 3rd trimester and when treating an anxiety disorder

General side effects oral antidepressants

Temporary (days to weeks)
- Nausea (most common)
- Constipation/diarrhea
- Lightheadedness
- Headaches

Long-term (weeks to months)
- Increased appetite/weight gain
- Sexual side effects
- Vivid dreams/insomnia
- **QTc prolongation (citalopram & escitalopram)

- Tell women to take medication with food and only increase dose if tolerating; otherwise wait until side effects dissipate before increasing.
- Start medication in morning; if patient finds it sedating recommend that she takes it at bedtime

Medication Treatment for Moderate/Severe Depression with Onset in Late Pregnancy or Within 4 weeks postpartum – brexanolone (Zulresso)

Brexanolone is an FDA-approved medication that can be considered for treatment of moderate to severe postpartum depression.

Brexanolone:
- is a formulation of intravenous allopregnanolone (a neurosteroid) that acts on GABA-A receptors
- requires an IV infusion over 60 hours
- has a faster onset of action (symptom reduction in 1-2 days) compared to available oral antidepressants, which generally take 4-8 weeks to work
- has been shown to maintain the reduction in depression symptoms at 30 days post-infusion

When is Brexanolone indicated?
If onset of depression occurs in 3rd trimester through 4 weeks postpartum and if patient is <6 months postpartum at screening, consider Brexanolone (IV allopregnanolone infusion over 60 hours in an inpatient setting).

More information can be found at Reprotox and LactMed on all pharmacological treatments

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Authors: Byatt N., Mittal L., Brendel L., Logan D., Masters G., Bergman A., Moore Simas T.
Follow-Up Treatment of Perinatal Mental Health Conditions

Once patient is determined to have a mental health condition, repeat screen in 4 weeks and re-evaluate treatment plan via clinical assessment

If no/minimal clinical improvement after 4 weeks

- If patient has no or minimal side effects, increase antidepressant medication dose until full symptom remission (e.g., EPDS/PHQ-9 < 10, GAD-7 <5, PC-PTSD <3)
- If patient has intolerable or serious side effects, taper medication to discontinue, and simultaneously start new antidepressant
- Maximize other treatments (e.g., therapy, lifestyle changes, support groups)
- If late in pregnancy, given physiological changes in pregnancy, may need to increase the dose of antidepressant above usual therapeutic range (e.g., sertraline [Zoloft] 250 mg per day rather than 50-200 mg)
- Consider adding additional medication. See page 20.
- Repeat screens every 4 weeks and re-evaluate treatment via clinical assessment until remission, or, if you are not continuing to manage the patient, provide a hand-off to the primary care physician

If clinical improvement and no/minimal side effects

- Re-evaluate every month in pregnancy and postpartum and adjust med accordingly. See page 20
- Encourage patient to stay on medication and continue therapy
- If you are not continuing to manage the patient, provide a hand-off to primary care physician

If you are not continuing to manage the patient postpartum:
- Contact PCP and provide handoff
- Ask patient to make appointment with PCP
- Send summary to PCP
- See patient again to make sure she is in treatment with PCP

Once patient experiences remission of symptoms (e.g., 2 sequential EPDS/PHQ-9 scores <10, GAD-7 <5, PC-PTSD <3)

Can consider tapering antidepressant when patient has been in remission for ≥ 6 months for depression and ≥ 12 months for anxiety

Taper medication slowly to minimize risk of relapse and discontinuation syndrome
- Shorter acting medications (e.g., paroxetine [Paxil], venlafaxine [Effexor]) have higher chance of discontinuation syndrome and thus need to be tapered slowly
- Establish postpartum birth control plan to help women make informed decision regarding family planning

Adjunctive Support Options
- Talk to your patient about adjunctive support options such as:
  - Self-care (See Self-Care Plan (page 27))
  - Balanced nutrition
  - Substance avoidance
  - Sleep hygiene
  - Mindfulness
  - Exercise
  - Books and workbooks (e.g., The Pregnancy and Postpartum Anxiety Workbook by Pamela S. Wiegartz and Kevin Gyoerkoe)

Social and Structural Determinants of Health
- Ask about/consider social and structural factors that can be a barrier to engagement in care:
  - Access to stable housing
  - Access to food/safe drinking water
  - Utility needs
  - Safety in home and community
  - Immigration status
  - Employment conditions
  - Transportation
  - Childcare
- Refer to social services as indicated
Assessing Risk of Suicide

Reports thoughts of self-harm and/or +self-harm question on the EPDS/PHQ-9 (any response other than “never”) Follow EPDS/PHQ-9 +self-harm with the Patient Safety Screener (suicide risk screener) to further stratify risk

Ask about thoughts of self-harm or wanting to die

Thoughts of death or of self-harm are common among women with perinatal mental health conditions. The following wording can help to get information about these thoughts.

Introduce assessment to patient

“Many people have intrusive or scary thoughts. When people are sad or down, they often have thoughts about death or wanting to die. These thoughts can feel awful. They can sometimes feel reassuring or like an escape from a hard life or something else that feels too hard to bear. We are here to help you. We ask about these thoughts because they are so common.”

To build up to assessing suicide risk, ask:

1. “Have you been feeling sad or down in the dumps?”
2. “Is it difficult to shake those sad feelings?”
3. “Do you sometimes wish you weren’t here, didn’t exist?”
4. “Have you thought about ways to make that happen?”

To assess risk of suicide, ask:

1. “In the past two weeks, how often have you thought of death or wanting to die?”
2. “Have you thought about ways in which you could harm yourself or attempt suicide?”
3. “Have you ever attempted to hurt yourself or attempted suicide in the past?”
4. “What prevents you from acting on thoughts of death or wanting to die?”

Assess Risk

LOW RISK
- Fleeting thoughts of death or wanting to die
- No current intent*
- No current plan**
- No history of suicide attempt
- Future-oriented (discusses plans for the future)
- Protective factors (e.g., social support, religious prohibition, other children, stable housing)
- No substance use
- Few risk factors (e.g., mental health or medical illness, access to lethal means, trauma hx, stressful event)

MODERATE RISK
- Regular thoughts of death or wanting to die
- Has thoughts of possible plans yet plans are not well-formulated or persistent
- History of suicide attempt
- Persistent sadness and tension, loss of interest, persistent guilt, difficulty concentrating, no appetite, decreased sleep
- Sometimes feels hopeless/helpless
- Somewhat future oriented
- Limited protective factors (e.g., social support, religious prohibition, other children)
- +/- Substance use
- Anxiety/agitation/impulsivity
- Poor self-care
- Some risk factors

HIGH RISK
- Persistent thoughts of death/that life is not worth living
- Current intent*
- Current well-formulated plan**
- Hx of multiple suicide attempts, high lethality of prior attempt(s)
- Hx of multiple or recent psychiatric hospitalizations
- Continuous sadness, unrelenting dread, guilt, or remorse; not eating, < 2-3 hours of sleep/night, unable to do anything, unable to feel pleasure or other feelings
- Hopeless/helpless all or most of the time
- Not future oriented (no plans for/cannot see future)
- No protective factors (e.g., social supports, religious prohibition, other children, stable housing)
- Substance use
- Not receiving mental health treatment
- Anxiety/agitation
- Many risk factors

Tell the patient that: “I hear that you feel distressed and overwhelmed. So much so that you’re having thoughts of death and dying.” (use patient’s language to describe)

“When people are overwhelmed, they often feel this way. It is common.”

“I’m so glad you told me. I’m here to help. There are many things we can do to help you.”

Intervene and Document Plan

LOW RISK
- Treat underlying illness
- Maximize medication treatment and therapy
- Monitor closely

Thoughts of suicide are common. Not all women need to be evaluated urgently or sent to emergency services, especially if risk factors are minimal and there is no plan or intent for suicide.

MODERATE RISK
- Treat underlying illness
- Maximize medication treatment and therapy
- Discuss warning signs with patient and family
- Discuss when and how to reach out for help should she feel unsafe
- Establish family, friends, and professional(s) she can contact during a crisis
- Establish and carry out a plan for close monitoring and follow-up (within 2 weeks)

HIGH RISK
- Do not alarm patient (reinforce her honesty). Do not leave mother and baby alone or let them leave until assessment is complete. Call another staff member
- If assessed to be at imminent risk of harm to self or others, refer to emergency services (custom link)
- Treat underlying illness
- Maximize medication treatment and therapy
- Discuss warning signs with patient and family
- Discuss when and how to reach out for help should she feel unsafe
- Contact family, friends, and professional(s) and establish how you and patient can contact them during a crisis
- Establish a plan for close monitoring and follow-up

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Assessing Risk of Harm to Baby

Ask about unwanted or intrusive thoughts

Unwanted or intrusive thoughts, including those of harming the baby, are common (up to 70%) among postpartum women. Most women will not act on these thoughts because they are usually due to anxiety, depression, and obsessive/compulsive disorder, which is very different than thoughts of harming the baby that are due to psychosis/delusions. The following wording can be used to get information about whether these thoughts are present and how current and concerning they are.

“People often have intrusive thoughts or thoughts that seem to pop in from nowhere. Women often have thoughts about something bad happening to their baby. These thoughts can feel awful and sometimes feel as if they could be an escape from something too hard to bear. We are here to help you. We ask about these thoughts because they are so common.”

− Have you had any unwanted thoughts?
− Have you had any thoughts of harming your infant, either as an accident or on purpose?
− If the patient answers yes to the above question, follow up with:
  • How often do you have them?
  • How recently have you had them?
  • How much do they scare you?
  • How much do they worry you?

Assess Risk

| LOW RISK  
| (symptoms more consistent with depression, anxiety, and/or OCD) |
| Thoughts of harming baby are scary |
| Thoughts of harming baby cause anxiety or are upsetting (ego dystonic) |
| Mother does not want to harm her baby and feels it would be a bad thing to do |
| Mother very clear she would not harm her baby |

| MODERATE RISK |
| Thoughts of harming baby are somewhat scary |
| Thoughts of harming baby cause less anxiety |
| Mother is not sure whether the thoughts are based on reality or whether harming her baby would be a bad thing to do |
| Mother is less clear she would not harm her baby |

| HIGH RISK  
| (symptoms more consistent with psychosis) |
| Thoughts of harming the baby are comforting (ego syntonic) |
| Feels as if acting on thoughts will help infant or society (e.g., thinks baby is evil and world is better off without baby) |
| Lack of insight (inability to determine whether thoughts are based on reality) |
| Auditory and/or visual hallucinations are present |
| Bizarre beliefs that are not reality based |
| Perception that untrue thoughts or feelings are real |

Consider Best Treatment

| LOW RISK |
| Provide reassurance and education |
| Treat underlying illness |
| Discuss warning signs with patient and family |
| Discuss when and how to reach out for help should she feel unsafe |

| MODERATE RISK |
| Treat underlying illness |
| Discuss warning signs with patient and family |
| Discuss when and how to reach out for help should she feel unsafe |
| Establish family, friends, and professionals she can contact during a crisis |
| Establish and carry out a plan for close monitoring and follow-up |

| HIGH RISK |
| A true emergency, refer to emergency services (custom link), as needed |
| Do not alarm patient (reinforce honesty) and do not leave mother and baby alone while help is being sought |
| Treat underlying illness |
| Discuss warning signs with patient and family |
| Discuss when and how to reach out for help should she feel unsafe |
| Establish family, friends, and professionals she can contact during a crisis |
| Establish and carry out a plan for close monitoring and follow-up |
**Why screen for bipolar disorder?**

- It is important to address bipolar disorder because 1 in 5 patients who screen positive for perinatal depression may have bipolar disorder.
- Treating with an unopposed antidepressant can induce mania, mixed states, and rapid cycling, all of which carry significant risks.
- Bipolar disorder is associated with increased risk of postpartum psychosis and postpartum psychosis is associated with suicide and infanticide.

**Assessment and Management of Bipolar Disorder and Psychosis**

**How is bipolar disorder different from depression?**

<table>
<thead>
<tr>
<th>Depression</th>
<th>Bipolar disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Depressive episodes</td>
<td>- Depressive episodes AND</td>
</tr>
<tr>
<td>- No mania or hypomania</td>
<td>manic (Type I) or hypomanic</td>
</tr>
<tr>
<td>- Medication treatment =</td>
<td>(Type II) episodes</td>
</tr>
<tr>
<td>antidepressant</td>
<td>- Mood stabilizers or</td>
</tr>
<tr>
<td></td>
<td>antipsychotics can be used to</td>
</tr>
<tr>
<td></td>
<td>stabilize mood</td>
</tr>
</tbody>
</table>

**Ask about current psychotic symptoms**

- Have you heard anything like sounds or voices or see things that others may not?
- Do you hold beliefs that other people may find unusual or bizarre?
- Do you find yourself feeling mistrustful or suspicious of other people?
- Have you been confused at times whether something you experienced was real or imaginary?

**Consider bipolar disorder if any of the following are present:**

- Patient reports a history of bipolar disorder
- MDQ is positive
- Patient is taking medication for bipolar disorder (e.g., mood stabilizer or antipsychotic)

**Assessment of bipolar disorder:**

- Assessment with a psychiatric prescriber is generally indicated due to complexity of diagnosis
- Broad DDx (e.g., includes unipolar depression, schizoaffective disorder, borderline personality disorder, PTSD). See page 29-31 of the toolkit

If patient cannot be assessed by a psychiatric provider in a timely manner:

- One option is to prescribe quetiapine (Seroquel) because it can treat unipolar and bipolar depression as well as mania and psychosis until patient can be assessed, and diagnosis clarified
- Start with quetiapine (Seroquel) 100mg qHS, increase by 100 mg increments as needed up to 800 mg/day

**Examples of Clinical Scenarios**

**Case Example #1:**
Patient is on medication for bipolar disorder or psychosis
- Establish liaison with psychiatry
- Continue current meds
- If not in therapy, refer
- Psychosis does not mean she can’t parent
- Not all patients with psychosis will need inpatient psychiatric hospitalization; some can be managed as an outpatient with close monitoring and follow-up

**Case Example #2:**
Prior history bipolar disorder
No current meds

**Case Example #3:**
Positive MDQ
Unidentified diagnosis
No current meds

Refer for assessment
Management of Bipolar Disorder and Psychosis

Medication Use During Pregnancy

Many mood stabilizers and antipsychotics can be used in pregnancy. Discontinuation greatly increases risk of decompensation or relapse.

Reassuring data; do not discontinue
- Typical* or Atypical** Antipsychotics
- Lamotrigine (Lamictal)
- Lithium
  - monitor lithium levels
  - fetal echocardiogram (16-18 wks GA)

Less reassuring data; can continue if high risk
- Carbamazepine (Tegretol)
- Oxcarbazepine (Trileptal)

Avoid, change medication
- Valproic acid (Depakote)

Valproic acid is contraindicated for women of childbearing age and pregnant and lactating women because it can cause maternal metabolic syndrome and is a structural and neurodevelopmental teratogen

If patient is on lamotrigine, carbamazepine, or oxcarbazepine, supplement with folate 4mg/day preconception and during pregnancy and obtain a detailed ultrasound evaluation

Medication Use During Breastfeeding

Reassuring data for antipsychotic use; do not discontinue
- Typical antipsychotics*: Monitor for stiffness
- Atypical antipsychotics**: Monitor maternal and infant weight and blood sugar

Usually considered compatible with breastfeeding
- carbamazepine (Tegretol): Monitor drug level, CBC, liver enzymes
- lamotrigine (Lamictal): Monitor rash, drug level

Must monitor the breastfeeding infant closely for lithium toxicity
- Collaborate with infant’s pediatric provider to create a monitoring plan
- Monitor infant lithium level, TSH, BUN, Creatinine at least every 6-8 weeks

Always coordinate with pediatric provider

General Management Strategies

To decrease and manage risk of decompensation:
- Prophylactically treat with a mood stabilizer and/or antipsychotic
- Develop post-birth plan (e.g., clear follow-up plan for after delivery)
- Monitor closely (patient may not recognize labor cues)
- Collaborate with newborn medicine/pediatric provider
- Develop a plan for breastfeeding
- Develop a plan to support adequate sleep (e.g., partner feeds baby at night)
- Develop a plan to support maternal-infant bonding (e.g., engage family in postpartum plan)

Mania or postpartum psychosis:
Patient needs to be evaluated by a mental health provider. This can be done through psychiatric emergency services or as an outpatient depending on acuity level and safety concerns.

*Typical Antipsychotics (1st generation) include: haloperidol [Haldol], perphenazine [Trilafon], chlorpromazine [Thorazine], loxapine [Loxitane], fluphenazine [Prolixin]
**Atypical Antipsychotics (2nd generation) include: quetiapine [Seroquel], olanzapine [Zyprexa], risperidone [Risperdal], aripiprazole [Abilify], clozapine [Clozaril]
## Summary of Perinatal Mental Health Conditions

<table>
<thead>
<tr>
<th></th>
<th>Baby Blues</th>
<th>Unipolar or Major Depression</th>
<th>Bipolar Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is it?</strong></td>
<td>Common and temporary experience right after childbirth when a new mother may have sudden mood swings, feeling very happy, then very sad, or cry for no apparent reason. This is not considered a psychiatric illness.</td>
<td>Depressive episode that occurs during pregnancy or within a year of giving birth.</td>
<td>Bipolar disorder, also known as manic-depressive illness, is a brain condition that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks.</td>
</tr>
<tr>
<td><strong>When does it start?</strong></td>
<td>First week after delivery. Peaks 3-5 days after delivery and usually resolves 10-12 days postpartum.</td>
<td>Most often occurs in the first 3 months postpartum. May also have started before pregnancy or begins during pregnancy, after weaning baby or when menstrual cycle resumes.</td>
<td>The average age-of-onset is about 25, but it can occur in the teens, or more uncommonly, in childhood. Some women can have a first onset in pregnancy or in the postpartum period.</td>
</tr>
<tr>
<td><strong>Susceptibility factors</strong></td>
<td>N/A</td>
<td>Personal history of depression or postpartum depression. Family history of postpartum depression. Fetal/newborn loss. Lack of personal/community resources. Substance use/addiction. Complications of pregnancy, relationship stress, labor/delivery, or infant’s health. Unplanned pregnancy. Domestic violence or abusive relationship. Adverse Childhood Experiences (ACES).</td>
<td>No single cause. Likely that many factors contribute to the illness or increase risk (e.g., brain structure and functioning, genetics and family history).</td>
</tr>
<tr>
<td><strong>How long does it last?</strong></td>
<td>A few hours to two weeks.</td>
<td>2 weeks to a year or longer. Symptom onset may be gradual.</td>
<td>Lifelong, can be well-managed</td>
</tr>
<tr>
<td><strong>How often does it occur?</strong></td>
<td>Occurs in up to 85% of women.</td>
<td>One in seven women.</td>
<td>The condition affects men and women equally, with about 2.6% of the U.S. population diagnosed with bipolar disorder and nearly 83% of cases classified as severe.</td>
</tr>
<tr>
<td><strong>What happens?</strong></td>
<td>Dysphoric mood, crying, mood lability, anxiety, sleeplessness, loss of appetite, and irritability. Baby blues is a risk factor for postpartum depression.</td>
<td>Change in appetite, sleep, energy, motivation, and concentration. May experience negative thinking including guilt, hopelessness, helplessness, and worthlessness. May also experience suicidal thoughts and evolution of psychotic symptoms. Thoughts of harming baby. Low self-care.</td>
<td>Manic or hypomanic episodes alternate with depressive episodes.</td>
</tr>
<tr>
<td><strong>Resources and treatment</strong></td>
<td>Resolves on its own. Resources include support groups, psychoeducation, and sleep hygiene (asking/accepting others’ help during nighttime feedings). Address infant behavioral dysregulation - crying, sleep, feeding problems - in context of perinatal emotional complications.</td>
<td>For depression, treatment options include individual therapy, dyadic therapy for mother and baby, group therapy, and medication treatment. Encourage self-care, and engagement in social and community supports. Encourage sleep hygiene and asking/accepting help from others during nighttime feedings.</td>
<td>Bipolar disorder responds well to treatment with individual therapy and medication management. Encourage stability in daily routine and sleep hygiene and asking/accepting help from others during nighttime feedings. Emphasize consistency with medication regime, as early hypomanic episodes can be associated with medication non-compliance and overall decompensation.</td>
</tr>
</tbody>
</table>
## Summary of Perinatal Mental Health Conditions

<table>
<thead>
<tr>
<th>Perinatal Anxiety Disorders</th>
<th>Schizoaffective and Schizophrenia</th>
<th>Postpartum Psychosis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is it?</strong></td>
<td>A range of anxiety disorders, including generalized anxiety, panic, and social anxiety, experienced during pregnancy or the postpartum period.</td>
<td>Schizoaffective disorder is a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression. Schizophrenia is a psychotic illness without mood episodes.</td>
</tr>
<tr>
<td><strong>When does it start?</strong></td>
<td>Immediately after delivery to 6 weeks postpartum. May also begin during pregnancy, after weaning baby or when menstrual cycle resumes. May have been untreated before.</td>
<td>Symptoms of schizoaffective disorder and schizophrenia usually start between ages 16 and 30.</td>
</tr>
<tr>
<td><strong>Risk factors</strong></td>
<td>Personal history of anxiety. Family history of anxiety. Life changes, lack of support and/or additional challenges (e.g., difficult pregnancy, birth, health challenges for mom or baby). Prior pregnancy loss. Adverse childhood experiences (ACEs).</td>
<td>The exact causes of schizoaffective disorder and schizophrenia are not known. A combination of factors may contribute to development of either condition (e.g., genetics, variations in brain chemistry and structure, and environment).</td>
</tr>
<tr>
<td><strong>How long does it last?</strong></td>
<td>From weeks to months to longer.</td>
<td>Lifelong, can be well-managed</td>
</tr>
<tr>
<td><strong>How often does it occur?</strong></td>
<td>Generalized anxiety occurs in 6-8% in first 6 months after delivery. Panic disorder occurs in 0.5-3% of women 6-10 weeks postpartum. Social anxiety occurs in 0.2 to 7% of early postpartum women.</td>
<td>1% of the population is diagnosed with schizophrenia. One in every 200 people (0.5%) develops schizoaffective disorder.</td>
</tr>
<tr>
<td><strong>What happens?</strong></td>
<td>Fear and anxiety, panic attacks, shortness of breath, rapid pulse, dizziness, chest or stomach pains, fear of detachment/doom, fear of going crazy or dying. May have intrusive thoughts. Fear of going out. Checking behaviors. Bodily tension. Sleep disturbance.</td>
<td>Schizoaffective disorder: hallucinations, delusions, disorganized thinking, depressive and/or manic episodes. Schizophrenia: hallucinations, delusions, thought disorder, disorganized thinking, restricted affect, and cognitive symptoms (e.g., poor executive functioning skills, trouble focusing, “working memory” problems).</td>
</tr>
<tr>
<td><strong>Resources and treatment</strong></td>
<td>Treatment options include individual therapy, dyadic therapy for mother and baby, and medication treatment. Encourage self-care, exercise, and nutritious eating. Behavioral exercises can be taught to decrease nervous system dysregulation. Encourage engagement in social and community supports (including support groups). Address infant behavioral dysregulation as needed.</td>
<td>These conditions can be well managed with a careful regimen of medication and support. Medication should be continued during pregnancy and closely monitored by a psychiatric provider in combination with outpatient therapy or support groups. When well-managed, women with these conditions can absolutely be skillful and caring parents.</td>
</tr>
<tr>
<td>Borderline Personality Disorder</td>
<td>Posttraumatic Disorder (PTSD)</td>
<td>Obsessive-Compulsive Disorder (OCD)</td>
</tr>
<tr>
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<td>-------------------------------</td>
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</tr>
<tr>
<td><strong>What is it?</strong></td>
<td>Borderline personality disorder is a condition marked by an ongoing pattern of varying moods, self-image, and behavior. Women often display impulsive actions and problems in relationships. People with borderline personality disorder may experience intense fluctuating feelings. <strong>This is not a mood disorder, yet women are often misdiagnosed with bipolar disorder.</strong> Borderline personality disorder is a pervasive, developmental condition that is not specific to peripartum period.</td>
<td>Distressing anxiety symptoms experienced after traumatic event(s). Symptoms generally cluster around intrusion, avoidance, hyperarousal, and negative world view.</td>
</tr>
<tr>
<td><strong>When does it start?</strong></td>
<td>Begins early and develops through life, though symptoms typically manifest in late adolescence or young adulthood. However, many women go through their entire lives without an accurate diagnosis.</td>
<td>Onset may be related to labor and delivery process, traumatic delivery, or poor OB outcome. Underlying PTSD can also be worsened by traumatic birth.</td>
</tr>
<tr>
<td><strong>Risk factors</strong></td>
<td>The cause of borderline personality disorder is not clear. Research suggests that genetics, brain structure and function, and environmental, cultural, and social factors play a role, or may increase the risk for it. Adverse childhood experiences (ACEs) are also associated with borderline personality disorder.</td>
<td>Depression or trauma/stress during pregnancy, obstetrical emergency, subjective distress during labor and birth, fetal or newborn loss, and infant complication. Prior trauma or sexual abuse. Lack of partner support. History of ACEs.</td>
</tr>
<tr>
<td><strong>How long does it last?</strong></td>
<td>Until treated.</td>
<td>1 month or longer.</td>
</tr>
<tr>
<td><strong>How often does it occur?</strong></td>
<td>Occurs in 6.2% of women.</td>
<td>Occurs in 2-15% of women. Occurs after childbirth in 2-9% of women.</td>
</tr>
<tr>
<td><strong>What happens?</strong></td>
<td>May experience mood swings and display uncertainty about how they see themselves and their role in the world. Tend to view things in extremes, such as all good or all bad. Their opinions of other people can also change quickly, leading to intense and unstable relationships. Rejection sensitivity, anger, paranoia, self-harm, and impulsivity may be seen.</td>
<td>Change in cognition, mood, arousal associated with traumatic event(s) and avoidance of stimuli associated with traumatic event. Constantly feeling keyed up.</td>
</tr>
<tr>
<td><strong>Resources and treatment</strong></td>
<td>The gold standard treatment is Dialectical Behavior Therapy (DBT). DBT uses individual, group, and phone therapy to teach mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness skills to help manage symptoms. Medication can also be helpful in addressing other untreated mental health conditions. A typical course of DBT lasts one year. Treatment is accessible through many community mental health outpatient settings.</td>
<td>Treatment options include individual therapy and group therapy. Encourage self-care, exercise, and healthy eating. Monitor avoidance patterns and emphasize engagement in social and community supports (including support groups). Follow up traumatic birth experiences with women. Can refer to Council on Patient Safety in Women’s Healthcare “Support after Severe Maternal Event” safety bundle : <a href="https://safehealthcareforeverywoman.org/council/patient-safety-tools/support-after-a-severe-maternal-event-patient-safety-bundle-aim/">https://safehealthcareforeverywoman.org/council/patient-safety-tools/support-after-a-severe-maternal-event-patient-safety-bundle-aim/</a></td>
</tr>
</tbody>
</table>

Summary of Perinatal Mental Health Conditions


Copyright © 2019 UMass Chan Medical School all rights reserved. Revision 01-05-2023. Lifeline for Moms Perinatal Mental Health Toolkit. Funding provided by CDC grant number U01DP006093. Authors: Byatt N., Mittal L., Brenchke L., Logan D., Masters G., Bergman A., Moore Simas T.
Ask open-ended questions
- “How are you managing to free yourself up to attend therapy appointments?”
- “I’m curious, what seems to be getting in the way of [use patient’s own words]?”
- “What was your experience with that?”

Use reflective listening
- “You’re really not sure if your new therapist can be helpful.”

Reinforce action, changes, and strengths
- “With all the obstacles that you’ve described, it’s impressive that you’ve been able to schedule your therapy intake. This really speaks to your commitment to yourself and to being the best mom you can.”
- “It was difficult, and you still were able to make it to your visit today. That didn’t just magically happen, you had to take specific, concrete action to get to where you are right now.”

Acknowledge and validate concerns
- “I hear that you feel concerned about how these mental health challenges will affect your life.”
- “It sounds as though you’ve been through a lot. How have you managed to cope with all of this?

Summarize the conversation
- “So, based on what you’ve described, it sounds like you’re concerned about your depression because it affects your relationship with your baby and your partner. You also said that you have to put in a lot of effort to attend therapy appointments and it costs money to get there, which makes you doubt the process. Do I have that right?”

Ask permission before providing advice/feedback and follow-up
- “Would it be ok if we talk about your depression?”
- “I have some thoughts about strategies to address this, would you be interested in hearing them?”
- “What’s it like for you hearing this feedback?”
- “What questions do you have for me?”

Avoid saying “I understand”
- Say instead, “I can’t imagine what you’re going through” or “that must be very difficult.” Sometimes patients are looking for simple validation, rather than a solution.

Avoid using the word “but” because it negates what came before it
- Avoid saying something like, “You’re working really hard, but you still feel overwhelmed.” Instead, use the word “and” to acknowledge both truths: “You’re working really hard, and it’s important to keep focusing on your mental health and self-care. You’ve already made progress by being here.”

Avoid talking about yourself and your personal challenges or situations
- No matter how well-intentioned or seemingly appropriate, patients often perceive this as you not hearing them.
“I can’t imagine what you’re feeling right now”

“The pain you’re feeling right now is the echo of the love you felt for…”

“It would be weird if you weren’t feeling the way you’re feeling now”

“Any idea that grief proceeds in a step-wise or linear way is total bullshit. Everyone experiences the process in their own way.”

“What wouldn’t you have to care about to not feel what you’re feeling now? If given the choice, would you have it any different way?”

“Give yourself the kindness to feel whatever you’re feeling in this moment.”

“What would you tell a close friend if they were going through what you’re going through now? Can you offer even a small part of that to yourself?”

“Some days are going to feel like you’re getting better, then you may feel guilty for feeling better. This is all part of it, again just feel what you feel.”

“Most people are terrible about expressing condolences and may say things like, ‘I know what you’re going through’ or ‘I felt the same way when...’ try to attend to their intentions, not their words”

“Access your support network when it feels helpful, and take time for yourself if helpful – though be mindful of isolating”

“I’m here with you”

“I see the pain you’re in”

“Pain is the natural response to what you’ve been through, suffering comes from how we respond to pain”

Inquire about religious/spiritual/cultural traditions or practices that the patient can apply, even if no longer active. Familiar rituals can provide a sense of direction and stability when everything feels overwhelming.

Provider displays of emotion are completely normal. Without taking the focus off of your patient, put words to what is happening without trying to mask your feelings. “I’m noticing that I’m very moved by what you’re sharing.”
## Action Plan for Mood Changes during Pregnancy or After Giving Birth

Feeling down, mood swings, feeling anxious, overwhelmed, and scared are very common for women during and after pregnancy. If your feelings are impacting your life or your ability to care for you or your baby, we want to make sure you have the resources and support you need. If a few of these feelings sound like you, see below for what you can do.

<table>
<thead>
<tr>
<th>If you...</th>
<th>You may be experiencing emotional changes that happen to many pregnant individuals and new parents. You should...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feel like you just aren’t yourself</td>
<td>Take special care of yourself. Get your partner to watch the baby, get a babysitter, or team up with another person to share childcare so that you can rest and exercise.</td>
</tr>
<tr>
<td>Have trouble managing your emotions (ups and/or downs)</td>
<td>Continue to watch for the signs of emotional mood changes in the yellow and red sections below.</td>
</tr>
<tr>
<td>Feel overwhelmed, but are still able to care for yourself and your baby</td>
<td>Find someone to talk to if things get worse. Talk to a health care provider if you feel unsure.</td>
</tr>
<tr>
<td>Feel mild irritability</td>
<td></td>
</tr>
<tr>
<td>Have slight difficulty falling asleep</td>
<td></td>
</tr>
<tr>
<td>Have occasional difficulty focusing on a task</td>
<td></td>
</tr>
<tr>
<td>Are less hungry than usual</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>If you...</th>
<th>You may be experiencing emotional changes during or after your pregnancy for which you should get help. You should...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feel intense uneasiness that hits with no warning</td>
<td>Contact us. Your mental health is important to us. We are here to help.</td>
</tr>
<tr>
<td>Feel foggy and have more difficulty completing tasks than usual</td>
<td>Talk to your partner, family, and friends about these feelings so they can help you.</td>
</tr>
<tr>
<td>Notice that you have stopped doing things that you used to enjoy</td>
<td>Contact your insurance company to find mental health providers.</td>
</tr>
<tr>
<td>Have scary or upsetting thoughts that don’t go away</td>
<td>Visit the Anxiety and Depression Association of America’s telehealth providers: <a href="https://adaa.org/finding-help/telemental-health/provider_listing">https://adaa.org/finding-help/telemental-health/provider_listing</a></td>
</tr>
<tr>
<td>Feel guilty, or are having thoughts that you are failing at motherhood</td>
<td>Call Postpartum Support International (PSI) 1-800-944-4773 (voice in English or Spanish), 800-944-4773 (text in English), 971-203-7773 (text in Spanish), to contact a volunteer who can provide support and resources in your area, or search online for a mental health provider at <a href="https://psidirectory.com/">https://psidirectory.com/</a></td>
</tr>
<tr>
<td>Are having difficulty falling or staying asleep (that doesn’t have to do with getting up with your baby)</td>
<td>Search the National Center for Posttraumatic Stress Disorder (PTSD) at <a href="https://www.ptsd.va.gov/">https://www.ptsd.va.gov/</a></td>
</tr>
<tr>
<td>Are falling behind with your job or schoolwork, or struggling in your relationships with family and/or friends</td>
<td>Read or complete workbook materials: <em>Pregnancy &amp; Postpartum Anxiety Workbook</em> by Pamela S. Wiegartz and Kevin Gyoerkoe</td>
</tr>
<tr>
<td>Have family/friends mention that your mood seems off, or you’re not acting like your usual self</td>
<td></td>
</tr>
<tr>
<td>Are being overwhelmed by feelings of worry</td>
<td></td>
</tr>
<tr>
<td>Have periods of feeling really “up,” and overly happy where you are doing more activities than usual, then feel very sad, “down,” or hopeless</td>
<td></td>
</tr>
<tr>
<td>Are taking risks you usually wouldn’t</td>
<td></td>
</tr>
<tr>
<td>Are on edge or always looking out for possible danger/threats</td>
<td></td>
</tr>
<tr>
<td>Feel numb or detached, like you are just going through the motions</td>
<td></td>
</tr>
<tr>
<td>Have no interest in eating – food tastes like nothing</td>
<td></td>
</tr>
<tr>
<td>Have thoughts of hurting yourself</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you...</th>
<th>Get help now!</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feel hopeless and in total despair</td>
<td>Go to the local emergency room or call 9-1-1 for immediate help.</td>
</tr>
<tr>
<td>Feel out of touch with reality (you may see or hear things that other people don’t)</td>
<td>Call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free and confidential emotional support</td>
</tr>
<tr>
<td>Feel that you may hurt yourself or your baby</td>
<td>Text the Crisis Line at 741741 (US) or 686868 (Canada)</td>
</tr>
<tr>
<td>Have family/friends that are worried about your or other’s safety due to your mood swings and/or changes in activity levels</td>
<td>Still not sure what to do? Call us and we’ll figure it out together.</td>
</tr>
</tbody>
</table>

Getting help is the best thing you can do for yourself and your baby. Your mental health is important to us, please call us with any concerns or questions. We are here to help.
Self-Care Plan

Your life may feel drastically changed during this time, and feeling overwhelmed, stressed, or sad are very common and understandable responses. It can be hard to cope with problems when you’re feeling sad and have little energy. A self-care plan can be a useful tool to help you attend to your own wellness needs, and those of your baby.

1. **Make time for pleasurable activities.** Commit to scheduling some simple and enjoyable activity each day.
   - Things I find pleasurable include: ______________________________________________________________
   - During the week I will spend at least_____ minutes doing (choose one or more of activity to try in the coming week) ____________________________________________________________________________________

2. **Stay physically active.** Make sure you make time to do some activity, even a few minutes of activity can be helpful.
   - During the week, I will spend at least _____minutes doing (write in activities) __________________________ __________________________

3. **Ask for help.** Look to those in your life who you can ask for help - for example your husband or partner, your parents, other relatives, your friends.
   - People I can ask to help me: __________________________________________________________________________
   - During the week I will ask at least _____ person/people for help.

4. **Talk or spend time with people who can support you.** Explain to friends or loved ones how you feel. If you can’t talk about it, that’s OK – you can still ask them to be with you or join you for an activity.
   - People I find supportive include ___________________________. During the week, I will contact _______________________________ (name/s) and try to talk with them_____times.

5. **Belly breathing** is about breathing in a specific way that triggers your body’s natural calming response.
   - Begin by slowly bringing your breath to a steady, even pace.
   - Focus on breathing in from the very bottom of your belly, almost as if from your hips/pelvis.
   - See if you can breathe in a way that makes your belly stick out on the in-breath and deflate totally on the out-breath. Your chest and shoulders should stay quite still, it’s all about breathing with your belly!
   - Any amount of time you can find to do this can help. Aim to practice 10-15 minutes at least twice daily.

6. **Mindful breathing** helps bring awareness into the present moment using our body’s natural rhythm of breath. Bring your attention to your own natural rhythm of breath.
   - Notice physical sensations with breathing, such as the textures of clothing or movement of body.
   - When your mind offers a distraction, notice this, and bring your attention back to the physical sensation of natural breath. Try and notice temperature of the in-breath and out-breath or notice the precise moment in the rhythm where an in-breath becomes an out-breath.
   - Practice this when you feel like you could use some present moment grounding.

7. **Sleep is a very important part of self-care.** Here are some helpful strategies to try to help you sleep better at night.
   - Watch how much caffeine you take in. Caffeine stays in the body for 10-12 hours. Consider limiting coffee, tea, soda, chocolate, and energy drinks, and setting a cut-off point during the day (such as lunchtime) to stop drinking or eating caffeine.
   - Set a routine. Set regular times for going to bed and waking up, even if you slept poorly the night before. Set up a relaxing routine 1-2 hours before bed where you do something calming and limit your exposure to electronics and light. Getting into a routine will train your body to prepare for sleep near bedtime.
   - Keep the bedroom mellow. Only use your bed for sleep and sexual activity. This helps your body link the bed with sleep, rather than other things that keep you awake. Keep your bedroom dark and cool and move your clock to prevent you from constantly checking it through the night.

8. **Simple goals and small steps.** Break goals down into small steps and give yourself credit for each step you finish.