Assessing and Managing Perinatal Mood Disorders

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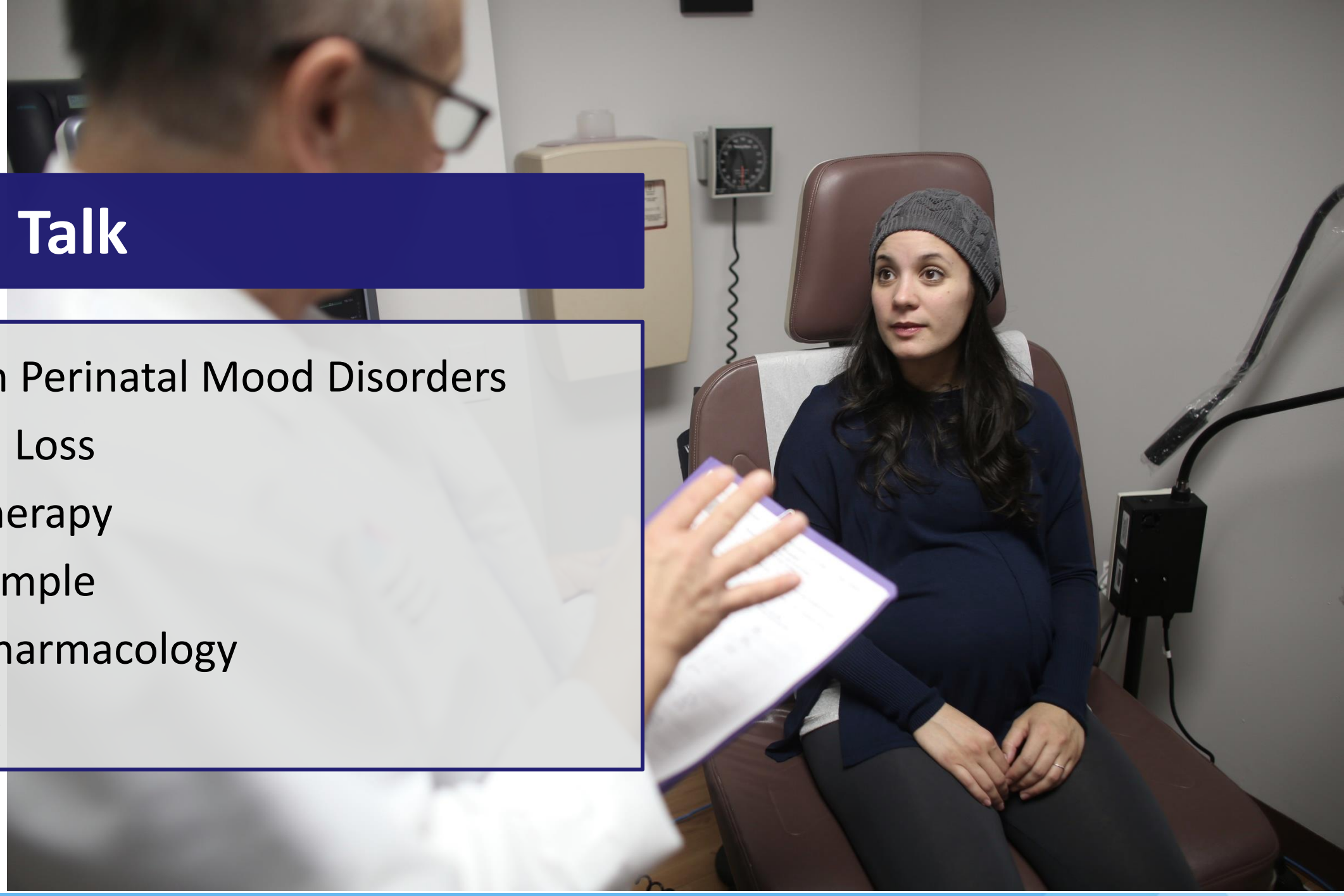
Project ECHO®

Learning Objectives

- Assess for symptoms of perinatal depression and anxiety
- Speak to patients about PMADS and resources for getting support
- Help patients cope with perinatal loss/ infertility issues
- Understand evidence-based therapeutic and pharmacological approaches to treating perinatal anxiety and depression

Today's Talk

- Common Perinatal Mood Disorders
- Perinatal Loss
- Psychotherapy
- Case Example
- Psychopharmacology
- Referrals



Terminology

Antenatal

During pregnancy

Postpartum

After birth, usually up to 12 months

Perinatal

Antenatal + postpartum

Perinatal Mood and Anxiety Disorders

PMADS

Parent

Not all pregnant individuals identify as female/women/mothers

Theories of Etiology

Biological sensitivities to hormonal changes

- Estrogen increases, progesterone increases, onset of oxytocin and prolactin at birth
- One's own vulnerability based on genetics

Psychosocial

- Changes in sleep and support
- History of trauma
- Poor social support
- Institutional and structural racism
- Relationship with one's own mother
- Ambivalence to parenthood
- Self- image

PSI, 2022

Risk factors for developing PMADS

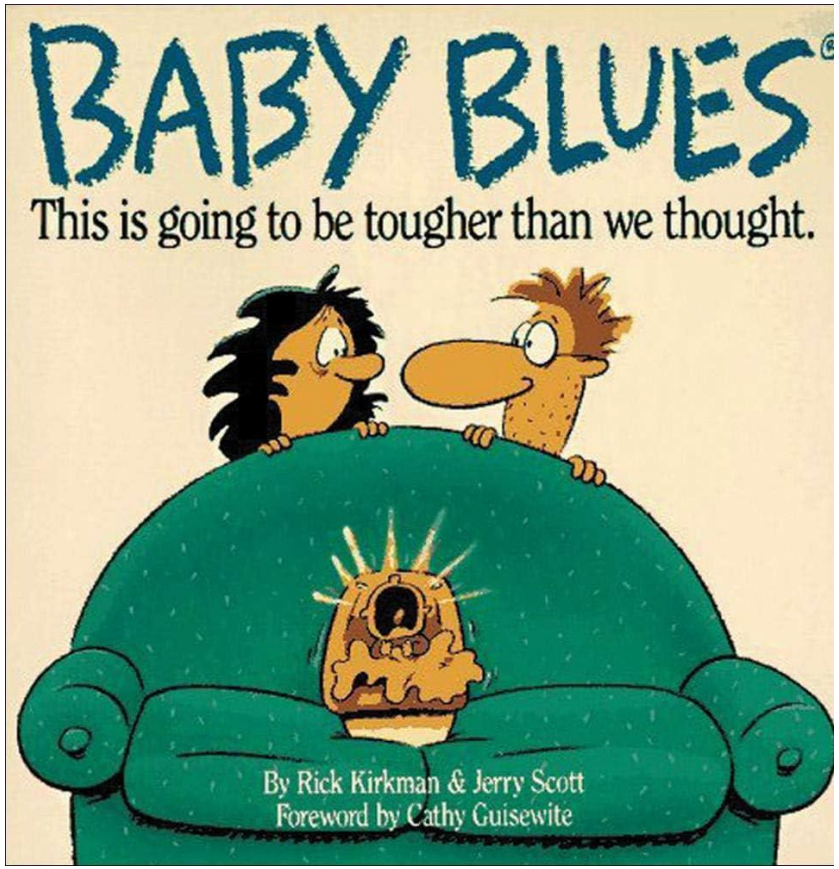
- Family or personal history of PMADS or mood disorders
- Pregnancy and delivery complications
  - preeclampsia, hypertension, preterm birth, traumatic birth
- Prior pregnancy loss
- Unplanned pregnancy
- History of childhood sexual abuse
- Relational conflict and/or IPV
- Low levels of social support
- Relationship dissatisfaction

Blackmore et al, 2016; Misri et al, 2016

Perinatal Depression vs “Baby Blues”

- Baby blues are characterized by mood lability, irritability, interpersonal hypersensitivity, insomnia, anxiety, and tearfulness
  - Self-esteem usually remains intact
  - 50-85% of women
  - Resolves within 10-14 days

- MDD in the perinatal period (aka “postpartum depression”)
  - Depressed mood, anhedonia, change in weight/appetite, insomnia or hypersomnia, low energy, indecisiveness, concentration issues, guilt or worthlessness, suicidal ideation
  - More days than not for at least 2 weeks
  - 30% of cases of PPD develops during pregnancy



What PPD Presentation “Looks Like”

- Overwhelmed
- Lack of connection with baby
- Inability to take care of oneself—showering, eating, changing clothes etc.
- Frequent comorbidity with anxiety
- Isolation, social withdrawal
- Agitation, irritability
- Increased somatic symptoms (headaches, back pain, GI distress, etc.)
- Thoughts about harming oneself or one’s baby

Perinatal Anxiety

Pregnancy-related concerns

- Worry or distress particular to pregnancy, including the health of the developing child, changes in appearance, labor and birth, and future parenting concerns
  - Tokophobia: fear of childbirth
  - Causes of tokophobia can be history of abuse, pressure to have vaginal birth, learning of other's traumas in childbirth, self-conscious or opposed to healthcare providers touching/being near private areas

Postpartum anxiety

- Safety of baby
  - is baby breathing, fear of dropping baby, baby injured by others, dirt= danger
- Sleep issues and/or pressure to sleep train
- Eating/weight concerns
- Breastfeeding
- Developmental milestones

Blackmore et al, 2016; Misri et al, 2016

Other Adjustment & Anxiety Disorders

PTSD

- 2-24% during pregnancy
- 1-20% during postpartum
- 2-5% related to traumatic birth outcomes
- PTSD is more common in pregnant than in nonpregnant populations

Obsessive-compulsive disorder (OCD)

- 0.2-3.9%
- Slow onset in pregnancy, rapid onset postpartum
- Usually **ego-dystonic** thoughts
- Guilt/shame
- Common presentations
  - Fear of deliberate harm, contamination, accidental harm, ordering/arranging
- Behaviors
  - Not letting other people touch baby, not touching baby, not putting down baby, not bathing baby, excessive cleaning

Postpartum Psychosis

- Incredibly serious, affects 1 to 2 out of 1,000 births; rapid onset
- Difference between “scary thoughts” and bizarre thoughts, delusions, or hallucinations
- Parent may not recognize actions/thoughts are unhealthy
- Minimal insight
- Might not see as much anxiety compared with perinatal OCD

PREVENT AND TREAT SEVERE EPISODES AFTER DELIVERY AND SAVE LIFES!

- In the US, 3.75 million deliveries, ~ 8000 women with a severe postpartum episode
  - These episodes can be prevented in women at high risk
  - Severe episodes have an EXCELLENT prognosis with the right treatment

- Risk factors for postpartum psychosis
  - Women with a history of postpartum psychosis
  - Women with bipolar disorder

- **Suicide or infanticide is a failure of our US health care system**

Audience Poll

1. What is your primary specialty?
   a. Internal medicine/family medicine
   b. Obstetrics/gynecology
   c. Pediatrics
   d. Psychology or psychiatry
   e. Other

2. Do you regularly screen for depression and/or anxiety in your practice?
   a. All patients are screened for depression and/or anxiety at least annually
   b. Most patients are screened for depression and/or anxiety at least annually
   c. Some patients are screened for depression and/or anxiety at least annually
   d. Few to no patients are screened for depression and/or anxiety at least annually

3. Which assessment(s) do you use?
   a. PHQ-2/9
   b. EPDS
   c. GAD-7
   d. Other

Assessment of PMADS

3 W's

Who is responsible for assessing for perinatal mood disorders?

- Obstetricians, primary care providers, pediatricians
- 40% of family practice physicians rarely or never assess for PMADS

With **what**?

- Edinburgh Postnatal Depression Scale (EPDS) or Patient Health Questionnaire (PHQ9 or PHQ2)

When? How often?

- ACOG recommends screening at the initial prenatal visit and at least once more during prenatal and again during postpartum (3 timepoints total)

Shklarski and Kalogridis, 2022

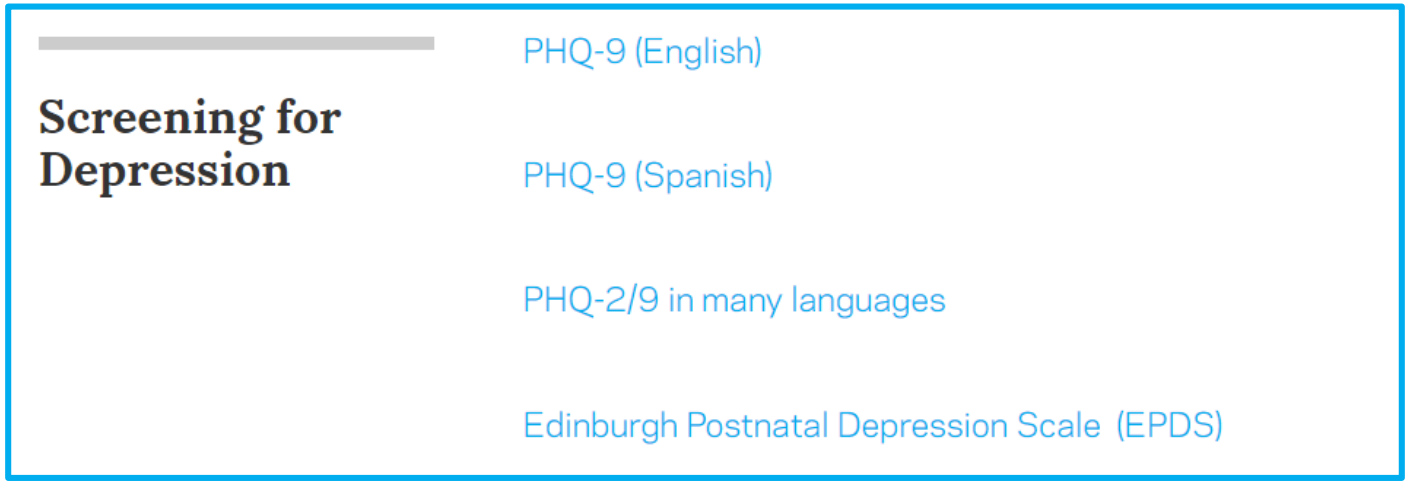
Pregnancy is a great window of opportunity for diagnosis of mental health disorders!

At least 10 appointments in OB

Mental health screening takes 5 minutes

EPDS and PHQ-2/9 are available:

- On the MSHP Behavioral Health Hub
- In EPIC
- Freely online via Google



https://mshp.mountsinai.org/web/mshp/resources

EPDS can be used both during pregnancy and postpartum to measure depressive and anxiety symptoms

In the past 7 days:

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

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

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

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

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

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

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

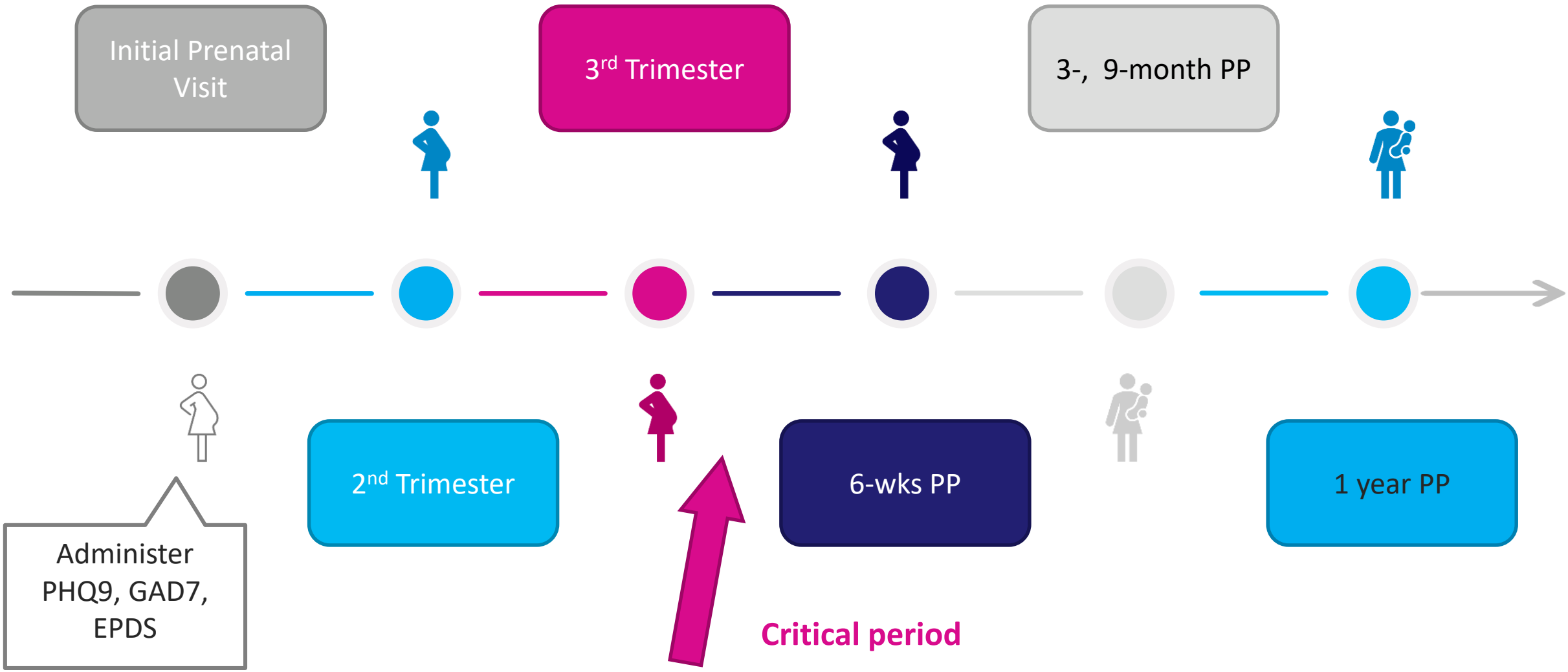
*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

PHQ-9 or PHQ-2 can also be used during entire perinatal period

Over the **last 2 weeks**, how often have you been bothered by the following problems?	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 asleep, 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're 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

Recommended Assessment Timeline



How can providers assess for PMADS?

- Be aware of symptoms to look out for

- Administer the Edinburgh Postnatal Depression Scale (EPDS), Patient Health Questionnaire (PHQ9), OR the Generalized Anxiety Disorder (GAD7)

- **Nonjudgmental risk inquiries**: *Some moms, when they are under a lot of stress, have distressing thoughts. Are you having thoughts of hurting or harming yourself? Are you having thoughts of hurting or harming your baby?*

ACOG, 2023

How to speak to patients about PMADS

- They are common
- They are medical conditions, like diabetes
- They are treatable
- The practice screens every pregnant woman
- That psychotherapy and medications can be very helpful

ACOG, 2023

Perinatal Loss

Perinatal Loss

- Loss at < 20 weeks gestation is considered “miscarriage” or spontaneous abortion
  - An estimated 25% of pregnancies end in miscarriage
  - About 15% of recognized or clinically diagnosed pregnancies end in miscarriage
- Loss at >20 weeks gestation is considered “stillborn”
  - 1 in 175 deliveries
- Death within the first month after birth is considered neonatal death

How can providers manage psychological factors associated with loss?

- Perinatal loss is a unique experience for every person
- Despite being medically common, the mental and emotional effects are often underestimated
- Associated with increased risk for mental health symptoms including **prolonged grief, anxiety, depression, guilt, shame, and trauma-related disorders**
- Associated with the highest prevalence of complicated grief among bereaved individuals
- No difference in intensity of grief between those who experience grief related to individuals who were living
  - 75% of individuals who miscarry feel as though they have lost a baby

How can providers assess for psychological factors associated with loss?

- *My body has failed me*
- *I can't trust my body*
- *I have no control*
- *My body is not mine*
- *This baby is not mine*

Factors associated with PMADS development

- *Guilt, shame or stigma from family or culture, previous perinatal losses*

How can providers support individuals going through loss?

- Early miscarriage (<20 weeks) is often an "**invisible loss**"

How can providers help?

- Psychoeducation can reduce feelings of blame, guilt, shame
  - Ambivalence and stress did not cause your loss
  - Known causes of miscarriage include: chromosomal abnormalities, genetic factors, health conditions, hormonal disorders, drug use, infections, uterine and cervical abnormalities

- Acknowledge the loss
  - Spend time with the patient answering questions
  - Allow parent to spend as much time with baby as they need

- Don't assume you know what they want: do they want to take a break from trying to conceive or move forward with attempting?

Psychotherapeutic Interventions

Interventions for PMADS

Interpersonal Psychotherapy

- Significant reduction in depressive symptoms compared to controls
- Even stronger outcomes when used with exposures

Cognitive Behavioral Therapy

- Strong evidence for perinatal depression first-line treatment
- Both individual and group formats
- Benefits racially and socioeconomically diverse populations and pregnant adolescents

Nondirective Counseling

Wenzel et al, 2016; Sokol, 2015

What is Interpersonal Psychotherapy (IPT)?

Present-focused

- Current relationships and functioning

Goal-oriented

- Identify goals for therapy, can be multiple and flexible

Time-limited

- 12-16 sessions

Evidence-based

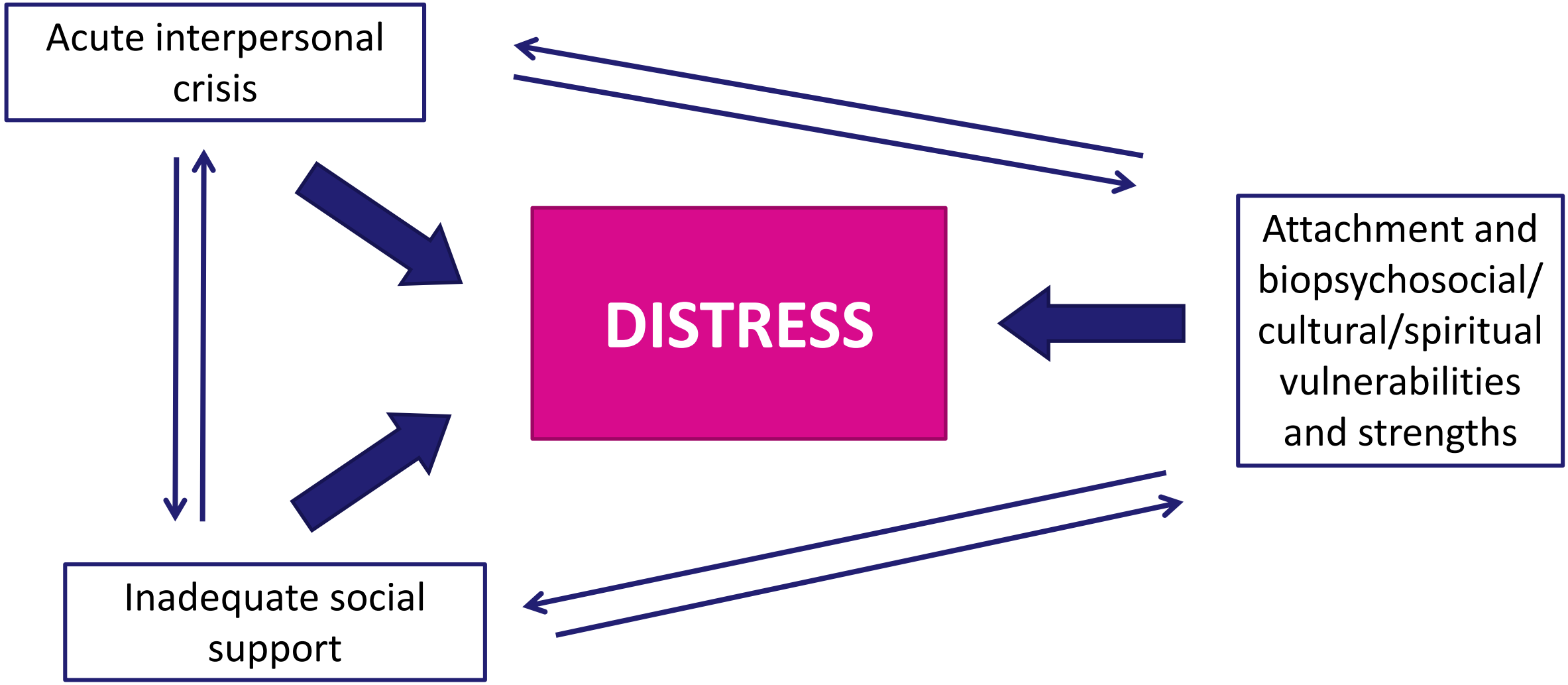
- IPT is an effective treatment for depression in perinatal patients, first line treatment

IPT for Perinatal Mood Disorders or Loss

- Based in attachment theory
- Pick a target area
  - **Grief** "What have I lost?"
  - **Role transition** "Where am I now?"
  - **Interpersonal dispute/deficit** "What do I need?"
- Depression occurs in the context of interpersonal relationships
  - Goals are to improve relationships with others, self, and modify expectations

Stuart, 2012

Interpersonal Triad



Stuart, IPT Institute

IPT Techniques for Therapy

- Psychoeducation of the biopsychosocial/cultural/spiritual model
- Empathy and support
- Communication analysis (e.g., exploration of faulty communications)
- Communication skills (e.g., "I" statements, discussion of timing, patient's tone)
- Directive techniques (e.g., education, modeling, direct help)
- Use of content and process affect
- Skill development
- Role playing

Stuart, 2012

Patient Case: Maggie

- 40-year-old cisgender Caucasian female with graduate degree in public health
- Married for 5 years; supportive partner
- History of fibroids and IVF (1 egg left)
- Family history of anxiety
- Anxiety & distress regarding 2+ years of infertility

Functional Assessment

Recreation/interests

- Still enjoys other aspects of life when adequately distracted

Work/school

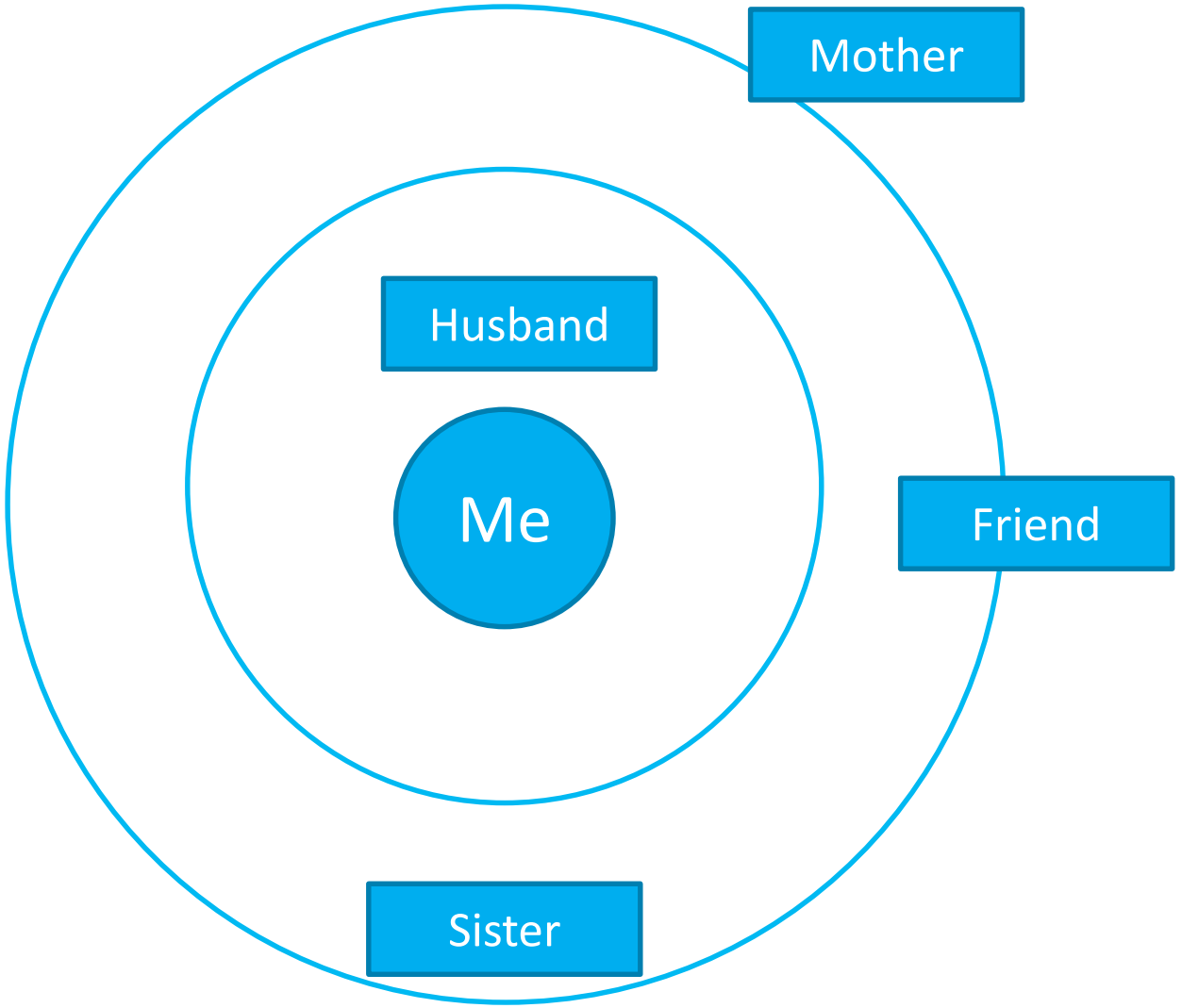
- Patient reports she suffers from burnout, overwhelmed at work, lack of support or appreciation, trouble concentrating, trouble sitting through meetings

Social support/relationships

- Identifies husband as supportive
- Does not rely on friends or other family for support, only husband
- Does not have good relationship with own mother who has PD

Intimate supports
Close supports
Extended supports

Interpersonal Inventory



Initial Phase

- **Role Transition** as the problem area: change in health status
- Met weekly, 14 sessions, 60 minutes each week
- Mourning her old role
  - "I had a good life before we decided to try to become parents"
- Engaging her social support network
- Managing the anxiety of the uncertainty
  - Skill development: feeling her feelings, tolerance of emotion, "worry time"

Middle phase

Part 1: Role Transition

- Patient became pregnant, fears shifted to her own identity and what it meant to be a “good mom”
  - Fears related to not being independent anymore
  - Fears related not liking being a mom and therefore being a “bad” mother

- Issues of her own mother’s difficulties with parenthood were brought into the therapy room

- Patient’s own mother became more involved and critical, therapy focused on boundary-setting and managing reactions to mother’s behaviors

Techniques: affect exploration, role playing, boundary-setting

Middle phase

Part 2: grief work

Techniques

- Educate about grief
- Build up social support
  - Allowing patient to be vulnerable
  - Encouraged patient to reach out to friends

Challenge beliefs

- Felt isolated for going through it herself (belief that husband doesn't fully understand)
- Feeling that body has failed her/broken

Support

- Grieve loss of what could have been; grieving the *expected future*
- Mourn her loss; ambivalence towards baby

Themes in working with perinatal women

Identity shifts

- *Who am I now? How do I maintain part of my own self? What does it mean that I miss my old life?*

Pressure from society

- What it means to be a “good mom” and to “soak up every second,” pressure for vaginal birth, pressure to breastfeed, gender expectations in society at large, and adjustment to other’s expectations

IVF/infertility issues

- Body being “broken,” others not understanding or saying insensitive things, pressure on self

Career balance

- Anxiety about sleep training, pumping issues (system issues), separating from baby at early age, bringing viruses home from the hospital, not being there for baby because of work, expectations from others in society

Psychopharmacologic Interventions

Women’s Mental Health Program

Veerle Bergink, MD/PhD

Director

Thalia Robakis, MD/PhD

Assistant Director

Kimberly Mangla, MD

Clinical Director

Collaborative Care Program

Mount Sinai Hospital

FPA OB Psych collaborative care

- Duration: pregnancy—6 months postpartum
- Monday mornings: intakes with residents/fellows
- Wednesday mornings: follow-up

E-clinic embedded collaborative care

- Community clinic
- Duration: pregnancy—6 weeks postpartum
- Friday mornings: resident/fellow

Objectives

1. Appreciate the risks of untreated perinatal mental illness including anxiety and depression
2. Increase comfort level of continuing necessary low-risk medications in pregnancy and postpartum
3. Provide basic counseling regarding risks of depression and antidepressant medication in pregnancy and lactation
4. Understand confounding factors in literature
5. Determine whether to refer patient to specialty care

Prenatal depression is the highest predictor of postpartum depression

- Studies estimate 33-50% of women with postpartum depression exhibited signs of depression during pregnancy

Heron 2004

Suicide accounts for up to 20% maternal death postpartum

Lindahl 2005

Treatment Considerations in Peripartum

- Risk AND benefit to mother AND baby
- Patient's past psychiatric history and severity of previous episodes
  - Past PPD
- Prior experience and response to medications and treatments
  - How has patient responded to trial off of medications?
- Non-pharmacologic options that can benefit patient
- Level of social support

Babies Do Better When Mom Does Better

Obstetric outcomes, growth, neurodevelopmental outcomes, and early behavioral outcomes

Obstetric risks associated with depression in pregnancy

- Miscarriage
- Preeclampsia
- Preterm delivery
- Cesarean section
- Low birthweight
- Impaired bonding
- Fetal neurodevelopment
- Neonatal/child development/behavior
- **Relapse

Obstetric risks associated with anxiety in pregnancy

- Meta-analysis including 29 studies of anxiety in pregnancy and adverse perinatal outcomes
  - Subjects with diagnosis/+screening tool c/t no anxiety disorder
  - PTB (OR 1.54)
  - LBW (OR 1.8)
  - Smaller head circumference
  - No significant difference for preeclampsia, low Apgar scores, Cesarean delivery
  - Additional known risks overlap with depression

Grigoriadis 2019

Medication in Peripartum

- Fertility
- 1st Trimester
  - Teratogenicity-risk of major malformations in general pop 2-4 %
  - Spontaneous abortion
- 2nd Trimester/3rd Trimester
  - Growth/Development
  - Neonatal Adaptation Syndrome
  - Neonatal Abstinence Syndrome/Withdrawal
- Lactation
  - Transmission
  - Neonatal adverse effects
- Early neonatal symptoms
- Long-term child development-IQ, speech, growth

Confounders

- Maternal psychiatric illness
- Behaviors associated with depression
  - Tobacco
  - Alcohol
  - Drugs
  - Poor nutrition
  - Decreased adherence
- Comorbid medical illness
- Polypharmacy
- Genetics

Antidepressant Medications

Obstetric Outcomes

(After adjustment for confounders)

SSRI/SNRI

- Fluoxetine
- *Paroxetine*
- Fluvoxamine
- Sertraline
- Citalopram
- Escitalopram
- Venlafaxine
- Duloxetine

Fertility

Likely not affected by AD use, but ↓ with psychiatric illness (Nillni 2016)

Miscarriage

Rate is likely the same in women with depression without AD exposure (Ross 2013)

Birth Defects

Majority studies show no increased risks

Preterm Delivery

Risk in increased with depression, possible slight increase with AD use (↓3-4 days)

Second Trimester

Low birthweight

- Conflicting results, likely little effect

PPHN

- General population prevalence 1-2 per 1000 births
- Limitations include sample sizes, recall bias, confounding by indication (cesarean section, tobacco use, alcohol use, diabetes, maternal age, SES)
- Conflicting results with max risk less than 1%

Postpartum Hemorrhage

- 13% prevalence in general population
- Serotonin depletion in platelets can disrupt aggregation and adhesion
- Limited studies without control for obstetric confounders

Third Trimester

Neonatal Adaptation Syndrome

- Up to 30% exposed
- Onset 24-48 hours postpartum, usually resolve within 1 week
- Symptoms include: irritability, tremor, hypo/hypertonia, weak cry, respiratory distress, sleep/feeding difficulty, hypoglycemia, weak seizures (rare), prolonged QT interval (transient-no long-term sequelae)
- Risk/duration increased with concurrent benzodiazepine use
- Unknown whether d/c or decrease in AD decreases risk of NAS

Other Antidepressants

Buproprion

- Limited data but likely no increased risk

Mirtazapine

- Limited data but likely no increased risk
- Can have benefit in hyperemesis gravidarum

Tricyclic Antidepressants (TCAs)

- Large body of data supports no increased risk
- Desipramine and nortriptyline preferred (less anticholinergic side effects)

Child Development

Speech/language/motor skills development

Autism Spectrum Disorder

Sedative Hypnotic Medications

Benzodiazepines

- Recent studies have not found increased risk of congenital malformations with benzodiazepines use in pregnancy
- Possible risk of miscarriage at high doses
- Possible risk of internalizing behaviors in toddlers
- Avoid drugs with high addictive potential (alprazolam/diazepam)
- Recommendation is to avoid sudden withdrawal, use lowest effective dose, intermittent use
- Lorazepam is good option (no active metabolites)
- Taper with conversion to long-acting agent Clonazepam

Medications for Anxiety and Sleep

- **Ambien-little prenatal data**
  - Registry study findings: not associated with congenital malformations, slight increased risk of SGA/preterm delivery (OR less than 1.5)
- **Mirtazapine**
  - Not associated with birth defects (~300 exposures)
- **Trazodone**
  - Not associated with birth defects (~300 exposures)
  - Limited data suggest 50-100 mg
- **Quetiapine/olanzapine**
  - No risk birth defects
  - Risk GDM
- **Gabapentin**
  - Likely no/low risk birth defects
  - PTL/SGA/NICU admissions?
- **Antihistamines**
  - Benadryl
  - Unisom
    - Diclegis-Unisom/B6 indication nausea/vomiting of pregnancy

Balancing Lactation and Maternal Mental Health

Is breast best?

- Sleep
  - May consider formula and breastmilk
- Risk of relapse postpartum
  - Not advisable to discontinue medication
  - Transmission much higher in utero
- Avoid sedating medication
- Communicate with pediatrician
- Low threshold to contact pediatrician with changes in infant behavior

Medication and Lactation

Antidepressants

- Sertraline first line given low transmission in breast milk (levels undetectable in most infants)
- Rare adverse events associated with Sertraline
  - This **does not suggest discontinuing alternative effective antidepressant**, especially if exposed during pregnancy

Benzodiazepines

- Possible sedation
- **No co-sleeping**

- Antihistamines may lower milk production

Pinheiroa 2015

Antidepressant Medications and Breastfeeding

Medication	% of Maternal Dose to Breastfeeding Baby	Reported Side Effects to Breastfeeding Babies*
Bupropion	2.0% - 5.1%	Possible seizures
Citalopram	2.5% -9.4%	Uneasy sleep, drowsiness, irritability, weight loss, restlessness
Desipramine	1.0%	None
Desvenlafaxine	5.5% - 8.1%	None
Duloxetine	0.14% - 0.82%	None
Escitalopram	3.9% - 7.9%	Enterocolitis
Fluoxetine	1.1% - 12.0%	Excessive crying, irritability, vomiting, watery stools, difficulty sleeping, tremor, somnolence, hypotonia, decreased weight gain, hyperglycemia, hyperactivity, reduced rooting, reduced nursing, grunting, moaning
Mirtazapine	0.6% - 3.5%	More rapid weight gain, sleeping through the night earlier
Nortriptyline	1.3%	None
Paroxetine	0.1% -4.3%	Agitation, difficulty feeding, irritability, sleepiness, constipation, SIADH
Sertraline	0.4% -2.3%	Benign sleep myoclonus, transient agitation
Venlafaxine	3.0% - 11.8%	None

*Based on case reports or case series of exposure as monotherapy during breastfeeding; no causal relationship is established in most cases (http://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm)

Remember…

- **There is no “safest” medication**
- Potential risks of untreated illness are weighed against potential risks and benefits of treatment
- Medication dose often needs to be increased with physiological changes in pregnancy and fluid shifts postpartum
- Use lowest **and** most effective dose
- Try to limit number of exposures

To Treat Or Not To Treat

To treat*

- Euthymic with anxiety/depression
- Euthymic with history of moderate-severe anxiety/depressions or history of perinatal mood disorder
- Low dose hypnotic

Not to treat

- Bipolar disorder
- Psychotic disorder
- Treated with antipsychotic, mood stabilizer, high dose benzodiazepine
- Active suicidal ideation

*or continue current effective treatment until consultation

Actionable Items

- **Assessment**
  - Use the EPDS or PHQ-2/9
- **Ask the hard questions**
  - *Are you having thoughts of hurting or harming yourself? Are you having thoughts of hurting or harming your baby?*
- **Take a non-judgmental approach;** provide psychoeducation
- **Make a plan with the patient**
  - Referrals

Support and Referrals

- Mount Sinai's Women's Mental Health Program
  - Contact Kimberly Mangla, MD
- The Center for Stress, Resilience, Personal Growth (CSRPG)
  - For Mount Sinai faculty, staff, employees, and dependents
  - Call CSRPG 212-659-5564 or email Lauren Blau, PhD
- Postpartum Support International
- The Motherhood Center
- Seleni Institute
- Podcasts, Instagram accounts, support groups can all be helpful in moderation

Thank you for your time and attention!

ANY QUESTIONS?

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