A Patient and Family Guide

CANMAT

Seeds of Hope

Nurturing Mental Health and Managing Perinatal Mood, Anxiety, and Related Disorders

Welcome

The **Canadian Network for Mood and Anxiety Treatments (CANMAT)** is a not-for-profit scientific and educational organization that produces clinical guidelines outlining the latest research and treatment options for managing mood, anxiety, and related disorders (www.canmat.org).

The scientific information in this guide is drawn from the **CANMAT 2024 Clinical Guidelines for the Management of Perinatal Mood, Anxiety, and Related Disorders**, published in the Canadian Journal of Psychiatry (available at www.canmat.org).

This **Patient and Family Guide** was created in partnership with individuals with lived experience of mood, anxiety and related disorders in pregnancy and postpartum. Many people reviewed the content in this guide, including people with lived experience of perinatal mood, anxiety, and related disorders, as well as perinatal mental healthcare providers.

Throughout the guide, we strive to use plain language and language that is inclusive of women and gender-diverse childbearing people and their partners and families as much as possible. We hope to empower people and their support persons with the knowledge to engage in conversations about their mental health in pregnancy and postpartum with their healthcare providers* and make informed choices about their treatment.

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*The term '**healthcare provider**' is used in this guide to indicate any healthcare professional involved in providing care and advice in managing your perinatal mental health including, but not limited to, psychiatrists, family physicians, midwives, obstetricians, nurses, psychologists, psychotherapists, social workers, pharmacists and others.

This Guide is for...

- → Anyone who is **pregnant**; or
- → Anyone who is **thinking of becoming pregnant**; or
- → Anyone who **has had a baby**, especially in the past year;

and

- → Is **worried about their mental health**, level of stress, or well-being; or
- → Has experienced or is **experiencing mental health challenges.**

As well as

- → Partners, families, trusted supports, and **anyone else who would like to learn more** about perinatal mental health.

Do I need immediate help?

If you are **thinking of suicide or of hurting yourself** in any way, please ask for help. Please reach out to the Suicide Crisis Helpline at **9-8-8** (by phone or text) or visit **988.ca** in Canada or the U.S. You can also call **9-1-1** for urgent help or go to your nearest emergency department.

If you are **thinking about hurting your baby, or anyone else,** or if you believe that you or a loved one may be experiencing mania or psychosis, please call **9-1-1** for urgent help or go to your nearest emergency department.

Read more on page 23 about how to know if you need help immediately.

Look out for...

Helpful symbols found throughout this guide

- Key Findings & Takeaways
- Tips for Speaking with Healthcare Providers
- Warnings & Urgent Information
- Common Questions
- Deeper Learning & Understanding
- Areas to Fill In for Personal Use

What's Inside

INTRODUCTION

ASSESSMENT

TREATMENT

Why is mental health in pregnancy and postpartum so important?

What is mental health?

"Mental health is a **state of mental well-being** that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community."

- World Health Organization

What is perinatal mental health?

Having a baby can be both a wonderful and stressful time. There are many big changes and unique challenges that come up during this time, and these can affect a person's mental health. For example, changes in the body during and after pregnancy, disrupted sleep, shifts in relationships, and the profound life and identity changes that come with becoming a parent can all impact mental health.

The time during pregnancy and up to one year postpartum is often called the "perinatal period", so mental health issues that happen during this time are called perinatal mental health issues or disorders. People with no past history of mental health problems can experience them for the first time in pregnancy and postpartum. People who have experienced mental health problems in the past can continue to experience them or have them come back again in pregnancy and postpartum.

Why is mental health important in pregnancy and postpartum?

Mental health issues are some of the most common conditions that come up in pregnancy and postpartum - up to 20% of people will experience a perinatal mood, anxiety, and related disorder (PMAD).

If perinatal mental health problems are not recognized and not properly treated, they can have a negative impact on you, your child, and your family.

The best way to support your mental health is to educate and empower yourself with the most up-to-date information. This knowledge will help you and your healthcare provider figure out how to choose the best care for your mental health needs during this time.

Key Takeaway

There is still a lot of stigma, fear, and misinformation around mental health, especially in pregnancy and postpartum. This can get in the way of getting help. If you're struggling with your mental health during pregnancy and postpartum, you are not alone.

The three most important things to know are:

1. Mental health issues in pregnancy and postpartum are real
2. Mental health issues in pregnancy and postpartum are not your fault
3. Mental health issues in pregnancy and postpartum typically get better with treatment

What are perinatal mood, anxiety, and related disorders (PMADs)?

Which perinatal mental health issues are covered in this guide?

- Depression
- Anxiety
- Obsessive-Compulsive Disorder (OCD)
- Post-Traumatic Stress Disorder (PTSD)
- Bipolar Disorder
- Postpartum Psychosis

! If you are struggling with a mental health problem not covered in this guide, speak to your healthcare provider to discuss what you are experiencing and make a treatment plan.

Perinatal Mood, Anxiety, and Related Disorders (PMADs) is the **clinical term** used by healthcare providers to describe some of the **most common mental health issues** that people can experience in pregnancy and the postpartum period.

There are various types of PMADs and many have overlapping symptoms. This is why it is so important to be **properly assessed by a healthcare provider**. Some common PMADs are depression, anxiety, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), and bipolar disorder. Other mental health issues can also require treatment perinatally either along with PMADs or on their own. These may include, for example, attention-deficit-hyperactivity disorder (ADHD), eating disorders, personality disorders, schizophrenia and other psychotic disorders, and substance or alcohol use disorders.

How are PMADs different from mood and anxiety disorders outside of the perinatal period?

Depression, anxiety disorders, OCD, PTSD, bipolar disorder, and postpartum psychosis each come with **specific symptoms**, whether or not they are experienced in the perinatal period (see the Appendix on page 48 for more details about specific symptoms for each of these diagnoses).

Depression

In **depression**, people feel **sad or low** and/or **don't feel that they can take as much pleasure in things that they normally enjoy**.

Anxiety

There are different types of **anxiety** difficulties, including **excessive worrying, intense physical symptoms of anxiety** (for example, tense muscles, trouble breathing, and/or racing heartbeat) or panic attacks, **or anxiety about specific situations**.

☆ **One thing that a lot of people don't know is that sometimes people can have symptoms of both anxiety and depression, and that in fact, anxiety might be even more common than depression in pregnancy and postpartum.**

What are ways that I may experience symptoms of depression and anxiety specific to pregnancy and postpartum?

- **Not experiencing joy** about or connection to the pregnancy or your baby
- **Feeling very tired**, but too anxious to sleep even when your baby is sleeping
- "Doing everything that needs to be done" but **feeling overwhelmed** at the same time
- **Feeling irritable** with your partner or with your baby in a way that seems out of proportion to what is going on
- Very **negative thoughts** about capacity as a parent (for example, being very critical or doubtful of yourself, or feeling like a failure)
- **Worrying too much about your ability to parent** and/or excessive guilt that your parenting choices or actions are having, or will have, a negative impact on your baby
- Feeling it is **hard to make small decisions** with regard to pregnancy or care of your baby (e.g., planning for their eating, sleeping, and balancing other tasks)
- **Worrying too much about the health, development, or safety of your baby**, which may also include feeling the need to seek reassurance or check on your baby's safety more than seems needed, or avoiding letting others look after your baby or being apart from your baby
- **Fear of childbirth** (tokophobia), which can include: fear of body changes, fear of pain, fear of death, or fear of loss of control

OCD

Obsessive thoughts – intrusive, unwanted, disturbing thoughts that you cannot control or get rid of – are very common in pregnancy and postpartum. Sometimes these include thoughts or images of harm coming to your baby or even of harming your baby on purpose. **These can also be part of OCD** – which is when a person has many different types of obsessive thoughts, often coming along with behaviours that temporarily reduce a person's anxiety around those thoughts, like repeatedly checking or cleaning – or other PMADs like depression or anxiety.

PTSD

PTSD may involve **distressing thoughts**, **memories**, **nightmares**, or **vivid reliving of a past traumatic event** (flashbacks). It might also include **extreme distress** or **intense negative emotions**, especially when reminded of the traumatic event. Healthcare interactions, including physical exams that are part of pregnancy care or during childbirth, can sometimes bring up past trauma. New symptoms can also come up related to difficult or traumatic experiences in pregnancy and postpartum.

Bipolar Disorder

Bipolar disorder is when a person has experienced **mania or hypomania** ("highs"), usually in addition to also experiencing **episodes of depression**. People with bipolar disorder have a high chance of relapse in the perinatal period, especially in the early postpartum. Most commonly, people with bipolar disorder relapse into depression, but there is also higher risk for the very rare condition called postpartum psychosis.

Postpartum Psychosis

Postpartum psychosis is a severe and high risk PMAD. It is linked to a higher risk of suicide and infanticide. It is rare (1-2/1000 births), but **when it occurs, it is an emergency.**

Postpartum psychosis is often a **unique combination of mood** (either depression or mania or a mix) and **psychotic symptoms** (symptoms that make it difficult for a person to distinguish what is real and what is not). The mania symptoms can include **extreme irritability** and/or **rapid mood swings**. The psychotic symptoms can include **paranoia** (including difficulty trusting people) and/or **false beliefs or thoughts**, including about your baby or childbirth, or believing that your partner is not who they say they are. There is often **confusion** and **disorganized behaviour**.

What is tricky about postpartum psychosis is that **symptoms can come and go**. Even if the person seems fine for the moment, **if they've had some psychotic symptoms, they still need to be checked out by a healthcare professional as soon as possible**. A pre-existing diagnosis of bipolar disorder or a family history of bipolar disorder increases the risk of developing postpartum psychosis. But people without a history of bipolar disorder can also develop postpartum psychosis.

What about the "baby blues"?

About **40-80%** of people experience the **"baby blues"** shortly after childbirth. Symptoms can include: **mood swings, sadness, crying more easily, anxiety, trouble with concentration, and difficulty sleeping**. These symptoms are mild and usually disappear on their own within two to four weeks without the need of any treatment. Your healthcare provider can help you to determine whether you are experiencing "baby blues" or a PMAD, and regardless, make a plan to monitor and watch for possible worsening symptoms.

What about the "baby pinks"?

The **"baby pinks"** are a phenomenon not as well-known as the "baby blues", but also occur shortly after childbirth. The "baby pinks" are different from mania or hypomania which can occur in bipolar disorder. There may be **feelings of intense excitement or happiness**, with some **increased energy** and **reduced need for sleep**. However, "baby pinks" do not usually cause big problems with functioning day-to-day and do not usually cause a lot of distress or stress in relationships. These symptoms usually disappear on their own in a few days, but it is good to watch these symptoms as they do turn into depression or mania in some people.

Does having mood and anxiety symptoms mean that I definitely have a PMAD?

Having some mood and anxiety symptoms in pregnancy or postpartum **does not** necessarily mean you have a PMAD.

You are more likely to be diagnosed with a PMAD if your **symptoms persist for the majority of days over at least a few weeks**, especially if the symptoms are getting worse AND making it harder to do the things you want or need to do. Sometimes medical issues that are fixable and commonly seen in pregnancy and/or postpartum, could be causing or worsening mood and anxiety symptoms. For example, sometimes having a low-functioning thyroid or low iron level can contribute to symptoms and your healthcare provider will want to check for this.

Mental health issues in pregnancy and postpartum typically get better with treatment.

Can fathers, partners, and other non-childbearing parents get PMADs too?

Yes. About **8-10%** of fathers, partners, and other non-childbearing parents develop PMADs. If you are a father, partner, or other non-childbearing parent who is struggling with mental health concerns, inform your healthcare provider.

The sooner you get help, the sooner you can enjoy the parenting journey too.

What puts me at risk for developing a PMAD?

The **strongest risk** factor for developing any PMAD is **having a previous history of that disorder** and untreated (or not fully treated) symptoms before getting pregnant. For example, if you have a history of depression in the past and some symptoms of depression before getting pregnant, you are at higher risk of developing depression in pregnancy and postpartum.

Not having enough social support and **experiencing a lot of stress** are also strong risk factors for PMADs. Some groups of people are more likely to experience more stress and have less access to support, including due to wider historical, political, and other systemic issues, which can make them more vulnerable to PMADs.

This can include people who are **Black**, **Indigenous**, and **People of Colour, 2SLGBTQIA+** people, **adolescents**, people with **disabilities**, **immigrants**, and **refugees**.

Some people may develop a PMAD even when they do not have any risk factors.

Read more about different PMAD risk factors on the following page. ▸▸▸

PMAD Risk Factors

Biological Risk Factors

- History of previous PMADs
- History of psychiatric symptoms related to menstrual cycle or birth control pills
- History of mood, anxiety, or related disorder outside of the perinatal period
- Other mental disorder present at the same time
- Chronic medical conditions, such as diabetes, and disabilities
- Family history of mental disorder, especially of PMADs and especially in a parent or sibling

Pregnancy and Postpartum-Specific Risk Factors

- Unintended pregnancy
- Having a child for the first time
- History of pregnancy loss
- Pregnancy complications (for example, severe nausea/vomiting of pregnancy, gestational diabetes, or preeclampsia)
- Childbirth and infant complications (for example, preterm birth or stillbirth)
- Difficulty sleeping
- Difficulty with breastfeeding chestfeeding (or stopping breastfeeding/chestfeeding early)

Social Risk Factors

- Age (adolescents and childbearing people over 40 years are at higher risk)
- Living in poverty or having few financial resources
- Stressful life events (for example, birth complications, birth trauma, illness in a child, death of a loved one, unemployment/financial strain, recent immigration, divorce)
- Low social support, including practical and emotional support
- Low partner/family support or partner/family relationship issues
- Domestic/intimate partner violence
- History of sexual or physical violence, or history of adverse childhood experiences

How are PMADs identified?

What should I do if I think I have a PMAD?

Tell your healthcare provider if you believe you may be struggling with a PMAD.

You are likely already meeting with different healthcare providers during pregnancy and postpartum (your family doctor, nurse, midwife, obstetrician, doula, psychiatrist, or your baby's pediatrician) and can bring up your concerns with any of them. If you do not have a family doctor or primary care provider, you can go to a walk-in clinic to begin to get help.

For more resources about PMADs and connecting with support, check page 47.

It may be hard to talk about your mental health. Fear, shame, mistrust, and mental health stigma can all get in the way of accessing care and support. You have the right to seek out trauma-informed and culturally-sensitive care with a healthcare provider who will be supportive, will not judge you, and will help you find the treatment that is right for you.

Tracking Your Symptoms

Use the chart on the following pages to write and record your symptoms like the example below.

You may find it helpful to take this chart with you when you meet with your healthcare provider so that you can express what you have been experiencing.

How to track your symptoms:

Date	Symptom(s)	Description
Include the date of the symptom(s)	What symptoms are you feeling that day?	Describe the symptom. How often? For how long? How severe? What makes it worse/better? How does it impact you?
Monday, November 25	*Loss of interest in things*	*Every day since my baby was born, so severe that I am not able to enjoy my baby*
Tuesday, November 26	*Reduction in Anxiety*	*Today I slept better and my anxiety improved a lot*

Symptom Tracking Sheet

Week #1

Print or copy this page and bring it with you when you meet with your healthcare provider.

Date	Symptom	Description

Symptom Tracking Sheet

Week #2

Date	Symptom	Description

You can track your symptoms for as long as they present, including how they may start to change and improve with treatment.

Identifying PMADs with your healthcare provider

Healthcare providers use **different tools** to assess PMADs, including questionnaires that they may ask you to fill out, regardless of if you have any risk factors or not. To **catch signs of PMADs early**, your healthcare provider is expected to **check-in with you about your mental health** at all routine appointments.

If you are concerned about your mental health or a loved one's, you should feel free to bring up that concern at ANY meeting with your healthcare provider.

Self-Assessment Questionnaire

The Edinburgh Postnatal Depression Scale (EPDS) is the most used questionnaire to identify possible perinatal depression. **If your score on the EPDS is 11 or higher, you may have perinatal depression.** If your score is below 11 but close, or there is some other important factor to consider (such as high anxiety or symptoms that are not covered in EPDS), your healthcare provider may still want to speak with you about your mental health further or offer some ways to help treat your symptoms.

You can complete the EPDS questionnaire on the following page and bring a copy to your meeting with your healthcare provider.

The EPDS has been translated into many **other languages** that can be accessed at www.albertahealthservices.ca/info/Page16138.aspx

Your healthcare provider may also use other questionnaires and tools to help identify PMADs.

How to complete the questionnaire:

Please place a **CHECK MARK** ✓ on the blank by the answer that comes closest to how you have felt **IN THE PAST 7 DAYS** – not just how you feel today. Complete all 10 items and find your score by adding each number that appears in parentheses (#) by your checked answer.

This is a screening test; not a medical diagnosis. If something doesn't seem right, call your healthcare provider regardless of your score.

Completed Example:

1 **I have felt happy:**

Yes, all of the time	✓ (0)
Yes, most of the time	____(1)
No, not very often	____(2)
No, not at all	____(3)

This would mean: "I have felt happy all of the time" in the past week.

Edinburgh Postnatal Depression Scale (EPDS)

In the past 7 days...

Print or copy this page and bring it with you when you meet with your healthcare provider.

1 I have been able to laugh and see the funny side of things:

- As much as I always could ____(0)
- Not quite so much now ____(1)
- Definitely not so much now ____(2)
- Not at all ____(3)

2 I have looked forward with enjoyment to things:

- As much as I ever did ____(0)
- Rather less than I used to ____(1)
- Definitely less than I used to ____(2)
- Hardly at all ____(3)

3 I have blamed myself unnecessarily when things went wrong:

- Yes, all of the time ____(3)
- Yes, most of the time ____(2)
- No, not very often ____(1)
- No, not at all ____(0)

4 I have been anxious or worried for no good reason:

- No, not at all ____(0)
- Hardly ever ____(1)
- Yes, sometimes ____(2)
- Yes, very often ____(3)

5 I have felt scared or panicky for no good reason:

- Yes, quite a lot ____(3)
- Yes, sometimes ____(2)
- No, not much ____(1)
- No, not at all ____(0)

6 Things have been getting to me:

- Yes, most of the time I haven't been able to cope at all ____(3)
- Yes, sometimes I haven't been coping as well as usual ____(2)
- No, most of the time I have coped quite well ____(1)
- No, I have been coping as well as ever ____(0)

7 I have been so unhappy that I have had difficulty sleeping:

- Yes, most of the time ____(3)
- Yes, sometimes ____(2)
- No, not very often ____(1)
- No, not at all ____(0)

8 I have felt sad or miserable:

- Yes, most of the time ____(3)
- Yes, sometimes ____(2)
- No, not very often ____(1)
- No, not at all ____(0)

9 I have been so unhappy that I have been crying:

- Yes, most of the time ____(3)
- Yes, sometimes ____(2)
- Only occasionally ____(1)
- No, never ____(0)

10 The thought of harming myself has occurred to me:

- Yes, quite often ____(3)
- Sometimes ____(2)
- Hardly ever ____(1)
- Never ____(0)

If your score is 11 or higher, you may have perinatal depression. Please discuss your results with your healthcare provider.

Total Your Score Here ▸▸▸

Edinburgh Postnatal Depression Scale (EPDS). Adapted from the British Journal of Psychiatry, June, 1987, vol. 150 by J.L. Cox, J.M. Holden, R. Segovsky. Reproduced with permission.

Meeting with your healthcare provider

What to Expect

Questionnaires **do not** provide the whole story and cannot be relied on alone to diagnose PMADs.

So, your healthcare provider will likely ask you some **additional questions** and might order some **laboratory tests** to see if common issues such as low iron or a low thyroid function might be contributing to your symptoms. Some questions might be about:

- your current symptoms;
- your experiences in your current or past pregnancy, labour and delivery, and postpartum;
- your sleep;
- your living situation;
- your supports;
- stressful life events and experiences of adversity or trauma;
- substance use;
- your lifetime mental health experiences and about any past treatment;
- your general medical history, including current medications and allergies; and
- if any of your family members have suffered from a mental health problem.

Support Person

It may be helpful to go to the meeting with a **support person** you trust, such as your partner, a close friend, or a family member. Your healthcare provider may have questions about your symptoms that someone who knows you well can help answer. It can also be useful to involve your partner or other trusted support people in creating your treatment plan.

Tips to make the meeting with your healthcare provider more helpful:

- ✓ Bring your **symptom tracking** sheet and **EPDS questionnaire.**
- ✓ Bring a **list of your current and past medications**, including prescription medications and over-the-counter medications.
- ✓ Tell your healthcare provider if you are taking any **nutritional or dietary supplements**, or herbal remedies.
- ✓ Tell your healthcare provider about **other medical conditions**, including any complications of pregnancy or labour and delivery.
- ✓ Review any **family history** of mental disorder.

Key Takeaway

The Tips list above may seem overwhelming. It is just a suggestion. The most important thing is to go to your healthcare provider for support. Do not delay seeking help in order to prepare everything listed here!

Questions for my Healthcare Provider

You may also have questions for your healthcare provider about PMADs and treatment options. It may be helpful to write down your list of questions and bring it with you. **Some questions you may want to ask include:**

How do I know if I have a PMAD?

Should I have any blood tests or other tests?

What are the different treatment options?

What treatment options are safer in pregnancy or breastfeeding/chestfeeding?

What are common or concerning side effects?

Do I need to see a psychiatrist or psychotherapist?

What support groups are available?

What will treatment cost?

When will I be expected to feel better?

Print or copy this page and bring it with you when you meet with your healthcare provider. You can also use the blank chart on the following page.

Questions for my Healthcare Provider

How do I know if I need immediate help?

Seeking Immediate Help

You need to **seek immediate help** if you are having:

- **Thoughts, a plan, or intent to harm yourself, your baby, or others**
- **Difficulty taking care of yourself or your child(ren)**
- **Intense agitation**, especially with extreme restlessness or aggression (this can occur due to mania or psychosis, a crisis or conflict, a medical condition, or substance use or withdrawal)
- **Manic symptoms**: intense high energy, euphoric or very irritable mood, little need for sleep, and impulsive or disruptive behaviours
- **Psychotic symptoms**: confusion, hallucinations, delusions, severe mood swings, and difficulty connecting with reality

If your **loved one** is experiencing any of the above, please support them to get **urgent help**.

Resources for Immediate Help

If you are **thinking of suicide or of hurting yourself** in any way, please ask for help. Please reach out to the Suicide Crisis Helpline at **9-8-8** (by phone or text) or visit 988.ca in Canada or the U.S. You can also call **9-1-1** for urgent help or go to your nearest emergency department.

If you are **thinking about hurting your baby, or anyone else**, or if you believe that you or a loved one may be experiencing mania or psychosis, please call **9-1-1** for urgent help or go to your nearest emergency department.

Are thoughts of harm to my baby always an emergency?

Thoughts of harming your baby (by accident or on purpose) happen, especially in the postpartum. Most of the time, these thoughts are unwanted and disturbing, with no actual desire or intent to harm your child. But, sometimes, these thoughts can be dangerous and indicate a high-risk issue - for example, if these thoughts are occurring in the context of psychosis. So it is important to talk to your healthcare provider about these thoughts and seek help.

Do not hesitate to discuss these thoughts with your healthcare provider to determine if there is cause for concern.

Treatment

How are PMADs treated?

Treatment for PMADs

Getting mentally well and staying well in pregnancy and postpartum is a **top priority**.

Your healthcare provider will help you create a treatment plan based on the *CANMAT Clinical Guidelines for the Management of Perinatal Mood, Anxiety, and Related Disorders* and your individual needs, including your symptoms, your diagnosis, your current life circumstances, and your own preferences. **You should continue to follow up with your healthcare provider until you recover**; this is really important in case you need to change to a different treatment if what you try first is not helping you enough.

You don't need a PMAD diagnosis to receive care.

Different types of treatments will be recommended depending on the **severity of your symptoms** and how much distress and disruption they are causing in your life, the kinds of symptoms that you are having, as well as what YOU prefer in your treatment.

MILD

For mild symptoms of PMADs, treatment usually begins with interventions focused on lifestyle modifications, improving social support, exercise, and sleep.

MODERATE

If more support, better sleep, and/or exercise are not enough to make you feel better, or if your symptoms are a bit more distressing and impairing to begin with, your recommended treatment plan might also include psychotherapy and/or medication.

SEVERE

For more severe PMADs, treatment usually also includes psychotherapy, seeing a mental health specialist, and/or medication from the beginning. Usually, you can receive treatment in an outpatient clinic. Only in very severe cases and urgent situations would you need to visit your closest emergency room or be admitted to the hospital.

How will my healthcare provider assess the severity of my symptoms?

Your healthcare provider will assess PMADs based on **these key factors**:

- **What kinds of symptoms you are experiencing**
- **How intense your symptoms are** (including how frequent they are, how long they have lasted, and how much distress they cause)
- **How much your symptoms get in the way of your daily function and your quality of life** (for example, how much they get in the way of taking care of your baby and yourself)

Look out for... Helpful Symbols

Very Strong support
Treatment has shown to be useful consistently across many research studies.

Good support
Treatment has shown to be useful in some studies, but not enough studies exist for very strong support.

Some support
Treatment may be useful, but research is still emerging. We don't know as much about it as we do other types of treatments.

Not Recommended
Research suggests that treatment is either not likely to be helpful, or it is not recommended due to extensive side effects or safety concerns.

What lifestyle interventions can help prevent and treat PMADs?

What lifestyle interventions can help with PMADs?

Lifestyle interventions that focus on **changes in diet, exercise, and/or sleep** may be useful to prevent and treat mental health problems. These interventions are helpful for prevention of PMADs or for treatment of mild PMADs. They can also play a role in more severe cases in combination with psychotherapy and/or medication. **You can speak with your healthcare provider to discuss what lifestyle interventions might be most helpful for you.**

Excercise

Recommendation
There is **good support** for 2.5 hours of moderate exercise per week such as brisk walking or jogging, swimming, cycling, or dancing.

How can it help with PMADs?
Exercise can help to prevent or treat mild perinatal depression and anxiety.

Considerations
Make sure to ask your healthcare provider what kind of exercise is safe for you to do, particularly while you are pregnant.

Better Sleep

to

Recommendation
There is **some support** for improving your sleep naturally. Try minimizing night-time wakings by involving your partner or another adult in overnight feedings, by having them bottle-feed with pumped breastmilk or formula.

If you suffer from insomnia, there is **very strong support** for Cognitive Behavioural Therapy for Insomnia (CBT-I).

How can it help with PMADs?
If you are consistently not sleeping well, you may be more likely to struggle with your mental health. If you have a history of PMADs or current symptoms of PMADs, especially bipolar disorder, finding a way to protect your sleep can prevent worsening symptoms.

Better sleep can help with anxiety and depression symptoms in pregnancy and with sleep difficulties in postpartum depression.

Diet

There is **no clear evidence for specific changes in diet** that would prevent or treat PMADs, however, see dietary supplementation recommendations on page 46.

What educational and social support interventions can help prevent and treat PMADs?

What educational and social supports can help with PMADs?

Receiving **support through your community, family, and friends** is incredibly important, as one key risk factor for PMADs is isolation and the feeling of not getting enough support. There are also **more formal support programs** that can provide emotional and/or practical supports.

These interventions are most recommended for mild PMADs, but can still play a role in treatment of moderate-severe PMADs in combination with psychotherapy and/or medication. **Speak with your healthcare provider to discuss what educational and social support interventions might be most helpful for you.**

Peer Support*

Recommendation

Get support and practical advice from people who are not therapists but have gone through similar challenges as you and have training in how to help.

Peer support can be helpful in individual or group sessions, in person or by phone or virtually.

How can it help with PMADs?

There is **very strong** support for reducing depressive symptoms in pregnancy and postpartum.

There is **good support** for reducing anxiety symptoms in pregnancy and postpartum, and helping to prevent postpartum depression in people at higher risk for it.

*While there are no perinatal studies, there is good support from non-perinatal studies that peer support in addition to medication is helpful to prevent symptom worsening in bipolar disorder.

Education

Recommendation

Connect with "Co-parenting Programs" where the focus is on educating parents and caregivers about how to share roles and effectively interact around parenting.

How can it help with PMADs?

There is **good support** for prevention and treatment of perinatal depression and anxiety with co-parenting programs.

Considerations

While education is important and part of best practices in healthcare, other types of education programs have not been shown to prevent or treat PMADs.

Home Visits

Recommendation

“Listening-visits” are a specific type of home visit that involves a nurse or other home visitor trained in the use of empathic listening and problem-solving.

How can it help with PMADs?

There is **good support** for “Listening-visits” to help reduce depressive symptoms in the postpartum.

Considerations

Other types of home visiting programs that are more “unstructured”, or where the visitors do not receive the same type of specific training, have not been shown to be helpful.

What psychological interventions can help prevent and treat PMADs?

What psychological interventions can help with PMADs?

Psychological interventions are what many people think of when they talk about "**therapy**" or "**talk therapy**".

There are many different kinds of talk therapy. Some common types that are known to help in the perinatal period are:

- **Cognitive-behavioural Therapy (CBT)**
- **Interpersonal Therapy (IPT)**
- **Behavioural Activation (BA)**
- **Mindfulness-based Therapies**

Getting Started

Therapy sessions are most effective when **attended consistently**. Most therapy sessions are usually delivered **weekly, last from 4-16 sessions**, and can be delivered **in person or online**, **individually or in a group**, by **nurses, midwives, or peers**, as well as by **specialist healthcare providers** (i.e., psychiatrist, psychotherapist, psychologist).

In some cases, psychological treatment can be done on your own (self-help), through a workbook or online modules, with or without the guidance of a coach. **Self-help interventions are more effective with the support of a coach.**

Sometimes you might be able to refer yourself to a therapist, and in other situations you may need a referral from your healthcare provider before beginning a treatment plan. The information in the following pages is a general guide, and **your healthcare provider can help you figure out whether to try therapy and what type might be best for you.**

What PMADs can be prevented or treated with psychological interventions?

Psychological treatment for PMADs is recommended for treating **mild or moderate-severity perinatal depression, anxiety, OCD, and PTSD**, sometimes in combination with medication. Some psychological interventions can also **prevent** perinatal depression and anxiety in people at higher risk (see some key risk factors for PMADs on page 12 for more information).

For **bipolar disorder**, even though medication is the main treatment, psychological treatment can help treat depression, improve quality of life, or maintain wellness in bipolar disorder in non-perinatal people. While there aren't many studies focused on pregnant and postpartum people, the same psychological treatments may still be helpful alongside medication for perinatal people with bipolar disorder, too.

Psychological Interventions for the Prevention of PMADs

There is **strong support** for **Cognitive-behavioural Therapy (CBT)** and **Interpersonal Therapy (IPT)** in prevention of depression in pregnancy and postpartum for people who have a lot of risk factors for developing these issues (see page 12).

There is **good support** for preventing PTSD with **CBT-like treatments** that focus on trauma symptoms for people who have had a preterm birth and are starting to develop PTSD symptoms. There is also **good support** for these interventions when they are done through **guided self-help** (using a workbook online or in print, but under the guidance of a coach), in the prevention of depression and anxiety.

Psychological Treatments for Perinatal Depression and Anxiety

There are **several types** of psychological treatments that are known to be helpful in the treatment of **depression and anxiety** both in **pregnancy** and in the **postpartum**.

Cognitive-behavioural Therapy (CBT) CBT can help identify and reframe negative thoughts and change negative behaviour patterns.	Perinatal Depression	Perinatal Anxiety
Behavioural Activation (BA) BA can empower people to "do differently" by identifying negative behaviours, solving problems, and making their lives more rewarding and less stressful.	Perinatal Depression	Perinatal Anxiety
Interpersonal Therapy (IPT) IPT can help address depression in the context of relationship challenges, life changes, grief, and loss.	Perinatal Depression	Perinatal Anxiety
Mindfulness-based Therapies Use techniques such as mindfulness meditation to teach people to consciously pay attention to their thoughts and feelings without placing any judgments upon them.	Perinatal Depression	Perinatal Anxiety
Guided Self-help Different types of psychological treatments that can be done on one's own through a workbook or online modules, with the guidance of a coach.	Perinatal Depression pregnancy postpartum	Perinatal Anxiety

Psychological Treatment for Fear of Childbirth

There is **good support** for several forms of psychological treatment, primarily those containing elements of **CBT**, in the specific treatment of fear of childbirth symptoms. There is even some support for these to be delivered in a guided self-help format.

Psychological Treatment for Perinatal Obsessive-Compulsive Disorder

There is **less information** about psychological treatment for perinatal OCD specifically. **CBT with exposure and response prevention (ERP)** is a highly-recommended treatment for non-perinatal OCD, so it is also recommended for treating OCD in pregnancy and postpartum. **CBT-ERP** can help people practice confronting situations and thoughts that are causing anxiety and obsessions and learn how to refrain from engaging in compulsive behaviours.

Psychological Treatment for Perinatal Bipolar Disorder

There is far less information about psychological treatments for perinatal bipolar disorder. Some research studies have shown that if **non-perinatal people** take **medication and try some psychological treatments**, their depression symptoms can improve, they feel they can function better, and it can help prevent their symptoms from coming back. This may be a helpful strategy for you as well.

Some examples of treatments that have helped when used outside of the perinatal period include:

Cognitive-behavioural Therapy (CBT)

As an add-on treatment to medication, CBT can help a person recognize and reframe negative thoughts and change negative behaviour patterns.

Family-Focused Therapy (FFT)

Family-Focused Therapy (FFT) is designed for people with bipolar disorder and their family or caregivers. It provides education about bipolar disorder and teaches communication and problem-solving skills.

Interpersonal and Social Rhythms Therapy (IPSRT)

IPSRT helps people develop healthy daily routines, including around sleep, and address stressful life events and relationship stress.

Postpartum Psychosis

There are **no psychological therapies** for acute postpartum psychosis.

Psychological Treatment for Perinatal Post-traumatic Stress Disorder

There is less information about psychological treatment for PTSD in pregnancy and postpartum specifically. There is **some support** for **Written Exposure Therapy** as a treatment for PTSD. In this therapy, people write about past traumatic experiences, along with their thoughts and feelings at the time, while receiving support and following specific instructions. Because at this time there is so little research about how to treat PTSD specifically in the perinatal population, your healthcare provider **might recommend** a type of therapy that has **evidence in non-perinatal people**, and this could be a very reasonable strategy for you.

Some examples of highly recommended treatments outside the perinatal period include:

Prolonged Exposure Therapy (PE)

PE (a type of CBT) can help an individual gradually confront their fears about the traumatic event and learn that trauma-related memories and reminders are not dangerous and don't need to be avoided.

Cognitive Processing Therapy (CPT)

CPT can help people learn how to challenge and change negative beliefs concerning the traumatic event.

Eye Movement Desensitization and Reprocessing (EMDR)

EMDR can help people access and process traumatic memories to reduce distress.

Read more about why **Debriefing Intervention** is not recommended to treat or prevent PTSD. ▸▸▸

Debriefing Intervention

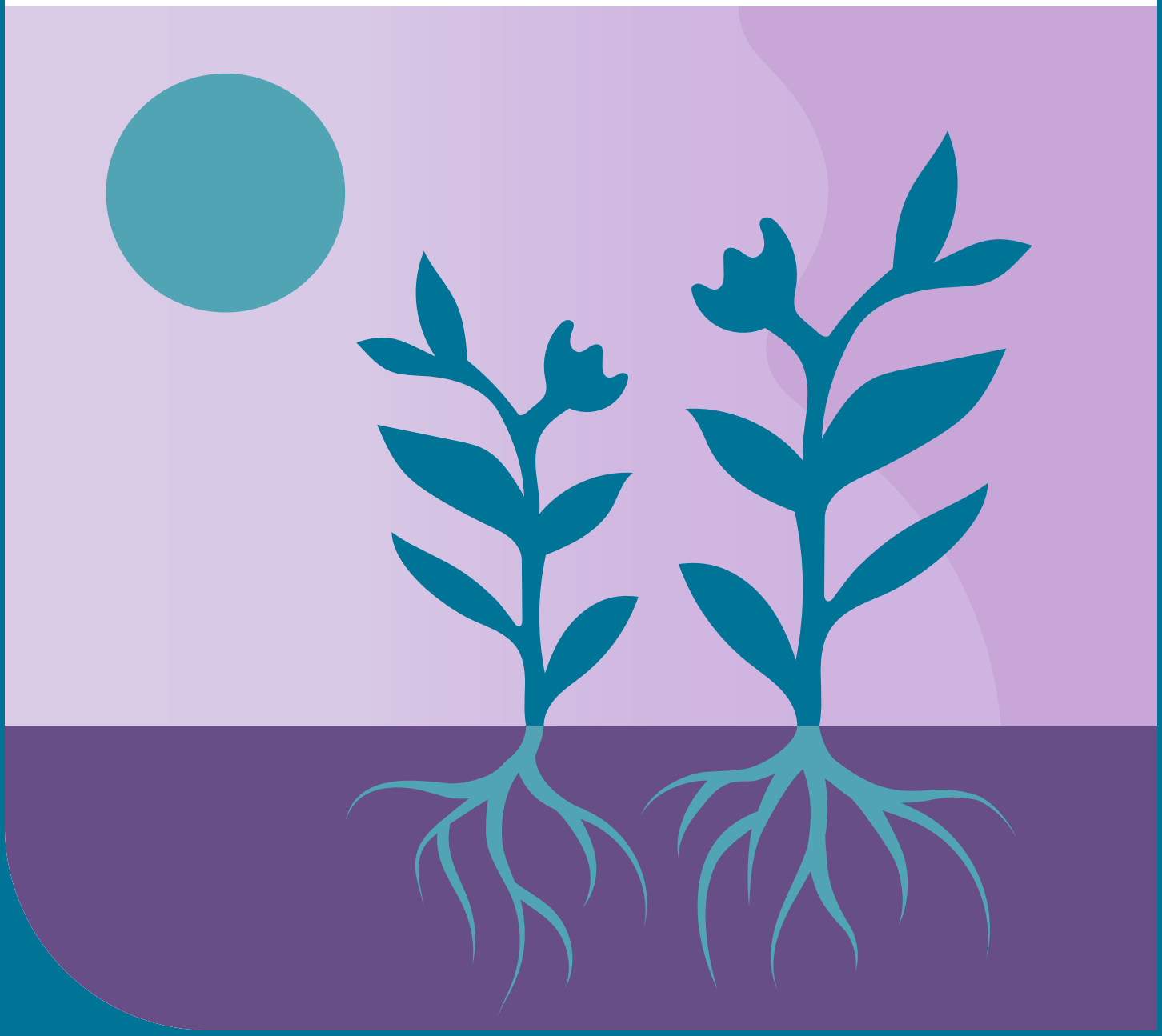
One type of prevention and treatment strategy that is not recommended for PTSD is called a "debriefing intervention". This intervention was developed to reduce the chances that someone would develop PTSD by encouraging all people to relive their experiences and feelings about a traumatic event shortly after it occurs.

This is **not recommended** to prevent PTSD or treat trauma-related symptoms after childbirth because it is not likely to be helpful. **There is concern that having to relive a traumatic experience and talking about your feelings before you are ready might actually have a negative impact.**

This does not mean that you shouldn't ask questions about something that happened or talk about it with your healthcare provider when you feel ready.

Notes from my Healthcare Provider about Psychological Interventions

What medications and related treatments can help treat PMADs?



What medications and related treatments can help treat PMADs?

The goal of treating PMADs with medications is to **significantly reduce or eliminate symptoms**, as well as **prevent episodes** in those who are at high risk of relapse.

Key Takeaway

There is strong evidence that all of the medications discussed in this guide are useful for reducing mental disorder symptoms from studies done in non-perinatal people. So, **in the perinatal period, safety information is the main issue in making decisions about medication** (see pages 39-42). Making a decision about medication is also a very **individualized choice**, so talk to your healthcare provider to get more information and support to make the best choice for you.

Depression, anxiety, OCD, and PTSD in pregnancy and postpartum

Medication is usually prescribed when symptoms are moderate to severe, and/or when non-medication interventions aren't available, and/or when non-medication treatment isn't working, and/or based on when you prefer medication over other options. Medications can also be used to prevent relapse in the perinatal period.

Perinatal Bipolar Disorder and Postpartum Psychosis

Medication is the main treatment regardless of how severe the symptoms are. Bipolar disorder has the highest risk of relapse of any PMAD in the postpartum, especially in people not taking medication.

If you already take medication, it can be helpful to start to think about this decision even before you get pregnant.

When are healthcare providers most likely to encourage people to stay on their medication to prevent relapse?

- People who still **have some ongoing symptoms** despite being on medication (even if the symptoms are not currently severe)
- People who **have had a relapse** when they tried to stop medication in the past
- People who have **had multiple episodes of illness**
- People for whom **it took trials of many different medications to get better** or for whom **it took a long time in the past to respond to medication**
- People with a **history of very severe episodes** or episodes that come on very quickly
- People with **bipolar disorder**

Is medication safe to take while pregnant or in lactation (breastfeeding/chestfeeding)?

A decision about taking medication in pregnancy or lactation can be difficult in some cases. While most medications used to treat PMADs are considered compatible with pregnancy and/or lactation, it is important for each person to weigh the potential benefits of a medication (i.e., getting well, which can help support a healthy pregnancy and healthy parent-child relationship) versus any potential side effects or safety considerations of taking the medication. These decisions can be harder when less is known about a particular medication.

Research has shown that the most common medications used to treat PMADs are **fairly low risk** to use in pregnancy and lactation. But there are **some exceptions**. When making decisions about medication in pregnancy and lactation, some **key things to think about and discuss with your healthcare provider are:**

- **Knowing all your treatment options** (including psychological therapies, medication, and not having treatment)
- **The benefits of medication** (including your past or current experiences with medication and the risk of relapse if you stop a medication you are currently taking)
- **The safety data of the medication** in pregnancy and lactation
- **The potential risks** of untreated PMADs
- **Your own values and preferences**

In this guide, we offer brief summaries of current information on the safety of the most common medications that are used in the treatment of PMADs. In the *CANMAT 2024 Clinical Practice Guideline for the Management of Perinatal Mood, Anxiety and Related Disorders* itself, we provide specific recommendations about which medications your healthcare provider might suggest first if you are starting a new medication. We then outline which medications to try second, or third, if the first ones give you side effects or do not work well enough.

These recommendations are made based on:

1. **How well specific medications help treat specific conditions and the typical side effects of those medications (often based on research outside of the perinatal period).**

2. **What is known about - and the amount that is known about - the safety of those specific medications in pregnancy and/or lactation.**

We know more about what happens when a person takes a single medication than when they take multiple medications in pregnancy and lactation. We think that taking only one medication, when possible, might help reduce safety risks. So, your healthcare provider will try to have you take only one medication if they can. For some people, however, multiple medications are needed to prevent and fully treat PMADs - and being well is a priority.

Please speak with your healthcare provider to learn more about the risks of taking and not taking medication. Your healthcare provider can use the **CANMAT guideline information** to help you find the best treatment for you and your baby to help you prevent or recover from PMADs.

Key Takeaway

If your current medication is working well for you and it isn't highlighted here or in the guideline as a medication that is NOT recommended, **your healthcare provider will often recommend that you keep taking it**. If your medication has been helpful in pregnancy, **reducing or stopping it near delivery generally is not recommended**, and it is usually helpful to continue taking it in postpartum even if you are breastfeeding/chestfeeding.

Safety Information for Common Medications used in the Treatment of PMADs

Antidepressants

Antidepressants are medications commonly used for treating depression, anxiety, OCD, and PTSD; and sometimes used for treating bipolar disorder.

Most safety information that we have is about **Selective Serotonin Reuptake Inhibitors (SSRIs)** (for example, **sertraline**, or **escitalopram**), **Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)** (for example, **venlafaxine** or **duloxetine)**, and **bupropion**, which are commonly used antidepressant types.

Pregnancy

If you are taking an SSRI, an SNRI or bupropion in pregnancy, there is **minimal evidence for concern about: miscarriage, major birth defects, or development problems**. While some babies are born a little bit earlier than term or weigh a little bit less than usual, many studies suggest that this risk would be similar if the depression or anxiety that you are taking the medication for in the first place went untreated.

There may be some small risks involved in taking antidepressants in pregnancy, which need to be weighed against the risks involved in having a PMAD that isn't well-treated.

Your healthcare provider can review the different types of antidepressants with you to determine to what extent these concerns would apply to the medication that you are taking or considering taking.

In general:

- **Less than 1% of babies are born with a heart defect**, such as a small hole in the heart. Some studies - but not all - have suggested that this risk could be slightly increased with SSRI or SNRI antidepressant use in pregnancy.
- **Less than 1% of babies are born with a rare serious breathing problem called persistent pulmonary hypertension of the newborn (PPHN)**. While it is not certain that antidepressant use increases that risk, it may increase it very slightly (e.g., from 2 to about 3 in every 1000 births).
- **Poor neonatal adaptation syndrome (PNAS)* can occur in 15-30% of newborns exposed to antidepressants in pregnancy**, although it has also been shown to occur in about 10% of newborns not exposed to antidepressants.

Breastfeeding/Chestfeeding

If you are taking an antidepressant in lactation, there is **minimal evidence of any significant negative impact on infants or on milk production** related to the majority of antidepressants.

* **Poor neonatal adaptation syndrome** (PNAS) has been reported in **15-30% of newborns exposed to antidepressants during pregnancy**, especially in the third trimester. **PNAS symptoms may include: difficulty feeding, trouble sleeping, low blood sugar, difficulty breathing, irritability, tremors, jitteriness, and very rarely seizures. These symptoms are usually mild and go away on their own;** they usually start within a few hours after birth and disappear within a few days in most cases. **Helpful strategies for these newborns include: providing a quiet environment, swaddling, skin-to-skin care, and frequent small feeds.** Breastfeeding/chestfeeding can also be helpful. In a small percentage of cases, Neonatal Intensive Care Unit (NICU) stay or medication for the newborn is needed, so giving birth in a hospital is recommended if you are taking medication in pregnancy. Stopping or decreasing your antidepressant near the estimated delivery date is not typically recommended. For more information, check out the recommendations from the Canadian Paediatric Society at cps.ca/en/documents/position/selective-serotonin.

Antiepileptics

Antiepileptics are medications sometimes used as "mood stabilizers" in bipolar disorder. These include **carbamazepine**, **lamotrigine**, and **valproic acid**.

Lamotrigine

There has been a lot of **reassuring safety research on lamotrigine** in pregnancy and lactation. If you are taking lamotrigine, there is **minimal evidence of major birth defects** or other significant negative effects on your baby in pregnancy or lactation.

Carbamazepine

There are **some increased risks with carbamazepine**, mainly related to an **elevated risk of birth defects** when used in pregnancy, so your healthcare provider would want to talk with you about how to reduce those risks. For example, folic acid supplementation is usually recommended when antiepileptics are prescribed in pregnancy, as it has been shown to reduce the risk for birth defects in these cases.

Valproic Acid

There is a **significant clinical concern around using valproic acid** in people who may become pregnant. Valproic acid is **not recommended** in pregnancy due to an elevated risk of major birth defects, including neural tube and heart defects - 3x higher than in the general population, and higher risks of developmental disorders - 4-5x higher than in the general population. If you are taking valproic acid and are considering becoming pregnant or are pregnant, speak to your healthcare provider as soon as possible.

Lithium

Lithium is a medication for treating bipolar disorder; and is sometimes used as add-on medication for depression.

Pregnancy

If you are taking lithium in pregnancy, there is **minimal evidence of any increased risk of miscarriage or developmental problems**. There may be a **small increased risk of heart defects** (including very rare Ebstein's Anomaly) **or of newborn complications**, including preterm birth, low infant blood sugar, or lower muscle tone.

Breastfeeding/Chestfeeding

There is **still debate about taking lithium during breastfeeding/chestfeeding**. Infants may be more vulnerable to the negative effects of too much lithium, especially if they get dehydrated. Lithium can also have a negative short-term impact on infant kidney or thyroid function. A discussion with your healthcare provider is very important to make the right individualized decision for you with respect to medication and feeding your baby. Some people choose to breastfeed while taking lithium and some people choose not to breastfeed. Stopping lithium suddenly in postpartum is generally not recommended because it can often lead to worsened mood symptoms shortly after stopping the medication.

Antipsychotics

Antipsychotics are medications for treating bipolar disorder; postpartum psychosis; and sometimes used as an add-on medication for depression, some anxiety disorders, OCD, and PTSD. These include **quetiapine, olanzapine**, and **aripiprazole**.

Most safety information currently available is about antipsychotics as a class, rather than as specific individual medications. **There is very limited information about long-acting injectable antipsychotic medications.**

Pregnancy

If you are taking an antipsychotic in pregnancy, there is **minimal evidence of concern about miscarriage, major birth defects, preterm or stillbirth, or developmental problems**. However, with **risperidone**, there may be a **small increased risk of heart defects**. With **second-generation antipsychotics**, there may be a **small increased risk of gestational diabetes or large-for-gestational age infants** (especially **olanzapine** and **quetiapine**). There may be **some increased risk of newborn complications**, such as breathing issues or fussiness, and your baby may need to stay in the NICU, with similar symptoms as described earlier in the PNAS section (see page 40).

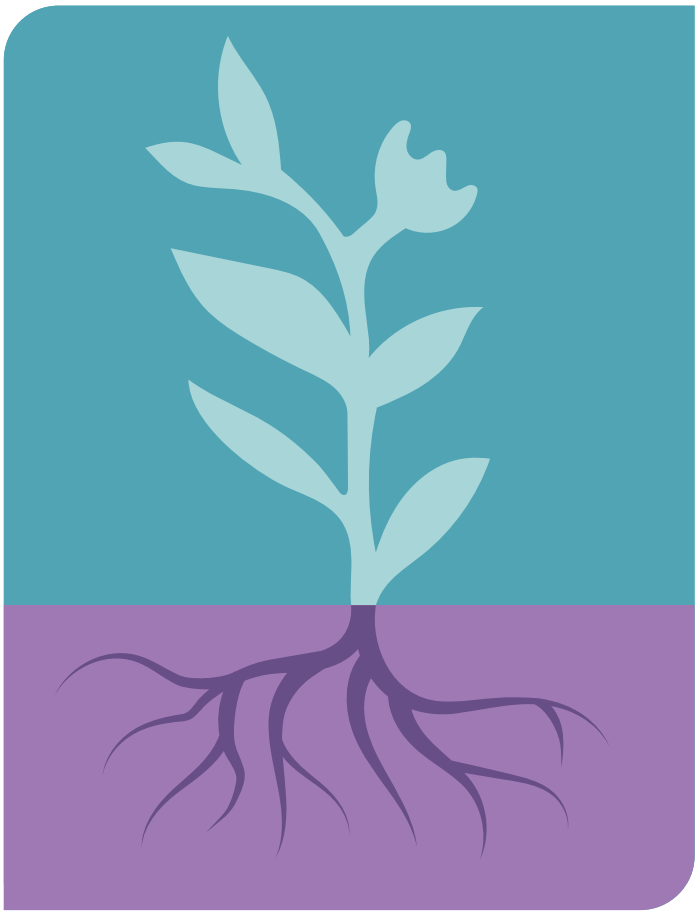
Breastfeeding/Chestfeeding

Most antipsychotics **do not appear to have a negative impact on infants through lactation**, although if you are taking a sedating medication, it can impact your ability to care for your baby at nighttime (requiring help from another caregiver). If you are breastfeeding/chestfeeding, then **second-generation antipsychotics are preferred**, especially **quetiapine** and **olanzapine** because there is the **most safety information available** about these two antipsychotics. There have been **some cases of decreased breast milk** production with **aripiprazole**.

Sedative-hypnotics

Sedative-hypnotics are medications sometimes used for severe insomnia or anxiety, such as **benzodiazepines** or **Z-drugs** (for example, **zopiclone** or **zolpidem**).

If you are taking sedative-hypnotics in pregnancy or lactation, it is **safer to use these medications as needed and short-term only** rather than regularly.



Other types of medical treatments for PMADs

Bright light therapy

There is **some support** for using a light therapy lamp to help treat postpartum depression.

Neuromodulation

Neuromodulation refers to **non-medication treatments where electrical currents or magnets are used to stimulate the parts of the brain** involved in psychiatric illness. They have been shown outside of the perinatal period to be effective, especially in the **treatment of depression**.

There is a lot of interest in these treatments because they are **potential alternatives to medication** in people who have moderately-severe or severe symptoms of PMADs.

There are neuromodulation treatments where you remain awake throughout the treatment. Of these treatments, **some research** in the perinatal period research has been done on:

- **transcranial direct current stimulation (tDCS)** - a procedure that uses a small electric current to stimulate the brain to treat depression; and
- **repetitive transcranial magnetic stimulation (rTMS)** - a procedure that uses magnets to stimulate the brain to treat depression.

rTMS and tDCS

rTMS and tDCS have **few possible side effects, but require frequent sessions**, often on a daily basis for a certain number of weeks. Although early evidence is promising, **more research is still needed** on the safety of rTMS and tDCS in pregnancy, so **these are not routine treatments for depression in pregnancy yet**. They could be used in the postpartum if the frequent treatment sessions are practical for the postpartum person.

ECT

Another type of neuromodulation treatment is **electroconvulsive therapy (ECT)** during which an electrical current adjusted to be the lowest needed to induce simultaneous activation of the brain, also called a seizure, is used to treat a mental disorder. ECT is a procedure that is done under general anesthesia, so it is **usually only used in severe PMADs** (severe depression or mania or psychosis, or severe suicidal thoughts or attempts) or where several medication treatments have not helped. There is very strong support for ECT from studies of non-perinatal people, but in pregnancy we only have some evidence about its usefulness in treating severe PMADs. **While there are a number of known side effects of ECT, it can be used in pregnancy if needed.**

Notes from my Healthcare Provider about Medication and Related Treatments

What about Complementary and Alternative Treatments?

What about Complementary and Alternative Treatments?

Many people ask about "complementary and alternative treatments" for PMADs, such as yoga, acupuncture, massage, or specific dietary supplements. The research on these types of treatments is not as strong as the research for other treatments in this guide (e.g., lifestyle, social support, therapy, and medication interventions). So, they are not usually recommended as the first treatment to try, and not usually recommended as treatments on their own.

However, there is some support for them in preventing and treating mild symptoms, most often of anxiety and depression, so they may be helpful to consider as well.

Please speak with your healthcare provider to discuss what complementary and alternative treatments might be most helpful for you.

St. John's Wort

St. John's Wort is an herbal supplement made from a plant. It is available without a prescription and is sometimes used to treat depression. **St. John's Wort interacts with many medications and can cause serious side effects. IT IS NOT recommended in pregnancy or breastfeeding/ chestfeeding, because not a lot is known about its safety and what IS known suggests that there could be potential risks of harm to the developing fetus or infant.**

Alternative Treatments

Yoga
A form of exercise that can incorporate stretches, breath work, and meditation. This was shown to reduce anxiety and depressive symptoms in pregnancy, and reduce depressive symptoms in postpartum.

Music Therapy
A trained music therapist uses music activities (playing instruments, singing, listening to music) to influence emotions. This was shown to reduce depressive symptoms in postpartum, as an add-on treatment.

Acupuncture
Small needles are temporarily placed in skin, tissue, and/or muscles to stimulate certain parts of the body. This was shown to reduce depressive symptoms in postpartum, as an add-on treatment.

Vitamin D
A nutrient that can be taken orally to help with normal functioning of the body. In one research study, 1000 IU of Vitamin D taken daily for six months postpartum was shown to improve depressive symptoms.

Massage Therapy
A treatment that involves rubbing or kneading the soft/deep tissues to help with relaxation, relieving stress and pain, and improving circulation. This was shown to decrease mild depressive symptoms and anxiety symptoms.

Saffron
An herbal supplement that can be taken orally. In one research study, 15 mg of Saffron taken twice daily for eight weeks was shown to improve postpartum depression symptoms.

In Conclusion

Key Points to Remember

1. Your **mental health** is a **top priority** during pregnancy and postpartum, and so is **your safety and the safety of your baby**. You and your baby deserve to feel well and have access to treatment if needed.

2. The **earlier** you begin to focus on your mental health, the **better** the outcomes for you, your pregnancy, your baby, and your family.

3. If you are struggling, remember that **it is not your fault**, **you are not alone**, and **there is help - PMADs are highly treatable**.

Helpful Resources:

Below are some general resources for mental health and perinatal mental health support:

- **Suicide Crisis Line**
  Call: 9-8-8
- **Your Life Counts - Find Crisis Resources Near You**
  www.yourlifecounts.org/find-help
- **Canadian Mental Health Association**
  www.cmha.ca
- **Postpartum Support International Canada**
  www.postpartum.net/canada
- **Life With A Baby**
  A national peer support organization with a focus on reducing social isolation, providing support groups, and a directory of service providers.
  www.lifewithababy.com
- Speak to your healthcare provider about **local resources** for perinatal mental health support, including perinatal psychiatry programs if you need a referral to a specialist.

Appendix

More Information about Symptoms of PMADs

Perinatal depression

Symptoms of depression that can be experienced perinatally or outside of the perinatal period:	Ways that symptoms of depression can **specifically** present in pregnancy and postpartum:
→ Sadness or hopelessness → Loss of interest in things you are usually interested in and enjoy → Change in appetite with/without unintended change in weight → Sleeping too much or too little → Feeling physically restless or very slowed down → Low energy → Feeling worthless or very guilty → Trouble with concentration → Thoughts of death or suicide, with or without suicide plan or attempt	→ Mood change can often show up as intense irritability or anger, in addition to or instead of sadness → Not feeling connected to your baby or other children or your partner → Not being able to eat enough to put on enough weight during pregnancy or to maintain milk supply in lactation → Not being able to sleep even when your baby is sleeping (sometimes because of worrying) → Feeling more restless or slowed down and/or tired than would be expected in pregnancy or with all of the physical issues after childbirth and caring for your baby → Very negative thoughts about capacity as a parent (for example, being very critical or doubtful of yourself, or feeling like a failure) → Excessive guilt about parenting choices/ actions having a negative impact on your baby → Feeling very overwhelmed and that it is hard to make small decisions with regard to pregnancy or with the care of your baby (for example, planning for their eating, sleeping, and balancing other tasks) → Thoughts about harm coming to your baby, by accident or on purpose

Perinatal anxiety

Symptoms of anxiety that can be experienced perinatally or outside of the perinatal period:	Ways that symptoms of anxiety can **specifically** present in pregnancy and postpartum:
→ Worrying too much about many things → Worry that is hard to control → Restlessness or trouble relaxing → Fatigue → Trouble with concentration → Feeling easily annoyed or irritable → Tense muscles → Trouble falling or staying asleep → Panic attacks, which are intense episode of fear with strong physical symptoms like not being able to breathe or racing heartbeat → Fear of specific situations, such as social situations → Avoiding situations that cause anxiety	→ Worrying too much about health in pregnancy or about the health, development, or safety of your baby → Intrusive thoughts or obsessive worries about harm to your baby → Worrying too much about ability to parent → Feeling overwhelmed and excessive difficulty coping with parenthood → Avoiding letting others look after your baby → Avoiding being apart from you baby → Repeatedly seeking reassurance about your baby's safety → Fear of childbirth (also known as tocophobia/tokophobia), which can include: fear of body changes, fear of pain, fear of death, or fear of loss of control

Perinatal obsessive-compulsive disorder (OCD)

Symptoms of OCD that can be experienced perinatally or outside of the perinatal period:	Ways that symptoms of OCD can **specifically** present in pregnancy and postpartum:
→ Repeated, unwanted, intrusive thoughts or images or urges, which cause distress (obsessions) → Often about disturbing themes (for example, violent thoughts of harm, inappropriate sexual thoughts, and/or about germs and contamination) → Attempts to ignore or undo intrusive thoughts → Doubt, fear and/or guilt related to intrusive thoughts → Repetitive behaviours that you feel driven to do in response to these intrusive, unwanted thoughts, or rigid rules (compulsions) → Compulsions are efforts to reduce distress and can be hard to resist even if you recognize it is not rational	→ Unwanted, intrusive, and disturbing thoughts or images of harm coming to your baby or even unwanted, intrusive, and disturbing thoughts or images of harming your baby on purpose → Repeated, rigid, ritualistic checking behaviours around your baby's safety → Repeatedly seeking reassurance about your baby's safety → Avoiding letting others look after your baby → Avoiding being apart from your baby

Perinatal post-traumatic stress disorder (PTSD)

Symptoms of PTSD that can be experienced perinatally or outside of the perinatal period:	Ways that symptoms of PTSD can **specifically** present in pregnancy and postpartum:
→ A difficult or traumatic lived experience → Unwanted thoughts, memories, or nightmares about the traumatic event, or reliving the event (flashbacks) → Extreme distress or intense negative emotions, like angry outbursts, especially when reminded of the traumatic event → Avoidance of memories, thoughts, feelings, people, places, and things that are linked to traumatic event → Loss of memory around the traumatic event or trouble concentrating → Extreme negative beliefs about self, others, world, including blaming self for the trauma → Feeling detached from others → Recklessness or taking more risks → Always on alert, extremely vigilant or very sensitive to being startled → Trouble sleeping → Feeling detached from oneself or one's surroundings (dissociation)	→ Traumatic experience is related to pregnancy and postpartum (for example, childbirth or pregnancy loss) → PTSD symptoms focus on traumatic birthing experience and reminders of the birth → Feeling detached from your baby → Triggers of prior traumatic experiences during healthcare interactions including physical exams that are part of pregnancy care, or during childbirths

Perinatal bipolar disorder and Postpartum psychosis

Symptoms of bipolar disorder that can be experienced perinatally or outside of the perinatal period:

Repeated episodes of mood disturbance, with both depression and hypomania and/or mania

Depression

- Sadness or hopelessness for at least 2 weeks
- Loss of interest in things you are usually interested in and enjoy
- Change in appetite with/without unintended change in weight
- Sleeping too much or too little - usually too much
- Feeling physically restless or very slowed down - usually very slowed
- Low energy
- Feeling worthless or very guilty
- Trouble with concentration
- Thoughts of death or suicide, with or without suicide plan or attempt

Mania

- Extremely elevated or irritable mood and energy for at least 1 week
- Thinking more quickly than usual
- Needing less sleep
- Being more active, especially if there are more risky or impulsive actions
- Feeling more distractible
- Having extremely increased confidence or self worth

Hypomania

- Similar symptoms as mania but less severe and lasting at least 4 days

Symptoms suggestive of **postpartum psychosis**:

Unique combination of mood (either depression or mania or a mix) and psychotic symptoms

Possible mood symptoms

- Extreme irritability
- Rapid mood swings
- Severe restlessness or tension
- Thinking, talking, and/or moving more quickly than usual
- Higher energy
- Needing less sleep
- Thoughts of death or suicide, with or without suicide plan or attempt
- Thoughts about harm coming to your baby, by accident or on purpose

Possible psychotic symptoms

- Paranoia
- Delusional beliefs, such as bizarre thoughts about your baby or childbirth
- Hallucinations (hearing things that don't exist, such as voices)
- Disorganized, inappropriate or disruptive or aggressive behaviours
- Confusion
- Feeling detached from oneself or one's surroundings

We hope this patient & family guide has been helpful to you!

Thank you to the team that put this guide together.

CANMAT

Canadian Network for Mood and Anxiety Treatments
www.canmat.org

CPMHC

Canadian Perinatal Mental Health Collaborative
www.cpmhc.ca