Perinatal Mental Health: a Conceptual Framework

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Disclosures

I have no conflicts to report.
Objectives

1. Understand the risks to families of under/untreated perinatal mood, anxiety, and trauma related disorders

2. Appreciate clinical approaches to psychiatric diagnosis and treatment during the perinatal period.

3. Review clinical approaches to care of co-occurring perinatal mood, anxiety and trauma related conditions.
Objective One

Understand the risks to families of under/untreated perinatal mood, anxiety, and trauma related conditions.
Postpartum depression is the number one complication of childbirth (Wisner, NEJM 2001)

“Postpartum depression is an illness that takes away a mother’s ability to access joy when babies need it the most.”
Katherine Wisner, MD
Up to 1 in 5 of those who are pregnant and in the postpartum period will suffer from a maternal mental health disorder like postpartum depression.

Less Than 15% receive treatment.

1 in 7 will experience depression during pregnancy.

Up to 50% living in poverty will suffer from a maternal mental health disorder.

Not Just Moms
Maternal mental health disorders impact the whole family.

More Than 600,000 will suffer from a maternal mental health disorder in the U.S. every year.

Anxiety and depression have risen 37% in teen girls.

This will increase the number suffering postpartum depression in the future.

Rates of Depression are more than doubled in the Black Population.

Due to cumulative effects of stress called “weathering.”

20/20 Mom
Visionaries for the Future of Maternal Mental Health

2020Mom.org
View citations at: 2020mom.org/mmh-infographic-citations
Barriers to Treatment

**Patient**
- Stigma/Fear
- Lack of detection
- Limited Access
- Under-resourced

**Provider**
- Lack of training
- Not enough time
- Discomfort
- Limited resources

**System**
- Isolated providers
- Screening not routine
- Siloed care
With very rare exceptions, what is best for the birthing person, is going to be best for baby too.
The goal of treatment is remission.
Risks of un/undertreated psychiatric illness

To the Birthing Person
- Suicide
- Pre-Eclampsia
- Reduced self-care/Prenatal care
- Substance use
- Increased total med exposures
- Disrupted parental-infant bonding

To the Baby
- Infanticide
- Preterm birth
- Low birth weight
- Decreased infant motor tone/activity
- ↑ risk of emotional, behavioral, cognitive and psych issues in children
- Disrupted parental-infant bonding

10% of men experience postpartum depression (JAMA 2010), comorbid anxiety common

Common symptoms for men include:
- Irritability
- Increase in substance use, gambling
- Isolation
- Restricted range of emotion
- Indecisiveness

Resources for fathers:
- https://www.postpartum.net/get-help/help-for-dads/
- Faceitfoundation.org
Objective Two

Clinical approaches to psychiatric diagnosis and treatment during the perinatal period
Family-centred care

- Dignity and Respect
- Collaboration
- Information sharing
- Participation
Healing happens in relationships.
Traditional leaf approach to healthcare

"physical health leaves"
✔ Insomnia
✔ Irritable bowel
✔ Endometriosis
✔ Joint Pain
✔ Fatigue
✔ Migraines

"mental health leaves"
✔ Depression
✔ Anxiety
✔ Chemical dependency
✔ Marital strain
✔ Parenting strain

Redleaf Center
For Family Healing
Healing through multi-generation, integrative, trauma healing approaches

**What is healing?**

**What is regulating?**

- Safety
- Support/Connection/Community
- Sleep
- Gut health/Nutrition
- Movement
- Purpose

**PERSISTENT TOXIC STRESS ENVIRONMENT**
(poverty, racism, discrimination, food/housing insecurity, unsafe neighborhoods)

Positive Childhood Experiences (PCEs) and Protective Experiences

**TRAUMA/Toxic Stress**
Adverse Childhood and Community Experiences
Complex Developmental Trauma
Ghosts in the Nursery
1975 – Selma Frailberg

Angels in the Nursery
2005 – Alicia Lieberman


Assessment Domains: Mother-Baby Program Four-Square
The 4 Ss

- Safety
- Sleep
- Support
- Structure
## Safety - Assessing Risk

<table>
<thead>
<tr>
<th></th>
<th>Suggests Lower Risk</th>
<th>Suggests Higher Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>No substance use</td>
<td>Substance Use</td>
<td></td>
</tr>
<tr>
<td>No prior attempts or self-harm</td>
<td>History of suicide attempts/self-harm</td>
<td></td>
</tr>
<tr>
<td>No plan</td>
<td>Current plan</td>
<td></td>
</tr>
<tr>
<td>No intent</td>
<td>Current intent/behaviors</td>
<td></td>
</tr>
<tr>
<td>Protective Factors – “What has prevented you from acting on these thoughts?”</td>
<td>Lack of protective factors</td>
<td></td>
</tr>
<tr>
<td>Able to safety plan with supports</td>
<td>Trauma (historical or current)</td>
<td>Family Hx of suicide</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Recent discharge from psychiatric hospital</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hopelessness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anxiety/Akathisia</td>
</tr>
</tbody>
</table>
### Safety - Assessing Risk

<table>
<thead>
<tr>
<th>Violence to Baby/Children</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Suggesting 2/2 Obsessions/Anxiety – LOW risk</strong></td>
<td><strong>Suggesting 2/2 Psychosis – HIGH risk</strong></td>
</tr>
<tr>
<td>Good Insight</td>
<td>Poor insight</td>
</tr>
<tr>
<td>Thoughts are intrusive, ego-dystonic</td>
<td>Thoughts are ego-syntonic (often altruistic)</td>
</tr>
<tr>
<td>No psychotic symptoms</td>
<td>Evidence of psychosis (delusions, hallucinations, delirium–like presentation)</td>
</tr>
<tr>
<td>Thoughts cause anxiety leading to great efforts to avoid acting on them (often avoidance)</td>
<td>In and out of touch with reality</td>
</tr>
<tr>
<td></td>
<td>Diagnosis or history of bipolar disorder</td>
</tr>
</tbody>
</table>
Prescribing Sleep

Focus on Self-Care over Self-Sacrifice
Change the message from “A good mother sacrifices for her family” to “Meeting a mother’s needs allows her to better care for her family.”

Consolidate Sleep
One chunk of 4-5 hours uninterrupted sleep plus another 2-3 hours is better than being woken all night every 2 hours.

Expand the Workforce
Infant night feedings are a job for more than 1 person. Recruit help if possible.

Flex the Breast
Breastfeeding women can pump during the day and have others bottle feed at night. If needed, formula is compatible with breastfeeding.
Support

Identifying and leaning into for both patient and provider
Structure

• What brings predictability and/or safety?
• What brings meaning and purpose?
You are not alone.

This is not your fault.

With help, you will feel better.
Objective Three

Review clinical approaches to care of co-occurring perinatal mood, anxiety and trauma related conditions.
Guiding Principles for Tx of COD in non-perinatal patients

Exhibit 2.1. Six Guiding Principles in Treating Clients With CODs

1. Use a recovery perspective.
2. Adopt a multiproblem viewpoint.
5. Plan for the client's cognitive and functional impairments.
6. Use support systems to maintain and extend treatment effectiveness.
Perinatal COD Considerations

- Women disproportionately face barriers to treatment related to children and childcare.
- Those in tx for SUD often do not receive tx for mental health
Women & COD

- Women with CODs are more likely than women with only SUDs to have:
  - experienced homelessness.
  - reduced partner support
  - a past history of physical or sexual abuse.
  - a longer substance use history.
  - more severe alcohol use–related problems.
  - more severe problems related to employment.
  - more severe medical conditions.
  - greater family dysfunctions.

(Evans et al., 2015)
Pregnant women with CODs report desiring SUD treatment that includes:

- More flexible treatment schedules
- Longer sessions
- Assistance with transportation to and from sessions
- Group treatments
- Interpersonal support
- Linkage to community resources
- Treatment environments that convey a sense of safety and comfort

(Kuo et al., 2013)
COD & Trauma

• More than half (and in some studies nearly all) of treatment-seeking women with CODs have a history of trauma

• Women with SUDs are more likely to have been raised by parents with SUDs

Cohen, Field, Campbell, & Hien, 2013; Macy, Renz, & Pelino, 2013; Mason & Dumont, 2015; Greenfield et al. 2010;
Growth & Healing

Coping & Safety