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."

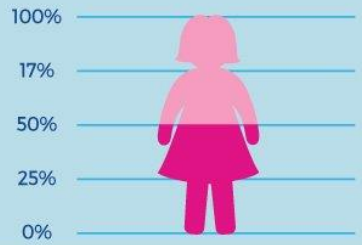
Katherine Wisner, MD

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 [1]

Less Than 15% receive treatment [2]

1 in 7 will experience depression during pregnancy [3]

Up to **50%** living in poverty will suffer from a maternal mental health disorder [4,5]



Not Just Moms

Maternal mental health disorders impact the whole family [6]

More Than 600,000 will suffer from a maternal mental health disorder in the U.S. every year [7]

Anxiety and depression have risen **37%** in teen girls

This will increase the number suffering postpartum depression in the future [5]

Rates of Depression are more than **Doubled in the Black Population**

Due to cumulative effects of stress called "weathering" [8]

20/20mom™

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

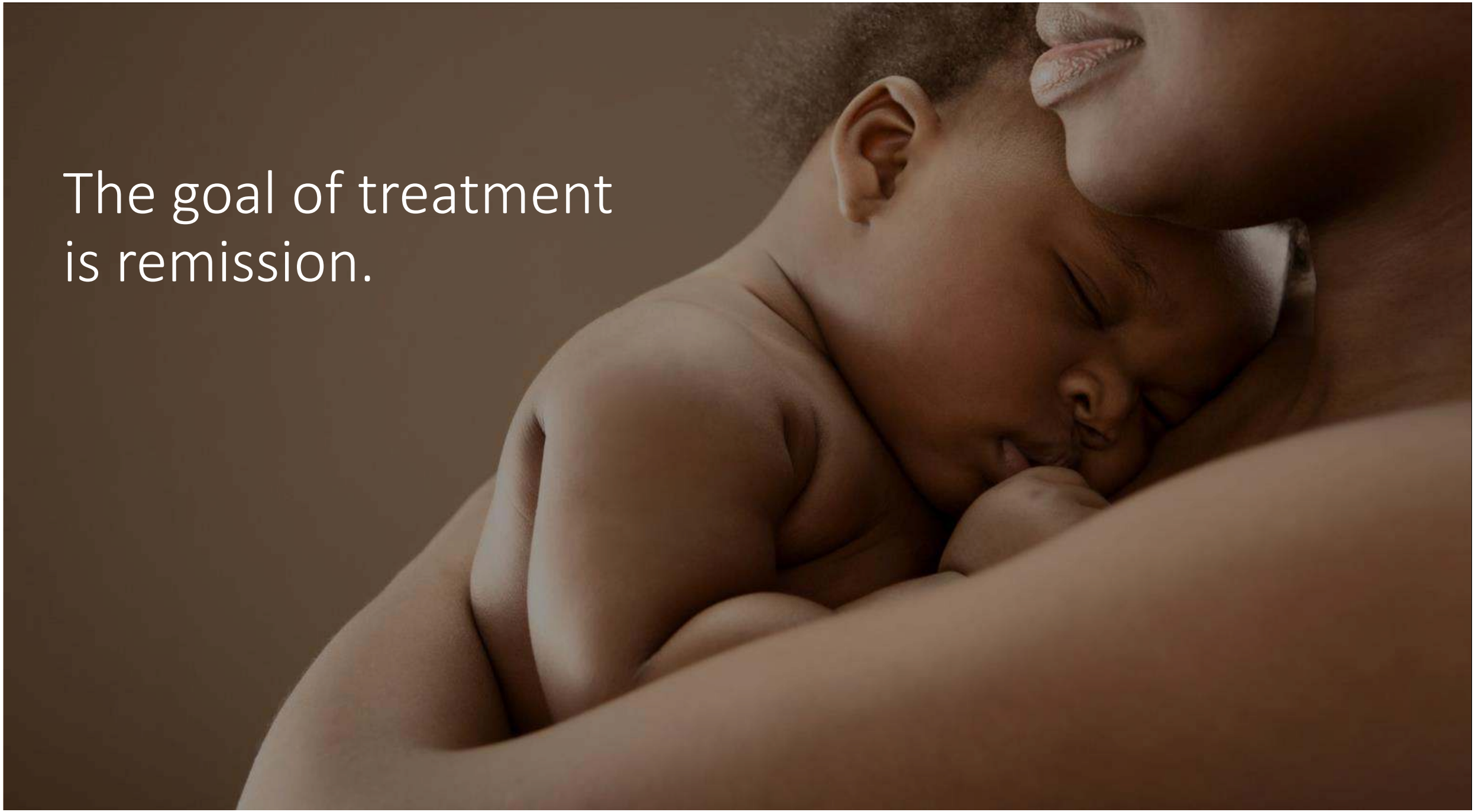
System

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

Sockol et al. *Clin Psychol Rev* 2013. USPSTF. *JAMA* 2019

Fathers and Postpartum Depression

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:

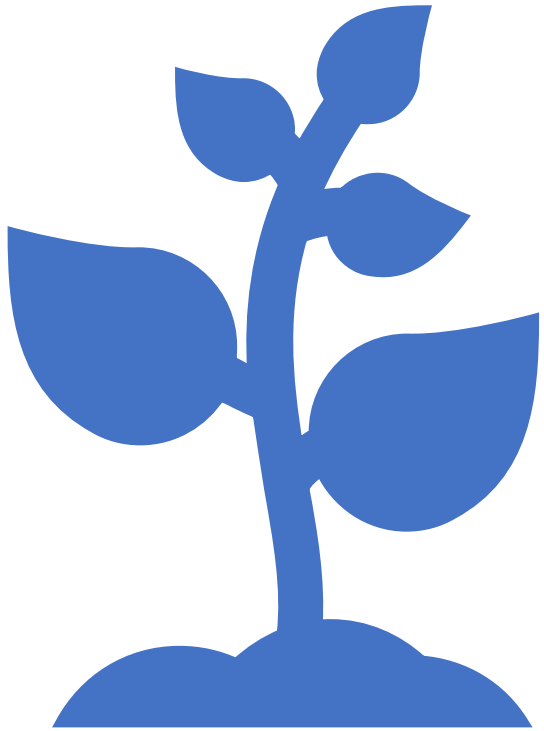
-https://www.postpartum.net/get-help/help-for-dads/

-Faceitfoundation.org

Objective Two

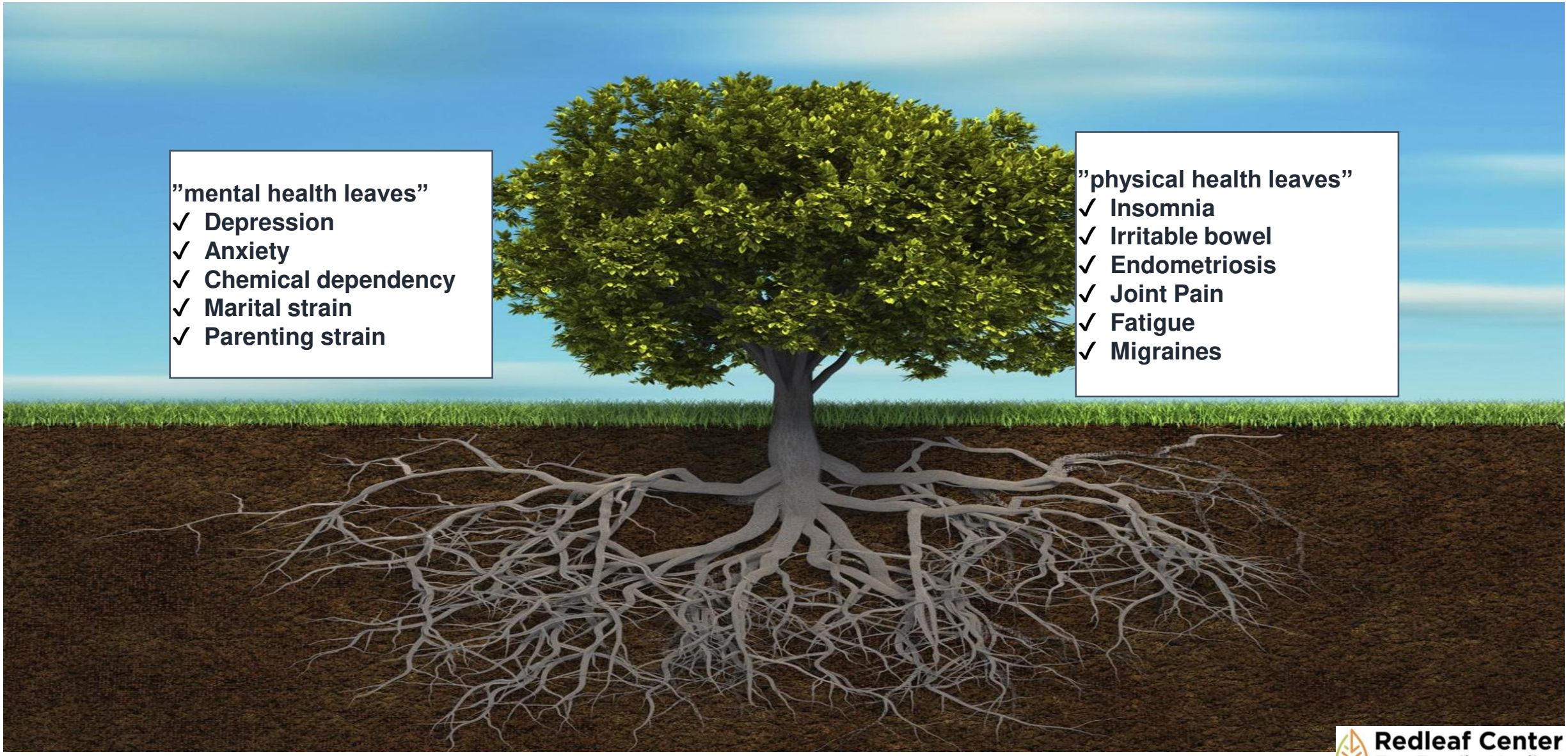
Clinical approaches to psychiatric diagnosis and treatment during the perinatal period


Dignity and Respect
Collaboration
Family-centred care
Information sharing
Participation



Healing happens in relationships.

Traditional leaf approach to healthcare



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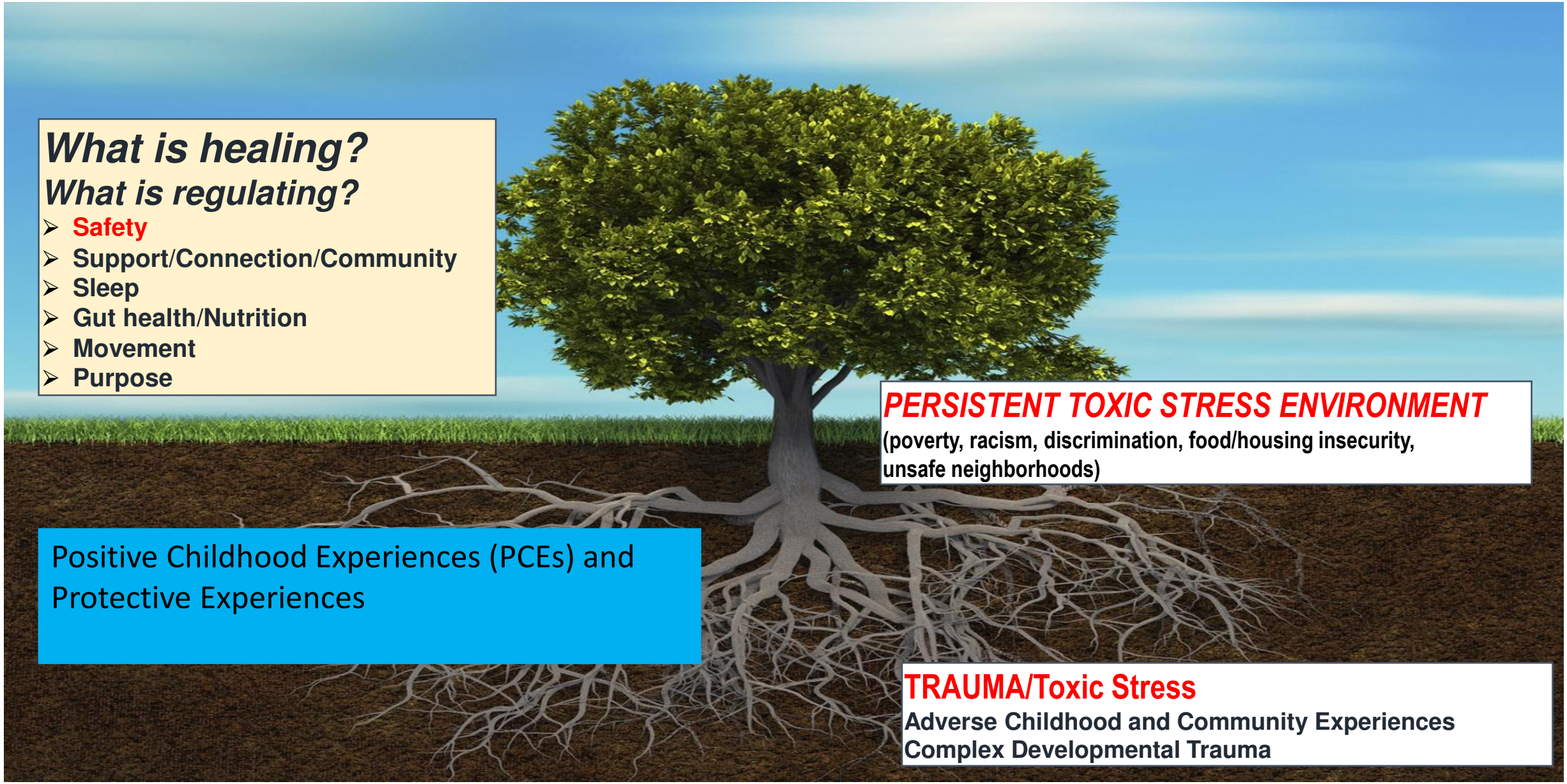
Healing through multi-generation, integrative, trauma healing approaches



Ghosts in the Nursery

1975 – Selma Frailberg

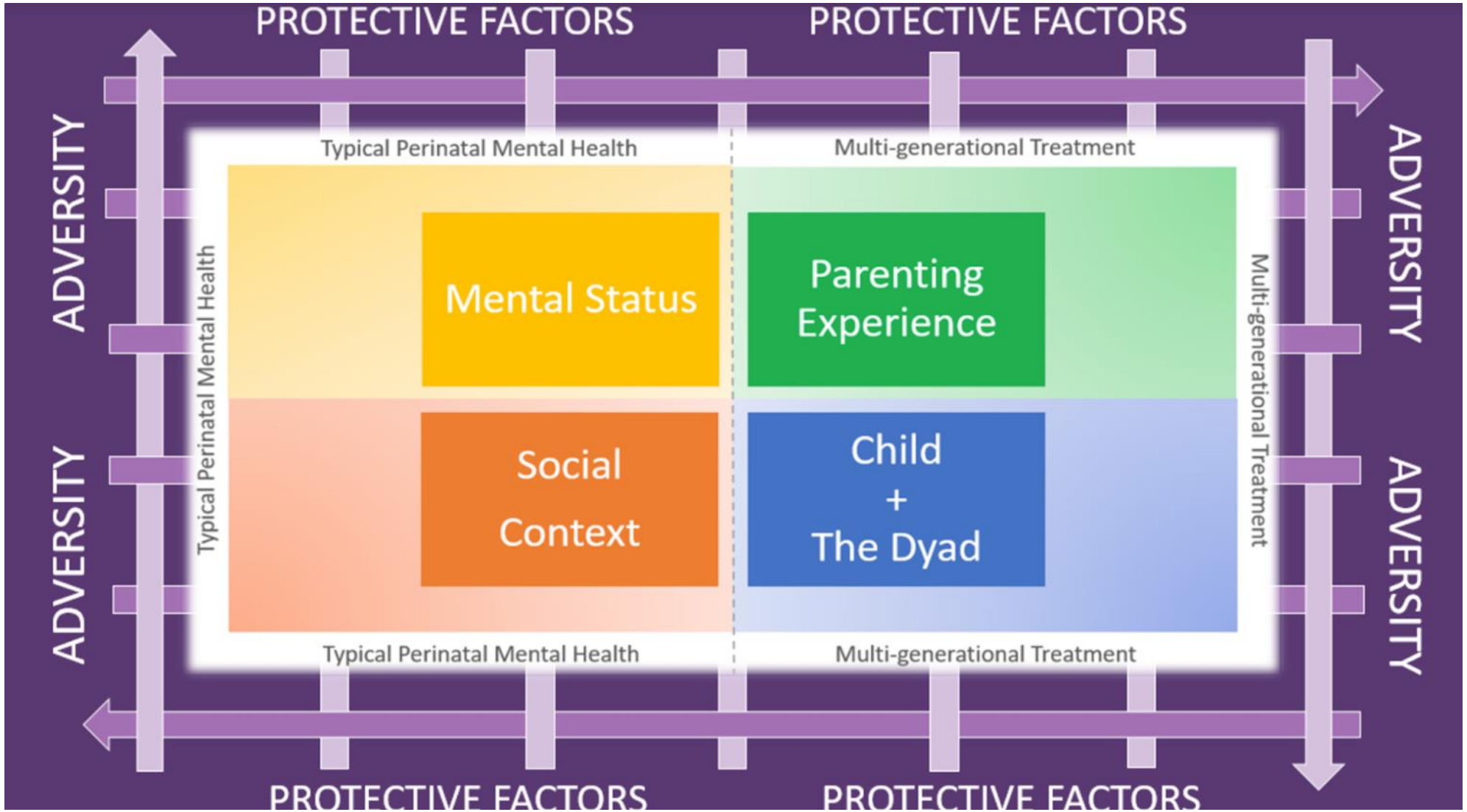
Fraiberg, Selma, Adelson, Edna and Shapiro, Vivian.1975. "Ghosts in the Nursery: A Psychoanalytic Approach to the Problems of Impaired Infant- ." Journal of American Academy of Child Psychiatry, 14(3): 387-421.

Angels in the Nursery

2005 – Alicia Lieberman

"Angels in the Nursery: The Intergenerational Transmission of Benevolent Parental Influences". Alicia F. Lieberman, Elena Padron, Patricia Van Horn, and William W. Harris. Infant Mental Health Journal, Vol. 26(6) 504-520 (2005).

Assessment Domains: Mother-Baby Program Four-Square



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The 4 Ss

- Safety
- Sleep
- Support
- Structure

Safety - Assessing Risk

Suicidal Ideation	
Suggests Lower Risk	**Suggests Higher Risk**
No substance use	Substance Use
No prior attempts or self-harm	History of suicide attempts/self-harm
No plan	Current plan
No intent	Current intent/behaviors
Protective Factors – *"What has prevented you from acting on these thoughts?"*	Lack of protective factors
Able to safety plan with supports	Trauma (historical or current)
	Family Hx of suicide
	Recent discharge from psychiatric hospital
	Hopelessness
	Anxiety/Akathisia

Safety - Assessing Risk

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

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.

Leistikow N, et al. Biol Psychiatry. 2022

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

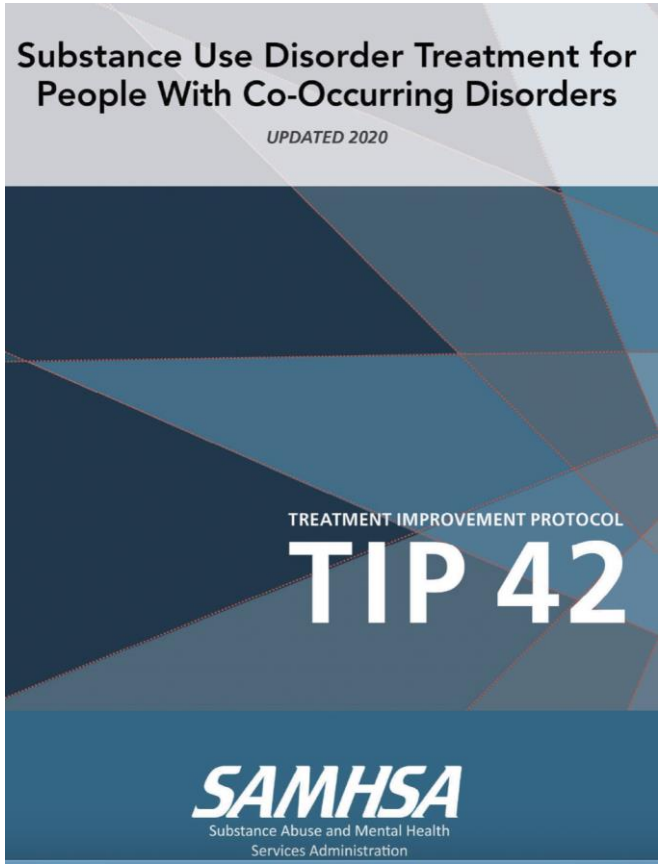


Exhibit 2.1. Six Guiding Principles in Treating Clients With CODs

1. Use a recovery perspective.
2. Adopt a multiproblem viewpoint.
3. Develop a phased approach to treatment.
4. Address specific real-life problems early in treatment.
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

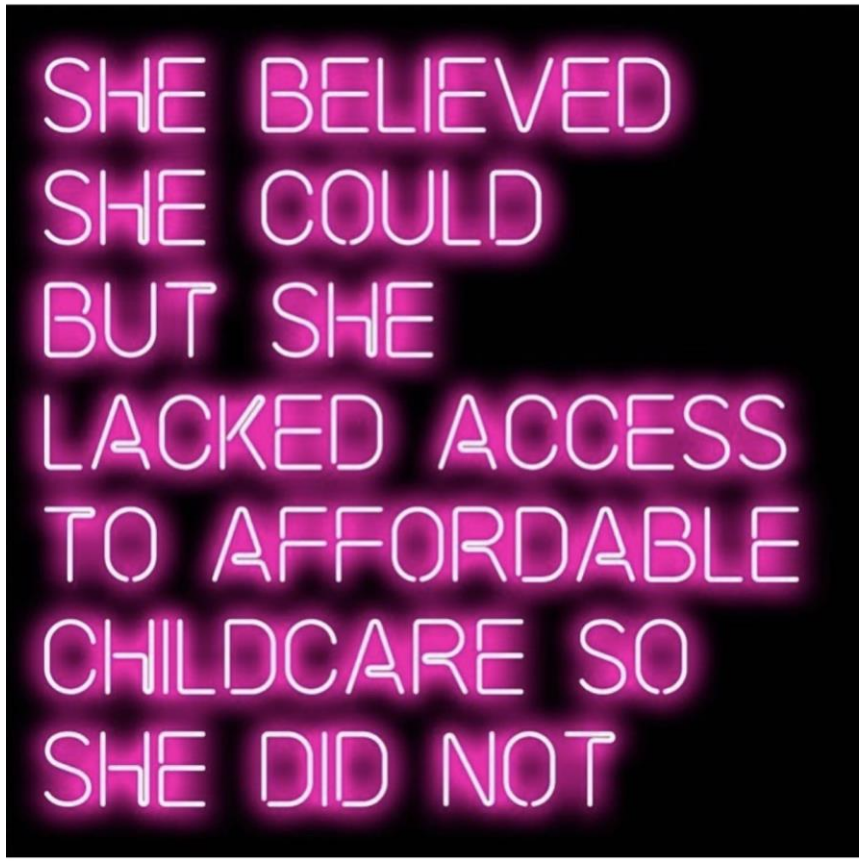
Women & COD

- 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