THE COMPLEX TERRAIN OF PARENTHOOD

Pregnancy

The Complex Experience

PHYSICAL
What is the experience of having a baby inside you?
Hormonal shifts: HCG, estrogen, progesterone, oxytocin
Nausea and vomiting
Thyroid
Fatigue
Profound physiological changes as pregnancy progresses
Body changes

MENTAL
What does the fetus represent?
Internal representations
Fantasies, hopes and dreams

EMOTIONAL
Physically driven
Driven by beliefs and internal representations
Identity shift

EXPECTATIONS
For mothers, fathers, partners?
Societal expectations

DREAMS

Maternal Preoccupation

A New Mental Landscape

A normative process

Internal representation: getting ready to be parents (partners and fathers, too)

Internal mental state overrides normal thought patterns = feels foreign

Parents + fetus + internalized image of baby = beginning of forming a relationship

Pregnancy history also shapes this developing relationship

Pregnancy

The Complex Experience

Consolidate Your Learning

- Consider the many ways that the physical, emotional, and social expectations all interact and influence the experience of pregnancy
- Consider the ways the new mental landscape affects parents, fathers to be, and partners
- Consider the ways that maternal preoccupation influences the thinking process

TRANSITION TO MOTHERHOOD

Learning Objective

At the conclusion of this lecture, you will be able to

- Discuss the three most clinically applicable aspects of the biopsychosocial model of adapting to parenthood and potential perinatal distress

Transition to Motherhood

Biological Influences

- Recognition that pregnancy is real
- Adaptive or maladaptive responses to expected biological changes
- Adaptive or maladaptive responses to unexpected biological changes and complications

Transition to Motherhood

Biological Influences: Sleep Disturbance

- Hormonal shifts
- Frequent urination
- Anxiety
- Sleep patterns shift
- Worries

Transition to Motherhood

Psychological Influences

- Changing identity
- New social roles
- Body image
- Boundary between self and fetus
- Adaptive or maladaptive representations
- Maternal preoccupation
- Attachment and bonding

Transition to Motherhood

Psychological Influences: "Mommy Brain"

- Belief that concentration, memory, attention decline
- No clear research findings suggesting that cognitive functioning is influenced by pregnancy or in the post-partum period

Transition to Motherhood

Social and Environmental Influences: Myths & Expectations vs Reality

Transition to Motherhood

Transition to Motherhood

Transition to Motherhood

Note for Clinicians

- Distress is normative
- Ok to seek support
- Motherhood is not easy
- Struggle to be a "successful" mother
- Resuming prior familial, social, and work roles
- Successful mothering involves not having all the answers

Consolidate Your Learning

GAINS	LOSSES
• *Personal growth and meaning*	• *Good sleep (quality and quantity)*
• *Additional responsibility*	• *Free time ("on call"24/7)*
• *Shifts in identity*	• *Shifts in identity*
• ----------	• ----------
• ----------	• ----------

Consolidate Your Learning

- Along with the myths that we have been discussing, what are some gains, what are some losses that a woman in the perinatal timeframe might experience?

PMADs: OVERVIEW OF RISK FACTORS

Learning Objective

At the conclusion of this lecture, you will be able to:

- Discuss the three most clinically applicable aspects of the biopsychosocial model of perinatal emotional distress

Perinatal Emotional Adjustment

Postpartum depression (PPD) VS Perinatal distress
- During pregnancy
- After childbirth

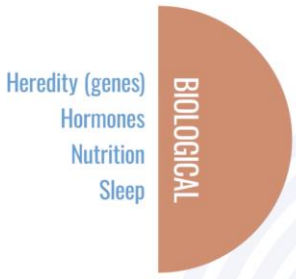
The phrase "perinatal mood and anxiety disorders" (PMADs) is now used to describe this range of disorders

Perinatal Emotional Adjustment

Developing a PMAD is the most common complication of pregnancy

Postpartum depression (PPD) VS Perinatal distress
- During pregnancy
- After childbirth

Potential Contributors to PMADs (Etiology)



Potential Contributors to PMADs (Etiology)

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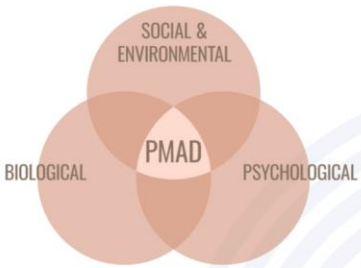


Consolidate Your Learning

- What are the ways that a new mother might be affected by biological, psychological, and social/environmental factors?

PERINATAL NORMATIVE AND NON-NORMATIVE RANGE OF DISTRESS

Learning Objective

At the conclusion of this lecture, you will be able to:

- Utilize diagnostic and epidemiological data for mental health concerns associated with the five most employed DSM-5 categories in pregnancy and the postpartum period
- Describe the diagnostic categories relating to PMADs and how these categories differ from postpartum psychosis

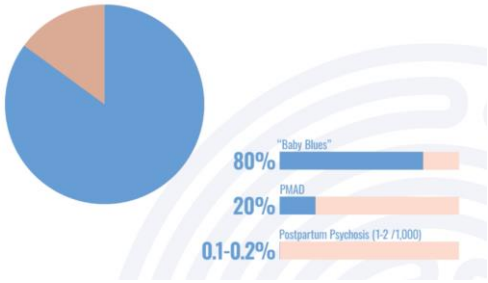
Perinatal Emotional Adjustment

Range of Distress

Perinatal Emotional Adjustment

Range of Distress

85% of women experience significant emotional distress during or after pregnancy



Perinatal Emotional Adjustment

Range of Distress

Baby Blues and Postpartum Reactivity

- Up to 80% of childbearing women
- Onset within the 1st week postpartum
- Generally resolves within 2-3 weeks postpartum

Not a mental health disorder; further assessment indicated if symptoms do not resolve by 3 weeks postpartum

Perinatal Emotional Adjustment

Range of Distress

Baby Blues and Postpartum Reactivity

Tearfulness, mood swings, irritability, and feeling overwhelmed

Not a mental health disorder: further assessment indicated if symptoms do not resolve by 3 weeks postpartum

"Baby blues" vs a Diagnosable PMAD

- Still able to function and begin creating a bond with their infant
- Typically resolves within 2-3 weeks

If it doesn't resolve after 3 weeks, reassess

Perinatal Emotional Adjustment

Range of Distress

Perinatal Mood and Anxiety Disorders (PMADs)

- Diagnosable mental health disorder
- 15-20% of childbearing women
- Symptoms typically develop within 2-3 months after delivery
- Symptoms can develop during pregnancy or up to 1 year postpartum

Most common complication of pregnancy: more common than gestational diabetes, preterm labor, and low birth weight

Perinatal Emotional Adjustment

Five Common PMADs

PMADs: Prevalence

- 7-15% Major Depressive Disorder (MDD)
- 7-10% Generalized Anxiety Disorder (GAD)
- 3-5% Obsessive Compulsive Disorder (OCD)
- 1-5% Panic Disorder
- 6-10% Posttraumatic Stress Disorder (PTSD)

Perinatal Emotional Adjustment

Range of Distress

Postpartum Psychosis (PPP)

- 0.1-0.2% (1-2 /1,000, childbearing women)
- Increased risk: suicide and infanticide
- Onset within the first days or 2-3 weeks postpartum
- A woman may or may not have a history of mental heath illness

PPP is a psychiatric emergency usually requiring hospitalization

Perinatal Emotional Adjustment

Range of Distress

Postpartum Psychosis (PPP)

Symptoms include rapid shifts in mood, decreased need for sleep, confusion, withdrawn, or erratic behavior, delusions, hallucinations

PPP is a psychiatric emergency usually requiring hospitalization

Consolidate Your Learning

- How does understanding the range of distress during the perinatal period affect our ability to create effective case formulations and treatment plans?
- Are there patients in your caseloads that you may view differently after completing this lecture?

PMADs AND INTRUSIVE THOUGHTS

Learning Objective

At the conclusion of this lecture, you will be able to:

- Discuss the prevalence of perinatal emotional distress and PMADs
- Define ego-dystonic and ego-syntonic intrusive thoughts
- Describe the diagnostic distinction along with clinical implications in correctly identifying ego-dystonic and ego-syntonic intrusive thoughts

Perinatal Emotional Adjustment

Postpartum depression (PPD)

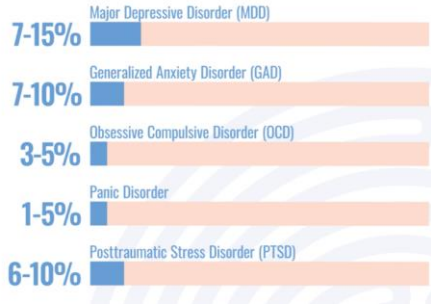
VS

Perinatal distress
- During pregnancy
- After childbirth

Perinatal Emotional Adjustment

PMADs In Depth

PMADs: Prevalence



Perinatal Emotional Adjustment

PMADs In Depth: Intrusive Thoughts

MAJOR DEPRESSIVE DISORDER	GENERALIZED ANXIETY DISORDER	OBSESSIVE COMPULSIVE DISORDER	PANIC DISORDER	POSTTRAUMATIC STRESS DISORDER
7-15%	7-10%	3-5%	1-5%	6-10%
Sadness and guilt	Constant worrying	Behaviors that reduce distress triggered by obsessions	Physical symptoms: palpitations, dizziness, chest pains	Traumatic experience that threatens her own or baby's life
Irritability and anger	Difficulties sleeping and eating	Irritability and anger	Constant worrying, fear of going crazy	Avoidance of trauma-related thoughts or feelings
Difficulties bonding with baby	Physical symptoms	Difficulties bonding with baby	Intrusive negative thoughts (Ego-dystonic)	Mood disturbance, physical arousal
Exhaustion	Intrusive negative thoughts (Ego-dystonic)	Unwanted, intrusive thoughts (Ego-dystonic)		Intrusive negative thoughts (Ego-dystonic) (including flashbacks)
Difficulties sleeping and eating				
Intrusive negative thoughts (Ego-dystonic)				

Perinatal Emotional Adjustment

PMADs In Depth: Intrusive Thoughts

- 90% of all new parents
- Common to all PMADs
- 57% of mothers with postpartum depression have OCD symptoms
- Avoidance
- Mothers are scared and ashamed

Perinatal Emotional Adjustment

Ego-dystonic Intrusive Thoughts

- Distressing: fear of harming the baby
- No higher risk of harming the baby
- Biological and emotional template to protect the baby
- Hallmark of the perinatal time frame
- Normative in pregnancy and postpartum
- Intrusive thoughts that make sense – possibility of postpartum psychosis

Consolidate Your Learning

- Have you had intrusive thoughts?
- Have your patients had intrusive thoughts?
- Consider the ways you might bring your understanding of intrusive thoughts into your clinical work

PMADs ETIOLOGY PART 1

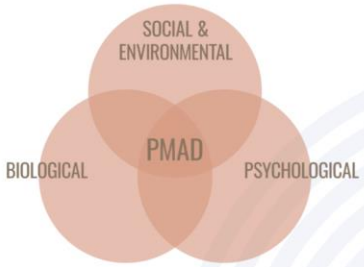
Learning Objective

At the conclusion of this lecture, you will be able to:

- Describe biological and psychological risk factors related to perinatal emotional distress or developing a PMAD

Perinatal Emotional Adjustment

PMAD Etiology



Perinatal Emotional Adjustment

PMAD Etiology

Perinatal Emotional Adjustment

PMAD Etiology – Social/Psychological

Personal History

- Episode of depression or anxiety pre-pregnancy
  - ➡ ***Greatest predictor of PMAD development***
- Anxiety symptoms in pregnancy
  - ➡ ***Significant risk for developing a PMAD***

Perinatal Emotional Adjustment

PMAD Etiology

Perinatal Emotional Adjustment

PMAD Etiology - Biological

Heredity

- Some studies indicate that the genetic susceptibility to PPD is no different than that to MDD
- Others suggest perinatal depression is distinctly heritable, with women whose sisters had PPD nearly 4 times more likely to develop it than those whose siblings did not

Perinatal Emotional Adjustment

PMAD Etiology - Biological

Epigenetics

- Genes turned on or off by biological, psychological or social/environmental input
- Genetic vulnerability to PMAD development?

Perinatal Emotional Adjustment

PMAD Etiology - Biological

Hormones

- Reproductive hormones – gonadal steroids estrogen and progesterone linked to mood disturbance
- Abnormal brain response to normal variations in hormonal levels
- Oxytocin linked to OCD-like symptoms

Perinatal Emotional Adjustment

PMAD Etiology - Biological

Nutrition

- Deficiencies in certain micronutrients is associated with increased risk for PPD
- Psychoneuroimmune connection: immune-to-brain model
- Vitamin D deficiency; inflammatory model
- HPA axis and cortisol levels

Perinatal Emotional Adjustment

PMAD Etiology - Biological

Sleep

- Poor sleep quality is associated with PMAD development
- Impaired sleep is in itself a symptom of a possible PMAD diagnosis
- Poor sleep can make symptoms worse from day to day

Perinatal Emotional Adjustment

PMAD Etiology - Psychological

Personality Traits Associated with PMADs

- Perfectionism – high concern over mistakes
- Introversion
- Interpersonal sensitivity
- Neuroticism and obsessionality

Perinatal Emotional Adjustment

PMAD Etiology - Psychological

Psychological and Cognitive Patterns Associated with Depressive and Anxiety Disorders

- Negative filtering
- All-or-nothing thinking
- Emotional reasoning
- Mind reading
- Catastrophizing

Perinatal Emotional Adjustment

PMAD Etiology - Emotional Responses

Emotional Responses Associated with Depression and Anxiety

- Uncertainty
- Helplessness/frustration
- Low distress tolerance
- Isolation, loneliness
- Low mood
- Anxiety/fear

Consolidate Your Learning

- Consider the complex interplay between biological and psychological factors in pregnancy and the postpartum time
- Consider the ways that these factors would influence your case conceptualization, treatment planning, and planned interventions

PMADs ETIOLOGY PART 2

Learning Objective

At the conclusion of this lecture, you will be able to:

- Describe social-environmental risk factors related to perinatal emotional distress or developing a PMAD

Perinatal Emotional Adjustment

PMAD Etiology - Social & Environmental

PMAD Risk Factors

- Lack of social support/marital strain
- History of physical and/or sexual abuse
- Unplanned pregnancy
- Fertility challenges and history of pregnancy loss
- Teen pregnancy
- Life stressors

Perinatal Emotional Adjustment

PMAD Etiology

Mode of Delivery

Is it a risk factor for PMAD?

- Some studies show increased PMAD risk
- Others show no increased risk

Degree of deviation from expectation increases risk, not mode of delivery itself

Perinatal Emotional Adjustment

PMAD Etiology

Breastfeeding

as risk vs. protective factor

- Relationship complex and not fully understood
- Hormone levels and improved sleep - protective factor
- Wanting to breastfeed but not being able to - risk factor
- Societal and personal expectations and stigma

Perinatal Emotional Adjustment

PMAD Etiology

Teen Pregnancy

- Body and brain still developing
- Still developing educational and career objectives
- Fetus competes with mother for resources
- Psychologically and socially not ready
- Negative self-image
- Blame reflects stigma

Perinatal Emotional Adjustment

PMAD Etiology

Poverty

- Limited access to high quality prenatal care
- Food insecurity
- Unstable home situation
- Lack of emotional and social support
- Premature birth

Consolidate Your Learning

- Consider risk factors in the general population for developing a mental health disorder, and those risk factors in the perinatal population discussed in this lecture. Compare and contrast the ways they are similar and different in those with whom you work clinically.

RANGE OF PERINATAL MOOD AND ANXIETY DISORDERS (PMADs)

Learning Objectives

At the conclusion of this lecture, you will be able to:

- Discuss three leading theoretical formulations related to perinatal mental health
- Utilize diagnostic and epidemiological data for mental health concerns associated with the five most employed DSM-5 diagnostic categories in the pregnancy and postpartum period

Clinical Application

Major Depressive Disorder

Significant Symptoms

- Low mood
- Anhedonia
- Changes in weight or appetite
- Sleep disturbance
- Psychomotor agitation or retardation
- Fatigue, low energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished ability to think or concentrate, or indecisiveness
- Recurrent thoughts of death: suicidal ideation, plan, or attempt

Clinical Application

Major Depressive Disorder

How does it look in the perinatal period?

Low excitement or joy about baby
Everything feels like a burden
Can't sleep even when baby sleeps
Feels like worst mom in the world
"I never should have had a baby"
"I don't know what's best for myself or my baby"
"Everyone is better at this than I am"
"My family would be better off without me"

Clinical Application

Generalized Anxiety Disorder (GAD)

Significant Symptoms

- Restlessness, feeling keyed up or on edge
- Being easily fatigued
- Difficulty concentrating
- Irritability
- Muscle tension
- Sleep disturbance

Clinical Application

Generalized Anxiety Disorder (GAD)

How does it look in the perinatal period?

Clinical Application

Generalized Anxiety Disorder (GAD)

How does it look in the perinatal period?

- The distress feels urgent to the mom
- Mom can't distract herself from her concerns
- Mom can't relax even when baby sleeps or is in another's care
- Mom is wound up, irritable, and uncomfortable in her own skin

Clinical Application

Obsessive Compulsive Disorder (OCD)

Significant Symptoms

- Behaviors that reduce distress triggered by obsessions
- Unwanted, intrusive thoughts

Clinical Application

Obsessive Compulsive Disorder (OCD)

Obsessions: unwanted, intrusive thoughts that cause significant distress

Compulsions: behaviors that reduce distress triggered by obsessions

Clinical Application

Obsessive Compulsive Disorder (OCD)

- Unwanted intrusive thoughts or images
  Usually focus on baby's safety
  Mom often fears that she will harm baby
- Obsessions cause great distress
- Ego-dystonic intrusive thoughts pose no risk of harm to baby

Clinical Application

Obsessive Compulsive Disorder (OCD)

- Unwanted intrusive thoughts or images
- Obsessions cause great distress
  Distress (anxiety) is clinically reassuring
  Distress indicates that thoughts are ego-dystonic
- Ego-dystonic intrusive thoughts pose no risk of harm to baby

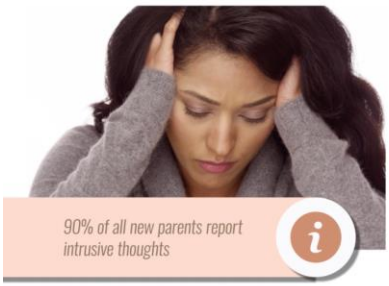
Clinical Application

Obsessive Compulsive Disorder (OCD)

- Unwanted intrusive thoughts or images
- Obsessions cause great distress
- Ego-dystonic intrusive thoughts pose no risk of harm to baby
  Ego-dystonic = inconsistent with mother's values, beliefs, and behavior
  Differentiated from psychotic thoughts, which DO increase risk

Clinical Application

Intrusive Thoughts



- Appear across diagnostic categories
- Meaning attributed to thoughts is of more concern than the content/occurrence
- Evolutionary explanation – threat appraisal
- Avoidance feeds into the obsession-compulsion loop

Clinical Application

Panic Disorder

Significant Symptoms

- Sudden episodes of intense fear or distress
- Physical symptoms: palpitations, sweating, trembling, shortness of breath, dizziness, tingling, chest pain, GI distress
- Psychological symptoms: fear of going crazy, fear of losing control, feeling of unreality
- Fear of triggering panic attacks leads to avoidant behavior

Clinical Application

Panic Disorder

How does it look in the perinatal period?

"I'm dying, and my baby won't be safe"
"I'm going crazy, I will lose control"

Clinical Application

Posttraumatic Stress Disorder

Significant Symptoms

- Can develop after an event that threatens her own or loved ones' lives
- Recurrent, intrusive memories of the traumatic event; nightmares; flashbacks
- Avoidance of trauma-related thoughts, feelings, or external reminders
- Mood disturbance, irritability, angry outbursts, difficulty concentrating
- Physical arousal, hyper-vigilance, exaggerated startle response, sleep difficulty

Clinical Application

Posttraumatic Stress Disorder

How does it look in the perinatal period?

- Pregnancy or birth complications leave mom fearful for her or her baby's life
- Vivid memories, "re-experiencing" the associated distress
- Attempts to avoid reminders/triggers: this is particularly concerning if baby is trigger

Perinatal Emotional Adjustment

PMADs In Depth: Intrusive Thoughts

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Exhaustion	Intrusive negative thoughts (Ego-dystonic)	Unwanted, intrusive thoughts (Ego-dystonic)		Intrusive negative thoughts (Ego-dystonic) (including flashbacks)
Difficulties sleeping and eating				
Intrusive negative thoughts (Ego-dystonic)				

Consolidate Your Learning

- Consider women or men with whom you've worked clinically
- What particular vulnerabilities might occur for them as they build their family?

CLINICAL APPLICATION: ISSUES AROUND DIAGNOSIS

Learning Objective

At the conclusion of this lecture, you will be able to:

- Describe two ways to utilize DSM-5 and ICD-10 diagnostic codes to accurately reflect perinatal clinical presentation
- Describe two ways to enhance empathic discussion with patients related to diagnostic codes being utilized for their care

Clinical Application

Range of Diagnostic Categories

PMAD Diagnoses

- Range of distress, as understood by specialists, is not represented in the DSM-5 or ICD-10
- In DSM-5, "peripartum onset" specifier exists for depression only. Onset required within 4 weeks
- In ICD-10, "postpartum mood disturbance" coded near "puerperal psychosis"
- Other category listings: "Other mental disorders complicating pregnancy" and "other mental disorders complicating the puerperium"

Clinical Application

Important Questions and Coding

PMAD Coding Options

- Use ICD-10 codes despite shortcomings
- Use the DSM-5 categories even though they don't have a specifier
- Use adjustment disorders to reflect perinatal emotional distress

Clinical Application

Important Questions and Coding

PMAD Coding Options

Seleni Approach

- Use the DSM-5 categories
- Translated into ICD-10 codes for insurance purposes
- DSM-5 conceptualization helps avoid the confusion and lack of clarity present in ICD-10

Clinical Application

Complex Clinical Picture

Women who experience postpartum distress

- Often experience an overlap of symptoms
- Most present multiple clusters of symptoms representing a range of distress
- Might meet full diagnostic criteria for one or multiple disorders or with subclinical symptoms from one or more
- Easier to use DSM-5 for coding

Clinical Application

Questions Around Coding

Coding Considerations

- Insurance reimbursement
- Short-and long-term implications
- Client preferences – perceived stigma
- Social justice

Clinical Application

"Diagnosis – The Conversation"

Explaining diagnostic and coding procedures to patients

What we are hearing the primary difficulty is and how we are going to move forward

Psychoeducation

Sometimes a diagnostic category does not reflect what specialists know about PMADs

Explain code being used – and why

If different from "treatment diagnosis," provide comprehensive psychoeducation, congruent with PMAD symptoms

Consolidate Your Learning

- Consider the diagnostic coding in the categories represented by DSM-5 categories and the ICD-10 codes
- What are the differences in the symptom patterns reflected in DSM-5 and the ICD-10 diagnostic categories, and how might you use one or the other?

CLINICAL APPLICATION: SCREENING AND SCREENING INSTRUMENTS FOR PMADs

Learning Objectives

At the conclusion of this lecture, you will be able to:

- Describe the strengths and weaknesses of three screening tools for PMADs
- Describe two ways to enhance empathic discussion with patients related to perinatal distress

Identification And Diagnosis

Screening

- Growing awareness of the prevalence of PMADs and interest in diagnosis and treatment
- The goal is to screen as many women as possible so that those who need help, get help
- Patients with positive screenings must undergo comprehensive diagnostic assessment
- Not intended to be diagnostic

Identification And Diagnosis

Screening

Sample Script

- Emotional distress is very common during and after pregnancy. It's hard to predict who might struggle
- Paying attention to risk factors can help us stay alert to any problems that might arise
- Let me know if you are bothered by any thoughts or feelings – sadness, worry, anger...
- These might be normal but they also can be symptoms of a mental health problem
- The earlier we address them, the faster we can help you feel better

Identification And Diagnosis

Screening Instruments

- If there are screenings, there must also be excellent treatment options
- Anyone who receives a positive screen needs to be referred to a provider for comprehensive assessment
- Standardized screening instruments can be helpful sources of information during the initial diagnostic process

PMADs are the most common complication of pregnancy

Identification And Diagnosis

Screening Instruments

Edinburgh Postnatal Depression Scale (EPDS)

PROS	CONS
• Gold standard • Strong reliability/validity • Translated into several languages • Familiar to interdisciplinary providers	• Focuses on depressive symptoms

Follow-up needed for comprehensive assessment and diagnosis

Identification And Diagnosis

Screening Instruments

Two-question Screen

PROS

- Strong validity and reliability
- Easy to administer and score

CONS

- Assesses depressive symptoms only

Identification And Diagnosis

Screening Instruments

Patient Health Questionnaire-9 (PHQ-9)

PROS

- Publicly available
- Familiar to providers and patients
- Strong validity and reliability
- Easy to administer and score

CONS

- Assesses depressive symptoms only

Identification And Diagnosis

Screening Instruments

Generalized Anxiety Disorder 7-Item Scale (GAD-7)

PROS

- Publicly available
- Easily scored
- Available in several languages
- Strong validity and reliability
- Useful for detecting anxiety

CONS

- Assesses anxious symptoms only

Comprehensive assessment needed for diagnosis

Identification And Diagnosis

Screening Instruments

Yale-Brown Obsessive Compulsive Scale II and Symptom Checklist

- "Gold standard" for rating severity of OCD
- Strong validity and reliability
- Publicly available
- Symptom list can be helpful psychoeducational piece
- Symptom list can be distressing
- Complicated to administer
- Clinician-rated so may lead to variations between providers' assessments
- Possibility of triggering anxiety, fear of consequences

Identification And Diagnosis

Screening Instruments

Yale-Brown Obsessive Compulsive Scale II and Symptom Checklist

PROS ⊕	CONS ⊖
• "Gold standard" for rating severity of OCD	• Symptom list can be distressing
• Strong validity and reliability	• Complicated to administer
• Publicly available	• Clinician-rated so may lead to variations between providers' assessments
• Symptom list can be helpful psychoeducational piece	• Possibility of triggering anxiety, fear of consequences

Identification And Diagnosis

Screening Instruments

Other screening instruments to consider

- Mood Disorders Questionnaire (MDQ), in conjunction with EPDS
- Beck Depression Inventory (BDI)
- Pregnancy Risk Assessment (PRAMS-6)
- Perinatal Anxiety Screening Scale (PASS)
- Postpartum Depression Screening Scale (PDSS)

Note for Clinicians

- Many states in the US have no system for screening or referral procedures
- Example set by New Jersey: mandated postpartum depression screening
- Are there adequate treatment options following a screening?
- Positive screening result might raise stigma, lead to removal of baby

Consolidate Your Learning

- Consider screening tools you have been trained to use in your clinical practice
- How do they influence the ways you conceptualize treatment as well as a patient's diagnostic picture?
- In what ways might these screening tools influence your diagnostic process as well as conceptualization of treatment?

CLINICAL INTERVIEW PART 1

Learning Objectives

At the conclusion of this lecture, you will be able to:

- Define three ways in which a clinical interview assessing perinatal emotional distress differs from a clinical interview conducted with patients in the general population
- Describe two ways to enhance empathic discussion with perinatal patients

Clinical Application

Distress/Symptoms

- Pregnancy – how was it for you?
- Impact?
- Relationship with baby? Attachment?
- Excessive crying?
- Social cues?
- Sleep deprived?
- Family patterns?
- Parents: Internal stories
- Intrusive, scary thoughts?

Clinical Application

Clinical Interview

Baby

Tell me about your baby...

- Name?
- Temperament?
- Excessive crying?
- Social cues?
- Who helps?

Clinical Application

Clinical Interview

Feeding

- How is the feeding going?
- Pumping?
- Source of stress? Satisfying?
- Concern for baby's weight?
- Disappointment or self-reproach?

Clinical Application

Clinical Interview

Pregnancy History

- Loss history?
- Fertility treatment/IVF?
- Complications?
- Nausea?
- Mood/anxiety symptoms?
- Pressures or stressors?
- Marriage/partnership?
- Financial stressors? Poverty?

Clinical Application

Clinical Interview

Labor and Delivery

- Expectations?
- Pain?
- Experience?
- Complications?
- Disappointment?
- Pride?
- Recovery?

Consolidate Your Learning

- Think about the way that you have been trained clinically to carry out an intake interview
- Describe the significant differences related to carrying out a clinical interview with a postpartum woman and her partner, and the general population

CLINICAL INTERVIEW RELATED TO MOTHER

Learning Objectives

At the conclusion of this lecture, you will be able to:

- Define three ways in which a clinical interview assessing perinatal emotional distress differs from a clinical interview conducted with patients in the general population
- Discuss and describe two ways to enhance empathic discussion with patients

Clinical Application

Clinical Interview – related to mother

Social Support

- Partner?
- Family of origin?
- In-laws?
- Friends?
- Midwife, doula, baby nurse?
- Medical team?
- Who knows?
- Genogram/Ecomap

Clinical Application

Clinical Interview – related to mother

Significant History

- Physical and Mental Health?
- What's helped before?
- Strengths?
- Substance use?
- Trauma?
- Abuse?
- Legal involvement?

Clinical Application

Clinical Interview – related to mother

Additional Stressors

- Other children?
- Other caregiving?
- Housing? Food insecurity?
- Employment?
- Finances?

Clinical Application

Clinical Interview – related to mother

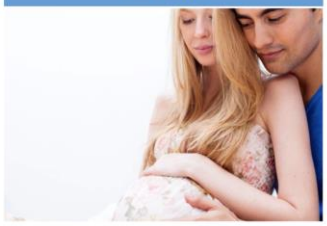
Body Image

- Feelings about pregnant and/or postpartum body?
- Any disordered eating? Body dysmorphia?
- Guilt?
- Breasts: source of nutrition or sexual ?

Clinical Application

Clinical Interview – related to mother

Sexuality



- Identity shift
- Adult relationship?
- Postpartum body?
- "Touched out?"
- Fatigue?

Clinical Application

Clinical Interview – related to mother

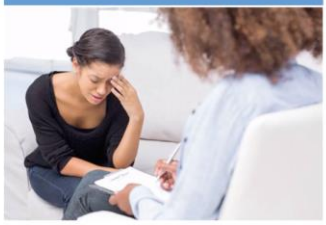
Strengths

- Sources of strength and pleasure?
- Coping skills?
- Faith/religion/meditation?

Clinical Application

Clinical Interview – related to mother

Suicide



- Ask directly. Say the word.
- Ideation? Plan? Intent? Means?
- History?
- Risk factors?
- Protective factors?

Clinical Application

Clinical Interview – related to mother

RISK FACTORS

- Previous attempts
- Ideation, plan, intent, means
- Impulsivity
- Isolation
- MDD, IPV, Substance use
- Psychosis

PROTECTIVE FACTORS

- Reason for living
- Strong social supports
- Spirituality
- Belief that suicide is immoral
- Being a mother or father

Clinical Application

Clinical Interview – related to mother

Barriers to Disclosure

- Lack of information - "But I'm not sad. I can't have PPD."
- Shame - "It's my fault. Good mothers don't think these things."
- Fear of consequences - Hospitalization, medication, child welfare involvement, lose child – custody concerns

Consolidate Your Learning

- In this lecture about the clinical interview we have focused on topics closely related to the new mother. What is the interplay between the mother as an adult and her new role as a mother? In what ways do these factors interact?

TREATMENT PLANNING
ASSESSING PROGRESS
SUICIDE SAFETY PLANNING

Learning Objectives

At the conclusion of this lecture, you will be able to:

- Identify and utilize strategies for treatment and safety planning that you can implement in your practice with mothers, fathers, and families

Clinical Application

Specific Plan Development

Developing the Treatment Plan

- Symptoms
- "Treatment diagnosis"
- Impact of symptoms on daily functioning
- Strengths/support system

Clinical Application

Treatment Plan - Assessing Progress

Guidelines for developing a treatment plan

- Achievement of measurable and specific goals
- Significant reduction of symptoms
- Improved score on standardized screening instrument

Clinical Application

Treatment Plan - Assessing Progress

Guidelines for developing a treatment plan

- Achievement of measurable and specific goals
  Successfully identified 3 self-care practices
- Significant reduction of symptoms
  No panic attacks in 4 weeks
- Improved score on standardized screening instrument
  Periodic administration of selected instrument
  Recommended every 4-6 weeks
  Achievement of subclinical score

Clinical Application

Suicide Safety Planning

Basic Safety Plan: LOW RISK

SAMPLE PRACTICES

- *Take a walk*
- *Watch favorite TV show*
- *Share feelings with listed supportive person*
- *Actively daydream/fantasize*
- *Coloring/drawing*
- *Light yoga or meditation*
- *Feel a very soft stuffed animal*

Clinical Application

Suicide Safety Planning

Advanced Safety Plan: ELEVATED RISK

- *Who to call and phone number*
- *Identify closest hospital*
- *Identify how to get to hospital*
- *Risk assessment each session*

Clinical Application

Options When Stable

Terminate therapy: Relapse prevention plan

Continue therapy: Build support and self efficacy, healthy relationships, long term goals

Clinical Application

Relapse Prevention

- Triggers/warning signs that symptoms are coming back
- Coping strategies
- People to call for support
- How to know when professional support is needed
- Names and contact information for professional supports

Consolidate Your Learning

- Bring to mind a current patient. What type of goals can you develop that can be translated into concrete steps toward symptom reduction? After considering symptoms, stressors, and level of risk, how can you develop an effective treatment and safety plan to manage symptoms and stressors as well as minimize risk?

OVERVIEW OF PSYCHOTHERAPEUTIC APPROACHES AND TIMELINES AT SELENI, PART 1

Learning Objective

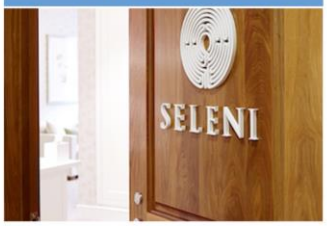
At the conclusion of this lecture, you will be able to:

- Describe various management strategies to address acute perinatal distress or PMADs in mothers, fathers, and their families that you can implement in your practices with mothers, fathers, and families

Overview Approach to Clinical Interventions

Seleni Approach

Best Practices - Seleni



- Based in empathy
- Therapeutic relationship is key
- Empathic connection
- Customized plan of care

Overview Treatment Trajectories

Crisis

Sources of Distress

Anxiety and depression
Pregnancy, Labor & Birth
Baby Blues or possible PMAD
Perinatal Loss
Sleep and feeding problems
Health related issues with the infant
Transition of the maternity leave ending

Therapeutic Tools

Psychoeducation
Therapeutic Holding/Active Listening
Scaffolding and Normalizing Cognitive and Emotional Experiences

Transition to Motherhood

Biological Influences: Sleep Disturbance

- Hormonal shifts
- Frequent urination
- Anxiety
- Sleep patterns shift
- Worries

PMAD Treatment Interventions

Sleep Restoration - Crisis to Short-term

Psychoeducation

- Identify and reframe unhelpful beliefs about sleep
- Focus on sleep quality over quantity
- Confront catastrophizing and black-or-white thinking
- Normalize sleep disturbances: body and mind will survive

PMAD Treatment Interventions

Sleep Restoration - Crisis to Short-term

Guidelines

- Finish most food ~4 hours before bed
- Avoid caffeine after 2:00 pm
- Wait until really drowsy to go to bed
- Can't sleep? Get out of bed until drowsy
- Nap or rest when baby sleeps (for mothers who were able to nap before baby)
- Protected sleep
- Create cool-down/log-off ritual
- Use bed for sleep, sex, and nursing only
- Have everything ready and close by, use the lowest light possible

PMAD Treatment Interventions

Nutrition - Crisis to Short-term

- Add healthy snacks (nuts, fruit, whole grains)
- Encourage 3 balanced meals

Nutrition serves as the bedrock for physical and emotional well-being

PMAD Treatment Interventions

Exercise - Crisis to Short-term

- Effective in reducing depressive and anxious symptoms
- Take a history of exercise and look at barriers
- Check with ob-gyn or midwife; identify guidelines or restrictions
- Aim for 30 minutes 3-5 days weekly. But even once a week or a short walk helps
- Getting started is key

Overview Treatment Trajectories

Crisis

Sources of Distress

Anxiety and depression
Pregnancy, Labor & Birth
Baby Blues or possible PMAD
Perinatal Loss
Sleep and feeding problems
Health related issues with the infant
Transition of the maternity leave ending

Therapeutic Tools

Psychoeducation
Therapeutic Holding/Active Listening
Scaffolding and Normalizing Cognitive and Emotional Experiences

PMAD Treatment Interventions

Psychoeducation - Crisis to Short-term

Meta-analysis of Psychoeducation:	Always include:	Use:
Simply understanding symptoms ⬇ Reduces symptoms	• Prevalence • Etiology • Symptoms • Prognosis	"This isn't your fault" "This happens to a lot of women" "You will get better"

Overview Treatment Trajectories

Crisis

Sources of Distress	Therapeutic Tools
Anxiety and depression Pregnancy, Labor & Birth Baby Blues or possible PMAD Perinatal Loss Sleep and feeding problems Health related issues with the infant Transition of the maternity leave ending	Psychoeducation Therapeutic Holding/Active Listening Scaffolding and Normalizing Cognitive and Emotional Experiences

Overview Treatment Trajectories

Postpartum Psychosis - When Symptoms Stabilize

- Supportive therapeutic work can avert a potential crisis
- Treatment modalities used to address crisis work with prevention as well

PMAD Treatment Interventions

Short-term and Long-term

- Prevention and crisis tools can overlap
- Assess if any risk factors related to developing a PMAD - limited social supports or substance use
- Psychoeducation
- Interventions reduce behaviors that increase risk
- Referral to other programs as needed, (for addiction, for example)
- Supportive work to prevent, to address acute crisis, and long-term therapeutic work

Consolidate Your Learning

- Consider the ways that addressing sleep and nutrition, and utilizing psychoeducaton with those in the peripartum timefame might influence your therapeutic approach – both with those in the peripartum timeframe and with those who are not in the peripartum timeframe

OVERVIEW OF PSYCHOTHERAPEUTIC APPROACHES AND TIMELINES AT SELENI, PART 2

Learning Objective

At the conclusion of this lecture, you will be able to:

- Describe various management strategies from two theoretical perspectives, including best practices of clinical treatment of PMADs, that you can implement in your practices with mothers, fathers, and families

Overview of Psychotherapeutic Approaches & Timelines at Seleni

Note for Clinicians

- In short and long-term work, there may be need to revisit therapeutic tools considered in crisis intervention, i.e. sleep quality, nutrition, and/or psychoeducation
- For each therapeutic approach mentioned in this lecture, there is a wealth of information and wide body of knowledge, comments won't be exhaustive
- This lecture focuses on the way each treatment or therapeutic framework is specifically applicable for pregnant women, partners, and their families

Treatments

Cognitive Behavioral Therapy (CBT)

Time Range: Crisis Through Long-Term

- Changing behaviors related to faulty cognitions
- Aims to bring about enduring emotional and behavioral change
- Structured and short term
- Includes psychoeducation

Treatments

Dialectical Behavioral Therapy (DBT)

Time Range: Crisis Through Long-Term

- Focus on building social skills and problem-solving
- Emphasis: Psychosocial aspects
- Identify problematic thoughts, beliefs, assumptions
- Connect these problematic thoughts with psychosocial functioning

Treatments

Interpersonal Therapy (IPT)

Time Range: Crisis and Prevention to Short-Term

Etiology of Psychological Distress

Depression: A medical illness (biological/genetic etiology)

Episodes of depression are connected to a current or recent life event (biopsychosocial model)

Mechanisms of Change

Therapy focus: depression in the context of interpersonal factors, incorporating 4 themes:

- *Grief*
- *Role transitions*
- *Role disputes*
- *Interpersonal deficits*

Treatments

Psychodynamic Psychotherapy

Time Range: Short-Term to Long-Term

- Both present focused and focused on history
- Most behaviors, feelings, and thoughts related to difficulties are not conscious
- Focus on affect and expression of emotion
- Exploration of avoided topics (resistance)
- Focus on interpersonal experiences that include past and present influences
- Emphasis on the therapeutic relationship – transference and the working alliance
- Exploration of wishes, dreams, and fantasies

Treatments

Psychoanalytic Psychotherapy

Time Range: Long-Term

- Focus on bringing unconscious conflicts into awareness
- Unconscious conflicts drive behavior, thoughts, and emotions, and are often at the root of mental illness
- Use of transference to uncover defense mechanisms that contribute to difficulties and interfere with maximal functioning in life
- Resulting insight reduces distress and informs improved capacity to love and work – deeply connected to happiness and satisfaction with life

Treatments

Attachment Informed Therapy

Time Range: Crisis to Long-Term

- Early attachment impacts neural and social development and establishes template for relationships
- Attachment orientation influences ways we cope with stress and mental illness
- Addresses and repairs: anxious, avoidant, or disorganized attachment styles that result in difficulties with emotion regulation
- Therapeutic encounter bypasses cognitive processing and helps repair attachment styles and dysfunctional emotional regulation

Treatments

Mindfulness Approach

Time Range: Short-Term to Long-Term

- Conscious breathing (emotional regulation)
- Breathe in to the count of three, and out to the count of five, through the nose
- Tools that have been "secularized" from sacred traditions, such as kindness & compassion for self and others

Consolidate Your Learning

- Consider the therapeutic modality or modalities you have been trained to use in your practice
- In what ways do the trajectories and treatments we describe here differ and in what ways are they similar to the way you work now?

CLINICAL APPLICATION BY DIAGNOSTIC CATEGORY: MAJOR DEPRESSIVE DISORDER (MDD)

Learning Objective

At the conclusion of this lecture, you will be able to:

- Identify perinatal Major Depressive Disorder (MDD)
- Identify and utilize best practices treatment of major depressive disorder in your treatment with mothers, fathers, families

Perinatal Emotional Adjustment

PMADs In Depth

MAJOR DEPRESSIVE DISORDER
7-15%
- Sadness and guilt
- Irritability and anger
- Difficulties bonding with baby
- Exhaustion
- Difficulties sleeping and eating
- Intrusive negative thoughts

GENERALIZED ANXIETY DISORDER
7-10%
- Constant worrying
- Difficulties sleeping and eating
- Physical symptoms
- Intrusive negative thoughts

OBSESSIVE COMPULSIVE DISORDER
3-5%
- Behaviors that reduce distress triggered by obsessions
- Irritability and anger
- Difficulties bonding with baby
- Unwanted, intrusive thoughts

PANIC DISORDER
1-5%
- Physical symptoms: palpitations, dizziness, chest pains
- Constant worrying, fear of going crazy
- Intrusive negative thoughts

POST-TRAUMATIC STRESS DISORDER
6-10%
- Traumatic experience that threatens her own or baby's life
- Avoidance of trauma-related thoughts or feelings
- Mood disturbance, physical arousal
- Intrusive negative thoughts (including flashbacks)

Perinatal Emotional Adjustment

PMADs In Depth

MAJOR DEPRESSIVE DISORDER
7-15%
- Sadness and guilt
- Irritability and anger
- Difficulties bonding with baby
- Exhaustion
- Difficulties sleeping and eating
- Intrusive negative thoughts

Clinical Application

Major Depressive Disorder

Recommended interventions (short-term to long-term)

- Psychoeducation and behavioral activation
- Cognitive restructuring (CBT)
- Psychodynamic therapy and family dynamics
- Strengths-focused supportive counseling
- IPT tools
- CBT tools

Clinical Application

Major Depressive Disorder

Behavioral activation

- Increase patient's engagement in activities that offer a sense of accomplishment or pleasure
- Encourage patient to "give herself credit"
- Assess impact on mood

Clinical Application

Cognitive Restructuring/CBT

- Help reframe and reassess negative thoughts
- Focus not on activities, but on feelings and thoughts
- Identify and modify the negative thoughts
- Help the patient get in touch with her feelings and modify the thoughts that accompany them
- Help patient find new positive solutions to feeling depressed and stuck

Clinical Application

Cognitive Restructuring/CBT

- Ask: "What's the evidence that you're a bad mom?" Identify how the evidence does not add up
- Ask: "What feelings come along with these negative thoughts?" Identify the feelings that go with the thoughts
- Ask: "What went through your head?" Talk about the feelings. Remember, thoughts are not the same as feelings
- Do not deny the difficulty but reframe thoughts more posivitely
- Construct a healthier, more realistic, and hopeful way of thinking about a painful situation

Clinical Application

Major Depressive Disorder: Psychodynamic Therapy

Long-term

- Unconscious conflicts, defenses, felt or real deprivations
- Begins with the mother's own family of origin
- Help patients understand they may be reacting to a situation unconsciously compared to their own childhood
- Separate the present from the past
- Greater freedom of action and feeling

Clinical Application

Major Depressive Disorder: Psychodynamic Therapy

What do we do in therapy?

- Talk about the mother's own history as a child
- Talk about important relationships
- Explore important milestones and how she responded to them
- Listen to how she constructs her story and point out patterns

Note for Clinicians

Psychodynamic Therapy

- Do not discourage or avoid angry, painful feelings
- Help mother reflect upon and express herself
- Therapist does not judge – therapeutic holding
- Show how past is alive in the present
- Help mother see she has more power to change and better decisions

Clinical Application

Major Depressive Disorder

Recommended interventions (short-term to long-term)

- Psychoeducation and behavioral activation
- Cognitive restructuring (CBT)
- Psychodynamic therapy and family dynamics
- Help patient become aware of her inner conflicts, fears, desires

Consolidate Your Learning

- What strategy might you utilize if a mother felt tired and unmotivated to get out of bed to care for her newborn?
- What if she were criticizing herself for not being in good enough physical shape for her partner?
- If she continually compared herself to her mother, what strategy or strategies might you use?

CLINICAL APPLICATION BY DIAGNOSTIC CATEGORY: GENERALIZED ANXIETY DISORDER

Learning Objectives

At the conclusion of this lecture, you will be able to:

- Identify the symptoms of Generalized Anxiety Disorder in perinatal women
- Identify and utilize best practices treatment for Generalized Anxiety Disorder in your treatment with mothers, fathers, and families

Perinatal Emotional Adjustment

PMADs In Depth

MAJOR DEPRESSIVE DISORDER	GENERALIZED ANXIETY DISORDER	OBSESSIVE COMPULSIVE DISORDER	PANIC DISORDER	POST-TRAUMATIC STRESS DISORDER
7-15%	7-10%	up to 5%	1-5%	6-10%
Sadness and guilt	Constant worrying	Behaviors that reduce distress triggered by obsessions	Physical symptoms: palpitations, dizziness, chest pains	Traumatic experience that threatens her own or baby's life
Irritability and anger	Difficulties sleeping and eating	Irritability and anger	Constant worrying, fear of going crazy	Avoidance of trauma-related thoughts or feelings
Difficulties bonding with baby	Physical symptoms	Difficulties bonding with baby	Intrusive negative thoughts	Mood disturbance, physical arousal
Exhaustion	Intrusive negative thoughts	Unwanted, intrusive thoughts		Intrusive negative thoughts (including flashbacks)
Difficulties sleeping and eating				
Intrusive negative thoughts				

Perinatal Emotional Adjustment

PMADs In Depth

GENERALIZED ANXIETY DISORDER
7-10%

- Constant worrying
- Obsessional thinking
- Difficulties sleeping, eating, concentrating
- Physical symptoms including GI problems
- Negative intrusive thoughts

Clinical Application

Generalized Anxiety Disorder (GAD)

CASE DESCRIPTION

Clinical Application

Generalized Anxiety Disorder (GAD)

Recommended interventions (short-term to long-term)

- Psychoeducation
- Behavioral and body based interventions
- Cognitive restructuring
- Psychodynamic therapy

Clinical Application

Generalized Anxiety Disorder: Psychoeducation

Focus on differentiating

New Mom Worries ≠ ***Pathological Anxiety***

Clinical Application

Generalized Anxiety Disorder: Body Based Interventions

Behavioral and body based interventions

- Bodywork
- Breathing exercises - diaphragmatic breathing
- Exercise and yoga - any activity that uses muscles and causes sweat triggers serotonin and dopamine release

Clinical Application

Generalized Anxiety Disorder: Cognitive Restructuring

Cognitive Errors in GAD

- Overestimation of threat
- Underestimation of coping capacity
- Difficult to tolerate uncertainty

Clinical Application

Generalized Anxiety Disorder: Cognitive Restructuring

- Normalize the situation
- Encourage patient to imagine baby happy and alive without her
- Encourage patient to think of times that were actually quite difficult that she successfully managed
- Help patient reflect upon uncertainty - uncertainty does not necessarily lead to disaster

Clinical Application

CASE DESCRIPTION

History of Present Illness

Clinical Application

Generalized Anxiety Disorder: Psychodynamic Therapy (Longer term)

- Help the patient clarify the underlying, unrecognized interpersonal patterns
- Help the patient see how the past is often triggered in the present
- Helps patient reflect upon and feel the tension, not to deny or negate them
- Helps the patient tolerate fearful states and uncertainty, and to develop the capacity to look at her inner fears

Perinatal Emotional Adjustment

PMADs In Depth

GENERALIZED ANXIETY DISORDER
7-10%

- Constant worrying
- Obsessional thinking
- Difficulties sleeping, eating, concentrating
- Physical symptoms including GI problems
- Negative intrusive thoughts

Clinical Application

Generalized Anxiety Disorder (GAD)

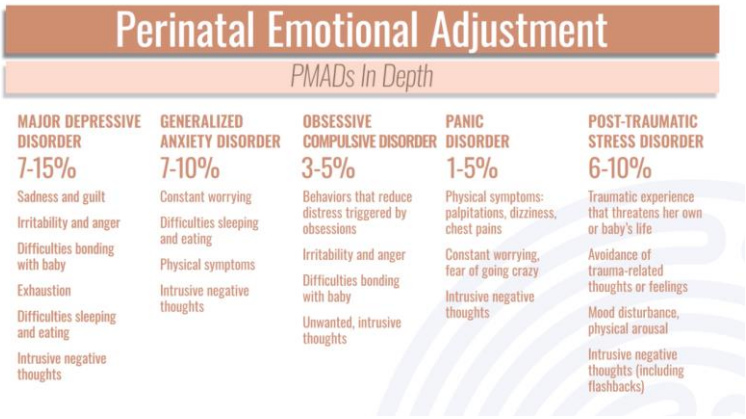
Recommended interventions (short-term to long-term)

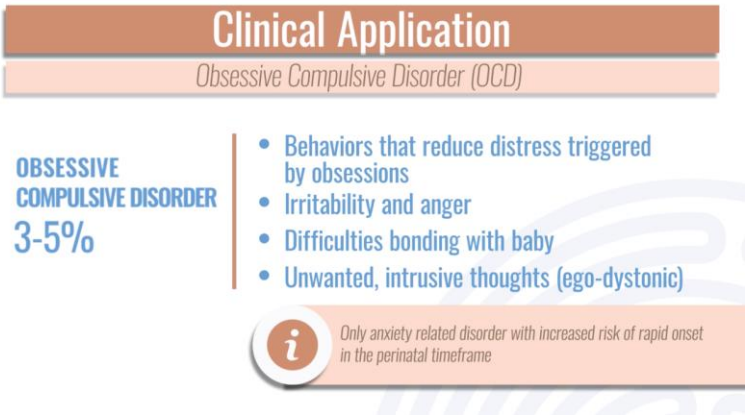
- Psychoeducation
- Behavioral and body based interventions
- Cognitive restructuring
- Psychodynamic therapy

Consolidate Your Learning

- When would you use CBT with a new mother?
- How would you assess whether a new mother would benefit from psychodynamic treatment, with or without her partner?

CLINICAL APPLICATION BY DIAGNOSTIC CATEGORY: OBSESSIVE COMPULSIVE DISORDER





Clinical Application

Obsessive Compulsive Disorder (OCD)

- **Obsessions**
  Recurrent thoughts, ideas, images, impulses, or doubts
  Unwanted, distressing, and often seemingly "senseless"
- **Common themes in pregnancy**
  Contamination, responsibility for causing improbable harm (intrusive thoughts), violence, sex, morality, and religion

Clinical Application

Obsessive Compulsive Disorder (OCD)

- **Compulsions**
  Urges to commit behavioral or mental acts or rituals to get rid of the obsessional distress or to avert feared consequences
- **Common compulsions**
  Reassurance seeking, ordering and arranging, repeating routine activities, counting, mentally praying, or balancing

Clinical Application

Obsessive Compulsive Disorder (OCD)

In pregnancy and postpartum

Excessive washing and cleaning
Excessive checking and monitoring

Clinical Application

Obsessive Compulsive Disorder (OCD)

CASE DESCRIPTION

Clinical Application

CASE DESCRIPTION

History of Present Illness

Clinical Application

Obsessive Compulsive Disorder (OCD)

Recommended interventions (crisis to short-term)

- Psychoeducation
- Behavioral and body based interventions
- Therapeutic holding = reduce terror
- Modified exposure and response prevention

Clinical Application

Obsessive Compulsive Disorder (OCD)

Special Considerations

If mom is afraid to be alone with baby...

- Refer to qualified ERP provider, if not you
- Psychiatric consultation – for symptom relief
- "You shouldn't have to put up with that"

Note for Clinicians

Importance of Correct Diagnosis

Differential diagnosis tip:

- In OCD, unwanted and distressing intrusive thoughts are usually unrealistic, irrational. In GAD, unwanted and distressing intrusive thoughts are usually rational but exaggerated.
- In OCD (and PMADs) the intrusive thoughts are deeply distressing – ego-dystonic. In Postpartum Psychosis (PPP), intrusive thoughts make sense.
- When treating OCD, do not examine the evidence, as in cognitive restructuring for GAD.

Clinical Application

Obsessive Compulsive Disorder (OCD)

Psychoeducation: Compulsions

- Short-term relief but never truly satisfying
- Obsession will always come back
- "Scratching a mosquito bite"

Clinical Application

Obsessive Compulsive Disorder (OCD)

Exposure and Response Prevention (ERP)

- Stay in presence of anxiety-provoking stimuli/thoughts until distress diminishes
- Effacacious treatment for OCD
- Demonstrate for the patient clinician confidence that thoughts are not dangerous

Consolidate Your Learning

Consider the symptom patterns associated with GAD, OCD, Panic, and Postpartum Psychosis

- What are the challenges you might face as a clinician while trying to make a differential diagnosis and treatment plan?

CLINICAL APPLICATION BY DIAGNOSTIC CATEGORY: PANIC DISORDER

Learning Objectives

At the conclusion of this lecture, you will be able to:

- Identify and utilize best practices of treatment for Panic Disorder that you can implement in your practices with mothers, fathers, and families
- Demonstrate your awareness of three unique clinical techniques utilized to address emotions and stress present in panic in the peripartum period

Perinatal Emotional Adjustment

PMADs In Depth

PANIC DISORDER
1-5%

- Physical symptoms: palpitations, dizziness, chest pains
- Constant worrying, fear of going crazy
- Intrusive negative thoughts

Clinical Application

CASE DESCRIPTION

History of Present Illness

Clinical Application

Panic Disorder

Psychoeducation

- "Catastrophic misinterpretation of bodily sensations"
- Feel like you're in danger
- Body's safety system - Fight/flight/freeze
- Anxiety and physical activation become triggers of panic
- Body reacts more - self-fueling loop

Clinical Application

Panic Disorder

Psychoeducation

- "Catastrophic misinterpretation of bodily sensations"
- Feel like you're in danger
- Body's safety system - Fight/flight/freeze
- Anxiety and physical activation become triggers of panic
- Body reacts more - self-fueling loop

Clinical Application

Panic Disorder

Coping skills for symptom relief

- Grounding practices - breath work, progressive muscle relaxation
- CBT - Engage realistic thinking. Correct cognitive distortions
- Face feared situations and sensations. Goal of riding the wave, not necessarily remaining panic-free

Clinical Application

Panic Disorder

Recommended Interventions (Crisis to Short-term)

- Psychoeducation
- Cognitive Behavioral coping skills
- "Ride the wave"
- Breathing, meditation, awareness of body sensations
- Therapeutic holding = build trust
- Shower or bath
- Interoceptive exposure (not with a pregnant woman)

Clinical Application

Panic Disorder

Notes for Patients

- Being out of control is normative
- She has survived panic
- Not life threatening
- She can do it again

Clinical Application

Panic Disorder

Recommended Interventions (Crisis to Short-term)

- Psychoeducation
- Cognitive Behavioral coping skills
- "Ride the wave"
- Breathing, meditation, awareness of body sensations
- Therapeutic holding = build trust
- Shower or bath
- Interoceptive exposure (not with a pregnant woman)

Clinical Application

Panic Disorder

Interoceptive exposure

- Intentional triggering of panic sensations
- Habituation vs learning theory
- Only if thoroughly trained and comfortable with intervention
- Question of safety in pregnancy

Consolidate Your Learning

- Consider the ways that panic represents a biological response that can be both adaptive and maladaptive
- How might you integrate this concept into your clinical treatment for panic?

CLINICAL APPLICATION BY DIAGNOSTIC CATEGORY: POSTTRAUMATIC STRESS DISORDER (PTSD)

Learning Objective

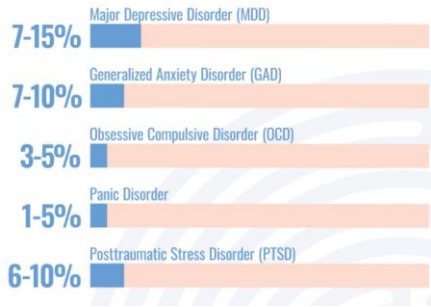
At the conclusion of this lecture, you will be able to:

- Identify and utilize best practices treatment of Posttraumatic Stress Disorder (PTSD) that you can implement in your practices with mothers, fathers, and families
- Demonstrate your awareness of three unique clinical techniques utilized to address emotional distress from PTSD in the peripartum timeframe

Perinatal Emotional Adjustment

PMADs In Depth

PMADs: Prevalence



Perinatal Emotional Adjustment

PMADs In Depth

POSTTRAUMATIC STRESS DISORDER
6-10%

- Traumatic experience that threatens her own or baby's life
- Avoidance of trauma-related thoughts or feelings
- Mood disturbance, physical arousal
- Intrusive negative thoughts (ego-dystonic) (including flashbacks)

The only disorder where the symptoms that cause the disorder stem from the traumatic experience

Perinatal Emotional Adjustment

PMADs In Depth

POSTTRAUMATIC STRESS DISORDER
6-10%

- Traumatic experience that threatens her own or baby's life
- Avoidance of trauma-related thoughts or feelings
- Mood disturbance, physical arousal
- Intrusive negative thoughts (ego-dystonic) (including flashbacks)

Clinical Application

Posttraumatic Stress Disorder

Additional Risk Factors

- Adolescent mothers may be at more risk than adults
- Women who experience a stillbirth or perinatal loss are at high risk
- Having newborn in the Neonatal Intensive Care Unit (NICU) raises the risk

Clinical Application

Posttraumatic Stress Disorder

CASE DESCRIPTION

Clinical Application

CASE DESCRIPTION

History of Present Illness

Clinical Application

Posttraumatic Stress Disorder

Recommended interventions (short-term to long-term)

- Psychoeducation
- Behavioral and body-based interventions to reduce overall anxiety
- Cognitive reprocessing
- Imaginal exposure and revisiting

Clinical Application

Posttraumatic Stress Disorder

PTSD Psychoeducation Main Points

- You've been through a life-threatening situation.
- So your body is on high alert to try to keep you safe.
- You are not crazy. You know what's happening.
- You will get better and feel more like yourself again.

Clinical Application

Posttraumatic Stress Disorder

Recommended interventions (short-term to long-term)

- Psychoeducation
- Behavioral and body-based interventions to reduce overall anxiety
- Cognitive reprocessing
- Imaginal exposure and revisiting

Clinical Application

Posttraumatic Stress Disorder

Cognitive Reprocessing

- Develop awareness of how trauma impacted thoughts and feelings
- Identify areas where thinking "stuck" on trauma
- Imaginal exposure - telling and retelling the story in small doses
- Revisiting - telling the traumatic story repeatedly
- Brain becomes habituated to and less triggered by memory
- Clinician "doses" exposure to elicit effect without flooding

Note for Clinicians

- Grounding and body-based interventions help transform the trauma from being a horrific memory held in the head (mentally) to a bad memory held in the body
- Identify new ways of thinking about self, experience, and the world
- Time each session to allow for integration - affect is reduced prior to end of session so the client feels safe

Consolidate Your Learning

- Think of individual vulnerabilities that might heighten risk factors for developing PTSD in the postpartum period
- Consider ways that perinatal mood or anxiety might accentuate or interact with these vulnerabilities related to being at risk of developing PTSD for a woman in the postpartum period

CLINICAL APPLICATION BY DIAGNOSTIC CATEGORY: POSTPARTUM PSYCHOSIS

Learning Objectives

At the conclusion of this lecture, you will be able to:

- Utilize diagnostic and epidemiological data for mental health concerns related to postpartum psychosis
- Identify and utilize best practices for handling diagnostic and treatment issues related to postpartum psychosis

Clinical Application

Postpartum Psychosis

- Rare and severe psychiatric disorder
- Occurs in one to two in a thousand (1-2/1,000) new mothers
- Severe, rapid onset
- Medical psychiatric emergency. Immediate psychiatric intervention and often hospitalization is needed

Clinical Application

Postpartum Psychosis

Significant Symptoms

- Delusions, false beliefs, hallucinations
- Thoughts of harming or killing the baby (ego-syntonic)
- Unwillingness to eat or sleep, frantic energy
- Severe depressive symptoms
- Sense of failure or inadequacy
- Suicidal thoughts and fears of harming the baby
- Religious imagery, sense of being evil
- Loss of touch with reality
- Irrational guilt

Note for Clinicians

- Postpartum women with previous psychiatric symptoms involving psychosis are at high risk
- Develops out of previous psychiatric problems such as bipolar illness or schizophrenia
- Postpartum psychosis: onset is sudden - within a few days to a few weeks after the birth of the baby
- Perinatal mood and anxiety disorders may develop up to 12 months postpartum

Note for Clinicians

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- Perinatal mood and anxiety disorders may develop up to 12 months postpartum

Clinical Application

Postpartum Psychosis - Prevalance

- In the general population, prevalence of postpartum psychosis is 1 to 2 per 1000
- In women who have been diagnosed with bipolar disorder, the prevalence rises to 260 per 1000
- In women with bipolar disorder and a family history of bipolar disorder, the prevalence rises to 570 per 1000

Clinical Application

Postpartum Psychosis

- Postpartum psychosis is a medical and psychiatric emergency. Immediate psychiatric intervention and often hospitalization is needed.
- There is always the risk of completed suicide in any depression.
- Media portrayals conflate postpartum depression and anxiety and OCD with postpartum psychosis.

Clinical Application

Postpartum Psychosis

CASE DESCRIPTION

Note for Clinicians

- For women, the age of peak onset of schizophrenia is 25 to 35 years old - peak childbearing years
- Women who are severely mentally ill do become pregnant and have babies, but they are at risk of suicide, of infanticide, and higher levels of anxiety and worry about their competence to be a successful mother

Clinical Application

Postpartum Psychosis - When Symptoms Stabilize

- With treatment, usually psychotherapy and psychiatric care plus medication, most women recover from the acute symptoms and regain high level functioning
- There are serious considerations and risk benefit analysis around medications to treat postpartum psychosis
- There needs to be a close collaboration with the therapist, her psychiatrist, and the patient
- Women who have had a postpartum psychotic episode need supportive care from all health professionals in the perinatal time frame

Clinical Application

Postpartum Psychosis

- Diagnostic clarity – in consultation with reproductive psychiatrist – to shape treatment interventions and support
- Build a therapeutic alliance in therapy + ongoing supportive care for new mother to enhance bonding with her baby and baby's father or her partner (and any other children)
- Therapeutic holding from the emergency through long-term care
- Holding mirrors bonding the baby, mother, family, and any other children

Clinical Application

Postpartum Psychosis

- Close collaboration with her medical team
- Good sleep
- Healthy diet
- Helping her bond and make a healthy attachment

Clinical Application

Diagnosing Postpartum Psychosis

POSTPARTUM OCD

- Postpartum obsessions are distressing thoughts of harm
- Distressing intrusive thoughts are unacceptable, repulsive, not usual
- Obsessions are resisted via rituals, thought suppression, or avoidance
- Risk of harm to the baby is very slight if any

POSTPARTUM PSYCHOSIS

- Thoughts of harm might be distressing but they are not resisted
- Belief that the devil is source of harm or she herself is source of evil
- Intrusive thoughts reflect delusional thinking patterns, hallucinations, or psychotic images
- Delusions are not resisted, are believed, and are ego-syntonic
- Increased risk of harm that requires hospitalization. A psychiatric emergency

IMPLICATIONS OF UNMANAGED MATERNAL MENTAL ILLNESS

Learning Objective

At the conclusion of this lecture, you will be able to:

- Discuss the implications of untreated mental illness in mothers, fathers, and families including the baby

Perinatal Emotional Adjustment

Impact of Unmanaged Maternal Mental Illness

Implications for Mothers

- Preeclampsia
- Preterm labor
- Disengagement from prenatal care
- Increased symptom severity
- Maladaptive coping (use of alcohol, tobacco, illicit drugs)
- Social withdrawal

Perinatal Emotional Adjustment

Impact of Unmanaged Maternal Mental Illness

Implications for the Baby

- Low birth weight
- Feeding and sleep challenges
- Difficult temperament
- Attachment difficulties
- Increased cortisol levels, excessive fear, difficulty regulating emotions and stress

Perinatal Emotional Adjustment

Impact of Unmanaged Maternal Mental Illness

Impact on Mother's Behavior - Depressed Mothers May be More likely to:

- Avoid reading, singing, and playing games with their child
- Be disengaged, talk less, and touch their infants less frequently
- Be intrusive and harsh with their infants
- Exhibit impaired behaviors such as lower rates of infant safety practices

Perinatal Emotional Adjustment

Impact of Unmanaged Maternal Mental Illness

Long-term Impact on the Child

- Difficulties developing healthy interpersonal relationships
- Higher rates of behavior problems, oppositional defiant disorder, learning disabilities, lowered intellectual performance
- Lower IQs than children of mothers without PMADs

Clinical Application

Impact of Unmanaged Maternal Mental Illness

Implications of Untreated Mental Illness

Emerging perinatal distress or PMAD + *Unrecognized or untreated* = *Potential long term suffering (Chronicity)*

Perinatal Emotional Adjustment

Impact of Unmanaged Maternal Mental Illness

Suicide

- Suicide is one of the leading causes of pregnancy-related death in the United States
- 10th leading cause of death for general population (all ages, sexes, etc.)
- One of the most devastating "outcomes" of mental illness

Consolidate Your Learning

- As a clinician, think about your patients with more severe PMAD symptoms and how your therapeutic relationship and interventions are having an impact on their well being.
- How does this influence the people around them, including their baby, other children, and family?

PRINCIPLES OF PERINATAL PSYCHIATRIC CARE

Learning Objective

At the conclusion of this lecture, you will be able to:

- Discuss two ways to enhance empathic discussion with patients around the possibility of a psychiatric referral
- Describe two ways to utilize collaborative work with reproductive psychiatrists
- Define three ways in which we assess the need for a psychiatric referral

Clinical Application

Principles of Perinatal Psychiatric Care: When to Refer

Psychiatric Referral

- History of Bipolar Disorder, Major Depressive Disorder, or Schizophrenia (sometimes OCD)
- Presence of psychosis regardless of diagnosis
- Symptoms (e.g., anxiety, intrusive thoughts, depressed mood, obsessions, compulsions) not alleviated by psychotherapy alone AND significant impact on patient's functioning

Clinical Application

Principles of Perinatal Psychiatric Care

Managing Fear/Resistance

- Psychiatric visit is an opportunity for more information (not necessarily a decision to take medication)
- Remind her that the decision is in her hands (even after scheduling a visit)
- Address concerns in depth, being careful not to minimize concerns
- Remind her that medication may also improve mood and bonding with the baby, and decrease irritability and anxiety

Clinical Application

Principles of Perinatal Psychiatric Care

Some fears might be

- "Medication will negatively affect the baby"
- "Medication will change my personality"
- "I will become addicted to medication"
- "I might feel weak because I am depending on medication"
- "I might have to take medication for the rest of my life"

Clinical Application

Principles of Perinatal Psychiatric Care

Recommendations

- Review each patient's history carefully and assess severity of previous and current status
- Discuss the often given yet misguided recommendation to discontinue medication while planning a pregnancy or becoming pregnant

Clinical Application

Principles of Perinatal Psychiatric Care

Question: "Should I go off of medication to get pregnant?"

Answer: Assess history.
If patient has been hospitalized, suicidal, manic, or psychotic, or truly dysfunctional, should consider staying on medication

Assess severity.
If previous episode(s) were mild to moderate:
- trial being off the medication
- assess in time to get back on if needed BEFORE pregnancy

Clinical Application

Principles of Perinatal Psychiatric Care

The Conversation About Medication

Review patient's previous responses to medications

Pregnancy is NOT the time to change medications or try something new, unless patient is on something definitively teratogenic

Clinical Application

Principles of Perinatal Psychiatric Care

The Conversation About Medication

Review patient's previous responses to medications

Pregnancy is NOT the time to change medications or try something new, unless patient is on something definitively teratogenic

Teratogenic: a medication with a definitive risk of an outcome with exposure, such as Valproic acid, which is known to cause behavior problems and significant IQ decreases with fetal exposure

Clinical Application

Principles of Perinatal Psychiatric Care

Best Practices

- Strive for single exposure to the least number of medications possible
- Higher doses of monotherapy recommended over small doses of several medications
- Patient on medication but undertreated? Adjust so that the person is only exposed to medication and not the illness
- Reducing dose or switching medication runs counter to good practice, which is to maintain wellness on the medication and dose that has been working

Clinical Application

Principles of Perinatal Psychiatric Care

Best Practices

- Mild to moderate symptoms can be treated with therapy alone and without medication
- Moderate to severe symptoms usually require addition of medication
- Gold standard for moderate to severe symptoms is talk therapy and medication

Clinical Application

Principles of Perinatal Psychiatric Care

Addressing Concerns About Medication

Limited data available on toxicity in newborns, yet risk of untreated depression far outweighs risk of breastfeeding newborns in women using antidepressants

Conversation with a reproductive psychiatrist can be very helpful

Myth of "pump and dump": worse to interrupt new mother's sleep than baby's exposure to trace amounts of antidepressants

Consolidate Your Learning

- Ask yourself, what are my views about psychiatry and medication?
- In what ways have your views about psychiatry and medication been influenced by the information in this lecture?
- If you collaborate with psychiatry, what ways has that psychiatric consultation influenced how you write your treatment plan and conceptualize a case?

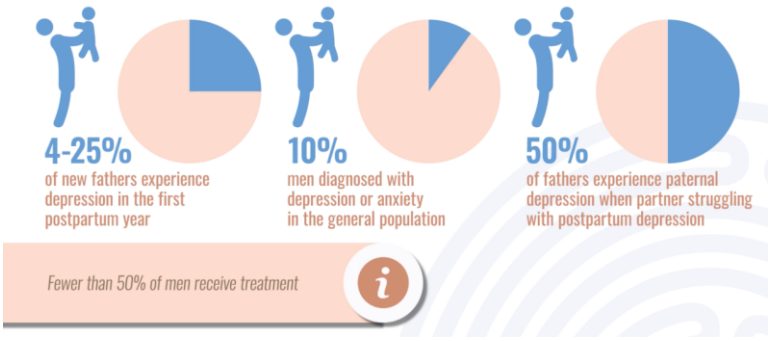
FATHERS AND PERINATAL DISTRESS

Learning Objective

At the conclusion of this lecture, you will be able to:

- Identify various ways mothers and fathers present differently and similarly when experiencing PMADs
- Demonstrate your awareness of the unique clinical techniques utilized to address emotional distress in the peripartum period

Fathers And Perinatal Distress



Fathers And Perinatal Distress

"Daddy Blues" vs Paternal Postnatal Depression (PPND)

DADDY BLUES

- Similar to baby blues, reaction to hormonal changes and stress
- Feeling down, labile mood, agitated, "not quite right," difficult to tolerate the crying of infant
- Transitory and not diagnosable

PPND

- Similar symptoms as postpartum depression
- Withdrawal, avoid coming home
- Irritability
- Substance use to handle pain

Fathers And Perinatal Distress

Anxiety and Worry

Anxiety and Worry

Safety of the infant

Financial security of the family

Intrusive Thoughts – 25% fathers have thoughts of harming the baby

Men receive little training or education and feel left out

No real increased risk of harming the baby

Fathers And Perinatal Distress

"Traditional" Fatherhood

"Traditional" Fatherhood

- Traditional role norms
- Masculine, independent
- Emotionless except for anger
- Breadwinner and provider
- Little role in child's life, birth to 5 years old
- When child 5+ father = disciplinarian

Fathers And Perinatal Distress

"Nontraditional" Fatherhood

Generative Fathering and Contemporary Male Norms

- Nurturing and hands on care
- Emotional openness to partner and child
- Men want to create healthy attachments with their family, teach through modeling

Fathers And Perinatal Distress

Gender Role Conflict

Gender Role Conflict LEADS To

- Stress related to keeping or challenging gender role
- Hesitant to seek help = more mental health problems
- More conflict = more shame/and often less help seeking

Fathers And Perinatal Distress

Developmental Changes + Shifts

Physiological and Hormonal

- Reduces aggression
- Increases sensitivity

Fathers And Perinatal Distress

Developmental Changes + Shifts

Psychological

- Most intense identity shift + development since puberty
- Unresolved conflicts with father
- New challenges with partner, sharing partner with child -loss of support/attention from partner, diadic to triadic relationship, role of sex

Fathers And Perinatal Distress

Note to Clinicians

Engaging and Treating Fathers

- Check our own biases: Are they grounded in traditional masculinity and fatherhood beliefs?
- Speak to strengths & values and vulnerabilities/challenges
- *Deficit perspective – focus on what's lacking*
- *Holistic perspective – focus on strengths*

Fathers And Perinatal Distress

What Do Fathers Need to Handle the Stress?

- ***Recognition, Awareness, & Education***
  More opportunities to learn about the process of becoming a parent
- ***Male Sensitive and Competent Mental Health Services***
  Make sure men are screened or counseled around perinatal and parental mental health and wellness
- ***Training and Modeling***
  Most fathers want to have a more active, hands on, nurturing, and loving relationship with their children
  Provide more education, coaching, or positive support to build confidence

Consolidate Your Learning

- As clinicians, how are you able to incorporate this information into your own work with fathers?

ASSISTED REPRODUCTIVE TECHNOLOGY (ART) AND THIRD PARTY REPRODUCTION

Learning Objective

At the conclusion of this lecture, you will be able to:

- Discuss the three most clinically applicable aspects of the biopsychosocial model of perinatal distress (PMADs) in relation to Assisted Reproductive Technologies (ART)
- Identify various ways mothers and fathers present differently and similarly when going through ART

Assisted Reproductive Technology (ART) & Third Party Reproduction

Infertility – a Crisis

- Infertility effects 80-160 million people around the world
- 1 in 10 couples experience primary or secondary infertility
- Infertility may be related to advanced maternal age (age 35+ for women), but is not always related

Assisted Reproductive Technology (ART) & Third Party Reproduction

A Brief History of ART

1904: Relationship between body temperature and phases of the menstrual cycle discerned and used to detect ovulation

1930s: Donor sperm insemination becomes an option

1978: Louise Brown is born after being conceived via In Vitro Fertilization (IVF) (England)

1984: First baby is born using egg donor technology (USA)

1986: Case of Baby M (traditional surrogacy) (USA)

Assisted Reproductive Technology (ART) & Third Party Reproduction

Types of ART

- Medications to induce ovulation, increase the number of follicles that contain oocytes, or prepare uterine lining
- IUI (Intrauterine Insemination)
- IVF (In Vitro Fertilization)
- ICSI (Intracytoplasmic Sperm Injection)

In 85% of cases, an exact cause for infertility is not found

Assisted Reproductive Technology (ART) & Third Party Reproduction

Sources of Distress and Psychological Impact

- Moodiness or depression due to medications
- PGS and PGD – screening tools add more distress and expense
- Highly medicalized – sense of failure and disappointment about not being able to conceive naturally and privately
- Expensive
- "Racing against the clock"

Assisted Reproductive Technology (ART) & Third Party Reproduction

Types of Third-Party Reproduction

- Sperm, egg, or embryo donation
- Surrogacy
  - Traditional surrogacy
  - Gestational surrogacy

Assisted Reproductive Technology (ART) & Third Party Reproduction

Sources of Distress and Psychological Impact

- Moodiness or depression due to medications
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Assisted Reproductive Technology (ART) & Third Party Reproduction

Sources of Distress and Psychological Impact

- Grief
- Waiting
- Securing a third party donor or carrier
- Limits on insurance reimbursement and coverage
- Big questions if not pregnant – break? stop? continue?
- Negative appraisals or internal representations as failure
- Increased distress and anxiety during procedures and pregnancy

Assisted Reproductive Technology (ART) & Third Party Reproduction

Sources of Distress and Psychological Impact

- Sense of loss
- Anger, rage, frustration, or depression, or sadness and grief
- Sense of hopelessness, futility
- Existential and identity questions
- Feeling overwhelmed
- Legal, ethical, emotional, financial, and medical complexities
- Ambivalence

Note for Clinicians

- Help reframe negative beliefs and thoughts – use of CBT tools
- Help when they need to decide continue trying or take a break
- When is it time to stop?
- Personality styles can influence the ways infertility is experienced

Assisted Reproductive Technology (ART) & Third Party Reproduction

Disclosure: "What do we tell our child?"

Best Practices

- Tell the story in age appropriate language from the beginning
- Children want to know who they are and they will find out

Assisted Reproductive Technology (ART) & Third Party Reproduction

Therapeutic Approach

Hold and Support

- Find strengths and competencies
- Keep engaged with life - things other than their reproductive story
- Rebuild positive self-esteem, grieve, and rebuild positive relationships with each other, their sexuality, themselves – no matter what the outcome

Consolidate Your Learning

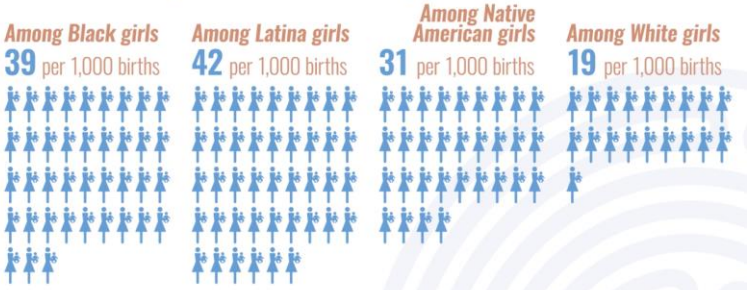
Consider the complex medical and psychological and social factors present when infertility is diagnosed and a couple or an individual decides to use ART

- In what ways might your case conceptualization and treatment planning take all of these factors into account?
- If a couple asks you, "should we continue or stop fertility treatments?" - what do you think would be the most helpful aspects of their experience to address in the short and the long term as you work through this question?

EXPANDING OUR FOCUS: ADOLESCENT PREGNANCY AND PARENTHOOD

Adolescent Mothers

More than **250,000** babies are born to teenage girls in the United States each year



Adolescent Mothers

Compared with their peers who delay childbearing, teen girls who have babies are

The birth rates for girls diagnosed with a major mental illness is 3x higher than for those without mental illness

...more likely to have children who have poorer educational, behavioral, and health outcomes over the course of their lives:

Infant mortality rates were more than 50% higher among adolescent mothers compared with older mothers

Only 2/3 of children born to adolescent mothers earn a high school diploma, compared to 81% of their peers born with older parents

Daughters of teen mothers are 3x more likely to become teen mothers themselves

Adolescent Mothers

Compared with their peers who delay childbearing, teen girls who have babies are

The birth rates for girls diagnosed with a major mental illness is 3x higher than for those without mental illness

...more likely to suffer from depression:

Postpartum depression affects 47% of adolescents, compared with 15-20% of adults

Rates of depression are between 16-44% postpartum, but non-postpartum depression is between 5 to 20%

19% of 15 to 19 year old teen mothers report suicide ideation and 9% reported an attempt

The prevalence of drug use among adolescent mothers ranges from 11-52%, but this statistic is most likely inaccurate because most adolescents under-report their experiences

Adolescent Mothers

- Adolescents often unprepared: little or no knowledge about the experience of giving birth, or child development
- May create strain in families
- History of child abuse and being raised in chaotic homes with limited social support networks
- Adolescents: might be looking for love or the adolescent mother is looking for relief from depression
- Racial disparities around educational opportunities and limited access to supports, including mental health support

Adolescent Mothers

Challenges for the Adolescent Mother

- Developing biologically and psychologically and socially
- Fewer physical resources in their bodies
- Demands of a maturing body and developing fetus compete and the fetus always wins

Adolescent Mothers

Comparing Adult and Adolescent Brain Functioning

- In adults, the brain functions to recognize facial expressions and the frontal lobes identify the meaning of that facial expression
- An adolescent's brain recognizes the face and the facial expression, but the frontal lobe is often not yet able to correctly identify the meaning of the facial expression
- This is important because an adolescent might *make mistakes* around what a facial expression means and attribute an incorrect meaning (i.e. safety or danger)

Adolescent Mothers

Risk Factors and Stressors

Challenges to transitioning to parenthood

Have access to fewer educational resources

Continuing to develop biologically and psychologically and socially – few educational supports

Responsibilities of parenting – including financial and social strains

Psychological and social challenges

Adolescent Mothers

Risk Factors and Stressors

Challenges to be addressed

Housing is likely to be much less stable, psychosocial support is not developed, family structure is often fractured or fragile

The ability to provide access to housing, nutrition, and healthcare resources are key

Address pervasive sense of isolation – often a teen mother feels desperate and emotionally overwhelmed

Adolescent Mothers

Risk Factors and Stressors

Because of physiological and nutritional challenges and delayed prenatal care:

- Babies at higher risk for complications/ developmental delays
- Risk of low-birthweight babies and higher rates of premature birth - more than twice that of adult pregnancies
- Risk of stillbirth and neonatal death may be increased because of inadequate nutrition and low socioeconomic status

Note for Clinicians

- Emotional support for teen mothers focuses on helping her resolve the immediate crisis
- Instill hope to address:
  - Loss of a vision of the future
  - Loss of relationships (judgement and stigma)
  - Rejection from family members, friends, classmates, teachers, or those in the religious community
- Address ways to cope with stresses that are part of the landscape of being a mother
- Remember you are treating two patients with their own distinct biopsychosocial needs

Adolescent Mothers

Therapeutic Approach

- Use psychoeducation to help adolescent mothers create and maintain healthy relationships

Address:

- Finding ways to stay in school
- Many teens feel "forced" out of school – so many pressures around being a mother + the deep social stigma connected to being an adolescent mother

Adolescent Mothers

Therapeutic Approach

- Provide information including basics around feeding and bonding
- Address ways to develop a healthy attachment with the baby
- Explore building confidence so that she can establish a more healthy attachment with her child than she had with her mother or other primary caregivers
- Recognize developmental milestones in her growing baby
- Help her identify her own developmental milestones as she moves from being an adolescent and into a young adult
- Help her: "Weather the storm" of feeling unprepared, of now living in two worlds - being an adolescent and being a mother

Adolescent Mothers

Therapeutic Approach

- Helping adolescent mothers find ways to be an empowered adolescent mother so that she can grow into a confident and empowered adult
- Recognized that an adolescent mother might be stabilized after becoming a mother – taking fewer risks and embracing her role as a mother
- Help her build confidence
- Seleni Young Parent Program (for teen parents) works to improve the likelihood of success in adulthood for teen mothers by providing critical and evidence based reproductive and maternal mental health services to pregnant and postpartum teenage girls

Consolidate Your Learning

- Consider the many complex factors described here that contribute to teen pregnancy and adverse and positive outcomes.
- What ways does this information potentially influence your case conceptualization and treatment planning for an adolescent mother?

EXPANDING OUR FOCUS: PATIENTS FROM LOW-INCOME AND/OR MINORITY BACKGROUNDS

Learning Objective

At the conclusion of this lecture, you will be able to:

- Identify various ways mothers who are low income and/or minorities present uniquely when experiencing PMADs
- Describe two ways to enhance empathic discussion with patients who are low income and/or minorities
- Demonstrate your awareness of three unique clinical techniques to address emotional distress with those who are low income and/or minorities in the peripartum period

Low Income and/or Minorities

Risk Factors

Pregnant women and mothers with low incomes, especially members of minority populations are at increased risk for mental health disorders

Being a single parent

Unemployment or underemployment

Educational difficulties and low educational attainment

Housing insecurity or chaotic living situations

Limited access to health care

Low Income and/or Minorities

Stressors and Outcomes

- Inadequate nutrition or food insecurity
- Adverse outcomes related to poverty include miscarriage, stillbirth, low birthweight, and medical problems during pregnancy and postpartum
- Insufficient prenatal care and low socio-economic status negatively influence children's social and cognitive skills
- Poverty, chronic stress, lack of support, maternal depression, and medical complications are associated with preterm and low birthweight infants

Low Income and/or Minorities

Risk Factors

Environmental pollutants, such as lead paint, can increase risk for developmental delays in the infant

Risk factors for developing depression are violence, being a single parent, food insecurity, and possible substance use or misuse

Alcohol abuse and intimate partner violence occurred in 42% of women living in poverty

Low Income and/or Minorities

Obstacles to Care

- 25% of women living in poverty who are mothers struggle with major depression
- Stigma of mental health illness and being given a diagnosis
- Internalized negative stigma

Note for Clinicians

- Recommendations appropriate for someone doing well financially might not apply to a mother struggling for food and shelter
- Refer to programs designed to help pregnant women and mothers living in poverty

Low Income and/or Minorities

Risk of PMADs

Poverty overlaps with a wide range of risk factors that place a mother at risk for developing a PMAD

- Biological: Insufficient nutrition resulting in low birthweight
- Behavioral: Intimate Partner Violence (IPV)
- Social: Single Parent Status
- Environmental: Pollution (e.g. air, lead)

Low Income and/or Minorities

Risks for Babies and Children

- Adverse health outcomes, including difficulties with social skills and delayed cognitive functioning and delayed language development

Low Income and/or Minorities

Risks for Babies and Children

- Researchers found that babies of women living in poverty experienced depressive symptoms, vocalized less, were more irritable, and explored less than babies of mothers not living in poverty

Low Income and/or Minorities

Risks for Babies and Children

- Researchers found that children of depressed mothers living in poverty also had difficulties in social interactions, including behavior problems

Low Income and/or Minorities

Incarcerated Mothers

Incarcerated Mothers

Mothers who are incarcerated are likely to have risk factors associated with poor perinatal outcomes

Most women who are incarcerated are of childbearing age, and 10% are pregnant when they are incarcerated

Low Income and/or Minorities

Incarcerated Mothers

- Depression is common among pregnant women who are incarcerated
- Many women who are incarcerated give birth while being physically restrained – handcuffed to the bed or shackled
- Amnesty International condemned shackling of incarcerated pregnant women during birth as a violation of pregnant women's rights
- Being shackled can limit movement during labor, placing stress on the mother's body and possibly limiting the flow of oxygen to the fetus
- The American College of Obstetricians and Gynecologists and the American Public Health Association also have condemned the practice of shackling pregnant incarcerated women

Note for Clinicians

- Cultural and socioeconomic status, values, and assumptions often influence the way psychological distress is experienced
- Mothers living in poverty or those who are minorities often believe that living with crisis is normal
- Be aware of our own world views, biases, prejudices, beliefs, and values
- Recognize the limits of our own competence and expertise; seek educational, consultative, and diversity training experiences

Consolidate Your Learning

- Consider the many risk factors described here related to perinatal outcome and mental health challenges for those experiencing poverty or who are ethnic minorities.
- Considering these factors, in what ways might you shift your approach when working with pregnant women or mothers living in poverty or who are members of an ethnic minority?

EXPANDING OUR FOCUS: LGBTQ+ FAMILIES: PREGNANCY AND PARENTHOOD

Learning Objective

At the conclusion of this lecture, you will be able to:

- Identify various ways LGBTQ+ parents present differently and similarly to the general population when experiencing PMADs
- Describe two ways to enhance empathic discussion with those who are LGBTQ+
- Demonstrate your awareness of three unique clinical techniques used to address emotional distress of LGBTQ+ parents in the peripartum timeframe

LGBTQ+ families

Language

- LGBTQ+ is an acronym that stands for: Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, and More
- Use culturally appropriate language when working with LGBTQ+ individuals. Listen for patients' language around pronouns, partners and spouses
- Lesbian and gay are the terms with which most clinicians are familiar. Both describe people whose preferred sexual and affectional relationships are with members of the same sex
- Bisexual refers to those who are attracted to and perhaps involved with people of more than one gender
- Queer refers to any sexual orientation or gender identity that are outside traditional norms

LGBTQ+ families

Language

- Trans refers to those who are transsexual, transitioned, or transgender, and genderqueer people
- Gender identity is one's perception of oneself as a man, or as a woman, or as another gender identity, such as nonbinary identity of being a "them"
- Some transgender individuals will have surgery to modify their bodies to match their self identified gender - a "sex change"
- Language and the use of pronouns is important – feminine, masculine, or gender neutral – "ze, zir, they"
- Cisgender means that an individual is comfortable with the gender he or she was born with

LGBTQ+ families

Building a Family

- ART (Assisted Reproductive Technology) options have expanded exponentially over the past 40 years
- Since June 2015, same sex marriage is legal in the US and in several countries around the world
- Issues of stigma associated with nontraditional gender identities or same sex relationships continue
- More social acceptance and decreasing stigma
- Unique challenges, options, and ranges of experiences

LGBTQ+ families

Building a Family - Using ART

Challenges and Complex Situations

- Judgments made by healthcare providers
- Financial barriers - insurance companies often cover fertility treatments only for married women because they are treating a medical illness: infertility
- Who will carry the fetus? The biological parent is automatically the legal parent
- Fertility is not the issue, but need for some kind of medical assistance to conceive

LGBTQ+ families

Building a Family - Surrogacy

- Some states don't allow surrogacy so a couple using a surrogate needs to use an agency out of their state
- Traditional genetic surrogacy: a sperm is implanted in the surrogate mother and she carries the fetus to term
- Gestational surrogacy or an IVF surrogacy: the embryo that resulted from a sperm and an egg is transferred into the surrogate mother's uterus and she carries the fetus to term
- Gestational surrogacy is most common (95% of all surrogacy pregnancies)
- Legal questions around who is allowed to use surrogacy – especially if a couple is not married

LGBTQ+ families

Building a Family - Adoption

- Open adoption: possibility of maintaining connection with the birth parents and the adoptive parents
- Closed adoption: no communication or contact between the adoptive parents and the birth parents
- International adoptions:
  - becoming more complex and many countries have severely curtailed these adoptions
  - same-sex partners are not allowed to adopt so one has to pose as a single parent seeking to adopt. This can cause deep friction in a relationship, anxiety or feeling left out or feeling invisible

LGBTQ+ families

Building a Family - Adoption

Adoption

- Public domestic adoptions, through the child welfare system, are the least expensive way
- Private adoptions can be expensive and sometimes involve long waits
- Adoption professionals often assume that their patients are heterosexual

LGBTQ+ families

Building a Family

Additional Stressors

Challenges around social support and heightened levels of distress

Family opposition to sexual orientation or the choice to build a family

Legal concerns, such as custody arrangements or the need for the nonbirthing partner to adopt the child carried in pregnancy by the partner

LGBTQ+ families

Building a Family

"What do we say to the children who are conceived in non-traditional ways?"

- Those using ART to conceive a child tell that child the truth and the story of how the child was conceived
- Children will find out the story, and by telling the story you have control of the story, and have the chance to shape the story in a loving way

Consolidate Your Learning

- Consider the ways the information in this lecture might shift the way you formulate your case conceptualization and treatment plan for an individual or couple who is LGBTQ+ and who are planning to become parents

EXPANDING OUR FOCUS: ACCULTURATION, IMMIGRATION, AND PMADs

Learning Objective

At the conclusion of this lecture, you will be able to:

- Describe ways to enhance an empathic discussion regarding the experiences of immigrants and refugees
- Discuss key clinical topics related to emotional distress in the peripartum period among immigrants and refugees

Immigration and Acculturation

Definitions

Immigrant: someone who moves to a foreign country and settles there permanently

Refugee: someone who is forced to leave their country of origin due to war, persecution, or natural disaster

Asylee: someone who seeks permanent asylum in another country

Immigration and Acculturation

Acculturation

Acculturation

Process of change in which the heritage culture and the mainstream culture meet

Behavioral and psychological shifts from their heritage identity to the mainstream culture's identity

Leads to heritage identity to decrease as more of the mainstream culture is embodied

Immigration and Acculturation

Acculturative Stress

Acculturative Stress

- When the values of the heritage culture are vastly different from the mainstream culture, they often clash
- This conflict can lead to emotional and psychological distress, known as acculturative stress
- Can lead to depression and anxiety due to internal and external conflicts

Immigration and Acculturation

Stressors

Stressors

- Financial stressors, due to underemployment and low socioeconomic status
- Loss of their home communities and social supports
- Language barriers

Immigration and Acculturation

Refugees and Undocumented Immigrants

Additional Risk Factors

- Fear of deportation, being stigmatized, having their child taken away due to an illness, being diagnosed with a psychiatric disorder
- Traumatic events that occurred before they came to the US, including war, violence, and for some, torture
- The trek to the US was often full of danger and trauma

Immigration and Acculturation

PMADs in Immigrant Population

- Significantly higher levels of PMADs in immigrants than native-born women
- Some likely had strong social networks and cultural traditions that supported new mothers throughout pregnancy and postpartum, allowing more ease in their transition to motherhood
- For some mothers who may have expected this tradition but are isolated and without a social network, this can lead to increased risk of depression and anxiety

Immigration and Acculturation

PMADs in Immigrant Population

- Conflict when mothers and mothers-in-law impose these traditions with a new mom
- Distress in the new mother as she navigates her independence and acculturation as well as transition to motherhood
- Higher rates of depression in women who felt forced into this 40-day period of confinement

Immigration and Acculturation

Psychotherapeutic Approach

- Patient most likely will not be comfortable sharing details of their symptoms, experiences, and even home life
- Some may experience their mental distress in the form of somatic symptoms, such as stomachaches or headaches
- Language used to describe the mental health disorder, like disorder or illness or mental illness, can be very stigmatizing
- They may seek help from family, friends, community members
- Need to build trust in these communities as well as with our patients
- Address their concerns about their well-being in the context of overall functioning

Consolidate Your Learning

Consider the experiences of a patient who may be a refugee

- Think about how you most effectively and sensitively and empathically can obtain important information about their experiences before coming to the US, their difficult travels here, the struggles after
- In what ways might these experiences contribute to developing perinatal distress or a PMAD?
- How would your approach be different with this patient compared to those who don't have these experiences?

CLINICIAN'S USE OF SELF & BURNOUT AND PREVENTION

Learning Objective

At the conclusion of this lecture, you will be able to:

- Identify two countertransferential vulnerabilities related to your reproductive story
- Develop three self-care strategies to ensure effectiveness and integrity of the therapeutic relationship for your future clinical practice

Clinician's Use Of Self

How might your standard approach to boundaries be challenged when working with new mothers and fathers?

How will you manage those challenges?

Clinician's Use Of Self

Experiential Exercise

What is your own reproductive story?

Do you have children? Planned? Wanted?
If not, is this a planned outcome? Future plans?

Your own mother and father?

Attitudes, feelings, internal representations of yourself and parenthood?

Any experiences that can be a potential vulnerability hot spots?
How do you care for these hotspots?

Countertransferential issues?

You will be asked: "Do you have children?"

Burnout

Definition and Signs

Physical, emotional and mental exhaustion caused by long-term involvement in emotionally demanding situations

Burnout

Definition and Signs

Disillusionment and negative feelings – loss of a sense of meaningful work, reduced sense of accomplishment

Burnout

Definition and Signs

Early Signs

- Somatic symptoms such as frequent colds, headaches, fatigue
- Not being able to tolerate pain or stories
- Lowered resiliency, moodiness

Burnout

Definition and Signs

- Somatic complaints
- Exhaustion
- Social withdrawal
- Depersonalization
- Cynicism
- Loss of meaning
- Feeling underappreciated and overworked
- Numbness
- Disillusionment

Burnout

Additional Symptoms

- Not making sure you get good sleep
- Feeling depleted, not getting emotionally nurtured
- Taking work home; self-esteem becomes dependent on patients' progress
- Drag yourself into work most days
- Repeating the same interpretations over and over
- Give advice as a shortcut rather than helping clients learn and grow

Burnout

Additional Symptoms

- Begin sessions late and/or end early and space out during sessions
- Experience less empathy
- Push your theory rather than listening
- Show a detached attitude towards patients who are perceived as draining
- Feeling relieved when clients cancel
- Disregard for professional boundaries and ethics
- Experience job dissatisfaction and poor job performance

Burnout

Causes

- Giving more than getting
- Tendency to focus on others
- Distraction: can lose track of own life or problems
- Losing ourselves, lack of self care
- Stress, emotional depletion
- Work feels ineffective
- Hard to shut off the therapeutic stance
- One-way intimacy carried over to friends and family

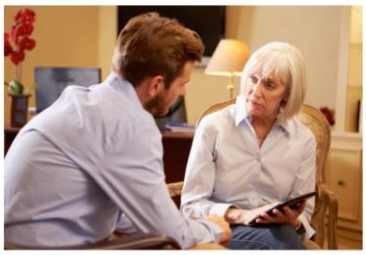
Burnout

Prevention

- ***Practice self care***
  Relax and recharge perhaps using mindfulness meditation, healthy time alone in reverie – solitude
  Regular exercise, good nutrition, enough sleep
- ***Engage with your life: create a life outside of work that includes hobbies, friendships, loved ones, and creativity - anything that feeds you emotionally and spiritually***
- ***Identity as therapist is valuable but not the whole story of who you are***

Burnout

Prevention



- Get supervision or peer support: consult on cases with experts and colleagues
- Your own therapy
- Work reasonable hours, don't answer phone calls or emails on weekends
- Be present at both work and play

Consolidate Your Learning

Circle back around to what we described at the beginning of the lecture

- Consider ways that you might be challenged by working with a peripartum population
- What themes emerged in your exploration around your own reproductive story? In what ways does this awareness of your story as well as the ways you might be challenged support you and possibly prevent burnout?

SUPERVISION

Learning Objective

At the conclusion of this lecture, you will be able to:

- Identify two countertransferential vulnerabilities related to your reproductive story
- Describe various ways that supervision ensures the effectiveness of your patient care and the integrity of the therapeutic relationship for your future clinical practice

Supervision

Definition

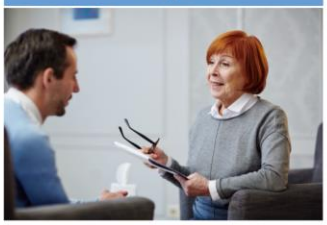
What is Supervision

Supervision is a dedicated relationship between a supervisor and a supervisee that is in many ways similar to the psychotherapeutic relationship, where the purpose and structure is essentially quality assurance around the care we provide – that is, ensuring the quality of patient care.

Supervision

New Clinicians

Seleni Approach



- Supervision can include ensuring that each clinician has a deep understanding of the unique clinical issues that arise for women, men, and families in the peripartum period
- Therapeutic work with women, men, and families in the perinatal timeframe presents unique challenges

Supervision

New Clinicians

Seleni Approach

- A thorough grounding in theoretical and clinical issues related to the perinatal time frame is necessary for effective case conceptualization, treatment planning and clinical intervention
- Often have trouble distinguishing between normative and nonnormative distress in parents

Supervision

An Effective Supervisor

- Ideally, a clinical supervisor facilitates open exploration where the supervisee can be open and vulnerable
- Trust is essential for a supervisee to explore questions or doubts or countertransference around her psychotherapeutic work
- An effective supervisor follows the supervisee's lead
- Leading from one step behind – letting the supervisee bring his or her concerns to the session while providing guidance around what the patient needs next

Supervision

Supervisory Process

- What concerns of the supervisee need to be addressed so excellent patient care is more likely?
- Address cognitive distortions in the patient and the supervisee
- Explore ways underlying thoughts and feelings connected to personal issues might impact the therapeutic process
- Support our clinicians and build competence and confidence while helping supervisees acquire what they need to know
- Facilitate and develop clinical skills and the capacity for creating sensitive case conceptualizations and treatment plans
- Encourage self-awareness and curiosity

Supervision

Case Study - Zika

- Women who came in were afraid and worried because they had been in areas where there was potential Zika exposure
- For some women the question was, "Shall I keep moving forward with this pregnancy?"
- Some could not imagine raising a child who had microcephaly
- What would family life be if the child were to be born with this devastating outcome?

Supervision

Case Study - Zika

- Follow the patient's lead and collaboratively develop a treatment plan
- Focus on emotional regulation related to the massive anxiety
- Correct in case formulation and seeing how maternal preoccupation was effected
- But still felt a sense of pressure to "fix it"

Consolidate Your Learning

- Consider your supervision experiences and your experiences with pregnant women, mothers, and families
- What aspects of supervision and the supervisory relationship have supported exploration of your countertransferential vulnerabilities? What do you see as ideal characteristics of supervision and a supervisor?