

What Can Early Childhood Mental Health Clinicians Do About Maternal Depression?

June 6, 2019

Who We Are

New York Center for Child Development

- NYCCD has been a major provider of early childhood mental health services through federal, state, city and philanthropic funded programs in New York
- NYCCD has a long history of providing system-level expertise to inform policy and support the field of Early Childhood Mental Health through training and direct practice

Training and Technical Assistance Center (TTAC)

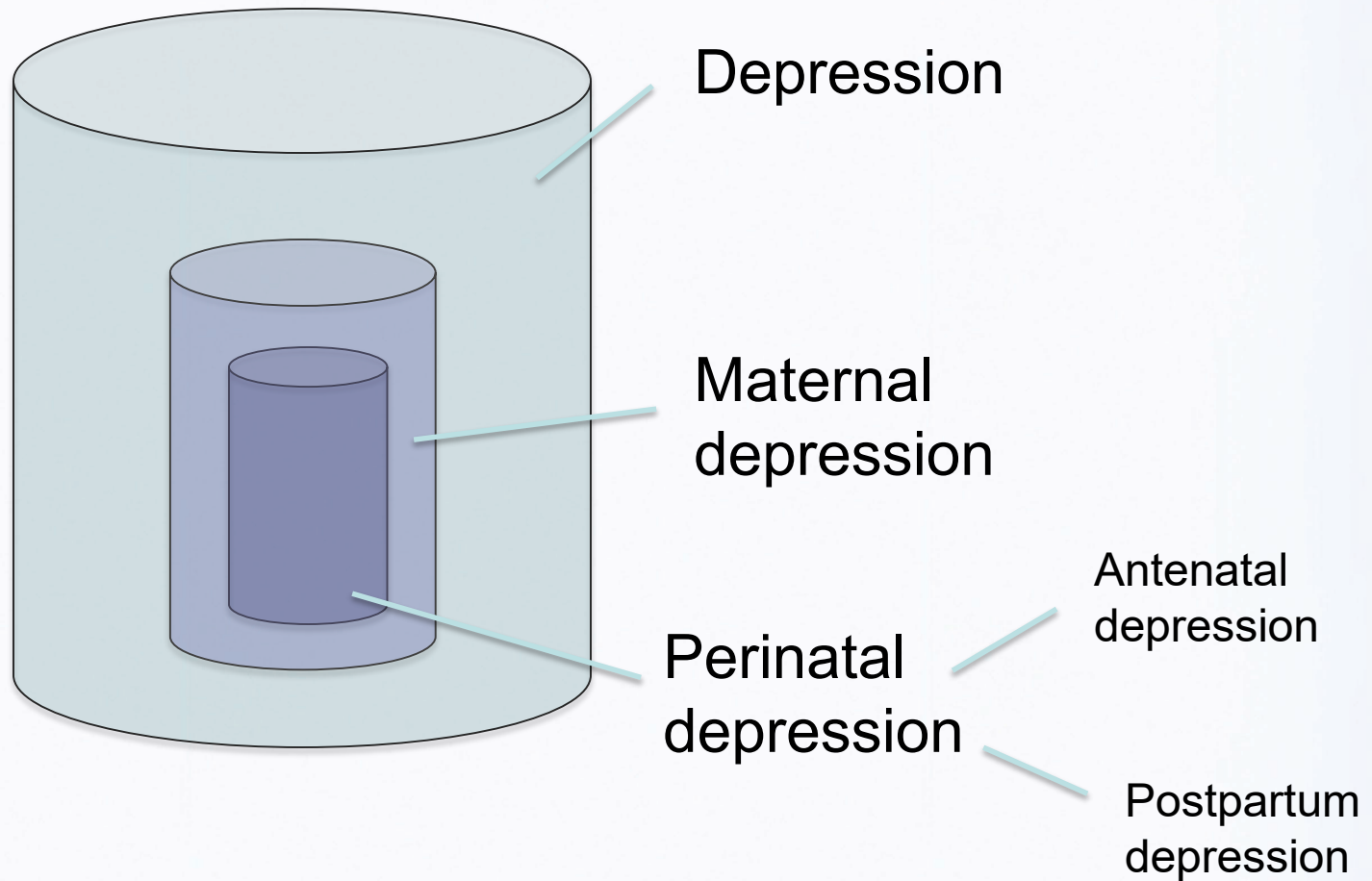
- NYCCD was selected by the New York City Department of Health and Mental Hygiene under Thrive NYC to develop a citywide Early Childhood Mental Health Training and Technical Assistance Center (TTAC)
- NYCCD's Subcontractor in the TTAC Center is New York University McSilver Institute for Poverty Policy & Research which offers clinic, business, and system transformation supports statewide to all behavioral healthcare providers.

<http://www.TTACny.org>

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Maternal depression terms



What is depression?



- Major depressive disorder is the most “classic” of the depression diagnoses, but not the only one
 - Persistent Depressive Disorder*
 - Depressive Disorder due to Another Medical Condition
 - Substance/Medication Induced Depressive Disorder
 - Other Specified Depressive Disorder
 - Unspecified Depressive Disorder
 - Premenstrual Dysphoric Disorder
 - *Specifiers – With Seasonal Pattern, With Psychotic Features, With Peripartum Onset, etc.*

Postpartum blues versus depression

Postpartum blues	Postpartum depression
50-85% of women	10-20% of women
Starts 4-5 days after delivery, brief	Emerges after delivery, per DSM within first month (debated)
Mood lability, tearfulness, irritability, anxiety	Symptoms as noted on previous slide, although with modifications
Remits on it's own within 2 weeks of delivery – not really an illness	Could last for months and be associated with negative outcomes



Both postpartum blues and postpartum depression are thought to be related to shifts in hormones after delivery

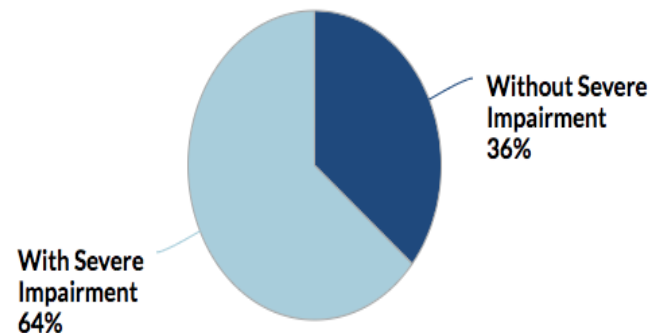
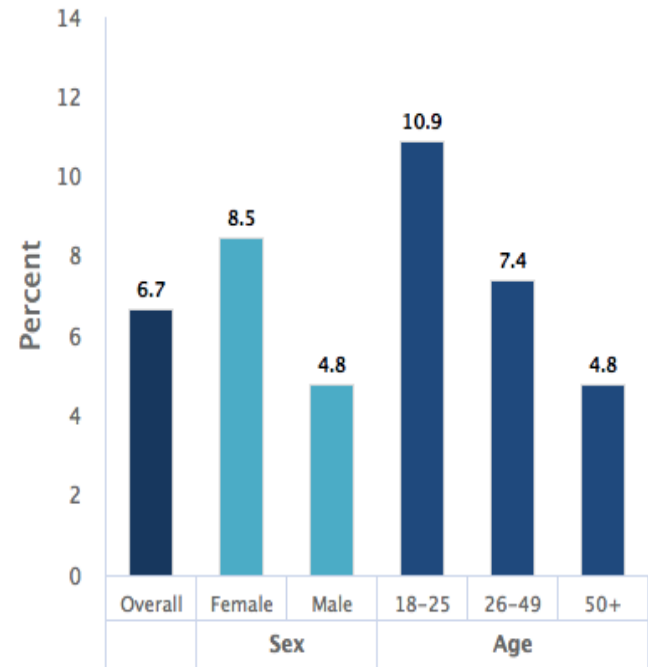
National statistics about depression

- In past year, 6.7% of all U.S. adults had at least one major depressive episode
 - Among women overall 8.5%
 - Among those 18-25 years old 10.9%
 - Severe impairment in 64% of those with depression
 - Measured with Sheehan Disability Scale - home management, work, close relationships with others, and social life*
- Prevalence of maternal depression 10% overall (children under 18 years)#

*2016 National Survey on Drug Use and Health

<https://www.nimh.nih.gov/health/statistics/major-depression.shtml>

#Ertel 2011





Category	% in NYC
Overweight/Obese before pregnancy	48.4
Mistimed/unwanted pregnancy	27.5
Private insurance during pregnancy/after pregnancy	45.8/43.5
Medicaid during pregnancy/after pregnancy	47.9/42.4
No insurance during/after pregnancy	2.8/9.0
Baby most often laid on back to sleep	68.9
Self-report of postpartum depressive symptoms	11.4

<https://www.cdc.gov/prams/index.html>

What about the dads?

- Paternal depression
 - 8% in the first three months post-partum
 - Much less research but what there is indicates that fathers go through some of the same things as mothers in transitioning to parenthood
 - Beyond the post-partum period, men 18-44 have 8.35% 12-month prevalence of depression per National Comorbidity Study – Replication (NCS-R)



National Epidemiologic Survey of Alcohol and Related Conditions

Associated demographic nationally	Percent with past-year depression
Age 18-24/25-34/35-44	14.30/11.93/9.13
Number of children 1/2/3/4+	10.20/10.25/9.43/13.19
Age of children <1/1-4/5-12/13-15/16-17	14.69/10.97/9.92/10.22/10.41
<High school/HS/Some college/Completed college	13.13/11.19/11.04/6.72
Income lowest - highest quartile	14.80/11.04/10.28/6.56
Unemployed/employed PT/employed FT	24.56/10.25/8.05

Maternal depression – risk factors



- Family history of mental health problems/depression
- History of Adverse Childhood Experiences
- Younger maternal age
- Personal history of depression or bipolar disorder
 - Previous episode of postpartum depression or depression during pregnancy
- Recent stressful life events
- Inadequate social supports
- Marital problems
 - Can be a chicken or egg situation
- Intimate Partner Violence
- Financial difficulties/unemployment

<https://womensmentalhealth.org/specialty-clinics/postpartum-psychiatric-disorders/>

<https://womensmentalhealth.org/posts/maternal-depression-persists-beyond-postpartum-period/>

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3253390/pdf/jwh.2010.2657.pdf>

Screening - Properties of tools

- Availability
 - All scales presented today are in the public domain (free, available for all to use)
- Self-report vs. clinician administered
 - Evidence for PHQ-9 and some other scales supports having patients complete themselves
 - Caveats to this?
- Validity
 - Does it measure what it intends?
 - Sensitivity/specificity
- Translations/cultural validity
 - Many are available in translations – but cultural variations play a role as well
- Supportive, not diagnostic

Tools to identify perinatal and maternal depression

The Patient Health Questionnaire-2 (PHQ-2)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Score of 3 or higher is considered positive – move to PHQ-9 or consider referral

- PHQ-9
- Score of 0-4 is considered normal
- Score of 5-9 minimal symptoms
- Score of 10-14 is mild depression
- Score of 15-19 moderate depression
- Score greater than 20 severe depression

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Edinburgh Postnatal Depression Scale

≥13 suggests depression

In the past 7 days:

- | | |
|---|---|
| 1. I have been able to laugh and see the funny side of things | *6. Things have been getting on top of me |
| <input type="checkbox"/> As much as I always could | <input type="checkbox"/> Yes, most of the time I haven't been able to cope at all |
| <input type="checkbox"/> Not quite so much now | <input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual |
| <input type="checkbox"/> Definitely not so much now | <input type="checkbox"/> No, most of the time I have coped quite well |
| <input type="checkbox"/> Not at all | <input type="checkbox"/> No, I have been coping as well as ever |
| 2. I have looked forward with enjoyment to things | *7. I have been so unhappy that I have had difficulty sleeping |
| <input type="checkbox"/> As much as I ever did | <input type="checkbox"/> Yes, most of the time |
| <input type="checkbox"/> Rather less than I used to | <input type="checkbox"/> Yes, sometimes |
| <input type="checkbox"/> Definitely less than I used to | <input type="checkbox"/> Not very often |
| <input type="checkbox"/> Hardly at all | <input type="checkbox"/> No, not at all |
| *3. I have blamed myself unnecessarily when things went wrong | *8. I have felt sad or miserable |
| <input type="checkbox"/> Yes, most of the time | <input type="checkbox"/> Yes, most of the time |
| <input type="checkbox"/> Yes, some of the time | <input type="checkbox"/> Yes, quite often |
| <input type="checkbox"/> Not very often | <input type="checkbox"/> Not very often |
| <input type="checkbox"/> No, never | <input type="checkbox"/> No, not at all |
| 4. I have been anxious or worried for no good reason | *9. I have been so unhappy that I have been crying |
| <input type="checkbox"/> No, not at all | <input type="checkbox"/> Yes, most of the time |
| <input type="checkbox"/> Hardly ever | <input type="checkbox"/> Yes, quite often |
| <input type="checkbox"/> Yes, sometimes | <input type="checkbox"/> Only occasionally |
| <input type="checkbox"/> Yes, very often | <input type="checkbox"/> No, never |
| *5. I have felt scared or panicky for no very good reason | *10. The thought of harming myself has occurred to me |
| <input type="checkbox"/> Yes, quite a lot | <input type="checkbox"/> Yes, quite often |
| <input type="checkbox"/> Yes, sometimes | <input type="checkbox"/> Sometimes |
| <input type="checkbox"/> No, not much | <input type="checkbox"/> Hardly ever |
| <input type="checkbox"/> No, not at all | <input type="checkbox"/> Never |



HELLO
my name is

Anxiety

Scoring:

answers are 0-3 except *
means reverse
scored (3-0)

Psychiatric co-morbidities with maternal depression

- Anxiety disorders (23.4% 12-month prevalence*)
 - Anxiety symptoms very frequent in perinatal period
 - Generalized anxiety and panic attacks most common
- Trauma related disorders
 - Acute stress disorder
 - Post-traumatic stress disorder (5.2%*)
 - Complex trauma
- Personality disorders (9.1%*)
- Substance or alcohol use disorder (11.6%*)
- Bipolar disorder (2.8%*)
- Psychosis . . .

*12-month prevalence based on NCS-R

GAD-7

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	
6. Becoming easily annoyed or irritable	0	1	2	
7. Feeling afraid as if something awful might happen	0	1	2	
<i>Add the score for each column</i>	+	+		
Total Score (add your column scores) =				

If you checked off any problems, how difficult have these made it for you to care of things at home, or get along with other people?

Not difficult at all _____
 Somewhat difficult _____
 Very difficult _____
 Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

Not just for GAD

Generalized Anxiety Disorder Screener (GAD-7)	
<u>Scoring and Interpretation:</u>	
GAD-2 Score*	Provisional Diagnosis
0-2	None
3-6	Probable anxiety disorder
GAD-7 Score	Provisional Diagnosis
0-7	None
8+	Probable anxiety disorder
*GAD-2 is the first 2 questions of the GAD-7	

Other possible resources to help with anxiety assessment

- Hamilton Anxiety Scale
 - <http://www.assessmentpsychology.com/HAM-A.pdf>
 - Scoring
<http://www.assessmentpsychology.com/HAM-A-scoring.pdf>
- American Psychiatric Association Assessment Measures
 - Made available as part of DSM-5
 - <https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures>

History of Trauma

Screening for PTSD

PC-PTSD-5

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide.

Have you ever experienced this kind of event?

YES

NO

If no, screen total = 0. Please stop here.

If yes, please answer the questions below.

In the past month, have you...

1. had nightmares about the event(s) or thought about the event(s) when you did not want to?

YES

NO

2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?

YES

NO

3. been constantly on guard, watchful, or easily startled?

YES

NO

4. felt numb or detached from people, activities, or your surroundings?

YES

NO

5. felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?

YES

NO

History of Trauma

LEC-5 Standard

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, as a medic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply.

Be sure to check the box for (a) as you go through the list of events.

	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Repeated, disturbing, and unwanted memories of the stressful experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Repeated, disturbing dreams of the stressful experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling very upset when something reminded you of the stressful experience?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Other unwanted or uncomfortable sexual experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Combat or exposure to a war-zone (in the military or as a civilian)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Life-threatening illness or injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Severe human suffering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Sudden violent death (for example, homicide, suicide)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Sudden accidental death	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Serious injury, harm, or death you caused to someone else	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Any other very stressful event or experience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Assessment for PTSD

More PTSD Resources

- U. S. Department of Veteran's Affairs
 - <https://www.ptsd.va.gov/index.asp>
- The National Child Traumatic Stress Network
 - <https://www.nctsn.org/>

Effects of childhood abuse and interpersonal violence on maternal depression and parenting

- Both history and current abuse/violence associated with increased rates of
 - Depression, anxiety, PTSD, substance use disorders
- History of child abuse
 - Assoc with insecure adult attachment patterns (dismissing, preoccupied, unresolved) (Zietlow 2017)
 - Assoc with adult personality disorders (Waxman 2014)
 - Sexual abuse associated with mother having negative views of self as parent and increased likelihood of using physical punishment to discipline
 - Sexual and/or physical abuse associated with problems in role differentiation between parent and child (Dubowitz 2001)
- Interpersonal violence-related PTSD
 - Maternal reflective functioning (MRF) lower when child's father was perpetrator
 - Lower MRF linked with lower maternal sensitivity (Suardi 2018)

Substance Use Disorders

- A number of tools available for
 - Screening
 - Assessment
- AUDIT-C for alcohol and DAST-10 for other substances are commonly used for screening
- <https://www.drugabuse.gov/nidamed-medical-health-professionals/tool-resources-your-practice/screening-assessment-drug-testing-resources/chart-evidence-based-screening-tools>
- What is your approach to asking about substance use given the possible implications in parent-child work?



Postpartum psychosis

- Rare – approximately 1 to 2 per 1000 women after childbirth (0.1-0.2%)
- Onset of symptoms as early as 48-72 hours after delivery
 - Majority of women develop symptoms within the first two postpartum weeks
- Frequently an episode of **bipolar illness** with concurrent mood symptoms
 - Delusional beliefs common – often center on the infant
 - Auditory hallucinations also common – may instruct the mother to harm herself or her infant
- Increased risk of suicide as well as infanticide
- Comprehensive psychiatric evaluation is required
 - In most cases, mother needs to go to the emergency room



Challenges to evaluating maternal mental health in ECMH settings

- Not the identified patient
 - Parent wasn't expecting to be evaluated
- Parent worry
 - About being judged by the clinic
 - Might be repercussions (such as reports to ACS)
- Community and cultural stigma about mental health
- Parent may feel guilty about feeling depressed (classic depression symptom!)
- May need to meet with the parent alone
 - Is there childcare?

Example script:

At beginning of treatment

“Most of the evaluation today has been focused on what you are noticing with your child. Of course, that’s why you are here, but parent health is extremely important for young children - so we ask every parent who brings a child to our clinic some questions, too. One of the most common health problems facing parents is depression.”

Continue on next slide . . .

Example script:

At beginning of treatment

If the parent already completed the PHQ-9 on paper:

- “I’d like to take a minute to review with you the questions you answered earlier about your mood. First of all, was it clear that these questions were about you?”
- Go over one or two questions with the parent to assure they understood questions/how to answer
- Ask if they had any questions about this form

Example script:

At beginning of treatment

If the parent did not already complete the PHQ-9 on paper –

- “I’d like to take a minute to go through the questions on this form with you.”
- Go over one or two questions with the parent to assure they understand questions/how to answer
- Ask if they have any questions about this form
 - “Would you prefer to finish this on your own or go over the questions together?”

Example script:

Treatment already started

“We’ve been working together for several weeks now. As I’ve gotten to know you and your child more, I’ve realized that there are some details that I’d like to talk with you about more. Would it be ok if I tell you a little more about what I’m thinking?”

Discussion point:
Why did that end with a question?



Presenting assessment and recommendations to mother – PHQ-9

“When I add up the answers you gave me, I see that the total is _____. That number often means that the person completing the form is (not/mildly/moderately/severely) depressed. How do you think that applies to the way you are feeling?”

(Patient answers)

“Now that we’ve established an understanding of what might be going on, let’s talk about some options that might help...”

Talking with mothers about depression

- Emphasize the positive impact of addressing the problem both for mother and child
 - Improved mother-infant bonding
 - Improved behavior at home and school once depression improves
 - Better learning potential in school
 - Decreased chance of depression and other mental health issues when child is a teen





“...Place the oxygen mask on yourself first before helping small children or others who may need your assistance.”



Mother not ready to address her mental health yet

- Some mothers will not be ready to accept a plan for intervention
 - As long as there is not acute danger, meet them where they are
 - Watchful waiting
 - Make a plan for when you will next check on their symptoms
 - If you've used a standardized questionnaire, you can compare scores over time – lack of improvement may help mother appreciate the need for treatment
 - Consider involving spouse/family (if the mother agrees) to help her keep track of symptoms and decide what needs to happen next

Evidence-based Therapies for Maternal Depression

- Structured psychotherapies with substantial evidence base for effectiveness
 - Interpersonal Psychotherapy (IPT)
 - Cognitive Behavioral Therapy (CBT)

For a good review of the evidence:

Nilini, YI *et al* (2018). “Treatment of depression, anxiety, and trauma-related disorders during the perinatal period: A systematic review”

Clinical Psychology Review 66:p136-148.

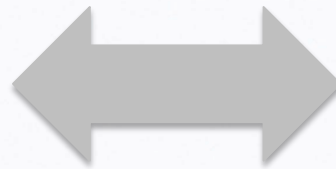
Interpersonal Psychotherapy for Depression

- Originally conceptualized by Gerald Klerman, Myrna Weissman, and others in 1984
- Time-limited (btw 8-16 wks) manualized psychotherapy
- Basic constructs have been adapted to address
 - Bipolar disorder, eating disorders, PTSD
 - Adolescents, **perinatal depression, mothers**

Theoretical Foundations of IPT

- Epidemiology: Depression is strongly linked to social stressors and personal loss
- Attachment Theory: Importance of security within close relationships as a condition of health and resilience
- Relationship between depression and relational experiences is bidirectional

Loss and conflict
contribute to
depressive
symptoms

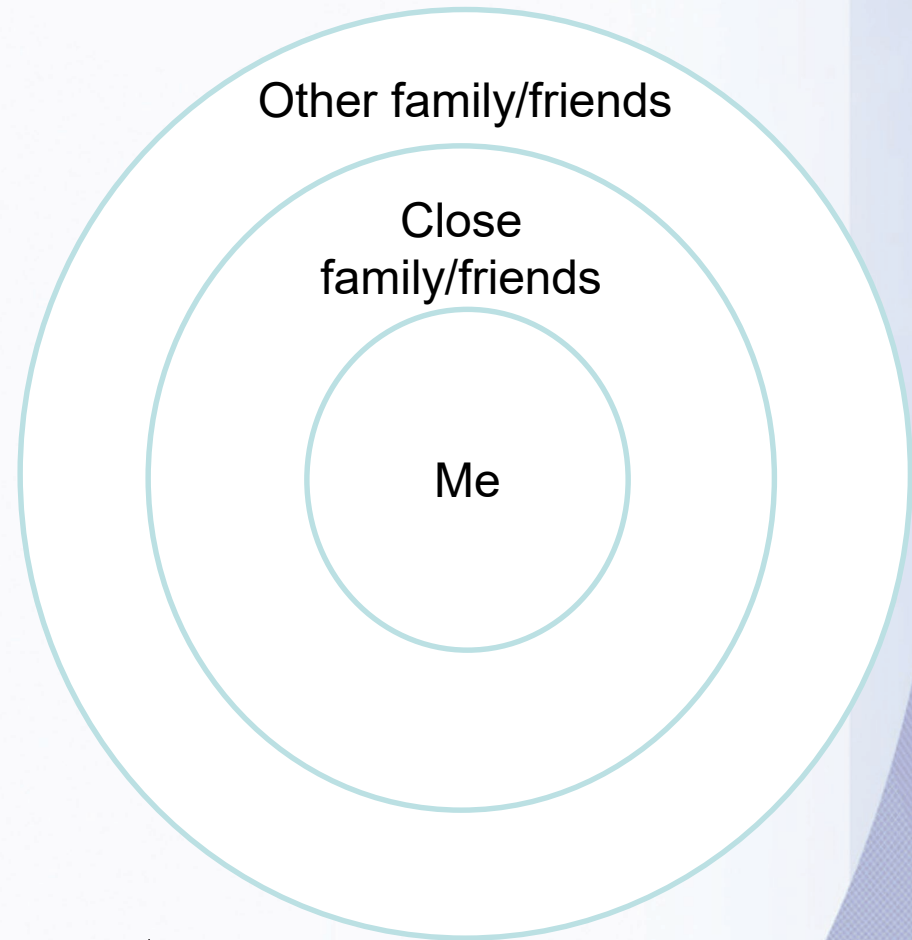


Depression
challenges healthy
interpersonal
relationships

Details of the interpersonal inventory

- Who are the important people in your life, now and in the past?
- Who raised you?
- Whom do you call when you're upset? Who confides in you?
- Whom do you communicate with on most days?
- Can you tell me about that person? What is [he/she] like?
- Can you give me an example of an interaction?
- Pay close attention to verbal and nonverbal communication, watching for subtle signs of emotions that patient is not overtly expressing – explore if possible

The Closeness Circle



Uses of the interpersonal inventory outside of full IPT

- Structured method for collecting more information about the relationships and attachments important to the parent
- Closeness Circle and Interpersonal Inventory can be used as launching points to discuss opportunities to re-connect with family/friends
 - Especially if you manage to identify someone with whom the parent has an overall positive relationship that has grown less close recently

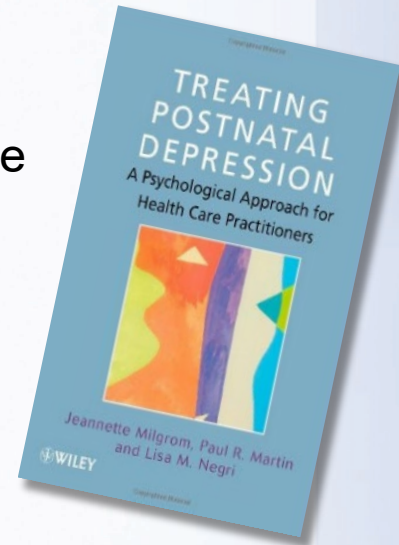
Additional References for IPT

- Sockol LE (2018) “A systematic review and meta-analysis of interpersonal psychotherapy for perinatal women” *Journal of Affective Disorders* 232:316-328.
- Ravitz P, Watson P, and Grigoriadis S (2013) Psychotherapy Essentials To Go: Interpersonal Psychotherapy for Depression. W.W. Norton & Company.
- Spinelli M (2017) Interpersonal Psychotherapy for Perinatal Depression: A Guide for Treating Depression During Pregnancy and the Postpartum Period. CreateSpace Independent Publishing Platform.
- <https://iptinstitute.com/>



Elements of CBT used for maternal depression

- The B of CBT
 - Behavioral activation and self-care
 - Specifically – encouraging pleasant activities and nurturing the self
 - Teach breathing or relaxation strategies
- The C of CBT
 - Link between thoughts and feelings (go back to the triangle)
 - Challenging unhelpful beliefs and thoughts
 - Additional components – relationship with partner, social support, mother-baby relationship
- Self-Help CBT Guides and resources
 - https://reproductivementalhealth.ca/sites/default/files/uploads/resources/files/coping_with_depression.pdf
 - <http://anxietycanada.com/general/new-moms/>
- Note: A number of resources focus more specifically on postnatal depression, which has received more attention – you have to adapt a bit for mothers of older children



Behavioral Self-Help

- Let mothers know there are things they can do to help themselves
- Encourage self-care as part of the solution
 - Discuss importance of taking time to
 - get out of the house
 - engage in some physical activity three or more times per week
 - eat healthy foods
 - Explore resources for social support and help that mother could access
 - make efforts to connect with friends and family
 - go to activities at religious organization or community centers
 - engage in specific activities designed for new mothers like mommy-and-me exercise classes
 - consider including family members (for example, father of baby) in plans when possible
 - consider asking someone else to do a nighttime feeding to increase mom's uninterrupted sleep

Many of these are part of Behavioral Activation – show mom the CBT triangle and explain that changing behavior can change feelings

Relaxation strategies

Ann needed to learn some new ways to deal with her frustration and anger. It's okay to feel mad; everyone does; it is how we choose to deal with it that is important.

Ways to Calm Down

1. Breathe deeply and center yourself
2. Count to ten slowly – or twenty or whatever it takes!
3. Take time-out – go in the bathroom and close the door
4. Use relaxation techniques that you developed with the NURSE program
5. Use visualization
6. Notice your thoughts and if you need to replace with fair and flexible thoughts.
7. Do something physical – any kinds of sport or activity will help to release tension
8. Do art – use large vigorous strokes and wild colors or model with play-dough
9. Listen to music – it could be angry to shake out your anger or a calming melody
10. Write in a journal or a letter to the person you are upset with – just don't send it!
11. Do something you enjoy, for example, a hobby
12. Use reflective listening
13. Get or give a caring touch
14. Stand under a hot shower and let the anger wash down the drain with the water
15. Lie down, cool down, relax

It's OK to ask for help!

What Your Partner Can do to Support You

It is common for partners to be baffled by the occurrence of depression and anxiety in the postpartum period. Rosetta suffered from a postpartum depression that baffled her husband. "We have everything to be happy about, I don't understand why you can't stop crying" and "Why can't you just snap out of it" were just some of the words he uttered in frustration. Antoine also needed to be receiving practical and emotional support during Rosetta's depression. Research indicates that women recover much faster if their partner is understanding and supportive. Here are some tips from the Pacific Postpartum Support Society on how your partner can help.

- A woman with PPD is going to be hard on herself. It is therefore very important she is receiving encouragement and reassurance that she is doing a good job.
- Getting practical help in the home either paid or help from family and friends can help. Find out specifically what you can do.
- Look at all the stressors and see which ones may be changed or relieved. You may not be able to change the fact that the baby is not sleeping but it may be possible to arrange to get up with the baby a few nights or let mom sleep on the weekends.
- Criticizing or commenting on the fact that the house isn't getting clean can only add to the guilt she is already feeling. Hiring someone to come and help once a week can make a huge difference.
- Try to be involved in her recovery as much as possible – i.e. Doctor appointments and learning about PPD. The first section of this manual can provide useful information.
- Take over some of the responsibilities for baby and provide breaks she can count on.
- Make sure you are also getting support and breaks. Hire someone to help with childcare if necessary. Planning one night a week for yourself and one night a week your wife can go out can also be helpful. Remember to be flexible. If mom has had a demanding day at home, it may be better to plan your night out for a different day.
- If finances are an issue there are other ways to get a break. Talk to your PHN or community centre and see what resources there are. Sometimes it may help to get your Doctor or PHN to advocate getting help for you.
- Notice the things she is doing rather than what hasn't been done.

Talking with mothers about depression – working on those cognitions!



- Educate, educate, educate . . .
 - First and foremost, normalize the situation
 - Remember, as many as 1 in 5 mothers are affected by depression during or after pregnancy and around 1 in 10 regardless of age of child
 - Depression is a treatable problem
 - There are a variety of treatment options including talk therapy or medication
 - Provide online or printed resources so women can learn more
 - https://reproductivementalhealth.ca/sites/default/files/uploads/resources/files/perinatal_depression_treatment_options_fact_sheet.pdf
 - Plus more in the referral section later

Talking with mothers about depression – working on those cognitions!

- Mothers often have significant misconceptions you may need to correct
 - Guilt about feeling bad during what is “supposed to be a happy time” or because “I’m just not strong enough”
 - Worries that symptoms will be interpreted adversely
 - “People will think I’m crazy”
 - “Maybe people would think I can’t take care of my baby”
- Culture can also impact how depression is viewed
 - Depression exists in all cultures
 - You may need to explore this with mother
 - What are her cultural syntonc expectations about how a mother should “be?”
 - What is the cultural view on mental health/depression?

Minding the culture

- Different cultures have widely varying concepts about
 - what being a mother means
 - how relationships between mothers and fathers should work
 - when and how emotions, including those that are part of mental illness, can be expressed
- Plus in NYC, people are bridging between cultures – where they came from and where they are now

What are the strategies you use to help you manage all this complexity?



Evidence-Based Treatments for Maternal Depression

- Psychotherapy
 - Cognitive-Behavioral Therapy (CBT)
 - Interpersonal Therapy (IPT-MOMS)
- Medication – antidepressants (SSRI's)
- Complementary/alternative medicine
 - Omega-3 fatty acids, particularly EPA, may be helpful in treatment of depression although results in perinatal period have not been conclusively positive
 - Folate, which pregnant women need to take anyway, may be helpful – continue prenatal vitamins!
 - Exercise, massage therapy, acupuncture, light therapy may be helpful as well in the perinatal period
 - **These should be considered adjunctive treatment – if a mother is truly depressed as there is not enough evidence to conclude they are consistently effective**

General Principles

1. Weigh the risks of UNTREATED ILLNESS against the risks of MEDICATION
2. Maximize non-pharmacologic interventions
3. Use the lowest EFFECTIVE dose
4. Avoid polypharmacy
5. Review the literature with an eye for confounders/biases
6. Be mindful of media bias of reporting positive studies



Antidepressants

Selective Serotonin Reuptake Inhibitors

fluoxetine	Prozac
paroxetine	Paxil
sertraline	Zoloft
fluvoxamine	Luvox
citalopram	Celexa
escitalopram	Lexapro

Selective Serotonin Norepinephrine Reuptake Inhibitors

venlafaxine	Effexor
desvenlafaxine	Pristiq
duloxetine	Cymbalta

Other antidepressants

bupropion	Wellbutrin
mirtazepine	Remeron
clomipramine	Anafranil
imipramine	

Antidepressant medication during pregnancy

- 7-13% of pregnancies are exposed to antidepressants
- SSRIs = constitute 80% of antidepressants prescribed
- SNRIs growing literature
- Wellbutrin, mirtazapine, trazodone, nefazodone, TCAs, MAOIs less commonly prescribed, fewer studies

How do you know if it's a side effect?

- In FDA studies for medications, any reported negative event or symptom occurring while taking the medication is required to be reported
 - Sometimes random events get associated with the medication
- In reality, there should be patterns with side effects
 - Timeline of new or increased event/symptom should match either starting the medication (at least within a few days) or increasing the dose of the medication
 - Side effects unlikely to fluctuate dramatically day-to-day if patient is taking medication consistently
 - Side effect should disappear if stop medication
- More meds, more chance of side effects!



Splitting treatment with a prescriber

- Importance of some form of ongoing communication
- What you need to know to effectively communicate with the prescriber and with your patients/parents about medications
 - Language with the patient/parent
 - “I understand your concern is about whether the medication is causing this problem. Would it be ok with you if I alert the doctor that you would like to speak with him/her about this soon?”
 - Language with the provider
 - Communication with the psychiatrist in the behavioral health setting
 - Reinforcing communication between the patient and the prescriber
 - Encourage patient to talk to doctor honestly
 - before stopping meds or changing doses,
 - about any possible drug interactions including to common OTC meds or alcohol/drugs

What if a mother needs more support?

- Criteria for referral to higher level of care:
 - PHQ-9 score is higher than 20
 - Symptoms have not improved despite initial treatment
 - Co-morbid conditions (not an exhaustive list)
 - Bipolar disorder
 - Severe anxiety
 - PTSD
 - Others . . .
 - Severe difficulty bonding with infant and lack of support from others
 - Systemic issues prevent you treating this mother
- Typically you make referral to a Mental Health Clinic . . .
- Some other options?



How to access resources

- NYC Well
 - Updated information and referral for mental health resources, including crisis services, peer supports and assistance connecting to care
 - Call 1 888 NYC WELL





COLUMBIA UNIVERSITY
MEDICAL CENTER

COLUMBIA PSYCHIATRY

NewYork
Presbyterian

The Women's Program

The Women's Program in the Department of Psychiatry at Columbia University addresses mental health needs related to the female reproductive life cycle. We offer state-of-the-art consultation and ongoing treatment conducted by psychiatrists and psychologists with particular expertise in reproductive and perinatal psychiatry. Contact: 212-305-6001



Contact: 212-305-6001

<http://columbiapsychiatry.org/clinicalservices/womens-program>

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**NEW YORK
CENTER FOR CHILD
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FOR POVERTY POLICY AND RESEARCH

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OF SOCIAL WORK

Perinatal psychiatry services

About Conditions Care at Northwell

About - The team - Services - Contact us

About

In the past, many women who experienced behavioral health challenges during pregnancy and new motherhood remained silent about their struggles. But now, more women are asking for the help they need to overcome a range of psychiatric disorders so they can be happier, healthier and ready to raise the new additions to their families.

The treatment offered at the Northwell Health Perinatal Program may benefit a wide range of new or expectant mothers including:

For more
information,
call:

(631) 608-6667 for Suffolk
County

(516) 470-4666 for Nassau
County

(718) 470-4666 for Queens

<https://www.northwell.edu/find-care/services-we-offer/perinatal-services>

Women's Mental Health

- Outpatient services through Bellevue Women's Health Clinic and Adult Psychiatry Clinic
- Outpatient services through Department of Psychiatry Faculty Group Practice

AT THE MOTHERHOOD CENTER, WE ARE HERE TO HELP EVERY STEP OF THE WAY

Call us at (212) 335-0034

Postpartum Support International

www.postpartum.net

- PSI Warmline (English and Spanish)
at 1.800.944.4773

<http://www.postpartum.net/locations/new-york/>

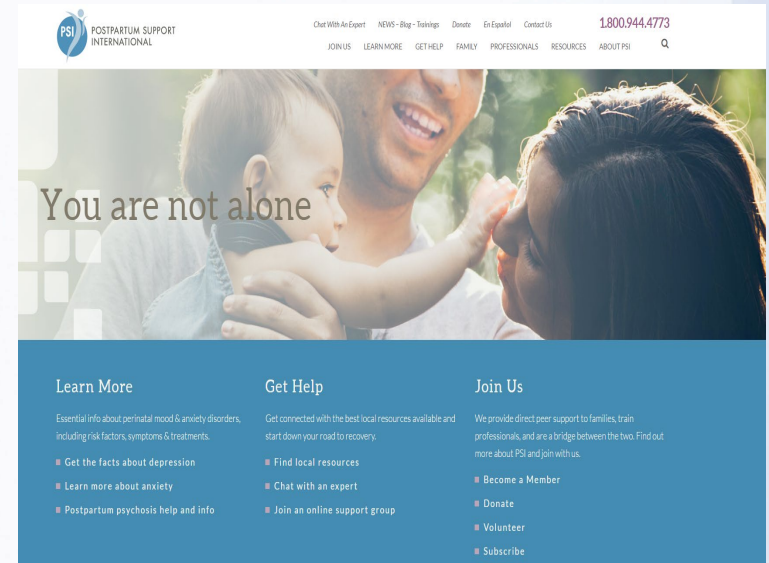
PSI Support Coordinators, NYC :

- Ann Smith, NP, CNM

Telephone: 917-207-0254 cell

Please contact between hours of 8am
and 10 pm

- Laudy Burgos, LCSW
- NY City Metropolitan area
Telephone: 917-828-1569
Spanish Speaking



Family Resource Centers

- Individual and group-based family support services to parents/caregivers of children and youth who have emotional, behavioral, or mental health challenges, using a family and youth peer model.
 - Emotional support
 - Advocacy to help navigate child-serving systems
 - Information about mental health conditions, services and family rights
 - Referrals to appropriate services and resources
 - Skill development through workshops and parenting classes

Circle of Security

Description

The Circle of Security (COS) program helps families understand and respond to their children's emotions and behavior. COS classes focus on parent-child interactions, responding to children's needs and reflecting on parent strengths and challenges.¹ COS helps parents look beyond their child's immediate behavior, better understand their child's attachment needs, and recognize when their own reactions impede an appropriate response.² Pediatric offices or community-based organizations can offer this service.

Evidence

- COS decreases caregiver helplessness and stress.³
- COS helps parents consider their children's emotions more, and be more patient and less frustrated with their children.⁴
- COS helps parents increase their own emotion regulation capacity and demonstrate greater empathy for their children.⁵
- COS reduces insecure attachment and increases security for children between toddlerhood and early school years.⁶

Implementation

Providers can link parents to an existing COS class at a neighborhood community-based organization. They can also set up a COS class within their practice through Vibrant Emotional Health's Circle of Security Parent Coaching Department. To register for a class or host a class at your organization, contact the COS Parent Coaching Department at 646-532-3545 or pcd@mhafnyc.org.

Home Visiting Programs

A promotional banner for Healthy Families New York. The background is a photograph of a smiling woman holding a baby. In the top left corner, there is a logo with three stylized figures in purple and the text "healthy families new york". On the left side, there are three small rectangular thumbnails with text: "How does HFNY work?", "Is HFNY for me?", and "Find a HFNY program". In the bottom right, there is a text box that reads "A free, voluntary home visiting program to support expectant and new parents".

healthy families
new york

How does HFNY work?

Is HFNY for me?

Find a HFNY program

A free, voluntary home visiting program to support expectant and new parents

<https://www.healthyfamiliesnewyork.org/>

Visit our Website

TTACNY.org
ttac.info@nyu.edu

NYC Early Childhood Mental Health TTAC
Training and Technical Assistance Center
TTAC is funded by the New York City Department of Health and Mental Hygiene through ThriveNYC.

ASK TTAC


ABOUT US TRAINING & TECHNICAL ASSISTANCE RESOURCES ECTC PORTAL EVENTS

Events

Wednesday, June 13, 2018
Sensory Integration and Self-Regulation: Sensory Contributions to Young Children's Social-Emotional Development

Monday, November 26, 2018
Foundations of Social-Emotional Development in Infants and Toddlers E-Learning Modules

[view more >](#)






NYC Early Childhood Mental Health Provider Resources

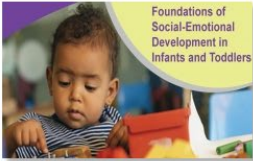
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A COLLABORATION BETWEEN



NYC DOHMH Bureau of Early Intervention E-Learning Modules




Foundations of Social-Emotional Development in Infants and Toddlers
[Learn More](#)



Foundations of Social-Emotional Development in Infants and Toddlers
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The Early Childhood Mental Health Network



Get to know the Early Childhood Therapeutic Centers (ECTCs)
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Thank You!

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