Preventing Postpartum Depression

Presented by Elizabeth Werner, Ph.D.

NYC Early Childhood
Mental Health
Training and Technical Assistance Center

Who We Are

The New York City Early Childhood Mental Health Training and Technical Assistance Center (TTAC), is funded by the NYC Department of Health and Mental Hygiene (DOHMH)

TTAC is a partnership between the New York Center for Child Development (NYCCD) and the McSilver Institute on Poverty Policy and Research

- **New York Center for Child Development** has been a major provider of early childhood mental health services in New York with expertise in informing policy and supporting the field of Early Childhood Mental Health through training and direct practice
- **NYU McSilver Institute for Poverty Policy and Research** houses PeerTAC and the Community and the Managed Care Technical Assistance Centers (CTAC/MCTAC), which offer clinic, business, and system transformation supports statewide to all behavioral healthcare providers

TTAC is tasked with building the capacity and competencies of mental health and early childhood professionals through ongoing training and technical assistance

http://www.TTACny.org

Updated TTAC Website

A Selection of Features:

- Seamlessly filter, toggle and search through upcoming and archived content, trainings and resources
- View videos, slides, and presenter information on the same training page
- Contact the TTAC team by clicking on Ask TTAC and filling out our Contact Us form
- And more!

Have questions or need assistance? Please contact us at **ttac.info@nyu.edu** and we'll be happy to assist you

TTAC Infant and Early Childhood Mental Health (IECMH) Learning Modules are now live!

Two Learning Modules:

- The first module in the series is**the Impact of Early Childhood Adversity (An Overview of the Topic)**
- The second module in the series is **Nurturing Resilience: Supporting Infant and Early Childhood Mental Health**
- CEUs Available upon completion!

Preventing Postpartum Depression

Presenter: Elizabeth Werner, Ph.D.

Director of Clinical Intervention Research, Perinatal Pathways Laboratory
Associate Director, Women's Mental Health @Ob/Gyn
Associate Director, Center for the Transition to Parenthood: Two Generation Impact

Key Terms

- Postpartum Depression = PPD (after birth)
- Perinatal Depression (during pregnancy and/or after birth)
- Perinatal Mood and Anxiety Disorders = PMADs (during pregnancy and/or after birth)

Overview

- Postpartum Depression/PMADs
    - Symptoms
    - Risk Factors
    - Long lasting effects
- Access to Treatment
- The "Missed Opportunity" for Perinatal Mental Health Care
- Models for preventive interventions
    - Mothers and Babies
    - ROSE
    - PREPP
- Conclusions

Postpartum Depression (PPD)

In the US, 20% of postpartum parents will experience an episode of major or minor depression within the first three months postpartum (Pearlstein, 2009).

Baby Blues

- The irritability, sadness, crying spells, or frustration that many parents experience in the first few days and up to two weeks after giving birth.
- Experienced by the majority of people who give birth.

Postpartum Depression

- Symptoms of PPD are similar to the Baby Blues but are more persistent and can include sleep difficulties, changes in appetite, and anxiety/panic. PPD can also affect your ability to bond with your baby.

Symptoms of PPD

- Feelings of anger
- Sadness
- Irritability
- Guilt
- Lack of interest in the baby
- Changes in eating and sleeping habits
- Trouble concentrating
- Thoughts of hopelessness
- Sometimes even thoughts of harming the baby or self.

Source: Postpartum Support International

Risk Factors for PPD

- Prenatal depressive/anxiety symptoms (Johansen et al., 2020; Beck, 2001)
- Pre-pregnancy history of mood disorders (Johansen et al., 2020; Beck, 2001)
- Postpartum stress/stressful life events (Leung & Martinson, 2005)
- Lack of social support (Cho et al., 2022)
- Obstetric risk factors & pregnancy-related complications (Gaillard et al., 2014)
- Multiparous pregnancies (Bassi et al., 2017)
- Young age at pregnancy (Ghaedrahmati et al., 2017)
- Low socioeconomic status (Goyal et al., 2010)
- Childcare stress (Beck, 2001)
- Relationship conflict (Beck, 2001)
- Unplanned or unwanted pregnancy (Beck, 2001)
- Infant temperament (Beck, 2001)

PPD: Effects on the Birthing Parent

- Long-term psychological health is affected, with greater occurrences of later anxiety and depression (Prenoveau et al., 2013; Vliegen et al., 2013; Costa et al., 2006)
- More relationship difficulties, with lower social support scores compared to nondepressed mothers (Vliegen et al., 2013)
- Suicidal ideation (Pope et al., 2013)
- Occupational challenges (Lewis et al., 2017)
- Lower overall quality of life (Darcy et al., 2016)

PPD: Effects on the Parent-Infant Dyad

- General ability to care for a new baby (Stewart, 2011)
- Parental responsiveness (Rados, 2021)
- Less positive parent-baby interactions (Field, 2010)
- Quality of bonding and attachment (Dubber et al., 2015)

PMADs & Child Development

Studies have consistently demonstrated the deleterious effects of PMADs on child development, including:

- Cognitive development (Kurstjens and Wolke, 2001; Rogers, 2020)
- Bonding/attachment (Monk et al., 2008; Dubber et al., 2015)
- Socio-emotional wellbeing (Rogers, 2020)

These associations also have been implicated in a broad range of child outcomes, including:

- Lower IQ scores in later childhood (Hay et al., 2001)
- Poorer Academic Performance (Netsi et al., 2018)
- Increased susceptibility to child and adolescent psychopathology (Rayce et al., 2020; Netsi et al., 2018; Field, 2010; Righetti-Veltema et al., 2002).

Despite the significant,
long-lasting effects of
PPD, there is limited
access to treatment.

Barriers to PPD Treatment

- **$: Cost and insurance match** were the most frequently cited variables hindering mental health treatment engagement (Coombs et al., 2021)
- **Lack of provider knowledge on PPD and PPD treatment** (Byatt et al., 2013)
- **Time: Added health care appointments typically uncoordinated with OB** and pediatric care. 65% of birthing parents cited time as a perceived barrier to obtaining professional help for perinatal depression (Iturralde et al., 2021)

Barriers to PPD Treatment

- **Stigma:** Shame in endorsing distress in the context of childbearing and stigma associated with receiving mental health services (Iturralde, 2021)
- **Medication:** Disinclination to take medications while pregnant or breastfeeding (Battle et al., 2013; Dennis & Chung-Lee, 2016, Goodman et al., 2009)

Recent Calls to Action

Clinical Review & Education

JAMA | US Preventive Services Task Force | RECOMMENDATION STATEMENT

Interventions to Prevent Perinatal Depression US Preventive Services Task Force Recommendation Statement

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN

Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice

Marian F. Earls, MD, MTS, FAAP,[a,b] Michael W. Yogman, MD, FAAP,[c] Gerri Mattson, MD, MSPH, FAAP,[d,e] Jason Rafferty, MD, MPH, EdM, FAAP,[f,g,h] COMMITTEE ON PSYCHOSOCIAL ASPECTS OF CHILD AND FAMILY HEALTH

Int Rev Psychiatry. 2019 Jan 31:1-19. doi: 10.1080/09540261.2018.1534725. [Epub ahead of print]

Perinatal depression care pathway for obstetric settings.

Byatt N[1,2], Xu W[1], Levin LL[1,3], Moore Simas TA[1,2].

Improving Accessibility to Treatment for PMADs

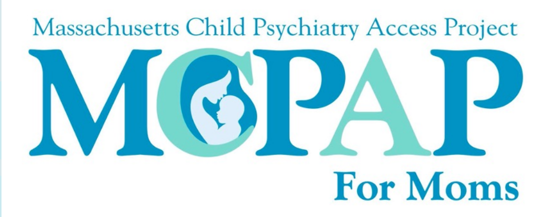
MCPAP for Moms in Massachusetts (Dr. Nancy Byatt), which offers providers with psychiatric consultation for behavioral health concerns surrounding pregnancy and support groups.

ProjectTEACH provides consultation with reproductive psychiatrists as well as trainings and educational programs

Postpartum Support International provides a confidential hotline and free groups

The U.S. Health and Human Services Department's Health Resources and Services Administration (**HRSA**) launched the **Maternal Mental Health Hotline**

National Curriculum for Reproductive Psychiatry (Lauren Osbourne, M.D.) which is designed to teach reproductive psychiatry to mental health professionals through an educational or self-guided program.



Given the many negative effects of PPD, **prevention of PPD** is essential.

U.S. Preventive Services
TASK FORCE

REACH OUT STAY STRONG ESSENTIALS

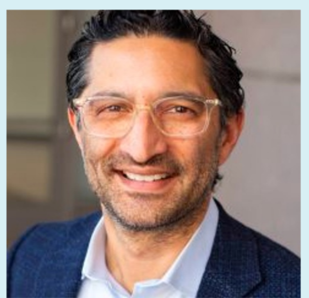
The Mothers and Babies Program

MB is an evidence-based intervention aimed at preventing PPD and alleviating stress during the perinatal period

- Utilizes **psychoeducation** through three modules: 1. **Pleasant Modes of Thought** 2. **Effective Utilization of Social Support** 3. **Engagement in Pleasant Activities**
- Delivered via self-directed **workbook** and trained facilitators
- One-on-one modality delivered in nine 20-minute sessions; group format delivered in six 90-minute sessions with 2 booster postpartum sessions
- Rooted in **cognitive-behavioral** and **attachment** theories

Shown to be effective to prevent PPD (Johnson et al., 2020)

- Recommended by the US Preventative Services Task Force
- Significant changes in PP depression and anxiety at 6 months (Tandon et al., 2018)



Dr. Daruis Tandon

Dr. Huynh-Nhu (Mimi) Le

MOTHERS
& BABIES

SCAN ME

ROSE for New Moms

ROSE is an evidence-based practice for reducing cases of PPD among low-income and racially/ethnically diverse birthing parents

- Four or eight 90-minute sessions during pregnancy and one 50-minute postpartum booster session
- Based primarily on IPT principles
- Sessions involve psychoeducation on postpartum depression, managing the transition to motherhood, managing relationships, self-care, assertiveness and goal-setting, and a review session
- Nurses, health educators, and others with or without mental health expertise can successfully provide ROSE, both in English and Spanish

ROSE prevents half of postpartum depression cases among low-income parents (Johnson et al., 2018)

- US Preventative Services Task Force recommendation

REACH OUT STAY STRONG ESSENTIALS

FOR NEW MOMS

Developed by Johnson & Zlotnick

REACH **O**UT
STAY **S**TRONG
ESSENTIALS

Developed by
Dr. Catherine Monk & Dr. Elizabeth Werner

- Begins in pregnancy
- Dyadic approach

An intervention based on the conceptualization of postpartum depression as a potential disorder of the dyad, and one that can be approached through preventative psychological and behavioral changes in the birthing parent that affect them and the child — even before birth

Parent-Infant Dyad

Parent-Infant Dyad: Unique bidirectional relationship between postpartum parent & infant

- Challenging behaviors in infants (crying and fussing) lead to increased levels of stress, depression, and anxiety in parents (Amici et al., 2022; Ölmestig et al., 2021)

The Parent-Infant Dyad

Behavioral techniques are effective in changing **infant fuss/cry and sleep behavior**

The Parent-Infant Dyad

PREPP uses this research to inform the intervention model

PREPP is Designed to be Accessible

1. Low cost and efficient

2. A variety of providers can deliver the intervention

3. Alternative to psychiatric medication

4. Reduce stigma: calling therapists "coaches" & focusing on parenting

5. Few sessions in conjunction with routine medical appointments

PREPP Treatment Protocol

Brief (5 sessions)

- 28-32 gestational weeks – 6 week postpartum

For those at risk of PPD

- Stress, depressive symptoms; experiencing poverty

Introduction to PREPP Sessions

	PREPP Session	Components
Session 1	28-32 weeks gestation In clinic or virtual 45-60 minutes	Harnessing a dyadic focus Establish alliance Self-reflection practice Sleep skills and mindfulness Distributed Materials: Prepp App/Mindfulness Audio File

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Session 3	18-72 hours post delivery Virtual 15-20 minutes	Review PREPP pamphlet Practice techniques: -Swaddling -Carrying -Mindfulness

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Session 4	2-3 weeks postpartum Virtual 15-30 minutes	Check in about mother & infant well-being Assess use of techniques Discuss challenges of newborn car

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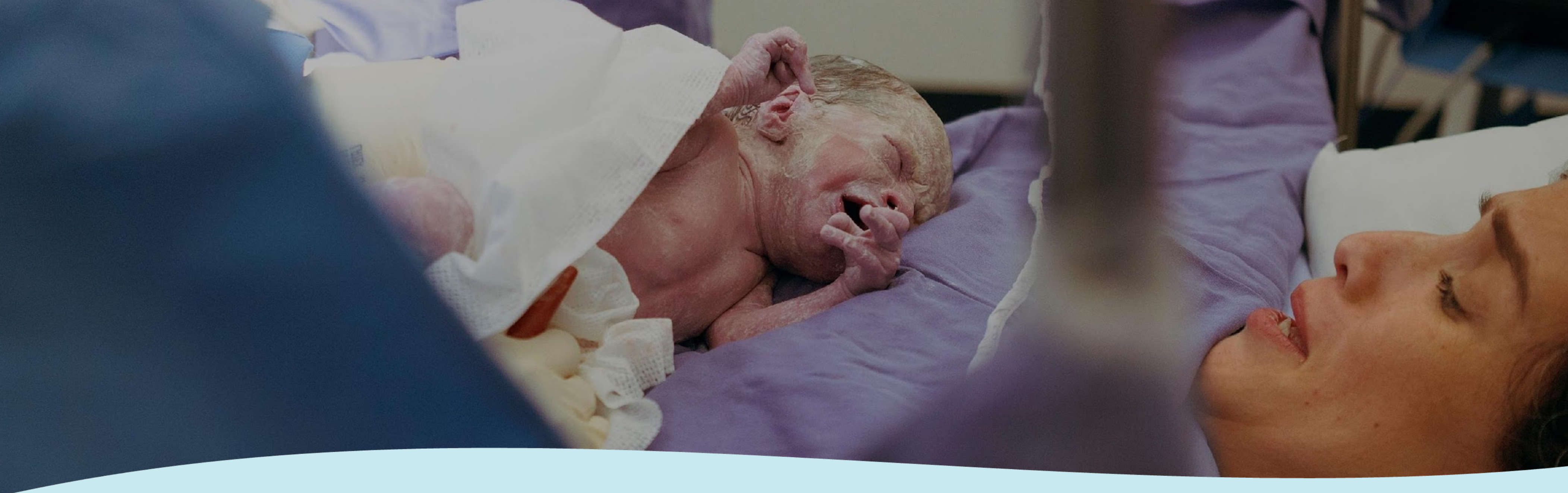
Session 3	18-72 hours post delivery Virtual 15-20 minutes	Review PREPP pamphlet Practice techniques: -Swaddling -Carrying -Mindfulness
Session 4	2-3 weeks postpartum Virtual 15-30 minutes	Check in about mother & infant well-being Assess use of techniques Discuss challenges of newborn care
Session 5	6 weeks postpartum In clinic or virtual 45-60 minutes	Practice self-reflection Assess use of techniques Review techniques where necessary

PREPP Components

Assessment & psychodynamic interviewing:

- Build the therapeutic alliance
- To gather information to tailor session materials to individuals
- Promote reflective functioning



PREPP Components

Psychoeducation: to limit negative attributions of self & infant

- Hormones
- Period of **PURPLE** Crying (Ronald Barr. M.D.)
- Sleep

The Letters in **PURPLE** Stand for

PURPLE

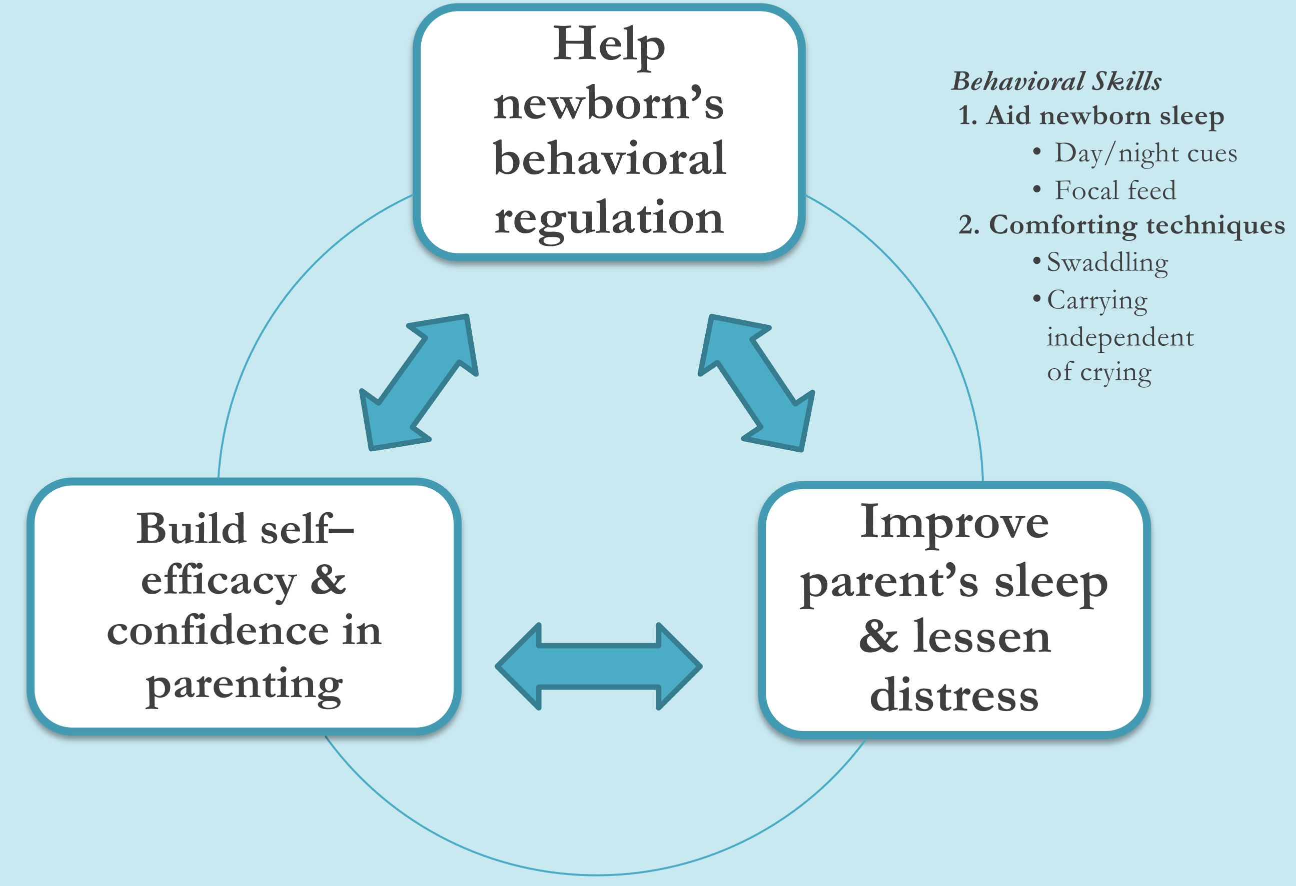
P	U	R	P	L	E
PEAK OF CRYING	**UNEXPECTED**	**RESISTS SOOTHING**	**PAIN-LIKE FACE**	**LONG LASTING**	**EVENING**
Your baby may cry more each week, the most in month 2, then less in months 3-5	Crying can come and go and you don't know why	Your baby may not stop crying no matter what you try	A crying baby may look like they are in pain, even when they are not	Crying can last as much as 5 hours a day, or more	Your baby may cry more in the late afternoon and evening

The word ***Period*** means that the crying has a beginning and an end.

Studied by Ron Barr, M.D.
Visit www.purplecrying.info for more information

PREPP Behavioral Techniques

- Behavioral techniques to reduce fuss/cry and increase nocturnal sleep
  - **Focal feed** (Pinilla and Birch, 1993)
  - **Day/night cues** (Pinilla and Birch, 1993; St James-Roberts, et al., 2001)
  - **Lengthening nighttime feeding intervals** (engage in other attentive activities) (Pinilla and Birch, 1993)
  - **Carrying infants at least 3 hours per day** (given carrier) (Hunziker and Barr, 1986; St James-Roberts, et al., 1995)
  - **Swaddling** (given swaddling blanket) (van Sleuwen, et al., 2007)
  - **Mindfulness** meditation to manage distress & improve sleep



- Assessment/Psychodynamic interviewing
- Psycho-education
- Mindfulness tools

Arch Womens Ment Health
DOI 10.1007/s00737-015-0549-5

ORIGINAL ARTICLE

PREPP: postpartum depression prevention through the mother–infant dyad

Elizabeth A. Werner[1] · Hanna C. Gustafsson[1] · Seonjoo Lee[3,4] · Tianshu Feng[3] · Nan Jiang[1] · Preeya Desai[1] · Catherine Monk[1,2]

Dr. Werner

ORIGINAL RESEARCH TRANSLATIONAL OBSTETRICS | VOLUME 2, ISSUE 4, 100230, NOVEMBER 01, 2020

Preventing maternal mental health disorders in the context of poverty: pilot efficacy of a dyadic intervention

Pamela Scorza, ScD · Catherine Monk, PhD · Seonjoo Lee, PhD · Tianshu Feng, PhD · Obianuju O. Berry, MD, PhD · Elizabeth Werner, PhD

Published: October 01, 2020 · DOI: https://doi.org/10.1016/j.ajogmf.2020.100230

Dr. Scorza

Journal of Affective Disorders
Volume 290, 1 July 2021, Pages 188-196

Research paper

Perinatal depression prevention through the mother-infant dyad: The role of maternal childhood maltreatment

Obianuju O. Berry[a, b, c, 1], Vanessa Babineau[d], Seonjoo Lee[c, e, f], Tianshu Feng[c], Pamela Scorza[d], Elizabeth A. Werner[d, e], Catherine Monk[c, d, e]

Dr. Berry

PREPP Treatment vs. ETAU

- Pregnant people (ages 18-45) were enrolled based on being at risk for PPD, and assigned to either:
  - PREPP Treatment or
  - Enhanced Treatment as Usual (ETAU)
    - ETAU: psychiatric evaluation and referral to community mental health care

Measures for Maternal Mood

Hamilton Rating Scale of Depression (blind clinician rating)

Hamilton Anxiety Rating Scale (blind clinician rating)

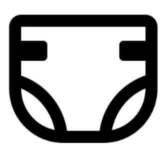
Patient Health Questionnaire-9 (self-report)

Edinburgh Postnatal Depression Scale (self-report)

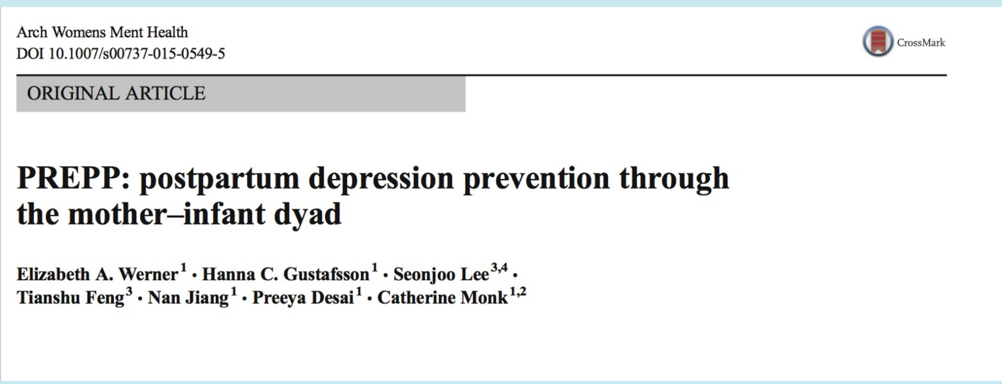
Measure for Infant Crying/Fussing and Sleep:

-Baby's Day Diary

(Barr, 1985)



Werner et al. (2016): Efficacy Data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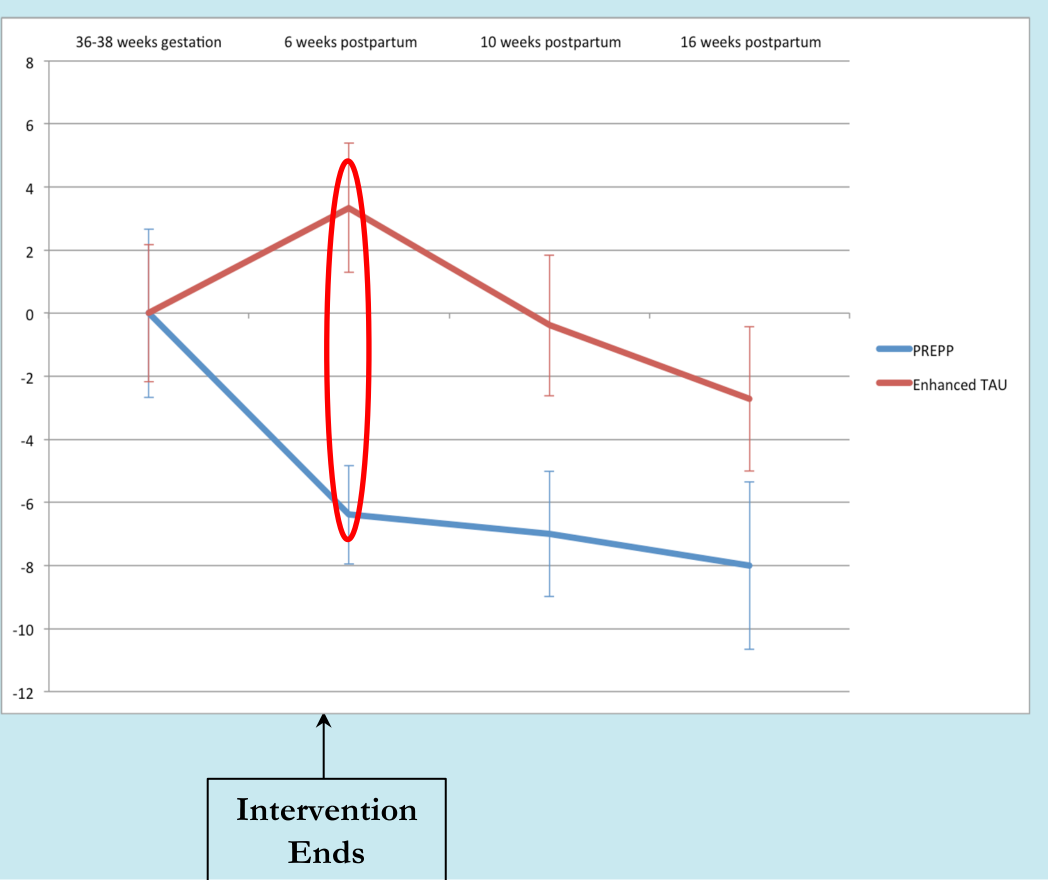
- 58% Latinx, 19% Black
- Age: 18-45 years old, average=30 years old
- At risk for PPD based on Predictive Index of Postnatal Depression (Cooper, 1996)
- Baseline mild to moderate depression symptoms
    - average of 16.11 on the HRSD, max 54, 14-17 mild to moderate
- Adherence: 100% completed PREPP intervention

Werner et al. (2016)
Results of Linear Mixed Effects Models

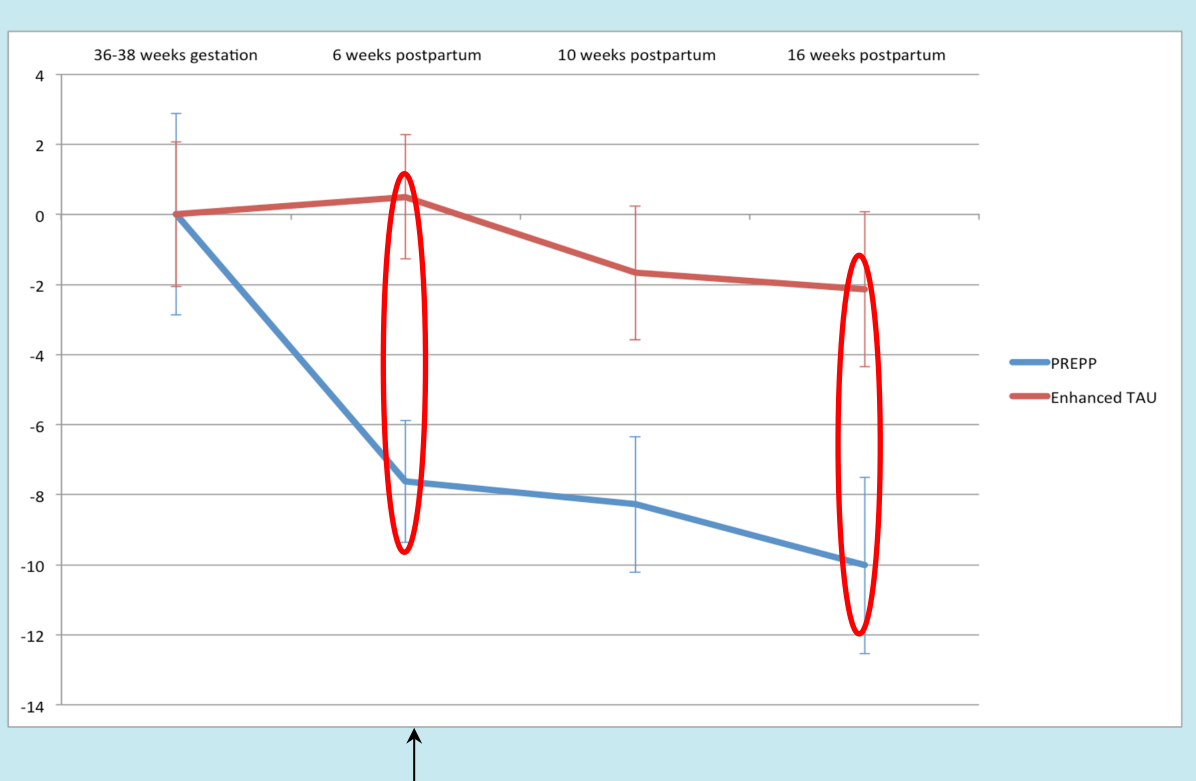
Variable		HRSD B	HRSD SE B	Ham-A B	Ham-A SE B	PHQ-9 B	PHQ-9 SE B
Intercept		14.21***	2.00	14.01***	1.95	7.78***	0.84
Main Effects							
Intervention Group[a]		4.27	2.87	5.34†	2.79	-1.26	1.18
Time[b]	6 weeks postpartum	3.02	2.46	0.24	2.41	2.44*	1.05
	10 weeks postpartum	-1.06	2.53	-2.10	2.47	0.41	1.07
	16 weeks postpartum	-3.42	2.43	-2.43	2.67	-0.82	1.18
Interaction Effects							
Intervention Group*Time	6 weeks postpartum	-9.56**	3.51	-8.07*	3.44	-1.83*	1.52
	10 weeks postpartum	-6.17†	3.47	-6.67†	3.60	-0.11	1.55
	16 weeks postpartum	-4.11	3.94	-7.69*	3.60	-2.20	1.75

***Note:** *p < .05, **p < .01, †p < .10. [a]0 = Enhanced Treatment as Usual, 1= PREPP. [b]The reference group for all time effects is 36-38 weeks gestation (prior to randomization). HRSD = Hamilton Rating Scales for Depression, Ham-A = Hamilton Rating Scales for Anxiety, PHQ-9 = Patient Health Questionnaire.*

Werner et al. (2016)
Hamilton Rating Scales for Depression Change Scores: ETAU versus PREPP

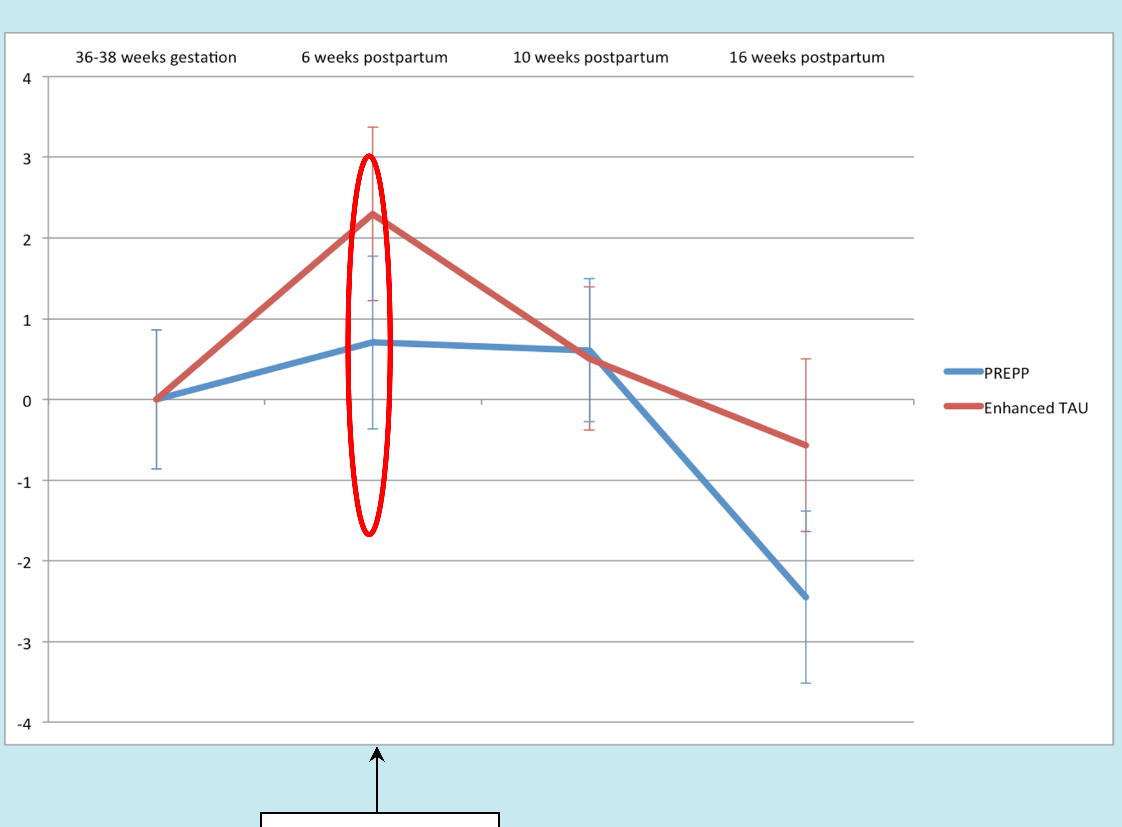


Werner et al. (2016)
Hamilton Anxiety Rating Scales Change Scores: ETAU versus PREPP



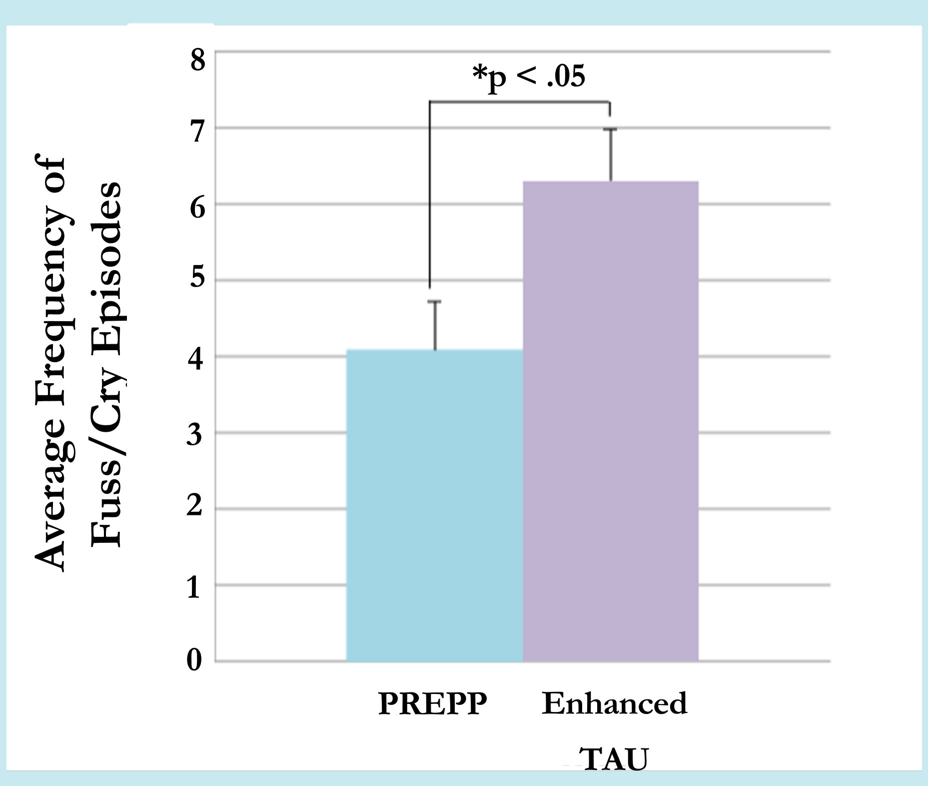
Intervention Ends

Werner et al. (2016)
Patient Health Questionnaire- 9 Change Scores: ETAU versus PREPP



Intervention Ends

Werner et al. (2016)
PREPP Associated with Less Infant/Fuss Cry Behavior at 6 weeks Old



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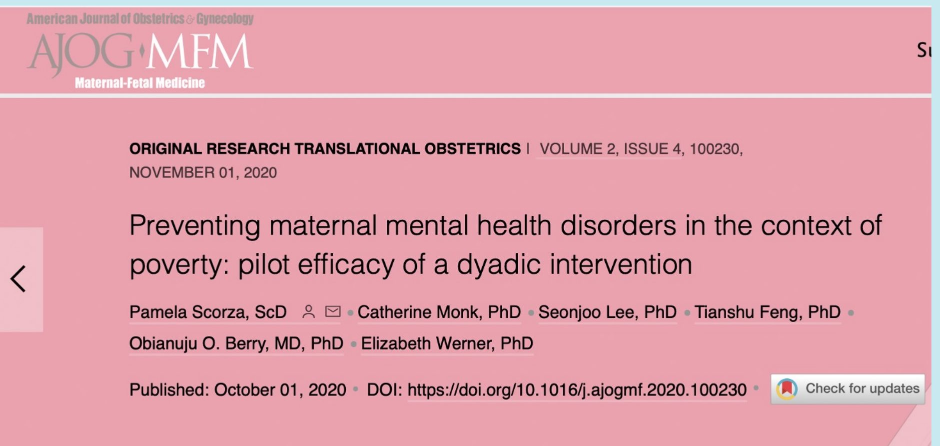
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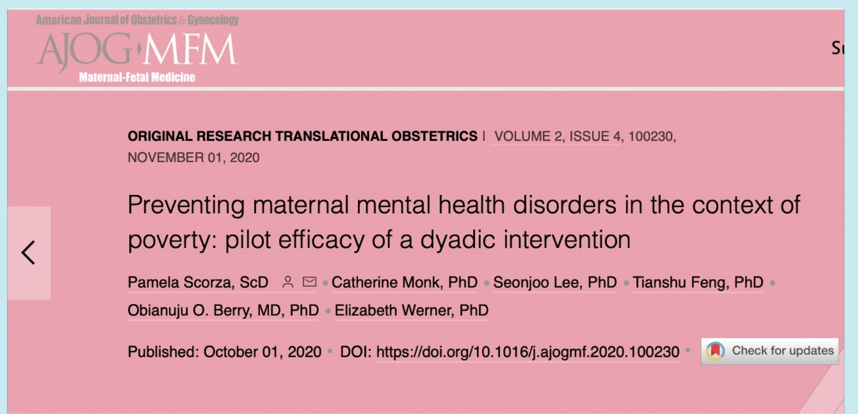
- Poverty is a risk factor for PPD
- Eligibility criteria included: Salary self-reported to be at standardized level of *"Near poor, struggling"* or lower (233% of national poverty levels, based on income criteria for Medicaid

Poverty is a Risk Factor for PPD

- Low SES was associated with increased depressive symptoms in late pregnancy and at 2 and 3 months postpartum. (Goyal et al., 2010)
- Women with four SES risk factors (low monthly income, less than a college education, unmarried, unemployed, unstable housing) were 11x more likely than women with no SES risk factors to have clinically elevated depression scores at 3 months postpartum. (Goyal et al., 2010)
- Subjective SES was the most consistent predictor of PPD, being significantly associated with major PPD at 6 months postpartum (Dolbier et al., 2013; Mukherjee et al., 2017).

Scorza et al. (2020): Efficacy Data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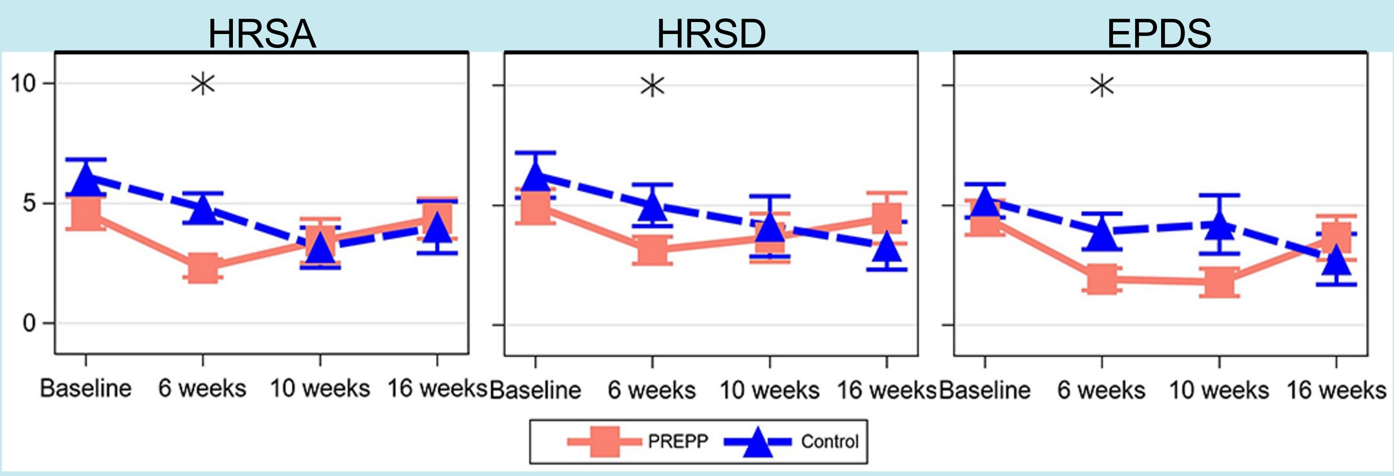
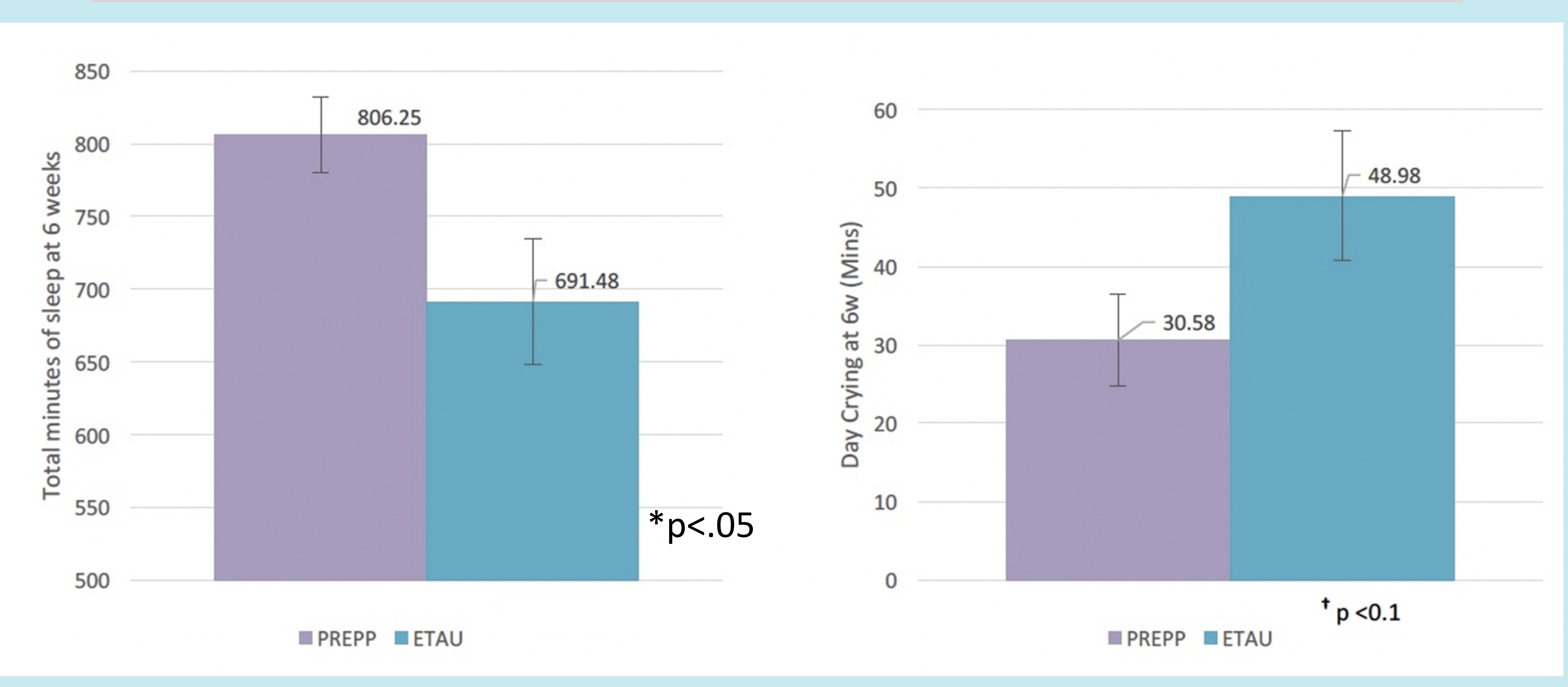
- 84% Latinx
- Age: 18-45 years old, average = 28 years old
- SES: (1) salary "near poor, struggling" (200% of national poverty levels) — $47,700 annually for a family of four, based on self-report—or (2) having met the income criteria for Medicaid
- 100% Medicaid for insurance
- Baseline depressive symptom relatively low
  - Average of 4.8 on the EPDS, 30 max, 10 possible depression
- Adherence: 83% completed PREPP intervention

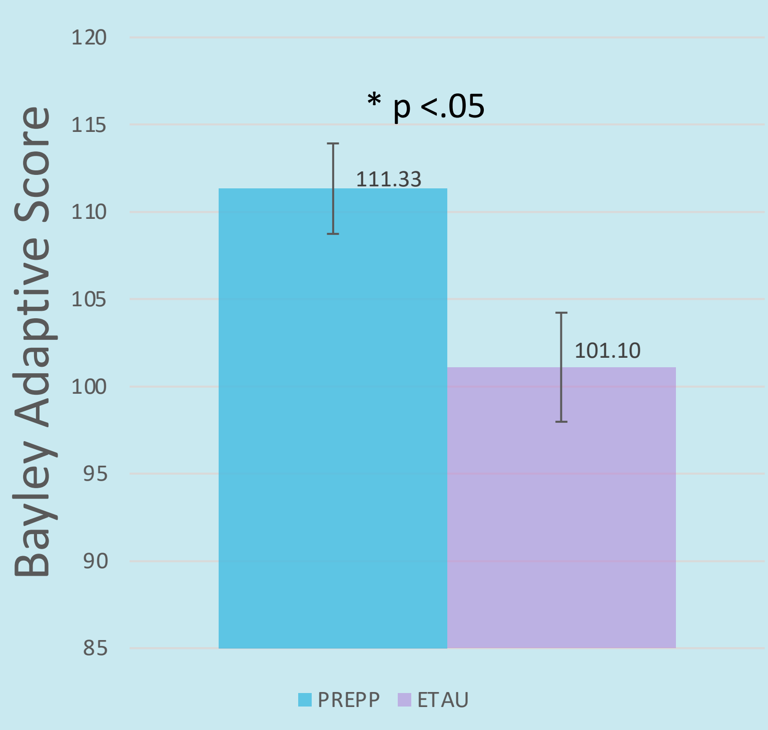
Scorza et al. (2020)



Scorza et al. (2020)
PREPP Associated More Infant Daily Sleep and Less Day Crying at 6 weeks Old

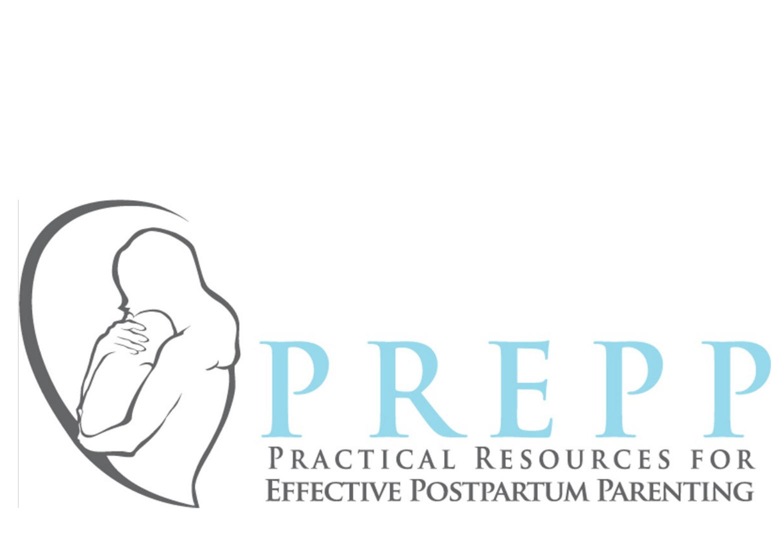


Scorza et al. (2020)
PREPP Associated with Higher Infant Development at 4 months old: Bayley Adaptation Score



PREPP Clinical Conclusions

- PREPP is a feasible clinical protocol
  - No/low drop out for PREPP sessions
- PREPP reduces sxs of depression and anxiety in birthing parents at risk for PPD (even for subthreshold sxs)
- PREPP may have an effect on infant behavior
- Preventative interventions for PPD should address the parent-infant dyad



PREPP Concluding Thoughts

Two RCTs show PREPP has positive effects on parents at risk for PPD.

PREPP increases accessibility to PPD treatment through:

- Few sessions in conjunction with routine perinatal medical visits
- Reducing stigma by calling therapists "coaches," focusing on dyad and infant behavioral interventions
- Low-Cost
- Different types of health providers can be trained in PREPP

Concluding Thoughts

- PREPP, ROSE, and Mothers & Babies are effective, evidence-based preventative measures for PPD.
- There is a two-generation, lasting impact of leaving PPD untreated; prevention is essential.
- Accessible prevention will not only improve parents' lives but also the lives of future generations.

Interested in receiving PREPP training?

Go to: https://www.perinatalpathways.org/prepptraining

Trainings are:

- Straightforward
- Tailored to the intended clinical population
- Customized to the trainee's experience & previous training
- Can be 100% virtual

Requires ~8 training hours and a 1 hour certification assessment.

Our previous trainees have come from a variety of clinical backgrounds.

- Clinical Psychologists
- Psychiatrists
- Occupational Therapists
- Social Workers
- Case Managers
- Community Health Workers
- Nurse Practitioners
- NP Students
- Social Work Student
- Masters Psychologist

Mental health providers & other clinicians from all over the U.S. & around the world have been trained in PREPP

ZERO TO THREE
Early connections last a lifetime

COLUMBIA UNIVERSITY
DEPARTMENT OF OBSTETRICS
AND GYNECOLOGY

PERSON TO PERSON
CLINICAL SERVICES

If you are interested in more information, you can contact:

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or visit the Perinatal Pathways website

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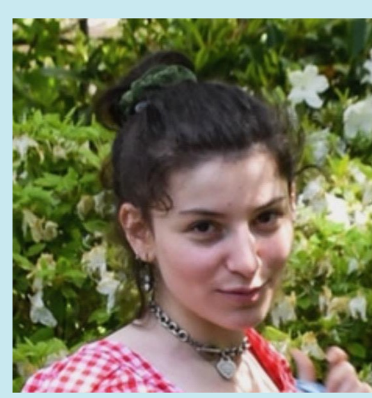

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