Honoring Pregnancy: Responding to Maternal and In-Utero Needs for Mothers and Babies

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Who am I?

- I am a licensed child psychologist who specializes in infant and early childhood mental health and trauma.
- I'm an Indian American mother to two biracial boys (ages 6 and 3).
- I am a state trainer in Child-Parent Psychotherapy and the DC:0-5 diagnostic system. I am also nationally-certified to provide multiple evidence-based treatments for trauma.
- I am a strong supporter of the Safe Babies Court Team model and have engaged with the Pulaski County Safe Babies Court Team in Arkansas for several years.
- I co-direct the Arkansas Building Effective Services for Trauma Program (ARBEST), a legislatively funded program that aims to improve outcomes for children and families who have experienced trauma through excellence in clinical care, evaluation, training, and advocacy

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Objectives

1. Understand the heightened risk for mental and physical health difficulties during pregnancy and the post-partum period
2. Recognize especially vulnerable populations for perinatal health challenges
3. Understand the impact of environmental and maternal factors on growing babies
4. Empower teams to utilize this knowledge to better serve growing families in their communities

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The Perinatal Period and Mental Health

"Perinatal" refers to woman's health during pregnancy and the postpartum period (6 weeks to 1 year after birth, depending on the utilized definition)

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The Perinatal Period and Mental Health

This period of time represents an especially vulnerable period for **new and recurrent** episodes of sever mental illness

- 1-2 of every 1,000 women will require a psychiatric admission in the first few months after birth. Women are 22x more likely to have a psychiatric admission in the month following birth than in the pre-pregnancy period. This is true for women with and without prior mental illness, though it is more risky for those with pre-existing mental health concerns (ex: 20% of women with pre-existing Bipolar Disorder have a severe postnatal episode).
- 12% depression incidence (new cases) and 17% prevalence (previous history of depression); 10% prevalence for anxiety
- This generation of mothers report higher depression than mothers 25 years ago: depression 51% more likely than 25 years ago.
- Young mothers display an approximately 6x fold increase in risk for any mental health condition: 45.1% under the age of 25; 15% for mothers over 25 years.
- Black mothers are at increased risk (ex: postpartum depression rates of 40%, more than double the general population)

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Suicide Risk

- Suicide is the leading cause of death during the perinatal period (5-20% of maternal death) → this is especially true in high-income countries like the United States.
- Most risky time is the second half of the first postpartum year (baby is 6-12 months of age).
- 50% of women who die by suicide during the perinatal period experience domestic violence (this is not accounting for deaths from domestic homicide).
- Suicide rate is dramatically increased for women who have moderate to severe mental illness (289x the rate of suicide in mothers with no psychiatric history), with the highest risk amongst women with severe depression.

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Physical Symptoms and Mental Health Difficulties

- Risk factors for mental health difficulties overlap with risk for physical illness (e.g., poverty, interpersonal violence, poor access to prenatal/postnatal care, hypertension, smoking, gestational diabetes).
- Women with severe mental illness during pregnancy have increased rates of physical health/birth complications, including pre-eclampsia, hemorrhage, placental abruption, and still-birth. This risk exists regardless of prescribed medication use.
- Common misattribution of physical symptoms of life-threatening complications (such as pulmonary embolism) to mental health conditions, like anxiety.

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What about Fathers?

- Relatively little research.
- Growing evidence that paternal mental illness negatively impacts maternal mental health and puts children at greater risk for emotional and behavioral difficulties.
- Between 5–10% of fathers experience perinatal depression and 5–15% experience perinatal anxiety
- It is increasingly recognized that fathers may also experience post-traumatic stress symptoms following the birth
- Men don't have natural access to healthcare in the perinatal period the way women do (such as prenatal appointments, child pediatric appointments)

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Understanding Uniquely Vulnerable Populations

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Recognizing Vulnerable Mothers

- Mothers with significant trauma histories
- Black mothers

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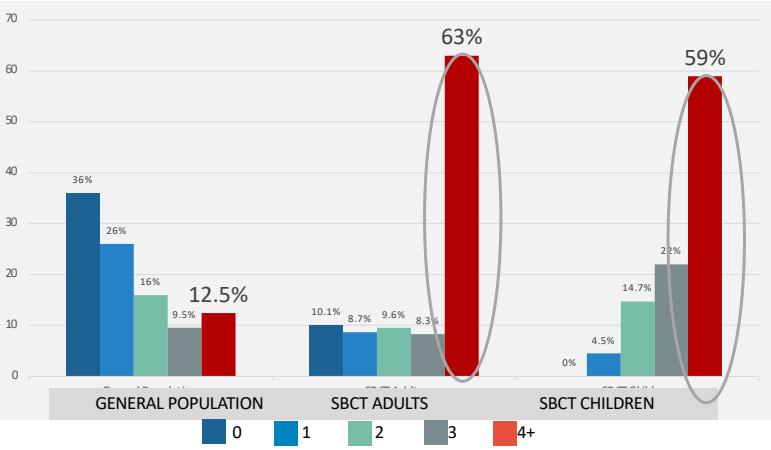
Prior Trauma History: Adverse Childhood Experiences



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4 or more ACEs

- **3x** the levels of lung disease and adult smoking
- **11x** the level of intravenous drug abuse
- **14x** the number of suicide attempts
- **4x** as likely to have begun intercourse by age 15
- **4.5x** more likely to develop depression
- **2x** the level of liver disease

People with 6+ ACEs can die

20 yrs

earlier than those who have none

1/8 of the population have more than 4 ACEs

https://www.wavetrust.org/adverse-childhood-experiences

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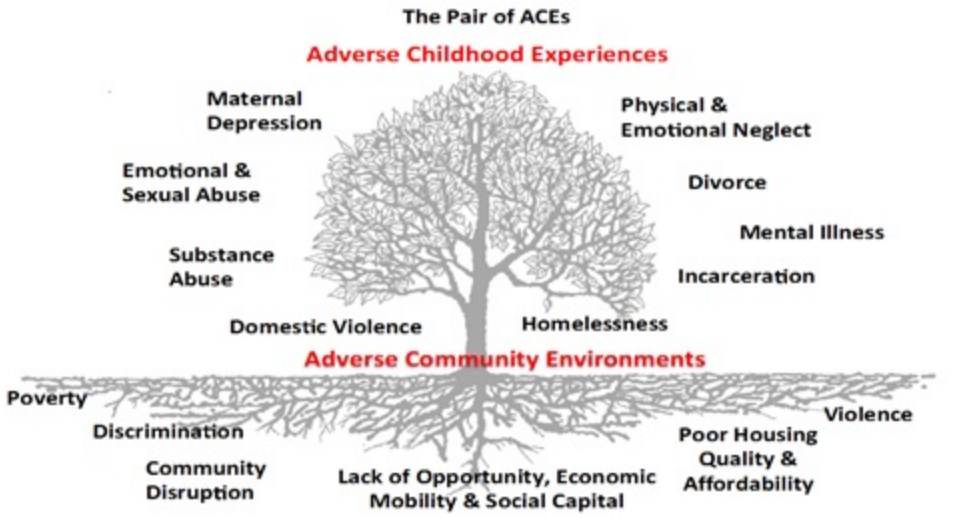

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Understanding the Risk for Black Mothers

- Black mothers are at heightened risk for perinatal physical and mental health difficulties, due to the following often occurring:
  - Lack of access to high-quality medical care
  - Higher risk of pregnancy and childbirth complications
  - Lack of social support
  - Gaps in medical insurance
  - Financial barriers, including lack of paid time off from work
  - Unsafe neighborhoods
  - Increased stress
  - Exposure to trauma

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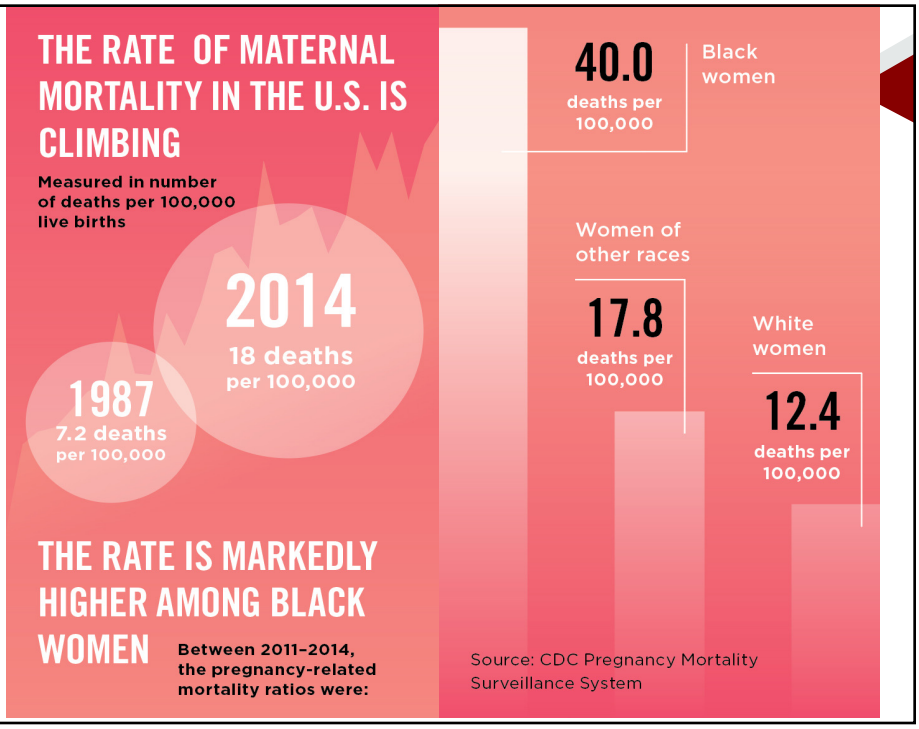
Black Mortality Risk

60% of all pregnancy-related deaths in the USA are considered "preventable"



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The Intersection between Race, Perinatal Health, and Child Welfare

- **Child welfare carries cultural ghosts associated with historical trauma (e.g., slavery).**
  - Black children account for 40% of cases in child welfare (despite being 12% of the population).
  - Recent studies have found that, although Black families on average tend to be assessed at lower risk than White families, they are still 15% more likely to have substantiated cases of maltreatment, 20% more likely to have cases opened, and 77% more likely to have their children removed instead of starting an in-home supportive services case.
  - Neglect is still the predominant form of maltreatment in the country, which is heavily influenced by low access to resources and higher levels of monitoring experienced by Black families.
- **There is valid Black mistrust of healthcare systems**
  - Black mothers are routinely mistreated within healthcare, including ignoring physical complaints, misattributing physical complaints to mental health, or exaggeration (implicit bias)
  - Some medical textbooks still include inaccurate information about Black individuals having a higher threshold for pain and this contributes to physician inaction in the face of Black pain
  - 3-4x more likely for Black women to die from pregnancy-related factors than White women
  - Infant mortality rate is 2.4x more likely in Black infants

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The Impact of Perinatal Mental Health on Babies

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The Impact of Perinatal Mental Health on Infants

- **Substance Abuse:** cognitive impairment,
- **Depression:** cognitive and behavioral problems, increased risk for ADHD and Autism
- **Anxiety:** emotional problems (slight increase). Mothers report difficulties bonding that are not necessarily observed by a neutral party during parent-child interactions.
- **Personality Disorders:** greater dysregulation in babies, less sensitive parenting that is observable by a neutral party, but not likely to be perceived by mother.
- **PTSD:** reduced maternal sensitivity

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How is mental health risk transmitted from mothers to children?

- **Biological:** higher rates of in-utero cortisol (maternal distress) linked to HPA axis sensitivity (stress pathways in the body), neurodevelopmental and mood disorders, and cognitive delays (this cannot be explained by any postnatal factors, parenting, socioeconomic factors).
- **Genetic:** epigenetic changes lead to fetal sensitization (how genes are expressed, not DNA changes)
- **Parenting/Attachment:** less maternal sensitivity and attunement, greater harsh/rejecting parenting

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How can we help?

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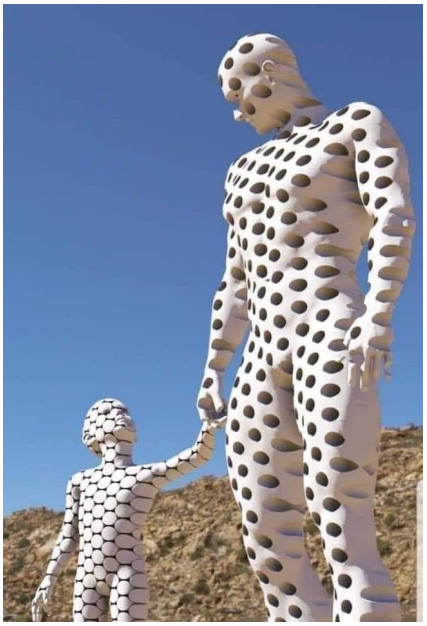

Fostering Resilience in Children Means Investing in the Adults who Support Them

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The trouble is that once you see it, you can't unsee it. And once you've seen it, keeping quiet, saying nothing, becomes as political an act as speaking out. There's no innocence. Either way, you're accountable.

— Arundhati Roy —

AZ QUOTES

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Be Aware of Intersectionality

- Recognize that members of our communities are at heightened risk during the perinatal period due to their identity (e.g., gender/sexual orientation, immigration status, disability status, race, socioeconomic status).
- Understand that the child welfare system is especially terrifying for some mothers, which leads to greater risk of hiding pregnancies and delaying care.
- Several websites exist to help individuals understand and work to correct bias.
  - http://kirwaninstitute.osu.edu/implicit-bias-training/
  - https://www.racialequitytools.org/resources/act/communicating/implicit-bias

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Facilitate access to family planning services

- Family planning policy has a complicated and harmful history of racism, including:
  - Experimentation without informed consent on Puerto Rican women in the development of the oral contraceptive.
  - Coercion of poor women, who in the U.S. are disproportionately women of color, to use long-acting contraceptives (LARC) like Norplant and Depo-Provera in order to receive social assistance.
  - Biases in providers more likely to recommend IUDs to poor women and women of color compared to wealthy and/or White women.
- Unsurprisingly, Black women have lower rates of contraception use than White women and report less routine access to family planning within preventative care.

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Proactively Create Emotionally-Safe Environments for Pregnancy

- Proactively provide information to mothers about what would happen if they were to become pregnant during their child welfare case.
- Check-in on perinatal health during family team meetings/staffings.
- Hold yourself and colleagues accountable for implicit bias and ways we might be approaching pregnancy differently, depending on identity factors within mothers we serve.
- Focus on the positive impact that seeking perinatal healthcare could have on baby's development, as opposed to focusing on punitive consequences if mothers do not seek care.

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Use visuals and resource lists to support pregnant mothers within the community

- Post information about perinatal health in spaces mothers commonly go (e.g., rooms in DHS office used for visitation, the physical space of family team meetings).
- Maintain a list of pregnancy-related community resources that can be proactively suggested to mothers.
- Empathize with the natural avoidance that occurs in mothers to seek out resources. Partner with them to help them understand the benefit of services and provide concrete support to help them access resources.

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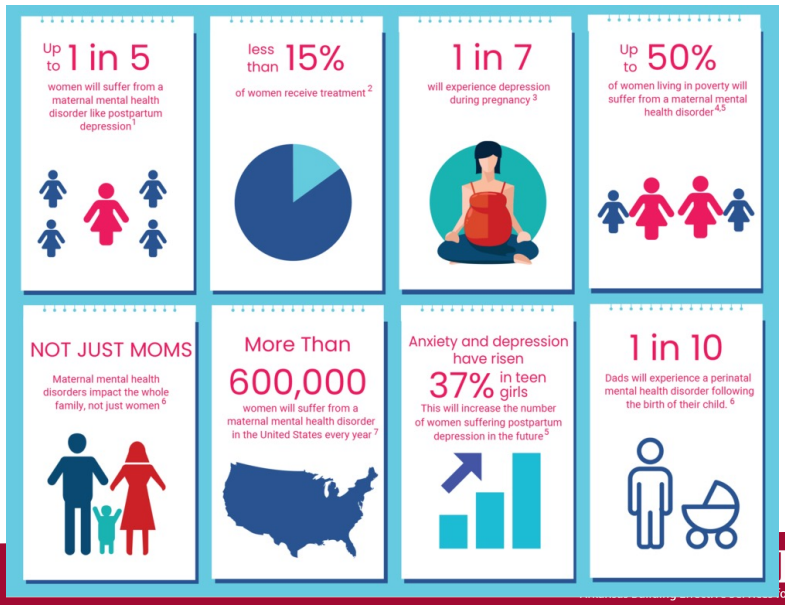
Consider Simple Graphics Instead of Words Alone



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Building Emotionally Safe Relationships Takes Time

- Relationships build over thousands of moment-to-moment interactions.
- We know we are safe and invested in helping families, so it is often difficult for us when a parent doesn't immediately trust our intentions.
- Remember, perceptions of threat are often heightened for those who have experienced trauma.
- We are also associated with a system that is mistrusted by members of our community.
- Ask yourself: what am I doing to create trust? Am I being transparent, genuine, and forthcoming? Am I really listening to the perspectives I am eliciting?

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- "Legacy of Trauma: Context of the African American Existence" https://www.health.state.mn.us/communities/equity/projects/infantmortality/session2.2.pdf
- Racism in Family Planning Care: https://providers.bedsider.org/articles/racism-in-family-planning-care

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Questions?

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