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

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Who am I?

- I'm a cis-gendered woman and Indian American mother to two biracial boys (ages 8 and 5). I am married to a philosophy professor and live in West Little Rock. I was born in New Jersey and was raised by my mother and father, who both immigrated from India in their early 20s. I have a chronic medical condition that I can adequately treat due to good access to medical care and financial stability to afford treatment.
- I'm a licensed psychologist and focus my work on intergenerational trauma and infant and early childhood mental health. I am a state trainer in Child-Parent Psychotherapy and the DC:0-5 diagnostic system.
- I am passionate about embracing cultural humility as a means for improving the care that we provide to children and families.

Who am I?

- I am a strong supporter of the Safe Babies Approach and the Infant Toddler Court Program National Resource Center.
- I have engaged with the Pulaski County Safe Babies Court Team in Arkansas for several years.

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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

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)

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

The Perinatal Period and Mental Health

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

- 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)

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 (3% prevalence rate).
- 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.

Produced by Together Perinatal Reference Group

SUICIDE IS ONE OF THE LEADING CAUSES OF **MATERNAL DEATH**

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.

What about Fathers?

- 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)

What About People who Identify as Trans, Nonbinary, and Gender-Expansive?

- Research, policies, and practice recommendations generally ignore the fact that not all people who give birth are women.
- The limited research available discusses a wide range of experiences in becoming pregnant, navigating pregnancy and access to medical care, giving birth, access to perinatal care, and infant care practices.
- Pregnancy hormones and the perinatal period can interact with gender transition care in complex ways.
- Pregnancy spaces are set up on the gender binary – designed for women.
- Postpartum needs often go unrecognized – baseline rates of many mental health concerns (like depression and suicide) are higher among transgender, non-binary, and gender-expansive people in general and this risk could be heightened in the perinatal period.

Kukura E. Reconceiving Reproductive Health Systems: Caring for Trans, Nonbinary, and Gender-Expansive People During Pregnancy and Childbirth. J Law Med Ethics. 2022;50(3):471-488. doi: 10.1017/jme.2022.88. PMID: 36398635; PMCID: PMC9679586.

Understanding Uniquely Vulnerable Populations

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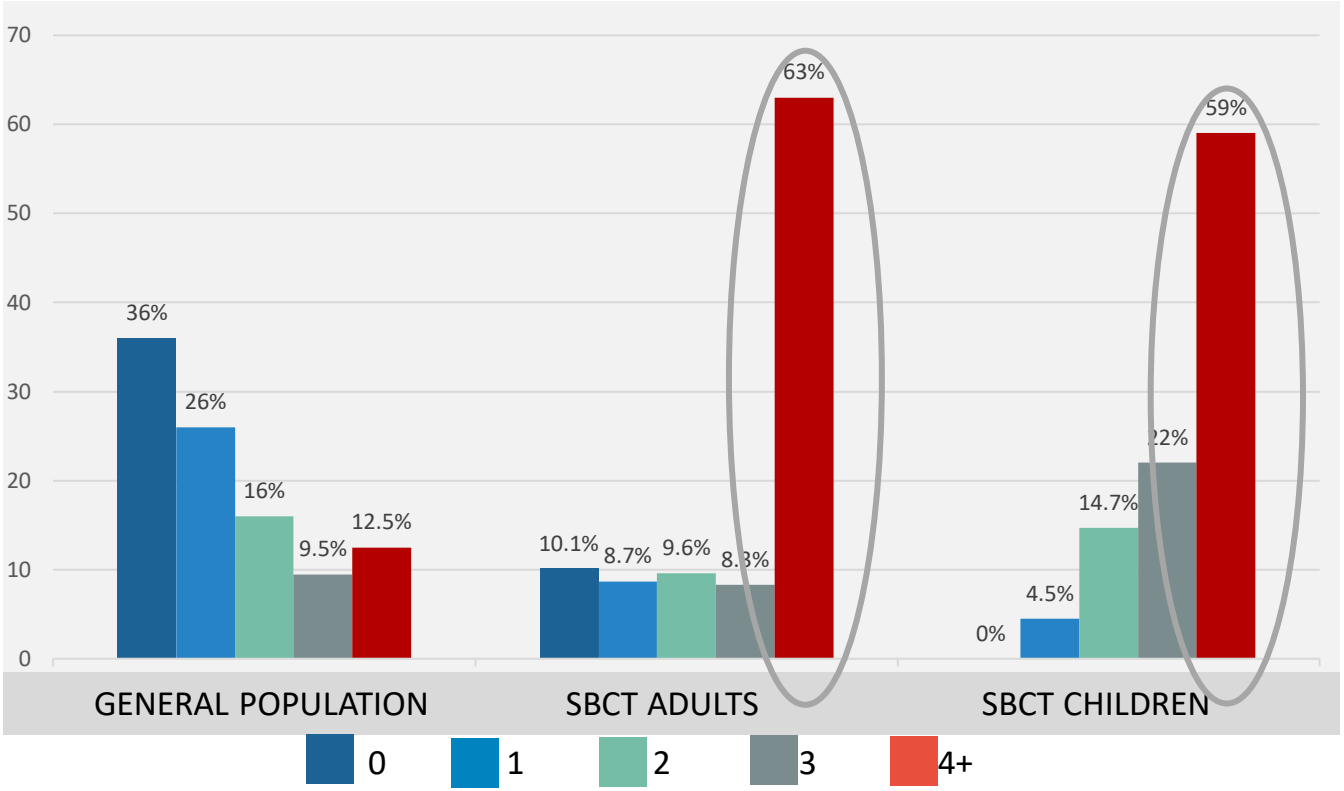
Recognizing Vulnerable Mothers

- Mothers with significant trauma histories
- Black mothers
- Mothers with substance use disorders

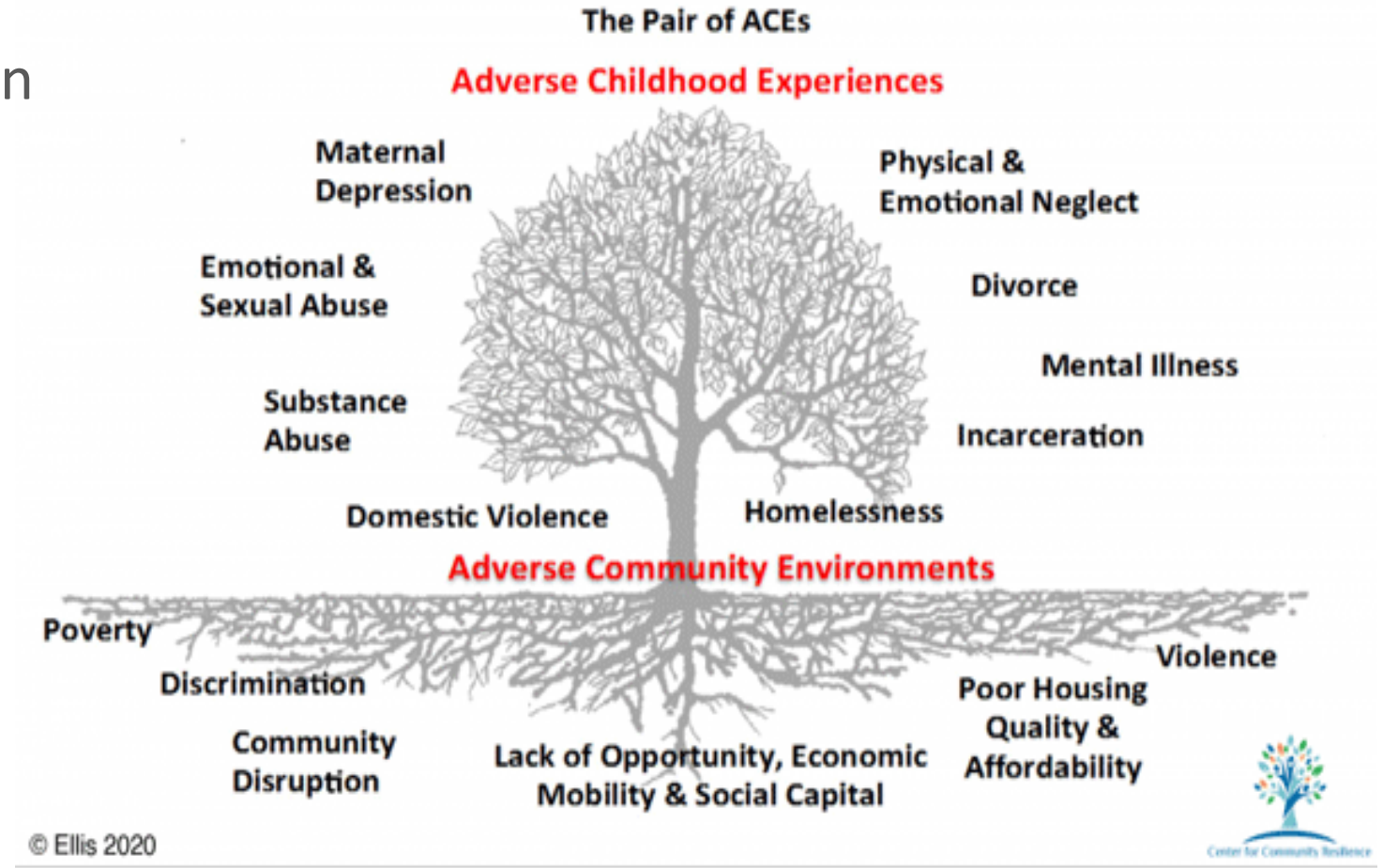
Prior Trauma History: Adverse Childhood Experiences

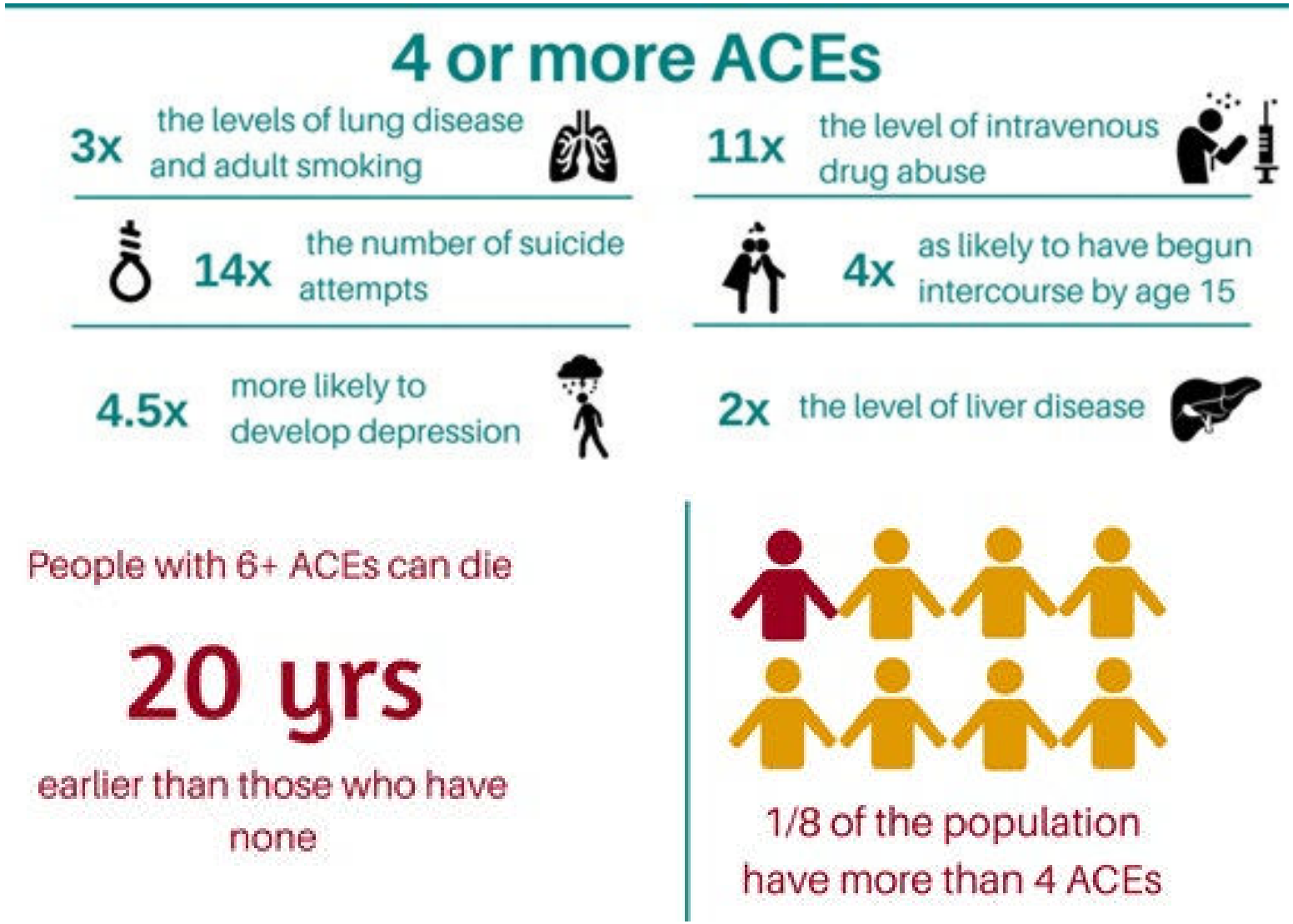


Osofsky, et al. (2018). *The Adverse Childhood Experiences of Very Young Children and Their Parents Involved in Infant–Toddler Court Teams.* Quality Improvement Center for Infant-Toddler Court Teams.

Adverse Child Experiences (ACES)

- Economic hardship
- Parental divorce or separation
- Living with somebody who has an alcohol or drug problem
- Neighborhood violence
- Living with somebody who was mentally ill
- Domestic violence
- Parental incarceration
- Experiences of racism
- Death of a parent





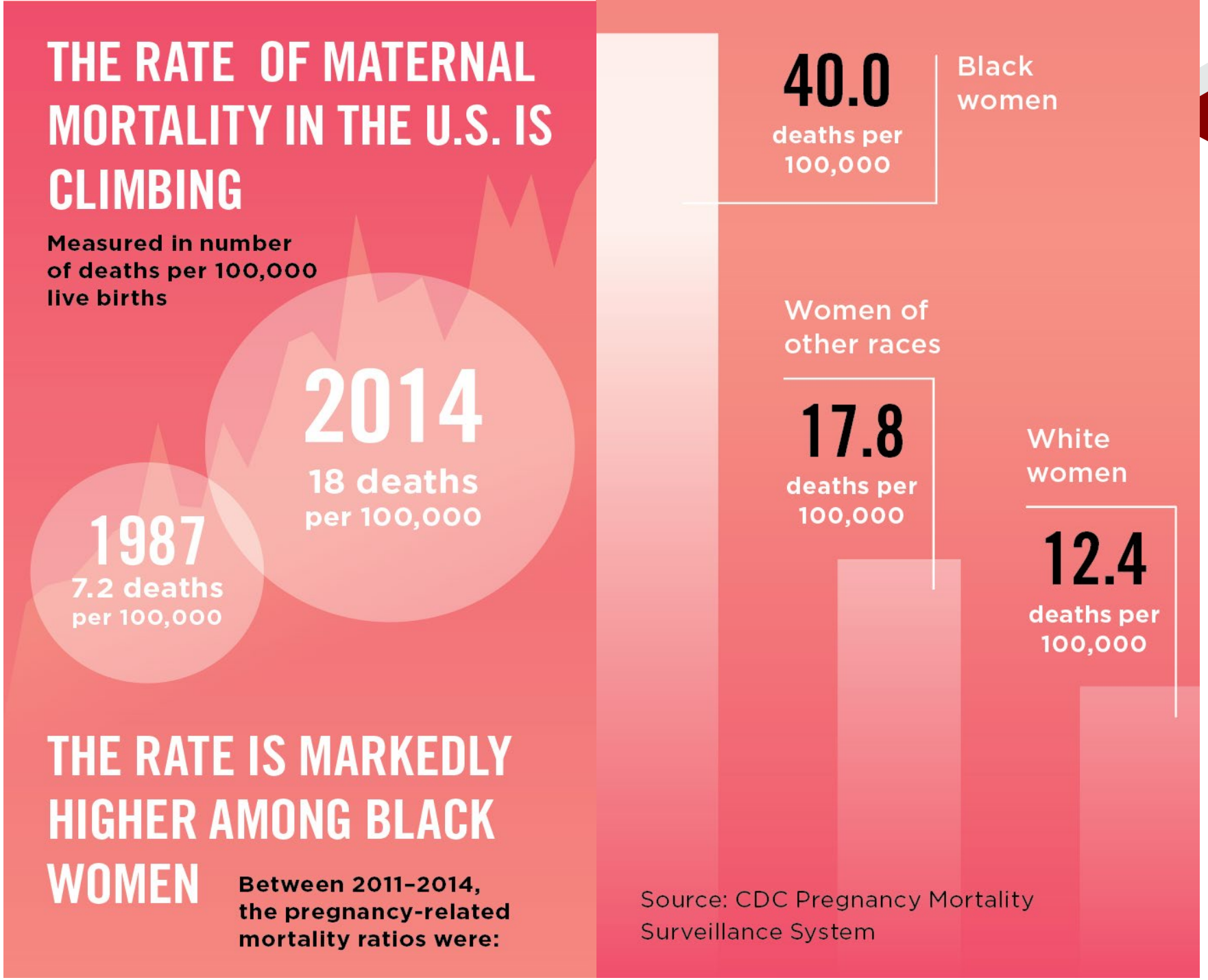
https://www.wavetrust.org/adverse-childhood-experiences

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

Black Mortality Risk

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



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.
- **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

Understanding Mothers with Co-Morbid Substance Use Disorders

- There is a high correlation between substance misuse and mental health difficulties (e.g., 30-60% of individuals with SA have PTSD; 30% with SA have a history of depression).
- Women who stop substance use while pregnant are at high risk for relapse during the postpartum period (triggers related to hormonal changes, sleep deprivation, increased stress). 80% of mothers who were abstinent in the last month of their pregnancy had resumed using at least one substance within two years post-delivery.
- Not all women who use substances during pregnancy have a substance use disorder (consider cultural biases into what we consider "safe" substance use during pregnancy/post-partum → research demonstrates 1/5-1/3 woman drink at some point during their pregnancy). We should examine substance use AND its impact on parenting and safety for the child.

Substance Use and Intersectionality

Understand the intersection between substance use, race, and policy

- **Policy** – Policy surrounding drug use is laden with racism (e.g., until recently, federal penalties for crack cocaine were 100x harsher than powdered cocaine, despite being the same pharmacologically; crack cocaine was much more commonly utilized in communities of color).
- **Access to treatment** - In the 2009 National Survey of Substance Abuse Treatment Services, counties that had no access to outpatient SUD facilities had a higher percentage of residents who were Latinx, living in poverty, uninsured, and living in rural areas.
- **Research** - Funded research in SUD has largely focused on neurobiological etiologies and interventions, and thus the broader social forces that shape SUD-related racial disparities remain understudied.

Woman-Centered Substance Use Treatment

- Women are more likely to enroll and complete substance use treatment when:
  - We allow them to bring their children to residential treatment programs
  - We ensure availability of childcare during treatment
  - We including case management to work on social determinants of health
- Setting matters: Outpatient may be especially helpful for women, due to their heightened childcare and work responsibilities (the only setting in which pregnant mothers retain at a higher rate than non-pregnant women was in outpatient treatment)

The Role of Harm Reduction?

- Harm reduction: focus on reducing drug-related harm without requiring complete cessation of substance use. Basically, approaching change outside of an “all-or-nothing” approach.
- Example: Seat belts, air bags, helmets for bicyclists and motorcyclists are all examples of harm-reduction strategies. These measures neither prevent crashes nor attempt to reduce the high-risk behaviors that lead to vehicle accidents. Instead, the primary goal is simply to reduce the likelihood and severity of injury.
- “Perinatal healthcare providers can make a significant impact on improving pregnancy outcomes by providing non-judgmental supportive care within a harm reduction model to address substance use issues and social determinants of health”

https://publichealth.gwu.edu/sites/default/files/downloads/JIWH/Pregnant_Women_and_Substance_Use_updated.pdf

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

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

How Can we Help?

Call to Action

- Be aware of intersectionality; all mothers are not equally at risk for poor outcomes in the perinatal period
- Facilitate routine prenatal care & family planning
- Understand the need for safe substance abuse treatment during pregnancy
- Proactively provide an emotionally-safe space to discuss pregnancy
- Use visual aids and compile resource lists for pregnancy in your community

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

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.
- Substance-abusing women also report lower use of contraception and greater risk for unintentional pregnancies.

Understand the Need for Safe Substance Use Treatment

- Reinforce to mothers that there are safe ways to treat substance use during pregnancy, including medications they can take to help.
- Openly communicate about the potential benefits of accessing substance use treatment in their current DCFS case.
- Explore residential programs where mothers can be with their children or outpatient programs that cause fewer disruptions to employment and childcare.
- Focus group participants consistently report fear that seeking out substance use treatment during pregnancy will result in their children being removed from their care. In fact, the most commonly-reported way to avoid detection of substance use by providers was for mothers to avoid participating in healthcare.

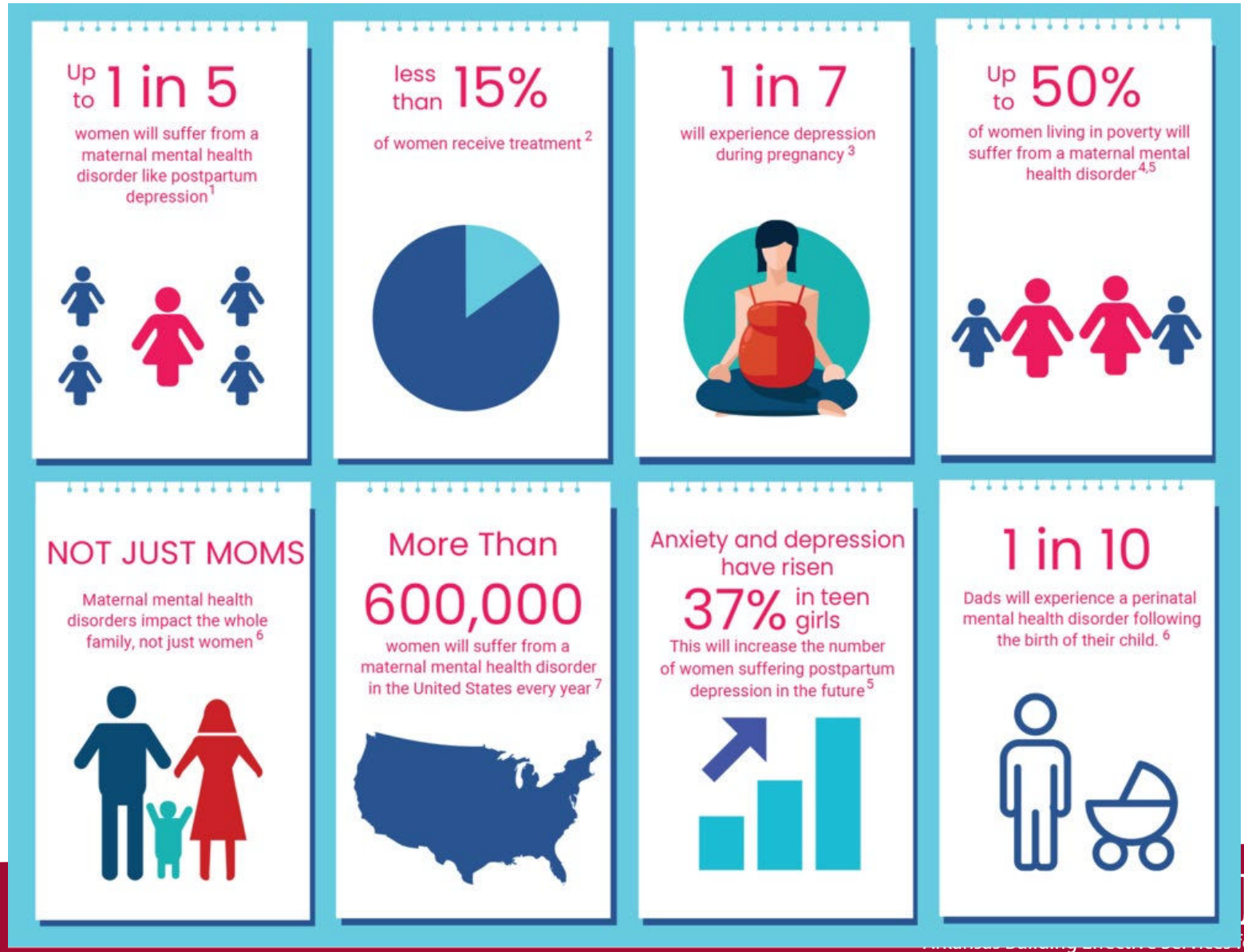
Proactively Create Emotionally-Safe Environments for Pregnancy

- 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.
- 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.
  - "Several women indicated that knowledge of specific health effects would have a powerful impact on their decision to stop marijuana use in pregnancy. In contrast, information about legal consequences seemed to motivate women to have a 'clean' urine test at delivery rather than consider the health consequences of perinatal marijuana use for themselves or their infants"

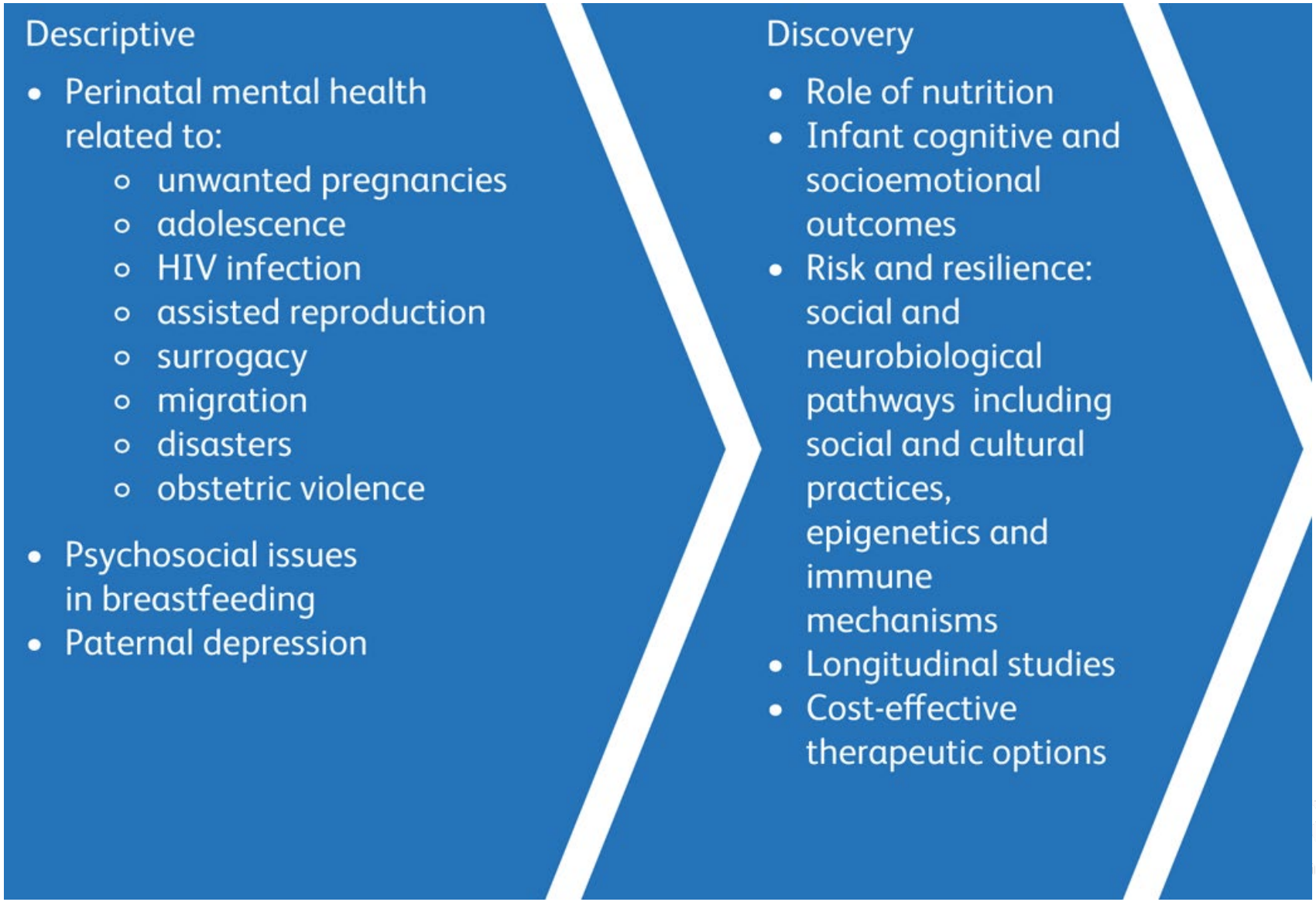
Use visuals and resource lists to support pregnant mothers within the community

- 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.

Consider Simple Graphics Instead of Words Alone



Offering Help Throughout the Perinatal Period



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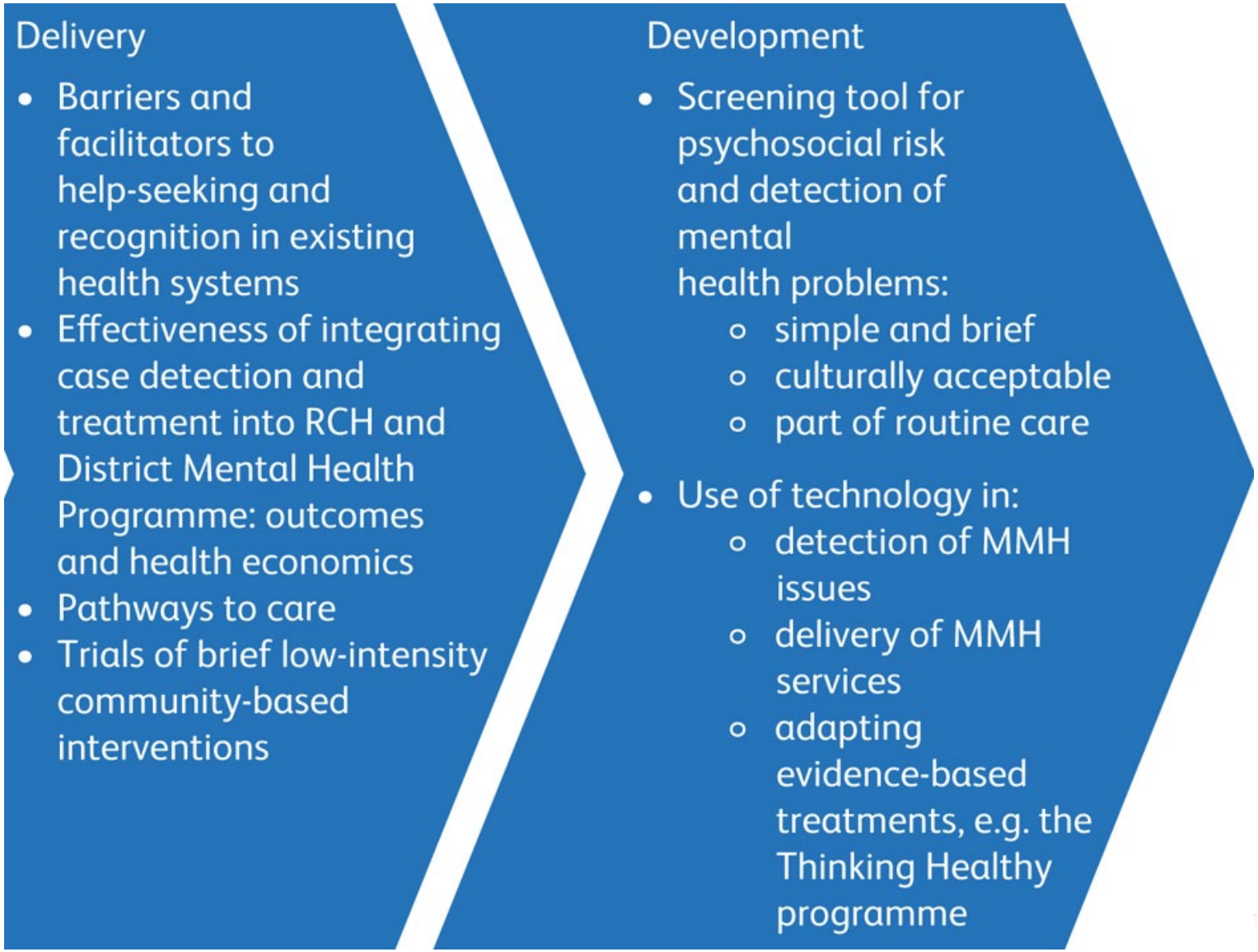
Offering Help Throughout the Perinatal Period



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Reflective Questions

1. What information today made an impact on me? Why do I think this portion was so impactful?
2. How will I intentionally integrate this knowledge within my role?
3. How do I and my team members naturally react to the news that a mother we are serving is pregnant? How does this natural reaction contribute to our team's behavior within caregiver-team interactions?

References

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- National Center for Trauma-Informed Care – www.mentalhealth.samhsa.gov/nctic
- National Scientific Council on the Developing Child at Harvard University - www.developingchild.net
- "Legacy of Trauma: Context of the African American Existence" https://www.health.state.mn.us/communities/equity/projects/infantmortality/session2.2.pdf
- Pregnant Women and Substance Use White Paper - https://publichealth.gwu.edu/sites/default/files/downloads/JIWH/Pregnant_Women_and_Substance_Use_updated.pdf
- Racism in Family Planning Care: https://providers.bedsider.org/articles/racism-in-family-planning-care

Questions?

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