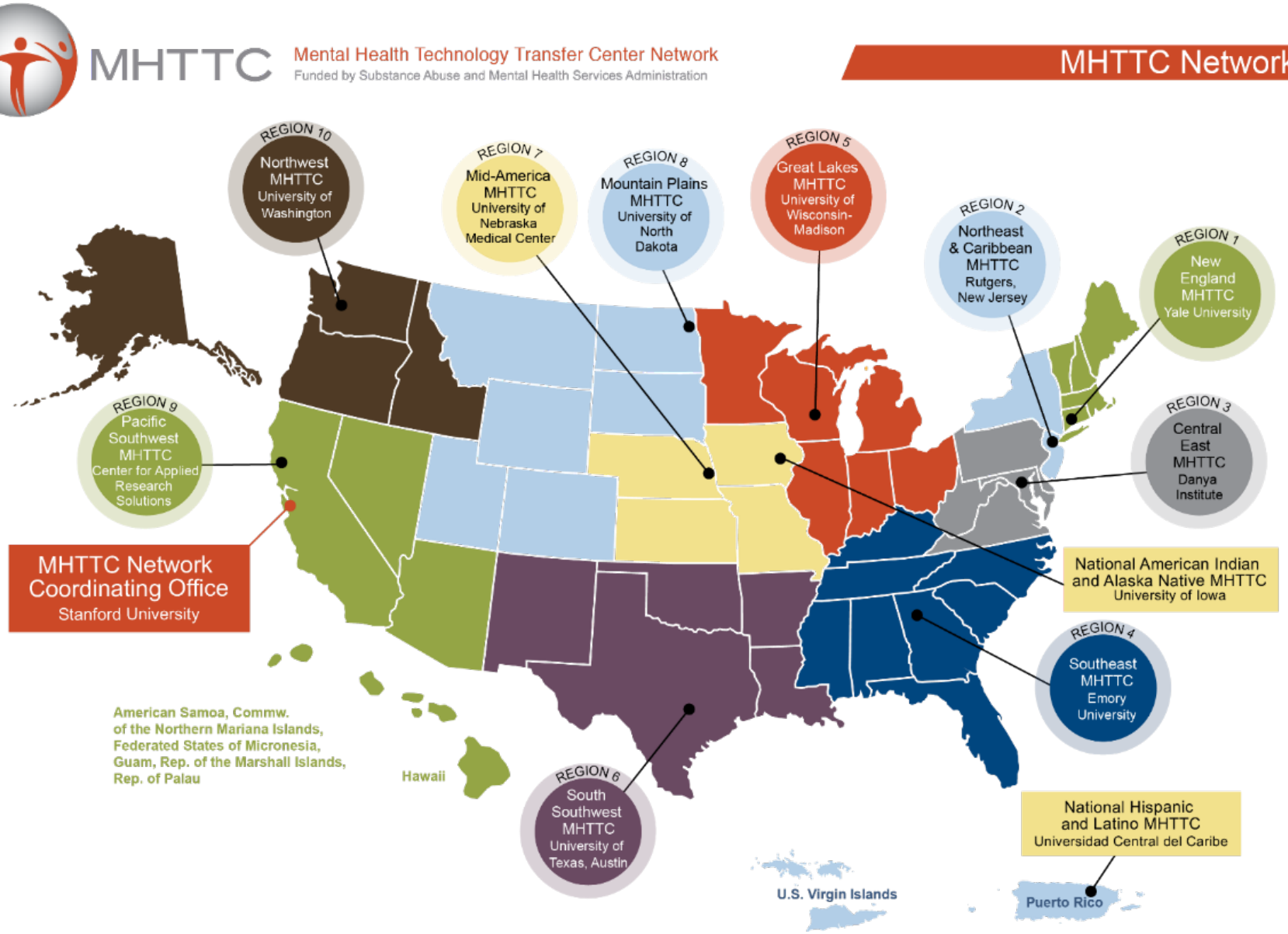
Maternal Child Mental Health in the Black Community

Tiffani L. Bell, MD

May 6, 2021

Central East (HHS Region 3)
MHTTC
Mental Health Technology Transfer Center Network
Funded by Substance Abuse and Mental Health Services Administration

MHTTC Network



MHTTC Purpose

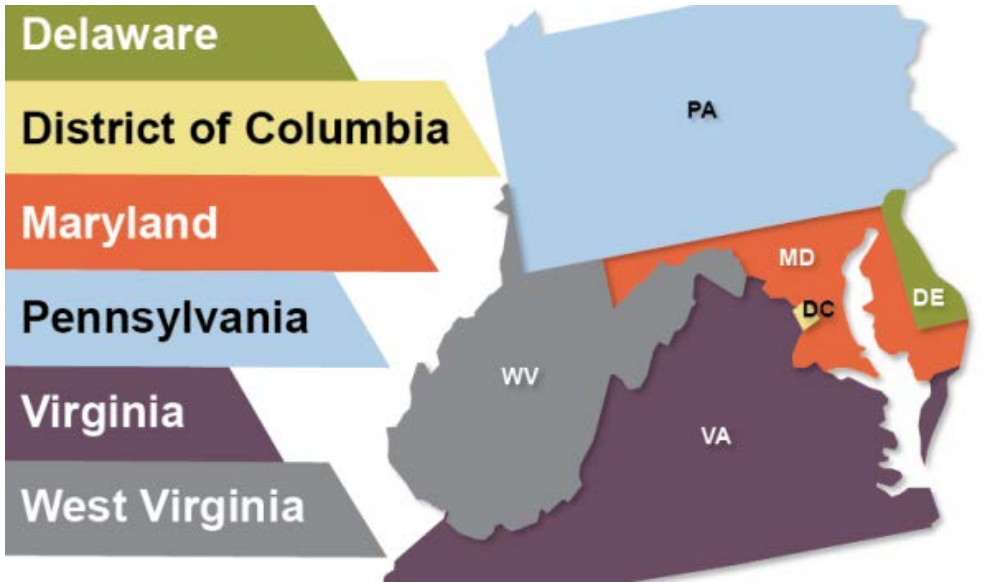
The MHTTC Network vision is to unify science, education and service to transform lives through evidence-based and promising treatment and recovery practices in a recovery-oriented system of care.

Central East MHTTC Goals

Funded by SAMHSA to:

- Accelerate the adoption and implementation of mental health related evidence-based practices
- Heighten the awareness, knowledge, and skills of the behavioral health workforce
- Foster alliances among culturally diverse practitioners, researchers, policy makers, family members, and consumers
- Ensure the availability and delivery of publicly available, free of charge, training and technical assistance

Central East Region 3



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Maternal Child Mental Health in the Black Community

Tiffani L. Bell, MD, FAPA, Diplomate of ABOM, ABLM
Eastern Trustee, Black Psychiatrists of America

Health Equity Webinar Series
A Collaboration of the Central East MHTTC and the Black Psychiatrists of America

May 6, 2021

Moderator:
Annelle B. Primm, MD, MPH
Black Psychiatrists of America, Council of Elders

COVID-19: Unprecedented Disaster

- Disproportionate impact on Black and other marginalized communities with excess illness, death and unemployment on top of pre-existing inequities in the social determinants of health
- Devastating impact on women economically, high pressure related to lack of childcare, and the need to supervise children's virtual education
- Social isolation and online learning has had a negative effect on mental health of children and youth

Today's Program

- Special thanks to the Central East MHTTC for its support of this seventh webinar in the Black Psychiatrists of America Health Equity Series
- Today's program features Tiffani Bell, MD, Board Member of the Black Psychiatrists of America

MATERNAL CHILD MENTAL HEALTH IN THE BLACK COMMUNITY

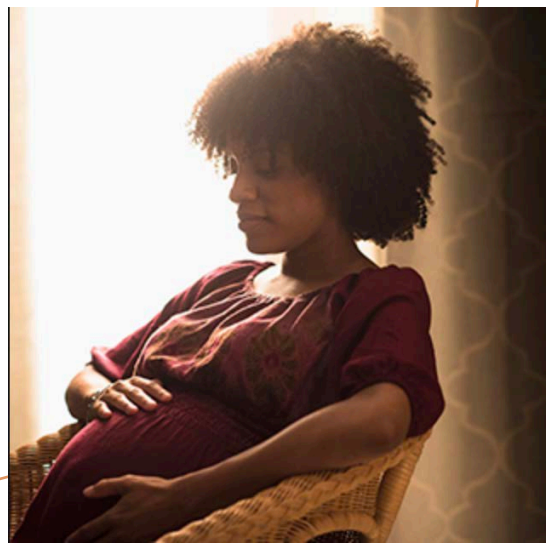
TIFFANI BELL MD, FAPA, DIP. ABOM, DIP. ABLM

BLACK PSYCHIATRISTS OF AMERICA

EASTERN TRUSTEE

LEARNING OBJECTIVES:

- 1. Identify the signs and symptoms of common maternal mental health issues.
- 2. Identify the signs and symptoms of common mental health issues in childhood.
- 3. Describe the importance of treating the mother-child dyad
- 4. Describe the pharmacological and non-pharmacological treatments available



POLL QUESTIONS

1. Maternal mortality in the U.S. is higher than in any other developed country and roughly 60% of the deaths are preventable. True/False
2. According to the CDC, Black mothers are two times more likely than White moms to die from complications during pregnancy or childbirth. True/False?
3. Postpartum Blues happens to most mothers and usually lasts just as long as Postpartum Depression. True/False
4. What percentage of Black mothers suffer from postpartum depression?
    a. 10%
    b. 20%
    c. 40%
    d. 60%
    e. 80%
5. Having a father who is not depressed can compensate for the adverse effects of maternal depressive symptoms on their children. True/False

Our Black maternal health crisis is an American tragedy

APR 15, 2021

Susan R. Bailey, MD

President

BLACK MATERNAL-CHILD HEALTH

- Black women are more than 3-4 times more likely to have a maternal death than white women in the United States
- Black infants make up just 15% of all births in the United States but account for 29% of all deaths
- ~700 pregnancy-related deaths occur each year, 2/3 of these deaths are considered to be preventable.
- In general, women with higher education tend to have lower preterm birth rates, but Black women who graduated from college have a higher risk of preterm birth than white women who dropped out of high school

HEALTH EQUITY

- Strive for the highest possible standard of health for all people AND give special attention to the needs of those at greatest risk of poor health.
- Social Determinants of Health can *positively or negatively* influence health equity.
  - Income, Education, job insecurity, food in/security, exposure to crime, housing, early childhood development, impact of racism, access to quality affordable health services.

Our Zip Code affects our life expectancy more than our Genetic Code!

Tejada-Vera B, Bastian B, Arias E, Escobedo LA., Salant B, Life Expectancy Estimates by U.S. Census Tract, 2010-2015. National Center for Health Statistics. 2020.

New mothers with low SES are twice as likely as higher SES mothers to *develop new onset depressive symptoms* at three months postpartum.

Women with four SES risk factors (low monthly income, less than a college education, unmarried, unemployed) were 11 times more likely than women with no risk factors to have clinically elevated depression scores at three months postpartum.

COMMON MATERNAL PSYCHIATRIC ISSUES

Worldwide ~10% of pregnant women and 13% of postpartum women experience an episode of mental illness. Depression & anxiety are the most common psychiatric disorders associated with pregnancy.

- Perinatal depression
- Perinatal anxiety
- Perinatal OCD
- Postpartum psychosis

PERINATAL DEPRESSION

- **Perinatal depression** – from conception to around one year after giving birth.
- About **1-2 out of every 10 women** will experience postpartum depression after delivery.
- **Postpartum Blues** – 50-85% of women experience Postpartum Blues. It should last less than 2 weeks. Women with the blues typically report mood lability, tearfulness, anxiety or irritability (not as much sadness).
    - These symptoms do not interfere with a woman's ability to function. *No specific treatment is required*

DEPRESSIVE SYMPTOMS

- Persistent sad, anxious, or "empty" mood
- Irritability
- Feelings of guilt, worthlessness, hopelessness, or helplessness
- Loss of interest or pleasure in hobbies and activities
- Fatigue or abnormal decrease in energy
- Feeling restless or having trouble sitting still
- Difficulty concentrating, remembering, or making decisions
- Abnormal appetite, weight changes, or both
- * Difficulty sleeping (even if baby is sleeping), awakening early in the morning, or oversleeping
- * Aches or pains, headaches, cramps, or digestive problems that do not have a clear physical cause or do not ease even with treatment
- *** Trouble bonding or forming an emotional attachment with the new baby
- *** Persistent doubts about the ability to care for the new baby
- **Thoughts about death, suicide, or harming oneself or the baby**

The Edinburgh Postnatal Depression Scale is a 10-item questionnaire that may be used to identify women who have PPD.

IS IT HORMONES OR DEPRESSION?

- Research shows that different cultures talk about mental illness in different ways. According to research by Dr. Breland Noble, African Americans are less likely to use the word depression but may say " I don't feel like myself" or "Something is off."
- Often in minority communities depression may show up as a physical complaint (headaches, stomach aches, fatigue)
- A study found that only 1 in 10 women who screened positive for postpartum depression at an urban medical practice sought any treatment within the following six months
- A 2011 study found that after examining three years' worth of New Jersey Medicaid claims; white women were almost twice as likely to receive treatment than were women of color

MATERNAL ANXIETY

15-23% of women worldwide experience anxiety during pregnancy & anxiety postpartum.

Signs of anxiety during pregnancy:

- Feeling in uncontrollable urge to worry
- Wiring in excessively how are things happening two yourself abi
- Sleeping poorly
- Feeling irritable or agitated
- Having a lot of tension in your body
- Difficulty concentrating
- Ruins

POSTPARTUM PSYCHOSIS

- Usually presents suddenly within two weeks of childbirth – an EMERGENCY!!
- Hallucinations and delusions are usually present
- Thought disorganization and/or bizarre behavior
- Often preceded by depression or mania, severe insomnia, rapid mood changes, anxiety, irritability, and psychomotor agitation
- Persistent severe insomnia (not related to caring for baby) is often the first sign of possible postpartum psychosis

About 1 in 1000 women will experience postpartum psychosis. Most women who experience it will need to be treated in the hospital!

POSTPARTUM OCD

- The obsessional thinking and compulsive behaviors of obsessive-compulsive disorder (OCD) *often focus on the pregnancy or baby*. During pregnancy, obsessions are often about fears of fetal death or contamination.
- Women who have new onset of OCD in the perinatal period tend to have a milder course
- Often women with preexisting OCD, earlier onset, and greater severity tends to be associated with a *more severe course* during pregnancy or postpartum
- New mothers may avoid the baby

PSYCHIATRIC ISSUES IN CHILDHOOD

PSYCHIATRIC ISSUES IN CHILDHOOD

- Anxiety
- Depression
- Attention-deficit/hyperactivity disorder (ADHD), anxiety (fears or worries), and behavior disorders

THINGS ARE CHANGING

- The rates of anxiety, depression, and behavior disorders among Black children doubled over the course of several decades. Rates of Black Americans > Whites
- Previous research investigating racial differences in rates of psychiatric disorders have typically found that Black Americans show *lower* rates than Whites, despite experiencing higher rates of social adversity and stressors (2006)
- The new study suggests that this may be changing for younger Black Americans, at least with regard to psychiatric disorders that start in childhood

Patricia Louie, Blair Wheaton, Prevalence and Patterning of Mental Disorders Through Adolescence in 3 Cohorts of Black and White Americans, *American Journal of Epidemiology*, Volume 187, Issue 11, November 2018, Pages 2332–2338

CHILDHOOD ANXIETY

There are different types of anxiety in children: Separation anxiety, phobias, social anxiety, generalized anxiety

Anxious children can be quiet, overly tense or uptight. Some may seek a lot of reassurance, and their worries may interfere with activities.

- Many worries about things before they happen
- Constant worries or concerns about family, school, friends, or activities
- Repetitive, unwanted thoughts (obsessions) or actions (compulsions)
- Fears of embarrassment or making mistakes
- Low self esteem and lack of self-confidence
- Feeling or appearing depressed, sad, tearful, or irritable
- Not enjoying things as much as they used to

Symptoms of separation anxiety include:

- Constant thoughts and intense fears about the safety of parents and caretakers
- Refusing to go to school
- Frequent stomachaches and other physical complaints
- Extreme worries about sleeping away from home
- Being overly clingy
- Panic or tantrums at times of separation from parents
- Trouble sleeping or nightmares

- *Symptoms of phobia include:*
- Extreme fear about a specific thing or situation (e.g., dogs, insects, or needles)
- Fears causing significant distress and interfering with usual activities

CHILDHOOD DEPRESSION

Common symptoms of depression in children and adolescents include:

- Feeling or appearing depressed, sad, tearful, or irritable
- Not enjoying things as much as they used to
- Spending less time with friends or in after school activities
- Changes in appetite and/or weight
- Sleeping more or less than usual
- Feeling tired or having less energy
- Feeling like everything is their fault or they are not good at anything
- Having more trouble concentrating
- Caring less about school or not doing as well in school
- Having thoughts of suicide or wanting to die

CHILDHOOD DEPRESSION

- Black youth in the U.S. unfortunately, experience more illness, poverty, and discrimination than their White counterparts
- This puts them at higher risk for depression and other mental health issues
- A 2019 study found that Black youth are less likely, however, to seek treatment. ~9 percent of Black youth reported an episode of major depression in the past year.
- For Depression: 40% of Black youth received treatment vs. 46% of White youth received treatment

Nneka Jon-Ubabuco & Jane Dimmitt Champion (2019) Perceived Mental Healthcare Barriers and Health-seeking Behavior of African-American Caregivers of Adolescents with Mental Health Disorders, Issues in Mental Health Nursing, 40:7, 585-592

SUICIDE RISK

- Suicide is now the second leading cause of death among Black children ages 10 to 19
- Unfortunately, this rate is rising faster for Black children!
- Data from the Centers for Disease Control and Prevention show the rate of suicide attempts for Black adolescents rose 73% from 1991 to 2017
- Black children, particularly Black boys 5 to 11 years of age, have experienced an increase in the rate of suicide deaths; and in Black children ages 5 to 12 years, the suicide rate was found to be 2 times higher compared with their white counterparts
- Girls, compared with their male counterparts, are more likely to attempt suicide and have suicidal ideation, and boys are more likely to die by suicide

Ivey-Stephenson AZ, Demissie Z, Crosby AE, et al. Suicidal Ideation and Behaviors Among High School Students
Trends of Suicidal Behaviors Among High School Students in the United States: 1991–2017 Michael A. Lindsey, Arielle H. Sheftall,et. All 2019,


Lesbian, gay, and bisexual U.S. high school students
were more likely to report a suicide attempt during the last year
CDC.GOV
Lesbian, gay, bisexual
23%
Not sure about sexuality
16%
Heterosexual
6%
Schools can:
Create safe spaces
Reduce stigma
Promote help-seeking behaviors
Train adults to recognize & respond to signs
Youth Risk Behavior Survey, United States, 2019
MMWR

CDC, 2019

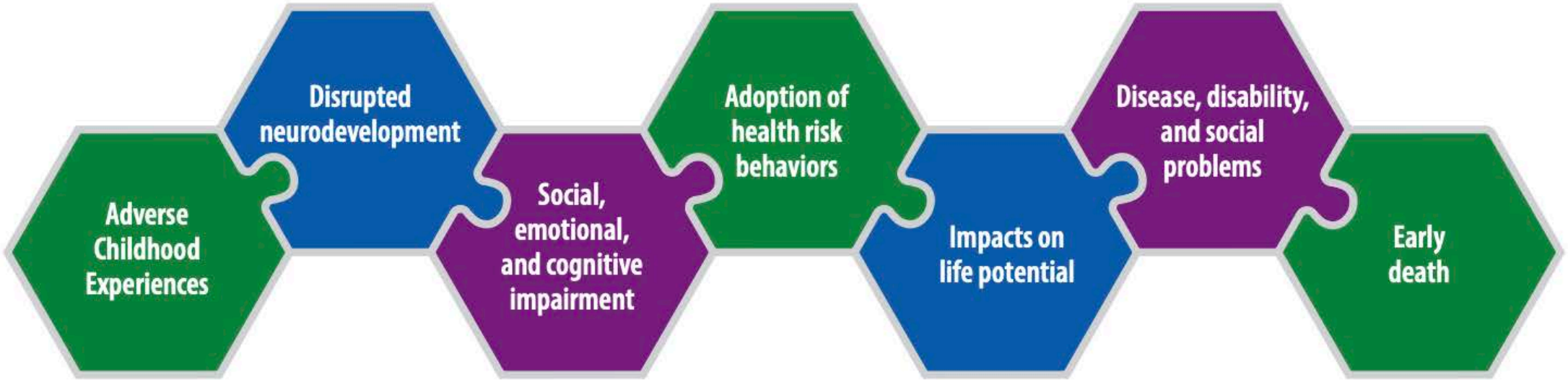
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD)

- ADHD inattentive type - Some people have only difficulty with attention and organization
- ADHD-hyperactive type - hyperactive and impulsive symptoms
- ADHD-combined type - difficulties with attention and hyperactivity

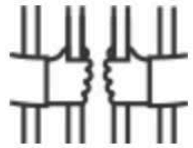
A CHILD WITH ADHD OFTEN SHOWS SOME OF THE FOLLOWING:

- trouble paying attention
- inattention to details and makes careless mistakes
- easily distracted
- loses school supplies, forgets to turn in homework
- trouble finishing class work and homework
- trouble listening
- trouble following multiple adult commands
- blurts out answers
- impatience
- fidgets or squirms
- leaves seat and runs about or climbs excessively
- seems "on the go"
- talks too much and has difficulty playing quietly
- interrupts or intrudes on others

ADVERSE CHILDHOOD EXPERIENCES



10 ACEs, as identified by the CDC-Kaiser study:

ABUSE	NEGLECT	HOUSEHOLD DYSFUNCTION	
			
Physical	*Physical*	*Mental Illness*	*Incarcerated Relative*
			
Emotional	*Emotional*	*Mother Treated Violently*	*Substance Abuse*
			
Sexual		*Divorce*	

TREATING THE MOTHER-CHILD DYAD

" To grow up mentally healthy, "the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment."

-John Bowlby, the father of Attachment Theory

RED FLAGS AND RISK FACTORS

Factor	Mother	Child
Red flags	Reduced maternal attunement • Blunted affect • Reduced eye contact with child/doctor • Lack/delayed response to child's cries • Tearful appearance • Irritability	Reduced child responsiveness to mother • Infant lacking eye contact with mother • Infant irritability/fussiness • Resistant behaviour • Infant rejecting mother after separation Restricted growth and development • Language delay • Global developmental delay • Failure to thrive
Risk factors[13]	• Adolescent mother • Single mother • Unwanted pregnancy • Low maternal education or intelligence level • Low parental socioeconomic status • History of depression in mother • Maternal catastrophic illness, e.g. cancer • Maternal substance abuse	• Autism spectrum disorder • Trisomy 21 or other congenital malformations • Sensory deficits, e.g. visual or hearing impairment • Adopted child

Tsang LPM, Ng DCC, Chan YH, Chen HY. Caring for the mother-child dyad as a family physician. *Singapore Med J.* 2019;60(10):497-501. doi:10.11622/smedj.2019128

THE IMPORTANCE OF BONDING

- Bonding is the intense attachment that develops between parents (mom) and baby
- Attachment - A secure attachment has at least three functions:
  - Provides a sense of safety and security
  - Regulates emotions, by soothing distress, creating joy, and supporting calm emotions
  - Offers a secure base from which to explore
- Builds trust in the newborn/infant, allows them to grow healthy and strong
- Many studies have observed that postpartum depression may negatively affect the mother-infant relationship and may impact bonding and attachment. The development of the child may be negatively impacted

AFFECT OF MOTHER'S DEPRESSION ON CHILDREN

- Research has discovered that simply exhibiting mild to moderate depression symptoms has a negative impact on the emotional health of children
- Children in this environment tend to be more hyperactive, anxious, and aggressive
- Findings suggest that an **absence** of depressive symptoms in their fathers *cannot compensate* for the adverse effects of maternal depressive symptoms upon their children

Pietikäinen JT, Kiviruusu O, Kylliäinen A, et al. Maternal and paternal depressive symptoms and children's emotional problems at the age of 2 and 5 years: a longitudinal study. *J Child Psychol Psychiatry*. 2020;61(2):195-204. doi:10.1111/jcpp.13126

- Mothers with depression have been found to be less attuned to their infant's needs, demonstrate poorer responsiveness to infant cues, and display more negative, hostile or disengaged parenting behaviors
  - This may lead to poor functioning, deficits in language, lower cognitive functioning and adverse emotional development in their children
- One of the strongest predictors of impaired mother-infant bonding was the *severity* of maternal depressive symptoms

- Short lapses in caregiving can be compensated for, but persistent attachment difficulties can cause longstanding ramifications
  - This shows the importance of evaluating and treating early!
  - Depression and anxiety are important targets for prevention and *early intervention* to support women transitioning into motherhood and improve the health and well-being of their children
- Children whose mothers had persistent and severe depression (as compared to children of mothers with transient postnatal depression) were at increased risk of behavioral problems by age 3.5 years, increased risk of depression in adolescence and increased risk of stunted growth
  - Developmental outcomes extended beyond infancy, into childhood and adolescence

TREATMENT

"For infants to thrive, mothers must thrive too; physically, emotionally, mentally. Too often all the focus is only on the needs of the newborn (which are of vital importance), but don't forget, when a baby is born, so is a mother." – Dr. Rosie Knowles

WHY DON'T WE GET HELP?

- Stigma/ Fear
- Concern about being seen as weak or dangerous
- Concern that CPS will take children away
- Not recognizing symptoms as mental health issues and depression/concerning.
- Unable to afford therapy visits, lack of insurance, child care
- Afraid of medication
- Myths about the Strong Black Woman/Superhero/ Never show vulnerability
- The screening tools to identify perinatal depression aren't always as accurate for black mothers as other races

TREATMENT

1. Evaluate and Treat mother's mental health issues as soon as possible
2. Consider non-pharmacological and pharmacological treatments
3. Recruit family members/community supports to help mother cope with new requirements of motherhood
4. Work to repair/strengthen the mother-child dyad

TREATMENT

- Treat the presenting symptoms of depression, anxiety, psychosis, OCD, etc.
- May use medications (SSRIs/SNRIs/antipsychotics/etc), therapy (CBT/IPT), combination of both
- In a randomized control trial of 117 depressed mothers, Horowitz and colleagues demonstrated that 8 weeks of interaction coaching significantly improved mother–infant interactions. (Enhanced bonding between mom-baby)
- Interaction coaching was developed to help mothers improve their interactions with their babies *by providing video feedback and giving them second-by-second suggestions as interactions occur* (Field 2006)

- A study also demonstrated that teaching depressed mothers to **massage** their infants has resulted in *less irritability and fewer sleep problems* in the infants and better mother-infant interactions, as well as *a reduction in the mothers' depressive symptoms* (Goldstein-Ferber, 2004).
- Studies have demonstrated that interventions focusing on the mother-infant relationship may be helpful in reducing depressive symptoms and improving maternal self-esteem.
- Parent-child behavioral therapy is aimed at improving parent-child relationships through enhanced parenting techniques. Behavioral interventions are most effective if parents are consistent. (usually 7-12 weeks)

- Adding exercise for treatment of mild to moderate postpartum depression may be helpful; exercise may represent an element of *behavioral activation*
- Social/peer (mother to mother) support, provided either in a group setting or individually, is a *psychosocial intervention* that can help improve postpartum depressive symptoms. A meta-analysis of four randomized trials (n >200 patients) compared social support with control conditions and found a significant, clinically moderate advantage favoring social support
- Social support may be more effective if it is *provided by a peer who is or was depressed*, rather than someone who has never been depressed

SEVERE POSTPARTUM DISORDERS

- Severely ill patients often report suicidal ideation and behavior, impairment of functioning, and may have poor judgement that places the patient and others (including children) at risk for imminent harm
- Patients are more likely to develop complications such as psychotic and catatonic features and have a history of severe or recurrent episodes
- In these cases we highly recommend antidepressant/antipsychotic medications. Can add psychotherapy when mother is able. Consider ECT if continuous suicidal thoughts or no response to medication. May need hospitalization!

POSTPARTUM DEPRESSION TX

- First and only medicine specifically designed to treat Postpartum depression
- ZULRESSO is the first and only FDA-approved medicine specifically for postpartum depression (PPD)
- In clinical studies, moms treated with ZULRESSO experienced a greater reduction in symptoms of PPD vs placebo in **2.5 days**
- In these studies, moms who took ZULRESSO generally still felt better 30 days after treatment began, as measured by a standard depression scale

RISKS OF NOT TREATING

- **Untreated depression** poses risks to the mother and infant, including:
- nonadherence with perinatal care
- poor self-care
- neglect of the infant (and other children)
- disrupted maternal-infant bonding/family dysfunction
- possible child abuse
- Worsening of disease, including, suicidal behavior, psychotic features, catatonia, and comorbid substance use disorders

POLL QUESTIONS REVISITED

1. Maternal mortality in the U.S. is higher than in any other developed country and roughly 60% of the deaths are preventable. True/False
2. According to the CDC, Black mothers are two times more likely than White moms to die from complications during pregnancy or childbirth. True/False?
3. Postpartum Blues happens to most mothers and usually lasts just as long as Postpartum Depression. True/False
4. What percentage of Black mothers suffer from postpartum depression?
    a. 10%
    b. 20%
    c. 40%
    d. 60%
    e. 80%
5. Having a father who is not depressed can compensate for the adverse effects of maternal depressive symptoms on their children. True/False

POLL ANSWERS

1. Maternal mortality in the U.S. is higher than in any other developed country and roughly 60% of the deaths are preventable. True
2. According to the CDC, Black mothers are two times more likely than White moms to die from complications during pregnancy or childbirth. False (Black mothers are 3-4 times more likely than White moms to die)
3. Postpartum Blues happens to most mothers and usually lasts just as long as Postpartum Depression. False (Postpartum Blues happens to up to 85% of new moms but only lasts 2 weeks)
4. What percentage of Black mothers suffer from postpartum depression?
    a. 10%
    b. 20%
    c. 40% (Close to 40% of Black Mothers will suffer from postpartum depression, more than double the rate for the general population)
    d. 60%
    e. 80%
5. Having a father who is not depressed can compensate for the adverse effects of maternal depressive symptoms on their children. False (Research suggest that an absence of depressive symptoms in their fathers *cannot compensate* for the adverse effects of maternal depressive symptoms upon their children)

REFERENCES

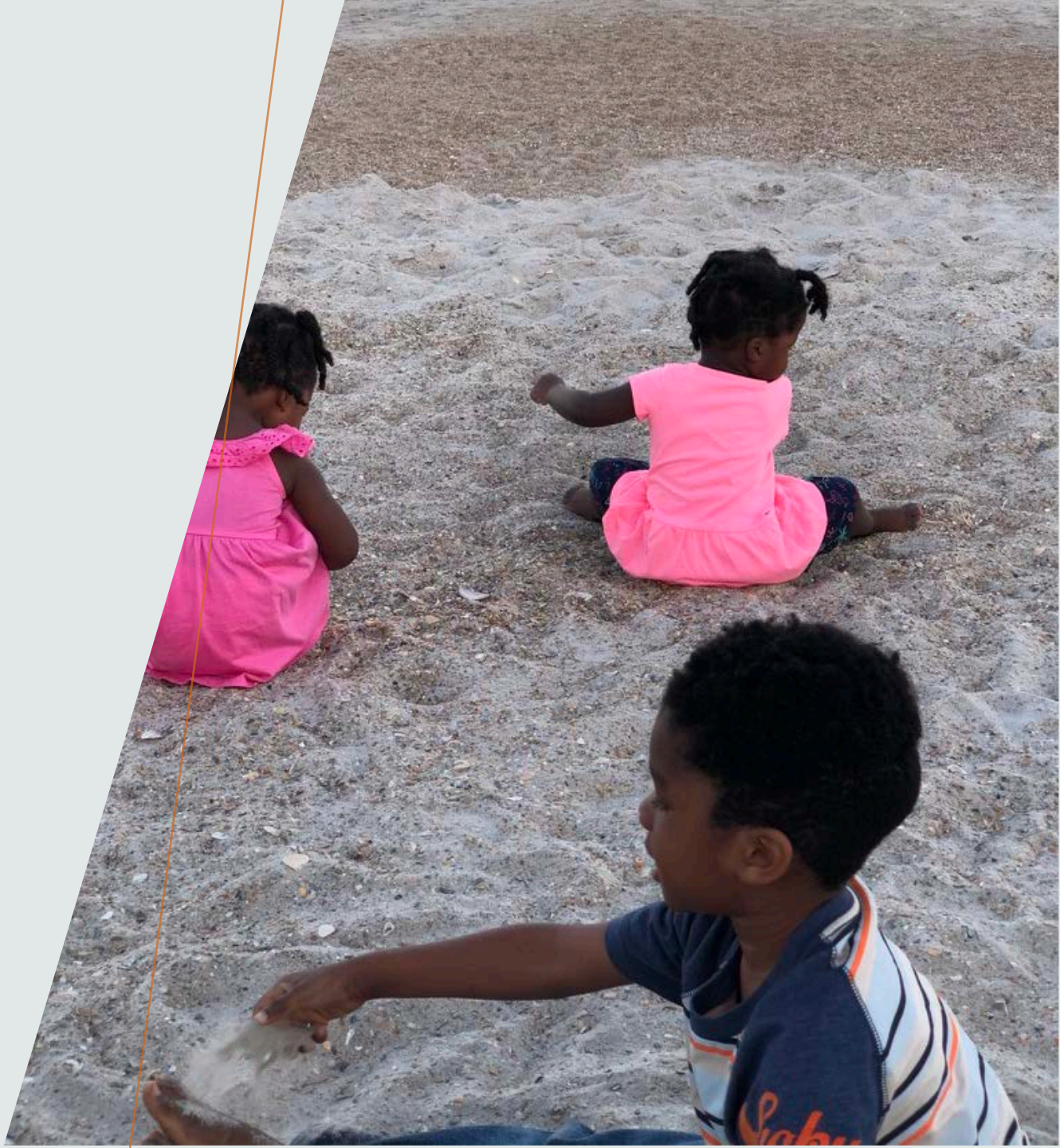
- Rogers A, Obst S, Teague SJ, et al. Association Between Maternal Perinatal Depression and Anxiety and Child and Adolescent Development: A Meta-analysis. *JAMA Pediatr.* 2020;174(11):1082–1092. doi:10.1001/jamapediatrics.2020.2910
- Kozhimannil, K. B., Trinacty, C. M., Busch, A. B., Huskamp, H. A., & Adams, A. S. (2011). Racial and ethnic disparities in postpartum depression care among low-income women. *Psychiatric services (Washington, D.C.), 62*(6), 619–625.
- Feldman, N., Pattani, A. Black Mothers Get Less Treatment for Postpartum Depression Than Other Moms. December 6, 2019
- Postnatal Depression and Perinatal Mental Health. Mind
- Melillo, G. Racial Disparities Persist in Maternal Morbidity, Mortality and Infant Health. American Journal of Managed Care. June 13, 2020
- What Are ACES? Joining Forces for Children
- Postpartum Psychiatric Disorders. Massachusetts General Hospital Center for Women's Mental Health
- What Is Children's Mental Health? Centers for Disease Control and Prevention
- Perry A, Gordon-Smith K, Jones L, Jones I. Phenomenology, Epidemiology and Aetiology of Postpartum Psychosis: A Review. Brain Sci. 2021 Jan 4;11(1):47. doi: 10.3390/brainsci11010047. PMID: 33406713; PMCID: PMC7824357.
- Miller ES, Hoxha D, Wisner KL, Gossett DR. Obsessions and Compulsions in Postpartum Women Without Obsessive Compulsive Disorder. J Womens Health (Larchmt). 2015 Oct;24(10):825-30. doi: 10.1089/jwh.2014.5063. Epub 2015 Jun 29. PMID: 26121364.
- Breslau J, Aguilar-Gaxiola S, Kendler KS, Su M, Williams D, Kessler RC. Specifying race-ethnic differences in risk for psychiatric disorder in a USA national sample. Psychol Med. 2006 Jan;36(1):57-68. doi: 10.1017/S0033291705006161. Epub 2005 Oct 5. PMID: 16202191; PMCID: PMC1924605.

- Scott KA, Britton L, McLemore MR. The Ethics of Perinatal Care for Black Women: Dismantling the Structural Racism in "Mother Blame" Narratives. J Perinat Neonatal Nurs. 2019 Apr/Jun;33(2):108-115. doi: 10.1097/JPN.0000000000000394. PMID: 31021935.
- Scott, Karen A. MD, MPH; Britton, Laura PhD, RN; McLemore, Monica R. PhD, MPH, RN The Ethics of Perinatal Care for Black Women, The Journal of Perinatal & Neonatal Nursing: April/June 2019 - Volume 33 - Issue 2 - p 108-115 doi: 10.1097/JPN.0000000000000394
- Desiree Y. Phua, Michelle Z.L. Kee, Michael J. Meaney, Positive Maternal Mental Health, Parenting, and Child Development, Biological Psychiatry, Volume 87, Issue 4, 2020, Pages 328-337, ISSN 0006-3223
- Kingston, D., Tough, S. Prenatal and Postnatal Maternal Mental Health and School-Age Child Development: A Systematic Review. *Matern Child Health J* **18,** 1728–1741 (2014).
- Parker A. Reframing the narrative: Black maternal mental health and culturally meaningful support for wellness. Infant Ment Health J. 2021 Jan 20. doi: 10.1002/imhj.21910. Epub ahead of print. PMID: 33470438.
- Cannon, C. (2019) A focus on postpartum depression among African American women: A literature review. *Annals of clinical psychiatry.* 31 (2), 138–143.
- Kallem, S., Matone, M., Boyd, R. C., & Guevara, J. P. (2019). Mothers' Mental Health Care Use After Screening for Postpartum Depression at Well-Child Visits. *Academic pediatrics*, *19*(6), 652–658.
- Agnafors S, Bladh M, Svedin CG, Sydsjö G. Mental health in young mothers, single mothers and their children. BMC Psychiatry. 2019 Apr 11;19(1):112. doi: 10.1186/s12888-019-2082-y. PMID: 30975129; PMCID: PMC6460673.
- Tsang LPM, Ng DCC, Chan YH, Chen HY. Caring for the mother-child dyad as a family physician. Singapore Med J. 2019 Oct;60(10):497-501. doi: 10.11622/smedj.2019128. PMID: 31663104; PMCID: PMC6875823.
- American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 5th edition. Arlington, VA., American Psychiatric Association, 2013
- Rishel CW, Greeno CG, Marcus SC, Sales E, Shear MK, Swartz HA, Anderson C. Impact of maternal mental health status on child mental health treatment outcome. Community Ment Health J. 2006 Feb;42(1):1-12. doi: 10.1007/s10597-005-9004-9. PMID: 16429249.
- Ivey-Stephenson AZ, Demissie Z, Crosby AE, et al. Suicidal Ideation and Behaviors Among High School Students — Youth Risk Behavior Survey, United States, 2019. MMWR Suppl 2020;69(Suppl-1):47–55. DOI:
- National Center for Health Statistics. U.S. Small-Area Life Expectancy Estimates Project (USALEEP): Life Expectancy Estimates File for {Jurisdiction}, 2010-2015]. National Center for Health Statistics. 2018.

- Horowitz JA, Bell M, Trybulski J, Munro BH, Moser D, Hartz SA, McCordic L, Sokol ES. Promoting responsiveness between mothers with depressive symptoms and their infants. J Nurs Scholarsh. 2001;33(4):323-9. doi: 10.1111/j.1547-5069.2001.00323.x. PMID: 11775301.
- Sockol LE, Battle CL, Howard M, Davis T. Correlates of impaired mother-infant bonding in a partial hospital program for perinatal women. Arch Womens Ment Health. 2014 Oct;17(5):465-9.
- Zambaldi CF, Cantilino A, Montenegro AC, Paes JA, de Albuquerque TL, Sougey EB. Postpartum obsessive-compulsive disorder: prevalence and clinical characteristics. Compr Psychiatry. 2009 Nov-Dec;50(6):503-9. doi: 10.1016/j.comppsych.2008.11.014. Epub 2009 Jan 20. PMID: 19840587.
- Goodman JH, Prager J, Goldstein R, Freeman M. Perinatal Dyadic Psychotherapy for postpartum depression: a randomized controlled pilot trial. Arch Womens Ment Health. 2014 Dec 20.
- Field T, Deeds O, Diego M, Hernandez-Reif M, Gauler A, Sullivan S, Wilson D, Nearing G. Benefits of combining massage therapy with group interpersonal psychotherapy in prenatally depressed women. J Bodyw Mov Ther. 2009; 13(4):297-303.
- Field T, Diego M, Hernandez-Reif M, Deeds O, Figueiredo B. Pregnancy massage reduces prematurity, low birthweight and postpartum depression. Infant Behav Dev 2009;32(4):454-60
- Tsang LPM, Ng DCC, Chan YH, Chen HY. Caring for the mother-child dyad as a family physician. *Singapore Med J*. 2019;60(10):497-501. doi:10.11622/smedj.2019128
- Facts for Families Guide: Anxiety and Children. No. 47. American Academy of Child and Adolescent Psychiatry
- Is Depression Worse in the Western World? Sermo. April 16, 2018
- Sad Child. Madison 365
- Erickson ME. Factors that influence the mother-infant dyad relationships and infant well-being. Issues Ment Health Nurs. 1996 May-Jun;17(3):185-200. doi: 10.3109/01612849609049914. PMID: 8707540.
- Coffman, S., Levitt, M. J., & Guacci-Franco, N. (1995). Infant-mother attachment: relationships to maternal responsiveness and infant temperament. *Journal of pediatric nursing*, *10*(1), 9–18.

THANK YOU FOR YOUR ATTENTION!

QUESTIONS?



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