One patient stands out for psychologist Ellen L. Poleshuck, PhD. When the woman came to see her, she already had three children by two fathers and was pregnant with a fourth. She felt ambivalent about the pregnancy, uncertain about her ability to manage and very depressed. With Poleshuck’s help, the woman not only got over her depression but found ways to be excited about becoming a mother again. She made regular prenatal care visits. She also stabilized her housing situation, negotiated how much involvement the baby’s father would have and reached out to relatives for help. As a result, says Poleshuck, the pregnancy and transition to having another baby went smoothly.

“It’s enormously important that the field start thinking about assessing and treating depression during pregnancy, not just postpartum,” says Poleshuck, an associate professor of psychiatry and obstetrics and gynecology (OB/GYN) at the University of Rochester School of Medicine and Dentistry, who directs the Women’s Behavioral Health Service at the university’s medical center. “It’s a time when women are already more likely to be engaged in health care, so we have better access to them and an opportunity to engage them in mental health care.”

Several factors are helping to expand the focus from postpartum care to care during pregnancy. New guidelines from the U.S. Preventive Services Task Force, for example, now include pregnant women and new mothers in depression screening recommendations. And with both the American Congress of Obstetricians and Gynecologists and the American Psychiatric Association discouraging pharmacological treatment of depression in pregnant women, psychologists are increasingly providing psychotherapeutic interventions to this population, for the good of both expectant mothers and their babies.

“It’s difficult for women who are suffering from untreated depression to come to their appointments,” says Ellen J. Tourtelot, MD, an assistant professor of OB/GYN at Rochester and director of the Women’s Health Practice at the university’s medical center. “Establishing successful breastfeeding after delivery is also much more difficult if the depression isn’t treated before the baby’s birth, since women often give up a few days after birth if breastfeeding isn’t going well.”

Continuing Education: Depression During Pregnancy Is an Often-Overlooked Opportunity to Intervene Early

BY REBECCA A. CLAY

Cultural norms say pregnancy is a blissful time, but 9 percent of women meet criteria for major depression.
A study of almost 65,000 women found that children whose mothers took antidepressants during pregnancy were more than four times as likely to be depressed themselves by age 15.

...tends to be relatively mild and transient,” says Spirito. While hormones can contribute to depressive symptoms during pregnancy, she says, they’re likely not the only source of distress. The mismatch between reality and social norms can make women feel even worse, says Spirito.

For one patient, for example, depression was rooted in an intense dislike of the experience of pregnancy itself. “She was being overwhelmed with feelings of tremendous discomfort, almost feeling like she didn’t have control or ownership of her body anymore,” says Spirito.

Even though she wanted another child, she didn’t feel bonded with her developing baby or the idea of another child, felt guilt and shame about her lack of excitement and was afraid she would wish the baby away. Therapy—and antidepressants began just before delivery—helped her accept that even though her experience wasn’t the norm, she could still be the mother she wanted to be. She went on to have a positive delivery and postpartum experience, says Spirito.

These preventive interventions also helped the woman avoid the postpartum depression she had experienced after her first pregnancy, she says.

Some women, especially first-time mothers, may get depressed as they struggle with issues of identity, says Spirito. “It’s about forging a new identity of being a mother while figuring out how to hold on to and continue to nurture other aspects of identity,” she says. Other women have past trauma, such as trauma or even post-traumatic stress disorder brought on by difficult previous deliveries, that can make pregnancy or the transition to parenthood especially difficult. Spirito will accompany women into the delivery room if they have extreme anxiety, histories of trauma or inadequate family support.

If pregnant women need antidepressants, Spirito refers them to the psychiatric OB/GYN resident or practice nurse on her team, who can help them weigh the pros and cons and prescribe medication if necessary. “The research supports the notion that nothing bumps a calm mom,” says Spirito. “When we can achieve that through psychotherapy alone … that’s awesome, but that’s not the case for all women. Sometimes we need … all the resources in our toolbox, including psychotropics.”

Because the mental health team is embedded in Children’s OB/GYN department, clinicians can coordinate care and triage patients who need psychological care immediately. And women can see their obstetrician, get ultrasounds and bloodwork done, obtain medications and have therapy in back-to-back appointments. “We get lots of positive feedback about this, as it is very difficult for pregnant women, especially those with other small children or those who are working, to juggle so many different medical appointments through pregnancy,” says Spirito.