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Dr. Loren Roth: Good day, and welcome to the UPMC Western Psychiatric Hospital podcast series. I am Dr. Loren Roth, distinguished professor and a senior psychiatrist at the hospital. This podcast series presents innovative research and patient centered programs at the cutting edge of psychiatry and the behavioral sciences. These are of special interest to diverse professionals and the interested public. Our hospital and clinics are the Behavioral Health Psychiatric Division of the UPMC Health System. The hospital houses the wide ranging missions, clinical, educational, and research of this UPMC specialty hospital and the nationally known Department of Psychiatry here at the University of Pittsburgh School of Medicine.

Dr. Loren Roth: My guest today is Dr. Eydie Moses-Kolko. Our topic is models of care, integrated and intensive mental health outpatient treatment in perinatal women. Dr. Eydie Moses-Kolko is a psychiatrist with much experience in women's mental health and perinatal psychiatry. Her clinical expertise includes the integration of behavioral health treatment in OB-GYN settings, perinatal psychopharmacology consultation and acute management, as well as pharmacological management of adults with mood disorders. Dr. Kolko teaches about and has considerable ongoing research experience in clinical characterization, treatment and the neurobiology of affective disorders in the perinatal period. So congratulations, and welcome, Dr. Moses-Kolko. Perhaps we could begin this conversation by your explaining to us why perinatal mental health is so important for public health generally, and certainly for these expectant and new mothers.

Dr. Moses-Kolko: Well, thank you very much, Dr. Roth, for inviting me to participate in this podcast, and that's an excellent question to get us started. I want to make the point that perinatal depression is really common. It affects one in seven women, and those rates actually double in disadvantaged populations and young mothers. The mother is the beginning of all future generations, and so even prior to conception, her body and her eggs and her genetic and epigenetic milieu can affect future generations. So if we can actually deliver treatment, preventive treatment, acute treatment, when women are demonstrating symptoms, we might be able to prevent a lot of untoward outcomes such as birth defects, obstetric complications, preterm birth, impaired child development, impaired attachment security in children, and improved family health and family systems functioning in general.

Dr. Loren Roth: Well, there's a lot of things here. I get it. And really, you're talking about the woman and the entire family milieu, and really some of the core things that are ongoing in her life. I understand that you treat patients in their OB-GYN office. What advantage does this offer women?

Dr. Moses-Kolko: So this is a new program that we're launching. We're actually expanding this program, and indeed we are located now in a very convenient place where women are coming every day to get their specialty OB-GYN care, even their routine GYN care, and coming to see a therapist or a psychiatrist in that setting greatly increases convenience, because women are planning to get care there for other medical reasons, and also greatly reduces stigma. We know that women are often so busy taking care of their family members that they forget to take care of themselves, and they don't get mental health treatment, so by coupling their medical care with mental health care, they're more likely to actually get evaluated and treated.

Dr. Loren Roth: Well, you have a bit of a ideal circumstance here, as I understand the usage of the term "integrated care," because that's a broad term, and it's obviously trying to tie together both mental health care and physical care. But you're in a situation where you can have some co-location. In other words, you're on the spot, and that would give you the opportunity to even speak with the patient's physician and truly have a team.

Dr. Moses-Kolko: Absolutely. There is a great deal of national funding that has looked into models of collaborative care, and there have been some excellent studies that show that when the ideal levels of collaboration occur between patient mental health providers and obstetrician-gynecologist, there can be a reduced time to getting care, there can be improved medical outcomes and big cost savings. That is our ideal goal, to be able to fully integrate and have that ideal level of collaborative care ultimately. At this point, we are launching placing licensed clinical social workers into the clinics in addition to myself, I've been working in these clinics for a couple years as a perinatal psychiatrist to advise mostly on medications and to refer out, but now we can actually use these skills of our social workers to deliver short term psychotherapy in the clinic as well and reach a much greater population, and have hopefully much greater benefits for obstetric outcomes.

Dr. Loren Roth: Yes. We have some similar programs to that, actually, in the entire childhood area, at Children's Hospital in our community network, and I agree very much, because in addition to you, all of the other aspects of the therapeutic discussions in more depth than maybe sometimes some care management as well. In other words, what's going to happen next in a practical way for the woman to be able to implement some of the things that is being talked about? So this sounds like a great idea. How long have you been doing this?

Dr. Moses-Kolko: I started ... It's probably coming close to three years, actually, going to the Wexford Clinic, the UNO Clinic, and also the Women Care Associates Clinic, and I've had a great experience providing some educational trainings for the OB-GYN providers, and also working with the patients and collaborating on their treatment. And we're actually doing some quality improvement data mining in the near future to really better understand who are the women who need these services, where we should deliver them, are we impacting health outcomes, and how can we refine this to serve even more women in better ways?

Dr. Loren Roth: Right. So you're getting a little more of the epidemiological picture about care, and how it might best be delivered.

Dr. Moses-Kolko: Exactly. Because this is really about population management. Women represent the lion's share of individuals with affective disorders, and by that I mean major depression and generalized anxiety disorders, so by accessing women where they come into the medical system in their OB-GYN office, we can actually start caring better for an entire population that might not enter the mental health sphere.

Dr. Loren Roth: Well, this sounds very good. I was reading a little bit about your program, and we've touched so far on the integrated care aspects, but we haven't touched yet on the intensive mental health outpatient treatment program that you have, and I was intrigued when I read that its title was NEST, N-E-S-T. So perhaps you'd like to say a little bit more about this and how your program is structured.

Dr. Moses-Kolko: Absolutely. So NEST stands for New and Expectant Mothers Specialized Treatment Program, and we like the name NEST because it represents that instinct that women who are pregnant and postpartum have to build a comfortable and nurturing home for their young, and so we intentionally chose that acronym. We are a nine hour per week intensive outpatient program that is based on dialectical behavioral therapy principles to help women with mood disorders, anxiety disorders, and even women recovering from postpartum psychosis, and women benefit from the support of one another. You can imagine a woman entering a program where there's group therapy with nine other women who they can identify with. They feel an inordinate amount of support, and a decrease of shame and decrease of stigmatization, and that support element is a really useful principle that attracts women to attend this program and helps them in their recovery.

Dr. Moses-Kolko: But probably most important is that we have an experienced team of clinicians that can deliver group therapy, individual psychotherapy, as well as medication management. We all have a lot of experience running these groups, meeting with individuals, treating and thinking about the risks and benefits of medication management in pregnancy and during lactation, so that we can, in a very efficient manner, help assess the woman in her whole bio-psycho-social set of risk factors, and deliver an efficient package of care over six to eight weeks so that she can feel empowered and able to return to her prior career or her role as a homemaker.

Dr. Loren Roth: So some of this might begin prenatal and some postnatal, in this particular program?

Dr. Moses-Kolko: Exactly. So women come during pregnancy, and they also come after delivery. I would say about two-thirds or more women are postpartum, and we know that there's a very high incidence of psychosis in the postpartum period, in terms of ... I shouldn't say an absolute high risk, but for a woman to have a psychotic episode in her lifetime, her risk is highest in the postpartum period.

Dr. Loren Roth: I see.

Dr. Moses-Kolko: Her risk is about 25 times higher than it is in the two years prior to delivery.

Dr. Loren Roth: Wow, well 25 is a good, big multiplier.

Dr. Moses-Kolko: Yes.

Dr. Loren Roth: You mentioned the term "dialectical behavioral therapy," and not everybody knows what that is. So I guess your challenge is to tell me, explain to our audience briefly, if at all possible, what is that DBT?

Dr. Moses-Kolko: DBT. I'm glad you asked. It's a therapy we've been using quite a lot at Western Psychiatric Hospital in many intensive outpatient programs, and it was created to really treat complex individuals with suicidal behaviors and self-injury, but later it's been adapted to lots of different individuals, even with less life threatening mental health disorders. So DBT operates by teaching skills, very practical life skills, to help women regulate their emotions, or to practice mindfulness, as well as to engage in more interpersonally effective conversations, for example, with their spouses when they're negotiating childcare, or with their employer when they're trying to negotiate their new hours after having had a baby. So these skills come in very, very handily for our patient population.

Dr. Loren Roth: Sounds to me confidence building.

Dr. Moses-Kolko: Absolutely. And it accepts women where they're at. There's a lot of validation, and one of the premises is that they're doing the best they can, but they can also do better.

Dr. Loren Roth: So just one aspect about the referral of the patients to your program. Are you doing all of this preventively, or something identifies this woman as needing you? Just what at core is that?

Dr. Moses-Kolko: Yeah. Excellent question. We have a lot of different avenues of referral. A lot of people coming to the Western Psych emergency room can include pregnant and postpartum women who are experiencing severe obsessions, perhaps. That's a common presentation, where women are having intrusive thoughts to harm their infants or to harm themselves or other children, and you can imagine how disturbing those symptoms are, and these women benefit from intensive outpatient treatment. In addition, women who have made overdoses and might be hospitalized in a medical or obstetric hospital, who need intensive care, get referred to our program. There are also times that women are in a standard community or Western psychiatric outpatient clinic but need a higher level of care. Their medication management sessions every few months and psychotherapy every couple of weeks are not adequate to maintain remission of symptoms.

Dr. Loren Roth: Okay. Yeah. I get it. So in other words, usually there's been some kind of clinical event, let's just say it that way.

Dr. Moses-Kolko: Oftentimes.

Dr. Loren Roth: The woman has come to notice by one of our professional staff somewhere along the line, and knows that you have this really ready to accept program, and I'd imagine that's good on the urgency dimension as well, from what you were telling me. In other words, you can quickly see these women.

Dr. Moses-Kolko: There is pretty good access, and I should also add that our obstetric colleagues know about our program and also refer patients, and sometimes the patients can get into our program even before they can see me or a therapist in the integrated program.

Dr. Loren Roth: Sure. Okay. Well, I'd like to know a little bit more about the role that infants play in your program. How is the mother-infant bond supported in the treatment sessions? How important is the whole infant presence?

Dr. Moses-Kolko: So we really encourage women to bring their infants. Women can take two different forms with respect to their infants. Some women are very overly attached to their infants. We see that these women might have a difficult time separating from their infants. They may not want to leave their infants at home, so while they're in the group, they might have opportunities to have small exposures to actually separating briefly from their infant and realizing somebody else might be able to take care of the infant. On the other hand, there are some women who are terrified of being with their infant, and they would much rather leave their infant with a caregiver back home or in daycare, and they become really anxious when they are with infant for three hours in a row. So we encourage those women to bring in their infant, and we observe their interaction and help facilitate attuned maternal responses and mindfulness on the infant so that they can start to really understand the infant's cues and feel more confident in their mothering role.

Dr. Loren Roth: Well, this seems very useful to me. So I'm interested a bit in simply the followup, since I've always thought that the followup in medicine is just as important as diagnosis or original intervention. So what is going to happen with the women when they're finished in your program?

Dr. Moses-Kolko: We take great precaution to make sure that women don't finish our program and then drop out of treatment. We start the conversation about longterm treatment probably halfway through their time in the IOP. We often are able to return women back to their outpatient community providers, both a therapist and often a psychiatrist. There are women who actually have been naive to mental health care, so they will need a new team, and we have a terrific group of social workers who really examine what are the geographically convenient options, what are the fiscally possible options based on people's insurance, and

they try to create a good fit so that women do maintain preventive care going forward.

Dr. Loren Roth: So you are trying really to keep that continuity of care, which is so ever important.

Dr. Moses-Kolko: Absolutely.

Dr. Loren Roth: Eydie, could you tell us a little bit about your career and how you came to study perinatal mental health, including your present research? We don't have all that much time in these podcasts, as you know, but I would like to hear about that briefly.

Dr. Moses-Kolko: Sure, absolutely. Well, I can say that I have spent almost my entire career here at the UPMC Western Psychiatric Hospital. I began as a resident in the 90s, the mid-90s, and I was really intrigued as a resident by the onset of affective illness during reproductive transitions in women's lives. For example, during the premenstrual phase, or the post-menopausal phase, and also particularly around the perinatal phase. So I had the opportunity to do clinical work in residency that later grew into some research on brain function in mothers, and I was really curious about serotonin and dopamine receptors and how those might change in the postnatal period.

Dr. Moses-Kolko: We also did some FMRI studies with my colleague Alison Hipwell, where we examined maternal responses to baby cries, and how that was linked with how the mother cared for the baby in a play session. Since that time, I have focused on clinical care, and I have tried to pioneer some of these new clinical programs, and have gotten a lot of gratification from seeing women improve in their wellness, and have greater satisfaction with their lives.

Dr. Loren Roth: Well, one of the features of your career ... First of all, we're thrilled to have people who we've known from the beginning, and that strengthens our work family. Why don't I just put it that way? We're always interested in providing additional reading and other materials, and giving tips to our listeners about these topics. It is interesting to me that just about two hours ago, I saw that just in the last day or two, the preventive US Preventive Services Task Force, which is concerned about perinatal mental health concerns, has issued a gigantic report about this which was written up in the New York Times today extensively. So today is February 12, and I would simply note to our readers that if you want to pick up an extensive New York Times article on this subject, please do so. We're also going to have this podcast on our UPMC website itself under the hospital of Magee-Women's Hospital, and in our departmental website as well, in the Department of Psychiatry.

Dr. Loren Roth: So my last question to you then, Dr. Kolko, is would you like to make any comment about that article, which I believe you've now seen?

Dr. Moses-Kolko: Absolutely, yes. The United States Preventive Services Task Force has come out with a tremendous recommendation just yesterday that they published in JAMA, that clinicians refer for counseling pregnant and postpartum women who are at risk for depression. Two years ago, they recommended that women be screened for depression in pregnancy and postpartum, and now this takes their recommendation a step further, to actually look at risk factors for depression. I think it's an excellent recommendation, and I hope it will compel policymakers to encourage screening and development of additional programs to address maternal mental health.

Dr. Loren Roth: Well, I want to thank you very much for your discussion today, but more importantly for the very important work that you and your colleagues are doing, and it's extremely interesting to me. I have two lovely women ... Well, I have my wife obviously, but I have two lovely daughters, and we watch these things carefully, on the basis of the kinds of information you said, during their pregnancies. And thank you.

Dr. Moses-Kolko: Well, thank you for having me. It was my pleasure to be here.