Transdiagnostic Approaches in Perinatal Mental Health

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Content Summary & Learning Objectives

Topics Covered

- **Overview of the issue**
- **Transdiagnostic care**
- **Assessment through a transdiagnostic lens**
- **Treatment principles**
- **Case study & formulation**
- **Suicide risk factors**
- **The mother–infant dyad**

Learning Objectives

- Define and describe the principles of transdiagnostic care and its role in contemporary mental health practice
- Explain the relevance and application of transdiagnostic approaches in perinatal mental health and addiction
- Develop a comprehensive assessment approach identifying overlapping psychological, behavioural, and contextual factors across diagnostic categories
- Apply a transdiagnostic framework to perinatal case formulation to inform assessment, intervention planning, and multidisciplinary care

Perinatal Mental Health & Addiction

15–20% of women experience a mental health or addiction disorder during pregnancy or within the first postpartum year

Individual prevalence estimates

~10–20%
Depressive disorder

~10–15%
Anxiety disorders

~5–15%
Substance use disorders

~2–5%
Bipolar spectrum disorders

Postpartum psychosis ~0.1–0.2% (1–2 per 1,000 births)

Maternal suicide — leading cause of direct maternal death in the perinatal period

The challenge

- High co-morbidity across diagnoses
- High rate of recurrence and deterioration
- Fragmented services (MH, Addictions, Maternity Care)

Maternal Mental Health Risk Factors

Risk emerges from the interaction between psychiatric vulnerability, psychosocial stressors, obstetric experiences, and systemic inequities

Psychiatric & Clinical

- Previous mental illness (depression, bipolar disorder, psychosis)
- Previous self-harm or suicide attempt
- Substance use disorders
- Sleep deprivation
- Medication discontinuation in pregnancy/postpartum
- Previous postpartum psychiatric episode

Psychosocial

- Family violence / intimate partner violence
- Relationship conflict or separation
- Social isolation
- Financial stress / poverty
- Housing instability
- Trauma history / adverse childhood experiences
- Child protection involvement
- Loss or grief

Perinatal & Systemic

Perinatal & Obstetric

- Unplanned pregnancy
- Pregnancy loss or infertility history
- Birth trauma / NICU admission
- Difficult breastfeeding experiences
- High caregiving burden

Systemic & Cultural

- Limited access to specialist perinatal services
- Fragmented maternity–MH–AOD care
- Stigma and fear of disclosure
- Barriers to culturally safe care
- Structural inequities affecting Māori wāhine

Why Transdiagnostic Care in the Perinatal Period?

Overlapping symptom clusters:

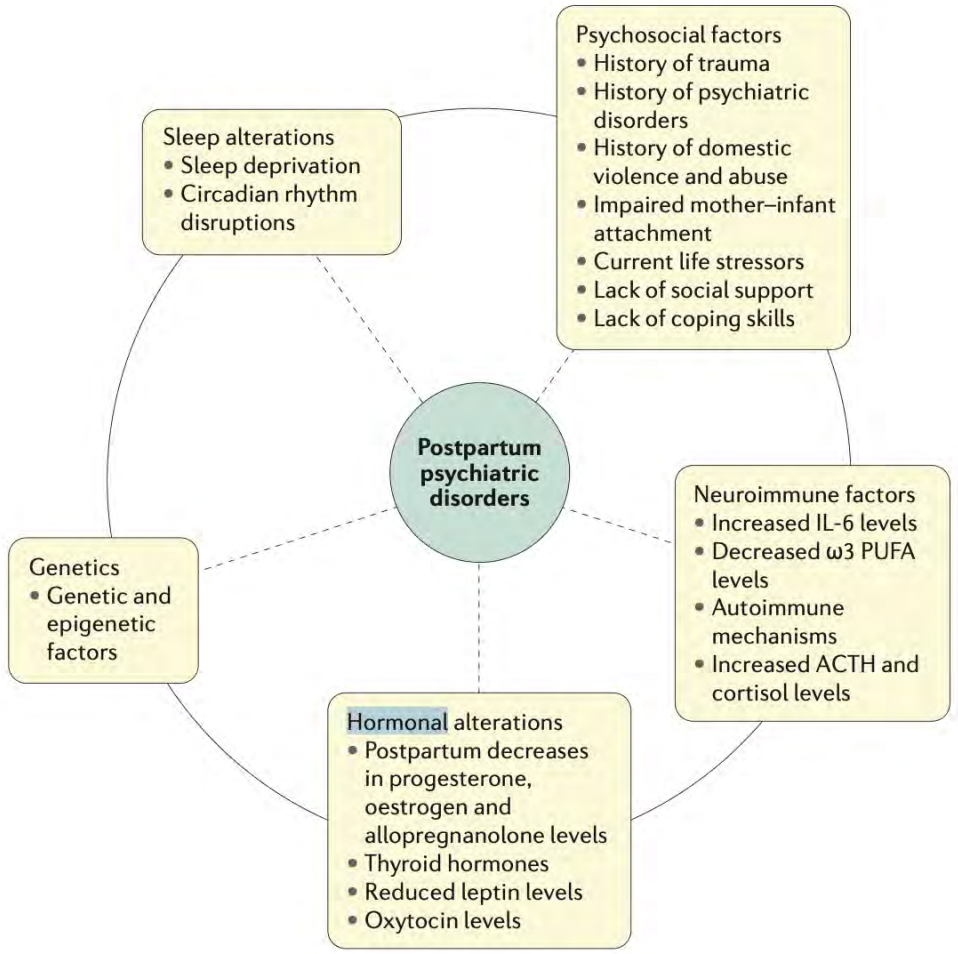
- Emotional dysregulation
- Sleep disturbance
- Trauma-related symptoms
- Impulsivity / reward sensitivity
- Identity crisis, attachment

Common risk factors:

- Trauma history
- Social adversity
- Neurodevelopmental conditions (e.g., ADHD)

Clinical reality:

- Patients rarely fit “pure” diagnostic categories



Core Transdiagnostic Mechanisms

Affect / Emotion Regulation

- Central across depression, anxiety, substance use
- Amplified by hormonal shifts, sleep deprivation

Cognitive Processes

- Rumination, worry, shame, self-criticism
- Common across mood, anxiety, and addictive disorders

Behaviour Patterns

- Avoidance, safety behaviours, reinforcement
- Maintain distress cycles across diagnoses

Physiological / Arousal

- Sleep, autonomic arousal (fight or flight)
- Somatic symptoms

Trauma & Threat Systems

- High rates of interpersonal trauma
- Perinatal period as a trigger window

Identity & Interpersonal

- Identity loss/disturbance
- Attachment experiences and style

Assessment Through a Transdiagnostic Lens

→ **Move beyond categorical diagnosis** — Map **domains** instead of disorders

Key Assessment Areas

Mood / Anxiety Symptoms
Depression, anxiety, panic, and their interaction with the perinatal context

Substance Use Patterns
Function of use, triggers, and maintenance cycles

Trauma History
Past and present trauma exposure and its impact on current functioning

Attachment & Parenting
Parenting representations, attachment style, and relational capacity

Social Determinants
Housing, violence, supports, and broader contextual factors

Risk: Individual + Dyad
Consider risk issues for both the individual and the mother–infant dyad

Treatment Principles

Integrated Care Model

- One team addressing MH + AOD + obstetric interface
- Avoid parallel or conflicting treatment plans

Prioritisation Framework

- Safety first: suicide/self-harm, family violence, infant neglect/harm, withdrawal risk
- Pathways to escalate

Psychological Interventions

- Therapies targeting shared processes
- DBT-informed skills (emotion regulation, distress tolerance)
- ACT (acceptance, values-based parenting)
- CBT (transdiagnostic modifications)

Pharmacological Considerations

- Balance maternal stability vs fetal/neonatal risk — conversations with prescriber and whaiora
- Avoid overly conservative prescribing when relapse risk is high
- Consider: stage of pregnancy, interactions, breastfeeding compatibility

Addiction-Specific Interventions

- Harm reduction vs abstinence (case-dependent)
- Opioid substitution therapy (specialist input required)
- Contingency management
- Address function of use

Case

32 year old māmā with a history of childhood ADHD. Discontinued treatment prior to a successful IVF pregnancy. Not known to specialist mental health services. First baby, very wanted. Lives with partner who has returned to work after 2 weeks

She is 8 weeks post partum after a challenging birth. She has self referred feeling anxious and overwhelmed, immediately sharing ”I feel like such a bad māmā!”. She reports she is breast feeding but struggling. Māmā is feeling exhausted but struggling with sleep.

She reports a couple of glasses of wine most evenings.

First diagnostic thoughts?

Perinatal Anxiety

Postpartum Depression

Generalised Anxiety Disorder

Alcohol Use Disorder

ADHD

PTSD

Adjustment Disorder

Bipolar Disorder

Presenting problems into transdiagnostic processes

Negative affect: anxiety, irritability, low mood

Cognitive: worry (“something will happen to the baby”), negative thoughts (“I’m not good enough”)

Behavioural avoidance: staying home, avoiding solo caregiving tasks

Self-criticism/shame: maternal inadequacy schema

Executive dysfunction: disorganisation, difficulty initiating tasks

Substance use: alcohol as short-term regulator

Sleep disruption: infant + hyperarousal

Identity: ”bad māmā", loss of previous competent identity

Domain-Based Assessment

Affect & Regulation

- High emotional reactivity (tearful, easily overwhelmed)
- Limited regulation strategies → defaults to avoidance + alcohol
- Low distress tolerance (panic when baby cries)

Cognitive Processes

- Catastrophic thinking (“baby will stop breathing”)
- Intolerance of uncertainty
- Persistent rumination (maternal identity, competence)
- ADHD-related distractibility worsening cognitive control

Behavioural Patterns

- Avoidance: not going out, not driving with baby
- Safety behaviours: excessive checking, reassurance seeking
- Alcohol use → rapid negative reinforcement loop
- Reduced engagement in rewarding activities

Physiological / Arousal

- Sleep fragmentation (infant + anxiety)
- Hyperarousal (on edge, scanning for threat)
- Fatigue → worsens emotional regulation and ADHD symptoms

Domain-Based Assessment

Self & Identity

- Shift to “I’m a bad mother” identity
- High shame and self-criticism
- Loss of previous competence identity (work, independence)

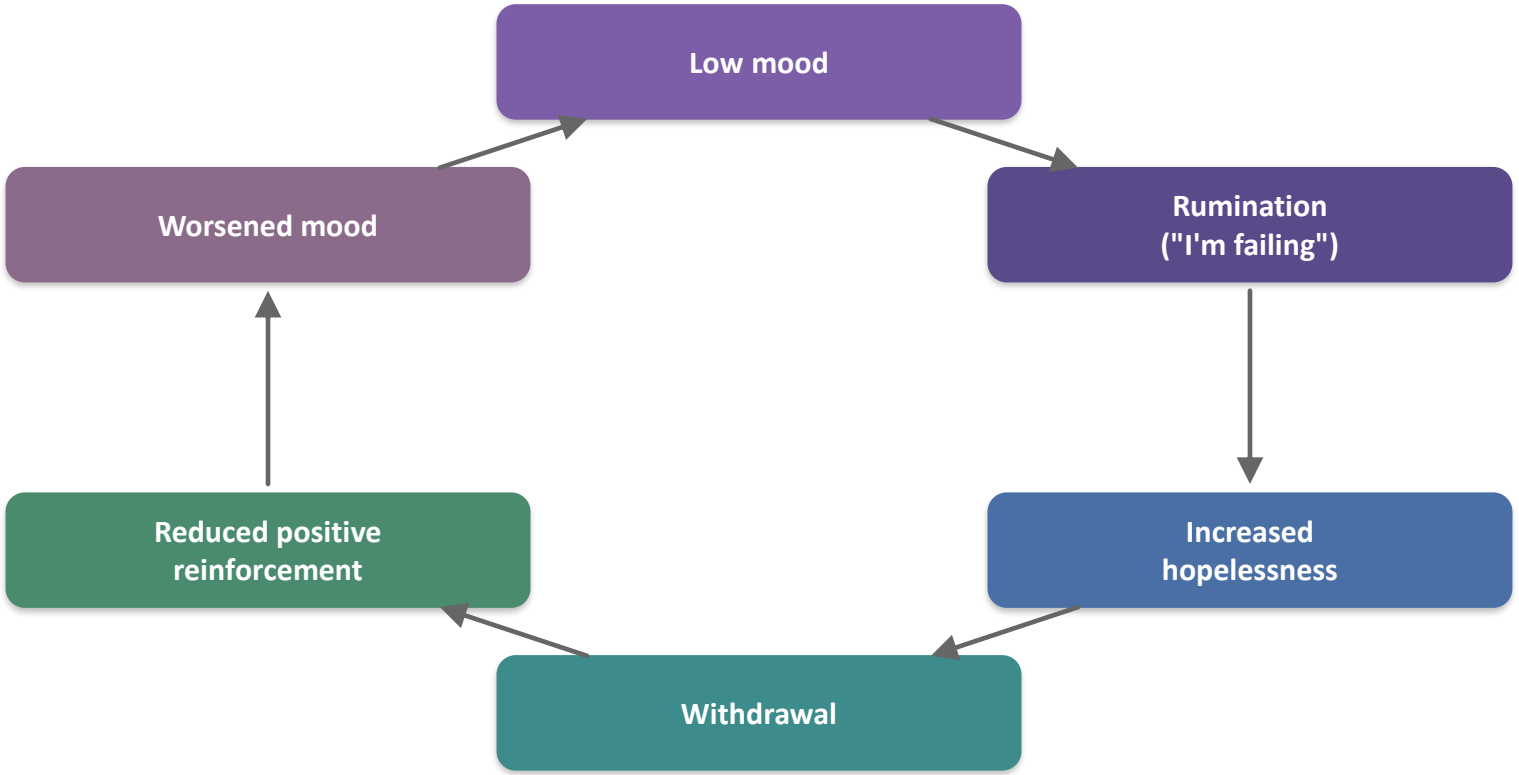
Interpersonal

- Increased reliance on partner but also resentment
- Reduced social contact → isolation
- Fear of judgement from others

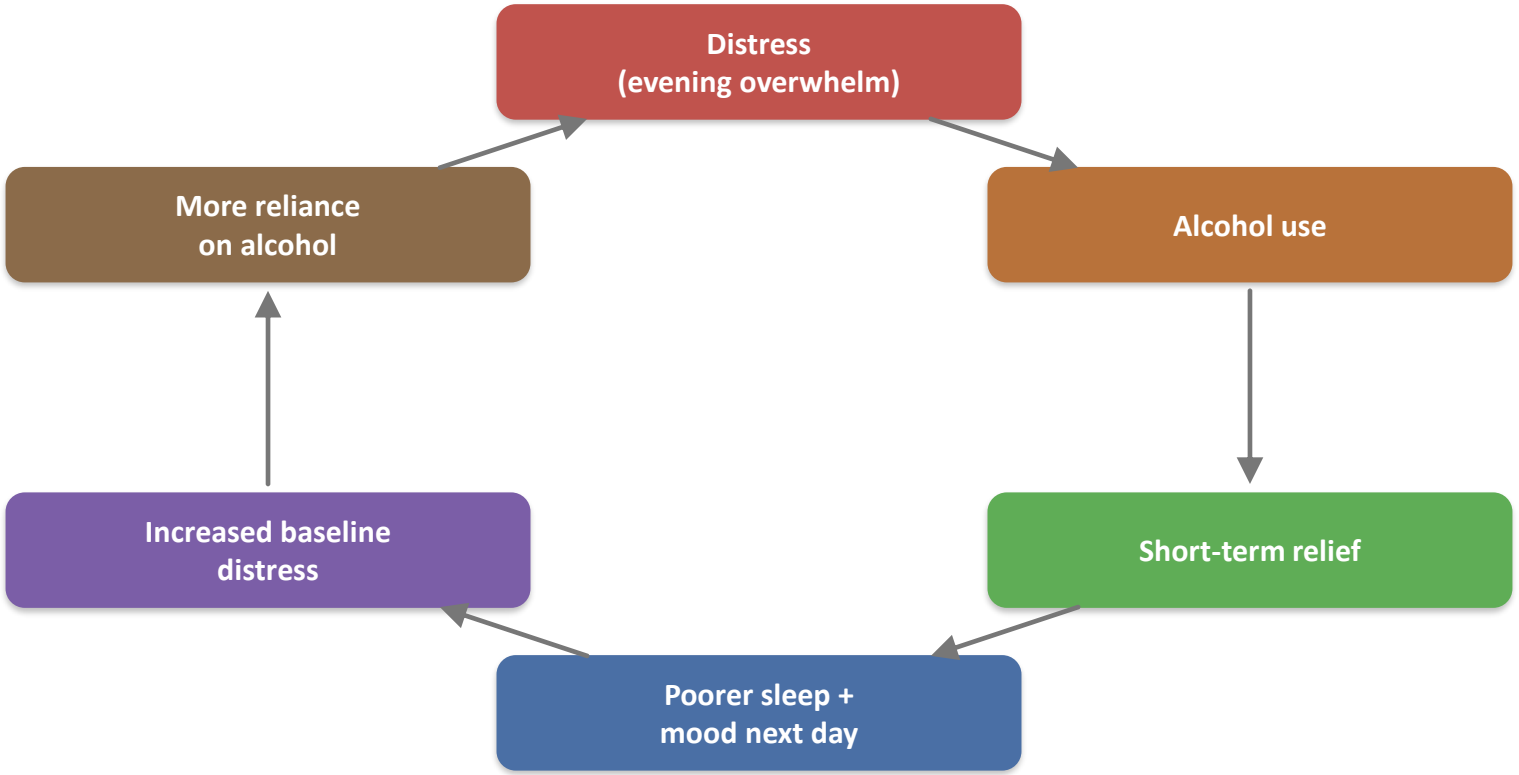
Executive Function

- ADHD baseline worsened postpartum
- Task initiation difficulty
- Disorganisation
- Emotional impulsivity
- *Reduced capacity amplifies avoidance and overwhelm*

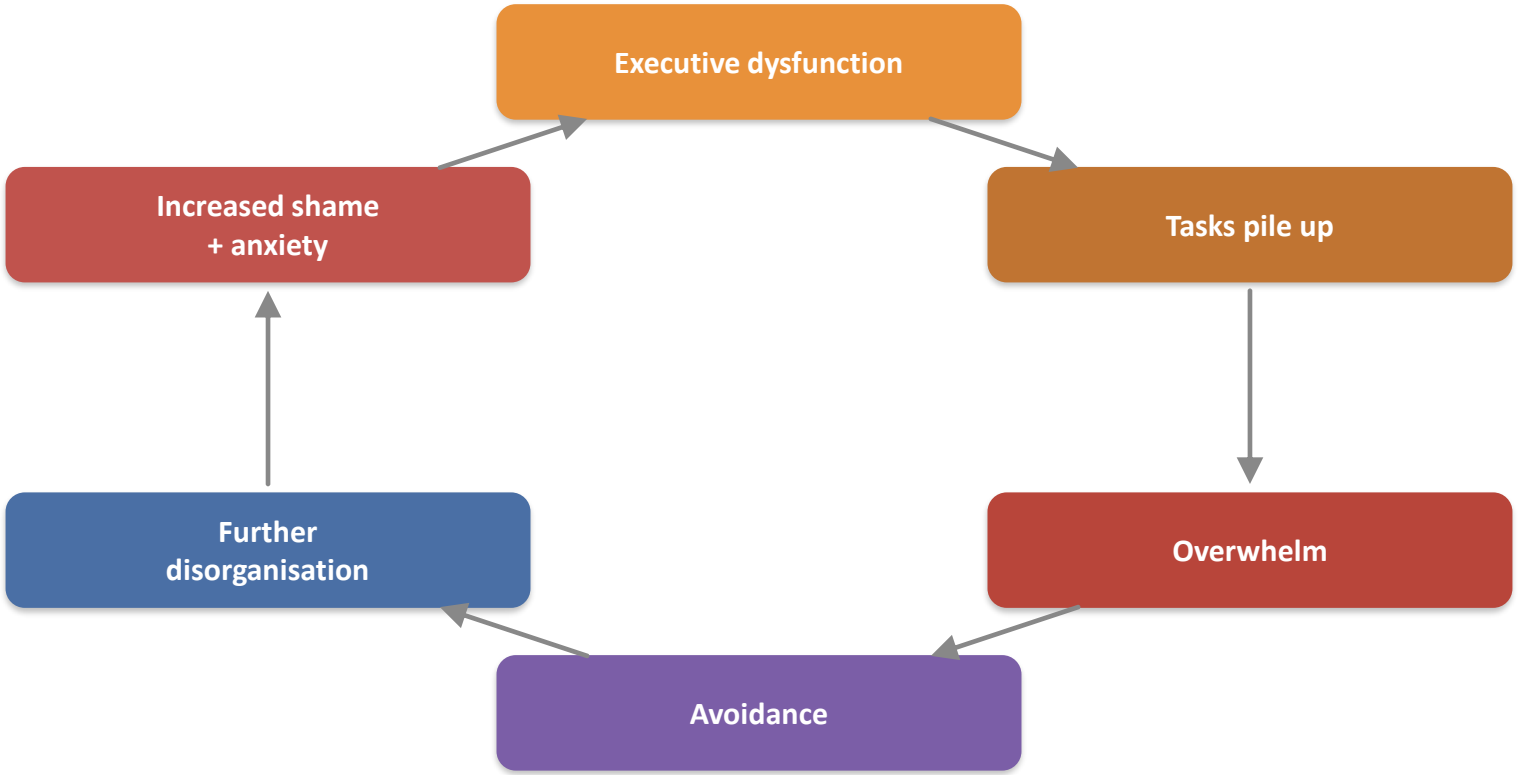
Maintaining Loop: Rumination–Mood Cycle



Maintaining Loop: Alcohol Reinforcement Cycle



Maintaining Loop: ADHD–Overwhelm Cycle



Transdiagnostic Treatment Targets

Instead of treating multiple diagnoses - target the shared mechanisms:

1. Emotional Regulation

- Skills: distress tolerance, grounding, paced breathing
- Normalise postpartum emotional load
- Consider medication review (risk-benefits)

2. Reduce Avoidance

- Graded exposure (e.g. short solo outings with baby)
- Drop safety behaviours gradually

3. Cognitive Processes

- Target rumination and worry (e.g. detached mindfulness, CBT)
- Work with maternal schemas (self-compassion focus)

4. ADHD Supports

- Environmental scaffolding (lists, routines, external structure)
- Consider medication review (risk–benefit in breastfeeding)

5. Substance Use

- Functional analysis of alcohol use
- Replace with alternative regulation strategies
- Harm reduction or reduction plan

6. Sleep

- Behavioural sleep strategies (as feasible with infant) + partner
- Reduce alcohol-related sleep disruption

7. Interpersonal

- Increase support exposure
- Address partner dynamics
- Reduce isolation

Suicide Risk Factors in Perinatal Mental Health

Identifying red flags, higher-risk presentations, and protective factors to guide clinical assessment and intervention

Red Flags

- Suicidal ideation
- Hopelessness
- Severe anxiety / agitation
- Psychotic symptoms
- Insomnia with elevated mood
- Sudden withdrawal from supports
- Thoughts of harm to self or infant

Higher-Risk Presentations

- Bipolar relapse postpartum
- Postpartum psychosis
- Co-occurring addiction
- Recent psychiatric discharge

Protective Factors / Interventions

- Early screening and identification
- Specialist perinatal mental health services
- Integrated addiction + mental health care
- Strong whānau/family support
- Continuity of maternity care
- Sleep protection and practical support
- Culturally responsive care

Mother ↔ Infant

Attachment • Neurodevelopment • Emotional Regulation • Wellbeing

↓ Impact of Maternal Mental Health on Infant

May contribute to:

- Reduced emotional availability
- Impaired bonding and attachment
- Less responsive caregiving
- Infant dysregulation
- Sleep and feeding difficulties
- Developmental and behavioural vulnerabilities

Severe illness may affect:

- Safety
- Consistency of care
- Parent–infant interaction
- Infant stress regulation

↑ Infant Factors Affecting Maternal Mental Health

Infant-related stressors:

- Colic / unsettled behaviour
- Prematurity or NICU admission
- Feeding difficulties
- Sleep disruption
- Neurodevelopmental concerns

Possible maternal impacts:

- Increased anxiety and guilt
- Reduced confidence
- Emotional exhaustion
- Heightened relapse risk

Attachment, Neurodevelopment & Clinical Importance

How early relational experiences shape development, and what this means for perinatal mental health care

Secure Attachment Supports

- Emotional regulation
- Stress tolerance
- Social development
- Cognitive development
- Future relational security

Early Adversity May Influence

- Infant cortisol / stress systems
- Attachment patterns
- Later emotional and behavioural outcomes

Clinical Importance

Perinatal mental health care should:

- Treat the parent and infant together
- Assess attachment and bonding
- Support co-regulation and responsiveness
- Include whānau/family supports
- Use trauma-informed and culturally safe approaches

1 in 5

women experience a perinatal mental health disorder

Leading Cause

Suicide is a leading cause of maternal mortality in NZ

Year 1

Risk is highest in the first postpartum year

Bipolar & SUD

Bipolar disorder and substance use markedly increase risk

Early identification and integrated culturally responsive care are critical protective interventions.
The postpartum period represents a particularly high-risk transition point.

Takeaways

Use formulation over diagnosis
Map transdiagnostic domains rather than fitting patients into categorical labels

Target mechanisms
Emotion regulation • Avoidance • Trauma • Cognitive processes

Integrate care across systems
One team addressing mental health, substance use, and obstetric interface together

Keep dyad in focus
Assess and plan for both parent and infant — risk is individual and relational

Key principle: Perinatal presentations are rarely "pure" diagnostic categories. A transdiagnostic formulation-driven approach addresses shared maintaining mechanisms, reduces treatment fragmentation, and keeps parent–infant wellbeing at the centre.