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LETTER TO THE EDITOR

Advanced training in reproductive psychiatry: The case for standardization in training and a path to sub-specialty recognition

Neha S. Hudepohl[1,2] · **Cynthia L. Battle**[1,2,3] · **Margaret Howard**[1,2]

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Reproductive psychiatry involves the study, evaluation, and treatment of psychiatric disorders throughout the reproductive cycle, including menarche, premenstrual periods, perinatal, and the perimenopausal transition. Published literature suggests that fluctuations in reproductive hormones, including estrogen and progesterone, can have profound impact on the development and exacerbation of a variety of psychiatric illnesses in women vulnerable to these transitions (Meltzer-Brody and Steube 2014). Further, reproductive transitions represent times of profound psychological and social-environmental change, often with increased stress. The perinatal period is arguably the most critical of these transitions, in that psychiatric illness impacts not only the mother but can influence pregnancy and infant outcomes.

In May 2015, the American College of Obstetrics and Gynecology (ACOG) issued a recommendation that perinatal women be screened at least once during this period for depression and anxiety using standardized tools (ACOG 2015). In January 2016, the United States Preventive Services Task Force issued a similar recommendation for screening for depression in pregnant and postpartum women but noted that screening should only be undertaken in systems where adequate diagnosis, treatment, and follow-up is available (U.S. Preventive Services Task Force 2016). The collective weight of these recommendations urges the field to intensify its focus on reproductive psychiatry training and concomitant establishment of specialty clinical programs, so appropriate specialists can be readily accessed.

Historically, general psychiatrists have felt unprepared to manage the intricacies of treatment around reproductive transitions. In addition, there is a dramatic lack of standardization in training during residency programs, a gap currently addressed in the United States by members of the National Task Force on Women's Reproductive Mental Health (Osborne et al. 2015). A recent survey of US psychiatry residency program directors by this Task Force found that only 59% of training programs required any formal education in reproductive psychiatry (Osborne et al. 2015).

Fellowship training in reproductive psychiatry, often subsumed in the broader specialty area of women's mental health (WMH), has grown considerably in the past 15 years (see Fig. 1). Such growth highlights the demand among graduating or junior psychiatrists for this specialized training. In 2015, the North American Society of Psychosocial Obstetrics & Gynecology detailed a list of clinical and research-oriented training programs on their website, and these programs were further detailed in a recent report by Nagle-Yang et al. (2017).

Currently, neither reproductive psychiatry nor the broader field of women's mental health are accredited subspecialties in psychiatry and do not have American Board of Psychiatry and Neurology (ABPN) recognition. As such, no known governing board exists to standardize the curriculum or training objectives, resulting in inter-program variability. Although reproductive psychiatry specialty training is in its relative infancy compared to other, more established Accreditation Council for Graduate Medical Education (ACGME)-

✉ Cynthia L. Battle
Cynthia_Battle@brown.edu

Neha S. Hudepohl
Neha_Hudepohl@brown.edu

Margaret Howard
Mhoward@wihri.org

[1] Warren Alpert Medical School of Brown University, Providence, RI, USA

[2] Women & Infants' Hospital of RI, Providence, RI, USA

[3] Butler Hospital, Providence, RI, USA

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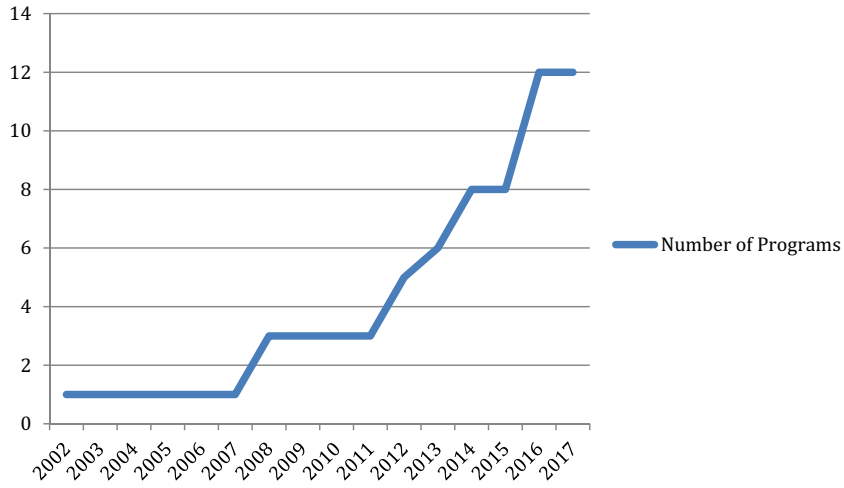

Fig. 1 Growth of reproductive psychiatry fellowship training programs, 2002–2017

accredited psychiatry subspecialty programs, the growth of new women's mental health and reproductive psychiatry fellowships underscores both the perceived value of such training and the growing clinical demand for such expertise.

With mandates from both ACOG (2015) and the U.S. Preventive Services Task Force (2016), the availability of expert psychiatrists, with solid grounding in reproductive psychiatry, is critical. Standardizing milestones and competencies in reproductive psychiatry would help ensure this consistent grounding which is offered across fellowships. Training milestones and competencies could be modeled directly on ACGME competencies and training milestones that are set for psychiatry residency programs, but with more focus on the content and skill expertise gained at this advanced level of instruction. While it would be premature to enumerate specific training competencies at this stage, reasonable expectations include (1) an understanding of the hormonal, biological, and psychosocial underpinnings of major reproductive transitions; (2) an understanding of the spectrum of psychiatric illness across the reproductive cycle, with a solid ability to risk-stratify, assess, and intervene appropriately; and (3) in light of the importance of the perinatal transition, experience with treatment approaches (e.g., dyadic therapy, mother-baby units) that incorporate infant needs in addition to maternal wellbeing.

To garner consideration for subspecialty recognition, the American Psychiatric Association (APA) and the ABPN would need to acknowledge the value of reproductive psychiatry expertise. This could be achieved by adhering to currently established models of psychiatric subspecialties such as psychosomatic medicine.

Now is an optimal time for existing reproductive psychiatry fellowship training programs to join forces and standardize the clinical core competencies and training milestones to ensure consistency. This conversation has been started among many experts in the field. By systemizing and unifying our instruction, training, and evaluation, we can move toward a shared understanding of expertise, and reproductive psychiatry can advance along the path toward subspecialty recognition.

Compliance with ethical standards

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Informed consent Not applicable. This manuscript does not report on any empirical research with participants, so no informed consent was required.

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