

NPA Position Statement 2018

Perinatal Mood and Anxiety Disorders



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Public Policy and Advocacy:

Mental health complications during the perinatal period, from time of conception through the infant's first year of life, are a growing concern for our community. Like other public health problems, Perinatal Mood and Anxiety Disorders (PMADs) by their complexity require broad interdisciplinary approaches and solutions. The National Perinatal Association (NPA) works in partnership and collaboration with other organizations that advocate for perinatal health care, including Mental Health America, Postpartum Support International, Premie Parent Alliance, National Association of Perinatal Social Workers, and the NPA NICU Psychologists Association to address these issues. Together with these organizations, NPA is focused on increasing awareness of these health conditions, advocating for assessment and treatment, and educating policy makers on the needs of these families. NPA supports de-stigmatization of perinatal mental health complications by providing education and awareness on the issue. A healthy society includes a focus on addressing the mental health needs of parents, their children, and their communities.

Issue:

The impact of mental health conditions can be felt in all communities, workplaces, and families in the United States. Assessment and treatment of PMADs is critical to optimal developmental and psychological functioning of the whole family. The National Perinatal Association (NPA) convened its 38th Annual Conference in March of 2017 on this topic. As a result of the two-and-a-half-day conference, an interdisciplinary work-group was created to write this NPA position statement on PMADs.

Pregnancy and the birth of a child is an exciting and celebratory time for many families. However, for approximately 20-25% of these women and their families, PMADs can have profound adverse effects on the women, children, and their family's mental, physical and emotional health. Postpartum depression is the most common complication following childbirth, affecting one in every seven women.^{1,2} Prevalence estimates of prenatal anxiety range from 13-21% of all new mothers, with postpartum prevalence estimated between 11-17%.³ Symptoms of a PMAD may develop during pregnancy or in the postpartum period. Symptoms usually present within 3 weeks to 3 months after birth, but can occur anytime during the first year after delivery.^{4,5} In fact, women are more likely to develop depression and anxiety during the first year after childbirth than at any other time in their life.⁴ Without treatment, PMADs can persist

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for a year or more. Indeed, Woolhouse and colleagues found one in three mothers report depressive symptoms at four years following birth.⁶ Symptoms may include depressive or anxious features such as:

- Persistent sadness
- Anxiety
- Feeling overwhelmed or “empty”
- Crying episodes
- Panic attacks
- Chronic fatigue
- Loss of interest in previously enjoyable activities
- Avoidant behaviors
- Persistent self-doubt
- Changes in sleeping and/or eating patterns
- Feelings of hopelessness, helplessness, guilt
- Experiencing irritable and/or angry moods
- Fear of being alone or separated from baby
- Problems with concentration or making simple decisions

Perinatal mood and anxiety disorders are associated with increased risks of maternal and infant mortality and morbidity and are recognized as a significant patient safety issue.¹ While postpartum depression is the most commonly discussed PMAD, there is a much broader class of psychiatric conditions commonly encountered by women of reproductive age. The broader spectrum of PMADs’ symptomatology and diagnoses includes:

- Depression
- Anxiety
- Obsessive-Compulsive Disorder
- Post-Traumatic Stress Disorder
- Bipolar Disorders
- Psychosis

Onset of these disorders can occur at any time during one’s life. However, there is a marked increase in prevalence of these disorders during pregnancy and the postpartum period. Of particular concern is that up to 50% of mothers with symptoms will not seek mental health treatment.⁷

Fathers, Partners, and Non-Gestational Parents:

While there is a large body of data demonstrating the prevalence of PMADs among women, little research and attention has been given to the rates of depression and anxiety among fathers. There is also a paucity of research around the experience of PMADs for non-gestational and non-biological parents, which may include a second parent in a same sex relationship, multiple parents in a polyamorous family, foster parents, or adoptive parents. As the literature emerges, evidence reflects that fathers, partners, and other non-gestational/non-biological parents (e.g. foster and adoptive parents) are also affected by the stress of having a newborn and may experience anxiety and depression. They are also at risk for anxiety and depression which directly relates to poor outcomes for the child.⁸ Based on a meta-analysis performed by Paulson and Bazmore, the 3-6-month postpartum period had the highest rate of depression for partners, with the first 3 months having the lowest. This analysis also spoke to the variation regarding country of origin, with U.S. fathers demonstrating a greater rate of depression than fathers internationally.⁸

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O'Brien and colleagues found 10% of fathers experience depression and anxiety during the perinatal period. Fathers have been shown to exhibit symptoms of irritability, self-isolation, overworking, substance abuse, and hopelessness.⁹ Research also demonstrates that the most significant risk factor for depression in fathers, both prenatally and in the postpartum period, is maternal depression.⁸ It is plausible that a non-gestational or non-biological parent might be at risk for perinatal depression or anxiety. However, more research is needed in this area.

The Impact of Perinatal Mental Health Conditions:

The impact of parental depression and anxiety, especially the mother, can be quite significant both on the attachment relationship and on the neurodevelopment of the baby. This impact is exacerbated when the parent experiences more clinically significant mental health issues, such as psychosis. The significant impact that a parent's mental health has on their baby's development has been repeatedly demonstrated in the literature.^{10, 11} Tronick's well-known Still Face Experiment demonstrates how emotionally distressed a child can become when a parent "checks out" or is emotionally unavailable.¹²

Recommendation 1: Routine Screening

Routine screening of pregnant and postpartum women for perinatal depression has been recommended by The American College of Obstetricians and Gynecologists (ACOG), The American College of Nurse-Midwives, U.S. Preventive Services Task Force, and the American Academy of Pediatrics (AAP).¹³⁻¹⁵ ACOG recommends universal screening for depression for all women, both as a part of routine gynecological care and during the perinatal period.¹³ The AAP recommends screening for postpartum depression at 1, 2, 3, and 6 months post-delivery. ACOG's Committee Opinion also adds that women at high risk of depression – for example, those with a history of depression or anxiety – warrant especially close monitoring.¹³ The necessity of universal screening becomes even more apparent when considering that only a small percentage of women will disclose symptoms of a PMAD. There are several screening tools validated for use during and following pregnancy (Table 1).

Screening Fathers and Partners:

In 2013, the NPA published a position statement on screening for new fathers for depression. This position statement recommended that fathers be screened at least twice during the first year postpartum. However, there was no guidance on the timing of these screenings. Given that most fathers experience depression between 3 and 6 months postpartum, the 2, 4, and 6 month well baby visits provide ideal opportunities to screen fathers.⁸ However, screening should not be limited to these times. Screening can happen during the obstetric visits, in the delivery nursery, during well child visits, and during a family practitioner visit too.¹⁶

Perinatal Mood and Anxiety Disorders Screening Tools

Screening Tool	Items	Time	Language	Administrator	Where to access/purchase
Edinburgh Postnatal Depression Scale	10	< 5 min.	18 languages	Health care professional	https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/practicing-safety/Documents/Postnatal%20Depression%20Scale.pdf
Postpartum Depression Screening Scale	35	5–10 min.	✓ English ✓ Spanish ✓ Italian	Health care professional	www.wpspublish.com
Patient Health Questionnaire 9	9	< 5 min.	Numerous languages	Health care professional	www.phqscreeners.com
Beck Depression Inventory	21	5–10 min.	✓ English ✓ Spanish	Health care professional	www.pearsonclinical.com/psychology
Beck Depression Inventory–II	21	5–10 min.	✓ English ✓ Spanish	Health care professional	www.pearsonclinical.com/psychology
Center for Epidemiologic Studies Depression Scale	20	5–10 min.	✓ English ✓ Spanish	Health care professional	www.chcr.brown.edu/pcc/cesdscale.pdf
Zung Self-rating Depression Scale	20	5–10 min.	English	Health care professional	www.mentalhealthministries.net/resources/flyers/zung_scale/zung_scale.pdf

Table 1: Perinatal Mood and Anxiety Disorder Screening Tools

Screening Black and Latina mothers:

There should be special consideration given to the effects of racial identification and racial status when screening mothers for PMADs who are from minority populations. Robert Keefe evaluated the differences in PMADs for Black, Latina, and White women and found that while Black women are less likely to express feelings of depression or anxiety, their rate of depression and anxiety is much higher rate than their White counterparts. He also found that Black and Latina women are less likely to seek support, treatment, and follow up after an initial psychiatric appointment.¹⁷ This suggests there may be an unmet need for culturally respectful and appropriate services for these communities. Additionally,

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he found that when Black and Latina women sought services, the time span between symptomatology and engagement with treatment was much longer than for White women.¹⁸ For these reasons, it has been recommended that a lower cutoff score be considered for these populations. It is proposed that a cutoff score of 2-3 points lower (greater than or equal to 7-8) will help to capture distress among these mothers and improve identification of depression and anxiety, which will hopefully increase likelihood of support and treatment.¹⁹

Screening Adolescent Mothers:

Screening for perinatal mood and anxiety disorders should be inclusive of adolescent mothers (under 20 years of age). The rate of reported depression amongst this population is 28-59%. With over 300,000 births to adolescent mothers annually, the rate of depression among adolescents is greater than in the adult population. Venkatesh and colleagues determined the Edinburgh Postpartum Depression Scale (EDPS) was appropriate for accurately identifying depression and anxiety in postpartum adolescent mothers.²⁰

Screening timeline for Perinatal Mood and Anxiety Disorders*					
	Pregnancy	OB/GYN	Pediatrician or Primary Health Care Provider		
Mother	At least once. Preferably each trimester.	6 week postpartum visit	2 month well baby/NICU	4 month well baby/NICU	6 month well baby/NICU
Partner	_____	_____	2 month well baby/NICU	4 month well baby/NICU	6 month well baby/NICU

Table 2: Screening timeline for Perinatal Mood and Anxiety Disorders

*Minimum recommendations, screening should be done as often as needed.

Recommendation 2: Training and Education of Healthcare Professionals

There are numerous perinatal specialists (e.g. Obstetricians, Pediatricians, Neonatologists, Nurses, Occupational Therapists, Physical Therapists, Psychologists, Social Workers, Speech Language Pathologists, and Lactation Consultants) who contribute to maternal-infant care. While some of these specialties are based in mental health, many specialists lack education regarding those mental health conditions associated with pregnancy and their potential to negatively impact child development. NPA encourages comprehensive training and education in perinatal mental health for all healthcare providers who serve families during the perinatal and postpartum period. NPA believes all healthcare providers should have an informed understanding of the signs and symptoms of PMADs, should be familiar with available treatment options, and should be empowered to make referrals to services and treatment.

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Moreover, NPA strongly recommends relevant professionals have the necessary skills to recognize and treat families as it relates to their scope of practice.

Summary:

In order to improve the care of a family's mental health during the perinatal period, routine screening must occur. NPA recommends that:

- The Edinburgh Postpartum Depression Scale (EPDS) be administered at least once during the pregnancy, but ideally in each trimester, as well as at the 6-week postpartum visit.
- Screening should, at minimum, be administered using the EPDS at the 2, 4, and 6 month well baby visits or in the NICU, if the baby has not yet discharged.
- All healthcare providers receive adequate training on identifying the warning signs of PMADs and establish an appropriate referral process for further assessment and/or treatment, when needed.

Given that research has demonstrated that the EPDS is useful in the detection of PMADs for adolescents, it is recommended that:

- Adolescents should be included in the screening population.

NPA is sensitive to the varying expressions of depression and anxiety as influenced by race, culture, class, and ethnicity and recommends:

- Using a cutoff score 2-3 points lower (greater than or equal to 7-8) for women of minority populations, as suggested in the clinical literature.

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Resources:

To support and enhance screening, practitioners should be familiar with perinatal mood and anxiety disorder resources in their community. Contact the following organizations for more information:

- Postpartum Support International (PSI)
<http://www.postpartum.net>
- Mental Health America (MHA)
<http://www.mentalhealthamerica.net>
- Massachusetts Child Psychiatry Access Program (MCPAP) for Moms
<https://www.mcpapformoms.org/Toolkits/Toolkit.aspx>
- National Institute of Mental Health (NIMH)
<https://www.nimh.nih.gov/health/publications/depression-in-women/index.shtml>
- National Alliance of Mental Illness (NAMI)
<https://www.nami.org/>
- The Blue Dot Project – Maternal Mental Health Toolkit
<https://www.thebluedotproject.org/mmh-week-2018-tool-kit>

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