From the National Perinatal Association: Shedding Light on the Dark Reality of Disparities in Perinatal Care

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The National Perinatal Association (NPA) is an interdisciplinary organization that strives to be a leading voice for perinatal care in the United States. Our diverse membership is comprised of healthcare providers, parents & caregivers, educators, and service providers, all driven by their desire to give voice to and support babies and families at risk across the country.

Members of the NPA write a regular peer-reviewed column in Neonatology Today.

The National Perinatal Association (NPA) mission is to optimize perinatal health in the United States. One of the most significant areas of concern is perinatal mental health and its impact on parents, their children and their communities. In 2017, the NPA annual conference addressed this issue with experts in clinical and research providing opportunities for discussion conference, NPA initiated a perinatal mental health work group. 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, Preemie Parent Alliance, National Association of Perinatal Social Workers, and the NPA NICU Psychologists Association to address these issues. Over the next two years, the NPA Perinatal Mental Health group worked to develop a position statement on Perinatal Mental Health issues. NPA developed stronger collaborations with Postpartum Support International, National Association of Perinatal Social Workers and the NPA NICU Psychologists Group to bring awareness to providers and families about perinatal mental health issues in the NICU.

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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 The numbers for parents with a child in the NICU are usually higher, closer to 40% for mothers. Often the symptoms emerge in the NICU, and all NICU professionals need to be aware of the symptoms, how to assess for these concerns and resources and treatment options for families.

Symptoms of Perinatal Mood and Anxiety Disorders

- 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

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The onset of these disorders can occur at any time during one's life. However, there is a marked increase in the 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)

Perinatal Mood and Anxiety Disorders in the Non-Gestational Parent

While there is a large body of data demonstrating the prevalence of PMADs among women, little research and attention have 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, the 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) Again, these numbers are found to be higher for the non-gestational

parent whose infant requires NICU hospitalization. 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 Infant

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)

With the knowledge gained from the research discussed, there are specific actions that NICU professionals need to take while families are hospitalized.

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 this time. Screening can happen during the obstetric visits, in the delivery nursery, during well-child visits, and during a family practitioner visit too.(16)

For families in the NICU, Postpartum Support International and the NPA Neonatal Psychologists group recommends screening two weeks after admission and every two weeks for the duration of the hospitalization. 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, 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 the likelihood of support and treatment.(19) In addition, 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 that the Edinburgh Postpartum Depression Scale (EDPS) was appropriate for accurately identifying depression and anxiety in postpartum adolescent mothers. (20)

Training and Education for Healthcare Professionals

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Treatment Options

Treatment requires psychotherapy, support of family and friends, potentially a peer mentor and ongoing treatment. The use of antidepressants has demonstrated some success but has not been as effective as was hoped. The FDA recently approved the use of ZULRESSO (brexanolone) for postpartum depression. ZULRESSO is administered over 60 hours by continuous IV infusion. It is an allosteric modulator of both synaptic and extrasynaptic GABAA receptors. This results in the desired activity instead of complete activation or inhibition of the receptor. Once the infusion is completed, the woman will not have any more symptoms. The research and clinical trials are very promising. (21)

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Screening Tool	Items	Time	Language	Administrator	Where to access/purchase
Edinburgh Postnatal Depression Scale	10	< 5 min.	18 languages	Health care professional	pesnc.org/wp-content/uploads/EPDS.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/pcoc/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

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21. Sage Therapeutics Announces FDA approval of ZURESSO (brexanolone) Injection, the First and Only Treatment Specifically Indicated for Postpartum Depression. Press Release March 19, 2019.

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