There are several reasons I wanted to share my thoughts on the recent ACOG Committee Opinion on screening for perinatal depression. First, I am a researcher. I have spent the last 15 years researching the suffering endured by women as a result of untreated perinatal mood and anxiety disorders. Researchers are trained to see problems, to methodically dissect the presentation of evidence and to question validity.

Second, I have also spent the last 15 years advocating for maternal health reform that includes maternal mental health. Lastly, I have direct experience with the life-threatening nature of untreated perinatal mood and anxiety disorders. As I write this, I am grieving the loss of a friend and fellow advocate to suicide. I am so critical of institutions that fail to adequately address maternal mental health because women die from mental illness that is untreated, overlooked, stigmatized and ignored.

Some of the most powerful images of women and motherhood are those held by the professional disciplines that lay claim to a special expertise in the field of reproduction—namely, medical science, clinical psychiatry and psychology.1

— Ann Oakley

Introduction

Oakely’s1 observation, cited above, is a great reminder for us to examine the paradigm of motherhood constructed by the medical establishment and identify the gaps between authority and authenticity. Birth advocacy by definition is a tradition of critical analysis of institutionalized power.2 Moreover, the international doula movement was founded on the principle of speaking women’s truth to medical power. Penny Simkin and countless other birth advocates have courageously shed light on the gaps between the medical establishment and a woman’s inherent abilities and needs in childbirth. It is from this perspective that I get my passion, as well. As a researcher, former DONA certified birth doula and author, I am trained to see the discrepancies in the maternal health policy for mothers who experience mental illness.

Here, at the intersection of the birth and the brain, I have spent the last 15 years wondering, questioning and grieving the loss of life and suffering at the hands of untreated perinatal mood and anxiety disorders.

Current paradigms of maternal health can also be understood through...
close examination of the published work and public statements of the medical establishment. Enter the American College of Obstetricians and Gynecologists’ (ACOG) latest committee opinion on screening for perinatal depression. Published in May of this year, ACOG’s Committee Opinion Number 631 regarding screening for depression and anxiety in the perinatal period, with the stated purpose “to increase awareness of depression and mood disorders in pregnant and postpartum women” recommends screening pregnant and postpartum women once during the perinatal period, replacing the previous 2010 opinion stating that screening was not recommended due to “insufficient evidence”. The change of opinion is noteworthy.

In this article I will first review the stated ACOG recommendations and the rationale used to support them, with careful attention paid to the quality of supporting evidence in the document. Secondly, I will review the screening instruments recommended and juxtapose current understanding of barriers to screening for obstetric providers.

Review of recommendations

The four central recommendations from ACOG’s recommended screening for perinatal depression and anxiety are:

1. Screening patients “at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool.”

2. “Closely monitoring” patients with risk factors for Perinatal Mood and Anxiety Disorders (PMADs), such as current depression or anxiety or a history of previous PMADs.

3. Clinicians should not rely solely on screening but must offer “appropriate follow-up and treatment when indicated,” including initiating medical treatment and referring patients to “appropriate behavioral health resources.”

4. “Systems should be in place to ensure follow-up for diagnosis and treatment.”

At first glance, the new recommendations appear progressive. However, upon closer examination, the document reveals anemic supporting evidence and impractical recommendations. The cited studies fluctuate among outdated studies, studies cited in the last opinion recommending against screening and in essence minimizes women’s mental health. The organization of the opinion merits mentioning. The paper presents an abstract, then bullet-pointed recommendations, followed by the introduction, and then recommended screening tools. Standard protocol for peer reviewed manuscripts recommends an abstract (which includes a brief summary of findings), followed by an introduction to the topic and background information. The paper is not a research study, yet it is published in a peer-reviewed research journal with the highest of standards for publication. Therefore, the layout itself was incongruous with the established protocol for peer-reviewed publication.

The inconsistencies in the research cited in support of the recommendations confuse and weaken the report. For example, the prevalence of depression in women is cited with a 20-year-old epidemiological overview article, not a research study. The authors then cite a well-respected 2005 meta-analysis to support their one-in-seven prevalence; however ACOG used the same study in the previous ACOG 2010 opinion against screening for PMADs.

The paper addresses the more recent evidence regarding comorbidity of symptoms of anxiety within perinatal for screening and in essence minimizes women’s mental health. The organization of the opinion merits mentioning. The paper presents an abstract, then bullet-pointed recommendations, followed by the introduction, and then recommended screening tools. Standard protocol for peer reviewed manuscripts recommends an abstract (which includes a brief summary of findings), followed by an introduction to the topic and background information. The paper is not a research study, yet it is published in a peer-reviewed research journal with the highest of standards for publication. Therefore, the layout itself was incongruous with the established protocol for peer-reviewed publication.

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The document notes deleterious effects of untreated PMADs, including maternal suicide: “maternal suicide exceeds hemorrhage and hypertensive disorders as a cause of maternal mortality” citing a current and important study regarding maternal mortality; but then uses another 20-year-old study to support their statement that PMADs are often unrecognized, when it is widely reported that as many as 50% of women with PPD go untreated.

The paper addresses the more recent evidence regarding comorbidity of symptoms of anxiety within perinatal
mood disorders but fails to cite any, let alone recent, studies. In vague and somewhat simplistic language, the authors only direct: “It may be helpful to ask a woman whether she is having intrusive or frightening thoughts or is unable to sleep.” It may be helpful? Here ambiguity is juxtaposed by the equally vague and somewhat stigmatizing “intrusive or frightening thoughts.” The authors offered no context as to when or how to approach such thoughts and fail to note whether these questions are already included within any of the recommended screening tools, nor did they offer a suggestion as to what to do if a patient says “yes” and there is an indication of a psychiatric emergency. The absence of discussion regarding next steps protocol weakens the best practices necessary to initiate the recommendations, and weakens the strength of the opinion.

Screening tools

The weak language is further evidenced in how the committee described PMAD screening tools: “Several screening instruments have been validated for use during pregnancy and the postpartum period to assist with systematically identifying patients with perinatal depression” (p. 2). They then list seven validated screening instruments and direct the reader to a table listing the same information. Neither the in-line text nor the table references the authors of the instruments listed. It is common practice and professional courtesy to cite the authors of screening tools. However, this document does not. Secondly, there are no clear supporting resources given for how to access the tools, nor how to integrate them into a clinical practice during the perinatal visit. Third, the opinion does not review the symptoms of PMADs, nor reference the DSMV$^{11}$ nor the ICD-1012 diagnostic criteria. Rather, the opinion offers: “Although screening is important for detecting perinatal depression, screening by itself is insufficient to improve clinical outcomes and must be coupled with appropriate follow-up and treatment when indicated; clinical staff in obstetrics and gynecology practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both” (p.2).

Be prepared to initiate treatment. What does that mean? A colleague of mine suggested that it would be like telling psychiatrists that they had to now be ready to assess preterm labor and initiate medical therapy to stop contractions. It is widely understood that the most common medical treatment intervention is psychopharmacology$^{13}$. Yet in this document, ACOG fails to note that the majority of women are resistant to taking medication without being offered a range of nonmedical based treatment options$^{14}$.

I was curious as to the training OB/GYN residents receive regarding psychopharmacology and PMADs. I reached out to ACOG Director of Media Relations and Communications Kate Connors, and asked about the standards for training. She shared: “There’s no specific amount of time that is dedicated to this training, but rather one of the educational objectives of the residency is the mental health care of women. Residents are taught to evaluate pregnant and postpartum women for wellness and mental health disorders. Also the objectives (as with all educational objectives) are matched to a progressive learning experience throughout the residency and competency rather than hours assessed. So, there is no one magic answer, but rather residents have to demonstrate proficiency and competency.” (Personal communication, July 7, 2015)

I query this: How does one demonstrate proficiency and competency without standardized learning? How do students prove they have learned the material without a formal assessment of their learning? It would be as if to say that you don’t have to take a driver’s test, nor complete the required hours of driver’s training, but just have to demonstrate you are proficient on the road. The gap between training and practice in screening for perinatal mood and anxiety disorders merits closer examination.

What is still more concerning is the recommendation, considering the practical application of proficient,
Conclusion

Using Oakley’s1 concept that we gain insight into the construct of motherhood through the lens of disciplines charged with their care, what might the ACOG recommendation detailed here illustrate? When the medical establishment demonstrates weakness in attention to academic detail, it reveals institutional (and possibly systemic) uncertainty, if not apathy. Most important, the ACOG recommendation to screen a woman at least once during the perinatal period may give license to providers to neglect women’s mental health throughout the rest of her life span, tethering a woman’s medical visibility and mental health care to reproductive events. The precedent set results in situations such as my own mother, whose lifelong depression was treated at the end of her life, by her oncologist. Who cares for mothers’ mental health after they are done birthing?

Perinatal mental health has yet to receive equal status in obstetric research and practice. The majority of maternal mortality research ignores suicide altogether — despite the fact that suicide is the second-leading cause of death for women in the postpartum period13-16 and that suicide accounts for more maternal mortality than hypertension and hemorrhage8, we have evidence in this document that the issue merits only loose, arbitrary recommendations and paltry evidence. The lack of academic rigor gives tacit permission to not address the most common complication in pregnancy and postpartum, promotes marginalization, fuels stigma and may institutionalize lack of appropriate care.

My hope is that this article will strengthen our understanding of the current paradigm of perinatal mental health in the medical establishment and encourage our own self-reflection as birth professionals and advocates. Doulas continue to lead the way in advocacy for childbearing women in labor, birth and postpartum. How can we improve?
Walker Karraa is a provocative thought leader in the field of maternal mental health and leadership. Her first book, Transformed by Postpartum Depression: Women’s Stories of Trauma and Growth, presents her research revealing the traumatic and transformational dimensions of postpartum depression. Dr. Karraa is a member of DONA International’s Advisory Council and serves on the board of the International Marcié Society for Perinatal Mental Health. She is a Research Fellow for the Center for Leadership Studies and Educational Research for the School of Advanced Studies at the University of Phoenix where she teaches qualitative research methods in the doctoral program. Dr. Karraa runs a perinatal research consulting practice, Postpartum Associates, Inc., and lives in Sherman Oaks, California with her two children.

REFERENCES: