# Too Little, Too Late

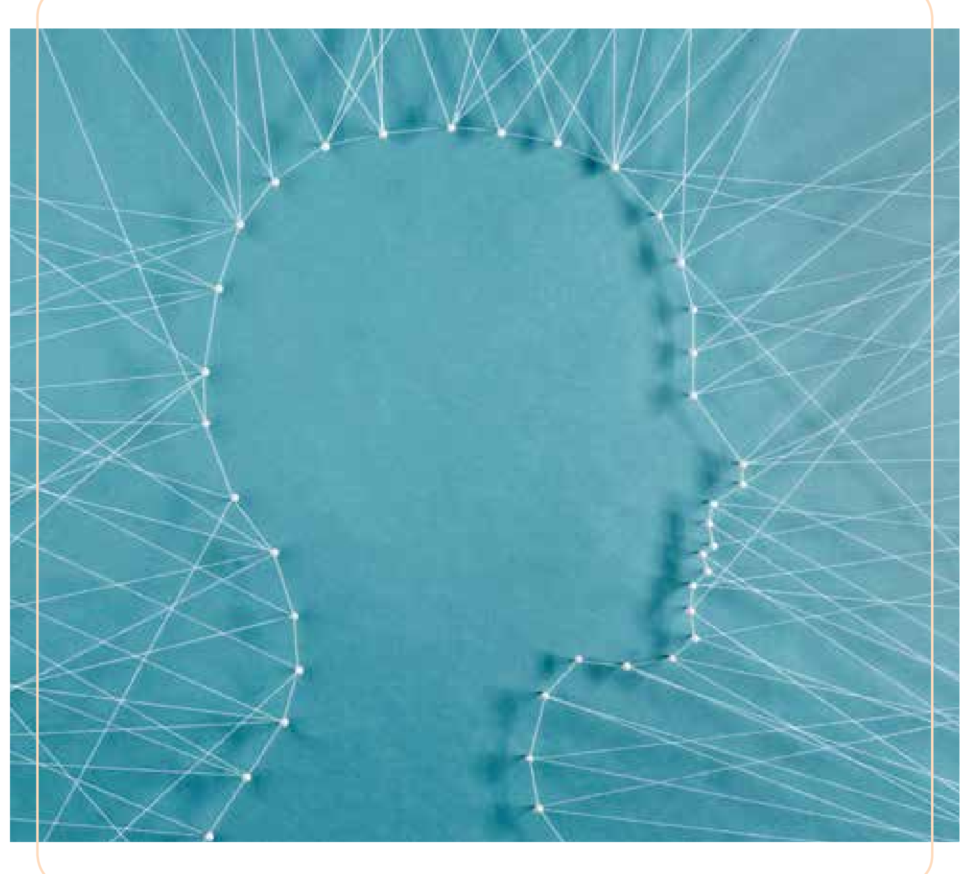
## A critical review of the ACOG Committee Opinion on screening for perinatal depression

By Walker Karraa, Ph.D.

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's[1] 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[3]. 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".[2] 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.

The gap between training and practice in screening for perinatal mood and anxiety disorders merits closer examination.

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 absence of citations. Academic writing requires the presentation of a rationale based upon previously validated research that is most current. Granted, the ACOG Committee Opinion was purposed to increase awareness. Nonetheless, it was published in a top-tier medical journal that requires rigorous peer-review and editorial scrutiny — including checking for the validity of the literature review. The lack of supportive evidence weakens the rationale 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.[4] 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[5], not a research study. The authors then cite a well-respected 2005 meta-analysis[6] to support their one-in-seven prevalence; however ACOG used the same study in the previous ACOG 2010 opinion[7] against screening for PMADs.

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[8]; but then uses another 20-year-old study[9] 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.[10]

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,

Valuable information is gleaned from every doula experience!

**COMPLETE A BIRTH OR POSTPARTUM DATA COLLECTION FORM**

for each and every experience YOU attend as a DONA doula and mail or fax it to the DONA home office:

35 East Wacker Drive, Suite 850,
Chicago, IL 60601
FAX: (312) 644-8557

certification committee

DONA certified birth and postpartum doulas, fluent in English and Spanish, volunteer to serve on the certification committee.

**CONTACT: certificationdirector @DONA.org**

competent clinical practice, of how often a provider should screen. I went back to Connors for a statement regarding the determination of screening once during the perinatal period, and received this official statement.

"OB/GYNs recognize that perinatal depression can be serious and debilitating. The Committee Opinion does not state that women should be screened once; it states that women should be screened at least once, with additional emphasis given to women with risk factors. Screening for depression is regularly part of perinatal visits and is an important way to help women get the treatment that is right for them." (Personal communication)

The vagaries in language and the random recommendation of screening at least once during pregnancy illustrate the image of motherhood held by ACOG. The opinion suggests that ACOG compartmentalizes and marginalizes women's perinatal mood disorders. The lack of substance in the opinion speaks to the lack of substance in ACOG's appreciation for the issue and clinical intentions.

Having been on several organizational working committees, I wondered about the conditions under which the members of this committee were asked to perform. Was there an unreasonable deadline for the paper? Were committee members given appropriate time and resources to accomplish the work? Did leadership reach beyond past protocol for opinions to suggest new standards for transdisciplinary inclusion, such as insuring perinatal psychiatry literature was reviewed? Were there any perinatal psychiatrists on the committee? Was the peer-review process inclusive of perinatal psychiatrists? Questions linger as the opinion lives in publication as a representation of current opinion regarding obstetric practice and perinatal mental health.

## Conclusion

Using Oakley's[1] 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 period[13-16] and that suicide accounts for more maternal mortality than hypertension and hemorrhage[8], 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 Marcé 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:

1. Oakley, A. (1993). Essays on women, medicine and health. Oxford, England: Edinburgh University Press.

2. Morton, C. H., & Clift, E. (2014). Birth Ambassadors: Doulas and the Re-emergence of Woman-supported Birth America. Amarillo, TX: Praeclarus Press.

3. American College of Obstetricians and Gynecologists Committee on Obstetric Practice. (2015). Committee opinion No. 631: screening for perinatal depression. Obstetrics & Gynecology, 125, 1272-5.

4. Publication manual of the American Psychological Association. Washington, DC: American Psychological Association, 2001.

5. Weissman, M. M. (1995). Depression in women: implications for health care research. Science, 269, 799-801.

6. Gavin, N. J., Gaynes, B. N., Lohr, K. N., Meltzer-Brody, S., Garthlehner, G., & Swinson, T. (2005). Perinatal depression: a systematic review of prevalence and incidence. Obstetrics & Gynecology, 106, 1071-83.

7. American College of Obstetricians and Gynecologists Committee on Obstetric Practice. (2010). Committee opinion No. 453: screening for depression during and after pregnancy. Obstetrics & Gynecology, 115(2, pt. 1), 394-395.

8. Palladino, C. L., Singh, V., Campbell, J., Flynn, H., & Gold, K. (2011). Homicide and suicide during the perinatal period: findings from the National Violent Death Reporting System. Obstetrics and gynecology, 118(5), 1056.

9. Whitton, A., Warner, R., & Appleby, L. (1996). The pathway to care in post-natal depression: women's attitudes to post-natal depression and its treatment. British Journal of General Practice, 46, 427-428.

10. Mental Health America, Substance Abuse, and Mental Health Services Administration. (2009). Maternal depression making a difference through community action: a planning guide. Washington, DC: Government Printing Office.

11. American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (DSM-5®). American Psychiatric Pub.

12. World Health Organization. (1992). The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization.

13. Marcus, S., Flynn, H., Blow, F., & Barry, K. (2003). Depressive symptoms among pregnant women screened in obstetrics settings. Journal of Women's Mental Health (Larchmont), 14(4), 373-380.

14. Oates, M. (2003). Suicide: the leading cause of maternal death. The British Journal of Psychiatry, 183(4), 279-281.

15. Chang, J., Berg, C. J., Saltzman, L. E., & Herndon, J. (2005). Homicide: a leading cause of injury deaths among pregnant and postpartum women in the United States, 1991–1999. American Journal of Public Health, 95(3), 471.

*Midwifery Workshops*
*at The Farm Midwifery Center*
*presented by The Farm Midwives*

**Midwife Assistant Workshops**
6-day Midwifery Assistant Workshops
March 13-19, 2016
April 17 -23, 2016
Aug. 7-13, 2016
Aug. 28 - Sept. 3, 2016
Nev. 6-12, 2016

**Neonatal Resuscitation**
Nov. 16-17, 2015
March 21-22, 2016 and September 5-6, 2016

*Advanced Workshop*
May 29-June 4, 2016
*Continuing education units offered.*

*For more information and curriculum, write:*
The Farm Midwifery Workshops
P.O. Box 217
Summertown, TN 38483
e-mail: midwives@midwiferyworkshops.org
www.midwiferyworkshops.org