

Perinatal Mental Health Disorders: A Review of Lessons Learned from Obstetric Care Settings

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Abstract: Perinatal mental health has garnered significant attention within obstetrics over the last couple of decades as the long- and short-term morbidities of untreated perinatal mental health disorders on both the mother and fetus/neonate have become increasingly apparent. There have been major strides in increasing screening for perinatal mental health disorders, clinician comfort with prescribing common psychiatric medications, and integrating mental health professionals into prenatal care via health services approaches such as the collaborative care model. Despite these advances, however, gaps still remain in the tools used for screening and diagnosis, obstetric clinician training in diagnosis and management of perinatal mood and anxiety disorders, as well as patient access to mental health care during pregnancy and especially postpartum. Herein we review the state of perinatal mental health from the perspective of the obstetric provider and identify areas of ongoing innovation.

Keywords: perinatal mental health, perinatal depression, perinatal anxiety, collaborative care

Introduction

Over the last couple of decades, there has been a paradigm shift in perinatal health care where mental health has been recognized as a major contributor to perinatal and fetal/neonatal wellness. Perinatal mood and anxiety disorders (PMAD) are among the most common pregnancy complications, impacting up to 1 in 5 women.¹ Untreated or undertreated PMAD are associated with major short- and long-term morbidities for both the mother and fetus/neonate including preterm birth, small for gestational age, compromised maternal-infant bonding, worsening PMAD symptom trajectory and, in rare cases, maternal mortality.²⁻⁹ The gap in diagnosis and treatment of PMAD is further exacerbated by the major social, racial and ethnic inequities that pervade maternal healthcare overall.¹⁰⁻¹²

Many of the contributors to PMAD such as social stressors and pre-existing psychiatric conditions including anxiety, depression and post-traumatic stress disorders were exacerbated by the COVID-19 pandemic.¹³⁻¹⁸ Challenges in access to care during the pandemic have also disproportionately impacted underrepresented and minoritized populations, compounding existing care gaps and brought additional attention to this area.^{19,20}

Existing Barriers

Screening

National organizations such as the American College of Obstetricians and Gynecologists (ACOG), the United States Preventive Services Task Force (USPSTF), the National Institute for Health and Care Excellence (NICE), as well as others, have emphasized the importance of universal screening for and active management of PMAD.^{2,21-25} Many of these organizations support screening at least once during pregnancy; however, there is little consensus or guidance about the optimal period in pregnancy that screening should be performed, and some guidelines even provide contradictory recommendations.^{24,25} The lack of guidance has resulted in incredibly varied practices where patients are inconsistently screened during pregnancy or never screened at all,²⁶ which may miss opportunities for active management of PMAD.

There is also a lack of consensus about how sub-clinical PMAD (scores that fall just below the threshold for a positive screen) should be managed. For example, do they require repeat screening, and if so, at what interval would screening optimally be performed?

Furthermore, there are significant time constraints to addressing all relevant perinatal issues in the context of standard prenatal visits. Due to a shortage of obstetric care providers,²⁷ clinicians are frequently allocated less than 15 minutes per visit to address all preventive obstetric care as well as problems that have arisen. Particularly within the context of a medically complicated pregnancy, mental health can easily be pushed aside for other, seemingly more pressing issues. Furthermore, the most commonly utilized screening tools, such as the Edinburgh Postnatal Depression Scale (EPDS)²⁸ and the Patient Health Questionnaire-9 (PHQ-9)²⁹ were developed and validated in pregnant populations that do not mirror most modern obstetric landscapes. There has been a push to develop culturally diverse mental health screening tools in the non-perinatal population;^{30–33} however, these efforts have yet to be rigorously applied to the perinatal sphere.

Recently, additional attention has been paid to the various conditions that are frequently comorbid with PMAD, particularly substance use disorders³⁴ and intimate partner violence (IPV).³⁵ Pregnancy provides a unique opportunity to identify for these comorbidities along with PMAD, and screening for both substance use and IPV is encouraged at least once in pregnancy as part of comprehensive obstetric care.^{34,35}

Unfortunately, perinatal mental health screening has not been a robust aspect of obstetric training. Specifically, few obstetric providers receive dedicated training in responding to positive responses on depression screens, and even less training on responding to findings concerning suicidality, which can serve as a deterrent to regular screening practices.^{36,37}

Treatment

Even if an obstetric provider feels comfortable screening for PMAD, most receive inadequate training on even basic management of these disorders.³⁸ Lack of knowledge around safe medication prescribing patterns in the perinatal period as well as the inability to provide interpersonal therapy options can make it challenging or uncomfortable for obstetric providers to initiate treatment in this population.^{37–40} This is compounded by discomfort by many mental health specialists in treating pregnant or recently postpartum individuals and the shortage of perinatal mental health specialists,^{41,42} which creates additional barriers to helping patients access comprehensive mental health care. These barriers are particularly challenging for pregnant or postpartum individuals with public insurance.^{43,44}

Access to Postpartum Care

Postpartum visit attendance is incredibly variable, with 25–96% of people attending a postpartum visit.⁴⁵ Among vulnerable populations, this can be as low as 30–50%,⁴⁶ with racial/ethnic minority populations, particularly Black women, having among the lowest rates due to structural racism and adverse social determinants of health.⁴⁷ Postpartum telehealth options that were introduced during the COVID-19 pandemic have been shown to mitigate existing disparities in postpartum care access and uptake,⁴⁸ but optimal implementation of postpartum telehealth, accounting for the need for a physical examination and potential placement of long-acting reversible contraceptives (LARC) has not been established.

Ongoing Areas of Innovation

Education

Recognizing the gaps in perinatal mental health education during psychiatry training, The National Task force in Women's Reproductive Mental Health recently launched the National Curriculum in Reproductive Psychiatry (NCRP).⁴⁹ This online, interactive training platform is tailored to mental health professionals and trainees, and was designed to deepen the knowledge of psychiatric issues that arise during the reproductive years. In a recent call to action on the importance of cultivating mental health in obstetrics and gynecology, creators of the NCRP revealed the plan to develop a curriculum oriented toward obstetric trainees that will be modeled after the NCRP.⁵⁰ The consistent gaps in education on perinatal mental health across both psychiatric and obstetric training programs highlight that there may be

untapped opportunities for collaborative learning across specialties. This could also foster open sharing of resources and help develop cooperative care networks and research infrastructure.

Collaborative Care Model

Integrated models of care, such as the collaborative care model, have garnered significant attention as a mechanism to increase access to and quality of perinatal mental health care.^{51–53} They involve convening a multidisciplinary team of obstetric providers, perinatal psychiatrists, case managers, social workers, among others who actively follow-up PMAD screening, funnel resources to those with active concerns, and encourage targeted treatment-to-goal throughout the perinatal period for a population of pregnant and postpartum people. They have been demonstrated to increase obstetric clinician comfort with screening and prescribing,⁵⁴ as well as mitigation of extant disparities in perinatal mental health care.^{1,55} However, there are some barriers to widespread implementation of this care model. Its implementation is time-intensive and personnel-intensive as it requires regular, ongoing multidisciplinary care. It also relies on regular screening and an ongoing system-wide commitment to incorporating mental health into routine perinatal care.

Partner Mental Health

Up to 8–10% of non-birthing partners (or depending on the study examined, fathers) experience PMAD,^{56–58} which has major implications for their health as well as the health of the birthing parent^{57,59–62} and their offspring.^{63,64} PMAD in the non-birthing person can be more challenging to diagnose due to the lack of consistent health care or screening, differences in the manifestation of PMAD by gender,^{65,66} and social stigma around seeking help for mental health indications. Improving partner mental health is an innovative way of positively impacting birthing-person mental health and related outcomes.⁶⁷

Resilience

Prior perinatal mental health research and innovation has largely been viewed through a pathological, Diagnostic and Statistical Manual of Mental Disorders (DSM) perspective. Improving somatic, birth experience, and mental health outcomes through bolstering maternal resilience remains an underappreciated and understudied area at the cross-section of obstetrics and mental health,⁶⁸ but one that has shown promise in non-obstetric populations.^{69,70}

Conclusions

Despite huge strides in understanding, screening for, and treating PMAD, much remains unknown. A number of innovative strategies to address some of the remaining gaps include structured trainee education in perinatal mental health, optimizing care access to vulnerable populations, establishing collaborative care models, improving partner mental health and harnessing improvements in resilience. Obstetric providers have a unique role as the primary care providers for most patients in the peripartum period, which is an underappreciated window into future health.

Disclosure

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