

Women's Health Literature Review

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Psychiatric disorders are common among women of childbearing age. 10% to 13% of pregnant women have a clinical diagnosis of depression and/or anxiety, while 3% have a bipolar disorder diagnosis and less than one percent have a diagnosis of a psychotic disorder (Mannisto et. al, 2016). Women with untreated psychiatric symptoms are less likely to access care, including prenatal care, and may be more susceptible to substance abuse before and during pregnancy (Mannisto et. al, 2016).

Research also shows that approximately one out of every seven women will experience PMADs (perinatal mood and anxiety disorders) symptoms and those numbers may even be higher if the women who are undiagnosed and untreated are included. Postpartum Support International (2022) also includes that one in ten dads will experience various depressive and anxiety symptoms during the postpartum period as well. Unfortunately, this is something that is rarely discussed or even thought about.

To further explore the effects PMADs has on not only the women but also on the infants, this literature review will focus on articles that will help to answer the following PICO question:

Does a lack of adequate screening/assessments for PMADs (perinatal mood and anxiety disorders) throughout pregnancy and up to one-year postpartum lead to an increase of pregnancy and birth complications in women with preexisting mental health diagnoses?

Current Screening Practices

To improve outcomes for women, children, and families, it is crucial that ongoing perinatal mood and anxiety disorder screenings, referrals for treatment, and follow-up occurs

(Association of Women's Health, 2022). Unfortunately, our current healthcare system does not consistently administer screening tools, and when they do, providers oftentimes do not feel comfortable enough to address mental health symptoms that may be identified from the assessments. "The American College of Obstetricians and Gynecologists (ACOG), the American College of Nurse Midwives (ACNM), the American Academy of Pediatrics (AAP), and the U.S. Preventative Services Task Force (USPSTF) recommend that systematic screening in pregnancy and during the postpartum period to help detect early symptoms of PMADs" (Association of Women's Health, 2022, p. 3).

Despite the recommendations from the various reputable groups mentioned above, there are still glaring gaps in care in our current healthcare system regarding screening protocols. Even if the screening tools are utilized as part of a mandatory process for a provider visit or hospital stay, the follow through is severely lacking in the majority of these and the women are oftentimes left to take the assessments alone and then never review and discuss them again.

Currently, the Edinburgh Postnatal Depression Scale (EPDS) and the Patient Health Questionnaire (PHQ-9) are two of the validated and reliable screening tools used to identify depression. However, these are severely lacking when it comes to identifying other PMADs such as anxiety, psychosis, and obsessive-compulsive disorder despite there being a subscale of three items that target anxiety symptoms.

There has been research that suggests utilizing the Hospital Anxiety and Depression Scale and/or the General Anxiety Disorder Scale (GAD-7) to get a more accurate picture of the symptoms a woman may be experiencing (Association of Women's Health, 2022).

The frequency of these assessments being administered is also not consistent among providers and hospitals. Ideally, a woman would be given these assessments multiple times over the course of the prenatal period during visits, immediately following the birth of the baby while in the hospital, and several times in the first year postpartum. However, this frequency is rarely, if at all, occurring.

According to Lomonaco-Haycraft et al. (2018), “Perinatal mood and anxiety disorders (PMADs) are the most common complication of pregnancy and have been found to have long-term implications for both mother and child. In vulnerable patient populations the prevalence of PMADs is nearly double the nationally reported rate of 15–20%. Approximately 17% of women will be diagnosed with major depression at some point in their lives and those numbers are twice as high in women who live in poverty” (p. 7).

As a result of the alarming statistics mentioned above, Lomonaco-Haycraft et al. (2018) were brought together to create a universal screen-to-treat process for PMADs in clinics as well as to adapt the existing Integrated Behavioral Health (IBH) model into a program better suited to the obstetric population.

They created a process that enforced screenings to occur at the first prenatal visit and then again at the start of the third trimester which also allows the screening to become a standard part of their prenatal care which will potentially reduce the stigma surrounding mental health issues. The process also required the women to be screened directly following birth as well as at the two- and six-week postpartum visits.

The consistency of these assessments being given alone proved to increase the compliance from 0% to over 75% but even more impactful was the implementation of same-

day collaboration with a licensed mental health provider which led to more treatment options and further assessments to occur (Lomonaco-Haycraft et al., 2018).

Unfortunately, many perinatal and women's health providers are not using best practices in screening for PMADs in the population, which inevitably leads to high rates of complications due to untreated disease.

Postpartum Depression vs PMADs

PMADs, also known as perinatal mood and anxiety disorders, can emerge at any point in pregnancy through the postpartum period. The substantial hormonal fluctuations that occur during this time in a woman's life as well as the significant transition to motherhood play an integral role in physical and psychological changes. It is estimated that up to 70-80% of women experience some sort of "baby blues" after delivery, for one to three weeks. (Langdon, 2019).

If these symptoms continue past the three- week mark or increase in severity, then it tends to evolve into postpartum depression which occurs in 10-20% of this population. This statistic only represents those who have reported or sought help for their depression. Some experts believe the rate of postpartum depression is doubled (Langdon, 2019).

This rate does not include the incidence of postpartum anxiety which is approximately 9%, and 3-5% of women develop postpartum obsessive-compulsive disorder (OCD) (ADAA, 2020). There are other psychiatric disorders that have the potential to emerge in the postpartum period, but these are rare. One example is postpartum psychosis. This rarity occurs in one to two out of every 1,000 births (PSI, 2022).

If medical experts are correct, and only half of the women with a perinatal mood disorder are seeking treatment and/or are diagnosed with a perinatal mood or anxiety disorder,

there is an alarmingly substantial number of women in this population that are falling through the cracks and not receiving the help they need. This can be attributed to the gap in care between physical and mental health. According to Glew & Chapman (2016), there is often “inter-professional fragmentation and confusion over who is responsible for providing care” (p. 506).

The fragmentation and lack of education/knowledge of mental health conditions among women’s health or primary care providers may contribute to the labeling of any mental health symptoms that may arise during and after pregnancy as postpartum depression.

Langdon (2019) believes that approximately 50% of those women who develop PMADs begin experiencing symptoms during pregnancy. This helps to validate the importance of early intervention and consistent screenings throughout pregnancy. However, postpartum depression is still the most recognized perinatal mood disorder that can potentially occur after birth. Symptoms of depression arise in more than a quarter of women during this time and anxiety symptoms present in 10-20% of this population. There is substantial evidence that these maternal symptoms can have an overwhelmingly negative impact on infant development (Cárdenas et al., 2019).

The discrepancies in the data and statistics surrounding PMADs and postpartum depression highlight the glaring gap and disconnect between physical and mental health providers and treatment which inevitably leads to women slipping through the cracks and being undiagnosed, untreated, and underreported.

Social Determinants of Health

Social determinants of health play a significant role in various aspects in everyone’s lives. As expected, SDoH also influence prenatal and postpartum care, and pregnancy in

general. Some conditions may represent a higher probability of unfavorable outcomes for the mother and/or baby which can be categorized as high gestational risk. “High gestational risk may refer to individual factors, unfavorable socioeconomic conditions, previous maternal diseases, previous reproductive history and/or current pregnancy. High gestational risk makes up about 15% of pregnancies” (Gadelha et al., 2020, p. 2).

Gadelha et al. (2020) looked at various aspects of social, physical, and emotional changes and the impact that they had on women’s health. Not only did they look at these changes, but they also took into consideration ethnicity/race, income levels, education, marital status, housing, health conditions, drug use, and type of pregnancy to determine if any combination of these led to an increase in a high gestational risk or negative outcomes.

Maternal mortality is an indicator of nationwide health and overall well-being. “In the United States, unacceptably high maternal mortality persists, and the dismal ranking relative to other developed nations is further marred by vast social inequities in the burden of loss. African American women experience maternal morbidity and mortality ratios several times higher than other groups” (Crear-Perry et al., 2021, p.232).

Attempts to recognize this imbalance have concentrated on behaviors of the individual as well as socioeconomic conditions, stereotypically assuming accounts of personal accountability and responsibility. As a result, the World Health Organization (WHO) introduced its directive on the SDoH to promote a global change to focus on the circumstances in which individuals are “born, grow, live, work, and age” (Crear-Perry et al., 2020, p. 233).

Despite the efforts made by WHO, the term SDoH has lost its meaning because of its misapplication and lack of perspective as well as the large social factors in outcomes persist.

The National Academies of Science, Engineering, and Medicine (NASEM) have identified five critical actions needed to successfully integrate social contexts into healthcare:

- Awareness
- Adjustment
- Assistance
- Alignment
- Advocacy

To address the profoundly engrained causes of inequities in maternal health, multiple and sustained interventions will need to occur at multiple facets such as paid family leave, improved health insurance, respectful and culturally appropriate care, and the investment in communities (Crear-Perry, 2021).

Since the universal assessments that current healthcare providers use only address depressive symptoms and physical health symptoms, this would also highlight a need for a more comprehensive assessment that would include SDoH to get a clearer picture of the person as a whole and what other factors may contribute to the outcomes for the mothers, babies, and other family members.

Prenatal Care and the Impact of Birth Outcomes

PMADs are one of the most prevalent complications surrounding childbirth, however, as outlined previously, goes unrecognized or treated. In a study conducted by McKee et. al (2020) an estimated 39,025,974 delivery hospitalizations from 2006 to 2015 in the U.S. were analyzed. Within that sample, PMADs increased from 18.4 to 40.4 for everyone thousand deliveries. Women with serious mental illness also showed an increase over time, from 4.2 to 8.1 per one

thousand deliveries. Women with a serious mental illness diagnosis that had Medicaid coverage accounted for 72% of deliveries compared to 44% and 43.5% amongst PMADs and the remaining births. Women with PMADs and serious mental illness experienced higher rates of cesarean deliveries, increased hospital transfers, longer lengths of stay, and delivery-related costs that rivaled other deliveries (McKee et al., 2020). Other complications that can arise from untreated PMADs in pregnancy are low birth weight, preterm delivery, and even maternal or infant mortality.

It is estimated that 50% of pregnant women that are diagnosed with a perinatal mood and anxiety disorder receive any treatment.

Women with untreated symptoms of PMADs have an increased risk of delivering prior to 40 weeks and have higher incidences of c-section deliveries. As a result, costs for both delivery and care of preemies are increased which also makes it increasingly difficult for mothers to resume working. Children whose mothers had difficulties with PMADs are also found to have higher risks of behavioral and developmental disorders such as ADHD, depression, anxiety, oppositional defiant or conduct disorders (Mathematica, 2019).

The currently available literature on pregnancy and PMADs discusses at length the contributing factors, however, the identification and treatment have been constrained by the inadequacy of applicable screening tools. As a result, the propensity for anxiety may be easier to identify and equivocally related to pregnancy itself. This may provide vital clinical significance such as potential identification in the perinatal period, to predict and address outcomes as early as possible (Ravid et al., 2018).

There is existing data that illustrates that teenage pregnancies, unemployment, ethnic background, and smoking status related to delayed access to prenatal services and negative fetal outcomes (Kapaya et al., 2015).

Poverty is linked to many negative health outcomes and unfortunately correlates with worse mental health for pregnant women. However, there has been inadequate research that has scrutinized the effects of material hardship such as adversities related to meeting basic needs such as access to nutritional food, reliable transportation, or stable housing throughout pregnancy on women's mental health (Katz et al., 2018).

"In the health care system, racism frequently manifests in differences in care. Individuals from racial/ethnic minority groups and of lower socioeconomic status tend to receive lower-quality health care than their White and high-status counterparts, even when issues of access are addressed" (Scrimshaw & Backes, 2020, p. 6).

It is estimated that one out of every five African American and Hispanic women experience mistreatment from providers in a hospital setting due to their race, ethnicity, cultural background, and/or language (Scrimshaw & Backes, 2020). While subpar treatment has been reported across all ethnicities and races, there is a startling trend in the reports. 8% of those that reported were Caucasian whereas 19% percent were Hispanic and 21% were African American.

Minority patients are also reported to experience the most palpable discrimination and lack of clinical attention, which directly results in the worst clinical outcomes (Scrimshaw & Bakes, 2020).

This startling data is just the beginning when trying to get to the root of poor outcomes in maternal health. Unfortunately, it becomes a compounding issue when PMAD symptoms are present and lack of education/experience from the physical health providers prevent appropriate screenings and treatment to take place.

Conclusion and Recommendations

After careful consideration and identifying supporting data and research, it is evident that the hypothesis that there is a direct correlation between a lack of adequate screening/assessments for PMADs throughout pregnancy and up to one-year postpartum leads to an increase of pregnancy and birth complications in women with preexisting mental health diagnoses.

These articles help to confirm that there is still much work to do in Women's Health to get to a level of best practices being implemented consistently and especially not limited by SDoH factors. A DBH is the perfect person to disrupt the current broken healthcare system and ensure that everyone gets treated individually, wholly, and accurately with compassion, advocacy, knowledge, and kindness. By removing the barriers in the current healthcare system, putting patients first, and integrating physical and behavioral health, there is hope that the DBHs can make an impact and get the healthcare system trending in the right direction.

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