



POSTPARTUM DEPRESSION

INTRODUCTION/BACKGROUND

While most women imagine new motherhood as a time of total fulfillment, days filled with mother-infant bonding, and boundless joy; many women experience a longer-lasting and more pervasive type of mood disorder with feelings of hopelessness and emptiness known as Postpartum Depression (PPD), that requires medical intervention.

World Health Organization (WHO) defines depression as an "illness characterized by persistent sadness and a loss of interest in activities that [one] normally enjoys, accompanied by an inability to carry out daily activities, for at least two weeks." Postpartum depression (PPD) is depression that occurs for a mother after childbirth.ⁱ It is a serious mental illness involving the brain and affects the new mother's behavior and physical health. PPD can happen a few days or even months after childbirth; and may occur after the birth of any child not only the first child.ⁱⁱ Although PPD has long been recognized by the psychiatric community, it was not until 1994 that it was formally included/described in the 4th edition of the Diagnostic and Statistical Manual (DSM IV).ⁱⁱⁱ

The precise cause/etiology of PPD remains unknown. When pregnant, the levels of estrogen and progesterone are at the highest they will ever be. Within just the first 24 hours of childbirth, the levels of these hormones quickly drop back to their normal, pre-pregnancy levels. The sudden changes in the levels of these hormones is one of the suggested mechanisms leading to depression.

Additionally, many mothers are unable to get the rest they need to fully recover from giving birth. Constant sleep deprivation can lead to physical discomfort and exhaustion, which can contribute to the symptoms of PPD.^{iv} Lack of social support also plays a big role in PPD.

RISK FACTORS AND DIAGNOSIS

Risk factors^v for PPD include:

1. Depression during pregnancy
2. Three or more stressful life events in the year preceding birth
3. Mother's age (≤ 19 years and 20-24 years age group)
4. Low social support
5. Less than 12 years of education
6. Unmarried
7. Postpartum smoker
8. Gave birth to term, low birthweight infants
9. Had infant(s) requiring NICU admission at birth

HOW COMMON IS PPD?

PPD is still underdiagnosed and undertreated. Being a mental disorder, PPD carries with it a stigma that acts as a barrier to seeking help. Moreover, the current standard of practice in the US is to "not screen" women for PPD, implying, most cases go undetected and untreated.

So far, the Centers for Disease Control and Prevention (CDC), and state health departments collect state-specific, population-based data on

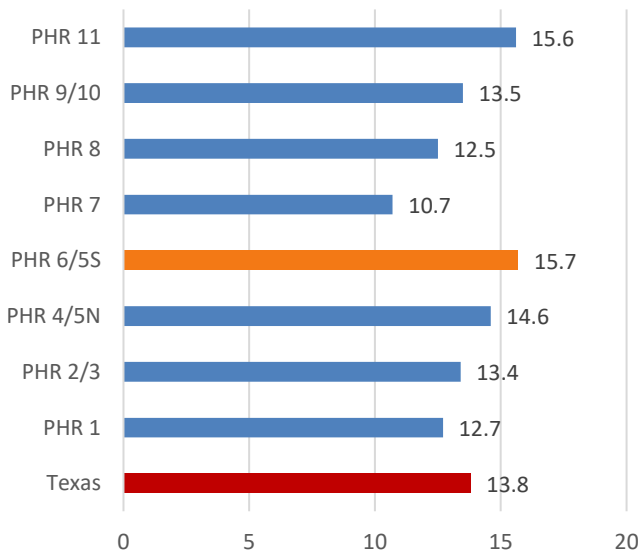




maternal attitudes and experiences before, during and shortly after pregnancy using the Pregnancy Risk Assessment Monitoring System (PRAMS). Nationally, between 2012 and 2015, the prevalence of PPD ranged from 11.8% to 12.8% respectively and was higher in Texas at 12.4% in 2012 and 14.7% in 2015!

Using the 2011-2015 pooled Texas PRAMS data the statewide prevalence of PPD symptoms was 13.8%, with disparities across the eight public health regions (PHRs, *these are areas in Texas where the Texas Department of State Health Services provide comprehensive public health services*). For example, 15.7% of women in PHR 6/5S (where Houston/Harris County lies), and 15.6% in PHR 11, compared to 10.7% in PHR 7 had PPD symptoms.

Figure 1: **Percent of Women Reporting Postpartum Depression Symptoms by Public Health Regions (PHR), 2012-2015**

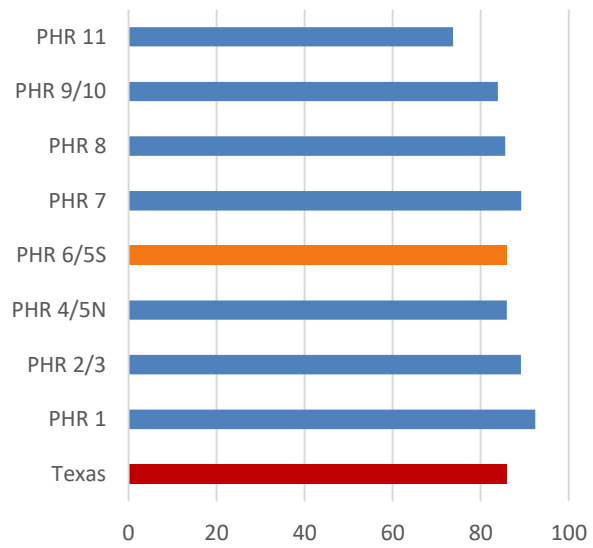


DISPARITIES IN PREVALENCE

Data for 2015 show other disparities. For instance, whereas the statewide prevalence of PPD symptoms among all women was 14.7%; it was 18.5% for Black women; 15.4% among Hispanic women; and 11.8% among White women^{vi}. PPD was higher (17.3%) among women from low income (\$22,000 per year) families; and lower (5.9%) in those from high income (\$79,000 and more) families.

About 18.7% of Medicaid covered mothers experienced PPD symptoms compared to 29.2% uninsured mothers. Young mothers aged 20 years and below are more (20.4%) likely to experience PPD than mothers 35 years and older (10.5%).

Figure 2: **Percent of Women Reporting Postpartum Checkup by Public Health Region (PHR), 2011-2015**





SCREENING FOR PPD

Screening for PPD occurs at the postpartum checkups usually done between 4-6 weeks after delivery.

A recent report - *Regional Analysis of Maternal and Infant Health in Texas* (April 2018), show similar disparities in the proportion of Texas mothers who have had their postpartum checkups done as 83.9% in 2009; and 86.1% in 2015.

Furthermore, the Texas pooled 2011-2015 PRAMS data for postpartum checkup or screening was 86.0%. Screening for PPD was highest (92.4%) for women in PHR 1; and least (73.7%) for women in PHR 11. In PHR6/5S which includes the City of Houston, 86% women reported completing their postpartum checkups or screenings (Fig

In 2015 alone, the postpartum checkup or screening rate was 90.4% for White/Other mothers, 89.9% among Black mothers, and 81.1% among Hispanic mothers. Eighty-one percent (81.8%) of women from low income families (\$22,000 per year) had postpartum visits compared to 95.6% among women from high income families (\$79,000 and more per year). Medicaid covered mothers were more (84.4%) likely to have received screening for PPD at their postpartum visits versus 74.5% of women who were uninsured.

IMPACT OF PPD

PPD can be detrimental to the mother, the child and the entire family. A woman suffering from PPD may have difficulty reacting to her child in appropriate ways. The lack of appropriate interaction can impact a child's cognitive, behavioral, and physical

development. Such infants often experience knowledge/skills among professionals. Destigmatizing PPD will entail psychoeducation, peer support, community education and training for professionals.

Few studies address the economic impact of PPD. A 2013 RAND Corporation report^{vii} indicated that "Reducing the prevalence of maternal depression may have short and long-term financial implications for the publicly funded systems that serve depressed mothers and their children". A 2016 posting by the American Mental Health Counselors Association also show that on a yearly basis each untreated depressed woman costs \$7,200. Thus, for the estimated 800,000 mothers each year, the annual cost of untreated depression including PPD in the U.S. is a whopping \$5.7 Billion!^{viii}

PUBLIC HEALTH ACTION

Destigmatizing and raising awareness of PPD

Barriers to addressing perinatal depression include fear of stigma, loss of parental rights, negative experiences with perinatal health care providers and lack of depression management knowledge/skills among professionals. To destigmatize PPD will entail psychoeducation, peer support and training for professionals.

Stress is a known predictor of postpartum depression and anxiety, therefore building supportive relationships can help reduce the onset of PPD symptoms. Prenatal and early postpartum may be "teachable moments" when parents are more open to behavior changes for the sake of the child. Fathers may be especially





amenable to education regarding how to communicate support with their child's mother.

Social workers can help family functioning by raising awareness among potential mothers and fathers about the importance of emotional support during the transition to motherhood.

Policy interventions to provide postpartum care to women

Recent efforts^{ix} to address maternal depression include extending postpartum Medicaid coverage for women, integrating behavioral health services within primary care, and provider reimbursement for postpartum depression screening at well-baby visits.

For instance, since July 01, 2019, Texas began testing and counseling for mothers who take their newborns for Texas Health Steps checkups through Medicaid or the Children's Health Insurance Program (CHIP). The policy allows one paid exam per eligible child over a 12-month period. It applies to infants enrolled in Medicaid managed care and fee-for-service programs.^x Implicit in this Texas House Bill 2466^{xi} is the improvement in the quality of services women receive during both the antenatal and postnatal periods in their health center visits.

TREATMENT OF PPD

On March 19, 2019, the U.S. Food and Drug Administration approved Zulresso (brexanolone) injection for intravenous (IV) use for the treatment of PPD in adult women. This is the first drug approved specifically for PPD and for certified health care facilities for efficient patient monitoring for PPD.

Zulresso is approved with a Risk Evaluation and Mitigation Strategy (REMS). It is to be administered to patients on the REMS program, and by a health care provider.

PPD is often treated with psychotherapy (also called *Talk Therapy of Mental Health Counseling*); medication (anti-depressant) or both.

In severe cases of PPD or postpartum psychosis, hospitalization may be necessary. If symptoms remain severe and are coupled with hallucinations (*false perceptions*), or delusions (*false beliefs*), or overwhelming suicidal thoughts electroconvulsive therapy (ECT) may be used.^{xii}

LOCAL RESOURCES

1. Psychology Today:

Pregnancy, Prenatal, Postpartum Support Groups in Houston, TX. (281) 783-3709

A 90-minute process that provides support and encouragement for mothers.

<https://www.psychologytoday.com/us/groups/pregnancy-prenatal-postpartum/tx/houston>

2. re:MIND Depression and Bipolar Support

HOUSTON COMMUNITY RESOURCES

Listing of resources helpful for people affected by depression and bipolar disorders.

Call the Harris Center 24-hr Hotline at: **713 970-7000.**

<https://www.remindsupport.org/houston-community-resources/>





ⁱ <https://www.curamericas.org/world-health-day-2017-postpartum-depression-means-communities/>

ⁱⁱ <https://www.womenshealth.gov/>

ⁱⁱⁱ <https://www.medicine.uiowa.edu/>

^{iv} <https://www.nimh.nih.gov/health/publications/postpartum-depression-facts/index.shtml>

^v Ko JY, Rockhill KM, Tong VT, Morrow B, Farr SL. Trends in Postpartum Depressive Symptoms – 27 States, 2004, 2008, and 2012. MMWR Morb Mortal Wkly Rep 2017; 66:153-158. Last reviewed and updated August 1, 2017

^{vi} Maternal and Child Health Epidemiology, April 2018. Regional Analysis of Maternal and Infant Health in Texas. PUBLIC HEALTH REGION 6/5S

^{vii} Sontag-Padilla L, Schultz D, Reynolds KA, Lovejoy SL, Firth R. 2013 Maternal Depression: Implications for Systems serving Mother and Child. www.rand.org

^{viii} American Mental Health Counselors Association. Depression Screenings for Pregnant and Postpartum Women Recommended. <http://connections.amhca.org/blogs/joel-miller/2016/01/27>

^{ix} <https://www.texmed.org/TexasMedicineDetail.aspx?id=48072>

^x <https://legiscan.com/TX/bill/HB2466/2017>

^{xi} <https://www.webmd.com/depression/postpartum-depression/understanding-postpartum-depression-treatment#1>

