AMERICAN COLLEGE of NURSE-MIDWIVES
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POSITION STATEMENT

MENTAL HEALTH DURING CHILDBIRTH AND ACROSS THE LIFESPAN

According to the National Institute of Mental Health, nearly 1 in 5 U.S. adults live with a mental illness, approximately 51.5 million in 2019. While bringing a new life into the world can be a joyous occasion, mental health disorders such as depression and anxiety, among other disorders may be experienced by an expectant person. Midwives have a unique role in supporting clients throughout their lifespan. To optimize the overall physical and mental health of their clients, the American College of Nurse-Midwives (ACNM) affirms the following:

- All people receiving midwifery care should be assessed for depression and other mental health disorders during routine visits, with special attention given during periods of increased vulnerability. Increased periods of vulnerability for mental health disorders include adolescence, peripartum, perimenopause, and late-stage menopause. Menstrual cycle disorders, such as premenstrual dysphoric disorder, can also have a significant impact on overall health and well-being.
- Health care providers should educate clients on how to recognize symptoms of mental health disorders, access more information, and seek treatment.
- All perinatal clients should be evaluated for depression and other mental health disorders at least twice during pregnancy and at regular intervals postpartum. ACNM recommends screening for depressive disorders with a validated tool. Medical and family history; experience with trauma, substance abuse, and interpersonal violence; and other risk factors should also be evaluated.
- Every midwifery practice should have a systematic response to a positive screen or risk assessment, including knowledge of treatment modalities and referral to trained mental health providers.
- All front-line providers require education on perinatal mental health and posttraumatic stress disorder (PTSD) including prevention, recognition, safety, suicide prevention, and treatment.
- ACNM supports legislation that improves access to quality mental health services for all people across their lifespan.

Background:

In the United States, 19.1% of adults have an existing mental health disorder[1] Depression, being most prevalent, is a leading cause of disability, costing billions annually in medical costs and lost productivity.[2] Even more tragic is the toll that mental health disorders take on human life. In 2018, the U.S. Department of Health & Human Services Substance Abuse and Mental

Health Services Administration reported 47,000 deaths resulting from suicide.[1] Social minorities are disproportionately affected by mental health disorders. Midwifery clients are especially vulnerable at specific reproductive periods including: adolescence, menstruation, peripartum, perimenopause, and menopause.[3] Screening during critical periods of vulnerability and at routine intervals can lead to early detection, prevention, and treatment.

Adolescence

One in 7 adolescents aged 12 to 17 have experienced depression in the past year.[1] Adolescents who experience mood and anxiety disorders are at greater risk for academic underachievement, early parenthood, substance abuse, and suicide.[3] Health care providers should routinely screen and educate adolescent clients about their mental health, and inform them about family planning, sexually transmitted infections, substance abuse, self-harm, sexual assault, and interpersonal violence.[3]

Childbearing Years

Premenstrual dysphoric disorder (PMDD) is a form of premenstrual syndrome, prevalent in 3% to 8% of people of childbearing age.[4] Onset of PMDD is often in a person's twenties.[3] Diagnosis is made when a client experiences a combination of physical and behavioral symptoms that are debilitating or disruptive to their life. Treatment options include hormonal contraception or use of a selective serotonin reuptake inhibitor during the luteal phase of the menstrual cycle or at the onset of symptoms.[4]

Perimenopause and Menopause

Depression and anxiety disorders are more common during perimenopause and the later phase of menopause. Clients often present with atypical symptoms, such as insomnia, weight gain, irregular bleeding, and fatigue.[3] People with a history of major depressive disorder are at higher risk for recurrence during either of these periods. Treatment options include behavioral therapy, antidepressant medications, and hormone therapy. Evidence suggests that cognitive behavioral therapy and complementary health practices including mindfulness meditation, hypnotherapy, and yoga may also decrease symptoms.[3]

Perinatal Mental Health Disorders

Perinatal mental health disorders affect 1 in 7 childbearing individuals, making mental illness the most common obstetric complication.[5] Left untreated, these conditions increase maternal and infant morbidity and mortality, and profoundly affect the well-being of families and communities.[3,6] Perinatal mental health disorders include depression, generalized anxiety disorder, obsessive-compulsive disorder, panic disorder, posttraumatic stress disorder, bipolar mood disorder, and psychosis.[7]

Psychosis affects 1% to 2% of the perinatal population.[8] Symptoms generally emerge suddenly and within the first few days to weeks following childbirth. Although postpartum psychosis is rare, it carries a high risk of a person hurting themselves, their infant, or others.

Severe childbirth-related morbidities are associated with a higher risk of postpartum psychiatric illness and substance abuse.[7] Approximately 1 in 10 people describe their birth as being traumatic due to either medical or emotional complications. History of posttraumatic stress disorder related to childhood maltreatment or other traumatic experiences is highly predictive of birth trauma, postpartum depression, and impaired parent-child bonding.[9]

Perinatal mental health disorders increase the risk of gestational hypertension, preeclampsia, substance abuse, preterm delivery, low birth weight, early cessation of breastfeeding or chestfeeding, delayed bonding, developmental delays, suicide, and infanticide.[10,11] Suicide is a leading cause of perinatal deaths, accounting for 1 in 19 deaths.[11] Yet, while it is a leading cause of death during the perinatal period, suicide during pregnancy or the first postpartum year is often under reported and under researched. Other leading causes of perinatal death include: cardiovascular events, infection, hemorrhage, and drug overdose.

Consensus Screening and Treatment

A key strategy in improving outcomes for people experiencing perinatal mental health disorders is early identification and treatment. Professional organizations including American College of Obstetricians and Gynecologists, Association of Women's Health, Obstetric and Neonatal Nurses, American Academy of Pediatrics, American Psychological Association, and U.S. Preventive Services Task Force, all recommend screening in pregnancy and the postpartum period but recommendations vary in the frequency of screening. [6, 10, 12, 13, 14]

As new research emerges and practice standards evolve, certified nurse-midwives and certified midwives strive to employ the safest, most effective treatment modalities. In 2015, the Council on Patient Safety in Women's Health Care convened an interdisciplinary work group, including ACNM representatives, to develop an evidence-based patient safety bundle to address maternal mental health.[14, 15, 16] The bundle provides broad direction for incorporating perinatal mental health screening and treatment into health care settings. Lifeline4Moms, a national program aimed at improving maternal mental health outcomes, offers a more comprehensive toolkit that includes validated assessment tools, treatment algorithms, and a mobile application or app, to assist physicians screen for postpartum depresssion.[17]

Several barriers to seeking and accepting professional mental health support have been identified. Perceived barriers among persons experiencing postpartum depression include lack of access, cultural stigmas around mental health, concern of symptoms being dismissed, and fear that their infant will be taken away.[10, 18] Without proper attention extended to the emotional toll of pregnancy and childbirth complications, history of trauma, or individual fears, a person's risk for PTSD increases from approximately 3% to 18%. [19]

Barriers to care are even more magnified within certain underrepresented communities. Social minorities are disproportionately affected by intersectional stigma, which is experienced when a Black, Indigenous, or person of color is a member of multiple stigmatized social groups. When stigma and discrimination intersect, these individuals experience heightened negative

health consequences. Understanding how these social categories intersect will be critical to mitigating disparities among this population.[20]

Collaborative care models integrate mental health specialists in primary and in sexual and reproductive health sites to support clinicians in the management of mental health complaints. These models have been shown to increase the number of people being treated according to best practice guidelines, improve medication management, mental health quality of life, and patient satisfaction.[10] The ACNM vision, "A Midwife for Every Community," is thus realized through a wider community of caregivers dedicated to achieving optimal health for all people across their lifespan.

REFERENCES

1. Substance Abuse and Mental Health Services Administration. *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health (HHS Publication No. PEP 19-5068, NSDUH Series H-54).* Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration; 2019. https://www.samhsa.gov/data/
2. U.S. Preventive Services Task Force *Final Recommendation Statement: Depression in Adults: Screening*. U.S. Preventive Services Task Force. 2019 May. https://www.uspreventiveservicestaskforce.org
3. Bhat A, Reed SD, Unutzer, J. The obstetrician-gynecologist's role in detecting, preventing, and treating depression. *Obstet Gynecol.* 2017;129(1):157-163. doi: 10.1097/AOG.0000000000001809.
4. Hantsoo L, Epperson CN. Premenstrual dysphoric disorder: epidemiology and treatment. *Curr Psychiatry Rep* 2015;17(11):87. doi: 10.1007/s11920-015-0628-3
5. Centers for Disease Control and Prevention. Pregnancy Mortality Surveillance System. 2019 Oct. https://www.cdc.gov/reproductivehealth
6. Byatt N, Carter D, Deligiannidis K, et al. American Psychological Association. Position Statement on Screening and Treatment of Mood and Anxiety Disorders During Pregnancy and Postpartum. 2018 December. Retrieved from http://www.psychiatry.org
7. Lewkowitz AK, Rosenbloom JI, Keller M, et al. Association between severe maternal morbidity and psychiatric illness within one year of hospital discharge after delivery. *Obstet Gynecol.* 2019;134 (4):695-707. doi: 10.1097/AOG.0000000000003434
8. Postpartum Psychosis. https://www.postpartum.net/learn-more/postpartum-psychosis/ Accessed January 1, 2020
9. Sperlich M, Seng JS, Li Y, Taylor J, Bradbury-Jones C. Integrating trauma-informed care into maternity care practice: conceptual and practical issues. *J Midwifery Womens Health,* 2017;62:661-672. doi: org/10.1111/jmwh.12674
10. Final Update Summary: Perinatal depression: preventative interventions. https://uspreventativeservicestaskforce.org. Updated February 2019. Accessed January 2, 2020
11. Zagrabbe K (2018). Perinatal suicide: highest risk occurs at 9 to 12 months postpartum. MGH Center for Women's Mental Health; 2018. http://www.womensmentalhealth.org
12. Earls MF. Committee on Psychosocial Aspects of Child and Family Health. American Academy of Pediatrics. Incorporating recognition and management of perinatal and

postpartum depression into pediatric practice. *Pediatrics*, 2010;126(5):1032-1039. doi: org/10.1542/peds.2010-2348
13. Screening for perinatal depression. ACOG Committee Opinion Number 757. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2018;132:208-12.
14. Kendig S, Keats JP, Hoffman MC, et al. Consensus Bundle on Maternal Mental Health: Perinatal Depression and Anxiety. *J Midwifery Womens Health,* 2017;62:232-239. doi: 10.1111/jmwh.12603
15. Maternal mental health: Perinatal depression and anxiety. Council on Patient Safety in Women's
16. Health Care. American College of Obstetricians and Gynecologists. (2016). Retrieved from https://www.safehealthcareforeverywomen.org
17. American College of Obstetricians and Gynecologists. (2019). Lifeline4Moms Perinatal Mental Health Toolkit. Retrieved from https://safehealthcareforeverywoman.org/
18. Hadfield H, Wittkowski A. Women's experiences of seeking and receiving psychological and psychosocial interventions for postpartum depression: A systematic review and thematic synthesis of the qualitative literature. *J of Midwifery Womens Health,* 2017;62: 723-736. doi: 10.1111/jmwh.12669.
19. Yildiz P D, Ayers S, Phillips, L. The prevalence of posttraumatic stress disorder in pregnancy and after birth: A systematic review and meta-analysis. *J of Affect Disord*, 2019;208:634-645. doi: 10.1016/j.jad.2016.10.009
20. Budhwani H, De P. Perceived stigma in health care settings and the physical and mental health of people of color in the United States. *Health Equity*, 2019;3(1):73-80. doi: 10.1089/heq.2018.0079

Note. This Position Statement replaces the ACNM Position Statement: Depression in Women.

Midwifery as used throughout this document refers to the education and practice of certified nurse midwives (CNMs) and certified midwives (CMs) who have been certified by the American College of Nurse-Midwives (ACNM) or the American Midwifery Certification Board (AMCB).

Source: Perinatal Mental Health Task Force & Clinical Standards & Documents Committee
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