Briefing Summary
"Preventing Postpartum Depression"
June 22, 2016

On June 22, 2016, Women's Policy, Inc. (WPI) sponsored a briefing, "Preventing Postpartum Depression," in cooperation with Reps. Kristi Noem (R-SD) and Doris Matsui (D-CA), Co-Chairs of the Congressional Caucus on Women's Issues (Women's Caucus), and Reps. Susan Brooks (R-IN) and Lois Frankel (D-FL), Vice-Chairs of the Women's Caucus. This briefing is the tenth in a women's health series sponsored by WPI over several years, with support from the Robert Wood Johnson Foundation. Cindy Hall, President of WPI, thanked the Foundation for its support and its work to improve the health and health care of all Americans, through its support for research and programs working to help build a national Culture of Health.

Speakers

Nancy C. Lee, MD

The first speaker was Dr. Nancy Lee, Deputy Assistant Secretary of Health—Women's Health, and Director of the Office on Women's Health at the Department of Health and Human Services. The Office's focus has included the Affordable Care Act and women's preventive services, women's health across the lifespan and violence against women.

Dr. Lee has been the Director of the Office on Women's Health (OWH) for five years, but noted she is a "short-timer," as the office was established in 1991. In 2010, OWH was established in statute as part of the Affordable Care Act. The mission of OWH is to provide national leadership and coordination to improve the health of women and girls through policy, education, and model programs. This year marks the 25th anniversary of OWH. More information can be found by visiting www.womenshealth.gov and www.girlshealth.gov

For Dr. Lee, the 25th anniversary is special, as she has been focused on health of women throughout her entire professional career. She is pleased to lead an organization that for 25 years has focused on the health and well-being of women and girls. She stated that through much effort across many sectors and with many different partners, great strides have been made in women's health. Women are now living longer with better access to information, services, and health care. Women are surviving cancer, HIV/AIDS, and heart disease more than ever before. Women have more and better choices of birth control, including the use of safe and highly effective methods of contraception, such as implants and IUDs. Society and public health are finally paying attention and casting light on the scourge of interpersonal violence that has battered and traumatized women and children for eons. Public health principles have been put into play to address this problem. Lastly, Dr. Lee noted that the Affordable Care Act has increased insurance access, improved preventive care, and made it illegal to charge more for health insurance just because a woman is a woman or has a preexisting medical condition.

Dr. Lee stated that postpartum depression is such a serious issue that in January 2016 the United States Preventive Services Task Force (USPSTF) highlighted screening pregnant and postpartum women for depression, and noted they should be screened both during pregnancy and after birth. Maternal mental illness is more common than previously thought, and in many cases postpartum depression occurs during pregnancy. Because of provisions of the Affordable Care Act, these screenings are available to women without cost-sharing.

Jean Y. Ko, PhD

Dr. Lee introduced Dr. Jean Ko, an epidemiologist with the Division of Reproductive Health at the Centers for Disease Control and Prevention, and a Lieutenant Commander in the U.S. Public Health Service. Dr. Ko also is adjunct faculty at the Emory Rollins School of Public Health in the Departments of Epidemiology and Behavioral Sciences and Health Education. Her work at CDC includes research and surveillance focused on maternal mental health and substance use.

She served as the CDC's Mental Health Workgroup Communications Chair from November 2013-2015. Her work related to maternal and public health at CDC has taken her to Tanzania, Bangladesh, and the American Territories. Dr. Ko has participated in CDC's responses to the Ebola Hemorrhagic Fever Outbreak in West Africa, and more recently, the Zika virus.

Dr. Ko began her presentation citing a Healthy People 2020 developmental objective to decrease the proportion of women who deliver a live birth who may experience postpartum depressive symptoms. Her presentation gave an overview of postpartum depression and one way Dr. Ko and her colleagues are addressing this illness on a population level.

Postpartum depression encompasses minor and major depression in the postpartum period—one year after childbirth. Postpartum depression is different than the "baby blues," which occurs the first seven to ten days after childbirth and usually resolves within a few days without intervention. According to the American Psychiatric Association's Diagnostic and Statistical Manual—V (DSM V), a person with depression must experience at least five or more of the following symptoms within a two week period:

- Depressed mood
- Diminished interest or pleasure in activities
- Weight loss or gain
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished ability to think or concentrate, or indecisiveness
- Recurrent thoughts of death, suicidal ideation, or suicide attempt

One of the symptoms has to be either depressed mood or diminished interest or pleasure in activities. These symptoms must reflect a significant impairment in a person's social, occupational or other functioning. In DSM-V, a peripartum onset specifier is applied if the depressive episode occurs during pregnancy or within 4 weeks postpartum.

Postpartum depression is common. In a 2005 systematic review, major and minor depression prevalence was 6.5 percent to 12.9 percent during the first year postpartum. Additionally, according to data from the Pregnancy Risk Assessment Monitoring System (PRAMS), 11.9 percent of women self-reported postpartum depressive symptoms after the recent birth of their child. PRAMS is a state specific population based surveillance system through the CDC, which collects maternal experiences before, during, and after pregnancy. The survey is sent two to six months after a woman has a live birth. Two survey questions assess postpartum depressive symptoms. Based on the responses from these two

questions, current PRAMS data shows that 1 in 8 women experience postpartum depressive symptoms. The proportion of women self-reporting these symptoms varies by state and is almost as high as 1 in 5 women in certain states.

Dr. Ko listed some risk factors for postpartum depression including:

- Low social support
- Low income
- Low education
- High stress
- Family or personal history of depression
    - Depression during pregnancy—54 percent of women with postpartum depression had a diagnosis of depression during or preceding pregnancy

It is important to remember that women without the risk factors listed above still can experience postpartum depression. Untreated depression can have negative effects on women and their families including:

- Substance abuse
- Lower use of effective contraceptive methods
- Suicide
- Low birth weight
- Preterm birth
- Poor maternal-infant attachment
- Altered neonatal, infant and child health and development

In 2015, the American College of Obstetricians and Gynecologists (ACOG) and USPSTF updated their guidelines to recommend screening of pregnant and postpartum women for depression. Both groups state that systems should be in place to ensure follow-up for diagnosis and treatment. Screening alone may not improve treatment rates or depressive symptomology. Further, 58.8 percent of women with depressive symptomology never receive a clinical diagnosis of depression and 50 percent of women with a diagnosis never receive treatment. Dr. Ko stated there is room to improve care, and one way is to screen and treat women at their usual site of care; however, the three randomized-controlled studies that have been done using such techniques are difficult to extrapolate across the population.

Last year, the CDC solicited applications to evaluate a stepped care approach to address depression in a broader population of pregnant and postpartum women. From this application process, the CDC has agreed to a five-year cooperative agreement with the University of Massachusetts, Worcester. This study evaluates 12 OB/GYN (academic, private and/or hospital-affiliated) clinics in Massachusetts with the clinics randomized for stepped care intervention or enhanced usual care through the Massachusetts Child Psychology Access Project (MCPAP) for Moms.

Earlier this month, ACOG released a Committee Opinion on optimizing postpartum care. This includes identifying mental health conditions during pregnancy and postpartum in an effort to close gaps in care for women. In closing, Dr. Ko stated the CDC continues to do research, surveillance, provide technical assistance to states, and provide bi-weekly news and literature updates to stakeholders. More information can be found at the two links below:

- http://www.cdc.gov/reproductivehealth/depression/index.htm
- http://www.cdc.gov/features/maternal-depression/index.html

Jennifer L. Payne, MD

Dr. Payne is the Director of the Women's Mood Disorders Center at Johns Hopkins Medical School. In addition to providing clinical care for women with mood disorders, Dr. Payne conducts research into the genetic, biological and environmental factors involved in postpartum depression. She and her colleagues have recently identified epigenetic biomarkers of postpartum depression and are working hard to replicate this work.

Additionally, Dr. Payne directs the Mood Disorders Clinical Trials group with the goal of developing novel therapeutic treatments for depression and bipolar disorder. She has developed two programs both aimed at understanding the pathophysiology underlying mood disorders and leading to improved treatments and outcomes for patients with mood disorders.

Dr. Payne stated that her presentation would focus on the prevention aspect of postpartum depression. When talking about prevention, we need to think about who is at risk. About 10-15 percent of women in the general population and 20-50 percent of women with a preexisting mood disorder are at risk of postpartum depression. For women who have to stop their medication regime during pregnancy, 70-90 percent will experience depression during pregnancy or postpartum.

There are several myths about depression during pregnancy that Dr. Payne dispelled.

Myth #1: Women should tolerate being depressed during pregnancy for the sake of the baby.
Truth #1: Depression during pregnancy leads to poor outcomes for mom and baby.

Depression during pregnancy is associated with a number of poor outcomes for the baby including:

- Preterm delivery
- Low birth weight
- Decreased motor tone and activity
- Higher cortisol levels that last up to adolescence
- Poor reflexes
- ADHD and behavioral problems, particularly in boys
- Postpartum exposed children are associated with lower IQ, slower language development, behavioral problems and psychiatric illness

Depression during pregnancy is associated with a number of poor outcomes for the mother:

- Depression during pregnancy is one of the biggest risk factors for postpartum depression
- Suicide is a major cause of maternal death in pregnancy and accounts for up to 20 percent of all postpartum deaths

Myth #2: Antidepressants during pregnancy are associated with poor outcomes for the infant.

Truth #2: Well-controlled studies do *not* find association with adverse long-term infant outcomes.

Antidepressant use during pregnancy has been associated with:

- Preterm birth
- Low birth weight
- Cardiac defects
- Persistent pulmonary hypertension
- Autism

However, Dr. Payne pointed out that most of the studies that have made the claims above do not control for underlying psychiatric illness, severity of psychiatric illness, additional risk factors that are found in a psychiatric population (diabetes, smoking, substance use, obesity, etc.), whether the mother was psychiatrically ill during pregnancy, and use of multiple medications. This leads to confounding studies that are misleading and inaccurate. The stigma associated with mental illness has led society to compare the wrong risks:

Myth: Antidepressant use vs. no antidepressant use
Reality: Antidepressant use vs. risks of untreated major depression

The way forward in prevention is about educating the population, but also educating physicians that stopping antidepressant use predisposes the woman to relapsing into depression. Further, Dr. Payne stated the need to provide psychosocial support programs that work on identifying women who are at risk and eliminating risk factors. In addition, psychotherapy has been touted as an alternative to antidepressant medication. However, there are numerous barriers to using psychotherapy for many women in high risk populations and further well-designed, randomized trials need to be conducted.

Dr. Payne mentioned there is a great need for research about antidepressant use during pregnancy. The FDA recommends tapering antidepressants prior to delivery, but there is no data to substantiate this recommendation. There are only three small, well-controlled studies on prevention and/or treatment of postpartum depression with medication. Research is complicated by the fact that not every woman who is pregnant is at high risk.

In an attempt to tease out postpartum depression risk factors for women, Dr. Payne focuses on the use of epigenetics. Epigenetics are the heritable changes in gene activity, which are not caused by changes in DNA sequence. Environmental exposures (like hormone levels during pregnancy) can induce epigenetic changes and change gene expression. In her study, Dr. Payne screened for genetic loci responsive to high doses of estrogen in the brains of mice and then cross-referenced those loci with DNA differences identified in blood samples from women who did and did not develop postpartum depression. Dr. Payne and her team identified two biomarker loci genes that predict postpartum depression in pregnant women with 80 percent accuracy. Three small studies have replicated Dr. Payne's initial findings, and there is great promise that the biomarkers will allow more sophisticated and efficient studies on ways to prevent postpartum depression.

In conclusion, Dr. Payne encouraged the education of the general public and physicians that psychiatric medications do not have to be stopped for pregnancy, and of the adverse consequences of untreated psychiatric illness during pregnancy. Interpretation of the research literature had been complicated by

poorly controlled studies and media hype that feeds into the stigma of psychiatric illness and complicates treatment decisions for women, particularly during and after pregnancy.

Danni Starr

Danni Starr is a national media personality and a mom, who while attending a women's college, realized the importance of raising awareness of women's issues. This year, Ms. Starr was beyond proud to join forces with the Department of Health and Human Services Office on Women's Health and currently serves as an ambassador. As an advocate, most important to her is sharing her survival story of postpartum depression and changing laws to better serve mothers and babies. Besides being the best mom possible to her two daughters, the former Miss Minnesota International 2007 can be seen weekly on the TLC network as host of TLCme Now.

Ms. Starr shared her personal story of postpartum depression:

Once upon a time I knew a woman. She was confident, fearless, and could stand next to Halle Berry and still feel beautiful. She was a powerhouse. She had a beautiful wedding and shortly thereafter got pregnant. She was thrilled—she had always wanted to be a mom.

After the birth of her daughter, she felt emotions she had never felt before with such severity. She was paranoid, irritable, angry, irrational, sad. She didn't eat, she didn't sleep. She quickly became a shell of the person she used to be. Her paranoia caused her to kidnap her own daughter, go on the run for fourteen days, to believe that her best friend in the entire world was trying to have an affair with her husband, to count enough sleeping pills to knock her out for a few days, but hopefully not kill her.

She suffered. She left her job, her marriage crumbled, every part of her life suffered. She was a woman who would do anything to help anybody that was in trouble, yet she couldn't even recognize her own struggle. She had postpartum depression—something she had never heard of despite the fact of taking every baby class possible and reading a million books. Nothing and no one told her to protect her mental health.

I knew her very well—she was amazing—but she doesn't exist anymore. She didn't die, although I can tell you she would not have been disappointed if she had. But still she doesn't exist. Postpartum depression changed her to her core. When she had her second baby she was happy and so excited. She knew she didn't have postpartum depression, but she had horrible, intrusive thoughts. She envisioned her children's deaths. She literally buried every person she loved in her mind. She planned escape routes in every situation, had to sit near an exit, kept sharp objects in her car—she had no idea that postpartum depression had an evil stepsister, postpartum anxiety.

She was amazing. She had babies. Her mind failed her. And then the medical field failed her, and government policies too. She will never be the same. I can tell you this with certainty because I knew her—I actually used to be her.

I am Danni and I am a postpartum depression and postpartum anxiety survivor. It was the scariest, most awful time of my entire life. I am not who I used to be. I had to find a new normal. I remember I used to read and hear stories about mothers who would kill their babies and think, "Wow, there is a special place in hell for them." Perspective is everything though. A few months after my daughter was born, I remember thinking, "Thank God she isn't a crier, because if she was I probably would have killed us

both." Those women shouldn't burn in hell; those women were living hell on earth. Their minds, emotions, and rationality turned against them and they needed help. They needed somebody to tell them that what they were going through was actually the most common side effect of childbirth. They needed to be screened. They needed laws in place to protect them and their babies. They needed to know they were not alone and that countless women have been where they are. There is power in hearing, "me too." It is very isolating to think you're going through something alone. Knowing that others have been where you are actually may be the thing that brings you out of it.

That is why I am here today. I want women to know they are not alone. I am here to say, "me too." I have been there. I have been where you are, and I am here to help you. I am here to bring light to the stigma to push for change, to make things happen. I feel their pain, and I know they feel worthless, but they are so worthy. If you took a walk in my postpartum shoes, I would hope you would be as tough as me. Most days I didn't think I was tough enough to make it, but I did. I am not afraid to say it.

Postpartum is my truth—an ugly truth that I happen to be on my way to conquering. It would be a lot easier for me and others struggling like me if policymakers made mothers and their babies a priority. I can't even put into words what it feels like when your mind betrays you.

I will leave you with this though. I am a talker by nature and profession. I am an oversharer by nature and profession. I got postpartum depression and it was the first time in my entire life that I didn't want anybody to know any detail about what I was going through. We need to change the way we treat mental health; we need to erase the stigma. Lastly, we need to take a moment of silence for the women I once thought should burn in hell, the ones that hurt themselves and their babies, the ones that didn't make it out of postpartum depression.

Discussion

Attendees were invited to ask questions of the panelists or offer brief observations.

An attendee representing the American Academy of Pediatrics posed a question to Danni Starr on how the medical profession can better serve their patients. Ms. Starr stated physicians need to educate their patients on postpartum depression and encourage home visits/check-ins. Home visiting programs are part of the Affordable Care Act, but not all women have access to the program.

Much of the public discussion included women sharing their own stories about postpartum depression and the need for women and healthcare professionals to educate the general public about the illness, expand screening before the postpartum period, expand access to treatment, and eradicate the stigma associated with mental illness.

The webcast of the briefing can be viewed by clicking here.