

Ask the Question: Screening for Postpartum Mood and Anxiety Disorders in Pediatric Primary Care

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Postpartum mood and anxiety disorders (PMADs) are a significant source of toxic stress for young children and can disrupt developing brain architecture resulting in long-lasting deleterious effects. Thus, screening for PMADs must be considered as an essential task of a pediatric primary care provider (PCP) and the pediatric medical home. Problems in parenting capacity in mothers with PMADs can lead to disorders in attachment and a range of other emotional and developmental challenges for a young child. Therefore, all PCP office visits with mothers should include surveillance as well as formal screening at regular, pre-determined intervals. During surveillance, identification of psychosocial, maternal, infant, and

maternal/infant risk factors is critical. There are a number of well researched, standardized, reliable, free and valid screening tools including the Patient Health Questionnaires (PHQ-2 and PHQ-9) and the Edinburgh Postnatal Depression Scale (EDPS). Office implementation includes availability of educational materials, resource information, and referrals so families can get appropriate treatment. Screening for PMADs is highly effective and helps to identify a common, underdiagnosed disorder in parents that without identification and appropriate treatment can lead to significant negative outcomes for a young child.

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When parental challenges such as postpartum mood and anxiety disorders (PMADs) are present in a young child's life, there can be devastating developmental consequences that impact the physical architecture of the child's brain and cause derailment across various developmental domains.^{1,2} From birth through age 5, brain development is in its most rapid and crucial phase whereby a child should develop the foundation and capabilities on which all subsequent development forms. For healthy development, young children require a secure attachment to a primary caregiver, contingent

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emotional responsiveness, and experiences that foster cognitive growth and social and emotional development. When infants and young children do not experience positive, sensitive and responsive caregiving they lose the opportunity to develop critical social,

emotional, and intellectual skills. These skills include the ability to trust, relate to others, have a positive sense of self, emotionally and behaviorally regulate, and develop executive functioning skills and learning readiness.¹ Consequently, the early formative years of life can be both a period of significant growth and a time of extreme vulnerability for young children.

Pediatric primary care providers (PCPs) are in an optimal situation to support the healthy development of young children, in part through the evaluation of the emotional well-being of mothers, as they typically see families earlier and more frequently than other health care providers. Bright Futures recommends that newborns and infants have at least 8 health maintenance visits during the first year (48–72 h after discharge, 1 week, 1, 2, 4, 6, 9 and 12 months).³ Asking how new

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The term postpartum mood and anxiety disorders (PMADs) is a complete description of the group of disorders that occur during and following the birth of a child. Depression can affect up to 20% of pregnant women⁵. Anxiety is a common characteristic of mothers' feelings both during and after pregnancy and is very common in postpartum depression⁴. Along with "baby blues", postpartum depressive and generalized anxiety disorders there is also the occurrence of psychosis, obsessive-compulsive disorder and posttraumatic stress disorder. Therefore, the term postpartum mood and anxiety disorders (PMADs) is preferred when referring to the whole spectrum of mental health concerns.

Fig. PMADs terminology.^{4,5}

mothers are feeling is not only important in assessing the environment of the infant but is an important component in establishing a supportive relationship with parents. Unfortunately, only 44% of surveyed American Academy of Pediatrics (AAP) pediatricians inquired about or screened for maternal depression in 2016; however, this number has increased from 33% in 2004 (Figure).⁴

The PCP has multiple opportunities to inquire and screen for parental mental health. The pediatric medical home is the ideal model for optimal pediatric primary care, of which an important task includes the ability to identify postpartum mood and anxiety disorders (PMADs).^{6,7} In a medical home, the PCP and their team work with families to address both medical and non-medical needs to ensure the overall health and well-being of each child and family. The medical home aims to routinely evaluate and screen multiple areas of health risk for the child and parent. Central to the practice of primary care pediatrics is asking caregivers about their own emotions and behaviors in order to understand the psychological issues and social determinants of their health and consequently, their child's health.⁸ Incorporating questions about PMADs as part of routine pediatric well care questions will add to understanding of familial risk factors and is comparable to asking about cigarette smoking, breastfeeding, water temperature, car seats, and domestic violence. Information that helps to identify concerns may impact both immediate and long-term health outcomes.

There is growing support for screening or inquiring about PMADs during the baby's first year. Several states have legislation supporting PMADs screening although payment is not guaranteed.⁹ Additionally, the Center for Medicare and Medicaid Services (CMS),¹⁰ the AAP and its Bright Futures guidelines,^{2,11} the American College of Obstetricians and Gynecologists (ACOG),¹² and the United States Preventative Services Task Force (USPSTF)¹³ all discuss screening or inquiring about PMADs during the baby's first year. While the need to screen mothers in the postpartum period has been endorsed, there are

no universally agreed upon guidelines for the timing of screening and monitoring PMADs.

Parents with significant mood and anxiety disorders during the postpartum period can have difficulty with the reciprocity of parent–infant interactions, which may negatively affect the attachment process.¹⁴ Early identification of these disorders should lead to early treatment, which can mitigate the detrimental effects on infants, mothers, and their developing relationship, as well as help to support healthy child development and mental health over time.^{6,14–18}

Prevalence and Symptoms of Postpartum Mood and Anxiety Disorders

Prevalence estimates for PMADs tend to vary widely depending on type of disorder, diagnostic criteria, sampling procedures, locations of populations, and measures used to assess each disorder.¹⁹ In general, estimates range from 8% to 25% of the population with some low-income populations reporting rates of PMADs in 50% of all new mothers.^{14,16} PMADs can have an adverse impact on all members in a family, as parental mental health is universally acknowledged as one of the key determinants for healthy development in infants.¹⁹ In order to understand the impact that different perinatal and postpartum mood and anxiety disorders have on developing infants, it is important to be able to recognize the differences in symptoms, presentation, and prevalence of each these disorders, including the variations in the presentation in select special populations.

Depression

There is a spectrum of depressive symptoms present in the perinatal and postpartum period. These range from "baby blues," minimal depressive symptoms lasting a few days to a couple of weeks, to postpartum major depressive episodes with or without psychosis. Each of these disorders and diagnoses has different effects on mothers and may impact infant development based on the severity of mothers' symptoms.¹⁹

"Baby Blues"

The "baby blues" typically occur during the first few days after delivery and can include symptoms such as crying, worrying, sadness, anxiety, irritability, and

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