Maternal Mental Health in Alaska

Poor maternal mental health adversely affects families, children, and infants. Supporting the association between maternal mental health and behavior in children, a recent study has shown that maternal mental health is significantly associated with the presence of Attention Deficit Hyperactivity Disorder (ADHD) in school-aged children.¹

There are varying degrees of depression that can occur after a pregnancy. During the postpartum period, women may experience postpartum blues, postpartum depression, or postpartum psychosis. Postpartum depression (PPD) can be disabling for a new mother and can impact her ability to adequately care for her infant. PPD affects women of all ages, economic status, racial and ethnic backgrounds. Any woman who is pregnant, had a baby within the past few months, miscarried, or recently weaned a child from breastfeeding can develop PPD.²

The Alaska Pregnancy Risk Assessment Monitoring System (PRAMS) provides data for self-reported postpartum depression. This is not a clinical diagnosis of PPD and is therefore not directly comparable.

### Seriousness

**Healthy People 2010 Targets and National Data**

<table>
<thead>
<tr>
<th>Proportion of who had self-reported postpartum depression</th>
<th>Alaska 2002¹</th>
<th>Nation 2000²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe</td>
<td>4.7%</td>
<td>5.1%-8.9%</td>
</tr>
<tr>
<td>Low to Moderate</td>
<td>51.9%</td>
<td>48.9%-62.3%</td>
</tr>
<tr>
<td>None</td>
<td>43.4%</td>
<td>31.0%-44.6%</td>
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</tbody>
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¹Range represents estimates from other PRAMS states for 2000. Refer to Data Sources and Notes for details.

There are developmental Healthy People 2010 objectives on maternal mental health, particularly postpartum depression. However, goals have not yet been defined.

- Approximately 1 in 21 Alaskan women reported they were very depressed and 1 in 7 reported they were moderately depressed. More than half reported they experienced low to moderate depression. (Figure 1)

- Although there is no comparable national estimate for self-reported postpartum depression, analysis of data from 7 Pregnancy Risk Assessment Monitoring (PRAMS) states for 2000 (including Alaska) reported a range of 5.1% to 8.9% of women that self-reported severe postpartum depression. During that time, Alaska had the second lowest prevalence of 5.4%.³

### Severity

Recent research has shown that children whose mothers had a chronic and activity-limiting mental health condition had a fourfold increased association of ADHD.¹

Postpartum blues are common, affecting approximately 70-80% of women who give birth,³ and usually occurring within the first week of delivery and peaking at 3 to 5 days. An estimated one in ten women, however, has a major depressive episode within four to 16 weeks after childbirth.³ Postpartum depression is a more serious disorder with potentially long-lasting consequences and postpartum psychosis is a very serious mental illness that requires treatment right away, almost always requiring medication and sometimes hospitalization.² Postpartum psychosis may manifest itself as one of several different disorders, of which bipolar mood disorder is the most common.⁶ Women affected with postpartum psychosis can lose touch with reality and often experience auditory hallucinations, delusions, and, although less common, visual hallucinations – other symptoms include insomnia, feeling agitated and angry, and strange feelings and behaviors.²

### Urgency

- Approximately 1 in 4 Alaskan women indicated that their prenatal period was a "moderately hard time", a "very hard time", or "one of the worst times of my life". (Figure 2)
Although more than half reported they had low to moderate depression, 1 in 4 Alaskan women (24.6%) indicated that a health care worker did not talk with them about postpartum blues or PPD.†

Alaskan women who self-reported postpartum depression (56.3%), more than 1 in 5 indicated they wanted to see a mental health professional and 1 in 8 had not seen one.†

A recent study indicated that stress was significantly associated with self-reported severe depression among mothers of newborns.3 Common maternal stressors surrounding the prenatal period among Alaskan women were moving to a new address (40.2%), problem paying bills (27.2%), and arguing with husband/partner more than usual (26.8%).7

Disparities
A recent study from the Centers for Disease Control and Prevention (CDC) indicated that single mothers and less affluent mothers were significantly more likely than married and affluent mothers to report a chronic, activity-limiting mental health condition.1

Women who have been depressed during an on-going pregnancy, have a history of PPD, or who have a previous history of depression are more at risk for PPD.5

An analysis of PRAMS data from seven states, which included Alaska, indicated that among mothers of newborns, women with fewer than 12 years of education, those who were Medicaid recipients, and those who delivered low birth weight infants were most likely to report severe depression compared to other women. In addition, women who experienced physical abuse during pregnancy and women who reported stress (emotional, partner-related, financial, or traumatic) were more likely than other women to report being severely depressed.5

Economic Loss
Economic loss was not evaluated.

Interventions & Recommendations
The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recommend that pregnant women be educated about PPD during the third trimester and that obstetricians/gynecologists consult with their patients about their risk for psychiatric illness during the postpartum period.8

Guidelines about health care have also emphasized that pediatrics should play a role in detecting family problems, especially maternal depression. Although not the mother’s provider, pediatricians may have a role as the only health care provider that mothers have frequent contact with. It is suggested that pediatricians who are willing to discuss issues of depression can help mothers understand how their mood might affect their parenting and possibly contribute to behavioral problems with their child.9

For women who are not breastfeeding or women with moderate to severe depression, antidepressants (Selective Serotonin Reuptake Inhibitors or tricyclics) are generally considered the first line of treatment for PPD. Studies have indicated that concentrations of antidepressants in breast milk are very low or undetectable, suggesting minimal risk of toxicity in infants. For women who are breastfeeding and who have mild to moderate depression, a careful risk-benefit must be done when prescribing antidepressants. Interventions such as household support, couples counseling, and psychotherapy are useful adjuncts to drug therapy. Women with severe PPD, who verbalize thoughts about self harm or harm to their infant must be referred immediately and treated aggressively – often with a combination of antidepressants, antipsychotics, and hospitalization.5

Intervention Effectiveness
At this time the effectiveness of interventions has not been well evaluated.

Capacity
Propriety
Maternal mental health is an important issue among the maternal and child health (MCH) population – poor maternal mental health adversely affects mothers, children, and families. Promotion and monitoring of maternal mental health issues fall within the overall mission of the Women’s, Children’s, and Family Health Section. National initiatives have been set forth to address mental health objectives (HP2010) which are also related to MCH indicators of well-being; and developmental indicators of maternal mental health, specifically postpartum depression, are in place but have not been defined at this time.

Economic Feasibility
Economic feasibility was not evaluated.
Acceptability
The public health community recognizes maternal mental health, such as postpartum depression, as an important issue. According to 2000 PRAMS data, 20% of women delivering a live-born infant who reported PPD wanted to see a mental health professional, but only 9% had already seen one.

Resources
Alaska PRAMS provides data that can be used to assess self-reported PPD and stress, and to identify high-risk groups for targeted interventions

Legality
Not an issue.

References

Data Sources
† Alaska Pregnancy Risk Assessment Monitoring System (PRAMS), 2002 Data: State of Alaska, DHSS, DPH.


Notes
Prevalence estimates for PRAMS data are among women that delivered a live-born infant.

The range used for the national prevalence of self-reported postpartum depression is from seven states (Alaska, Louisiana, Maine, New York State, North Carolina, Utah, and Washington) participating in PRAMS during 2000 that collected data on this topic.