WISCONSIN ASSOCIATION for Perinatal Care

POSITION statement

SCREENING FOR PRENATAL AND POSTPARTUM DEPRESSION

Depression screening can improve health outcomes when combined with a system for treatment. This WAPC position statement includes the rationale and plan for routine depression screening and treatment of pregnant and postpartum women by health care providers.

Facts About Depression

- Depression in the perinatal period (pregnancy through one year postpartum) is a major public health problem affecting almost 20% of all women[1] and up to 40-60% of low-income and pregnant/parenting teenagers.[2]
- 400,000 infants in the U.S. are born to mothers with depression annually, making perinatal depression the most underdiagnosed perinatal complication.[2]
- Perinatal depression can affect the whole family.[2,3]
- Maternal illness has detrimental effects on infant wellbeing, with developmental effects beginning in infancy and lasting at least into adolescence.[3]
- The developmental delays in children due to persistent and untreated maternal depression are less responsive to intervention over time.[2]
- Screening is effective in identifying symptoms of depression.[1]
- Depression is treatable and may not resolve without treatment.

Pregnancy and the postpartum period can be exciting times for women. However, they can also be times when women are vulnerable to perinatal mental illness, including mild postpartum blues, depression and anxiety, mania, and psychosis. The precise mechanisms causing these illnesses are unknown. Symptoms can be identified through screening women during pregnancy and the postpartum period. Detection and management of these disease states are essential for the wellbeing of both the woman and the child.[1]

The signs and symptoms of depression include depressed mood, tearfulness, sleep or appetite disturbances, nervousness or anxiety, irritability, weight gain or loss, loss of interest and pleasure, low energy, loss of concentration, guilt, hopelessness, and thoughts of harming self, infant, or others. Depressive symptoms may range from mild to severe. Severe symptoms often include thoughts of dying or suicide. The thoughts of wanting to flee or get away, being unable to feel love for the unborn baby or infant, and having thoughts of hurting–or not being able to protect–the infant are particularly troubling to mothers.

The scope of this position statement is limited to screening and follow-up for perinatal depression. Perinatal depression is defined as an episode of minor or major depression during pregnancy (antenatal depression) or during the first 12 months postpartum (postpartum depression). Perinatal depression is one of several illnesses included in the broader category "perinatal mental illness." Both the DSM-IV and DSM-5 have specifiers for perinatal depression with a peripartum onset[3]; however, the definitions of perinatal depression continue to be complicated as approximately 85% of women experience postpartum blues during the first two weeks following childbirth.[1,2,3] Those who care for women and their infants during pregnancy and the first year of life should be alert to women describing these symptoms. These symptoms warrant further psychosocial assessment.[3]

Why do we advocate screening for depression during pregnancy and in the postpartum period? Screening women during pregnancy and the postpartum period can identify women struggling with the disease and can facilitate prompt intervention. In addition,

- You can't tell by looking that someone is depressed.[4]
- There is a stigma around mental illness and treatment that may adversely affect a woman's ability to seek treatment.[3,5]
- Women with perinatal depression may not seek treatment for a variety of reasons including: lack of knowledge about depression; unrealistic views about coping with motherhood; feelings of failure; and barriers due to the disease itself such as low energy levels.[3,6]
- Perinatal depression is associated with premature labor and adverse obstetrical outcomes.[3,7]
- Perinatal depression threatens the mother-child attachment and bonding process.[2,8]
- Perinatal depression, both during pregnancy and the postpartum period, can affect the child and is linked to changes in brain development, developmental delays, impaired social skills, and behavioral problems.[2,3,9]
- Perinatal depression can affect parenting skills, decreasing the attention given to the child's health and safety.[2,10]
- Perinatal depression can be life threatening to both the woman and the child and others.[11,12]

WHY SCREEN?

Perinatal depression is a disease state that is amenable to screening, as it is severe, prevalent, under-detected, and treatable.[3] In addition, it has a tolerable screening process.[13] Early symptoms can be identified by screening women during pregnancy and during the postpartum period. Early identification and effective treatment is critical for this disease state.[1]

All women are at risk for depression during pregnancy and during the postpartum period. Pregnancy and the postpartum period are characterized by stress and adaptive endocrine changes which may increase women's risk for mental illness.[14] Increased risk factors for the development of postpartum depression include history of depression and/or anxiety, neuroticism, low self-esteem, postpartum blues, stressful life events, domestic violence, poor marital relationship, and poor social support. In addition, perinatal depression is associated with complications of pregnancy, neonatal admission to the NICU, substance use disorders, and post-adoption status.[15]

Perinatal depression can affect the entire family. At the most basic level, maternal depression can adversely affect the maternal-infant relationship. Maternal depression is associated with lower quality of maternal bonding.[16] Maternal depression is also closely associated with feeding issues[17] that may extend into early childhood.[18,19] It also has long-term behavioral, emotional, cognitive, and neurodevelopmental consequences for the child, which are less amenable to intervention if maternal disease is chronic and untreated.[2,9] Maternal depression can affect care and is associated with suboptimal child care practices[10,20] and inappropriate health care utilization.[21,22] Finally, there is a correlation between maternal depression and paternal depression that can further compromise infant/child growth and development.[23] When maternal depression is present, paternal depression rates between 24% and 50% have been reported.[24] The interaction of maternal depression and couple conflict has a significant effect on the relationship between paternal postnatal depression and infant behavior.[25]

Determining Safety Risk

Questions in three areas, 1) thoughts, 2) intent, and 3) means, can help a clinician make a decision about whether a safety risk is present and whether the risk requires immediate referral or not.

The US Preventive Services Task Force recommends screening for depression in the general adult population, including pregnant and postpartum women.[25a] The American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG), and Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) support screening women for depression in the perinatal period.[2,26,27]

HOW TO SCREEN?

Effective screening programs or processes must be tolerable and acceptable by the target populations. To optimize the effectiveness of screening for women in the perinatal period, women must be comfortable with the process and have a trusting relationship with their health care providers.[3] If screening is incorporated into the routine and explained in a guided conversation, care providers can develop a supportive relationship in a non-judgmental and non-stigmatizing manner, For their part, care providers need to be sensitive to potential cultural differences and personal life experiences that can influence understanding of depression and the screening process.[3]

Health care clinicians may be unsure of how to bring up the subject of depression. A clinician may start a discussion with a statement such as, "It is routine for us in this office to check with all pregnant women [new mothers] about how they're feeling. We like to know a little about your emotional health."

Valid screening tools are available. The three self-assessment tools described in Figure 1 are easy to use. Two of the assessments are available in Spanish (the CES-D and EPDS). They take approximately 5 to 10 minutes to complete. The statements can be read to women who have difficulty reading. Remember, these tools are not for diagnosis. They alert a clinician that a woman is experiencing a high level of distressing symptoms that may indicate a major depression. In addition, it is important to consider possible safety risks and whether the risks require immediate referral.

Screening is facilitated if it is part of the routine and includes an element of flexibility.[28] Screening questionnaires can be incorporated into the electronic health record[29], or administered over the telephone[30] or via the Internet.[31]

WHO COULD SCREEN?

Clinicians and service providers who could screen pregnant women and new mothers for depression include nurse midwives, family practice and OB/GYN physicians, nurse practitioners, pediatricians, NICU personnel, emergency department personnel, public health and hospital nurses, prenatal care coordinators, clinic nurses, WIC dietitians and nurses, lactation educators and consultants, and home visitors. Anyone who screens should have a follow-up action plan in place.

WHEN TO SCREEN?

Screening at the first prenatal visit, the third trimester of pregnancy, the 6-week postpartum exam and one other time in the postpartum year would identify most women who experience depression during that period. If only one screening is done in the postpartum period, the 6-week postpartum visit is the optimal time.[43] All pregnant and postpartum women should receive written materials on depression and a number to call for information or help.

Although women may only have one postpartum visit with obstetric clinicians at six weeks, they have earlier and frequent interactions with pediatric and family clinicians. Family clinicians see both mothers and infants over time and are ideally suited to do routine depression screening. The literature suggests that pediatricians can effectively screen and refer women for appropriate treatment.[44,45]

REFERRAL AND TREATMENT

A successful screening program requires a responsive system of care. "Standardized Screening and Follow-up" (Figure 2) provides a model for screening and subsequent assessment, diagnosis, treatment, referral, and follow-up. The pathway presents a concise overview of the necessary communication links between and among clinicians.

Figure 1-Depression Screening Tools

Center for Epidemiological Studies-Depression (CES-D) Scale. 20 items. Score of 16 or higher indicates a high level of depressive symptoms. English and Spanish versions are available on the WAPC/Perinatal Foundation Website at http://www.perinatalweb.org/major-initiatives/postpartum-depression/resources.

Edinburgh Postnatal Depression Scale-EPDS. 10 items.[32,33] Asks about symptoms during the past two weeks. Low: <10; possibly depressed: 10-12; probably depressed: >12. English and Spanish versions are available on the WAPC/Perinatal Foundation Website at http://www.perinatalweb.org/major-initiatives/postpartum-depression/resources. Additional studies support the validity of the EPDS during pregnancy[34], with adolescents[35], with learning-disabled women[36], and with partners.[37]

Postpartum Depression Screening Scale (PDSS). 35 items.[38] Total score for positive screen: 80 or above. The only scale among those listed that is composed of dimensions or categories. Available from Western Psychological Services, 12031 Wilshire Boulevard, Los Angeles, CA 90025-1251. http://www.wpspublish.com/store/p/2902/postpartum-depression-screening-scale-pdss.

Depression Scale in Hmong, courtesy of Gundersen Lutheran Medical Center, La Crosse. Available on the WAPC/Perinatal Foundation website at http://www.perinatalweb.org/major-initiatives/postpartum-depression/resources.

Other screening tools are available, including the Patient Health Questionnaire (PHQ)-9, the Patient Health Questionnaire (PHQ)-2, and the Perinatal Depression Inventory (PDI)-14.[39,40,41,42]

This section provides suggestions for understanding and communicating with women about their situation. Currently, depression screening is covered under the Affordable Care Act as a preventive service for women.

1. When a woman presents with signs and symptoms of depression and/or a high score on a screening tool, clinicians may start with saying something like, "Based on what you've told me and your score, I'm concerned that you have some symptoms of depression. It's hard to be going through

this when you are pregnant [or 'when you have a new baby']. Remember, depression is partly due to an imbalance of the chemicals in your body and things that cause stress in your life. There are things to do to feel better. Let's talk about some ideas that might work for you."

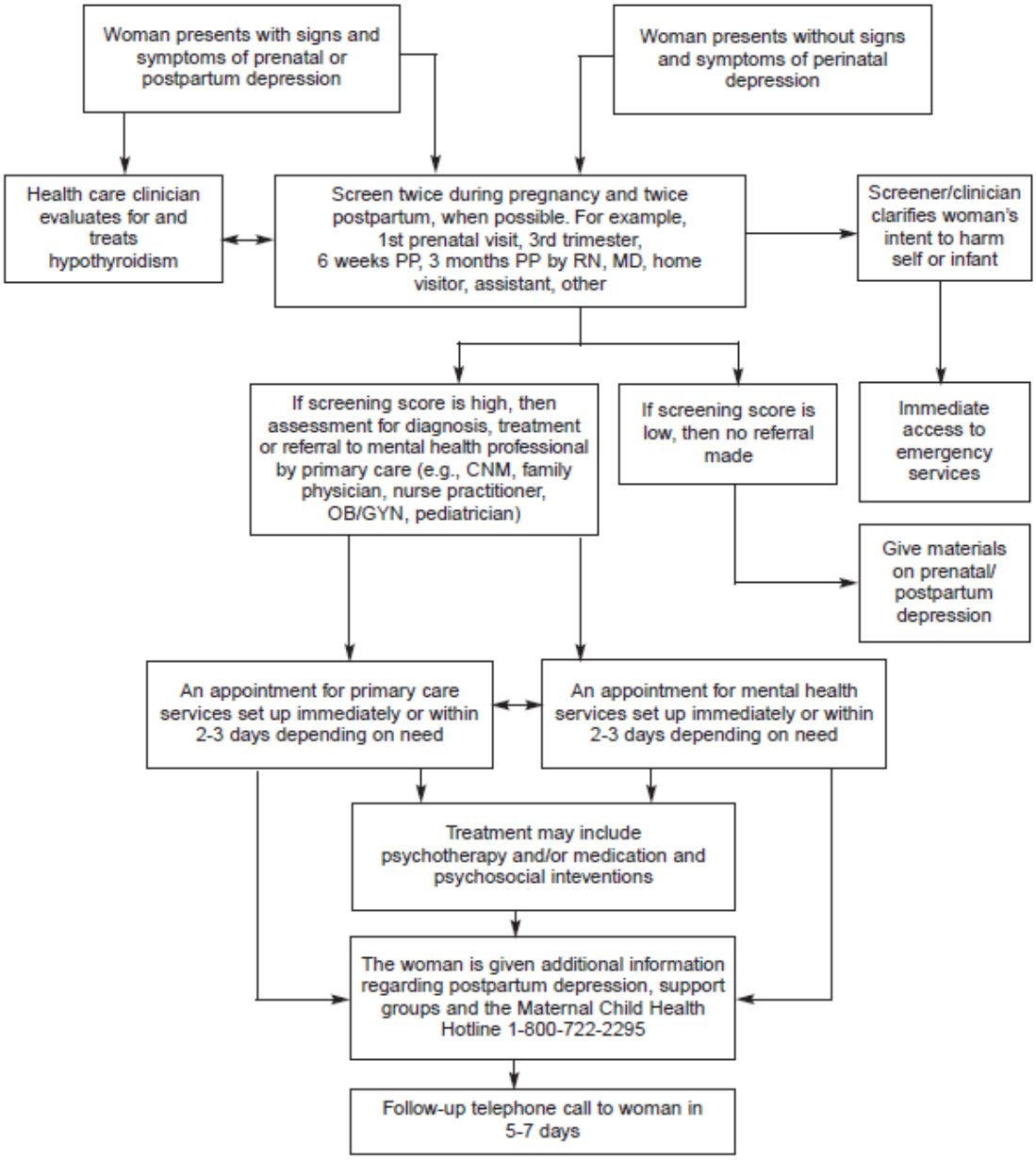
A woman's functioning, meaning her ability to care for herself, her infant, and/or her other children should be assessed separately from depression screening. When a woman is unable to care for herself, the infant, or her other children adequately, it may be necessary to determine if an imminent safety risk is present. Questions in three areas, 1) thoughts, 2) intent, and 3) means, can help a clinician make a decision about whether a safety risk is present and whether the risk requires immediate referral. An affirmative response to these questions requires a safety plan (see 8. below) that considers the environment in which she is being screened.[46] For example, screening in a clinical setting may allow the clinician to leverage immediately available resources. On the other hand, an assessment in the home can yield important information about the woman's functional status and may require immediate intervention so she receives the services she needs.

2. Assess level of social support. It does not matter how many people are around her. What matters is the mother's perception of actual support. This support may be found among families and friends, as well as local and national telephone, group, and Internet support services. Helping a woman identify her support during pregnancy or postpartum is an important psychosocial intervention.
3. Acknowledge depression's effect on relationships. Ask about family members. Include them in information and planning. Those close to someone with depression often feel helpless. The person they once knew is different and they can't fix the problem.[47]
4. Consider clinical therapies[48]: a) medication–antidepressants; (b) psychotherapy–individual, couples, group, and parent-infant. For individual psychotherapy, research indicates that interpersonal (IPT)[49] and cognitive-behavioral (CBT)[50] approaches are effective. Research continues on treatments and treatment effectiveness. Which treatment or treatments to use is a decision between the clinician and the mother. The decision may be based on effectiveness, preference, severity of the symptoms, cost, and availability.
5. Encourage nonclinical interventions: exercise, diet, rest, and rethinking of expectations.
6. Research continues on the potential effects of ongoing depressive symptoms and antidepressants on breastfed and unborn babies. Clinicians must evaluate the risks and benefits for both the mother and the baby of treating with medications. Prescribers can obtain recommendations and current information on lactation and antidepressant use through a number of print (e.g., Hale, T.W. & Rowe, H.E. (2014). *Medications and Mothers' Milk*,16th ed.) and online sources. A clinician who prescribes antidepressant medication for a pregnant or postpartum woman should follow with regularly scheduled medication checks to ascertain the response and side effects.
7. Assess the risk for harming herself or her infant. One way of approaching this is to ask first about feelings of hopelessness. The clinician might say, "Sometimes mothers feel so down and depressed that they think life isn't worth living or that they would be better off dead. Have you had thoughts like that?" (known as suicidal ideation). If she has such thoughts, assess whether she has a plan. If so, determine the likelihood that the plan will be carried out. Does she have materials? Time? Opportunity? Reasons not to? Precipitating factors? Thoughts of harming the infant in some way without intent to do so are common with postpartum depression.
8. If a woman has thoughts, intent, and means for harming herself or her infant, a safety plan is necessary. Such a plan should first include a determination of whether she is willing to be transported to an emergency department for further evaluation and management. Then, she should be transported in the most timely and appropriate manner, whether through family and friends or emergency transport. If the woman is unwilling to be transported to an area emergency department, transportation should be arranged through emergency medical services (i.e., call 911).[46]
9. Treatment for prenatal or postpartum depression should be initiated and monitored by a clinician with experience and expertise in perinatal depression.
10. It is important for health care clinicians to become familiar with the health expectations and practices of those to whom they typically give care. For example, learning simple words and phrases about depression in a person's native language can help build a bridge to a woman's experience.
11. In a broader context, the clinician recognizes that a person's socioeconomic status, race, ethnicity, and gender affect access to and availability of health care.
12. Health care clinicians should be aware that pregnancy and the postpartum period may be devoid of expected joy and lightheartedness or at best, characterized by ambivalence. New mothers who described themselves as very depressed in the weeks and months after delivery were statistically

more likely to describe their pregnancies as "a very hard time" or "one of the worst times of my life."[51] Saying, "You must be so thrilled to be pregnant!" or "Oh, what a beautiful baby! Isn't being a new mother great?" may stifle a woman's desire to say how she's really feeling. The clinician can ask, "How are things going?" in an interested and engaging way or say, "I've learned over the years that being pregnant [or having a new baby] can be a struggle as well as a joy. How are things for you?" Leaving the door open for the possibility that she is sad, anxious, irritable, has lost interest in things, has trouble concentrating, or feels little if any connection with her baby provides a context within which both the clinician and woman can speak about depression.

13. Health care clinicians should consider innovative approaches to treatment, including Web-based treatment[52,53] and support.[54]

Figure 2: Standardized Screening and Follow-up



*We recommend your agency develop a model that reflects best practices.

For an example of a model for home visitors, see Laszewski, A., Wichman, C. L., Doering, J. J., Maletta, K., & Hammel, J. (in press). Perinatal depression algorithm: A home visitor step by step guide for advanced management of perinatal depressive symptoms. *Zero to Three*.

Despite the progress made in the past ten years, there is still room to improve the care of women at risk for and suffering from perinatal depression. Barriers negatively impact both women and providers. For women, two of the most significant barriers are stigma and lack of understanding of perinatal depression.[55,56] In addition, financial barriers may limit their access to appropriate services.[57] For providers, issues related to screening and treatment may limit optimal identification and management strategies.[58,59]

At the same time, there are opportunities to improve the process and outcomes. Facilitators include validating women's experiences and empowering them during their interactions with health care providers, supporting the educational and training needs of health care providers who work with women and their infants, and using innovative strategies to improve screening and treatment access.[60] Finally, current research steeped in a better understanding of the relationship between genetics, biochemistry, psychology, and life experiences offers hope for effective prevention strategies.[50,61,62,63]

CONCLUSION

Motherhood is not magical for women suffering from perinatal depression. Mothers shrouded in depression need to know that what they are experiencing has a name and a treatment. Their dream of motherhood does not have to be lost in darkness and hopelessness. Prenatal and postpartum depressions are treatable. This position statement on screening and follow-up provides a new area of opportunity for health care clinicians to make a difference. Remember, you can't tell by looking.

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This statement was originally developed by the members of the Perinatal Depression Task Force under the auspices of the WAPC's Preconception and Prenatal Care Committee, in 2002. It is intended to serve as a guideline and should not be interpreted as excluding other acceptable courses of care. The positions taken in the statement reflect the consensus of those who participated, but may not reflect in total their individual viewpoints. The Wisconsin Association for Perinatal Care acknowledges them for their participation.

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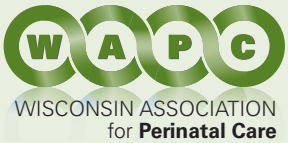

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