Screening for Perinatal Depression

Obstetricians have a critical role in the detection and treatment of perinatal depression.

CONTENTS

> Mental and physical health conditions are inextricably connected and should be treated as such. Obstetricians are a critical key to the detection and treatment of perinatal depression.

INTRODUCTION

Perinatal depression occurs in up to 15% of all pregnancies in the United States. Obstetricians are critical to the early detection and treatment of perinatal depression and are in a unique position to address this intergenerational issue. It is important for obstetricians to be aware that perinatal depression is a common and primary risk factor for poor pregnancy and birth outcomes if left unaddressed.

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) criteria, perinatal depression (known as peripartum depression) is defined as an episode of major depressive disorder occurring during pregnancy or within the first four weeks postpartum. Experts in the field however, include the time period up to one year postpartum. It is one of the most common complications of the both the prenatal and postpartum period. Depression in pregnancy has been linked to preeclampsia, fetal growth restriction, and preterm delivery. Perinatal depression has substantial personal consequences and can interfere with quality of child-rearing—adversely affecting parent-child interactions, maternal responsiveness to infant vocalizations and gestures, and other stimulation essential for optimal child development. Severe depression can result in child neglect, but even moderate depression that is untreated can have lasting adverse effects on the emotional and behavioral development of young children. Despite extensive prenatal opportunities for early detection and the well-known benefits of treatment, early detection of perinatal depression remains suboptimal.

THE NEW WAY TO THINK ABOUT DEPRESSION

Mental and physical health conditions are inextricably connected, especially during pregnancy, as depression affects not only the brain and body systems but also the ability of a woman to participate in her care. The need for integrated care is now more fully recognized and practitioners are realizing the importance of attending to both behavioral and physical health simultaneously. Obstetricians are a critical key to the early detection and treatment of this serious disorder.

Continued on next page

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Obstetrician & Gynecologist Brief 5

WHAT CAN OBSTETRICIANS DO? SIGNS AND RISK FACTORS OF PERINATAL DEPRESSION

Most obstetricians are familiar with the symptomology of depression:

- Sadness
- Low energy
- Exhaustion
- Loss of interest
- Insomnia or hypersomnia
- Crying for no apparent reason
- Excessive weight gain or loss during pregnancy
- Feeling little or no connection to the pregnancy
- Feeling like a failure
- Increased irritability
- Difficulty concentrating and making decisions
- Having excessive guilt

Significant anxiety about the pregnancy or other health issues may also be a sign of depression. As experienced practitioners are aware, **it is not always possible to determine by looking at or talking to someone that they might be depressed**. Some women do not appear outwardly sad or tearful, but may seem more irritable or may even put on a "cheerful face".[1] The American Congress of Obstetricians and Gynecologists (ACOG) recommends that clinicians screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool.[2] Use of a depression screening tool is encouraged because many patients are reluctant to spontaneously describe their symptoms.

How and When to Screen

Screening for depression is not a lengthy or difficult process. Several validated tools may be used throughout the pregnancy and at the postpartum visit to detect if a woman may be experiencing perinatal depression. Both the Patient Health Questionnaire (PHQ-9) and the Edinburgh Postnatal Depression Scale (EPDS) are brief, valid, and free to the public. Both may be completed by the patient or administered by the clinician and are easily scored immediately and can categorize risk as low, mild, moderate, or as "probable depression."

How to Talk with Patients About Depression

Simply talking about depression screening may increase anxiety for some patients. In situations where patients' nonverbal behaviors indicate anxiety, ask the patient if there are specific concerns that worry her. Allowing the patient to discuss her concerns can be therapeutic and can offer the clinician insight into the patient's coping strategies with adverse health effects (e.g., smoking, substance abuse, overeating, and high-risk sexual behavior). This offers an opportunity to engage with the patient in a collaborative discussion on healthy coping techniques and behavior change.

> The strongest risk factor for depression is a previous history of depression.

One simple and validated question that can be used to accurately determine lifetime depression is: *"In your lifetime, have you ever had two weeks or more of feeling sad, blue, depressed, irritable, or lost all interest or pleasure in things like work, school or family?"* This question is important because the strongest risk factor for depression is a previous history of depression.

Scores on the screening tool may fluctuate across the perinatal period. While ACOG recommends screening at least once during pregnancy, screening is best repeated throughout the pregnancy when possible to look for either a stable or changing pattern of scores. Clinicians should educate the patient about the purpose of the screening tool and the meaning of the scores. It may be helpful to use a medical analogy such as blood pressure. In the same way that a high blood pressure reading may or may not indicate a problem with hypertension, a high depression score may or may not indicate clinical depression. It is only an indication that additional questioning, assessment, and diagnosis should be completed.

Suggested language could include:
"Depression is common during pregnancy and after childbirth. It can be managed in a variety of ways, which will help you and your baby. Once we have the screening results, we can talk more about how we can get more information and figure out how to help."

Paternal Depression

Surprisingly, 10% of men experience depression sometime between their partners' first trimester and their baby's first birthday.[3] The most accurate predictor for male depression is if his partner is depressed. Ask your patient how the father of the baby is coping and his level of involvement in the pregnancy.

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Following Up with Screening Results

Using the cut-off scores for the screening tool, clinicians can determine the patient's initial risk level (such as low, moderate, high), and any individual items that are rated as urgent (such as suicide risk). After explaining the purpose and meaning of the screening tool, clinicians should ask the woman how she has been feeling, and what has contributed to the feelings and symptoms. Specifically ask about the following:

Social support: Having a support system is a key protective factor for emotional well-being. *"Tell me about how you feel about the amount and kind of support you are getting from others? What would you like in terms of support that you are not getting?"* If the answer is inadequate, *"Getting support from the people in your life is very important and is critical to your health. Can you think of ways to get more or better support? What is the best way to talk to (your partner, sister, mother, boss, etc.) about this issue?"*

Sleep: *"Have you had any trouble falling asleep, staying asleep, or with waking up too early?"* If yes, *"What have you tried to improve your sleep?"*

Suggestions to offer:

- Make sure sleeping partners know that sleep is critical to overall health and the pregnancy.
- No bright lights or electronic screens within two hours of bedtime.
- Write down worries and concerns in a journal.
- Have a "wind-down" routine (dim lights, do something relaxing, perform bedtime rituals).
- Make sure temperature is low in the bedroom and the room is free of distractions.
- Take a warm bath two hours before bed to allow body temperature to rise, then lower in time for bed.
- No pets in the bed.

Intervention Options

There are several intervention options based on the screening and assessment results (see Table 1). If the woman has low or mild risk for depression, indicates no risk for suicide, and has no history of depression, then offer anticipatory guidance with a discussion of simple non-clinical strategies for improving mood. These include: healthy strategies for stress management, the importance

Table 1: Follow-up and possible interventions based on depression screening results

Risk level	Ways to determine	Possible interventions
None-minimal	PHQ-9 score < 4; Or EPDS score < 9; No history of depression	Re-screen in third trimester and postpartum visit.
Mild	PHQ-9 score 5-9; Or EPDS score 9-11; No history of depression	Re-screen in third trimester and postpartum visit; ask patient to elaborate on specific symptoms and address those. Talk about healthy strategies for stress management.
Moderate[1]	PHQ-9 score 10-14; Or EPDS score < 12; and history of depression	Consider initiation of evidence-based treatment or referral for mental health assessment. Re-screen at every visit.
High	PHQ-9 score 15-19; Or EPDS score 12-18, regardless of history of depression	Definitely initiate evidence-based treatment (either counseling or medications) at that visit or make a referral to a mental health specialist as soon as possible. Re-screen at every visit.
Severe	PHQ-9 score 20-27; Or EPDS score > 18, regardless of history of depression	Immediately initiate treatment, strongly consider pharmacotherapy, and make an immediate referral to mental health specialist.
Any suicide risk[2]	Item 9 on PHQ-9; Item 10 on EDPS	Refer to mental health professional immediately. If no on-site psychiatric services are available, transport the patient to the nearest emergency department or psychiatric receiving facility. Consider BA-52 if there is concern for immediate harm to self or others.

1 Any woman with a history of depression, especially prior postpartum depression, should be re-screened and monitored throughout pregnancy and into the postpartum period.

2 Anytime the suicide item is endorsed, clinicians should ask the woman her exact thoughts around harming herself. Ask, if she has been thinking about death or hurting herself; has she thought about how she would do it (plans) and whether or not she thinks she will (intention), and whether she has access to things that would help carry out a plan (means). If the woman has any of the above (plan, intention, means), an emergency safety plan should be implemented.

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of getting enough rest, healthy diet, and vitamins. Encourage daily walking outside for 20 minutes which increases blood flow, serotonin and dopamine activity in the brain, reduces tension and anxiety, increases energy, helps coping, and improves mood. Remind patients that alcohol worsens depression and there is no safe amount of alcohol for pregnant women. Encourage self care and other stress reducing strategies.

Continue with a "watchful waiting" approach which entails re-screening at each visit to determine if score / risk level is improving, worsening, or staying the same.

Evidenced-based treatment options include anti-depressant medications, and depression-specific psychotherapies such as Cognitive Behavioral Therapy (CBT) or Interpersonal Psychotherapy (IPT). Research has examined maternal depression and effective treatment options—especially for the 30% of women who have low grade symptoms of depression and found the results of using CBT encouraging. The intervention consists of three main components: modification of negative dysfunctional thoughts; increasing pleasant activities; and decreasing behaviors leading to low mood.[4] Therapists trained in CBT can be found online at the website www.abct.org.

Women with a depression risk based on the cutoff score and a probable diagnosis of a Major Depressive Disorder should be either referred to a mental health professional for further evaluation, or started on a course of treatment by the obstetrician or a consulting mental health professional. If any suicide ideation is noted, an immediate evaluation by a mental health professional is warranted. Obstetricians should have a protocol in place to quickly and safely have these women evaluated.

Strategies to Support Women with Perinatal Depression

Screening is the first step in detection of depression and must be coupled with appropriate treatment when warranted.

On-site mental health referral. Unfortunately, up to two-thirds of women will not follow through with an off-site mental health referral to a community provider. It is more effective to have an on-site mental health professional that the woman could meet with on the same day as her OB appointment whenever possible.

Refer to her managed healthcare plan's case management services. Most health plans provide care coordination that can assist in linking her to appropriate mental health services in the community.

Provide a "warm hand-off". Studies have found that mental health utilization is more likely with a warm hand-off which involves calling the mental health professional's office with the patient, or calling the office ahead of time to ensure the referral was received. It is also helpful to let the woman know what to expect when she attends the appointment.

For example:
"I think you will like people at the Community Mental Health Center. They are very experienced with this kind of situation and I have worked with them before. I have given them a head's-up" that you will be coming. It is normal to have some mixed feelings or worries about these kinds of appointments, but your stress and mental health is just as important to this pregnancy as all other aspects of your health. At that appointment, a social worker or nurse will first do a more thorough assessment in order to get to know you better and figure out the best treatment option. They will recommend different types of treatments, such as individual or group counseling, or medications, or some combination. Of course, your preference for treatment is an important factor. If you have any difficulties with the appointment, please let me or the obstetrical nurse know, and we will work with you until you get the help you need."

Whatever the treatment option, it is vital to check in with the patient at the next visit about the outcome of the referral and progress with the recommended treatment. It is beneficial to both you and the patient if she signs a release of information so that you can exchange information with the mental health provider. Mental health providers are very accustomed to releases with primary care and other medical services. The MMA health plan has care coordinators who may be available to help with the referral process if needed.

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SUMMARY

Depression is an important public health issue and can be associated with comorbid conditions. If left untreated, maternal depression can negatively affect birth comes or cause prematurity. Untreated postpartum depression can worsen, adversely affecting the mother, her baby, and the entire family. Maternal depression is also the strongest predictor of paternal depression which can exacerbate the negative impact on both the mom and the baby's development. Depression screening is quick and easy and there are many treatment options including anti-depressant medications and depression-specific psychotherapies.

Obstetricians are in a unique position to address the intergenerational issue of perinatal depression to optimize pregnancy outcomes affecting the mother, the developing fetus and the infant.

RESOURCES AND ADDITIONAL INFORMATION

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Edinburgh Postnatal Depression Scale

The Patient-Health Questionnaire

Agency for Health Care Research and Quality Perinatal Screening Report

Efficacy and Safety of Screening for Postpartum Depression – Agency for Healthcare Quality

Perinatal Depression Screening: Tools for Obstetrician-Gynecologists. American Congress of Obstetricians and Gynecologists

American Congress of Obstetricians and Gynecologists

Substance Abuse and Mental Health Services Administration. Depression in Mothers: More than the Blues

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