



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 clinicians.^{1,2}

The Facts About Depression

- Depression in the perinatal period (pregnancy through one year postpartum) is a major public health problem affecting 10-15% of all women and up to 28% of women living in poverty.^{3,4}
- Depression affects how a woman is able to relate to others, including her new baby.^{5,6,7}
- The chronicity, rather than severity, of maternal depression has more long-term effects on infants and young children.^{8,9}
- Approximately 50% of women with postpartum depression are untreated.¹⁰
- Screening is effective in identifying depression.^{11,12}
- Depression is treatable and may not resolve without treatment.
- Early identification and treatment by primary care clinicians or mental health specialists is essential.

Being pregnant and becoming a mother are life highlights. We expect pregnancy and new parenthood to be filled with wonderment, hope, and anticipation. But these are also times when women are vulnerable to depression. In the best of circumstances, the child-bearing period from conception through the first year of life (prenatal through postpartum) is fraught with ups and downs. When the downs are depression, the mother needs treatment.

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 or infant. The depressive symptoms may range from mild to severe. Severe symptoms often include thoughts of dying or suicide. Wanting to flee or get away, being unable to feel love for the unborn baby or infant, and having thoughts of

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hurting—or not being able to protect—the infant are particularly troubling to mothers. Even a mild depression needs to be treated.

The scope of this position statement is limited to screening for a specific disorder, "major depression" (see the DSM-IV¹³). However, sometimes "depression" is used as an umbrella term for other mood and anxiety problems. These include the "baby blues," panic and obsessive compulsive disorders, and postpartum psychosis. Those who care for women and their infants during pregnancy and the first year of life should be alert to women describing these types of uncomfortable symptoms. These symptoms warrant further evaluation by a skilled primary care or mental health clinician.

You can't tell just by looking that someone is depressed. Recent studies have demonstrated that the incidence of major depression with postpartum onset identified through use of a valid screening tool was significantly higher than the incidence detected by routine clinical evaluation alone.^{14,15,16} Screening is recommended for high-risk groups, which include pregnant and postpartum women.¹⁷

Why do we advocate screening for depression during pregnancy and in the postpartum period?

- There is a stigma associated with mental illness. It's hard to talk about. It's also hard to seek treatment.
- Women may not recognize that what they're experiencing is actually depression. They may think that this is what pregnancy and new motherhood is like.
- Irritability may be the primary symptom of depression, especially in adolescents.
- Depression has been shown to be at least as common, and perhaps more so, during pregnancy as it is during the postpartum period.^{17, 18} If depression in pregnancy is not treated it may continue into the postpartum period.^{3,19,20}
- Depression may interfere with a woman's determination and motivation to seek and continue prenatal care and to provide a safe environment for infants and young children,^{21,22} resulting in poorer health outcomes for mother and baby.

- Depression interferes with how a mother relates to her baby, during pregnancy and after birth.^{5,23}
- Depression may be associated with spontaneous preterm birth.²⁴
- At its extreme, depression is life threatening.

WHY SCREEN

Depression occurs across the population and throughout the life span. All women are at risk. The prevalence of perinatal depression is about the same as at other times in a woman's life.²⁵ However, the consequences of a mother's depression are more compelling because they involve infants and young children. Depression is a biological as well as psychosocial illness.^{26,27} A prior history of depression, anxiety, or other mental illness, especially during a previous pregnancy or postpartum, and a family history of mood or anxiety disorders are significant risk factors in the perinatal period. There are social risks as well: poverty, unemployment, childcare stress, and lack of support from a partner.^{4,18,28}

Depression affects how a woman is able to relate to others, including her new baby. Screening is an easy, affordable method of identifying those women whose symptoms are interfering with functioning in their multiple roles. Treatment of depression is typically straightforward, particularly when the depressive symptoms are not severe.

The American College of Obstetricians and Gynecologists recently published *Depression in Women, Clinical Updates in Women's Health Care Monographs, 1(2)*, 1-82, (2002). Designed for OB/GYNs who provide primary health care to women, the monograph emphasizes screening, diagnosis, and management of depression. See www.acog.com for order information.

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HOW TO SCREEN

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."

There are valid screening tools 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.

Figure 1-Depression Screening Tools

*Center for Epidemiological Studies-Depression (CES-D) Scale.*²⁹ 20 items. Score of 16 or higher indicates a high level of depressive symptoms. Available in Spanish from www.psy.miami.edu/faculty/ccarver/sclspan.html. You may download the English and Spanish versions of the CES-D from the WAPC/Perinatal Foundation website at www.perinatalweb.org. Click "WAPC," click "publications."

*Edinburgh Postnatal Depression Scale-EPDS*³⁰ (called the Edinburgh Depression Scale [EDS] when used for non-postpartum screening)-10 items. Symptoms during the past two weeks. Low: <10; possibly depressed: 10-12; probably depressed: >12. Available on the WAPC/Perinatal Foundation website at www.perinatalweb.org, click "WAPC," click "publications." Spanish version³¹ available on WAPC website, courtesy of Michael O'Hara.

Postpartum Depression Screening Scale (PDSS)^{32,33}—35 items—C. T. Beck and R. K. Gable. 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. 1-800-648-8857. Fax: 310-478-7838. email: custsvc@wpspublish.com.

Depression Scale in Hmong, courtesy of Gundersen Lutheran Medical Center, La Crosse. Available on the WAPC/Perinatal Foundation website at www.perinatalweb.org, click "WAPC," click "publications."

WHO SHOULD 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, 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, as recommended in the recently published guidelines from Scotland on postpartum depression diagnosis, screening, and prevention.³⁴

WHEN TO SCREEN

Most postpartum depressions tend to occur within the first three months (see O'Hara, 1997, for a review).²⁵ Many experienced clinicians suggest screening at least once during pregnancy while the Scottish guidelines recommend postpartum screening be done at 6 weeks and then again at 3 months. 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.¹¹ 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,³⁵ 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. When infants are seen by pediatricians, the literature suggests that mothers would accept screening and referral for their health problems at the pediatric site.³⁶ Clinicians who see new mothers and/or infants should listen for mothers' descriptions of their infants' temperament. Depressed mothers describe having fussy, colicky babies more often than nondepressed mothers.³⁷

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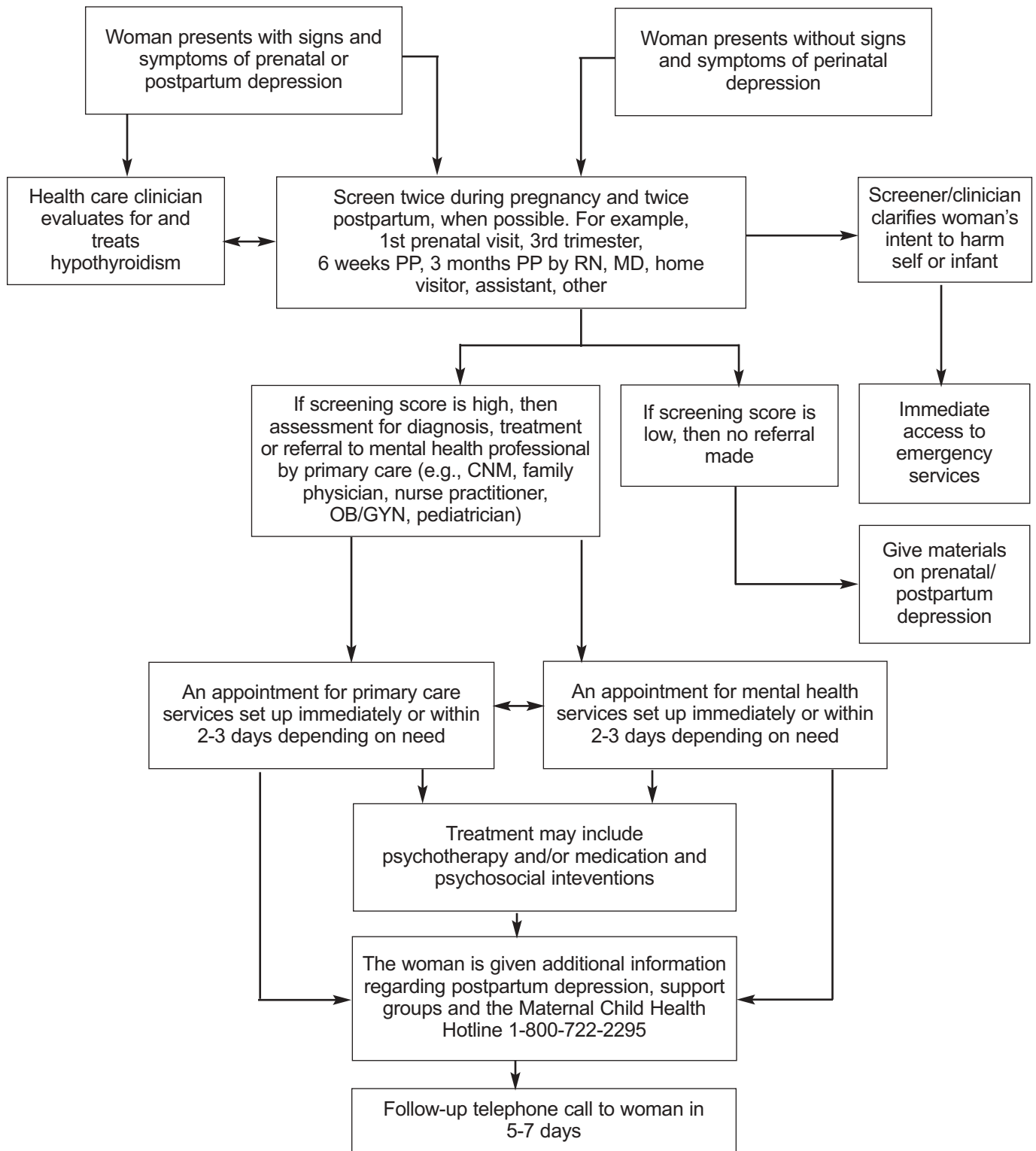
REFERRAL AND TREATMENT

A successful screening program requires a responsive system of care. "Pathways For Accessing Treatment & Support Services For Women Experiencing Prenatal and Postpartum Depression" (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. This section provides suggestions for understanding and communicating with women about their situation.

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."
2. Encourage nonclinical interventions: exercise, diet, rest, and rethinking of expectations.
3. 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.
4. 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.³⁸
5. Consider clinical therapies: a) medication—antidepressants; (b) psychotherapy—individual, couples, group, and parent-infant. For individual psychotherapy research indicates that interpersonal or cognitive-behavioral approaches are preferred over other methods.³⁹ One study notes that Interpersonal Psychotherapy (IPT) may have a protective effect in preventing postpartum depression in a woman with prenatal depression.⁴⁰ Research continues on treatments and treatment effectiveness (for a summary, see Goff, 2002).⁴¹ 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.
6. Research continues on the potential effects of ongoing depressive symptoms and antidepressants on breastfed and unborn babies. Clinicians must evaluate the risk and benefit of treating with medication for both the mother and the baby. Prescribers can obtain recommendations and current information on lactation and antidepressant use through books (see, e.g., Briggs;⁴² Lawrence & Lawrence⁴³) and recent journal articles. A clinician who prescribes antidepressant medication for a pregnant or postpartum woman should follow up with regularly scheduled medication checks to ascertain the response and side effects.^{44,45,46,47}
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? If so, refer for psychiatric emergency services. *Thoughts of harming the infant in some way without intent to do so are common with postpartum depression.*

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Figure 2: Pathways For Accessing Treatment & Support Services For Women Experiencing Prenatal and Postpartum Depression*



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

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8. Treatment for prenatal or postpartum depression should be initiated and monitored by a clinician with experience and expertise.
9. 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.
10. 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.
11. 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. A recently-published retrospective study found that 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."⁴⁸ 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 (see Stuart & Lieberman, 1993, for more ideas).⁴⁹

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 just by looking.*

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This statement was prepared by the members of the Perinatal Depression Task Force under the auspices of the WAPC's Preconception and Prenatal Care Committee, I. Mary Anderson, chair. 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. *The Perinatal Foundation provided funding for printing.*

Contributors:

I. Mary Anderson, RN, MS, Waukesha County Health Department, Waukesha
Roseanne Clark, PhD, UW-Madison Medical School, Department of Psychiatry
Rebecca Cohen, MS, BFA, Department of Health and Family Services, Division of Supportive Living, Bureau of Community Mental Health, Madison
Sarah Dillman, Postpartum Adjustment, Support and Education, Edgerton
Teresa Halverson, Gundersen Lutheran Medical Center, La Crosse
Ruth Hoffman Hein, RN, BSN, Family Enhancement, Madison
Terry Kruse, BSN, RN, Department of Health and Family Services, Division of Public Health, Bureau of Family and Community Health, Madison
Linda Denise Oakley, PhD, RN, CS, University of Wisconsin-Madison School of Nursing
Ana Schaper, PhD, RN, Gundersen Lutheran Medical Foundation, La Crosse
Lois Seefeldt, RNC, MSN, PhD, Waukesha Memorial Hospital, Waukesha
Laurie Tellier, MSN, RN, former State of WI MCH Consultant
Beth Turner, Madison

Consultants:

Cheryl Tatano Beck, RN, DNSc, CNM, FAAN, University of Connecticut, Storrs
George Benton, MD, Dean Health System, Madison
Lynn Carey, PhD, RN, Covenant Healthcare System, Milwaukee
Michael Hynan, PhD, University of Wisconsin-Milwaukee
Jon Jackson, MD, private psychiatry practice, Madison
Michael O'Hara, PhD, University of Iowa, Iowa City
Barbara Yawn, MD, MSc, Olmsted Medical Center, Rochester, Minnesota

WAPC Staff: Rana Limbo, PhD, RN, CS

WAPC Statewide Office
McConnell Hall
1010 Mound Street
Madison, Wisconsin 53715
Telephone 608/267-6060
Fax 608/267-6089
Email at wapc@perinatalweb.org
Website at www.perinatalweb.org



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