Postpartum Depression Screening

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Question: When I screen mothers for postpartum depression, I often wonder about how best to explain the reason for doing this or how to ensure I am being helpful to these moms. Any thoughts?

A: Professional organizations, including the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, recommend that health care providers screen mothers for the occurrence of postpartum depression. Pediatricians are asked to do this Because in the year after delivery, the only health care provider that most young mothers will see is their child’s pediatrician. If they don’t inquire about maternal depression, it is possible that no one else will. Doing worthwhile screening, however, requires some extra understanding about depression in moms.

More than half of all moms experience a period of “baby blues” in the first few weeks after delivery, meaning they experience a period of significant sadness, exhaustion, fear, and mood instability. More often than not, this experience resolves just fine on its own, particularly in the presence of good social supports. So, I describe the extremely common experience of “baby blues” with new parents as a common transitional reaction to the life changes inherent to the birth of a child.

However, there are times when the “baby blues” don’t go away in just a few weeks. Sometimes this evolves into an episode of major depression, with more severe and more persistent symptoms. As many as 1 of every 8 mothers are reported to develop an episode of major depression in the month immediately following delivery, although the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5) reports that this frequency is about half that rate.

Postpartum depression differs from major depression only in regard to its timing, occurring within 4 weeks after delivery. DSM-5 points out that for about one-half of those cases initially identified as “postpartum” depression, these mood disorder episodes actually started in the month prior to delivery. This is why DSM-5 recommends that clinicians instead use the diagnosis descriptor “Depression with Peripartum Onset.” So hereafter I will refer to this as “peripartum depression.”

Peripartum depression is a concern for children because depressed moms are not able to be as interactive and responsive to their children as they would otherwise be during a critical phase of life. Children of depressed mothers have poorer mother-infant bonding, impaired social engagement, and increased negative emotionality. Longer term, peripartum depression is associated with child cognitive impairments, and child emotional and behavioral problems. In extreme cases (about 1 in 1,000), an episode of peripartum depression can bring along psychotic symptoms in the mother that pose a more direct risk of harm to an infant. As pediatric primary care providers, we have many reasons to believe that doing something to identify and resolve a young mom’s depression quickly will yield benefits for the child.

Peripartum depression is also a concern for the moms who experience major depression around the time of their child’s birth, because they are likely to experience persistent symptoms (about 30% will still have major mental illness at 2 years after delivery).

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depression 4 months to 3 years postpartum). Those with greater overall severity who find their way into specialist treatment have an even higher rate of persistence. Major depression is highly life impairing, but it can respond well to treatment. The challenge is to get that mom identified and into treatment before too much time has passed and before long-term impairments develop for both parent and child.

After doing extensive analyses of the topic, advisory agencies like the Agency for Healthcare Research and Quality (AHRQ) and the US Preventive Services Task Force (USPSTF) have recommended that health providers only do universal screening for peripartum depression when there are staff-assisted depression care supports available to them (ie, they know that they can do something useful with the results). The process of how to access local crisis services for an acutely suicidal mom is fairly clear in most communities, so if a screening were to reveal someone with very severe depression, then what to do next should be relatively straightforward. However, for any mom found via a screening to be possibly depressed and not in such a severe situation, it is much more challenging to know what to do next.

As a primary care practitioner, if you follow a universal screening approach with questionnaires, those results still need to be interpreted well enough to avoid referring every positive rating scale score along to specialty mental health services. Universal referral for every mom who has some symptoms of depression causes unnecessary parent stress, unnecessary costs, and strains on your parent-provider relationship if that parent doesn’t really want to see a specialty mental health provider.

Staff assistance for depression care support is considered to be important in part because follow-through rates on referrals to specialty mental health providers after positive screens are not very high. Some amount of ongoing assistance and follow-up are needed to succeed in making that connection into specialty care. I personally prefer to target my specialty referral and follow-through efforts with a parent in a situation where specialty mental health engagement is clearly important, not just for those with a rating scale score over a certain threshold number and no clarity about the need for treatment.

Depression rating scales, especially in the context of common peripartum depression symptoms, have a high false-positive rate. Depending on what the actual prevalence rate of depression is in your patient population, a screening tool that has something on the order of 85% sensitivity and sensitivity may flag 2 to 4 times as many false-positive results as the number of true-positive results. This highlights why additional interaction and diagnostic interviewing is pertinent to follow up on rating scale results. Another challenge is that there is no specific screening tool that is considered to be the standard of care to use for peripartum depression screening. Although many people choose to use either the Edinburgh Postnatal Depression Scale or the Patient Health Questionnaire-9, we cannot say that either of these are consensus recommended to be the “best” scales to use for peripartum depression screening.

By taking this all into account, the cautions expressed by the USPSTF and AHRQ on universal peripartum depression screening programs become understandable. I would like to assert that it is not controversial for general pediatric practices to focus on offering “universal education” to moms in the peripartum phase about “baby blues,” and the possibility that “baby blues” could convert into a much more harmful episode of major depression. Introducing the topic of peripartum depression as something that you personally care about, thereby showing that you care about their parental well-being too and not just their child, is a very positive approach that should both feel comfortable and be well received by your patients’ parents. If your practice can support implementing a more-involved depression screening and referral support program for parents, then all the better.

REFERENCES