



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 630 • May 2015

(Replaces Committee Opinion Number 453, February 2010)

Committee on Obstetric Practice

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Screening for Perinatal Depression

ABSTRACT: Perinatal depression, which includes major and minor depressive episodes that occur during pregnancy or in the first 12 months after delivery, is one of the most common medical complications during pregnancy and the postpartum period, affecting one in seven women. It is important to identify pregnant and postpartum women with depression because untreated perinatal depression and other mood disorders can have devastating effects on women, infants, and families. Several screening instruments have been validated for use during pregnancy and the postpartum period. Although definitive evidence of benefit is limited, the American College of Obstetricians and Gynecologists recommends that clinicians screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool. Although screening is important for detecting perinatal depression, screening by itself is insufficient to improve clinical outcomes and must be coupled with appropriate follow-up and treatment when indicated; clinical staff in obstetrics and gynecology practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both.

Recommendations

- Although definitive evidence of benefit is limited, the American College of Obstetricians and Gynecologists (the College) recommends that clinicians screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool.
- Women with current depression or anxiety, a history of perinatal mood disorders, or risk factors for perinatal mood disorders warrant particularly close monitoring, evaluation, and assessment.
- Although screening is important for detecting perinatal depression, screening by itself is insufficient to improve clinical outcomes and must be coupled with appropriate follow-up and treatment when indicated; clinical staff in obstetrics and gynecology practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both.
- Systems should be in place to ensure follow-up for diagnosis and treatment.

Introduction

The purpose of this document is to increase awareness of depression and mood disorders in pregnant and postpartum women. It is important to identify pregnant and postpartum women with depression because untreated perinatal depression and other mood disorders can have devastating effects on women, infants, and families. Regular contact with the health care delivery system during the perinatal period should provide an ideal circumstance for women with depression to be identified and treated. The College recommends that clinicians screen patients at least once during the perinatal period for depression and anxiety symptoms. This document discusses the obstetric provider's role in the initiation of medical therapy and referral of patients to appropriate behavioral health resources when indicated.

Depression, the most common mood disorder in the general population, is approximately twice as common in women as in men, with its initial onset peaking during the reproductive-age years (1). Therefore, it is not surprising that perinatal depression, which includes major and minor depressive episodes that occur during pregnancy

or in the first 12 months after delivery, is one of the most common medical complications during pregnancy and the postpartum period, affecting one in seven women (2). Perinatal depression and other mood disorders, such as bipolar disorder and anxiety disorders (3), can have devastating effects on women, infants, and families; maternal suicide exceeds hemorrhage and hypertensive disorders as a cause of maternal mortality (4).

Perinatal depression often goes unrecognized because changes in sleep, appetite, and libido may be attributed to normal pregnancy and postpartum changes. In addition to clinicians not recognizing such symptoms, women may be reluctant to report changes in their mood. In one small study, less than 20% of women in whom postpartum depression was diagnosed had reported their symptoms to a health care provider (5). Therefore, it is important for clinicians to ask the pregnant or postpartum patient about her mood. Newborn care appointments also may be an opportunity to ask a mother about her mood. Obstetric providers should collaborate with their pediatric colleagues to facilitate treatment for women with mood disorders identified during newborn care (6).

Anxiety is a prominent feature of perinatal mood disorders, as is insomnia. It may be helpful to ask a woman whether she is having intrusive or frightening thoughts or is unable to sleep even when her infant is sleeping. Women with current depression or anxiety, a history of perinatal mood disorders, or risk factors for perinatal mood disorders (Box 1) warrant particularly close monitoring, evaluation, and assessment. These women may benefit from evidence-based psychologic and psychosocial interventions and, in some cases, pharmacologic therapy to reduce the incidence and burden of perinatal depression (7). If there is concern that the patient suffers from mania or bipolar disorder, she should be referred to a psychiatrist before initiating medical therapy because antidepressant monotherapy may trigger mania or psychosis (8). Mania symptoms include inflated self-esteem or grandiosity, feeling rested after only 3 hours of sleep, or engaging in risky behaviors that worry her friends and family (3).

Although screening is important for detecting perinatal depression, screening by itself is insufficient to improve clinical outcomes and must be coupled with appropriate follow-up and treatment when indicated; clinical staff in obstetrics and gynecology practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both. Recent evidence suggests that collaborative care models implemented in obstetrics and gynecology offices improve long-term patient outcomes (9). For example, in one model of collaborative care, a depression care manager, such as a nurse or social worker, can provide psychotherapy and support under the supervision of a mental health specialist and a primary care clinician. Systems should be in place to ensure follow-up for diagnosis and treatment (7, 8).

Box 1. Risk Factors for Perinatal Depression ←

Depression during pregnancy:

- Maternal anxiety
- Life stress
- History of depression
- Lack of social support
- Unintended pregnancy
- Medicaid insurance
- Domestic violence
- Lower income
- Lower education
- Smoking
- Single status
- Poor relationship quality

Postpartum depression:

- Depression during pregnancy
- Anxiety during pregnancy
- Experiencing stressful life events during pregnancy or the early postpartum period
- Traumatic birth experience
- Preterm birth/infant admission to neonatal intensive care
- Low levels of social support
- Previous history of depression
- Breastfeeding problems

Data from Lancaster CA, Gold KJ, Flynn HA, Yoo H, Marcus SM, Davis MM. Risk factors for depressive symptoms during pregnancy: a systematic review. *Am J Obstet Gynecol* 2010;202:5–14 and Robertson E, Grace S, Wallington T, Stewart DE. Antenatal risk factors for postpartum depression: a synthesis of recent literature. *Gen Hosp Psychiatry* 2004;26:289–95.

Screening Tools

Several screening instruments have been validated for use during pregnancy and the postpartum period to assist with systematically identifying patients with perinatal depression (Table 1). For example, the Edinburgh Postnatal Depression Scale consists of 10 self-reported items, takes less than 5 minutes to complete, has been translated into 12 languages, has a low required reading level, and is easy to score. The Edinburgh Postnatal Depression Scale includes anxiety symptoms, which are a prominent feature of perinatal mood disorders, and excludes constitutional symptoms of depression, such as changes in sleeping patterns, that are common in pregnancy and the postpartum period. The inclusion of these constitutional symptoms in other screening instruments, such as the Patient Health Questionnaire 9, the Beck Depression Inventory, and the Center for Epidemiologic Studies Depression Scale (Table 1), reduces their specificity for perinatal depression. With the exception of the Patient Health Questionnaire 9 and the Edinburgh Postnatal Depression Scale, other instruments have at least

Table 1. Depression Screening Tools ←

Screening Tool	Number of Items	Time to Complete (Minutes)	Sensitivity and Specificity	Spanish Available
Edinburgh Postnatal Depression Scale	10	Less than 5	Sensitivity 59–100% Specificity 49–100%	Yes
Postpartum Depression Screening Scale	35	5–10	Sensitivity 91–94% Specificity 72–98%	Yes
Patient Health Questionnaire 9	9	Less than 5	Sensitivity 75% Specificity 90%	Yes
Beck Depression Inventory	21	5–10	Sensitivity 47.6–82% Specificity 85.9–89%	Yes
Beck Depression Inventory-II	21	5–10	Sensitivity 56–57% Specificity 97–100%	Yes
Center for Epidemiologic Studies Depression Scale	20	5–10	Sensitivity 60% Specificity 92%	Yes
Zung Self-rating Depression Scale	20	5–10	Sensitivity 45–89% Specificity 77–88%	No

20 questions and, thus, require more time to complete and to score. As with any screening test, results should be interpreted within the clinical context. A normal score for a tearful patient with a flat affect does not exclude depression; an elevated score in the context of an acute stressful event may resolve with close follow-up.

Conclusions

Although the adverse consequences of perinatal depression, as well as the benefits of its treatment, are clear, there is only limited evidence that screening to identify and treat this condition improves outcomes (10). This seeming paradox may be due in part to variation in resources to effectively treat or refer patients if screening identifies concerns. Nevertheless, perinatal depression is a common complication of pregnancy with potentially devastating consequences if it goes unrecognized and untreated. Therefore, although definitive evidence of benefit is limited, the College recommends that clinicians screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool. Obstetric providers should be prepared to initiate treatment and refer patients as needed. Systems should be in place to ensure follow-up for diagnosis and treatment.

Resources

(Also found at <http://www.acog.org/Womens-Health/Depression-and-Postpartum-Depression>)

The following resources are for information purposes only. Referral to these sources and web sites does not imply the endorsement of the American College of Obstetricians and Gynecologists. These resources are not meant to be comprehensive. The exclusion of a source or web site does not reflect the quality of that source or web site. Please note that web sites are subject to change without notice.

American College of Obstetricians and Gynecologists. Postpartum depression. Patient Education Pamphlet AP091. Washington, DC: American College of Obstetricians and Gynecologists; 2013.

Beck CT, Gable RK. Postpartum depression screening scale (PDSS). Los Angeles (CA): Western Psychological Services; 2002.

Dell D. Mood and anxiety disorders. Clin Update Womens Health Care 2008;VII(5):1–98.

Postpartum Support International. 6706 SW 54th Avenue, Portland, OR 97219. (503) 894-9453. Support Helpline: 1-800-944-4PPD (4773). Available at: <http://www.postpartum.net>. Retrieved February 2, 2015.

Substance Abuse and Mental Health Services Administration. Patient health questionnaire (PHQ-9). Available at: <http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf>. Retrieved December 8, 2014.

UCSF Fresno Center for Medical Education and Research. Edinburgh Postnatal Depression Scale (EPDS). Available at: <http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf>. Retrieved December 8, 2014.

Use of psychiatric medications during pregnancy and lactation. ACOG Practice Bulletin No. 92. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2008;111:1001–20.

References

- Weissman MM, Olfson M. Depression in women: implications for health care research. *Science* 1995;269:799–801. [PubMed] ←
- Gavin NI, Gaynes BN, Lohr KN, Meltzer-Brody S, Gartlehner G, Swinson T. Perinatal depression: a systematic

- review of prevalence and incidence. *Obstet Gynecol* 2005;106:1071–83. [PubMed] [*Obstetrics & Gynecology*] ↩
3. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington (VA): APA; 2013. ↩
 4. Palladino CL, Singh V, Campbell J, Flynn H, Gold KJ. Homicide and suicide during the perinatal period: findings from the National Violent Death Reporting System. *Obstet Gynecol* 2011;118:1056–63. [PubMed] [*Obstetrics & Gynecology*] ↩
 5. Whitton A, Warner R, Appleby L. The pathway to care in post-natal depression: women's attitudes to post-natal depression and its treatment. *Br J Gen Pract* 1996;46:427–8. [PubMed] [Full Text] ↩
 6. Earls MF. Incorporating recognition and management of perinatal and postpartum depression into pediatric practice. Committee on Psychosocial Aspects of Child and Family Health American Academy of Pediatrics. *Pediatrics* 2010;126:1032–9. [PubMed] [Full Text] ↩
 7. Yonkers KA, Vigod S, Ross LE. Diagnosis, pathophysiology, and management of mood disorders in pregnant and postpartum women. *Obstet Gynecol* 2011;117:961–77. [PubMed] [*Obstetrics & Gynecology*] ↩
 8. Yonkers KA, Wisner KL, Stewart DE, Oberlander TF, Dell DL, Stotland N, et al. The management of depression during pregnancy: a report from the American Psychiatric Association and the American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2009;114:703–13. [PubMed] [*Obstetrics & Gynecology*] ↩
 9. Melville JL, Reed SD, Russo J, Croicu CA, Ludman E, LaRocco-Cockburn A, et al. Improving care for depression in obstetrics and gynecology: a randomized controlled trial. *Obstet Gynecol* 2014;123:1237–46. [PubMed] [*Obstetrics & Gynecology*] ↩
 10. Myers ER, Aubuchon-Endsley N, Bastian LA, Gierisch JM, Kemper AR, Swamy GK, et al. Efficacy and safety of screening for postpartum depression. Comparative Effectiveness Review 106. AHRQ Publication No. 13-EHC064-EF. Rockville (MD): Agency for Healthcare Research and Quality; 2013. Available at: <http://www.effectivehealthcare.ahrq.gov/ehc/products/379/1437/postpartum-screening-report-130409.pdf>. Retrieved December 8, 2014. ↩
-
- Copyright May 2015 by the American College of Obstetricians and Gynecologists, 409 12th Street, SW, PO Box 96920, Washington, DC 20090-6920. All rights reserved.
- ISSN 1074-861X
- Screening for perinatal depression. Committee Opinion No. 630. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2015;125:1268–71.