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

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Committee on Obstetric Practice

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice.

INTERIM UPDATE: This Committee Opinion is updated as highlighted to reflect a limited, focused change in the language and supporting evidence regarding prevalence, benefits of screening, and screening tools.

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. Several screening instruments have been validated for use during pregnancy and the postpartum period. The American College of Obstetricians and Gynecologists recommends that obstetrician–gynecologists and other obstetric care providers screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool. It is recommended that all obstetrician–gynecologists and other obstetric care providers complete a full assessment of mood and emotional well-being (including screening for postpartum depression and anxiety with a validated instrument) during the comprehensive postpartum visit for each patient. If a patient is screened for depression and anxiety during pregnancy, additional screening should then occur during the comprehensive postpartum visit. There is evidence that screening alone can have clinical benefits, although initiation of treatment or referral to mental health care providers offers maximum benefit. Therefore, 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 and Conclusions

The American College of Obstetricians and Gynecologists (the College) makes the following recommendations and conclusions:

- The American College of Obstetricians and Gynecologists (the College) recommends that obstetrician–gynecologists and other obstetric care providers screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool. It is recommended that all obstetrician–gynecologists and other obstetric care providers complete a full assessment of mood and emotional well-being (including screening for postpartum depression and anxiety with a validated instrument) during the comprehensive postpartum visit for each patient. If a patient is screened for depression and anxiety during pregnancy, additional screening should then occur during the comprehensive postpartum visit.
- Women with current depression or anxiety, a history of perinatal mood disorders, risk factors for perinatal mood disorders, or suicidal thoughts warrant particularly close monitoring, evaluation, and assessment.
- There is evidence that screening alone can have clinical benefits, although initiation of treatment or referral to mental health care providers offers maximum benefit. Therefore, 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 prevalence of perinatal depression is a significant cost to individuals, children, families, and the community. In 2011, 9% of pregnant women and 10% of postpartum women met the criteria for major depressive disorders (1). It is important to identify pregnant and postpartum women with depression because untreated perinatal depression and other mood disorders can have devastating effects. 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 obstetrician–gynecologists and other obstetric care providers screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool. It is recommended that all obstetrician–gynecologists and other obstetric care providers complete a full assessment of mood and emotional well-being (including screening for postpartum depression and anxiety with a validated instrument) during the comprehensive postpartum visit for each patient (2). If a patient is screened for depression and anxiety during pregnancy, additional screening should then occur during the comprehensive postpartum visit. When indicated, obstetrician–gynecologists and other obstetric care providers share a role in initiating medical therapy or referring patients to appropriate behavioral health resources, or both.

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 (3). 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 (4). Perinatal depression and other mood disorders, such as bipolar disorder and anxiety disorders (5), can have devastating effects on women, infants, and families; maternal suicide exceeds hemorrhage and hypertensive disorders as a cause of maternal mortality (6).

Perinatal depression often goes unrecognized because changes in sleep, appetite, and libido may be attributed to normal pregnancy and postpartum changes. In addition to health care providers 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 (7). Therefore, it is important for obstetrician–gynecologists and other obstetric care providers 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 (8).

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, risk factors for perinatal mood disorders (Box 1), or suicidal thoughts 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 (9). 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 (10). 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 (5).

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.

In 2016, the U.S. Preventive Services Task Force changed its recommendation for routine depression screening to a B, endorsing depression screening in the general adult population, including pregnant and postpartum women (11). Although there are no large randomized controlled trials that definitively prove the benefits of screening alone without the necessary treatment, the task force changed its recommendation based on a large systematic review. This review combined six randomized controlled trials that screened pregnant or postpartum patients with or without additional care offered based on results of screening. Most of the trials provided some type of treatment or support beyond screening, such as counseling, treatment protocols, or training to clinicians and ancillary staff. Thus, it is difficult to distinguish the effect solely due to screening or screening combined with some type of intervention. Nevertheless, follow-up of these patients several weeks to months later demonstrated an absolute risk reduction in depression prevalence of as much as 9% (12). Greater benefits were seen if clinical support and training were offered to the staff that provided the screening tool.

Initiation of treatment or referral to mental health care providers offers maximum benefit. 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 (13). 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 provider. Systems should be in place to ensure follow-up for diagnosis and treatment (9, 10).

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). The Edinburgh Postnatal Depression Scale (EPDS) is most frequently used in the research setting and clinical practice for several reasons. The scale, which has been translated into 50 different languages, consists of 10 self-reported questions that are health literacy appropriate and take less than 5 minutes to complete. The EPDS includes anxiety symptoms, which are a prominent feature of perinatal mood disorders, but excludes constitutional symptoms of depression, such as changes in sleeping patterns, which can be 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. In addition, with the exception of the Patient Health Questionnaire 9 and the EPDS, other instruments have at least 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.

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

Conclusion

Perinatal depression is a common complication of pregnancy with potentially devastating consequences if it goes unrecognized and untreated. There is evidence that screening alone can have clinical benefits, although initiation of treatment or referral to mental health care providers offers maximum benefit. Systems should be in place to ensure follow-up for diagnosis and treatment. Therefore, the College recommends that obstetrician–gynecologists and other obstetric care providers screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool. It is recommended that all obstetrician–gynecologists and other obstetric care providers complete a full assessment of mood and emotional well-being (including screening for postpartum depression and anxiety with a validated instrument) during the comprehensive postpartum visit for each patient. If a patient is screened for depression and anxiety during pregnancy, additional screening should then occur during the comprehensive postpartum visit.

For More Information

The American College of Obstetricians and Gynecologists has identified additional resources on topics related to this document that may be helpful for ob–gyns, other health care providers, and patients. You may view these resources at www.acog.org/More-Info/PerinatalDepression.

These resources are for information only and are not meant to be comprehensive. Referral to these resources does not imply the American College of Obstetricians and Gynecologists' endorsement of the organization, the organization's website, or the content of the resource. The resources may change without notice.

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This information is designed as an educational resource to aid clinicians in providing obstetric and gynecologic care, and use of this information is voluntary. This information should not be considered as inclusive of all proper treatments or methods of care or as a statement of the standard of care. It is not intended to substitute for the independent professional judgment of the treating clinician. Variations in practice may be warranted when, in the reasonable judgment of the treating clinician, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology. The American College of Obstetricians and Gynecologists reviews its publications regularly; however, its publications may not reflect the most recent evidence. Any updates to this document can be found on www.acog.org or by calling the ACOG Resource Center.

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