Screening for Postpartum Depression

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Short time seems long in sorrow's sharp sustaining. —William Shakespeare

Learning Objectives:
1. Describe the timing and symptoms of postpartum depression (PPD).
2. Discuss potential consequences of PPD for both mother and child.
3. List appropriate, validated screening tools for detecting PPD.
4. Outline management strategies in the pediatric office for a mother identified as having PPD.
5. Identify ways advocacy can play a role in improving PPD screening rates.

Primary Reference:
   https://pediatrics.aappublications.org/content/143/1/e20183259

CASE ONE:

Dee Presaud is an 18-year-old woman who brings her 7-week-old baby, Carankay, for his 2-month routine visit. She shares that she is “very stressed out” and took her son to the ED multiple times over the last month due to frequent episodes of crying. “I just want to find out what's wrong with my baby!” On further questioning, you discover that her boyfriend recently got a new job, is working more than 50 hours a week, and has not been around much to help. She has found herself crying more frequently, but states she is “just tired.” She is not interested in getting together with friends and has fallen below her pre-pregnancy weight “because I’m just not hungry.”

1. How often are new mothers affected by postpartum depression (PPD)? What are the known risk factors for PPD? What symptoms does Dee have that are suggestive of PPD?

Depression is common in pregnant and postpartum women and affects both the mother and her child. Depressive symptoms in the postpartum period range from “baby blues” (“maternity blues”) to PPD and postpartum psychosis and are collectively the most common obstetric complication in the United States. Baby blues occur in the first few days after delivery, affect 50-80% of new mothers, and usually resolve within 1-2 weeks. Correlated with the fall in progesterone at the time of delivery, these symptoms frequently consist of crying, emotional lability, and anxiety. Baby blues are benign and should be expected and normalized for families.

In contrast, PPD causes a range of mild to severe depressive symptoms and affects 10-20% of new mothers each year. The DSM-5 categorizes PPD as a major depressive episode with peripartum onset (within 4 weeks of delivery). Anxiety can also be a prominent feature of PPD. Continuation of depressive episodes accounts for approximately 50% of PPD cases. The timing of maternal depression shows a peak at 6 weeks after birth for major depression, a second peak at 2-3 months for minor depression, and a third peak 6 months after the birth of a child. The average length of a depressive episode is approximately 5 months, but in approximately 20% of women, PPD symptoms persist 1 year after delivery.

Postpartum psychosis is relatively rare, affecting approximately 1-3 mothers per 1000 deliveries, and most often occurs in the first month after delivery. Symptoms of postpartum psychosis include paranoia, mood shifts, hallucinations, delusions, and suicidal or homicidal thoughts. This is a serious condition which requires immediate medical attention and usually hospitalization.
The strongest risk factor for PPD is a personal history of depression, whether pre-pregnancy, antepartum, or postpartum. Other risk factors shown to increase a woman’s risk for PPD include:

- Young maternal age (40-60% of adolescent mothers report depressive symptoms)
- Low attained education
- Single marital status
- Low socio-economic status (prevalence is two times higher)
- Personal or family history of mood disorder
- Psychosocial stress
- Lack of social support (especially minority, immigrant, and refugee populations)
- Marital discord
- Chronic illness
- Maternal substance use
- Infant preterm birth, significant medical concerns, and difficult temperament

Depressed women often do not recognize their symptoms as depression. A study of 78 patients with PPD found that only 32% believed they were suffering from the disorder, and 80% had not reported their symptoms to a clinician.

It is important for providers to understand that fathers may also suffer from PPD, with a prevalence rate from 2% to as high as 25%. This rate increases to 50% when the mother experiences PPD. Fathers with PPD are more likely to present with symptoms of substance use, domestic violence, and undermining breastfeeding than with reports of sadness. In contrast, a father who is not depressed is a protective factor for children of mothers with depression. The moderator may refer to the chapter on Fatherhood for additional discussion points.

Dee is presenting at a time of peak PPD prevalence. She has several risk factors (young age, low attained education level as she is only 18 years of age, unmarried, lack of social support, and psychosocial stress) and multiple symptoms concerning for PPD. Further evaluation is needed.

2. What are the consequences of unrecognized maternal PPD? What are the potential effects on children like Dee’s son?

Parental PPD is a common adverse childhood experience associated with adverse health outcomes both immediately, in childhood, and later, in adulthood. Untreated PPD may result in poorer outcomes for both the mother and her child including discontinuation of breastfeeding, child abuse and neglect, family dysfunction, and increased healthcare utilization. Recent studies have shown that health care expenditures are 90% higher for mother and infant care among women with PPD than for postpartum women without PPD. Mothers may be less likely to implement injury-prevention anticipatory guidance (e.g., car safety seats and supine sleeping), have higher emergency room utilization, and experience greater challenges in the management of chronic health concerns.

Maternal depression has a negative impact on the cognitive, social, and behavioral development of children. Infants as young as 3 months of mothers with PPD are more likely to show impaired social interaction, insecure attachment patterns, and developmental delays. When children screen in a concerning range on a social-emotional screening tool, the provider should consider PPD in the differential. In school, with children of mothers with PPD can exhibit school dysfunction, including poor self-control, difficulty with peer relationships, increased aggression, and academic challenges.

Up to 60 percent of women with PPD have obsessive thoughts of aggression toward the infant. These thoughts are usually intrusive (similar to those in obsessive-compulsive disorder) and do not represent a desire to hurt the infant. The shame and guilt associated with these intrusive images or thoughts can lead to avoidance of the infant and reduce the likelihood of mothers divulging this symptom to a healthcare provider. Providers should ask the mother specifically about thoughts of harming the infant as part of the diagnosis of PPD.

3. What is the role of pediatric providers in assessing women for PPD? What tools are available to help identify mothers affected by PPD?

Pediatric health care providers are well-positioned to screen mothers for PPD. Women often will not see their obstetric provider until the 4- to 6-week postpartum visit and then not again for another year.
However, they see the infant’s provider many times throughout the first postpartum year. Screening for PPD is performed for the benefit of the infant because the well-being of the infant is inextricably linked to the mother’s social and mental well-being. Providers can also collaborate with obstetric antenatal care providers to assess for maternal risk factors, which can be done prenatally.

One way to start is by asking open-ended questions about how the mother is doing in general. Even questions as simple as “How are you doing with the new baby?” or “How are you coping with the stress of having a new baby?” may be effective. However, informal screening for maternal depression is inadequate as almost 50% of women who have clinically significant symptoms of PPD remain undetected by physicians using history alone. Universal screening at well-child visits with validated instruments like the Edinburgh Postnatal Depression Scale (EPDS) is key to identifying depressive symptoms and need for referral. In a 2016 statement on depression screening, the U.S. Preventive Services Task Force specifically recommends that pregnant and postpartum women be screened (grade B recommendation), a stance also supported by the American Academy of Family Physicians (AAFP) and the Centers for Medicare and Medicaid (CMMS) 2016 statement. The American Academy of Pediatrics (AAP) recognizes the EPDS as the preferred screening instrument, and recommends screening mothers for PPD at least 4 times in the postpartum period, targeting the 1-, 2-, 4-, and 6-month well-infant visits, coinciding with the peak times for PPD. Some experts recommend screening additionally at the 12-month visit. While many screening instruments for depression in adults exist, none have as strong evidence for detecting PPD as the EPDS. The AAP recommends that pediatricians should consider screening the partner as well at the 6-month visit with the EPDS. PPD screening with the EPDS has been validated for both men and women. Unless the parent has limited literacy skills, she or he should complete the EPDS without assistance. There are multiple non-English language versions available, and a trained medical interpreter is preferred over a family member if an interpreter is required.

The EPDS consists of 10 short statements with four possible responses. The patient circles the response closest to how she has been feeling in the previous seven days. While the creators of the scale recommend a score of ≥12 as an indicator of possible depression, the AAP recommends that a score of ≥10 be used to indicate risk for depression is present. An affirmative response on question 10 (suicidality indicator) also constitutes a positive screen result. If suicidality, psychosis, or severe depression is a concern, it is necessary to access emergency mental health services. The moderator should review a sample copy of the EPDS with learners (see Resources).

In the 2013 survey of AAP members, less than half of pediatric providers reported screening post-partum mothers for depression. Barriers to implementation of screening mothers for PPD in the ambulatory setting include perceived lack of time, incomplete training to diagnose or counsel, inadequate referral sources for mental health, fear that screening means ownership of the problem, and poor or no reimbursement. Pediatric providers can help overcome these barriers by advocating for improved access to these services in their communities, reimbursement for use of validated screen tool in pediatric practice, and by educating funders (e.g., legislators charged with managing state Medicaid dollars and commercial payers) about the importance of screening for PPD. Current Procedural Terminology (CPT) code 96161 (Administration of caregiver-focused health risk assessment instrument) can be used.

**CASE continued:**

You review Dee’s completed EPDS, which your front desk staff appropriately provided on check-in. Her total score is 13, with 0 points for question 10. She asks, “Doc, it looks like I’m depressed. What can I do about this?”

4. **How would you respond to her positive screen?**

Currently, there are no national guidelines specific to the treatment of PPD, and treatment should be tailored to the individual patient based on symptom severity, treatment history, and breastfeeding status. Appropriate response to positive screens depends on the level of severity; suicidality, maternal concern for infant safety, or the provider’s suspicion for severe depression, suicidality, homicidality, psychosis, or mania is an indication for emergent referral.

It is important to note that a positive screen does not require the pediatric provider to treat a mother - the infant is the primary patient. However, acting within the best interest of the patient, pediatric
providers should support mothers who screen positive by helping them to access services that foster optimal growth and development of the child and family unit.

The pediatric provider’s role is to:

- Provide information about PPD and emphasize that PPD is common and treatable;
- Educate the parents on non-clinical strategies to manage PPD (e.g., rest, exercise, and family and social support);
- Refer the affected parent for resources, such as a personal primary care or obstetric provider, a psychiatrist or social worker, and local community organizations that educate and support parents, or a list of web sites of organizations that provide PPD education and networking services.

Social support for the affected parent should include communication with the other parent and family members, as appropriate and consistent with patient confidentiality. It should be emphasized that if, at any time, there is concern for suicidality or psychosis, or other acute risk to mother or child, emergency mental health services should be activated. In the interest of providing family-centered care, it may be appropriate to shift the focus of the visit to the mother’s PPD evaluation (e.g., assessing severity, counseling her about the importance of referral/treatment). In some cases, this might mean de prioritizing and rescheduling certain aspects of the well-child visit (assuming the infant has no urgent medical needs). The provider should attempt also to focus on promoting the strength of the mother-infant relationship (e.g., by reading and responding to infant cues, promoting routines, and setting realistic expectations). One need not go into a mother’s chart since the care is being provided in the context of caring for the infant.

In addition to follow-up at subsequent well-visits, pediatric providers should consider implementing office processes to track and follow-up parents who screen positive for PPD in their office, including assigning a staff member to communicate with the parent’s primary care or obstetric provider (or making the phone call oneself), follow-up telephone calls by an office social worker, or referral to community agency, such as a visiting home nurse or community health worker.

The affected parent may also be a patient in the same practice. Practice settings that provide care for patients across the age spectrum (e.g., multi-specialty medical group, family medicine, medicine-pediatrics) may be uniquely situated to provide timely follow up on medical needs of children's parents.

Finally, there is a growing literature on the value of co-locating mental and physical health services; maternal mental health may be one targeted diagnosis to include as pediatric offices consider this option.

CASE continued:

Two months later, you see Carankay and his mother for his 4-month routine visit. She seems much brighter and happier than at the previous visit. She reports that the weekly follow-up phone calls from your office social worker encouraged her to see her obstetrician about her postpartum depression. She is currently attending biweekly counseling sessions with a therapist and has been started on sertraline by her obstetrician. During the visit, she asks you, “Doc, is it safe to take my antidepressant while breastfeeding my son?”

5. How would you respond to her question?

Pediatric providers should be familiar with the various antidepressants used by breastfeeding mothers. LactMed is an online, peer-reviewed resource maintained by the U.S. National Institutes of Health which provides information on the safety of medications in mothers who breastfeed, also available as a mobile app (see Resources). Hale’s Medications and Mother’s Milk is another helpful reference manual.

For women with moderate to severe postpartum depression, selective serotonin reuptake inhibitors (SSRIs) have become the mainstay of treatment because of their favorable adverse effect profiles and relative safety in overdose compared with tricyclic antidepressants. There is minimal passage of sertraline into breastmilk, making it a good first line option. Detectable levels of fluoxetine and citalopram have been found in infant serum, but the milk-to-plasma ratio is well below the standard acceptable ratio of 0.1, making these SSRIs good options as well. Moderators can have learners look up
these or other anti-depressants in the LactMed database or similar reliable resources for information on medication safety in breastfeeding. Formula feeding should be considered in women with severe postpartum depression who require medication known to cause adverse effects in breastfed infants.

References:

Resources:
2. National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
3. Postpartum Resource Center of New York: www.postpartumny.org
4. Shades of Light: http://shadesoflightfps.org/

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