EDITORIAL

Screening and counseling interventions to prevent peripartum depression: A practical approach

After successful implementation of screening for perinatal depression, the USPSTF is recommending a new approach: screen for women at high risk for peripartum depression and recommend that screen-positive women receive preventive counseling

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Perinatal depression is an episode of major or minor depression that occurs during pregnancy or in the 12 months after birth; it affects about 10% of new mothers.[1] Perinatal depression adversely impacts mothers, children, and their families. Pregnant women with depression are at increased risk for preterm birth and low birth weight.[2] Infants of mothers with postpartum depression have reduced bonding, lower rates of breastfeeding, delayed cognitive and social development, and an increased risk of future mental health issues.[3] Timely treatment of perinatal depression can improve health outcomes for the woman, her children, and their family.

Clinicians follow current screening recommendations

The American College of Obstetricians and Gynecologists (ACOG) currently recommends that ObGyns screen all pregnant women for depression and anxiety symptoms at least once during the perinatal period.[1] Many practices use the Edinburgh Postnatal Depression Scale (EPDS) during pregnancy and postpartum. Women who screen positive are referred to mental health clinicians or have treatment initiated by their primary obstetrician.

Clinicians have been **phenomenally successful** in screening for perinatal depression. In a recent study from Kaiser Permanente Northern California, 98% of pregnant women were screened for perinatal depression, and a diagnosis of depression was made in 12%.[4] Of note, only 47% of women who screened positive for depression initiated treatment, although 82% of women with the most severe symptoms initiated treatment. These data demonstrate that ObGyns consistently screen pregnant women for depression but, due to patient and system issues, treatment of all screen-positive women remains a yet unattained goal.[5,6]

New USPSTF guideline: Identify women at risk for perinatal depression and refer for counseling

In 2016 the United States Preventive Services Task Force (USPSTF) recommended that pregnant and postpartum women be screened for depression with adequate systems in place to ensure diagnosis, effective treatment, and follow-up.[7] The 2016 USPSTF recommendation was consistent with prior guidelines from both the American Academy of Pediatrics in 2010[8] and ACOG in 2015.[9]

Now, the USPSTF is making a bold new recommendation, jumping ahead of professional societies: screen pregnant women to identify those at risk for perinatal depression and refer them for counseling (B recommendation; net benefit is moderate).[10,11] The USPSTF recommendation is based on growing literature that shows counseling women at risk for perinatal depression reduces the risk of having an episode of major depression by 40%.[11] Both

interpersonal psychotherapy and cognitive behavioral therapy have been reported to be effective for preventing perinatal depression.[12,13]

As an example of the relevant literature, in one trial performed in Rhode Island, women who were 20 to 35 weeks pregnant with a high score (≥27) on the Cooper Survey Questionnaire and on public assistance were randomized to counseling or usual care. The counseling intervention involved 4 small group (2 to 5 women) sessions of 90 minutes and one individual session of 50 minutes.[14] The treatment focused on managing the transition to motherhood, developing a support system, improving communication skills to manage conflict, goal setting, and identifying psychosocial supports for new mothers. At 6 months after birth, a depressive episode had occurred in 31% of the control women and 16% of the women who had experienced the intervention (P = .041). At 12 months after birth, a depressive episode had occurred in 40% of control women and 26% of women in the intervention group (P = .052).

Of note, most cases of postpartum depression were diagnosed more than 3 months after birth, a time when new mothers generally no longer are receiving regular postpartum care by an obstetrician. The timing of the diagnosis of perinatal depression indicates that an effective handoff between the obstetrician and primary care and/or mental health clinicians is of great importance. The investigators concluded that pregnant women at very high risk for perinatal depression who receive interpersonal therapy have a lower rate of a postpartum depressive episode than women receiving usual care.[14]

Pregnancy, delivery, and the first year following birth are stressful for many women and their families. Women who are young, poor, and with minimal social supports are at especially high risk for developing perinatal depression. However, it will be challenging for obstetric practices to rapidly implement the new USPSTF recommendations because there is no professional consensus on how to screen women to identify those at high risk for perinatal depression, and mental health resources to care for the screen-positive women are not sufficient.

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Challenges to implementing new USPSTF guideline

CHALLENGE 1: There is no widely accepted approach for identifying women at risk for perinatal depression. The USPSTF acknowledges "there is no accurate screening tool for identifying who is at risk of perinatal depression and who might benefit from preventive interventions."[10]

Obstetricians have had great success in screening for perinatal depression because validated screening tools are available. Professional societies need to reach a consensus on recommending a specific screening tool for perinatal depression risk that can be used in all obstetric practices.

CHALLENGE 2: The USPSTF guideline identifies many risk factors for perinatal depression. The USPSTF concluded that pregnant women with one (or more) of the following risk factors are at high risk for perinatal depression and recommended that they be offered a counseling intervention:

- personal history of depression
- current depressive symptoms that do not reach a diagnostic threshold
- low income
- all adolescents
- all single mothers
- recent exposure to intimate partner violence
- elevated anxiety symptoms
- a history of significant negative life events.

For many obstetricians, most of their pregnant patients meet the USPSTF criteria for being at high risk for perinatal depression and, per the guideline, these women should have a counseling intervention.

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CHALLENGE 3: The counseling intervention recommended by the USPSTF may not be available to all women at risk for perinatal depression. The USPSTF literature review, including a meta-analysis of 49 randomized clinical trials, concluded that for women at risk for perinatal depression, a counseling intervention reduces the risk of depression. In the published literature, many counseling interventions to reduce the risk of perinatal depression involve 6 to 12 hours of contact time over 4 to 8 episodes.

For many health systems, the resources available to provide mental health services are very limited. If most pregnant women need a counseling intervention, the health system must evolve to meet this need. In addition, risk factors for perinatal depression are also risk factors for having difficulty in participating in mental health interventions due to limitations, such as lack of transportation, social support, and money.[4]

Fortunately, clinicians from many backgrounds, including psychologists, social workers, nurse practitioners, and public health workers have the experience and/or training to provide the counseling interventions that have been shown to reduce the risk of perinatal depression. Health systems will need to tap all these resources to accommodate the large numbers of pregnant women who will be referred for counseling interventions. Pilot projects using electronic interventions, including telephone counseling, smartphone apps, and internet programs show promise.[15,16] Electronic interventions have the potential to reach many pregnant women without over-taxing limited mental health resources.

A practical approach

Identify women at the greatest risk for perinatal depression and focus counseling interventions on this group. In my opinion, implementation of the USPSTF recommendation will take time. A practical approach would be to implement them in a staged sequence, focusing first on the women at highest risk, later extending the program to women at lesser risk. The two factors that confer the greatest risk of perinatal depression are a personal history of depression and high depression symptoms that do not meet criteria for depression.[17] Many women with depression who take antidepressants discontinue their medications during pregnancy. These women are at very high risk for perinatal depression and deserve extra attention.[18]

To identify women with a prior personal history of depression, it may be helpful to ask open-ended questions about a past diagnosis of depression or a mood disorder or use of antidepressant medications. To identify women with the greatest depression symptoms, utilize a lower cut-off for screening positive in the Edinburgh questionnaire. Practices that use an EPDS screen-positive score of 13 or greater could reduce the cut-off to 10 or 11, which would increase the number of

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women referred for evaluation and treatment.[19]

Clinical judgment and screening

Screening for prevalent depression and screening for women at increased risk for perinatal depression is challenging. ACOG highlights two important clinical issues[1]:

"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."

When screening for perinatal depression, 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."

In addition, women who screen-positive for prevalent depression and are subsequently evaluated by a mental health specialist may be identified as having mental health problems such as an anxiety disorder, substance misuse, or borderline personality disorder.[20]

Policy changes that support pregnant women and mothers could help to reduce the stress of pregnancy, birth, and childrearing, thereby reducing the risk of perinatal depression. The United States stands alone among rich nations in not providing paid parental leave. Paid maternity and parental leave would help many families respond more effectively to the initial stresses of parenthood.[21] For women and families living in poverty, improved social support, including secure housing, protection from abusive partners, transportation resources, and access to healthy foods likely will reduce both stress and the risk of depression.

The ultimate goal: A healthy pregnancy

Clinicians have been phenomenally successful in screening for perinatal depression. The new USPSTF recommendation adds the prevention of perinatal depression to the goals of a healthy pregnancy. This recommendation builds upon the foundation of screening for acute illness (depression), pivoting to the public health perspective of disease prevention. ●

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