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Screening for perinatal depression

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Perinatal depression is prevalent, under-diagnosed and can have serious long-term effects on the wellbeing of women, their partners and infants. In the absence of active identification strategies, most women with perinatal depression will neither seek nor receive help. To enable early detection and timely intervention, universal screening is coming to be seen as best practice in many settings. Although the strength of recommendations and the preferred methods of identification vary in different countries (e.g. the Edinburgh Postnatal Depression Scale, brief case-finding questions), appropriate training for health professionals in wider psychosocial assessment is essential to maximise usefulness while minimising potential harms. Clear pathways of systematic follow up of all positive screening results with a diagnostic procedure and access to effective treatment are centrally important both for the clinical effectiveness of screening and for health system costs. It is also necessary to further build on the emerging evidence base for the clinical effectiveness of screening.

Perinatal depression

Perinatal depression can be defined pragmatically [1] as an episode of major or minor depression with an onset either during pregnancy or during the first 12 months postpartum (commonly called antenatal depression and postnatal depression respectively). By contrast, the DSM-IV listed a 'specifier'

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for postnatal (postpartum) depression as having an onset within 4 weeks of childbirth [2]. Although the DSM-5 now includes an updated specifier for depression with 'peripartum onset', which includes pregnancy [3], these definitions remain problematic given that during the very early postpartum period, around 85% of women experience the transitory 'postnatal blues' (or 'baby blues') [4]. As a result, the DSM specifiers are somewhat at odds with the pragmatic definitions most commonly applied in practice by working clinicians and researchers.

Rationale for perinatal depression screening

If a health condition is serious, prevalent, under-detected and treatable, and if a tolerable screening procedure of known accuracy is available, then screening can be an effective measure in principle [5]. Ultimately, a worthwhile screening process must result in a clinical benefit for those screened (a reduction in morbidity associated with the condition).

In the case of depression during pregnancy or the postpartum (perinatal depression) many of these prerequisites for undertaking screening are met.

Perinatal depression is serious and has lasting consequences. The effect on the woman herself is profound. Depression in pregnancy is linked to poor maternal self-care, inadequate nutrition [6], premature labour and adverse obstetric outcomes [7–9]. In the postpartum, at a time when many women expect a positive parenting experience, the symptoms of depression such as low mood, loss of interest, fatigue and feelings of worthlessness can be devastating. Suicidal thoughts may occur along with feelings of failure as a mother. Partners of depressed women are also vulnerable to mental health difficulties in the perinatal period [10,11]. A unique feature of perinatal depression is the additional effect of maternal illness on infant wellbeing. Several longitudinal studies have confirmed that maternal depression in the postpartum period has detrimental effects on development beginning in infancy and lasting at least into adolescence [12–17]. Evidence also shows that maternal emotional distress in pregnancy affects the fetus *in utero*, linked to lasting problems in child cognitive and behavioural domains [18].

Perinatal depression is highly prevalent, with point prevalence estimates commonly exceeding 10% in most high-income countries [19–23]. The best available meta-estimates suggest a point prevalence of 13% at 3 months postpartum [24]. In the antenatal period, at each of the three trimesters of pregnancy, about 9% of women suffer major or minor depression [24].

Adequate screening tools exist, and their properties and limitations are well established. Among the many tools and strategies for identification, a rapid, inexpensive screening tool for perinatal women, the Edinburgh Postnatal Depression Scale (EPDS), is the most widely applied [25]. Its accuracy and psychometric properties are the most established of any depression screening tool in a range of perinatal populations.

Depression can be successfully treated [26,27]. For depression in general, good-quality evidence shows that both antidepressants and psychological treatments are effective [28]. There is also limited support for combination therapy [29,30]. Depression in the postpartum can be treated successfully with psychological therapies (cognitive behavioural therapy or interpersonal psychotherapy) [26,31,32], which most, but not all women, prefer to medication during pregnancy and lactation for reasons such as potential side-effects on infants [33–35].

Non-detection by health professionals in the absence of an active identification strategy appears common [36,37]. Furthermore, although perinatal depression can be treated successfully, it is unlikely that most depressed perinatal women will actively seek treatment [38]. Seeking or accepting help for emotional distress in the perinatal period may prove difficult for women for a number of reasons [33]. These can include perceptions of stigma and self-stigma; lack of knowledge about depression; unrealistic beliefs about coping with motherhood; feelings of failure; and fears around contact with mental health services. Such barriers are easily compounded by the symptoms of depression themselves, such as low energy, and this can result in women feeling de-motivated about accessing help [39]. As a result, most affected women do not actively seek assistance [38]. Non-identification may result in prolongation or worsening of depression and make women vulnerable to parenting difficulties [15].

Screening seems to be acceptable to most perinatal women, both depressed and non-depressed (although most research is confined to the acceptability of the EPDS [40]), and most perinatal