Panel Calls for Depression Screenings During and After Pregnancy

By Pam Belluck

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Women should be screened for depression during pregnancy and after giving birth, an influential government-appointed health panel said Tuesday, the first time it has recommended screening for maternal mental illness.

The recommendation, expected to galvanize many more health providers to provide screening, comes in the wake of new evidence that maternal mental illness is more common than previously thought; that many cases of what has been called postpartum depression actually start during pregnancy; and that left untreated, these mood disorders can be detrimental to the well-being of children.

It also follows growing efforts by states, medical organizations and health advocates to help women having these symptoms — an estimated one in seven postpartum mothers, some experts say.

“There’s better evidence for identifying and treating women with depression” during and after pregnancy, said Dr. Michael Pignone, a professor of medicine at the University of North Carolina at Chapel Hill and an author of the recommendation, which was issued by the United States Preventive Services Task Force. As a result, he said, “we specifically called out the need for screening during this period.”

The recommendation was part of updated depression screening guidelines issued by the panel, an independent group of experts appointed by the Department of Health and Human Services. In 2009, the group said adults should be screened if clinicians had the staff to provide support and treatment; the new guidelines recommend adult screening even without such staff members, saying mental health support is now more widely available. The 2009 guidelines did not mention depression during or after pregnancy.

“It’s very significant that the task force is now putting forth a recommendation that’s specific to pregnant and postpartum women,” said Katy Kozhimannil, an associate professor of public health at the University of Minnesota. “Policy makers will pay attention to it. Increased screening and detection of depression is an enormous public health need.”

The panel gave its recommendation, which was published in the journal JAMA, a “B” rating, which means depression screening must be covered under the Affordable Care Act.

For years, obstetricians and other health care providers who saw women during and after pregnancy often felt ill equipped or reluctant to ask about problems like depression, anxiety and obsessive-compulsive disorder.

“OB-GYNs thought that if they identify something and don’t have resources to support it, it puts them at significant legal risk,” said Dr. Samantha Meltzer-Brody, the director of the perinatal psychiatry program at the University of North Carolina at Chapel Hill. “Pediatricians have the added caveat that the mom isn’t really their patient — the child is.”

And, she said, many women are reluctant to share symptoms with doctors on their own. If a mother is “feeling so anxious you’re going to come out of your skin or feeling that you’re going to harm your baby, you may think: ‘Oh, my God, I’m having these crazy feelings and nobody’s talking about it. I must be a terrible mother.’ ”

No one screened Melissa Mead, 30, of The Dalles, Ore., during or after her first pregnancy, five years ago. Shortly after her son Brady’s birth, “I experienced postpartum depression, anxiety and O.C.D.,” she said, and “I didn’t know what it was.”

Ms. Mead cried continually, barely slept, rarely left home and was “scared to death that my baby was going to suffocate,” she said. At her job as an optician, she said, people asked, “‘Isn’t everything so wonderful?’ and I was like, ‘I kind of feel like dying on the inside,’ and you don’t want to say that because you’re afraid what people will think of you.”

After a year, she saw a psychiatrist for talk therapy. When her second son, Emmett, was born, and she had more symptoms, including fearing that she would stab herself with a kitchen knife, Ms. Mead tried several medications until one worked. She now volunteers for Postpartum Support International.

The panel’s recommendations do not specify which clinicians should screen or how often, and Dr. Pignone said that “anyone who has a caring relationship with the patient” should “sit down and say, ‘How do we want to do this in our practice?’ ” For screening methods, the group said the Edinburgh Postnatal Depression Scale, a 10-question survey, was effective.

The panel said evidence showed that cognitive behavioral therapy, a kind of talk therapy, was helpful to mothers. It said that the use of some antidepressants during pregnancy could cause “potential serious fetal harms,” but that “the likelihood of these serious harms is low.”

Dr. Pignone also emphasized that “untreated depression has a lot of adverse consequences itself.”

Among them, experts say, are that pregnant women with depression often take poorer care of their prenatal health. And maternal mental illness can affect children, leading to behavioral problems, emotional instability and difficulty in school.

Besides citing evidence that screening accompanied by even minimal counseling helped women with depression, the panel found that screening caused no harm.

“A decade ago, there was more concern that screening pregnant and postpartum women for mental health would do more harm than good,” said Wendy N. Davis, the executive director of Postpartum Support International. “Medical providers would say to me, ‘If I screen and she screens positively for depression and anxiety, I’m afraid that it will just make her feel more scared, or there’s more stigma to that label.’ ”

But, she said, “screening tools actually can give a language for both the providers and the patients to feel comfortable talking about it and prevent the stigma.”

The panel recommended that clinicians have the ability to give women a diagnosis and treatment, or to refer them elsewhere.

That is crucial, said Dr. Lee S. Cohen, the director of the Center for Women’s Mental Health at Massachusetts General Hospital. “I applaud identifying women who are ill,” he said, but “will she be appropriately referred, will she get treated whether it’s medication or therapy, and over time, does she actually ever get well?”

The only state that requires screening, New Jersey, has had mixed results because too few treatment options have been available. While pediatricians and obstetricians were trained to screen, they were not compensated for screening, a study by Dr. Kozhimannil found.

A dozen other states, including New York, have laws encouraging screening, education and treatment. And Mayor Bill de Blasio of New York recently announced a goal of universal screening of pregnant and postpartum women, saying it “should be a part of routine care.”

Routine screening could have benefited Jenna Zalk Berendzen, 40, of Cedar Falls, Iowa, even though during her first pregnancy, five years ago, she was studying to be a nurse practitioner and had medical knowledge. She also had a family history of postpartum depression but had assumed “it’s not going to happen to me,” she said.

A week after she delivered a son, Maxwell, depression “hit me very, very severely,” she said. She felt suicidal, and at one point, while her husband and baby were sleeping, “I had in front of me 15 bottles of different kinds of meds,” she said. “I would open the bottles up and I would close them, open them and close them. I didn’t want to die, I just thought, ‘It’s never going to get better.’ ”

Ms. Zalk Berendzen ultimately found effective treatment, and has since weaned herself to a low dose of medication. She had no symptoms with the 2014 birth of another son,

Samuel. She now works in gynecology at Unity Point Health in Waterloo, Iowa, where, she said, “within the last year, we’ve started to recognize we need to be screening every woman.”