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**The American College of Obstetricians and Gynecologists**
*Women's Health Care Physicians*

# COMMITTEE OPINION

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**Committee on Obstetric Practice**

*This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.*

# Screening for Depression During and After Pregnancy

**ABSTRACT:** Depression is very common during pregnancy and the postpartum period. At this time, there is insufficient evidence to support a firm recommendation for universal antepartum or postpartum screening. There are also insufficient data to recommend how often screening should be done. There are multiple depression screening tools available for use.

Clinical depression is common in reproductive-aged women (1). A recent retrospective cohort analysis in a large U.S. managed care organization found that one in seven women was treated for depression between the year prior to pregnancy and the year after pregnancy (2). According to the World Health Organization, depression is the leading cause of disability in women, which accounts for $30 billion to $50 billion in lost productivity and direct medical costs in the United States each year (3).

Screening for, diagnosing, and treating depression have the potential to benefit a woman and her family. Infants of depressed mothers display delayed psychologic, cognitive, neurologic, and motor development (3). Furthermore, children's mental and behavioral disorders improve when maternal depression is in remission (4). Women with current depression or a history of major depression warrant particularly close monitoring and evaluation. Pregnancy and the postpartum period represent an ideal time during which consistent contact with the health care delivery system will allow women at risk to be identified and treated.

There are multiple depression screening tools available for use. These tools usually can be completed in less than 10 minutes. Most have a specificity ranging from 77% to 100%. Thus, it can be argued that sensitivity should be the determining factor to maximize the number of depressed patients identified. Many of these screening tools have been validated with specific ethnic populations. Examples of highly sensitive screening tools include the Edinburgh Postnatal Depression Scale, Postpartum Depression Screening Scale, and Patient Health Questionnaire-9 (see Additional Resources) (5). Other appropriate screening tools are listed in Table 1.

## Conclusion

Depression is very common during pregnancy and the postpartum period. At this time there is insufficient evidence to support a firm recommendation for universal antepartum or postpartum screening. There are also insufficient data to recommend how often screening should be done. However, screening for depression has the potential to benefit a woman and her family and should be strongly considered. Women with a positive assessment require follow-up evaluation and treatment if indicated. Medical practices should have a referral process for identified cases. Women with current depression or a history of major depression warrant particularly close monitoring and evaluation.

## Coding

Many payers require that evaluation and management services linked to mental health diagnoses be performed only by a psychiatrist or psychologist. Such payers typically cross-check the diagnosis submitted against the health care provider's specialty. The appropriate diagnosis code will depend on the nature of the patient's depression. Postpartum depression is assigned to code 648.4X (X is an indication that a fifth digit is required). However, if a code from the mental health chapter of the International Classification of Diseases, Ninth Revision, Clinical Modification (codes 290–319) is submitted by a health care provider whose specialty does not match their criteria, the claim is often denied. Medical practices should check with all payers concerning coverage for mental health services before billing for these services.

**Table 1.** Depression Screening Tools

| Screening Tool | Number of Items | Time to Complete | Sensitivity/ specificity | Spanish Available |
|---|---|---|---|---|
| Edinburgh Postnatal Depression Scale (EPDS) | 10 | Less than 5 min | Sensitivity: 59–100%<br>Specificity: 49–100% | Yes |
| Postpartum Depression Screening Scale (PDSS) | 35 | 5–10 min | Sensitivity: 91–94%<br>Specificity: 72–98% | Yes |
| Patient Health Questionnaire-9 (PHQ-9) | 9 | Less than 5 min | Sensitivity: 75%<br>Specificity: 90% | Yes |
| Beck Depression Inventory (BDI) | 21 | 5–10 min | Sensitivity: 47.6–82%<br>Specificity: 85.9–89% | Yes |
| Beck Depression Inventory-II (BDI-II) | 21 | 5–10 min | Sensitivity: 56–57%<br>Specificity: 97–100% | Yes |
| Center for Epidemiologic Studies Depression Scale (CES-D) | 20 | 5–10 min | Sensitivity: 60%<br>Specificity: 92% | Yes |
| Zung Self-Rating Depression Scale (Zung SDS) | 20 | 5–10 min | Sensitivity: 45–89%<br>Specificity: 77–88% | No |

Data from Boyd RC, Le HN, Somberg R. Review of screening instruments for postpartum depression. Arch Womens Ment Health 2005;8:141–53; Sharp LK, Lipsky MS. Screening for depression across the lifespan: a review of measures for use in primary care settings. Am Fam Physician 2002;66:1001–8; *and* Spitzer RL, Kroenke K, Williams JB. Validation and utility of a self-report version of PRIME-MD: the PHQ primary care study. Primary Care Evaluation of Mental Disorders. Patient Health Questionnaire. JAMA 1999;282:1737–44.

## References


1. Gavin NI, Gaynes BN, Lohr KN, Meltzer-Brody S, Gartlehner G, Swinson T. Perinatal depression: a systematic review of prevalence and incidence. Obstet Gynecol 2005; 106:1071–83.
2. Dietz PM, Williams SB, Callaghan WM, Bachman DJ, Whitlock EP, Hornbrook MC. Clinically identified maternal depression before, during, and after pregnancies ending in live births. Am J Psychiatry 2007;164:1515–20.
3. Gjerdingen DK, Yawn BP. Postpartum depression screening: importance, methods, barriers, and recommendations for practice. J Am Board Fam Med 2007;20:280–8.
4. Weissman MM, Pilowsky DJ, Wickramaratne PJ, Talati A, Wisniewski SR, Fava M, et al. Remissions in maternal depression and child psychopathology: a STAR*D-child report. STAR*D-Child Team [published erratum appears in JAMA 2006;296:1234]. JAMA 2006;295:1389–98.
5. Gaynes BN, Gavin N, Meltzer-Brody S, Lohr KN, Swinson T, Gartlehner G, et al. Perinatal depression: prevalence, screening accuracy, and screening outcomes. Evid Rep Technol Assess 2005;119:1–8.


## Additional Resources

Perinatal Depression Information Network (PDIN)
www.pdinfonetwork.org

Perinatal Depression Information Network (PDIN) is a nationally recognized web-based platform of state-specific perinatal depression initiatives with resources for professionals as well as women and their families and friends.

### Publications


American College of Obstetricians and Gynecologists, District II/NY. Perinatal depression screening: tools for obstetrician–gynecologists. Albany (NY): ACOG; 2008. Available at: http://mail.ny.acog.org/website/ Depression ToolKit.pdf. Retrieved October 14, 2009.

Dell DL. Depression in women. Clin Update Womens Health Care 2002;I:1–82.

University of California. San Francisco, Fresno, School of Medicine. Edinburgh Postnatal Depression Scale (EPDS). Available at: http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf. Retrieved October 14, 2009.

Beck CT, Gable RK. Postpartum depression screening scale (PDSS). Los Angeles (CA): Western Psychological Services; 2002.

MacArthur Initiative on Depression and Primary Care. Patient health questionnaire (PHQ-9). Available at: http://depression-primarycare.org/clinicians/toolkits/materials/forms/phq9. Retrieved October 14, 2009.

Yonkers KA, Wisner KL, Stewart DE, Oberlander TF, Dell DL, Stotland N, et al. The management of depression during pregnancy: a report from the American Psychiatric Association and the American College of Obstetricians and Gynecologists. Obstet Gynecol 2009; 114:703–13.



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