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Making a Difference: Pediatricians and Maternal Peripartum Depression

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In a recently released issue of *Pediatrics*, both an AAP Policy Statement and an AAP Technical Report address "Incorporating Recognition and Management of Perinatal Depression into Pediatric Practice."

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In a recently released issue of *Pediatrics*, both an AAP Policy Statement (10.1542/peds.2018-3259)and an AAP Technical Report (10.1542/peds.2018-3260) address "Incorporating Recognition and Management of Perinatal Depression into Pediatric Practice." Both documents are comprehensive and summarize key information for pediatricians about perinatal depression. The term "perinatal depression" is now preferred to "postpartum depression" due to the likely onset of depression during pregnancy and prior to delivery. Did you realize that perinatal depression is both the most prevalent (15-20% prevalence) and the most underdiagnosed and undertreated obstetrical complication? It is estimated that 50% of women who are perinatally depressed are neither diagnosed nor treated, yet we know that maternal depression has profound negative impacts on the short term and long term health of mothers and children, and on the entire family unit. Increasing evidence reveals that fathers, too, experience perinatal depression, and that the father's affect also directly impacts the child's mental health and wellbeing.[1] These long and strong articles review multiple aspects of perinatal depression, including use of screening tools for identification of at-risk parents, referral and treatment plans and obligations, and the sequallae of lack of treatment.

Screening for perinatal depression has been advocated for nearly a decade, but only relatively recently have formal professional recommendations from the American Academy of Pediatrics, the American College of Obstetrics and Gynecology (ACOG) and the American Academy of Family Practitioners (AAFP) endorsed screening.[2-5] The Fourth Edition of Bright Futures (2017) recommends that pediatricians screen for maternal perinatal depression at 4 well care visits in the first 6 months of life, and the American College of Obstetrics and Gynecology (ACOG, 2015) now recommends routine antenatal screening for depression.[3,5] Billing is also finally aligned with practice and patient care needs since the Center for Medicaid and Medicare Services agreed that pediatricians can bill for depression screening of the child's caregiver in 2016. The approved CPT code is 96161. It is a huge relief for providers when time well spent is specifically reimbursed.

It is a fascinating paradox to me as a provider that screening requires adherence to the very specific words and phrasing of the screening tool, yet also demands that each of us be flexible and attentive for signs and symptoms of potential depression in individual parents. A mother may provide stoic denials to specific screening questions on validated tools, yet at the same visit may respond with clear endorsement of depressive symptoms to indirect queries, such as, “Did you have depression with your other kids?” or “Have you slept or eaten at all since the baby came home?” or “Do you think you might have depression?” Mothers may be willing to endorse fatigue, anxiety and feelings of being overwhelmed without realizing these may be depressive symptoms. So screen each mother, and father too, for perinatal depression with approved and recommended tools, but at the same time make sure your clinical antennae are always tuned, so that you miss as few depressed parents as clinically possible. This one’s on us.

References

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- Father-Inclusive Perinatal Parent Education Programs: A Systematic Review
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