



A clinically informative screening for perinatal depression: bringing psychopathology and positive mental health together

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Abstract

Universal screening for perinatal depression (PND) has been widely debated, and several trustworthy guidelines have been published worldwide on how to effectively conduct it. Nevertheless, a narrow view of perinatal mental health and the strict adherence to condition-specific assessment protocols limit the clinical utility of such screenings. In this paper, traditional approaches to screening for PND are revisited to simultaneously consider two main and highly correlated psychopathological dimensions (i.e., anxiety and depression), as well as the complementary aspects of flourishing mental health. For that purpose, straightforward methodological guidelines are discussed on the grounds of current empirical research to maximize the cost-effectiveness of clinically informative PND screenings.

Keywords: Perinatal depression, perinatal mental health, screening, psychopathology, positive mental health, flourishing.

Perinatal depression (PND) is a prevalent, under-detected and treatable clinical condition.^[1] The consequences of this depressive disorder are serious and affect the woman herself, her family relationships, and the fetus and/or the developing infant.^[2–4] Screening for PND is likely to have the greatest benefits in the context of a broader psychosocial risk assessment with consideration of common comorbidities (e.g., anxiety disorders), and clear pathways to diagnostic procedures and effective treatment.^[5] However, a strict focus on screening for psychopathological symptoms may only provide an incomplete picture of perinatal women's mental health. The recovery approach emphasizes the distinction between clinical recovery and personal recovery.^[6] Given the fact that the absence of mental illness does not equate to complete mental health,^[7,8]

particularly in postpartum women,^[9] an accurate psychosocial risk assessment followed by a tolerable screening for psychopathology and flourishing mental health would optimally inform tailored referrals to comprehensive clinical interventions promoting perinatal mental health.

Perinatal Depression Screening Put Into Practice

The American College of Obstetricians and Gynecologists (ACOG) recommends that obstetric clinicians screen all women for depression and anxiety symptoms, at least once during the perinatal period, using a reliable and valid tool.^[10] In fact, there are good reasons for advocating universal screening for PND: first, in the absence of an established strategy for case identification, non-detec-

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tion of PND by healthcare professionals is rather common;^[11] second, perceptions of stigma related to mental health issues preclude most depressed perinatal women from seeking help for their emotional distress;^[12] and third, non-identification of PND may result in the maintenance or worsening of the depressive disorder, thus perpetuating its pervasive detrimental effects.^[5] However, the need for universal PND screening is debatable, with some authors arguing that such procedure would eventually lead to increased rates of costly false-positive referrals or even to mismatched treatment for some women inaccurately identified as depressed.^[13] In order to minimize those potential risks and maximize the clinical effectiveness of screening, some influential position statements published worldwide do recommend the conduction of a psychosocial risk assessment, followed by a depression (and sometimes anxiety) symptom screening in the perinatal period.^[14–16]

Psychosocial risk assessment is aimed at providing a multidimensional picture of the woman's broad developmental context, and does not set out to identify women with a possible diagnosis of some clinical condition. Specifically, this psychosocial assessment should encompass the evaluation of well-documented risk factors impacting on the perinatal women's mental health – such as poor partner relationship, lack of social support, history of abuse/domestic violence, personal history of mental illness, unplanned/unwanted pregnancy, adverse life events, and present/past pregnancy complications^[17] – and may be undertaken as a component of clinical interview or using a structured tool,^[15] such as the renowned “Postpartum Depression Predictors Inventory-Revised” [PDPI-R].^[18–20] It bears noting that some women identified through such assessment as being at “high-risk for PND” may nevertheless experience different levels (good, moderate or impaired) of mental health in terms of depression/anxiety symptoms and flourishing,^[21] which constitutes an additional argument for universal screening.

There are essentially four broad methods to facilitate the detection of PND: specialized depression screening questionnaires (e.g., Edinburgh Postnatal Depression Scale [EPDS]),^[22] generic depression questionnaires (e.g., Beck Depression Inventory [BDI]),^[23,24] antenatal psychosocial assessment to identify those women at increased risk for developing depression (e.g., administering the PDPI-R); and training of healthcare professionals to improve recognition of clinical symptoms.

Additionally, the following brief case-finding questions have also been recommended to identify depression in perinatal women: (1) “During the past month, have you often been bothered by feeling down, depressed or hopeless?”; (2) “During the past month, have you often been bothered by little interest or pleasure in doing things?”; and (3) “Is this something you feel you need or want help with?”^[16,25]

Notwithstanding, the relative clinical utility of all the aforementioned detection procedures, the EPDS stands as the most widely applied screening tool for PND.^[22] The EPDS presents a number of advantages over other methods or questionnaires used in screening for PND: first, it is a brief, inexpensive, and easy to administer tool; second, scoring is simple and the interpretation of results is immediate, since a general cut-off point is well-established at 13 points or over (specifically: 12 for major depression, and 10 for major/minor depression combined);^[26] third, the instrument deliberately excludes some depressive somatic symptoms (e.g., disturbances in appetite and sleeping patterns) that commonly occur in perinatal women without mental disorders; fourth, it includes one item (item #10) addressing thoughts of self-harm and suicidal ideation, which may rapidly point to the specific issue of suicide prevention and the related severity of depression symptoms; fifth, its acceptability among women and healthcare professionals has been consistently demonstrated in several studies;^[27] and sixth, besides its ability to screen for depression, there is good evidence for the possibility of EPDS accurately detecting perinatal anxiety disorders in both the antenatal and postnatal periods.^[28]

Given the fact that anxiety and depression tend to correlate highly with each other,^[29] and particularly in perinatal women,^[5] it has been argued that screening for perinatal mental health should seek to identify both cluster of symptoms.^[17] Specifically, one of the features that distinguish PND from depression not related to childbirth is that the anxiety symptoms are more often present in PND.^[30] In fact, these two psychopathological dimensions share clinical similarities, such as increased negative affect and the experience of distress, but they also display distinct features, with depression (and not anxiety) being characterized by a substantial decrease or absence of positive affect.^[31]

As regards the identification of anxiety symptoms in the context of screening for PND, three main proce-

dures may be pondered, either jointly or independently. First, the following case-finding questions may be asked to perinatal women: (1) “During the past month, have you been feeling nervous, anxious or on edge?”; and (2) “During the past month, have you not been able to stop or control worrying?”^[16] Second, a general (e.g., the Generalized Anxiety Disorder scale [GAD-7];^[32]) or a specific (e.g., The Perinatal Anxiety Screening Scale [PASS];^[33]) measure of anxiety may be administered in combination with the selected instrument for depression screening. Third, anxiety and depression subscales of generic (e.g., Hospital Anxiety and Depression Scale [HADS]) or perinatal-specific (e.g., EPDS, items #3, #4 and #5) measures that may be scored in parallel can be used.^[28,34]

For women in the perinatal period, it is worth noting that the prevalence of both classes of disorders tends to increase under specific methodological conditions: when symptoms (not categorical disorders) are examined; when depression or anxiety is assessed through self-report rating scales; or when established criteria are not used for the diagnosis.^[35] Therefore, when selecting any of the aforementioned assessment procedures, clinicians should be mindful that a flexible, multi-method approach (rather than a “one size fits all” approach) is to be preferred. Finally, even if some world-renowned guidelines recommend screening for substance misuse^[16] and psychotic disorders,^[14] an all-inclusive screening protocol would certainly weaken its clinical practicality. Besides, substance abuse tends to co-occur with depressive and/or anxiety disorders, and the validity of screening for psychosis within general health settings remains to be ascertained.^[36]

Screening Beyond Perinatal Psychopathology: Why and How?

Depression and anxiety, along with life satisfaction and positive affect, are core dimensions of mental health.^[37] Accordingly, if psychological well-being and psychological distress are not necessarily orthogonal dimensions, it will be reductive to equate perinatal mental health screening to the identification of depression and anxiety symptoms. Bearing in mind that perinatal depression and anxiety disorders are the most prevalent psychological problems during pregnancy and the postpartum period,^[38] and broadening the scope of symptom screening in a feasible way provides a tangible opportunity to

improve the accuracy and clinical utility of perinatal mental health screenings. From the practitioner’s point of view, the principles for a clinically informative screening advocated herein, substantiate a comprehensive working model that endorses well-established guidelines for effective perinatal mental health care pathways. Taken altogether, such guidance model embodies a commitment to the provision of a perinatal mental health care that is needs-led, responsive and delivered in a way that empowers people, promotes recovery and resilience, and supports families and caregivers.^[39]

To counteract a widespread tendency to portray mental health as the absence of psychopathology, Keyes^[7,8] defined mental health as a syndrome encompassing positive feelings (i.e., presence of positive affect, absence of negative affect, and perceived satisfaction with life) and positive functioning in life (i.e., self-acceptance, positive relations with others, personal growth, purpose in life, environmental mastery, and autonomy).

Furthermore, instead of assuming mental health and psychopathology as opposite ends of a continuum, the dual-factor model of mental health conceptualizes well-being and distress as two distinct but interrelated constructs.^[40] In fact, research has shown that the alleviation of psychopathological symptoms does not automatically improve positive mental health, thus suggesting that both outcomes should be monitored in psychotherapeutic interventions.^[41] Even if changes in psychopathology are better predictors of future positive mental health than changes in positive mental health of future psychopathology, these effects are indeed bidirectional^[42] and underline the need for a unified clinical approach including both the traditional and positive clinical psychology.^[43] Moreover, factors related to positive mental health and the absence of psychopathology seem to be rather distinct in perinatal women: on the one hand, younger infant age, higher levels of maternal confidence, and resilience increase the likelihood of flourishing (i.e., spiraling upward); on the other hand, higher income, fewer problems with an infant’s sleep, perceiving an infant’s temperament as easy, and higher psychological flexibility increase the likelihood of not having depressive symptoms; overall, positive appraisals of social support and higher levels of self-compassion increase the likelihood of both outcomes.^[9]

In order to keep a screening protocol feasible, it is highly advisable to administer brief measures on positive

mental health, along with similarly brief screening instruments for depression and anxiety symptoms. Currently, two well-studied measures are recommended for that purpose: the “Flourishing Scale”,^[44] and the “Mental Health Continuum – Short Form” [MHC-SF].^[45] While both scales provide a general score of positive mental health, the former contains 8 items (e.g., “I lead a purposeful and meaningful life.”; “My social relationships are supportive and rewarding.”; “I am engaged and interested in my daily activities.”), and the latter includes 14 items (e.g., “During the past month, how often did you feel that you had warm and trusting relationships with others?”; “During the past month, how often did you feel that you had experiences that challenged you to grow and become a better person?”; “During the past month, how often did you feel that your life has a sense of direction or meaning to it?”). Notably, the MHC-SF has been recently shown to be a reliable and valid instrument to measure positive mental health in perinatal women.^[46]

Conclusions

Screening for PND may provide a unique opportunity to examine and promote women’s mental health with a life course lens, having pregnancies and developmental contexts in mind.^[47] In fact, screening for perinatal mental health is recommended when it is implemented as a well-resourced program with clearly defined pathways to clinical management, including appropriate diagnostic and therapeutic services. They imply adequate training for healthcare professionals in psychosocial assessment to maximize the usefulness and minimize potential harms of perinatal mental health screenings,^[5] especially given the fact that clinicians’ perceived interpersonal competence is decisive to ensure the acceptability of such procedure by perinatal women.^[27]

To ensure the practicality of assessment protocols, screening for PND should desirably include brief measures (using measures that are short achieve the goal of showing respect for women’s time, and are more likely to increase their compliance) to address anxiety as a most common comorbid condition, and flourishing as an indicator of hedonia and positive functioning. By this means, clinicians should be cognizant of the contributions of positive mental health assessment to improve case formulation and intervention planning. First, it enables the identification of suboptimal mental health,

which is a strong predictor of preeclampsia and premature all-cause mortality.^[48,49] Second, it facilitates shared understanding and shared decision-making as regards the clarification of women’s valued living directions when providing tailored care. Third, and perhaps most importantly, it broadens the focus of perinatal mental health care from exclusively dealing with “what is wrong and how to fix it”, to also attend to “what is right and how to cherish it”.

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