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Postpartum Depression: Clinical Screening, Diagnosis, Treatment and Follow-up

Weijing Wang[1,2], Kexin Liu[1,2], Yongkang Yang[1,2,*]

[1]The Second Clinical Medical College, Shaanxi University of Chinese Medicine, Xianyang 712046, Shaanxi, China
[2]The Second Affiliated Hospital of Shaanxi University of Chinese Medicine, Xianyang 712046, Shaanxi, China
Correspondence Author

Abstract: ***Postpartum depression (PPD) can impair maternal functioning, infant care, and family well-being. Effective management requires symptom screening followed by diagnostic evaluation, safety assessment, treatment, and follow-up. This narrative review summarizes clinical guidelines, systematic reviews, and major trials published through October 2026. The Edinburgh Postnatal Depression Scale and Patient Health Questionnaire-9 support screening and symptom monitoring but do not establish diagnosis. Cognitive behavioral therapy, interpersonal psychotherapy, and antidepressants remain established treatments. Oral zuranolone offers a short-course option for selected patients, subject to safety and infant-care planning. A randomized trial supports supervised telemedicine and task-shared psychotherapy. Coordinated obstetric and mental health follow-up supports continuity of care.***

Keywords: Postpartum depression, Screening, Diagnosis, Psychotherapy, Antidepressants, Zuranolone, Follow-up**.**

1. Introduction

Postpartum depression (PPD) occurs after childbirth and can impair maternal functioning and infant care [1]. It is distinct from transient postpartum blues. Although DSM-5-TR uses a four-week peripartum-onset specifier, clinical surveillance commonly extends through the first postpartum year [2]. The broader term perinatal depression includes episodes beginning during pregnancy.

ACOG recommends linking positive results to diagnostic assessment, treatment, and follow-up [2]. WHO recommends validated screening linked to diagnostic and management services [3]. Clinical care must also recognize bipolar disorder, suicidality, and postpartum psychosis.

This review addresses clinical presentation, screening, emergency assessment, treatment selection, breastfeeding, and follow-up.

2. Scope and Evidence Approach

This focused narrative review examines selected ACOG, WHO, and NICE recommendations, systematic reviews, diagnostic accuracy research, randomized trials, and drug-safety information available through October 9, 2026. Evidence is organized by clinical decision rather than synthesized quantitatively.

Clinical guidelines and evidence syntheses inform this review of screening, treatment, and risk factors [1,4,5].

3. Clinical Phenotype, Burden, and Risk Stratification

3.1 Clinical Presentation and Diagnostic Boundaries

PPD may involve persistent low mood, anhedonia, guilt, poor concentration, sleep or appetite changes, anxiety, and impaired functioning [1]. Symptom persistence and functional impairment help distinguish depression from common postpartum changes [2].

Postpartum blues typically resolves within two weeks. Major depression requires assessment of symptom duration, severity, impairment, and alternative explanations. A 2025 guideline reported a pooled postpartum depression prevalence of approximately 17.4%, with estimates differing across populations and assessment methods [1].

3.2 Factors that Should Modify Clinical Vigilance

History of depression is an important marker of clinical risk. An umbrella review of 77 meta-analyses found associations with previous depression (odds ratio [OR] 3.09), intimate partner violence (OR 2.50), sleep disorders (OR 2.36), and poor social support (risk ratio 3.57) [5]. The review rated most associations as having low or very low certainty.

Assessment should also cover antenatal symptoms, adverse reproductive experiences, neonatal illness, family stress, interpersonal safety, and access to support [2,6].

4. Screening, Diagnostic Confirmation, and Safety Assessment

4.1 When and Where to Screen

ACOG recommends depression and anxiety screening at the first prenatal visit, later in pregnancy, and during postpartum care [2]. WHO supports validated screening linked to diagnostic and management services [3], while NICE recommends continued clinical enquiry during the postnatal period [6]. Repeated contacts allow detection beyond the conventional postpartum visit.

Obstetric, primary care, and pediatric services can identify symptoms. A complete pathway specifies who reviews screening results, performs diagnostic assessment, responds to self-harm alerts, arranges treatment, and confirms follow-up [2,3].

4.2 Interpreting EPDS and PHQ-9

The Edinburgh Postnatal Depression Scale (EPDS) and Patient Health Questionnaire-9 (PHQ-9) are screening tools, not diagnostic interviews. In an individual-participant-data meta-analysis, EPDS ≥11 had sensitivity 0.81 and specificity 0.88; EPDS ≥13 increased specificity to 0.95 but reduced sensitivity to 0.66 [7]. Thresholds should be adapted to local validation and referral pathways.

A positive screen requires assessment of symptom onset, severity, functioning, psychiatric history, comorbidity, social support, and safety [2]. Persistent clinical concern warrants evaluation even with a negative score. For treated patients, repeated EPDS or PHQ-9 scores can complement functional assessment and document response [8].

4.3 Excluding Bipolar Illness and Identifying Emergencies

Before antidepressant treatment, assess past mania or hypomania and possible bipolar disorder [2]. Review thyroid dysfunction or anemia when clinically indicated, and distinguish unwanted intrusive thoughts with preserved insight from psychotic beliefs [6].

Any positive self-harm item warrants immediate assessment of suicidal intent, plan, means, and protective factors [2]. Psychosis, mania, severe confusion, or delusions involving the infant require urgent psychiatric evaluation; postpartum psychosis is an emergency that may require hospitalization [9].

Table 1: Core tools and escalation decisions in the clinical assessment of postpartum depressive symptoms

Clinical task	Recommended approach	Interpretation or action
Initial depression screen	EPDS or PHQ-9 [2,3]	Symptom detection; a positive result requires diagnostic interview.
Comorbid symptoms	Focused assessment of anxiety, trauma, sleep, substance use [6]	Evaluate competing or coexisting conditions.
Bipolar screening	Ask about mania/hypomania before antidepressant initiation [2]	Seek psychiatric input when bipolar disorder is suspected.
Immediate safety	Direct suicide/self-harm and psychosis assessment [2,9]	Emergency evaluation when acute risk or postpartum psychosis is present.
Treatment follow-up	Repeat the same symptom scale and evaluate functioning [8]	Track change, adverse effects, adherence, and remission.

5. Prevention and Early Intervention

The US Preventive Services Task Force recommends counseling interventions for pregnant and postpartum individuals at increased risk of perinatal depression, particularly cognitive behavioral and interpersonal approaches [10]. A 2025 guideline also supports preventive psychological interventions [1].

Prevention can include timely treatment of antenatal depression, relapse planning for women with prior severe episodes, psychological support, and assessment of sleep and interpersonal safety [1,5].

6. Treatment Selected by Severity and Patient Circumstances

6.1 Psychological Therapies

Cognitive behavioral therapy (CBT) and interpersonal psychotherapy (IPT) are established options for mild to moderate PPD. CBT targets negative thinking and behavioral avoidance; IPT addresses role transitions and interpersonal difficulties [1,6]. Treatment choice depends on severity, availability, and patient preference.

A 2026 network meta-analysis of 35 randomized trials identified benefits across psychological interventions, with IPT ranking highly for short-term depressive symptoms and online CBT for short-term anxiety [11].

6.2 Antidepressant Pharmacotherapy

For moderate to severe unipolar PPD, selective serotonin reuptake inhibitors (SSRIs), psychotherapy, or both may be indicated. ACOG supports individualized medication decisions based on prior response, adverse effects, comorbidities, and lactation plans [8]. Suspected bipolar disorder or psychosis requires specialist assessment before antidepressant monotherapy [2].

At initiation, document symptom severity and functioning, discuss treatment expectations, and arrange early review for adverse effects and suicidality. ACOG recommends validated measures to monitor response and remission [8]. For partial response, reassess diagnosis, adherence, dose, tolerability, and ongoing stressors before changing treatment.

6.3 Neuroactive Steroids and Rapidly Acting Treatment

Zuranolone is an oral neuroactive steroid that modulates GABA-A receptors. At the day-15 assessment, depressive symptom scores improved more with zuranolone than placebo in the phase 3 SKYLARK trial [12]. A 2025 Cochrane review found probable improvements in short-term response and remission, alongside more maternal adverse events [13].

ACOG updated its guidance on zuranolone and brexanolone in 2025 (2026 print issue) for depression beginning in the third trimester or within four weeks after childbirth [14]. The US zuranolone label specifies 50 mg orally each evening for 14 days with fat-containing food and advises against driving or hazardous activities for at least 12 hours after each dose. It also advises effective contraception during treatment and for one week after the last dose [15]. Sedation, interacting medicines, and safe infant care require advance planning.

Brexanolone is an intravenously administered neuroactive steroid that previously required monitored infusion [14]. Its US product, ZULRESSO, ceased commercial availability in December 2024, and the FDA withdrew its approval effective April 14, 2025 [16].

6.4 Severe or Treatment-resistant Presentations

Acute suicidality, psychotic depression, catatonia, inability to maintain nutrition, or threats to infant safety require urgent specialist assessment and possible hospitalization [2,9]. Electroconvulsive therapy may be considered for selected severe or treatment-resistant episodes within specialist care [6].

Table 2: Evidence-to-decision summary for postpartum depression management

Presentation	Clinical approach	Main supporting evidence
Elevated score without confirmed disorder	Diagnostic interview; assess suicidality, bipolarity, social context; arrange follow-up	Guideline-based pathway [2,3]
Increased risk without major depression	Offer structured preventive counseling, particularly CBT- or IPT-informed	USPSTF recommendation and guideline synthesis [1,10]
Mild to moderate confirmed PPD	Offer evidence-based CBT or IPT; consider medication based on preferences and course	Guidelines and meta-analyses [1,6,11]
Moderate to severe unipolar PPD	Consider SSRI and/or structured psychotherapy, with measurement-based review	Clinical practice guidelines [6,8]
Selected adults considered for zuranolone	Specialist-informed prescribing, infant-care arrangements, adverse-effect counseling and follow-up	Placebo-controlled trial, Cochrane review, prescribing label [12,13,15]
Suicidal crisis, mania, or psychosis	Immediate safety assessment and emergency psychiatric care	ACOG and postpartum psychosis clinical review [2,9]

7. Treatment and Infant Feeding

Depression treatment and breastfeeding plans should be discussed together. A 2024 consensus supports continuing an effective antidepressant when clinically appropriate [17]. LactMed identifies low sertraline transfer into breast milk and generally undetectable infant serum concentrations, making it a commonly preferred SSRI when treatment is newly initiated during lactation [18]. Previous maternal response also matters.

Infant prematurity, feeding, growth, clinical vulnerability, and concomitant medicines guide monitoring [18]. Zuranolone requires separate, drug-specific counseling on infant exposure and maternal sedation, including arrangements for safe infant care [15].

8. Monitoring Response, Relapse, and Recovery

A follow-up plan should identify the responsible clinician, timing of review, symptom measures, treatment adherence, adverse effects, and a response to clinical deterioration. ACOG supports repeated validated scales to assess treatment response or remission [8]. Functioning and infant-care capacity should be reviewed alongside scores.

Remission should include symptom improvement, restored functioning, and sustained safety. Continued care should address relapse, medication duration, psychiatric comorbidity, and future pregnancy planning [6,8].

Clinical programs should report diagnostic evaluation after a positive screen, time to treatment, referral completion, symptom improvement, remission, and safety events. WHO emphasizes continuity after screening [3]. Digital alerts also require a designated clinical response.

9. Integrated Care and Emerging Service Delivery Evidence

Collaborative care links obstetric or primary care teams with mental health professionals and structured follow-up. In the 2025 SUMMIT trial (n=1,230 pregnant or postpartum participants), behavioral activation delivered by supervised nonspecialists was noninferior to specialist delivery, and telemedicine was noninferior to in-person treatment for depressive symptoms at three months [19].

A 2026 retrospective cohort of 185 patients enrolled in a technology-enabled perinatal collaborative care program reported declining depression and anxiety scores during follow-up [20].

Remote treatment may reduce travel and childcare barriers, but clinicians must safeguard privacy, assess crises, and provide access to in-person care when indicated [3,6]. Relevant outcomes include access to assessment, treatment adherence, safety, and remission.

10. Priorities for Future Clinical Research

Future trials should compare newer agents with established treatments using remission, functioning, infant outcomes, adverse events, and relapse beyond the initial treatment course. The neuroactive steroid evidence particularly needs longer follow-up and active-comparator studies [13,14].

Implementation studies should measure completion of assessment and treatment after screening. The SUMMIT trial provides a model for testing supervised delivery approaches [19]; observational collaborative care cohorts can inform feasibility and implementation [20].

11. Conclusions

PPD care extends from repeated screening to diagnosis, safety assessment, treatment, and documented recovery. ACOG and WHO guidance supports screening linked to clinical action [2,3]. CBT, IPT, and antidepressants remain central treatments, while zuranolone is an option for selected patients [1,8,13]. Supervised telemedicine offers an additional route to psychotherapy [19].

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