Postpartum Depression:

Education and Early Detection

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Postpartum Depression

Abstract

Postpartum mood disorders affect individuals, families, and communities within the state of Texas. Untreated symptoms have resulted in “baby blues”, mild to severe depression, and psychosis. Outcomes of untreated mood disorders may lead to dysfunction within the family unit, delays in cognitive, psychological, and social development of the newborn, and may pose the risk of the individual either harming or murdering her children. With implementation of the integrated Health Belief and the Social Network and Social Support models, the state of Texas can be on the cutting edge of implementing a plan of action for early detection and treatment of postpartum mood disorders.
Introduction

Postpartum mood disorders have become a serious maternal-child health concern. Beck (1999b) describes them as “a dangerous thief that, after delivery, robs a mother of precious time spent with the infant she has anticipated throughout her pregnancy” (p.1). Besides directly impacting the emotional wellbeing of mothers, postpartum depression (PPD) affects marital relationships (Goodman, 2004; Meighan, Davis, Thomas & Dropleman, 1999), mother-infant interaction (Beck, 1995), infant behavior (Field, 1998; Beck, 1999a) and cognitive and emotional development of children (Beck). Children of depressed mothers have significantly lower intelligence quotient (IQ) scores, attention problems (Hay, Pawlby, Sharp, Asten & Mills, 2001), violent behavior related to attention-deficit/hyperactivity disorder and problems with anger management (Hay, et al.) that endure into childhood.

Because of the mass media coverage of 3 recent cases of homicide of infants and children in Texas involving women with possible postpartum psychosis, the authors determined a need to investigate the problem of postpartum mood disorders. The target population is all pregnant women and women who have given birth within the past year in the state of Texas. The purpose of this paper is to propose a plan for education, screening and early detection of postpartum mood disorders in order to raise community awareness, effect early diagnosis, and maximize social support.

Discussion

The Centers for Disease Control (2004) state that 12% of women report being moderately depressed and 6% very depressed after childbirth. With 4 million annual births in the United States, that represents 480,000 cases or one in every 8 postpartum women. According to the
Postpartum Resource Center of Texas (PRCT) (2003), at least 36,500 mothers in Texas suffer from postpartum mood disorders every year. PPD can occur anytime in the postpartum year, but is most frequently seen in the first 3 months (Beck, 1999b). Episodes of this crippling mood disorder last 6 months or more in 25-50% of mothers (Beck, 2002). Yonkers, et al. (2003) states that 80% of women experiencing PPD will have another episode.

According to the American Psychiatric Association (APA) (1994), a postpartum mood episode, which may include psychotic features, is one whose onset is within 4 weeks of birth. According to Beck (1999b), PPD can occur anytime in the postpartum year, but is most frequently seen in the first 3 months. Depressed women often suffer covertly without confiding their sadness or negative feelings (Beck) because of feelings of shame and guilt and the stigma that prevents them from seeking help. These disorders are severely under diagnosed. More than half of women identified by screening to have PPD had not been identified as depressed by their health care provider (Hearn, et al, 1998).

The U.S. Census Bureau (2000) reports that 32% of Texans are Hispanic (of which 76% are Mexican) and 12% are Black. The Surgeon General (U.S. Department of Health and Human Services [USDHHS], 1999) in a report on cultural diversity, reported that higher rates of mental disorders among minorities is accounted for by the disproportionate number of minority women living in poverty and thus experiencing more frequent, threatening and uncontrollable life stresses than members of the rest of the population. A study of minority women in Dallas County showed that the rates of postpartum depression among Hispanics and African Americans were similar to rates for Caucasians (Yonkers, et al., 2001). Racial and ethnic minorities tend to minimize the significance of stress. They also tend to have strong family orientations that
provide support to individuals coping with mental health problems, and they are underrepresented in mental health services (USDHHS, 1999).

The American Academy of Pediatrics (AAP) (2002) and the American College of Obstetricians and Gynecologists (ACOG) (2002) recommend that pregnant women be educated about PPD in the third trimester and assessed for risk during the postpartum period. This education and assessment would help accomplish the Healthy People 2010 objectives to reduce maternal illness and complications due to pregnancy, including PPD, and to increase the number of persons seen in primary health care who receive mental health screening and assessment (USDHHS, 2000).

Post Partum Mood Disorders

Baby blues.

Postpartum depression is often used as a catchall phrase for many postpartum mood disorders that encompass physical and emotional changes that a mother can experience after birth. It can be conceptualized as a continuum with symptoms worsening over time in some women (Clemmens, Driscoll & Beck, 2004). There are three levels of severity: baby blues, postpartum depression, and postpartum psychosis. Up to 80% of women experience baby blues, usually within the first week postpartum that may persist for several hours to several weeks (National Mental Health Association [NMHA], 2003; PRCT, 2003). Baby blues are experienced as mood swings, crying spells, sadness, anxiety, or dependency (Bennett & Indman, 2003). Other symptoms might include impatience, irritability, restlessness, or loneliness (USDHHS, 2002). These symptoms are sometimes attributed to rapid physical and hormonal changes. The hormonal fluctuations include decreased thyroid, estrogen and progesterone levels (Baker, Mancuso, Montenegro & Lyons, 2002). Psychological manifestations include emotional letdown
after birth, anxiety about the increased responsibilities of motherhood, fatigue or sleep deprivation, or feelings of disappointment with the birth experience (Bennett & Indman). Treatment consists of rest, proper nutrition, help with infant and household responsibilities, support from family and friends, and avoidance of isolation (PRCT).

Postpartum depression.

Postpartum depression is more severe than the baby blues and can occur anytime in the first year postpartum. It affects 10% (PRCT, 2003) to 20% (Bennett & Indman, 2003) of mothers. The onset can be rapid or gradual with two significant common signs being persistent sadness and lack of joy in motherhood (NMHA, 2003; Beeber, 2002). Behavioral symptoms include depressed mood (Beeber) or uncontrollable mood swings (NMHA), hopelessness (NMHA; Bennett & Indman; Chan & Levy, 2004), downcast or blank facial expression (Beeber), persistent guilt (Bennett & Indman; Beeber), perceptions of flaws in herself and/or the infant (Beeber), indecisiveness (NMHA; Bennett & Indman; Beeber), lack of focus or concentration (Bennett & Indman), irritability (NMHA; Bennett & Indman; Beeber), social withdrawal (NMHA; Beeber), and loss of interest in self care (NMHA; Beeber).

Physical symptoms may include constipation (Beeber, 2002), exhaustion or fatigue (NMHA, 2003; Troy, 2003; Chan & Levy, 2004; Beeber), eating disturbances and weight fluctuations (NMHA; Bennett & Indman, 2003; Beeber), sleep problems (NMHA; Bennett & Indman; Beeber), vague, chronic pain (Beeber), and hyperventilation or heart palpitations (NMHA). Depressed women report feelings of ambivalence toward the baby (Chan & Levy). Signs representing potential danger to both the mother and the infant are extreme distraction or lapses of attentiveness to the infant, repetitive thoughts of harming herself or her baby, or
inability to function (Beeber). Postpartum depression requires assessment by a medical
professional and medical care and counseling (PRCT, 2003).

*Postpartum psychosis.*

The more severe condition, postpartum psychosis (PPP), occurs in 1 or 2 in 1,000
postpartum women (Bennett & Indman, 2003). Onset can vary from 2 to 3 days (Bennett &
Indman) to 3 months (USDHHS, 2002) after childbirth. Symptoms include severe insomnia,
disinterest in eating, extreme anxiety and agitation (PRCT, 2003). Visual or auditory
hallucinations, delusions denying birth or about the infant's death, and suicidal or homicidal
thoughts or gestures can occur along with delirium and mania (Bennett, & Indman). Postpartum
psychosis requires immediate assessment by a medical professional and hospitalization for
medical and psychiatric treatment. This condition is considered a severe medical emergency,
because without treatment it can have tragic results for both the mother and her infant or other
children (PRCT). Postpartum psychosis has a 5% suicide and a 4% infanticide rate (Bennett &
Indman).

*Risk Factors for Postpartum Depression*

Many risk factors for postpartum depression have been identified. Pre-pregnancy risk
factors include history of depression (NMHA, 2003); Beck, 1999b) or substance abuse (NMHA,
2003), severe premenstrual syndrome or premenstrual dysphoric disorder (Baker, 2002; Bennett
& Indman, 2003), mood instability while taking oral contraceptives or fertility medications,
thyroid dysfunction (Bennett & Indman) or previous obstetric complications (NMHA).
Pregnancy risk factors include mistimed or unwanted pregnancy (McLennan, Kotelchuck & Cho,
2001), increased number of somatic complaints during pregnancy (Baker, 2002), and depression
or anxiety during pregnancy (Beck; Bennett & Indman). Risks associated with birth include
premature or late birth (Baker), labor or birth complications (NMHA), dissatisfaction with labor and delivery (Baker), separation from infant after delivery (Baker), or early hospital discharge (Hickey, Boyce, Ellwood & Morris-Yates, 1997).

Risks associated with the infant include difficult infant temperament (Baker, 2002) or infants with medical, feeding, or sleeping problems (NMHA, 2003; McLennan, Kotelchuck & Cho, 2001; Baker), abrupt weaning (Bennett & Indman, 2003) and bottle-feeding (McLennan, Kotelchuck & Cho; Yonkers, et al., 2001). Family risk factors include family history of depression (Baker; Bennett & Indman), negative perceptions of the patient’s parents’ parenting (Baker), not living with one’s spouse or significant other (NMHA; Yonkers, et al.), marital dissatisfaction or discord (Beck, 1999b; Baker), lack of support from family and friends (NMHA; Beck; Baker; Bennett & Indman), and other young children at home (Yonkers, et al.). Other risk factors are adverse life events (NMHA; Swendsen & Mazure, 2000) or life stress (Beck), and recent bereavement (Misri, 2001). Acculturation has been identified as a risk factor for PPD in Mexican American women (Martinez-Schalmoser, Telleen & Macmuller, 2003).

**Predictors of Postpartum Depression**

The development of assessment tools to identify women at risk requires the identification of predictors of PPD. In a meta-analysis of 44 studies on postpartum depression, Beck (1996) found significant correlations in 8 predictor variables. History of previous depression, prenatal anxiety, prenatal depression, and maternity blues were identified as predictors. Others include low marital satisfaction, low social support, difficult infant temperament, and life stress. Beck (1996) acknowledges that the significant correlations between these predictor variables and postpartum depression do not imply causation. In a later meta-analysis of 84 studies, Beck (2001) confirmed these 8 predictors and added 4 more: low self-esteem, single marital status,
low socioeconomic status, and unplanned/unwanted pregnancy. These predictors can alert health care providers to the risk for PPD.

Integration of Health Belief and Social Networks and Social Support Models

The proposed plan for education and early screening for postpartum depression will use two models; the Health Belief Model (HBM) and the Social Networks and Social Support (SNSS) model. An integration of the two models will incorporate individual perceptions of modifying factors for postpartum depression from the HBM with social support, stressors, and individual coping resources of the SNSS model. The resulting integrated model (see Figure 1) will provide education and prenatal screening for postpartum mood disorders; provide referrals for treatment and community support resources.

Health belief model.

According to Glanz, Rimer & Lewis (2003), the HBM is one of the most widely used conceptual frameworks utilized to explain change and the maintenance of health-related behaviors, as well as being used as a guiding framework for health behavior interventions. Poss (2001) reports, “Because the HBM is a psychosocial model, it accounts for only as much of the variance in health behaviors as can be explained by attitudes and beliefs that are obvious to and consciously evaluated by individuals” (p.3). Poss goes on to say that other factors such as personality factors, social support, previous health experiences or demographic variables, which may play a role in influencing behavior, are not an important part of the HBM. Because of these limitations in the HBM, the authors identified the need to incorporate additional aspects from social support and social networks.
**Social network and social support.**

The SNSS improves the individual’s ability to access new information and contacts and to identify and solve potential problems (Glanz, Rimer & Lewis, 2003). Lara, Leader, Klein & Kendler (1998) report that individuals with strong social support adjust better to stress and recover more quickly from depression and other psychiatric disorders. Vandervoort (1999) reports that the quality is more important than the quantity of relationships with respect to health outcomes when identifying the need for social support/network systems.

**Integrated model.**

In the proposed model (see Figure 1) that integrates HBM and SNSS, data is collected during pregnancy on all women regarding modifying factors such as age, sex, ethnicity, personality, socioeconomics and level of knowledge of mood disorders. Physical, mental and social health are assessed along with identified risk factors for depression. These factors are all influenced by her identified social network or social support system. Further assessment identifies her stressors as well as individual coping resources, problem solving abilities and perceived control. This cumulative data is influenced by the client’s perceived threat and perceived susceptibility to the development of postpartum mood disorders.

The total assessment will trigger cues to action that consist of the proposed plan to do individual screening for depression during the prenatal period. An additional cue to action is education of the community about the risks, symptoms and sequelae of the disease in order to reduce its stigma and promote early self-reporting of symptoms. Education for healthcare providers is also proposed to enhance their knowledge and competence in assessment, screening, referral and treatment options.
Based on prenatal screening results, clients exhibiting illness behaviors will be referred for treatment and channeled into community resources and other sources of social support. Those without illness behaviors will receive reinforcement for their social support systems and encouragement to access community resources for maintaining positive mental health. They will be reassessed as appropriate.

As the community and healthcare providers are educated about postpartum depression, community resources are developed which will strengthen social networks and social support. This in turn will influence the social networks and social supports for other pregnant women in the community. Community education will additionally raise awareness of the problem and reduce its stigma.

**Education**

Intervention and treatment of postpartum depression requires education and screening. Communities, as well as individuals, must be educated in regard to risk factors, symptoms, and etiology of postpartum depression. Education about postpartum mood disorders begins with awareness. This can be possible through prenatal classes, physician offices, health clinics, and media blitzes. Education is provided on two levels, with the individual and with the community. Community education can be accomplished by newspaper articles, women’s health newsletters, and community lectures (Straub, et al., 1998). Ugarriza (2002) suggests emphasizing the roles of family members in helping new mothers gain rest and support. Baker, et al.(2002) recommend including family members or significant others in the educational process. These authors also state that education regarding depression should be a routine part of every patient’s antepartum care.
Intervention should focus on identified risks factors, self-esteem (Daracab & Williams, 1970 as cited in Pfost, Stevens, & Matejcak, 2001), attitudes toward pregnancy (Pfost et al.), and mothering skills. Seeman (2001) found that no women enrolled in the course, *Survival Skills for New Moms*, developed postpartum depression compared to 33% in the control group who did not attend the class and did develop depression. Findings of a study in Taiwan among five hundred women, who were screened for postpartum depression, indicated that informational support about postnatal depression given to women may contribute to lower scores on screening than those who did not receive the informational support (Heh & Fu, 2003).

Some states have taken the initiative to provide resources for those diagnosed with a postpartum mood disorder. The state of Texas, through the passage of HB 341 in 2003, requires physicians, midwives, hospitals and birthing centers to provide pregnant patients with a postpartum depression resource list and document that in the patient chart. Texas Department of Mental Health (TDMH) provides healthcare providers and families with tips on dealing with depression. Through its website, TDMH (2003) suggests that when working with a depressed family member or friend it is important to keep routines as normal as possible even if the family member does not want to participate in the routine. TDMH goes on to recommend including, a) being a role mode, b) seeking help if experiencing any mental problems, and c) joining a support group in order to talk with others experiencing the same problems.

Healthcare providers require more in depth knowledge relating to the screening, identification, and interventions of PPD. Recognition of symptoms and intervention early in the pregnancy may improve postpartum outcomes. In order for this to occur, professional organizations such as the American Medical Association (AMA) and the American Nurses Association (ANA) must take a proactive step in setting guidelines and standards for practice.
relating to early identification and implementation of care in postpartum mood disorders.
Screening of only those women who present with symptoms may leave many undiagnosed and untreated. It is recommended that all women be provided information regarding PPD in the third trimester of pregnancy and sooner if at risk (ACOG, 2002, AAP, 2002). The authors would like to amend this recommendation by adding screening as a routine intervention in the third trimester of pregnancy.

Screening

Screening tools such as the Edinburgh Postnatal Depression Scale (EPDS), the Postpartum Depression Scale (PPDS), and the Zung Scale are recommended for self-reporting during both the antepartum and postpartum periods. It has been suggested that antepartum depression is predictive of PPD and therefore, it is suggested that screening, education, and treatment begin during pregnancy (O’Hara, Stuart & Li, 2000 as cited in Baker et al., 2002).

The EPDS and the PPDS have the highest specificity and sensitivity in detecting minor and postpartum depression (Baker, et al., 2002). The EPDS is a 10 item self-report scale developed to specifically address the postpartum period. The questions relate to the two week period preceding administration of the test. Both the EPDS and PPDS may be administered during the antepartum period or during the postpartum period at the time of the postnatal checkup (Clemmens, et al., 2004).

The Zung Scale involves twenty questions not specific to the postpartum period, but is brief and concise enough to identify depressive behavior. It is recommended that screening be ongoing and performed by healthcare providers such as obstetricians, nurses, midwives, childbirth educators, pediatricians, lactation consultants, or public health officials through either a formal screening process or by listening to patient stories related to the postpartum experience.
Postpartum Depression (Clemmens, et al., 2004). Clinicians should have a network which includes social workers, psychiatrists, and psychologists (Baker, et al., 2002). Screening should take place at regular times prior to and following childbirth, in person or by phone.

Screening tools may focus on different behaviors; therefore more than one tool may need to be used. It is important that healthcare providers administering the screen be able to differentiate between pathology and normal maternal adaptation. Screening will provide a baseline so that subsequent depression will be recognized (Baker, et al., 2002). Once a diagnosis of postpartum mood disorder is made, it is important to include mother’s partner, family, or friends in the intervention plan (Beeber, 2002). They can assist the mother in finding needed resources such as child care and household assistance.

Support groups, family education and the emphasis on friend and family care giving support are especially important following childbirth. A telephone bank or on-line support group with professional assistance made available may be able to decrease isolation, to answer family questions, and to serve as a forum for sharing experiences (Baker, et al., 2002).

Conclusion

Postpartum mood disorders continue to be misunderstood by individuals, families, communities and healthcare providers. It is the responsibility of all providers of care for pregnant women to take the initiative to implement a process for early screening and education of postpartum mood disorders. With the use of the integrated HBM and the SNSS model the goal of early detection and treatment of postpartum mood disorders can be accomplished through a concerted effort by all stakeholders who include individuals, families, communities, and health care providers. Having experienced some of the most horrific outcomes of untreated postpartum mood disorders, Texas needs to be proactive in requiring early screening and education by
healthcare providers. In addition Texas needs to fund and make available community resources accessible to all individuals. By doing this, Texas can become one of the pioneers in identifying and treating postpartum mood disorders.
Figure 1. Integration of Health Belief and Social Network/Social Support Models
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