Educating Physicians In their Communities (EPIC)

POSTPARTUM DEPRESSION
Today’s objectives

At the end of this presentation the participant should be able to:

- Differentiate between normal “Baby Blues”, major depression postpartum onset, and postpartum psychosis
- Identify risk and protective factors for mothers and families
- Recognize the effects of postpartum depression and maternal depression on children and families
- Utilize the Edinburgh Postnatal Depression Scale (EPDS)
- Develop follow up procedures to use after screening a mother for depression
Syndromes of the Postpartum Period

- Postpartum or maternity “blues”
- Adjustment disorder in the postpartum period
- Major depression in the postpartum period
- Mania in the postpartum period
- Psychosis in the postpartum period
Severity of Postpartum Mood Symptoms

- **Transient, nonpathologic**
- **Serious, disabling**
- **Medical emergency**

### Postpartum Blues
- Risk for MDD
- 50% to 70%

### Postpartum Depression
- 2/3 have onset by 6 wks postpartum
- 70% are affective (bipolar, MDD)
- 0.01%

### Postpartum Psychosis
- 10%
# Postpartum Mood Disorders

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Incidence</th>
<th>Treatment</th>
<th>Presentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity blues</td>
<td>26 to 85%</td>
<td>Support and reassurance</td>
<td>80% resolve by week 2; 20% evolve to PPD</td>
</tr>
<tr>
<td>Adjustment disorder</td>
<td>About 20%</td>
<td>Support/reassurance Psychotherapy</td>
<td>Excessive difficulties adjusting to motherhood</td>
</tr>
<tr>
<td>Postpartum depression</td>
<td>10 to 20%</td>
<td>Antidepressants, mood stabilizers &amp; psychotherapy</td>
<td>Onset within 1 year Agitated Major depression often with obsessions</td>
</tr>
<tr>
<td>Postpartum psychosis/mania</td>
<td>0.2%</td>
<td>Hospitalization; antipsychotics; mood stabilizers; benzodiazepines; antidepressants; ECT</td>
<td>Onset after PP day 3. Mixed/rapid cycling. Risk of infanticide.</td>
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</tbody>
</table>

Maternity “Blues”

“Blues” = heightened reactivity, not depression

- Reported by 50-80% of women
- Present in all cultures studied
- Symptoms
  - Feelings of loss, sadness, anxiety, confusion, fear or being overwhelmed
- Occurs within 3-5 days after delivery
- Usually resolves within 10 days to two weeks after child’s birth
- Appears unrelated to environmental stressors
- Probably physiologically based
- Predisposes to postpartum depression
Postpartum Depression
Common Symptoms

- Sadness or down mood
- Diminished interest/pleasure
- Appetite problems or unexplained weight change
- Sleep problems
- Agitation and anxiety
- Fatigue or low energy
- Feeling worthless or guilty
- Suicidal or infanticidal ideation

New Jersey Statistics on Postpartum Depression (Annual)

- 110,000 live births
- 800 fetal deaths

Assuming a 10-15% incidence of PPD:
  - Between 11,000-16,620 cases of Postpartum Depression would be expected annually

Governor’s Work Group on Postpartum Depression, Spring, 2005
Myths about Postpartum Depression

- Depression in new mothers is not serious
- Postpartum depression is more common in white middle class women
- Postpartum depression will go away on its own
- Women with postpartum depression cannot breastfeed
## Risk Factors for Postpartum Mood Disorders

### Major Risk Factors
- Depression during pregnancy
- Anxiety during pregnancy
- Previous history of depression
- Teen pregnancy
- Lack of social support
- Conflict with spouse/significant other
- Stressful life events outside of pregnancy

### Minor Risk Factors
- Socioeconomic factors
- Obstetrical complications

Adapted from Gaynes, Gavin, et al. AHRQ
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Psychiatric Admissions: 2 Years Pre and Post Delivery

Psychiatric History Predicts Risk of Major Depression in the Postpartum Period

- Risk in general population: 11%
- History of major depression: 25%
- MDD during pregnancy: 33%
- History of postpartum depression: 50%

Not Risk Factors

- Maternal age (beyond 18)
- Level of education
- Number of children
- Length of relationship with partner
- Gender of child

Effects of Maternal Depression on Children
Effects Of Postpartum Mood Disorders

- Mother/Infant Relationship
- Child Development
- Partner Relationship
About Maternal Depression
Still Face Paradigm

Forming Relationships
Brief Separations
Childcare Separations
and Coping
About Maternal Depression
Still Face Paradigm
About Maternal Depression
Still Face Paradigm
About Maternal Depression
Still Face Paradigm
Depressed Mother’s Infant Interaction

Withdrawn

- Infant first protests, attempts to engage, then over time withdraws

Intrusive and over stimulating

- Anger/irritation/rough handling 40% of the time
- Infant tries to avoid mother, fusses most of the time

*Remember not all mothers show these behaviors in public*
Persistence of effect:

- EEG changes at 1, 3 months and beyond to age 3 years
- Limited play and exploration and altered Bayley score at 2 and 12 months
- Delayed growth and developmental delays at 12 months
- Males by age 4 have lower cognitive performance
- Increased behavior problems by ages 3 & 4
  - Passive withdrawn, Angry aggressive
How Depression Can Influence Breastfeeding

Depression can:

– decrease maternal sensitivity and responsiveness

– cause a lack of persistence in the face of difficulties

– be related to some maladaptive cognitions regarding the baby (e.g., “the baby is sucking the life out of me”)
Major Long Term Impact on Children

- 61% of children of parents with a major depressive disorder will develop a psychiatric disorder during childhood or adolescence.

- Offspring of depressed parent are 4 x more likely to develop an affective disorder than if non-depressed parent

- 40% chance of experiencing an episode of depression by age 20 and 60% by age 25
Importance of Screening

Why Screen Mothers?

> Providers are the only professionals who see mothers with regularity in the child’s first year of life

> Interrelatedness
  - Mother’s mental health affects baby’s well being and the entire family
  - Child’s development influenced by early relationship history
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Possible Barriers

> Traditional focus of visit - the child
> Family’s cultural view of depression
> Lack of referral sources
> Lack of appropriate tools

> AAP Study
  – Insufficient time for history, education, counseling
  – Insufficient knowledge to diagnose or treat
Challenges for clinicians in detecting depression

- Only the most severe, chronically depressed are detected in routine encounters, even with psychologists.
- Up to half of mothers may not realize their discouragement, irritability, fatigue are depression.
- Mothers commonly conceal depression out of the home where they may rally the resources to function with other adults.
- Irritability, hostility and withdrawn behavior occurs most within the family.
How pediatricians determine if the parent is depressed?

- 8% routinely ask about depressive symptoms
- 81% rely on mother’s behavior, appearance or complaints

How effective is this approach?
- 37% detect documented depression during the clinical visit
- Only 50% of those who screen positive observed to have a depressed affect

Olson, Pediatrics, 2002
Henneghan, Pediatrics, 1998
Building a Relationship

Establish a trusting relationship with the mother

- Show her that you are invested in her mental health and well being
- The relationship may take time
- Encourage entire staff to show interest in how mom is doing
Using the Edinburgh Postnatal Depression Scale

- Developed to identify depressive symptoms in new mothers
- Widely used
- Cross cultural validity
- Validated to identify depressive symptoms in pregnancy
- Easy to use, self-administered
- Effective
  - Sensitivity = 86%
  - Specificity = 78%
- Available in many languages
Using the Edinburgh

Edinburgh Postnatal Depression Scale (EPDS)

Name: ____________________________  Address: ____________________________

Your Date of Birth: ____________________________  Phone: ____________________________

Babys Date of Birth: ____________________________  Phone: ____________________________

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt in the past 7 days, not just how you feel today.

Here is an example, already completed.

I have felt happy:

☐ Yes, all the time
☐ Yes, most of the time
☐ No, not very often
☐ No, not at all

This would mean ‘I have felt happy most of the time’ during the past week.

In the past 7 days:

☐ I have been able to laugh and see the funny side of things.
☐ As much as I always could.
☐ Not quite so much now.
☐ Definitely not much now.
☐ Not at all.

☐ I have missed people I used to see.
☐ As much as I ever did.
☐ Rather less than I used to.
☐ Definitely less than I used to.
☐ Nearly at all.

☐ I have blamed myself unnecessarily when things went wrong.
☐ Yes, most of the time.
☐ Yes, some of the time.
☐ Not very often.
☐ Not at all.

☐ I have been anxious or worried for no good reason.
☐ Yes, most of the time.
☐ Yes, some of the time.
☐ Not very often.
☐ Not at all.

☐ I have felt sick or miserable.
☐ Yes, most of the time.
☐ Yes, quite often.
☐ Not very often.
☐ Not at all.

☐ I have been constantly tired.
☐ Yes, most of the time.
☐ Yes, quite often.
☐ Not very often.
☐ Not at all.

☐ I have thought the baby was a burden.
☐ Yes, most of the time.
☐ Yes, quite often.
☐ Sometimes.
☐ Hardly ever.

☐ The thought of harming myself has occurred to me.
☐ Yes, most of the time.
☐ Yes, quite often.
☐ Sometimes.
☐ Never.

Administered/Reviewed by ____________________________  Date: ____________________________

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)

Postpartum depression is the most common complication of childbirth. The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for ‘perinatal’ depression. The EPDS is easy to administer and has proven to be an effective screening tool.

 Mothers who score above 13 are likely to be suffering from a depression illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week. In doubtful cases it may be useful to repeat the test after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

Women with postpartum depression need not feel alone. They may find useful information on the website sites of the National Women’s Health Information Center (www.aapcpm.org) and from groups such as Postpartum Support International (www.postpartum.com) and Depression after Delivery (www.depressionafterdelivery.com).

QUESTIONS 1, 2, & 4 (without an *)

Are scored 0, 1, 2 or 3 with top box scored as 3 and the bottom box scored as 0.

QUESTIONS 3, 5-10 (marked with an *)

Are reverse scored, with the top box scored as 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Users may reproduce the scale without further permission, providing they respect copyright by quoting the names of the authors, the title, and the source of the paper in all reproduced copies.

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.


©WIC/MCC/ & OA/Sandiders/Peripartum Website Materials/EPDS by Kerry McInerny 10-25-04.doc
Using the Edinburgh

Instructions

> The mother is asked to underline the response that comes closest to how she has been feeling in the previous 7 days.

> All ten items must be completed.

> Care should be taken to avoid the possibility of the mother discussing her answers with others.

> The mother should complete the scale herself, unless she has limited English or has difficulty with reading.
Using the Edinburgh

Scoring

> Score/review test (maximum score 30)
> Consider action/referral on score of 10 or greater (indicates possible depression)
> Review answers to individual questions
> Discuss items with high scores
> Pay special attention to question #10 (regarding suicidal thoughts)
The thought of harming myself has occurred to me.

- Yes, quite often
- Sometimes
- Hardly ever
- Never
Determining Risk of Harm

Any mother scoring 1 or higher on question #10 of the Edinburgh should be asked the following questions taken from “Perinatal Psychiatry” by Cox and Holden

- Severity
- Plan
- Support System
Using the Edinburgh

When and How to Screen

- Screen **ALL** mothers
- Develop practice guidelines for frequency
  - during pregnancy
  - at least 2 times in the baby’s first 6 months of life
    - Depending on well-baby visit schedule
  - 1st screen should occur 4 to 6 week visit
- Use of the Edinburgh
  - OK to photocopy, distribute, reformat
  - For more copies/Spanish version: http://www.njspeakup.gov
- Consider additional times of risk during child’s first 3 yrs. of life
Using the Edinburgh

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Using the Edinburgh

Discussing results with mothers

> Become comfortable with sensitive issues
> Recognize the resource you can be for mother
> Reinforce how mother’s health impacts her child
Inaccurate self-report
  – Undiagnosed mood disorders
  – Denial of illness

Fear of involvement of child protection agencies

Ability to mask symptoms especially if highly functional

Motherhood myth
Can one fit depression screening into the well child visit?

Clinician’s choice between time involved and the value or benefit for the child
What practices say about feasibility

Time

- Less than one minute for interview questions
- Prepared with knowledge of depression resources
- Parenting issues already part of care
- Role not to diagnose or solve problem that day
- Discussion time not seen as a barrier

Value

- Gratifying to help, appreciated by parent
- Other efforts with child’s problems not effective unless tend to parental depression
- Early interventions: able to help validate as parent, enlisting support, being available
- Preventive mental health care for the child
Enhanced Care

Respond to
- Parent requests
- Obvious need

Improve Recognition

Explore:
- severity/child impact
- Engage/motivate

Refer to PCC or MH
- Ongoing parenting support
- Intervene to help child

Usual Care

Respond to
- Parent requests
- Obvious need

Recommend
- Parent seek mental health care
Referral and Support

Provider’s Role

> Increase awareness/recognition
> Not responsible for diagnosis
> Discuss options for further help/assessment
  - Mental health provider
  - Community resources
> Mention treatment options
  - Counseling, support groups, parenting coaching, medications
Making it Work

Team Member Roles

> Decide as group who will take what role
  - Office staff flags charts, pulls copies of screen
  - Mother fills out screen in exam room
  - Nurse collects and scores screen
  - Doctor, NP, PA reviews and discusses with mother

> Team work
  - Entire staff ensures screenings occur
  - Responsibility is shared
Practice preparations to respond and follow up

- **Determine options for follow up**
  
  Schedule second visit or MD call
  Local adult primary care and mental health referral sources
  Social worker follow up
  Follow up call from nurse

- **Display social/emotional and mental health educational materials in your office**
  
  (Self help for depression handouts, Family information about depression, Postpartum depression resources, Community parenting support resources)

  Shows you value these issues

  Encourages families to discuss their concerns
Relationship and Referral

> Establish a trusting relationship with the mother
> Respect the mother’s societal, cultural, and familial beliefs regarding depression
> Educate the mother about depression – prevalence, treatment, impact on family

> Referrals
  – PPD Helpline, 1-800-328-3838
  – Investigate community parenting support resources

> Tools are easy and provide consistency, records
The 800-328-3838 telephone number is answered on a 24 hour/7 day per week basis. Calls can come from women experiencing distress, family members asking for information, and clinicians requesting teaching materials.

The hotline has the ability to directly link callers with a provider agency through a “warm line transfer” feature.
Call Family Health Line

Request information

Brochures mailed

Woman needing further assessment

Call transferred to UBHC

Clinician triages call

Immediate Danger

Notify crisis center

Needs Assessment and uninsured or underinsured

Appointment arranged with community mental health center

Needs Assessment and has private insurance

Referred to her insurance company
Steps Toward Intervention

- **Listen** carefully to what the mother says
- **Talk** with her about the many factors that could be influencing her emotional state without “explaining away” her symptoms
- **Teach** some specific strategies that can help
- **Help** her mobilize her own support system. This includes offering referrals to people or organizations that can offer long-term support
Referral Considerations

Multidisciplinary approach is imperative

- Obstetrician
- Pediatrician
- Nurse
- Primary Care Provider
- Psychiatrist
- Psychologist/Social Worker/Psychotherapist
- Endocrinologist
The efficacy of postpartum support groups

“A psychoeducation group for women with low post partum mood can significantly reduce depressive symptoms,”

“A program of supportive group therapy for post partum mothers can significantly lower or eliminate depressive episodes,”
- Lane, B., Roufeil, M.M., Williams, S., Tweedie, R..(2001)

“Post partum mothers attending a group integrating supportive educational and cognitive behavioral components yielded significant reductions in symptom frequency and intensity after 4 – 6 weeks.”
Support for partners

- Ongoing demands to run the house, care for the new baby, the mother and other children
- Jealousy
- “…Marital problems which appear to have emanated from PPD often persist long after symptoms are abated…”
  - Hickman, (1982)
Self Help and Clinical Resources

- **PPD Helpline**, 1-800-328-3838
- **Crisis Hotline**, 1-877-294-HELP
- **Postpartum Support International**, 1-805-967-7636
  - [www.postpartum.net](http://www.postpartum.net)
- **NJ Self Help Clearinghouse**, 1-800-367-6274 or [http://www.njgroups.org](http://www.njgroups.org)
- **National Institute of Child Health and Human Development**
  - [http://Postpartum.nichd.nih.gov](http://Postpartum.nichd.nih.gov)
- **Womenshealth.gov; The Federal Government Source for Women’s Health Information**, 1-800-994-9662 or [http://4woman.gov/faq/postpartum.htm](http://4woman.gov/faq/postpartum.htm)
Postpartum Depression WEBSITE

http://www.njspeakup.gov
“I couldn’t snap out of it. I was so down. I had a knot in my stomach. I kept wringing my hands. Sometimes I held my head, knowing that at any second, it was going to explode. I was petrified to get up with my baby. I would cry at the drop of a hat. I was afraid I would lose my temper. I felt guilty because I couldn’t control myself. I couldn’t bring myself to eat I had to force myself to chew. I couldn’t sleep even though I was exhausted.”
Key Points

- Perinatal mood disorders (excluding “blues”) are highly prevalent and serious
- They can have serious negative effects on the family system, not only the mother
- Pediatric clinicians are the professionals who have the most contact with parents and children
- The Edinburgh screening tool helps recognize women at risk for depression
- Pediatric clinicians and their staff are in a unique position to recognize, respond and intervene
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