Identification of Mothers at Risk for Postpartum Depression by Hospital-Based Perinatal Nurses

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Abstract

In the western world, most women deliver their infants in a hospital setting. The purposes of this article are to provide guidelines and suggest best practices related to hospital-based care for postpartum depression by perinatal nurses; with this information, policies, procedures, and educational programs can be implemented to improve nursing care of new mothers. Hospital-based perinatal nurses need to "launch" new mothers from the hospital into the community so that the new mothers are prepared for self-monitoring for symptoms of depression, and know what steps to take if they do experience depressive symptoms.

Keywords: Acute maternity care; Hospital; New mothers; Perinatal nurses; Postpartum depression

Postpartum depression (PPD) is a common experience for approximately 13% of new mothers internationally (Gavin et al., 2005). The symptoms are usually experienced by women by 4 to 6 weeks postpartum (American Psychological Association [APA], 2000). Risk factors for PPD include stress, low socioeconomic status, low levels of social support, a previous history of depression, and unexpected birth outcomes (Beck, 2001; Logsdon & Davis, 2003; Vigod, Villegas, Dennis, & Ross, 2010). PPD has an adverse and long-lasting impact on the woman's relationships, functioning, development, and her ability to mother her infant (Beck, 1998; Logsdon, Wisner, & Hanusa, 2009).

In the western world, most women deliver their infants in a hospital setting. Hospital-based perinatal nurses have extended contact with new mothers for 2 to 3 days. This provides a unique opportunity to identify new mothers with risk factors for PPD, link them with available healthcare services, and provide them with tools and resources needed if PPD does occur. Few studies have provided evidence related to nursing care for PPD that women receive while hospitalized including identification of depression risk factors, depression screening, patient education, and referrals. In terms of patient education, pamphlets about PPD may be included in educational packets sent home (Garg, Morton, & Heneghan, 2005), but little attention is paid to the preferred learning style of new mothers (Summers & Logsdon, 2005; Wisner, Logsdon, & Shanahan, 2008). Hospital maternity nurses may not feel confident to actively teach mothers about PPD (Logsdon, Pinto Foltz, Scheetz, & Myers, 2010) as few have received formal education related to care of women with PPD. The purposes of this article are to provide guidelines and suggest best practices related to hospital-based care for PPD by hospital-based perinatal nurses; with this information, policies, procedures, and nursing staff educational programs can be implemented to improve nursing care of new mothers. We begin with a discussion of PPD risk factors, provide an overview of depression screening tools and related disorders that may be confused with PPD during screening, outline key points in patient education, and conclude with recommendations for policy and procedures and an example of a family teaching plan.

Identification of Risk Factors and Screening Women for PPD

Risk factors for PPD include stress, low socioeconomic status, low levels of social support, a previous history of depression, and birth complications such as preterm birth that results in separation of mother and baby (Beck, 2001; Logsdon & Davis, 2003; Vigod et al., 2010). Before symptoms are readily identifiable by healthcare professionals, beginning signs of PPD may be present in mothers early in the postpartum period. Screening is the most widely used method for early detection. However, it should be noted that a positive screening result does not always equate to possessing the targeted condition, as screening procedures *are not* diagnostic. In addition, the value of a nurse's intuition that "something is just not right" cannot be overemphasized.

Importance of Depression Screening

Research has consistently demonstrated maternal mood in the immediate postpartum period (e.g., first 2 weeks postpartum) is a significant predictor of PPD (Beck, 2001) and confirms the need for heightened awareness in the early postnatal period. In a meta-analysis of 85 studies (Beck, 2002a), "maternity blues" was a significant predictive factor of PPD, further confirming these preceding studies that depressive symptoms in the immediate postpartum period are important.

Two-Phase Depression Screening to Increase Accuracy of Early Identification

There is growing evidence to suggest that a single screen for PPD in the early postpartum period has a high false-positive rate (Dennis et al., 2009), indicating that a two-stage process is required to increase screening accuracy. For example, any women who scores positive for depressive symptomatology in the first few days after birth should be screened again to confirm the depressive symptomatology. Although there is no research suggesting the best time to perform the second screen, waiting 2 weeks would be consistent with diagnostic criteria, which suggests the presence of depressive symptoms almost every day for at least a 2-week period. This second screen can be performed over the telephone to decrease resource implications or in community agencies to which the postpartum woman is referred.

Screening Tool to Identify PPD Risk Factors

The Postpartum Depression Predictors Inventory—Revised (PDPI-R) consists of 13 risk factors related to PPD. The first 10 items are risk factors that can be assessed during pregnancy and comprise the Prenatal Version of the PDPI-R: marital status, socioeconomic status, prenatal depression, prenatal anxiety, unplanned/unwanted pregnancy, history of depression, social support, marital/partner satisfaction, and life stress. After a woman gives birth, the last three predictors (child care stress, infant temperament, and maternity blues) can be assessed. The PDPI-R can be administered via an interview conducted by a clinician (Beck, 2002b) or as a self-report inventory (Beck, Records, & Rice, 2006).

Measures for Current Depression Symptomatology

Postpartum Depression Screening Scale

The Postpartum Depression Screening Scale (PDSS) is a 35-item self-report instrument (Beck & Gable, 2005). The scale indicates the severity of PPD symptoms and

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whether a mother needs to be referred for a diagnostic evaluation. The PDSS consists of seven dimensions or subscales: Sleeping/Eating, Disturbance, Anxiety/Insecurity, Emotional Lability, Mental Confusion, Loss of Self, Guilt/Shame, and Suicidal Thoughts. These individual dimension scores help clinicians to know which symptoms of PPD a mother is struggling with. With a cutoff score of 80, the PDSS achieved a sensitivity = .94 and specificity = .98 for major depression criteria.

Edinburgh Postnatal Depression Scale

One of the most widely used instrument to assess for postpartum depressive symptomatology is the Edinburgh Postnatal Depression Scale (EPDS), a 10-item self-report scale specifically designed to screen for PPD in community samples (Cox, Holden, & Sagovsky, 1987). The items include questions related to maternal feelings during the past 7 days and refer to depressed mood, anhedonia, guilt, anxiety, and suicidal ideation. One advantage of this scale is that it does not include common somatic symptoms such as insomnia and appetite changes, which may occur naturally in postpartum women. Although a 12/13 cutoff is suggestive of major depressive symptomatology, a lower threshold of 9/10 has been recommended for community screening to ensure all potential cases of PPD are identified (Murray & Carothers, 1990). Importantly, researchers have consistently found the EPDS to be (1) convenient to administer (requires little time or special training and can even be done via telephone), (2) inoffensive to women (high acceptability in diverse cultures), (3) readily incorporated into everyday clinical practice, and (4) widely available at no cost.

Detecting Related Disorders

Since the Andrea Yates' tragedy, PPD has received increased attention from clinicians, researchers, and legislators. PPD, however, is not the only mental disorder that can plague new mothers. It is important to differentiate PPD from these other postpartum disorders so that mothers will not be misdiagnosed and receive inappropriate treatment. Symptoms of the disorders discussed below should result in immediate psychiatric consultation.

Postpartum Psychosis

Postpartum psychosis can have grave consequences for a mother and her infant, including suicide and infanticide. Symptoms can include hallucinations, delusions, confusion, extreme agitation, rapid mood swings, and inability to sleep or eat. The delusions and hallucinations are perceived as consistent with the mother's reality. She is not distressed by thoughts of harming her infant and can act on these thoughts (Wenzel, 2011). Psychotic mothers frequently believe they need to harm their baby so that the baby can be saved.

Postpartum Bipolar II Disorder

This disorder has been called the PPD imposter (Beck & Driscoll, 2006). Hypomanic episodes are key components of this disorder. A hypomanic episode is defined as a distinct period of "persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days" that occurs within 4 weeks after birth (APA, 2000). Common symptoms can include decreased sleep, increased self-esteem, increased talkativeness, and increased goal orientation.

Postpartum Panic Disorder

A panic attack is the cardinal symptom of this postpartum anxiety disorder. Panic attacks are distinct periods of intense fear, which may involve symptoms such as sweating, heart palpitations, shortness of breath, chest pain, numbness, dizziness, sense of impending doom, fear of going crazy, and losing control.

Postpartum Obsessive–Compulsive Disorder

In this anxiety disorder mothers experience obsessive thoughts and/or compulsive behaviors. Obsessions are recurrent thoughts or images that are intrusive, such as harming their infant, and can result in distress. Mothers try to remove or stop these images and thoughts but to no avail. Compulsions are repetitive thoughts or actions that mothers perform in response to an obsession to decrease distress or stop a horrible event from occurring (APA, 2000). In obsessive–compulsive disorder (OCD) these intrusive thoughts a mother can have of harming her baby are not consistent with her reality (Wenzel, 2011). She is horrified that she can even have such thoughts and does not want to share them with others. A mother with OCD does realize that her obsessions and/or compulsions are not reasonable. Unlike psychotic mothers, OCD mothers are unlikely to act on these thoughts.

Posttraumatic Stress Disorder Due to Childbirth

Traumatic childbirth is "an event occurring during the labor and delivery process that involves actual or threatened serious injury or death to the mother or her infant." The birthing woman experiences "intense fear, helplessness, loss of control, and horror" (Beck, 2004, p. 28).

Posttraumatic stress disorder (PTSD) is composed of three symptom clusters: (1) reexperiencing the traumatic event through flashbacks and nightmares; (2) avoidance of triggers of the trauma, and (3) hyperarousal, which can include exaggerated startle response, anger, or sleep disturbance (APA, 2000).

Education of Women About PPD

A major maternal help-seeking facilitator is education about PPD (Dennis & Chung-Lee, 2006). Further, women feel that any open discussion about PPD may help reduce the stigma associated with this condition and promote help-seeking (Mauthner, 1997).

Preferred Learning Styles of New Mothers

Some women prefer to obtain health information from Web sites rather than to read printed handouts. Summers and Logsdon (2005) reviewed 34 Web sites on PPD for content, ease of use of technology, and readability. The information was only complete and accurate in 14.7% of the Web sites. All Web sites had reading levels of 8th grade or higher, instead of the recommended reading level of 5th grade or lower to be appropriate for all populations of new mothers (Logsdon & Hutti, 2006). Hospital-based perinatal nurses should recommend Web sites that have been evaluated for accurate content and appropriate reading level (e.g., www.MedEdPPD.org). Hospitals with rich information technology resources may want to consider developing an educational program that includes Facebook, text messages, and their own Web site.

Barriers to PPD Identification and Treatment to be Addressed in Patient Education

Many women with PPD are not identified and do not receive depression treatment. Barriers to treatment can be categorized into personal, family, healthcare provider, healthcare system (Sobey, 2002; Wisner, Parry, & Piontek, 2002), and society/community barriers (Sealy, Fraser, Simpson, Evans, & Hartford, 2009). In their assessment, nurses should identify the barriers that are specific to each woman (e.g., risk factors for PPD, depression screening results, and family and professional barriers in specific community and individualize the teaching plan to overcome these barriers). Discharge education on PPD has been effective in reducing depressive symptoms in at least one research study (Ho et al., 2009).

Personal Barriers

Women from diverse cultures do not proactively seek help for PPD (Dennis & Chung-Lee, 2006). Many women have difficulty understanding the problems they are experiencing, often assuming their struggles are a normal part of motherhood and reasonable response to adversity (Edge, Baker, & Rogers, 2004). For women who recognize that they are experiencing PPD, many are unwilling or unable to disclose their feelings to partners, family members, friends, and healthcare professionals (Amankwaa, 2003; Mauthner, 1997; Nahas & Amasheh, 1999). Many mothers report not knowing where to obtain assistance or being unaware of treatment possibilities (Dennis & Chung-Lee, 2006). Some mothers consider professional or medical assistance as inappropriate for treating emotional problems (Thome, 2003) and that the role of healthcare professionals is to provide physical care (Parvin, Jones, & Hull, 2004).

The fear of losing one's baby is a major help-seeking barrier (Mauthner, 1999; Shakespeare, Blake, & Garcia, 2003; Templeton, Velleman, Persaud, & Milner, 2003). Shame, stigma, and the fear of being labeled mentally ill are also significant factors in whether women decided to seek or accept help (Dennis & Chung-Lee, 2006). Some depressed mothers refuse to seek treatment due to perceived insufficient time and the inconvenience of attending appointments. In some cultures, depression is a sign of internal weakness and not a legitimate illness. The importance of fulfilling traditional gender roles is also found among some cultures resulting in women not informing anyone about their emotional problems for fear of failing to perform their role as a woman and mother (Parvin et al., 2004). Clinical practice guidelines are available to address PPD education plans in culturally diverse women (Callister, Beckstrand, & Colbert, 2010).

Family and Friends Help-Seeking Barriers and Facilitators

Research suggests that family members are often unable to provide assistance or promote help-seeking due to a lack of understanding about PPD. However, in some cultures family members may actively discourage women from obtaining help, as it is unacceptable to admit to depressive symptoms or discuss such difficulties external to the family context (Dennis & Chung-Lee, 2006). For example, among Arabic women the family is the reference for assistance and mediates between the mother and the outside world (Nahas & Amasheh, 1999). In the Korean culture, having and raising children is a key family function; accordingly, any concern about the mother rapidly mobilizes resources as the whole family works together to resolve the crisis. An attempt should be made to include family in teaching about PPD if appropriate.

Healthcare Professional Help-Seeking Barriers and Facilitators

Healthcare professionals play a salient role in either promoting help-seeking behaviors or hindering the obtainment of treatment since research suggests that depressed mothers may be high utilizers of health services (Dennis, 2004). Significant PPD treatment barriers include inappropriate assessments paralleled with an insufficient knowledge about PPD (Mauthner, 1997; Thome, 2003). Access to healthcare is a barrier for some women (Amankwaa, 2003). Several qualitative studies suggest that healthcare professionals had a

Table 1. Policy/Procedure

Purpose:

To provide nursing guidelines for assessment, education and referral of patients for postpartum depression (PPD).

Policy Statement:

During the admission process, the registered nurse will assess all obstetric patients for risk factors for PPD and suicide which include but are not limited to: low socioeconomic status, low level of social support, and previous history of depression.

Departments Affected:

OB Complex

Guidelines:

Admission and inpatient

1. Risk factors for PPD and suicide will be identified and documented by the RN as noted in the admission assessment/ psychosocial assessment.
2. If a patient is identified to be at risk for suicide, this will be reported immediately to the obstetrical physician and also to oncoming staff during report.
3. If a patient is identified to be at risk for PPD, this will be reported to the obstetrical physician and also to oncoming staff during report.
4. Awareness of culture and ethnic background is important to include as part of the admission assessment for PPD risk factors. For information regarding various cultures and ethnicities, please refer to the Diversity Community website as well as the reference text on each unit entitled: *Guide to Culturally Competent Health Care* (2009, 2nd ed.) by Larry D. Purnell.

Postpartum

- All postpartum patients will be screened the **evening prior to anticipated discharge** for PPD by the RN utilizing the Edinburgh Postnatal Depression Scale (EPDS). (See attached). If the score on the Edinburgh Scale is 13 or greater, the patient is at risk for depression. The higher the score, the greater the risk.
- If the patient is identified to be at risk based on risk factors and EPDS, the nurse will communicate this to the obstetrical physician, social services and the oncoming nurse during shift report.
- The RN who administered the EPDS will review the results of the screen with the patient and their support persons along with discussion of symptoms, how to self monitor symptoms, steps to take if experiencing symptoms of depression and sources of help in the community.
- The RN will give the patient a list of resources in the community as well as a hospital brochure to reinforce education and referral.

Resources include:

- www.mededppd.org
- AWHONN/The role of the nurse in postpartum mood and anxiety disorders. Position Statement. June 2008.
- http://www.postpartum.net/Get-Help/Support-Resources-Map-Area-Coordinators/PSI-Locations-United-States/PSI-Kentucky.aspx
- Community Specific Mental Health facility
- County Health Department
- Healthy Start Mental Health Services
- Suicide hotlines

Note. Based on information from American College of Obstetricians and Gynecologists (2010), Association of Women's Health, Obstetric and Neonatal Nurses (2008), and McQueen et al. (2008).

tendency to normalize depressive symptoms and to dismiss them as self-limiting (Mauthner, 1997), while other studies reported that women felt their depressive symptoms were given only cursory attention (Amankwaa, 2003). Not surprisingly, when healthcare professionals minimized a mother's feelings and symptoms she became reluctant to pursue treatment (Edge et al., 2004). A U.S. qualitative study found that after depressed mothers made the decision to seek professional help, they felt disappointment, frustration, humiliation, and anger due to their interactions with healthcare professionals (Beck, 1993). In another qualitative study, Australian mothers felt that their physicians displayed disinterest and "patronizing attitudes," which increased their feelings of worthlessness and guilt in their inability to cope. They also described dissatisfaction with their hospital doctors and family physicians claiming they had limited time for counseling and preferred to prescribe medication that alleviated symptoms but reinforced feelings of inadequacy.

Comparably, women in the United Kingdom (UK) complained that (a) there was insufficient time in their consultations with their general practitioner, (b) their problems were not taken seriously, (c) they were not examined properly, and (d) they were not referred to secondary services as necessary (Parvin et al., 2004). Lack of language support services further contributed to some of these women not seeking help. Language barriers were also an obstacle for UK women in Black and minority ethnic communities (Templeton et al., 2003).

Women need individualized care from healthcare providers that is nurturing, identifies their risk factors for PPD, and gives them the tools and resources to obtain healthcare that they need after hospital discharge. Hospital-based perinatal nurses are the key members of the healthcare team

to fulfill these roles and to prepare women to overcome barriers that they will likely encounter.

Obtaining Support and Healthcare for PPD After Hospital Discharge

Women should be encouraged to take care of themselves by eating well-balanced diets, drinking a lot of water, and resting as much as possible. Fatigue has been found to exacerbate PPD (Bozoky & Corwin, 2002). National groups such as Postpartum Support International and LaLeche League are invaluable sources of accurate information and support. For women with PPD, a clinical disorder, this support will not be sufficient and they will need to seek treatment.

Community Resources

Hospital-based perinatal nurses should be knowledgeable about the mental healthcare that is available in the community for women with PPD. Case managers and social workers frequently can provide this information. Antidepressant therapy and counseling are generally effective for treatment of PPD, but not all mental health providers can offer both. For example, clinical psychologists and psychiatric social workers generally are unable to prescribe medications. Psychiatrists and advanced practice nurses may prescribe and monitor medications but may not offer counseling.

Each community will differ in terms of healthcare providers who have expertise and are available to treat women for PPD. In the United States, the rules for referral to specialty practices (mental health) vary by the source of reimbursement. Some insurance plans require that primary care providers must refer woman to mental health providers. Other plans allow women to self-select into mental health providers within the network system. For low-income women without healthcare insurance, a Medicaid application for mental health services is required. In some communities, programs for low-income women such as Healthy Start provide mental health services in the woman's home or neighborhood as part of overall services provided. Table 1 provides an example of a PPD policy and Table 2 is a teaching plan.

Conclusions

Hospital-based perinatal nurses need to launch new mothers from the hospital into the community. With education new mothers will be prepared for self-monitoring for symptoms

Table 2. Case Study With Sample Discharge Teaching Plan to Address PPD

Subjective Assessment:

Dakota Smith is an African American, 18-year-old high school senior, who delivered a healthy 7-lb baby boy 2 days ago. Her birth was uncomplicated, and she expresses that she is happy with her birth experience and her labor nurse. She has no history of mental illness. Dakota is unmarried and has no relationship with the baby's father. She states that her best friend, Lamar Joseph McCauley, and her mother are her constant and positive sources of support. Dakota is enrolled in a public school and will graduate next semester. Her maternity costs are covered by Medicaid, but she is not enrolled in state or federal programs for pregnant and parenting women and their babies. Dakota has child care experience with her two younger siblings and appears to be comfortable handing the baby. She has no plans yet for child care for when she returns to school. Dakota uses the city bus system for most transportation. She is most comfortable obtaining health information from the Internet, but she is not familiar with the American Academy of Pediatric, or other professional organizations.

Objective Assessment:

No apparent distress. Smiles and talks to baby and handles him easily. EPDS score is 3, indicating no significant symptoms of depression at this time. Risk factors include low socioeconomic status, no support from baby's father, no previous use of state, and federal support programs or teen pregnancy programs.

Intervention:

Dakota's teaching plan included the following:

1. Use Web sites for health information that are based upon the highest levels of evidence such as the American Academy of Pediatrics, MedEdPPD.org, and Postpartum Support International. Note that new Web sites that profile personal experiences of other adolescent mothers may have inaccurate information if they are not led by healthcare professionals.
2. Review results of EPDS score and describe PPD. Recommend that Dakota repeat the test at home at 2 weeks postpartum and notify her obstetric or pediatric healthcare provider if her scores equal or exceed 13, if she feels exceptionally sad or has trouble functioning. If she feels that she is threat to herself or her baby, she should seek help from her support providers and her healthcare providers immediately.
3. Recommend state and federal programs that provide support for new mothers, such as Healthy Start.
4. Provide phone numbers and names of community agencies that are available for assistance, e.g., Teen Parent Programs.

Evaluation:

Dakota's mother and her best friend, Lamar, were present during teaching at her request. Dakota, her mother, and Lamar all state that they understand the symptoms of PPD, and they are familiar with community resources and contact information.

Note. Names of all individuals are fictitious.

Hospital-based perinatal nurses need to launch new mothers from the hospital into the community so that the new mothers are prepared for self-monitoring for symptoms of depression, and know what steps to take if they do experience depressive symptoms

of depression and know what actions to take if they experience depressive symptoms. Some hospital-based nurses may decide to go further to promote the mental health of new mothers. In some communities, hospital nurses have been involved with community-wide task forces to educate healthcare providers about PPD, to help identify women who might be affected by PPD, and to develop interventions to help women to adjust to the role of mother (Straub et al., 1998; Wroblewski & Tallon, 2004). Internationally, nurses screen women for PPD and offer counseling to those with high scores (Cowley, Caan, Dowling, & Weir, 2007), and women in the United States find screening and counseling by nurses to be acceptable (Segre, O'Hara, Arndt, & Beck, 2010). Perinatal nurses who do not feel comfortable with identifying risk factors for depression, conducting depression screening, or preparing the new mother for depression care in the community should seek professional development opportunities. Although the Registered Nurses' Association of Ontario (2005) previously published a best practices guideline entitled Interventions for Postpartum Depression, the practice recommendations did not focus on the first few days postpartum or nursing care while the woman was hospitalized. Thus, our recommendations for nursing practice of hospital-based perinatal nurses go beyond previous published guidelines. ✣

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