Postpartum Depression: Who is Checking In with Supermom?

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Abstract: One in seven women in the United States experience postpartum depression (PPD). However, despite general awareness of this condition many cases are not identified or treated. Left untreated, postpartum depression may become severe, affecting not only the mother, but also her family—most notably her child's development and health. A major question is who will screen women for PPD? Medical professionals may or may not ask a new mother about depressive symptoms (either formally via questionnaire or informally in conversation), and mothers may or may not answer these questions truthfully. This research evaluated the current state of PPD screening in Harrisonburg, Virginia, by surveying local mothers who have experienced PPD as well as local medical professionals (pediatricians, ob-gyns, midwives, primary care physicians, and nurses). It was found that PPD screening procedures can be improved in Harrisonburg.

Keywords: Postpartum Depression, Supermom, PPD

There's no question that motherhood has been in the media spotlight over the last few years. *Time* magazine asked mothers, "Are you mom enough?" (Pickert, 2012) and showcased attachment parenting; Sheryl Sandberg's *Lean In* (2013) asked mothers to step it up in the workplace; Amy Chua's *Battle Hymn of the Tiger Mother* (2011) emphasized Chinese authoritarian parenting methods as the key to a child's success, and Pamela Druckerman's *Bringing up Bébé* (2012) said children get ahead when they emulate the French way of life. It is obvious that in modern society, mothers are under an incredible amount of pressure.

Childbearing is no exception. New moms wonder, should I breastfeed or use formula? Co-sleep or sleep-train? Vaccinate or not vaccinate? Use cloth diapers or Huggies? Make homemade, organic baby food or buy Gerber's? With these impossibly high standards—what some might call "supermom" standards—some sort of depression or anxiety is a given, particularly if mom is working, single, has other kids at home, had a traumatic childbirth experience, or has a baby who is ill. But there's one thing we haven't factored in yet: hormones.

A pregnant woman lives for almost 10 months with significantly increased levels of estrogen and progesterone; once she gives birth, it takes less than 24 hours for those levels to plummet (U.S. National Institute of Health, 2014). For many women, this sudden, drastic change leads to depression. For some, it might be the "baby blues," which fade away after a few tearful, desperate days of adjusting to life with a newborn. But for one in seven mothers (Wisner et al., 2013)—even "supermoms"—the depression does not go away, it gets worse. Baby is not sleeping; mom is not sleeping. Mom does not feel supported. This isn't what she thought motherhood would look like, and so she feels overwhelmed and anxious and guilty about all of it. "Supermom" has been hit with postpartum depression but chances are no one knows this, because no one asks. The doctors stopped asking when her baby was 6 weeks old, and that was months ago. She's afraid to bring it up with her friends and definitely can't talk about it at a mom's group, where she has carefully orchestrated the way she presents herself as a parent. And so now, she suffers in silence.

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While postpartum depression (PPD) is the most common complication of childbirth, many cases remain undiagnosed—up to 50 percent according to one study (Thurgood, Avery, & Williamson, 2009). According to research, there are two reasons for this: 1) physicians' inconsistent PPD screening methods and 2) mothers' fears about social acceptability (Thurgood et al., 2009). The purpose of this research was to explore these barriers in one area of the United States: Harrisonburg, Virginia.

To uncover screening methods, I surveyed and interviewed local medical professionals (ob-gyns, midwives, nurses, pediatricians, and family physicians) about their practice's PPD screening procedures. To look at mothers' fears, I surveyed and interviewed women in Harrisonburg about their experiences with and perceptions of PPD and PPD screening. My hope is that, with this research, both local mothers and the medical community can more effectively talk about this very common—and very treatable—condition.

Literature Review

Definition and Symptoms of Postpartum Depression

Postpartum depression is most commonly defined as depression experienced by a mother following childbirth, typically arising from a combination of hormonal changes, psychological adjustment to motherhood, and fatigue (U.S. National Library of Medicine, 2013). The National Institute of Health (NIH) explains the symptoms of postpartum depression as the same as symptoms of depression that occurs at other times in life, and may include any of the following: sad or depressed mood, irritability, changes in appetite, feeling worthless or guilty, feeling withdrawn or unconnected, lack of pleasure or interest in most or all activities, loss of concentration, loss of energy, problems doing tasks at home or work, significant anxiety, thoughts of death or suicide, and trouble sleeping (U.S. National Institute of Health, 2014). In the Diagnostic and Statistical Manual of Mental Disorders 5th Edition, PPD is labeled a major depressive episode with peripartum onset, with 50 percent of PPD cases actually beginning during pregnancy (American Psychiatric Association, 2013).

It is important to distinguish PPD from postpartum psychosis, which is a rare, acute, and psychotic episode that often begins in the first two weeks after delivery (Sit, Rothschild, & Wisner, 2006) and includes thoughts of infanticide/homicide, as exemplified by Andrea Yates of Texas, who killed her 5 children in a PPD psychotic episode. Additionally, PPD is different from other depressive disorders in that it is marked by anxiety (Gilibrand, 2012). PPD is also different from the postpartum blues, or "baby blues," a common (experienced by 40-80 percent of women) mood disturbance that occurs three to five days after childbirth (O'Hara & McCabe, 2013). The baby blues typically result in feelings of anxiety, irritation, tearfulness, and restlessness (U.S. National Institute of Health, 2014). However, the DSM-V notes that the baby blues may increase a woman's risk for a postpartum major depressive episode (American Psychiatric Association, 2013).

Timing of PPD

While the definition of PPD is relatively consistent, the timeframe when it may occur is not. The DSM-V specifies the condition as occurring during pregnancy or in the four weeks after delivery (American Psychiatric Association, 2013); however, other research shows that PPD may occur soon after delivery or up to a year later (O'Hara & McCabe, 2013, Association of Women's Health, Obstetric, and Neonatal Nurses, 2008). In a study by Stowe, Hostetter, and Newport (2005), one-third of the women evaluated experienced postpartum depression after their child was six weeks old.

Physicians are also noticing late onset PPD, occurring in women who develop symptoms of PPD after weaning their child, which may be up to three or four years after childbirth for some (State of New Jersey Department of Health, 2012). Overall, the research showed that it is important to evaluate a mother for PPD throughout the first several years of her child's life.

Risk Factors

According to O'Hara and McCabe (2013), many women enter the postpartum period with clearly identifiable risk factors. Women who have experienced previous depression (particularly previous PPD),

stressful life events, current conflict with their partner, and are lacking social support are more likely to experience PPD (Dennis, Janssen & Singer, 2004; O'Hara & McCabe, 2013). Additionally, women who experience pregnancy- and childbirth-related health issues are more at risk. In a study of 4,940 women, those experiencing a range of complications including pre-eclampsia, prenatal hospitalization, and emergency cesarean section were more likely than other women to score in the clinical range on the Edinburgh Postnatal Depression Scale (EPDS) at two months postpartum (Blom et al., 2010). Other factors include low socioeconomic status, low maternal confidence in infant care at time of discharge, substance abuse, and difficult infant temperament (Vik et al., 2009, as cited in O'Hara & McCabe, 2013).

In the largest study of PPD to date (Wisner et al., 2013), 10,000 mothers who gave birth at a Pittsburgh hospital were screened for PPD. This was also the only study in which women who showed signs of depression were given a full psychiatric evaluation (Wisner et al., 2013). The study revealed that 30 percent of the women who showed signs of depression after delivery had experienced an episode of the condition before pregnancy, 40 percent had one during pregnancy, and more than two-thirds of the women also had signs of an anxiety disorder, the symptoms of which are not often associated with depression. Additionally, 20 percent of the women were diagnosed with bipolar disorder, a condition that can be worsened by antidepressants, which are often prescribed for women experiencing PPD. According to Wisner et al., this indicates a big change for medical professionals who work with pregnant women and new mothers; healthcare providers should be looking for a more complex set of symptoms instead of just one depressive episode in order to identify women who need help. They also assert that screening initiatives should be accompanied by accessible and effective treatment.

Screening Tools

In the literature, two screening tools were most commonly cited: the Edinburgh Postnatal Depression Scale (EPDS) and the PHQ-2 questionnaire. The EPDS, a 10-question, multiple-choice self-rating scale, was viewed as the most successful screening tool because it explores both depression and anxiety (Hanusa, Scholle, Haskett, Spadaro, & Wisner, 2008). In the U.S. the PHQ-2 is the most commonly used screening tool (Hanusa et al., 2008); however, it does not address anxiety, which researchers considered a "major flaw" (PPD is marked by a prominent anxiety component) and may be why so many cases of PPD are missed (Hanusa et al., 2008).

The Importance of Postpartum Depression Screening

For the sake of the mother.

In some cases, women may experience depression or anxiety for the first time in their life after childbirth. This represents a unique opportunity to recognize and treat these symptoms in such women, who may have more contact with a medical professional (including the benefit of health insurance) than at other times in their life (Wisner et al., 2013). Additionally, it is important to recognize symptoms of PPD since a woman's risk of recurring PPD with subsequent children is estimated at 50-100 percent.

Lastly, suicide accounts for 20 percent of postpartum deaths and is the second most common cause of death in postpartum women (Wisner et al., 2013). The American Academy of Family Physicians (AAFP) recognized that "because suicide is a leading cause of maternal death, physicians should ask women suspected of having postpartum major depression about suicidal ideation" (Hirst & Moutier, 2010). The AAFP notes that although a mother with active or passive suicidal ideation may cite her infant or family as a reason not to harm herself, as depression worsens, she may view herself as a bad mother and believe that her child would be better off without her (Hirst & Moutier, 2010).

For the sake of the child.

The detection of PPD has extensive consequences for the well-being of children. Across the literature, PPD is attributed to negative maternal-infant interactions and a mother's negative perceptions of infant behavior, which results in attachment insecurity, emotional development delay, and social interaction difficulties (Dennis et al., 2004). Freeman et al. (2005) states that infants of mothers who have

experienced PPD are more likely to develop insecure attachments and behavioral problems, as well as decreased cognitive abilities. Additionally, mothers with PPD are less likely to engage in preventive health measures for their babies, such as using a car seat and covering electrical outlets (McClennan & Kotelchuck, 2000).

Healthcare Providers' Opinions on Screening

Ob-gyns

Currently, women may be screened by their obstetrician at their six-week postpartum visit; however, this is not a universal mandate. In 2010, the American College of Obstetricians and Gynecologists (ACOG) held that there was "insufficient evidence to support a firm recommendation" (p. 1) for universal screening for depression (American College of Obstetricians and Gynecologists' Committee on Obstetric Practice, 2010). However, the committee noted the potential benefits of screening and said that women experiencing depression in the past or present warranted "close monitoring and evaluation" (p. 2). This opinion was reaffirmed in 2012.

Pediatricians

The American Academy of Pediatrics' (AAP) Committee on Psychosocial Aspects of Child and Family Health recommended that pediatricians screen mothers for PPD at their baby's one-, two-, and four-month visits (Earls, 2010). The AAP held that pediatricians "can establish a system to implement postpartum depression screening and to identify and use community resources for the treatment and referral of the depressed mother and support for the mother-child (dyad) relationship" (p. 1032). The AAP decreed that this system would "have a positive effect on the health and well-being of the infant and family" (p. 1032).

Primary care physicians

The American Academy of Family Physicians (AAFP) noted the opinion of ACOG, yet offered physicians advice and strategies for screening women for PPD **(**Hirst & Moutier, 2010). The AAFP stated that women with PPD are less likely to report feeling sad, but have notable feelings of guilt or worthlessness, and a lack of interest in activities that would usually make them happy. It suggested asking a mother "whether she can sleep when her infant sleeps at night" (p. 928) to clarify her symptoms, since many women with PPD have difficulty staying or falling asleep (Hirst & Moutier, 2010).

Nurses

According to the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN), a significant factor in the duration of PPD is the length of delay to treatment. AWHONN held that even if a new mother does not show signs of PPD in the early postpartum months, she may develop PPD within the first year after the birth of her baby; therefore, the organization recommends that during the first year after delivery, screening mechanisms should be available in all health care facilities where new mothers typically may be—including obstetric, neonatal, and pediatric settings (Association of Women's Health, Obstetric, and Neonatal Nurses, 2008).

Midwives

The American College of Nurse-Midwives (ACNM) (2002) recommends the "NURSE" approach in recognizing and treating PPD: Nourishment, Understanding, Rest & Relaxation, Spirituality, and Exercise. The National Association of Certified Professional Midwives (NACPM) stated that NACPM members offer care, education, counseling, and emotional support to women and their families from pregnancy through the postpartum period. It held that midwives are "trained to recognize abnormal or dangerous conditions needing expert help outside their scope and should have a plan for consultation and referral when these

conditions arise" (National Association of Certified Professional Midwives, 2004).

Obstacles/Barriers to Screening and Diagnosis

In a study of women 3-36 months postpartum, participants reported barriers such as stigma and fear, as well as lack of provider knowledge and skills regarding depression (Byatt, Biebel, Friedman, Debordes-Jackson, & Ziedonis, 2013).

Stigma

Because childbirth is supposed to be a happy life event, many mothers may feel ashamed or guilty about being depressed in the context of having a new baby (Freeman et al., 2005; O'Hara & McCabe, 2013). The Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) (2008) also recognizes this, stating, "Many new mothers are reluctant to admit that they are not experiencing motherhood's idealized standard of perfection, complicating the ability to express all of their feelings —including negative emotions—about their role as mothers" (p. 2). According to Thurgood et al. (2009) the majority of undiagnosed cases of PPD are likely due to the social stigma of being labeled an "unhappy mother." While women may accept they are depressed after scoring as such during screening, they reject the term "postpartum depression" because this implies that their feelings are caused by their babies. Adding to this is the idealized societal portrayal of motherhood **(**Thurgood et al., 2009**)**; when mothers don't experience this ideal, they may feel shame, guilt, and embarrassment. Instead of seeking treatment, depressed mothers hide their distress or minimize their symptoms and continue to suffer in silence (O'Hara & McCabe, 2013).

Fear

Particularly in the pediatric setting, mothers may hide symptoms of PPD because they are afraid their child will be removed (Byatt et al., 2013; O'Hara & McCabe, 2013; Brealey et al., 2010). In one study (Byatt et al., 2013) many women said they felt pediatricians would notify Child Protective Services if they said they felt depressed. As a result they were more guarded and defensive about mental health concerns. Some avoided pediatric visits altogether. Others felt like they had to "hold it together" at well-baby visits in order to appear competent (Byatt et al., 2013). In research conducted by Brealey and colleagues (2010), women in four studies reported that they deliberately lied on PPD screening questionnaires for fear of answering questions honestly (Alder, 2007). Without completely re-working the way the healthcare system works with expectant mothers, Byatt et al. (2013) suggest that pediatricians become better educated about how to more openly discuss mothers' health in a non-threatening way.

Many postpartum women also fear current treatment methods of PPD, particularly the use of antidepressants and the transmission of medication to infants while breastfeeding (O'Hara & McCabe, 2013). This hesitancy hinders disclosure. If risks and outcomes of such scenarios were broadly known or available in a resource guide for mothers, it might allow the mother to speak more freely to their healthcare provider (Gilibrand, 2012).

Physician competence

Even the most informed physicians may not attribute symptoms of depression in new mothers to PPD, instead assuming they are result of new motherhood and the changes that come with it (Freeman et al., 2005). In a study (Byatt et al., 2013) of mothers' attitudes and perceptions toward pediatricians, some women felt that pediatricians invalidated and minimized the transition to motherhood. Pediatricians were also perceived to lack training in how to address infant and mother well-being. One mother recalled completing a questionnaire on a computer while her child was being evaluated by the pediatrician, who did not later discuss the results of the questionnaire or offer resources or referrals. Many mothers in the study felt that screening without offering accompanying referrals or resources was futile.

Increasing Detection of PPD

The following recommendations emerged from the research.

Increase PPD screening by pediatricians

Both Freeman et al. (2005) and Byatt et al. (2013) support the idea that pediatricians are in an ideal position to improve detection of PPD due to regularly scheduled visits in the child's first year of life. Mothers who are depressed may not seek help from their ob-gyn, midwife, or primary care physician (Freeman et al., 2005); however, even if they are neglecting their own health they may bring their child in for routine check-ups and vaccinations (Byatt et al., 2013). Since mothers are often the caregivers bringing their child(ren) to well-baby visits, Freeman et al. (2005) assert that maternal depression should be considered a risk factor in a child's overall health assessment and should be routinely addressed, similar to evaluating exposure to lead and car seat use.

Have a conversation

An evaluation of 16 research studies about the acceptability of postpartum depression screening to mothers and healthcare professionals (Brealey et al., 2010), found that many mothers felt more comfortable talking about PPD rather than completing a questionnaire (Brealey et al., 2010). Overall the mothers wanted more than a checklist—they wanted a conversation. One mother, after reporting a positive experience talking about PPD with her child's pediatrician, said, "…He wasn't just saying 'here's that pamphlet…' it was a human connection" (Brealey et al., 2010). Mothers also desired feedback from the physician about the result of the assessment, which made them feel listened to and more free to talk (Brealey et al., 2010).

The mothers preferred to have this conversation with a medical professional at home (Brealey et al., 2010), rather than in a doctor's office, which they found distracting and uncomfortable. The consensus of the women was that, at home, they would have more privacy and time to discuss issues concerning their emotional health. One example of assessing mothers for PPD in the home are "Listening Visits," a form of brief client-centered counseling developed for Health Visitors in the United Kingdom specifically to assess and treat PPD. In the UK, Health Visitors are public health nurses who typically work out of the offices of general practitioners and provide a great deal of primary care and visit families in their homes (O'Hara & McCabe, 2013). It is recommended that a similar system or method be used in the U.S. (O'Hara & McCabe, 2013).

Emphasize relationship

The literature showed that women are more likely to seek help from a physician they know (Brealey et al., 2010). Two studies evaluated in Brealey's research (2010) found that the preexisting relationship between the mother and the person administering the questionnaire affected how it was completed. Mothers were found to be more honest and self-disclosing when they felt their health professional was supportive, caring, and truly interested in their well-being. A key factor in these relationships is that they improved over a number of meetings; the more often they met, it became more likely that a mother would disclose personal information. It was also found that when a woman and physician made contact before delivery, good rapport was established and mothers were more trusting of physicians, which may prevent them from perceiving them as "agents of social control," or someone who could potentially remove their children (Brealey et al., 2010).

Provide increased training for medical professionals

Since women are more likely to seek help from a physician they know, it is important that any physician who interacts with a postpartum woman familiarize themselves with the symptoms, risk factors, and screening techniques of PPD (Brealey et al., 2010).

Brealey and colleagues (2010) found that some medical staff sought training in counseling to acquire skills for dealing with disclosure about symptoms of PPD. Other literature showed that some

mothers would like their pediatricians to be more knowledgeable about how to deal with symptoms of PPD; they desired psycho-education from the pediatrician about caring for their infant and themselves as well as resources and referral guides to help maintain their mental health (Byatt et al., 2013).

Consider timing

In the studies evaluated by Brealey and colleagues, the majority of women said they should be screened for PPD after eight weeks, after a period of adjustment to motherhood (2010). Wisner et al. (2013) determined that mothers should be screened throughout the first postpartum year. Regardless of timing, women asserted that they would like to be informed in advance—even during pregnancy—that they are to complete a questionnaire to screen for PPD; otherwise, they said they might feel anxious and reluctant to answer questions honestly (Brealey et al., 2010).

Awareness and normalization

Since so many postpartum mothers feel overwhelmed, sleep-deprived, and overworked, PPD screening must be simple and nonthreatening (Freeman et al., 2005). Additionally, physicians can make women more aware that PPD is common and assure them that experiencing depressive symptoms after childbirth does not make them "unfit" or bad parents **(**Hirst & Moutier, 2010**)**.

Methods

Participants

I worked with two types of participants: 1) Mothers who may have experienced PPD within the last five years, but have not experienced PPD symptoms for at least one year; and 2) Medical professionals, including obstetricians, midwives (both CPM and CNM), pediatricians, and family physicians.

Mothers

I identified local women who experienced PPD in the last five years by distributing a survey to several local parenting groups (Harrisonburg MOMS, Brookhaven Birth Center's mailing list, the Shenandoah Valley Respectful Parenting group, and the Birth Matters group). Additionally, since Harrisonburg has a large Latino population, I provided a translated survey in Spanish to be distributed at Spotswood Elementary School and in a local playgroup for Latino mothers and young children. Those who wished to be interviewed were informed they could note this in the survey.

Medical professionals

I invited all known Harrisonburg obstetricians, midwives, pediatricians, and family physicians to participate in a survey about PPD screening; all local obstetricians were selected as those certified by The American College of Obstetricians and Gynecologists (ACOG) Physician Directory in Harrisonburg, as well as those located via Google search. Local certified nurse midwives (CNM) were identified as those certified by The American Midwifery Certification Board (AMCB). Certified professional midwives (CPM) were identified by Google search and word-of-mouth. Harrisonburg pediatricians were identified as those certified by the American Board of Pediatrics. Family physicians were identified as those certified by the American Academy of Family Physicians as well as those located via Google search. Additionally, several nurse practitioners who worked at a family or ob-gyn practice also received the survey. Those who wished to be interviewed were informed they could note as such in the survey.

Procedures

To inform participants (both medical professionals and mothers) about the purpose of the research, I enclosed an introductory letter with surveys detailing the purpose of my research. I also enclosed an

informed consent form, detailing what the research was about and how their information would be disclosed. This informed consent was also used for those who were chosen to be interviewed. I also requested participants' permission to audio record our interviews.

The survey for medical professionals required less than an hour to complete. The survey for mothers potentially required several hours, depending on the individual's experience. Those who were interviewed (both professionals and mothers) were told to expect to spend at least one hour being interviewed about their experiences.

Results

PPD Screening Survey for Medical Professionals

Distribution and return

Sixty surveys were distributed to local medical professionals. Surveys were sent to 20 pediatricians, 14 family physicians, 10 ob-gyns, nine midwives (six certified nurse midwives and three certified professional midwives), four nurse practitioners, and one licensed professional counselor who works in a pediatrician's office. Fifteen surveys total were returned, completed by five certified nurse midwives, three family physicians, two certified professional midwives, two ob-gyns, one pediatrician, one licensed professional counselor, and one nurse practitioner.

Survey results

The survey included six questions. Six participants were willing to be interviewed: two family physicians, two RNs, and two midwives.

1. Do you screen postpartum women for postpartum depression (PPD)? If so, when and how often?

Twelve participants said yes, they do screen women for PPD. One said no; another said, "If appropriate; when they bring up symptoms of depression and happen to have recently delivered a child." Almost all participants said they screen women just after birth and at six weeks postpartum. Several midwives said their patients are screened after birth and at two weeks and six weeks postpartum. A pediatrician stated mothers are screened, but "not explicitly."

One family physician said he actively screens new mothers for PPD: "I really see it around 4-6 months, and usually I've known them for awhile. I can see it in their eyes—they're just flat. So I just ask more questions and tell them what they are experiencing is not insignificant. Then they just start to cry. We talk about what to do next—do they want to see a therapist, do they need medication? Often they just want to unload and just talk."

As of April 1, 2014, Sentara Rockingham Memorial Hospital (RMH), located in Harrisonburg, implemented a new screening procedure for all postpartum mothers: On the day of discharge, all mothers (rather than only those who show symptoms of PPD) complete the Edinburgh Postnatal Depression Scale (EPDS) before going home. If a woman scores in a mid-to-high range, a staff social worker or counselor is consulted and the mother is treated as needed.

2. Which methods do you use to screen women for PPD?

Four participants stated they screen women for PPD using the Edinburgh Postnatal Depression Scale (EPDS). One midwife cited using the PHQ-2 first, followed by the EPDS if the PHQ-2 is positive. Others described doing more informal screening, using a "standard interview" and asking patients about their moods. One midwife said she uses a scale but doesn't hand it out because "it feels awkward."

3. If a patient is assessed positively for PPD, what is your practice's procedure?

Eight participants stated they refer patients to counseling resources and suggest medication. Several participants said they need assistance in this area. As one midwife asked, “If they have it, then what? Who do I send them to? We often give them advice on support, herbal remedies, getting vitamin D and rest; but I can’t prescribe medication, and a lot of our moms don’t want to take meds, but I don’t want them to be suicidal either. Who do I send them to, to help them figure that out?”

4. What would enable you to best screen patients for PPD?

The most common responses were time and resources, including a reliable instrument and trained staff. At least two midwives said it would be helpful to have a counselor in their office they could refer their patients to. One midwife stated: “I’d like to go to some sort of workshop on PPD and find out what I can do to get people to disclose things…it would be helpful to know warning signs.” Additionally, a family physician stated it would be helpful to have a flier or pamphlet about PPD with counseling resources in the office or waiting room.

5. Do you currently have access to names of local counselors for patients exhibiting symptoms of PPD? If not, would this be a helpful resource?

Six participants stated that yes, they do have a list of counselors. Four participants do not, and three said they could use specific names of counselors who specialize in PPD. One midwife said, “I’ve actually called around many times looking for counselors in this area who specialize in PPD and I’ve found nothing.”

6. Please provide any other comments related to PPD screening for mothers.

Several participants said they do not see it very often. Another said PPD is a “significant problem and there are not enough resources in the community to help.” One physician said, “unavailability of prompt local care except via the ER is a problem.”

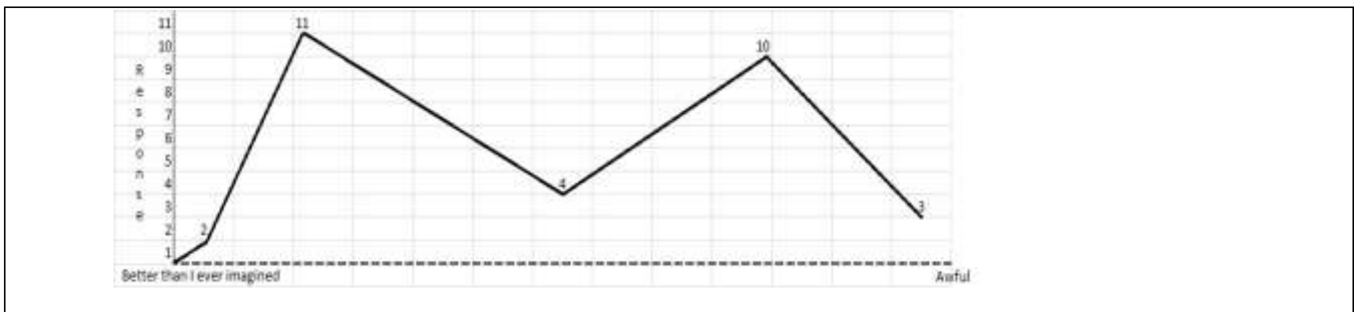
PPD Experience Surveys for Mothers

Distribution and return of surveys

Three-hundred-and-fifty-six surveys were distributed to local mothers. Forty-three surveys were returned. No surveys were returned from Spanish speaking mothers.

Survey results

The survey included 10 questions. For the first question, participants were asked to note on a continuum with an ‘X’ the area that best described their general experience post-delivery. The results were almost split, with 11 mothers responding their experience was closer to “Better than I ever imagined” and 10 responding it was closer to “awful.”



2. Please describe your postpartum experience.

Mothers' comments included phrases such as, "It just kind of exploded for me"... "I couldn't do it all"... "It ended up snowballing"..."It was like an avalanche." The mothers described feeling depressed, tearful, overwhelmed, inadequate, and powerless. Most described not sleeping and having trouble nursing their child. Many spoke about the pressure mothers feel to "hold it all together" despite feeling overwhelming sadness and anxiety. One mom stated, "I only shared when the bottom dropped out. I could not juggle all the balls in my life any longer."

Five participants described their PPD as related to traumatic experiences during or just after birth, such as emergency cesarean sections, their child being in the NICU, not being able to hold or nurse their child in the days following birth, and the loss of a parent around the same time their child was born. These mothers reported long-lasting depression. "It still affects me on his birthday," said one mother. Another mom, whose son was sent to the NICU while she was still recovering from childbirth, said, "I cared for my stitches and post-birth bleeding in public restrooms and slept on waiting room couches." She said she still experiences PTSD-like symptoms related to that time in her life.

Others spoke about the surprise of feeling negative emotions after childbirth. "I had never gone through depression before; it was a totally new feeling—like, what the heck is going on?" said one mother. Another said, "Being a mother was a dream come true; it was difficult for me to accept that I was struggling." Some women reported a history of depression before giving birth; they knew to expect PPD, especially if they had experienced it with an earlier child.

3. How soon after childbirth did PPD occur?

The women interviewed experienced PPD at a range of times. Many said their symptoms started soon after birth. One mother remembered "a specific moment of panic" the first night she was in the hospital: "I think I was expected to know more," she said. "In the hospital I got very little assistance or help. That night, thinking about going home the next day with a new baby, I just cried, wondering how I would ever know how to care for the baby, feeling terribly inadequate."

Other mothers noticed their symptoms became more severe around five or six months. Many stated they experienced depression at or around their child's first birthday, and several noted it lasted longer, until their child was 2 years old.

4. At any point during or after your pregnancy, did a medical professional ask if you were experiencing symptoms of depression? If so, who asked and when were you asked?

Nineteen women said they were asked by a medical professional about PPD. Thirteen participants reported being asked at the six-week follow-up visit with their ob-gyn (8) or midwife (5). None reported being asked about PPD during a pediatrician visit. Six participants reported they were never asked about depressive symptoms by any physician.

5. If it was determined that you were experiencing symptoms of PPD, what were your clinician's recommendations or suggestions?

Most participants reported that clinicians suggested counseling, finding "someone to talk to," or medication. Others were told to "try to get more sleep," "try to exercise," or to "wait it out and see if it improves." Most women reported the suggestions from their clinicians were helpful and they did seek counseling or try medication. However some mothers said they could have used more assistance. One mother stated, "Trying to 'sleep as much as I could' while breastfeeding a child, particularly when I also struggled with milk supply, seemed like contradicting advice." Another mother echoed those feelings: "All the things that fight depression would have helped but I couldn't do any of them because I had other children to take care of."

6. Was a counseling referral provided for you?

None of the women who completed the survey said they received a referral from their physician or midwife. Five women already had a therapist or sought a referral from a friend.

7. Do you feel your physician's or midwife's postpartum depression screening procedures could be improved? If so, how?

Eleven women said they were satisfied with their physician's or midwife's PPD screening procedures; 17 said they could be improved; most of these women suggested screening before and after the usual six-week checkup by their ob-gyn or midwife. Others felt the pediatrician should ask at every visit through the child's first year, especially since the pediatrician sees the mother a few days after birth. One mother said physicians should pay more attention to non-verbals: "I can say a pretty bubbly, 'Don't worry about me, I've got it handled,' but my body language would say that I'm experiencing some stress…I'm acting."

One mother said, "It would make a lot of sense for pediatricians to play a larger role in screening for PPD. They see babies with their moms every few months and should either provide a screening quiz or talk with moms about their symptoms. When I took my son to the pediatrician around seven weeks for inconsolable crying she said it put me at risk for PPD. But she never mentioned it again... it would have been a great opportunity to ask me how I was doing." Another mother stated, "I think every pregnant woman should be asked about a history of depression, educated in the symptoms of postpartum depression and assured that it is not usual nor indicative of being bad mother." She went on to say it would be helpful for physicians to help patients brainstorm ways to be proactive in working against situations that might exacerbate baby blues (i.e. being home alone with a new and demanding infant with little sleep much of the time).

8. What might make you most inclined to disclose feelings related to PPD to a medical professional?

Most women responded that three things would allow them to open up: feeling comfortable, having enough time to discuss their experience, and not feeling judged or shamed by the clinician. One mother said, "I would have been more likely to disclose my feelings if I had been asked how I was doing as opposed to me initiating the conversation." Another mother said it would help her talk more openly if she knew that her doctors were supportive "and that by admitting depression I would not risk having the baby taken away." One mom said that it would have helped her to know that PPD is not uncommon, "that would make it feel like 'this is a disease that strikes some people,' rather than, 'you'll feel this way if you are a bad mother.'"

9. What helped you in your experience with PPD?

Many participants said medication helped them the most. Several cited therapy as making a big difference in their recovery; one participant mentioned attachment-based and emotion-focused therapy as being helpful. Others said the support of friends and family helped most. One mom who had a history of depression was grateful for the advice of her ob-gyn, who suggested that she find a way to get out of the house and be with other people after the baby was born. This woman took a pottery class at a community college and said the experience "saved" her.

Discussion

Gaps in PPD Screening in Harrisonburg

Who is (and isn't) screening?

Based on the research and surveys returned, ob-gyns and midwives are screening the majority of postpartum women; pediatricians and family physicians may or may not, depending on whether the mother is showing symptoms of PPD. While the American Academy of Pediatrics suggests screening mothers for

PPD at infant well-visits for the first six months of the child's life, no women reported being screened by their pediatrician in Harrisonburg. As a result, local mothers who may be experiencing symptoms of PPD may be going undiagnosed and untreated.

Timing

This research found that most local women are being screened at six weeks postpartum; however, the research also showed that this is not the time at which most women experience PPD, which, as both the literature shows and mothers reported, can be anytime within the child's first year or beyond. Based on the research, women in Harrisonburg should be screened for PPD through their child's first birthday and beyond, at each encounter with a physician or midwife if needed. While the new EPDS screening procedure at Sentara RMH may address the mothers who feel symptoms of PPD within the first 24-48 hours of birth, there will be women who notice symptoms later.

What Mothers Want

More conversations about PPD

Many mothers requested "a conversation" or a "natural place" to talk about PPD with a medical professional. Medical professionals also learned women had symptoms by talking with them, not necessarily as a result of a screening procedure. Mothers want to talk more with their physician or midwife about PPD while they are pregnant. They feel it would be helpful to know they may cry after childbirth or may not want to spend time with their baby, and that neither makes them a bad mother. They want to know what to look for so it is not a surprise. This warning may also help mothers open up to medical professionals after the baby is born. Additionally, since many women reported feeling the same depressive symptoms with each child at around the same time, this shows that often, if PPD was experienced with a previous birth, a mother can expect it again and at around the same time. This warning was found to be useful for the mothers who received it.

Normalization and support

Based on this research, many postpartum mothers need support outside their family. As one participant stated, "In a society where many mothers are not close to their own mothers either geographically or emotionally, I think it is crucial that midwives and ob-gyns take more initiative in educating women about postpartum depression as well as checking in with them for several weeks and months afterward."

Normalization: They don't have to be supermom

As one midwife said, "You're not crazy or a bad mother if you don't want to hang out with a baby all day." Since mothers are interacting with midwives and physicians regularly during the pre-and postpartum period, these professionals may be helpful in debunking the myth of "supermom."

Recommendations

Universal screening

The fact that some midwives and physicians said PPD is a "significant problem" while others said they do not see it very often indicates that there is an inconsistency in screening. While Sentara RMH is implementing one universal screening procedure, all physicians (including ob-gyns, pediatricians, and primary care providers) and midwives who are in contact with a pregnant or postpartum woman should address her emotional state in the days before and after childbirth (through the first year, at minimum).

Bring counselors in

Members of the medical community are the natural witnesses of a mother's experience after childbirth, but may not be prepared for what happens next. According to the research, mothers want to be asked how they are feeling. As the healthcare providers who participated in the research indicated, this may require increased training and/or staff, such as a counselor, who can effectively talk with a mother about her postpartum experience. Many of the concerns physicians and midwives voiced (i.e. Where do I send a mother who wants to talk about meds? How do I talk through the results of a high score on the EPDS? How do I interact with a mother who has just had a traumatic birth?) are issues that can be addressed by counselors. Ideally, postpartum counselors could work with mothers in the hospital, in a midwife's or physician's office, or in a woman's home, similar to the "listening visits" in the U.K.

Next Steps

More research is needed related to PPD in Harrisonburg. First, a more thorough evaluation of all mothers (not just English-speaking) is required, based on the city's diverse population. Additionally, more research could be done specifically on PPD in women who experienced trauma around their delivery. This came up repeatedly in the survey results, and there seems to be a strong tie to childbirth trauma and an increased chance of PPD.

A campaign to reduce stigma of PPD among mothers would be effective. Posters in waiting rooms asking, "Do you still have the (baby) blues? It's ok, we can help" might encourage a mom to initiate a conversation with her physician, or possibly respond more honestly to questions about PPD. Additionally, medical professionals—anyone who is in contact with a postpartum mother—could benefit from a comprehensive resource guide about PPD. This guide could include local counselors who specialize in PPD as well as provide information on local support groups.

Conclusion

PPD isn't talked about very much. It's a topic that, even when presented at mom's groups, mothers were not eager to talk about; several turned away once they heard the topic, others left the room altogether. And based on the results of the survey, physicians don't want to talk about it either. But someone has to acknowledge this experience, referred to by one nurse as "the loss of the dream of [motherhood] being so wonderful and going through a traumatic time they didn't count on." It is possible that just by acknowledging this experience, by realizing that, as this nurse said, "These aren't just moms who are forever complaining," that mothers may finally feel they don't have to be super mom; being "mom" is more than enough.

References

Alder, E. (2007). NAPD: The National Audit of the Detection and Management of Postnatal Depression. Edinburgh: NHS Scotland.

American College of Nurse-Midwives (2002). Women's moods. What every woman should know about hormones, the brain, and emotional health. *Journal of Midwifery & Women's Health, 47*(5). Adapted with permission from Sichel, D. & Driscoll, J. W. (1999).

American College of Obstetricians and Gynecologists' Committee on Obstetric Practice (2010). Screening for depression during and after pregnancy. Retrieved from http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Obstetric%20Practice/co453.pdf?dmc=1&ts=20130420T0434133346

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders (5th ed.*) Arlington, VA: American Psychiatric Publishing.

Association of Women's Health, Obstetric, and Neonatal Nurses (2008). The role of the nurse in postpartum mood and anxiety disorders. Retrieved fromhttp://www.awhonn.org/awhonn/

Blom, E.A., Jansen, P.W., Verhulst, F.C., Hofman, A., Raat, H., Jaddoe, V.W. …, & Tiemeier, H. (2010). Perinatal complications increase the risk of postpartum depression. The Generation R Study. *BJOG: An International Journal of Obstetrics and Gynaecology, 117*(11), 1390-98.

Brealey, S. D., Hewitt, C., Green, J. M., Morrell, J., & Gilbodya, S. (2010). Screening for postnatal depression—is it acceptable to women and healthcare professionals? A systematic review and meta-synthesis. *Journal of Reproductive and Infant Psychology, 28*(4), 328-344.

Byatt, N., Biebel, K., Friedman, L., Debordes-Jackson, G., & Ziedonis, D. (2013). Women's perspectives on postpartum depression screening in pediatric settings; a preliminary study. *The Archives of Women's Mental Health, 16*(5), 429-232.

Chua, A. (2011). *Battle hymn of the tiger mother***.** New York, NY: Penguin

Dennis, C.-L. E., Janssen, P. A., & Singer, J. (2004). Identifying women at-risk for postpartum depression in the immediate postpartum period. *Acta Psychiatrica Scandinavica,110*(5), 338-346.

Druckerman, P. (2012). *Bringing up Bébé: One American mother discovers the wisdom of French parentin*g. New York, NY: Penguin

Earls, M.F. (2010). Incorporating recognition and management of perinatal and postpartum depression into pediatric practice. *Pediatrics, 126*(5), 1032-1039.

Freeman, M. P., Wright, R., Watchman, M., Wahl, R. A., Sisk, D. J., Fraleigh, L., & Weibrecht, J. M. (2005). Postpartum depression assessments at well-baby visits: screening feasibility, prevalence, and risk factors. *Journal of Women's Health, 14*(10), 929-935.

Gilibrand, R. (2012). Surviving postnatal depression. *The Psychologist, 25*(10), 756-758.

Hanusa B. H., Scholle, S. H., Haskett, R. F., Spadaro, K., & Wisner, K. L. (2008). Screening for depression in the postpartum period: a comparison of three instruments. Journal of Women's Health, 17(4), 585-96.

Hirst, K. P., & Moutier, C.Y. (2010). Postpartum major depression. *American Family Physician, 82*(8), 926-933.

McClennan, J.D., & Kotelchuck, M. (2000). Parental prevention practices for young children in the context of maternal depression. *Pediatrics, 105*(5), 1090-1095.

National Association of Certified Professional Midwives (2004). Essential documents of the national association of certified professional midwives. Retrieved from http://www.nacpm.org/Resources/nacpm-essential-documents.pdf

O'Hara, M. W., & McCabe, J. E. (2013). Postpartum depression: current status and future directions. *Annual Review of Clinical Psychology, 9,* 379-407.

Pickert, K. (2012). The man who remade motherhood. *Time,* May 21.

Sandberg, S. (2013). *Lean in: Women work and the will to lead*. New York, NY: Knopf.

Sit, D., Rothschild, A.J., & Wisner, K.L. (2006). A review of postpartum psychosis. *Journal of Women's Health, 15*, 352-68.

State of New Jersey Department of Health (July 2012). Retrieved from http://www.state.nj.us/health/fhs/postpartumdepression/faq.shtml#q4

Stowe, Z. N., Hostetter, A. L., & Newport, D. J. (2005). The onset of postpartum depression: Implications for clinical screening in obstetrical and primary care. *American Journal of Obstetrics and Gynecology, 192*(2), 522-526.

Thurgood, S., Avery, D. M., & Williamson, L. (2009). Postpartum depression (PPD). *American Journal of Clinical Medicine, 6*(2), 17-22.

U.S. National Institute of Health (2014). Postpartum depression. Retrieved from http://www.nlm.nih.gov/medlineplus/postpartumdepression.html

U.S. National Library of Medicine (2013). Postpartum depression. Retrieved from http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0004481/

Vik, T., Grote, V., Escribano, J., Socha, J., Verduci, E., Fritsch, M., … & European Childhood Obesity Trial Study Group. (2009). Infantile colic, prolonged crying and maternal postnatal depression. *Acta Paediatrica, 98*(8), 1344-48.

Wisner, K. L., Sit, D. K.Y., McShea, M. C., Rizzo, D. M., Zoretich, R. A.; Hughes, C. L., … , & Hanusa, B. H. (2013). Onset timing, thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings. *JAMA Psychiatry, 70*(5), 490-498.