

Jessica Brennan
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Postpartum Depression Prevention and Screening

The Role of OB/GYN's and Pediatricians in the Diagnosis and Treatment of Postpartum Depression

Postpartum depression (PPD) is a depressive disorder that affects women who have just given birth. Women with PPD experience a wide range of [symptoms](#), the most common of which include prolonged crying episodes, withdrawal from family and friends, disinterest in her newborn, and overwhelming feelings of guilt or doubt over her ability to raise her new baby. These symptoms last longer and are more intense than those experienced during “baby blues”, which is characterized by feelings of worry, sadness, and tiredness caused by the drastic hormonal changes experienced after birth. [Research](#) from the CDC has shown that 1 in 9 women will experience postpartum depression in her lifetime and that those who had preterm or complicated births, multiple births, low social support, or especially high levels of stress were at higher risk for developing PPD. Teen pregnancy and motherhood was also found to be a risk factor.

Despite its high prevalence, 60% of women with symptoms of PPD do not receive a diagnosis and 50% of women with a diagnosis [do not receive treatment](#). This could perhaps be due to the fact that women do not receive much postpartum care aside from an appointment with their OB/GYN 6 weeks after giving birth. Meanwhile, pediatricians visit with both the mother and the child on a regular basis following the birth. While these visits are generally focused on the newborn's well being and development, they provide an excellent opportunity for assessment of the mother through PPD screening.

The Effect of PPD on Infant and Child Development

Mothers with postpartum depression can have a profound effect on their child's cognitive, social, and emotional development from infancy to adolescence. [Research](#) has shown that mothers with depressive symptoms interact less with their child leading to delays in the newborn's non-verbal communication skills at 14 months of age. This lack of bonding between depressed mothers and their infants [has been shown](#) to lead to behavioral problems by the age of 2. The same research indicated a link between maternal PPD and stunted growth during toddlerhood. These effects last far into early childhood: maternal postpartum depression [has been linked](#) to an increase in anxiety, depression, and other mood disorders in 8 year old children whose mothers experienced

PPD in the first year of their lives. [Evidence](#) suggests that these effects may even persevere into adolescence as maternal postpartum depression may lead to the development of an anxiety or depressive disorder in teenage children. The effects of postpartum depression on child development are more severe when the mother experiences subsequent periods of depression later on in the child's development. Postpartum depression has the potential devolve into a disorder called postpartum psychosis, which may cause mothers to harm themselves or their children, leading to an enduring effect on the child's life and development.

The multitude of adverse effects that postpartum depression may initiate in the children of affected mothers shows that prevention, early recognition, diagnosis, and treatment of PPD is crucial. By diagnosing and treating women affected with PPD, healthcare providers can prevent any harm from being done to the child, either physically or in terms of his/her long term development. It is imperative that providers, especially OB/GYN's and pediatricians, are able to recognize the signs and symptoms of PPD and treat women experiencing these symptoms efficiently and effectively.

Prevention of PPD

There is no proven way to prevent the onset of postpartum depression. However, [research](#) has shown that merely communicating about the disorder during prenatal care can lower the woman's risk of developing depressive symptoms. Additionally, assessing protective factors before pregnancy can help the healthcare provider implement a plan to help reduce the woman's likelihood of developing PPD. These [protective factors](#) include stress management skills, hormone levels, social support, a healthy diet, regular exercise, healthy sleeping patterns, sunlight exposure during the day, breastfeeding, and planned pregnancies. By assessing women before or early on in their pregnancy, the OB/GYN can determine the areas in which the patient is lacking and provide her with strategies to increase her resistance to depressive symptoms. For example, the practitioner might refer the patient to psychotherapy in the hopes of providing her with effective stress management or sleeping strategies or encourage the patient to adopt a healthier diet or regular exercise routine. OB/GYN's might consider referring their patients to a registered dietician or working in conjunction with their primary care physician in order to ensure that women attain all the protective factors possible before birth. The OB/GYN can additionally provide the patient with family planning support by educating and providing her with various contraceptive options like hormonal birth control or an IUD.

After birth, OB/GYN's can ensure that the patient receives breastfeeding support from nurses while still in the hospital. Breastfeeding releases hormones that help the mother feel [more attached](#) to her newborn, possibly preventing the onset of PPD or alleviating its symptoms. By helping women attain protective factors against the development of PPD, OB/GYN's can effectively prevent the onset of the disorder in select women. Prevention of PPD is primarily the OB/GYN's responsibility as he/she is the sole provider assessing the woman prior to the birth of

her newborn. It is imperative that OB/GYN's assess their patients for protective factors in order to ensure a high quality of life for the mother and her newborn after birth.

Screening Methods for PPD

When prevention is not possible, adequate screening for postpartum depression is crucial to the recognition, diagnosis, and treatment of the disorder. [Research](#) has suggested that women experiencing depressive symptoms are unlikely to actively seek help: in a sample of 337 women experiencing symptoms of PPD between two and six months after birth, 60.5% did not speak to their doctors or other health professionals about their symptoms. This is most likely due to their reluctance to share their feelings or a lack of trust and comfort experienced with their healthcare provider. The responsibility then falls on the practitioner to recognize potential symptoms in their patients and treat them accordingly. The most common way to achieve this is by screening postpartum women using the [Edinburgh Postpartum Depression Scale](#) (EPDS).

The EPDS is a brief screening method consisting of 10 questions regarding the woman's mental state during the 7 days prior to her appointment. There is a maximum score of 30 and a score of 10 or more indicates possible depression. The EPDS is widely accepted amongst physicians as a valid measurement of postpartum depression, and [various studies](#) have supported its improvements over other screening methods. However, a newer screening method, [Patient Health Questionnaire](#) (PHQ-9) has recently gained popularity amongst physicians screening for postpartum depression. PHQ-9 is a 9-item questionnaire that is intended for the diagnosis of any major depressive disorder, not solely PPD. Its ability to assess both the diagnostic criteria of depression as well as the severity of the disorder has led to its [rising popularity](#) amongst physicians and other healthcare professionals. The PHQ-9 assesses for the severity of PPD by posing questions in which the patient may indicate how often she has experienced symptoms over the past two weeks. The EPDS poses no such questions. However, [studies](#) comparing the EPDS and the PHQ-9 have shown that the two screening methods were concordant for 87.5% of respondents. For the cases in which the two screening methods yielded different results, the EPDS was accurate half of the time and the PHQ-9 was accurate the other half of the time. While both screening methods appear to be equally accurate, they are both only moderately accurate: only 67.1% of those that screened positive actually showed evidence of depressive symptoms associated with PPD. There is some concern that the EPDS detects distress but not necessarily depression. It is therefore critically important that the practitioner performing the screening asks follow up questions regarding the patient's screening results as opposed to assuming the results are accurate for every screening.

Some health care providers have suggested screening only women who exhibit risk factors for postpartum depression. While this approach might save time and effort on the part of the practitioner, screening only women at high risk may cause practitioners to miss those women

who develop the disorder without exhibiting any risk factors. [Research](#) has shown that this form of targeted risk factor screening has the potential to miss up to 36.4% of women who would potentially screen positive. However, [other studies](#) have indicated that low risk women may need to be screened only once as low scores on early screens generally predicted low scores on subsequent screenings. Screening low risk women only once would allow excess resources to be routed towards women at higher risk. While this method would certainly save time and resources, it is possible for low risk women to develop the disorder after screening negatively, especially when the screen is conducted very early in the postnatal period. It is therefore imperative that every woman attending a postpartum or well child visit is screened regardless of her history of risk factors.

When PPD Screening Should Occur

Most women are screened for postpartum depression by their OB/GYN at their first appointment after birth, which generally occurs within the first 6 weeks of the postpartum period. This is effective at diagnosing women who are already exhibiting symptoms of the disorder, but can potentially miss women who have yet to develop these symptoms. However, [studies](#) have suggested that many OB/GYN's feel uncomfortable screening for PPD because they do not know the most effective way to treat it or do not have a referral system in place to guide their patients to a psychotherapist or other professional who is trained in the treatment of PPD.

Well child visits provide a prime opportunity for PPD screening as they occur at regular intervals during the first year of the child's life, allowing the pediatrician to screen the new mother multiple times and assess for any changes in mood that may be caused by the onset of postpartum depression. [Studies](#) have found that screening for PPD during well child visits improves the detection of symptoms. Despite this, the majority of pediatricians do not screen for PPD due to their lack of experience and training regarding the diagnosis and treatment of the disorder. When surveyed, 57% of pediatricians indicated that they felt responsibility for diagnosing the disorder, but only 32% expressed confidence in their ability to do so.

Treatment Options for Women with PPD

Pediatricians' and OB/GYN's lack of experience with postpartum depression may explain why less than half of women diagnosed with PPD are provided with treatment. [One study](#) showed that 44.8% of women who screened positively for PPD with the EPDS were prescribed an SSRI while only 21.4% were referred to a therapist for follow up mental health care. Postpartum depression is most commonly treated with antidepressant medication or psychotherapy. [Studies](#) have found that antidepressant medication, specifically SSRIs, are more effective than psychotherapy sessions in treating PPD; however, long term therapy has been shown to be most effective if the patient is seen weekly for at least 6 weeks. Despite medication being the most

effective treatment option, many women prefer talk therapies with a trusted professional over antidepressant medication due to concerns over the medication's side effects or its effects on her breastfeeding infant. To alleviate these concerns, physicians can educate their patients on the [recent evidence](#) that has found that antidepressant levels in the infant's serum are not necessarily harmful in the long or short term. In addition, most of the time, antidepressants are not detectable in the infant's serum: paroxetine, sertraline, and nortriptyline specifically have shown to be undetectable. Physicians may also instruct the mother to breast feed before her daily intake of her medication and monitor her child for changes in mood, including irritability and sedation, that [may be related](#) to exposure to antidepressant medication.

There are many barriers preventing women from seeking the treatment they desperately need for postpartum depression. Weekly psychotherapy may be difficult for mothers who must schedule child care or transportation for each of their appointments. Additionally, some women may lack insurance coverage or access to adequate mental health facilities thereby preventing them from receiving adequate treatment. Social stigma about PPD and other mental illnesses may also be a barrier for women seeking treatment.

It is crucial that pediatricians and OB/GYNs provide timely follow up care in order to ensure that their patients with postpartum depression are continuing their treatment and are not experiencing any adverse side effects. Some practitioners may prefer to refer their patients to mental health professionals as opposed to overseeing the treatment of PPD themselves. While this is certainly an effective method, it is nevertheless important to schedule regular follow up appointments for patients with postpartum depression to ensure that they are continuing with their mental health care provider and finding the treatment to be effective.

Conclusion

Postpartum depression is a debilitating mental disorder that affects not just new mothers, but their children as well. Postpartum and well child visits provide practitioners with prime opportunities to screen women for PPD with one of the accurate and efficient screening tests that are currently available. Since OB/GYNs only see women for one postpartum visit, well child visits may be the best time for women to be screened. Additionally, the wide range of adverse effects postpartum depression has on children should be seen as motivation for pediatricians to screen for the disorder among their patients' mothers as the early detection and treatment of PPD can significantly increase the child's quality of life and development. Ultimately, pediatricians hold the most responsibility for recognizing and diagnosing PPD in new mothers as they are in contact with them most often and the disorder directly affects their patients' wellbeing.

However, many pediatricians and OB/GYNs feel as if they do not have sufficient training or experience dealing with PPD to accurately diagnose and treat the women it affects. Physicians

and other practitioners must become more familiar with PPD, through courses, lectures, research, or discussions with providers who have more experience dealing with the disorder. The [American Congress of Obstetricians and Gynecologists](#) (ACOG) suggests that the OB/GYN determine with the patient during her postpartum visit whether the primary care provider or the obstetrics provider will continue with her postpartum care. If the woman has exhibited symptoms of PPD or screened positively for the disorder during the postpartum visit, the OB/GYN may consider transferring her care to the PCP, who may have greater ability to refer the patient to an adequate mental health care provider. If this is the case, the ACOG encourages the OB/GYN to maintain open communication with the PCP in order to understand the implications of PPD or other complications and maintain continuity of care. Pediatricians, meanwhile, should refer women with PPD symptoms back to their PCP, as it is not the pediatrician's responsibility to maintain the treatment of their patients' mothers. In regards to the prevention of PPD, OB/GYNs must again work in conjunction with the PCP to ensure the highest quality of care for the patient. Primary care physicians have the resources required to refer a patient to a dietician or psychotherapist and likely have already formed connections with these providers.

The effective treatment and prevention of postpartum depression requires communication and cooperation between the OB/GYN, the pediatrician, and the PCP. The OB/GYN or pediatrician should screen for and diagnose the disorder using the EPDS or PHQ-9 and then pass off care of any patients exhibiting depressive symptoms to the PCP, who will have the resources required to get the patient the care they need. In the bigger picture, postpartum depression should ideally become integrated into the medical school curriculum of those specializing in obstetrics and gynecology or pediatrics to give practitioners a better understanding of its diagnosis and treatments. Additionally, health plans and networks should ease patients' access to mental health providers by improving the referral processes for physicians and patients alike. Mental health professionals should be accessible to all patients in need. These changes require action from health organizations and government associations; in the meantime, OB/GYNs and pediatricians can assist women with PPD by effectively screening, diagnosing, and connecting them to the resources they need for proper and effective treatment of the disorder.