

## Maternal Depression

### Importance

Maternal depression affects approximately 12% of pregnant women with rates doubling for low-income mothers, particularly among teen mothers.<sup>1-3</sup> Women may experience depressive symptoms for the first time during pregnancy, within days of childbirth or up to 12 months following birth. Others may have a history of depression and be at increased risk for recurrent depression associated with pregnancy. Maternal depression encompasses the entire life continuum from before, during and following pregnancy.

The problem of maternal depression is a national public health issue affecting approximately one out of every four women over their lifetime. The profound consequences of maternal depression on maternal and child health include maternal self-neglect, poor nutrition and sleeping patterns, refusal of prenatal care, domestic violence, drug and alcohol abuse, child abuse, poor coping skills, high levels of stress and anxiety, inability to bond and care for one's baby, subsequent poor parenting skills, and sub-optimal child development. Maternal depression is related to increased risk for low birthweight and preterm birth, likely as a result of the factors listed above.

There is increasing evidence that maternal depression has a negative emotional, cognitive and behavioral impact on infants and young children that lead to emotional and learning disabilities. Maternal depression can be readily identified and effectively treated. Early intervention is essential, as the degree of risk to children appears related to the length of the mother's depression. However, for the most part, neither obstetric nor pediatric providers routinely assess for depression before, during or after pregnancy. Therefore, a carefully planned approach to addressing maternal depression before and during pregnancy as well as postpartum is an important factor in the promotion of healthy development among

children and their mothers.

### Facts about Maternal Depression

- Approximately 80% of women experience "postpartum blues" following childbirth.
- Postpartum affective disorders (maternal depression and postpartum anxiety disorders) are estimated to affect 10-25% of women--with rates doubling for low-income mothers particularly if they are adolescent mothers.
- Postpartum psychosis, which may take the form of psychotic depression, postpartum mania, or a schizophrenic-like psychosis, affects 1-2 per thousand new mothers.
- If a woman has experienced an episode of maternal depression, there is a 50% chance she will experience maternal depression again.
- A woman with a history of major depression has a 25% chance of developing depression after childbirth.
- Infants whose mothers remain depressed past six months following delivery are more likely to score below average on developmental measures and have lower weight percentiles and higher rates of behavioral problems as preschoolers.
- At age two, children of depressed mothers have more difficulty with emotional regulation, lower levels of self-esteem, and display more aggressive behavior.

### General Guidelines for Screening for Maternal Depression

The following information is designed to help identify who is at risk and the signs and symptoms of maternal depression:

**A. Risk Factors**

1. History of maternal depression – *the single greatest risk factor*
2. Family or personal history of depression in general
3. History of any kind of abuse: physical, emotional or substance abuse
4. Complications during pregnancy and childbirth
5. Difficulties breastfeeding or weaning
6. Mood swings
7. Difficulty with premenstrual symptoms - PMS
8. Lack of social support
9. Recent stressful life events: deaths, loss of job, miscarriage, move

**B. Symptoms of Maternal Depression**

Any of the following symptoms that persist beyond a two week period may indicate maternal depression:

1. Crying and sadness
2. Hopelessness and despair
3. Anxiety
4. Loss of appetite or overeating
5. Inability to sleep/excess sleep
6. Indifference towards the baby
7. Excessive worry about the baby's well being
8. Inability to cope
9. Fears of harming self or baby

## Key Components of Best Practices for Implementing Maternal Depression Screening & Treatment

While there are no nationally recognized guidelines for screening for depression during pregnancy, several steps are recommended to address maternal depression. Active, ongoing strategies for detection of depression are required. Questions included in assessment tools should be selected for or tailored to be culturally and linguistically appropriate.

### 1. Identification of Women At-Risk for Maternal Depression

#### a) Increase awareness about maternal depression within organization

- Establish ongoing training on maternal depression including recognition of signs and symptoms and screening procedures in order to promote earlier and more accurate detection.
- Educate expectant parents about maternal depression and encourage women and men to come forward if they or their partner feel they may be experiencing symptoms.
- Identify appropriate community resources such as support groups and services
- Be aware of the sensitivity of this topic. Remember that women may initially find it difficult to share or express their symptoms, and may deny them or minimize their severity. Use a sensitive, non-judgmental approach.

#### b) Screen all pregnant women and new mothers for maternal depression

Each population has women at risk. Women may be missed because service and health providers lack specific understanding of the symptoms of depression and potential benefits from treatment of maternal depression, or because specific screening practices are not in place to identify women during their prenatal course. Therefore, a universal screening program that is appropriate for all pregnant women, regardless of race/ethnicity,

primary language, educational level, or socio-economic/insurance status is recommended.

The **PHQ-9** is a popular screening tool that has been validated for use in perinatal depression. It is a 9 item depression screening tool used by many clinicians. The PHQ-9 has been shown to be a reliable tool for the detection of depression. This tool has also been validated in measuring the severity of depression.

The **Edinburgh Postnatal Depression Scale** or EPDS, has been validated for both pregnant and postpartum women. This ten-item questionnaire has been translated and validated in multiple languages.

Another commonly used screening tool is the **Beck Depression Inventory** (BDI). Several versions of this tool exist, and in general the person is asked to rate the intensity of a list of 21 symptoms and attitudes over the “last week including today” (BDI) or the “last two weeks” (BDI-II, and BDI-PC). Concerns are raised by experts regarding the potential for higher scores or false positive results during pregnancy, because this scale relies heavily upon symptoms that may occur in pregnancy in the absence of depression, such as fatigue.

The Agency for Healthcare Research and Quality recently reviewed existing evidence on effectiveness of screening tools for identification of major and minor depression among pregnant and post partum women.<sup>6</sup> Briefly, the report concludes that commonly used screening tools, such as EPDS and BDI identify major depression most accurately, and that the instruments are “imprecise” for identifying women categorized with either major or minor depression.<sup>6</sup> The PHQ-9 was not evaluated in this report.

### 3. Referral of Women and Families At-Risk to Appropriate Services.

If the Edinburgh Postnatal Depression Scale indicates that the woman may have maternal depression, she should be referred to a professional immediately. The onsite availability or accessibility of a case manager to make the appropriate referrals for mental health and social

health services, and to assist the woman with specific barriers (transportation or childcare) that may keep her from accessing the mental health provider is crucial. Treatment strategies should be comprehensive and should involve the affected woman as well as significant others in her life. Often a medical referral to a physician is the first step. In addition, the woman may need support services such as therapy, a support group, or assistance with basic needs.

Treatment options for women suffering from maternal depression often include:

- Individual therapy
- Family/marital therapy
- Participation in a postpartum support groups
- Psychoeducation interventions
- Hormonal prophylaxis or replacement
- Medications including antidepressants

### 2. Referral Tracking System

Organizations must have an infrastructure that documents the treatment needs of the patient and tracks clinical follow up and communication across providers within individual systems of care. Women suffering from maternal depression are at a high risk of not following through with their treatment plan. Continual support and follow-up is needed to ensure the woman is accessing and utilizing the services she needs to treat depression.

## Source Materials & Useful Resources

1 .O’Hara MW, Swain AM. Rates and risk of postpartum depression –a meta-analysis. *International Review of Psychiatry* 1996; 8:37-54.

2. Hobfoll SE, Ritter C, Lavin J, Hulsizer MR, Cameron RP. Depression prevalence and incidence among inner-city pregnant and postpartum women. *J Consult Clin Psychol* 1995; June; 63(3):445-53.

3. Panzarine S, Slater E, Sharps P. Coping, social support, and depressive symptoms in adolescent mothers. *J Adolescent Health* 1995; 17:113-119.

4. Hendrick, V and K Daly, *Parental Mental Illness*, in N Halfon, E Shulman, M Hochstein and M Shannon, eds., *Building Community Systems for Young Children*, UCLA Center for Healthier Children, Families, and Communities, 2000.

5. Postpartum Mood and Anxiety Disorders: Information for Healthcare Providers. PASS-CAN: Postpartum Adjustment Support Services-Canada.

6. Gaynes BN, Gavin N, Meltzer- Brody S, Lohr KN, Swinson T, Gartlehner G, Brody S, Miller WC. Perinatal Depression: Prevalence, Screening, Accuracy, and Screening Outcomes. Summary, Evidence Report/ Technology Assessment No. 119. (Prepared by the RTI-University of North Carolina Evidence- based Practice Center under Contract No. 290-02-0016.) AHRQ Publication No. 05-E006-1. Rockville, MD: Agency for Healthcare Research and Quality. February 2005.

*For more information on maternal depression:*  
<http://www.nlm.nih.gov/medlineplus/postpartumdepression.html>

- U. S. Department of Health & Human Services  
<http://www.Womenshealth.gov>
- Postpartum Support International  
<http://www.postpartum.net>
- Postpartum Stress Center  
<http://www.postpartumstress.com>
- PASS-CAN Postpartum Adjustment  
<http://www.passcan.ca>  
Support Services -Canada

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