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Postpartum Depression and Universal Screening: Consequences, Benefits, and Barriers

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Abstract

In the United States our society has a perception that after a mother has given birth she should be overjoyed and the happiest she has ever been in her life as well as in love with her baby the instant the first breath is taken. As all parents know, having a child is a stressful, life-changing event (Brewer, 2001). No one wants to believe a mother is not happy or may be unable to care for the new baby much, less that she might be able to harm the child (Brewer, 2001). Unfortunately, the reality is many women suffer from postpartum depression (PPD). For those who go undiagnosed or untreated it can have very tragic consequences including maternal suicide and infanticide.

Postpartum depression is finally being recognized as a worldwide public health problem. PPD can affect any woman. It is found on every continent, in every country, culture, race, ethnicity, socioeconomic level, age, and educational level (Gjerdingen, Crow, Miner, & Center, 2009a; Hanusa, Scholle, Haskett, Spadaro, & Wisner, 2008; Pearlstein, Howard, Salisbury, & Zlotnick, 2009). At least 50% of women who are diagnosed with PPD suffer from symptoms that last at least six months or longer (Beck, 2002). One of the most important factors affecting duration of PPD is delay in diagnosis (Beck, 2002). The longer a woman goes untreated for PPD the longer her illness will last 1 (Beck, 2002). Therefore, every woman should be screened for postpartum depression during their pregnancy and several times throughout the year after giving birth (Andrews-Fike, 1999; Brewer, 2001).

This chapter of the literature review will discuss the three different types of postpartum mood disorders including onset, symptoms, and risk factors associated with each one. Secondly, the impact PPD can have on each member of the entire family will be described. Finally, Chapter I will conclude with the purpose of this research which is to review and synthesize the available body of research literature pertaining to the lack of universal screening for postpartum depression in women during pregnancy and after childbirth. Specifically, the study was designed to describe the individual and population health consequences of untreated PPD. Barriers to identification and treatment will also be discussed.

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CHAPTER I

INTRODUCTION

In the United States our society has a perception that after a mother has given birth she should be overjoyed and the happiest she has ever been in her life as well as in love with her baby the instant the first breath is taken. As all parents know, having a child is a stressful, life-changing event (Brewer, 2001). No one wants to believe a mother is not happy or may be unable to care for the new baby much, less that she might be able to harm the child (Brewer, 2001). Unfortunately, the reality is many women suffer from postpartum depression (PPD). For those who go undiagnosed or untreated it can have very tragic consequences including maternal suicide and infanticide.

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Postpartum Mood Disorders

Postpartum depression is one of three types of postpartum mood disorders which also includes postpartum blues and postpartum psychosis. Several studies have examined the possible etiologies for PPD which include fluctuations in hormones, patient and family psychological problems, biological factors, as well as psychosocial factors (Andrews-Fike, 1999; Bloch, Rotenberg, Koren, & Klein, 2006). There is much debate among

researchers as to the actual cause of PPD. Studies indicate inconclusive and contradictory evidence of a specific etiology for this illness (Andrews-Fike, 1999; Clay & Seehusen, 2004; Cole, 2009). There are varying opinions as to what the risk factors are for each of the postpartum mood disorders. Researchers noted several risk factors that are not related to postpartum blues or PPD which include socioeconomic status, ethnicity, level of education, type of conception - natural or in-vitro fertilization, normal or cesarean birth, number of children in the family, newborn gender, whether it was a planned or unplanned pregnancy, and marital status (Bloch, Rotenberg, Koren, & Klein 2005; Clay & Seehusen, 2004).

Postpartum Blues

The most common type of postpartum mood disorder is postpartum blues which has a prevalence as high as 85% of all women who give birth (Pearlstein et al., 2009). Postpartum blues is characterized by symptoms that are mild and include anxiety, mood swings, tearfulness (for no apparent reason), sleep and appetite disturbances, fatigue, and sadness (Andrews-Fike, 1999; Pearlstein et al., 2009; Perfetti, Clark, & Fillmore, 2004; Robertson, Grace, Wallington, & Stewart, 2004). The onset of postpartum blues can be a few hours or up to 10 days after birth and the symptoms will usually resolve on their own within 14

days without intervention (Andrews-Fike, 1999; Pearlstein et al., 2009; Perfetti et al., 2004; Robertson et al., 2004).

Research indicates there are several risk factors for postpartum blues. These include depression during pregnancy, history of premenstrual dysphoric disorder (PMDD), previous history of PPD, and psychological problems either in the patient or the patient's family (Bloch et al., 2006). One study found psychosocial and obstetric factors were not considered to put a woman at risk for the early depressive symptoms of postpartum blues (Bloch et al., 2006).

Postpartum Depression

The second type of postpartum mood disorder is postpartum depression. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) does not separate postpartum depression (PPD) from major depression, but instead notes that the onset is within four weeks of delivering a child (Andrews-Fike, 1999; Chaudron, Szilagyi, Campbell, Mounts, & McInerny, 2007). There is much debate among researchers about the postpartum depression classification. Most clinicians and researchers agree that postpartum depression has an onset of as early as right after delivery up to one year postpartum for symptoms to appear with the majority of cases starting in the first three months after birth (Andrews-Fike, 1999; Pearlstein et al., 2009; Perfetti et al., 2004; Robertson et al., 2004).

Postpartum depression symptoms can range from mild to severe and include mood swings, inability to concentrate, sleep and appetite disturbances, feelings of guilt, irritability, fatigue, depressed mood, inability to cope with infants needs, anxiety, and thoughts of suicide (Andrews-Fike, 1999; Pearlstein et al., 2009; Perfetti et al., 2004; Robertson et al., 2004). The prevalence of postpartum depression can be as high as 20% in the United States (Cole, 2009).

Several studies have examined risk factors for PPD. One major risk factor researchers agree on is the postpartum blues (Bloch et al., 2006; Clay & Seehusen, 2004; Pearlstein et al., 2009; Perfetti et al., 2004; Roberston et al., 2004). If a woman experiences postpartum blues after giving birth that increases her risk of developing PPD (Bloch et al., 2006; Clay & Seehusen, 2004; Pearlstein et al., 2009; Perfetti et al., 2004; Robertson et al., 2004). Other risk factors, which researchers disagree on, include personal or family history of mental illness (including depression), depression during pregnancy, previous history of PPD, anxiety during pregnancy, marital discord, lack of support (including financial, social, and emotional), psychosocial stressors, history of PMDD, low self-esteem, childcare stress, life stress, hormonal fluctuations, younger maternal age (especially adolescence), cigarette smoking, and number of pregnancies because the risk increases with each

pregnancy (Andrews-Fike, 1999; Beck, 2001; Bloch et al., 2005, 2006; Clay & Seehusen, 2004; Cole, 2009; Freeman, Wright, Watchman, Wahl, Sisk, Fraleigh, & Weibrecht, 2005; Howell, Mora, & Leventhal, 2005; Kennedy, Beck, & Driscoll, 2002; Meir, 2002; Pearlstein et al., 2009; Perfetti et al., 2004; Robertson et al., 2004). Predicting who will be affected by this illness is impossible (although some studies indicate certain groups with greater risk), therefore, all women should be screened before and after giving birth (Andrews-Fike, 1999; Brewer, 2001).

Postpartum Psychosis

The final postpartum mood disorder is postpartum psychosis. It is the rarest form of the postpartum disorders with a prevalence as high as 1 in 500 women who give birth (Andrews-Fike, 1999; Pearlstein et al., 2009; Perfetti et al., 2004; Robertson et al., 2004). The onset of postpartum psychosis can be as early as one day postpartum up to the first year after giving birth with the majority of women showing symptoms in the first four weeks (Andrews-Fike, 1999; Pearlstein et al., 2009; Perfetti et al., 2004; Robertson et al., 2004).

Postpartum psychosis symptoms are severe and include mood swings that can fluctuate rapidly, delusions, hallucinations, severe depression, and racing thoughts including suicide and infanticide (Andrews-Fike, 1999; Friedman, Resnick, & Rosenthal, 2009; Pearlstein et al., 2009; Perfetti et al., 2004; Robertson

et al., 2004). Other clues that a woman has reached postpartum psychosis and would need immediate medical attention include saying things like: "the baby is heavy, caring for the baby is too difficult, she has thoughts of harming herself, or she has strange thoughts about the baby" (Meier, 2002, p.298). Pearlstein et al.(2009) states that infanticide is one of the most serious risks of postpartum psychosis where a "rate of homicide of infants up to 1 year of age is 8 in 100,000 in the United States" (p. 359).

Brewer (2001) states "there are no social, economic, or educational predictors for postpartum psychosis; it can affect anyone" (p. 102). Sometimes a stressful event that occurs in the life of a mother suffering from PPD could send her into postpartum psychosis or at the very least deepen the depression (Brewer, 2001). Other times a patient who has seemed completely normal can suddenly develop PPD or postpartum psychosis (Brewer, 2001). The risk factors that could increase the likelihood of postpartum psychosis are sleep deprivation in a patient that is already susceptible, hormonal fluctuations, personal or family history of postpartum psychosis, psychosocial factors, previous bipolar or schizophrenic disorder, and any prior hospitalizations for psychiatric care (Friedman et al., 2009). The seriousness and potentially life threatening condition of postpartum psychosis requires immediate medical treatment and

hospitalization (Andrews-Fike, 1999; Pearlstein et al., 2009; Robertson et al., 2004). All three of these postpartum mood disorders can have devastating effects not only for the patient, but her family as well.

Effects of Postpartum Depression on Family

Effects on Offspring

Postpartum depression not only affects the woman, but her entire family. Research has consistently shown an association between untreated postpartum depression and detrimental effects on child development (Pearlstein et al., 2009). Some of the children's developmental problems include cognitive, emotional, neurological, motor, behavioral inhibition, language development, lack of social skills as well as mother-infant bonding, and emotional maladjustment in infants and children (Chaudron et al., 2007; Clay & Seehusen, 2004; Freeman et al., 2005; Gjerdingen & Yawn, 2007; Howell et al., 2005; Pearlstein et al., 2009; Peindl, Wisner, & Hanusa, 2004; Robertson et al., 2004; Seehusen, Baldwin, Runkle, Clark, 2005; Steiner, 2002).

Mothers suffering from PPD are also less likely to engage in preventive health practices such as not attending the well child visits or getting immunizations, not using a car seat or baby proofing the home (e.g., covering electrical outlets), and not engaging in breastfeeding practices (Chaudron, Kitzman, Szilagyi, Sidora-Arcoleo, & Ansen, 2006; Chaudron et al., 2007;

Freeman et al., 2005). The affects of maternal depression on children's developmental difficulties starts as infants and can last up to eight years of age (Beck, 2002; Bloch et al., 2006; Gjerdingen & Yawn, 2007). PPD also increases problems in adolescents including behavioral problems (which are usually violent), disruptive behaviors such as conduct problems and attention-deficit hyperactivity disorder (ADHD), as well as other psychiatric illnesses (Pearlstein et al., 2009).

Effects on Partner

Postpartum depression can affect the woman's partner as well. Another impact of PPD is stress on the marital relationship which could lead to problems in the marriage (Clay & Seehusen, 2004; Seehusen et al., 2005). One less discussed aspect of PPD is the fact that fathers and partners are more prone to developing depression if the mother is suffering from PPD (Clay & Seehusen, 2004; Seehusen et al., 2005).

In some respects it seems like the prevalence of PPD has increased over the last few years, but it is actually due to the media coverage of cases like Andrea Yates who drowned her five children in Texas after experiencing what some believe was postpartum psychosis (Brewer, 2001). Unfortunately, PPD is one of the least recognized and under-treated childbirth complications in the United States and worldwide (Gjerdingen et al., 2009a; Hanusa et al., 2008; Pearlstein et al., 2009; Stowe,

Hostetter, & Newport, 2005). Recognizing the consequences of PPD is important because of the impact it has on the entire family. Postpartum depression can cause detrimental short- and long-term affects on child development and can also have negative effects on the partner as well, including marital conflicts and paternal depression (Clay & Seehusen, 2004; Pearlstein et al., 2009; Seehusen et al., 2005). Therefore, screening for PPD should be of utmost importance so health care providers can ensure that diagnosis and treatment takes place as early as possible to reduce the harmful effects and increase the quality of life for women and their entire family.

Problem Statement

The purpose of this study was to review and synthesize the available body of research literature pertaining to the lack of universal screening for postpartum depression in women during pregnancy and after childbirth. Specifically, the study was designed to describe the individual and population health consequences of untreated PPD. Barriers to identification and treatment will also be discussed.

CHAPTER II

REVIEW OF LITERATURE

In Chapter I we discussed the fact that postpartum depression is a worldwide public health concern. PPD is "more prevalent than preeclampsia, gestational diabetes, and pre-term labor, this condition is the most undiagnosed, cavalierly dismissed, and misinterpreted postnatal complication" (Cole, 2009, p. 460). It can affect any woman no matter her race, socioeconomic status, education level, ethnicity, culture, or country of origin (Gjerdingen et al., 2009a; Hanusa et al., 2008; Pearlstein et al., 2009).

The cost of postpartum depression is very high consequentially. It is important to recognize the negative impact PPD has on the entire family (Pearlstein et al., 2009). Some of these consequences include harmful short- and long-term effects on child development, marital conflicts, and paternal/partner depression (Clay & Seehusen, 2004; Pearlstein et al., 2009; Seehusen et al., 2004). Kim, Gordon, La Porte, Adams, Kuendig, and Silver (2008) state that "the extreme consequences of undetected and untreated perinatal depression (suicide and infanticide) have awakened public interest and engendered support for maternal depression screening" (Kim, Gordon, La Porte, Adams, Kuendig, & Silver, 2008, p. 509.e4).

This chapter will review screening for postpartum depression. The methods and design, as well as the limitations and delimitations, of this review of literature will be discussed. This chapter will also examine the importance of screening for PPD. A description of the screening instruments and the role of health care providers in the screening process will be provided. Barriers to identification and treatment as well as state and federal legislation pertaining to screening for PPD will also be discussed.

Methods and Design

The design of this study is a non-experimental descriptive review of literature. The literature searches were done by locating journal articles through the on-line database at the UNI Rod Library using the Boolean Searching system. Specifically, the literature search was conducted using the US National Library of Medicine's Medline's internet portal PubMed (http://www.ncbi.nlm.nih.gov/sites/entrez). The time parameters used were 1999 to 2009. The first search used the terms postpartum depression and screening and there were 1,050 articles worldwide of varying types, lengths, and languages. This research narrowed the search field and reviewed the literature that was available in full text articles in the English language pertaining to the United States by using the terms postpartum depression and screening as well as postpartum

depression and diagnosis as the keywords. All articles not pertaining to the United States were eliminated. Internet searches were also conducted using !Yahoo (www.yahoo.com) to locate and obtain copies of state and federal legislative bills at government websites.

Limitations

The limitations identified in the study include the following: most of the studies researched were located in the PubMed database and were not large scale experimental studies. Also, the research was limited to the United States.

Delimitations

This study was delimited to the following: research that was published in the last 10 years (1999-2009), research located through the on-line database at UNI Rod Library, research that pertained to postpartum depression and the population that is affected, research that investigated screening tools used by health care providers and barriers to using them, and the research examining the state and federal legislation related to postpartum depression screening as well as the roles medical providers play in the screening process for PPD.

Purpose of Review of Literature

The purpose of this review of literature is to examine selected research literature from the last 10 years pertaining to the screening of women for postpartum depression. This

chapter reviewed the reasons women are greatly under diagnosed or go untreated for PPD altogether. Current screening tools and the use of these tools by health care providers was examined. Improvements in patient education and health care provider training in PPD were investigated as well. The review of literature also analyzed the next steps that need to be taken to ensure that every woman is screened for postpartum depression including current and past state and federal legislation pertaining to PPD screening.

Screening for Postpartum Depression

Introduction to Screening

This chapter will examine the first actions that need to be taken in order to reduce the number of women who suffer each year from PPD. Screening is the first step in diagnosis and treatment for PPD which is necessary for maternal, child, and family well being (Hanusa et al., 2008). Overcoming the constraints related to PPD screening is possible through research, patient education, health care provider education and training, universal screening instruments and standardized screening practices and procedures, as well as state and federal legislation requiring screening. These could ultimately reduce the number of women suffering in silence and enhance maternal and infant outcomes.

Importance of Screening

Therefore, we need to examine the importance of screening for PPD. According to the Centers for Disease Control, "approximately 4 million births occur annually in the United States (www.cdc.gov/nchs/fastats/births.htm), serial screening has the potential to identify and create opportunities to intervene with approximately 200,000 additional women, their infants, and their families whose depressive risk might not otherwise be identified with a single-screen strategy" (Kim et al., 2008, p. 509.e4). In order to reduce the number of women suffering from PPD we have to look at the importance of routine screening since more than 50% who have PPD symptoms remain undiagnosed and untreated (Clay & Seehusen, 2004; Hanusa et al., 2008). Most symptoms of PPD do not present clinically unless they are screened for during a routine visit (Andrews-Fike, 1999). Perfetti et al. (2004) state that "given the high prevalence rates of postpartum depression, the potential for dire consequences to mother and infant and the high likelihood for successful treatment, the importance of screening for postpartum depression is evident" (p. 59). Screening is the first step leading to diagnosis and treatment of PPD (Hanusa et al., 2008).

Screening Instruments

The importance of routinely screening all women for PPD cannot be emphasized enough. There are many instruments available to screen for postpartum depression. Several commonly used PPD screening tools include: Postpartum Depression Screening Scale (PDSS), Postpartum Predictors Inventory - Revised (PDPI-R), Beck Depression Inventory-II (BDI-II), Patient Health Questionnaire (PHQ-9), and the Edinburgh Postnatal Depression Scale (EPDS). These instruments are used to detect which women are at high risk for PPD throughout the first year after childbirth.

Postpartum Depression Screening Scale (PDSS)

The Postpartum Depression Screening Scale (PDSS) is a 35 question Likert scale self-report screening instrument written at a 7th grade reading level which is used after delivery and takes approximately 5-10 minutes to administer (Beck, 2001; Beck & Gable, 2001; Cole, 2009; Hanusa et al., 2008; Le, Perry, & Sheng 2009; Pearlstein et al., 2009). The PDSS assesses the following seven dimensions of PPD: sleeping problems (not being able to sleep when the baby sleeps), sudden weight gain or loss, anxiety (which is almost always present with PPD), feelings of guilt, impaired reasoning, emotional instability, and suicidal thoughts (Beck, 2001; Beck & Gable, 2001; Hanusa et al., 2008; Le et al., 2009). Each of these dimensions contain five

questions (Beck, 2001; Beck & Gable, 2001). The woman is asked to evaluate her feelings over the last two weeks by answering each question on a scale of (1)strongly disagrees, to (5)strongly agrees (Beck, 2001; Beck & Gable, 2001). The PDSS scores are evaluated as 1) in the normal range, 2) indicating PPD symptoms, and 3) indicative of major PPD (Le et al., 2009). Research indicates conducting phone interviews with mothers using the PDSS can be as successful as the pencil and paper method (Hanusa et al., 2008). One limitation is the cost associated with the use of this screening instrument (Hanusa et al., 2008).

Postpartum Predictors Inventory Revised (PDPI-R)

The Postpartum Predictors Inventory Revised (PDPI-R) is a screening questionnaire that is used during each trimester of pregnancy as well as after delivery and takes approximately five minutes to administer (Beck, 2002, 2003; Cole, 2009). The PDPI-R evaluates 13 demographic risk factors for PPD (Beck, 2002, 2003; Cole, 2009; Humenik & Fingerhut, 2007). These include history of depression (both pre-pregnancy and prenatal), life stressors, social and emotional support, prenatal anxiety, marital status and relationship satisfaction, self-esteem, whether or not pregnancy was planned or wanted, socioeconomic status, child care stress, newborn temperament, and history of postpartum blues (Beck, 2002, 2003; Cole, 2009; Humenik & Fingerhut, 2007).

Questions pertaining to postpartum risk factors (postpartum blues, child care stress, and newborn temperament) will not be asked during the pregnancy, but will be added to the interview postpartum. One limitation of the PDPI-R is that it is not a self-report screening instrument (Beck, 2002). Instead it is designed to be used in an interview format which has to be conducted by a clinician (Beck, 2002). Therefore, the clinician has to be trained in administering the PDRI-R as well as how to evaluate the results.

Beck Depression Inventory-II (BDI-II)

The Beck Inventory-II is a 21 symptom self-report screening instrument (Beck, 2001; Beck & Gable, 2001). The BDI-II is a tool that closely follows the American Psychiatric Association's DSM-IV postpartum depression classification (Beck, 2001; Beck & Gable, 2001). It contains several risk factors also included in the PDSS which are sleeping and eating difficulties, emotional instability, impaired reasoning, guilt, and thoughts of self-harm (Beck, 2001; Beck & Gable, 2001). The BDI-II also evaluates anxiety, feelings of worthlessness, problems concentrating, and reduction in energy levels (Beck & Gable, 2001). One limitation of the BDI-II is symptom overlap with major depression which is the category used by the DSM-IV (Beck & Gable, 2001). Therefore, this instrument does not focus on the primary PPD symptoms and

could potentially overestimate the number of PPD cases (Beck & Gable, 2001; Ugarriza, 2000).

9-item Patient Health Questionnaire (PHQ-9)

The 9-item Patient Health Questionnaire is a self-report nine question instrument using Likert scale responses that are based on the DSM-IV criteria for Major Depressive Disorder in which PPD is included as a subcategory (Gjerdingen et al., 2009; Kroenke, Spitzer, & Williams, 2001). The nine risk factors include loss of interest in doing things, feelings of hopelessness, sleep problems (too much or not enough), energy loss, eating difficulties (overeating or lack of appetite), feelings of worthlessness, concentration difficulties, moving and speaking slowly or very fast, and suicidal thoughts (Kroenke et al., 2001). This screening instrument asks the woman to evaluate her symptoms over the past two weeks with answers (0)not at all, (1)several days, (2)more than half the days, and (3) nearly every day (Kroenke et al., 2001). Each symptom is scored 0-3 points and a score of 10 or more indicates a positive diagnosis for depression with the exception of suicidal thoughts which if answered with a one or higher is considered positive for depression (Gjerdingen et al., 2009; Kroenke et al., 2001). This instrument has the same limitation as the BDI-II. It only assesses symptoms of major depression as described by the DSM-IV

and does not take into account symptoms only associated with PPD.

Edinburgh Postnatal Depression Scale (EPDS)

The Edinburgh Postnatal Depression Scale (EPDS) is one of the most common screening instruments used to detect PPD. The EPDS is a 10-item self administered questionnaire that is validated in the United States and 23 other countries worldwide (Andrews-Fike, 1999; Clay & Seehusen, 2004; Chaudron, Szilagyi, Kitzman, Wadkins, & Conwell, 2004; Delatte, Cao, Meltzer-Brody, Menard, 2009; Freeman et al., 2005; Le et al., 2009; Perfetti et al., 2004; Robertson et al., 2004). This is a free screening tool that is written at the 5th grade level and is available on-line to patients, health care providers, hospitals, and family members (Cole, 2009). A score of 5-9 means the patient is at high risk for PPD at any point during the first year after birth, whereas a score of 9-11 indicates a patient needs to be evaluated further while a score of $\geq$ 12 indicates PPD (Le et al., 2009; Pearlstein et al., 2009; Dennis, 2004; Peindl et al., 2004).

The goal of the EPDS is to assess postpartum depression symptoms including both emotional and cognitive (Le et al., 2009). It is the one screening tool that includes the anxiety element of PPD which is a defining factor in diagnosing this illness (Kabir, Sheeder, & Kelly, 2008). The EPDS is the only

self-report screening instrument that has been validated for use both prenatally and postpartum (Thoppil, Riutcel, & Nalesnik, 2005).

Several advantages in using the EPDS to screen for postpartum depression have been identified. One advantage is the lack of false positives and negatives which greatly reduces the chance for overestimating the number of PPD cases (Seehusen et al., 2005). Some other advantages include the instrument's brevity with only 10 questions, short administration time, it is free of charge to patients, patient's families, health care providers, investigators, as well as hospitals and clinics, it is available in 23 different languages, and research indicates this screening tool has great specificity and sensitivity (Hanusa et al., 2008; Thoppil et al., 2005). The EPDS is brief enough that it can be quickly scored by a nurse or other non-medical office personnel so that the result can be discussed between patient and health care provider at that visit (Perfetti et al., 2004). A copy of the EPDS is available in Appendix A.

One other screening method physicians use while determining a PPD diagnosis is a thyroid test (Brewer, 2001). Thyroid-related problems can be the cause of depression in nearly 10% of postpartum mothers (Brewer, 2001). Most family practice clinicians will perform a thyroid check first to rule

out a specific biological problem before further screening for PPD (Brewer, 2001).

Recent research indicates a new and promising way to screen for PPD (Le et al., 2009). Using the internet to administer screening PPD questionnaires (Le et al., 2009). One study compared using the internet to pencil- and paper-based screening techniques and found that both instruments generated equivalent information (Le et al., 2009). Over 60% of Americans who use the internet have searched for information pertaining to their health with 25% of those searching topics on mental health issues (Le et al., 2009). One limitation to this study was the concern of how to ensure that women who scored positively for PPD would be connected to community resources needed for diagnosis and treatment which could create challenges both ethically and legally (Le et al., 2009).

Role of Health Care Providers

The screening tools mentioned above will do nothing to reduce the number of women who suffer from PPD if there are no health care providers to administer the screening instruments and interpret the results. Most health care providers agree that there is an important and heightened need to screen women for PPD (Gjerdingen et al., 2009a). Although it is feasible for health care providers to screen women before and after childbirth during routine obstetric visits, postpartum visits,

and during well child visits, over 50% of women are still going undiagnosed and untreated for PPD (Gjerdingen et al., 2009a). Health care providers that have a great opportunity to detect possible PPD are obstetricians, gynecologists, and nurse midwives at the postpartum visit, as well as pediatricians, general practitioners, pediatric nurse practitioners, or other office nurses in the pediatric, family practice, and other primary care settings who participate in routine well baby visits (Gjerdingen & Yawn, 2007; Meier, 2002; Perfetti et al., 2004). These are the health care providers that women see most often and on a regular basis after childbirth (McGarry, Kim, Sheng, Egger, & Baksh, 2009; Perfetti et al., 2004).

Obstetrician's Role in Screening for PPD

Obstetricians can play an important role in screening women for PPD. One key element to diagnosing postpartum depression is screening patients during their pregnancy as well as after they deliver (Brewer, 2001; Perfetti et al., 2004; Thoppil et al., 2005). Perfetti et al. (2204) states "research has shown that as many as 23% of women who are diagnosed with postpartum depression had symptoms that started in pregnancy" (p. 58). Screening during the pregnancy is very important because depression during pregnancy is one of the risk factors for PPD. The earlier the diagnosis the shorter the duration for the illness and the less impact it will have on the family. Thoppil

et al. (2005) states that obstetricians are in a unique position for this type of screening as well as diagnosis and treatment intervention. Obstetricians routinely screen for many types of illnesses that could cause pregnancy complications (Thoppil et al., 2005). Therefore, PPD should be included in that list of illnesses.

Patient and partner prenatal education is a key factor in early recognition of PPD symptoms. The obstetrician can help prepare the couple by making them aware of possible challenges and methods in dealing with the illness (Andrews-Fike, 1999). This education could take place in the obstetrician's office or it could be included in the curriculum for prenatal childbirth classes given by the hospital.

Family Practice Physician's Role in Screening for PPD

Other clinicians that play a major role in treating women after childbirth are family practice physicians. Andrews-Fike (1999) states "family physicians are key players in the detection and treatment of PPD owing to the nature of the disease and the tendency for new mothers to negate their feelings as something other than a treatable psychiatric illness" (p. 9). There is evidence to indicate screening for PPD in outpatient care can increase the diagnosis and ultimate treatment even by using just a few questions (Gjerdingen & Yawn, 2007; Kabir et al., 2008; Steiner, 2002). Unfortunately less

than 50% of women suffering from PPD are currently being screened in primary care practices (Gjerdingen, Crow, McGovern, Miner, & Center, 2009b; Gjerdingen & Yawn, 2007).

Pediatrician's Role in Screening for PPD

Researchers are increasingly calling for pediatricians to include PPD screening during well child visits. Chaudron et al. (2007) states, "the American Academy of Pediatrics has described the scope of pediatricians' responsibilities to include assessment and consideration of parental and family environmental factors that may affect children's health, maternal depression being one of these" (p. 124). Clarification needs to take place to ensure pediatricians' roles only involve screening the mother in reference to enhancing the well being of the child which is the pediatrician's patient (Chaudron et al., 2007). There is no universal screening tool or standard requiring pediatricians to screen and refer mothers suffering from PPD for diagnosis and treatment although screening mothers for PPD is starting to gain acceptance in the pediatric community (Chaudron et al., 2007; Sheeder, Kabir, & Stafford, 2009a).

Sheeder et al. (2009a) state pediatricians are in a position to screen for PPD through the first 12 months postpartum due to the number of scheduled well child visits. The majority of pediatricians will see the mother at well-child

visits which normally take place at 2 weeks, 4 weeks, 2 months, 4 months, 6 months, 9 months, and 1 year after birth. Research shows that if pediatric health care providers screen mothers for PPD at the 2 month and 6 month well child visit then detection and ultimately treatment is enhanced (Sheeder, Kabir, & Stafford, 2009b). If that screening was included in every well child care visit throughout the first postpartum year there would be a much greater rate of detection of PPD symptoms since they can reappear or present for the first time after six months postpartum (Chaudron et al., 2006; Chaudron et al., 2004; Meier, 2002). Detection of PPD could greatly reduce the risk of infanticide and maternal suicide which is not only seen in postpartum psychosis, but also in severe cases of PPD (Pearlstein et al., 2009).

The U.S. Preventive Services Task Force (USPSTF) recommends that all health care providers provide a routine screening for depression to the general adult population which includes pregnant and postpartum women because it improves outcomes of women, infants, and their entire family. The USPSTF states there is fair evidence to recommend depression screening. Fair evidence is defined by USPSTF as "evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or

indirect nature of the evidence on health outcomes." The USPSTF also concluded that the benefits of depression screening outweigh the risks.

Research indicates varied rates of screening for PPD (Seehusen et al., 2005). Recent medical school graduates are more likely to routinely screen for PPD than older health care providers (Seehusen et al., 2005). Reasons for this include the importance of PPD screening being taught during residency, research in the medical literature indicating it is recognized as a serious but treatable condition, continuing education training, and media coverage (Seehusen et al., 2005).

Without health care providers, screening for PPD will not take place. Through medical provider education on the importance of PPD screening and training on implementing and interpreting screening instruments the number of women successfully being treated for PPD would increase. Therefore, the impact on the family would decrease and quality of life would be enhanced. Unfortunately, there are several barriers to screening for PPD.

Barriers to Screening

Overcoming the constraints related to PPD screening is possible through research, patient education, health care provider education and training, universal screening instruments and standardized screening practices and procedures, as well as state and federal legislation requiring screening. These could

ultimately reduce the number of women suffering in silence and enhance maternal and infant outcomes. There are three general types of barriers for PPD screening: patient barriers, health care provider barriers, and system barriers.

Patient Barriers to Screening for PPD

Women can create barriers to the screening process for PPD. One patient barrier is the hesitation many women have and the fact they will not disclose their symptoms to their health care provider (Andrews-Fike, 1999; Freeman et al., 2005; Kabir et al., 2009; McGarry et al., 2009; Pearlstein et al., 2009). This hesitation can be out of fear of being judged, the child being removed from the home, or the stigmatization associated with being diagnosed with a mental health disorder if they were to reveal the symptoms they are experiencing (Burstein, 2004; Freeman et al., 2005; Gjerdingen & Yawn, 2007; Perfetti et al., 2004; Ugarrizza, 2002). Women also feel guilty and ashamed that the reality of motherhood is not this blissful, happy, and joyous time in their lives (Andrews-Fike, 1999; Freeman et al., 2005; Kabir et al., 2009; McGarry et al., 2009; Pearlstein et al., 2009). Women need to understand that PPD is nothing more than a treatable illness just like any other medical condition (Andrews-Fike, 1999).

Similarly, lack of patient education creates another patient barrier among postpartum women (Clay & Seehusen, 2004;

Freeman et al., 2005; McGarry et al., 2009). They may not even realize they are experiencing symptoms of PPD (Clay & Seehusen, 2004; Freeman et al., 2005; McGarry et al., 2009). Patient education is a must and should include understanding what PPD is, how to recognize signs and symptoms as well as where and how it can be treated (Meier, 2002). Other constraints include lack of insurance coverage for treatment and lack of mental health resources in the community (Chaudron et al., 2007; Gjerdingen & Yawn, 2007). Through patient education alone many of these barriers can be removed.

Health Care Provider Barriers to Screening for PPD

Many obstacles are encountered by health care professionals which might explain why so many women still fall through the cracks of our health care system in the United States. Pearlstein et al. (2009) state "clinician discomfort with psychiatric disorders, time constraints, low belief in maternal mental health having an important effect on child development, and lack of knowledge about resources are some of the barriers to clinician screening for psychiatric disorders in medical settings" (p. 358). Research indicates another health care provider barrier being lack of universal screening instruments, to screen all postpartum women without exception, because many health care providers are not aware free screening tools exist in the medical literature and on-line (Seehusen et al., 2005).

Other reasons women are not screened for PPD include health care provider lack of knowledge regarding PPD and lack of education on how to implement screening instruments (Gjerdingen & Yawn, 2007). A major health care provider barrier to PPD screening is the fact that "it takes an average of 17 years after new medical knowledge has been generated in clinical trials to become incorporated into clinical practice" (Seehusen et al., 2005, p. 107). Additionally, lack of screening is also related to the health care provider perception that it will be time consuming, with few incentives, which reduces the likelihood physicians will see the importance of including it in their routine visits (Chaudron et al., 2004; Gjerdingen & Yawn, 2007; Kabir at al., 2008; Seehusen et al., 2005).

One example of a pediatric health care provider barrier is the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that refers to the sharing of patient records between providers (Chaudron et al., 2007). The fact that the mother is not the pediatrician's patient and there is an increase in confidentiality when it pertains to a patient's mental health records creates another problem for screening (Chaudron et al., 2007). Also, since the mother is not the pediatric health care provider's patient many insurance companies will not allow a mental health referral for diagnosis and treatment or

reimbursement for services for someone who is not their patient (Chaudron et al., 2004; Gjerdingen & Yawn, 2007).

One study identified a "gap between what providers know should be done and what is actually being done at postpartum visits" (Delatte et al., 2009, p. e64). In many cases PPD screening is just not being done during office visits (Chaudron et al., 2004). One reason for this may be the medical profession changing from paper medical records to electronic ones which makes it difficult to include a questionnaire (Gjerdingen et al., 2009a). Another aspect of concern to health care providers is liability for the patient they are screening (Chaudron et al., 2007; Gjerdingen & Yawn, 2007). There is uncertainty and confusion of who will be responsible for patient follow-up (Chaudron et al., 2007). Other health care providers do not think they have the proper education, training, or valid screening instrument needed to diagnose PPD (Gjerdingen & Yawn, 2007; Gjerdingen et al., 2009a).

Health Care System Barriers to Screening

Barriers related to the health care system also prevent screening of PPD (Gjerdingen & Yawn, 2007). One is lack of communication between primary and mental health care providers (Clay & Seehusen, 2004; Gjerdingen & Yawn, 2007). Other constraints include not having a standardized protocol for screening, diagnosing, and referral of patients (Clay &

Seehusen, 2004; Gjerdingen & Yawn, 2007). Also included in health care system barriers are managed care policies and pressures as well as lack of community mental health resources (Clay & Seehusen, 2004; Gjerdingen & Yawn, 2007).

State and Federal Legislation For PPD Screening

To improve mother and infant postpartum outcomes this review of literature examined current and past state and federal legislation. The Healthy Start Initiative Grants, which are received by the following: Department of Health and Human Services, Health Resources and Services Administration, and Maternal and Child Health Bureau, go one step further stating all pregnant women should be screened for depression (Kim et al., 2008).

Two states have passed and enacted state legislation requiring PPD screening: New Jersey and Illinois (Kim et al., 2008). On April 13, 2006, New Jersey was the first state to sign into law a mandate requiring physicians to educate pregnant women and their families about PPD signs and symptoms and to also demand health care providers screen for PPD in new mothers (Bender, 2006). This was ground breaking legislation, known as Public Law 2006 c12, that was spearheaded by State Senate President and former N.J. Governor Richard Codey and his wife, who experienced PPD after she gave birth to their children (Bender, 2006). Likewise, the state of Illinois was the second

state to enact a similar bill, The Perinatal Mental Health Disorders Prevention and Treatment Act (Senate Bill 15), pertaining to PPD education and screening. This law requires all health care professionals providing prenatal and postnatal care as well as hospitals who have labor and delivery units, to provide education for the woman and her family pertaining to PPD signs, symptoms, treatment options, and resources (Perinatal Mental Health Disorders Prevention and Treatment Act, 2008). Also required by this law is for health care professionals to ask each woman in her third trimester of pregnancy and postpartum to complete a PPD screening questionnaire according to the American College of Obstetrics and Gynecologists recommendations and to discuss the results with each patient (Perinatal Mental Health Disorders Prevention and Treatment Act, 2008). The law also states pediatric health care providers must ask the mother to complete a PPD screening questionnaire at each well baby visit until the end of the infant's first year of life and to discuss the results with the mother (Perinatal Mental Health Disorders Prevention and Treatment Act, 2008).

Similar legislation at the federal level includes "US Senate S.3529 Mom's Opportunity to Access Help, Education, Research and Support for Postpartum Depression Act" (Kim et al., 2008, p. 509.e5). The H.R. 20 which is also known as the *Melanie Stokes Postpartum Depression Research and Care Act* seeks to

expand and intensify medical research on the cause, diagnosis, and treatment of postpartum depression and postpartum psychosis (H.R. 20, 2007). This bill was first introduced to the 107th Congress in the 2001-2002 session, but it took seven years to pass in the House. Meier (2002) states that "mental health parity legislation is difficult to pass Congress" (p. 296). As of September 13, 2009, the H.R. 20 Bill had been passed by the House and was awaiting a Senate vote and if it passes the Senate it will then need to be signed by the President before it is enacted. Unfortunately, state and federal legislation is usually born out of someone's tragic loss of a mother, child, or both. Legislation at both the state and federal levels are necessary in order for universal screening tools and practices to be mandated nationwide and eventually worldwide. Le et al. (2008) state "the World Health Organization has outlined criteria that help practitioners and policy makers identify conditions that warrant widespread screening" and that will "certainly apply to postpartum depression" (p. 220).

Postpartum depression is an increasing global public health concern that affects the majority of postpartum women and their families and costs the United States billions of dollars each year (Gjerdingen & Yawn, 2007). Unfortunately there are "no clear cut predictors for diagnosing PPD (although subgroups of women are described in the literature), it would seem advisable

to screen all women for depression during both the antepartum and postpartum periods" (Andrews-Fike, 1999, p. 12). Most physicians miss the diagnosis for PPD because the symptoms are not apparent and patients need to be screened for PPD using such instruments as the EPDS (Andrews-Fike, 1999).

To improve mother, infant, and family outcomes this review of literature examined state and federal legislation pertaining to PPD screening. Only 2 out of 50 states in the United States have passed legislation requiring PPD screening: New Jersey and Illinois (Kim et al., 2008). The first federal legislative act pertaining to PPD screening has passed the House and is in the Senate waiting for a vote (Kim et al., 2008). If all 50 states passed a law requiring PPD screening then the majority of health care provider barriers and health care system barriers would be addressed and diagnosis and treatment of this debilitating illness would increase as would the mothers, infants, and their families quality of life.

CHAPTER III

SUMMARY, RECOMMENDATIONS, AND CONCLUSION

Summary

In our society the birth of a child is associated only with happiness, love, and being completely overjoyed. No one speaks of this life-changing event in terms of the stress and challenges it brings to your life. The reality is this year over 500,000 women in the U.S. will be affected by the most common and treatable childbirth complication. Even with all of the medical advances and technology we have available today, it is one of the most under-diagnosed and untreated global mental health issues. This illness is postpartum depression (PPD).

Postpartum depression, postpartum blues, and postpartum psychosis are all types of postpartum mood disorders that women may experience after the birth of a child. Postpartum blues are the mildest and most prevalent form of the postpartum mood disorders with approximately 85% of women experiencing symptoms within the first few hours up to 10 days. The postpartum blues will resolve on their own usually within two weeks. All researchers agree that the postpartum blues is a risk factor for PPD.

Postpartum psychosis is the most severe and rare form of postpartum mood disorder and affects approximately 1 in 500 women. Postpartum psychosis can appear from birth up to the end

of the infant's first year of life. The onset can be sudden and have detrimental consequences such as maternal suicide and infanticide. Immediate medical attention and hospitalization is usually required.

Postpartum depression has a mild to severe range of symptoms with an onset at around three months, but can be seen up to one year after childbirth. Any woman can be affected by PPD no matter her socioeconomic status, educational level, ethnicity, culture, country of origin, age, or race. Only about 50% of women who suffer from this debilitating illness are actually diagnosed. The earlier PPD is diagnosed the shorter the length of illness and the less impact it will have on the entire family.

PPD not only affects the woman, but her family as well. Untreated PPD can be harmful to a child's cognitive development and the effects can last into adolescence. There is an increased probability of mother's who suffer from PPD putting their child's life at risk because they are less likely to attend well child visits and get immunizations, use a car seat, or baby proof the home. PPD can cause marital strife as well as increase the likelihood of partner depression. The financial, emotional, and medical impact on a family is extensive.

The first step in diagnosing and treating PPD is routine screening for this illness. PPD does not present clinically so

it is necessary to screen each and every woman routinely through pregnancy and the first 12 months postpartum. This will help detect the more than 50% of women who go undiagnosed and untreated each year.

Many screening instruments are available to identify women with PPD. The most promising and commonly used is the Edinburgh Postnatal Depression Scale. This tool was developed over 20 years ago and has been used and validated in the United States and numerous other countries worldwide. The EPDS is available in 23 languages and is an easily administered self-report questionnaire that usually takes less than five minutes to complete. This screening instrument is available to everyone on-line for free.

Health care providers play an important role in screening women for PPD. All providers need to be educated on how to administer and interpret the results of the screening instruments. The providers with the greatest opportunity for screening are obstetricians, family practice physicians, and pediatricians.

The obstetrician as well as some family practice physicians can start screening women during pregnancy. These providers also see patients at least once postpartum. The provider with the most opportunity for screening in the 12 month postpartum period

is the pediatrician. Well child visits take place approximately seven times during the infant's first year of life.

Screening for PPD can be difficult because of three different types of barriers: patient, health care provider, and health care system. The most common patient barriers are guilt- and fear-based. Many women hesitate revealing the fact they are suffering from PPD symptoms because they fear the child will be taken away, that they will be viewed as a bad mother, or labeled with a mental health disorder. Patient education will resolve most of these barriers.

Health care provider barriers are more challenging. The stigma of the term psychiatric disorder seems to make physicians just as uncomfortable as the patient when it comes to discussing postpartum depression. Other barriers include lack of time during appointments, not believing that PPD affects a child's development, HIPPA constraints related to mental health referrals, as well as concerns about patient liability. Also, another provider barrier is the inordinate amount of time, approximately 17 years, that it takes for medical research to be incorporated into clinical practice (Seehusen et al., 2005).

The last barrier discussed in this literature review is health care system barriers. Many physicians do not communicate between disciplines which is not in the best interest of the patient. Also, there are managed care policies that make

screening for PPD more difficult. Many communities do not have the mental health resources available to women and their families. This is where the government needs to step in with state and federal legislation mandating PPD screening.

Only 2 of 50 states have enacted state legislation requiring physicians to routinely screen for PPD in all women for 12 months after giving birth. Both New Jersey and Illinois laws also require patient education and screening for PPD during the 3rd trimester of pregnancy for every woman. Similar federal legislation about PPD screening has passed the House of Representatives and is currently awaiting a vote in the Senate.

Postpartum depression has been a health care concern for decades. Perfetti and colleagues (2004) state that "given the high prevalence rates of postpartum depression, the potential for dire consequences to mother and infant and the high likelihood for successful treatment, the importance of screening for postpartum depression is evident" (p. 59). Screening for PPD is necessary for diagnosis and treatment of this debilitating illness. Screening could have a tremendous impact on the entire family by decreasing the harmful consequences as well as increasing the quality of life.

Recommendations

Patient Recommendations

Patients need to be educated about postpartum depression. This education can start in our high school and college sex education classes. Therefore, at least the term postpartum depression will be familiar. Women also need to be educated about PPD from a mother, aunt, grandmother or any other female relative who has experienced giving birth, especially if they also experienced PPD. Letting the patient know about their PPD experiences and the challenges women face when you become a mother would help prepare women for the possibility they may experience PPD themselves. This would also help give women a realistic view of the stress and challenges associated with becoming a mom and help remove the unrealistic societal view that motherhood is all about love, joy, and happiness. The family members may also have ideas and information about resources available in their community to help them. This would open up communication about PPD and remove some of the stigmatization surrounding it. One very important point for all women to know is they did nothing to cause the PPD and they should not feel guilty or ashamed about dealing with this very treatable childbirth complication. If everyone started referring to PPD as a childbirth complication rather than a mental health disorder, more women would be willing to find help and seek

treatment. At that point some of the patient barriers would disappear.

Health Care Provider Recommendations

Several of the barriers mentioned above could be eliminated through patient and health care provider education. All health care providers need to be trained and educated about the signs and symptoms of PPD as well as the possible consequences and impacts on each woman and her family if this disease goes undiagnosed and untreated. Providers need to be aware of the reason it is so important to screen for PPD. Health care providers could receive continuing education credits through on-line courses or educational conferences to learn about PPD, how to administer the screening instrument and interpret the results, and what steps to take to ensure a patient who tests positive for PPD gets diagnosed and treated.

An open dialogue between the mother and her health care provider about PPD should be started at the first prenatal visit and should continue with each subsequent visit throughout the first postpartum year. Increasing communication about PPD between patient and provider would reduce the stigmatization of a mental health illness and help both patients and providers see PPD as a treatable illness just like other pregnancy and childbirth complications. Educating both the provider and patient will make screening during and after pregnancy more

straightforward and less complicated. Screening could then be seen as just another test that is performed both during and after pregnancy. One team of researchers suggested having health care providers include the EPDS screening as part of the patient's vital signs (Delatte et al., 2009).

Policy Recommendations

The Illinois state legislation known as the "Perinatal Mental Health Disorders Prevention and Treatment Act" is the most comprehensive bill that has been signed into law pertaining to postpartum depression screening. This law states that all licensed health care professionals who provide women with prenatal or postnatal care are required to administer a PPD screening questionnaire and review the results with the patient. Also required in this law is for licensed health care professionals providing pediatric care to an infant to administer a PPD questionnaire to the infant's mother at every well baby checkup until the infant is 12 months old. The pediatric professional is also required to review the results of the questionnaire with the mother. In order for the results to be shared with the mother's primary care provider or other mental health professionals the mother is required to sign a consent form according to the state's Health Insurance Portability and Accountability Act. The only time consent is not

required is if the mother poses an immediate threat of danger to herself or others.

All states in the United States desperately need a bill that includes all of these aspects related to PPD screening to ensure that all women are screened for this illness. Every concerned person can impact whether or not a bill is created and introduced in the state legislature by lobbying their state politicians and elected officials. The time it takes for a bill to be introduced until it becomes law can be many years.

Health Care System Recommendations

Health care system barriers are probably the most challenging to overcome. A standardized protocol for screening, diagnosing, and referral of patients will be necessary in each hospital and clinic (Clay & Seehusen, 2004; Gjerdingen & Yawn, 2007). Also, an open line of communication needs to be established between mental health professionals and health care providers who care for women prenatally and during the first postpartum year. Signing a consent form, in accordance with HIPPA, will facilitate sharing of PPD screening results between disciplines. This will help expedite diagnosis and treatment which will reduce the duration of the illness. Continuity in the screening process among health care providers is absolutely necessary and with standard protocols for screening, diagnosis, and treatment it is possible. PPD screening needs to be

addressed through more research so that we may create a universal screening and diagnostic tool, implement screening guidelines for health care providers, and ensure treatment for each woman who suffers from this debilitating, sometimes life threatening, and, most importantly, treatable illness.

Conclusion

Universal screening for postpartum depression is necessary to improve the rates of diagnosis and treatment in women after childbirth. So many new mothers suffer in silence with over 50% never being diagnosed or treated for PPD. There are many negative consequences that are associated with untreated PPD that can affect the entire family. These include detrimental effects on child development, marriage strife, increasing the risk of partner depression, as well as maternal suicide and infanticide in severe cases. As a PPD survivor, I know the importance of screening for PPD during pregnancy and the 12 month postpartum period.

Postpartum depression can be especially difficult for first time moms because they do not know what to expect when their first child is born. They are very familiar with the picture society has portrayed for women when they become mothers although it is anything but realistic. This most stressful and life changing event can cause mothers to very easily become

consumed with shame and guilt that the birth of her baby is not the most joyful and happy time in her life.

Routine screening is essential to decrease the harmful effects of PPD on the woman and her family and to increase quality of life for each person. Health care providers play an important role in administering PPD screening instruments as well as interpreting the results which will help facilitate diagnosis and treatment. Many of the barriers to PPD screening can be overcome by each state passing a law, similar to the one in the state of Illinois, requiring screening for postpartum depression for both prenatal and postnatal women up to 12 months postpartum. Screening is imperative for the ultimate well being of the mother, infant, and entire family.

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APPENDIX A

Edinburgh Postnatal Depression Scale (EPDS)

Circle the number for each statement, which best describes how often you felt or behaved this way *in the past 7 days*.....

I have been able to laugh and see the funny side of things.

0 As much as I always could

1 Not quite so much now

2 Definitely not so much now

3 Not at all

Things have been getting on top of me.

3 Yes, most of the time I have not been able to cope at all

2 Yes, sometimes I have not been coping as well as usual

1 No, most of the time I have coped quite well

0 No, I have been coping as well as ever

I have looked forward with enjoyment to things.

0 As much as I ever did

1 Rather less than I used to

2 Definitely less than I used to

3 Hardly at all

I have felt so unhappy that I have had difficulty sleeping.

3 Yes, most of the time

2 Yes, sometimes

1 Not very often

0 No, not at all

I have blamed myself unnecessarily when things went wrong.

0 No not at all

1 Hardly ever

2 Yes, sometimes

3 Yes, very often

I have felt sad and miserable.

3 Yes, most of the time

2 Yes, quite often

1 Not very often

0 No, not at all

I have been anxious or worried for no good reason.

3 Yes, quite a lot

2 Yes, sometimes

1 No, not much

0 No, not at all

I have been so unhappy that I have been crying.

3 Yes, quite a lot

2 Yes, sometimes

1 No, not much

0 No, not at all

I felt scared or panicky for no very good reason

3 Yes, quite a lot

2 Yes, sometimes

1 No, not much

0 No, not at all

The thought of harming myself has occurred to me.

3 Yes, quite often

2 Sometimes

1 Hardly

0 Never

Total = _____