SCREENING WOMEN FOR POSTPARTUM DEPRESSION

By

PEGGY ANN STEWARD

A manuscript submitted in partial fulfillment of the requirements for the degree of

MASTER OF NURSING

WASHINGTON STATE UNIVERSITY
Intercollegiate College of Nursing

December 2006
To the Faculty of Washington State University:

The members of the Committee appointed to examine the manuscript of Peggy Ann Steward find it satisfactory and recommend that it be accepted.

[Signatures]

Chair

[Signature]

[Signature]
ACKNOWLEDGMENTS

I am so grateful for the opportunity to attend graduate school at Washington State University, Intercollegiate College of Nursing. I appreciate the support I have received from the facility in Yakima and also in Spokane.

To Lorrie Dawson, my faculty chair who has been a great source of information and support with my research project. To Denise Smart and Laura Hahn, who graciously agreed to be a part of my committee and have worked hard to assist me in my efforts.

To the wonderful professors that have been so supportive and helpful along the way: Lorna Schumann, Ed Gruber, Ruth Bindler, and Mel Haberman. They have been great examples to me and probably do not realize how much help they have been to me.

To Margaret Ruby, who helped guide me through the program answering many of my questions.

To my wonderful parents who have supported me in countless ways throughout my educational experiences: my father who has been very encouraging and motivational along the way, and my wonderful mother who has been very patient and supportive and has been able to take time to care for my two boys even during her struggle with cancer. Although she enjoyed it, I know it had not been easy. There is no way I could have done it without them.

To my wonderful husband, Aron, who has been very supportive with my goals to become a nurse practitioner. You have been patient with me as I have taken much time away from being a mother and wife to pursue my education. In many ways you have had to do a lot more work. To my sons, Kainoa and Kalani, who have also been patient with
me and have made this experience of being away from you a lot easier, although it has been hard. I love you all very much.
SCREENING WOMEN FOR POSTPARTUM DEPRESSION

Abstract

By Peggy Ann Steward, M. Nurs.
Washington State University
November 2006

Chair: Lorrie Dawson

Postpartum depression has been a major topic of discussion over the last few years in the media, health, and research. The effects of postpartum depression can be damaging to mothers, infants, and families. This research paper will review current screening tools, risk factors, and treatment options for postpartum depression. A previous or current history of psychiatric illness, including depression and/or bipolar disorder increases the risk of PPD. It is important to assess women prenatally to help reduce the risk of PPD. Although the EPDS appears to be the most widely used tool for PPD screening, the two item tool recommended by the USPTF has been found to be equally as effective. Antidepressants and/or psychotherapy are successful treatment options for women with prenatal and postpartum depression. The research reviewed helped develop an algorithm to assist healthcare providers screen women for PPD during their childbearing and childrearing years.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGEMENTS</td>
<td>iii</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>v</td>
</tr>
<tr>
<td>LIST OF TABLES</td>
<td>vii</td>
</tr>
<tr>
<td>LIST OF FIGURES</td>
<td>viii</td>
</tr>
<tr>
<td>CHAPTER</td>
<td></td>
</tr>
<tr>
<td>1. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>1</td>
</tr>
<tr>
<td>Statement of the Purpose</td>
<td>3</td>
</tr>
<tr>
<td>Conceptual Framework</td>
<td>3</td>
</tr>
<tr>
<td>2. REVIEW OF LITERATURE</td>
<td>5</td>
</tr>
<tr>
<td>Screening/Assessment</td>
<td>5</td>
</tr>
<tr>
<td>Risk Factors</td>
<td>9</td>
</tr>
<tr>
<td>Treatment</td>
<td>11</td>
</tr>
<tr>
<td>3. NURSING IMPLICATIONS</td>
<td>12</td>
</tr>
<tr>
<td>4. SUGGESTIONS FOR FUTURE RESEARCH</td>
<td>13</td>
</tr>
<tr>
<td>5. CONCLUSION</td>
<td>13</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>15</td>
</tr>
</tbody>
</table>
LIST OF TABLES

1. Symptoms of Major Depression.................................................19
2. Symptoms of Postpartum Depression.....................................20
3. Useful Websites...........................................................................21
LIST OF FIGURES

1. Postpartum Depression Algorithm ......................................................... 22
Dedication

This research project is dedicated to my mother
(December 16th, 1952- September 5th, 2006),
father, and husband who provided both
emotional and financial support.
Screening Women for Postpartum Depression

The psychiatric condition of childbearing women has become a major health issue (Mazur, Keita, & Blehar, 2002). Postpartum depression (PPD) has been a serious topic of discussion over the last few years in the media, health, and research. PPD can also affect the maternal-infant bond (Mazur et al.). Women have become more aware of signs and symptoms of PPD, however there are insufficient use of screening tools for women by providers. Major depression is managed mainly by primary care providers, but 35% to 50% of the situations go unrecognized (Whooley, Avins, Miranda, & Browner, 1997). By identifying risk factors and prevalence of PPD, depression can be better assessed prior to pregnancy, during pregnancy, and postpartum to minimize the effects of PPD. With the serious rates of depression in women, and the recent acknowledgement of postpartum depression, it is crucial that research be on-going to understand, screen, treat, and prevent depression that occurs during childbearing and childrearing years.

Statement of the Problem

Depression is an illness prevalent among women ages 20 to 30. Depression has been noted to begin as early as age 15 and decline around age 45, the common years of childbearing (Kahn, Moline, Ross, Cohen, & Altshuler, 2001). Depression affects 1 in 4 women (Kahn et al.). In 2004, 1 in 20 women who were either pregnant or had given birth experienced major depression (“New AHRQ”, 2005). Major depression is a mood disorder that affects the way people undergo normal mood states (Kahn et al., 2001). See Table 1 for Symptoms of Major Depression. Research suggests that mood disorders are biological illnesses involving changes in brain chemistry. Emotional stress can sometimes generate these changes. Pregnancy can be a time of emotional and physical
stress. Researchers have observed PPD as affective and/or psychotic symptoms that are brought on by the stress of pregnancy, birth, and postpartum changes and happen to occur in the postpartum period (Ugarriza, 2000).

Women with a history of depression prior to pregnancy are about two and one-half times more likely to experience PPD. It is important to be aware of depression in pregnancy to reduce the risks of PPD (Buesching, Glasser, & Frate, 1986). One out of five women experience some symptoms of depression during pregnancy and one out of ten women experience major depression. Women with a history of depression have a greater risk of developing depression in pregnancy, especially if antidepressant use is discontinued while trying to become pregnant (Kahn et al). If major depression is not treated in pregnancy, there may be serious risks for mother and fetus. Prenatal depression involves a biological dysregulation that can be harmful to fetal development. Untreated prenatal depression can result in behavioral risks such as smoking, alcohol consumption, poor nutrition, and suicidal behavior. These behaviors can result in low birth weight and prolonged or preterm labor (Kahn et al.). Prenatal depression often goes unrecognized because many of the discomforts of pregnancy and the postpartum period are comparable to symptoms of depression (Gaynes, et al., 2005). Many women are not assessed for depression during pregnancy or the postpartum period although it is a major health concern (Lintner & Gray, 2006).

Women are able to self-identify symptoms of depression, but few are diagnosed by their providers. This may be due to lack of screening tools available or administered or lack of compliance in seeking care for depression. In addition, the stigma or denial of depression may be a factor. Women with a history of depression (about 25% of women)
are twice as likely to have signs of prenatal depression (Marcus, Flynn, Blow, & Barry, 2003). Additionally, a large number of women screened in obstetric settings have significant symptoms of depression but most of them are not being monitored or treated for depression. Women with depression experience decreased psychological adjustment and quality of life (Badger, Braden, Mishel, & Longman, 2004). Although depression has physical causes, some people view it as a character flaw or personal weakness (Aetna, 2005). This stigma may prevent people from seeking treatment for depression.

It is imperative that future efforts are made to help reduce the risks of developing PPD. The Summit on Women and Depression, recommends future research and funding for the following: a) prevention, b) services research and treatment, c) public education, and d) treatment, prevention, and service delivery (Mazur et al., 2002).

Statement of the Purpose

The purpose of this paper is to provide a review of current research regarding PPD and provide an algorithm to help assist health care providers screen for PPD in women during their childbearing and childrearing years.

Conceptual Framework

Reva Rubin first introduced concepts of maternal identity. There are four maternal tasks a mother deals with during pregnancy: (a) seeking safe passage, (b) ensuring the acceptance of the child by others, (c) binding in or bonding with the fetus, and (d) learning to give of oneself (Rubin, 1984). Rubin focused her work on the “traditional” mother’s dealing with Maternal Role Attainment (MRA) from the point of acceptance of the pregnancy to one month postpartum (Sartore, 1996). MRA is a process in which a mother achieves competence in her role and integrates the mothering
behaviors into her established role set, so she that she may become comfortable with her identity as mother (Mercer, 2004). Building on the efforts of Rubin, Mercer studied mothers of all age groups and extended the process to 12 months postpartum. Mercer’s (2004) research demonstrated that first-time mother’s self-efficacy with infant care was enhanced from 4 to 12 months. However, their satisfaction of parenting did not improve. Self-efficacy with infant care was associated with both parenting and marital satisfaction (Mercer, 2004).

Mothers with PPD experience alteration in the process of MRA. The mother is not comfortable with her role and is not confident with her identity as a mother. Mothers with PPD also have more negative perceptions of their infants, of themselves as mothers, and of their ability to provide appropriate care for their infants at 2 to 3 months following birth (Fowles, 1998). Mothers who reported higher levels of depression, anxiety, and marital ambivalence and conflict during pregnancy reported less meaning in the parenting role (Porter & Hsu, 2003). When dealing with PPD, the goal is to enhance MRA by allowing the mother to build confidence in herself and her role. This may be accomplished by encouraging support groups and parenting classes during the prenatal and postpartum periods. Allowing mothers to remain in the hospital the full recommended time could help mothers adjust to their role as a new mother. Swedish mothers who had longer postpartum hospitalization had greater confidence in their ability to cope. Prenatal identification with the mother role was related to mothers’ satisfaction with motherhood (Mercer, 2004). It is important to encourage mothers to take part in understanding the mother role during the prenatal period. Although women with more child-care experience had more confidence in their role as a mother during pregnancy, it
was not a determining factor of postpartum self-efficacy (Mercer). By identifying and supporting women who do not have MRA and/or may have a risk of prenatal depression, may help prevent or minimize the effects of PPD.

Review of Literature

In the 1950s, scientific observation and investigation of dysphoric episodes in the early puerperium began (Henshaw, 2003). The definition of dysphoric is “a state of feeling unwell or unhappy” (Merriam-Webster Online, 2005). Although sometimes unclear, there are three distinct postpartum disorders. These include: (a) postpartum “blues”, a transient syndrome that usually spontaneously resolves within 2 weeks, (b) postpartum psychosis, a serious but uncommon disorder, experienced by 1 in 1,000 to 2,000 postpartum women and may include a brief psychosis, schizophrenia, an organic brain disorder, or a major affective disorder, and (c) postpartum depression (Ugarriza, 2000). The incidence of postpartum depression is estimated to occur in 10 to 30% of postpartum women (Ugarriza). Research on postpartum mood disorders has increased over the last 30 years, which has improved our knowledge about PPD (Gale & Harlow, 2003).

Screening/Assessment

In identifying risk factors of PPD, it is important to know about a woman’s history of depression prior to pregnancy. The long term effects of PPD on mothers and their families can be reduced if there is early identification of PPD. All women should be assessed with validated screening tools because of the heightened risk of depression during childbearing (Lintner & Gray, 2006). Women with increased levels of prenatal depression were also two and one-half times more likely to have increased levels of
depression at six weeks postpartum and three times more likely to have a past history of depression. However, only 30% of women experienced transient postpartum depression; concluding that past depressive episodes and prenatal depression increase the risk of postpartum depression (Buesching, Glasser, & Frate, 1986).

Although prenatal depression is as common as PPD, it often goes unrecognized because many of the distresses of pregnancy such as fatigue, emotional changes, weight gain, and trouble sleeping mimic the symptoms of depression (Gaynes et al., 2005; “New AHRQ”, 2005). It is important to be aware of the severity and characteristics of the symptoms to help distinguish between depression and the normal discomforts of pregnancy.

Midwives or prenatal nurse practitioners need to assess for PPD risk factors prenatally. The prenatal assessment history should include preexisting or past medical history of mental illness. Nurses need to be allowed time to educate women about PPD and obtain resources for interventions if necessary (Edebohs & Ecklund, 2002). The likelihood of having prenatal depression and PPD could be decreased if psychosocial variables such as daily stress, pregnancy-specific stress, anxiety, and depressed mood are assessed and appropriate pharmacologic or therapeutic interventions are made (Da Costa, Larouche, Dritsa, & Brender, 2000). Table 1 contains common symptoms of postpartum depression.

Screening improves the correct identification of depressed patients in primary care settings and treatment of depressed adults recognized in primary care settings decreases clinical morbidity. The benefits of screening are expected to outweigh any risks (USPSTF). The USPSTF (U.S. Preventive Services Task Force) also recommends
follow-up support after screening. It is also important to provide local resources to assist mothers, such as educational materials about depression, handouts about self-help approaches for depression, parental assistance and referral (Olson et al., 2005). See Table 2 for useful websites discussing PPD.

Existing screening tools can be beneficial in identifying prenatal depression but have been found to be more reliable in identifying major depression (Gaynes et al., 2005). Whether assessing for major or minor depression, screening tools are appropriate to use to identify women who do not have depression, but are less accurate in distinguishing those who do (Gaynes et al).

A prospective time-series descriptive design was used to screen women for prenatal and PPD (Ugarriza, 2000). Although the Atypical Depression Diagnostic Scale (ADDS) and the Beck Depression Inventory (BDI) are used to screen for depression, they are not specific to PPD. The ADDS and the BDI were used to measure different facets of depression. These tools were given to 124 women two times before delivery and two times during the postpartum period. Results revealed that these tools may not be effective screening tools to measure PPD (Ugarriza). The ADDS increased false positives in diagnosing depression due to the similarity in symptoms of normal occurrences of pregnancy and the postpartum period. The BDI also overestimated depression and did not concentrate on the specific symptoms of postpartum like having thoughts of harming the baby or being overwhelmed by motherhood (Ugarriza).

Research has found that only the Postpartum Depression Screening Scale (PDSS), the Edinburgh Postnatal Depression Scale (EPDS), and the Bromley Postnatal Depression Scale (BPDS) have been created specifically to measure PPD symptoms, whereas other
screening instruments have been used for general symptoms of depression and psychiatric stress (Boyd, Le, & Somberg, 2005). The tools discussed are brief and can be administered in a fairly short time. The PDSS or the BDI-II has been found to be most effective in screening highly educated, predominately Caucasian participants. The PDSS could also be used for an assessment of the postpartum experience (Boyd et al.). However, the EPDS is the most extensively utilized screening tool for PPD and reveals moderate to good reliability properties (Cronbach’s $\alpha = .73-.87$) among samples from an extensive variety of languages and countries. The EPDS is a 10-item questionnaire measuring cognitive and emotional symptoms. The EPDS, regrettably, has low to moderate correlations (.45-.52) with State Anxiety Inventory (STAI) concluding that the EPDS may not be an accurate measure of postpartum depression because it includes anxiety symptoms, and should cautiously be used as an accurate screening tool for PPD (Boyd et al.).

Given that the EPDS may not be an accurate measure of postpartum depression, alternative screening tools may be necessary. Two questions that the USPSTF (2002) recommends may be just as effective as other screening tools in diagnosing depression: (a) “Over the past two weeks, have you ever felt down, depressed, or hopeless?” and (b) “Over the past two weeks, have you felt little interest or pleasure in doing things?” These two questions may be more efficient for use by providers and patients at health care visits (USPSTF). Screening tools can identify prenatal and postpartum depression and these tools may more accurately identify major depression (“New AHRQ,” 2005).

Whooley et al. (1997) researched two similar questions: (a) “During the past month, have you often been bothered by feeling down, depressed, or hopeless?” and (b)
“During the past month, have you often been bothered by little interest or pleasure in doing things?” They found that these two questions were effective in identifying patients with major depression. If the patient answered “no” to each question, depression was highly unlikely. A positive response to either question had sensitivity of 96% (95% confidence interval [CI], 90-99%) and specificity of 57% (95% CI, 53-62%). This concludes that the two-item questionnaire is effective for measuring depression in primary care, is less-time consuming, and has similar characteristics to other depression screening tools. These questions should be used to improve diagnosis of major depression in patients who present with symptoms or are at high risk for depression (Whooley et al.).

**Risk Factors**

Women are at greater risk for PPD if they have preexisting psychiatric disorders, including bipolar disorder and depression. If there is a positive family history of mental illness or previous history of PPD, women are also at higher risk (Edebohls & Ecklund, 2002; Henshaw, 2003; Lee, n.d.). Risk factors for prenatal or postpartum depression include past history of depression, recent stressors, negative life events during pregnancy, diminished quality of the mother's own parenting, substance abuse, feeling fatigued and not getting enough sleep, doubts about being a good parent, sharp change in hormone levels, problems with previous birth or pregnancy, changes in work and home routines, anxiety about the unborn child, and financial or marital problems, past or current history of abuse or neglect, lack of support from significant others, and decreased self-esteem and negative personality traits (Austin, 2004; “New AHRQ,” 2005).
A history of depression prior to pregnancy or prenatal depression and/or anxiety substantially increases the risk for recurrent episodes of depression during the postpartum period (Gale & Harlow, 2003; Battle & Zlotnick, 2005; Lee, n.d.) Women with a history of PPD will have about a 25% chance of a recurrence and about 50% of women with PPD will have symptoms last up to a year after delivery. In addition, almost one-half of the occurrences of PPD are extensions of depression that occurred before or during pregnancy (Lee).

Certain personality types have been found to be a significant risk factor of PPD, although the risk factors are generally psychological in nature, particularly with aspects of social support, life stress, and past psychopathology (Dennis & Boyce, 2003). Women with a history of major depression need to be counseled regarding their risk of PPD before delivery (Nonacs, Viguera, Cohen, Reminick, & Harlow, 2001).

Women with a history of a previous depressive episode or neurotic depression often experience the most severe symptoms of PPD in the first week postpartum (Henshaw, 2003). About half of the women experiencing a depressed mood during pregnancy also become depressed during the postpartum period, thus entailing the involvement of other risk factors in the development of PPD (Da Costa et al., 2000). A history of psychiatric illness, involving a history of postpartum psychosis and/or bipolar disorder is the most significant risk factor for postpartum psychosis. This also increases a woman’s risk of experiencing postpartum psychosis with subsequent births (Gale & Harlow, 2003). Women with bipolar disorder have an increased risk of a postpartum psychotic episode if they have a family history of postpartum psychosis. This
suggests an association between postpartum psychosis and genetics (Gale & Harlow, 2003).

Treatment

Women with a risk of developing PPD need to be referred to a mental health provider for treatment with psychotherapy or antidepressants (Gale & Harlow, 2003). This can be initiated before, during, or with women at risk postpartum. It is appropriate to identify high-risk women and consider initiation of treatment prior to delivery (Blenning & Paladine, 2005). Providers need to be aware of the risks and benefits of prescribing medications near delivery and during postpartum lactation (Gale & Harlow).

Antidepressants and/or psychotherapy/psychosocial support can be a successful treatment for women with prenatal and postpartum depression ("New AHRQ," 2005). PPD may be prevented if women at risk are given emotional support and antidepressants during and after labor (Blenning & Paladine, 2005). If women have a history of antidepressant use, it is appropriate to use a medication that has been effective in the past, as long as the medications are safe during pregnancy.

Although it is suggested to continue on medication during pregnancy if a women has a history of antidepressant use, providers should try to treat symptoms with psychotherapy alone for a woman who is mildly depressed, wanting to conceive, and not currently taking medication. If the symptoms are severe, either first episode or beyond, medication and psychotherapy is advised (Kahn et al., 2001).

Postpartum support groups and counseling with non-mental health professionals also show improvement in symptoms in mildly depressed women. Research has shown that when a lay person (peer volunteers were women with previous PPD and received
appropriate training) provided feedback, information, and emotional assistance, and made referrals to health care services if needed, there was a significant decrease in depressive symptoms at both 4 and 8 weeks during the postpartum period. However, it is recommended that women with severe depression be counseled by highly trained mental health professionals (Kopelman & Stuart, 2005).

Kopelman and Stuart (2005) recommend the following stepwise approach for PPD:

For a postpartum woman with mild depression, a less costly intervention, such as nurse-delivered nondirective counseling, would be a reasonable first step. For postpartum women with more severe depression, or for those who do not respond to less intensive interventions, it may be appropriate to make a referral for or provide an intervention such as interpersonal psychotherapy. Women with depression that does not respond or women for whom medication is otherwise indicated should be treated with antidepressants in addition to counseling. (p. 565)

Because interpersonal psychotherapy focuses on interpersonal function and role transition, it is an essential treatment option prenatally and postpartum.

Although less commonly used as a treatment option, electroconvulsive therapy appears to be safe and effective. However, it is most effective with more severe postpartum depression, particularly psychotic depression (Mazur et al., 2002).

Nursing Implications

The discussion of the current research on postpartum depression has helped develop an algorithm that could be used for screening and treatment of women with PPD (see Table 3). It is anticipated that this algorithm will help make screening and treatment
for nurse practitioners more efficient and thorough. Counseling and assessment of symptoms also need to be ongoing with each patient. It is also important to assess current support mechanisms and networks. Pertaining to depression, the role in nursing is to understand depression during the childbearing and childrearing years and to continue with the innovative research to develop both assessment tools, training for nursing students, nurses, and providers who work with this population of women and families to help minimize the risk of PPD. It is also important to educate and counsel all women prenatally to become more aware of the signs and symptoms of PPD.

Suggestions for Future Research

With the high rates of depression in women, and the recent acknowledgement of postpartum depression, it is crucial that research be ongoing to understand, screen, treat, and prevent depression that occurs in women. Further research could expand upon effective treatment options for women with PPD and also effective depression screening tools for women in childbearing and childrearing years. It would also be beneficial to determine the effectiveness of the USPSTF 2-item questionnaire to screen specifically for postpartum depression.

Conclusion

Research has found that there are certain predisposing factors that heighten the risk of developing postpartum depression. A history depression prior to pregnancy or prenatally, substantially heightens the risk of recurrent episodes of depression during the postpartum period. By knowing these risk factors, providers can be more aware of at-risk women and treat them accordingly either prenatally and/or postpartum. There has also been research that includes effective screening tools for postpartum depression.
Although many tools have been developed to screen for depression, only a few are specifically used for PPD. The EPDS appears to be the most widely utilized tool for screening of PPD. However, the EPDS has 10 items compared to the two questions that the USPTF recommends for the screening of depression. The latter would be a more efficient way of screening for depression. It was also found that counseling/psychotherapy (either professionally or by providers is the best initial treatment for women with postpartum depression and no history of depression. For women with postpartum depression and a history of major depression or women who are not responding to counseling or psychotherapy, it would be beneficial to initiate anti-depressants in addition to psychotherapy. It is imperative that after the initiation of screening for depression there is compliance in the follow-up care by the patient and the provider.
References


I


Table 1. *Symptoms of Major Depression*

<table>
<thead>
<tr>
<th>Symptoms of major depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressed mood most of the day, nearly every day for 2 weeks or longer</td>
</tr>
<tr>
<td>And/or loss of interest or pleasure in activities that the person enjoys</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of energy or fatigue</td>
</tr>
<tr>
<td>Restlessness</td>
</tr>
<tr>
<td>Feeling slowed down</td>
</tr>
<tr>
<td>Difficulty concentrating</td>
</tr>
<tr>
<td>Feelings of worthlessness or guilt</td>
</tr>
<tr>
<td>Sleeping too much or not sleeping enough</td>
</tr>
<tr>
<td>Recurrent thoughts of suicide or death</td>
</tr>
</tbody>
</table>

Kahn et al., p. 110
**Table 2. Symptoms of Postpartum Depression**

<table>
<thead>
<tr>
<th>Symptoms of postpartum depression</th>
</tr>
</thead>
</table>

**Thoughts**
- Worry about harm or death to baby or partner
- Lack of concentration and poor memory
- Ideas about suicide
- Running away from everything
- Inability to think clearly and make decisions
- Fear of being rejected by partner

**Feelings**
- Exhaustion, sadness, emptiness, tearfulness
- Failure, inadequacy, helplessness, hopelessness
- Confusion, panic, anxiety
- Fear for the baby and of the baby
- Guilt, worthlessness, shame
- Fear of being alone or going out
- Persistent low mood

**Behaviors**
- Overeating or not eating
- Withdrawal from social contact
- Lack of interest or pleasure in usual activities
- Insomnia or excessive sleep, nightmares
- Poor self-care
- Inability to cope with routine tasks
- Decreased motivation and energy

*(Doermann, n.d.)*
<table>
<thead>
<tr>
<th>Website Name</th>
<th>Web Address</th>
<th>Available Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Jersey Department of Health and Senior Services</td>
<td><a href="http://www.state.nj.us.health/fhs/ppd/home.shtml">http://www.state.nj.us.health/fhs/ppd/home.shtml</a></td>
<td>Support and resources for women, families, and health care providers. Information available in Spanish</td>
</tr>
<tr>
<td>Depression after Delivery, Inc.</td>
<td><a href="http://www.depressionafterdelivery.com/Home.asp">http://www.depressionafterdelivery.com/Home.asp</a></td>
<td>Testimonials, resources information on symptoms and treatment</td>
</tr>
</tbody>
</table>
1. Over the past two weeks, have you ever felt down, depressed, or hopeless?

2. Over the past two weeks, have you felt little interest or pleasure in doing things?

- Yes to either:
  1. Counsel with pt regarding symptoms of depression
  2. Assess need for anti-depressant use or referral to therapist, support group, and future follow-up
  3. Evaluate whether breastfeeding, and if previous medication is compatible with breastfeeding

- No to both:
  1. Assess current support mechanisms and networks
  2. F/u @ annual exam, initial prenatal exam, postpartum, and/or pm

- History of anti-depressant use
  - YES
  - NO (or previous anti-depressant ineffective)
    1. Counsel with pt regarding symptoms of depression
    2. Assess need for referral to therapist, support group, and future follow-up
    3. Assess current support mechanisms and networks

1. Prescribe previously effective anti-depressant if compatible with breastfeeding
2. Assess current support mechanisms and networks