Postpartum Depression: A Guide For Healthcare Providers

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By

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Dedication

This project is dedicated to my son, who has made motherhood such an incredible journey. Sedi bear you make mommy’s heart fill up with pure love and happiness and I am the luckiest mom. I would like to thank my family and friends for loving me and supporting me as I pursue my dreams. To my professors, you have all guided me through this incredible journey to make one of my life goals a reality. Thank you for your continued support, encouragement and kindness. To my Thursday night supervision, you are an amazing group and have shown me unconditional love and support. I enjoy the laughs we share and appreciate the support you gals/guy show me. Bobbie, I could not have completed this project without you. You are an amazing woman and I love you sissy. Mom and dad, I love you and thank you for pushing me to get an education. You are amazing parents and have provided me with great opportunities. Sid, you are a remarkable man and without you I would not have my beautiful son. Thank you for the endless love you give me, and for holding my hand and never letting go. Your unrelenting support, encouragement and patience has seen me through the past three years.
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ABSTRACT

POSTPARTUM DEPRESSION:
A GUIDE FOR HEALTHCARE PROVIDERS

By

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Master of Science in Counseling,
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The purpose of this workshop is to increase both health providers’ and their patients’ awareness of postpartum depression. Providing awareness to health providers is the starting point to providing much needed treatment and relief of a silent and debilitating disorder. The material is laid out in PowerPoint format and serves as a guideline for intervention and treatment. It is imperative that healthcare providers work in a collaborative effort to treat antenatal and postpartum depression. It is estimated that 950,000 women suffer from postpartum depression each year, yet it is hardly recognized by providers (postpartumprogress.com, 2010). This major health concern deserves the same attention as other serious health conditions. Although in recent times men have begun to share the load of responsibilities that encompass parenting and raising a family, women are still considered the primary caregivers. This may be especially true during an infant’s first year of life.
Chapter 1

Introduction

Postpartum Depression is a growing epidemic that continues to go undetected, undertreated, underreported and most often overlooked. Approximately 10%-28% of women will suffer from postpartum depression (Fox, Hostaras, & Misri, 2000). Often times postpartum depression will be dismissed by the woman and by the treating physician as the “baby blues,” or just a normal part of adjusting to having a new baby. It is important for health providers and women to be aware of not only the physical aspects of a pregnancy but the mental as well. Woman may not be aware that they can speak to their doctors about mental health issues. The proposed project is to bring that level of awareness to both women and their providers. Treating physicians may not be responsible for treatment per se but they can help women by referring to appropriate providers who can. Postpartum depression increases a woman’s risk for reoccurring episodes of depression (Bryan, Gforgiopoplos, Wollan and Yawn, 2001).

Health providers are required to take part in continued education courses/workshops. The workshop is to provide health care providers with much needed education on the various aspects of postpartum depression and how crucial the screening process is. Health providers have the most contact with women before conception, during the prenatal period and postpartum periods. The workshop will also assist health providers with understanding their role in early identification and how to proceed from there. Providing a level of awareness and comfort with the topic may prompt health providers to include postpartum depression in their routine check-ups or office visits. The prevalence rates for postpartum depression are high, yet the identification and treatment remain low (Goodman & Tyer-Viola, 2010).
Statement of need

The significant rate of women suffering from postpartum depression is alarming and warrants the need for health practitioners to gain a greater awareness and understanding of postpartum depression, intervention and treatment. Support and understanding is a great tool that can assist with recovery and maintenance of alleviating depression both prenatal and postpartum. Throughout the literature many providers express feeling unsure of how to not only assess for postpartum depression but how to approach the subject with their female patients during and after pregnancy. An ideal way to communicate the need for awareness and intervention to providers is through a workshop. The proposed workshop is designed as a tool for providers to access and acquire knowledge. Providers will gain a better understanding of the signs and symptoms, risk factors, rates of occurrence, and various ways to discuss postpartum depression with their patients. The intention is for participants of the workshop to leave with a greater understanding of the devastating affects this disorder has on women and their families.

Unfortunately there is not much research on the effectiveness of provider workshops. There is, however, an abundance of literature on the effectiveness of group therapy facilitated by various types of healthcare providers. Although the studies proceeded with caution when generalizing the results due to limitations, many studies were able to find significant improvement in the reduction of postpartum depression with women who received group therapy, or a combination of group therapy and interpersonal therapy. If providers themselves do not poses a level of knowledge of the disorder, then how will they be able to help their patients through the recovery process? The workshop is designed for all healthcare providers.
**Purpose of the project**

The purpose of this project is to present material on postpartum depression to a diverse group of providers in a flexible manner to make it easy for them to incorporate into their practice. The ideal outcome is for providers to walk away with confidence and motivation to assist their patients in the battle of this debilitating disorder. As a mother who has recovered from postpartum depression I remember feeling isolated and in a hole of unrelenting despair after I gave birth to my son. During my prenatal and postpartum checkups my doctor never discussed the possible complications that could occur. Postpartum depression was not part of the discussion of a healthy pregnancy. The focus remained on the baby and my physical health.

A few days after my son and I were released from the hospital, he had to be readmitted and treated for jaundice. Hospital policy required a social worker to take my partner and I into a room and discuss my son’s stay in the hospital. Once she finished she provided time for my partner and I to discuss any concerns. At this time I disclosed how anxious and detached I was feeling. I told her that I could not stop crying, I was having difficulty sleeping, I was extremely anxious and I felt a certain void. I did not want to be alone with my son. It was as if I was afraid to be with him. His presence made me feel nervous. I did not feel like hurting him but I did not want to be near him. I told her that this was not a normal feeling. I knew something was not right. She simply dismissed it as a normal aspect of recovery and quickly dismissed it as hormones. I did not feel validated, I felt discouraged and felt I should not discuss this with my doctor for fear he may tell me the same thing. I began to think that there was something wrong with me, that maybe I was defective in some way. I was mentally deficient. At the time I did not have health coverage.
and was not able to pursue any type of counseling. I did not know there was such as thing as a sliding scale for low-income families. Unfortunately my depression persisted for more than a year. Had my doctor or the social worker been more educated on the signs of postpartum depression and took the time to listen to me instead of being quick to dismiss it as “normal,” then I might have had a quicker recovery.

The workshop is an intervention of sorts. The goal is to provide education on how to be present and attuned to the patients’ mental health needs during the prenatal and postpartum period. Areas of coverage will be prevalence rates, risk factors, how to present the topic with a level of ease and understanding while normalizing how she may be feeling, and various ways to incorporate awareness into the providers practice. After much research it is apparent that the intervention may in fact need to begin with providing knowledge to healthcare providers. At first the motivation behind this workshop was to provide women and their families the education and awareness needed. After much thought and research it is apparent that if the professionals women seek help from do not know how to help them then the awareness women poses will be irrelevant and the depression will persist. The focus then changed to providers.

The workshop will cover the criteria for postpartum depression, statistics, prevalence rates, treatment and stories from women of various backgrounds who have suffered through and recovered from postpartum depression. The workshop will also be a platform for providers to voice concerns they may have about postpartum depression and how to intervene. It is important to remind the doctors and nurses who have the most contact with women that treatment does not need to solely lie in their hands. The resource section is to
provide ways to find local mental health providers including those that offer payment on a sliding scale. The workshop is relevant to all providers.

**Terminology**

*Postpartum Depression* defined by Ericksen et al. (2011) is an episode of minor or major depression occurring within the first year postpartum. According to the DSM-IV-TR, *postpartum depression* is a specifier for Major Depressive Disorder. It is considered Major Depressive Disorder With Postpartum Onset.

*Health care* is defined by Merriam Webster Dictionary as efforts made to maintain or restore health. *Provider* is defined as supplying what is needed, to supply for use. When put together it is defined as one that provides healthcare.

*Workshop* as defined by Merriam Webster Dictionary is a seminar emphasizing exchange of ideas and practical methods.

*Social support* defined by Logsdon and Usui (2001) is a well-intentioned action that is willingly given to an individual with whom he or she has a personal relationship with and that creates an immediate or delayed positive response in the recipient.

*Parenting stress* is defined as disparity between the demands associated with parenting and the perceived resources available to meet those demands (Gunau, et al., 2010).

Fischbach and Herbert, (1997) define *Abuse* as an act that results in, or is likely to result in, psychological, physical, or sexual harm or suffering to, including threats of such acts, coercion or arbitrary deprivation of freedom, whether occurring in public or private (as cited by Ansara et al., 2002).

The journey into motherhood requires a major life adjustment. At some level the expectant parents are aware of the change that will occur but never does once fully
understand until the baby arrives. Some women may anticipate changes in mood after birth. Experienced mothers enjoy recounting the early days of their baby’s life and retell their stories of how their hormones were “out of wack” but in time they return to normal. A mother’s story is her badge of honor and her words of wisdom will be passed on to expectant moms. It is a rarity to hear a woman warn an expectant mom about the not so minor mood disturbances. This project is the starting point to making it a spoken reality, and to provide hope and recovery. Postpartum depression is the unspoken truth, the unspoken reality for many mothers. The following section is a review of the literature on various subtopics of postpartum depression. This section will provide statistics on the prevalence rates. Several studies will be cited and possible implications will be discussed. The literature review will provide insight to the readers about the darkness a woman can experience during the pregnancy and postpartum period.
Chapter 2

Literature Review

Prevalence and Predictors

Postpartum depression seems to be a growing epidemic that calls for more in depth research in order to bring more awareness and knowledge to the public. There is a general consensus amongst the literature that the postpartum period of a woman’s life is a vulnerable time. Campbell & Cohn (1991) explain that the postpartum period is a time of elevated risk for the onset of adjustment difficulties and psychiatric disorders for women. Psychosis, which is a more severe form of postpartum depression, is said to affect about one in six hundred women (Buist, 2002). Due to this alarming concern, several training programs have been created to assist health providers learn how to identify and assess postpartum depression.

The majority of the programs have been created to extend the care outside of the practice for the convenience of the women to ensure a chance of a higher success rate for treatment and intervention. Many of these programs focus on provider care that is conducted by nurses facilitating home visits to help new mother’s deal with their feelings (Buist, 2002). The purpose of these programs is to alleviate possible barriers to treatment. The opportunity to schedule the process to begin this extension of care is discussed during the well baby visits (Logsdon and Usui, 2001). Countries including, Australia, Germany and the UK have found these programs to be successful (Ellefsen et al., 2010). Some programs have been created to recognize antenatal depression, which has been identified as a significant factor in determining postpartum depression (Austin et al., 2010). Based on the findings, a greater importance should be placed on antenatal depression.
The earlier depression is identified the sooner it can be properly treated. The development and implementation of programs for families providing education and awareness must co-exist with the treatment of healthcare practitioners to be effective. In the United States very little information is provided to women during the prenatal period regarding the multitude of changes that will be experienced subsequent to labor. On the contrary, other countries offer specialized centers and hospitals for postnatal care.

In the United States there seems to be a great deficiency in resources available to women and their families. There are vast amounts of media and literature on what to expect both during the prenatal and postpartum period. However, there is a shortage of information exploring the dark realities of postpartum depression. The magnitude of postpartum depression deserves so much more than one chapter in a book. More routes to recovery are needed than what is currently offered by social media and/or a five-minute conversation during a prenatal postpartum visit. Knowledge and education is key in overcoming this ever-present damaging condition.

It is necessary for Healthcare providers to develop an open dialogue to discuss the challenges mothers may encounter. This is where the conversation can begin to include the darker aspects of motherhood, such as postpartum depression or psychosis. At a minimum a provider’s practice ought to include support, which can come in the form of educational resources or referrals to professionals who may be better equipped to treat postpartum depression. According to Arndt et al. (2007) in 2006 the state of New Jersey passed a law called the Postpartum Depression Law in which women were screened for postpartum depression. Buist (2002), stated women will not fall into depression if asked by her provider how she feels. An open line of communication between patient and provider not only helps
build good rapport but offers a safe environment for the patient to discuss any foreign feelings she may be experiencing. Provider outreach may elicit a sense of comfort and safety in disclosing threatening symptoms.

There is a link between depression and women who fall in the lower range of the socio-economic ladder (Arndt, O’Hara, Segre, and Stuart, 2007). Goodman and Tyer-Viola (2010) state 13% of new mothers will suffer from postpartum depression and up to 38.2% of new mothers in the lower range of the socioeconomic ladder. Coping with life stressors may be more difficult for women who do not have adequate wages to support their family system. Those without reliable modes of transportation or adequate housing may be more susceptible to falling into a depression. Arndt et al., (2007) studied the affects of life stressors on prenatal and postpartum women and found a significant relationship between depression and being on the low end of the socioeconomic ladder. Arndt et al., (2007) found 28.3% of women with an annual income of less than $10,000 are at an elevated risk of experiencing postpartum depression. Although women with low income are at higher risk for postpartum depression, it does not necessarily mean that they will suffer from postpartum depression. In fact (Arndt, et al., 2007) have found that 60% of these women were not depressed.

Poverty alone is not enough to trigger postpartum depression in low-income women. Other variables such as education levels and abuse have been identified as possible risk factors. However, Campbell and Cohn (1991) only included high school graduates in their sample, which may have contributed to the findings for lower levels of education being correlates of postpartum depression. Most researchers have identified an onset of depression occurring in the first month to six months postpartum. Campbell and Cohn (1991) used a
sample size of 1,033 women and contacted the women by letter, phone, or a visit in the hospital as a means of gathering data for their study. They have found that 96% of these women met depression criteria and 38% of these women experienced five or more symptoms, indicating a possible diagnosis of major depression.

Campbell and Cohn (1991) found that in addition to lack of education and financial means of survival, complications during delivery also contributed to depressive symptomology in first time mothers. Records and Rice (2005) have also cited social support, history of depression and socioeconomic hardship as contributing factors to postpartum depression. Many of these predictive factors are evident during the prenatal period. Beck (2001) identifies prenatal depression, lack of social support and prenatal anxiety as strong predictors of postpartum depression. Several studies have used self-reporting tools as a means of measuring depression. As a result, women may either underreport or over report their symptoms. One can infer that healthcare providers need to acquire a level of awareness to recognize and intervene when women display or disclose feelings of depression.

Mental Health and Help Seeking Behaviors

There are many stressors and life changes that accompany a pregnancy and birth of a new baby. A woman’s mental health prior to, and during the birth of her child may be possible determinants of whether she experiences postpartum depression or depressive symptomology. Buist (2002) suggests that all health providers interacting with pregnant women should be thoroughly educated and more aware of depressive symptomology. In order to properly diagnose and treat postpartum depression, healthcare providers, not limited to doctors and nurses, must become more aware of varying symptoms of at risk mothers. As a result, the occurrence of postpartum depression and its effects on the mother,
infant and family may substantially decrease. Symptoms that providers commonly dismiss as normal parts of early parenting may be indicators of depressive symptomology. Symptoms include; fatigue, frequent crying, irritability, sleep disturbance, anxiety, lethargy and feelings of inadequacy (McIntosh, 1993).

The research that has been conducted primarily in Australia, Buist (2002) has found that one of the major predictors of postpartum depression is antenatal depression. The screening tool used was the Edinburgh Postnatal Depression Scale (EPDS), which can be found in most studies and has been found to be highly effective with identification of depression during the prenatal and postpartum period. According to Baksh, Egger, Kim, McGarry and Sheng (2009), women are at a higher risk of experiencing postpartum depression than they are of experiencing any other complication during pregnancy. With this being said, postpartum depression is still not detected as often as other complications such as; gestational diabetes or pregnancy associated hypertension (Beksh et al., 2002).

Regardless of a woman’s educational background postpartum depression may not be a familiar topic or a topic she is comfortable discussing. However, if she is aware of “the baby blues,” then this could be considered the beginning of normalizing the occurrence of postpartum depression and reassure her that there is help without negative repercussions. Normalization of postpartum depression and removing the stigma of the subject may help to eliminate the barriers to help women openly discuss. Talking about the “baby blues” can be used as a starting point to discuss the different levels of depression escalating to postpartum depression. It is typical for a woman to experience “the baby blues” postpartum, but these feelings usually do not last for too long and have less of an impact on the mother’s ability to care for her infant. It is important health providers distinguish the difference between baby
blues and postpartum depression and not confuse the two. Proper understanding of levels of depression can eliminate accidental dismissal of more serious conditions. Once discussion is open it may be possible to normalize the subject and help to reassure women that they are not alone.

Some factors that may contribute to postpartum depression and help-seeking behaviors have been identified as lower levels of education, the woman’s age, and lower income levels (Baksh, et al., 2002). Women who fall into any of these categories seem to be less likely to report depressive symptomology. Reasons for this may be due to cultural background, income levels and medical coverage, or the woman’s inability to identify what she is feeling. Emotional abuse has been identified as another variable related to women not seeking treatment or not disclosing depressive symptomology (Baksh, et al., 2002). It is possible that this may be due to fear of the abuser or the woman’s inability to derive a relationship between the abuse and feelings of depression.

Two-thirds of the women who reported symptoms of postpartum depression did not seek help or disclose their symptoms to their doctor, nurse or any other health care provider. These women tended to be non-white, less educated and younger than their counterparts (Baksh, et al., 2002). According to Records and Rice (2005) less than 25% of depressed women reported to their primary health-care provider their symptoms. Another 50% have been undiagnosed and or undetected for over a month after delivery.

**Emotional Abuse**

A history of physical or sexual abuse prior to pregnancy has been associated with postpartum depression (Loudon and Silverman, 2010). Ansara, Cohen, Gallop, Schei, Stewart, and Stuckless, (2002) reported several studies confirming a relationship between
abuse and low mental health. With more exposure and awareness, the public is more conscious of violence against women and the commonality of it. In particular, abuse during childhood is associated with depression in the adult woman (Ansara, et al., 2002). Higher rates of depression, chronic medical problems, obesity, and increased medical use have been reported in the general population succeeding abuse (Records and Rice, 2005).

Certain, Fleming, Jagodzinski and Mueller, (2008) reported that 7.4% of their samples had been either emotionally or physically abused by someone they knew within the last year. Race and emotional abuse were found to be strong predictors for postpartum depression in (Baksch, et al., 2009) study. Records and Rice (2005) suggested physical and sexual abuse might be predisposing factors of postpartum depression. Cohen (et al., 2002) states that a history of violence is one factor that has not been widely examined but did find that women with a history of abuse are at increased risk for postpartum depression. Studies that do not specifically ask subjects about abuse could be the reason the link between the two is underreported. Cohen, et al., (2002) found that 29.6% of women in their sample reported emotional abuse as an adult and 3.5% reported emotional abuse as a child.

Loudon and Silverman (2010) used The Edinburgh Postnatal Depression Scale (EPDS) as their tool for gathering data for postpartum mood changes associated with postpartum depression. Women’s age, ethnicity, marital status and education were part of the variables being measured in their study. It was reported that 21.4% of women scored ≥9, which indicates a significant change in mood postpartum. The study provides evidence of a relationship between abuse prior to pregnancy and postpartum depression (Loudon and Silverman, 2010). Buist (1998) provided their participants with a mood questionnaire, the Monash Scale, and was given 1 week to complete and return the forms. Other self-reported
scales were provided to the women to assess the severity of depression, anxiety, social support and adjustment postpartum. All the women who had been physically or emotionally abused had been given a diagnosis of major depression. Ansara (et al., 2002) found that 11.01% of women in their study had a history of childhood or adult abuse. Specifically, adult emotional abuse was reported by 29.6% of women and 3.5% was reported for emotional abuse as a child. Adult emotional abuse was the only abuse variable that was found to be significantly associated with postpartum depression (Ansara, et al., 2002).

Records and Rice (2005) state that physical, sexual or emotional abuse is an influential factor on an individual’s mental state. It is believed that the impact of abuse subsists regardless if the abuse occurred during childhood, adolescence or adulthood. Abuse itself does not cause mental or physical disease, however depression is one outcome that abused people are at a higher risk of developing once abused (Patricelli, 2005). Abuse may change a woman’s thought process and ability to see life clearly for fear of repercussions from the abuser. The abusers manipulative ways make the woman feel that it is something she has done to deserve the abuse she is receiving. Whether physical or mental there is a toll it takes on her sense of self worth. Abused women seem to have an altered concept of self and experience anxiety and depression more so than non-abused women (Records and Rice, 2005). Violence and abuse induces heightened arousal due to the threat of physical injury (Records and Rice, 2005).

As cited by (Certain, et al., 2008), 29% of women experienced domestic abuse in their lifetime. It was also cited that poor social support and low socioeconomic status were consistent correlations in domestic abuse during pregnancy, (Certain, et al., 2008) but this relationship has not been found in other studies. It was found in a study conducted by
(Ansara, et al., 2002), that a history of depression prior to or during the current pregnancy was associated with the current relationship’s occurrence of emotional abuse. A reporting of abuse was more likely to occur if women screened positive for postpartum depression (Certain, et al., 2008). One out of fourteen women who have attended their postpartum visit have been emotionally abused by a partner in the past year (Certain, et al., 2008). The detrimental affects of emotional abuse on a woman’s health may be indicative of her risk for postpartum depression.

In a study conducted by Barrett-Connor, Hirst and La Coursive (2011) identified one hundred and twenty one women out of one thousand thirty eight women had a history of abuse and were more likely than the other women to have inadequate insurance, were not married and were more likely to have a history of depression. In the same study the authors found that 17.3% of the women who took part in the study suffered from postpartum depression. The goal of the authors was to find if stressors and abuse were contributing factors or predictors of postpartum depression. The literature suggests that women who are on the lower ends of the socioeconomic ladder and who have a history of abuse tend to be at increased risk for postpartum depression. Many studies have found a significant relationship between stress and abuse in relation to postpartum depression. Barrett-Connor et al., (2011) suggest women with a history of abuse, whether physical or sexual, were twice as likely to suffer from postpartum depression compared to women who do not have a history of abuse. The same population of women were less likely to suffer from postpartum depression if they had fewer life stressors even if there was a history of abuse.

**Life Adjustment**
Parenthood requires a great deal of new adjustments both physically and emotionally. The demanding transition into motherhood may be much more complicated if a woman is depressed postpartum. The feelings of dread and despair may overshadow every aspect of her life and supersede what she does and feels. A person suffering with depression may find even normal tasks cumbersome and difficult to accomplish, in addition to the arduous task of caring for a child. Caring for an infant demands so much from a mother and can be overwhelming, the mother needs time to adjust (Fox et. al., 2000). With or without depression present a woman typically needs support both physically and emotionally as she navigates the new waters of parenthood. According to Crockenberg et al, (2003) memories of acceptance-rejection of a parent in childhood are a likely influence on postpartum depression and maternal sensitivity. Findings are noted as being consistent with previous literature, the more accepting the mother remembers her caregivers to be, the more accepting of her parenting skills she is and the fewer depressive symptoms she displays/reports.

According to Gunau, et al., (2010) many women who are depressed postpartum have a higher tendency to rate their baby as having a difficult temperament. Mothers with postpartum depression tend to have a more negative view of their children and parenting (Abel, Howared, Sharp, and Wan, 2011). Another strong predictor of parenting stress is antenatal depression and anxiety. Gunau et al., (2010) cite babies of mothers who experience antenatal depression were more fussy and cried more frequently than babies whose mothers did not experience antenatal depression. Infants as early as age two months tend to show less interest in objects, decreased activity, and look at their mother less often (Earls et. al., 2010).

From an attachment theory perspective, Crockenberg and Leerkes (2003), assess postpartum depression and parental acceptance as well as relationship adjustment. The
authors discuss the effects of a mother’s relationship with her caregivers and whether that is a contributing factor as to how she and her partner will adjust to the newborn. Mothers that are depressed in the early months postpartum show flat affect and reciprocate positive affect as well as showing less sensitive response to their infants Crockenberg et al, (2003).

Depression may affect more than just the mother and infant’s relationship or the infant’s development. Children, siblings and the parent are three to five times more likely to suffer from major depression if the onset is before the age of thirty (Earls et. al., 2010).

Much of the literature on postpartum depression, parenting stress and adjustment show a relationship between the above mentioned variables with a negative consequence on the child’s development and a disruption in the family system. For centuries society has placed women in the role to procreate and naturally be a loving, nurturing mother. The expectation is that every woman desires to bear children and when that time comes she is instinctively supposed to know how to be a mother. What society fails to mention are the changes that occur in a woman’s body during and after pregnancy. This also encompasses the physical and mental demands of pregnancy and motherhood. Postpartum depression leaves little room for a woman to experience the expected joys of motherhood.

Maternal role attainment, a term coined in 1967 by Rubin, expresses the belief that a woman’s identity is determined by her connection to her child and her cognitive/social process. This term was later revised to convey the belief that “maternal role attainment” is a dimension of the woman’s personality defining who she is to become (Hines-Martin, Koniak-griffin, Logsdon, and Turner, 2006). This thought process is what has contributed to the oppression of a woman being anything but a nurturing mother or seeking to be anything more. Once she has given birth she is to become and only exist as a mother. Society frowns
upon those who do not wish to be parents, thus has created a culture that is naïve in its own creation of the stigma of postpartum depression. Women who do not immediately feel lovingly towards her child after birth are regarded as unfit and defective. Women have been conditioned to suppress negative feelings associated with birth rather than discuss these valid concerns out of shame and fear of being labeled.

Rarely if at all are women told that the road to motherhood is exhausting and that it is ok to feel other emotions besides sheer enjoyment. Contrary to popular belief, it is normal for a woman to feel anxiety and to question her feelings about motherhood. Unfortunately, many women feel guilt and shame when any of these unspoken emotions are felt. It is long overdue for practitioners and society to wake up and embrace the entire process that encompasses birth in its full capacity, negative feelings included. It is imperative to the healing process that women gain a greater understanding of their symptoms and break through the shame. Society’s one-sided expectations and set standards of parenting should not be the determining factor in a woman’s self worth. Not one person will share the same experience; therefore setting these conditions on motherhood are torturously unrealistic and many times unattainable.

Abel et al., (2011) note an association between negative cognitions in regards to motherhood and depressive symptoms postpartum. It is also suggested that regardless of treatment modality views and relationship problems can improve as maternal mood elevates. This does not mean that negative cognitions, views and behaviors cease, it means that there is a possible reduction in the severity of these problems. Abel et al., (2011) found in their study that there was not an added advantage to the long-term adjustment of the mother in regards to attitudes and cognitions if her depression remitted early. However, short-term benefits were
found if the mother participated in treatment and started antidepressants. The short-term benefits can be seen in the attitude towards parental stress and the infant/parent relationship. Relationships naturally transition throughout the course of time. Pregnancy and parenting are no exceptions. There are added stressors to the relationship when a woman finds out she is expecting a child. The couple must now think about providing for a new person. The couple must now consider how any or every aspect in their lives will change in the process of raising, caring for and supporting a new life. A solid foundation is imperative to the emotional health of all family member involved. Support in a relationship is imperative for survival.

The postpartum period can be very stressful or add more stress and/or pressure to a relationship than what may already exist. Davila and Whisman (2011) cite one possible predictor of the onset of postpartum depression is poorer functioning in a relationship after the birth of a baby. Depressive symptomology can be a cause of marital discord, and an environment with high levels of stress can elevate depressive symptomology (Fox et. al., 2000). The question many researchers ask is whether stress in a relationship is one cause for depression or is depression a cause of marital stress? According to Davila and Whisman (2011) higher levels of anxiety and depressive symptoms tend to be associated with decreased levels of relationship adjustment in women. Dissatisfaction in a relationship amongst women who have had previous bouts of depression tend to have a relapse postpartum (Fox et. al., 2000).

**Identification and Treatment Responsibilities**

Women who have had postpartum depression are at an elevated risk of experiencing reoccurring episodes of depression (Bryan, Gforgiopoplos, Wollan and Yawn, 2001). One
result of depression is the mother’s inability to provide even the most basic care for her child and herself. The ideal entrance into motherhood is for women to actively engage in the process and commit to becoming a mother. Active participation involves a commitment to not only being present but allowing the child to influence the mother’s shift into parenthood (Hines-Martin, Koniak-Griffin, Logsdon, and Turner, 2006).

Depression immobilizes a woman’s ability to take part in simple everyday tasks that others take for granted. For example, bathing, brushing teeth, combing hair and even sleeping can become monumental tasks to achieve. Depression makes something that may seem so simple become so far reaching due to the internal exhaustion that seems to prohibit daily functioning. Most mother’s stuck in the depths of depression hardly recognize how bad it is and easily find themselves isolated and confused. It is difficult for most to comprehend how debilitating this disorder can be. This is why the process of recognition becomes so vital for professionals to wholeheartedly grasp and commit to being the first step in a woman’s recovery.

Despite the evidence of the detrimental affects of postpartum depression it still remains under identified and left untreated. Some possible reasons for the under reporting of depressive symptoms are perhaps a woman’s reluctance to acknowledge or disclose the disapproving symptoms she is feeling. Health practitioners take oaths to uphold the law and ethics of their respective practices. Each provider is required to take part in continued education to stay up to date with current material in the field, including postpartum depression. The primary goal should be to ensure the most beneficial treatment is provided to each individual. Unfortunately, there seems to be a lack of treatment options available as evidenced by the literature. It is ironic that such little help is available, when the need is
enormous. The fact that more providers are not interested in addressing the issue at hand brings to light the concern that postpartum depression is failing to fall under provider’s radar. In turn, they are failing to incorporate proper assessment and intervention of this disorder, which ultimately is a form of neglect.

Although postpartum depression has received national attention as cited by Sorenson and Tschetter (2009), when Congress introduced the Melanie Blocker Stokes Postpartum Depression Research and Care Act H.R. 846 it seems that health care practitioners still exhibit discomfort with identification, intervention and referral for services. According to the literature many health providers that have contact with pregnant and postpartum women have some type of screening tools but seldom use the tools or feel comfortable discussing depression during pregnancy and postpartum. The fact that providers are uncomfortable diagnosing and treating this disorder is troubling indeed, however to be fair, the concern is valid in the sense that any other provider except a trained therapist may not be familiar with how to proceed because it is not a common part of their practice. It is understandable that this concern may be deterring their willingness to intervene. An important part of practice would be to network with providers outside the scope of their expertise. To build relationships with mental health providers can serve as an excellent referral source.

Sorenson et al., (2009) studied the effects of affirming and disaffirming interactions from providers to their patients and what affect this may have on the expectant mother. The authors note that several providers in their study did not feel women’s perceptions of whether the physician’s affirming or disaffirming interactions were important to health outcomes, perceptions of the birthing process, or in the postpartum period. A patient assigns a level of authority to providers based on his or her expertise and with this authority comes a level of
influence. It is important for providers to understand this when interacting with their patients.

Extending past the scope of practice a provider must also take into consideration his/her demeanor when interacting with patients. Similar to how words carry significant weight, facial expressions and/or body language speaks volumes. Patients suffering from depression already have an altered perception of the current reality that may make them more vulnerable to interpret their provider in as indifferent, detached or uninterested. If a health provider appears apathetic he/she validates a woman’s sense of hopelessness and ultimately her lack of options.

Obstetrics and gynecologists have frequent contact with women especially during the prenatal and postpartum period (Tyer-Viola and Goodman 2010). There are several valid screening tools available to health care providers to screen for various aspects of depression during the prenatal and postpartum period. If providers were to start utilizing these tools they would increase detection and treatment, thus decreasing the devastating consequence postpartum depression has on the family system. Children with depressed mothers tend to receive less consistent care (Dauber et. al., 2008). There is a level of responsibility Ob/Gyn’s feel regarding the identification of postpartum depression (Dabuer et. al., 2008). Although there may be confidence in the ability to identify postpartum depression, most providers are still not screening patients and feel their affirming or disaffirming interactions have any bearing on the mother’s mental well being. Provider’s behaviors, which can be modified, as women do not seem to internalize, have been found to correlate with depressive symptomology postpartum (Sorenson et. al., 2009).
Many common complaints during pregnancy are also common to depression. As a result, it is difficult to distinguish the difference between depressive symptomology and symptoms normal to pregnancy. A health provider that is not trained to identify mental health issues may overlook symptoms such as changes in appetite, anxiety, or fatigue (Goodman et. al., 2010). According to Dauber et. al., (2008) the providers used in their sample found the majority of health providers accepted responsibility in identifying postpartum depression and felt confident doing so except for Pediatricians. Although these providers possess a level of comfort screening for depression they cite the most common reasons for not screening is time limits, a lack of knowledge, retaining responsibility of treatment and patient barriers. Aside from the providers’ reasons for not screening for postpartum depression there are the patients’ reasons for not disclosing depressive symptomology. A mother’s fear of retribution from peers and professionals is at the forefront of her decision to not fully disclose her mental health issues. She may not completely comprehend what she is feeling. In addition a common fear is that her child will be removed from her care due to her assumed inadequacy.

In a study conducted by Goodman et. al. (2010) 109 participants were screened for depression and anxiety using the Edinburgh Postnatal Depression Scale (EPDS). Of the 109 women, 22% fell in the range of depression, 8.6% fell in the range of major depression. During the prenatal stage 11% of women screened positive for panic disorder and 7.3% screened positive for anxiety disorder. The authors discovered only 41% of the woman had any type of documentation of mental health symptoms or diagnoses. Out of the 41%, 37% had mental health treatment documented in their records and only 43% had been referred
mental health or social services. Clearly women continue to slip through the cracks of the healthcare system and are not being referred to the appropriate agencies.

In another study more than three fourths of women who had screened positive for varying levels of suicidal ideation on the EPDS did not have documentation of immediate follow up and evaluation (Bryan et. al., 2001). The scores of the women in the study were in the range of “sometimes” thinking about suicide and “occasionally” thinking about suicide. The women who were at a significantly greater risk of committing self-harm had documentation of immediate action being taken concerning their condition. Who then should be responsible for the screening of postpartum depression? All providers have a responsibility to screen or to assess and intervene when needed. Providers understand how important it is to screen for postpartum depression and regardless of why they may not be doing so, it is now time to stop the excuse making and start the screening process on a regular basis. If not, when will postpartum depression ever get the attention it needs and when will women start receiving the help needed to overcome this disorder?

Other countries have found success utilizing different treatment programs. For example, Australia has found success using a three-tier treatment model to address the different degrees of postpartum depression. The first tier is a 24-hour hotline accessible to families with concerns. A trained nurse who offers guidance, support and also anonymity to the caller answers each call. The second tier is an outreach and day-stay service where women can speak with trained professionals. The last tier offers mothers and infants a 5-7 day stay in a residential facility where women are offered day-to-day parenting assistance along with emotional support from trained professionals. The above services, with the exception of the hotline require a referral from the treating physician (Barnett et al. 2001).
The specialized programs shown to be effective in other countries barely exist in the United States outside of the research realm.

**Postpartum Care**

There are various views in the literature regarding the cause of postpartum depression. One position holds that the disorder might be a result of a woman’s predisposition to depression either by genetics or a previous history of depression and is triggered by childbirth (Nicolson, 1990). More research is needed to determine if a genetic predisposition places a woman at further risk for postpartum depression. It has been found that depressive symptoms during the postpartum period do not differ from depressive symptoms during any other time in a woman’s life. It is common during the postpartum period to be concerned primarily for the child’s safety and well-being. Unfortunately, the mother who is often blamed for the feelings she has little control over is neglected and silently suffering without any hope for treatment. It rarely occurs to the provider that the mother also needs help rather than blame. Early intervention shows to be beneficial for the prevention of long-term suffering of the mood disorder and the mother-child relationship (Ellefsen, Glavin, Smith and Sorum, 2010). Brown, Clark and Tluczek (2008) cite a study comparing a mother-infant interaction approach to therapy and a “wait, watch and wonder” approach. The results of the study showed that both interventions were successful in decreasing infant symptoms resulting from the mother’s depression. Parental stress was also reduced and the mother-infant relationship had improved. More research is being conducted on the effects postpartum depression has on the mother-infant relationship as well as effective treatment for the dyad.
Although treatment is beneficial it is not guaranteed that women will not relapse and fall back into depression. According to Michigan et. al., (2010) within the first year of treatment 29% of women will relapse into depression and within the first two years 54% of women will relapse. Despite the occurrence of relapse, providers should not be discouraged or stop the identification and treatment process. Providing unconditional positive regard throughout treatment and reinforcing that the woman is not to blame is important in the recovery process. As previously stated society puts pressure on women to have this life altering moment filled with overwhelming joy and happiness.

As previously stated there is enormous pressure by society placed on women to experience overwhelming joy and happiness during and following the birth process. Deviating from the norm is unacceptable. When a woman does not feel what she is “should” she may turn within herself and ask, “What is wrong with me?” The literature suggests that the most common onset of postpartum depression is typically around 6-8 weeks postpartum. Nicolson (1990) suggests that there are different stages to motherhood that contribute to postpartum depression. This potentially extends the postpartum depression up three years.

Despite the growing knowledge regarding postpartum depression there seems to be several barriers to treatment. Ellefsen et al. (2010) note several barriers being women’s lack of knowledge or denial about postpartum depression, and providers’ inability to identify and treat postpartum depression. Several studies have tested various modalities of treatment by training various health care providers and have seen positive results in the detection and alleviation of depression. Adequate training of various providers may be a keynote in the process of intervention of postpartum depression. In a study conducted by Ellefsen et al. (2010) nurses were trained, providing information about the risk factors, symptoms,
identification and treatment for new mothers. The training stressed the importance of open communication about health issues, noting that this needed to be done during every visit. The study showed that the redesigned postpartum care provided by the trained nurses resulted in improved scores up to a year postpartum.

According to Montoya, Moss and Pierce (2009) interventions such as Interpersonal therapy (IP), Individual Cognitive Behavioral Therapy (CBT), standard care, Non directive counseling and Psychodynamic therapy were successful with the reduction of postpartum depression immediately following treatment but were not able to alleviate symptoms long-term. However, the authors do note that group therapy as well as individual therapy was more successful than primary care. Ericksen et al. (2011) tested the effectiveness of group management, adjunctive counseling-CBT from a nurse and adjunctive counseling-CBT from a psychologist compared with primary care providers trained in CBT. Sixty-eight women participated in the study and were randomly assigned to the various groups. The authors caution application of the results to a generalized population, as there were limitations to the study. With that being said the results showed that women who received group management compared to women who received adjunctive counseling-BCT had improvement in symptoms of anxiety and depression. Although minor, there was some evidence that showed adjunctive counseling-CBT provided by a nurse was more effective.

The “Gruen” model of group therapy is comprised of three phases. Phase I focuses on education and information, relaxation techniques, development of support systems, and restructuring of cognitions. Phase II encompasses parts of phase I but further development of stress management and support, and focusing on cognitions relating it to self and increasing self-esteem. Phase III focuses on grieving unmet expectations of the birthing process and
parenting, reconciling and accepting all the feelings involved. Ugarriza (2004) utilized this method in a study to facilitate therapy for mothers who were diagnosed with postpartum depression. The treatment group was run by a psychiatric nursing student for ten weeks and lasted sixty minutes. Using the Beck Depression Inventory-II as the screening tool, mothers were assessed pre-treatment and post-treatment. The results showed a significant difference in the scores post-treatment indicating that the group started off as mildly depressed and ended with an alleviation of depression. The author does note that there are limitations to the study such as the sample size.

The literature shows promising results and implementation of various treatment modalities. Despite the growing evidence providers remain skeptics about the impact screening and intervention may have on postpartum depression (Flynn, Marcus, Massey and O’Mahen, 2006). Skepticism may be a natural part of growth and eventual acceptance in a newer concept to treatment in the provider’s practice but it should not be an excuse for avoidance or denial of intervention. This major health concern should be receiving the same amount of attention and care as any other major health concern. Even if the benefits of treatment, regardless of modality, are short-term providers should continue to attempt assessment and treatment while improving the various modalities. Once the practice of intervention and treatment have been established it will only improve with time and continued implementation. If society feels the need to exert so much pressure on women to feel overwhelming joy and happiness surrounding the birth of a child, it is equally important for society to reinforce the importance of treatment for women who were robbed of this experience. Providers should not stop at simply assessing their patients for postpartum depression. According to Flynn et al. (2006) assessment is not enough to limit the impact of
depression and improve symptoms. Assessment needs to be followed by provider follow-up and treatment.

Cognitive behavioral therapy has been proven to be effective for depression and anxiety with evidence for long-term effectiveness (Aclin, Austin, Frilingos, Hadzi-Pavlovic, Lumley, Parker, and Roncolato, 2007). Interpersonal therapy, without specifying a modality, has greater rates of improvement of postpartum depression (Adams, Fisher, Owen, Reay and Robertson, 2006). Primary health care providers can begin discussing postpartum depression by going over the physical and mental changes a woman will experience following childbirth. This may open the door for further discussion and give the provider the opportunity to mentally assess for possible symptoms of depression and concerns. This dialogue will lead the way to probe for patient fears, anxieties and any additional worries.

Individual therapy has yielded positive results in the reduction of postpartum depression but has not been as beneficial for the more severe postpartum psychosis (Ugarriza, 2004).

As previously noted treatment from a trained nurse can be just as effective if he or she is trained specifically in postpartum depression assessment, intervention and treatment. Health care providers such as pediatricians and gynecologists may not have the time, the means or the credentials to treat postpartum depression on an ongoing basis. However, the aforementioned are in contact with mother and child on a regular basis and would be prime candidates to best screen or assess both for symptoms postpartum. It could be considered great practice for a provider to have a nurse who is specially trained to do home visits for women suffering from postpartum depression. According to Ellefsen et al. (2010) multi-focused home visits conducted by trained nurses improved the detection and management of postpartum depression. There was a decrease in symptoms one year postpartum. The home
visits included focus on the mothers’ mental health and providing supportive counseling. Ericksen et al. (2011) suggests screening for depression along with a well-coordinated effort amongst providers toward identification and treatment may have the biggest impact on postpartum depression.

Although the literature review discusses doctors’ and nurses’ participation in the intervention of postpartum depression, it would be equally beneficial for therapists, psychologists and psychiatrists to be as informed and knowledgeable about the subject. Mental health practitioners are necessary agents in the restoration of health. A crucial step in the recovery process should consist of health practitioners’ providing referrals to mental health providers whom specialize in the treatment of postnatal depression. Becoming familiar and networking with local practices may make the referral and treatment process more successful. Collaboration does not have to stop with nurses and doctors; therapists too have an obligation to women’s mental health.
Chapter 3

Project Audience and Implementation Factors

Introduction

As indicated in chapter 2, there is a great need for provider awareness to take place in the health care system. Although the literature on postpartum depression does not have a specific intervention noted as the most beneficial in the reduction or alleviation of the debilitating disorder, it was suggested by several studies that individual and group therapy had moderate affects on the improvement of symptoms. It has been stated numerous times that postpartum depression is a major public health concern for women, children and the family system, therefore suggesting immediate attention is needed. Health care providers need training specific to postpartum depression and how to identify and intervene as well as knowing who to refer women to. It is a necessary step in the identification, intervention and recovery process.

Many mothers suffering from postpartum depression may not understand what they are feeling or may not have the time or energy to reach out to providers for help. It is vital to assist providers so they can begin to screen and assist women who are at risk or suffering from postpartum depression on a regular basis.

Development of Project

The development of the project has been a long thought out process. After giving birth to my son in August 2005, I thought my world had crumbled. A feeling a woman “should” not feel after giving birth. The first night in the hospital was good. I was happy and excited to finally meet this being that had been kicking my ribs and interrupting my sleep for months now. After the pregnancy I had, I was happy to finally have him join me in my
world. The pregnancy for the most part was overshadowed by stress and shame. The pregnancy was not accepted by all of my family in the beginning, which caused great stress for me. Often times I felt shame as my belly grew. The fact that I was growing this amazing being inside of me was not enough to some. Finally close to my eighth month everyone was on board and I was finally “allowed” to feel happiness. One would think at the age of twenty-four I would not need family approval. I know I did not think so. But the fact was that I did, I needed support.

I went to the doctor’s office on my due date and there were no signs of labor. The doctor decided to induce labor the following day. I did not think to research induction and complications. I just said yes and was elated to finally have him out. Something I would question for the next year. I was in labor for twelve hours and it was more excruciating than I had anticipated. Now I understand all induction encompasses. I tried to do it naturally but a few hours in I could no longer bare it. I was given an epidural. Unfortunately the epidural was turned off too late making it impossible for me to feel myself push my son out. My doctor was not supportive. Throughout my pregnancy he seemed to always commit to just the basics of the appointments. He never really discussed anything with me and really did not seem interested in doing so. To sum it up he was always hurried and treated me as an inconvenience. He lacked patience and was condescending. Most of all he acted more so like he was doing a favor for me, one that he could care less about and did not want to do. So it was no surprise that when he arrived for the delivery he was unsupportive and seemed like he was in a rush to be done.

I was threatened, and I say that because of the doctor’s tone, that if I did not push my son out in fifteen minutes he would do a c-section. Finally my son was vacuumed out. As
my doctor sewed me up he so casually commented, “you really couldn’t feel a thing, could you.” I was too happy that “the hard part” was over to say anything to him. My son was healthy and generally did not cry, at least for the first night. I stayed in the hospital for three days and was happy to get the ok to go home. I was told to keep an eye on my son, as he seemed to have signs of jaundice. After three days we had to take him back to the hospital. He was yellow and dehydrated. I was devastated. I blamed myself. I was struggling with breastfeeding but was intent on giving it my all. When the doctor said he was dehydrated I immediately burst into tears and continued at a steady pace as they tried to find a vein to start an I.V. The doctor and nurses kept trying to assure me that it was not my fault but I could not help but feel I was already letting him down. I had already been doubting my capabilities and decision to be a mom. Everyone kept telling me it was normal, it was my hormones making me feel this way.

I could not help but feel it was more. I felt a void, I was not overwhelmed with joy the way I “should” have been. That had worn off the second day. After several days at home I struggled with connecting to my son. It was almost as if I was in denial, I could not accept the fact that I was now a mom. My mom had told me it was the baby blues and reassured me it would go away. A few days after my son and I were released from the hospital, he had to be readmitted and treated for jaundice. Hospital policy required a social worker to take my partner and I into a room and discuss my son’s stay in the hospital. Once she finished she provided time for my partner and I to discuss any concerns we may have. At this time I disclosed how anxious and detached I was feeling. I told her that I could not stop crying, I was having difficulty sleeping, I was extremely anxious and I felt empty. I did not want to be alone with my son. It was as if I was afraid to be with him. His presence made me feel
nervous. I did not feel like hurting him but I did not want to be near him. I told her that this was not a normal feeling. I knew something was not right.

The social worker responded by saying what I was feeling was normal and that I would be feeling better soon. After that I was sure nobody would be able to help me. When we were told we could bring him home I had mixed feelings. I wanted my baby home but I still did not feel connected. Weeks passed and the feeling did not go away, if anything it got worse. For at least the first two months I kept asking my partner if I made the right choice. I kept questioning myself, and why I felt no joy. He was supportive and shared that he felt the same at first too. He assured me that I was just exhausted and since I was home all day with him I just needed time to myself.

I was terrified to be left alone with my son. I felt dread when everyone left to work and I counted the hours until someone would get home to relive me from my current life. I loved my son, I really did but I felt like I could never do things right. He was not easy to soothe and the second I laid him down he would cry. I thought I was going to loose my mind. This did not subside. When he did sleep I could not, I was too worried that he was not breathing or that he would wake up again so it was pointless to try. I would call my cousins or friends and try to carry on a conversation but eventually I would start to cry hysterically. After a couple of times I would no longer call anybody and nobody would really call me. I think I cried more in that one year than I did any other time in my life. I never thought of hurting him but there were times when I had to walk away from him because I felt like if I didn’t I was going to shake him until all my emotions inside of me went silent.

Besides the constant crying and feelings of void and anxiety, I also felt like I lost my identity. I was no longer me, I was his mom and was not able to be anything other than that.
Immediately following this feeling I was plagued with guilt for not feeling the bond I had heard so much about. After a few months I no longer made attempts to reach out to family or friends. I was usually told that this is what being a mom is and that it was my choice. They would also say that eventually I would feel better. I mustered a smile and agreed. I would make up any excuse to not go out or go to family functions. I just wanted to curl up under a rock and be left alone. I didn’t have suicidal thoughts per se but at times I wondered if he would be better off without me. He had so many people to love him, and he would not miss a mother that couldn’t even feel connected or present. A year passed and I never sought help, I thought I would be labeled an unfit mom.

This was my process, remembering my internal pain and suffering during the first year of my son’s life is what motivated me to create this workshop for providers. As scared as I was to reach out and disclose what I had been feeling, I was desperate for someone to reach out to me. I want this workshop to not only educate providers but to also convey the depths of despair a woman can feel. The contents of the workshop are based on the contents of the literature review and what I felt I needed during my pregnancy and postpartum. The first thought I had was to create a pamphlet but after much thought I felt this would be less beneficial than a group. When I began to do my extensive research for this project it was clear that I would need to create more than a group. Awareness and intervention does not necessarily begin with women and their families, it begins with health care providers. My hope is that this can be a workshop that will fulfill CEU (Continuing Education Units) requirements for health care providers to motivate them to learn more about postpartum depression.

**Intended Audience**
The target population for this workshop is health care providers. Any provider that has contact with women and families such as doctors, nurses, and therapists can take part in the workshop. Although the workshop is intended for health care providers woman can also take part. The material may in fact empower women, knowing what postpartum depression is and how to address their concerns with their provider may also be beneficial. I would caution women that the workshop is not a forum for individual sharing and processing but they may use resources provided in the workshop to find a local support group if desired.

**Personal Qualifications**

I will be the primary person to run the workshop. Currently I am in the process of completing the requirements to receive my Master of Science in Counseling, Marriage and Family Therapy. Once I have acquired the necessary amount of hours as an intern, I will begin the process to become a licensed therapist. During this time I will be researching the requirements and policies for running a workshop and the requirements for the workshop to count towards CEU’s. The project has personal significance, which motivates my desire to educate professionals as well as women and their families. I am in the process of acquiring the skills and certifications to specialize in treating women during the prenatal and postpartum period. My education and experience is likely to enhance the effectiveness of the workshop and providing the necessary education to providers and their patients.

It would be more beneficial for a licensed provider to run the workshop, if the workshop is to count for continuing education units. A trained therapist would be qualified to conduct the workshop as well.

**Environment and Equipment**
The ideal environment to conduct the workshop would be a lecture hall or spacious conference room. However, for convenience the workshop can also be conducted for providers and their staff at their practice. The room will need to have a projector, a screen, a laptop and adaptors for the set up and presentation of the powerpoint. The material presented will also be printed and handed out to the providers so each can follow along and engage in discussion throughout the workshop. The providers will be allowed to take home the material to assist with implementing the knowledge they have acquired into their practices.

**Running Time**

The estimated running time for the workshop presented below is approximately four hours. It is advised that the presenter provide an additional fifteen minutes at the conclusion of the presentation of material for questions and/or concerns. An additional recommendation is to allow attendees two fifteen-minute breaks.

**Project Outline**

I. Let’s Make a Difference Too

   a. Recommendations to providers. Ways to incorporate postpartum depression into their practice.

   b. Possible questions to ask patients/clients to probe for postpartum depression.

II. Criteria

   a. DSM-IV-TR

   b. Postpartum depression defined by researchers.

III. Symptoms

IV. Prevalence
V. Risk Factors

   a. Risk factors for mothers.
   b. Effects of postpartum depression on children.

VI. Screening Tools

VII. Treatment

   a. Barriers.
   b. Modalities.

VIII. Building Support

IX. Limitations of Research

   a. Demographic Characteristics.
   b. Difference in criteria and definitions of postpartum depression.
   c. Self-reporting tools.

X. Resources/Referrals

   a. Housing.
   b. Food Banks.
   c. WIC.
   d. Medical.
   e. Welfare.
   f. Employment.
   g. Support.
   h. Counseling.
Chapter 4

Conclusion

The goal of this paper has been to help educate and bring awareness to a cause that I hold dear to my heart. My ultimate goal is to begin a movement and provide awareness to society. After conducting my research for this project it became evident that the best place to begin is with healthcare providers. I realized the awareness would need to start on a smaller scale and with continuous work and effort awareness will grow.

As a woman who has recovered from postpartum depression and works in the mental health field, it is disappointing to find that there were no available workshops for postpartum depression or workshops that addressed a similar subject. Creating this project is my way of being proactive, and creating more opportunities for women to access adequate treatment.

Healthcare providers have been chosen as the targeted audience for this project as they have access to diverse groups of women, whether the women are at risk or not. As evidenced in the research, depending on the provider’s demeanor, a woman can feel validated and safe or invalidated and can loose motivation to seek further treatment. It is imperative to create a safe environment, in all healthcare settings, to provide an opportunity for women to address concerns or inquire about possible complications during and after labor. Refuting society’s myth about motherhood and normalizing the difficulties women face may begin to break down the stigma of postpartum depression. In recent years celebrity moms have come forth and shared their varied experience with postpartum depression. Celebrities are often viewed as untouched by common occurrences and in some aspects of life are regarded as perfect. Regardless of a woman’s social status or class, postpartum does
not have bounds and does not discriminate. All mothers’ are susceptible to this painful disorder. The difference may be that some women have access to adequate treatment.

Prevalence rates seem to be rising as the research continues to be updated. This can be both a positive and a negative. The growing percentage rates may imply that more women are coming forth with their struggle and are seeking aid. Readers may also infer that awareness is on an upward rise. Another implication is that the occurrence is greater because identification and treatment are inadequate or insufficient. It seems safe to say that there is not a single reason; rather there are several reasons that contribute to the growing numbers and the seemingly unrelenting prevalence of this disorder. It is also important to consider the risks that increase a woman’s chance of suffering from postpartum depression. Many of the risk factors also have no bounds and do not discriminate. Mental health disorders affect women of any shape, size, color and occupation. Poverty does not choose its victims based on beauty and body type. Domestic violence is similar to postpartum depression in that the victims often times suffer in silence.

It is appalling that the available treatment services specific to postpartum depression are few and far between in the United States. Women face obstacles to access resources to alleviate pain and suffering. The few treatment facilities that are in existence are located in the upper Northern region of California or outside of the country. In spite of the progress other countries have documented in numerous studies, it remains unclear why the United States is behind on implementing treatment programs. It would be invaluable to incorporate the subject of postpartum depression into a required curriculum for healthcare providers. The coverage of the subject should be commonplace due to the widespread problem it has become recognized as.
Extending past provider awareness would be for publishers of books for expectant moms to devote at least a chapter to prenatal and postpartum complications including antenatal and postpartum depression. The book *What to Expect When Expecting* has a page that briefly discusses postnatal depression. Books and other media sources could include postpartum depression as an important subject to discuss with your provider, just as there are sections dedicated to how to choose a provider. Doctors and nurses can include postpartum depression as part of the birthing plan. When discussing the plan, doctors and nurses can help women devise a plan of action and resources to access should postpartum depression occur. Mental health providers who have access to prenatal and postpartum women could assist women by not only creating a plan but by researching the best treatment modality and tailoring it to the client.

There is no such thing as one size fits all with regard to motherhood and the emotions that occur. It behooves us all to take an interest in the intervention and treatment of postpartum depression, and to stop placing unrealistic expectations on women. The family system consists of more than one individual. Each person influences the functioning of the system and when one individual is not healthy the system as a whole is affected. It is never too late to provide support.
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Appendix A

Lets Make a Difference Too

- Mother’s recovering from PPD have expressed a collective appreciation in finding comfort and solace from other women’s honest accounts of shared stories and recovery.
- It is a concern that women who are sharing their experiences about PPD are mother’s recovering from PPD rather than presently suffering the effects.
- Seldom are any other parties mentioned in the recovery process. It is vital women have a support system. Strong support systems that can provide significant routes to recovery can include the women’s family, partner, friends and healthcare providers.
- “We won’t make women depressed by asking them about how they feel. For some, it may make them more aware of problems, but providing they have the opportunity to discuss this, it is unlikely to cause distress” (Buist, 2002).
- An important aspect when assisting patients/clients is to be empathic, encouraging, actively listen and provide a safe environment for exploration and discussion.
- Disaffirmation from a provider denies or contradicts personhood, meaning a person is treated as an object. Affirmation validates and supports a person (Sorenson and Tschetter, 2009).
- Become interested in more than just the usual aspects of office visits. Be proactive and have material ready for women and their families regarding birthing plans, possible complications, PPD, and the adjustments of parenting.
• It may be difficult to incorporate new practices due to time constraints but with all change comes trial and error. The point is to make an effort and commitment to improvement.

• Create dialogues and opportunities to educate patients/clients about PPD. Practice creates an opportunity to revise, enhance or produce several ways to engage in a dialogue. Nothing is easy in the healthcare system and it can be exhausting but we also thrive on excellence and our ability to be the best and most effective at what we do. Do not let the discomfort or difficulty of the subject get in the way of your work ethic, but rather allow it to be a motivating force.

• It is important to discuss the joys and excitement of pregnancy and parenting, as well as the fears and anxieties that exist.

• Inform women of the physical and emotional adjustments that will also occur. Reassure women and their families that adjustment is normal but concerns are always welcomed and discussion is encouraged.

• Provide awareness in the office environment. Post resources and posters for postpartum depression. If there is an office bulletin, incorporate information on PPD. This may extend past the office and into the community.

• Possible questions to ask (Bennett and Indman, 2006).
  o How are you doing? (*maintain good eye contact while asking this question*
  o How are you feeling about being a mom? (*women who feel like they are doing a bad job or who generally do not like the job, may be depressed*)
  o Do you have any particular concerns?)
○ How are you sleeping (quality and quantity)? (*five hours minimum of uninterrupted sleep per night is required for a complete sleep cycle, necessary to restore brain chemistry*).

○ Can you sleep at night when everyone else is asleep? (*insomnia is a symptom of every mood disorder*).

○ How is the baby sleeping? (*a fussy baby could further agonize a depressed mother*).

○ Who gets up at night with the baby? (*look for signs of a detached, exhausted, not mentally present mother*).

○ Have you had any unusual or scary thoughts? (*If yes, this is the time to refer her to a perinatal psychotherapist for evaluation. Some thoughts may be common but it may also be an indicator of OCD or psychosis*).

○ Are you receiving adequate physical and emotional help? *A good support system of family and friends can make a significant difference)*.[Providers-ask the patient/client if she understands what a support system is, and do not assume she has one.]

○ Do you generally feel like yourself? (*women with postpartum mood disorders often report not feeling like their usual selves*).

○ How is your appetite? (*this can be a red flag*).

○ What and how often are you eating and drinking?

○ If breastfeeding, how is it going? (*poor milk production can be an indicator of a thyroid problem or anxiety*).
Are you taking any medications or herbs on a regular basis? (*some women who are experiencing depressive symptoms may be self-medicating and should be evaluated*).

Are you feeling moodier than usual (tearful, irritable, or worried)? (*another red flag*).

Have there been any health problems for you or the baby? (*these factors may increase the risk of mood disorders*).

How are you feeling toward your baby? (*ambivalence and anger are two feelings associated with PPD*).

**Criteria**

- DSM-IV-TR
  - 296.2x Major Depressive Disorder, Single Episode
    - B. The Major depressive Episode is not better accounted for by Schizoaffective Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
    - C. There has never been a Manic Episode (see p. 362), a Mixed Episode (see p. 365), or a Hypomanic Episode (see p. 368). **Note:** This exclusion does not apply if all of the manic-like, mixed-like, or hypomaniac-like episodes are substance or treatment induced or are due to direct physiological effects of a general medical condition.

If the full criteria are currently met for a Major Depressive Episode, *specify* its current clinical status and/or features.
Mild, Moderate, Severe Without Psychotic Features/Severe
With Psychotic
Features (see p. 412)
Chronic (see p. 417)
With Catatonic Features (see p. 417)
With Melancholic Features (see p. 419)
With Atypical Features (see p. 420)
With Postpartum Onset (see p. 422)
If the full criteria are not currently met for a Major Depressive
Episode, specify the current clinical status of the Major Depressive
Disorder or features of the most recent episode:

In Partial Remission, In Full Remission (see p. 412)
Chronic (see p. 417)
With Catatonic Features (see p. 417)
With Melancholic Features (see p. 419)
With Atypical Features (see p. 420)
With Postpartum Onset (see p. 422)

- 296.3x Major Depressive Disorder, Recurrent
  A. Presence of two or more Major Depressive Episodes (see p. 356)

  Note: To be considered separate episodes, there must be an
  interval of at least 2 consecutive months in which criteria are not
  met for a Major Depressive Episode.
  B. The Major Depressive Episodes are not better accounted for by
Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

C. There has never been a Manic Episode (see p. 362), a Mixed If Episode (see p. 365), or a Hypomanic Episode (see p. 368).

Note: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

If the full criteria are currently met for a Major Depressive Episode, specify its current clinical status and/or features:

- **Mild, Moderate, Severe Without Psychotic Features/sever With Psychotic Features** (see p. 412)
- **Chronic** (see p. 417)
- **With Catatonic Features** (see p. 417)
- **With Melancholic Features** (see p. 419)
- **With Atypical Features** (see p. 420)
- **With Postpartum Onset** (see p. 422)

If the full criteria are not currently met for a Major Depressive Episode, specify the current clinical status of the Major Depressive Disorder or features of the most recent episode:

- **In Partial Remission, In Full Remission** (see p. 412)
- **Chronic** (see p. 417)
With Catatonic Features (see p. 417)

With Melancholic Features (see p. 419)

With Atypical Features (see p. 420)

With Postpartum Onset (see p. 422)

Specify:

Longitudinal Course Specifiers (With and Without Interepisode Recovery) (see p. 424)

With Seasonal Pattern (see p. 425)

• Depression defined by McIntosh (1993) is the experience of depressed mood lasting for at least 14 days, and occurred at any time after the first week postpartum. This definition was used to assess is sample of women.

• Postpartum depression defined by Crockenberg and Leerkes (2003) as a mild to moderate disturbance in taking place from birth to 6 months postpartum, rather than the less frequent, more severe postpartum psychosis, or the more common but transient blues.

• Nicolson (1990) cites “the blues” as weepiness and anxiety occurring between 2-10 days postpartum. Depression and anxiety once baby is home which lasts about a week or two. Depressed moods consisting of good and bad days may last up to 3 months post delivery, and clinical depression, which is enduring and includes symptoms such as loss of appetite and sleep disturbance.

• According to Bronwyn et al., (2011) postnatal depression is an episode of major or minor depression occurring in the first year following delivery.
• Postnatal depression is a term used to explain an assorted group of conditions with features of both depression and anxiety-in women who present postnatally (Acland et al., 2008).

**Symptoms**

• Difficulties with identifying symptoms
  
  o Many of the symptoms that are common to the adjustment of a new baby are shared with postpartum depression. Due to the commonality it has proven to be difficult in distinguishing between the typical symptoms of adjustment and diagnosing PPD. Some common signs are insomnia/hypersomnia, fatigue, depressed mood, and change in appetite.

• Feelings of hopelessness/guilt.

• Decrease in concentration.

• Depressed mood and or loss of interest in usual activities.

• Suicidality.

• A red flag to assess for during an office visit is the mother’s response time to her child and the amount of interest she shows the infant. Depressed mothers are at times detached from their child and do not exhibit appropriate response times.

• Unsettled infant behavior is thought to be another red flag. Babies are generally fussy at times but infants with depressed mothers tend to be fussier than most and are less responsive to the mother’s attempts to console. Depressed mothers rate their infants as difficult.

**Prevalence**
• The postpartum period is a vulnerable time for a woman and is a time of increased risk for adjustment difficulties and the onset of psychiatric disorders (Campbell and Cohn, 1991).

• The “baby blues” is a common occurrence amongst mothers after delivery and can last anywhere from a few hours to a few days.

• Postpartum depressive symptomatology is a common condition that occurs in 25-30% of women. Although the depressive symptomatology causes distress and disturbances, it’s sometimes not enough to meet diagnostic criteria. Nonetheless the symptoms are still damaging to the postpartum adjustment period (Bernazzani et al., 1997).

• Postpartum depression hovers around 10%. Prevalence in the first 2 months is around 8.2%.

• In a study conducted by O’Hara et al. (1990), non-psychotic PPD has a prevalence rate of 8.7% at 3 months postpartum.

• Approximately 13% of women experience PPD within the first year (Beck, 2001).

• The onset typically begins 4 weeks postpartum and can last up to a year.

• Postpartum Psychosis
  
  o 1 in 600 women will be affected by postpartum psychosis (Buist, 2002).

  o Onset varies but can take place 2-3 weeks post delivery.

  o More often than not mothers are unable to care for themselves or their infants. The more severe cases require the mother to be hospitalized for proper treatment. Oftentimes hallucinations and delusions are experienced.

**Risk Factors**
• Mother

  o A powerful predictor of PPD is antenatal depression (Buist, 2002).

  o Chronic stressors such as poverty, inadequate or poor living conditions and unreliable modes of transportation have been shown to be risk factors (Arndt et al., 2007).

  o Cutrona (1993) suggests that pregnancy and delivery complications have been associated with postpartum depression (as cited by Campbell and Cohn, 1991).

  o Poor marital or domestic relationship. A woman is more vulnerable to abuse during pregnancy. Domestic abuse during pregnancy has a prevalence rate of 0.9%-20.1% (Certain et al., 2008).

  o A history of physical, sexual, or emotional abuse.

  o Low social support, living below the poverty line, chronic stress, inadequate childcare, lower levels of education and inadequate access to transportation.

  o Previous episodes of depression prior to the prenatal and postpartum period.

  o Predisposition to depression (genetics) and/or (environment).

• Effects on the child

  o Prompt and effective treatment is needed to diminish infant exposure to maladaptive maternal stress, anxiety and cognitions (Abel et al., 2011).

  o Children are also affected by this debilitating and non-discriminatory disorder. Several problems have shown to persist in children such as their ability to regulate emotions and cope with life stressors.
Mothers who are depressed tend to provide inconsistent care to their infants (Dauber et al., 2008).

Some studies have found a correlation between PPD and a delay in the development of a child’s brain. Speech and cognitive difficulties may be encountered in early childhood.

The mother-infant relationship is jeopardized if the dyad is unable to form an appropriate attachment. Infants are at risk of forming insecure attachments, which may have implications on his or her ability to form secure attachments in other relationships throughout the course of his or her lifetime.

A child may experience difficulties adjusting to new environments and situations.

Infants with mother’s who are depressed tend to be inconsolable, are fussy more often than not, are less responsive to their mothers and can also have a delayed response to their environment.

Screening Tools

- The most common tool used to assess women for PPD is the Edinburgh Postnatal Depression (EPDS). The EPDS covers a 7-day time period and is a ten-item self-report questionnaire.

- The Inventory to Diagnose Depression (IDD) is a 22-item self-report scale. This tool was developed to identify a major depressive episode consistent with DSM-III. The IDD has demonstrated strong reliability and has shown success in identifying PPD (Arndt et al., 2007).
• Beck Depression Inventory (BDI) or the BDI-II.

• The Composite International Diagnostic Interview (CIDI) is a structured psychiatric interview and can be conducted over the phone. The DSM-IV is used to obtain diagnoses and results are computerized.

Treatment

• “Although some aspects of perinatal depression may be unpreventable, providers are challenged to reassess current practice to identify alternative cost-effective, noninvasive, and low-risk approaches to prevention, detection, and early treatment” (Sorenson and Tschetter, 2009).

• Providers can conduct routine office-based screenings using valid screening tools. The EPDS and the BDI-II are frequently used throughout the literature and valid in detecting PPD.

• Assessment or screening should be provided for every patient/client regardless of risk. It is better to err on the side of caution, than to miss detection in women. The provider can reassure the women that the screening is a routine part of practice and all women are to participate. Women may take comfort in knowing they are not being singled out, or feel embarrassed or shame that they need to be assessed.

• Assessment by the Primary Care Physician does not mean that he or she is required to treat the mother. Screening is the first step to intervening and referring women to the appropriate provider.

• Barriers to TX
  
  o A delay in adequate treatment is a significant factor in the duration of PPD (Beck, 2001).
One important barrier to treatment is a woman’s reluctance to seek help for her symptoms. Several factors have been cited and include but are not limited to, worrying that she will be labeled an unfit mother, the stigma attached to PPD, embarrassment, and the fear that her child or children will be removed from her care.

Recognition of the signs and symptoms is another common barrier to treatment.

Cultural considerations can be a reason why women do not disclose their symptoms to their providers. More research is needed on the demographic characteristics of women who seek help and those who do not.

Low-income families might not have access to health insurance or their health insurance does not cover mental health services. There are several agencies and mental health facilities that offer fees on a sliding scale. This is a great resource for families to accesses. An important factor to keep in mind is that many agencies have waiting lists, so it is recommended that a minimum of three referrals are provided.

There is a greater need for mental health services than previously thought. Goodman et al., (2010) found that only 41% of prenatal women and 31% of postpartum women, in their sample of 491 women, receive services.

Modalities

Interventions such as education, support, therapy, and medication are available to treat PPD.
o Interpersonal therapy or group therapy should have an emphasis on educating moms on parenting, incorporating coping skills and the importance of support.

o Specific interventions for PPD might increase the benefits of therapy and decrease the recovery time.

o TF-CBT (Trauma Focus Cognitive Behavioral Therapy) is a great tool in treating clients who have survived traumatic life events. For instance an isolated-one time event such as a natural disaster or reoccurring event such as abuse. PPD is a traumatic event in a woman’s life, but it would be more beneficial to create a treatment plan specific to PPD. It can be specific treatment for families who have been burdened with this disorder.

o It is important not to be quick to prescribe medication, or to prescribe medication without therapy. Antidepressants are controversial and the long-term effects have not been well established. Prescribing medication can leave a woman feeling hopeless and she might fear that she will need to take medication for the remainder of her life. Medication should be included in the discussion but not referred to as the “fix all” remedy.

o Group therapy facilitated by doctors, nurses, and mental health providers have been effective in treating PPD. Whomever facilitates the group must be educated and trained on the specifics of PPD.

o Group therapy concurrent with interpersonal therapy has been as beneficial as any other treatment modality.

• Stress reduction exercises and relaxation techniques are useful tools for women to practice and will help reduce the severity of symptoms. *(The facilitator of the*
**workshop can take a few minutes to demonstrate to providers how to engage patients/clients in these exercises.**

- Breathing techniques, grounding techniques, meditation techniques and the thoughts-feelings-behaviors triangle are a few methods used to alleviate anxiety.

- A simple suggestion such as recommending a patient/client to go outside for five to ten minutes a day will help her step out of isolation. The task is not monumental and does not pressure her to socialize if she is not ready to. It simply allows her to step outside the confines of her home, allow her to breathe fresh air, provides vitamin d and can be the start of her starting a routine of self-care.

**Building Support**

- Support from a partner has been shown to improve a woman’s depressive symptoms. [If possible providers can ask that both parents be present during the prenatal and postpartum check-ups. This can build the strength in awareness and possibly allow a partner to take a proactive stance in the detection and treatment process if his or her partner is at risk or suffering from PPD.]

- Providing referrals for support groups and online forums is a helpful tool. The more relevant the group or forum is for PPD the more likely a woman is to continue. Women who are suffering from PPD may feel out of place or uncomfortable in a parenting group or support group that consists of mother who have not experienced the same entrance into motherhood. This may leave a women feeling inadequate, angry, even more isolated and possibly discourage any further outreach for treatment.

**Limitations of Research**
• Researchers have had difficulty attaining participants for their studies, or throughout the course of the study several women drop out. Women express reasons related to exhaustion, lack of time and childcare, or fail to respond altogether.

• Several studies provide readers with the limitations encountered that may have a small or significant effect on the results. Many cite that the sample sizes are too small, some were samples of convenience and the sample lacked a diverse group of women. Caution is advised when generalizing the results to all women.

• Demographic Characteristics
  • Samples typically do not consist of multi-ethnic women.
  • Women are either the same age or fall in age categories. Rarely if at all do samples include women ranging from adolescence to age 50.
  • Generally women in a sample will either be in the lower ranges of the socioeconomic range or considered upper/middle class. Once again samples have either or, and do not include both.
  • Level of education is seldom diverse.
  • Married or in a domestic relationship, or single.
  • If the study was conducted in the United States only women who spoken English were accepted to participate.

• Difference in criteria
  • Gavin et al., (2005) suggest that a limitation in the research may be that rates vary depending on the diagnostic criteria, sampling methods, timing of assessment and the measures used (as cited by Austin et al., 2010).

• Self-reporting tools
According to Campbell and Cohn (19910, self-reporting tools have several limitations. The first limitation is the over-reporting or under-reporting of symptoms. The next limitation noted is the symptom checklist assesses a variety of symptoms that are not specific to depression. This can elevate a woman’s score and qualify her for a diagnosis that is not fitting. The self-reporting tool may also miss criteria, especially if the interviewer or questionnaire does not succeed at eliciting more specific symptom-relevant behaviors.

Resources/Referrals

- **Housing**
  - Low Income Housing Search
    - [http://lowincomehousingsearch.com/b/?t202id=215&t202kw=low%20income%20housing](http://lowincomehousingsearch.com/b/?t202id=215&t202kw=low%20income%20housing)
  - Low Income Housing Voucher
    - [http://www.housingvoucher.org/landers/search/112-section8-v1/](http://www.housingvoucher.org/landers/search/112-section8-v1/)
  - Low Income Apartment Search
    - [http://www.apartmentguide.com/?WT.mc_id=9320&WT.srch=1&ef_id=x@JPrZVp2j4AABVS:20120520193235:s](http://www.apartmentguide.com/?WT.mc_id=9320&WT.srch=1&ef_id=x@JPrZVp2j4AABVS:20120520193235:s)
  - Section 8 Programs
    - [http://www.section8programs.com/lowincomehousing.html](http://www.section8programs.com/lowincomehousing.html)
  - CA Department of Housing and Community Development
    - [http://www.hcd.ca.gov/fa/affordable-housing.html](http://www.hcd.ca.gov/fa/affordable-housing.html)
  - Low Income Housing US.
- [http://www.lowincomehousing.us/](http://www.lowincomehousing.us/)
- Income Based Apartments
  - [http://www.incomebasedapartments.net/low-income-housing-programs.html](http://www.incomebasedapartments.net/low-income-housing-programs.html)
- Affordable Housing
- Low Income Housing Credit Program
  - [http://www.nyshcr.org/Programs/LIHC/](http://www.nyshcr.org/Programs/LIHC/)

- **Food banks**
  - Los Angeles Regional Food Bank
  - Los Angeles Food Pantries
  - Greater West Hollywood Food Coalition
    - 1106 N Cahuenga Blvd
    - Los Angeles, CA
  - California Association of Food Banks
    - [http://www.cafoodbanks.org/LosAngeles.html](http://www.cafoodbanks.org/LosAngeles.html)

- **WIC**
  - WIC Contact Information
    - California WIC Program
      - Dept. of Public Health
      - P.O. Box 997375
What is WIC and Who Can It Help?

- The Women, Infants, and Children (WIC) Supplemental Nutrition Program is a federally-funded health and nutrition program for:
  - Women who are pregnant, breastfeeding, or just had a baby
  - Children under 5 years old (including foster children)
  - Families with low to medium income (working families may qualify)

What can you get at WIC?

- Special checks to buy healthy foods from WIC-authorized vendors – milk, eggs, bread, cereal, juice, peanut butter, and much more (see Authorized Foods)
- Information about nutrition and health to help you and your family eat well and be healthy
- Support and information about breastfeeding your baby
Help in finding health care and other community services

- Where can I find WIC?
  - WIC has local offices all over California. Call 1-888-WIC-WORKS (1-888-942-9675) or use our online search feature (opens a new browser window). Outside California please call (1-916-928-8500).

- Do I qualify?
  - Generally, WIC is available to:
    - Low income pregnant, breastfeeding, and postpartum women
    - Low income parent or guardian who is the sole provider of children under age five who are at nutritional risk and who are at or below 185 percent of the federal poverty level (See income guidelines (PDF) )

- Medical
  - Affordable Health Insurance
    - http://www.easierhealthinsurance.com/welcome?id=4603105004&m=e&creativeID=687969115&oID=5947004932&q=free%20health%20clinics
  - Free Health Clinics
    - http://findahealthcenter.hrsa.gov/Search_HCC.aspx
- [http://meded.ucsd.edu/freeclinic/](http://meded.ucsd.edu/freeclinic/)
- [http://nafccclinics.org/](http://nafccclinics.org/)

  o Healthy Families Insurance
    - [http://www.healthyfamilies.ca.gov/Home/default.aspx](http://www.healthyfamilies.ca.gov/Home/default.aspx)
    - [http://www.healthyfamiliesenrollment.org/AboutHF.aspx](http://www.healthyfamiliesenrollment.org/AboutHF.aspx)
    - [http://www.healthy-families.us/](http://www.healthy-families.us/)
    - [http://www.healthyfamilies.org/](http://www.healthyfamilies.org/)

- Welfare
  o CalWORKs:
    - [http://www.ladpss.org/dpss/calworks/default.cfm](http://www.ladpss.org/dpss/calworks/default.cfm)
    - [http://www.co.san-diego.ca.us/hhsa/programs/ssp/calworks/index.html](http://www.co.san-diego.ca.us/hhsa/programs/ssp/calworks/index.html)
    - [http://dpss.co.riverside.ca.us/CalWorks.aspx](http://dpss.co.riverside.ca.us/CalWorks.aspx)
  o Welfare Assistance
    - [http://www.dpw.state.pa.us/](http://www.dpw.state.pa.us/)
  o Planned Parenthood
    - [http://www.plannedparenthood.org/](http://www.plannedparenthood.org/)

- Employment
  o Worksource Centers

  o Job search sites

    - http://jobs.monster.com/?WT.srch=1&WT.mc_n=olm11msrchj
    - http://jobsearch.youremployment.com/?CID=6813
    - http://www.indeed.com/
    - http://www.careerbuilder.com/
    - http://www.snagajob.com/
    - http://www.usajobs.gov/
    - http://govtjobs.com/
    - https://www.governmentjobs.com/

  o Employment Agencies

    - http://www.manpower.com/
    - http://jobagencies.com/

  o Libraries offer free or low-cost internet

- Support

  o Postpartum Support International: postpartum.net
  o Baby Blues Connection: www.babybluesconnection.org
  o www.postpartum-depression.net
  o www.circleofmoms.com
• familydoctor.org

• www.ppdhope.com

• National Hopeline Network-(800) 784-2433 [SUICIDE]

• North American Society for Psychosocial OB/GYN- www.naspog.org

• Postpartum Support International- www.postpartum.net

• www.babycenter.com

• www.postpartum.org

• www.postpartumhealth.com

• www.postpartumdads.org

• www.motherisk.org

• Counseling Facilities

  • Sliding scale fees for mental health counseling
    ▪ http://clearwaterclinic.com/docs/referrals.html
    ▪ http://www.azdhs.gov/404.htm
    ▪ http://westsidebehavioral.com/insurance/self-pay-mental-health-providers.html
    ▪ http://www.chservices.org/mental_health/mentalhealth.html
    ▪ http://www.resourcedirectory.com/
DON'T DISMISS YOUR FEELINGS

Postpartum Depression affects 13-20% of Women

Get the facts.

TALK ABOUT IT.
Appendix C

P.P.D. IS REAL

P.P.D. HURTS

TALK ABOUT IT
Appendix D

AGE
GENDER
ETHNICITY

PPD DOES NOT DISCRIMINATE

TALK ABOUT IT
Appendix E

Edinburgh Postnatal Depression Scale (EPDS)

Name: _______________________________
Address: ___________________________________________________
Baby’s Age: ____________________________

As you have recently had a baby, we would like to know how you are feeling. Please
UNDERLINE the answer which comes closest to how you have felt IN THE PAST 7 DAYS,
not just how you feel today.

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

As much as I always could
Not quite so much now
Definitely not so much now
Not at all

2. I have looked forward with enjoyment to things.

As much as I ever did
Rather less than I used to
Definitely less than I used to
Hardly at all

3. * I have blamed myself unnecessarily when things went wrong.

Yes, most of the time
Yes, some of the time
Not very often
No, never

4. I have been anxious or worried for no good reason.

No, not at all
Hardly ever
Yes, sometimes
Yes, very often

5. * I have felt scared or panicky for not very good reason.

Yes, quite a lot
Yes, sometimes
No, not much
No, not at all

6. * Things have been getting on top of me.
Yes, most of the time I haven’t been able to cope at all
Yes, sometimes I haven’t been coping as well as usual
No, most of the time I have coped quite well
No, I have been coping as well as ever

7. * I have been so unhappy that I have had difficulty sleeping.
Yes, most of the time
Yes, sometimes
Not very often
No, not at all

8. * I have felt sad or miserable.
Yes, most of the time
Yes, quite often
Not very often
No, not at all

9. * I have been so unhappy that I have been crying.
Yes, most of the time
Yes, quite often
Only occasionally
No, never

10. * The thought of harming myself has occurred to me.
Yes, quite often
Sometimes
Hardly ever
Never

Response categories are scored 0, 1, 2, and 3 according to increased severity of the symptoms. Items marked with an asterisk are reverse scored (i.e. 3, 2, 1, and 0). The total score is calculated by adding together the scores for each of the ten items.
The goal of this workshop is to provide much needed awareness to a population of persons who are in the most opportune position to empower and heal women suffering from postpartum depression.

The goal is to open a window of opportunity to learn more about this debilitating disorder and for providers to begin to assess and intervene.

"I have been astonished to discover just how prevalent - and "closeted" - postpartum depression is. I make a point of "coming out" about it immediately to other moms and non-parents that I meet, and I inevitably hear a response like "I thought I was the only one." The wimpy paragraph in most standard parenting/babycare books doesn't begin to cover this. I would be delighted to share my experience."

(From The Mother-to-Mother Postpartum Depression Support Book-Sandra Poulin, 2006)
"The only thing that kept me sane was knowing that others had PPD and made it through. I searched desperately for anyone with my symptoms to reassure myself that I, too, would one day have my life back and be happy to be alive. By far the most help came from former sufferers. This book will be a great resource.”

(From The Mother-to-Mother Postpartum Depression Support Book-Sandra Poulin, 2006)

A common praise from women, who have recovered from PPD, is that they found solace and comfort from other women who recovered and shared their stories.

The concern is that the women who share their stories are ones that have recovered, not ones that are currently suffering.

Seldom are any other parties mentioned in the recovery process. It is important that women have other support systems. Family, partners, and healthcare providers can be significant routes to recovery.
“We won’t make women depressed by asking them about how they feel. For some, it may make them more aware of problems, but providing they have the opportunity to discuss this, it is unlikely to cause distress” (Buist, 2002).

An important aspect when assisting patients/clients is to be empathic, encouraging, actively listen and provide a safe environment for exploration and discussion.

Disaffirmation from a provider denies or contradicts personhood, meaning a person is treated as an object. Affirmation validates and supports a person (Sorenson and Tschetter, 2009).

Become interested in more than just the usual aspects of office visits. Be proactive and have material ready for women and their families regarding birthing plans, possible complications, PPD, and the adjustments of parenting.
It may be difficult to incorporate new practices due to time constraints but with all change comes trial and error. The point is to make an effort and commitment to improvement.

Create dialogues and opportunities to educate patients/clients about PPD. Practice creates an opportunity to revise, enhance or produce several ways to engage in a dialogue. Nothing is easy in the healthcare system and it can be exhausting but we also thrive on excellence and our ability to be the best and most effective at what we do. Don’t let the discomfort or difficulty get in the way of your work ethic, let it be a motivating force.

Discuss the joys and excitement of pregnancy and parenting, but also discuss fears and anxieties.
Inform women of the physical and emotional adjustments that will occur. Reassure women and their families that adjustment is normal but concerns are always welcomed and discussion is encouraged.

Provide awareness in the office environment. Post resources and posters for postpartum depression. If there is an office bulletin, incorporate information on PPD. This may extend past the office and into the community.
Possible questions to ask (Bennett and Indman, 2006).

- How are you doing? *(have good eye contact while asking this question)*
- How are you feeling about being a mom? *(women who feel like they are doing a bad job or who generally do not like the job, may be depressed).*
- Do you have any particular concerns?
- How are you sleeping (quality and quantity)? *(five hours minimum of uninterrupted sleep per night is required for a complete sleep cycle, necessary to restore brain chemistry).*
- Can you sleep at night when everyone else is asleep? *(insomnia is a symptom of every mood disorder).*
- How is the baby sleeping?
- Who gets up at night with the baby?
Have you had any unusual or scary thoughts? (If yes, this is the time to refer her to a perinatal psychotherapist for evaluation. Some thoughts may be common but it may also be an indicator of OCD or psychosis).

Are you receiving adequate physical and emotional help? A good support system of family and friends can make a significant difference) [Providers-ask the patient/client if she understands what a support system is, and do not assume she has one.]

Do you generally feel like yourself? (women with postpartum mood disorders often report not feeling like their usual selves).

How is your appetite? (this can be a red flag).

What and how often are you eating and drinking?

If breastfeeding, how is it going? (poor milk production can be an indicator of a thyroid problem or anxiety).
Are you taking any medications or herbs on a regular basis? (some women who are experiencing depressive symptoms may be self-medicating and should be evaluated).

Are you feeling moodier than usual (tearful, irritable, or worried)? (another red flag).

Have there been any health problems for you or the baby? (these factors may increase the risk of mood disorders).

How are you feeling toward your baby? (ambivalence and anger are two feelings associated with PPD).
DSM-IV-TR
- 296.2x Major Depressive Disorder, Single Episode
- Presence of a single Major Depressive Episode (see p. 356).
- The Major depressive Episode is not better accounted for by Schizoaffective Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- There has never been a Manic Episode (see p. 362), a Mixed Episode (see p. 365), or a Hypomanic Episode (see p. 368). **Note:** This exclusion does not apply if all of the manic-like, mixed-like, or hypomaniac-like episodes are substance or treatment induced or are due to direct physiological effects of a general medical condition.
If the full criteria are currently met for a Major Depressive Episode, *specify* its current clinical status and/or features:

- Mild, Moderate, Severe Without Psychotic Features/Severe With Psychotic
- *Features* (see p. 412)
- *Chronic* (see p. 417)
- *With Catatonic Features* (see p. 417)
- *With Melancholic Features* (see p. 419)
- *With Atypical Features* (see p. 420)
- *With Postpartum Onset* (see p. 422)

If the full criteria are not currently met for a Major Depressive Episode, *specify* the current clinical status of the Major Depressive Disorder or features of the most recent episode:
In Partial Remission, In Full Remission (see p. 412)
Chronic (see p. 417)
With Catatonic Features (see p. 417)
With Melancholic Features (see p. 419)
With Atypical Features (see p. 420)
With Postpartum Onset (see p. 422)
  296.3x Major Depressive Disorder, Recurrent
Presence of two or more Major Depressive Episodes (see p. 356)
Note: To be considered separate episodes, there must be an interval of at least 2 consecutive months in which criteria are not met for a Major Depressive Episode.
The Major Depressive Episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

There has never been a Manic Episode (see p. 362), a Mixed Episode (see p. 365), or a Hypomanic Episode (see p. 368). Note: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition.

If the full criteria are currently met for a Major Depressive Episode, specify its current clinical status and/or features:
Mild, Moderate, Severe Without Psychotic Features/sever With Psychotic Features (see p. 412)

Chronic (see p. 417)

With Catatonic Features (see p. 417)

With Melancholic Features (see p. 419)

With Atypical Features (see p. 420)

With Postpartum Onset (see p. 422)

If the full criteria are not currently met for a Major Depressive Episode, specify the current clinical status of the Major Depressive Disorder or features of the most recent episode:
In Partial Remission, In Full Remission (see p. 412)
Chronic (see p. 417)
With Catatonic Features (see p. 417)
With Melancholic Features (see p. 419)
With Atypical Features (see p. 420)
With Postpartum Onset (see p. 422)
Specify:
Longitudinal Course Specifiers (With and Without Interepisode Recovery) (see p. 424)
With Seasonal Pattern (see p. 425)
Depression defined by McIntosh (1993) is the experience of depressed mood lasting for at least 14 days, and occurred at any time after the first week postpartum. This definition was used to assess the sample of women.

Postpartum depression defined by Crockenberg and Leerkes (2003) as a mild to moderate disturbance in taking place from birth to 6 months postpartum, rather than the less frequent, more severe postpartum psychosis, or the more common but transient blues.

Nicolson (1990) cites “the blues” as weepiness and anxiety occurring between 2-10 days postpartum. Depression and anxiety once baby is home which lasts about a week or two. Depressed moods consisting of good and bad days may last up to 3 months post delivery, and clinical depression, which is enduring and includes symptoms such as loss of appetite and sleep disturbance.
According to Bronwyn et al., (2011) postnatal depression is an episode of major or minor depression occurring in the first year following delivery.

Postnatal depression is a term used to explain a assorted group of conditions with features of both depression and anxiety-in women who present postnatally (Acland et al., 2008).
Difficulties with identifying symptoms

- Many of the symptoms that are common to the adjustment of a new baby are shared with postpartum depression. Due to the commonality it has proven to be difficult in distinguishing between the typical symptoms of adjustment and diagnosing PPD. Some common signs are insomnia/hypersomnia, fatigue, depressed mood, and change in appetite.

- Feelings of hopelessness/guilt.
- Decrease in concentration.
- Depressed mood and or loss of interest in usual activities.
- Suicidality.
A red flag to assess for during an office visit is the mother’s response time to her child and the amount of interest she shows the infant. Depressed mothers are at times detached from their child and do not exhibit appropriate response times.

Unsettled infant behavior is thought to be another red flag. Babies are generally fussy at times but infants with depressed mothers tend to be fussier than most and are less responsive to the mother’s attempts to console. Depressed mothers rate their infants as difficult.
The postpartum period is a vulnerable time for a woman and is a time of increased risk for adjustment difficulties and the onset of psychiatric disorders (Campbell and Cohn, 1991).

The “baby blues” is a common occurrence amongst mothers after delivery and can last anywhere from a few hours to a few days.

Postpartum depressive symptomatology is a common condition that occurs in 25-30% of women. Although the depressive symptomatology causes distress and disturbances, it’s sometimes not enough to meet diagnostic criteria. Nonetheless the symptoms are still damaging to the postpartum adjustment period (Bernazzani et al., 1997).

Postpartum depression hovers around 10%. Prevalence in the first 2 months is around 8.2%.
In a study conducted by O’Hara et al. (1990), non-psychotic PPD has a prevalence rate of 8.7% at 3 months postpartum.

Approximately 13% of women experience PPD within the first year (Beck, 2001).

The onset typically begins 4 weeks postpartum and can last up to a year.

Postpartum Psychosis

- 1 in 600 women will be affected by postpartum psychosis (Buist, 2002).
- Onset varies but can take place 2-3 weeks post delivery.
- More often than not mothers are unable to care for themselves or their infants. The more severe cases require the mother to be hospitalized for proper treatment. Often times hallucinations and delusions are experienced.
Risk Factors

Mother

- A powerful predictor of PPD is antenatal depression (Buist, 2002).
- Chronic stressors such as poverty, inadequate or poor living conditions and unreliable modes of transportation have been shown to be risk factors (Arndt et al., 2007).
- Cutrona (1993) suggests that pregnancy and delivery complications have been associated with postpartum depression (as cited by Campbell and Cohn, 1991).
- Poor marital or domestic relationship. A woman is more vulnerable to abuse during pregnancy. Domestic abuse during pregnancy has a prevalence rate of 0.9%-20.1% (Certain et al., 2008).
- A history of physical, sexual, or emotional abuse.
- Low social support, living below the poverty line, chronic stress, inadequate childcare, lower levels of education and inadequate access to transportation.
- Previous episodes of depression prior to the prenatal and postpartum period.
- Predisposition to depression (genetics) and/or (environment).
Effects on the child

- Prompt and effective treatment is needed to diminish infant exposure to maladaptive maternal stress, anxiety and cognitions (Abel et al., 2011).
- Children are also affected by this debilitating and non-discriminatory disorder. Several problems have shown to persist in children such as their ability to regulate emotions and cope with life stressors.
- Mothers who are depressed tend to provide inconsistent care to their infants (Dauber et al., 2008).
- Some studies have found a correlation between PPD and a delay in the development of a child’s brain. Speech and cognitive difficulties may be encountered in early childhood.
The mother-infant relationship is jeopardized if the dyad is unable to form an appropriate attachment. Infants are at risk of forming insecure attachments, which may have implications on his or her ability to form secure attachments in other relationships throughout the course of his or her lifetime.

A child may experience difficulties adjusting to new environments and situations.

Infants with mother’s who are depressed tend to be unconsoleable, are fussy more often than not, are less responsive to their mothers and can also have a delayed response to their environment.
The most common tool used to assess women for PPD is the Edinburgh Postnatal Depression (EPDS). The EPDS covers a 7-day time period and is a ten-item self-report questionnaire.

The Inventory to Diagnose Depression (IDD)-is a 22-item self-report scale. This tool was developed to identify a major depressive episode consistent with DSM-III. The IDD has demonstrated strong reliability and has shown success in identifying PPD (Arndt et al., 2007).

Beck Depression Inventory (BDI) or the BDI-II.

The Composite International Diagnostic Interview (CIDI) is a structured psychiatric interview and can be conducted over the phone. The DSM-IV is used to obtain diagnoses and results are computerized.
“Although some aspects of perinatal depression may be unpreventable, providers are challenged to reassess current practice to identify alternative cost-effective, noninvasive, and low-risk approaches to prevention, detection, and early treatment” (Sorenson and Tschetter, 2009).

Providers can conduct routine office-based screenings using valid screening tools. The EPDS and the BDI-II are frequently used throughout the literature and valid in detecting PPD.

Assessment or screening should be provided for every patient/client regardless of risk. It is better to err on the side of caution, than to miss detection in women. The provider can reassure the women that the screening is a routine part of practice and all women are to participate. Women may take comfort in knowing they are not being singled out, or feel embarrassed or shame that they need to be assessed.
Assessment by the Primary Care Physician does not mean that he or she is required to treat the mother. Screening is the first step to intervening and referring women to the appropriate provider.

Barriers to TX

- A delay in adequate treatment is a significant factor in the duration of PPD (Beck, 2001).
- One important barrier to treatment is a woman’s reluctance to seek help for her symptoms. Several factors have been cited and include but are not limited to, worrying that she will be labeled an unfit mother, the stigma attached to PPD, embarrassment, and the fear that her child or children will be removed form her care.
- Recognition of the signs and symptoms is another common barrier to treatment.
Cultural considerations can be a reason why women do not disclose their symptoms to their providers. More research is needed on the demographic characteristics of women who seek help and those who do not.

Low-income families might not have access to health insurance or their health insurance does not cover mental health services. There are several agencies and mental health facilities that offer fees on a sliding scale. This is a great resource for families to access. An important factor to keep in mind is that many agencies have waiting lists, so it is recommended that a minimum of three referrals are provided.

There is a greater need for mental health services than previously thought. Goodman et al., (2010) found that only 41% of prenatal women and 31% of postpartum women, in their sample of 491 women, receive services.
Modalities

- Interventions such as education, support, therapy, and medication are available to treat PPD.
- Interpersonal therapy or group therapy should have an emphasis on educating moms on parenting, incorporating coping skills and the importance of support.
- Specific interventions for PPD might increase the benefits of therapy and decrease the recovery time.
- TF-CBT (Trauma Focus Cognitive Behavioral Therapy) is a great tool in treating clients who have survived traumatic life events. For instance an isolated-one time event such as a natural disaster or reoccurring event such as abuse. PPD is a traumatic event in a woman’s life, but it would be more beneficial to create a treatment plan specific to PPD. It can be specific treatment for families who have been burdened with this disorder.
It is important not to be quick to prescribe medication, or to prescribe medication without therapy. Antidepressants are controversial and the long-term effects have not been well established. Prescribing medication can leave a woman feeling hopeless and she might fear that she will need to take medication for the remainder of her life. Medication should be included in the discussion but not referred to as the “go to” remedy.

- Group therapy facilitated by doctors, nurses, and mental health providers have been effective in treating PPD. Whomever facilitates the group must be educated and trained on the specifics of PPD.
- Group therapy concurrent with interpersonal therapy has been as beneficial as any other treatment modality.
Stress reduction exercises and relaxation techniques are useful tools for women to practice and will help reduce the severity of symptoms.

- Breathing techniques, grounding techniques, meditation techniques and the thoughts-feelings-behaviors triangle are a few methods used to alleviate anxiety.

A simple suggestion such as recommending a patient/client to go outside for five to ten minutes a day will help her step out of isolation. The task is not monumental and does not pressure her to socialize if she is not ready to. It simply allows her to step outside the confines of her home, allow her to breath fresh air, provides vitamin d and can be the start of her starting a routine of self-care.
Support from a partner has been shown to improve a woman’s depressive symptoms. [If possible providers can ask that both parents be present during the prenatal and postpartum check-ups. This can build the strength in awareness and possibly allow a partner to take a proactive stance in the detection and treatment process if his or her partner is at risk or suffering from PPD.]

Providing referrals for support groups and online forums is a helpful tool. The more relevant the group or forum is for PPD the more likely a woman is to continue. Women who are suffering from PPD may feel out of place or uncomfortable in a parenting group or support group that consists of mother who have not experienced the same entrance into motherhood. This may leave a women feeling inadequate, angry, even more isolated and possibly discourage any further outreach for treatment.
Researchers have difficulty attaining participants for their studies, or throughout the course of the study several women drop out. Women express reasons related to exhaustion, lack of time and childcare, or fail to respond altogether.

Several studies provide readers with the limitations encountered that may have a small or significant effect on the results. Many cite that the sample sizes are too small, some were samples of convenience and the sample lacked a diverse group of women. Caution is advised when generalizing the results to all women.

Demographic Characteristics
- Samples typically do not consist of multi-ethnic women.
- Women are either the same age or fall in age categories. Rarely if at all do samples include women ranging from adolescence to age 50.
Limitations of Research Contn’d

- Generally women in a sample will either be in the lower ranges of the socioeconomic range or considered upper/middle class. Once again samples have either or, and do not include both.
- Level of education is seldom diverse.
- Married or in a domestic relationship, or single.
- If the study was conducted in the United States only women who spoken English were accepted to participate.
- Difference in criteria and definition of PPD.
- Gavin et al., (2005) suggest that a limitation in the research may be that rates vary depending on the diagnostic criteria, sampling methods, timing of assessment and the measures used (as cited by Austin et al., 2010).
Self-reporting tools

According to Campbell and Cohn (1991), self-reporting tools have several limitations. The first limitation is the over-reporting or under-reporting of symptoms. The next limitation noted is the symptom checklist assesses a variety of symptoms that are not specific to depression. This can elevate a woman’s score and qualify her for a diagnosis that is not fitting. The self-reporting tool may also miss criteria, especially if the interviewer or questionnaire does not succeed at eliciting more specific symptom-relevant behaviors.
Resources/Referrals

- **Housing**
  - Low Income Housing Search
    - [http://lowincomehousingsearch.com/b/?t202id=215&t202kw=low%20income%20housing](http://lowincomehousingsearch.com/b/?t202id=215&t202kw=low%20income%20housing)
  - Low Income Housing Voucher
    - [http://www.housingvoucher.org/landers/search/112-section8-v1/](http://www.housingvoucher.org/landers/search/112-section8-v1/)
  - Low Income Apartment Search
    - [http://www.apartmentguide.com/?WT.mc_id=9320&WT.srch=1&ef_id=x@JPrZVp2j4AABVS:20120520193235:s](http://www.apartmentguide.com/?WT.mc_id=9320&WT.srch=1&ef_id=x@JPrZVp2j4AABVS:20120520193235:s)
  - Section 8 Programs
    - [http://www.section8programs.com/lowincomehousing.html](http://www.section8programs.com/lowincomehousing.html)
  - CA Department of Housing and Community Development
Resources/Referrals Contn’d

- [http://www.hcd.ca.gov/fa/affordable-housing.html](http://www.hcd.ca.gov/fa/affordable-housing.html)
- Low Income Housing US.
- [http://www.lowincomehousing.us/](http://www.lowincomehousing.us/)
- Income Based Apartments
- [http://www.incomebasedapartments.net/low-income-housing-programs.html](http://www.incomebasedapartments.net/low-income-housing-programs.html)
- Affordable Housing
- Low Income Housing Credit Program
- [http://www.nyshcr.org/Programs/LIHC/](http://www.nyshcr.org/Programs/LIHC/)

- **Food banks**
  - Los Angeles Regional Food Bank
  - Los Angeles Food Pantries
Resources/Referrals Contn’d

- Greater West Hollywood Food Coalition
  1106 N Cahuenga Blvd
  Los Angeles, CA
- California Association of Food Banks
  http://www.cafoodbanks.org/LosAngeles.html

- WIC
  WIC Contact Information
  California WIC Program
  Dept. of Public Health
  P.O. Box 997375
  Sacramento, CA 95899-7375

  3901 Lennane Drive
  Sacramento, CA 95834

- Toll Free Number
  1-800-852-5770
  1-888-WIC-WORKS or 1-888-942-9675
What is WIC and Who Can It Help?

The Women, Infants, and Children (WIC) Supplemental Nutrition Program is a federally-funded health and nutrition program for:

- Women who are pregnant, breastfeeding, or just had a baby
- Children under 5 years old (including foster children)
- Families with low to medium income (working families may qualify)

What can you get at WIC?

- Special checks to buy healthy foods from WIC-authorized vendors – milk, eggs, bread, cereal, juice, peanut butter, and much more (see Authorized Foods)
- **Information about nutrition and health** to help you and your family eat well and be healthy
- Support and information about breastfeeding your baby
- Help in finding health care and other community services
- Where can I find WIC?
- WIC has local offices all over California. Call 1-888-WIC-WORKS (1-888-942-9675) or use our [online search feature](#) (opens a new browser window). Outside California please call (1-916-928-8500).
- Do I qualify?
- Generally, WIC is available to:
- Low income pregnant, breastfeeding, and postpartum women
- Low income parent or guardian who is the sole provider of children under age five who are at nutritional risk and who are at or below 185 percent of the federal poverty level ([See income guidelines (PDF)](#))
Medical

- Affordable Health Insurance
  - http://www.easierhealthinsurance.com/welcome?id=4603105004&m=e&creativeID=687969115&oID=5947004932&q=free%20health%20clinics
- Free Health Clinics
  - http://findahealthcenter.hrsa.gov/Search_HCC.aspx
  - http://meded.ucsd.edu/freeclinic/
  - http://nafcclinics.org/
  - http://www.freemedicalcamps.com/
- Healthy Families Insurance
  - http://www.healthyfamilies.ca.gov/Home/default.aspx
Resources/Referrals Contn’d

- http://www.healthyfamiliesenrollment.org/AboutHF.aspx
- http://www.healthy-families.us/
- http://www.healthyfamilies.org/

- Welfare
  - CalWORKs:
    - http://www.dss.cahwnet.gov/calworks/
    - http://www.ladpss.org/dpss/calworks/default.cfm
    - http://dpss.co.riverside.ca.us/CalWorks.aspx
  - Welfare Assistance
    - http://www.welfareinfo.org/
    - http://www.dpw.state.pa.us/
Resources/Referrals Contn’d

- Planned Parenthood
  - http://www.plannedparenthood.org/

- Employment
  - Worksource Centers
  - http://www.worksourcecalifornia.com/

- Job search sites
  - http://jobs.monster.com/?WT.srch=1&WT.mc_n=olm11msrchj
  - http://jobsearch.youremployment.com/?CID=6813
  - http://www.indeed.com/
  - http://www.careerbuilder.com/
Resources/Referrals Contn’d

- http://www.snagajob.com/
- http://www.usajobs.gov/
- http://govtjobs.com/
- https://www.governmentjobs.com/
- Employment Agencies
  - http://www.manpower.com/
  - http://jobagencies.com/

- Libraries offer free or low-cost internet

- Support
  - Postpartum Support International: postpartum.net
  - Baby Blues Connection: www.babybluesconnection.org
  - www.postpartum-depression.net
  - www.circleofmoms.com
  - familydoctor.org
  - www.ppdhope.com
Resources/Referrals Contn’d

- National Hopeline Network-(800) 784-2433 [SUICIDE]
- North American Society for Psychosocial OB/GYN- [www.naspog.org](http://www.naspog.org)
- Postpartum Support International- [www.postpartum.net](http://www.postpartum.net)
- [www.babycenter.com](http://www.babycenter.com)
- [www.postpartum.org](http://www.postpartum.org)
- [www.postpartumhealth.com](http://www.postpartumhealth.com)
- [www.postpartumdads.org](http://www.postpartumdads.org)
Resources/Referrals Contn’d

- www.motherisk.org
- Counseling
  - Sliding scale fees for mental health counseling
  - http://clearwaterclinic.com/docs/referrals.html
  - http://www.azdhs.gov/404.htm
  - http://www.chservices.org/mental_health/mentalhealth.html
  - http://www.resourcedirectory.com/