

Maternal Depression and Child Development: Strategies for Primary Care Providers



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Learning Objectives:

Upon completion of the program, the health care provider should be able to:

1. Differentiate between normal “baby blues,” postpartum depression, and postpartum psychosis.
2. Gain knowledge about the impact of postpartum depression on children and families.
3. Identify risk and protective factors for maternal depression.
4. Become familiar with maternal depression screening tools.
5. Learn referral procedures.
6. Implement culturally-appropriate care for patients with postpartum depression.

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Faculty Disclosures:

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Margaret Wiedmann, MD and Craig Garfield, MD report no drug or device company affiliations that could represent potential conflicts of interest. Scientific writers Lucy Elam and Charles A. Goldthwaite, Jr., Ph.D. report no drug or device company affiliations that could represent potential conflicts of interest.

There is no specific FDA approval for use of antidepressant medications during pregnancy and lactation. This guideline therefore includes discussion that may be considered “off-label” medication use.

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Introduction

Maternal depression can occur throughout the life cycle. However, this educational program will focus primarily on identifying and treating maternal depression following childbirth, or postpartum depression, which can affect up to 20% of women who have children.¹⁻⁴ Postpartum depression may negatively impact a mother's ability to be responsive to her child and may lead to poor parenting. The potential impacts of postpartum depression on a child include depression, anxiety, and attention deficit. Children of depressed mothers may perform more poorly in school and may experience lifelong deficits in coping and interpersonal skills. Maternal depression is a serious condition for mothers and can have long-lasting sequelae in children. Primary care providers play a critical role in identifying women at risk for depression, including new mothers, and in ensuring that they receive prompt and effective care.^{1, 5-12} Furthermore, if depression during pregnancy is not treated, the condition may worsen after giving birth; pre-existing depression has been associated with a 50-62% risk of a postpartum episode.¹

Primary care providers play critical roles in identifying mothers at risk for postpartum depression and ensuring that they receive prompt and effective care.

Impacts of Maternal Depression

Impact on Parenting. The impacts of postpartum depression on a mother's ability to parent are well documented, although they vary between individuals (Table 1).^{1, 3, 5-8, 10-16} In some cases, maternal depression has no effect on parenting or outcomes related to the baby. In general, however, depressed mothers tend to be less able to read their babies' cues than are non-depressed mothers, resulting in decreased awareness of their babies' needs. Coupled with this behavior is the reduced ability to communicate a range of emotions, making the mother less responsive to her baby. These behaviors usually result in reduced care and stimulation for the baby, although in some instances, depressed mothers who misread their infants' cues may over-stimulate their babies.¹¹ Mothers who are depressed tend to engage in less interactive behavior and lack empathy as compared to their non-depressed counterparts; depressed mothers are less likely to read, sing songs, or tell stories to their children.¹⁰ Children of depressed mothers are less likely to breastfeed.¹³ A depressed mother may also display reduced attention to her baby's health needs, thereby lowering the likelihood of obtaining preventive care for the baby and increasing the probability of using acute care, including emergency rooms.¹⁵

Table 1 Behaviors Commonly* Associated with Depressed Mothers^{1, 3, 5-8, 10-16}

- Less responsiveness to baby's cues
- Less awareness of baby's needs
- Reduced ability to communicate range of emotions
- Reduced care and stimulation of baby
- Less interactive behavior
- Less empathy
- Less likely to obtain preventive health care for baby

*In some instances, maternal depression may have no effect on parenting.

Impact on the Infant. Maternal depression also affects the physical and emotional well-being of the offspring. The condition often promotes long-term consequences such as a failure to thrive and grow; emotional, behavioral, and cognitive problems; and a lifelong decreased ability to handle stress (Table 2).^{1, 5, 6, 8, 11, 17} Data suggest that children of depressed mothers may have difficulty developing a trusting relationship, therefore impeding subsequent social and emotional development.^{1, 5, 6, 8, 11} Infants of depressed mothers may not grow as well during the first year of life and are more likely to display difficult temperaments. Physical manifestations in infants that have been associated with maternal depression include inactivity, irritability, hypersensitivity to sounds and disturbances, and irregular sleep and feeding behaviors.^{1, 5, 6, 8, 11} As young

children, offspring of depressed mothers tend to suffer from depression, anxiety, and attention deficit.^{1, 5, 6, 8, 11} They may also display deficits in academic and social skills, including difficulty modulating aggression towards peers and adults.^{1, 5, 6, 8, 11} It should be noted, however, that poor outcomes can be averted for children whose mothers are depressed. The child's disposition, the family's cohesion and warmth, and supportive figures including other family members (e.g., father, grandparents), may serve as protective factors.⁵

Table 2 Effects of Untreated Postpartum Depression on Infants^{1, 5, 6, 8, 11, 17}

- Difficulty in developing trusting relationships
- Impeded growth during first year of life
- Inactivity or hyperactivity
- Irritability
- Irregular sleep and feeding behaviors
- Lifelong decreased ability to handle stress

Impact on Family Members. Maternal depression can affect other family members including spouses or intimate partners and other children. Fathers often experience depression when mothers are depressed.^{7, 16}

Maternal depression can affect the entire family—mother, father, newborn, and other children.

Maternal Mental Health Conditions

For maternal mental health conditions, there is a wide variance in severity, including the normative condition of postpartum blues (the "baby blues"), and more severe conditions such as postpartum depression and postpartum psychosis (Figure 1). Each of these conditions is discussed below.

The "Baby Blues." Postpartum blues, also called the "baby blues," refers to a transient, normative condition experienced by about 50% of new mothers (Table 3).^{17, 18} The "baby blues" results from hormonal changes following birth and does not have a basis in clinical depression. The "blues" refers to a state of emotional lability in which women may experience tearfulness, irritability, fatigue, insomnia, anxiety, and feelings of loss or being overwhelmed. Symptoms peak approximately five days after birth and generally resolve within two weeks.^{17, 18}

Postpartum Depression. Postpartum depression affects 8% to 20% of women in the first year after birth.^{17, 18} Postpartum depression is a clinically significant condition that is essentially identical to major depression. It is distinguished from the "baby blues" by features that

include a prolonged depressed mood and/or an inability to experience pleasure, and often the presence of triggering stresses, and a personal and/or family history of mood disorders. Unlike women with “baby blues”, women with postpartum depression may have thoughts of self-harm or harming the baby (Table 3).¹⁹ Other features associated with normative postpartum conditions, such as irritability, and fatigue, are also seen in postpartum depression.

Whereas the “baby blues” usually resolves after two weeks, postpartum depression may last from a few weeks to over a year. Some experts claim that diagnostic symptoms are evident within four weeks of delivery.^{17, 18} Results of epidemiologic studies show that peak onset occurs within the first three months of giving birth, although risk for depression remains heightened throughout the first year postpartum.²⁰ If such depression is not treated, up to 50% of mothers will remain depressed one year following birth.

Women experiencing postpartum depression should be evaluated and subsequently treated or referred for mental health evaluation and treatment. Strategies for evaluation, treatment, and referral for these women are detailed in subsequent sections of this document.

Postpartum Psychosis. Approximately 1 to 3 per one thousand new mothers suffer from postpartum psychoses in the first year after birth.^{17, 18} While rare, symptoms of postpartum psychoses represent a serious condition that requires immediate attention. Symptoms can include hallucinations, paranoia, delusions, illogical thoughts, insomnia, extreme feelings of anxiety and agitation. Such symptoms can be attributed to a variety of diagnoses, including depression, bipolar disorder, and thyroid disease. Therefore, it is crucial to diagnose the underlying condition when women develop psychotic symptoms

postpartum, in order to provide appropriate treatment. Symptoms of postpartum psychoses often develop rapidly, usually within the first few days of giving birth. Women who suffer from postpartum psychoses may consider harming themselves or their children; therefore, healthcare providers should query the mother about such thoughts in order to assess the level of risk for harm.^{17, 18} Women with postpartum psychoses require emergent care and possible hospitalization.

Risk Factors

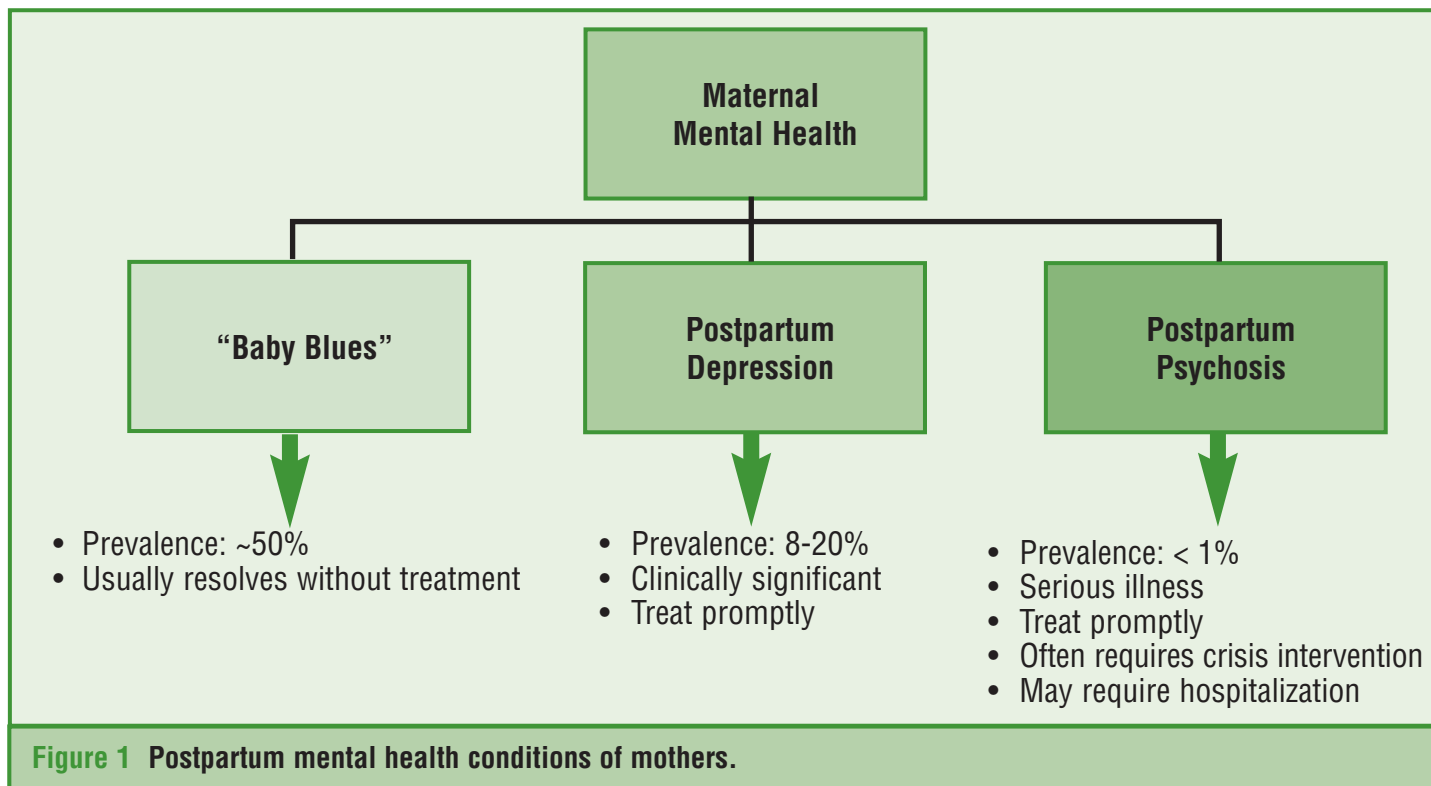
Several factors have been associated with an increased risk of depression after childbirth.^{17, 21-23} These include a previous history of depression or postpartum depression, a family history of depression, domestic violence, lack of social support, and certain environmental factors (e.g., lack of food, inadequate income or housing conditions).

It is important for primary care providers to be especially alert to the possibility of depression among patients who have a previous history or family history of depression, lack social support, or have environmental factors related to inadequate finances.

Other factors that have been cited as risk factors for depression subsequent to childbirth include violent relationships and traumatic experiences, substance abuse, and major stressful life events.^{17, 21-24} The presence of one or more of these factors does not indicate that a woman will experience depression, nor does their absence mean that a woman is not at risk for depression. Therefore, healthcare providers are strongly encouraged to screen all pregnant women and new mothers for depression.

Table 3 How “Baby Blues” and Postpartum Depression Differ¹⁹

Characteristic	“Baby Blues”	Postpartum Depression
Predominant mood state	Happiness (but mother cries easily and is emotionally reactive)	Sadness and/or anhedonia (lack of ability to feel pleasure)
Prevalence	About 50% of new mothers	About 20% of new mothers
Time of onset	3 – 5 days after delivery	Up to a year after delivery
Duration	Days to weeks	Can be months to years, if untreated
Triggering stressors	No association	Often present
Sociocultural influence	No; present in all cultures studied	Yes; prevalence varies widely by culture
History of depression	No association	Often yes
Family history of depression	No association	Often yes
Tearfulness	Yes (due to emotional reactivity)	Yes (due to sadness)
Mood lability	Yes	Sometimes, but usually mood is uniformly sad
Hopelessness	Not present	May be present
Suicidal thoughts	Not present	May be present



The Importance of Screening

Maternal Depression is Often Not Recognized or Treated. Although perinatal depression affects up to 20% of mothers, recent surveys of healthcare providers suggest that the condition remains under-recognized and under-treated. A recent American Academy of Pediatrics study on pediatricians’ attitudes about maternal depression indicated that 57% of respondents reported feeling responsible for recognizing maternal depression.⁴ However, when asked about barriers, 73% reported insufficient time for educating or counseling the mothers, 70% reported insufficient time for taking the mother’s history, 64% felt that they did not have enough training on the topic to diagnose or counsel the mothers, and 48% felt they had insufficient knowledge of treatment options.

Why Screening for Maternal Depression Is Important. Maternal depression is a treatable condition, and treatment improves the short- and long-term outcomes for mothers and for their children. Formal screening provides a reliable way to detect postpartum depression, as many women are otherwise reluctant to admit that they are depressed, and they may resist answering questions related to mood.^{25, 26}

Routine screening will help to reduce the stigma associated with mental health issues, especially among an ethnically diverse patient population. Screening is simple, convenient, rapid, and reimbursable. Several user-friendly, validated screening tools are readily available (see below for details). Because of these reasons, the ABCD II:

Healthy Beginnings project recommend that healthcare providers screen all pregnant women and new mothers for depression, regardless of whether risk factors are apparent.

The Well-Child Visit: A Convenient Opportunity to Screen. While national organizations such as the American Academy of Pediatrics and the American Academy of Family Physicians recommend screening for maternal depression, they have not issued specific guidelines regarding the timing of screens. The Illinois Healthy Beginnings Project recommends offering the screening at least once during pregnancy and at least twice during the postpartum period. The first postpartum screen should occur around the time when the child is 4 to 6 weeks old. The subsequent screens may occur at the 2-, 4-, and/or 6-month visits. In the state of Illinois, maternal depression screening can be reimbursed through the child’s first year of life (Healthcare and Family Services, HFS; formerly the Illinois Department of Public Aid).

Because of the frequency of recommended well-child visits during the child’s first year, the primary care provider is uniquely positioned to monitor simultaneously the baby’s growth and development and the mother’s emotional well-being. Ideally, the provider will see the mother and her partner during the well-child visits and can discuss the health of the child and the mother.

Postpartum Depression Screening Tools

The state of Illinois recognizes three screening tools for postpartum depression, which are currently available in Spanish-language format and are eligible for reimbursement through the HFS.²⁷ The healthcare provider may choose the screening tool that meets specific practice needs. Approved screening tools include:

Edinburgh Postnatal Depression Scale (EPDS). The EPDS is a 10-item, self-reporting questionnaire that identifies depressive symptoms in pregnant women and new mothers.²⁸ Patients answer each question on a scale of 0-3, establishing a maximum score of 30. The patient bases her answers on how she has felt during the previous seven days, and one question is related to suicidal thoughts. A score of 10-12 is suggestive of depression; scores ≥ 13 are highly correlated with depression. The EPDS has been validated cross-culturally and is available in more than 20 languages. The tool is not linked with formal (DSM-IV) diagnostic criteria for depression and cannot be used for assessment of depression severity or tracking of treatment. The ease of EPDS administration and scoring make the tool a recommended choice for clinics that only serve peripartum patients and for clinics that follow the “screen and refer” model (see below for details).

Many patients are sensitive about issues of mental health, so discussions of EPDS screening results need to be carefully framed in a way that builds the patient’s trust and confidence. With this strategy, the provider is more likely to be accepted as a valuable resource for the mother, who may be considering or already seeking help. The healthcare provider can reinforce the concept that the mother’s mental health greatly impacts her child’s development. All reinforcement can be made without increasing the mother’s feelings of guilt.

Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PHQ-9). The PHQ-9 is a 9-item, self-reporting questionnaire that is suitable for primary care clinics and for clinics that wish to treat depression onsite.²⁹ The PHQ-9 is a screening tool for clinical depression; unlike the EPDS, the PHQ-9 is not designed specifically for postpartum depression and is less well-validated for peripartum depression. However, items and scores are linked to DSM-IV depression criteria, and the tool can be used to assess and track treatment response. The PHQ-9 is easy to score and can be used for all patients in the clinic. The tool is recommended for clinics that follow the “screen and treat” model (see below for details).

Beck Depression Inventory (BDI). Like the PHQ-9, the BDI screens for general depression.³⁰ The 21-item, self-rating scale allows the patient to select choices that best describe his/her feelings during the preceding week.

Choices for each item are weighted on a scale of increasing severity (0=least severe; 4=most severe). The BDI was updated in 1996 as the BDI-II.³¹ When interpreting the BDI-II, a total score of 14-19 indicates mild depression, and a score ≥ 29 indicates severe depression. The BDI-II has a high internal consistency and has been used to assess depression in a variety of patient populations.³¹ Limitations of the test are those associated with self-report inventories, including exaggeration of scores and influence by the mode of administration.³²

Billing and Reimbursement for Screening

The Illinois Department of Healthcare and Family Services (HFS) reimburses prenatal and postpartum depression screening as a “risk assessment” to identify women who may be at risk of, or who are experiencing, perinatal depression. Enrolled providers who perform primary care services may complete a perinatal depression screening during a prenatal, postpartum, infant well-child, or episodic visit. Family Case Management agencies that are certified local health departments are also reimbursed by HFS for depression screening.

Prenatal depression screening should be billed using procedure code H1000. If the woman is postpartum and covered by HFS’ Medical Programs, the perinatal depression screening should be billed using procedure code 99420 with modifier HD (pregnant/parenting women's program) under the woman’s Recipient Identification Number (RIN). Results and a copy of the screening instrument should be kept in the mother’s file. If the postpartum depression screening occurs during a well-child visit or episodic visit for an infant (under age one) covered by HFS’ Medical Programs, the screening may be billed as a “risk assessment” using procedure code 99420 with modifier HD under the infant's RIN. This screening should be recorded as a “risk assessment” in the infant’s record, and the results plus a copy of the screening tool should be kept in a file separate from that of the infant. Information about HFS' reimbursement rates is available at <http://www.hfs.illinois.gov/feeschedule>

Use of a perinatal depression screening tool other than the EPDS, BDI, or PHQ-9 requires written approval from HFS to obtain reimbursement. Requests must be submitted in writing to HFS' Maternal and Child Health Program. Additional information is available from the Illinois Department of Healthcare and Family Services at 1-800-843-6154 or http://www.hfs.illinois.gov/mch/perinatal_prov.html.³³

The state of Illinois reimburses for screening services that utilize one of the three recognized tools—EPDS, PHQ-9, and BDI.

Treating Postpartum Depression

The Healthcare Provider’s Role. The main role of the primary care provider is to increase awareness and recognition of perinatal depression and provide support for patients who require additional assessment and ongoing services. Additional roles of the provider include:

- Use screening or risk-factor evaluation to identify mothers who may experience postpartum depression
- Assess and determine referral needs
- Discuss problem with mother’s primary care provider (where appropriate)
- Discuss treatment options and adjunctive interventions (e.g., pharmacotherapy, counseling, support groups, parenting coaching)
- Discuss options for further help/assessment (e.g., mental health providers, community resources)

Several sources are available to help practitioners and patients locate a local mental health professional for referral and treatment of perinatal depression. The Evanston Hospital Postpartum Depression Hotline provides 24/7 access to a mental health professional for postpartum support (866-ENH-MOMS). For daytime, weekday referrals, the Illinois Department of Human Services has established a toll-free Customer Care Line (1-800-843-6154, TTY number 1-800-447-6404). Daytime, weekday referrals can also be obtained by calling the DHS' ALLKIDS Program at 1-800-222-0768 or 1-866-ALLKIDS (TTY 1-877-204-1012). HFS also has a website that provides information about perinatal and postpartum depression for caregivers and for families.³⁴

Models for Treating Postpartum Depression in Primary Care. Depending upon the nature of the primary care practice, providers may choose between two models for treating postpartum depression (Table 4). The “screen and refer” model involves in-office screening using, for example, the EPDS, followed by referral to a mental health professional for assessment and treatment. The “screen and treat” model includes onsite screening using, for example, the PHQ-9, and treatment on site of those candidates whose depression is mild or moderate. These candidates may be treated with medication, and their progress can be tracked using the PHQ-9. Those who do not respond adequately warrant mental health referral. Individuals who are suicidal require emergency intervention. In this model, bipolar disorders may be screened concomitantly using the Mood Disorder Questionnaire (MDQ), a 13-item, validated self-report screening tool.³⁵ Individuals who are assessed as bipolar should be referred for additional mental health evaluation and treatment.

A detailed algorithm for the “screen and treat” model is provided in Figure 2. This sample algorithm for care can be adapted to individual clinical settings.

Treatment Modalities. Peripartum depression can be treated with pharmacotherapy (e.g., antidepressants). Mothers experiencing peripartum depression and its consequences can also be helped by use of strategies such as psychotherapy, couples therapy, parenting coaching, and support networks. It should be noted that many women are embarrassed when they receive a diagnosis of depression, making them hesitant to join support groups or participate in psychotherapy. The healthcare provider should recognize that he or she provides key support in helping the depressed patient receive proper treatment. In some cases, the provider may represent the patient’s sole resource when seeking help.

Table 4 Overview of Postpartum Depression Treatment Models in Primary Care

Model	Screening Tool	Actions
“Screen and Refer”	EPDS	<ul style="list-style-type: none"> • Refer to mental health professional for assessment and treatment • Follow-up to determine adherence to referral and to provide additional support
“Screen and Treat”	PHQ-9	<ul style="list-style-type: none"> • Identify onsite treatment candidates • Treat with medication • Consider referral for adjunctive interventions, e.g. counseling, support groups • Track progress using PHQ-9 • Refer patients with inadequate response to mental health professional

The following considerations should be reviewed when establishing a treatment plan:

1. Untreated depression, during pregnancy or postpartum, can lead to long-term negative consequences for the mother (e.g., worsening of the condition, unhealthy lifestyle choices, thoughts of suicide) and child (e.g., failure to thrive and grow, an increased likelihood of depression, anxiety, and attention deficit).
2. Combinations of therapies (e.g., medication plus psychotherapy or related support) can be discussed and offered.

3. Treatment should be considered on an individual basis, using a risk/benefit analysis of each patient. While antidepressant use may pose risks, the healthcare provider should weigh the risks of the medications against the risks of the untreated symptoms in each case. Cessation of medications in depressed mothers may lead to relapse, thereby compromising parenting/caretaking ability.

Use of Antidepressants. Most women with postpartum depression are diagnosed by the child's caregiver when the mother brings her baby for a well-child visit. Some of these mothers might have been identified earlier, since depression can also occur during pregnancy.

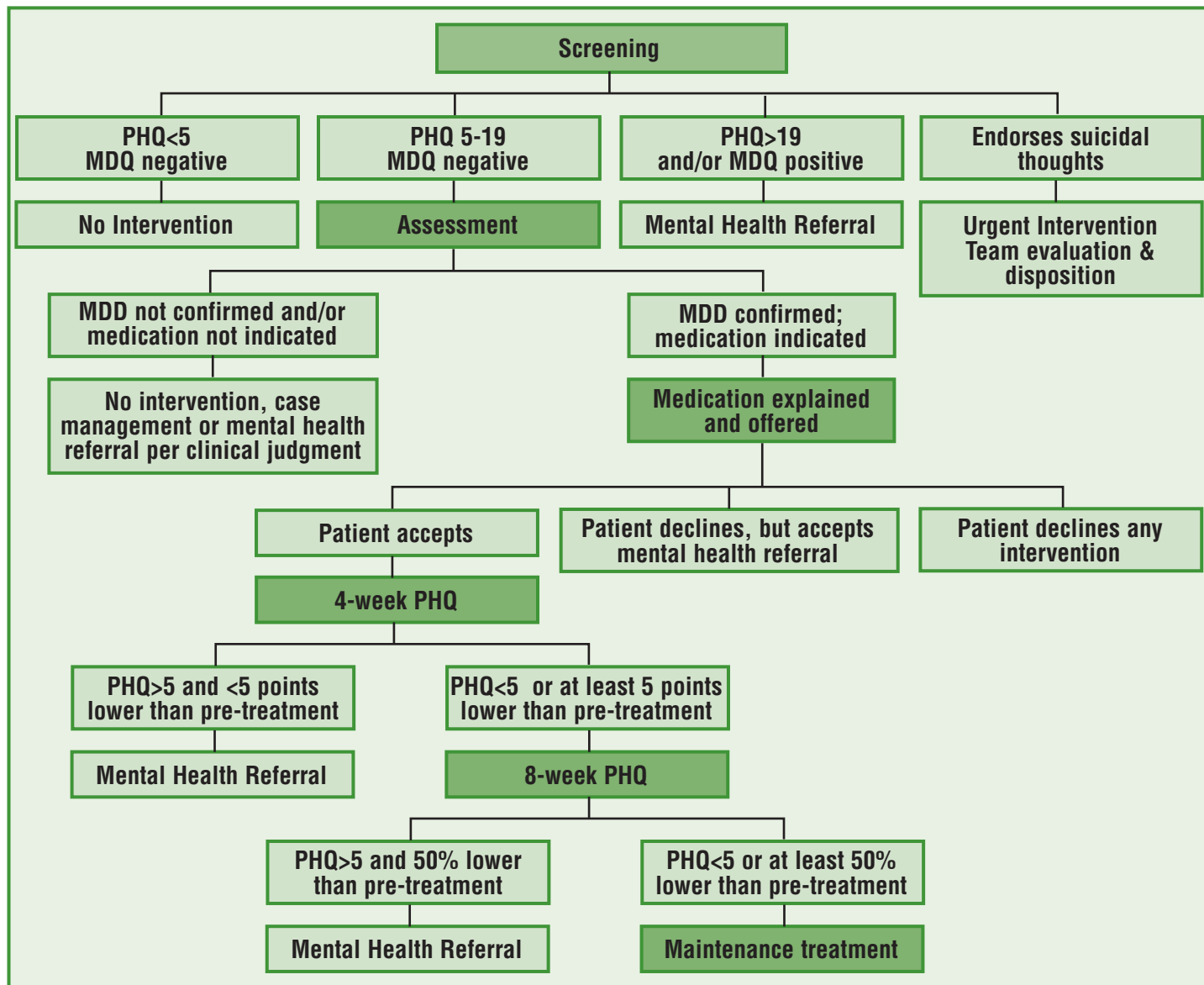


Figure 2 Sample Algorithm for Care According to the “Screen and Treat” Model (Onsite Treatment) of Maternal Depression.

Legend: MDQ= Mood Disorder Questionnaire (screen for bipolar disorder); MDD=major depressive disorder.

Source: Women’s Mental Health Program, University of Illinois at Chicago.

Untreated antenatal depression can lead to low birth weight, preterm delivery, preeclampsia, neonatal irritability, and excessive crying by the baby.

Antidepressant medication is the main modality used to treat moderate to severe postpartum depression. According to a clinical practice review in the *New England Journal of Medicine*, treatment with antidepressant drugs is appropriate for women who are given a diagnosis of major depression with postpartum onset.³⁶ While there is no specific FDA-approved indication of antidepressants during the antenatal period, most guidelines recommend choosing well-studied agents, such as the selective serotonin reuptake inhibitors (SSRIs).¹⁸ The state of Illinois maintains a list of medications prescribed for maternal depression on its Health and Family Services website.³³

Impact of SSRIs on Infants. Antidepressants cross the placenta and are secreted in breast milk.^{3, 33} Available data suggest that the percentage of the dose to which the breast-feeding infant is exposed is generally less than 10%, with sertraline being the best-studied agent with a low percentage of exposure.³³ Most SSRIs peak in breast milk seven to nine hours after ingestion.³⁷ Little information is available on the impact of SSRIs on fetuses and infants. The use of SSRIs during pregnancy can lead to withdrawal symptoms in up to 30 percent of newborns^{3, 38} and may cause respiratory distress in newborns in approximately 1% of cases.^{33, 39} However, most of these effects are short-lived. Preliminary studies have indicated that sertraline and fluoxetine are not associated with increased risk for teratogenicity, or cognitive defects.^{3, 40}

Risk-Benefit Analysis. For patients who are being treated for depression and wish to discontinue the use of antidepressants during pregnancy and/or breastfeeding, consideration should be given to the possibility of relapse of major depression if medication is discontinued. A recent prospective study of 201 pregnant women who were receiving or had recently received (<12 weeks prior to last menstrual period) antidepressant treatment indicated a rate of relapse of 68% in women who discontinued medication versus 26% among women who maintained their medication throughout their pregnancy.⁴¹ Thus, women who discontinued medication relapsed significantly more frequently over the course of their pregnancy than did women who maintained their medication (hazard ratio, 5.0; 95% CI [2.8-9.1]; $P < .001$).

For practitioners who will be treating peripartum depression in their practices, the risks and benefits of antidepressant use should be weighed for each patient. Concerns about prenatal exposure to these medications should be weighed against (1) benefits of avoiding depressive relapse during pregnancy and (2) the

alternative risks of untreated depression on infant and maternal well-being. The risks of untreated depression during the prenatal period may include decreased prenatal care, decreased nutritional quality, increased use of addictive substances, and increased risk of becoming a victim of violence. Untreated antenatal depression can lead to low birth weight, preterm delivery, preeclampsia, neonatal irritability, and excessive crying by the baby.

SSRI Recommendations for Perinatal Maternal Depression. Two SSRIs, **sertraline** and **fluoxetine**, are recommended for treatment of antenatal maternal depression. Either agent is appropriate for postpartum women who are not breastfeeding, a category of patients that is commonly identified as depressed during well-child visits.

Fluoxetine is the most well-studied with regard to the effects of use during pregnancy, and is a recommended medication for use during pregnancy.^{3, 30} However, a relatively high percentage of the dose (1.2% - 12%) may be passed to the breastfeeding baby.³⁶ Side-effects reported for breastfeeding infants whose mothers take fluoxetine are rare, although the agent has occasionally been associated with vomiting, watery stools, excessive crying, difficulty sleeping, tremor, somnolence, and decreased weight gain in breastfeeding babies.³⁶ Although fluoxetine should not be considered as the first-line agent for women who are breastfeeding or planning to breastfeed, it may be the most effective agent in some cases and should be considered on a case-by-case basis using a risk/benefit analysis.

Sertraline is a recommended medication for women who are breastfeeding and for pregnant women who are planning to breastfeed.³⁶ A relatively small percentage of the dose (0.4% -2.3%) is passed to the baby through breast milk,⁴² and there are no reported side effects of sertraline to breastfed infants.

Alternative and Adjunctive Interventions. In some cases, psychotherapy can be used instead of, or in addition to, medication to treat maternal depression. Support groups and parenting coaching can be helpful adjuncts to treatment in cases where a mother has limited social support and/or has difficulty parenting her baby due to depression.

Implementing Culturally-Competent Care for Patients with Postpartum Depression

Case Study: Gloria

Gloria is a 22-year-old Latin-American woman who brings her infant for a 6-month well-child visit. She is accompanied by her husband. When the primary care provider begins routine inquiry about the baby, Gloria's husband answers the questions with certainty, assuring the provider that everything is well with mother and child. Gloria remains reserved and sits quietly in the background, delegating communication to her husband.

As a primary care provider, how should you proceed in this situation?

Why Cultural Competence is Important. Practicing cultural competence is more than simply being thoughtful; it has become a necessary component of contemporary medical practice in the US. According to the 2000 US Census, people of color (Latinos, African-Americans, Asian/Pacific islanders, and American Indian/Alaskan Natives) make up nearly one-third of the US population.⁴³ In addition, 19.4% of the US population speaks a language other than English at home, and an estimated 12.4% of the US population is foreign-born. Because of the increasing need for medical personnel to interact with persons from diverse cultural backgrounds, governing bodies of medical schools (e.g., the Liaison Committee on Medical Education) and residency programs (the Accreditation Council for Graduate Medical Education) require that cultural competence be included in medical school and residency curricula.

Cultural Beliefs and Norms Shape Attitudes toward Depression. Attitudes toward mental illness and its treatment are influenced by cultural beliefs and norms. Some cultures deny the existence of mental illness as a medical condition, while others may discourage the patient from seeking necessary help. A culturally-diverse practice will serve patients whose cultural norms vary widely with respect to disease causation, acceptable forms of treatment, spiritual beliefs, and family structure and member roles—all factors that will impact the diagnosis and treatment of maternal depression. While it is impossible to understand the nuances of every cultural *milieu* that will be encountered in primary healthcare, some considerations may be established to help the provider communicate effectively with minority populations commonly encountered in a culturally-diverse practice. Considerations for delivering culturally-appropriate care to African-American and Latin-American patients are detailed below.

Establishing a Culturally-Competent Office Environment. Establishing a culturally competent office environment is the first step toward providing culturally-appropriate care. Patients within specific ethnic groups will exhibit major differences in the degree of their sensitivities toward the prevailing American culture. For example, recent African immigrants will exhibit cultural sensitivities that differ widely from those seen in African-American patients, and Spanish-speaking patients will represent diverse cultural backgrounds based on their home countries (e.g., Guatemala, Mexico, Nicaragua).

Components of a culturally-competent office include the appropriate physical environment (e.g., language- and topic-appropriate magazines for adults, books and toys appropriate to children, a staff to match the patient population served, and bilingual or language-appropriate wall posters and signs). Interpretation services should also be made available; as per Federal law (enforced through the US Office of Civil Rights), the healthcare provider's office must provide a trained medical interpreter. Staff should also be trained in a culturally-competent manner to overcome assumptions about, or bias against, particular cultural backgrounds.

Conducting the Cross-Cultural Interview. Conducting an interview with a patient from another culture should be carried out carefully and appropriately in order to establish trust.⁴⁴ Key elements of such an interview are listed in Table 5. A list of cross-cultural interview questions that may be adapted to suit a specific patient is provided in Table 6.

Table 5 Strategies for a Successful Cross-Cultural Interview

- Establish trust through "small talk"
- Use open body language
- Speak slowly and directly to the patient (rather than to the interpreter)
- Use short sentences and a normal tone of voice
- Avoid use of idioms
- Ask patient what illness means to her and about current treatments she is using
- Provide treatment instructions in writing
- Have patient repeat instructions in own words

Source: Juckett G. *Am Fam Physician* 2005;72:2267-2274.

Table 6 Cross-Cultural Interview Questions

- What do you call the illness?
- What do you think has caused the illness?
- Why do you think that the illness began when it did?
- What problems do you think that the illness causes?
- How severe is your illness?
- What kind of treatment do you think is necessary?
- What are the most important results you hope to receive from this treatment?
- What are the main problems that the illness has caused for you?
- What do you fear most about the illness?

Source: Juckett G. *Am Fam Physician* 2005;72:2267-2274.

Considerations for Delivering Culturally-Competent Care to African-American Patients. Respectful behavior and a demonstrated willingness to listen and communicate are necessary to build trust with the African-American patient. To foster communication, the healthcare provider should initiate the following:⁴⁵

- Respect the patient's understanding of his/her illness
- Use open-ended questions to ensure that you and patient have common meaning
- Avoid "labeling" (e.g., maternal depression, developmentally-slow child), as such labels may invoke concerns over the loss of public financial support or concerns about communal stigmatization
- Recognize the medical beliefs of the patients/parents, including folk-, home-, and herbal-based remedies. This may require cross-cultural negotiation regarding treatment.
- Incorporate beneficial or neutral folk remedies into the plan of care.

Religion, spirituality, and kinship may play important roles in the African-American patient's understanding of illness and treatment. Therefore, the provider must incorporate suggestions and recommendations within these contexts. For example, treatment barriers such as "God will heal me" may be overcome by using an appropriate explanation, such as "God would want you to feel good so you can care for your baby." To assist in adherence to a treatment regimen, the provider may also recommend support groups or services at the patient's church and should ask about key individuals in the community who may assist in supporting medical recommendations. African-American cultural norms may include a denial of the concept of "illness," especially in regard to mental health conditions. Therefore, the provider should consider incorporating a family member in the treatment and should be careful to introduce gradually the diagnosis of maternal depression by discussing symptoms and treatment before "labeling" the condition.

Considerations for Delivering Culturally-Competent Care to Latin-American Patients.⁴⁶ With Latin-American patients, the primary care provider should recognize the central role of male family members (especially among individuals who have recently come to the US). Husbands may make the family's health care decisions for their wives. The newborn's father may also serve as the family interpreter, making it difficult for the mother to discuss issues of depression or domestic violence. Additionally, women may depend upon their husbands to drive them to clinic.

The provider should also recognize cultural views of illness, which may be seen as the result of an imbalance between external and internal sources (e.g., hot and cold, body and soul). Cultural views of depression indicate that the disorder may be viewed as a weakness and/or an embarrassment to the family rather than an illness. If necessary, the provider should consider involving/offering services of a clergy member to a Latin-American patient who suffers from depression. Additionally, Latin-American patients may define certain diseases using folk idioms [e.g., *empacho* (stomach ailment)] while defining others according to Western medical criteria (e.g., measles, asthma). Finally, the provider must recognize the role of spiritual belief in treatment. Latin-American patients may believe that God determines the outcome of the treatment or course of disease; therefore, the provider must help the patient take an active role in her recovery process.

When addressing a Latin-American mother, the provider should refer to the woman as *Señora* rather than *Señorita*, even if she is a young and possibly unmarried mother. *Señora* implies the dignity of a mature woman.

Case Study: Gloria

Follow-Up:

The provider should recognize that Gloria's deference of responses to her husband likely reflects the husband's central role in the Latin-American family unit. However, her reticence may indicate more than simple deference. Gloria should be screened for maternal depression using the EPDS (if following the "screen and refer" model) or PHQ-9 (if following the "screen and treat" model).

When screened, Gloria's PHQ-9 score is 17, suggesting depression. Based on this finding, the provider should assess for depression. Depression was confirmed, and a combination of sertraline and counseling was explained and offered.

Key messages of this case:

- Routine depression screening is important for all mothers.
- Attitudes toward mental illness are influenced by cultural beliefs and norms (patients may not be forthcoming about their concerns or may deny existence of mental illness).
- A culturally diverse practice should recognize the roles of other family members.

The provider should also recognize the central role of the family (*la familia*) as a source of emotional support during treatment and recovery processes. Therefore, when possible, the provider should engage the entire family in discussions that involve decisions about care. To ensure understanding, the provider should ask open-ended questions and encourage the patient to ask questions. Nodding of the patient's head may signify that she is listening but not necessarily that she understands.

Postpartum Depression Resources for Providers and Patients

A variety of resources is available for patients and healthcare providers regarding support and treatment for maternal depression. Table 7 lists resources for health care providers to find information, consultation, and educational materials about postpartum depression. Table 8 lists resources for Illinois healthcare providers and patients to find referral care and services for treatment of postpartum depression. A selection of patient support networks and sources for information about perinatal maternal depression is provided in Tables 9 and 10.

Table 7 Resources for Health Care Providers (information, consultation, education)		
Resource	Available support	Contact information
Illinois Healthcare and Family Services	Perinatal depression information, screening tools, chart summarizing medication use during pregnancy and breast-feeding	http://hfs.illinois.gov/mch
MedEdPPD (sponsored by the National Institute of Mental Health)	On line, peer-reviewed provider training about postpartum depression	www.mededppd.org
Reproductive Toxicology Center (membership fee required)	Up-to-date, evidence-based information about medications during pregnancy	www.reprotox.org
UIC Perinatal Mental Health Program (sponsored by Health Resources & Services Administration)	Provider consultation and workshops, free of charge to Illinois health care providers	www.psych.uic.edu/clinical/HRSA 800-573-6121
Public Health Questionnaire-9 (PHQ-9)	Download a free copy of the 9-question screening tool	http://www.pfizer.com/pfizer/phq-9/index.jsp
PHQ-9 en Español	Download a free Spanish-language copy	http://www.nyc.gov/html/doh/downloads/pdf/csi/depression_kit-clin-questionnaire-sp.pdf
Edinburgh Postnatal Depression Scale (EPDS)	Download a free copy of the 10-item self-reporting questionnaire	http://www.dbpeds.org/media/edinburghscale.pdf

Table 8 Resources for Patients to Find a Clinician	
Resource	Telephone
Evanston Hospital Postpartum Depression Hotline†	866-ENH-MOMS
Illinois Department of Human Services toll-free Customer Care Line*; will be referred to appropriate regional mental health service site	1-800-843-6154
ALLKIDS Program, Illinois Department of Human Services*	1-800-226-0768 or 1-866-ALLKIDS
†Staffed with a mental health professional 24 hours a day, 7 days a week. * Network hours vary; all are available during daytime hours on weekdays.	

Table 9 Resources for Patients (crisis hotline, advocacy, support groups)

Resource	Telephone	Internet Address
Evanston Northwestern Hospital Perinatal Depression Project† crisis hotline		866-ENH-MOMS
Erikson Institute's Fussy Baby Network	888-431-BABY	www.fussybabynetwork.org

†Staffed with a mental health professional 24 hours a day.

Table 10 Resources for Patients (information)

Resource	Telephone	Internet Address
Women's Health-line of the Illinois Office of Women's Health (HFS)	888-522-1282	
Illinois Healthcare & Family Services		www.hfs.illinois.gov/mch
MedEdPPD (sponsored by the National Institute of Mental Health)		www.mededppd.org
National Alliance on Menatal Illness; request information specific to postpartum depression	800-346-4572	www.nami.org
National Women's Health Information Center		http://womenshealth.gov/faq/postpartum.htm

Conclusion

Postpartum depression is a significant illness that may have long-lasting effects on the well-being of the mother, her infant, and her family. Although the condition may not self-resolve, as does the “baby blues,” postpartum depression is easily screened and is treatable. Through well-child visits and routine checkups, primary healthcare providers are uniquely positioned to screen women for postpartum depression and either treat them onsite or refer them to a mental health professional. The IAFP and EDOPC recommend that all new mothers be screened for postpartum depression, and the establishment of a culturally-competent office will help the provider to screen and assist women whose cultural milieu may discourage the admission of mental illness. Through screening, referral, and treatment, the primary care provider plays a vital role in improving the quality of life for new mothers who suffer from depression and for their families.

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Learning Objectives

1. Understand the difference between normal “baby blues,” postpartum depression, and postpartum psychosis.
2. Gain knowledge about the impact of postpartum depression on children and families.
3. Identify risk and protective factors for maternal depression.
4. Become familiar with maternal depression screening tools.
5. Learn referral procedures.
6. Implement culturally-appropriate care for patients with postpartum depression.

For a CME Certificate, please log onto www.iafp.com/CME/ and complete the online self-study guideline post-program test and evaluation form for “Identifying Postpartum Maternal Depression during the Well-Child Visit--Resources for Referral and Treatment” or complete the test and evaluation form on the next page, and send to:

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In the space provided, indicate whether each item is True (T) or False (F).

- _____ 1. “Baby blues” is a form of clinical depression that requires immediate treatment.
- _____ 2. Postpartum depression may occur any time during the first year after delivery.
- _____ 3. Postpartum depression occurs in about 50% of all new mothers.
- _____ 4. Infants under six months of age are not affected by maternal depression.
- _____ 5. Anti-depressant medications are contraindicated while breastfeeding.
- _____ 6. Children of a depressed mother can experience a decrease in cognitive stimulation and bonding.
- _____ 7. Healthcare providers who plan to screen and treat postpartum depression onsite should use the EPDS to screen and track treatment response.
- _____ 8. Women who show no symptoms of postpartum depression do not need to be screened.
- _____ 9. The consequences of relapse must be weighed against medication side-effects in a risk/benefit analysis for pregnant/breastfeeding women who wish to discontinue antidepressant use.
- _____ 10. Attitudes toward depression and mental health may be shaped by cultural norms.

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