

Postpartum Depression:

Prompt Detection and Treatment Prevents Life-Threatening Consequences

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Abstract

Postpartum depression (PPD) is a dynamic mental disorder that is found in many new mothers. Although postpartum depression is a common disease with many severe symptoms, its diagnosis is often missed. The purpose of this paper is to inform nurses on how to assess, identify, and treat women who are either at risk for postpartum depression, or currently suffering from the disease. Qualitative and quantitative methodology was used to analyze a case study of a woman who suffered from PPD. The findings regarding the etiology and manifestations as described in the nursing research literature were validated in the case study. Nurses should provide education to pregnant and postpartum women regarding the manifestations and time-line of PPD. A timely diagnosis of PPD is vital to prevent life-threatening outcomes.

Introduction

Pregnancy and childbirth are a time in a woman's life when anticipation and excitement are at their greatest. A woman often relates the birth of her new child with happiness, yet the actual experience is often quite different. Although a woman may go into her pregnancy with elated thoughts, postpartum depression (PPD) "occurs in approximately 10% to 15% of new mothers..."(Lowdermilk, Perry, & Bobak, 2000, p. 952). Misri (2002) calls PPD "the single most frequently occurring complication of pregnancy" (Pugh, 2002, p. 1). Many depressive episodes are preceded by a traumatic event, in this case the event being the birth of a child (Fortinash & Holoday-Worret, 2000).

There are three categories of PPD. The first, "baby blues," is the most commonly found mood disorder in new mothers presenting within days following delivery (Harvard, 2002). The second, non-psychotic PPD usually begins two weeks after delivery and may not occur for up to six months (Lowdermilk et. al, 2000). The last, postpartum psychosis is a collection of symptoms that most often occur within eight weeks of birth and are characterized with delusions and hallucinations most often related to the infant (Lowdermilk et. al, 2000). When a Houston mother, Andrea Yates drowned her five young children on June 20, 2001, post-partum psychosis "became a household word" (DeCraene, 2002). In order to completely understand PPD, a clear understanding of the implications of this illness as well as taking a "multidisciplinary approach" that includes biologic, psychological, and sociocultural theories is needed (Lowdermilk et. al., 2000, p. 953).

Scope of the Problem

Social Factors

Postpartum depression can be quite devastating for the woman and her family. These women feel ashamed because they believe they should be overjoyed and excited about the new member of their family and their new role. When they do not feel these joyous feelings, they believe they are at fault. It is important for these women to know that they are not at fault (Sanford, 2002).

PPD does not only affect the mother, but the baby is affected as well. Because infants are highly aware of the affect and feelings of the mother, they will learn the same behavior (Harvard, 2002). Studies done on 3 month-old babies whose mothers were asked to stimulate a depressed mood and affect for 3 minutes found the babies responded by looking away from their mothers and showing signs of distress. This distress continued long after the mothers began acting normally (Harvard, 2002). Long-term effects on child development have also been assessed. "Children of depressed parents in general are highly vulnerable to depression, and long-term adjustment is sometimes a problem for the children of mothers with postpartum depression" (Harvard, 2002, p. 2). Recognizing and treating this illness is vital for the well being of the child as well as the mother.

Economic Dimension

The economic implications of PPD can only be speculated. The problem with PPD lies not with those women who are diagnosed and treated, but with those women who are not diagnosed and treated in a timely fashion. The plausible results of what may occur to the woman or the child of an untreated patient of PPD is astonishing. For

example untreated PPD can lead to extensive hospitalizations and follow-up therapy as well as a medication regimen that can be quite costly. As mentioned above, Andrea Yates was a victim of untreated postpartum psychosis. The result of her illness was her drowning her five young children (DeCraene, 2002). Untreated PPD can lead to postpartum psychosis, which needs to be “treated as a medical emergency” (Sanford, 2002, p. 2). Hospitalization is mandatory for women suffering from postpartum psychosis in order to control the delusions and mandate the safety of the mother and her child (Sanford, 2002).

Untreated PPD can lead to crisis situations, which can in turn raise the economic implications. The increase in the amount of hospital stays as well as the increase in the amount of medications and therapies occur in PPD that does not get treated until it is out of control. Many studies have proven that the children of mothers who suffered from untreated PPD were seen more in the offices of their primary physicians and require more hospitalizations (Van Arsdale, 2001).

Ethical Implications

Ethical implications can lie in the views of the safety of the baby by the community. Many mothers do not discuss their illness or admit their symptoms because of fear of losing their baby. An outside worker looking in on this sick woman may believe she is not able to take adequate care of her child and place the child in foster care; this fear alone will prompt the woman to disguise her illness.

Purpose

The purpose of this paper is to inform nurses on how to assess, identify, and treat women whom are either at risk for PPD or currently suffering from the disease. The need

for health care providers to take the time to actually inquire, respond, and listen effectively to the feelings, emotions, and lifestyles of mothers-to-be as well as new mothers is vital to preventing an unfortunate situation. Training nurses and physicians to actually hear what is being said and putting two and two together is needed instead of passing a woman's emotional vulnerability off to hormones (Pugh, 2002). Timely diagnosis and treatment of PPD will not only allow for the woman to get her life back on track, but it will assure her that her health care provider does care for her and her infant's well being and present themselves as a person for social support.

Literature Review

Although this disease is quite common, the pain and suffering of this illness often gets overlooked. Misdiagnosing PPD may result in concurrent events not only affecting the mother, but posing harm to the child as well. These adverse events may include many problems such as social isolation, lack of mother/infant bonding, financial difficulties, poor self-esteem, or could even end in infanticide as in the Andrea Yates case (Harvard, 2002). The baby blues are commonly acknowledged and recognized in the postpartum woman as well as socially accepted, but the "true range and depth of emotional difficulties following childbirth is often missed by health care providers" (Pugh, 2002, p.1).

Etiology

Biologic. In the case of baby blues, it is well known that the frequent mood swings are a result from "abrupt hormone withdrawal" (Miller, 2002, p. 2). Studies have shown that the larger the fluctuation in estrogen and progesterone levels between pregnancy and postpartum, "the greater the likelihood of developing postpartum blues"

(Miller, 2002, p. 2). Although the correlation between fluctuating hormonal levels and bouts of baby blues is quite distinct, the etiology of PPD is less reliant on biological factors (Lowdermilk, et. al., 2000).

Although biology may play a huge part in baby blues, genetic susceptibleness plays the leading role in PPD (Miller, 2002). “There is no direct evidence that hormonal imbalance causes postpartum depression” (Miller, 2002, p. 2). Many studies have shown that “stimulating the postpartum state by administering hormones and rapidly withdrawing them is significantly more likely to produce depression in women with a history of postpartum depression than in women with no history of depression” (Miller, 2002, p. 2). This evidence proposes that although a postpartum woman who goes through rapid hormonal changes may experience bouts of fears and tears for up to one week postpartum, it does not guarantee them a diagnosis of postpartum depression.

Psychologic. Poor, or non-existent marital relationships play a key role in predicting PPD (Lowdermilk, et. al., 2000). Many of the women who present with postpartum depression show a lifestyle with added stressors, lack of social support, a personal history or family history of depression, a difficult or complicated pregnancy, traumatic birth experience, or a high or special needs infant (Epperson, 1999; Sanford 2002). Each of these situations adds to the “negative impact score of life events” which in turn makes these women more vulnerable to PPD (Lowdermilk, et. al., 2000, p.953). Conversely those women who feel confident in their marital relationships, confident in their parenting skills, and who are open to the changes an infant brings into their life have reported less depressive symptoms (Lowdermilk, et. al., 2000). A woman trying to

recover from the hormonal fluctuations that comes with childbirth added with certain psychosocial situations makes for a perfect formula for PPD.

Sociocultural. Sociological reports have found that cultures with increased ideals of feminism, over exaggerated roles, and specific labels are quite contributory to the onset of PPD in new mothers (Lowdermilk, et. al., 2000). Women with these ideals may feel too independent to ask for help or feel they are a failure if they cannot raise their children, take care of their families, be good wives, and take care of themselves without any assistance. Miller (2002) found the following:

There appear to be significant differences among different cultures in the prevalence of postpartum depression. Field observations have found that cultures with an apparently low prevalence of postpartum depression are characterized by strong social support for new mothers, such as help with child care, special foods, ritual baths, or return of the mother to her home of origin (p.2).

Also considered high risk for PPD are women from lower socioeconomic backgrounds who are more likely to have added stressors, such as financial difficulties, and single women who do not have the support of a husband.

Manifestations

Distinguishing between the symptoms of PPD and the normal emotional changes a woman experiences along with childbirth is quite difficult. While the baby blues has a rapid onset within days after delivery, the onset for PPD is usually slower and the symptoms increase over time (Sanford, 2002). A woman who recently had a child presents the concern that she “feels bad all the time” and nothing can alleviate her emotions, if she exhibits at least three of the following symptoms, she most likely has

PPD. These symptoms include: depressed mood most of the time; crying or weepiness; difficulty falling asleep or returning to sleep; fatigue, exhaustion, or lack of energy; loss of appetite; nausea; irritability; being upset by little things; negative thoughts or feelings about self and motherhood; lack of self-esteem, especially about being a mom; loss of interest in previously enjoyed activities; lack of pleasure in life; frequent mood changes; physical symptoms such as headaches, backaches, or stomach aches; anxiety or feeling overwhelmed most of the time; thoughts of harming the baby; feelings of hopelessness; strange or irrational beliefs about the baby or self; and feeling confused or out of touch with reality (Sanford, 2002). Coming to terms with her symptoms and confronting her pain can allow the woman to take back control of her postpartum recovery.

Beck (1993) conducted a study by interviewing 12 different postpartum women who were diagnosed with PPD. When these women were asked to describe their feelings and emotions felt during their bouts with PPD, these mothers stated that their feelings of loss of control were the main manifestations in what Beck calls a “four-stage process called Teetering on the Edge” (p. 43). These four stages described by Beck (1993) include: encountering terror, dying of self, struggling to survive, and regaining control.

Detection

Detecting the prenatal or postnatal woman suffering from PPD is the first step in guiding her through her recovery. “Screening instruments must be able to not only differentiate among the various postpartum affective disorders but also estimate the degree or depth of depression” (Ugarriza, 2000, p. 52). Many studies have been done in assessing different screening tools for depression. Ugarriza (2000) analyzed two different measures of study, the Beck Depression Inventory (BDI) and the Atypical Depression

Diagnostic Scale (ADDS). Vieira (2003) assessed the BDI and the Edinburgh Postnatal Depression Scale (EPDS) (See Appendix A to view screening tools).

The BDI uses 21 items with a choice of 4 answers and is answered by the postnatal woman independently (Ugarriza, 2000). The BDI “is used to gauge major depression as defined in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition” (Ugarriza, 2000, p. 44). This instrument of measurement includes different categories of attitudes and symptoms and the questions are ranked according to the severity of symptoms. Most researchers use this tool for depression screening with 10 indicating a diagnosis of PPD (Vieira, 2003).

Another instrument used in screening for PPD alone is the Edinburgh Postnatal Depression Scale (EPDS). This screening tool “is known for its excellent statistical properties and is available in Spanish” (Van Arsdale, 2001, p.6). This scale consists of 10 or 13 questions that are specifically designed for accurate measurements of PPD and only takes 5 minutes to fill out (Van Arsdale, 2001; Ugarrizza, 2000; Vieira, 2003). According to Ugarrizza (2000) the EPDS consists of questions that describe specific symptoms, which are graded, on a 4-point scale, 0 being the least severe. Vieira (2003) states, “mothers who score above a threshold 12/13 are likely to be suffering from a depressive illness of varying severity” (p. 510). Throughout research on PPD, the EPDS is consistently used and recommended in initial detection of PPD.

A third measurement of PPD discussed by Ugarrizza (2000) is the Postpartum Depression Checklist. This instrument is also designed specifically to detect PPD. This checklist consists of 11 items with lists of symptoms. The woman answers these

questions with a simple “yes” or “no” answer. If a woman answers “yes,” it gives a flag for additional questions to be answered (Ugarizza, 2000).

In reference to the comparison studies of the different screening tools, Ugarizza (2000) concluded that the BDI more accurately detected PPD than the ADDS. According to Ugarizza (2000), the downfall of the BDI is that it detected normal symptoms experienced by most all postpartum women, such as fatigue, changes in body image, and sleep disturbances, as symptoms of depression. Vieira (2003) states that the BDI “only identifies 3 of the 11 cluster themes found in PPD, which are contemplating death, loss of interests and guilt” (p. 511). Although these are not positive effects of postpartum, they are not distinguishing symptoms in order to diagnose PPD. Vieira (2003) concludes that the EPDS is simple for the mothers to complete and does not require a health care provider to be specialized in psychology to be able to interpret the results which gives the EPDS benefit over the BDI.

Although these tools give us a definite ability to screen and discuss PPD with the mother, many factors that may affect postpartum adaptation need to be taken into consideration when reading the results, like culture (Vieira, 2003).

Treatment

Family Centered Care. There are different treatment modalities recommended by a variety of different nursing studies. According to Bondas and Eriksson (2001), “there is a need to incorporate the women’s experiences as a basis for perinatal care and to include the women as well as their families as active participants in care . . . even though the woman carries the baby, the whole family experiences the pregnancy” (pg. 836). Because nursing care is directed at a holistic approach, and as stated above, the affects of PPD

affect many different aspect of the woman's life, listening to more than just what words come out of the woman's mouth is very important in treatment and therapy for PPD (Bondas et. al., 2001).

Listening. As Bondas and Eriksson (2001) reported, listening is not only listening, but also caring, and it plays an important role in assessing what is needed for support and treatment. Because caring is perceived differently by many people, a comparative survey was done by targeting different patients of the maternity wing of a hospital and evaluating what they considered as caring (Schultz, Bridgham, Smith, & Higgins, 1998).

Caring. Caring is primarily a nursing concern and many nurses believe professional technical skills and completing nursing responsibilities as caring. Florence Nightingale introduced the concept of caring into nursing and this concept still has not been able to be correctly defined (Schultz et. al., 1998). Many of the women evaluated in this study perceived caring as "giving high priority to meeting the physical needs of the patient – for example, rest and comfort may mean that higher-level needs, such as learning complex care-taking tasks, will be better met by nurses during a home visit" (Schultz et. al., 1998, p. 370). These women believed extra care out of the home would have been beneficial to not only the treatment of PPD, but to the knowledge that some of the feelings they were having were acceptable (Schultz et. al., 1998). According to these women, just because they were taken care of in the hospital, they felt they were still vulnerable patients when they went home, and it is then that they felt the different educational sessions would have been beneficial (Schultz et. al., 1998). In a study done by Miller (2002), one woman expressed:

Presentation of self as a coping and competent mother to those perceived to be experts became an overriding concern. Yet while the work of midwives and health visitors is increasingly targeted at those whose transition is perceived to be problematic, new mothers can feel bewildered and baffled by the changes in their life (pg. 20).

Comments like these explain the frustration, guilt, and conflicting feelings a woman suffering from PPD experiences.

Education and Support. In Ugarriza's (2002) qualitative research interviewing several different women who have suffered from PPD, these women suggested that providing them with more public education and support would aid in not only preventing, but also in treating PPD. Many of these women stated that they felt more education regarding PPD would have helped their diagnosis. The general assumption among PPD sufferers was, "had they known of the existence of and the possibility of their experiencing PPD, they would be able to handle it better" (Ugarriza, 2002, p. 823).

The women interviewed by Ugarriza (2002) reported that they felt that having someone help them with the baby and allowing them to get out of the house for a while would alleviate some of the overwhelming responsibility they felt during the day. When the mention of the various support groups arose as a method of helping these women through their crisis, they stated, "attending a group meeting was considered as too difficult because of the mothers' already overburdened days" (Ugarriza, 2002, p. 234).

Pharmacological. Ugarriza (2002) stated, very few of the women interviewed believed that prescription medications such as antidepressants would have benefited their lives. Of these five women who reported their hesitance regarding prescription

medications, three were prescribed antidepressants for their therapy and said the drugs did not help (Ugarriza, 2002). Many of these mothers expressed their fears regarding medication use as fears of their babies ingesting the medications through breastfeeding regardless of what their physicians told them about the safety. These women stated, "they did not want to fail at breastfeeding because they had already failed at being good mothers" (Ugarriza, 2002, p. 234).

Based on the studies above, support from trusted family members in these women's lives would be of great benefit regarding the treatment of PPD. Because of the fears of "loss of control" and overwhelming feelings of anxiety and despair of these women, a helping hand or even just someone to listen allows an increase in self-esteem and confidence these women lacked (Aranda, Castaneda, Lee & Sobel, 2001). Health care professionals can use this information to sit down and truly listen to the stressors postpartum women face. "A planned postnatal intervention aimed to help women rest and recover after childbirth" (Morrell, Spiby, Stewart, Walters & Morgan, 2000, p. 594) is an intervention that should be considered daily practice in the role of an obstetrics nurse. This action will allow them to evaluate to what extent a suffering woman's treatment might entail. For some women medications may be the answer, for others an extra hand or listening ear can be the key to alleviating their turmoil.

Implications for Further Research

Lack of education seems to be the main issue among the women suffering from PPD. Not only do mothers need to be made aware of the various symptoms and disorders surrounding PPD, but health care workers do as well. People in general do not feel comfortable discussing a topic with others about which they are not fully educated. It is

not a surprise that women feel they need to hide their feelings in guilt and shame when they do not know what their disorder entails. It is only through thorough education and evaluation that a postpartum woman could feel comfortable enough to honestly and openly discuss these unwelcome emotions she perceives as so abnormal. It is also only after appropriate education for health care providers that the appropriate interventions can be carried out.

As in the Andrea Yates case, PPD is a serious disorder. The only way health care providers will be able to tackle this disease is to take a step forward and inform the community as well as themselves that while this disease happens to “good people,” it can be treated. Left untreated, PPD can result in tragedy like we saw with Andrea Yates.

Women with PPD are often “silent sufferers” and they deserve and need to be properly diagnosed and treated. The nursing process is just as vital in this situation as it is with any other health care conditions. Each nurse dealing with prenatal and postnatal women should be able to assess, diagnose, plan, intervene, and evaluate problems that point to the possibility of PPD. Although PPD is serious, it can be treated and even possibly prevented.

Methodology

The research methods utilized for this study are both a qualitative study of a case regarding PPD as well as quantitative PPD inventory/screening tools. The purpose of a qualitative study is to “develop understanding and meaning from participants” (Fain, 1999, p.151). A qualitative study focuses on the participant rather than cases and subjects; therefore, most of the data used during this study is subjective. Qualitative

method of research allows the researcher to discuss the description of the phenomena represented by the participant and explore the information related to the literature.

Quantitative research is “directed at the discovery of relationships and cause and effect” (Fain, 1999, p.146). Because quantitative design utilizes measurement and testing predominately, PPD inventory/screening tools were used to measure whether and to what degree the subject suffered from PPD. These tools were used to develop a relationship between the variables (symptoms) and the extent to which the woman taking the questionnaire has PPD. These tools used during this study were the Beck Depression Inventory (BDI), the Edinburgh Postnatal Depression Scale, and the Postpartum Depression Checklist (See Appendix A). Although each of these tools varies in their amount of reliability and validity, they each measure a certain aspect of PPD better than the other. This is discussed further in the “detection” part of this paper.

The researcher obtained informed consent by the participant before beginning any interviews. Before obtaining informed consent, the researcher provided the participant with sufficient knowledge and information regarding her participation in the following project. The participant was informed of her rights and responsibilities of the project as well as correct documentation of the nature of the agreement. Discussion between the researcher and the participant stated that the participant’s initials would be changed as well as any distinguishing information about the participant (See Appendix B).

The method of measurement used for this research project was personal face-to-face taped interviews. These interviews consisted of the researcher asking questions regarding the participant’s experiences before, during, and after pregnancy. The

information obtained revealed the participant's lifestyle and family dynamics as well as the participant's feelings, thoughts, and emotions during her bout with PPD.

Findings

Etiology

Biologic. Amy is a 45-year-old Gravida 3 Para 1. Amy has had one successful pregnancy out of three. Her first two pregnancies ended in spontaneous abortions due to a "uterine condition." Amy was also treated throughout her pregnancy with Heparin injections because of a problem with her blood coagulation. Amy was sent to Great Falls, MT, a tertiary health care center, to undergo observation weekly because of her high-risk pregnancy status. Amy's high-risk status stemmed from her having a bi-cornate uterus, being over childbearing age, and having placenta accreta (invasion of the uterine muscle by small "finger-like" protrusions of the placenta). The results of the final prenatal observation showed intrauterine growth retardation as well as a placental abruption; therefore, an immediate Cesarean Section took place. During the C-section the physician made a T-incision into the skin in order to get the neonate quickly. Amy delivered a small for gestational age baby girl weighing one pound, twelve ounces at 29 weeks gestation. A total hysterectomy was done at this time.

Psychologic. Amy stated that she has had no history of depression herself, or in her immediate family. As stated above, Amy has experienced two past miscarriages, which contributed to some degree to her anxiety for the first few months of pregnancy. Because of an emergency C-Section Amy delivered a premature infant who required care in the neonatal intensive care nursery (NICU). Everything that Amy underwent (i.e., emergency c-section, hysterectomy, husband not able to attend) contributed greatly to a

traumatic birth experience. Because it was February by time Amy was able to return home, Amy felt she dealt with some seasonal depressive symptoms relating to the dark, dreary, cold weather and her inability to go outside. In addition to the weather Amy was upset by the imminent invasion of Iraq. Although Amy experienced some isolation, she stated that while her infant was still on oxygen and apnea monitors she felt she was not experiencing the depression as much as she did once her baby was off all of the monitors and her health was secure. Although Amy had quite a few of psychologic factors putting her at risk for PPD, she did express that she felt very secure in her marital relationship and had a large support system of family and friends.

Sociocultural. Amy is a freelance artist and her husband is an engineer. Amy expressed that she felt financially secure even though they had a lot of medical expenses. Amy stated that she considered herself liberated and quite independent. She talked about how she always had high expectations of herself. Amy had to leave home and live in Great Falls away from her husband while her infant was in the NICU. Once Amy returned home with her infant she felt isolated because their home was far out of town and a trip to town seemed to be a huge ordeal considering all the equipment necessary to help her infant breathe such as the apnea monitor, oxygen tubing, and oxygen tank.

Manifestations

Throughout the interview Amy expressed all of the different feelings she was experiencing during her bout with PPD. She brought her baby home on February 15, but it was not until the latter part of March when it was clear that her infant was doing well, but that something within her was seriously wrong. Amy described the depression as having a gradual onset; magnified by other external factors.

After the pressure lifted it started boiling up and came on very slowly and part of it felt like exhaustion, recovering from surgery, dark, winter, can't go outside, roads down the hill are bad, far from anybody, nobody to hang out with during the day, and the war.

Amy stated she always had enjoyed reading and writing and she felt she suffered from anhedonia (loss of enjoyment in things one previously found joy in) because she no longer enjoyed doing those things. Even if Amy tried to sit down and read a book or write she felt she could not concentrate. She discussed that she had a hard time staying focused on anything. She felt that the simple things, like preparing a meal for dinner, seemed too overwhelming for her to do. With regard to communicating with her friends and family, Amy stated that unless they were talking about the baby, she could not stay focused and maintain with a normal conversation. Amy expressed that she just wanted to stay in bed.

Although a common perception of depression is sadness, and Amy did experience some of this, she related her feelings more to an anxiety. She described these feelings by stating she felt like there was a "tightening band around my chest." While talking about how Amy felt about herself and if she felt that the baby was taking away who she was, she explained that she felt a small amount of "loss of self," but more questions of "what now?" Amy said that anxiety brewed by just thinking about what her future was going to bring now and what to do next. She said she worried about whether everything was going to be okay, if she would have enough energy to raise a child at her age, and what would happen if her baby had developmental problems because of her prematurity. Amy's fear of her baby not doing well grew to enormous proportions even though she

was doing just fine. Amy stated, "All of these thoughts permeated everything, I felt like I could not go on." Amy described herself as having a "concrete fear of everything."

Throughout the discussion regarding her thoughts about harming her baby or herself, Amy expressed that she did not have thoughts about harming her baby, but she did state, "If I could just put her out on the porch for the afternoon and sleep." Amy did have enough control of her mind that during those times she did call her friends and they would come up and take the baby and let Amy sleep. Amy did express feelings such as, "I can't go on like this" and "What's the point of living if you're just going to grow old and die?," But she said, "None of these thoughts were concrete enough to ever come down to a plan because she [the infant] needed me too much."

Amy manifested physical symptoms of "quivering and trembling with fear." She described her physical reaction as "feeling like my body had gone into some kind of shock." She expressed that she felt like her body had created some sort of chemical imbalance, stating she felt her anxiety was creating large amounts of adrenaline and she could not control it. By the end of April Amy said she was in a "full-blown depression." Amy described herself as a "huddling mass in the corner." Amy stated that throughout the two months she suffered from this illness before she went to the physician, she said, "It was the worst feeling ever felt; it was so pervasive."

By the end of April the weather was getting better, and Amy started taking her baby out for eight hours at a time, but she explained she felt she was "in a state of panic catatonia." It was at this point that Amy called the O.B. office and talked with the nurse there. She said that the reason she called the office was because she did not want her infant to absorb any bad vibes from her and although she did not know what was

happening to her and why she was feeling like this, she did know that at this time she should be enjoying her child and she could not.

The nurse at the office discussed Amy's symptoms with the physician and he prescribed Prozac for her right away. After two weeks on Prozac Amy did not experience any relief of her symptoms so she called the O.B. office again and was then prescribed Paxil. After a couple of weeks on Paxil, Amy stated she started feeling like her normal self. She stated, "I was so happy to feel good, that whenever I had a good day I was ecstatic." After one month Amy felt back to normal and felt she was experiencing appropriate emotions for the situation. Amy is currently on Paxil after six months and the physician said she should look to start getting off of it. Amy expressed she is nervous that once she stops taking the Paxil the horrible feelings she once experienced will return.

Screening Tools

Amy filled out the Edinburgh Postnatal Depression Scale, the Beck Depression Inventory, and the Postpartum Depression Checklist. While filling out these tools she attempted to answer the questions in the same state-of-mind, as she was when she was suffering from PPD. According to the results of the screening tools, Amy was experiencing non-psychotic PPD.

The Beck Depression Inventory filled out by Amy resulted in a score of 23 out of 63. Amy's score on the BDI indicated that she was suffering from moderate to severe depression. This screening tool required Amy to circle the number that was next to a statement that best related how she felt. Some of the statement's Amy circled were, "I am so sad or unhappy that I can't stand it," "I feel that the future is hopeless and that things cannot improve," "I have lost more than 15 pounds," "I get tired from doing

almost anything,” and “I don’t enjoy things the way I used to.” Although the BDI does measure the extent of depression, it is not a tool designed to specifically measure PPD (Viera, 2003).

Amy filled out the Edinburgh Postnatal Depression Scale, which is a scale designed to measure PPD and is widely used and highly accurate in detecting the illness. Amy rated ten statements on the EPDS by circling the letter that corresponds with the degree to which she was feeling the statement. The degree’s ranged from, “Yes, most of the time,” to “No, never.” Some of the statements used in this tool were, “I have been able to laugh and see the funny side of things,” Amy answered, “Definitely not so much now.” Another statement used by the EPDS was, “I have felt scared or panicky for no very good reason,” Amy circled, “Yes, quite a lot.” The EPDS Amy filled out concluded; Amy was suffering from PPD as evidenced by the answers she circled and the corresponding manifestations of PPD.

The final screening tool Amy filled out was the Postpartum Depression Checklist. This checklist consists of eleven manifestations of PPD, for example, “Lack of concentration,” “Lack of positive emotions,” “Contemplating death,” and “Anxiety attacks.” Amy checked “yes” or “no” to each of the manifestations she experienced. The results of the checklist showed that Amy checked “yes” to all of the manifestations except “Guilt,” where she checked the “no” box. This screening tool also allows a few blank lines for comments. Amy’s comments were as follows, “Contemplating death is not the same as contemplating suicide or harm to the baby. I feared the death of the baby or my husband, and became rather obsessed with those thoughts.” This screening tool as well as the other’s reiterated Amy’s emotions, feelings, and experiences during her bout

with PPD. All three screening tools were accurate in detecting the non-psychotic PPD Amy suffered from.

Discussion

Throughout the research regarding PPD as well as the case study done for this paper, the lack of proper awareness to prenatal and antepartum women by nurses seemed to be the biggest flaw in proper health care regarding PPD. Because of the various stages and severity of PPD, many women, including the woman represented by the case study, thought that PPD only occurred up to one week after delivery. This confusion with baby blues is quite common among women and some nurses. Because this woman did not experience the majority of her symptoms until April, three months after delivery, she did not even consider that her problems related to PPD.

Sampson (2004), an OB nurse who suffered from PPD, explained that she believed her negative feelings were related to all the visitors and commotion in her house. It was not until her husband asked her friends and family to stay away for a while and she got back into her normal routine did she realize there was something seriously wrong because the negative feelings were still haunting her. She explained that not once did she relate her feelings to PPD and she was a nurse who taught the PPD awareness education to many postpartum patients during her 10 years in OB. Situations like this prove that no matter how educated or experienced you are as either a nurse or a mother, PPD is unfortunately undetected.

If nurses continually provided information to women on the signs, symptoms, and time-line of PPD during prenatal visits as well as during their postpartum stay and by phone calls once the new mother and her infant were at home, more women may be able

to be aware that their intense feelings of sadness, anxiety, fear, and loneliness might be symptomatic of PPD, and will then in turn call their health care provider for treatment. Without the proper awareness of the risk factors and manifestations of this disease as well as the fact that they can experience PPD as long as six months after delivery, it is common for these women to pass their feelings off as something irrelevant, or hide their thoughts because they do not understand they are suffering from an illness.

Because PPD is so often disguised in the assessment phase of the nursing process, it is vital for nurses to pay special attention to detecting the signs and symptoms of PPD. Detection of this disease is a very important step in preventing life-threatening outcomes for the suffering woman. Screening tools like the ones presented in this paper can be very helpful to the nurse in understanding the exact feelings the woman is experiencing and matching these feelings with the manifestations of PPD. Nurses need to be current on research regarding screening tools. A new Postpartum Depression Prediction Inventory (PDPI) is being researched for its validity (Hanna, Jarman, Savage, & Layton, 2004). This tool will be useful in detecting the risk factors of PPD in order to allow health care providers to adapt their care plan accordingly. These types of screening tools should be used not only in the woman's initial postpartum visit, but six months after the birth of the baby. Although screening tools can be quite helpful in detecting PPD and the risk factors, they are not to be used to determine the exact level and type of treatment for the woman's depression (Hanna, et.al., 2004).

It is just as important to inform the significant other of the signs and symptoms of PPD, as it is the woman. Many times it is the partner that begins to see the woman's suffering before the woman notices it. Educating the partner of the timeline of PPD and

the manifestations is very important in detection and treatment in PPD. Many women feel ashamed of not being able to handle being a new parent so therefore, they will attempt to hide feelings from doctors and nurses, but it would be very hard for the woman to try to hide her suffering and devastation from her significant other.

Although many nurses are very intent on finding all of the biological manifestations in a disease and assessing these findings to perfection, detection and treating PPD is just as important. Taking time to listen intently to what the woman is saying and how she is expressing her concerns as well as watching her relate to her baby can unveil many important warning flags that may indicate PPD. Many nurses have found that assessing a mother's anxiety level five months after the baby was born can be a better predictor of PPD than assessing the woman's mood before pregnancy and the first few days after (Rivieres-Pigeon, Saurel-Cuvizolles, & Lelong, 2004). Nurses must continually ask the mother questions regarding her occupational and private life throughout the postpartum period in order to be able to unveil a possible woman suffering from PPD.

Because many women do not know they are experiencing PPD when they are suffering from these unwanted emotions and thoughts, they will not be able to know when to call the doctor. The media can play a large part in educating women regarding the manifestations of PPD. Many women subscribe to a variety of parenting and women's magazines. This type of media can be very beneficial in getting the message regarding PPD out. These magazines list symptoms for mother's to look for when their child is ill, why can't they inform mothers what to look for in PPD? By the media writing articles for the average woman to read in popular magazines, it will help

eliminate the stigma in PPD so many women are afraid of. If women actually read about other "real" women experiencing this "silent disease" they will be more apt to pinpoint their illness and get help rather than trying to hide this common condition that has such an awful stigma.

The prenatal, postpartum, and clinical nurse plays the key role in assessing the patient for the risk factors of PPD as well as assessing the woman for the manifestations present in PPD. The earlier these nurses can detect PPD and collaborate with the physician regarding the treatment of this woman, the less time the woman and her family have to suffer and the less likely it is that for any life-threatening consequences will occur.

Appendix A

Screening Tools



Postpartum Depression Checklist

Yes

No

- Lack of Concentration
- Loss of Interests
- Loneliness
- Insecurity
- Obsessive Thinking
- Lack of positive emotions
- Loss of Self
- Anxiety Attacks
- Loss of Control
- Guilt
- Contemplating Death

Comments: _____

(Ugarriza, 2000)

Edinburgh Postnatal Depression Scale

In The Past Seven Days:

1. I have been able to laugh and see the funny side of things:
 - a. As much as I always could
 - b. Not quite so much now
 - c. Definitely not so much now
 - d. Not at all

2. I have looked forward with enjoyment to things:
 - a. As much as I ever did
 - b. Rather less than I used to
 - c. Definitely less than I used to
 - d. Hardly at all

3. I have blamed myself unnecessarily when things went wrong:
 - a. Yes, most of the time
 - b. Yes, some of the time
 - c. Not very often
 - d. No, never

4. I have felt worried and anxious for no very good reason:
 - a. No, not at all
 - b. Hardly ever
 - c. Yes, sometimes
 - d. Yes, very often

5. I have felt scared or panicky for no very good reason:
 - a. Yes, quite a lot
 - b. Yes, sometimes
 - c. No, not much
 - d. No, not at all

6. Things have been getting on top of me:
 - a. Yes, most of the time I haven't been able to cope at all
 - b. Yes, sometimes I haven't been coping as well as usual
 - c. No, most of the time I have coped quite well
 - d. No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping:
 - a. Yes, most of the time
 - b. Yes, sometimes
 - c. Not very often
 - d. No, not at all

8. I have felt sad or miserable:
 - a. Yes, most of the time
 - b. Yes, quite often
 - c. Not very often
 - d. Not at all

9. I have been so unhappy that I have been crying:
 - e. Yes, most of the time
 - f. Yes, quite often
 - g. Only occasionally
 - h. No, never

10. The thought of harming myself has occurred to me:
- i. Yes, quite often
 - j. Sometimes
 - k. Hardly ever
 - l. Never
- (Ugarriza, 2000)

Beck Depression Inventory

1. 0 I do not feel sad
 1 I feel sad
 2 I feel sad all of the time and I can't snap out of it
 3 I am so sad or unhappy that I can't stand it

2. 0 I am not particularly discouraged about the future
 1 I feel discouraged about the future
 2 I feel I have nothing to look forward to
 3 I feel that the future is hopeless and that things cannot improve

3. 0 I do not feel like a failure
 1 I feel that I have failed more than the average person
 2 As I look back on my life, all I can see is a lot of failures
 3 I feel I am a complete failure as a person

4. 0 I get as much satisfaction out of things as I used to
 1 I don't enjoy things the way I used to
 2 I don't get real satisfaction out of anything anymore
 3 I am dissatisfied or bored with everything

5. 0 I don't feel particularly guilty
 1 I don't feel guilty a good part of the time
 2 I feel quite guilty most of the time
 3 I feel quite guilty all of the time

6. 0 I don't feel like I am being punished
 1 I feel I may be punished
 2 I expect to be punished
 3 I feel I am being punished

7. 0 I don't feel disappointed in myself
 1 I am disappointed in myself
 2 I am disgusted with myself
 3 I hate myself

8. 0 I don't feel that I am worse than anybody else
 1 I am critical of myself for my weaknesses or mistakes
 2 I blame myself all the time for my faults
 3 I blame myself for everything bad that happens

9. 0 I don't have any thoughts of killing myself
 1 I have thoughts of killing myself, but I would not carry them out
 2 I would like to kill myself
 3 I would kill myself if I had the chance

10. 0 I don't cry more than usual
 1 I cry more than I used to
 2 I cry all of the time now
 3 I used to be able to cry, but now I can't cry though I want to

11. 0 I am no more irritated now than I ever am
 1 I get annoyed or irritated more easily than I used to
 2 I feel irritated all of the time now
 3 I don't get irritated at all by the things that used to irritate me

12. 0 I have not lost interest in other people
 1 I am less interested in other people than I used to be
 2 I have lost most of my interest in other people
 3 I have lost all of my interest in other people
13. 0 I make decisions about as well as I ever could
 1 I put off making decisions more than I used to
 2 I have greater difficulty in making decisions than before
 3 I can't make decisions at all anymore
14. 0 I don't feel I look any worse than I used to
 1 I am worried that I am looking old or unattractive
 2 I feel that there are permanent changes in my appearance that make me look unattractive
 3 I believe I look ugly
15. 0 I can work about as well as before
 1 It takes an extra effort to get started at doing something
 2 I have to push myself very hard to do anything
 3 I can't do any work at all
16. 0 I can sleep as well as usual
 1 I don't sleep as well as I used to
 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep
 3 I wake up several hours earlier than I used to and can't get back to sleep
17. 0 I don't get more tired than usual
 1 I get tired more easily than I used to
 2 I get tired from doing almost anything
 3 I am too tired to do anything
18. 0 My appetite is no worse than usual
 1 My appetite is not as good as it used to be
 2 My appetite is much worse now
 3 I have no appetite at all anymore
19. 0 I haven't lost much weight, if any, lately
 1 I have lost more than 5 pounds
 2 I have lost more than 10 pounds
 3 I have lost more than 15 pounds
 *I am purposely trying to lose weight by eating less Yes_No_
20. 0 I am no more worried about my health than usual
 1 I am worried about physical problems such as aches and pains or upset stomach
 2 I am very worried about physical problems and it's hard to think of much less
 3 I am so worried about my physical problems that I can't think about anything else
21. 0 I have not noticed any recent change in my interest in sex
 1 I am less interested in sex than I used to be
 2 I am much less interested in sex now
 3 I have lost interest in sex completely

- 10 to 15 points - Mild Depression
- 20 to 29 points - Moderate to Severe

- 16 to 19 points - Mild to Moderate
- 30 to 63 points - Severe Depression

(Ugarriza, 2000)

Appendix B
Informed Consent



Informed Consent for Research Procedure

Study Title: Postpartum Depression: Prompt Detection and Treatment Prevents Life-Threatening Consequences.

Researcher: Cassidy J. Johnson, Student Nurse, Carroll College, Helena, MT

Cassidy J. Johnson is a senior nursing student studying the effects and consequences of Postpartum Depression (**research purpose**). Although the study will not benefit you directly, it will hopefully provide information of the subject to aid in nursing knowledge in regards to preventing, detecting, and treating Postpartum Depression (**potential benefits**).

This study will not involve any foreseeable risks to you or your family (**potential risks**). The procedures include: (a) Participating in a taped interview with Ms. Johnson that will center around your views of your experience with the above stated illness. Participation in this study will take approximately 1 hour of your time (**time commitment**). You are free to ask any questions to Ms. Johnson as well as being able to refuse to answer any questions (**offer to answer questions**).

Your participation in this study is strictly voluntary. You have the right to withdraw at any time (**option to withdraw**).

Your anonymity will be ensured; your identification will remain unknown to the reader by only utilizing information that may distinguish who you are under your permission. All data from this study will be kept by Ms. Johnson and will not be shared with anyone without your permission (**assurance of anonymity and confidentiality**).

I have read this consent form and voluntarily consent to participate in this study.

Participants Signature: _____ Date: _____

Researcher's Signature: _____ Date: _____

Copy to be provided to participant

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