

Report Addendum

ALABAMA WOMEN'S COMMISSION:

A Further Exploration of Postpartum Depression in Alabama with Key Informants:
Information, Education and Prevention

September 14, 2009

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Acknowledgements

The researchers would like to thank the obstetricians, pediatricians, and nurses who took time out of their busy schedules to share with us their knowledge and experience with postpartum depression. We would especially like to thank the mothers who sacrificed some time away from their infants to share their knowledge and experience with us as well. Without each of these participants, this study would not have been possible. We are extremely grateful.

Introduction

As identified in the original report, *The Status of Women with Children Age One and Below in Alabama* (Zugazaga, et.al, 2008), Postpartum Depression (PPD), infant mortality, and access to quality child care emerged as the most significant issues for women with children age one and below. While each of these issues demand further study, it was decided by the Alabama Women's Commission and the researchers that the successive study should focus on obtaining more information regarding PPD from medical personnel (Obstetricians and Pediatricians) as well as mothers themselves in an effort to increase understanding of PPD in Alabama. One of the challenges experienced by the researchers during the initial inquiry was the difficulty of identifying the frequency with which women in Alabama are diagnosed and treated with PPD. The second study (presented here) was designed to provide a more comprehensive picture of women with PPD in Alabama and the intersection of issues they face, as well as reflect the experiences of the medical professionals who serve them. This study will also provide direction for further development or enhancement of existing prevention and intervention programs, sighting those areas which would benefit from concentrated enrichment.

The frequency with which women experience PPD is of great concern to the researchers. The data reported in the initial study (Zugazaga, et.al, 2008) suggests that the issue is a substantial one. The current study was designed to allow women who are most susceptible to experiencing PPD and those charged with caring for them to tell their own stories and elucidate their knowledge of and experiences with PPD. This inquiry will also help to understand the impact this condition may have on motherhood and maternal behaviors.

This broadening of the initial study was executed in an effort to further explicate some of the surprising trends uncovered with regard to Alabama's women with children age one (1) and below. By employing qualitative methods here in the second phase of the research, the authors were able to illuminate aspects of these women's lives and postpartum experiences that are believed to be of interest to Alabama's citizens and leadership. As directed by findings of the first study and review of the literature, the focus of this subsequent study includes the identification of: 1) physical changes that may be indicative of Postpartum Depression; 2) emotional changes that may be indicative of Postpartum Depression; 3) formal or informal screening or assessment methods used by medical personnel to identify PPD, and 4) best methods of disseminating information on PPD to mothers and/or their family and friends.

Methodology

Recruitment

Using convenience and snowball sampling techniques, Alabama medical professionals (including Obstetricians, a Nurse Practitioner, Registered Nurses, Licensed Practical Nurses and Pediatricians), and Alabama mothers with children age one and below were recruited to participate in the study. The primary selection criterion for the medical professionals was that they served women with children under the age of one at any point during their pre-natal or post-natal period through the year following birth. The primary selection criterion for the mothers with children under the age of one was that they had given birth within the previous 12 months. Focus groups for medical professionals were scheduled at a mutually agreed upon time during the morning or afternoon. Participants were served lunch or breakfast and provided a \$25 gift card as a token of our appreciation of the time they gave to participate in the study.

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The focus group for mothers was scheduled during the hours of a weekly clinic at an Alabama prenatal clinic. Nursing administration at the clinic contacted an estimated 15 mothers who were scheduled for a 6-week postpartum checkup (all on the same date) and invited them to participate in the focus group on the day of their appointment. Those who volunteered to participate were provided a light lunch, and \$25 cash as a token of our appreciation of the time they gave to participate in the study.

Participants

A series of 4 focus groups were conducted from April until mid- August 2009. In the first focus group, 5 Obstetricians participated (one white female and four white males). The second focus group included 1 nurse practitioner and 4 other nurses (all white females); the third group consisted of 4 mothers with children age one and below (three African-Americans, one of African/Taino-Panamanian ancestry). In the final focus group, there were 4 Pediatricians (two white males, two white females). In the mothers' focus group, their ages ranged from approximately 19 to 35 years. Upon the request of one participant (and agreed to by all participants) her mother was included for a brief time in the beginning of the session – thus the number of actual participants in this group was five.

Focus Group Interviewing

All of the focus group interviews were led by two co-investigators, with one investigator leading the discussion, while the other recorded responses on newsprint in full sight of the participants, to allow for clarification and correction. The medical professional's groups' interviewing took place in medical practice private conference rooms and the clinic conference room. The mother's group was held in an examination room which had been nicely transformed to a work room with a group of chairs

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arranged in a circle and a covered bed for use as a table to display refreshments for the investigators' use. After the study was introduced and described, anonymity, confidentiality, risks of emotional distress, and the audio taping process was discussed. Each participant was asked to sign the informed consent statement and a form allowing the investigators to audio tape the interview. Each interview lasted from 60-90 minutes. Led by the literature, an interview guide was used to direct the discussion. In the mother's group, each participant was asked to introduce herself by first name, and to give the age of their child(ren). This interview lasted 90 minutes. All of the interviews were audio taped and transcribed.

Instrumentation

As indicated previously, an interview guide was developed for each group. The study had several orienting questions. Responses were sought from both staff members and mothers. These questions included the following:

(Obstetricians/Nurses) Describe some of the physical changes you often see in your patients that may be indicative of postpartum depression? What is your estimate of the percentage of your patients who likely experience postpartum depression each year? How has this number increased/decreased over the past 10 or 20 years in your experience? Please describe any emotional changes you often see in your patients that may be indicative of postpartum depression? Please describe how you assess your patients for postpartum depression (i.e. use of formal instruments or informal questioning, observations etc.). Please describe what treatments you prescribe for your patients or resources in the community you may refer your patients to follow-up with regard to mental health concerns in the postpartum period? To your knowledge what written information about postpartum depression signs and symptoms are given to mothers either upon discharge from the hospital after birth or at their six-week postpartum visit to your office. What do you believe would be the best means in which

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to provide education to new moms, other obstetricians, pediatricians? In what method? What is your perception of the role of pediatricians in the provision of mental health treatment or referral for mothers related to PPD?

(Pediatricians) Please describe symptoms you would consider to be indicative of PPD in mothers of your patients who are 1 year of age or younger. What is your estimate of the percentage of your patient's mothers who exhibit symptoms of PPD? Has this number changed over the last 10-20 years? Please describe how you formally assess your patient's mothers for PPD? Informally address? Please describe how you respond (clinically) when you suspect PPD in a patients' mother. Are there specific resources or referrals you make for these individuals? Which of these do you perceive as most helpful? To your knowledge, what written information about postpartum depression signs and symptoms are given to mothers upon discharge from the hospital? At your patient's 1 month visit to your office? Please describe what procedures or instruments you use to assess your patient's mothers for PPD. What do you believe would be the best means in which to provide education to new moms? And in what method? What do you believe is the role of the pediatrician in the provision of mental health treatment?

(Mothers) Please describe any physical changes you experienced right after giving birth. Please describe any lifestyle changes you experienced right after giving birth. Please describe any emotional changes you experienced right after giving birth. What do you know about postpartum depression? Do you think that new mothers should be given written information about postpartum depression before they leave the hospital? Would that be helpful? Why or Why not? What advice would you give to obstetricians when moms come in for their six-week postnatal appointment with regard to screening for or identifying symptoms of PPD?

Coding and Analysis

Documented transcripts of the interviews were carefully reviewed. The resulting data was then analyzed using Glaser and Strauss' (1967) constant comparative method. Coding yielded 13 core categories. There were four categories related to physical issues, six categories related to emotional issues, six categories related to relational issues, and three categories of changes or challenges related to postpartum depression which could serve as cues which suggest PPD for medical professionals. There were two categories for currently used interventions and resources, - either there were no interventions identified or there were interventions which were informally or inconsistently utilized. The interviews yielded six recommended interventions or preventive measures for PPD.

Findings

Presenting Symptoms Related to PPD

Rates. The obstetricians estimated that 80% of their patients experienced a mild form of "Baby Blues" with no change in their childcare functioning, and that approximately 10-15 percent experienced the more severe PPD. They suggested that this is likely a reflection of increased rates of depression in the broader population. The nurse practitioner and nurses estimated that between 5-10 percent or more of their mothers experienced PPD symptoms at their 6 week postpartum follow-up. The pediatricians estimated that between 10 and 15 percent of their patients' (infant's) mothers exhibited symptoms of PPD. Though, contrary to their obstetric and nursing colleagues, these pediatricians believed that there has likely been no increase in the rates of PPD, but that improved detection, better screening, and increased awareness of the depressive disorder may account for the perceived increase in frequency of diagnoses.

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Emotional symptoms. Several medical practitioners identified emotional factors suggestive of emotional presentations that may indicate a mother was experiencing symptoms of PPD. They include being **teary** or a mother sobbing throughout an examination or in response to many questions. They also suggested that a mother who became **angry** when being questioned about symptoms of PPD might be reflective of a mother experiencing PPD. The professionals listed mothers who were overly quiet or **withdrawn** as being mothers who would be observed for other symptoms of PPD. Additionally, the pediatricians listed mothers who presented with flat affects or who avoided eye contact as equally significant indicators.

The participants in the mothers' group were asked to describe any emotional changes they experienced after birth. They listed increased feelings of anger, being short-tempered and having widely **varying moods** within short periods of time. Some of the mothers discussed "getting tired just thinking about what has to be done" and feeling like there was too much to do but they just "had to press on." One mother discussed having to manage feelings of **guilt** related to her baby's low birth weight and related illnesses. Along this line, another mother who had expressed having a low-birth weight baby later qualified this admission by asserting that she in no way had done anything to jeopardize her baby's health. Mothers who had more than one child thought that one more baby wouldn't be too much more demanding, but that the additional child was more **overwhelming** than it often appears. The majority of the mothers pointed out that it is difficult synchronizing sleep between their babies and themselves. The younger mothers discussed having difficulty with managing generational and cultural differences in childrearing practices, particularly when residing in multi-generational households. One mother specifically mentioned the "Back-to-sleep" campaign as one area of contention between her and her mother which results in some stress for her.

Physical symptoms. The obstetric participants identified several of their patient's physical presentations that would likely be perceived as reflective of possible PPD. They include

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the presentation of extreme **fatigue**, extreme and irregular postpartum **weight gain or loss**. In addition, they mentioned a mother's dress and **appearance**, especially if it is uncharacteristically unkempt or disheveled, as noteworthy. The nurses and the pediatricians concurred that the baby's apparent cleanliness (or lack thereof) is highly indicative of the mother's emotional stability.

Mothers expressed feeling exhausted, and having body aches and back **pain** immediately after birth and upon discharge. One mother reported that she hemorrhaged during birth and required a blood transfusion. Another mother reported having difficulty with her feet in the form of painful heels after discharge.

Relationship factors. The symptoms that were most highlighted by the medical professionals were associated with the mothers' **connections** to and relationships with others in their support systems and their babies. They identified that a mother's inability to maintain eye contact with the practitioner would heighten the practitioner's concern regarding the mother's susceptibility to PPD. The pediatricians noted that teen mothers who seemed to be **disengaged** toward their own mothers might be a marker of challenges related to PPD. Pediatricians also stated that when teenage mothers are involved, very often it will be the grandmother that brings the child in for well-baby checks; so they will not see mom at all to be able to observe any problems with teen moms. Additionally, a mother who discussed a spouse or partner as being uncaring or expresses feelings of receiving little attention from partners or others after birth may also be signs that would concern a medical practitioner. The obstetricians cited contemporary lifestyles, which are marked by extended family members dwelling further apart as influencing (negatively) how mothers are able to manage newborn babies. The nurses and the pediatricians particularly mentioned the physical **placement** of the baby in the exam room – that is, if a mother placed a car seat or infant carrier with some physical distance between her and the baby in the exam room, the respondents identified this as a sign of possible symptoms of PPD. The obstetricians acknowledged

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a similar behavior, but spoke specifically of mothers who were inattentive to their babies in the exam room as heightening their concern, regardless of the physical proximity to the baby.

Other Exacerbating Issues

Role diffusion and lifestyle change. Mothers were asked to share any significant lifestyle changes postpartum. The interviewees repeatedly mentioned being challenged with securing order and being organized. This was especially the case for one mother who was a student, and another mother who employed full-time. They expressed difficulty with fulfilling the multiple roles they held – mother, daughter, partner/spouse, student, and employee. They shared that the more difficulty they had with fulfilling these roles, the more difficult it became to manage them, particularly because the maternal responsibilities were so demanding.

Social support. All participants in the mothers' group identified needing support from their mothers. The majority of the respondents identified their mothers as their primary source of support – and in some cases their only source of support. This phenomenon speaks to the lack of broader emotional, tangible and other forms of support mothers tend to have during their early postpartum period. One participant was even accompanied by her mother (briefly) to the focus group. Though each of the participants mentioned the fathers of their children cursorily – their mothers appeared to play a central role in their lives and in the support they receive. This could be problematic and lend to experiences of PPD or at the very least experiences of emotional challenge – particularly if a new mother's support system is limited to 1 person.

Cultural factors. The nurses, in particular, mentioned culture as a factor which could confound a practitioner's attempt to diagnose PPD. For example, they discussed the idea that a baby and mother's cleanliness is a factor that is considered when attempting

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to determine the possibility of a PPD diagnosis. In some cultures, there are moirés which promote the idea that submerging one's self or an infant into water is physically harmful during the first 7-10 days after birth. This and other beliefs are long standing cultural moirés which are respected and held to fairly strongly in many communities. The nurses suggested that it is often difficult to ascertain whether a mother is unaware of medically acceptable care or are subscribing to cultural knowledge.

Knowledge of Depression. The mothers were asked to share what they knew about PPD. They summarized PPD as "really, really depressed." They were surprised to find that PPD was a common experience for as many as 13% of women in Alabama (and most likely many more). They were able to describe the presentation of depression as "sad." They portrayed someone who was depressed as someone who would not socialize, would stay at home, would not eat, and would demonstrate a noticeable change in behavior. Lack of knowledge could contribute to mothers being unaware of the presentation of PPD as they are experiencing it – and reinforcing the silence which so often results in the PPD related crises we wish to avoid and prevent.

Assessments for Postpartum Depression

Informal. The obstetricians particularly reported **informal** means being used to assess women for PPD. They indicated that though they used no specific questionnaires or other instruments, they asked specifically whether the mothers had experienced or were experiencing any "problems" initially in the hospital or later at home. They also noted that they ask whether mothers are breastfeeding – they indicated that mothers who struggle with initiating breastfeeding often experience feelings of inadequacy, and thus may become depressed. The nurses indicated that although they desired to implement assessment instruments like the Edinburg Postnatal Depression Scale, at the point of the interview, they had not. One pediatrician who participated in the focus group interviews clearly articulated that the pediatric focus is on the health of the child. This

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pediatrician situated themselves unequivocally in the care of the child, and thus did not believe that assessment of mothers was within their purview. This pediatrician also identified liability issues, increased screening requirements for their patients, and volume of patients as factors that limit their ability to extensively include the condition of infants' mothers in their assessment of patients. The pediatricians did, however, acknowledge that the condition and well-being of mothers directly impacted the condition of their patients (infants) and therefore could not be ignored. Most of the pediatricians in this study appeared willing to broaden the scope of their engagement and assessment from simply looking at the babies only-- to looking at the babies and their mothers and families to the extent that they are able, given the constraints identified above.

Formal. The obstetricians proposed that any formal screenings for PPD could occur at the hospital pre-release and during the nurse's home visit. They described a template which prompts nurses to question mothers about problems that occur while in the hospital, and after their return home. Chiefly these questions were related to challenges with breastfeeding, which they suggested could cause or be the result of experiences of PPD. Similarly, the nurse practitioner and nurses from an Alabama prenatal clinic reported no formal instruments were used to screen for PPD. They did, however, indicate a desire to institute the use of the **Edinburgh Postnatal Depression Scale** (or a similar instrument) as a screening tool in their practice. These nurses did, however, express concern about the impact of their patients' literacy rates on the effectiveness of such a tool. Though the pediatricians affirmed that they completed no formal assessment of PPD for the parent, they did point out that the Early Periodic Screening, Diagnosis and Treatment (EPDST) program requires an annual exam for children who are covered by Medicaid to assure that all their physical and mental health needs are met. Thus, the EPDST allows for some identification of existing risk factors including familial structure and social support resources. They reported that they had no other procedures or instruments to formally assess their patients' mothers for PPD.

Treatments for Postpartum Depression

Psychotropic. The obstetricians indicated that their treatments for diagnosed PPD are primarily psychotropic and included selective serotonin reuptake inhibitors (SSRIs) which are commonly known as antidepressants and include Lexipro, Zoloft, Celexa and Prestiq. The obstetricians reported that they would schedule several follow-up appointments with these mothers (as indicated) to monitor their body's symptoms and condition as well as their response to the medication. The nurse practitioner and nurses from the prenatal clinic reinforced that psychotropic interventions are more easily complied with. They indicated that new mothers find it more difficult to abide by the terms of other mental health clinical services.

Counseling. Though obstetricians, the nurse practitioner and nurses at the prenatal clinic all suggested that mental and emotional health support would be helpful to mothers experiencing symptoms of PPD – all expressed challenges. The clinic staff estimated that 10 percent of their patients diagnosed with PPD actually attend the PPD support group when referred. The nurse practitioner and nursing staff observed that mothers experience a number of barriers that prevent them from receiving ongoing treatment and care including lack of access to reliable transportation. The obstetricians described having difficulty securing appointments with local psychiatrists and psychologists, primarily due to the low numbers of these specialists in their region of Alabama. Additionally, they cited low numbers of general practitioners as a key challenge to meeting the mother's postpartum emotional and mental health needs. When there are overwhelmingly clear signs that their patient's mother might be experiencing PPD, the pediatricians indicated that they encourage the mother to see their obstetrician. In the most extreme cases, though rare, the pediatricians reported that they initiate referrals to the Department of Human Resources, when they believe a child is in impending

danger. The pediatricians also discussed concerns and legal impediments to responding to or completing mental health or medical referrals on a non-patient.

Available Services. Both the obstetricians and the nurse practitioner and nurses identified the lack of mental health providers and available services to mothers challenged with PPD as problematic. The nurses indicated that though the numbers of women who are affected by PPD have increased, the medical and mental health systems that serve this population have not altered their response or service provision in any significant way in order to address the increased need.

Printed Materials Used for Postpartum Depression Information and Education

Available Resources. The prenatal clinic staff and the obstetricians recalled brochures and pamphlets which cursorily discussed the symptoms of PPD or Baby Blues. This written material, according to the obstetricians, is placed in the patients' discharge packages. The nursing staff at a prenatal clinic identified the *Great Expectations* booklet which is distributed prenatally as one specific source of this information. Both groups agreed that very little information about PPD was provided upon discharge from the hospital. The pediatricians acknowledged the dearth of resources available, but did cite "Baby Basics," available in paper and digital format, as a resource which addresses PPD. Additionally, they referenced a "1-month Old" handout which parents receive at baby's 1-month check-up. This brochure briefly summarizes emotions that mothers should be aware of that the pediatricians thought might be helpful. The majority of mothers could not recall receiving any information about PPD. One mother indicated that she "thought" there was information in the papers she received prenatally.

Recommended Intervention Materials / Methods. When asked to recommend education methods to prevent or ameliorate PPD symptoms, duration, and pervasiveness, the

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nurse practitioner and nurses at a prenatal clinic advised researchers that the mother's primary care physician and the infant's pediatrician would have numerous opportunities to observe the mother and thus would be the optimal practitioners to provide educational and/or interventional materials or media. Both groups of respondents listed short **video** presentations, simplified pamphlets with culturally representative pictures, adding 3-4 questions to traditional pre and postpartum screenings, and efforts aimed toward increasing professionals' practical awareness of risk factors as means they would recommend for prevention and intervention. They also prescribed specific cross sections of time at which these methods might be most effective. For example, allowing mothers to view a short video (with a recognizable and culturally relevant face presenting the symptoms of PPD) in the obstetrician's office before one of their prenatal clinic appointments – perhaps at their 36-week pregnancy visit – or even at their 6-week postpartum follow-up visit. The viewing of such a video could also occur in the waiting room of the WIC office, or at a county health department. The obstetricians extolled the value of **lactation consultants**, breast feeding classes, enhanced **postpartum packets**, **religious institution connections**, and **direct support** for first time and adolescent mothers as matters which compelled the attention of practitioners. The pediatricians did have a number of methods and media that they believed would facilitate increasing PPD knowledge and awareness. These included required visits with the lactation center and consultants; the development of a central clearinghouse for PPD and other pre and postpartum information and literature. Additionally they thought that a community awareness or **education campaign** where friends, mothers, and partners of pregnant women would be informed about the signs, symptoms and preventions for PPD would be beneficial. The pediatricians also suggested that such information should be distributed to the Department of Public Health local offices, and each county Department of Human Resources office in the state, in order to get the information to the target population.

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Mothers agreed with the nurses that a DVD with well-known personalities addressing the symptoms of PPD would be useful, and something they would pay attention to. They added that if those personalities had experience with PPD, the related DVD would be even more effective. They thought it might help dissipate some of the stigma associated with postpartum challenges. Mothers also noted that receiving these educational materials right after the birth of a baby, or during the hospital discharge is not helpful – because it would most likely get lost amidst all the other brochures and paperwork mothers are given upon discharge from the hospital. The mothers stressed that receiving this information throughout the pre-natal period in the “Baby Basics” book or other new-baby resources would be more user-friendly so that they could become informed **before** delivery and the potential onset of symptoms, when they would be less likely to sufficiently ingest such materials. The mothers also identified a lack of congruence between parenting and health information they received from medical practitioners and the culturally-based information they received from their homes, families and communities. They acknowledged how that incongruence, which incidentally was alluded to initially by the nurses, can be confusing and present a challenge in child rearing.

Pediatrician’s role in PPD Treatment

The Mother is not the Client. As is typical in qualitative research using focus groups as the method of inquiry, interviews allow for inquiry extension and identification of subtle nuances in the data. Because participants in the first 2 professional focus groups (i.e. obstetricians & nurse practitioner/nurses) identified pediatricians as the optimal practitioner to observe PPD (as a result of mom bringing in baby for several well-baby visits during the first 12 months), pediatricians were asked to describe their perception of the pediatrician’s role in identifying mothers who were struggling with PPD related issues, and secondly to produce PPD referrals as indicated. Most of the pediatricians were very clear that screening and diagnosis of their client’s mothers was beyond their purview. In fact, one pediatrician stated that if he or she were to make any specific

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recommendations to the mother then this would in a sense be establishing a doctor/patient relationship with the mother – which could have some serious legal ramifications for the pediatrician. This pediatrician went on to say it's not that they are not concerned about the mother's well-being (they are well aware of how the physical and mental health of the mother is directly related to the well-being of their patient – the *child*) but that this was not a pediatrician's responsibility. The majority of the pediatricians in the focus group agreed that they and their colleagues needed to be more aware of the signs and symptoms of PPD. Some suggestions offered by pediatricians on how they could take advantage of their numerous contacts with mothers include their willingness to provide information on their web site about PPD (maybe include links to more specific PPD related web sites/information). One pediatrician suggested that they would be willing to provide brochures or other types of information regarding PPD to the babies' mothers at the 1-month well-baby visit. They also commented that the American Academy of Pediatrics (AAP) should soon establish a public stance on PPD and pediatrician-related responsibilities. The pediatricians suggested that information re: PPD should be available with lactation consultants (who often have numerous contacts with mothers postpartum for longer periods of time – even if mothers are not breastfeeding), in daycare centers, at the Department of Human Resources offices (where families go to certify children for Medicaid or food stamps) or the Public Health Department [where mothers can apply for the Special Supplemental Nutritional Program for Women, Infants & Children (WIC)].

Like the obstetricians' and nurses' focus groups, participants in the mothers' focus group suggested that having an opportunity to address the challenges *they* might be experiencing with the pediatrician during each of the well-baby visits might allow them to better manage some of those issues and thereby provide optimal care for their infant.

Advice from Mom to OB

The participants in the mothers' focus group were asked to advise obstetricians on the best means to screen for and identify symptoms of PPD. The mothers made three primary points. First, they recommended that the first postpartum visit be in the home and made by a nurse. They intimated that this would provide the nurse a chance to observe the mother and child in a broader context, and to "really see" how the mother is faring at home. They discussed how mothers will be at their best in the doctor's office, especially if they are aware of what signs may indicate they are having problems. Next, they proposed that the obstetrician provide materials that are less focused on the baby and more focused on the mother and her needs as she fulfills her other roles as mother (possibly to others), wife, woman, employee, among others. Finally, they advocated for parenting training prenatally and postpartum (particularly with first-time moms) with some coverage of development of organizational and management skills.

Discussion**Symptoms of Postpartum Depression**

In support of findings from our analysis of Alabama Public Health data, the medical professionals estimated that up to 15 percent of their patients were experiencing depressive symptoms and syndromes during the first year following birth, known as Postpartum Depression. A smaller percentage, less than two percent would be categorized as experiencing Postpartum Psychosis which is the most extreme of three levels of psychiatric postpartum experiences. The least traumatic of the three, "Baby Blues" is considered a common experience for 50 to 80 percent of mothers (Chaudron, 2003). The normalcy of these experiences are often overlooked or even minimized. Mothers are expected, generally, to be weary, but nonetheless, elated about their new experience of the "joys of motherhood" - especially in the context of rural, suburban

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and Southern cultures. Beyond practical family and community application, even clinicians continue to struggle with attaining a clear comprehension of the pervasiveness of this disorder. A study by Chaudron et.al (2004), found that among young and socioeconomically disadvantaged mothers, the prevalence rates of PPD are even greater: 1 in 4 women. Given that in Alabama many of our mothers are young and/or socioeconomically disadvantaged; it is likely that the estimated rate of PPD here (13% estimated in original study) is significantly higher.

It is noteworthy that while all medical professionals had some knowledge of what was indicative of an atypical mothering experience, none employed any formal methods to either screen or otherwise document these concerns. The symptoms indicated by the medical professionals and mothers were supported by the literature (Evans, et al. 2001). The symptoms were categorized into: 1) Emotional (anger, tearful, withdrawn, mood swings, feeling overwhelmed, flat affect, and feelings of guilt); 2) Physical (fatigue, unusual weight gain or loss, disheveled appearance for mom or baby, body aches; and 3) Relational [disconnection (to father, friends and baby), disengagement (from self, family communications)]. Though some of these are easily detected, others require some moderately directed interaction with and observation of the mother to perceive – particularly the relational factors.

Of note is the mothers' discussion of the difficulty with fulfilling multiple roles. Many of these mothers were from lower income and working class communities. The challenges they expressed with managing the maternal responsibilities while managing a household, being a student, wife and a mother to older children. This struck the authors – because much of the literature, professional and policy dialogue tends to focus on the plight of middle and upper class professional women. The discussion centers around this groups' challenges with maternity leave, and husbands ability to execute the obligatory FMLA for paternity leave. But women in this group characteristically have access to quality childcare, household support, and significant

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others, yet even they grapple with the issues related to managing the emotional and logistical adjustments related to postpartum life. Comparatively, the challenges that women with much less support and fewer resources confront must be more than overwhelming and in fact in some cases may be virtually stagnating.

Postpartum Depression Assessment

The lack of formal assessment for PPD among any of the medical practitioners was of genuine concern to the researchers, although most likely a fairly common practice of health care providers. Particularly after referring back to the literature and discovering the wealth of discussion surrounding the benefits of screening for PPD symptoms - all of which concluded that using a standardized screening tool like the Edinburgh Postnatal Depression Scale (EPDS) during the first year of well-child visits is both feasible and could play a significant role in early detection of PPD (Chaudron, et al., 2003; 2004; Beighly, et al., 2002; Cadrow, Armstrong, & Fraser 1999; and Cox, et al., 1996). A recent study by Kabir, Sheeder and Kelly (2008) found that PPD could be effectively screened just by asking 3 questions from the Edinburgh Postnatal Depression Scale. These three questions make up the anxiety subscale and were shown to identify PPD with the same accuracy as using the entire EPDS. So regardless of the medical setting, be it the obstetrician's or pediatrician's office, asking mothers 3 questions would be enough in most cases to identify PPD.

It was patently clear that all of the medical professionals were aware of the problem of undetected and untreated PPD. This was supported by two groups of medical professionals and alluded to by the mothers, that pediatricians would have the greatest access to the mothers during the time of typical onset of PPD and thus would be the best practitioner to screen for the disorder. Admittedly, the pediatrician's primary patient is the child. Still, one must consider the health and well-being of a child from an ecological standpoint. That is, an emotionally unhealthy mother will have great difficulty providing for the affectional and physical needs of an infant without support

or intervention. Children can suffer from the direct effects of a mother's depression which may be associated with various symptoms such as impaired attachment (Fowles, 1996), or abuse or neglect (Cadzo, Armstrong & Frazier, 1999; Buist, 1998; Zuravin, 1989). Children may also suffer from the indirect effects such as lack of attendance at well-child visits, parental inattention to preventive actions such as immunizations or use of car seats, and maternal reluctance to engage in and continue breastfeeding.

PPD Treatment

Treatment is obviously a barely reached conclusion, as many mothers experiencing the symptoms of PPD are never even diagnosed. None of the practitioners in this study were aware of any self-help or therapeutic groups dedicated to addressing PPD. The OB/GYN's stated that if their patients were significantly impaired, they would most likely prescribe psychotropic medications and have the mother follow-up for a re-check in a few weeks. No other treatment was identified in the focus groups.

Because most often pediatricians are not the mother's medical provider (unless mother is an adolescent and in care from pediatrician before birth of child), they are left in what many consider to be a "gray zone." In these situations, the pediatrician can refer mothers back to primary care providers, offer information about local and national mental health resources, disseminate educational materials about PPD, and provide educational counseling on the effects of depression on children and families (Chaudron, 2007). In addition, the lack of mental health resources was identified by the medical practitioners as a barrier to appropriate care. This is a challenge for all health care providers particularly for those in areas of the country where mental health resources are scarce or where mothers do not have adequate insurance coverage to access needed mental health services. This is a challenge for all health providers and is not limited to just women with PPD (Chaudron, 2007).

Limitations of the Study

This study is limited by the small number of participants. The information presented here by no means claims to be representative of all medical practitioners (specifically obstetricians, nurse practitioners, nurses and pediatricians) and mothers in the state of Alabama. The study was not designed to be representative of these groups. The study was designed to learn more details related to postpartum depression and to better understand issues and concerns related to the diagnosis and treatment of PPD. We also wanted to be able to discuss with new mothers the best way in which to convey information regarding PPD to them and their families. Again, we were able to engage in a detailed dialogue with the mothers who raised issues regarding parenting and PPD that the researchers had not considered. The researchers chose to use focus groups in order to be able to ask open-ended questions and to be able to ask probing follow-up questions and engage in a dialogue with each group of participants. The kind of rich “thick description” available via the use of focus groups simply cannot be obtained through any other means of data collection. The intent of the utilization of focus groups here in the second phase of our study was to augment the agency data that was analyzed in the initial phase of the study.

Future Recommendations

One of the most disturbing symptoms associated with extreme cases of PPD, is postpartum psychosis. Rarely, postpartum psychosis leads to infanticide. Though the frequency of infanticide was negligible among the infant mortality numbers, it is clear that infanticide rates are probably the category of infant mortality that is most preventable.

There are a number of challenges that have been illuminated by this research extension. However the overarching purpose of this study was to better understand the pervasiveness of PPD in Alabama and the information and resources available in our state to address this problem. We also wanted to determine the best means by which to get this information into the hands of not only mothers, but their families, friends, obstetricians, nurses and pediatricians as well. Thus we are recommending the adaptation and enhancement of some existing methods be used throughout the country. First, we would like to recommend a partnership between the Alabama Women's Commission and the Alabama Partnership for Children. This study has helped to reinforce the research team's opinion that an enhancement of the Smart Start Alabama kit would be an economically feasible and efficient means to positively affect Alabama's rates of PPD. Based on data from the focus groups we would like to amend the original Smart Start recommendation to include selecting an individual with face or name recognition for an educational video, like Miss Alabama, or a well known female Congressperson or Senator, or a performer, who would briefly educate women about the symptoms of PPD, and means by which to access support. The original description of the Smart Start program and accompanying recommendations are re-printed below.

Smart Start Alabama Kit

The Alabama Partnership for Children (APC) is a non-profit organization aimed at improving outcomes for children ages five and under in Alabama. The organization has a 26 member board of directors with appointments from the Governor, the Speaker of the House of Alabama and the Pro Tempore of the Alabama Senate. The Alabama counties that work in partnership with Kidstuff, the APC program, are: Cherokee, Conecuh, Covington, Dekalb, Escambia, Geneva, Hale, Houston, Jefferson, Lauderdale, Lee, Madison, Montgomery, Shelby and Talladega. One way in which the Smart Start Alabama (formerly Kidstuff) program works is by providing a parenting kit for new parents. The Kidstuff Kit is a comprehensive tool that is designed to answer questions

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for new parents, give information concerning child health and safety, inform new parents of toll-free phone numbers and websites for public programs and state agencies, give parents information regarding quality childcare and give other useful information that will be of help to parents through all of their child's developmental stages. The kit is distributed at birthing hospitals throughout select counties based on the availability of funding. Included in the kit are the following: *The Alabama Guide for Families* – a comprehensive resource and referral guide; *Baby's First Year Calendar*; A congratulatory card to parents with Kit partners recognized; A message from the State Superintendent of Education emphasizing the importance of early literacy; A children's first book to highlight the importance of reading and talking to children from birth; and a video entitled: *Parenting Right From the Start*.

APC reports that, since 2002, five pilot counties have participated in parenting kit distribution (Cherokee, Houston, Jefferson, Madison and Marengo). The Alabama Medicaid Agency's Maternity Care Program has distributed over 15,000 kits to its network of 14 Primary Care Contractors statewide. The Alabama Early Intervention Systems distributed over 2,000 kits to its network of families and providers. In total, more than 50,000 kits have been distributed since the beginning of the project in 2002. When evaluated, 83% of surveyed families reported decreased stress as a result of getting the kit. Additionally, 80% of families said they had increased confidence in parenting as a result of the kit. Finally, 83% of families surveyed said they had increased positive feelings about parenting as a result of receiving the kit.

Based on the reported effectiveness, we are suggesting a more in-depth evaluation of the program's impact on postpartum depression rates. If the recommended evaluation supports the program's positive influence, we would recommend further consideration of an expansion of the current program through an increase in the targeted distribution sites. Inclusion of those sites which serve populations which have been identified as particularly at risk for postpartum depression, like urban dwelling pregnant women, pregnant teens, single mothers, would be especially desirable. The cost of implementing an inclusive distribution practice such that all women giving birth in Alabama each year (approximately 63,000) have access to this Kidstuff Kit, would be roughly \$630,000 (@\$10 each) for the kits, and an estimated additional \$75,000 for program administration and overhead, \$36,000 for storage, shipping and travel, and \$85,000 for delivery, follow-up, and evaluation for a total cost of **\$826,000** annually. Each kit would include *The Alabama Guide for Families*, A Smart Start Bag, A First Book (for the child), a parenting video, *Baby's First Year Calendar*, a congratulatory card with a literacy

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message, a county – specific resource directory insert, as well as health and developmental brochures which are donated free from partner agencies. We believe that major corporations whose products are targeted at mothers and infants would be interested in sponsoring a portion of the costs or donating products. We would also propose enclosing an additional flyer or brochure in the kit that would provide detailed information regarding postpartum depression symptoms and treatment options.

Further information may be obtained via:

<http://www.kidstuffalabama.org/programs.htm>

Another option (a more economical program) considering the current economy, which would more directly target PPD, would be one that is modeled after Washington’s PPD awareness campaign originally presented in the first stage of this study. The *Speak Up When You’re Down*” campaign is described below.

“Speak Up When You’re Down”

In 2005, the state of Washington’s legislature passed Senate Bill 5898, which created a Postpartum Depression (PPD) Awareness Campaign for women and families in WA that was state funded (\$25,000). The campaign was designed to educate the public about the signs, symptoms and treatment of PPD. The Children’s Trust of Washington (formerly the WA Council for Prevention of Child Abuse and Neglect) led the campaign with help from partner organizations and citizen advocates throughout WA. Because early reporting of experiences of depression symptomology minimizes the severity of PPD and its effects, the campaign message was “Speak Up When You’re Down.” The goal of the campaign was to increase the public’s understanding of postpartum depression and to create more resources for women experiencing PPD. The campaign included: a toll-free PPD ‘warm line’ staffed by trained volunteers; a comprehensive website with links to helpful resources (www.speakup.wa.gov); 200,000 brochures in English and Spanish distributed statewide; media kits (including fact sheets, press releases, and articles); media coverage (TV, radio, newspapers, magazines, etc.); more than 50 presentations to various audiences; and \$44,750 worth of in-kind support. For evaluation purposes, the campaign leaders regularly communicated about the progress, identified sources to secure extra resources, supported the work of advocates, and convened a Leadership Advisory Group. In addition, the campaign developed a video project - a locally-produced video released in 2006 with a running time of 5-7 minutes which was distributed to pregnant women/new mothers to help them better

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understand the signs and symptoms of PPD. According to the campaign website, in 2007 the campaign was enhanced with more funding to continue its work.

An estimated cost of the project's components, if implemented in the state of Alabama, would include the creation and printing of brochures (\$8,300), media coverage (in-kind/\$50,000), production & copying of a DVD for distribution through (for example) Communication and Journalism students (one-time cost, \$30,000/repeated costs, \$5,000), collaboration with existing support "warm line," like "Parenting Assistance Line" (PAL) 1-866-962-3030, and program administration. After further investigation of the outcomes of the program, if considered for implementation in Alabama the cost would total approximately **\$113,300.00** for the first year and an estimated **\$83,300** annually thereafter.

Information can be sought at: <http://www.wcpcan.wa.gov/ppd/home.htm> and <http://www.wcpcan.wa.gov/documents/SpeakUpPostCampaignReport.pdf>

Data gleaned from the mothers' focus group appear to point to a definitive need for in-home support for new mothers across risk status, age, class, and ethnicity. In the first stage of this study there was reference made to the *Help Me Grow* program of Ohio. For the readers' convenience we present the original discussion again here along with the nominal projected cost for Alabama.

Help Me Grow Program.

Help Me Grow is an Ohio program for expectant parents, newborns, infants and toddlers which incorporates a home visiting component as a part of its service. The aim of the program is for parents and their newborns to thrive, infants and toddlers to thrive and to make sure children are healthy and ready for school. The services that the Help Me Grow program provides at no cost include: developmental screenings, developmental evaluation and assessment, development and review of the Individualized Family Service Plan, service coordination, a newborn home visit for first time and parents under 25 years old, ongoing home visits for support, education and linkage to community resources, family support opportunities (e.g. playgroups, parent support groups, workshops, one-on-one support), transition services and family literacy. Specialized services are facilitated by a variety of community agencies and

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organizations. Services are provided by professionals such as physical therapists, developmental specialists, occupational therapists, nutritionists and social workers to name a few. Ongoing services are available to those who qualify through the child's third birthday. The Service Coordinator will facilitate a transition planning conference upon the child aging out of the services. The program is funded through a private-public partnership under the county commissioner's Invest in Children program. In 1999, the partnership launched a three-year \$40 million early childhood initiative, including \$10 million awarded by the private philanthropic community. Invest in Children is a public-private partnership that includes community service agencies, hospitals, private funders, and county, state and federal government. Implementation of a similar program in Alabama would cost in excess of \$12.3 million annually at approximately \$195 per birth.

Further details may be found at: <http://www.ohiohelpmegrow.org/>

*Depression During and After Pregnancy:
A Resource for Women, Their Families, and Friends*

A final recommendation is for **all** medical practitioners to provide written information regarding PPD from the U.S. Department of Health and Human Services (HRSA) to their patients. HRSA has created an excellent educational booklet that is available online at:

mchb.hrsa.gov/pregnancyandbeyond/depression

We suggest that **all** medical practitioners who come in contact with expectant or new mothers to acquire this booklet on behalf of their patients. This option is economically feasible, given that medical providers are able to go online and print out copies of the booklet in PDF format, or they may contact HRSA directly to request that hard copies of the booklet be mailed to their medical offices at no cost. This booklet can be obtained from the HRSA Information Center at 1-888-Ask-HRSA. We also suggest that this booklet be **directly given** to all expectant mothers or mothers who have recently delivered. Simply placing a stack of brochures on a table in the medical office waiting

room is not sufficient. A designated professional on the medical staff should hand-deliver these booklets to mothers during office visits and speak with mothers (and her family if present) about PPD and offer to answer any questions that mothers may have. We suggest that these steps be taken **immediately** by all medical practitioners' offices while each of the other options presented here are explored and considered for implementation.

Conclusion

Overall, the second stage of this study elucidated what the quantitative data suggested – but in a richer manner. It is obvious that new mothers are faced with many challenges related to the life change of a new baby. Many articulated their frustration, lack of support, and sheer exhaustion which accompanied their new parenting experiences. Though these mothers represented only a minute sample of mothers in Alabama – it is likely that their experiences are not dissimilar from thousands of new mothers in the state. Thus, practitioners and policy makers must act in order to move toward a healthier Alabama for all its citizens. PPD affects not just mothers, but their children, spouses and other family members as well.

When one considers all of the risk factors associated with PPD identified in the literature, some of which include: age of birth mother, education of birth mother, and socioeconomic status of birth mother; all of which have been associated with higher rates of PPD and all of which occur with increased frequency in Alabama, it becomes clear that the pervasiveness and impact of PPD in Alabama is not well-understood at this time. It is also clear that further research is needed to identify which (if any) of the previously discussed educational approaches might have the most life changing and cost effective impact on mothers, children, friends and other family members in Alabama.

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