

POSTPARTUM DEPRESSION SCREENING AND TREATMENT IN A RURAL
SETTINGAN EVIDENCE BASED POLICY

by

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ABSTRACT

Despite years of research and discussion surrounding the impact of postpartum depression, it continues to be under diagnosed and under treated. Many women believe they are failing to handle the stress of motherhood and are embarrassed to seek help. Women living in rural communities have the added pressure of limited access to services and embarrassment related to a lack of anonymity that accompanies living in a small town. Equally important to successfully addressing this pervasive mental health issue is education and engagement of clinicians who provide the bulk of care for expectant mothers and their families. The purpose of this project is to develop a policy utilizing evidence-based screening and interventions which can be initiated during prenatal office and subsequent follow up visits during the first year postpartum.

CHAPTER 1

INTRODUCTION

Problem Statement

Postpartum Depression (PPD) is a debilitating condition affecting 10% to 25% of women within the first 12 months after having a baby, with fewer than half of the cases being recognized or treated effectively (Gjerdingen & Yawn, 2007). Up to 80% of women experience some level of mood alteration in the first few days to weeks following delivery. According to the Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV TR), the following is a list of diagnostic criteria for a Major Depressive Disorder (MDD) with a postpartum onset:

- 1.) The patient must present with at least one of the following for a two week period:
 - depressed mood
 - anhedonia - inability to feel pleasure in normally pleasurable activities.
- 2.) The patient must report at least five of the following in a two week period:
 - feeling depressed most of the time nearly all day
 - decrease pleasure or interest in all or almost all activities of daily living
 - changes in appetite with marked weight loss or gain
 - sleep disturbance (even when baby is sleeping)

- psychomotor retardation or agitations nearly every day
 - lack of energy or fatigue nearly every day, intense feelings of inappropriate or excessive guilt or worthlessness
 - difficulty concentrating or making decisions nearly every day
 - or frequently occurring thoughts of death, suicide or suicidal plan (including harming newborn)
- 3.) Symptoms chosen are causing significant impairment or distress in social, vocational, or other important daily living functions
 - 4.) “Postpartum Onset Specifier” is applied if the current onset of symptoms occurs within four weeks following childbirth (American Psychiatric Association [APA], 2000)

As of May 2013, the DSM-5 diagnosis of depression during the postpartum period still utilizes the onset specifier format. However the specifier has changed, it is now titled *with peripartum onset* which is defined as the most recent episode occurring *during pregnancy* as well as in the four weeks following delivery (Segre & Davis, 2013). This modification to the diagnostic criteria represents a positive step towards addressing PPD, but growing research supports extending the period of evaluation for a treatable depressive mood disorder beyond the four week end point indicated.

Postpartum depression can be distinguished from the “baby blues”, which is a transient mood disturbance that affects up to 75% of new mothers in the 10 days following delivery, and consists of crying, irritability, fatigue, anxiety, and emotional lability. Symptoms of baby blues are generally mild and self-limited, and do not involve total loss of pleasure or interest, persistent low mood, or suicidal ideation. At the opposite end of the diagnostic spectrum is a disorder known as postpartum psychosis. This disorder is a psychiatric emergency that requires immediate intervention, and is

characterized by the rapid onset of severe mood swings, a waxing and waning sensorium, delusions, hallucinations or disorganized behaviors, and a high incidence of suicidal ideation or homicidal ideation toward the newborn (Fitelson, Kim, Baker & Leight, 2011)

Beck (2006) describes a woman's attempt to manage lost control of her thoughts and actions as the precursor to PPD in a four stage process she calls "teetering on the edge". These stages consist of 1) encountering terror as the symptoms hit unexpectedly and suddenly, 2) dying of self as mothers no longer know who they have become, 3) struggling to survive, and 4) regaining control of their lives. In a meta-analysis of 18 qualitative studies four recurrent themes were found: 1) incongruity between expectations and reality of motherhood; 2) spiraling downward, which consisted of anxiety, obsessive thinking, anger, cognitive impairment, isolation, loneliness, overwhelmed, guilt, and contemplating harming self; 3) pervasive loss of control, self, relationships, and voice; and 4) making gains of reintegration and change (Beck, Records, & Rice, 2006).

Left untreated, PPD poses risks for long term damage to the mother, her newborn, and the entire family. Depressed mothers, compared with non-depressed mothers, report a 3-fold greater risk of serious emotional problems in their children and a 10-fold greater risk of having poor mother-child relations. The withdrawn, unresponsive, or negative behavior of a depressed mother early in the infant's life affects maternal-infant attachment and can result in fussier infants who vocalize less and make fewer positive facial expressions than infants of mothers who are not depressed. (Gjerdingen & Yawn, 2007) In children older than one year of age whose mothers experienced PPD reported problems including insecure attachment, antisocial behavior such as temper tantrums, less

sharing, less sociability with strangers, being uncontrollable and demonstrating poorer cognitive performance with significant intellectual deficits still detected by age four years (Logsdon, Winter, & Pinto-Foltz, 2006). Added to the spectrum of familial dysfunction is the effect of a mother's mood disorder on the father. Maternal depression has been indicated as the largest predictor of paternal depression during the postpartum period (Goodman, 2004). In an integrated literature review, Goodman (2004) reports the incidence of depression in fathers ranges from 1.2% to 25.5% in community samples; however, it ranges from 24% to 50% in fathers whose partners were suffering from postpartum depression, placing their newborn and family at even greater risk.

Women who experience PPD report significant barriers to seeking and following through with treatment which including: struggling to fulfill their vision of an ideal mother while concealing their own needs, reluctance of family members, partners and healthcare professionals to acknowledge or respond to the mother's needs, adhering to myths about depression, shame at the thought of being labeled mentally ill, fear of being perceived as weak or becoming a burden to their family and fear of losing their child (Dennis & Chung-Lee, 2006).

Prenatal depression, a history of depression and/or a family history of mood or anxiety disorders are significant risk factors for postpartum depression. Disturbing thoughts such as a desire to flee or get away, inability to feel love for the unborn baby or infant and thoughts of hurting or being unable to protect the infant are especially troubling during the perinatal period (Wei, Powell, Freeman & Holmes, 2012). Adding to a woman's confusion is the fact that expectations of mothering are predominantly

dictated by the prevailing culture; there are no specific job descriptions or rules. This ambiguous definition of a mother's role detracts from successful parenting for many women (Logsdon et al, 2006).

In rural areas, where mothers are less able to access mental health care, the downward spiral of PPD, as described by Beck (2006) may go unrecognized. Custer County is located in rural southeastern Montana, with the county seat being Miles City, a town of 8,000. Median income for Custer County is \$38,000; well below the statewide median income; 16% of the population does not have health insurance of any kind and 15% of the population live below poverty level (City-data.com, 2012). Eastern Montana is considered one of the most underserved regions for mental healthcare in the nation. Currently, only the Eastern Montana Community Mental Health Center (EMCMHC) provides care for 15 rural counties in this region. EMCMHC takes payment from multiple sources including, Medicare, Medicaid, private insurance, and sliding scale fees. The suicide rate for Custer County is 32.8/100,000 compared to 11.8/100,000 in the nation overall (Montana Department of Health and Human Services, 2010). With the entire population of Custer County and its seven surrounding counties under 30,000, creating policy which includes screening, referral and access for new mothers to resources is a daunting mental health issue.

Purpose

The Agency for Healthcare Research and Quality, in collaboration with the Safe Motherhood Group, commissioned a report from the North Carolina Evidence-based

Practice Center which recommends screening of postpartum women for depression throughout the first postpartum year. New mothers are unlikely to seek treatment for depression, so many cases remain undiagnosed and untreated despite effective available treatment options (Logsdon et al, 2006). The intent of this project is to investigate the experience of postpartum depression for new mothers living in rural and frontier settings where access to mental health service is limited. The aim is to develop a policy for identifying women at risk for PPD and referring them for treatment. By evaluating existing research, barriers to screening, the policy will suggest appropriate screening tools and the most effective time and place for screening. Applying information gained from this research review, a viable evidence-based policy outlining screening processes to be utilized before and after delivery will be developed, with a goal of indicating if a mother is at an increased risk of experiencing postpartum depression. Once risk has been indicated, interventions are incorporated in the woman's treatment plan in the prenatal period to mitigate conditions placing her in danger of experiencing PPD and appropriate care is established to support the transitioning mother and her family.

In this chapter, the prevalence and spectrum of postpartum mood alterations was presented. Diagnostic criteria, role specific transitional factors, and the impact of PPD on family members were also considered. Information was provided about rural demographic factors affecting policy development and the aim and intent of policy recommendations.

In the next chapter, theory framework providing the underpinnings of policy creation will be discussed. Also to be considered, a literature review identifying,

evidence-based risk factors, research proven screening tools, and timing for initial and subsequent screening evaluations. Finally, barriers and opportunities for effective screening and intervention will be presented followed by research-based treatment and interventions.

CHAPTER 2

BACKGROUND

Ramona Mercer's Maternal Role Attainment Model will provide grounded middle range theory for the proposed policy. This theory's roots are found in Reva Rubin's Maternal Identity Theory (1967) in which a progression of stages are identified as a woman transitions into a confident mother. Rubin's work sparked interest in researching the implications of this transition for nursing care. Mercer expanded on Rubin's work by developing the Maternal Role Attainment Theory, which she and other nurse researchers involved in studying the maternal transition have proposed occurs as a series of lifecycle events identified as "Becoming a Mother". Four stages in this process of establishing maternal identity were created from qualitative research: 1.) commitment, attachment, and preparation occur during pregnancy; 2.) acquaintance, learning and physical restoration occur during the first 2 to 6 weeks following delivery; 3.) moving toward a new normal occurs between 2 weeks to 4 months; and 4.) achievement of the maternal identity usually occurs around 4 months. The last three stages are variable and easily influenced by outside factors. All of these stages may overlap in their progression towards successfully maneuvering through this transitional phase of becoming a mother (Meleis, 2010) For women overwhelmed by the process of motherhood, it is vital to support them as they transition into their role as mother of a newborn and emerge with confidence.

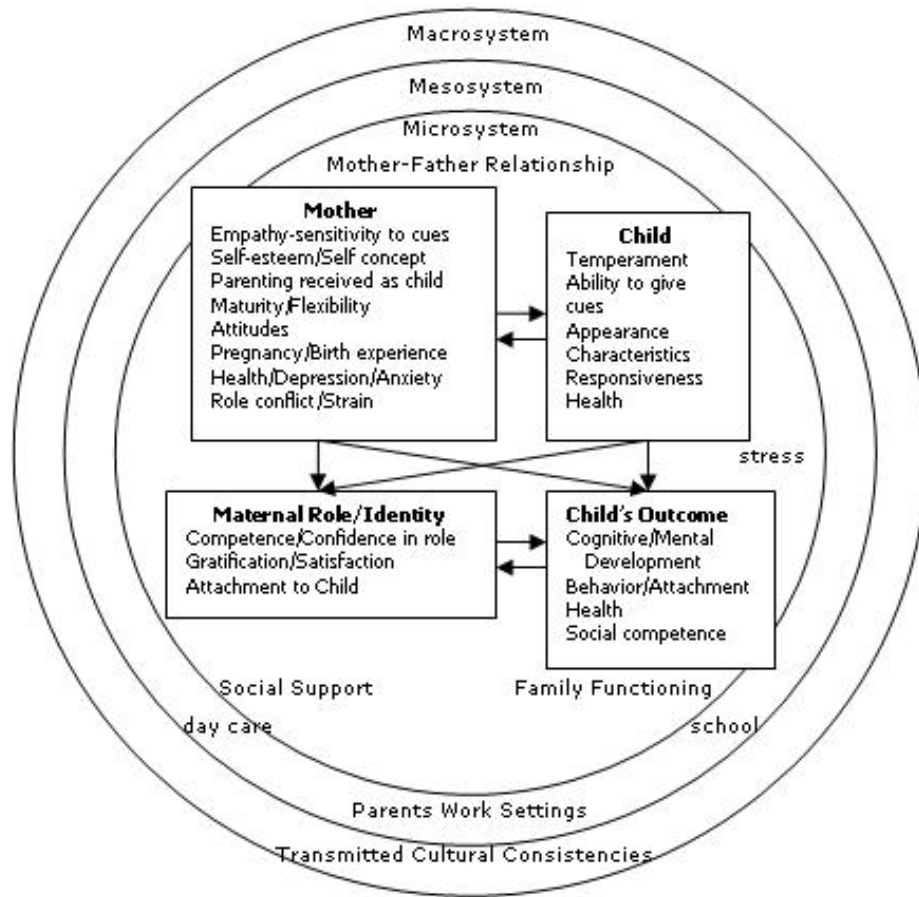


Figure 1. Mercer's Maternal Role Attainment Model (Fabio, 2008).

The Rural Nursing Theory will also be incorporated into this project. With several counties reporting fewer than six people per square mile, application of this theory is key for developing effective policy to care for the frontier population living in Eastern Montana. There are three basic statements in this theory which are pertinent to women of this area: 1.) Rural dwellers define health primarily as the ability to work, to be productive, to do usual tasks. 2.) Rural dwellers are self-reliant and resist accepting help or services from those seen as national or regional 'welfare' programs. 3.) Lack of anonymity also applies to the recipients of health care in rural areas as all persons in that

environment have a “limited ability” . . . to have [a] private area in their lives (Lee & Winters, 2004). Policies created to serve an urban population, with readily available services, are destined for failure when applied in this setting. Effective application of Rural Nursing Theory in creating policy will help identify and treat women at risk of postpartum depression in this unique demographic and will improve the likelihood of achieving successful outcomes by restoring well-being to these women and their families.

Review of Literature for Policy Development

A review of pertinent literature for developing a policy that will be implemented for screening women at risk of Postpartum Depression will be divided into sections as follows: report of evidence-based risk factors which may indicate a propensity for depression following delivery; identification of research proven screening tools; investigation into the barriers and opportunities for implementation of screening; and finally, identification of effective treatment options for PPD. Analyzing relevant information in this manner provides clarity for creating clinician workflows delineated in the policy.

Evidence-Based Risk Factors for Postpartum Depression

Data reported by Robertson et al. (2004) establishes factors which predispose a woman to greater risk of experiencing a postpartum mood disorder. The two strongest indicators are *antenatal* depression (effect size=0.75) or anxiety (effect size=0.68). They also reported a significant correlation between the level of prenatal anxiety and severity

of postnatal depressive symptoms. Ryan (2005) reports a history of any psychiatric diagnosis co-occurring with pregnancy or occurring when she is not expecting, places a woman at high risk of experiencing PPD. Additional strong indicators of impending postpartum depression reported by Schachman and Lindsey (2013) were adolescence, low self-esteem, and a perception of minimal social support. Factors with cultural overtones reported by Robertson et.al (2004) indicate recent life events such as the death of a loved one, relationship breakdown or divorce, losing a job, or moving home are known to cause stress and can trigger depressive episodes in individuals with no previous history of affective disturbance most notably in North American and British mothers. Added ethnic risk was reported by Lucero, Beckstrand, Callister, & Sanchez-Birkhead, (2012) who noted an increased incidence of PPD in immigrant Hispanic women and urban minorities.

Narrowing review to applicable information gathered from studies relative to rural women, Villegas, McKay, Dennis and Ross (2011) note an increased prevalence of PPD (27%) in women residing in rural regions, higher than women living in urban areas or the population of women overall. Villegas et al (2011) also identify the presence of multiple children in the home as potentially creating additional risk for rural women. They recommend further investigation of this factor noting minimal supportive resources available for rural women raising a young family.

Research Proven Screening Tools

There are several screening tools which have been evaluated for effectiveness in identifying women at high risk for a PPD. Due to a lack of clinical trials in regard to

postpartum depression screening, inferences must be drawn from data on how well the screening test or activity distinguishes between patients who truly have the condition of interest and those who do not, which is commonly reported as sensitivity (the likelihood that people with the condition will have a positive test) and specificity (the likelihood that people without the condition will have a negative test). The sensitivity and specificity of a test are characteristics that are independent of the population being tested. Higher sensitivity means fewer people with the condition are missed, while higher specificity means fewer people without the condition will be falsely identified; importantly, sensitivity and specificity are indirectly correlated—increasing sensitivity decreases specificity and vice versa. One advantage of sensitivity and specificity is that, because they are characteristics of the tests themselves, sensitivity and specificity estimates of a given test can be compared and pooled across different studies (AHRQ, 2012). The focus for screening women targeted by this policy will therefore include sensitivity and specificity of the three tools utilized: The Postpartum Depression Predictors Inventory-Revised (PDPI-R), The Edinburgh Postnatal Depression Scale (EPDS), and The Public Health Questionnaire-9 (PHQ-9).

The Postpartum Depression Predictors Inventory-Revised (PDPI-R) Beck (2002) is a 13 question screening tool developed from the original 8 question PDPI as a clinical interview guide used to identify risk factors shown to predispose a woman to postpartum depression. Once risks are identified appropriate treatment or resource referrals can be implemented and the woman can be followed closely for further signs of decompensation. The first 10 questions can be administered antenatally or postnatally

and the last three are specific to postpartum. Based on three meta-analysis, 13 PPD predictors were identified for use in the PDPI-R: prenatal depression; life stress; social support, prenatal anxiety; marital relationship/satisfaction; history of previous depression; self-esteem; unwanted/unplanned pregnancy; marital status; socioeconomic status; child care stress; infant temperament; and maternity blues.(Beck, 2001) According to Beck the greatest indicator predicting postpartum depression was incidence of prenatal depression.

In 2004, the PDPI-R was adapted by Australian researchers into a self-administered, scored checklist that could be completed independently at home and reviewed with a trained clinician for a trial study comparing the PDPI-R to the EPDS for use in screening and identifying women at risk of experiencing PPD. Results from the study concluded clinicians preferred the newly revised PDPI-R over the EPDS due to ease of use and it allowed greater investigation of the offending factor during subsequent visits. Each of the 32 prenatal items requires a “no” or “yes” answer that is scored with a “0” or “1,” respectively. Item scores are summed to obtain a total scale score, with higher scale scores indicating an increased risk for PPD. Total scale scores for the prenatal version range from 0 to 32. A cut-off point was established so that scores greater than 10.5 warranted further evaluation and monitoring. Utilizing a cut off score of 10.5 yields a sensitivity of .76 and a specificity of .54 in predicting depression during the postpartum period.(Beck, Records, & Rice, 2006) Construct validity findings are strong for the prenatal version of the PDPI-R when using concurrent, predictive and contrasted group approaches. Initial evidence supporting the reliability and validity of the prenatal version of the PDPI-R indicates that prenatal care providers can comfortably

begin using it in clinical practice. Results can help care providers identify women most at risk for PPD (Records, Rice, & Beck, 2007).

The Edinburgh Postnatal Depression Scale (EPDS) is a ten item self-administered questionnaire which was developed by John Cox and Jeni Holden in Scotland in 1987 to assist providers in evaluating a woman's risk for depression following childbirth. It is written at a 5th grade reading level and asks respondents to evaluate their feelings over the past seven days. Each question is scored on a scale of "1" (no problem) to "3" (severe problem), with higher total scores indicating greater depressive symptomatology. Total scores greater than "10" are an indication that further evaluation is needed. This scale is by far the most widely used screening tool that is specific for PPD and has been used in diverse countries with varying degrees of sensitivity and specificity, different cutoff scores may be indicated for different cultures and populations. Current research indicates the cutoff point of 9 increases the sensitivity of the instrument from 84 to 100% and the specificity from 82 to 88% (Schumacher & Zubaran, 2008). Another attractive feature of this tool is that it can be administered, less than five minutes. The EPDS is available for use without cost.

The EPDS is not without notable drawbacks. There are key areas that must be addressed when identifying a mood disorder which are not presented in the EPDS. Readers are cautioned, it does not provide diagnostic value; its utility is for screening purposes indicating women who require additional psychometric testing and clinical interview for appropriate evaluation.

The Patient Health Questionnaire (PHQ) is a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders. The PHQ-9 is the depression module, which scores each of the 9 DSM-IV criteria for depression as “0” (not at all) to “3” (nearly every day). Using the structured mental health professional (MHP) interview as the criterion standard, a PHQ-9 score ≥ 10 had a sensitivity of 88% and a specificity of 88% for major depression. The PHQ-9 defines severity as follows- >5 =mild depression, >10 =moderate depression, >15 =moderately severe depression, and >20 =severe depression. Similar results have been found in both primary care and obstetrics-gynecology samples. The PHQ-9 is both a screening and severity measure for major depressive disorder which responds to change in the client’s condition with repeat administration over time (Koenke, Spitzer & Williams, 2001). Because of its ability to provide information about both diagnostic criteria and depression severity, the PHQ-9 is thought by some to be the “best available depression screening tool for primary care” (Gjerdingen & Yawn, 2007). Although there are no readily available published reports on the validity of the PHQ-9 in screening for postpartum depression, the PHQ-9 has been effectively used as a screen in obstetrics/gynecology practices that include both women of childbearing age and older women (Gjerdingen & Yawn, 2007).

Research-Based Timing and Intervals for PPD Screening

These tools comprise a foundation for screening and identifying women at risk of experiencing some level of postpartum depression. They each offer research based

properties that support their use as PPD screening tools. Policy guidelines will indicate intervals for their use during routine prenatal visits and for the year following delivery.

Although no current standard exists for when to screen, discussion and research are ongoing. Instrument developers suggest screening with the PDPI-R can begin as early as the first trimester and repeated throughout pregnancy, but no ideal time has been identified for use. Due to time and resource constraints involved in clinical practice, screening with the PDPI-R in this policy will occur somewhere in the late second trimester of pregnancy to the early third trimester, identifying women at risk in order to appropriately target intervention.

Recommendations released by the by the AHRQ, in April 2013, reports value in two phase postpartum screening. The first phase consists of screening with an instrument which shows a high level of sensitivity such as the EPDS followed by a tool showing increased specificity such as the PHQ-9. The PHQ-9 provides a more specific assessment for major depressive disorder in women identified as possibly depressed by the EPDS. The PHQ-9 was also utilized in the Translating Research into Practice for Postpartum Depression (TRIPPD) effectiveness study which implemented this multistep process for screening and diagnosis. The TRIPPD study interventions and recommendations were used to screen and treat 2,343 women throughout 21 states from 2006- 2010 with their primary care provider is the basis for this policy. The goal is providing comprehensive care with a primary provider by establishing a treatment plan and interventions for women at risk prior to delivery and continuing to screen and treat women after delivery as needed.

The DSM IV-R and DSM-5 indicate by 4 weeks after delivery criteria for postpartum depression should be present. This is also traditionally when a woman returns for her postpartum follow-up appointment and lends itself to capturing the majority of women who may be experiencing PPD. Results from the CARE (Communicating and Relating Effectively) study completed in 2010 emphasize that although 4-6 weeks is the recommended time period for PPD screening, women should be screened during the first year after birth whenever they make a well-child, obstetrician, or primary care appointment. Horowitz et al also report universal postpartum depression screening may reduce resistance among women who feel singled out for depression assessment that is not a routine part of their care.

Barriers and Opportunities for Effective Screening and Intervention

The AHRQ report, *Efficacy and Safety of Screening for Postpartum Depression* (2013) outlined the merits of research related to measureable positive outcomes by recommending women be educated, screened, evaluated, treated and followed in their primary care setting. The TRIPPD Study generated research supporting this recommendation and differed from previous studies that had failed to realize positive outcomes at twelve months after delivery in that care occurred with a woman's primary provider and the Structured Clinical Interview for DSM IV-TR (SCID) was not utilized to validate the diagnosis of PPD (Yawn, Dietrich, Wollan, Bertram, Graham, Huff, Kurland & Madison, 2012). There are a number of studies that suggest self-report measures such as the EPDS are as accurate in detecting PPD as a SCID. Requiring a

SCID to diagnose PPD requires women to go outside their usual care sites and appears to be a major barrier to evaluation and diagnosis. The need for the SCID assessment is based on results from studies of high-risk patients with complex mental health problems and who are referred to psychiatrists. This criteria may not be generalizable to a lower-risk population assessed at the primary care level (Yawn, Olson, Bertram, Pace, Wollan & Dietrich, 2012). Also of note, women screened as at risk of PPD who were referred to mental health facilities for a diagnostic interview did not return or follow through with treatment (Gjerdingen, McGovern, & Center, 2011). Benefits of requiring a SCID for PPD diagnosis must be weighed against the risks of missing PPD and a chance to provide therapy and care to the women identified by screening without a SCID confirmation (Yawn et al, 2012).

A qualitative study of 23 women with PPD performed by Flynn et al (2010) found perceived barriers to effective treatment follow through included: 1.) Women not only prefer to remain with their primary provider, but several felt in-home visits would be a valuable and attractive addition. 2.) A desire for proactive, timely referrals and treatment. Women lost interest or desire (perhaps related to their depression) when the referral or treatment process became too cumbersome and delayed. 3.) Pregnant women and new mothers desired flexible options for care, rather than a standardized plan to be applied across the board. 4.) An additional need for education related to postpartum depression and both pharmacologic and non-pharmacologic treatments is needed throughout a woman's pregnancy. 5.) Concerns about the stigma related to depression and its treatment needed to be discussed. Women fear being labeled a failure by asking

for help (Flynn, Henshaw, O'Mahen & Forman, 2010). Placing these concerns in a rural context where there exists not only limited access to services for a variety of reasons, Dennis and Moloney (2009) align with Rural Nursing Theory in noting powerful stigma related to being labeled as “mentally ill”, and a lack of anonymity deterring women from seeking care. Women also report difficulties obtaining childcare during multiple visits for treatment, financial concerns, worries related to the effect of medications on their baby, and anxiety related to possible involvement of child protective services ultimately fearing the loss of their child (Gjerdingen & Yawn, 2007).

Primary care providers report a separate list of barriers that impede screening and treatment of PPD. These include: lack of time, managed care policies, competing demands, insufficient training/knowledge, insurance or payment problems, and fear of legal repercussions (Gjerdingen & Yawn, 2007). Clinic processes generate added issues such as: lack of objective, proactive monitoring of recovery, infrequent follow-up visits for mothers, and separation of primary care and mental health services (Gjerdingen & Yawn, 2007). In order to address PPD the need for good communication accompanied by comprehensive and coordinated care between clinicians trained to treat physical, mental, and social welfare is vital.

Evidence-Based Treatment Options for Postpartum Depression

Ongoing research supports developing a proactive plan for detecting and treating postpartum depression in a woman's primary healthcare setting. Screening alone is ineffective and irresponsible without a well-developed treatment plan which includes

further evaluation, and options for readily available care. This type of policy is essential for producing positive outcomes in the treatment of PPD.

Treatment recommendations for PPD generally mirror those for a major depressive disorder in any context, with the caveat that a breastfeeding mother may have concerns for her baby should pharmacologic treatment be introduced. The initial process of treating PPD is to educate women and their families about the disease process, treatment modalities, expectations, and need to practice a healthy lifestyle, including family and social support (Fitelson et al, 2010).

Recommended treatments include both pharmacologic and non-pharmacologic methods. When creating a treatment plan for PPD, a clinician must partner with each client to support a sustainable process. Since loss of control is at the foundation of this disorder, encouraging the new mother to provide input and feedback about her plan of care promotes ownership of her recovery and helps build confidence.

There is an expanding body of research addressing the safety and efficacy of psychotropic medications in treating PPD, with results showing similar disease response as traditional major depressive disorder. Most depression will show improvement over time with or without treatment, but medication can hasten the process. If a woman has been previously treated for a major depressive disorder or PPD and had positive results from a particular medication, this should be the default pharmacologic intervention with recurrent episodes of the disorder (Freeman, 2009). If she is breastfeeding, a decision must be made weighing benefit versus risk, should the medication be one known to produce elevated serum levels in the baby. For breastfeeding mothers experiencing PPD

which is interfering with daily function, sertraline and paroxetine have shown to have the least traceable effect on breast milk with reported instances of adverse side effects occurring in the baby are rare, if at all. Conversely, citalopram and fluoxetine have a higher passage into breast milk; studies report conflicting information related to infants experiencing a range of side effects (Weissman, Levy, Harz, Bentler, Donohue & Ellingrod, 2004).

Following delivery, women experience a dramatic fluctuation in hormone levels which plays a factor in mood lability for most women. During pregnancy, levels of endogenous glucocorticoids and estrogens increase, and then plummet after delivery, producing a transient hypoactivation of the hypothalamic-pituitary axis that can last for weeks to months. Recent studies show some value in estrogen replacement therapy for women at high risk of experiencing PPD. It has also shown to be effective in treatment of Postpartum Psychosis. Consideration must be given to the effect of hormone replacement therapy on breast milk production and increased risk of thromboemboli with this treatment intervention. Progesterone replacement is not recommended and has proven to have a negative effect on mood following delivery (Gjerdingen, 2003).

Individual and/or group psychotherapy in various forms has proven helpful in treating PPD with or without pharmacologic augmentation. Common psychological therapeutic modalities that have been studied with reported success are, Cognitive Behavioral Therapy and Interpersonal Therapy.

Cognitive Behavioral Therapy (CBT), is a well-studied and effective treatment for major depression that endorses the idea that both perceptions and behaviors are intimately

linked to mood. CBT focuses on teaching depressed patients to modify distorted patterns of negative thinking and alter their behavior to enhance coping and reduce distress.

There have been several trials which support measured success in the use of CBT for treating women experiencing PPD (Fitelson, Kim, Baker & Leight, 2011).

Interpersonal Therapy (IPT) is a time-limited treatment for major depression which focuses on the connection between interpersonal problems and mood. IPT frames depression as a medical illness occurring in a social context. The patient and clinician select role transition, role dispute, grief, or interpersonal deficits as a treatment theme. Over the therapeutic course, tools are introduced to assist patients in modifying problematic approaches to relationships and in building better social supports. IPT's time-limited and goal-focused format have proven successful and fit well for a postpartum mother (Fitelson et al, 2011).

Fitelson et al (2011) also found measurable success in reducing the symptoms of PPD through psychosocial interventions such as non-directive counseling and peer support provided by trained clinicians or lay persons. Regardless of the therapeutic treatment modality, either psychologic or psychosocial women involved in some type of therapy exhibited more effective remission of depressive symptoms than those receiving no care or "usual care".

Additional consideration should be given to several small studies which offer limited and conflicting data for recommendation of electroconvulsive therapy, light therapy, Omega 3 fatty-acid supplementation, exercise, acupuncture and massage. As with any mental disorder, these options and the data related to their efficacy needs to be

open for discussion between client and provider should the occasion arise for additional or alternative treatment pathways.

In Chapter 2, Ramona Mercer's Maternal Role Attainment Theory and Lee and Winter's Rural Nursing Theory were introduced for PPD policy application. Factors placing a woman at increased risk of PPD were identified by literature review. The PDPI-R, EPDS, and the PHQ-9 all research proven screening instruments for measuring PPD were detailed for use in policy. Time frames and intervals for PPD screening after delivery were proposed as well as barriers and opportunities that have been identified as components influencing effective screening and treatment. Finally, pharmacological and non-pharmacological evidence-based treatment for PPD were offered for consideration.

Chapter 3 will discuss staff education plans that are critical during the implementation process. Preparing stake holders to educate adult learners and engage them in the process is an important factor in guaranteeing policy sustainability. Also included in this chapter is a discussion about directions for future policy development. Measuring policy outcomes in a variety of settings, with a diverse cultural base will provide additional support for its wide-spread use.

CHAPTER 3

CONCLUSION AND RECOMMENDATIONS

Future DirectionsClinician Education and Implementation

Key to success is the education of clinical staff. The theoretical model for education of clinical staff will be based on adult learning theory as proposed by Malcolm Knowles in the 1970's. Knowles identifies attributes of adult learners as:

- Internally motivated and self-directed.
- Bringing life experiences and knowledge to learning experiences.
- Goal oriented.
- Concerned about relevance.
- Practical.
- Need to feel respected (Queensland Occupational Therapy Fieldwork Collaborative, 2010).

To achieve these key principles in a clinical setting, staff education may utilize the following guidelines suggested by experienced professional trainer Robert Pike:

- Don't talk at participants. Involve them.
- Encourage positive group dynamics. Reform and move students into groups as needed.
- Allow participants to discover data for themselves.
- Ask participants to keep an action or idea list, and revisit it throughout the session.

- Learning is directly proportionate to the amount of fun you have.
- Change the pace. Listening with retention only lasts about 20 minutes at a time.
- Design your class so participants leave impressed with themselves and what they learned.
- Allow adults learners to use their expertise by leaving time to share experiences.
- Don't offer material only one way. Recognize your participants will learn differently.
- Teach the things you have a passion for! (Biech, 2008)

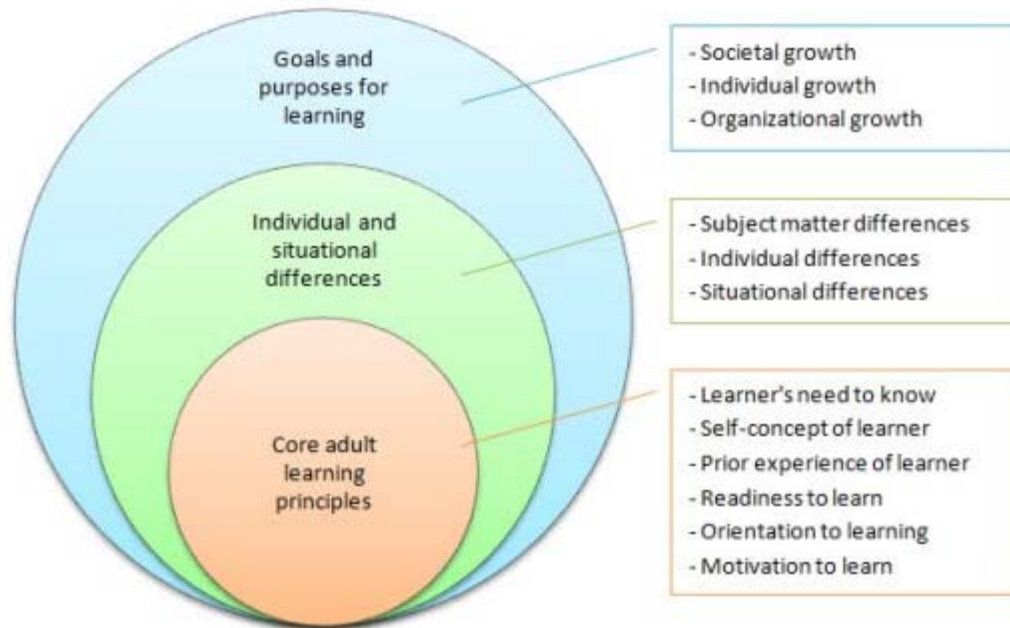


Figure 2. Andragogy in Practice Model, Adapted from the Adult Learner (Knowles, Holton, & Swanson, 2012).

Once clinician education goals have been realized, and defined workflows have been implemented, the policy champion will routinely evaluate policy effectiveness. Any concerns related to timely or appropriate policy functionality or content can be addressed.

Policies created for screening and treatment of PPD will be unsuccessful without adequate and appropriate clinical staff education. A workable format for achieving this goal would proceed as follows: identification of prime stakeholders, preparing staff champion and policy owner, determining dates for policy related staff education and implementation, communicating key dates and implementation strategy with staff, complete clinical staff education including policy process and patient education, educate community and patient population, implement policy workflow, provide ongoing staff support and workflow optimization as needed.

Prospective plans for continued development of screening and treating for PPD would include organizing research to measure policy outcomes. It would also include implementing the policy in clinics treating Native Americans. Two final directions for study would include adjusting PPD screening time intervals or screening methods such as administering the tool via phone or internet.

Conclusion

Postpartum depression has been described as the thief that steals motherhood (Beck, 2002, p.394). The transition to motherhood is fraught with psychosocial as well as physical challenges which carry the potential to create long term ramifications for the entire family. New mothers living in a rural setting are particularly at risk since they are compelled to seek assistance within a chronically underserved healthcare demographic. Less than half of the women experiencing PPD are identified and treated, creating a significant opportunity for notable improvement in care of this population.

Research has identified evidence based screening tools, and treatment methods that can be used to develop care options which will support women with PPD. Policy introduction will include identifying stake holders, selecting a champion, and completing clinician education and engagement. Additionally, reaching out to rural community resources for referral, should the need arise will increase policy success and sustainability. The TRIPPD study outlines clinic workflows and provides tools which have proven to produce measurable positive outcomes for treating postpartum mood disorder at one year post-delivery. A program based on this study includes care coordination provided via a woman's primary care provider. By including Beck's self-scored Postpartum Depression Predictors Inventory-Revised in the policy, conversation about identified risk factors for perinatal depression can be initiated and needed interventions can be put in place prior to delivery. Introducing PPD screening prior to delivery will establish need for continued vigilance and an elevated level of attention once the baby is born. Four to six weeks following birth, routine follow-up appointments at a woman's primary clinic provides an opportune time to revisit screening and initiate appropriate care pathways. This process is attractive in rural communities where it is not unusual for women to travel extensive distances for care. Providing women with depression patient education throughout their pregnancy and informing them of universal screening will normalize uncomfortable or unusual emotions and empower them to seek aid in adjusting to their new role. Perinatal mood disorders are complicated and difficult to study due to a variety of factors. Rural providers have the potential to alter life-long dysfunction by addressing lack of education and having the courage to bring this

crippling process to the forefront of care. Utilizing evidence-based practice as outlined herein when caring for each woman and her family is another opportunity to strengthen the fabric of an entire community.

Appendix A presents the core policy for screening and treatment of PPD. The chapters begin with policy statement and clinical workflow procedure. Also included are policy documents comprised of prenatal assessment and follow-up algorithm, PPD assessment and follow-up algorithm, phone and visit follow-up plan for women identified as at high risk or experiencing PPD, clinical staff follow-up call form, immediate action plan, examples of screening tools indicated for use i.e. PDPI-R, EPDS, PHQ-9. Patient education information and scoring criteria for each tool can be found in Appendix B.

APPENDICES

APPENDIX A

POSTPARTUM DEPRESSION POLICY, SCREENING TOOLS
AND SUPPORTING DOCUMENTS

Policy:**Postpartum Depression- Screening and Referral****Policy Statement:**

Postpartum Depression (PPD) is a debilitating mood disorder affecting up to 10-20% of women and their families any time within the first 12 months following delivery. As high as 80% of women report experiencing some degree of depressed mood during the same time period. This downward spiral consists of anxiety, obsessive thinking, anger, cognitive impairment, isolation, loneliness, feelings of being overwhelmed, guilt, and in extreme cases, thoughts of hurting oneself or newborn (Beck, 2002b). New mothers are unlikely to seek treatment for depression; so many cases remain undiagnosed and untreated despite effective available treatment options (Logsdon, Wisner, & Pinto-Foltz, 2006). Research has proven the most profound indicator placing a woman at risk for PPD is prenatal or earlier episodes of depressive mood dysfunction (Beck, 2001). By initiating the screening process for women at risk of experiencing PPD at routine office visits with an evidenced based tool such as the Postpartum Depression Predictors Inventory-Revised (PDPI-R), it is possible to identify and attempt to mitigate factors which exacerbate the risk of PPD.

Once delivered, implementing a policy to screen all women with research based tools (EPDS, PHQ-9), initiate treatment, provide psychoeducation and follow a proven workflow adapted from the Translating Research into Practice for Postpartum Depression (TRIPPD) study with a new mother's primary provider will address the gap in care which can prove to be devastating for the mother/baby dyad as well as the entire family. This policy contains recommendations supported by evidence of improved outcomes at 12 months postpartum.

Procedure:

1. At a routine office visit, when a woman is approximately 5 months pregnant, the clinician will provide a PDPI-R screening tool and educate her about its use and administration.
2. The Clinician will request she bring her completed tool to the next office visit for review.

3. Results of the PDPI-R are reviewed by clinician with the expectant woman at her next scheduled office visit and workflow recommendations implemented according to Prenatal Screening Flow Chart (attached). Assess for Suicidal Ideation and implement Immediate Action Plan (attached) as needed. See attached flow chart and screening tool.
4. After delivery, prior to visiting with clinician at approximately 4-6 weeks postpartum, new mothers will be provided with either the EPDS/or PHQ-9, as indicated. Women already identified as high risk will complete the PHQ-9. Women not currently identified as at risk will complete the EPDS.
5. Providers will implement Postpartum Screening Flow Chart (attached) and follow recommendations. Assess for Suicidal Ideation and implement Immediate Action Plan (attached) if indicated.

Appendices:

Postpartum Depression Predictors Inventory-Revised

Edinburgh Postnatal Depression Scale

Public Health Questionnaire-9

Prenatal Screening Flow Chart

Postpartum Screening Flowchart

Immediate Action Protocol for Suicidal Ideation

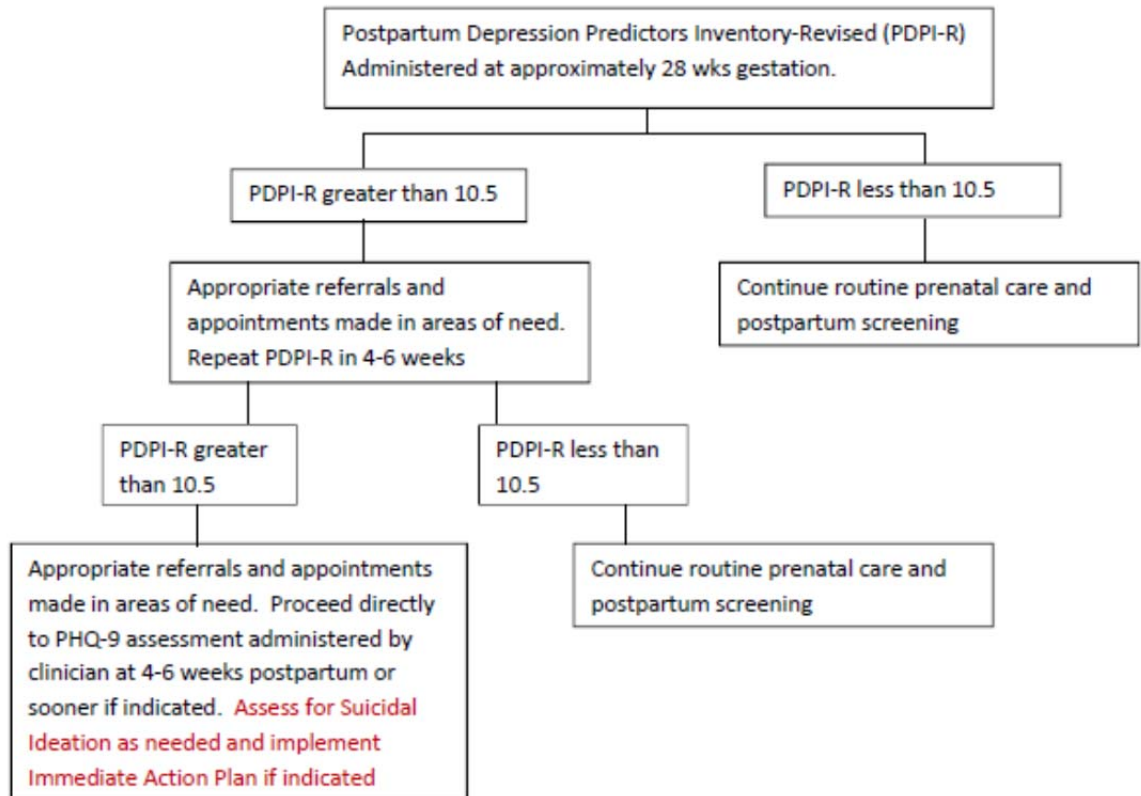
Phone and Office Visit Follow-up Format

Depression Self-Care Action Plan

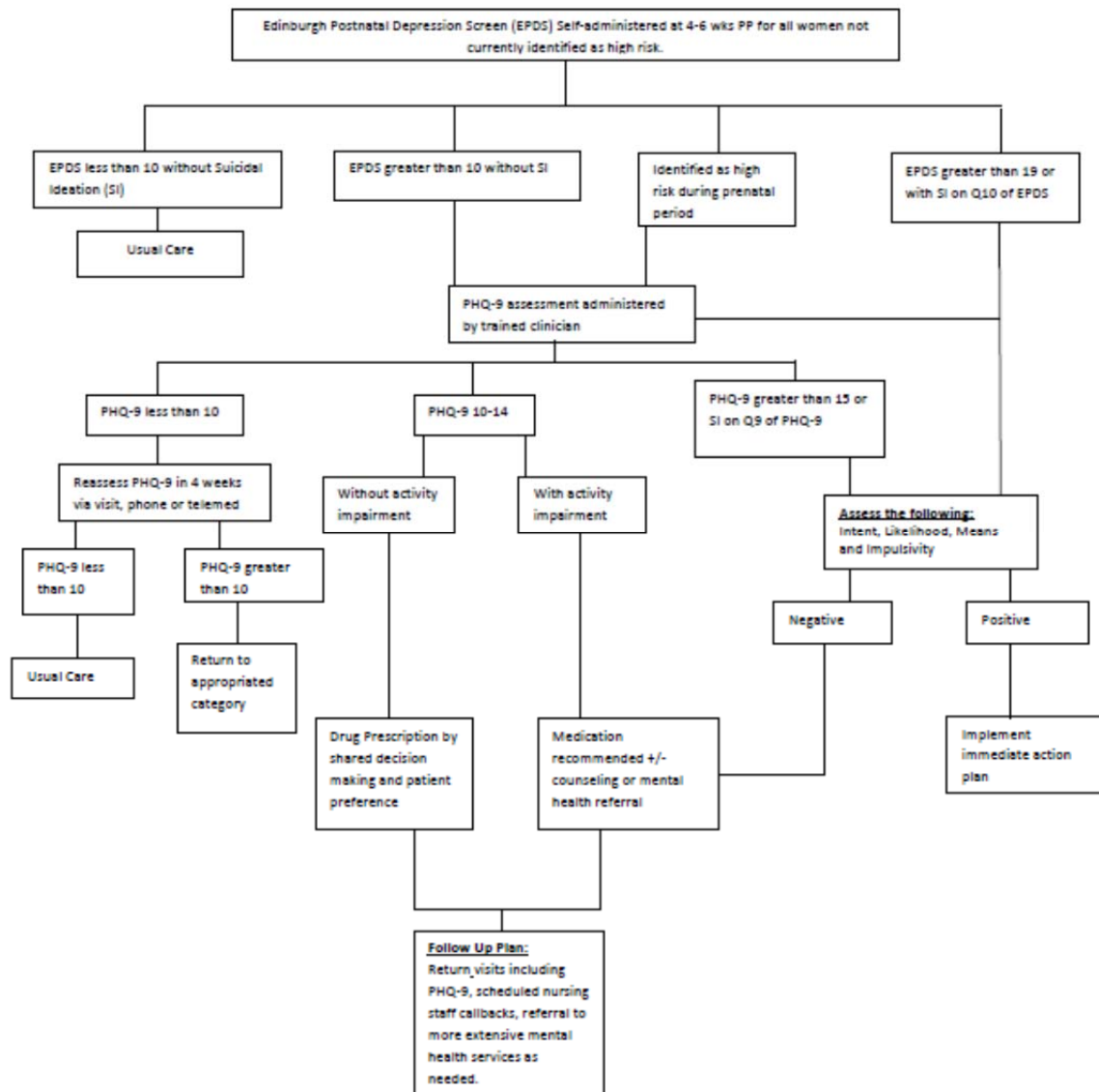
Medication and Paternal Education

Follow-up Call Format

Prenatal Assessment and Follow-up



Postpartum Depression Assessment and Follow-up



(Yawn, et al, 2012)

Phone and Visit Follow-up Plan for Women Identified as Experiencing a Postpartum Mood Disorder

Week 0: Woman diagnosed by postpartum assessment and screening process as experiencing PPD. Plan implemented accordingly and treatment initiated. Depression Self-Care Action Plan, medication education, Educational Hand-outs for both parents provided.

Week 1: Follow-up phone call completed per staff RN

Week2: Follow-up phone call or office visit

Assess Suicide Risk at each visit

During visit assess using the PHQ-9, as well as reviewing medication side effects, adherence and satisfaction.

Week 4: **DOING WELL**

PHQ-9 drops by 4-5 points indicating woman is responding to therapy continue or increase med dose if necessary.

NOT DOING WELL

PHQ-9 has only dropped by 1-3 points indicating the woman is not responding. Check diagnosis/reassess. Increase medication to full therapeutic dose. If at full dose, consider changing medication or mental health referral.

Month 2: Follow-up phone call per RN

Follow-up phone call at 6 weeks

Office visit at 8 weeks to recheck PHQ-9 and review medication side effects, adherence and satisfaction

During visit assess using the PHQ-9, as well as reviewing medication side effects, adherence and satisfaction.

Month 3: **DOING WELL**

PHQ-9 drops to 50% of initial score or to less than 5. She is recovering. Maintain therapy. If PHQ-9 falling, but not at recovery level, modify therapy.

NOT DOING WELL

PHQ-9 is not down to 50% of initial score or to less than 5. Reassess diagnosis. Consider changing medication. Consider Referral. If woman denies referral continue with monthly visits with reassessment utilizing the PHQ-9, review adherence to medication schedule, side effects, and satisfaction.

Month 4: Follow-up phone call per RN

Month 5: Follow-up phone call per RN

Month 6:

Office visit assess with PHQ-9. Check med side effects, adherence, and satisfaction. Assess parenting and relationships. If problems, move to the right side. *If doing well, continue as follows*

If woman is not referred by 6 months continue MONTHLY visits. Follow-up phone calls should be done on any missed visits.

Month7: Follow-up phone call per RN if needed

Month8: Follow-up phone call per RN if needed

Month9:

Office visit assess with PHQ-9. Check med side effects, adherence, and satisfaction. If problems, move to the right side. *If doing well, continue as follows*

Check PHQ-9 at each monthly visit. If scores do not return to less than 5 or 50% lower than original score, referral is recommended.

If PHQ-9 score begins to fall or is less than 5 or 50% lower than initial score, move to left side of sheet.

Month 10: Follow-up phone call per RN if needed

Month 11: Follow-up phone call per RN if needed

Month 12: Office visit to assess readiness to discontinue therapy

Additional visits or phone calls are to made as needed.

(Yawn, et al, 2012)

Immediate Action Plan

Use this action plan with the following:

- a. The EPDS score is greater than 19
- b. The answer to EPDS question #10 (the thought of harming myself has occurred to me) is "sometimes" or "yes, quite often".
- c. The PHQ-9 score is equal to or greater than 15.
- d. The answer to PHQ-9 question #9 (Thoughts that you would be better off dead or of hurting yourself in some way) is greater than "not at all".
- e. Clinical judgment suggests concern about suicide.

First step: Assess suicidal risk:

-This can be done by the primary care physician using the Suicide Risk Assessment Questions below.

OR

-by immediate (same day) referral to a mental health professional who has access to an inpatient psychiatric facility or referral to an emergency department. Establish a verbal "No Suicide Contract" for at least 24 hours. *(Attach local immediate referral resources.)*

Suicide Risk Assessment: Examples of questions.

- a. *Intent-You have said that you think about killing or harming yourself. Have you made any plans?* (Use the answers on the EPDS or PHQ-9 to lead into the first questions.)
- b. *Means-Can you describe your plans? Or How have you thought about killing yourself (your infant)?* (You will want to assess access to weapons, drugs or other methods she has which are concerning)
- c. *Likelihood-Do you think you would actually harm or kill yourself?* (May be especially useful in those who state they think about but would never do it because it would leave their children without a mother or those who report no social support.)
- d. *Impulsivity-Have you ever tried to harm yourself before?* (Identifying factors such as alcoholism, drug use or a history of previous attempts that suggest impulsive behavior or episodes of reduced control.)

If the response to any of these is positive then referral to inpatient management is strongly recommended. Also establish a verbal "No Suicide Contract" for at least 24 hours.

Patient not in the office:

If clinician has a concern about active suicidal thought but the patient is not in the office:

- a. Ask to speak with another adult in the house to alert them to the situation.
- b. If no other person is available in the house and there is an immediate concern, keep the person on the phone and notify another staff member to dial 9-1-1.
- c. Do not hang up!
- d. Dispatch an ambulance/police and stay on the phone until someone arrives at the woman's location.
- e. Establish a "No Suicide Contract" for at least 24 hours.

(Names, addresses and telephone numbers for local referral and support will be attached to this document)

(Yawn, et al, 2012)

Postpartum Depression Predictors Inventory-Revised

During Pregnancy

Marital Status

- | | |
|-------------------------|-----------------------|
| 1. Single | ☐ |
| 2. Married/cohabitating | ☐ |
| 3. Separated | ☐ |
| 4. Divorced | ☐ |
| 5. Partnered | ☐ |

Socioeconomic status

- | | |
|-----------|-----------------------|
| 1. Low | ☐ |
| 2. Middle | ☐ |
| 3. High | ☐ |

Self-esteem

- | | Yes | No |
|---|-----------------------|-----------------------|
| 1. Do you feel good about yourself as a person? | ☐ | ☐ |
| 2. Do you feel worthwhile? | ☐ | ☐ |
| 3. Do you feel you have good qualities as a person? | ☐ | ☐ |

Prenatal Depression

- | | | |
|---|-----------------------|-----------------------|
| 1. Have you ever been depressed during your pregnancy?
(To be reviewed with clinician):
If yes, when and how long have you been feeling this way?
If yes, how mild or severe would you consider your depression? | ☐ | ☐ |
|---|-----------------------|-----------------------|

Prenatal Anxiety

- | | | |
|---|-----------------------|-----------------------|
| 1. Have you been anxious during your pregnancy?
(To be reviewed with clinician):
If yes, how long have you been feeling this way? | ☐ | ☐ |
|---|-----------------------|-----------------------|

Unplanned/unwanted Pregnancy

- | | | |
|--------------------------------|-----------------------|-----------------------|
| 1. Was this pregnancy planned? | ☐ | ☐ |
| 2. Is this pregnancy wanted? | ☐ | ☐ |

History of Previous Depression

- | | | |
|---|-----------------------|-----------------------|
| 1. Before this pregnancy have you ever been depressed?
(If yes, review the following questions with clinician) | ☐ | ☐ |
|---|-----------------------|-----------------------|

If yes, when did you experience this depression?

If yes, were you under a physician's care for this depression?

If yes, did you take medication for this depression?

Social Support

Yes No

- | | | |
|---|-----------------------|-----------------------|
| 1. Do you feel you receive enough emotional support from your partner? | ☐ | ☐ |
| 2. Do you feel you are getting enough help from your partner with chores? | ☐ | ☐ |
| 3. Do you feel you can rely on your partner when you need help? | ☐ | ☐ |
| 4. Do you feel you can confide in your partner? | ☐ | ☐ |
| | | |
| 1. Do you feel you receive enough emotional support from your family? | ☐ | ☐ |
| 2. Do you feel you are getting enough help with chores from your family? | ☐ | ☐ |
| 3. Do you feel you can rely on your family when you need help? | ☐ | ☐ |
| 4. Do you feel you can confide in your family? | ☐ | ☐ |
| | | |
| 1. Do you feel you receive enough emotional support from your friends? | ☐ | ☐ |
| 2. Do you feel you are getting enough help with chores from your friends? | ☐ | ☐ |
| 3. Do you feel you can rely on your friends when you need help? | ☐ | ☐ |
| 4. Do you feel you can confide in your friends? | ☐ | ☐ |

Marital Satisfaction

- | | | |
|--|-----------------------|-----------------------|
| 1. Are you satisfied with your marriage/living arrangement? | ☐ | ☐ |
| 2. Are you currently experiencing any relationship problems? | ☐ | ☐ |
| 3. Are things going well between you and your partner? | ☐ | ☐ |

Life Stress

- | | | |
|---|-----------------------|-----------------------|
| 1. Are you currently experiencing any of the following events in your life: | | |
| Financial problems | ☐ | ☐ |
| Marital problems | ☐ | ☐ |
| Death in the family | ☐ | ☐ |
| Serious illness in the family | ☐ | ☐ |
| Moving | ☐ | ☐ |
| Unemployment | ☐ | ☐ |
| Job change | ☐ | ☐ |

Comments:

Edinburgh Postnatal Depression Scale¹ (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____

Baby's Date of Birth: _____ Phone: _____

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

Here is an example, already completed.

I have felt happy:

- ☐ Yes, all the time
☒ Yes, most of the time This would mean: "I have felt happy most of the time" during the past week.
☐ No, not very often Please complete the other questions in the same way.
☐ No, not at all

In the past 7 days:

- | | |
|--|--|
| <p>1. I have been able to laugh and see the funny side of things</p> <p>☐ As much as I always could</p> <p>☐ Not quite so much now</p> <p>☐ Definitely not so much now</p> <p>☐ Not at all</p> <p>2. I have looked forward with enjoyment to things</p> <p>☐ As much as I ever did</p> <p>☐ Rather less than I used to</p> <p>☐ Definitely less than I used to</p> <p>☐ Hardly at all</p> <p>*3. I have blamed myself unnecessarily when things went wrong</p> <p>☐ Yes, most of the time</p> <p>☐ Yes, some of the time</p> <p>☐ Not very often</p> <p>☐ No, never</p> <p>4. I have been anxious or worried for no good reason</p> <p>☐ No, not at all</p> <p>☐ Hardly ever</p> <p>☐ Yes, sometimes</p> <p>☐ Yes, very often</p> <p>*5. I have felt scared or panicky for no very good reason</p> <p>☐ Yes, quite a lot</p> <p>☐ Yes, sometimes</p> <p>☐ No, not much</p> <p>☐ No, not at all</p> | <p>*6. Things have been getting on top of me</p> <p>☐ Yes, most of the time I haven't been able to cope at all</p> <p>☐ Yes, sometimes I haven't been coping as well as usual</p> <p>☐ No, most of the time I have coped quite well</p> <p>☐ No, I have been coping as well as ever</p> <p>*7. I have been so unhappy that I have had difficulty sleeping</p> <p>☐ Yes, most of the time</p> <p>☐ Yes, sometimes</p> <p>☐ Not very often</p> <p>☐ No, not at all</p> <p>*8. I have felt sad or miserable</p> <p>☐ Yes, most of the time</p> <p>☐ Yes, quite often</p> <p>☐ Not very often</p> <p>☐ No, not at all</p> <p>*9. I have been so unhappy that I have been crying</p> <p>☐ Yes, most of the time</p> <p>☐ Yes, quite often</p> <p>☐ Only occasionally</p> <p>☐ No, never</p> <p>*10. The thought of harming myself has occurred to me</p> <p>☐ Yes, quite often</p> <p>☐ Sometimes</p> <p>☐ Hardly ever</p> <p>☐ Never</p> |
|--|--|

Administered/Reviewed by _____ Date _____

¹Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

²Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered
by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____
=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your
work, take care of things at home, or get along with other people?

Not difficult at all ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐
---	---	---	--

APPENDIX B

POSTPARTUM DEPRESSION POLICY SCREENING TOOL
SCORING AND PATIENT EDUCATION INFORMATION

TABLE 2
Scoring Directions for the Postpartum Depression Predictors Inventory-Revised

<i>Prenatal Version</i>	<i>Assigning Scores</i>	<i>Total Possible Score Per Item</i>	<i>Total Possible Score Per Predictor Group</i>	<i>Total^a</i>
Marital status	Range = 0-1		1	1
Single, married, separated, divorced, widowed, partnered	Married/partnered = 0; all single status = 1	1		
SES	Range = 0-1		1	2
Low, middle, high	Middle or high = 0; low = 1	1		
Self-esteem	Range = 0-3		3	5
Do you feel good about yourself	Yes = 0; no = 1	1		
Do you feel worthwhile	Yes = 0; no = 1	1		
Do you have good qualities	Yes = 0; no = 1	1		
Prenatal depression	Range = 0-1		1	6
Have you felt depressed during your pregnancy	No = 0; yes = 1	1		
If yes, when and how long	Not used			
If yes, how mild or severe	Not used			
Prenatal anxiety	Range = 0-1		1	7
Have you been feeling anxious during your pregnancy	No = 0; yes = 1	1		
If yes, how long	Not used			
Unplanned/unwanted pregnancy	Range = 0-2		2	9
Was the pregnancy planned	Yes = 0; no = 1	1		
Was the pregnancy unwanted	No = 0; yes = 1	1		
History of depression	Range = 0-1		1	10
Before this pregnancy, have you ever been depressed	No = 0; yes = 1	1		
If yes, when did you experience this depression	Not used			
If yes, have you been under the care of an MD	Not used			
If yes, did the MD prescribe medication	Not used			
Social support	Range = 0-4 for each area of partner, family, and friends		4	22
Partner				
Do you believe that you receive adequate emotional support from your partner	Yes = 0; no = 1	1		
Do you believe that you can confide in your partner	Yes = 0; no = 1	1		
	Above two items = partner affective support			
Do you believe that you can rely on your partner	Yes = 0; no = 1	1		
Do you believe that you receive adequate instrumental support from your partner	Yes = 0; no = 1	1		
	Above two items = partner instrumental support			

(continued)

TABLE 2
(Continued)

<i>Prenatal Version</i>	<i>Assigning Scores</i>	<i>Total Possible Score Per Item</i>	<i>Total Possible Score Per Predictor Group</i>	<i>Total^a</i>
Family			4	
Do you believe that you receive adequate emotional support from your family	Yes = 0; no = 1	1		
Do you believe that you can confide in your family	Yes = 0; no = 1	1		
	Above two items = family affective support			
Do you believe that you can rely on your family	Yes = 0; no = 1	1		
Do you believe that you receive adequate instrumental support from your family	Yes = 0; no = 1	1		
	Above two items = family instrumental support			
Friends			4	
Do you believe that you receive adequate emotional support from you friends	Yes = 0; no = 1	1		
Do you believe that you can confide in your friends	Yes = 0; no = 1	1		
	Above two items = friend affective support			
Do you believe that you can rely on your friends	Yes = 0; no = 1	1		
Do you believe that you receive adequate instrumental support from your friends	Yes = 0; no = 1	1		
	Above two items = friend instrumental support			
Marital/partner satisfaction	Range = 0-3		3	25
Are you satisfied with your marriage or living arrangement	Yes = 0; no = 1	1		
Are you currently experiencing any marital/relationship problems	No = 0; yes = 1	1		
Are things going well between you and your partner	Yes = 0; no = 1	1		
Life stress	Range = 0-7		7	32
Are you currently experiencing any stressful events in your life such as				
Financial problems	No = 0; yes = 1	1		
Marital problems	No = 0; yes = 1	1		
Death in family	No = 0; yes = 1	1		
Unemployment	No = 0; yes = 1	1		
Serious illness in family	No = 0; yes = 1	1		
Moving	No = 0; yes = 1	1		
Job change	No = 0; yes = 1	1		

(continued)

INSTRUCTION MANUAL

Instructions for Patient Health Questionnaire (PHQ) and GAD-7 Measures

<u>TOPIC</u>	<u>PAGES</u>
Background	1
Coding and Scoring	2, 4, 5
Versions	3
Use as Severity and Outcome Measures	6-7
Translations	7
Website and Other Issues	8
Selected References	9

BACKGROUND

The Primary Care Evaluation of Mental Disorders (PRIME-MD) was an instrument developed and validated in the early 1990s to efficiently diagnose five of the most common types of mental disorders presenting in medical populations: depressive, anxiety, somatoform, alcohol, and eating disorders.[1] Patients first completed a one-page 27-item screener and, for those disorders for which they screened positive, were asked additional questions by the clinician using a structured interview guide. However, this 2-stage process took an average of 5-6 minutes of clinician time in patients without a mental disorder diagnosis and 11-12 minutes in patients with a diagnosis. This proved to be a barrier to use given the competing demands in busy clinical practice settings.

Therefore, in two large studies enrolling 6000 patients (3000 from general internal medicine and family practice clinics and 3000 from obstetrics-gynecology clinics), a self-administered version of the PRIME-MD called the Patient Health Questionnaire (PHQ) was developed and validated.[2,3] In the past decade, the PHQ in general and the PHQ-9 depression scale in particular [4-6] have gained increasing use in both research and practice. The original PRIME-MD is now largely of historical interest and seldom used except in a few types of research studies.

Given the popularity of the PHQ-9 for assessing and monitoring depression severity, a new 7-item anxiety scale using a response set similar to the PHQ-9 was initially developed to diagnose generalized anxiety disorder (hence its name, the GAD-7) and validated in 2740 primary care patients.[7] Though originally developed to diagnose generalized anxiety disorder, the GAD-7 also proved to have good sensitivity and specificity as a screener for panic, social anxiety, and post-traumatic stress disorder.[8] Finally, the PHQ-15 was derived from the original PHQ studies and is increasingly used to assess somatic symptom severity and the potential presence of somatization and somatoform disorders.[9]

Each PHQ module can be used alone (e.g. the PHQ-9 if depression is the condition of interest), together with other modules, or as part of the full PHQ. Also, alternative or abbreviated versions of the PHQ-9 and GAD-7 are sometimes used in certain screening or research settings [10-14]. Although the PHQ was originally developed to detect five disorders, the depression, anxiety, and somatoform modules (in that order) have turned out to be the most popular.[10] Also, most primary care patients with depressive or anxiety disorders present with somatic complaints and co-occurrence of somatic, anxiety, and depressive symptoms (the SAD triad) is exceptionally common. This is the rationale behind the PHQ-SADS screener.[15] The most commonly used versions of the PHQ scales are summarized in Table 1, page 3.

CODING AND SCORING

The full PHQ, Brief PHQ, and PHQ for Adolescents (PHQ-A) can be used to establish provisional diagnoses for selected DSM-IV disorders. The diagnostic algorithm for the PHQ modules are included in footers at the bottom of each page of the PHQ, and also reiterated in Table 2, page 4. The other measures are principally used to derive severity scores (PHQ-9 and PHQ-8 for depressive symptom severity; GAD-7 for anxiety symptom severity; PHQ-15 for somatic symptom severity) or as ultra-brief screeners (PHQ-2, GAD-2, PHQ-4). An example in which the PHQ depression module can be used as both a diagnostic module as well as a depression severity score (PHQ-9 score) is shown in Table 3, page 5.

Over time, the severity scores have been a particularly popular use of the measures, and are now used much more commonly than the provisional diagnoses. For example, cutpoints of 5, 10, and 15 represent mild, moderate, and severe levels of depressive, anxiety, and somatic symptoms, on the PHQ-9, GAD-7, and PHQ-15 respectively. Also, a cutpoint of 10 or greater is considered a "yellow flag" on all 3 measures (i.e., drawing attention to a possible clinically significant condition), while a cutpoint of 15 is a "red flag" on all 3 measures (i.e., targeting individuals in whom active treatment is probably warranted). For the ultra-brief measures (PHQ-2 and GAD-2), a score of 3 or greater should prompt administration of the full PHQ-9 and/or GAD-7, as well as a clinical interview to determine whether a mental disorder is present.

The final question on the PHQ (and some of its abbreviated versions) asks the patients to report "how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?" This single patient-rated difficulty item is not used in calculating any PHQ score or diagnosis but rather represents the patient's global impression of symptom-related impairment. It may be useful in decisions regarding initiation of or adjustments to treatment since it is strongly associated with both psychiatric symptom severity as well as multiple measures of impairment and health-related quality of life.

A particularly important question is how to assess suicide risk in individuals who answer positively to the 9th question of the PHQ-9. A four-item screener has been developed that may assist in positive responses to this 9th question [16], although a final decision about the actual risk of self-harm requires a clinical interview.

Table 1. Versions: Patient Health Questionnaire (PHQ) Family of Measures

Measure	Description	Scoring	References
Core			
PRIME-MD	Predecessor of PHQ, now mainly of historical interest.	Combined self-administered patient screener with clinician follow-up questions.	1
PHQ	Five modules covering 5 common types of mental disorders: depression, anxiety, somatoform, alcohol, and eating.	Selected (but provisional) DSM-IV diagnoses for all types of disorders except somatoform.	2, 3
PHQ-9	Depression scale from PHQ.	Nine items, each of which is scored 0 to 3, providing a 0 to 27 severity score.	1, 4, 5, 6, 10
GAD-7	Anxiety measure developed after PHQ but incorporated into PHQ-SADS.	Seven items, each of which is scored 0 to 3, providing a 0 to 21 severity score.	7, 8, 10
PHQ-15	Somatic symptom scale from PHQ.	Fifteen items, each of which is scored 0 to 2, providing a 0 to 30 severity score.	9, 10
PHQ-SADS	PHQ-9, GAD-7, and PHQ-15 measures, plus panic measure from original PHQ.	See scoring for these scales above.	10
Variants			
Brief PHQ	PHQ-9 and panic measures from original PHQ plus items on stressors and women's health.	See scoring for PHQ above. Stressor and women's health items are not diagnostic or scored.	3
PHQ-A	Substantially modified version of PHQ developed for use in adolescents. Moderate data exists for validity but much less than for original PHQ.	Diagnostic scoring described in manual, available upon request.	11
PHQ-2	First 2 items of PHQ-9. Ultra-brief depression screener.	Two items scored 0 to 3 (total score of 0-6)	10, 12
GAD-2	First 2 items of GAD-7. Ultra-brief anxiety screener.	Two items scored 0 to 3 (total score of 0-6)	8, 10, 12
PHQ-4	PHQ-2 and GAD-2.	See PHQ-2 and GAD-2 above.	10, 12, 13
PHQ-8	All items of PHQ-9 except the 9 th item on self-harm. Mainly used in non-depression research studies.	Eight items, each of which is scored 0 to 3, providing a 0 to 24 severity score.	5, 10, 14

Table 2. Diagnostic Algorithms for the PHQ

Page 1
Somatoform Disorder if at least 3 of #1a-m bother the patient "a lot" and lack an adequate biological explanation. Major Depressive Syndrome if #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all) . Other Depressive Syndrome if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all). <i>Note:</i> the diagnoses of Major Depressive <u>Disorder</u> and Other Depressive <u>Disorder</u> requires ruling out normal bereavement (mild symptoms, duration less than 2 months), a history of a manic episode (Bipolar Disorder) and a physical disorder, medication or other drug as the biological cause of the depressive symptoms.
Page 2
Panic Syndrome if #3a-d are all 'YES' and 4 or more of #4a-k are 'YES'. Other Anxiety Syndrome if #5a and answers to three or more of #5b-g are "More than half the days". <i>Note:</i> The diagnoses of Panic <u>Disorder</u> and Other Anxiety <u>Disorder</u> require ruling out a physical disorder, medication or other drug as the biological cause of the anxiety symptoms.
Page 3
Bulimia Nervosa if #6a,b, and c and #8 are 'YES'; Binge Eating Disorder the same but #8 is either 'NO' or left blank. Alcohol abuse if any of #10a-e are "YES".

Additional Clinical Considerations. After making a provisional diagnosis with the PHQ, there are additional clinical considerations that may affect decisions about management and treatment.

- Have current symptoms been triggered by psychosocial stressor(s)?
- What is the duration of the current disturbance and has the patient received any treatment for it?
- To what extent are the patient's symptoms impairing his or her usual work and activities?
- Is there a history of similar episodes, and were they treated?
- Is there a family history of similar conditions?

Table 3. Example of PHQ Depression Module for both Diagnostic and Severity Purposes

Patient: A 43-year-old woman who looks sad and complains of fatigue for the past month.

2. Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following:	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
a. Little interest or pleasure in doing things?.....	☐	☐	☐	☒
b. Feeling down, depressed, or hopeless?.....	☐	☒	☐	☐
c. Trouble falling or staying asleep, or sleeping too much?.....	☐	☐	☒	☐
d. Feeling tired or having little energy?.....	☐	☐	☐	☒
e. Poor appetite or overeating?.....	☐	☒	☐	☐
f. Feeling bad about yourself—or that you are a failure or have let yourself or your family down?.....	☐	☐	☒	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television?	☐	☐	☐	☒
h. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?.....	☒	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way?	☐	☒	☐	☐

FOR OFFICE CODING: Maj Dep Syn if #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all) . Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all).

Major Depressive Disorder Diagnosis. The criteria for Major Depressive Syndrome are met since she checked #2a "nearly every day" and five of items #2a to i were checked "more than half the days" or "nearly every day". Note that #2i, suicidal ideation, is counted whenever it is present.

In this case, the diagnosis of Major Depressive Disorder (not Syndrome) was made since questioning by the physician indicated no history of a manic episode; no evidence that a physical disorder, medication, or other drug caused the depression; and no indication that the depressive symptoms were normal bereavement. Questioning about the suicidal ideation indicated no significant suicidal potential.

PHQ-9 Depression Severity. This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively. PHQ-9 total score for the nine items ranges from 0 to 27. In the above case, the PHQ-9 depression severity score is 16 (3 items scored 1, 2 items scored 2, and 3 items scored 3). Scores of 5, 10, 15, and 20 represent cutpoints for mild, moderate, moderately severe and severe depression, respectively. Sensitivity to change has also been confirmed.

USE OF SOME SCREENERS AS SEVERITY AND OUTCOME MEASURES

PHQ-9 Depression Severity. This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively. PHQ-9 total score for the nine items ranges from 0 to 27. In the above case (see table 3, page 5), the PHQ-9 depression severity score is 16 (3 items scored 1, 2 items scored 2, and 3 items scored 3). Scores of 5, 10, 15, and 20 represent cutpoints for mild, moderate, moderately severe and severe depression, respectively. Sensitivity to change has also been confirmed. The PHQ-8 is scored just like the PHQ-9 and its total score ranges from 0 to 24. Cutpoints on the PHQ-8 are identical to the PHQ-9.

GAD-7 Anxiety Severity. This is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively. GAD-7 total score for the seven items ranges from 0 to 21. Scores of 5, 10, and 15 represent cutpoints for mild, moderate, and severe anxiety, respectively. Though designed primarily as a screening and severity measure for generalized anxiety disorder, the GAD-7 also has moderately good operating characteristics for three other common anxiety disorders – panic disorder, social anxiety disorder, and post-traumatic stress disorder. When screening for anxiety disorders, a recommended cutpoint for further evaluation is a score of 10 or greater.

PHQ-2 and GAD-2 Severity. These consist of the first two items of the PHQ-9 and GAD-7 respectively, and constitute the two core DSM-IV items for major depressive disorder and generalized anxiety disorder, respectively. Each ranges from a score of 0 to 6. The operating characteristics of these ultra-brief measures are quite good; the recommended cutpoints for each when used as screeners is a score of 3 or greater. When used together, they are referred to as the PHQ-4 a 4-item screening measure which ranges from a score of 0 to 12, and serves as a good measure of "caseness" (i.e., the higher the score, the more likely there is an underlying depressive or anxiety disorder). In particular, the PHQ-2 and GAD-2 subscores of the PHQ-4 provide separate depressive and anxiety scores, and can be used as screeners for depression and anxiety.

PHQ-15 Somatic Symptom Severity. This is calculated by assigning scores of 0, 1, and 2 to the response categories of "not at all", "bothered a little", and "bothered a lot", for the 13 somatic symptoms of the PHQ (items 1a-1m). Also, 2 items from the depression module (sleep and tired) are scored 0 ("not at all"), 1 ("several days") or 2 ("more than half the days" or "nearly every day"). Thus, a PHQ-15 score can be derived from page 1 of the PHQ, or from separate administration of the PHQ-15 scale or the PHQ-SADS. PHQ-15 scores of 5, 10, and 15 represent cutpoints for low, medium, and high somatic symptom severity, respectively.

Sensitivity to Change for Monitoring Treatment Outcomes. A particularly important use of a measure is its responsiveness to changes of condition severity over time. This is well-established for the PHQ-9 which is increasingly used as a measure to assess the level of depression severity (for initial treatment decisions) as well as an outcome tool (to determine treatment response).[6,10] An example of how different PHQ-9 severity levels might guide treatment is shown in Table 4, page 7. There is preliminary evidence that the PHQ-15 may be responsive to changes as individuals with somatoform disorders or high somatization are treated.[10] The GAD-7 has demonstrated change as a secondary anxiety outcome in several depression trials, but has not yet been studied as a primary outcome in anxiety trials. Also, since there is more diagnostic splitting for anxiety than for depressive disorders, it remains to be determined whether a single anxiety measure can suffice as an outcome measure. It is likely the GAD-7 will be useful but not yet certain it will be sufficient.

Psychometrics. The psychometrics of the PHQ and its component scales are described in the validation articles for specific measures (see Selected References on page 9) and are summarized in a review article on the PHQ-9, GAD-7, and PHQ-15.[10]

Table 4. PHQ-9 Scores and Proposed Treatment Actions *

PHQ-9 Score	Depression Severity	Proposed Treatment Actions
0 – 4	None-minimal	None
5 – 9	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10 – 14	Moderate	Treatment plan, considering counseling, follow-up and/or pharmacotherapy
15 – 19	Moderately Severe	Active treatment with pharmacotherapy and/or psychotherapy
20 – 27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

* From Kroenke K, Spitzer RL, *Psychiatric Annals* 2002;32:509-521

TRANSLATIONS

There are numerous translations of the PHQ as well as the PHQ-9 and GAD-7 available in many languages, which are freely downloadable on the PHQ website (www.phqscreeners.com). The abbreviated versions of these measures – PHQ-8, PHQ-2, GAD-2, and PHQ-4 – can simply be derived from the translations by selecting the relevant items (see Table 1, page 3). The PHQ-15 can also be simply derived by selecting the 13 somatic items (1a-1m), plus the *sleep* and *tired* items (2c and 2c) from the PHQ translations.

Many of the translations have been developed by the MAPI Research Institute using an internationally accepted translation methodology. Thus, most of the translations are linguistically valid. However, unlike the English versions of the PHQ and GAD-7, few of the translations have been psychometrically validated against an independent structured psychiatric interview.

If a translation is not available for a language you are interested in using, and you have the interest and resources to develop a linguistically valid translation, please send an e-mail to questions@phqscreeners.com for instructions on how to proceed. One requirement is that we are provided a copy of the final translation as well as a description of the translation methodology.

WEBSITE

Copies of the PHQ family of measures, including the GAD-7, are available at the website:

www.phqscreeners.com

Also, translations, a bibliography, an instruction manual, and other information is provided on this website.

QUESTIONS NOT ADDRESSED IN THIS INSTRUCTION DOCUMENT

For further questions, please send an e-mail to questions@phqscreeners.com

QUESTIONS REGARDING DEVELOPMENT, ACKNOWLEDGMENTS AND USE

The PHQ family of measures (see Table 1, page 3), including abbreviated and alternative versions as well as the GAD-7, were developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

All of the measures included in Table 1 are in the public domain. No permission is required to reproduce, translate, display or distribute.

Depression Self-Care Action Plan

Patient: _____

Provider: _____

Clinic: _____

Phone Number: _____



Depression is treatable!

1. Stay physically active.

Make sure you make time to address your basic physical needs, for example, walking for a certain amount of time each day.



Every day during the next week, I will spend at least _____ minutes (make it easy, reasonable) doing _____.

2. Make time for pleasurable activities.

Even though you may not feel as motivated, or get the same amount of pleasure as you used to, commit to scheduling some fun activity each day – for example, doing a hobby, listening to music, or watching a video.



Every day during the next week, I will spend at least _____ minutes (make it easy, reasonable) doing _____.

3. Spend time with people who can support you.

It's easy to avoid contact with people when you're depressed, but you need the support of friend and loved ones. Explain to them how you feel, if you can. If you can't talk about it, that's OK – just ask them to be with you, maybe accompanying you on one of your activities.



During the next week, I will make contact for at least _____ minutes (make it easy, reasonable, with

_____ (name) doing/talking about _____.

_____ (name) doing/talking about _____.

_____ (name) doing/talking about _____.

4. Practice relaxing.

For many people, the changes that come with depression – no longer keeping up with our usual activities and responsibilities, feeling increasingly sad and hopeless – leads to anxiety. Since physical relaxation can lead to mental relaxation, practicing relaxing is another way to help yourself. Try deep breathing, or a warm bath, or just finding a quiet, comfortable, peaceful place and saying comforting things to yourself (like "It's OK.")



Every day during the next week, I will practice physical relaxation at least _____ times, for at least _____ minutes each time. (make it easy, reasonable)

5. Simple goals and small steps.

It's easy to feel overwhelmed when you're depressed. Some problems and decisions can be delayed, but others cannot. It can be hard to deal with them when you're feeling sad, have little energy, and not thinking clearly. Try breaking things down in to small steps. Give yourself credit for each step you accomplish.



The problem is _____

My goal is _____

Step 1: _____

Step 2: _____

Step 3: _____

How likely are you to follow through with these activities prior to your next visit?

Not Likely 1 2 3 4 5 6 7 8 9 10 Very Likely



Things you should know about your antidepressant medication



Your antidepressant medication is
NOT ADDICTIVE OR HABIT FORMING.

They are **NOT** uppers; they are **NOT** downers.

It is safe for you to take according to your provider's orders.

If you are using alcohol or other drugs, please discuss this with your PCP.



Did you know? Antidepressants only work if taken every day!

Target symptoms for antidepressant medications are:



- Sleep
- Appetite
- Concentration
- Mood
- Energy

It takes time for your medication to work.
Most people begin to feel better in **2–4 weeks**.
Don't give up if you don't feel better right away.



Let's talk about side effects:

Always ask your pharmacist for a printout of side effects for your medications. List any side effects you are having:

1).

2).

3).

The first week is the hardest.

Some people have mild side effects, but they don't feel the medicine working yet.

Try to stick it out.

The side effects usually go away in a few days, and the medicine will start to work.



If you are thinking about stopping your medication, **CALL YOUR PROVIDER FIRST.**



IMPORTANT things for YOU to do:

- Keep all appointments
- Take all medication exactly as your PCP prescribes – even if you feel better.
- TALK TO YOUR PROVIDER – ask questions; tell how you feel
- If you forget a dose DO NOT DOUBLE DOSE – take your next dose at the regular time.

Stop taking your medication and call the clinic if any of the following happen:



- Rash
- Severe side effects



Provider Name: _____

Provider Telephone #: _____

Information for Fathers & Partners



The postpartum adjustment for all family members is often an overwhelming and confusing experience. Though a happy and joyful event, the welcoming of a newborn into your family, may also be a source of stress and anxiety during this time.

You may be the first one to recognize that your partner is exhibiting signs of a Postpartum Anxiety or Depression (PPD), and you will become her life-line toward treatment and support. PPD often inhibits the mothers' ability to care for herself and the baby. She has no control over her self-doubts, fears and emotional upset. You will need to provide the family leadership for

the baby's and mother's health and safety.

Help is available through your family physician, the doctor who delivered your baby, or the baby's doctor. Reach out and ask for help. Resources are also available on our Postpartum Depression website. It may take some time for the combination of medication and psychotherapy to work effectively to control the symptoms of Postpartum Anxiety and Depression.



Here is what you can do to help your partner until she feels like herself again:

- BE EMPATHIC – Show love and compassion, not anger or impatience.
- BE NON-JUDGEMENTAL – Reassure, don't criticize.
- BE OBSERVANT – Report what you observe to the doctors and nurses.
- BE AWARE – Of your partner's concerns and feelings.
- BE AVAILABLE – Be present and actively involved with your newborn.
- BE PATIENT – This will go away. It will get better.
- BE COLLABORATIVE – Work with our resources toward shared goals.
- BE A FATHER – Active interest and participation prevents isolation.

The leadership you provide for your family during this difficult adjustment will empower all of you toward health, happiness, and strong family relationships.



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