



Original article

Examining the Screening Practices of Physicians for Postpartum Depression: Implications for Improving Health Outcomes



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A B S T R A C T

Purpose: Postpartum depression (PPD), the most common complication of childbirth, remains largely undetected by providers. Pediatricians, obstetricians/gynecologists, and family practitioners have a responsibility to identify PPD as the condition has long-term adverse effects on their patients.

Methods: Using PubMed and Psycinfo databases, this review explores and summarizes studies on the screening practices of physicians.

Findings: The prevalence and method of screening their patients for PPD was low and variable among the three types of physicians. Pediatricians were the least likely to screen compared with obstetricians/gynecologists and family practitioners. However, the majority of all physicians felt it was within their professional purview to screen for PPD and were willing to learn more about PPD detection.

Conclusions: Screening rates can increase if physicians are educated about PPD and trained on the ease of routinely using a validated tool to identify PPD. This is critical, because more detection can lead to improved access to treatment, and the long-term detrimental impact that untreated PPD has on a mother and her children might be mitigated.

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Postpartum depression (PPD) is an affective mood disorder occurring within the first year after childbirth (Santoro & Peabody, 2010). PPD, the most common complication of childbearing, is problematic because it impedes maternal–infant interactions, leading to weak attachment, developmental issues, and poor socialization in affected children with effects lasting into their early adulthood (Boyd, Zayas, & McKee, 2006; Field, 2010; Santoro & Peabody, 2010; Tandon, Cluxton-Keller, Leis, Le, & Perry, 2012; Vigod, Villegas, Dennis, & Ross, 2010; Zimmer & Minkovitz, 2003). PPD also puts the mother at greater risk for

suicide and recurrent depressive episodes (Santoro & Peabody, 2010; Tandon et al., 2012; Vigod et al., 2010). Once recognized, the deleterious effects of PPD can be mitigated with pharmaceutical and/or specific types of psychotherapy that reduce parenting stress and improve the mother–infant interaction, such as child–parent psychotherapy and home-based early intervention programs, have demonstrated positive outcomes (Earls, 2010; Field, 2010; Horowitz & Goodman, 2005).

Although exact estimates of prevalence are unknown, it is generally accepted that 10% to 20% of women develop depressive symptoms after childbirth (Santoro & Peabody, 2010). Prevalence rates of postpartum depressive symptoms have been found to be higher among women who are low-income, African American, Hispanic, first-time mothers, teenage mothers, and/or experienced a high-risk birth (e.g., low birthweight or preterm birth), with rates ranging from 21% to 60% (Table 1).

The strongest predictors of, and also risk factors for, PPD are having previously experienced PPD, having anxiety or depression before or during pregnancy, and being low income (Beeghly

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Table 1
Postpartum Depression Prevalence Data by Race, Ethnicity, and Income

Population with Postpartum Depressive Symptoms	Rate (%)	Sources
National estimate	10–20	Santoro & Peabody, 2010
National sample; predominately well-educated, partnered, high SES	16.1	Goodman & Tyer-Viola, 2010
Nationally representative sample	9.5	Witt et al., 2011
Subpopulation data		
Low-income and teenage mothers	40–60	Earls, 2010
Urban, poor, predominately Black or Hispanic	27–56	Chaudron, 2004; Chaudron, 2010
Low-income mothers	28–51	Boury et al., 2004; Segre et al., 2007
Experienced a high-risk birth	23–48	Northrup et al., 2013; Vigod et al., 2010
Low-income African American	39.1	Tandon et al., 2012
Primarily White and on Medicaid	35.4	Evins, Theofrastous, & Galvin, 2000
Low-income, predominantly Hispanic	35	Gress-Smith et al., 2012
African Americans	20–35	Beeghly et al., 2003; Segre et al., 2007; Tandon et al., 2012
Tri-racial, bi-ethnic sample (52% Native Americans, 24% African Americans, 14% Hispanic, 9% White, 1% other)	25*	Wei et al., 2008

* Racial differences existed, but were not significant.

et al., 2003; Boyd et al. 2006; Northrup, Evans, & Stotts, 2013; Santoro & Peabody, 2010; Segre, O'Hara, Arndt, & Stuart, 2007; Vigod et al., 2010; Wei et al., 2008; Witt et al., 2011). Other risk factors and predictors of PPD include a family history of depression, substance abuse, adolescence, lacking social support, race (African Americans and Hispanics), and experiencing stressful life events that impact caregiving, such as living in a crime-ridden neighborhood (Beeghly et al., 2003; Boury, Larkin, & Krummel, 2004; Boyd et al., 2006; Chaudron, Szilagyi, Kitzman, Wakins, & Conwell, 2004; Chaudron et al., 2010; Earls, 2010; Gold, Singh, Marcus, & Palladino, 2012; Gress-Smith, Luecken, Lemery-Chalfant, & Howe, 2012; Northrup et al., 2013; Santoro & Peabody, 2010; Segre et al., 2007; Tandon et al., 2012; Vigod et al., 2010; Witt et al., 2011).

Precise screening rates for PPD are unknown. Tandon et al. (2012) estimate that only a small percentage of perinatal women are screened, whereas others (Gjerdingen & Yawn, 2007; Thurgood, Avery, & Williamson, 2010) estimate that less than one-half of all cases of PPD are identified. With more than 400,000 infants born annually to mothers who are depressed, Earls (2010, p. 1032) calls perinatal depression “the most underdiagnosed obstetric complication in America.”

Several screening tools have been developed to aid in the detection of PPD in which a positive screen warrants a more in-depth evaluation of PPD (Liberto, 2012). Table 2 is from the American College of Obstetricians and Gynecologists (ACOG) committee opinion number 630 on screening for depression during and after pregnancy and summarizes the different PPD screening tools available (ACOG, 2015). The Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden, & Sagovsky, 1987) and the Postpartum Depression Screening Scale (PDSS; Beck & Gable, 2000) were developed specifically for detecting depression in the postpartum period, whereas the other tools measure depressive symptoms in the general population (Boyd, Le, & Somberg, 2005). The EPDS, PDSS, and Beck Depression Inventory II traditional cut-off scores can accurately identify PPD in urban, low-income women, but the optimal score for PPD detection is slightly different and should be noted when using these tools in this particular patient population (Chaudron et al., 2010).

The postpartum period is a vulnerable time for mental illness to develop, but also presents a time of increased interaction with health care providers through an uptake in health services primarily via postpartum and well-child visits (ACOG, 2015; Boyd et al., 2006; Horwitz et al., 2007; Kozhimannil, Trinacty, Busch,

Huskamp, & Adam, 2011; Leddy, Haaga, Gray, & Schulkin, 2011; Leiferman, Dauber, Heisler, & Paulson, 2008, 2010). Most women have at least eight interactions with their child's pediatrician during the child's first 2 years of life (Liberto, 2012), and it falls within pediatricians' professional purview to screen for PPD because of the long-lasting adverse effects PPD has on children (Zimmer & Minkovitz, 2003). Obstetricians/gynecologists (OB/GYNs) and family practitioners also have a vested interest in their postpartum patients' mental well-being (ACOG, 2015; Santoro & Peabody, 2010; Tandon et al., 2012; Vigod et al., 2010).

Screening rates may be low for several reasons. The signs and symptoms PPD are similar to other phenomenon that can occur during the postpartum period, making diagnosing and treating PPD difficult (Leddy et al., 2011). Maternity blues (or the “baby blues”), affecting 50% to 80% of new mothers, are the normal hormonal and physical changes that occur during and after pregnancy, resulting in the mother acting and feeling differently than she usually does but subsides within 2 weeks postpartum without causing debilitating functional impairment (Earls, 2010; Santoro & Peabody, 2010). PPD, however, with symptoms similar to the “baby blues,” has an onset that can occur immediately after childbirth and throughout the first postpartum year (Santoro & Peabody, 2010). Furthermore, the specialty and general guidelines for screening are conflicting or relatively new (Gjerdingen & Yawn, 2007; Tandon et al., 2012). Whereas the ACOG Committee on Obstetric Practice (2010) and the American Board of Family Medicine fail to give definitive recommendations for universal screening for PPD (Gjerdingen & Yawn, 2007; Tandon et al., 2012), the American Academy of Pediatrics in 2010 recommended routine universal screening for maternal depression (Earls, 2010; Tandon et al., 2012). Although it did not specify postpartum women, the U.S. Preventive Services Task Force (USPSTF) in 2009 recommended routine depression screening in nonpregnant adults if staff could assure accurate diagnosis, treatment, and follow-up (USPSTF, 2009). However, in July 2015, the USPSTF drafted an updated recommendation that included pregnant and postpartum women (USPSTF, 2015). Similarly, it was not until May 2015 that the ACOG withdrew its committee opinion from 2010 and replaced it with universal screening recommendations during the perinatal period and added that OB/GYN clinical staff is also responsible for follow-up and treatment for patients (ACOG, 2015).

PPD is common, detectable, and treatable. However, the estimated low screening rates are worrisome given the long-

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