Maternal Depression:
Everyone Can Play a Role to Help Families Thrive

Questions and Answers from a Recent Webinar (watch it here).

Respondents

- *Karina W. Davidson, PhD, MASc, Vice Chairperson, US Preventive Services Task Force*
- *Constance Guille, MD, Associate Professor and Director of the Women's Reproductive Behavioral Health Program, The Medical University of South Carolina*
- *Elaine DeaKyne, Executive Director, Postpartum Support Charleston*

Q1: What can we do to support teen moms experiencing prenatal or postpartum depression?

Dr Davidson: Teen moms are at increased risk of having or developing postpartum depression if it's not yet present. Screening, supporting and aiding these persons in finding appropriate and personally acceptable in-person or online treatment options is particularly important.

Q2: Near where I live is very rural, so for a woman to get this type of help it is far away. Is there anything online to help?

Dr. Davidson: The Substance Abuse and Mental Services Health Administration (SAMHSA) provides resources for locating mental health services in a patient's area. Some cognitive behavioral therapy programs (e.g., Mothers and Babies program) also provides web-based resources for families and clinicians.

SAMHSA's National Helpline, 1-800-662-HELP (4357), (also known as the Treatment Referral Routing Service) or TTY: 1-800-487-4889 is a confidential, free, 24-hour-a-day, 365-day-a-year, information service, in English and Spanish, for individuals and family members facing mental and/or substance use disorders. This service provides referrals to local treatment facilities, support groups, and community-based organizations. Callers can also order free publications and other information.

Dr. Guille: Telemedicine is an important resource for those living in rural areas. You can receive treatment through phone calls, video chats, and other digital mediums.

Q3: What are some suggestions regarding strategies or tools related to maternal depression that could be implemented into a community child abuse prevention plan? (as a tool to help parents)

Dr. Guille: If you are screening for any kind of mental health problems when working to prevent child abuse, you should be screening for postpartum depression. These screenings can help identify parents experiencing depression, and refer them to supportive services, ultimately interrupting or forestalling abuse. Maternal depression screenings include: Edinburgh Postnatal Depression Scale and the Patient Health Questionnaire (PHQ-9 List).

Q4: How can I address postpartum depression in the neonatal intensive care unit (NICU)?

Dr. Davidson: Consultation-Liaison Psychiatry at your hospital may have a list of local resources and referral sources.

Dr. Guille: When screening women for postpartum depression in the NICU, we often find very high rates of people screening positive. Having a designated social worker on-hand to meet with families is important for these high-risk situations. The social worker can talk with families, provide support, and then assess if there is a greater need and refer to supportive services.

Q5: Question for Elaine: Do you have varying support group times to reach working mothers and those with difficult transportation issues?

Ms. DeaKyne: We have had an online Facebook group for a couple years and have noticed that moms really enjoy this type of support. Moms interact with each other and provide support and guidance. We have a Sunday support group to accommodate working moms and also did one online support group (4-week course) using Zoom. That was very successful, and we hope to do more of those. I've heard upwards of 98 percent of moms have a cell with data service and can attend online groups.

Transportation has been an issue for our in-person support groups. Those are not as well attended in our community. Child care is also tricky for moms. There are so many factors that can cause barriers to in person support. Facebook closed groups and Zoom online support groups are the way we are going.

Q6: Are there any studies or numbers around postpartum depression for new immigrants to the country?

Dr. Davidson: Major life stressors or life events are a risk for developing depression. So, although we know of no direct studies to provide postpartum depression estimates, recent migrancy would constitute a postpartum depression risk and would fall under the US Preventive Services Task Force prevention intervention guideline.

Q7: Is postpartum depression hereditary?

Dr. Davidson: There is not good evidence to address this question. However, a family history of depression does put a pregnant or peripartum person at increased risk of developing perinatal depression.

Dr. Guille: Because a family history of depression and bipolar disorder increases risk for maternal depression, it is important to screen for family history when assessing risk.

Q8: When should we screen women for postpartum depression? For example, if we are expected to see the mother and infant for a year. Would you screen once during enrollment? How often should they be screened?

Dr. Davidson: There is not yet sufficient evidence about the optimal start or frequency of depression screening during the perinatal period. One practical way to consider proceeding is to screen during first prenatal and first postpartum visit. If elevated depression symptoms not yet meeting depression diagnostic criteria are detected, prevention interventions should be started. If low/no depressive symptoms are found, rescreening frequency should be decided based on clinical judgement.

Ms. DeaKyne: From an advocate view, it is so important to talk about postpartum depression and when that screening will happen. I say screen often. We have to normalize the conversation and reduce the stigma. I have talked to many women who say they were shocked when they had the screening in the hospital after delivery. Moms are caught off guard. We are told that this should be the happiest time of our lives, and many never know that postpartum depression is common. We cannot expect a mom to admit that they are having a hard time just days after delivery if that is the first time they are hearing of the symptoms.

Note from NICHQ: The American Academy of Pediatrics (AAP) recommends integrating PPD surveillance and screening at the 1-, 2-, 4-, and 6-month well-child visits.

Q9: How do we address the need for medical providers to have better education regarding maternal mental health issues?

Dr. Davidson: We hope the broadcast of the recent webinar and other educational activities will provide better education. This will take many stakeholders to provide education and awareness, so we hope all of you will join us in this effort.

Dr. Guille: Ideally, training on maternal depression prevalence, screenings and referrals should be integrated into health professionals' training, whether as a nurse midwife or during residency training. There are also trainings available through Postpartum Support International that can be taken after health professionals have finished their residency or respective program.

Q10: The studies Dr. Davidson referenced for cognitive and behavioral therapy, were those group therapy or individual or a mixture of both?

Dr. Davidson: The evidence-based programs were a mixture.

One example of a cognitive behavioral therapy approach is the Mothers and Babies program. This program involved multiple weekly group sessions during pregnancy and several postpartum booster sessions. The program sessions covered issues such as the effects of stress, importance of rewarding activities, importance of social networks, and parenting strategies to promote child development.

One example of an Interpersonal therapy approach is the Reach Out, Stand Strong, Essentials for New Mothers program. It involved multiple prenatal group sessions and one postpartum session. The program sessions covered issues such as the "baby blues" and postpartum depression, stress management, development of a social support system, and discussion of types of interpersonal conflicts common around childbirth and techniques for resolving them.

Q11: Due to stigma of mental health, we noticed that many women that receive screenings do not follow-up; do you have advice for self-referrals?

Ms. DeaKyne: The conversation around postpartum depression needs to happen early and often. A mom needs to understand that it is an illness, that it is common, and they need to know that they can trust their provider. The conversation needs to happen to reduce the stigma. That is when moms can feel confident in seeking help. A mother's biggest fear is that admitting to postpartum depression will result in her child being taken away. The sad truth is that does happen. A lot stems from lack of education and lack of support. We need to do better for our moms.

Dr. Guille: Too often, we only tell mothers who screen positive about the health risks for them. And this doesn't always resonate. Instead, we need to make more of an effort to help them understand the impact their illness has on their child's development, because this is more likely to encourage them to seek treatment.