

Review Article

## Postpartum Depression; Nurses Need to Be Trained in Administering the EPDS to All Mothers of Infants.

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### Abstract

One out of eight mothers typically experience postpartum depression. When the mental health of the mother is comprised it has the potential to affect her and her entire family. As frontline caregivers, nurses are presented with the opportunity to assess their patients and implement tools such as the Edinburgh Postnatal Depression Scale (EPDS) to improve the communication within the care team leading to higher quality outcomes for the patient.

Unfortunately, the assessment for postpartum depression is often overlooked and not included in routine after birth care. Including the EPDS assessment in all inpatient settings for mothers with children 1 year old and under will greatly improve the chances for detecting and treating depression prior to the detrimental effects of postpartum depression.

**Key Words:** (postpartum depression), (holistic care), (EPDS)

### Postpartum Depression – How Big is the Problem

It is recorded that up to 15% of mothers experience symptoms of postpartum depression (Langvik, Haberg, & Storholt, 2020). However, there potentially are many women that are undiagnosed. Undiagnosed depression gradually worsens with time, prolongs recovery, and leads to greater consequences, even if the mother reaches out for help at a later time. Postpartum depression (PPD) has a great impact on the relationship with the mother and child. Postpartum depression for mothers is associated with impatience, low sensitivity, and hostility (Langvik, Haberg, & Storholt, 2020). Postpartum depression for the infant is associated with behavioral problems, cognitive problems, and poorer physical health, emotional problems, linguistic and social challenges for children (Langvik, Haberg, & Storholt, 2020).

A study completed by the CDC determined that 1 out of 8 mothers will not be asked at their postpartum visit if they are experiencing any depression symptoms (CDC, 2020a). This data shows a potential for non-diagnosed postpartum depression. More alarming is the fact that postpartum visits are typically 6 weeks after birth, allowing significant time to lapse without diagnosis or treatment.

Another study conducted by the CDC revealed that 1 out of every 8 mothers in the United States experiences postpartum depression. (CDC, 2020b). Mother's may become depressed after the birth of their newborn; however, postpartum depression is a more serious issue than simple "baby blues". Approximately 50% of new mothers have mild depressive symptoms which usually occur immediately after birth and is characterized by sudden mood swings ranging from euphoria to intense sadness (Illinois Department of Public Health, 2022).

Typically these symptoms begin to abate within a couple of weeks; however, some cases will progress to postpartum depression. Long term postpartum depression can have severe consequences for the mother and her children. Hansotte, Payne, and Babich state “maternal suicides account for up to 20% of all postpartum deaths” (2017). These statistics could be improved by the implementation of the EPDS and early detection.

### **Those with Greater Risk**

Generally speaking, the individual who has an anxiety disorder or other mental health conditions will be more prone to develop postpartum depression. The Illinois Department of Public Health states, “there is no single cause for postpartum depression. Physical, emotional and lifestyle factors all may play a role. Depression also runs in some families” (2022). Individuals that realize they have a mental health disorder and inform their healthcare provider have a better chance of being assessed for PPD. Many of PPD traits can be labeled as symptoms of stress. In the inpatient environment, nurses may see mental health disorders as a trigger and are more apt to screen these individuals.

When the infant is hospitalized it potentially can exacerbate symptoms of postpartum depression; however, to the nurse that is not specifically trained to screen for depression this may appear as a normal response. Not all mothers who have hospitalized infants will experience PPD; it is difficult to determine the difference between symptoms of stress or lasting symptoms of PPD. The EPDS helps to determine the difference and initiates a more thorough assessment. Postpartum depression can occur with “any woman who is pregnant, had a baby within the past several months, miscarried, recently weaned a child from breastfeeding, or adopted a child” (Illinois Department of Public Health, 2022). Unfortunately these mothers are potentially sent home without the needed resources. One article states the consequences of little to no sleep impacted the parent’s ability to comprehend medical “information and making healthcare decisions was described as difficult when tired” (Nassery & Landgren, 2018). It continues to explain that with decreased sleep it was “difficult to keep up a positive attitude and bright thoughts about the future, making the stay at the hospital more difficult

to manage” (Nassery & Landgren, 2018). Having a hospitalized child is stressful and can cause parents to lose sleep, becoming impatient, frustrated, and tearful. However, these symptoms mirror PPD predictors and may lead nurses to think that these parents will be back to normal once their child is out of the hospital. While this may be true, there are far too many mothers going home vulnerable to the turmoil PPD will cause in their family.

Postpartum depression is more prevalent in impoverished communities. One article states that “socioeconomic status is often thought to be the most consistent predictor of PPD” (Hansotte, Payne, & Babich, 2017). Individuals from a lower socioeconomic class potentially have a greater risk of developing postpartum depression and may have an increased difficulty in receiving interventions for this problem. Mothers with lower socioeconomic status, generally, have barriers with: resources available in their environment, less access to transportation, and less access to child care.

### **Consequences of Postpartum Depression**

Maternal depression affects mothers and infants. Mothers with PPD were more likely to resort to formula feeding versus breastfeeding, preventing the passive immune response that babies receive from their mothers’ milk; thus putting the infant at a greater risk for acquiring susceptible illnesses (Madlala & Kassier, 2017). One study showed that mothers with PPD were unable to provide holistic care for their babies and lacked in providing for their own basic needs. (Madlala & Kassier, 2017). Therefore, prompt identification of PPD will not only improve the health of the mother but “ensure optimal infant development” (Hoffman, Dunn, & Njoroge, 2017). Consequently, if a mother with postpartum depression goes unnoticed, children by the age of 14 months “were found to be at higher risk for non-verbal communication delays” (Hoffman, Dunn, & Njoroge, 2017). When the mental health of the mother is compromised it affects her entire family. Postpartum depression can be reoccurring for many women “regardless of how many previously non-complicated pregnancies and postpartum adjustments she has had” (Illinois Department of Public Health, 2022). This emphasizes the importance behind screening every mother, whether she has had one child or multiple children.

Lingering postpartum depression has detrimental effects on the entire family. Depressed mothers have difficulty with caring for their family and are potentially unable to work increasing financial instability. With these things in mind, it is crucial to “highlight the importance of expanding access to mental health support services for low-income pregnant and postpartum individuals” (Rokicki, McGovern, Von Jaglinsky, & Reichman, 2022). Early detection and treatment improves the quality of life for the entire family.

There is an increased potential for women experiencing postpartum depression to search for relief with substance abuse. A study sample of 106,142 women was conducted from 2008 to 2014 on women during their reproductive years of 18-44 (Zhou, Ko, Haight, & Tong, 2019). The results showed that an alarming number of “women with major depressive episodes are significantly more likely to suffer from substance abuse”. (Zhou, Ko, Haight, & Tong, 2019). PPD consumes the mother’s mind with unhealthy thoughts and without prompt intervention, it can create a domino effect that could damage generations to come.

### Personal Experiences from Nurses

A nurse shares her inpatient experience with a mother and child:

I once had a patient who was only a couple days old and accompanied by both parents. I noticed right away the mother had a very tired, flat affect; she rarely smiled or interacted with the baby. The father was doing most of the care such as feeding, changing, and cuddling with the baby. The mother would pump her breast milk and then go back to sleep. At first this seemed normal; assuming she was extremely fatigued from giving birth and having to wake up every couple of hours to pump. However, I soon realized that it was not normal for her to act this way. There was more going on. She never smiled or even held the baby. I did not know how to ask her if she had postpartum depression because I had never had the training. I asked this mother if she had an appointment set up with her *obstetrician-gynecologist* (OBGYN) in 2 weeks. She stated that she was told to cancel the 2 week appointment and come in at 6 weeks due to having an uncomplicated birth. This was a mom who clearly needed help and she was not going to be assessed for PPD until week 6 post birth. This mom

requested a consult with a social worker on her first day in the unit. I took the initiative and submitted a request for a consult. However, she had been there a couple of days and would be leaving before a social worker was available on Monday. This was a missed opportunity. She went home with potentially a non-diagnosed depression, and no services to help her (personal communication N.P, 2020).

One nurse shares her experience with speaking to a mother:

After I had my first child I starting experiencing symptoms of postpartum anxiety and depression. Even though I realized what was happening, I just did not know who to reach out to. I had no idea my midwife and pediatrician dealt with these issues. I prolonged getting help until I was unable to care for myself and my baby. It was at the point where I realized I needed to be hospitalized and spent a number of days in the hospital (personal communication N.P, 2022).

If this mother had been given the EPDS assessment and had the opportunity to discuss her mental and emotional well-being with her provider, then perhaps she could have prevented a hospital stay. This is precious bonding time away from her baby and created a burden on her working husband who watched the child until she was discharged from the hospital. If her nurse, midwife or pediatrician had provided the Edinburgh Postnatal Depression Scale (EPDS) assessment and then discussed this with her during their appointment, this mother would have felt comfortable enough to share what she was going through and received the proper follow-up care.

One nurse retold her experience with a psychiatric home care patient.

My patient was severely impaired, under the care of a psychiatrist. She told me it all started with her being bed bound with the second child for the last six months prior to birth. She became very depressed; however, she was not diagnosed at that time. After the birth of her baby she gradually got worse until she was unable to care for anyone in the family, even herself. She eventually started seeing a psychiatrist and was put on some pretty strong medication. At the time I was working with her, she still had difficulty functioning as a mother and wife. This was a woman who was a nurse; she was a productive member in society, and now she could

not even work. (personal communication, P.C., 2022).

If someone would have assessed this woman and helped her at the time her depression began, it might not have developed into clinical depression that was very debilitating to her. Other nurses might have been intimidated to assess her because she was a nurse. Depression is not restricted by employment or education. Everyone should be given the EPDS and assessed after the birth of their baby with reassessment until the baby is at least a year old.

### **Barriers**

Some major barriers to the solution are inexperienced nurses assessing for depression and having no knowledge of the EPDS. Training during Obstetrics and Pediatric rotations in nursing school should include assessing for postpartum depression. Nurses should be required to take a holistic approach to care which includes mental health, emotional health, physical health, and spiritual wellbeing of the mother and child. Another barrier is the lack of hospital policy related to assessment of maternal depression and anxiety. Hospital policymakers identifying obstacles such as the lack of training, lack of referral systems, and lack of using a standardized tool can potentially overcome these barriers and improve patient outcomes.

Postpartum depression and anxiety are forms of mental health. Some individuals potentially see these through the stigma of mental illness. The mother may be fearful of this diagnosis. She may feel that society views her incapable of caring for her children with a diagnosis of depression. Nurses may be hesitant to broach the subject of depression for fear of offending and making the mother withdraw from them. Studies agree “universal screening of all mothers seems to reduce that barrier for the informants” (Langvik, Haberg, & Storholt, 2020). The use of a standardized tool used for all mothers can reduce the tension and stress involved in these situations.

### **Solution**

The most widely used PPD screening tool is the Edinburgh Postnatal Depression Scale (EPDS). The EPDS is a self-report questionnaire consisting of ten short statements with four response options, in which the new mother chooses the answer that best corresponds to her well-being over the past seven

days (Langvik, Haberg, & Storholt, 2020). This gives the mother a chance to confess her feelings but in a non-confrontational way if she is too nervous to reach out for help herself. The use of screening tools has not only aided in diagnosing postpartum depression but additionally improves professional confidence and increases job satisfaction levels with nurses (Langvik, Haberg, & Storholt, 2020). When these mothers receive the help they so desperately needed, their nurses will feel as though they made a positive impact in that family’s life.

It is the nurse’s responsibility to give their patients, mother and infant the most holistic care possible. This care is lacking if there is no screening to determine if the mother is experiencing postpartum depression. The solution is a two-pronged approach; training nurses and including all mothers. Nurses need to be trained in assessing for depression and be comfortable analyzing the results of the EPDS form. As well as, screening all postpartum mothers for depression with the EPDS form. More specifically, all mothers with a hospitalized child under the age of one should be given the EPDS form upon admission of their child. The results of that assessment will help the healthcare professional determine if they need to escalate care including assessing the mother for suicidal intentions. It is not generally current hospital practice to provide this to inpatient mothers but rather up to the discretion of the nurse to be an advocate and seek help for mothers. However, far too often PPD symptoms are disguised under typical exhaustion and stress from a child being in the hospital. By making the EPDS assessment part of the admission requirements for children one year old and under, this will prevent the majority of mothers going home undiagnosed and helpless. By providing the EPDS form to all mothers with a hospitalized child, it adds another layer of protection for the mothers who might have slipped through the cracks by not being screened at the pediatrician’s office or their postpartum visits.

**Conclusion:** In conclusion, the mother/infant experience will potentially be improved with more holistic approaches to nursing care. Unfortunately, many undiagnosed mothers can be overlooked with the current hospital practice. Holistic approaches include screening for postpartum depression with the EPDS form that should be included in the admission paperwork for all mothers with infants under one. Potential catastrophic consequences can

be avoided with early detection and intervention. Nurses are the front line caregivers with the opportunity to assess their patients and implement tools such as the EPDS to improve communication within the care team leading to higher quality interventions for these mothers and their families' outcomes.

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