

Perinatal Mental Health Toolkit

2014



Winnipeg Regional
Health Authority

Caring for Health

Office régional de la
santé de Winnipeg

À l'écoute de notre santé

Toolkit – *“a collection of information, resources, and advice for a specific subject area or activity”*

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This Toolkit and additional resources can be found online at WRHA Mental Health Promotion, Perinatal Mental Health Resources
<http://www.wrha.mb.ca/extranet/publichealth/services-healthy-parenting-perinatal.php>

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Additional WRHA Perinatal Mental Health Resources:

- WRHA 1 in 8 Postpartum Depression Brochure
- WHRA Perinatal Mental Health Quick Reference Guide
- Life with a New Baby: Dealing with Postpartum Mood Disorders DVD

SECTION A

INTRODUCTION

This Perinatal Mental Health Toolkit is a resource developed primarily for the purpose of supporting the practice of Winnipeg Regional Health Authority Public Health Nurses in their work with perinatal women and families.

This toolkit provides current best practice information and resources on perinatal mental health that will assist in the provision of evidence-informed care. Research indicates that perinatal mental health issues are the most common complications of childbirth yet many women do not seek help.

It is critical that Public Health Nurses be knowledgeable on the range of perinatal mental health issues and the array of effective treatment and support options that can reduce the negative impact on the wellbeing of the perinatal woman and her family.

Public Health Nurses play a key role in:

- Educating women and families on perinatal emotional health
- Assisting in identifying women who may be at risk for perinatal mental health issues
- Supporting prenatal and postpartum women who may be experiencing mental health issues
- Guiding and referring women with perinatal mental health issues to timely and appropriate assessment, treatment and support options
- Promoting follow-up support for women who may be experiencing perinatal mental health issues

There are a number of factors that can make the identification and intervention of perinatal mental health issues a complex one. It is the intent of this toolkit to address these challenges and to provide information and resources that will facilitate family awareness and education, early intervention and access to timely and appropriate treatment and support.

** This Toolkit refers to the person giving birth as a woman or mother; however, transgender men (born female, but identifying as a male) who have or are undergoing biological transition may become pregnant and give birth (Adams, 2010). This document is intended to be inclusive of all birthing clients; public health nurses should be sensitive to the needs of transgender families. For more information contact the Rainbow Resource Centre*

<http://www.rainbowresourcecentre.org/>

The information in this toolkit supports the Service Standards and Clinical Practice Guidelines of WRHA Public Health Nurses regarding Perinatal Mental Health.

MENTAL HEALTH AND MENTAL ILLNESS – KEY CONCEPTS

WRHA Population and Public Health goal is to improve the health of the population through education, advocacy and work with people and communities to reduce health differences and to improve everyone's health. The program works with all to promote health, prevent disease and injury, as well as to create healthy places and relationships (WRHA).

From a population health perspective, mental health promotion, prevention and early intervention is a key role for public health staff. Knowledge of the following concepts is pivotal.

Mental health is the capacity of each of us to feel, think and act in ways that enhance our ability to enjoy life and deal with the challenges we face. It is a positive sense of emotional and spiritual well-being that respects the importance of culture, equity, social justice, interconnections and personal dignity (Public Health Agency of Canada, 2006).

According to the World Health Organization, mental health is “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (World Health Organization, 2001).



Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress — such as family and relationship problems, serious health problems or workplace and financial stressors. It has been referred to as "bouncing back" from difficult experiences. Resilience is not a trait that people either have or do not have. It involves behaviors, thoughts and actions that can be learned and developed in anyone (American Psychological Association, 2014). Resilience is also related to a person's culture, environment and community.

“Mental health promotion is any action taken to enhance the capacity of individuals, families, organizations or communities to take control over their lives and improve their mental health and well-being by using strategies to create and enhance supportive environments and individual resilience” (Joubert & Raeburn, 1998).

There is significant evidence that mental health promotion and prevention interventions can have long-lasting positive effects such as improved mental health and reduced risk of mental disorders (Jané-Llopis et al., 2005).

Mental health problems are broadly described as disturbances in thoughts and emotions that decrease a person's capacity to cope with the challenges of everyday life.

Mental illness or mental disorder is defined as any clinically significant behavioural or psychological syndrome characterized by alterations in thinking, mood and behavior (or some combination thereof) associated with significant distress and impaired functioning (Government of Canada, 2006).

Traditionally, mental health and mental illness were thought of as being along *one* continuum, with positive mental health on one end and mental illness on the other. Our current understanding of mental health and mental illness has broadened. Corey Keyes (2007) has challenged us to think of mental health and mental illness within a two or dual continua model. This model recognizes that those with a mental illness diagnosis can have positive mental health and those without a diagnosable mental illness can suffer from poor mental health.

The key message in the model is that the entire population can benefit from strengthening and protecting their mental health and well-being which leads to a more flourishing life. When our mental health is flourishing (with or without a mental illness) we are far less likely to suffer from the effects of poor mental health including poor relationships, absenteeism, chronic health conditions, helplessness, and other limitations to daily living (Keyes, 2007).

Keyes Dual Continua Model of Mental Health



Mental health literacy is another important concept and refers to the knowledge and beliefs about mental disorders which aid their recognition, management or prevention (Jorm, 2000).

The components of mental health literacy include:

- a) The ability to recognize specific disorders or different types of psychological distress
- b) Knowledge and beliefs about risk factors and causes
- c) Knowledge and beliefs about self-help interventions
- d) Knowledge and beliefs about professional help available
- e) Attitudes which facilitate recognition and appropriate help-seeking
- f) Knowledge of how to seek mental health information

Improving the mental health literacy of the population including healthcare providers can significantly impact the mental health of the population in several ways by:

- a) Increasing behaviours that promote mental health and prevent mental illness
- b) Encouraging people to seek treatment earlier (early intervention) which leads to improved outcomes and quicker recovery
- c) Building a more understanding and supportive community which reduces stigma and enhances social support which in turn benefits mental health and well-being for all
- d) Strengthening the efforts of mental health promotion, prevention and early intervention

(Jorm, 2012)

RESOURCES

For more information about **WRHA Mental Health Promotion**:

<http://www.wrha.mb.ca/prog/mentalhealth/MentalHealthPromotion.php>

Exploring Positive Mental Health, Canadian Institute for Health Information 2009

http://www.cihi.ca/cihi-ext-portal/pdf/internet/improving_health_canadians_en

The Human Face of Mental Health and Mental Illness in Canada 2006

<http://www.phac-aspc.gc.ca/publicat/human-humain06/index-eng.php>

PERINATAL EMOTIONAL ADJUSTMENTS AND MENTAL HEALTH

The perinatal period (conception to approximately one year postpartum) is a time of significant change and transition for a woman and her family. Pregnancy, childbirth and the postpartum period are recognized as a particularly vulnerable period in a woman's life.

There is a broad range of emotional responses to pregnancy and childbirth that are recognized as typical adjustments.

Emotional Adjustments

Despite the expectations of joy and happiness during the perinatal period, the reality is that many women *also* experience the following emotional responses during pregnancy and following childbirth.

Feelings of loss	Anxiety	Guilt
Frustration	Fear	Anger
Vulnerability	Irritability	Resentment

There is a significant societal expectation that women will experience joy after the birth of their baby and that any negative emotions will be fleeting and insignificant.

Research reveals that new mothers who are not depressed can experience negative thoughts and feelings similar to those of mothers who are depressed but not with the same intensity and duration (Hall & Wittkowski, 2006).

Distressing emotions and negative feelings can become a mental health problem or a more serious mood disturbance when they interfere with the woman's sense of self-satisfaction or the woman's ability to function and care for herself or her infant.

Healthcare providers can support and encourage new mothers to acknowledge and accept the *range* of perinatal emotional adjustments and ensure that they are informed about when to reach out and who to call should they encounter more distressing and debilitating emotional reactions throughout the entire perinatal period.

ANTENATAL MENTAL HEALTH

Antenatal mental health issues have not received the same attention and research that postpartum mental health issues have in the healthcare community. **There is a growing awareness that postpartum mental health issues often begin prior to conception or in the antenatal period.** For example, women have reported the onset of postpartum depression as 33.4% antenatal onset and another 26.5% report onset before pregnancy (Wisner et al., 2013).

Untreated anxiety and mood disturbances, for example, before and during pregnancy may have a lasting negative impact on both the developing fetus and the mother. Depression and anxiety during pregnancy is associated with greater maternal psychosocial and lifestyle risks. Women with untreated mental health issues may not be as vigilant about prenatal health care such as nutrition and check-ups and are more likely to use tobacco, alcohol and drugs (Bowen & Muhajarine, 2006; Nonacs, 2006).

Prenatal maternal distress has been found to be negatively associated with cognitive, psychomotor, and behavioural infant development (Kingston et al., 2012).

Women and health care professionals often overlook antenatal mental health issues. These issues are not easily detected as they can present themselves in many different ways and women are often reluctant to disclose mood disturbances during a time when they expect to feel happy. Sometimes when they do so, they are dismissed as being transient and of little concern. While this may be the case, it is now known that mood and anxiety disturbances are relatively common antenatally and that those women with a history of anxiety or depression are at increased risk.

Good antenatal care will include discussions and follow up with the woman around her emotional and mental health. The identification of risk factors and an assessment of psychosocial supports during pregnancy are very important.

The following questions may be helpful in identifying women at risk for antenatal mental health problems (Bennett et al., 2008).

Prenatal psychosocial assessment questions:

- Is there a history of mental health issues in your family?

- Have you ever suffered from depression, anxiety or psychosis? If so, when did it occur and what did you do about it? N.B. The risk for postpartum psychosis in women with bipolar disorder is approximately 25%, but is greater than 50% if they have had a previous episode of psychosis (Jones & Craddock, 2001).
- How do you feel about this pregnancy?
- Are you satisfied with the support that you receive from your partner (if applicable)?
- Do you have other social supports in your life?
- Have you experienced any major life events in the last year?
- How do you cope with stress in your life? How does your partner cope?
- In the past two weeks have you been bothered by feeling down, depressed or hopeless?
- In the past two weeks have you been bothered by having little interest or pleasure in doing things?

If the woman responds in a way that indicates:

- current mental health concerns, signs or symptoms
- a history of mental illness or if
- several risk factors are present

Further assessment and follow-up with a mental health clinician is warranted to develop a plan of action and a support plan throughout the entire perinatal period.

RESOURCES

Baby's Best Chance Parent's Handbook of Pregnancy and Baby Care 6th Edition
2012 <http://www.health.gov.bc.ca/library/publications/year/2013/bbc.pdf>

The Sensible Guide to a Healthy Pregnancy, Public Health Agency of Canada,
2012. <http://www.phac-aspc.gc.ca/hp-gs/guide-eng.php>

First Nations and Inuit – Healthy Pregnancy
<http://www.hc-sc.gc.ca/fnihah-spnia/famil/preg-gros/index-eng.php>

BABY BLUES

Postpartum blues or maternity blues, often called the “baby blues” is the most common postpartum mood disturbance affecting between 30 to 75% of all women after childbirth (O’Hara et al., 1991). Although baby blues are included in the spectrum of peripartum mood disturbances it is considered to be a part of normal postpartum adjustment.

The baby blues most commonly appear within the first few days after the birth, typically last hours to several days, but subside within two weeks (O’Hara et al., 1991). Studies show that the symptoms of the baby blues often peak around day three to day five after delivery.

Common features of the baby blues:

- ⌘ *Tearfulness*
- ⌘ *Irritability*
- ⌘ *Feeling vulnerable*
- ⌘ *Anxiety*
- ⌘ *Sleep disturbance*
- ⌘ *Appetite disturbance*
- ⌘ *Mood changes*
- ⌘ *Worry*

The baby blues are thought to be a reaction to the physiological and psychological changes a new mother experiences after the birth of the baby including the rapid decline in hormone levels, fatigue, and the emotional adjustments of caring for a newborn. The symptoms of the baby blues are mild and transient, do not interfere with the mother’s ability to function and generally do not require treatment.

Women who experience more severe baby blues are more likely to go on to meet the criteria for postpartum depression and anxiety (Reck et al., 2009).

Sometimes a new mother experiencing baby blues will begin to look for reasons for her emotional upheaval and will attribute the symptoms of the baby blues to not being a “good mother” or that she must not have been “ready” to be a mother. Informing the new mother about the nature of the baby blues can **alleviate fears and reassure the new mother** that the emotional upheaval is not a reflection of her skills or preparedness for motherhood (Nonacs, 2006).

Common myths of motherhood within society may set expectations very high for women after childbirth. The incongruity between a woman’s expectations of motherhood and the reality of her experience can undermine a new mother’s confidence, lead to feelings of failure and can contribute to adjustment difficulties (Nonacs, 2006).

Other issues that may complicate the baby blues include:

- ⌘ Feelings of loss
- ⌘ Feelings of incompetence
- ⌘ Disappointment
- ⌘ Sleep deprivation and exhaustion
- ⌘ Changes in couple or marital relationships
- ⌘ Loss or changes in social support networks
- ⌘ Navigating the role transition from woman to mother

While some of the signs of the baby blues are similar to postpartum depression or anxiety, they are distinguished by the fact that *symptoms of the baby blues are less intense and pervasive than during depression.*

- **Listen for clues that the mother is consistently feeling overwhelmed, does not experience positive as well as negative emotions, or is feeling distressed for most of the day over several days. These signs should be explored and monitored closely.**

Helpful strategies for coping with baby blues:

- Emphasize that the baby blues are part of a new mother's emotional adjustment and that *most* new mothers experience it.
- Help the postpartum woman to understand that experiencing baby blues does not mean she is failing at motherhood or that she has made a big mistake having a baby; postnatal adjustment takes time.
- Encourage the postpartum mother to talk about her feelings and acknowledge and validate the feelings expressed.
- Stress the importance of rest and or sleep whenever possible.
- Encourage good nutrition and adequate fluid intake.
- Provide the postpartum woman and family with information on self-care and coping strategies.
- Facilitate and encourage the mother to get extra help and support with childcare, housekeeping, meals, etc.
- Encourage mild physical activity and/or getting outdoors if possible such as walking around the block, simple stretches, or having a shower and getting dressed.

- It may also be helpful to inquire with the mother about what strategies she has used that have helped to cope with challenges in the past.

Provide anticipatory guidance around the typical duration of the baby blues and encourage the postpartum mother and her partner or family to call her Public Health Nurse/Midwife/Doctor should she experience more distressing or persistent emotional concerns.

RESOURCES

Caring for Yourself and Baby after Giving Birth

<http://www.sbggh.mb.ca/patientcare/files/wcPEcareYouBaby.pdf>

Coping with Change - A New Mother's Guide

A free publication of the Women's Health Clinic. Copies are available at: Women's Health Clinic Mothers Program at 204.947.2422 ext. 113 or at <http://womenshealthclinic.org/what-we-do/birthing-mothering/mothering-support/>

The Winnipeg Public Library system has books such as the one below on emotional well-being during the perinatal period:

Mothering the New Mother: Women's Feelings and Needs after Childbirth: A Support and Resource Guide, by Sally Placksin, New Market Press, 2000.

POSTPARTUM DEPRESSION

Postpartum depression is a term used to describe a non-psychotic depression that occurs shortly after birth. By definition, the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition) criteria for postpartum depression is classified as a **Major Depressive Disorder** with a peripartum onset from pregnancy to within four weeks of giving birth (American Psychiatric Association, 2013). Clinicians and researchers often go beyond this four-week criterion, since postpartum depression can occur at any time within the first year after giving birth.

*“I don’t know who I am anymore.”
“I’ve never felt like this.”
“I’d like to go to sleep and never
wake up.”
“They’d all be better off without me.”*

(Watson Driscoll, 2006)

A meta-analysis of 59 studies, which included more than 12,800 women, found that postpartum depression affects an average of **13 percent** of women after childbirth (O’Hara & Swain, 1996). A systematic review of prevalence and incidence of perinatal depression by Gavin and colleagues (2005) found rates of major and minor depression to be **between 7.1% and 19.2%**, with the rates highest at *three months postpartum*. Rates of postpartum depression in adolescent mothers aged 14 - 18 years are much higher, suggested to be at **26 percent** (Troutman & Cutrona, 1990; Kleiber & Dimidjian, 2014).

Symptoms of Major Depressive Disorder:

Individuals must have exhibited either

- a) **depressed mood or**
- b) **loss of interest or pleasure**

for a minimum of two weeks continually.

In addition to at least **four** of the symptoms below:

- Changes in weight or appetite
- Sleep disturbance
- Physical retardation or agitation
- Fatigue
- Decreased concentration or ability to think
- Feelings of worthlessness or guilt
- Recurrent thoughts of death or suicide

Depression can vary from mild to severe.

Only a physician, psychiatrist, psychologist or nurse practitioner can make a formal diagnosis of Clinical Depression.

It is recommended that the postpartum woman have a medical assessment to rule out physical conditions that may have similar symptoms to depression such as anemia, thyroid dysfunction, diabetes, and vitamin deficiencies, etc.

There currently is no evidence that depression is more prevalent in perinatal women versus non-childbearing women of the same age. In Canadian adults over 18 years the lifetime prevalence rates for major depression are about 12% (Government of Canada, 2006). In Canada, 16% of women will experience major depression in the course of their lives (Health Canada, 2009).

In addition to the clinical symptoms of major depression, a postpartum mother may experience the following:

- ⌘ Feelings of numbness, either physical or lack of any emotion
- ⌘ Lack of feeling or connection with the baby
- ⌘ Scary thoughts or feelings about harming the baby or harm coming to the baby

It is not known precisely what causes postpartum depression. It is hypothesized that a combination of psychosocial factors, along with an individual's predisposition and genetic vulnerability to depression plays a role.

It has been reported that 40% of postpartum women with depression report the episode onset postpartum, 33.4% report antenatal onset and 26.5% report onset before pregnancy (Wisner et al., 2013).

Strong Risk Factors for Postpartum Depression:

- ⌘ Depression or anxiety during pregnancy
- ⌘ Family history of depression
- ⌘ Previous history of depression
- ⌘ Recent stressful life events
- ⌘ Lack of social support (perceived or received)

For women who have experienced one episode of postpartum depression, the risk of experiencing another episode of postpartum depression is about 25%-40%

(Wisner et al., 2004)

Other risk factors that may play a role:

- ⌘ Maternal personality (perfectionist, worrier, anxious)
- ⌘ Low-self-esteem
- ⌘ Relationship difficulties
- ⌘ Low socio-economic status
- ⌘ Unwanted, unplanned pregnancy
- ⌘ Infant temperament (irritable, fussy, colicky)
- ⌘ Adolescent mothers

(Ross et al., 2005)

Risk factors can be “red flags” for healthcare providers in that they assist in identifying clients who *may* be at increased risk for postpartum depression. Risk factors do not determine who gets depression. It is possible for women who have NO risk factors to develop postpartum depression.

PREVENTION OF POSTPARTUM DEPRESSION

A Cochrane systematic review (2013) which examined the effectiveness of psychosocial and psychological interventions for preventing postpartum depression concluded that women who received a psychosocial or psychological intervention were significantly less likely to develop postpartum depression than those that received standard care.

The promising interventions included intensive, individualized postpartum home visits provided by public health nurses or midwives, peer-based telephone support, and interpersonal psychotherapy (Dennis & Dowswell, 2013).

“Analyses suggest that a wide range of interventions including therapy, social support, and modified care are effective in the prevention of postpartum depression. By six months postpartum, these interventions are associated with a 27% reduction in the prevalence of depressive episodes and a reduction in levels of depressive symptoms compared to control conditions” (Sockol et al., 2013, p. 1215).

While more research is needed there is promising evidence that psychosocial and psychological interventions can play a role in preventing postpartum depression.

Implications for practice

The evidence suggests that interventions during the postpartum period are more effective than prenatal interventions and those interventions targeting high-risk women yield increased results.

Although WRHA Public Health Nursing scope of practice does not include the *specific* preventive interventions identified in these reviews, the evidence points to the fact that public health nurses have a role in supporting prevention efforts by an approach that is congruent with these interventions, i.e. an approach that is empathic, supportive, hopeful and knowledgeable (Glavin et al., 2009; Rossiter et al., 2012).

POSTPARTUM PSYCHOSIS

Postpartum psychosis (also called puerperal psychosis) is the most severe and rare type of postpartum mood disorder affecting **one to two mothers per 1000** births (Kendell et al., 1987).

The symptoms of postpartum psychosis are severe and usually develop rapidly within two to three days after childbirth. Most cases of postpartum psychosis develop within the first two weeks after delivery.

Symptoms of postpartum psychosis include:

- ⌘ Elated mood, or less often depressed mood which can fluctuate rapidly
- ⌘ Disorganized thoughts, bizarre behaviour, confusion
- ⌘ Insomnia
- ⌘ Loss of touch with reality, psychotic symptoms such as delusions and hallucinations
- ⌘ Risk of suicide and infanticide

Delusions are described as fixed beliefs that are not based in reality (such as a mother believing her baby possesses special powers).

Hallucinations are sensory or perceptual distortions that have no basis in external stimulus. A mother experiencing auditory hallucinations may “hear voices” that tell her to protect her baby from certain people or situations.

Postpartum psychosis is more common in women with bi-polar disorder and women with a family history of mood disorders.

The risk for postpartum psychosis in women with bipolar disorder is approximately 25%, but is greater than 50% if they have had a previous episode of psychosis (Jones & Craddock, 2001).

Since the mother’s concept of reality is compromised and judgment impaired, postpartum psychosis is considered a psychiatric emergency. Healthcare providers who detect or suspect these signs or symptoms in postpartum women should not leave the postpartum woman alone or alone with her infant until a psychiatric assessment has been completed.

Call WRHA Mobile Crisis Service (MCS) at 204-940-1781 (24 hours) to access mental health clinicians who can come to the woman’s home and assess the client and situation. The MCS has access to an on-call psychiatrist for psychiatric assessment OR the client could go to the Crisis Response Centre at 817 Bannatyne Avenue or the nearest Hospital Emergency Department.

PERINATAL ANXIETY

There are several types of anxiety disorders that could affect a woman during pregnancy and following childbirth. They are not much different from anxiety disorders that occur at other times in a person's life. Prevalence rates of perinatal anxiety are difficult to determine due to the fact that few studies use diagnostic criteria and a clinical interview to determine rates. It is known however, that anxiety disorders are relatively common among the *general* population (combined anxiety disorders affect approximately 12% of Canadians: about 9% of men and 16% of women during a one-year period, Government of Canada, 2006) and in perinatal women (Ross & McLean, 2006).

- ⌘ Panic Disorder
- ⌘ Obsessive Compulsive Disorder (OCD)
- ⌘ Posttraumatic Stress Disorder (PTSD)
- ⌘ Generalized Anxiety Disorder (GAD)

Women who have a history of an anxiety disorder could experience worsening of the symptoms in the perinatal period due to increased stress and sleep disruptions. Postpartum depressive symptoms and history of trauma are significantly associated with postpartum PTSD (Grekin & O'Hara, 2014).

Signs of anxiety:

- ⌘ Constant or excessive irritability
- ⌘ Constant or excessive worry or fear, often related to baby's health or care
- ⌘ Fear or reluctance to leave the home
- ⌘ Sleep disturbances/insomnia
- ⌘ Racing thoughts/feeling "keyed up"
- ⌘ Feelings of wanting to "bolt" or run away
- ⌘ Physical symptoms such as sweating, palpitations, lightheadedness, faintness, tightness or painful chest
- ⌘ Loss of appetite, nausea or stomach upset

Depression and anxiety are closely linked. Some people experience depression with significant symptoms of anxiety.

If a postpartum mother appears to be experiencing anxiety that is causing significant distress and/or is getting in the way of caring for herself or her baby, it is important that she speak to her Public Health Nurse/Midwife/Doctor to facilitate referrals to appropriate treatment and support services.

RESOURCES

Anxiety BC – a website for women and families, information, self-management strategies

<http://anxietybc.ca> Go to the *New Mothers* tab

The Pregnancy & Postpartum Anxiety Workbook – Practical skills to help you overcome anxiety, worry, panic attacks, obsessions, and compulsions, Pamela S. Wiegartz & Kevin L. Gyoerkoe, New Harbinger Publications, 2009. Available through the Winnipeg Public Library.

TREATMENT OPTIONS FOR PERINATAL MENTAL HEALTH DISORDERS

Postpartum depression and anxiety are treated in the same way as depression at any other time in a woman's life. Mild to moderate postpartum depression may be effectively treated with psychotherapy and social interventions which are considered first line treatment, but more severe symptoms are likely to require medication as well. Breastfeeding mothers are often reluctant to take medication as all medications cross into breast milk. However, for these women a discussion with their physicians is needed to assess the risk/benefit analysis of medication.

Talk therapy/counseling

In individual therapy, a therapist meets with the client to assess their specific problems, needs and goals. Therapy or counselling is most effective when the client is comfortable with the therapist and there is a level of trust so that the client can be open and honest about their feelings and issues. The role of the therapist is to listen to the client in a non-judgmental way and move the client forward through their difficulties by assisting them with a process to gradually improve their symptoms. Successful therapy often requires weekly sessions of one hour each with a course of treatment from 6 to 20 weeks. There are several modalities or types of therapy that are effective in treating perinatal depression and anxiety (Stuart & Koleva, 2014).

Interpersonal Therapy (IPT)

IPT is a type of brief treatment that has been shown to be effective for reducing symptoms of postpartum depression (Mulcahy et al., 2010). IPT focuses on one of four main areas including 1) role transitions, 2) interpersonal disputes, 3) grief or 4) interpersonal skill deficits. A basic model of treatment is 16 weeks and is aimed at symptom reduction and improved social functioning. IPT is effective for

both individuals and groups. The main focus for postpartum women is role transition and the implications on lifestyle, self-concept and relationships.

Cognitive-Behavioural Therapy (CBT)

CBT is another type of therapy that has been shown to be effective in treating depression and anxiety (Scope et al., 2013). The goal of CBT is to help the client recognize and change negative thought patterns that perpetuate depressive symptoms and prevent a person from resolving problems and issues in their life. There is a focus on client education on the connection between thoughts, feelings and behaviour. The client is taught specific skills to replace counterproductive thought patterns with more realistic thought processes that lead to better coping mechanisms.

Non-directive Counselling

Sometimes referred to as “listening visits”, non-directive counselling involves listening, encouraging and validating expression of feelings in the postpartum woman as well as providing social support. The focus is not on problem solving, giving advice or baby related issues, which are dealt with separately but rather the focus is on reducing anxiety, guilt and isolation. The premise is that an empathic and non-judgmental approach will assist women experiencing postpartum depression to feel more confident in making decisions based on their own judgment, improve self-esteem and relieve depression symptoms. (Glavin et al., 2009; Holden and Sagovsky, 1989).

Medication

A woman’s decision to take medication can be a difficult one. There is limited research on the effects of medication on fetuses and breastfeeding infants. A client and her doctor will need to weigh the risks of medication use with the risks of untreated perinatal mood and anxiety disorders. The woman may choose non-pharmacotherapy as a first option.

There are two types of antidepressants most often prescribed for postpartum depression.

- SSRIs selective serotonin reuptake inhibitors
- SNRIs serotonin-norepinephrine reuptake inhibitors

Some improvement in symptoms may begin in one to two weeks but more often noticeable improvement may take up to six weeks. In a recent review of pharmacotherapy for postpartum depression, SSRI treatment improved symptoms in 43-87% of women and 37-65% of women for complete symptom remission (Kim et al., 2014). For example, sertraline (brand name *Zoloft*) was

found to be efficacious in between 50 and 67% of women responding to treatment at 6 to 8 weeks (Kim et al., 2014).

Side effects such as appetite loss, nausea, diarrhea or constipation, dry mouth, sweating, agitation, insomnia, fatigue, weight gain, decreased libido and headaches may be present but often subside in the first few weeks and should be reported to the physician.

*The use of paroxetine (brand name Paxil) is not advised during pregnancy as it has been linked to slightly higher risk of birth defects in infants who are exposed.

Antidepressants should not be discontinued abruptly as sudden withdrawal can cause flu-like symptoms, dizziness and nightmares.

Public Health Nurses can find information on medications at:
<http://home.wrha.mb.ca/prog/pharmacy/micromedex.php>

Groups

Support Groups for women with postpartum depression may be helpful in the treatment of postpartum depression although more research is needed on the types of groups that are most effective. Groups can be peer-led or professionally led and usually involve a weekly meeting either with a closed group or an open group of 5 to 10 postpartum women. Stated benefits of such groups include breaking down the isolation women feel in their struggles with postpartum adjustments.

The Mood Disorders Association of Manitoba offers a postpartum depression support group once a month.

<http://www.mooddordersmanitoba.ca/winnipeg-support-groups/>

Therapy groups for women with postpartum depression are typically led by a psychologist or other therapists trained in group therapy. Group treatment has been shown to reduce depressive symptomatology specific to postpartum depression (Goodman & Santangelo, 2011). The closed group usually meets weekly and is facilitated through a process of learning about what depression is and how it affects people, then moves on to a process of learning how to change negative patterns of behavior and incorporate coping strategies and self-care measures into one's life.

Transportation, childcare and fatigue make consistent attendance one of the greatest challenges for postpartum women and their success in group therapy.

THERAPY SERVICES:

Psychology Services

There are 3 options for accessing the services of a psychologist.

- 1) A person *with* an extended health benefit plan through an employer *may* have coverage for psychology services, usually to a maximum number of visits or dollar limit per year.

A person *without* extended health care benefits has two options.

- 2) Ask their doctor for a referral to a private practice Psychologist and pay a fee for each session (approximately \$170 per hour although some may use a sliding scale).

OR

- 3) Ask their doctor or public health nurse for a referral to **WRHA Clinical Health Psychology**. Perinatal clients can only be prioritized up to six months postpartum, *after* that time they will be added to the regular depression waitlist. **Clearly identify the perinatal nature of the situation on the referral form.**

Information on **Clinical Health Psychology** can be found at:
<http://www.wrha.mb.ca/prog/psychology/index.php>

Shared Care

WRHA Shared Care Fact Sheet

<http://www.wrha.mb.ca/prog/mentalhealth/files/SharedCareFactSheet.pdf>

Other Counseling Services in Winnipeg

A comprehensive list of counseling services in the community can be found within the *Mental Health Resource Guide for Winnipeg*.

http://winnipeg.cmha.ca/mental_health/finding-help/

Mindfulness-Based Therapy and Mindfulness-Based Stress Reduction(MBSR)

There is evidence that mindfulness-based therapy reduces anxiety and depressive symptoms (Hofman et al., 2010). Mindfulness-based stress reduction may be a helpful self-care approach to manage stress, pain and illness (Fjorback et al., 2011). For local information contact the Canadian Mental Health Association, http://winnipeg.cmha.ca/programs_services/mindfulness-based-stress-reduction/

Electroconvulsive Therapy (ECT)

Electroconvulsive therapy involves applying an electric current to the brain while the patient is anesthetized. ECT is currently performed at all Winnipeg hospitals that have psychiatric inpatient units.

Although there is very limited research on ETC in the perinatal period, ECT is considered the treatment of choice for very severe depression, if there are psychotic features or if the woman is not responding to medication (Focht & Kellner, 2012). The benefit of this therapy is that there is likely to be a fairly quick response to treatment. Transient memory loss is identified as an adverse effect of the treatment. A typical course of ECT treatment may include two to three treatments per week for approximately two to three weeks.

Social Support

In addition to treatment options, social support plays a significant role in the recovery of postpartum depression (Razurel et al., 2013).

Women experiencing challenges with perinatal emotional adjustments and women with postpartum depression or anxiety benefit from:

- Practical and instrumental support (childcare, housekeeping, etc.)
- Emotional support (empathy, love, understanding, trust and caring) from partner, friends, family and other women with PPD
- Informational support needs (on baby care, breastfeeding, emotional adjustments, etc.)
- Appraisal support (information which helps in self-evaluation, helps to identify one's capabilities and strengths)
- Social support from peers - other women and mothers who share the experience of perinatal depression and anxiety alleviating the isolation women often experience.

Psycho-educational Groups

Psycho-educational groups such as *Coping with Change* offered by the Women's Health Clinic help new parents to understand the range of emotional adjustments that accompany early parenthood. These facilitated groups are supportive and validating and can reduce anxiety regarding parental experiences in the postpartum. Self-care strategies and tips for developing a support system are discussed. These groups are not therapy groups however, and parents who require assessment and therapeutic treatment will be assisted to find appropriate services. You can request to be added to the email list for WHC Program Announcements and upcoming programs.

<http://womenshealthclinic.org/what-we-do/birthing-mothering/mothering-support/>

Self-Management Tools

In addition to self-help books, there are a variety of resources on the internet that have been developed to help people self-manage mental health symptoms. These can be effectively used in conjunction with other forms of therapy.

Supported self-management is welcomed by the public and has been shown to be effective particularly for depression and anxiety (Bilsker et al., 2012).

Managing Depression: A self-help skills resource for women living with depression, during pregnancy, after birth and beyond
http://www.beststart.org/resources/ppmd/DepressionWorkbookFinal_14JL22.pdf

Coping with Depression during Pregnancy and Following the Birth, A cognitive behaviour therapy-based self-management guide for women (2011)
<http://www.heretohelp.bc.ca/workbook/coping-with-depression-in-pregnancy>

Coping with Anxiety during Pregnancy and Following the Birth – a cognitive behaviour therapy-based self-management guide for women and health care providers (2013)
http://www.cw.bc.ca/library/pdf/BCRMH_AnxietyGuide_final.pdf

Anxiety BC – a website for women and families, information, self-management strategies
<http://perinatal.anxietybc.com/>

See *The Postpartum Depression Association of Manitoba* for more tools and resources: www.ppdmanitoba.ca

Mental Health Promotion and Self-Care Tools

Self-care tools are used to promote well-being, not manage symptoms; however, when women are able to care for themselves in positive ways it can decrease distressing feelings and thoughts which promotes overall mental health and well-being and has the potential to prevent more distressing symptoms from occurring or worsening.

Bright Futures- a Woman's Guide to Emotional Wellness
<http://mchb.hrsa.gov/pdfs/bfwomen.pdf>

Tools for Healthcare Providers to Use with Women

The following toolkit is intended to be used by healthcare service providers in their work with perinatal women. It includes a number of handouts and tip sheets that can be helpful in both self-care and self-management planning.

Mothers' Mental Health Toolkit – a Resource for the Community
A collection of resources intended to support those who work with vulnerable mothers and families.

<http://www.iwk.nshealth.ca/mmh>

PERINATAL DEPRESSION AND THE IMPACT ON THE FAMILY

Untreated postpartum depression can have negative consequences for the mother, the infant, other children and the whole family.

It is well known that parents and families play the primary role in children's lives and positive family functioning promotes the healthy growth and development of the child. Parent-child interaction that is positive, responsive and consistent leads to the best outcomes for children.

With mothers often being the primary caregivers of infants, they make up the main source of social stimulation and interaction for their infant's first year (Logsdon et al., 2006).

Mothers with postpartum depression are less likely to engage in positive parenting behaviours.

Mothers with depression symptoms:

- Tend to be more focused on their thoughts and feelings and disengaged from parental role
- Are less responsive to infant cues, less interactive
- Exhibit decreased attachment behaviors with infant
- Have a disturbed communication pattern with infant

(Cohn et al., 1990; Field, 1998; Paulson et al., 2006)

The effects of maternal depression on children will vary according to:

- ***Duration of the depression***
- ***Severity of the depression***
- ***Infant's temperament***
- ***Involvement of other family members and caregivers***

Maternal depression and the effects on infants:

- ⌘ Infants are more tense, less content
- ⌘ Demonstrate less positive facial expressions, more negative expressions and protest behaviour (Field et al., 1988)
- ⌘ More withdrawn behavior, avoidant (Cohn et al., 1986)
- ⌘ Effects on cognitive development
- ⌘ Poorer infant mental and motor development

Maternal Depression and the effects on children from 1 to 6 years:

- ⌘ Insecure attachment
- ⌘ Antisocial behavior
- ⌘ Cognitive deficits
- ⌘ Behavioural problems at school
- ⌘ Poorer language and IQ development
- ⌘ Negative effect on cognitive development (may be more pronounced in boys than girls)

(Beck, 1998; Goodman et al., 2011; Kingston et al., 2012; Murray & Cooper, 1996; Murray & Cooper, 1997)

Maternal depression has been found to be significantly related to higher levels of internalizing (poor self-esteem, social withdrawal, anxiety, depression etc.) externalizing (aggression, hyperactivity, conduct problems etc.) and general psychopathology, negative affect and behaviour and to lower levels of positive affect/behaviour in children, with these associations being small in magnitude (Goodman et al., 2011).

Research indicates that the effects of maternal depression are diminished when the infant is provided with positive, consistent, warm and nurturing caregiving by a caregiver. The negative effects of postpartum depression can also be mitigated by early identification and intervention.

New mothers coping with perinatal mental health issues often experience feelings of excessive guilt and inadequacy. The following brochure may help to reassure them that every simple thing they do every day helps to promote attachment and may reinforce the message that there are no perfect parents.

10 things your baby wants you to know – The Attachment Network of Manitoba
<http://attachmentnetwork.ca/wp-content/uploads/2014/06/10-things-brochure-final.pdf>

Partners and Fathers

Family members and supporters of a person living with depression experience a significant amount of stress. Fathers, particularly those who are also parents for the first time, are experiencing the adaptation to the parenting role in addition to assisting the new mother dealing with depression which can lead to high levels of stress and paternal depressive symptoms.

Maternal depression and the effects on fathers/partners:

- ⌘ Experience emotional distress observing the mother's symptoms of despair, irritability and hopelessness
- ⌘ May have guilt feelings, feelings of helplessness
- ⌘ May feel insecure as to whether mother and baby are safe
- ⌘ Feelings of constant worry and exasperation
- ⌘ May be unaware of postpartum depression and resources available
- ⌘ Are at increased risk for depressive symptoms

(Roberts et al., 2006; Goodman, 2004)

In a meta-analysis of paternal depression, depression was evident in about 10% of men, (up to one year postpartum) and was relatively higher in the 3 to 6-month postpartum period (Paulson et al., 2010). Paternal depression also showed a moderate positive correlation with maternal depression, meaning fathers were more likely to have symptoms of depression if the mother was also depressed.

Partners and fathers should be encouraged to also strive for a balance of caring for family and caring for oneself.

RESOURCES

See the WRHA Tip Sheet for Fathers/Partners

http://www.wrha.mb.ca/extranet/publichealth/files/FactSheet_PPHFathers_Apr07.pdf

The Postpartum Depression Association of Manitoba has a page for fathers/partners that includes information on self-care.

<http://www.ppdmanitoba.ca/get-help/partners/>

In-Home Family Supports

Family Dynamics provides practical assistance with child care, household management and parenting as well as emotional support and encouragement to families during difficult times. For families experiencing an illness, hospitalization, struggles with parenting and child behaviour, multiple births, feeling overwhelmed and having difficulty coping.

Call the Family Support Intake Coordinator at 204-947-1401 from Monday – Friday between 8:30 a.m. and 4:30 p.m.

<http://www.familydynamics.ca/families/in-home-family-support/>

Child Protection: Early Intervention and Prevention

If there is a concern that a family is unable to ensure the safety, security and well-being of their child(ren) for any reason including a perinatal mental health issue, a referral can be made to Child & Family All Nations Coordinated Response Network (ANCR) 204-944-4200.

Early intervention and prevention services assist families with staying together while ensuring that children are safe and protected. These short-term services provide families with timely supports that can help them to address problems before they develop into crises. In this way, early intervention and prevention services promote healthier family relationships.

Service Teams – provide intensive and culturally relevant services that support families to prevent further child protection issues from developing and escalating.

Family Resource Centres – ensure accessible, wrap around services to families delivered through supportive prevention and intervention focused group and individual programs and services.

<http://www.ancr.ca/contact.php>

http://www.ancr.ca/early_intervention_program.php

SOCIO-CULTURAL ISSUES

Research demonstrates that postpartum depression exists across cultures and is a universal experience though it may be described and labelled differently by those various cultures. Studies reveal that non-Western cultures use the term *unhappiness* most often to describe their feelings of distress.

The literature also supports the fact that the **risk factors** for postpartum depression are similar across cultures including:

- ⌘ Previous history of depression
- ⌘ Recent life stress
- ⌘ Ambivalent feelings about the pregnancy
- ⌘ Relationship difficulties
- ⌘ Low social support
- ⌘ Low self-esteem
- ⌘ Fatigue

In addition to these risk factors is the impact of the **sex of the infant** and increased risk for postpartum depression in cultures where male offspring are more highly valued than female offspring. This effect was reported in China, Turkey and India (Goldbort, 2006).

Immigrant, asylum-seeking, and refugee women have higher PPD symptoms than Canadian women (Stewart et al., 2008). They also report receiving less prenatal care and social support.

In another study on identifying risk factors it was noted that **recent immigrant women (within five years) were five times more likely to develop postpartum depression** than were mothers who were not immigrants (Dennis et al., 2004). Immigrant women are dealing with a number of factors that may complicate the postpartum experience including feelings of isolation, feeling disconnected from family of origin and other supports as well as language barriers and other cultural adjustment issues.

Some cultural groups engage in traditions around the time of birth that are intended to provide protection and care to the mother and the newborn. These traditions may support the mother and have a protective effect from developing postpartum depression; it may also be that the woman finds this traditional care to be isolating and incongruent with her own personal perspective about the care she and her baby should receive. The mother's **perceptions** around the support she is receiving are of utmost importance (Bina, 2008).

Some common practices across various cultures include organized support from immediate and extended family, rest periods, restricted activities, diet (restrictions or promotion of certain foods/drinks), hygiene practices, physical warmth (avoidance of cold), rituals such as binding, use of oils, massage and burning particular materials (Dennis et al., 2007).

Helpful Strategies when working with diverse cultures:

- ⌘ **Ask the mother** about her experience, expectations and adjustments rather than make any assumptions about the impact of culture on postpartum emotional adjustment.
- ⌘ **Be aware** of your own belief system around childbirth and the postpartum and that it is likely to differ from your client's.
- ⌘ Note that **age, gender and education** also impact cultural variables.
- ⌘ **Learn** about the cultural groups that you work with regularly and know the relevant community resources.
- ⌘ Be aware that within some cultures and families, mental health issues are **taboo** and that efforts are often made to “keep it in the family”.
- ⌘ Make use of **translators** whenever necessary to facilitate the provision of appropriate healthcare.
- ⌘ Make print information available in the **client's language** when possible.
- ⌘ **Work in partnership** with community cultural organizations to provide education and support to clients.

RESOURCES

Giving Birth in a New Land – Strategies for Service Providers Working with Newcomers, (2009) published by Best Start Ontario available for download at http://www.beststart.org/resources/rep_health/index.html

Celebrating the Circle of Life – Coming back to Balance and Harmony (2009)
An Aboriginal guide to emotional health in pregnancy and early motherhood: for women and their families from Perinatal Services BC
<http://www.perinataleservicesbc.ca/FamilyResources/CelebratingCircleLife/default.htm>

Multilingual Resources

Fact Sheet on Postpartum Depression

<http://www.heretohelp.bc.ca/publications/factsheets/postpartum> BC Here to Help

Mental health information in multiple languages:

http://www.camh.ca/en/hospital/health_information/Pages/information_in_other_languages.aspx

OTHER SPECIAL POPULATIONS AND CONSIDERATIONS

Adolescent Mothers

Adolescent parents have higher rates of postpartum depression. Rates of postpartum depression in adolescent mothers aged 14 - 18 years are much higher, suggested to be at 26 percent (Troutman & Cutrona, 1990; Kleiber & Dimidjian, 2014). Factors that put adolescent mothers at greater risk of depression include a lack of social support, interpersonal difficulties, social isolation, increased family conflict, and lack of partner support (Kleiber & Dimidjian, 2014). A young mother's self-esteem, coping strategies and level of perceived stress also play a role.

RESOURCES

Adolescent Parent Interagency Network

<http://www.apin.org/>

Pregnancy Loss

There is scant literature on prior pregnancy loss and perinatal mood disorders. A recent U.S. study (n=192) including predominantly minority, inner city women, found that those mothers who had experienced a prior pregnancy loss (either induced abortion or miscarriage) were more likely to be diagnosed with depression or anxiety than women without a history of pregnancy loss, irrespective of the type of loss (Giannandrea et al., 2013).

Please refer to the *Clinical Practice Guideline: Bereavement: Public Health Nursing Services with Families who have experienced maternal death, perinatal death, pregnancy loss, stillbirth or neonatal death* available at:

<http://www.wrha.mb.ca/extranet/publichealth/files/BereavementPolicy2014.pdf>

Multiple Births

Research into multiple births and postpartum depression seems to indicate that multiple births may be associated with increased risk for postpartum depression symptoms (Ross et al., 2010). It should be noted however, that the studies in this review used self-report measures rather than clinical assessment for identification of depressive symptoms which tends to drive rates of depression higher.

Use of Assisted Reproductive Technologies (ART)

In a systematic review of assisted reproductive technologies and risk for postpartum depression it was found that there is *no increased risk* for clinical postpartum depression among women who conceive using assisted reproductive technologies relative to women who conceive naturally; however, it is known that the process of infertility treatment is associated with increased psychological stress and anxiety (Ross et al., 2010). It is hypothesized that women who typically use ART are older, are of higher economic status and with higher education than women who have conceived without ART and therefore may have fewer overall risk factors for postpartum depression.

OVERCOMING BARRIERS TO HELP-SEEKING

One of the greatest challenges with perinatal mental health concerns is that women are reluctant to seek help. Without awareness, support or intervention, therefore, mild symptoms tend to progress into clinical symptoms and become much more disruptive and difficult to treat. The following barriers have been identified as playing a role in preventing women with perinatal mental health issues from seeking and accessing help.

- ⌘ Symptoms of postpartum depression are **confused with typical postpartum emotional adjustment** such as fatigue or relationship difficulties.
- ⌘ Women experiencing emotional distress and depressive symptoms are **reluctant to talk about them** even with health professionals.
- ⌘ Women experience significant **stigma and shame**, which often prevents them from seeking and getting help in a timely manner (Edwards & Timmons, 2005).
- ⌘

- ⌘ Parents **may not receive adequate information** and education on the emotional challenges experienced during early parenthood.
- ⌘ Many **symptoms of postpartum depression are minimized or dismissed** by family and friends and in fact, in some cultures it is unacceptable to discuss such matters.
- ⌘ Health care providers having **limited training or expertise** in detecting, assessing and managing postpartum depression have dismissed a woman's disclosure of symptoms leaving the woman feeling embarrassed, disappointed and frustrated.
- ⌘ Many women **fear labels** such as "mentally ill" or "unfit mother" and believe that disclosing symptoms could result in someone **taking away their child**.
- ⌘ For some women, **not knowing where to seek help** is another barrier.
- ⌘ **Health services may not be culturally or linguistically sensitive** to client needs thereby discouraging them from seeking help or speaking openly with a health care provider when they do see one.

Strategies that can facilitate help-seeking

- Enhance opportunities for prenatal and postpartum education and information about the range of emotional adjustments.
- Address myths and be open about the "truths" of motherhood and around perinatal mental health issues.
- Educate fathers and partners on perinatal mental health issues so that they can assist the woman in reaching out when there are concerns.
- Childcare arrangements can facilitate a woman to attend groups, outings, medical appointments etc. Assist in brainstorming childcare strategies.
- Peer support programs are particularly helpful to women who want to connect with other women who are going through similar experiences.
- Provide and make available to women and families, information on resources, services and supports in the community and how to access them.

For many mothers, the most desired treatment was simply having the opportunity to talk about their feelings with a sympathetic and empathetic listener. Having someone to talk to and “talking therapies” with health professionals if their assistance was sought were universally expressed as a treatment preference in a cross-cultural study incorporating 11 countries. Specifically, women wanted:

- a) to be given permission to talk in-depth about their feelings, including ambivalent and difficult feelings*
- b) to talk with a nonjudgmental person who would spend time listening to them, take them seriously, and understand and accept them for who they are*
- c) recognition that there was a problem and reassurance that other mothers experience similar feelings and that they would get better*
- d) However, for the reassurance to be effective, the mothers needed to feel confident that the person listening had some understanding of the nature and extent of their problem*

Source: Dennis, C.-L., & Chung-Lee, L. (2006). Postpartum Depression Help-Seeking Barriers and Maternal Treatment Preferences: A Qualitative Systematic Review. *BIRTH*, 33(4), 323-331.

SECTION B

This Toolkit is a companion document to the Service Standards and Clinical Practice Guidelines on Perinatal Mental Health which can be found at: <http://www.wrha.mb.ca/extranet/publichealth/services-healthy-parenting-perinatal.php>

RATIONALE for APPROACH

As previously mentioned, women's reluctance to discuss perinatal emotional struggles can be a major barrier to help-seeking. However, empathic enquiry by a healthcare professional, particularly a public health nurse who is making a home visit, can provide an important opportunity for women to speak about their struggles and have them addressed, leading to improved outcomes for women and their families.

A recent Australian study demonstrated that enquiry by a health professional about women's past or current emotional and mental health, together with a referral for additional support, facilitates help-seeking through the perinatal period (Reilly et al., 2014). Women who indicated that they had experienced significant emotional distress during the perinatal period, but were NOT asked about their current emotional health or their mental health history were over 90% less likely to seek help (Reilly et al., 2014).

Public health nurses play a pivotal role in the emotional and mental health and wellbeing of the perinatal woman and her family. The home visit provides a unique opportunity to engage with clients in an environment that is comfortable for them, thereby often facilitating establishment of trust and rapport.

Although the standardized contacts with clients may be few or brief they are nonetheless crucial in imparting information, providing support and anticipatory guidance.

INITIAL POSTPARTUM ASSESSMENT

During the initial postpartum contact(s) with families, the PHN uses the WRHA 1 in 8 Postpartum Depression brochure to initiate a conversation about emotional well-being and highlights the range of emotional adjustments that women often experience in the postpartum period.

It is beneficial for **partners/fathers** to gain this awareness as well so that if they notice any concerning changes, they can talk to the mother about them and/or reach out for assistance.

If there is a **known history** of depression or anxiety or if the mother is currently undergoing treatment, this dialogue can also facilitate a discussion around support and resource planning.

Since many families only receive this initial postpartum assessment, it is critical that families are made aware that if they have concerns about the mother's emotional well-being at any time in the postpartum year, they can call their PHN for assistance in linking to resources.

Goal of Assessment:

The goal of an assessment process is to gather information that will guide your response and support to the client. The goal of the assessment is:

- To identify women who may be at risk for perinatal mental health issues.
- To identify women who are currently experiencing perinatal mental health symptoms and may not be receiving treatment so that they can be provided support and linkage to services.

A) Identify Risk Factors for Perinatal Mental Health Issues:

Strongest risk factors for postpartum depression:

- ⌘ Depression or anxiety during pregnancy
- ⌘ Family history of depression
- ⌘ Previous history of depression
- ⌘ Recent stressful life events
- ⌘ Lack of social support (perceived or received)

Other risk factors that may play a role:

- ⌘ Maternal personality (perfectionist, worrier, anxious)
- ⌘ Low-self-esteem
- ⌘ Relationship difficulties
- ⌘ Low socio-economic status
- ⌘ Unwanted, unplanned pregnancy
- ⌘ Infant temperament (irritable, fussy, colicky)
- ⌘ Adolescent mothers (Ross et al., 2005; Beck 2001)

Risk factors can be “red flags” for healthcare providers in that they assist in identifying clients who *may* be at increased risk for postpartum depression. It should also be noted that risk factors do not determine who gets depression and that it is possible for women who have NO risk factors to develop postpartum depression.

B) Observations:

Observations can assist PHNs in making an assessment of their client’s health and well-being. In the case of perinatal mental health issues, appearances may be deceiving.. Postpartum mental health issues can be hidden or “masked” by women who may be reluctant to share their struggles and who fear that their emotional upheaval will reflect poorly on their capacity to be a mother. Many women with postpartum depression have admitted that they “put on a good front” by keeping themselves and their home well-groomed for others, while they were suffering significant internal distress.

Nevertheless, it is important to include observations about the client since they may offer some useful information.

Mother

- Does she appear to be caring for herself?
- Does she appear distracted, anxious, jittery, and fearful?
- Does she appear emotionally flat or distant? (Is there a cultural context for this or is this presentation unusual for her?)

Infant

- Weight gain
- Normal development and responses

Interaction with infant

- Does the mother interact and respond positively to the infant?
- Does the mother appear to be able to care for her infant?

Family/social dynamics

- If there are other people in the home, what do you notice about their communication with one another?
- Are there others in the home providing support to the mother?

Environment

- What do you notice about the environment in the home?
- Are there any safety concerns?

The chart below highlights the potential effects of depression on a person’s thoughts, feelings, actions, interpersonal relations, and body sensations along a continuum from mild to severe. It provides an understanding of the multidimensional aspects of depression and offers insight into the complexity of its effects. These are not discrete severity levels: a person may have mild intensity in some aspects and moderate intensity in others. Viewing the person comprehensively is crucial.

Continuum of Depressive Phenomena

DIMENSIONS	MILD	MODERATE	SEVERE
Thoughts	Guilt over minor infractions and mistakes/ preoccupation with dark subjects	Disgust extends to most aspects of the self Ruminates about death, failure, hopeless situations	Delusions of causing catastrophes; may believe that symptoms are punishment or a sign of terminal illness
	Distracted, but able to perform	Scattered or so focused on a few depressive thoughts that unable to focus on other thoughts; short attention span	Consumed with depressive thoughts; unable to concentrate on even simple thoughts other than depressive ones
	Suicidal thoughts are transient, vague, abstract	Suicidal ideas are more organized and concretized by a plan and a method; danger of carrying them out is present because energy remains available	Suicidal ideas are profound and unimpeded by other thoughts; distraction and lack of energy may inhibit action, but potential is present
Feelings	Sadness, “down in the dumps” not in response to events	Distinct depressed mood; some modulation	Profoundly depressed mood; no modulation
	Little pleasure in things but can be coaxed into activities	Pleasure minimal; hostile toward others who enjoy themselves	Pleasure absent; cannot imagine ever having had pleasure
	Dislike of aspects of self with focus on those aspects; calls attention to deficits	Little or nothing good about the self; accomplishments are hollow or criticized	Hatred of self; delusions that own badness has infected others
Actions	Mobility is slowed and distracted; dragginess noticeable to self but not to others	Others can detect slowness in response, work, movement, looking and acting	Profound levels of retardation; health-endangering outcomes
	Functions impaired by irritation toward tasks/demands; feels used by needs of others; hostile toward others’ requests	Lapses and breaks in functions; performance in roles noticeably impaired	Unable to perform roles
	Social sluggishness; finds excuses to withdraw; irritated with others but functions socially	Noticeable withdrawal from others; hostility toward others is overt and has an impact; others may withdraw in response	Withdrawal of any interest or motivation to interact; flat, emotionally empty response to others attempts to interact
Body sensations and processes	Sleep disrupted but returns to normal occasionally	Sleep changes become an established pattern (insomnia; hypersomnia)	Broken sleep characterized by early morning awakening and changes in sleep architecture/ no rest gained from sleep
	Appetite/eating erratic; may skip meals and have little interest in eating or may eat compulsively	Pattern of over/under eating established; begins to show changes in weight	Profound loss of interest in food; noticeable weight loss
	Elimination disrupted; abdominal discomfort, transient constipation	Constipation noticeable problem	Hypomotility with health outcomes (impaction)
	Sexual interest dulled	Anorgasmic; no interest in sex; may be hostile about being approached	No sexual energy available
	Fatigue is task related, but less endurance and energy for tasks	Consistently fatigued even if sleep is not disrupted	Crippling fatigue; cannot get up or out of bed

Source: Treating Depression Through The Therapeutic Nurse-Client Relationship. Linda S. Beeber, PhD, RN, CS Nursing Clinics of North America, Vol. 3:1 (1998)

C) Assessing Emotional Well-being

Establishing a comfort level

Women may feel uncomfortable talking openly about their emotions in a perinatal visit. It is imperative that the Public Health Nurse demonstrates her own comfort level with the discussion around emotional adjustments and reassures the new mother that her feelings will be validated and respected.

Comments such as the following may help to put the woman at ease and build trust and rapport between practitioner and client.

“In our work with new mothers, we find that it is very common to experience difficult emotions such as anxiety, anger or frustration after having a baby.”

“Many mothers are surprised at how difficult adjustment to motherhood can be.”

“Often our expectations of motherhood are very different from what it is really like.”

Statements similar to these will assist in reassuring the woman that her feelings are common and that she isn't the only mother to have these feelings.

Questions to ask:

After the introductory portion of the home visit, begin a conversation related to postpartum health with general questions such as:

- How have you been feeling?
- How have you been sleeping? Are you able to sleep when the baby sleeps? Do you have trouble falling asleep or staying asleep?
- How has your appetite been?
- Are you getting out?
- Is there anything you have been worrying about?
- Are you having scary and/or repetitive thoughts?
- Tell me more about how you have been feeling.

(Ross et al., 2005, IMPrint Volume 27, Spring 2000, Best Start *Postpartum Mood Disorder Desk Reference*)

The following two questions may be used during any interaction with a perinatal woman where the previous questions and dialogue have indicated that the woman *may* have perinatal mental health concerns. These questions may facilitate identification of women who may require further assessment and support regarding mental health concerns.

- 1) In the last two weeks, have you been bothered by feeling down, depressed or hopeless?
- 2) In the last two weeks, have you often been bothered by having little interest or pleasure in doing things?

(Arroll et al., 2003; Canadian Paediatric Society, 2004; Jesse and Graham, 2005; Kroenke et al., 2003; Lowe et al., 2005; MacMillan et al., 2005; Mann et al., 2012; Olson et al., 2005; Olson et al., 2006; Sanders, 2006; Whooley, 1997)

If the response to either of the above questions is yes (or to some degree in the positive), explore further with questions such as:

- Tell me more about how you have been feeling.
- When people are feeling...
(name the **feelings or behaviours** you've identified or seen such as feeling hopeless, overwhelmed, desperate, etc.)
...they are sometimes thinking about suicide.
- Are you having thoughts of suicide? (Refer to ASIST training <http://www.wrha.mb.ca/education/>)
- I am here to listen. I want to connect you with someone who can help.
(LivingWorks Education Inc.)

If through observations and conversation you identify that the woman is experiencing: significant distress in any of the above areas, such as feeling out of control, overwhelmed or anxious most of the time, significant changes in appetite, sleep or mood, inability to care for herself or her infant:

Recommend that the mother contact a doctor for a medical assessment and evaluation while you are present. Provide the mother with rationale regarding this recommendation and ensure follow up as per Perinatal Mental Health - Quick Reference Guide. If the mother is not able to see her Primary Care provider within a few days or does not have a Primary Care provider, advise her to visit a walk-in or Quick Care clinic.

For access to Primary Care in WRHA see
<http://www.myrightcare.ca/> or

call Family Doctor Finder at 204-786-7111
www.gov.mb.ca/health/familydoctorfinder

If the woman is experiencing thoughts of harming herself or her baby and you believe that there is a possibility that she *may* act on these thoughts:

Call WRHA Mobile Crisis Service (MCS) at 940-1781 (24 hours) to access mental health clinicians who can come to the woman's home and assess the client and situation. The MCS has access to an on-call psychiatrist for psychiatric assessment.

A secondary option would be to assist the client and family in going to the WRHA Crisis Response Centre at 817 Bannatyne Avenue or to the nearest Hospital Emergency Department.

Consultation

If PHNs are in need of consultation regarding a client they can consult with:

- a) PHN colleagues
- b) Clinical Nurse Specialist(s)
- c) Community Mental Health Worker
- d) Team Manager
- e) Mental Health Promotion Facilitator
- f) Mobile Crisis Services (for crisis/urgent situations)

Public Health Nursing Role

Research demonstrates that an approach that is **individual, flexible and collaborative** shows the most promise in terms of preventing postpartum depression and improving women's mental health in the postpartum period. As well, such an approach facilitates the development of a trusting, therapeutic relationship between nurse and client, which may promote safe opportunities for her to talk about her feelings and mental health questions. Studies have indicated that the opportunity for dialogue and perceived support are effective in assisting women to link with resources, and engaging in mental health promotive activities.

Active listening will begin in the assessment but will be very important in every interaction with the postpartum woman.

Active Listening

- Listen carefully to what a client is saying without interrupting or immediately moving into problem-solving.
- Ask the client what issue is the most troubling for them at the moment.
- Validate the client's feelings, by nodding, paraphrasing what they said
- Provide encouragement by acknowledging the client's efforts in coping with their situation.
- Acknowledge the experience of the client by sharing that it is common to have these feelings.
- Explore the mother's expectations of motherhood; there is a link between unrealistic expectations and depression and anxiety. Help the woman to understand that unrealistic expectations may be contributing to the stress she is feeling.

Provide information

- Share information on the range of perinatal emotional adjustments, including the prevalence of depression and anxiety.
- Share relevant information on the range of services and supports that can assist in managing perinatal emotional adjustments.
- Encourage the mother to use relevant and effective self-care strategies.
- Provide written material selectively where helpful: address only one or two topics at a time.

Problem-solving/client teaching

- Address issues such as feeding/breastfeeding, which may be contributing to worry and stress.
- Address questions around baby care/self-care.
- Demonstrate and encourage strategies that promote mother-infant attachment.
- Address fears and concerns that may be interfering with the development of a process toward healthy emotional adjustment.
- Encourage client to take things one day at a time.

Instilling hope

- Women who are struggling with postpartum emotional adjustments need to hear that that they won't always feel this way.
- Reinforce that there is help and effective treatments available for women who are dealing with postpartum depression or anxiety.
-

- Reaffirm to the mother that she is not alone in her feelings, and that many women deal with postpartum emotional adjustment difficulties.
- Recognize and validate the strengths you see in her and the relationship with her baby. Example: “Even though you are really struggling right now, your baby feels your love when you hold him and that is very important to both of you” or “Even though you are feeling really low right now, your family is wanting to support you through this”.

Develop a care plan

- Based on the woman’s situation and needs, develop a care plan with her to address the priority issues.
- Support the healthy choices the woman makes.

Linkage and referral to resources

- Based on the woman’s situation, provide linkage and referral to appropriate supports and services using the Perinatal Mental Health Quick Reference guide.

Follow up

- Based on the urgency of the situation, follow up with the postpartum woman as per Perinatal Mental Health Quick Reference Guide.
- Follow-up with client to see if she was able to link with resources as planned.
- Ask if there is anything you could do to support her self-care plan.

ADDITIONAL RESOURCES:

Postpartum Depression A guide for front-line health and social service providers
Centre for Addiction and Mental Health 2005

Copies available at all Public Health Offices in Winnipeg

www.camh.net/Publications/CAMH_Publications/Postpartum_Depression/

Ontario provincial initiative on postpartum mood disorders – Life with a New Baby
resources including DVD - www.lifewithnewbaby.ca

Self-care Tip Sheets - WRHA Tip Sheets

Tips for Postpartum Health: Emotional

Tips for Postpartum Health: Fathers, Partners and Supporters

Tips for Postpartum Health: Nutrition

Tips for Postpartum Health: Sleep

Available at:

<http://www.wrha.mb.ca/extranet/publichealth/services-healthy-parenting-perinatal.php>

PERSONAL EXPERIENCES

A 32-year-old teacher...

“I had no idea how physically and emotionally difficult new motherhood would be. I love working with children as a teacher...everyone always commented, “You’ll be such a good mother.” My sister made motherhood look so easy. It wasn’t until after I told her my feelings that she told me she had felt the same way. I guess people just don’t talk about it.”

A 38-year-old writer...

“The depression peaked when she was about a month old. I was filled with anxiety by the sense that I had so much to learn and by feelings of grief because my life changed so irrevocably. I was terrified that I’d never recover my old self, that I’d never feel relaxed or happy again.”

A 28-year old mother of twins...

“My depression started at seven weeks postpartum when I developed severe insomnia and was lucky to manage one or two hours of sleep per night...I became obsessed with sleep and thought if only I could sleep, everything would improve...One morning I woke up and thought, “I don’t want to be here anymore,” ...I couldn’t see that things would ever get better. It didn’t matter what anyone told me.”

A 21-year old at home mom...

“I felt trapped in my own home. My new baby was colicky. My mum took my daughter every now and then to give me a break...my emotions were so extreme I thought I was going mad. Sleep deprivation made it really hard for me to think or remember anything. On some days I’d cry all day long, on other days I’d be angry. The only constant was my exhaustion and how my body ached. I stopped painting and began to have anxiety attacks; I was terrified I couldn’t take care of my son.”

A 30-year old social worker...

“I felt so guilty. I kept apologizing to my daughter that she didn’t have a better mom. I had severe insomnia. As soon as I shut my eyes, my thoughts would start racing. I read many books about newborns and I was sure she had every illness in them...I didn’t feel happy or sad. I didn’t feel love or hate. Just nothing. It was the worst “non-feeling” I’ve ever had in my life. Rarely leaving the house made me think of it as a prison.”

Source: *The Mother-to-Mother Postpartum Depression Support Book*, by Sandra Poulin, Berkley Publishing Group, 2006.

References

- Adams, E.D. (2010). If transmen can have babies, how will perinatal nursing adapt? *The American Journal of Maternal/Child Nursing*, 35(1), p. 26-32.
- American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.
- American Psychological Association. (2014). *The Road to Resilience*. Retrieved from <http://www.apa.org/helpcenter/road-resilience.aspx>
- Arroll, B., Khin, N., & Kerse, N. (2003). Screening for depression in primary care with two verbally asked questions: cross sectional study. *British Medical Journal*, 327,p. 1144-1146.
- Beck, C.T. (1998). The effects of postpartum depression on child development: A meta-analysis. *Archives of Psychiatric Nursing*, 12(1), p.12-20.
- Beck, C.T. (2001) Predictors of postpartum depression an update. *Nursing Research* 50(5), p. 275-285.
- Beeber, L. (1998). Treating depression through the therapeutic nurse-client relationship. *Nursing Clinics of North America* , 33(1), p. 153-172.
- Bennett, I.M., Coco, A., Coyne, J.C., Mitchell, A.J., Nicholson, J., Johnson, E., Horst, M. & Ratcliffe, S. (2008). Efficiency of a two-item pre-screen to reduce the burden of depression screening in pregnancy and postpartum: An IMPLICIT network study. *Journal of the American Board of Family Medicine*, 21(4), p. 317-325.
- Bilsker, D., Goldner, E.M., & Anderson E. (2012). Supported self-management: A simple, effective way to improve depression care. *The Canadian Journal of Psychiatry*, 57(4), p. 203-209.
- Bina, R. (2008). The impact of cultural factors upon postpartum depression: A literature review. *Health Care for Women International*, 29(6), p. 568-592.
- Bowen, A. & Muhajarine, N. (2006). Prevalence of Antenatal Depression in Women Enrolled in an Outreach Program in Canada. *Journal of Obstetrics, Gynecologic & Neonatal Nursing* , 35(4), p. 491-498.
- Canadian Paediatric Society. (2004). Maternal depression and child development Position Statement. *Paediatric Child Health* , 9(8), p. 575-583.

- Cohn, J., Campbell, S., Matias, R., & Hopkins, J. (1990). Face to face interactions of postpartum depressed and nondepressed mother-infant pairs at 2 months. *Developmental Psychology*, 26, p. 15-23.
- Cohn, F., Matias, R., Tronick, E.Z., Connell, D., & Lyons-Ruth, D. (1986). Face-to-face interactions of depressed mothers and their infants. In EZ Tronick & T. Field (Eds.), *Maternal Depression and infant disturbance* (pp 31-45) San Francisco Jossey-Bass.
- Dennis, C.-L., & Chung-Lee, L. (2006). Postpartum depression help-seeking barriers and maternal treatment preferences: A qualitative systematic review. *BIRTH*, 33(4), p. 323-331.
- Dennis, C.-L., & Dowswell, T. (2013). Psychosocial and psychological interventions for preventing postpartum depression. *Cochrane Database Systematic Review* 2013 (2); CD001134.
- Dennis, C.-L., Fung, K., Grigoriadis, S., Erlick Robinson, G., Romans, S., & Ross, L. (2007). Traditional postpartum practices and rituals: A qualitative systematic review. *Women's Health*, 3(4), p. 487-502.
- Dennis, C.-L., Janssen, P., & Singer, J. (2004). Identifying mothers at risk for postpartum depression in the immediate postpartum period. *Acta Psychiatrica Scandinavica*, 110, p. 338-346.
- Edwards, E., & Timmons, S. (2005). A qualitative study of stigma among women suffering postnatal illness. *Journal of Mental Health*, 14(5), p. 471.
- Field, T. (1998). Maternal depression effects on infants and early interventions. *Preventive Medicine*, 27(2), p. 200-203.
- Field, T., Healy, B., Goldstein, S., Perry, S., Bendell, D., Schanberg, S., Zimmerman, E., & Kuhn, S. (1988). Infants of depressed mothers show "depressed" behavior even with nondepressed adults. *Child Development*, 59, p. 1569-1579.
- Focht, A., & Kellner, C.H. (2012). Electroconvulsive therapy (ECT) in the treatment of postpartum psychosis. *Journal of ECT*, 28(1), p. 31-33.
- Gavin, N.I., Gaynes, B.N., Lohr, K.N., Meltzer-Brody, S., Gartlehner, G., & Swinson, T. (2005). Perinatal depression: A systematic review of prevalence and incidence. *Obstetrics & Gynecology*, 106(5), p. 1071-1083.
- Giannandrea, S., Cerulli, C., Anson, E., & Chaudron, L. (2013). Increased risk for postpartum psychiatric disorders among women with past pregnancy loss. *Journal Of Women's Health*, 22(9), p. 760-768.

- Glavin, K., Smith, L., Sorum R., & Ellefsen, B., (2009). Supportive counselling by public health nurses for women with postpartum depression. *Journal of Advanced Nursing*, 66(6), p. 1317-1327.
- Goldbort, J. (2006). Transcultural analysis of postpartum depression. *The American Journal of Maternal/Child Nursing* , 31(2), p. 121-126.
- Goodman, J.H. (2004). Paternal postpartum depression, its relationship to maternal postpartum depression and implications for family health. *Journal of Advanced Nursing*, 45(1), p. 26-35.
- Goodman, S.H., Rouse, M.H., Connell, A.M., Broth, M.R., Hall, C.M., & Heyward, D. (2011). Maternal depression and child psychopathology: A meta-analytic review. *Clinical Child and Family Psychology Review*, 14(1), p.1-27.
- Goodman, J.H. & Santangelo, G. (2011). Group treatment for postpartum depression: a systematic review. *Archives of Women's Mental Health*, 14(4), p. 227-293.
- Government of Canada. (2006). *The human face of mental health and mental illness in Canada*. Minister of Public Works and Government Services Canada.
- Grekin, R., & O'Hara, M.W. (2014). Prevalence and risk factors of postpartum posttraumatic stress disorder: A meta-analysis. *Clinical Psychology Review*, 34(5), p. 389-401.
- Hall, P., & Wittkowski, A. (2006). An exploration of negative thoughts as a normal phenomenon after childbirth. *Journal of Midwifery & Women's Health* , 51(5), p. 321-330.
- Holden, J., & Sagovsky, R.C. (1989). Counselling in a general practice setting: controlled study of health visitor intervention in treatment of postnatal depression. *British Medical Journal* , 298 (6668), p. 223-226.
- Jané-Llopis, E., Barry, M., Hosman, C., & Patel, V. (2005). Mental health promotion works: a review. *Promotion & Education. Supp 2*. 12(9) p. 10.
- Jesse, E., & Graham, M. (2005). Are you often sad and depressed? Brief measures to identify women at risk for depression in pregnancy. *The American Journal of Maternal/Child Nursing* , 30(1), p. 40-45.
- Jones, I. & Craddock, N. (2001). Familiarity of the puerperal trigger in bipolar disorder: Results of a family study. *American Journal of Psychiatry*, 158(6), p. 913-917.

Joubert, N. & Raeburn, J. (1998). Mental health promotion: people, power and passion, *International Journal of Mental Health Promotion*. September 1998, p. 6.

Jorm, A. (2000). Mental health literacy: Public knowledge and beliefs about mental disorders. *The British Journal of Psychiatry*, 177: p. 396-401.

Jorm, A. (2012). Mental health literacy: Empowering the community to take action for better mental health. *American Psychologist*, 67(3), p. 231-243.

Keyes, C. (2007). Promoting and protecting mental health as flourishing: A comprehensive strategy for improving national mental health. *American Psychologist*, 62(2), p. 95-108.

Kim, D.R., Epperson, C.N., Weiss, A.R., & Wisner, K.L. (2014). Pharmacotherapy of postpartum depression: An update. *Expert Opinion on Pharmacotherapy*, 15(9), p. 1223-1234.

Kingston, D., Tough, S., & Whitfield, H. (2012). Prenatal and postpartum maternal psychological distress and infant development: A systematic review. *Child Psychiatry and Human Development*, 43(5), p. 683-714.

Kleiber, B.V., & Dimidjian, S. (2014). Postpartum depression among adolescent mothers: A comprehensive review of prevalence, course, correlates, consequences, and interventions. *Clinical Psychology: Science and Practice*, 21(1), p. 48-66.

Kroenke, K., Spitzer, R., & Williams, J. (2003). The Patient Health Questionnaire-2. *Medical Care*, 41(11), p. 1284-1292.

Logsdon, C., Wisner, K.L., & Pinto-Foltz, M.D. (2006). The impact of postpartum depression on mothering. *Journal of Obstetrics, Gynecologic & Neonatal Nursing*, 35, p. 652-658.

Lowe, B., Kroenke, K., & Grafe, K. (2005). Detecting and monitoring depression with a two-item questionnaire (PHQ-2). *Journal of Psychosomatic Research*, 58, p. 163-171.

MacMillan, H., Patterson, C., & Wathen, N.C. (2005). Screening for depression in primary care: recommendation statement from the Canadian Task Force on Preventive Health Care. *Canadian Medical Association Journal*, 172(1), p. 33-35.

Mann, R., Adamson, J., & Gilbody, S.M. (2012). Diagnostic accuracy of case-finding questions to identify perinatal depression. *Canadian Medical Association Journal*, 184(8), p. E424-E430.

Matthey, S., Kavanagh, D., Howie, P., Barnett, B., & Charles, M. (2002). Prevention of postnatal distress or depression; An evaluation of an intervention at preparation for parenthood classes. *Journal of Affective Disorders*, 79, p. 113-126.

Mulcahy, R., Reay, R.E., Wilkinson, R.B., & Owen, C. (2010). A randomised control trial for the effectiveness of group interpersonal psychotherapy for postnatal depression. *Archives of Womens' Mental Health*, 13(2), p. 125-139.

Munroe, P. (2000). Creative health solutions: Postpartum support program of Quinte. *IMPrint*, 27(Spring 2000), p. 11-13.

Murray, L., & Cooper, P.J. (1996). The impact of postpartum depression on child development. *International Review of Psychiatry*, 8(1), p. 55-64.

Murray, L., & Cooper, P.J. (1997). Effects of postnatal depression on infant development. *Archives of Disease in Childhood*, 77, p. 99-101.

Nonacs, R. (2006). *A deeper shade of blue – A woman's guide to recognizing and treating depression in the childbearing years*. New York: Simon & Schuster Paperbacks.

O'Hara, M., & Swain, A. (1996). Rates and risk of postpartum depression; A meta-analysis. *International Review of Psychiatry*, 8, p. 37-54.

O'Hara, M., Schlechte, J., Lewis, D., & Wright, E. (1991). Prospective study of postpartum blues. *Archives of General Psychiatry*, 48, p. 801-806.

Olson, A., Dietrich, A., Prazar, G., & Hurley, J. (2006). Brief maternal depression screening at well-child visits. *PEDIATRICS*, 118,(1), p. 207-215.

Olson, A., Dietrich, A., Prazar, G., Hurley, J., Tuddenham, A., Hedberg, V., & Naspinsky, D. (2005). Two approaches to maternal depression screening during well child visits. *Journal of Developmental & Behavioural Pediatrics*, 26 (3), p. 169-176.

Paulson, J.F., Sharnail, D., & Bazemore, S.D. (2010). Prenatal and postpartum depression in fathers and its association with maternal depression: A meta-analysis, *The Journal of the American Medical Association*, 303(19), p. 1961-1969.

Paulson, J., Dauber, S., & Leiferman, J. (2006). Individual and combined effects of postpartum depression in mothers and fathers on parenting behavior. *Pediatrics*, 118(2), 659-668.

Public Health Agency of Canada. (2006). *The human face of mental health and mental illness in Canada 2006*. Ottawa, ON: Minister of Public Works and Government Services Canada, 2006.

Razurel, C., Kaiser, B., Sellenet, C., & Epiney, M. (2013). Relation between perceived stress, social support, and coping strategies and maternal well-being: A review of the literature. *Women & Health*, 53(1), p. 74-99.

Reck., C., Stehle, E., Reinig, K., & Mundt, C. (2009). Maternity blues as a predictor of DSM-IV depression and anxiety disorders in the first three months postpartum. *Journal of Affective Disorders*, 113(1-2), p. 77-87.

Reilly, N., Harris, S., Loxton, D., Chojenta, C., Forder, P., & Austin, M.P. (2014). The impact of routine assessment of past or current mental health on help-seeking in the perinatal period. *Women and Birth*, 359.

Roberts, S.L., Bushnell, J.A., Collings, S.C., & Purdie, G.L. (2006). Psychological health of men with partners who have post-partum depression. *Australian and New Zealand Journal of Psychiatry*, 40; p. 704-711.

Ross, L., Dennis, C.L., Blackmore, E.R., & Stewart, D. (2005). *Postpartum sepression; A guide for front-line health and social service providers*. Toronto: Centre for Addiction and Mental Health.

Ross, L.E., & McLean, L.M. (2006). Anxiety disorders during pregnancy and the postpartum period: A systematic review, *Journal of Clinical Psychology*, 67(8), p. 1285-1298.

Ross, L., McQueen, K., Vigod, S., & Dennis, C.-L. (2010). Risk for postpartum depression associated with assisted reproductive technologies and multiple births: A systematic review. *Human Reproduction Update*, 17(1), p. 96-106.

Rossiter, C., Fowler, C., McMahon, C., & Kowalenko, N. (2012). Supporting depressed mothers at home: Their views on an innovative relationship-based intervention. *Contemporary Nurse*, 41(1), p. 90-100.

Sanders, L.B. (2006). Assessing and managing women with depression: A midwifery perspective. *Journal of Midwifery & Women's Health*, 51, p. 185-192.

Scope, A., Leaviss, J., Kaltenthaler, E., Parry, G., Sutcliffe, P., Bradburn, M., & Cantrell, A., (2013). Is group cognitive behaviour therapy for postnatal depression evidence-based practice? A systematic review. *BMC Psychiatry*, 13, p. 321.

Sockol, L.E., Epperson, C.N., & Barber, J.P. (2013). Preventing postpartum depression: A meta-analytic review. *Clinical Psychology Review, 33*(8), p. 1205-1217.

Stewart, D.E., Gagnon, A., Saucier, J-F., Wahoush, O., & Dougherty, G. (2008). Postpartum depression symptoms in newcomers. *The Canadian Journal of Psychiatry, 53*(2), p. 121-124.

Stuart, S., & Koleva, H. (2014). Psychological treatments for perinatal depression. *Best Practice & Research Clinical Obstetrics and Gynaecology, 28*(1), p. 61-70.

Troutman, B., & Cutrona, C.E. (1990). Nonpsychotic postpartum depression among adolescent mothers. *Journal of Abnormal Psychology, 99*, p. 69-78.

Watson Driscoll, J. (2006). Postpartum depression; How nurses can identify and care for women grappling with this disorder. *AWHONN Lifelines, 10*(5), p. 400-409.

Whooley, M., Avins, A., Miranda, J., & Browner, W. (1997). Case-finding instruments for depression; two questions are as good as many, *Journal Of General Internal Medicine, 12*, p. 439-445.

Winnipeg Regional Health Authority, (2013). *WRHA Population & Public Health Conceptual Framework*, Retrieved from <http://www.wrha.mb.ca/extranet/publichealth/index.php>

Wisner, K., Perel, J., Peindl, K., & Hanusa, B. (2004). Timing of depression recurrence in the first year after birth. *Journal of Affective Disorders, 78*, p. 249-252.

Wisner, K.L., Sit, D., McShea, M.C., Rizzo, D.M., Zoretich, R.A., Hughes, C.L., Eng, H.F., Luther, J.L., Wisniewski, S.R., Costantino, M.L., Confer, A.L., Moses-Kolko, E.L., Famy, C.S., & Hanusa, B.H. (2013). Onset, timing, thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings. *JAMA Psychiatry, 70*(5), p. 490-498.

World Health Organization. (2001). *Mental health: Strengthening mental health promotion*, Fact Sheet No. 220. Geneva, Switzerland: WHO, p. 1.