Screening for Postpartum Depression at Pediatric Visits

Because of the potential for detrimental effects on children, postpartum depression has emerged as an important issue for nurses working in pediatric health care settings. Pediatric health care settings such as offices and clinics have been identified as optimal screening sites for postpartum depression on the basis of opportunities for repeated interactions. Nurses working in pediatric settings are ideally situated to identify and refer mothers experiencing maternal depressive symptoms because many mothers interact more frequently with pediatric nurses and other health care providers than any other provider during their child’s first year of life (Sheeder, Kabir, & Stafford, 2009).

Due to the frequency of visits during the first year postpartum, a trusting, continuous relationship between the nurse and mother may develop. Such a relationship may enhance the discussion and detection of maternal depressive symptoms. Awareness of maternal depressive symptoms during the first postpartum year allows nurses to have a better understanding of parenting issues and other concerns raised about the child (Olson et al., 2005). Screening, identification, and intervention for postpartum depression are important and may prevent long-term negative child outcomes, as well as adverse maternal outcomes (Heneghan, Morton, & DeLeone, 2007).

When screening for postpartum depression, the use of a formal screening instrument is recommended because inaccurate detection of postpartum depressive symptoms may occur with informal screening. Although lengthier screening tools are available, it has been found that screening with two questions about mood and anhedonia may be as effective as using a longer screening instrument. Two screening questions endorsed by the U.S. Preventive Services Task Force (2009) may allow nurses to screen mothers during routine pediatric visits: “Over
the past 2 weeks, have you been down, depressed, or hopeless?” and “Have you felt little interest or pleasure in doing things?” (Whooley, Avins, Miranda, & Browner, 1997). Less than 1 minute is required to administer these two questions to new mothers, making it realistic for use with parents in pediatric visits.

When working with mothers at risk for postpartum depression, listening in a nonjudgmental fashion may encourage them to share their feelings. Nurses can use “sometimes” statements such as, “Sometimes mothers report [symptom/feeling]. Have you experienced similar feelings/symptoms?” It is important for mothers to understand that other people experience these same feelings and symptoms. Although feelings of depression may not be disclosed immediately, if the mother feels that she is working with a trusted nurse, she may call or return later seeking assistance with her symptoms (Meadows-Oliver & Sadler, 2010).

While screening for symptoms of postpartum depression is extremely important, it is essential to recognize the barriers to screening. Nurses working in pediatric settings are well placed to screen for and detect early symptoms of postpartum depression, but they may lack time, training, and/or referral sources to feel comfortable evaluating new mothers for depressive symptoms (Heneghan et al., 2007). To improve comfort in screening for postpartum depression, the knowledge and skills required for detecting it should be taught in nursing school—before nurses enter the workforce. Students in both undergraduate and graduate nursing programs should be taught the importance of and skills for screening for postpartum depression. Direct training experiences in the identification, use, and application of screening tools, as well as specific guidelines for addressing and referring identified patients for intervention, should be provided (Connelly, Baker, Hazen, & Mueggenborg, 2007). Such educational experiences should take place in both the classroom and clinical settings.

Postpartum depression is a treatable condition, and timely recognition and treatment of depressive symptoms can substantially improve health outcomes for children, mothers, and families. Nurses are in an ideal position to ensure that mothers with symptoms of postpartum depression receive the help they need. Those working in pediatric settings can provide multiple and flexible opportunities for women to disclose and discuss their emotional health issues (Armstrong & Small, 2010). In addition to screening and referring for necessary treatment, nurses working closely with families can ascertain the mothers' personal coping strategies and determine whether any interpersonal relationships are available for the mother that provide support.

Screening for postpartum depression can be successful when presented as a routine part of the care provided (Connelly et al., 2007). Nurses working in settings where they have contact with mothers in the first postpartum year (e.g., pediatric offices, obstetrical/gynecological offices, visiting nurse services) are encouraged to incorporate detection of maternal depressive symptoms into their standard care (Olson et al., 2005). If using the 2-item screening questionnaire, it is important to remember that mothers who have only one positive response still may have depressive symptoms and may benefit from discussions with and support from the nurse. Parents often regard nurses in their child’s pediatric office as trusted sources of information and advice. By building on a previously established relationship with families, nurses can bring about positive outcomes for mothers with depressive symptoms during the first postpartum year.

REFERENCES

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