Postpartum Depression: A Collaborative Approach to Assessment and Treatment

by

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Abstract

While often viewed as an exciting time, becoming a parent does not come without its challenges. While it is typical to experience fluctuations of emotions while the body adjusts from pregnancy to postpartum, around one in five women experience symptoms that are consistent with diagnostic criteria for postpartum depression (PPD). Unfortunately, there is still a lack of consistency in screening protocols, resulting in an increased risk of cases going undetected and mothers not receiving the support they need. This capstone examines the impacts of untreated PPD on mothers and infants, ranging from psychosocial and physiological to disruptions in attachment. Current evidence for treatment outlines a variety of psychotherapeutic modalities and psychopharmacological interventions, including the emergence of the first oral medication that specifically targets PPD. Following the literature review on PPD screening, impacts, and treatment, the capstone discusses potential next steps in improving perinatal healthcare. The discussion conclusions with a proposal for a multidisciplinary collaboration presentation template designed to improve the well-being of mothers and infants in this transitional period.

Keywords: Perinatal, postpartum, attachment theory, cognitive behavioural therapy, multidisciplinary healthcare

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Dedication

This capstone is dedicated to not only my mother, but to the women in my life who have shown me the power of a mother's love. To my sisters, extended family, and friends, you all amaze me and inspire me in different ways, and have all shown that no matter what life throws at you, your love for your families remains fierce.

This is for mothers all over the world. You are seen, you are appreciated, and you are not alone. As for strong women: may we know them, may we be them, may we raise them.

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Chapter 1: Introduction

Postpartum depression (PPD) is a widely known complication affecting women in the first year after giving birth. In many cases, it can persist beyond the early postpartum period into early toddler age (Lackie et al., 2021; Putnick et al., 2020). The terms PPD and "baby blues" are globally recognized and common symptoms of PPD are studied in an ongong way to improve diagnostic criteria. It is important to understand when these symptoms are experienced and how healthcare institutions and other individuals supporting women experience them. Despite being a global phenomenon, there is a lack of clarity and consistency in guidelines outlining when PPD assessment should take place and which assessment tools should be used (Levis et al., 2020).

The physical processes of pregnancy and childbirth are complex and come with an extensive list of potential complications. Emphasis is placed on physical wellness up until a baby is born, and the majority of doctors' appointments in the weeks and months following birth focus on the physical health and wellness of the new baby. Even with increasing awareness of how common it is for women to experience PPD—whether diagnosed or simply experiencing symptoms—there still does not seem to be an agreed upon timelines for PPD testing or assessment. Although medical practitioners are aware of the effects PPD can have on mothers and their babies, in the United States (U.S.) screening is rarely done during initial well-child visits (Sriraman et al., 2017). PPD remains a taboo topic within modern society, yet reports show that 10-25 percent of mothers are affected by it, making PPD the most common underdiagnosed obstetric complication (Bass & Bauer, 2018; Sriraman et al., 2017). Additionally, there are multiple levels of severity when it comes to PPD, creating a spectrum of disease starting with the most commonly experienced “postpartum blues”, on to PPD, and finally to the least common diagnosis: postpartum psychosis (Bass & Bauer, 2018). It was only recently that the American

Academy of Pediatrics recommended a screening protocol during well-child visits, stating that although the mother may not be the patient of the child's pediatrician, multiple facets of the child's well-being are impacted by the well-being of the mother and the strength of the mother-child relationship (Earls et al., 2019). Previous research has also concluded that there are many important developmental events that occur in the first few weeks and months following birth (Surkan et al., 2012), which supports the importance of assessing the mother's well-being during initial well-child appointments.

Theoretical Framework

Attachment Theory

Attachment theory is the primary lens used throughout this capstone when reviewing research into the importance of maternal mental health for both infants and mothers. Initial and early contributions from John Bowlby and Mary Ainsworth highlight the importance of secure infant-caregiver attachment early on in infant development, emphasizing the importance of appropriate responses to infants' needs to foster secure attachment (Bowlby, 1988). A secure attachment is formed when a caregiver is attuned and properly responds to an infant's needs. Securely attached children typically grow up to have a solid sense of trust and safety, and a stronger ability to build meaningful social connections. On the other end of the spectrum, an insecurely attached child did not have their needs properly met in infancy/early childhood or may have experienced various forms of neglect and/or abuse (emotional, physical, psychological, etc.). Insecure attachments are traditionally categorized into three groups: anxious/preoccupied, avoidant/dismissive, and disorganized/fearful. In recent years, theorists have proposed insecure attachment styles move away from a solid categorization, and towards a spectrum-based approach, as the previously proposed groups tend to have some co-occurring traits (Fern, 2020).

Overall, children with insecure attachments struggle with trust and a sense of safety in the world, believing they cannot rely on people. Because we begin to develop our attachment styles early on as an infant/child, it is imperative that medical professionals understand the importance of secure attachment, how PPD can threaten the development of secure attachment, and how to best support mothers in early postpartum to help combat disruptions in attachment.

Feminist Theory

A secondary framework considered throughout this capstone is feminist theory. Women have historically been marginalized in almost all facets of life, and parenthood is no exception. Due to factors such as the rise in social media use and access in the last two decades (Aker et al., 2024; Olpin et al., 2023) and the dismissal of women—especially women of colour—within the healthcare system (Gutowski et al., 2022), it is imperative to analyze this topic from a feminist standpoint as well. Another feminist consideration in the context of this paper is the importance of combined supports from both mother and father. A solid and understanding partnership between parents is as important for a child's development as the mother's connection to her baby. Partners of women in the postpartum period have been shown to be valuable assets in the assessment and treatment process for PPD (Brandon et al., 2012; Moran & O'Hara, 2006).

Research Problem

Considering the correlation between early infant development and a mother's mental well-being, there is potential for prevention and early treatment of PPD symptoms. Putnick et al. (2020) found that many women do not seek help for their symptoms, hoping that symptoms will subside on their own over time. Additionally, assessing too soon and only once during the early postpartum period poses risk for mothers whose symptoms do not show up immediately; PPD symptoms can present early on and persist until late toddlerhood (Lackie et al., 2021; Putnick et

al., 2020). If left untreated, there are many potential impacts on an infant's social-emotional development; the longer the mother goes without treatment and the mother-infant bond does not receive intervention, the child is less likely to respond to intervention later (Earls et al., 2019). Through an attachment lens, the relationship between an infant and their caregiver is an important contributor to the infant's psychological and social development and functioning throughout life (Ainsworth et al., 1979). There is plenty of evidence that supports the claim that children who develop secure attachments experience more positive outcomes socially, emotionally, and psychologically compared to their insecurely attached counterparts (Crugnola et al., 2022; Meins et al., 2018). Because PPD and other postpartum mental health disorders can cause a range of disruptions to a mother's ability to properly tend to their infant's needs, it is extremely important for all professionals involved in postpartum medical care to recognize and identify symptoms of PPD and guide mothers to the appropriate supportive professionals.

Research Question

In accordance with the Canadian Paediatric Society, well-child visits should occur starting around two days to one week after birth, followed by visits at two-, four-, six-, nine-, twelve-, and eighteen-months (2021). During these visits, the infant's health and development are the main concern for the pediatrician. The mother is not assessed during these appointments; she needs to make her own follow up appointments with her primary care physician. There are many reasons why a mother may not make follow up appointments for herself, especially if she is experiencing symptoms of PPD or "baby blues." Factors may include: embarrassment, fear of the infant being taken from her care, lack of education on PPD symptoms, lack of (whether perceived or not) proper support or treatment within her community, amongst others. The purpose of this capstone is to analyze the use of PPD assessment/screening at all well-child

doctor's appointments with the goals of early intervention and potential prevention of PPD symptoms and/or diagnosis. The following questions guide this capstone:

1. What role does attachment theory play in PPD risk assessment, and what does this have to do with pediatric visits?
2. What tools are used or should be used when assessing for PPD and other postpartum mental health disorders?
3. Should pediatricians be required to maintain working relationships with postpartum mental health specialists within their community/work settings to assist in bridging the gap between mothers who need treatment but do not receive it, and those who are able to seek it out?
4. What are the most commonly used treatment modalities for PPD?

Key subthemes that are explored include: attachment theory and infant/child development, PPD assessment tools and their variations, importance and benefits of multidisciplinary healthcare teams and the most commonly used treatment methods/modalities for PPD.

Methodology

To ensure I reviewed the most up to date information during my research, as well as ensured reliability and validity, I filtered my searches to only include results published within the last 8 years, as well as strictly peer-reviewed articles. Searches were conducted using the City University Library databases, University of Windsor library database, and occasionally Google Scholar. To organize the research, I used the following key words from the previously mentioned sub questions: postpartum depression (PPD), perinatal depression, birth trauma, Edinburgh postnatal depression scale, postnatal depression, maternal mental health, well-child visit, attachment theory, infant caregiver dyad, cognitive behavioural therapy (CBT) and PPD,

interpersonal therapy, and perinatal mental health counseling. I chose to keep my searches open to globally conducted studies in hopes of comparing assessment and treatment in other parts of the world beyond North America, and to expand assessment and treatment suggestions. Over 120 articles were reviewed in full. Most of the studies examined focused specifically on postpartum depression and/or perinatal depression, rather than general mood disorders. I also chose not to include studies that focused on postpartum psychosis as this is a severe but less common disorder. Articles that discussed diagnostic criteria, prevalence, screening practices, and treatment were prioritized and filtered out based on relevance to each section and subsection. Additionally, research design, sample size, and methodological rigor were taken into account and limitations related to these factors were highlighted.

When reviewing articles located through Google Scholar, I refrained from opinion-based pieces, filtered my search results to only show peer-reviewed articles, and only used information from websites that are nationally recognized agencies or approved by appropriate collegiate affiliations (e.g. appointment timelines proposed by the Canadian Pediatric Society). Articles published before the 8-year cut-off were included to show the increase in research and understanding of PPD over time, the evolution of assessment and treatment approaches, and for comparison purposes. Articles that were not available in English were not used to avoid translation errors. Studies that were unrelated to screening, prevention, and intervention were also excluded.

Reporting of Results

The literature reviewed is presented in traditional-narrative format, including research from multiple academic disciplines, various study methodologies, and a comprehensive synthesis of key issues, research trends, and discrepancies (Efron & Ravid, 2018). The literature reviewed

was analyzed for gaps and themes pertaining to the assessment of a mother's mental health at well-child visits and the relationship between PPD diagnosis and treatment. The goal is to support a more comprehensive understanding of the importance of increased maternal assessment as it directly relates to the developmental well-being of a child. The findings and applied practice proposal will be presented to faculty and staff, and possibly to a few of my family members, during a dissemination event held by City University of Seattle. I am also open to presenting at new student orientations or any other speaking opportunities within City University of Seattle.

Contribution to the Field

One of the main goals of this capstone is to highlight the importance of a multi-disciplinary support team when it comes to the assessment and treatment of women in the postpartum period. There is a plethora of research on the topic of PPD as a disorder, but there does not seem to be consensus on the importance of healthcare practitioners working in collaboration with each other to help with the diagnosis and treatment of women with PPD. This is a topic that falls within what is described as preventative healthcare as it has the potential for intergenerational impacts, including impacts on the well-being of society more broadly.

In the realm of counselling and psychotherapy, another important goal of this capstone is to further consider potential training possibilities for those in the mental health field about how to build positive working relationships with medical professionals. This discussion also strives to contribute to training protocols for medical professionals working in collaboration with mental health professionals. Suggestions on ways to build and foster these relationships will be made towards the end of the paper.

Reflexivity & Positionality

For a capstone such as this, it is essential to examine how my social location continues to shape both my understanding of and approach to postpartum mental health care. I am a white, cisgendered, able-bodied female raised in a middle-class, blended family in a very small lake town in Ontario. My perspectives are informed by privileges that both inform and limit my understanding. These intersecting identities influence how I interpret experiences of postpartum mental health, particularly in relation to access to care, social supports, and systemic responsiveness. Acknowledging these privileges requires consistent reflection on the assumptions I bring to this line of work, and the blind spots that remain after reflection. I currently live on the traditional territory of the Anishinaabe people—specifically the Chippewa, Odawa, and Potawatomi nations who are a part of the Three Fire Confederacy—land ceded through Treaty #2 (the McKee Purchase). Living and working on these lands is an unearned privilege that shapes my relationship to healthcare systems, research, and access. I acknowledge how colonial histories and ongoing inequities intersect with maternal mental health, particularly for Indigenous communities whose experiences are frequently marginalized within modern healthcare frameworks. Throughout this capstone, my analysis is grounded in the context of Canada's publicly funded healthcare system. While universal healthcare may seem equitable, there are persistent systemic barriers marginalized populations face, highlighting that reduced financial burden does not equate to universally accessible or culturally responsive care.

Another key influence on my perspective is my role as a sister and an aunt. As the youngest of six siblings and an aunt since the age of 13, my experience and understanding of PPD is through second-hand accounts shared by family members, rather than through lived experience of pregnancy or childbirth. While these relationships offer insight into the emotional

realities of motherhood, they also risk narrowing my understanding to experiences shaped by familial and social proximity and support. As I have yet to personally navigate perinatal healthcare systems, my understanding remains informed by observation, research, and relational proximity rather than embodiment. Finally, as someone who aspires to pursue a career in maternal mental health counselling, my interest in this topic is shaped by both professional motivation and ethical responsibility. This dual positioning warrants sustained reflexivity to ensure that advocacy does not obscure critical analysis. This capstone seeks to raise awareness of the effects of unrecognized and untreated PPD while examining how maternal healthcare professionals—including myself—can collaborate more effectively while remaining attentive to the power, privilege, and assumptions embedded within our current healthcare systems.

Definition of Terms

Baby Blues/Postpartum Blues: Refers to the first few days after delivery where a new mother is experiencing difficult symptoms similar to those of PPD, but that do not impair maternal function (Bass & Bauer, 2018). The "blues" fade on their own with emotional support.

Multidisciplinary Approach: Refers to "the combination of different expertise towards a common purpose ... while keeping the existing boundaries between each unique discipline" (Najm et al., 2020, p. 1).

Perinatal Period: Refers to the full timeframe of pregnancy through one year postpartum (Li et al., 2022).

Puerperium: Refers to a specific window in the postpartum period: directly after birth through the first six weeks (World Health Organization, 2025).

Chapter Summary

This chapter outlines the purpose and intent of this capstone, and highlights discrepancies within current maternal mental healthcare practices. The next chapter consists of a literature review, wherein current research on PPD is summarized and analyzed focusing on three main themes: assessment and diagnosis; impacts on mothers and infants; and treatments and interventions. In the third and final chapter, I discuss gaps in the current research and outline a proposal to help improve the assessment and support of women experiencing difficulties on their journey into motherhood.

Chapter 2: Literature Review

This chapter is split into three sections to review, summarize, and discuss current and relevant literature surrounding each theme. The first section looks at the screening process and diagnosis of PPD. Section two focuses on the developmental, physiological, and psychosocial risks that undiagnosed/untreated PPD may have on mother and baby, along with the impact of cultural influences and societal stigma on care traditions and help-seeking, highlighting the pros and cons of social media platforms. Finally, part three examines current and emerging interventions and treatments, and barriers to accessible culturally attuned care.

Postpartum Depression

Beyond the physical process of giving birth, the postpartum period comes with a plethora of emotional, mental, and physiological changes. The period commonly known as "baby blues" typically refers to the first week or so after giving birth when the mother's body is healing and her hormones are balancing. When emotional changes surpass a manageable threshold, a postpartum mood disorder may be on the horizon. It is imperative to recognize and understand the risk factors and symptoms associated with PPD to diagnose and support mothers. Furthermore, a collaborative approach between healthcare and mental health professionals supports screening and assessment, helping to mitigate cases missed and mothers who may struggle in silence. Though there are multiple perinatal mood and anxiety disorders (PMADs), this review focuses on peripartum/postpartum depression (PPD). PPD falls within the major depressive disorder diagnostic criteria in the *DSM 5-TR* (American Psychiatric Association [APA], 2022), with a specifier of peripartum onset. The current depressive episode (or most recent episode if a previous diagnosis of MDD is in partial or full remission) must begin during pregnancy or within four weeks following delivery. PMADs can have an onset of symptoms

during pregnancy or after delivery, so this time frame is collectively referred to as *peripartum*. A major factor in recognizing the difference between the commonly experienced "baby blues" and PPD is that PPD causes prolonged functional impairment. Within the first week after giving birth, a mother experiences many physiological changes that could influence mood and overall daily functioning, but according to the *DSM 5-TR* (APA, 2022) this experience is temporary and improves without the need for treatment.

Screening

Before diagnostic assessment can happen, a medical practitioner must first screen individuals to determine the need for further clinical assessment. There has been much debate about the efficacy of and need for universal screening of all pregnant women for depression during the peripartum period, with no clear consensus nationally or internationally. The Canadian Task Force on Preventive Health Care (Lang et al., 2022) recommends against depression screening for all peripartum individuals as their most recent research was inconclusive about whether universal screening using screening instrument or questionnaire improves outcomes. Lang et al. (2022) conclude that universal screening of new mothers could lead to an increase in false positives and false negatives, leading to unnecessary referrals, diagnostic evaluations, and possible overdiagnosis.

In contrast, the American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG, 2017), and the Registered Nurses' Association of Ontario (RNAO, 2018) recommend using an evidence-based screening tool at least once during the perinatal period. The Canadian Network for Mood and Anxiety Treatments practice guidelines (Vigod, 2024) recommend clinicians implement case identification throughout the different stages of the perinatal period (once per pregnancy trimester, at first postpartum follow

up, and within family/pediatric care within first 12 months postpartum). Screening throughout the pregnancy journey may increase opportunities to connect parents with supports or treatments that could change the severity and longevity of the symptoms they could experience. The RNAO is made up of individuals from various health-care settings with expertise in perinatal depression; the panel is interprofessional with nurses holding clinical, administrative, and academic positions. Best practice guidelines are reassessed and updated every five years to reflect findings from emerging literature in the field. Within their best practice guidelines, the RNAO states that routine screening is positively associated with increased detection of PPD (2018), thus supporting universal screening protocols.

In further contrast, a key message from the Canadian Task Force is "do ask, but don't screen" (Patrick, 2022). Lang et al. (2022) mention that this recommendation comes with the assumption care providers will inquire about and be attentive to maternal mental health and well-being as part of usual postpartum care. An important question remains: What does "usual postpartum care" mean? It is noted that "making a judgement about a patient's status after a personalized assessment, based on all information available to a practitioner, is considered to be routine clinical care and not screening" (Lang et al., 2022, p. E982). It is important to consider that healthcare clinicians vary in their training for PPD symptom detection (Gavin et al., 2015), which may increase the risk of symptoms going unnoticed and women not being properly assessed. Additionally, the Canadian Perinatal Mental Health Collective (CPMHC) found that 57.3% of the clinicians surveyed did not have formal training or a background in perinatal mental health (Hooykaas, 2021), further highlighting the risk of relying on clinical judgement rather than periodic universal screening. The risks associated with missed diagnosis in both mother and infant are discussed in section two.

Beyond differences in professional guidelines, methodological limitations within the screening literature contribute to ongoing disagreements regarding best practices. Many studies that evaluate screening efficacy rely on observational or cross-sectional designs, limiting their ability to determine whether screening itself drives improved outcomes rather than subsequent access to care. In many cases, positive associations between screening and symptom reduction depend on the availability of follow-up services, suggesting that screening in isolation may be insufficient to produce meaningful change. This raises an important distinction between the identification of symptoms and the capacity of healthcare systems to respond effectively once concerns are identified.

Additionally, variability in study design, screening instruments, cut-off scores, and timing of assessment complicates comparisons across studies. Some evaluations focus on a single screening point, while others incorporate repeated assessments across pregnancy and the postpartum period, resulting in markedly different detection rates. These inconsistencies limit the generalizability of findings and contribute to the lack of consensus reflected in national and international guidelines. As a result, debates surrounding universal screening may be less reflective of screening efficacy itself and more indicative of broader systemic limitations in perinatal mental healthcare infrastructure. Given the lack of consensus regarding universal screening practices, identifying consistent opportunities for assessment within the healthcare system is important. Routine well-child appointments may provide one such setting, allowing for postpartum depression screening across the first year postpartum and supporting earlier identification and intervention.

While there are multiple evidence-based screening tools for depression and general depressive symptoms (PHQ-9, Beck Depression Inventory, Whooley Scale, etc.), there are two

screening tools that are centered on postpartum depression: the Edinburgh Postnatal Depression Scale (EPDS) and the Postpartum Depression Screening Scale (PDSS). Both the EPDS and PDSS are validated for use postpartum, while the EPDS is the only tool that has been validated for use during the peripartum period.

Edinburgh Postnatal Depression Scale. The EPDS was first developed by John Cox, Jeni Holden, and Ruth Sagovsky, and was specifically designed for the perinatal period (Cox et al., 1987). It is used in many countries and is now available in over 60 languages. There is overlap in symptoms when comparing what is commonly known as the "baby blues" and PPD, notably the duration and severity of symptoms; PPD symptoms last longer than two weeks, occur almost daily, and may result in maternal functional impairments (Bass & Bauer, 2018). The EPDS is a 10-question self-report questionnaire that typically takes between 5-10 minutes to complete and asks about symptoms of depression that have been present in the last seven days (Cox et al., 1987). The questionnaire is scored from 0 to 30, with each question having an experience severity rating of 0 to 3 (Appendix A). The cut-off score varies, as each translated version has a cut-off score recommendation. Originally, Cox et al. (1987) proposed a threshold score of 9/10, but recently CANMAT concluded that a cut-off score of 11 or higher maximizes identification accuracy (Vigod et al, 2024). It is important to note that for question 10 on the EPDS, any answer other than 0 requires an immediate, comprehensive risk assessment, and often an immediate referral.

Although the EPDS is the only validated tool used to identify PPD within the perinatal period, guidelines about its use are not universally agreed upon. For instance, in Ontario, the Provincial Council for Maternal and Child Health ([PCMCH], 2021) seemingly agrees with the Canadian Task Force's recommendations against universal screening, with the development of

the Perinatal Mental Health guidance document (PCMCH, 2021) and supplementary Care Pathway Tool (Appendix B). Instead of screening every patient who is pregnant or in early postpartum, the Care Pathway recommends using a 5-step model for perinatal mental health assessment: Ask, Advise, Assess, Assist, and Arrange. The first step, Ask, emphasizes early identification through open communication between the pregnant or postpartum person and their healthcare provider. This includes asking the patient in a sensitive manner about their mental well-being, inquiring about their feelings, coping capabilities, and any specific symptoms they may be experiencing. This care model leaves it up to the healthcare provider to determine whether a screening tool like the EPDS is needed, which could depend on the patient-doctor relationship. Considering barriers associated with the access to primary care and routine antenatal care in Canada, as well as stigma around mental health in general, symptoms may go unnoticed or undisclosed if a patient does not feel confident or comfortable having a conversation with their health care provider; access to assessment and care may vary based on the quality of the patient-doctor relationship (Bonacquisti et al., 2017).

Postpartum Depression Screening Scale. The PDSS is the other validated screening tool used specifically to identify PPD. It was developed by Cheryl Beck and Robert Gable between the late 1990's into the early 2000's, with the goal to create a screening tool that better represents the most common symptom experiences of mothers (Beck & Gable, 2000). Since the PDSS was first published in 2002, it has been translated into 14 languages (Beck, 2024). During the research for and development of the PDSS, Beck noted that items on the EPDS are similar to those on general depression screening tools and they do not contain questions written to address the context of a new mother's experience, with all items being quotes from women who had participated in Beck's previous research on PPD (Beck & Gable, 2000).

The PDSS is a self-report questionnaire consisting of 35 statements relating to how a mother may have felt within the past two weeks. The patient responds using a 5-point Likert scale to indicate their degree of agreement with each statement. The questionnaire typically takes 5-10 minutes to complete (Beck, 2024). Total scores are between 35-175, and are interpreted in three ranges: normal postpartum adjustment (35-59 range), significant symptoms of PPD (60-79 range), and positive screen for PPD (80-175 range). To better understand the new mother's experience and to aid in treatment/intervention recommendations, results landing above the normal adjustment range should be further examined using the supplementary symptom content scale (Beck, 2024). The seven symptoms are: sleep/eating disturbances (SLP), anxiety/insecurity (ANX), emotional lability (ELB), mental confusion (MNT), loss of self (LOS), guilt/shame (GLT), and suicidal thoughts (SUI) (Beck, 2024). Each symptom area has possible score of 5-25 and a specific elevated score threshold to better indicate which symptoms are causing higher levels of distress. These results can help clinicians discuss interventions or treatment plans to best support specific symptoms.

Women whose total score is within the 80-175 range are in definite need of further psychiatric evaluation, and similarly to item 10 on the EPDS, a score higher than 5 on the SUI symptom subscale should receive a suicide risk assessment and, depending on the item the patient agreed with, an immediate referral to emergency psychiatric services. The PDSS is also available in a short form version, the PDSS_SF, which has been shown to identify cases of MDD as well as the complete version (Mitchell, Mittelstaedt, & Schott-Baer, 2006). One major difference (and limitation) when comparing the PDSS to the EPDS is that the PDSS is only used in the postpartum period, not during pregnancy, thus eliminating the possibility for intervention or possible prevention before birth. Additionally, the EPDS is free for clinical use and available

online, whereas the PDSS is a commercial instrument that requires purchase through the publisher site. Additional comparison of both screening tools can be found in Appendix C.

Comparative Strengths and Limitations of PPD Screening Tools

When considered together, the EPDS and PDSS illustrate the trade-offs inherent in postpartum depression screening. The EPDS's brevity, cost-free availability, and validation across the peripartum period support its widespread adoption in clinical settings; however, its limited symptom scope may overlook experiential dimensions of PPD that are particularly salient for new mothers. Conversely, the PDSS offers a more nuanced representation of postpartum distress and facilitates symptom-specific intervention planning, yet its length, cost, and postpartum-only application limits feasibility and preventative utility. These differences underscore the absence of a universally optimal screening tool and reinforce the importance of contextual decision-making. Tool selection must account for setting, provider training, resource availability, and population needs. Without accompanying clinical pathways and access to treatment, even the most psychometrically robust screening tool risks functioning as a procedural exercise rather than a meaningful entry point into care.

Diagnosis

When screening for PPD, it is imperative that healthcare professionals recognize symptoms most commonly observed in diagnosed women. Symptoms that researchers tend to refer to as the most common in PPD cases are: sadness, weepiness, low mood, irritability, impaired concentration/mental confusion, feeling overwhelmed, sleep disturbances, feelings of worthlessness or guilt, loss of interest, feelings of doubt (related to perceived ability to bond with and care for baby), anxiety (rumination/obsessional thoughts about baby's welfare), and thoughts of self-harm/suicide or harm of the infant (Beck, 2024; Gavin et al., 2015; O'Connor et al.,

2019). As previously mentioned, there is a normal threshold for experiencing these symptoms during the typical "baby blues" period (Bass & Bauer, 2018), which means that identifying the length and severity of the symptoms being experienced is an integral part of the screening process. It is also important to note that although women of colour face a significantly higher risk of experiencing symptoms of PPD, they are less likely to be screened for it compared to white women (Sidebottom et al., 2021; Wenzel et al., 2021). Although they strive to work in relation to one another, the American Psychiatric Association (APA) and the World Health Organization (WHO) have slightly different diagnostic processes.

American Psychiatric Association. The American Psychiatric Association (APA) is responsible for the creation of and amendments to the *Diagnostic and Statistical Manual of Mental Disorders*, commonly known as the DSM. The most recent edition is the *DSM-5-TR* (APA, 2022). The *DSM-5-TR* does not have a stand-alone diagnosis for PPD but instead has a peripartum onset specifier for individuals who meet diagnostic criteria for a depressive disorder, commonly MDD (APA, 2022). The *DSM-5-TR* defines peripartum onset as symptoms occurring during pregnancy or within 4 weeks following delivery, emphasizing the need to distinguish depressive disorders with peripartum onset from "baby blues" as the latter is not considered a disorder. For an MDD diagnosis, a person must have at least five of the following symptoms present almost daily over a consecutive two-week period: depressed mood most of the day, diminished interest or pleasure in almost all activities, significant changes in weight, insomnia or hypersomnia, psychomotor agitation/retardation, fatigue or loss of energy, feelings of worthlessness or excessive guilt, diminished ability to think or concentrate, and recurrent thoughts of death or suicidal ideation (without plan, with specific plan, or suicide attempt).

Additionally, symptoms must cause significant distress or impairment in an individuals' functioning and not be attributable to the effects of a substance or another medical condition.

World Health Organization (WHO). Comparatively, the newest edition of the WHO's *International Classification of Diseases and Related Health Problems*—the *ICD-11* (2022)—categorizes PPD within mental or behavioural disorders associated with pregnancy, childbirth, or the puerperium, with symptom onset spanning from six weeks after birth (World Health Organization, 2025). Diagnostic criteria are similar but include difficulty bonding with the baby and withdrawing from family and friends as additional symptoms to watch for. As research has suggested that the onset of symptoms extends well into the first year after delivery, both publications are seemingly restrictive in their diagnostic windows and do not account for women who have later onset of symptoms (de Moraes et al., 2017; Lackie et al., 2021; Putnick et al., 2020). The timeframe labelled as the "postpartum period" ranges from birth up to one year in clinical practice and research studies. In view of this, for over a decade, researchers dedicated to understanding PPD have proposed expanding the *DSM* peripartum onset specifier to up to six months after delivery to better reflect that range (O'Hara & McCabe, 2013).

Limitations of Diagnostic Timeframes

The diagnostic timeframes outlined in both the *DSM-5-TR* and the *ICD-11* present notable challenges for the identification and treatment of postpartum depression. Although these criteria are intended to differentiate PPD from transient postpartum mood disturbances, growing evidence suggests that the specified windows are too restrictive to reflect the lived experiences of many women. Research consistently demonstrates that clinically significant depressive symptoms often emerge several months after delivery, frequently in response to cumulative stressors such as sleep deprivation, role adjustment, and reduced social support. This

misalignment between diagnostic criteria and clinical reality has important implications for access to care. Women whose symptoms develop outside the designated diagnostic timeframe may be less likely to receive timely diagnosis, referral, or access to insurance-covered treatments, increasing reliance on informal clinical judgement and alternative diagnostic labels. As a result, care may be delayed or inconsistently delivered. Calls to expand the peripartum onset specifier aim to better align diagnostic frameworks with contemporary research and clinical practice, emphasizing the need for criteria that supports early identification and intervention across the full postpartum period.

The efficacy of universal screening for postpartum depression remains a major point of contention among governing medical bodies, reflecting fundamentally different assumptions about risk identification, clinical responsibility, and health system capacity. Targeted screening approaches emphasize the identification of individuals with known risk factors to reduce false positives and conserve limited resources; however, this approach presumes that risk factors are consistently recognized, disclosed, and accurately interpreted by clinicians. Given documented variability in practitioner training and comfort with perinatal mental health assessment, reliance on clinical judgement introduces a significant risk of missed or delayed diagnosis. In contrast, those in support of universal screening argue that many individuals who develop PPD do not present with identifiable risk factors during pregnancy, rendering selective approaches insufficient for early detection.

Importantly, reliance on targeted screening may inadvertently exacerbate existing inequities in care. Women from marginalized backgrounds—including racialized, immigrant, low-income, and gender-diverse populations—are more likely to encounter barriers related to stigma, limited access to consistent care, and implicit bias within healthcare encounters, all of

which reduce the likelihood of symptom disclosure. In this context, universal screening may function not only as a clinical tool, but as an equity-oriented intervention by standardizing assessment practices and reducing dependence on subjective judgement. When considered alongside the documented risks of untreated PPD for both mothers and infants, early and repeated screening across the perinatal period emerges as a critical component of preventative, population-level mental healthcare rather than an optional additive to usual care.

Impacts on Mothers and Infants

Unrecognized/untreated PPD has the potential to severely harm a mother's wellbeing; emotional outbursts, distressing ruminating thoughts, and an increase in mood swings are common symptoms. Symptoms like these can have an impact on a mother's relationship with her partner, family, and friends, leading to increased feelings of isolation and shame (Gavin et al., 2015). In the prenatal phase, reduced attendance to prenatal appointments and increased substance use are attributed to undetected/untreated PPD and higher risk of preterm labour and low infant birth weight (RNAO, 2018). The RNAO (2018) also highlights commonly experienced phases of PPD that include: emotional spiraling, conflicting expectations and reality, fears of being labelled, and a sense of loss—of self, of control, and of voice. Furthermore, Dowse et al. (2020) found that 50-70% of women who experience antenatal depression remain depressed 6-months after delivery when left untreated, and 25% of women develop recurrent depression without proper treatment of perinatal depression. Because PPD can contribute to reduced social support and self-care, these women are at risk of maladaptive coping mechanisms such as increased substance use and smoking (Gavin et al., 2015; Li et al., 2022).

On a physiological level, hormonal changes after childbirth may contribute to the development of depressive symptoms in some mothers. For example, a systemic review

conducted by Schmidt et al. (2022) found that shifts in thyroid function and the presence of thyroid antibodies have been linked to an increased risk of postpartum depression, although findings across studies are inconsistent. In addition, emerging evidence indicates that fluctuations in reproductive hormones such as estrogen and progesterone may help predict a mother's vulnerability to postpartum depression, with rapid declines after delivery potentially contributing to mood disturbances. It is important to note that this author could not obtain full access to the Oborne et al. (2025) article cited by Ter-Mikaelian (2025). While causality has not been established, these findings highlight the role of endocrine changes in shaping emotional vulnerability during the postpartum period. Furthermore, research has found a connection between allopregnanolone, a progesterone metabolite, and depression (Leader, O'Connell, & VandenBerg, 2019). Allopregnanolone increases during pregnancy, and then dramatically declines after childbirth, resulting in the "downregulation of γ aminobutyric acid A (GABAA) receptors…thought to trigger PPD" (Powell et al., 2019, p. 158). These findings may present a specific pathophysiology in PPD.

Finally, considering the long-term effects of PPD on a mother's physical health, emerging evidence suggests that PPD may have lasting implications on cardiovascular health. Ackerman-Banks et al. (2023) found that individuals with perinatal depression face significantly increased risks of ischemic heart disease, arrhythmia or cardiac arrest, cardiomyopathy, and new-onset hypertension, underscoring the potential for depressive symptoms during the perinatal period to act as predictors of long-term cardiovascular morbidity. Supporting this, Abate et al. (2025) demonstrated that prenatal depression, specifically when paired with metabolic complications such as diabetes or hypertension, heighten the risk of both PPD and subsequent cardiovascular disease. Together, these findings highlight that PPD is not only a critical mental

health concern but also a biological stressor that may accelerate cardiovascular disease, especially in women with existing metabolic vulnerabilities.

Developmental Impacts on Infants

PPD has significant impacts on infant development. Attachment theory outlines that a secure attachment to one's primary caregiver lays a foundation for emotional, social, and cognitive growth (Li, 2022). When a caregiver is emotionally unavailable due to PPD, the attachment process is disrupted, increasing the infant's risk of later emotional and behavioral issues. Della Vedova et al. (2023) highlights the crucial role of maternal sensitivity in early interactions, which promotes secure attachment and healthy child development. Conversely, maternal depression is linked to an increased risk of insecure attachment (Barnes & Theule, 2019), which can impede social-emotional development. Mothers experiencing PPD may struggle to recognize and respond to their child's emotional cues, which can lead to feelings of neglect in the infant. According to Bowlby's (1973) attachment theory, infants have an innate biological drive to remain close to their caregivers for survival. A secure base fosters a sense of safety, enabling the child to explore their environment and manage stress. Disruption to this attachment can result in heightened anxiety and relational difficulties later. Harlow's (1958) study strongly illustrates that attachment relies on emotional security and comfort, rather than mere physical sustenance. While ethically problematic, these findings highlight the necessity of stable early care for healthy psychosocial development.

Inadequate maternal responsiveness can contribute to insecure patterns of attachment in infants, impeding effective emotion regulation and social functioning. The RNAO (2018) reports that unresolved attachment issues may negatively impact language development, emotional intelligence, and social adaptation. Children of mothers with untreated PPD face increased risks

for cognitive and socio-emotional impairments (Fransson et al., 2020). Bass and Bauer (2018) highlight that PPD affects over 400,000 infants annually in the United States, increasing their likelihood of developing social anxiety and learning difficulties. These risks extend into adolescence, as a history of maternal depression correlates with elevated levels of anxiety and mood disorders. Thus, early identification and treatment of PPD is vital for breaking the cycle of intergenerational mental health issues.

Cognitive Impacts. Racine et al. (2024) conducted a meta-analysis examining the association between maternal PPD symptoms and early childhood developmental milestones. Based on 76 studies encompassing over 90,000 mother–child dyads, they synthesized findings across motor, language, social-emotional, and cognitive domains. Their findings revealed that elevated PPD symptoms were consistently linked to delays in achieving developmental milestones, with the strongest associations found for language and cognitive outcomes. These effects persisted after accounting for study quality, sample size, and measurement type. Importantly, their findings highlight the negative influence of PPD symptoms (even in nonclinical ranges), providing evidence of disruptive effects on child development and caregiving capabilities in mothers who may not meet full diagnostic thresholds. Racine et al. (2024) emphasize the idea that maternal mental health lies on a continuum and mild symptoms also warrant attention. They note that maternal depression may undermine sensitive caregiving, reduce stimulation, and increase stress exposure, in turn compromising children's attainment of early milestones.

One limitation of the research by Racine et al. (2024) is its reliance on majority Western, high-income samples, which decreases generalizability to more diverse cultural and socioeconomic contexts. Additionally, the analysis largely assumes unidirectional causality

(maternal PPD symptoms → child outcomes), whereas emerging research suggests reciprocal influences, where child developmental delays may exacerbate maternal stress and depressive symptoms. Addressing this bidirectionality in longitudinal and cross-cultural studies could deepen our understanding of these dynamics.

An important factor Racine et al. (2024) reinforces is the importance of integrated mother–child health services. By presenting evidence on the early and pervasive effects of PPD, the authors provide compelling justification for routine perinatal mental health screening—specifically suggesting screening during well-child visits and early intervention programs. Practical barriers such as stigma, accessible resources, and limited access to culturally competent services must also be considered in implementing these recommendations.

Implications from a Sociocultural Perspective

Cultural context strongly influences both the prevalence and developmental impacts of PPD. Social and cultural norms shape how care is sought and provided, as well as attitudes toward mental health (Abdollahi et al., 2016). Stigma in certain communities may lead mothers to postpone or avoid necessary care, adversely affecting their children's development. Additionally, caregiving practices differ across societies, altering the relationship between maternal depression and infant outcomes.

Prevalence estimates of perinatal depression vary considerably, ranging from nearly 0% in some high-income countries to over 50% in certain low- and middle-income nations (Registered Nurses' Association of Ontario, 2018). For instance, Brazil and South Africa report high rates, while Denmark and Austria show lower prevalence rates, likely reflecting stronger social support networks and higher-quality maternal healthcare. In recent years, research has emerged showing infant gender to be a risk factor for PPD in some developing countries (Ye et

al., 2022). In nations such as Pakistan, where local culture follows more patriarchal traditions, recent research shows a link between higher levels of PPD in mothers who gave birth to baby girls compared to baby boys (Tarar et al., 2021), which is similar in countries such as China, Turkey, and India (Ye et al., 2022). This is a risk factor not commonly experienced in Western countries and can add to fears of stigma in immigrant women if counsellors are not informed about collectivist societal influences. Additionally, multiple studies show that due to experiences of cultural stigma, current and historic discrimination causes a lack of trust in health care providers and gaps in culturally and structurally competent mental health care. People of colour tend to seek treatment less often than postpartum people who are white (Bossick et al., 2022).

Intersectionality and Structural Determinants

Racial disparities in maternal mental health are among the most consistent and concerning findings in perinatal research. Black mothers in the United States experience disproportionately high rates of maternal morbidity and mortality, and this disparity extends into mental health outcomes, including PPD and its sequelae. Intersectional research underscores how structural racism and overlapping identities (e.g., race, gender, SES) shape both risk and healthcare access. A recent study examining intersectional maternal health experiences found that Black women's perceptions of racialized stress—including awareness of broader disparities in maternal outcomes—contributed to heightened anxiety and depressive symptoms during the perinatal period (Gilliam et al., 2024). These compounded experiences of racism, gendered expectations, and societal pressures illustrate how social determinants function as psychosocial stressors for Black women before and after birth.

A recent study also indicates that racial and ethnic disparities persist in the identification and management of perinatal mood disorders. For example, research tracking 4,542 postpartum

people across multiple U.S. jurisdictions found that although the *diagnosis* rates of perinatal mood and anxiety disorders did not significantly differ by race, treatment access did (Haight et al., 2024). Among respondents with depressive symptoms, 67% of White participants received some form of mental health care within the first postpartum year, compared with only 37% of Black and Hispanic respondents—evidence of profound inequity in the pathway from symptom recognition to treatment engagement (Haight et al., 2024).

Socioeconomic Status. Recent studies consistently show the role a woman's socioeconomic status (SES) plays on the onset and severity of their PPD symptoms. In Greece, Natsiou et al. (2023) identify income, education level, and occupational status as significant predictors of depressive symptoms in the perinatal period. Similarly, Chen, Qiao, and Zong (2025) used a parallel mediation model to examine the effects of SES on PPD and found that low SES predicted higher rates of depressive symptoms, both directly and indirectly through higher stress and reduced social support. Socioeconomic disadvantages seem to contribute to PPD through multiple pathways; financial strain and material hardship create stress, which increases vulnerability to depressive symptoms. Although SES significantly influences access to healthcare for postpartum mothers, Chen, Qiao, and Zong (2025) found that the impact of access to healthcare did not significantly mediate the effect of SES on PPD; Chinese culture sees family members taking care of mother and newborn, which in turn helps mitigate anxiety and depression in mothers. Agrawal et al. (2022) had similar findings in terms of lower SES impacting access to healthcare and postpartum education, also noting that immigration and residency status are risk factors. Mental health clinicians should be aware of affordable and culturally competent options to access treatment and care, especially those providing care in rural areas and lower SES urban areas.

Indigenous Mothers' Experiences. Struggles with attachment are seemingly common among the Indigenous population in Canada. Leason (2018) details one interviewee whose partner's parenting style was reportedly impacted by generational trauma caused by residential schools. This impacted her partner's ability to foster a loving attachment to her and their children because he had never experienced unconditional love himself. This not only affected his relationship with his children, but his relationship with his partner, resulting in more stress and feelings of depression for her. Leason (2018) also discusses the unique barriers Indigenous women face when accessing healthcare, including negative stereotypes, beliefs, and misconceptions contributing to avoidance of healthcare supports, including maternal health services. A large contributing factor to the avoidance of seeking help is fear of child apprehension. There is an overrepresentation of Indigenous children in the child welfare system, further reinforcing this fear (Leason, 2018). When creating treatment plans that are culturally sensitive to not only Canada's vast Indigenous populations, but for all minority and marginalized women, counsellors need to be aware of their geographical demographic and consistently seek to understand, design, and implement practices that support the needs of women in their communities.

In sum, untreated PPD is a critical public health concern, with consequences extending beyond mental distress and into physiological and developmental complications for both mothers and infants. Tensions lie within the bidirectional and multisystemic nature of PPD, compromising maternal sensitivity and attachment (Barnes & Theule, 2019) through physiological components (allopregnanolone levels) and sociocultural influences. Causality cannot be narrowed down to a one-size-fits-all answer and generalizability is difficult to establish as literature relies heavily on Western samples. Counsellors need to champion routine

perinatal mental health screening within integrated mother-child health services (well-child visits), while actively implementing strategies to mitigate sociocultural barriers associated with stigma and fear.

Psychosocial Effects of Untreated PPD

If left untreated, PPD can have psychosocial consequences for not only mothers, but their partners and families too. Women with chronic symptoms often withdraw from social interactions, perpetuating a cycle of isolation that exacerbates depression. Relationship tensions are common, with many mothers reporting increased dissatisfaction and conflict with partners (Wang et al., 2023). The prevalence rates of paternal depression are estimated to be between 2 - 25%, and up to around 50% in cases where the mother is experiencing PPD, with the highest rates occurring between 3 and 6 months postpartum (Earls et al., 2019; Paulson & Bazemore, 2010). Wainwright et al. (2023) conducted a study on paternal PPD screening in a postpartum primary care clinic in the Midwest. Of the 24 participants who completed screening, 87% identified as belonging to a racial or ethnic minority and reported low rates of stress and preexisting mental health conditions (Wainwright et al., 2023). It was found that 7 (30%) of respondents screened positive for PPD on the EPDS, with two participants requesting mental health services after screening (Wainwright et al., 2023). Reluctance to seek treatment seems to be a common contributing factor in the increase of symptom experience and severity, as fathers often feel excluded from perinatal care spaces.

Men also may be less expressive about their feelings which could lead to them underreporting symptoms (Hambidge et al., 2021; Scarff, 2019; Wainwright et al., 2023; Walsh, Davis, & Garfield, 2020). To better address this, Scarff (2019) discusses using collateral information from family, and using the EPDS-P to further assist with identification and

diagnosis. Additionally, Hambidge et al. (2021) noted that several participants in their study suggested longer paternity leave and education on practical help with keeping the home running could potentially mitigate factors that contribute to mental health struggles. These findings suggest widespread impacts of untreated maternal depressive symptoms on the family unit and suggest the need for partner-inclusive perinatal care. Although results were insightful and support previous research on paternal PPD, and the participant population was highly diverse, Wainwright et al.'s (2023) major study limitation is its small sample size, which contributes a lack of generalizability.

Neglecting to treat PPD exacerbates maternal disengagement from support systems, creating additional stress and hindering recovery. Social disconnection is a strong predictor of increased depression severity and decreased relationship satisfaction (Wang et al., 2023). Targeted psychoeducation, counseling, and peer-based support can help reverse these trends by fostering more supportive networks. Interventions that focus on both mothers and families can effectively restore relational harmony while promoting maternal well-being.

Impacts of Technology

Social media and digital platforms offer numerous innovative ideas for supporting mothers experiencing PPD. Aker et al. (2024) found that mothers frequently access platforms such as Facebook, Instagram, and YouTube to connect with others and seek parenting advice. Their study revealed that 94% of mothers had social media accounts, primarily using them for entertainment (94%), social connection (79%), and information gathering (63%). While social media can provide invaluable support, it can also portray unrealistic standards of motherhood, which may intensify feelings of guilt or inadequacy. The concept of "super mother syndrome," which suggests that mothers should fulfill all expectations perfectly, is often reinforced through

social media imagery, contributing to increased stress and declining mental health (Aker et al., 2024; Kirkpatrick & Lee, 2022). Furthermore, the high engagement of mothers with social media highlights the necessity for digital literacy and intentional interaction to mitigate potential harm.

Constructive, growth-oriented online communities can help reshape the narrative for mothers, affirming their identities beyond motherhood. Online peer-to-peer support groups foster connections and reduce feelings of isolation, especially when in-person supports are limited. Some research has found that many mothers refer to social media friends as their main form of social support (Baker & Yang, 2018), with others admitting they prefer advice from social media over healthcare providers (Moon et al., 2019). Online groups provide a larger window of access, allowing mothers to connect during off-hours or when geographically distant from support networks, creating a sense of belonging and solace in sharing personal experiences. Ryan (2020) suggests that realistic and relatable reflections of motherhood on social media can protect against harmful comparisons and assist with postpartum adjustment. Although these findings stem from a doctoral dissertation rather than peer-reviewed research, they offer valuable insights into the pros and cons of online supports.

For many new mothers, social media presents both advantages and disadvantages. Ryan (2020) finds that viewing content of idealized representations of motherhood on Instagram can decrease self-compassion and life satisfaction, while authentic portrayals of everyday challenges increase body image satisfaction and reduce shame. Although this was an experimental study conducted by a doctoral student that has not been through the peer-review process, the results show the effect social media can have on women's perceptions of social media supports. These findings suggest that social media can either reinforce harmful myths about motherhood or provide supportive, normalizing content.

Digital Platforms: Enhancing eHealth Interventions

The implementation of structured eHealth interventions has broadened access to mental health support for mothers. Online therapy platforms, mobile apps, SMS, telehealth, and immersive technology options provide flexible and evidence-based supports. Jimenez-Barragan et al. (2025) conducted a study to evaluate the effectiveness of immersive virtual reality eHealth intervention on symptom reduction in pregnant women, with findings showing a significant reduction in depression symptoms. This study yielded high adherence and satisfaction rates, but it was also noted that the sample demographics were not particularly diverse; future research should consider seeking participants from a wider variety of educational, socioeconomic, and cultural backgrounds. eHealth platforms offer therapy delivery via accessible means (e.g., phone or internet), minimizing the need for in-person support and helping to prevent social isolation and related mental health issues (Lackie et al., 2021). By integrating telehealth supports, mothers can connect with both peer supports and professional care from their homes, addressing their logistical and psychological needs. Programs like "Be a Mom," an online cognitive-behavioral therapy intervention, have proven to be both cost-effective and clinically beneficial. Monteiro et al. (2024) found that participants in the intervention group experienced fewer depressive symptoms and had higher adherence compared to the control group, with a 97.6% probability of cost-effectiveness at standard thresholds. Despite the advantages of digital supports, there is some reluctance to embrace these resources. In terms of clinical application, Jimenez-Barragan et al. (2025) mention that effective and safe implementation of eHealth technologies will require rigorous data protection, clear informed consent procedures, and high-level cybersecurity programs to protect user confidentiality.

Research on digital platforms presents a core paradox for mothers managing PPD: digital supports are simultaneously a source of vital peer-to-peer connection and effective eHealth support, while also being a breeding ground for harmful comparisons and guilt. Many mothers heavily rely on social media for social connection and information, sometimes even prioritizing this informal advice over advice given by healthcare providers (Moon et al., 2019). In addition, structured eHealth interventions like online CBT and immersive VR are proven to be clinically beneficial and cost-effective in symptom reduction (Jimenez-Barragan et al., 2025; Monteiro et al., 2024). The central tension, however, is the content itself. Idealized portrayals of motherhood on social media platforms can reinforce "super mother syndrome," intensifying feelings of inadequacy. In contrast, exposure to authentic, realistic content fosters self-compassion and improved body image (Kirkpatrick & Lee, 2022; Ryan, 2020). For counsellors, this necessitates a practical approach in terms of assessing a client's digital engagement to help promote digital literacy and intentional interactions, while guiding mothers toward constructive, relevant, growth-oriented online communities and away from content that reinforces harmful myths. Furthermore, while recommending evidence-based digital tools to enhance access and adherence, counsellors must proactively address the necessity for rigorous data protection and confidentiality to ensure the safe and ethical integration of digital platforms into treatment plans.

Treatment and Intervention

As previously outlined in this chapter, the consequences of untreated PPD on mothers, infants, and families is well documented, supporting the urgent need for accessible and effective treatments for women and families experiencing PPD. Psychotherapies are typically considered first-line treatment options, and tend to be preferred by mothers experiencing PPD over pharmacological approaches, with many citing concerns about medication effects on infants

(Pettman et al., 2023). Research into alternative treatments such as acupuncture, herbal medicine and nutrient supplements, exercise, and hormonal treatments is emerging, but a more comprehensive look into the efficacy of these methods is needed (Chow et al., 2021). The final section of this chapter focuses on current literature on the best treatment approaches for PPD.

Psychotherapy

Research into psychotherapy treatments for PPD have mainly focused on cognitive behavioural therapy (CBT) and interpersonal therapy (IPT). Both modalities have been around for many years and have been proven effective in the treatment of depression and anxiety. These positive findings have resulted in them being the typical approaches to managing perinatal mental health.

Cognitive Behavioural Therapy (CBT). CBT is the leading evidence-based treatment modality for PPD. Through cognitive restructuring, CBT focuses on helping clients to identify, understand, and change maladaptive thoughts, cognitive distortions, and behavioural patterns that enhance or maintain distress (Li et al., 2022). When it comes assessment of CBT treatment, Li et al (2022) found few meta-analytic studies on the effectiveness of CBT focused on the perinatal period. Pettman et al. (2023) conducted one of the most comprehensive systemic reviews and meta-analyses to date on the effectiveness of CBT for perinatal depression. Based on inclusion criteria, 31 studies were eligible for narrative synthesis, and of those 31, 26 were randomized controlled trials (RCTs). The primary objective was to "examine the effectiveness of CBT-based interventions for PND (perinatal depression) on symptoms of depression and depression diagnosis" (Pettman et al., 2023, p. 3). To be deemed eligible for inclusion, studies needed to meet the following criteria: participants were adult women with a diagnosis of PND (as per *DSM 4* or *5* criteria); participants reported depressive symptoms within the perinatal

period using a validated screening tool; interventions targeted PND with CBT-based interventions (defined as focusing on evaluating, challenging, and modifying dysfunctional beliefs); and only RCTs were included with trial designs allowing for the isolation of the effects of CBT. Results revealed a medium overall effect in favor of CBT-based interventions compared to control groups for reducing PND symptoms. Although results provide strong evidence that CBT-based interventions offer viable and effective treatment, these results should be interpreted with caution as multiple limitations were identified: there were high levels of methodological heterogeneity making it difficult to pinpoint the most effective components of CBT; and moderators to treatment efficacy (such as intervention type, control condition, and provider type) had a strong influence on perceived outcomes. Future research should focus on improving methodological quality to better address risks of bias and to explore the role of moderators (such as type of treatment provider and intervention type). Additionally, few existing studies include long-term follow-up, leaving questions remaining about treatment durability and sustained impacts.

Interpersonal Therapy (IPT). IPT is also considered a front-line treatment for PPD and for those experiencing symptoms of PPD. IPT is a time-limited, structured treatment for depression that focuses on four interpersonal problems: role transitions; interpersonal disputes; grief; and interpersonal deficits (Bright et al., 2022; Dennis et al., 2020; Stamou, Garcia-Palacios, & Botella, 2018). In contrast to CBT, IPT seeks to address the interpersonal contexts that are central in the postpartum period, a method of treatment that has previously shown positive results when administered by healthcare professionals who are not specialized mental health workers (Posmontier et al., 2016). In their systemic review, Wang et al. (2023) concluded

that IPT can improve depressive symptoms of women with PPD but note that higher quality studies need to be conducted to further solidify these claims.

Like Posmontier et al. (2016), Dennis et al. (2020) conducted a study using an RCT of postpartum women with major depression (diagnosed using SCID-I). One major purpose of this study was to address barriers to accessible care, specifically for those experiencing geographical and childcare constraints in terms of access to in-person treatments, lack of available specialized care providers, and stigma related to seeking care. Dennis et al. (2020) sought to determine the acute effectiveness of telephone-IPT delivered by trained nurses, with the hypothesis that fewer women in the intervention group would remain clinically depressed at the 12-week mark compared to women in the control group, with follow-ups at 24 and 36 weeks. 241 participants were sorted into two groups: a control group that had access to standard, locally available postpartum care, and an intervention group that had access to local standard care in addition to 12 weekly 60-minute sessions of nurse-delivered telephone IPT. At the 12-week endpoint, Dennis et al. (2020) found that women in the intervention group were 4.5 times less likely to meet criteria for clinical diagnosis of major depression compared to the control group. They also cited improvement in relationship quality with partners and decreased attachment avoidance. These differences were sustained at the 24-week, but results were no longer statistically significant at the 36-week check in (the participation retention rate at 36 weeks was around 81%). Limitations such as performance bias and heterogeneity within the control group were noted as limitations, as well as the exclusion of non-English speakers which impacted the generalizability of results. Additionally, the control group was treated with standard local postpartum care instead of an alternative psychotherapy treatment, limiting the capacity to make conclusions on comparative efficacy of psychological interventions for PPD. Ultimately, this

study positively contributes to task-shifting in mental healthcare, which could help to mitigate barriers such as patient location, lack of time or childcare for in-person appointments, and cost of/shortages in specialized psychotherapists.

Lastly, in their systematic review of available literature on IPT in the perinatal period, Bright et al. (2020) found that reduction in depressive symptoms was significantly larger in studies where group IPT was used compared to individual IPT. Through vicarious learning, group therapy helps women to increase their use of coping strategies/skills and to help others find solutions to their problems, increasing their sense of competence (Bright et al., 2020). This approach helps foster community and understanding during a time when feelings of loneliness may be increased. Group therapy for PPD, specifically group-IPT, has shown promising results as a first-line treatment for women experiencing symptoms of PPD.

Both CBT and IPT are strongly validated and effective front-line treatments for PPD. A key tension between the two lies within treatment focus; CBT-based interventions target maladaptive thoughts and behaviours, while IPT addresses the interpersonal context of the postpartum period, specifically role transitions and relationship disputes (Dennis et al., 2020). Limitations arise due to methodological heterogeneity in CBT studies, and there is a need for more comparative efficacy research between the two modalities, especially in terms of understanding the long-term durability of IPT effects. Counsellors should leverage the accessibility and scalability of telephone-administered IPT and encourage training of non-specialist providers to help mitigate barriers like geographical constraints and issues surrounding childcare (a task-shift model of mental healthcare). Counsellors may also consider group IPT to maximize benefits through peer connection, vicarious learning, and community building.

Comparative Treatment Modalities

While cognitive behavioral therapy (CBT) and interpersonal psychotherapy (IPT) remain the most empirically supported treatments for postpartum depression (PPD), emerging research suggests that other therapeutic modalities offer meaningful and clinically relevant contributions. Broadening the psychotherapeutic lens recognizes that women present with distinct histories, relational patterns, emotional processes, and treatment preferences. Alternatives such as psychodynamic psychotherapy, emotion-focused therapy (EFT), and acceptance and commitment therapy (ACT) have shown promising results as alternative options to CBT and IPT.

Psychodynamic Psychotherapy. Psychodynamic approaches conceptualize postpartum depression within the context of internalized attachment patterns, unresolved developmental conflicts, and identity transitions associated with motherhood. Rather than targeting symptom reduction directly, psychodynamic therapy explores how past relational experiences shape current emotional responses, expectations of self, and experiences of caregiving. A recent systematic review of psychodynamic interventions for PPD identified consistent reductions in depressive symptoms across both individual and group formats, delivered in outpatient and home-based settings (Valverde et al., 2023). Although sample sizes were modest and methodological rigor varied, the review concluded that psychodynamic approaches demonstrate promising effectiveness for perinatal populations. These findings suggest that for women whose depressive symptoms are embedded in relational trauma, identity disruption, or complex attachment histories, an insight-oriented framework may address underlying mechanisms not fully captured by cognitive restructuring or interpersonal role transition models. Within a collaborative care framework, psychodynamic therapy may be particularly valuable for clients

presenting with persistent relational themes, ambivalence toward motherhood, or intergenerational trauma that surfaces during the postpartum period.

Emotion-Focused Therapy. Postpartum depression frequently involves heightened emotional reactivity, shame, guilt, and difficulty regulating affective states. EFT and emotion-regulation based therapies aim to strengthen clients' capacity to identify, tolerate, and transform emotional experiences rather than solely focusing on cognitive restructuring. A systematic review examining interventions targeting emotion regulation in perinatal populations found moderate to large reductions in depressive and anxiety symptoms across randomized and quasi-experimental studies (Kaya Yildirim & Dirik, 2025). These findings underscore the clinical importance of affect regulation as a mechanism of change in perinatal mental health. Dialectical and emotion-focused approaches may be particularly relevant for women who experience intense mood fluctuations, self-criticism, or difficulty tolerating distress associated with infant caregiving demands.

Compared to CBT's emphasis on thought patterns and IPT's focus on interpersonal role transitions, emotion-centered approaches conceptualize depressive symptoms as reflecting dysregulated affective processing. This distinction broadens the treatment landscape by acknowledging that postpartum distress is emotionally complex, and not solely cognitive or relational.

Acceptance and Commitment Therapy. ACT emphasizes psychological flexibility, helping clients to engage in valued action while accepting difficult internal experiences such as intrusive thoughts, guilt, or emotional ambivalence. To understand the effectiveness of an ACT group approach, Waters et al. (2020) investigated an 8-week group-delivered ACT intervention for women with moderate-to-severe perinatal mood and anxiety disorders, including postpartum

depression. This open-label study found high engagement (88% completion) and significant reductions in global distress and depressive symptoms (effect sizes approaching large magnitude), alongside increases in psychological flexibility following treatment. Participants also reported that both therapist support and the integration of ACT principles into daily life contributed meaningfully to perceived benefits. Though not a randomized controlled trial, these findings support ACT's feasibility, safety, and clinical promise within routine perinatal care settings.

Beyond formal intervention trials, related research underscores the theoretical relevance of acceptance processes for postpartum mental health. For example, studies examining at-risk postpartum women have identified that higher levels of psychological flexibility and nonjudgmental acceptance of internal experiences are associated with a greater likelihood of *not* developing significant depressive or anxiety symptoms, suggesting that these processes may serve as protective factors (Monteiro et al., 2019). Although there is a need for studies with larger controlled trials, the available research highlights ACT's promising potential to help mothers struggling with pervasive self-criticism, avoidance, and/or the existential challenges of new motherhood.

Psychopharmacology

Selective Serotonin Reuptake Inhibitors. Despite earlier mention of many women's hesitancy to use medication as a form of treatment, nearly one third of women with perinatal mood disorders are treated with antidepressants, the most common being selective serotonin reuptake inhibitors (Hutchison et al., 2023). Many women are hesitant to choose SSRIs as their first choice of treatment because SSRIs taken during pregnancy expose infants to small amounts of medication in utero because SSRIs cross through the placenta and fetal blood-brain barrier.

Although there is evidence that shows prenatal SSRI use can lead to short term impacts on infants (slightly lower APGAR scores, slightly smaller birth weight, earlier gestational date at delivery), these impacts are short lived and resolve between the first few hours to first few weeks of the infant's life. Current available research does present a firm consensus that risks associated with exposure to SSRIs in utero outweigh the benefits compared to untreated PPD (Muzik & Hamilton, 2016). As previously outlined, there is an abundance of research on the developmental effects on babies born to mothers with untreated PPD, but stigma surrounding taking anti-depressant medication during the perinatal period remains. That said, it is important that mental health practitioners and health professionals are aware of the full range of impacts caused by untreated PPD when assessing and discussing the risks of using SSRIs.

An important study to highlight is that of Hutchison et al. (2023), who completed a 12-year longitudinal study to further understand the links between SSRI use, PPD, and anxiety rates in children. Results from this study revealed that maternal depressive symptoms were predictive of increased internalizing and anxiety behaviours in children when compared to children subject to SSRI use in pregnancy (Hutchison et al., 2023). Although this study was not without limitations (the exclusion of a postpartum measurement of depression within 1 year of birth and excluding measures for anxiety symptoms) it highlights the importance of understanding that SSRI use may be the best treatment option for many pregnant and postpartum women as there are significant impacts on mothers and infants if PPD is left untreated. Clinicians need to support future efforts to destigmatize the use of medication during the perinatal period to better aid in the treatment of postpartum women.

Zulresso (brexanolone) and Zurzuvae (zuranolone). As of 2023, there were only 2 FDA approved medications specifically indicated for the treatment of PPD—Zulresso

(brexanolone) and Zurzuvae (zuranolone). Powell et al. (2019) conducted a literature search and review of clinical information about drug and clinical trials relating to the FDA's approval. As briefly mentioned before, allopregnanolone is a major metabolite of progesterone that increases during pregnancy and drastically decreases after giving birth, presenting a possible pathophysiological aspect of PPD. The goal of brexanolone is to act as a synthetic formulation of allopregnanolone, functioning as a positive allosteric modulator of GABA-A receptors, helping to resolve symptoms of PPD more rapidly than traditional anti-depressants (Leader, O'Connell, & VandenBerg, 2019). It is administered as a continuous intravenous infusion over 60 hours and must be administered through inpatient treatment due to risks of sedation and sudden loss of consciousness (Powell et al., 2019). Although this medication showed positive results, it was announced in March of 2025 that the pharmaceutical company that produced the drug (Sage Therapeutics Inc.) and held the FDA approval had requested a withdrawal of the approval as it was no longer marketing Zulresso as of April 14th, 2025 (Food and Drug Administration, 2025). The FDA stated that inventory of Zulresso (brexanolone) may still be dispensed until supplies deplete or the products reach expiration (2025). Powell et al. (2019) also highlight a few limitations of Zulresso, listing the extremely high cost (upwards of $34,000 per treatment) and logistical demands (three-day inpatient stay) as barriers to accessibility and clinical adoption.

In August of 2023, Zurzuvae (zuranolone) was approved by the FDA, making it the first and only approved oral drug specifically for the treatment of PPD (Barnes, Vogl, & Nelson, 2023). Whereas SSRIs can take up to 8 weeks to take full effect, zuranolone is fast acting and is taken once daily at bedtime for14 days. Similar to brexanolone, zuranolone also mimics allopregnanolone, acting as a positive allosteric modulator of GABA-A, allowing these receptors to regain their pharmacologic effects while the body readjusts to new homeostatic levels (Barnes,

Vogl, & Nelson, 2023). As with SSRIs, breastfeeding while taking zuranolone should be done with caution, as trace amounts of the drug were found in breast milk (though is not expected to cause any harm to infants) (Barnes, Vogl, & Nelson, 2023). Like brexanolone, the cost of zuranolone is a major concern. The wholesale cost of a 14-day supply is $15,900, but the manufacturer, Sage Therapeutics Inc, stated that they are working with another company called Biogen to help with access to those prescribed the medication, including working on financial assistance to help cover most, if not all, of the cost of the treatment (Sage Therapeutics, 2023). Additional information found on grey literature source GoodRx, a prescription price comparison website, stated that as of March of 2025 most state and territory Medicaid programs do cover Zurzuvae (zuranolone), and offer a manufacturer copay assistance card program called Zurzuvae For You for those with commercial insurance (Lusk, 2025).

The use of SSRIs as treatment for PPD has shown promising results while consistently monitoring for any adverse effects on infants and children. When it comes to newer treatments such as zuranolone, the most recent available information from the Drugs and Lactation Database (2024) stated that the amount of zuranolone in breastmilk is so low that taking the medication is no reason to discontinue breastfeeding. More research needs to be done to identify any adverse effects on breastfed infants of mothers prescribed zuranolone. Working towards destigmatizing the use of medication in the perinatal period is an important step in providing the necessary support mothers need to best care for themselves and their babies.

Conclusion

Postpartum depression is an internationally experienced yet paradoxical perinatal health complication. The discourse surrounding PPD highlights the profound risks on maternal physical health, infant development, and family psychosocial dynamics that call for early and decisive

intervention; yet, there is significant disagreement over the optimal strategy and timeline for screening. While a handful of influential healthcare bodies recommend universal screening using a validated screening tool to mitigate the numerous risks associated with undiagnosed/untreated PPD, others caution against it, citing potential over-diagnosis and potential backlog in diagnostic services, instead encouraging clinical judgement. This tension underscores a broader need to address restrictive diagnostic windows and significant sociocultural barriers. Ultimately, effective care must transition from fragmented practice to an integrated, collaborative, and culturally attuned model that utilizes evidence-based treatments and emerging digital platforms to ensure that all mothers can access the support they need.

Synthesis and Bridge to Practice

The final chapter highlights key findings and limitations such as assessment discrepancies, the multidimensional impacts of untreated PPD, reputable and evidence-based treatment methods, and systemic difficulties within peripartum healthcare. It outlines how mental health professionals could work alongside peripartum healthcare professionals to better support mothers, infants, and families in the perinatal period.

Chapter 3: Discussion, Applied Practices, and Conclusions

The first two chapters of this capstone explored the importance of understanding postpartum depression (PPD) and the numerous detrimental effects it can have when left unrecognized and untreated, highlighting disparities in screening and diagnostic processes. Through an in-depth review of current literature, several key findings emerged, including the identification of specific physiological risks for mothers and infants, and that reliance on clinical judgement often exacerbates undetected cases of PPD (Gavin et al., 2015; Hooykaas, 2021). Crucially, the literature review highlighted the emergence of new frontiers in care, including research on paternal PPD and pharmacological advancements, such as the first FDA-approved intravenous and oral medications specifically for PPD (Barnes, Nobl, & Nelson, 2023; Sage Therapeutics, 2023). While research on psychotherapy modalities and the safe use of SSRIs continues to be a focus, there remains a clear need for additional evidence and structural solutions to properly support perinatal women.

Through the lens of attachment theory, the findings in Chapter 2 underscore the central role maternal mental health plays in shaping early relational environments. Bowlby's conceptualization of attachment as a biologically driven system reliant on caregiver sensitivity provides a useful framework for understanding how untreated PPD disrupts foundational caregiving processes. Across the reviewed literature, maternal depressive symptoms were consistently associated with reduced emotional availability and impaired attunement, increasing the risk of insecure attachment and subsequent socio-emotional and cognitive challenges for infants (Barnes & Theule, 2019; Della Vedova et al., 2023). From this perspective, routine and repeated assessment of maternal well-being—particularly during well-child visits—represents not only a screening strategy, but an attachment-informed preventative intervention.

Feminist theory further contextualizes these findings by drawing attention to the structural inequities embedded within perinatal healthcare systems. The expectation that women must self-identify distress and independently seek support reflects broader gendered assumptions that position maternal mental health suffering as a private responsibility rather than a shared public health concern. The literature demonstrated how women's symptoms are frequently minimized or normalized, particularly among women facing intersecting barriers related to race, socioeconomic status, and systemic mistrust of healthcare institutions. From a feminist standpoint, inconsistent screening practices represent not merely clinical oversights, but manifestations of the ongoing undervaluation of maternal mental health within institutional care.

Together, these theoretical perspectives highlight the limitations of fragmented care models and reinforce the need for an integrated, and coordinated response to PPD. While advances in psychotherapy, pharmacological treatment, and emerging research on paternal PPD are promising, their impact remains constrained without parallel improvements in early identification, clear referral pathways, and interprofessional collaboration. Based on these findings, this chapter presents a working and customizable interdisciplinary collaboration proposal template for local healthcare providers and perinatal mental health practitioners.

Limitations

Although the literature on postpartum depression continues to expand, several limitations must be acknowledged. A consistent concern within this area of research is the overrepresentation of white, middle- to upper-class women from high income Western countries. While some studies have begun to focus on racial and ethnic minorities and lower-income populations (Chen et al., 2025; Leason, 2018; Natsiou et al., 2023; Tarar et al., 2021; Wenzel et al., 2021; Ye et al., 2022), the prominence of Western samples limits the generalizability of

findings for a phenomenon that is experienced globally. Small sample sizes and a lack of longitudinal studies create another gap in important research on the long-term effectiveness of treatments and long-term effects of medications. Recall bias and self-report bias were also noted as limitations within multiple studies.

Beyond sample characteristics, methodological limitations further constrain interpretation of the literature. Many studies relied on cross-sectional designs, limiting the ability to draw causal conclusions regarding symptom progression, treatment timing, and long-term outcomes. While associations between PPD and adverse maternal and infant outcomes are well documented, fewer longitudinal studies examine symptom trajectories or intergenerational effects across developmental stages. Measurement-related limitations are also a factor. Heavy reliance on self-report screening tools poses a risk of underreporting and social desirability bias, particularly in contexts where stigma or fear of child apprehension may discourage disclosure. Variability in screening instruments, cut-off scores, and timing of assessment further reduces comparability across studies and contributes to ongoing debate regarding the effectiveness of universal screening protocols.

While the focus of this capstone is primarily on women/mothers experiencing PPD, there is a major gap in the literature on fathers experiencing PPD. Although several studies addressing paternal PPD were included (Hambidge et al., 2021; Paulson & Bazemore, 2010; Scarff, 2019; Wainwright et al., 2023; Walsh, Davis, & Garfield, 2020), prevalence rates varied widely. Further research is needed to clarify the risks associated with unidentified or untreated paternal PPD and its effects on mothers, infants, and family systems. While the literature review highlighted numerous important complications, and protective practices to reduce the risk of PPD, these limitations suggest that current prevalence estimates and treatment outcomes may

underestimate the scope and complexity of PPD, emphasizing the need for more diverse, longitudinal, and culturally responsive research.

Applied Practices

Even with differing opinions on protocols, the literature reviewed in Chapter 2 made one thing very clear: early identification and intervention is the best course of action when it comes to treating PPD. As discussed in Chapter 2, a multidisciplinary approach to pediatric care extends to the care of the mother, showing positive contributions to the overarching well-being of the infant (Buchholz et al., 2021; Sidebottom et al., 2021; Sriraman et al., 2017). Additionally, it was difficult to find studies that highlighted the benefits of screening based on clinical judgement over mandated screening schedules, assuming that "usual care" for perinatal women includes inquiries from their healthcare providers about their mental health. As previously mentioned, there are discrepancies among healthcare professionals when it comes to mental health training (Hooykas, 2021), which leaves room for symptoms to go unnoticed and untreated.

An interdisciplinary approach to perinatal mental healthcare is therefore supported by both empirical evidence and clinical necessity. No single discipline encounters postpartum women with sufficient frequency or scope to independently address the multifaceted nature of PPD. Obstetricians and midwives are positioned to identify antenatal risk factors and provide anticipatory guidance; pediatricians may observe early disruptions in caregiver–infant interaction during well-child visits; and primary care physicians often manage pharmacological treatment. Without structured collaboration, disparate observations frequently remain unacknowledged, delaying intervention and increasing reliance on maternal self-navigation. Without a nationally mandated PPD screening protocol, and because consequences of untreated PPD affect both mother and baby on numerous levels, perinatal primary care practitioners need to actively foster

partnerships with local perinatal mental health professionals to help educate pregnant women, new mothers, and their partners/immediate support systems on the prevalence, symptoms, and treatments of PPD.

Clearly defined collaborative roles enhance continuity of care while preserving professional scopes of practice. Integrating referral pathways and shared communication strategies within perinatal healthcare systems supports timely access to services and promotes more preventative models of care. The proposed collaboration model emphasizes prevention rather than reactive intervention. By integrating periodic screening, psychoeducation, and referral planning into routine perinatal services, healthcare teams can intervene before symptoms escalate into crises requiring intensive treatment. Tailoring collaborative practices to the demographic and cultural composition of local communities further strengthens accessibility and relevance, positioning interdisciplinary care as a preventative public health strategy with the potential for intergenerational benefit.

For clarity and to demonstrate the adaptability of the proposed model, I used services available within my local community as a sample presentation. The proposal consists of discipline-specific themes addressing periodic screening, awareness of local treatment resources, patient education, and consideration of family dynamics and support networks. Instructions, presentation slides, and speaking notes are provided in Appendix D

Reflection and Conclusion

For as long as I can remember, I've wanted to be a mom. As I navigated my way through early adulthood, this desire has only strengthened. I have been blessed with nine nieces and nephews, and have been the support person during childbirth twice, so I have witnessed how diverse the perinatal journey is while also seeing many commonalities. Specifically, I have

observed how common PPD is. Throughout my journey towards my masters, I turned my focus to postpartum mental health as a main topic for numerous courses. An assignment I completed in 2021 for my group counselling course really solidified the decision to focus my capstone on PPD. I reached out through social media and conducted informal interviews with women in my life who had experienced PPD. Based on those experiences, and throughout my research for this capstone, a troubling finding was the lack of information and care given when it comes to maternal mental health. My home, and most of my family, is situated between two hospitals that provide delivery services, so the majority of friends and family I interviewed about their perinatal experiences gave birth at one of those two hospitals. The remaining interviewees were in other hospitals across Ontario. Many women do not receive the proper information or support due to no mandated assessment schedule during the perinatal period and reliance on a doctor's clinical judgement. Almost every single woman that I spoke with was white; no one identified as a member of the LGBTQIA2S+ community; and the majority would be considered middle-class.

Through this capstone, and my previous research for other assignments, I have come to understand the deep and complex impacts that cultural stigmas, systemic barriers associated with race and ethnicity, and other personal identities and experiences have on the support-seeking process. I have a deeper understanding of how social media and online platforms both hinder and support a woman's self-worth and competency as a mother, and of the mixed messaging we receive from content creators and "influencers" that contributes to either a sense of togetherness and understanding or feelings of isolation and inadequacy. Because of this capstone, I was able to form a connection with a reputable postpartum therapist in my city who offers professional development training that focuses on PPD treatments.

This capstone started as an interest and a passion project for supporting mothers in my community. Throughout the research process my focus shifted from wanting to create some type of support measure for women experiencing PPD to looking into how to improve prevention measures in Ontario. There are numerous support avenues available both in person and online for women experiencing PPD, but this capstone highlights the need for improvement when it comes to collaborative maternal healthcare and education on preventative measures. It became clear that expectant and new mothers need more education on PPD throughout the entirety of the perinatal period, making it imperative for healthcare professionals to work together to provide their patients with the proper information and support during such a vulnerable experience.

Conclusion

I began this capstone with a longstanding admiration for the complexity and beauty of motherhood. Based on the presented literature, it is evident that the current prevention and screening practices, not only in my province but in Canada, need major restructuring. A driving purpose of this capstone was to investigate these inconsistencies and to advocate for a multidisciplinary approach to assessment and treatment. Major disconnections in care were revealed, marked by significant disagreement among major healthcare bodies regarding PPD screening protocols versus sole reliance of clinical judgement. Furthermore, the restrictive diagnostic windows of the *DSM-5-TR* and *ICD-11* are insufficient, as PPD symptoms often persist well beyond the specified four-to-six week period postpartum. Critically, untreated PPD is strongly linked to long-term maternal physiological complications, including cardiovascular disease, and significantly jeopardizes secure infant-caregiver attachment and subsequent child development. For those in the counselling field, these findings underscore the need for mental health professionals to pursue interprofessional collaborations to work towards effectively

bridging the referral gap with medical professionals, and to commit to advocacy for evidence-based prevention and routine, culturally competent care. Structural changes like this are essential to transition care from fragmented practice to an integrated, comprehensive, and preventative model that strives for positive intergenerational impacts.

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Appendix A

Edinburgh Postnatal Depression Scale 1 (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt ***IN THE PAST 7 DAYS***, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- ☐ Yes, all the time
- ☒ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week.
- ☐ No, not very often — Please complete the other questions in the same way.
- ☐ No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Edinburgh Postnatal Depression Scale1 (EPDS)

Postpartum depression is the most common complicationof childbearing.[2] The Edinburgh (EPDS) is a valuable and efficient way of identifying patients at risk for "perinatal" depression. The EPDS is easy to administer and has proven to be an effective screening tool. Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt ***during the previous week***. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders. Women with postpartum depression need not feel alone. They may find useful information on the web sites of the National Women's Health Information Center <www.4women.gov> and from groups such as Postpartum Support International <www.chss.iup.edu/postpartum> and Depression after Delivery <www.depressionafterdelivery.com>.

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Arescored0,1,2or3withtopboxscoredas 0 and the bottom box scored as 3.

QUESTIONS 3, 510 (marked with an *)
Arereversescored,with the top boxscoredas a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)

Instructions for using the Edinburgh Postnatal Depression Scale:

1. The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. ***British Journal of Psychiatry*** 150:782-786.

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Retrieved from: https://www.socialworkerstoolbox.com/edinburgh-postnatal-depression-scale-epds/

Appendix B

Appendix A: Care Pathway Tool

(Access and download the PDF document: PCMCH-Care-Pathway-for-the-Management-of-Perinatal-Mental-Health_23July2021.pdf)

CARE PATHWAY FOR THE MANAGEMENT OF PERINATAL MENTAL HEALTH

This Care Pathway provides a recommended approach for the identification, assessment and monitoring of mental health issues for pregnant and postpartum people in Ontario.
This tool **does not replace individualized assessment, and clinical judgment is required** to ensure safe, effective, equitable and inclusive treatment of your patient.

1. ASK ABOUT THE WELL-BEING OF THE PREGNANT OR POSTPARTUM PERSON AT EVERY VISIT TO IDENTIFY THE NEED FOR MENTAL HEALTH SUPPORT AND TREATMENT

- Ask about mood and well-being of the pregnant or postpartum person at each visit and consider input from patient's circle of care. Assessment Tools can be used, including the Generalized Anxiety Disorder (GAD-7), Patient Health Questionnaire (PHQ-9) and Edinburgh Perinatal/Postnatal Depression Scale (EPDS) (see table below).
- Initiate a dialogue to understand the context of the person's mental health within their own unique situation with a lens on equity, diversity and inclusion.
- Identify factors that precipitate or exacerbate mental health symptoms (e.g., lack of support, financial difficulties, domestic violence, alcohol or substance use disorders, etc.)

2. ADVISE BY PROVIDING EDUCATION ON PERINATAL MENTAL HEALTH AND ARRANGE SUPPORT TO MITIGATE FACTORS THAT ARE AFFECTING MENTAL HEALTH

- Provide information about mental health problems in pregnancy and postpartum, how common they are and that effective treatments are available.
- Discuss strategies to increase practical and emotional social support, improve night-time sleep and incorporate regular meals and physical activity. These factors may improve mental health on their own for those with mild or subclinical symptoms and in conjunction with mental health treatments for those with problems that are more severe.
- Link to community supports
  - Across Ontario, the Healthy Babies Healthy Children (HBHC) program is a free program delivered through Ontario's public health units in partnership with hospitals and other community partners to help families receive supports and services to enhance mental health, self-care and parenting capacity in the community.
  - Arrange assistance in addressing precipitating and perpetuating factors, including resources available in the community to provide support (e.g., accessing financial, legal and domestic violence support, and accessing care for substance use disorders).

3. ASSESS THE SEVERITY OF THE MENTAL HEALTH CONCERN

4. ASSIST BY RECOMMENDING OR IMPLEMENTING A TREATMENT STEP (SEE DETAILS ON PAGE 2)

	MILD	MODERATE	SEVERE	URGENT
ASSESS Severity and Symptom Level	Mild or few, but persistent symptoms, minimal impact on day-to-day function	Multiple symptoms, persistent, impacting day-to-day function and quality of life	Many symptoms, persistent, significant impact on day-to-day function and quality of life	Psychosis, mania, or risk of harm to self or others
Assessment Tools (Depression & Anxiety ONLY)*				
GAD-7 (Anxiety)	Score = 5-9	Score = 10-14	Score = 15 or more	Not applicable
PHQ-9 (Depression)	Score = 5-9	Score = 10-14	Score = 15 or more or Q9 > 0	Intent or plan for suicide
EPDS (Depression and Anxiety)	Score = 10-12	Score = 13-18	Score = 19 or more or Q10 > 0	Intent or plan for suicide
ASSIST Initial Suggested Treatment Step	**Treatment Step 1** (if very mild, can monitor and reassess at 2-4 week intervals)	**Treatment Step 2**	**Treatment Step 2 of 3**	**Treatment Step 4**

*Patient Health Questionnaire (PHQ-9), Generalized Anxiety Disorder (GAD-7), Edinburgh Postnatal Depression Scale (EPDS) – Scores are a guide only; clinical assessment is required.

5. ARRANGE FOLLOW-UPS TO MONITOR RECOMMENDED TREATMENT PLAN. MAKE MODIFICATIONS OR CHANGES TO TREATMENT STEP AS REQUIRED

- Address barriers to treatment uptake, review risk factors and discuss progress to determine whether new level of Treatment Step is required.
- Frequency of initial follow-up should be at minimum every two weeks during active treatment phase (12 weeks). More frequent contact may be required if there is a higher severity of illness or medication is prescribed, and may be less frequent as symptoms improve. Be clear about which health professional is providing follow-up care.
- Use the assessment tools to monitor symptoms. Scores on a GAD-7 <5, PHQ-9 <5 or EPDS <10 on at least two assessments that are at least two weeks apart suggest remission.
- Follow patient to remission. Follow the individual on medication treatment for at least six months or longer after remission to assess need for ongoing treatment.

Appendix C

PPD Screening tool comparison

Measure	Edinburgh Postnatal Depression Scale (EPDS)	Postpartum Depression Screening Scale (PDSS)
Typical Cut-Off Score	**≥10 or ≥13**	**≥80**
Target Condition	Major or Minor Depression	Major Depression (MDD)
Sensitivity (Ability to correctly identify those *with* depression)	**81% to 85%** (for ≥11 or ≥10 cut-offs)	**94%** (for ≥80 cut-off for MDD)
Specificity (Ability to correctly identify those *without* depression)	**84% to 88%** (for ≥10 or ≥11 cut-offs)	**98%** (for ≥80 cut-off for MDD)
Area Under the Curve (AUC) (Overall diagnostic accuracy)	**0.85 to 0.90** (High overall accuracy)	≥**0.8** (When used as a continuous measure, it often performs comparably to EPDS)
Alternate Cut-Offs & Targets	≥13 (for higher specificity, lower sensitivity). A cut-off of 7 to 9 is sometimes used to capture minor depression.	≥60 (for Major or Minor Depression, typically yielding lower specificity, 72%)

Appendix D

Presentation Instructions and Speaking Notes

Because this is a working template, slides that require personalization to reflect the services and supports within the presenter's service area will have a large white asterisk in the top left corner. The presentation can be presented either in person or virtually, and invitations to attend would be sent out to maternal and paediatric healthcare professionals near a hospital with a birthing unit. The "surrounding area" is at the discretion of the presenter to account for hospitals that have larger service areas (i.e. smaller hospitals within rural areas). To help decide the max radial distance, presenters should speak with the hospital's public relations/communications departments or use their own discretion.

Attendees should include, but are not limited to, the following: paediatricians, midwives, OB-GYNs, family doctors, public health units, labour and delivery nurses, patient advocates, social workers, psychotherapists, psychiatrists, psychologists, mental health counsellors, lactation consultants, Indigenous medicine men/women, and executive/leadership members from the chosen hospital. The presenter should have knowledge of the service area's population demographics to be as inclusive as possible when curating their list of attendees.

Should the use of this template be requested outside of this capstone, I would like to be in attendance to assist the presenter, and to receive feedback from professionals in the field to ensure the presentation remains up to date, inclusive, and relevant in our ever-changing society, including ensuring that the presentation used has the most recently available information. Also, the second to last slide consists of frequently asked questions, so feedback from presentations will help add to this slide should there be additional common questions asked throughout

different presentations. Finally, speaker notes/slide scripts will be supplied, but presenters are free to summarize and personalize to best fit their audience, presentation style, and community

Slide One: Introduction

The purpose of this presentation is to propose a working collaboration centered around Windsor Regional Hospital's labour and delivery services and postpartum healthcare professionals in the surrounding service area. Postpartum depression (PPD) is the most common, underdiagnosed obstetric complication (Bass & Bauer, 2018; Sriraman et al., 2017) and results in an abundance of potential complications for both mother and baby if left untreated. The goal of this proposed collaboration is to provide pregnant women and new mothers with important information and access to local resources in hopes of decreasing the number of women who go unsupported.

Slide Two: Why This Topic Matters

A woman in the perinatal period will attend numerous healthcare settings which may include: monthly/biweekly/weekly prenatal check ups, ultrasound appointments, lab work, maybe she opted to see a midwife, or check ins with her primary care physician or family doctor. When it's time to give birth she'll see multiple nurses, maybe a different OB than the one she was seeing for prenatal check ups, possible NICU nurses and doctors. After this comes lactation consultants, or maybe she needs to speak with a patient advocate or social worker. After she is discharged, and her entire life has changed, a typical experience will see her bring her new baby in for check ups starting around 2-7 days old and then at two-, four-, six-, nine- twelve-, and eighteen-months (Canadian Paediatric Society, 2021). If she volunteers for it, add check ins from the public health unit Healthy Babies program, in addition to a paediatrician/her family doctor and public health nurses to the list of medical professionals she has interacted with.

Slide Three: Why This Topic Matters cont'

Throughout all these appointments and interactions and experiences, both prenatal and postpartum, the main focus tends to be on the health and well-being of the developing baby. That is not the issue–the health and well-being of the baby is obviously very important–but there is an additional important aspect that majorly contributes to the health and well-being of that baby… the health and well-being of the mother. As we all know, a mother's physical and mental health directly affects the health and well-being of her baby. If we refer to attachment theory, numerous studies have found that maternal sensitivity plays a crucial role in developing a secure attachment, and that maternal depression is linked to an increased risk of insecure attachment (Barnes & Theule, 2019; Della Vedova et al., 2023). Delays in achieving milestones, cognitive and socio-emotional impairments, anxiety, learning and speech difficulties, and heightened risks of mood disorders are all risks that have been linked to maternal depression (Bass & Bauer, 2018; Fransson et al., 2020; Racine et al., 2024; RNAO, 2018).

Slide Four: What Does This Mean?

Early intervention seems to be the best way to help mitigate the risks associated with PPD, making early recognition an essential component. As of now, Windsor Regional Hospital follows a "clinical judgement" approach to screening for PPD, meaning screening protocols are at the discretion of the patient's healthcare team. Screening for PPD is not required during any prenatal check up appointments, as these appointments tend to center around mom's physical health and fetal development. Mental health is not a major focus during these appointments unless the woman mentions that she's struggling, has a history of mental health difficulties, or the physician/OB asks how she is feeling. This leaves a lot of room for symptoms to go undetected and/or possibly to increase. So, what can we all do to help mitigate this risk?

Slide Five: How Can We Help?

Although the Canadian Task Force on Preventive Health Care (Lang et al., 2022) recommends against screening all peripartum individuals, other governing healthcare bodies such as the American Academy of Pediatrics (AAP), the American College of Obstetricians and Gynecologists (ACOG, 2017), and the Registered Nurses' Association of Ontario (2018) all recommend using an evidence-based screening tool during the perinatal period. Additionally, the Canadian Network for Mood and Anxiety Treatments (CANMAT) recommends screening multiple times during the perinatal period – once per trimester, at first postpartum follow up, and within pediatric/family care within the first 12 months postpartum (Vigod et al., 2024). The most widely recognized, accessible, and used screening tool is the Edinburgh Postnatal Depression Scale (EPDS). It can be administered by anyone and typically takes between 5-10 minutes to complete. Scoring and interpreting scores is simple, and clinical judgement is still needed after scoring. This is where the proposed collaboration comes in.

Slide Six: Working Together

Based on the EPDS score, physicians/OBs give the patient a list of services and programs based on those who chooses to include themselves in this collaboration. Windsor Regional Hospital already works in partnership with numerous community organizations related to maternal mental health, so this proposal seeks to expand that to include services that extend outside of Windsor-Essex county. Windsor Regional Hospital is a regional provider for other specialized services, meaning it draws people in from the entire Erie St. Clair area, which consists of Sarnia-Lambton, Chatham-Kent, and Windsor-Essex counties. With that in mind, we sought to include services and programs that extend to these areas as well. This includes, but is

not limited to, services/programs within public health units, psychological services specializing in postpartum care, community organizations and programs dedicated to maternal social support.

Slide Seven: How Does This Work?

Our first goal has been met—you all took the time to attend this presentation and learn what our proposal is about. Next steps include further outreach and networking within the previously mentioned areas to further include healthcare professionals that are interested in "promoting" their services to their respective communities. The list of services/programs will remain a work-in-progress document to account for services/programs that reach out over time. What is needed from you today is simply just an expression of interest to be included.

Slide Eight: What Would This Require From You?

Honestly, not much. Your participation is voluntary and does not require any sort of membership or fee to be included—essentially all we want is your passion for improving maternal healthcare. Depending on the scope of your profession and where your position falls in the peripartum healthcare timeline, I will be recommending some small changes to a few specific appointment structures.

Slide Nine: Prenatal Care

As mentioned, Windsor Regional Hospital follows a "clinical judgement" model of care when it comes to mental health assessments in prenatal care. What I am recommending aligns with the recommendations outlined by CANMAT, which incorporates a PPD assessment using the EPDS throughout pregnancy—ideally once per trimester. Seeing as the EPDS is quick, accessible, and very easy to score and interpret, this can be done at any point of the appointment. The patient can complete the questionnaire on her own in the waiting room and then have it scored by a nurse, or if she requests assistance, it can be completed with the intake nurse who

would then calculate the score for the OB to interpret and decide if further steps are needed. This is also where the working collaboration comes in—if she scores within a range that requires further mental health assessment, the OB will have an updated list of professionals who are qualified to diagnose mental health disorders. This small change comes with little to no interruption of the typical appointment structure since the EPDS is a very simple, yet clinically proven and effective tool.

Slide 10: Postpartum Care

For clinicians involved in postpartum care—OBs, pediatricians, family doctors/primary care physicians, public health nurses, etc.—CANMAT proposes an assessment be done at each well-child appointment. This would mean the EPDS would be administered at the first newborn check-up appointment, and at all well-child visits within the first 12 months. I understand that the infant, not the mother, is the patient for the pediatrician, and that these appointments are meant to check in on the infant's health and development, but as we have learned, the mother's health and wellbeing has been proven to positively or negatively affect the development of the infant. Incorporating this assessment into the well-child appointments is an additional protective measure that contributes to the healthy development of the infant.

Slide 11: Professional Outreach

Okay, so you did the EPDS assessment and have the mother's score… now what? This is where your clinical judgement is needed. Based on CANMAT's proposed cut off score of 10/11, which suggests further evaluation, women who score below the cut-off score should be questioned about their symptoms and what their support system looks like. The services and programs list would then be given to her, and if you feel inclined to you can recommend specific services on the list (i.e. if she states she doesn't have a lot of social support, you could suggest

she look into pre- or post-natal groups depending on where she is in her perinatal journey). One thing that needs to be remembered is that if a person answers anything other than “never” on question 10, she MUST be further assessed and if needed, referred to emergency psychiatric services for full evaluation.

Slide 12: Extra Details

As I said before, this proposed collaboration does not require anything from you other than your interest and support. As the person proposing this collaboration, I take full responsibility for the creation and maintenance of the services/programs list and would be the main point of contact should you wish to be added to the list or would like to subscribe to receive a copy of the list as it evolves. This is a project that I have chosen to take on voluntarily as a means of professional development, and because it is an area of practice that I have a strong passion for.

Slide 13: Wrap Up

To close, I want to reiterate that even though PPD is a globally experienced complication, it is manageable; early identification is a major contributor to its prevention and management. Untreated PPD poses different risks and complications to mom and baby at every stage of the perinatal period and is relevant to the care provided by every clinician, physician, and medical practitioner who is here today. Supporting women during such an extraordinary and complex experience benefits our communities and contributes to the overall wellbeing of current and future generations. I want to thank you all for your time and participation. I will now be opening the floor for questions and feedback.

Slide 14: Questions

This slide will be continually edited to add frequently asked questions should this presentation be utilized by others