



Background

Pregnancy and childbirth can be a very rewarding and exciting time, but it can also be a period of severe emotional stress as seen in the estimated 10-20% of women suffering from postpartum depression within six months of delivery.¹ Postpartum depression can be disabling for the mother and limit her ability to care for her new infant resulting in increased use of health care services and more hospitalizations.² Additionally, women with postpartum depression are less likely to do basic preventive services such as putting the infant to sleep on the back, attending well child visits, and keeping up to date on immunization coverage.² In severe cases of postpartum depression, women may harm themselves, their infants, and others. Fortunately, most cases of postpartum depression, when identified early, can be treated effectively on an outpatient basis.

Methods

Two survey questions found in PRAMS have been shown to be highly sensitive of postpartum depression and are recommended clinical screening questions.^{2,3}

- 1) *Since your new baby was born, how often have you felt down, depressed, or hopeless?*
- 2) *Since your new baby was born, how often have you had little interest or little pleasure in doing things?*

Self-reported postpartum depression (SRPPD) was defined if a women reported a response of “always” or “often” to either one of these two questions. This identifies women at high risk of having postpartum depression and should receive further evaluation for postpartum depression by a health care provider. We evaluated SRPPD among common racial/ethnic and socio-demographic groups in Hawai'i using 3 years of PRAMS data, 2004-2006.

Data Highlights

- About 1 out of 7 women (14.8%) with a recent live birth report SRPPD
- Among race/ethnicity groups in Hawai'i, women who were Black, Hispanic, Hawaiian, Samoan, other Pacific Islander, and other Asian had the highest SRPPD estimates
- Women more likely to report SRPPD were younger, less educated, not married, were Medicaid/QUEST insured, had an unintended pregnancy, smoked and used illicit drugs in pregnancy, reported intimate partner violence, and participated in WIC during prenatal care

“The most stressful time was 6 weeks after baby was born due to recovery from delivery, overwhelming emotions, difficulty with latching on, and overall fatigue.”

“Need longer postpartum period on Quest for postpartum depression.”

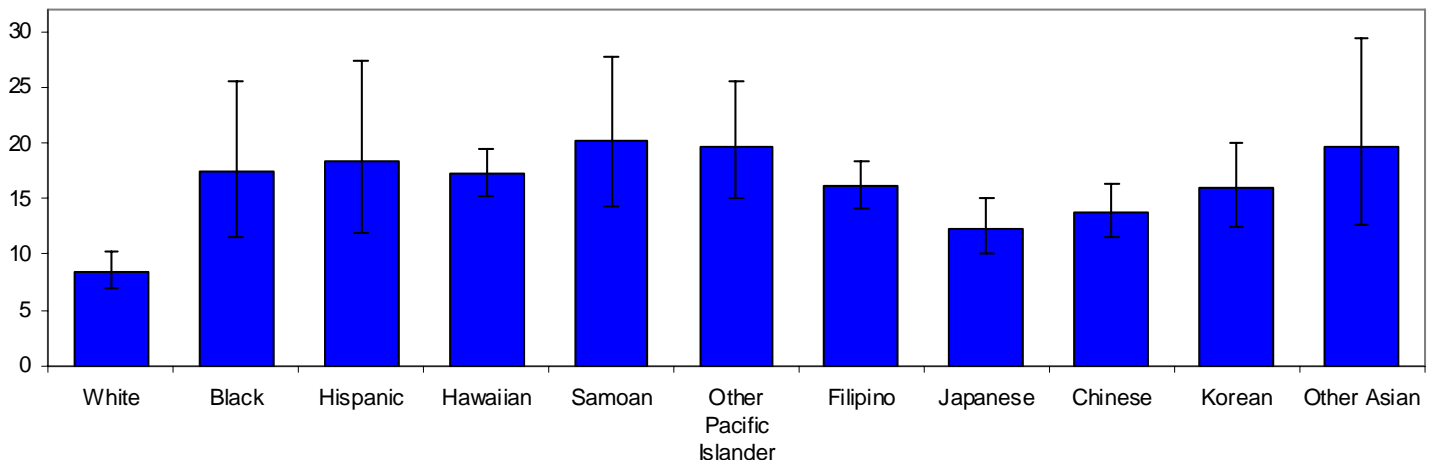
“OB doctors/nurses should tell women who are pregnant that they may become depressed after they give birth. Then they should tell them what to do if this should happen.”

–Hawai'i PRAMS Participants

Race/Ethnicity Related to SRPPD

Approximately 15% of mothers in Hawai'i have SRPPD and all Asian and Pacific Islander groups have much higher estimates than the white population in Hawai'i. Blacks Hispanic, Hawaiian, Samoan, other Pacific Islanders, and other Asian women have high estimates.

Self-reported Postpartum Depression by Race/Ethnicity, Hawai'i PRAMS 2004-2006



Maternal Characteristics Related to SRPPD

Women more likely to have SRPPD were younger, less educated, unmarried, had Medicaid/QUEST coverage of their recent delivery, had an unintended pregnancy, smoked in the last 3 months of pregnancy, used illicit drugs in pregnancy, experienced intimate partner violence during pregnancy, and participated in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) during prenatal care.

Discussion

In Hawai'i, the overall rate of being at high risk for postpartum depression as assessed with SRPPD is consistent with national estimates. This translates to approximately 3,000 new mothers every year with variation among several racial/ethnic and other socio-demographic characteristics. Several high risk activities that may affect the perinatal period were also related to SRPPD including smoking, illicit drug use, and experiencing intimate partner violence. It is important to note that having Medicaid/QUEST or participating in WIC did not cause the observed differences; as the association likely reflects the populations of women with higher associated risks that these programs serve. To improve health in Hawai'i, it will be important to develop culturally appropriate programs to increase awareness of postpartum depression and its impact on society. The Family Health Services Division provides depression screening services through its Perinatal Support Services and Baby Safe programs using different standardized instruments ranging in time from the initial visit to 6 months postpartum.

Those that work with women during and after their pregnancy should be aware of postpartum depression, be able to do a brief assessment, and be aware of appropriate resources so that women with postpartum depression and society can enjoy the rewards and excitement of childbirth and raising a child.

References

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About the Data

The **Hawai'i Pregnancy Risk Assessment Monitoring System (PRAMS)** is a self-reported survey of recent mothers conducted by mail with telephone follow-up. It is designed to monitor the health and experiences of women before, during, and just after pregnancy. Every year, about 2,000 women who deliver a live infant are randomly selected to participate.

Suggested Citation

Hayes D, Eshima M, Fuddy L. "Postpartum Depression Fact Sheet." Honolulu, HI: Hawai'i Department of Health, Family Health Services Division; September 2008.

Self-Reported Postpartum Depression by Maternal Characteristics, Hawai'i PRAMS 2004-2006

	SRPPD % (95% CI)*
Race/Ethnicity	
White	8.5 (7.0-10.3)
Black	17.5 (11.6-25.5)
Hispanic	18.4 (12.0-27.4)
Hawaiian	17.2 (15.2-19.4)
Samoan	20.2 (14.3-27.8)
Other Pacific Islander	19.7 (15.0-25.5)
Filipino	16.1 (14.1-18.3)
Japanese	12.3 (10.1-15.0)
Chinese	13.7 (11.5-16.3)
Korean	15.9 (12.5-20.0)
Other Asian	19.7 (12.7-29.4)
Maternal Age	
Under 20 years	25.4 (21.3-30.1)
20-24 years	16.9 (14.9-19.1)
25-34 years	12.1 (10.9-13.4)
35 and greater	14.6 (12.6-16.8)
Maternal Education	
< High School	24.2 (20.2-28.6)
High School	16.5 (14.9-19.1)
Some College	15.1 (13.3-17.0)
College Graduate	8.1 (6.8-9.5)
Marital Status	
Married	12.4 (11.3-13.5)
Not married	19.5 (17.6-21.4)
Health Insurance at Delivery	
Private Insurance	11.5 (10.5-12.5)
Medicaid/QUEST	21.8 (19.8-24.1)
None	14.0 (7.8-23.7)
Intention of Pregnancy	
Unintended	17.7 (16.2-19.4)
Intended	12.6 (11.5-13.8)
Smoking last 3 months of pregnancy	
Yes	24.5 (20.6-28.9)
No	13.9 (13.0-14.9)
Illicit Drug during pregnancy	
Yes	26.8 (19.9-35.0)
No	14.3 (13.3-15.3)
Intimate partner violence during pregnancy	
Yes	37.8 (30.7-45.4)
No	13.9 (13.0-14.9)
County of Residence	
Honolulu	14.7 (13.7-15.9)
Hawai'i	15.6 (13.0-18.7)
Maui	15.2 (12.4-18.5)
Kauai	12.4 (8.7-17.3)
Prenatal WIC participation	
Yes	19.0 (17.4-20.8)
No	11.4 (10.3-12.6)
Overall	14.8 (13.9-15.8)

*note 95% CI refers to the 95% confidence interval around estimate.

For more information Contact:

Hawai'i PRAMS Coordinator
Hawai'i Department of Health
PRAMS@doh.Hawaii.gov
(808) 733-4060