# The Effect of a Pamphlet on Women's Experiences of Postpartum Depression

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**ABSTRACT**

A randomized controlled trial was used to test the effect of an educational pamphlet mailed at 4-weeks postpartum to women who were at low risk of postpartum depression ($n$ = 256). Based on telephone interviews at 3-months postpartum, women in the intervention group scored significantly lower on the Edinburgh Postnatal Depression Scale (EPDS) than those in the control group. Few women scored 12 or higher on the EPDS ($n$ = 3 intervention group, $n$ = 9 control group). The pamphlet did not influence the women's awareness of the symptoms of postpartum depression.

Postpartum depression (PPD) is a non-psychotic depression that occurs within 1 year of childbirth and has serious short- and long-term consequences for women and their babies (Beck, 2002a; Dennis, 2004a; Dennis & Creedy, 2005; Ogrodniczuk & Piper, 2003). The incidence of PPD is not precisely known (Gaynes et al., 2005); reported rates range from 6.5% to 20% in the general population (Beck, 2002a; Dennis, 2004a, 2004b; Dennis & Creedy, 2005; Gaynes et al., 2005; Stowe, Hostetter, & Newport, 2005; Verkerk, Pop, Van Son, &Van Heck, 2003). Clinicians and researchers have radically

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advanced knowledge about the etiology and symptoms of PPD, and the efficacy of various interventions (Beck, 2002a; Dennis 2004a; Dennis & Creedy, 2005; Ogrodniczuk & Piper, 2003); however, research is limited with respect to whether this knowledge is being integrated among postpartum women in the community. Some researchers are concerned that the rates of PPD are underestimated by up to 50% and that many affected women do not seek services (Letourneau et al., 2006; Logsdon, Wisner, Billings, & Shanahan, 2006; Sobey, 2002; Tam, Newton, Dern, & Parry, 2002). Letourneau et al. (2006) identified that many symptomatic postpartum mothers did not reveal their depressive symptoms to any health care provider. Explanations for the underestimation of the rates of PPD and a reduced level of help-seeking behaviours included women's lack of knowledge of PPD and the available services, reticence of postpartum women to disclose their feelings out of embarrassment or fear of being stigmatized as "unfit" mothers, cultural barriers, and clinicians either being unable to assess PPD or minimizing women's symptoms (Dennis, 2004a, 2004b; Dennis & Creedy, 2005; Letourneau et al., 2006; Ogrodniczuk & Piper, 2003; Ross, Dennis, Blackmore, & Stewart, 2005; Sobey, 2002; Ugarriza, 2002; Wroblewski & Tallon, 2004).

Even though education on PPD has been implemented for over 10 years through public health units, clinicians, and the media, a concern exists that consumer information on PPD is inaccurate (Summers & Logsdon, 2005) and that health professionals may be unable to assess or are minimizing women's symptoms (Logsdon et al., 2006). Heh and Fu (2003) reported that women who were at risk of developing PPD and who received informational support at 6-weeks postpartum experienced lower Edinburgh Postnatal Depression Scale (EPDS) scores at 3-months postpartum than women in the comparison group who did not receive the intervention. A limitation of the Heh and Fu study was that awareness of the symptoms of PPD and sources of assistance were not measured.

## PURPOSE

The purpose of this research was to evaluate the effect of an educational pamphlet on PPD for postpartum women who were at low risk of experiencing PPD. Low-risk women were the focus of this research in order to contribute to the debate on universal screening for postpartum women. There is no consensus on approaches for screening (time and frequency) for PPD (Gaynes et al., 2005; Ross et al., 2005), with recommendations for screening ranging from the prenatal period to throughout the first year postpartum (Davies, Howells, & Jenkins, 2003; Dennis, 2004a, 2004b; Dennis, Janssen, & Singer, 2004; Gaynes et al., 2005; Logsdon et al., 2006; Milgrom, Ericksen, Negri, & Gemmill, 2005; Mosack & Shore, 2006; Peindl, Wisner, & Hanusa, 2004; Ross et al., 2005; Stowe et al., 2005). Universal screening promotes the early identification of women who may have PPD to facilitate early intervention and improve their quality of life, but it is costly to provide these services (Ross et al., 2005). Given the low frequency of PPD at 3-months postpartum for low-risk women (1.1%), as compared with 17.5% for high-risk women (Verkerk et al., 2003), we were interested in identifying whether low-risk women who received an educational pamphlet that explained the symptoms of PPD and identified local services for PPD would be aware of depressive symptoms and access services should they become symptomatic, thus contributing to lower EPDS scores.

### Hypotheses

Postpartum women who were at low risk of experiencing PPD and who received the educational pamphlet would have

- lower levels of PPD and lower EPDS scores;
- greater awareness of PPD and its symptoms; and
- higher probability of accessing services, if symptomatic, as compared with the control group.

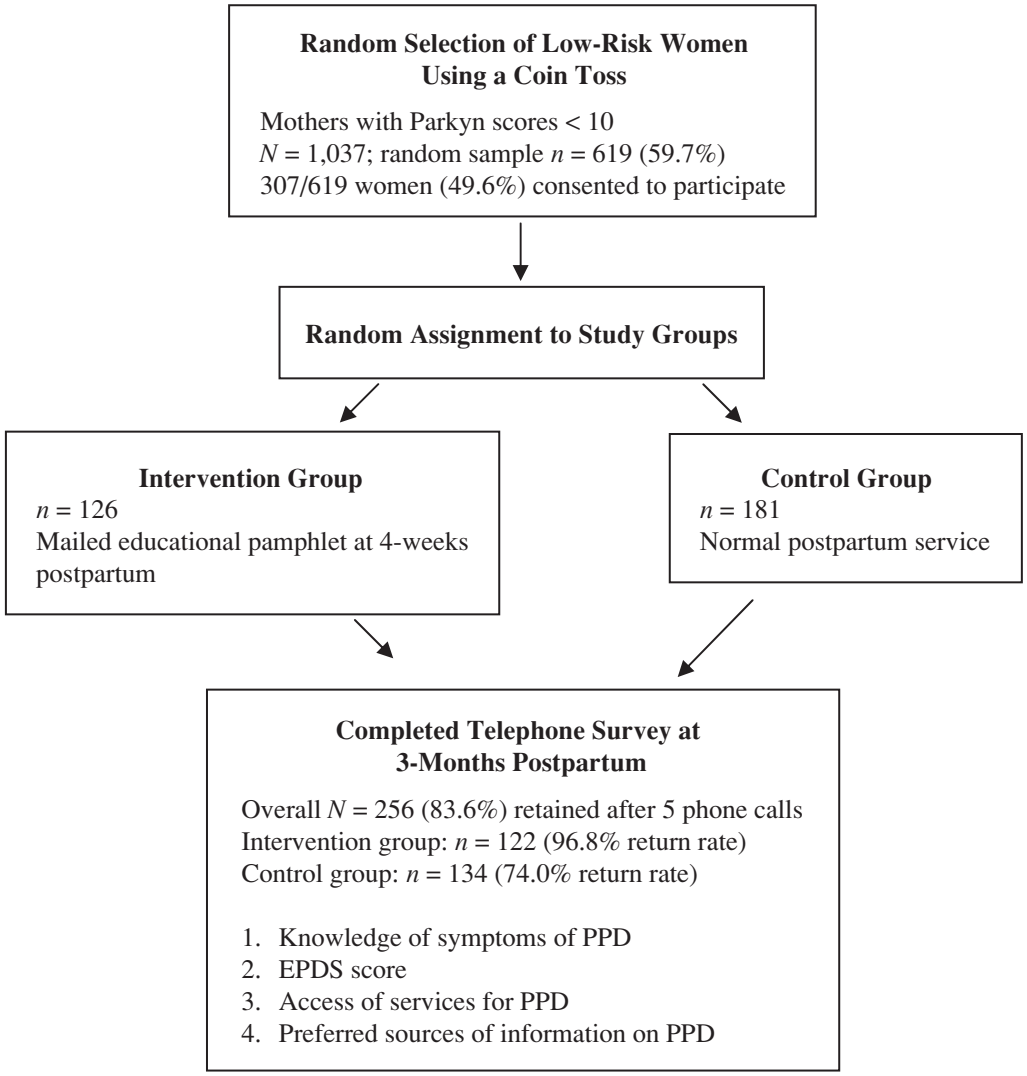
## STUDY DESIGN AND METHOD

Women who were at low risk of experiencing PPD were selected for this study using a randomized controlled design with a population-based sample from a primarily urban area in southwestern Ontario (Figure 1). The sampling frame was obtained using data from women who had completed the Healthy Babies Healthy Children Postpartum (Parkyn) Screening Tool, since it is universally implemented in Ontario during hospitalization postbirth (Ontario Ministry of Health and Long-Term Care, 2006; Parkyn, 1998). The Parkyn tool assesses the mental health of the mother, as well as her social situation, financial status, and family interaction status. In this study, the Parkyn tool was used to exclude women who potentially had a higher risk of PPD (women with scores less than 10) by screening out women with a history of PPD, psychosis, and inadequate social support (Beck, 2002b; Verkerk et al., 2003). A limitation of the Parkyn tool is that its primary purpose is to identify potential problems with early childhood development; it does not include Verkerk et al.'s other criteria of risk, such as having a poor relationship with one's parents during childhood, a poor marital relationship, low self-esteem, and stressful life events. Only women who could speak English were included in this study. The women who were chosen at random to participate in this research did not have a personal relationship with any member of the research team. Ethical review of this evaluation study was completed by the Middlesex-London Health Unit Research Advisory Committee.

The proposed sample size for this study was 170 women (85 per group), based on an expected standard deviation of 3.5 in the EPDS. This sample size would enable researchers to detect a difference of 1.5 in the EPDS score at the 5% level of significance (two-sided) and 80% power (Kelsey, Thompson, & Evans, 1986). A total of 1,037 women were found to be at low risk of PPD using the Parkyn tool from October 2005 to March 2006. In order to obtain the required sample size, given concerns about participant attrition related to increased demands on new mothers during this role transition, during the data collection phase 60% of the postpartum women were randomly selected by a coin toss and then approached to participate by public health nurses during the routine 48-hour postpartum follow-up telephone call ($n = 619$). Approximately half (49.6%) of these women consented to participate in this study. There was a statistically significant, but non-clinical difference in the age of women who consented to participate (consenting women mean age 29.8 years, standard error 0.33; non-consenting women mean age 28.8 years, standard error 0.31; $t = 2.086$; $p = .035$). There were no significant differences in their living situations (parenting alone or parenting with partner/family, $p = .581$).

**Figure 1**

**Selection of Sample and Assignment of Intervention Group**




Women were randomly assigned to the intervention or control group using a coin toss. Women in the intervention group were mailed an educational pamphlet at 4-weeks postpartum, in order to avoid information overload at the time of the birth of their baby and after the typical period of the "Baby Blues" had dissipated (Ross et al., 2005), yet earlier than the 6-week period used by Heh and Fu (2003). Women in the control group received routine follow-up postpartum care from their primary care provider.

Consistent with the literature (Beck, 2002a, 2002b; Dennis, 2004a; Dennis & Creedy, 2005; Registered Nurses' Association of Ontario, 2005; Ross et al., 2005; Stowe et al., 2005), the educational pamphlet "Why is everyone happy but me?" described the symptoms of PPD (feeling overwhelmed, helpless, hopeless, empty, inadequate, lonely, sad, anxious, extreme feelings of fatigue/exhaustion, changes in appetite, and thoughts of self-harm or harming her baby), as well as the available services for PPD (sympathetic listeners, partners, family and friends, as well as midwives, doctors, obstetricians, public health nurses, the website www.helpformom.ca, and a hopeline telephone number that offered a complete listing of local services). The literacy level of the pamphlet was grade 6.9 according to the Flesch-Kincaid grade level in MS Word (Windows XP).

At 3-months postpartum, women from both study groups participated in a 15 to 20 minute telephone interview conducted by trained interviewers (registered nurses) who were blind as to the women's assignment to the intervention or control group. The interview was invariant. First, women were asked questions to identify their awareness of the symptoms of PPD using an instrument consistent with the Rapid Risk Factor Surveillance System (RRFSS, 2005) Module on Postpartum Mood Disorders, in order to reduce a response bias that might occur should women recognize the symptoms of PPD in the EPDS. Women were asked open-ended questions with respect to the symptoms of PPD. Second, women were screened with the EPDS (Cox, Holden, & Sagovsky, 1987; Eberhard-Gran, Eskild, Tambs, Opjordsmoen, & Samuelsen, 2001; Ross et al., 2005; Teissèdre & Chabrol, 2004), which has been effectively administered over the telephone (Dennis, 2004b). EPDS scores of 12 and higher are indicative of PPD. Women were then asked whether they had accessed services for PPD and the types of services that they had accessed. Finally, women were asked about their preferences as to sources of information on PPD. When participants were concerned about their depressive symptoms or scored 12 or higher on the EPDS, they were given a contact at their local public health unit for assistance.

Analyses using unpaired *t*-tests were used to identify mean differences in the EPDS scores and the total number of symptoms of PPD identified by the women. A chi-square test was used to determine the proportion of women who accessed services for PPD. Data were analyzed with SPSS version 14.0; *p* values less than .05 (two-sided) were considered to be statistically significant.

## RESULTS

### Sample Characteristics

Two hundred fifty-six women (83.6%) could be contacted (after a maximum of five attempts) for the telephone interview at 3-months postpartum. The majority of the women (96.8%) who received the educational pamphlet participated in the follow-up interview, as compared with 74% of women in the control group ($p < .001$). The mean age of study participants was 30.1 years ($SD = 5.47$ years; see Table 1). The majority of these women had post-secondary education (78.9% ± 2.48%), lived with partners (93.0% ±1.4%), and viewed themselves as Canadian (72.3% ± 4.46%) rather than Latin American, European, Middle Eastern, or Asian. There were no clinically important differences between the participants in the intervention and the control groups.

**Table 1**
**Demographics of the Women in the Intervention and Control Groups**

| Variable | Intervention ($n$ = 122) | Control ($n$ = 134) | Total ($n$ = 256) | $p$ values |
|---|---|---|---|---|
| Age | | | | |
| Mean (*SD*) | 30.0 (5.1) | 30.1 (5.9) | 30.1 (5.5) | .914 |
| Education, *f* (%) | | | | |
| Post-secondary education | 98 (80.3) | 104 (77.6) | 202 (78.9) | .647 |
| High school or less | 24 (19.7) | 30 (22.4) | 54 (21.1) | |
| Primary ethnic status, *f* (%) | | | | |
| View self as Canadian | 86 (70.5) | 99 (73.9) | 185 (72.3) | .578 |
| View self as another ethnic group | 36 (29.5) | 35 (26.1) | 71 (27.7) | |
| Living situation, *f* (%) | | | | |
| Living with a partner | 114 (93.4) | 124 (92.5) | 238 (93.0) | .777 |
| Living alone | 8 (6.6) | 10 (7.5) | 18 (7.0) | |

### Experiences of Postpartum Depression

Women in the intervention group had EPDS scores significantly lower than women in the control group (EPDS intervention group 4.14; control group 5.01; $t = 2.180$; $df = 254$; $p = .030$; see Table 2). Three women in the intervention group (2.5%) had EPDS scores of 12 and higher, as compared with 9 women (6.7%) in the control group. Nevertheless, 11 women in the intervention group (9.1%) reported that they had concerns that they might have PPD, as compared with 21 women (15.7%) in the control group.

### Access of Services for PPD

Access of services for PPD was not significantly different among women in the intervention group (18 women, 15.3%) and the control group (30 women, 22.6%; Table 2). All 3 women in the intervention group with EPDS scores of 12 or higher accessed services for PPD, compared with 6 women (66.7%) in the control group. Overall, public health nurses (10.2%) and family physicians (6.3%) were the most frequently accessed services. None of the women reported that they accessed their obstetricians, local crisis services, or PPD support groups. Of the subgroup of women who had self-concerns of PPD, approximately two thirds of women (19, 63.3%) accessed services.

### Awareness of PPD

All participating women were aware of the term *postpartum depression*. There were no significant differences in the number of symptoms of PPD identified by the women in the intervention group

compared with the control group. Women in the intervention group recognized a mean of 3.57 symptoms of PPD compared with a mean of 3.37 symptoms in the control group ($p$ = .242; Table 2). Overall, the most frequently identified symptoms were sadness and crying (87.1%), followed by thoughts of harming the baby, and sleep and appetite problems (44.5% to 46.1%). Less than 10% of the women reported social isolation, helplessness, and hopelessness as symptoms of PPD.

**Table 2**
**Impact of the Educational Package on the Women in the Intervention and Control Groups**

| Variable | Intervention ($n$ = 122) | Control ($n$ = 134) | $p$ values |
|---|---|---|---|
| EPDS score<br>Mean (*SD*) | 4.14 (2.94) | 5.01 (3.45) | .030 |
| Women with EPDS scores 12+, *f* (%) | 3 (2.5) | 9 (6.7) | Fisher's exact two-tailed test = .142 |
| Women with self-concerns of PPD, *f* (%) | 11 (9.1) | 21 (15.7) | Fisher's exact two-tailed test = .132 |
| Women who accessed services for PPD, *f* (%) | 18 (15.3) | 30 (22.6) | .151 |
| Total number of symptoms of PPD recognized<br>Mean (*SD*) | 3.57 (1.43) | 3.37 (1.40) | .242 |

*Note*. EPDS = Edinburgh Postnatal Depression Scale. PPD = postpartum depression.

### Preferred Sources of Information on PPD

There were no significant differences between the intervention and the control group as to their preferred sources of information. Women preferred to obtain information on PPD while hospitalized after the birth of their baby (64.0%), followed by a pamphlet (34.4%), and/or from their family physician (29.7%). Posters, billboards, newspapers, telephone help lines, and mental health centres were the least preferred sources of information (< 7%).

## DISCUSSION

This study focused on the evaluation of the effect of an educational pamphlet on PPD for women who were at low risk of experiencing PPD. These women were well educated, spoke English, and identified themselves as Canadian.

Similar to Heh and Fu (2003), we found that postpartum women receiving the educational pamphlet on PPD had significantly lower EPDS scores than those in the control group. The majority of women did not exceed the EPDS threshold for depression. The 3-month-point prevalence of PPD in the intervention group (2.5%) and the control group (6.7%) was slightly higher than the finding of 1.1% by Verkerk et al. (2003). The study rate of PPD may have been higher because the Parkyn tool did not allow for the measurement of the additional risk factors of self-esteem, marital difficulties, past difficulties in relationships with parents, and exposure to stressful life events. The prevalence rate of PPD in this study was limited, since it was a point prevalence at 3-months postpartum and women may experience PPD up to 1-year postpartum (Ross et al., 2005). Given limited resources, we support that during pregnancy or the postpartum period (at minimum) women be universally asked whether they have a past history of depression and lower levels of social support, and that more thorough screening be conducted for women who experience these risk factors. Questions about mood and the effectiveness of emotional support should address the full year postpartum.

Even though the majority of women did not have EPDS scores of 12 or higher, some women identified concerns that they had PPD. The majority of these low-risk women with concerns about PPD (63.3%) accessed services by 3-months postpartum, thus highlighting the need for women to be able to discuss and clarify their PPD concerns. Wroblewski and Tallon (2004) and Ugarriza (2002) have argued that providing information on PPD is a major help-seeking facilitator for new mothers experiencing depressive symptoms. In contrast to the finding of Letourneau et al. (2006), all of the women in the intervention group who had EPDS scores of 12 or higher accessed services for PPD, as compared with approximately two thirds of the women in the control group. These results may be limited by an effect bias, since women who received the educational pamphlet were significantly more likely to participate in the telephone interview at 3-months postpartum than the women in the control group. The future use of an attention control group versus standard care may reduce this potential bias. In addition, we recommend that future randomized controlled studies use a table of random numbers, rather than a coin toss, to assign participants to the intervention and control groups. Further research is needed in order to generalize this result to postpartum women identified at low risk of developing PPD, due to the small sample size of women who were symptomatic. In addition, data were self-reported and only generalizable to women at 3-months postpartum and who could speak English.

Since public health nurses and family physicians were the most frequently accessed services for PPD, it is crucial that these health professionals are aware of the symptoms of PPD and the available local resources (Logsdon et al., 2006). Public health nurses are in an ideal position to conduct further screening of women's symptoms and concerns of PPD, as well as to suggest self-care strategies and resources, or to make referrals as they meet with women face-to-face or speak with them over the telephone. None of the women in this study reported that they accessed their obstetricians, local crisis services, or PPD support groups. Further research is needed to identify postpartum women's awareness of the sources of assistance for PPD, and whether there are barriers that prevented these women from accessing services, especially women with more ethnically diverse backgrounds.

Distribution of the educational pamphlet did not significantly increase the identification of the symptoms of PPD. This result might have occurred through a selection bias, since women who may

not have been aware of PPD may not have consented to participate in the study. A second explanation might be that women were sensitized to information on PPD through concurrent information campaigns throughout Ontario. We support that the best approach to measuring women's understanding of the symptoms and sources of assistance for PPD is through the use of open-ended questions such as in the RRFSS Module on Postpartum Mood Disorders (2005). Letourneau et al. (2006) suggest that educational campaigns are necessary to assist women and their supports to understand all of the symptoms of PPD. Since the majority of women who were at low risk of experiencing PPD were only aware of the primary symptom (sadness) and not other symptoms, we recommend that future educational materials on PPD emphasize symptoms of isolation and hopelessness as indicators for a more thorough assessment by a health professional. In order to be responsive to women's preference to receive information at birth regarding PPD, we recommend that a pamphlet outlining the symptoms of PPD and the local services be made available to women at the time of the birth of their baby and, if possible, be mailed at 4-weeks postpartum after the typical period of "Baby Blues" has dissipated, to encourage women who continue to be symptomatic or who become symptomatic to seek services. Further research is still indicated to determine the most effective educational strategies, such as optimum timing and content, for informing postpartum women about PPD.

## RÉSUMÉ

Un essai contrôlé randomisé a été employé pour évaluer l'impact d'une brochure éducative postée à 4 semaines post-partum aux femmes qui sont à faible risque de dépression post-partum (DPP) ($n$ = 256). Sur la base d'entrevues téléphoniques à 3 mois post-partum, les femmes dans le groupe d'intervention ont réalisé des évaluations selon l'échelle de dépression postnatale d'Édimbourg sensiblement inférieures à celles dans le groupe témoin. Peu de femmes ont atteint 12 ou plus sur l'échelle ($n$ = 3 groupe d'intervention, $n$ = 9 groupe témoin). La brochure n'a eu aucune influence sur la sensibilisation des femmes aux symptômes de DPP.

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