

Introduction

- Postpartum depression (PPD) affects 10-15% of mothers worldwide.
- PPD may inhibit parental engagement and adherence to early intervention services that are critical for children's development.
- Few studies have explored PPD among mothers of children with Down Syndrome (DS).

Objective

- To identify the prevalence of PPD among mothers of children with DS in a subspecialty pediatric DS clinic.
- To identify the association of PPD with demographic variables.

Methods

- Mothers of children ages 0 to 12 months with DS, completed the Edinburgh Postpartum Depression Scale (EPDS).
- A positive screen was identified by scoring 10 or higher, or a positive answer on the critical item.
- Positive screen prevalence was calculated.
- Associations between PPD screening and demographic variables were analyzed.

References

• Cho H, Lee K, Choi E, et al. Association between social support and postpartum depression. *Sci Rep.* 2022;12(1):3128. Published 2022 Feb 24

• Marian F. Earls, Michael W. Yogman, Gerri Mattson, Jason Rafferty, Committee on Psychological Aspects of Child and Family Health. Rebecca Baum, Thresia Gambon, Arthur Lavin, Lawrence Wissow; Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice. *Pediatrics* January 2019; 143 (1) 2018-3259

Results

- 233 mothers completed the EPDS between July 2023 and December 2025; 199 questionnaires were included in the analysis.
- 29 (14.6%) of mothers screened positive for PPD; 63.3% received additional consultation with a social worker.
- Mothers of children diagnosed postnatally had lower EPDS scores than those who learned of DS risk or diagnosis prenatally.

Table 1. Mother and child characteristics	
Characteristic	n (%)
Total sample	199 (100)
Child gender	
Male	103 (51.8)
Female	96 (48.2)
Child ethnicity	
Hispanic	120 (61.2)
Non-Hispanic	76 (38.8)
Child race	
White or Caucasian	147 (76.2)
Black or African American	23 (11.9)
Asian	5 (2.6)
American Indian and Alaska Native	2 (1.0)
Other	16 (8.3)
Child insurance category	
Medicaid	127 (63.8)
Commercial/Private	67 (33.7)
Exchange	2 (1.0)
Self-Pay	3 (1.5)
Child diagnoses	
Additional diagnosis documented	115 (57.8)
No additional diagnosis documented	84 (42.2)
Mother primary language	
English	137 (68.8)
Spanish	62 (31.2)

Table 2. Relationship between EPDS screening and scores and mother and child factors

Variable	Test	Value	df	p-value
EPDS binary screening outcome				
Child gender	Chi-square	0.140	1	0.845
Child ethnicity	Chi-square	0.000	1	1.000
Child race	Fisher's exact	11.897	4	0.023*
Child insurance category	Fisher's exact	3.170	-	0.332
Child additional diagnosis	Chi-square	0.185	1	0.411
Mother primary language	Chi-square	0.021	1	1.000
First living child of mother	Chi-square	0.068	1	0.819
Timing of child diagnosis	Fisher's exact	5.933	-	0.046*
EPDS score				
Child gender	t-test	0.201	197	0.841
Child ethnicity	t-test	0.804	194	0.422
Child race	ANOVA	1.858	4, 192	0.120
Child insurance category	ANOVA	0.287	3, 198	0.835
Child additional diagnosis	t-test	-0.417	197	0.677
Mother's primary language	t-test	0.901	197	0.369
First living child of mother	t-test	-0.348	197	0.729
Timing of child risk/diagnosis	ANOVA	5.160	2, 197	0.007*

Conclusions

- These findings indicate mothers of children with DS are at risk of PPD.
- Pediatric specialty clinics, in addition to primary care clinics, should screen for PPD through 12 months.
- Diagnostic timing may impact the level and timing of support mothers need to prevent and manage postpartum depression.
- Further research is warranted regarding therapeutic and social support to enhance parent and child outcomes.