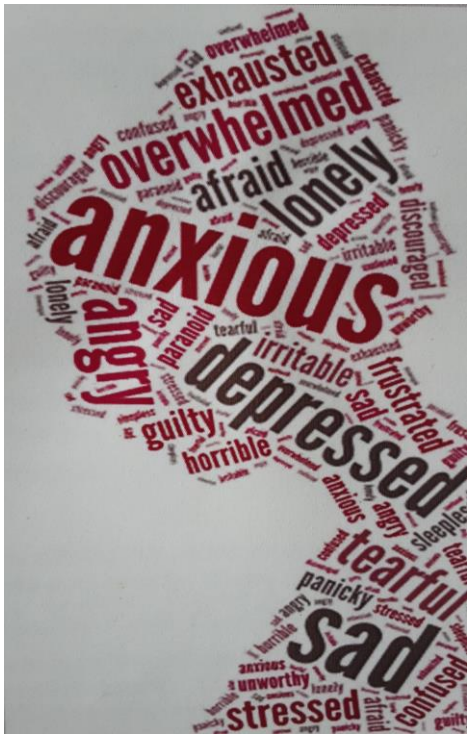
Tucson
Postpartum Depression
Coalition

Perinatal Mood and Anxiety Disorders Information Guide



You are not alone. You are not to blame. With help you will be well.

Tucson Postpartum Depression Coalition

Greetings from the Tucson Postpartum Depression Coalition **(TPDC),**

Depression and anxiety are debilitating conditions that strike 1 in 7 women during pregnancy and the year following childbirth. It affects women across all cultural, ethnic and socio-economic boundaries. We welcome you to join with us in our efforts to reduce both the incidence and degree of suffering related to anxiety and depression that mothers may experience during reproductive changes.

During the last decade, response to advocacy groups like TPDC has led to important practice changes. Along with position statements by ACOG, AAP, APA and March of Dimes, and federal research recommendations through NIMH and HRSA, an encouraging response in the way many agencies and providers address mothers in their care has taken hold. We hope that this will continue and that physicians who are not already targeting this population will be encouraged to do so.

No doubt many of your own patients have suffered from mood illness even though they often hide their feelings due to cultural taboos regarding mental illness, feel confused about their symptoms, and want to meet familial or societal expectations of good mothering.

Research now shows that NOT treating mood disorders during pregnancy can affect the gestational age and weight of the baby at birth, resulting in increased numbers of infants in the NICU. This is just one of the harmful outcomes. The devastating effects of perinatal mood disorders on the mother, family, partner and the baby cannot be overstated. But, many of the adverse outcomes are PREVENTABLE when families are provided adequate information to assist in self-identification, education and resources.

You can make a difference! The recommendations of this Coalition include:

1. Education for staff about perinatal mood and anxiety disorders
2. Provision of education and resource materials to pregnant and postpartum women in your care. The TPDC provides an informative brochure that is available in both English and Spanish at no cost.
3. Screening at prenatal and postpartum visits with the Edinburgh Postnatal Depression Scale (EPDS), PHQ-9 and GAD 7.

In order to support your efforts, TPDC is offering this packet of information. Because resources change we do not provide a print copy. Please check our website for the most up-to-date listings: www.tucsonpostpartum.com. Additionally the Postpartum Support International (PSI) website offers many free online support options and resources for moms and dads: www.postpartum.net.

We would be happy to schedule someone to come to your office to discuss the symptoms, progression and treatment of the disease. To schedule a presentation or request brochures, please write to us at info@tucsonpostpartum.com

Best wishes from the TPDC Board of Directors.

American Academy of Pediatrics (AAP) (**2019**)
Policy Statement, Incorporating Recognition and Management of Perinatal Depression into Pediatric Practice, *Pediatrics, 143*(1)

The Role of the Medical Home

PCCs caring for infants have crucial opportunities to promote healthy social-emotional development, to prevent (beginning at prenatal visits) and/or ameliorate the effects of toxic stress, and to provide routine screening for PPD in early infancy. Pediatric PCCs also have the opportunity to perform depression screening in pregnant mothers at sibling visits. Pediatric medical homes can establish a system to implement screening and to identify and use community resources for the further assessment and treatment of the mother with depression as well as for the support of the mother-child dyad. Identification and coordinating access to treatment of PPD are evidence-based examples of the successful buffering of toxic stress or an adverse childhood experience by pediatricians. Despite previous recommendations, less than half of pediatricians screened mothers for maternal depression in the 2013 periodic survey of AAP members, and it is now time to close the gap.

There is much support for primary care incorporating these approaches. The AAP policy statement "The Future of Pediatrics: Mental Health Competencies for Pediatric Primary Care" recognizes the unique advantage the PCC has for surveillance, screening, and working with families to improve mental health outcomes. The AAP Task Force on Mental Health promotes the use of a common-factors approach to engage families and build an alliance for addressing mental health issues. *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents* in identifying parental strengths and discussing social determinants of health. Screening for PPD in the medical home is consistent with this 2-generation emphasis.

American Psychological Association (APA) (**December 2020)**
Position Statement on Screening and Treatment of Mood and Anxiety Disorders During Pregnancy and Postpartum.

The APA recognizes that the risks for psychiatric illness in women and other persons who are pregnant or postpartum are greatest during the reproductive years of their lives, including during pregnancy and the postpartum periods. To prevent long-lasting, adverse effects on the mother, infant, and the family, the APA strongly recommends the following:

- All women and other persons in the peripartum period should be clinically assessed for the presence of and risks for psychiatric disorders including mood, anxiety, PTSD, substance abuse and psychotic disorders throughout the pregnancy and postpartum period.

• All pregnant and postpartum women and their family members should receive education from their medical providers on how to recognize the symptoms of mood, anxiety, and psychotic disorders.

• We recommend that obstetric clinicians screen for mood and anxiety disorders, including suicidal thoughts and behaviors, with a validated screening tool at least twice during pregnancy, and once postpartum, and that pediatric clinicians screen during the 1, 2, and 4 months well-child visits in pediatric settings. Screening for bipolar disorder should occur at least once during pregnancy or once during the postpartum period in obstetric settings.

• Women and other persons who are pregnant or postpartum who screen positive should be referred for further evaluation to establish the diagnosis of a mood or anxiety disorder. A systematic response to screening should be in place to ensure that psychiatric disorders are appropriately referred, treated, and followed.

• The APA recommends that psychiatrists educate their patients about the risk factors associated with untreated psychiatric illness during pregnancy and lactation, as well as the risks and benefits – for both the woman and her baby – of using psychotropic medications while pregnant or breastfeeding.

• APA recommends that psychiatrists maintain current knowledge regarding the evidence-based approaches to the treatment of patients who are pregnant and postpartum, including the risks of no treatment or under treatment, and actively participate in the treatment of women and other persons who are pregnant or postpartum.

American College of Obstetricians and Gynecologists (ACOG) (November 2018)
Committee Opinion, Screening for Perinatal Depression.

Recommendations and Conclusions

- The American College of Obstetricians and Gynecologists (the College) recommends that obstetrician-gynecologists and other obstetric care providers screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized, validated tool. It is recommended that all obstetricians-gynecologists and other obstetric care providers complete a full assessment of mood and emotional well-being (including screening for postpartum depression and anxiety with a validated instrument) during the comprehensive postpartum visit for each patient. If a patient is screened for depression and anxiety during pregnancy, additional screening should then occur during the comprehensive postpartum visit.
- Women with current depression or anxiety, a history of perinatal mood disorders, risk factors for perinatal mood disorders, or suicidal thoughts warrant particularly close monitoring, evaluation, and assessment.

- There is evidence that screening alone can have clinical benefits, although initiation of treatment or referral to mental health care providers offers maximum benefit. Therefore, clinical staff in obstetrics and gynecology practices should be prepared to initiate medical therapy, refer patients to appropriate behavioral health resources when indicated, or both.
- Systems should be in place to ensure follow-up for diagnosis and treatment.

March of Dimes Position Statement – Improving Maternal Mental Health (March of Dimes) (2022)

March of Dimes strongly supports efforts to improve screening, diagnosis and treatment for women with maternal mental health disorders. Most maternal mental health disorders can be treated once identified and diagnosed, and studies show that screening at least once during the perinatal period can help identify maternal depression.1 March of Dimes has identified five key elements that are critical to addressing and improving maternal mental health.

Access. Mothers need access to and insurance coverage for all types of mental health care in order to receive the appropriate diagnosis and treatment. To achieve this, perinatal mental health needs to be a higher priority for both public and private health insurers. Medicaid coverage should be extended to one year postpartum in all states to ensure women with public insurance have access to mental health care throughout pregnancy and the full postpartum period. Despite increasingly strong mental health parity laws, there are still barriers to telehealth care, particularly as the public health emergency ends. All women need access to timely, appropriate mental health services provided either in-person or via telehealth.

Universal Screening. Mental health screenings are critical components to identifying and treating maternal mental health disorders. March of Dimes strongly supports universal screening of all pregnant and postpartum women using an evidence-based screening tool. Screenings can be incorporated into prenatal visits, well-child visits and postpartum check-ups. Some Neonatal Intensive Care Units (NICU) have incorporated screening parents for post-traumatic stress disorder (PTSD) into their protocols. March of Dimes supports universal screening during each trimester of pregnancy, at the first postpartum visit, and at a 6-month postpartum obstetrics or primary care visit. March of Dimes also endorses the recommendation of the US Preventative Services Task Force and the Centers for Medicare and Medicaid Services (CMS) that parents be screened by pediatric providers at the 1-,2-,4-, and 6-month well-child visits. CMS has provided guidance noting that maternal mental health screenings can be billed under well-infant visits as “screening of the caregiver”.

Referral and Treatment. It is important that once screened for mental health conditions, pregnant and postpartum mothers who screen above the cut-off score on an evidence-based screening tool and/or who indicate any suicidal ideation are referred to behavioral health providers, including reproductive psychiatric specialists when necessary. Coordination of care between the provider who does the screening/referral, the mom’s primary care provider and the mental health provider is needed to ensure that moms with perinatal mood and anxiety

disorders do not fall through the cracks. To achieve this, all providers must be sufficiently reimbursed for the role they play in the screening, diagnosis and treatment process.

Education. Symptoms of perinatal mood and anxiety disorders are sometimes misattributed to normal pregnancy changes, or those experiencing symptoms my act like they are fine and not seek treatment because of concern about perceptions of others (i.e., stigma). In both cases, symptoms often go under- or unreported. It is important that the full range of health care providers and the public are educated to recognize the symptoms of perinatal mood and anxiety disorders. Public education on the prevalence of maternal mental health issues that focuses on normalizing the stress new parents face and stigma reduction strategies is also vital.

Surveillance. In order to support research and treatment initiatives, March of Dimes supports robust funding to support tracking maternal mental health disorders, as well as data collection on maternal mental health screening initiatives and treatment outcomes.

Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) (2022)
Position Statement, Perinatal Mood and Anxiety Disorders

The Association of Women's Health, Obstetric, and Neonatal Nurses maintains that individuals should be screened for mood and anxiety disorders, especially during pregnancy and the postpartum period. It is imperative that on-going screening and referral to treatment occurs in both the perinatal and pediatric setting. Nurses are in key positions to screen individuals and provide education regarding Perinatal Mood and Anxiety Disorders (PMAD). To effectively impact PMAD, it is crucial for health care facilities, especially those serving women and children, to have policies and processes that address screening, intervention, referral to treatment and education for those assessing for or impacted by PMAD.

Screening and Treatment
To improve outcomes for pregnancy and postpartum people, children, and families it is imperative that ongoing PMAD screening, referral to treatment, and follow-up occurs.

Screening
Early recognition, through using a reliable screening tool, leads to better management of PMAD and promotes the health and well-being of women, pregnant, and postpartum people, and their children. The American College of Obstetricians and Gynecologists (ACOG), the American College of Nurse Midwives (ACNM), the American Academy of Pediatrics (APA), and the U.S. Preventative Services Task Force (USPSTF), recommend that systematic screening in pregnancy and during the postpartum period to help detect early symptoms of PMAD. Furthermore, several states currently legally mandate perinatal depression screening.

Since PMAD is a frequent occurrence during and after pregnancy, promoting appropriate screening and offering early intervention strategies at healthcare facilities is essential. If a pregnant or postpartum woman is contemplating suicide or harming her infant, emergency mental health interventions are necessary. Implementing shorter item screening tools are more accurate and more likely to be

completed by the patient. Use of a validated and reliable screening tool increases identification rates of patients with symptoms of PMAD to assist in determining appropriate diagnoses.

The Edinburgh Postnatal Depression Scale (EPDS), Patient Health Questionnaire 9 (PHQ-9), and the Postpartum Depression Screening Scale (PDS) are validated screening tools that have the best sensitivity and specificity for screening depression. Also, highly effective psychometric tools used to screen for anxiety during the perinatal period include the EDPS anxiety subscale (items 3, 5, 13) and the General Anxiety Disorder Scale (GAD-7).

Treatment

ACOG, AAP, American Psychological Association (APA), and the ACNM recommend and endorse treatment for people who suffer with PMAD. Current recommendations include psychomonotherapy, psychotherapy combined with pharmacotherapy, or pharmacotherapy only based upon recommendations from the healthcare provider and key provisions (e.g., access, availability, and cost of care). In circumstances where psychopharmacotherapy is initiated by healthcare providers and is required to maintain a pregnant person's psychiatric health, it is recommended that the individual discuss the risks and benefits with their obstetrical and mental health provider. Pharmacologic recommendations and collaborative medication management between obstetrics and psychiatry is considered best practice, which includes psychopharmacology counseling and education about any potential risk of fetal exposure versus the risk of untreated maternal mooed and anxiety disorder.

Tucson Postpartum Depression Coalition Fact Sheet

History

TPDC was founded in 2005 by its lead agency, Carondelet St Joseph's Hospital. It became an Arizona charitable non-profit under the IRS designation 501 (c)(3) in 2007. It is directed by a volunteer Board of Directors that meets quarterly.

Vision

Emotional wellness for all women from preconception through motherhood.

Mission

To promote maternal emotional health through education, support and advocacy.

Priorities

1. Advancing awareness and education about perinatal mood disorders for healthcare professionals and the public.
2. Being a recognized leader in perinatal support.
3. Creating and nurturing partnerships with community organizations and healthcare professionals serving women of childbearing age.
4. Being an influential voice for maternal emotional health promotion.

Awareness and education

TPDC disseminates resource information on perinatal mood disorders for the greater Tucson area. The Coalition is closely linked to organizations with similar missions like Postpartum Support International (PSI) and its Arizona Chapter. Through membership meetings, local providers and survivors share information and strategies to improve the climate for identification and services for families touched by these illnesses. TPDC provides a free educational brochure available in Spanish and English. Through Operation Educate Tucson, the TPDC provides presentations to professional and lay audiences and distributes a resource packet to providers. The bilingual team aims to educate Spanish speaking families and community supporters.

Leader in perinatal support

TPDC members are engaged in a variety of service areas including direct care, advocacy, education and outreach. TPDC has received funding for its programs through the Pima County Prenatal Block Grant, Jenny's Light Foundation, Zuckerman Foundation, Altrusa International of Tucson, the March of Dimes Community Grant, the Harriet Silverman Fund/Women's Foundation of S. AZ, Cenpatico, and Tucson Federal Credit Union.

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Partnerships

Through its community education and networking lunch meetings, many Tucson agencies learn about PMADs and then advocate for policy initiatives within their organizations. With the support of Carondelet St. Joseph's Hospital, Banner University Medical Center, Tucson Medical Center, Northwest Medical Center and El Rio Community Health Center, TPDC has provided FREE quarterly meetings since 2005 with 50-75 in attendance. A sample of TPDC advocates includes Tucson Outpatient Psychiatry, Healthy Families, Pima County Public Health Nursing, Healthy Start, Early Head Start, WIC, Arizona Youth Partnership/Starting Out Right (formerly Teen Outreach Pregnancy Services), CODAC Health, Recovery and Wellness, Inc, Cenpatico Integrated Health, De Novo Wellness Center, Mama's Latte, MothertoBabyAZ, Nurse-Family Partnership, Easter Seals Blake Foundation, United Way, and local nurses, obstetricians, pediatricians, psychiatrists, therapists and agencies serving women of childbearing age. TPDC has also partnered with the University of Arizona, Arizona State University and Pima Community College to provide academic internships for students choosing a PMAD research project in the Colleges of Nursing, Social Work and Public Health.

Board of Directors

TPDC is led by an all- volunteer Board of Directors with 7-12 members serving renewable 2 year terms. Members who have served on the board include physicians, therapists, nurses, lactation consultants, social workers, childbirth educators, doulas, grant writers and moms who have 'been there.' The President of the Board serves as the Executive Director of the organization. There are no paid staff.

What are Perinatal Mood and Anxiety Disorders?

Perinatal mood and anxiety disorders (PMAD) are considered the leading complication of childbirth. The period of concern includes preconception health, pregnancy and the first 18 months postpartum. Pregnancy and new motherhood place a woman at greater risk for developing a perinatal mood disorder which can include prenatal depression and anxiety, postpartum depression, postpartum anxiety disorders including obsessive-compulsive disorder (ODC), panic disorder and post-traumatic stress disorder (PTSD), and postpartum psychosis (PPP). It is estimated that 1 in 7 childbearing women suffer from a diagnosable perinatal mood and anxiety disorder, with higher prevalence rates where multiple risk factors occur. Otherchildbearing women will be affected by perinatal anxiety, panic or OCD and another 3-5% are estimated to suffer from postpartum PTSD. One to two women in one thousand will develop postpartum psychosis. In Pima County, where an estimated 14,000 live births occurred, approximately 4000 women and their families may have been affected by perinatal mood disorders.

Awareness of PMAD is increasing as a result of growing concern about the effects of PMAD on women, infants and their families. PMADs are associated with adverse obstetrical outcomes such as pre-term labor, low birth-weight babies and transmission of psychopathology to the fetus. A woman's ability to establish critical attachment to her infant significantly compromised when suffering from a PMAD. Studies demonstrate that children (pre-school through adolescence) who had attachment problems in infancy are more aggressive, display difficulty managing emotions, and are at risk for developing serious psychopathology. PMADs have long-term con sequences on women's lives as well as their partners with increased risk for substance abuse, chronic depression and severed relationships.

The American College of Obstetricians and Gynecologists (ACOG) recommends screening for postpartum depression.

Risk factors: (partial list only)

Life history: unresolved issues, unmet childhood needs, sexual and other trauma, history of depression or family history of mood illness, drug or alcohol use.

Social risk: isolation from family, lack of support, relationship difficulties, financial and job stress, less than high school education, teens, unwanted pregnancy, single motherhood, significant loss.

Pregnancy/childbirth risk factors: miscarriage, abortion, infertility, difficult pregnancy, long/difficult labor, premature infant, birth not going as planned, breastfeeding difficulty.

Definitions:

Prenatal anxiety and depression: Although fluctuations in mood seem 'normal' for a pregnant woman, it is now known that about 20% of women have anxiety or depression. Miscarriage and termination of pregnancy can also trigger this complication.

Baby blues: This is not a disorder but a natural occurring event following childbirth. Onset is birth to 2 weeks and often most prominent on day 3 or 4 postpartum. The blues will resolve without treatment and occur in up to 80% of women. Commons symptoms: crying with no apparent reason, impatience, irritability, restlessness, anxiety, overwhelm.

Perinatal Depression: This disorder is documented as the leading complication of childbirth occurring in between 10-25% of women world-wide. Onset is usually between 4 weeks and one year postpartum. PPD responds well to treatment and does not usually resolve without treatment. Symptoms include:

-sluggishness, fatigue, sadness, hopelessness, in a fog

-appetite and sleep change (more or less), confusion, poor concentration, memory loss

-lack of interest in the baby, lack of interest in sex, uncontrollable crying, over-concern for baby

-guilt, inadequacy, shame, worthlessness, fear of being alon

-fear of harming self/baby, exaggerated highs and lows

-anger and irritability

The above symptoms can be mild to severe. Women report bad days and good days. The experience is as unique as each woman.

Perinatal anxiety disorders- anxiety, panic, OCD, PTSD:

To a certain extent, anxiety can be explained through heightened maternal instinct and the cascade of oxytocin and other hormones. This level of preparedness and pro-active parenting protects the infant. It is a disorder when it leads to dysfunction, distress and panic, for which treatment is available. Symptoms include: intense anxiety, fear, nervousness, rapid breathing, fast heart rate, sense of doom, numbness, loss of sensation, tingling, hot or cold flashes, chest pain, shaking, dizziness.

Perinatal OCD is an anxiety disorder in which women feel very uncomfortable with how they feel and what they think. Occurring in up to 5% of women, it is sometimes misunderstood as psychosis, and women who experience it sometimes feel like they are going crazy. A woman with a history of OCD is at greater risk and her postpartum symptoms may be more severe. Symptoms include: obsessions (persistent thoughts), compulsive behaviors (repetition) to reduce discomfort and fear, a sense of horror at the thoughts, avoidant behavior. A woman with OCD who is having scary thoughts about harm to her baby may avoid being with the baby, both to safeguard the baby and to minimize the opportunity for these thoughts. It is important to note that women with OCD are disgusted or frightened by their thoughts and wonder why they are happening. It is believed that there is no harm risk to the baby as there might be in postpartum psychosis.

What are Perinatal Mood and Anxiety Disorders?

Perinatal PTSD is another anxiety disorder. Two scenarios exist. Women with a history of PTSD often relive that experience during childbirth or the postpartum period. Triggers may cause her to have poor sleep, night-mares, physiological symptoms, hyper-reactivity. It is often the case that the mother does not consciously know the origins of her responses. A woman experiencing a traumatic childbirth can develop postpartum PTSD. In this case, the response is to some event(s) that did not go according to plan, or were unexpected. This might range from pain of childbirth to surgical rather than vaginal childbirth, feeding difficulties, infant complications, etc. Internally, the mom may feel, "this is not what I expected." She has a challenge in resolving the scenario that caused her anxiety, often feeling a sense of failure due to a change in planned or hoped for outcome. It can take many months to come to terms and resolution of this, but these women often are both anxious and depressed. The 'definition' of trauma in this disorder is very personal to the woman, and may not at first seem like a traumatic event to the observer.

Perinatal bipolar disorder: 2% to 8% of pregnant and postpartum women will experience symptoms of bipolar disorder. Bipolar disorder is a mental health disorder involving severe depression and mania or hypomania. There are two types of Bipolar Disorder. Bipolar I Disorder is more severe as episodes of depression and mania are extreme. During mania, people will experience decreased need for sleep (sometimes requiring no sleep), very high energy, impulsive and poor judgement, racing thoughts, and rapid speech. Mania can include hallucinations and delusions and last days. Bipolar 2 Disorder is a less extreme presentation with episodes of depression and hypomania. Hypomania can be described by being more productive, more irritable, better mood, and more energy despite less sleep (2 to 3 hours) than usual. Bipolar 2 symptoms can last weeks. Mothers are at highest risk for hypomania and mania in the first two weeks postpartum because the lack of sleep can trigger an episode. It is important to address perinatal bipolar disorder as soon as possible because the risk of either a depressed or manic episode is much higher than the general population and becomes more difficult to treat the longer the episode goes unmanaged.

Perinatal psychosis: This is the most severe and rare postpartum reaction. It occurs in about 0.1% of women (1 in 1000). Time of onset is usually within the first 3 weeks to 4 months after childbirth. It is now believed that women with bipolar disorder are at greater risk than the general population. Symptoms are usually noticeable and exaggerated, but many women wax and wane between reality and unreality during the day. When agitation, delusional thoughts and mania are present it is easy to recognize that something is very wrong. Postpartum psychosis usually requires hospitalization and stabilization with medication. If left untreated, it can lead to suicide or infanticide in 10% of its victims. Women who develop PPD often have risk factors that include her life history and the amount of support she receives. Other stressors around childbirth can be catalysts. A woman with PPP is often responding to severe, untreated depression or anxiety, and will have lost the ability to make good judgments; her cognitive thinking is disordered. She has hallucinations and delusions, and often feels she is acting in the best interest of her baby or children when she harms them or herself. Command hallucinations: voices she is hearing that are outside herself, or another voice within herself tell her she must commit the act. Symptoms: hallucinations, delusions, mania, agitation, insomnia, bizarre behavior

Treatment Options:

Mood disorders during pregnancy and postpartum should be treated with the same attention as other physical complaints. Traditional interventions include:

Support groups

Individual psychotherapy

Medication

Couples counseling

Other non-traditional modalities that have been studied and can be used as adjuncts, and sometimes instead of traditional treatments include:

Exercise programs

Nutritional counseling

Yoga

Dance

Acupuncture

Massage

Social support: doula care, home visitor programs

De-briefing: telling about the childbirth

Prevention:

ACOG and the Dept. of Health and Human Services recommend screening for mood disorders at prenatal and postpartum visits. The Edinburgh Postnatal Depression scale (EPDS) is a self-report tool that is used throughout the world to determine 'risk' during pregnancy and postpartum. The Patient Health Questionnaire (PHQ-9) and the Generalized Anxiety Disorder (GAD-7) are used in addition to the EPDS, or as alternative screening tools for depression and anxiety. Screening leads to identification, diagnosis and treatment, which can reverse the adverse outcomes when PMADs are not identified or treated.

What constitutes a Perinatal Medical Emergency?

Are you a healthcare provider seeking assistance for a client?

Each year new mothers are hospitalized against their will- traumatizing them, separating them from their babies and jeopardizing the breastfeeding relationship. It is essential that healthcare providers are able to correctly determine when these women are actually a risk to themselves or their infants, and help them find appropriate treatment.

Tucson Postpartum Depression Coalition

Commonly reported, Non-Emergency Symptoms*:

- Tearfulness and sadness
- Irritability
- Feeling inadequate
- Scary, intrusive thoughts that won't go away
- Nervousness and anxiety
- Overwhelm
- Sleep and eating changes
- Feeling like the baby or partner would be better off without her
- Suicidal ideation **WITHOUT** a plan - thinking about death for self or loved ones is not uncommon

Symptoms* that may indicate a CRISIS:

- Seeing or hearing things that aren't there
- Mom is not making sense to you
- Flat affect as she describes a plan to hurt herself, her baby or someone else
- Delusions
- Manic behavior
- **Active SUICIDE intention** or plan

Active SUICIDE intention or plan is rare among mothers but constitutes an emergency whether or not it is accompanied by psychotic symptoms.

*Symptoms listed are examples and not a comprehensive list.

The mother with obsessive-compulsive thoughts needs support so that she is not always alone, another adult to help care for the baby to allow mom a chance to rest, and possibly medication to reduce the frequency of the intrusive thoughts. These interventions can make all the difference!

As a healthcare provider you have the right to consult with someone who has knowledge about perinatal mood and anxiety disorders. *PRIOR* to using emergency medical intervention as a first line of defense, please consider listening and gathering information. The following resources are available to help you and the mom take appropriate steps to emotional wellness.

KNOW YOUR FACTS: Perinatal anxiety/depression is NOT perinatal psychosis! Approximately 20% of mothers will experience depression or anxiety to some degree during pregnancy and in the year following childbirth. Only 1-2 in 1000 will experience psychosis.

Resources for mothers or providers:

Providers: Please go to number 1 if you would like to speak to a specialist in PMAD treatment. If this is not an emergency, you can guide your client to numbers 2-5 below.

1. (Providers) PSI Perinatal Psychiatric Consult Line: 1-877-499-4773, OR contact local Tucson psychiatrist and reproductive mental health expert Kristine Norris DO, Tucson Outpatient Psychiatry. 520-780-8413. drnorris@psychiatrytucson.com

2. PSI Helpline: Call or Text: 1-800-944-4773. En Espanol Text: 971-203-7773.

3. National Maternal Mental Health Hotline: 1-833-943-5746.

4. Medication use during pregnancy and lactation. Call MothertoBaby AZ. University of AZ College of Pharmacy. 520-626-3410 or 888-285-3410. www.mothertobaby.org

5. Tucson Postpartum Depression Coalition maintains an informational website and provides a list of local resources and free resource guides for providers. info@tucsonpostpartum.com

If this is an emergency and you do not feel your client is safe, please call the Tucson Crisis Line: 520- 622-6000 or the Crisis Resource Center at Banner South: 520-301-2400, or send her to the nearest emergency room.

Suicide and Crisis Lifeline. Call or text: 988

These recommendations are brought to you by the Tucson Postpartum Depression Coalition (TPDC) and a consortium of TPDC partners seeking solutions to assist healthcare providers, mothers and families to find knowledgeable and appropriate care regarding pregnancy and postpartum adjustment and mood disorders. We hope to reduce unnecessary hospitalizations and separation of mother and baby by providing community based resources that might offer a more appropriate intervention. Since 2005, the TPDC, a 501(c)(3) nonprofit organization, has raised awareness about perinatal mood and anxiety disorders, provided community and professional education, and opened a support center for perinatal women. TPDC encourages you to incorporate this document into your standard of care of the perinatal woman.

For opportunities to educate your staff or parent/mother group about perinatal mood and anxiety disorders, or to receive educational handouts for mothers, please go to our website, www.tucsonpostpartum.com or email: info@tucsonposstpartum.com

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
- □ No, not very often
- □ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

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 Scale[1] (EPDS)

Postpartum depression is the most common complication of childbearing.[2] The 10-question Edinburgh Postnatal Depression Scale (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 *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5-10 (marked with an *)
Are reverse scored, with the top box scored as 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

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ **DATE:** _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: _____

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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Generalized Anxiety Disorder Screener (GAD-7)

Over the *last 2 weeks*, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritated	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
	Add columns			
	Total Score			
8. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

When did the symptoms begin? _____

Generalized Anxiety Disorder Screener (GAD-7)

Scoring and Interpretation:

GAD-2 Score*	**Provisional Diagnosis**
0-2	None
3-6	Probable anxiety disorder
GAD-7 Score	**Provisional Diagnosis**
0-7	None
8+	Probable anxiety disorder

*GAD-2 is the first 2 questions of the GAD-7

References:

- Spitzer RL, Kroenke K, Williams JB, Lowe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Archives of internal medicine. May 22 2006;166(10):1092-1097. PMID: 16717171
- Kroenke K, Spitzer RL, Williams JB, Monahan PO, Lowe B. Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. Annals of internal medicine. Mar 6 2007;146(5):317-325. PMID: 17339617
- Lowe B, Decker O, Muller S, et al. Validation and standardization of the Generalized Anxiety Disorder Screener (GAD-7) in the general population. Medical care. Mar 2008;46(3):266-274. PMID: 18388841