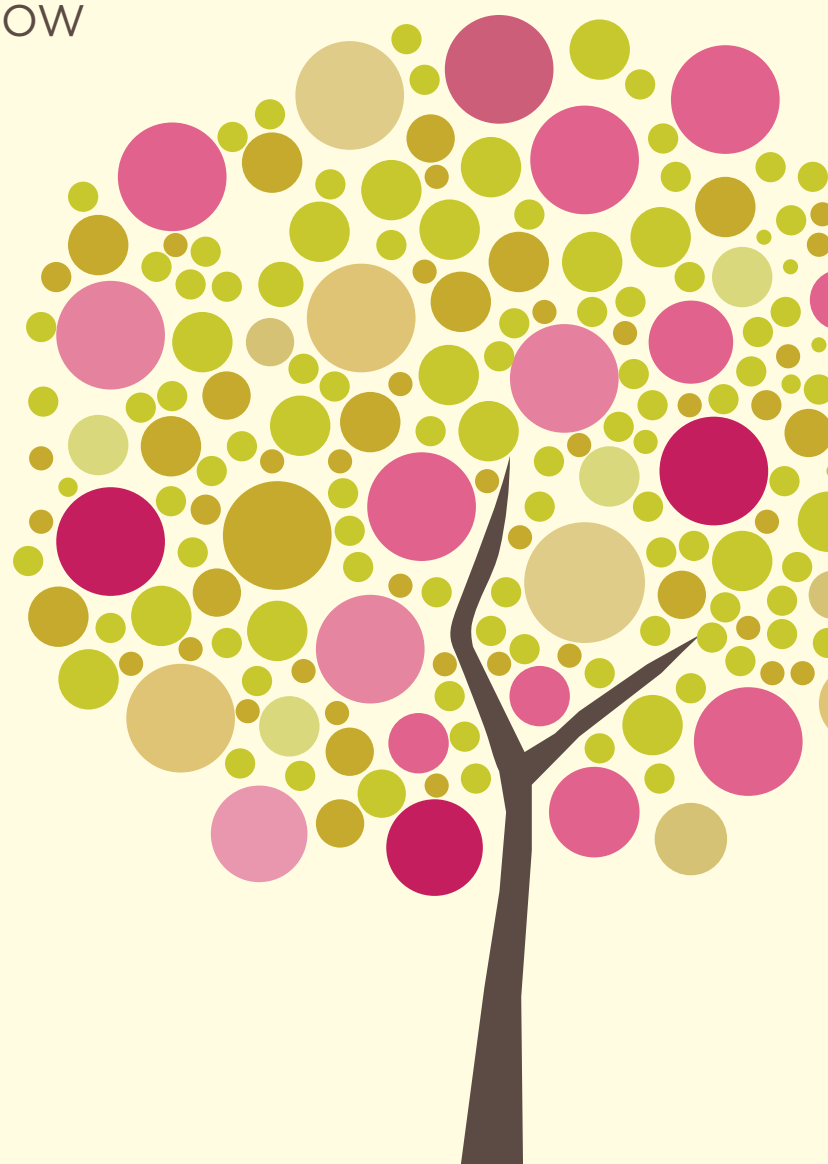
Third Edition

BRINGING LIGHT TO MOTHERHOOD

Perinatal Mental Health Community Provider Toolkit

Created by Maternal Mental Health NOW



INTRODUCTION

Perinatal mood and anxiety disorders affect millions of people in America each year. The impact of these illnesses extends beyond the mother and affects children, partners, loved ones and communities.

In efforts to fulfill the mission of Maternal Mental Health NOW, and in partnership with Jenny's Light and Los Angeles Best Babies Network, we have created this toolkit, the goal of which is to address the needs of families struggling with perinatal mental illness (depression and anxiety) and to help them cope with their symptoms and enjoy a healthy, happy parenthood. This toolkit is informed by the principles and practices of the Strengthening Families protective factors model. Our multi-generational, multi-modal approach incorporates evidence-based decision-making principles, as well as a holistic framework that includes the entire family and community.

This toolkit is intended for use by community workers, social workers, mental health professionals, nurses, physicians and other care providers with the goal of improving the coordination and functioning of systems of care. It contains information on prevention, assessment and treatment of perinatal mood and anxiety disorders, as well as details about special circumstances, handouts for clients, suggestions for loved ones, and a medical guide for medication intervention.

You may find that these sections overlap, because perinatal mood disorders are often complex and co-exist with other disorders and circumstances.

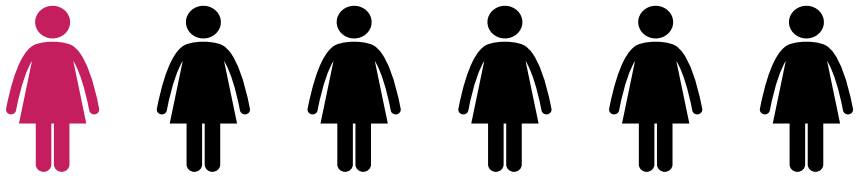
It is our hope that you find this toolkit helpful in establishing your own organization's protocols. We appreciate your feedback, so that we may continue to improve and update this manual to best serve the needs of our communities.

MATERNAL MENTAL HEALTH NOW
supporting the well-being of growing families
A Project of Community Partners

PERINATAL MENTAL HEALTH
Los Angeles County

Perinatal Mood And Anxiety Disorders

More than postpartum depression, perinatal mood and anxiety disorders encompass a range of mental health disorders- including depression, anxiety, obsessive compulsive disorder, and post-traumatic stress disorder- that occur during pregnancy or up to two years postpartum.



Maternal depression is the leading complication of childbirth, affecting 1 in 6 women in Los Angeles County.

Recent research shows that men suffer too. Nationally, 1 in 10 new fathers is impacted by perinatal depression.

When Maternal Depression Goes Untreated, The Impact Can Be Profound:

Impact on the CHILD
- Preterm delivery
- Low birth weight
- Less breastfeeding
- Disrupted attachment
- Developmental delays
- Behavior problems

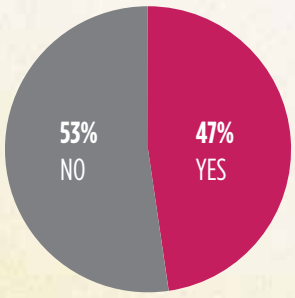
Impact on FAMILY
- Domestic Violence
- Divorce
- Child abuse and neglect
- Substance abuse

System-wide COSTS
- Child Welfare
- Healthcare
- Public Assistance
- Early Intervention
- Education

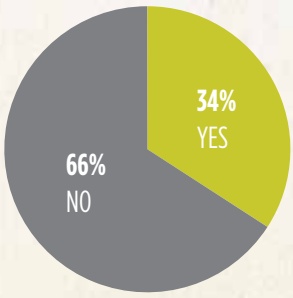
SUICIDE is the #1 cause of death for women during the perinatal period.

Many healthcare providers do not screen for maternal depression and anxiety.

Asked about DEPRESSION at postpartum visit:



Asked about ANXIETY at postpartum visit:



Fortunately, maternal depression is **HIGHLY TREATABLE** and can be **PREVENTABLE**.

1. **TRAIN** providers to recognize and respond
2. **SCREEN** all pregnant women and new parents
3. **RESPOND** with effective interventions
4. **SPEAK UP** to eliminate stigma

PREVENT maternal depression from impacting growing families

To learn more and for additional resources: www.maternalmentalhealthnow.org

Data source: LAMB Survey of LACDPH

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Maternal Mental Health NOW (formerly the Los Angeles County Perinatal Mental Health Task Force), is a non-profit organization that works to remove barriers to the prevention, screening, and treatment of prenatal and postpartum depression in Los Angeles County.

THE LEADING EXPERT IN THE FIELD OF MATERNAL MENTAL HEALTH

MMH-NOW is the leading organization in LA County offering training, technical assistance and consultation to healthcare and community-based organizations on the screening and treatment of postpartum depression and other maternal mental health disorders. Our faculty, experts in the field of perinatal mental health, have trained thousands of providers including pediatricians, obstetricians, family doctors, nurses, midwives, doulas, early childhood education providers, promotoras, mental health providers, and more. In addition to a wide variety of in-person training opportunities, MMH-NOW offers an online and on-demand Bringing Light to Motherhood certification training.

ADVANCING A NEW SYSTEM OF CARE

But simply training health care providers is not enough. The fragmented behavioral health and physical health care systems that serve women and their children present barriers to access. In order to address these barriers, MMH-NOW partners with health care facilities to develop and implement innovative care models that integrate maternal mental health care into medical settings. As a result, we are creating replicable models to increase access to depression screening and treatment services to underserved populations.

INNOVATIVE RESOURCES AND ADVOCACY

MMH-NOW works to change the system of care in Los Angeles County and beyond through innovative collaborations with public and private partners, and advocacy on a local and state level. MMH-NOW offers numerous resources, policy briefs, and reports. MMH-NOW offers a first-of-its kind online Maternal Mental Health Resource Directory, featuring more than 200 referral resources across Los Angeles County.

ENDING STIGMA NOW

MMH-NOW is committed to reducing the stigma surrounding perinatal mental health disorders and empowering women and families who are struggling to speak up. MMH-NOW offers educational materials in seven languages, as well as programs and events that aim to reduce stigma and encourage women—in an empathic and culturally relevant way—to share their stories about maternal mental health challenges.

Additional information is available at: www.maternalmentalhealthnow.org

MATERNAL MENTAL HEALTH NOW
supporting the well-being of growing families

ONLINE TRAINING

MATERNAL MENTAL HEALTH CERTIFICATE

Bringing Light to Motherhood

Learn on your **OWN SCHEDULE** from the comfort of your home

For Healthcare Providers including:

- Mental Health Professionals
- Doctors
- Nurses
- Health Educators
- Birth Professionals

What do we cover?

- Risk Factors & Prevalence
- Stigma, Myths, & Expectations
- Impact of fetus, infant, mother & family
- Intergenerational transmission of trauma & resilience
- Screening & Assessment
- Differential Diagnoses
- Prevention & Intervention
- Cultural Considerations
- Attachment theory & practice
- Pharmacological considerations

Cost: $495

For more information and to register visit **www.maternalmentalhealthnow.org**

Continuing Education Provided by

pac/lac

12 CMEs available for **physicians**[1]

12 CEUs available for **LMFTs, LPCCs & LCSWs**[2]

14 CEUs available for **RNs**[3]

12 CEUs available for **CHES**[4]

[1] For Physicians: This activity has been planned and implemented in accordance with the Institute for Medical Quality/ California Medical Association's CME Accreditation Standards through the joint providership of the Perinatal Advisory Council: Leadership, Advocacy and Consultation (Pac/Lac) and Maternal Mental Health NOW. PAC/LAC is accredited by the institute for Medical Quality/ California Medical Association (IMQ/CMA) to provide continuing education for physicians. PAC/LAC designates this education activity for a maximum of 12 AMA PRA Category 1 Credit(s). Physicians should only claim credit commensurate with the extent of their participation in the activity. This credit may also be applied to the CMA Certification in Continuing Medical Education.

[2] PAC/LAC is an approved provider by the California Board of Behavioral Sciences. The course meets the qualifications for 12 hours of continuing education credit for LCSW, LMFT and LPCC as required by the California Board of Behavioral Sciences. PAC/LAC's provider number is PCE5563.

[3] PAC/LAC is an approved provider by the California Board of Registered Nursing Provider CEP 5862. This course is approved for 12 contact hours of continuing education credit.

[4] This activity is sponsored by the Perinatal Advisory Council: Leadership, Advocacy, and Consultation (PAC/LAC), a designated provider of continuing education contact hours (CECH) in health education by the National Commission for Health Education Credentialing, Inc. This program is designed for Certified Health Education Specialists (CHES) to receive up to 12.0 total Category 1 continuing education contact hours.

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Maternal Mental Health NOW

Community Perinatal Mental Health Provider Toolkit

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STEPPING INTO THE LIGHT

What Is This All About?

"I feel sad and anxious all the time…what is happening to me?"

Maternal depression is the number one complication of pregnancy and childbirth. While it is extremely common to experience what we call the "baby blues," up to 20% of American women suffer from a more serious health problem, Perinatal Mood and Anxiety Disorders (PMADs). During the perinatal period (the preconception period, pregnancy itself, and the child's first year of life), approximately one million women in the United States struggle with PMADs each year. This category of mental health disorders has serious consequences for mothers, infants and families regardless of ethnicity, race, age or income level. It is our goal to help to establish systems of care for these women so they can recover and go on to full emotional health, and their children can have a greater chance for a happy, healthy life.

"What are PMADs?"

Perinatal Mood and Anxiety Disorders have many faces. Most women do not experience all symptoms, but may notice some from this list:

- Feelings of sadness
- Mood swings: highs and lows, feeling overwhelmed
- Difficulty concentrating
- Lack of interest in things they used to enjoy
- Changes in sleeping and eating habits
- Panic attacks, nervousness, and anxiety
- Excessive worry about their babies
- Thoughts of harming themselves or their babies
- Fearing that they cannot take care of their babies
- Feelings of guilt and inadequacy
- Difficulty accepting motherhood
- Irrational thinking; seeing or hearing things that are not there

There are some frightening crisis situations created by PMADs, and we cover this in detail in our **Crisis Management** section. However, most women are not in danger. They do, however, need our support, acceptance, education, and care. In the signs and symptoms section of this toolkit, specific diagnoses and symptoms are more fully explained.

"How did this happen?"

We don't fully understand the causes of PMADs. The rapid change of hormone levels, genetic risk, and other biological or inflammatory processes are often given as reasons for these mental illnesses. However, social stressors, such as financial strain, violence, and troubled relationships, increase a woman's chances for PMADs (see the **Special Considerations** section). In additon, personal or family history of depression or anxiety, as well as a history of trauma or traumatic loss, may contribute to the overall picture. The cumulative effect of all these risk factors seems to account for maternal depression and anxiety. ***When working with women suffering from PMADs, remember, they are NOT to blame!***

"Who is at risk?"

All moms should be screened for PMADs. Women who were depressed during pregnancy have a much greater risk of developing postpartum depression. But mothers are not the only ones at risk from perinatal mental health issues. During pregnancy, the fetus is at risk for exposure to stress hormones, for preterm delivery and low birth weight, and for exposure to drugs, alcohol, or tobacco. Infants with mothers suffering from maternal depression often are more irritable, suffer poor attachment to their mothers, and are at increased risk of child abuse or neglect. Loved ones may express feelings of abandonment, detachment, and hurt from a mother with PMADs and believe they are unable to help her. Children whose mothers have suffered from untreated PMADs often struggle with developmental delays, emotional problems, behavioral and sleep problems, and social difficulties. Clearly, PMADs are not just a problem for new moms, but a concern that affects the whole family.

"What can be done?"

The great news is that PMADs are treatable. In the **Prevention** section of this toolkit, you will find information on what can be done before and during pregnancy. In the **Screening** section, we provide the protocol for regular screening and the tools necessary to identify signs and symptoms of PMADs. In addition, in the **Intervention/Treatment** section, we give details of the treatments that are most successful for PMADs. These are usually a combination of building social supports, receiving psychotherapy (group or individual), seeing a doctor, and when necessary, taking medication.

"Do I see a doctor?"

We suggest that all women, if possible, consult with their health care provider to make sure they are receiving the treatment necessary to overcome their depression and anxiety. We have provided a thorough packet for the medical provider to help him/her select the best screening and treatments for each woman. This includes information on teratogens that is important to consider when a mother is pregnant or nursing.

"Is there anything else I should know?"

We have provided some handouts for clients to assist them with basic self-care, building social supports, and information about their illness. It is also imperative to remember the partner or dad when we address the issue of PMADs. To this end, we have articles on how to help loved ones support one another in coping with PMADs and information about how dads themselves may struggle with postpartum depression.

"Will I get better?"

Most women with PMADs recover fully and are able to return to their lives and become confident and healthy mothers. By providing support, education, treatments, and referrals, we can make a real difference in the lives of the families we serve.

WHAT AND WHY OF PMADS

What Are Perinatal Mood and Anxiety Disorders?

Maternal depression is the most common complication of pregnancy and childbirth. Also referred to as Perinatal Mood and Anxiety Disorders (PMADs), these conditions present a widespread public health problem that has serious consequences for mothers, infants, and families. They can affect women regardless of ethnicity, race, age, or income level. **The perinatal period refers to the preconception period, pregnancy itself, all the way through the child's first year.** Many women experience mild mood changes during the perinatal period, a time when women are particularly vulnerable to PMADs.

An estimated 15 to 20% of women – or approximately one million women – in the U.S. suffer significant symptoms of depression and/or anxiety during the perinatal period. Many women do not seek help for PMADs, for reasons that include profound stigma and lack of information. Without screening and effective interventions, the consequences for women, infants, and families can be devastating and chronic. With the proper help, however, new mothers can recover and go on to full emotional health, and their children will have a greater chance for a happy, healthy life.

Stigma
Mental illnesses don't look the same as physical illnesses. They are not detectable by an x-ray or a blood test. They are often misunderstood and judged. Some common misconceptions about mental illness are that they are "a personal weakness," "a spiritual disorder," "not real, or able to be controlled," "a personal family matter that doesn't require medical attention." A National Health Association survey's results showed that 71% of those surveyed believe that mental illness is caused by an emotional weakness and 35% believe that mental illness is caused by sinful or immoral behavior. These stigmas can prevent those in need from getting better. Stigma can lead to isolation and may discourage people from seeking the treatment they need. Mothers who are experiencing feelings of sadness or anxiety may feel particular shame that they cannot do what is "instinctual," "expected," or "normal" and as a result, may not even want to share their thoughts and feelings with a care provider or loved one. They will need education, support and acceptance in order to feel safe in sharing their experiences. Remind them that getting treatment means they are good moms, help them to know that they are not alone, share with them that they are NOT their illness and provide them with resources to cope. We must all work together to erase perinatal mental illness stigma.

The causes of PMADs are not fully understood. Some theories that have been suggested are rapid change of hormone levels, genetic risk, and other biological or inflammatory processes. We also know that social stressors - such as financial strain, violence, or troubled relationships – greatly increase a woman's chances for PMADs. In all likelihood, it is a combination of these and other risk factors – in other words, "cumulative stressors" – that can result in maternal depression or anxiety.

Why Do We Care About Maternal Depression?

Maternal depression creates clear public health concerns. For instance, current research shows that untreated depression increases the risk of preterm delivery as much as smoking 10 cigarettes a day during pregnancy. Fortunately, PMADs are treatable and responsive to proper care. Without intervention, however, there can be negative life-long repercussions for the mother, the child, and for their relationship. These negative effects impact the woman, her developing fetus, the infant, child, and family. Here are ways that maternal depression may have a negative impact:

For Mother:

- Inconsistent prenatal care
- Poor weight gain in pregnancy
- Excessive fatigue
- Increased risk of substance abuse
- Increased risk of smoking
- Increased risk of pre-eclampsia
- Difficulty following health and safety guidelines for herself and her children
- Impaired care-taking
- Suicidal thoughts or actions
- Long-term depression or anxiety

For Fetus:

- Preterm delivery
- Low birth weight
- Elevated levels of “stress hormones”
- Increased risk for exposure to drugs, alcohol, or tobacco

For Infant:

- Low Apgar scores
- Increased crying and irritability
- Poor attachment to mother
- Increased risk for abuse or neglect
- Decreased duration of breastfeeding
- Increased risk of failure to thrive
- Physical dysregulation
- Poor weight gain

For Family:

- A significant factor in marital friction and divorce
- Contributes to father's feelings of helplessness and depression
- Effects older children (emotional, behavioral)
- Effects father's perception of relationship
- Causes feelings of loss and grief in family (not the experience they thought they would have)
- Effects extended family (grandparents, aunts, uncles)

For Children:

- Developmental delays:
  - Late walking and talking
  - Delayed readiness for school
  - Learning difficulties and problems with school work
  - Attention and focus impairment
- Emotional problems:
  - Low self-esteem
  - Anxiety and fearfulness
  - Greatly increased chance of developing major depression early in life
- Behavioral problems:
  - Increased aggression
  - Acting out in destructive ways
- Social difficulty:
  - Problems establishing secure relationships
  - Difficulty making friends in school
  - Social withdrawal
- Sleep problems

Impact on Early Parenting Practices:

- Safety Practices:
  - Decreased use of car seats and electrical outlet covers
  - Decreased use of smoke detectors
  - Less likely to place baby on back to sleep
  - Increased use of corporal punishment
- Feeding practices:
  - Less likely to breastfeed or may breastfeed for shorter duration
  - More likely to give water, juice or cereal before the age of 4 months
- Behaviors that promote early development:
  - Less likely to talk daily to infant while in the home
  - Less likely to play daily with infant
  - Less likely to show books daily to infant
  - Less likely to be affectionate with infant
  - Less likely to follow 2 or more routines at meals, naptime, and bedtime
  - Less likely to make pediatric appointments and follow through on pediatric guidelines
  - More likely to display anger and disengagement

Effects on Attachment

A secure attachment to his or her mother or caregiver provides a baby with an optimal foundation for life, leading to an eagerness to learn, healthy self-awareness, trust, and consideration for others. The single most important predictor of a child's healthy growth and development is the attachment formed with a consistent, loving caregiver. The primary protective factor for at-risk children is a significant positive adult attachment relationship. Research findings demonstrate that a child who experiences at least one significant positive attachment relationship fares better in the face of multiple risk factors (poverty, disabilities, etc.), than a child who lacks a healthy attachment relationship early in his/her life.

Evidence suggests that secure bonding and attachment cause the parts of an infant's brain responsible for interaction, communication, and relationships to grow and develop. The attachment bond becomes the foundation of a child's ability to connect with others in a healthy way. An insecure attachment relationship is one that fails to meet an infant's need for safety and understanding, which leads to confusion about oneself and difficulties in learning and in relating to others. When children are unable to consistently connect with a parent or caregiver, an insecure attachment may occur. In some instances, separation is unavoidable. However, a baby who does not feel "safe" can develop an "insecure attachment." Some situations when this can occur include:

When a baby or young child is moved from one caregiver to another (can be the result of adoption, foster care, or the loss of a parent).
When a baby cries and no one responds or offers comfort.
When a baby is hungry or wet, and is not attended to for hours.
When a baby is not looked at, talked to, or smiled at, so the baby may feel alone.
When a young child or baby is mistreated or abused.
When a baby's needs are sometimes met and sometimes not met. S/he never knows what to expect.
When an infant or young child is hospitalized or separated from his or her parents.
When a parent is emotionally unavailable because of depression, an illness, a substance abuse problem, or other reason.

Depression can put attachment relationship at risk!

It is helpful to provide psycho-education and coaching about normal early development, brain development, attachment, and the importance of eye contact, vocalization, soothing behaviors, and reciprocal interaction to mothers and their partners. Other interventions and dyadic therapies can be helpful as well.
*(For more information, see **Intervention/Treatment** section.)*

With early detection, it is possible to improve a mother's attachment with her infant. This, in turn, can be beneficial to lifting a mother's mood and functioning.

For additional information on attachment, see

www.pbs.org/thisemotionallife/topic/attachment

A baby experiencing insecure attachment may display the following behaviors:

Avoids eye contact or doesn't track (follow you with his/her eyes)
Doesn't smile
Doesn't reach out to be picked up
Rejects your efforts to calm, soothe, and connect
Doesn't seem to mind or is not aware when you leave him/her alone
Cries inconsolably
Doesn't make sounds or coo

Attachment can begin during pregnancy

Early attachment can be formed during pregnancy. The way a mother feels about her pregnancy and the growing fetus can affect her ability to bond with her baby after s/he is born. You can help a mother attach during pregnancy, or help her realize that there may be relevant barriers to attachment to explore during the pregnancy. Asking her about her feelings about being pregnant and her dreams of her future life as a mother can be helpful in identifying if she may be at risk for not bonding with her baby postpartum.

Some questions to ask are:

- How long have you known you are pregnant?
- How did you feel when you found out you are pregnant?
- Do you think of the fetus as your future baby/child yet?
- If so, what do you think this baby/child will be like?
- What are your hopes and dreams for this child?
- Is there anything you are worried about for this child?
- What do you think it will be like to see your baby's face for the first time?
- Do you think it will be easy or difficult for you to show this baby that you love him/her?
- Did you feel loved by your own mother?
- How did your mother show you she loved you?
- What do you think it will be like to be a mother to this baby?
- If you have other children, what is your relationship like with them?
- Has any healthcare or early childhood professional ever talked to you about possible attachment issues with your other child(ren)?

Maternal Depression and Child Abuse

Maternal depression puts children at risk for both abuse and neglect. Depressed mothers can often be emotionally distant from their infants and fail to engage in reciprocal interactions. Infants may try to gaze into their mothers' faces, a natural phenomenon, only to find that their efforts go unrewarded. The infant may then withdraw, become apathetic, not eat, and fail to thrive. Both growth and development may be adversely affected. Depressed mothers at times may be less vigilant, exposing children to greater risk of unintentional injury. Inflicted trauma, including abusive head trauma and fractures that may occur as a result of the mother's frustration at her baby's normal crying, is characteristic of young infants. Maternal depression may be associated with childhood depression as well. A child's well-being is intimately tied to parental mental and physical well-being. When mommy is not happy, no one in the family is happy.

-Carol Berkowitz, M.D.

SIGNS AND SYMPTOMS

What Are the Signs and Symptoms?

The number one complication of childbirth is depression. When looking at the signs and symptoms of perinatal mental health disorders, there are different ways they may manifest. For some women, their symptoms go undetected because they are similar to the normal adjustment to new parenthood: decreased sleep, anxiety or mild sadness. Doctors may suggest that these are normal reactions and, as a result, a woman may feel too ashamed to continue to share her experiences. The important thing about listening to a woman share her emotional experiences during pregnancy and postpartum is to keep in mind that her feelings are real. Each mother experiences depression or anxiety in her own way. **Pay attention to the severity, duration, and range of symptoms she expresses, and remind her that maternal depression is treatable!**

What Are Perinatal Mood and Anxiety Disorders?

Definitions

Perinatal: The preconception period, pregnancy itself, all the way through the child's first year

Depression: A period of at least two weeks during which there is either depressed mood or loss of interest or pleasure in nearly all activities

Anxiety: Persistent and excessive anxiety or worry (with or without depression)

Baby Blues

50-80% of postpartum women experience baby blues

Symptoms persist no more than 14 days

Symptoms usually diminish without intervention

- Mild sadness
- Tearfulness
- Anxiety
- Irritability for no apparent reason
- Fluctuating moods
- Increased sensitivity
- Fatigue

If it lasts more than 14 days, it is more than the blues

What is postpartum depression?

Onset usually between day 3 and day 14 postpartum but can develop anytime within the first year

10-22% of new mothers

Symptoms include (much greater severity than with baby blues):

- Social withdrawal
- Deep sadness, crying spells, hopelessness
- Excessive worrying and fears
- Irritability or short temper
- Mood swings
- Feeling overwhelmed
- Feeling very emotional
- Difficulty making decisions
- Changes in appetite
- Sleep problems
- Mixed emotions about the baby

The Importance of Sleep

Sleep is crucial to everyone's health, and it is often very hard for new mothers to get enough sleep. A major red flag for depression is the inability to sleep, EVEN WHEN THE BABY IS SLEEPING. Another way to screen for this is by asking, "If you could have eight hours to yourself in a nice, quiet, clean bed, knowing that someone else is caring for your baby, would you be able to sleep?"

If the answer is NO, further assessment for depression is important.

How Is Postpartum Depression different from "the blues?"

Postpartum depression can be triggered by the dramatic changes in hormone levels that happen during pregnancy and after delivery

13% of women will develop a major depression postpartum

It can occur anytime within the first year

Early assessment and treatment is critical – or it may become a chronic condition

There is a 50% - 75% recurrence rate in subsequent births

DSM-V DIAGNOSTIC CRITERIA FOR DEPRESSION

For major depressive disorders, at least five of the following symptoms must be present most of the day, nearly every day, for at least two weeks. At least one of the first two bolded symptoms must be present.

1. **Depressed mood ("feel low, sad, blue")**
2. **Markedly diminished interest in usual activities**
3. Significant increase or decrease in appetite/weight
4. Insomnia/hypersomnia
5. Psychomotor agitation ("speeding up")/retardation ("slowing down")
6. Fatigue or loss of energy
7. Feelings of worthlessness or guilt
8. Difficulty with thinking, concentrating, or making decisions
9. Recurrent thoughts of death or suicide

However, for many pregnant or postpartum women, certain "symptoms of depression" are actually common in a normal pregnancy or postpartum period. These can include sleep disruption, appetite changes, and low energy. Assessing for SEVERITY thus becomes important: For example, wanting to nap in the afternoon in the first trimester is normal; not getting out of bed for days is NOT.

The Voices of PPD

"I want to cry all the time."
"I feel like I'm on an emotional roller coaster."
"I will never feel like myself again."
"I don't think my baby likes me."
"Everything feels like an effort."
"I hate the way I look now. It's the baby's fault."

Depression in pregnancy

- Multiple or severe physical complaints
- Pronounced anxiety
- Tearfulness
- Severe low mood/hopelessness

Postpartum Depression with Anxiety

- Insomnia
- Weight loss
- Inability to cope
- Hopelessness
- Confusion and disorientation
- Difficulty concentrating
- Feeling detached from infant-"going through the motions"
- Overwhelming anxiety-fear of being left alone

Panic Disorder

- Shortness of breath, chest pain, dizziness
- Trembling, numbness
- Restlessness and agitation
- Sudden episodes of extreme anxiety, excessive worries

Postpartum Post Traumatic Stress Disorder

- Reliving traumatic events
- Flashbacks, nightmares, images
- Sense of doom
- Hypervigilance
- Increased arousal
- Can be triggered by traumatic childbirth

Postpartum Obsessive/Compulsive Disorder

- Occurs in 5% of postpartum women
- Intrusive/repetitive thoughts/images
- Presents as thoughts of harming child, often accompanied by anxiety-reducing behaviors
- Very upsetting to mother; she recognizes these thoughts as "foreign"
- Generally, there is no danger of mother harming the baby because these thoughts are distressing to her and she will endeavor to keep her baby safe
- *BOTTOM LINE: If she expresses ANY thoughts of harming baby, call for a psychiatric consultation.*

Postpartum Bipolar Disorders

Bipolar I and II

60% of women present initially as depressed (antidepressants alone might induce cycling into mania)
71% of bipolar women who go off their medications during pregnancy will have a bipolar relapse before delivery
50% of women with bipolar disorder are diagnosed postpartum

Alternating periods of depression and elevated mood

Hypomania: Up to four days in length, often improves functioning
Mania: Severe symptoms, impaired functioning, lasts at least seven days or requires hospitalization, or psychotic symptoms (hallucinations, paranoia or disorganized thinking)

Elevated mood symptoms

Euphoria or agitation
Decreased need for sleep
Racing thoughts
Increased productivity
Pressured speech
Increased energy
Noticed by others

Postpartum Psychosis-A TRUE EMERGENCY

Thoughts of harming baby that are NOT recognized as “foreign”
Hearing voices or seeing visions
Acting paranoid or notably frightened
Profound agitation and lack of sleep
A true emergency: Must have a protocol
Infanticide rates up to 4%

Risk Factors

The most important risk factor for PMADs is a personal history of anxiety or depression. In particular, a woman who is depressed in pregnancy is highly likely to remain depressed after the baby arrives, or even have it worsen. This is the opposite of what many women believe: that if they can tough it out during pregnancy, they will feel better once the baby comes. Also, women who have had mood or anxiety changes before their period starts or while on hormonal birth control are at higher risk.

Medical and psychiatric risk factors:

- Family history of mood disorders or other mental illness, personal history of depression, depression or anxiety during pregnancy
- Prior history of trauma or loss, especially loss of one's mother
- Difficult or high-risk pregnancy
- High stress levels
- Unplanned pregnancy
- Birth trauma or complications
- Medical problems
- Ill or special-needs baby
- "Fussy baby" or baby with difficult temperament
- Substance abuse, perinatal loss, infant death (see **Special Considerations**)
- Infertility history (see **Special Considerations**)

Social risk factors:

- Conflict with husband or partner
- Domestic violence
- Homelessness
- Limited social support
- Poverty or financial hardship
- Relationship stress

Populations at higher risk:

- Adoptive families
- Recent immigrants
- Military families
- LGBTQI families
- Single mothers
- Teen mothers

Intimate Partner Violence

A pregnant woman is more likely to experience domestic violence during those nine months than at any other time in her life. Homicide is the leading cause of death during pregnancy in the United States.

Helpful Links for Signs and Symptoms:

Women's Mental Health
www.womenshealth.gov

Mental Health - Fact Sheets
www.womenshealth.gov/health-professionals/womens-health-today/mental-health.cfm

Mental Health Ilness
www.womenshealth.gov/mental-health/conditions

Postpartum Depression
www.womenshealth.gov/mental-health/conditions/postpartum-depression.cfm

Postpartum Psychosis
www.postpartum.net/Get-the-Facts/Postpartum-Psychosis.aspx
www.pregnancy-info.net/postpartum_psychosis.html

Resources
www.womenshealth.gov/mental-health/resources

CRISIS MANAGEMENT

In rare circumstances, detrimental or life-threatening crisis situations can occur in the perinatal period. Postpartum psychosis is not an extreme case of postpartum depression, but a severe crisis (1 in 1000 births) that requires immediate attention and intervention. It is crucial that health care providers have protocals for risk assessment and action in the unlikely event of a mother exhibiting psychotic or suicidal symptoms or posing a serious threat to her infant. Infanticide, an extreme and uncommon consequence of postpartum psychosis, is often given exaggerated attention in news media compared to its actual prevalence. Crisis situations may be difficult to predict because the signs are sometimes subtle or covert. Knowledge about early signs and risk factors is critical to emergency assessment and timely intervention. Remember, asking about a crisis will only reduce the risk of harm.

Suicide Screening

Clinicians have an important role in preventing suicide. Assessing for suicidal thoughts in mothers with postpartum depression is extremely important. Developing a trusting relationship can be the difference between the important honest disclosure and suffering in silence. Your response to suicidal mothers can make a real difference in their long-term health and the health of their families.

Asking questions about suicide will NOT make a mother more or less suicidal than she already is. The opportunity to discuss the suicidal thoughts is usually cathartic for the suicidal mother.

The information you must find out is:

1. Does she have suicidal thougths?
2. Does she have suicidal plans?
3. Does she have a history of suicidal thoughts or acts?
4. How recently did this occur?

Look for evidence of risk in *all* mothers. Most suicidal mothers will display warning signs that can be picked up by alert clinicians, as well as by family members and friends. Collecting information from collateral sources is essential. These may include: first responders, partners, parents, friends, and other clinicians.

SAFE-T:
Suicide Assessment Five-Step Evaluation and Triage for Mental Health Professionals

1. Identify risk factors - Note those that may be modified to reduce risk.
2. Identify protective factors - Note those that may be enhanced.
3. Conduct suicide inquiry - Ask about suicidal thoughts, plan, behavior, intent.
4. Determine risk level/intervention - Determine risk and choose appropriate interaction to address and reduce risk.
5. Document - Document assessment of risk, rationale, intervention and follow-up plan.

Resources

National Suicide Prevention Lifeline: 1.800.273.TALK (8255)

Suicide Prevention Resource Center: www.sprc.org

Didi Hirsch: www.didihirsch.org/spc

Risk Factors

- Current/past mental disorders, especially mood disorders, schizophrenia, anxiety disorders, certain personality disorders, and PTSD
- Alcohol and other substance use disorders
- Key symptoms: Hopelessness, anxiety/panic, insomnia, command hallucinations
- Impulsive and/or aggressive tendencies
- History of trauma or abuse
- Physical illness
- Previous suicide attempt, aborted suicide attempt or self-injurious behavior
- Family history of suicide
- Job or financial loss
- Relational or social loss
- Easy access to lethal means or firearms
- Lack of social support and sense of isolation
- Particular vunerability to stigma associated with help-seeking behavior
- Barriers to accessing health care, especially mental health and substance abuse treatment
- Certain cultural and religious beliefs
- Exposure to, including through the media, and influence of others who have died by suicide
- Homelessness

Protective Factors

- Effective clinical care for mental, physical, and substance use disorders
- Easy access to a variety of clinical interventions and support for seeking help
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes
- Cultural and religious communities that discourage suicide and support self-preservation

Suicide Inquiry

- Ideation: frequency, intensity, duration in last 48 hours, past month and worst ever
- Plan: timing, location, lethality (method), availability, preparatory acts
- Behaviors: past attempts, aborted attempts, rehearsals
- Intent: extent to which the patient (1) expects to carry out the plan and (2) believes the plan/act to be lethal vs. self-injurious; explore ambivalence: reasons to die vs. reasons to live

Risk Level/Intervention

- Signs of psychosis always make a high-risk situation.
- Even when an individual has a secure support network, this may not be enough to counteract suicide risk.
- Remember to continually reassess as circumstances change.

If screening tools are used, they must be followed up with clinical interview questions.
Caring for a suicidal mother evokes strong emotional and behavioral reactions in clinicians-even among seasoned mental health professionals. The clinician's responsibility is to manage those reactions in a way that does not interfere with the quality of care for the suicidal patient, and to seek appropriate supervision.

Postpartum Psychosis

Postpartum psychosis is the most severe, and rare, perinatal mood/anxiety disorder. It affects one to two women per 1,000, and in 80% of cases occurs within the first two to three weeks after delivery. Untreated postpartum psychosis can have tragic consequences: It carries a 5% suicide rate and a 4% infanticide rate.

Often described as losing touch with reality, postpartum psychosis is characterized by the following symptoms:

- Hallucinations
- Delusions
- Illogical thoughts
- Insomnia
- Refusing to eat
- Extreme anxiety and agitation
- Periods of delirium or mania
- Suicidal or homicidal thoughts

Although some women realize they are experiencing symptoms, fewer than 20% reveal them to their healthcare provider. Typically, a partner or close family member sees the extreme behavioral manifestations of postpartum psychosis, realizes the new mother is experiencing a frightening, dangerous thought disorder and gets her the medical attention she needs. This can require a call to 911 or a trip to the emergency room.

Women at highest risk of experiencing postpartum psychosis have a:

- History of psychosis, bipolar disorder or schizophrenia
- Family history of psychosis, bipolar disorder or schizophrenia
- Previous incidence of postpartum psychosis (20% - 50% likelihood)

If you suspect a client is experiencing symptoms of postpartum psychosis, immediately call 911. Treatment requires intervention by a psychiatrist and centers around anti-psychotic medication. In some cases, antidepressant and/or anti-anxiety medications are helpful, as well. If a woman is considered a danger to herself or others, she will be hospitalized for a short time. Many women will experience a period of postpartum depression after the psychotic episode resolves, but most will fully recover with the proper care.

POSTPARTUM PSYCHOSIS IS A TRUE EMERGENCY THAT REQUIRES IMMEDIATE MEDICAL ATTENTION

Infanticide and Pregnancy Denial

Our expectations of mothers as nurturing and fiercely protective make it impossible to imagine that a new mother could turn against her own infant in destructive and violent ways. And yet, postpartum psychosis, the most serious of the perinatal mood disorders, elevates infants' risks of dying at the hands of their own mothers to 4%.

Infanticide (the taking of an infant's life within the first year) and neonaticide (the killing of an infant within the first 24 hours of life) are often accompanied by two significant symptoms. These are depersonalization, which is defined as the sense of being an external observer of one's own actions, and dissociation, which is a brief lapse in awareness of one's own behavior and surroundings.

Any assessment should include questions about personal or family history of bipolar disorder or schizophrenia as well as inquiry about sensory experiences, including hearing voices, seeing visions, and experiencing tactile and olfactory sensations. Because the cognitive disorganization caused by psychosis often waxes and wanes, it is critical to ask the same questions intermittently throughout a clinical interview.

Sometimes the existence of a pregnancy is acknowledged, but its emotional significance is denied. This is called pregnancy denial. There are no preparations made, and no relationship created with the fetus during the pregnancy. Sometimes, acknowledgment of the pregnancy is concealed beyond awareness, not only from those around them, but from themselves as well.

While both infanticide and pregnancy denial are undeniably tragic, both of these conditions are extremely rare. It is imperative to contact emergency services (911) whenever there is any serious safety concern.

Helpful links:

Postpartum Psychosis

www.postpartum.net/Get-the-Facts/Postpartum-Psychosis.aspx
www.pregnancy-info.net/postpartum_psychosis.html

Suicide

www.suicide.org/postpartum-depression-and-suicide.html
http://psychcentral.com/news/2008/08/07/risk-of-post-partum-suicide/2711.html

SCREENING AND ASSESSMENT

Screening and assessment is imperative to the recognition and treatment of perinatal mental health disorders. Screening should be practiced prior to pregnancy, during pregnancy and postpartum. It is possible that symptoms will not be apparent in early meetings with a health care provider but may come on later. Remember, each woman experiences her symptoms differently. By making sure that we allow each woman to share her own individual story and that we offer a safe and nonjudgmental atmosphere, we create a greater opportunity to provide treatment when necessary.

When speaking to a woman who expresses feelings of depression or anxiety, here are a few phrases we have found helpful:

- "Many women who have had babies experience feelings like those you have been describing."
- "This isn't your fault."
- "I am going to give you some information that can help you understand why you feel this way and what we can do to change it."
- "There are treatments that are often successful in treating the symptoms you are experiencing."
- "This is treatable."

Clinicians have an important role in preventing suicide. Developing a trusting relationship can be the difference between the important honest disclosure and suffering in silence. Your response to suicidal mothers can make a real difference in their long-term health.

For suicide screening, see **Crisis Management** section.

Screening for Perinatal Mental Health Disorders

Why Screen?
Early detection can impact the course of treatment and potentially decrease the impact of maternal depression on children and loved ones.

WHEN Do I Screen?

- At initial prenatal visit
- At all prenatal visits
- At postpartum visits
- At all well-child visits

WHOM Do I Screen?

ALL WOMEN – you must ask! No one is immune from depression.

High-risk groups include women:

With a personal history of depression or other mental illness
With a family history of mood or anxiety disorders
With little or no social support
Who are victims of intimate partner violence
With significant medical issues
With a history substance abuse

HOW Do I Screen?

- Use a validated tool (EPDS, PHQ9 etc.).
- A screen is not a substitute for clinical judgment.
- A full assessment is critical for diagnosis.

WHAT Do I Say?

- "The number one complication of childbirth is depression. Please answer these questions to help us determine if you might need some additional support at this time."
- The Universal Message as stated by Postpartum Support International:
  "You are not alone." "You are not to blame." "With the right help, you will get better."
- Privacy Language:
  "We will not release this information without your permission, unless we are concerned about your safety or the safety of anyone else (including child or elder abuse)."

WHEN to Refer?

- Severe sleeplessness, even when the baby sleeps
- Thoughts of harm to oneself or baby
- Hearing voices or feeling paranoid
- Neglect of or pronounced disconnection from infant
- Panic attacks
- Obsessions and compulsions
- Severe drop in appetite
- Patient preference
- No response or relief after two medication trials

What to Do with a Positive Screen?

- Provide education/support/intervention/referrals.
- When in crisis, seek emergency intervention.

How to Refer?

- It is very helpful to actually make the referral connection rather than simply giving a name and telephone number. Stay connected with mom, and try to make an in-person introduction.

* Minnesota Department of Health, www.health.state.mn.us/divs/fh/mch/fhv/strategies/ppd/ppdpolicy.html

Postpartum Anxiety Disorder: Screening

For many women, symptoms are not the same as those in depression. They may be more like panic or anxiety. Use this survey to find out if help is needed.

Do you experience any of the following?

- Excessive worry, occurring more days than not, for more than two weeks
- Unreasonable worry about events or activities, such as work, school, your baby or your health
- Inability to control the worry
- Restlessness, feeling keyed-up, or on edge
- Being easily tired even when you have slept
- Difficulty concentrating
- Irritability
- Muscle tension
- Difficulty falling or staying asleep, restless or unsatisfying sleep, or inability to sleep when the baby is asleep
- Anxiety about going outside the house
- Fear of driving with or without the baby
- Fear of caring for your baby because you don't "trust yourself"
- Fear of leaving the baby with someone else
- Is your anxiety interfering with your daily life or your ability to care for your baby?

If you are experiencing more than three of these symptoms, you should talk to your care provider about your anxiety, how it may indicate a perinatal mood or anxiety disorder, and how to get help.

Perinatal Psychosocial Assessment

This survey is to be used as an intake tool to establish risk for PMADs

GENERAL INFORMATION

Name: DOB: Teen: yes/no

Address and phone:

Marital status:

Lives with:

Education:

Access to a computer/library:

Employment:

Is your job stressful or physically demanding?

Means of financial support:
- self:
- spouse:
- alimony:
- child support:
- SSI: SSD:

Financial stress: minimal ☐ moderate ☐ severe ☐

Health insurance:

Other children at home: Special needs:

Caregiver for elderly/ill family member:

Transportation: **Childcare available if needed:**

MATERNITY HISTORY

Pregnancy history:

- Number of pregnancies:
- Years of pregnancies:
- Live births:
- Terminations (# weeks):
- Miscarriages/Stillbirths (# weeks):
- Teen pregnancies (under 18):
- Multiples (twins, triplets, etc...):
- Planned vs. unplanned:
- Fertility treatment:
- Adoption:

Delivery history (circle and explain):

- C-sections (planned; emergency), traumatic deliveries, prematurity/NICU

Children:

- Ages, genders, names, adopted

Children's health:

- Birth trauma, genetic conditions, medical conditions, psychiatric conditions

Perinatal Psychosocial Assessment (continued)

MATERNITY HISTORY (continued)

Current pregnancy:

- # Weeks:
- Planned or unplanned:
- Length of time to conceive:
- Infertility treatment:
- Date began prenatal care:
- Birth plan:
- Complications:

Are you going to a doctor or a midwife yet for this pregnancy? Do you feel supported by him/her?

Feelings about this pregnancy:

What are you looking forward to regarding this baby?

What are you worried about?

Father of baby's feelings about this pregnancy:

Family and friends' feelings about this pregnancy:

MEDICAL HISTORY

Genetic conditions:

Chronic illnesses/disorders:

Recent acute illnesses:

Hospitalizations:

How do you feel your medical issues might affect this pregnancy?

Negative medical experiences:

Significant family medical history:

MENTAL HEATH HISTORY

Illness/diagnosis:

Date:
Duration:
Severity: mild ☐ moderate ☐ severe ☐
Treatment:
Resolved or ongoing:

Substance abuse history:

Substance:
Date:
Duration:
Severity:
Treatment:
Result:

Perinatal Psychosocial Assessment (continued)

History of PMADs in previous pregnancies:

In an earlier pregnancy, did you ever feel sad, blue, or low for more than two weeks? Y ☐ N ☐

In an earlier pregnancy, did you ever feel as if you didn't care about or weren't interested in things that normally gave you pleasure? Y ☐ N ☐

After the baby was born, did you ever feel sad, blue, or low for more than two weeks? Y ☐ N ☐

After the baby was born, did you ever feel as if you didn't care about or weren't interested in things that normally gave you pleasure? Y ☐ N ☐

Either while pregnant or after the baby was born, how often did you blame yourself unfairly when things went wrong?
Never ☐ Not very often ☐ Some of the time ☐ Most of the time ☐

Either while pregnant or after the baby was born, have you felt scared or panicky for no good reason?
No, never ☐ Not very often ☐ Yes, some of the time ☐ Yes, most of the time ☐

Either while pregnant or after the baby was born, have you felt anxious or worried for no good reason?
No, never ☐ Not very often ☐ Yes, some of the time ☐ Yes, most of the time ☐

Did you receive counseling or therapy to help with these feelings? Y ☐ N ☐

Did you receive medication to help with these feelings? Y ☐ N ☐

If you received counseling or medication, was it helpful? Y ☐ N ☐

CURRENT MENTAL HEALTH

Current mental health:
Diagnosis:
Onset:
Treatment:
Medication:
Mental health provider(s):

Feelings about mental health treatment:

Current substance use (circle and list all that appy):
Alcohol Tobacco Recreational Drugs Currently Sober 12-step program

FATHER'S MEDICAL HISTORY

Medical health:

Mental health:

Substance abuse history:

FAMILY MENTAL HEALTH HISTORY

Has anyone in your family ever struggled with sadness, nervousness, or moodiness? List who.

If yes, did they receive medication, were they hospitalized, did they struggle postpartum? (circle and explain positive answers)

TRAUMA HISTORY

Significant losses:

Significant traumas:

Did you witness violence in your home when you were growing up? Y ☐ N ☐

When you were growing up, were you ever abused physically? Y ☐ N ☐

Were you ever abused emotionally or verbally? Y ☐ N ☐

Did anyone ever touch you inappropriately or against your will? Y ☐ N ☐

Other?

Coping strengths:

When you've had hard times in the past, what has helped you to get through them?

Perinatal Psychosocial Assessment (continued)

RELATIONSHIPS

Relationship with father of the baby:

Relationship with father(s) of other children:

HISTORY OF INTIMATE PARTNER VIOLENCE

WITHIN THE LAST 12 MONTHS - INCLUDING THIS PREGNANCY - HAS YOUR PARTNER OR EX-PARTNER EVER	YES	NO	REFUSED
1. threatened you or made you feel afraid or unsafe for any reason?			
2. pushed, hit, slapped, kicked, or otherwise tried to physically hurt you?			
3. forced you to take part in any sexual activity when you did not want to, including touching that made you feel uncomfortable?			

"YES" on any question is High Risk

FAMILY SUPPORT

Who, how, where do they live:

RELATIONSHIP WITH MOTHER

Mother alive: Y ☐ N ☐

Relationship with mother:

Mother's feelings about her own pregnancies/births:

If mother if deceased, how old were you when she died?

What has it been like to be without her during this pregnancy?

Perinatal Psychosocial Assessment (continued)

SOCIAL SUPPORT APPRAISAL

How often is there	None of the time	A little of the time	Some of the time	Most of the time	All of the time	Refused
a. someone to help you if you were confined to bed	0	1	2	3	4	7
b. someone who shows you love and affection	0	1	2	3	4	7
c. someone to take you to the doctor if you needed it	0	1	2	3	4	7
d. someone to confide in	0	1	2	3	4	7
e. someone who hugs you	0	1	2	3	4	7
f. someone to get together with for relaxation	0	1	2	3	4	7
g. someone to help with daily chores of you were sick	0	1	2	3	4	7
h. someone to turn to for suggestions about how to deal with a personal problem	0	1	2	3	4	7
i. someone to love and make you feel wanted	0	1	2	3	4	7

Score Range: 0-36
Cutpoint for Low Social Support: <=9

SELF-CARE

Exercise:

Nutrition: History of eating disorder? Food insecurity? Do you ever run out of food?

Sleep:Restorative?

Recreational activities:

POSTNATAL PLAN

Plan for assistance at home when baby is born:

Plan for return to work/school:

Childcare plan if returning to work/school:

CULTURE

Country of origin:

Recent immigrant:

Language: Interview interpreted by:

Relevant cultural background/beliefs:

Religion/spirituality:

COMMUNITY INVOLVEMENT

WIC:
Other programs, groups and services:

Volunteer work:

OVERALL STRENGTHS:

IMPRESSION OF OVERALL RISK/CHALLENGES: HIGH ☐ MEDIUM ☐ LOW ☐

REFERRALS GIVEN:

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **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 fidgety 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 in some way	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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The PHQ9: Using Scores to Move Forward with Assessment and Care

Using PHQ9 to Screen for Depression

- Add up all scores to questions 1-9
- Compare this score to the grid below to screen for Depression Severity
- Look at question 9 to screen for suicidality. If answer is a 1 or above, see page 98 for completing a more thorough suicide assessment.
- Look at question 10 to assess the degree of functional impairment; an answer of at least "Some what Difficult" is necessary for a provisional diagnosis of depression.

PHQ9 Symptoms and Impairment	*Depression Severity*	*Provisional Diagnosis*	*Treatment Recommendations*
1 to 4 Symptoms, Functional Impairment	<10	Mild or Minimal Depressive Symptoms	Reassurance and/or supportive counseling Education to call if deteriorates
2 to 4 Symptoms, Question (a) or (b) +, Functional Impairment	10-14	Moderate Depressive Symptoms	Watchful waiting Supportive counseling If no improvement after two weeks, consider use of antidepressant or brief psychological counseling
>= 5 Symptoms, Question (a) or (b) +, Functional Impairment	15-19	Moderately Severe Major Depression	Patient preference for antidepressants and/or psychological counseling
>= 5 Symptoms, Question (a) or (b) +, Functional Impairment	>20	Severe Major Depression	Antidepressants and psychological counseling

*If symptoms present for > 2 years, Chronic Depression, or functional impairment is severe, remission with watchful waiting is unlikely, immediate active treatment indicated for moderate depressive symptoms (minor depression).

**Referral or co-management with mental health specialty clinician if patient is a high suicide risk or has bipolar disorder, an inadequate treatment response, or complex psychosocial needs and/or other active mental disorders. See "When to Refer" sheet for more details.

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 felY ***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 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

PREVENTION

Can perinatal mental health disorders be prevented? While there are many reasons a woman may develop a perinatal mental health disorder, it is important to keep in mind that she is not to blame. There may be ways to identify and reduce risk factors, to intervene to decrease stress during her pregnancy, and to help her to plan ahead to reduce upcoming stressors. Completing a comprehensive assessment covering concerns ranging from physical health and mental health, to social strengths and environmental strains can offer a good idea of what to address early on with a mother. Providing local resources, hotlines, nutrition, and self-care suggestions may be significant in reducing the stressors that can contribute to a perinatal mental health disorder.

Our approach is informed by the Strengthening Families Protective Factors model (https://www.cssp.org/young-children-their-families/strengthen-ingfamilies). Using this model, we can help a family to build skills neces-sary to cope with perinatal mental health issues and to recognize when they need to reach out for support.

Perinatal mental health issues are not always avoidable, but it helps to be prepared.

Protective Factors

Helping families cope with perinatal mental health issues requires looking at the "big picture." We must look at the mother's health history and her environment. Maternal Mental Health NOW encourages the development of "protective factors." These personal, family and community strengths ensure the safety of families and the development of coping skills for when challenges arise. The Center for the Study of Social Policy program identifies the following protective factors to prevent child abuse and neglect and to strengthen and support families.

Protective Factors are:

1. Parental Resilience

"Be strong and flexible"

Help parents develop the strength, flexibility, and resources to bounce back when adversity hits. If parents were treated harshly themselves as children, they may need role models, resources, and encouragement to be able to deal with challenges while nurturing their children. Help parents develop resilience, by encouraging them and providing them with concrete strategies.

2. Social Connections

"Parents need friends"

Parents need friends. When they have an informal network of trusted friends in their community, they have a support system for meeting both practical and emotional needs. They can brainstorm about problems together, give and receive back-up child care, and help meet unexpected needs such as transportation. As a social group, parents provide one another with norms for how family and community issues should be handled.

3. Knowledge of Parenting and Child Development

"Being a great parent is part natural and part learned"

Parents who understand typical child development have reasonable expectations for their children, and by having alternative strategies for dealing with children's challenging behavior, they can avoid harsh punishments.

4. Concrete Support in Times of Need

"We all need help sometimes"

We all need help sometimes, and families that receive help when they need it are able to stay strong and healthy. Being able to ask for and receive help is important to keeping families strong. Sometimes a parent's first step in getting help is seeing that the child's well-being depends on it.

5. Social and Emotional Competence of Children

"Parents need to help their children communicate"

Parenting can be especially difficult when children act out or exhibit challenging behaviors. When children communicate their feelings appropriately and interact positively with their families and with other adults and children, parenting becomes less stressful. Teaching social and emotional skills is the foundation of quality early childhood education.

■ "Strengthening Families is a framework developed by the Center for the Study of Social Policy (CSSP) to prevent child abuse and neglect by building five protective factors. CSSP is a nonprofit public policy, research and technical assistance organization headquartered in Washington, D.C., www.cssp.org"

Reproductive Life Care

What is a reproductive life plan?
A reproductive life plan is your set of goals about having or not having children. It also states how to achieve those goals. Everyone needs to make their own reproductive life plan. Planning helps you think about how you want to live your life and reach your goals. It will also help you be healthy and ready if you choose to get pregnant.

How do I make a reproductive life plan?
There are many kinds of reproductive life plans. First, think about if you want to have children. If you do, think about when you want to get pregnant. If you do not, think about how you will prevent pregnancy. Then take actions to help yourself achieve those goals. For example, you can use birth control so you do not get pregnant before you want to. If you have had a problem with a pregnancy before, talk to your doctor. You can learn how to prevent problems if you choose to have another child.

What does a reproductive life plan look like?
Your plan will depend on your own goals and dreams. Think about your goals for school, for your job or career, and for other important things in your life.

Here are some examples of reproductive life plans:

- I'm not ready to have children now because I want to finish school first. I'll make sure I don't get pregnant. Either I won't have sex, or I'll use birth control every time.
- I want to have children when my relationship feels secure and I've saved enough money. I have diabetes, so when it is time, I'll go to see my doctor to make sure my body is ready for pregnancy. In the meantime, I'm taking really good care of myself just for me.
- I've had two kids, and they're only a year apart. Both times, it just happened. I want to have another kid, but I want to wait at least two years. I'll talk to my doctor about timing between pregnancies. This time, I'm going to make sure I only get pregnant when I want to.
- I'm just going to let pregnancy happen whenever it happens. Since I don't know when that will be, I'm making sure that I'm in the best health now, just in case!
- My partner and I are ready to have a child, but we'll need to use a sperm bank or fertility service to get pregnant. I will make sure I'm in good health before we use those services.
- I've decided that I don't want to have children. I will find a good birth control method, or I will talk to my doctor about permanent birth control methods.

www.everywomancalifornia.org

Sexual Health and Perinatal Mood and Anxiety Disorders

Sexual dysfunction, especially decreased libido, is a common symptom of perinatal mood and anxiety disorders. Women with PMADs are less likely to have resumed sex at six months after delivery and more likely to report sexual health problems. Studies indicate that a woman's sex life before delivery often predicts how it will be afterwards.

Generally, more than a third of first-time mothers report a loss of libido at eight months after delivery. Not all women experience lack of libido, but many struggle with the sexual changes of pregnancy and motherhood. Women taking SSRI antidepressants may also experience sexual dysfunction symptoms as a side effect. Clinicians must inquire about changes in sexual functioning when treating women with PMADs.

Common worries/fears:

- Will sex during pregnancy harm the baby?
- Will sex after delivery harm the mother?
- Will a vaginal birth have long-term effects on the mother's sex life?
- How will the partner react to the bodily changes of pregnancy and motherhood?
- How to deal with delay of sexual activity after delivery?
- What if I get pregnant again right away?

Sex during pregnancy

Most research suggests that during pregnancy sexual desire and frequency of sexual activity decrease. Some women also report increase of sexual desire. A common worry is whether sex during pregnancy can hurt the child. Generally, sex is considered safe during all stages of normal pregnancy, and carries a low risk for complications. However, individual conditions should always be assessed. Sex during pregnancy is low-risk behavior unless the health care provider advises against it. In some pregnancies, sexual activity may lead to serious complications or health issues, such as premature labor or a ruptured uterus. The decision should always be based on thorough individual examination and consideration of the woman's medical history.

For more information on Sexual Health, see:

www.cdc.gov/sexualhealth

Sex after delivery

Resuming sexual activity after delivery is delayed from a few weeks for some women up to several months for others. Studies indicate that about 50% of women resume sexual intercourse six weeks after delivery. Long delay may be related to postpartum depression or anxiety.

Complications of having sex early after pregnancy can include tears to incisions or infection of the uterus. Women should consult their primary physician for individual assessment of when it is medically safe to have sex after delivery. Women with damage or tears to their perineum will often have to postpone resuming sexual intercourse in order to heal properly. It is common to experience discomfort when resuming intercourse, but it should never be painful.

The change of hormone levels after delivery causes vaginal tissue to become thinner, and lubrication can decrease. Vaginal dryness may occur up to three months after delivery due to the hormone changes. Women who are severely affected by this can be treated with topical estrogen cream to strengthen the tissue.

It is a common myth that women who are breastfeeding do not get pregnant. This is not true. It is important for women to have the opportunity to make a reproductive plan and be provided with information about contraception.

What can be done:

- Medical counseling: asking questions about any concern and providing thorough answers
- Psychotherapy or sex therapy can help the woman work through sexual health issues
- Communication with the partner is extremely important
- Performing pelvic floor muscle exercise may improve sexual function
- Lubrication and/or topical estrogen cream may relieve vaginal dryness
- Adjusting sexual behavior: going slower, allowing more time for foreplay and stopping if pain occurs
- Consulting a doctor whenever there is pain and bleeding during intercourse
- Making a reproductive plan that includes family planning and birth control if desired

Important for clinicians:

- Inquire about sexual functioning!
- Never make assumptions about sexual behavior or dysfunction.
- Be sensitive to LGBTQI issues: use non-normative language.
- Be sensitive to cultural and religious issues, e.g., pay attention to own gender vs. clients.
- Ask about the mother's reproductive plan, and provide education about interconception.
- Offer referrals if necessary.

Building a Network of Support

What is a support network?

A social support network can be a powerful tool in coping with maternal depression and anxiety. This support network can be made up of friends, family, peers, members of her church, parents at her children's school or even neighbors. Having a network a woman can rely upon can help her get through challenging times, increase her sense of belonging to a community, and help her feel better about herself. When she has a support network, she may even feel safer.

What can a support network provide?

- A caring ear to talk to about parenting, her feelings, her relationships, or just to talk
- A loving shoulder to cry on when things are difficult
- An enthusiastic response to her good news
- Help in caring for her baby
- Help in grocery shopping, with recipes, cooking
- Information about schools and other resources
- An understanding presence when she is struggling

How does she build a support network?

Some people are fortunate enough to have a nurturing family that provides support. Others live far away or have more complicated relationships with their families. Building a support network takes effort and creativity. She may find a friend at a park, the coffee shop, the grocery store, the doctor's office, the library or at church. She may find that she has a lot in common with someone, and that forms a bond. On the other hand, she may be very different from someone but have the same values. What matters most is that she has a caring and trusting friend. The key is to be open and willing to reach out.

How does she keep her support network?

Nurturing her support network takes effort. The best times to build her network is when she is in a strong place. However, the times she may need her network most are when she is struggling. Here are some things to keep in mind:

- Stay in contact when things are good and when they are not.
- Share her appreciation and gratitude.
- Be open to meeting new people even when she is busy and overwhelmed.
- Offer to help but don't be afraid to receive help too.
- Be kind and not overly critical of her support network. Communicate when she is feeling hurt.
- Reach out, even when she may not feel like it. Being isolated is a key symptom and contributor to depression.

INTERVENTION/TREATMENT

Overall, the prognosis for perinatal mood disorders is very good. Postpartum depression and anxiety are treatable with a variety of effective interventions, including psychotherapy, counseling, social support, and medical treatment, often used in combination. An important aspect of intervention is to facilitate self-care (physical health, nutrition, exercise, and rest), which can make a significant impact on a woman's recovery. Comprehensive assessment and evaluation are necessary before determining the most appropriate interventions. Considerations of the different treatment options should be discussed with the individual to ensure participation and consent. Intervention ideally should be offered as early as possible, as that may quicken recovery.

Building Blocks of Maternal Well-Being

Perinatal mental health disorders are a major public health issue. However, some of the most important solutions are easy steps that a mother can take on her own. Our minds and bodies are not separate, so it is essential to include self-care in treatment.

Keep these things in mind as you talk to a woman about her emotional health.

Education

Informing women about perinatal mental health in the preconception, pregnancy, and postpartum period is essential in helping her to care for herself. Sometimes, knowledge can be the difference between suffering in silence and getting help. You can provide education by distributing materials in your waiting rooms, putting posters on your walls, and offering internet links or recommendations for books.

Sleep

As we will discuss further in this section, sleep is essential in caring for a mother as she copes with her symptoms of depression or anxiety. Help mom develop a sleep plan and try to remove obstacles preventing restorative sleep (noises, light, having no one to take turns on the “night-shift”).

Exercise

What kinds of activities does mom engage in? Does she like to run, dance, walk? Many of these activities can be altered to include her baby. By keeping physically active, the body releases endorphins, which may improve mood and increase energy.

Social Support

Being a mother can feel very overwhelming. Having a friend, neighbor, family member, or professional in whom a mother can confide can make all the difference. Help mothers learn the benefits of asking for help. Remind them they can help out others when they are feeling better.

Nutrition

Often, a mother neglects to care for herself in her efforts to care for her baby. Remind her that proper nutrition is essential in order for her to get better and have the strength to care for her family. If she is breastfeeding, she may need to take in extra calories to produce enough milk. We have included some nutrition information for families. (See **Client Handouts.**)

Referrals to Professionals

Make sure you have local resources for support groups, medical care, lactation consulting, and other needs so that you can help mom when things are too much to manage without additional support. Make sure you know when, to whom, and how to refer.

Returning to Work

Helping a mother think about how she will provide care for her baby upon returning to work can be an emotional subject. It is not uncommon to feel guilty about leaving a young baby with a caregiver. Exploring ways mom can stay in touch with the caregiver, feel safe about her child's care, and get support for this emotional transition is extremely important.

Building Blocks of Maternal Well-Being (Continued)

Working Mothers and PMADs
The Guilt Game

For some women, returning to work after having a baby is a significant stressor. Being a working mother can be challenging even for a woman who is not struggling with maternal depression and anxiety. At times, the pull to be at work and the pull to be at home are at odds with one another. The balance between different worlds and different roles can be difficult to achieve. This experience, the working mom's plight, might be described as one where the mother is engaged in a losing battle of the Guilt Game. Working moms have shared, "I feel guilty when I leave my baby at home to go to work. But, I also feel guilty when I am at work and not able to be as productive as I used to be." "I feel guilty when I don't do enough work and then leave early to be with my baby. But I also feel guilty when I stay late and don't go home on time." The Guilt Game goes even deeper for some moms. "I feel guilty when I am happy to be at work. Wouldn't a good mom want to be with her baby all the time?" Some mothers feel that by both working and being a mom, they are not successful at either. This double bind has some women feeling alone, exhausted, and confused. A woman who had a strong sense of accomplishment and identity that was fulfilled at work may feel guilty if she doesn't feel the same anymore. "My priorities have changed, but my boss doesn't understand that." On the flip side, she may feel that work is the one place where she feels competent. But that feeling may contribute to feeling ashamed that she does not have a "true maternal instinct" and, as a result, is flawed because of this.

When a mother who is struggling with a perinatal mood and anxiety disorder is faced with returning to work, she may become even more swept up by self-criticism, more anxious and more depressed. In essence, she is more vulnerable to the Guilt Game. It is imperative to support her through this time, reminding her to continue with her therapeutic regimen, reach out for help, and maintain basic self-care.

In supporting working moms, encourage them to step off the Guilt Game wheel and take a new view of their changing roles.

Here are a few tips:

1. There is no one version of working motherhood. Be kind to yourself as you figure out your own definitions.
2. Now that you are a mom, you are different, but that is not a bad thing.
3. Find another working mom to talk to. It is likely that she has been juggling as well. Find out what she has done to cope with the multiple demands of being a mom and working.
4. Remember to take time for yourself. Being at work is not the same as taking care of yourself.
5. Remember to pay attention to your mood and anxiety, and stay in close contact with your healthcare professional.
6. Above all, be patient, the adjustment may take some time.

COMMUNITY SUPPORT

When supporting a woman struggling with maternal mental health issues, it is important to include all her support networks. Often that includes her local school, neighborhood, or faith-based community. This strengths-based building block might make a significant difference in helping her feel she has a caring community.

Faith-Based Support

What are faith communities?

- Faith communities are groups of indiviuals who share common spiritual and religious understandings/ beliefs.
- Often these communities share worship, prayer, education and sometimes political and social experiences.
- Usually faith communities have one spiritual leader, but sometimes there are multiple leaders and roles within the community.
- Some communities meet regularly for weekly or daily prayer, but some convene only for rites of passage or holidays.

Why use faith communities in treatment of PMADs?

- Family may feel great comfort with their spiritual leader.
- There may be greater access in community.
- Belief may serve as an anchor for someone with depression.
- Faith communities may be places where women feel less stigma than medical setting.
- Congregants may be able to help providing meals, prayer, childcare to help family.
- Often faith communities have traditions of welcoming baby to faith, good opportunity for spiritual leader to assess for symptoms of PMADs.

Barriers to receiving support for PMADs from faith communities

- Lack of comfort with PMADs by faith communities and clergy (usually related to lack of knowledge or training)
- Fear of judgment by faith leader, congregants, God
- Discomfort mother may feel with spiritual leader being male
- Shame mother may feel for her community to know about her disorder
- Discomfort with receiving food, help from others

How to help faith communities better serve families with PMADs

- Education of clergy about signs and symptoms as well as treatment options for perinatal mood and anxiety disorders
- Education about red flag symptoms requiring intervention and the need for coordination of care with mental health caregivers
- Encouragement of faith community to form a “visiting new mothers” program
    - Train volunteers on signs and symptoms
    - Help coordinate meals for new parents or other ways to help family
    - Offer help with childcare for older siblings
    - Bring a welcome basket with information about PMADs and resources
    - Follow up with the family
- Hold a support group at the church/synagogue

Psychotherapy Interventions for Perinatal Mood and Anxiety Disorders

Support Groups offer women help in coping with the distress that accompanies a perinatal mood and anxiety disorder through the support of women who are suffering in a similar situation. A support group can be especially effective in helping women not to feel alone or at fault for their symptoms. These factors alone are often an enormous relief to a woman suffering from a perinatal mood or anxiety disorder. In addition, support group members are often able to share unique suggestions with each other for dealing with very specific problems. To learn more about helping to build social support, please see **Prevention** section.

Psychotherapy is an important component of effective treatment for perinatal mood and anxiety disorders, even when medication is prescribed. The goal of treatment is to restore the woman to her previous level of functioning, to ensure that she is securely attaching to her baby and that her family adjustment is on track. Several modes of psychotherapy have been shown to be effective in treating perinatal mood and anxiety disorders. However, the symptoms of perinatal mood and anxiety disorders can vary from woman to woman, both in their nature and severity. Therefore, in order to receive care tailored to meet a woman's individualized needs, she should first receive a comprehensive evaluation from a mental health professional with specific knowledge about maternal mental health. Her treatment plan should also take into account whether or not she is currently pregnant or is in the postpartum period, and may consist of one or an integrated combination of the therapies described below. One of the most consistent findings in the psychotherapy literature is that the therapeutic relationship is a critical factor in effective psychotherapy.

Interpersonal Therapy focuses on helping the woman to grieve personal losses, identify interpersonal role disputes, navigate this life-changing role transition, address interpersonal deficits and attend to specific problems related to pregnancy.

Cognitive Behavioral Therapy/Dialectical Behavior Therapy is a skills-based therapy that helps women who struggle with issues that can complicate pregnancy and the postpartum period, such as substance use (including smoking), eating disorders, a history of trauma, or a previously diagnosed psychiatric illness. Skills in emotion regulation, mindfulness, distress tolerance, and interpersonal effectiveness are taught in order to decrease behaviors that interfere with the health of the mother and baby and to encourage interpersonal effectiveness and self-respect.

Creative Arts Therapies use the creative process to help individuals improve their emotional well-being. Through art, music, or movement, women can increase self-awareness, experience greater attunement with others, and improve coping for symptoms of stress and trauma. Creative art therapies are often very effective in helping a woman suffering from a perinatal mood and anxiety disorder to deepen her understanding of her issues and improve her bonding with her baby.

Dyadic (Mother/Baby)

The most efficacious treatment approaches are those that address the needs of the mother, child, and their relationship, reduce mother's symptoms, and increase her understanding of her infant's internal experience. Because of the potential for poor outcomes for children of mothers with untreated depression, it is important to identify early on the development of emotional and cognitive difficulties in babies and young children. Treatment of depressed mothers should include this awareness and should focus on parenting skills, safety practices, and parents' ability to respond to children's social and emotional needs. Dyadic interventions such as Interactive Guidance (using video to help mothers become aware of their interactions with their babies and young children) have proven effective with depressed, isolated and substance-recovering parents.

Goals of Dyadic Treatment include:

- To increase parents' ability to appropriately and effectively respond to their children's emotional needs and non-verbal cues
- To improve children's social, emotional, and developmental functioning by partnering with parents and sharing in the child's progress
- To strengthen family when there is maternal or paternal depression
- To use infant massage to decrease maternal or paternal depression

Family Meeting

The Family Meeting (William Beardslee) is an approach to parental depression that takes into account that all members of a family are affected when a mother struggles with depression. It focuses on how to help all of the children in the family become resilient when dealing with chronic maternal depression. The following are the essential components: share her history of depression; relate her knowledge of depression to her circumstances; address the needs of her children; plan the family meeting; conduct a family meeting; keep the dialogue going.

Emotion Focused Therapy for Couples is an empirically supported humanistic treatment derived from emotion theory and attachment theory. The birth of a baby brings with it both a time of deeply felt emotion and alterations in attachment in the parenting couple. The parents must adjust their relationship to include the new baby and separately and together bond as a family. Mood or anxiety symptoms can further complicate an already challenging time in any family. Couple's therapy aimed at fostering the healthy functioning of the parental couple can enhance this primary relationship and each parent's bond to the child.

Psychodynamic Therapy explores a woman's unique history and reveals how that history influences her reactions to the emotional challenges she is currently facing.

Group Psychotherapy provides postpartum women with a forum of peer support where they may gain strength by sharing their feelings and experiences with others facing similar obstacles. Group psychotherapy may help decrease isolation, increase self-worth, and restore a sense of normalcy. Group psychotherapy has been shown to be effective in reducing depression, grief, and symptoms of post-traumatic stress disorder. According to the American Group Psychotherapy Association, being surrounded by a peer group helps women heal and regain a sense of hope, increase their self-esteem, and function better within their families.

Sleep

One of the crucial areas of concern for most new mothers is sleep. Cultural ideology about a mother's role has promoted an erroneous belief that exhaustion and sleep deprivation are an expected and integral part of the early months postpartum, without any regard for the potentially serious consequences when a new mother is not sleeping. Current research documents the critical importance of proper sleep for maternal mental health. In fact, the literature on perinatal illness informs that a consistent lack of adequate sleep can actually contribute to the onset of a mood or anxiety disorder postpartum, and in some rare cases, can even trigger a break in reality, setting off a psychotic episode.

Mothers with postpartum depression tend to describe a sense of disorientation, extensive fogginess, difficulty with focus and concentration, as well as impairments in memory, all of which are exacerbated by chronic disruptions in sleep. Any clinical interview should include the following questions:

- *How many hours of uninterrupted sleep are you getting per night?*
- *After your baby returns to sleep, do you return to sleep easily, with difficulty or not at all?*

The mother who is getting less than five hours of uninterrupted sleep a night or who is having difficulty falling and staying asleep should be further evaluated for a perinatal mood or anxiety disorder. Pharmacological treatment for the sleep disruptions that are symptomatic of a postpartum depression are essential, in conjunction with increased support for the new mom during the nighttime hours so as to create opportunities for her to get more rest.

Here are a few ideas to help with sleep:

- *Find someone to take turns to care for the baby for a few hours at night.*
- *Try to nap when the baby is napping during the day.*
- *Turn off the computer and television an hour before bedtime.*
- *Make proper exercise and nutrition a priority.*
- *When necessary, consult with a counselor or physician specializing in perinatal mental health.*

Breastfeeding and Perinatal Mental Health

Breastfeeding can be one of the most wonderful ways a mother has to bond with her infant. When successful, a mother who can breastfeed her baby may feel pride, strength, and a sense of importance in her role as mother. Studies have shown that the benefits of breast milk to an infant are many. In terms of forming a secure attachment between mother and infant, breastfeeding can be a powerful tool.

A woman suffering from postpartum depression or anxiety may find that nursing can improve attachment. Breastmilk production releases calming hormones (prolactin) for the baby and the mother. Encouraging a new mother to breastfeed may be just what she needs to push away the baby blues.

For some women, their struggles with breastfeeding (not producing enough milk, pain, difficulty with expressing milk) can compound their feelings of inadequacy and may contribute to their depression or anxiety. A mother with PMADs may have a distorted perception related to breastfeeding and think, "If I choose not to breastfeed, I am not a good mother!"

> *The profound feelings of guilt, shame, inadequacy, fear, insecurity, abandonment, failure and despair can immobilize the mother and prevent her from taking steps toward recovery.*
>
> *-Karen Kleinman, MSW, www.postpartumstress.com*

What can we do to help?

- Provide education about successful breastfeeding techniques and other forms of infant nutrition.
- If she needs medication, encourage her to talk to her doctor about whether she can take medication that is compatible with breastfeeding.
- Inquire whether breastfeeding is enhancing her self-esteem as a mother or whether it contributes to her feelings of sadness and despair.
- Provide information about peer support to help mom feel good about whatever decision she makes.
- Be aware of your own biases and any cultural influences.

The ultimate goal is to help mom find meaningful ways to bond with her baby. Make sure you talk to her about breastfeeding!

Infant Mental Health

Healthy babies become healthy children.

Infant/family mental health refers to the healthy social and emotional development of infants and toddlers within the context of family well-being and infant-parent relationships. The attachment between mother and infant is central to all areas of development. Infants learn to trust the world and expect their needs will be met, when their caregivers are predictively responsive to their emotional needs. Early nurturance and guidance lay the foundation for enduring meaningful relationships, regulation of emotions and behavior, and the child's initiative to explore, discover, and learn.

It is more likely that a mother will be attuned to her infant's internal state if she herself has a regulated emotional state, family stability, and positive social supports. Disruptions in infant-parent relationships may occur when a mother is overwhelmed by her feelings of depression or anxiety to the extent she is unable to attend to or is unaware of her young infant's emotional needs. If a mother is unable to respond to her baby's internal emotional state and if there is no other primary caregiver available to meet the baby's emotional needs, the young child's mental health may be negatively affected.

Infants with unmet emotional needs often respond with increased fussiness, poor sleep patterns, and difficulty initiating and responding to engagement with caregivers. All of which can result in increased anxiety and depression in a vulnerable mother. This creates a cycle of disconnection, unmet needs, and failure to attune for both caregiver and child.

Infant/family mental health specialists focus on infants' and toddlers' relationships with their parents. Research evidence demonstrates that early intervention is critical in the prevention of later problems potentially impacting child well-being and school readiness. Treatment goals are aimed at the promotion of the child's capacity to turn to caregivers for support and guidance, to develop an eagerness to learn, to focus attention, to persist in the face of challenges, and to form peer relationships.

Behavioral signs in an infant or toddler that may indicate the mother could benefit from extra parenting help include:

- Excessive fussiness
- Sleep problems
- Feeding problems
- Lack of initiating engagement with caregivers
- Lack of responsiveness to tender loving care
- Disinterest in play
- Excessive clinging
- Aggressive behaviors toward self
- Aggressive behaviors toward others
- Overly active
- Excessive fearfulness
- Pervasive sadness
- Long and frequent tantrums

When an infant or toddler exhibits the above behaviors, consultation with an infant mental health professional will be helpful. The goal of helping a mother bond with her infant and guide her infant's development can be achieved by employing dyadic work, family therapy, and individual counseling for the mother.

Helpful Links:

Breastfeeding Task Force of Greater Los Angeles
www.breastfeedla.org

Psychotherapy Interventions for Perinatal Mood and Anxiety Disorders

Cognitive Behavioral
www.nacbt.org

Creative Arts
www.nccata.org
www.adta.org

Dialectical Behavior Therapy
www.perinatalpro.com/pmadbooksandarticles/dbtandppd.html

Dyadic (Mother/Baby)
www.lacgc.org/programs_firststeps.htm
www.projectabc-la.org
www.lachild.org

Emotion Focused Therapy for Couples
www.iceeft.com

Family Therapy
www.familyaware.org

Group Psychotherapy
www.agpa.org

Infant Massage
www.infantmassageusa.org

Infant Mental Health
www.projectabc-la.org
www.lacgc.org

Interpersonal Psychotherapy
www.interpersonalpsychotherapy.org

Psychodynamic Therapy
www.apa.org/news/press/releases/2010/01/psychodynamic-therapy.aspx

SPECIAL CONSIDERATIONS

The special issues discussed here are co-occurring conditions and considerations that can impact perinatal mood and anxiety disorders. This is not meant to be a comprehensive list, nor is it meant to imply that these conditions or circumstances always predict a PMAD. As with all psychosocial generalizations, this list is meant to inform, not to stereotype. Heightened awareness, not assumption, is the goal.

The special issues we address here are:

Adoption
Culture
Homelessness
Infant loss
Infertility
Intimate partner violence
LGBTQI
Military Families
Substance Abuse
Teen Pregnancy

Substance Abuse and **Intimate Partner Violence** are two of the most common issues that coexist with perinatal mood and anxiety disorders. In the case of substance abuse, a PMAD usually precedes the secondary issue. In fact, substance abuse is often described as "self-medicating" to cope with perinatal depression or anxiety. On the other hand, intimate partner violence during the perinatal period most commonly comes first. A PMAD can be the result of family violence.

Adoption Issues:

Adoptive moms (and dads) are at risk of post-adoption depression syndrome (PADS). Like the pregnant mom with a history of infertility, the adoptive mom has probably sustained a lengthy period of high stress. She is likely to have undergone infertility treatment. She is likely to be financially overextended and perhaps physically exhausted from traveling for an international adoption. Sometimes an adoption is arranged with only a few days notice, sending the adoptive parents into a whirlwind of stressful activity after long months or years of feeling like their lives were on hold. There is not a culturally recognized timeline to the waiting period, complete with traditional markers, such as ultrasounds, baby's first kick, and baby showers, so adoptive parents have no signposts to hang onto or to share with their family and friends.

Further, the adoptive mom may not have the kind of family support experienced by the pregnant woman, even though in some ways, she has been an expectant mother. Her parents may be experiencing their own grief over the loss of a biological grandchild.

Due to these factors and many more, it is now recognized that adoptive moms can experience post-adoption mood and anxiety disorders, and, in fact, can have symptoms during the often lengthy period of time before the baby is placed in the home. When sleep deprivation and the usual circumstances of life with a newborn begin, an adoptive mom can be at very high risk.

Some of the adoptive mother's distressing thoughts and fears can be:

- "The birthmother is going to take the baby back."
- "The adoption agency will realize we are not fit parents and will take the baby away."
- "The baby's 'real' mother would know how to do everything right."
- "Does the baby miss her biological mother? Is that why she is crying? I can't help her."
- "Was the baby exposed to drugs? Did the agency/attorney lie to me?"
- "My parents won't feel this baby is a 'real' grandchild."
- "My partner won't love this baby like a real father. He is pretendng."
- "If something goes wrong, my partner will blame me because we adopted due to my infertility. He will leave me."
- "I can't tell anyone how I feel, because everyone thinks I should be thrilled."
- "In order to be a 'real' mother, I have to be perfect."

Adoption Issues (continued)

PMADs can be triggered when these kinds of thoughts and fears overwhelm the new adoptive mother (or father). Anxiety can be present, as well, and can sometimes escalate into obsessive compulsive disorder when the new adoptive parents begin to feel:

> *If I just do (x) behaviors exactly right and exactly the right number of times, no one will come and take my baby away.*

Birthmothers are at very high risk of PMADs, as well, due to issues of loss, guilt, isolation, and familial and cultural disapproval of their choice to make an adoption plan for their baby. While adoption agencies offer both pre- and post-adoption counseling to birthparents, their services are of variable quality. In addition, many adoptions take place outside of the structure of an agency, and birthmothers who use private attorneys and adoption providers often go without crucial emotional/psychological support.

Cultural Issues:

Every culture and religion has its own belief systems and traditions surrounding pregnancy and birth. Some of these beliefs support a healthy pregnancy and new motherhood; some do not. The risk of perinatal mood and anxiety disorders increases if a culture's traditions tend to limit recognition of symptoms and motivation for treatment. Stigma is particularly strong in some cultures, creating an environment in which a woman is unlikely to believe she has a treatable condition or that accessing treatment is an acceptable goal.

Some women from traditional cultures may fear leaving their children in the care of family members who are not aware they are seeking treatment. Since childcare is usually not available in an outpatient setting, this can be a significant barrier to care.

Other barriers are lack of transportation and lack of understanding/distrust of the services and programs that are available.

In recent immigrant populations, these issues can be strongest. Cultural dislocation, language barriers, financial barriers, and immigration status issues compound other stressors and can put immigrant women at extremely high risk. Further, refugee women may bring a history of trauma and symptoms of post-traumatic stress disorder (PTSD) with them to their new country.

In general, women living in poverty who are facing mental health issues have higher rates of co-occurring physical health issues. Access to good primary care is critical, but often lacking. Co-occurring medical conditions can exacerbate perinatal mood and anxiety disorders.

Cultural/Socioeconomic Barriers to Perinatal Mental Health Care:

- Belief systems that exacerbate risk of PMADs or undermine diagnosis/treatment
- Lack of knowledge about/fear of American healthcare system
- Language barriers
- Lack of childcare
- Lack of transportation
- Financial deficit
- Lack of good primary medical care
- History of trauma or PTSD in immigrant/refugee women

How to help:

Ask your client what her culture's beliefs are about pregnancy and childbirth. Ask her to teach you about her special issues. Learn more about her culture by contacting agencies that serve women of her culture/race/ethnicity/religion. Refer to these agencies if it appears they will be supportive. Do not refer to them if it appears they will further shame her. Do not make assumptions.

If referring to a mental health professional, locate one who is culturally sensitive to your client's particular issues.

Barriers to Receiving Mental Health Services For Women of Color and Women Living in Poverty

There are numerous **barriers** women of color and women living in poverty face when trying to receive services for mental health and/or substance abuse problems.

Culturally appropriate services are not always available. Services need to be provided:

- In the patient's language if they are non-English speaking, preferably by someone of a similar culture, race, and background
- By staff who have a clear understanding of the acculturation process
- By staff who can address the needs of immigrant women

Access to Childcare:

- Childcare is usually not available in outpatient settings.
- Some women fear leaving their children with family members who may not be aware that they are receiving treatment.

Access to Transportation:

- Locating programs on bus lines, providing transportation vouchers and offering services in proximity to related programs help keep women motivated and seeking treatment.

Access to Safe Housing:

- A return to a former environment, especially one filled with abuse, is a risk factor for relapse to substance abuse or lack of compliance to medication.
- Safe, affordable housing with adequate space and facilities for children is a critical need in effective treatment of all women, but especially women of color.

Access to Health Care:

- Women with mental health/substance abuse problems have higher rates of co-occurring physical health problems.
- Access to primary care is critical.

Homelessness:

Women are the fastest growing demographic among the homeless. Over 1 million American women experience homelessness every year, which is a tenfold increase since 1963. Single mothers head more than 85% of homeless families; these families include 1.35 million children. Being homeless is extremely traumatic for an adult of either gender, but it can be especially devastating for women, especially for mothers and pregnant women. Further, homeless women are as much as 30% more likely to be or become pregnant than low income housed women.

Homelessness is a significant risk factor for perinatal mood and anxiety disorders; and getting assessment, support and treatment is especially difficult for homeless women simply because of the physical circumstances under which they live. Therefore, a pregnant or postpartum homeless woman is very high risk.

Homelessness is caused by events and co-morbidities that are themselves well-known risk factors for PMADs. A woman who is homeless has usually suffered at least some, if not many, of these as precursors to losing her housing.

Factors that lead to homelessness in women include:

- Domestic violence
- Sexual violence (pregnancy/baby may be a result of rape)
- Substance abuse
- Preexisting mental illness
- History of childhood physical/sexual abuse
- History of incarceration
- Financial crisis
- Recent undocumented immigration
- Disrupted family and social relationships

The number one cause of homelessness in women is domestic violence, and the most common time in a woman's life for the onset or escalation of intimate partner violence is during pregnancy. Therefore, pregnancy, intimate partner violence and homelessness can be a trifecta of circumstances that propels women toward perinatal mood and anxiety disorders.

Sexual violence can be of particular concern in pregnant and postpartum homeless women. Pregnancy may be a result of a rape that caused the woman to leave her home/partner, or the pregnancy may be a result of sexual violence on the streets or in a shelter. Either way, a homeless mother is more likely to have a history of sexual violence or be living with ongoing sexual violence than a woman living in safe shelter. Survival sex (sex for food, money or drugs) is also more common among homeless women.

If it weren't enough for pregnant/post-partum homeless mothers to be stressed by the distressing factors that caused their homelessness, the traumatic environment of homelessness itself and the predicament of what is/was likely a crisis pregnancy, their other children are often a cause of stress themselves. Homeless children are at high risk for psychiatric, developmental, behavioral problems and health problems, which, in itself, is a risk factor for PMADs for a mother.

Living in the dangerous environment of the streets fills a woman with fear for her (and her baby's/children's) safety, which can quickly lead to considerable anxiety. It may cause PTSD from multiple kinds of traumatic street experiences, and almost always results in sleeplessness due to hyper vigilance to nighttime threat, and the noise, lights, weather and physical discomforts that are unavoidable.

Homelessness (continued)

Homeless woman with PMADs have numerous barriers to treatment and recovery. Some of them are:

- Lack of transportation
- Shelter requirements for day-program attendance
- Noncompliance with treatment plan due to lack of a regular daily schedule, including inability to take medicines according to directions
- Poor nutrition
- Poor sleep
- Shame
- Perceived lack of respect and coercion by health care providers
- Poor prenatal care, which increases the likelihood of high-risk pregnancy and poor birth outcomes
- Lack of social support
- Fear of losing baby/children to DCFS if symptoms are disclosed
- Lack of childcare

How to help:

- Build rapport and trust by taking extra time and really "seeing" the woman who is inside the cloak of homelessness. Be aware that you if you don't regularly work with the homeless population you may feel uncomfortable with her due to hygiene issues, behaviors, and what may seem to you to be her "choice" to live as she does. Try to be as nonjudgmental as possible.
- Assess for likely co-morbidities: domestic violence and substance abuse. (See Special Considerations sections on domestic violence and substance abuse.)
- Make warm referrals, i.e., call referral yourself (with client in your office, if possible), make appointment for client, write down information for client, and arrange transportation, if possible.

- Referrals:
  - MediCal : http://www.dhcs.ca.gov/Pages/default.aspx
  - Head Start: 877 773-5543
  - Los Angeles Downtown Women's Center shelter for women: 213 683-3333.
  - Shelters for women and children:
    - Elizabeth House in Pasadena, specifically for pregnant women and their children: 626 577-4434 or www.elizabethhouse.net.
    - Beyond Shelter: 213 252-0772
    - House of Ruth: 323 266-4139
    - Gramercy Place Family Shelter: 213 387-0171
    - Good Sheperd Center Farley House: 213 387 0171
    - Watts Labor Community Action Committee: 323 563-5639
    - Los Angeles Family Housing, North Hollywood: 818 982-4091
    - Harbor Interfaith Services, San Pedro: 310 831-0580

Sources:

Gelberg, L., Browner, C.H., Lejano, E. & Arangua, L. Access to Women's Health Care: A Qualitative Study of Barriers Perceived by Homeless Women, Women and Health, 40:2, 87-100, 2008.

Teruya, C., Longshore, D., Nyamathi, A., Leake, B. & Gelberg, L. Health and Health Care Disparities Among Homeless Women, Women & Health, 50:8, 719-736, 2010.

Infant Loss, SIDS, Miscarriage, Grief and Loss:

According to the March of Dimes, as many as 50% of all pregnancies end in miscarriage most of which will occur in the first three months of gestation. Less frequent, but deeply heart-rending, are late-term miscarriages or stillborn deliveries (about 1% pregnancies in America).

Not all women who have experienced a miscarriage or infant loss will suffer from postpartum depression. Profound sadness and feelings of grief are normal reactions to death and loss and are important to support. However, when bereavement persists for an extended period of time or impacts daily functioning, it may require treatment.

The complexities of miscarriage and infant loss are wide in range. Triggers for painful reactions in individuals who have lost babies may include anniversaries, seeing other babies, seeing pregnant women. Grief may be not only for the loss of a baby, but is compounded by feeling robbed of parenthood. For some women, miscarriages follow long periods of infertility and multiple miscarriages – other losses. Late losses are not necessarily more painful than earlier miscarriages. Stillborn or neonate death may allow for the mother to hold her baby to say goodbye. Some more difficult losses include:

- Loss due to fetal anomaly
- Loss that precipitates a referral to genetic testing due to likelihood of recurrence
- When the circumstances of the loss – where and how – are particularly traumatic (watch for PTSD symptoms)

It is crucial that care for women in the period after a perinatal loss include an understanding of the normal grieving process and different grieving styles (even between spouses). Learning to cope with a loss takes time, patience, and most mourners go through multiple stages before they are able to move beyond. If symptoms of grief begin to lessen over time and resolve within six months to a year, and there is no safety issue, it is not considered a complicated grief. Some symptoms, similar to depression, may persist and greatly impact daily functioning. They may include:

- Preoccupation with loss
- Difficulty accepting the loss
- Inability to trust others
- Intense yearning for the lost baby
- Thinking s/he should have died with the baby
- Intense bitterness
- Blaming self or others

Other symptoms, like those of depression, may persist:

- Lack of interest in activities they used to enjoy
- Social withdrawal
- Guilt and self-blame
- Insomnia or hypersomnia
- Decrease/Increase in appetite
- Hopelessness, or suicidal thoughts

Infant Loss, SIDS, Miscarriage, Grief and Loss (continued)

Moving beyond does not necessitate that the loss cease to be painful. However, an eventual return to functioning and improvement in symptoms indicates that the healing process is occurring. If grief is unresolved, it is often called pathological and may develop into other disorders like post traumatic stress disorder, major depression, general anxiety disorder or other mental health disorders. As well, there is a physiological impact of prolonged unresolved grief. Treatment includes psychotherapy, medication and family support. If pathological grief is suspected, a referral to a healthcare professional may be necessary.

In supporting a couple it is imperative to address them within their cultural context. A burial or other religious rite may be healing, but in some cultures may not be accepted. Recognize the additional challenge of a mother whose body is still producing milk or may appear pregnant despite the infant/fetal loss. Avoid statements like, "It's better your baby died," "She's in heaven now," "You'll have another baby," which are not helpful in recovery.

The following are a few things to say to a mother/couple who has experienced a loss:

- Did you name the baby yet? (if so, use baby's name)
- Who did you feel this child was going to be? ("prospective life review"-- help her express her vision of what this child's life would be and then mourn that particular loss, not a generic child loss)
- What did you think your baby would look like? (again, helping her grieve a more concrete loss)
- Is there someone close to you who has had a similar loss – your mother, sister, friend? Do you feel comfortable sharing your thoughts/feelings with her?

Grief Counselors are available
24/7 at First Candle

1.800.221.7437

http://firstcandle.org

Infertility Issues:

Ten percent of American couples of childbearing age are diagnosed with infertility. The stress of infertility and infertility treatments takes its toll physically and psychologically, leaving a newly pregnant woman who has a history of infertility in a very vulnerable state. Side effects of medicines used to treat ovulation disorders, for example, can be unpleasant and debilitating. The psychological/emotional "side effects" of infertility treatment can be just as debilitating and are often much longer lasting.

Some of the distressing thoughts and fears that can repeatedly go through the mind of a pregnant woman with an infertility history are:

- I'm going to lose this pregnancy.
- I'm defective; therefore, I'm not going to be a good mother.
- Something must not be right in my marriage or we would have gotten pregnant easily (not "meant to be" parents together if it was this hard to achieve).
- Something is going to be wrong with the baby because of the infertility treatments.
- I am sick of feeling terrible from fertility treatments and of being a patient. I don't know that I can stand morning sickness, doctor visits, and everything else that "regular" pregnant women take in stride.
- Now that I'm finally pregnant I don't know if I can actually get through this because I'm already so tired and stressed. I might have a nervous breakdown.
- This isn't really "my" or "his" or "our" baby if sperm/egg donation or surrogacy was used.

These kinds of negative, repetitive thoughts and fears can trigger a PMAD.

How to help:

Refer to **Resolve National Infertility Association**, which has online support, support groups, website, newsletters, education, and workshops.
www.resolve.org
(703) 556-7172

Intimate Partner Violence:

The Centers for Disease Control and Prevention defines domestic violence during pregnancy as "physical, sexual or psychological/emotional violence, or threats of physical or sexual violence that are inflicted on a pregnant woman."

Pregnancy is the most common time of onset and escalation of domestic/intimate partner violence. *The following facts tell the story:*

- The incidence of reported violence during pregnancy ranges from 4 to 20%.
- One in six abused women reports that her partner became abusive during pregnancy.
- A pregnant woman is more likely to experience violence than she is to develop high blood pressure or gestational diabetes.
- Homicide is the leading cause of death during pregnancy.
- The pregnancy itself may be the result of assault, marital rape, or the woman being coerced into having sex without contraception.
- Beatings during pregnancy tend to focus on the abdomen, breasts, and genitals.

Like all domestic abuse, perinatal intimate partner violence is about **power** and **control.** The abuser escalates his/her violence to gain or retain power and control, because the pregnancy threatens his/her position *in the following ways*:

- A pregnant woman must interact with healthcare professionals, to whom she might reveal the nature of her relationship.
- A partner loses the power of his primary dyadic relationship with a pregnant woman. Already it is clear he is "sharing" her with a fetus.
- A pregnant woman gains power as everyone focuses on her – and not the partner.
- A partner didn't want this pregnancy, so feels tricked and trapped.
- A partner believes the pregnant woman cheated on him and the baby isn't his, or he accuses her of this whether or not he believes it to be true.

Intimate Partner Violence (continued)

Living with intimate partner violence can create anxiety/depression in women who are not pregnant, but pregnant women are particularly vulnerable to developing mood disorders from intimate partner violence.

Some of the reasons are:

- Hormonal fluctuations and other physical symptoms of pregnancy
- Shock, shame: How could he hurt me when I am carrying his baby?
- Fear of miscarriage
- Fear he/she will hurt the baby once it is born
- Financial dependence
- Physical reliance on partner if pregnancy is difficult
- Fear of leaving partner and then being alone with baby

Further, pregnant women who are experiencing intimate partner violence are prone to late entry into pre-natal care, missed appointments and fewer postpartum follow-up visits. Therefore, PMADs are less likely to be diagnosed and treated than in women not experiencing violence.

Risk is higher and opportunity for diagnosis and treatment is lower.

An abused pregnant woman's two greatest fears are:

- If I call the police, he/she will kill me/the baby.
- If I call the police, Department of Child and Family Services (DCFS) will take my baby away.

Both fears are actually grounded in fact. Most intimate partner homicides do occur when the women has recently left her abuser. DCFS can remove children from a home in which there is domestic violence.

How to help:

- Address the two fears directly, even if the client doesn't:

  "I'm sure you are afraid he will try to kill you if you leave, but there are safe shelters that will take you now or when the baby is born. Even if DCFS does get involved, witnessing a father's ongoing violence toward a mother is more damaging to a child than temporary DCFS placement."

- Make a safety plan.
- Encourage her to confide in someone trustworthy.
- Make referrals to hotlines, drop-in groups, and shelters.

Intimate Partner Violence (continued)

If you are assisting a client/patient in contacting a shelter, be sure to get permission to reveal to the shelter that client is being seen/treated for or has symptoms of a PMAD, for continuity of care, particularly since going into a shelter is a significant crisis that can exacerbate the illness. Do not assume the client will do this herself.

There are screening tools that can be helpful in determining the level of risk in intimate violence situations. One such tool is the **H.I.T.S. tool**. It can be found at:

Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings
https://www.cdc.gov/violenceprevention/pdf/ipv/ipvandsvscreening.pdf

Lesbian, Gay, Bisexual, Transgender, Queer, Questioning and Intersex Special Considerations:

LGBTQI parents face a multitude of barriers when attempting to access appropriate and affirmative care for PMADs. These include:

- Lack of culturally sensitive and unbiased services:
  - Many medical and birthing professionals may not understand the difference between sex, gender identity, gender expression and sexual orientation.

- Mental health risk factors
  - Intimate partner violence (IPV) – As many as 50% of same-sex partners under the age of 30 experience some form of IPV.
  - Trauma - The LGBTQI population has a higher incidence of childhood traumatic stress, including emotional abuse, peer ostracization and bullying.

- Legal, biological and social concerns for an LGBTQI parent may include:
  - Statutes barring equal marriage rights and lack of legal recognition for non-biological parents
  - Lower socio-economic status due to less fiscal recognition of same-sex families
  - Denied access to family leave due to a lack of marital status or legally recognized parental rights
  - Unique challenges in becoming pregnant, including infertility concerns
  - Family stigma for LGBTQI individuals resulting in loss of family support
  - Limited LGBTQI advocacy groups for LGBTQI raising children while coping with a PMAD

How to Help

Become culturally competent in LGBTQI concerns. Educate yourself about the difference between sexual orientation and gender identity. Engage your client in trauma work around painful childhood experiences and the biased system he/she may be encountering now. Consider using LGBTQI affirmative therapy techniques, in addition to strengths-based therapies. Interpersonal Therapy (IPT) may be particularly helpful for this population, as support systems are often limited due to bias. Consider encouraging clients to begin their own peer support group or use online support groups to counter isolation.

PMADs in Military-Connected Context:

As the number of women serving as active duty members of the US Armed Forces has risen to about 14%, and almost 20% among the Guard and Reserve components, maternal depression is increasingly being recognized as a significant health issue adversely affecting military readiness, children of military families, and the overall health of female service members and veterans, as well as military spouses and their children.

Studies have shown that among military mothers screened for postpartum depression, approximately half were significantly symptomatic. Recent studies have also demonstrated that fathers are also at increased risk for depression and elevated anxiety, especially in the first year after their spouses have given birth. Younger parents (24 years or less) and those with history of depression were shown to be at greatest risk. In 2010, 42.3% (527,670) of all children of active duty personnel were in the 0 to 5 age group, with the vast majority of parents still in their reproductive years. With this issue potentially impacting hundreds of thousands of families, it's urgent that military-connected women and their families be recognized as a population at risk for perinatal mood and anxiety disorders.

Risk Factors and Stimuli for Depression and Anxiety

Preterm delivery (5x more common among active duty women as compared to civilian women)
First pregnancy before age 25
Frequent moves
Extended spousal absence
Financial instability
Limited social support

Military-related issues, including those listed below, may provide ongoing stimuli for depression and anxiety in military-connected women.

- Fear of potential injury or death of self or loved ones
- Premature separation from one's young infant due to deployment and training
- Increased stressors related to single parenting of multiple-aged children
- Divorce, blended families, dual active duty parents
- Financial hardship (brought about by activation to active duty from Guard/Reserve status, and/or veteran reintegration into a stressed job market)
- Families with exceptional needs (mental and/or physical health injury or challenge of a service member, veteran or a family member, Guard and Reserve families) from the Operation Iraqi Freedom (OIF), Operation New Dawn (OND) in Iraq, and Operation Enduring Freedom (OEF) in Afghanistan wars (2002-present) who are experiencing multiple and prolonged deployments are particularly vulnerable.
- Postraumatic stress
- Traumatic brain injury
- Sexual assault (considerably higher rates than community norms)

Emotional burdens of the female spouses of military and veterans also must be recognized as possible contributions to perinatal mood and anxiety disorders in this population.

PMADs in Military-Connected Context (continued)

Treatment Needs: Barriers and Opportunities

The stigma of mental health persists in the military to an even greater extent than in civilian communities. Studies have shown that fear of negative consequences within the military can adversely affect seeking preventive or early intervention and treatment services for mental health concerns. Although health care in the military is quite comprehensive (through TRICARE and at Military Treatment Facilities (MTF)), upon discharge from military service, limitations or lack of adequate medical insurance for female spouses or veterans who are ineligible for care at the Veterans Health Administration (VHA) constitutes a potential treatment barrier Although VHA is the largest integrated health care system in the United States, with 152 medical centers and about 1000 community-based outpatient clinics, its hospitals do not generally provide pregnancy-related care. Eligible female veterans are referred out to fee-based providers who may only be reimbursed for obstetrical care, so fragmented care is a concern.

To help fill the current gap in reproductive mental health care for military-connected women and veterans as their numbers increase, community based providers must become aware and culturally competent to address the special needs and experiences of this population so they can be proactive in screening, assessment, treatment, and promotion of self-care. Increased awareness among community-based programs such as WIC, home visitors, parenting programs, social services, child care providers, and faith-based organizations of military-connected women who may be at-risk for PMADs will support efforts to increase case-identification, prevention, and early intervention services to mitigate challenges within this population. To meet our ethical obligation to our veterans and all-volunteer military community, it is recommended that these providers demonstrate competency in working with military-connected women, as well as their partners, who may be suffering from PMADs.

PMADs in Military-Connected Context (continued)

To achieve this, it is recommended that providers demonstrate the following:

- Understanding of the unique needs of military-connected women (including military sexual trauma, PTSD, traumatic brain injury, and combat operational stress) and their family/support context
- Knowledge of military culture and the range of experiences affecting relationships in military-connected families, including unique issues of Guard/Reserve
- Capacity to establish confidential climate within which trust can be established
- Ability to accurately elicit pre-existing (prior to military service or connection) psychiatric history and current comorbidities
- Ability to provide supportive case management to help ensure compliance and successful engagement with treatment recommendations and accessing of resources
- Capacity to build upon individual's strengths and access to social support with other mothers – especially military-connected women, spouses, and veterans experiencing PMADs
- Ability to deliver home visitation services for prenatal and postpartum mothers to provide monitoring and educational support of their emotional needs and the developmental needs of their infant and other children
- Ability to utilize a multi-disciplinary approach to early identification, intervention and treatment
- Awareness of resources in the community to assist a mother with PMADs, noting need for cultural competence with military-connected women whenever possible
- Capacity to refer military-connected women and their families suffering with PMADs to resiliency-building programs to ensure short-term and long-term resiliency skills acquisition
- Willingness to collaborate with military providers in order to enhance interagency relationships and support community engagement and awareness

Substance Abuse:

Self-medicating with drugs/alcohol to cope with symptoms of undiagnosed or under-treated psychiatric illnesses is common. Perinatal mood and anxiety disorders are no exception. The difference here is that the potential damage is much higher because the substance abuser is putting another life at risk.

The effects of maternal substance abuse on fetus, neonate and infant/child overlap some of the effects of PMADs, thus putting the growing child of a woman who is both using drugs/alcohol and experiencing a PMAD at extremely high risk for the following:

Effects on fetus:

- Decreased oxygen flow to growing organs
- Restricted head circumference development
- Restricted overall size development

Effects on neonate:

- Pre-term delivery
- Low birth weight
- NICU stay
- Withdrawal
- Irritability
- Tremors
- Poor feeding
- Poor muscle tone
- Fetal alcohol syndrome

Effects on baby/child:

- Developmental delays
- Learning disorders
- Increased risk of child abuse/neglect
- Increased risk of being taken into child protective custody, which can exacerbate postpartum mood disorder in the mother
- Increased risk of substance abuse during adolescence

Drugs most commonly used to self-medicate for PMADS:

- Alcohol
- Tobacco
- Marijuana
- Methamphetamine
- Cocaine
- Tranquilizers
- Sleeping pills
- Pain killers

Substance Abuse (continued)

Mother's partner may be the one struggling with abuse of substances. This will affect both the mother and the baby. Be sure to ask about this, as well.

How to refer for treatment:

- Substance abuse + a PMADs = dual diagnosis.
- Refer to residential programs that treat women who have dual diagnoses.
- Refer to outpatient substance abuse treatment and refer to separate PMADs treatment.
- For residential treatment resources in Los Angeles, see **Resources** section.

It can be helpful to use a screening tool to assess substance dependence and abuse. One such tool is the **CAGE Assessment**. See:

https://pubs.niaaa.nih.gov/publications/inscage.htm

Teen Pregnancy:

Teens are extremely high risk for PMADs. Almost one half of adolescent mothers report postpartum depressive symptoms, making teens more than twice as likely to experience a PMAD as adult women.

Teen moms make up a very large group of mothers. In the United States, 750,000 teens become pregnant every year. Eleven percent of all births are to teenage mothers.

Adolescence itself is a high-risk stage of life. Adolescents experiment with drugs, are exposed to violence, and are extremely vulnerable to social pressure. They are in the process of separating from their parents, struggling to fit in with peers, searching for their own identities – traversing the uncertain terrain between childhood and adulthood. They are neither physically nor mentally fully mature, yet they are forced to deal with high levels of stress every day. Adding a pregnancy to this almost certainly creates a serious crisis.

A pregnant teen is at high risk of intimate partner violence, significant substance abuse for self-medication, rejection or physical/verbal abuse from her parents, and being ostracized and bullied by her peers.

PMADs are higher amongst teens in lower economic groups, although a teen pregnancy is often less stigmatized and more supported in Latina families, for example, regardless of financial constraints.

Teens are at greater risk of a second pregnancy soon after delivery than are adult mothers. It has been shown that PMADs tend to increase in severity in subsequent pregnancies.

Some samples of teen mothers reveal moderate to severe depressive symptoms continuing for four years after delivery.

Highly Predictive Factors for Occurrence of Teen PMADs

- Maternal history of teen pregnancy
- History of eating disorder or high level of concern with weight/body shape
- Low self-esteem, which can be a factor in early sexual activity
- Public rejection at school/online by father of the baby
- Pregnancy the result of incest or date rape
- Lack of support from parents
- Target of cyber bullying
- Being from a culture that highly stigmatizes teen pregnancy
- High level of denial (sometimes up to the delivery itself) and guilt

How to help:

In addition to all of the therapeutic modalities recommended for adult women, the following have proved particularly helpful to teens:

- Family counseling
- Group counseling with other teens
- Educational interventions
- Referrals to pregnant and parenting teens programs

Links to Special Considerations:

Adoption

www.adoptivefamilies.com
www.adoptionissues.org
www.adoptionsupport.org
www.cubirthparents.org
https://www.pactadopt.org/app/servlet/HomePage
https://www.pactadopt.org/resources/grief-and-loss-in-adoption.html

Infant Loss

www.californiasids.com/universal/mainpage.cfm?p=10
www.cjsids.org
www.compassionatefriends.org/home.aspx
www.facesofloss.com
www.firstcandle.org/grieving-families
www.marchofdimes.com/baby/loss_miscarriage.html
www.missfoundation.org

Infertility

www.fertilitycommunity.com/fertility/postpartum-depression-and-infertility.html
www.springerlink.com/content/g503t1826jq0737m

Intimate Partner Violence/Domestic Violence

www.domesticviolence.org
www.marchofdimes.com/pregnancy/stayingsafe_abuse.html

Military Families

www.postpartum.net/Get-Help/PSI-Support-for-Military-Families.aspx
www.postpartumprogress.com/postpartum-depression-military-wives-army-marines-navy-air-force

Substance Abuse

www.health.nih.gov/topic/pregnancyandsubstanceabuse
www.marchofdimes.com/pregnancy/alcohol_illicitdrug.html

Teen Pregnancy

www.livestrong.com/article/136548-about-teenage-mothers-depression

MEDICAL PROVIDER PACKET

Medical Provider Packet: Introduction Sheet

Medical providers feel comfortable prescribing medications in most circumstances. Typically, for pregnant or nursing women, more caution is used, and this is certainly appropriate. However, at other times, women with serious mood or anxiety disorders are taken off critical medications and told that they should "push through" because of risks of drug exposure to the fetus or infant. Extensive research demonstrates that untreated mental illness is harmful for both mother and child. This creates a difficult dilemma: "Exposure always occurs, whether to untreated illness or to treatment itself." This packet is designed to help you navigate that dilemma. We will address the following questions:

1. When / how do I screen / assess pregnant and postpartum women for depression?
2. How do I decide whether or not to treat?
3. What interventions do I choose (medication, individual therapy, support groups)?
4. How do I obtain adequate informed consent from the patient and her family?
5. How do I monitor and perform good follow-up care?
6. When do I refer?

In order to address these questions, this packet contains the following materials:

1. Guidelines for Maternal Depression Screening
2. The PHQ9
3. Using the PHQ9 to Move Forward with Assessment and Treatment
4. Assessment Checklist, including Suicide Assessment Guidelines
5. Algorithm for Maternal Depression Care
6. Treatment and Interventions: General Guidelines
7. Risks of SSRI Use in Pregnancy and Lactation
8. Risks of Untreated Depression
9. Guidelines for Monitoring and Follow Up
10. Guidelines for When to Refer
11. Patient Education "Fact Sheet" on SSRI Use in Pregnancy and Nursing

We hope that this packet will increase your comfort level with adequately treating pregnant and postpartum women with significant depression and anxiety. Thank you for your commitment and compassion for this very special, important, and vulnerable population.

Guidelines for Maternal Depression Screening

WHEN Do I Screen?

- At initial prenatal intake
- Once each in the second and third trimesters
- In the postpartum period (two weeks, six to eight weeks, six months)

WHOM Do I Screen?

- ALL WOMEN- you must ask! No one is immune from depression.
- High-risk groups:
  - Women with a personal history of depression, in the postpartum or at any other time
  - Women with a family history of mood or anxiety disorders
  - Women with little social support or victims of intimate partner violence
  - Women with significant medical issues

HOW Do I Screen?

- The Universal Message from Postpartum Support International consists of three short statements that breaks down stigma and creates a relationship of trust:
  - You are not alone.
  - You are not to blame.
  - With the right help, you will get better.
- Use a standard screening tool: the packet uses the PHQ9.
  - The PHQ9 contains a brief, nine-item, patient self-report assessment.
  - It has been validated in pregnant and postpartum populations.
  - It can be used to make a provisional diagnosis (see next page for chart).
  - However, it is NOT a substitute for a clinical diagnosis – if the screen is "positive," a full assessment is critical for clinical diagnosis.
- Privacy Language:
  - "We will not release this information without your permission, unless we are concerned about your safety or the safety of anyone else (including child or elder abuse)."

While a full screening is often necessary, it may not always be feasible. By using the PHQ2 and the Edinburgh Postnatal Depression Scale 3, five simple questions can provide an idea as to whether further assessment is indicated. By adding the questions for anxiety you are less likely to miss PMADs that often manifest more as anxiety.

PHQ2 – Screen for Depression (any "yes" answer warrants a full assessment)

Answer Yes or No

1. During the past month, have you often been bothered by feeling down, depressed, or hopeless?
2. During the past month, have you often been bothered by little interest or pleasure in doing things?

Edinburgh Postnatal Depression Scale 3 – Screen for Anxiety

Answer "Yes, most of the time," "Yes, some of the time," "Not very often," or "No, never."

1. I have blamed myself unnecessarily when things went wrong
2. I have felt scared or panicky for no good reason.
3. I have been anxious or worried for no good reason.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **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 fidgety 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 in some way	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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The PHQ9: Using Scores to Move Forward with Assessment and Care

Using PHQ9 to Screen for Depression

- Add up all scores to questions 1-9
- Compare this score to the grid below to screen for depression severity
- Look at question 9 to screen for suicidality. If answer is a 1 or above, see page 98 for completing a more thorough suicide assessment.
- Look at question 10 to assess the degree of functional impairment; an answer of at least "Somewhat Difficult" is necessary for a provisional diagnosis of depression.

PHQ9 Symptoms and Impairment	*Depression Severity*	*Provisional Diagnosis*	*Treatment Recommendations*
1 to 4 Symptoms, Functional Impairment	<10	Mild or Minimal Depressive Symptoms	Reassurance and/or supportive counseling Education to call if deteriorates
2 to 4 Symptoms, Question (a) or (b) +, Functional Impairment	10-14	Moderate Depressive Symptoms	Watchful waiting Supportive counseling If no improvement after two weeks, consider use of antidepressant or brief psychological counseling
>= 5 Symptoms, Question (a) or (b) +, Functional Impairment	15-19	Moderately Severe Major Depression	Patient preference for antidepressants and/or psychological counseling
>= 5 Symptoms, Question (a) or (b) +, Functional Impairment	>20	Severe Major Depression	Antidepressants and psychological counseling

*If symptoms present for > 2 years,chronic depression, or functional impairment is severe, remission with watchful waiting is unlikely, immediate active treatment indicated for moderate depressive symptoms (minor depression).

**Referral or co-management with mental health specialty clinician if patient is a high suicide risk or has bipolar disorder, an inadequate treatment response, or complex psychosocial needs and/or other active mental disorders. See "When to Refer" sheet for more details.

Assessment Checklist:

After completing the PHQ9 scoring, you should have a good idea of your patient's depression levels. **However, a screening tool score is not the same thing as a clinical diagnosis, and your job for any score above 10, or if the answers to questions about suicidality are positive, is to complete a more thorough assessment. A complete assessment includes the following areas:**

1. Assess depression symptoms and major red flags (see DSM-V Diagnostic Criteria for Depression, Box). The PHQ9 addresses these symptoms directly, and the patient's score should already give you a good idea of her symptoms level.

DSM-V DIAGNOSTIC CRITERIA FOR DEPRESSION

For major depressive disorders, at least five of the following symptoms must be present most of the day, nearly every day, for at least two weeks. At least one of the first two bolded symptoms must be present.

1. **Depressed mood ("feel low, sad, blue")**
2. **Markedly diminished interest in usual activities**
3. Significant increase or decrease in appetite / weight
4. Insomnia / hypersomnia
5. Psychomotor agitation ("speeding up") / retardation ("slowing down")
6. Fatigue or loss of energy
7. Feelings of worthlessness or guilt
8. Difficulty with thinking, concentrating, or making decisions
9. Recurrent thoughts of death or suicide

However, for many pregnant or postpartum women, certain "symptoms of depression" are actually common in a normal pregnancy or postpartum period. These can include sleep disruption, appetite changes, and low energy. Assessing for SEVERITY thus becomes important: for example, wanting to nap in the afternoon in the first trimester is normal; not getting out of bed for days is NOT.

Assessment Checklist (continued)

"Red Flag Symptoms" for Maternal Depression:

- **Sleep:** Sleep is crucial and often hard to get for a new mother. Asking if she is sleeping is not helpful, as she may not be sleeping because of the baby's demands. A much more helpful question is this: "If the baby sleeps, and you have the opportunity to rest, are you able to sleep?" A "NO" answer to this question is a MAJOR red flag for maternal depression.

- **Bond with baby:** Many women do not feel an instant bond with their newborn. However, if several weeks have passed, and a disconnection between mother and child remains, you should suspect depression.

- **Suicidal thinking:** Suicidal thinking is never normal. Women may express the desire to "escape, run to a desert island," etc, but the desire to die requires attention.

- **Thoughts of harming the baby:** This is an EXTREMELY important question to ask and is NOT covered on most standard screening questions. If the answer is YES, explore further. This should be another red flag for an emergent referral to a mental health specialist, as it could be a sign of postpartum psychosis (a serious condition with a 4% infanticide rate and, thus, a true emergency).

The above symptoms can be quickly assessed with the **"The Postpartum Triple Screen":**

1) "Can you sleep when the baby is sleeping / have you slept?"
2) "Are you feeling hopeless?"
3) "Are you having thoughts of harming yourself or others, including the baby? What would stop you from acting on those thoughts?"

IF ANY RESPONSE IS "YES" OR "I DON'T KNOW," SHE DOES NOT SIMPLY HAVE THE BABY BLUES AND THERE NEEDS TO BE A CLINICAL INTERVENTION

2. Assess and document impairment of function. This is also a part of the PHQ9 screen. Other questions that can be helpful include:

- "How are you managing at home? Work? School?"
- "Are there any major tasks which are falling by the wayside? Any balls getting dropped?"
- "Have your relationships gotten tougher recently?"

3. Evaluate pertinent history/comorbid conditions.

MEDICAL AND PSYCHIATRIC RISK FACTORS:

- History repeats itself! High-risk women are those with the following:
  - Personal history of depression at any time
  - Personal history of depression in pregnancy or postpartum
  - Family history of perinatal depression (mother, sister)
  - Personal history of mood changes premenstrually or while on hormonal contraception
- Physical difficulties: nausea/ vomiting, pain, complicated birth
- Unplanned pregnancy
- Infertility history

SOCIAL RISK FACTORS:

- Lack of social support (not "Are you married?" but "How is your marriage?")
- Social isolation ("Who do you turn to when you need to talk?" "Who helps you through a crisis?")
- Intimate partner violence
- Loss of one's own mother (to death, immigration status, etc)
- Low income/financial stress

COMORBID CONDITIONS:

- Substance abuse (For CAGE questions, see **Special Considerations** section)
- Bipolar illness
- Profound anxiety
- Panic attacks
- Obsessions or compulsions

Assessment Checklist (continued)

4. Assess risk of suicide

As part of a complete assessment, suicidality needs to be assessed. ***Suicide is the number one cause of maternal death in the first year postpartum.*** Often there is hesitation on the part of the clinician to ask about suicide. Sometimes clinicians worry that if they ask about suicide, it will "give the patient the idea" and trigger a suicide attempt. This has not proven to be true at all. In fact, most patients feel relieved that someone is asking about their safety and are glad to have the chance to express these distressing thoughts.

Another reason why clinicians often don't ask about suicide is discomfort with *how* to ask. Easy, simple language is best, such as:

- Have these symptoms/feelings we've been talking about led you to think you might be better off dead?
- This past week, have you had any thoughts of harming yourself (or harming your baby)?
- IF YES, what have you thought about? Have you actually done anything to hurt yourself?

Finally, the question always arises of what to do if a patient expresses suicidal thinking. Using answers from the questions above, you can stratify the patient's risk for suicide into the following:

Risk	***Description***	***Action***
Low Risk	No current thoughts, no major risk factors	Continue follow-up visits and monitoring
Intermediate Risk	Current thoughts, but no plans, with or without risk factors	Assess suicide risk carefully at each visit and contract with patient to call you if suicide thoughts become more prominent; consult with an expert as needed
High Risk	Current thoughts with plan	Emergency management by a qualified expert

Assessment Checklist (continued)

We strongly advise having a clinic protocol in place on what to do if a patient demonstrates high risk for suicidality. This can include making sure patient is not left alone or alone with the baby until further help is obtained; calling 911 or a local Psychiatric Emergency Team for immediate assessment; or transferring patient to a mental health expert or emergency room on-site. Having this protocol established and staff trained can go a long way toward decreasing anxiety around screening for suicide.

Treatment and Interventions: General Guidelines

Based on the PHQ9 score and your own clinical assessment, you can now make decisions about interventions. For most women with mild to moderate depression, counseling and/or support groups are preferable to medication. It is important for your clinic to maintain an accurate, up-to-date list of such resources.

For women with moderately severe to severe depression (PHQ9 scores of 15 or higher), antidepressant medications should be seriously considered. However, it is important to remember that there is no clear-cut answer as to what the correct course of treatment is for each woman. **Two individual women, given the same set of symptoms and provided with the same information about treatment options, may make very different choices, based on their personal values, preferences, and symptom history.**

This brings up a few unique aspects of prescribing antidepressants to pregnant and nursing women:

- Remember that for perinatal women who are depressed, there is no easy solution. As one clinician put it, **"Exposure [to the fetus or infant] always occurs, whether it is to treatment or to the illness itself."**
- Your job is not only to serve as clinician, but also as educator and "coach" who helps each woman make choices that are the right ones for her.
- It is essential to feel comfortable with the risks and benefits of both untreated depression and the medications themselves, and to be able to discuss these knowledgably.
- No pregnant or nursing woman is eager to admit depression and to take medication; she already feels like a "bad mother" because of her illness. Sensitivity and a non-judgmental stance are the best treatments you can offer her.

How do I choose a medication?

- Remember safety THROUGHOUT the perinatal period: pregnancy, delivery, and breastfeeding.
- Ideally, you can choose ONE medication that can be used through pregnancy and into the postpartum period. The goal is to minimize the number of exposures to the child and prevent relapse in the mother.
    * Consider what has worked best for the patient in the past
    * Consider what is most tolerable in terms of side effects
- Start with the lowest possible dose and increase as appropriate. Your goal is to treat until symptoms are well-contained. GENERAL RULE: "Start low, go slow, but GO." Treating at sub-therapeutic levels exposes the fetus to risks of both medication and untreated illness.
- Note that the "safest" medication according to the literature may not be the medication that WORKS BEST for your individual patient. It's important to find the approach that works best for her. "Nothing trumps euthymia" in terms of working toward best outcomes.
- Choosing a specific medication can feel overwhelming. However, there are many online reputable resources that provide up-to-date information. Because the research and treatment guidelines change more quickly than this toolkit can go to print, we recommend checking these websites:

www.motherisk.org
www.womensmentalhealth.org

Informed Consent: Nuts and Bolts

- It is vital that risks and benefits of both untreated illness as well as medication exposure are explained and understood by the patient. This needs to be documented in written form in the chart, and ideally, the patient should be given a written copy as well.
- Give her your contact information should questions arise and schedule follow-up within two weeks (see Follow-Up and Monitoring Sheet for more details). Inform her of the following:
    * Most antidepressants take four to six weeks to start working – don't give up!
    * These medications are NOT addictive, but she should not stop suddenly because she may feel physical discomfort.
    * She should let you know if she feels uncomfortable side effects, increase in suicidal thinking, or change in medical or psychiatric status.
- Encourage her to share information with her partner or primary support person and to have him or her accompany patient to next visit.
- Document verbal permission to speak with her primary support person; include that person's contact information in the chart.
- Also obtain a release of information from patient to speak with other treatment providers, including other physicians, therapists, or other medical staff.

Antidepressant Guidelines

Sources of data:
Understanding safety of medications versus illness in pregnant and lactating women is complicated. Randomized, controlled trials are unethical in this population, and there are often many confounders.

■ Pregnancy data: Data summarized here are from controlled studies in human pregnancy. The Food and Drug Administration (FDA) Pregnancy Risk Categories, as found in the Physician's Desk Reference, are based on both animal and human studies. No antidepressants are yet specifically FDA-approved for use during pregnancy. All antidepressants cross the placenta. As such, they are never Category A ("no risk"). Medications that are non-teratogenic in animal studies but have never been studied in humans are classified as Category B. Since teratogenicity does not generalize across species, a Category B classification does not imply greater safety in human pregnancy than a Category C or D classification. Several medications have been shifted from Category B to C or D as their risks became better known.

■ Breastfeeding data: Data about antidepressant effects on breastfeeding babies are predominantly from case reports and case series. For medications with no reported side effects, this does not necessarily mean the medication is "safe"; often it means there are few case reports available.

■ General risks of untreated depression versus selective serotonin reuptake inhibitors (or SSRIS, the most frequently prescribed medications for anxiety and depression) as a class are discussed below. For more specific risks, please see the websites on page 107.

Risk of Untreated Perinatal Depression:

1. On Mother:
- Inadequate or excessive weight gain
- Sleep disruption / excessive fatigue
- Increased risk of substance and tobacco use
- Increased risk of suicidal thinking and behavior
- Fewer prenatal visits and noncompliance with prenatal recommendations

2. On Infant and Neonate
- Increased risk of preterm delivery
- Increased risk of irritability, jitteriness, and excessive crying in at least the first six months of life
- Decreased duration of breastfeeding
- Increased risk of abuse or neglect

3. On Developing Child:
- Cognitive: worse grades in school, poorer performance on cognitive tests
- Behavioral: higher rates of attention deficit hyperactivity disorder and conduct disorder
- Psychological/ Emotional:
    * Higher rates of anxiety and mood disorders
    * Higher rates of anxious attachment
- Stress of living in strained family and / or marital situations

Risks of SSRIs (Selective Serotonin Reuptake Inhibitors):

With any medication prescribed in pregnancy, there are three major categories of risk. In addition, breastfeeding should be considered from the very beginning of treatment. Research is rapidly expanding in this field, but new findings can be incorporated into this basic framework. If these areas are all considered and addressed, you can be confident that you have done a complete informed consent.

1. Birth Defects / Pregnancy Loss

- Data on SSRIs and birth defects is mixed, with some studies showing slight increases in certain birth defects and others showing no increased risk. It is important to note that roughly 1-3% of all babies, regardless of exposure, are born with a congenital abnormality. Any increased risk from SSRI use appears to fall within population norms.
- *One exception: Paroxetine (Paxil) and congenital heart defects*
    - * Raised risk of right ventricular outflow tract abnormalities
    - * Other studies have not shown this rate of increase
- As a class, SSRIs may increase risk of septal heart defects from 0.5% to 0.9%.
- Antidepressants may increase miscarriage rate, but rates are still within the population norms. Data is unclear and further exploration needed, but patient should be advised (particularly if high risk for miscarriage based on medical history or condition).

2. Medical Issues / Perinatal Concerns

- On average, babies exposed to SSRIs are born one week earlier.
- Increased risk of preterm delivery, from control group rate of 6% to SSRI-exposed rate of 22%. However, untreated depression increased risk of preterm delivery to 20%.
- Increased risk of Poor Neonatal Adaptation (PNA; also called Discontinuation Syndrome or Neonatal Abstinence Syndrome). Rates increase from a population norm of 5-10% to roughly 10-30% in babies exposed to SSRIs. Symptoms include respiratory distress, irritability, jitteriness, hypotonicity, poor latching and feeding, and in rare cases, seizures. The syndrome is self-limited and treatment is symptomatic; there are no reported deaths Poor Neonatal Adaptation is often erroneously referred to as “withdrawal.”
- Possible increased risk of Persistent Pulmonary Hypertension of the Newborn (PPHN). The initial study demonstrating risk showed an increase from 1/1000 (population norm) to 6/1000. Subsequent studies have showed at most an increased risk from baseline population of 1/1000 to 2/1000.

3. Long-term Effects on the Child

- One study in 2011 explored a possible association between SSRI use in pregnancy and a 1% increase in Autism Spectrum Disorder diagnoses in offspring. Thus far, this study – which had some methodological limitations –has yet to be replicated, though we await future data.
- Overall, there are no clearly documented long-term developmental or cognitive developments to date.

4. Breastfeeding

- Any breastfeeding that a new mother is able to offer her child is a gift.
- Flexibility in approach is often vital to a mother’s mental health.
- If medications are in order while breastfeeding, sertraline (Zoloft) and paroxetine (Paxil) are first-line choices. When studies have been done on infants exposed to these medications through nursing, medication levels in infant serum have been undetectable.
- However, if a mother is stable on another medication, please consider continuing it rather than switching. Please see medication websites for further safety data.

Monitoring and Follow Up

- During pregnancy, check in two weeks after starting medication to make sure side effects are tolerable and that there is no increase in suicidal thinking, anxiety, or manic symptoms.

- During pregnancy, continue to monitor monthly at a minimum, and more frequently as necessary.

- Once a woman delivers:
  - Have her call you two to three days postpartum.
  - Assess her in person at two weeks postpartum.
  - Assess again at six weeks postpartum.

- Have her or her partner call you if any of the following occur:
  - Persistent insomnia
  - Overwhelming anxiety or panic
  - New or worsened suicidal thinking
  - Thoughts of harming the child

INITIAL RESPONSE AFTER FOUR WEEKS OF AN ADEQUATE DOSE OF AN ANTIDEPRESSANT

PHQ9	***Treatment Response***	***Treatment Plan***
Drop of >5 points from baseline	Adequate	No treatment change needed; Follow up in four weeks
Drop of 2-4 points from baseline	Possibly Inadequate	May warrant an increase in antidepressant dose
Drop of 1 point, no change, or increase	Inadequate	Options include: Increase dose Augmentation Switch Psychiatric consultation Add psychotherapy

The goal of acute phase treatment is remission of symptoms so that patients will have a reduction of the PHQ9 to a score <5. Patients who achieve this goal enter into the continuation phase of treatment. Patients who do not achieve this goal remain in acute phase treatment and require some alteration in treatment (dose increase, augmentation, combination treatment). Patients who do not achieve remission after two adequate trials of antidepressant and/or psychological counseling or by 20 to 30 weeks should have a psychiatric consultation for diagnostic and management suggestions.

When to refer?

When to refer to mental health specialist?

- Severe sleeplessness, even when baby sleeps
- Thoughts of harm to self or baby
- Hearing voices or feeling paranoid
- Neglect or pronounced disconnection to infant
- Panic attacks
- Obsessions and compulsions
- Severe drop in appetite
- Patient preference
- No response or relief after two medication trials

Additional helpful links:

www.motherisk.org
www.womensmentalhealth.org

CLIENT HANDOUTS

Taking Care of Mom

Chances are that when mama is happy, the rest of the family is, too. Being a good parent means knowing when it is important to care for yourself. A mother who gets enough sleep, eats well, has a reliable support network and is able to find activities that she enjoys is more able to be present for the challenging tasks of parenting. These behaviors may not eliminate her depression or anxiety, but can improve her state of mind and do contribute to a wellness plan that may include medication and therapy, as well. Here are some tools that may be helpful when working with a new mom. Sometimes they can even play a role in prevention. We have included information about healthy nutrition, support networks, pleasurable activities, and medication management. Please copy and distribute these to families who may find them helpful.

6 Things
Every New Mom and Mom-to-Be Should Know About Perinatal Depression

1
Perinatal depression is common

It is, in fact, the number one complication of pregnancy. In the US, 15% to 20% of new moms, or about 1 million women each year, experience perinatal mood and anxiety disorders, and some studies suggest that number may be even higher.

YOU ARE NOT ALONE.

Perinatal depression can affect any woman regardless of age, income, culture, or education.

2
You may experience some of these symptoms

- Feelings of sadness
- Mood swings: highs and lows, feeling overwhelmed
- Difficulty concentrating
- Lack of interest in things you used to enjoy
- Changes in sleeping and eating habits
- Panic attacks, nervousness, and anxiety
- Excessive worry about your baby
- Thoughts of harming yourself or your baby
- Fearing that you can't take care of your baby
- Feelings of guilt and inadequacy
- Difficulty accepting motherhood
- Irrational thinking; seeing or hearing things that are not there

Some of the ways women describe their feelings include:

I want to cry all the time.
I feel like I'm on an emotional roller coaster.
I will never feel like myself again.
I don't think my baby likes me.
Everything feels like an effort.

3
Symptoms can appear any time during pregnancy, and up to the child's first year

Baby blues, a normal adjustment period after birth, usually lasts from two to three weeks. If you have any of the listed symptoms, they have stayed the same or have gotten worse, and you're five to six weeks postpartum, then you are no longer experiencing baby blues, and may have a perinatal mood or anxiety disorder.

4

You did nothing to cause this

You are not a weak or bad person. You have a common, treatable illness. Research shows there are a variety of risk factors that may impact how you are feeling, including your medical history, how your body processes certain hormones, the level of stress you are experiencing, and how much help you have with your baby.
THIS IS NOT YOUR FAULT.

5

The sooner you get treatment, the better

Recent studies show that your baby's well-being and development are directly tied to your physical and emotional health. You deserve to be healthy, and your baby needs a healthy mom in order to thrive. Don't wait to reach out for HELP. It is available.

6

There is help for you

There comes a time in every woman's life when she needs help. NOW is the time to reach out to a caring professional who is knowledgeable about perinatal depression and who can help you through this time of crisis. He or she can understand the pain you are experiencing and guide you on the road to recovery. Contact Postpartum Support International, 1.800.944.4773 or www.postpartum.net, for referrals and support near you.

Taking Care of Mom

Chances are that when mama is happy, the rest of the family is too. Being a good parent means knowing when it is important to care of yourself. Someone who gets enough sleep, eats well, has a reliable support network, and is able to find activities that she enjoys is more able to be present for the challenging tasks of parenting. These behaviors may not eliminate your depression or anxiety, but do contribute to a wellness plan that may include medication and therapy as well.

Here are some tools that may be helpful:

Building a Network of Support

What is a support network?

A social support network can be a powerful tool in coping with maternal depression and anxiety. This support network can be made up of friends, family, peers, members of your church, parents at your children's school or even neighbors. Having a network you can rely upon can help you get through challenging times, increase your sense of belonging to a community, and help you feel better about yourself. When you have a support network, you may even feel safer.

Why do I need a support network?

- A caring ear to talk to about parenting, your feelings, your relationships, or just to talk
- A loving shoulder to cry on when things are difficult
- An enthusiastic response to your good news
- Help in caring for your baby
- Help in grocery shopping, with recipes, cooking
- Information about schools, resources
- An understanding presence when you are struggling

How do you build a support network?

Some people are fortunate enough to have a nurturing family that provides support. Others live far away or have more complicated relationships with their families. Building a support network takes effort and creativity. You may find a friend at a park, the coffee shop, the grocery store, the doctor's office, the library or at church. You may find that you have a lot in common with someone and that forms a bond. On the other hand, you may be very different from someone but have the same values. What matters most is that you have a caring and trusting friend. The key is to be open and willing to reach out.

How do I keep my support network?

Nurturing your support network takes effort. The best times to build your network are when you are in a strong place. However, the times you may need your network most are when you are struggling. Here are some things to keep in mind:

- Stay in contact when things are good and when they are not.
- Share your appreciation and gratitude.
- Be open to meeting new people even when you are busy and overwhelmed.
- Offer to help but don't be afraid to receive help too.
- Be kind and not overly critical of your support network. Communicate when you are feeling hurt.
- Reach out, even when you may not feel like it. Being isolated is a key symptom of depression.

Healthy Eating

Healthy eating gives you energy to get through your day and be a better mom. Here are some things to keep in mind when coming up with a meal plan:

- Eat a variety of foods.
- Make sure you have enough dairy, protein, vegetables, and fruits in your diet.
- Avoid skipping meals.
- Whole grain breads, pastas, oatmeal and brown rice are healthy carbohydrates that keep you going throughout the day.
- Try to reduce your fat, salt, and sugar intake. Read nutrition labels to make sure the foods you choose have the nutrients you need and lower fat, sodium and sugar.
- Drink plenty of water. If you are breastfeeding, this can help you produce enough milk. Avoid drinking sodas.
- Eat three main meals a day with several small snacks in between.
- Healthy snacks can include carrots, apples, nuts, cheese sticks, hummus, and pita.
- Look for low fat options such as fat free milk, low fat cheese, baked or grilled chicken.

Sleep

One of the crucial areas of concern for most new mothers is sleep. Ask yourself:

- How many hours of uninterrupted sleep am I getting per night?
- After my baby returns to sleep, do I return to sleep easily, with difficulty or not at all?

Here are a few ideas to help with sleep:

- Find someone to take turns to care for the baby for a few hours at night.
- Try to nap when the baby is napping during the day.
- Turn off the computer and television an hour before bedtime.
- Proper exercise and nutrition can help with sleep disruptions.
- When necessary, consult with a counselor or physician specializing in maternal mental health.

If you are getting less than five hours of uninterrupted sleep or have difficulty falling asleep, you may need to consult with your doctor.

Exercise

Sometimes, the endorphins released when you exercise can improve your mood. Staying fit gives you more energy and may help you lose the weight gain from your pregnancy. However, make sure your doctor gives his/her “okay” before you start your exercise plan. You may even want to include a friend in your exercise plan to help motivate you. Some activities you can do with the baby include:

- Walking
- Hiking
- Dancing
- Yoga
- Bike riding (use proper gear – helmets, baby seat, etc.)

Pleasurable Activities

Engaging in things we enjoy helps us to feel better. When someone is depressed, the depression itself can get in the way of even being able to think of activities you enjoy.

Here is a list of activities that some people like to do. Look through the list and see what you might want to try. If it doesn't work out, try something else. Soon, you may find that you feel just a little bit better.

Collecting things (coins, shells, etc.)
Dancing in the living room
Thinking how it will be when…
Recycling old items
Going on a date
Singing
Arranging flowers
Practicing religion (going to church, prayer, etc.)
Going on a hike or walk
Stay at home date/picnic in the living room
Relaxing and resting
Thinking "I have done a full day's work"
Listening to music
Soaking in the bathtub
Laughing
Listening to others
Doing hobbies
Spending time with good friends
Planning a day's activities

Meeting new people (at the park, etc.)
Remembering beautiful scenery
Saving money (clipping coupons)
Eating a healthy meal
Repairing things at home
Remembering the positive words and deeds of loved ones
Doodling
Exercising
Being with family
Riding a bicycle
Dancing
Doing something spontaneously
Knitting, needlework, sewing
Going to group meetings
Doing arts and crafts
Making a card or gift for someone
Cooking or baking

Playing musical instruments
Doing arts and crafts
Making a card or gift for someone
Cooking or baking
Writing poems, letters or journaling
Gardening
Painting my nails
Enjoying coffee or tea
Watching my children smile, play, grow
Focusing on my positive qualities
Finding free local events
Daydreaming
Completing a task
Eating a treat
Taking pictures
Thinking about pleasant events
Playing with animals
Reading a book, magazine or newspaper
Finding private time
Cleaning
Going on a picnic
Thinking "I did that pretty well" after doing something
Meditating
Playing cards
Solving crossword puzzles
Seeing and/or showing photos
Dressing up and looking nice
Reflecting on how I've improved
Talking on the phone
Going to museums
Lighting candles
Saying "I love you"
Going to the library
People watching
Trying something new
Thinking "I'm a person who can cope"
Showing an interest in what others say
Enjoying the good things that happen to others
Complimenting/praising someone
Accepting a compliment
Watching a sunset
Going to a garage sale
Helping someone else
Rearranging my room or home
Doing volunteer work
Getting a haircut/hair done
Saying prayers
Sitting in the sun

Medication Information

Exposure always occurs, be it to treatment or illness

Risks of untreated depression in pregnancy:

Risks to Mother's Health	Risk to Baby's Health
Appetite changes/poor weight gain	Small for gestational age
Sleep problems /fatigue	Preterm delivery
Higher risk of postpartum depression	Low birth weight
Poor prenatal care	Lower APGAR scores
Increased risk of alcohol or drug use	Elevated stress hormones
Suicidal thoughts and/or actions	Increased crying and irritability
	Poor bonding to mother
	Increased risk of neglect/abuse

Risks of untreated postpartum depression:

- Mothers tend to breastfeed for less time.
- Mothers have difficulty forming bonds with baby, and baby also has problems with attachment to mom.
- Moms can have worse anxiety and depression later on in life.
- Moms may have problems with their other relationships.
- Children of depressed mothers get worse grades in school and have an increased risk for mental illness.

Treatment options:

- Psychotherapy (or talk therapy)
- Support groups
- Medications

Risks of medication for depression:

- Birth defects:
  - SSRIs are unlikely to cause birth defects.
  - However there is a small risk of heart defect with all types of SSRIs but especially with Paxil.
- Medical problems in pregnancy:
  - Babies are at more risk for low birth weight or preterm delivery.
  - Mom is at more risk for high blood pressure during pregnancy.
  - However, depression raises risk for early delivery or high blood pressure about as much as medications do.
  - Moms need to consider the risks of medication versus risks of untreated depression.
- Medical problems at birth:
  - PNA – "Poor Neonatal Adaptation"
    - * Babies may experience jitteriness, irritability, breathing problems, or feeding problems.
    - * These are usually mild and go away on their own. Symptoms last 48-72 hours and can be treated.
  - PPHN – "Persistent Pulmonary Hypertension of the Newborn"
    - * There is a small increase in risk of this serious and at times fatal condition – from 1 in 1000 to between 2-4 in 1000 newborns.
- Long-term effects:
  - There are no long-term problems in intelligence, hitting milestones, or behavior in the babies whose mothers took SSRIs.

Risks of SSRI use in breast feeding:

- Medications cross into breast milk, just as they cross the placenta in pregnancy, but in smaller amounts.
- Nortriptyline, paroxetine, and sertraline have been shown to cross into breast milk the least and thus are safest.
- No bad effects of these medications have been reported in breastfeeding babies.

Sleep hygiene and social support is extremely important:

- Getting a good night's rest is crucial for the treatment of depression.
- Ask for partner or family support, take turns with baby, consider pumping if breastfeeding.
- Work with family and friends to get the help you need, so you can be the best mom you can be.

SPANISH

Perinatal mental health disorders cross all cultural, ethnic and socio-economic lines. While there are cultural differences in the treatment of mental health concerns, women across the world struggle with maternal depression and anxiety. Isolation is an enormous risk factor and symptom of maternal depression. Our efforts are to reduce this isolation with education and materials in languages other than English. There is a greater likelihood that we will reach mothers in need by having materials available that are culturally competent and in the language of the individuals we hope to serve. In Los Angeles, the Spanish language is widely spoken. By providing a section with materials in Spanish, we do not mean to imply that this is the only community that requires information in its language of origin. We are merely beginning to reach out to a greater community.

El Cuidado de la Mamá

Lo más probable es que cuando mamá está feliz, el resto de la familia también lo está. Ser un buen padre significa saber cuándo es importante cuidarse a sí mismo. Una madre que duerme lo suficiente, come bien, tiene una red de apoyo confiable, y es capaz de encontrar actividades que le gusta es más capaz de estar presente en las difíciles tareas de la crianza de los hijos. Estos comportamientos no pueden eliminar la depresión o la ansiedad, pero sí contribuyen a un plan de bienestar que puede incluir medicamentos y terapia. Éstos son algunos consejos que pueden ser útiles:

La Construcción de una Red de Apoyo

¿Qué es una red de apoyo?

Una red de apoyo social puede ser una poderosa herramienta para hacer frente a la depresión materna y la ansiedad. Esta red de apoyo puede estar compuesta por amistades, familiares, compañeros, miembros de su iglesia, los padres en la escuela de sus hijos e incluso vecinos. Tener una red a la que puede confiar en que puede ayudar a superar los momentos difíciles, aumentar su sentido de pertenencia a una comunidad, y ayudarle a sentirse mejor consigo misma. Cuando usted tiene una red de apoyo, incluso se puede sentir más segura.

¿Por qué necesito una red de apoyo?

- Un oído atento a escuchar acerca de la crianza, sus sentimientos, sus relaciones, o simplemente hablar con alguien
- Un hombro para llorar cuando las cosas son difíciles
- Una respuesta entusiasta a sus buenas noticias
- Ayuda en el cuidado de su bebé
- Ayuda en la compra de comestibles, con recetas de cocina
- Información sobre escuelas, recursos
- Una presencia comprensiva cuando usted está luchando

¿Cómo se construye una red de apoyo?

Algunas personas tienen la suerte de tener una familia acogedora que proporciona apoyo. Otros viven lejos o tienen una relación más complicada con sus familias. La construcción de una red de apoyo requiere de esfuerzo y creatividad. Usted puede encontrar una amiga en un parque, la cafetería, la tienda de comestibles, la oficina del médico, la biblioteca o en la iglesia. Puede encontrar que usted tiene mucho en común con alguien y que forma un enlace. En otras ocasiones, puede ser muy diferente entre sí pero tienen los mismos valores. Lo que más importa es que usted tiene una buena amiga en quien confiar. La clave es estar abierta y dispuesta a pedir ayuda.

¿Cómo puedo mantener mi red de apoyo?

Fomentar su red de apoyo requiere de esfuerzo. Los mejores momentos para construir su red es cuando usted está en un lugar fuerte. Sin embargo, las veces que puede necesitar su red más es cuando usted está luchando. Aquí están algunas cosas a tener en cuenta:

- Manténgase en contacto cuando las cosas son buenas y cuando no lo son.
- Comparta su aprecio y gratitud.
- Esté abierta a conocer gente nueva, incluso cuando usted está ocupada y abrumada.
- Ofrezca ayuda, pero no tema recibir ayuda también.
- Sea amable y o demasiado crítica de su red de apoyo, cuénteles cuando se sienta mal.
- Pedir ayuda, incluso aunque no tenga ganas. El aislamiento es un síntoma clave de la depresión.

La alimentación saludable

La alimentación saludable le da energía para pasar el día y ser una mejor madre. Aquí están algunas cosas a tener en cuenta cuando piense en un plan de alimentación:

- Coma una variedad de alimentos.
- Asegúrese de tener suficientes lácteos, proteínas, verduras y frutas en su dieta.
- Evite saltarse las comidas.
- Panes de granos integrales, pastas, avena y arroz integral son carbohidratos saludables para tener energía durante todo el día.
- Trate de reducir su grasa, sal y azúcar. Lea las etiquetas nutricionales para asegurarse de que los alimentos que usted elija tienen los nutrientes que necesita y menor grasa, sodio y azúcar.
- Tome mucha agua. Si usted está amamantando, puede ayudarle a producir suficiente leche. Evite beber bebidas gaseosas, la cafeína y el alcohol.
- Coma tres comidas principales al día con varios aperitivos en el medio.
- Bocadillos saludables pueden incluir zanahorias, manzanas, frutos secos, palitos de queso, puré de garbanzos y pan pita.
- Busque opciones bajas en grasa como la leche sin grasa, queso bajo en grasa, pollo al horno o a la parrilla.

El sueño

Una de las áreas cruciales de preocupación para la mayoría de las nuevas madres es el sueño. Pregúntese a usted misma:

- ¿Cuántas horas de sueño ininterrumpidas tengo por noche?
- Luego que mi bebé se vuelve a dormir, ¿me duermo fácilmente, con dificultad, o no logro dormir? Aquí hay algunas ideas para ayudar con el sueño:
- Encuentre a alguien que se turne con usted por algunas horas en la noche para cuidar al bebé.
- Trate de dormir cuando el bebé está durmiendo la siesta durante el día.
- Apague el ordenador y la televisión una hora antes de acostarse.
- El ejercicio y una nutrición adecuada puede ayudar a las perturbaciones del sueño.
- Cuando sea necesario, consultar con un consejero o un médico especializado en salud mental perinatal.

Si usted está recibiendo menos de 5 horas de sueño ininterrumpido o tienen dificultades para conciliar el sueño, puede que tenga que consultar con su médico.

El ejercicio

A veces, las endorfinas liberadas cuando hace ejercicio pueden mejorar su estado de ánimo. Mantenerse en forma le da más energía y puede ayudar a bajar la ganancia de peso de su embarazo. Sin embargo, asegúrese de que su médico le da su visto bueno antes de empezar su plan de ejercicio. Incluso se puede incluir a una amiga/una amistad en su plan de ejercicio para ayudar a motivarla. Algunas de las actividades que puede hacer con el bebé incluyen:

- Caminar
- Danza
- Yoga
- Andar en bicicleta (Usar el equipaje apropiado - cascos, asientos para bebés, etc)

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Planifique con anticipación

Mientras que usted todavía está embarazada, haga un plan para que usted tenga el apoyo adecuado para las primeras semanas después del parto. Piense en dejar comidas preparadas y congeladas antes de que nazca el bebé, para que, tras el parto, no tenga que gastar tiempo en eso. Decida antes del nacimiento del bebé, cómo puede reducir sus responsabilidades y cambios en su horario para disminuir su estrés.

El pedir ayuda

No sea tímida acerca de cómo obtener la ayuda de su esposo o pareja, amigos de confianza y de la familia con quien se sienta cómoda. Deje que se hagan cargo de las tareas del hogar, como la preparación de algunas comidas, lavar la ropa, las compras o ayudar a otros niños en la casa, para que usted pueda descansar y pasar tiempo con su bebé.

Sea buena con usted misma

No se preocupa por vestirse durante el primer par de semanas en casa. Permanezca en su pijama. Le recordará a usted y a los demás que aún se está recuperando tras el parto. Pídale a alguien de su confianza quedarse con el bebé, incluso durante períodos de tiempo muy corto, para que pueda tener un momento para sí misma.

Las actividades placenteras

Participar en las cosas que disfrutamos nos ayuda a sentirnos mejor. Cuando alguien está deprimido, la depresión en sí misma puede ser un obstáculo para poder pensar en actividades que disfrute.

He aquí una lista de actividades que a algunas personas les gustan hacer. Mire la lista y vea lo que podría querer probar. Si no funciona, pruebe otra cosa. Al poco tiempo, es posible que se sienta un poco mejor.

Coleccionar cosas (monedas, conchas, etc)
Bailar en la sala de estar
Pensar en cómo será cuando ...
Reciclaje de viejos temas
Ir a una cita
Cantar
Arreglos florales
La práctica de la religión (ir a la iglesia, la oración, etc)
El ir de excursión o paseo
Tener una cita/picnic en la sala de estar
Relajarse y descansar
Pensando que han hecho un trabajo de un día completo
Escuchar música
Sumergirse en la bañera
Reír
Escuchar a los demás
Hacer pasatiempos
Pasar tiempo con buenos amigos
Planificación de las actividades de un día
Conocer a gente nueva (en el parque, etc)
Recordar bellos paisajes
Jardinería
Pintarme las uñas
Disfrutar de café o té
Mirar a mis hijos sonreír, jugar, crecer
Centrarme en mis cualidades positivas
Encontrar libre eventos locales
Soñar despierto
Completar una tarea
Comer una golosina
Tomar fotos
Pensando en eventos agradables
Jugar con animales
Leer un libro, revista o periódico
Encontrar el tiempo privado
Limpiar
Ir a un picnic
Pensar “que lo hice bastante bien” después de hacer algo
Meditar
Jugar a las cartas
Resolver crucigramas
Ver y / o mostrar fotos
Reflexionar sobre cómo hemos mejorado
Hablar por teléfono
Ir a museos
Ahorrar dinero (corte del cupón)
Comer una comida saludable
Reparación de las cosas en casa
Recordar las palabras y los hechos positivos de seres queridos
Dibujar libremente
El ejercicio
Estar con la familia
Andar en bicicleta
Bailando
Hacer manualidades o artesanías
Hacer algo espontáneamente
Tejido, bordado, costura
Asistir a reuniones de grupo
Tocar instrumentos musicales
Hacer artes y oficios
Realización de una tarjeta o un regalo para alguien
Cocinar u hornear
Escribir poemas, cartas o diario
Encender las velas
Decir “Te amo”
Ir a la biblioteca
Observar a la gente
Intentar algo nuevo
Pensar “yo soy una persona que se la puede”
Mostrando interés en lo que otros dicen
Disfrutar de las cosas buenas que suceden a los demás
Complementando / alabar a alguien
Aceptar un cumplido
Viendo una puesta de sol
Ir a una venta de garaje
Cómo ayudar a alguien más
Reorganización de mi cuarto o en el hogar
Hacer trabajo voluntario
Conseguir un corte de cabello / pelo hecho
Decir oraciones

6 Cosas
Cada Nueva Mamá Debe Saber Sobre La Depresión Perinatal y Portparto

1

La depresión perinatal es muy común.

De hecho, esta es la complicación más frecuente del embarazo. En los Estados Unidos, entre el 15% y el 20% de las nuevas madres–casi 1 millón de mujeres cada año–experimenta una depresión postparto, y según algunos estudios, esta cifra podría ser aún más elevada.

USTED NO ESTÁ SOLA.

La depresión durante el embarazo y postparto afecta a mujeres de cualquier edad, nivel económico y raíces raciales o étnicas.

2

Usted podría experimentar algunos de estos síntomas

- Sentirse deprimida, triste o llorar mucho.
- Sufrir altibajos en el estado de ánimo, sentirse abrumada.
- Experimentar problemas para concentrarse.
- Sentir falta de interés o placer por las actividades que antes disfrutaba.
- Experimentar cambios en las rutinas para dormir o comer.
- Sufrir un ataque de pánico, nervios o ansiedad.
- Estar extremadamente preocupada por el bebé.
- Tener miedo de lastimar al bebé o a usted misma.
- Dudar de su capacidad de ser buena madre.
- Sentirse inútil y culpable.
- Tener dificultad para aceptar la maternidad.
- Tener pensamientos irracionales o alucinaciones.

Algunas mujeres describen sus sentimientos así:

Me dan ganas de llorar todo el tiempo.
Me siento como si estuviera en un subibaja emocional.
Nunca me sentiré como yo misma otra vez.
No creo que mi bebé me quiera.
Todo me parece difícil.

3

Los señales pueden aparecer en cualquier momento del embarazo o el primer año después de dar a luz.

La disforia postparto (*baby blues* en inglés) es un sentimiento normal después del nacimiento del bebé, y puede durar entre 2 y 3 semanas. Si usted ha experimentando algunos de los síntomas de la lista anterior y si se siente igual o peor 5 o 6 semanas después del nacimiento, ya no se trata de los *baby blues*. Es posible que sea la depresión postparto.

4

Usted no hizo nada para causar esta situación.

Esto no significa que usted sea débil o mala. Al contrario, la depresión perinatal es una enfermedad común y tratable. Diversas investigaciones identifican varios factores de riesgo tales como su historia médico, la forma en que su cuerpo procesa ciertas hormonas, el grado de estrés que está experimentando, y el apoyo con el que cuenta para cuidar a su bebé. Lo que sí sabemos es que NO ES SU CULPA.

5

Es mejor que reciba tratamiento cuanto antes.

Estudios recientes han demostrado que la salud de su bebé está directamente relacionada con el estado físico y emocional de usted–su mamá. Usted merece gozar de buena salud y su bebé necesita una madre saludable para prosperar. Hay AYUDA disponible. ¡Búsquela!

6

Hay ayuda disponible.

Toda mujer necesita ayuda en algún momento de su vida. AHORA es el momento de buscar a un profesional de salud compasivo y bien informado acerca de la depresión perinatal que le pueda ayudar a superar este momento de crisis. Él comprenderá el dolor que está experimentando y le guiará hacia la recuperación. Comuníquese con Postpartum Support International al 1.800.944.4773 o www.postpartum.net para referencias y apoyo en su área.

SPANISH

CUESTIONARIO SOBRE LA SALUD DEL PACIENTE-9 (PHQ-9)

Durante las últimas 2 semanas, ¿qué tan seguido le han afectado cualquiera de los siguientes problemas? *(Marque con una "✔" para indicar su respuesta)*	**Para nada**	**Varios días**	**Más de la mitad de los días**	**Casi todos los días**
1. Poco interés o placer en hacer las cosas	0	1	2	3
2. Se ha sentido decaído(a), deprimido(a), o sin esperanzas	0	1	2	3
3. Dificultad para dormir o permanecer dormido(a), o ha dormido demasiado	0	1	2	3
4. Se ha sentido cansado(a) o con poca energía	0	1	2	3
5. Con poco apetito o ha comido en exceso	0	1	2	3
6. Se ha sentido mal con usted mismo(a) – o que es un fracaso o que ha quedado mal con usted mismo(a) o con su familia	0	1	2	3
7. Ha tenido dificultad para concentrarse en cosas tales como leer el periódico o ver televisión	0	1	2	3
8. ¿Se ha estado moviendo o hablando tan lento que otras personas podrían notarlo?, o por el contrario – ha estado tan inquieto(a) o agitado(a), que se ha estado moviendo mucho más de lo normal	0	1	2	3
9. Ha pensado que estaría mejor muerto(a) o se le ha ocurrido lastimarse de alguna manera	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

Si usted marcó cualquiera de estos problemas, ¿qué tan difícil fue hacer su trabajo, las tareas del hogar o llevarse bien con otras personas debido a tales problemas?

Para nada difícil	**Un poco difícil**	**Muy difícil**	**Extremadamente difícil**
☐	☐	☐	☐

ESCALA DE EDINBURGO (Spanish Version)

Como usted hace poco tuvo un bebé, nos gustaría saber como se ha estado sintiendo. Por favor SUBRAYE la respuesta que más se acerca a como se ha sentido en los últimos 7 días.
Or
Por favor haga un círculo alrededor de la respuesta que más se acerca a como se ha sentido en los últimos 7 días.

Éste es un ejemplo ya completo:

Me he sentido contenta:
0 Sí, siempre
1 Sí, casi siempre
2 No muy a menudo
3 No, nunca

En los últimos 7 días:

1. He podido reír y ver el lado bueno de las cosas:
   0 Tanto como siempre
   1 No tanto ahora
   2 Mucho menos
   3 No, no he podido

2. He mirado al futuro con placer:
   0 Tanto como siempre
   1 Algo menos de lo que solía hacer
   2 Definitivamente menos
   3 No, nada

3. Me he culpado sin necesidad cuando las cosas marchaban mal:
   0 Sí, casi siempre
   1 Sí, algunas veces
   2 No muy a menudo
   3 No, nunca

4. He estado ansiosa y preocupada sin motivo:
   0 No, nada
   1 Casi nada
   2 Sí, a veces
   3 Sí, a menudo

5. He sentido miedo o pánico sin motivo alguno:
   0 Sí, bastante
   1 Sí, a veces
   2 No, no mucho
   3 No, nada

En los últimos 7 días:

6. Las cosas me oprimen o agobian:
   0 Sí, casi siempre
   1 Sí, a veces
   2 No, casi nunca
   3 No, nada

7. Me he sentido tan infeliz, que he tenido dificultad para dormir:
   0 Sí, casi siempre
   1 Sí, a menudo
   2 No muy a menudo
   3 No, nada

8. Me he sentido triste y desgraciada:
   0 Sí, casi siempre
   1 Sí, bastante a menudo
   2 No muy a menudo
   3 No, nada

9. He estado tan infeliz que he estado llorando:
   0 Sí, casi siempre
   1 Sí, bastante a menudo
   2 Sólo ocasionalmente
   3 No, nunca

10. He pensado en hacerme daño a mí misma:
    0 Sí, bastante a menudo
    1 Sí, a menudo
    2 Casi nunca
    3 No, nunca

SPANISH

Información sobre los medicamentos

La exposición ocurre siempre, ya sea al tratamiento o a la enfermedad

Los riesgos de la depresión no tratar la depresión durante el embarazo:

Los riesgos a la salud de la madre	Los riesgos a la salud del bebé
Cambios del apetito/ insuficiente aumento de peso	Parto prematuro
Problemas en dormir /cansancio	Peso de nacimiento bajo
Un riesgo más alto de la depresión postparto	Bajo puntaje APGAR
Cuidado prenatal inconsistente	Hormonas de estrés elevadas
Riesgo mas alto de uso del alcohol o de la droga	Mayor irritabilidad y llanto
Pensamientos y/o acciones suicidias	Dificultades en el vínculo con la madre
	Pequeño para la edad gestacional
	Mayor riesgo de negligencia/maltrato

Los riesgos de depresión postparto no tratada:

- Las madres tienden a amamantar por menos tiempo
- Las madres tienen dificultad en vincularse con el bebé y el bebé tiene dificultades en el apego con su madre.
- Las madres pueden tener cuadros más graves de ansiedad o depresión más adelante en su vida.
- Las madres pueden tener problemas con sus otras relaciones
- Los niños de madres deprimidas obtienen peores calificaciones en escuela y tienen mayor riesgo de sufrir una enfermedad mental

Opciones del tratamiento:

- Psicoterapia (o terapia de la charla)
- Grupos de apoyo
- Medicamento

Riesgos de medicación para la depresión:

- Defectos de nacimiento:
  - ISRS tienen poca probabilidad de causar defectos de nacimiento
  - Sin embargo hay un pequeño riesgo de defecto del corazón con todos los tipos de ISRS pero especialmente con Paxil
- Problemas médicos en el embarazo:
  - Los bebés presentan mayor riesgo de tener bajo peso de nacimiento o parto prematuro
  - La madre presenta mayor riesgo de tener la tensión arterial alta durante el embarazo
  - Sin embargo, la depresión misma aumenta el riesgo de parto prematuro o elevación de la tensión arterial, al igual que la medicación
  - Las madres necesitan considerar los riesgos de la medicación contra los riesgos de la depresión no tratada
- Problemas médicos en el nacimiento:
  - PNA - "adaptación neonatal insuficiente"
    * Los bebés pueden experimentar ansiedad, irritabilidad, problemas de respiración, o problemas de alimentación
    * Los síntomas son generalmente suaves y se quitan pronto. Los síntomas duran 48-72 horas y pueden ser tratados
  - PPHN - "hipertensión pulmonar persistente del recién nacido"
    * Hay un pequeño aumento en el riesgo de esta condición seria y ocasionalmente fatal - de 1 en 1000, a entre 2 a 4 en 1000 recién nacidos
    * Efectos de largo plazo:
  - No hay problemas de largo plazo en la inteligencia, el desarollo o el comportamiento de los bebés cuyas madres tomaron SSRIs

Los riesgos de el uso de ISRS en el amamantamiento:

- Los medicamentos pasan a la leche materna, igual que como pasaban por la placenta durante el embarazo, sólo que en menor cantidad
- La nortriptilina, la paroxetina y la sertralina son lo más seguros porque se ha demostrado que son los que menos pasan a la leche materna.
- No se han reportado efectos adversos de estos medicamentos en bebés amamantados

El sueño y la ayuda social son extremadamente importantes:

- Conseguir que duerma suficiente por las noches es crucial para el tratamiento de la depresión.
- Pida apoyo a su pareja o familiares, hagan turnos para cuidar del bebé, considere un extractor de leche si amamanta.
- ¡Trabaje con la familia y los amigos para conseguir la ayuda que usted necesita, para que así pueda ser la mejor madre que usted puede ser!

FATHERS/PARTNERS

Having a child is a life-changing experience for the entire family. A shift occurs after the birth of a baby and each family member must adapt to his and her new role. While it is not as widely known, men may experience symptoms of depression and anxiety in the postpartum period. Paternal postpartum depression is currently being researched in greater depth. While paternal postpartum depression symptoms may differ from maternal depression or anxiety, they can still be debilitating to the family functioning.

Another aspect of father care we address in this section is the impact of maternal depression or anxiety on the father and the family. Often, when a mother is suffering, the rest of the family has to pick up the pieces and learn how best to support her and care for the family. We recognize that families may be comprised of two fathers, two mothers, grandparents, extended family and other loved ones. Please utilize the suggestions we offer in caring for mom as a means to be inclusive of anyone you believe could benefit from some education and assistance. We believe that by including the family in treatment, mom is more likely to seek the help she needs when she needs it and may recover sooner.

Fathers and Other Family Members

Being a spouse or family member, you may be the first to see that something is wrong. Reaching out and helping her get help is a brave and critcal move. You should remember to get some support for yourself in the process of her recovery. She needs you to be strong, understanding, and involved. Here are some helpful suggestions of how best to be a partner in her recovery.

What can I do?

Postpartum Depression Help for Fathers and Family Members

Seeing your wife or loved one suffer can be painful. You may feel helpless and even guilty. But remember, you did not cause this. You cannot fix it. However, there are a few things to keep in mind and some things you can do.

1. Understand and recognize the symptoms. Signs and symptoms of depression after childbirth vary depending on the type of depression. If you are aware of any of these, you can help the mother understand and get help.

Baby blues

Signs and symptoms of the baby blues — which last only a few days or weeks — may include:

- Mood swings
- Anxiety
- Sadness
- Irritability
- Crying
- Decreased concentration
- Trouble sleeping

Postpartum depression

Postpartum depression may appear to be the baby blues at first — but the signs and symptoms are more intense and longer lasting, eventually interfering with the mother's ability to care for her baby and handle other daily tasks. Signs and symptoms of postpartum depression may include:

- Loss of appetite
- Insomnia
- Intense irritability and anger
- Overwhelming fatigue
- Loss of interest in sex
- Lack of joy in life
- Feelings of shame, guilt, or inadequacy
- Severe mood swings
- Difficulty bonding with the baby
- Withdrawal from family and friends
- Thoughts of harming herself or the baby

Postpartum psychosis

With postpartum psychosis — a rare condition that typically develops within the first two weeks after delivery — the signs and symptoms are even more severe. Signs and symptoms of postpartum psychosis may include:

- Confusion and disorientation
- Hallucinations and delusions
- Paranoia
- Attempts to harm self or baby

2. Help her to get help. You can ask your pediatrician, family doctor, ob/gyn, or other person you trust for recommendations. Finding someone you and your wife both trust, and feel comfortable with, is crucial for recovery. You may want to try to find a support group or therapist. If you need help, go to www.postpartum.net.

3. Please be patient. PPD is not something that can be fixed overnight. It may take a few weeks or it may take a few years for your wife to recover and for your family to heal. Your wife or loved one may not be able to do all the things she used to. Some women reject their husbands, children, family, and friends, and still do not realize they have a serious problem. Some women refuse to talk to their husbands and blame them for all their problems. Do not assume she is "over-reacting" or being "unreasonable." In time, and with help, this will pass. Your love and tenderness make a difference.

4. Help your wife or loved one continue treatment even when she starts feeling better. While discontinuing treatment is very tempting once she starts feeling better it can be very dangerous. The chances of relapse are much higher if treatment is stopped too early.

5. Get help for yourself and your family. Let others know you need help and make sure you take care to find a support network for yourself.

6. Be there for your family. You may have to take over other roles in the home. Your wife may not be able to shop, cook, clean, or care for your other children. If you cannot do this on your own, don't be ashamed to ask for help.

7. Know when she is in crisis. If your wife is a danger to herself or others, either take her to the emergency room or call 911.

Fathers and Postpartum Mental Health

Postpartum depression in males has only recently been acknowledged and studied by health professionals. It is important to remember that fathers can experience postnatal reactions too, in connection to their first-born as well as later children.

As for women, the displayed symptoms are individual. Some men may also display symptoms related to specific male depression, often referred to as male depressive syndrome, covert depression or masked depression. These symptoms may also appear in women, but their frequency is higher in men. The reactions can vary from anxiety and depression (and severe crisis-reactions to that anxiety and depression) to thought disorders, and the course of the illness may vary tremendously from person to person.

Research has only recently begun to focus on the father's postpartum reactions and their particular symptoms. In addition, a growing body of research suggests that men are less likely than women to seek professional help. This makes it very important to be attentive to postpartum reactions in fathers and the different symptomatologies. Some fathers' depressions will not be observed if these specific male symptoms are neglected.

Symptoms of depression men may display:

- Lowered stress threshold
- Increase in aggression and outward-reacting behavior, problems with self-control
- Feeling burnt-out and empty
- Irritability, restlessness and frustration
- Denial of problems
- Withdrawal from relationships
- Workaholism
- Refusing to get help
- Feeling left out of the intense mother-infant relationship

Suggestions for communication when screening for Paternal Postpartum Depression

- Be concrete; ask concrete questions.
- Focus on showing sympathy instead of pity. Pity can give a sense of not being in control.
- Let the father decide – help draw up possibilities.
- Some men may prefer down-to-earth and specific information and informative dialogue.

Helpful Links for Fathers and Families:

www.postpartumdads.org
www.postpartum.net
www.postpartummen.com
www.fatherhood.gov
www.menexcel.com

RESOURCES

When giving a resource, it is best to help facilitate that connection. A name and phone number may not be enough to help a woman get the help she needs. Her depression, anxiety, confusion, or low self-esteem may prevent her from following through on any referrals provided to her. A "warm hand off" is a more personal approach. While you may not always be able to "walk her over" to a service, you can phone on her behalf, provide her with an appointment time, give her the name of a direct contact, check in with her to see if she has made that appointment, and finally, follow up with her a few weeks later. We recognize that this is additional work, but we have found that these extra efforts make a significant impact on successful referrals for services.

This section of resources is provided to help you take the next steps in working with a family. Some are related to the topics covered in this toolkit, and some are links and numbers to use to obtain local resources. As we are located in Los Angeles, we have provided resources specific to our area. However, we have included national links as well.

Mental Health Resources and Crisis Hotlines

RESOURCES AND REFERRALS - PHONE OR WEB SUPPORT

General Resources

911- www.211la.org
LACPMHTF - **www.MaternalMentalHealthNow.org**
Postpartum Support International - 800-944-4773 or www.postpartum.net

Special Topics

Adoption
www.adoptivefamilies.com
www.adoptionsupport.org
www.cubirthparents.org
www.adoptionarticlesdirectory.com

Depression
National Depression Hotline: 800-773-6667
www.depressionafterdelivery.com
www.postpartumsupport.com
www.depression-primarycare.org
www.nmha.org
www.womensmentalhealth.org

Dads/Partners
www.postpartumdads.org
www.postpartum.net
www.postpartummen.com
www.fatherhood.gov
www.dad.info/health/your-health/post-natal-depression-dads

Infant Loss
www.marchofdimes.com/baby/loss_miscarriage.html
www.compassionatefriends.org/home.aspx
www.missfoundation.org
www.facesofloss.com
www.cjsids.org
www.firstcandle.org
www.californiasids.com/universal/mainpage.cfm?p=10

Mental Health Resources and Crisis Hotlines

Infertility
www.resolve.org
https://fertility.org/
www.springerlink.com/content/g503t1826jq0737m

Intimate Partner Violence/Domestic Violence
www.domesticviolence.org
www.marchofdimes.com/pregnancy/stayingsafe_abuse.html
www.thehotline.org - 800-799-7233

Medical Provider
www.aafp.org/afp/2002/0915/p1001.html
www.motherisk.org
www.otispregnancy.org
www.mededppd.org
www.psych.org

Military Families
www.postpartum.net/Get-Help/PSI-Support-for-Military-Families.aspx
www.postpartumprogress.com/postpartum-depression-military-wives-army-marines-navy-air-force

Postpartum Depression
www.jennyslight.org
www.postpartum.net - 800-944-4773
www.emedicinehealth.com/postpartum_depression/page15_em.htm
http://labestbabies.org/
www.nlm.nih.gov/medlineplus/postpartumdepression.html
www.perinatalweb.org
2020mom.org

Postpartum Psychosis
www.ncbi.nlm.nih.gov
www.pregnancy-info.net/postpartum_psychosis.html

Mental Health Resources and Crisis Hotlines

Psychotherapy Interventions

Cognitive Behavioral
www.nacbt.org/whatiscbt.htm
Creative Arts
www.nccata.org
www.adta.org
Dialectical Behavior Therapy
http://www.postpartumprogress.com/8-types-of-psychotherapy-for-postpartum-depression-treatment
Dyadic (Mother/Baby)
http://www.lacgc.org
www.projectabc-la.org
www.lachild.org
Emotion Focused Therapy
http://www.iceeft.com
Family Therapy
www.familyaware.org
Group Psychotherapy
www.agpa.org
Infant Mental Health
http://www.projectabc-la.org/
www.ecmhtraining-ca.org
www.lacgc.org
Interpersonal Psychotherapy
www.interpersonalpsychotherapy.org
Psychodynamic Therapy
www. Apa.org/news/press/releases/2010/01/psychodynamic-therapy.aspx

Sexual Health
www.cdc.gov/sexualhealth

Substance Abuse
http://health.nih.gov/topic/pregnancyandsubstanceabuse
www.marchofdimes.com/pregnancy/alcohol_illicitdrug.html
www.mchlibrary.info/pubs/pdfs/subabuse.pdf

Suicide
National Suicide Prevention Lifeline: 800-273-8255
www.suicide.org/postpartum-depression-and-suicide.html
www.psychcentral.com/news/2008/08/07/risk-of-postpartum-suicide/2711.html
www.sprc.org

Teen Pregnancy
www.livestrong.com/article/136548-about-teenage-mothers-depression

Mental Health Resources and Crisis Hotlines

Los Angeles Resources

211 Los Angeles County Information Line: Dial 211 or www.211la.org

ACCESS Line (Los Angeles County Mental Health phone referral service): 800-854-7771

Breastfeeding Task Force of Greater Los Angeles: www.breastfeedla.org

Center for Postpartum Health: www.postpartumhealth.com

Didi Hirsch Community Mental Health Center: 310-390-6612 or www.didihirsch.org

First 5 Los Angeles: www.first5la.org

Healthy Cities: www.healthycity.org

Kedren Community Health Center: 323-233-0425 or www.kedrenmentalhealth.com

Los Angeles Best Babies Network: www.labestbabies.org

Los Angeles County Department of Mental Health, Birth to 5 Program: http://dmh.lacounty.gov/wps/portal/dmh

Los Angeles County Department of Public Health MCAH Programs: www.ph.lacounty.gov

New Moms Connect of Jewish Family Service of Los Angeles: 323.761.8800 or www.jfsla.org

Pathways: www.pathwaysla.org

PHFE-WIC: www.phfewic.org

Project ABC/Children's Hospital/USC Keck School of Medicine: www.projectabc-la.org

Queens Care Health and Faith Partnership: www.queenscare.org

Suicide Prevention Resource Center: 800-784-2433 or 310-391-1253 or www.sprc.org

Zero to Three: www.zerotothree.org

CITATIONS

Photography Credits

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Gabrielle Kaufman, pp 17,71,77,81,87
Linda Ko Photography , pp. 113, 140:
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First 5 LA www.first5la.org
Ivy & Osborn www.ivyandosborn.com
Jewish Family Service of Los Angeles www.jfsla.org
Junior Leagues of California /SPAC www.jlla.org
LA Best Babies Network www.labestbabies.org
LA County Department of Mental Health http://dmh.lacounty.gov/wps/portal/dmh
LA County Department of Public Health MCAH Programs www.ph.lacounty.gov
LA Unified School District--School Mental Health Services www.lausd.net
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Para Los Ninos www.paralosninos.org
Pathways www.pathwaysla.org
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Project ABC/Children's Hospital/USC Keck School of Medicine www.projectabc-la.org
Postpartum Support International (PSI) www.postpartum.net
Queens Care Health & Faith Partnership www.queenscare.org
UCLA Health Services Research Center UCLAhealth.org
UCLA, School of Public Affairs www.publicaffairs.ucla.edu
USC-Eisner Family Medicine Clinic https://keck.usc.edu/family-medicine/about-family-medicine/
Welcome Baby
Zero to Three www.zerotothree.org

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supporting the well-being of growing families

A Project of Community Partners

In-person training is also available. For more information visit us online at www.maternalmentalhealthnow.org

Los Angeles, California
www.maternalmentalhealthnow.org