

# PEACE FOR MOMS



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# WHO IS AT RISK OF PERINATAL DEPRESSION?



## 1 in 7

women will develop pregnancy related symptoms of depression, anxiety or psychosis.

**50%**  
to  
**85%**

will experience symptoms of  
**BABY BLUES.**

**2%**  
to  
**3%**

will display symptoms of  
**BIPOLAR DISORDER.**

## WHO IS AT GREATER RISK?

- Personal history of a mood disorder or anxiety
- Family history of a mood disorder or anxiety
- Lack of social support (single mother, geographically isolated)
- Low socioeconomic status
- History of trauma including birth trauma
- Current domestic violence and/or relationship discord
- Multiple births
- Chronic medical illness

# SCREENING THE PATIENT - WHEN AND HOW

## WHEN TO SCREEN

### During Pregnancy

- Initial Visit
- Visit following the Glucola Test

### Post-Partum

- High risk patient:  
Two weeks postpartum
- All patients: 6 weeks postpartum
- 8-12 weeks postpartum
- 9-12 weeks postpartum



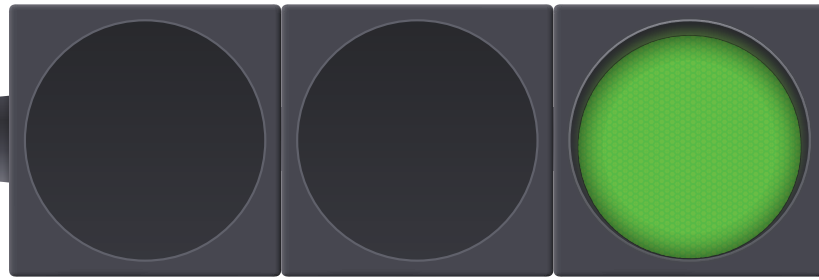
## HOW TO SCREEN

- Acknowledge that your practice screens all women for mood and anxiety disorders while pregnant
- Explain that emotional complications are very common during pregnancy and after birth
- In a private space, have the clinical staff share the Edinburgh Postnatal Depression Screen (EPDS) with patient

## WHY SCREEN

- 1 in 7 women experience depression, anxiety or frightening thoughts during this time
- Depression is twice as common as diabetes and it often happens for the first time during pregnancy or after birth
- These emotional symptoms impact women and their babies
- The Edinburgh Postnatal Depression Screen (EPDS) is a brief survey of the patient's thoughts and mood symptoms

# INTERPRETING EPDS SCORES 8 AND LOWER



An EPDS score of 8 or lower suggests the patient is NOT DEPRESSED and their current level of functioning ought to be supported.

Options include observation and support.

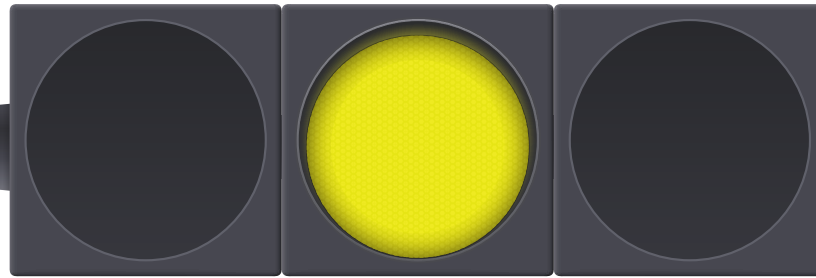
## Patient Reports

- Occasional sadness
- Some inner tension
- Generally content
- Normal appetite, sleep and personal hygiene
- Good concentration and motivation
- Enjoying social interactions
- Good self esteem
- Improvement with rest or sleep
- NO SUICIDAL IDEATION
- NO PSYCHOTIC SYMPTOMS

## Treatment Options

- Support and education
- Address difficulty infant may be having with sleep, colic or feeding
- Emphasis on self care, i.e., sleep, diet, rest
- Dietary supplements such as Omega 3 Fatty acids
- Complimentary/Alternative therapies
- Community and social support
- Support groups and peer counseling

# INTERPRETING EPDS SCORES 9-13



An EPDS score between 9 and 13 suggests the patient may be **MILDLY DEPRESSED** and comorbid illnesses must be considered:

Psychiatric - Substance Abuse, Anxiety, PTSD

Medical - Anemia, Thyroid Disorder, Infection

Intervention and close follow-up may be helpful

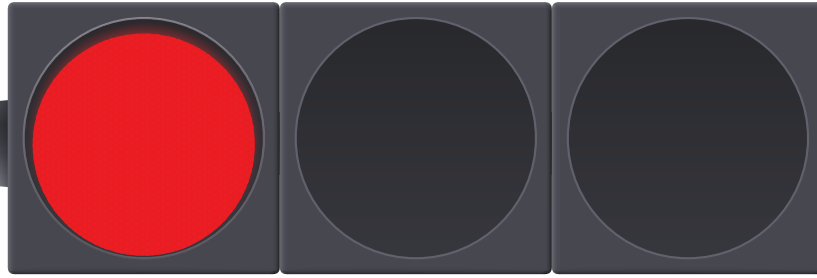
## Patient Reports

- Mild apparent sadness but brightens easily
- Feelings of edginess and inner tension
- Problem staying or falling asleep
- Reduced appetite
- Difficulty concentrating
- Difficulty motivating self
- Less interest in being with friends, family
- Feels inferior or inadequate
- Angry outbursts, mood swings
- FLEETING SUICIDAL IDEATION

## Treatment Options

- Consider medication
- Psychotherapy for mother (i.e., “talk therapy” or counseling)
- Support and education
- Address difficulty infant may be having with sleep, colic or feeding
- Emphasis on self care, i.e., sleep, diet, rest
- Community and social support
- Support groups and peer counseling

# INTERPRETING EPDS SCORES 14-18



An EPDS score between 14 and 18 suggests that the patient is **MODERATELY DEPRESSED**, with high suspicion for comorbid psychiatric or medical illness.

Psychiatric - Substance Abuse, Anxiety, PTSD

Medical - Anemia, Thyroid Disorder, Infection

Observation and close follow-up are recommended

## Patient Reports

- Pervasive feelings of sadness or tearfulness
- Continuous tension
- Persistent anxiety and episodic panic
- Sleep reduced by two or more hours, multiple prolonged awakenings, early morning waking
- Feelings of inadequacy or self-hatred
- Hopelessness or despair
- Reduced appetite
- Poor motivation, concentration
- Withdrawal from friends and family
- Angry outbursts or mood swings
- POSSIBLE SUICIDAL IDEATION
- NO PSYCHOTIC SYMPTOMS

## Treatment Options

- Medication recommended
- Inpatient hospitalization should be considered if there are concerns for safety
- Partial hospitalization or day program may be appropriate
- Short term follow-up appointment
- Support and education
- Address difficulty infant may be having with sleep, colic or feeding
- Emphasis on self care, i.e., sleep, diet, rest
- "Talk" therapy - psychotherapy, counseling, group therapy

# INTERPRETING EPDS SCORES 19 OR HIGHER



An EPDS score of 19 or higher suggests that the patient is **SEVERELY DEPRESSED**, with high concern for self harm or suicide. These patients are very likely to have comorbid psychiatric illness and potential medical illness:

Psychiatric - Substance Abuse, Anxiety, PTSD

Medical - Anemia, Thyroid Disorder, Infection

Intervention and close follow-up necessary

## Patient Reports

- Pervasive feelings of sadness, gloominess, or hopelessness
- Continuous tension, intermittent panic
- Sleep reduced by two hours, multiple prolonged awakenings or early morning waking
- Poor appetite or unplanned weight loss
- Difficulty concentrating
- Difficulty initiating tasks and activities
- Loss of interest in being with friends, family
- Overwhelming feelings of inadequacy and self-hatred
- **SUICIDAL THOUGHTS ARE COMMON**
- **NO PSYCHOTIC SYMPTOMS**

## Treatment Options

- Engage patient and family in safety planning, awareness of patient's needs
- Medication recommended
- Inpatient hospitalization if there are concerns for safety
- Partial hospitalization or day program may be appropriate
- Short term follow-up appointment
- Support and education
- Address difficulty infant may be having with sleep, colic or feeding
- Emphasis on self care, i.e., sleep, diet, rest
- "Talk" therapy - psychotherapy, counseling, group therapy



## SUICIDE RISK ASSESSMENT

A positive response on question 10 [of the EPDS] suggests the patient is **SEVERELY DEPRESSED** and may be at risk of self-harm or suicide and further assessment is necessary

1. In the past two weeks, how often have you thought of hurting yourself or ending your life?
2. Have you ever attempted to hurt yourself in the past?
3. Have you made any plans or taken action to prepare to kill yourself?
4. Do you have access to a gun?

*Document assessment and plan in the medical record including the factors below*

### The Protective Factors

Positive self esteem  
Problem solving skills  
Community connection  
Financial security  
Positive relationships to family, friends  
Cultural, religious proscription against suicide

### The patient with LOWER risk

No prior attempts  
No plan  
Non intent  
No substance use  
Has protective factors  
Able to name reasons for being alive or not acting on suicidal thoughts

### The patient with HIGHER risk

History of suicide attempt  
High lethality of prior attempts  
Current plan  
Current intent  
Substance use  
Access to lethal means  
Lack of protective factors

# TALKING TO MOMS ABOUT DEPRESSION OR ANXIETY

## **Offer your patient an opening to bring up her emotional state:**

- How are you feeling about being pregnant / a mother?
- What things are you most happy about?
- What things are you most concerned about?
- Do you have anyone you can talk to that you trust?
- How is your partner doing?
- Are you able to enjoy your baby?
- Do you worry about your baby's safety?
- Are you having thoughts or experiences that you find frightening?



## **Patients may not identify as depressed and instead use words or phrases such as:**

- I'm feeling overwhelmed
- I'm having a hard time
- I've been having a lot of bad days
- I'm really stressed / frustrated right now

## **Normalizing the experience can help:**

- This is really tough
- You're dealing with a lot
- It's difficult when you have so much going on
- Many moms feel overwhelmed / frustrated / sad in these situations

# IDENTIFYING POST PARTUM PSYCHOSIS

## POST PARTUM PSYCHOSIS: A RARE EVENT, BUT A PSYCHIATRIC EMERGENCY.



Many women experience intrusive thoughts post partum. These thoughts may be driven by, but also worsen, anxiety and depression. Intrusive thoughts (sometimes referred to as obsessions) are thoughts, images or phrases that are difficult to avoid or dismiss. Many times these intrusive thoughts focus on the mother harming her child. Differentiating intrusive thoughts from psychosis is important.

### **Patient with intrusive thoughts:**

- Finds thoughts to be inappropriate or wrong
- Has no visual or auditory hallucinations

### **Patient with post partum psychosis**

- Does not consider thoughts to be inappropriate or wrong
- Poor insight (Delusional beliefs, distortion of reality, paranoia)
- May present with visual or auditory hallucinations
- Has increased risk of harming child based on their delusions or hallucinations

### **ASK YOUR PATIENT:**

- Are you experiencing problematic thinking?
- Are you having thoughts or experiences which you find frightening?

# CONSIDERATIONS FOR PRESCRIBING MEDICATION

## Medications may not be indicated

- Mild depression per clinical assessment (EPDS  $\leq 8$ )
- No suicidal ideation
- Engaged in psychotherapy or other treatment
- Symptoms have improved in past with psychotherapy
- Able to care for self and family as required
- Strong preference for psychotherapy

## Medications should be strongly considered

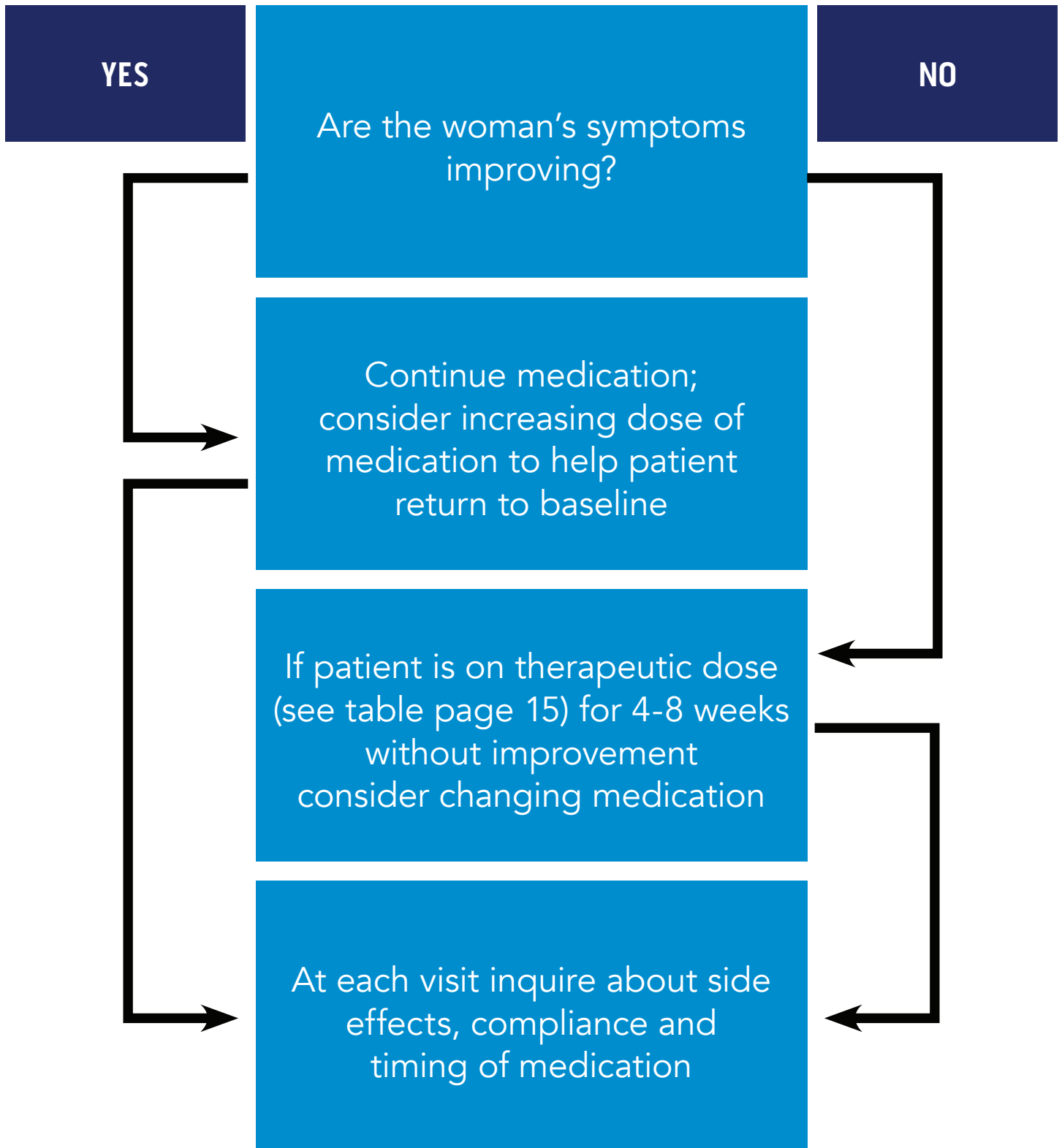
- Moderate to severe depression per clinical assessment (EPDS  $\geq 9$ )
- Suicidal ideation
- Impaired ability to care for self or family
- Current or prior history of severe depression
- Current or prior suicide attempts or ideation
- Comorbid anxiety diagnosis or symptoms

## Consider urgent psychiatric consult

- Patient is reporting active hallucinations
- Expresses clearly delusional beliefs
- Reports suicidal ideation with a plan or intent to harm self
- Reports ideation with a plan or intent to harm their baby

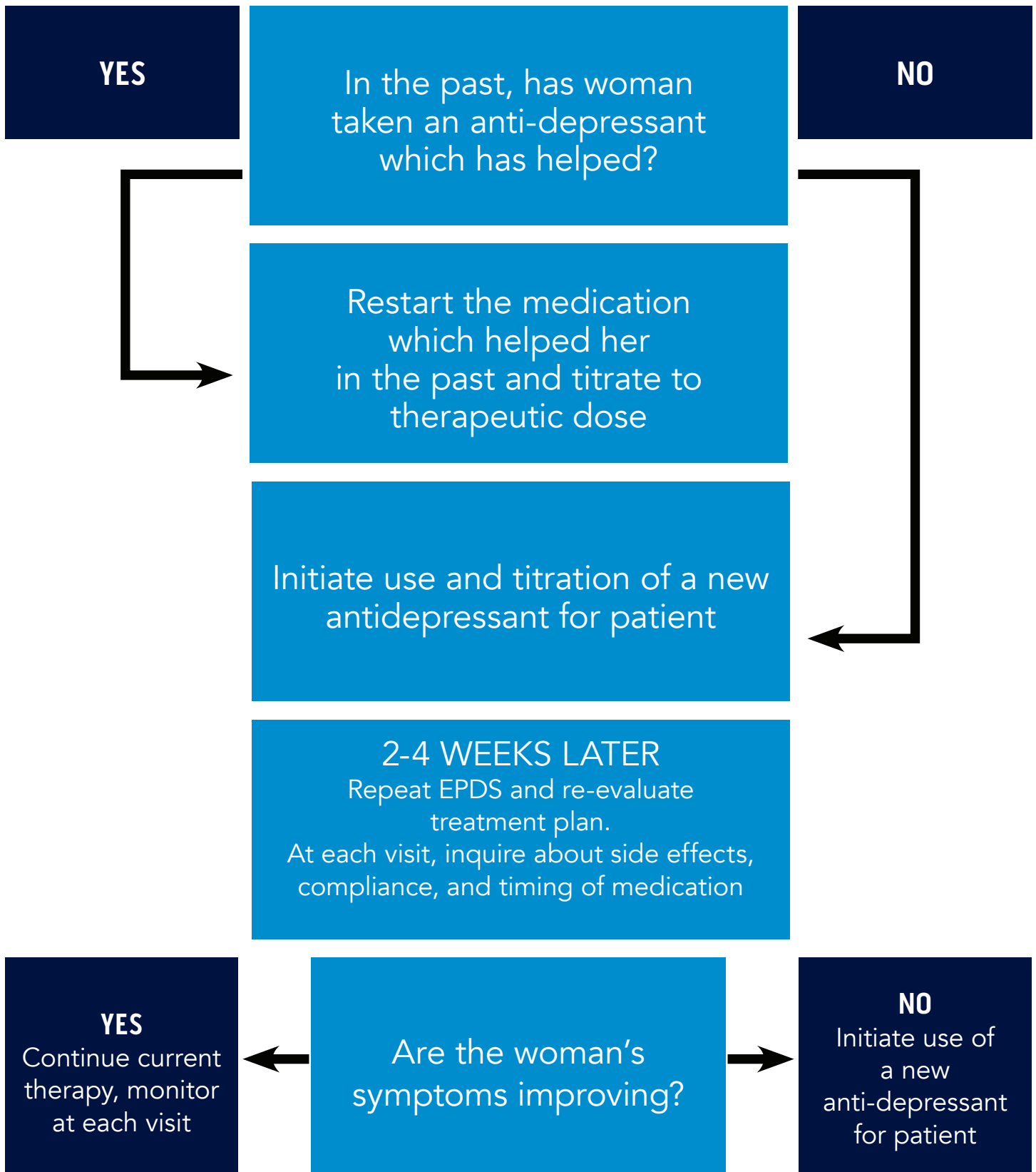
# ANTI-DEPRESSANT TREATMENT ALGORITHM

FOR THE WOMAN CURRENTLY TAKING ANTI-DEPRESSANT



# ANTI-DEPRESSANT TREATMENT ALGORITHM

## FOR THE WOMAN NOT CURRENTLY TAKING ANTIDEPRESSANT



# MEDICATIONS

Medication	Starting Dose	How to Increase <sup>¥æ</sup>	Therapeutic Range	Side Effects
Sertraline <sup>‡</sup> (Zoloft)	25 mg	Increase to 50 mg after 4 days. Increase to 100 mg one week later.	50-200 mg	<b>TEMPORARY</b> Nausea Constipation Diarrhea Unsteady Groggy Headaches Dizziness Dry Mouth Vivid Dreams  <b>PROLONGED</b> Weight Gain Increased Appetite Low Libido Anorgasmia Insomnia
Fluoxetine (Prozac)	10 mg	Increase to 20 mg after one week.	20-40 mg	
Citalopram (Celexa)	10 mg	Increase to 20 mg after one week.	20-40 mg	
Escitalopram (Lexapro)	5 mg	Increase to 10 mg after one week.	10-20 mg	

- Most side effects will subside within a few days and can be addressed with minor changes.
- If patient is having intolerable side effects and not improving, change anti-depressant.
- If patient has not improved or has adverse side effects on two or more SSRI, recommend change medication class. Please call PEACE for MOMS for guidance.

<sup>‡</sup> Considered to be safer alternative in lactation. However, if woman has done well on other anti-depressant recommend that you do not switch.

<sup>¥æ</sup> If the patient has demonstrated no or minimal improvement and has minimal side effects dose should be increased.



# PEACE for MOMS

Perinatal Psychiatry Education Access and Community Engagement for Georgia



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